



Citizens' Council on Health Care

A free-market resource for designing the future of health care

February 8, 2007

Dear Mr. Chair and Members of the Health and Human Services Committee,

RE: HF 1 – Author Rep. Thissen (Children’s Health Security Act)

Thank you for this opportunity to share our thoughts about HF 1. As you know, I had planned to testify in person, however, I have a previous commitment today that cannot be changed.

Citizens’ Council on Health Care is a free-market health care policy organization supportive of patient and doctor freedom, medical innovation and entrepreneurship, and the confidential patient-doctor relationship.

CCHC supports policies that advance individual freedom for citizens; policies that limit the size of government and policies that limit government intrusion in the lives of individuals and the relationship individuals have with their doctors.

Entitlement Expansion

HF 1 would create a new entitlement. When government assumes a function of the private market, in this case medical insurance, government grows and private initiative, options, and innovation shrink. With every expansion of entitlement programs, the taxpayer is tapped to keep the program funded. He or she must work harder to meet his or her own needs while paying the growing tax bill. This means that the working taxpayer finds himself or herself with fewer and fewer dollars to make ends meet – or in this instance, to pay for private health insurance, and to cover medical bills through private means.

Eventually these taxpayers may find themselves forced to seek government health care because they’ve been taxed out of their ability to pay privately. Thus, entitlement programs can lead to ever increasing numbers of people entitled to the hard-earned dollars of an ever-shrinking base of working taxpayers.

Dignity

Entitlement programs diminish the dignity of every recipient. When is the last time you heard someone bragging that they were on Medicaid? As the Minnesota Department of Health’s 2002 report on the uninsured notes, people are not comfortable with receiving welfare:

“Anything that can be considered county assistance or is registered by the county through the health and human services is associated with welfare. It is a pride issue. People just don’t want to go on welfare.”

Employer Effect

HF 1 offers a health care entitlement for every child who is a resident of the State of Minnesota. Although the program is voluntary, one of the likely effects is that the mere presence of the program will encourage employers to drop coverage for the children of employees, thereby shifting the burden to taxpayers.

Moral Hazard

HF 1 specifies that there will be no cost-sharing or premiums for recipients. This enables the moral hazard already well associated with entitlement programs, the lack of cost-consciousness. The taxpayer cost for this plan to cover children statewide will be extraordinarily high, yet the recipients will see it as free: Free care for all children. As in other programs, the entitled may find spending “somebody else’s” money easy.

Intrusive Government

Section 12 enables government to intrude on the confidential patient-doctor relationship. The legislation requires doctors, hospitals and health plans to send private medical data to the commissioner “in the form

and manner specified by the commissioner.” No details. The commissioner will decide outside the purview of the legislature. This is private data on the recipients and on “private sector enrollees.” (*line 6.17*)

We don’t know, the legislation doesn’t say, but most likely this reported data will be detailed information on physician treatment decisions and so-called “patient outcomes,” as well as data on physician compliance with whatever treatment and initiatives the commissioner determines to be “quality of care.” The bill will empower government in the practice of medicine, monitor patients, and police human behavior.

This is a serious infringement on the rights of patients and doctors to be free.

Report cards on patient outcomes not only require government intrusion in the lives of patients, but they have also led to less care for patients. There have been several studies, but I’ll cite just one. According to a 2003 study, the New York state report cards on cardiac outcomes led not to decreased mortality and morbidity as initially reported, but rather to the sickest patients being denied care, and needing to seek care outside the state of New York. (*When Doctor’s Slam the Door, March 16, 2003, The New York Times*)

Such attempts to monitor and control physician behavior can lead to implicit or explicit rationing of medical care for patients, putting their lives in danger.

Section 12 also appears to be an attempt to undo the will of the people of Minnesota:

- In March 2003, the Pawlenty administration was forced to withdraw the MN Department of Health (MDH) data collection rule. Our opposition to the government’s plan to collect private patient data elicited over 1000 letters to the department, and front-page news articles in the *StarTribune* and the *St. Paul Pioneer Press*, as well as all the major television news stations.
- In 2004, at the last minute, a sunset date was added to the “best practices” section of the HHS omnibus bill. The section authorized MDH to begin directing the practice of medicine, and DOER and DHS to write contracts in accordance with physician adherence to those directives. We had opposed this section and our efforts brought nearly 2,000 petitions to the Governor’s Office just days before the omnibus bill was finalized. As a result, that section of law expired June 2006.

Coverage is not Care – DHS Authorized to Deny

Finally, having “coverage” does not guarantee access to care. Ask anyone facing a government or managed care denial. DHS has statutory authority to ration care. The federal 1115 Medicaid/MNCare waiver allows placement of public recipients into HMOs, and the 2005 HHS omnibus bill gave DHS authority to define “evidence-based” treatment. The DHS medical director can deny a recipient’s access to the HMO appeals process if the prescribed treatment does not meet the director’s definition of an “evidence-based” treatment. Children “covered” by HF 1 could find their care limited.

As Bernadine Healy MD, former director of the NIH and now columnist for *U.S. World and News Report*, warned last year in her column, “evidence-based medicine” can be used to deny access to care.

Better Idea

Truly competitive markets decrease the price and increase the quality of any product in which they operate. Governments expand bureaucracy and administrative costs leaving fewer dollars available for improving the private product’s quality, price or accessibility. Legislation that supports real competition and expands private insurance options can better protect the dollars, dignity and rights of your constituents. Thank you.

Sincerely,



Twila Brase, RN, PHN
President