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Reimbursement and Funding of Hospital-Based Drug Therapies

Stephen Hull, Robert Reidy & Kaytlyn Oliver
Hull Associates LLC

Abstract/synopsis

It has been well established that the growth of specialty pharmaceuticals, which today represent approximately 45% of the United States pharmaceutical market, has been accompanied by greater spending by hospitals on inpatient drugs (Healthcare Distribution Alliance, 2019) (NORC, 2019). In part, this shift may coincide with greater numbers of physician-administered therapies for rare and difficult-to-treat diseases. Analyses of US spending on inpatient drugs have found that annual spending increased almost 10% per hospital admission between 2015 and 2017 (NORC, 2019).

But are the systems of reimbursement for inpatient care designed to address these costs? Because many hospital environments are reimbursed via bundled payment methods, innovator companies selling to hospitals must address a completely different set of challenges from prescription pharmaceuticals – in particular previously determined, fixed payments for hospital stays, and in some international markets, capped annual budgets that limit overall spending on such products.

Globally, the most common scenario of payment in hospitals is the use of Diagnosis Related Groups (DRG) to pay a predetermined amount for an entire patient discharge, which reflect the primary diagnoses and procedures provided to the patient. But DRG systems create obvious disincentives for adoption of promising new therapies and diagnostics since hospitals often cannot cover their additional costs. Starting with the US in 2000, special pathways to address the high additive costs of new innovative drugs were developed in a number of DRG payment systems (106th Congress, 2000). England, Germany and France all subsequently implemented systems of add-on payment for certain inpatient innovations as part of their DRG type-systems.

Drugs that achieve supplemental payment are often indicated for rare or severe diseases. But different requirements and lack of transparency in health technology assessments (HTAs) for these products varies by country, which can lead to delays in reimbursement and patient access for new drugs (Akehurst, 2017). Variability may even be greater for hospital-based therapies.

This chapter describes the special pathways established for high-cost, specialty drug products in the United States, Germany, France, and England along with recent developments that directly impact the evidence portfolios that manufacturers need to anticipate to succeed in today’s markets.
USA reimbursement schemes – inpatient hospital setting

Medicare

In the United States, the cost of Medicare inpatient care is covered by a patient’s DRG payment for each admission in over 3,000 hospitals nationwide (Centers for Medicare & Medicaid Services, 2020). Because DRGs pay for admissions with a pre-determined, bundled payment that is calculated from prior year data, there is a time lag in the update to payments for new innovations. Hence, new innovations may struggle to gain adoption until DRG payment rates for admissions reflect the added costs of the drug. For small volume therapies used in select patients, it is quite possible the DRG rates for large volume conditions will never adjust upward sufficiently to compensate their costs.

Section 533 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) mandated that Medicare implement an add-on payment to adequately cover the costs of new innovations introduced in the hospital setting (106th Congress, 2000). The core concept of the US legislation was to create a bridge for promising innovations to receive add-on payment to the DRG payment, while Medicare collected data on the overall costs of admissions so it could then make a permanent assignment to an appropriately paying DRG.

While the original statute required Medicare to pay additionally for qualified new drugs, it did not specify the exact criteria for eligibility. This was refined in 2001 when CMS used its authority under the statute to provide the process and criteria for new technology add-on payments (NTAP) (Centers for Medicare & Medicaid Services, 2001). Additional modifications to the statute were implemented under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which amended the NTAP criteria (Medicare Modernization Act, 2003). The current eligibility criteria are:

1. the drug or technology must be new;
2. the drug, medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and
3. the drug, service or technology must demonstrate a substantial clinical improvement over existing services or technologies (Centers for Medicare & Medicaid Services, 2019).

“New” under CMS rules means within two to three years following market introduction (Centers for Medicare & Medicaid Services, 2001). Drugs that are considered substantially similar to older technologies are not considered new (Centers for Medicare & Medicaid Services, 2010).

Demonstrating inadequate payment involves a formula for the applicable DRG payment groups, based on the lesser of 75% of the standardised amount increased to reflect the difference between costs and charges, or 75% of one standard deviation beyond the geometric mean standardised charge for all cases to which the new technology is assigned (Centers for Medicare & Medicaid Services, 2019).

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Determining substantial clinical improvement under the Medicare definition can be complex. Drugs are considered eligible if:

- the drug offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments; or
- use of the drug significantly improves clinical outcomes for a patient population as compared to currently available treatments (Centers for Medicare & Medicaid Services, 2001).

Applicants must submit data to CMS verifying that the average charge per case exceeds the MS-DRG cost threshold. CMS makes add-on payments only for individual cases that are more costly. The payment caps for traditional NTAP approved drugs currently are the lesser of:

1. 65% of the cost of the new drug; or
2. 65% of the excess cost compared to the standard DRG payment (Centers for Medicare & Medicaid Services, 2019).

Recently, CMS established an alternative pathway for NTAP approval. This alternative pathway applies to a special class of anti-microbial drugs designated by the FDA as a Qualified Infectious Disease Product (QIDP) (Centers for Medicare & Medicaid Services, 2019).

QIDPs are antibacterial or antifungal drugs for human use intended to treat serious or life-threatening infections, including those caused by an antibacterial or antifungal resistant pathogen, including novel or emerging infectious pathogens, or any qualifying pathogens listed by the US Secretary of Health and Human Services (HHS) (United States House of Representatives, 2020).

Under this new alternative NTAP pathway, such drug products given a QIDP designation by the FDA will be considered new and not substantially similar to an existing technology for purposes of NTAP payment under the IPPS, and will not need to meet the previously defined “newness” criterion that it represents an advance that substantially improves, relative to technologies previously available (Centers for Medicare & Medicaid Services, 2019).

Applicants seeking NTAP approval through the alternative QIDP pathway must submit data to CMS verifying that the average charge per case exceeds the MS-DRG cost threshold, and CMS will make add-on payments only for individual cases that are more costly. For FDA-designated QIDPs, the payment caps for alternative NTAP approved technologies are currently the lesser of:

1. 75% of the cost of the new service or technology; or
2. 75% of the excess cost compared to the standard DRG payment (Centers for Medicare & Medicaid Services, 2019).

As the NTAP legislation approaches the end of its second decade, there is debate as to whether it has had any true impact, with only a small volume of drug products deemed eligible. By September 30, 2007, 28 applications had been received, eight had been approved – and only one of these was a drug product, drotrecogin alpha (activated) protein for treatment of severe sepsis associated with acute organ dysfunction (Bockstedt, 2010). But now, in 2020, there are currently 14 newly approved or continually approved drugs that qualify for NTAP (Centers for Medicare & Medicaid Services, 2019) (Centers for Medicare & Medicaid Services, 2018). Two drugs designated as QIDPs are currently approved for NTAP: VABOMERETM and ZEMDRI™ (Centers for Medicare & Medicaid Services, 2019).
The drugs newly approved for NTAP in FY 2020 are:

- **AZEDRA®** – a treatment for cancers known as heochromocytoma and paraganglioma.
- **CABLIVI®** – therapy for thrombotic thrombocytopenic purpura, a blood disorder.
- **ELZONRIS™** – a drug used to treat blastic plasmacytoid dendritic cell neoplasm, a cancer of the blood and bone marrow.
- **ERLEADA™** – a breakthrough treatment for prostate cancer.
- **SPRAVATO®** – a nasal spray medication for treatment resistant depression.
- **XOSPATA®** – medication used to treat acute myeloid leukemia that is resistant to other treatments.
- **JAKAFI™** – treatment for bone marrow disorders.
- **BALVERSA™** – second-line treatment for locally advanced or metastatic urothelial carcinoma.

**Medicaid**

Medicaid reimbursement of hospital care varies by state, with some states applying a bundled, DRG system known as the All Patient Refined – Diagnosis Related Groupings (APR-DRG) and others relying on a per diem or fee-for-service model (Henry J Kaiser Family Foundation, 2012). As of November 2018, 37 states rely on DRGs, eight established per diem rates, and one state uses a combination of the two methods for inpatient hospital services. The remaining five states use another approach, such as a per stay payment or cost-based reimbursement (MACPAC, 2018).

Each state government determines the amount of payment. Unlike commercial or Medicare plans, the payments are often considered to be below the cost of care (Reinhardt, 2009).

Alongside the system of reimbursement for hospitals is the outpatient 340b drug discounting programme, which provides hospitals access to discounted drugs for low income patients. This programme has been criticised as providing hospitals with undue financial margins, without any mandate to pass on savings to patients (US Government Accountability Office, 2011). Hence, it may help hospitals adjust to disproportionately low Medicaid payments, but it does not help support manufacturer introductions of innovations in that setting.

**Private commercial payers**

Under commercial plans, payment for inpatient pharmaceuticals can also be bundled with no separate payment, although generally commercial payment rates are higher than Medicare rates. Only 23% of payers, based on covered lives, are reimbursed based on the Medicare model, an 11-percentage point decline from the previous year (Magellan Rx Management, 2019).
The system of discounted charges has been criticised as providing hospitals with excessive margins for dispensing and prescribing drugs, both physician-administered and prescription. One recent study found average hospital mark-ups for 20 leading drugs to be 487% (Moran Company, 2017). When compared to the reported costs for those same cases, the authors found average hospital reimbursement by the commercial payers was 252% above costs. Thus, the commercial payer methods of reimbursement may provide an avenue of payment that helps offset losses for the same drugs used for other patients whose DRG-based reimbursement shifts risk for the drug costs onto the hospital. The net impact of these two very different systems of payment regularly leads to the phenomena of “cost shifting” within hospitals, where the revenue for certain commercially insured patients helps to balance a hospital’s books for capped reimbursement under DRG systems, both public and private.

**Germany’s NUB process and hospital therapies**

With European Union or national drug regulatory approval, a drug can be adopted by German hospitals. In 2011, the Act on the Reform of the Market for Medical Products (Arzneimittelmarkt-Neuordnungsgesetz, AMNOG) mandated a G-BA (Joint Federal Committee) review prior to local Statutory Health Insurance (SHI) reimbursement for all new drugs. The G-BA is the highest authority in German healthcare and is the key decision-maker for assignment of premium drug pricing. Otherwise the new therapy is reimbursed at the level of the standard therapy.

Clinical evidence presented in the AMNOG dossier is usually the same evidence used for regulatory drug approval. The G-BA, with the support of the Institute for Quality and Efficiency in Health Care (IQWiG), subsequently analyses the potential additional patient benefit based on the following parameters:

- **Clinical**: mortality, morbidity, quality of life and side effects.
- **Economic**: duration of therapy, dosage and cost of drug/yearly therapy cost, if applicable, size of target patient group based on clear definition of indication, any additional/accompanying health services needed with the new therapy.

The AMNOG dossier evaluation and subsequent discussion in the G-BA, including hearings with experts from industry, physicians’ and patients’ associations, have a fixed timeframe of six months (Joint Federal Committe (G-BA), 2017).

Hospital adoption initially depends on clinicians, but long-term adoption depends on adequate reimbursement. Larger university hospitals may adopt new drugs before reimbursement is established to ensure the availability of an innovative therapy to patients in need. Long-term, all types of hospitals need to achieve cost-covering reimbursement via the German DRG system.

**G-DRGs and NUB innovation payment**

The German DRG system (G-DRG) for hospital payment was originally based primarily on the Australian Refined DRG system, with a number of modifications, including the possibility of both short-term and permanent supplemental add-on payments for certain therapies.

One G-DRG payment usually covers all costs of a patient’s hospital stay, including treatment, drugs, and devices. As of 2020, nursing fees are excluded from this bundle and are paid separate daily fees. Hospitals must also follow annual hospital budgets, which are calculated according to annual case mix.

Permanent implementation of new (and higher) tariffs for innovative drugs into the DRG system takes at least three years. Temporary bridge funding is possible for new hospital
drugs under the NUB Innovation Clause (Neue Untersuchungs- und Behandlungsmethoden). NUB funding must be applied for each year, by each hospital using the new drug (Cornelia Henschke, 2013). To qualify, drugs must fulfil the following criteria (InEK Institute for Remuneration System in the Hospital, 2018 to 2020):
(1) not properly reimbursed via existing coding and fees;
(2) have been used for less than four years in German hospitals; and
(3) cause significant additional costs for the hospital stay.

InEK (Institut für das Entgeltsystem Im Krankenhaus), the agency that administers the German DRG system, has never published a threshold for determining “additional cost” but a commonly known unofficial threshold is €500 per case.

Hospitals apply individually for NUB funding through the InEK. Once approved, NUB status allows each hospital to negotiate one-year supplemental fees with local Statutory Health Insurance (SHI) funds (IGES, 2018). Each hospital must reapply for each NUB supplement, annually, and products are typically eligible for up to four years. Notably, there is no official time limitation on eligibility for NUB, and it can widely differ between products.

To date, oncologic drugs and antimycotics make up the majority of drugs approved for NUB. Severity of illness, demonstrated proven patient benefit and cost are the major success factors in obtaining NUB funding.

Following the NUB process, InEK then reviews data from “calculation” hospitals to determine the appropriate, long term integration into the G-DRG system based on the total cost of associated care. Hence, a drug may be integrated into the cost structure of identified G-DRGs or be assigned a permanent supplemental payment.

As the trend depicted below shows, drug-related NUB applications, as well as approvals, have increased annually. Overall, applications from 2018 to 2020 have experienced a 43% success rate.

Drug-related NUB applications and approvals, 2018–2020

(InEK Institute for Remuneration System in the Hospital, 2018 to 2020)

**ZE permanent supplemental payments**

If drugs do not “fit” into the DRG structure, InEK may consider ZE (Zusatzentgelt) permanent supplemental payment. ZE payments are used for drugs with multiple DRG assignments. ZE services are nationally designated but issued in two forms: one with a nationally fixed reimbursement price; and a second that is locally negotiated (similar to the NUB).
Eligibility requirements for a ZE are:
• clearly defined procedure (with OPS code);
• used with multiple DRGs without fixed association to any DRG; and
• relevant cost for the total DRG system, especially the hospitals rendering the service.

While permanent supplemental payments slightly decreased over the past few years, negotiable ZEs for drugs are increasing. Drug related ZEs often are published with a whole list of reimbursable amounts depending on dosage (if applicable) and are reviewed annually.

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**InEK ZE assignments for inpatient drugs, 2018–2020**

(InEK Institute for Remuneration System in the Hospital, 2018 to 2020)

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**The French Liste en Sus and Hospital Funding**

In France, the High Authority on Health (Haute Autorité de Sante, HAS) review pathway is mandatory for hospital use of all new drug products. Manufacturers must submit a clinical dossier to the HAS Transparency Committee, which analyses the severity of the pathology, the drug efficacy, the side effects, and positioning.

The HAS applies an evidence review process and assigns an appraisal of “Medical Services Rendered” (SMR) and “Improvement to Medical Services Rendered” (ASMR). The SMR takes into account the seriousness of the pathology for which the drug is indicated and data specific to the drug itself in a given indication (efficacy and adverse effects; positioning in the therapeutic strategy – particularly in relation to other available therapies – and existence of therapeutic alternatives; and public health relevance). The SMR can be important, moderate, low or insufficient. The ASMR corresponds to the therapeutic progress made by a drug. Depending on the assessment, several levels of ASMR have been defined on a five-point scale, where only products with an ASMR level III or better are eligible for Liste en Sus supplemental payment.

If expected drug sales are over €20 million, a health economic review will also likely be required.

If the HAS review is positive, the drug can either be listed on the list for community (Homologation assurés sociaux) and/or on the list for hospitals (Homologation collectivité). The Comité économique des produits de santé (CEPS) will review the economic dossier provided by the manufacturer:
• The CEPS will negotiate the tariff with manufacturer. Budget impact models are critical.
• For ASMR I to III, drugs are eligible for a listing on the Liste en Sus, paid in addition to the GHS.
In some cases, some hospital pharmacies can deliver drugs to ambulatory patients for home use. These drugs are listed on the “Retrocession list”.

Reimbursement rates will depend on the SMR level in the outpatient setting.

Each drug reviewed by the HAS CT receives an SMR and ASMR according to the clinical evidence submitted, which will determine the level of reimbursement.

- SMR (Service Medical Rendu) is written for drugs at the time of the review, which can be confirmed, upgraded or downgraded for old drugs according to available clinical studies. New drugs also receive a rating (major/important, moderate/low, insufficient).
- ASMR (Amelioration de Service Medical Rendu) reviews are written for drugs that are improvements on existing medications or variations on existing treatments (HAS Haute Autorité De Santé, 2014).

SMR and ASMR reviews must be sufficiently favourable for the new drug to be listed on the Liste des Médicaments Remboursables (Reimbursed Drugs List), which allows the drugs to be reimbursed.

Each French hospital reviews new drugs via internal technology appraisal committees and may take a few months following approval of reimbursement in France. These committees include physicians, pharmacists and finance managers. Medico-economic evidence is welcomed by finance managers in order to understand incomes and costs of standard versus new protocols.

Price negotiations are more substantial in public than in private hospitals. Typically, there is little price negotiation with private hospitals, where acquisition prices are close to the Liste des Médicaments Remboursables (Reimbursed Drugs List). Conversely, in public hospitals, there are significant negotiations for some of the drugs listed.

Hospital Inpatient Payment for Drugs

French inpatient or outpatient acute hospital services are financed through a payment-per-case prospective payment system, using two related groupings. Cases are assigned to a DRG-like type of classification among 700 Groupes Homogènes de Malades (GHM), which has severity adjustment for comorbidities. A nationally fixed tariff (Groupe Homogène de Séjours, GHS, Homogeneous Discharge Groups) is then applied to each GHM.

The GHS tariffs are used to pay public hospitals and a portion of costs in private hospitals. The GHS assignment of each patient discharge reflects a combination of diagnosis (ICD-10) and procedure (CCAM) codes.

A unique feature of the French system is the tendency to pay for a large number of drugs via add-on, supplemental payment. These drugs are listed on the Liste en Sus, which is published annually.

Unlike the US and German temporary add-on payments, the Liste en Sus technically does not have a time limitation, and some products can remain listed for years.

The Liste en Sus mostly includes anticancer, anti-inflammatory, auto-immune and immunoglobin drugs. It is reserved for drugs that are not used uniformly for all patients in a GHS, and where the cost is considered significantly higher than the applicable GHS payment. Nevertheless, drugs are reassessed every five years.

There are five conditions that the hospitalisation council sets out for inclusion on the Liste en Sus:

1. expected usage of the drug;
2. evidence level appraised for the drug (assuming an ASMR above III);
3. frequency of the new drug prescriptions within the GHS is below 80%;
4. cost is more than 30% of the GHS tariff; and
5. cost is similar to that of comparable products (Ministère des Affaires sociales et de la Santé, 2018).
There has been a consistent increase in the number of drugs listed on the Liste en Sus, and as of 2019, there are total of 256 products listed, 30 of which are newly listed. From 2011 to 2019, the number of listed drugs increased by over 42%.

Drugs listed on the Liste en Sus

![Graph showing the number of drugs listed on the Liste en Sus from 2005 to 2019](image)

(Liste en Sus, 2019)

Provision of high-cost drugs to the English NHS

In England, the Health Resource Groups (HRG) system is comprised of a case-mix payment system for all hospitals, both public and private. There is a national tariff of fixed prices for hospital admissions, reflective of averages nationwide. Each specific procedure is assigned a reference cost.

High cost drugs and devices account for around 25% of expenditures on specialised care in England. To ensure that providers and commissioners of health services can deliver the best value of care to patients, NHS England continues to implement measures introduced in recent years which are designed to reduce excess spending and maximise clinical benefit.

In England, drug add-on payments are negotiated locally with Clinical Commissioning Groups (CCGs) or designated nationally for specialised services. The High Cost Drug List in the NHS is intended for specialised products whose use is concentrated in a relatively small number of centers. The purpose of this list is to enable additional payment by NHS England to the hospital trust for inpatient or outpatient-dispensed, high-cost drugs (NHS England and NHS Improvement, 2016).

As in all markets, eligibility for separate payment depends on several requirements. Requirements for the High Cost Drug list have historically been:

1. The drug and its expected associated costs of care are disproportionately high compared to the other expected costs of care within the HRG, which would affect fair reimbursement.
2. There is, or is expected to be, more than £1.5 million spend or 600 cases in England per annum.

Drugs which no longer meet the criteria, and so will not lead to systematically incorrect reimbursement of providers will be considered for removal from the high cost list (Department of Health and Social Care, 2012).
• In the 2015/2016 time period, a total of 314 drugs were listed, 38 were added or altered (NHS England and Monitor, 2014).
• For the 2016/17 list, 53 were added or altered, and five were removed, leaving a total of 354 drugs listed (NHS England and Monitor, 2016).
• For 2017/2019, 54 drugs were newly added or altered to the inpatient High Cost Drug List. Only one drug was removed. There were 404 drugs listed (NHS England and Monitor, 2017).
• For 2020/2021, 16 drugs were proposed to be added to the inpatient High Cost Drug List. Five drugs were proposed to be removed. There are a total of 470 drugs listed (NHS England and Monitor, 2020).

Though it is encouraged, prior appraisal by the National Institute for Health and Care Excellence (NICE) is not a requirement for listing on the High Cost Drugs list.

NHS England recommends payments for high cost drugs excluded from National Tariff be made on the basis of a pass-through of the actual price charged to providers. A central repository of prices for excluded drugs, known as Pharmex, is currently being developed to provide robust data for effective procurement. Providers are mandated to provide Pharmex data.

An online clinical decision support tool (known as “Blueteq”) was implemented in 2015/16 as NHS England’s standard electronic contractual prior approval system and covers a range of high cost drugs excluded from tariff.

Starting in 2016/17, the scope of items covered by Blueteq has been extended to all high cost drugs excluded from tariff where NHS England Clinical Commissioning Policies or NICE Technology Appraisals exist, or where there is variation in uptake, or significant financial risk (NHS England, 2015).

Cancer Drugs Fund

The Cancer Drugs Fund (CDF) was initially established in 2011 as a temporary solution to enable access to cancer drugs that are not routinely available through the NHS. The budget for the CDF increased annually in the initial years, but actual spending continued to exceed its budget. The Fund was originally scheduled to conclude in 2014 but was later extended to the end of March 2016, and then taken over by NHS England and a new appraisals approach was enacted (NHS England, n.d.). The new process offers managed access arrangement to new treatments, while additional evidence is collected to address clinical uncertainty. The additional evidence is used to help NICE to decide if a new treatment should be routinely funded.
NICE appraises all new systemic anti-cancer therapy drug indications expected to receive a marketing authorisation. The process aims to publish draft guidance before a drug receives marketing authorisation, with final guidance published within 90 days of marketing authorisation. The appraisal process is based on the NICE Technology Appraisal, but with additional specific amendments for the Cancer Drug Fund (National Institute for Health and Care Excellence, 2014) (National Institute for Health and Care Excellence, 2016).

The process allows NICE to make one of three recommendations:
• recommended for routine commissioning – ‘yes’;
• not recommended for routine commissioning – ‘no’; or
• recommended for use within the CDF (new).

“Recommended for use within the CDF” can be applied for drugs for which NICE considers there to be “plausible potential” to meet the criteria for routine commissioning, but there remains significant clinical uncertainty.

For those drugs that have received either a “yes” or a draft recommendation for use within the CDF, interim funding is available at the point of marketing authorisation. However, in order to receive this funding, pharmaceutical manufacturers must agree to the expenditure control mechanism (NHS England Cancer Drugs Fund Team, 2016).

Since the new approach to funding cancer drugs began in July 2016, approximately 41,000 patients have been registered to receive treatment with 79 drugs, treating 160 different cancer indications (NHS England Cancer Drugs Fund Activity Update, 2020). As of May 2020, 32 drugs covering 57 indications are listed (NHS England, 2020).

The CDF budget remains fixed at £340 million (NHS England Cancer Drugs Fund Activity Update, 2020). If this fixed budget is exceeded, the additional cost is paid back by companies who generate income from the CDF via a proportional rebate to NHS England and NHS Improvement. In December 2019, the UK government promised to extend the CDF into an ‘Innovative Medicines Fund’ which could add an additional £160 million. There are still questions about what drugs outside of cancer could qualify, with indications suggesting candidates may be from medicines selected for the Early Access to Medicines Fund (EAMS) – a pre-licensing indicator of promising innovation given by the Medicines and Healthcare products Regulatory Authority (MHRA).

Recent Decisions on CAR-T Therapies

Currently CAR-T is not routinely commissioned in the UK. It is only available through the CDF for a limited period of around two years, as further data is collected for reappraisal. The CDF will only pay for the CAR-T drug; all other hospital-related costs are commissioned by NHS England Specialised Services, as in the case for allogeneic haematopoietic stem cell transplantation (i.e. the service specification sets out an approach to defining the pathway as commencing from decision to transplant [30 days] and ends 100 days following the transplantation procedure). After this, commissioning responsibility returns to CCGs (NHS England, 2018).

Conclusions

While there is growing attention to the costs of prescription pharmaceuticals, hospital dispensed specialty pharmaceuticals may face increasing challenges to justify premium prices under increasingly constrained methods of hospital payment. Notably, DRG payment systems are adding tighter controls on overall drug spending and may, in some markets, be very reluctant to provide supplemental add-on payment.

In the USA, hospitals help compensate under-reimbursement for some inpatient
pharmaceuticals via higher markups on other patients. But in single payer environments, such as Britain or Germany, no such cost shifting is possible.

Some systems have maintained special pathways to fund cancer drugs specifically, which has, to some extent, created a safe harbour in some markets. However, these pathways typically place limitations on drug prices.

In those markets in particular, manufacturers face a multi-tiered economic challenge and must prove therapeutic value from an economic standpoint at both societal and provider levels. Robust economic modelling, based on well-designed comparative clinical trials, has thus become a necessity for market success. In addition, for the newest generations of immune-oncology therapies, hospitals simply cannot afford acquisition of the product. In these cases, some manufacturers are obliged to negotiate direct payment agreements with insurers so that costs can be amortised over time, and in some instances, payments can be linked to therapeutic outcomes.

* * *

References


Stephen Hull
Tel: +1 781 982 8600 / Email: shull@hullassociates.com
Stephen Hull, MHS, is the Principal and Founder of Hull Associates LLC, a specialised global market access strategy firm. Stephen Hull has over 25 years of experience in health policy and medical product strategy, for pharmaceuticals, medical devices, diagnostics, and biotech products. He is a former Sr. Vice President of the Advanced Medical Technology Association, and has served as chairman of the medical devices council of the International Society of Pharmacoeconomics Outcomes Research (ISPOR). Stephen has an advanced degree in health policy from the Johns Hopkins Bloomberg School of Public Health, and a Bachelor’s Degree in International Relations and French from Colgate University.

Robert Reidy
Tel: +1 781 982 8600 / Email: rreidy@hullassociates.com
• Bachelor of Science in Journalism with a concentration on Neurobiology, Boston University College of Communication and College of Arts and Sciences.
• Background in clinical cancer outcomes research and European Union consumer rights advocacy journalism.
• Clinical trial management expertise in multisite international studies and published journalist in Ireland’s flagship consumer rights magazine.
• Departmental research coordinator in the Boston Medical Center Department of Otolaryngology with a focus on patient tracking, data collection and analysis, protocol development, and trial design.
• Combined two years’ experience in the public hospital and journalism sectors.

Kaytlyn Oliver
Tel: +1 781 982 8600 / Email: koliver@hullassociates.com
• Master’s of Public Health with a focus in Healthcare Management, Boston University School of Public Health.
• Member of Upsilon Phi Delta, National Academic Honor Society for Healthcare Administration.
• Background in emerging health technology and start-up market entry in multiple international markets.
• Workflow expert in maximising clinical efficiency for a patient-tracking application in the hospital setting.
• Project Manager in a healthcare consulting company with a focus on project success in credentialing, provider enrollment, and billing.
• Combined three years’ experience in healthcare and public health sectors.

Hull Associates LLC
Global Headquarters, 100 Ledgewood Place, Suite 202, Rockland, Massachusetts 02370, USA
Tel: +1 781 982 8600 / URL: www.hullassociates.com
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