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President and Chief Executive Officer



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Senator Tom Daschle
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Dear Senator Daschle:

Congratulations on your appointment to serve as our next Secretary of Health and Human Services. As Chief Executive Officer of BJC HealthCare and as Chairman of the Council of Teaching Hospitals of the AAMC, I look forward to working with you and your staff. Attached is a Health Care Policy Paper authored by the Blue Ridge Academic Health Group. I am a member of the Group and believe it presents an important construct for how to move forward with an agenda for health care reform. You will be pleased to note that the Policy Paper calls for the creation of a United States Health Board, legally chartered and established by Congress in a fashion similar to the Federal Reserve. We were all gratified to read that you endorse this construct and we referenced your work in the Paper.

The Federal Reserve model offers us a longer term planning horizon and a viable alternative worthy of serious consideration. As you know, in the Federal Reserve Model there are seven governors on the board, appointed by the President, and confirmed by the Senate. Their term is 14 years. District Banks of the Federal Reserve each select a President who is approved by the Board of Governors. The seven governors and the twelve district presidents make up the Federal Open Market Committee, the policy setting body that votes upon and sets the federal funds rate (the interest rate at which banks lend to one another), and the key instrument of monetary policy under the Fed's control.

In our proposed model, members of the United States Health Board would also be appointed for 14 years, longer than the term of a president, a senator or a congressman. Broad participation in the formulation of health care policy can be secured through a network of District Boards, just as in the Fed Model.

Obviously you also know that the Fed has influence over monetary policy using interest rates as its key instrument of effecting change. The United States Health Board would need an analogous instrument to set policy direction and effect change. This Policy Paper suggests that the enabling legislation transfer authority over the regulation and supervision of all health insurance from the states to a United States Health Board. Congress would set the guiding principles that would govern the Health Board's regulation and supervision role: all citizens would have guaranteed access to insurance whether they are employed or not, rich or poor, pre-existing condition or not. Premiums would be affordable, as would out of pocket cost-sharing. Americans would have a



choice in physicians, hospitals and insurance plans. With those goals as guideposts, (similar to low inflation and full employment as guideposts for the Fed), the United States Health Board could use its power of regulation and supervision to achieve these desired outcomes.

I hope these reasons are sufficiently compelling to get you to read the Blue Ridge Group Policy Paper, and we soon get a chance to discuss its merits.

Warm regards,

Steven Lipstein
President and Chief Executive Officer



The Blue Ridge Academic Health Group

Fall 2008 Policy Proposal
A United States Health Board



Blue Ridge Academic Health Group Fall 2008 Policy Proposal

A United States Health Board

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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Original Concept Paper

Make It Easier: The National Health Care Reserve Bank

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**ABSTRACT**

How many of us can claim that we truly understand how the nation's doctors and hospitals get paid for what we do? We need a pricing scheme that is simple and easy enough for the average citizen to understand. We need a payment process that is not so fraught with complexity that doctors and hospitals must spend billions of dollars on billing and collections. We need more and better data, organized and accessible for all payors. The author calls for the creation of a National Health Care Reserve Bank (NHCRB), modeled after the Federal Reserve (Fed). The NHCRB would be a clearinghouse for all patient-physician and patient-hospital billing transactions. The Fed was created in the early 1900s, responding to recurring financial crises. Does health care mirror the banking crises of the early 1900s? Physicians are marching on state capitals. One of every six Americans was without health insurance throughout 2002.¹ Insurance premiums are rising at double-digit percentages four years running.² Governments are running huge budget deficits.³



The Federal Reserve was created in 1913 in response to recurring financial crises, leading to “panics” wherein people rushed to the bank to withdraw their deposits. Congress chartered the Federal Reserve System, but importantly gave the Federal Reserve the autonomy to carry out its responsibilities, buffered from political considerations.

What follows is a proposal, calling for the creation of a National Health Care Reserve Bank (NHCRB), analogous to the Federal Reserve (Fed). Americans clearly do not embrace the notion of government controlled health care. So, like the Fed, the National Health Care Reserve Bank will operate independently of the Federal Government to carry out its core responsibilities. Here are the core elements:

1. The major insurance companies in America (of which there are probably now fewer than 10 who are national underwriters of health insurance) should get together with the Centers for Medicare and Medicaid Services (CMS) and create a National Health Care Reserve Bank. Like the Federal Reserve, this new creation will be an independent agency chartered by the Federal Government. It will have a Board of Governors to act as the agency’s centralized “policy-making” component. Like the Fed, the Governors



will oversee the activities of Regional Health Care Reserve Banks (RRBs). Each RRB will have its own regional board made up of insurers, doctors, and lay citizens who contribute local understanding of the health care resources and the health care economy in their local communities.

2. The role of these Regional Reserve Banks is to serve as a clearinghouse for all billing transactions among physicians, hospitals, the government and insurers, as well as to provide a data bank for all provider-patient encounters. The initial information technology necessary to build the infrastructure (hardware and software) and necessary working capital will be financed by the Federal Government.

3. After each patient encounter, physicians and hospitals would complete an on-line encounter form and submit it electronically to an RRB. This electronic form would contain patient information (demographics and insurance), patient clinical descriptors (diagnosis and chief complaint), and diagnostic/therapeutic interventions (prescriptions, tests, procedures, referrals, anticipated follow up). It would be simple and standardized. One form for all payors. It would use point and click "mouse"



technology. It would replace existing insurance and billing forms. And, it would provide a rich and robust database to assess the clinical effectiveness and service orientation of physicians and hospitals.

Clinical Effectiveness: From the encounter forms, the NHCRB will know how many high cholesterol patients are on lipid lowering agents; how many elderly patients get pneumonia vaccine; how many heart attack patients are on aspirin, ace inhibitors and beta blockers; how many diabetics are being appropriately medicated and managed; and so forth.

Patient Satisfaction: From the encounter forms, the NHCRB will know patient phone numbers and can conduct random statistically valid patient satisfaction surveys and tabulate results.

4. The NHCRB would maintain a single charge master for all CPT codes and for all DRGs, relieving all hospitals from maintaining their own charge masters, and relieving all doctors from maintaining individual fee schedules.



Medicare and Medicaid would legislate their payment rates as a multiple of the NHCRB charge master and utilize the RRB to administer their claims processing and adjudication, much as fiscal intermediaries do now. Private payors would negotiate payment rates with individual providers much as they do now, only, they would present the rates to the RRB as a schedule of negotiated multipliers to be used in conjunction with the NHCRB charge master to calculate the agreed to amounts. The insurance companies would utilize the RRB to administer their claims processing and adjudication, as if they were outsourcing these functions to a third party.

5. Importantly, the NHCRB must devise a uniform mechanism to deal with the private insurers' requirements for pre-authorization, medical management and claims denial and appeal. These are important cost-management tools for the insurers. They are also great sources of frustration, administrative burden and lost income for physicians and hospitals. The encounter form can be designed in such a way as to preclude electronic submission, unless all mandatory data fields (including pre-authorization codes and medical justification documentation) are complete and conform to NHCRB requirements.

**DISCUSSION**

Let's return to the analogy of the NHCRB to its namesake, the Federal Reserve. Research economists at all 12 Regional Reserve Banks monitor the economies of their districts; they gather, analyze and disseminate information about the economy and key economic trends. Private insurers, government, physicians and hospitals can do the same kind of research, and engage in the same policy-making process as the Federal Reserve. Instead of setting policy to manage the nation's money supply, to manage inflation, and to sustain economic growth, the NHCRB would set policy to simplify physician and hospital billing practices and procedures, and to determine the standardized mechanics for all billing transactions.

This is not a single payor solution. A single payer is probably not politically feasible, but even if it were, there would be adverse consequences. The health care system derives benefit from the competition among providers and among insurers. We need to have economic incentives to work hard, to improve quality and to manage our costs. Competition yields those benefits. In the Federal Reserve System, banks still compete with one another and work hard to earn customers, to generate profits, and to stimulate economic growth and investment. The



NHCRB version of this model can do the same. Doctors can still compete with one another. So, too, will their hospitals, and the insurance companies who pay them. But, just as the Federal Reserve ensures that the banking system is safe, sound and able to respond to a financial crisis, the NHCRB could ensure that health care billing transactions are sound and streamlined so as to minimize cost and maximize accuracy and timeliness of payments to doctors and hospitals.

Today, there is enormous variability in the ways that doctors and hospitals get paid. For doctors, private insurers pay variable amounts, usually measured as a percentage of what Medicare pays (e.g. 110% of Medicare's fee schedule). Medicare pays according to a fee schedule that is very complicated and nearly impossible to administer (without falling into a "pothole" that the government may decide constitutes fraud and abuse or over/under billing). And, Medicaid, in many states pays physicians at rates that are so low as to constitute a disincentive for physicians to treat Medicaid patients.

For hospitals, the payor mechanics are equally complex. Certainly, the way that hospitals get paid makes little sense to most Americans. While Medicare DRGs and cost reporting bring some degree of standard practice across all hospitals, the



private insurers typically pay a negotiated percentage of charges or per diem rates, both of which have caused hospitals to escalate their gross chargers (prices) to a level that no consumer would consider reasonable and no person lacking insurance could afford.

Make it easier for doctors.

Doctors are truly overwhelmed by the circumstances surrounding their ability to generate sufficient income. First, there's the malpractice insurance situation. No matter the cause, the result is putting a real burden on the cost of maintaining a viable practice. Next, there's the Medicare fee schedule. Doctors will continue to receive less "per unit of service" reimbursement from Medicare because Medicare does not have a budget that can keep pace with beneficiary demand for more and better services, and more and better insurance coverage for those services. After that, physicians have come to realize they have little or no pricing leverage with managed care companies and insurers.

Some physicians have options. Some are responding with "boutique" practices, wherein a substantial up-front fee paid by the patient buys 24-hour physician availability, rapid access,



house calls, and other high end services. Other physicians are trying to build alternative revenue sources by taking ownership positions in single specialty hospitals, free-standing surgery centers, imaging centers and other diagnostic and procedure facilities.

But, for the great majority of the nation's 830,000 physicians, their practice is an economic enterprise that doesn't set its own prices, and can't control large components of the expense base. If they work harder, the system works to reduce their prices even further. They are asked to see patients who may not have the ability to pay. And, they are expected to be available 24 hours a day, every day of the year, or alternatively, to make arrangements for coverage.

To be sure, many physicians love what they do, and will keep on doing it no matter what. At least, we all hope so. But we should be able to make it just a little easier. The NHCRB and RRBs could streamline and make more efficient the process of billing and collections for all physicians. The Bank could take the "hassle" out of the doctor-insurer relationship. And, yes, the Bank could make it so easy and reliable, that it would be near impossible to inadvertently commit acts of fraud and abuse.

**Make it easier for hospitals.**

Today, hospitals spend literally billions of dollars on billing and collections. We are now entering an era where almost all billing transactions are processed via electronic data interface.

But even so, hospitals devote enormous resources to managing their receivables, coding medical records, submitting supporting documentation with each claim, and adjudicating hundreds of managed care contracts that are often payor and employer specific.

The NHCRB could make it easier by creating a single standardized encounter form. The Bank would receive from Medicare, Medicaid, and each private insurer a schedule of hospital-specific multipliers to use in conjunction with the hospital encounter forms to adjudicate each claim. It would be akin to working with a single "super" fiscal intermediary for all hospital billing transactions.

**Make it easier for the government and insurers.**

CMS and private insurers should be willing to move their financial transaction-processing infrastructure to a National Health Care Reserve Bank. It allows for all kinds of efficiencies that accompany standardization and economies of scale and automation.

Even if all insurers adopt uniform standards for pre-authorization and medical necessity, there remains competition among insurers based on benefit design, premium, administrative efficiency, and member services. The insurers will realize lower per-transaction processing costs, and a data base that helps insurers to manage other components of their expenses, e.g. pharmaceuticals, outpatient diagnostic testing and procedures. If private insurers can better manage costs and produce better outcomes, they can engender the support of clients and shareholders alike.

There are other important constituencies that stand to benefit from NHCRB's data bank of patient encounters. The quality pundits like the National Quality Forum, Leapfrog, CMS, the Joint Commission, and myriad professional associations would all welcome a comprehensive patient encounter database. It provides



the foundation for helping health care professionals to better understand which interventions are most effective for treating specific diagnoses and medical conditions. It provides the "evidence" for evidence-based medicine.

Make it easier for employers.

Employers are clamoring for data on cost and quality that can be made available to the general public. The NHCRB's data bank of patient encounters can provide doctor-specific and hospital specific clinical quality and patient satisfaction metrics.

Perhaps, the NHCRB could somehow devise a methodology to neutralize the multipliers for graduate medical education (GME and IME), disproportionate share, outliers, new technology and other legitimate cost differentials so that fair "apples-to-apples" comparisons of cost efficiency can be made transparent to health care consumers. Without such a "level playing field" methodology, price comparisons would be unfair to those hospitals that add the costs of social and academic missions to their prices. These missions are clearly in the public interest and today, comparative price shopping and price tiering erode the base of financial support for these important programs and services.



Make it easier for the American people.

Patients should be able to understand how their doctors and hospitals get paid for what they do. Today, few if any patients understand the relationship between charges, allowable charges, contractual adjustments and actual payments for health care services.

The RRBs could send each patient a copy of the encounter form submitted by the hospital or doctor along with easy-to-understand explanation of how the claim was paid, and what if any monies are still owed by the patient to the provider. (The hospital or doctor would receive the same explanation at the time the claim is paid by the Bank.)

It is my hope that this proposal to create a National Health Care Reserve Bank will trigger a dialogue among Congress, the nation's insurers, CMS, the physician and hospital communities and the professional associations interested in improving quality. Clearly, what we are doing today in terms of physician and hospital payment systems, methods and algorithms is making less and less sense and producing less and less value. Perhaps, we can learn from the Federal Reserve System; why it was



necessary, how it works, who makes it work, and the benefits it brings to society. Does anybody have a better idea?

Epilogue

Before submitting this paper for publication, I asked several colleagues to serve as "reviewers," professional associates representing various constituent groups: insurers and employers, doctors and hospitals.

All thought the concept of a National Health Care Reserve Bank is a step in the right direction, a "forcing function" that could bring about a framework for real and lasting change.

Some of the reviewers think the NHCRB goes too far; others think it does not go far enough. Those who think the model comes up short continue to worry that the proposal does not do enough to address serious issues from a consumer perspective. They cite the almost complete erosion of pooling risk to provide individuals and small businesses with health insurance.*

*"Today's market encourages insurers and managed care companies to avoid risk rather than manage risk. Why would individuals pay premiums into a system when they are healthy if that same system will deny them coverage if they develop a health risk?" - Employer Coalition Perspective



These same critics point out that the NHCRB does not do anything to realign financial incentives that encourage over-utilization of medicines, technology and expensive services. The NHCRB does not explicitly address the complicated challenge of publicly available transparent comparisons of cost and quality performance. (It does, however, provide the underpinnings of a robust and comprehensive data base of physician and hospital-specific information.) And finally, the critics continue to believe that any national health care initiative that ignores the crisis of 44 million uninsured Americans is side-stepping what should be our top priority.

The insurance companies in the United States constitute a powerful "special interest," with a strong and influential lobby. They believe that the NHCRB goes too far in the direction of a single payer. Even as many insurers have already started to "off-shore" their claims adjudication and transaction processing apparatus to lower cost labor markets, they remain reluctant to relinquish a proprietary data base of paid claims, believing that the data is a strategic asset and provides a competitive advantage.



For hospitals and doctors, the NHCRB brings much needed relief from a very complex bureaucracy with mountains of paper, and the cost burden of managing billing and collections.

My response to these reviews is simple. Let's get started. Now. Right after the November 2004 election. Let's not wait for the perfect solution. It will never come.

Once the NHCRB is established and accepted, once it has mastered the over-simplification of health care financial transaction processing, and once it has ensured the individual privacy of every medical claim and the accuracy and timeliness of payments to doctors and hospitals.....then, it is well-positioned to a) implement a political solution to the problem of the uninsured (a market solution is unrealistic), b) publish consumer-friendly and valid comparisons of hospitals, doctors, and insurers, and c) assist with the development of new approaches to physician and hospital compensation that reward safe and effective medical practice and provide financial incentives to appropriately utilize the American health care system.

**NHCRB – Phase I**

1. Establish National and Regional Health Care Reserves Banks, modeled after the Federal Reserve Bank structure and enabling legislation.
2. Create a clearinghouse for all doctor-patient-insurer and all hospital-patient-insurer financial transactions.
3. Build off of the HIPPA mandated use of standardized code sets for: encounter data, eligibility, obtaining referrals, and notification of payments.
4. Require uniform download of current CPT, DRG, ICD information.
5. Provide on-line access to referral numbers and authorizations.
6. Provide employer access to utilization data.
7. Create consumer friendly and standardized Explanations of Benefits (EOBs).
8. Ensure integrity, privacy of individual patient information, accuracy of information, timeliness of payments, and transparency of process.

These improvements could reduce payment denials by as much as 30%, and reduce the costs of billing and collections by as much as 20%. Estimates show that the United States spends \$300 billion annually to administer its health care system. (Source: National Coalition on Health Care, 2004)

NHCRB – Phase II

1. Solve the problem of individual and small group insurance; use the NHCRB to create a large enough risk pool for those without insurance, who are able to afford coverage, but without options.
2. Make provider and insurer comparability data available to the public; ensure validity of comparisons; protect academic and social missions of hospitals and doctors.
3. Report regional performance on cost and quality metrics.



1. U.S. Census Bureau Report, September 2003.
2. Wall Street Journal, September 29, 2003.
3. CNN Money, August 27, 2003.
4. CMS, Office of the Actuary, National Health Statistics Group,
National Health Expenditures 2001.
5. U.S. Census Bureau Report, September 2003.
6. CMS, Office of Financial Management, June 2002 Edition.