

December 21, 2018

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-5528-ANPRM
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-5528-ANPRM, Medicare Program; International Pricing Index Model for Medicare Part B Drugs

Dear Administrator Verma:

On behalf of all people who are impacted by primary immunodeficiency diseases, the Immune Deficiency Foundation (IDF) appreciates the opportunity to submit comments on the advanced notice of proposed rulemaking (ANPRM) on potential options for testing changes to payment for certain separately payable Part B drugs.

Background on Primary Immunodeficiency Diseases

Primary Immunodeficiency diseases (PI) are a group of more than 350 rare, chronic genetic disorders in which part of the body's immune system fails to function properly, and in the most severe cases, at all. Because of their condition, individuals with PI are far more susceptible to infections from even relatively modest viruses. People with PI are fortunate to have an effective treatment in immunoglobulin (Ig) replacement therapy, which is derived from human plasma collected at plasma donation centers and that undergoes a rigorous purification process before being developed into treatments. Regular, lifelong Ig treatments restore the antibodies the body is unable to produce and allows a person with PI to live a full life.

Proposed International Pricing Index Model

As outlined in the advanced notice, the purpose of the International Pricing Index (IPI) model demonstration is to improve care for beneficiaries and reduce expenditures. IDF and the PI community appreciate the agency's efforts in this area and recognizes the burden of cost to patients. We are eager to see what is in the proposed rule but remain cautious about any potential consequences that could limit beneficiary access to life-sustaining Ig therapies. We also would like to highlight that in the analysis of average drug costs released by the Department of Health and Human Services concurrent with the ANPRM, an Ig product stood out as being less-expensive in the United States than in other countries. Specifically, the October 2018 report entitled *Comparison of U.S. and International Prices for Top Medicare Part B Drugs by Total Expenditures*, released by the Assistant Secretary' for Planning and Evaluation (ASPE), stated that "one of the products for which this is not the case is an IVIG [intravenous

immunoglobulin] product.”¹ One IVIG drug was found to have a lower cost than the average international price ratio.² The report also notes that “specific brands of IVIG drugs are not uniformly available in each country.” This could mean that individuals with PI randomly selected to be part of the demonstration may be limited to preferred Ig products that could be different from the product prescribed to them by their physician. This could put people at risk of significant allergic reactions or of having to receive treatments that are less effective for them. While the ASPE analysis notes that Ig therapies may be less costly in the United States compared to other nations, this does not in any way mean that they are not expensive. In fact, many patients on Ig medications often meet their deductible requirements in the first month of the year, and thus cannot afford any additional expenses.

Production of Ig Therapy is Uniquely Complex

Unlike other pharmaceuticals, the collection and production of plasma based therapies including Ig replacement therapy is very complex and therefore costly. Ig is prepared from the plasma collected from a large number of individuals, usually between 10,000-50,000, who have been carefully screened to make sure they are healthy and do not harbor certain infectious diseases. In order to ensure an adequate supply, donors in the United States are compensated for their donations. The plasma contains a broad range of specific antibodies to many different types of bacteria and viruses. To prepare the Ig for treatment, the immunoglobulin must be extracted from the plasma through a process called plasmapheresis at centers specifically designated for this purpose. The immunoglobulins are then chemically purified from the plasma in a series of steps. The final Ig product contains highly purified plasma IgG that has a broad range of specific antibodies to many types of bacteria and viruses.³ From start to finish, manufacturing process takes 7 to 12 months. Fifty-seven percent of the cost of Ig and other plasma based proteins is attributed to manufacturing and raw materials as compared to only 14 percent that other pharmaceuticals expend.⁴

Because of the high cost of production and the dependence on live donors, the international price of Ig products has been comparable to or, in one case, higher than the price in the United States. As a result, the IPI pricing model will not drive down the out-of-pocket costs for patients. Including Ig drugs in the IPI pricing model demonstration could create unnecessary or additional costs for patients and hinder access to the specific Ig therapy that was prescribed by the patient’s physician. We want to ensure that this proposal does not result in Ig products being more expensive for Medicare beneficiaries with PI. To prevent this from occurring, we are requesting that CMS exempt plasma protein therapies from the IPI Model demonstration.

Full Access to All Therapy Options is Necessary

Another concern is the need to ensure that individuals with PI have access to all available products, sites of care and modes of administration. Ig is administered to PI patients in two ways: subcutaneously (SCIG) or intravenously (IVIG). The most recent data from our patient surveys estimates that 70 percent of those diagnosed with PI are being treated with Ig, and of

¹ Report available at

<https://aspe.hhs.gov/system/files/pdf/259996/ComparisonUSInternationalPricesTopSpendingPartBDrugs.pdf>

² The 2018 ASPE report noted that the US prices for Gammagard, an IVIG product, “were lower than the average international price ratio.” p. 9

³ Immune Deficiency Foundation, Patient and Family Handbook, 2015, p. 149

<https://www.primaryimmune.org/plasma-partners-program>

⁴ Plasma Protein Therapeutics Association data 2018; available at <https://www.pptaglobal.org/ipaw/media-center>

those, approximately 60 percent use SCIG and 40 percent use IVIG.⁵ Medicare beneficiaries may receive IVIG in hospitals, infusion centers or physician offices or may infuse at home through the Medicare IVIG demonstration project. Beneficiaries with specific PI diagnoses may receive SCIG under Part B coverage and others may receive it, with significant co-pays, under Part D. It is essential that the decision as to what form of treatment an individual receives is determined by the individual with PI and his or her physician. This includes ensuring choice of specific Ig products since these and other plasma protein therapies are non-interchangeable biologics which cannot be swapped for non-medical reasons without the risk of adverse health outcomes for patients.⁶

There are benefits and side effects for each type of treatment and only a patient and their physician can determine what is best for them. Even decisions as to whether to infuse at home or at a facility is very individualized. For one person, the convenience of home infusions will ensure better compliance and improved outcomes and for another, getting infusions in a healthcare setting will provide the support the person needs to be successful. A proposed model that may limit choice regarding product or mode of administration for Ig therapy would be problematic for people with PI who need to have all choices of treatments available to them to ensure the best outcomes.

People with PI Rely Upon an Adequate Plasma Supply

Because of the reliance on donated plasma, the market for Ig and other plasma protein therapies are susceptible to supply constraints. In addition, these therapies are used to treat rare disorders including PIs and therefore, unlike other products, manufacturers are generally not able to find savings through bulk production. A recent analysis on key economic and value considerations in the U.S. market for plasma protein therapies predicts that “price controls would result in shortages for these lifesaving products.”⁷ IDF is aware of plasma shortages that have affected people with PI in other countries and is highly engaged in advocacy to guard against plasma shortages in the United States. We are concerned that utilizing reimbursement rates based on foreign prices could negatively affect the supply of plasma protein therapies which in turn will impact access to Ig therapy for the PI community.

Proceed with Caution on Implementing Revised Purchasing Models

In addition to the concerns outlined above, we note that the ANPRM proposes a drug distribution model that was briefly implemented a decade ago. We appreciate the department’s interest in exploring innovative solutions including changing the system that currently requires doctors to purchase and take custody of Part B drugs. There is potential value in a reform that would remove this burden from physicians, however, given the failure of a similar model in the past, we urge the department to proceed with caution and ensure that any similar proposal addresses the deficiencies from the prior model.

Ultimately, IDF is concerned that people with PI could lose access to some Ig therapies if providers are unable to contract with a sufficient supply of qualified vendors. Because Ig drugs

⁵ Immune Deficiency Foundation (2018). IDF 2017 National Patient Survey [PowerPoint slides].

⁶ To be interchangeable, a biologic product must be “expected to produce the same clinical result as the reference product in any given patient” and “the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alteration or switch.” Sections 351(k)(4)(A) and 351(k)(4)(B) of the Public Health Services Act

⁷ Grabowski, H., & Manning, R. (2018). *Key economic and value considerations in the U.S. market for plasma protein therapies*. Washington, DC: Bates White at 23.

are formulated differently, and because there are over 350 types of primary immunodeficiency diseases, the type of Ig drug prescribed to people with PI frequently varies. This unique nature of our community further reinforces our primary request that the department exclude Ig products from the initial model.

Conclusion

IDF appreciates the administration's interest in addressing drug pricing and related access issues, and wants to ensure that any of these proposals do not negatively impact the ability of patients to obtain the treatment recommended by their physicians. We thank the agency and the larger department for assembling this proposed rule and hope you will take our thoughts into consideration as you finalize the proposal and consider additional actions. IDF looks forward to working with the agency, and we are pleased to serve as a patient focused community resource.

If you have any questions, please contact Lynn H. Albizo, Senior Director of Public Policy at lalbizo@primaryimmune.org.

Sincerely,

A handwritten signature in blue ink that reads "John G. Boyle". The signature is written in a cursive style with a large initial "J".

John G. Boyle
President & CEO