

From: Twila Brase RN, President, Citizens' Council on Health Care (CCHC)
To: All Representatives – House
Date: Tuesday, March 23, 2004
Subject: Response to Rep. Bradley's March 1, 2004 Email to House Members

CCHC has received a copy of the following email (see italics below) from several sources. It was sent by Rep. Fran Bradley to all members of the House on March 1, 2004. As you perhaps recall, the email called into question the statements that we emailed to all of you on February 28, 2004 (see attached). Because the email to which we are responding has been circulated outside the legislature, our response will also be public.

At best, it is difficult to respond to charges of falsehood and exaggeration when there are no specifics given. In fact, more than half of our February 28th email was devoted to quoting verbatim several sections of the proposed bill (HF 1681). However, we will respond to the specific comments raised in Rep. Bradley's March 1, 2004 email.

Please find below our response to each of Rep. Bradley's assertions. The message of his email is included in its entirety. It is italicized to separate it from our comments which are in plain text.

From: Fran Bradley
To: All Representatives – House
Date: Mon, Mar 1, 2004 8:55 AM
Subject: Re: HF 1681 – 6 concerns: medical practice directives

Fellow House Members:

I know that many of you already realize that the February 28 email from Twila Brase is, at best, baseless exaggeration and, at worst, blatantly false. She does a disservice to the health care cost containment debate by distortion and misrepresentation of market based best practices proposals. Let me set the record straight.

CCHC RESPONDS: Our organization does not consider proposals that promote growth of government power in health care decision-making, or government intrusion in private medical records as “market-based” – no matter what kind of title they are given (ie. “best practices”).

1. We call upon the Health Department to facilitate, with healthcare stakeholders, identification of six already accepted best practices so that we can work together to aggressively apply them to save lives and improve health outcomes. The Minnesota Medical Association and other health care provider groups are fully supportive of this effort and willing to work actively to improve best practices compliance. There is simply no government practice of medicine involved! Provider and health plan reporting on these key outcomes is already occurring. We are simply trying to broaden the effort so all Minnesotans can gain.

CCHC RESPONDS:

RE: “Best practices.” The creation of “best practices” guidelines is fraught with bias, value judgments and political and cost containment agendas. William E Cayley, MD writes that the values and biases of researchers determine “which research to pursue, which articles to read, and

which patient-oriented outcomes are most important” (“Evidence or bias?” The Journal of Family Practice, May 2003, 52(5): 380-1). A recent report from the Institute of Medicine, a federal health policy research organization, notes, “There are gaps and inconsistencies in the medical literature supporting one practice versus another, as well as biases based on the perspective of the authors” (Patient Safety/Achieving A New Standard for Care, Institute of Medicine, 2003).

RE: Saving lives. Practice guidelines raise serious issues. Milliman USA, a major guideline developer is currently involved in a lawsuit over a pediatric care guideline (“Not by the numbers, please.” Modern Healthcare. May 8, 2000). In addition, a study of 19 practice guidelines—the entire output of a high-profile guideline developer—found 7 guidelines in need of a major update and 6 in need of a minor update (Shekelle et al. “Validity of the Agency for Healthcare Research and Quality Clinical Practice Guidelines: How Quickly Do Guidelines Become Outdated,” Journal of the American Medical Association, September 26, 2001).

RE: The MMA. The public has not yet been provided with evidence that the Minnesota Medical Association and other health care provider groups are “fully supportive” of this initiative. Second, the MMA does not speak for all physicians and even if it presumed to, legislation that intrudes on the patient-doctor relationship should not be supported. Third, legislators sworn to uphold the constitutional rights of citizens should protect patients against physicians and others who would let the government dictate, direct, influence, incent, track and monitor medical treatment without patient consent.

2. Ms. Brase seems to prefer the status quo. I join virtually the entire health care community in believing the status quo is unacceptable. How can we justify the fact that less than half of people with diabetes, asthma, heart conditions, etc. actually receive health care matching the best sciences known today. The costs in terms of both human and financial impact are enormous.

CCHC RESPONDS:

RE: “Status quo”. Legislators should ask that the term “status quo” be defined. If the status quo is the rising cost of health insurance, or growth in administrative expenses, or more time spent on paperwork than patient care, CCHC would join Rep. Bradley in finding the status quo unacceptable. However, the “best practices” initiative will add to state bureaucracy, increase paperwork and reporting requirements, siphon dollars away from patient care, and leave practitioners with even less time to interact with patients. In addition, the tracking and adherence provisions will cause practitioners to focus on the State’s objectives rather than the patient’s individual needs. Many thoughtful observers have stated that extensive third party payment is the root of rising costs, yet this initiative will further institutionalize third party involvement in every health care decision.

RE: “Best sciences.” According to Rep. Bradley, “less than half of people with diabetes, asthma, heart conditions, etc. actually receive health care matching the best sciences known today.” We will concentrate on diabetes, since that has been the focus of Rep. Bradley’s testimony in support of this proposal. First, researchers studying practice guideline compliance with Type 2 diabetic patients found only 24% of physicians not complying with guidelines. The researchers explain that “Our data suggest that failure to follow guidelines is not necessarily explained by ‘bad doctors,’ or forgetfulness; rather, noncompliance may reflect valid questions about the usefulness and applicability of a best practice to an individual patient.” (“Best practices not best for all,” AMNews, December 3, 2001)

Second, the oft-cited data from the Institute for Clinical Systems Improvement (ICSI, pronounced “ick-see”) which claims that only 24% of patients receive optimal diabetic care does not measure physician care or physician compliance with practice guidelines. ‘Optimal diabetes care’ is less about care and more about condition. It is measured using the following five items (John Frederick [MD, PreferredOne] and Gail Amundson [MD, HealthPartners]. “Medical Group Quality Data: a Reality,” MetroDoctors Jan/Feb 2004):

- % of patients with HbA1c [Hemoglobin A1C] less than or equal to 8.0
- % of patients with LDL-Cholesterol less than 130
- % of patients with blood pressure less than 130/58
- % of patients over age 40 taking aspirin
- % of patients known to be non-smokers

Notably, these are not medical practices. Nor are these measurements of practice guideline use. These are conditions, behaviors and lifestyles of patients.

Third, another study of diabetic care found the maximum amount of variation in outpatient visits and hospitalizations due to differences in physicians at around 4% for outpatient visits and 1% for hospitalizations. The other 96% and 99% variations are due to patient factors or chance. (Timothy P. Hofer et al. “The unreliability of individual physician ‘report cards’ for assessing the costs and quality of care of a chronic disease,” Journal of the American Medical Association, June 9, 1999)

3. We also call upon DOER and DHS to be models in making best quality/value judgements in purchasing health care for our employees and public assistance recipients. In this case we suggest selecting the top three best practices areas for application. Health care providers embrace the opportunity to improve their practice of medicine - there is no conflict of interest, only interest in better helping patients. Would we ever buy a high cost, low quality product of any kind? It's time for the state taxpayer to get the best possible value for the health care they finance.

CCHC RESPONDS:

RE: “Why would we buy”: Unfortunately, the statement “Would we ever buy” reflects a misunderstanding about markets. State purchasing of health insurance does not allow effective and competitive markets based on individual preferences. Far better for the legislature to support state and federal legislation that frees individuals from the purchasing and health insurance decisions of employers and state government. To ask DHS and DOER to be the purveyor of quality and value is to presume that state officials can know and meet the individual needs of patients. They cannot.

Patients get better care when they become consumers, explained Jim Frogue, health policy director for the American Legislative Exchange Council, at CCHC’s October seminar on Consumer-Driven Health Care. He noted the positive experience of Medicaid recipients in Cash and Counseling pilot programs around the country. They have enjoyed the freedom and value associated with holding the dollars in their own hands. And as one woman testified at the HHS Finance hearing last Thursday (3/18/04), she has done a “better job” managing her daughter’s care than agencies could.

RE: “embracing” state-issued best practices. Rep. Bradley claims that “health care providers embrace the opportunity to improve their practice of medicine.” It would be interesting to know

who these “providers” are (physicians? nurses? health plans? hospitals?), and to see the data that supports the statement that these individuals or entities embrace state-issued practice directives—or that they embrace DHS and DOER officials as sufficiently schooled in medical practice and medical decision-making for the purpose of determining the best treatment regimens for patients.

4. We are purposely keeping the development and identification of best practices in the provider community. We encourage innovation and the application of technology to make sure new and changed information gets into practice quickly. Today, best practices often take more than 10 years to become common and, unfortunately, may never reach full implementation.

CCHC RESPONDS:

RE: “Innovation” and “Implementation.” First, CCHC has yet to see evidence supporting the “10 years” claim. Second, since practitioners disagree about what constitutes a “best practice,” we wonder whose best practices is being used in this example? Third, a study found half of the practice guidelines under review were outdated in 5.8 years—and needed review every 3 years (Shekelle et al. “Validity of the Agency for Healthcare Research and Quality Clinical Practice Guidelines: How Quickly Do Guidelines Become Outdated,” JAMA, September 26, 2001).

RE: Provider Community. Who is included in this “provider community”? The groups and health plans with government relation staff or individual practitioners taking care of patients every day?

5. Defensive medicine cost consumers billions of dollars. Our proposal attempts to provide some protection for doctors using accepted best practices from malpractice lawsuits. Too often unavoidable bad outcomes bring costly lawsuits. In the end, our constituents pay for these costs.

CCHC RESPONDS:

RE: Defensive Medicine. Reducing the costs of defensive medicine does not require micromanagement of medical practice. Patients who are given control over their own health care dollars (ie. Health Savings Accounts) will readily resist the practice of defensive medicine. When patients are paying more in cash, they will count—and require accounting for—every penny. A physician will be forced to provide the patient with sufficient rationale for every treatment decision, and every anticipated cost. This is the essence of consumer cost-consciousness, and the impetus behind the Health Savings Account.

RE: “protection for doctors.” Given the built-in bias of researchers and guideline developers (as noted above), physicians should not be protected from making bad decisions. Nor should they be coerced into following government-approved guidelines or into making bad decisions that are approved by and protected by the government. Just as problematic, innovation will be stifled as physicians fear treating outside of the approved guidelines even for the sake of patient care. The malpractice provision (deleted on 3/18/04) would have encouraged doctors to think about their own protection first and their patients second.

RE: “constituents pay these costs.” Rather than the high cost Rep. Bradley suggests constituents would pay, an even higher long-term cost will be paid as patients are left with doctors who only practice cookie-cutter, state-approved, follow-the-bouncing-ball medicine.

Guidelines as Defense. Before the March 18th amendment, the bill proposed use of a guideline as an “absolute defense” against malpractice allegations. However, “there is no hard and fast rule as to which guidelines have ‘reliable authority’” in the courts (Defensive Medicine and Medical Malpractice (Appendix H), U.S. Office of Technology, 1994). The federal report goes on to say that while guidelines have been viewed as a method of cost containment, courts have been averse to accepting the high cost of a procedure as a defense against medical malpractice.

RE: “malpractice lawsuits”. Legislators should consider the impact of other factors on any reported rise in malpractice litigation. In more than 80 percent of cases, communication issues have been cited as the main reason patients pursue a malpractice lawsuit (Thomas May and Mark P. Aulisio, “Medical Malpractice, Mistake Prevention, and Compensation,” Kennedy Institute of Ethics Journal, June 2001). Another study found that the surgeon’s tone of voice may influence a patient’s decision to sue (Surgery, July 2002 [News] accessed online at Agency of Healthcare Research and Quality). Harvard professor Troyen Brennan said in a recent presentation that the 1999 Institute of Medicine report on medical errors (whose claims of 44,000 – 98,000 deaths per year have since been refuted) has caused juries to more readily believe the plaintiff’s attorney (U of MN Deinard Memorial Lecture, 2/26/04). *Consider also:* physicians burdened with paperwork requirements, cannot as easily build a congenial trusted patient-doctor relationship, or spend the necessary time with patients to improve diagnostics, reduce errors or sufficiently communicate.

6. Since we are not building a “medical decision-making bureaucracy in state government”, the issue of cost to taxpayers is hollow. Virtually everyone else but Ms. Brase seems to realize that the market (health plans, employers and employees) are demanding cost and quality information. The state government, as the largest employer in the state, can and should join in this movement. Success will save taxpayers hundreds of millions of dollars. The great news is that we do not have to reinvent best medical science, we need only to take advantage of free market forces.

CCHC RESPONDS:

RE: Bureaucracy building. The health department has not dropped its plans to eventually use statutory access to everyone’s medical records to build a list of “best practices.” As Buddy Ferguson (MDH Public Information Officer) said in a Univ. of MN presentation (“Human Rights, Civil Liberties and Public Health in an Age of Terrorism,” 11/7/04), the department planned to use claims and outcome data garnered through Minnesota Statutes 62J to identify “which treatment modalities are and aren’t effective.” Because the health department’s data access law was not repealed last year—only the administrative rule was withdrawn—MDH is authorized to engage in this process as long as funding is provided or found. The health department has already collected over 130 million patient medical records at last count. The actual figures are on the Citizens’ Council on Health Care website: <http://www.cchconline.org/medrecords.php>

I stand firm. The bill is creating a medical decision-making bureaucracy in state government that will negatively impact patient care and put government in the exam room and in the middle of the patient-doctor relationship.

RE: “demanding cost and quality data”. We fail to see any evidence that the “little guy”—the average, ordinary citizen—is clamoring for his or her doctor to be tracked and their medical records accessed without consent. Which employees have asked the State to tell their doctors how to practice medicine? Instead, we see only the employer groups and the health plans advocating for the imposition of state-issued medical practice guidelines. Guidelines are just another way to

do the business of managed care. As demonstrated by the HMO backlash, the Patient Bill of Rights, and the reaction of audiences to movies that mention HMOs, patients are generally not pleased with managed care, the micromanagement of their doctors or the various strategies used to limit access to care. What recourse will patients have against the State when government officials, political agendas and committee decisions interfere with their medical care?

RE: “free market forces.” Again, free markets are never enhanced by expanding the size and influence of government, by interfering in the individual choices of patients or by limiting the autonomy of health care practitioners. Furthermore, government interference will stifle innovation, increase costs and limit free-market competition. The “best practices” provision will make it more difficult for independent physicians and other practitioners to stay independent and in business. Without the electronic data systems to “prove” that his or her practice meets the State’s idea of “best practices,” s/he will be at a significant disadvantage in contract negotiations.

RE: Cost. By my calculation, the 3/12/04 Fiscal Note on House File 1681 (prior to the 3/18/04 amendment) was \$1.2 million. Moreover, the Department of Finance said the full cost of the provision was unable to be determined. No matter what the *amended* Fiscal Note is determined to be, this language represents an expensive camel’s nose. The identification, tracking, monitoring and compliance enforcement system will not stop with whatever initial “best practices” determinations are made. Bureaucracy is never cheap.

The Health Savings Account Conundrum. This bill proposes to give Minnesotans access to choice-enhancing Health Savings Accounts while at the same time it proposed to tie the hands of physicians and other health care professionals through the “best practices” initiative. HSAs are supported by CCHC, and we support Rep. Bradley’s proposal to conform Minnesota law with the HSA provisions in the Medicare Act of 2003. HSAs will not only decrease the cost of care, they will make health insurance more affordable, lessening the State’s Medicaid burden. However, we sincerely hope that Rep. Bradley will grasp the problems discussed above. He may have accepted these ideas from proponents in good faith, but mistakenly so, we believe.

I find it interesting that Ms. Brase spends so much energy criticizing our free market proposal and seems to pay very little attention to the Senate DFL proposals to simply cap insurance premiums and to expand government subsidized health care programs. What about the Senate DFL proposals that call for an outright single payer government run health care system? Again, little comment. Ms. Brase could do a lot to restore her dwindling credibility by addressing the real threats and sticking to the facts.

CCHC RESPONDS:

RE: “free market proposal.” Our organization supports free-market proposals, but I must sincerely disagree with Rep. Bradley that this proposal, or any proposal that implements government-managed health care, will advance the free market. The “best practices” initiative is the first step toward state-based health care rationing, a concept defeated last year with the demise of the Oregon Health Plan proposal (though this year’s MN Senate has it again in SF 1760).

RE: Single-payer system. As it can be seen in the November 18, 2003 press release on our website, CCHC does not support single-payer government-run health care: <http://www.cchconline.org/pr/pr111803.php> However, because our time is limited, energy and effort are only put into proposals that look like they have the potential to become law.

If you have any questions, please feel free to contact me. Thanks.

*Representative Fran Bradley
Chair, Health & Human Services Finance
WEB Site: www.franbradley.org*

ADDENDUM: Comment on Disease Management (DM) Amendment

In the time between Rep. Bradley's March 1st email and our response, House File 1681 has been amended. Added was a variation on the theme of state-issued practice guidelines. The amendment not only authorizes the Departments of Human Services and Employee Relations to require use of such medical practice guidelines in State contracting decisions with insurers, it also requires 'disease management' (DM) in public health care programs. Since the above discussion detailed issues surrounding such guidelines, I add this comment to show the connection between DM and practice guidelines, and to highlight concerns about costs and cost-shifting.

DM Defined: "Disease management...emphasizes prevention of exacerbation and complications utilizing cost-effective, evidence-based **practice guidelines**..." according to the definition of DM from the Disease Management Association of America (DMAA). ("Disease Management and Disease Registries: Opportunities for MCOs," Managed Care Interface, October 2001)

Cost Concern: Disease management appears to be the latest iteration of managed care—and a growth strategy for some managed care organizations. Specialty disease management companies have gone from annual revenues of \$85 million in 1997 to more than \$600 million a year in 2002 (Short et al, "Disease Management: A Leap of Faith to Lower-Cost, Higher-Quality Health Care," MetroDoctors, Jan/Feb 2004). **More than \$1.0 billion was spent on DM programs in 1999 alone, "yet there is relatively little evidence on whether DM programs have significantly affected either costs or quality of care."** (Selby et al, "Determining the Value of Disease Management Programs," Joint Commission Journal on Quality and Safety. September 2003).

We expect the disease management proposal to shift more state health care dollars into managed care activities, leaving fewer dollars for hands-on patient care by physicians and others, thus exacerbating the problem of cost-shifting. We also expect, as with state-issued "best practices" guidelines, that DM will promote government interference with patient care.

Thank you for taking the time to consider our comments regarding the assertions made in Rep. Bradley's March 1st email. The fact that you have reached this point in reading our response shows that you take these issues seriously, just as Citizens' Council on Health Care does. Thus, whether or not you agree with CCHC's concerns on this matter, we share a mutual belief in good faith discussion and debate. Feel free to contact me at any time. Again, thank you.

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