

Obamacare's enormous administrative and regulatory costs imposed on Americans far outweigh its benefits.



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What Are We Getting for Our Obamacare Dollars?

The architects of Obamacare promised a U.S. health care revolution that would control costs, improve quality, and provide coverage for all. They guaranteed access to health care regardless of income or health status. They promised that coverage for all would reduce costs by preventing disease. After more than eight years, Obamacare has failed to make good on its promises. Thanks to its poor design, it continues to increase health care costs, degrade health care quality, and weaken the market for private coverage. This Brief Analysis identifies the Obamacare promises and describes how they have been broken.

Broken Promise: Insuring the Uninsured with Private Insurance.

If Obamacare means anything it means making private health insurance more affordable and more accessible. For low-income families, the federal government has been providing generous subsidies. As of 2016, no low-income family must spend more than 8.16% of its income on health coverage.

But Obamacare also outlawed charging health insurance premiums that were based on the size of health expenses an individual was likely to incur in the future. It thus effectively outlawed health insurance, an arrangement in which individuals pay a third party to assume the risk that their health will decline and they will need expensive medical care.

Instead, Obamacare required that Americans buy health coverage and that companies offering health coverage issue a policy to anyone willing to pay for it. To make things

worse, companies offering coverage cannot charge a different price to two people of the same age, sex, smoking status, and residential zip code even if one of them has a chronic disease that costs tens of thousands a year to treat. This makes premiums go up because people in good health have little incentive to purchase a policy until they get sick, and people who are sick have a strong incentive to buy an expensive policy.

How well has it worked? Not well.

In the U.S., people are covered by a variety of health arrangements. People in the military, the Veteran's Administration, Medicaid, and Medicare are covered by government-run programs. Most people of working age have private coverage either through direct purchase of an individual policy or through an employer group health plan. One of the major goals of Obamacare was to reduce

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the percentage of people without coverage, preferably by increasing the purchase of private plans through the health benefits exchanges that the law created.

Unfortunately, eight years after Barack Obama was elected president, the percentage of people with private coverage was lower in 2016 (69%), than it was in 2008 (69.6%). During recessions, people tend to drop coverage to conserve cash. The Great Recession lasted from December 2007 through June 2009. After five years of economic growth and higher employment, one would expect more people to have coverage in 2016 than in 2008, and the number of people with health insurance would almost certainly have inched back up to its pre-recession level without Obamacare.

The coverage numbers don't look much better even if we start counting from 2014, the year health insurance became mandatory. Although private individual coverage grew by 5.3 million from 2014 through 2016, private coverage in the employer market fell by 3.6 million. As a result, Obamacare witnessed a net increase in private coverage of a mere 1.7 million people – slightly less than half of the natural increase in the civilian labor force¹.

Even if we give Obamacare credit for every bit of the increase since 2014, we have paid a heavy

price for that gain. Not counting the money spent on setting up and operating the state and federal exchanges, the federal government spent \$341 billion subsidizing individual coverage during this period. That's \$200,000 per newly insured person, or almost \$70,000 per person per year.

Broken Promise: Caring for the Needy through Medicaid

The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary estimates the federal government spent \$148.2 billion from 2014 through 2016 on Medicaid expansion. Although the forecasted cost was just \$3,500 per enrollee,² the actual cost was almost \$6,000. Even at that, it looks as though taxpayers got a lot more for their money from Medicaid than from Obamacare subsidies for private coverage.

The people in the expanded Medicaid population tended to be less expensive than the people already enrolled in Medicaid. People with chronic illnesses or disabilities were often already enrolled through SSI or another disability pathway.³ Those who were already eligible for Medicaid, but had not signed up until the publicity and outreach surrounding the individual mandate encouraged them to do so, also tended to be lower cost.⁴ In 2012, of the children who were without health coverage, an estimated

¹Federal Reserve Economic Data (FRED). Civilian Labor Force. CBO actuals and estimated spending (2017) for federal subsidies through exchanges. <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53094-underlyingdata.xlsx> referenced in <https://www.cbo.gov/publication/53094>; Edmund F. Haislmaier and Drew Gonshorowski, "2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed." Issue Brief (Washington, D.C: Heritage Foundation, July 26, 2017), http://www.heritage.org/sites/default/files/2017-07/IB4743_0.pdf.

²Jonathan Ingram and Nic Horton. February 1, 2018. A Budget Crisis in Three Parts: How ObamaCare is Bankrupting Taxpayers. Naples, Florida. Foundation for Government Accountability, <https://thefga.org/wp-content/uploads/2018/02/A-Budget-Crisis-In-Three-Parts-2-6-18.pdf>, accessed June 17, 2018.

³John Holahan, Genevieve Kenney, and Jennifer Pelletier. August 2010. The Health Status of New Medicaid Enrollees Under Health Reform. Timely Analysis of Immediate Health Policy Issues, Urban Institute, Washington, DC. <https://www.issuelab.org/resources/7301/7301.pdf> accessed July 4, 2018.

⁴Amy Davidoff, Bowen Garrett, and Alshadye Yemane. October, 2001. Medicaid-Eligible Adults Who Are Not Enrolled: Who Are They and Do They Get the Care They Need? New Federalism, Issues and Options for States, The Urban Institute, Series A, No. 1-48.



68 percent were eligible for Medicaid or CHIP but had not signed up.⁵ Results from the 1997 National Health Interview Survey suggested that just 51 percent of the adults eligible for Medicaid had enrolled in it. Because they were generally healthy, they needed relatively little medical care.

One reason Medicaid expansion costs were higher than expected is that when Obamacare expanded Medicaid, most of the newly enrolled able-bodied adults were enrolled in a managed care program rather than traditional Medicaid.⁶ In traditional Medicaid, people do not generate spending unless they get medical care. In Medicaid managed care, managed care contractors receive monthly payments even if enrollees receive no care.⁷

Together—pushing healthy people whose annual income was below certain levels into Medicaid and encouraging states to pay managed care organizations monthly payments regardless of service use—these elements of Obamacare likely increased the amount Medicaid spends on healthy people.

Medicaid money spent on healthy people is

money that could otherwise have been available to people with serious needs. In 2016, there were [423,735 intellectually or developmentally disabled people](#) on waiting lists⁸ for home and community based services in the 47 states⁹ with 1915 (c) waivers. The people on the waiting lists generally have severe intellectual disabilities, severe developmental disabilities, or are victims of traumatic brain and spinal cord injuries. To live outside of an institution with their families they need a variety of services including home health aides, adult day care, respite care for family caregivers, and homemaker services.

Although federal law forbids Medicaid waiting lists for institutionalization, it allows states with 1915(c) waivers to use waiting lists to limit home and community-based services for people who would otherwise be eligible for immediate institutionalization. Absent an emergency, like the death of a parental caregiver, families trying to avoid institutionalizing a loved one often wait years for help, doing their best to provide needed care without Medicaid's help.¹⁰

Rather than finding funds to pay for services for

⁵Genevieve M. Kenney et al., “Children Eligible for Medicaid or CHIP: Who Remains Uninsured, and Why?” *Academic Pediatrics* 15, no. 3 (May 2015): S36–43, <https://doi.org/10.1016/j.acap.2015.01.009>.

⁶Office of the Actuary, Centers for Medicare and Medicaid Services. 2016. 2016 Actuarial Report on the Financial Outlook for Medicaid, pp. 27-28. <https://www.medicare.gov/medicaid/finance/downloads/medicaid-actuarial-report-2016.pdf>.

⁷Although Medicaid managed care was promoted as a money-saving reform, the evidence suggests that it has failed to reduce expenditures in many states. It has a mixed effect on the quality of care and access to it. One reason may be that higher administrative costs outweigh any savings from lower health care utilization. Another is that capitated payments create an incentive to skimp on expensive procedures. See Medicaid and CHIP Payment and Access Commission. *Managed Care's Effect on Outcomes*, <https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/>, accessed June 17, 2018, and Mark Duggan. 2017. “The Impact of Contracting Out on Medicare and Medicaid,” NBER Reporter, National Bureau of Economic Research, Cambridge, MA. Issue 1, pp. 21-24.

⁸Kaiser Family Foundation. *Waiting List Enrollment for Medicaid Section 1519(c) Home and Community-Based Services Waivers*, 2016. <https://www.kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>, accessed July 4, 2018.

⁹Molly O'Malley Watts and MaryBeth Musumeci. January 19, 2018. *Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies*. Kaiser Family Foundation. <https://www.kff.org/report-section/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies-report/>, accessed July 4, 2018.

¹⁰Carol Beatty. “Implementing Olmstead by Outlawing Waiting Lists,” *Tulsa Law Review*, 43, 3 (Spring 2014).

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profoundly disabled people who needed help, the Obama administration chose to defray 90 percent of states' costs of enrolling able-bodied, working-age, adults in Medicaid. Expanding Medicaid to this group cost \$148 billion from 2014 through 2016, money that could have been used to reduce the waiting lists for care for the disabled.¹¹

Broken Promise: Making Health Care Delivery More Efficient

According to Donald Berwick, a former administrator of the Centers for Medicare and Medicaid Services (CMS) and an able representative of the intellectual cadre of thought behind Obamacare, the lack of central planning creates a great deal of waste in U.S. health care. Because “no single group of participants—physicians, hospitals public or private payers, or employers—takes full responsibility for guiding the health of a patient or community, care is distributed across many sites, and integration among them may be deficient. Fragmentation leads to waste and duplication—and unnecessarily high costs,” he writes.¹²

U.S. medicine has generally paid individuals and organizations who provide medical services a fee for each service rendered. Berwick and his colleagues sought to do away with fee-for-service payments and transform the U.S. medical system to one in which payers provided fixed (capitated) payments designed to cover all the estimated cost of care.¹³ Their idea: providers providing too much care would have an incentive to root out services of low value. Payments linked to a variety of quality measures would lower costs by moving “the system” from one that focused on volume to one that focused on value.¹⁴

Yet studies show that when payments for services rendered increase, providers both provide more services and respond by adjusting the mix and intensity of the services they provide.¹⁵ Studies also show that more intensive hospital care reduces mortality,¹⁶ that fee-for-service payment reduces provider incentives to inappropriately skimp on care, and that many of the results showing lower expenditures in capitated care systems result from favorable patient selection and disenrollment rather than

¹¹Office of the Actuary, Centers for Medicare and Medicaid Services. 2016. 2016 Actuarial Report on the Financial Outlook for Medicaid, p. 28. <https://www.medicaid.gov/medicaid/finance/downloads/medicaid-actuarial-report-2016.pdf>.

¹²Donald M. Berwick. “Launching Accountable Care Organizations—The Proposed Rule for the Medicare Shared Savings Program,” *New England Journal of Medicine*, 364 (2011), e32. <https://www.nejm.org/doi/full/10.1056/NEJMp1103602>, accessed June 19, 2018.

¹³Ezekiel Emanuel et al., “A Systemic Approach to Containing Health Care Spending,” *New England Journal of Medicine* 367, no. 10 (September 6, 2012): 949–54, <https://doi.org/10.1056/NEJMs1205901>.

¹⁴For a sample of the current discussion on value based care and health care costs see Lia Winfield et al., “What’s Driving Health Care Costs?,” *Health Affairs* (blog), June 27, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180625.872430/full/>.

¹⁵See, for example, Marie Allard, Izabela Jelovac, and Pierre Thomas Léger, “Treatment and Referral Decisions under Different Physician Payment Mechanisms,” *Journal of Health Economics* 30, no. 5 (September 2011): 880–93. <https://doi.org/10.1016/j.jhealeco.2011.05.016>; Toby Gosden et al., “Capitation, Salary, Fee-for-Service and Mixed Systems of Payment: Effects on the Behaviour of Primary Care Physicians” in *Cochrane Database of Systematic Reviews*, ed. The Cochrane Collaboration (Chichester, UK: John Wiley & Sons, Ltd, 2000), <http://doi.wiley.com/10.1002/14651858.CD002215>; Jack Hadley et al., “Medicare Fees and the Volume of Physicians’ Services,” *Inquiry* 46, no. 4 (December 2009): 372–90, <https://doi.org/10.5034/inquiryjrnl.46.4.372>.

¹⁶Joseph Doyle et al., “Do High-Cost Hospitals Deliver Better Care? Evidence from Ambulance Referral Patterns” (Cambridge, MA: National Bureau of Economic Research, March 2012), <http://www.nber.org/papers/w17936.pdf>.



from improved efficiency.¹⁷ In other words, in spite of “no consistent evidence that any one system of care has been more effective at minimizing the overuse of health care services,”¹⁸ Obamacare theorists simply asserted that fee-for-service medicine encourages self-interested behavior by physicians, resulting in “wasteful use of high cost tests and procedures.”

In fact, the ideas behind Obamacare reforms were virtually the same as the ideas that drove the growth of Health Maintenance Organizations (HMOs) in the 1990s. While the move to HMOs may have fostered a one-time reduction in expenditures, there is little evidence that HMOs reduced costs or improved quality over the long term. According to Burns and Pauly, “the primary vehicles for cost containment were lower payment to providers...and saying no to patients.”¹⁹

To paper over the fact that their assertions had little empirical support, the Obamacare architects invented new names for old concepts. Their HMOs were called Accountable Care Organizations (ACO), and experiments with ACOs were made part of the Medicare program. Even though ACOs aspired to be like HMOs and faced economic incentives similar to Medicare Advantage plans, the administration could claim they were new and different.

In effect, the Obamacare system transformation experiments were little more than attempts to reproduce the centrally managed health care delivery forms that were rejected by the private sector in the 1990s. The difference is that the experiments in the 1990s were stopped when people refused to enroll in the HMO plans

that blocked access to the care they needed. The people stuck in Obamacare ACOs had no alternative to Medicare and could not leave the system forced upon them. Patients are almost never aware they have been enrolled in an ACO, and they are not informed they are getting medical advice from a provider entity that receives a financial reward for reducing their health care use.

Beginning in 2012, Medicare started experiments with three waves of ACOs. The original Pioneer ACO program became the Medicare Shared Savings Program with the Advanced Payment program for rural ACO providers. When a health care organization volunteered to participate as an ACO, Medicare patients were “aligned” with an ACO based on the proportion of certain types of care they received from ACO-participating providers. As physicians left or joined ACO networks, many of their patients went with them. The Centers for Medicare and Medicaid Services (CMS) decided to measure ACO performance against a comparison group of “similar” patients chosen by algorithms.

In general, only a small percentage of each physician’s patients are in an ACO because most physicians treat both privately insured patients and Medicare patients. About 500,000 beneficiaries are assigned to an ACO in any given year. A roughly similar number of people who have at least one visit with an ACO provider are assigned to “spillover” groups.

In the Pioneer program, the algorithms assign patients to a primary care provider based on visit patterns. But patients often see different

¹⁸Salomeh Keyhani et al., “Overuse and Systems of Care: A Systematic Review,” *Medical Care* 51, no. 6 (June 2013): 503, <https://doi.org/10.1097/MLR.0b013e31828dbafe>.

¹⁹Lawton R. Burns and Mark V. Pauly, “Transformation of the Health Care Industry: Curb Your Enthusiasm?” *The Milbank Quarterly* 96, no. 1 (March 2018): 57–109, <https://doi.org/10.1111/1468-0009.12312>

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doctors, and their visit patterns can change with their health. In one New England Pioneer ACO, only 45 percent of the beneficiaries originally assigned to the ACO were connected to it in each of the two succeeding years. On average, only about 30 percent of beneficiaries who were ever assigned to a Pioneer ACO were continuously connected to it.²⁰ The fluid patient population makes it difficult to design programs for specific patients, difficult to attribute improved health to any particular physician, and impossible to attribute any cost savings to any particular care model.²¹

To date, the results from structural experiments designed to transform U.S. health care with ACOs and new payments systems have been unimpressive. Relatively small reductions in annual patient costs have been offset by high administrative costs in enhanced primary care programs.²² When bonuses are accounted for, ACOs as a group actually increased Medicare spending.²³ About half of the ACOs reduced spending, but only 30 percent reduced expenditures enough to earn a share of Medicare's savings. Performance on quality measures was variable, and Leavitt Partners reported that measured ACO quality was unrelated to either spending or savings.²⁴

Only about one-third of the physicians involved participated in the program for all three years. By the end of the Pioneer program in 2016, 23 of the 32 original ACOs had dropped out, and Cornerstone Health Care, "one of the few ACOs that succeeded in achieving both higher quality and lower cost compared to its peers," had ceased operation as "an independent entity" due to the amount of personal debt physicians took on to finance its infrastructure.²⁵

Broken Promise: Paying for Value

Obamacare's quality reporting requirements rapidly increased hospital and physician administrative workloads. In 2016, Casalino et al. estimated that physicians in four types of practices spent 15.1 hours a week on reporting for quality measures, at an estimated cost of \$15 billion a year.²⁶ The number of quality measures had exploded. By 2015, there were "nearly 1,700 measures in use by CMS programs," the National Quality Forum's measure database had 630 measures, and the Healthcare Effectiveness Data and Information Set measures for coverage plans had 81 different measures.²⁷

Virtually all published studies on the value of Obamacare quality measurement ignore whether the quality gains would have occurred anyway,

²⁰L&M Policy Research, LLC, "Evaluation of CMMI Accountable Care Organization Initiatives, Pioneer ACO Final Report," December 2, 2016, 29, <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf>.

²¹John Hsu et al., "Patient Population Loss At A Large Pioneer Accountable Care Organization And Implications For Refining The Program," *Health Affairs* 35, no. 3 (March 2016): 422–30, <https://doi.org/10.1377/hlthaff.2015.0805>.

²²<https://khn.org/news/mixed-results-for-obamacare-tests-in-primary-care-innovation/>.

²³James C. Capretta. May 11, 2017. "Replacing Medicare ACOs with a Better Integrated Care Option. Mercatus on Policy. <https://www.mercatus.org/publications/replacing-medicare-acos-better-integrated-care-option>.

²⁴L&M Policy Research, LLC, "Evaluation of CMMI Accountable Care Organization Initiatives, Pioneer ACO Final Report."

²⁵Burns and Pauly, "Transformation of the Health Care Industry," 80.

²⁶Lawrence P. Casalino et al., "US Physician Practices Spend More Than \$15.4 Billion Annually To Report Quality Measures," *Health Affairs* 35, no. 3 (March 2016): 401–6, <https://doi.org/10.1377/hlthaff.2015.1258>.

²⁷Vital Signs: Core Metrics for Health and Health Care Progress (Washington, D.C.: National Academies Press, 2015), 6, <https://doi.org/10.17226/19402>.



and whether the gains in quality are worth their substantial costs. These issues are important as careful analysis of prior attempts at quality measurement suggest their costs may well outweigh their benefits. The high hopes for the effect of quality measurement in the late 1990s were dashed when the 2003 Medicare Premier Hospital Quality Incentive Demonstration found that even with 34 quality indicators for hospital care, the “small increases in quality of care” would have occurred “in the absence of the demonstration.”²⁸

Medicare’s hospital readmission policy is an example of how measures that seem reasonable on the surface can have unintended consequences. We know that sicker people with more functional impairments are more likely to need readmission to a hospital within 30 days of their initial discharge. Using readmissions as a quality measure makes it more likely that hospitals who tend to care for the aged or very ill will be penalized.²⁹ The readmissions quality measure may also penalize hospitals that admit patients with lower socioeconomic status. Though authorities claimed that readmission quality measures could be risk-adjusted, it was known at the time Obamacare passed that most risk prediction models for avoidable readmission had “poor predictive power.” Kasahara et al. reviewed prediction models for hospital readmission in *JAMA* in 2011 and concluded:

Use of readmission rates as a quality metric assumes that readmissions are related to poor quality care and are potentially preventable. However, the preventability of readmissions remains unclear and understudied. We found only 1 validated prediction model that explicitly examined potentially preventable readmissions as an outcome, and it found that only about one-quarter of readmissions were clearly preventable.³⁰

Plus, people can only be readmitted to a hospital if they are alive at discharge. Measuring readmission without taking inpatient fatalities into account and coupling it to hospital payments can bias hospital quality rankings and do financial harm to good hospitals.

Because the Obamacare readmission quality measure does not account for the possible effect of high inpatient mortality on readmissions, lower quality hospitals with higher inpatient mortality due to “high rates of failure to rescue may discharge fewer sick patients, and these patients may be less likely to be readmitted. Using the current readmission metric, these high-mortality hospitals may ‘appear’ to be delivering high-quality care because they have fewer readmissions.”³¹ Worse, there is some evidence that although Medicare’s Hospital Readmission Reduction Program did reduce readmissions, its introduction coincided with an increase in the observed 30-day risk-adjusted mortality rate for

²⁸Kathryn Nix. November 20, 2013. What Obamacare’s Pay-For-Performance Programs Mean for Health Care Quality. The Heritage Foundation, Washington, DC. https://www.heritage.org/health-care-reform/report/what-obamacares-pay-performance-programs-mean-health-care-quality#_ftn9, accessed June 21, 2018.

²⁹For a description of how the Obamacare statute linked quality measures to payments see Foley & Lardner LLP. May 21, 2010. PPACA Will Drive Quality Health Care Reform. <https://www.foley.com/ppaca-will-drive-quality-health-care-reform-05-21-2010/>, accessed June 21, 2018.

³⁰Devan Kansagara et al., “Risk Prediction Models for Hospital Readmission: A Systematic Review,” *JAMA* 306, no. 15 (October 19, 2011): 1696, <https://doi.org/10.1001/jama.2011.1515>.

³¹Laurent G. Gance, Yue Li, and Andrew W. Dick, “Impact on Hospital Ranking of Basing Readmission Measures on a Composite Endpoint of Death or Readmission versus Readmissions Alone,” *BMC Health Services Research* 17, no. 1 (December 2017), <https://doi.org/10.1186/s12913-017-2266-4>.

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heart failure patients, an increase that occurred after a decade of decline.³²

Despite the well-documented problems with existing quality measurements, the 2015 Medicare And CHIP Reauthorization Act (MACRA) will put up to 9 percent of a physician practice's Medicare Part B [fee-for-service revenue at risk](#) for failing to meet Merit Based Incentive Payment System (MIPS) standards.³³ MACRA requires budget-neutral MIPS bonuses. This means that bonuses cannot increase total expenditure and penalties cannot reduce it. As a result, some physicians will be penalized even if all physicians improve on a given year's quality metrics. The budget neutrality requirement holds even although another section of MACRA appropriates \$500 million a year to a slush fund for distribution to MIPS providers with "exceptional performance."³⁴

Broken Promise: Electronic Medical Records

The 2009 Health Information Technology for Economic and Clinical Health Act (HITECH) authorized \$30 billion in financial incentives to encourage the adoption and "meaningful use" of electronic health records in everything from large

teaching hospitals to solo practices.³⁵ Physicians who were eligible for the Medicare incentive program and did not adopt an electronic health records system by 2015 were to be penalized 1 percent of Medicare payments in 2015, 3 percent in the following 3 years, and 5 percent in later years.³⁶

The U.S. health system was already using electronic health records where it made sense, and the technology was not well enough developed for many of the uses Obamacare architects envisioned. Thanks to the HITECH meaningful use requirements, doctors and hospitals were forced to adopt immature, difficult to use, and unproductive electronic medical records software.³⁷ In 2013, just four years after HITECH became law, the "meaningful use" requirements for electronic health records were routinely singled out as a primary cause of physician dissatisfaction.³⁸

Shanafelt et al. reported that the computerized order entry required by the meaningful use requirements was associated with a higher risk of physician burnout in a nationwide survey of physicians. By 2016, Sinsky et al. found that

³²Gregg C. Fonarow, Marvin A. Konstam, and Clyde W. Yancy, "The Hospital Readmission Reduction Program Is Associated With Fewer Readmissions, More Deaths," *Journal of the American College of Cardiology* 70, no. 15 (October 2017): 1931–34, <https://doi.org/10.1016/j.jacc.2017.08.046>.

³³Kavita Patel, Loren Adler, Margaret Darling, Paul B. Ginsburg, and Steven M. Lieberman. July 12, 2016. How the Money Flows under MACRA. Report of the Leonard D. Schaeffer Initiative for Innovation in Health Policy, Brookings Institution, Washington, DC, <https://www.brookings.edu/research/how-the-money-flows-under-macra/>, accessed July 5, 2018.

³⁴Kavita Patel, Loren Adler, Margaret Darling, Paul B. Ginsburg, and Steven M. Lieberman. July 12, 2016. How the Money Flows Under MACRA. Brookings Institution, Washington DC, <https://www.brookings.edu/research/how-the-money-flows-under-macra/>, accessed July 5, 2018.

³⁵Michael L. Marlow, "Should Government Subsidize Electronic Health Records?" Mercatus Working Paper (Arlington, Virginia: Mercatus Center at George Mason University, March 2017), 4, <https://www.mercatus.org/system/files/mercatus-marlow-health-records-v2.pdf>.

³⁶Stephen T. Mennemeyer et al., "Impact of the HITECH Act on Physicians' Adoption of Electronic Health Records," *Journal of the American Medical Informatics Association* 23, no. 2 (March 2016): 375–79, <https://doi.org/10.1093/jamia/ocv103>.

³⁷Lisa Rosenbaum, "Transitional Chaos or Enduring Harm? The EHR and the Disruption of Medicine," *New England Journal of Medicine* 373, no. 17 (October 22, 2015): 1585–88, <https://doi.org/10.1056/NEJMp1509961>.

³⁸See, for example, Mark W. Friedberg et al., "Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy," *Rand Health Quarterly* 3, no. 4 (2014): 1.



physicians providing ambulatory care in 4 specialties spent almost 2 hours working on electronic health records and other desk work for every hour of direct clinical face time with patients. In 2017, Arndt et al. reported similar results for primary care physicians.³⁹ The American College of Physicians issued a position paper entitled “Putting Patients First by Reducing Administrative Tasks in Health Care.”⁴⁰ Wachter, Rosenbaum, and others have vividly described how poorly electronic systems interface with physician work flows.⁴¹

Dranove et al. estimate that the cost of generating additional adoption of electronic records by a hospital was \$48 million, and that the same number of hospitals would have adopted electronic records without HITECH just two years later.⁴² Mennemeyer et al. reached a similar conclusion in 2015, finding at best “weak evidence” that HITECH meaningful use requirements increased electronic health record uptake.

At present, CMS estimates that more generous exemptions for practices treating low numbers

of Medicare patients result in just 37 percent of [clinicians being required to participate](#).⁴³ Unfortunately, those who are required to participate face payment penalties of up to 2 percent if they do not file proper reports and they are burdened with keeping up with annual rule changes, some of which are over 1,000 pages long.

In 2017, even the American Medical Association, long a dogged supporter of the Affordable Care Act, called on CMS to “address the lack of actionable data for patient care; convoluted workflows that take time away from patients; and long hours added to difficult clinical days just to complete quality reporting and documentation requirements.”⁴⁴

Despite the lavish spending there is [surprisingly little evidence](#) that current health information technology either improves patient care or lowers health care costs.⁴⁵ Early evidence suggested that hospitals adopting health information technology had slightly higher charges with little change in the quality of care they delivered.⁴⁶ Some studies found a

³⁹Brian G. Arndt et al., “Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations,” *The Annals of Family Medicine* 15, no. 5 (September 2017): 419–26, <https://doi.org/10.1370/afm.2121>.

⁴⁰Shari M. Erickson et al., “Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians,” *Annals of Internal Medicine* 166, no. 9 (May 2, 2017): 659, <https://doi.org/10.7326/M16-2697>. A rap video by a group called Doctors Be Doctors details the problems of EHRs in a less academic manner.

⁴¹Robert M. Wachter, *The Digital Doctor: Hope, Hype, and Harm at the Dawn of Medicine’s Computer Age*, Business Classics (New York: McGraw-Hill Education, 2017).

⁴²David Dranove et al., “Investment Subsidies and the Adoption of Electronic Medical Records in Hospitals,” *Journal of Health Economics* 44 (December 2015): 309–19, <https://doi.org/10.1016/j.jhealeco.2015.10.001>.

⁴³Andis Robeznieks. November 14, 2017. “2018 Another Transition Year for Quality Payment Program,” *AMA Wire*, <https://wire.ama-assn.org/practice-management/2018-another-transition-year-quality-payment-program>. Accessed July 5, 2018.]

⁴⁴American Medical Association, September 11, 2017. “Type & Click Tasks Drain Half the Primary Care Workday.” <https://www.ama-assn.org/type-click-tasks-drain-half-primary-care-workday>, accessed May 14, 2018.

⁴⁵Saurabh Rahurkar, Joshua R. Vest, and Nir Menachemi, “Despite The Spread Of Health Information Exchange, There Is Little Evidence Of Its Impact on Cost, Use, and Quality of Care,” *Health Affairs* 34, no. 3 (March 2015): 477–83, <https://doi.org/10.1377/hlthaff.2014.0729>.

⁴⁶Leila Agha, “The Effects of Health Information Technology on the Costs and Quality of Medical Care,” *Journal of Health Economics* 34 (March 2014): 19–30, <https://doi.org/10.1016/j.jhealeco.2013.12.005>.

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reduction in adverse drug events,⁴⁷ others found small reductions in mortality with no effect on adverse drug events.⁴⁸ Results on patient safety outcomes differ by setting and illness severity.⁴⁹ Two papers concluded that electronic medical records increase expenditures because they allow hospitals to document more diagnoses, increasing illness severity and the payments they receive.⁵⁰

Obamacare supporters defend meaningful use requirements by asserting that health information technology enables better care coordination. At present, only weak evidence supports this belief.⁵¹ A 2009 JAMA summary of 15 randomized trials of care coordination for Medicare patients with chronic illnesses found no

reductions in hospitalizations and no consistent cost savings or quality of care improvements.⁵²

Many advocates claim that electronic health records will improve treatment by letting researchers observe what works in very large patient populations. But the value of historical treatment records is limited because medical innovation rapidly makes past treatment guidelines obsolete. When [Chen et al.](#) reviewed all inpatient hospitalizations at Stanford University Hospital, they concluded that data older than 4 months was not particularly useful for describing current inpatient clinical decisions.⁵³ Research using electronic health records that limits a sample to “complete” records may also produce biased estimates. Weber et al. noted that the

⁴⁷Michael F Furukawa et al., “Meaningful Use of Health Information Technology and Declines in In-Hospital Adverse Drug Events,” *Journal of the American Medical Informatics Association* 24, no. 4 (July 2017): 729–36, <https://doi.org/10.1093/jamia/ocw183>.

⁴⁸Ryan M. McKenna, Debra Dwyer, and John A. Rizzo, “Is HIT a Hit? The Impact of Health Information Technology on Inpatient Hospital Outcomes,” *Applied Economics* 50, no. 27 (June 9, 2018): 3016–28, <https://doi.org/10.1080/00036846.2017.1414934>.

⁴⁹See Samantha K Brenner et al., “Effects of Health Information Technology on Patient Outcomes: A Systematic Review,” *Journal of the American Medical Informatics Association* 23, no. 5 (September 2016): 1016–36, <https://doi.org/10.1093/jamia/ocv138>. and Julian Varghese et al., “Effects of Computerized Decision Support System Implementations on Patient Outcomes in Inpatient Care: A Systematic Review,” *Journal of the American Medical Informatics Association* 25, no. 5 (May 1, 2018): 593–602, <https://doi.org/10.1093/jamia/ocx100>.

⁵⁰Bingyang Li, “Cracking the Codes: Do Electronic Medical Records Facilitate Hospital Revenue Enhancement?” (Kellogg School of Management, Northwestern University, January 18, 2014), www.kellogg.northwestern.edu/faculty/b-li/JMP.pdf; Gautam Gowrisankaran, Keith Joiner, and Jianjing Lin, “Does Health IT Adoption Lead to Better Information or Worse Incentives?” (Cambridge, MA: National Bureau of Economic Research, December 2016), <https://doi.org/10.3386/w22873>; M. H. Reckmann et al., “Does Computerized Provider Order Entry Reduce Prescribing Errors for Hospital Inpatients? A Systematic Review,” *Journal of the American Medical Informatics Association* 16, no. 5 (September 1, 2009): 613–23, <https://doi.org/10.1197/jamia.M3050>; Zilma Silveira Nogueira Reis et al., “Is There Evidence of Cost Benefits of Electronic Medical Records, Standards, or Interoperability in Hospital Information Systems? Overview of Systematic Reviews,” *JMIR Medical Informatics* 5, no. 3 (August 29, 2017): e26, <https://doi.org/10.2196/medinform.7400>.

⁵¹Rahurkar, Vest, and Menachemi, “Despite The Spread of Health Information Exchange, There Is Little Evidence of Its Impact on Cost, Use, and Quality Of Care”; Andrew Georgiou et al., “The Effect of Computerized Provider Order Entry Systems on Clinical Care and Work Processes in Emergency Departments: A Systematic Review of the Quantitative Literature,” *Annals of Emergency Medicine* 61, no. 6 (June 2013): 644–653.e16, <https://doi.org/10.1016/j.annemergmed.2013.01.028>; E. Coiera, J. Ash, and M. Berg, “The Unintended Consequences of Health Information Technology Revisited:,” *IMIA Yearbook*, no. 1 (2016): 163–69, <https://doi.org/10.15265/IY-2016-014>.

⁵²Deborah Peikes et al., “Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries: 15 Randomized Trials,” *JAMA* 301, no. 6 (February 11, 2009): 603, <https://doi.org/10.1001/jama.2009.126>.

⁵³Jonathan H. Chen et al., “Decaying Relevance of Clinical Data towards Future Decisions in Data-Driven Inpatient Clinical Order Sets,” *International Journal of Medical Informatics* 102 (June 2017): 71–79, <https://doi.org/10.1016/j.ijmedinf.2017.03.006>.



same patient could be treated at multiple institutions with the result that data from a single site or system might miss critical events, and that commonly used data filters tended to select people who were older and more likely female than the population in their claims dataset of 7 million people.⁵⁴

Broken Promise: Patient Privacy

Medical records contain more detailed information than credit card records or Social Security numbers. This makes it easier to falsify an identity that can be used to purchase goods and services, establish and use credit, or get medical care by impersonating someone else. An FBI private industry notification notice informed readers that stolen Social Security or credit card numbers sold for less than \$1 in 2013, while even partial electronic health records were worth \$50.⁵⁵ According to a [2017 Accenture survey](#), half of those who have had their records stolen ended up as victims of medical identity theft. Of the identity theft victims, 37 percent of people had their stolen identity used to purchase items, 35 percent were fraudulently billed for health care, 26 percent had their identities used by others who were fraudulently receiving health care, and 26 percent of people had their IDs used to fill fraudulent prescriptions.⁵⁶

The Obamacare claim that data in electronic health records would be secure has turned out to be an empty promise. In [2015](#), more than 100 million patient records were stolen.⁵⁷ There are

few laws limiting individual exposure to losses stemming from medical identity fraud, and there have already been cases in which electronic patient records contain serious errors—in one case a patient record claimed a pacemaker had been installed even though the actual person was pacemaker free. When identity fraud corrupts an individual's electronic health record by adding treatments that the patient described in the record never received, it can result in delays, misdiagnosis, and mistreatment.

In recent years, criminals have shown an interest in holding electronic records systems for ransom. In a ransomware attack, a cyber attacker injects malware into a health system's computers. The malware encrypts files, blocking access to information in the system. Though hackers promise that access will be restored if a ransom is paid, generally in untraceable Bitcoin, some attackers demand more money after the target capitulates to the first demand. The serious disruption in operations often has bad repercussions for health systems and their patients.

In February 2016, Hollywood Presbyterian Medical Center suffered an attack. It agreed to pay \$17,000 for the encryption key needed to unlock its records. In March 2016, MedStar Health in Washington DC and Maryland was infected with SamSam ransomware. To keep SamSam from spreading, hospital officials shut down the email and electronic records systems. Operations

⁵⁴Griffin M Weber et al., "Biases Introduced by Filtering Electronic Health Records for Patients with 'Complete Data,'" *Journal of the American Medical Informatics Association* 24, no. 6 (November 1, 2017): 1134–41, <https://doi.org/10.1093/jamia/ocx071>.

⁵⁵Federal Bureau of Investigation, Cyber Division. April 8, 2014. Health Care Systems and Medical Devices at Risk for Increased Cyber Intrusions for Financial Gain. Private industry notification, CYD-CC-1674. <https://info.publicintellgence.net/FBI-HealthCareCyberIntrusions.pdf>.

⁵⁶Accenture Consulting. 2017. Digital Trust. https://www.accenture.com/t20171218T064302Z_w_us-en/_acnmedia/PDF-43/Accenture-Health-Are-You-One-Breach-Away-From-Losing-a-Healthcare-Consumer.pdf#zoom=50.

⁵⁷Nate Lord. June 25, 2018. Top 10 Biggest Healthcare Data Breaches of All Time. *DigitalGuardian.com*, accessed July 5, 2018.

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across its 10 hospitals and 250 outpatient facilities were halted, and the hospital switched to a paper backup system. Operations were restored using system backups.⁵⁸

In May 2017, 80 of England's integrated National Health Service's 236 hospital trusts were either infected by the WannaCry ransomware or were forced to turn off their computers to prevent infection. Five hospitals closed their emergency departments, and tens of thousands of patient appointments were canceled.⁵⁹ In 2018, Allscripts, a U.S. electronic health record and practice management software provider, was infected with SamSam ransomware. Patient records, scheduling, billing, electronic prescribing, and prescribing for controlled substances were offline for 1,500 medical

practices for about a week.⁶⁰ Earlier, SamSam had closed Hancock Health's hospital in Greenfield, Indiana. It elected to pay a four-bitcoin ransom worth about \$55,000.⁶¹

Conclusion

Obamacare has imposed enormous administrative and regulatory costs on U.S. citizens. The costs of its brute force interventions outweigh their benefits. It is long past time for sober reflection on the size of its overall benefits compared to its total costs, including the many ways in which it skews investments in patient care, limits the kind of health coverage people want to buy, reduces the productivity of physicians and hospitals, and encourages practitioners to avoid providing medical care to high-risk patients.

⁵⁸Kyle Murphy. March 29, 2016. "Ransomware Leads to HER Downtime at DC-Area Health System," EHRIntelligence, <https://ehrintelligence.com/news/ransomware-leads-to-ehr-downtime-at-dc-area-health-system>, accessed June 18, 2018.

⁵⁹United Kingdom National Audit Office, Department of Health. April 24, 2018. Investigation: WannaCry Cyber Attack and the NH, <https://www.nao.org.uk/report/investigation-wannacry-cyber-attack-and-the-nhs/>, accessed June 19, 2018.

⁶⁰Erica Teichert. January 26, 2018. "Allscripts Sued over Ransomware Attack That Downed System," Modern Healthcare, <http://www.modernhealthcare.com/article/20180126/NEWS/180129909>, accessed January 26, 2018.

⁶¹Heather Landi. January 16, 2018. "Hancock Health Hit with Ransomware Attack, Pays \$55K to Recover Data," Healthcare Informatics, <https://www.healthcare-informatics.com/news-item/cybersecurity/hancock-health-hit-ransomware-attack-pays-55k-recover-data>, accessed June 19, 2018.



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