



UnitedHealth Group®

**UnitedHealth Group Speaking Proposal – Dr. Deneen Vojta
June 10, 2009 Federal Coordinating Council for Comparative Effectiveness Research
Listening Session**

Overview

The \$400 million allocated to the Office of the Secretary for Comparative Effectiveness Research (CER) as part of the American Recovery and Reinvestment Act of 2009 can play a significant role in advancing comparative effectiveness, a critical aspect of any major effort to improve the quality of health care in the United States, while achieving greater value for patients from resources spent on health care.

However, these resources must be allocated strategically and in a coordinated manner, targeting both existing bodies of comparative effectiveness research, as well as new areas of study pursuant to national priorities. Simply put, patients, families, physicians, and public and private purchasers deserve to know what works best, and in whom, and what's the value, so they can make more informed choices and decisions about health care. That is the value of CER.

At the Listening Session on June 10, I would like to discuss key insights from my experience in the area of comparative effectiveness research during my career in pediatric medicine and health system and health plan administration, including my time at UnitedHealth Group, a diversified health and well-being company that provides services to over 70 million Americans.

Clarifying the Goal of CER

First, as the coordinating council makes its recommendations for setting priorities, we highly recommend clarity regarding the overall goal of investment in CER. In our view, the goal of this research is:

- First to inform patients, providers, and decision-makers, responding to their expressed needs, about which interventions are most effective for which patients under specific circumstances; and
- Second, to produce the best outcomes from the resources used.

Promoting Dissemination and Application of Existing CER

Second, consider focusing stimulus package dollars on broader dissemination and application of the existing body of comparative effectiveness research, a strategy we have used at UnitedHealth Group. For many years, UnitedHealth Foundation provided every U.S. physician with a copy of the *British Medical Journal's* "Clinical Evidence," one of the world's most authoritative medical resources for informing treatment decisions and improving patient care. More recently we have supported broad dissemination of the U.S. Preventive Services Task Force "Guide to Clinical Preventive Services."

In our experience, physicians greatly appreciate receiving this rigorous, credible information, which informs what they do with their patients. There are many additional ways to connect physicians across the country with vital existing CER. Using the \$400 million in allocated funds to explore new distribution channels, or to better leverage existing ones, would be an effective way to drive momentum.

While not all CER is appropriate for consumer use, there are multiple conditions where solid comparative research exists that could clearly benefit patients, allowing them to engage in more knowledgeable discussions with their physicians, make more informed choices and become their own best advocates to help ensure they receive recommended care. For example, patients with diabetes, back pain and prostate cancer could in short order begin to reap the benefits of comparative effectiveness knowledge, if the main players in the health care reform arena – policymakers, providers, employers and the medical community, among others – develop simple, secure ways to share this information.

Investing in New CER to Inform Patients and Their Physicians: Diabetes as a Case Study

In addition to existing bodies of CER, there are also vital areas of medicine where new studies need to be done – and quickly.

Let's look at diabetes - the numbers are staggering. There are 23.6 million people in the United States, or 8 percent, of the population, who have diabetes, and an additional 57 million who have pre-diabetes, the precursor to diabetes. The total prevalence of diabetes increased 13.5 percent from 2005-2007. The total economic cost of diabetes in 2007 was around \$174 billion, of which \$116 billion was the result of direct medical costs. Much of this spending comes from the aggressive use of expensive new drugs and procedures. Yet, in a recently released report on a BARI 2D trial, diabetic patients with heart disease receiving these newer modalities did no better preventing deaths, heart attacks or strokes than patients receiving the older, less expensive medications.

UnitedHealthcare recently launched the Diabetes Health Plan, an innovative “Value Based Insurance Design (VBID)” health plan, which responds to consumers’ interest in a health plan option that offers a reduction in out-of-pocket expenses for compliance with evidence-based standards. While this is an extremely exciting and promising approach, patients and their physicians would benefit from CER that provided answers to clinically meaningful and economically important questions such as:

- What combination of drugs would work best for me?
- What are the advantages and disadvantages of new therapies for type II diabetes versus more established therapies?
- What care management support works best, and for whom?

We are encouraged by our early findings on consumer acceptance of this health plan and believe it can potentially bode very well for future CER-based health care programs. As investments in CER are made, and the research base strengthens, approaches like these can be extended into other conditions and other patient groups, and again, move the health system towards higher levels of quality and value performance.

I appreciate the opportunity to comment at this listening session.