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**Testimony before the Subcommittee on Health  
of the House Committee on Ways and Means**

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Mr. Chairman and distinguished members of the Committee. It was an honor to have served the people of Minnesota for three terms in the Senate, a challenge to go to conference near the end of each of those 16 years with the chair of this sub-committee, and to have been asked by him to testify here today.

I do so in the spirit that for most of those years characterized our relationships and our efforts to make national health policy and to improve our health system by changing the financing incentives for providers in the Medicare program.

Not since the Presidential campaign of 1992 have Americans been as concerned about their financial well-being. Most Americans know they cannot afford the rapid rise of health insurance premiums...especially now when it is accompanied by escalation in the cost to them of almost every basic necessity of life.

Public opinion polls reflect this in the strong support for plans to guarantee access for all to health and medical services for all Americans through some system of health insurance.

The debate, as it has always been, is between universal coverage and cost containment and between social insurance systems and private insurance. For example Senator Clinton advocates a UC path that can utilize a form of Medicare lite for persons under 65. Senator Obama advocates using the model of the FEHBP, and Senator McCain advocates cost containment through greater tax subsidies for private major medical insurance. Interestingly, each advocates similar cost containment measures through re-aligning financial incentives to produce better quality, outcomes, effectiveness and efficiency from the delivery system. Similar battles are waged at the state level.

And so it has always been. Unfortunately critics of the Democratic proposals characterize them as socialized medicine and of the Republican proposal as doing nothing to meet the issue of affordability which is driving up the numbers of un insured and under insured.

As policy-makers we have always followed a two-path course to universal coverage. It is most obvious in the Medicare program where we have been making most national health insurance policy since I became active in health reform in the early to mid 1970s. We have used both social insurance and private insurance in our financing policy changes aimed at expanding access, coverage and cost containment.

The test for high value health insurance is how well it does for people when they are sick, seriously injured or chronically ill (The 80-20 problem)....Not how many benefits the plan has or how little people use a deductible....The Value test for both social insurance and private insurance is how well each does to consistently pay for quality, outcomes, effectiveness, and efficiency.

For example, the FEHBP has always been a model for consumer choice of private health plans and the impact of that choice in creating healthy competition in health insurance competition community by community of federal employees and retirees across the country. My first health legislation was the Consumer Choice Health Plan of 1979 to require similar choices in private employment in exchange for the employer tax subsidy.

Medicare always used private insurance, first in its benefit design and its implementation through BCBS carriers and intermediaries. Then, on my watch, in HMO Cost demos and in a major national test of HMO Risk Contracts starting in 1985. They were hugely successful in areas of the country where they were tried and where medical practice and relations with community and state based health insurance guaranteed success. (Upper Midwest example). The rest of the country chose to follow the path of hospital DRGs we instituted at the same time. Of necessity by 1989 we adapted the PPS to physician payment and created other problems.(explain)

The mistake we always made was in not leaving more of the financial savings for reducing the overuse of medical services with the care professionals, hospitals, and plans responsible as an incentive to continue to do better by improving benefit design, quality, outcomes, effectiveness and efficiency.

The mistake the medical industry made was to take these community based examples of physician/hospital cooperation national and to take the local managed care organization national. For example, United Health Group became the largest health insurer in the country through merger and acquisition of local HMOs. Likewise Wellpoint became the largest insurer in the country through conversion of local/state Blues plans to for-profits and their merger and acquisition.

For a while, this new private insurance phenomenon was very successful in driving down health care premiums and their profits made them Wall Street darlings. By the end of the 1990s the managed care plans were a national industry playing by either state rules or by no rules in the employer self-insured market. When Congress in 1997 authorized private plans to do what markets usually do - determine through price competition for basic benefits the real cost of required medical services which would vary from community to community the industry refused to play.

The managed care industry slowly but surely adapted itself to the realities of consumer demand for freedom of choice, access, innovation and expectation in various communities in this country. Where population was growing, the ability of health plans to improve on value became difficult. Where practice ethic was prevalent, and/or health maintenance organizations still existed the financial rewards from physician or hospital performance went too often to the health plan and not to the medical community. The result was discouragement with managed care and a revolution against HMO, managed care, capitation, and green eye- shade nurses. All of this contributed to the difficulty the Bipartisan Commission on the Future of Medicare experienced in trying to find financing policy consensus in 1998.

At the Medicare Payment Advisory Commission we simply ask the public policy question that members of Congress like me have been asking since Senator John Heinz "HMO Risk Amendment in 1982." If traditional Medicare is less effective in achieving performance improvement than private insurance, then how do we structure the value proposition in the

relationship between Medicare and private health insurance? Paying financial bonuses to Medicare Advantage insurance companies for simply adding service benefits to the Medicare program is something Congress can do. But it's not the right thing to do without clear evidence that the services have value-added over existing insured services. Which takes us to issues around comparative effectiveness. Many assume that the health insurance industry is more capable than the public sector in doing this and can afford to do right now – and in some cases does.

There are many reasons that universal coverage is important, many of them relate to the vastly improved economics of reducing or eliminating cross subsidies from paying to non-paying services and hospitals especially. I have now lived long enough with the consequences of our national failures to secure financial access to needed health care services for all Americans, that I believe a commitment of the next President to this goal is important to my vote.

I do not believe it is possible in this federal system for the states to accomplish this goal. There fiscal capacity and their populations are to disparate. This is a matter of income security policy for the action of which we are all citizens. We have no income security policy, but a large number of aging entitlement programs which are bending, and sometimes breaking, under the weight of population health and aging and the cost of medical technology and its providers. It would be appropriate for the Ways and Means Committee to take the lead in going beyond “reforming” programs enacted in and for the 1930’s and the 1960’s, and developing an income security policy that will guide entitlement program reform we desperately need.

I have no reason to believe that as Republicans or Democrats we have much disagreement about the need to agree quickly on how to collect data, measure performance, motivate better outcomes and reward the first rate performers with the business of an informed consumer in as many communities as possible.

I am pleased to have been afforded this opportunity. Much is expected of each of you in an area that is too complex to be understood by any one of you. But challenging circumstances also bring out the best. I hope that I may continue to serve whatever interest you may continue to take in health coverage and reform.