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PAIN MANAGEMENT

House Bill 4681 as enrolled
Public Act 421 of 1998
Sponsor: Rep. Gerald Law

House Bill 4682 as enrolled
Public Act 422 of 1998
Sponsor: Rep. Penny Crissman

House Bill 4683 as enrolled
Public Act 423 of 1998
Sponsor: Rep. Michael J. Griffin

House Bill 4684 as enrolled
Public Act 424 of 1998
Sponsor: Rep. Sharon Gire

House Bill 4685 as enrolled
Public Act 425 of 1998
Sponsor: Rep. Beverly Hammerstrom

House Bill 4686 as enrolled
Public Act 426 of 1998
Sponsor: Rep. Kirk Profit

House Committee: Health Policy
Senate Committee: Health Policy and Senior Citizens

Third Analysis (1-8-99)

House Bills 4681 - 4686 (1-8-99)

THE APPARENT PROBLEM:

In Michigan, as well as across the nation, this decade has seen a long and heated debate over the legal and moral aspects of assisted suicide. However, discussions around assisted suicide have revealed and focused attention on the fact that the medical community often provides inadequate treatment for patients suffering from chronic pain. Reportedly, pain specialists have been warning for over 25 years now that pain is being under-treated in this country. Indeed, statistics compiled through various surveys in recent years have uncovered some astounding facts. For example, an estimated 34 million people in the U.S. suffer from chronic pain (though one poll puts the estimate for chronic or recurring pain at 120 million people). One quarter of all sick days are used for pain, resulting in $13 billion in lost wages. Seventy-nine billion dollars are spent annually in direct and indirect expenditures to treat pain.

However, according to a 1996 Harris poll, “[d]espite its immense cost to the American economy, and independent of the suffering and loss of quality of life that it brings, business, government, and insurers have not offered a systematic approach to the treatment of this high cost, poorly managed disorder, nor have credentialed systems of care been made available to most patients who require it.” Further, the results of several major studies involving 3,089 patients have revealed that 832 fewer back surgeries were performed on patients who had been treated at comprehensive pain centers, resulting in a savings of over $33 million in medical costs just for those patients; a 58 percent reduction in overall medical costs, with an estimated savings of almost $10 million (after the cost of comprehensive care was subtracted); and that of the 50 percent of patients receiving disability payments, half returned to work and terminated their disability claims, at an estimated savings of about $176 million.

The Michigan legislature attempted to address the problem of management in 1994 by enacting Public Act 232, which created the Interdisciplinary Advisory Committee on Pain and Symptom Management to, among other things, develop an integrated approach to understanding and applying pain and symptom management techniques, develop and encourage the implementation of model core curricula on pain and symptom management, and develop recommendations to the health occupations and social workers boards on integrating pain and symptom management into the customary practice of health care professionals. Further, the legislature appointed the Michigan Council on Pain in 1995 to study pain problems and make recommendations. Despite these efforts, a recent survey conducted by the council shows that one in five adults in Michigan live with chronic pain.

In addition, anecdotal testimony given in hearings conducted around the state regarding pain management legislation have revealed story after story of people with chronic pain being given prescription drugs too weak to control their pain adequately or an insufficient amount of medication to last between office visits, doctors refusing to accept chronic pain sufferers as patients, emergency room physicians refusing treatment of people with out-of-control pain or refusing to prescribe narcotic drugs to control the pain, refusal of HMOs and other managed care plans to refer patients to pain specialists, and of insurers denying payment for certain drugs or pain treatments. Yet, many reported that when given strong enough pain medicine at appropriate dosages to control their pain, they were able to get their lives back, so to speak, and so regain functioning lost to the pain, return to work, and engage in social and family activities once again.

Many chronic pain sufferers report that their doctors are reticent about prescribing certain narcotics either because of fear of license sanctions or from ignorance of recent developments in pain treatments. Support for this contention can be found in media reports and medical literature. According to an article entitled “The Quality of Mercy” in the March 17, 1997 issue of U.S. News & World Report, more than 200 doctors and pharmacists a year are arrested on charges that they prescribed or dispensed narcotics too freely. Further, the article reported that though more doctors are beginning to prescribe narcotics for patients with terminal diseases who are at the end of their lives, few doctors even consider using such drugs to treat pain that is not caused by cancer. The article cites a recent survey of 204 chronic pain sufferers that found that most patients had sought help from an average of ten doctors, “yet only half had received drugs that reduced their agony.” An article in the November 1997 issue of MichiganMedicine attributes this practice of "under-prescribing" on the part of physicians to confusion between drug addiction and drug dependency. Addiction is a psychological phenomenon in which a person craves narcotic or other euphoria-inducing medications. Drug dependency, on the other hand, is a physiological change that occurs when patients are placed on long-term pain killers. Unless the medication is tapered off, a drug-dependent person will show signs of withdrawal when the medication is stopped. However, it should be pointed out that drug dependency occurs with a wide range of prescription drugs, including blood pressure medications and heart medications, yet doctors don’t hesitate to write prescriptions for those drugs.

Another part of the problem appears to lie with ignorance. Pain relief in cancer patients (as well as with other pain patients) “remains inadequate because it is not given priority and because there is a lack of education about and inappropriate attitudes toward the nature of pain and the appropriateness of opioid therapy among health care providers, patients, and patients’ families.” (“Pharmacologic Treatment of Cancer Pain”, The New England Journal of Medicine, Oct. 10, 1996.) Medical schools do not offer course work on pain management. Only recently have some schools begun to teach on palliative care (comfort care, as opposed to a curative approach), and then only on an elective basis. However, the U.S. News & World Report article reports that there are a few national initiatives beginning. The National Institutes of Health has convened a pain consortium to coordinate research on pain management from various disciplines into commercial development, the Dartmouth Medical School is drafting a curriculum for teaching pain management and palliative care, and the American Pain Society is encouraging hospitals to include a description of a patient's pain on the chart that records other vital signs. Most importantly, perhaps, the article reports that the U.S. Department of Health and Human Services has issued guidelines instructing hospitals to treat both chronic and acute pain aggressively with strong opioids (for example, morphine and codeine).

In an attempt to further address the issue of pain management for residents of this state, legislation has been proposed that would focus on increased measures to educate health care providers and the public about chronic pain and pain management treatments.

THE CONTENT OF THE BILLS:

The package of bills would amend various acts to, among other things, specify that the treatment of intractable pain was an appropriate issue for the legislature to consider, revise membership composition and duties of the Interdisciplinary Advisory Committee on Pain and Symptom Management, and require insurance companies and health maintenance organizations (HMOs) to clearly indicate in writing how the covered benefits would apply in the evaluation and treatment of intractable pain. House Bill 4681 would define "intractable pain" as a pain state in which the cause of the pain could not be removed or otherwise treated, and which, in the generally accepted practice of allopathic or osteopathic medicine, no relief of the cause of the pain or cure of the cause of the pain had been possible or none had been found after reasonable efforts that included, but were not limited to, evaluation by the attending physician and by one or more other physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. The bills would take effect April 1, 1999. More specifically, the bills would do the following:

House Bill 4681 would amend the Public Health Code (MCL 333.16204a) to change the name of the Interdisciplinary Advisory Committee on Pain and Symptom Management created by Public Act 232 of 1994 to the Advisory Committee on Pain and Symptom Management. Currently, the statute requires each board created under Article 15 of the code, entitled "Occupations", with the exception of the Michigan Board of Sanitarians and the Michigan Board of Veterinary Medicine, and the joint task force on physician's assistants, to appoint one member to the advisory committee. Instead, the bill would specify that one pharmacist, one registered professional nurse, and one dentist with training in the treatment of intractable pain, and one psychologist (each of whom was associated with the education and training of students in his or her field) be appointed by his or her respective boards. One physician's assistant with training in the treatment of intractable pain would have to be appointed by the Michigan Task Force on Physician's Assistants. In addition, the governor would be required to appoint one individual to represent each of the following categories: the general public, the Michigan Hospice Organization or its successor, one representative from each of the state's medical schools, and one individual diagnosed as a chronic pain sufferer. Further, the Michigan Board of Medicine and the Michigan Board of Osteopathic Medicine and Surgery would still each appoint two members, one of whom would be a primary care physician; but, instead of the second appointee being a physician specializing in the treatment of patients with chronic pain or terminal illness, the bill would require the physician to be certified in the specialty of pain medicine by one or more national professional organizations approved by the Department of Consumer and Industry Services that would include, but not be limited to, the American Board of Medical Specialists or the American Board of Pain Medicine. The bill would delete the position held by a social worker appointed by the Board of Examiners of Social Workers.

The term of office of current advisory committee members would expire on the bill's effective date and the new advisory committee members would have to be appointed within 45 days of the effective date. However, under the bill, advisory committee members would serve for two years or until a successor was appointed, whichever was later. Vacancies would be filled in the same manner as the original appointments. (The bill would delete the requirement that the advisory committee duties be completed within 180 days of the appointment of advisory committee members, and would change the nature of the advisory committee from being biennial to meeting annually.) The tasks of the advisory committee would essentially remain the same as the current requirements, except that instead of providing an open forum for human health care professions and hospices, the advisory committee would have to annually, at least once, consult with all licensure boards created under Article 15 of the code (except the Michigan Board of Veterinary Medicine) and with the Board of Examiners of Social Workers in order to develop an integrated approach to understanding and applying pain and symptom management techniques.

Currently, the code requires the advisory committee to biennially report and make recommendations to the standing committees in the Senate and House of

Representatives that have oversight over public health issues. The bill would instead require annual reports to the directors of the Departments of Consumer and Industry Services and Community Health that include recommendations on: 1) pain management educational curricula and continuing education requirements of institutions providing health care education; 2) information about the impact and effectiveness of previous recommendations that had been implemented, and; 3) on activities undertaken by the committee in complying with provisions currently required by the code pertaining to developing and encouraging the implementation of model core curricula on pain and symptom management and the development of recommendations to the licensing and registration boards on integrating pain and symptom management into the customary practices of health care professionals. Beginning in January of the first year after the bill's enactment, the advisory committee would also have to annually review any changes occurring in pain and symptom management. Further, the bill would delete a provision that requires the advisory committee to develop and distribute written information on pain and symptom management.

House Bill 4682 would amend the Public Health Code (MCL 333.16204b) to provide a statement of legislative intent. The bill would state that the legislature found that the treatment of intractable pain was an appropriate issue for the legislature to consider, and that the citizens of Michigan would be well served by the enactment of legislation that accomplished all of the following:

--Provided more and better information to health care consumers regarding the medical treatment of intractable pain, health care coverage and benefits, and the education of health professionals in pain and symptom management.

--Provided for the appointment of an advisory body to study and make recommendations on model core curricula on pain and symptom management for state institutions that provided health care education, continuing education for health professionals on pain and symptom management, and the integration of pain and symptom management into the regular practice of health care.

--Educated health professionals about the official prescription form program (MCL 333.7107 and 333.7334) and the disciplinary process for state licensees and registrants, including, but not limited to, how the department of Consumer and Industry Services processes allegations of wrongdoing.

House Bill 4683 would amend the Public Health Code (MCL 333.16204c, 333.16204d, and 333.16228) to specify legislative findings in regard to the use of controlled substances in treating intractable pain and to require the Department of Consumer and Industry Services, in consultation with the Department of Community Health, to develop, publish, and distribute an informational booklet on intractable pain. The bill would specify the following legislative findings:

--That the use of controlled substances was appropriate for treating certain forms of intractable pain, and that efforts to control diversion or improper administration of controlled substances should not interfere with the legitimate, medically recognized use of those controlled substances to relieve pain and suffering.

--That some patients have been unable to obtain sufficient pain relief through prescriptions for narcotic drugs from their health care providers due to the regulatory scheme of the official prescription form program that was created in the Public Health Code (MCL 333.7333 and 333.7334).

--That the triplicate reporting scheme program for narcotics (drugs listed under schedule 2 of the code) has been perceived in some cases to discourage the appropriate use of opioids in the treatment of patients with intractable pain.

The bill would also specify that the legislature states that the prescription form program had been created to prevent the abuse and diversion of schedule 2 controlled substances and not to prevent or inhibit the legitimate, medically recognized use of those drugs to treat patients with cases of intractable pain, and especially for long-term treatment. The bill would further specify that the intent of the legislature is to permit and facilitate adequate treatment for intractable pain by licensed health professionals, which would include dispensing schedule 2 drugs when medically appropriate.

The booklet on intractable pain developed by DCIS would have to include at a minimum the definition of intractable pain, and the pain management educational curricula and continuing educational requirements of institutions providing health care education recommended by the Advisory Committee on Pain and Symptom Management as stated in House Bill 4681, along with any other information considered to be relevant or useful by DCIS.

DCIS would also have to develop and conduct an educational program, in conjunction with the controlled substances advisory commission, for health professionals who are licensed under the code to prescribe and/or dispense controlled substances. At a minimum, the following would have to be included in the program:

--Information on the history and purpose of the official prescription form program.

--Information on how DCIS collects, processes, and compiles the prescription form information.

--Information on how DCIS processes allegations of wrongdoing against licensees, including, but not limited to, how the permanent historical record is maintained for each licensee, how and why a review of the permanent record is done, and how the decision is made to issue a formal complaint against a licensee.

--Information on the disciplinary process, including a licensee's rights and duties if an allegation of wrongdoing had been filed against her or him, or if another circumstance had prompted the review of the licensee's record.

--Any other information considered to be relevant or useful.

Further, the bill would allow DCIS to establish an ad hoc review panel that would provide the department with expert information regarding a specific health profession or specialty or a specific health care treatment or procedure as it related to an investigation involving the prescription of a controlled substance. The department would have to establish on a triennial basis a pool of ten licensed physicians, half of whom would be allopathic physicians and the other half osteopathic physicians. For each review panel, the department would have to appoint three physicians from the pool. The panel would have to provide the information to the department during the investigation process and before a formal complaint was issued.

Public Acts 472, 516, and 517 of 1996, part of the "Patient Bill of Rights" package of legislation, required insurers, beginning October 1, 1997, to provide certain prescribed information, such as covered benefits and the service area, to members and enrollees. In addition to the information required by this previous legislation, House Bills 4684-4686 would require insurers to include information as to how the covered benefits would apply in the evaluation and treatment of intractable pain. The bills would also add a definition of "board certified" as being certified to practice in a particular medical or other health professional specialty by the American Board of Medical Specialties or another appropriate national health professional organization. Further, the Patient Bill of Rights legislation required insurers, among other things, to provide upon request to subscribers the professional credentials of all participating health professionals. The bills would specify that this provision included, but was not limited to, participating health professionals who were board certified in the specialty of pain medicine and the evaluation and treatment of intractable pain and who had reported that certification to the insurer. House Bill 4684 would amend the Insurance Code (MCL 500.2212a), which regulates commercial insurance companies; House Bill 4685 would amend the Public Health Code (MCL 333.21052), which regulates health maintenance organizations; and House Bill 4686 would amend the Nonprofit Health Care Corporation Act (MCL 550.1402a), which regulates Blue Cross and Blue Shield of Michigan.

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, House Bills 4682, 4684, 4685, and 4686 would have no significant fiscal impact. House Bill 4681, which would rename the Advisory Committee on Pain and Symptom Management and modify the makeup and reporting requirements of the committee, would have no significant fiscal implications; however, the recommendations of the Advisory Committee may have a fiscal impact if implemented. Further, the agency reports that House Bill 4683, which would require the Department of Consumer and Industry Services to conduct an education program for health professionals regarding its controlled substances procedures may result in some added costs to the state for the education program, but the increases in expenditures are expected to be minimal. (2-9-98)

ARGUMENTS:

For:

Though there is broad consensus that the state of chronic pain treatment needs to be addressed, there is disagreement on how pain management reform should take place. Earlier versions of proposed legislation took a much stronger approach than the bills under discussion, with prescribed standards of care and mandates on insurance carriers to pay for all referrals to specialized pain clinics. The problem with such a legislative approach is that there are different approaches to relieving chronic pain, and a "one-size-fits-all" method of treating chronic pain does not exist. Even among accredited pain centers, approaches vary. Some centers ascribe to a functional restoration approach that involves exercise or physical therapy, counseling and behavioral-modification services, and vocational rehabilitation. Other centers, including some hospital-based clinics, are affiliated with anesthesiology departments and so may depend more on treatments involving drug therapy, nerve blocks, and surgical interventions. Still other health care providers and pain centers offer a holistic approach and alternative medicine. The point is, the area of pain management is in a state of flux, with new developments occurring rapidly. To be too specific in legislation could actually tie the hands of health care providers trying to help chronic pain sufferers.

The enrolled bills, on the other hand, focus on educating both the public and health care providers. As patients become better educated, they can more actively participate in treatment decisions. Several provisions of the bills would result in more information being disseminated to current practitioners, and in pressure being brought to bear on medical schools and other health care educational programs to develop and include training in pain management and palliative care as part of the regular and continuing education curricula. These provisions should have a major impact on the delivery of pain treatment in the future. No, the bills do not provide a quick fix. However, they represent a major first step in bringing the plight of chronic pain sufferers to the forefront and changing the way the health care professions view pain management.

For:

The primary problem with the treatments available to pain sufferers is that few doctors are aware of them, skilled in delivering them, or courageous enough to aggressively apply them. The bills, especially House Bills 4681 and 4683, provide some important first steps in addressing physician ignorance of available pain treatments and fearfulness of prescribing narcotics to non-terminal chronic pain sufferers. House Bill 4681 would change the makeup of the Advisory Committee on Pain and Symptom Management to include a dentist, nurse, and pharmacist who were trained in pain management and a psychologist, all of whom were involved in teaching in their respective professions, as well as a physician's assistant with experience in treating intractable pain. Since the difficulties of living in chronic pain are not easily understood unless experienced, the addition to the committee of a person who had been diagnosed as a chronic pain sufferer would add a unique perspective. The inclusion of these professionals, as well as the chronic pain sufferer, would add greatly to the knowledge base of the committee, which would in turn affect the quality and strength of the recommendations made annually to the Departments of Consumer and Industry Services (which provides regulation for the health occupations) and the Department of Community Health (which oversees health care facilities). In addition, the committee would have to annually consult with the health care licensing boards and with the social workers board to develop an integrated approach to understanding and applying pain and symptom management techniques.

House Bill 4683 would make a significant dent in physicians' fears of license sanctions for prescribing narcotics to non-terminal pain patients by requiring the Department of Consumer and Industry Services to develop and conduct an educational program for health professionals licensed to prescribe and dispense controlled substances. Further, the bill would clearly state that the intent of the prescription form program was not to prevent or inhibit the legitimate, medically recognized use of narcotics to treat intractable pain, but to discourage diversion. Besides allaying physician fears, the statement of legislative intent should help prevent undue harassment by law enforcement agencies. In a nutshell, the bills, with their focus on educational changes, are an appropriate first step in reforming the delivery of pain management to the state's chronic pain sufferers.

Against:

Chronic pain sufferers in Michigan have suffered long enough. The enrolled version of the bills are considerably weaker than the bills as introduced. For example, insurance carriers now only have to tell subscribers and enrollees if pain management treatments are covered benefits under the plan or not. Many plans do not pay for such treatments, or might pay for surgery to implant an internal pump to deliver pain medication, but refuse to pay for the medication to fill the pump, and vice versa. If insurance companies refuse to act responsibly and pay for effective treatments (which have been proven to reduce overall treatment costs), then legislative mandates are needed to ensure that patients receive appropriate and effective pain relief.

Response:

Many feel that such insurance mandates are dangerous precedents to set. Others feel strongly that such mandates result in dramatic price increases, which in turn could price small businesses out of being able to offer insurance coverage for their employees. Some have estimated that mandates, such as referral to pain specialists and pain treatments, would raise costs to the state Medicaid program alone by $500 million. There simply isn't the revenue to handle such a dramatic increase. The bills should be allowed a reasonable amount of time to determine their impact on the delivery of pain management services. Many believe that the increased awareness of available treatments, coupled with a nationwide initiative for medical schools to add pain management and palliative care courses to their curricula and the bills' clarification of the intent of the prescription form program for controlled substances, may change the face of physician education and practice, which would in turn require a corresponding response from insurance companies. Further, the bills represent a carefully crafted compromise between health professionals, insurance providers, and advocates for pain sufferers. The approach on increased training and education of health care professionals should be tested before more specific legislative requirements are considered.

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