



Summary of Results

Advancing Health Care Reform by Creating a United States Health Board

A session of the Annual Meeting of the 7th Annual Medical Banking Institute meeting

March 12, 2009, Nashville, TN

Summary by Mayo Clinic Health Policy Center

On March 12, 2009 during a two-hour session of the 7th Annual Medical Banking Institute meeting held in Nashville, TN, keynote speaker Robert Smoldt, moderator Ceci Connolly and panelists [David M Mirvis, MD](#), Professor of Medicine, University of Tennessee Health Science Center, Memphis, TN, [Murray N. Ross, Ph.D.](#), Vice President, Kaiser Foundation Health Plan, Inc., Oakland, CA, [Roy Ramthun](#), CEO, HSA Consulting Services, Silver Spring, MD, and [Stephen Parente, Ph.D.](#), Associate Professor Finance, Carlson School of Mgt, University of Minnesota, MN, examined the potential role of a "Federal Health Board" or United States Health Board in advancing patient-centered health care reform in America.

Following a presentation by Robert Smoldt regarding the Mayo Clinic Health Policy Center (MCHPC) cornerstones for health care reform, possible roles for a United States Health Board, and the results of the recent MCHPC policy forum on the health board concept, participants heard panelists discuss their thoughts and reactions. Significant time was allowed for Q&A from the audience, and those in attendance were then asked to discuss and reach consensus in small groups regarding three questions.

1. For true health care reform to occur, what functions should be shielded from the political arena?
2. Considering the response to question #1, would an entity like a U.S. Health Board be the way to address those functions?
3. If a U.S. Health Board is established, what are some pitfalls its leadership should try to avoid?

The compiled responses to those questions are noted here.

For true health care reform to occur, what functions should be shielded from the political arena?

In response to this question, groups provided a significant list of functions that should be shielded from the political arena. Some groups chose to suggest things that *should* be addressed within the political arena. In some cases these suggestions were directly contradictory – with one group indicating that the only function that the political arena should address is setting standards for interoperability and movement of clinical and administrative data, while another group specifically took the opposite position, commenting that these topics would be the most easily removed from the political arena. In many cases,

points made by these groups were specifically in concert with results obtained at the recent MCHPC forum. An example is transparency, specifically the concept that data must be broadly available for analysis and the government should not be the sole determinant of data interpretation. The following is the complete list of responses.

- Access - Universal Access should be a given
- Quality Measures - Also a given. They must be tracked.
- Determination of medical necessity should be shielded from the political arena
- The value of a healthcare board would be to develop healthcare research policies. This should be shielded from the political arena.
- Consensus is that the easily shielded topics would be the technical/operational issues that would not be of particular interest to Congress anyway. Like Visa does for bank credit card transactions, this Board could set payment standards (but not procedural rates), penalties, etc.
- The group feels that on the broader questions of coverage levels, etc. it would be difficult, if not impossible to remove political influence entirely.
- Pricing; Medical Necessity
- Anything that would slow down getting uninsured covered.
- Anything that trespasses on the sanctity of the patient/provider relationship.
- The US Health Board should not be involved in patient care options and provider compensation. These components should be regulated by demand and driven by patients.
- Initial scope should be limited to tightening HIPAA transaction set standards and then enforcing uniform compliance to these transaction sets.
- One perspective - shield nothing; otherwise you won't be able to reform the shielded parts.
- Entrenched players hard to move out of their protected areas.
- HIPAA - created lots of jobs, lots of inconsistency - guidelines, not standards. Payers poor at enforcing consistency.
- Government should be exposed to trends and data for healthcare delivery but not be the sole determining entity on how that data interpreted.
- How can we learn from PBMs to see how they were successful in managing data and payment flows for pharmacies to extend that success into other parts of health care system?
- Banks do have lots of data from which outcome and value decisions could be made.
- Stakeholder pool is large - public, providers, payers, vendors, banks, etc. Hard to figure out how to make sure all are represented.
- Stronger role for central agency could have stronger positive effects - e.g., Australian rates for skin cancer much better than US, but very centrally managed and manifested in covered playgrounds, sunscreen and high-coverage clothes for children, etc.
- Patient education critical - managing own care, advocating for selves and family.
- Could leverage health education with student health report cards - year over year comparisons of BMI, height, weight, simple measures of health indicators.

- The 'standard' of quality of care should not be determined by government - rather by an organization of experts/physicians which can determine a minimum standard that would not be open to liability/malpractice.
- Vendor Selection of any entity selected to create a 'federal reserve' model of data and transaction routing/settlement.
- Competition should be protected and stimulated and best practices.
- Create outcome measures, set technical standards, and determining infrastructure needs for things furthest removed from the decision-making process related to coverage, payment, clinical decision-making; national data feeds required
- Moral decisions on treatment for things like abortion, replacing a liver of an alcoholic, etc
- Decisions on the definitions of healthcare quality.
- Creation of the reform direction.
- Need to distinguish between Clinical and Financial issues that are considered by the National Health Board.
- Shielded should be all administrative, clinical, and reimbursement policies.
- We believe that one has to define the term "true healthcare reform." Politics and healthcare have not endured as the best of friends in previous years. And political reform certainly has been from the unique standpoint from the legislator or their constituents as well as the privately held corporations who have something to gain from the initiatives proposed. Preventative care.
- Accessibility, health education, need to start in the school systems. Nutrition, physical education, mandatory sports, etc., are currently being cut across the country. How can we have healthcare reform if there is a lack of the opportunity for our children to learn healthy habits at a young age? These habits will then carryover to adulthood. So are we missing an important part of healthcare reform by not addressing this?
- Payment rates should be shielded.
- The 'standard' of quality of care should not be determined by government - rather by an organization of experts/physicians which can determine a minimum standard that would not be open to liability/malpractice.
- Vendor Selection of any entity selected to create a 'federal reserve' model of data and transaction routing/settlement.
- The only function that should be addressed by the political arena is setting the standards for the interoperability and movement of the clinical and administrative data.

Considering the response to question #1, would an entity like a U.S. Health Board be the way to address those functions?

Of the twenty groups participating in the activity, some groups did not respond to this specific question. Of those groups that responded, three said “no.” Eleven groups said “yes” with the following additional or qualifying comments:

- Provided that the board does not decide policy.

- One federal standard needs to be set and enforced that supersedes state regulations.
- But there is some lack of consensus whether this Board would look more like Visa or The Federal Reserve or more like MedPAC or BRAC. Visa sets more operational standards and the Fed sets interest rates which have more direct impact on industry, and MedPAC and BRAC only advise Congress, which means that more political debate will occur
- Conceptually, we say yes, but we need to understand and define the tools to make it happen.
- We need US Health Board that functions like the FED in the banking industry. It should regulate through laws and enforce desired behavior.
- But could be handled by the Federal Reserve is limited to financial transactions only (claims and payments)
- It could, given right players, right level of focus, ability to expand focus over time
- It could also fail miserably - guidelines vs. standards, dogmatic attention to own group's biases
- True health care reform has to come from consumers
- Patient education
- As long as the board was staffed with all the stakeholders being represented.
- Could be, but needs to be protected from being shut down or abandoned
- The board could not make moral decisions
- They should not restrict innovative solutions they should enable them.
- The board could readily provide guidance on a healthcare reform direction.
- Dissemination of evidence base
- Payment mechanisms
- Board should establish and enforce standards of transparency, formats, and timing, not the admin, clinical, and reimbursement policies.
- As long as the board was staffed with all the stakeholders being represented.

If a U.S. Health Board is established, what are some pitfalls its leadership should try to avoid?

Groups provided significant insight concerning potential pitfalls, including the vital importance of broad and fair representation for all stakeholders, the danger of an agenda that is too broad to be effective, and the potential lack of real authority to drive to change. Complete responses are listed below.

- Regional preferences based on political capital (Example, CA providers receive greater remuneration from Medicare vs AL providers).
- The omission of smaller players. Further, all stakeholders organizations should be represented. (The reason there are 12 FED districts is to allow local influence in the creation of the federal policy and execution.)
- "Boiling the ocean." If a standard can make a difference for 80% of healthcare, implement it. In healthcare the great is the enemy of the good. There may not be a

perfect solution but we must start somewhere. We can incrementally move to where we want this to go.

- Don't invest the board with limited flexibility. Otherwise, it won't be able to react quickly and evolve in a changing healthcare/financing landscape.
- Standardization can drive innovation.
- Current Fed has too much authority vested in the chairman, but too little power or ability would stunt operation. A Supreme Court model is good.
- Allowing personal political agendas to drive objectives.
- "Too broad" an agenda.
- Lack of objective measurements.
- "Too much" regulation that halts progress.
- Costs to implement and operate.
- Creating confusion instead of adding clarity, especially with other government agencies, such as CMS and the Federal Reserve.
- How to figure out how to get proper (fair?) representation across the various stakeholders.
- Political arena - inertia will make change very difficult. Each stakeholder will believe they're going to lose in one or more ways from proposed changes.
- Lack of authority to make change happen.
- Education of consumer to change behaviors is very difficult to execute effectively, and long-term investment - will take a generation to get real substantive change, starting with children.
- Being bought - avoiding undue/inappropriate influences.
- Too often based on the 'agenda' different stakeholders (various levels) have limited opportunity to provide feedback.
- Mandatory treatment protocols and reimbursement at a micro-level.
- Needs to move in a stepped process that builds infrastructure and trust by everyone affected by the health care system; need early "wins" to demonstrate proof of concept.
- Making decisions based only on cost or efficiency.
- Slowing down innovation if the board becomes an approving body.
- Failing to drive open architecture and restricting market pricing.
- Failing to maintain robust mix of stakeholders (providers, payers, employers, banks).
- Failing to provide term limits of members of the board.
- Who determines the qualifications for being seated for the board? Is there anyone who does not have the political affiliations that would allow a neutral point of view?
- There are too many pitfalls at this point due to lack of definition of the board, board functions, responsibility, governmental interaction etc.