



Getting Medicare right

December 17, 2018

VIA ELECTRONIC SUBMISSION

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4187-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Drug Pricing Transparency

Dear Administrator Verma:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the **Medicare and Medicaid Programs; Regulation to Require Drug Pricing Transparency (CMS-4787-P)**. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year.

While Medicare Rights appreciates the Centers for Medicare & Medicaid Services (CMS) turning its attention to drug pricing, we feel this transparency proposal will have at best little effect, at worst significant negative effect, while making no progress in the real barrier to affordability—high prescription drug prices. People with Medicare struggle to afford drugs not because they are not smart shoppers but because drug prices are astronomical. No amount of savvy comparison shopping can make a \$100,000 medication cost \$10.

CMS states that people with Medicare or Medicaid need more pricing information to make informed decisions about their prescription drugs. Therefore, CMS proposes to require prescription pharmaceutical direct-to-consumer (DTC) television ads to include list prices for the products being advertised. By doing so, CMS hopes to reduce the out-of-pocket costs borne by the beneficiaries as well as reducing the costs to the Medicare and Medicaid programs.

In explaining this proposal, CMS identifies price shopping as the mark of rational economic behavior, stating that consumers need to be able to gauge the reasonableness of stated prices against alternatives. Historically, drug advertisements lack such price disclosure, where ads for cars, other consumer products, or services like cell phone contracts include them. However, there are several important elements of price disclosure in other markets that would be missing from the market for prescription drugs and biologics.

First, the drug prices that would be included in ads would not reflect the actual cost of the drug to the consumer. Other consumer ads include an approximation of the actual cost of the goods or services represented in the advertisement. There may be some confusion about which features are included for the price, and savvy shoppers may be able to find a discount at a given retailer, but generally the advertised price will have some close relationship to the price the consumer would actually pay. This is not true for the “list price” for pharmaceuticals, where the cost to the consumer is related to the list price but not directly discernible.

Second, car ads, to use one example, show consumers classes of vehicles they are largely familiar with: trucks, SUVs, sedans, sports cars, etc. Compare this to prescription medications such as Jardiance. Jardiance is one of several drugs that are Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors—a fact that is not likely apparent to most ad viewers and, in all likelihood, to most people who are current users of Jardiance. Comparing drugs across classes is not necessarily useful and comparing within classes is impossible if the classes are not known. This is even more complex for some drugs and biologics which have no direct competition within a class, or where the mechanism by which the drug works is unique. For consumers to make use of pricing information, they must have a price that is at least somewhat accurate and a medical context within which to compare alternatives. Both of these are missing in the proposed drug pricing disclosure.

CMS acknowledges that third-party payment causes an absence of meaningful prices but offers no mechanism to provide such meaningful prices. The list price does affect the out-of-pocket cost to consumers but cannot be a substitute for providing those actual costs. It is akin to advertising not the cost of a car but the cost of wages in the manufacturer’s factory; the costs are related, but the average consumer is not likely to be able to extrapolate effectively.

CMS points out that increases in the list price for pharmaceuticals are driving increases in out-of-pocket costs, and the shift from copayment to coinsurance contributes to this increase. High-cost medications, which are often the most advertised, are especially likely to have high coinsurance on non-preferred formulary tiers. But the reliance this proposal places on public scrutiny and outcry appears to ignore the years of public scrutiny and outcry that have already occurred with little change in the trajectory of drug pricing. Public shaming has not been an effective strategy for reducing drug costs and there is little reason to expect it to increase in efficacy when coupled with drug ads that they can quickly, and honestly, say paint an inaccurate picture of drug pricing.

CMS shows that DTC advertising plays a large role in drug utilization and that consumers who see drug ads may be more likely to pursue a prescription of that drug. This can lead to consumers increasing utilization of the drugs that are more widely advertised—often new or expensive drugs—which means an increase in their costs and the costs for their insurer, including

Medicare. CMS proposes that more pricing transparency would affect not only the out-of-pocket costs for the individual but also the Medicare and Medicaid programs.

Again, however, this overlooks the bare fact that drug prices, no matter how carefully compared and shopped for, are simply too high. Instead of tackling the underlying problem, CMS is attempting to shift the burden for spending onto the backs of consumers—the people with the least information about the value of drugs, the least ability to directly compare drugs, and the least ability to directly affect pricing. If a car’s price is too high, the solution for the consumer is to refrain from buying the car. If a drug’s price is too high, a patient who will otherwise suffer, or even die, cannot be expected to simply forgo the medication in order to save Medicare money. They may be forced to forgo the drug if they cannot afford the out-of-pocket costs, but this is a tragedy, not a strategy for lowering prices.

CMS acknowledges that few people use current tools like shopping through online pharmacies and states that physicians rather than patients control the writing of the prescription and know what drug is being prescribed. It is precisely this fact that makes reliance on consumer shopping so futile. While consumers may ask about certain drugs, they are not the gatekeepers for medication access. They are also not pharmaceutical experts but must rely on the expertise and training of professionals in their fields.

CMS seeks input on how providing the list price of medications may influence interactions with prescribers and acknowledges that consumers may be intimidated by the high prices. Medicare Rights has serious concerns that eye-popping list prices will serve to frighten consumers away from seeking treatment for serious conditions or illnesses. Without true context for the prices, few consumers would understand that a drug with a list price of tens of thousands of dollars may still be affordable under some circumstances. Providing consumers with their actual out-of-pocket costs would be a vital counterbalance for list price disclosures, but this proposal does not include mechanisms for conveying that information.

CMS seeks input on three additional measures that could support price transparency and informed decision making: 1. An enhanced CMS drug pricing dashboard; 2. A new payment code for drug pricing counseling; and 3. Intelligent plan selection or use of intelligent assignment. Each of these could provide important information for consumers and family caregivers who are researching drug prices for needed medications. Any such measures must ensure consumer rights are protected without increasing consumer burden, and an over-reliance of consumer shopping is fundamentally flawed when the underlying problem is not shopping but sky-high and rapidly escalating prices for drugs consumers may need to survive.

Fundamentally, this proposal is based on the assumption that consumers who need a medication should shop their way to massive discounts or be frightened, shamed away, or priced out of using expensive drugs. It is an attempt to place the burden, and the blame, for high drug prices on a failure of consumers.

It is vital that CMS explore the true cause of high drug prices rather than ask consumers to shop their way to savings. While transparency is an inherent good, being “transparent” with inaccurate and likely misleading information is not true transparency. For this reason, we do not support the

requirement that drug advertisements include a list price that will do little to increase consumers' ability to assess the drug's value, out-of-pocket cost, or appropriateness.

Thank you again for this opportunity to comment. We look forward to working together to advance policies that truly reduce drug prices to the benefit of both beneficiaries and the Medicare and Medicaid programs. Such policies cannot rely on shopping or on simply shifting burdens between entities. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

A handwritten signature in black ink, appearing to read "Joe Baker". The signature is fluid and cursive, with a large loop at the end of the last name.

Joe Baker
President
Medicare Rights Center