

Upper Midwest Bariatric Forum
Remarks by Senator Dave Durenberger
November 20, 2009

I am pleased to have known **Henry Buchwald** for many years and to have been asked to speak with you this evening. I am fresh from my class at the Opus College of Business at St. Thomas so this convenient location is helpful. Otherwise, the idea of speaking to people smarter than I at the end of the work week, after drinks and dinner, is daunting.

Henry asked me to talk about the health policy reform going on in Washington. You know what Bismarck said about watching legislation and sausage making. Well, watching health policy reform this year seems to give sausage a bad name. At least a bad smell.

There are people in this room, I suspect, who think that little they hear proposed as health reform is as essential to the national interest or to their patient and professional interests as, say lower taxes, less spending, less regulation, better payment systems, and defining how many wars the U.S. can afford to fight at any one time. And why? But it is a discussion we must have as a nation no matter the challenge of understanding it.

I started understanding health policy in this town in the early-mid 1970s. With a dozen large employers, my company agreed to try and lower health care costs by providing employees with at least three choices of health insurance plans, including one of the 5 or 6 HMOs then growing in this community. My first bill in the Senate was the *Consumer Choice Health Act of 1979*. My first health policy book is entitled *Prescription for Change*, health care reform through consumer choice.

In 1983, I authored the Senate version of prospective hospital payment called DRGs and, with **Senator John Heinz**, the privatizing of Medicare by paying HMOs 95% of what Medicare paid doctors and hospitals under Parts A and B and allowing them to convert savings from behavior changes by doctors and hospitals into additional benefits. In Minneapolis the Medicare payments per beneficiary -which had been at or above the national average for the country – went to 17% below the national average in two years. Because physicians changed their practice referrals and admissions.

Why isn't that Medicare payment policy today? Because in most parts of the country medical practice culture defied the use of group practice or the shared stakeholder interests of the HMO. Because we didn't then understand the considerable incentive in allowing doctors to share some of the financial savings that come from doing a job better for less money. Because we were tied to the notion that consumer choice of health insurance plans each year was the way to create insurance competition. Instead of encouraging them to work with doctors and hospitals to ensure that members stay with a plan for as long as possible so that all can benefit financially from everyone's success at behavior change.

By 1989 it was obvious we needed a payment policy to restrain the widening financial gap between primary and specialty care created by new technology and the growth in service utilization. With **Senator Jay Rockefeller**, I passed the Part B physician payment reform in Medicare using the RBRVS developed by the AMA and Dr. Hsiao at Harvard. This didn't change the underlying proliferation of coded services. Today we have 18,000 codes for services and zero for cures

We failed to deal adequately with volume performance policy. How Medicare rewards reduction in utilization of unnecessary services and penalize over-utilizers making up for lost income. We called them VPS and treated all docs alike. In 1997 Congress tried to cut doctor payments and installed the SGR and that's the pain that you have been dealing with ever since. A one year relief costs \$210 billion.

America's elected leaders have tried for a century to provide affordable access to health care to all Americans. Just as every other developed nation at some time has tried and succeeded. We have not. Why? Because the American system has found ways to deal with the problem by creating public programs like Medicare and Medicaid for those on fixed or low incomes, or by cost-shifting with hospitals and clinics the costs of the unpaid to the charges for paying patients.

In addition, we are like other countries in how political partisans deal with the issues of cost and quality. If costs are too high we vote for conservatives who reduce them – and our taxes. If quality is going down and the queues are getting too long, we vote for liberals who will spend more.

At every opportunity I was the conservative who said no to Democratic efforts to force universal coverage until we found a way, as a nation, to get medical costs under control. The last time was 1993. Today I have come to a different conclusion. The diverse medical industry is dedicated to not containing costs.

Our failure to provide access for all Americans to both low cost health care and high-cost acute care is adding enormously to the cost of care and to the ability of the health care professions to help us reduce the cost consequences of avoidable illness, life-style conditions, chronic illnesses, and disabilities.

Or to help communities of Americans to deal with the socio-economic conditions which breed poor health and expensive health care behavior challenges. Or to re-invest a fraction of the multi-billions currently directed into new medical discoveries and new medical technology, into providing every health professional with access to information about every disease or illness which maximizes their effectiveness in diagnosis and treatment. Research on what works, to what end, and how well is an imperative. Federal research grants directly to physician specialty societies and to multi-specialty clinical and research organizations will speed such results.

I have concluded that the chaos that seems to reign in Washington this year simply reflects the chaos that exists in health care in America. And every year it gets worse. You might want to read the new book by **Drs. Thomas Lee** and **James Mongan** at Partners HealthCare in Boston. Jim retires this year as Partner's CEO. The book's title is *Chaos and Organization in Health Care*.

Look at what passes for a health system in America today. Nothing. It's either a national non-system, or it's a series of local systems, as different from each others as practice cultures differ across the country. So, if a President asks 535 members of Congress to adapt their view of health care to national access, payment and performance policies, what do you get? Chaos.

Insurance companies are rewarded for picking, choosing, and dumping patients and claims. Payment systems are still rewarding volume rather than performance because we can't invest in using claims data for effectiveness research. To convert what surgeons like you have discovered long ago. That surgery saves money if you spread its costs over time (like 4 to 5 years) and over the savings from not having to treat secondary conditions and co-morbidities.

Health professionals and care systems are still treating symptoms and conditions rather than people. In part because little of the information technology revolution has penetrated either the science or the art of medicine. And, importantly, the medical liability threat increases as our capacity to know what seems to work, and to change our mind about that (as in mammography this week), grows exponentially.

We cannot expect a system like this, which makes \$2.5 trillion a year delivering \$1.7 trillion in value added, to reform itself. But someone in this country must. So the President, faced with all the problems we've helped create for him all around the world, has.

The goal of this year's health reform legislation is to begin to change the current condition, First: To provide all Americans access to high quality, affordable health care services through a system of public and private insurance and public assistance programs which provide everyone with health security and financial security. Second: To enact payment and other policies which, over time, will reduce the growth in health care costs in ways that protect future generations from the individual, economic, and tax costs of the first goal (universal access).

Much has been made, by those who have chosen to oppose any effort by a Democratic majority to enact universal access, that the legislation does not reduce costs in any way. However, The same people oppose most efforts to reduce the systemic cost differences between \$2.5 trillion and \$1.7 trillion. Preferring to cap punitive malpractice damages as a remedy for defensive medicine and for 90,000 avoidable deaths in American hospitals each year.

These same opposition forces argue the majority can only meet the second goal – universal access or coverage - if the government takes over the health care system and reduces access to costly procedures or technology and rations access as in the Oregon experiment. Or as in the

August death panels. The U.S. Preventive Health Task Force recommendations on mammography this week were turned into evidence of that in less than 24 hours.

If you bought that, then I refer you to **Gail Collins** column in Thursday's *New York Times* in which she calls this *The Decade of Medical Backtracking*. And, if you need further proof, I suggest a read of the history of the U.S. Preventive Health Task Force advisory 18 years ago on PSAs. My friends **Senators Bob Dole and Ted Stevens**, having just gone through prostate surgery, condemned the advice and rushed to pass legislation requiring PSAs of all men in America. After a brief fling as a candidate for President, Bob found a career as a Viagra salesman.

Out of all this chaos will come a bill the President will sign. Out of the law will come several years of implementation. Much of it by the Secretary of HHS and especially by CMS which runs the Medicare and Medicaid programs. By the FDA, the AHRQ, by the NIH, by the IOM. By the Medicare Payment Advisory Commission, and perhaps other expert commissions as well. These are all respectable, professional entities. If they aren't undermined by tea party politics, by medical industry politics and the thousands of lobbyists that stand outside every agency waiting to visit with friends inside they used to work with.

From experience I can assure you, that whether he is Democrat or Republican, no President likes to deal with health policy. It's too complex. He wants it done right. And right now if that's possible. He will seek to put the best people in office to do it. If Congress permits. A medical doctor like Mark McClellan, for example, whom George Bush appointed to turn the FDA around, then appointed him to implement the 2003 Medicare reform bill. **Dr. Mark McClellan** should be asked to come back to HHS and implement this legislation. He couldn't turn down the opportunity.

Insurance Reform: Includes expansion to more than 30 million uninsured and improved benefits for underinsured. Insurance exchanges for employers and individuals. National rules on risk assumption and rating band limitations. Simplification of claims and claims processing to allow doctors to do health information but not insurance processing. The co-op as HIPC or as HMO.

Financing Reform: If Congress and CMS did nothing more in the next four years than reform Part B of Medicare and improve physician payment it would change everything. To re-value both specialty care and primary care. To recognize as you do, but few other surgical specialties do, the value of ancillary and allied health professionals. Taking down the barriers in primary care open up the opportunities for all health professionals. Chronic Care 75%...1%=35% and 5% = 50% andcapitation – bundled payments to ACO...18,000 billing codes for services//zero for cures.

Care Delivery Reform: Changing doctor-patient relationship...informed patient choice...make the right thing easier to do...health information – a patient friendly care system...comparative effectiveness.

All of this and more. The final bill will be written in a conference Committee of no more than a half dozen people, including the President's chief of staff, a former member of the House Ways and Means Committee, trained up by one of the great Congressional leaders - **Dan Rostenkowski** of Chicago. To get things done. That may not be reassuring to you. But it's what I was asked to report.

Thank you for allowing me to be with you this evening. Now to your concerns and your questions.