Perspective on EU HTA implementation in NL

A discussion on challenges and opportunities

NVTAG Symposium on EU HTA

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Disclaimer

I do not speak on behalf of the Dutch industry. These opinions are not necessarily reflecting the opinions of other pharmaceutical companies in the Netherlands.

The intent of EU HTA

"Greater transparency will empower patients, by ensuring their access to information on the added clinical value of new technology that could potentially benefit them.

More assessments could lead to effective, innovative health tools reaching patients faster.

For national authorities it means being able to formulate policies for their health systems based on more robust evidence.

Furthermore, manufacturers will no longer have to adapt to different national procedures."

-European Commission HTA Regulation proposal press release statement

Transparent

"Greater transparency will empower patients, by ensuring their access to information on the added clinical value of new technology that could potentially benefit them.

Faster

More assessments could lead to effective, innovative health tools reaching patients faster.

High quality

For national authorities it means being able to formulate policies for their health systems based on more robust evidence.

No duplication

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-European Commission HTA Regulation proposal press release statement

Poll: On which aspect do you think EU HTA can help us do better regarding reimbursement decision-making in the Netherlands?

(multiple options possible)

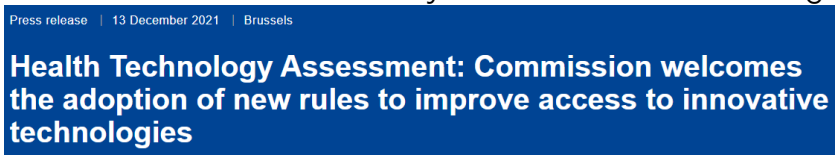
- More transparency
- Faster
- Higher-quality
- Less duplication
- None, it will stay the same or get worse on all fronts

Roche’s history with EU HTA

Roche has been supportive of the intent of EU HTA since the start

- Participated in EUnetHTA Joint Assessments

- Contributed to the advocacy for EU HTA when the legislation was being drafted



- Has been an active contributor to stakeholder workshops and public consultations on draft methods and guidelines

Roche experience with EUnetHTA joint assessments

PTJA03 ⇨ most used EUnetHTA report (22 organizations)

2017 - 2018

PTJA03

Extension of indication

- **Author:** TLV, Sweden
- **Co-Author(s):**
  - HVB, Austria
  - AAZ, Croatia
- **Dedicated Reviewers:**
  - NICE, UK
  - Regione Veneto, Italy
  - Uniba, Slovakia
  - AETSA, Spain
  - NIPN, Hungary
- **Observer:** MoH, Malta

2019 - 2020

PTJA06

First indication (initial MAA)

- **Author:** IQWiG, Germany
- **Co-Author(s):**
  - HAS, France
  - Dedicated Reviewers:
  - FIMEA, Finland
  - SUKL, Czech Republic
  - TLV, Sweden
  - INFARMED, Portugal
- **Observer:** G-BA, Germany

2019 - 2021

PTJA06

First indication (initial MAA)

- **Author:** INFARMED, Portugal
- **Co-Author(s)**
  - EUR, The Netherlands
  - ZIN, The Netherlands
  - Dedicated Reviewers:
  - AEMPS, Spain
  - JAZMP, Slovenia
  - HIS, Scotland
- **Observer:** VVKT, Lithuania

Roche is getting ready for EU HTA

Our perspective on the current implementation of EU HTA
-> focused on implications for the Netherlands

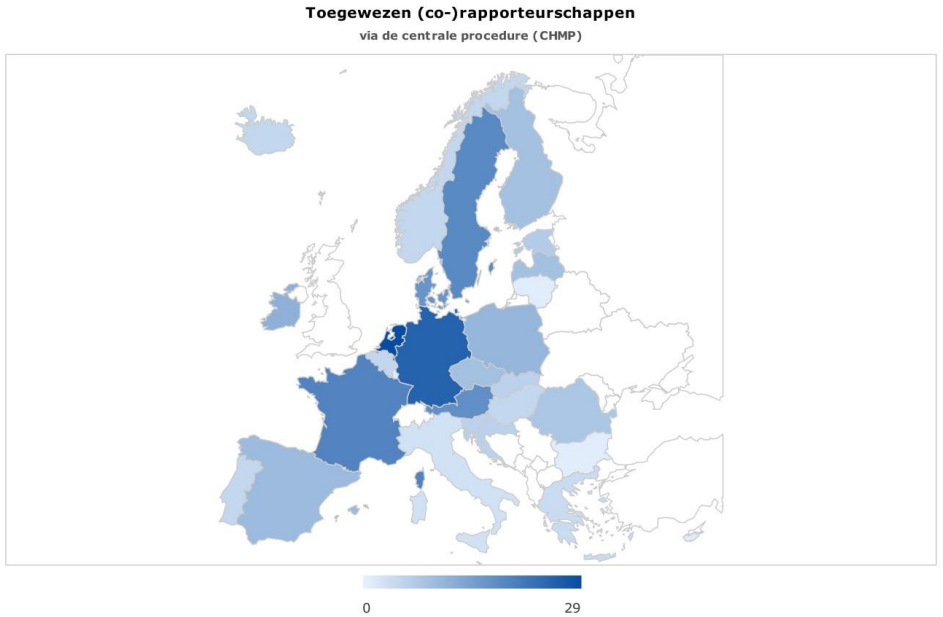
Joint scientific consultation

JSC considerations

- Using JSC and parallel JSC
- Worry about capacity (2024 → 2025+)

ZIN to allocate resources to help out with and lead JSCs within EU HTA

Similar to the active role of CBG-MEB



"Qua procedures en 'productie', de hoeveelheid werk die we doen binnen Europese netwerk, zitten we in de kopgroep. Dat bleek ook weer in 2022" – CBG Jaarverslag 2022 (figure from 2020)

Joint Clinical Assessments

Transparent

"Greater transparency will empower patients, by ensuring their access to information on the added clinical value of new technology that could potentially benefit them.

Faster

More assessments could lead to effective, innovative health tools reaching patients faster.

High quality

For national authorities it means being able to formulate policies for their health systems based on more robust evidence.

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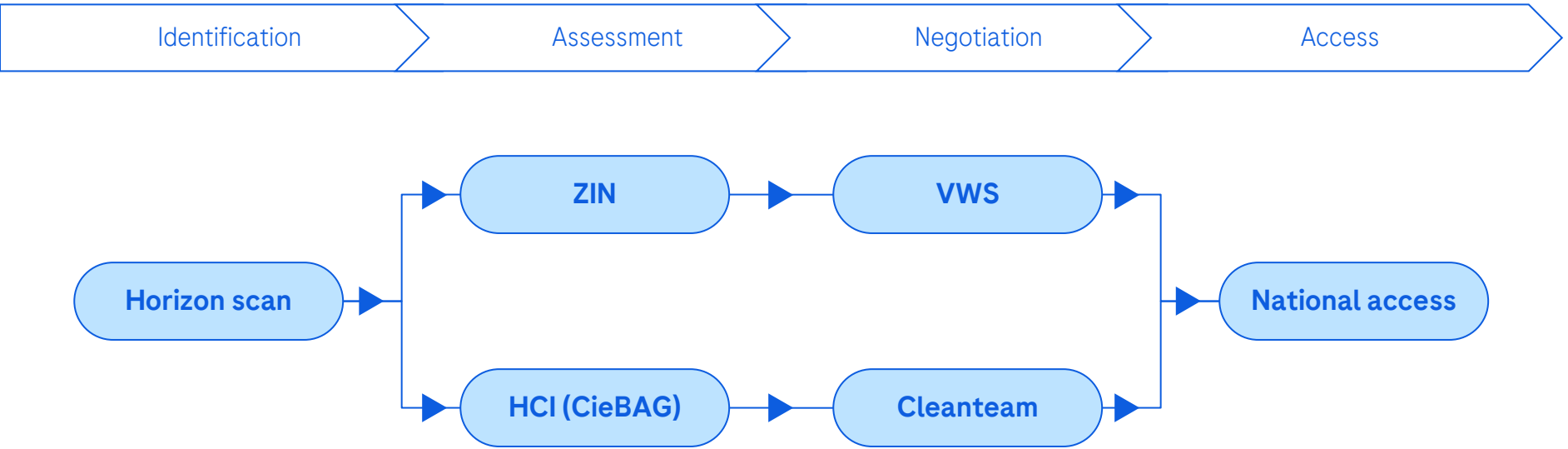
“EU HTA will increase transparency”

National HTA in the Netherlands

Simplified



Obligations for national HTA procedures in NL

Article 13 (1)

"When carrying out a national HTA on a health technology for which joint clinical assessment reports have been published or in respect of which a joint clinical assessment has been initiated, Member States shall:"

Annex dossiers submitted by the HTD at EU level to the HTA documentation at national level

Annex published JCA reports to the national HTA report

MS **must share** information/data **received at national level** that is part of the EU level submission request

MS **must not request data** at national level that have **already been submitted** by a developer **at EU level**

MS give **due consideration** to JCA reports and other information published on the dedicated IT platform

MS **must provide** Coordination Group with information on national HTA and **how the JCA report has been used in national HTA**

Considerations for Transparency

- **ZIN**
  - Is already transparent, from an industry perspective no major issues foreseen in annexing the report etc.
  - Dutch vs English

- **CieBAG**
  - Systematically publishing assessments, accommodate article 13 obligations
  - Facilitated through ZIN?

Giving due consideration should mean that the JCA report is leading in assessments when possible.

Not yet clear what the reporting will entail exactly.

“EU HTA will lead to faster decision-making”

Poll: How long do you believe a Dutch assessment should take after the JCA report is available?

(only one option)

- 1 day
- 1 week
- 1 month
- 3 months
- 6 months or more
- I don’t know

EU HTA provides an opportunity to be faster in the Netherlands

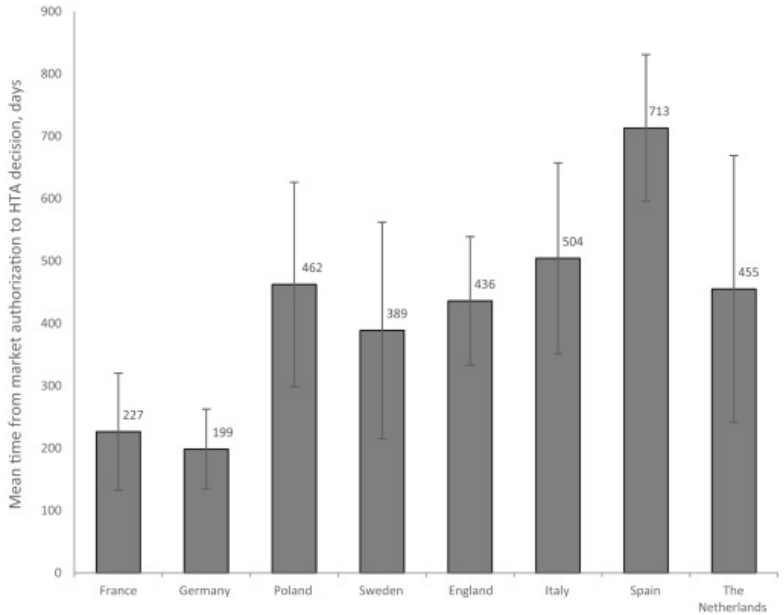


Fig. 2 Mean length of time from EMA authorization to HTA decision for oncology products. Dates are taken from the product decision/publication date on the relevant country agency Web pages. For Germany, the time is from EMA authorization to IQWiG recommendation. Error bars: SD. EMA, European Medicines Agency; HTA, health technology assessment; IQWiG, Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen.

Akehurst RL, Abadie E, Renaudin N, Sarkozy F. Variation in Health Technology Assessment and Reimbursement Processes in Europe. Value Health. 2017 Jan;20(1):67-76.

EU HTA provides an opportunity to speed up reimbursement decision-making in the Netherlands

Think about:

- Submission timing & establishment of Dutch PICO
- Early interactions required of patients, physicians, HCI, ZIN, VWS, HTD
- Access route choices, triage (-15 months)
- Parallel processes
- As little additional national requirements as possible
- Unpublished data will likely be the norm
- Capacity ZIN & HCI (now and then)

Decision timing in the Netherlands:

Max 30 days after JCA report becomes public (MA+60)

A little bit more on EU timelines

- Start EU HTA at EMA submission at the latest, with notification & PICO information
- Dossier preparation vs EMA clockstop
- Establishing PICO vs dossier preparation vs assessment

The EU **JCA must be efficient and also workable** for both HTDs and assessors within the tight procedural timelines.

Specifically on the PICO process

- PICOs drive JCA
- NL already experienced
- Earlier interactions = better (BIA + CEA)

We ask for transparency in what member states put forward in the scoping process, to make sure we can prepare for any complementary national assessments.

On the PICO survey

EUnetHTA21 results, 3 PICO exercises:

- 6 PICs * 16 Outcomes = 96 PICOs (contributions of 8 countries)
- 5 PICs * 16 Outcomes = 80 PICOs (contributions of 10 countries [13 HTAb])
- 9 PICs * 16 Outcomes = 144 PICOs (contributions of 10 countries [14 HTAb])

Balancing relevance to nHTAs with workability of EU HTA

- Evidence-based establishment
- Single PICOs?

Considerations for “Fast decision-making”

At different levels

On a European level:

- EU PICOs relevance vs workability.
- Timelines can be improved.

For the Netherlands:

- ZIN+HCI reports max. JCA+30 days.
- EU and NL in parallel, with unpublished data.
- Start much earlier.
- NL to conform to EU HTA & JCA.
- ZIN needs capacity, and to contribute extensively.
- Developers needs to know *early* what they need to deliver - interaction in scoping phase!

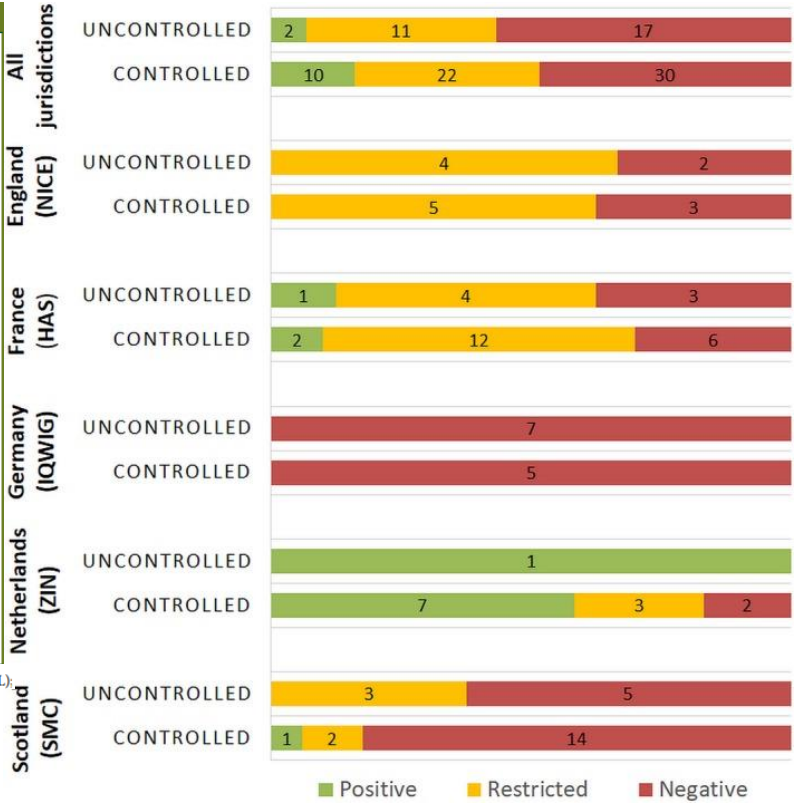
“EU HTA will lead to higher-quality HTA”

Assessment conclusions vary in Europe even when they are based on the same evidence

Table 2. List of medicines included and outcome of recommendations that inform pricing and/or reimbursement decisions

Abbreviated indication	Medicine (generic name)	England	France	Germany	The Netherlands	Poland	Scotland
Bone metastases from solid tumors	Denosumab	⊕ (optimized)	⊕ (minor)[a] ⊕[a]	Not assessed	⊕	⊖, c and €	Not assessed
Breast cancer	Eribulin	⊖, €	⊕ (minor)	⊕[b] ⊕[b]	⊕	⊖, c and €	⊖, €[c]
	Pertuzumab	Not assessed	⊕ (moderate)	⊕ (major)[d]	Not assessed	⊕	⊖[e], €
Colorectal cancer	Aflibercept	⊖, c and €	⊕	⊕ (minor)	Not assessed	⊕	⊖[f], €
Gastric cancer	Tegafur/gimeracil/ oteracil	Not assessed	⊖, c	Not assessed	⊖, c	⊖, c	⊕ (with restrictions)
Melanoma	Ipilimumab, second-line Tx	⊕[g]	⊕ (minor)[h]	⊕ (considerable)	⊕	⊕	⊖, c and €
	Vemurafenib	⊕[g]	⊕ (moderate)	⊕ (considerable)[i]	⊕	⊕	⊖, €[c]
	Dabrafenib	⊕	⊕	⊕	Not assessed	⊕	⊕ (with restrictions)[j]
Non-small-cell lung cancer	Afatinib	⊕	⊕	⊕ (major)[k] ⊕ (minor)[k] ⊕[k] ⊖, c[k]	Not assessed	⊕	⊕
	Crizotinib	⊖, €[g]	⊕ (moderate)	⊕	Not assessed	⊖, c and €	⊖, €[c]
Prostate cancer	Cabazitaxel	⊖, €	⊕ (minor)[l]	⊕ (considerable)[m] ⊕ (minor)[m]	⊕	⊖, c and €	⊖, c and €
	Abiraterone, after Tx with taxane	⊕[g]	⊕ (moderate)	⊕ considerable)[n]	⊕	⊕	⊖ €[o]
	Enzalutamide	⊕[g]	⊕ (moderate)	⊕ (considerable)[p] ⊕ (major)[p]	Not assessed	⊕	⊕ (with restrictions)
Renal-cell carcinoma	Axitinib	⊕ (optimized)[g]	⊕ (minor)	⊕ (considerable)[q]	Not assessed	⊕	⊖ €[c]
	# assessments	12	15	18	7	14	13
	n ⊖/% ⊖	4/33%	1/7%	1/6%	1/14%	5/36%	9/69%

⊕, recommended/added benefit; ⊕, no added benefit proven (GE)/similar therapeutic value (NL, FR); ⊖, not recommended (EN, PO, SC)/lesser benefit (FR, GE, NL);



(L) Kleijnen S, Lipska I, Leonardo Alves T, Meijboom K, Elsada A, Vervölgyi V, d'Andon A, Timoney A, Leufkens HG, De Boer A, Goettsch WG. Relative effectiveness assessments of oncology medicines for pricing and reimbursement decisions in European countries. Ann Oncol. 2016 Sep;27(9):1768-75. doi: 10.1093/annonc/mdw233. Epub 2016 Jun 20. PMID: 27329251.

(R) Vreman RA, Bouvy JC, Bloem LT, Hövels AM, Mantel-Teeuwisse AK, Leufkens HGM, Goettsch WG. Weighing of Evidence by Health Technology Assessment Bodies: Retrospective Study of Reimbursement Recommendations for Conditionally Approved Drugs. Clin Pharmacol Ther. 2019 Mar;105(3):684-691.

European versus national assessment

- EUnetHTA21 guideline proposals: leave (any) judgments to Member States

EUnetHTA 21 Guideline	Text extract
D4.3.1	“Each MS should be enabled to decide on the validity of direct or indirect treatment comparisons itself based on the JCA report.”
D4.3.1	“Substantiating the Proportional Hazards assumption without such evidence might be possible in some cases, but the acceptance is then at the discretion of the MSs.”
D4.3.2	“We recognise that there is an element of subjectivity in the assessment of many assumptions and that decisions may vary between member states.”

Implementation uncertainty

- Uncertainty how this will play out:
  - Variation between countries in methodological requirements
  - Proposed guidelines for JCA leave a lot of interpretations to MS

Obviously, developers cannot submit all methodological approaches for all PICOs within the JCA

- Will it depend on the country that assesses whether it is acceptable?
- Will individual countries ask for slight variations on the applied methods after the JCA?
- Will countries conform to what is asked/delivered in EU HTA?
- Will we get negative national conclusions because of methodological choices made on an EU level?
- Will we get more precise guidelines that define which (single) method is most appropriate in which instance?

A reflection on assessment conclusions

Germany	• Major added benefit • Moderate added benefit • Minor added benefit • No added benefit • Non-quantifiable benefit/ benefit not proven • Less benefit
The Netherlands	• Added benefit • No added benefit • Less benefit / non-quantifiable benefit

Considerations for “high-quality HTA”

At different levels

On a European level:

- Indirect comparisons are a necessity for the JCA and its many PICOs, such analyses should not be disregarded at the outset.
- The same goes for endpoints.

For the Netherlands:

- ZIN has expertise and should contribute to JCAs and methodology development.
- ZIN & CieBAG should evaluate whether current assessment conclusions and their consequences are still appropriate in the context of EU HTA.

“EU HTA will prevent duplication”

On duplication

Roche experience with a EUnetHTA procedure

NOTE: procedure was in 2020 under EUnetHTA. Many aspects may be different from EU HTA.

- Positive experiences:
  - Good interactions, positivity
  - Due consideration

- Opportunities for improvement:
  - Many unknowns
  - Pharmacotherapeutic “supplement” still extensive

- What is different now:
  - The JCA report will not include a scientific discussion. This might make it harder to interpret.
  - We expect more simplification of the submission format for the NL supplement (less duplication).

Considerations for “no duplication”

For the Netherlands

- What concessions is ZIN willing to make, to ensure the success of EU HTA?
  - English vs Dutch
  - Only one with a specific PICO?
  - ZIN should not ask anything on top of the JCA report that is not explicitly local (epidemiology, Dutch treatment guideline)

Conclusions

“Greater transparency will empower patients, by ensuring their access to information on the added clinical value of new technology that could potentially benefit them.

More assessments could lead to effective, innovative health tools reaching patients faster.

For national authorities it means being able to formulate policies for their health systems based on more robust evidence.

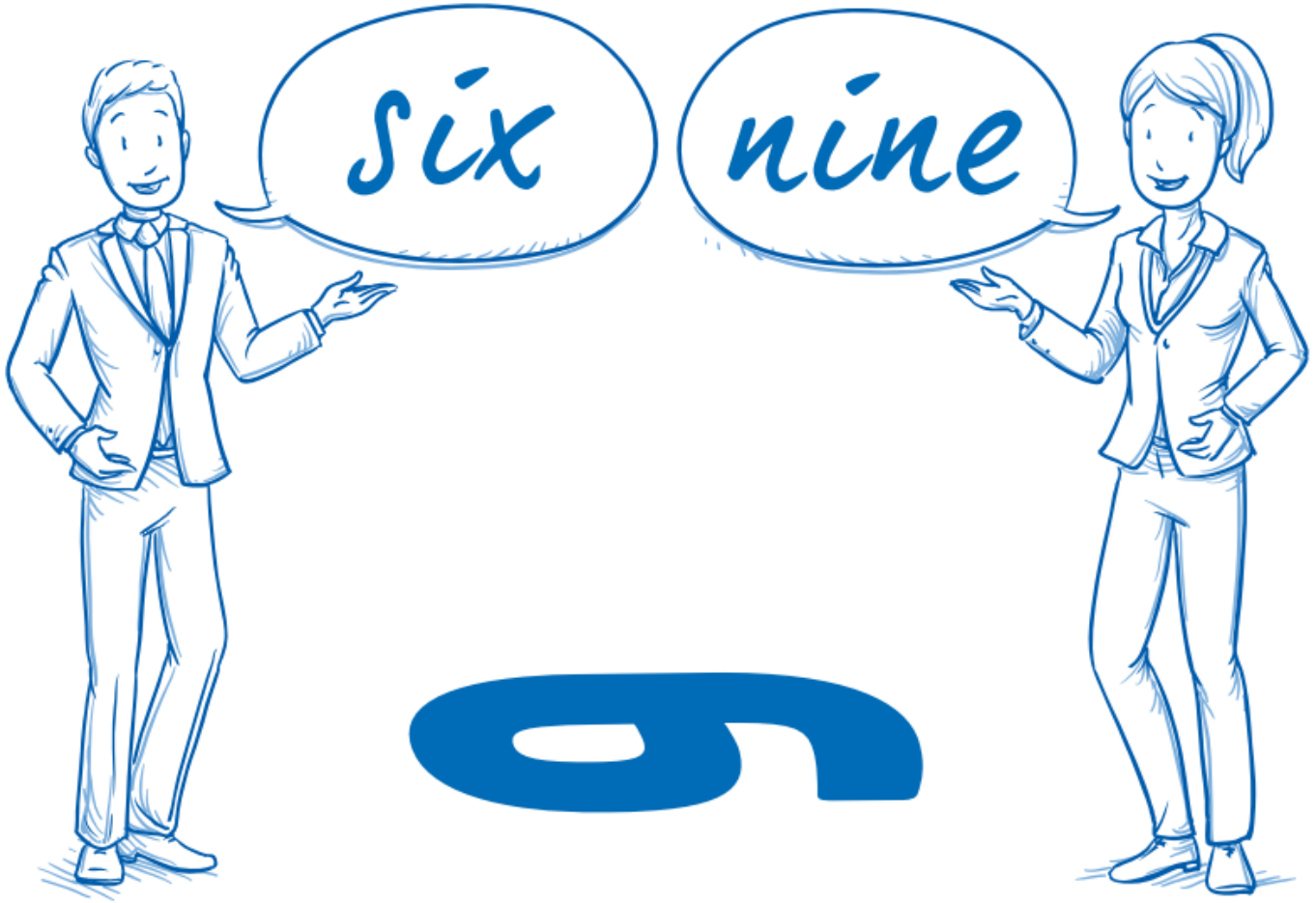
Furthermore, manufacturers will no longer have to adapt to different national procedures.”

-European Commission HTA Regulation proposal press release statement

Take home messages

For Roche Netherlands

- EU HTA provides lots of opportunities to optimize access decision-making in the Netherlands!
- Implementation is key, interaction is vital.
- Proactivity Dutch stakeholders.
- There are 15 months left to get ready. All of us have a lot of work to do!
  ZIN, VWS, cieBAG, developers, patients, physicians, academics, ……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Doing now what patients need next