

Good Morning Mr. Chairman, Committee members, fellow witnesses, and attendees. Thank you for the opportunity to come before you this morning to discuss the impact of the Patient Protection and Affordable Care Act (ACA) specifically, insights I may be able to share with you from the perspective of a practicing physician.

My name is Jeff Reinhardt. I am a full time practicing OB/GYN and am President of The Longstreet Clinic, P.C. We are a physician owned multi-specialty group, formed in 1995. Currently there are about 160 medical providers including about 100 physicians in the group. Geographically we have offices in locations in more heavily populated areas in Duluth, Buford, Braselton, Oakwood and Gainesville working out of large medical centers in Gwinnett Co, population about 842,000; and Hall County, population about 185,000. We also have offices in more rural areas including Dahlonega and Baldwin, caring for patients in smaller hospitals including Chestatee Regional Hospital in Lumpkin Co, population about 30,000; Habersham County Medical Center in Habersham Co, population about 43,500; and Ty Cobb Regional Medical Center in Franklin Co, population about 22,000. Also, we are in partnership with the Department of Community Health, providing obstetric services for patients in our local health department, many of which are currently uninsured and economically disadvantaged. As you can see, we have an extremely diverse patient base – ethnically, socioeconomically and geographically.

Presently, I wear several hats as it relates to healthcare – I am a consumer, provider and employer. Each of these roles has a different set of needs, challenges and motivators. I was asked to speak today about my perspectives as a physician and provider of care.

It is not new news that healthcare in this country is in crisis. Dating all of the way back to 1926, out of concern for the costs and utilization of medical care, our congress formed the Committee on the Cost of Medical Care. The committee was abolished in 1932 after their recommendations were felt to be too radical. This illustrates that issues of cost, access, quality of care – and the government’s role in these issues has been ongoing for 90 years.

It is widely accepted that the cost of medical care in this country is a problem. Over the last 20+ years, according to data reported by the World Health Organization, the cost of healthcare in the US changed from being flat and predictable at around 13.5% of our GDP during the 1990's, to increasing annually to almost 18% this year. Just last month, Aon Hewitt, a worldwide leader in employee benefit and insurance consulting reported average health-care premium per worker increases ranging from 3.3% to 8.5% per year for each of the last 7 years, with an estimated increase of 6.7% for next year. Also, noting average cost to employees for out-of-pocket expenses, increasing by nearly 13 percent last year, continuing a trend that has seen employees' share of total health-care costs jump 150 percent since 2004. Clearly increasing cost is a problem. A budget item of nearly 2.5 trillion dollars, with no obvious end in sight to increases is a strong motivator for change.

Access to medical care is an extremely complex issue. It is influenced by geographic location; a person's literacy; disabilities; and the ability to pay for services including both out of pocket costs and costs covered by a payor – be it government program or private insurance. In general, there is a perceived lack of access to care, but few good comprehensive studies about the issue of access exist. Certainly, when there is a decrease in the number of providers per capita, or when providers and hospitals move from more rural areas, geographic access to care is negatively influenced. Here in Georgia, there has been a reduction in the number of OB/GYN providers from 13.5/100,000 to 10.9/100,000 between 2004 and 2008, this from data reported by the Georgia Health News. This will directly impact our ability to prevent preterm births. The reasons for this reduction in provider ratio include stagnant Medicaid reimbursements for over 10 years; the increased cost of compliance with government mandates - such as electronic medical records; lack of meaningful protections against frivolous law suits; and increasing student loan debt.

In general, the safety net for care is the emergency department. This is where the nearly 50 million uninsured, nonelderly Americans receive much of their healthcare, this estimate being from the U.S. Census Bureau data from 2010. These patients have typically delayed seeking care for chronic issues until their

medical needs are much more complicated than they might be had they received ongoing care in a traditional office setting. In a study by the National Institutes of Health (NIH) from 2010, about 25% of all emergency room visits are for non-emergent problems. The Center for Medicare and Medicaid Services (CMS) estimates that cost to the taxpayer for this care is roughly \$176 billion. About 55% of care provided in the ER is uncompensated – meaning no payment at all is received for services rendered by either the hospital or physicians. Historically, doctors and hospitals have been able to “cost shift,” paying for this “charity” care with “profits” available from the care provided to those with private insurance. However, with stagnant or declining reimbursements, this is becoming increasingly difficult and in some cases, impossible. This has led to consolidation of providers, where small physician practices and small hospitals, are merging with larger physician groups or hospital systems. This has resulted in increased numbers of physicians as employees rather than owners of practices; a reduction in services offered at rural hospitals; and increased costs of care due to increased reimbursement allowances for services performed by hospitals and hospital providers. There are headlines about hospital closings in every state – which implies reduced access, but a presentation 2 weeks ago using Medicare Payment Advisory Commission (MedPAC) data concluded that “access is expected to be strong despite declines in margins.” Therefore, it is difficult to make solid conclusions about the availability of access to care, but certainly there is concern about providing the appropriate location for this access.

The imperative about quality is a tough nut to crack. Agreement in the definition of quality is not generally universal and our ability to gather clinical data is poor. Many of our current indicators of quality are based on billing codes and medical claims submitted for charges, and not based on clinical information. For instance, I can submit a charge for Tobacco Abuse, but may not submit a charge for my care which may have included counselling a person about the benefits of stopping smoking.

So, how does the ACA play a role as cause and solution? Clearly, from the data I have reported – almost all of which preceded 2010, these are not new issues, and

have not been the result of the ACA which was signed into law in 2010. This law includes multiple provisions that take effect between 2010 and 2020.

Just looking at 2010, there was a requirement for insurance plans to allow dependents to remain on their parents plans until age 26 – insuring many young adults in school and in transition to the working world; phase outs on both annual and lifetime coverages; eliminating insurance denials for children with “pre-existing conditions;” additional funding for Community Health Centers; as well as Small business tax credits for insurance premiums paid for.

In 2011 there was implementation of “free” preventive care and contraception – with no co-pay for the patient; allowable medical loss ratios for insurance companies; additional taxes for manufacturers and importers of brand-name drugs – subsequently passed on to patients; elimination of over-the-counter medications as allowable purchases from Health Savings Accounts and Flexible Spending Accounts.

Calendar year 2012 brought payment reforms incentivizing quality and penalizing avoidable complications; incentives and imperatives for using electronic health records and standardized billing practices – ultimately with penalties for those noncompliant; and incentives for provider groups to better coordinate patient care and improve quality, help prevent disease, illness and reduce unnecessary hospital admissions.

This year, 2013 brought new funding to state Medicaid programs that choose to cover preventive services for patients; excise taxes for medical devices; limitations on Flexible Spending Account contributions; more payment reforms incentivizing providers to work even more closely to provide care; and it also, brought with it enrollment in Small Business Health Options Plan and individual exchanges.

2014 and 2015 are slated to bring more Consumer Protections, Improvements to Quality and Cost and Increased Access.

Well, here is what I know and what I don't know. When I finished medical school I thought an exchange was what I did the day after Christmas with the sweater that

didn't fit, and right now, I am struggling to educate myself about Private Exchanges, Medicaid Expansion and "doughnut holes." I know that many of the problems discussed here this morning preceded the ACA. I know that when the coordinator called me to testify this morning, I was in one of my rural offices, and the patient I had just seen remarked at checkout, about how happy she was that she didn't have a copay for her visit. I know that her copay was going to be rolled into the premium for her insurance and that ultimately she would pay for it – just not at the time of her visit. I know that the pre-ACA system is broken. I know one of my dear employees and friends has been stricken with metastatic pancreatic cancer and that her treatments would have bankrupted her if not for the elimination of annual and lifetime insurance maximums – for her, thank god for the ACA. I know that particularly the parts of the ACA slated for implementation in 2014 will bring great change, with real people tragically affected, and others benefitted. I know that it is too premature to know the full impact of the Affordable Care Act, judicious data collection and interpretation is needed before objective conclusions can be drawn. I know that change is hard. And, I know that I appreciate the opportunity to have been here today to present to you my limited view and answer any questions that you may have.