

April 22, 2024

Sarah K. Emond, MPP
President and Chief Executive Officer
Institute for Clinical and Economic Review
Two Liberty Square, Ninth Floor
Boston, MA 02109

Dear Ms. Emond,

The Partnership to Improve Patient Care (PIPC) appreciates the opportunity to comment on the Institute for Clinical and Economic Review (ICER) assessment on post-traumatic stress disorder (PTSD).

As ICER acknowledges, PTSD is a deeply challenging condition that puts extensive stress on both patients and their caregivers. Current treatment options for PTSD are limited and many patients do not respond to them. Given this urgent need, it will be important for ICER to take an unbiased approach to this assessment to evaluate the potential value of treatments reflecting the diversity of PTSD patients.

ICER should approach this assessment from the societal perspective.

The burden of PTSD impacts patients, their families and caregivers and others. We are concerned that ICER neglects to incorporate the wider indirect costs of PTSD, such as the financial and emotional costs to caregivers and the wider societal impact of the disease, despite relying on sources that describe in detail the significant burden of PTSD.

We urge ICER to consider the robust data that exists on the life effects and day-to-day burden experienced by family members and informal caregivers when caring for someone with PTSD.¹ As PIPC has commented to ICER previously, for diseases that have a considerable caregiver burden and high societal costs, like PTSD, the societal perspective presents a clearer picture than only using the health care perspective. A societal perspective is also recommended for cost-effectiveness models by the 2nd panel on cost-effectiveness² convened by ISPOR, the Professional Society for Health Economics and Outcomes Research.³

¹ Thandi G, Harden L, Cole L, Greenberg N, Fear NT. Systematic review of caregiver burden in spouses and partners providing informal care to wounded, injured or sick (WIS) military personnel. *BMJ Military Health*. 2018 Sep 1;164(5):365-9.

² Sanders GD, Neumann PJ, Basu A, Brock DW, Feeny D, Krahn M, Kuntz KM, Meltzer DO, Owens DK, Prosser LA, Salomon JA. Recommendations for conduct, methodological practices, and reporting of cost-effectiveness analyses: second panel on cost-effectiveness in health and medicine. *Jama*. 2016 Sep 13;316(10):1093-103.

³ Garrison Jr LP, Mansley EC, Abbott III TA, Bresnahan BW, Hay JW, Smeeding J. Good research practices for measuring drug costs in cost-effectiveness analyses: a societal perspective: the ispor drug cost task force report—Part II. *Value in Health*. 2010 Jan;13(1):8-13.

Though ICER acknowledges PTSD to be a highly heterogeneous condition, it still focuses its report on an “average” patient.

ICER states early on that PTSD is a highly heterogeneous condition. PTSD’s complexity is widely acknowledged, both in terms of PTSD sub-types⁴, how it is experienced⁵ and how it can be treated.⁶ ICER chooses, however, to focus its assessment on a hypothetical “average” patient. If ICER intends to provide insight into decision-making around the value of a new therapy for beneficiaries, it should produce an estimate – or a range of estimates – for as many of that wide range of patients, or patient types, as possible. ICER’s methodology falls short of doing this. Providing an estimate of the value of a new drug to a hypothetical “average” patient is not useful information on value, particularly for this diverse of a patient population in which one patient is not representative of most other patients.

It is well established that generating and reporting on differential value assessment estimates across subgroups captures substantial health gains that would not otherwise be considered, both through treatment selection and coverage.^{7,8} For ICER’s work to be informative to health policy decision makers about the value of new therapies for the diversity of patients seeking treatment, it needs to move away from assuming all patients are the same and the value to each patient can be determined by estimating average value to a patient archetype.

ICER Continues to Use the Discriminatory QALY and the Similar Measure evLYG.

Multiple studies have shown that cost-effectiveness models using the quality-adjusted life year (QALY) discriminate against patients with chronic conditions⁹ and people with disabilities.¹⁰ There is widespread recognition that the use of the QALY is discriminatory, reflected in laws that bar its use in government decision-making. The National Council on Disability (NCD), an independent federal agency advising Congress and the administration on disability policy, concluded in a 2019 report that QALYs discriminate by placing a lower value on treatments which extend the lives of people with chronic illnesses and disabilities. NCD recommended that

⁴ Campbell-Sills L, Sun X, Choi KW, He F, Ursano RJ, Kessler RC, Levey DF, Smoller JW, Gelernter J, Jain S, Stein MB. Dissecting the heterogeneity of posttraumatic stress disorder: differences in polygenic risk, stress exposures, and course of PTSD subtypes. *Psychological medicine*. 2022 Nov;52(15):3646-54.

⁵ DiMauro J, Carter S, Folk JB, Kashdan TB. A historical review of trauma-related diagnoses to reconsider the heterogeneity of PTSD. *Journal of anxiety disorders*. 2014 Dec 1;28(8):774-86.

⁶ Bonanno GA, Mancini AD. Beyond resilience and PTSD: Mapping the heterogeneity of responses to potential trauma. *Psychological trauma: Theory, research, practice, and policy*. 2012 Jan;4(1):74.

⁷ Basu A. Economics of individualization in comparative effectiveness research and a basis for a patient-centered health care. *Journal of health economics*. 2011 May 1;30(3):549-59.

⁸ Espinoza MA, Manca A, Claxton K, Sculpher MJ. The value of heterogeneity for cost-effectiveness subgroup analysis: conceptual framework and application. *Medical Decision Making*. 2014 Nov;34(8):951-64.

⁹ Paulden M. Recent amendments to NICE’s value-based assessment of health technologies: implicitly inequitable?. *Expert review of pharmacoeconomics & outcomes research*. 2017 May 4;17(3):239-42.

¹⁰ Nord E, Pinto JL, Richardson J, Menzel P, Ubel P. Incorporating societal concerns for fairness in numerical valuations of health programmes. *Health economics*. 1999 Feb;8(1):25-39.

policymakers and insurers reject QALYs as a method of measuring value for medical treatments.¹¹

Additionally, we share the concerns of the NCD about the equal value of life year gained (evLYG), a similar measure created by ICER to supplement the QALY. The evLYG is a simplistic fix attempting to address criticism that the QALY devalues life years lived with a disability, yet it fails to account for oversimplified measures of quality-of-life gains in expected life years (not extended life years) and it does not account for any health improvements in extended life years. Like the QALY, the evLYG relies on average estimates based on generic survey data and obscures important differences in patients' clinical needs and preferences, particularly those with complex diseases and from underrepresented communities.¹² It assumes that people value life year gains more than quality of life improvements, giving a lower value to health interventions in patient populations that have a lower life expectancy or fewer life years gained from treatment, which may include people with disabilities, underlying chronic conditions, the elderly, and certain communities of color.¹³ With the evLYG and the QALY, ICER promotes two compromised and flawed measures of health gain. Deciding which to choose is confusing and inconsistent.

ICER assumes a linear relationship between severity of disease and utility increments, which is no longer best practice in value assessment.

In recent years, in an effort to ensure that value assessments are portraying an accurate picture, there has been a widespread questioning of several of the assumptions that underpin cost utility analysis.¹⁴ One flaw that has been widely criticized is the assumption that every unit of health gain – measured here in health-related quality of life – is equal in value.¹⁵ In other words, a single unit of health generates the same utility whether that health is accrued to someone with considerable disease burden, or to someone with minimal disease burden.¹⁶ Many HTAs have moved away from this system and apply multipliers to capture the benefit of treatments that provide relief from high levels of burden from disease or disability. HTA systems the world

¹¹ https://www.ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf

¹² DiStefano MJ, Zempenyi A, Anderson KE, Mendola ND, Nair KV, McQueen RB. Alternative approaches to measuring value: an update on innovative methods in the context of the United States Medicare drug price negotiation program. *Expert Rev Pharmacoecon Outcomes Res.* 2024 Feb;24(2):171-180. doi: 10.1080/14737167.2023.2283584. Epub 2024 Jan 25. PMID: 37961908.

¹³ Mike Paulden, Chris Sampson, James F. O'Mahony, Eldon Spackman, Christopher McCabe, Jeff Round, Tristan Snowsill, Logical Inconsistencies in the Health Years in Total and Equal Value of Life-Years Gained, *Value in Health*, Volume 27, Issue 3, 2024, Pages 356-366.

¹⁴ Beresniak A, Medina-Lara A, Auray JP, De Wever A, Praet JC, Tarricone R, Torbica A, Dupont D, Lamure M, Duru G. Validation of the underlying assumptions of the quality-adjusted life-years outcome: results from the ECHOUTCOME European project. *Pharmacoeconomics.* 2015 Jan 1;33(1):61-9.

¹⁵ Sund B, Svensson M. Estimating a constant WTP for a QALY—a mission impossible? *The European Journal of Health Economics.* 2018 Jul;19(6):871-80.

¹⁶ MacKillop E, Sheard S. Quantifying life: understanding the history of quality-adjusted life-years (QALYs). *Social Science & Medicine.* 2018 Aug 1;211:359-66.

over, such as in Norway, the Netherlands and the United Kingdom,¹⁷ are known to adjust their models to account for severity of illness. PIPC suggests ICER also account for the value of health improvements for people experiencing a higher burden of disease or disability.

Conclusion

PIPC urges ICER to consider evolving its value assessment methodology to better account for value to patients and move away from the use of blunt tools that fail to capture the reality of patients' experiences and the benefits of treatment for heterogenous populations.

Sincerely,



Tony Coelho
Chairman
Partnership to Improve Patient Care

¹⁷ Phelps CE, Lakdawalla DN. Methods to Adjust Willingness-to-Pay Measures for Severity of Illness. Value in health: the journal of the International Society for Pharmacoeconomics and Outcomes Research.:S1098-3015.