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spotlight

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Your Health, Your Choices

Employers and the State Fail to Meet Individual Health Care Needs

SUMMARY: Health care is again a top priority for most Americans. Health savings accounts offer promise and are growing in popularity among companies and individuals. Three states will soon begin consumer-directed Medicaid pilot programs. These are more realistic approaches than proposals by the NC Institute of Medicine and others to expand Medicaid or to force employers to provide health insurance. Individuals, not companies or the state, are best equipped to manage their own health care. Health care reform should start from this premise.

An improving economy and lack of major terrorist attacks in the country have allowed voters to focus more of their attention on considerations like the cost and quality of health care.[1] Health care is a greater concern than education in North Carolina.[2] Health care was a major focus of the National Governors Association at its annual conference and meetings with the Bush Administration in late February.[3]

In Maryland and Massachusetts they are attempting to force companies to bear the cost of insurance for their workers. Closer to home, the North Carolina Institute of Medicine (NCIOM) wants the government to share the responsibility with employers through an expansion of Medicaid, the state-federal health welfare program. Unfortunately, what most of the proposed "solutions" have called for is additional doses of the very thing that has caused most of our health care cost problems in the first place – government control of health care and health insurance markets.

Paying for Care

Health care is already the victim of too much government intervention. The state and federal governments are intricately involved in how insurance is purchased and what it must cover, and is a direct purchaser of health care services through Medicare and Medicaid. In fact, the federal government's Center for Medicare and Medicaid Services found that patients directly paid just 13.7 percent of personal health care costs in 2002.[4] Third-party private insurers or government programs paid the rest. According to one international study, Canadians pay more of their own health bills than Americans do.[5]

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There is no reason for this. The famous RAND Health Insurance Experiment found little effect on health when individuals had higher deductible insurance plans and paid more of their own health care expenses directly out of pocket rather than through higher insurance premiums. This result occurred as overall usage declined.[6] In other words, "people with excessive coverage utilize care that does nothing to improve health."[7] When government is the purchaser of services, as opposed to insurance companies, the wastefulness is even more apparent. A Dartmouth study found that 20 percent of total Medicare expenditures have no apparent effect on survival or quality of life.[8] Other studies have estimated wasteful spending as high as 40 percent. Spending varies greatly by region, but "most high-spending states rank near the bottom in quality of care, Medicare data show."[9]

Health Savings Accounts

Health Savings Accounts (HSAs) are one way to address the problems identified by the RAND study. HSAs can be used as a vehicle for reforming both government-run programs such as Medicaid or the state health plan and the private sector provision of health insurance.[10] With an HSA, an individual can purchase a high deductible health plan with relatively low premiums and invest the savings over a lower deductible plan tax free in an HSA up to the amount of the deductible. The combination makes the individual responsible for paying regular bills and encourages saving for larger health care expenses in the future.

Employers can pay the premiums for the high-deductible policy and can even contribute to their employees' HSAs. Contributions to an HSA are immediately vested with the employee. HSAs make the compensation aspect of employer-provided insurance clearer and make the system work more like defined contribution retirement plans. Moreover, HSAs contain the overall level and growth of health care spending by making health care consumers conscious of what they are spending. As a result, Whole Foods Market and other companies that have switched to HSAs have found that premiums grew much more slowly after the switch from traditional health insurance.

HSAs have only been available for two years but have already attracted over three million subscribers to high-deductibility health plans, 31 percent of them were previously uninsured. Also, 33 percent of small companies that adopted HSAs for their employees "previously did not offer coverage."[11]

Wrong Solutions

Arkansas received federal approval for a plan to reform its Medicaid program that would offer coverage with significantly reduced benefits to an expanded population.[12] The Massachusetts state legislature wants to charge businesses with 10 or more employees that do not provide health coverage $295 per worker to pay for state-paid services those workers could use.[13] The argument for doing this is that these uninsured employees often end up on Medicaid, costing the state money

The Massachusetts approach is particularly bad because it is a tax on hiring more workers. This is a recipe for increased unemployment, especially for those at the bottom rung of the economic ladder who are most likely to be working for businesses that do not offer health insurance. Rather than help these people the Massachusetts legislature's approach would simply make it more difficult for them to find work.

In North Carolina, the NCIOM Task Force offers something of both approaches in its recommendations. Its "limited expansion" of Medicaid is similar to the Arkansas program as it would eliminate some Medicaid coverage areas such as dental care, but it would still cost the state $100 million in its first year. Rather than charge companies that do not provide insurance, NCIOM would have the state offer a tax credit to employers that do.[14] Although still not good, this proposal is certainly better than Massachusetts' approach because it would not raise the cost of employment.

The problem with both the Arkansas and Massachusetts approaches, and by extension the NCIOM approach, is that they rely on employers and the state to insure individuals. Large companies are retreating from their defined benefit pension and health obligations.[15] Medicaid expansions accelerate the trend as workers drop insurance or find it no longer offered by their employer. Tying insurance to employment is also bad for the individual because of "job lock," or the tendency of workers to stay in a job to keep their healthcare. Job lock reduces voluntary job changes by 23 to 38 percent.[16] Because of employer subsidies for insurance, when someone loses his job he must pay higher premiums for

continuing coverage under COBRA or find coverage in the individual market. As more employers move to 401(k)s and other defined contribution pensions, health insurance is becoming the only area of insurance where individuals do not own their own policies.

Beyond the practical implications, there is the fundamental concern that providing insurance through employers or government is a second-best solution. If individuals are to be insured and receive care, they should pay for the insurance and care directly rather than through lower wages, which is how these services are mostly paid for now. The fact is that employer provided insurance is not free. These costs are part of the total value of an employee's compensation package and ultimately are paid for with lower wages or salaries. Public policy should focus on ways to make the individual insurance market work, allowing people to exchange health insurance benefits for higher wages, making it possible to purchase their own policies—much like they do with other forms of insurance.

Right Approaches

Until the federal tax code changes to level the playing field for self-purchased and employer-provided health insurance, the General Assembly should provide tax credits for individual insurance purchases. Now employer provided health insurance benefits are tax-free, but individual plans must be paid for with after-tax dollars. North Carolina has offered tax credits for the purchase of insurance for dependents and for long-term care, but both lapsed despite their positive results. Two other steps could help make insurance less expensive.

The first would be to eliminate coverage mandates. Here the NCIOM Task Force applies a good idea too narrowly, making reduced benefit policies available only to Medicaid recipients. The NCIOM Task Force sensibly limits Medicaid expansion and offers a reduced package of benefits to those enrolled. It should go further and extend the same idea by calling for the elimination of state mandates for insurance coverage in the private insurance market. North Carolina has between 34 and 44 mandates depending on the source. A Heritage Foundation report found that health insurance premiums for a 30-year-old male in states with more than 26 mandated benefits were $23.58 higher per month than in states with fewer mandated benefits.[17] Arkansas, Colorado, Florida, Georgia, Kentucky, Montana, North Dakota and Utah now allow mandate-free or mandate-light insurance options as one way to provide some coverage at a lower price.[18] Coverage mandates drive up costs without added benefits for most of the market.

Similarly, while Medicaid would subsidize premiums for employer-provided insurance, the offer does not extend to premiums for policies bought in the individual market.

The second would be to open the state insurance market to products from other states. This would give consumers the ability to choose the level of coverage they want – purchasing policies from states with fewer mandates or more mandates based on the policy's cost and the individual's needs.

Florida, South Carolina, and West Virginia have received approval for plans that will introduce consumer directed health care like HSAs to their Medicaid programs. These reform efforts reward healthy choices by recipients and can help the state save money.[19]

The General Assembly should study the Medicaid reforms in Florida and South Carolina as a way to reduce the program's rate of growth. Further, the General Assembly should end the $400 million counties pay to Medicaid. Until it relieves counties of this burden, it should not consider expanding Medicaid eligibility or outreach efforts that can cost taxpayers another $97 million at the state and county levels.

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Notes

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