The James A. Baker III Institute for Public Policy
and the Baker Institute Health Policy Forum
Rice University

National Healthcare Reform: Policy Options and Imperatives

James A. Baker III Hall
Rice University, Houston, Texas

Friday, February 23, 2007
Opening Remarks at 8:30 am
Closing Remarks at 3:30 pm

Conference Presentation

Cost-Conscious Coverage

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For more information about the Baker Insitute Health Policy Forum: www.bakerinstitute.org.

Summary: Cost-Conscious Coverage

Fundamental to any health care reform effort will be determination of the health insurance coverage that is considered essential. Coverage decision making in the United States today is primarily evidence based. Both Medicare and private insurers focus primarily on the effectiveness of new medical treatments when deciding what to cover, without considering whether these interventions are of high- or low-value to the patient.

That is, care that is not categorically excluded (such as cosmetic surgery) is typically considered eligible for coverage if there is strong evidence supporting its clinical effectiveness. This approach leads to coverage of some interventions that provide little benefit in terms of survival or quality of life yet dramatically raise health care expenditures and health insurance premiums due to their high costs. The evidence standard, however, does not directly address the value of the treatment, since it does not consider costs.

I discuss how value can be incorporated into coverage decision making and argue that, without consideration of value, it will not be possible to promote efficiency in health care.

This talk proposes that we invest more resources in measuring the cost-effectiveness, or value, of treatments to patients and disseminating this information to consumers.

Consumers could then choose which low-value interventions they would be willing to exclude from their health insurance policies in order to obtain more affordable insurance premiums. Consumers who bear more of the costs are going to be the most interested in the value information.

Cost-conscious coverage changes the demand for monopoly products. When a monopolistic care provider sets a price that is too high to be considered cost-effective, the insurance mechanism will no longer act as a price-taker. Since the insurance mechanism has the option not to cover an intervention that is not cost-effective, this will lead to negotiations on the price of the monopoly product.

Coverage policy is only part of the answer. Reference pricing and similar approaches promote value-based purchasing when competing products are available. Benefit-based co-payments offer greater flexibility, but their implementation is challenging.

In the proposed policy, coverage would be determined by both evidence of effectiveness and cost-effectiveness. Many plans would be available where plans covering low-value interventions are available at an additional cost. As an added benefit, cost-conscious coverage will encourage innovation by rewarding high-value products and services rather than those that provide little benefit at a high cost.

Cost Conscious Coverage

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VA Palo Alto Health Care System and Stanford University

Health Expenditure Control in the United States

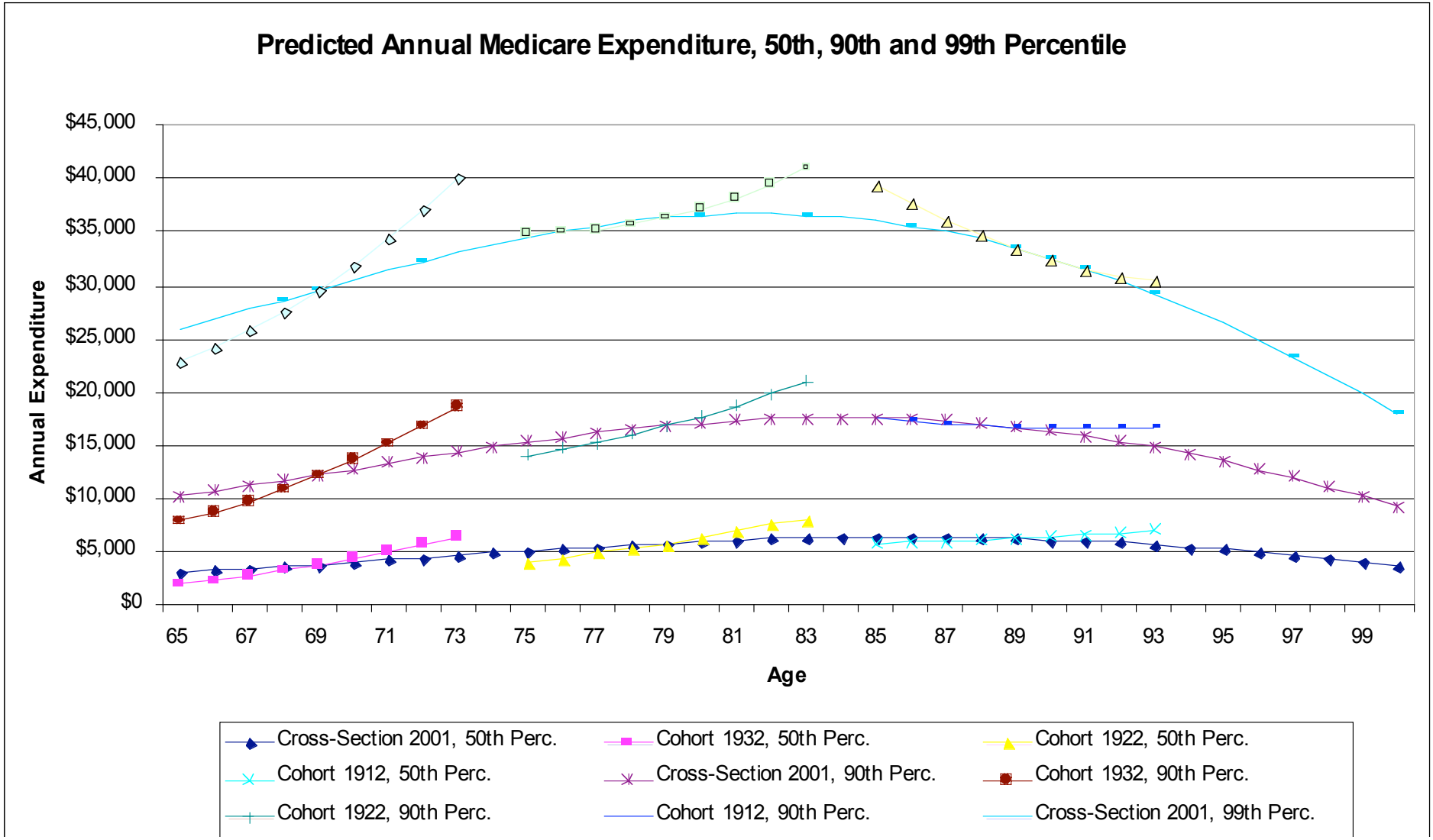
Today’s solution: cost sharing

Cost Sharing Curbs Utilization

- Rand Health Insurance Experiment: 10% increase in copayments for medical care leads to about 2% reduction in utilization
- Higher copayment levels reduce the use of drugs for high cholesterol (statins), high blood pressure (ACE inhibitors) and heartburn (proton pump inhibitors) *Huskamp et al., N Engl J Med 2003;349:2224-32.*

Is cost sharing the answer?

- Most high-deductible plans lack features to limit high-end expenditures
- Compromises risk protection and risk pooling


Predicted Annual Medicare Expenditure, 50th, 90th and 99th Percentile
Annual Expenditure
$45,000
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$0
65
67
69
71
73
75
77
79
81
83
85
87
89
91
93
95
97
99
Age
Cross-Section 2001, 50th Perc.
Cohort 1932, 50th Perc.
Cohort 1922, 50th Perc.
Cohort 1912, 50th Perc.
Cross-Section 2001, 90th Perc.
Cohort 1932, 90th Perc.
Cohort 1922, 90th Perc.
Cohort 1912, 90th Perc.
Cross-Section 2001, 99th Perc.

Coverage Policy is Key to Health Care Goals

- How much farther can cost sharing go?
- "Managed care" remains unpopular
- Coverage policy creates incentives for better information

Coverage Policy Today is *Evidence* Conscious

Medicare Coverage

- Medicare authorizing legislation:

"No payment may be made [by the Medicare program] for any expenses incurred for items and services that 'are not **reasonable and necessary** for the diagnosis or treatment of illness or injury…' "

Title XVIII of the Social Security Act

Commercial Plans: Reimburse for Care that is "Medically Necessary"

- Based upon prevailing practices/community standards in past
- Today explicit processes are usually evidence-based

Blue Cross Blue Shield Association's TEC Criteria

- Technology must have final approval from the appropriate government regulatory bodies
- **Scientific evidence must permit conclusions concerning the effect of the technology on health outcomes**
- **Technology must improve the net health outcome**
- **Technology must be as beneficial as any established alternatives**
- Improvement must be available outside the investigational settings

What is evidence?

- Hierarchy of quality of evidence
  - Opinion, anecdotes, poorly controlled observations considered lowest quality
  - Randomized controlled clinical trials – previously entered in registry - considered the best form of evidence
  - Formal pooled analyses of multiple studies (meta-analysis) common

"Some fear that evidence based medicine will be hijacked by purchasers and managers to cut the costs of health care. This would not only be a misuse of evidence based medicine but suggests a fundamental misunderstanding of its financial consequences. Doctors practising evidence based medicine will identify and apply the most efficacious interventions to maximise the quality and quantity of life for individual patients; this may raise rather than lower the cost of their care."

Sackett et al, British Medical Journal 1996;312:71-72

More Stringent Evidence Standards?

What is wrong with evidence-based coverage policy?

- Absence of evidence vs. evidence of absence
- Applying results beyond the trial population
- The tyranny of the p value
- What to do when evidence is inconclusive?
- Ignores cost

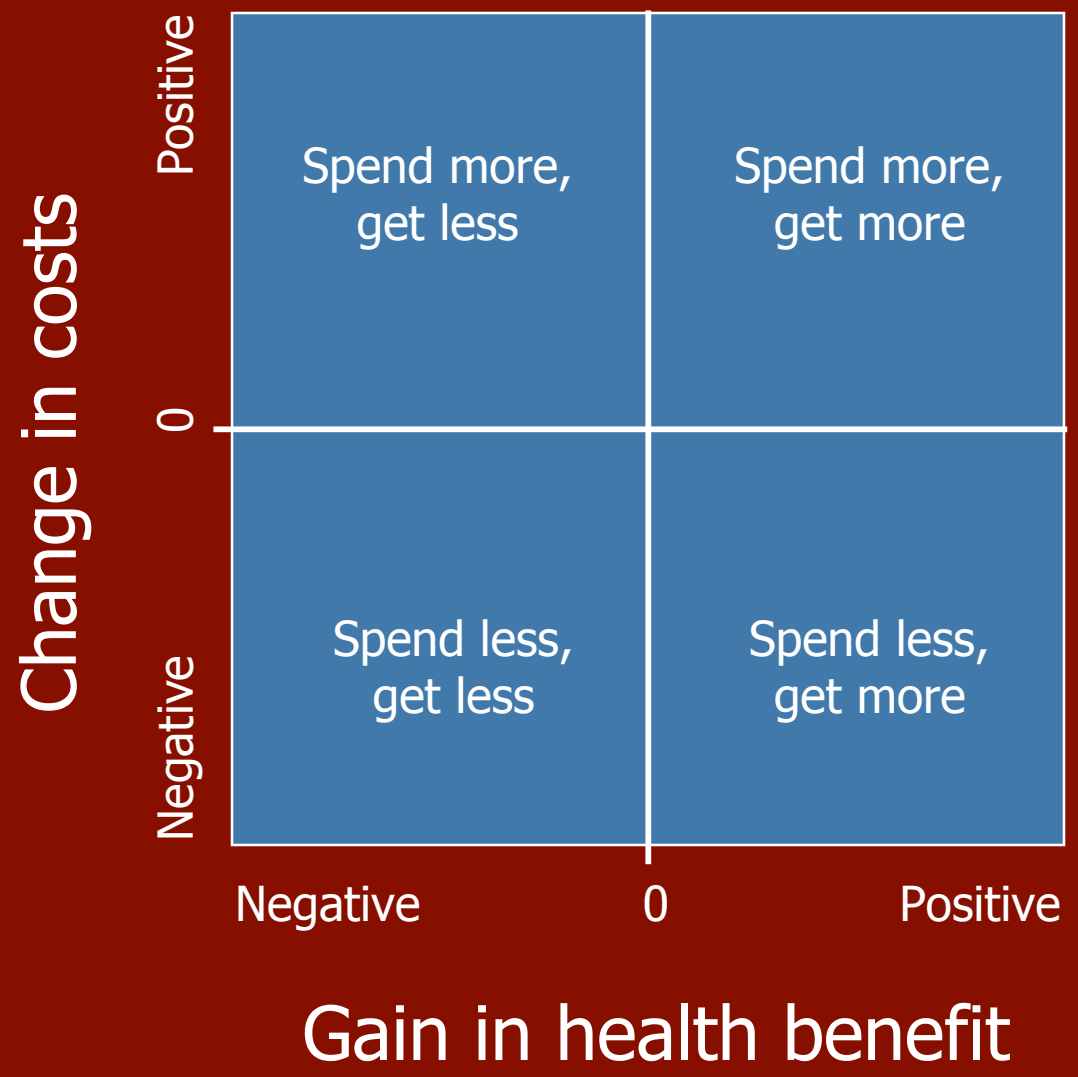
Biotech Products

- Cerezyme for Gaucher disease: up to $500,000/yr
- Avastin for breast and lung cancer: about $8,000/month ($65,000/yr cap ??)
- Erbitux for colon cancer: about $115,000/yr
- Remicade for rheumatoid arthritis: about $20,000/yr

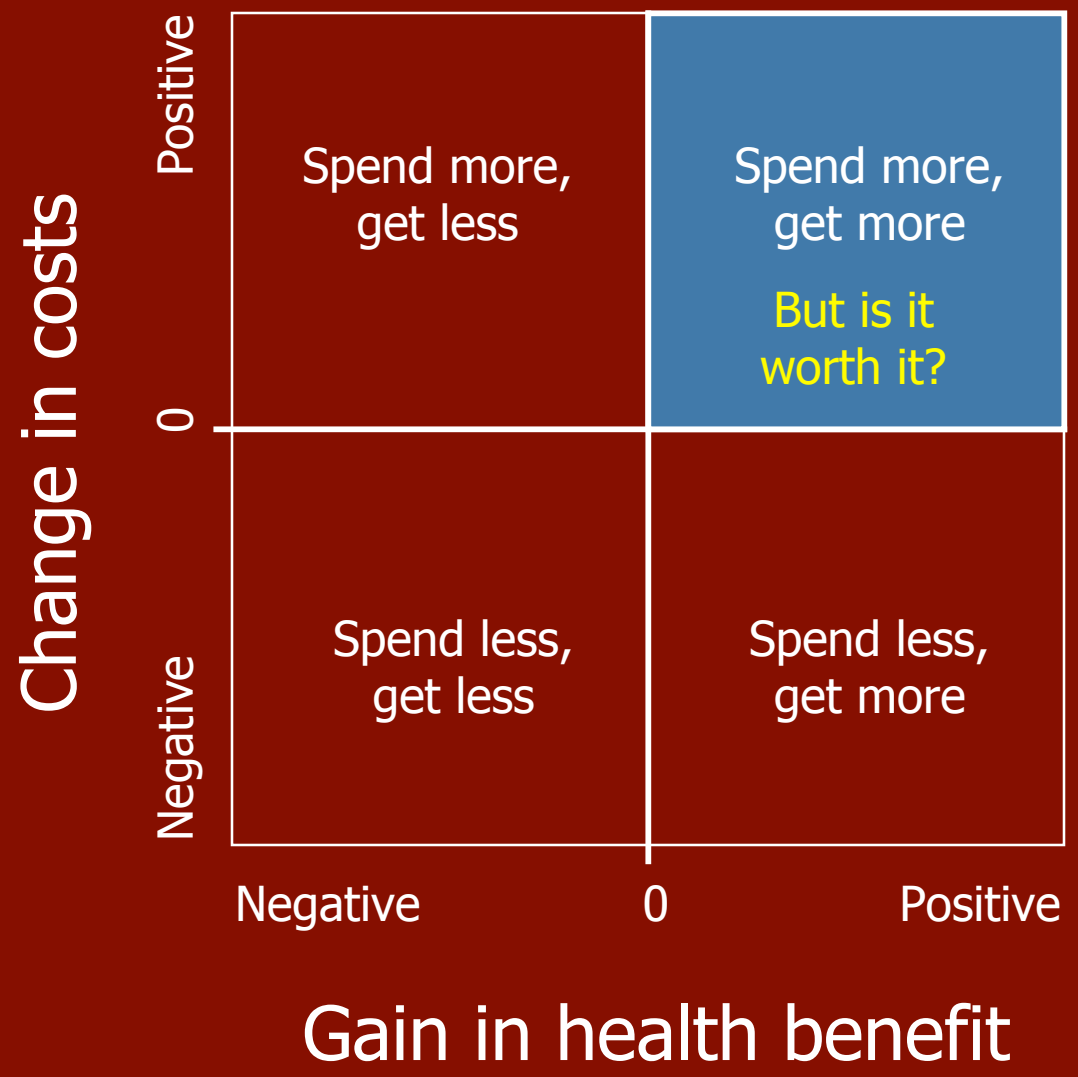
Cost-Conscious Coverage Policy: Cover Interventions That Represent Good Value

Cost-effectiveness analysis is tool for obtaining the greatest health impact from a given dollar expenditure on care

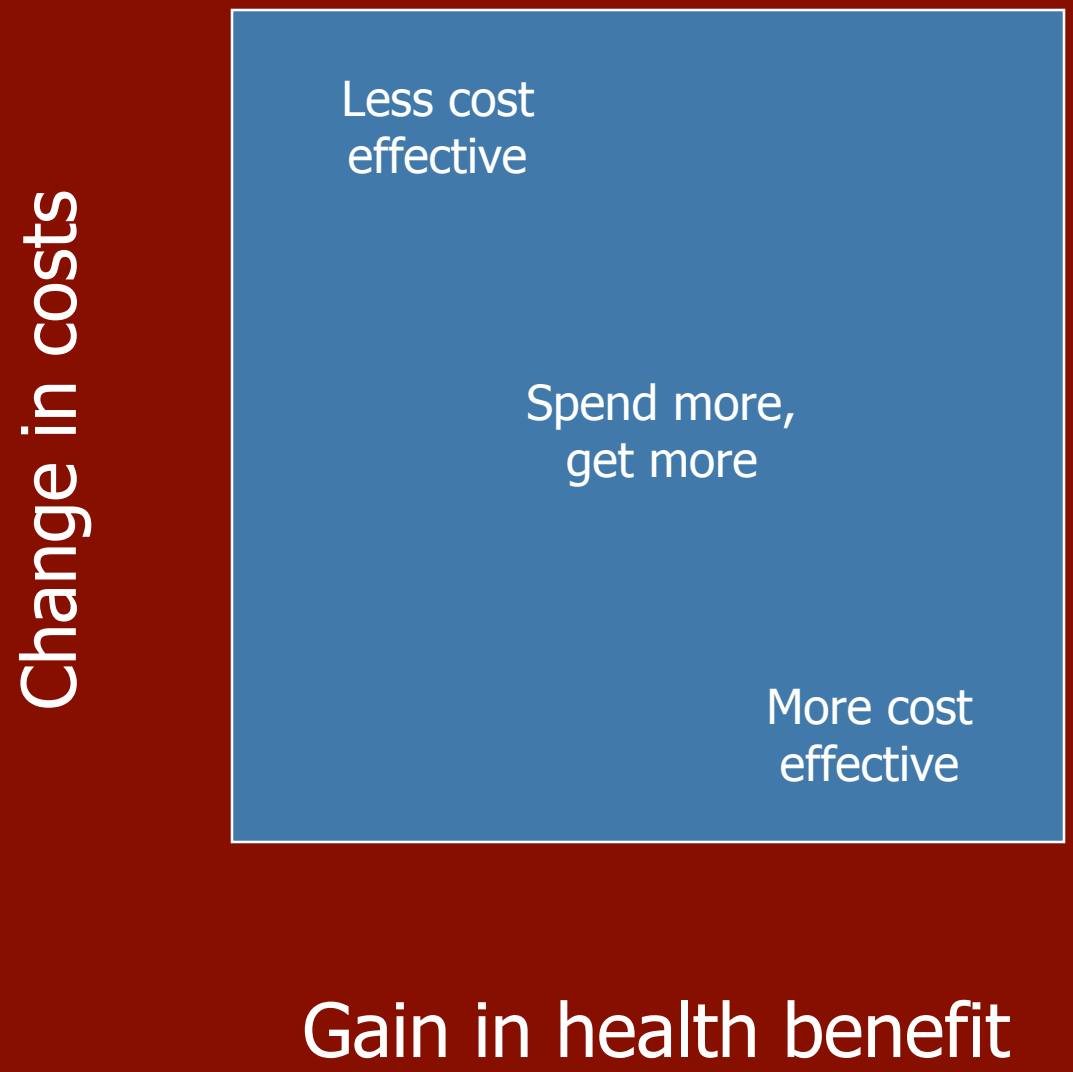
Accounting for value


Change in costs
Positive
0
Negative
Spend more, get less
Spend more, get more
Spend less, get less
Spend less, get more
Negative
0
Positive
Gain in health benefit

Accounting for Value



Accounting for Value

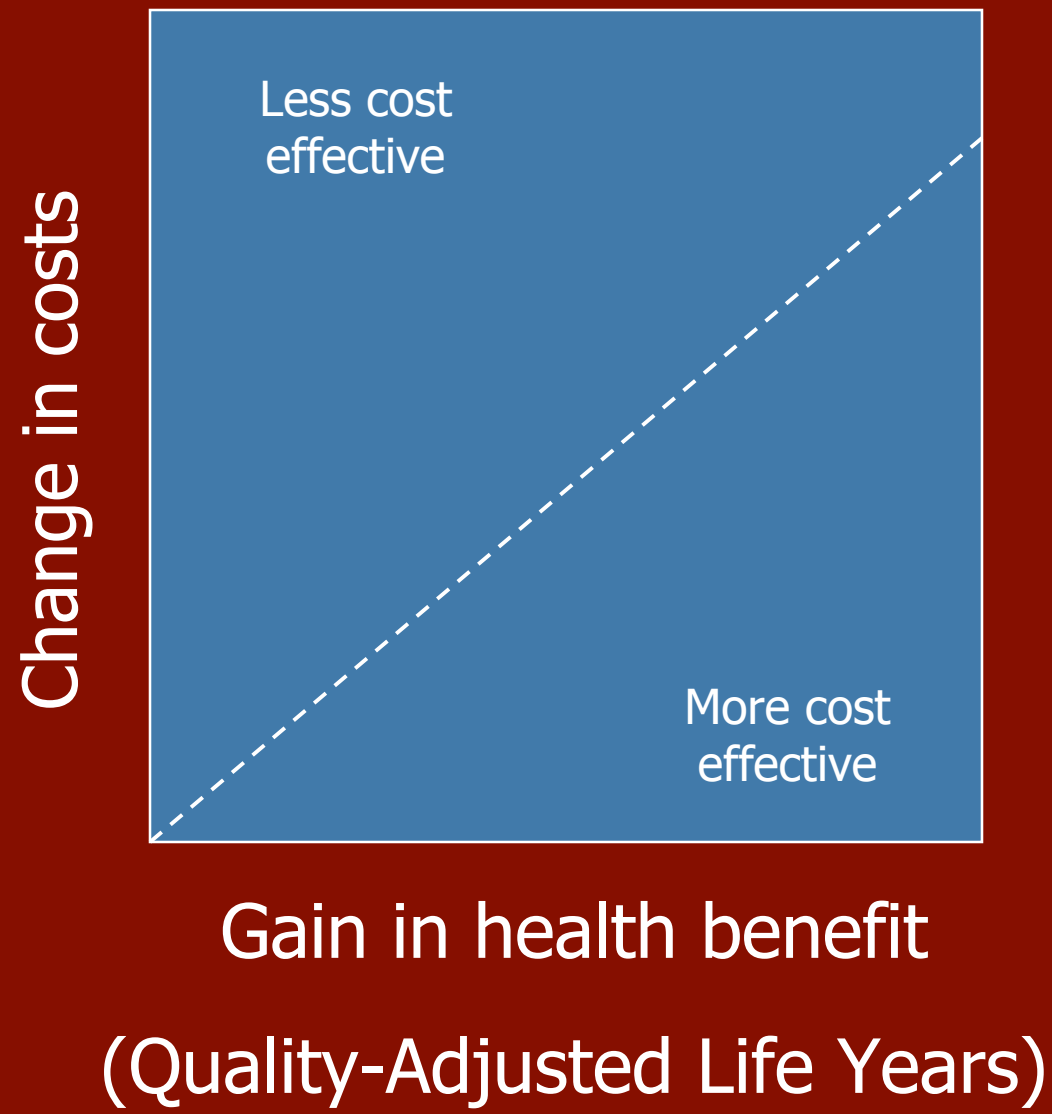


Accounting for Value

- **Health benefit measured in QALYs**
- **Value accounted by incremental cost-effectiveness ratio (CER)**

$$\text{CER} = \frac{\text{Chg in \$}}{\text{Chg in QALYs}}$$

- **Greater CER means less cost effectiveness**

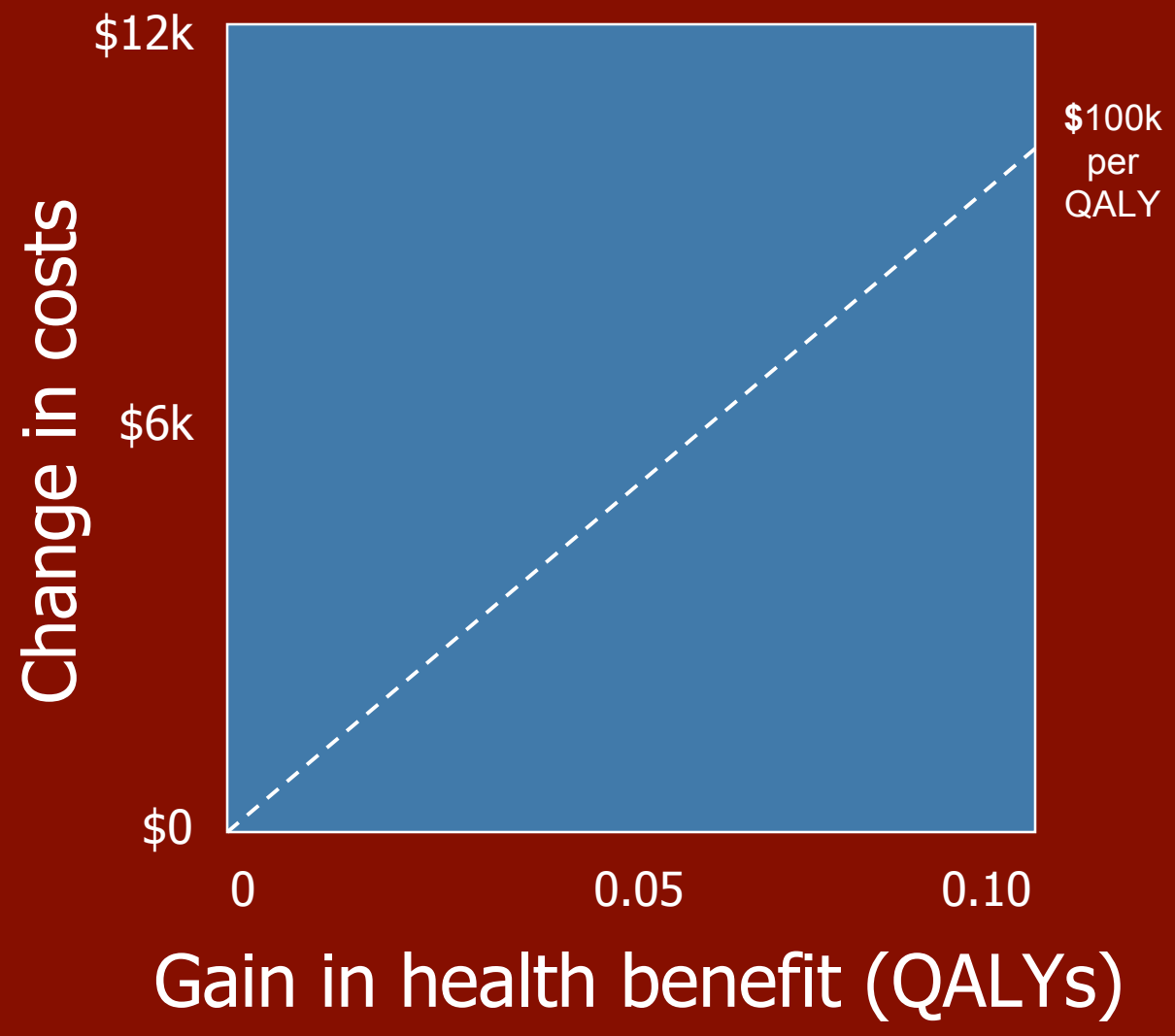


Applying Cost-Effectiveness Analysis:

COX-2 Inhibitors

COX-2 Inhibitors vs NSAIDS

Comparator:
Naproxen



Source: Spiegel et al., The Cost-Effectiveness of Cyclooxygenase-2 Selective Inhibitors in the Management of Chronic Arthritis, Ann Intern Med. 2003;138:795-806.

COX-2 Inhibitors vs NSAIDS

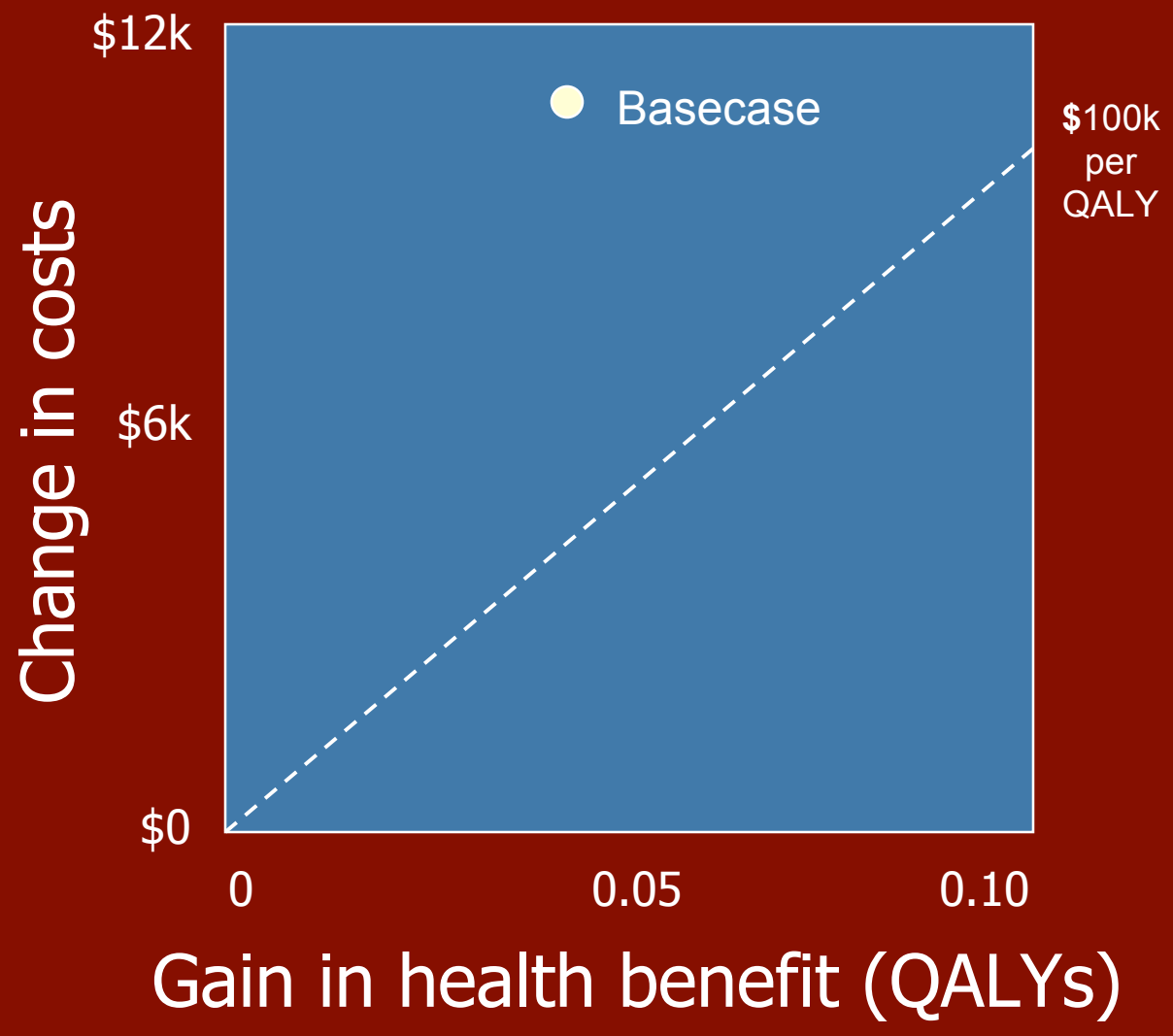
Comparator:
Naproxen

Assumption:
Excludes effects on heart

Change in cost:
$11,600

Change in benefit:
0.04 QALYs

Incremental CER:
$290,000/QALY



Source: Spiegel et al., The Cost-Effectiveness of Cyclooxygenase-2 Selective Inhibitors in the Management of Chronic Arthritis, Ann Intern Med. 2003;138:795-806.

COX-2 Inhibitors vs NSAIDS

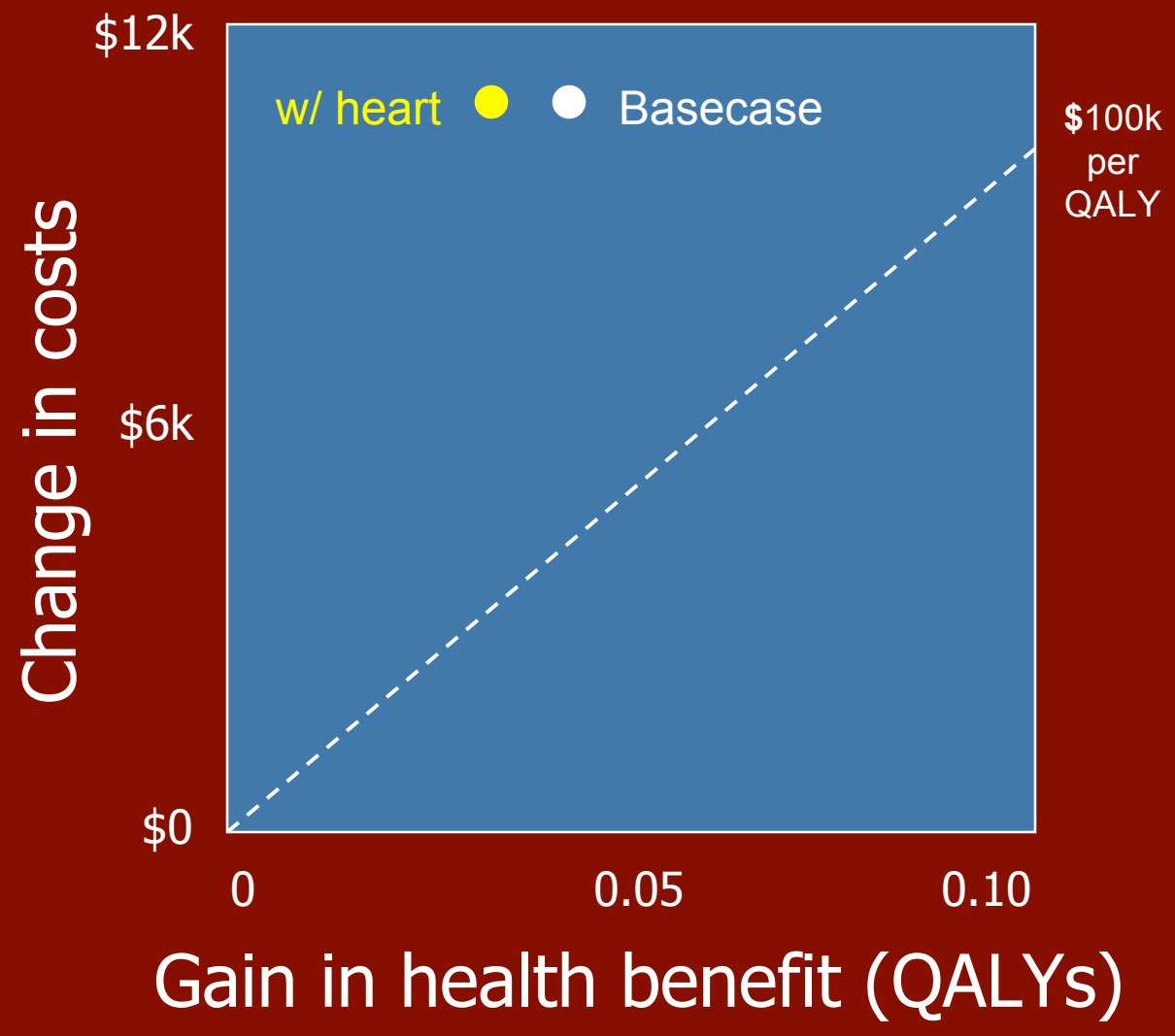
Comparator:
Naproxen

Assumption:
INCLUDES
effects on heart

Change in cost:
$11,600

Change in benefit:
0.03 QALYs

Incremental CER:
$395,000/QALY



Source: Spiegel et al., The Cost-Effectiveness of Cyclooxygenase-2 Selective Inhibitors in the Management of Chronic Arthritis, Ann Intern Med. 2003;138:795-806.

COX-2 Inhibitors vs NSAIDS

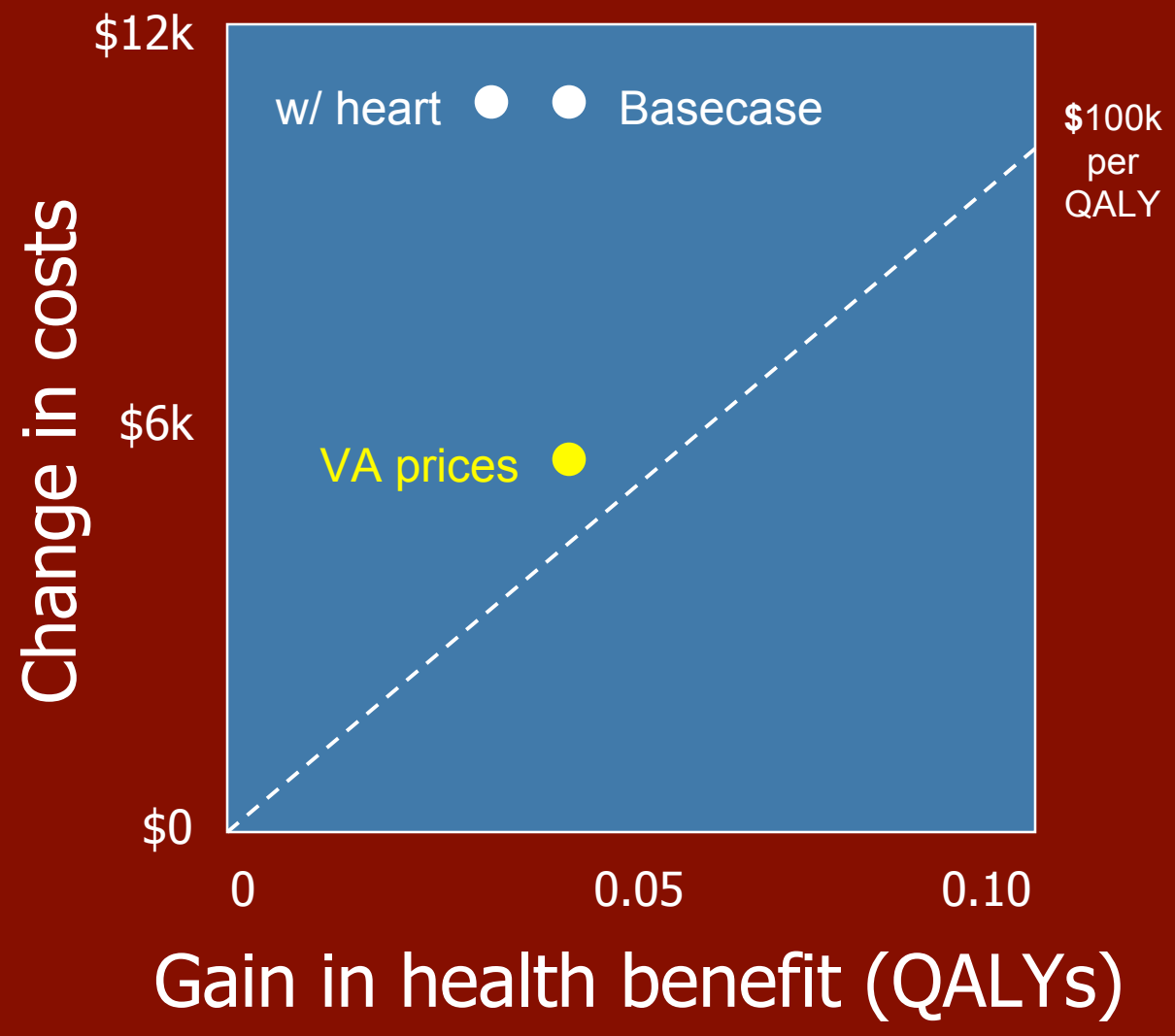
Comparator:
Naproxen

Assumption:
VA prices

Change in cost:
$5,970

Change in benefit:
0.04 QALYs

Incremental CER:
$142,000/QALY



Source: Spiegel et al., The Cost-Effectiveness of Cyclooxygenase-2 Selective Inhibitors in the Management of Chronic Arthritis, Ann Intern Med. 2003;138:795-806.

COX-2 Inhibitors vs NSAIDS

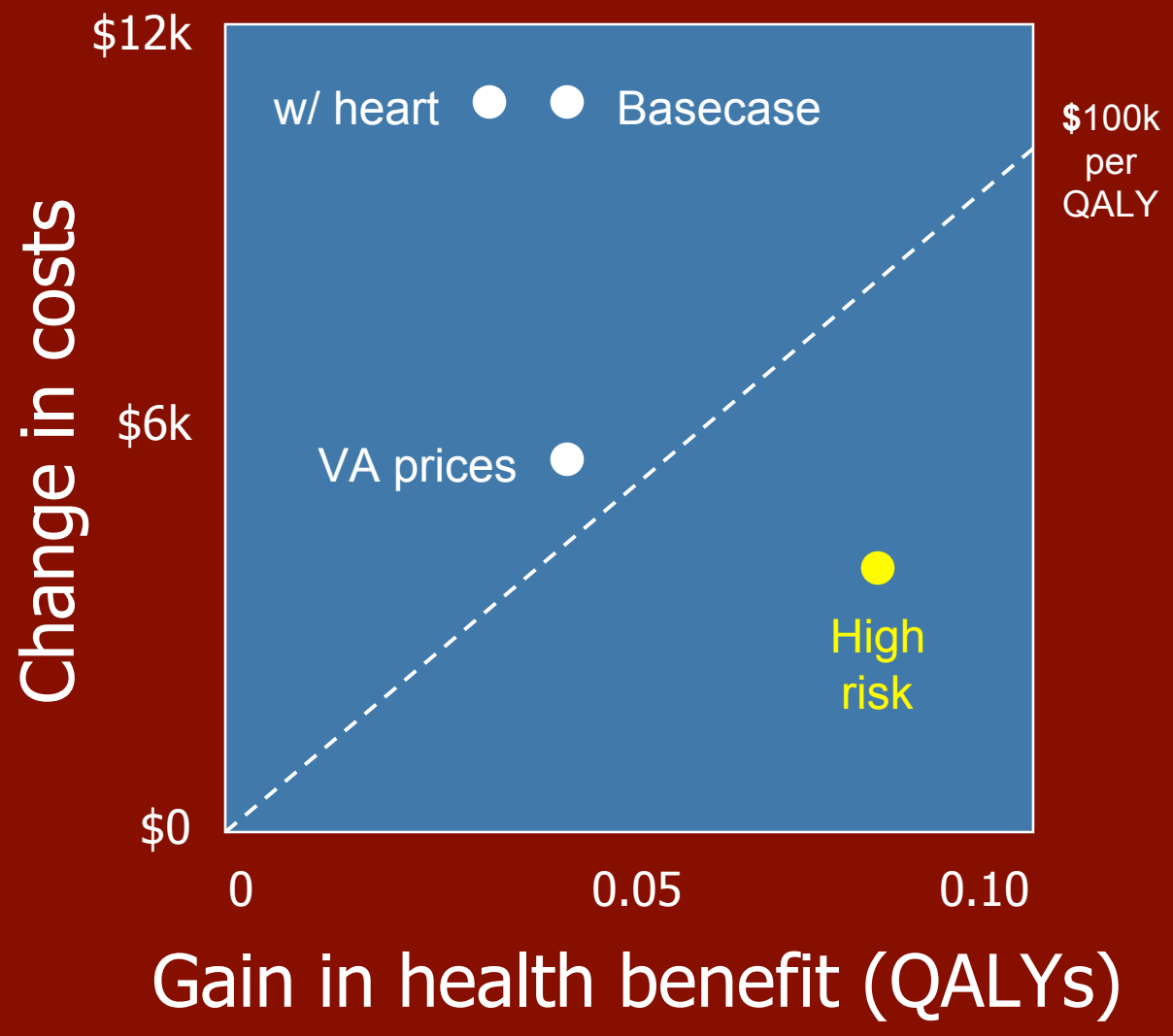
Comparator:
Naproxen

Assumption:
High-risk patients

Change in cost:
$4,720

Change in benefit:
0.08 QALYs

Incremental CER:
$56,000/QALY



Source: Spiegel et al., The Cost-Effectiveness of Cyclooxygenase-2 Selective Inhibitors in the Management of Chronic Arthritis, Ann Intern Med. 2003;138:795-806.

Why Cost-Conscious Coverage Now

- Consumers may choose tailored coverage over high coinsurance rates
- Value information more important to consumers who bear more of the cost directly

- Reduced reimbursement rates to providers may be offset by increases in volume
- Cost-conscious coverage changes demand for monopoly products

Coverage Policy only Part of the Answer

- Reference pricing and similar approaches promote value-based purchasing when competing products available
- Benefit-based copayments offer greater flexibility, but implementation challenging

Implementing Cost Conscious Coverage

- Coverage determined by both evidence of effectiveness and cost-effectiveness
- More expensive, more comprehensive plans available at additional cost
- A cost-conscious policy might forgo coverage for some expensive treatments at the end of life, and substitution of lower tech approaches to care

- Value information to be provided by public or public-private agency with dedicated funding
- Cost-conscious coverage will shape innovation by rewarding high-value products and services