

## What ails health care

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**N**OW are we ready to talk about health care?" asked Senator Hillary Clinton in the title of her *New York Times* op-ed last year. In fact, have we ever *stopped* talking about it? Medicare reform, prescription drug costs, the uninsured—these issues are much discussed. No wonder. A decade after Senate Majority Leader George Mitchell declared HillaryCare dead, polls suggest that Americans are more worried than ever about their health insurance. In a Market Strategies poll, 86 percent of people expressed deep concerns about rising costs and six out of ten regarded the likelihood of bankruptcy due to major illness as a serious problem.

That health care remains a major issue, though, is not due to a lack of effort on the part of American politicians, with bold efforts made to reform health care at the state and national levels. Washington expanded Medicare's scope and Medicaid's reach. The statehouses have worked furiously to help the insured and uninsured alike. And the

health-care industry itself has gone through a massive reorganization, embracing managed care as a panacea and then rejecting it as a poison.

And, at the end of the day, we seem no further ahead than when Americans elected Governor Bill Clinton to the White House with a promise of health-care reform. Many of the problems remain the same: middle class angst, millions without insurance, double-digit spending increases. In fact, the situation has worsened: Health spending is at a historic high, consuming 15 percent of GDP. More Americans are without insurance. And those with insurance carry a greater burden—the typical worker now pays \$750 more per year for insurance than just three years ago.

If the problems are familiar, so are the solutions proposed. While the grand design of the Clinton White House went unrealized, some type of national effort appears increasingly inviting. Just this summer, the National Coalition on Health Care, a bipartisan organization chaired by former Presidents Bush and Ford, announced support for a universal coverage scheme that would centralize key health decisions to a government committee. It's not that the coalition, comprised of big businesses like General Electric and AT&T, as well as union interests, holds a big-government bias. Rather, it's that the status quo appears untenable. So we're returning to the debates of the last decade: HillaryCare.

Perhaps that's not surprising. While the American health-care system has gone through much "reform," relatively little of its overall economics has changed. Reform, thus, has largely been an exercise in shifting costs from payer to patient, from insurance plan to hospital, from hospital to physician, from uninsured to insured. Since the 1970s, much has been made of the idea of managing care—but really, these have been exercises in managing *cost*. For most Americans, the end result has been less control over basic health-care decisions, a prescription for universal dissatisfaction.

If we really want to address the system's shortcomings—to tame health inflation and broaden coverage—a new approach is needed. We must recognize that the structure of American health care is flawed, and we must seek

to address this by giving people more control over their own health care.

### **Third-party payership**

In other sectors of the economy, costs fall with time. Think of agriculture or transportation—areas that, like health care, have been transformed by technology and innovation. But the advancement of medical science has, curiously, not followed the trend. Indeed, progress means greater expense. Year after year, health spending rises—from 5 percent of GDP in 1960 to triple that today. So accepted is this phenomenon that few pause to ask why health care has grown so much more expensive over the years.

The central problem is the way Americans pay for their care. Rather than paying directly, most people get their health insurance from their employers. Someone else foots the bill. Our employers don't pay directly for other basic needs, like food, clothing, or shelter. So how did this odd financing arrangement develop for health care, and why does it remain? The answer can be found in the tax code.

Tax and health policies are intimately linked. Consider that the biggest event to shape American health insurance occurred on October 26, 1943. Given the importance of that date, some may think that Congress passed a major piece of legislation, or that the Supreme Court decided a landmark case. Actually, the date marks a special ruling on health benefits by the Internal Revenue Service, declaring that employees would not be taxed on premiums paid on their behalf by their employers. Simply put, the IRS ruled that health benefits are tax free.

The IRS didn't make this ruling out of the blue. Two years earlier, in 1941, the FDR administration had imposed wage and price controls as part of the war effort. The effects of price controls are well remembered—for instance, a black market for gasoline quickly developed. Wage controls also produced unintended consequences as employers sought ways to provide workers with competitive salaries without violating the law. Across America, employers found their answer in health benefits. The IRS ruling legitimized the practice.

Today, most Americans receive their health insurance through their employers. No wonder—historically, it has made sense for firms to offer health benefits, and lots of them do. If an employer offers his employee a raise of \$1,000 a month, after income and payroll tax, the employee will probably take home \$600. But if the employer offers \$1,000 more of health benefits, the employee gets every dollar's worth. It's not surprising, then, that many company plans offer sunglasses, massage therapy, and marital counseling. These aren't essential ingredients for wellness; they represent disguised income. "This loophole in the tax system has done tremendous harm," suggests economist Milton Friedman. "It has caused the medical care industry to develop in an inefficient and unnatural way."

Public insurances—Medicare and Medicaid—were also shaped by the 1940s. It was then that the British conceived and designed their National Health Service, a zero-dollar deductible insurance. It took the United States a couple of decades to implement its own public coverage, with principles based on the British experience. Thus, for the most part America's elderly and poor also pay little out of pocket for covered health services.

The resulting accidental system is fraught with problems. For one thing, health insurance covers just about everything. Usually, insurance covers people for rare and unforeseen events. Car insurance, for example, helps in the event of a major accident—but not for filling the car with gas after a long Sunday drive or replacing worn brake pads. In contrast, health coverage kicks in when people get an annual physical exam or routine blood work. Indeed, between private and public coverage, Americans are overinsured, paying pennies on the dollar. By 2003, out-of-pocket expenses—the amount not covered by public and private insurance—accounted for just 14 cents on every health dollar spent in the United States. That figure included dentistry and allied health professions, like physiotherapy. American health care, thus, came to be dominated by third-party payment.

The implications for cost were quite direct. As Nelson Sabatini, twice Maryland's Secretary of Health and Mental Hygiene, would reflect in 2004: "Using health care in

this country is like shopping with someone else's credit card." American patients did not have to think twice before demanding expensive tests or procedures. Because they paid so little for their health care themselves, they had little incentive to economize. They had no reason to think twice about seeing a specialist or getting an expensive test.

When health care had been relatively inexpensive—in 1950, per capita spending was just \$500 per year, adjusting for inflation—overinsurance was unproblematic. But as medicine advanced, developing in an environment unconstrained by cost, employers began to feel the bite. They were directly invested in the health cost of their employees, and those costs were exploding. By 1970, health spending per capita had tripled. The generous benefits that companies had agreed to give their workers had become an overwhelming commitment. By decade's end, an executive at General Motors noted that Blue Cross Blue Shield had become a bigger supplier to the company than U.S. Steel. In 1989, a Robert Wood Johnson Foundation survey found that 60 percent of corporate executives labeled health costs a "major concern" and 35 percent called them a "top concern."

It was clear that health insurance needed to be rethought. By 1993, health care had ballooned to 13.7 percent of GDP. Business and government would no longer write blank checks. The federal government had already started to rein in Medicare and Medicaid by creating de facto price controls on most doctor and hospital bills. The Congressional Budget Office feared the worst: Costs, the actuaries projected, would continue to rise until spending hit 18.9 percent of GDP by the end of the decade. Some employers dropped coverage for their employees. Everyone looked for a new way of managing health benefits, one that would place cost before individual needs.

### **The rise of managed care ...**

By the mid 1990s, health maintenance organizations (HMOs) were widely seen to offer a solution. They would attack wasteful spending by a variety of means, such as

requiring tests, prescriptions, and procedures to be pre-approved by someone other than the patient or her doctor.

HMOs were a new take on an old idea. The concept of managed care actually originated in the fraternal orders and lodges of the end of the nineteenth century. Many of these organizations had already offered their membership life insurance, and health care seemed a natural extension. In exchange for an annual fee, physicians provided service. By the early twentieth century, these contracts came under assault from organized medicine. In part out of blatant self-interest, in part out of genuine concern, physicians fretted over the poor standards of their prepaid colleagues. Some experimentation with prepayment continued (in Washington and Oregon, for example), but the practice faded.

In the late 1930s, the idea gained a new lease on life. Sidney Garfield, a California physician, approached the industrialist Henry Kaiser with an offer. He and his group of physicians would cover Kaiser's Los Angeles construction workers for a set amount, five cents a day. Kaiser accepted. With success in the City of Angels, Kaiser extended the deal to his workers in Washington state. For the employer, prepaid health care offered predictable costs, and physicians felt that patients benefited.

When the Second World War broke out, Kaiser's shipyards swelled with people—as did the enrollees in this first large-scale HMO. When the war ended, however, the shipyards slowed. Kaiser decided to offer the plan to the public, and the Kaiser health plans were born.

Managed care, however, was anything but a stellar success. With under four million members in 1970, HMOs appeared to be just a "West Coast thing." But the Kaiser concept had an important booster in Washington: President Richard Nixon. With pressure for national health insurance, coupled with rising costs, Nixon felt that he needed to do something on health care. HMOs—never previously considered a Republican idea—appealed to the president and his aides, offering a middle ground between the unfettered market and the socialistic plans of liberal Democrats like Wilbur Mills. Nixon made HMOs the center-

piece of his health strategy and set an ambitious goal: enrolling 90 percent of Americans in managed care within the decade.

Congressional enthusiasm was more tempered but did eventually cement around the HMO Act of 1973. The legislation counted Senator Ted Kennedy as one of its chief proponents. To facilitate the start-up and expansion of HMOs, the act offered an interesting mix of deregulation and regulation: It overrode state laws that had restricted the development of HMOs but also required any company with 25 or more employees to offer two HMO plans as part of its benefits package. And Washington gave a remarkable incentive for companies entering the HMO business: \$1.6 billion (adjusted for inflation) in grants and loans.

White House support for HMOs continued after Nixon resigned. In the late 1970s, pushed by the White House, Congress again moved, amending the HMO Act to further subsidize managed care. But while Washington was keen on HMOs, the rest of the country was more hesitant: In 1980, total enrollment was only 10 million.

Rising health costs changed that. In a few short years, employers would completely rethink the way they offered health benefits. In 1988, three quarters of American workers with employer-sponsored health insurance were covered by traditional (indemnity) plans; by the end of the 1990s, those indemnity plans represented only 14 percent of the market. By 1998, HMO enrollment had soared to 79 million—an eightfold increase in eighteen years.

The attraction of managed care in general, and HMOs in particular, was clear. HMOs held down costs with a variety of techniques, such as paying family doctors *not* to refer patients to specialists and utilization reviews of medical practices. To eke out even greater savings, HMOs used their enormous buying power to push hospitals for discounts. For a health-care industry used to the tranquility of indemnity plans—send a bill to the insurance company, get a check back with no questions asked—HMOs represented a perfect storm.

As a cost-saving system, managed care was a smashing success. By the late 1990s, health spending was increas-

ing by slightly less than the overall growth of the economy, leaving expenditures at about 13 percent of GDP, amounting to \$300 billion less than the Congressional Budget Office's projection. For every privately insured American, that translated into savings of \$2,000 a year. In the private insurance market, where managed care had the greatest impact, premiums remained relatively stable in the mid- to late 1990s. Private health spending per capita grew at a meager rate (just 2 percent, for instance, in 1996). Through much of the mid 1990s, hospital spending actually *dropped*. In 1997, for instance, it fell 5.3 percent.

### **... and its fall**

Managed care, it seemed, was a miracle cure. In 1995, House Republicans, under the leadership of Speaker Newt Gingrich, even suggested that HMOs would help rein in the cost of Medicare and Medicaid. The Republican plan won applause from, among others, Vermont Governor Howard Dean. Rarely had an idea been so widely embraced. Despite these measurable successes, however, a backlash was brewing.

HMOs were set up to control costs, and they did. But did patients suffer as a result? Where once critics had suggested that American health care was indifferent to cost, they now asserted that it was insensitive to quality. Many in the media found examples to illustrate the point. Perhaps the best publicized case of HMO denial involved Nelene Fox, a 38-year-old California woman sick with breast cancer. In 1992, she tried to get coverage for a bone-marrow transplant. Her HMO denied the claim. Fox died a short time after—and her grieving family sued, winning a landmark judgment of \$89 million. The Fox case, though, seemed to be just the tip of the iceberg. In the 1997 movie *As Good As It Gets*, a single mother broke into profanity when her HMO was mentioned. Many theatergoers burst into sympathetic applause.

Americans had come to despise managed care. In a 2004 Gallup poll asking people to rank the ethical standards of different professions, HMO managers ranked second-last, behind journalists and politicians, and ahead

(barely) of car salesmen. Politicians naturally took note. After winning the 2004 New Hampshire primary, for example, Senator John Kerry declared: "I'm running for President to free our government from the dominance of the lobbyists, the drug industry, big oil, and HMOs—so that we can give America back its future and its soul."

How much of the criticism of managed care was justified—and how much was mere rhetoric? In his book on managed care, *The Economic Evolution of American Health Care*, David Dranove, a professor at Northwestern University's Kellogg Graduate School of Management, exhaustively reviewed the literature, and cited several large-scale studies. In a 1996 study, Fred Hellinger reviewed the published literature on HMO quality, and found few measurable differences between managed care and indemnity insurance. A review by Robert Miller and Harold Luft of 35 studies published between 1993 and 1997 found that "fears that HMOs uniformly lead to worse quality of care are not supported by the evidence.... Hopes that HMOs would improve overall quality also are not supported." A 1998 Johns Hopkins University review of cardiovascular care concluded that "the HMOs studied provided as good, and in some cases better, quality than the non-HMO settings studied."

The evidence collated by Dranove was overwhelming. "Each month's new studies generally confirm what many have already concluded," he wrote, "namely, that the quality of care in [managed care] is comparable to that under traditional indemnity insurance."

Even the famous Fox case was worth a second look. Yes, Fox wanted a bone-marrow transplant and, yes, she did succumb to cancer, but important details have often been overlooked. Fox actually did get the bone-marrow transplant; she just relied on charity support to finance it. But bone-marrow transplantation for breast cancer has never been shown to be useful, and, a decade later, no oncologist would recommend it.

But if the negative perceptions about HMOs were not always grounded in reality, those perceptions nevertheless began to shape and change reality. By the late 1990s,

HMOs were on the wane. Between 1997 and 2000, enrollment in cities like Miami and Seattle, once hotbeds of managed care, had dropped by as much as 25 percent. Of course, managed care had not disappeared. By 2004, HMO enrollment, though down 12 percent since the late 1990s, still stood at 70 million. Indemnity plans, once the standard for health insurance, accounted for less than 5 percent of employer-sponsored health insurance. Preferred provider organizations (PPOs) and other types of managed care covered most of working America and their families. But no one was looking to HMOs as the solution for America's health care woes.

### **Why HMOs failed**

HMOs had faced a stunning consumer rebellion. The idea of being told what tests to get or which hospital to go to was seen as absurd and offensive. As Michael DeBakey, a pioneering heart surgeon and director of the DeBakey Heart Center at the Baylor College of Medicine, puts it, "We would not allow an unqualified clerk to recommend repairs for our car, so why would we settle for one when it comes to our own health?" That comment isn't quite fair. As the health outcome data suggests, HMOs were hardly run by unqualified managers making arbitrary, reckless decisions. But the public outcry, the threat of litigation from trial lawyers, and state regulations restricting their ability to operate all forced insurance companies away from managed care.

To Americans, HMOs represented a loss of autonomy. In contrast to vastly more mundane choices—which car to buy or which pizzeria to order dinner from—Americans discovered that when it came to health matters, someone else made the decisions. Consumerism—demanding the services or goods you want, when you want them, at the lowest possible price—is relatively new to medicine. Traditionally, patients have done what they were told to do. But today, people increasingly approach health care with a consumerist impulse. Consider health information: According to a 2002 Harris poll, some 110 million American adults surf the Internet for medical advice. And the rest

of us glean information from a plethora of sources. Bookstores teem with volumes about health and wellness; national newspapers dedicate whole sections to health issues; TV shows focus on exercise and diet. In an age of consumerism, managed care is an unworkable idea.

Thus, after the collapse of the managed-care gambit, the future of American health care looks increasingly unclear. Since Nixon's embrace of HMOs, the debate has been between two different visions: national insurance and managed care. For the most part, from Wilbur Mills to Hillary Clinton, Democrats have spent the last four decades promoting some version of the former; from Richard Nixon to Bob Dole, Republicans have favored the latter. As both visions are fundamentally paternalistic, neither appears especially compelling.

### **From MSA to HSA**

Today, a state of confusion reigns, as people can agree on their dislike for the past system but are unsure of how to proceed. Many Americans are now enrolled in "managed-care-lite." In some ways, it's a case of back-to-the-future. Without the discipline of HMOs, double-digit premium increases have returned with the ensuing problems: employers balking at costs and dropping coverage (or holding wages), and more Americans going without insurance. Managed care has collapsed. But is it possible to contain health spending without the paternalism Americans resent? Health care driven by the choices and priorities of consumers offers an alternative.

The most basic problem with American health care is that Americans don't really pay for the health care they receive. How to address this? The beginning of wisdom may be found in the musings of two economists. In 1974, Jesse Hixson and Paul Worthington in the Social Security Administration developed the idea of "health banks." With traditional (indemnity) insurance and HMOs, Americans were overinsured and thus insulated from the consequences of their health-care decisions. Hixson and Worthington proposed an alternative: Employers would deposit money for health care directly into the savings accounts of em-

ployees at specially chartered health banks. For smaller expenses, employees could then draw on their accounts; for catastrophic events, the bank would pool multiple deposits and thus be able to offer loans if an employee's account was insufficient to cover the medical bills.

Hixson went on to work for the American Medical Association, eventually becoming its principal economist. He continued to promote the idea of involving employees more in health decisions. He found a supporter in John Goodman at the National Center for Policy Analysis in Dallas. Goodman was initially excited by the prospect of using individual accounts—modified IRAs—to reform Medicare. He developed the idea further and, in 1990, organized a task force with representatives from the worlds of academia, think tanks, and business. Drawing on the task force's report, Goodman then wrote *Patient Power* with economist Gerald Musgrave in 1992. The idea was simple: Employees would get tax-free dollars to purchase health care for smaller expenses but would have a high-deductible insurance for catastrophic events. Third-party payership, thus, would cover only catastrophic events, bringing the bulk of decisions to individuals.

*Patient Power* is a long, detailed book, spanning nearly 700 pages. The book doesn't just comment on employer-sponsored insurance, it covers a smattering of other topics: Canadian health care, the need for rural medical enterprise zones, and challenges for the individual health insurance market, to name a few. It uses technical jargon and a plethora of statistics. All things considered, *Patient Power* hardly seems like a bestseller—and yet incredibly, it was, selling over 300,000 copies. Pat Rooney, a businessman, heard Gerald Musgrave give a lecture and became a convert. Rooney offered medical savings accounts (MSAs) to his employees at Golden Rule Insurance. Impressed by the popularity of this type of health insurance, he began marketing it to other companies. Rooney and Goodman worked tirelessly to promote MSAs, popularizing the concept.

If MSAs were gaining purchase in the imagination of America's polity, the business world remained unconvinced. Golden Rule Insurance sold plans to small employers, while

a few big companies, like Quaker Oats and Forbes, offered MSA plans to their employees. But these efforts were limited by tax law. Unlike employer-paid premiums, MSA deposits were subject to income and payroll taxes, and unspent funds could not be rolled over.

Fortunately, on Capitol Hill interest in MSAs was robust. Republican Congressman Bill Archer, then chairman of the House Ways and Means Committee, championed the idea and favored a tax-code change. Working with Democratic Congressman Andy Jacobs, Archer amended the Kennedy-Kassebaum bill of 1996 to include a provision making MSAs tax free for the self-employed and small businesses. MSAs were a Washington answer to the mess of American health care. MSAs offered a clear alternative to the paternalism of managed care—people would be literally empowered with health dollars. Conservatives enthused that MSAs would change everything; liberals fretted MSAs might just do that. But for all the debate and discussion, it would be difficult to think of another health-reform initiative that affected so few. MSAs were doomed from their creation.

The legislation was just too limiting. The 1996 legislation restricted MSAs to small employers (those with fewer than 50 employees) and individuals, and was overly rigid as to the way MSAs must be structured. Making the situation worse. MSAs were approved as an “experiment,” lasting just four years. Congress capped enrollment at 750,000 people; fewer than 100,000 signed up. Congress extended the experiment, but MSAs were a flop.

In 2003, Congress made a second effort. As a last-minute addition to the Medicare Modernization Act, aimed at gaining the support of congressional conservatives, House Ways and Means Chairman Bill Thomas added provisions creating Health Savings Accounts (HSAs). Unlike MSAs, HSAs are freer in structure and, more importantly, permanent. Anyone—mom-and-pop operations, large corporations, individuals—can set up a health savings account. HSAs marry real insurance (that is, coverage for high and unpredictable costs) with contributions to a savings account that can be used to pay for smaller health expenses and “rolled over” from year to year. HSA cover-

age, thus, is built on two components: a high deductible health insurance and a personal savings account. High deductible is defined as at least \$1,000 for individuals and \$2,000 for families. With regard to the account, up to \$2,600 for individuals or \$5,150 for families per year can be deposited, or the value of their deductibles, whichever is less.

For companies and individuals looking to avoid high-cost health insurance, HSAs are immediately attractive. Writing in the *Wall Street Journal*, Harvard economist Martin Feldstein notes that a typical Blue Cross of California family policy costs \$8,460, with a \$500 deductible per member. But a similar HSA policy costs just \$3,936, with a \$2,500 deductible—in other words, the difference in savings (\$4,524) actually exceeds the maximum additional out-of-pocket expense that the family would face if they reached the maximum deductible. The HSA approach results in great savings, by giving people incentive to think twice about where and how they spend their health dollars. It also appeals to Americans' desire to make their own decisions, especially in a matter so important as health.

### **Making HSAs work**

Architecturally, the glass visage of the Texas Heart Institute is stunning. But what's really amazing is the care that goes on inside. Focused on cardiology and cardiac surgery, the Texas Heart Institute delivers care at half the cost of some academic centers. The institute, incidentally, attracts the most complex cases and boasts solid outcomes. The specialization, in other words, pays off—the Texas Heart Institute has drawn national and international attention. *U.S. News & World Report* ranks the institute in the top 10 American hospitals for cardiac care. Harvard Business School professor Michael Porter routinely cites the Texas center as an example of health-care innovation. The Texas Heart Institute represents a significant break from the traditional hospital, which attempts to offer everything for everybody. In an age of consumerism, the Texas Heart Institute would seem to be a model.

Except that Congress doesn't see it that way. The Medicare Modernization Act of 2003 includes an 18-month

moratorium on the building of specialty hospitals. And, as a recent joint Federal Trade Commission–Department of Justice report suggests, state laws also undermine the establishment of such specialty hospitals. Even if Congress doesn’t extend the moratorium, it seems unlikely that the facilities will ever be established in more than seven or eight states. And herein lies the basic problem with health savings accounts: Government has spent five decades undermining choice and competition in health care.

Americans view health care as a sector of the economy that is largely untouched by government. In fact, the opposite is true—health care is riddled with laws and regulations that govern financing, billing, and basic practice. “The U.S. health care system, while among the most ‘market oriented’ in the industrialized world,” observes University of Rochester economist Charles Phelps, “remains the most intensively regulated sector of the U.S. economy.” But here’s the problem with the surfeit of rules: HSAs will never flourish as long as the heavy hand of government weighs down on the sector.

Let’s start with insurance options. Many states have regulated health insurance so extensively that even basic plans are prohibitively expensive. A leading online insurance brokerage, eHealthInsurance, recently compared the cost of a standard family insurance policy (\$2,000 deductible with a 20 percent co-pay) across the nation’s 50 largest cities, involving some 4,000 insurance plans and 140 insurance companies. The results are startling. A non-employer-based family policy for four in Kansas City, Missouri, costs about \$170 per month, while similar coverage in Boston tops more than \$750 a month.

As noted above by Feldstein, health savings accounts are like a low-cost alternative to more comprehensive insurance. Except that in several states (Rhode Island and Hawaii) regulatory restrictions have hindered their availability; in other states (like New York and New Jersey), regulations drive up the cost of an HSA. Deregulation of state insurance requirements—which Congress could easily do by allowing out-of-state insurance purchases—would mean that all Americans have the opportunity to buy basic, no-frills plans.

Over the years, Medicare's administrators have written more than 100,000 pages of rules governing clinics, hospitals, and physicians. The resulting mountain of paperwork means that time and energy is lost on bureaucratic compliance instead of patient care. The American Hospital Association estimates that for every hour spent on patient care, hospitals must spend more than an hour completing paperwork for Medicare. Because some Medicare regulations require that they be applied to non-Medicare patients, the regulatory excess colors the care (and cost) of *all* patients. Cutting the red tape is the key.

As noted above, between state and federal ownership laws, hospitals are the only game in town for many surgeries and procedures. As an alternative, Congress can free providers to form specialty clinics, challenging hospital monopolies, and allowing innovation in the delivery of care. Addressing the regulatory burden would be a thankless task. Middle America isn't exactly fretting about, say, the specialty hospital moratorium. But Washington needs to make HSAs work.

### **Up from paternalism?**

American medicine has accomplished amazing things in the past few decades. Our researchers have won more Nobel Prizes in medicine since 1975 than nationals from all other countries combined. When *Health Affairs* listed the ten greatest innovations in medical technology, eight of them were made in America. These results have had an impact: The health of Americans has improved steadily over the decades.

Ironically, though, neither patients nor doctors are satisfied with health care in America. Perhaps that isn't surprising. We have struggled to push the square peg of modern medicine through the round hole of a 1940s concept of health insurance. American health care is paternalistic and top-down in an age of autonomy, choice, and consumerism. Health savings accounts offer an alternative.

Let's be clear: HSAs will not single-handedly change the way Americans think about or receive health care. But HSAs are critically important. They may help change the way employers, employees, and providers—indeed, all Americans—view health care.