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LEGISLATIVE MEMO

The Health Technology and Assessment Program

HB 1798 and SB 5640

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Key Findings

- The Health Technology Assessment Program (HTA) was created by the Washington State Legislature in 2006. The decisions of the agency affect the 763,000 people who receive care through state-purchased, fee-for-service health care programs.
- Provider satisfaction and compliance with the program are unknown, although there is anecdotal evidence of strong dissatisfaction within some specialty groups.
- The program's use of comparative effectiveness research (CER) raises important ethical concerns for doctors.
- Used properly, CER can protect taxpayers from overpaying for entitlement health care and can help with cost-effective decision making.
- The HTA program should be improved by allowing thorough patient and provider input and should be made more responsive to allowing patients to benefit from new medical technologies. It must be transparent to the public and should fully utilize expert review about whether the program is serving patients ethically.
- Although it is only four years old, the HTA program in Washington has the potential to be a national model. The fact that millions of patients throughout the country may be affected by the HTA decisions adds a greater level of responsibility to the program and highlights the urgent need to reform it.

Two bills, HB 1798 and SB 5640, address the problems that have developed in the HTA program in Washington state. This Legislative Memo reviews the current HTA program and describes how passage of these two bills would result in significant improvements in the quality of care delivered through state-purchased coverage.

Comparative Effectiveness Research in Washington State

In 2006, Governor Gregoire's Blue Ribbon Commission on Health Care recommended creation of a state agency to undertake comparative effectiveness research (CER).[1] Legislation to do so was passed by unanimous votes in both the House and Senate. State-wide medical organizations, such as the Washington State Medical Association and the Washington State Hospital Association, as well as large provider groups were firmly in support of adopting a CER policy.

The agency was established later in 2006 and is called the Health Technology Assessment Program (HTA). The decisions of the agency affect the 763,000 people who receive care through state-purchased, fee-for-service health care programs, including Medicaid, state employees and retirees, Department of Labor and Industry, and patients in state prisons. The HTA was added to a number of existing programs (for example the Prescription Drug Program, the Surgical Care

[1] http://www.leg.wa.gov/JointCommittees/HCCA/Documents/Final%20Report.pdf, accessed August 20, 2010.

Outcomes Assessment Program and the Patient Decision Aids) and together state managers call these programs "Health Care that Works."

The primary goals of the HTA program are to make:

- Health care safer by relying on scientific evidence and a committee of practicing clinicians
- Coverage decisions of state agencies more consistent
- State-purchased health care more cost-effective by paying for medical tests and procedures that are proven to work
- Coverage-decision processes more open and inclusive by sharing information, holding public meetings, and publishing decision criteria and outcomes.

Provider satisfaction and compliance are unknown, although there is anecdotal evidence of strong dissatisfaction within some specialty groups. CER is also known to some analysts as "best practices" medicine, but is viewed negatively by many physicians as "cookbook medicine." Doctors treat every patient as an individual and consequently they strongly object to a centralized system that makes patients seem uniform and that dictates how doctors can practice medicine.

Many doctors recognize the practice of medicine as being as much art as science, and believe that decisions about appropriate care are best made by the doctor that knows the patient, is aware of the patient's personal and medical history, and who has examined the patient personally.

For this reason the restrictive nature of CER raises important ethical concerns for doctors. Trained to treat the sick, and obligated by the moral standards of their profession to make their best efforts on behalf of each patient, providers are now required to consider restrictions imposed by a third party, the state. Decisions made by a distant committee may deny patients access to treatments or medicines their doctor would otherwise prescribe. Doctors are trained to think of their patients' well-being first and cost second, so for many doctors the state's CER process further disrupts the intimate doctor/patient relationship and the ethical practice of medicine.

Patient satisfaction has not been measured as it specifically relates to the HTA program. Medicaid patients in general, however, are finding it more difficult to access health care because of poor provider reimbursement from the government, prompting doctors to drop out of the Medicaid program. Further restrictions on patient treatment and diagnostic tests will need to be monitored to insure patients covered by state-funded health care programs receive the best quality of care, and are not given worse care so the government can save money.

Drug and medical device manufacturers have expressed a number of concerns with the HTA program. They question the use of non-technology specific expertise, the limited amount of time allowed for public and provider participation, the lack of nationally-recognized clinical guidelines, the actual number of procedures used in Washington state and the timeliness of reviewing relevant data. They also question the cost-savings projections. Their concern is that the anticipated savings are flawed and too simplistic because the numbers do not include the cost of the actual procedure or test used. Drug and medical device manufacturers are concerned the HTA process denies needed medical care to patients, simply because those patients receive care through a state program.

Policy Analysis

Everyone, including taxpayers, wants to get the most value for their money. CER, if done properly, could be an effective program to protect taxpayers from overpaying for entitlement health care. The program makes financial sense if the savings realized compared to the cost of the program is a ratio of about ten to one (for example, $3 million in costs for $30 million saved). This assumes that health outcomes for patients will be the same even if the state denies certain medical treatments.

Patients enrolled in state taxpayer-funded health care programs under the current system are forced to rely on distant bureaucratic decisions before they can receive care. If these patients had control of their own health care dollars, for example through a voucher program, they would have a vested interest in treatment and diagnostic alternatives from a financial standpoint. Conversely, if all patients lose control of spending their own health care dollars, for example through a single-payer government program, potentially all medical decisions would be made by government committees imposing comparative effectiveness research rules on patient care.

Most providers do not have an understanding of health care costs. Used properly, comparative effectiveness research can help with cost-effective decision making while maintaining high standards in the practice of medicine. On the other hand, physicians spend four years in medical school and four to eight years in specialty training to be able to evaluate medical research. Having a government committee order providers to use certain treatments and diagnostic tools to use is, from a medical standpoint, arrogant, condescending and not in the best interest of patients.

Drug and medical device manufacturers have valid concerns. The HTA program must allow for thorough patient and provider input and must be responsive to new technologies. It must be transparent and must utilize expert testimony from industry professionals. State officials should not use the HTA program to deny patients access to the latest medical advances recommended by their doctor, simply so the state can save money.

Policy Recommendations

HB 1798 and SB 5640 would change the HTA program to comply with our following recommendations:[2]

- Track and regularly publish actual savings from the HTA program and have the state auditor evaluate the program
- Allow sufficient public input and publish these comments
- Rely on specialty-trained provider expertise in the decision process
- Allow enough time for public and provider review of the data
- Establish a mechanism to promptly review new data and incorporate this into the decision process
- Insure that the HTA program follows nationally recognized clinical guidelines.

Although it is only three years old, the HTA program in Washington state has the potential for being a national model. Other states, as well as the federal government, may very well use the researched data already provided by the HTA program. The fact that millions of patients throughout the country may be affected by the HTA decisions adds a greater level of responsibility to the program and to the need for reforming it.

Dr. Roger Stark is a retired surgeon and a Health Care Policy Analyst with Washington Policy Center, a non-partisan independent policy research organization in Washington state. Nothing here should be construed as an attempt to aid or hinder the passage of any legislation before any legislative body. For more information, visit washingtonpolicy.org.

[2] http://www.washingtonpolicy.org/publications/notes/comparative-effectiveness-research-washington-state-health-technology-assessment-