Medicare And Cost-Effectiveness Analysis: Time To Ask The Taxpayers

Americans are able and willing to assist Medicare in setting coverage priorities.

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ABSTRACT: Maintaining Medicare’s affordability for taxpayers and beneficiaries is becoming harder. Although cost containment strategies have been proposed, using cost-effectiveness analysis (CEA) to prioritize coverage decisions has not been among them. There is a widespread but largely untested perception that Americans are unwilling to accept limits in health care. We review existing evidence about the public’s willingness to accept constraints and set health care priorities. We suggest that given the opportunity to weigh in on ethical and normative issues that surround CEA, members of the public are appropriate parties to engage in shaping Medicare’s broadest resource allocation questions. [Health Affairs 26, no. 5 (2007): 1399–1406; 10.1377/hlthaff.26.5.1399]

These are challenging times for the Medicare program; the Medicare trustees reported recently that without increases in taxes to workers and employers, the payroll- and employer-supported Hospital Insurance fund (Part A) will be exhausted by 2019.1 Parts B and D are forecast to be solvent going forward, in part because their financing is tied to automatic increases in premiums that fall directly on beneficiaries. In 2003, an average of 22 percent of the income of noninstitutionalized beneficiaries went to health care, up from 18 percent in 1999.2 The public’s ability and willingness to keep pace with large Medicare premium increases, as either taxpayers or beneficiaries, is unexplored but in question.1

Strategies to constrain costs by increasing deductibles and copayments have been implemented in both private insurance plans and Medicare, raising concerns that people of more limited means will forgo needed care.4 For example, the “doughnut hole” in Medicare Part D has been seen to place a disproportionate burden on sicker people of modest means, so that those with readily manageable chronic diseases (such as diabetes and hypertension) may fail to fill prescriptions that have been shown to effectively forestall serious and expensive complications.3 Consumer-driven health plans, championed by some as controlling costs by holding patients responsible for first-dollar expenses, have been challenged as conceptually flawed because they lack brakes on spending once deductibles have been met. These approaches sidestep a fundamental question: Can Medicare continue to fund all “effective” interventions without regard to the...
effects achieved and their cost?

■ Promise of cost-effectiveness analysis. The use of cost-effectiveness analysis (CEA) to set priorities for coverage of new or costly interventions is an untested option that could mitigate cost increases within Medicare. CEA compares the incremental cost in dollars of one intervention to another in creating a health gain. Health gains are typically measured in quality-adjusted life-years (QALYs), a construct that combines health-related quality of life with years of survival to create a unitary outcome measure. Thus, the territory of CEA is the value of an intervention as demonstrated by both its effectiveness and its efficiency in creating health per dollar spent; interventions can be compared both within and across disease and treatment categories.

CEA is an appealing method for cost control because it informs decisions at the level of coverage policy, thereby maintaining the equivalence of the Medicare benefit for all beneficiaries without respect to their ability to meet copays and deductibles or their underlying health status. Setting priorities at a “macro” level is arguably a more equitable stance for a public program to adopt than is setting them at a “micro” or individual level. Although affluent Americans would likely be able to buy selected services the less affluent could not afford, these services would be those at the margin of cost-effectiveness; care that was demonstrably efficient and effective could be made available to all.

■ Experience elsewhere. A number of industrialized nations, including Canada, Australia, and the Netherlands, use CEA as a component of drug coverage decisions; others, such as New Zealand and the United Kingdom, use it more broadly in considering new technologies. For example, in 1999 the U.K. National Health Service (NHS) established the National Institute for Health and Clinical Excellence (NICE) to set standards and review new and resource-intensive technologies and procedures for use within the health care system. NICE issues “appraisals” of drugs and other treatments based on effectiveness and cost-effectiveness. When a favorable appraisal is issued, the NHS must make access to the service available in all localities within three months. When an appraisal is unfavorable, localities have the imprimatur of NICE in denying coverage.

CEA: Why Not In The United States?

CEA methods have become more robust and better harmonized over the past decade. The U.S. academic community has increasingly called for its use to inform U.S. health care coverage decisions. The Medicare statute does not discuss cost in its criteria for determining covered benefits, and the received wisdom at the policy level is that the public would not support its use. Statements by Medicare officials have underscored the perceived political vulnerability associated with incorporating economic criteria into coverage decisions, particularly in the context of public backlash against managed care plans’ utilization management practices. In 1997, Bruce Vladeck, then administrator of HCFA (now the Centers for Medicare and Medicaid Services, or CMS), testified before Congress that CEA raised “fears of rationing” and would not be used by the agency for coverage decisions.

Vladeck’s testimony came in the context of a protracted review of a 1989 HCFA-initiated regulation proposing that cost-effectiveness become a criterion in Medicare coverage decisions. The regulation underwent extensive internal agency review and external vetting and was ultimately withdrawn a decade later after contentious debate. Susan Bartlett Foote has documented the resistance mounted by the medical device industry, which feared that use of CEA would diminish their markets. Both congressional representatives and disease-advocacy organizations were rallied against CEA, and arguments were framed that the public would not stand for rationing.

The American public’s aversion to “rationing” (and hence insurers’ resistance to the use of CEA) has been a widely invoked theme over the past two decades. Decisionmakers’ wariness notwithstanding, there has been little empirical work on the public’s attitudes to-
ward priority setting in health care services, and even less on their views on using cost-effectiveness as a consideration in coverage policy. What do we actually know?

- **Oregon Medicaid.** The Oregon Health Services Commission's (OHSC’s) attempt to expand health insurance in the early 1990s remains unique in its efforts to solicit public commentary on placing priorities on health service coverage within a tax-supported program. The OHSC sought a waiver from HCFA to make coverage determinations for its Medicaid program on the basis of the cost-effectiveness of a rank-ordered list of treatment/condition pairs to be funded until the yearly state budget gave out. The commission used public meetings as a forum in which to solicit the views of Oregonians on the types of services that should be given priority consideration for coverage, whatever their cost-effectiveness ratio. Based on these discussions, certain life-saving, palliative, and preventive care services were moved up the list.

Although this natural experiment explored Oregonians’ views about the categories of service to be given priority, it avoided asking head-on questions about ethical or normative views held by the public about allocating funds based on efficiency. The explicit focus on “rationing” (albeit specific to low-income groups) resulted in high-profile media coverage of the process, but there was no systematic exploration of the public’s views on CEA and the underlying issues it raises.15

- **California.** Focusing on public attitudes toward CEA directly, Sacramento Health Decisions examined the views of members of the California public toward trade-offs between cost and coverage.18 The majority of participants stated that they would accept the use of CEA by a patient’s physician as a criterion for assessing treatment options; some concerns were raised, however, by such judgments’ being made by insurance plans. The use of CEA to determine covered benefits in a public program was not explicitly addressed.

- **Medicare.** Recent work used focus groups to explore the public’s views on using CEA in Medicare coverage decisions.19 A diverse sample of citizens recruited from the New York County jury pool were informed about and discussed health care costs, CEA methods, and common ethical issues embedded in CEA, including “fair innings,” the rule of rescue, trade-offs between length and quality of life, and the role of individual responsibility.20 At a first meeting, participants received information about the effectiveness of treatments for fourteen conditions covering a range of preventive, chronic disease management, mental health, and quality of life–improving and lifesaving interventions. Three of these, lung-volume reduction surgery, implantable cardioverter-defibrillator, and left-ventricular assist device, had proved controversial for the Medicare Coverage Advisory Committee (MCAC). They were asked to assume the role of social decisionmaker and prioritize the coverage of these fourteen treatments under assumptions of a constrained Medicare budget. At a second meeting, participants received
cost-effectiveness information on the fourteen treatments and were then asked to revisit and discuss their rankings.

Provision of cost-effectiveness information greatly influenced coverage priorities in the direction of favoring more cost-efficient services. At the conclusion of the focus group meetings, 75 percent of participants felt “somewhat” or “very” comfortable with the use of CEA to inform Medicare coverage of new treatments; 10 percent said that it should “never” be used. Participants were also asked if they agreed or disagreed that “people like yourself” should serve on an independent commission charged by Medicare with making rationing decisions about health care; 83 percent said that they agreed.

Cumulative evidence. Although the U.S. literature remains sparse in this area, the cumulative evidence in the United States and elsewhere supports the idea that the public is both able and willing to engage questions about what types of services and what populations should be given priority for insurance coverage. This suggests that involving Americans more systematically in conversations of priority setting within Medicare would be, at minimum, feasible. We argue that it would also be desirable.

Potential Roles And Issues For Members Of The Public

Collective decisionmakers. Jonathan Lomas has described distinct perspectives that members of the public can bring to discussions about health care priority setting: “patient,” “taxpayer,” and “collective decisionmaker.” Collective decisionmakers contribute their views of the actions they believe would best serve the general good of the community. They are asked to examine their views from behind a Rawlsian “veil of ignorance” in which they have no knowledge of what their future health needs are and are therefore less likely to be motivated by self-interest. Although no one comes to such processes without experiences that shape their views (that, after all, is the point of their participation), the empirical literature supports the idea that people are capable of deliberating within this framework.

Technical expertise versus public values. Some political scientists have argued that policy is best made by those with technical expertise and that the electoral process provides sufficient opportunity for public input. Specific to citizen participation in health care policy, concerns have been raised about what participants can be effective at doing. Others have endorsed public participation and deliberation on policy issues as democratizing (that is, leading to increased social solidarity and non-elitism), activating of citizenship, and leading to better-quality decisions.

Judgments on clinical effectiveness and on health care financing and management are subjects on which technical expertise is integral to sound decision making. On the other hand, at its heart, resource allocation is value-based. Yet the inherent values and norms of experts are rarely explicitly examined, and their relation to those of the public is unknown. It is at the fundamental level of “what is fair?” that we see the appropriate place for public representatives to weigh in on issues that assist Medicare in setting coverage priorities.

In the case of CEA, the literature tells us that rote use of cost-effectiveness ratios to determine coverage policy will be at variance with public values around distributive justice and equity. In large measure, this is because a simple ratio aggregates QALYs equally and because trade-offs between old and young, between better- and worse-off (economically and in terms of health status), and between improving quality of life and saving lives are not delineated. Thus, these ratios embed ethical and normative assumptions that need fuller examination by the society for whom the resources are intended. If CEA is to become an acceptable input into coverage policy, citizens’ views on value-based issues that accompany its use in priority setting become of increasing importance.

A Model From Abroad

Countries where CEA is used to inform coverage policy have studied public value structures and have implemented processes...
Looking Backward And Moving Forward: How Do We Gain The Public’s Voice?

Selecting the advisory groups. Giving “voice” to the public carries major challenges that need sorting through. Earlier efforts at citizen involvement at national and state levels have been criticized for reliance on participant self-selection and the homogeneity of occupation, education, and race that predictably accompanies this method of outreach. NICE’s method for recruiting its Citizens Council relied on a community-based organization that employed a broad outreach strategy. Final membership, culled from more than 3,500 applications, was selected to reflect as much as possible the populations of England and Wales. This approach may hold lessons for construction of such groups to advise Medicare.

Providing sufficient information. Once advisory groups are formed, participants need to be given sufficient information to comfortably engage the issues with which they are presented. Group members can be expected to lack experience with the practice of deliberation and resolution of issues within groups. These challenges require that public input be harvested in a setting where value-neutral, comprehensible information is readily available to participants and that thought be given to how and by whom the process will be facilitated. The political science literature and international work with citizens’ juries in health offer some guidance.

Confronting The “Elephant In The Room”: Setting Coverage Priorities

The U.S. health care system has been slow to engage the public in a process that explores allocation of health care spending in an equitable and affordable manner. The historical dominance of private insurance has delayed confrontation of the tension between universal coverage and affordability. This avoidance is striking in the output from the recently convened Citizens’ Health Care Working Group, charged by Congress with soliciting the public’s attitudes toward important issues of
health care reform. Although its community meetings and online surveys took on many key issues, left unexamined in the discussion questions and in the group’s interim recommendations was the elephant in the room: How shall we set priorities for insurance coverage in a system that might not be able to provide everything to everyone?34

■ The “who” and “what” in Medicare. In the case of Medicare, a cornerstone of security for aged and disabled Americans and a program from which all taxpayers will benefit, we have suggested that the public should be engaged in discussions that address fundamental values of who and what should gain priorities for coverage. By “who,” we mean consideration of questions such as how to factor in people’s capacity to benefit from care; their level of suffering or disadvantage; their behavioral choices; and their age. By “what,” we mean considerations of questions such as whether interventions that improve the quality of life can be thought about in the same language (such as QALYs) as those that are life saving; whether we should prioritize investments in prevention or cure; and how effective a treatment must be to warrant coverage.

■ The logical venue. A logical place to convene these discussions is as counsel to the Medicare Evidence Development Coverage Advisory Committee (MedCAC).35 MedCAC does not consider cost-effectiveness information in making its recommendations, but it shares similar functions to those of NICE appraisal committees as advisers to national health programs. The NICE Citizens Council may provide a model for recruiting and structuring discussions with the public. The charge for this council has been to examine normative questions that follow from key issues on which CEA is silent; use of CEA has been a given from the start. Depending on the political environment, a group of U.S. taxpayers might challenge whether CEA is an acceptable input to coverage decision making, thereby bringing this debate forward from the grassroots level. Alternatively, if the political apparatus moves forward in incorporating CEA into coverage criteria (through CMS rule making or congressional statute), public councilors could be asked to consider the contextual issues that should guide the use of CEA. Either way, media coverage of these discussions is bound to foster a deeper public understanding of what the choices are for Medicare. We believe that these conversations can provoke a broader national dialogue on how to shape a more equitable and efficient health care system.

■ Americans’ readiness. Our review of the U.S. evidence base and our experience talking with members of the public suggest that Americans understand and are prepared to engage the issues that arise when setting priorities and imposing limits for their public programs. This is in contrast to the perceptions of the policy community and certainly to many in the for-profit medical industry who have the most to gain materially from the current coverage approach that excludes examination of value received for money spent.36 We believe that the public might be more concerned about the nontransparent use of cost considerations in coverage decision making by parties they see as self-interested than they would be about open discussions of resource allocation decisions in the programs that operate in the public interest.

P roviding the public with a voice in commenting on and shaping proposed directions for Medicare may embolden policymakers to become more proactive in their approaches to reform. Seemingly controversial approaches that have been publicly vetted could give legislators more confidence in making changes. At a time when the political process has produced so little practical movement forward in stabilizing the Medicare program’s budget, strategies to educate the public and capture its values merit pursuit. We believe that such efforts will assist in crafting solutions to sustaining an equitable and efficient Medicare program, and more broadly, the U.S. health care system.
The authors thank the anonymous reviewers whose provocative questions contributed to helping shape the ideas presented here.

NOTES


22. Russell et al., “The Role.”


30. Rawlins, “Pharmacopolitics.”

31. See, for example, efforts to involve consumers through the National Health Planning and Resources Development Act (P.L. 93-641) and within the Oregon Health Experiment. Nagel, “Combining Deliberation and Fair Representation”; and J.A. Morone and T. Marmor, “Representing Consumer Interests: The Case of American Health Planning,” *Ethics* 91, no. 3 (1981): 431–450. Those self-selecting for civic participation are known to share the higher educational attainment, affluence, and white race of their decisionmakers, diminishing the richness of perspectives represented. Random sampling can achieve diversity (thereby increasing legitimacy), but recruitment is more labor-intensive, and those who do participate, no matter what background they come from, remain self-selecting and differ from those who choose not to. Groups constituted through random sampling will be more inclusive, then, but not necessarily more representative. See Ryle, “Does Deliberative Democracy Work?”


35. Although most Medicare coverage decisions occur locally through administrative contractors, this practice has been seen to damage credibility, efficiency, and fairness in coverage policy, and we suggest that efforts to engage the public be directed at central decision making. See Foote, “Why Medicare Cannot Promulgate”; and S.B. Foote, “Resolving the Tug-of-War between Medicare’s National and Local Coverage,” *Health Affairs* 23, no. 4 (2004): 108–123.