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Personal Medical Savings Accounts (Medical IRAs) An Idea Whose Time Has Come

Last year, about 150 members of Congress cosponsored at least one of 12 different bills designed to create personal Medical Savings Accounts (MSAs). [See the sidebar on legislation in the 102nd Congress.] Also called Medisave Accounts and Medical IRAs, Medical Savings Accounts are attracting growing support again this year, as new MSA bills are fashioned in the current legislative session.[1]

"The advocates of Medical Savings Accounts span party lines and ideological divisions."

The advocates of MSAs span party lines and ideological divisions. They include Democrats and Republicans, liberals and conservatives. MSAs also have wide support outside of Washington. The concept has been endorsed by such disparate groups as the American Medical Association, the American Farm Bureau, the National Association of Health Underwriters and the National Association for the Self-Employed.

Why have so many people, representing so many points of view, decided that personal Medical Savings Accounts are essential to health care reform? Because MSAs are more effective than any alternative in reaching five important goals: (1) controlling health care costs, (2) maintaining the quality of health care, (3) getting more Americans covered by private health insurance, (4) making the market for medical care more competitive and (5) reforming Medicare, Medicaid and other government health care programs.

Under the current system, 250 million Americans find it in their self-interest to take actions that contribute to our nation's health care crisis. With MSAs, individual patients would become part of the solution instead of remaining part of the problem. Let's see how.

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Congressional Support for Medical Savings Accounts

Last year, about 150 members of the 102nd Congress cosponsored at least one of 12 different bills designed to create Medical Savings Accounts (MSAs). The advocates of MSAs span party lines and ideological divisions. They include Democrats and Republicans, liberals and conservatives.

Some of the bills included MSAs as a fundamental part of a comprehensive health care reform package. Others focused exclusively on creating MSAs. All of the sponsors saw MSAs as an integral part of the move to bring market-oriented incentives into the health care system. The bills, their sponsors and their number of cosponsors are listed below.

H.R. 3084 Rep. Dannemeyer (R-CA). 5 total cosponsors.

H.R. 4130 Rep. Santorum (R-PA), with DeLay (R-TX), Duncan (R-TN), Gingrich (R-GA), Kasich (R-OH), Rohrabacher (R-CA), Miller (R-WA), Weber (R-MN), Johnson (R-CT). 44 total cosponsors.

H.R. 4280 Rep. Rhodes (R-AZ), with Gross (R-FL), Hastert (R-IL). 17 total cosponsors.

H.R. 5250 Rep. Jacobs (D-IN), with Archer (R-TX), Inhofe (R-OK), Torricelli (D-NJ). 72 total cosponsors.

H.R. 5315 Rep. Gunderson (R-WI). No cosponsors.

H.R. 5970 Rep. S. Johnson (R-TX), with Kyle (R-AZ), Thomas (R-WY), Riggs (R-CA), Doolittle (R-CA), Nichols (R-KS). 5 total cosponsors.

H.R. 5325 Rep. Michel (R-IL), with Gingrich (R-GA), Lewis (R-CA), Edwards (R-OK), Hunter (R-CA), McCollum (R-FL), Weber (R-MN), Vander Jagt (R-MI), Archer (R-TX), Gradison (R-OH), McDade (R-PA) and others. 97 total cosponsors.

H.R. 6100 Rep. Gekas (R-PA). No cosponsors.

S. 2095 Sen. Symms (R-ID). 1 cosponsor.

S. 2540 Sen. Coats, (R-IN), with Cochran (R-MS), Gorton (R-WA), Lugar (R-IN), Smith, Robert C. (R-NH). 10 total cosponsors.

S. 2873 Sen. Breaux (D-LA), with Coats (R-IN), Daschle (D-IA), Dixon (D-IL), Lugar (R-IN), Nunn (D-GA). 10 total cosponsors.

S. 3348 Sen. Hatch (R-UT). 4 total cosponsors.

Ten Advantages of Medical Savings Accounts

Saving Money. When people purchased medical care with funds in a Medical Savings Account (MSA), they would be spending their own money rather than someone else's. As a result, they would tend to become careful, prudent customers in the medical marketplace.

Restoring the Doctor-Patient Relationship. Bureaucratic efforts to control costs are increasingly interfering with the doctor-patient relationship. With MSAs, patients and doctors would be encouraged to manage the care — and would probably do a much better job.

Maintaining the Quality of Care. Bureaucratic efforts to reduce costs are also threatening the quality of patient care. To the degree that patients are spending their own money, patients and doctors will make the decisions.

Encouraging Rationing by Choice. Unless someone makes the difficult choice between medical care and other uses of money, we will be spending the entire GNP on health care. MSAs allow individuals — rather than large, impersonal bureaucracies — to make those decisions.

Creating a Competitive Marketplace. Most patients cannot discover the price of even routine procedures before entering a hospital and cannot read the bill when they are discharged. But with MSAs, as with cosmetic surgery in the United States and privately paid surgery in England, a single package price stated in advance would become the norm.

Providing Funds for Preventive Care. MSAs would be a source of funds for services not covered by health insurance.

Providing Funds for Health Insurance Premiums. MSAs would provide funds to continue health insurance coverage when people are unemployed.

Providing Funds for Long-Term Care. MSA funds not spent during a person's working years would be available for long-term care, long-term care insurance and other postretirement medical needs not met by Medicare.

Creating Real Insurance. With MSAs, health insurance would likely return to its traditional function — payment for risky, unforeseen, costly medical episodes — and many of the problems in the health insurance marketplace would disappear.

Creating Personal and Portable Employee Benefits. MSAs would be the private property of the individual account holder. Their establishment would be a movement in the direction of a worthwhile social goal: making all employee benefits personal and portable.

Source: John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.

The establishment of personal Medical Savings Accounts for employees would require only a small change in the tax law governing employer-provided health insurance. Yet this small change would give individuals an opportunity to control a substantial portion of their own health care dollars. If they took full advantage of this opportunity, there would be a major transfer of money and power from third-party-payer bureaucracies (employers, insurance companies and government) to individual patients. The result would be a radical transformation of the medical marketplace. [See the sidebar on the Ten Advantages of Medical Savings Accounts.]

"Medical Savings Accounts would be tax-free accounts used to pay medical bills not covered by insurance."

How Medical Savings Accounts Would Work. Medical Savings Accounts would be tax-free personal accounts used to pay medical bills not covered by insurance. Regular deposits could be made by individuals or their employers, but they would be the property of individuals. Money could be withdrawn without penalty only to pay medical expenses and health insurance. Money not spent would grow tax free and could be used for medical expenses or rolled over into an IRA or private pension plan after retirement, or would become part of the owner's estate.[2] MSAs would ensure that people had money to pay small medical expenses, including expenses for preventive care, and to pay insurance premiums if they changed jobs or became unemployed.

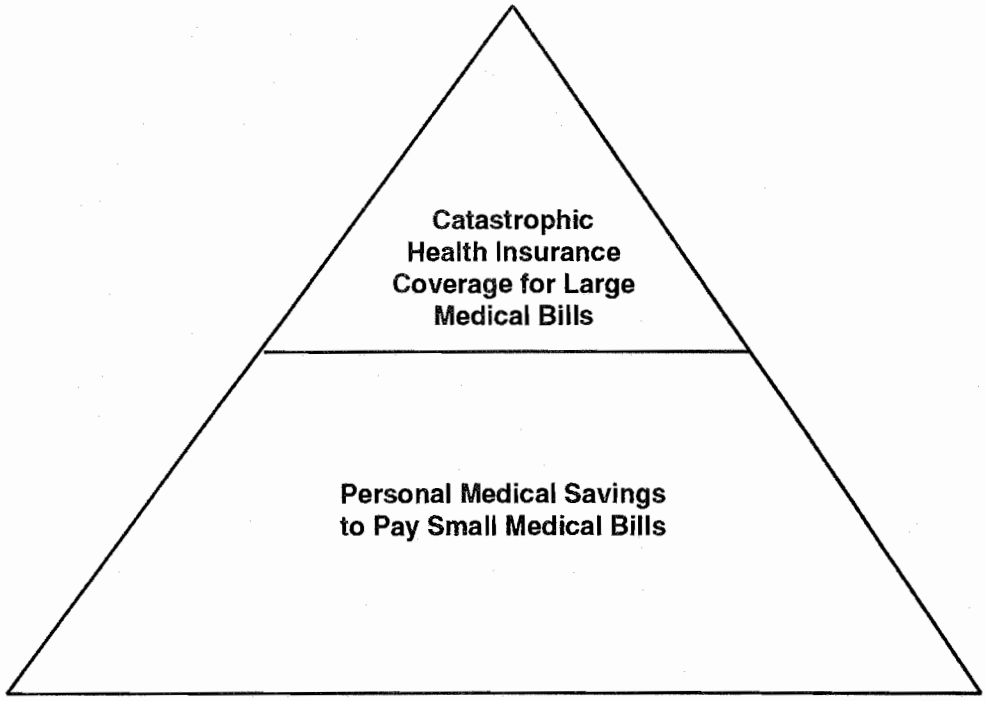
The Relationship Between Medical Savings Accounts and Health Insurance. Medical Savings Accounts represent a new way of paying for health care. Under traditional health insurance, people make monthly premium payments to an insurer such as Blue Cross, and the insurer pays medical bills as they are incurred. Under the new system, people could confine health insurance to catastrophic coverage, reduce their monthly insurance premiums and make deposits to a Medical Savings Account instead. Insurance would be used to pay for expensive and infrequent treatments, while MSA funds would be used to pay small bills covering routine services. [See Figure I.] As an illustration of how this might work, consider a family that purchases a catastrophic policy with a $2,500 deductible and makes annual deposits of $2,500 to an MSA.[3]

- In this example, the family uses its MSA money to pay for the first $2,500 of medical expenses.
- After reaching the catastrophic insurance deductible of $2,500, the family's health insurance pays all remaining expenses.

Note that MSA funds not spent would build up over time, thus after a few years most families would have MSA balances equal to, or greater than, the deductible on their catastrophic policy. For example, Figure II shows that if the family had no medical expenses for five years, the MSA balance (at 6 percent interest) would accumulate to $14,516.

FIGURE I

Medical Savings Accounts and Catastrophic Health Insurance



"Insurance pays for large medical bills which occur infrequently."

"MSA funds pay for small medical bills covering routine services."

The Financial Advantages of Medical Savings Accounts. Although Medical Savings Accounts would be optional, most people would find it in their financial self-interest to increase their deductible and put the premium savings in an MSA. For example, people who choose a $1,000 deductible rather than a $250 deductible often save more than $750 in reduced premiums. Thus without any reduction in the amount of money available to pay medical bills, these people would have an opportunity to add to tax-free savings.[4]

Case Study: Family Health Insurance Premiums in Indianapolis. Consider a male employee (age 35) with a dependent wife and one child living in Indianapolis. Under a conventional group health insurance policy, the premium for this family would be $3,330. The policy has a $250 per person deductible and a 20 percent copayment up to a maximum out-of-pocket expense of $1,000 per person.[5] Thus the family's exposure — the amount of potential liability — is $3,750 (three $1,000 potential copayments plus three $250 deductibles).

Now consider a policy covering identical services but with a single "umbrella" deductible of $3,000.[6] If the family chooses this policy, its exposure actually decreases by $750 (the difference between the $3,000 deductible and the $3,750 of exposure under the traditional policy). However, the price of the umbrella policy is only $1,725. By purchasing the catastrophic policy, the employee and his employer not only reduce the family's total exposure, they also save the $1,605 difference in the price of the two policies.

If the family knew exactly what its future medical bills would be, under some circumstances it might choose the low-deductible policy.[7] But if people do not know their medical expenses in advance, most families will probably prefer the higher deductible.

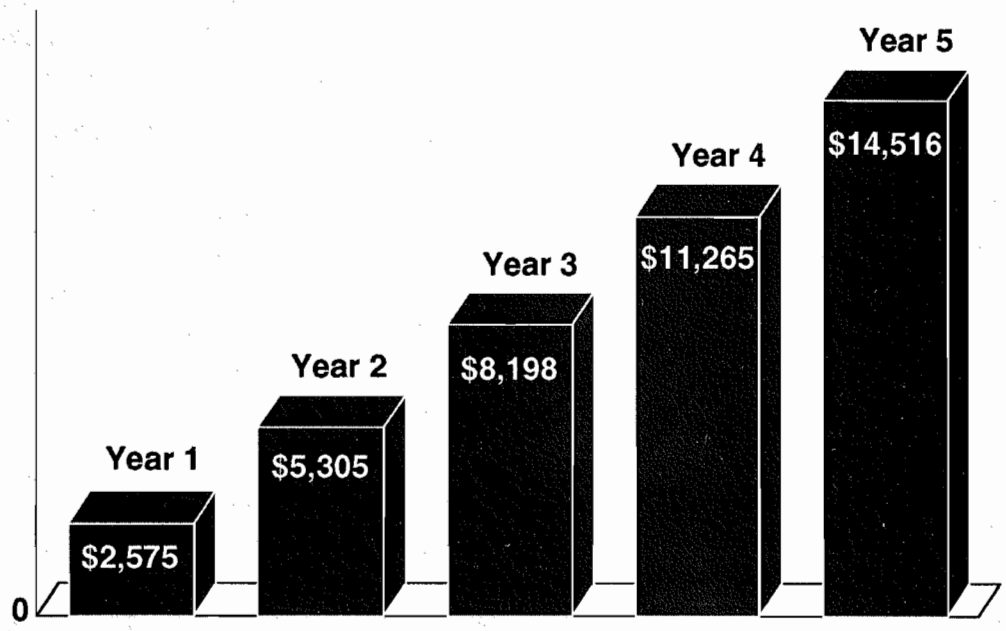
Why Government Action Is Needed. Under current law, every dollar of health insurance premiums paid by an employer escapes, say, a 28 percent income tax, a 15.3 percent Social Security (FICA) tax and a 4, 5 or 6 percent state and local income tax, depending on where the employee lives. Thus government is effectively paying up to half the premium — a generous subsidy that encourages employees to overinsure.[8] At the same time, the federal government discourages individual self-insurance by taxing income that individuals try to save in order to pay their own future medical expenses. By subsidizing third-party insurance and penalizing self-insurance, federal tax law prevents employees and their employers from taking advantage of the opportunities that a Medical Savings Account option would create.

Building on the Current System. More than one-third of all full-time employees have the opportunity to reduce their pretax wages and make pretax deposits to Flexible Spending Accounts (FSAs).[9] Funds in these accounts may

"Money not spent would grow tax free."

FIGURE II

Growth of Family Medical Savings Accounts with $2,500 Annual Deposits[1]



[1] Year-end balance, assuming monthly deposits, no withdrawals and a 6 percent rate of interest.

be used to pay medical expenses (including deductibles and copayments) not paid by the employer's health plan. However, FSA plans are governed by a "use-it-or-lose-it" rule, requiring employees to spend all of the money in the account or forfeit it within, say, a 12-month period. This rule creates perverse incentives that are the opposite of the philosophy governing MSAs. Medical Savings Accounts are simply Flexible Spending Accounts with new and better options.

In another development, a number of employers have created programs that attempt to get around the perverse incentives of the current tax law.[10] [See the sidebar on what employers are doing.] These efforts are no substitute for tax law revision. However, they do show that the private sector is willing and ready to take advantage of an MSA option.

"Employers are discovering they can save money by empowering their employees."

Employee Empowerment vs. Managed Care. Until recently, most health policy discussions assumed that there were only two private-sector approaches to cost control: (1) raise deductibles and copayments or (2) turn the health care dollar over to a managed care bureaucracy such as an HMO. However, innovation in the marketplace reveals not two, but a multitude of ways to partition responsibility between employees and third-party-payer bureaucracies. For example:[11]

- International Paper (Purchase, New York) caps its payments for surgical procedures at the 50th percentile of providers' charges in each community. Employees can use any surgeon but must pay any excess over the cap out of their own pocket.
- Both International Paper and Quaker Oats [see the sidebar on what employers are doing] maintain data bases on health care prices and quality that their employees can use to compare values for various procedures.
- The Federal Reserve Bank of San Francisco maintains a 24-hour telephone hot line through which employees can get medical advice by phone and avoid nonessential visits to physicians' offices and hospital emergency rooms.
- Employees at Betts Industries (a tanker-truck equipment manufacturer in Warren, Pennsylvania) can get cash payments for adopting healthier lifestyles.
- Western Newspaper (Yuma, Arizona) has only a $100 deductible for its employees but requires a 50 percent copayment, which it says has cut its health care costs in half.

In the future, new and better techniques will undoubtedly be devised. The federal government can encourage them by creating a level playing field under the tax law for self-insurance and third-party insurance.

How Employers Are Trying to Overcome Government Obstacles to Medical Savings Accounts

Although employees cannot receive the tax advantages of genuine Medical Savings Accounts under current law, several companies have devised creative ways to help employees benefit from making prudent health care decisions.

Case Study: Quaker Oats (Chicago). In 1983, this 11,000-employee food company raised its deductibles and copayments and made annual contributions (now set at $300) to personal health accounts, which employees use to pay their share of medical expenses. Money not spent is given in cash to the employees at the end of the year. Between 1982 and 1992, Quaker's costs grew at an annual rate of 6.3 percent — well below the national average.

Case Study: Forbes, Inc. (New York City). The parent of *Forbes* magazine gives its employees a health insurance policy with a deductible equal to 1 percent of base pay. Under what is called a Nondiscriminatory Medical Reimbursement Plan, Forbes also gives its employees cash bonuses if they use their health insurance sparingly. The bonuses are not taxed, based on the assumption that employees incur health care expenses that would otherwise go uncompensated. Employees who avoid filing any health insurance claim during the year receive a $1,000 bonus. Small claims result in smaller bonuses, with the employee losing $2 in bonus for every $1 in claims filed. Those who spend $500 or more receive no bonus. One-third of those enrolled in 1992 received a bonus check, and the company's 1993 premiums went down by 20 percent, which more than paid for the bonuses.

Case Study: Dominion Resources, Inc. (Richmond). Employees of this utility holding company choose among plans with different deductibles. The company pays a fixed amount toward any employee's health insurance plan, so that extra coverage (a lower deductible) is paid for entirely by employee contributions. The company encourages employees to choose the high-deductible policy ($1,500 for an individual, $3,000 for a family) and voluntarily put the premium savings into a standard bank account for smaller expenditures. The company also has established voluntary "Medical Savings Accounts," into which the company deposits aftertax dollars by payroll deduction. The money can be used anytime for anything, but the company encourages employees to save for smaller medical expenses. Moreover, under a bonus incentive, those whose health care spending does not exceed the deductible receive a share of half of the money the company saves on its overall health care bill. Since the plan was adopted in 1989, the company's health care costs, including the bonus payments, have gone up less than 1 percent, and 100 employees recently received bonus checks for up to $800.

Case Study: Golden Rule Insurance Co. (Indianapolis). The company gives its employees a choice between a low-deductible and a high-deductible policy. Both policies require an employee contribution of aftertax dollars, but contributions made to the high-deductible plan are put into a separate account which can be used to fund medical expenses not paid by the policy. Funds not used are returned to the employee at the end of the year, so that employees benefit from being prudent health care consumers. Among insured employees, 81 percent have chosen the high-deductible plan.

Sources: Rosalind Resnick. "Enlisting Employees in the Battle to Cut Health Care Costs," *Business & Health,* June 1993, pp. 24-29; and Chris Warden, "Letting Employees Rein in Costs: Firms Save on Health Care by Letting Market Work," *Investor's Business Daily,* May 20, 1993.

"Three states have enacted MSAs at the state level; three others have called on Congress to enact them."

What the States Are Doing About Medical Savings Accounts

Enacted MSAs at the State Level

Missouri

Mississippi

Colorado[1]

Legislation That Failed to Pass

Connecticut (H 5406)

Indiana (H 1762)

Indiana (S 514)

Maryland (H 265)

Mississippi (H 2686)

Virginia (HJR 591)

Resolutions Calling on Congress to Enact MSAs

Texas (HCR 145)

Montana (HJR 19)

Utah (HJR 22)

Pending Legislation

Georgia (S 161)*

Indiana (SCR 22)

Michigan (H 4593)

Michigan (HR 47)

New York (A 8602)

Oklahoma (H 1310)*

Oklahoma (H 1436)*

Oregon (H 3387)

Pennsylvania (H 1449)

South Carolina (S 171)*

Washington (SJM 8025)*

[1] Funds can be used without penalty only after retirement.

* These bills will carry over to the 1994 session.

Medical Savings Accounts at the State Level. Several states have taken steps to enact or endorse some version of Medical Savings Account legislation. Under its state income tax system, Colorado allows tax-free deposits to medical IRAs and tax-free buildup in the accounts. The money can be withdrawn to pay medical bills during retirement. Under their state income tax systems, Mississippi and Missouri have created conventional Medical Savings Accounts, which allow withdrawals at any time to pay medical bills. Texas, Montana and Utah have passed resolutions calling on the federal government to adopt Medical Savings Accounts. MSA legislation is also being considered in other states, including Georgia, Indiana, Michigan, New York, Oklahoma, Oregon, Pennsylvania, South Carolina and Washington. [See the sidebar on what the states are doing]. A bill in Montana would combine MSAs with workers' compensation insurance so that employers

could put money in the employee's account and then provide the employee with a high-deductible workers' comp policy.

"The tax law should create a level playing field; the winners and losers should be determined in the marketplace."

Medical Savings Accounts in Other Countries. Several countries have Medical Savings Accounts. For example, Singapore has built its entire health care system around self-insurance through MSAs (called Medisave Accounts) and only recently has encouraged third-party insurance for catastrophic medical expenses. Unlike the proposals under consideration in the United States, contributions to Singapore's Medisave Accounts are mandatory — part of the government's insistence that people save to meet needs that might otherwise have to be met by the state.[12]

How Medical Savings Accounts Can Help Control Rising Health Care Spending

One of the most serious problems we face is rising health care spending.[13] Over the past decade, health care expenditures grew about twice as fast as our gross national product. If that trend were to continue — which it cannot — we would be spending 100 percent of our income on health care by the middle of the next century.[14]

Medical Savings Accounts are part of the solution. They would give people strong incentives to be prudent consumers of health care because people would get to keep the money they did not spend. And all of the evidence suggests that, in the face of such incentives, people would substantially change the way they consume health care.

"Most of the time when we enter the medical marketplace, we are spending someone else's money."

Why Third-Party Payment of Medical Bills Is the Cause of the Problem. A primary reason why health care spending is out of control is that most of the time when we enter the medical marketplace as patients we are spending someone else's money rather than our own. Economic studies — as well as common sense — confirm that we are less likely to be prudent, careful shoppers if someone else is paying the bill:[15]

- Over the past thirty years, the share of our income spent out-of-pocket on health care has actually declined — falling from 4 percent of total consumption expenditures in 1960 to 3.6 percent in 1990.
- Over the same period, the amount spent from all sources has more than tripled — rising from 4.2 percent of consumption in 1960 to 13.3 percent in 1990.

These numbers suggest that when we are spending our own money we are conservative shoppers in the medical marketplace. The explosion in spending has occurred because most of the time someone else is paying the bill.

The Extent of Third-Party Payment of Medical Bills. Although polls show that most people fear they will not be able to pay their medical bills from their own resources, the reality is that most of us pay directly for only a small portion of the medical care we receive. Figure III shows that, on the average:[16]

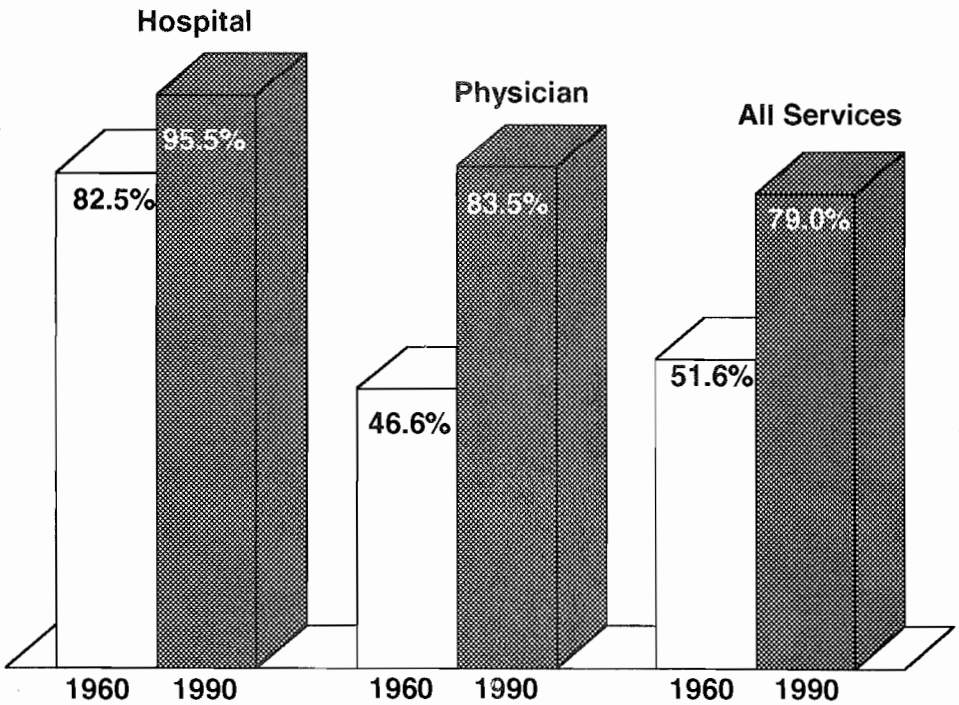
- Every time we spend $1 in a hospital, we pay only 5 cents out-of-pocket, and 95 cents is paid by a third party (employer, insurance company or government).
- Every time we spend $1 on physicians' fees, we pay less than 17 cents out-of-pocket.
- For the health care system as a whole, every time we consume $1 in services, we pay only 21 cents out-of-pocket.

Moreover, the explosion in health care spending over the past three decades parallels the rapid expansion of third-party payment of medical bills. The patient's share of the bill has declined from 48 percent in 1960 to 21 percent today.

"For the health care system as a whole, every time we consume $1 in services, we pay only 21 cents out-of-pocket."

FIGURE III

Percent of Personal Health Expenses Paid by Third Parties



Source: NCPA/Fiscal Associates Health Care Model. Data adjusted for tax subsidies.

Why Having Too Much Third-Party Insurance Causes Waste. A great deal of the waste in our health care system is caused by people who have too much insurance. And one way in which people overinsure is through low deductibles or, in some cases, first-dollar coverage. Low-deductible health insurance is usually wasteful for three reasons. First, it encourages people to consume services they do not need. This ultimately causes costs and premiums to rise for all policyholders. Second, it discourages people from seeking low prices for the services they consume. Third, using insurance to pay small medical bills leads to wasteful administrative expenses. For example, a $25 physician's fee can easily become $50 in total costs after an insurer monitors and processes the claim — thus doubling the cost of medical care.[17]

The Necessity of Choosing Between Health Care and Other Uses of Money. Most proposals to control health care costs turn out to be proposals to create a one-time reduction in health care spending. These proposals focus on ways of eliminating waste and improving efficiency. Yet even if they were successful, they would not affect the long-term trend. The long-run problem exists because people are rarely asked to choose between health care and other uses of money. As a consequence, they have an incentive to consume as though health care services were costless. And as long as people act on that incentive, health care spending will continue to soar. Take MRI brain scans, for example:

"Someone must choose between health care and other uses of money."

- There is a small chance (about one in 3,000) that each of us has a brain tumor, and that if the tumor were detected early enough by an MRI scan, an operation might save our life.[18]
- Thus if MRI brain scans were free, it would be in everyone's self-interest to have one as part of an annual checkup.
- Yet at $1,000 apiece, if everyone in America got an annual brain scan, we would add $250 billion to the nation's annual health care bill — increasing it by almost one-third.

On other diagnostic tests, we potentially can spend much more. For example, medical science has identified 900 tests that can be done on blood.[19] Except for the cost and inconvenience, why not make all 900 part of our annual checkup? Even if we ordered only a handful of these tests, we could easily spend $3,000 to $4,000. Yet if everyone did that, we would double the nation's annual health care bill.

As an example of how the demand for the services of primary care physicians could soar in the absence of any monetary or nonmonetary constraints, consider that:[20]

- In any given year, Americans make about 472 million office visits to primary care physicians.
- If only 2 percent of nonprescription drug consumers sought professional care rather than self-medicating, the number of patient visits would climb to 721 million.

- The number of primary care physicians would need to increase by 50 percent to meet the increased demand.
- If every person who now uses nonprescription drugs chose professional care over self-medication, we would need 25 times the current number of primary care physicians.

How Medical Savings Accounts Would Help Control Spending. Given that someone must choose between health care and other uses of money, who should that someone be? Medical Savings Accounts would give patients themselves the opportunity to make those decisions, after consulting with their physicians. Even though some people would undoubtedly make mistakes, MSA holders would find it in their self-interest to make good decisions. And studies of actual patient behavior indicate that empowering patients would have beneficial results. For example, Rand Corporation studies imply that families with a $2,500 deductible consume 50 percent less health care than families with no deductible — with no adverse effects on health.[21]

"With MSAs, people would get to keep the money they did not spend."

Why the MSA Option Is Better Than the Alternatives. If patients are not allowed to decide how to ration their own health care, a bureaucracy that is ultimately answerable to government will decide. For example, in Canada, England, New Zealand and most other developed countries, hospitals or area health authorities are forced to operate within global budgets. In effect, government severely limits the resources available to the medical community and forces health care providers to ration health care.

There is considerable evidence that when health care is rationed, the principal victims are the poor, the elderly, racial minorities and people who live in rural areas.[22] Moreover, there is no evidence that global budgets lead to greater efficiency. To the contrary, they almost certainly encourage inefficiency. Consider the experience of three English-speaking countries with cultures similar to our own:

"When health care is rationed, the principal victims are the poor, the elderly, racial minorities and rural residents."

- Currently the number of people waiting for surgery totals more than one million in Britain,[23] 60,000 in New Zealand[24] and 165,000 in Canada.[25]
- Although those waiting represent a small percent of the total population (2 percent or less), they probably represent a large portion of those who need access to modern medical technology.[26]
- Yet in spite of the lengthy waiting lists, at any one time about one-fifth of all hospital beds are empty in all three countries[27] and another one-fourth are being used as an expensive nursing home by nonacute elderly patients.[28]

How Medical Saving Accounts Can Help Maintain the Quality of Care

In an effort to stem the tide of rising costs, third-party-payer bureaucracies increasingly are imposing arbitrary rules and regulations on the providers of health care. Whereas it was once considered unethical for third-party payers to interfere with the doctor-patient relationship, today some bureaucracies are dictating medical practice. Although this trend is often defended on the grounds that it makes medicine more scientific, in practice it may substitute "cookbook" medicine for the judgment of trained professionals. With increasing frequency, physicians who want to admit a patient to a hospital or order a routine diagnostic test find that they must phone for permission to do so. Permission is often given or denied, not by another physician, but by a clerk looking up symptoms in a manual.

"Patients often are not told about better but more expensive drugs or medical devices because a third-party payer refuses to pay for them."

Why Information Is Often Withheld from Patients. One of the most striking developments in the practice of medicine in recent years is the degree to which important decisions about the quality of care are made without any consultation with patients. For example, hospital patients often receive drugs without being told that safer, more efficacious but more expensive drugs are not being administered because a third-party payer refuses to pay for them. Similarly, a patient receiving a pacemaker or a joint replacement may not be told that higher quality but more expensive implants are not being used because a third-party payer refuses to incur the higher cost.

It is not surprising that difficult decisions must be made concerning the trade-off between cost and quality. What is surprising is that patients may never learn that such decisions were made not by their doctors but by an employer, an insurance company or the government. Why are patients being denied access to vital information? Because, to an unhealthy degree, third-party payers have replaced patients as the real clients of the suppliers of medical services and products.

How Third-Party Payers Are Replacing Patients as the Real Customers of Providers. Because health insurance is the primary method of payment for the medical care Americans consume, in a very real sense it is the insurer rather than the patient who is the customer of medical providers. For example, when Medicare patients interact with the health care system, *what* procedures are performed — and *whether* they are performed — increasingly is determined more by Medicare's reimbursement rules than by the patient's preferences or the physician's experience and judgment. Although this phenomenon is more evident in government health care programs (e.g., Medicare and Medicaid), private insurers and large companies are increasingly copying the methods of government.

Under the current system, Medicare patients may get one type of care, Medicaid patients another and Blue Cross patients a third. Each employer plan can have its own reimbursement rules. As a result, we are evolving not into a two-tier system of medical care but into a multi-tier system — in which the quality of health care a patient receives is determined by which third party pays the bill.

How Some Patients Are Denied Access to Hospital Care. In many places, a hospital must receive telephone approval from a third-party bureaucracy before admitting a patient. The person giving or denying the approval has not met or examined the patient. The decision is based on a cost-benefit analysis using statistical averages, with little or no room for the nonaverage, abnormally sick patient. These decisions can have life or death consequences.[29] There are reports of patients who died as a result of being denied hospital admittance because of Medicare's rules, and numerous reports of patients being prematurely released. In one recent poll of physicians, 78 percent of the respondents reported being "pressured to discharge Medicare patients before they were ready to leave the hospital," and 88 percent reported that Medicare's payment system is "adversely affecting the quality of medical care for Medicare patients."[30]

"Seventy-eight percent of physicians reported pressure to discharge Medicare patients too soon."

How Some Patients Are Denied Access to the Drugs They Need. Another way in which third-party payers are dictating medical practice is through controls on the use of prescription drugs. For example, the restrictions placed on physicians include: (1) substituting a less expensive (and different type of) drug for a more expensive one, (2) requiring prior authorization, (3) limiting the physician's choice to a list of approved drugs, (4) limiting reimbursement for prescriptions deemed experimental or for "off-label" applications, (5) requiring that drugs be prescribed in a predetermined sequence and (6) mandating generic substitution.

To determine the effects of these practices, Gallup polled cardiologists, internists and general practitioners for the Oregon Medical Society. Table I shows the most frequently mentioned negative outcomes. On the average, there were 16.2 negative outcomes per physician polled, and in nine cases physicians reported that patients died because of the restrictions.[31]

Subjecting Patients to "Cookbook" Medicine. A hidden premise behind many managed care programs is that one-size-fits-all is an appropriate medical strategy. But whereas bureaucratic guidelines and protocols may work for the average patient under normal circumstances, they may be inappropriate for a nonaverage patient in abnormal circumstances. Although the advocates of managed care say that physicians can request permission to use unapproved therapies, some bureaucracies make it difficult and burdensome for physicians to do so.

TABLE I

Ten Most Frequent Negative Outcomes Resulting from Third-Party Interference with Access to Prescription Drugs

Negative Outcomes	Percent of Total
Lessened therapeutic response	**28%**
Therapeutic failure	**24**
Allergic reaction/side effects	**13**
Poor/loss of blood pressure	**12**
Heart failure/chest pain	**8**
Underdosed/lack potency/too strong	**8**
Convulsions/seizures	**7**
Recurring symptoms/pain/fever	**5**
Patient didn't recover	**5**
Adverse reaction/patient almost died	**4**

Source: Oregon Medical Association, 1990. Reported in *Medical Benefits* 7, No. 17, September 15, 1990.

"Physicians frequently report negative outcomes from third-party dictates on drugs."

Moreover, there is growing evidence that a one-size-fits-all approach to medical practice can be especially bad for minorities. Recent studies show that:[32]

- Black and Hispanic patients suffer greater side effects from some antidepressants, and Asian patients generally require lower doses of antidepressants.
- The schizophrenia drug Clozane (made by Sandoz) is linked to a serious blood disorder in 20 percent of Jewish patients but in only 1 percent of patients overall.
- Among black patients treated for high blood pressure, Cardizen (made by Marion Merrell Dow) was the most effective drug and Carpoten (made by Bristol-Myers Squibb) the least effective; among young white patients, the reverse was true.
- Although black heart patients generally do not respond as well as white patients to beta blockers, Labetalol (made by Schering) is equally effective in controlling blood pressure in black and white patients.

Case Study: Les Aspin's Vaccination. When Les Aspin became Secretary of Defense, he needed additional vaccinations because of his expanded international travel. In order to save $1.55, however, his physicians

gave him a cheaper but slightly more risky vaccine, and Aspin ended up in an intensive care unit. To our knowledge, he was never asked if he would be willing to pay $1.55 out-of-pocket to avoid the risk.[33]

"Had Bob Dole been a member of an HMO, he might not be alive today."

Case Study: Bob Dole's Prostate Cancer. Most proponents of managed care see little medical benefit in a cancer blood test known as prostate-specific antigen (PSA), and therefore do not routinely provide it. Fortunately U.S. Senator Bob Dole had the opportunity to make his own decision and opted for a PSA test in 1991. The test led to the biopsy and surgery the senator contends saved his life.[34] Had Bob Dole been a member of an HMO, he might not be alive today.[35]

Case Study: Troy Aikman's Back Surgery.[36] Following the Dallas Cowboys' Superbowl victory, star quarterback Troy Aikman's back problem worsened. Rather than follow the "conservative management" prescribed by the Cowboys' physicians, Aikman used his own money to obtain an MRI scan, a second opinion at Baylor Medical Center in Dallas and finally back surgery in Los Angeles. All professional athletes are aware that team owners have different incentives with respect to the player's health. The owner's incentive is to get maximum results on the playing field, while athletes must live with their bodies for an entire lifetime. In Aikman's case, however, the team would have been better off if it had followed Aikman's hunch sooner and been less conservative. Their star quarterback would have missed less practice time and fewer games.

How Medical Savings Accounts Could Make a Difference. The primary reason why third-party payers are interfering with the practice of medicine — denying people access to new drugs and new technologies — is that under the current system they are paying most of the bills. Since patients are encouraged to perceive health care as free at the time they receive it, third-party payers must exercise the responsibility for choosing between health care and other uses of money. They cannot be blamed for making these decisions. Given that people entrust their health care dollars to them, they would be irresponsible if they didn't attempt to eliminate unnecessary procedures and to substitute cheaper drugs when they judge the risk to be acceptable. The problem, of course, is that third-party-payer judgments may be very different from those of patients. In fact, it could not be otherwise, since patients themselves vary widely in their willingness to bear additional costs in order to avoid risks.

"MSAs would give patients the opportunity to satisfy their own preferences."

Medical Savings Accounts would give patients the opportunity to make their own choices. Rather than give all the money and power to a bureaucracy, MSA holders would control a substantial fraction of their own health care dollars. As a result, medical providers would begin to regard patients — not employers, insurance companies and government — as their customers. Patients with both money and decision-making power would receive a great deal of information that today they are denied.

Some question whether patients are intelligent enough or informed enough to make good choices in the medical marketplace. However, this concern is misplaced. As noted above, many of the private employers who are empowering their own employees are also supplying them with up-to-date information about physicians and hospitals. And even if employers do not supply any new information, people with MSAs could consult the same experts that third-party payers now consult — while remaining free to reject the experts' advice.

Finally, the real test is not whether patients are smarter than doctors. The test is whether patients together with doctors who act as *their* agents can outperform clerks using medical manuals and doctors whose medical practices are governed by clerks and manuals. That test is best conducted in the marketplace, not in the political arena.

How Medical Savings Accounts Would Increase the Number of People with Private Health Insurance

Like being unemployed, being uninsured is an experience that many Americans will endure sometime in their lives. But the experience is likely to be short-lived. Just as there are very few long-term unemployed, there are very few long-term uninsured:[37]

- Of the 37 million Americans who are uninsured this month, more than 50 percent will be insured four months from now.
- More than 70 percent will be insured within one year.
- Only 15 percent of the uninsured will remain continuously uninsured for the next two years.

"Of the 37 million Americans who are uninsured this month, more than 70 percent will be insured within one year."

Moreover, contrary to widespread impressions, most of the 37 million people who are currently uninsured are healthy, not sick. Sixty percent of the uninsured are under 30 years of age and in the healthiest population age groups.[38] They have below-average incomes and few assets. As a result, they tend to be very sensitive to premium prices. Moreover, the primary reason why most of them are uninsured is that they have judged the price too high relative to the benefits. Less than 1 percent of the population is both uninsured and uninsurable.[39]

How Government Policy Causes People To Be Uninsured. Government policy adds to the number of uninsured in three ways.[40] First, federal tax policy encourages an employer-based system in a very mobile labor market. When people leave a job, they eventually lose their health insurance coverage. Second, government tax policy encourages people to remain unin-

sured while they are between jobs in which they will have employer-provided coverage. Currently, government "spends" more than $90 billion a year in tax subsidies for health care — mainly by allowing employer-provided health insurance to be excluded from the taxable income of employees. As a result, some employees receive tax subsidies worth 50 cents for every $1 of health insurance. Yet those who must purchase their own health insurance get no help from government and often pay twice as much aftertax for the same coverage. Those discriminated against include the self-employed, the unemployed and employees of small businesses that do not provide health insurance.[41]

Finally, state regulations increase the cost of private health insurance and price millions of people out of the market. For example, state-mandated health insurance benefits laws force insurers to cover diseases ranging from mental illness to alcoholism and drug abuse, services ranging from acupuncture to in vitro fertilization and providers ranging from chiropractors to naturopaths. These mandates cover the serious and the trivial: heart transplants in Georgia, liver transplants in Illinois, hairpieces in Minnesota, marriage counseling in California, pastoral counseling in Vermont and deposits to a sperm bank in Massachusetts.[42]

"One out of every four uninsured people has been priced out of the market by state-mandated benefit laws."

By one estimate, one out of every four uninsured people has been priced out of the market by state-mandated benefits laws.[43] In addition to mandates, private insurance is burdened by premium taxes, risk pool assessments and other regulations. Ironically, most large corporations are exempt from these regulations because they self-insure.[44] As a result, the full weight of the regulations falls on the most defenseless part of the market: the self-employed, the unemployed and the employees of small businesses.

How Medical Savings Accounts Can Be Part of the Solution. One way to undo the harm caused by government policies is to change the policies that cause the harm. Thus we could end the practice of subsidizing an employer-based health insurance system, extend tax relief to those who purchase their own health insurance and repeal onerous state regulations. Even if these changes are not made, however, Medical Savings Accounts can make a big difference.

With Medical Savings Accounts, people would have savings with which to pay their premiums during periods of unemployment[45] or to purchase a new policy. And because MSA contributions would be tax-subsidized, the tax subsidies provided to companies would effectively be extended to individuals. MSAs would also make health insurance more affordable. Since people would have funds available to pay small medical bills, they could opt for less expensive catastrophic coverage. Moreover, because MSAs would encourage high-deductible health insurance, they would allow people to escape the most costly burdens of state-mandated health insurance benefits. Mandates have much less impact on the price of a $3,000-deductible policy than they do on the price of a $250-deductible policy.

"People could use MSA funds to pay insurance premiums while they are between jobs."

How Medical Savings Accounts Would Help Make the Medical Marketplace More Competitive

In most American cities, patients cannot find out a hospital's charge in advance, even for routine surgical procedures. At the time of discharge, they learn that there is not one price but hundreds of line-item prices for everything from a single Tylenol capsule to the hospital's admission kit.[46] After a patient has been in the hospital for only a few days, a typical bill stretches many feet in length. If restaurants priced their services the way hospitals do, at the end of their meals customers would be charged for each sprinkle of salt, pat of butter and sip of water. However, there would be this difference: at least they could read the restaurant's bill.

Hospital Bills for Third-Party Payers. About 90 percent of the items listed on a hospital bill are unreadable. In only a handful of cases can patients both recognize what service was rendered and judge whether the charge was reasonable. For example, $15 for a Tylenol capsule is common but clearly outrageous, as is $25 for an admission kit. In other cases, patients recognize the service but have no idea whether they are being overcharged. What's a reasonable price for an x-ray, a complete blood count or a urinalysis? The patient who tries to find out learns that prices for such services can vary as much as five to one among hospitals within walking distance of one another, and in most cases the prices charged bear no relationship to the real cost of providing the service.

"About 90 percent of the items listed on a hospital bill are unreadable."

Patients who try to find out about prices prior to admission face another surprise. A single hospital can have as many as 12,000 different line-item prices. For potential patients of the 50 hospitals in the Chicago area, there are as many as 600,000 prices to compare. To make matters worse, different hospitals can use different accounting systems. As a result, the definition of a service may differ from hospital to hospital.[47]

Hospital Bills for Patients Who Pay Their Own Way. There is overwhelming evidence that hospital prices are the result of market domination by bureaucratic institutions rather than any intrinsic feature of the services rendered. To see what happens when the bureaucracies are out of the way, consider cosmetic surgery. In general, cosmetic surgery is not covered by private or public health insurance. Yet in every major city there is a thriving market for it. Patients pay with their own money and, despite the fact that many separate fees are involved (payments to the physician, nurse, anesthetist or anesthesiologist, hospital, etc.), patients are almost always given a fixed price in advance — covering all charges.[48] Patients also have choices about the level of service (for example, surgery can be performed in a physician's office or, for a higher price, on an outpatient basis in a hospital). Overall, patients probably have more information about price and quality in cosmetic surgery than in any other area of surgical practice.

The characteristics of the market for cosmetic surgery also are evident in other medical markets in which patients pay with their own funds. For example, private-sector hospitals in Britain frequently quote package prices for routine surgical procedures. U.S. hospitals often quote package prices to Canadians who come to this country for care that is rationed in Canada. In many cities, Humana hospitals now advertise package prices for well-baby delivery. And although they rarely discuss it, many hospitals have special package prices and discount rates for uninsured patients who pay their own bills — especially if they pay in advance.

"Physicians — and, increasingly, hospitals — will usually give patients a better deal if they pay their own bill."

Why Medical Savings Accounts Would Make a Difference. Most patients already know that some physicians will give them a better deal if they pay their own bill — especially at the time of treatment — rather than ask the physician to collect from a third-party payer. Increasingly, the same is true of hospitals. By empowering patients and making patient payment a dominant force in the medical marketplace, the market would become increasingly competitive.

How Medical Savings Accounts Can Help Reform Government Health Care Programs

Most discussions of the problem of rising health care spending in the United States imply that it is a private-sector problem. Those who adopt this view are also inclined to believe that successful health care reform need not include such government programs as Medicare and Medicaid. In fact, the primary source of the problem is government itself, and the primary way in which government is creating the problem is through direct spending programs.

The Size of the Public Sector. When federal tax subsidies for health insurance are combined with direct spending, government at all levels (federal, state and local) spends more than half of all health care dollars. Overall:[49]

- Direct government spending has increased from 24 percent of all health care spending in 1960 to 42 percent in 1990.
- When tax subsidies for health insurance are included, the government's share of health care spending has increased from 34 percent in 1960 to 53 percent today. [See Figure IV.]

Government Spending vs. Private Spending. As noted above, U.S. health care costs have been rising because the fraction of our own money we spend when we consume medical care has been falling. The primary reason is that direct government spending and tax subsidies for private health insurance have soared. Between 1960 and 1990, personal health care as a fraction of total consumption grew at a rate of 2.6 percent per year. The portion of health care paid by the private sector — out-of-pocket costs plus private insurance, net of tax subsidies — grew much more slowly, however:

- Over the past three decades, the share of private health care spending in total U.S. consumption grew at an annual rate of 1.3 percent.
- The share of *government* health care spending in total U.S. consumption grew at three times that rate.

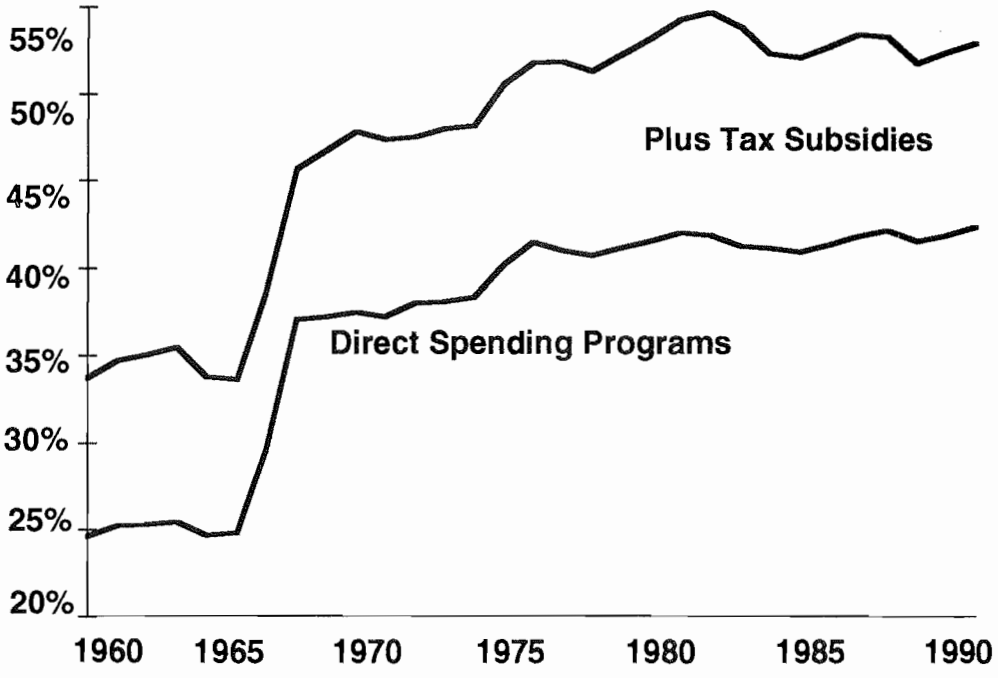
Using Medical Savings Accounts to Control Costs in Government Programs. Since the primary reason why health care costs are rising is government subsidy and since 80 percent of government spending is through direct spending programs, primarily Medicare and Medicaid, it follows that if health care spending is to be controlled, Medicare and Medicaid must be reformed.

MSAs could change incentives, and therefore behavior, in these programs. For example, one way to change Medicare is to have government give each Medicare beneficiary catastrophic coverage with a deductible equal to, say, 10, 20 or 30 percent of their income. In return, the beneficiaries could deposit their current Medicare Part B premium, medigap insurance premiums and perhaps out-of-pocket money into a Medical Savings Account.[50]

"The government's share of health care spending has increased from 34 percent in 1960 to 53 percent today."

FIGURE IV

Government Spending as a Share of All Health Care Spending



Source: NCPA/Fiscal Associates Health Care Model.

Another approach is to allow private insurers to repackage Medicare benefits. For example, in return for a higher deductible, beneficiaries might receive full catastrophic acute coverage and expanded nursing home coverage. To meet the deductible, beneficiaries would be allowed to make deposits to Medical Savings Accounts in the manner described above.[51]

Using Medical Savings Accounts to Avoid Rationing in Public Programs. Under the current system, the political pressures governing Medicare and Medicaid are to expand benefits and then refuse to pay for them. One consequence is that most doctors try to avoid seeing pregnant women on Medicaid, and other Medicaid services are frequently rationed. There is also increasing evidence of rationing under Medicare.[52]

"MSAs could change incentives, and therefore behavior, in the Medicare and Medicaid programs."

MSAs could help solve these problems. For example, pregnant Medicaid patients might have an account upon which they could draw to pay for their choices in the medical marketplace. This would empower patients and expand the number of providers to whom they have access. Similarly, elderly persons with MSAs would be free to negotiate their own arrangements rather than accept Medicare's arbitrary reimbursement schedules.

Answering the Insurance Industry Critics

The widespread use of Medical Savings Accounts would result in a major transfer of money from third-party-payer bureaucracies to individuals. It should come as no surprise, then, that many within the health insurance industry oppose MSAs — seeing their development and use as leading to a major loss of premium income. Indeed, some of the largest health insurers urge us to move in the opposite direction — giving virtually all of our health care dollars to third-party-payer bureaucracies, which would then manage everyone's health care. The health insurance industry is far from united, however. Many medium-sized and smaller health insurers favor Medical Savings Accounts on the theory that insurers would cease being vehicles for the prepayment of medical expenses and could return to their traditional role of selling real insurance and managing risk.[53]

What follows is a brief analysis of some of the arguments made against Medical Savings Accounts by their opponents.[54] Readers will note that except for the last argument, that MSAs would lead to a loss of revenue for government, these are not really arguments against putting self-insurance and third-party insurance on a level playing field under tax law. Instead, they are arguments about why employers and employees should not take advantage of MSAs given the opportunity to do so. If the first 11 arguments are correct, then people would not use MSAs, and there would be no loss of federal revenue. On the other hand, if a loss of revenue occurred, it would be because people took advantage of MSAs — an indication that the first 11 arguments against their use are invalid.

Questions and Answers About Medical Savings Accounts

1. How would Medical Savings Accounts be administered?

MSAs would be administered by qualified financial institutions in much the same way as Individual Retirement Accounts (IRAs). Individuals could exercise choice over the investment of account balances, but with the same restrictions on the type of instruments the accounts could own as now apply to IRAs.

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

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

3. 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 allow individuals to divide their normal health insurance costs into two parts: self-insurance and third-party insurance. Currently, the tax law discriminates against people who have their own health insurance by denying them the tax advantages of employer-provided insurance. Health insurance would become more affordable for the currently uninsured if they could deduct some or all of their premiums from their taxable income. It would become even more affordable through a system of refundable tax credits, which would give greater tax relief to low-income families.

4. What types of services could be purchased with Medical Savings Account funds?

In general, any type of expense considered a medical expense under current IRS rules would qualify, including postretirement health insurance and COBRA health insurance payments during periods of unemployment.

5. 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, FICA taxes, state and local income taxes. If the opportunity to receive a tax deduction or a tax credit were extended to individuals who purchase their own health insurance, their deposits to MSAs would receive the same tax treatment. MSA balances would grow tax free and would never be taxed if the funds were spent on medical care.

6. What would prevent fraud and abuse?

In order 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. But if IRS auditors discovered fraud, the provider would lose the right to receive MSA funds and might be subject to criminal penalties.

7. How could individuals build up funds in their Medical Savings Accounts?

One way would be to choose a higher deductible insurance policy and deposit the premium savings in an MSA account. 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) is to allow people to reduce the amount of their annual, tax-deductible contributions to IRAs, 401(k) plans and other pension plans and deposit the difference in an MSA.

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

One solution would be to establish a line of credit 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 adopt the Singapore practice of allowing family members to share their MSA funds. This would become much less of a problem as MSA balances grow over time.

9. How would members of the same family manage their Medical Savings Accounts?

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

10. Are there circumstances under which individuals could withdraw Medical Savings Account funds for nonmedical expenses prior to retirement?

A reasonable policy is to apply the same rules that now apply to tax-deferred savings plans such as IRAs and 401(k)s. Nonmedical withdrawals would be fully taxed and would face an additional 10 percent tax penalty.

11. 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 so that money not spent on medical care could be used, after taxes, to purchase other goods and services. Alternatively, MSA balances could be maintained to pay postretirement health care expenses not covered by employers or by Medicare, or to purchase long-term care or long-term care insurance.

12. 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" is an annual MSA deposit that equals the deductible for a standard catastrophic health insurance policy.

13. What about people who join HMOs?

They would have the same opportunities as those who join conventional, fee-for-service health insurance plans. Because many HMOs are now instituting deductibles, HMO members have new incentives to acquire Medical Savings Accounts. Their HMO premiums plus their deposits to MSAs could not exceed a reasonable amount, however.

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

Allowing employees to make individual choices makes sense. Over time, different people will have different accumulations in their MSAs and, thus will likely have different preferences about health insurance deductibles. However, under current law, employers have the option of fashioning employee benefit plans, and it is in their self-interest to create a plan that is most pleasing to employees. As a practical political matter, it seems wise to continue that feature of the current system.

15. What would happen to the Flexible Spending Accounts now available to some employees?

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

Argument No. 1: People may not regard MSA funds as their own money but may instead treat them just like insurance.

Answer: Eight years of experience in Singapore, where government manages the accounts, and the experiences of such U.S. employers as Quaker Oats, demonstrates that employees would be well aware that MSA funds are their own money.

Argument No. 2: Even if people did treat MSA funds as their own money, individuals cannot price-shop or bargain with providers as well as managed care plans can.

Answer: In fact, there is abundant evidence that individuals frequently outperform third-party bureaucracies in deciding whether to obtain a service and in negotiating a price if they do obtain it.[55] The tradition in medicine has been to undercharge individuals and overcharge bureaucracies, not the other way around. Furthermore, among different medical services, costs have been contained largely in proportion to the percentage of payments made out-of-pocket by patients. Over the past 30 years, for example, drug costs (mainly paid by individuals) have increased modestly, while hospital costs (mainly paid by third parties) have soared.[56] As an interesting exception to the general pattern, the cost of drugs in Ford Motor Company, where many employees are in HMOs and have little or no out-of-pocket costs for drugs, have been increasing 15 percent annually. For the country as a whole, drug prices have increased at an average rate of 8.5 percent annually since 1986, while prices for the health care system as a whole have increased at an annual rate of 11 to 12 percent.[57]

"The burden of proof is on those who assert that bureaucracies can outperform individuals spending their own money."

Will individuals always outperform bureaucracies in the medical marketplace? That's not clear. Certainly the burden of proof today is on anyone who argues in favor of bureaucracies. But new ideas can change things, and competitive markets are laboratories in which new ideas can be tried and tested. Government can help by creating a level playing field and allowing the market to work.

Argument No. 3: Health care spending may go up, not down, because people would spend MSA funds on services not covered by an employer's policy.

Answer: Many employer policies do not cover such providers as chiropractors and marriage counselors and such services as acupuncture or in vitro fertilization. Given access to MSA funds, would employees spend more on these types of services? They might. But many employees can spend pretax dollars on these services today through Flexible Spending Accounts (see the discussion above).

More importantly, this argument perpetuates a fundamental confusion. Health care spending is a social problem only because most of the time we are spending someone else's money. If we were spending our own money, it would not be a social problem. For example, most of us do not know — and have no reason to care — how much the nation spends on shoes, or what shoe spending is as a fraction of GDP. Similarly, we have no social reason to care how much people spend on chiropractors — as long as it is their own money.

Argument No. 4: People may forego needed health care services in order to allow tax-free funds to grow in their MSA.

Answer: The fact that individuals may not always make the best decisions is not an argument for forcing them (either directly or through the tax law) to turn their money over to a third-party bureaucracy. The argument is no more persuasive with respect to health care dollars than it is with respect to spending on food, clothing, housing and transportation. Although many Americans have found HMO memberships satisfactory, many others have left HMOs — and were glad they had the right to leave — because their HMOs did not meet their needs. According to one survey, approximately 30 percent of Medicare recipients who had enrolled in HMOs disenrolled within two years due to dissatisfaction.[58] These patients discovered that bureaucracies rarely care more about us than we care about ourselves.

"Many Americans have left HMOs and were glad they had the right to leave."

Argument No. 5: Individuals acting on their own lack the resources to become intelligent consumers in the medical marketplace.

Answer: One thing people can do is solicit advice from others who claim to 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 should be performed. These experienced professionals might help patients make decisions about complicated and expensive procedures. But the professionals' role as advice-givers need not extend to decision-making power. We can let the experts advise and the patients decide.[59] Moreover, the fact that individuals maintain MSA accounts does not preclude their taking advantage of employer-negotiated price discounts from providers or managed care programs.

"People with MSAs can still get advice from professionals: but after the experts advise, the patients will decide."

As noted above, Quaker Oats, International Paper and other companies that have opted for employee empowerment have provided their employees with access to sophisticated data bases — containing information about quality and price. Furthermore, there is abundant evidence that individuals get more and better information and can therefore make better decisions when they are spending their own money.[60] Not only do the providers supply more information, but the patients take more actions to acquire it.

Even if employers do nothing, employees can get numerous medical questions answered at little or no cost. According to the *Harvard Health Letter*:[61]

- *Ask-A-Nurse* is a 24-hour-a-day free service under which registered nurses with an average of 10 years of emergency room experience answer patient inquires.
- *Doctors By Phone* charges $3.00 per minute over a 900 number and callers' questions are answered by physicians who are usually board certified.
- *Pharmacy Questions? Ask the Pharmacist* is another 900 number service; at $1.95 per minute, licensed pharmacists answer questions about drugs 24 hours a day.

There are many other ways for laypersons to learn about treatment options, both from public and private sources.[62] For example, the National Institutes of Health makes available to the general public recommendations on a range of treatments and technologies, as does the Public Health Services' Agency for Health Care Policy and Research.[63] People without access to a major medical library can access the latest journal articles via computer and modem; Medline, the National Library of Medicine's data base, contains as many as 3,700 different journals.[64] And several private organizations will search out data for a modest fee. These include the Planetree Health Resource Center in San Francisco and the nonprofit World Research Foundation in Sherman Oaks, California.[65]

Argument No. 6: Medical Savings Accounts would undermine managed care because managed care works best when there is first-dollar coverage.

"Over time, almost everyone gains from a high-deductible insurance policy — even patients who are currently sick."

Answer: Some evidence suggests that managed care has improved quality and reduced costs for such very expensive procedures as heart surgery. Because these procedures are so costly, it pays to spend money managing them. There is very little evidence that managed care saves more than it costs for such smaller expenditures as CAT scans and blood tests. Moreover, the extremist view that managed care works best when patients have no financial interest in its success — first-dollar coverage — should be tested in the market, not imposed by fiat.

If the purpose of managed care is to ration health care and deny people services, it probably does work best when the *deniers* control all of the money and the *deniees* control none of it. But if the purpose is to meet people's needs in an efficient way, it probably works best if the patients have a financial interest in seeing their needs met efficiently.

Argument No. 7: High deductibles may help people who are healthy, but they may hurt people who are already sick.

Answer: In any given year, people with substantial medical expenses might be better off with a low deductible. However, over time almost every-

one gains from a high deductible unless they have recurring, large medical bills year after year. Such people are few, and their problems are best treated as special cases rather than as a reason for denying all other employees access to MSAs. For example, employers could either extend credit to employees who are especially disadvantaged, with the loan to be repaid from future MSA contributions, or bear part of the expense during the transition period to MSAs. Moreover, a number of employers, including Forbes and Golden Rule Insurance Co., reward employees who reduce their medical expenses but do not impose new penalties on those whose expenses are high. [See the sidebar on what employers are doing.]

Argument No. 8: Employers' costs will not go down because any money saved from higher deductibles will simply go into employee MSAs.

"MSAs would be especially advantageous for small business."

Answer: This argument confuses the reason why health care costs are a problem in the first place. Ultimately, employees earn their entire compensation — wages plus fringe benefits. If what they produce is not at least as valuable as their total compensation, they will not continue to be employed. Health care costs in the long run, therefore, are a substitute for wages, not profits. The reason why health care costs are a problem for employers is that there is considerable waste in the traditional system of third-party payment of medical bills. Employers who discover how to eliminate this waste will be able to create more attractive compensation packages and attract better employees. Those who do not eliminate the waste will be at a competitive disadvantage.

Argument No. 9: If some employees have positive MSA balances at the end of the year, there will not be enough money to pay the medical expenses of other employees unless the employees change their behavior.

Answer: Even if employees did not change their behavior, there would be significant savings from lower administrative costs alone. [See the answer to Argument No. 11 and the related discussion in the sidebar on Questions and Answers.] In fact, employees' behavior will change substantially — leading to less overall spending on medical care. As an example, Forbes discovered that when it paid employees bonuses for not making claims against the company insurance plan, the bonuses paid for themselves in reduced overall health costs. [See the sidebar on what employers are doing.]

Argument No. 10: Medical Savings Accounts contributions would be difficult for small employers who find it difficult to pay for traditional health insurance.

Answer: MSAs represent an opportunity, not a requirement. They would be especially advantageous for small business precisely because they are an alternative to traditional insurance. In the first place, catastrophic insurance is always cheaper than low-deductible insurance. Thus health insurance costs would be lower because MSAs would make catastrophic insurance a viable option. Second, since the administrative costs of small group insurance are higher than normal, by confining third-party insurance to

catastrophic coverage, small business would experience above-average savings on administrative costs.

Third, unlike large companies that can self-insure under federal law, small business is especially vulnerable to state-mandated health insurance benefits. As we have seen, MSA funds would escape the burden of these mandates. Moreover, because mandates apply mainly to small-dollar services, they make catastrophic policies even more attractive for small employers. Finally, within small groups one is likely to find the greatest variation in employee preferences. MSAs are ideal vehicles for allowing individuals to satisfy their own preferences without imposing their wishes on the group.

Argument No. 11: Since the administrative costs of Flexible Spending Accounts are high, the administrative costs of MSAs also would be high.

Answer: The administrative costs of traditional FSAs are high because most companies administer them in traditional ways. With the use of health care debit cards and clear-cut IRS rules governing who could draw on MSA funds, the costs of administering MSAs should be quite low. [See Questions 1 and 2 in the sidebar on Questions and Answers]

Argument No. 12: Widespread use of MSAs would cause a substantial loss of federal tax revenue.

Answer: In fact, MSA contributions would no more lead to a loss of tax revenue than IRA contributions do. Those who argue that tax-deferred saving causes a loss of revenue are looking only at the first-round effects and ignoring the fact that new saving leads to new investment which leads to increased output which causes increased income which leads to increased tax revenues.[66] For example, numerous studies have found that the bulk of IRA contributions (about 80 percent) represents new savings.[67] And in a short amount of time the new revenue generated by new investment exceeds the revenue loss created by the IRA tax shelter.[68]

"Like IRA contributions, MSA deposits would increase government revenue in a short period of time."

Conclusion

Primarily because of U.S. tax law, most Americans are overinsured. People use health insurance to pay for nonrisky medical episodes, including diagnostic tests and routine checkups. They also use health insurance to pay small medical bills they could pay more economically from personal funds. As a consequence, the administrative costs of the U.S. health care system are much too high, and patients and physicians are often wasteful.

"Primarily because of tax law, most Americans are overinsured."

Health care costs in the United States could be reduced substantially if people relied on third-party insurance for catastrophic expenses only and paid small medical bills with health care debit cards, drawing on individual savings accounts. No one should be forced to self-insure for small medical bills. But Congress should create the opportunity for people to do so by giving just as much tax encouragement for individual medical savings as it currently grants to employer payments for third-party insurance.

"MSAs would restore the doctor-patient relationship and encourage a competitive medical marketplace."

Personal Medical Savings Accounts would also help to solve other problems. By restoring the doctor-patient relationship, MSAs would allow patients to make the tough choices between health care and other uses of money, rather than delegate those decisions to large, impersonal bureaucracies. By assuring that people have a store of savings when they are unemployed, MSAs would make it easier for families to continue their health insurance coverage or buy a new policy. And by putting money into the hands of consumers, MSAs would be a powerful positive force for competition in the medical marketplace.

John C. Goodman

Gerald L. Musgrave

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Footnotes

[1] The general case for Medical Savings Accounts is presented in John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, DC: Cato Institute, 1992). A shorter version of the argument may be found in John C. Goodman and Gerald L. Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," National Center for Policy Analysis, NCPA Policy Report No. 168, January 1992.

[2] Some have suggested more liberal options for using the funds, including tax-free withdrawals to purchase a home or to pay for education expenses. Others have suggested that once the balance exceeds a certain level, account holders should be able to withdraw funds tax free — or at least without a penalty. Other proposals would restrict the use of MSA funds by, for example, limiting the amount that could accumulate in an MSA or taxing the interest income.

[3] We assume that the $2,500 deposit represents the savings in reduced premiums from choosing a catastrophic policy over a conventional low-deductible policy.

[4] See Goodman and Musgrave, "Controlling Health Care Costs with Medical Savings Accounts," and Goodman and Musgrave, *Patient Power*, pp. 231-61.

[5] Figures provided by Golden Rule Insurance Company.

[6] In other words, the family pays the first $3,000 of expenses, and the insurer pays all expenses above $3,000. This policy, which was developed for the small group market, is currently being test-marketed by Golden Rule Insurance Company.

[7] For example, suppose one family member had medical bills of exactly $3,000. Then the family would pay out-of-pocket $2,200 more if it has the umbrella policy — almost $595 more than the premium savings. Considering all possible outcomes, however, most people will find that the umbrella policy is a better buy.

[8] Given a fixed amount of total compensation, employers will tend to be indifferent about its makeup, i.e., how much is paid in wages vs. fringe benefits. The tax law, however, encourages employees to choose too much nontaxed health insurance and too little taxable wages. See Goodman and Musgrave, *Patient Power*, chapter 9.

[9] According to the Bureau of Labor Statistics, 37 percent of full-time employees working for medium-sized or large private employers in 1991 were offered Flexible Spending Accounts. "Employee Benefits in Medium and Larger Private Establishments," Bulletin No. 2422, May 1993. For a description of FSAs, see Alain Enthoven, "Health Policy Mismatch," *Health Affairs,* Winter 1985, pp. 5-13.

[10] Chris Warden, "Letting Employees Rein in Costs: Firms Save on Health Care by Letting Market Work," *Investor's Business Daily,* May 20, 1993.

[11] Rosalind Resnick, "Enlisting Employees in the Battle to Cut Health Care Costs," *Business & Health,* June 1993, pp. 24-29.

[12] See Goodman and Musgrave, *Patient Power,* pp. 598-605.

[13] This problem is often described as a problem of rising costs. However, it is not clear that costs in the sense of average cost per treatment are rising. More importantly, the term "costs" encourages people to focus solely on the supply side of the market, when the fundamental source of the problem is on the demand side. See the discussion in Gary Robbins, Aldona Robbins and John C. Goodman, "How Our Health Care System Works," National Center for Policy Analysis, NCPA Policy Report No. 177, February 1993.

[14] See Goodman and Musgrave, *Patient Power,* p. 76.

[15] Robbins, Robbins and Goodman, "How Our Health Care System Works."

[16] These estimates are based on National Health Accounts data for personal health expenditures adjusted for tax subsidies and include the administrative costs for private health insurance. See Robbins, Robbins and Goodman, "How Our Health Care System Works."

[17] See the discussion in Goodman and Musgrave, "Controlling Health Care Costs with Medical Savings Accounts."

[18] Robert Wright, "The Technology Time Bomb," *The New Republic,* March 29, 1993. Figure based on a personal conversation of the author with William B. Schwartz, professor of medicine, University of Southern California.

[19] The University of Michigan Medical Laboratories perform, in house, approximately 900 different tests on blood. Other tests can be performed, but they are so rare that they are sent to private reference laboratories. See also Glenn Ruffenbach, "Medical Tests Go Under the Microscope," *Wall Street Journal,* February 7, 1989.

[20] Simon Rottenberg, "Unintended Consequences: The Probable Effects of Mandated Medical Insurance," *Regulation,* Vol. 13, No. 2, Summer 1990, pp. 27-28.

[21] The Rand Corporation, in a study conducted from 1974 to 1982, found that people who had access to free care spent about 50 percent more than those who had to pay 95 percent of the bills out-of-pocket up to a maximum of $1,000. A $1,000 deductible over that period would be equivalent to a deductible between $1,380 and $2,482 today. See Robert Brook et al., *The Effect of Coinsurance on the Health of Adults* (Santa Monica, CA: Rand, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Economic Review,* June 1987. The Rand study found no significant differences in the health status of people who had high and low deductibles. The one exception was vision care. See Joseph Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine,* Vol. 305, No. 25, December 17, 1981, pp. 1501-07; and Robert Brook et al, "Does Free Care Improve Adults' Health?" *New England Journal of Medicine,* Vol. 309, No. 23, December 8, 1983, pp. 1426-34.

[22] See John C. Goodman and Gerald L. Musgrave, "Twenty Myths about National Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 166, December 1991.

[23] Patricia Day and Rudolf Klein, "Britain's Health Care Experiment," *Health Affairs,* Fall 1991, p. 43. See also Bruce Pyenson, "Inflation Hits British Private Medicine," *M&M Journal,* May/June 1992.

[24] See Patricia Danzon and Susan Begg, "Options for Health Care in New Zealand," CS First Boston NZ Limited, April 1991.

[25] Joanna Miyake and Michael Walker, "Waiting Your Turn: Hospital Waiting Lists in Canada, Third Edition," *Fraser Forum,* May 1993, Fraser Institute, Vancouver, B.C.

[26] The number ranges from 1/2 percent in Canada to 2 percent in Britain. Note, however, that in the United States about 4 percent of the population accounts for about 50 percent of total health care costs. These are the patients who require surgery and access to expensive technology. If the same percent holds for the other three English-speaking countries, this implies that from 1/8 to 1/2 of all patients who need access to expensive medical technology are not receiving it — at least not promptly.

[27] George J. Schieber, Jean-Pierre Poullier and Leslie M. Greenwald, "U.S. Health Expenditure Performance: An International

Comparison and Update," Health Care Financing Administration, *Health Care Financing Review,* Vol. 13, No. 4, Summer 1992, Table 11. For New Zealand, estimate of the New Zealand Department of Health.

[28] In Canada, the latest estimate is 23 percent. Edward Neuschler, *Canadian Health Care: The Implications of Public Health Insurance* (Washington, DC: Health Insurance Association of America, 1989), p. 18.

[29] See Robert A. Berenson, "Meet Dr. Squeezed," *New York Times,* July 21, 1989.

[30] These results should be taken as indicative, since the poll was not random. See *Private Practice,* October 1985, pp. 18-19.

[31] Reported in *Medical Benefits* 7, No. 17, September 15, 1990, p. 10.

[32] See Richard A. Levy, "Ethnic and Racial Differences in Response to Medicines: Preserving Individualized Therapy in Managed Pharmaceutical Programs," *Pharmaceutical Medicine,* Vol. 7, June 1993, pp. 139-65; and Elyse Tanouge, "Drug Switching Called a Danger for Minorities," *Wall Street Journal,* June 16, 1993.

[33] Eric Schmitt, "Military Gave Aspin a Riskier Vaccine," *New York Times,* February 24, 1993.

[34] Richard N. Carter, "My Prostate, My Choice," *Wall Street Journal,* March 10, 1993.

[35] For an overview of the controversy over the test, see Gina Kolata, "Prostate Cancer Test Questioned," *New York Times,* June 23, 1993.

[36] See Tim Cowlishaw, "Feeling the Pain," *Dallas Morning News,* June 2, 1993; Tim Cowlishaw, "Cowboys Say Carelessness Not a Factor," *Dallas Morning News,* June 22, 1993; and Kevin B. Blackistone, "Cowboys Slow Response on Aikman Reflects Sport's Nature," *Dallas Morning News,* June 22, 1993.

[37] Katherine Swartz and Timothy D. McBride, "Spells Without Health Insurance: Distributions of Durations and Their Link to Point-in-Time Estimates of the Uninsured," *Inquiry* 27, Fall 1990.

[38] Jill D. Foley, *Uninsured in the United States: The Nonelderly Population Without Health Insurance* (Washington, DC: Employee Benefits Research Institute, April 1991), p. 16.

[39] Karen M. Beauregard, "Persons Denied Private Health Insurance Due to Poor Health," Agency for Health Care Policy and Research, Public Health Service, AHCPR Report No. 92-0016, December 1991.

[40] See the discussion in Stuart Butler and Edmund Haislmaier, eds., *A National Health System for America,* rev. ed. (Washington, DC: Heritage Foundation, 1989).

[41] See Goodman and Musgrave, *Patient Power,* chapter 9. The problem is exacerbated by the fact that the tax subsidies tend to go to people who least need help from government. Families in the top 20 percent of the income distribution get almost six times as much benefit from these subsidies, on the average, as families in the bottom fifth. See C. Eugene Steuerle, "Finance-based Reform: The Search for Adaptable Health Policy," paper presented at an American Enterprise Institute conference on American Health Policy, Washington, DC, October 3-4, 1991.

[42] John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 134, November 1988.

[43] Ibid.

[44] This is made possible under the provisions of the Employee Retirement Income Security Act (ERISA), 1974.

[45] Under the provisions of the Consolidated Budget Reconciliation Act (COBRA) of 1986, employees are entitled to continue coverage for up to 18 months after they leave an employer.

[46] Today's hospital billing muddle is the result of a traditional cost-plus system, in which insurers were billed not by the amount of services patients actually used, but by the percentage of total hospital costs an insurer's clients represented. As a result, patients have never been charged the real cost of services they have actually used and no system of billing that could reflect those costs has ever evolved. See Goodman and Musgrave, *Patient Power,* chapters 5 and 6.

[47] See Goodman and Musgrave, *Patient Power,* pp. 52-58.

[48] To our knowledge, no one has studied the market for cosmetic surgery. That is unfortunate, because most of what employers and insurers have unsuccessfully tried to accomplish for other types of surgery over the past decade has occurred naturally with few problems and little fanfare in cosmetic surgery.

[49] Source: NCPA/Fiscal Associates Health Care Model.

[50] See Milton Friedman, "Input and Output in Medical Care," Hoover Institution, Essays in Public Policy No. 28, 1992.

[51] This approach was originally advocated in the NCPA Health Care Task Force Report, "An Agenda for Solving America's Health Care Crisis," National Center for Policy Analysis, NCPA Policy Report No. 151, revised June 1991. See also Goodman and Musgrave, *Patient Power,* pp. 58-59.

[52] Ibid., pp. 59-62.

[53] See Victoria C. Craig, "Medical Savings Accounts: Questions and Answers," Council for Affordable Health Insurance, February 1993. On the distinction between real insurance and prepayment for the consumption of medical care, see John C. Goodman, "A Layperson's Guide to Health Insurance Reform," National Center for Policy Analysis, NCPA Backgrounder No. 121, September 1992.

[54] See Principal Financial Group, "Medical Savings Accounts," November 1993; and Health Insurance Association of America (HIAA) memo, "Preliminary Analysis of a Proposal for Medical Savings Accounts," June 23, 1992. Note that the HIAA memo raises "issues" and "questions" instead of making arguments. The HIAA's position is that MSAs should not be adopted until the questions are answered and the issues addressed. Note that whereas arguments require consistency, questions do not. There is no contradiction in asking: "How do we know MSA holders would not spend too little, or too much, on health care?", but there is a contradiction in arguing that people would spend *both* too little and too much. Thus by putting its objections in question form, the HIAA increases the number of possible objections without being inconsistent.

[55] In addition to the above examples of hospitals' charges, see Wendy Bounds, "Sick of Skyrocketing Costs, Patients Defy Doctors and Shop for Cheaper Treatment," *Wall Street Journal,* June 16, 1993.

[56] Whereas the average per capita expenditure on hospitals rose from a little over $200 per year in 1960 to $1,000 in 1990, the per capita expenditure on drugs rose from approximately $100 to a little over $200. See Bounds, "Sick of Skyrocketing Costs, Patients Defy Doctors and Shop for Cheaper Treatment."

[57] See Kathleen Day, "Drug Industry Tries Quiet Defense," *Washington Post,* February 20, 1993; and Shawn Tully, "Why Drug Prices Will Go Lower," *Fortune,* May 3, 1993.

[58] See "Managed Care and the Medicare Program: Background and Evidence," U.S. Congressional Budget Office, Washington DC, May 19, 1990.

[59] Surveys of patients who are given information about their medical options confirm that they tend to choose less expensive, low-tech health care over expensive, high-tech procedures. See Ron Winslow, "Videos, Questionnaires Aim to Expand Role of Patients in Treatment Decisions," *Wall Street Journal,* February 25, 1992. See also Lee Francesca Kritz and Janet Novack, "Patient, Educate Thyself," *Forbes,* September 14, 1992; and David Holzman, "Interactive Video Promotes Patient-Doctor Partnership" *Business & Health,* mid-March 1992.

[60] Bounds, "Sick of Skyrocketing Costs, Patients Defy Doctors and Shop for Cheaper Treatment."

[61] *Harvard Health Letter,* Vol. 18, No. 2, December 1992. To determine whether *Ask-A-Nurse* operates in your calling area, dial 1-800-535-1111. *Doctors by Phone* may be reached at 1-900-77-DOCTOR. *Pharmacy Question? Ask the Pharmacist* may be reached by calling 1-900-420-0275.

[62] We are indebted to Rita Rubin of *U.S. News & World Report* for assembling the following information.

[63] Both the HIAA (1-301-496-1143) and the policy agency (1-800-358-9295) provide free summaries of their recommendations and guidelines for patients.

[64] For information on how to use Medline, call 1-800-638-8480.

[65] Patients may contact Planetree at 1-415-923-3680 and the World Research Foundation at 1-818-907-5483.

[66] See Gary Robbins and Aldona Robbins, "Taxes, Capital and Growth," National Center for Policy Analysis, NCPA Policy Report No. 169, October 1989.

[67] Steven F. Venti and David A. Wise, "The Determinants of IRA Contributions and the Effects of Limit Changes," in Zvi Bodie, John Shoven and David Wise, eds., *Pensions and the U.S. Economy* (Chicago: University of Chicago Press, 1988). For a literature survey, see Norman Ture and Stephen Entin, "Save, America: A Primer on U.S. Savings and Its Effect on Economic Health," sponsored by Merrill Lynch Consumer Markets, 1989, pp. 27-31.

[68] See, for example, Aldona Robbins and Gary Robbins, "The Case for IRAs," National Center for Policy Analysis, NCPA Policy Report No. 112, April 1991.

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