The Health Care Quality Improvement Act of 1986 Meets the Era of Health Care Reform: Continuing Themes and Common Threads

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INTRODUCTION
After nearly two decades, the health care reform debate has become permanently intertwined in the nation's political and economic dialogue. Given the vast sums of money spent by Americans on health care each year and the sizable portion of the nation's gross domestic product health care consumes annually,¹ this continuing thread should not surprise—or be viewed as unreasonable by—anyone. Rather, the
American people, and their political representatives, should rightfully demand to know if they are getting their money’s worth—in terms of cost and quality, among other metrics.

As part of this ongoing health care reform debate, the Patient Protection and Affordable Care Act of 2010 (PPACA)\(^2\) constitutes the latest, largest, and most litigious addition to the patchwork of federal health law and policy. Alternatively lauded and lampooned, the permanence of this most recent and highly politicized health care reform measure within the fabric of U.S. health law remains in question more than a year after its enactment, due in part to challenges to its individual coverage mandate.\(^3\) Despite the controversy and continued uncertainty enveloping PPACA, the legislation’s themes stretch far beyond coverage and access, and interweave other, far less controversial and long-standing, strands at the heart of United States health policy. These themes have been stitched into the nation’s health policy cloth for at least 25 years, since the enactment of the Health Care Quality Improvement Act of 1986 (HCQIA),\(^4\) and include quality, provider accountability, provider integration, and related governmental oversight.\(^5\)

Passed at a time, similar to the present, characterized by “the need to improve the quality of medical care,”\(^6\) HCQIA features two key filaments: (1) promotion of meaningful medical peer review, through the provision of procedural due process\(^7\) and qualified immunity related to good faith professional review activities in furtherance of health care quality;\(^8\) and (2) establishment of a national
clearinghouse for provider-specific medical malpractice and disciplinary data reporting, known as the National Practitioner Data Bank (NPDB). As a result, the legislation, which, like PPACA, experienced a perilous path to passage, had significant implications for hospital-physician linkages, antitrust in the health care arena, provider data collection and monitoring, and the related role of government oversight and enforcement.

Again similar to PPACA, HCQIA, at the time of its enactment, garnered much attention—some in the form of adulation and some in the form of alarm—related to the changes it was expected to engender within health care. By and large, HCQIA served as a catalyst in bringing to bear significant enhancements in peer review, and in provider data reporting and monitoring. Its ultimate implications, however, have been far broader than the scope of its language, extending into the overarching arenas of health care quality, provider accountability, and provider integration. In fact, some of those same threads have been picked up once more in PPACA, including concerns about medical malpractice, “problem” provider monitoring and reporting, and provider integration in the interest of quality of care.

THE 2011 SOUTHERN ILLINOIS HEALTHCARE/SOUTHERN ILLINOIS UNIVERSITY HEALTH POLICY INSTITUTE

Healthcare/Southern Illinois University Health Policy Institute in Carbondale, Illinois, on May 20, 2011. The day-long symposium was designed to unwind the skein of health law and policy related to health care quality, provider accountability, provider data reporting, provider integration, and the role of governmental oversight of these functions that has been accumulating over the course of the last quarter century, starting with the implementation of HCQIA and extending through the present-day era of health care reform and the enactment of PPACA. The Institute featured the following nationally noted speakers: David C. Pate, M.D., J.D., FACHE, FACP, president and chief executive officer of St. Luke’s Health System in Boise, Idaho, and one of Modern Healthcare’s 2008 top 50 most powerful physician executives; Mark Rust, J.D., managing partner of the Chicago office of Barnes and Thornburg LLP, and chair of the firm’s national healthcare department (who was a health care journalist at the time of HCQIA’s passage); William A. Robinson, M.D., M.P.H., former chief medical officer for the Health Resources and Services Administration, director of the Office of Minority Health and Health Disparities, and director of the Center for Quality, who was at the epicenter of federal regulation before, during, and after HCQIA’s enactment; Kristin Madison, J.D., Ph.D., professor of law at the University of Pennsylvania Law School; and James N. Thompson, M.D., FACS, otolaryngologist, senior consultant with the Hayes Group, former dean of Wake Forest University School of Medicine, and former president and chief operating officer of the Federation of State Medical Boards.
Bringing together knowledge and perspectives from the practices of law and medicine, health care administration, the legal and medical academies, and government oversight, the presenters addressed not only HCQIA’s history but also laid out how it has affected in the field and led to present practices and policy. This symposium issue of *The Journal of Legal Medicine* features articles by the Institute’s presenters.

The first article, “Hospital-Physician Relationships in a Post-Health Care Reform Environment,” by Dr. Pate, details the rapidly changing environment of health care organization-physician relationships, specifically physician employment and the development of Accountable Care Organizations. Dr. Pate describes the factors contributing to the trend toward physician employment by health care organizations, including falling patient revenues, increasing practice expenses, decreasing access to capital, growing compliance burdens, changing practice patterns, and evolving lifestyle considerations. In addition, he considers health care’s crisis of confidence due to its unsustainable and insufficient levels of quality, safety, reliability, convenience, integration, effectiveness, and affordability. Dr. Pate goes on to address how these phenomena provide a prime environment in which to create accountable health care organizations by aligning provider incentives, identifying overarching issues to be addressed and critical changes to be made, and observing that PPACA is merely “an accelerant of change” rather than a catalyst in and of itself.
In the second article, “From HCQIA to PPACA: The 180° Arc of Provider Antitrust Concerns in Healthcare Over 25 Years,” Mr. Rust tells tales of the evolution of antitrust litigation in health care prior to and since the enactment of HCQIA. After describing how health care came to fall within the realm of antitrust regulation, Mr. Rust unveils the history of the contentious Supreme Court case of *Patrick v. Burget*, which spurred the enactment of HCQIA. After reviewing HCQIA’s peer review due process protections and presumptions, Mr. Rust explains that HCQIA, coupled with the increased business sophistication within health care, refocused antitrust enforcement on consolidation, including mergers, acquisitions, and the resulting market concentration. In today’s epoch in which providers are striving for the true clinical integration envisioned under PPACA, he concludes that antitrust concerns “are a long way from the concerns 25 years earlier,” and that “[t]his arc parallels the ... commercial sophistication ... within the health care sphere.”

Dr. Robinson shares “Historic and Personal Reflections on HCQIA: Perspectives of a Former Federal Executive,” in the third article of this symposium issue. Through this living history, he offers a uniquely contextual account of the events shaping United States health policy leading up to, during, and after HCQIA’s enactment and implementation. Specifically, Dr. Robinson observes how HCQIA was the “spark” that inspired “many who sought to address issues aimed at improving patient protections and health care quality.” He also describes how that “spark” continues today through PPACA, other federal legislative enactments and regulatory
efforts, as well as through private-sector initiatives and public-private joint ventures.  

In “From HCQIA to the ACA: The Evolution of Reporting as a Quality Improvement Tool,” Professor Madison aptly teases apart and independently examines the distinct forms, functions, and evolutions of HCQIA’s NPDB and of the separate phenomenon of health care quality reporting. In so doing, she crystallizes the dichotomy between “competence” and “quality,” noting that, while “[t]he ‘Q’ in HCQIA refers to ‘quality,’ ... much of the debate surrounding HCQIA’s adoption used the term ‘competence’...” Despite the different roles of and roads taken by the NPDB and health care quality reporting in the quarter century between HCQIA and PPACA, Professor Madison concludes that both have advanced synchronously and in alignment; as a result, she articulates how they dovetail in the drive toward enhanced health care quality improvement moving forward.

The fifth and final article, “State Medical Boards: Future Challenges for Regulation and Quality Enhancement of Medical Care,” by Dr. Thompson and Lisa A. Robin, MLA, chief advocacy officer for the Federation of State Medical Boards, concludes this symposium issue with a salient review of the origins of and future challenges facing the proactive oversight of medical licensure. Dr. Thompson and Ms. Robin detail the history of physician licensure as a public safety mechanism, noting how the enactment of HCQIA significantly stepped up provider oversight. With an eye toward the necessary next steps in quality improvement related to
provider monitoring, the authors consider the limitations of the medical licensure and oversight system, including: its reactive nature; the increasing complexities of medical practice and, therefore, the regulation thereof; and the finite resources dedicated to this public safety function. Despite these fundamental challenges, the authors elucidate why and how physician oversight systems evolve, and must continue to do so, by "shift[ing] from simply assessing the professional ability of those entering the practice of medicine to the early development of a reliable system that will do much to assure the public that physicians are maintaining their competence throughout their practice."\(^{29}\)

**CONCLUSION**

The articles in this 13\(^{th}\) Annual Southern Illinois Healthcare/Southern Illinois University Health Policy Institute symposium issue of *The Journal of Legal Medicine* plait the cords connecting 1986’s HCQIA and 2011’s PPACA. Such a historically contextual approach to viewing key themes and how they are stitched, over time, into the fabric of the nation’s health law and policy leads to a much more robust understanding not only of where U.S. health law and policy has come from—and why—but also aids in developing informed and integrated health law and policy moving forward.
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4 26 U.S.C. §§ 5000A(a), (b), & (c) (Supp. IV 2010) (covering PPACA’s individual coverage mandate, penalty imposition, and penalty amount, respectively).


10 See Robert S. Adler, Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act,


12 See 42 U.S.C. § 1320a-7e (Supp. IV 2010) (merging the NPDB with the Healthcare Integrity and Protection Data Bank (HIPDB)). The HIPDB is a federal data repository, which was established by the Health Insurance Portability and Accountability Act of 1996, that monitors health care fraud and abuse. See The Data Bank: About Us, HEALTH RESOURCES & SERVICES ADMIN., http://www.npdb-hipdb.hrsa.gov/topNavigation/aboutUs.jsp (last visited Nov. 4, 2011). Both the HIPDB and the NPDB are administered by the Health Services and Resources Administration. Id.; see also 42 U.S.C. § 1396r-2 (Supp. IV 2010) (state licensing authority information repositories for sanctions against health care providers).

13 See, e.g., 42 U.S.C. § 1395jjj (Supp IV 2010) (quality improvement and ACOs).
The Health Policy Institute is an annual event jointly sponsored by Southern Illinois Healthcare, Southern Illinois University School of Law, Southern Illinois University School of Medicine, and the Paul Simon Public Policy Institute. The program is supported, in part, by an unrestricted educational grant from Southern Illinois Healthcare, the Southern Illinois School of Law, and a grant from the law firm of Sandberg Phoenix & von Gontard PC.


Id. at TK2-3.

Id. at TK4-5.

Id. at TK9.


Id. at TK.

Id. at TK.

Id. at TK30-31.

24 Id. at TK13.


26 Id. at TK5.

27 See, e.g., id. at TK17 tbl. 1.


29 Id. at TK34.