A Congressional Leader Looks At Health Care:
An Interview With Robert J. Dole
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Prologue:

Ever since his razor-thin reelection to the United States Senate in 1974 - attracting 51 percent of the vote in a bitter contest against former Rep. William R. Roy - the political fortunes of Robert J. Dole have been on the rise. At the moment, the Republican senator from Kansas is riding a crest of popularity shaped by his quick wit but, more fundamentally, by his performance last year, almost singlehandedly, in engineering a massive tax increase in the face of a recalcitrant president and Congress. As chairman of the powerful Senate Finance Committee, which has purview over federal programs that will cost $435 billion in fiscal 1983, not to mention every detail of the tax code, Dole is among the most powerful figures on Capitol Hill. In the health sphere, Dole ranks up the single most important legislator serving in Congress today. Dole’s relationship to the health care system was shaped initially by a personal experience, spending almost two years in a hospital recovering from a World War II injury. For years, he was an unquestioning advocate of the American medical care system. More recently, though, Dole has begun to not only ask questions, but also to express doubts that medical practitioners can contain the cost of care given the economic incentives that drive the current system. Dole’s skepticism developed largely as a consequence of the failure of the private sector’s Voluntary Effort to contain health care costs. In the months ahead, with a federal budget deficit that in fiscal 1984 alone is approaching $200 billion, the fifty-nine-year-old senator and his committee will be primary actors in deciding whose ox will be gored when Congress considers whether to raise taxes or cut spending or, us seems likely, do both. Recently, Dole has expressed the view that 1983 could be the year that Congress looks closely at the way Medicare reimburses physicians. The Reagan administration’s budget proposes new controls on Medicare physician reimbursement. Dole is a politician with burning ambition. Physicians represent a powerful professional elite. Congressional debate over the economic standing of physicians - and Dole’s place in that debate - should be an interesting spectacle indeed. In this interview, Dole’s comments were sometimes amplified by members of his professional health staff.
Q: As the Reagan administration and Congress take steps to reduce the staggering federal deficit that faces the U.S. government in fiscal 1984, what do you regard as the major targets of opportunity in the social welfare and health programs?

A: Well, there is really no one major target. In 1982, through the Tax Equity and Fiscal Responsibility Act (TEFRA), we asked that cost savings be borne by all parties to the Medicare program—hospitals, doctors, and beneficiaries. However, because we felt that cost savings imposed on physicians could all too easily translate into a burden on beneficiaries, most physicians were not affected by the changes we made. So in that sense physicians represent an opportunity for additional cost savings for 1984. Indeed, we’re committed to examining physician reimbursement in detail—to examining changes in the way we pay for physician services that provide savings without reducing access to care or unreasonably increasing out-of-pocket expenses for beneficiaries.

Hospitals, of course, are bearing the largest burden of the cuts made in the last two years. This should not be viewed as unusual given that over two-thirds of all Medicare dollars are spent on hospital services, some $37 billion in 1983. I would expect continued work on hospital reimbursement in the hopes of providing long-term reform and moving us away from cost-based reimbursement. However, it is not likely that this will result in further substantial reductions in hospital payments over the next year or two.

Certainly beneficiary cost sharing and a restructuring of the Medicare benefit package will also receive considerable attention. The administration has made a number of suggestions in these areas and they will be given every consideration. We must keep in mind that whether or not Congress chooses to deal with steadily rising health care spending, it nevertheless faces a major crisis regarding the financial condition of the Medicare program that will have to be addressed in the near future.

As far as the low-income cash assistance programs are concerned, to a large extent, I don’t believe further reductions will be possible or appropriate. The AFDC (Aid to Families with Dependent Children) program, and even the nutrition programs for the poor, like WIC (Women and Infant Children), have seen substantial cuts in the last two years. Further cuts could seriously hamper these programs from providing the support needed so desperately by the poor in our society. In fact, some increases in spending may be necessary.

In Medicaid there do not appear to be many major opportunities for cost savings, but we can do something. We certainly intend to continue providing the states with the flexibility necessary to allow them to improve program operations and service delivery.
Q: Unlike President Carter who sought to impose cost controls on the entire health system, President Reagan has limited his health constraints to public programs—Medicare and Medicaid. Generally speaking, what do you consider us representing the government’s responsibility for cost containment purposes—the entire health care system or only that portion of it that is financed with tax dollars?

A: Well, certainly the rapid growth of the entire health care system is a concern. After all, that growth affects a major portion of the economy. As to whether we should impose cost controls across the board—I don’t think this is a practical solution. They create new problems and the benefits are short term; they simply delay the day of reckoning. When it comes to spending tax dollars, we need to interject our concern as a prudent buyer of health care services. Indeed, some would say that we—the federal government and other third-party payers—are the reason for ever-increasing health care costs. We insulate the consumer from the costs of care and, in the case of Medicare, the greater the cost, the more we pay. It’s time we changed that. The provisions of TEFRA start us down that road to change.

Repairing Medicare

Q: Medicare is intimately tied to the dilemma currently facing the Social Security system. Describe your broad view or inclination on how you would repair the Medicare fund. Do you favor or oppose the broader use of general revenues to correct Medicare’s problem?

A: The Medicare fund can be repaired by increasing revenues, decreasing expenditures, or doing both. It seems to me we need to do both. As I’ve already said, on the expenditure side we’ve started down the road to reform. On the revenue side, there is a lot to be considered. As an insurance program, the premiums paid by the insured for the medical insurance portion of Medicare are already well below the value of the care provided. For every $1 paid in premiums, $3 of general revenues are added to subsidize the Part B program. Greater use of general revenues is almost a moot question; the already staggering federal deficit you mentioned clearly shows that there are no additional general revenues available to bolster the Medicare fund. I do not believe we should increase the national debt to further subsidize the fund. However, changes in the premium calculations and changes in the benefit structure should be examined along with increasing reliance on other resources, for example, private insurance. Of course, these changes are all in addition to reimbursement reform.

Q: The Reagan administration is of the belief that by imposing more stringent cost-sharing requirements on Medicare and Medicaid beneficiaries, beneficiaries will be more sensitive to the high cost of care. Do you favor this approach? If so, should such requirements be tied to the income status of the individual...
A recipient?
A: Beneficiaries should be made sensitive to the high cost of care but this is not much help unless the patient can do something about it. Price sensitivity makes sense where the beneficiary’s decision to seek medical care is his or hers to make and it does not cause needless delay in seeking needed care. Cost sharing can be useful and is appropriate in many instances, but we must use caution. Whether or not income should be a factor remains to be seen. I’ve heard arguments for income testing that make sense when the income levels discussed are quite high. However, a generally applicable income test would be difficult to administer and could be seen by many as a movement away from traditional Medicare principles.

Proponents point out that unlike the Social Security retirement and disability income programs, health insurance benefits are not related in any way to the level of the individual’s past earnings, and generally are paid regardless of any additional resources he has. This, of course, was modified last year with the approval of the so-called working aged provision, providing that Medicare become the secondary payer in certain instances.

Q: Medicare is an acute care program; it provides little of benefit to elderly individuals with chronic care needs. Can you envision the day that the Congress might broaden Medicare to include a more liberal long-term care benefit?
A: There will continue to be great interest in seeking alternatives to institutional care. This past year we agreed to cover hospice services; in recent years we expanded the home health benefit. Both of these could be considered “liberalizations” of the program. Further changes of this nature will depend in large part on our ability to finance the current benefits and to reduce the extraordinary rate of increase in the hospital side of the program. Our discussions in Medicaid, and its large long-term care component, will also have a bearing on our consideration of Medicare changes.

New Federalism

Q: How would you characterize your view of the administration’s New Federalism strategy? Do you favor the devolution of authority to subnational levels of government? If so, to what extent and what kind of programs would you favor devolving? Would you federalize Medicaid?
A: Which new strategy? It’s been a little hard to keep up with what’s newest about New Federalism. In general terms I believe that if federal dollars are involved, the Congress will want to have a say in where those dollars go. But at the same time, the Congress has made a great deal of progress in eliminating federal red tape and giving states the flexibility needed to provide services efficiently and effectively. In some ways that
means a devolution of authority, and I hope to see it continue. But there are limits. Flexibility, yes, but in my opinion, absolute control of federally funded programs by the states is not something the Congress will allow in all areas, for example, the food stamp program.

There have already been extensive discussions about federalizing Medicaid and establishing broader federal standards for the program in the past. However, these discussions have always been complicated by questions about levels of benefits, eligibility, reimbursement, and administration. I don’t believe the answers to these questions have yet been found. However, as I have noted, our current policy as reflected in the 1981 and 1982 budget reconciliation legislation is clearly a shift away from broader federal controls to increased state flexibility. I personally would certainly be willing to consider a fundamental shift in the program from a state/federal administration and financing to total federal control. But in the final analysis, the federalization of Medicaid will depend on reaching a consensus with the states on exactly which programs might be traded back to the states and what the net costs will be to the states and to the federal government.

Q: You have been critical of the private sector’s Voluntary Effort as the chief means to control health care costs. Given that view, what alternative, generally speaking, do you favor?
A: Health care costs need to be controlled, as I said, from the federal government’s perspective as a prudent buyer. Reimbursement reform is the route we will take. For now, that is the federal alternative to the voluntary effort. Allowing states to develop state reimbursement systems is another effort.

Q: There seems to be growing sentiment for imposing some limit on the tax deductibility of employer-paid health insurance premiums for employees. Would you favor some limit and, if so, at about what level would you set the limit?
A: Well, this goes back to your previous question about increasing the sensitivity of health care consumers to health care costs. All in all, a limit on the tax deductibility of health insurance premiums is an idea worth considering if structured correctly. Certainly for many employees the level of health insurance is an issue given little attention; the general principle that holds seems to be “more is better.” A tax cap is one way of interjecting sensitivity; as a nice side effect it also raises revenues. There should be some limit as to how much income-in-kind should be tax free, not only as a sensitivity mechanism, but also because it makes good sense from a tax policy standpoint. But before we can talk about what the limit should be, we need to know more about the effect a particular limit will have and how that limit relates to the benefits provided. Questions as to regional variations in the price of premiums and the cost of care, and possible future adjustments in the limit must also be answered. I can’t yet tell you what level will be most appropriate. It will obviously depend in
part on the answers to the questions I’ve noted.

Q: Do you believe that anything short of strong presidential leadership—whether it is this president or any future president—will bring about major reforms of health care? Is the magnitude of the problem of change that great in your mind?

A: We’re making reforms in health care reimbursement and will continue to do so, not so much as a function of who is president but as a direct result of financial pressures. And those pressures are strong and are expected to remain so. Certainly long-term reform in such an enormous industry will require the support of the administration in power along with members of Congress and the public as a whole. Health care is, and will continue to be, a problem of some magnitude, requiring cooperation among all parties concerned.

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**Competition and Health Care**

Q: Some legislators have been promoting the greater use of marketplace principles as an approach that would lead to less government involvement and greater cost efficiency in health care. You seem to be decidedly skeptical of this notion. Could you outline your views on this approach?

A: Marketplace principles mean to me that consumers, sensitive to costs, limit consumption to that which is necessary; and providers, sensitive to competition, restrain the cost of needed care. For all practical purposes that does not occur at present, at least with respect to how consumers interact with health care providers. When it comes to choosing a doctor, it’s reputation, familiarity, bedside manner, and the like, not fees, that decide which doctor a patient sees. Traditionally it is your doctor who decides which hospital you use, what services you need, and how long you will stay. Cost is seldom a factor. Third-party payment has taken care of that. So, I’m not convinced of our ability in the near future to use marketplace principles given the traditional behavior patterns associated with health care services.

Health care insurance is another matter. Consumers can and sometimes do shop for insurance looking for the best protection at the best price, although employer contributions and the generous treatment of these contributions by the tax laws have reduced price sensitivity here also. The principle of insurance places the responsibility upon the insurer to interact with the providers with respect to the setting of fees and benefit construction. As a result, cost sensitivity in the choice of when and where to seek care on the part of the patient is reduced.

HMOs (health maintenance organizations) and preferred provider organizations are kinds of mechanisms that interject cost sensitivity into the health care system. They are perceived, at least by some, as acceptable alternatives to the traditional patterns of consumer and provider inter-
action. Whether and how we move the federal programs toward those kinds of mechanisms requires careful consideration.

Business coalitions have done a lot to educate employers and employees of the value of shopping for the best buy and designing innovative benefit packages. I encourage them to keep up the good work.

Q: The Tax Equity and Fiscal Responsibility Act of 1982 includes a new provision that would establish a peer review system for overseeing the cost and quality of medical care. What is your position on this provision? Do you have great hopes for it or have you adopted a wait-and-see attitude?

A: First, let me say that we need an effective peer review system, foremost to assure the quality of the care provided. By assuring that only quality care is provided, we also assure the appropriate utilization of services and that implies an element of cost control in that we don’t pay for unnecessary care. Whether the new system works is largely the responsibility of the Secretary of Health and Human Services. Certainly we have provided the legislative framework for effective peer review. It’s up to the Department to specify what it wants in peer review and how it will measure the results. I’m optimistic and I’m anxious to see the Secretary implement the new provision.

Q: Private health interest groups have become among the largest contributors to political campaigns. Looking at the health sphere specifically, what impact do political action monies have on public policymaking?

A: Contributions from any special interest group provide some ease of access to a member, in the sense of the group being given an opportunity to meet with the member or his or her staff. It does not in any sense guarantee the member’s support for their cause. Nevertheless, your question is one that reflects my own concerns about whether political action committees (PACs) have gotten out of hand. It’s sort of a chicken or egg kind of thing. Do PACs reward past behavior or attempt to influence future behavior? I think the answer is both. But I’m less sure whether that’s good or bad. I believe interest groups serve the nation’s interest when they attempt to influence by argument, facts, and opinion. This input is important to any legislator.

Health Care’s Future and Congress

Q: Your general attitude toward the health field seems to have evolved over the years. You no longer seem to accept on blind faith the views of medical professionals. Have you lost faith or are you more skeptical today than you were several years ago?

A: I’ve neither lost faith with the American health care system nor become unreasonably skeptical. It is, however, fair to say that I have become more cautious. We have the finest health care system in the world, but that doesn’t mean more is always better, or that there is no room for
improvement or change.

Q: Do you anticipate that the Senate Finance Committee will have any time during 1983 to deal with health legislation outside the context of the budget process? If there is time, what do you regard as the health and social policy areas that you most would like to examine in 1983?

A: I would certainly hope that we have an opportunity to examine a number of issues in addition to those which will be raised in the context of the budget. For example, prospective payment for skilled nursing facilities; physician assignment rates under the Medicare program; the payment of teaching costs by the Medicare program; the administration of the changes made in the end stage renal disease program; health insurance coverage for the unemployed; and the implementation of the maternal and child health block grant.

Q: You have expressed, from time to time, some reservations about the directions of the end stage renal disease program? What is your attitude today?

A: I continue to be concerned that the financing of the end stage renal disease program provides an adequate reimbursement for the services provided, along with encouraging provider efficiency. We must retain the right of the individual patient and the physician to choose the location of treatment best suited to the patient’s needs while creating honest incentives to use less costly alternatives. Work must also continue on sorting out what differences, if any, exist between hospital-based units and freestanding units. It’s important that services remain accessible nationwide.

Q: Related to that question, at one point you questioned the growing role that entrepreneurship is playing in ESRD. Is that a general concern you have about medicine?

A: No, not really. The strength of the free enterprise system is based in part on the entrepreneur. The question should be, Are we paying a fair and equitable price for a quality service, irrespective of the ownership structure of the organization?

However, I believe it is important that the community orientation that is the foundation of much of our hospital system remains. If profit becomes the sole motivating factor behind the administration of a hospital or any health care delivery system, there is a tremendous risk in those areas that serve the low-income or rural populations, where there is little or no profit to be made, of an increased shortage of services. Obviously this is not in any of our best interests. We continue to need a pluralistic system able to meet a diversity of needs.

Q: As time passes, more questionable practices arise in federal health programs. The latest example is Medicare’s experience with pacemakers. Are you of the view that the “underside” of medicine is growing as competition intensifies?

A: The underside of any industry is bound to grow as that industry grows. Health is no exception. We continue to devise ways to prevent and dis-
encourage this behavior through changes in the reimbursement structure, increased audit and review activities, and increased penalties for wrongdoing.

Q: As you know, the Graduate Medical Education National Advisory Committee (GMENAC) has projected that by 1990 the United States will have almost 70,000 too many physicians, and by the year 2000 the surplus will approach 145,000. Although manpower programs do not concern your committee jurisdictionally, Medicare and Medicaid finance the care rendered by physicians. In your view, should the government be taking any steps today that seek to reduce the number of future physicians?

A: I am not in possession of a sufficient amount of information to make a judgment as to how many physicians are enough. However, I do believe that Medicare’s reimbursement policies should not be the mechanism used to control the number of physicians.