Senator Outlines Vision For Health Care Reform

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WASHINGTON — With the introduction of the Healthy Americans Act last January, Oregon Sen. Ron Wyden (D) became the first major political player to launch a proposal for significant health care reform since the early days of the Clinton administration.

Sen. Wyden's plan calls for federally mandated, federally subsidized, portable health insurance coverage for all Americans. The plan is designed to break the nation's reliance on employer-funded health insurance, a dependence Sen. Wyden believes has become detrimental to the well-being of many American citizens and crippling to American businesses.

Speaking at the fourth annual World Health Care Congress, a conference sponsored by the Wall Street Journal and CNBC, Sen. Wyden outlined his vision for reform, emphasizing that he is most definitely "trying to upset the applecart."

The Healthy Americans Act (S. 334) would guarantee all Americans access to private-sector health plans that provide benefits equal to those currently provided to members of Congress. It would do so without increasing corporate or individual income taxes, and—more importantly—do so without obliging employers to pay any more than 25% of health care costs for their employees. The bill would create incentives for both individuals and health care insurers to bolster disease prevention and wellness programs, Sen. Wyden emphasized at the meeting. He said that he believes this is attainable in a fiscally responsible way that would not require any spending beyond the $2.2 trillion currently spent on health care in America; he projected that his plan would save the government roughly $1.48 trillion over a 10-year period, and that these savings would be reinvested in new prevention-oriented initiatives.

"We're currently spending enough on health care that we could have a doctor for every seven families in the U.S., and pay them $200,000 per year. We're spending more than enough money; we're just not spending it in the right place," the senator said.

Under the Wyden plan, which has support from a diverse group of corporate, labor, and health care leaders, uninsured individuals would choose health insurance coverage from a variety of plans in their states. Federally funded but state-specific Health Help Agencies (HHA) would be created to provide citizens with meaningful comparisons among the various competing plans and to guide them through the enrollment process. The HHAs would also be able to negotiate sliding scale premium reductions to ensure that monthly costs are reasonable and within the reach of working families. HHAs would also provide financial assistance for low-income individuals and families who would not otherwise be able to afford coverage. People who have employer-financed health insurance through their jobs would undergo a 2-year transition during which their employers would "cash-out" the annual total of the individual's health insurance premiums and pass this on to employees as real wages, which, of course, would be tax sheltered once applied to individual or family health insurance policies.

After the 2-year transition, employers would begin to make shared responsibility payments—meaning they would pay up to 25% of the average premium for essential care—but they would no longer be burdened with having to find and manage health care plans for their employees.

Giving employers an honest exit from the health care arena is fundamental to Sen. Wyden's vision. "There's a general awareness that employer-based health care is already melting like a popsicle on a summer sidewalk. A lot of people in their 50s are just hanging on by their fingernails, hoping that their employers will cover them until they're Medicare eligible. My bill is the first and only bill to cut the line between coverage and employment. Back in the 1940s, we as a nation made the decision to put everything on employers. But that doesn't make sense in 2007."

The aging of the population, the increased burden of chronic diseases, and the emergence of global competition have made employer-based health care increasingly problematic, both for individuals and for the employers themselves.

The other central tenet of Sen. Wyden's vision is to realign the value placed on medical services to support meaningful preventive medicine, disease management, and individual wellness programs.

To this end, the Wyden plan would eliminate individual copayments for all preventive health care services as well as ongoing disease management programs for people with chronic disorders. His plan would encourage insurers to offer financial incentives for participation in wellness programs, nutrition counseling, tobacco cessation, and exercise.

He believes current payment structures unduly favor procedure-based acute care at the expense of primary care, an inequality he hopes to reverse. Under the Healthy Americans Act, primary care physicians would be reimbursed for time-intensive preventive medicine and chronic disease management. The regional HHAs would rate competing health plans, in part based on how well their disease prevention and disease management programs perform.

"Insurance companies will ultimately be competing to keep Americans healthy," the senator said.

Sen. Wyden contends that the savings obtained by reducing administrative overhead, unnecessary procedures, and costly acute care will more than adequately cover the costs of insuring all uninsured Americans. And at bottom, the Wyden plan is all about universal coverage. He said that he strongly believes universal coverage would free American businesses from the tremendous fiscal ball and chain that health care has become, while protecting individuals from the loss or change of benefits, as often happens with employer-sponsored coverage. ■

Physicians Urged to Speak Up

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on the gross domestic product. The major medical specialty societies have been lobbying for years to change the formula, which they say does not account for their rising practice costs.

A permanent fix is unlikely to come this year or even before the 2008 presidential election, said Dr. Rick Kellerman, president of the American Academy of Family Physicians. However, there is an understanding among most members of Congress that significant payment cuts are not realistic and that some type of temporary fix must be passed this year, he said. "Physicians are going to have to gear up to encourage Congress to avert the cut," Dr. Kellerman said.

Dr. Kellerman envisions a 1- or 2-year positive update to the fee schedule. A 2-year fix would be better, he said, since physicians and policy makers are wasting so much time addressing the payment issue each year. As a result, he said, other important issues such as expanding health care coverage for the uninsured, health information technology adoption, and medical education funding have not been given their due.

A temporary payment fix is expected to be passed this year but probably would have strings attached in terms of quality reporting requirements.

Although a temporary payment fix is expected to be passed by Congress this year, it is also likely to have some strings attached in terms of quality reporting requirements, predicted Dr. Bruce Sigsbee, a neurologist and a member of the Medical Economics and Management Committee of the American Academy of Neurology.

Even before reduced access to physicians began to occur under the proposed cuts, quality and safety issues would develop as physicians struggled to do more with less, said Dr. Richard Hellman, president of the American Association of Clinical Endocrinologists. Quality and safety would suffer as physicians tried to see patients faster and refer complex conditions earlier, he predicted.

The projected cuts would also threaten to derail the voluntary CMS' Physician Quality Reporting Initiative (PQRI) that began July 1, Dr. Hellman said. The PQRI program gives physicians a chance to earn up to a 1.5% bonus payment on all of their allowed Medicare charges if they report on certain quality indicators. CMS officials have touted the program as the first step in aligning payments with quality.

But a significant payment cut could hamper those efforts, Dr. Hellman said, noting that physicians are unlikely to put the effort into a time-consuming, resource-intensive program where they can earn a 1.5% bonus when facing a 9.9% payment cut at the same time.

The proposed rule also addresses the continuance of PQRI in 2008, and outlines new quality measures for next year. CMS officials are also considering the feasibility of accepting clinical data from electronic health records. The agency will weigh whether to accept data on a limited number of ambulatory care PQRI measures for which data may also be submitted under the current Doctors Office Quality Information Technology Project (DOQ-IT). In 2008, submission through an electronic health record would be an alternative to the current claims-based reporting of data.

The proposed rule also outlines ways the agency would like to test the use of clinical data registries to report PQRI data. The testing, which would begin 2008, would evaluate methods for physicians to report data to clinical data registries and the registries to submit the data on the physician's behalf to CMS. For example, the Society of Thoracic Surgeons has a national database registry that collects quality data on cardiac surgeries, including two PQRI quality measures. However, under the current setup for 2007 and 2008, physicians must report these measures separately to CMS through the claims-based reporting process.

CMS officials are proposing to fund the bonus payments for the 2008 PQRI program by using $1.35 billion provided by Congress as part of the Physician Assistance and Quality Initiative Fund. In the proposed rule, CMS stated that the bonus payments were likely to be about 1.5% of allowed Medicare charges, not to exceed 2%. That decision was criticized by the American Medical Association, which said the $1.35 billion should be used to reduce the projected 2008 physician pay cut. CMS estimates the $1.35 billion would reduce the projected cut by about 2%.

"The AMA and 85 other physician and health professional organizations sent a letter strongly urging the Administration to use this money to help Medicare physician payments keep pace with increases in practice costs. The Medicare Payment Advisory Commission made a similar recommendation," Dr. Cecil B. Wilson, AMA board member, said in a statement.

"CMS has chosen to spend all of the money to provide just 1.5% to 2% to physicians who report on certain quality measures."

The proposed rule also made several other policy changes, including revising the methodology used to determine the average sales price for Part B drugs purchased in bundling arrangements. CMS is proposing to require drug manufacturers report price concessions proportionately to the dollar value of the units of each drug sold under the bundling arrangement. The aim is to ensure that the average sales price better reflects the true costs paid by physicians when buying drugs, according to CMS. ■