Commonwealth Fund Medicare Drug Negotiation Prices International Comparison Rebuttal

The Commonwealth Fund's report, "How Prices for the First 10 Drugs Up for U.S. Medicare Price Negotiations Compare Internationally," seeks to compare the U.S. prices of the drugs selected through the 2022 Inflation Reduction Act to the prices in seven OECD countries (Australia, Canada, France, Germany, Japan, Switzerland, United Kingdom). The authors suggest these international prices should be used as an affordability benchmark in the negotiation process. However, setting medicine prices based on the policies and practices in other countries would upend our system without addressing the broader challenges facing American health care – thereby sacrificing patient access to medicines, jobs and future medical innovation. It is the opposite of the competitive environment needed to expand patient access, improve affordability, and encourage investment in the next generation of treatments and cures.

American patients have access to new medicines, including the ones selected in 2022 by the Inflation Reduction Act (IRA), earlier than patients in other countries.

- On average, 85% of new medicines are covered in the Medicare and Medicaid programs, compared to 40% in the public health insurance programs across the seven OECD comparator countries used in the report. In addition, patients in these seven countries wait 2.5 years longer, on average, for public program access.[i]
- Seven of the 10 medicines selected through the IRA were available in the United States within one year of first global launch, compared to only three medicines, on average, for the other countries included in the study.
- On average, the 10 medicines launched a year-and-a-half later in the seven OECD countries than in the United States. Additionally, patients in several of these countries often experience even longer access delays because the national public insurance programs take additional time to decide whether all approved uses of the medicine will be covered and for whom.
- The restricted access policies we see in other countries would have a detrimental impact on U.S. patients. For example, one study shows that if Americans diagnosed with metastatic non-small cell lung cancer – the most common form of lung cancer – had the lower levels of access seen in Australia, Canada and France, then the aggregate survival gains in the United States during 2006-2017 would have been cut in half.[ii]

Other governments' determination of the value of medicines is an inappropriate metric for American patients and the U.S. coverage and reimbursement system.

- Referencing prices set by other governments in effect imports their reimbursement decisions, which are often based on discriminatory methods that could limit access for the disabled, the chronically ill and seniors. Patients and persons with disabilities have repeatedly pointed out the harms that could arise from importing these standards[iii] and that such policies could violate existing protections against reliance on such metrics in Medicare.[iv]
- Referencing prices set by other governments ignores differences in the standard of care and the costs of alternative treatments across countries. In addition, prices in other countries are often a result of more limited funding for their public health insurance programs.
- The Commonwealth Fund comparison overlooks the deeply discounted prices manufacturers provide to Medicaid and the 340B program through statutory rebates. Economists have further noted that these deep discounts may lead to higher prices for patients and the U.S. health care system as a whole.[v]
- Low government-set prices in these seven OECD countries does not demonstrate that the U.S. could similarly set prices without reducing innovation. Harmful government-pricing policies in these smaller seven OECD markets have a much smaller impact on global innovation than if the United States adopted these policies.

The IRA is not "negotiation," it is price setting, and it threatens patient access now and in the future.

- There is no harmless way for the government to interfere in existing private Medicare prescription drug negotiations that already occur between manufacturers and health plans.
- The Congressional Budget Office has repeatedly said government interference in private negotiations will only produce savings for Medicare if the government removes patient protections and/or restricts access, establishes a national formulary and/or excludes medicines from coverage, or if prices are set by the government.[vi]
- Analysts have noted that Medicare Part D patients could lose access to the medicines they are currently taking and be forced to switch to products the government prefers under the IRA.[vii] With utilization management techniques like step therapy and prior authorization applied broadly across plans to favor the medicines that are price-set under the IRA, the opportunity for patients to access certain medicines in Medicare Part D could essentially vanish.

Efforts to import international prices to the United States are not unlike state-run importation schemes, which have consistently failed to show any savings to patients.

- Numerous states are trying or have tried to import drugs over the years, but the supposed savings continues to be a mirage.
    - For example, the state of Wyoming conducted a study considering drug importation and concluded much of the potential saving would be kept by pharmacies and insurers, rather than patients, and that Canadian export controls could quickly make the policy unsustainable.
- According to the Congressional Budget Office, importation through Canada, which is currently being pursed in Florida, "would produce a negligible reduction in drug spending." These savings would likely be quickly eclipsed by the numerous direct and indirect costs that would stem from importation schemes.
- Canadian officials have said that U.S. drug importation is unworkable, could lead to shortages for Canadian patients, and even issued an order prohibiting the export of medicines if the distribution would cause or exacerbate a drug shortage in Canada.
    - According to a study published in the Canadian Pharmacists Journal, Canada's drug supply would be exhausted in 224 days—less than eight months—if just 10% of U.S. prescriptions were filled with Canadian drugs.
    - Drug importation is simply not a policy solution. Canada has about one-tenth the population of the United States with 40 million people. Given the sheer magnitude of the U.S. population, Canada cannot supply medicines for Americans.

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[i] PhRMA, Global Access to New Medicines Report. April 2023. Available at: https://phrma.org/en/resource-center/Topics/Access-to-Medicines/Global-Access-to-New-Medicines-Report

[ii] IHS Markit. Comparing Health Outcome Differences Due to Drug Access: A Model in Non-Small Cell Lung Cancer. December 2018. Available at: https://ihsmarkit.com/research-analysis/populationhealth-outcomes-american-patients.html.

[iii] National Council on Disability. Quality-Adjusted Life Years and the Devaluation of Life with Disability. November 2019. Available at: https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf

[iv] Social Security Act § 1182(e).

[v] Conti R, Bach P. Cost Consequences of the 340B Drug Discount Program, *JAMA: The Journal of the American Medical Association*, 2013;309(19):1995-1996. doi:10.1001/jama.2013.4156.

[vi] Congressional Budget Office Letter to the Hon. Ron Wyden, April 10, 2007, CBO Letter to Hon. Max Baucus, CBO Letter to the Hon. Chuck Grassley, May 17, 2019

[vii] Hayden Consulting Group commentary on impact of H.R. 3. (2021) https://www.haydencg.com/post/controlling-competition-the-impact-of-government-pricecontrols-on-competition-and-the-market-1; https://www.haydencg.com/post/controlling-competition-the-impact-of-government-price-controls-oncompetition-and-the-market-2; https://www.haydencg.com/post/controlling-competition-the-impact-of-government-price-controls-on-competition-and-themarket-3.