EXAMINING THE IMPACT OF OBAMACARE ON DOCTORS AND PATIENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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CONTENTS

EXAMINING THE IMPACT OF OBAMACARE ON DOCTORS AND PATIENTS

Tuesday, July 10, 2012

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS, AND THE NATIONAL ARCHIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2154, Rayburn House Office Building, Hon. Trey Gowdy [chairman of the subcommittee] presiding.

Present: Representatives Gowdy, Gosar, DesJarlais, Walsh, Issa (ex officio), Davis, Norton, Clay, and Murphy.

Also Present: Representatives Chaffetz, Gingrey, Benishek, Fleming, Harris, Speier, and Maloney.

Staff Present: Ali Ahmad, Communications Advisor; Brian Blase, Professional Staff Member; Molly Boyl, Parliamentarian; John Cuaderes, Deputy Staff Director; Adam P. Fromm, Director of Member Services and Committee Operations; Mark D. Marin, Director of Oversight; Laura L. Rush, Deputy Chief Clerk; Noelle Turbitt, Assistant Clerk; Jason Bourke, Minority Director of Administration; Yvette Cravins, Minority Counsel; Adam Koshkin, Minority Staff Assistant; Suzanne Owen, Minority Health Policy Advisor; and Safiya Simmons, Minority Press Secretary.

Mr. GOWDY. Good morning. This is a hearing entitled "Examining the Impact of ObamaCare on Doctors and Patients." The committee will come to order. I will recognize myself for the purpose of making an opening statement, and then the ranking member, the gentleman from Illinois. Good morning, again, and thank you for being here.

The recent Supreme Court decision focuses anew our attention on health care and the role of government therein. People are rightfully concerned about how the rising cost of health care is crowding out other financial priorities for their families; however, in the ongoing debate over increasing health costs and taxes, we will do well to study the impact on doctors and patients.

Today we will examine an often neglected, but very relevant aspect of the Affordable Care Act. We will hear from doctors whose primary concern is that the Affordable Care Act significantly increases government's role in healthcare. For example, the law creates 159 new agencies, boards, and committees to control how physicians do their jobs. Additionally, the Affordable Care Act has already generated over 12,000 pages in regulations and administrative requirements that only serve to distract and delay a doctor's

primary objective, which is to provide care to patients. These requirements disproportionately hurt small practice doctors the most, since larger practices have more leverage with insurance companies and larger staff to handle the burden of an ever-increasing paperwork.

According to the American Association of Medical Colleges, America will experience a doctor shortage of 124,000 to 159,000 physicians by 2025. Compounding this problem will be a surge in demand. The Affordable Care Act spends nearly $2 trillion subsidizing health insurance over the next decade. The result of this new spending will be a massive increase in the demand for healthcare services, which will inevitably mean longer wait times for appointments and less time doctors are able to spend with each patient.

Without fundamental reform our Nation's healthcare infrastructure will not be able to handle this surge in demand. The problem of access to care is especially troubling for participants in government programs; namely, for those on Medicaid and Medicare. The Affordable Care Act increases Medicaid enrollment by nearly 20 million Americans. Medicaid is already in dire need of reform. It is too large and complicated to effectively serve its patients. In fact, it is so overburdened right now less than half of all physicians accept new Medicaid patients because of the low payment rates and high administrative cost. Under the new healthcare law, enrollees will continue to overwhelm emergency rooms because of a lack of access to primary care physicians.

The Affordable Care Act is also bad for seniors on Medicare. First, the law cuts Medicare Advantage, reducing choices for seniors; secondly, the law cuts overall Medicare spending by $500 billion over the next decade and uses these savings for new government spending.

In fact, these effects are so disparaging that the chief actuary at the Center for Medicare and Medicaid Services believes the cuts to Medicare will lead to 15 percent of providers closing their doors by the end of the decade.

At point, a personal digression, and in the interest of full disclosure, my father was a physician. I suspect it is best to characterize him as still being a physician. He just doesn't practice medicine anymore.

I remember when I was a kid he was paid in vegetables. He was paid by people who would cut the grass at our home in exchange for him taking care of their children because they couldn't pay in cash, some of which is now illegal. He never refused to see anyone regardless of their ability to pay, and he didn't need the government telling him that it was the right thing to do. He did it because medicine was, and is, a noble profession. It is a helping profession. Regrettably, it now looks more like a business.

I have scores of friends back home who are doctors, which is unusual for a lawyer, but nonetheless I do, and I don't know a single one who would recommend to his or her kids that they pursue a career in medicine.

So I will look forward to hearing from our witnesses about the Affordable Care Act's impact on doctors' ability to effectively practice medicine and the key challenges they face from the law. In-

stead of retroactively addressing the impediments of the Affordable Care Act, it is my hope that this hearing will aid the committee in its efforts to move forward in implementing genuine healthcare reform, reform that is backed by doctors that empowers patients and that lowers healthcare cost for everyone.

With that, I would recognize the ranking member, the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman, and let me just say that, you know, I think that people like your father were absolute jewels. They were the salt of the earth, pillars of the universe. As a matter of fact, I encountered a few of them where I grew up. There was one doctor in our county, named Dr. Crandall, and you couldn't get a better physician than he was.

Mr. Chairman, let me thank you for calling this hearing, and let me state up front that I believe that healthcare should be a right and not a privilege afforded to just a few. And I am absolutely and firmly convinced that because of the Affordable Health Care Act millions of Americans will live better, longer, healthier, and higher quality lives.

Now that the United States Supreme Court has held the law to be constitutional, millions of Americans can know that their health coverage is on the way and that it is here to stay.

I must confess that I am somewhat mystified by what the majority thinks it's doing. Today the Republican leadership scheduled the House to begin debate on a bill to repeal the Affordable Care Act. This will be the 31st time that House Republicans voted to repeal the Affordable Care Act, and it will be the 31st time it will not be repealed.

Today's subcommittee hearing purports to examine the efforts of doctors and patients. But for a serious discussion of the impact of mandated care on doctors and patients we need to look no further than Massachusetts. Since 2006, Massachusetts under Governor Romney mandated near universal coverage for its population. Curiously, the majority did not invite a single doctor or patient from Massachusetts to share their experiences.

In fact, the majority invited no patients at all. The lone patient representative invited today was chosen by the Democrats of the committee. The majority has granted us only one witness. Why are there no physicians on the panel from the only State in the union with mandated care? Perhaps it is because the majority know that you do not hear complaints from physicians there. In fact, polls show that Massachusetts' doctors in large numbers support the healthcare law. The New England Journal of Medicine published a poll recently, conducted by the Blue Cross/Blue Shield Foundation, of over 2,000 doctors, and 88 percent believe the reforms improved or did not affect negatively the quality of patient care in Massachusetts.

So in order to complete the record to date, I am supplementing the hearing record with actual testimony from Massachusetts doctors. Many Americans are already benefiting from the protections provided to patients in the ACA. Eighty-six million Americans have free preventive care; 6.6 million college students remain on their parents' insurance policy; 105 million Americans have no lifetime coverage limits; and 16 million are no longer vulnerable to rescis-

sion of insurance coverage after precipitated health events. For doctors the ACA provides grants to States to increase the healthcare workforce. There are incentives for primary care physicians, nurses and healthcare practitioners, and doctors are no longer saddled with debts from uninsured patients.

I want the American public to know that Massachusetts doctors firmly believe the bill has gone through thousands of hours and they believe that the doctors there think it's necessary, that it's beneficial, and that it is helpful.

So today, we will hear from physicians who have not had the same experiences as the doctors in Massachusetts. But I certainly thank you for the hearing, and thank the witnesses for their participation.

Mr. GOWDY. I thank the gentleman from Illinois. Members may have 7 days to submit opening statements and extraneous material for the record. It is now our pleasure to——

Mr. ISSA. Mr. Chairman.

Mr. GOWDY. Yes, sir, Mr. Chairman.

Mr. ISSA. If I could seek recognition for one minute.

Mr. GOWDY. Without objection.

Mr. ISSA. I appreciate that. Listening to the ranking member, I do have to comment that when ObamaCare was being rammed down the throat of the minority we were denied any witnesses. When ObamaCare was being put together in the dark of night without Republicans in the room, or even the public in the room, we were denied all activity.

In fact, when the Speaker said, we have to pass it to find out what is in it, we knew exactly what we were in for. Something that purported not to be a tax, and then had to be distorted into being a tax in order to pass constitutional muster.

So as the ranking member said, yes, the Supreme Court has spoken, and yes, with 12,000 new pages, and growing, of additional bureaucracy and requirements, and costs going up logarithmically, the gentleman in fact is correct that maybe no one is complaining in Massachusetts, a State with only 4 percent at the time of the enactment uninsured, but the Nation and my State, with over 16 percent uninsured, finds itself with no cost controls, Medicaid, a very ineffective program from a cost-containment standpoint, and other programs driving up the cost while in fact driving out doctors from practicing. And people like the chairman's father are choosing to retire rather than live under ObamaCare.

So I certainly hope that the ranking member when he complains about the one witness, which is the custom, would try to remember that under Chairman Towns, the minority was given no witnesses repeatedly, and ObamaCare was not even offered for this committee to have an opportunity under the previous chairman.

And I thank the gentleman and yield back.

Mr. DAVIS. Will the chairman yield?

Mr. ISSA. Of course I yield.

Mr. DAVIS. Thank you, Mr. Chairman, and let me just say that I certainly appreciate your comments, and you know, I remember my mother telling us when I was growing up that right is right, if nobody is right and wrong is wrong if everybody is wrong.

Thank you.

Mr. ISSA. Well, I'm glad to hear that you realize that you were all wrong. I yield back.

Mr. GOWDY. I was a little premature in beginning to introduce our panel of witnesses. We will recognize the vice chairman, the gentleman, the doctor, from Arizona, and then the gentleman from Missouri for opening statements as well. Dr. Gosar.

Mr. GOSAR. Thank you, Mr. Chairman, and thank you for calling this hearing today. We certainly appreciate it. And thanks for all of the distinguished witnesses. I want to offer a special welcome to Dr. Eric Novack from the State of Arizona. It is an absolute privilege, Eric, for all you have done for Arizona, the patient/doctor relationship and across the country. So thank you so very, very much. It was great seeing you traverse Arizona all those times.

You know, we need a patient-centered reform, not reform dictated to every doctor's office in the country from bureaucrats. In fact, as a dentist for over 25 years of private practice before coming here to Congress, most of the symptoms of our ailing healthcare system come down to one root cause; the fracturing of the doctor/patient relationship. When President Obama set out to pass a healthcare reform package he promised doctors that little would change for them in their practices and that the folks who didn't have insurance would now have it. Today's hearing will examine the ways in which this promise has rung false.

The President's healthcare law is full of reporting requirements and regulations for practicing physicians. It stands to reason that the larger practices or hospitals will have greater leverage to handle these requirements than a sole practitioner. Physicians in my district are worried that the private practice model will erode and eventually be unsustainable. Such a development would be devastating to the practice of medicine.

The law also contains over 100 new boards, panels, and groups of bureaucrats to manage and dictate healthcare decisions, and gives the Secretary of Health and Human Services unprecedented authority to dictate standards of care across the country. Imagine a Washington bureaucrat sitting with you in the doctor's office as you are examined, as you discuss delicate issues concerning your health. That is the effect that this law will have on the doctor/patient relationship.

Furthermore, the proposed expansion of an unreformed broken Medicaid system will be unmitigated disaster. What good is expanding Medicaid if the program is such a bad deal for providers that a Medicaid card isn't worth the paper it is printed on. When I was a dentist practicing in a low income area of a rural community, I found that I was better able to deliver care to people of all incomes and ages when I took the Medicaid system out of the equation entirely.

We need to come together as a nation, and find ways to lower the cost of health care for the young, the old, the healthy, and the sick, not pursue party-line legislation, that enriches bureaucrats and special interests at the expense of our healthcare system. Let's reenervate the doctor/patient relationship with a patient-centered patient-friendly healthcare system, and I yield back the balance of my time.

Mr. GOWDY. Thank the gentleman from Arizona. The chair would now recognize the gentleman from Missouri, Mr. Clay.

Mr. CLAY. Thank you, Mr. Chairman, and thank you for conducting this hearing. And in response to the last two speakers on your side, Chairman Issa as well as Dr. Gosar, I think it would have been relevant if we could have had a doctor from Massachusetts to be a part of this hearing. You know, their views would have been relevant since for the past 5 years they have been living with comprehensive healthcare reform, signed into law by Governor Mitt Romney, that is substantially similar to the Affordable Care Act.

But the Democratic staff gathered testimonials of numerous Massachusetts physicians relating to their experience and the impact upon their patients and let me share just a few of them.

From a Boston cardiologist, I quote him, "I have never felt more confident when my patients and I together are making the best decision for them without influence of outside agents."

Another Boston primary care physician, quote, "Before health reform my patient was not able to see a physician and tried to avoid care except in the case of emergency. Now, I or a colleague can see her for both preventive and urgent care since insurance is within her reach."

A physician from Brookline, Massachusetts states, "Instead of worrying about getting paid for each individual visit, we reach out to patients to prevent repeat office visits, hospitalizations, and deteriorations. My patients feel cared for and I know they are receiving better evidence-based care."

So there are benefits to a law like the Affordable Care Act when you look at how the insurance industry has come on board, and voluntarily, seeing some of the benefits in this. It speaks volumes about how this law will help hundreds of millions of Americans, and it also speaks volumes about the majority in this House who has decided that they want to repeal this law. And it kind of defines where we are going with this debate; that we are going to divide this country between the haves and the have-nots, and that this is a class struggle.

If you are fortunate enough to be able to afford health insurance, then it is okay. You can take care of yourself. But if you are not, you are on your own, or if you have a job that doesn't provide you with healthcare coverage, then too bad. And I think we are a better nation than that, Mr. Chairman, and we should try to follow that example in this institution.

With that, I yield back, and look forward to the witnesses' testimony.

Mr. GOWDY. I thank the gentleman from Missouri. It is now our pleasure to welcome our distinguished panel of witnesses. I will introduce from your right to left, my left to right, and then we will recognize you for your opening statement in the same manner. Dr. Jeff Colyer is a physician and the Lieutenant Governor for the great State of Kansas. Dr. Richard Armstrong is a physician in Michigan and Chief Operating Officer of Docs4PatientCare. Mr. Ron Pollack is Founding Executive Director of Families USA. Miss Sally Pipes is President and CEO of the Pacific Research Institute. Mr. Kelvyn Cullimore, Jr., is Chairman, President, and CEO of

Dynatronics, a medical device manufacturer. Dr. Eric Novack, is an orthopaedic surgeon at Phoenix Orthopaedic Consultants.

My apologies if I mispronounced anyone's name. The lights that you will see mean what they traditionally mean in life. Green means go, yellow means go as fast as you can and try to get under the red light, and red means stop. So with that, we will recognize the distinguished Lieutenant Governor, Dr. Colyer.

Chairman ISSA. Point of order, Mr. Chairman. Are the witnesses being sworn?

Mr. GOWDY. You are correct, per usual. It is the policy of our committee to swear all witnesses. I would ask that you please rise and lift your right hands and repeat after me. Don't repeat after me, just affirm or not affirm.

Do you solemnly swear or affirm the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

WITNESSES. Yes.

Mr. GOWDY. May the record reflect all witnesses answered in the affirmative. Thank you. You may be seated.

Again, please limit your testimony to the extent that you are able to do so to 5 minutes, keeping in mind your entire statement will be made part of the record. And with that, thank you, Mr. Chairman, and I would recognize the Lieutenant Governor from Kansas.

WITNESS STATEMENTS

STATEMENT OF THE HON. JEFF COLYER, M.D.

Dr. COLYER. Thank you, Mr. Chairman. Thank you, Ranking Member Davis, and Chairman Issa, and members of the subcommittee.

My name is Dr. Jeff Colyer. As a practicing surgeon, as Lieutenant Governor of Kansas, I care fiercely about my patients. They need real results.

I had an interesting experience. Twenty-five years ago I was part of a team writing on Soviet military spending. The Soviets claim that they spent about one-fifth what the United States did to produce a fantastic array of tanks, planes, and millions of men under arms, many times more than the United States. But under the Soviet-style central planning, prices and costs had no relationship to production and real expenses. And to get around that economic reality they created a massive bureaucracy to ensure results, and it failed.

I have learned that my patients, whether they have insurance or not, are economically rational. We have bureaucratized health care so much that it distorts health outcomes and pricing and, as I described in my written testimony, health bureaucracy misaligns our basic price signals and economic forces that would actually help my patients and consumers. For example, in my own practice, two-thirds of my employees are dealing with the bureaucracy while only one-third of them are dealing with direct patient care. And so we can do a better job and we have some lessons to learn if we use real economic principles.

One example is Kansas Medicaid. About a decade ago, previous administrations in Kansas tried a Massachusetts-style reform. They decided to cut our relatively low uninsured rate by dramati-

cally expanding the Medicaid program. In those days our uninsured rate was about 10 percent. Commercial insurance covered 70 percent, and government programs were about 20 percent. Ten years later, commercial insurance has collapsed; 59 percent of people are in commercial insurance, government programs have expanded dramatically, and guess what? The number of uninsured has actually ticked up. Those are exactly the wrong trend lines.

So without flexibility, and with these mandated maintenance of effort requirements Kansas Medicaid's budget has now ballooned from $2.4 billion to $3 billion. To deal with these cost increases previous administrations decided to increase taxes. They cut provider rates. They refused dental benefits. They created long waiting lists and even told Kansans if they are over the age of 18, they are not eligible for a heart transplant. Those bureaucratic savings certainly did nothing to improve patient outcomes.

States have a better way.

When Governor Brownback and I took office in January of 2011, Kansas faced a $500 million deficit, largely due to Medicaid. Furthermore, the Medicaid program was in disarray. It was scattered across four cabinet agencies without a common budget, without common health goals. Governor Brownback and I made an important decision. Rather than cut people off or make massive across-the-board cuts, we would try to remake Medicaid to be more consumer-oriented and provide integrated care.

Two weeks ago, Kansas signed three contracts to provide integrated care for needy Kansans. And in those contracts, we specifically insisted on no rate cuts for providers, and that no one who is eligible for Medicaid would be thrown off. We estimated that we might save about $800 million. But the signed contracts actually turned out better than our original estimates. Every Kansan on Medicaid can keep their participating doctor. They will have at least three choices of different health plans and offered benefits like opportunity accounts and personalized health programs. Our projected savings are now $1 billion, and we added additional services, like preventive dental coverage, coverage for heart transplants, bariatric services for obesity, and we created an off ramp from Medicaid to get people back into the stable commercial insurance market. And to make sure that we achieve these health outcomes that we are after, we are actually going to hold back $.5 billion from Medicaid providers to get real results for real Kansans.

In other words, if you let the States make those decisions on a local level, we can actually set and achieve real health outcomes and not cut providers and not throw people off of programs, and we can actually increase benefits.

Of course, all of this depends on CMS approval, which we are still waiting for. It is clear that a global waiver tied to health outcomes would more effectively allow States to deal with these issues. Private insurance has decreased dramatically in the State of Kansas. Our child-only plans were cut from four plans to just two counties with one single plan. We have seen premiums increase dramatically. There is a better way, and that is to let the States do this. We are working on Kansas solutions and we appreciate the opportunity to share those with you and to work with other States.

[Prepared statement of Dr. Colyer follows:]

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Jeff Colyer, M.D., Lieutenant Governor

Sam Brownback, Governor

TESTIMONY BEFORE THE HOUSE SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS, AND THE NATIONAL ARCHIVES

July 10, 2012

Jeffrey Colyer, M.D.
Lieutenant Governor, Kansas

Good morning, Chairman Gowdy, Ranking Member Davis, and members of the Subcommittee on Health Care, District of Columbia, Census and the National Archives. My name is Dr. Jeff Colyer. I have the privilege of serving the State of Kansas as Lieutenant Governor and I am also a practicing surgeon. It is an honor to be invited to visit with this very important committee today to discuss the impact of the Patient Protection and Affordable Care Act.

There are several reasons the ACA should be repealed. We need to start over before irreversible damage is done to patients, taxpayers, states or the fiscal health of the United States. The states are the crucible where we can best get results for our patients. I will summarize some of the problems and suggest some solutions that would lead us to a better, more stable healthcare system.

TRANSPARENT HEALTH CARE ECONOMICS

Twenty five years ago I was part of a team of analysts writing on Soviet military spending at London's International Institute for Strategic Studies. Then I never imagined I would relive Soviet style economics as a surgeon, patient, or policy maker in Kansas in the next millennium.

The Soviets claimed they spent only about one fifth of what the US did to produce a fantastic array of tanks, planes, and millions of men under arms--many times larger than the United States. The reality was closer to 15-18% of their GDP. Under Soviet central planning, the problem was that prices and costs had no relationship to production and real expenses. Nobody—the CIA, the DIA, the Brits, the French, even the Russians themselves, could price the Soviet military machine. The problem was that operation and production of a giant economy ignored economic reality by creating a massive bureaucracy to ensure "results." It was that economic absurdity that ultimately caused the collapse of the USSR.

As a surgeon I work in an industry that consumes 16% of the GDP but there is no pricing mechanism that connects transparent prices to consumers or services or to even basic accounting. It is a system dominated by monopolies and oligopolies. We produce the best health care in the world and yet the economics don't make sense. None of our economic signals align in the system.

Let me give you an example of how dysfunctional the economics of healthcare are on the micro-level. If I remove four moles covered by insurance, I have to send a claim form to get paid. I know the price I will be paid is roughly $175, but I have to submit a bill for $800. However the claim form price — and the accounts receivable on my books — by CMS regulations has to be the highest possible price -- $200 per mole -- a price I have never been paid in my 18 years of practice. The basic example is that the insurer might pay $100 for the first mole, $50 for the second, $25 for the third, and nothing for the fourth.

You can imagine how irrational the books are for any medical practice. Every patient thinks you are gouging them by charging $800 and then only getting paid $175. No wonder there is no competition in the market and prices are not related to outcomes. The basis of supply and demand is a transparent price signal and we don't have that in conventional medical care.

However if you do not have insurance for something like a hand injury, we can quote our patients the cost of surgery, hospital and anesthesia fees and even deal with complications before you decide to have surgery. The price signal and the outcomes are real and visible to everyone.

And then there are the "freakonomics" of Medicaid.

Right now a Medicaid recipient can only visit fewer and fewer doctors because many do not participate in the program. So patients often make a rational economic decision-- the least expensive option for them and the most expensive option for taxpayers-- the emergency room.

The state may spend thousands of dollars on care for diabetes and obesity, but there are no rewards for quitting smoking or losing weight which could cure the problem.

One problem is that Medicaid pays less than the actual cost of care so the cost gets shifted to commercial insurance. As commercial insurance rates increase, more people are forced or rewarded to rely on Medicaid. And getting off Medicaid back into the commercial market is even more expensive and daunting. It is a vicious cycle. This trend will be exacerbated by the ACA.

We have bureaucratized health care so much that it distorts health outcomes. In my own practice two thirds of my employees deal with bureaucracy and only one third are involved in direct patient care. The problem is that the Affordable Care Act further distorts markets and makes it difficult to focus on real results for real patients. There is no question healthcare is complex and expensive. However the ACA makes everything more complex and more expensive without connecting the economics of medicine to the real needs of real Americans.

MEDICAID

I would like to address the state-federal partnership of Medicaid. The State of Kansas has a long and proud history of caring for those in need. However, like many other states, Kansas has recognized the trajectory of the Medicaid program is unsustainable. States understand the program must be improved, and we need flexibility to take action. The passage of American Reinvestment and Recovery Act and PPACA, and particularly their inclusion of Maintenance of Effort provisions, have made flexibility a challenge to obtain.

Without flexibility to reform Medicaid to improve outcomes and reduce costs, Kansas will continue to see increases in Medicaid costs. From 2002-2008, Kansas Medicaid spending grew 33 percent, while enrollment increased 25 percent. This growth occurred as Kansas tax revenues remained strong. Since then, Kansas' Medicaid budget has ballooned from $2.4 billion in 2008, at the onset of federally mandated "maintenance of effort" requirements, to what will reach nearly $3 billion in 2013 without reforms.

To deal with these cost increases previous Administrations proposed tax increases, cut provider rates across the board, refused dental benefits, raised premiums, created long waiting lists, and even told Kansans that if they were over the age of 18 they were not eligible for heart transplants when their lives were on the line.

Those bureaucratic savings certainly did nothing to improve patient outcomes. The ACA creates even more bureaucracy and further restricts options a state may have at its disposal.

When Governor Brownback and I took office in January of 2011, the State of Kansas faced a $500 million budget deficit. This deficit was heightened by an increased caseload demand of $265 million for Medicaid recipients. Furthermore, the Kansas Medicaid program was in

disarray scattered across four cabinet agencies without a common budget, without health goals, and with few providers.

Governor Brownback and I made an important decision. Rather than cut people off or make massive across the board rate cuts, we would remake Medicaid. We covered the shortfall with highway funds and then began to remake the program to be consumer oriented, provide integrated care, and focus on saving money by actually getting better outcomes.

Two weeks ago, Kansas signed three contracts to provide integrated care for needy Kansans. In those contracts, we specifically insisted on no rate cuts for providers and that no one who is eligible for Medicaid be cut off. We originally estimated savings of $830 million over a five year period.

The signed contracts turned out better than our original estimates. Every Kansan on Medicaid can keep their doctor if they participate. They will have at least three choices of different plans that offer benefits like opportunity accounts and personalized health programs.

Projected savings are over one billion dollars (rather than $830 million) and, we added the following services:

1) Basic dental coverage
2) Coverage for heart transplants
3) Bariatric services for obesity
4) Created an offramp from Medicaid back to the commercial insurance market

In addition we are changing our focus to push preventive care and health outcomes. To make sure we have good behavior and achieve health outcomes, Kansas will hold back more than half a billion dollars unless they meet specific health outcomes—real results for real Kansans.

We are improving care in Kansas and saving money without hurting our most vulnerable. In other words if you let the states make decisions we can actually set and achieve goals for health outcomes, not cut providers, not throw people off the program, and actually increase benefits.

All of Kansas' reforms depend on CMS approval of our waiver request. And while tere are some avenues for state innovation, they are narrow paths. The State of Kansas is in the process of applying for a Section 1115 Demonstration project to implement a series of innovative reforms that were the result of nearly a year of public input.

As a state, we envision a future in which the federal government offers us the opportunity to meet a similar challenge. The first track of our proposed 1115 demonstration is not revolutionary on its own; the kind of authorities we are seeking have been approved in other states. However, the State of Kansas strongly feels that a global waiver, or more specifically a per capita block grant tied to health outcomes, would more effectively allow states to reflect the needs of their citizens. We have indicated our intention to pursue that after the first track has been

implemented. Our vision is the restoration or reinvention of a state-federal partnership that will provide a model for reform that honors the program's statutory goal of improving the health of Americans in the greatest need.

MEDICAID EXPANSION

For years Kansas was a leader in healthcare with lower insurance costs, one of the lowest rates of uninsured, and access to care. About a decade ago, our governor decided to try to cut our relatively low uninsured rate by dramatically expanding the Medicaid program.

In those days our uninsured rate was roughly 10%, commercial insurance covered nearly 70%, and the remaining 20% were in government programs. Ten years after that experiment began, commercial coverage collapsed to 59%, government programs exploded, and the number of uninsured ticked up despite billions in new Medicaid spending. Exactly the wrong trendlines for a stable healthcare system.

Kansas is attempting to create an offramp from Medicaid to more stable commercial insurance. We want to create incentives for jobs with benefits. We have implanted reforms to to reward individuals and businesses to voluntarily get off long term disability and rejoin the workforce. This will result in better health outcomes and less costs.

Another key provision in PPACA that affects states is the expansion of Medicaid. Designed as a mandate, this expansion, even though now optional, potentially poses high costs to the states. While some have characterized the expansion population as a free service to states, quite the opposite is true. The Congressional Budget Office estimated that over the next decade the expansion will cost states $73 billion. While some federal observers may suggest this cost is negligible, in the world of balancing budgets, these costs will be challenging for states to maintain. States already stymied by expansive interpretations of "maintenance of effort, " which remains in place in the ACA, have to consider the long-term implications.

These are important decisions for many citizens and each state is going to have to weigh the specific advantages and disadvantages for their citizens and the long term solvency of their state. Knowing the quality of governors and legislatures across the country, I know these decisions will not be taken lightly.

PRIVATE INSURANCE

Despite the promises from President Obama that premiums would decrease and access would increase, we have not seen that happening in Kansas. However since the passage of the Affodable Care Act, the percentage of people covered by private insurance continues to fall in Kansas, while premiums everywhere increased.

Kansas private insurance – employment-based and other private insurance – currently comprises the source of health insurance for 59% of all Kansans. A decade-long downward trend in employment-based insurance continues, and ACA policies only exacerbate the pressures on the private market.

A simple but powerful example is what happened to the child-only health insurance policy market in Kansas. Prior to the implementation of the ACA, four insurance companies offered child-only policies in Kansas. It was a relatively small but important market. In the fall of 2010, faced with uncertainty about how regulators would allow them to manage risk while still honoring the law's requirements to not deny coverage based upon pre-existing conditions, the companies stopped writing new child-only policies.

In 103 of Kansas' 105 counties, that meant no child-only policies were available, as a result of the ACA. Only one insurer in the Kansas City area continued to sell the policies, but in just two counties.

True to form, the State responded the next year by adopting legislation to allow children under 19 otherwise unable to obtain coverage to gain coverage through Kansas' high-risk pool, operated by the Kansas Health Insurance Association. It was a state solution, yes, but one forced upon the state by an unintended but still predictable consequence of the federal law.

While more mandates are to come, the private insurance market has registered the effects of the ACA in other ways. Private market premiums spiked in 2011. Nationally, the average family insurance premium increased 9 percent, the largest increase in six years.

The private insurance requirements of the federal law are another example of "Washington knows best" policy making. The outcome will be less choice, which in almost every kind of market ultimately means less value and higher cost.

HEALTH CARE SOLUTIONS

There is a better way of improving healthcare in Kansas and the United States. It is naïve to think that one huge piece of legislation will solve a complicated problem like healthcare. We need to continually improve and work on it. And the best way is to do it in continuous incremental reforms on the state and federal levels. Today I want to make some alternative suggestions that would allow Kansas to be more responsive to our citizens needs.

Our state of Kansas has lots of innovative providers, patients, insurers, and technology specialists. We believe we can better solve this using Kansas solutions and working with our neighboring states. We should repeal the ACA. But if it is not replaced a series of waivers and state compacts could greatly improve healthcare. Let me list a few.

1) Restore the traditional power of the individual states to regulate and manage health insurance. Allow states to determine insurance mandates, regulation, and competitive markets.
2) Allow states to quickly form compacts that will increase competition, lower costs, improve coverage in both private and government funded programs. Allow portability across states.
3) Allow everyone access to portable individual or group polices that can be financed by a combination of individuals, employers, and government.
4) Revise Medicaid so that instead of pages and pages of mandates, a state has complete flexibility in program design and implementation. While money would be "block granted" the federal-state partnership would focus on agreed health outcomes on the macro level not micro level program management. Allow some Medicaid participants to participate in the private market.
5) Encourage state coverage pools for pre-existing conditions as well as uninsurable pools. Federal funds could be redirected to cover the most needy. Standard open enrollment and qualifying events mechanisms could be used.
6) Allow insurers offer products that allow the consumer to create Personalized Benefit Designs.
7) Create provider price transparency to allow cost comparison and incentivize consumers to utilize cost effective options. Align actual prices with providers, insurers, consumers, and programs.
8) Encourage disability income insurance and allow it to be paired with health insurance plans to protect consumers from bankruptcy and severe economic hardship.
9) Allow states to opt out or have complete flexibility on exchanges. Allow states to use other mechanisms to provide subsidies where appropriate.

Mr. Chairman, thank you very much for the opportunity to visit with you today.

Mr. GOWDY. Thank you, Mr. Lieutenant Governor.
Dr. Armstrong.

STATEMENT OF RICHARD A. ARMSTRONG, M.D.

Dr. ARMSTRONG. Mr. Chairman, members of the committee, ladies and gentlemen, it is an honor to speak with you today on behalf of doctor/patient care and thousands of practicing physicians nationwide who share our deep concern about the effects of the Affordable Care Act upon the practice of medicine and specifically upon our relationship with patients.

You have my written testimony and the attached information. In the interest of time, I will depart from the written documents. In response to the question, how does this law affect the physician/patient relationship, the answer is, it destroys it.

This has been developing for many years, but this law truly makes it crystal clear. In fact, Dr. Donald Berwick, the former head of CMS, has written that for this law to work the traditional physician/patient dyad must end.

All of you on this committee see your doctor from time to time. What do you expect from the visit? You would like a friendly, compassionate doctor, who will listen to you, examine you, and talk to you. The doctor will call on extensive training and experience to devise a plan that you both agree upon and understand. Your doctor simply wants to do what their training and experience has prepared them to do: Listen to your history, do a physical exam, discuss the findings and recommend a plan.

Unfortunately, that is not how things are going in medicine. To illustrate how these things are changing, I would like to share some stories.

The electronic medical record systems have been touted as a cure for many of the problems in our healthcare system today. Unproven and untested, these claims are simply not true. During a recent sales demonstration at my hospital, the presenter, a physician's assistant, took 30 minutes to demonstrate how to document the patient encounter in their system. The process was unfriendly to both patient and doctor. One of our primary care physicians asked, how do you propose that I do this in the 15 minutes that I have with patients? He answered, the goal is to reach at least a level 3 visit. I will say that again. The goal is to reach at least a level 3 visit.

In other words, billing trumps medical care. He added, so you have your nurse enter the history data. You fill in the physical exam, make the plan and move on to the next patient.

Really? Where in these 15 minutes do you talk to the patient or listen to the patient, you, the doctor?

As a patient, how do you feel? Did you develop a relationship, or are you part of an assembly line? I think that most of us know the answer and it should make us both sad and angry.

And then there is this account of a fellow physician's recent experience taking her father to visit his new primary care doctor. This is her story.

I took my father, 80 years old and living independently, to meet his new internal medicine physician yesterday. I sent ahead a brief summary of the history, list of medications and request that he do

a physical exam since it had been well over 3 years since it was done. After introducing himself he immediately announced that Federal guidelines no longer allow regular exams. An exam allows only listening to heart, lungs, and bowel sounds with the patient sitting. It does nothing else unless there is a specific complaint to justify it. I ask if anemia, which my father has, justified a rectal exam. He said no. He, of course, quoted repeatedly the U.S. preventive task force recommendations as one of the standards. He recited the statistics and the societal cost arguments. He had it all down. A perfectly useful idiot.

He said he only does evidence-based medicine. In fact, he had just had been to a conference to confirm the validity of his position. I did not engage him. It was not appropriate with my poor father sitting there listening to how he is too old for, well, anything.

Eventually, to pacify me the doctor went through the motions of the rectal exam after having to leave the exam room to get gloves and lubricant, which are, of course, of no use to him. I doubt he even knows how to do a rectal exam since my dad who has had many of them hardly felt it.

Again, guidelines trump medical care. This is the reality of ObamaCare. There is no care. This law supported by organized medicine, has been consistently opposed by Docs4PatientCare and AAPS.

Things don't need to be this way, ladies and gentlemen. This doesn't have to occur. American physicians need to be free to do what they have been trained to do, excel at practicing medicine. American patients need to be free to choose the health insurance plans and medical treatments that suit their needs, not something coerced by a central authority. This is simply impossible under the suffocating burden of the Affordable Care Act.

Thank you very much for your invitation to speak today, and I will be happy to entertain questions.

[Prepared statement of Dr. Armstrong follows:]

Testimony of Richard A. Armstrong MD FACS, Chief Operating Officer of Docs4PatientCare before the House of Representatives Oversight Committee

On the effect of the Affordable Care Act on the physician-patient relationship

The Honorable Darrell Issa R-CA
Chairman

Mr. Chairman, members of the committee, ladies and gentlemen; it is an honor to speak with you today on behalf of Docs4PatientCare and thousands of practicing physicians nationwide who share our deep concerns about the effects of the Affordable Care Act upon the practice of medicine and specifically upon our relationship with patients.

In preparation for this testimony, I spent some time reviewing a paper published in the *Annals of Internal Medicine* on October 19, 2010 entitled: *The Affordable Care Act and the Future of Clinical Medicine: The Opportunities and Challenges* authored by Robert Kocher MD, Ezekiel Emanuel MD and Nancy-Ann DeParle JD, all members of the administration's team while the ACA was being drafted. A copy of the paper is attached for your review.

Almost two years since this paper was published, the reality of medical practice in America and the stark contrast with the views expressed in the paper is even more apparent. The authors were obviously attempting to sell the ACA to a nation of skeptical physicians.

For over a century, the relationship between physicians and their patients has been highly regarded because it was understood that the relationship is private and that the physician is serving only the

individual patient as their professional advocate in matters of life and death, health and well being.

Changes in medical financing systems over the last 5 decades, including the passage of Medicare and Medicaid, have resulted in gradual and insidious intrusion into this private relationship. During the 90s the concept of "social justice" began to enter the discussion and soon medical ethicists began to embrace the idea that a third party was present in the examination room: society. No longer is an agent for the individual patient, the physician now told that in the privacy of the examination room, the needs of society must be addressed when making decisions about individual patient care. However, patients don't understand this. They expect and deserve the doctor's individual attention as part of an honest and trusting relationship.

Although the ACA attempts to address many of the perceived problems with our health care system, it ignores the fact that enormously complex systems cannot be successfully centrally designed or controlled. We have been attempting that with Medicare and Medicaid for almost five decades. Any honest and objective appraisal would conclude that we are failing with those programs. The ACA will fail as well, for the same reasons.

We could not possibly address all of the effects that the law will have on the physician-patient relationship, but we can address some of the most critical aspects here.

Dr. Kocher et al, claim in their paper that the ACA will remove the burdens of bureaucracy and overhead that currently plague our nation's practicing physicians. How can we possibly take this seriously? It creates an estimated 159 new agencies, boards and committees governing in detail how physicians are to care for their patients and run their practices. In a time of decreasing reimbursement and the lack of

an alternative for the Sustainable Growth Rate formula in Medicare, these claims of bureaucratic simplification ring hollow with experienced physicians.

Shifting to electronic medical records has been touted as a means to improve patient care. Even though the HITECH portion of the Stimulus Bill provides financial support for the adoption of electronic medical records and the ACA provides incentives for those who meet federally defined meaningful use, only a minority of physician practices have adopted EMR systems. A majority of those who have attempted have been met with major frustrations and financial burdens. This is because the existing systems are not designed to enhance patient care. They are business systems designed for medical coding and billing. They are cumbersome in design, difficult to use and detract from the already limited time most physicians have to spend with patients.

The ACA promotes a new model of care, The Accountable Care Organization (ACO). This is a re-worked capitation model that was introduced in the 90s with HMOs. The ACO model involves coordination of care with multiple providers and receives a lump sum payment for a group of at least 5000 Medicare covered lives. Physicians receive a bonus if they are able to care for the group of patients for less than the lump sum payment. There are several problems with this model.

In demonstration projects supported by CMS from 2005 to 2010 even America's best practices failed to achieve a meaningful bonus. With this model, the physician is no longer an advocate for the patient and has a financial incentive to ration care. The ACA places tremendous pressure on physicians to move to this model of care which because of infrastructure, EMR and reporting requirements will only be possible in hospital based organizations or pre-existing large physician group

practices. This major shift will limit patient's choice of physician by eliminating most solo or small primary care practices.

As a cost control measure, the ACA creates a new board of experts, The Independent Payment Advisory Board. Appointed by the President and confirmed by the Senate, this 15 member board has the authority to determine what Medicare and other programs will pay for and how much they will pay. Their recommendations are final unless Congress can propose something better with a super-majority vote of both houses in a very short window of time. Their decisions will be based upon Comparative Effectiveness Research which uses population studies to draw conclusions about best practices in medicine. Anyone who has witnessed the results of the recent recommendations of the United States Preventative Services Task Force concerning screening mammography for the detection of breast cancer and PSA testing for the early detection of prostate cancer will immediately understand why the decisions of this board will be suspect. Their purpose is simply to cut costs by reducing reimbursement to providers until 2020, when they can begin to target hospitals. The effect on physicians' ability to make medically accurate choices for their individually unique patients is likely to be sharply curtailed.

For practicing physicians the bureaucratic and financial burdens resulting from just these issues, combined with steadily declining reimbursement and price fixing in both public and private insurance plans, has dealt a crushing blow to the ability to sustain a private practice. All of these intrusions steal valuable and limited time from direct patient interaction, virtually destroying the traditional physician-patient relationship.

American physicians need to be free to do what they have been trained to do...excel at practicing medicine. American patients need to be free

to choose the health insurance plans and medical treatments that suit their needs, not something coerced by a central authority. This simply cannot occur under the suffocating burden of the Affordable Care Act.

Thank you for this invitation and the opportunity to share this brief summary with the committee.

Mr. GOWDY. Thank you, Dr. Armstrong.
Mr. Pollack.

STATEMENT OF RON POLLACK

Mr. POLLACK. Thank you, Mr. Chairman, and thank you Ranking Member Davis, and members of the panel.

I am delighted to join and serve as ballast for the five other members of this panel. You know, one of the questions obviously being asked here at this hearing is what does the medical profession think about the Affordable Care Act? I think we have a pretty clear answer from the groups that have expressed their support for the Affordable Care Act, starting with the American Medical Association, the American Academy of Pediatrics, the American Association of Family Physicians, the American College of Physicians, that is the umbrella of all internal medicine groups, the Association of American Medical Colleges, the American Congress of Obstetricians and Gynecologists; groups like Doctors for America, National Physicians Alliance, and the American Nurses Association.

But with respect to patients, we also have a pretty clear example of how patients feel that the Affordable Care Act will serve a positive role. Groups like AARP, the American Cancer Society, Cancer Action Network, the American Diabetes Association, the American Heart Association, Consumers Union, the National MS Society, and many others. And why is it? It is because the Affordable Care Act provides patients with peace of mind, and security; security and peace of mind that health care will be there for them when they need it.

For example, no longer can insurance companies deny coverage to somebody like a child with asthma or diabetes simply because that child has a preexisting condition. Why would we want to repeal that protection?

The Affordable Care Act rescinds the rules that insurers have followed that they terminate coverage when somebody is sick or has an accident. Why would we want to repeal that protection?

The Affordable Care Act prohibits insurers from charging discriminatory premiums based on health status. Why would we want to repeal that protection? It prevents insurers from establishing arbitrary annual and lifetime limits in what is paid out when somebody has a major illness or an accident. Why would we want to repeal that protection?

It stops discriminatory premiums based on gender, as women have to pay more in premiums than men simply because of their gender. Why would we want to repeal that protection?

And at the same time, in addition to providing these protections, it makes health coverage more affordable. It provides tax credit premium subsidies for middle class and working families that will go to tens of millions of people so that health coverage would be more affordable. Why would we want to repeal that and increase the tax burden on middle class and working families?

It provides tax credit subsidies for small businesses so they can better afford providing health coverage for their workers; currently, a 35 percent tax credit; in 2014 that will go up to 50 percent. Why would we want to hurt small businesses by repealing that?

For seniors it provides a significant benefit. It closes a big coverage gap with respect to prescription drugs, the so-called donut hole. Why would we want to continue that big gap in coverage and see it grow with each passing year?

It provides seniors with free preventive care services so they don't have to pay deductibles and copays for annual physicals, mammograms, and cancer screenings. Why would we want to stop that?

And it provides for healthier communities because it provides funding to increase the number of primary care doctors, nurses, long-term care providers, community health centers. It establishes school-based health centers. So it will increase the number of primary care doctors to serve patients.

And I should add that with respect to Massachusetts, as a couple of you, Mr. Davis and Mr. Clay, have indicated, experience in Massachusetts has been terrific. Uninsured rate has dropped in half, while the rest of the country, the uninsured rate has grown. Employer coverage is stable. People are receiving more preventive care. They have a usual source of care. There is less care provided in emergency rooms. And as I think Mr. Clay indicated, 88 percent of the physicians in Massachusetts say it has either improved quality or it hasn't diminished it.

Thank you, Mr. Chairman.

[Prepared statement of Mr. Pollack follows:]

Written Statement for the Record by
Ron Pollack, Executive Director, Families USA

For the U.S. House of Representatives
Oversight and Government Reform Committee
Health Care, District of Columbia, Census and National Archives Subcommittee

Examining the Impact of ObamaCare on Doctors and Patients
July 10, 2012

Mr. Chairman and Members of the Committee:

Thank you for inviting Families USA to participate in today's hearing on the impact of the Affordable Care Act. Families USA is a non-profit organization that advocates on behalf of patients and consumers in health policy debates.

When fully implemented, the Affordable Care Act will provide significant help to patients and health care consumers, giving them more freedom and control in their health care choices. The law will end discrimination and unfair practices by insurance companies, make quality health insurance affordable for working families and give Americans peace of mind knowing they will not lose coverage just because they get sick.

We know from the experience in Massachusetts that health reform helps patients and we also know that the cost of doing nothing – the cost of not addressing our biggest health care challenges – is too high. The highest court in the land has upheld the Affordable Care Act and now we must move forward together, to make sure the law works for all Americans.

The Benefits of the Affordable Care Act for Patients

New Rules for Insurers: At its heart, the Affordable Care Act is about improving Americans' security. The Affordable Care Act puts in place rules that prohibit insurance companies from denying coverage to people with pre-existing conditions. Insurers are also prohibited from imposing lifetime or annual caps on coverage and cannot drop or cancel coverage when people get sick. Insurance companies will be required to spend the majority of the premium dollars they earn paying for health care for their customers, rather than CEO salaries and bonuses, overhead, and advertising.

Better Coverage for All Americans: When the law is fully implemented, no one will risk losing health insurance if they change jobs. Starting in 2014, low- and middle-income consumers who do not receive their health coverage through an employer will get tax credits to help them purchase insurance. A new marketplace with regulated insurance plans will help consumers shop and compare among plans so they can find coverage that best suits their needs.

The law is already providing small businesses with tax credits to help them cover their employees. Young adults are allowed to stay on their parents plan until age 26. Seniors with high prescription drug costs are already getting additional help paying for their medicines and just next month women will have access to free preventive care, including mammograms and contraception.

Creating Healthier Communities: The Affordable Care Act has a number of other benefits that are less well known. For example, the law provides funding to increase the number of primary care physicians, nurses, long-term care providers and community health centers. The law takes steps to build healthier communities by expanding school-based health centers, helping at-risk families with services like parenting classes, boosting anti-smoking programs, and expanding programs that fight childhood obesity. And the law provides the federal government with significantly more tools to combat fraud, such as better screening of providers and suppliers in Medicare and Medicaid and better coordination among federal agencies.

Expanding Medicaid: Millions of low-income Americans will have new access to coverage through Medicaid. We now know conclusively that patients on Medicaid have better outcomes than those who do not have insurance. A recent study of Oregon's Medicaid program by Harvard economics professor Katherine Baicker, a former advisor to President George W. Bush, provides irrefutable evidence that patients benefit from being on Medicaid. In 2008, Oregon had funding to expand its Medicaid program by 10,000 people, but nearly 90,000 people applied to enroll. The state used a lottery to decide who could enroll. This lottery system made it possible for researchers to build a randomized study of Oregonians who won the lottery and received Medicaid and those who did not. The results of the study were decisive, showing that those who got to enroll in Medicaid were more likely to have a regular doctor and were more likely to get preventive care like mammograms and cholesterol screenings than those who were not. Those who got to enroll in Medicaid were also less likely to report having financial troubles related to medical expenses and were more likely to say they were healthy.

Because of the expansion of Medicaid in the Affordable Care Act, millions of more low-income Americans will have the advantage of better health and greater financial security. Since the federal government will provide 100 percent funding to states from 2014 to 2016 for the expansion of Medicaid to 133 percent of poverty and no less than 90 percent in ensuing years, we expect states around the country to expand their programs. Indeed Medicaid funding by the federal government (averaging 56 percent) and the Children's Health Insurance Program (CHIP) funding are far less generous than the new funds available under the Affordable Care Act. Since all states continue to implement Medicaid and CHIP, even at these lower payment levels, it stands to reason that the states will fully take advantage of the Affordable Care Act's more generous support.

The Experience in Massachusetts

In 2006, under the leadership of Governor Mitt Romney, the Commonwealth of Massachusetts passed comprehensive health reform designed to provide universal health care for its citizens. The Massachusetts experiment worked, and it serves as a model for the Affordable Care Act. In the six years since Governor Romney signed the Massachusetts reform bill, the uninsured rate in the state has fallen

by almost half, to 6.3 percent, while the U.S. average has climbed from 17.1 percent to 18.4 percent, according to Current Population Survey data. According to the Kaiser Family Foundation, employer sponsored coverage remains the primary source of insurance for consumers in the state. Massachusetts residents report receiving more preventive services and are more likely to say they have a usual source of care than they were prior to reform. Unnecessary visits to hospital emergency rooms have dropped and more medical students are enrolled in primary care programs. And doctors in the state are solidly behind the reform. According to a poll published in the New England Journal of Medicine, 88 percent of Massachusetts physicians believe reform improved, or did not affect quality of care.

The Cost of Doing Nothing

For the last two decades, American consumers have struggled with two enormous and related problems: the increasing number of people without health insurance and the skyrocketing cost of insurance. In 2010, Congress passed and the President signed the Affordable Care Act in an attempt to address these problems. Repealing the Affordable Care Act would undermine the significant gains for patients and would once again put consumers at the mercy of insurance companies.

The number of uninsured Americans reached an all-time high in 2010, as nearly 50 million Americans went without health insurance. Some of these uninsured people go without coverage because they cannot afford it and some are denied coverage by insurance companies because they have a pre-existing condition.

For many of those uninsured people, the consequences of going without coverage are dire. The uninsured frequently face medical debt or go without necessary care. Too many uninsured die prematurely. Families USA has estimated the number of Americans who are died due to the lack of health coverage, using a methodology developed by the Institute of Medicine. Across the nation, 26,100 people between the ages of 25 and 64 died prematurely due to a lack of health coverage in 2010. This works out to 72 people who die prematurely every day because they do not have insurance.

But the huge numbers of uninsured American also affects those who have insurance. Private health insurance premiums are higher, at least in part, because uninsured people who receive health care often cannot afford to pay the full amount themselves. The costs of this uncompensated care are shifted to those who have insurance, ultimately resulting in higher insurance premiums for businesses and families.

When the uninsured do obtain care, they struggle to pay as much as they can afford. Often, however, the uninsured cannot afford to pay the entire bill, and a portion of it goes uncompensated. To make up for these uncompensated care costs, doctors and hospitals charge insurers more for the services provided to patients who have health coverage. In turn, the costs that are shifted onto insurers are passed on in the form of higher premiums to consumers and businesses that purchase health coverage. This cost shift to health insurance premiums is a hidden health tax and Families USA estimates that the hidden health tax on annual premiums in 2008 was $1,017 for family health care coverage, and $368 for individuals.

The expansion of health coverage will certainly help the uninsured, but it will also help consumers who have insurance, and who are already bearing the extra costs of Congress's decades-long failure to address the problem of the uninsured. Repealing the law would mean walking away from these problems and would be a devastating abdication of responsibility.

Conclusion

The Affordable Care Act is the most significant step forward in ensuring Americans' economic security in generations. The Supreme Court has affirmed the constitutionality of the law and Congress should now turn its attention to implementing the law as effectively as possible. It is time to turn the promise of the Affordable Care Act into a reality.

Mr. GOWDY. Thank you, Mr. Pollack.
Ms. Pipes.

STATEMENT OF SALLY PIPES

Ms. PIPES. Mr. Chairman and Ranking Member, I would like to thank you for inviting me to testify here today. I am going to focus on the impact of the Affordable Care Act on patients.

The latest Rasmussen poll, by the way, shows that 54 percent of Americans would still like to see this legislation repealed. Everyone agrees we all want affordable, accessible, quality care. The question is, how do we achieve that goal?

There are two competing visions when it comes to answering that question. One focuses on empowering doctors and patients. The other focuses on expanding the role of government in our healthcare system.

This latter vision is the vision of President Obama. It is my belief that his ultimate goal is to move us all into a single-payer Medicare for all system.

The President's two main goals are for universal coverage and bending the cost curve down. On universal coverage, it is expected that 34 million out of 50.2 million Americans will become insured beginning in 2014. Approximately 18 million will be added to Medicaid, with about another 16 million receiving subsidies from the government. The Congressional Budget Office has estimated, though, that by 2021, 23 million Americans will still be uninsured. This is not universal coverage.

It is also important to note that just because a person does not have health insurance, they do not get health care. Under the Federal law EMTALA, anyone can turn up at an emergency room and receive treatment, and they can also pay out of pocket to the doctor or hospital.

As to cost, the U.S. spent 17.9 percent of gross domestic product, one-sixth of our economy on health care. An article in Health Affairs recently said that by 2020, we will be spending 20 percent, one-fifth of our economy on health care. The ACA will not achieve the goal of lowering the cost of health care.

Spending in the U.S. is often compared to spending in Canada, the country where I'm from. Canada spends 11.4 percent of gross domestic product on health care. The question is, how do they accomplish that? Well, the government took over the healthcare system in the '70s. The government sets a global budget of what they are going to spend on health care. As a result, you have rationed care, long waiting lists for care, and lack of access to the latest treatments.

Take the case of my own mother. In June 2005, my mother felt that she had colon cancer. So I suggested she make an appointment with her primary care doctor, which she did. Her doctor said she didn't have colon cancer, but he did order an X-ray, which she got. When she called me, I said you do not detect colon cancer with an X-ray. You need a colonoscopy. And so she went back to her doctor and said, my daughter says I need a colonoscopy. Her doctor said, unfortunately, as a senior, you will not be able to get a colonoscopy. There are too many younger people waiting for treatment.

My mother, by November, had lost 30 pounds and she started to hemorrhage. My mother went to the emergency room in an ambulance. She spent 2 days there at Vancouver General Hospital. She spent 2 days in a transit lounge waiting for a bed in a ward. My mother got her colonoscopy and she passed away 2 weeks later from metastasized colon cancer.

By denying or rationing care, it is possible to keep costs down, but it does not bode well for the patient's future health. Under the Affordable Care Act, it is inevitable that in order to keep costs down, care will be rationed and patients will suffer.

The President wanted a health care bill that cost $900 billion over 10 years. The CBO has recently said the decade 2012 to 2022, the cost will be $1.76 trillion. Richard Foster, Chief Actuary at CMS, said he did not think that the Affordable Care Act would let everyone keep the health insurance that they have if they like it.

This goes against the President's oft repeated statement, if you like your health insurance and you like your doctor, nothing will change. Kaiser Family Foundation showed that from 2011—from 2010 to 2011, the average premium for family plans went up 9 percent up to $15,073. In the previous year, they only went up 3 percent.

Under the employer mandate starting in 2014, any employer with 50 or more employees who drops coverage will have to pay a fine of $2,000. I believe that a number of employers, the CBO said up to 20 million, will lose their employer-based coverage. So much the President's statement.

America needs a healthcare system that empowers doctors and patients. Only then will we achieve affordable, accessible, quality care. The question is, who do you want to be in charge of your health care: An HMO bureaucrat, a government bureaucrat, or do you yourself want to be in charge? Universal choice is the key to universal coverage.

Thank you.

[Prepared statement of Ms. Pipes follows:]

**THIS TESTIMONY IS EMBARGOED UNTIL 10:00 AM ON TUESDAY, JULY 10, 2012

PACIFIC RESEARCH INSTITUTE

STATEMENT BEFORE THE OVERSIGHT AND GOVERNMENT REFORM

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE

NATIONAL ARCHIVES

The Affordable Care Act and Its Impact on Patients

July 10, 2012

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The views expressed in this testimony are my own and do not necessarily represent those of the Pacific Research Institute or its Board of Directors.

Introduction:

Mr. Chairman and Ranking Member, I would like to thank you so very much for the invitation to testify before the Oversight and Government Reform Subcommittee on Health Care, District of Columbia, Census, and the National Archives.

Testimony:

I am going to focus my testimony on the impact of the Affordable Care Act on patients in the United States. On June 28th, 2012, the U.S. Supreme Court ruled in a 5-4 decision that the individual mandate is constitutional under Congress' power to tax. As a result, the law remains in effect until such time as it is repealed by Congress. It is noteworthy that according to the latest Rasmussen poll, 54 percent of voters would like to see the Act repealed. This percentage has been fairly constant since before the bill was signed into law on March 23rd, 2010.

Everyone agrees that the key goal for all Americans is affordable, accessible, quality care. The question is how best do we achieve that goal? There are two competing visions when it comes to answering that question. One focuses on empowering doctors and patients, and the other on expanding the role of government in our health care system through increased mandates, new subsidies, higher taxes, and controls on insurance companies. This latter vision is President Obama's which he managed to enact in the 2700-page Patient Protection and Affordable Care Act. It is my belief that his ultimate goal is a single payer, "Medicare for All" program for all Americans.

The President's two main goals for health care reform were universal coverage and bending the cost curve down. On universal coverage, it is expected that 34 million out of the 50.2 million Americans who were uninsured in 2011 according to the latest U.S. Census Bureau figures, will become insured starting in 2014. Approximately 18 million will be added to the 50 million currently enrolled in Medicaid, the federal-state funded program for low income Americans who earn under 133 percent of the Federal Poverty Level (FPL). A further 16 million will receive subsidies from the government on a sliding scale up to 400 percent of the FPL.

The Congressional Budget Office (CBO) has estimated that by 2021 there will be approximately 23 million who are still uninsured. This is not the universal coverage that was promised. It is also interesting that of the 50.2 million uninsured in 2010, 14 million were eligible for Medicaid and CHIP and had not signed up. It is my belief that most do not sign up because of the difficulty in finding a doctor. Physicians do not want to treat Medicaid patients because the government reimbursement rates are so low. It is projected by HHS that Medicaid payments are between 58 percent and 66 percent of private health insurance payments, a 34 to 42 percent underpayment.

It is also important to note that just because a person does not have health insurance it does not mean he or she does not get health care. Under the federal law EMTALA, anyone can turn up at an emergency room and receive treatment. In addition, of the roughly 50 million uninsured about 20 million live in households with incomes greater than $50,000 a year. Two-thirds are young people between 18 and 31, the young invincibles, who decide that purchasing insurance is not a good economic decision for them. Many of them pay for their care out of pocket when they need it.

Now for the issue of cost, the U.S. spent 17.9 percent of GDP or $2.6 trillion on health care in 2010—one-sixth of our economy. It has been projected in an article in *Health Affairs* that by 2020, the U.S., under the President's law, will spend about $4.6 trillion on health care or 20 percent of GDP. This projection suggests the ACA will not achieve its goal of lowering the cost of health care.

Spending in the U.S. is often compared to Canada, a country that spends 11.4 percent of GDP on health care. The question is raised, if Canada can spend a much lower percentage, why can't the U.S.? The answer is that Canada has a single payer system which began when the government took over health care in the 1970s. The government sets a global budget and determines what percent of GDP can be spent on health care. The problem is that the demand for health care is much greater than the government is prepared to spend. As a result, costs are kept down but care is rationed, there are long waiting lists for care, as well as a lack of access to the latest treatments and procedures.

According to the Fraser Institute's latest report *The Private Cost of Public Queues, 2012*, the average wait time from seeing a specialist to getting treatment by a specialist is 9.5 weeks, up from 9.3 weeks in 2010. The report also showed that in 2011, 941,321 Canadians out of a population of 35 million are waiting for treatment.

Take the case of my own mother who lived in Vancouver, Canada. In June 2005, she thought that she had colon cancer so I suggested that she make an appointment with her primary care doctor which she did. Her doctor felt that she did not have colon cancer but did order an X-Ray which did not reveal cancer. I told her that she needed a colonoscopy to determine whether or not she had colon cancer. She followed up with her doctor who told her that because she was a senior and because there were many younger people already on a waiting list for the procedure, that she would not be eligible for one. By late November, my mother had lost 30 pounds and was hemorrhaging. I called the doctor and she went to Vancouver General Hospital in an ambulance. She spent two days in the Emergency Room and two days in the "transit lounge" waiting for a bed in a ward. My mother got her colonoscopy but she passed away two weeks later from metastasized colon cancer. By denying or rationing care, it is possible to keep costs down but it does not bode well for a patient's health.

Under the Affordable Care Act, it is inevitable that in order to bend the cost down, care will be rationed like it is in Canada and the U.K. Patients will suffer.

The President wanted a health care bill that cost $900 billion over 10 years. The CBO estimated that the final bill would cost $940 billion over the decade beginning in 2010. The CBO recently revised its forecast saying that the cost of the ACA will be $1.76 trillion from 2012 to 2022. This is almost double the amount projected. Richard Foster, Chief Actuary at the Centers for Medicare and Medicaid Services (CMS) told Congress that he did not think that "the ACA would hold down costs or let everyone keep their insurance if they like it." This goes against the President's oft-repeated promise "if you like your health insurance and you like your doctor, nothing will change." During the lengthy debate on the law, the CBO said that the average family would see their premiums increase by $2100 rather than decrease by $2500 as the President kept promising.

The Kaiser Family Foundation reported in 2012 that premiums in 2011 were up 9 percent for families over 2010 compared to a 3 percent increase over the preceding year. They said the average premium in 2011 was $15,073. The consulting firm Milliman has predicted that the average family premium in 2012 will be $20,728.

Several economists have projected that the cost of the law from 2014 to 2024 will be closer to $2.6 trillion. That is because most of the cost drivers do not go into effect until 2014—Medicaid expansion, individual and employer mandates, subsidies, state-based exchanges, and the end of price discrimination for insurance for those with chronic conditions.

Since the Supreme Court ruled the individual mandate is constitutional under Congress' power to tax, it is projected by the CBO that 4 million will pay the $95 tax starting in 2014. According to estimates by *The Wall Street Journal*, 75 percent of the tax will be paid by people earning under $120,000 a year. This is a highly regressive tax that goes against the President's commitment not to increase taxes on the middle class.

Under the employer mandate, starting in 2014, any employer with 50 or more employees who drops coverage or who has a single employee who receives a subsidy will have to pay a fine of $2000 per employee. A new CBO report predicts that up to 20 million will lose their employer-based coverage. McKinsey predicted one-third of the approximately 160 million Americans with this coverage could lose it. This is another example of the emptiness of the President's promise of no change in your insurance under the law.

With the projected $675 billion in new taxes under the law, patients will ultimately have less income to purchase the type of health coverage that fits their individual needs. For example, there is the 2.3 percent tax on medical device companies starting next year, the 3.8 percent tax on unearned income for those individuals earning $200,000 a year or more, the tax on drug and on insurance companies.

While the final law did not have a "public option", I believe that if the ACA is not repealed and replaced, there will be pressure for a public option which the government will price lower than the plans offered in the exchanges. Ultimately, private insurers will be "crowded out," care will be rationed, and we will be on our way to a Canadian-style "Medicare for All" health care system.

America needs a health care system that empowers doctors and patients. Only then will we be able to achieve affordable, accessible, quality care for all. This is the vision that we should be embracing in the health care reform debate. For example, we need to change the federal tax code so that individuals can purchase health insurance with pre-tax dollars just like those who have employer-based coverage. The federal government got us into this mess during WWII and it has distorted the system so that if you lose or quit your job, you lose your insurance. We need to make insurance portable so it stays with the individual and then it will be possible to build a competitive market in health care just like in other aspects of our lives.

State-based medical malpractice reform will go a long way to reducing the cost of defensive medicine which PriceWaterhousecoopers estimates at $210 billion a year. This is turn will make health care less expensive.

Medicare and Medicaid both need major reforms—premium support, vouchers, means testing, raising the eligibility age, and block-grants to the states for Medicaid. If these changes are not made, Medicare and Medicaid will cost, according to the CBO, $1.8 trillion a year. Both programs will be bankrupt and not there for those who need them most.

Tax breaks for Health Savings Accounts are the way to encourage people to have coverage and at a lower cost. It is estimated that there are 13.5 million HSA holders as of January 2012.

The ultimate question is who do the American people want to be in charge of their health care: an HMO bureaucrat, a government bureaucrat, or do they themselves want to be in charge?

Universal choice is the key to universal coverage. If the ACA is not repealed and replaced early in 2013, it will not be possible to reverse this program. This is the most important battle facing the American people today. Taxes will be up, care will be rationed, and the quality of our care will go down. We will be on the path to a health care system controlled 100 percent by the government.

Mr. GOWDY. Thank you, Ms. Pipes.
Dr. Novack.

STATEMENT OF ERIC NOVACK, M.D.

Dr. NOVACK. Mr. Chairman, Ranking Member, members the committee, thank you very much for allowing me to participate in this hearing today. I would preface my comments by mentioning in response to Mr. Pollack that the AARP recently revealed that their actual membership were getting phone calls and emails 14 to 1 against the Affordable Care Act during the process.

And so that kind of information does bring a bit into question whether or not the organizations that he listed actually have members that actually were in favor of it as opposed to just the leadership.

A system that combines the spending discipline of the Defense Department with all of the accountability of the public education system, that sadly is what the President's healthcare law's legacy is going to be for the country. Patients and families are the losers, and none of you or your families will be immune from the consequences either.

I would like to spend the next few minutes highlighting some portions of my submitted testimony. According to the administration's own researchers, the bottom 70 percent of the healthcare users in this country, accounting for over 220 million Americans, spent only 11 percent of all healthcare dollars, or about $290 billion. The bottom 50 percent, 150 million people, spent only 3 percent of all healthcare dollars, which is $80 billion.

The President's healthcare law does nothing to increase transparency, heighten competition, or make the healthcare experience one iota better for these people. Instead, the law imposes mandates of nearly every kind imaginable, and creates health insurance exchanges that are by design meant to turn patients and families into bankable commodities for the nearly $2 trillion in direct Washington subsidies to insurers and other corporations is at stake over the next 10 years alone.

Our Arizona efforts to work on the issues of transparency and competition have been met with a level of opposition reminiscent of shock and awe. Hospital CEOs, insurance company lobbyists, and even physician representatives essentially stated that pricing in health care is too complicated and that patients are simply not smart enough or sophisticated enough to understand.

In my orthopaedic surgery practice I help care for many children who have broken bones from a fall at the park, at school, and even on the trampoline in the backyard. For the parents of these children, a system where doctors are competing with one another to provide comprehensive care at a competitive price, a savings of $20, $30, and even $100 would be achievable. While members of this committee might not think much of that, for my patients that money pays for gas, food, and new school clothes.

The President's healthcare law either directly through government or through insurance, hospital, company surrogates is making it harder not easier for these children to get access to timely health care, and the studies support it.

The administration also shows that they are high utilizers; 1 percent of the country, which is about 3 million people, spend 20 percent of all healthcare dollars and the top 5 percent spend 50 percent of all the healthcare dollars. And while we tend to spend more on health care as we get older, there is little evidence that low healthcare users necessarily enter the top 5 percent at some time.

Rigid coverage rules and cookbook treatment plans are bad for patients of all types. I had a patient I treated for shoulder problems for several years. He is also has heart issues and is on a blood thinner. In spite of being considered safer to have a noninvasive colonoscopy, Medicare refuses to pay for that. Faced with little other options, he came off his blood thinner, subsequently had a blood clot, a cardiac arrest. Miraculously, he survived and has done well, though at great preventable cost to his system.

Under the President's healthcare law as the decision-makers move further away from the patients and instead resides in boards of experts, government rulemakers, and insurance and hospital administrators, to whom will doctors be listening? American medicine has already begun to shift to a veterinary ethic described by my friend and colleague Dr. Jeffery Singer. When you bring your dog or cat to the vet, the doctor listens to the decision-maker, the owner, and not the patient, the pet. The pet, of course, cannot decide for itself which treatment course will be undertaken, whether it is teeth cleaning or euthanasia. And within reason, the vet will follow the advice of the decision-maker.

Doctors are mortal, fallible, and respond to incentives like all others. If the person who pays the bills creates a framework that patients need to be put into category A or treatment B, for the doctor to remain compliant there is little doubt that this is ultimately what is going to happen.

Mr. Chairman, members of the committee, you were generous to ask me to speak about the impact of the healthcare law on the doctor/patient relationship. That relationship is complex, intertwined with many of the finer points of policy, the economy, and patient autonomy. We need real healthcare reform that put patients ahead of the special interests who wrote the healthcare law and who stand to profit substantially from it, both in financial wealth and power. Healthcare decisions belong to patients and families, not politicians and their pals. That is how you protect and defend the doctor/patient relationship.

Thank you.

[Prepared statement of Dr. Novack follows:]

Testimony to House Government and Oversight Committee 10 July 2012

Eric Novack, MD

Mr. Chairman, members of the Committee, thank you very much for allowing me to participate in this hearing today. There is no area of our lives more personal or private than our health.

A system that combines the spending discipline of the defense department with all the accountability of the public education system- that, sadly, is what the President's health care law's legacy will be for the country.

Members of this body squandered an opportunity to improve access to care for many of those in need, while increasing transparency and stabilizing costs.

Patients and families are the losers.

In medicine, our broken tort system led to an environment where doctors and other providers became unable to say, "I'm sorry" because the apology would be used as a bludgeon in court. So-called "I'm sorry" legislation protecting doctors from showing empathy has been passed in at least 36 states with impressive results.[1] Fears that an admission of a problem or error would lead to even more lawsuits have, in fact, resulted in exactly the opposite.[2] Honesty and transparency has allowed the doctor-patient relationship to flourish in places it had begun to whither.

Members of Congress, the President, and all candidates would be wise to understand that, when the policies you promoted or supported are failing, or have failed, owning up to those failures is not just leadership, but also good politics.

Efforts based upon keeping patients and families in control of their health care decisions, not politicians and their pals, is both good health care policy, and good politics.

In 2007, I embarked on what has become the Health Care Freedom movement- an effort that has, arguably, been as successful as any truly grassroots legislative movement in our nation's history. The Health Care Freedom Act aims to put into state Constitutions or by statute protections against government-forced health insurance and to protect the right of people to spend their own resources on lawful health care services.

The basic concept I pioneered in Arizona has become a constitutional amendment in 3 states[3] and a statute in 11 others[4], with 4 more amendments pending this November[5]—

[1] http://www.healthleadersmedia.com/page-1/PHY-265488/Doctors-Im-Sorry-Doesnt-Mean-Im-Liable

[2] http://www.ncbi.nlm.nih.gov/pubmed/20713789

[3] Arizona, Ohio, Oklahoma

[4] Virginia, Idaho, Utah, Georgia, Louisiana, Missouri, Tennessee, North Dakota, Kansas, Indiana, New Hampshire

Testimony to House Government and Oversight Committee 10 July 2012

Eric Novack, MD

and, outside of our initial efforts in Arizona, not one penny has been spent on lobbying anywhere. The success has been remarkable- in Ohio, in the same election that the collective bargaining law was overturned, the Health Care Freedom Amendment won with 67% of the vote—winning all 88 counties.[6]

Based upon 2 simple concepts- mandated insurance does little to stop 'free riders' while simultaneously raising costs for younger generations and giving massive new authority over private healthcare decisions to disinterested (in the patient) bureaucrats, combined with the protection of patient rights of getting access to lawful health care services using their own resources, the health care freedom act is a foundation upon which other health care reforms ought to be based.

Democrats in Congress and President Obama support a mandate—and the big insurance companies and hospital corporations are laughing all the way to the bank. And previously, in bipartisan fashion, Congress and President Clinton supported, and signed, legislation to restrict access to services for seniors, by imposing severe limits on the ability of America's seniors to use their own resources to access legal health care services. The former is now ensconced within the health care law, and the latter can be found in Section 4507 of the Balanced Budget Act of 1997.[7]

The doctor – patient relationship, ultimately, has little to do with some contrived policy developed on K Street and moved through the halls of Congress, or passed in any state House. It is the sum total of all the tangible and intangible factors that become part of the way patients and families interact and choose to trust and work with, their physicians.

Over the past 24 years, I have been extremely fortunate—I have worked as an emergency medical technician in rural, suburban, and inner city urban settings; I have worked as a mental health worker in an inpatient psychiatric hospital; I have volunteered in homeless clinics in San Francisco during the AIDS crisis; I have worked as a student and resident in multiple VA hospitals, trauma centers, and tertiary care hospitals; and, in the last 12 years in practice as an orthopedic surgeon, have worked in a trauma hospital and several community hospitals, with over 50,000 patient visits and nearly 5000 surgeries performed.

And, I have spent thousands of hours over the past 5 years speaking to, and talking with, thousands of American families about the health care system and what they think works and what needs improving.

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[5] Florida, Montana, Wyoming, Alabama
[6] http://www.wfmj.com/story/16003348/issue-3-win-reaction
[7] http://forhealthfreedom.org/Publications/LegalIssues/NoConstitutionalRight.html

Testimony to House Government and Oversight Committee 10 July 2012

Eric Novack, MD

According to the Obama administration's own Agency for Healthcare Quality Research, the bottom 70% of health care users in the country, accounting for about 224 million Americans, spent only 11% of the health care dollars, or about $290 billion dollars.

The bottom 50% (160 million people) spent only 3% (about $80 billion).[8]

In other words, for the vast majority of Americans, the President's health care law does nothing to increase transparency, heighten competition, or make the 'health care experience' one iota better. Instead, by imposing mandates of nearly every kind imaginable, creating health insurance exchanges that are, by design, meant to turn patients and families into bankable commodities for insurers and 'vertically oriented health care organizations'- regardless of ownership by a hospital or other organization.[9]

It is not hard to see why not a single paragraph in the entire health care law seems to promote true transparency and competition—the special interests, and physician groups can be included, are 100% opposed to anything resembling transparency and competition.

Our Arizona efforts to work on this issue have been met with a level of opposition reminiscent of 'shock and awe'.

CEOs and their representatives basically stated that pricing in health care is too complicated and that patients are simply not smart enough, or sophisticated enough, to understand. It was reminiscent of when former Ohio governor Ted Strickland was being interviewed in November 2011, about the special election where health care freedom won. He claimed that Ohioans were not quite smart or informed enough to understand that mandated health insurance was good for them.[10]

That is the first lesson in understanding the doctor – patient relationship—patients and families are not stupid, in many cases, if we stop and listen to them, they hold the clues to the both the diagnosis and treatment options. And, much of the time, patients and families understand better than physicians which course of treatment is best.

(Follow through on the part of patients can be quite a different matter, on occasion- for doctors too- and the health care law will do little that currently was not beginning to be done anyway.)

The Agency for Healthcare Quality Research also provides insight into the other extreme—those that are the high utilizers of health care. 1% of the country (about 3.2

[8] http://meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.pdf
[9] http://midwestdemocracy.com/articles/health-reform-would-bring-a-windfall-for-insurers/
[10] http://www.youtube.com/watch?v=rkhuNOTVRpQ

Testimony to House Government and Oversight Committee
10 July 2012

Eric Novack, MD

million people) spends 20% of the health care dollars ($520 billion). The top 5% (16 million people) spend 50% of the health care dollars ($1.3 TRILLION).[11]

And, while we tend to spend more on our health care as we get older, there is little evidence that the bottom 50% of utilizers necessarily enter the top 5% at some time.

Changing the utilization and cost of the care of the highest user of health care has proven (again and again) extremely difficult. It is one of the reasons that a January 2012 review by the Congressional Budget Office of over 3 dozen Medicare demonstration projects have failed to show any real cost benefit.[12]

Simply changing where the money gets spent does not lower costs. It does not even reliably improve the health of those for whom the programs were ostensibly designed to help.

Evidence based medicine—that is, finding treatments that work, and even more importantly, finding which treatments are actually detrimental or cause harm—is critical. But using limited studies' results and generalizing them to the whole population without the circumstances that make each patient unique being taken into account is senseless. I believe that this is one area that members of both parties on this committee can agree.

But that ought to extend not only to the treatments, but also to the *POLICIES* under which the evidenced based care is delivered.

So, I ask the question so many of my colleagues and patients are asking, why would the entire health care law be based around pushing tens of millions of Americans into Accountable Care Organizations which have never been shown to work in the aggregate, and which were rejected under another name- capitation- by the American people in the 1990s?

The chronically ill, those with multiple complicated medical problems, some of those with acute illness or cancer, *might* do better in a coordinated environment- but many factors can intervene. Certainly, as the CBO report noted above found, government driven delivery changes do not result in any savings, let alone a 'bending of the cost curve'. But why force the over 220 million Americans who rarely go to the doctor into an environment with fewer choices and more bureaucracy?

The 'accountable care revolution' is fast becoming a 21st century gold rush—with 'non-profit hospitals' replacing hard working Americans, and Washington, DC, and the halls of this institution replacing the mountains, hills, streams, and rivers of California.

[11] http://meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.pdf
[12] http://www.cbo.gov/publication/42859

Testimony to House Government and Oversight Committee 10 July 2012

Eric Novack, MD

Patients can become almost the afterthought—the dance between subsidy seekers and their patrons in Congress and the agencies reigns supreme. And, of course, this same dance goes on at the state level as well.

Working to create the best product—the right care and the right time in the right place is much less important when the person who pays the bills is no where near the patient and her family. Much more important is following the myriad of rules that will allow the subsidy dollars to keep on flowing.

The doctor-patient relationship necessarily must suffer greatly.

The health care law's insurance exchanges are perhaps the most expensive example of this in action.

The Congressional Budget Office estimates over $800 billion in exchange subsidies directly to insurance companies over the next 10 years (a figure that could easily be off by hundreds of billions if big employers bail out or if states realize that Washington should easily be on the hook for millions more instead of expanding Medicaid).[13]

The $800 billion- and following the rules to maximize getting those dollars—will become the life force of an insurance industry that already, according to Bloomberg, has seen its dependence upon government dollars soar.[14,15] Since it is often easier to get local officials to buckle under to make rules and regulations that tip the playing field, the industry is pushing hard on every front to get states to implement exchanges.[16]

The 'local control' is mythical—exhibit A is the 27 page 'checklist' states will need to follow to set up their exchange… but many of the checklist items themselves will require extensive clarification and ultimately arbitrary interpretation.[17]

The arguments against the Exchange are numerous, and mostly beyond the scope of the focus of this hearing—but, Austin Frakt, writing on liberal columnist, pundit, and health care policy wonk Ezra Klein's Washington Post blog, made clear a few key facts about the Exchanges in a 2011 piece- the subsidies may be much lower than expected in terms

[13] http://waysandmeans.house.gov/UploadedFiles/Table_2_CBO.pdf
[14] http://www.bloomberg.com/news/2012-01-05/health-insurer-profit-rises-as-obama-s-health-law-supplies-revenue-boost.html
[15] http://washpost.bloomberg.com/Story?docId=1376-LX8D9Y1A74E901-0KI9LGIDCUT0FUI4FNJ7R9ODTV
[16] http://thinkprogress.org/health/2011/10/06/338024/health-insurers-lobby-red-states-to-implement-health-reform-exchanges/
[17] http://cciio.cms.gov/resources/files/Exchangeblueprint05162012.pdf

Testimony to House Government and Oversight Committee 10 July 2012

Eric Novack, MD

of total insurance costs, many children may not be eligible for subsidies, and the subsidies are not designed to keep up with rising health care costs.[18]

None of this bodes well for health care… let alone the doctor-patient relationship.

My friend Jeff Singer, a Phoenix, Arizona, general surgeon with about 30 years in practice, recently wrote an article that brings the ethical dilemma that the health care law presents. To be fair, much of this was well underway prior to March 23, 2010, when the law was signed, but its pace has quickened considerably since then.

As the decision-makers in health care move further and further away from the patient—and instead reside in boards of experts, government rule makers, and insurance and hospital administrators—to whom will doctors be listening?

In the veterinary ethic he describes, the doctor listens to the decision-maker (the owner) and not the patient (the pet). The pet, of course, cannot decide for itself which treatment course will be undertaken, whether it is a teeth cleaning or euthanasia. Within reason, the vet will follow the advice of the decision maker.[19]

The doctor-patient relationship exists- particularly in modern American medicine- with shared decision making as a fundamental piece.

Doctors are mortal, fallible, and respond to incentives like all others. If the person who pays the bill creates a framework that patients need to be put into category 'A' or treatment 'B' for the doctor to remain 'compliant', there is little doubt that this is what ultimately will happen.

For some conditions- chemotherapy regimens, for example- guidelines and protocols make sense. For most of medicine, however, the model being promulgated by the 'experts' and those who stand to profit handsomely from getting a small piece of the $2.6 trillion dollar pie under the law, will mean eroding trust and satisfaction.

And both of those are critical to both the ultimate outcome of treatment and the doctor-patient relationship.

As someone who, along with so many other physicians, nurses, allied staff, volunteers and technicians have devoted our professional lives to the world of health care, the satisfaction and pride in our profession comes from seeing that patient get better, become

[18] http://www.washingtonpost.com/blogs/ezra-klein/post/exchange-subsidies-not-ready-for-prime-time/2011/06/02/AG32XXHH_blog.html?wprss=ezra-klein
[19] http://reason.com/archives/2012/03/15/the-coming-medical-ethics-crisis/print

Testimony to House Government and Oversight Committee 10 July 2012

Eric Novack, MD

productive again, get quality time with his or her family, or even just be content and happy in life.

Policies that are failing, failed, or are guaranteed to fail in their stated mission (ulterior motives aside) will make it increasingly impossible for us to work with patients and families so that ***they*** can achieve their goals.

The President's health care law, sadly, reads like an encyclopedia of failed promises and policies.

1. Costs reduced by $2500 per year per family- reality, costs are up about $2000 per family since the law passed.[20],[21]
2. No taxes on those making less than $250,000 per year, meaning more money in their pockets for all needs, from food to clothing to shelter to education- reality, the Wall Street Journal reported that 75% of all new taxes under the law will be paid by those making less than $120,000 per year.[22]
3. 400,000 new jobs 'immediately', so said then House Speaker Nancy Pelosi- reality, this simply did not happen.[23]
4. The high-risk pool program (PCIP) would provide insurance to over 700,000 by this time per predictions- reality, enrollment is 88% *less than* expected, but per participant costs are *twice* what was expected.[24],[25]
5. Staying on parents' insurance until age 26- reality, the near record high unemployment among the 21-25 age group is likely a contributing factor to the numbers who have signed up- but younger workers and families are paying another tax of up to 3% on their premiums as a result. This is $450 per year for a younger worker's family policy that already costs $15,000 per year.[26]
6. No preexisting condition exclusions for children- reality, 34 states at least are no longer offering a single child only policy, making access to what was generally very affordable insurance for most unavailable at all. Some major unions stopped offering child/ dependent policies for their members entirely.[27],[28]

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[20] https://my.barackobama.com/page/community/post/stateupdates/gG5B8v
[21] http://ehbs.kff.org/pdf/2011/8225.pdf
[22] http://online.wsj.com/article/SB10001424052702303561504577494472052048242.html
[23] http://www.youtube.com/watch?v=ELcgS9gTKhU
[24] http://www.healthcare.gov/news/factsheets/2012/04/pcip04132012a.html
[25] http://www.cciio.cms.gov/resources/files/Files2/02242012/pcip-annual-report.pdf
[26] http://prescriptions.blogs.nytimes.com/2011/11/23/young-adults-coverage-may-cost-parents-even-more/
[27] http://dyn.politico.com/printstory.cfm?uuid=DBEF51A4-BD55-4D9C-9DD6-3413549BA7A4

Testimony to House Government and Oversight Committee
10 July 2012

Eric Novack, MD

7. The urgent moral imperative of an essential health benefits package- reality, the Obama administration first provided waivers to nearly 1200 unions and companies, leaving about 4 million Americans out of 'luck'.[29] Then the administration punted entirely on what the essential benefit package should even look like. And, in an issue that has gotten little press, the administration and Congressional Democrats wrote an exemption into the law for self-funded companies, meaning over 100 million Americans *were never going to get a benefit* from the provisions.[30,31]
8. 'Health care reform is entitlement reform'- reality, by every known measure, the health care cost curve is bending upward, with a huge spike set to occur in 2014. The law has further damaged the solvency of our other major spending programs- Medicaid, Medicare, and Social Security. If there is simply no money left, those programs may find themselves falling off the cliff.[32]
9. Millions will benefit from Medicaid- reality, Medicaid is already a program past its breaking point in many states. Medicaid spending has surpassed education spending and continues to trend upward, forcing education spending downward. Over 40 states moved to cut payments (reducing access) or benefits in the last year. Recent studies suggest that giving people insurance in the form of Medicaid does not necessarily mean more access to care, and one suggested that for routine care, the uninsured might have better access.[33,34,35,36,37]
10. Access to care for Americans will be improved- reality, inner city hospital closings have accelerated, payment cuts to those hospitals will be $50 billion over the next decade, cuts to home health services will further hurt low income and those without a strong family safety net. Payment cuts for Medicaid, which will worsen with 16 million new Medicaid beneficiaries, will mean hospitals and

Comment [EN1]:

Comment [EN2]:

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[28] http://blogs.wsj.com/metropolis/2010/11/20/union-drops-health-coverage-for-workers-children/

[29] http://thehill.com/blogs/healthwatch/health-reform-implementation/202791-hhs-finalizes-more-than-1200-healthcare-waivers

[30] http://www.irs.gov/pub/irs-drop/n-12-31.pdf

[31] http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf (sections 2707 and 1301)

[32] http://www.healthcare-informatics.com/news-item/cms-predicts-modest-cost-growth-2012-2013-spike-2014-expanded-health-coverage

[33] http://www.nytimes.com/2011/12/14/us/in-downturn-medicaid-takes-up-more-of-state-budgets-analysis-finds.html

[34] http://www.ama-assn.org/amednews/2011/11/07/gvl11107.htm

[35] http://www.annemergmed.com/article/S0196-0644(12)00125-4/abstract

[36] http://www.ncbi.nlm.nih.gov/pubmed/22299763

[37] http://online.wsj.com/article/SB10001424052748704758904576188280858303612.html

Testimony to House Government and Oversight Committee
10 July 2012

Eric Novack, MD

> doctors will find it increasingly difficult to keep their doors open in low income areas. And the highly touted community health clinics are overwhelmingly failing to provide consistent care, yet Obama administration officials have stated no interest in holding them accountable.[38],[39],[40],[41]

Mr. Chairman, members of the committee, you were generous to ask me to speak about the impact of the President's health care law on the doctor-patient relationship. That relationship is complex and intertwined with many of the finer points of policy, the economy, and patient autonomy.

We need real health care reform that puts patients ahead of the special interests who wrote the health care law and who stand to profit substantially from it- in both financial wealth and power.

Health care decisions belong to patients and families, not politicians and their pals. That is how you protect and defend the doctor patient relationship.

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[38] http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads//PPACA_2010-04-22.pdf

[39] http://capsules.kaiserhealthnews.org/index.php/2011/11/medicare-cuts-home-health-pay/

[40] http://www.bricker.com/documents/publications/1937.pdf

[41] http://www.kaiserhealthnews.org/stories/2012/april/18/community-health-centers-under-pressure.aspx?referrer=search

Mr. GOWDY. Thank you, Dr. Novack.
Mr. Cullimore.

STATEMENT OF KELVYN CULLIMORE, JR.

Mr. CULLIMORE. Chairman Gowdy, Ranking Member Davis, members of the committee, thank you for the opportunity to testify here today. My name is Kelvyn Cullimore. I am the President and CAO of Dynatronics Corporation, which is headquartered in Salt Lake City, Utah, with manufacturing also in Chattanooga, Tennessee. We are a publicly-traded company engaged in the manufacture and distribution of medical devices and products primarily for physical therapy and sports medicine applications, and provide employment for about 180 people.

Dynatronics is a relatively small company with sales about $32 million, but that is common in this industry. A majority of medical device companies are small companies, approximately 80 percent having 50 or fewer employees. Many are in the early stages of product development with no sales, or with sales, but no profits. Like many companies, we have been required to implement several rounds of layoffs to cope with difficult economic circumstances of the last few years. If policies such as the 2.3 percent medical device tax included in the Affordable Care Act are implemented, I fear this added burden will not only harm patient care and stifle innovation but threaten the very existence of companies like Dynatronics.

Despite widespread economic challenges I do consider myself extremely fortunate to be part of a generally vibrant industry that plays a critical role in improving health care and patient care in this country. There are over 2 million hard working Americans who help make the United States the global leader in medical device technology. Data from the Department of Commerce shows that the medical device industry exported $36 billion of products in 2010 and had a trade surplus of approximately $3.2 billion. Not many segments of the U.S. economy can claim to be a net exporter.

It is probably not the first time you have heard this but I want to be very clear that the United States is in very real danger of losing our global leadership position. If this happens, it will be virtually impossible to get this position back as capital and human resources flow to new centers of innovation outside of our country.

The challenges of an uncertain regulatory environment, reimbursement pressures, and of course the medical device tax, among others, have created what many describe as a perfect storm. I believe this perfect storm could quickly lead to a Class 5 hurricane for patients, providers, and innovators.

The Dynatronics story in this current environment is not really unique, but it is illustrative of how harmful policies such as the medical device tax are to our ability to improve patient care and drive job creation. Our fiscal year just ended on June 30th. We will report sales in excess of $32 million, but for only the fourth time in 25 years will not show a profit. After reporting a pretax profit of over $400,000 last year, we will report a pretax loss of just under $300,000 for this fiscal year.

In other words, despite not earning a penny in profits this year, the Affordable Care Act will require that we pay hundreds of thousands of dollars in a device tax.

Quite simply, a company such as ours and thousands of others that are similarly struggling or have not yet crested the hill of profitability as a startup company will have a very difficult decision to make in addressing this added tax if it is not repealed.

Where do I get the money to pay the tax? Research and development are the easier short-term cuts, but they lead to less innovation and negatively impact patient care. Do I drop product lines that are marginally profitable that now are no longer profitable due to the tax but still may have benefit to patients? Some would say that we make it up by raising our prices. Pass it along to the end user. Anyone operating in the current environment knows that there is no appetite on the part of hospitals or practitioners to accept price increases of any kind. To the contrary, we are under tremendous pressure to lower prices.

Because the tax is levied on sales and not profits, it will take a significant bite out of resources available for innovation and growth regardless of the company's size, or stage of development. This hurts patients and providers as the ability and pace at which innovation occurs slows dramatically, reducing improved patient care and quality of life.

Many of the most innovative device companies are pre-profit, and struggling to achieve sufficient profitability to recover the millions of dollars invested into research, clinical trials and other development costs or, more importantly, attract the additional capital needed to complete product development. This tax is a huge disincentive to attracting investors.

If a company such as Dynatronics decides to address the device tax by making severe cuts to R&D, what I have essentially done is limit the potential for my company to have new technologies and devices in 3 to 5 years down the road. I cannot emphasize enough just how delicate the innovation ecosystem is for medical device makers. Any cuts to R&D today will manifest themselves down the road in ways that hurt patients and providers the most.

Medical device innovation plays a central role in patient care, but we face many head winds and need your help to calm those head winds and enable the United States to maintain our global leadership position. I respectfully request that you recognize the misguided nature of this medical device tax and the effect it will have not only on companies like Dynatronics, but the resulting impact on technological innovation and patient care. Help us avoid this impending hurricane. America's patients, providers, and workers are counting on it.

Thank you.

[Prepared statement of Mr. Cullimore follows:]

Testimony of

Kelvyn Cullimore Jr., President and CEO of Dynatronics

U.S. House of Representatives

Committee on Oversight and Government Reform's Subcommittee on Health Care and D.C.

Thank you Chairman Gowdy and Ranking Member Davis for the opportunity to testify here today. My name is Kelvyn Cullimore. I am the President and CEO of Dynatronics Corporation. I also serve on the board of the Medical Device Manufacturers Association and am a Trustee of the Utah Technology Council. Dynatronics is a NASDAQ listed company engaged in the manufacture and distribution of medical devices and products primarily for physical therapy and sports medicine applications. We have a manufacturing facility and corporate headquarters in Cottonwood Heights, Utah a suburb of Salt Lake City, where we manufacture high tech electronic devices and employ about 70 people. We also have a facility in Chattanooga, TN where we employ 46 people in manufacturing hot packs, cold packs, treatment tables and other similar products that we both manufacture and import. We have 14 employees at satellite sales and staging offices in Detroit, MI, Pleasanton, CA, Youngstown, OH, Minneapolis, MN, and Houston, TX. We are one of two companies left in our market niche that has a direct sales force with 50 direct sales representatives scattered around the country. Including all direct sales reps, we provide employment for over 180 people.

Dynatronics is a relatively small company with sales of about $32M. But that is common in this industry. A majority of medical device companies are small companies. Many are in the early stages of product development with sales, but no profits. My father and I started Dynatronics over 30 years ago. We have had good years, but the last few years have been a struggle. Like many companies facing difficult economic conditions, we have been required to implement several rounds of layoffs to reduce expenses. In such a difficult economic environment it is doubly hard to accept the imposition of a new tax that will further hamper our ability to innovate and provide jobs for the number of people we have traditionally employed.

Despite widespread economic challenges, I consider myself extremely fortunate to be a part of a generally vibrant industry that plays a critical role in improving healthcare in this country. The medical device industry is comprised of over 400,000 highly skilled and science-driven professionals, with well over 1 million jobs that are part of our industry supply chain. Including other support and related business, there are over 2 million hard working Americans who drive this proud success story, and one where the United States is the global leader (2010, State of the Industry, The Lewin Group). The most recent data from the Department of Commerce shows that the medical device industry exported $36 billion of products in 2010 and had a trade surplus of approximately $3.2 billion. Few segments of the United States economy can lay claim to a trade surplus.

Since I first joined the medical device industry over 30 years ago, that is a statistic that has been widely touted; that we are the global leader in medical technology innovation. This is probably not the first time you have heard this, but I want to be very clear that the United States is in very real danger of losing our leadership position, and if this happens, it will be virtually impossible to get this position back as capital and human resources flow to new centers of innovation out of our country. The challenges of an uncertain regulatory environment, reimbursement pressures, and of course the medical device tax, among others, have created what many who have testified in Congress before describe as a "perfect storm." I am here today to share the sobering news that this "perfect storm" could lead to a Class 5 hurricane for patients, providers and industry.

The Dynatronic's story in this current environment is not really unique, but it is illustrative of how harmful policies such as the 2.3% medical device tax in the Affordable Care Act are to our ability to improve patient care and drive job creation.

Our fiscal year just ended on June 30th. We will report sales in excess of $32,000,000 but for only the fourth time in 25 years will not be profitable. After reporting a pre-tax profit of just over $400,000 last year, we will report a pre-tax

loss of just under $300,000 for this fiscal year. The reduction in profitability is due to slightly lower sales and increased R&D expenses. The profit last year represented 1.2% of sales. If the 2.3% medical device EXCISE tax was in place last year – which as you know is a tax on revenue, regardless of profitability – we would have owed the IRS hundreds of thousands of dollars in excise taxes significantly reducing or even eliminating our profits. Worse than this would be the scenario for the most recent fiscal year wherein we expect to show a loss of just under $300,000. For our effort, we would still be obligated to pay the IRS approximately the same hundreds of thousands of dollars in excise taxes despite not being profitable.

Quite simply, a company such as ours and thousands of others that are similarly struggling, or have not yet crested the hill of profitability as a start-up company, will have a VERY difficult decision to make in addressing this added tax. Where do I get the money to pay the tax? How do I return to past levels of profitability? How do I keep my company viable? Research and development are the easiest short term cuts but they lead to less innovation and growth. Do I reduce employee benefits? Do I drop product lines that are marginally profitable that now are no longer profitable due to the tax? This would reduce employment but possibly save expenses.

Some would say that we offset the tax by raising our prices. Pass it along to the end user. Anyone operating in the current environment knows that there is no appetite on the part of hospitals and practitioners to accept price increases of any kind. To the contrary, we are under tremendous pressure to lower prices. Much of what we manufacture is capital equipment. Capital equipment is only replaced if there is something significantly more innovative or if the products are wearing out. In this environment, practitioners and facilities are extending the useful life of their devices and equipment and if R&D is cut, innovation will suffer. Increasing prices to cover the medical device tax will not encourage practitioners to open their wallets to purchase new devices – not to mention that larger, more financially

strong competitors can absorb the tax better than the small companies like Dynatronics.

There is also talk that adding millions to the rolls of the insured will bring more patients needing care, thus more business for those paying the tax. That may be comfortable rhetoric for justifying the imposition of the tax, but at least in our case, and in the case of many like us, we do not expect the additional coverage to increase sales of our products. Existing capital equipment may get used more, but it will not necessitate the purchase of additional capital equipment. It may help with those who sell consumable products, but not capital products. Besides, many of those newly insured being added were already accessing necessary care through existing charitable and emergency room channels. The real increase in demand for medical products is expected to be modest at best and mostly affecting consumable type products. This dynamic is currently being validated in the state of Massachusetts where near universal health insurance exists and yet manufacturers have not experienced a significant increase utilization of their products and services.

In our particular case, there is also the current effort by Congress to put caps on reimbursement for physical therapy services. If the caps are imposed, revenue for physical therapists will diminish leaving even fewer resources for the purchase of new or additional capital equipment and supplies. As a company we are being squeezed in a legislative vice between capped reimbursements for physical therapy services and being assessed the medical device excise tax on sales of manufactured products. It will eventually crush us.

Regardless of a company's size, success or stage of development for medical technologies, a 2.3% excise tax will have a significant impact, and hurt patients and providers at the end of the day. What is unique about our innovative industry as a whole is that it is comprised overwhelmingly of small companies. It is estimated that 80 percent have less than 50 employees. While Dynatronics is fortunate to have existing devices and products on the market to generate revenue

and hopefully a return to profitability, the majority of device companies are pre-profit and struggling to get to the point where they can begin to recover the millions of dollars spent on research, clinical trials and other development costs.

Most importantly, what does this mean to patients and providers? Sadly, policies such as the medical device tax are placing huge hurdles to delivering on the promises of improved patient care and a better quality of life.

For example, my company has devices and technologies in hospitals, therapy centers and facilities throughout the United States, being used on average by tens of thousands of patients every day. If a company such as Dynatronics decides to address the device tax by making severe cuts to R&D, what I have essentially done is limited the potential for my company to have new technologies and devices in place 3-5 years down the road. I cannot emphasize enough just how delicate the innovation ecosystem is for medical device makers. Any cuts to R&D today will manifest themselves down the road in ways that hurt patients and providers the most.

Think of all the amazing technologies and procedures we read about today: Aortic stents, dialysis machines, surgical robotics and so many more.

Despite the unbelievable amount of innovation and ingenuity it took to deliver these life-changing technologies, many of us take it for granted that these amazing tools are available for providers to help patients.

But imagine if the medical device tax was implemented in 2003 instead of 2013. How many small and innovative companies would simply have folded due to an inability to generate profit in a reasonable time? How many jobs would have been lost, adding to the roles of the unemployed and uninsured? How many cuts to R&D would have been made leading to unknown losses in innovation and patient care? Would all the cutting edge devices and technologies developed over the past decade really be available today?

Some have tried to minimize the impact of the device tax saying it is only 2.3% of sales as though that number is insignificant. It is not. Most medical device companies will operate on profit margins averaging 5-7% of sales. As a percentage, 2.3% is the equivalent of 33-45% tax. Imagine further trying to attract needed capital from investors and explaining that the first 2.3 dollars of every hundred in sales is paid to the government before the investors receive anything. Not only does this chill investment in medical device technology as investment dollars seek other venues not so burdened, but it makes the hill to profitability for innovative start-up companies that much harder to climb. And for those already established, it will reduce the return to investors and the price-earnings ratio for those who have the misfortune of being a public company. This tax will reduce their market cap, discourage investors and affect millions of shareholders who will lose value in their stock as profits potentially decline and the market absorbs the impact of this tax. The consequences of taxing medical device companies to support broader public policy relative to more universal health care reform are not insignificant and will be far reaching relative to future innovation and expansion of this industry.

It is often said that while we fear the known obstacles in our lives, it is the unknown ones that can present the greatest challenges. The impact of the medical device tax and various other unreasonable policies in the Affordable Care Act will clearly have a negative impact on innovation and patient care, but to what degree is unknown. We DO know that it has already led to job losses; we DO know that companies have already stated they are cutting back on R&D; and we DO know that it has been identified as a major factor in the steady decline in investments and venture capital to young start-ups in this crucial field of innovation.

The United States simply cannot lose our leadership position in something as important as patient care. The jobs the medical device innovators create are great, the technologies and devices being developed literally are changing lives each and every day, and we all recognize that we need to improve outcomes and drive down

the costs of care. Medical device innovation plays a central role in patient care, but we face many headwinds and need your help to temper the headwinds and avoid the creation of that Category 5 hurricane.

Dynatronics is but one example of a Company that faces an extreme challenge in coping with the burden of this tax combined with the other economic factors we are confronting including reduced reimbursements. The perfect storm is becoming a Class 5 hurricane for us. We will fight to preserve what we have built over the past 30 years. We will fight to save as many jobs as we can. We will not willingly be sacrificed at the altar of universal health care as an unfortunate casualty for the greater good. But it will require significant restructuring that will inevitably include loss of jobs and reduction in research and development. Industry-wide, this will ultimately and unfortunately have a dire impact on patient care and the tools providers have at their disposal.

I respectfully urge our national leaders to work together to provide an environment where tomorrow's technologies and devices will not be sacrificed for misguided policies today. America's patients, providers and workers are counting on it. Thank you.

Mr. GOWDY. Thank you, Mr. Cullimore. I would ask unanimous consent that our colleagues, Drs. Gingrey, Benishek and Fleming be allowed to participate in today's hearing. Without objection, so ordered. I would now recognize the distinguished chairman of the full committee, the gentleman from California, for his questioning, Mr. Issa.

Chairman ISSA. Thank you, Mr. Chairman. Later today we will have a panel of business people who will also be before this committee at the full committee level on the same subject.

No surprise, we won't have a doctor from Massachusetts.

Mr. Pollack, are you a doctor from Massachusetts?

Mr. POLLACK. No, I'm not.

Chairman ISSA. Okay, so the Democrats didn't pick a doctor from Massachusetts to bring in either, did they?

Mr. POLLACK. I'm not a doctor from Massachusetts.

Chairman ISSA. Okay, and when you were mentioning the various groups that supported the legislation, you didn't seem—and all the things we wouldn't want to do, you didn't seem to mention one thing that I'm concerned about I want each of you to address. Under the ACA, or ObamaCare, if somebody has 50 employees and doesn't provide care, it is going to cost $2,000. Just sort of a shake of heads, is that true? And if somebody doesn't buy their own insurance, whether they are offered it at their company or not, it is going to cost them $2,000 on their tax return, isn't that true?

Mr. POLLACK. Not necessarily. It really depends on the——

Chairman ISSA. It is a sliding scale. But if they make $50,000 in their family, they are going to pay $2,000.

Mr. POLLACK. It depends on what portion of one's income actually is attributed to what one has to pay.

Chairman ISSA. Exactly. So it is based on a rather obscure household income for the entire family, not known at the beginning, but in fact a family of four with $50,000 will find themselves with a $2,000 fine if they don't buy it. But in fact, they won't necessarily know that until the end of the year.

So let's go through a couple of other similar questions.

If you are an employer and you do provide a healthcare system under ObamaCare, and then you find that one of your employees went to an exchange, which they have a right to do, and did not go through your healthcare system even though you have a Federally complying healthcare system, isn't it true you can be billed back $1,000 from the exchange because an employee with a certain household income chose to do that?

For the Lieutenant Governor, are you familiar with that provision?

Dr. COLYER. Yes, I am.

Chairman ISSA. So included in all of this good work is a series of taxes that in fact can represent as much as $4- or $5,000 between the employer and employee, none of which actually goes to the health care.

Now wait a second, just, Mr. Pollack, you are going to be asked a lot of questions by the Democrats. That is why they brought you here as an apologist for ObamaCare, but Dr. Colyer, I guess my question is, isn't it true, and I think you can all answer this as yes, even Mr. Pollack, that if an employer cannot afford to offer health

care but was willing to put $2,000 into the pocket of their employee for health savings, or something along that line, but a non-federally compliant system, and the employee has $2,000 that they could put into a healthcare system, together they have $4,000. But if they don't buy the $12,000 system they would have to buy, the government will take $4,000 in many cases from the combination of two of them, providing no health care for that $4,000.

Lieutenant Governor, isn't that true?

Mr. COLYER. Yeah, that's what happens when you take away flexibility.

Chairman ISSA. Okay. So one of the provisions of the ObamaCare is, in fact, that you can tax and of course now the chief justice has made it clear that I guess the Democratic majority in this House with no Republican support could in fact tax $2,000 by the family and $2,000 by the employer, and provide no real solution. Isn't that true?

Mr. COLYER. Yes.

Mr. POLLACK. So Mr. Chairman, one of the things you are missing——

Chairman ISSA. No, no, no, Mr. Pollack. Mr. Pollack. Mr. Pollack. Mr. Pollack, you can answer a question that is asked as a yes or no as a yes or no. If you do anything else, what you are really doing is being the Democrat's witness and being obstreperous. So if you will please wait until they ask you a question. In my remaining moments, for the witnesses, other than Mr. Pollack, who will be asked by the Democrats to apologize for ObamaCare, is there anything so far that has occurred as ObamaCare is implemented that has reduced cost and thus made healthcare more affordable for Americans, not more subsidized, not more taxed? Is there anything that has occurred so far that has made health care less expensive for any of our witnesses.

Mr. COLYER. No.

Mr. POLLACK. The answer is yes.

Chairman ISSA. The record will indicate that our witnesses all found it to be a no, and you obviously can answer when called on.

Mr. Cullimore, I just have one question for you. Can you find a single basis, other than scoring a cheap trick in order to say ObamaCare didn't cost, is there a single basis under which you should tax health care, inherently—healthcare products, inherently making them more expensive? Other than a cheap trick from Members of Congress, was there any basis to tax your products?

Mr. CULLIMORE. I am not aware of any.

Mr. ISSA. And any basis under which by taxing them they don't inherently become more expensive?

Mr. CULLIMORE. That seems basic economics to me.

Mr. ISSA. So we have taxed health care, made it more expensive, even in your kind of products, even if you are making no profit at all, and that is what you are finding undeniably under ObamaCare?

Mr. CULLIMORE. That is what we are finding. And more important than just making it more expensive, is it is threatening the ability to do research and development and provide the kinds of tools that our practitioners need to improve patient care.

Mr. ISSA. Thank you. Thank you, Mr. Chairman, I yield back.

Mr. GOWDY. I thank the gentleman from California. The chair will now recognized the gentleman from Illinois, Mr. Davis.

Mr. DAVIS. Thank you, Mr. Chairman, and, Mr. Chairman, I ask unanimous consent to insert into the record testimony from seven physicians who are members of—

Mr. ISSA. Reserving a point of order.

If I may state the point of order, if the gentleman would phrase that as anything other than "testimony." Committee rules require that testimony be sworn. This would be unsworn. So if you would call them statements for the record, I would withdraw my objection.

Mr. DAVIS. Statements for the record.

Mr. ISSA. I withdraw.

Mr. GOWDY. Without objection.

Mr. DAVIS. Mr. Chairman, let me thank you again.

Dr. Colyer, what kind of physician are you?

Dr. COLYER. I'm a plastic and craniofacial surgeon in Kansas City.

Mr. DAVIS. So you are a plastic surgeon?

Dr. COLYER. Yes, sir.

Mr. DAVIS. Are the services that you provide covered by the Affordable Health Care Act?

Dr. COLYER. Yes. I spend many days, many nights in the emergency room taking care of people who have had their hands blown off by fireworks injuries, women with breast cancer, and a variety of services.

Mr. DAVIS. So then you actually do more than plastic surgery?

Dr. COLYER. That is plastic surgery.

Mr. DAVIS. Yes, that is your specialty, and all of those things associated with it you do.

Let me also ask you, you indicate in your written testimony that we've got to do something quick before irreversible harm is done to our health care delivery system. Could you tell me what irreversible harm is done to the more than 30 million people who for the first time in their lives have access to health insurance? And could you tell me what irreversible harm is done to those individuals who for the first time have an opportunity for a private practicing physician who becomes their primary care as opposed to the emergency rooms that you just mentioned?

Dr. COLYER. Yes, sir. For example, in the State of Kansas, we had four insurers that provided child only policies. And since the formation of the ACA, those insurers, three of them have pulled out completely. We have one insurer. That only covers two out of 105 counties. I doubt that those are going to be coming back any time soon.

Mr. DAVIS. Well, could you tell me how those individuals are going to receive care?

Dr. COLYER. How they will receive care?

Mr. DAVIS. Yes.

Dr. COLYER. Yes. In Kansas, doctors do take care of patients. We have a wide array of opportunities through qualified health clinics, through a number of State programs and Federal programs, and also the generosity and the willingness of many physicians to work there. There are solutions that we can deal with these problems

and we can add additional things. We are very compassionate. We want to work with them. It is just one solution mandated from someplace else may not work in Kansas.

Mr. DAVIS. Mr. Pollack, your organization, Families USA, estimated that across the Nation 26,100 people between the ages of 25 and 64 died prematurely due to a lack of health coverage, and that was from your June 2012 report Dying For Coverage.

Could you describe how lack of health care coverage impacts premature death.

Mr. POLLACK. Sure. Mr. Ranking Member, first, I should say the methodology for this report was developed by the Institute of Medicine scientific panel in 2002. But the main way this occurs is that when somebody does not have health care coverage, typically they delay getting care. At the onset of a pain, at the onset of a health problem, people who are uninsured often feel they can't pay for a doctor or to get an exam, and so they delay care. And when they delay care, sometimes the illness gets worse, sometimes it spreads. Unfortunately, about 26,100 people pay the ultimate price because they were uninsured.

One other thing I should say, this also affects people with health insurance, and the reason it does that is when people who are uninsured get care in an emergency room, they usually can't pay for that care or at least they can't pay for a portion of it, and a hospital has to make up for those costs. And the way they make up for that cost is a hidden surcharge for all of us who have health insurance, and that ultimately results in premiums being raised on average more than $1,000 per family per year.

Mr. DAVIS. Thank you, Mr. Chairman. I yield back.

Mr. GOWDY. I thank the gentleman from Illinois.

The chair will now recognize himself for 5 minutes of questions.

Eight out of 10 physicians would reconsider their decision to practice medicine. A significant doctor shortage is on the horizon. Naively, I suppose, I want the smart kids in class to be the ones to operate on me. And I want the smart kids in class to be the ones to put me to sleep, more importantly, to wake me up. One of the reasons—so I guess unless this administration plans to cross train the 13,000 IRS agents as nephrologists and pediatricians and OB/GYNs, things look pretty bleak in this country. And one of the reasons I hear that doctors are frustrated is their fear of litigation and their requirement to practice defensive medicine. And they are in something of a Hobson's choice because when my colleagues on the other side of the aisle ask them whether they practice defensive medicine, it is really a setup to admit that you engage in Medicaid or Medicare fraud which is why I'm not going to ask the physicians on this panel whether they practice defensive medicine. We all know that they do it.

I heard the President in his State of the Union devote about one-1000th of 1 percent of the time he took in his State of the Union to mention tort reform.

So, Mr. Pollack, you didn't mention tort reform in your opening statement. Do you support caps on noneconomic damages?

Mr. POLLACK. No, we would not support that. We would support some changes that deal with malpractice, but not——

Mr. GOWDY. Mr. Pollack, let me tell you the way this works. I ask the questions, and then you answer them.

Mr. POLLACK. I want to give you a full answer.

Mr. GOWDY. Well, I'm going to ask you a series of questions.

Mr. POLLACK. Good.

Mr. GOWDY. And I want crisp answers. Not filibusters; crisp answers. Do you support limits on noneconomic damages? That is not a complicated question. That is not a multi-part question. Do you or do you not?

Mr. POLLACK. Do not.

Mr. GOWDY. Do you support limits on joint and several liability?

Mr. POLLACK. Do not.

Mr. GOWDY. Do you support a different standard of care for emergency medicine as opposed to medicine where a physician has a robust chart or file in front of them?

Mr. POLLACK. I'm not sure I follow the question.

Mr. GOWDY. Emergency medicine where a physician is called upon in a matter of seconds to make a decision, they don't have the benefit of patient history or a lot of tests, do you support a different standard of care for those physicians as opposed to ones who do have a full history in front of them?

Mr. POLLACK. No, not——

Mr. GOWDY. So you would hold physicians who have a matter of seconds to make a decision to exactly the same standard that you hold physicians who have treated patients for 20 years?

Mr. POLLACK. Most physicians have access to clinical guidelines as to what works, and I would expect that any physician, emergency physician or otherwise, would look at those guidelines, not necessarily feel bound by those guidelines, but would use those guidelines in order to make a thoughtful decision for his or her patient.

Mr. GOWDY. So the answer is no?

Mr. POLLACK. I gave you a full answer to that question.

Mr. GOWDY. The answer was no. Do you support loser pays?

Mr. POLLACK. I'm not sure I follow that.

Mr. GOWDY. Loser pays? You file a lawsuit, the jury finds it frivolous. With a special verdict form, do you support a——

Mr. POLLACK. I think anyone who files a frivolous claim should pay physician costs.

Mr. GOWDY. So you support loser pays?

Mr. POLLACK. Anyone who files a frivolous claim should pay physician costs.

Mr. GOWDY. Do you know where the majority of the litigation comes from in this country, whether it is paying patients or nonpaying patients?

Mr. POLLACK. It comes from paying patients.

Mr. GOWDY. No, sir, it comes from nonpaying patients. The majority of the litigation, the lawsuits filed, come from nonpaying patients.

Mr. POLLACK. I don't believe that.

Mr. GOWDY. I can't help what you believe. I can just tell you what the facts are.

Dr. Colyer, what should we be doing to incentivize the best and brightest to go into medicine and reverse the trend that 8 out of

10 would reconsider their decision to practice medicine, and I don't know a single physician that would encourage his or her kids or grandkids to practice medicine?

Dr. COLYER. Let them be a doctor. Let them make the decisions. Let them have a relationship with their patients and really do their specialty their experience. That's what would make the difference, and it is the bureaucracy that is driving us crazy.

Mr. GOWDY. Mr. Pollack, you twice made a reference to "free" which I found to be a fascinating word. Free preventative care. What is free about it? Does that mean the doctor donates his or her time and the pharmaceutical company donate the drugs and the medical device company just donates it? When you say free preventive care, free contraception, what do you mean by free?

Mr. POLLACK. Well, with free preventive care, it means that one's insurance policy will pay for that without a deductible and without a copay.

Mr. GOWDY. How will the insurance company make sure that it doesn't go broke? It will pass the cost on to other people, right?

Mr. POLLACK. By providing preventive care, it avoids much more costly and cumbersome services later on, so that somebody——

Mr. GOWDY. So it is free in an economic—from the futuristic economic sense it's free?

Mr. POLLACK. If you're asking "free" in terms of dollars——

Mr. GOWDY. I'm just fascinated by the word "free."

Mr. POLLACK. It will save money in the long term because it means a problem will be diagnosed at an earlier stage and it means somebody will not need complex care later on, which is far more expensive.

Mr. GOWDY. I'm out of time. I will now recognize the gentleman from Missouri, Mr. Clay.

Mr. CLAY. Thank you, Mr. Chairman.

Since 2001, employer sponsored health coverage for family premiums has more than doubled, crowding out other investments in human capital and innovation and placing coverage out of reach for more families. The ACA was designed to reform our system of health care delivery to incentivize high quality care, appropriately priced services, and fight waste, fraud and abuse. In fact, the ACA contains almost every cost-containment provision that policy analysts have considered and touted as effective in reducing the growth of health care spending.

Mr. Pollack, do you believe that the provisions contained in the ACA to incentivize high quality care, appropriately priced services, and fight waste, fraud and abuse are important to a robust, affordable health care system?

Mr. POLLACK. I do, sir.

Mr. CLAY. Mr. Pollack, won't access to preventative care as designed by the ACA assist in controlling the cost of overall care as folks no longer have to use the emergency room for treatment of preventable health care problems.

Mr. POLLACK. Mr. Clay, as you are inferring, care in an emergency room tends to be the most expensive care possible. And when it occurs, it normally occurs when somebody has actually had a disease spread and the illness now needs heroic treatment. So I do be-

lieve that if we can avoid that, it is both good medicine and it is more cost effective medicine.

Mr. CLAY. You know today and tomorrow the Republican majority will try for the 31st time this Congress to repeal the Affordable Health Care Act. But what is their alternative? They have none. They have no solution to continue growth in health care spending and have offered no comprehensive approach to deal with the systemic causes of growth in health care spending.

You know, research has shown that the uninsured are more likely to delay or forgo needed medical care than insured individuals. As a result, the uninsured are more likely to be hospitalized for avoidable medical conditions which increases overall health care costs for everyone.

The CBO believes that the Affordable Health Care Act will expand coverage to 32 million Americans with approximately 19 million Americans benefiting from premium assistance credits for the purchase of private health insurance.

Mr. Pollack, as you know, this vote will not repeal the Affordable Care Act. But it signals what would happen if Republicans were to win the White House, the Senate, and hold on to the House.

Mr. Pollack, have the Republicans offered a viable plan to insure the uninsured and improve health outcomes while containing the very problematic increase in health care costs?

Mr. POLLACK. Well, Mr. Clay, at the outset of this debate in the first of 31 different efforts to repeal the statute, we heard a lot about repeal and replace. Since that time we have only heard repeal, repeal, repeal and precious little with respect to replace.

Mr. CLAY. Without the protections and expanded eligibility made possible by the ACA, how else do we guarantee that poor and working class Americans access cost effective primary care services?

Mr. POLLACK. We do this not just by expanding Medicaid, and I take issue with my fellow panelists who criticize the program, but one of the key ways we do it is by improving private health insurance, and we make it more affordable by providing tax credit subsidies so that people can afford it.

The chairman of the committee talked about a family with $50,000 in income. That family will receive huge tax credit subsidies to make health coverage affordable. If we repeal the Affordable Care Act, not only will health coverage be unaffordable, but there will be a tax increase experienced by those middle-class families.

Mr. CLAY. There we go again, beating up on the little guys. Thank you so much, and I yield back.

Mr. GOWDY. I thank the gentleman from Missouri.

The Chair will now recognize the gentleman from Tennessee, Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman. I do thank the panel for coming today and giving us their insight. I also would like to thank some of the non-committee members, my physician colleagues, that have joined us today. You have six members of the Doctors Caucus sitting before you on the panel today. We have 15 physicians in Congress now and three in the Senate. We make up a combined 600 years of total experience in health care. I would say that—I think I can say for all of us sitting here, not a single

one of us went to medical school thinking that one day we would be sitting in Congress. We went into medicine because we want to help people, and my colleagues are joining me here today because they want to talk about this important issue.

Despite what Mr. Pollack said about the numerous groups that are in support of the health care law, I think that there are several doctors here and doctors across the country that clearly oppose it, and I think there is patients across the country that oppose it. This was evident by the fact that 63 percent of the people were opposed to this health care law when it was passed, and that continues to be the case. The majority of the people don't want it. So to sit here and say that we should keep it is disingenuous. And now with the Supreme Court ruling saying that we will all be taxed, clearly the President has broken his promise about not raising taxes on the middle class with this enormous tax, and it also cuts and hurts Medicare. And I'm tired of these attacks as a physician because we care about patients having good access to care, and I don't think there is a physician on the panel that thinks that this will control costs or improve the quality of care, and it certainly is going to hinder the doctor/patient relationship. Doctors, would you agree with that?

All of the doctors are nodding.

Mr. Pollack, you said that this is going to make health care more affordable. How do you justify that when the cost, as Ms. Pipes has stated, has doubled since President Obama initially said $800 billion has gone to $1.7 trillion; how do you justify that?

Mr. POLLACK. First of all, I want to just correct one thing. The Chief Justice did not say this is going to be a broad tax. In fact, if you read his opinion, his opinion makes clear that only about 1.3 percent of the American public would face this tax penalty. He cited in his——

Mr. DESJARLAIS. I thought it was clearly a tax, sir.

Mr. POLLACK. I'm not disputing the language of tax or penalties. That's not the purpose of what I'm saying.

Mr. DESJARLAIS. How is it making it more affordable? How is it more affordable? You say it is more affordable. Ms. Pipes, I will give you a chance, too, to debate this.

Mr. POLLACK. Well, it makes it more affordable because it provides huge tax credit subsidies so that people can afford private health coverage.

Mr. DESJARLAIS. Who is going to pay for the subsidies? Where does that come from, taxes? We don't have free. As the chairman said, we don't have free in this country. You said it reduces cost, that isn't free, and it is not reducing costs.

Mr. POLLACK. There are some savings and efficiencies created in the Affordable Care Act. I will give you an example.

Mr. DESJARLAIS. Do you think Medicaid is efficient, cost efficient?

Mr. POLLACK. Yes, it is. The Congressional Budget Office made clear during the debate that that would be the most efficient way to expand coverage to people who don't have coverage.

Mr. DESJARLAIS. Ms. Pipes, do you think Medicaid is affordable or is this law affordable?

Ms. PIPES. No. As I said, the CBO said $1.76 trillion. Many economists, myself included, believe that in 2014, the decade 2014 to 2024, this law will cost about $2.6 trillion because of the cost drivers, the exchanges, the individual mandate, the employer mandate, the ending of price discrimination based on preexisting conditions. It is going to be very, very expensive.

On the issue of Medicaid and Medicare, the Congressional Budget Office and the Medicare trustees have shown, the Medicare trustees say by 2024 Medicare will cost about $1 trillion, almost double what it is today, Medicaid $800 billion, and these programs will be bankrupt. We need to make changes so that the people who do need Medicare and Medicaid have access.

But interestingly, under the Affordable Care Act, Medicare is being cut by $500 billion over the decade to add those 18 million people to Medicaid.

Mr. DESJARLAIS. Thank you.

Dr. Colyer, do you have anything to add to that? Actually, let me be specific. Let's talk about the bureaucracy. What has happened with ObamaCare? How much of your time is spent on bureaucracy versus medicine?

Dr. COLYER. Two-thirds of my staff are dealing with the bureaucracy aspect of it. We are even seeing this in State government. We've put together health reforms that are really going to save money and actually reverse a lot of problems and outcomes, and it is going to take us months to actually get that through the bureaucracy.

Mr. DESJARLAIS. Is there anything affordable about that?

Dr. COLYER. No. Our State has had tremendous financial problems.

Mr. DESJARLAIS. All right, thank you. My time has expired, and I yield back.

Mr. GOWDY. Thank you, and the chair recognizes Ms. Holmes Norton.

Ms. NORTON. Thank you, Mr. Chairman. In our discussions about doctor-patient relationships, and so we all agree that we would want most patients to have a doctor. And let us stipulate for the record that the cost of health care will go up. The question is costs compared under the Affordable Health Care Act compared to no Affordable Health Care Act. So throwing out trillions of dollars will get you nowhere unless we have a comparison to make, and one that is as credible as the CBO's comparison, I might add.

It may be, Doctor, Lieutenant Governor Colyer, you may be the appropriate person for this question because you serve in both roles. I don't know if the Lieutenant Governor of the State of Kansas has an operational role as well, but let me ask you this question because you may be the most familiar with it.

Some, a few Governors have said that they will not accept the 100 percent Medicaid funding, going down gradually to 90 percent, to fund working class and working poor people who are now included under Medicaid and the Affordable Health Care Act. Is Kansas, by the way, one of those States that has not yet made a decision?

Dr. COLYER. No, we are in the midst of a major Medicaid reform and we are trying to make it so it is much more responsive to patients.

We have got an election coming up. The Governor has said we need to change the system, and we are going to make a decision afterwards.

Ms. NORTON. Well, I appreciate you're thinking it through rather than responding the day after the Supreme Court decision, but I have a question about where these people, many of them, most of them, indeed, working people went before and will now go? Where they went before, of course, was to the costliest doctors, and those were the doctors in the emergency room, where in fact they cost the State and the Federal Government five and six times what they would cost if they had a medical home.

My concern is with hospitals. Hospitals in big cities like my own, and particularly hospitals in rural areas, can hospitals survive if these patients are thrown back with what looks like to be now no uncompensated care. You do the charity care and it falls back mostly on the State, it fell back mostly on the State before, but there was a little something that the Federal Government gave for uncompensated care.

Again, what are your hospitals saying about the effect on them if these patients are thrown back into their emergency rooms at greater cost to the State, and I suppose not to the Federal Government since they won't be on Medicaid?

Dr. COLYER. Actually, we are creating a system that does exist, the majority of people without insurance don't end up in the emergency room. They get their care through a variety of clinics, through their private physicians in the State of Kansas. We have a number of federally qualified health clinics, for example, with very low cost.

Ms. NORTON. We all have those.

Dr. COLYER. And we all have those, but they are a really important safety net. But there are some other solutions.

Ms. NORTON. And they are also often largely federally funded as well.

Dr. COLYER. And also State funded.

We are also able to create incentives for doctors to take care of people in their own community. It's giving the States, the individual States the opportunity to make these solutions. That's what's so important.

Ms. NORTON. I can understand that, Dr. Lieutenant Colyer. I just hope in the process the State will consult with the hospitals because they may be one of the victims in all of the play back and forth. We don't know, but I appreciate the approach you are taking that looks at all of the factors involved.

May I ask a question of you, Mr. Pollack? I was astounded by the number, almost 60 million Americans, nonelderly now, have what are called preexisting conditions. This is a frightening number. One in five Americans. Prior to the Affordable Health Care Act, where were these people receiving treatment? Were they receiving treatment?

Mr. POLLACK. They were uninsured by and large because people with preexisting conditions, a child with asthma or diabetes could

not get health insurance coverage from an insurer. Now that the Affordable Care Act with respect to that aspect of the law is in effect for children, those children are now getting coverage and they are getting care. In 2014, for adults that protection will be extended.

Ms. NORTON. Is there a way other than the way that the Affordable Health Care Act has found, putting as many people in the pool as possible, is there a way to provide health insurance in an affordable fashion for people with preexisting conditions?

Mr. POLLACK. The best answer to that question is some States have established high risk pools and high risk pools are a substitute. But the problem is when you have a pool composed completely of people who have illnesses and health conditions, the premium costs per person skyrocket and that's why you want to integrate them into private insurance pools that include healthy and young people along with sicker and older people.

Ms. NORTON. Thank you very much.

Mr. GOWDY. I thank the gentlelady from the District of Columbia.

The chair would now recognizes the gentleman from Arizona, Dr. Gosar.

Mr. GOSAR. I would like to run a clip first and have you watch this clip and then I want to get your opinions:

"And that means no matter how we reform health care, we will keep this promise to the American people: If you like your doctor, you will be able to keep your doctor; period. If you like your health care plan, you will be able to keep your health care plan; period. No one will take it away no matter what. My view is that health care reform should be guided by a simple principle—fix what's broken and build on what works, and that's what we intend to do. If we do that, we can build a health care system that allows you to be physicians instead of administrators and accountants."

Mr. GOSAR. Dr. Colyer, let me get your opinion to that comment. I thought the backdrop was very interesting. It was at the AMA.

Dr. COLYER. In Kansas, you will not be able to keep your more affordable plan under the ACA. We've developed a wide variety of health insurance plans and opportunities, health insurance accounts, a whole variety of things. And we can expand those and do that. We have now got a one size fits all that is much more expensive than what we have in the State of Kansas. It may work in other States, but it's not for us.

Mr. GOSAR. How about you, Dr. Armstrong?

Dr. ARMSTRONG. That is obviously completely false. And for the President to say that we are going to allow doctors to not be bureaucrats any more, when you look at what has been done so far, we have 12,000 pages of regulations that we don't even know what they say. How can that possibly not allow doctors to be bureaucrats? That's just ridiculous. Those two statements that he made, if you like your doctor, you can keep him; if you like your plan, you can keep it, it is obvious now that that is just false. That is just completely false. That was a sales pitch to the American Medical Association.

I might remind everyone that the American Medical Association receives $80 to $100 million a year from their sale of CPT coding

books and CPT licensing, so they have a small amount of financial incentive to go along with whatever CMS thinks is a good idea.

Mr. GOSAR. Can I ask a quick question, interject there? What percentage of the physicians in the country do they represent?

Dr. ARMSTRONG. The latest numbers are that approximately 10 percent of actively practicing physicians belong to the American Medical Association.

Mr. GOSAR. I find that interesting. I am a dentist and the American Dental Association represents over 70 percent of the dentists across the country.

Dr. ARMSTRONG. In 1962 when Dr. Ed Annis gave his famous talk against Medicare at Madison Square Garden, the American Medical Association represented 70 percent of American doctors.

Mr. GOSAR. Dr. Novack, I want to get your opinion.

Dr. NOVACK. Well, it is certainly not the case. As was mentioned earlier, the protection against so-called preexisting conditions for children means that in at least 34 States is almost impossible to get a child only policy. If you are a member of at least two branches of the SCIU in New York State and you have a child who is insured, you didn't get to keep what you have because in response to this they dropped all child policies.

If you had certain health care policies in the Midwest with a company that had about 900,000 members, they just stopped offered health insurance entirely.

So people are not keeping what they have. Their costs are going through the roof. Ultimately, if the goal was to provide more accessible care for the people who need it at a more affordable rate, what I have seen in the past 2 years is that we are going in exactly the opposite direction.

Mr. GOSAR. I just had two health care forums on Friday. And we are from Arizona, and there are large rural parts. If we are dumping so many more patients into Medicaid, and by the way, you said we're going to work on things that actually work. The last time I looked at Medicaid, it doesn't really work.

Dr. NOVACK. Arizona's Medicaid system, as people know, Arizona was the last State to join Medicaid in 1982, came in under a waiver, and has always existed in a managed care system. And even that, the system is basically at its breaking point. There was a $1 billion shortfall in the last year or two at the legislature to try to cover Medicaid. The system just isn't working. The number of cuts to services, because that's really the only option that the system has, so now if you're on Medicaid in Arizona, you can't get durable medical equipment. So I can't put my patients in certain kinds of boots to help them get around better. They have to be in a cast or nothing, which is a big problem for a lot of the working folks I take care of. You can no longer see a podiatrist if you're on Medicaid in the State of Arizona. So if you have diabetes and you need regular footcare and you're on Medicaid, you're out of luck because the system simply doesn't cover it.

Mr. GOSAR. There are groups that are exempt from ObamaCare; are there not? One that we are very familiar with, the Native Americans?

Dr. NOVACK. Well, there are all sorts of different waivers. There were things put into the law. But the real problem, and I think,

speaking from the provider side and from the policy side and from the government side, is that the application of the law is turning out to be completely arbitrary. It would be one thing if those of us involved in the practice of medicine could actually count on the letter of the law and try to make adaptations. But what we've seen with the nearly 2,000 waivers affecting over 4 million Americans who won't get certain benefits, if we look to the fact that actually snuck into the law was that if you were in a self-funded insurance plan, which is over 100 million Americans, 60 percent of all people with commercial insurance, you will never get the benefits of the essential health benefit package that the President and the Democrats said was urgent or imperative because they were exempted from that entirely.

So we are finding complete arbitrariness in the application, and that is making it ultimately harder for people to get care.

Mr. GOSAR. And I find it real interesting that the group of people who have had government-dictated health care the longest are rebelling enormously across the board, the self-determination type plans.

So thank you.

Mr. GOWDY. I thank the gentleman from Arizona.

The chair will now recognize the gentleman from Georgia, a distinguished physician, Dr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you very much, and I want to thank you and members on both sides of the aisle, too, for extending us this courtesy to be guests today and indeed to ask some questions.

Let me real quickly turn to Dr. Novack. ObamaCare does not address the problems of most Americans who have very low expected health care expenditures. According to the Agency for Health Care Quality Research, and I think you talked about this in your testimony, the bottom 70 percent of health care users in this country, that's about 224 million Americans, spend only, I think you said 11 percent of health care dollars, or about $290 billion out of $2.7 trillion. In your testimony, you stated that ObamaCare harms these 224 million Americans that are very low utilizers. Why?

Dr. NOVACK. Number one, costs are going up. That is number one. Number two is the creation of all of these new bureaucracies and boards and the effort to shove these people who are just occasional users of health care into very complicated medical home models that make it harder to get access to specialty care when that may be what they need, just to get in and get out, that makes the system more difficult to navigate. It makes the process of going to the doctor a less pleasant experience.

Mr. GINGREY. Dr. Novack, thank you.

Turning to Dr. Colyer, Lieutenant Governor Colyer, you talk about what you and Governor Brownback have done in the State of Kansas in regard to the Medicaid program. So I want to focus in real quickly this question to you. You spoke about the off ramp, I think you used that phrase, that off ramp of getting people off of Medicaid into private insurance. You know, part of PPACA, the Affordable Care Act, has this maintenance of effort requirement under Medicaid for at least the next 2 or 3 years before the expansion kicks in, the additional 20 million people. As I understand

that maintenance of effort, it would prevent you and Governor Brownback and Governor Deale of the State of Georgia and folks that are working on trying to solve their Medicaid problem in a State based way, the crucibles of innovation, that you couldn't even look at your roles and determine if many people in Kansas who 2 years ago were eligible for Medicaid but maybe today they are not. Indeed, maybe they are not even legal citizens, legal residents of this country. But more importantly, from the economic standpoint, they are not eligible.

Isn't this a tremendous problem for you to get these folks onto that off ramp, as you describe?

Dr. COLYER. We want to give people the opportunity to get back into stable, commercial insurance that they can control, that is very portable, that they can take with them. Maintenance of effort does decrease that. But part of the problem with the maintenance of effort is not just that people are in, it is being really interpreted in very broad ways. The previous Governor asked for just a small increase in the premiums that were paid by certain CHIP members, and instead of a few dollars it was just a few cents.

Mr. GINGREY. Yes. Essentially what you're saying is you have got handcuffs on you that prevent you from doing some of these things in an innovative way to make sure that the dollars get to the people that need them the most on the Medicaid program.

Let me utilize, Mr. Chairman, the remaining portion of my time to talk to and ask questions of Dr. Armstrong.

Dr. Armstrong, thank you for wearing that white coat. That means a lot, believe me, to we physician members that are sitting up here asking the questions. On page 78 of Public Law 111–148, otherwise known as PPACA, Affordable Care Act, ObamaCare, there is a section entitled "Enhancing Patient Safety." Let me read you the section.

Beginning on January 1, 2015, a qualified health plan, otherwise known as an insurance company, may contract with a health care provider only if they implement mechanisms to improve health care quality as defined by the Secretary, indeed by regulation.

My concern is that nowhere in the many pages of ObamaCare is the word "quality" defined. So I'm interested in the thoughts of the panelists. If ObamaCare gives the Secretary of Health and Human Services the power to invalidate the private business contracts that providers need to stay in business, in other words they have to be on the panel, what type of authority does that give the Secretary to direct how providers deliver care and practice medicine?

Dr. Armstrong, in your testimony you cite the U.S. Preventative Services Task Force and its findings. It recommended against mammography screenings for women below the age of 50. I'm an OB/GYN, 26 years in practice. I do not believe such a recommendation is the kind of personalized medicine that my patients deserve. Each patient is different and therefore I would probably not adhere to this bureaucratic directive from Secretary Sebelius, or any other Secretary of Health and Human Services. I would listen to my specialty society, the American College of OB/GYNs.

So tell me real quickly—I know I'm a little out of time—so tell me, Dr. Armstrong, could the Secretary of Health and Human

Services literally drive me or any other practitioner out of business under the authority given to her to enhance patient safety?

Dr. ARMSTRONG. Yes.

Mr. GINGREY. Thank you. Mr. Chairman, thank you for your indulgence, and I yield back.

Mr. GOWDY. I thank the gentleman from Georgia.

The chair will now recognize the gentleman from Michigan, the distinguished Dr. Benishek.

Mr. BENISHEK. Thank you, Mr. Chairman. I appreciate the privilege of being here on this committee this morning.

Dr. Armstrong, you've been in practice for a long time. What is the worst feature of practicing medicine today?

Dr. ARMSTRONG. Probably the risk of a malpractice suit if you had to say what the worst risk is, but there are many. But we could start there.

Mr. BENISHEK. Did the Affordable Care Act do anything to adjust this problem?

Dr. ARMSTRONG. Essentially no. There was money in it to fund State demonstration projects for looking at different alternatives to tort reform, but there were some strings attached to that money that made it very difficult for States to do it. For instance, if your State proposed a cap on noneconomic damages, you couldn't get the demonstration money.

Mr. BENISHEK. All right. Dr. Novack, what do you think is the most difficult aspect of practicing medicine today?

Dr. NOVACK. As was alluded to earlier, the challenge that in our practice where we have nine providers, we have three times that many allied health personnel. So as opposed to being able to devote the resources to try to provide as comprehensive and as widespread care as possible, we have large expending of our resources on things that really have very little to do with patient care.

Mr. BENISHEK. Is the Affordable Care Act improving that situation then?

Dr. NOVACK. Thus far it has made it significantly worse since regulations. New regulations seem to appear every week, since we have an environment now where the other parties in health care are seeking to take huge steps to really take ownership over these huge chunks of money. In large part we can look at the potential for the $900 billion in Medicaid spending that the CBO anticipates over the next 10 years and the $800 billion in direct insurance company subsidies. The problem there is that patients and families cease to become patients and families and become entities where if you can get them under your umbrella you can then get those Federal dollars. That has very little to do with patient care.

Mr. BENISHEK. Taking care of patients and seeing what is happening with medicine now with the Affordable Care Act and just the third-party payer system, it concerns me that it seems that physicians are working less and less for the patient and more and more for some other bureaucracy which is going to dictate the form of care that they give to those patients. My feeling is that the doctor-patient relationship should be one where the patient is in control of the situation.

Dr. Armstrong, do you think that patients can be trusted to take care of their own health care or do you think that they need the Affordable Care Act to guide their care for them?

Dr. ARMSTRONG. I think there are many concrete examples that show that patients can be excellent consumers in health care markets.

Mr. BENISHEK. Okay, give us one example.

Dr. ARMSTRONG. For instance, in Indiana with the Healthy Indiana Plan that has been established by Governor Mitch Daniels, under Medicaid, patients are given power accounts and they have to make their own decisions similar to a health savings account about where the money goes, and they have actually shown that they have reduced their health care spending but not affected outcomes. So they have reduced health care spending by up to 30 percent but have not affected their health care outcome. That is just one thing. This has also been done in private industry and private contracts and continues to be advocated in other areas.

Mr. BENISHEK. Dr. Colyer, do you have any comments in that vein?

Dr. COLYER. Yes. I think there are lots of opportunities where patients can make their own choices. And they can work with their doctor for good solutions. For example, if you empower a patient to—we can oftentimes do their procedure in the office rather than under certain rules it would only be paid for only if you do it in the hospital setting. Those are common sorts of problems.

Mr. BENISHEK. Thank you very much.

Dr. Novack, who do you think should be in charge of health care decisions, doctors and patients or the bureaucrats?

Dr. NOVACK. I think and patients and families in conjunction with the treating physician and other health care personnel.

Mr. BENISHEK. Does the Affordable Care Act encourage that?

Dr. NOVACK. It moves it in the opposite direction. As I mentioned, when you create 150 plus new bureaucracies, when you manage to have 13,000 pages of regulations, and that is just the tip of the iceberg, on top of the 130,000 pages of regulations that Medicare has created since 1965, and have a health exchange network that is likely to adopt nearly wholesale the Medicare regulations, then foisting that on the patient population and the providers, you create an environment where the decision makers and ultimately the payers are not patients and families but people far removed. As I mentioned in testimony, the ultimate reality will become that the people who provide care, whether it is physicians, nurses, other people, are being more responsive to the decision makers rather than patients. I just don't see, after 24 years of taking care of patients in almost every setting, how that is good for patient care.

Mr. BENISHEK. Thank you, Dr. Novack. I certainly agree with you.

My time is up. Thank you.

Mr. GOWDY. I thank the gentleman from Michigan.

The chair now recognizes the distinguished gentleman from Louisiana, Dr. Fleming.

Mr. FLEMING. Thank you, Mr. Chairman. Thank you again for having us as guests for the panel.

I want to bring the panel's attention to this card here. Now this, you may not be able to see it from there, so I will explain to you what it is. This is my health care card. This is Blue Cross/Blue Shield. Despite what you may read on the Internet, I actually pay 28 percent of my premium and it is a private insurance plan. This is my on ramp into the health care system. This is my key in the door.

Now, the ranking member, Mr. Davis, made a comment a moment ago that sort of tweaked my ear. He said that the ObamaCare would give access to care to 30 million more Americans, and therein lies the problem. There is a tremendous myth that just because you have a card that entitles you to coverage that you actually have access to care.

Now, let's go to you, Ms. Pipes. You made a really good point, a really moving story about your mom. And I am sure that some would like to say that that was an exception, but I have heard many stories like that as well in Canada where people had cancer and never got the treatment that they needed. In fact, if you look at the statistics, death rates from prostate cancer, death rates from breast cancer in both Great Britain and Canada where there is supposed to be 100 percent coverage, everybody carries a card, but yet the death rates as a result of late diagnosis and also inadequate treatment are much higher in those countries. So I would love to hear your response on this differential between carrying a card that says you're covered and the actual access to care.

Ms. PIPES. Thank you.

Yes, the United States ranks number one in 13 of the 16 most prominent cancers—breast cancer, colon cancer, mammography. So we do extremely well compared to Canada.

Mr. FLEMING. In terms of positive outcomes?

Ms. PIPES. Yes, right. The 5-year survival rate.

In a country like Canada, the Fraser Institute's new study on hospital waiting list, the average wait today in Canada from seeing a specialist to getting treatment by a specialist is 9.5 weeks. It is the highest since they started reporting wait times, and it is up from 9.3. The average wait from seeing a primary care doctor to getting treatment by a specialist is 19 weeks, almost 5 months.

In a Supreme Court case in Canada, Madam Chief Justice Beverly McLaughlin, in looking at the Province of Quebec and denied care, she said: Access to a waiting list is not access to health care.

So in a country like Britain and Canada, you do have these long waits. You read stories in the press all the time. As my friend, the former head of the Canadian Medical Association, who runs an illegal orthopedic clinic in Vancouver, said a family can get a hip replacement for their dog in less than 2 weeks and for their family the average wait is 2 years.

I believe unless this act is repealed and replaced with solutions that empower doctors and patients, we will face the same kind of rationed care and long waits in America.

Mr. FLEMING. There are those who would say well, look, we don't have the single payer system that they have there, therefore that is not going to be a problem here. But I would take everyone back to the health care debate. Many on the other side of the aisle, many Democrats, actually wished for wanted, and pushed for sin-

gle payer, and in fact hope—and this is their words, not mine—hope that this evolves into that. So would it be fair to say that there is something different about the government takeover of health care under ObamaCare and single payer when it comes to access to care?

Ms. PIPES. Well, as the late Senator Ted Kennedy used to say, his goal was Medicare for all, which is a single payer system.

I believe, as you say, there was no public option in the Senate bill or in the final bill, but we've already seen Congressman Jim McDermott from Washington State introducing a single payer bill. We've seen some of the States, Vermont has, Governor Shumlin has a single payer bill. I think ultimately private insurers are going to be crowded out because they are not going to be able to offer insurance at the rates that they have to with the essential benefit plans. And even Howard Dean the other day, who said he was against the individual mandate, has been pushing for single payer. So if we don't get an off ramp, we are on the road to serfdom with a single payer system, I truly believe, and I think it is going to happen.

Mr. FLEMING. I only have a few moments. Dr. Novack, Dr. Armstrong, would you like to weigh in?

Dr. ARMSTRONG. I agree with Sally.

Mr. FLEMING. Access versus?

Dr. NOVACK. There are multiple studies showing that people on Medicaid do not necessarily have any better access to certain kinds of care than people with no insurance at all.

Mr. FLEMING. I would just add to that, since you brought up Medicaid real quickly, I am a physician and I see Medicaid patients all the time. The reimbursement levels are very lower in Medicaid. They are going lower on Medicare, and so we have a lot of people in this country, a lot of people in my State of Louisiana who walk around with a Medicaid card and now a Medicare card, and they ring up the doctor's office and they are told that they don't have access. Now, some would say, well, that is an arbitrary physicians. No, physicians all over this country are saying we're closing our office down. We're going to have to work in the emergency room. I'm going to have to do something else as an occupation because I can't survive, I can't make payroll as a doctor because of the low reimbursement rates. So where do these people end up going? They end up going to the emergency room which the other side of the aisle would be the first to tell you is where the care is the most expensive.

Thank you, Mr. Chairman, and I yield back.

Mr. GOWDY. I thank the gentleman from Louisiana.

The chair would now recognize the gentleman from Maryland, the distinguished physician, Dr. Harris.

Mr. HARRIS. Thank you very much, Mr. Chairman and members of the committee, for allowing the members of the Physicians Caucus to participate.

Mr. Pollack, I'm a physician who has always depended on the conscience clause protection in my practice. Does Families USA support the HHS mandate that includes abortifacients and sterilizations and that is now the subject of lawsuits claiming infringement of religious freedom?

Mr. POLLACK. Families USA does support.

Mr. HARRIS. Thank you very much.

Dr. Novack—a simple yes or no, so you support that?

Mr. POLLACK. We support the preventive care services in the Affordable Care Act.

Mr. HARRIS. Sure, okay. Thank you. That's what I needed to know.

Dr. Novack, do you think the average American senior understands that to make ObamaCare work you're cutting $500 billion out of Medicare over the next 10 years plus $300 billion in SGR scheduled cuts, $800 billion cut out of senior health care funding, do you think the average senior understands that?

Dr. NOVACK. What I'm seeing both in my practice and doing some of the work I do around the country is seniors recognizing when they call to try to find a physician they are not finding doctors who are taking Medicare patients.

Mr. HARRIS. Do you think ObamaCare will make that worse or better?

Dr. NOVACK. It will make it worse. As you mentioned, the numbers, which were cooked, which of course in our business if you could cook your anesthesia concoctions——

Mr. HARRIS. I would live in a courtroom all my life if I did that.

Dr. NOVACK. Yes. The supposed savings of course is predicated on these $300 billion in SGR payments, including a 30 percent in January of next year.

Mr. HARRIS. Sure.

Dr. NOVACK. If those go into effect, we will really significantly adversely impact access to care.

Mr. HARRIS. Thank you.

Ms. Pipes, we heard a lot about free preventive care, and so I was giving a town hall a couple of months ago and two physicians stand up in the back and go, we work in federally qualified health centers, and they told me that the free flu vaccine, they get paid over $200 from the Federal Government for the free flu vaccine that people get when you can walk down to the Rite-Aid or Walgreen's and get it for $39.95. Ms. Pipes, correct me if I'm wrong, doesn't this—and a very short answer—indicate that in fact free preventive care is not free? And not only that, when the Federal Government delivers it, it can cost five or six times as much as the private sector?

Ms. PIPES. Yes.

Mr. HARRIS. Thank you very much.

Dr. Colyer, Lieutenant Governor, why would you possibly recommend to your Governor to participate in Medicaid, the expansion from 100 to 133 percent, when you know if you choose not to every one of those patients will be covered under a Federal health exchange at not cost to your State? No administrative cost, no cost at all. And you see, as the chairman pointed out, and the Congresswoman from Louisiana, in Texas right now only 31 percent of physicians will take a Medicaid patient, but a whole lot more will take a private patient. And, in fact, Mr. Pollack said under this plan, you get a private health insurance plan. Why would any Governor possibly do it to those people, those poor people who we heard about from the gentlelady of the District of Columbia, those poor

working people we heard about from the ranking member, why would you foist Medicaid on them when their option under affordable care is a federally subsidized health exchange plan?

Dr. COLYER. An even better solution is win the election in November.

Mr. HARRIS. Well, I understand that. But given the scenario, any Governor who does this to their poor people, to their people in that 100 to 133 who opt to expand Medicaid, ought to talk to some of the docs about what, I urge and everyone listening, call up your doc and ask them if they take Medicaid and then decide whether you would want to be on Medicaid or not.

Ms. Pipes, we heard Mr. Pollack say that "some States have high risk pools." Don't 35 States have high risk pools?

Ms. PIPES. Yes, they do.

Mr. HARRIS. Thank you very much. I just want to clarify that in fact the vast majority of Americans are already covered under preexisting conditions in high risk. Mr. Pollack, it is a fact, including Maryland. I'm not asking you a question.

Mr. POLLACK. These are all very small.

Mr. HARRIS. Mr. Pollack, I'm not asking you a question. Listen to what the chairman, how he admonished you. You are to answer a question when I ask you. I didn't ask you the question. You already made the statement that some States. We understand that to you 35 of 50 is just some.

Ms. Pipes, I'm an obstetric anesthesiologist. I have spent my life delivering health care to women. I've watched the caesarean section rate go from 18 when I started in 1980 to 35 now. That's the C section rate. Just for all of you young ladies in the audience, you are twice as likely to have a caesarean section as you would have been when I started my practice 30 years ago. You can't find an experienced OB who's been doing it for 30 years to deliver your baby any more. They all gave it up. You get the inexperienced, well-intended young physicians because the experienced OBs have given up. Because of lack of tort reform, you have a doubling of the caesarean section rate. If any of you young ladies think that is better health care, raise your hand. I don't think so. Does this Affordable Care Act do anything at all to address a rising caesarean section rate or the fact that experienced obstetricians are leaving the field?

Ms. PIPES. No. And tort reform is one of the things that we have seen, the OB/GYNs in West Virginia, Pennsylvania, Nevada, the States that have the highest med mal insurance rates, the decline in OB/GYNs has been very significant. And who does that hurt? It hurts all women who are of child bearing age.

Mr. HARRIS. It hurts women. I suggest, Mr. Pollack, you take that information back to your group that opposes tort reform.

Thank you very much, Mr. Chairman.

Mr. GOWDY. I thank the gentleman from Maryland.

On behalf of all of the panelists, we want to thank our distinguished panel of witnesses.

Mr. DAVIS. Mr. Chairman, Could I just clarify something. I was mentioned in terms of something that I said, and I don't think that I really said that.

Mr. GOWDY. Sure.

Mr. DAVIS. Doctor, you implied that I suggested that because individuals had access to insurance they had access to care. I've been in this business much too long to have not understood that insurance does not necessarily mean access to care. We have many——

Mr. FLEMING. Would the gentleman yield?

Mr. DAVIS. Let me just finish.

We have serious manpower shortage areas. We have areas where there are no physicians. We have areas where there are no facilities. And so access to insurance means that you have a way to pay for care. It does not necessarily mean that the care, and I'm amazed when I hear individuals suggest that we're going to put such a burden on the health care delivery system. It just depends on how you look at it. If you are a young person who wanted to become a physician or who wanted to become a nurse, it creates a tremendous opportunity for you to go to medical school, to go and be trained so that you can provide care for these millions of people who don't have any.

I just wanted to clear that up.

Ms. NORTON. Mr. Chairman, could I correct the record on a factual matter?

Mr. GOWDY. Yes, the gentlelady from the District of Columbia can. But I think in fairness, I should give the gentleman from Louisiana a chance to respond since he attempted to do so and then I will recognize the gentlelady.

Mr. FLEMING. Let me say parenthetically that a study just came out today that I believer 83 percent of physicians when asked, when polled, this was a survey, a scientific survey, said they are reconsidering their occupation. And I can tell you that I get questions a lot from medical students who ask me did they do the right thing. So again, I would just say to the gentleman that right now ObamaCare means for health care workers a very uncertain future. Yes, they do want to take care of patients, insured or not, but they see a very dark cloud ahead of them.

But to respond to your statement, yes, you did say access to care. That is the actual term. And I'm sure we could pull it up in the transcript if we need to. Why that is important is because that is a common myth. Whether or not the gentleman meant it or not is beside the point.

Mr. FLEMING. The point I needed to make with that is that Americans are getting that message, that once you get that card that means that you go into the healthcare system and you are just going to be taken care of, and that is the whole point. Half of the additionally covered Americans under ObamaCare, and this is by Democrat numbers, not mine, I think fewer are going to be covered than the 30 million that are claimed, but half of them will be covered under Medicaid. And you just heard the gentleman from Maryland say that very few doctors accept Medicaid, not because they don't want to accept Medicaid, because they can't afford to accept Medicaid.

If we don't deal with the cost realities that go with malpractice insurance and all of that, the access problem is going to only get worse. So I think that is something we need to leave with today that just because you have a card, just because you are in a system does not mean you have access, and I yield back.

Mr. GOWDY. I thank the gentleman from Louisiana, and now I recognize the gentlelady from the District of Columbia.

Ms. NORTON. Thank you, Mr. Chairman. On the matter of the health, people on—who would receive Medicaid under the Affordable Health Care Act, going to the exchange, go to the exchange, you need to have some cash to pay for the health care and the exchange. These are people above the limit of Medicaid but unable to pay for health insurance, and my question is, the payment for health insurance and the high-risk pool—I'm sorry, the exchange will not help those people which is why they were included, in Medicaid. For preexisting, for those with preexisting conditions going to the high-risk pool, the high-risk pool is anything but affordable. It should be called the unaffordable high-risk pool because clustered there are all of those who have sought refuge there and therefore it becomes unaffordable for almost everyone who would want access, who have the diabetes and can't find a podiatrist; I guess what he couldn't find if he weren't on Medicaid at all.

So the problem, the system has its faults. But it certainly doesn't have the faults that the present system, which leaves out of it those with preexisting condition and people who simply cannot afford health care.

Mr. GOWDY. Thank the gentlelady from the District of Columbia. Anything else for the Good of the Order? The gentleman from Maryland.

Mr. HARRIS. Thank you very much. Well, just to, I don't know what preexisting pools and high-risk pools cover in other States, but in Maryland it is very affordable. It is funded by a small tax on hospital admissions, and in fact, when we started it, the premiums were $300, $300 and something a month for someone with a preexisting condition. That's pretty darn affordable for individual insurance. And just to correct, I was talking about in my comments about Medicaid, the 100 to 133 percent of Federal poverty level would be 100 percent covered under the exchanges; higher up you need cash, but at that level, 100 percent coverage. So that was my point, just in that narrow range.

Thank you, Mr. Chairman.

Mr. GOWDY. I thank my colleagues on both sides, and again, on behalf of all of us, we want to thank our distinguished panel of witnesses for taking time from their busy schedules to appear before us today.

With that, the committee stands adjourned.

[Whereupon, at 12:09 p.m., the subcommittee was adjourned.]

TESTIMONIALS FROM PHYSICIANS*

*These testimonials represent each physician's personal opinions, not the opinions of their employers or affiliated institutions.

Dr. Asaf Bitton, MD, MPH
Primary Care Physician
Boston, MA

The bottom line for me as a practicing primary care physician is that Massachusetts health reform has had an overwhelmingly positive effect for me and my patients. I essentially no longer worry that my patients will suffer preventable harm and avoid necessary care just because they lack insurance.

I see the benefits every week. Recently a young patient of mine in between jobs was admitted to the hospital with newly diagnosed diabetes that was out of control. He was able to get insurance and avoid crippling hospital and drug costs. Instead of avoiding potentially expensive care, he is actively engaged in managing his diabetes and is doing well, without any costly readmissions to the hospital so far. Another young patient, diagnosed with an aggressive blood cancer, was able to get the insurance he needed to get treatment though he too was in between jobs and his previous insurance had expired. Now he is getting the care he needs with the top specialists at Dana Farber and Harvard Medical School. Finally, I am seeing patients of all ages come in for more regular preventive visits to work on the diet, exercise, and other lifestyle changes that we and they know will keep them healthy.

Moreover, by covering almost everyone, we have now created an environment in Massachusetts where we can better tackle difficult issues of cost and inadequate quality. We have focused on integrating and better coordinating care, and I have seen a real shift in focus toward revitalizing primary care. And let me be clear, the overwhelming majority of people in Massachusetts as well as physicians support health reform. It's good for all of us, and I am proud that it is serving in part as a model for US health reform.

Dr. Allen Kachalia, MD, JD
Internal Medicine Hospitalist
Health Care Quality and Safety Expert
Boston, MA

The focus on the individual mandate has taken away from much of the discussion on the rest of the ACA. That said, it is first worth briefly discussing the mandate. Whether one believes we should have a mandate on coverage or not, it is hard to argue with the mandate's goal: giving everyone access to affordable health care. From a patient perspective, having access to physicians and not worrying about costs at times of illness can we invaluable—not only from a care perspective, but an emotional one. In fact, the experience in Massachusetts has illustrated over and over again how coverage can not only help patients at their time of illness but also help with continuity of care because prospectively setting up follow up care is now possible for everyone.

However, the ACA will do more than this for patients—It has already done so. The new value focused initiatives that have come out of the ACA: value based purchasing, readmissions reduction, and hospital acquired conditions payment adjustment have all generated an unprecedented level of activity in hospitals aimed at improving quality of care and the patient experience. Amazingly, despite the rapid pace of improvement required and the high benchmarks that have been set, he ACA's approach of aligning financial incentives with the care desired has been remarkably effective. Most of us believe that in the long run care for patients will only improve as a result. Of course, other ACA investments such as the Patient Centered Medical

Home and Accountable Care Organizations have also started new efforts that will hopeful lead to new more efficient models of better care for patients. With the ACA, it is hard to imagine that any of this would have happened so quickly.

Dr. Reena Pande, MD
Cardiologist
Boston, MA

I am a practicing cardiologist. I love taking care of patients. More accurately, I love making people just plain feel better and happier. And I love doing this without having to think about insurance, and dollars and cents, and prior authorizations, and how much patients are going to have to pay out of pocket if they don't have insurance. That thing we do between doctor and patient, that thing we call 'doctoring,' should be cost-unconscious. Thankfully in Massachusetts, this has increasingly become reality.

Equally important is that some patients who did not have insurance at all are finally coming in to see us. I recently saw a 52 year old woman, owner of her own home decorating business. She had been hypertensive for a long time with blood pressure levels above 200/100 mm Hg (normal is less than 140/90 mm Hg). And she was unable to afford insurance. Newly insured in MA after health care reform here, she finally decided to get evaluated. We started her on medication (which she can now afford), and talked at length about healthy living changes she could make, such as diet and exercise, that would positively impact her blood pressure. She did everything we recommended and returned with normal blood pressure a few months later.

Some have expressed concern that new laws will dictate the treatment decisions that doctors will make for patients. This is simply not true. I have never felt more confident that my patients and I are together making the best decisions for them without influence of outside agents.

I now have the opportunity to take care of my patients and worry less about the financial consequences of our encounter. I can make people feel better, and I can make people happier. This is how medicine should be practiced. More changes to that end would continue to allow me to sustain great relationships with my patients.

Dr. Lydia Siegel, MD
Primary Care Physician
Boston, MA

The impact of Massachusetts health reform on me and my practice is tremendous. Ms. H is a 62 year-old woman with diabetes diagnosed about 10 years ago. Until she had regular health insurance, her blood sugar control would vary tremendously according to when she could afford to buy her medications. When it ran high, her risks for developing the complications like kidney failure and eye damage were also very high. Now, she has seen the impact of regular medications on her sugar levels, and her risks have gone down as well.

I also work in an innovative medical home practice, which is one of the care models being explored under the ACA. Before, in a more traditional practice, what I could do for patients was limited to my very brief visits with them and phone calls in between visits. In the medical home, I can spend more time with my patients. And I have a team that gets to know each patient as well, and they are there to help my most at-risk patients try to stay out of the hospital and avoid readmissions.

Ms. Bow is a 68 year-old woman with chronic lung disease, hypertension, and osteoporosis. Her lung exacerbations would send her to the emergency department at least once per month if not more, and she was often admitted for up to several weeks at a time, including ICU stays. At the medical home practice, we have been able to see her as soon as she starts to feel ill, and start medications that prevent a severe exacerbation. Since we opened almost a year ago, she has only been admitted twice and has not had to use the emergency

department any other times. This level of access and the support of a team, including a nurse case manager, are not possible in the traditional funding model for primary care, but it's the level of access and support that every patient may someday need.

I am seeing musicians, artists, and freelance consultants in my practice, in their 20s and 30s, like Ms. N, who is 32 and works as a freelance software developer, for routine preventive care, including regular pap smears and vaccines. Before health reform, she was not able to see a physician and tried to avoid care except in case of emergency. This meant several emergency room visits, when she did not have a regular doctor, for an eye infection or a wrist sprain. Now, I or a colleague can see her for both preventive and urgent care, since the insurance available through the exchange is within reach. And she is able to pursue her own independent career path while having the security of health insurance.

Dr. Martin Solomon, MD
Primary Care Physician
Brookline, MA

It would be hard to imagine a more traditional primary care doctor than me. After 35 years in practice, I continue to make house calls, round on patients in the hospital and make myself available to patients nearly 24/7, though admittedly I do use email and texting, a more modern form of connectability.

In spite of all my efforts, I recall vividly problems with treating patients who were uninsured. One particular patient, an employee of a local retail company sat tearfully in her emergency room stretcher, having left her so with a neighbor because her asthma was out of control. The reason- she couldn't afford her inhalers. Since the creation of the Commonwealth Connector in Massachusetts, she and thousands of patients like her have been able to get insurance and needed medication, avoid lost work and failed family responsibilities as well as emergency room visits and unnecessary hospitalizations.

As we moved from Governor Romney's Massachusetts health care plan to President Obama's version of the same model, I was fearful of the changes that would result from the Affordable Care Act and the move to ACOs. When you've done things the same way for more than 3 decades, the possibility of change can be intimidating, particularly when it comes to my relationship with patients, the nature of acute illness oriented care and the method of reimbursement.

Rather than toiling to meet the designs of others, I find myself practicing medicine in a whole new way, working with a team of nurses, medical assistants, social workers and pharmacists. We meet regularly to discuss our most difficult and problematic patients and I have learned to allow more decision-making responsibility to all the members of the team. Instead of worrying about getting paid for each individual visit, we reach out to patients to prevent repeat office visits, hospitalizations and deterioration. My patients feel cared for and I know they are receiving better evidence based care. My job is clearly more satisfying and rather than getting ready for retirement as I should be at this stage in my life, I can truly say that the effect of the Massachusetts Health Care Plan and the Affordable Care Act has been to make my job more rewarding and my patients healthier and happier.

Dr. Nick Vazquez, MD
Emergency Medicine Physician
Immediate Past President of the Arizona College of Emergency Physicians
Phoenix, Arizona

The question before this committee is simple: Does the ACA hurt the doctor/patient relationship? The short answer is no. I urge the committee to remember how things were a few short years ago before the act was passed. Insurance was always the rate-limiting step for my patients. Often, there were rigid policies that

removed the doctor's choice impacting my patients' care. Still, those with insurance were the lucky ones. In Arizona where I practice, nearly 20% of my patients had no insurance. These patients were at the risk of bankruptcy if they were sick, and many chose to go without medical care. As a practicing Emergency Physician, I have been witness to the myriad of ways our health care system fails us. I have often thought of the emergency department as a filter where all of society's ills show up. I can emphatically state that the ACA will fix many of these issues.

My patients come from all backgrounds, most with insurance and some without. Recently, the State of Arizona has seen fit to reduce its Medicaid eligibility making nearly 250,000 childless adults uninsured. The greatest impediment I have as a physician to healing my patients is the lack of insurance. Beyond that, it is the lack of access to healthcare. How are we going to solve these issues without the ACA? There is no magical marketplace that wants to take poor people with cancer or diabetes. We all know that disease has a social component, and that the poor do worse for no other reason than poverty. The only solution is to employ policies, like the ACA, that remind us to act more like a community of citizens and less like disconnected consumers. I urge the committee to consider this in its vote.

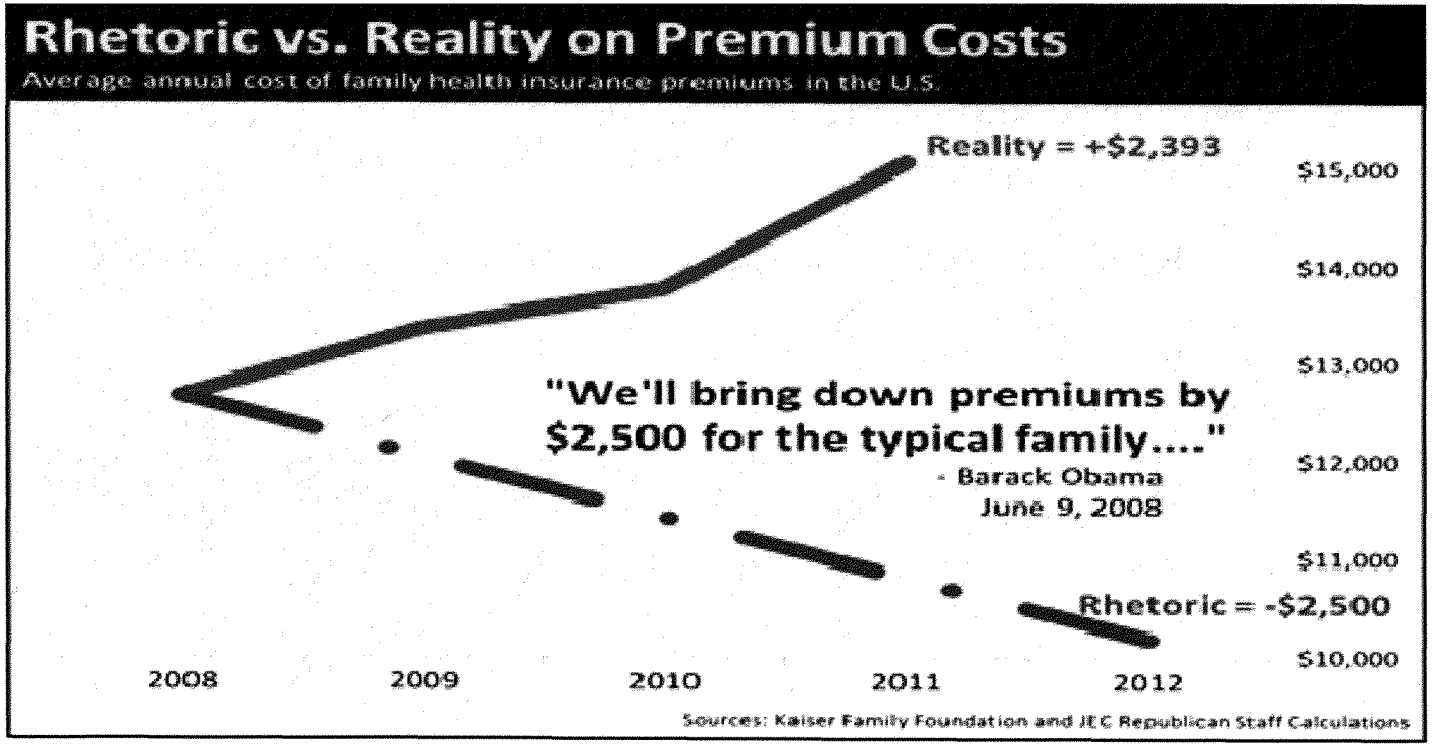
Carol Duh
4th year medical student
Nashville, TN

In this day and age, training to be a doctor in Tennessee now means learning how to do every procedure twice. Once on a healthy-sized person, once on an obese person. The state regularly ranks in the top five fattest in the country, and the consequences are quite heavy for our hospitals and doctors. The state currently is at a 31% obesity rate. This means that almost one in three of our patients are obese, and are at high risk of developing and suffering from the costly chronic diseases that walk hand-in-hand with a lifetime of obesity. Caring for these patients is demanding and difficult, as not only do we have to monitor and manage these chronic diseases in a broken system, but we also have to develop strong relationships with Tennessee's children to promote healthy behaviors and habits in order to prevent obesity. Tennessee spent an estimated $1.57 billion on obesity related diseases last year, 22% more per capita than the national average. This number is projected to rise to $7.08 billion by 2018.

The ACA is here to help our doctors. Tennesseans need health insurance coverage. Without it, people are unable to comply with hypertension follow-up visits or diabetes drug regimens, breaking the therapeutic bond between a doctor and a patient and increasing the rate of preventable and costly complications. Tennesseans need access to preventative care. Without it, doctors cannot prescribe the appropriate health promoting behaviors that Tennesseans desperately need. Tennesseans need healthy communities. Health care extends far beyond the walls of a doctor's clinic. Since the ACA was passed in 2010, the Department of Health and Human Services has awarded more than $15.1 million in Prevention Fund grants to Tennessee in efforts related to community prevention, clinical prevention, and public health workforce.

The Affordable Care Act is an indispensible ally in Tennessee's fight against obesity. It builds a system that allows patients access to the services and drugs they need to care for chronic diseases that stem from obesity, and it facilitates the preventative care doctors and patients need to put a stop to it. Us doctors-in-training may have had to learn how to do every procedure twice, but our patients only had to tell us once, that the time is now for a system that works.

April Wortham, "Tennessee health ranking improves, but obesity looms," Nashville Business Journal, November 18, 2009, http://www.bizjournals.com/nashville/stories/2009/11/16/daily17.html?page=all.


Rhetoric vs. Reality on Premium Costs
Average annual cost of family health insurance premiums in the U.S.
Reality = +$2,393
$15,000
$14,000
$13,000
$12,000
$11,000
$10,000
"We'll bring down premiums by $2,500 for the typical family...."
- Barack Obama
June 9, 2008
Rhetoric = -$2,500
2008
2009
2010
2011
2012
Sources: Kaiser Family Foundation and JEC Republican Staff Calculations

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The Honorable Trey Gowdy
Chairman

The Honorable Danny Davis
Ranking Member

House Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia, Census and the National Archives
2157 Rayburn House Office Building
Washinton, DC 20515

July 10, 2012

RE: Committee Hearing *Examining the Impact of Obamacare on Doctors and Patients.*

Dear Chairman Gowdy, Ranking Member Davis, and Committee Members:

Thank you for the opportunity to contribute to your hearing on the effect of the Patient Protection and Affordable Care Act on doctors and patients. We are writing on behalf of the members of *Doctors for America* -- 15,000 physicians and medical students who believe that the Affordable Care Act is already strengthening the doctor-patient relationship and will strengthen it more and more as the law becomes fully implemented.

Doctors for America members are physicians and medical students in all 50 states, spanning all generations, specialties, and political viewpoints. We are dedicated to advocating for meaningful health system reform to improve access to affordable, high-quality health care for all Americans.

When we entered into the profession of medicine, we took an oath that the medical care we provide will be centered on our patient's needs, values, and best interests. In accordance with this oath, the relationship for which we strive with our patients is one of trust and honest communication, and the ideal environment in which we wish to practice would allow us to place their interests above our own and that of others.

Unfortunately, our current health care system has created an environment that threatens to erode that relationship. The status quo is fraught with inefficiency and fragmentation of health care services and tremendous inequality in the access to health care. Poorly aligned financial incentives force physicians to work harder to see a higher volume of patients, so that the time necessary to understand patients' medical problems and their values has shrunk incredibly. The scientific evidence needed to make patient-centered decisions is inadequate and unreliable. Prescribing medications, tests, and procedures earns more reimbursement than managing chronic disease, coordinating care, and preventing illness. Without proper evidence, these interventions expose patients to more risk and more medical error. Meanwhile an increasingly costlier system and restrictive insurance industry has left 50 million Americans with no health insurance and no relationship with a doctor at all.

Fortunately, the passage of the Affordable Care Act (ACA) has shifted our system in the right direction, and the doctor-patient relationship will thrive as we re-focus health care back to our patient's needs. Beginning in 2014,

over 30 million Americans will finally have affordable access to a primary care provider. That means they can form that crucial relationship instead of depending on emergency room visits for non-urgent symptoms and hospitalizations for complications of their chronic disease. Right now, primary care is getting reimbursed at higher rates by Medicare. Many preventive services are now free of co-payment, aligning providers' and patients' incentives to preserve health. New models of delivering care, such as the Patient-Centered Medical Home, are helping providers to communicate and coordinate with ancillary health providers and with patients, using telephone care instead of costly visits and technological innovation through electronic records and internet-based media. Increased funding of National Health Service Corps and transformation of the practice models is attracting our brightest, most committed medical students to primary care, the cornerstone of patient advocacy within an increasingly complex health system.

Though not fully implemented until 2014, the ACA has already inspired a number of shifts in our system towards patient-centered care, coordination, and safety. Medicare programs such as *Partnership for Patients* promotes public-private partnerships to reduce hospital-acquired infections and to improve patients' transitions from hospital to home or skilled nursing facilities. The *Readmissions Reduction Program* incentivizes improved communication of instructions with patients at the end of their hospitalization and coordination of follow-up with their doctors afterwards, ending the cycle of repetitive hospitalizations for the same illness. With Medicare soon moving to a value-based purchasing model of hospital reimbursement in 2013, hospitals have responded by closely measuring and innovatively improving on the quality and safety of their services. Dr. Allen Kachalia, associate chief quality officer at the Brigham and Women's Hospital in Boston, stated that these programs have launched an "unprecedented level of activity in hospitals aimed at improving quality of care and the patient experience," and that "without the ACA, it is hard to imagine any of this would have happened so quickly."

Rather than folding to unfounded conjecture and speculation, we have solid evidence for the potential impact of the ACA on patient care. The Massachusetts experience, having achieved near-universal coverage through Medicaid expansion and a requirement for all individuals to purchase insurance, has shown that physicians' satisfaction with their jobs, patients' satisfaction with their care, and the doctor-patient relationship have improved greatly with health system reform. Patients have more access to a primary care provider and emergency room visits have decreased. As a result of health reform innovations, Dr. Martin Solomon, a primary care physician who has practiced for over 30 years in Massachusetts, said he no longer worries "about getting paid for each individual visit; we reach out to patients to prevent repeat office visits, hospitalizations and deterioration... My patients feel cared for and I know they are receiving better evidence based care."

We realize that several elements of the ACA concern many medical industry stakeholders, including the development of Accountable Care Organizations (ACO's) and the Patient-Centered Outcomes Research Institute (PCORI). Many stakeholders claim that these institutions will damage the doctor-patient relationship by refusing payment for doctors' services, restricting treatment options, and rationing care for the sick. We find, however, that these fears are unfounded. Instead of misrepresenting their intent and fearing the consequences, we should embrace the mission of these institutions to augment patients' health and satisfaction. For example, ACOs can create a financial environment for primary care providers and specialists to coordinate care for patients' sake, ensuring proper follow-up after episodes of illness and sharing in savings from unnecessary interventions and re-hospitalizations. Furthermore, PCORI prioritizes robust comparative effectiveness research that will empower patients and providers alike with data to inform individualized therapeutic decisions around issues that matter most to patients such as quality of life, avoidance of inpatient hospitalization, and the preservation of functional vitality. These efforts finally provide doctors and patients with un-biased scientific information needed to personalize treatment alternatives focused on patient's health—and not on cost-effectiveness, as the ACA specifically prohibits.

This is an exciting time for our health care system and for our profession. We entered medicine with the passion to serve others and to make an impact on people's lives. The sanctity of the individual doctor-patient relationship is essential to ensure that service is of the highest ethics. But the quality and fairness of the system in which we serve is fundamental to making the most positive impact. **There is much more work to be done in reforming our health care system, but we are confident that the Affordable Care Act helps, not harms, our relationship with our patients and our system of care.**

Doctors for America is a national movement of physicians and medical students working together to improve the health of the nation and to ensure that everyone has access to affordable, high-quality health care.

Sincerely,

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