

# A Strategic Plan for Integrating Cost-effectiveness Analysis Into the US Healthcare System

Peter J. Neumann, ScD; Jennifer A. Palmer, MS; Norman Daniels, PhD; Karen Quigley, MPH; Marthe R. Gold, MD; and Schumarry Chao, MD, MBA, for the Panel on Integrating Cost-Effectiveness Considerations into Health Policy Decisions

Understanding resistance to cost-effectiveness analysis (CEA) in the United States has been the topic of numerous papers, books, and conferences.<sup>1,2</sup> The Panel on Integrating Cost-Effectiveness Considerations into Health Policy Decisions was convened to build upon these efforts in 2 ways: (1) to explore the views of health plan purchasers on the value and use of CEA in their organizations and (2) to develop a strategic plan for policymakers to address obstacles and to integrate CEA into health policy decisions, drawing on stakeholders as part of the solution.

The panel, consisting of medical and pharmacy directors at public and private health plans, addressed this charge at a conference in Gaithersburg, Maryland, in May 2006. Members were selected based on their experiences in coverage and benefit-design decisions, and with an eye toward assembling a diverse group with respect to geography, type of health plan, and professional background. This commentary integrates discussion at the conference and the deliberations that followed.

The panel agreed that formal CEA can, in theory, provide policymakers with a useful technique for informing coverage and reimbursement decisions. Panel discussions also underscored the uneven acceptability of CEA in the United States. Although some initiatives have incorporated CEA,<sup>3-5</sup> formal use of the approach is limited. Panelists noted that although their own organizations are actively engaged in efforts to deliver care more efficiently, they generally do not use CEA explicitly. Instead, policies focus on evidence-based medicine, cost-sharing, disease management, consumer-driven care, and pay-for-performance initiatives.

## Identifying the Obstacles

The panel deliberations emphasized that resistance to CEA in the United States is tied to multiple factors. In part, it reflects American cultural conventions, which lean toward market-based solutions and away from government policies that examine returns on investment in medical interventions from the public's perspective.

Another challenge involves the evidence base. Cost-effectiveness data often are unavailable at the time of a technology's diffusion into practice.<sup>6</sup>

Existing CEAs may ignore the practical needs of decision makers by excluding implementation costs for programs or the fidelity of implementation in actual practice. Despite harmonization

The Panel on Integrating Cost-Effectiveness Considerations into Health Policy Decisions, composed of medical and pharmacy directors at public and private health plans, was convened to (1) explore the views of health plan purchasers about cost-effectiveness analysis (CEA) and (2) to develop a strategic plan for policymakers to address obstacles and to integrate CEA into health policy decisions, drawing on stakeholders as part of the solution. Panelists expressed strong support for a greater role for CEA in US health policy decisions, although they also highlighted barriers in the current system and challenges involved in moving forward. The strategic plan involves a series of activities to advance the use of CEA in the United States, including research and demonstration projects to illustrate potential gains from using the technique and ongoing consensus-building steps (eg, workshops, conferences, town meetings) involving a broad coalition of stakeholders. Funding and leadership from policymakers and nonprofit foundations will be needed, as well as the active engagement of legislators and business and consumer groups. Panelists emphasized the importance of the Medicare program taking a lead role, and the need for new "infrastructure," in the form of either a new institute for conducting research or increased funding for existing institutions.

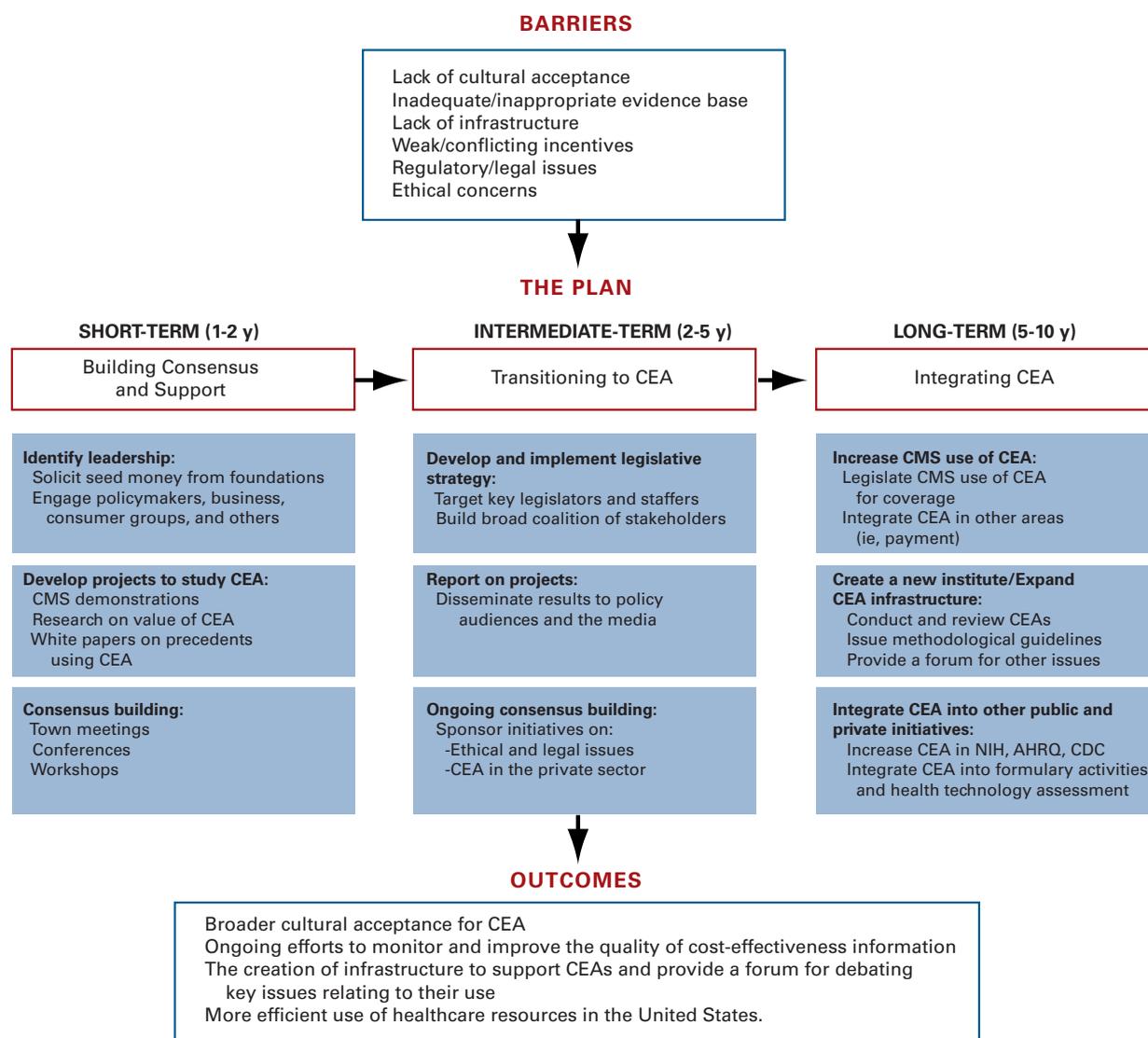
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**In this issue**  
Take-away Points / p187  
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**For author information and disclosures,**  
see end of text.

■ COMMENTARY ■

■ **Figure.** Phases of the Strategic Plan for Cost-effectiveness Analysis Integration



CEA indicates cost-effectiveness analysis; CMS, Centers for Medicare & Medicaid Services; NIH, National Institutes of Health; AHRQ, Agency for Healthcare Research and Quality; CDC, Centers for Disease Control and Prevention.

of CEA techniques, the complexity of analyses remains an obstacle, especially for those concerned about bias in industry-sponsored CEAs.<sup>7</sup> The absence of a trusted, independent entity to develop and/or vet studies compounds concerns about quality, reliability, and relevance.

Even if CEA would assist in gaining greater overall value for consumers, private payers have been reluctant to openly deny care on the basis of cost for fear of losing market share. Also, plan officials and physicians described concerns that patients who are denied coverage for a new treatment offering positive benefits will bring lawsuits. Although some scholars have argued that health plans might withstand these chal-

lenges, litigation remains a fear.<sup>8</sup> In addition to ethical questions raised by placing explicit limits on care, CEAs may not capture a program's distributional effects across different population subgroups or over time, and there is no systematic process in place in the United States that assuages concerns about fairness.<sup>9</sup>

**The Strategic Plan**

The strategic plan is offered as a means to address the obstacles and to move forward on CEA integration. Cultural acceptance for CEA likely will involve a long-term and gradual process, but can advance through active consensus

building and experience. Panelists underscored that Medicare, as the largest health payer in which all citizens have a stake, is a logical agency to assume a leading role. The incomplete evidence base and lack of infrastructure can be helped by expanded resources devoted to CEA research, either at a new agency or at the Agency for Healthcare Research and Quality. Such an entity also can provide a standing forum for addressing legal and ethical issues. The conflicting incentives that private plans have for using CEA is a perpetual challenge, but other elements of the plan (eg, greater experience with CEA at the national level, an improved evidence base) could smooth its use in the private sector.

Several premises underlie this strategic plan. First, CEA is one input into decisions and can and should be used flexibly. Second, CEA is a tool for achieving better value for our healthcare system, rather than simply a cost-containment tool or a means of denying care. Third, CEA is an approach that can exist alongside other initiatives for cost control and quality improvement, and even enhance their design. Finally, conventional wisdom about the lack of acceptability of CEA in the United States among the American public has never truly been tested.

Panelists envisioned 3 phases of implementing the strategic plan, each of which incorporates specific steps: building consensus and support; transitioning to CEA; and integrating CEA (Figure).

**Phase I: Building Consensus and Support (1-2 Years).** Phase I, covering roughly 1-2 years, focuses on laying the groundwork. Key to this phase will be identifying leadership among legislators, policymakers, and stakeholders representing business, consumer, employers, and health plans. Non-profit foundations can serve in a critical catalyst role by providing seed money to fund research projects and consensus-building steps.

The research projects should include white papers on precedents for using CEA abroad and in selected cases in the United States, as well as empirical estimates showing the potential gains in terms of increased health and decreased costs from using the technique. In early stages, the Centers for Medicare & Medicaid Services (CMS) should undertake demonstration and research projects to explore the potential value of CEA and to experiment with approaches for its implementation. Consensus-building steps should focus on educating stakeholders about the potential role and flexibility of CEA. Ideally, steps would include the convening of public forums, conferences, and workshops to help create and com-

### Take-away Points

A panel composed of medical and pharmacy directors at public and private health plans developed a strategic plan for incorporating cost-effectiveness analysis (CEA) into US health policy decisions.

- The plan has 3 long-term goals: increasing use of CEA by the Centers for Medicare & Medicaid Services; creating infrastructure to support research, either at the Agency for Healthcare Research and Quality or at a new independent institute; and integrating CEA into other public and private initiatives.
- The plan includes a series of activities to achieve these goals, including consensus-building steps with a broad coalition of stakeholders, developing research on CEA application, and implementing a legislative strategy.

municate an explicit framework for considering resource allocation decisions.<sup>9</sup>

**Phase II: Transitioning to CEA (2-5 Years).** In Phase II, covering roughly 2-5 years, the strategic plan involves learning from the research and demonstration projects developed in Phase I and solidifying support for CEA integration. This work would include researchers disseminating and publicizing findings of the Phase I projects and ongoing consensus building in the form of workshops and conferences on methodologic, legal, ethical, and private-sector application issues related to CEA.

Phase II also would include the development and implementation of a dedicated legislative strategy to lay the groundwork for longer-term integration. The strategy would include plans for targeting key legislators and staffers; building support among a broad coalition of groups including employers, health plans, patients, and health professionals; enlisting academic champions; and holding congressional hearings on the issue. Importantly, CEA could be integrated into ongoing efforts to provide resources and possibly to create a new independent entity to conduct comparative-effectiveness research.<sup>10</sup>

**Phase III: Integrating CEA (5-10 Years).** In Phase III, integration of CEA could occur at 3 levels: legislating Medicare's use of CEA for coverage decisions, expanding infrastructure for CEA research, and integrating CEA into other public and private initiatives.

Congress could eventually authorize in statute the criteria that Medicare uses in covering new technologies, including CEA considerations. When legislating new benefits to the Medicare program, Congress could direct CMS to determine the most cost-effective strategy for implementing the new service. CMS also could incorporate CEA into other areas, including its use to inform payment rates and incentive-based programs such as its pay-for-performance initiative.

Further, Congress could expand infrastructure and funding for CEA through existing institutions such as the Agency for Healthcare Research and Quality or a new independent pub-

lic/private institute (possibly piggybacking on ongoing efforts to develop comparative-effectiveness research, which in proposals to date focus on clinical effectiveness and exclude cost-effectiveness considerations).<sup>10</sup> New research findings could provide guidance to public and private healthcare payers on the cost-effectiveness of drugs, medical devices, diagnostic techniques, and medical and surgical procedures, and the clinical management of specific conditions. Expanded resources also could be used to provide direction on methodologic standards and key challenges for the field, thus helping to improve the quality of evidence and acceptability of the approach.

Finally, panel members envisioned that, in the longer run, this coordinated strategy would have important spillover effects at numerous levels. These effects include increased funding for CEA at government agencies such as the National Institutes of Health and the Centers for Disease Control and Prevention, and further use of CEA at the state level and in the private sector within formulary committees and technology assessment agencies.

### The Road Ahead

Successful execution of the plan will begin with broad recognition that greater use of CEA can help the nation face its challenges in paying for effective healthcare. Implementation will require time, resources, and above all, political will. Support and action will require the involvement of multiple stakeholders.

Achieving the plan's objectives is likely to be a long-term process. The plan involves early concrete steps and successes that can lead to further goals and accomplishments. The time frame presented is offered as a guideline. It will take time to build consensus and to foster an accommodating political environment. Many details on tactics and resources will need to be filled in. CEA will not solve all of the healthcare system's problems, but it can be a key ingredient. This plan is offered as a start down that road.

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