



**Statement
on
Comparative Effectiveness Research Activities**

**Carmella Bocchino
America's Health Insurance Plans
Washington, DC**

**Submitted to the
Federal Coordinating Council on Comparative Effectiveness Research
Public Listening Session**

April 14, 2009

I. Introduction

America's Health Insurance Plans (AHIP) appreciates the opportunity to share its member companies' perspectives on comparative effectiveness research (CER). AHIP is the national trade association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of products in the commercial marketplace – including health, long-term care, dental, disability, and supplemental coverage – and also have a long history of participation in public programs.

Health insurance plans are strongly committed to advancing an evidence-based health care system in which information generated through clinical research is quickly and effectively translated into everyday medical practice. They also are committed to using the evidence available to make appropriate decisions about coverage of health care services. In their decision-making, insurers rely on the work of the U.S. Preventive Services Task Force as well as physician panels, internal staff and private entities such as the Cochrane Collaboration, ECRI, Hayes and the Blue Cross Blue Shield Association Technology Evaluation Center. Our members, however, are continuously looking for more and better evidence to promote a system which delivers higher value-based care and thus, support CER.

New drugs, devices, procedures, and biologics often are widely used without sufficient evidence of their effectiveness, particularly as compared to alternative ways to treat medical conditions. Too often, the newest and most expensive is deemed to be the “best” therapy when that particular treatment does not always provide the safest or best approach to certain medical conditions. With the rapid diffusion of new treatments and technologies, providers need credible information that provides useful guidance on treatment options.

Moreover, according to the CBO -- which has reported that the use of new technologies is the primary contributor to rising health care costs -- comparative effectiveness research represents the best option through which we can both achieve higher quality for patients and lower overall costs for the nation. In June 2008, the American College of Physicians (ACP) recommended both comparative clinical and cost-effectiveness data to insure the most effective and efficient

use of limited health care resources.¹ As consumers become more concerned about health care affordability, comparative effectiveness has the potential to be an important tool to eliminate waste and unnecessary variation.

The U.S. has taken steps to build a more reliable evidence base -- for example, the evidence-based practice centers at the Agency for Healthcare Research and Quality (AHRQ), Oregon's Drug Effectiveness Review Project and several private sector entities such as the Blue Cross Blue Shield Association Technology Evaluation Center. But, more needs to be done to make useful information available to clinicians, payers, innovators and importantly, consumers, to aid in decision-making and selecting therapies. By filling the gaps in information, translating scientific evidence into understandable terms, gaining knowledge about the performance of new treatments versus existing therapies and helping clinicians and patients make more informed health care decisions, CER holds great promise for improving health care quality and containing overall health care costs.

In addition, comparative effectiveness research can help facilitate our understanding of individual's medical needs to support innovation that is increasingly tailored to fit the needs of individuals and sub-populations. Comparative effectiveness will enhance the need for individualized care, not lead to a "one size fits all" kind of medicine.

As stated in a Congressional Research Service report in 2007, "changing clinical practice is not a simple or inexpensive process, and requires more than disseminating information and expecting individuals to comb-through research studies and find ways to translate the findings into action."² If we are to change clinical practice, we need to build a sustainable infrastructure not only for robust scientific evidence but for disseminating reliable comparative information to clinicians that can be easily translated into care and discussed with patients at the point of care. While health plans and physicians groups have created disease registries, observational databases and decision-support tools to inform decision-making, much more needs to be done. The U.S.

¹ American College of Physicians. June 2008. Information on cost-effectiveness: An essential product of a national comparative effectiveness program. *Annals of Internal Medicine*; Volume 148.Number 12

² Jacobson, G.A.. October 15, 2007. *Comparative clinical Effectiveness and cost-effectiveness Research: Background, History and Overview*. Washington, DC: Congressional Research Service

currently lacks an acute surveillance system enabled by electronic data sets to assess adverse events, produce reliable information on use of therapies and identify populations impacted by such events.

II. Considering Priority Areas for Comparative Effectiveness Research

CER should encompass reviews of preventive services, diagnostics, and treatments including complementary and alternative therapies. In considering priority areas, AHIP commends the prior work of the IOM, “Knowing What Works in Health Care”, which offered sound methods for identifying priority criteria: disease burden, economic cost, variation in care, the adequacy of existing evidence, new evidence that might change previously held conclusions, and those interventions that have the potential to improve health outcomes and quality of life.³ The recommendations of this report should be considered as the Federal Coordinating Council determines priority areas for CER.

In addition, consideration should be given to:

- high volume, high cost areas affecting key populations, communities or the nation;
- medical conditions where current evidence is limited or not available;
- the impact of interventions for multiple diseases and co-morbidities; and
- minority populations disproportionately impacted by disease or illness.

Unfortunately, there continues to be a major gap in care for diverse populations, many of which have not been part of the traditional clinical research model. Therefore, we need to better understand these populations and how their cultural and ethnic differences impact access to care and acceptance of treatment interventions. For example, African-Americans are at higher risk for prostate cancer, yet we do not have a reliable screening test for early diagnosis. Meanwhile, Hispanics are reluctant to accept current treatment interventions.

³ Institute of Medicine (IOM).2008.Knowing what works in health care: A roadmap for the nation. Washington, DC: The National Academies Press

III. The Importance of Information on Cost

We believe that comparative information on cost is critical, especially in today's economic environment. Understanding the clinical effectiveness and cost of a service or technology as well as its potential impact on reducing the need for other health care services and expenditures will help consumers and physicians in selecting the right treatment for each patient.

There are two instances when evaluating cost effectiveness is most critical:

(1) if clinical effectiveness is comparable, then it will be important to know which intervention is less costly, looking not only at the acquisition costs but also any downstream effects and potential savings in reducing hospitalizations, adverse events or other health care services; and

(2) if one intervention is marginally better than another, it may still be important to know the cost of the marginal benefit, so that physicians and consumers can discuss such benefits and help guide their collective decision-making.

For example, there is little evidence to help differentiate the mortality benefit of different treatments for prostate cancer. Some newer forms of radiation therapy cost 4-5 times as much as other treatment forms. In this case, cost effectiveness is an important component of the overall comparative evaluation to help weigh the cost and benefit of such treatments to certain patient populations.

Researchers in the United States are world leaders in the field of cost effectiveness analysis methods, and these methods have an established place in academic research. When applied in a rigorous, unbiased environment, these methods can sustain scientific and public scrutiny.

IV. Activities of the Federal Coordinating Council

We are pleased that the Congress has taken action to make an investment in comparative effectiveness research by providing additional funding to AHRQ and the National Institutes of Health.

We believe that the Federal Coordinating Council will play a critical role in furthering the nation's goal in improving the delivery of care for consumers. This role includes:

- clearly defining the type of research that will be conducted, what parameters of “comparative” information will be studied (e.g., strength of the evidence, outcomes, cost-benefit analysis), the methodology for comparative studies, and a process to reduce potential conflicts or biases; and
- potentially setting a broader national research agenda for the nation and coordinating all federal research activities, including CER.

As the Council conducts its work, it will be essential that the processes for setting priorities, developing research study designs and making subsequent recommendations resulting from this research are transparent and take into consideration patient preferences that will impact adherence and compliance.

Additionally, the Council should continually emphasize that its recommendations and findings are based on its scientific expertise, and are not politically driven. The Council should become a trusted source of reliable information for clinicians, consumers and purchasers who can then use this research to make better informed decisions about the right care.

V. Conclusion

AHIP and our member companies stand ready to work with the Federal Coordinating Council to advance the potential of comparative effectiveness research. Robust comparative effectiveness information is needed if we are to achieve value-based and affordable health care.