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Issues in Coverage Expansion Design

Building Quality Improvement Into Health Coverage Expansion Proposals

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REAL REMEDIES FOR THE UNINSURED

The purpose of this paper is to identify and explain how proposals to expand health insurance coverage can build in features to promote and facilitate health care quality improvement. Of course, there is a strong association among health insurance coverage, better health care, and improved health outcomes.[1] Thus, we would expect that almost all coverage expansions would improve quality of care for newly insured individuals. But the favorable impact of coverage expansion on quality of care can be substantially augmented if proposals to extend health coverage to the uninsured build in various design features specifically targeted to improving quality. These design features might be incorporated into a wide variety of health reform plans, regardless of the mix of purchasing responsibility between single and multiple payers or the relative roles for the public and private sectors. Some reform plans may be more conducive to quality improvement than others, but all could benefit from building quality-promoting requirements and incentives into their core designs.

The Quality Problem

There are important reasons to give close attention to quality in designing coverage expansion plans:

- There is widespread evidence of inappropriate medical care. Three reports by the Institute of Medicine have documented the shocking extent of medical errors and inappropriate care.[2] These reports have established

[1] Committee on the Consequences of Uninsurance, *Care Without Coverage: Too Little, Too Late*, Board on Health Care Services, Institute of Medicine, 2002.

[2] Institute of Medicine. *To Err is Human: Building a Safer Health Care System*. Washington, D.C. National Academy Press. 1999; Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C. National Academy Press. 2001. Institute of Medicine. *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*. Washington, D.C. National Academy Press. 2002.

that the problem is not primarily one of a few individuals acting in bad faith or abject neglect. The problem is a health care system that, for all its dazzling medical technology, is decades behind on information technology and lacking in accountability for reporting medical errors, adopting available means for reducing their prevalence, and taking steps to adhere to best clinical practices. While we spend tens of billions of dollars on basic medical research, we spend only a tiny fraction of this amount to learn how to apply appropriately the new technology emerging from this research.

- A growing body of literature documents the tragic under-use of medically effective preventive and primary care; routine referrals to hospitals conducting a low volume of procedures, which is associated with adverse outcomes; unnecessary tests and procedures; and a number of related problems.[3]
- We lack an integrated, electronically based clinical decision support system. Given the vast amount of ever-changing medical research findings—there are some 10,000 peer-reviewed control-trial medical studies each year—keeping up with best clinical practices without benefit of electronic retrieval of information is a daunting task for health providers.
- Medical care is frequently delivered in a piecemeal, uncoordinated way. In a hospital, for example, the attending physician, other physicians, nurses, pharmacists, therapists and social workers may not have access to each other's notes and orders in a timely way. Bottlenecks in the delivery system (for example, long waits for lab results) may delay discharges.
- We lack comprehensive information technology standards for health care. Hospital systems and other providers may be reluctant to commit substantial resources to quality improvement because they feel that the quality standards are not well defined.
- We are only slowly developing the ability to track the delivery of care across settings or assess healthcare outcomes produced by individual providers.
- Health care purchasers—both public and private—frequently fail to establish clear and enforceable quality standards, build these standards into contractual obligations for health plans and providers, and set up rewards, incentives, and penalties to drive quality improvement.
- Health providers and plans are faced with a bewildering array of information requirements by the multitude of health care payers.

Proposals to extend health coverage, including those prepared for the *Covering America* project, envision various forms of purchasing on behalf of newly (and currently) insured people: federal and state government purchasing through expansions in Medicaid, S-CHIP, or Medicare; employers who are purchasing under either voluntary or mandatory arrangements; insurance exchanges that serve small business and their employees and perhaps the unemployed or others receiving subsidies; and individuals using tax credits to buy coverage on their own. The impact on quality will depend on the way physicians, hospitals, and other health care providers are motivated under these reform plans to take the lead in improving quality. This, in turn, will be influenced in part by the extent to which government, business, and individual purchasers have incentives to hold these providers accountable for making a serious effort to learn and adopt best medical practices.

[3] See, for example, Chassin, Mark. "Assessing Strategies for Quality Improvement," *Health Affairs*. Vol. 16, no. 3 (1997) pp. 151-161; Shuster, Mark A. et. al. "How Good is the Quality of Health Care in the United States?" *Milbank Quarterly*, vol. 76, no. 4 (1998), pp. 517-563; and Dudley, RA et. al." Selective Referral to High-Volume Hospitals: Estimating Potentially Avoidable Deaths," *JAMA*. 2000 March 1;283(9):1159-66.

The Coverage Expansion Design Series explores issues that policy makers designing comprehensive expansions of health coverage need to address. This series is a part of the *Covering America* project, which promotes serious consideration of a diverse range of comprehensive proposals to provide affordable health coverage for the millions of uninsured Americans. The project has published 13 proposals for major expansion of health coverage written by leading health analysts and researchers. The proposals are available from the Economic and Social Research Institute or on line at www.esresearch.org.

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Therefore, two important questions must be answered. First, what tools and strategies do providers and purchasers need to improve health care quality? Second, what features of a reform plan would facilitate that effort?

Quality Improvement Tools and Strategies

We focus on three types of quality improvement strategies: improving information on quality; developing quality standards based on this information and disseminating these standards to consumers; and holding providers and health plans accountable for meeting quality goals through rewards and penalties.

Improvement in Quality Information Infrastructure

There is much consensus among experts that a quality improvement strategy must include investments to improve information systems and information technology capabilities. Such investments would help any health care reform plan achieve a critical goal: improving access to timely and appropriate health services and improving health outcomes.

As a recent report by the Institute of Medicine (IOM) observes, health care is provided through a series of complex processes. These include diagnosing and treating a patient's medical problem; receiving and following up on lab, radiology, and other diagnostic tests; communicating the results with patients; monitoring patient progress; and ensuring appropriate follow-up. At each step, communication among providers and between clinicians and patients is critical, and timely information and knowledge is essential.[4]

There is no single "right way" to combine the elements of a better information system; many variations are possible. What we present here are a few of the key building blocks.

First, an *integrated clinical support system* would address the information gaps and deficiencies in several ways. In the IOM framework, this system would involve the establishment of a secure platform for communication and sharing of clinical information between patients and providers and among providers. This could facilitate the rapid movement of *computer-based* information to multiple sites on a need-to-know and right-to-know basis. The platform could be gradually built out to include appointment scheduling, tele-consulting and e-mail communications between patients and physicians; insurance eligibility checking; decision-support tools for both patients and clinicians, such as reminder systems, medication order entry, and chronic disease management; and e-health delivery modes.[5] The goal would be to develop a clinical data repository with computerized, confidential records tracking each patient's changing conditions.

Second, if payers coordinate their requests to hospitals and medical groups using *common quality indicators*, the reporting burden on plans and providers would be reduced.

Third, a quality improvement strategy may include a *national quality information base* that collects, organizes, and disseminates quality-related information. Emerging models include the National Guideline Clearinghouse and the Quality Forum's quality measurement and public reporting strategy (See Box 2).

The strategies presented here could improve the current system in several ways. An integrated clinical support system would provide a better source of information for quality assessment than traditional medical insurance claims, which frequently do not in-

Box 1. Quality improvement (QI) strategies that can be built into a range of reform proposals:

- Improvement in quality information infrastructure
- Quality measurement, standards, and report cards
- Financial incentives and accountability

Box 2. Examples of National Quality Information Base

- The National Guideline Clearinghouse™ (NGC) is a comprehensive database of evidence-based clinical practice guidelines and related documents produced by the Agency for Healthcare Research and Quality (AHRQ) in partnership with the American Medical Association (AMA) and the American Association of Health Plans (AAHP). The NGC is intended to provide health professionals, health plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation and use.
- Emerging from the recommendations of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, the National Forum on Health Care Quality Measurement and Reporting (Quality Forum) is developing a comprehensive quality measurement and public reporting strategy. The Quality Forum is identifying and endorsing, on a periodic basis, core sets of quality performance and consumer protection measures to meet the common information needs of purchasers, consumers, providers, plans, quality oversight organizations, federal and state policymakers, and public health officials. The group is promoting standardized measurement specifications, collection, verification, and audit tools, and analytical tools for quality measurement along with education plans for all stakeholders.

Sources: http://www.guideline.gov/FRAMESETS/static_fs.asp?view=about, and http://www.qualityforum.org.

[4] Institute of Medicine: *Fostering Rapid Advances in Health Care: Learning from System Demonstrations.* November 2002. p. 57.

[5] IOM, op. Cit., p. 58-59.

clude key clinical information and are sometimes unavailable under managed care arrangements. It would foster team-based, coordinated care, which would improve health outcomes. A national quality-related database could underpin decision-making with timely and up-to-date clinical information. And all of the steps described would streamline the process and reduce demands on providers, increasing their compliance and freeing up time that can be better devoted to patient care.

Quality Measurement, Standards, and Report Cards

Another key component of a quality improvement strategy would be to use the kind of clinical information and research findings described above to develop evidence-based medical guidelines and quality indicators that permit comparisons across various systems delivering health care, and means for disseminating these performance comparisons.

There are several current examples of health care purchasers working with physicians and hospitals to develop practice guidelines, provide these guidelines to health plans and practitioners, track indicators of provider performance, and report comparative quality performance information to the public in the form of user-friendly "report cards." The intent of arming consumers and other purchasers of health care with information about comparative performance is that they will *use* the information to select higher-quality providers and health plans. Public dissemination of performance comparisons also motivates lower-quality providers to improve. Organizations taking this approach include the Pacific Business Group on Health, the Niagara Health Quality Coalition, The Alliance in Madison, Wisconsin, Massachusetts Health Quality Partners, and a collaboration of the major automobile manufacturers. Similarly, the Midwest Business Group on Health worked with Union Pacific to identify quality problems in one city where the company has a significant presence. (See Box 3).

Box 3. Examples of Quality and Cost-Quality Measurement Initiatives

- Union Pacific worked with the Midwest Business Group on Health to audit potential quality problems among health plans and providers serving Union Pacific employees. Using The Dartmouth Atlas and HEDIS (Health Plan Employer Data and Information Set), the review revealed a number of quality problems including a history of high mortality rates for bypass surgery patients; under-use of stress testing, aspirin, beta-blockers, and smoking cessation guidance to heart attack patients; and potential over-use of angioplasty and bypass surgery. Union Pacific is using the results to inform health care providers, consumers, and other employers.
- One research organization, CareScience, has assessed nearly 3,000 hospitals using an amalgamated measure of quality (incorporating risk-adjusted mortality rates, complication frequency, and a measure of the severity of complications) combined with one element or indicator of cost, length of stay. CareScience is also digging beneath the hospital-wide measures to see how each institution performs in specific services (ICD-9 codes).
- Dr. Brian Jarman of the Imperial College of Medicine (U.K.) and colleagues at the Institute for Healthcare Improvement in the U.S. are examining case-mix adjusted mortality rates and costs (using a measure of reimbursement) for over 1,700 U.S. hospitals.

Sources: Midwest Business Group on Health; *Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing.* 2002 and personal communications with Ron Paulus, CareSciences, and Brian Jarman, M.D.

Much effort in the last two decades has focused on developing health plan performance indicators, and this has been helpful. But with so much overlap in health plan networks, such measures have become less meaningful. In response, quality experts have more recently called for the development of performance measures at the *provider* (physician practice and hospital) level.

The process of digging beneath the health plan level will be facilitated by the implementation of a new version of the Consumer Assessment of Health Plans that measures quality at the group practice level. The new system (G-CAHPS), developed by AHRQ, is being developed and is expected to be available for use in 2003 or early 2004.

The accuracy and utility of performance measurement and comparisons can be enhanced by making adjustments for the level of health risks posed by the patients that a health plan or a provider serves. Comparing outcomes among provider groups or health plans when one serves a sicker population than another can produce misleading results because even with the best care, more severely ill patients are likely to have poorer outcomes. Improved severity-adjustment has played a crucial role in the success of outcomes-reporting initiatives such as New York State's Cardiac Surgery Reporting System and assessments of care delivery systems undertaken by the Buyers Health Care Action Group in Minneapolis-St. Paul. More developmental work on risk-adjustment approaches is needed to provide the foundation for new and expanded initiatives.

Another area that is in its infancy but shows promise involves comparing providers' performance in terms of a "value" measure encompassing both providers' cost of delivering care and quality. Both CareSciences, a research organization in Philadelphia, and Dr. Brian Jarman of the Imperial College of Medicine in the U.K. are pursuing such work (See Box 3). Further research in this area may provide insight into reducing variation in outcomes and cost to acceptable levels, and promoting high quality while reducing or containing costs.

Coverage expansion proposals may not be expected to detail a specific quality measurement strategy. But they can call for the development and dissemination of these measures, and earmark some resources to facilitate their improvement and implementation.

Financial Incentives and Accountability

The third step in a quality improvement strategy is accountability. Information itself will not drive change in the health care system unless it is acted on. Designers of health care coverage expansion proposals can outline a set of incentives to reward adherence to good medical practices and to put pressure on provider groups that fall short.

First, new coverage models can build a *requirement for reporting quality indicators* directly into the program design. According to David Lansky, the President of the Foundation for Accountability (FACCT), "Any major change in federally funded health benefits should require the appropriate agency to receive and publish standardized reports regarding the quality, safety, and effectiveness of care delivered with any public funds authorized by the legislation."[6] Providing a precedent for this approach was the State Children's Health Insurance Program (S-CHIP) legislation enacted in 1997, which requires states to submit to the Department of Health and Human Services an evaluation plan on the effectiveness of quality improvement efforts. To foster consistency across various states' initiatives to measure quality under S-CHIP, AHRQ, in cooperation with several private foundations and non-governmental organizations, formed a consortium to develop specific tools to measure the quality of children's health. More than 80 organizations participated in the Child and Adolescent Health Measurement Initiative (CAHMI). Lansky reports that clinical and quality measurement experts developed three sets of quality measures based on published, validated research instruments—covering pediatric care for children up to age three, care for children with chronic illness, and preventive services for adolescents.

Second, new coverage models can *tie financial incentives to quality performance*. Public subsidies for health insurance, for example, could be linked to quality indicators. Some of this linkage could occur at the health plan level. For example, lower consumer cost sharing or richer benefits could be available for people choosing plans designated as "higher-quality." Tying employee premium contributions to the quality and cost of health plans has been undertaken by General Motors for its salaried workers.

Financial incentives can also emerge from purchasers' decisions to build a requirement that health plans report progress toward achieving quality improvement targets into their contracts. For example, government and business purchasers might hold health plans accountable for increasing the proportion of their enrollees who receive preventive health screening tests over the term of their contracts. Another form of incentive involves directly rewarding providers and plans that perform well. This may include higher payments to better performing providers, or bonuses or set-asides for plans or providers meeting performance goals, with the amounts large enough to affect behavior. Other forms of incentives may involve directing patients or enrollees to better-performing entities through selective contracting, centers of excellence, creating a preferred provider organization, or, for Medicaid or other public coverage, rewarding high-performing plans with a larger share of default enrollees (those who, when they do not choose a plan on their own, are assigned to a specific plan). An overall challenge in this area is to develop incentives that reward plans and providers for keeping patients well, not just for providing a needed service effectively once a person is sick. Examples of purchasers that incorporate financial incentives into their practices are presented in Box 4.

Building Quality Improvement Design Features into Coverage Expansion Proposals

This section explores the types of design features that coverage expansion proposals might build in to facilitate the quality improvement initiatives described above. Indeed, most of the quality improvement (QI) strategies presented in this brief could be incorporated into any major reform proposal. A national clearinghouse of information on quality of care and performance, electronic medical records, computer-based technology, and other methods of improving quality information and infrastructure could be incorporated in reform proposals that span the political and ideological spectrum. The primary differences lie in the entities playing the roles and carrying out the functions across various reform plans. For example, the roles for purchasers outlined in this paper could be played by large employers, business coalitions, large regional "insurance exchanges," various forms of "sickness funds," states, or other government agencies such as Medicare.

That said, some reform proposals may be more *conducive* to certain QI strategies than others. In addition, the sources and level of funding for QI, and the strength of QI incentives and/or directives will also influence

[6] Lansky, David. "Improving Quality Through Public Disclosure of Performance Information." *Health Affairs.* July/August 2002. P. 53.

Box 4. Examples of Financial Incentives to Promote Quality Improvement

- The state of Rhode Island has incorporated performance-based financial incentives into its Medicaid contracts with participating health plans. Launched in 1998, the RIte Care Performance Goal program measures and rewards health plan performance related to administration, access, and clinical service standards. It ties performance to financial rewards separate from and in addition to the negotiated capitation payments.
- General Motors structures its premium contributions for salaried workers so that employees pay less out of pocket if they choose health plans that score well on the company's cost and quality-based performance rating system.
- Six large California health plans agreed to set aside $100 million in annual incentives to medical groups representing 35,000 physicians. The plans will use a common medical group performance scorecard, with payments based on a mix of prevention, chronic care management, and patient satisfaction measures that the Pacific Business Group on Health is helping to develop.
- Five members of The Leapfrog Group in the New York area (Xerox, IBM, Pepsi, Verizon, and Empire Blue Cross and Blue Shield), are increasing DRG payments by about 4 percent for hospitals that invest in two quality improvement mechanisms (computer-assisted physician order entry and closed-staff intensive care units).
- The Buyers' Health Care Action Group in Minneapolis pays higher fees to provider care systems that demonstrate superior performance based on patient satisfaction, delivery of preventive services, and documented implementation of clinical quality improvement initiatives.

Sources: Silow-Carroll, Sharon. *Building Quality into RIte Care: How Rhode Island is Improving Health Care for its Low-Income Populations,* The Commonwealth Fund, January 2003; and Midwest Business Group on Health. *Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing*. 2002.

the magnitude and ultimate success of QI efforts.

A series of initiatives led by the medical community, and supported by government and private sector purchasers of care, could be geared to the development of quality indicators and measurement tools, and the identification and use of effective and efficient medical practices. Clearly, physicians, hospitals, and other health care providers and researchers must take the lead in determining best medical practices and forging practice guidelines, but other stakeholders can play a role in encouraging adherence to these practices by providers, as well as fostering other key QI functions.

Proposals that Promote Multiple Group Purchasers

One set of health reform proposals would establish and promote *large, multiple group purchasers*.[7] In addition to buying health care for various segments of the population, these group purchasers could be structured to have primary QI responsibilities. The theory is that large group purchasers are likely to have considerably more leverage to drive medical practice improvements than are individuals or small groups working by themselves.

Large group purchasers could supplement the work of the medical community by adopting their own set of quality benchmarks, and they could use a variety of "carrots and sticks" to increase compliance by providers to adopt best medical practices and to meet quality goals. Group purchasers could disseminate comparative assessments of plans and providers, tie financial incentives and sanctions to meeting standards, and promote quality-based competition among health plans through purchasing pools offering multiple plans or care systems to enrollees. They could require health care providers to deliver information on their practice styles and health outcomes to some type of "clearinghouse" entity described earlier.

Large group purchasers may include states (for Medicaid/S-CHIP and state employees), the federal government (for Medicare, veterans, CHAMPUS and federal employees), large employers and business consortia, and/or new entities such as insurance exchanges. Under some approaches (such as that developed by Sara Singer, Alain Enthoven, and Alan Garber of Stanford University for the *Covering America* project), people not connected to insurance options through large employers, Medicare, or Medicaid would be aggregated into large purchasing pools, or "insurance exchanges," that offer a range of insurance coverage products. In addition to encouraging greater competition among the health plans, such pooling gathers up a large number of people (for example, the unemployed, employees of small companies, people doing part-time and temporary work who are ineligible for employer coverage) and creates entities with the leverage to demand and develop robust quality improvement efforts. If everyone is included in some form of large purchasing pool, purchasers will presumably find it easier to require data reporting from plans and providers and to implement performance measures and performance-based purchasing.

Another approach (for example, the one offered by *Covering America* authors David Kendall, Jeff Lemieux, and Robert Levine) would create state-established purchasing groups

[7] See, for example, proposals by Singer, et. al, Holahan, et. al., and Gruber, in Jack A. Meyer and Elliot K. Wicks, *Covering America: Real Remedies for the Uninsured*. Economic and Social Research Institute. 2001.

that offer all individuals and businesses an array of health plan options. This approach assigns to the federal government the role of building a health information infrastructure to store timely computer-based information on quality and to report results to the public. It would be possible (as Kendall and his colleagues do) to combine this with incentives: federal grants to the states to help cover the uninsured would be contingent upon meeting quality improvement targets.

Another related design feature (incorporated in both of the proposals referenced above) is the development of a body similar to the Securities and Exchange Commission to help set national goals for health care quality, monitor progress toward those goals, and recommend remedial solutions. It could be designed to make available standardized benefit plans along with comparative information on benefits, pricing, quality measurement, and quality improvement initiatives (see Box 5).

Box 5. QI Design Features from Two *Covering America* Proposals

Singer, Enthoven, and Garber – Using Tax Credits and Insurance Exchanges to Expand Coverage

- Insurance "exchanges" would require plans to offer standardized basic benefits (to facilitate plan comparison) and meet minimum standards for measuring quality.
- Exchanges must make available comparative information on plan benefits, pricing, quality measurement, and quality improvement initiatives.
- A new federal Insurance Exchange Commission (IEC) would establish minimum quality measurement and reporting standards for participating health plans. The IEC would also develop new quality measures and encourage standardization of data across exchanges and with other purchasers. Plan quality data would be reported directly to the IEC by plans.

Kendall, Lemieux, and Levine – Using Refundable Tax Credits and Performance-Based Grants to States to Develop Purchasing Groups to Expand Coverage

- The federal government would help build a health information infrastructure to improve communications and enhance information exchange between stakeholders. The result would be an information warehouse similar to the SEC which would report on healthcare quality and outcomes.
- Comparative information would be produced at the provider as well as at the health plan level.
- Individuals could choose where to carry their tax credit, supported with information on quality of care.
- The federal government would make grants to the states that are, over time, contingent on meeting quality improvement targets.

Source: *Covering America: Real Remedies for the Uninsured.* Economic and Social Research Institute, Volume 1, June 2001; and Volume 2, November 2002.

Proposals that Emphasize Individual Insurance and Consumer-based Reform

Other health reform proposals promote *individual health coverage* and *consumer-driven health care*.[8] Quality improvement under this model would be led primarily by consumers. Physicians and other providers would compete for consumers' business on the basis of both performance and costs. Consumers would educate themselves and become informed buyers of health care services. Without group purchasers playing a major role, it would be up to the medical community to identify quality standards and best practices, and up to government or some other objective entity to monitor performance measurement and provide information for consumers.

This type of reform would be designed to include the development of internet-based tools that would allow consumers to identify the prices, credentials, experience, and performance records of providers. Under some proposals, individual buyers could actually use this information to design their own networks of providers. Web-based tools are being developed that could also compare health plans and physicians in ways that are tailored to consumers' particular medical conditions or problems. For example, the Pacific Business Group on Health has developed a computer assessment tool for consumers allowing them to view side-by-side comparisons of medical groups' experience treating specific diseases such as diabetes or hypertension.

Another premise of this strategy is that quality would be improved by the removal of managed care restrictions that have stood between doctors and their patients. Some proponents of this reform strategy assert that health status would be enhanced by giving patients unfettered access to health care providers. A national clearinghouse on quality, electronic medical records, and computer technologies described earlier could improve quality under these reforms as well.

Several specific design features could be built into this consumer-driven movement to facilitate actual improvements in health care quality.

First, the new consumer-driven health plans that feature personal care

[8] See, for example, Tom Miller, "Improving Access to Health Care without Comprehensive Health Insurance Coverage: Incentives, Competition, Choice, and Priorities." In Jack A. Meyer and Elliot K. Wicks. *Covering America: Real Remedies for the Uninsured: Vol. 2*. Economic and Social Research Institute. 2002.

accounts,[9] health insurance coverage for major medical expenses, and an array of web-based information and decision support tools could be designed to give consumers an incentive to economize on the use of discretionary health services without discouraging the use of essential services. For example, the consumer-driven health plans are supposed to convert today's medical benefits model featuring generous front-end coverage into a true insurance model under which consumers pay most of the cost of routine medical bills. But an exception could be made for cost-effective health services such as screening to detect diseases and preventive care. Second, the insurance component of these new plans could kick in just above the amount of the personal care account so that consumers are not left with a large gap between cash and coverage. Third, some of the essential features of a good care management model could be retained, such as centers of excellence for advanced medical procedures, financial incentives to use higher-quality providers, and disease management programs for people with chronic illness and disability. Another useful feature would be to help ensure that patients have access to the Internet and that reliable disease management and prevention information is appropriately positioned within web sites to give patients user-friendly and medically sound information.

Reforms that Establish National Health Systems

Some health reform proposals would essentially establish a national health plan, such as expanding Medicare to the entire population.[10] Nearly all of the quality improvement strategies outlined earlier could also be applied to a national health plan. Investments in information technology, a national clearinghouse of clinical data and best practices, the development of quality standards and indicators, and measurement and dissemination of performance comparisons can improve quality of health care under a national health plan as under other reform scenarios.

Further, financial incentives are not incompatible with national health plans and could be used to improve quality. Payments to providers by a "single payer" or multiple public payers, for example, could be tied to adherence to best practices and eventually to performance, if adequate case-mix adjusters are developed.

In fact, the limited number of payers under national health plans means that those payers have considerable leverage to drive quality improvement. In this respect, it can be argued that national health systems are even more conducive than private group-based or individual-based reform plans to establishing common electronic information systems and requiring providers to meet quality standards and report outcomes.

An entity modeled after the Securities and Exchange Commission, described above, could be an important design feature of a national health plan as well. This entity could set national quality goals, monitor performance and the dissemination of comparative data, establish the national standard benefit plan, and conduct other QI-related functions.

Conclusion

Incorporating quality improvement into major coverage expansion proposals, or even building onto our current system, involves many choices and considerations. Purchasing entities—whether they are employers, government, individuals, or insurance exchanges—can promote quality improvement as they buy health coverage for various populations. The strategies outlined above require reform designers to make choices about investing in information technology and creating an integrated clinical data support system; measuring, comparing, and publicizing provider/health plan performance; structuring incentives to foster accountability; and pooling purchasing power to exert leverage on the delivery system.

These issues present challenges to policymakers as they try to improve the U.S. health care system. Whether pursuing major coverage expansions such as the *Covering America* proposals, or promoting incremental reforms to our current system, a careful, systematic consideration of how to incorporate quality improvement is vital. ■

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[9] Personal care accounts are cash accounts for employees that are solely funded by employers and usable only for qualified medical expenses. Unused cash balances can be carried forward from one year to the next without tax penalty.

[10] See, for example, James A. Morone, "Medicare for All." in Meyer and Wicks, vol. 2, op. cit.