Approved: Feb. 23, 1995
Date

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Bill Bryant at 3:30 p.m. on February 15, 1995 in Room 527S of the Capitol.

All members were present except: Representative Tom Sawyer, Excused

Committee staff present: Bill Wolff, Legislative Research Department
Bruce Kinzie, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Representative Susan Wagle
David Ross, Kansas Life Underwriters
Mary Jane Stattleman, Kansas Farm Bureau
Dr. Robert D. Durst, Dermatologist
Bob Corkins, Kansas Chamber of Commerce
Susie Katt, Golden Rule Insurance

Others attending: See attached list

Hearing on HB 2010 -- Medical Savings Accounts

Representative Susan Wagle reminded the Committee of the passage of a medical savings account bill in 1994 which was vetoed by the Governor (Attachment 1). Health care debate was a major issue in deciding the recent election indicating that people want less government and want to make their own health care decisions. Passage of this bill would:

1. Give ALL Kansans the same tax break on health care coverage now enjoyed by those whose employers provide such coverage.

2. Encourage market-driven solutions to the escalating cost of health care.

3. Would allow participants to enjoy total portability of their health care plan.

MSA plans encourage families to buy a high deductible health insurance plan. The bill would allow individuals $2,000 and families $5,000 (pre-tax) to spend on medical care before the insurance plan would kick in. The bill does not allow families to take money out of the account at the end of the year unless they pay a 10% penalty and pay tax on the money. The reason for this is to encourage families to save this money for big or catastrophic illness. The amount of paper work doctor's offices are required to do will be decreased.

David Ross, Kansas Association of Life Underwriters, stated that medical savings accounts would introduce personal responsibility back into the health care arena and encourage people to save money when they are healthy to pay for medical care when they are not (Attachment 2). Deductibles can be increased as more money is accumulated in such accounts.

Mary Jane Stattelman, Assistant Director of the Public Affairs Division of Kansas Farm Bureau, expressed her company's support of the bill which would establish a fund that allows individuals to assist themselves and their dependents in setting aside pre-tax dollars in order to purchase medical, dental or other long-term health care plans (Attachments 3 and 4). She shared with the Committee a copy of the resolution in support of innovative health care plans which was adopted at their Annual Meeting.

Dr. Robert D. Durst, a practicing dermatologist in Topeka, said that the key element in the medical savings model is that it empowers the individual patient by setting aside a significant pool of money each year to pay medical bills during the year with any resultant under-spending returning to the patient (Attachment 5). He related his practice of telling patients where they can find prescriptions or services at the lowest rate. Those with health insurance are unconcerned with price as they have minimal out of pocket expense. Medical savings accounts makes the money the patient's money vs. health insurance which requires the person to be ill in order to receive the benefits of the money.

Bob Corkins, Director of Taxation of the Kansas Chamber of Commerce and Industry, reported that a survey showed that a substantial number of their membership support the medical savings account concept (Attachment 6). The bill would create no incentive for businesses to change their current employee health insurance benefits because:

1. The HB 2010 tax incentive would be claimed by the employee who sets up an MSA, not by the employer who may contribute to it.

2. Employers get a significant tax incentive under current federal and state law for paying employees health insurance premiums, but no additional incentive through HB 2010.

The bill represents state assistance to the self-employed, helping to reduce their after-tax premium costs where they get comparatively little assistance now. The cost of group health insurance appears to be the principle reason why employers do not offer a health insurance program. The bill would create a more responsible way of offering higher-deductible insurance coverage.

Chip Wheelen, Kansas Medical Society , presented written testimony only (Attachment 7).

Susie Katt of the Golden Rule Insurance Company in Indianapolis, Indiana, reviewed the success of their Medical Savings Accounts Plan which was implemented in 1993 (Attachment 8). The plan has a $3000 deductible with the company paying $2,000. The balance returned to the employee can be placed in an annuity or given directly in cash to the employee. The average refund was $1,002 per employee in 1994. There have been no rate increases for the employees or the company for 2 years. Employers in Kansas would have no tax advantage as they would not receive the same tax break as they do for carrying employee health insurance. The state of Indiana charges $2.00 per employee per year for the administration of the plan for more than 2,000 small businesses.

Another advantage for medical savings accounts is that it can add to retirement income or be used for long term care: when you leave the job, you can take the money with you. Medical savings accounts are not available to an individual if they are covered by another plan. Some doctors charge more for specific services if the patient is covered by insurance. A less costly service which works just as well may be provided for the patient if they do not have health insurance coverage. Some doctors charges are less for patients who pay cash because they do not have to do all the paperwork required by insurance.

A revised fiscal note for the bill will be requested from the Division of the Budget.

Representative Correll moved that the minutes of the February 7 meeting be approved. The motion was seconded by Representative Gilbert. Motion carried.

The meeting adjourned at 4:40 p.m. The next meeting is scheduled for February 16, 1995.

HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 15 February 1995

NAME	REPRESENTING
Allison Peterson	Kansas Medical Society
Joe Furjanic	KCA
Brad Smoot	BCBS
Bob Corkins	KCCI
Mary Jane Stattelman	KS Farm Bureau
Tom Wilden	Kansas Dept of Insurance
Bill Sneed	KIRA
Kimberly Phillips	State Farm
David Ross	K. Assn. Life Underwriters
Keith R Landis	Christian Science Comm on Publication for KS
Steve Stotts	KDOR
Billy Boyle	With Susan Wagle
Jim Schwartz	KS Employer Coalition on Health
Ray Menendez	KS Dept on Aging
Danny Ulmer	Overland Park Chamber
Michelle Petersen	Golden Rule Ins Co.
Cauiann E. Richey	Golden Rule Ins. Co
Suzanne Katt	Golden Rule Ins. Co.
Susan Wagle	

State of Kansas
House of Representatives

Susan Wagle

Speaker Pro Tem

TESTIMONY HB 2010

Mr. Chairman and members of the House Committee on Financial Institutions and Insurance. Thank you for scheduling this hearing and granting us the opportunity to address health care reform in the framework of the implementation of Medical Savings Accounts.

Last year this House and the Senate agreed that MSA legislation was a meaningful health care reform tool which would equalize the playing field, lower health care costs, empower individuals in decision making, and make health care more available to all Kansans. In the heat of the health care debate, with a single payer plan promoted by a legislatively established health care reform committee and with other bureaucratic solutions at our disposal, the House chose to pass MSA legislation -- only to have it vetoed by the Governor.

Now, after an election cycle and much study and analysis, the political experts and pollsters claim the health care debate was the major issue which decided the recent election. It was the debate that fueled our change in Federal elected officials as well as, I believe, the large turnover here in the Kansas House. I think the message from the electorate is clear. People want less government and they want to make their own health care decisions!

I believe one solution to the high cost of health care and its availability is the passage of legislation creating MSA's. (1) First, such passage would give ALL Kansans the same tax break on health care coverage now enjoyed by those whose employers provide such coverage. (2) Second, passage would encourage market-driven solutions to the escalating cost of health care. MSA legislation would restore the connection between rational individual choice and public purpose, rewarding wellness and frugality instead of waste. (3) Third, MSA participants would enjoy total portability of their health care plan.

We have experts here who have flown in to share with you their experience in utilizing MSA accounts in their businesses. They have brought with them invaluable testimony on the success of MSA's in other states. I feel they can better answer any technical questions you may have, so have kept my testimony short.

I have attached to this testimony an analysis of legislation passed in other states which you will want to analyze in your free time.

REPRESENTATIVE, 99TH DISTRICT
BUTLER/SEDGWICK COUNTIES
14 SANDALWOOD
WICHITA, KANSAS 67230

ROOM 330-N
STATE CAPITOL
TOPEKA, KS 66612-1504
(913) 291-3500

House FI&I
Attachment 1
2-15-95

Comparison of Enacted MSA Legislation

STATE	ARIZONA	COLORADO	IDAHO
Bill Number	SB 1175 (1994)	HB 1058 (1994)	SB 1548 (1994)
Effective Date	December 31, 1994	January 1, 1995	Tax years beginning after 1993
Additions to Gross Income	Amount withdrawn by the taxpayer during the taxable year from an individual MSA. §43-1021(17)	Any amount withdrawn from a MSA. §39-22-104(3)(f)	Amount withdrawn by taxpayer in tax year and interest earned in tax year of withdrawal. §63-3022(f).
Subtractions from Gross Income	(1) Amount of contributions made by employer, to extent that the contributions are included in federal adjusted gross income; (2) Amount deposited by taxpayer. §43-1022(22)	Any amount contributed to a MSA by an employer, to extent such amount is not claimed as a deduction on the taxpayer's federal tax return. §39- 22-104(4)(h)	(1) Amount of contributions on behalf of taxpayer to extent accepted by account administrator; (2) Interest earned on MSA to the extent included in adjusted gross income. §63-3022(s).
Who May Establish	Residents may establish individual MSAs. §43-1028(A) Employers may contribute to employee's MSA. §431028(B)	Employer may offer to establish MSAs or employee may establish on his own behalf. §39-22-504.7(1)&(2)	MSAs must be established through an employer. §41-5302(10).
Maximum Yearly Deposit	For 1995, $2,000 for account holder plus $1,000 for each dependent, up to a maximum of 2. Adjusted in future years by change in GDP price deflator. §43-1028(C).	$3,000. Future adjustments are not addressed. §39-22-504.7(2)(a)	$3,000 for 1994. Adjusted in future years by change in urban hospital component of CPI. §41-5302(10)(b).
Non-Medical Withdrawals	May withdraw on last business day of calendar year without penalty. Considered income. Withdrawals at any other time subject to 10% penalty. §43-1028(F).	May withdraw for any reason after the end of the year in which moneys were contributed. Subject to state income tax. §39-22-504.7(3)(b)(III)(B)	May withdraw on last business day of calendar year without penalty. Considered income. Withdrawals at any other time subject to 10% penalty, and interest earned during year considered income. §41-5305(1) & (2).
Eligible Medical Expense Definition	Expenses paid by or on behalf of an account holder for medical care described in 213(d) of IR code. §43-1028(I)(2)	Any medical expenses that is deductible for purposes of §213(d) of the IR code. §39-22-504.6(2.4)	Expenses paid by taxpayer for medical care that is described in 213(d) of IR Code. §41-5302(5).
Upon Death of Account Holder	Principal and accumulated interest distributed to estate. §43-1028(H).	Principal and accumulated interest distributed to estate. §39-22-504.7(6)(d)	Principal and accumulated interest distributed to estate. §41-5305(4).

Comparison of Enacted MSA Legislation

STATE	ILLINOIS	MICHIGAN	MISSISSIPPI	MISSOURI
Bill Number	HB 1066* (1994)	HB 4878, SB 926 (1994)	HB 647 (1994)	HB 564 (1993)
Effective Date	Tax years beginning after 1993	Tax years beginning after 1993	January 1, 1994	July 1, 1993
Additions to Gross Income	Amount withdrawn from an MSA in taxable year and the interest earned thereon. §203(a)(2) (D-5)	Not addressed.	Amount withdrawn from MSA for purposes other than paying eligible medical expenses or procuring health coverage. §27-7-15(4)(r).	Not addressed.
Subtractions from Gross Income	Amount contributed to an MSA in the taxable year, and any interest earned thereon. §203(a)(2)(S)&(T)	A taxpayer may credit against his state income tax an amount equal to 3.3% of the amount contributed in the tax year to an MSA. SB 926 §1	Amount deposited in a MSA, and any interest accrued thereon. §27-7-15(4)(r).	MSA deposits not subject to taxation while in account. Amount spent on medical expenses and interest accrued thereon are totally exempt from taxation. §18.1(3).
Who May Establish	MSAs must be established through an employer. §5.	Employer may establish MSAs, or a resident individual may establish for himself and his dependents. HB 4878 §3(1)	Employer may establish MSAs, or a resident individual may establish for himself and his dependents. §2(h), 3.	Must be established through an employer. §18.1(1)
Maximum Yearly Deposit	For 1994, $6,000 for 2 taxpayers filing a joint return if both have MSAs, or $3,000 in all other cases. Amount to be adjusted annually to reflect increases in the CPI. §5.	For 1994, $3,000. Amount to be adjusted annually to reflect increases in the general price level. HB 4878 §2(k)(i)(B).	For 1994, higher deductible means between $1250 and $2250 for individual coverage, and between $1750 and $3500 for family coverage. Adjusted in future years by medical cost component of CPI. §2(f).	Not addressed.
Non-Medical Withdrawals	May withdraw on last day of business year without penalty. Considered income. Withdrawals at any other time subject to 10% penalty, and interest earned during year is income. §20(a) & (b)	May withdraw on last business day without penalty. Withdrawals at any other time subject to 10% penalty, & amount must be deducted from the amount used to calculate the credit. HB 4878 §5(1) & (2); SB 926 §1	Funds in excess of higher deductible may be withdrawn for non-medical expenses. Considered income. §5.	Director of Dept. of Insurance to establish by rule a balance which, if exceeded, may be withdrawn by account holder. §18.1(2)
Eligible Medical Expense Definition	Expenses paid by taxpayer for medical care that is described in §213(d) of IR Code. §5.	Expenses paid by taxpayer for medical care that is described in §213(d) of IR Code. HB 4878 §2(f).	Expenses paid by taxpayer for medical care that is described in §213(d) of IR Code. §2(e).	Bona fide medical and health care expenses to be defined by regulation. §18.2.
Upon Death of Account Holder	Principal and accumulated interest distributed to estate. §20(d).	Principal and accumulated interest distributed to estate. HB 4878 §5(4).	Principal and accumulated interest distributed to estate, unless a beneficiary has been designated. §4(3)	Not addressed.

*Illinois HB 1066 has not been signed by the Governor.

Mr. Chairman and members of the committee,

I am David Ross representing the Kansas Association of Life Underwriters. I appear before you in support of HB2010, the Medical Savings Account Act.

Since the seventies, people have demanded that health insurance policies provide coverage for more risks and have less out-of-pocket expense for the policyholders. The insurers responded and provided greater coverage. This created a demand upon the medical community to provide the services and they responded with more doctors, new procedures, and new medicines. As a result, the cost for health care accelerated and premiums for health insurance increased accordingly taking more and more from household spendable incomes.

Medical savings accounts will not reduce the demand for health services and will not reduce the resulting costs. They will introduce personal responsibility back into the health care arena and encourage people to save money when they are healthy to pay for medical care when they are not. As people accumulate money in their medical savings accounts, they can increase their deductibles for health insurance policies and correspondingly reduce their premiums to the extent they are insuring for catastrophic losses only.

The benefit from medical savings accounts is not limited to select economic groups. Deductibles for policies range from $100, $250, $500, etc. Each level provides a reduction in premium that can be spent for other obligations or fed into the account to further reduce premium cost.

I urge your support for HB2010

House F.D.A.
Attachment 2
2-15-95

Rural Health Care **PHW-4**

Access to high quality and affordable health care is essential to all Kansans. Access and affordability will not be achieved by mandating employers to pay health insurance costs for employees, nor by enacting a single-payer, government-based health care plan.

Health care is primarily the responsibility of the individual. Health care policy changes should endorse the following principles:

1. Promotion of personal wellness, fitness and preventive care as basic health goals;
2. Minimal government intervention in decisions between providers and receivers of health care; and
3. Tax policies that encourage individuals to prepare for future health care needs.

We support the following measures which will assist in preserving this vital service to rural Kansas:

1. Encouraging students to enter the health care professions, serve residencies in rural areas, and establish and maintain practice in rural areas. Providers in urban areas should be encouraged and given incentives to participate in respite, locum tenens and sabbatical programs for rural physicians;
2. State scholarship programs for all health care professionals, requiring scholarship recipient graduates to provide service in underserved areas. Create a strong disincentive for any scholarship recipient "buying out" of that required service;
3. Expedite visas for foreign doctors who are qualified, willing to work in rural areas, and sponsored by a rural hospital or clinic;
4. Programs which implement joint use and cooperation between and among health care facilities, school districts, municipal and county governments to enhance health education, preventive health care, and efficiency of health care delivery;
5. Establish innovative managed care programs through incentives for government, providers and private insurers where medical services are offered through a network of physicians and hospitals at discounted costs; and
6. Authorization and support by the Kansas Board of Regents for Kansas State University/University of Kansas School of Medicine (Kansas City and Wichita) for the joint effort underway to develop the Rural Health Dynamics Program.

In order to provide affordable health insurance coverage to all Kansans, we encourage consideration of the concept of "community based health insurance rates." If the insurance industry continues to use a review of health care utilization as a method of establishing rate increases in Kansas it should use a running average to establish rates.

We believe the financial stability of some hospitals is being threatened by the increasing number of non-paying patients. We will support the following:

1. Amend state law to allow hospitals greater access to small claims courts so they may collect more debts from those who can pay;
2. Establish a statewide risk pool for those who cannot access health insurance due to pre-existing conditions; and
3. Change the health care coverage rules to make preventive care as well as emergency care available to the medically needy.

Denial of claims for pre-existing conditions, once an individual has been covered by insurance, changes jobs, or has filed a claim for such condition, should be prohibited.

For many of our elderly, nursing home care will be a necessity. For others, remaining in their own homes will be far preferable. We believe health care programs for senior citizens in Kansas should maximize the independence of the elderly for as long as possible. Development of local Home Health Care organizations would assist both affordability and availability of health care. The Kansas Legislature should provide more flexibility in the allocation of per diem rates for nursing staff.

House F&L
Attachment 3
2-15-95

PUBLIC POLICY STATEMENT

HOUSE FINANCIAL INSTITUTIONS AND INSURANCE

RE: H.B. 2010 - Medical Savings Accounts

February 15, 1995
Topeka, Kansas

Presented by:
Mary Jane Stattelman, Assistant Director
Public Affairs Division
Kansas Farm Bureau

Good morning! My name is Mary Jane Stattelman and I am representing Kansas Farm Bureau in support of H.B. 2010.

Kansas Farm Bureau has long supported the concept of establishing a fund that allows individuals to assist themselves and their dependents in setting aside pre-tax dollars so as to purchase medical, dental or other long-term healthcare plans. Our members recently, at our Annual Meeting, reiterated this belief in passing the attached resolution. (See PHW-4)

Medical Savings Accounts can allow employees to seek medical care without the fear of facing out-of-pocket deductibles or they can buy services not covered by their employer's plan. We believe that it is wise to give as much encouragement to self-insurance through Medical Savings Accounts as it gives to third party insurance.

Insur FI&I
Attachment 4
2-15-95

The Medical Savings Account concept is an integral part of most of the major healthcare reform proposals. Because of this fact we commend the Committee for trying to better assist Kansans in managing their healthcare.

Thank you for giving me the opportunity to testify in support of H.B. 2010. I would be glad to answer any questions you may have.

Dermatology, P.A.
ROBERT D. DURST, JR., M.D.
1706 S.W. 10TH STREET
TOPEKA, KANSAS 66604
TELEPHONE 357-5166

February 15, 1995

The Honorable William Bryant
Chairperson
House Committee on Financial Institutions
and Insurance
Kansas Legislature
State House
Topeka, KS 66612

Dear Rep. Bryant and Members of the Committee:

Please empower the people of Kansas by approving HB2010 to allow medical savings accounts.

Of every health care dollar spent in this country, 76 cents are paid by someone other than the actual patient, i.e. by government, by insurers, or by employers. Consequently, in most situations many patients benefit minimally when they spend wisely. It is no surprise that costs are soaring.

The key element of the medical savings model is that it empowers the individual patient by setting aside a significant pool of money each year to pay medical bills during the year with any resultant under-spending returning to the patient. The money remaining at the end of the year may be taken as a cash bonus, after the required taxes are paid or rolled over into deferred saving accounts to be used for future medical expenses or retirement purposes.

The advantages of the medical saving account (MSA) model are: 1) the dollars spent by the patient are the patient's dollars and they become real dollars to the patient which are spent more prudently; and 2) most families receive money back at the end of the year; 3) people are financially encouraged to pursue a more healthy life style; and 4) most families again have first dollar coverage for their medical expenses.

Most years most patients with MSA will have first dollar coverage for their medical bills; however, for those years when the set aside is not sufficient there needs to be a means to carry over the excess funds from one year to another year without tax penalty to cover those years when medical expenses are higher. This can be done in Kansas with HB2010 enacting medical saving account legislation.

House FI&I
Attachment 5 2/15/95

expenses are approximately 20% of the total health care expenses) In dermatology most of that outside expenses goes for prescriptions. Nationally for every dollar spent in a dermatologist office, three dollars are spent in the pharmacy. Twenty years ago when I came to Topeka, I knew that many patients struggled to pay for the prescriptions necessary to treat many of the diseases I was trained to treat. I knew that the hospital price for many drugs was far less than what my patients had to pay. My philosophy was that if my patients could afford the medication to get well, I would gain a good reputation for curing patients. Over twenty years time this has worked.

Within one year I was able to help several pharmacies negotiate with the drug companies a price so the local pharmacies could make a profit at selling my most commonly prescribed medications at a fraction of cost they sold for previously. For years I have had the satisfaction of writing prescriptions that I estimate probably saved over a million dollars for my patients during the past twenty years.

More and more, as I hand one of these prescriptions to a patient and tell them they can have it filled anywhere,(.... however, the least expensive places will be...), they tell me that they have insurance that covers prescriptions for a small co-pay. They go where it is the most convenient because they don't care whether it costs $10 per jar or $40 per jar (real numbers!!) because they have insurance. Believe it or not about two thirds of my patients seem to feel this way. More recently my patients hand my prescription back to me and ask me to double or triple the quantity since with their insurance it "won't cost them any more".

Several years ago my wife was having stomach problems and a drug was prescribed. A half month's supply was nearly one hundred dollars which we purchased. Later that month she was talking to her father, ordinarily a financially conservative man. Her father said he had stomach problems the year before. He thought he had taken the same medicine and might have some left. Fortunately he has an insurance plan through his employer with good medical benefits; however they do have to send off for any medications they need to take on a continuing basis "to save money". When he checked his medicine cabinet he had nearly five hundred dollars of the stomach medicine. He was surprised he had so much, didn't realize it was that expensive, but always kept enough medicine on hand in case the prescriptions he had to mail "to save money" were delayed.

Last year, a new drug for psoriasis was introduced which was quite different than anything else we have used, with what appears to be significantly less side effects. After writing a few prescriptions, I called a pharmacist friend and asked what was the price of this new drug. He said a 100 gram tube (approximately 3 ounces or about half the size of an average toothpaste tube) was $120 wholesale. My mouth fell open, and I

gasped "who can afford a $150 dollar tube cream". He reminded me that many of my patients had insurance that covered prescriptions.

Think about how carefully two patients would apply the new psoriasis cream in order to maximize its effectiveness. One patient knows that every dollar he saves is a dollar being returned to him at the end of the year. Another patient applies this cream whose insurance "covers all he needs". It is not hard to see which system is the most economical.

Personally, I know I am more prudent writing prescriptions, ordering tests and performing procedures when I know the patient has to pay out of pocket. I have worked in various cost containment programs over the past twenty-five years and although I follow the rules, I know I don't work as hard for these large organizations as I do the individual patient. If my patients were charged with spending their own money in my office this would save hundreds of dollars a day, thousands in Topeka, millions a day nationally and billions for our country annually.

Medical saving accounts (MSA) work. The MSA concept has worked for the Golden Rule Insurance Company, Dominion Resources and Quaker Oats Company and will work for Kansans. MSA empowers the patient to control their own health care dollars and rewards them by saving health care dollars. Under the present system of health care coverage you only get your money's worth when you spend health care dollars. MSA rewards you for saving those dollars.

I urge you to pass HB2010 to establish Medical Saving Accounts for Kansas.

Sincerely,

Robert D. Durst, Jr. M.D.

Robert D. Durst, Jr., M.D.

"Giving people choices in health care and instilling cost-consciousness is plain old common sense. In Medical Savings Accounts, authors Goodman and Musgrave have hit upon a bold concept that may revolutionize the way health care is delivered throughout America."

—Sen. Phil Gramm

Our present health care system is suffering from runaway prices and spending. For the past three decades, health care spending has been growing more than twice as fast as the overall economy; as a percentage of gross national product, it has risen from 6 percent in 1965 to 14 percent today. Meanwhile, the system is plagued not only by overspending, but also by underinclusion: at any given time about 35 million Americans do not have health insurance. That combination of ills appears to pose an intractable problem: any move to extend health insurance in its current form to those without coverage will only fuel demand for health care and push spending up even further.

Fortunately, there is a solution to the predicament. The key is recognizing exactly what is driving spending through the roof. While many conditions have contributed to the spending explosion, one stands out as *the* fundamental problem with the U.S. health care system today: the consumer, the patient, has been cut out of the decisionmaking loop. Of every health care dollar spent in this country, 76 cents are paid by someone other than the actual patient—by the government, insurers, or employers. Consequently, in most situations patients neither benefit when they spend wisely nor bear the consequences of spending foolishly. With those incentives, it's no surprise that costs are soaring.

To reform the system we need to change the incentives. We need policies that will allow people to choose whether and how to *spend their own money* on health care needs. That is the idea behind the free-market approach to health care reform, which we call the Patient Power plan. The plan is explained in detail in *Patient Power: Solving America's Health Care Crisis* (Cato Institute,

1992) by John C. Goodman, president of the National Center for Policy Analysis, and Gerald L. Musgrave, president of Economics America, Inc.

Under the Patient Power plan, people would be able to switch from their current low-deductible health insurance policies to high-deductible catastrophic policies and put the premium savings in tax-free Medical Savings Accounts (MSAs). Those accounts would be used to pay ordinary and routine medical expenses, and catastrophic insurance would still be available to cover any major expenses. Whatever money was left in MSAs at the end of the year would remain there and continue to earn interest—you would get to keep what you didn't spend.

The Patient Power plan would give people a direct financial incentive to spend prudently on health care, because they would be spending their own money. Furthermore, Patient Power would extend the same tax advantages to all Americans, unlike the current system that discriminates against the unemployed, the self-employed, and employees of small businesses that don't offer health insurance. Ensuring tax fairness would go a long way toward making

To reform the system we need to change the incentives. We need policies that will allow people to choose whether and how to spend their own money on health care needs.

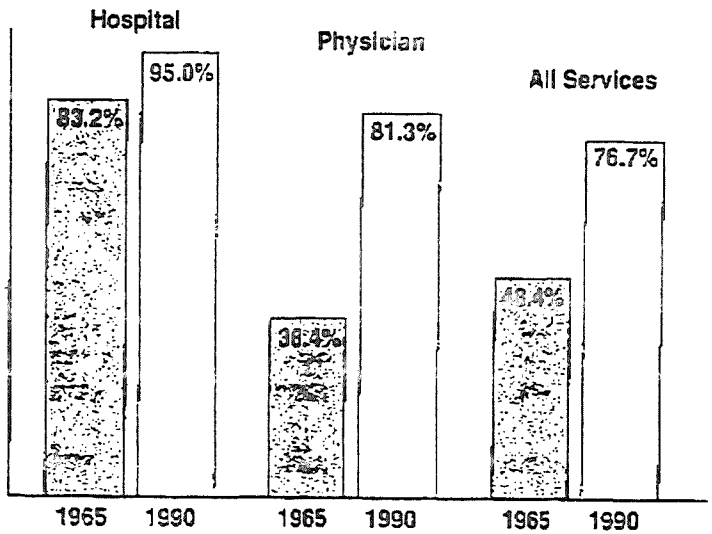
health care affordable for people who are now without health insurance.

The Patient Power plan is explicitly voluntary: it is not designed to compel universal coverage under some one-size-fits-all arrangement. The most basic element of a truly competitive health care system is to allow people the freedom of opting out of it—true patient power begins with that fundamental freedom of choice. Accordingly, the Patient Power plan strives to expand options, not foreclose them—to let people make up their own minds about what works best for them.

The Rise of Third-Party Payment

Before 1965 spending on health care was restrained by the fact that most payments were made out-of-pocket by patients. Since then Medicare and

Figure 1
Percentage of Personal Health Expenses Paid by Third Parties, 1965 and 1990



Source: *Patient Power.*

Medicaid have expanded government third-party insurance to more and more services for the elderly and the poor, and private health insurance has expanded for the working population. As Figure 1 shows, 95 percent of the money Americans now spend on hospitals is someone else's money at the time it is spent. Some 81 percent of all physicians' payments are now made with other people's money, as are 76 percent of all medical payments for all purposes.

Third-party payment is now so dominant that the term health insurance has become a misnomer. True insurance is supposed to protect people against losses from rare high-cost events. Today's health insurance, however, covers all kinds of routine expenses that are entirely under the patient's control; such coverage is less insurance than prepayment of medical services. Auto insurance doesn't cover fill-ups and oil changes, but today's health insurance covers the equivalent.

As a result of the dramatic rise of third-party payment, the consumers of health care, the patients, no longer have much incentive to spend money wisely. When people pay only five cents on the dollar for hospitalization, they are

unlikely to be very prudent consumers, and hospitals are under little pressure to offer good deals. Elementary economics teaches that as prices go down, demand increases, and the recent history of the U.S. health care system confirms that basic truth. Because of third-party payment, health care has become nearly free at the point of sale, triggering an explosion in spending.

Putting Patients Back in Control

The health care reform proposals favored by the Clinton administration do nothing to address the third-party payment problem that is the root of the health care crisis. In fact, the administration's plan for "managed competition" would worsen the problem by creating a new third-party payment system that would be universal in coverage. To try to keep costs down, managed competition would impose onerous new bureaucratic controls and limitations on patients' choices.

Not only would managed competition fail to control costs, it would also pose a serious threat to the continued quality of American medical care.

In Britain kidney dialysis is generally denied to patients older than 55, causing at least 1,500 people to die every year for lack of dialysis.

Managed competition means greater bureaucratic rationing of health care—whether openly through price controls and expenditure limits (so-called global budgets) or less obviously through increased third-party control over what services are paid for. But whatever form it takes, bureaucratic rationing means lower quality care. Just look at what has happened in countries where government controls the health care purse strings. In Britain kidney dialysis is generally denied to patients older than 55, causing at least 1,500 people to die every year for lack of dialysis. In Sweden the wait for heart x-rays is more than 11 months. And surgeons in Canada report that, for patients in need of heart surgery, the danger of dying on the waiting list now exceeds the danger of dying on the operating table.

The Patient Power plan rejects the bureaucratic approach of managed competition. Combatting artificially stimulated demand with top-down

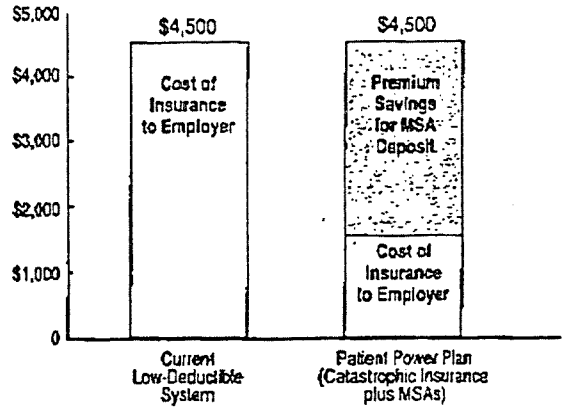
bureaucratic interference is a multiplication of mistakes. The result is higher costs *and* lower quality care. What we need instead is a system that controls demand at the source: the individual patient. The way to get individual patients to control demand is to give them a financial incentive to do so.

Supplying that financial incentive is what the Patient Power proposal for Medical Savings Accounts is all about. Under the Patient Power plan, people would be able to deposit up to a certain amount of money every year in tax-free MSAs. Most people would fund their accounts by switching from their current low-deductible health insurance policies to high-deductible catastrophic policies and depositing the premium savings. They would then be able to draw down their account balances to pay ordinary, routine medical expenses, such as doctor's office visits, prescription drugs, diagnostic tests, and minor procedures. Catastrophic insurance would still cover the big-ticket items.

Whatever money you didn't spend during the year would remain in your MSA to build up tax-free interest over time. Most people would be able to accumulate substantial savings over their working lives, which they could use upon retirement for whatever medical or nonmedical purpose they chose.

Patient Power is thus diametrically opposed to the Clinton administration's managed-competition approach. Managed competition seeks to reform the health care system by adding new layers of bureaucratic control

Figure 2
Typical Health Insurance Costs in a City with Average Cost of Living



Source: Golden Rule Insurance Company.

and further restricting consumer choice. Patient Power does just the opposite: it seeks to strip away third-party-payment bureaucracy and expand consumer choice. That is why we call this proposal Patient Power: the goal is to empower patients, not bureaucrats.

How Medical Savings Accounts Would Work

Figure 2 gives an indication of how Patient Power would operate in practice. In a city that has an average cost of living—say Cincinnati or Denver—employers pay roughly $4,500 a year to provide an employee and his family with health insurance coverage. The policy has a low deductible, typically from $100 to $250. By contrast, the premium for a catastrophic policy with a $3,000 deductible is only about $1,500 a year. Under the Patient Power plan, an employer could provide a catastrophic policy and then put the $3,000 in premium savings in the employee's MSA. The employer is out $4,500 either way; it makes no difference to him how the money is split up. But for the employee, the advantages of the switch are enormous: he actually gets more money in cash (tax-free, interest-bearing cash) than he loses in reduced insurance coverage—even during the first year. Over time unused savings continue to build up with tax-free compound interest.

The vast majority of Americans would greatly benefit from the combination of less expensive high-deductible policies and Medical Savings Accounts. In any given year most Americans have no or very small med-

The vast majority of Americans would greatly benefit from the combination of less expensive high-deductible policies and Medical Savings Accounts.

ical expenses, and 94 percent have medical expenses under $3,000. Under such a system, your maximum personal exposure every year is capped by your catastrophic policy; meanwhile, your savings to meet that possible exposure keep accumulating every year with interest. In other words, the deck is stacked in favor of your coming out ahead.

Medical Savings Accounts would be of particular help to employees

and their families when money was tight. Even today's low deductibles, particularly when combined with copayments, can create true hardship for those struggling to make ends meet. With an MSA, money would be available to pay the *first dollar of medical costs*—no deductibles, no copayments. In addition, people who were between jobs could use their MSAs to buy insurance coverage. About half the people who are uninsured remain that

Under current law, employers spend pre-tax dollars on health care; everyone else is forced to spend (for the most part) post-tax dollars.

way for four months or less; typically, they are between jobs that provide them with health insurance benefits. The accumulated savings in Medical Savings Accounts would be available to tide people over during such times.

Establishing Tax Fairness

If Medical Savings Accounts are as great as they sound, why haven't employers made them available already? Why don't employers offer high-deductible policies and cash bonuses as an alternative to conventional low-deductible insurance?

The reason such arrangements are currently unattractive is that under existing tax laws, only the *employer's* spending on health care is fully tax-deductible. Today, all the money an employer spends on health insurance for employees is tax-deductible; furthermore, none of it is included in the employee's taxable income. By contrast, self-employed people can deduct, at best, only 25 percent of their health insurance expenses—and even that limited deduction is not a permanent part of the law; it is on-again, off-again from year to year depending on whether Congress reauthorizes it. And the unemployed and employees of small businesses that don't offer health insurance get no deduction at all when they try to purchase insurance on their own.

Thus, under current law, employers spend pre-tax dollars on health care; everyone else is forced to spend (for the most part) post-tax dollars. The tax bias in favor of employer-provided health insurance is considerable. As Table 1 indicates, a dollar of pre-tax health insurance benefits can be worth almost two dollars of taxable salary. Accordingly, once filtered through the various tax

collectors, the premium savings from switching to a high-deductible policy would shrink as much as 50 percent if they were given as cash to employees. And if employees tried to establish their own make-do Medical Savings Accounts with that post-tax money, they would also have to pay taxes on the interest they earned. It is little wonder that employers and employees opt for the tax-favored benefit over the tax-discouraged one.

It should be noted that under the current system, some people covered by employer-provided insurance are able to earmark money to go into so-called flexible savings accounts, from which they can pay health expenses with pre-tax dollars. The problem with flexible spending accounts is that at the end of the year, any unspent money reverts to the employer. That "use it or lose it" approach obviously encourages wasteful spending—the opposite of what Medical Savings Accounts would do.

The bias in the tax system not only discourages self-insurance through medical savings, it also renders conventional health insurance unaffordable for many Americans. The self-employed, the unemployed, and employees of many small businesses must pay post-tax dollars for their health insurance, and not surprisingly they rarely do. About 90 percent of Americans who have private health insurance get it through their employers. Those not lucky enough to qualify for tax advantages through their employers must fend for themselves, and their numbers swell the ranks of the 35 million uninsured.

The present indefensible system came about, strangely enough, because of wage and price controls during World War II. Businesses tried to get around

Table 1
Relative Value of a Dollar of Employer-Provided Health Insurance Benefits

Federal Tax Category[1]	Value with No State and Local Income Tax	Value with State and Local Income Tax
FICA tax only	$1.18	$1.24[2]
FICA tax plus 15 percent income tax	$1.43	$1.57[2]
FICA tax plus 28 percent income tax	$1.76	$1.97[3]

Source: *Patient Power.*

[1] Includes employer's share of FICA taxes.

[2] State and local income tax rate equals 4 percent.

[3] State and local income tax rate equals 6 percent.

wage freezes by offering health insurance benefits to their employees. The Internal Revenue Service went along, granting them a tax deduction and excluding the fringe benefit from employees' income. The law of unintended consequences frequently haunts governmental intervention, and here is a textbook case. Thanks to wartime emergency measures taken 50 years ago, we now have a health insurance system in double crisis, plagued by both explosive overspending and underinclusiveness caused by discriminatory tax rules.

Because of wartime emergency measures 50 years ago, we now have a health insurance system in double crisis, plagued by both explosive overspending and discriminatory underinclusiveness.

What we must do, and what the Patient Power plan proposes, is to end the current discriminatory tax treatment of health care spending and establish tax fairness for all Americans. That goal could be accomplished in one of two ways. Individuals not covered by employer-provided insurance could be granted the same tax deduction that employers are allowed to take. Or, alternatively, employer-provided health insurance could be included in the taxable income of employees, and then all Americans could be granted individual tax credits for health care expenses.

Whatever form the tax incentive takes, it should be structured to allow a direct tradeoff between lower deductible third-party health insurance and self-insurance through depositing money in a Medical Savings Account. For example, the deduction or credit could be tied to the average cost of a low-deductible policy. The higher the deductibles of the policies people chose, the lower their premiums would be, and thus the more money (up to a certain limit, say $3,000 a year) they could deposit in tax-free MSAs. Such an arrangement would allow individuals to choose the mix they preferred of third-party insurance and personal savings.

Cost Savings through Patient Power

The Patient Power plan of Medical Savings Accounts and tax fairness would revolutionize the incentives operating in the health care sector.

Roughly two-thirds of all health-insurance-claim dollars in this country fall in the under-$3,000-per-year category. Under the Patient Power plan, people would be spending *their own money* in this dominant sector of the health care market.

Because they could keep what they did not spend, people would have an incentive to spend wisely for health care. A RAND Corporation study found that people enjoying free health care spend about 50 percent more than those who pay 95 percent of their bills out-of-pocket (up to a $1,000 maximum). Furthermore, people with free care are 25 percent more likely to see a doctor and 33 percent more likely to enter a hospital. All that extra spending of other people's money, though, doesn't necessarily buy better results: the RAND study found no apparent differences in most health outcomes for the two groups.

It is important to realize that given the current state of medical

With people spending their own money on health care, doctors, hospitals and other service providers would be forced to compete on price, quality, and convenience to attract patients.

technology, the amounts we could spend on health care are potentially limitless. We could probably spend half our gross national product on diagnostic tests alone. There are currently some 900 different blood tests that can be performed. Why not make all 900 part of an annual checkup? And consider what would happen if every person who chooses to medicate himself with nonprescription drugs decided instead to go to the doctor. To handle the explosion in demand, we would need 25 times the current number of primary care physicians.

Given that the demand for medical services is potentially infinite, health care spending must be limited one way or another. And normally, he who pays the piper gets to call the tune. Thus, under the current system, health care is increasingly rationed by the third-party payers—insurance companies and government bureaucrats. Their control over who gets what—up to and including who lives and who dies—would increase dramatically under managed competition. Patient Power offers the only

viable alternative to bureaucratic rationing: individual choice, with people making their own personal tradeoffs between medical services and other needs.

With people spending their own money on health care, doctors, hospitals, and other service providers would be forced to compete on price, quality, and convenience to attract patients. Currently, such competition is stifled because, by and large, patients are not the real paying customers—government and insurers are. Accordingly, the "prices" on medical bills are not really market prices at all; they are simply a means of passing along costs to third-party payers. And information on quality—for example, mortality rates at hospitals—is not normally made available to patients.

By contrast, competition has been vigorous in those exceptional areas of the health care sector where third-party payment does not dominate. Consider cosmetic surgery, which is not covered by any private or public insurance policy. Patients pay with their own money, and they are treated accordingly. They are generally quoted a fixed price in advance, covering both medical services and hospital charges. They are given choices about the level of service (for example, surgery performed at the doctor's office or, for a higher price, on an outpatient basis at a hospital). For another example, consider America's $12-billion eye care industry, in which costs have been holding steady or even falling in recent years. The simple reason: unregulated price competition.

By eliminating the third-party paper shuffling from small-dollar-amount expenditures, Patient Power would dramatically reduce administrative costs. Such costs today are unusually high (the cost of marketing and administering private health insurance runs between 11 and 12 percent of premiums) because of the enormous number of small claims that unnecessarily clog the present system. The cost of processing many small claims actually exceeds the amount of the claims. By converting to high-deductible policies and letting people pay routine expenses directly out of their Medical Savings Accounts, all that excessive paperwork would be eliminated.

Enormous cost savings could be achieved if the combination of catastrophic insurance and Medical Savings Accounts were extended universally (including replacing Medicare and Medicaid). Total administrative savings are estimated (based on 1990 figures) to be as high as $33 billion a year; in addition, more prudent spending by patients would produce savings of up to an estimated $147 billion a year. After factoring in extra costs of $12

billion a year due to instituting tax fairness, net total cost savings come to $168 billion—or nearly one-fourth of total annual health care spending in this country. And that rough estimate doesn't even include the savings gained from lower prices that would surely be a major benefit of the new competitive health care marketplace that Patient Power would help bring about.

Conclusion

The Patient Power plan to reform health insurance has three main elements:

1. allow people to make deposits in tax-free Medical Savings Accounts to finance their routine medical expenses;
2. allow people currently receiving employer-provided insurance to fund their Medical Savings Accounts by switching from low-deductible policies to high-deductible catastrophic policies with much lower premiums; and
3. allow all Americans, regardless of whether they receive employer-provided insurance, to claim tax benefits (whether in the form of deductions or credits) for purchasing catastrophic health insurance and making deposits in Medical Savings Accounts.

Notice the key word repeated in all three elements of the Patient Power plan: *allow*. The plan is voluntary: it does not force anyone to do anything. The purpose of Patient Power is to expand people's choices, not narrow them—to enable people to make their own decisions about tradeoffs between health care and other needs, not to create yet another bureaucracy to make those decisions for us.

Only by empowering patients can we tap the power of market incentives to transform our bloated, bureaucratized health care system. So-called reform packages based on further restricting patient choice move in precisely the wrong direction; not only would they be unable to control costs effectively, but they would also imperil the high quality of medical care that Americans currently enjoy. Managed competition is not the answer. Real competition is. The Patient Power plan, by enabling people to spend their own money on medical needs, would inject a whopping dose of real competition into our ailing health care system.

Twenty 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 individual retirement accounts (IRAs) are.

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

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

3. What would prevent fraud and abuse?

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. If IRS auditors discovered fraudulent behavior, the provider would lose the right to receive MSA funds and would be subject to criminal penalties.

4. What types of services could be purchased with MSA funds?

Any type of expense considered a medical expense under current IRS rules would qualify. In general, the IRS has been fairly broad in its interpretation of what constitutes a medical expense. An unhealthy step in the wrong direction, however, was the IRS decision to disallow cosmetic surgery. There is no apparent reason why the removal of a disfiguring scar or a change in facial appearance that improves employability and self-esteem is any less important than an orthopedic operation that allows an individual to play a better game of tennis or polo.

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, Social Security taxes, and state and local income taxes. If the opportunity to receive a tax deduction or a tax

credit for the purchase of health insurance were extended to individuals, their deposits to Medical Savings Accounts would receive the same tax treatment. MSA balances would grow tax-free and would never be taxed if the funds were used to pay for medical care or purchase long-term care or insurance to cover long-term care.

6. 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 enable individuals to divide their normal health insurance costs into two parts: self-insurance and third-party insurance. Currently, little or no tax advantage is available for people who purchase health insurance on their own. Health insurance would become more affordable for the currently uninsured if they could deduct the premiums from their taxable income. A system of refundable tax credits, which would grant greater tax relief to low-income people, would make insurance even more affordable.

7. How could individuals build up funds in their MSA accounts?

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

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

One solution would be to establish lines of credit (either with employers or with the financial firms that managed MSAs) 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 permit family members to share their MSA funds. This concern would vanish as MSA balances grew over time.

9. How would members of the same family manage their MSA accounts?

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

10. What about people who are already sick and have large medical obligations at the time the plan is started?

Such people might be harmed by a sudden increase in the health insurance deductible unless transitional arrangements were made. Most would benefit from a high deductible in the long run, but they might suffer financially at the outset. One solution is the use of credit lines that can be repaid from future MSA contributions.

11. What about people who have a catastrophic illness with large annual medical bills likely to last indefinitely into the future?

Most of those people would be disadvantaged if they had an annual deductible. A better form of health insurance would be one with a per-condition deductible, which would be paid only once for an extended illness.

12. Are there circumstances under which individuals could withdraw MSA funds for nonmedical expenses before retirement?

A reasonable policy is to apply the same rules that now apply to tax-deferred savings plans (for example, IRAs and 401(k) plans). Thus, withdrawals for nonmedical purposes would be fully taxed and would face an additional 10 percent tax penalty.

13. How do we know people would not forgo needed medical care (including preventive care) in order to conserve their MSA funds?

We don't. The theory behind Medical Savings Accounts is that people should have a store of personal funds with which to purchase medical care. And because the money they spend would be their own, they would have strong incentives to make prudent decisions. Undoubtedly, some of their decisions would be wrong. But many decisions made under the current system are also wrong. Under the new system people would at least have funds

Ten Advantages of Medical Savings Accounts

1. The cost of health insurance would be lower.

MSAs would allow people to substitute less costly self-insurance for more costly third-party insurance for small medical bills. To the degree they were self-insured, people would no longer face premium increases caused by the wasteful consumption decisions of others. And to the extent that third-party insurance was reserved for truly risky, catastrophic events, the cost per dollar of coverage would be much lower than it is today.

2. The administrative costs of health care would be lower.

Because we rely on third parties to pay a large part of almost every medical bill, unnecessary and burdensome paperwork is created for doctors, hospital administrators, and insurers. By one estimate, as much as $33 billion a year in administrative costs could be saved by the general use of Medical Savings Accounts.

3. The cost of health care would be lower.

Medical Savings Accounts would institute the only cost-control program that has ever worked: patients' avoiding waste because they have a financial incentive to do so. When people spent money from their MSAs, they would be spending their own money, not someone else's—an excellent incentive to buy prudently. By one estimate, the general use of Medical Savings Accounts would reduce total health care spending by almost one-fourth.

4. Financial barriers to purchasing health care would be removed.

Under the current system, employers are responding to rising costs of health insurance by increasing employee deductibles and copayments. Market prices are also encouraging people who buy their own health insurance to opt for high deductibles and copayments. One problem with that trend is that people with low incomes who live from paycheck to paycheck may forgo medical care because they cannot pay their share of the bill. Medical Savings Accounts would ensure that funds were available when people needed them.

5. Financial barriers to purchasing health insurance during periods of unemployment would be removed.

Under current law, people who leave an employer who provided their

health insurance are entitled to pay the premiums and extend their coverage for 18 months. Yet, the unemployed are the people least likely to be able to afford those premiums. Medical Savings Accounts would solve that problem by providing funds that were separate from those available for ordinary living expenses. MSA funds might also be used to purchase between-school-and-work policies or between-job policies of the types already marketed.

6. The doctor-patient relationship would be restored.

Medical Savings Accounts would give individuals direct control over their health care dollars, thereby freeing them from the arbitrary, bureaucratic constraints often imposed by third-party insurers. Physicians would view patients rather than third-party payers as the principal buyers of health care services and would be more likely to act as agents for their patients rather than for an institutional bureaucracy.

7. We would enjoy the advantages of a competitive medical marketplace.

Patients who enter hospitals can neither obtain a price in advance nor understand the charges afterward. Those problems have been created by our system of third-party payment and are not natural phenomena of the marketplace. When patients pay with their own money (as is the case for cosmetic surgery in the United States and most routine surgery at private hospitals in Britain), they usually get a package price in advance and can engage in comparison shopping.

8. We would enjoy the advantages of real health insurance.

Because health insurance today is largely prepayment for consumption of medical care, people with preexisting health problems often cannot buy insurance to cover other health risks. Medical Savings Accounts would encourage a market for genuine catastrophic health insurance and would make such insurance available to more people.

9. Incentives for better choices of lifestyle would be created.

Because MSAs would last people's entire lives, they would allow individuals to engage in lifetime planning and act on the knowledge that health and medical expenses are related to their choices about lifestyle. People would bear more of the costs of their bad decisions and reap more of the

on hand with which to pay their share of medical bills. And, since people would have an incentive to protect future account balances to cover future medical costs, some would certainly spend more on preventive health care. Because we cannot spend our entire GNP on health, health care has to be limited in some way. The only alternative to government rationing, with decisions made by a health care bureaucracy, is individual choice, with people making their own tradeoffs between medical services and other needs.

14. Given the increasing complexity of medical science, how could individuals possibly make wise decisions when spending their MSA funds?

One thing people can do is solicit advice from others who 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 will be performed. Those experienced professionals could play an important role in helping patients make decisions about complicated and expensive procedures. Also, telephone advisory services, which are springing up around the country, could well become an important source of expert information in the coming years. In any event, we should let the experts advise and the patient decide.

15. Given the problems that major employers and insurance companies have in negotiating with hospitals, how could individual patients possibly do better?

The reason large institutions have so much difficulty negotiating with hospitals is that institutions are not patients. And the reason patients who spent their own money would wield effective power is the same reason consumers wield power in every market—they can take their money and go elsewhere. Physicians, hospitals, and other health care providers would have considerable incentive to win their business. Moreover, Medical Savings Accounts would not preclude individuals from using employers as bargaining agents.

16. 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. Thus, money not spent on medical care could be used,

after taxes, to purchase other goods and services, including post-retirement health care and insurance coverage for long-term care.

17. 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" would be an annual MSA deposit that would equal the deductible for a standard catastrophic health insurance policy.

18. What about members of HMOs?

They would have the same opportunities as people covered by conventional, fee-for-service health insurance plans. Note that because many HMOs are now instituting copayments, HMO members would have incentives to acquire Medical Savings Accounts. Their HMO premiums plus their MSA deposits could not exceed a reasonable amount, however.

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

Permitting employees to make individual choices makes sense. Over time, different people would have different accumulations in their MSAs and, quite likely, different preferences about health insurance deductibles. Accordingly, employers would have an incentive to provide a range of benefit plans to suit different employee needs.

20. What would happen to flexible spending accounts now available to some employees?

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

benefits of their good ones. Those who didn't smoke, ate and drank in moderation, refrained from drug use, and otherwise engaged in safe conduct would realize greater financial rewards for their behavior.

10. Health insurance options during retirement would be expanded.

Most Medical Savings Accounts would eventually become an important source of funds with which to purchase health insurance or make direct payments for medical expenses during retirement. Such funds would help solve the growing problem of long-term care for the elderly.

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Copied from:

National Center for Policy Analysis

Policy Background #131

Released July 7, 1994.

According to Statistics Canada, 45 percent of those waiting describe themselves as "in pain," and the Canadian press is full of examples of patients who have died because their heart surgery was delayed.[66]

And despite the claim that in Canada everyone has a right to health care, Canadians have no enforceable right to any particular medical service. They don't even have a right to a place in the rationing line. For example, the 100th person waiting for heart surgery is not entitled to the 100th surgery. Other patients can and do jump the queue for any number of reasons. Until adverse publicity put a stop to it, even animals could jump the queue and get a CAT scan at York Central Hospital in a Toronto suburb. The tests were done at night and the charge was $300 each. But people are not allowed to pay for a CAT scan.[67]

"Americans have more rights in the Canadian health care system than Canadians do."

Americans would ultimately be subject to the same delays, waiting periods and loss of access to expensive technology that Canadians are. These global budgets would be a central planning approach to controlling costs, totally inconsistent with free markets in health care. Federal government bureaucrats have no way of knowing how much the nation should spend on health care, and their global budget limits would be wholly arbitrary. Moreover, such heavy government control is inherently authoritarian and oppressive. It is inconsistent with the essential freedom of the people to control one of the most fundamental, intimate aspects of their lives — their own health care.

Do We Need Medical Savings Accounts?

The root cause of rapidly rising health costs is third-party payment of medical bills. In health care, someone other than the consumer is usually paying the bills — whether that someone is an employer, insurance company or the government through Medicare and Medicaid. As a result, consumers have weak incentives to avoid unnecessary or overly expensive care. Moreover, since they seldom pay for services themselves, they choose doctors and hospitals almost entirely on the basis of quality rather than cost. For that reason, doctors and hospitals compete almost exclusively to maximize quality rather than to reduce costs.

"With Medical Savings Accounts, people would control their own health care dollars."

How Medical Savings Accounts Work. Medical Savings Accounts (MSAs) are designed to correct this problem.[68] Instead of using all their health care dollars for third-party health insurance, employers and their employees could choose third-party catastrophic insurance with a high deductible, say $3,000 per year. They could then put the remainder of what would otherwise have been premium expense into a tax-free Medical Savings Account for each employee. The employee could then pay for health expenses below the deductible with funds from the MSA. Ideally, the employee could withdraw any remaining MSA funds for any purpose at the end of the year — subject only to normal income taxation — and roll over any unspent MSA funds into an IRA or other tax-deferred savings fund at the time of retirement.

Individuals and families would pay routine health expenses out of their own MSA funds. This would give patients strong incentives to control costs. Perhaps more importantly, doctors and hospitals would compete to reduce costs as well as maximize quality. They would seek to please consumers by advising them on how to lower costs while maintaining quality.

Medical Savings Accounts in the Private Sector. The MSA concept has been implemented at Golden Rule Insurance Company in Indianapolis with great success. Employees are offered a traditional insurance policy with a $500 deductible and a 20 percent co-payment up to a maximum of $1,000. Or they can choose an MSA. In that case, the employer deposits $2,000 into an MSA in 12 equal installments over the year and provides the employee with complete catastrophic coverage above a deductible of $3,000. Each employee's maximum out of-pocket expense is $1,000.[69]

In 1993, 80 percent of Golden Rule employees chose the MSAs. At year-end, they were able to withdraw the remaining funds in their accounts — an average of $602 per employee — and health costs for the company were reduced by 40 percent. In 1994, 90 percent of the employees chose MSAs.

Other companies have tried similar approaches and also have had impressive results:[70]

- Dominion Resources, a utility holding company, deposits $1,620 a year into a bank account for the 80 percent of employees who choose a $3,000 deductible rather than a lower deductible. As a result, the company has experienced no premium increases since 1989, while other employers have faced annual increases averaging 13 percent.
- *Forbes* magazine pays each employee $2 for every $1 of medical claims they do not incur up to a maximum of $1,000. As a result, *Forbes'* health costs fell 17 percent in 1992 and 12 percent in 1993.

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- Beginning in 1982, Quaker Oats implemented a high-deductible policy and paid an annual $300 into the personal health accounts of employees, who get to keep any remaining balance. Although the IRS recently forced the company to abandon this plan, it was highly successful; over the past decade the company's health costs grew an average 6.3 percent per year, while premiums for the rest of the nation grew at double digit rates.

The United Mine Workers recently adopted a similar approach for their workers. Last year they had a health plan with first-dollar coverage for most medical services. This year they accepted a plan with a $1,000 deductible. In return, each employee receives a $1,000 bonus at the beginning of the year, and employees get to keep whatever they don't spend.

"Employees get to keep the money they don't spend."

The Need for a Change in the Tax Law. Under current law, unspent Medical Savings Account balances are taxable, but health insurance premiums paid by an employer are not. Thus the tax law subsidizes third-party insurance and penalizes individual self-insurance. In this way, the tax law subsidizes the problem and penalizes the solution. Wise tax policy would give just as much encouragement to self-insurance through Medical Savings Accounts as to third-party insurance.

Does Health Reform Require Tax Reform?

Because federal tax law states the conditions under which health insurance and health care expenditures qualify for generous tax subsidies, in a very real sense the tax law has shaped and molded our health care system. As a result, fundamental reform of our health care system is impossible without changing the tax law.

We just discussed how the tax law needs to be changed to put individual self-insurance through Medical Savings Accounts on a level playing field with third-party insurance. Other changes are also needed.

Tax Fairness: Equal Treatment of Equals. The federal government currently "spends" about $86 billion a year in tax subsidies for health insurance, and state and local governments spend another $10 billion. These subsidies exist because employer-provided health insurance is excluded from employees' taxable income.

At the same time, the self-employed, the unemployed and employees of small companies that do not provide health insurance are discriminated against. They must pay taxes first and buy health insurance with what's left over. This can make their health insurance cost twice as much as it would if provided by an employer.

LEGISLATIVE TESTIMONY

Kansas Chamber of Commerce and Industry

835 SW Topeka Blvd. Topeka, Kansas 66612-1671 (913) 357-6321 FAX (913) 357-4732

HB 2010 February 15, 1995

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

House Committee on Financial Institutions and Insurance

by
Bob Corkins
Director of Taxation

Honorable Chair and Members of the Committee:

My name is Bob Corkins, director of taxation for the Kansas Chamber of Commerce and Industry, and I appreciate the opportunity to express our members' support for HB 2010. Our board of directors has established a policy for pursuing innovative purchasing techniques and market incentives to encourage employers to provide health care insurance to their employees. We believe today's bill would meet that objective.

The Kansas Chamber of Commerce and Industry (KCCI) is a statewide organization dedicated to the promotion of economic growth and job creation within Kansas, and to the protection and support of the private competitive enterprise system.

KCCI is comprised of more than 3,000 businesses which includes 200 local and regional chambers of commerce and trade organizations which represent over 161,000 business men and women. The organization represents both large and small employers in Kansas, with 55% of KCCI's members having less than 25 employees, and 86% having less than 100 employees. KCCI receives no government funding.

The KCCI Board of Directors establishes policies through the work of hundreds of the organization's members who make up its various committees. These policies are the guiding principles of the organization and translate into views such as those expressed here.

House FI&I
Attachment 6
2-15-95

A survey of our membership has shown substantial business support for the medical savings account (MSA) concept. When comparing all major health care reforms which were pending last year in Congress, 29% of respondents preferred Senator Phil Gramm's proposal which had MSAs at the heart of its plan. The second most preferred was Representative Bob Michel's plan which also featured an MSA component.

Taken together, the Gramm and Michel MSA plans received over half of KCCI members' preference. This result is particularly striking when you consider that the publicity of these bills paled in comparison to others. There is every reason to believe the new Congress, particularly with its emphasis on tax reform, will place an even greater preference on this approach to health care accessibility.

Turning now to some specific implications of HB 2010, I will offer an outline of the major points of our analysis.

I. Businesses now providing employee health insurance

This bill would create no incentive for businesses to change their current employee health insurance benefits because:

a. The HB 2010 tax incentive would be claimed by the employee who sets up an MSA, not by the employer who may contribute to it; and

b. Employers get a significant tax incentive under current federal and state law for paying employee health insurance premiums, but no additional incentive through HB 2010.

II. Self-employed persons

Under federal law, the self-employed may deduct only 25% of their health insurance premium costs as a business expense (compared to other businesses which can deduct 100% of the premiums they pay for employees). Nor can the self-employed exclude the cost of such premiums from their taxable income.

Therefore, HB 2010 represents state assistance to the self-employed, helping to reduce their after-tax premium costs where they get comparatively little assistance now.

III. Businesses *not* now contributing to health insurance

National and KCCI surveys indicate a small employer is less likely to insure their employees than a large employer. The cost of group health insurance appears to be the principle reason why employers do not offer a health insurance program.

HB 2010 would encourage the initiation of employer plans by creating a more responsible way of offering higher-deductible insurance coverage. That is, employers can more readily afford premiums on a higher-deductible policy while employees pay those deductibles with their tax exempt MSA resources. HB 2010, in fact, improves upon last year's MSA proposal by making higher-deductible insurance plans its explicit goal.

Example: Typical costs for a family sickness/accident major medical insurance policy with $2 million maximum benefits

$350 deductible	$1,000 deductible	$5,000 deductible
$3,000/yr	$1,687/yr	$1,024/yr
or $250/mo	or $141/mo	or $85/mo
per employee	per employee	per employee

IV. Extremely unlikely tax haven.

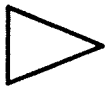
Medical withdrawals from an MSA can be made at any time, so an MSA's rate of return would be less than other (more time bound) investments. This characteristic of an MSA does not make it a comparably attractive means of housing money. For example, investments in tax exempt municipal bonds could easily achieve the same tax benefits while providing a higher return. Even a common passbook savings account would provide the same interest rate while allowing the account holder total freedom (rather than just for health care) as to the purposes for withdrawals.

As long as funds in an MSA are used for health care insurance premiums or deductibles, we do not believe its function should ever be viewed as a tax haven. If an employee were to use an MSA to pay the deductibles for health insurance his employer is *already* providing, that is still part of the legitimate objective of HB 2010 to ease the cost burdens of health care. The key question is "will the taxes avoided on the amount withdrawn for non-health care uses ever exceed the 10% penalty plus tax owed at the time of withdrawal?"

We thought of one narrow type of situation in which it could:

Example: Taxpayer (married, with one child) contributes $5,000 to MSA each year for 10 years, then withdraws $50,000 for non-medical uses. Assuming the $50,000 is his only taxable income for the year of withdrawal, taxpayer "wins" if tax rates average no less than 15% annually over 9 years and then drop back to 3.5% just before his withdrawal.

$5,000 x 15% x 9 years
= $6,750 cumulative tax savings



10% penalty + 3.5% tax on $50,000
= $6,750 due at withdrawal

Given such a limited possibility for abuse and such limited incentives now available for the self-employed and low-wage earners, KCCI believes that HB 2010 would be a useful part of any health care reform initiative. The enticement would certainly be much greater if similar federal legislation were enacted, but today's proposal alone would still be a meaningful improvement.

Again, thank you for this opportunity to speak. We encourage your favorable action upon HB 2010.

KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 15, 1995

To: House Financial Institutions and Insurance Committee

From: C. L. Wheelen, KMS Director of Public Affairs

Subject: House Bill 2010; Medical Savings Accounts

Thank you for the opportunity to express our support for the provisions of HB2010. I am sorry that I could not be present to deliver these comments in person.

The Kansas Medical Society supports the medical savings account concept because it would provide an incentive for patients to utilize health care services more prudently. It would restore much needed consumer participation in cost considerations.

In 1992 the Kansas Medical Society adopted a statement of "Health Care Access Objectives." Among the many issues addressed in our concise statement of objectives is to "encourage cost-conscious utilization of services by patients and physicians." We believe that if enacted, HB2010 would improve patient awareness of their financial stake in health care decisions. This would motivate them to consult with their physicians regarding treatment options and decide together whether lower cost alternatives may be acceptable.

The existing system of financing health care no longer consists of insurance in a traditional sense. In the past, we purchased accident and sickness insurance to indemnify against catastrophic episodes that might require hospitalization and costly treatment. For a variety of reasons, most health insurance products today are instead pre-paid health care. This removes or at least insulates the patient from the impact of cost.

House Bill 2010 is not a panacea to address all of the problems in our health care system. It is, however, a meaningful way of addressing one of the significant flaws; lack of cost consciousness among consumers of health care services.

Thank you for the opportunity to comment. We respectfully request that you recommend passage of HB2010.

House FI&I
Attachment 7
2-15-95

1994 Results of Medical Savings Accounts Plan

- $734,037 refunded to employees
- 90% of employees chose MSAs.
- Average refund was $1,002 per employee.
- No rate increase for company or employees for second straight year.
- 98% of employees satisfied with their MSA (Luntz Research).
- Employees liked the MSAs because MSAs:
  - Help lower-income employees go to doctor
  - Pay for preventive care
  - Pay for eyeglasses and dental care
  - Encourage shopping for health care

House F&A
Attachment 8
2-15-95

Options For Golden Rule Employees

Traditional Plan

or

Medical Savings Plan

Employees may choose either,
and may switch on each anniversary.

	INDIVIDUAL		FAMILY	
	Traditional Policy	Medical Savings Account Policy	Traditional Policy	Medical Savings Account Policy
Maximum deductible	$500	$2,000	$500	$3,000[3]
+ Maximum copayment	+ $1,000[2]	+ -0-	+ $1,000[2]	+ -0-
- MSA deposit	- -0-	- $1,000	- -0-	- $2,000
Total out-of-pocket exposure	= $1,500	= $1,000	= $1,500	= $1,000

[1] The figures in this column are per family member up to a maximum of three people.

[2] 20% of the first $5,000 of expenses above the deductible.

[3] Under the Medical Savings Account Plan, the major medical insurance has a family deductible of $2,000 or $3,000. All expenses for the family count.

MSA Comparison for 1993 to 1994

	1993	1994
Refund to Employees	$468,549	$734,037
Average Refund/Employee	$ 603	$ 1,002
Rate Increase on Insurance Premium	0%	0%

8-2

COPY

Golden Rule®

TO: Pat Rooney

FROM: Shelli Johnson SJ

RE: MSA savings June 1, 1994

Pursuant to our conversation last week, I am providing you with the details of the experience I had with "shopping around" for a better price on medical care.

After having been told by my primary care physician that I needed to have a couple of tests run at a hospital, I explained to him about my medical savings account and inquired about the cost of the tests. The doctor was uncertain but had his nurses call the local hospital and I was given the following approximate costs:

Test 1	$250.00
Test 2	$295.00
Reading of Test 1	$120.00
Reading of Test 2	$120.00
	$785.00

The grand total of the tests and readings was $785.00. I thought that was way too much, so I asked the doctor to hold off on scheduling the tests until I had time to shop around.

I called several hospitals and was given a wide range of costs. Finally, I found one that was almost too good to be true. St. Vincent's did both tests and readings for a grand total of $114.00! That's a savings of $671.00.

Pat, I know if I had not had a medical savings account, I would never have even thought to ask about the cost of the tests, not to mention thinking of shopping around for a better price.

St. Vincent is one of the largest hospitals in Indianapolis, the city's

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Indianapolis, Indiana 46278-1719
Telephone (317) 297-4123

8-4

Golden Rule®

TO: Pat Rooney

FROM: Billie Godby

RE: Management of My MSA June 7, 1994

As you know, I chose the Medical Savings Account (MSA) last year over the traditional plan. I have attached a testimony of my experience with the MSA in 1993 (prepared for Brian McManus). As my testimony states, I was so pleased with the MSA that when the opportunity came in 1994, I chose it again.

Of course I, like everyone, hoped that I wouldn't have to spend the money in my account so that I would have that money at the end of the year. But, I was also glad to know it was there if I needed it -- and, I did.

In early January 1994, I experienced a great deal of abdominal pain. I have recurring ovarian cysts for which, up until January, I had three D & Cs in the past eight years. My doctor had given me a prescription for the pain during my last check-up (June 1993). I was supposed to call him if I had any abnormal bleeding or other problems. I wasn't experiencing any other symptoms at the time, but I knew there was a possibility that I would need another D & C this year.

Later in January, I went to the dentist for a check-up and was told that I needed extensive work (including two porcelain crowns and two in-lays) done to four of my teeth ($506/tooth = $2024). This would completely wipe out my MSA and would not be applied to my $3000 deductible for the year. If I were to need a D & C later or if my daughter were to need medical attention, I would have to pay it out of pocket. So, I called my friend's dentist to ask what he would charge for the same treatment. He would charge $385/tooth = $1540 -- that is if he thought I needed to have the work done.

I went to see him. While I was there he examined and x-rayed my teeth. In his opinion, the crown work and in-lays for those four teeth were unnecessary. He did, however, replace the filling in one of them costing all of $66.

In April of this year, I had additional symptoms that indicated to me that I had another cyst. I went to my doctor and he verified that I did have another cyst and would need to have another D & C immediately.

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8-5

His office manager scheduled the surgery for April 29 at Women's Hospital. I knew that my MSA fund would cover part of the expenses incurred from the D & C, but that I would have to pay for part of it out of pocket. So, I called Women's Hospital for an estimate on the cost of an outpatient D & C. Then, I called St. Vincent's Hospital for an estimate. St. Vincent's cost ranged $300-$400 cheaper than Women's. I had my surgery changed to a date when the doctor would be at St. Vincent's (May 6).

I had already asked my doctor what his total charge would be for the surgery. I told him to send his bill directly to me so that I could draw the money from my MSA and pay him 100 percent of his fee. I had an estimate for St. Vincent's, but I didn't know how much the anesthesiologist would cost. I knew that if the hospital could incur the balance of the deductible to be satisfied, I could make monthly payment arrangements with them. But, the doctors usually prefer to be paid in full. So, when I met the anesthesiologist on the morning of my surgery, I explained the situation to him and asked him to hold his bill for a month so that the hospital could incur the deductible. He agreed to do so.

I won't have that lump sum of money left at the end of the year, but as a result of good management of my MSA, I saved $1958 of unnecessary work on my teeth, had my D & C performed, and managed the money so that the doctors are paid in full and I can now make monthly payments to the hospital where I also save $400 due to my comparison shopping.

Now that I have met my 1994 deductible, any other covered medical expenses that my daughter or I incur this year will be paid 100 percent.

/bg

Attachment

cc: Suzy Katt,
Brian McManus

I am a single parent who receives no outside support. Therefore, it is very important for me to have insurance coverage for my 12-year-old daughter and me. I made the decision to try the Medical Savings Account (MSA) because:

1) If the MSA did not work for me, I had the option of converting back to the traditional plan.

   This was a safety net for me. But because the MSA did work so well for me last year, I chose it again this year.

2) Although vision and dental expenses were not covered under the traditional plan, I would be able to use the MSA money for these expenses.

   Both my daughter and I wear glasses/contact lenses. Both of our prescriptions had changed this past year; therefore, I incurred the cost of the exams along with the cost of new contacts for myself and new glasses for my daughter (lenses and frames because her head had grown).

   I have always tried to have regular dental exams (preventive) for my child and myself. Even so, there are still sealants, fillings, crowns, root canals, etc. that need to be taken care of, but are very expensive.

3) At the end of the year I could conceivably have something left over -- not a feature available with the traditional plan.

4) Even if I did use all/most of the money from my fund, which I did, I still had not experienced any out-of-pocket expenses.

   I did have necessary medical expenses last year that used all but $37 of my MSA fund. While I may have received less than others who had MSAs last year, I gained a great deal more than those who had the traditional plan. I had no out-of-pocket expenses and still had $37 come back to me.

There was nothing to lose and everything to gain.

Billie K. Godby

Billie K. Godby Date

Golden Rule Insurance Company
Lawrenceville, IL & Indianapolis, IN

	Individual Coverage: Traditional Policy	Individual Coverage: MSA Catastrophic Policy	Family Coverage: Traditional Policy	Family Coverage: MSA Catastrophic Policy
Annual Premium	$1,572.00	$404.00	$4,296.00	$1,862.04
Maximum Deductible	$500.00	$2,000.00	$1,500.00 (3 ded)	$3,000.00
Maximum Copayment	$1,000.00	$0.00	$3,000.00	$0.00
Medical Savings Account Deposit	N/A	$1,000.00	N/A	$2,000.00
Total Out of Pocket Cost	$1,500.00	$1,000.00	$4,500.00	$1,000.00
Total Plan Cost - -before and after	$1,572.00	$1,404.00	$4,296.00	$3,862.04

8-8

[redacted]

Indianapolis, IN
16 Employees

		Individual Coverage: Traditional Policy	Individual Coverage: MSA Catastrophic Policy		Family Coverage: Traditional Policy	Family Coverage: MSA Catastrophic Policy
* Annual Premium		$2,302.68	$1,002.60		$5,909.88	$2,387.16
Maximum Deductible		$500.00	$1,500.00		$1,000.00 (2 ded)	$2,000.00
Maximum Copayment	**	$500.00	$0.00	**	$1,000.00	$0.00
Medical Savings Account Deposit		N/A	$1,500.00		N/A	$2,000.00
Total Out of Pocket Cost		$1,000.00	$0.00		$2,000.00	$0.00
Total Plan Cost - -before and after		$2,302.68	$2,502.60		$5,909.88	$4,387.16

* Annual premium includes: Traditional Policy: Major Medical, Life, Prescription Drug Card, Maternity, Preferred Provider Option (for inpatient confinements only)
MSA Catastrophic Policy: Major Medical, Life, Maternity

** Does not include $5 copayment and 80% coinsurance on brand name prescriptions or $5 copayment and 100% coinsurance on generic brands.

Information Verified By: Fortis Benefits Insurance Company

8-8

[redacted]

Brighton, MI
51 Employees

		Individual Coverage: Traditional Policy	Individual Coverage: MSA Catastrophic Policy		Family Coverage: Traditional Policy	Family Coverage: MSA Catastrophic Policy
* Annual Premium		$2,520.00	$1,031.28		$5,520.00	$2,775.12
Maximum Deductible		$100.00	$1,500.00		$200.00 (2 ded)	$2,000.00
Maximum Copayment	**	$1,000.00	$0.00	**	$1,000.00	$0.00
Medical Savings Account Deposit		N/A	$1,200.00		N/A	$1,699.92
Total Out of Pocket Cost		$1,100.00	$300.00		$1,200.00	$300.08
Total Plan Cost - -before and after		$2,520.00	$2,231.28		$5,520.00	$4,475.04

* Annual premium includes: Traditional Policy: Major Medical, Prescription Drug Card, Dental, Vision, Maternity
MSA Catastrophic Policy: Major Medical, Life, Maternity

** Does not include additional $5 copayment or 10% copayment which ever is greater on diagnostic testing. Prescription copayment of $3. Dental copayment of 50% and vision copayment of $5 per visit.

Information Verified By: Blue Cross Blue Shield

01-8

[redacted]

Dayton, OH
10 Employees

	Individual Coverage: Traditional Policy	Individual Coverage: MSA Catastrophic Policy	Family Coverage: Traditional Policy	Family Coverage: MSA Catastrophic Policy
*Annual Premium	$1313.88	$ 744.12	$5124.72	$1710.96
Maximum Deductible	$ 250.00	$1500.00	$ 500.00 (2 ded)	$2000.00
Maximum Copayment	$ 200.00	$ 0.00	$ 400.00	$ 0.00
Medical Savings Account Deposit	N/A	$ 750.00	N/A	$1000.00
Total Out of Pocket Cost	$ 450.00	$ 750.00	$1100.00	$1000.00
Total Plan Cost --before and after	$1313.88	$1494.12	$5124.72	$2710.96

* Annual premium includes: Traditional Policy: Major Medical, Life, Dental

MSA Catastrophic Policy: Major Medical, Life

11-8

Information Verified By: Home Life Financial

[redacted]

Richmond, IN
54 Employees

		Individual Coverage: Traditional Policy	Individual Coverage: MSA Catastrophic Policy		Family Coverage: Traditional Policy	Family Coverage: MSA Catastrophic Policy
* Annual Premium		$3,188.88	$1,127.16		$8,527.56	$2,947.20
Maximum Deductible		$250.00	$1,500.00		$500.00 (2 ded)	$2,000.00
Maximum Copayment	**	$1,000.00	$0.00	**	$1,000.00	$0.00
Medical Savings Account Deposit		N/A	$750.00		N/A	$1,000.00
Total Out of Pocket Cost		$1,250.00	$750.00		$1,500.00	$1,000.00
Total Plan Cost - -before and after		$3,188.88	$1,877.16		$8,527.56	$3,947.20

* Annual premium includes: Traditional Policy: Major Medical, Life, Disability, Maternity, Dental, Prescription Drug Card
MSA Catastrophic Policy: Major Medical, Life, Maternity

** Does not include the additional $10 copayment per physician visit and the $5 copayment per prescription.

Information Verified By: Chubb Group of Insurance Companies

8-12