Industry perspective on current Risk Sharing Agreements in Korea; Reference to experience in Australia and other countries

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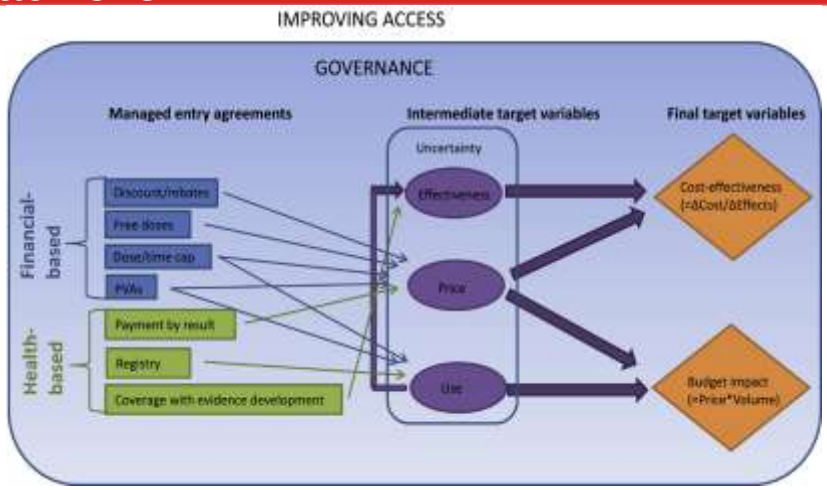
Agenda

1. What are we trying to achieve with Risk Sharing Agreements or “Managed Entry Schemes”?
2. Learning from Managed Entry Schemes in Australia and other markets
3. Issues for consideration in Korea

1. What are these schemes trying to achieve?



Dealing with uncertainty and high prices of new medicines: A comparative analysis of the use of managed entry agreements in Belgium, England, the Netherlands and Sweden. Ferrario and Kanavos Social Science & Medicine 124 (2015)

Uncertainty

- *The concepts of "uncertainty" and value, when applied to health technology are prone to interpretation and influenced by clinical, economic, political and socio-economic aspects.*

- *Clinical development plans should aim at addressing or attempting to address some of the main areas of uncertainty (e.g. drug performance over longer follow up periods, clinical relevance of endpoints, QOL and resource use) as early as possible.*

Morel, T et al, Reconciling uncertainty of costs and outcomes with the need for access to orphan medical products: A comparative study of MEAs across seven European countries. Orphanet J of Rare Diseases 8:198 (2013)

2. Experience in Australia

- Relatively long experience with a wide range of “special arrangements”
- Most were price-volume agreements or utilisation restrictions
- More recently, government – industry agreement on a framework for MES
- Limited but increasing experience, especially in oncology

MES framework agreed between government and industry

- Framework states PBAC “may recommend PBS coverage at a price justified by the existing evidence, pending submission of more conclusive evidence of cost-effectiveness to support listing of the drug at a higher price”.

- MES considered when:
  - there is ‘a high clinical need for the proposed drug in the indication requested by the sponsor’, and
  - that ‘new clinical data would resolve the issues of uncertainty in relation to the extent or value of the clinical effect which would have otherwise prevented an initial positive recommendation’.

- This includes the possibility of a randomised controlled trial (RCT)-based MES with a trial protocol available at the time of the original submission, and that other non-RCT level evidence “may be appropriate, such as data collection for the purpose of confirming cost-offsets in economic analyses”.

Framework for the introduction of a Managed Entry Scheme for submissions to the Pharmaceutical Benefits Advisory Committee: http://www.pbs.gov.au/info/publication/factsheets/shared/framework-for-introduction-of-managed-entry-scheme-for-PBAC-submissions, accessed 11/08/2016

Industry perspectives on implementation of the framework

- Support for general principle, recognising that value may not be adequately demonstrated at time of 1st HTA, additional evidence helpful.
- Appreciation of the flexibility in regard to source of additional evidence.
- Concern that industry takes risk in regard to launch at lower price (agency view that this would reflect value supported by available evidence). Some exceptions emerging, where proposed price accepted for listing, subject to review (may exclude option of an increase)
- Concern that price premiums / increases that might be supported by subsequent evidence would never occur.
- Recognised stakeholder concern that "cant take anything away from patients once it has been reimbursed" – but argued that de-listing is rarely the only option.

Recent experiences / perspectives

- Accommodating evolving evidence within the standard PBAC process
- MES to develop new evidence based on actual use
- MES to accommodate new evidence known to be in development
- Decisions on new technologies impacted by ongoing MES for a comparator

Emerging issues

- Positive recognition that “not one size fits all”
- Includes willingness to accept evidence from various sources if likely to address the key uncertainty
- BUT
  - MESs are accompanied by a legally binding Deed of Agreement
  - Deeds are very specific and failure to deliver on specific aspects may invalidate, even when evidence shows promised result
  - New products being assessed that are tied to other already subject to a MES, by virtue of therapeutic area reference pricing
  - This is resulting in some complex inter-relationships: price reduction for Product A (because MES has not demonstrated desired outcome) flows on to Product B (which may itself be subject of a MES) and then to product C etc

MESs in other markets: Not “one size fits all”

- England:
  - Explicit focus on improving cost-effectiveness more than addressing uncertainty.
  - Predominantly discounts and free doses rather than CED.
- Belgium:
  - Main objectives are limiting budget impact complemented by addressing uncertainty
  - PVAs, rebates and time cap schemes together with CED.
- Netherlands:
  - Improving access to expensive hospital and orphan medicines and reducing geographical inequalities.
  - Mainly achieved by additional funding rather than on the use of CED. However, CED agreements seen for medicines with an initial added therapeutic value but an uncertain ICER.
- Sweden:
  - Objective of TLV to alleviate uncertainties around cost-effectiveness
  - Use of CED and registries (it is worth noting that in Sweden registries are often the enabling factor to implement a MEA, i.e. they were already in place before a MEA was introduced). The use of discounts and registries for agreements concluded by the county councils is also reflected in the objectives the latter are pursuing.

Ferrario and Kanavos (ibid)

RSAs for multiple indications: 1) Bevacizumab

- In **Italy** the product is subject to mandatory inclusion of patients in **indication-specific registries** maintained by the AIFA (Italian medicines agency) for all its approved indications except for: breast and colorectal cancer (CRC); **risk-sharing agreements apply on an indication-by-indication basis for all indications**;
- **A specific additional 7 per cent discount applies to the product when used in advanced CRC;** also, **an annual budget cap, with mandatory paybacks in case of "excessive" sales, applies in the latter indication;** no reimbursement is as yet applicable in the case of use in platinum-resistant ovarian cancer
- In **Switzerland**, a cost-sharing agreement is in place for use of bevacizumab in breast cancer and in renal cell carcinoma, with **different rebate levels on a per-mg basis in the two indications**; in lung cancer, the product is only reimbursed if the low dose regimen (7.5 mg/kg) is used

RSAs for multiple indications: 2) Cetuximab

- In **Italy** the product is subject to mandatory inclusion of patients in **indication-specific registries** maintained by the AIFA (Italian medicines agency) for its three most recent indications (metastatic CRC in combination with FOLFOX, first-line and in monotherapy in irinotecan failures; head and neck cancer, in combination with platinum-based chemotherapy);
- **Payment by results and/or cost-sharing agreements apply for all indications except head and neck cancer,** in combination with radiotherapy; **a specific additional 5 per cent discount applies to the product when used in metastatic CRC,** in combination with irinotecan;
- Also, **an annual budget cap**, with mandatory paybacks in case of "excessive" sales, **applies in the latter indication**

Expert view on additional indications

- Economists favor of value-based rewards for innovation, suggesting the ideal is "indication-specific" reimbursement.
- However, most developed country standard claims and electronic data systems don't always capture the relevant indication information. An Italian-style web overlay is probably an efficient way to overcome this.
- Operationally, a more simple option would be to maintain a constant list price per pill or per vial, and then monitor volume by indication and settle up (e.g., via manufacturer rebates) periodically with differential rebates tied to value

Professor Lou Garrison, University of Washington and lead author, ISPOR Task Force on Performance-based Risk-sharing Agreements: Personal communication

Other learning from Australia

- Perspective of patient groups:
  - Appreciate efforts to resolve uncertainty, but confused by complexity and disappointed when this appears to delay listings even further
  - Concerned regarding any apparent loss of trust and calling for all parties to collaborate to make MESs work for the sake of patients
- Transparency:
  - Good recognition from all parties of the need to maintain confidentiality over price negotiations
  - PBAC Public Summary Documents provide good detail on basic frameworks as proposed for a MES (source of additional data, time line, acceptance of proposed price or alternative)
  - "devil is in the detail" in regard to Deeds of Agreement and other stakeholders (e.g. patients, clinicians)will not be aware of this details

3. Observations regarding MES / RSAs in Korea

- Still relatively low spend on pharmaceuticals
- Low prices as a result of multiple policies and practices
- But increasingly sophisticated HTA approach, leading to greater awareness of uncertainty of effectiveness and cost-effectiveness for higher cost medicines, especially oncology
- Logically, MES should be part of the policy / reimbursement toolkit
- But…low baseline prices leave little room for additional rebates and are a disincentive for companies to participate in RSAs

Observations on RSA and “PE Exempt” options in Korea

- Constructive effort to deal with realities of medicines for areas of high unmet need but small patient numbers, where data will often remain uncertain
- However, not always clear why certain medicines are in one category or the other
- May be able to learn from Germany, France or Italy, where pragmatic decisions are made to ensure reimbursed access, sometimes with further evaluation of benefit after 1-2 years of use (without requiring full cost-effectiveness analysis)
- These countries allow additional indications to be included with minimal complexity, usually based on additional discount for new indication.
- Might the categories (RSA and PE) be combined in some way?
- Other major issue is low “baseline” prices! This leaves little or no room for further discounts / rebates associated with MESs, and if not addressed will result in more medicines not moving forward with a MES and Korean patients missing out on reimbursed access to needed treatments.

Thank you, Kamsahamnida!