RWD21

Assessing the feasibility of the implementation of a subscription model pricing solution aimed at broadening access to all eligible patients within the HER2 indication

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Introduction

Breast cancer is the most common malignant tumour diagnosed in Irish women, with an average of 3422 cases diagnosed each year during 2019-2023.[1] HER2-positive disease represents between 15%-20% of breast cancer cases.[2-3]

Newer HER2-targeted agents, combination regimens, and expanded indications have improved outcomes, but as patients live longer with disease, treatment duration and cumulative costs rise, placing additional pressure on healthcare budgets.

Approximately 46% of the Irish population holds private health insurance.[4] Private health insurers, such as Vhi Healthcare, face increasing, unpredictable oncology expenditure, and sustained utilisation, leading to challenges in financial planning, greater budget uncertainty, and barriers to patient access.

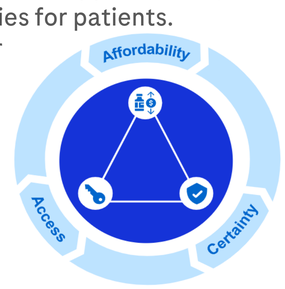
Innovative pricing models could provide the solution to broader, sustainable access to innovative therapies through more predictable reimbursement approaches.

Objective

To enable and encourage broad accessibility to HER2+ BC treatment in Ireland, Roche partnered with Vhi Healthcare to co-create and test a subscription based pricing model, using the Roche HER2+ treatment portfolio and Vhi Healthcare utilisation data.

The objective of the endeavour was to:

- Evaluate the viability of a subscription-based payment model through a shadow contract implemented across the 2024 calendar year.
- Determine its usefulness in enhancing financial planning and budget predictability.
- Assess whether the approach could support broad, cost-neutral access for HER2+ therapies for patients.
- Determine its scalability to other therapeutic areas or company-wide portfolios.



Method

Three Roche products were identified from our HER2+ treatment portfolio to model in this study.
A fixed-fee subscription model was developed in Microsoft Excel to predict the number of patients that would require treatment with each of the three products based on historical vial usage data, and understanding of future market shifts.

A fixed-fee was determined per patient independent of which product they ultimately received.

Two approaches were then analysed:

1. Patient approach: which assigned a set price per patient per month
2. Cohort approach: which assigned a set total cost per month

Using real-world data provided by Vhi Healthcare throughout 2024, we mapped the actual treatment costs against the predicted subscription costs to test the model performance and operational viability.

Results

We compared the monthly predicted patient numbers and costs against real-world data from Vhi Healthcare. While accuracy varied significantly from month to month (±30% in some cases), the overall annual results for both approaches were closely aligned.

As anticipated, the per-patient model demonstrated greater accuracy (101%) than the cohort model (92%). Both approaches remained within the ±10% acceptability range agreed between Roche and Vhi Healthcare at the initiation of the exercise.

Figure 1 shows the difference between estimated and actual patient numbers.

Figure 2 illustrates that although there was a general monthly underestimate of total patients treated, the distribution of patients treated with each of the three products was closely aligned with real-world patterns, and explains why the per-patient model demonstrated a higher accuracy than the cohort model.

Figure 3 shows the proportional monthly and annual cost differences for both models relative to actual spend. Both approaches delivered stable annual cost estimates within the ±10% threshold, despite expected monthly variation.

Figure 1. Estimated vs actual number of patients treated

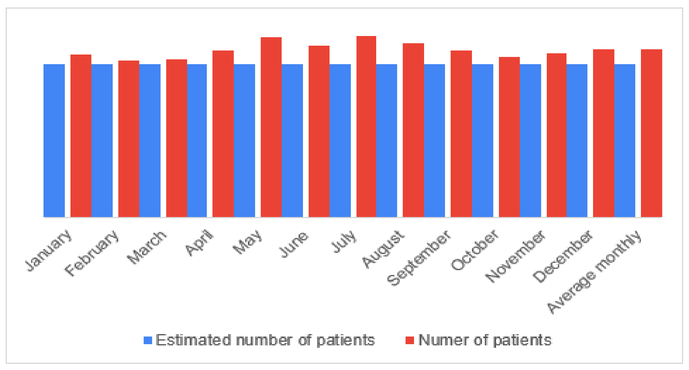


Figure 2. Estimated vs actual product usage shares (based on individual product usage per patient)

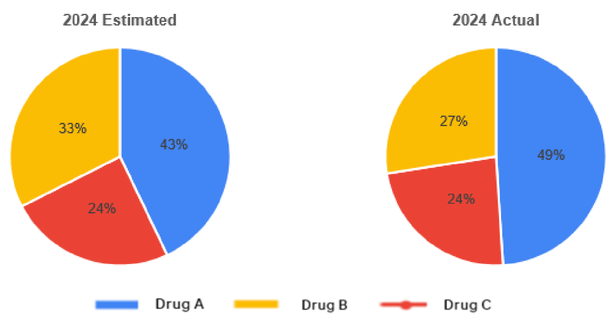
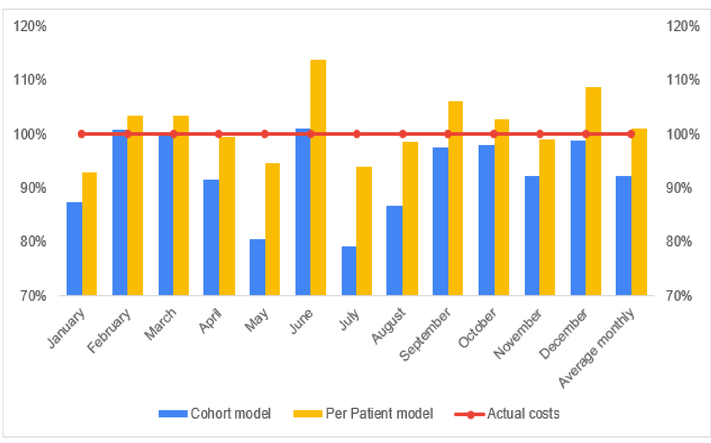


Figure 3. Proportionate difference of per-patient and cohort models from actual costs



Actual costs are represented as 100%. The chart demonstrates that the cohort model routinely underestimated monthly costs, by as much as 26% in some months. However, the total variance for the cohort model was 92%, which fell within the ±10% tolerance range agreed between Roche and Vhi.

The chart also demonstrates that the per-patient model frequently underestimated monthly costs as compared to the actual costs, due to fluctuation of the patient mix on treatment across the months. However, over the course of the year, these variations balanced out, resulting in only a 1% differential between the estimated and actual annual costs.

Conclusions

The development of this fixed-price subscription model has shown that innovative pricing approaches can support broad patient access to HER2-targeted treatments, provide budget stability, and enhance financial planning for payers treating patients with a specific disease whose treatment pathways can vary across patient types. Accurate patient forecasting is essential, particularly for the cohort-based approach, which relies on a fixed monthly cost to the payer irrespective of patient numbers.

The fixed-price per-patient model demonstrated consistently better performance than the cohort model, as its forecasting depends on the anticipated treatment mix rather than total patient volume. As a result, this approach delivered greater precision and maintained close alignment with real-world treatment patterns.

There is potential to broaden this model to additional therapy areas where a Health Technology Developer (HTD) has multiple products available to treat patients with the same disease. The model could additionally be scaled to cover a whole portfolio of products across multiple therapy areas, though improved forecasting capability would be required; potentially supported by improvement and advancements in AI technology.

Additional benefits to this approach include reduced administration burden over time once initial setup and monitoring processes have been established. Overall, this risk-sharing approach can strengthen long-term partnerships between payers and the HTD, improve budget predictability and support and broaden patient access to innovative therapies.

References

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