
Comparative Effectiveness... Cost Effectiveness?

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The Case for a National Comparative Effectiveness Capability

- **Need more real world evidence and decision support tools to improve quality and efficiency**
- **Experience is that good evidence and good tools will change practice (e.g., LVRS, glycemic control/cardiac surgery)**
- **Need to develop standards for “good” studies (observational studies, meta analyses)**
- **Need a way to set priorities for analysis**
- **Need more robust investment in comparative studies**
- **There is broad agreement and support for this capability if done transparently and inclusively**

Why Not Cost Effectiveness?

- **Cost effectiveness analysis is used by countries to limit coverage of treatments (e.g., NICE) – and is a poison pill**
- **“Incremental cost effectiveness” favors already covered treatments, if used in coverage decisions**
- **Cost effectiveness is an assessment based on averages and can under-estimate value for individual patients**
- **Methods are imperfect & controversial (cost/QALY)**
- **Not suited to products with short lifecycles and rapidly changing prices**
- **Difficult to do with varying treatments for a condition and treatments with long term impact**
- **It’s the latest “magic bullet” – but will not address the underlying drivers of costs**
- **Will undermine or overwhelm the focus on increasing comparative effectiveness research**

What Would Medicare Do?

- **Likely not to deny coverage if any beneficiaries could benefit**
- **Would consider in setting reimbursement rates**
- **Medicare doesn't have cost information except hospital proxy info and settled cost reports – and don't pay marketplace rates, e.g., hosp MRI**
- **Based on evidence, could allow conditional or facility/physician specific coverage but don't need cost data**
- **Could use comparative effectiveness information to reward use of best practices, through P4P**
- **Has moved in direction of incentives, away from micro-management – exception is NCDs, which are few in #**
- **Need to focus on drivers of Medicare costs – chronic disease, fee-for-service (“pay for doing”)**