National Pharmaceutical Council®
1717 Pennsylvania Avenue, NW, Suite 800, Washington, DC 20006 | Phone 202-827-2100 | Web www.npcnow.org

June 30, 2023

Steven D. Pearson, MD, MSc, FRCP
President, Institute for Clinical and Economic Review
<via email>

RE: Proposed Changes to 2023 Value Assessment Framework

The National Pharmaceutical Council (NPC) appreciates the opportunity to submit comments on ICER's proposed changes to its value assessment framework (VAF).

NPC is a health policy research organization dedicated to the advancement of good evidence and science and to fostering an environment in the US that supports medical innovation. We have rich experience conducting research and disseminating information about the critical issues of evidence, innovation, and the value of medicines for patients. Our research helps inform important healthcare policy debates and supports the achievement of the best patient outcomes in the most efficient way possible.

NPC's recommendations focus on the shortcomings of ICER's proposed changes in terms of transparency, credibility, and methodological rigor:

I. **ICER's assessments should rely on scientifically supported methods and align with best practices for value assessment.**

II. **ICER proposes multiple changes intended to tackle pervasive problems in the healthcare system, including accounting for health equity, productivity, and patient engagement. Significant improvements are needed to address these problems in reliable, appropriate, and patient-focused value assessments.**

III. **ICER is progressively eroding the transparency and rigor of its assessments, procedures, and interactions with stakeholders.**

I. ICER's assessments should rely on scientifically supported methods and align with best practices for value assessment.

ICER's shared savings scenarios should not be used as the basis for ICER's health benefit price benchmarks (HBPBs); these scenarios are not supported by economic science or empirical evidence and can incentivize the use of less effective treatments.

ICER's cost offset cap ($150,000) and shared savings allocations (50% of cost offsets allowed) are not supported by any scientific research or empirical evidence. One of the many arguments that ICER has put forth for these scenarios is that savings should be "shared" by manufacturers with insurance plans. These trade-offs are the subject of negotiations between payers and manufacturers, not 3rd party value assessments. Furthermore, there is a strong consensus in the literature that US manufacturers receive a small percentage of the total social value arising from new drugs.[i,ii,iii,iv]

As acknowledged by ICER in a prior technical brief, the introduction of SSTs may often result in real-world cost offsets that far exceed $150K per year, which include recurring patient treatment burdens and

health system monitoring costs often missing from ICER assessments.[v] In such cases, ICER's application of its cost offset cap will result in value-based price determinations that are artificially and arbitrarily low and do not reflect the full value of the assessed treatments, biasing their HBPBs. ICER states it may further elect to apply shared savings analyses to determine HBPBs not only for SSTs, but also for any "*other treatments with relevant and substantial potential cost-offsets."*[vi] By purposefully and artificially underestimating treatment value for SSTs or other treatments ICER promotes use of inefficient and expensive standards of care, further entrenching inefficiencies in healthcare provision.

ICER should not lower its cost-effectiveness thresholds, as doing so is not supported by the literature and could have severe downstream implications for patient access.

ICER discusses adjusting its cost-effectiveness thresholds in three distinct contexts: 1) application of an opportunity cost scenario; 2) the potential to shift its HBPB range to $50,000 to $100,000 per QALY in the future; 3) the potential to use a lower cost-effectiveness threshold in "highly unusual" situations.

First, ICER appeals to a flawed opportunity cost rationale, suggesting a top threshold of $104K/QALY. However, ICER's justification to support such an analysis derives from a single simulation study[vii] which relies on a myriad of unvalidated assumptions and narrowly selected methods for estimating cost-effectiveness thresholds.[viii] Moreover, this estimate is based on increases in total healthcare costs. This has no validity since this effectively assumes that drugs account for all increases in total healthcare spending. In contrast, prescription drugs account for less than 20% of spending and the multi-year downward trend in pharmaceutical net prices demonstrates that drug prices are not driving premium increases[ix,x] rather, health insurance premiums are increasing for many reasons, including the aging US population, the increasing prevalence of chronic disease, and cost growth in other forms of care. In a 2022 report, the Congressional Budget Office wrote "*The main reason for the growth of per-person spending by commercial insurers—and for the difference from the growth of per-person spending by Medicare FFS—has been rapid increases in the prices that commercial insurers pay for hospitals' and physicians' services*."[xi] Furthermore, as ICER noted in its most recent Policy Leadership Forum publication, markups charged to payers by hospitals when clinicians administer drugs in the hospital setting have been found to be as high as 200-300% of the base price of the drug.

ICER's myopic, cost effectiveness-driven approach sets HBPBs that are unjustified and unreasonably punish drug interventions – and by extension patients - for insurance market failures, inefficient health care services, and demographic changes. This underscores a disconnect between ICER's methodological intention and its actual application: ICER aims to account for health care marketplace distortions, but solely penalizes emerging prescription drugs for these issues in their value assessments.

Second, ICER states that it will pursue further discussion with academic experts and stakeholders to consider whether the HBPB range should be shifted to $50,000 to $100,000 per quality-adjusted life-year (QALY). These lower cost-effectiveness ranges are substantially out of step with the literature on US willingness to pay for improved health. Application of these thresholds would be inappropriate and hold severe implications for innovation. A recent analysis found that authors of cost-effectiveness analyses increasingly cite $100,000 to $150,000 as appropriate thresholds, with cancer-related cost-effectiveness analyses referencing even higher thresholds.[xii] Thresholds, where used, are known to vary by disease state and certainly by severity, resulting in a wide range of appropriate values which ICER

does not acknowledge or incorporate. More broadly, applying threshold-based reporting, recommendations and decision-making can lead to lack of patient centric and clinically nuanced care.

Third, ICER states "*In highly unusual situations such as pandemics, in which there is an exceptionally large magnitude and urgency regarding the use of new health care interventions, ICER may consider using a lower cost-effectiveness threshold to provide additional accommodation between pricing to value and affordability…ICER will highlight these analyses in the Draft Report and provide justification for their planned inclusion within ICER's HBPB range in Final Reports."* NPC is very concerned that ICER's inclusion of this language creates the potential for ICER to subjectively use ever-lower cost-effectiveness thresholds in future assessments, and to arbitrarily make unjustified methodologic changes on a whim without transparency or stakeholder engagement.

ICER's attempt to make itself useful to CMS's Medicare Drug Price Negotiation Program (DPNP) is fraught with data gaps, uncertainty, and methodological limitations.

ICER proposes calculating new cost-effectiveness analyses related to the potential effects of the DPNP. However, significant uncertainty and gaps in data negate the utility of such analyses. ICER examines new treatments, many of which do not even have a list price, so ICER will have to make a series of ill-informed assumptions regarding future CMS spending on novel treatments and treatment prices many years after their value assessments.

ICER's decision to speculatively estimate whether and how emerging products will be subject to the DPNP 9 to 13 years in the future underscores ICER's inconsistent approach to evidence-based analysis. ICER is willing to undertake deeply speculative analyses that will be of no use to CMS, yet ICER refuses to undertake lifecycle dynamic pricing analyses incorporating the impact of branded and generic competition for which there is ample evidence.[xiii] This remains a gap in the VAF.

ICER should incorporate additional dimensions of value not fewer; ICER's proposed changes will further narrow the definition of value in ICER assessments.

NPC has repeatedly called for ICER to better include patient-centered value elements in its assessments, both quantitative and qualitative. ICER states that "*methodological issues related to double counting and the inability to measure related opportunity costs present a strong argument to keep these dimensions as qualitative considerations at this time*." However, this assertion ignores noteworthy progress that has been made in identifying rigorous theoretical and mathematical foundations for additional dimensions of value including insurance value, real option value, value of hope, and value of knowing.[xiv,xv,xvi,xvii] Moreover, incorporating these dimensions aligns with recommendations from patient groups, researchers, and health economists to advance more comprehensive and patient-focused assessments of treatment value.

ICER's justification for excluding broader value evidence due to a lack of evidence demonstrates its inconsistency and contradictory approach to performing evidence-based analyses. We are concerned that ICER is progressively including fewer dimensions of value in its appraisal committee deliberations, now including only votes on unmet need, caregiver quality of life, and equity considerations. Previously these votes incorporated factors of importance to patients such as complexity, lifetime impact, and mechanism of action. Not only is ICER failing to include these important value elements quantitatively; ICER is limiting even their meaningful qualitative inclusion.

ICER should incorporate sub-group analyses that are appropriate for a given disease and treatment.

NPC encourages ICER's interest in sub-group analyses but is concerned about the process by which these sub-groups will be defined and implemented. Sub-group analyses are clearly important to prescribers and plans regarding choices about appropriate care and benefit design. However, relevant sub-groups will vary substantially by disease state and specific indication for which reimbursement is sought. In addition, sub-groups not pre-specified in clinical trials may not have adequate sample size to make firm conclusions and urge caution and clarity when assessing the impact of sub-group analyses on HBPBs. We recommend that ICER include patients, manufacturers, and payers in the discussions leading to sub-group definitions incorporated into scoping documents and assessment protocols. We further encourage ICER to clarify the role of these sub-groups in estimated HBPBs.

ICER should include a true societal perspective as a co-base case in accordance with best practices for health technology assessment (HTA).

Despite repeated stakeholder calls to increase its use of the societal perspective, including past guidance from NPC, ICER will not promote the societal perspective to a co-base case for all assessment. This decision is out of step with other HTA bodies, Second Panel recommendations,[xviii] and feedback from stakeholders representing patients, industry, and academia.[xix] And, as employers and their employees are the ultimate payer for most non-elderly healthcare in the US, we further call on ICER to greatly expand the role of patient and caregiver perspectives on treatment value. Incorporating diverse employer perspectives in assessments will help achieve this goal.

II. ICER proposes multiple changes to its framework that are intended to tackle pervasive issues in value assessment, including accounting for health equity, productivity, and patient engagement. Additional improvements are needed to advance reliable, appropriate, and patient-focused assessments.

NPC appreciates ICER's recognition that productivity is an essential component of treatment value. Accounting for productivity when calculating cost-effectiveness using a modified societal perspective, even when data are unavailable, will lead to more comprehensive assessments.

ICER proposes to include "non-zero" productivity data when using a modified societal perspective. NPC appreciates ICER's acknowledgement of the importance of productivity data and encourages ICER to expand this acknowledgement to recognizing the importance of a co-base case for the societal perspective and the inclusion of other patient-centered value elements.

NPC is concerned about the validity and implementation of ICER's proposed indirect approach to estimating the potential impact of productivity. As a first step, we encourage ICER to conduct straightforward evaluations of the large number of real-world productivity studies in the US where productivity data appear to be lacking. More importantly, best practices have emerged to better account for productivity gains due to life extension, delayed disease progression, and improved physical functioning. [xx,xxi] In addition, greater clarity is needed around how this methodology will be applied in cases where relevant productivity data are available.[xxii] Clarity on how ICER will decide which estimates to use is needed.

Improving clinical trial diversity is imperative. However, NPC cautions that ICER should not be the arbiter on this issue – improving and assessing clinical trial diversity is a multi-stakeholder collaborative effort.

Advancing equity in health care and value assessment is critical. However, ICER's rationale for choosing to opine on clinical trial diversity is unstated. Will this be incorporated into ICER's HBPBs; will comparator treatments also be subject to this evaluation? Ultimately, the proposal to incorporate new ICER-developed methods for rating clinical trials diversity is premature and subject to many data limitations identified by ICER itself in its health equity white paper, such as dated and imprecise definitions of race and ethnicity categories and lack of reliable disease-specific prevalence estimates for some racial and ethnic groups. Registrational trials are necessarily multi-national with designs driven by clinical, ethical, and regulatory concerns, not dictates of value assessment. Importantly, the FDA has initiated numerous efforts to improve clinical trial diversity and is in a better position to assess and evaluate progress than is ICER. [xxiii]

ICER is proposing to improve its approach to patient engagement, but additional steps must be taken to ensure these efforts will lead to more patient-focused inputs being incorporated into ICER's analyses and results vs. being a simple box-checking exercise.

ICER proposes multiple changes to its Patient Engagement Program, including honoraria for patient representatives to help address financial barriers that may hinder participation and convening a Patient Counsel to advise and strengthen ICER's current Patient Engagement Program. ICER must take steps to empower the Patient Counsel to independently evaluate whether these changes result in more meaningful and patient-focused assessments and results.

III. ICER is progressively eroding the transparency and rigor of its assessments, procedures, and interactions with stakeholders, ICER needs to adopt transparent review and assessment processes and implement a multi-stakeholder engagement approach.

NPC is deeply concerned that ICER is preparing to change its methods on a whim without transparency or stakeholder input. As noted, ICER states it "*may identify additional analyses within an assessment that are of relevance to policymaking such as shared-savings analyses. In such situations, ICER will highlight these analyses in the Draft Report and provide justification for their planned inclusion within ICER's HBPB range in Final Reports*." This provides an opening for ICER to change the methods on the fly during any report. This is not a transparent, credible, stakeholder-informed approach.

In the simple process of describing these proposed updates to the VAF, ICER falls short of scientific norms. Any updates to the VAF should begin with a stated purpose for the update and include possible impact on HBPBs to allow stakeholders to make informed decisions. Further, with these proposals, ICER has shown its willingness to create in-house "methods" and implement them without scientific support (shared savings, trial diversity, e.g.) when it suits unstated aims and ignores scientific advancements developed elsewhere (broader value measures value, e.g.) when those run counter. ICER further notes that its topic selection and stakeholder engagement processes "*will be updated on an ad hoc basis and will not follow the standard three-year update cycle that the ICER value assessment framework currently follows*." Added to the ever-decreasing stakeholder input and restricted comment periods that further limit external comments, ICER's process is becoming stridently anti-stakeholder.

We fear that this trend, coupled with a flawed VAF 'update', will further undermine patient-centered value assessment in the US.

***

We appreciate this opportunity to provide input on proposed changes to ICER's VAF. NPC's continued engagement with ICER signifies our commitment to the critical dialogue necessary to ensure the development of high-quality, meaningful value assessment tools that help patients, physicians, payers, and others make informed decisions about all aspects of their health care.

Sincerely,

John Michael O'Brien, PharmD, MPH
President & Chief Executive Officer
National Pharmaceutical Council

References

[i]. Hult KJ, Philipson TJ. The Value of Medical Innovation Versus Industry Rewards. Value Health. 2023 Mar;26(3):320-327. doi: 10.1016/j.jval.2022.12.001. Epub 2022 Dec 9.

[ii]. Berdud M, Wallin-Bernhardsson N, Zamora B, Lindgren P, Towse A. The Allocation of the Economic Value of Second-Generation Antipsychotics Over the Product Life Cycle: The Case of Risperidone in Sweden and the United Kingdom. Value Health. 2023 Mar;26(3):328-335.

[iii]. Refoios Camejo R, McGrath C, Miraldo M, Rutten F. Distribution of health-related social surplus in pharmaceuticals: an estimation of consumer and producer surplus in the management of high blood lipids and COPD. Eur J Health Econ. 2014 May;15(4):439-45. doi: 10.1007/s10198-013-0484-1. Epub 2013 May 3. Erratum in: Eur J Health Econ. 2014 May;15(4):447.

[iv]. Lindgren P, Löfvendahl S, Brådvik G, Weiland O, Jönsson B. Value appropriation in hepatitis C. Eur J Health Econ. 2022 Aug;23(6):1059-1070. doi: 10.1007/s10198-021-01409-7. Epub 2021 Dec 2. PMID: 34855072; PMCID: PMC9304061. Jena AB, Philipson T. Cost-effectiveness as a price control. Health Aff (Millwood). 2007 May-Jun;26(3):696-703.

5. Institute for Clinical and Economic Review. Value Assessment Methods and Pricing Recommendations for Potential Cures: A Technical Brief. August 6, 2019. https://icer.org/wp-content/uploads/2020/10/Valuing-a-Cure-Technical-Brief.pdf

6. ICER Proposes Updates to Value Assessment Framework Methods and Procedures. ICER. Accessed June 22, 2023. https://icer.org/news-insights/press-releases/icer-proposes-updates-to-value-assessment-framework-methods-and-procedures/#:~:text=ICER%20is%20accepting%20public%20comment%20on%20these%20proposals.

7. Vanness DJ, Lomas J, Ahn H. A health opportunity cost threshold for cost-effectiveness analysis in the United States. Annals of internal medicine. 2021;174(1):25-32.

[viii] Examples include the value of a statistical life (VSL) and willingness-to-pay (WTP).

8. IQVIA Institute. The Use of Medicines in the U.S. 2023: Usage and Spending Trends and Outlook to 2027. May 2, 2023. Available at: https://www.iqvia.com/insights/the-iqvia-institute/reports/the-use-of-medicines-in-the-us-2023

9. Janssen. The 2022 Janssen U.S. Pricing Transparency Brief. May 2023. Available at: https://transparencyreport.janssen.com/_document/2022-janssen-transparency-report-pdf?id=00000188-267e-d95e-abca-7e7e58750000

[xi]. The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services. Congressional Budget Office. https://www.cbo.gov/publication/57422

11. Neumann PJ, Kim DD. Cost-effectiveness Thresholds Used by Study Authors, 1990-2021. *JAMA*. 2023 Apr 18;329(15):1312-1314.

12. Cohen JT. The impact on cost-effectiveness of accounting for generic drug pricing: Four case studies. *Value in Health*. Published online November 2022. doi:https://doi.org/10.1016/j.jval.2022.09.011

13. Neumann PJ, Garrison LP, Willke RJ. The History and Future of the "ISPOR Value Flower": Addressing Limitations of Conventional Cost-Effectiveness Analysis. Value Health. 2022 Apr.; 25(4):558-565.

14. dosReis S, Butler B, Caicedo J, Kennedy A, Hong YD, Zhang C, Slejko JF. Stakeholder-Engaged Derivation of Patient-Informed Value Elements. Patient. 2020;13(5):611-621.

15. Mattingly, T.J., Slejko JF, Onukwugha E, Perfetto EM, Kottilil S, Mullins CD. Value In Hepatitis C Virus Treatment: A Patient-Centered Cost-Effectiveness Analysis. PharmacoEconomics. 2019;38(2):233-242.

16. Ma S, Olchanski N, Cohen JT, Ollendorf DA, Neumann PJ, Kim DD. The Impact of Broader Value Elements on Cost-Effectiveness Analysis: Two Case Studies. Value Health. 2022 Aug;25(8):1336-1343.

17. The Second Panel on Cost-Effectiveness in Health and Medicine. Recommendations on perspectives for the reference case. In: Neumann PJ, Sanders GD, Russell LB, Siegel JE, Ganiats TG, eds. *Cost-Effectiveness in Health and Medicine*. 2nd ed. New York: Oxford University Press; 2017.

18. Institute for Clinical and Economic Review. Public comments on Methods Update: Value Assessment Framework 2020-2023. October 18, 2019. Available at: https://icer.org/assessment/value-assessment-framework-2020/#timeline

[xx] Basu A. Estimating costs and valuations of non-health benefits in cost-effectiveness analysis. In: Neumann PJ, Sanders GD, Russell LB, Siegel JE, Ganiats TG, editors. Cost-effectiveness in health and medicine, 2nd edn. Oxford University Press, New York; 2017.

[xxi] Jiao B, Basu A. Associating Health-Related Quality-of-Life Score with Time Uses to Inform Productivity Measures in Cost-Effectiveness Analysis. Pharmacoeconomics. 2023 Mar 6.

[xxii] Basu A. Understanding Productivity Benefits and Related Future Research Needs in Cost-Effectiveness Analysis. Value and Outcomes Spotlight. July/Aug 2018. https://www.ispor.org/docs/default-source/publications/value-outcomes-spotlight/july-august-2018/ispor-vos-august-2018-heor-article-understanding-productivity.pdf?sfvrsn=88036c16_2

19. FDA Takes Important Steps to Increase Racial and Ethnic Diversity in Clinical Trials. FDA. Published April 20, 2022. https://www.fda.gov/news-events/press-announcements/fda-takes-important-steps-increase-racial-and-ethnic-diversity-clinical-trials