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ORIGINAL ARTICLE

Confidentiality in the Pharmaceutical Managed Entry Agreements in Romania

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Abstract: *Background and Aim: Health technology assessment for drugs is a necessary step in developing health policies that are focused on patients and getting the best value for scarce resources. One important feature of health technology assessment is transparency. In many countries, health technology assessment is followed by negotiations between pharmaceutical companies and health authorities to determine whether a drug will be publicly funded. These negotiations often result in Managed Entry Agreements, which typically include confidentiality clauses covering the final price of the drug. Methods: We reviewed Romanian legislation starting in 2014 to assess the level of confidentiality and transparency in drug pricing and reimbursement. Results: We found that for drugs with Managed Entry Agreements, the level of discounts is confidential, the public does not know how much the government is paying for each of these drugs, the volumes (units) of drugs are not transparently published by the payer, the outcomes, in terms of patients treated by therapeutic area, therapeutic success, and resource utilization, are confidential. Conclusions: We consider that too much confidentiality can prevent the public from knowing if the government is getting good value for money, but too little confidentiality can lead to higher drug prices or a lack of drugs from the market.*

Keywords: *managed entry agreements, health technology, confidentiality, pricing, reimbursement*

INTRODUCTION

Every year, the pharmaceutical industry introduces new drugs on the market, constantly developing new solutions for known illnesses. The licensing mechanisms of new drugs are already fully regulated, and the beneficial effects and potential risks have been proven through numerous preclinical and clinical studies [1].

One of the main concerns of each country in establishing its policy on medicines is the permanent increase in the price of new medicines, which generates a growing pressure on the budgets allocated to health [2]. Once they enter the market, the big challenge for a new drug is to be accepted for financing from public funds (or through the health care mechanisms specific to each country). For this, in most of the EU countries, each drug is passed through the very fine sieve of the Health Technology Assessment (HTA) process, the ultimate goal of which is to provide health decision-makers with sufficient relevant information based on which to establish priorities in the field of care, such as the reasonable cost that they afford, and the level of financing, their efficiency, respect for legal and ethical values, and equity.

To develop patient-focused health policies that seek to achieve the best value for scarce resources, one characteristic of the HTA is the transparency of the process [3]. Together or after the HTA process, in numerous countries, there is a practice of negotiations between the Marketing Authorization Holder (MAH) and health authorities to get access to a drug to public financing using Managed Entry Agreements (MEA). In 1993, first-time conventions, lately called MEAs, were introduced between producers and third-party payers, targeting discounts and rebates for innovative drugs [4,5].

The need for these contracts was born from the producers' desire to make price reductions only in the conditions in which they obtain guarantees regarding the avoidance of parallel import and the downward spiral of the price as a result of the fact that the visible price decrease in one country attracts a decrease in all other countries and finally even in the respective country as a result of the use of reference prices. From this perspective, MEAs have a common denominator,

respectively, the confidentiality covering the final price of the drug generally as a means to avoid price decreases in other countries.

On the other hand, the third-party payer is interested in keeping costs within a predictable and bearable margin, obtaining superior outcomes for patients, and spending the available resources as efficiently as possible [4]. MEAs can be divided into financial agreements that directly affect the budget (confidential discount or rebate, price-volume agreements, volume or expenditure cap, free initial treatment, etc.) and performance-based agreements that evaluate the treatment's performance (coverage with evidence development, payment by result, conditional treatment continuation, etc.) [4,6,7].

In Romania, a scorecard model called HTA was introduced in 2014. This is based primarily on the results of the assessments or reimbursement status for the respective drugs in EU countries. The health authorities decided in 2015 to increase the financial sustainability of the new drugs through the transfer of financial risk to MAHs via Managed Entry Agreements (known locally as Cost-Volume contracts, which are financial-based agreements, and Cost-Volume-Results contracts, which are performance-based agreements) [8]. The introduction of MEAs allowed a thawing of the introduction of innovative products on the reimbursement list for medicine (the List), after many years of impasse.

To conclude a functional MEA for a drug, there are several mandatory steps in Romania, some of which are confidential and some of which are transparent. These steps are (1) publishing of the List prices in the Official Gazette; (2) submitting the HTA dossier, obtaining the HTA body's approval and publishing the HTA Report; (3) negotiating the MEA, if applicable; and (4) adding the drug on the List.

METHODS

We performed a critical review of the Romanian legislation and rules, from the last 10 years, looking for the confidentiality and transparency aspects covering the pricing and reimbursement of drugs with MEA.

In our research, we worked to identify the elements of the lack of transparency in the price negotiation process for medicines or related to it that could lead to a discrepancy between the benefits offered to patients and the actual price paid.

RESULTS

The Romanian regulations do not stipulate the confidentiality of the final purchase prices. The joint order from the Minister of Health and the President of the National Health Insurance House (NHIH) requires that any confidential information obtained during the execution of the MEA contract (Cost-Volume contract) be used only to fulfill the MEA's purpose and not be disclosed or utilized for other reasons, including the final price of the medication in question [9].

Our analysis revealed that drug reimbursement in Romania through MEAs involves a blend of public and confidential data.

In Romania, there are two List Price catalogs: (1) one used for public reimbursement (Canamed) [10] and (2) one used only by pharmacies or health care providers not having a public reimbursement (Public Catalogue) [11]. Both catalogs are publicly available in the Official Gazette and on the Ministry of Health website [12], while Canamed can be seen also with the reimbursement price on the local payer website [13] (last update on July 1st, 2021). For the International Reference Pricing process done by other countries, the Ministry of Health recommends the use of the Public Catalogue (with higher List prices than Canamed).

The submission of the HTA dossier is a highly confidential process, with most of the steps not transparent: the content of the HTA dossier, the members of the evaluation team from the HTA body, the deadline for the evaluation, and the involvement or not of the Specialty Commissions from the Ministry of Health. Every month, the HTA body (National Agency for Drugs and Medical Devices – ANMDM) publishes a list of the drugs received for HTA evaluation. Next, the HTA report for each drug and the decision and the meeting minutes of the Appeal Committee (only for the drugs where the MAH was not satisfied with the results of the HTA report) are also published.

The HTA methodology allows the MAH to offer (part of the HTA dossier) a "confidential discount" to the payer (NHIH), one key aspect of confidentiality, resulting in a lower price compared to its competitor. This "confidential discount" should be part of a Protocol between MAH and the payer to include the obligation of the MAH to lower the net price (not visible) once the HTA report is positive and then the drug is included in the Reimbursement List 2020 [14].

The negotiation of a MEA is mainly a confidential process. The decision to apply for an MEA relies on the MAH level and also the proposal to be addressed to the Negotiation Committee. The negotiation is contingent upon the number of patients under contract and the eligible population. Ministry of Health (MoH) Specialty Commissions establish the eligible population and publish it on the payer website. Often, these Commissions are not transparent about the data they use to define and establish the eligible population. The number of contracted patients is strictly confidential because the ratio of contracted patients to eligible patients determines the discounts to be

paid by MAH as part of MEA (between 25-75%). The table with these discounts is publicly available and published in the Official Gazette (Table 1) [9,15]. This section may be divided by subheadings. It should provide a concise and precise description of the experimental results, their interpretation, as well as the experimental conclusions that can be drawn.

Table 1: Discounts for MEA depending on the market share covered

Percent (%) applied to quarterly consumption (single drug)	Percent (%) applied to quarterly consumption (multiple winners for substitutable drugs)	Percent (%) no. of contracted patients from the no. of total eligible patients
25%	30%	<5%
30%	35%	5-15%
35%	40%	15-25%
40%	45%	25-35%
45%	50%	35-45%
50%	55%	45-55%
55%	60%	55-65%
60%	65%	65-75%
70%	75%	>=75%

The term for these MEAs is one year and is publicly available, their starting point is the first month after the inclusion of the drug in the List.

The renegotiation process involves a simpler approach, with a publication of the moment for negotiation and a clear request for the Specialty Commissions to provide arguments regarding the change in the eligible population.

Other optional aspects of the negotiation, like the coverage by the MAH of some testing or other services, are usually available to the public on the websites of the local affiliates of the payer, due to the need to inform the providers of these aspects [9].

After the conclusion and the execution of the MEA, the MAH will pay the final discount to the payer according to the effective patient share, irrespective of the contracted patient share and discount. The respective data is provided by the payer only to the MAH and nobody else could access this information.

The Parliament approves the payer budget for MEA negotiation and contracting through the State Budget Law. The process of determining this MEA budget is not transparent to the public [16]. Meanwhile, the payer discloses the remaining budget after every round of MEA negotiations. The payer typically reserves a certain amount of its drug budget for drugs that require a new yearly MEA contract to ensure the continued operation of existing MEAs. If the contracting budget is over, no new MEA is signed and for the existing MEAs, there is no renegotiation; only the included patients can continue their treatment and there are no new inclusions of patients.

The budget for drugs with MEA is not available to the public on a monthly or quarterly basis, but at the end of each year, the authorities issue a note detailing the total budget used. MEA's budget information is also included in the Payer Yearly Report, published in the second half of the following year.

The decision to include the drug on the List is highly political, as it requires budget allocation for its introduction. The process for the calculation of budget needs for new drugs is not transparent. The information is only publicly available once the draft of the List is published for public comment.

DISCUSSION

Some authors have pointed out that the classically invoked reasons, namely that the prices of new drugs are very high because most of the income is reinvested in research, are no longer in line with the reality of the time. Drug manufacturers often carry out a series of additional purely financial operations, such as mergers and acquisitions and stock transactions, and play an active role in the capital market, etc. [9,17]. In recent years, concern has grown regarding the confidentiality of the final purchase prices of medicines; in 2019 WHO recommended to member states that they take measures in this regard [18].

The MEA process's opacity creates advantages and disadvantages for the MAH and NHIH regarding the confidentiality of final prices paid by the public payers. The opaque process of setting new budgets extends also for the case when MEAs and the random addition of expenses every time a new product is conditionally approved creates confusion among drug beneficiaries and competing MAHs. Other beneficiaries of the health-care system who require additional

funds (except for new drugs) frequently raise concerns.

The legislation for the MEA budget grants access to new drugs on a first-come, first-served basis. Priority criteria are also considered and include the unmet need, the drugs with EU emergency approval, and the public health reasons [15].

The payer does not transparently publish the volume (units) of drugs, including those with MEAs. The only publicly available data on the payer's website is at the ATC3 level and the INN level for the top 10 drugs in terms of value reimbursed in open pharmacies for each category (A, B, C, D, and E) of the reimbursement List [19]. Contract monitoring is challenging because currently there is no way to access treatment outcome data or resource utilization for patients receiving MEA treatments; the payer does not conduct cost-effectiveness analyses or publish data; and manufacturers do not have access to confidential patient outcomes.

The confidentiality stipulated in the MEA prevents not only price comparisons but also the comparisons of the treatment outcomes, making it impossible for any researcher to develop any pharmacoeconomic analysis or to monitor the physician's performance.

There are no transparent rules on the term to publish the updated List (and include the newly evaluated drugs), as the legislation only specifies an update once a year. The practice has shown that shorter terms are needed.

The payer agrees to keep the final prices confidential to avoid the risk of the producer choosing not to sell in Romania than to affect the prices in other countries and decrease the access to new technologies for the population, which would be discriminatory.

The confidentiality of the final price could also be viewed as means to respond to limited resources available in the healthcare sector and is linked with delayed access to innovative technology which could address also the quality of care and patient safety, but even with more resources these aspects will be removed only through a better understanding from the health care professionals [20].

Before 2017, payers and manufacturers would sign collaboration protocols, which included confidential discounts. Protocols aimed to decrease prices in Romania's public healthcare system without affecting the visible drug price or international reference price. Due to unclear legislation, these protocols were abolished and replaced with a new type of protocol where the MAH could support some of the financing burden of the payer [21].

The Payer determines the reimbursement prices (reference price) based on a specific methodology, but its application is not transparent [22]. Anyone can find prices on NHIH's website, and pharmacies will charge co-payments if drug prices are higher than the reimbursement price.

As other authors have already pointed out, the various confidentiality elements of the MAH process prevent other possible cost-containment policies from being used. Meanwhile, in Romania, some of these policies are also used (biosimilars/generic stimulation for prescription, reference pricing, protocols and guidelines for prescriptions, some open tenders for exclusivity) while others are waiting to be implemented (price ceilings, value-based pricing, pay for performance, etc.) [23]

Looking at the future development of MEA in Romania, there are plans to expand from simple cost-volume contracts to other types of MEA, including the payment for performance mechanisms. For this aspect, there will be a need for merging patient-level data with drug-patient data, yet not generally available in Romania at the health system level, but only in some of the hospitals, and the definition and the confidentiality of these patient outcomes will be a new issue during the implementation [24,25].

The future of MEA in Romania will be linked with the new EU Directive on HTA, which will become effective in 2025, and some local projects funded by the MOH in regarding pricing, reimbursement, and HTA. The utilization of a classic HTA model with cost-effectiveness in place could replace the actual scorecard HTA model. This will create the case for the confidentiality of prices used in the cost-effectiveness analysis but will benefit from the public availability of outcomes measures like the local values for Quality Adjusted Life Years (QALY) and will catalyze the efforts to determine the cost of QALY in Romania [26,27,28].

CONCLUSIONS

The negotiation process for the MEA in Romania results in a confidential final price, making it difficult to compare with other EU countries.

Confidential price rises question the legitimacy of some decisions and, in particular, the impossibility of checking over time the cost-effectiveness of drugs in the absence of the knowledge of the cost effectively paid. The solution is finding proper ways to provide more transparency in the process, especially regarding budget allocation. This can be obtained using guidelines as a result of cooperation between all interested actors.

From this perspective, the entire process of delivering drugs to the public domain is a new paradigm that requires new means of increasing the equity of financial allocations within the

healthcare system while ensuring profitability for the MAH and accessibility for the patients. The key solution is better collaboration and communication between stakeholders keeping in mind to meet patients' needs and expectations.

Conflicts of interest and sources of funding

The authors declare no conflict of interest. This research received no external funding.

Authors' contribution

Conceptualization, M.S.P. and C.P.R. methodology, M.S.P. and C.P.R., validation, M.S.P. and C.P.R., formal analysis, M.S.P., C.P.R., and B.C.P. resources, M.S.P., C.P.R., B.C.P., data curation, M.S.P., writing—original draft preparation, M.S.P., writing—review and editing, C.P.R., and B.C.P. visualization, B.C.P.; supervision, M.S.P. All authors have read and agreed to the published version of the manuscript.

Ethics approval and consent to participate

Not applicable

Patient consent for publication

Not applicable.

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