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NPLB Statement on ICER’s Flawed Value Assessment Framework

ICER math must be significantly updated to incorporate quantifiable patient & societal benefits of innovative treatments as recommended by patients and leading health economists.

WASHINGTON, D.C.— No Patient Left Behind (NPLB), a non-profit organization dedicated to eliminating patients’ out-of-pocket costs and ensuring that drugs go generic without undue delay, today announced that it will not submit public comments to the Institute for Clinical and Economic Review’s (ICER) value assessment framework update. NPLB, alongside leading patient advocates, economists, academics, and innovators, has repeatedly made clear that ICER’s proposed updates to its “methods” are rhetoric designed to obscure ICER’s flawed and harmful cost-effectiveness analysis (CEA) math.

“ICER’s faulty and outdated math lacks academic credibility and seeks to hide its political agenda. No patient, payer, or policymaker should be misled that ICER is an ‘independent’ arbiter of cost-effectiveness assessments,” said Peter Rubin, Executive Director of No Patient Left Behind. “Participating in ICER’s public comment request only legitimizes an organization that continues to try to mislead today’s and tomorrow’s patients, which is to say all of us, into thinking that premium-paying families are not worth the coverage cost of new medicines to health plans.”

Patient advocates have spent countless, fruitless hours participating in ICER meetings, only to learn that their arguments and evidence are being ignored. “In the end you feel unbelievably used, as if you’re only there to legitimize their flawed process,” said Siri Vaeth, Executive Director of the Cystic Fibrosis Research Institute (CFRI). “Many patient advocacy groups have had the same experience. ICER takes our time and effort, our patients’ time and effort, yet it is consistently clear that they already know what their outcome will be.”

“Undervaluing the impact of medicines, and patient input, is a symptom of a system that prioritizes cost efficiency over lives and veneers of progress over systemic change,” said Susan Wysoki, Executive Director, PALtown. “It’s time for patients to take back power by not engaging in bad-faith efforts.”

Rubin noted that NPLB supports improving cost-effectiveness math to better appreciate what innovation is worth it to patients, payers, and society and understand why some medicines are valued by the market and others are not. NPLB’s GCEA animation showcases the CEA elements of value that ICER and other health technology assessment entities omit. Even when ICER claims that it is open to developing its method, such as by incorporating dynamic pricing (i.e., accounting for the fact that a drug’s price will change over time, such as by going generic), it qualifies that concession to the point of mathematical and practical irrelevance.

For example, ICER’s version of dynamic pricing will only be taken into account when a drug is subject to Medicare negotiation, disregarding decades of data showing how generic and in-class competition
reduce net drug prices. And even in the case of Medicare negotiation, ICER says it will assume that the price will only decline by the IRA’s statutory minimum discount. Others, including the Congressional Budget Office (CBO), have modeled that Medicare will drive much steeper price reductions since there is no floor to how low Medicare could go, and it has considerable leverage.¹

Furthermore, ICER’s version of dynamic pricing only considers changes in price that would impact a medicine taken by the people who start on therapy in the first year that a drug is approved. By doing this “single cohort” analysis, ICER is ignoring that many more patients will start treatment in later years, even after a drug has gone generic. A proper dynamic model would therefore incorporate “stacked cohorts.”

Leading health economists also have questioned ICER’s underlying math. Professor Emeritus Lou Garrison at the University of Washington said: “Health economists and others have long recognized that conventional CEA has generally not accounted for patent expiry (or, more generally, “loss of exclusivity”).”² And he went on to comment: “In the age of emerging long-lived cures, however, these anomalies can have perverse implications for incentives and ultimately for dynamic efficiency—and thus, global health.”

Any changes ICER does make that show drugs are actually more cost effective than its prior framework had shown will not be retroactively implemented. So even if changes to its framework would overturn a prior “verdict” that a drug was not cost-effective, ICER will not admit that. And yet, ICER and its backers have made it clear that their aim is for payors to set coverage policy based on ICER’s assessments. Were that to come to pass, payors guided by ICER would continue to deny patients access to medicines that ICER’s own updated methods would show were worth covering after all.

“When you consider that ICER has been willfully ignoring feedback on quantifiable, real world value elements like dynamic pricing for a long time, it reveals its biased and political agenda. ICER seems committed to ensuring that any methodology that might suggest drugs are worth their prices won’t see the light of day,” said Peter Kolchinsky, Managing Partner of RA Capital Management and member of the advisory committee of No Patient Left Behind. “So, when drug companies fund ICER and participate in their charade of a commenting process, they’re validating them. Innovators should make their arguments at intellectual forums like the ones offered by ISPOR, not on ICER’s rigged stage.”

Learn more about how to improve ICER’s faulty and outdated math [here](#).

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**About NPLB**

NPLB is dedicated to ensuring patient affordability and continued biotech innovation by arming stakeholders with research, information, and educational tools to fight for lower out-of-pocket costs and ensure brand name drugs go generic without undue delay. If a doctor prescribes a therapy and the insurer authorizes it, the copay should be affordable to the patient.