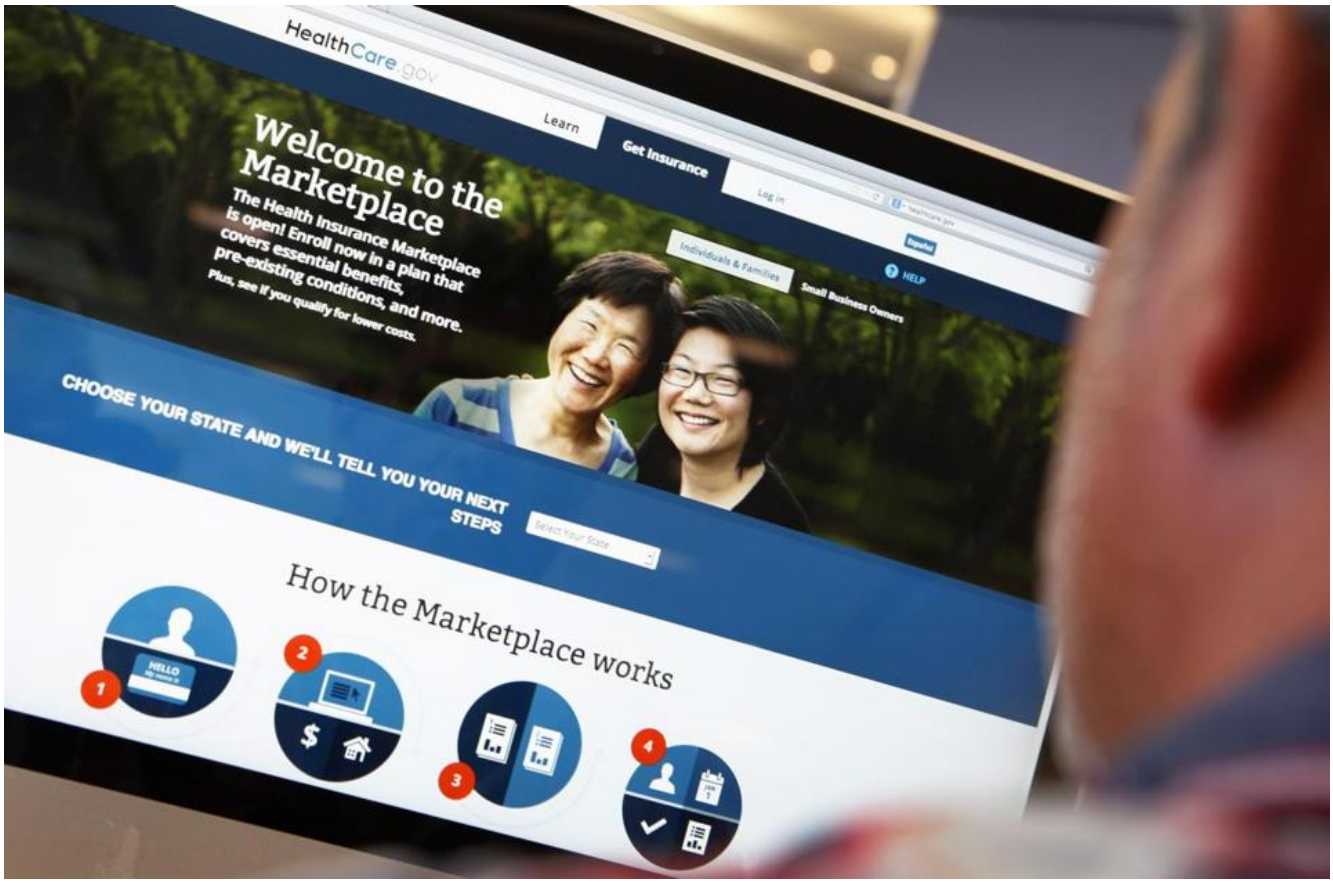
OPINION | STEPHEN SOUMERAI AND ROSS KOPPEL

Address economic flaws in Obamacare

By Stephen Soumerai and Ross Koppel

| NOVEMBER 15, 2014



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FOR ALMOST six years, the Affordable Care Act has been a political lightning rod. Many congressional Republicans want to repeal the law, which has provided 10 million more Americans with health insurance, and their impressive gains in the midterm

elections have galvanized their resolve. But Obamacare does not need to be gutted; it just needs to be adjusted. Many health initiatives and penalties mandated by the law are ineffective and Congress should work together to get rid of them.

A significant flaw in the law is its crude application of economic theories to justify incentives and penalties to doctors and hospitals. The aim is to reduce health care costs and improve safety. For example, the government rewards doctors for documenting that they have asked patients to quit smoking and it penalizes hospitals for not using electronic record systems. Last month, it almost doubled penalties on hospitals that re-admit certain patients within 30 days. The theory is that the penalty will force the hospitals to do a better job of keeping patients who need longer stays and will provide better follow-up care after discharge. But many readmissions are beyond the hospital's control — and are a result of a hospital treating the sickest and poorest of patients.

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While well-intended, some of the law's policies are generally unsupported by scientific evidence, are costly, and often backfire. Moreover, health care professionals often respond poorly to these carrots and sticks because money is only one of many drivers affecting the outcome of their care. We have studied these fashionable economic "panaceas," and find them wanting.

Pay-for-performance. This ACA policy pays doctors to improve their "measures" of quality of care — for example, it pays bonuses to doctors who prescribe adequate numbers of certain diabetes tests. While that sounds good theoretically, our long-term studies and international reviews show that many of these incentives are not effective. Giving physicians small incremental payments to do things they already do, like taking blood pressure, is counterproductive, insulting, diverts attention from more critical concerns, and doesn't increase quality.

Worse, some rewards generate unwanted consequences, causing some doctors to "cherry- pick" healthy, active, and richer patients over "costly" sick ones to show better results.

Non-payment for preventable infections. Medicare's refusal to reimburse hospitals for "preventable" infections contracted while in the hospital may sound like a reasonable policy, but it is often ineffective. Frequently, medical records fail to document if infections were already present when the patient was admitted. Also, these

penalties are unlikely to improve clinicians' infection prevention skills. Worse, some doctors fail to document "new," in-hospital infections — thus giving false appearances of reduced infections.

Unfortunately, this policy is expanding. Penalties to hospitals with the highest 25 percent of such infections will increase, even if those hospitals do everything right or serve particularly sick populations. Also, penalties often generate bureaucracies rather than improvements. Studies show that when Medicare fines hospitals for "inappropriate or poorly documented" care, armies of accountants respond — both in government and hospitals — a huge additional cost.

Charging the sick more for health insurance. This ACA regulation allows employers to increase health insurance premiums by 30 percent for people with high cholesterol or high blood pressure who don't participate in wellness programs or improve their test values. The economic theory assumes that people will become healthy to avoid fines. But some people have hard-to-treat, genetically determined illnesses or don't disclose medical information that could endanger future job opportunities. Worse, objective data reveal wellness programs don't improve lipid levels or chronic illnesses. Ironically, this regulation discriminates against those with pre-existing conditions — exactly the opposite of the ACA's intent.

Penalizing doctors for failing to adopt electronic health records. Medicare and Medicaid will penalize doctors and hospitals who fail to use electronic prescribing and health records. Even though the government is investing $34 billion in subsidies and incentives to help buy these systems, most doctors find them clunky, ill-suited to medical needs, and damaging to patient-doctor interactions. In addition, there is little evidence that electronic health records improve health or efficiency.

What all these incentives and penalties have in common is that their benefits are few, unknown, or counter-productive. Yet this naive economic hypothesis — embedded in the ACA — is accepted on faith and continues to dominate health care policy even though it ignores the real impediments to better care that arise from our fractured health care system, such as excessive paperwork required by multiple insurers or patients requesting dubious treatments they've seen on TV.

It's time to think bigger. Rather than impose unproductive penalties, we could stop subsidizing foods associated with obesity and diabetes, and better subsidize post-hospitalization clinician visits to vulnerable patients, a proven life and money saver.

Crude economic approaches are not panaceas for human behavior. We need more than blind faith in pocketbook motivation; we need evidence-based laws that reflect the complexity of human behaviors — both by clinicians and patients.

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Stephen Soumerai is professor of population medicine and director of the Drug Policy Research Group at Harvard Medical School and the Harvard Pilgrim Health Care Institute. Ross Koppel is on the faculty of the sociology department at the University of Pennsylvania and a senior fellow at the Leonard Davis Institute of Health Economics.