24. Health Care

Congress should

- expand medical savings accounts;
- allow Medicare recipients the freedom to choose private options such as private insurance, managed care, and medical savings accounts;
- gradually increase Medicare deductibles;
- return control of Medicaid to the states through block grants; and
- allow states to opt out of Kennedy-Kassebaum provisions.

The central issue in health policy is who has the ultimate power and control over your health and its care—you or the government? Who ultimately decides what health services and treatments you receive, what doctors you see, what hospitals provide you critical care?

The Clinton health plan of 1993-94 came down squarely on the side of government control. Although the Clinton administration attempted to sell the plan as expanding health coverage and care to include everyone, in reality, the plan was a massive government rationing scheme that would have ultimately denied care and greatly depreciated the quality of care for the middle class in order to control costs.

The Clinton administration supported cost control as a way of obtaining funds to expand health care for the low-income population, essentially redistributing health care from the middle class. They also saw the middle class as consuming overly lavish health care and wanted to clamp down on such consumption to obtain resources for other, supposedly more urgent, "social needs."

The Clinton plan would have achieved rationing through a system that would ultimately have forced everyone into heavily regulated health maintenance organizations (HMOs), which would have enjoyed the ulti-

mate power to decide what health care patients would receive and from whom. The HMOs would then have carried out the government's rationing policies. In hiding behind private, government-controlled megacorporations to perform such hideous rationing—under which the government and its big corporate deputies would have decided who lived and in what condition and who died and when—the Clinton plan was in its essence classic Italian fascism.

Fortunately, the American people rejected the idea of government-run health care. In the end, the Clinton health plan didn't receive a single vote in Congress.

Given that decisive debate and turn in American politics, the direction of health care reform in the future should be the opposite of the Clinton direction—power to the people. There are four major issues that the new Congress needs to address, applying that principle: medical savings accounts (MSAs), Medicare, Medicaid, and federal health insurance regulation.

Medical Savings Accounts

MSAs are the centerpiece of market-oriented health care. With MSAs, only a modest portion of health funds is paid to the insurer for catastrophic insurance covering all expenses over a high deductible, perhaps $3,000 per year. The rest, perhaps $2,000 per year, is paid into an individual account for each worker. The worker can then use the funds in the account to pay medical bills below the deductible amount. The funds can be used for whatever medical services or treatments the worker chooses. Whatever account funds the worker doesn't spend on health care can be withdrawn at the end of the year and used for any purpose.

With MSAs, therefore, workers would effectively be spending their own funds for noncatastrophic health care. As a result, they would have full market incentives to control costs for such care. They would seek to avoid unnecessary care or tests, look for doctors and hospitals that would provide good-quality care at the best prices, and consider whether the health care or service was worth the cost. That, in turn, would stimulate true cost competition among doctors and hospitals. Since consumers would be choosing among them on the basis of cost as well as quality, as in a normal market, providers would compete to minimize cost as well as maximize quality.

MSAs are already becoming popular. Some insurance brokerage firms now specialize in selling only MSA-type plans. As a result, over 3,000

companies in the United States now have MSAs for their workers, and the number is growing. Their experience is confirming the above analysis—MSAs are consistently reducing health costs by 30 percent or more. A growing body of actuarial data, as well as economic studies, confirms that result.

MSAs are just the opposite of the Clinton health plan. They shift power and control over health care away from government and third-party insurance bureaucracies to the individual patients and consumers themselves. That is why there is an unholy alliance against MSAs between the left-whig advocates of government-ran health care and big corporate insurers.

Legislatively, the goal is to provide MSAs the same tax-exempt treatment afforded other forms of employer-provided insurance. Employer payments into an MSA plan should be deductible to the employer and not included in the employee's income. Interest or other returns earned on MSA funds should not be taxed until withdrawn. Funds withdrawn for health care should not be subject to tax. Funds withdrawn for any other purpose should be included in taxable income. Because individuals who purchase health insurance directly should have the same tax advantages as those who receive their insurance from their employers, the same tax treatment should be extended to individual contributions to MSAs.

Late in the last session of Congress, an MSA bill was finally enacted into law. Those who fought vigorously for MSAs, including prominently Ways and Means Committee chairman Bill Archer, should be commended for their efforts. But the truth is that the bill that finally passed was badly compromised and flawed. Consequently, the next Congress should quickly pass a new MSA bill that would fix those problems and finally offer sound MSAs to everyone.

The enacted MSA legislation would allow MSAs to only the first 750,000 workers who are either in small businesses of less than 50 workers or self-employed. The 750,000 limitation is administratively unworkable and would deny the new MSAs to most Americans. Moreover, even the permitted 750,000 MSAs are limited to four years. Those limitations will probably discourage all but a few insurers from offering MSAs, leaving workers without a real market in MSAs. The legislation contains numerous further complex restrictions and limitations that will probably discourage all but a few small employers from offering MSAs.

Another major problem with the legislation is that it provides for a 15 percent penalty on MSA withdrawals for non-health-care expenditures.

That is a crippling provision whose perverse impact is not well understood. The whole point of MSAs is to give people full market incentives not to spend money unnecessarily on health care. A penalty on non-health-care expenditures runs exactly contrary to that goal, penalizing people unless they do spend the money on health care. The current penalty is a distorting 15 percent bias toward spending money on health care unnecessarily, sharply undermining the MSA incentives to control costs.

Indeed, with the 15 percent penalty most workers with MSAs are worse off with the new MSA legislation than without it. Without the new law, all MSA funds, whether used on health care or not, are fully taxable, but there is no penalty for non-health-care withdrawals. With the legislation, MSA expenditures for health care are not taxed, but non-health-care expenditures are both taxed and subject to a 15 percent penalty. So the majority of workers who would not spend most of their MSA funds in a year are worse off.

Congress should pass a new bill providing for full MSAs. That would involve applying the tax treatment described above to MSAs and offering them to all workers, without a penalty on non-health-care withdrawals.

Medicare

Those who have not enjoyed the recent debate over Medicare should consider this: the fun has just begun. Until Medicare is fixed, this issue will be with us, growing bigger and bigger.

Medicare has a fundamental structural problem. It makes grand promises but does not have revenue sources anywhere near sufficient to finance them. The government's own projections show that over the long run the program's current revenue sources will finance only about a third of future expenditures.

Medicare Part A, the Hospital Insurance program, is financed by a flat payroll tax of 2.9 percent on wages. The latest projections by the trustees show that, under intermediate assumptions, paying all benefits to today's young workers in retirement will require a Medicare payroll tax rate of almost 9 percent. Medicare Part B, the Supplementary Medical Insurance program, pays doctors' bills and other health care charges. Monthly premiums paid by the elderly finance only about a third (31.5 percent) of the costs of this program. Taxpayers finance the rest out of general revenues.

By the time today's young workers retire, keeping the premiums at about one-third of Part B expenditures would require increasing premiums about four times (in 1996 dollars), again under intermediate projections.

That means current monthly premiums of almost $50 per person and $100 per couple would be increased to the equivalent of almost $200 per person and $400 per couple. Meanwhile, the Medicare Part B deficit financed by general revenues would alone be larger in constant 1996 dollars than the entire federal deficit today.

And those projections may well be overoptimistic. They assume, for example, that the rate of increase in life expectancy over the next 75 years will be substantially less than it has been over the last 50 years, while current and prospective advances in modern medical technology seem to suggest the opposite. Longer life expectancies, of course, would mean higher Medicare expenditures because retirees would be collecting benefits longer. The projections also assume that real wages will be growing twice as fast over the next 75 years as they have over the past 25 years. But if real wages continue to grow at the slower pace, the payroll tax will generate less revenue than expected.

Congress must be honest with the American public. The current system is unsustainable, and fundamental reform is necessary. It is a betrayal of congressional responsibility to allow this issue to become a partisan football or to allow fear of the seniors' vote to forestall needed changes.

Over the long run, Medicare must be transformed into a system that grants each retiree his share of whatever Medicare funds are available each year to use to purchase any of the full range of coverage options in the private sector. Those available funds would be the payroll tax revenues generated with the current 2.9 percent rate, and the premium payments and general revenue contributions would be limited to increase no faster than income and economic growth. Medicare would then continue to grow sustainably at the rate of economic growth, however fast that may turn out to be, but no faster. If necessary, the poor could be provided additional supplements to purchase private coverage.

The great criticism of this plan is that the Medicare funds granted to each retiree would not be sufficient over time to pay the full costs of coverage. But current Medicare revenue sources growing at the rate of economic growth represent all that society can devote to pay the medical expenses of retirees who are not poor. If retirees must make some contribution to the costs of their own coverage, mat would not be unreasonable.

However, the cost-controlling incentives and efficiencies of private MSAs offer the prospect of keeping private coverage for the elderly near the amount of available Medicare funds described above. As noted previously, MSAs can be expected to reduce health costs by 30 percent.

At the same time, MSAs would provide even better benefits than Medicare, broader freedom of choice, and improved quality. That is why MSAs as one of the private options are so essential for such reform to work.

Moreover, another component of private-sector reform offers the prospect of completely closing the remaining long-term gap. Workers could be allowed to withdraw what they and their employers pay into Medicare each year and invest it through their own individual retirement accounts. In retirement, they would use the saved funds in those accounts to pay for their private health coverage. Because the saved funds would earn full market investment returns over the years, by the time the owners retired, they would be able to pay far more than Medicare. Indeed, on the basis of studies done on Social Security taxes and benefits, we can estimate that for the average worker the private savings account would pay three times what Medicare would pay.

Consequently, with this complete private-sector reform, retirees would have three times what Medicare Part A, the Hospital Insurance program, would pay, and they could use that money, along with the rest of their Medicare funds, to buy private coverage that would cost about one-third less than Medicare.

Congress should also investigate the possibility of allowing young workers to divert their 2.9 percent Medicare payroll tax to the purchase individual private insurance that would "kick in" at age 65. An early study by Professor Thomas Saving of Texas A&M University indicates that such insurance could be purchased by most young workers for far less than the current payroll tax. Of course, as with Social Security privatization, there are important transition questions—including how to continue paying current beneficiaries. There are other issues that remain unresolved as well, but this idea clearly deserves further consideration.

At the same time, Medicare benefits under both Part A and Part B should be subject to an increased deductible, adjusted each year to be large enough to keep Medicare expenditures no greater than Medicare revenues. That amount would be modest in the first year and would grow slowly over time. Several decades down the line, the deductible would be several thousand dollars per year. At the same time, limits on Medicare reimbursements should be removed so that the program would cover catastrophic expenses without limit. In the end, Medicare would be transformed from a first-dollar insurance plan to a back-up catastrophic program.

This private-sector reform is the only hope for solving the otherwise intractable Medicare financing crisis. Such reform would again shift more

power and control to the people, allowing them to gain greater control over their Medicare funds and use them to buy the health coverage and services that best suited their needs and preferences.

Medicaid

Medicaid is another runaway entitlement program, with costs that have been rising by 10 to 15 percent per year for some time now. Indeed, the National Entitlement Commission, co-chaired by Sen. Robert Kerrey (D-Neb.) and now-retired Sen. John Danforth (R-Mo.), found that if no reforms are adopted, then in just 15 years all federal revenues will be consumed by just five federal obligations: Social Security, Medicare, Medicaid, federal employee retirement, and interest on the national debt. No revenue would be left for any other federal function, including national defense, welfare, and federal law enforcement. Those programs and any other federal spending would all have to be financed through bigger deficits. Obviously, fundamental reform of major entitlement programs is urgently needed.

State governments should be given complete responsibility for—and control over—Medicaid. Ideally, that should be done by returning responsibility for the program, along with the tax sources needed to fund it, to the states, thus eliminating any federal role. However, it may be necessary to begin the transition more gradually by block granting the federal share of the program's funding to the states. Each state would men be free to use the funds to address the health needs of the poor through whatever means best suited local conditions. The amount of the block grants would be limited, however, to grow no faster than the rate of economic growth. That would limit the program to sustainable levels; it would continue at the same size, relative to the nation's economy, as today.

States could then best use those funds by providing low-income beneficiaries vouchers that they could use to buy coverage, including MSAs, in the private sector. The cost-saving incentives of the private alternatives would enable the beneficiaries to get better benefits with the available funds. And such reforms would once again shift maximum power and control away from federal bureaucrats to the beneficiaries themselves.

Federal Regulation of Health Care

Last year Congress passed the ill-advised Kennedy-Kassebaum bill. That legislation will come back to haunt its supporters the same way the Medicare catastrophic health act of the late 1980s did.

The law runs flatly contrary to the principles of the Republican majority, by centralizing power once again in Washington, rather than devolving power to the states and the people. Indeed, it begins the process offederalizing health insurance regulation that was formerly the province of the states.

Moreover, the law will serve only to increase the cost of health insurance. Contrary to popular claims for it, the legislation does not allow workers to keep their current health insurance when they leave their jobs. Rather, it provides for guaranteed issue by forcing new insurers to accept them under either an individual policy between jobs or the group policy offered by their new employers.

Guaranteed issue will have a potentially catastrophic cost-increasing effect on the individual health insurance market, where workers pay for their coverage directly themselves. Only about 10 percent of workers are in that market, compared to 90 percent in the big group insurance market where employers pay for the coverage.

Consider a worker who has been healthy for 30 years, with the employer paying his premiums to a big group insurer all of that time. Now suppose he gets cancer, or heart disease, or AIDS and has to quit work as a result. Under the law, he can now force any individual insurer to cover him, even though he never paid any premiums to that insurer when he was healthy. His premiums now will cover only a small fraction of his costs, imposing huge losses on the insurer he chooses.

As a result, under the law, all of the sickest, highest cost workers in the big group market will now be dumped on the much smaller individual market. Insurers in that market will have to sharply increase their premiums as a result. That in turn will cause many low-cost, healthy workers to drop their coverage, forcing insurers to raise their premiums even higher. Eventually, this process may cause individual health insurance to become unmanageably expensive.

Indeed, individual insurers may simply withdraw from the market altogether in the face of this danger. Workers will then be unable to get insurance unless their employers buy it in the big group market. That will almost certainly result in pressure for the government to step in and provide them coverage.

Those provisions were sold to Congress on the basis of studies that concluded that the resulting cost increase for insurance would be small. But the studies unreasonably assumed that states would allow insurers to charge the sick high enough premiums to cover most of their high costs. On the contrary, states will likely force companies to charge the sick little

or no more than the healthy. Otherwise, the law will be ineffective, as it would only offer workers coverage that is too expensive to buy. That would cause initial rate increases of at least 30 percent, and probably more after the healthy workers start dropping out.

A better approach would be to rely on guaranteed renewability and state risk pools. Guaranteed renewability would require insurers to continue to renew coverage for all who desired it, even those who left their jobs, with the same standard rate increases for everyone. That would effectively enforce the insurance contract, as insurance that allows the insurer to drop beneficiaries after they become sick is not insurance against anything at all; it simply misleads buyers. This would actually do what the recently enacted legislation was wrongly advertised as doing—allow workers who leave their jobs to take their insurance with them. Moreover, instead of forcing insurers in the much smaller individual market to cover all of the sickest workers from the big group market, tibis approach would require insurers in the big group market, who received the premiums when those workers were healthy, to continue to cover them when they became sick. This workable approach is already in effect for all individual health insurance and would have little effect on cost.

Those who had coverage would then all be assured of keeping it. For those who didn't buy coverage and became too sick to buy it later, each state should set up its own risk pool. The pools would charge above-market prices, perhaps 50 percent more than standard rates, to help cover the higher costs of those sick people. But to keep the insurance affordable, states would subsidize the pools from general revenues to cover remaining costs. The states could provide further subsidies for those who were too poor to pay all of the premiums.

Such risk pools are in fact already in effect in almost 30 states and have been shown to be workable. Only about 1 percent of the working-age population is uninsurable, so the cost of such pools is not great. Through such pools, necessary subsidies can be channeled to the small number who are truly in need, keeping costs low and avoiding disruption of the market for everyone else.

States under the Kennedy-Kassebaum legislation are supposed to be free to opt out of the onerous guaranteed issue provisions noted above and adopt other means of achieving the goals, such as the above-described guaranteed renewability and risk pools. But whether states will actually be able to do that under the law as passed is highly dubious.

The new Congress should repeal the dangerous Kennedy-Kassebaum legislation. But, if that is impossible, it should at least enact changes to

ensure that states can choose the better reforms. Legislation should provide that governors can certify that their states have passed legislation to satisfy the goals of Kennedy-Kassebaum, and such certification would avoid all further requirements of that legislation. Each state could then hold its own governor accountable for his or her actions.

The 104th Congress also passed several other measures interfering in the operation of private insurance markets, including a mandate that insurers pay for a minimum of 48 hours of hospital maternity care and a requirement for parity in coverage of mental illnesses. Both provisions will lead to increased premiums and should be repealed. In the future, Congress should avoid the temptation to become the national insurance regulator.

Conclusion

The nation's major health care problems must be quickly addressed by taking an approach that is the opposite of that taken by the Clinton administration in 1993 and 1994. Ultimate control over the health care of workers and their families should not be shifted to the government and third-party insurance bureaucrats; control must be fully restored to the workers and their families themselves.

Suggested Readings

Ferrara, Peter. "More Than a Theory: Medical Savings Accounts at Work." Cato Institute Policy Analysis no. 220, March 14, 1995.

_____. "The Establishment Strikes Back: Medical Savings Accounts and Adverse Selection." Cato Institute Briefing Paper no. 26, April 24, 1996.

Goodman, John, and Gerald Musgrave. *Patient Power: Solving America's Health Care Crisis*. Washington: Cato Institute, 1992.

Liebowitz, Stan. "Why Health Care Costs Too Much." Cato Institute Policy Analysis no. 211, June 23, 1994.

Saving, Thomas. "Medicare Reform: In Search of a Permanent Solution." Private Enterprise Research Center, Texas A&M University, College Station, Texas, November 15, 1996.

Tanner, Michael. "Medical Savings Accounts: Answering the Critics." Cato Institute Policy Analysis no. 228, May 25, 1995.

Tanner, Michael, and Doug Bandow. "The Wrong and Right Ways to Fix Medicare." Cato Institute Policy Analysis no. 230, June 8, 1995.

Wasley, Terree. *What Has Government Done to Our Health Care?* Washington: Cato Institute, 1992.

—Prepared by Peter Ferrara