Lawmaker's Bill Would 'Wyden' Health Coverage

BY ERIK L. GOLDMAN
Contributing Writer

WASHINGTON — With the introduction of the Healthy Americans Act last January, Oregon Senator Ron Wyden (D) became the first major political player to launch a proposal for significant health care reform since the heady 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 apple cart."

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 (HHAs) 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.

Under the Wyden plan, uninsured individuals would choose health insurance coverage from a variety of plans in their states.

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 equation 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.

"Under my plan, if you lose your job, you do not lose your coverage. Your subsidy would go up, so you'd be able to continue to pay for coverage, and you will still have to pay the portion for which you are responsible. But through the magic of electronic transfers, you will be guaranteed continuous coverage," he said.

By introducing the Healthy Americans Act, Sen. Wyden has beaten the Democratic presidential hopefuls to the battlefield. Does it have a chance of passing, given a split government and a major election in the offing?

Many observers think not, but Sen. Wyden believes the split Congress and election campaign pressures are an asset. "We want to work together [with Republicans in accordance with] the principles of the Healthy Americans Act. Ten Senators have joined me—five Democrats and five Republicans—in a letter to the President. We're trying to leverage the conditions of a divided government. Remember, welfare legislation got passed in a divided government. Health care is a top issue, and both parties have to go to the voters in 2008." ■

Residency Rule Changes, Hospital Mortality Reductions Linked

BY DEBRA L. BECK
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TORONTO — In the second year after the new Accreditation Council for Graduate Medical Education duty-hours rules became effective, mortality in patients hospitalized for four common medical conditions—acute myocardial infarction, heart failure, gastrointestinal bleeding, and stroke—were significantly reduced at more-teaching-intensive hospitals, compared with less-teaching-intensive hospitals.

This apparent survival benefit was not seen for surgical patients. No changes in mortality were seen in surgical patients during either the first or second year post reform, Dr. Kevin Volpp and his colleagues at the Philadelphia VA Medical Center and the University of Pennsylvania, Philadelphia, reported at the annual meeting of the Society of General Internal Medicine.

The Accreditation Council for Graduate Medical Education (ACGME) duty-hour reform policy went into effect in July 2003. Designed to improve patient safety, the rules limit the number of hours residents can work to 80 per week, with a minimum of 10 hours of time off between shifts.

The study cohort included all unique patients (n=320,685) admitted to acute-care VA hospitals between July 2000 and June 2005 with principal diagnoses of acute myocardial infarction (AMI), heart failure, gastrointestinal bleeding, stroke, or Diagnosis-Related Group classification of general, orthopedic, or vascular surgery.

Logistic regression analysis was used to examine the change in mortality for patients in more- versus less-teaching-intensive hospitals before and after duty-hour reform. The primary study outcome was all-cause mortality within 30 days of hospital admission.

In the second year, a significant 26% reduction in mortality risk was seen for patients with MI, heart failure, gastrointestinal bleeding, or stroke.

In the first year after duty-hour reform, no significant relative changes in death rates were reported for either the medical or surgical patients. In the second year, a significant 26% reduction in mortality risk was seen at the more-teaching-intensive hospitals for patients with any of the four medical conditions. That change was predominantly driven by a highly significant 52% relative reduction in mortality risk in AMI patients.

For patients in hospitals in the 75th percentile of teaching intensity, mortality improved from prereform year 1 to postreform year 2 by 0.70 percentage points—or a relative improvement of 11.1% for medical patients—compared with patients in hospitals in the 25th percentile of teaching intensity, Dr. Volpp said.

At hospitals in the 90th percentile of teaching intensity, the improvement in mortality was even greater: about 0.88 percentage points, or a relative improvement of about 14%, compared with hospitals in the 10th percentile of teaching intensity.

Dr. Volpp noted during his presentation that the study was limited because "we don't have any information on compliance with the ACGME rules or actual number of hours worked."

VA hospitals are the largest single site for residency training in the United States, Dr. Volpp noted. Ongoing studies are assessing mortality and other outcomes in non-VA settings, he added.

The study was funded by the VA Health Services Research and Development Service. ■