



The Blue Ridge Academic Health Group

Fall 2008 Policy Proposal
A United States Health Board

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A FRAMEWORK FOR HEALTH POLICY DEVELOPMENT AND STRATEGIC DIRECTION, with a long-term planning horizon, buffered from the political considerations that attend to every-other-year election cycles

- America will soon become incapable of spending more and more money on health care
- Special interest opposition to any change in existing “cash flows” is a powerful obstacle to needed change and inhibits reform
- The principles and incentives of “free market competition” are not easily applied to the health care sector, and just as we observe in the financial services sector, there can be adverse consequences absent appropriate regulation and oversight.
- 17% of Americans live in poverty while the developed country average is 10.2%. The nation’s health status is highly correlated with social determinants of health (income, education, poverty status) and lifestyle behaviors. Reform of the health care system is necessary, but not sufficient to markedly improve the health of the population.

These are major obstacles and considerations that surface in any discussion of why fundamental change to the American health care system is so difficult. The next President, the next Congress, public policy makers and influential leaders representing the relevant stakeholder groups must come together to create the framework through which solutions can be designed and implemented.

The Framework

The Blue Ridge Group sets forth the following approach to take us further toward the goal of a more effective health care system in the United States. We recommend a nationwide policy framework that will:

- a) Bring together leaders from across the healthcare spectrum in a private-public organizational structure conducive to long-term planning and decision-making (to bring stability and consistency to a system now buffeted about from one election cycle to the next);
- b) Take up the key challenges facing our health care system such as health insurance benefit equity, attention to mission-critical and vulnerable populations, insurance reform and pooling risk; and economic viability (to embark on a course of needed change that allows system participants to make long-term investments and patients to adapt with changes to lifestyle behaviors because there is a longer-term planning horizon for system configuration);

- c) Standardize and simplify the capture of health information and financial data, including encounter forms and billing transactions among the government, private insurers and providers of health care services (to eliminate waste);
- d) Collect and analyze encounter-level data specific to individual providers so as to enable identification of best practices and the most effective models for health services delivery (to reduce variation); and
- e) Make information available to the public and to the health care community (to inform health care decision-making).

The Blue Ridge Group believes that serious consideration should be given by our next President and the Congress to creating just such a nationwide policy framework. As suggested by the 2007 IOM Report on Comparative Effectiveness Research, Senator Tom Daschle, and others, we see real promise in using the history and the evolution of the Federal Reserve to guide thinking on how best to get us started. ¹

The Federal Reserve as a Model

“When the Federal Reserve was created in 1913, it was the nation’s third attempt at a central bank. The First Bank of the United States, chartered in 1791, and the Second Bank of the United States, chartered in 1816, did not last. They both failed to gain the trust of a public fearful of concentrated power. (This should sound familiar to health care insiders fearful of “government controlled” health care). To address this concern, the creators of the Federal Reserve crafted a plan for a central bank with a unique structure: what some have called a decentralized central bank.”

“An independent federal agency in Washington, D.C., the Board of Governors of the Federal Reserve System oversees 12 regional Banks, which serve as the operating arms of the System and blend public and private elements (This should also sound familiar to health care insiders as health care in America clearly has both public elements such as Medicare and Medicaid, as well as private elements, much of the provider community, suppliers, pharma, and private insurers). Importantly, the presidents of the 12 Reserve Banks participate, along with the Washington-based Board members, in the monetary policy deliberations of the Federal Open Market Committee. The Presidents bring a wealth of knowledge acquired from their regional contacts. Thus, in making policy, they are able to view the economy not just from a Washington perspective, or a Wall Street perspective, but also from a Main Street perspective. This system has served the nation well for nearly a century”.

“Nationally, 278 private citizens, including business people, bankers, nonprofit executives, and community, agricultural and labor leaders serve on the Boards of our 12 Banks and their Branches. These individuals

¹ Institute of Medicine. 2007. Learning What Works Best: The Nation’s Need for Evidence on Comparative Effectiveness in Health Care. <http://www.iom.edu/ebm-effectiveness>. And see: Critical Condition: How Health Care in America Became Big Business and Bad Medicine, Bartlett, DL & Steele JB, Doubleday, New York, 2004; Critical: What We Can Do About the Health-Care Crisis, Daschle T, Lambrew JM, Greenberger, SS St. Martin’s Press, New York, 2008, 239ff; Make It Easier: The National Health Care Reserve Bank, Lipstein SL, unpublished monograph, August 2004.

provide us with extensive and current information about economic conditions from a unique local perspective. Often, they provide an early warning of shifting economic conditions before they show up in official government statistics” (Ben S. Bernanke, Speech, June 12, 2008).

Americans do not embrace the notion of government-controlled health care. Using the Federal Reserve as a model from which to adapt and evolve a national policy apparatus for health care, Congress could charter a United States Health Board (USHB) to operate independently of the Federal Government to carry out its responsibilities.

The Charge to the Inaugural United States Health Board and District-Level Boards

We recommend that the inaugural USHB be constituted with a Board of seven members, including the Chair. These seven individuals shall be appointed by the President of the United States and confirmed by the Senate. The term of each board member shall be 14 (fourteen) years, with the chair serving in his or capacity as chair for renewable terms of 4 years.

The USHB shall establish no fewer than 12 district boards; each said district board with no fewer than nine members, representing no fewer than three classes of members: providers, insurers, and the public. The chair of each district board shall be one of the “public” members.

District Boards shall recommend appointment of a paid executive who shall serve as President of the District Board, subject to approval of the USHB. The President shall be responsible for the recruitment of district board staff.

The Presidents of all District Boards, together with the seven members of the USHB shall constitute the National Health Policy Committee (NHPC), similar in concept to the FOMC of the Federal Reserve model, and chaired by the same individual who is Chair of the USHB. The NHPC shall be authorized by Congress to make national policy decisions within an established set of guidelines, with authority to include health insurance regulation, payment mechanisms (not payment rates) among providers and payers, and dissemination of evidence-based standards of medical practice.

It is worth noting that within the Federal Reserve structure, each district bank also has a board chairman and a bank president who come together with their peers from all twelve banks to form a Council of Chairmen and a Council of Presidents. Similar councils could be established in the health care version of this model, and working with USHB staff in Washington, there would be formal and established mechanisms by which the various districts could work together to develop policy, share best practices, and realize the full potential of district level innovation and creativity yielding better and better approaches to the delivery of health care services in the United States.

All funding for operations of the USHB and the activities of the District Boards shall be the responsibility of the federal government, with annual appropriation and budget approval handled much the same as with the current Federal Reserve System.

We believe that it will be important for the inaugural USHB to establish a credible standing among the public and the industry by working initially to eliminate waste and variability in the current system.

We offer the following scenario as one example of what might be possible under the auspices of a private-public health policy framework such as the USHB.

An Example of What Might be Possible

Working with and through District-level Boards, the USHB can bring together the insurance industry, federal and state governments and the provider community to create a uniform and standard clearinghouse(s) for all health care billing transactions in much the same manner as banks and merchants have come together through clearinghouses to process credit card transactions.

These transactions could derive from a uniform and standardized on-line electronic encounter form that contains patient information (demographics and insurance), patient clinical descriptors (diagnosis and chief complaint), provider identification, and diagnostic/therapeutic interventions (prescriptions, tests, procedures, referrals, anticipated follow-up) and outcomes.

The clearinghouse(s) could use these encounter forms to create a de facto national data repository with provider-specific measures of clinical effectiveness, patient satisfaction, clinical outcome, and cost.

The trade-off for the insurance industry is important to delineate. Insurers will continue to develop networks of health care providers, they will continue to negotiate prices with those providers in a free and open market, they will continue to package those networks together with employee health benefit designs, premium structure, member services, and market them to employers and individuals, again in a free and open market context.

Insurers, along with providers and the public, will now have access to the national data. They will be able to develop networks of providers based on parameters of quality and cost, without the statistical limitations of relying on a claims data set specific to one insurer or one employer.

In exchange, insurers and governments will relinquish their financial transaction processing functions, outsourcing them to the clearinghouse(s). In the process of designing the transaction processing apparatus, hardware configuration, software, decision-making logic, and payment algorithms (all of which can be programmed into a computer), the clearinghouse(s) will need to accommodate private insurers' requirements

for pre-authorization, medical management, and claims adjudication, denial and appeal. These can remain important cost management tools for the insurers and under their sole purview.

However, we anticipate that the result of creating this simplified and standardized transaction processing apparatus will be substantial net savings for the overall system: savings to insurers by spreading the fixed cost of processing claims over the entire universe of claims, and savings to providers as they will be able to simplify, standardize and shorten the revenue cycle.

Importantly, robust and comprehensive data will reveal opportunities to coordinate services across people, functions, activities, locations, and time to increase value. Moreover, the clearinghouse(s) can become a trusted mechanism to synthesize scientific, clinical, and medical information to advance the science of health care delivery. The 2007 IOM Report on Comparative Effectiveness Research cited the Federal Reserve as a model with certain features well suited to the operation of a clinical effectiveness research entity including a government mandate, independent funding, public-private character, non-partisan independent governance, shared stakeholder priority setting and central policy authority.

With new knowledge, payers for health care services can create payment mechanics that provide incentives for providers and patients to coordinate care, improve outcomes, and that support informed decision-making.

Concluding Remarks

Some Americans and their political representatives may not be convinced that access to the current health care system is a step towards a healthier society and that investing more resources in the current system is money well spent. Others believe that access to needed health care, no matter the frailties and failings of the current system, is paramount, and that our top priority should be universal coverage for all Americans. Members of the Blue Ridge Group feel strongly about universal coverage and believe we must take immediate steps to bring the uninsured into an improved system that assures access to services proven to be effective. At the same time, we are convinced that the current system is neither affordable nor sustainable.

Creating a United States Health Board, with a Board of Governors, and with District-Level Boards will not be easy. We need a national policy-making framework that is buffered from the political considerations of government. We should re-work those aspects of the system that are the most wasteful; to bring about improved access, better insurance coverage, and real cost savings for the American people. We should work to better understand what aspects of the current system have the greatest potential to improve the health of individuals and the public at large, and which aspects add little or no value. We may not be able to make all the changes needed at one time, within one session of Congress or during one Presidential administration. But, we can establish the necessary framework to move us in the right direction.

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