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Cato Institute Briefing Paper No. 19: Patient Power: The Cato Institute's Plan for Health Care Reform

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Executive Summary

The crisis of soaring health care costs has one fundamental cause: people are usually spending someone else's money when they purchase health care services. The rise of third-party payment has created an incentive structure that makes runaway spending inevitable. Health insurance is now the equivalent of auto insurance that covers fill-ups and oil changes.

The Cato Institute's Patient Power plan for health care reform seeks to put control over spending back in the hands of individual patients. Under the Patient Power plan, people could make deposits to tax-free Medical Savings Accounts to finance routine medical expenses. Workers currently covered by employer-provided insurance could fund their MSAs by switching from low-deductible policies to high-deductible catastrophic policies and depositing the premium savings. Furthermore, the Patient Power plan would eliminate the arbitrary discrimination of today's tax system and allow all Americans, regardless of employment status, to claim tax benefits for purchasing catastrophic insurance and making deposits to Medical Savings Accounts.

Introduction

Our present health care system is suffering from run-away prices and spending. For the past three decades, health care spending has been growing more than twice as fast as the overall economy; as a percentage of gross national product, it has risen from 6 percent in 1965 to 14 percent today. Meanwhile, the system is plagued not only by overspending, but also by underinclusion: at any given time about 35 million Americans do not have health insurance. That combination of ills appears to pose an intractable problem: any move to extend health insurance in its current form to those without coverage will only fuel demand for health care and push spending up even further.

Fortunately, there is a solution to the predicament. The key is recognizing exactly what is driving spending through the roof. While many conditions have contributed to the spending explosion, one stands out as the fundamental problem with the U.S. health care system today: the consumer, the patient, has been cut out of the decisionmaking loop. Of every health care dollar spent in this country, 76 cents are paid by someone other than the actual patient--by the government, insurers, or employers. Consequently, in most situations patients neither benefit when they spend wisely nor bear the consequences of spending foolishly. With those incentives, it is no surprise that costs are soaring.

To reform the system we need to change the incentives. We need policies that will allow people to choose whether and how to spend their own money on health care needs. That is the idea behind the Cato Institute's Patient Power plan. The plan is explained in detail in Patient Power: Solving America's Health Care Crisis by John C. Goodman, president of the National Center for Policy Analysis, and Gerald L. Musgrave, president of Economics America, Inc.[1]

Under the Patient Power plan, people would be able to switch from their current low-deductible health insurance policies to high-deductible catastrophic policies and put the premium savings in tax-free Medical Savings Accounts (MSAs). Those accounts would be used to pay ordinary and routine medical expenses, and catastrophic insurance would still be available to cover any major expenses. Whatever money was left in MSAs at the end of the year would remain there and continue to earn interest--you would get to keep what you did not spend.

The Patient Power plan would give people a direct financial incentive to spend prudently on health care, because they would be spending their own money. Furthermore, Patient Power would extend the same tax advantages to all Americans, unlike the current system that discriminates against the unemployed, the self-employed, and employees of small businesses that do not offer health insurance. Ensuring tax fairness would go a long way toward making health care affordable for people who are now without health insurance.

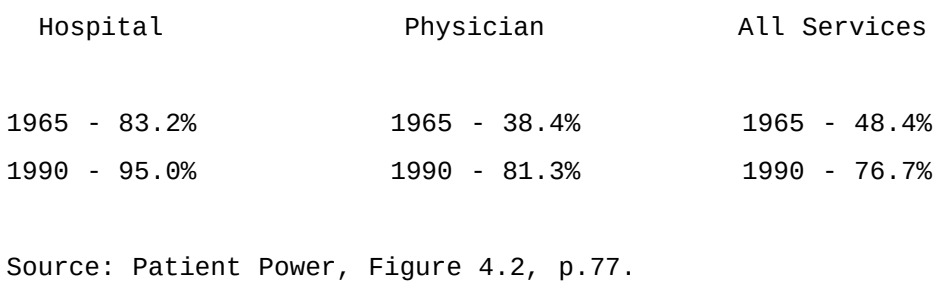
The Patient Power plan is explicitly voluntary: it is not designed to compel universal coverage under some one-size-fits-all arrangement. The most basic element of a truly competitive health care system is to allow people the freedom of opting out of it--true Patient Power begins with that fundamental freedom of choice. Accordingly, the Patient Power plan strives to expand options, not foreclose them--to let people make up their own minds about what works best for them.

The Rise of Third-Party Payment

Before 1965 spending on health care was restrained by the fact that most payments were made out-of-pocket by patients. Since then Medicare and Medicaid have expanded government third-party insurance to more and more services for the elderly and the poor, and private health insurance has expanded for the working population. As Figure 1 shows, 95 percent of the money Americans now spend on hospitals is someone else's money at the time it is spent. Some 81 percent of all physicians' payments are now made with other people's money, as are 76 percent of all medical payments for all purposes.

Third-party payment is now so dominant that the term health insurance has become a misnomer. True insurance is supposed to protect people against losses from rare high-cost events. Today's health insurance, however, covers all kinds of routine expenses that are entirely under the patient's control; such coverage is less insurance than pre-payment of medical services. Auto insurance does not cover fill-ups and oil changes, but today's health insurance covers the equivalent.

Figure 1
Percentage of Personal Health Expenses Paid by Third Parties, 1965 and 1990



Source: Patient Power, Figure 4.2, p.77.

As a result of the dramatic rise of third-party payment, the consumers of health care, the patients, no longer have much incentive to spend money wisely. When people pay only five cents on the dollar for hospitalization, they are unlikely

to be very prudent consumers, and hospitals are under little pressure to offer good deals. Elementary economics teaches that as prices go down, demand increases, and the recent history of the U.S. health care system confirms that basic truth. Because of third-party payment, health care has become nearly free at the point of sale, triggering an explosion in spending.

Putting Patients Back in Control

The health care reform proposals favored by the Clinton administration do nothing to address the third-party payment problem that is the root of the health care crisis. In fact, the administration's plan for "managed competition" would worsen the problem by creating a new third-party payment system that would be universal in coverage. To try to keep costs down, managed competition would impose onerous new bureaucratic controls and limitations on patients' choices.

Not only would managed competition fail to control costs, it would also pose a serious threat to the continued quality of American medical care. Managed competition means greater bureaucratic rationing of health care--whether openly through price controls and expenditure limits (so-called global budgets) or less obviously through increased third-party control over what services are paid for. But whatever form it takes, bureaucratic rationing means lower quality care. Just look at what has happened in countries where government controls the health care purse strings. In Britain kidney dialysis is generally denied to patients older than 55, causing at least 1,500 people to die every year for lack of dialysis. In Sweden the wait for heart x-rays is more than 11 months. And surgeons in Canada report that, for patients in need of heart surgery, the danger of dying on the waiting list now exceeds the danger of dying on the operating table.

The Cato Institute's Patient Power plan rejects the bureaucratic approach of managed competition. Combatting artificially stimulated demand with top-down bureaucratic interference is a multiplication of mistakes. The result is higher costs and lower quality care. What we need instead is a system that controls demand at the source: the individual patient. The way to get individual patients to control demand is to give them a financial incentive to do so.

Supplying that financial incentive is what the Patient Power proposal for Medical Savings Accounts is all about. Under the Patient Power plan, people would be able to deposit up to a certain amount of money every year in tax-free MSAs. Most people would fund their accounts by switching from their current low-deductible health insurance policies to high-deductible catastrophic policies and depositing the premium savings. They would then be able to draw down their account balances to pay ordinary, routine medical expenses, such as doctor's office visits, prescription drugs, diagnostic tests, and minor procedures. Catastrophic insurance would still cover the big-ticket items.

Whatever money you did not spend during the year would remain in your MSA to build up tax-free interest over time. Most people would be able to accumulate substantial savings over their working lives, which they could use upon retirement for whatever medical or nonmedical purpose they chose. Patient Power is thus diametrically opposed to the Clinton administration's managed-competition approach. Managed competition seeks to reform the health care system by adding new layers of bureaucratic control and further restricting consumer choice. Patient Power does just the opposite: it seeks to strip away third-party-payment bureaucracy and expand consumer choice. That is why the Cato Institute calls its proposal Patient Power: the goal is to empower patients, not bureaucrats.

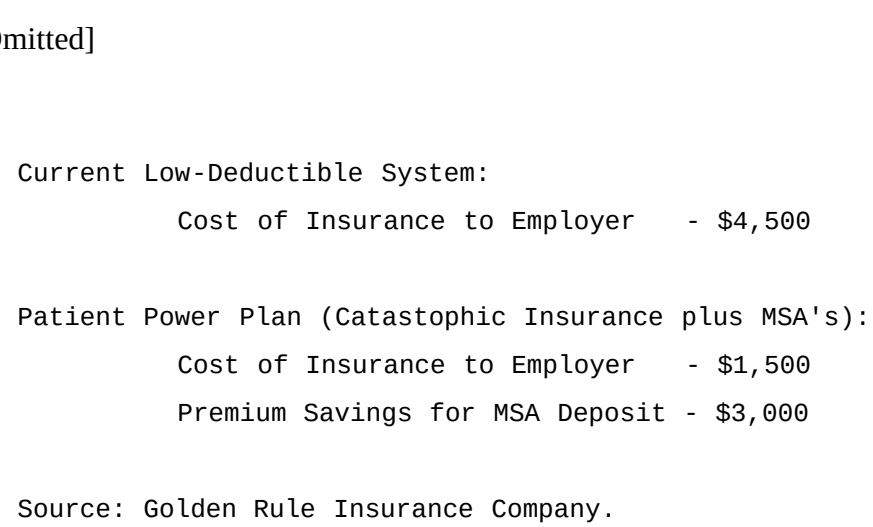
How Medical Savings Accounts Would Work

Figure 2 gives an indication of how Patient Power would operate in practice. In a city that has an average cost of living--say Cincinnati or Denver--employers pay roughly $4,500 a year to provide an employee and his family with health insurance coverage. The policy has a low deductible, typically from $100 to $250. By contrast, the premium for a catastrophic policy with a $3,000 deductible is only about $1,500 a year. Under the Patient Power plan, an employer could provide a catastrophic policy and then put the $3,000 in premium savings in the employee's MSA. The employer is out $4,500 either way; it makes no difference to him how the money is split up. But for the employee, the advantages of the switch are enormous: he actually gets more money in cash (tax-free, interest-bearing cash) than he loses in reduced insurance coverage--even during the first year. Over time, unused savings continue to build up with tax-free compound interest.

The vast majority of Americans would greatly benefit from the combination of less expensive high-deductible policies

and Medical Savings Accounts. In any given year most Americans have no or very small medical expenses, and 94 percent have medical expenses under $3,000. Under such asystem, your maximum personal exposure every year is capped by your catastrophic policy; meanwhile, your savings to meet that possible exposure keep accumulating every year with interest. In other words, the deck is stacked in favor of your coming out ahead.

Figure 2
Typical Health Insurance Costs in a City with Average Cost of Living



Medical Savings Accounts would be of particular help to employees and their families when money was tight. Even today's low deductibles, particularly when combined with copayments, can create true hardship for those struggling to make ends meet. With MSAs, money would be available to pay the first dollar of medical costs--no deductibles, no co-payments. In addition, people who were between jobs could use their MSAs to buy insurance coverage. About half the people who are uninsured remain that way for four months or less; typically, they are between jobs that provide them with health insurance benefits. The accumulated savings in Medical Savings Accounts would be available to tide people over during such times.

Establishing Tax Fairness

If Medical Savings Accounts are as great as they sound, why have employers not made them available already? Why do employers not offer high-deductible policies and cash bonuses as an alternative to conventional low-deductible insurance?

The reason such arrangements are currently unattractive is that under existing tax laws, only the employer's spending on health care is fully tax-deductible. Today, all the money an employer spends on health insurance for employees is tax-deductible; furthermore, none of it is included in the employee's taxable income. By contrast, self-employed people can deduct, at best, only 25 percent of their health insurance expenses--and even that limited deduction is not a permanent part of the law; it is on-again, off-again from year to year depending on whether Congress reauthorizes it. And the unemployed and employees of small businesses that do not offer health insurance get no deduction at all when they try to purchase insurance on their own.

Thus, under current law, employers spend pretax dollars on health care; everyone else is forced to spend (for the most part) posttax dollars. The tax bias in favor of employer-provided health insurance is considerable. As Table 1 indicates, a dollar of pretax health insurance benefits can be worth almost two dollars of taxable salary. Accordingly, once filtered through the various tax collectors, the premium savings from switching to a high-deductible policy would shrink as much as 50 percent if they were given as cash to employees. And if employees tried to establish their own make-do Medical Savings Accounts with that posttax money, they would also have to pay taxes on the interest they

earned. It is little wonder that employers and employees opt for the tax-favored benefit over the tax-discouraged one.

Table 1
Relative Value of a Dollar of Employer-Provided Health Insurance Benefits

Federal Tax Category[1]	Value with No State and Local Income Tax	Value with State and Local Income Tax
FICA tax only	$1.18	$1.24[2]
FICA tax plus 15% income tax	$1.43	$1.57[3]
FICA tax plus 28% income tax	$1.76	$1.97[3]

[1] Includes employer's share of FICA taxes.
[2] State and local income tax rate equals 4 percent.
[3] State and local income tax rate equals 6 percent.
Source: Patient Power, Table 9.2, p. 266

It should be noted that under the current system, some people covered by employer-provided insurance are able to earmark money to go into so-called flexible savings accounts, from which they can pay health expenses with pretax dollars. The problem with flexible spending accounts is that at the end of the year, any unspent money reverts to the employer. That "use it or lose it" approach obviously encourages wasteful spending--the opposite of what Medical Savings Accounts would do.

The bias in the tax system not only discourages self-insurance through medical savings, it also renders conventional health insurance unaffordable for many Americans. The self-employed, the unemployed, and employees of many small businesses must pay posttax dollars for their health insurance, and not surprisingly they rarely do. About 90 percent of Americans who have private health insurance get it through their employers. Those not lucky enough to qualify for tax advantages through their employers must fendfor themselves, and their numbers swell the ranks of the 35 million uninsured.

The present indefensible system came about, strangely enough, because of wage and price controls during World War II. Businesses tried to get around wage freezes by offering health insurance benefits to their employees. The Internal Revenue Service went along, granting them a tax deduction and excluding the fringe benefit from employees' income. The law of unintended consequences frequently haunts governmental intervention, and here is a textbook case. Thanks to wartime emergency measures taken 50 years ago, we now have a health insurance system in double crisis, plagued by both explosive overspending and underinclusiveness caused by discriminatory tax rules.

What we must do, and what the Patient Power plan proposes, is to end the current discriminatory tax treatment of health care spending and establish tax fairness for all Americans. That goal could be accomplished in one of two ways. Individuals not covered by employer-provided insurance could be granted the same tax deduction that employers are

allowed to take. Or, alternatively, employer-provided health insurance could be included in the taxable income of employees, and then all Americans could be granted individual tax credits for health care expenses.

Whatever form the tax incentive takes, it should be structured to allow a direct tradeoff between lower deduct- ible third-party health insurance and self-insurance through depositing money in a Medical Savings Account. For example, the deduction or credit could be tied to the average cost of a low-deductible policy. The higher the deductibles of the policies people chose, the lower their premiums would be, and thus the more money (up to a certain limit, say $3,000 a year) they could deposit in tax-free MSAs. Such an arrangement would allow individuals to choose the mix they preferred of third-party insurance and personal savings.

Cost Savings through Patient Power

The Patient Power plan of Medical Savings Accounts and tax fairness would revolutionize the incentives operating in the health care sector. Roughly two-thirds of all health-insurance-claim dollars in this country fall in the under-$3,000-per-year category. Under the Patient Power plan, people would be spending their own money in this dominant sector of the health care market.

Because they could keep what they did not spend, people would have an incentive to spend wisely for health care. A RAND Corporation study found that people enjoying free health care spend about 50 percent more than those who pay 95 percent of their bills out-of-pocket (up to a $1,000 maximum).[2] Furthermore, people with free care are 25 percent more likely to see a doctor and 33 percent more likely to enter a hospital. All that extra spending of other people's money, though, does not necessarily buy better results: the RAND study found no apparent differences in most health outcomes for the two groups.

It is important to realize that given the current state of medical technology, the amounts we could spend on health care are potentially limitless. We could probably spend half our gross national product on diagnostic tests alone. There are currently some 900 different blood tests that can be performed. Why not make all 900 part of an annual check-up? And consider what would happen if every person who chooses to medicate himself with nonprescription drugs decided instead to go to the doctor. To handle the explosion in demand, we would need 25 times the current number of primary care physicians.

Given that the demand for medical services is potentially infinite, health care spending must be limited one way or another. And normally, he who pays the piper gets to call the tune. Thus, under the current system, health care is increasingly rationed by the third-party payers--insurance companies and government bureaucrats. Their control over who gets what--up to and including who lives and who dies--would increase dramatically under managed competition. Patient Power offers the only viable alternative to bureaucratic rationing: individual choice, with people making their own personal tradeoffs between medical services and other needs.

With people spending their own money on health care, doctors, hospitals, and other service providers would be forced to compete on price, quality, and convenience to attract patients. Currently, such competition is stifled because, by and large, patients are not the real paying customers--government and insurers are. Accordingly, the "prices" on medical bills are not really market prices at all; they are simply a means of passing along costs to third-party payers. And information on quality--for example, mortality rates at hospitals--is not normally made available to patients.

By contrast, competition has been vigorous in those exceptional areas of the health care sector where third-party payment does not dominate. Consider cosmetic surgery, which is not covered by any private or public insurance policy. Patients pay with their own money, and they are treated accordingly. They are generally quoted a fixed price in advance, covering both medical services and hospital charges. They are given choices about the level of service (for example, surgery performed at the doctor's office or, for a higher price, on an outpatient basis at a hospital). For another example, consider America's $12-billion eye care industry, in which costs have been holding steady or even falling in recent years. The simple reason: unregulated price competition.

By eliminating the third-party paper shuffling associated with small-dollar-amount expenditures, Patient Power would dramatically reduce administrative costs. Such costs today are unusually high (the cost of marketing and administering private health insurance runs between 11 and 12 percent of premiums) because of the enormous number of small

claims that unnecessarily clog the present system. The cost of processing many small claims actually exceeds the amount of the claims. By converting to high-deductible policies and letting people pay routine expenses directly out of their Medical Savings Accounts, all that excessive paperwork would be eliminated.

Enormous cost savings could be achieved if the combination of catastrophic insurance and Medical Savings Accounts were extended universally (including replacing Medicare and Medicaid). Total administrative savings are estimated (based on 1990 figures) to be as high as $33 billion a year; in addition, more prudent spending by patients would produce savings of up to an estimated $147 billion a year. After factoring in extra costs of $12 billion a year due to instituting tax fairness, net total cost savings come to $168 billion--or nearly one-fourth of total annual health care spending in this country. And that rough estimate does not include the savings gained from lower prices that would surely be a major benefit of the new competitive health care marketplace that Patient Power would help bring about.

Conclusion

The Cato Institute's Patient Power plan to reform health insurance has three main elements:

1. allow people to make deposits in tax-free Medical Savings Accounts to finance their routine medical expenses;

3. allow people currently receiving employer-provided insurance to fund their Medical Savings Accounts by switching from low-deductible policies to high-deductible catastrophic policies with much lower premiums; and

5. allow all Americans, regardless of whether they receive employer-provided insurance, to claim tax benefits (whether in the form of deductions or credits) for purchasing catastrophic health insurance and making deposits in Medical Savings Accounts.

Notice the key word repeated in all three elements of the Patient Power plan: allow. The plan is voluntary; it does not force anyone to do anything. The purpose of Patient Power is to expand people's choices, not narrow them--to enable people to make their own decisions about tradeoffs between health care and other needs, not to create yet another bureaucracy to make those decisions for us.

Only by empowering patients can we tap the power of market incentives to transform our bloated, bureaucratized health care system. So-called reform packages based on further restricting patient choice move in precisely the wrong direction; not only would they be unable to control costs effectively, but they would also imperil the high quality of medical care that Americans currently enjoy. Managed competition is not the answer. Real competition is. The Patient Power plan, by enabling people to spend their own money on medical needs, would inject a whopping dose of real competition into our ailing health care system.

Twenty Questions and Answers about Medical Savings Accounts

1. How would Medical Savings Accounts be administered?[3]

   MSAs would be administered by qualified financial institutions in much the same way individual retirement accounts (IRAs) are.

3. How would funds from Medical Savings Accounts be spent?

   The simplest method would be by debit card. Patients would use their debit cards to pay for medical services at the time they were rendered. At the end of each month, account holders' statements would show recent expenses and account balances. No more paperwork would be needed than with any other credit card.

5. What would prevent fraud and abuse?

To receive MSA funds, a provider of medical services would have to be qualified under IRS rules. Qualifying should be a simple procedure, involving little more than filing a one-page form. If IRS auditors discovered fraudulent behavior, the provider would lose the right to receive MSA funds and would be subject to criminal penalties.

7. What types of services could be purchased with MSA funds?

   Any type of expense considered a medical expense under current IRS rules would qualify. In general, the IRS has been fairly broad in its interpretation of what constitutes a medical expense. An unhealthy step in the wrong direction, however, was the IRS decision to disallow cosmetic surgery. There is no apparent reason why the removal of a disfiguring scar or a change in facial appearance that improves employability and self-esteem is any less important than an orthopedic operation that allows an individual to play a better game of tennis or polo.

9. What tax advantages would be created for Medical Savings Account deposits?

   MSA deposits would receive the same tax treatment as health insurance premiums. Thus, under employer-provided health insurance plans, MSA deposits would escape federal income taxes, Social Security taxes, and state and local income taxes. If the opportunity to receive a tax deduction or a tax credit for the purchase of health insurance were extended to individuals, their deposits to Medical Savings Accounts would receive the same tax treatment. MSA balances would grow tax-free and would never be taxed if the funds were used to pay for medical care or purchase long-term care or insurance to cover long-term care.

11. What about low-income families who cannot afford to make Medical Savings Account deposits?

    If low-income families can afford to buy health insurance, they can afford to make MSA deposits, since the primary purpose of the MSA option is to enable individuals to divide their normal health insurance costs into two parts: self-insurance and third-party insurance. Currently, little or no tax advantage is available for people who purchase health insurance on their own. Health insurance would become more affordable for the currently uninsured if they could deduct the premiums from their taxable income. A system of refundable tax credits, which would grant greater tax relief to low-income people, would make insurance even more affordable.

13. How could individuals build up funds in their MSA accounts?

    One way would be to choose a higher deductible insurance policy and deposit the premium savings in an MSA. For most people, a year or two of such deposits would exceed the amount of their insurance deductible. An alternative (which tends to be revenue neutral for the federal government) would be to permit people to reduce the amount of their annual, tax-deductible contributions to IRAs, 401(k) plans, and other pensions and deposit the difference in Medical Savings Accounts.

15. What if medical expenses not covered by health insurance exceed the balance in an individual's Medical Savings Account?

    One solution would be to establish lines of credit (either with employers or with the financial firms that managed MSAs) so that individuals could effectively borrow to pay medical expenses. Repayment would be made with future MSA deposits or other personal funds. Another solution would be to permit family members to share their MSA funds. This concern would vanish as MSA balances grew over time.

17. How would members of the same family manage their MSA accounts?

Because family members often are covered under the same health insurance policy, it seems desirable to permit couples to own joint MSA accounts and for parents to own family MSA accounts. In those cases, more than one person could spend from a single account. But even if family members maintained separate accounts, that should not preclude the pooling of family resources to pay medical bills.

19. What about people who are already sick and have large medical obligations at the time the plan is started?

    Such people might be harmed by a sudden increase in the health insurance deductible unless transitional arrangements were made. Most would benefit from a high deductible in the long run, but they might suffer financially at the outset. One solution is the use of credit lines that can be repaid from future MSA contributions.

21. What about people who have a catastrophic illness with large annual medical bills likely to last indefinitely into the future?

    Most of those people would be disadvantaged if they had an annual deductible. A better form of health insurance would be one with a per-condition deductible, which would be paid only once for an extended illness.

23. Are there circumstances under which individuals could withdraw MSA funds for nonmedical expenses before retirement?

    A reasonable policy is to apply the same rules that now apply to tax-deferred savings plans (for example, IRAs and 401(k) plans). Thus, withdrawals for nonmedical purposes would be fully taxed and would face an additional 10 percent tax penalty.

25. How do we know people would not forgo needed medical care (including preventive care) in order to conserve their MSA funds?

    We don't. The theory behind Medical Savings Accounts is that people should have a store of personal funds with which to purchase medical care. And because the money they spend would be their own, they would have strong incentives to make prudent decisions. Undoubtedly, some of their decisions would be wrong. But many decisions made under the current system are also wrong. Under the new system people would at least have funds on hand with which to pay their share of medical bills. And since people would have an incentive to protect future account balances to cover future medical costs, some would certainly spend more on preventive health care. Because we cannot spend our entire GNP on health, health care has to be limited in some way. The only alternative to government rationing, with decisions made by a health care bureaucracy, is individual choice, with people making their own tradeoffs between medical services and other needs.

27. Given the increasing complexity of medical science, how could individuals possibly make wise decisions when spending their MSA funds?

    One thing people can do is solicit advice from others who have superior knowledge. For example, most large employers and practically all insurance companies have cost- management programs in which teams of experts make judgments about whether, when, and where medical procedures will be performed. Those experienced professionals could play an important role in helping patients make decisions about complicated and expensive procedures. Also, telephone advisory services, which are springing up around the country, could well become an important source of expert information in the coming years. In any event, we should let the experts advise and the patient decide.

29. Given the problems that major employers and insurance companies have in negotiating with hospitals, how could individual patients possibly do better?

    The reason large institutions have so much difficulty negotiating with hospitals is that institutions are not patients. And the reason patients who spent their own money would wield effective power is the same reason consumers wield power in every market--they can take their money and go elsewhere. Physicians, hospitals, and other health care providers would have considerable incentive to win their business. Moreover, Medical Savings Accounts would not preclude individuals from using employers as bargaining agents.

31. What would happen to Medical Savings Account balances at retirement?

    People should be able to roll over their MSA funds into an IRA or some other pension fund. Thus, money not spent on medical care could be used, after taxes, to purchase other goods and services, including postretirement health care and insurance coverage for long-term care.

33. What would prevent wealthy individuals from misusing Medical Savings Accounts to shelter large amounts of tax-deferred income?

    An individual's total tax-advantaged expense for health insurance plus MSA deposits could not exceed a reasonable amount. One definition of "reasonable" would be an annual MSA deposit that would equal the deductible for a standard catastrophic health insurance policy.

35. What about members of HMOs?

    They would have the same opportunities as people covered by conventional, fee-for-service health insurance plans. Note that because many HMOs are now instituting copayments, HMO members would have incentives to acquire Medical Savings Accounts. Their HMO premiums plus their MSA deposits could not exceed a reasonable amount, however.

37. Under employer-provided plans, would employees have a choice of deductibles?

    Permitting employees to make individual choices makes sense. Over time, different people would have different accumulations in their MSAs and, quite likely, different preferences about health insurance deductibles. Accordingly, employers would have an incentive to provide a range of benefit plans to suit different employee needs.

39. What would happen to flexible spending accounts now available to some employees?

    Medical Savings Accounts would replace FSAs under employee benefits law. Currently, employees who make deposits to FSAs must use the money or lose it, typically within 12 months. Similar deposits made to Medical Savings Accounts would have no such restrictions.

Ten Advantages of Medical Savings Accounts

1. The cost of health insurance would be lower.[4]

    MSAs would allow people to substitute less costly self-insurance for more costly third-party insurance for small medical bills. To the degree they were self-insured, people would no longer face premium increases caused by

the wasteful consumption decisions of others. And to the extent that third-party insurance was reserved for truly risky, catastrophic events, the cost per dollar of coverage would be much lower than it is today.

3. The administrative costs of health care would be lower.

   Because we rely on third parties to pay a large part of almost every medical bill, unnecessary and burdensome paper-work is created for doctors, hospital administrators, and insurers. By one estimate, as much as $33 billion a year in administrative costs could be saved by the general use of Medical Savings Accounts.

5. The cost of health care would be lower.

   Medical Savings Accounts would institute the only cost-control program that has ever worked: patients' avoiding waste because they have a financial incentive to do so. When people spent money from their MSAs, they would be spending their own money, not someone else's--an excellent incentive to buy prudently. By one estimate, the general use of Medical Savings Accounts would reduce total health care spending by almost one-fourth.

7. Financial barriers to purchasing health care would be removed.

   Under the current system, employers are responding to rising costs of health insurance by increasing employee deductibles and copayments. Market prices are also encouraging people who buy their own health insurance to opt for high deductibles and copayments. One problem with that trend is that people with low incomes who live from paycheck to paycheck may forgo medical care because they cannot pay their share of the bill. Medical Savings Accounts would ensure that funds were available when people needed them.

9. Financial barriers to purchasing health insurance during periods of unemployment would be removed.

   Under current law, people who leave an employer who provided their health insurance are entitled to pay the premiums and extend their coverage for 18 months. Yet the unemployed are the people least likely to be able to afford those premiums. Medical Savings Accounts would solve that problem by providing funds that were separate from those available for ordinary living expenses. MSA funds might also be used to purchase between-school-and-work policies or between-job policies of the types already marketed.

11. The doctor-patient relationship would be restored.

    Medical Savings Accounts would give individuals direct control over their health care dollars, thereby freeing them from the arbitrary, bureaucratic constraints often imposed by third-party insurers. Physicians would view patients rather than third-party payers as the principal buyers of health care services and would be more likely to act as agents for their patients rather than for an institutional bureaucracy.

13. We would enjoy the advantages of a competitive medical marketplace.

    Patients who enter hospitals can neither obtain a price in advance nor understand the charges afterward. Those problems have been created by our system of third-party payment and are not natural phenomena of the marketplace. When patients pay with their own money (as is the case for cosmetic surgery in the United States and most routine surgery at private hospitals in Britain), they usually get a package price in advance and can engage in comparison shop- ping.

15. We would enjoy the advantages of real health insurance.

    Because health insurance today is largely prepayment for consumption of medical care, people with preexisting health problems often cannot buy insurance to cover other health risks. Medical Savings Accounts would encourage a market for genuine catastrophic health insurance and would make such insurance available to more people.

17. Incentives for better choices of lifestyle would be created.

    Because MSAs would last people's entire lives, they would allow individuals to engage in lifetime planning and act on the knowledge that health and medical expenses are related to their choices about lifestyle. People would bear more of the costs of their bad decisions and reap more of the benefits of their good ones. Those who did not smoke, ate and drank in moderation, refrained from drug use, and otherwise engaged in safe conduct would realize greater financial rewards for their behavior.

19. Health insurance options during retirement would be expanded.

    Most Medical Savings Accounts would eventually become an important source of funds with which to purchase health insurance or make direct payments for medical expenses during retirement. Such funds would help solve the growing problem of long-term care for the elderly.

Notes

[1] John C. Goodman and Gerald L. Musgrave, Patient Power: Solving America's Health Care Crisis (Washington: Cato Institute, 1992).

[2] Robert Brook et al., The Effect of Coinsurance on the Health of Adults (Santa Monica, Calif.: RAND Corporation, 1984).

[3] This section is taken from Goodman and Musgrave, pp. 257-61.

[4] This section is taken from Goodman and Musgrave, pp. 249-51.