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Cost-Effective Care in Patients' Best Interest

HEALTH CARE CAN BE COST EFFECTIVE AND STILL BE IN THE PATIENT'S BEST INTEREST

What if 65% oxygen, 18% carbon, 10% hydrogen, 3% nitrogen cost less than a dollar. You're listening to ReachMD XM 157, The Channel For Medical Professionals. Welcome to the Clinicians Round Table. I am Dr. Bill Ruttenberg, your host, and with me today is Dr. Jeffrey Joyce. Dr. Joyce is a senior consultant with the RAND Corporation of Santa Monica, California. Dr. Joyce's work has been Impact of Medicare Part D, Drug Benefit Design, Smoking Cessation, and Cost Of Disease. Today, we will be discussing if health care can be cost effective and still be in the patient's best interest.

DR. BILL RUTTENBERG:

Hi, Dr. Joyce. Glad to have you joining us for the Clinicians Roundtable.

DR. JEFFREY JOYCE:

My pleasure.

DR. BILL RUTTENBERG:

Has clinicians were being pressured to practice cost-effective medicine? How does an economist value the treatment and what makes something cost effective?

DR. JEFFREY JOYCE:

It’s a good question. I think field is still trying to debate these issues, but I think this has been a historical legacy of valuing life in certain parameters and the standard today is, is the life saved, cost less or more than $100,000 for example, and part of this is a way to try and rash and should we invest in this technology or another technology in trying to quantify that what we think are the clinical benefits and the cost effectiveness of one intervention versus another, and I think that $100,000 is somewhat arbitrary and that sort of a standard metric that use more for comparative purposes, I think than sort of an of an absolute number.

DR. BILL RUTTENBERG:

Ya, I don't want to blow you out of the water, but on the Indiana University School of Medicine web page, they peg the value of the human body at 45 million dollars with bone marrow costing 23 million based on the 1000 g at $23,000 a gram. So, I mean, it seems like what we pick as cost effective is really hangs on that number, doesn't that?

DR. JEFFREY JOYCE:

To some degree, but again, I do think important metric is to say what do we think it is worth when we are deciding upon which technologies to invest in and not to hold that number and absolute, and what I was referring to $100,000 that is typically to save 1 year of life for someone at a decent quality of life and that will typically trend late in to sort of lifetime value of anywhere in the range of 6 to 8 million for the value of someone's life over the course of lifetime.

DR. BILL RUTTENBERG:

How's that come up with? I mean, I know, we don't have time to go into the large economic models, but there is something I read about called the standard gamble. Could you explain that?

DR. JEFFREY JOYCE:

Typically what you do and these are somewhat of hypothetical that your presenting individuals and you would say how much would you be willing to pay to extend your life certain amount of time for example in perfect health or less than perfect health and to be trying to tease out what peoples willingness to pay is to extend their life under these different states. Another alternative might be to say historically this came from the ESRD, the end-stage renal disease, and we think of how much should be covered this under medicare, how much is the cost to extend someone on kidney dialysis his life and at that time it was $50,000 until that became the benchmark for a while. Another way we typically might do what is to try in for market behavior. We are looking at your likelihood of using seatbelt. We know that reduces your probability of dying by certain percentage and then we can infer and ask him how much you are willing to take risks or to improve your safety and then quantify that in dollar terms. Remarkably those estimates kind of come out on the same range and that is the where we get this $100,000, people are typically willing to invest for an additional year of life.

DR. BILL RUTTENBERG:

Can we give a concrete example of where this type of modeling for cost effective care supports the patient's best interest where it has been applied and the patient really has said, you know, this in my best interest, I am getting taken care of properly.

DR. JEFFREY JOYCE:

To be honest with you, this is a form of rationing. Where the people like or not, we do that implicitly in this country. Other countries do it more formally, but we do it through price mechanisms in this country, so from an individual patient's perspective, they may not have access to a particular technology it is has been deemed not to be cost effective, so you can always find patient who will think this is crude and arbitrary and not fair, but from an economist point of view, we have to look at the world as there are scarce resources and we have to make decisions about what to invest, what technologies are worth investing, what the government should pay for or not pay for, and that's why sort of this the whole arena has developed. I think from a societal perspective, we could say, I think it is better to invest in

technology X, which is going to save a life at $40,000 than there is other technology that is going to save 1 life on average at a cost of 50 million dollars. So, it really does come down to a relative versus an absolute.

DR. BILL RUTTENBERG:

You mentioned, basically and again, the government certainly is the biggest payer for healthcare. You have expertise in the area of Medicare Part D and Drug Benefit Design; cost of medications is certainly astronomical both to society and to individuals. One of which I have heard is using cost sharing. Is that something that you have looked at?

DR. JEFFREY JOYCE:

Oh! in great deal. There are 2 different worlds, I think, 1 was the sort of the traditional oral pharmaceuticals, your statins that lower your cholesterol, your blood pressure medication, and what we have seen over the past decade is employers and the government sort of making people pay higher cost sharing, typically a co-payment that is now more linked towards the cost of the drug. So, in old days, we used to pay 2 or 5 dollars for 30-day prescription, now firms and the government are saying well, if is a generic drug, it might have a 5 or 10 dollar co-pay, if it is a preferred brand or a branded drug that we have got a good deal on, it might be 30 dollars, and if it is a non-preferred brand, it might be 50 or 60 dollar co-pay, and what is trying to do is make consumers or patients more price sensitive and steer them towards lower cost drugs. In some ways that is not a bad idea and in general, I think economist's like sending price signals to say, you know, a branded drug does cost society more than a generic drug but the two production costs are different, and we want consumers to be aware of that when they make their decisions, but there is some irrationality to it too. For example, an antidepressant such as hypothetically Prozac might end up on that second tier with a 20-dollar co-pay or third tier with a 50-dollar co-pay depending on the negotiations with the manufacturer and a health plan and has nothing to do with the patient, and so the drug we are taking can sort of arbitrarily seen more or less expensive and that bothers consumers and patients.

I would like to welcome those who have just joined us at the Clinicians Roundtable on ReachMD XM 157, the Channel for Medical Professionals. I am Dr. Bill Ruttenberg and I am speaking with Dr. Jeffrey Joyce, senior economist at the RAND Corporation. We are discussing can healthcare be made cost effective without harming patients.

DR. BILL RUTTENBERG:

Today's Wall Street journal reported <_____> you just mentioned. Pharmacy benefit manager expressed scripts agree to pay 9.5 million dollars to settle allegations that it asked doctors to switch drugs primarily, so it could get bigger rebates from pharmaceutical companies. They had previously settled a 38.5 million dollar multistate gentleman in February. Doesn't this concern you? I mean here doctor is being forced; patient is being forced to use medication so the pharmacy company can make more money.

DR. JEFFREY JOYCE:

There have been some clearly some less than ethical practices in this industry and I think that's why, so the public's perception that people are more skeptical of pharmaceutical manufacturers and PBMs in general. I think, there is some truth to that and I also think people forget the value that these companies have created and the life saving technologies they have created, but getting to that I do think that PBMs which are the Pharmacy Benefit Managers, which are sort of middle men between the manufacturers and the health plans and physicians. I think people are resentful when the clinical decisions are not being made by their doctor. The PBMs, these Pharmacy Benefit Managers, don't have to act necessarily in the best interest of the firm or client that they are representing, but they claim they do add efficiency and they do lower prices that they negotiate rebates and reductions and prices with manufacturers. So, overall, in the big picture, they save society some money, but clearly there is some scope for them not to act in the best interest of all

other parties, but to act in their own self-interest.

DR. BILL RUTTENBERG:

Medicare part D, what is that been the impact on healthcare economics and does it need to be tuned up or fined. Where do we go?

DR. JEFFREY JOYCE:

Really, I think there was lot of doom and bloom prior to 2006 when Medicare first introduced the drug benefits. It is done better than anticipated by almost everyone's perspective. There are a few problems in the program. The <_____> where people lose coverage for a period of time, but overall I think the statistics say that now more than 90% of seniors have drug coverage at least as good as the Medicare part D benefit which is a decent benefit, and I do think we have to there are some minor things that could be changed, but I do think we have to ask what we want insurance for and it really is to protect you from catastrophic of very high expenses and at least part D and most insurance plans do that and so despite its minor flaws it really did accomplish the goal of providing more seniors with drug coverage and catastrophic coverage.

DR. BILL RUTTENBERG:

I also read recently that Med-Co, one of the pharmacy benefit companies has adopted a policy by which they are going to provide the cheapest drugs

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