April 22, 2021

Speaker of the House Nancy Pelosi
U.S. House of Representatives
H-222, The Capitol
Washington, D.C. 20515

Majority Leader Steny Hoyer
U.S. House of Representatives
H-107, The Capitol
Washington, D.C. 20515

Majority Whip Jim Clyburn
United States House of Representatives
H-329, The Capitol
Washington, D.C. 20515

Chairman Richard Neal
U.S. House of Representatives
372 Cannon House Office Building
Washington, D.C. 20515

Chairman Frank Pallone
United States House of Representatives
2107 Rayburn House Office Building
Washington, D.C. 20515

Chairman Bobby Scott
United States House of Representatives
2328 Rayburn House Office Building
Washington, D.C. 20515

Dear Speaker Pelosi, Majority Leader Hoyer, Majority Whip Clyburn, Chairman Neal, Chairman Pallone, and Chairman Scott,

The undersigned organizations are writing, in anticipation of the reintroduction of the Elijah E. Cummings Lower Drug Costs Now Act (i.e., H.R. 3), to urge Congress to keep any international reference pricing proposals (including "International Pricing Index" or "Most Favored Nation") out of drug pricing reform legislation. International reference pricing will have an outsized negative impact on people with Alzheimer's disease and related dementias (ADRD), as well as decimate the clinical development of therapies for ADRD and other complex co-occurring medical conditions experienced by many people living with ADRD. Additionally, such reference pricing would undermine critical elements of the Affordable Care Act, the Rehabilitation Act, the Americans with Disabilities Act, and the 2020 DNC Platform while exacerbating health disparities in direct contradiction of the Biden Administration's core promise to advance health equity.

The development of effective therapies to prevent, delay, and better manage Alzheimer's disease and related dementias is one of the most pressing and complex public health challenges facing our nation. Alzheimer's disease is the only top-ten cause of death in the United States without a cure. One in three older adults who die have ADRD, and over six million Americans suffer from Alzheimer's disease. According to NIH-sponsored research, the total healthcare and

caregiving costs for a person with probable dementia are $287,000 in the last five years of life, compared to $173,000 for someone with cancer and $175,000 for someone with heart disease. In 2020, Medicare and Medicaid spent $206 billion on the total cost of care for Alzheimer's disease.

In the 116th Congress, H.R. 3 proposed the adoption of international reference pricing for the Medicare program to lower Part B and Part D prescription drug costs. Specifically, the bill would have imposed foreign price controls based on the volume-weighted average of drug prices in Australia, Canada, France, Germany, Japan, and the United Kingdom. While payers in these countries pay lower prices than in the United States, their citizens also have experienced delayed and reduced access to new medical treatments. The United States has access to nearly 90 percent of novel medicines, while developed countries with price control mechanisms have access to only 47 percent.

Similar concerns extend to other international reference pricing proposals. In January 2021, the Medicare Payment Advisory Commission expressed they were "very concerned about the potential reductions in [Medicare Part B] beneficiary access" in their comments regarding the Trump Administration's Most Favored Nation model. Further, the CMS Office of the Actuary (OACT) acknowledged that much of the projected "savings" from the model would come from reduced patient access.

Implementation of international reference pricing would also effectively endorse the use in the U.S. of discriminatory cost-effectiveness standards used by foreign governments. Most referenced countries, such as the U.K., Canada, and France, make drug reimbursement and coverage decisions based on inherently flawed cost-effectiveness assessment methodologies tied to the quality-adjusted life-year (QALY). These QALY assessments assign a value between 0 (death) and 1 (perfect health) to the people for whom a given treatment is intended. People who are sicker, older, or have a disability are assigned lower values.

Use of QALY-based cost-effectiveness analysis is a significant issue for people with Alzheimer's disease since the majority of those with dementia are the oldest old—of the estimated 6 million people with Alzheimer's disease who are age 65 and older, 80 percent are 75 years or older, and more than a third are 85 years or older.[1] Also, people aged 65 years and older with Alzheimer's disease are likely to have a comorbid condition such as coronary artery disease (38 percent), diabetes (37 percent), chronic kidney disease (29 percent), congestive heart failure (28 percent), and chronic pulmonary disease (25 percent). When applied to health care

[1] Rajan KB, Weuve J, Barnes LL, McAninch EA, Wilson RS, Evans DA. Population estimate of people with clinical AD and mild cognitive impairment in the United States (2020-2060). Alzheimers Dement 2021;17. In press.

decision-making by insurance companies, this can mean that treatments for these more vulnerable people are deemed "too expensive" and therefore "not cost-effective" to cover.

Objections about reliance upon QALY-based methodologies also extend to race. For example, Black Americans have an average life expectancy lower than whites. As such, treatments for conditions that disproportionately affect Black individuals may be assessed as lower value. Furthermore, Black and Latino communities experience Alzheimer's disease at higher rates than the general population. Data from the CHAP study shows that 18.6 percent of Black Americans and 14 percent of Hispanic Americans age 65 and older have Alzheimer's disease compared to 10 percent of White Americans.[2] Congress should not codify the use of standards that fail to incorporate equity considerations, which may inadvertently promote structural discrimination.

The United States has historically opposed the use of the QALY, and a ban on its use in Medicare was included in the Affordable Care Act (ACA). Prior to the ACA, the Rehabilitation Act ensured individuals with disabilities would not "be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination" under any program offered by any executive agency, including Medicare. Title II of the Americans with Disabilities Act (ADA) extended this protection to state and local governments' programs and services. In 1992, President George H.W. Bush's Administration established it was an ADA violation for states to employ cost-effectiveness standards in Medicaid out of concern it would discriminate against people with disabilities.

In 2019, the National Council on Disability (NCD), an independent federal agency, cautioned against relying on the QALY in any federal program, finding that relying on the QALY to make coverage decisions would violate United States disability and civil rights laws. Additionally, the 2020 Democratic National Committee platform stated, "Democrats will ensure that people with disabilities are never denied coverage based on the use of quality-adjusted life-year (QALY) indexes." Given these clear statements, policies that rely on QALY-driven international pricing metrics should be prohibited.

Unfortunately, the Congressional Budget Office (CBO) relied upon the use of QALYs to determine projected savings from Title I in H.R. 3. The CBO recognized the "limitations of using incremental QALYs and life years to approximate the benefit of a treatment," yet utilized the methodology in their scoring model despite these concerns and legal prohibitions listed above. However, the CBO did not assess changes in patient access that would occur due to international reference pricing – unlike the CMS OACT – and the potential negative impacts on patient care or increases in other types of utilization, such as hospitalizations, due to access limitations.

[2] Ibid

International reference pricing policies would have a severe impact on medical innovation and access to new medicines. The CBO offered a conservative estimate that H.R. 3 would reduce industry spending on research and development between $500 billion to $1 trillion and reduce the number of new drugs between 8 to 15 over ten years. Yet this policy would have much more dramatic effects in the longer run because of the 12-year average time it takes to develop and achieve a new drug's approval. The analysis does not take into account the new therapeutic programs that will be dissuaded from starting up because of H.R. 3. Another independent analysis of H.R. 3's price controls has determined that small and emerging biotech companies would be particularly hit hard. It is expected there will be 61 fewer medicines making it to market from these companies over ten years, with neurology being one of the most impacted clinical spaces.

Alzheimer's disease is a critical area of unmet medical need, and the human cost of not finding a cure is astronomical. An Alzheimer's disease drug development program's total cost is estimated at $5.7 billion, with an expected study time of 13 years from preclinical studies to market approval. However, due to the clinical complexity of ADRD, **the failure rate for test therapies in the clinical pipeline to treat Alzheimer's disease is 98 percent.** Between January 2008 and February 2019, 87 clinical programs investing and researching Alzheimer's disease closed. The clinical trial success rates for Alzheimer's disease candidates are lower than observed for all other disease areas combined.

This past decade, the federal government has dramatically increased its investment in Alzheimer's disease research, starting with $448 million in 2011 and increasing annually to $3.1 billion in 2021. This investment is essential. However, the vast amount of translational research in Alzheimer's disease continues to be funded by biotech companies. Seventy percent of all Alzheimer's disease clinical trials are sponsored or co-sponsored by pharmaceutical companies. However, a new analysis by Vital Transformation has shown that large pharmaceutical companies have already downsized investment into Alzheimer's disease and other neurological disorders by more than 50 percent due to the associated high risk of study failure.[3] **Were international reference pricing to advance, there is a serious and material risk that the research dollars supporting this vital, yet high-risk research, would evaporate.**

We thank you for your hard work in tackling prescription drug affordability. Congress must take action to address patients' ability to reasonably afford their medications while ensuring that policies to achieve these aims **do not institutionalize discrimination against older adults, patients with chronic conditions, people with disabilities, women, and communities of color.**

[3] Vital Transformation. Alzheimer's Drug Discovery: Potential Impacts of H.R. 3, April 22, 2021

The undersigned patient advocacy organizations appreciate your consideration of our concerns. If you have questions about the letter or would like to schedule a meeting, please contact Susan Peschin, President and CEO of the Alliance for Aging Research, at speschin@agingresearch.com.

Sincerely,

- ACCSES
- ACTNow for Mental Health
- Alliance for Aging Research
- Allies for Independence
- American Behcet's Disease Association (ABDA)
- American Society of Consultant Pharmacists
- Axis Advocacy
- Bridge the Gap - SYNGAP Education and Research Foundation
- Caregiver Action Network
- Chronic Care Policy Alliance
- Dementia Alliance International (DIA)
- Easterseals
- Global Coalition on Aging
- Global Liver Institute
- Healthcare Leadership Council
- HealthyWomen
- Latino Alzheimer's and Memory Disorders Alliance
- Livpact
- Men's Health Network
- National Association of Nutrition and Aging Services Programs (NANASP)
- National Consumers League
- National Hispanic Council on Aging
- National Partnership for Healthcare and Hospice Innovation
- Not Dead Yet
- Parkinson & Movement Disorder Alliance
- Partnership to Improve Patient Care
- Patients Rising Now
- PMD Alliance
- Puerto Rican Chamber of Commerce
- RetireSafe
- Second Wind Dreams
- The Association for Frontotemporal Degeneration
- The Foundation for Social Connection
- United Cerebral Palsy National