



January 31, 2008

The Citizens' Report of Dissent

A Critical Evaluation of the Principles and Recommendations of the Minnesota Health Care Transformation Task Force

The 2007 legislature required Governor Tim Pawlenty to “convene a Health Care Transformation Task Force to advise and assist the governor regarding activities to transform the health care system, and to develop a statewide action plan... for transforming the health care system to improve affordability, quality, access, and the health status of Minnesotans”¹ The overarching goal of the plan was to reduce health care spending by 20 percent by January 2011—three years from now.

All members of the committee, except two legislators from the Minnesota House of Representatives and two legislators from the Minnesota Senate, were appointed by the Governor. The report of the Minnesota Health Care Transformation Task Force recommendations is due on February 1, 2007.

On behalf of all the citizens of Minnesota who care about access to individualized patient care, Citizens' Council on Health Care is providing the following dissenting comments on the Task Force's recommendations under each of the six “transformation principles” established by the members of the committee.

This Citizens' Report uses the 11.1 version of the Task Force recommendations dated January 23, 2008 and marked “FINAL VERSION FOR APPROVAL.” No fiscal note on the cost of the proposal—or the purported savings from implementation of the Task Force recommendations—has yet been published.

NOTE: Italics indicate quotes or paraphrases from the Transformation Task Force recommendations.

TTF PRINCIPLE I: IMPROVE HEALTH.

“The Health of Minnesotans Must Be Significantly Improved and All Stakeholders in the State Should Accept Responsibility for Helping Achieve Aggressive Health Improvement Goals”

CCHC COMMENT

Task Force Recommendations Jeopardize Individual Privacy and Self-

Determination: While improving health is a laudable goal on its face, health improvement is an activity of individual citizens defined by individual citizens. The responsibility for health improvement lies with each and every individual. Placing the responsibility for improving the health of individuals into the hands of state legislators, government agencies, corporate health plans, employers, non-profit organizations and others assures that the individual's rights to privacy and self-determination will be jeopardized.

For instance, the Task Force assigns intrusive tasks to citizens, government and industry to reduce the obesity, smoking, drinking and drug use of individuals. One particularly troubling recommendation would create a government database annually filled with the obesity scores of all Minnesota children. The Task Force recommends:

- *“Minnesotans should complete a confidential health risk assessment in order to help in establishing individual goals for health improvement...Minnesotans should complete health risk assessments in accordance with the [Minnesota Department of Health] recommendations and establish individual goals for health improvement.”*
- *“Every employer, school, community, and health provider should encourage its employees to complete health risk assessments, to discuss the results with their physician...and to establish and achieve annual health improvement goals.”*
- *“The Minnesota Departments of Education and Health should establish a cost-effective system for measuring the Body Mass Index of children, in order to measure progress in reducing the percentage of children who are overweight and obese.”*
- *“The Legislature and state agencies should encourage and/or require employers, schools, communities, and health care organizations throughout the state to adopt similar, age-specific goals for each of these priority health conditions and diseases by December 31, 2008.”*
- *“The State of Minnesota should be accountable for achieving the goals for its employees.”*
- *“The Minnesota Department of Education should be engaged to determine the best way to ensure that schools are held accountable for making progress on health improvement goals.”*

The Task Force also recommends that the legislature and “key stakeholders” (government, schools, employers, “communities”) adopt the Minnesota Department of Health’s Comprehensive Statewide Health Improvement Plan. This plan—estimated at a November 2007 meeting of the Minnesota Legislative Commission on Health Care Access to cost \$26.5 million per year—would increase government bureaucracy, administrative burdens, taxes, and health insurance premiums. The plan according to the recommendations includes:

- *Enacting state standards for physical activity in schools*
- *Comprehensive land use plans to increase physical activity of all citizens*
- *State requirements for food served in schools*
- *Higher taxes on tobacco products*
- *Interventions that are directed at individuals, at populations, and at environmental factors should be included.*
- *Employers, schools, communities and healthcare providers providing the resources needed by their employees to implement the plan.*
- *Enact state requirement for health insurance coverage for preventive care services.*

Given the evidence to the contrary, it is a surprise to see the task force's recommendation that coverage for preventive care be required by state law. Many economists have publicly stated that preventive care can actually be rather expensive. As noted last summer in *The New York Times*:

"It's a nice thing to think, and it seems like it should be true, but I don't know of any evidence that preventive care actually saves money," said Jonathan Gruber, an M.I.T. economist who helped design the universal-coverage plan in Massachusetts...

But any effort to promote health has its own costs. Doctors and nurses need to spend time with patients to persuade them to change their behavior. (Ever tried to get someone to stop smoking or drinking?) For a new program to work, it has to reach people who are not being helped by whatever exists now — and who thus will be among the most difficult and expensive patients to treat. The program would also have to treat a whole lot of people who never would have gotten sick...

As Dr. Mark R. Chassin, a former New York state health commissioner, says, preventive care "reduces costs, yes, for the individual who didn't get sick... But that savings is overwhelmed by the cost of continuously treating everybody else."²

TTF PRINCIPLE II: INCREASE QUALITY.

"Dramatic Improvements Must Be Made in the Quality, Costs, and Patient-Centeredness of Health Care in Minnesota Through a Combination of Collaboration and Competition by Providers"

CCHC COMMENT

Task Force Recommendations Impose Privacy Intrusions & Limits on Care: Principle II is focused on building expensive, time-consuming, bureaucratic patient and doctor tracking systems, essentially putting outsiders in charge of medical decision-making and violating the patient-doctor relationship. Of particular concern is the focus on

using electronic data systems and outside determinations of “necessity” and “quality” to determine whether doctors and hospitals will receive payment for the care they provide.

Quality is a term that resonates with the public. However, members of the task force do not define “quality,” leaving the legislature and the public to make assumptions about the interpretation of the word. Instead, the task force connects “quality” to terms more akin to the production industry than the exam room: “necessary,” “effective execution,” “efficient,” and “evidence-based”—all terms that can have a variety of interpretations:

- *Consumers must “utilize the highest-quality, most efficient health care providers.”*
- *“Providers should deliver care to patients consistent with evidence-based guidelines, where such guidelines exist.”*
- *“Health care providers must compete to achieve the most efficient and effective execution in delivering necessary, quality care.”*

The term “necessary” begs the question of who decides what treatments are necessary. The doctor? The patient? The government? The employer? The health plan? And the most “efficient” doctor may never have time to hear the real reason the patient walked in the door, or the real cause of the presenting symptoms, potentially leading to incorrect diagnoses and improper treatment.

Of great concern is the Task Force recommendation that payment for care be tied to patient outcomes and the doctor’s use of “systematic patient tracking systems”:

- *“Collaboratives should define the minimum standards/expectations for outcomes of care, and both purchaser and payer should refuse to pay for care that does not meet the standards.” [our emphasis]*
- *“Providers should be required to implement and use electronic medical record systems and systematic patient tracking systems as a condition of payment.” [our emphasis]*
- *“All providers should be required to submit standardized electronic information on the outcomes and processes associated with patient care...for the purposes of public reporting.” [our emphasis]*
- *“Where good outcome measures and/or good complexity/risk adjustment methods do not exist, [public]reporting should focus on the extent to which the provider complies with evidence-based guidelines for care.” [our emphasis]*

In making these recommendations, it appears that the Task Force gave little consideration to the realities of medical practice, research studies, physician scoring systems, and the behavior of patients and doctors. For example:

- Physician orders may have little to do with individual patient outcomes.
- Patient compliance impacts patient outcomes.
- Risk adjustment and patient complexity ratings involve algorithmic judgments.
- Various studies have already demonstrated that outcome reporting can reduce care for the highest risk, sickest patients.³
- Whose evidence should be classified as the right evidence for every patient? As the Institute of Medicine reports, “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, who may be specialists, general practitioner, payer, marketers, or public health officials.”⁴

- Most research studies focus on treating single diseases. Few studies deal with the complications associated with treating patients who have multiple disease conditions (co-morbidities).
- Studies show privacy concerns lead to delays in seeking care, and incomplete disclosures of patient information.⁵ What will be the impact on care once patients know their data is being entered into a patient tracking system and analyzed by outsiders?

A “patient tracking system” as defined by the Task Force is:

“a list of patients all of whom have a common condition or group of conditions, along with information about the care they receive and the outcomes they experience. It would be used for evaluating the effectiveness of care programs across a large group of patients and also to help providers ensure adherence with clinical guidelines by identifying individual patients who need specific procedures or services consistent with guidelines.”
(p. 12) [our emphasis]

TTF PRINCIPLE III: REFORM PAYMENT

“Health Care Payment Systems Should Be Restructured to Support and Encourage Evidence-Based, High-Value Health Care”

CCHC COMMENT

Task Force Recommendations Impose Conflicts of Interest: The transformed system envisioned by the Task Force would impose extraordinary financial conflicts of interest between patients and doctors.

Capped Payments; Legal Battles

Reaching back to the old failed HMO model of lump-sum, capitated payments to doctors for a defined group of patients, the Task Force recommends making doctors and hospitals accountable for the “*total cost of care.*” The Task Force sets a three-stage process for physicians, clinics, hospitals, and other clinicians to become financially responsible for caring for a *population* of patients:

- **LEVEL ONE PAYMENT REFORM:** *“Providers would be measured based on the outcomes they achieve for their chronic disease patients, including the extent to which those patients use expensive services at a high rate, and would receive bonus/penalty payments based on those measures of quality and efficiency.”*⁶ [our emphasis]

- Notably, indicators of care quality and efficiency will include the measures of total cost of care and the presence of electronic infrastructure that enables ongoing intrusive surveillance of patient care and physician treatment decisions:
 - *Electronic record systems*
 - *Collection and internal/external reporting*
 - *Measures of efficiency*
 - *Measures of the overall cost of care for individuals (p. 19) [our emphasis]*
- **LEVEL TWO PAYMENT REFORM:** *“Patients with chronic disease would be encouraged to choose and use a medical home, which would be paid a care management fee for managing the patient’s care in order to improve their health and reduce utilization of expensive services. Medical home providers would also receive a bonus/penalty payment based on the quality of their outcomes and on the extent to which their patients utilize expensive services.”⁷ [our emphasis]*
- **LEVEL THREE PAYMENT REFORM:** *“Health care systems would bid for providing the total costs of care to a population, including patients with chronic disease. The health care system would need to provide coordinated, effective care and find ways to reduce utilization of expensive health care services by individuals with chronic disease in order to (a) set a bid price that would be accepted by the health plan and which would translate into a premium cost that would attract patients, (b) keep their costs within the bid price, and (c) maintain or improve health outcomes.”⁸ [our emphasis]*

How will patients fare? In level two, care management fees for “monitoring and managing care” will be higher for sick patients with multiple chronic conditions and lower for healthy patients needing preventive care, creating a two-tier systems of patients.. However, in level three, “total cost of care for a population” is a lump sum paid by health plans for all care associated with a group of patients whose health status may change suddenly. If finances are tight, rationing is a real possibility.

Ultimately, the envisioned level three of the payment reform plan can be expected to lead to many battles over responsibility for payment. Although the Task Force says doctors, clinics, and hospitals will not be responsible for higher cost of care solely due to caring for sicker patients, that assurance is good only ***“as long as the illnesses were not preventable through actions by the provider.”***

One can imagine health plans, doctors and hospitals fighting in and out of court over who is responsible for any particular illness and condition of the patient in question—and who is responsible for paying for it.

A Single Price for a “Basket” of Services

Medical services would also be paid for in grouped bundles of services. Included in Principle III is the requirement that all doctors, clinics, hospitals, and other health care practitioners set “a single price for each service billed on a fee for service basis” (Medicaid and Medicare would likely be exempt), and “establish mechanisms for

consumers to select and pay a single price for “baskets” of health care services, particularly for major medical services. As defined in the Task Force recommendations:

A “basket” means a collection of individual services that are currently paid separately under the fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient. For example, a “hip replacement basket” would include all of the charges for the hospital stay, the surgeon’s fees, the medication costs, and post-surgical rehabilitation.”

In reality, most of today’s patients do not pay for the services they receive. The health plan pays, and nothing in the Task Force recommendations appear to change that reality. Few patients will “select and pay a single price.” Instead, the requirement appears to be a way to reduce payment for services provided. By requiring that services be bundled into payment “baskets” prior to treatment, health plans and other payers may be protected from paying the true cost of care if that cost is higher than the set “basket” pre-payment. This could create another incentive for health care rationing.

TTF PRINCIPLE IV: REDUCE COSTS

“The Overall Size and Cost of the Health Care System Should Be Reduced”

CCHC COMMENT

Task Force Recommendations Support Health Care Rationing: The main focus of Principle IV is not cost reduction. Instead, the purpose appears to be care reduction. Point after point discusses placing explicit limits on the availability of treatment, medication, new technologies, and other patient care services:

- *“Health Care Technologies, Services, and Medications Should Only Be Used When They Improve Value.”*
- *“Health insurance plans should only pay for care that is known to be effective...”*
- *“For technologies, services, and medication that have not been proven to be effective or ineffective, consumers should be told that evidence of effectiveness does not exist, and should be informed about alternative options for care, including lower-cost options.”*
- *“Payment for new technologies, services, and medications should be limited to those patients and conditions for which effectiveness has been proven by randomized controlled trials” [RCT can take years to complete, cost \$50 - \$100 million to conduct,⁹ and from which treatment guidelines are produced which may or may not be outdated.¹⁰]*
- *“For new technologies, services, and medications that have been proven to be effective, but which do not provide substantially different benefits to patients than existing, lower-cost technologies, services, and medications, consumers should be told about the relative value of the alternatives and should be required to pay all or part of the difference in cost if they choose to use the higher-cost technology, service or medication.”*

- “A collaborative, non-regulatory [unelected, unaccountable] body (such as the Institute for Clinical Systems Improvement) should be designated or established to review new technologies, services, and medications, including complementary and alternative medicine, and to recommend whether these technologies, services, and medications should be covered by health insurance plans. The methods used by NICE [National Institute for Health and Clinical Excellence] in Britain or by other technology assessment entities could serve as models.”
- “The determination of which services should be included in the essential benefit set and in the standardized benefit set...should be based on the value (i.e., the quality and cost) provided by each service.”

Except for the call to reduce administrative requirements imposed by health plans and licensing organizations, much of the Task Force’s Principle IV runs contrary to the new regulatory burdens they laid out in Principles II and III. It is difficult to reduce the size and cost of health care while at the same time mandating expensive electronic data systems, expanding administrative reporting requirements, requiring doctors to engage in an extensive bidding process to access patients and receive payment, and establishing a new super agency for coordination of the entire health care system—the Health Care Transformation Organization proposed in Principle VI.

Principle IV also runs contrary to the Task Force’s next principle. Principle V (see below) mandates yet another new government-established bureaucracy—a Health Insurance Exchange—and requires everyone to purchase health insurance, new government subsidies to be issued, and expensive guaranteed issue and community rating to be implemented.

An insurance mandate would be very expensive.

As the *Boston Globe* and other news services recently reported, the cost of Massachusetts' health insurance mandate will rise a shocking 85 percent—\$400 million—in 2009. The Massachusetts legislature apparently underestimated the number of people who would sign up for state subsidized health care.¹¹

TTF PRINCIPLE V: INSURE EVERYONE

“All Minnesotans Should Be Able to Obtain Necessary Health Care at An Affordable Cost”

CCHC COMMENT:

Task Force Recommendations Mandate Universal Health Care and Bureaucratic Health Insurance Exchange: Principle V would establish universal

health care in the State of Minnesota. Everyone would be required to purchase health insurance, violating their right to choose not to be insured. And despite the assertion that individuals will be able to purchase health insurance outside the controversial Minnesota Health Insurance Exchange proposed by Governor Pawlenty, most people will be forced to purchase health insurance through the Exchange (see caveat below).

The Exchange, which failed last year due to public outcry, will eliminate the individual's right to purchase health insurance privately. The Exchange will be governed by a group of unelected, unaccountable individuals and will likely be used to monitor individual compliance with the health insurance purchasing mandate. Specific Principle V recommendations by the Task Force include:

- *“It should be the responsibility of all citizens to obtain health insurance coverage unless (a) no insurance is available that meets the affordability standards established by the state, and (b) no subsidy is available to make available insurance policies affordable.”*
- *“A health insurance exchange should be established through which individual and small group insurance products would be sold.”*
- *“An individual and small group insurance product may be purchased outside the Exchange, as long as the insurance product has the same premiums both inside and outside of the Exchange.”*
[our emphasis]
- *“At least initially, there should be a limited selection of plans through the Exchange (e.g. 3 products per health insurance carrier at each benefit level...)”*
- *“If voluntary use of the Exchange fails to support an adequate individual and small group insurance market, use of the Exchange may need to be mandated.”* [our emphasis]
- *“The use of health insurance brokers to purchase insurance should be voluntary for individuals and organization ...”* (Principle IV, p. 35)
- *The Exchange would conduct education and outreach “to ensure that all citizens are aware of their responsibility to obtain health insurance coverage.”*
- *Guaranteed issue and “modified community rating.”*
- *“The Minnesota Comprehensive Health Association should be phased out.”*

TTF PRINCIPLE VI: IMPLEMENT RAPIDLY AND COMPREHENSIVELY (sic)

“All of the Recommended Transformations—Health Improvements in the Population, Improved Quality and Reduced Cost of Health Care Systems, Restructuring of Payment Systems, and Health Insurance Reform—Are Essential to Each of the Others’ Success, and All Should Be Implemented No Later Than 2011.”

CCHC COMMENT:

Task Force Recommendations Create Unelected Super Agency; Increase Provider Tax: A new government-established bureaucracy is needed, according to Task Force members. The proposed Health Care Transformation Organization would start up where the Task Force leaves off. All the current players pushing for government-based solutions would be secured to advise the Organization, including the “Institute for

Clinical Systems Improvement, Minnesota Community Measurement, the Health Information Exchange, corporations and state agencies in the Governor’s Smart Buy Alliance, health insurance plans, health care providers and other organizations.” The Health Care Transformation Organization would continue to operate through 2013—and longer if necessary.

After noting that *“the recommended plans and policies...are necessary but not sufficient to ensure success in reducing health care costs by 20%, limiting annual increases in health care costs, improving the health of Minnesotans, improving the quality of health care services, and providing all Minnesotan with access to quality, affordable health care”* [our emphasis], the Task Force essentially tasks citizens, employers, doctors and health plans with a list of collective responsibilities:

- *“All citizens must commit themselves to reducing and eliminating unhealthy behaviors, utilizing appropriate health prevention services, obtaining and retaining health insurance, and choosing and using high-value health providers and services.”*
- *“Health care providers must commit themselves to significantly reducing their costs and improving the quality of the services they provide.”*
- *“Health insurance companies must commit themselves to supporting the new payment system, reducing administrative costs, and providing health insurance to all citizens at an affordable cost.”*
- *“Private and public employers must commit themselves to supporting the new payment system, continuing to provide health insurance to their employees, and encouraging and supporting their employees to improve their health.”*

MinnesotaCare Provider Tax Increase

After claiming their recommendations will result in savings, the Task Force says a “mechanism” must be established to “capture a portion of the savings from reduced health care costs in order to cover the costs of the subsidies needed to implement [universal health care], the cost of expanded health improvement programs, and the administrative and other costs associated with other new programs and agencies established.”

The specific option mentioned in the recommendations is an increase in the tax on doctors, hospitals, surgical centers, and other health care services—the MinnesotaCare provider tax. This long controversial tax is ultimately paid by patients—in higher costs and diminished access to care. Nevertheless, the Task Force recommends that the MinnesotaCare tax:

“be increased by an amount that will generate revenues equivalent to the state’s net costs from the transformation of the health care system...but with the increase in the tax rate set in such a way that the increased revenues from the tax are less than the total savings achieved system-wide, so that payers would still achieve net savings in health care costs after application of the increased MinnesotaCare tax to provider bills.”

CCHC CONCLUSION

In conclusion, the Minnesota Health Care Transformation Task Force recommends a top-down approach that expands the size and power of government in the lives of citizens, infringes on the professional practice of medicine, and violates the individual rights of patients and citizens.

Disappointingly, the Task Force completely misses the following time-tested, fail-safe reality when it comes to reducing the cost of health care:

Patients care most about cost when the dollar is coming out of their own pocket.

The Task Force recommendations leave out health savings accounts, higher deductibles, non-prepaid health care policies, cash payments, reducing the role of health insurance in medical care, opening Minnesota's borders to less expensive out-of-state insurance options, and other inexpensive strategies that would naturally produce transparency of pricing and cost sensitivity behaviors in patients and consumers without the force of law or the expense of new government bureaucracies.

If implemented, the Minnesota Health Care Transformation Task Force recommendations would impose intrusive monitoring on citizens and patients, improperly provide doctors, clinicians, clinics, and hospitals with a multitude of financial incentives to ration medical care, and leave patients with little reason to personally reduce their utilization of health care services.

ENDNOTES

¹ Chapter 147, Article 15, Section 21. Minnesota Session Law 2007.

² "Free Lunch on Health? Think Again." David Leonhardt, *The New York Times*, August 8, 2007.

³ "Is More Information Better? The Effects of 'Report Cards' on Health Care Providers." David Dranove, et al. *Journal of Political Economy*, 2003, v111 (June 3), p. 555-588.

⁴ Patient Safety: Achieving a New Standard for Care. Institute of Medicine. 2004: p. 158.

⁵ "Medical Privacy and Confidentiality Survey: Summary and Overview, California HealthCare Foundation, January 28, 1999

⁶ "How Health Care Competition and Cost Control Will Work Under Minnesota's Transformed System." Draft Version 2.0, January 23, 2008.

⁷ "How Health Care Competition and Cost Control Will Work Under Minnesota's Transformed System." Draft Version 2.0, January 23, 2008.

⁸ "How Health Care Competition and Cost Control Will Work Under Minnesota's Transformed System." Draft Version 2.0, January 23, 2008.

⁹ Sidney Goldstein, M.D., Cardiologist (Clinical Trialist for 41 years), Division of Cardiovascular Medicine, Henry Ford Hospital, remarks at CCHC Annual Health Care Policy Event (*Who Else Has Your Doctor's Ear?*), November 10, 2005.

¹⁰ Shekelle PF {M.D., Ph.D.} 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; v 286(12): 1461 – 7.

¹¹ "Massachusetts Healthcare Plan Costs Skyrocket." Monisha Bansal. *CNSNews.com*, January 25, 2008.