

**COST OF HEALTH SERVICES REGULATION
WORKING PAPER SERIES**

PEER REVIEW

**HEALTH FACILITIES REGULATION
WORKING PAPER No. F-16**

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PEER REVIEW

Background

Rationale. Peer review was established as an on-going mechanism to monitor and improve quality of care for Medicare and Medicaid patients. However, in the mid-1980's, concerns arose that the threat of private money damage liability under Federal law, especially treble damages under antitrust statutes, was unreasonably discouraging physicians from engaging in professional peer review that could improve quality of care.¹

Statutory Authority. Peer Review Organizations (PROs) were established through the Peer Review Improvement Act of 1982 (a part of the Tax Equity and Fiscal Responsibility Act of 1982),² replacing Professional Standards Review Organizations (PSROs) that had been established in 1972. In FY2002, they were renamed Quality Improvement Organizations (QIOs). The Health Care Quality Improvement Act of 1986 (HCQIA) became effective November 1986 and contained two major provisions. The first was the creation of the National Practitioner Databank (NPDB)³, and the second provision was to give peer review actions conditional immunity from monetary damages so long as certain statutory thresholds are met and explicit requirements regarding due process are followed.

Key Elements. QIOs are statewide physician-sponsored or physician-access organizations paid through federal contracts to review Medicare-reimbursed medical services and are the principal mechanism for ensuring quality for Medicare patients. To participate in Medicare, a hospital must enter into agreements with the QIO serving its area, giving the QIO authority to review the quality and appropriateness of care provided. The immunity provided by HCQIA “forecloses damage actions under state law of all kinds as well as under federal antitrust law” (Havighurst, Blumstein and Brennan 1998: 797). Congressional intent was to create a rebuttable presumption in favor of immunity, thereby allowing this to be resolved prior to trial (and in so doing, creating a sizable evidentiary burden on plaintiffs seeking to defeat immunity). However, unlike parallel state laws aimed at protecting the peer review process, HCQIA did not confer a federal evidentiary privilege to the records and deliberations of the peer review process (Scheutzow 1999). Subsequent court rulings have denied hospitals immunity for failure to meet these notification and due process requirements.

Scope. QIOs are designed to improve the quality of care for beneficiaries by ensuring that professionally recognized standards of care are met; enhance program integrity by ensuring that Medicare only pays for items that are reasonable and medically necessary; and, protect beneficiaries by addressing individual beneficiary's complaints, hospital

¹ The immediate precipitating cause for HCQIA was the case of *Patrick v. Berget*, in which the Supreme Court ultimately (shortly after HCQIA was enacted) upheld a jury's awarded of \$2.2 million in damages for a bad faith peer review found to have violated antitrust statutes (van Geertruyden 2001: 245).

² Bhatia et al. (2000) provide a good background and description of PROs.

³ The NPDB is discussed under regulation of health professionals, so neither its costs or benefits are included here.

issued notices of non-coverage, and Emergency Medical Treatment and Labor Act (EMTALA) “dumping” violations. State QIOs carry out these responsibilities through federally funded contracts.

Theoretical Evidence

Cost. Peer review entails regulatory costs borne by the federal government, including the costs of funding QIOs. QIOs impose a cost on facilities in terms of staff time taken to provide medical records or other information to them. HCQIA imposed notice and hearing requirements that add to costs, leading to the possibility that such procedural costs could outweigh the intended litigation savings. Moreover, since HCQIA, physicians may challenge peer review decisions only on grounds that they violated procedural requirements or can be shown to be taken in bad faith. In many states, peer review proceedings are kept strictly confidential; hence physicians face a difficult burden of proving bad faith (van Geertruyden 2001). At a more intangible level, some have questioned whether HCQIA might damage the evolution of sound antitrust principles and ultimately protect behavior that is anti-competitive (Havighurst 1986).

Benefits. In theory, peer review should improve quality since physicians know that any of their cases face some chance of being reviewed. Likewise, HCQIA theoretically could reduce costs by eliminating some litigation, including earlier dismissal of suits as well as providing a disincentive for antitrust actions.

Empirical Evidence

We found a large body of literature related to these regulations but most was very dated.

- *Federal Regulatory Costs.* DHHS budget figures show that federal outlays for PROs were \$535 million in FFY2002.
- *Industry Compliance Costs: QIOs.* We could not locate a reliable estimate of QIO compliance costs in the literature. There were extensive and very sophisticated cost studies of PSROs conducted in the late 1970’s by Arthur Young and Company, Macro Systems, Inc. and others for the Department of HEW (summarized in Bodin, Pfaffenberger and Robeson 1980). These studies examined the full gamut of costs associated with review, including audit costs, UR committee costs, and general administrative costs, but these have two limitations. First, they do not differentiate between the costs of review itself and the compliance costs needed to maintain records/respond to queries etc. associated with review. Moreover, they apply to the old PSRO program, but since that program was eliminated in part due to its excessively high costs, these figures are not appropriate to use for PROs, especially since PROs themselves have evolved from an initial focus on reducing inappropriate admissions to more of a focus on continuous quality.⁴ Moreover, the old system had a mechanism whereby a hospital could be delegated (fully or partially) the responsibility for conducting reviews: roughly 75 percent of reviews were delegated during this period. A 1991 case study in Pennsylvania showed that compliance costs were 1.9

⁴ Bhatia et al. (2000) describes this evolution in detail.

times as high as PRO expenditures, but the study authors acknowledged that while the cost estimates were based on the best data available at the time, in many cases this data was crude.

- *Industry Compliance Costs: HCQIA.* Apart from NPDB, we could find no literature that focused on the costs or cost savings related to HCQIA. We found one article claiming that HCQIA notice and hearing requirements were “costly” and offered no more than existing protections.⁵ While acknowledging some of the potential benefits cited above, the author encouraged facilities to examine both costs and benefits of compliance (Simonds 1988).
- *Indirect Benefits.* We did not find any literature documenting benefits related to peer review organizations.

Net Assessment

We have calculated the regulatory costs in the following fashion (minimum and maximum parameter estimates are shown in parentheses: full details of methods and sources are in Table C-16).

- *Federal Regulatory Costs.* We used DHHS budget figures for PROs without further adjustment.
- *Industry Compliance Costs.* In light of all the aforementioned problems with cost estimates regarding PSROs, using either direct extrapolation of 2 decade-old figures or even trying to obtain a ratio of compliance to PSRO agency costs was not feasible. The best alternate figure we could locate was from the Pennsylvania study; accordingly we used the 1.9 figure for our most likely case, implying compliance expenditures of \$528 million; we used a 1:1 ratio for our lower bound and for our upper bound used a ratio that was 3 times the estimated ratio in Pennsylvania.
- *Social Welfare Losses: Efficiency Losses from Tax Collection.* To account for the efficiency losses associated with raising taxes to pay for government regulatory costs, we multiply the latter times the marginal cost of income tax collections (see Table B-1 for how these costs are calculated).
- *Social Welfare Losses: Efficiency Losses from Regulatory Costs.* All industry compliance costs are presumed to be roughly equivalent to an excise tax, i.e., raising prices and reducing demand/output correspondingly. We therefore multiply these costs times the marginal excess burden associated with output taxes, using 21% (15%, 28%) as the expected value of MEB (see Table B-1 for details of how MEB is calculated).

Our net assessment yields a cost estimate of \$2,064 million (1,314, 5,481) and benefits of \$0.

⁵ This view is confirmed in Baxter (2002) who notes that the notice and fair hearing requirements of HCQIA are less stringent than those of Joint Commission on Accreditation of Health Care Organizations (JCAHO) and most hospital staff bylaws. JCAHO, unlike HCQIA has no appeal process requirement. Note that the HCQIA protections also already were included in many state statutes enacted for a similar purpose (van Geertruyden 2001).

Acronyms

DHHS	Department of Health and Human Services
PRO	Peer Review Organizations
PSRO	Professional Standards Review Organizations

References

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HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

Background

Theoretical Evidence

Costs.

Empirical Evidence

Net Assessment

Absent any information about the cost impact of HCQIA not associated with the NPDB, we assumed costs and benefits of \$0.

Acronyms

HCQIA	Health Care Quality Improvement Act of 1986
NPDB	National Practitioners Databank

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