

A Wydened View of Health: Universal Insurance

The Oregon senator's plan seeks federally mandated, subsidized, and portable coverage for all Americans.

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 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 pro-

jected 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 es-

sential 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 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." ■

Cigna, Aetna Ranked Highest, Medicaid Plans Lowest in 2006

BY ALICIA AULT
Associate Editor, Practice Trends

In 2006, Cigna Healthcare moved from fifth place to top ranking among national payers, and Aetna moved from fourth place to second, according to the second annual assessment of overall payment performance conducted by one of the nation's largest physician revenue management companies.

Not surprisingly, state Medicaid programs ranked near the bottom.

The performance rankings were compiled for the second year in a row by AthenaHealth, a Watertown, Mass.-based company that collects about \$2 billion a year for medical providers.

AthenaHealth used claims data from 8,000 providers, representing 28 million "charge lines," or line items. The medical services were billed in 33 states. The ranking included national payers that had at least 120,000 charge lines and regional payers with at least 20,000 charge lines.

In 2005, Humana was the top-ranked payer, followed by Medicare. A year later, Medicare held the third position, while Humana dropped to fourth. Rounding out the top eight national payers were UnitedHealth Group,

WellPoint, Coventry Health Care, and CHAMPUS/TriCare.

According to AthenaHealth, there were several trends observed from year to year. In 2006, days in accounts receivable (DAR) dropped by 5%, from 36.2 days to 34.4 days. Blue Cross & Blue Shield of Rhode Island had the lowest DAR at 16.8 days. New York's Medicaid plan had the highest, at 111 days.

Payers are also asking patients to pay more up front, which places a greater collections burden on physicians. Last year, there was a 19% increase in the amount of billed charges transferred to patients, according to AthenaHealth.

The overall ranking was based on how often claims were resolved on the first pass, the denial rate, denial transparency, percentage noncompliance with national coding standards, and percentage of claims requiring medical documentation.

Denial rates ranged from a low of 4% at Cigna's southern plan to a high of 48% at Louisiana's Medicaid program. The Medicaid programs were laggards on all performance measures. The Illinois Medicaid program paid

medical claims on the first attempt only about 30% of the time, and was the second slowest payer overall, with an average 103 days to pay a claim. In Texas, physicians resubmitted denied claims at least twice 47% of the time, according to AthenaHealth.

"We are seeing disturbing administrative process breakdowns with some state Medicaid plans that are resulting in a growing number of physicians no longer accepting new Medicaid patients, said Jonathan Bush, chairman and CEO of AthenaHealth.

The company said that some states have experimented with managed care as a solution to Medicaid's administrative difficulties. But in Georgia, that may have backfired. A year after patients were moved into managed care, the Medical Association of Georgia "has had to troubleshoot more than 500 complaints from physicians, most of which should have been eliminated by the Care Management Organizations shortly after the start-up," said Dr. S. William Clark, III.

The rankings are posted at www.athenapayer.com. ■

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