
Medical Savings Accounts: The Acute Importance of Patient Power

John C. Goodman

Economist John C. Goodman, Ph.D., is president of the National Center for Policy Analysis, which he founded in 1983. The Wall Street Journal called him “the father of medical savings accounts,” and National Journal declared him “winner of the devolution derby” because his ideas on how to transfer government back to the people have had a significant impact on Capitol Hill. He regularly briefs members of Congress on economic policy issues and testifies before congressional committees on health, welfare, and tax policy and on Society Security reform. He is credited with helping to defeat the Clinton administration’s health care plan.

Dr. Goodman is the author of seven books, including *Patient Power: Solving America’s Health Care Crisis*; articles in the Wall Street Journal, USA Today, Investor’s Business Daily, and other newspapers; and numerous policy studies. He appears regularly on ABC World News Tonight with Peter Jennings, NBC Nightly News with Tom Brokaw, The NewsHour with Jim Lehrer, The Wall Street Journal Report, and C-SPAN’s Washington Journal and has been featured on several PBS Firing Line miniseries with William F. Buckley Jr. and on Firing Line debates on the flat tax, welfare, and Social Security privatization.

His March 1999 Center of the American Experiment speech was one in a series moderated by Distinguished Senior Fellows Tim Penny and Vin Weber on issues raised in the Minnesota Policy Blueprint, published by American Experiment in early 1999.

I want to explore three problems: the growing number of people who lack health insurance; increasing concern among people who do have health insurance about the quality of care they are getting; and growing concern among people who get health insurance through an employer about lack of portability—really an issue of lack of continuity of care as people are being forced out of one plan and into another.

These problems are made worse by unwise government policies—in some cases, federal policies; in other cases, state policies; and sometimes a combination of the two. Minnesota does some things very well and some things not so well. A number of my recommendations are consistent with and parallel to the ideas in the Minnesota Policy Blueprint.

The Uninsured

Let's begin with lack of insurance. Nationwide, there are an estimated 45 million people without health insurance, and that number keeps growing. Some people say the estimate is high; the Urban Institute says the number is really about 10 percent lower. Even so, it is a large number. It is also true that most people without health insurance are only temporarily uninsured: about 70 percent of those who are uninsured in any given year have insurance by the end of the year. Nonetheless, it is a serious problem, and one that is getting worse.

Why should we care that there are people who are uninsured? The traditional argument is that when unin-

sured people who go to hospitals for help are unable to pay their bills, the rest of us, as taxpayers, get stuck paying. Therefore, it is a free-ride problem: they are not paying their fair share if they are going uninsured and expect to get health care when they get sick. In fact, it is probably not true that the uninsured, as a group, are free riders. They pay higher taxes precisely because they are uninsured.

At the National Center for Policy Analysis (NCPA), we calculated a few years ago that the extra taxes the uninsured pay because they are uninsured probably is about equal to the free care they get at the nation's hospitals. The problem is that the extra taxes they pay mainly go to Washington and get dumped into general revenues, but the free care is delivered locally.

Why is the problem getting worse? Regulations and tax policies: People who pay for their own insurance get almost no tax relief; the most tax relief goes to those who least need help. At the same time, regulations are pricing some people out of the market and are making it increasingly easy for others to obtain health insurance after they get sick.

We are spending more than \$100 billion a year on tax subsidies for people who get insurance through their employers. For people who have to buy their own insurance, there is virtually no tax subsidy. We are subsidizing some people very generously (often those who least need help) and giving no help to others (often those who most need it).

Under federal tax law, every dollar an employer pays on behalf of an employee is excluded from the employee's taxable income. Take, for example, a middle-income family in the 28 percent income tax bracket, and add on to that a 15 percent FICA payroll tax. In many states, this family would also be facing 6 to 7 percent in state and local taxes. So the tax subsidy in most places is really closer to 50 percent: out of every dollar an employer pays for employee health insurance, fifty cents actually is contributed by government, and the other fifty cents is contributed by employers as an alternative to wages. This is a generous tax subsidy.

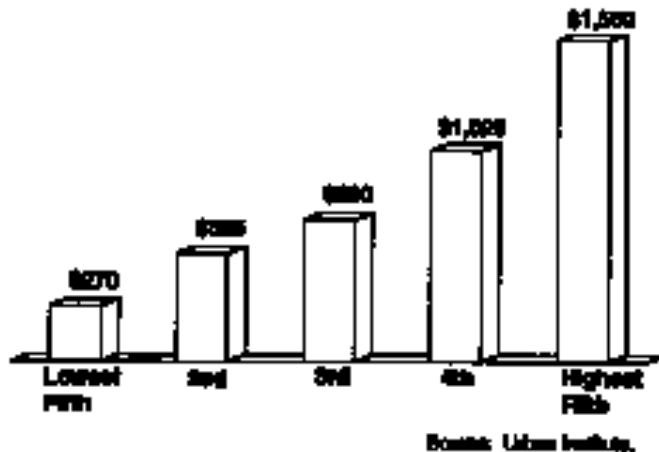
To give you an idea of what this means, suppose we have a health insurance policy that costs \$4,000. If one member of the family works for an employer who can purchase it, \$4,000 of pre-tax wages will buy the policy.

But if that same family has to purchase the policy on its own, assuming it is in the 50 percent tax bracket, it has to earn \$8,000 in order to be able to pay \$4,000 in taxes and \$4,000 for the insurance. The family that buys its own insurance pays twice as much because of this distortion in the tax law.

The benefits of the more than \$100 billion a year in tax subsidies are spread unevenly and unfairly. Families in the top one-fifth of income distribution get six times as much benefit as families in the bottom fifth. We are generously subsidizing people who don't need help, many of whom would purchase insurance even without the help, yet people who are most in need get very little subsidy.

Meanwhile, state regulations are increasing the cost of insurance and pricing more people out of the market. We've had an explosion of mandated

Average Benefit for a Family from Tax Subsidies for Health Insurance



health insurance benefits over the past decade—a flurry of laws that require insurers to cover providers ranging from chiropractors to naturopaths, and services ranging from acupuncture to in vitro fertilization. Hairpieces are mandated in Minnesota, marriage counseling in California, pastoral counseling in Vermont. Vanderbilt University economists estimate that these laws are responsible for as many as one-fourth to one-fifth of the number of people who are uninsured: they have been priced out of the market by regulations like these.

Another kind of misguided regulation is ostensibly designed to help people who have become uninsurable. These laws say that insurers have to sell to people who are already sick. Census Bureau surveys tell us that only 1 percent of the population is denied health insurance because of a health problem, but laws designed to help this 1 percent can have a devastating effect on the other 99 percent—encouraging them to go without insurance until they actually have a health problem. After all, why buy health insurance while you are healthy if you can wait until after you get sick? Despite the humanitarian objective, the states that have passed the most rigorous legislation are making their problems worse.

What can we do about all of this? First, we need to resolve the tax fairness issue at the federal level. We at the NCPA believe strongly that everyone ought to get the same help from the federal government regardless of how they purchase insurance. If you

purchase insurance on your own, you ought to get the same kind of tax relief that you get if you purchase it through an employer.

Second, we need to create a safety net for the uninsured, paid for with their tax money. When we offer people a tax subsidy to purchase health insurance and they turn down the offer and decide to remain uninsured, they are going to pay higher taxes as a result. Instead of dumping those higher taxes into general federal revenues, we ought to return that money to state and local governments to create a safety net.

In other words, the penalty for being uninsured ought to become safety-net money so that when uninsured people get sick and go to the hospital and cannot pay for their care from their own resources, this money is available. This is not the same thing as giving them a right to any care they happen to want or need. It is a fund to be used in case uninsured people cannot pay their medical bills.

Third, we need to avoid costly state regulations. Minnesota could lower the price of health insurance simply by removing cost-increasing regulations.

Finally, we need a better way of handling the problem of uninsurable people. This is an area in which Minnesota has taken the lead. Minnesota is one of two states that pioneered the concept of a risk pool. You didn't do it exactly the way I would have done it, but you are to be congratulated for having done it at all. Other states have followed, and more than half now have a risk pool of some sort.

What I would do is let people into the risk pool at a low premium, provided that it is clear that their lack of insurance wasn't willful. On the other hand, if they willfully remained uninsured for a long period of time and used the money to buy other things, I would make it more expensive for them to join the risk pool. I would discriminate depending on the circumstances of the individual who wants to join. This is much better than distorting insurance markets by saying that insurers have to ignore the health of the people who join their plans.

Distorted Incentives

Turning from the uninsured to those who do have health insurance, we find that many of the insured are not happy with the quality of the care they receive. This problem arises because of distorted incentives in the medical insurance marketplace.

First there are the distorted incentives of employees. Right now, about 75 percent of everybody who has health insurance through an employer is in an HMO. And of those who are aren't in an HMO, many have very generous coverage with very low co-payments and deductibles. The bottom line is that for the vast majority of all employees, care is free. They pay virtually nothing at the time they consume it.

So what do you do when price is no object? If health care is free, you will want to grab all the benefits you can get.

At the NCPA, we've thought a lot about what health care you might want if price were no object. One of my favorite examples is a special six-hour

checkup offered by a Dallas clinic run by Ken Cooper, the father of aerobics. It involves a treadmill test and blood tests and maybe a CAT scan. Larry King does it every year. Ross Perot does it. A lot of other people do it. I am a member of the Aerobic Center, but I have never considered the checkup a good use of money. It costs \$1,200. My back-of-the-envelope calculation says that if everybody in America got this checkup, it would increase the nation's health care bill by 25 percent. Yet most people probably would want it if someone else paid the bill.

Almost 12 billion times a year, Americans buy nonprescription drugs, presumably because something is wrong with them. What if, on their way to get nonprescription drugs, they stopped off and saw a doctor on the way? It costs nothing, so why not? If all of these people saw a doctor before they purchased nonprescription drugs, we would need twenty-five times the number of primary care physicians we now have.

All of this is just to convince you that employees have the capacity to spend an enormous amount of money.

Now let's turn to the incentives of employers. These incentives are to care only about cost. One of the employers' cost-reduction goals is to prevent employees from doing the very things I just described, and they are spending a great deal of money and time and effort doing just that.

Another goal is to try to force the supply side of the market to provide efficiency. Health care is the only market where buyers are trying to force

sellers to produce efficiently. It doesn't work, because the only way to get efficient production is if the incentives are on the supply side to begin with.

Next we have the doctors. With employees whose incentive is to care only about quality, and employers whose incentive is to care only about cost, where do the providers stand? They quickly figure out that the employers are paying the bills, so their incentive is to do what the employers want: hold down costs. Providers are also discovering that it is easier and cheaper to meet practice guidelines by lowering quality than by being efficient.

Finally, we have the health plans themselves. Minnesota is one of the states that pioneered the concept of managed competition: competitive systems in which employees can move back and forth among health plans at a community-rated premium. You have it for your state employees, and you have a form of managed competition for employees of your larger companies.

One of the problems I have with managed competition is that the way it is normally set up creates perverse incentives for the health plans. The sick and the healthy all pay the same premium, and we expect the plans to compete for these people. The plans realize that they are making a profit on healthy people and incurring losses on sick people. Obviously, when you give plans this incentive structure, they will try to avoid the sick and attract the healthy. These perverse incentives do not end at the time of enrollment; they continue to be present at the time of treatment. The health plans discover

that one of the most effective ways to attract the healthy is to overprovide—to provide services that they really don't need—and one of the ways to discourage the sick is to underprovide. Why give health plans incentives of this type when there are other ways to foster competition?

Realigning the Incentives

To avoid the consequences of these perverse incentives, we need to change each of them. That will require four fundamental changes: (1) encourage employee self-insurance through medical savings accounts, (2) adopt the casualty model of insurance, (3) remove tax law distortions, and (4) avoid the managed competition model.

We don't have to turn over all of our health care dollars to employers. There is no reason why employees can't manage some of their own health care money. Where they have been allowed to do so, they have shown that they can do it quite well.

This is what we do for our employees at the National Center for Policy Analysis. For families, we have a \$2,000 deductible. We put \$1,500 in our employees' medical savings accounts. When they go into the medical marketplace, the first \$1,500 comes from their account, the next \$500 is out of pocket, and after they hit the \$2,000 mark, the plan pays everything. Employees get to keep anything that is left at the end of the year in their medical savings accounts. For this reason, they have an incentive to spend wisely in the medical marketplace.

We've been doing this for several years, and it is very popular—both with the healthy and with the sick. It is popular with the healthy because at the end of the year, they are taking home money they otherwise wouldn't have had. It is popular with the sick because their out-of-pocket costs have been reduced; under our old plan, they would have spent more on deductibles and co-payments.

Unfortunately, the federal government discriminates against medical savings accounts (MSAs). Whereas premium payments made by an employer are excluded from the employees' taxable income, MSA deposits are fully taxed. An exception is a medical savings account pilot program for self-employed people and small businesses in which the deposits are tax free. One problem with this program is that only 750,000 people can have an MSA. Another problem is that they require a high deductible, making it impossible for a person in an HMO to have a medical savings account.

But 75 percent of the people who have employer-provided insurance are in HMOs. If we are going to find a way to let those employees control some of their health care dollars, we have to have a medical savings account that integrates with an HMO. We are now recommending to members of Congress an MSA that wraps around any health insurance plan—an HMO, a fee-for-service plan, or any other plan. The medical savings account simply pays for items that are not paid for by the health insurance plan.

Another part of the solution is to

rethink how we organize the health insurance product. Everyone knows what casualty insurance is—you have casualty insurance on your car and your home. If hail damages your roof, a claims adjuster assesses the damage and writes you a check to cover repairs. Then you are in the driver's seat, free to shop in the marketplace. You can choose a roofer, and the roofer becomes your agent, not the insurance company's agent.

We should consider doing this in health care as well. We could let people pay for non-risky events—preventive care and diagnostic tests—with their medical savings account money. Let them have as many mammograms, Pap smears, and PSA tests as they want with the MSA money. But once cancer is discovered, the third-party insurer takes over. When a catastrophic event occurs, the insurer estimates how much it will cost for an entire treatment regime and perhaps makes its own facilities available. The insurer then gives the insured the opportunity to take the money elsewhere, putting the patient back in the driver's seat even for extensive care. In this way, providers would be agents for patients rather than for third-party payers.

Third, we need to remove tax distortions. The current tax law encourages us to overinsure and to give all of our health care money to a third party. Medical savings account deposits are taxed, whereas employer payments to an HMO are not taxed. If we want to keep our taxes low, we are encouraged to give all our health dollars to an insurer. And the tax law encourages

employer provision of health insurance and discourages people from purchasing insurance on their own.

If we want neutrality under the tax law, we must remove these distortions. If we want to encourage people to make wise choices, then we need to limit the tax subsidy for health insurance to the basic health insurance we want everybody to have and let people purchase additional insurance out of pocket with after-tax dollars. The tax then becomes neutral with respect to the choice between additional insurance benefits and spending on other goods and services. The tax law also needs to be neutral between third-party insurance and self-insurance. Any subsidy we give to a dollar going to an HMO ought to also be available to a dollar going into a medical savings account. We also ought to be neutral between employer purchase and individual purchase of insurance. The same subsidy we give to employer-provided insurance ought to be given to families who purchase their own coverage. Once we have a neutral tax law, we will let the marketplace determine the appropriate amount of insurance, the division between self-insurance and third-party insurance, and the appropriate role for the employer.

Finally, we need to avoid the kind of competitive systems that encourage health plans to overprovide to the healthy and underprovide to the sick.

Personal, Portable Insurance

Lack of portability is really a problem of lack of continuity of care. In

today's marketplace, individuals who purchase insurance are buying into a network. Who your insurer is determines what doctors you can see, what clinics you can go to, what hospital you can enter. If you are forced to change health insurance plans, you may have to change doctors and other providers. If you get your insurance through an employer—and 90 percent of us do—then you are subject to all of the things that can go wrong with employer-provided insurance. Your employer can change plans or stop offering insurance benefits. You can quit or be laid off or be fired. Any of these events will trigger your leaving your insurance plan.

Two kinds of insurance are sold in Minnesota and every other state: individual insurance and group insurance. Group insurance is sold primarily through employers. Among the advantages of employer-based insurance are the economies of group purchase and no individual underwriting (no health questions). The employer also serves a monitoring role. All of this works to the benefit of the employee. There are also disadvantages: people get locked in their jobs by their health insurance, and sometimes they delay retirement in order to stay in a health insurance plan. They can lose coverage if they quit or they are fired.

By contrast, once you buy into an individual insurance pool, your insurance is by definition personal and portable. You get to stay in the pool. You get guaranteed renewals. You pay the same premium increases as everyone else in the pool. They can't reevaluate your premium based on a change

in your health. The premiums go up only with costs for the pool as a whole.

I asked Blue Cross of Texas this simple question: Why can't we combine the advantages of group insurance and individual insurance? Why can't I as an employer at the NCPA buy individual insurance for all of our employees, so we get the advantages of group purchase, but all of our employees would own their own insurance? They would be in a pool and stay in that pool when they leave the NCPA. Blue Cross thought about it and said it might be possible. In Texas, the legislature is currently considering legislation that would allow employers to buy individual insurance for their employees.

Minnesota probably has a law that makes this difficult, if not illegal. That law needs to be changed. In order to get personal and portable insurance, we must allow employers to purchase individual insurance that their employees can take with them on their journey through the job market.

Following his presentation, Dr. Goodman took questions from American Experiment Distinguished Senior Fellows Tim Penny and Vin Weber and from other members of the audience.

Liz Quam Berne: What is the appropriate role for employers in a system based on the casualty insurance model?

John Goodman: If we had a neutral tax law, the marketplace would determine if there is a role for employers. Everybody says that the employer is in

a unique position to group people in ways that cannot otherwise occur. Well, let's find out. We may find that there is no role for the small employer, that only medium-sized and large employers have an important role to play in the health insurance marketplace. But we need tax law neutrality to determine whether the employer has a role in helping people get into an insurance pool.

Tim Penny: I'm not sure I understand how you structure individual health care with the benefits of what we would normally identify as a group plan. What does it look like?

John Goodman: Let me talk about this in terms of the problems of small business. I am convinced that but for incentives distorted by government policies, we wouldn't have this thing we call small-group insurance. But we do have it, and here's how it works. A group like the NCPA buys insurance a year at a time. At the end of the year, if an employee has become sick and has generated large health care costs, we are penalized with a hefty premium increase. So even though we ultimately get merged into a larger pool, the terms and conditions under which our small group gets into that pool change every year.

Why can't we buy our employees directly into the insurer's large pool and pay their premiums for as long as they are our employees? When they leave, they take over paying the premiums, but they have the right to remain in that large pool, and their premium does

not change if their health changes.

Steve Moore: I'm a physician, and I have a question regarding Medicare patients. How would you deal with retired people who have really suffocating costs for pharmaceuticals?

John Goodman: Medicare is an insurance plan with holes in it, and one of the holes is that it doesn't cover prescription drugs. An elderly person on Medicare is exposed to thousands and thousands of dollars of out of pocket costs. Many elderly people buy supplementary insurance—called Medigap insurance—but the economists tell us that combining these two types of insurance produces a wasteful result: medical spending is probably 20 to 30 percent higher if you combine two types of insurance in an inefficient way.

Over the past few years, Congress has proposed a solution: to allow the elderly to go into the private marketplace and to allow plans to provide a single health insurance plan to the elderly as an alternative to Medicare plus Medigap. It began with just HMOs, but in 1997 Congress expanded the idea, so now, in principle at least, the elderly are supposed to have the full range of options, the same options that the nonelderly have: medical savings account plans, fee-for-service plans, doctor-run plans. Unfortunately, the Washington bureaucracy that runs Medicare has held all of this up.

But the solution to the problem remains the same: private plans putting together reasonable options at affordable prices.

Twila Brase: When an employee gets an individual policy from an employer and then moves to another employer, does the new employer then pay? Is an employer eventually paying into many different individual pools, or is there a contractual agreement with a certain plan? And with the risk pools, how do we prevent cherry picking by the insurance companies?

John Goodman: Remember that the reason we have this problem is that the federal government gives tax relief to employer purchase of health care insurance but not to people who buy their own. So we've got to go through the employer. Let's say the NCPA buys all of our employees into an individual pool and someone leaves the NCPA and goes to a firm where you are the CEO. I would leave it up to you to decide what to do. You can say, "If you want to join my plan, then we will contribute part of the cost. If you want to stay in the plan you are in, you will have to pay the whole premium out of your own pocket." Employers should have the same freedom they have now to encourage employees to join their own plan or else pay out of pocket for their insurance. But I believe that over time a lot of small businesses would want to move to a defined-contribution approach: put up X dollars for an employee, and that employee can decide where it goes. That gets the employer out of the insurance business.

About the risk pool, I am just saying that I would be a little more discriminatory about the terms and conditions

under which people can join. It would matter to me whether people were uninsured through no fault of their own, or whether they have been willfully uninsured for a decade while they were healthy and want the state to pick up the bill now that they are sick. In the latter case, I would make the premium higher.

Vin Weber: What are the implications of this for long-term care, which seems to be a looming crisis?

John Goodman: I think this is going to be a huge problem, and I don't see any way to solve it except with savings. We are going to have to start putting money aside during our working years so it's there when we retire. Much of what we call long-term care is choice of living environment, not health care, and it is hard to insure against that. Personal savings has to be a component in long-term care.

Bob Geist: I'm a retired physician. The HMO people tell us that medical savings accounts would be terrible for people, and if we give the HMOs our money, they will take much better care of us.

I did an analysis of what would happen to premium dollars if everybody bought MSAs rather than HMOs: HMOs would lose about 40-plus percent of their premium dollar if people bought MSAs. Could you comment about quality of care in that sense? Also, could you tell us what is going on in Washington and what is likely to happen this year, if anything?

John Goodman: The HMO industry hasn't been frank about the fact

that in a sense doctors are paid to deny care. The doctors are in a financial arrangement in which it is in their economic self-interest to provide less care. It is also true that HMOs often contract with independent practice associations for fixed fees and don't monitor quality. The medical savings account is one way to offset that. The casualty model is another way.

There is a lot of interest in Washington in radical change, though it may not happen in this session. I am helping Dick Armev put together a health plan with tax credits for people who purchase their own insurance, medical savings accounts for most people, and a safety net for the uninsured. Almost everything I just talked about is going to be in this plan, or at least right now it is. We expect Democrats to cosponsor this plan. We want it to be bipartisan. Our problem is we don't have any leadership from the White House. The administration seems totally focused on the next election and does not seem to want to solve problems right now.

Tim Penny: The White House obviously wants to aid the Gore candidacy, but when a president is on his way out of office, this is the time to set partisan instincts aside and focus on some of the larger issues. Not only has Medicare reform run into difficulty, but Social Security reform, which seemed to be moving to the front burner a year ago, is now on the back burner again. All of that is a consequence of lack of presidential leadership.

You mentioned that an underlying problem with our health care system is

that the consuming public can demand more and more without feeling the pinch themselves. It has often been said that Americans want all the care that someone else pays for. That is the structure of our system today. It drives us to a debate about quality and to overregulation, which drives up costs and actually denies care at the lower end. We are focusing debate on quality instead of analyzing what we really need and what we are really willing to pay for.

Three years ago, a rather ambitious plan to move toward private accounts in the Social Security system was put forward. No one thought we were ready for a Social Security debate, let alone a debate about moving at least some portion of the Social Security payroll tax to private accounts. Now that is a central element of the debate. It has been stalled because of Clinton's problems, but nonetheless, the Social Security issue has been joined, and it has been joined under those terms. Even those who protect the status quo are now talking about the government investing some portion of the payroll tax. In other words, they are admitting that the returns could be better if the money were invested in private markets. That is a victory for advocates of private accounts. The debate is about how the government should invest your payroll

taxes: does the government control the money and keep it if you die at an early age—or do you and your estate get to keep it? Advocates of private accounts win that debate hands down.

What is going on with medical savings accounts is very much in the same vein. Your organization is being creative in finding a way for MSAs to work. Critics have said that MSAs are only good for the healthy. Your wrap-around plan would work for people of all ages: not only for working people, but also for retirees. I think your innovative work in this area is going to carry the day.

Vin Weber: The country seems to be in a cultural transition in terms of the Social Security issue and the educational choice issue. We've had a very status-oriented government-controlled system. People are now expressing a preference for decentralization, market orientation, individual choice—yet they like the security of a government-imposed system. Nobody suggests that the existing government system is without flaws, but the alternatives are expected to be perfect as people try to wean themselves from the generations-old affinity for a government model. The next election is going to be a referendum on this issue whether we want it to be or recognize it as such or not. n