



Free Market Health Care: Health Savings Accounts Primer

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Executive Summary

The cost of health care in America is typically at least twice as high as in other industrialized countries. The fact that most payments for medical services are paid by third parties, such as insurance companies, employers, or a government program, rather than by the consumer of those services, is one of the forces driving health care costs upward. A response that returns the responsibility of paying for health care to the consumer is required. Recent alterations to federal tax laws make Health Savings Accounts an effective, consumer-driven response that allows individuals to accrue tax-exempt savings that can be used to pay for medical expenditures.

Summary Recommendation

It is recommended that an HSA pilot program for all public employees, teachers, and children under permanent state conservatorship in Texas be implemented.

Background

Health care used to be an out-of-pocket expense for most Americans. When someone got sick, they would go see a doctor and pay at the point of service. With the deductibility of employer-paid health benefits during World War II and the advent of Medicare in 1965, however, America started down a long path toward increased government intervention in health care and separation between doctors, patients and payment of services. The result has been today's awkward and unworkable structure in which a third party pays for the care and the real cost is largely unknown to the patient, only serving to increase the divide between consumers and their health care. In fact, the National Center for Policy Analysis (NCPA) points out that in 1960, out-of-pocket medical spending was 50%. By the year 2000, out-of-pocket spending for health care had fallen to a mere 15%.

Evidence that the third-party payer experiment has failed is strong: health care costs have grown unabated. From 1980 to 2004, national health expenditures jumped from \$245.8 billion to \$1.9 trillion¹. This number alone does not tell the whole story however, since inflation, population and other factors are not considered. When Gross Domestic Product (GDP) is factored into national health expenditures, a shocking new figure arises: in 1980, national health expenditures accounted for 8.8% of GDP; in 2004, national health expenditures accounted for 16.0% of GDP, an increase of close to 50% in less than 25 years². Put plainly, health care is becoming more and more costly. Out of data available for 29 countries in the Organization for Economic Cooperation and Development (OECD), the United States currently spends a far higher percentage of its Gross Domestic Product (GDP) on health care, almost 16%, according to Peter Scherer, Head of the Health Division in the Employment and Social Affairs Directorate at the OECD.³ Health care spending in the US is typically “almost two and a half times the amount spent by Canada, France, the United Kingdom or other industrialized countries,” according to Professor Gerard Anderson of the John Hopkins Bloomberg School of Public Health.⁴

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Third-Party Payment

A significant factor in the increasing costs of health care is how money flows through the system. Nobel Prize winning economist Milton Friedman acknowledges that “government has come to play a leading role in financing, producing, and delivering medical service.” Dr. Friedman’s key point of analysis however is derived from his tried and true cliché, “no one spends someone else’s money as wisely or as frugally as he spends his own.” Friedman points out that payments for medical services rendered, be they by a physician, a surgeon, hospital, or other caregiver, are not made directly by the patient (the consumer) but rather by a third party: an insurance company, employer, or governmental entity (with the exception of co-pays). No other business works in this fashion, and no other business has suffered as much for it. Getting away from third-party payment is difficult because the federal tax code strongly favors the third-party payment structure.

First, if an employer provides medical care coverage, an employee’s medical expenditures are paid out of earned wages that the employee never sees. This

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expenditure is exempted from the federal income tax.

However if the employee pays for medical care coverage himself, out of his paycheck, those dollars are taxed by the IRS. That alone is huge incentive for consumers to arrange for medical care insurance through their employer. Dr. Friedman and other economists, including Dr. John

Goodman and Dr. Tom Savings, have argued that the system

of third-party payment drives medical costs up because consumers have no incentive to control costs, in the same way that “all you can eat” buffets create a similarly dysfunctional incentive: consume as much as possible given the apparent low cost of service. Employees (synonymous with “consumers” for this argument) are much more likely to monitor their health care costs if they are obligated to control payment of

services. However, the current system emphasizes employer-provided or taxpayer-funded health care (HMOs and CHIP), which alleviates the consumer of responsibility for monitoring and controlling costs.

“The economic problem lies in the fact that traditional medical insurance covers two dissimilar events, catastrophic and minor illnesses. Consumers' demand for catastrophic medical incidents is inelastic: a consumer will not use more of the heart-surgeon's services just because his out-of-pocket spending is zero. Consumers' demand for care for minor illnesses is elastic: it is inversely related to price. At the true high price a consumer would consult the medical encyclopedia and use over-the-counter drugs. At a low price (zero if her insurance pays the entire cost) a person would consume much more freely, mainly by making appointments with her doctor for every sniffle and headache. The problem with the prevailing health insurance is that the third-party payment of health-care bills insulates the consumers from the real costs of medical care services for non-catastrophic incidents.”⁵

Secondly, since health care expenditures made through an employer are tax exempt, employees are more likely to remunerate a larger portion of earnings for health care than they would if the medical care expenditures were taxed as are other expenditures⁶:

“Under current law, medical care purchased through an employer's insurance plan is tax-free, while direct medical care purchased by patients must be made with after-tax income. As we and many others have observed, this tax preference has given patients the incentive to purchase care through low-deductible, low-co-payment insurance instead of out-of-pocket, which in turn leads to cost-unconsciousness and wasteful medical practices. In addition, the tax preference for insurance creates incentives for the health-care system to rely on gatekeepers rather than deductibles and co-payments when it does try to control costs. The cost of gatekeepers are [sic] financed out of insurance premiums that are paid with before-tax dollars; deductibles and co-payments are paid with after-tax dollars.”⁷

The Health Insurance System

Another indicator that health care spending is reaching near crisis levels, according to Friedman, is the system's perversion of the meaning of insurance. Dr. Friedman argues:

“We insure our houses against loss from fire, not against the cost of having to cut the lawn. We insure our cars against liability to others or major damage, not against having to pay for gasoline. Yet in medicine, it has become common to rely on insurance to pay for regular medical examinations and often for prescriptions.”

Friedman chalks this perversion up to federal tax structure as well, arguing that tax-exemptions for employer-provided medical care, coupled with the advent of Medicare and Medicaid, caused the medical insurance market to develop into a daily necessity as opposed to a safeguard in the event of a health catastrophe. The effect of this, according to Friedman, is more costly medical insurance with fewer consumer options. One public policy consequence of the aggrandized medical insurance industry is the framing of health care expenditures as a “right” to be bestowed upon every citizen. It is in this intellectual framework

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that the justification for the Children's Health Insurance Program (CHIP) can be understood. CHIP really isn't about health care -- it's about insurance because insurance has become the sine non qua of a rights-based approach to health care. The evaluation of the relative well-being of America's youth isn't so much a function of their actual health and outcomes of health care, but whether they (more precisely, their parents) have insurance.

Eduardo Porter of The Economist points out a real life application of how this problem is affecting real people. Health care costs are hurting business owners and causing them to

make hiring decisions not on a need basis, but on the basis of whether or not they can afford the health benefits. This means that labor markets are distorted, which has a macroeconomic impact. “In the second quarter [of 2004], the cost of health benefits rose at a 12-month rate of 8.1% – more than three times the inflation rate and the rate of increases in wages and salaries.” Porter cites several business owners who say they could use more employees, but can’t afford to pay for their health care⁸.

To further illustrate the effects of third party payment and the perversion of health insurance, examine the costs associated with a medical expense that is not covered by insurance but is paid out of pocket: cosmetic surgery. While general medical costs have risen sharply in comparison to the cost of general goods, the cost of cosmetic surgery has risen less than that of general goods. In other words, medical expenses are growing disproportionately to inflation, but cosmetic surgery, due to its out-of-pocket pay structure, has become cheaper over time, even accounting for inflation⁹. It is not that consumer-driven health care is necessarily more rational when people spend their own money, but that they do so more in accordance with their real and perceived preferences. When consumers are allowed to make choices, prices tend to drop. So the relative frequency with which one patient consumes health care has much less impact – if at all – on other patient/consumers when payment is rendered at the time of service.

A Consumer-Driven Response

Haavi Morreim, Ph.D. and professor in the College of Medicine at the University of Tennessee, argues forcefully for a more consumer-driven answer to the market dysfunctions caused by government policy. Dr. Morreim notes that employers offer defined benefit plans under which consumers have no choice of the type of coverage offered. This one-size-fits-all approach undermines individual liberty by limiting choice and undermining personal responsibility through third party action. The alternative that Dr. Morreim offers is a defined contribution plan, under which employers determine upfront how much they will spend on employee health care and then offer an array of

options from which employees can choose, including options in which employees (again, synonymous with “consumers”) can define their own contribution¹⁰. Defined contribution plans begin the process of putting the consumer back in the driver’s seat of health care. Alone, however, they cannot correct the overarching problem; they need to be coupled with serious statutory and tax reforms as well.

Texas, for example, has statutory barriers in place that block insurers and consumers

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from working with a wide range of options. 28 TAC s 3.3704 prevents employers and/or consumers from purchasing low-cost insurance with more cost-sharing options. The state should allow consumers the choice of purchasing a preferred provider plan that has different levels of cost-sharing. This would simply give consumers more options and more control over their own health.

A serious information void also acts as a de facto statutory regulation on consumerism in health care. In Texas, most surgeries occur in an outpatient capacity. The State does not, however, require those outpatient facilities to report their data. In addition, consumers have no guarantee that they will receive pricing information before non-emergency care is given. When consumers have informed choices, prices go down. Empowering health care consumers with both choices and information is the next logical step in moving away from nationalized health care, and Texas has some work to do in that area.

Health Savings Accounts

Fortunately, Federal law is moving toward providing choices, information, and tax incentives for consumers. Part of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (heretofore MMA2003) implemented Health Savings Accounts, which give consumers more control of their medical care and alters Federal tax structure to ensure that the changes are meaningful. Health Savings Accounts (HSA’s)

are hardly a new idea. John Goodman, president of the National Center for Policy Analysis (NCPA), published a study twenty years ago, proposing HSA legislation. Throughout the 1980s, the idea didn't gain a foothold, mostly because no one in Congressional leadership was willing to take on the issue. In the early 90s however, J. Patrick Rooney took up the fight for more consumerism in health care and, by 1996, caught the attention of former House Speaker Newt Gingrich of Georgia and Representative Bill Archer of Texas. Although the Gingrich/Archer plan for HSA's (actually Medical Savings Accounts at the time) was only a pilot program and didn't provide tax relief like that allowed by today's HSA's, the plan laid the foundation for the 2003 incarnation of Health Savings Accounts.

HSA's, similar to Medical Savings Accounts and Flexible Spending Accounts, are a giant step forward in giving control of medical care to consumers. Although relatively simple in their application, HSA's empower health care consumers in ways similar to the conditions prior to the advent of Medicare in 1965. A consumer first chooses to open an HSA. Contributions are then made into the account either by the consumer's employer or directly by the consumer. However, the most important facet of HSA contributions is that the funds are tax exempt whether they are contributed by the employer or by an individual. The consumer then purchases a low premium, high deductible health insurance policy and pays both the premium and the deductible out of the HSA, the concept being that the deductibles for most physicians' visits, medicine costs, and other routine medical care will be paid out of the savings account. The high deductible, low premium insurance policy, although required by the MMA2003, mainly serves as a back up for catastrophic injuries and expensive procedures such as surgery.

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Another key component of the new health savings accounts is that money accrued rolls over to the next year with no penalty. A consumer can put money in the account up to the maximum federally-mandated limit, and that money stays there until it is used for a

qualified medical expenditure (the money may be withdrawn for any purpose, but withdrawals that are not for qualified medical expenses are assessed a 10% penalty)¹¹.

Couple this with the fact that tax free interest accrues in these accounts, and the HSA

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program becomes a strongly conservative first step toward putting the consumer back in charge of health care. Simply put, HSA's offer consumers options: consumers can choose to stay with their employer provided health care; they can choose to pay for health care individually; or they can choose to open an HSA. It is widely believed that health care consumers will acquire a liking for all of their newfound choices, and consumerism in health care will expand as a result. Most significantly, 25 – 40% of those signing up for HSA's were previously uninsured, according to the U.S. Treasury¹².

Insurers are tending to support HSA's and other consumer-driver plans. In July 2004, Aetna announced an expansion of its consumer based policies¹³. This came just days after the company released the results of its 12-month study of 13,500 people on consumer-based plans. The study “[validates] that the consumer-directed plan encourages active engagement in health care decision-making.” In addition, employers offering these consumer-driver plans as an option experienced a 3.7% increase in medical costs, while employers offering Aetna's full replacement plan experienced an 11% decrease in medical costs. Preventative examinations increased greatly, while the number of prescriptions written decreased (for the prescriptions that were written, there was a 7% overall increase in generic utilization).¹⁴ Although this study was not HSA-specific, it speaks volumes for the power of consumerism in health care.

A great example of the power of consumer-driven health care exists in South Africa. Under the leadership of Nelson Mandela, South Africa began to privatize its health care system, largely by allowing Medical Savings Accounts. This lowered discretionary health care spending by 47% for the nation. In addition, to date, MSAs have captured about half of South Africa's health care market¹⁵, alluding to their widespread popularity. Health care spending in general has gone down for South Africa because of their privatized and consumer-driver health care structure.¹⁶ The success of the South African

experiment with privatized health care further emphasizes that the American inclination towards nationalized health care will be a costly failure.

Answering the Critics of HSAs

Not surprisingly, there are vocal critics of consumer-driven health care. Robert Greenstein and Edwin Park of the Center for Budget and Policy Priorities (CBPP) list a whole litany of complaints in their paper, Proposal for New HSA Tax Deduction Found Likely to Increase the Ranks of Uninsured¹⁷. First, the duo argues against the new tax structure accompanying and enabling HSA's:

“[T]he tax-sheltering opportunities that HSA's provide are unprecedented. HSA's are the only feature of the tax code that provides for both tax-deductible deposits into accounts and tax-free withdrawals from the accounts.”

Park and Greenstein are clearly opposed to people keeping more of their own money. The “tax sheltering” is an essential component of the HSA's legislation in that it provides an incentive for consumers to open an account. The pair also argues that the cost of the deductions will be \$25.1 billion. The Bush Administration's numbers are close to this figure, at \$24.8 billion¹⁸, but it is the intellectual prism through which Park and Greenstein view this issue that is objectionable. When using the word “cost”, they imply that the government must spend money to allow consumers to opt into HSA's. Not only is that highly misleading, it is the opposite of the reality of HSA's. The “cost” is actually money that the government would be taking in if not for the HSA program, but will no longer take in because of tax deductions and tax exemptions. When put in the proper perspective, the “cost” that Park and Greenstein complain of is actually a sign of shrinking government, yet another upside to the HSA program.

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This last argument, however, is not Park and Greenstein’s weakest. Using data from economist Jonathon Gruber, the pair actually posits that more people will be uninsured after the implementation of HSA’s than before. The argument holds that, because some employees will be opting out of employer provided coverage, the employers will simply stop offering it, causing those who rely on said coverage to become uninsured. The total number of uninsured, according to Park and Greenstein, will rise by 341,000, and all thanks to HSA’s.

However, the two inadvertently reveal the weakness of their argument through the subheading used to expound it. The subheading, “Deduction Could Induce Some Employers to Drop Coverage” amounts to nothing more than a giant “what if”, as does the entire argument that follows. Not only is the word “could” in the subheading a clue to the weakness of the following argument, the very first sentence reads: “The proposed deduction is likely [emphasis added] to induce some employers to drop existing health insurance coverage or decide not to offer coverage in the first place...” These “ifs” and “might” statements would be somewhat more credible if Park and Greenstein had some data on which they were founded, but they don’t.

The real evidence, on the other hand, shows that employers are adopting HSA’s and the new breed of health care consumers adapt to them eagerly.

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Studies by insurers such as Aetna and ehealthinsurance.com, and studies from the U.S. Department of Commerce show that the new incentives offered by HSA’s are viewed favorably by employers as tools that educate and empower their employees¹⁹. The roles of uninsured Americans will decrease as a result of Health Savings Accounts. Richard Nadler and

Dan Perrin of the HSA Coalition estimate a net gain of two to three million insured Americans as a result of HSA’s²⁰, and their argument is based on fact. Quite to the contrary, the Nadler-Perrin study uses the successful history of defined contribution

accounts, such as HSA's, and hard facts to counter the assumptions of Park and Greenstein.

Additionally, data from both Assurant Health and eHealthInsurance shows that 43% of those purchasing HSA's were previously uninsured, and 46% had family incomes of less than \$50,000. Perrin and Nadler, of the HSA Coalition, estimate that 1.8 to 4.4 million Americans will gain health insurance from HSA's. According to the Assurant and eHealthInsurance data, a wide range of age groups are purchasing HSA's as well. More than 70% of HSA purchasers through Assurant are over the age of 40. What about data that suggests only the relatively healthy will be able to purchase HSA's? Only 6.1% of applicants weren't able to buy health care coverage, meaning that 94% of those who tried were able to obtain coverage²¹. The numbers are strong indicators of the potential for success contained with the HSA's enacting legislation.

Finally, Park and Greenstein allege that employers will drop coverage, adding to the rolls of the uninsured. There are two problems with this. First, data from the Treasury Department and from insurers' studies shows that the rolls of the uninsured are shrinking because of HSA's. Secondly, Eduardo Porter of The Economist points out just how detrimental the cost of health care can be to businesses. Businesses need health costs to decrease, and HSA's do that just. Grace Marie-Turner, of the Galen Institute cites an example under which HSA's were directly beneficial to a business. Logan Aluminum in Kentucky began to offer its employees HSA's. After a year, the company had saved 19% on its health care costs. That is \$925,000 in real money saved by one business²².

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Logan Aluminum is an example of a small business that has successfully turned to consumer-based health care. On the national scene, Whole Foods, a health food grocer, was spending more on employee health care than it was taking in premiums -- \$7 million more, in 2002. The company put health reimbursement accounts (similar to HSA's) to a

vote with its employees. The plan passed by an overwhelming margin and was implemented in 2002. During its first year, costs dropped by 42%. Of all employee accounts, a total of \$14 million in unused funds rolled over to the next year²³. Both the company and the employees have benefited from the consumer-driver health plan in this example of the cost savings that come with putting the consumer in control of his own health care.

Recommendation: HSA Pilot Programs

In the light of the benefits associated with HSA's, an HSA pilot program for all state employees and teachers is recommended. The Employees Retirement System of Texas

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(ERS) and the Teacher Retirement System (TRS) should be required to give employees and teachers the option to hold an HSA rather than a traditional insurance plan.

During enrollment, ERS and TRS must ensure that enrollees fully understand the HSA option. In preparation for annual enrollment, ERS and TRS should mail all employees a statement of their total compensation that

includes the increased cost of benefits over the previous year, and a comparison of total compensation with, and without benefits. Since benefits received through an employer are, in fact, wages hidden from view, were employees to know the total increase in compensation they receive each year, as a result of the increasing cost of health insurance, many employees would surely forego the benefit, and opt instead for the cash. Some or all of this increased wage compensation could be invested in an HSA by employees. Instead of shielding its employees from the private health care market, the state should allow them to benefit from it through HSA's.

Additionally, the state should implement an HSA program for children under permanent state conservatorship through the Department of Family and Protective Services.

Although accommodations have been made to continue providing certain government

assistance for eligible foster care children for a limited time when they “age out” of the system, many find themselves without jobs, and without health insurance. Allowing children in the permanent care of the state to accrue money in an HSA would give some of these young adults a cushion as they transition out of state care. For those children who might not accrue any savings, the health care they receive would be the same as the care they would have received on traditional Medicaid. For those who accrue savings however, they can use those funds for qualified medical expenses as an adult, including paying premiums, co-payments, or for other medical services. This cushion would provide these former foster-care children with an important source of financial support until they are able to settle on their own.

Conclusion

The American experiment in nationalized health care over the past sixty years has failed. The South African experiment in health care -- increased consumerism via medical savings accounts -- has been a great success. America must move away from nationalized and third-party health care and toward consumer-driven, privatized health care. The time has come to end the third-party payment structure and redefine “medical insurance”. When people spend their own money on themselves, they do so in accordance with their perceived preferences, whereas third-party payments are based on someone else’s preferences and judgments. The consumer-driven nature of HSA’s, coupled with the inherent tax changes they force, is the new direction of health care in America.

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Endnotes

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