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.

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name:

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2009. Include the source and amount of each grant or contract.

None

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

Docs4PatientCare, a 501(c)6 non-profit physicians membership organization.
I am the Chief Operating Officer and a member of the Executive Board.

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2009, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

None

I certify that the above information is true and correct.

Signature: Richard A. Armstrong M.D.

Date: July 5th, 2012