Competition in the health care marketplace

In the last issue of the AANA Journal, this column explained the many changes brought about by the budget reconciliation law. These changes affect Medicare, Medicaid and various grant programs, such as the Nurse Training Act. Since then, Congress has been in a summer recess. Its members returned on September 8, only to find that the Reagan Administration was proposing even deeper Federal budget cuts for 1982 than were included in the Budget Reconciliation Law.

It was during the months of August and September that the realization was made that the original budget estimates for 1982 were too low, causing a deficit that could be well over the $42 billion level anticipated by the Reconciliation Law. Now the question is how to save additional funds. With more than $50 billion expended on Medicare and Medicaid (almost 10% of the total Federal budget), a primary focus for savings has been on health expenditures. The other major sources of savings are the Defense budget and Social Security.

In the health field, savings can be reached by one of the following methods: (1) greatly reducing benefits, (2) greatly narrowing the number of individuals eligible for the programs, or (3) restructuring the system of financing or the way services are provided. The first two possibilities seem to have been discarded by all concerned as being too politically volatile, at least with respect to Medicare.

Restructuring Medicare financing through cost containment legislation which would limit reimbursement amounts is supported by a few Senators and Congressmen; however, the Reagan Administration and the Congressional leadership seem to believe that such cost control laws are too regulatory and counterproductive. They propose alternatively a system to restore competition in the health insurance marketplace, thereby reducing costs. The competitive model they propose applies to both private insurance and Medicare.

In the last Congress as well as in this one, numerous “pro-competition” health financing bills have been introduced. Former Senator Schweiker, now a Cabinet Secretary, and former Congressman Stockman, now the OMB Director, introduced such bills. The two Senators who chair the two Health Subcommittees in the Senate—Senator Hatch of Utah and Senator Durenberger of Minnesota—have introduced such bills. The Reagan Administration has had a Task Force in place during the summer reviewing pro-competition legislation. It is responsible to Secretary Schweiker. A number of newspaper stories have indicated some of the possibilities being considered including “Medicare Vouchers.”
Competition, Medicare and Vouchers

Not much is presently known about the "Medicare Voucher" proposal. It is still being developed by Secretary Schweiker's Task Force. Voucher systems have been experimented with as a substitute for public housing programs and public education, but not for Medicare or Medicaid.

A voucher system generally involves estimating the dollar value to the program beneficiary of the service involved and converting the service payments to a direct but limited cash payment. Thus, an actuarial estimate of the average annual dollar value of Medicare benefits for an aged or disabled beneficiary would be made and that amount would be provided each year to the individual for the limited purpose of buying his or her own health insurance coverage. If the full amount were not spent on health premiums, a cash rebate might be allowed.

States could be authorized to do the same with the Medicaid program. Under Medicare, if the average annual value of Medicare hospitalization and other coverage (both Parts A and B) were $2,000 per year, the individual would get $2,000 to shop for private health insurance.

The theory of this approach is that insurers will compete and offer lower cost programs which, in turn, will hold down health expenditures generally as well as under Medicare. Presently, Medicare costs reflect payments to hospitals and others for whatever services are delivered to Medicare beneficiaries. The Federal program is both the insurer and the paying agent, and its revenues come from employer and employee contributions under Social Security.

Under the new proposal, Medicare income would still come from employer and employee contributions, but the payments and costs of Medicare would be for premium payments for private insurance. The assumption is that the insurers will keep provider costs down and offer lower premium programs, with the result that costs will not rise as they have done recently under Medicare.

At the moment, this voucher system is being considered only as an option for Medicare beneficiaries. No one would have to take it. If one did, he or she would shop for policies. It is likely that the proposal will limit the health insurance plans one could purchase with the voucher to assure that the basic Medicare coverage is included such as Part A hospitalization and most Part B medical and other health services.

The voucher approach could open up other areas to insurance company discretion in its packaging of policies; for example, the areas of how reimbursement of providers is calculated and who can be directly reimbursed would be left to the insurers. Certainly this would be an area in which an insurer might save funds by reducing its costs. To the extent that private insurance plans are presently more liberal in their approach to reimbursement, the use of such plans through a voucher system could produce substantial reimbursement policy change.

Competition and private insurance

The legislation introduced both in the last Congress and in this one deal with private health insurance mainly. The intent of the bills primarily is not to affect the Federal budget picture, but rather to slow inflation in the health care part of the private sector. The bills which have been introduced are S. 139 introduced on January 15, 1981 by Senator Hatch of Utah; S. 433 introduced February 15, 1981 by Senator Durenberger of Minnesota; and H.R. 850 introduced January 10, 1981 by Congressman Gephardt of Missouri. S. 139 is similar to a bill Secretary Schweiker had formerly introduced when he was a Senator, and H.R. 850 was introduced in the prior Congress by both Congressmen Gephardt and Stockman.

Under H.R. 850, Medicare is affected because a Medicare eligible individual could use a voucher to purchase a private plan: a similar idea to that being discussed within the Reagan Administration. The other bills do not cause major Medicare changes.

The focus of the bills is upon the tax code. They make favorable tax treatment for employer and employee contributions to health insurance dependent upon a number of things. First, employers would have to offer their employees a choice among a variety of insurance plans. If the plans cost less in terms of employee contributions, the employee would get a cash rebate in most bills. Limits on contributions would be established for employers' and employees' contributions to the insurance, that is, toward premiums. Contributions above the limits would not be deductible for employers and would be treated as taxable income to employees.

The effect would seem to be the offering of lower cost plans. The issue is, how is the coverage affected? The bills propose basic minimum coverage which all plans would have to meet in order to assure quality of some kind. For example, S. 433 would essentially require that all Medicare
Part A and B coverage be included in the private plans as a minimum, although the deductibles and co-payments could vary.

We will follow these bills and the entire process closely. In October, the House Ways & Means Committee, Subcommittee on Health, begins a long series of hearings on the competition approach. Other Committees are likely to follow with hearings as well. We will provide you with more details about the bills and proposals being considered in the future. (The Administration's proposal should be ready shortly.) For further information on the details of the bills mentioned above, you may wish to consult a recent publication of the Blue Cross-Blue Shield Association called "Competition and Consumer Choice".

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