

Defined Contribution Health Care

A Revolution on Hold?

IN TIMES OF TRIAL, Americans are more inclined to trust in government solutions to their problems. On Sept. 11, 2001, our annual health care debate was blown off the agenda in Washington; when it resurfaces, we must be wary of this inclination. Government solutions are notorious breeders of unintended consequences. World War II wage controls spawned the exclusion of health care benefits from taxable income. This exclusion helped fuel consumption and costs and, if current trends continue, may lead us to a national health system. We must be mindful of what seeds we sow in the aftermath of our time of trial.

In the spring of 2001, defined contribution health care was being touted as the health care revolution of the future. Vindicated by the collapse of global communism, free market economists stood ready to revolutionize the delivery of health care with the power of consumer self-interest. Employers, wary of looming liability under the current arrangement and troubled by the revival of price inflation, seemed willing to try something new. Employees loved defined contribution pensions; why not defined contribution health care?

Defined contribution health care has several names and many forms. Proponents often refer to the structure as self-directed or consumer-driven health care, emphasizing the beauty of expanded choice and responsibility. The various forms differ based on the envisioned legal environment, and range from an adaptation of our current environment to a radical transformation to an individual marketplace.

These forms are all variations on a theme. The core characteristics are fixed or defined employer contributions, and expanded choice and responsibility for the employee. The plans typically harness consumer self-interest by pairing a savings account with a high-deductible insurance policy. In order for this combination to compete on a level tax playing field with traditional plans, the savings account must be fund-

ROBERT A. KELLY IS ASSISTANT VICE PRESIDENT AT HORIZON BLUE CROSS/BLUE SHIELD IN NEWARK, N.J.



STUART ARMSTRONG

ed with pre-tax dollars, and withdrawals from the account for health care expenses must be tax free. The accounts should roll over from year to year, to discourage wasteful spending. Ideally, the accounts would be portable from job to job, and cashable for non-health-related expenses.

Medical savings accounts (MSAs), allowed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) on a pilot basis and since extended, have all these desirable features. They're tax free in and out, they roll over from year to year, they're portable, and they allow for non-health-related withdrawals subject to ordinary income taxes and penalties, if made before Medicare eligibility.

However, they're less than ideal. They're available only to the self-employed and small-group markets, they complicate your tax returns, and they come with limitations on the design of the companion high-deductible insurance policy.

Flexible spending accounts (FSAs) are subject to the use-it-or-lose-it rule where unused balances are forfeited at year's end. Employer-funded medical reimbursement accounts, excludable under Section 105(b), appear to roll over with no adverse tax consequences, but they're neither portable nor cashable.

In the spring of 2001, Washington blossomed with legislation designed to eliminate or minimize these problems. MSA expansion seemed a sure thing. FSA rollovers seemed probable. Even refundable tax credits, a form of government defined contribution, seemed

possible. Collectively these three initiatives can be thought of as the consumer-driven health care reform agenda. Although not formally tied together, all three put a premium on choice and responsibility, and passage in whole or in part would have powerfully fueled the consumer-driven health care revolution.

Hopes ran high. Wall Street got into the act, as venture capital firms lined up with business models designed to accommodate consumer-driven health care. In May, the optimism of market liberals was bridled when Sen. James Jeffords declared his independence from the Republican Party, signaling a subtle shift in the balance of power in Washington.

Consideration of the consumer-driven health care agenda gradually bowed to the Patient's Bill of Rights debate. Refundable tax credits fell off the political radar screens. FSA reforms seemed unlikely, and MSA expansion would pass only as a bargaining chip in the larger Pa-

tient's Bill of Rights negotiation. Then the events of Sept. 11 deferred the debate, putting the consumer-driven health care revolution on hold.

The debate will return because the issue is perennial. The core characteristic of consumer-driven health care is enhanced choice and responsibility. The implied meaning is enhanced freedom of choice, or simply enhanced freedom. It's a wonder that there's any political opposition at all. Freedom is the cornerstone of this nation; it's what makes us different from our adversaries. Choice and responsibility are not only the keys to wealth but also the hallmarks of freedom.

Critics argue that freedom in health care will increase the number of uninsured and make comprehensive low-cost pay insurance unaffordable, especially for those who need it most. Proponents argue that the price of equality is poverty. This argument begs the question of whether health insurance is for unex-

pected catastrophic events or whether it serves the additional function of income redistribution. Within all these debates lies a core issue, which can be simply stated: Is health care a right?

If health care is a right, then the government's concern about affordable comprehensive health insurance makes perfect sense. After all, we the people have declared that the very purpose of government is to secure our rights. If, however, we decide that comprehensive state-of-the-art health care is a right of every citizen, we're confronted with the following proposition: If the government is responsible for health care, is unhealthy behavior criminal?

As preposterous as this appears, the conclusion seems to flow from the premise. If the government is responsible, it's responsible for funding. Unhealthy behavior, which leads to overutilization, is therefore essentially theft of public funds.

Who then defines "unhealthy"? If the unhealthy becomes illegal, then those who define "unhealthy" have dictatorial powers no less than those who define "unholy" have powers in the camps of our adversaries. The footing seems pretty treacherous in the land where health care is a right, and the slippery slopes lead straight to dark places.

We the people have a choice to make when the health care debate returns. We can let our surging trust in government spill over to our domestic agenda, and essentially drift to a single-payer system. With any luck, the unhealthy will not become illegal, and the emergence of the health police will remain a contingency. Alternatively, we could give free markets a chance in health care by enacting the consumer-driven health care reform agenda.

Winston S. Churchill, the greatest warrior of the 20th century, once said that the short road to ruin was to emulate the methods of your adversary. Our adversaries don't believe in freedom. We do. They believe in craven submission to authority. We don't. This is our fundamental difference. Perhaps we should think long and hard before we turn our backs on freedom in health care. ●

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