

Blue Cross advocates universal coverage

Blue Cross and Blue Shield of Minnesota rolled out its plan for achieving universal health coverage in Minnesota in September. The plan closely resembles the MMA's own reform proposal, "Physicians Plan for a Healthy Minnesota," which was released in January 2005.

The Blue Cross proposal calls for a state mandate that all individuals have coverage, a requirement that insurers accept all individuals who apply for coverage, an essential benefit set, and increased government subsidies for those who cannot afford coverage.

Blue Cross COO Colleen Reitan called for Minnesota to provide coverage to the 383,000 Minnesotans, or 7.4 percent of the state's population who lack health insurance. Blue Cross presents its vision for reform in the paper "Unfinished Business."

Reitan estimated the cost of the Blue Cross proposal at about \$900 million annually, with the bulk of the expense attributable to subsidies to low-income Minnesotans.

The Minnesota Department of Health estimated the cost of insuring all Minnesotans in August and concluded the tab would run about \$900 million to purchase private coverage and \$663 million to do it through the MinnesotaCare program.

But Blue Cross estimates universal coverage would likely save about \$560 million annually in worker productivity, preventable illnesses, and uncompensated medical care. MDH estimated universal coverage would save about \$250 million in uncompensated care.

Reitan was also optimistic about the possibility of achieving universal coverage now. She pointed to Massachusetts' passage of universal coverage legislation and collaborative efforts here such as Healthy Minnesota, A Partnership for Reform, a health care reform initiative sparked by the MMA's reform ideas.

"States are the place where the action is ... This just isn't going to be done out of Washington," she said.

To achieve universal coverage, Blue Cross says Minnesota must

mandate that all individuals have health insurance and create an essential benefit set that would serve as a minimum coverage benchmark.

"Our modeling suggests that without this sort of mandate for individuals to have health care coverage, you can't get much closer to universal coverage than we have gotten to today in Minnesota," Reitan said.

For insurance scofflaws, Blue Cross proposes a "fair share" penalty — based on a person's income and the cost of buying insurance that would be assessed by garnishing employee wages. Blue Cross also said the state needs to sign up more people for existing health insurance programs. Of the state's uninsured, 59 percent, and three out of four of the approximately 80,000 uninsured children in the state, are already eligible for an existing public program, she said. The state also will need a sliding-scale premium subsidy for people who cannot afford insurance. ■

	MMA's "Physicians' Plan for a Healthy Minnesota"	Blue Cross's "Unfinished Business"
State mandate that all individuals have health coverage	X	X
The need to define an essential benefit set	X	X
Guaranteed coverage for all who apply	X	X
Financial assistance for those unable to afford coverage	X	X

Donald Jacobs, M.D., on the Blue Cross plan



Hennepin County Medical Center surgeon Donald Jacobs, M.D., has been spending a lot of time working to reform Minnesota's health care system. Jacobs, CEO of Hennepin Faculty Associates and an MMA member, is currently serving as chair of Healthy Minnesota, a collaborative initiative to reform health care that was sparked by the MMA's reform ideas. Speaking as an MMA member, he expressed some of his thoughts about Blue Cross's plan.

Q: How does the Blue Cross plan compare with the MMA's "Physicians' Plan for a Healthy Minnesota"?

A: Both the Blue Cross and MMA proposals include elements that reach beyond universal insurance coverage. To succeed, we need to allow individuals to exert more control over health care choices and support them with information and education. We also need to more effectively support public health efforts designed to prevent disease and reduce the cost of future care.

Q: What do the similarities between the plans mean?

A: In recent years, a growing concern that we are headed toward a crisis in health care affordability has brought together stakeholders often at odds over health care issues such as physicians, insurers, consumers, employers, legislators, and regulators. What we share is a sense of urgency to find solutions and a belief that the collaborative efforts of many will be required to make progress.

Q: What challenges lie ahead?

A: One of the challenges ahead remains affordability. We must commit to changes that make health care readily available and affordable. To reform only the insurance issues without addressing the rest of the system will lead to an unsustainable model.

Another challenge is reaching political agreements on the role of government versus the private sector. Finally, with the federal government spending so many health care dollars, we need to work toward national health reform. Until that happens, we need to work with the Centers for Medicare and Medicaid Services to create a system flexible enough to incorporate state and private efforts to provide universal health care. ■

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The Tiering of Minn

MMA grades tiering plans

The Minnesota Medical Association (MMA) released a report in September that graded health plan tiering programs that slot physician clinics into tiers on the basis of cost and sometimes quality measures.

The MMA supports tiering efforts as a way to provide patients more information. However, it found shortcomings in the way insurers are tiering clinics.

MMA President David Luehr, M.D., was quoted in the *Star Tribune* as saying that the MMA is calling on insurers to provide more information concerning the methodol-

“We support the idea of getting information to the patient, and tiering is one way to do that. It just needs to be done right.”

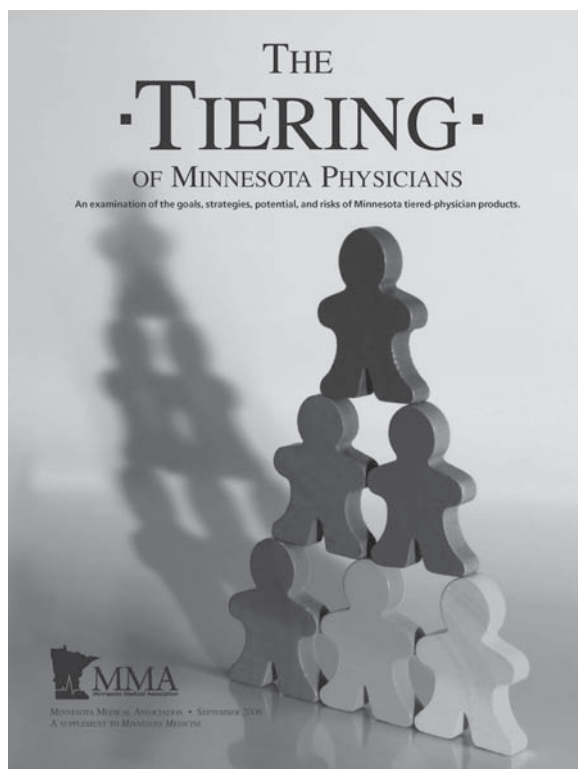
**— David D. Luehr, M.D.
Former MMA President**

ogy used to place physicians in different tiers.

“We support the idea of getting information to the patient, and tiering is one way to do that,” Luehr said in the article. “It just needs to be done right. We need quality information, cost of care information, so you get valid data points to check on tiering.”

MMA President Robert Meiches, M.D., also commented about the tiering issue during a Minnesota Public Radio story.

Meiches said during the interview that it’s not always clear how health plans determine which tier to place a clinic in, and there is very little consistency from one



The full report was included in the September issue of *Minnesota Medicine* and is also available online at www.MMAonline.net.

health plan’s tiering network to the next. “How can you be in one health plan in the most efficient, best-quality tier and in another one, in the opposite tier? It doesn’t make sense,” he said.

To be effective, Meiches said, tiering must be consistent and transparent; otherwise, consumers won’t be able to make good decisions when choosing a tiered plan.

The state of Minnesota received low marks for its Minnesota Advantage Health Plan, which lags behind Blue Cross, HealthPartners and Medica on most criteria. The state plan is the only one that doesn’t use any quality measures to assign tiers.

In general, health plans use cost, rather than quality, as the driving element in assigning tiers and overstate the weight they give quality in assigning tiers, Luehr said. “The MMA is urging health plans to be clear about how much they take quality into account when they make tiering decisions.” Otherwise, “a clinic that is spending more money to provide medical care that patients need and getting better results could be rated as less efficient than a clinic that spent less, did less, and didn’t have as good results,” Luehr said.

Another limitation of tiering efforts is that physicians often cannot know how reliable or valid the methods are that are used to calculate the cost of care. Health plans are making decisions based on the tiering software packages that are available; but research suggests that plans’ decisions about how to implement and use that software can affect the accuracy of the results.

Blue Cross, HealthPartners, and Medica score fairly well on transparency, providing “advanced” information about tiering methodology to physicians, and “basic” information to enrollees. The state’s advantage health plan, however, provides only “limited” information to enrollees.

To correct this situation, the MMA is asking health plans and the state to give physicians more information about the criteria used to set the cut-off line between tiers and to determine where physician groups rank.

The MMA based its rankings on the following criteria including:

- the methodology used to tier physicians,
- the criteria for cut-off decisions between tiers,
- data that determined tiering placements,
- usefulness of information about cost and quality of referral, and treatment options,
- access to data on which quality measures are based, and
- relevance of quality measures. ■

■ FIGHTING TOBACCO ADDICTION

Smoking group changes name

The Minnesota Partnership for Action Against Tobacco (MPAAT) unveiled its new name, ClearWay Minnesota, at the Minnesota State Fair. The new ClearWay Web site is www.clearwaymn.org.

The new name was chosen to better identify the organization’s commitment to improving health and providing smoke-free environments for all Minnesotans.

The organization’s research, grant-making, and stop-smoking programs will continue unchanged. QUITPLAN Services will continue to provide stop-smoking assistance through the QUITPLAN Helpline (888/354-PLAN or 7526), quitplan.com and other community-based programs. In the past five years, these stop-smoking programs have helped more than 7,800 Minnesotans successfully quit tobacco use and have saved \$24.3 million in health care costs.

ClearWay Minnesota is an independent, nonprofit organization working to reduce tobacco use and exposure to secondhand smoke through research, action, and collaboration. Created in 1998, the organization is entrusted with overseeing 3 percent of the state’s tobacco settlement funds and operates under the jurisdiction of the Ramsey County District Court.

■ ELECTION 2006

MEDPAC endorses Pawlenty



The MEDPAC Board of Directors voted to endorse Gov. Tim Pawlenty for re-election in September.

MEDPAC, the political arm of the MMA, is governed by a 24-member board of directors, which includes physicians and medical students from all areas of Minnesota. The MEDPAC board is completely separate from the MMA Board, and

MMA member dues are not used to support MEDPAC activities. Instead, MEDPAC is funded by voluntary contributions.

The basis for MEDPAC’s endorsement was the Governor’s support for a statewide smoking ban in restaurants and bars; his support for meaningful reform of the medical liability system that is causing severe patient access problems in many states in the country; his administration’s participation in Healthy Minnesota: A Partnership for Reform; and his commitment that he would not use the Health Care Access Fund for purposes other than health care.

The MEDPAC Board invited all three endorsed candidates from the major parties to be interviewed by a screening com-

mittee. But only Gov. Pawlenty and Peter Hutchinson met with the screening committee.

“Both candidates had positive and negatives, as identified by the screening committee. The MEDPAC Board endorsed Governor Pawlenty because of his commitment to work with the MMA to improve the health of Minnesotans,” said MEDPAC Chair Blanton Bessinger, M.D. “As we work to control health care costs, to improve the quality of health care for our state, and to ensure access to care for all Minnesotans, we look forward to working closely with Gov. Pawlenty.”

Pawlenty also vowed to support a smoking ban in restaurants and bars.

“I appreciate the close working relationship I have with physicians on all important health care issues,” Pawlenty said. “Tobacco use is the number one preventable cause of death and disease in our country, and secondhand tobacco smoke is the third leading preventable cause. I look forward to continuing to work with physicians to pass Freedom to Breathe and other legislation needed to improve the health of all Minnesotans.” ■

Minnesota Physicians

Comparing the plans

	Blue Cross and Blue Shield of Minnesota: Blue Precision	HealthPartners: Distinctions Benefit Option	Medica: Patient Choice	Medica: Patient Choice Insights	State of Minnesota: Minnesota Advantage Health Plan
Who is tiered	Physician groups in 26 specialties	Primary care clinics and cardiology, orthopedic, ENT, and Ob/Gyn specialty clinics.	Care systems	Primary care and multi-specialty clinics and many specialty clinics.	Care systems
Number of tiers	2	2 or 3	3	3	4
Covered lives	Unknown	Approximately 160,000	Approximately 70,000	7,500 covered lives	Approximately 115,000
Tier definitions/assignments	Medical groups are placed in tiers based on the average combined cost and quality results. BCBS makes final determination of tier positions.	For the 2-tier product, tier 1 clinics must score below the mean on cost and above the mean on quality.	Care systems are placed based on their submitted bid, costs and, if reported, quality credit. Employers review placements and determine final tier positions.	Primary care and multi-specialty clinics are placed based on submitted bid, their costs, and, if reported, quality credit. Employers review placements and determine final tier positions.	Primary care clinics are distributed into one of four cost levels. Initial tier placement is then reviewed as part of the collective bargaining process. Minnesota Department of Health HMO access standards (HMO administrative rules) of 30 minutes/30 miles are used to determine required access to at least tier 2 clinics. To meet these access standards, clinics may be moved from their initial placement.
Quality data incorporated?	Yes - BCBS incorporates 31 quality metrics into the tiering methodology for 17 specialties.	Yes - HealthPartners incorporates measures of access, care/communication, chronic condition care, and generic use in its tiering methodology.	Voluntary - Medica provides for a quality "credit" for those care systems that voluntarily report performance.	Voluntary - Medica provides for a quality "credit" for those primary care and multi-specialty clinics that voluntarily report performance.	No

Minnesota tiering facts

- About 352,000 Minnesotans are covered under tiered insurance plans.
- With 31 quality metrics across 17 specialties the Blue Cross tiering product uses the most clinical quality measures among Minnesota products.
- HealthPartners equally uses cost and quality to tier clinics.
- Most tiered plans are limited to communities with some level of competition.
- The only statewide plan is the Minnesota Advantage Health Plan for state employees.
- The state's plan is the only one that tiers exclusively on cost.
- At this time, tiering occurs at clinic or care system level. No individual physicians are being tiered. ■

Higher tiers cost state employees

The state places providers into cost levels. Patients then pay more out of pocket to see providers in the higher cost levels.

Deductible (family):

- Cost Level 1: \$60
- Cost Level 2: \$200
- Cost Level 3: \$560
- Cost Level 4: \$1,000

Lab/Pathology/X-Ray:

- Cost Level 1: 0 percent coinsurance
- Cost Level 2: 0 percent coinsurance
- Cost Level 3: 10 percent coinsurance
- Cost Level 4: 30 percent coinsurance

Office visit out of pocket for illness/injury:

- Cost Level 1: \$20
- Cost Level 2: \$25
- Cost Level 3: \$25
- Cost Level 4: \$35

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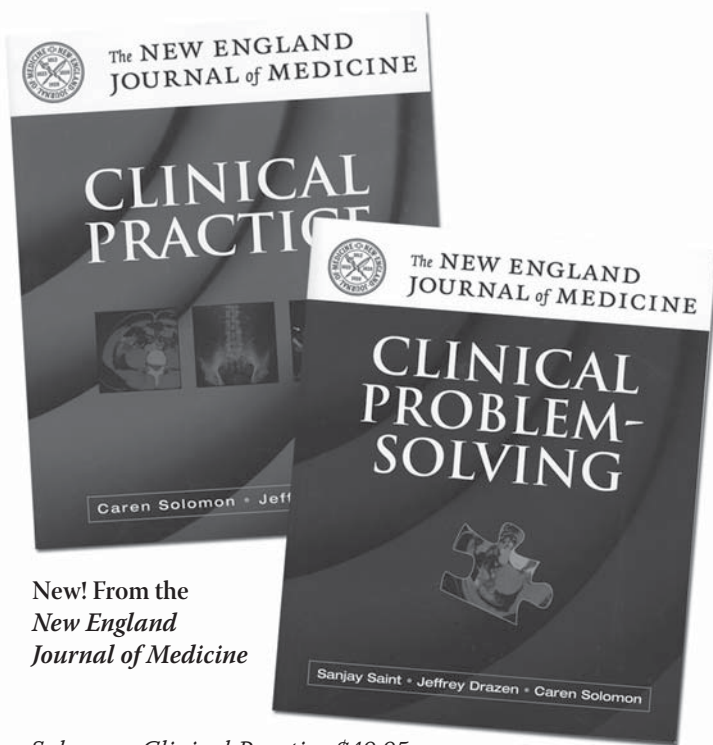
Pending Medicare cuts get worse

Medicare released a proposed rule on August 8 that would result in a 5.1 percent payment cut to physicians starting January 2007. The federal government previously proposed a 4.7 percent reduction.

Medicare is proposing deeper cuts in physician payment rates to offset the cost of greater utilization of physician services by Medicare beneficiaries.

In the Medicare system, if costs exceed a pre-set target, payment rates are cut to make up the difference.

Congress must act before the end of the year in order to avoid the deeper cuts. Please visit the MMA's Grassroots Action Center online at www.MMAonline.net to e-mail your representatives and urge them to stop these cuts. ■



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Inside

Blue Cross, MMA advocate similar path to universal coverage

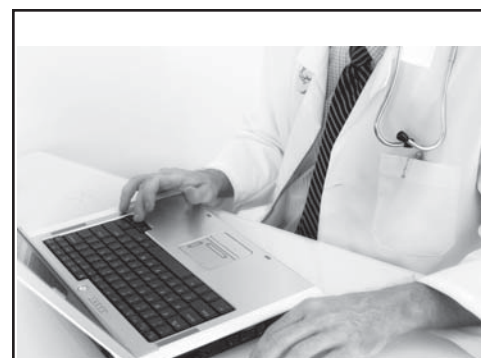
Blue Cross released a proposal for achieving universal coverage in Minnesota that includes features similar to those proposed by the MMA such as a mandate that all individuals have health coverage, an essential benefit set, and guaranteed insurance from the private market regardless of an individual's health condition. Page 1.

MMA grades tiering plans

The MMA has found many of the state's tiering plans have shortcomings and is calling for insurers to improve their tiering methods by making them more transparent. Page 2 and 3.

MEDPAC endorses Pawlenty

The MMA's political action group has endorsed Pawlenty for governor because of his support for liability reform, smoke-free public places, and the health care reform initiative Healthy Minnesota. Page 2.



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