Are there indications of conflicts of interest?

Voting behaviour in AMNOG benefit assessments

The study examines the voting behaviour in the G-BA in AMNOG benefit assessments since 2011, showing on the one hand that most decisions (93%) are passed unanimously. On the other hand, it is particularly striking that the National Association of Statutory Health Insurance Funds (GKV-SV) voted in favour of a lower classification of added benefit in 100% of the dissenting resolutions compared to the other benches. The result empirically illustrates a procedural conflict of interest at the GKV-SV and underpins the structural criticism regarding the governance deficits of the G-BA. Even in the unanimously adopted procedures, these deficits can lead to a systematic negative distortion of the benefit assessment. This cannot be verified due to a lack of documentation at the G-BA. Overall, the unity of the GKV-SV as regulator, referee and player in the AMNOG procedure should be scrutinised more closely. This also applies in particular to the evaluation of the more recent statutory interventions (guard rails and combination discounts), which are highly susceptible to conflicts of interest.

>> Since 2011, all new drugs have been subject to special drug regulation as part of the German Act on the Reform of the Market for Medicinal Products (AMNOG). In the AMNOG procedure in accordance with Section 35a SGB V, the Federal Joint Committee (G-BA) first assesses the additional benefit of these medicinal products. On the basis of this assessment, pharmaceutical companies then negotiate reimbursement amounts for the new drugs with the National Association of Statutory Health Insurance Funds (GKV-SV). The G-BA, as the highest body of joint self-administration in the healthcare system, is therefore the central institution that decides on the benefit assessment. For the AMNOG benefit assessments, its decision-making body (plenum) consists of 5 members of the SHI-SV as the payer bank; 2.5 votes each are allocated to the National Association of Statutory Health Insurance Physicians (KBV) and the German Hospital Federation (DKG) as the service provider bank; three further votes come from the two impartial members and the impartial chairman. Decisions are made by a majority of 13 votes in total. This rules out a stalemate situation. Although the patient representatives currently have the right to co-advise and submit motions to the G-BA, they do not have the right to vote.

In recent years, structural concerns have been raised regarding a lack of institutional separation of powers in the AMNOG procedure (Vorderwülbecke 2013, Frick/Bungenstock 2016, Hüer et al. 2021, Dintsios/Chernyak 2024). The focus of criticism is primarily on the SHI-SV with its multiple roles in the AMNOG. It is not only significantly involved in determining the assessment framework (e.g. in advising pharmaceutical companies or determining the appropriate comparator therapy), but also in the benefit assessment decisions themselves, which in turn form a decisive basis for its subsequent negotiations with the respective pharmaceutical companies in accordance with Section 130b SGB V. A procedurally problematic entity is seen here as a 'rule-maker, referee and player' or an 'institutional omnipresence' (Frick/Bungenstock 2016, Cassel/Ulrich 2015). This puts the GKV-SV in a position to gain negotiating advantages as early as the benefit assessment stage, e.g.through a lower categorisation of the added benefit or the determination of a specific appropriate comparator therapy.

This study analyses the voting behaviour of the G-BA in AMNOG benefit assessments. The focus is on non-unanimous (dissenting) decisions, which can provide indications of potential conflicts of interest or distortions in the benefit assessment.

Results

In total, the AMNOG procedure database contained 974 completed AMNOG benefit assessment procedures for 439 drugs at the time of the analysis (as of 5 June 2024). At 93% (N=905), the vast majority of decisions were taken unanimously in the plenary session of the G-BA. A further 7% (N=69) of the decisions were made without overall consensus from 13 available votes. Of these, 8 decisions were formally unanimous, but with

Methodology

All decisions taken by the G-BA on the benefit assessment of new drugs since the AMNOG came into force in 2011 were used for the analysis. The documentation in the AMNOG procedure database of the vfa (German Association of Research-Based Pharmaceutical Companies) served as the basis. In general, information on voting behaviour in the plenary session is not included in the G-BA documentation. It is only possible to record the voting results by tracking the public plenary sessions. In the case of disagreements that could not be resolved before the plenary session, the reasons are usually summarised by the G-BA chairperson and optionally presented by the respective representatives of the benches. For resolutions in the years between 2011 and 2019, the voting behaviour was documented by on-site participation of a vfa representative in the public part of the plenary sessions. Since 2020, the documentation has been carried out via the live streams of the plenary meetings. The recordings of these meetings are stored in the G-BA's media archive so that the votes can also be viewed by the public retrospectively since 2020. In the case of dissenting resolutions, the respective votes and statements in the plenary sessions were also analysed. In the case of dissenting votes on the added benefit, the categorical classification was compared and categorised. For the probability of added benefit, the increasing order was applied: indication, hint, evidence. For the extent of the added benefit, the following order was used: minor benefit, not proven, minor, not quantifiable, considerable, substantial.

abstentions from one of the G-BA's banks. There were therefore dissenting votes from the G-BA benches in 61 procedures. These non-unanimous decisions are analysed in more detail below.

Over time It can be seen that the proportion of dissenting decisions has continuously decreased over the last few years (see Figure 1). While around 13% of procedures were not concluded unanimously in the first few years, this figure has recently fallen to around 4%

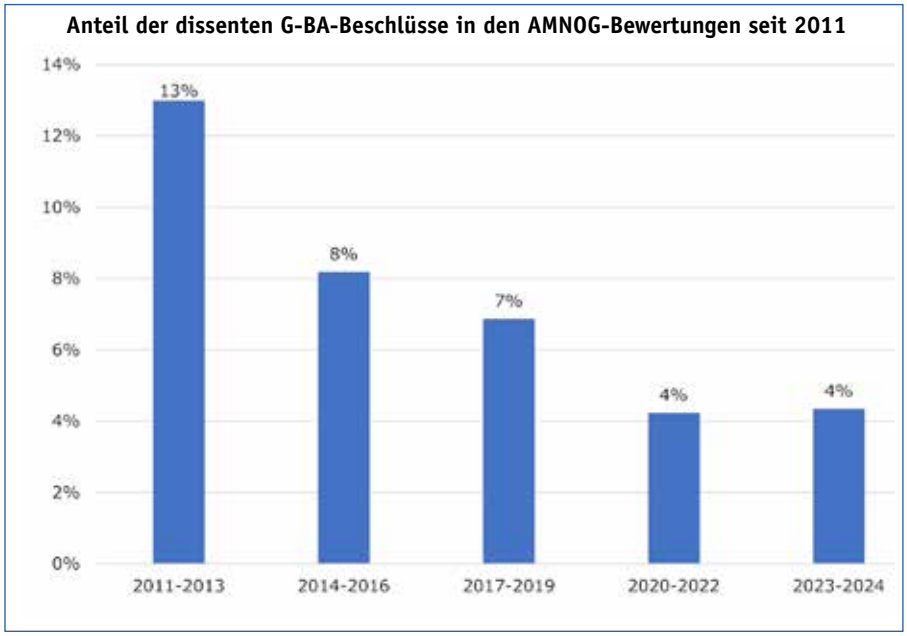


Fig. 1: *Anteil der dissenten G-BA-Beschlüsse in den AMNOG-Bewertungen seit 2011. Eigene Darstellung.*

Therapeutic areas

Most dissenting decisions concerned oncological diseases (N = 27), endocrine, nutritional and metabolic diseases (N = 15), infectious diseases (N = 8), followed by diseases of the nervous system (N = 3), diseases of the skin (N = 2), diseases of the circulatory system (N = 2) and others (N = 3). The proportion of orphan drugs was 23% (N = 14) availability of new findings (N = 6 each), exceeding the sales limit for orphan drugs (N = 3) and the assessment of the existing market (N = 5).

Additional benefits

In 21% (N = 13) an additional benefit was categorised as not proven. In 23% (N = 14) the G-BA decided on a non-quantifiable additional benefit, in 26% on a minor additional benefit (N = 16), in 26% on a considerable additional benefit (N = 17) and in one case on a considerable additional benefit.

Dissenting votes

In terms of content, almost all dissents (N = 57) concerned the basic proof of added benefit or its extent or probability. In four other procedures, the dissents concerned other aspects of the decisions (time limit, presentation of the study results or additional information on the proven added benefit).

With regard to the distribution of votes, it should be noted that in dissenting decisions on added benefit (N = 57), the GKV-SV voted in favour of a lower classification or an unproven added benefit in 100% of the procedures compared to the other benches of the G-BA. In most procedures (N = 40), the GKV-SV voted in favour of an unproven added benefit, and in a further 17 procedures in favour of a lower classification of the extent or probability. The GKV-SV also voted in favour of a restrictive position in four dissenting votes on other aspects of the decisions.

In 61% (24 out of 61) of the votes, the vote of the GKV-SV was overruled, as it only received its own 5 votes or 6 votes together with a dissenter (see Figure 2). For 5 older resolutions (8.2%), the exact vote of the two impartial parties was not known (in these cases, the SHI-SV received 5 or 6 votes). In contrast, the position represented by the GKV-SV prevailed in 39% of the contest votes with a majority of 7 to 10.5 votes.

Over time, it can be seen that the dissenting vote of the SHI funds in plenary has not been followed since June 2022 (see Fig. 3). The non-voting patient representatives voted against the position of the GKV-SV in 69% of the procedures (42 out of 61) and in favour in 31%. In the votes of the institutionalised patient representatives, it can also be seen over time that they have not followed the position of the GKV-SV in the last 18 dissenting decisions on added benefit since August 2020.

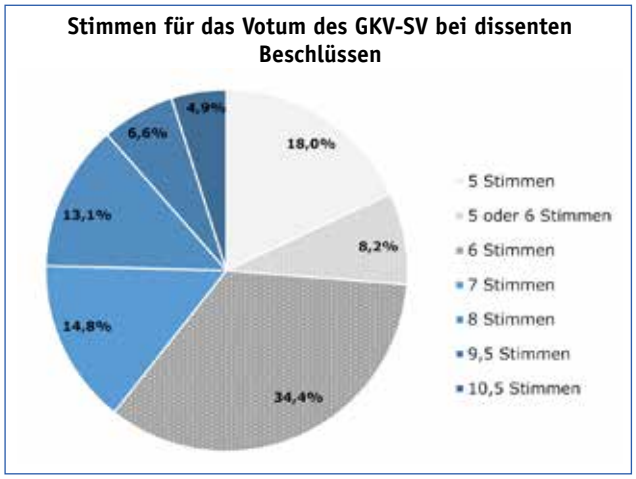


Fig. 2*: Stimmen für das Votum des GKV-SV bei dissenten Beschlüssen. Eigene Darstellung.*

Discussion

It should be noted that the existence of dissenting draft resolutions, their justifications and the voting behaviour can only be inferred from the discussion in the G-BA plenary session. The first two dissenting AMNOG resolutions are an exception, in which at least the dissenting draft resolutions (as position 1 and position 2) were initially included in the summarising documentation (G-BA 2013, G-BA 2013a). In later procedures, information on dissenting items is no longer included in the G-BA documentation (e.g. G-BA 2013b and G-BA 2013c).

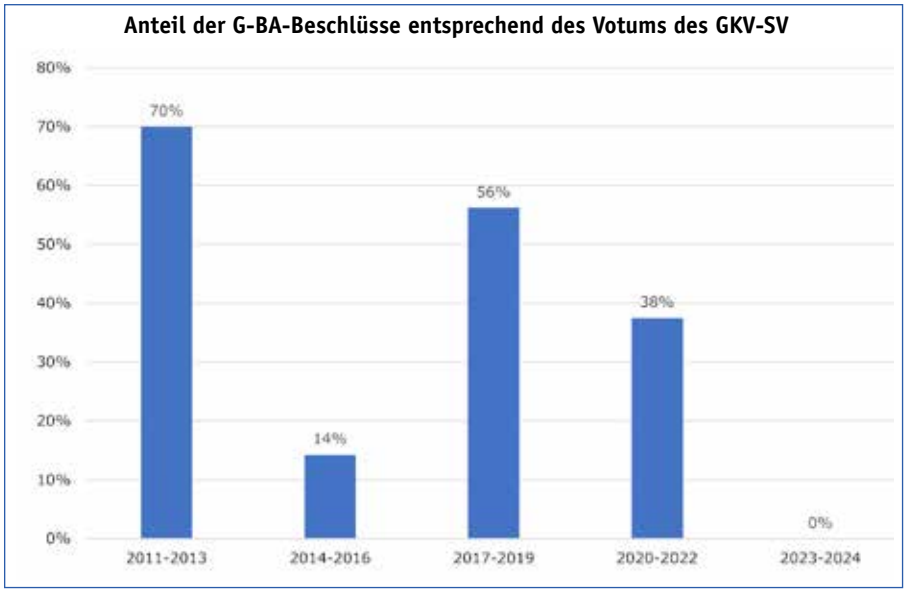


Fig. 3: *Anteil der G-BA-Beschlüsse entsprechend des Votums des GKV-SV. Eigene Darstellung.*

This makes it more difficult to record dissenting resolutions and voting results (see above). At the same time, it should be noted that other subject areas of the G-BA (e.g. quality assurance or method assessment) contain documentation of dissenting positions. The omission of such a presentation for the AMNOG decisions is not comprehensible.

There are no noticeable differences in the respective characteristics of the dissenting procedures analysed, such as the therapeutic area or the reason for the assessment. On the other hand, the proportion (79%) of procedures with an attested additional benefit is higher than for all AMNOG procedures as a whole (54%). This seems plausible, as assessments with a claimed added benefit and potentially relevant studies are more likely to provide a basis for different assessments. The content mostly relates to aspects of the benefit assessment such as the determination or implementation of the appropriate comparator therapy (e.g. decision on niraparib/abiraterone acetate of 2 May 2024, cemiplimab of 19 October 2023 or tucatinib of 2 May 2024).2023 or tucatinib of 2 September 2021), splitting of patient groups (decision on empagliflozin of 15 September 2022) or uncertainties regarding the interpretation of the study results (decision on polatuzumab vedotin of 20 August 2020).

It should be a fundamentally undisputed requirement that the AMNOG procedure ensures the most objective and neutral benefit assessment possible for new medicinal products. Ideally, this requirement should apply to all G-BA benches. An occasionally differing assessment of the quality of the available evidence or the categorisation of the added benefit would be perfectly understandable, as benefit assessment is not an exact science. In an assessment without conflicts of interest, it would therefore have to be assumed for each G-BA bank that there is an even spread on both sides around the imaginary 'true' value. If an objective and neutral assessment were required, a levelling out of the deviating votes between the G-BA banks over time would then be expected.

However, the exact opposite is the case. It is striking that the GKV-SV voted in favour of a lower classification of added benefit compared to other benches in 100% of the dissenting decisions. This treatment of chronic hepatitis C (e.g. in the decision on sofosbuvir of 17 July 2014).

For the dissenting decisions, this results in a dramatic distortion in a negative direction due to the obvious special interests of the GKV-SV with a view to downstream price negotiations. The votes of the service providers can only partially compensate for the negative distortion by the payers, as there are at least no plausible explanations for a systematic positive distortion of the votes (however, a negative distortion cannot be ruled out for them either). Overall (negative bias for payers and at least no positive bias for service providers), the results therefore suggest a systematic negative bias towards less favourable evaluations (see Fig. 4).

In principle, these findings can also be applied to unanimous decisions, although this could not be empirically tested. The discussions and consensus building in the working committees of the G-BA are not documented for the public. Apart from absolute exceptions (for example, the main reasons for the decisions regarding the patient relevance of the endpoint progression-free survival (PFS) always refer to differing opinions within the G-BA), upstream disagreements are therefore not transparent. In such cases, too, a conflict of interest on the part of the payers can be assumed. Figuratively speaking, the conflict of interest that comes to light in dissenting decisions is therefore only a visible 'tip of the iceberg'.

The empirical findings confirm the theoretically founded concerns regarding a governance deficit in the AMNOG procedure. As the significant involvement of the GKV-SV in the benefit assessment serves to prepare the conditions for its own price negotiations, a conflict of interest can be observed. These aspects must also be considered from the perspective of competition theory and regulatory economics (Coenen et al. 2016). It has been pointed out that the composition of the G-BA can lead to socially undesirable compromises. For example, in cases of a harmony of interests between the represented interest groups of payers and service providers, there is a risk of 'horse-trading' at the expense of third parties. The AMNOG procedure is categorised as a regulatory instrument in which there is a risk of outsider discrimination (also by insider service providers).

When discussing the composition of votes, the role of the two impartial parties and the impartial chairman must also be scrutinised. It can be seen that in half of all dissenting resolutions, the two impartial members are without exception in favour of the respective bank that previously proposed them (votes of 6 to 7 or 7 to 6). Over time, such resolutions were mainly observed from 2020 onwards. Prior to 2020, the two non-partisans predominantly voted in unison with the chairmen (votes of 5 to 8 and 8 to 5 respectively). This illustrates the increasing relevance of the vote of the impartial chairperson in the event of a deadlock. At the same time, it seems questionable to

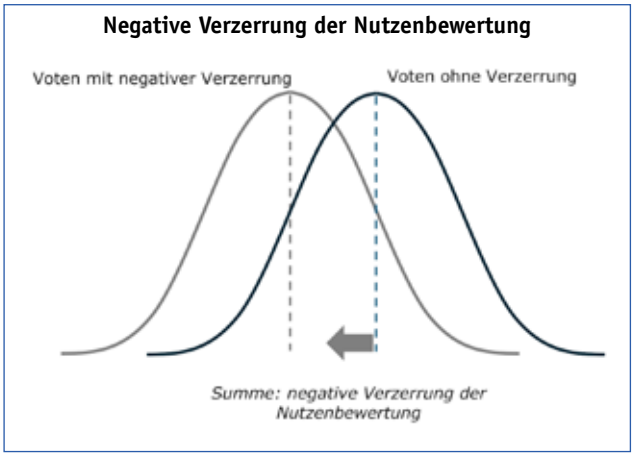


Fig. 4: *Negative Verzerrung der Nutzenbewertung. Eigene Darstellung.*

what extent, in the event of a systematic negative bias by a bank, this can be permanently offset by a chairperson without jeopardising impartiality.

In the future, patient representatives could be given a temporary right of veto in accordance with the draft Healthcare Reinforcement Act (GVSG) (Federal Ministry of Health 2024). According to this, it should be possible to prevent a resolution being passed in the G-BA on a one-off basis in order to enable a renewed discussion of the existing concerns or objections of the patient representatives in the committees of the G-BA. It remains to be seen whether such a temporary veto right would be applied in the AMNOG procedure.

With the SHI Financial Stabilisation Act (GKV-FinStG) coming into force in 2022, the discussion about the practical effects of governance deficits also deserves greater importance (Rasch 2023). This applies both to the new guidelines for negotiating the reimbursement amount (so-called 'guard rails') and to the application of the new combination discount. The new guard rails depend on two factors. Firstly, if there is patent or document protection for the defined appropriate comparative therapy. Secondly, if the additional benefit has been categorised as unproven, minor or unquantifiable.

The GKV-SV is thus significantly involved in the decision on such levers for the validity of the guard rails in the subsequent negotiation, which are also the most frequent points of disagreement. The application of the new combination discount again depends on whether the G-BA has previously determined at least a considerable additional benefit for a drug combination. Here, too, the application is therefore directly linked to a lever that is highly susceptible to conflicts of interest.

On the one hand, it can be seen that most AMNOG benefit assessment decisions are passed unanimously. On the other hand, it is particularly striking that the GKV-SV voted in favour of a lower classification of added benefit in 100% of the dissenting resolutions compared to the other benches. As the decisions of the G-BA serve as the basis for the subsequent price negotiations with the GKV-SV, this result appears unsurprising in principle. It highlights a procedural conflict of interest at the GKV-SV and underpins the structural criticism regarding the G-BA's governance deficits. Even in the unanimously adopted procedures, these deficits can lead to a systematic negative distortion of the benefit assessment as part of the upstream consensus-building process; this cannot be empirically verified due to a lack of documentation. In particular, the procedural unity of the GKV-SV in the AMNOG procedure as regulator, referee and player should therefore be critically scrutinised. Finally, it is evident that the more recent legal interventions (introduction of the guard rails and the combination discount) in particular are highly susceptible to strategic conflicts of interest. This should also be critically scrutinised when evaluating these legal instruments. <<

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Literature

Bundesministerium für Gesundheit (2024): Gesetzentwurf der Bundesregierung Entwurf eines Gesetzes zur Stärkung der Gesundheitsversorgung in der Kommune (Gesundheitsversorgungsstärkungsgesetz– GVSG). URL: https://www.bundesgesundheitsministerium.de/service/gesetze-und-verordnungen/detail/gvsg.html (Stand 5.6.2024)
Cassel, D./Ulrich, V. (2015): AMNOG auf dem ökonomischen Prüfstand: Funktionsweise, Ergebnisse und Reformbedarf der Preisregulierung für neue Arzneimittel in Deutschland. Gesundheitsökonomische Beiträge, Bd. 56, Baden-Baden.
Coenen, M./Haucap, J./Loebert, I. (2016): Bestandsaufnahme zum gemeinsamen Bundesausschuss (G-BA). In: Stiftung Münch, München.
Dintsios, C.-M./Chernyak, N. (2024): 10 Jahre AMNOG: "Value-based Pricing" mit einem Monopsonisten und seine Implikationen für die gesetzlich intendierte Zielsetzung. Sozialer Fortschritt, 73 (2024) 5: 371 – 392
Frick, M./Bungenstock, J. (2016): Problem AMNOG-Governance: Macht ohne Gewaltenteilung. In: Verbesserung der Patientenversorgung durch Innovation und Qualität: 19. Bad Orber Gespräche über kontroverse Themen im Gesundheitswesen. Allokation im marktwirtschaftlichen System, No. 71. Peter Lang International Academic Publishers, Frankfurt a. M.
G-BA (2013): Nutzenbewertungsverfahren zum Wirkstoff Linagliptin (Erneute Nutzenbewertung: Diabetes mellitus Typ 2). In: https://www.g-ba.de/bewertungsverfahren/nutzenbewertung/37/ (Stand 5.6.2024)
G-BA (2013a): Nutzenbewertungsverfahren zum Wirkstoff Ruxolitinib. In: https://www.g-ba.de/bewertungsverfahren/nutzenbewertung/38/ (Stand 5.6.2024)
G-BA (2013b): Nutzenbewertungsverfahren zum Wirkstoff Saxagliptin/Metformin. In: https://www.g-ba.de/bewertungsverfahren/nutzenbewertung/43/ (Stand 5.6.2024)
G-BA (2013c): Nutzenbewertungsverfahren zum Wirkstoff Apixaban (neues Anwendungsgebiet: Prophylaxe von Schlaganfällen und systemischen Embolien). In: https://www.g-ba.de/bewertungsverfahren/nutzenbewertung/57/ (Stand 5.6.2024)
Hüer, T./Abels, C./Wasem, J. (2021): 10 Jahre AMNOG aus Sicht der Gesundheitsökonomik, Gesundheits- und Sozialpolitik (G+S) 1/2021
Rasch, A. (2023): Die neuen „Leitplanken" im AMNOG-Prozess. Monitor Versorgungsforschung (04/23), S. 40–44
Vorderwülbecke, U. (2013): Gemeinsamer. Bundesausschuss und Arzneimittelhersteller: Ein Governance-Problem. PharmR 35: 149-152