



For Immediate Release  
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Contact: Carol Guthrie  
202-224-4515

**Floor Statement of Senator Max Baucus (D-Mont.)  
Regarding Introduction of The Comparative Effectiveness Research Act of 2008**

In 2006, America spent more than \$2 trillion on health care. By any standard, \$2 trillion is an enormous figure. Health care accounts for 16 percent of our nation's economy. That means that for every \$100 in goods and services produced and consumed in America in 2006, \$16 were for health care. And the health care share of the economy is expected to reach 20 percent in just ten years.

These projections are cause for concern. If so much of our nation's resources are devoted to health care, we need to ask ourselves what we are—or are not—getting for it.

The answer is that we are getting a mixed bag of goods. Some patients receive medical treatments that work well. Some patients receive treatments that don't work well. And in many cases, doctors and patients don't have enough reliable evidence to know whether treatments work or don't.

Of the \$2 trillion spent on health in 2006, only one-tenth of one percent was spent to assess what works and what doesn't. At the Federal level, only \$15 million was directly appropriated to compare the effectiveness of health interventions and services. People who purchase other goods—anything from cars to computers—use information to compare the value of the different products before they purchase. Physicians and patients deserve better. We should devote more than one-tenth of one percent of health spending to study how well health goods and services actually work.

Rapid innovation has led to an ever-changing array of new and sometimes expensive technologies. The age of personalized medicine and genetic engineering will provide even more choices for patients and their physicians. Indeed, patients and physicians can face great difficulty in choosing among treatment options.

But much of the information about those options is biased. Much information about those options is of poor quality. And for many treatments, there are large gaps in what is known to be most effective.

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With a paucity of sound evidence, clinical guidelines and treatment protocols can vary widely. If there has ever been a need for better information—on what works, for which patients, under which circumstances—it is in this age of rapid innovation of technology.

Several august bodies—including the Institute of Medicine, the Medicare Payment Advisory Commission, and the Congressional Budget Office—have called on Congress to create a national entity charged with conducting research to determine what works in health care.

Today, I am proud to introduce the Comparative Effectiveness Research Act of 2008. I am joined by the Chairman of the Budget Committee, Senator Conrad. He and I share a deep concern about rising health care costs. And we share a deep commitment to finding ways to address it.

This bill does what the experts suggest. It would create a new entity responsible for generating better information on the effectiveness of health care treatments.

Specifically, the bill would create a nonprofit corporation responsible for setting national priorities for comparative effectiveness research. The corporation, which would be called the Health Care Comparative Effectiveness Research Institute, would be a private entity. But it would be governed by a public-private sector Board of Governors. It would not be an agency of the Federal Government.

In addition to setting national priorities, the Institute would provide for the conduct of research studies that answer the most pressing questions about what works in health care. The Institute would have the authority to contract with experienced Federal agencies, such as the Agency for Healthcare Research and Quality, or AHRQ, and the National Institutes for Health, or NIH, or with private researchers if appropriate, for the conduct of the actual research. The Institute would also be charged with disseminating the findings of the research in ways that patients and providers can understand.

The Institute would be required to assess the full spectrum of health interventions, including pharmaceuticals, medical devices, medical procedures, medical services, and other therapies. This type of research is often called “comparative effectiveness research,” because it evaluates and compares the clinical effect of alternative medical treatments. This type of research provides better quality evidence concerning the best treatment, prevention, and management of the health conditions. Most importantly, this type of research helps patients, providers, and payers of health care to make more-informed decisions.

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While many experts have called for creation of a new entity, they do not specify how the entity should be structured. This bill would create a private, nonprofit institute rather than a new entity within the executive branch or legislative. Keeping it private would remove the potential for political influence on the development of national research priorities. Comparative effectiveness research will be more credible, and more useful, if it is done independently of political influence and with broad stakeholder input.

This bill includes stringent requirements for public input, transparency of process and findings, and integrity of the research. For example, the Institute would be required to publish its rules, proceedings, and reports on a public Internet site. Its meetings would be open to the public. And it would be required to provide public comment periods at key stages, in addition to open forums to solicit and obtain public input on the Institute's activities.

This bill would also require accountability and government oversight of finances and the mission. The Institute would be subject to annual financial audits. And the Comptroller General would perform periodic audits of the activities of the Institute to ensure that the Institute would meet its statutory mission and would do so in a fair, open, and credible way.

Finally, this bill would provide a stable source of funding for the Institute. For the first three years, general revenues would be used to start up the Institute. In the fourth year, funding would move to an all-payer system—from both public and private sources. Annual contributions would be made from the Medicare Trust Funds, from revenues generated by a fee on private health insurance policies, and from general revenues. The work of the new Institute would benefit Americans who receive health care through the public and private sources. Therefore, public and private sources should contribute to this type of research. The private insurance fee would be \$1 per insured person per year. Funding from Medicare would also be \$1 per beneficiary per year.

All sources of funding for the Institute would sunset after ten years. That way, Congress could review a report from Comptroller General on the value of the research to the public and private insurance sectors. Total funding for the first year would be \$5 million, and funding would increase to \$300 million a year by the year 2013.

It's high time that America invested more than a fraction of a percent to generate knowledge about what works in health care, to improve the efficiency and the quality of our health care system, and to give patients and doctors better information to make treatment decisions. It's high time that we built a foundation of evidence for the trillions of dollars spent on health in America each year.

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