

# NICE for US?

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# Should there be something like NICE in the US?

- My answer: yes, but not too much like it because....
- We do not have and will not have a national health authority
- We do not have and will not have a fixed budget, so there is no patient or dollar in the waiting room.
- We are more onery.

# Cost effectiveness in a mixed system

- There is a public good dimension to knowledge, and a good CE or CB study can have high fixed costs and zero marginal cost.
- The best general model: public finance of data, private choice about use.

# NICE for private insurance

- A more complete (though not monopoly) process might help in hard decisionmaking
- Might create lawyerproof safe harbor in denying coverage.
- Different plans can adopt different types of applications (e.g., yes or no on coverage, conditional payment, old products or new products) and different CE thresholds (“We are the \$200,000 per QALY plan.”)

# NICE for Medicare

- Even saying the words (much less publishing the regs) has been hard for big Medicare.
- I think CE could be used by a private plan or a drug plan, as long as it covered broad categories (not quite sure).
- I would prefer that the inevitable rationing of my Medicare be done in a tidy way.

# Nose in the Tent or Pain in the...

- A plan using CE could delay coverage. OK sometimes but not always. Let people choose between the Au Courant Coverage and the Prudent Wait Plan.
- CE analysis has many warts. You would not use market prices of patented drugs if you did the analysis from a societal perspective. Could there be a market failure if private plans did? If Medicare did?

# Conclusion

- Consumer/Medicare vouchers for information?
- Given the noise around the data, may be least helpful when most needed.
- But having a CE model for presentation of information (*not* for uniform decisions) might be a step to transparency.