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News from Senator

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Senate Finance Subcommittee on Health

Opening Statement of Senator Bob Dole

I am pleased to be able to join with the Chairman of the Health Subcommittee in welcoming all of our witnesses today. Cost sharing in health insurance is a very controversial topic particularly, when it comes to medicare and medicaid. However, the idea of using cost sharing to deter unnecessary utilization and hold down rapidly rising health care costs is hardly new.

There are those who strongly favor some form of cost sharing, believing that it is necessary to discourage overutilization. Alternatively, there are those who strongly oppose any form of deductibles and coinsurance, fearing that it may make care inaccessible to all but a few, and will hinder access to needed services, particularly by the poor and chronically ill.

Both those in favor of cost sharing and those opposed agree that cost sharing does result in reduced utilization of certain services. In fact, Dr. Newhouse who is with us today will, I hope, share the results of the work done by Rand in this area which demonstrates this quite clearly. The obvious question that comes to mind is whether individuals are able to make wise choices as to when they should seek care, and whether the decision is really theirs to make, given the role of the physician.

Also of importance to us is the question of the impact of cost sharing on the use of particular kinds of services. Can we perhaps construct cost sharing requirements that encourage the use of ambulatory services? Will this in turn reduce the use of hospital care?

Implications for Medicare

The larger question that needs to be answered is, "What are the implications of increased cost sharing on the medicare program?" Certainly we know less about how access and utilization of medicare services are affected by cost sharing than we do about cost sharing in general. Most of the existing research on the subject deals exclusively with individuals below the age of 65.

The medicare hospital insurance trust fund is in serious financial condition and the prognosis does not look good. The fund could be broke as early as 1988 unless something is done. I do not believe it will be any one thing that will correct the situation, but a combination of changes affecting providers, taxpayers, and beneficiaries. Certainly, cost sharing cannot do it all, but until we determine otherwise it should be considered as a part of the solution. What we learn today will go a long way toward helping us make that determination.

Medicaid Cost Sharing

The research done to date is applicable to medicaid beneficiaries in that more than three-quarters of them are less than 55 years old. We must remember, however, that the medicaid program serves a beneficiary population that is poor and cannot be expected to meet more than nominal cost sharing requirements. We recognized that fact last year, through the Tax Equity and Fiscal Responsibility Act, when we allowed the States to impose no more than nominal copayments on most beneficiaries and services. Whether the flexibility granted the States should be replaced with a mandate to impose cost sharing is a matter which must be carefully considered.