

## Background and objectives

- Unlike several European health technology assessment bodies with explicit cost-effectiveness thresholds, France's Haute Autorité de Santé (HAS) does not define a formal willingness-to-pay (WTP) threshold for reimbursement decisions.<sup>1</sup>
- While the Economic and Public Health Evaluation Committee (CEESP) critiques health economic analyses, it remains unclear whether it applies a consistent implicit Incremental Cost-Effectiveness Ratio (ICER) ceiling, or whether that threshold varies between orphan and non-orphan treatments.
- Orphan designation in the European Union (EU), as per the European Medicines Agency (EMA), applies to medicines intended for rare conditions with a prevalence no greater than 5 in 10,000 people. It is a regulatory status that can influence evidence expectations and access pathways.<sup>2</sup>

**“At the present time in France, public decision-makers do not regulate prices and rates of healthcare products with reference to a particular cost-effectiveness threshold.”<sup>3</sup>**

- We aimed to determine whether an implicit WTP threshold can be inferred for orphan and non-orphan treatments from CEESP opinions issued between 2024 to 2025.

## Methods

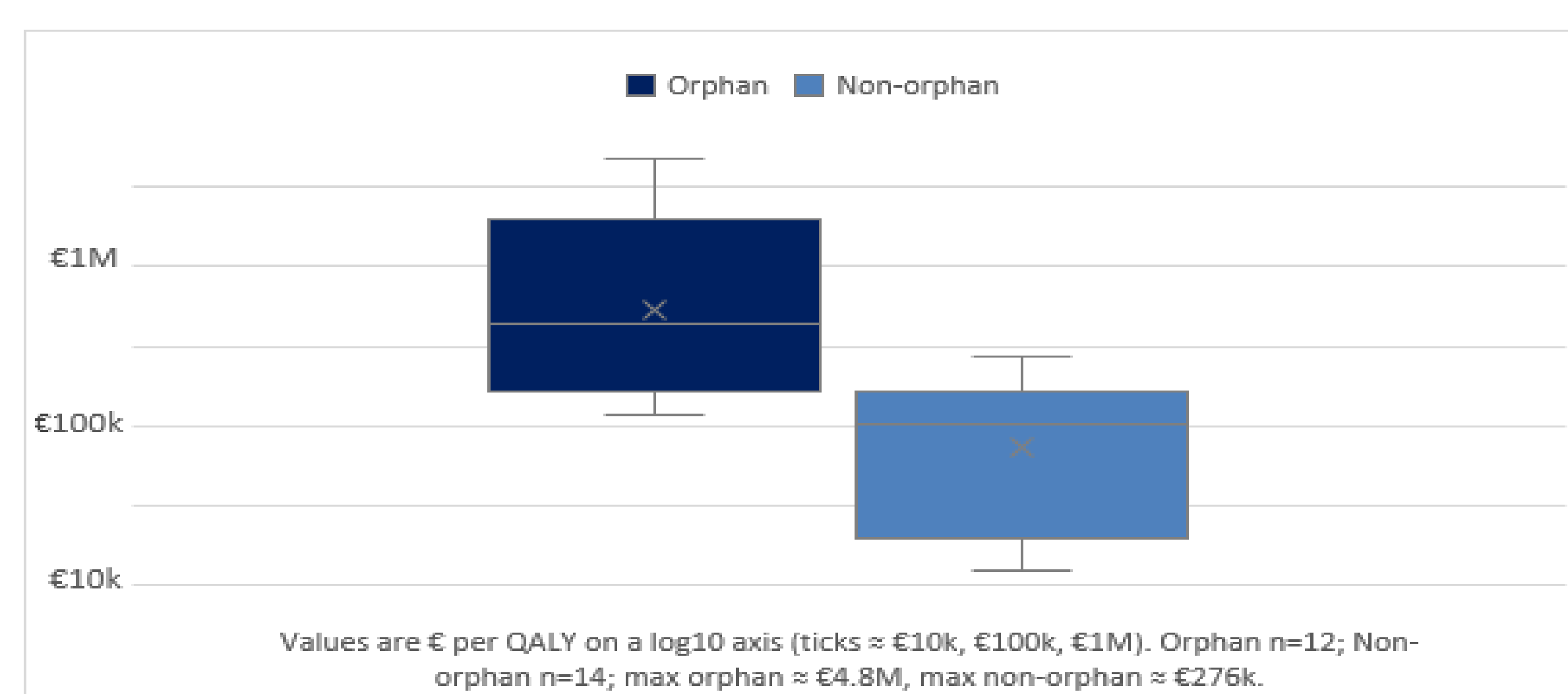
- All single-technology CEESP opinions on the HAS website from 1 January 2024 to 30 September 2025 were screened.
- Records were eligible if they included at least one ICER expressed in euros per Quality-Adjusted Life Year (QALY).
- Orphan status was assigned if explicitly stated in the economic analyses. For each dossier, the base-case ICER, Amélioration du Service Médical Rendu (ASMR), and Service Médical Rendu (SMR) ratings were collected.
- ICER distributions were summarised with medians and inter-quartile ranges (IQR) and stratified by orphan and non-orphan treatments.

## Results

- We screened 29 CEESP opinions. Of these, 23 met our eligibility criteria and were included. Two products within this group reported multiple ICERs for different populations: one product provided three ICERs, and another provided two. We treated each of these ICERs as a separate entry in our analysis, resulting in a total of 26 ICERs included in our research.
- Among the 26 ICERs included, we identified 12 ICERs for orphan treatments and 14 ICERs for non-orphan treatments.

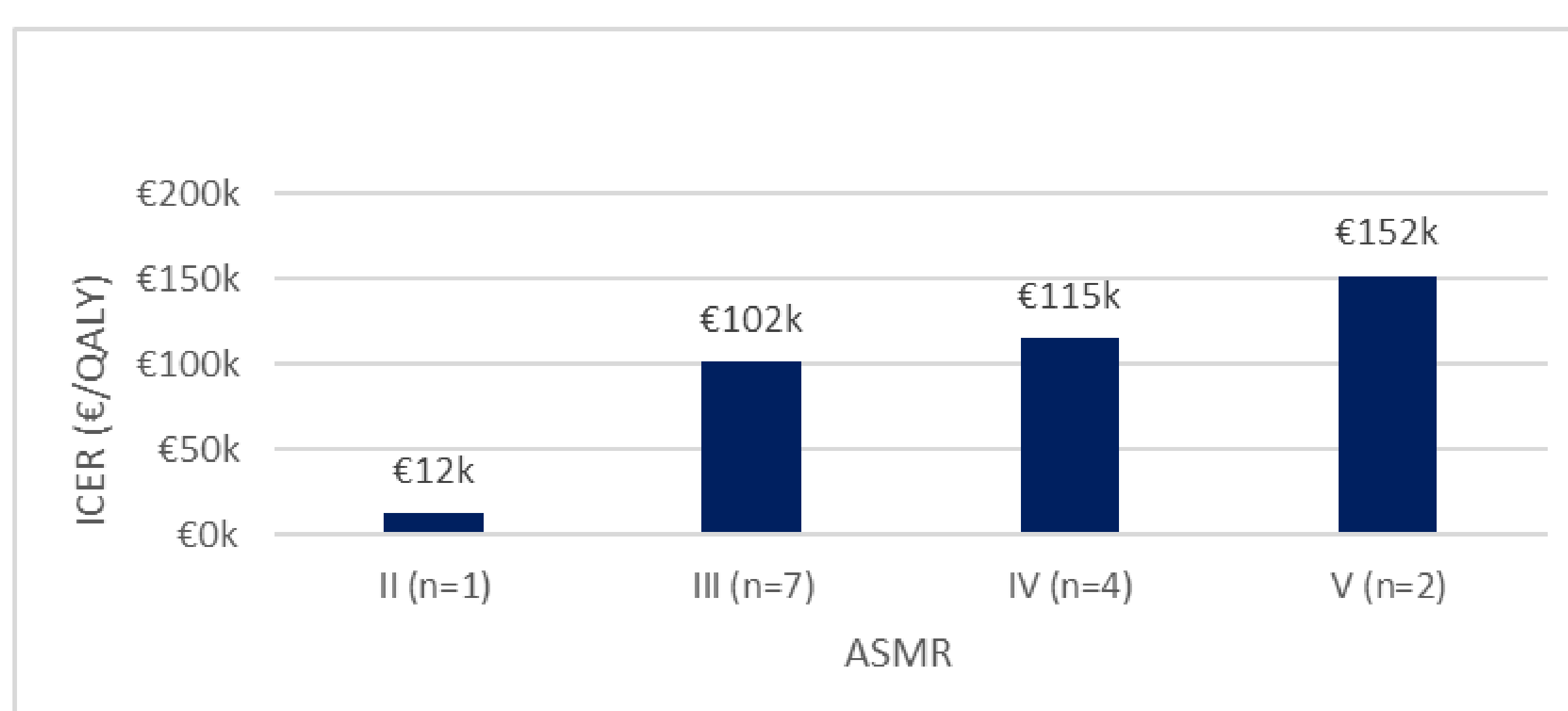
- The median ICER for orphan treatments was €495,000 per QALY (IQR: €162,000 – €2,174,000; range: €116,000 – €4,700,000), compared to €104,000 per QALY for non-orphan treatments (IQR: €59,000 – €166,000; range: €12,344 – €276,000) (**Figure 1**).
  - Although not a primary focus of this research, our analysis revealed the median ICER was €256,581 per QALY for oncology treatments and €152,033 per QALY for non-oncology treatments over the corresponding time period.

Figure 1: ICERs (€/QALY) distribution by orphan status



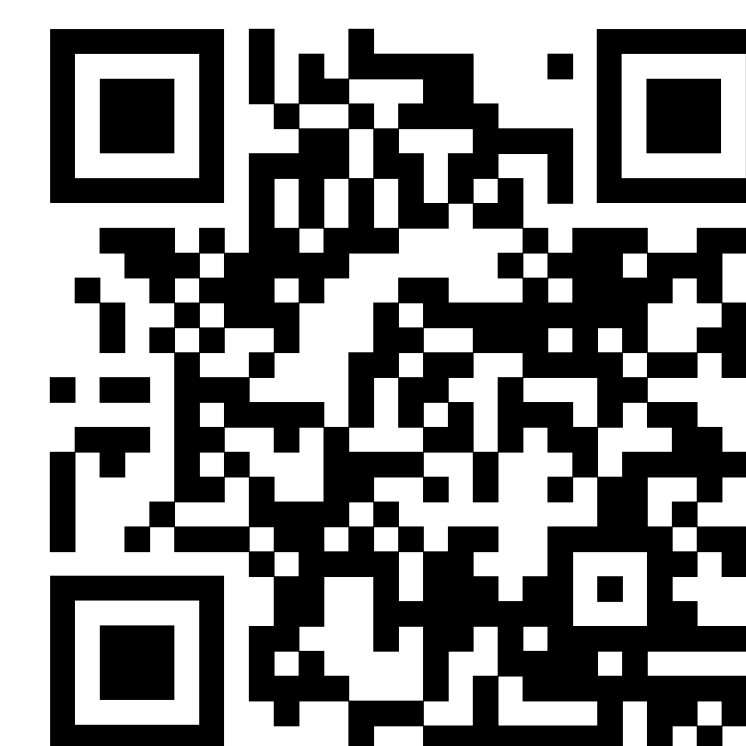
- A larger share of orphan submissions exceeded typical ICER thresholds: 92% were >€150,000 per QALY and 58% were >€300,000 per QALY. In contrast, for non-orphan submissions, 29% were >€150,000 per QALY and 0% were >€300,000 per QALY.
- Figure 2** presents the association between ASMR levels and ICERs for non-orphan treatments within the analysed time period. Non-orphan treatments with low added benefit ratings have progressively higher ICERs compared with non-orphan treatments with higher added benefit ratings, suggesting higher confidential discounts are likely to be required for treatments with lower added benefit ratings.

Figure 2: Median ICERs (€/QALY) by ASMR for non-orphan treatments



## Conclusion

- The median WTP threshold for orphan treatments are, on average, approximately five times higher per QALY than non-orphan treatments; with non-orphan treatment ICERs rarely exceeding €150,000 per QALY and orphan treatment ICERs often reaching greater than €300,000 per QALY.
- Among non-orphan treatments, ICERs were higher when the ASMR rating was IV–V compared with II–III.



### Acknowledgements

FIECON Ltd. supported this analysis. Corresponding author: [ines.bouajila@fiecon.com](mailto:ines.bouajila@fiecon.com)

### References

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- Annual report of the European Medicines Agency 2009, Annual report of the European Medicines Agency 2009, May 2010.
- Haute Autorité de Santé, Doctrine of the Commission for Economic and Public Health Evaluation. July 2021.