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Ten Easy Health Reforms

by John C. Goodman

While the idealists among us still hope for a major overhaul of our health care system, there are some minor reforms lawmakers could enact that would pay big dividends. Here are 10 suggestions along with the Web addresses of NCPA publications that discuss them in greater detail.

Reform No. 1: Roth HSAs for Seniors. Currently, the elderly pay half their health care costs out of pocket. Even with the new Medicare prescription drug benefit, health care costs will continue to claim a significant chunk of their income. Roth IRAs are an attractive way for seniors to build up savings for medical contingencies. Since deposits to these accounts are made with after-tax funds, withdrawals are tax-free and penalty-free (after age 59).

Roth accounts offer better incentives than conventional Health Savings Accounts (HSAs). A dollar withdrawn from a Roth account to pay medical bills is a dollar that could have been spent on other goods and services. So, seniors won't spend a dollar on medical care unless it is worth a dollar to them. With a conventional HSA, by contrast, taxes must be paid on any dollar withdrawn for nonmedical purposes. In this case, the choice between a dollar spent on medical care and, say, 65 cents spent on something else — encourages the choice of medical care, even if it is worth only 67 cents to the buyer.

Roth IRAs could be turned into Roth HSAs by (1) allowing deposits even in the absence of wage income, (2) lifting the five-year moratorium on withdrawals for health needs, and (3) removing the income limits on participation. (www.ncpa.org/ba/ba315/ba315.html)

Reform No. 2: HSAs for Medicaid. Twenty-five states have obtained federal waivers to allow disabled patients to manage some of their own health care dollars (a program sometimes referred to as Cash and Counsel). These patients generally get better care and (potentially) save taxpayers money. Experiments like these should be expanded and encouraged — beginning with those patients with chronic conditions who consume most of state Medicaid budgets. Parents of children with diabetes or asthma, for example, can be trained to monitor their children's health and recognize when self-medication is a sensible alternative to emergency room care. When people can reap financial rewards for making wise health decisions, they will better manage their health care dollars.

HSAs for Medicaid enrollees are, in many ways, even more promising than conventional HSAs — now so popular in the marketplace. The reason: there is no need to worry about high deductibles and other restrictions that burden people who want the tax advantages of a conventional HSA. Since Medicaid recipients usually don't pay income taxes, we can ignore these restrictions and design HSAs for Medicaid in ways that create maximum advantages for patients and taxpayers. (www.ncpa.org/pub/st/st257/)

Reform No. 3: FSA Rollovers. Up to 21 million Americans have access to Flexible Spending Accounts (FSAs), allowing employees to make before-tax deposits to an account used to pay medical bills. These accounts have limited value, however, because a use-it-or-lose-it rule requires that the account be completely exhausted by year's end. Studies have shown that FSA owners who don't accurately predict their health care needs tend to engage in last-minute spending on items of marginal value**.** President Bush has proposed allowing up to $500 in unused FSA funds to roll over each year. Allowing all unused funds to roll over would be even better. It would eliminate year-end spending sprees, encourage more employees to make annual contributions to their accounts, and encourage employers to make matching deposits as well. (www.ncpa.org/pub/ba/ba439/)

Reform No. 4: Private Insurance Options for Medicaid. For every one dollar increase in Medicaid spending, spending on private insurance is reduced by 50 cents to 75 cents, as taxpayer-funded insurance crowds out private sector spending. We should reverse that process. Medicaid enrollees should be allowed to join private plans, including employer plans and individually owned insurance, paid in part with Medicaid funds. Although private sector plans may appear less generous on paper than the current Medicaid program, they usually allow enrollees access to a greater range of providers and facilities, and there is less rationing of care. This proposal would save taxpayer dollars and allow Medicaid enrollees to participate in the same kinds of health plans as other citizens. (www.ncpa.org/pub/st/st257/st257e.html)

Reform No. 5: Health Insurance and the Minimum Wage. Employer-provided health insurance is a substitute for money wages. One study concludes that in most cases the trade-off is dollar for dollar. As a result, a higher minimum wage encourages employers to drop health coverage along with other fringe benefits. To avoid this socially undesirable outcome, employers should be able to count health insurance contributions toward the minimum wage. (www.ncpa.org/ba/ba306/ba306.html)

Reform No. 6: Employee Access to Portable Insurance. Under the current system, employers cannot buy individually-owned insurance for their employees. Specifically, lawyers interpret the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to say that if employers purchase employee health insurance with untaxed dollars, the insurance must be group insurance. This type of insurance eventually ends when the employee changes jobs and in any event tends to change every 12 months, even with the current employer. Moreover, employees have no assurance that their new insurance will have the same benefits and include the same providers as their old insurance. A better alternative would allow employers to purchase individually-owned, personal and portable insurance for their employees. Even though employers would pay some or all of the premiums, employees could take the insurance with them as they move from job to job. A place to start with this idea is to give individual states the option to create this opportunity. (www.debatecentral.org/topics/2002/pers_port.html)

Reform No. 7: Insurance Options for Spouses and Dependents. Though two-earner households are common these days, employee benefits law operates on outmoded assumptions about how families live. Employees who turn down employer-provided health insurance (because, say, they have coverage at a spouse's place of work) should be able to get higher wages instead. Under current law, employers cannot give employees that option without jeopardizing the tax-free status of their entire health benefits program. (www.womenintheeconomy.org/healthcare.pdf)

Reform No. 8: Insurance Options for Part-time Employees. Part-time work is common, especially for single mothers and spouses in two-earner couples. While some need health insurance, those who don't should be able to choose between health insurance and higher wages. As in the previous example, employers generally cannot give their employees such choices under current law. (www.womenintheeconomy.org/healthcare.pdf)

Reform No. 9: Fair Prices for Emergency Room Care. Some states bar hospitals from charging lower prices to uninsured patients. This legislation prevents normal market responses, where patients who need elective surgery and pay out-of-pocket would ordinarily be charged no more than the marginal cost of the procedure. Clearly, such laws should be repealed. Congress should consider a federal override.

Reform No. 10: Flexibility for HSAs. HSAs are giving millions of Americans the opportunity to control some of their own health care dollars. However, a simple reform could improve them substantially. Rather than codify the health insurance design, we should allow insurers and employers to innovate and experiment to ascertain what works and what doesn't. Under current law, for example, employers cannot establish low-deductibles for wellness programs; they cannot create specially-designed accounts for patients with chronic diseases (such as diabetes and asthma); and in the future they will not be allowed to waive deductibles (for example, to encourage heart patients to take beta-blockers).

As is currently the case in South Africa, American insurers should be able to vary deductibles and out-of-pocket limits depending on the health care service provided. The market, not politicians, should determine health insurance design. (www.ncpa.org/pub/st/st254/)

Conclusion. Any one of these 10 health reforms would expand consumer choice and increase the efficiency of health care markets. Implementation of all 10 would not solve all our health care financing problems, but it would be a good start.

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