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We Need Medical Savings Accounts Now

Health care is still a major national domestic issue. It didn't go away with the defeat of the Clinton totalitarian proposal in 1994. The Democrats, led by President Bill Clinton and Senator Ted Kennedy, are still trying to achieve their longtime goal of national (socialized) health care, but they are now trying to do it incrementally instead of whole hog. Their piecemeal approach is the Kennedy-Kassebaum health bill, which was demanded by Clinton in his 1996 State of the Union Message.

All Americans who care about individual freedom and privacy should be up in arms against all Clinton/Kennedy/Kassebaum proposals. At stake is our right to choose our own doctor, select our own health treatment, keep our personal medical records off a government computer, and spend our own money.

The Kennedy-Kassebaum health bill pretends to address the need for what is called "portability." When workers switch jobs or are laid off by downsizing, they find they can't take their health insurance with them because it's owned by their employer. Then, when they try to join a health insurance plan with their new employer, or try to buy health insurance as an individual, they sometimes are denied insurance because of a "preexisting condition." Lack of portability is a particular problem for many mothers who would like to switch to part-time or self-employment, but are tied to their jobs ("job lock") by their health insurance.

The system of having your employer own your health insurance policy is bad government policy, stupid economic policy, and very unfortunate for the individual worker. There is no more reason why your boss should own your health insurance than your automobile insurance. When you switch jobs, your car and your car insurance go with you, and your health insurance should, too. Yet 90 percent of Americans who have private health insurance are tied into employer-based health insurance.

The reason why this system is so widespread is the discriminatory provision of federal tax law which gives tax-deductibility to company-owned health insurance but, for the most part, denies tax deductibility to individually-owned health insurance. The tax-deductible feature is a powerful incentive to perpetuating a system that is wrong from every standpoint and grievously unfair. It means that the officers of big corporations enjoy gold-plated group health insurance paid for with tax-deductible dollars, but the waitress, the part-timers, the self-employed, and those who work for small firms that can't afford fringe benefits must buy costly individual health insurance and pay for it with after-tax dollars.

The Clinton/Kennedy/Kassebaum solution to this problem is to increase federal control of our health care system through more federal regulations. That's the wrong way to go. It would reduce our freedom, be costly in many ways, and lead inevitably to more federal controls, price fixing, and the rationing of health care. It is the stepping stone to the national (socialized) system that Clinton and Kennedy have always sought.

The correct solution instead is to move toward a system in which individuals can own their own health insurance and be treated by federal laws at least as well as corporations are treated.

Medical Savings Accounts (MSAs) — owned by individuals — are a necessary step toward solving all the problems connected with health care: portability, affordability, preserving your right to choose your own doctor, pre-existing conditions, job lock, uninsured Americans, gatekeepers, capitation, deductibles, co-payments, paperwork, long-term care, Medicare going bankrupt, and even the decline in real wages.

At least 1,000 employers, both private and public, have already instituted a type of Medical Savings Account plan for their employees, so we know how they work. Instead of a traditional high-cost, low-deductible company plan, your employer buys lower-cost, high-deductible health insurance and deposits the premium savings in your individual Medical Savings Account (up to $2,000 per year for singles and $4,000 for families).

Your MSA would grow as your employer puts in a new payment every year. Only 11 percent of all insured individual Americans spend more than $2,000 a year on health care, so 89 percent would save some portion of the contribution to their MSA every year. You can use this ready cash for your medical costs with the doctors,

hospitals and clinics you choose, and the high-deductible policy covers you for additional expenses.

Unfortunately, MSAs now in existence do not have the same tax deductibility that traditional company-paid plans have. All money deposited in MSAs today must be treated as additional wages subject to income and payroll taxes. Congress should change the law to provide for deductibility, so that whatever you don't spend stays in your MSA and builds up as a tax-free, interest-bearing savings account.

Our present system is unjust, discriminatory, and intolerable because it grants tax-deductibility only to plans owned by employers, but **not** to plans that allow individual employees to own their own health insurance, control their own health care spending, or set up their own plan. Congress should change the tax code so that individual MSAs will be treated the same as company-paid group insurance.

If MSAs become widespread, health care costs will fall dramatically because MSAs put consumer discipline into the marketplace and provide incentives to save. Nobel Prize-winning economist Milton Friedman said that MSAs could cut health care costs in half.

MSAs would be available now and in the future for many medical expenses often not covered by company plans (such as eye glasses, dental care, or preventive care) or by Medicare (prescriptions and long-term care). MSAs would also be available from the first dollar of medical expense (which would be helpful to the single mother whose child gets ill on New Year's Day and can't afford to pay the usual deductible).

MSAs Needed to Help Jobs and Wages

MSAs will help us deal with the tremendous economic and political issues involved in jobs, wages and income. Real (inflation-adjusted) weekly wages have dropped almost 5 percent since 1979 — for those who have jobs. Income is a lot less for those who have been downsized.

Business spokesmen are trying to downplay this data by arguing that employee fringe benefits have risen from 17 percent of total compensation in 1955 to 40 percent in 1994. Total compensation equals take-home pay plus fringe benefits, of which health care is a large component.

Workers aren't buying this argument because, while the employer's cost to provide the health-care benefit has risen, the value of the health care benefit to the employee has declined. Whereas in 1979, the employee's health-care package allowed him to go to any doctor or hospital of his choice, millions of employees are now being herded into HMOs (Health Maintenance Organizations) where they are at the mercy of Gatekeepers.

MSAs are a good answer to these problems. They would put extra money in the pockets of workers whose real wages have declined, they would encourage savings, and they would ease the strain of layoffs by allowing them to take some of their benefits with them when they leave the company.

MSAs Are the Alternative to HMOs

Republicans spent two years attacking the totalitarian Clinton health plan because it would force all Americans into Managed Care, allow medical care only as permitted by Gatekeepers, deny our right to choose our own doctors, limit access to specialists, put everyone's medical history on government computers, and impose price fixing and rationing. Republicans won the argument, defeated all versions of Clintoncare in 1994, and used Clinton's health plan as a central issue in winning a Republican majority in Congress.

In 1993 and 1994, when "conventional wisdom" said that Clinton's health bill would surely pass, the five largest insurance companies invested heavily in Managed Care. As the national debate went on, they beamed their sales talk directly at corporations and persuaded many to convert their company health insurance to HMOs or some form of Managed Care. It's clear that this has made billions of dollars for HMOs. It's also clear that there is an enormous backlash against HMOs among the millions of individuals who were involuntarily forced into them.

According to the *New York Times* (5-19-96), 53 million Americans are now in HMOs and another 70 million are in other types of Managed Care plans. Most did not choose these plans; they were put in them by their employers.

HMOs suffer from a built-in conflict of interest; HMO Gatekeepers and HMO CEOs make more money if they deny your right to see a specialist. That's why opposition to the tactics of the HMOs, and to the windfall profits these tactics produce for HMO CEOs and stockholders, is bubbling over. At long last, the media (*Time, Newsweek, 20/20*) are starting to throw the spotlight of publicity on what they are calling HMO "horror stories." Some 400 bills to regulate HMOs practices have been introduced into state legislatures. Republican leadership in Congress, however, has been strangely silent.

The *New York Times* quoted a surgeon in White Plains, New York, Dr. Carl Weber, as saying, "We believe the whole concept of managed care is spurious. It is predicated on financial incentives to restrict care and access to care." A Sacramento nurse, Kit Costello, has collected more than 800,000 signatures to put an initiative on the California ballot to restrict the use of financial incentives for denying or delaying appropriate care. She says, "We see the human wreckage every day."

Managed Care has introduced several new words into our vocabulary. A "Gatekeeper" is the primary-care physician you are required to see first, and whose permission you must get in order to see a specialist. The function of Gatekeepers is to discourage or deny the use of specialists because they are more expensive. (The now-defunct Clinton health plan would have required medical schools to reduce the numbers of specialists trained.)

"Capitation" is the practice of paying physicians a set amount (called a capitation fee) for each person who

enrolls as their patient. Capitation has its own built-in financial incentives. The fewer times a doctor sees you, and the fewer tests he orders, the more profitable a patient you are. Every time you walk into the HMO doctor's office, you are costing **him** money and cutting into **his** leisure time. Sometimes the cost of the tests or specialist treatment comes out of the primary physician's fee.

"Withholds" are the portion of a physician's annual salary that is withheld until the end of the year as an incentive to keep costs below certain targets. Bonuses are frequently paid by the HMO to reward Gatekeepers who keep costs down by **not** referring patients to specialists.

The Managed Care lobby reputedly has $9 billion (not million) in cash reserves, so it's not surprising that it is the biggest special-interest group lobbying Congress today. The HMO trade group, the American Association of Health Plans, funnels its arguments to both Democrats and Republicans, who then try to tell us that people just love HMOs.

Sheila Burke, Bob Dole's chief of staff and one of the most powerful persons in Washington, played a key role for four years in building Republican leadership support for Managed Care plans rather than Medical Savings Accounts. Her husband, David Chew, held options to buy 18,200 shares of Aetna stock at the beginning of 1995. Aetna is one of the dominant insurance companies dealing in Managed Care. If Chew exercised his options in January, he could have purchased more than $1.3 million in stock, making an instant profit of $482,000. (*Kansas City Star*, 1-21-96)

The billions of dollars of windfall profits in the hands of the Managed Care industry are the only rational explanation for why Republican Congressional leaders in both Houses rarely, if ever, criticize HMOs. This big money is also the best rational explanation for why leading Democrats are launching false and demagogic attacks against MSAs. The Managed Care profiteers and their political spokesmen understand clearly that MSAs are the alternative to HMOs.

The Managed Care lobby recognizes that, if Americans have the freedom to choose the kind of health insurance they want, most will choose the freedom of MSAs rather than subservience to the Gatekeepers of HMOs. The liberal Democrats recognize that MSAs put us on the road to a free-market economy, while HMOs put us on the road to national health care and a planned (socialized) economy.

The Portability Issue

The Kennedy-Kassebaum health bill was presented as the solution to the portability problem, but its "solution" is to federalize the insurance industry by imposing what is called "guaranteed issue." That means requiring insurance companies to "guarantee" that they will "issue" **individual** insurance to anyone previously covered by **group** insurance, without regard to their health status and preexisting conditions. "Guaranteed issue" is intended to help those Americans who can't qualify for health insurance, the so-called uninsurables, but it is another bad idea that has dangerous and very costly unintended consequences.

Take the case of a worker whose job benefits for 20 years included a company-paid health plan. Then he becomes terminally ill and can't work any more. All the premiums paid while he was healthy were pocketed by the company-paid insurer and are now a total loss to the sick worker. There is no justice in requiring some other insurance company to "guarantee" coverage and pick up all the costs of his terminal illness.

The inevitable result of the Kennedy-Kassebaum regulation would be that insurance premiums would rise out of sight. When people can no longer afford the premiums, the number of the uninsured will increase. The public will demand relief. The Democrats will move to impose mandatory universal coverage (which the Kennedy liberals have always sought), and that can be achieved only by a government-run system.

Guaranteed issue of medical insurance would be like forcing banks to issue loans and mortgages without asking applicants about their financial condition. It would be like requiring insurance companies to insure houses after they are already on fire. It would be like requiring auto insurance companies to sign up drunk drivers. If you could buy insurance for your house when it is going up in flames, why buy it ahead of time?

If the law guarantees the issue of health insurance coverage, why would people buy insurance when they are healthy? The answer is, they won't. People will just wait until they get sick and then buy coverage.

We already know how guaranteed issue works in practice. When only sick people buy medical insurance, rates increase. And when rates increase, more people cancel, and then rates go up again in a vicious cycle. Similar laws in New York and other states have had exactly this result.

What about those who can't qualify for health insurance, the people whom guaranteed issue is supposed to help? Look at the example of the states that have successfully dealt with this problem.

At least 29 states have established high-risk pools for people who can't get health insurance, much like the high-risk pools for drivers with bad records. Enrollees in the high-risk pool pay a premium for the coverage, which is capped at a certain percentage of standard rates, usually 135 percent. Since the high-risk pool spends more than it collects, the losses are made up through various funding mechanisms. Illinois uses general revenues. Wisconsin and 18 other states fund the pool by an assessment on insurance companies based on the amount of health insurance each company writes in the state. The cost this puts on insurance companies is acceptable. Published figures indicate that the average assessment on insurance companies is one-half of one percent of the health insurance premiums they collect in the state.

We certainly should not destroy normal market forces for the entire health insurance market in order to satisfy the needs of a relatively small high-risk pool.

New Health Care Crimes

One of the most obnoxious features of the Clinton health plan was its creation of a long list of new federal "Health Care Crimes." Title II of the Kennedy-Kassebaum health bill includes an equally obnoxious crime section. When Dr. Jane Orient, executive director of the Association of American Physicians and Surgeons (AAPS), read the bill, she discovered that much of this health crime section was copied from the Clinton bill.

The Kennedy-Kassebaum bill criminalizes what are called "federal health care offenses." The definition is excruciatingly broad: a violation or conspiracy that involves "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual." And, hear this: "No proof of specific intent to defraud is required."

The bill specifies monetary penalties of "up to $10,000 for each instance" of "failure to comply with statutory obligations," for "incorrect coding," or for providing "a medical or other item or service that a person knows or should know is not medically necessary." Big Brother, not your doctor, will decide what health services are "necessary." The new crime of "health care fraud" carries fines plus imprisonment of up to ten years. "If the violation results in serious bodily injury," imprisonment can be up to 20 years, and if death results it can be "for any term of years or for life."

A person who "intentionally misapplies" any assets of a health care benefit program "shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the value of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both."

"In any investigation relating to any act or activity involving a Federal health care offense, . . . [the Attorney General] may require the production of any records that may be relevant." "Whoever" makes a false statement to a health care plan is liable to a five-year prison term. "Whoever" can mean anybody, patient or provider. Failure to provide health information, "oral or recorded in any form or medium," to a criminal investigator from any government agency carries a five-year prison term. Information extracted under this provision can be used against the patient if "the action or investigation arises out of and is directly related to the receipt of health care or payment for health care."

The bill's exotic forfeiture provisions put health care offenses on a par with racketeering and drug dealing, and are actually broader than under the failed Clinton bill. "The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense."

The bill requires the Federal Government to "establish a national health care fraud and abuse data collection program" and specifies that "the information in this database shall be available to Federal and State government agencies and health plans" pursuant to any procedures set by the Secretary of Health and Human Services (that's Donna Shalala). This will empower the Federal Government to use medical records to prosecute almost anybody Janet Reno wants to target.

These provisions mean the end of patient privacy and confidentiality of the physician-patient relationship. They lay the foundation for forcing all medical professionals to submit electronic information on every medical encounter to a central computer, a practice that is already required by a new Maryland law that takes effect this month. This law requires all health care professionals to disclose to the government the details of every patient encounter, including diagnosis, test results, therapy, charges, and 32 pieces of demographic data on every patient. (See *Forbes*, 5-20-96.)

The effect of creating all these Health Care crimes will be to drive physicians in private practice out of business. Creating these crimes will make it unsafe for any doctor in private practice to bill a patient for any treatment or test, knowing that some HHS bureaucrat may afterwards decide that it was "not medically necessary" and therefore is criminal fraud. The HMOs will take over the entire practice of medicine and will have plenty of money to hire lawyers to defend their practices. The HMOs have already solved the problem of any physician ordering medical treatment that could be construed as "not medically necessary" by the financial incentives put on the Gatekeepers.

The winners in this process will be the HMOs whose profits are based on rationing by Gatekeepers. The losers will be the American people whose level of medical care will be drastically reduced.

We support MSA legislation to change federal tax law so that individual self-insurance is treated the same as HMO insurance. Anyone who wants to stay in HMOs can do so. No one would be forced to set up an MSA account but, on the other hand, individuals should be able to set up an MSA with the same tax treatment as HMOs. We want options, not requirements.

We know that President Clinton and House Minority Leader Dick Gephardt have taken the side of the HMOs by opposing MSAs. Which side will the Republicans take?

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