

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 wither.

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 states³ and a statute in 11 others⁴, with 4 more amendments pending this November⁵—

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

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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.

⁵ Florida, Montana, Wyoming, Alabama

⁶ <http://www.wfmj.com/story/16003348/issue-3-win-reaction>

⁷ <http://forhealthfreedom.org/Publications/LegalIssues/NoConstitutionalRight.html>

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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>

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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>

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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://cciiio.cms.gov/resources/files/Exchangeblueprint05162012.pdf>

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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>

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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}

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>

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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]:

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/gv111107.htm>

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

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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.

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>