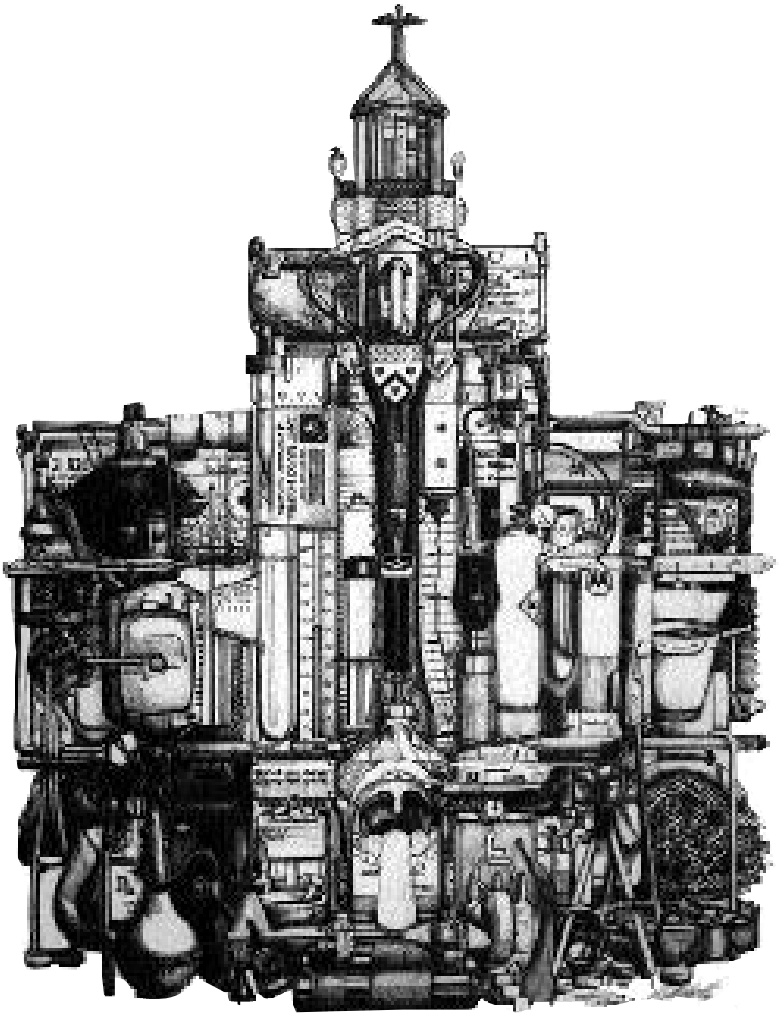

St. Mary's Hospital *(1986), by Don Stewart, M.D.*

A New Prescription

by Peter J. Ferrara

Years of debate have not produced much agreement on the future of the American health-care system. But people who study the system are virtually unanimous in their diagnosis of what's wrong with the country's traditional forms of health-care financing. The patient (with advice from a doctor) ultimately decides what services and care are purchased, but another party—an insurance company, or the government, through Medicaid or Medicare—pays the bills.

As a matter of basic economics, this is a prescription for runaway health costs. In deciding what to purchase, patients have no incentive to weigh costs against benefits, for the simple reason that someone else is paying the bill. As a result, they are likely to buy any service that offers any conceivable benefit regardless of cost—from a test of dubious utility to perhaps a minor surgical

procedure. And consumers' lack of concern has ripple effects. When patients are not careful shoppers, doctors and hospitals do not adequately compete to control costs. They compete instead primarily on the basis of quality.

This fundamental flaw can be overcome only by uniting in one party the ultimate power to decide what services are purchased and the responsibility to pay for those services. There are only two ways this can be done. One is to shift the ultimate power to decide from the patient to the third-party payer. This is what is done in government-financed health-care systems: through rationing, the government or some deputized third party ultimately decides what health-care patients receive. This is also the approach taken by health maintenance organizations and other managed-care plans. The insurer ultimately decides what care patients will receive. This was the essence of President Bill Clinton's ill-fated health-care plan. It is also the reason why the proposal was so soundly defeated. The American people simply do not want to surrender control over their own health-care decisions to a third party. And who can blame them?

The only other way to overcome the defect of traditional health-care financing is to turn the purse strings over to the patient. This is the idea behind medical savings accounts (MSAs). In a traditional system, employers and employees buy all health coverage from an insurer. With MSAs, the insurer is paid a much more modest sum for catastrophic insurance, which covers only bills over a high deductible of perhaps $3,000 per year. The rest of the money that would have gone to the insurance company is paid instead into an individual account for each worker. He can then use the funds to pay his medical bills below the deductible amount, choosing any medical services or treatments he wants. If there is money left in the account at the end of the year, he can, depending on how the system is designed, roll it over or withdraw it and use it for any purpose he pleases.

Workers with MSAs, therefore, spend what is in effect their own money for noncatastrophic health care. As a result, they have every incentive to control costs. They will seek to avoid unnecessary care or tests, look for doctors and hospitals that will provide quality care at the best prices, and consider whether each proffered service is worth the cost. If MSAs were in wide use, they would stimulate true cost competition among doctors and hospitals, who would seek not only to maximize quality, as they do now, but to minimize costs as well.

MSAs already exist and, despite a substantial tax disadvantage compared with standard health insurance, they are rapidly growing in popularity. Under current law, the dollars that employees pay toward health insurance are excluded from taxable income, but MSA contributions are not. (Legislation according MSAs equal treatment is under consideration in Congress.) Nevertheless, more than 3,000 employers in the United States now offer MSAs to their employees, including *Forbes* magazine and Dominion Resources, a Virginia utility company. The United Mine Workers union has negotiated a plan for about 15,000 employees of coal mine operators. Perhaps the leading example of MSAs in practice is at Golden Rule Insurance Company, which has offered the plan to its 1,300

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workers in Indianapolis. In 1994, more than 90 percent of the company's workers chose MSAs, and they received an average year-end rebate of about $1,000, half the amount deposited in the account. Yet health costs for the company dropped about 30 percent from what they would have been with traditional health insurance.

Typically, an MSA plan might have a $3,000 deductible and $2,000 or more per year in the savings account, leaving maximum out-of-pocket exposure for the worker of $1,000 per year. By contrast, under a standard traditional insurance plan with a $500 deductible and a 20 percent copayment fee on the next $3,000, out-of-pocket expenses could reach $1,500 per year. The MSAs also offer, in effect, "first-dollar" coverage: the first $2,000 in expenses can be paid directly out of the account, with no deductible.

Critics charge that if MSAs were more widely available, only the healthy would choose them, leaving the sick "ghettoized" in increasingly expensive conventional plans. But it is easy to see why this is wrong. With less out-of-pocket exposure, and with first-dollar coverage as well as complete freedom to spend the money as they see fit, the sick as well as the healthy would prefer MSAs. This has been the experience with the firms that already offer the option. More than 90 percent of workers who are given a choice pick MSAs, with no differences between the healthy and the sick. Moreover, workers who become sick show no tendency to leave MSAs.

In practice, MSAs have also increased the use of cost-effective preventive care. That is because of their first-dollar coverage for any care the patient chooses, including preventive care. Many traditional plans, by contrast, do not cover the costs of routine checkups and other preventive care. At Golden Rule, about 20 percent of the company's workers reported in a survey that they used funds in their accounts to pay for preventive care they would not have bought under the company's traditional insurance policy. What the MSA patient *does* have is an incentive to avoid preventive care that costs more than it yields in benefits. Good candidates for trimming, for example, are the batteries of tests that often get ordered up. (John Goodman, president of the National Center for Policy Analysis, has pointed out that we could spend the entire gross national product on prevention simply by getting every American to take all of the blood tests that are currently available.)

It is true, as critics argue, that when people exhaust their MSAs and begin to draw on their catastrophic coverage, we revert to the problematic arrangement of traditional health care: the patient is choosing services but an insurer is paying the bill. But the potential savings from MSAs are so vast that this problem should not be our first concern. If they are designed with reasonable deductibles, MSAs can bring 50 percent or more of all U.S. outlays for health care under the sway of market forces. Overall, they have the potential to cut our $1 trillion national health-care bill by 30 percent or more.

Vast savings are not the only benefit. Instead of granting even more power to government, big insurance companies, and managed-care bureaucracies, MSAs would shift control of health care to individual workers and patients, and to the doctors and hospitals they choose to serve them. In short, they would solve the health cost problem by giving more power to the people.