Citizens' Council on Health Care

Minnesota Health Care Reform Task Force

Will Appointees Support ObamaCare or Health Freedom?

2010 LEGISLATIVE CHARGE: *"The governor shall convene a Health Care Reform Task Force to advise and assist the governor and the legislature regarding state implementation of federal health care reform legislation."* (see entire statutory language on page 5 below)

TAXPAYER COST: **$198,000**

APPOINTMENTS ANNOUNCED: June 30, 2010

FIRST MEETING: July 15, 2010

LOCATION: Room 144-145, Freeman Building, MN Dept. of Health, 625 N. Robert St, Saint Paul, MN 55164

APPOINTEES:

TASK FORCE APPOINTEES	**STATEMENTS & POSITIONS THAT MAY INDICATE SUPPORT FOR OBAMACARE OR CONFLICT WITH HEALTH FREEDOM *** [ie. Health Insurance Exchange; Government databases and tracking systems on patients and doctors, Electronic medical records/health information technology (HIT) mandate, "Pay-for-Performance" reward & penalty payment systems, "Value-Based" health care, Government-imposed treatment directives, and "Quality" (compliance with government directives) reporting and measurement mandates.
State Agency representatives	
DHS Commissioner **Cal Ludeman** – Chair	Current Chair of the Governor's Health Cabinet; Former Member of the Minnesota House of Representatives from 1979 – 1985. Mr. Ludeman is Co-Chair of the **Smart-Buy Alliance**, a coalition of public and private health care purchasers, including state government purchasers, Buyer's Health Care Action Group, Minnesota Business Partnership, the CEO Roundtable, Employers Association, Inc., the Minnesota Chamber of Commerce and labor unions. The Alliance members agree to "set uniform **performance standards, cost/quality reporting requirements**…" The Smart-Buy Alliance, which buys health insurance on behalf of about 70% of state residents "pool their purchasing power to **drive value** in the health care delivery system"... *(The Commonwealth Fund, May 26, 2005)* Commissioner Ludeman has suggested that employers get involved in patient decision, not just purchase health

**Obtained from online documents and CCHC history at the State Capitol*

	insurance for their employees. Employers, he said, should make "sure that employees are connected to the right providers." *("In Sickness & In Health," Kevin Featherly, Minnesota Technology, April 2008)* He supports 2008 health care reform law, which requires government collection of patient, and doctor data without patient consent. He also supports equation-based "**value-driven health care**" and **pay-for-performance** payment system for doctors (ppt presentation at 2008 CCHC health care policy event) Ludeman on Executive Order which directed state government to **"apply Qcare standards and align payments and incentives"** for all health care purchased by the State: "Purchasing health care based on volume, as we do now, does not provide incentives to increase quality. Improving quality will save lives, improve the quality of life for people living with chronic illness, and help to keep health care affordable. QCare will help us change the system to change the results." *(Press Release, Office of the Governor, July 31, 2006)* – *NOTE:* **Qcare stands for: "Quality Care and Rewarding Excellence"**
MMB Commissioner **Tom Hanson** – Member	Former Director of Legislative and Cabinet Affairs to the Governor
MDH Commissioner **Dr. Sanne Magnan** – Ex-officio (non-voting) member	Dr. Magnan has served on the Board of **Minnesota Community Measurement**, was a vice president and medical director at Blue Cross Blue Shield of Minnesota, and is former President of the Institute for Clinical Systems Integration **[ICSI],** an organization which generates standardized treatment protocols for physicians and supports "**value-driven care**." *[FMI on ICSI, see Montreuil below]* "We're probably best known for developing guidelines, But ICSI's primary focus is to change the health care delivery system…Guidelines are here to stay. They're a tool to work on quality improvement….The ICSI board supports pay for performance, and guidelines provide an evidence-based framework for **what practices could be rewarded**. I think people recognize that we need to find a way to have the proper rewards, incentives, and alignment for quality care, and **pay for performance is a step in that direction**." – response to questions about 1) ICSI; 2) physicians saying guidelines are too long, burdensome, and 'cookie-cutter medicine'; and 3) the relationship between practice guidelines and pay-for-performance (Interview of Dr. Magnan, ICSI president, in *Minnesota Physician*, November 2006) Interview on *Almanac (TPTelevision):* After her appointment as Commissioner, she said she'd like to change the health care system to get "a better **value** for all the money we're putting into it." And she asked, "How do we **reward** physicians for good quality outcomes…versus procedures and tests?" *(9/28/07)* As Minnesota's current Commissioner of Health, her efforts led to enactment of the 2008 health care reform law (62U), which requires health insurers to send private **medical data on all patients and treatment decisions to a data warehouse** in the state of Maine for access to—and ownership by—the Minnesota Department of Health. The law requires the data to be used for monitoring doctors and patients, and implementing "payment reform." Dr. Magnan has **refused to comply** with the Minnesota genetic privacy law in the Department's retention and use of newborn DNA for genetic research without informed written parent consent, despite the March 2007 ruling

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	of an administrative law judge that the actions violate state law. She has also asked a Hennepin county judge (October 2009) and the Minnesota Court of Appeals (June 2010) to dismiss the 9-family lawsuit filed against her Department on March 11, 2009 for its failure to comply with the state genetic privacy law's written informed consent requirements for collection, storage, use and dissemination of genetic information.
Leaders in Health Care Organizations and Health Plans	
Carolyn Jones – Senior Director, Express Scripts	As former Senior Policy Advisor to Governor Pawlenty she championed the proposed Minnesota Health **Insurance Exchange (MHIE).** The MHIE was defeated twice (2007 and 2008). CCHC conducted a citizen petition campaign against the Exchange and brought testifiers to legislative committees to oppose it. As the Governor's health care policy advisor, Ms. Jones also worked to secure legislative support for the MN Department of Health's bill to **undo the State Genetic Privacy law** and exempt the collection, storage, use and dissemination of newborn DNA from the Minnesota genetic privacy law's written informed consent requirements. As a former lobbyist and health care policy director of the Minnesota Chamber of Commerce, in 2003, she testified against the bill that would have restored informed written patient consent requirements for government access to private medical records. She also testified in support of Rep. Fran Bradley's 2004 legislation giving state government officials authority to issue **"best practices"** in medicine and financially penalize physicians for failure to comply with these government-issued treatment directives. "'Customers want the best **value** in health care,' said Carolyn Jones, director of health care policy for the Minnesota Chamber. 'That means getting the highest quality care at the best price,'" [she said in the MN Chamber of Commerce endorsement of the **Smart-Buy Alliance** *(FMI on the Alliance: see Ludeman above)*]. (11/29/04, PR Newswire) Express Scripts has also designated Ms. Jones as a 'Deputy" to the Minnesota Business Partnership, which is a member of the Smart-Buy Alliance, which "fostered improvement in health care delivery by aligning **best-practice** purchasing principles" (quote).
William H. Wenmark – Former Chairman and Founder, NOW Medical Centers	**Not found.** *Instead, Mr. Wenmark **has opposed "best practices"** in testimony: "We are very, very concerned on the part of patients we represent that the government would get into the practice of medicine…This is not the Betty Crocker cookbook of Minnesota Medicine."* ("Reducing Costs for Care," *Session Weekly*, Minnesota House of Representatives, March 26, 2004)
Henry T. Van Dellen – Senior Vice President, Health and Welfare Practice Leader, Aon Consulting	Former Member of the Minnesota House of Representatives, 1994 – 2000; Health Insurance Executive of a corporation that supports **"'value-based'** insurance design, consumer-directed health care, **medication adherence** strategies."

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Labor and Business Community representatives	
Harry Melander – MN State Building and Construction Trades Council	Not found
Scott Walker – United Brotherhood of Carpenters	Not found
Chris Schneeman – SevenHills Benefit Partners	"Chris Schneeman, owner of SevenHills Benefit Partners in St. Paul, said insurance brokers 'have long been **frustrated by the lack of reliable and objective information about costs and quality** in the health care market.' He said the new site is a 'game-changing tool' for both brokers and their customers." *("State site has data on health care costs: Consumers can see plan prices for basic procedures," Pioneer Press, Aug 27, 2009)*
Experts in Financing, Access, and Quality	
Fran Bradley – former Chairman, Health and Human Services Finance Committee, Minnesota House of Representatives	Former Member of the Minnesota House of Representatives, Chair of the House Health and Human Services Policy Committee. He was author of the **controversial government-issued "best practices"** legislation in 2004, which was defeated by CCHC's statewide citizen petition campaign. A last-minute 2006 sunset requirement was added as legislators went home to campaign for re-election. "Rep. Fran Bradley, R-Rochester, who heads the House Health and Human Services Finance Committee, has proposed reducing health regulations, opening the field to for-profit providers, cutting health care taxes, promoting health **'best practices'** and limiting medical malpractice lawsuits." *("Health care moving to Capitol front burner," Star Tribune, Nov. 18, 2003)* "RE: Minnesota's health and human services appropriations bill SF4 (enacted June 2001), which appropriates funds for a variety of programs under the heading, "Eliminating Health Disparities.": 'Minnesota state representative Fran Bradley described how a sobering look at one state's statistics led the legislature to enact a historic Eliminating Health Care Disparities initiative. The legislature reviewed the state's public health statistics and found that, although **state-level data** were excellent, there were glaring disparities…The initiative built in strong **measurement** and called for a 50 percent improvement by 2010 on key measures. "We have **eight measures from diabetes to coronary disease** to other things where the indicators were clear that communities of color were worse off" (ibid.: 5)."" *("State Legislation and Disparities" Excerpted from: Kala Ladenheim and Rachel Groman, State Legislative Activities Related to Elimination of Health Disparities, 31 Journal of Health Politics, Policy and Law 153- 181, 153-155, 166 (February, 2006) [emphasis added]*
Charles Montreuil – Vice President of Human Resources, Best Buy Co., Inc.	Former Chair of the employer-based Buyer's Health Care Action Group (BHCAG), current member of the BHCAG Board of Directors, and President of Bridges to Excellence (BTE). The BTE **pay-for-performance** programs,

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	"recognize and reward clinicians who deliver superior patient care" (Health Care Incentives Improvement Group) *Summary of a Montreuil Presentation:* "Carlson participates in the Bridges to Excellence (BTE) pay-for-performance initiative as a part of a collaborative effort with other community stakeholders. The Minneapolis market has a number of building blocks in place that allow these types of collaborations to flourish. The Buyers Health Care Action Group (BHCAG), for example, is a coalition of private and public employers working to redirect the health care system to focus on the collective goal of optimal health and total value. (Carlson Companies is a BHCAG member.) The **Institute for Clinical Systems Integration (ICSI)** is a non-profit organization that develops **evidence-based guidelines and standards for care**, while **Minnesota Community Measurement** is a non-profit organization that **collects, analyzes, and publicly reports performance data**. BTE is the **pay-for-performance** component of this public reporting effort. As a part of BTE, Carlson and other local employers have agreed to reward providers and clinics that offer high-quality care." *("Health and Productivity: The Business Imperative" Charles Montreuil presentation, National Health Leadership Council, National Business Coalition on Health, June 27-29, 2007)* The Buyers Health Care Action Group was a "founding member of the Smart Buy Alliance" and has a mission to "Redirect the health care system to focus on a **collective goal of optimal health and total value**." (BHCAG) The Buyer's Health Care Action Group also has a "data warehousing tool" called the National Data Cooperative, which was launched in 2001, and "allows participants to **integrate medical, pharmacy and eligibility data to analyze cost and quality information individually** or in the aggregate."
Peter Nelson – Policy Fellow, Center of the American Experiment (CAE)	*Author of several reports and articles including:* What the Headlines Missed in Governor Pawlenty's Health Policy Speech I Peter J. Nelson I November 27, 2006 I CAE website: "Governor Pawlenty referenced Gov. Mitt Romney and the Massachusetts plan as a source for his ideas. The Massachusetts plan, not incidentally, draws heavily on the work of the Heritage Foundation. Under both the Massachusetts and Heritage plans, getting to **universal coverage requires mandating that all people get health insurance**, combined with a subsidy to those who truly can't afford it. Pawlenty had good things to say about both provisions." *MinnPost.com:* According to Mayo's four principles, health reform should create value, coordinate care, reform the payment system and provide insurance for all. The first three focus on value — **the need to measure value** properly and the need for a payment system that rewards providers that deliver high-value care. Unfortunately, as the Mayo blog laments, the Democratic congressional proposals actually undermine these principles. ("America is well served by Mayo Clinic's thoughtful health-reform critique," I Peter Nelson I Aug. 5, 2009) "Health Insurance Exchange would put people back in control of their health care" Peter J. Nelson I May 1, 2007: "Tucked within the Minnesota House omnibus health and human services bill rests a proposal to create a statewide Health Insurance Exchange, a big idea that if passed into law would be a strong first step toward more

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	affordable, consumer-focused, portable, accessible, and equitable health insurance coverage…With little to lose and much to gain, **an Exchange deserves a home in the final omnibus health and human services bill."** "As for cost containment, both bills include a number of measures designed to push and, in some cases, force private markets to implement very specific business practices. For instance, the Senate bill establishes a program to divert people who show up at emergency rooms with non-emergency conditions to a "medical home," a place where physicians can coordinate care more appropriately and less expensively. Other measures push evidence-based care, team-based care, **pay-for-performance**, and wellness promotion programs. These reforms borrow from **promising efficiency-driven ideas** already developing in the marketplace, but why on earth should the state become involved in such operational minutiae? It's one thing, and maybe a good thing, to implement these ideas in public healthcare programs administered by the government and quite another to push them on the private market. *("Health and Human Services bill falls short," April 27, 2007, CAE website)*
Stephen Parente – Director, Medical Industry Leadership Institute, Carlson School of Management	"At the moment the payment systems out there are largely insurance claim systems, and they don't necessarily have the clinical specificity to tell us about outcomes. Instead they tell us about the process of care in limited instances. What we are talking about is **linking the mountains of administrative claims data to mountains of digitized medical records** and laboratory information with some sort of composite sense of health care for an individual." ("e-Health - Minnesota Health Care Roundtable, Aug. 2, 2001" - *Minnesota Physician*, Nov. 2001) *Co-author of several reports including:* **National health data warehouse: issues to consider.** Journal of healthcare information management: JHIM 2004; 18(1): 52-8. ABSTRACT: "A national data warehouse that links public and private data could be used to **monitor** trends in healthcare costs, utilization, quality of care, and adherence to quality guidelines and changes in treatment protocols. The development of the data warehouse, however, would require overcoming a number of political and technical challenges to gain access to private insurance data. This article outlines recommendations from a national conference sponsored by the Agency for Healthcare Research and Quality (AHRQ) on the private sector's role in quality monitoring and provides an operational outline for the development of a national private sector health data warehouse." **The role of the private sector in monitoring health care quality and patient safety.** Joint Commission Journal on quality and safety 2003; 29(8): 425-33. ABSTRACT: "As payers, purchasers, and providers, both the public and private sectors have a stake in developing sound methods of measuring health care quality and patient safety. However, the role of the private sector in a **national quality monitoring system** remains largely underdeveloped….Barriers and gaps to the development of such a system include the cost of data collection, the diversity of the units of data collection, data privacy, and limitations of administrative data elements. SUMMARY: A comprehensive, public/private data collection system would address the multidimensional nature of quality and use data to effectively represent this complexity to the extent possible."

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Elisabeth Quam – Executive Director, CDI Quality Institute, Center for Diagnostic Imaging	Former Minnesota Assistant Commissioner of Health Care Resources & Systems under Health Commissioner Mary Jo O'Brien (1993 – 1995); Former Assistant Commissioner of Health **Quality** Assurance under Health Commissioner Anne Barry (1995). "The growing emphasis at all levels of the federal government to encourage **adoption of HIT [health information technology] presents an opportunity** for the Coalition to elevate e-Ordering as a much more provider-friendly, patient-centered alternative to the RBM model," **said Liz Quam**, director, Center for Diagnostic Imaging, and founding member of the Imaging e-Ordering Coalition. "As a provider of diagnostic imaging services in nine states, my company has seen the inconsistencies in insurers' utilization efforts. None of those efforts are without hassle for the health care providers striving to offer patient-centered care. Using an **electronic decision support tool offers regulators and insurers the assurance that the patient is receiving appropriate care** without adding unnecessary time or administrative expense." *("Imaging e-Ordering Coalition Formed" Imaging Economics, Aug 2009)*

AUTHORITY:

Sec. 4. **HEALTH CARE REFORM TASK FORCE.**
Subdivision 1. **Task force.** (a) The governor shall convene a Health Care Reform Task Force to advise and assist the governor and the legislature regarding state implementation of federal health care reform legislation. For purposes of this section, "federal health care reform legislation" means the Patient Protection and Affordable Care Act, Public Law 111-148 **[OBAMACARE]**, and the health care reform provisions in the Health Care and Education Reconciliation Act of 2010, Public Law 111-152. The task force shall consist of:
(1) two legislators from the house of representatives appointed by the speaker and two legislators from the senate appointed by the Subcommittee on Committees of the Committee on Rules and Administration;
(2) two representatives appointed by the governor to represent the governor and state agencies;
(3) three persons appointed by the governor who have demonstrated leadership in health care organizations, health plan companies, or health care trade or professional associations;
(4) three persons appointed by the governor who have demonstrated leadership in employer and group purchaser activities related to health system improvement of whom two must be from a labor organization and one from the business community; and
(5) five persons appointed by the governor who have demonstrated expertise in the areas of health care financing, access, and quality.
The governor is exempt from the requirements of the open appointments process for purposes of appointing task force members. Members shall be appointed for one-year terms and may be reappointed.
(b) The Department of Health, Department of Human Services, and Department of Commerce shall provide staff support to the task force. The task force may accept outside resources to help support its efforts.
(c) Task force members must be appointed by July 1, 2010. The task force must hold its first meeting by July 15, 2010.

(Omnibus State Budget Bill, Special Session HF 1, Signed into law on May 21, 2010)

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