Approved: 3-24-95
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on March 16, 1995 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Jo Ann Bunten, Committee Secretary

Conferees appearing before the committee:

Terry Leatherman, Kansas Chamber of Commerce and Industry
Chip Wheelen, Kansas Medical Society
Larry Magill, Jr., Kansas Association of Insurance Agents
Davis Ross, Kansas Association of Life Underwriters
Jim Schwartz, Kansas Employer Coalition on Health
Keith Landis, Christian Science Committee on Publication for Kansas

Others attending: See attached list

Continued Hearing on HB 2010 - Medical savings accounts authorized

Terry Leatherman, KCCI, testified in place of Bob Corkins, Director of Taxation for KCCI, in support of **HB 2010** as outlined in his written testimony. It was noted that the bill would encourage the initiation of employer plans by creating a more responsible way of offering higher-deductible insurance coverage, and that employers can more readily afford premiums on a higher deductible policy while employees pay those deductibles with their tax exempt MSA resources. (Attachment 1) During Committee discussion Mr. Leatherman outlined an analysis of the MSA plan in regard to businesses providing employee health insurance and those businesses not providing employee health insurance. A member noted it would be helpful to have information from other states that have implemented MSAs.

Chip Wheelen, KMS, testified in support of **HB 2010** because it would provide an incentive for patients to utilize health care services more prudently and restore much needed consumer participation in cost considerations. (Attachment 2) Mr. Wheelen suggested the date on page 2, line 20, should read 1996 instead of 1995, in order to be in compliance with reference to other dates in the bill, as well as language on page 4, line 23, regarding remitting the penalty payment to the department of revenue may need to be credited to another fund such as the state general fund. During Committee discussion Mr. Wheelen noted that if Congress sees enough states passing this type of legislation, they may also do this at the federal level.

Larry Magill, Kansas Association of Insurance Agents, expressed his support for the bill because it would encourage businesses and individuals to buy large deductible policies while setting aside state income tax-free funds to pay for the routine expenses, uncovered expenses such as eye care or dental care and premiums for catastrophic coverage. (Attachment 3)

David Ross, representing the Kansas Association of LIfe Underwriters, appeared in support of **HB 2010** and noted that medical savings accounts 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. (Attachment 4)

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE, Room 526-S Statehouse, at 10:00 a.m. on March 16, 1995.

Jim Schwartz, Kansas Employer Coalition on Health, raised the question on who would take advantage of an MSA if it were available since most people in Kansas have some kind of deductible and co-insurance, and those that have any kind of deductible would be foolish not to set aside some of that money in an MSA. If you were a Medicare recipient and pay something for your pharmacy and Medicare supplement -- all of that could be bought on a tax preference basis to an MSA. He felt that it was not the intent of the bill to help Medicare recipients, people who are on standard insurance, managed care but have some deductible and co-insurance, but all of us woud take advantage of it if we knew about it. He suggested the Committee might want to have a provision in the bill to target it for people who are intended and not be a tax break for 2.4 million Kansans who might set aside money just for a tax break and not really change their insurance but would use it as a tax shelter. Mr. Schwartz provided a written article on the pros and cons of medical savings accounts. (Attachment 5)

Staff noted that the bill really has two parts to it in a sense that you can have a medical savings account, but it is part of a medical savings program, and the first part of that program is purchase of a higher deductible health care policy. Staff called attention to language on page 2, starting at line 28 of the bill. The bill defines for 1995 the higher deductible which means a deductible of not more than $10,000. This is not a stand alone medical savings account that you can just open up, but part of a medical savings program that is a defined entity in the Act.

Keith Landis, Christian Science Committee on Publication for Kansas, suggested that the way the bill is drafted, Christian Scientists could take advantage of it also, and called attention to page 2, lines 11 through 13 of the bill which speaks of the definition of an eligible medical expense. Mr. Landis noted that the section of the Internal Revenue code recognizes their treatment as an eligible medical expense, and an example of an expense would be Christian Science nurses working in Christian Science nursing facilities or the home, and also practitioners who treat through prayer.

Written testimony in support of the bill was received from Terri Roberts, Kansas State Nurses Association, (Attachment 6); Jonathan P. Small, Koch Industries, Inc., (Attachment 7); and Anne Kimmell, AARP, (Attachment 8)

The Chair noted that the hearing on **HB 2306** will be held on March 17, 1995.

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for March 17, 1995.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 3-16-95

NAME	REPRESENTING
Joe Furjanic	Ks Chiropractic Assn
Carriann Richey	Golden Rule Insurance Co.
Michelle Peterson	Ks. Gov Consulting
[illegible]	Health Midwest
Chip Wheelen	KS Medical Soc.
David Ross	Ks. Assn. Life Underwriters.
[illegible]	Hein, Ebert & Weir
Keith R Landis	Christian Science Comm on Publication for KS
Jim Schwartz	KS Employer Coalition on Health
Nikki Kimberlin	
Melissa Cannon	
Crystal Glover	
Mary Spink	D of A – Health Benefits
Carrie Johnson	
Tina Wilson	Public
Trisha Raber	public
Samantha Cookson	
Alana Edwards	public
Erin Steinbrink	

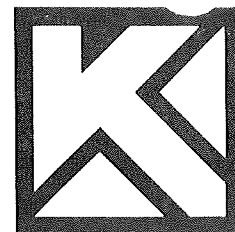
SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 3-16-95

NAME	REPRESENTING
John Federico	Pete McGill + Assoc
Larry Magill	KAIA
Tom Bell	KHA
Terry Leatherman	KCCI

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 March 15, 1995

KANSAS CHAMBER OF COMMERCE AND INDUSTRY

Testimony Before the

Senate Committee on Public Health and Welfare

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.

Senate Public Health & Welfare
Date: 3-16-95
Attachment No. 1

A survey of our membership has shown substantial business support for the medical s[illegible]gs 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. Business *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 principal reasons why employers do not offer a health insurance program.

HB 2010 would encourage the initiation of employer plans by creating a more respons[illegible] ay 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 or $250/mo per employee	$1,687/yr or $141/mo per employee	$1,024/yr or $85/mo per employee

IV. Extremely unlikely tax haven

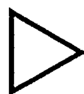
Medical withdrawals from an MSA can be made at any time, so an MSA's rate of return would be less than other (more time bound) investments. This characteristic of an MSA does not make it a comparably attractive means of housing money. For example, investments in tax exempt municipal bonds could easily 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 withdrawl

Given such a limited possibility for abuse and such limited incentives now available for 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

March 15, 1995

To: Senate Public Health and Welfare Committee

From: C. L. Wheelen, KMS Director of Public Affairs *(initials)*

Subject: House Bill 2010; Medical Savings Accounts

Thank you for the opportunity to express our support for the provisions of HB2010. 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 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.

Senate Public Health & Welfare
Date: 3-16-95
Attachment No. 2

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

Kansas Medical Society
Health Care Access Objectives

May, 1992

The Kansas Medical Society Health Care Access Objectives are based upon the premise that all Kansans are entitled to basic health care services and that it is the responsibility of both private and government entities to encourage the development of a program to provide such care. It is the belief of the Kansas Medical Society that health care reform is needed; that quality patient care should remain the primary consideration; and that reform efforts should not discard the strengths of the existing system. The objectives are intended to outline a broad framework of action, and to encourage a process of collaboration among all interested parties. The principal objectives are:

1. Create a forum for dialogue and collaboration among interested parties for the purpose of defining a uniform health insurance plan to be made available to all Kansans. The uniform benefits plan should be offered, based on ability to pay, through a combination of government and private sources such as Medicare, an expanded Medicaid program, employers, private insurance, and a state risk pool for the uninsurable.

2. Encourage and support programs and incentives to train, recruit and retain an adequate supply of primary care physicians in order to improve access to health care in rural and other underserved areas.

3. Encourage insurance reforms which: a) spread financial risk broadly, as with community rating of policies; b) end cost-shifting among payors; and c) guarantee availability of the uniform benefits plan at reasonable cost.

4. Encourage programs that: a) promote healthy lifestyles; b) emphasize preventive medicine; c) discourage unnecessary capital expenditures; d) discourage care and services which are of marginal benefit; e) reduce administrative costs; f) encourage cost-conscious utilization of services by patients and physicians; and g) actively encourage health care cost containment.

Testimony on HB 2010
Before the Senate Public Health & Welfare Committee
By: Larry W. Magill, Jr., Executive Vice President
Kansas Association of Insurance Agents
March 15, 1995

Thank you, Madam Chair, and members of the committee for the opportunity to appear today in support of the medical savings account concept contained in HB 2010. Finding a way to control rapidly escalating health care costs is clearly a top priority of Kansans and this legislature.

One way to lower health care costs is to lower medical malpractice insurance costs through tort reforms. Kansas needs to pass HB 2220 amending the common law collateral source rule.

Another way to approach the problem is through the cost of insurance. Insurance works best when it provides catastrophic coverage. Coverage for large but infrequent claims. Not when it is used to pay for routine health maintenance expenses like inoculations and physicals. The reason is simple. If a routine physical costs $100, it will cost something more than $100 when it is processed through the insurance mechanism. Insurance companies have to add their administrative expenses to their claims payments to calculate their premiums.

Medical savings accounts, HB 2010, is a way to encourage businesses and individuals to buy large deductible policies while setting aside state income tax-free funds to pay for the routine expenses, uncovered expenses such as eye care or dental care and premiums for catastrophic coverage.

Medical savings accounts also offer individuals the chance to put

Senate Public Health & Welfare
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tax-free funds aside for the inevitably higher costs of nursing home care and generally much higher senior citizen health care costs after retirement. It is not an annual "use it or lose it" program like flexible spending accounts, which is a major advantage to this concept.

Admittedly, HB 2010 is not necessarily a way to insure the uninsured except to the extent it encourages more businesses and individuals to pay part or all of the cost of health insurance because it is less expensive.

But the fact that medical savings accounts do not solve the uninsured problem is not particularly relevant. The concept is targeted at the cost side of the problem, not the coverage side.

HB 2010 makes good common sense. It encourages people to budget for the expected, routine costs of health care and helps them lower their insurance costs for the catastrophic expenses. We urge the committee to act favorably on HB 2010.

Madam 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

Senate Public Health and Welfare
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The Pros and Cons of Medical Savings Accounts

A robust debate in Congress about medical savings accounts never got off the ground in 1994. Democrats' initial dismissal of MSAs undermined examination of the concept. But most Republican health reformers tenaciously held on to the idea. An MSA option was in every major Republican reform proposal.

By mid-summer, as the political winds shifted, Democratic opposition to the idea had worn down and an MSA option was contained in the House Leadership Bill proposed by Richard Gephardt (D-Mo.). It also was in the House bipartisan plan that surfaced in late July. But it was not in the Senate mainstream coalition bill. Six senators, three Republicans and three Democrats, including liberal Paul Simon (D-Ill.), said on Aug. 18 that they would offer an MSA amendment to any bill that reached the Senate floor.

If no bill or only minor tinkering is passed this year, there's little doubt MSAs will be a major component of next year's health reform deliberations. Those deliberations are likely to center on the following issues:

• *Are MSAs compatible with managed care?* On the surface, MSAs appear to depend on—and even require—a large indemnity environment. They are, after all, coupled with high-deductible indemnity coverage. Critics argue that MSAs are designed to preserve the small insurance fee-for-service market and don't work well with managed care. In fact, the major lobbying group for MSAs, the Council for Affordable Health Insurance, a research group in Alexandria, Va., is the lobbying group for small insurers. Many small business groups believe MSAs are a limited option. "Small business will be better off in the long term forming or joining purchasing alliances," says John Galles, executive vice president of National Small Business United, a trade group in Washington.

But advocates of MSAs argue that the plans could be coupled with managed care. "The fact is that managed care is not effective or cost efficient for minor everyday health services," says Greg Scandlen, the council's executive director. "It works best at saving money at the high end of health care expenses." There's no reason employees couldn't have MSAs and be enrolled in an HMO or PPO, if health plans would price their premiums accordingly, he says.

Business groups retort that employers have few incentives to control costs at the low end, since that's not where the cost problems lie. "The rise in costs has come when expenses go above the $5,000 mark or so," says Rick Smith, legislative analyst at the Association of Private Pension and Welfare Plans, in Washington. "That's where employers want the controls through managed care."

In fact, MSAs go in the opposite direction from that of most large employers, which are moving to get more employees into managed care. To the extent that segments of their workforces choose MSAs and indemnity coverage, fewer workers would be in HMOs and PPOs, where costs are controlled and more predictable under capitation.

• *Will MSAs lead to adverse selection?* A major argument against MSAs is that they are designed primarily for healthy people who expect to use few medical services and want to save money for future health care and other expenses. In contrast, older people with higher risks would prefer to have as much coverage as possible, even if the accounts were tax free, critics argue. The Congressional Budget Office, in an analysis of one of the Republican MSA plans, concluded that MSAs offered widely would raise the cost of standard coverage sharply, undermine broad community pooling, and in the long run create a two-tiered system.

But MSA advocates say this analysis is flawed. Older, higher-risk people typically choose fee-for-service indemnity coverage, costing them and their employers more money than those who choose managed care, the MSA advocates say. These older workers are frustrated as well that they can't save for expenses, such as long-term care, that aren't covered by employers or Medicare. MSAs would attract large numbers of these people, say proponents. With an MSA, they'd spend less of their own money and would be able to save for future needs. But MSA critics reply that this population would be better served by managed care anyway.

• *Would MSAs help solve the problem of the uninsured?* Opponents say no, at least not in any significant way if MSAs were the only reform in the system. Small employers, for example, that currently don't offer coverage (and where most of the uninsured work) aren't likely to be induced to offer MSAs.

But MSA advocates disagree. They argue that even without government subsidies to help people buy coverage, MSAs have the potential to extend health insurance to millions. MSAs would cut employers' health costs and thus allow them to insure more people. Also, MSAs would be a source of funds for individuals to pay for coverage when they were between jobs or out of work. As many as 40% of the uninsured are between jobs. Conversely, skeptics doubt that enough money would build up in participants' accounts to allow them to pay for their own premiums for very long.

—**Steven Findlay**

Senate Public Health and Welfare
Date: 3-16-95
Attachment No. 5

WILL' M.
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INCORPORATED

The Mercer Report

Number 44
January 31, 1995

Report

Medical savings accounts may have good prospects in Republican Congress

Although comprehensive health reform has been abandoned by both Congress and the Administration, one feature of "incremental" reform — medical savings accounts — has many proponents. Several versions of the savings accounts have been proposed, and at least two bills have already been introduced.

Medical savings accounts are based on the concept that if individuals are spending their own money, they will be more careful consumers of healthcare services. Thus, the argument goes, routine expenses should be paid directly from individuals' pockets. Health insurance, whether purchased as an individual policy or provided through an employer plan, should cover only catastrophic expenses.

The two parts of the system — catastrophic coverage plus the MSA, a tax-advantaged vehicle in which employees can accumulate money for routine expenses — go together. MSAs would be similar to flexible spending accounts, with pretax contributions, except they would have no use-it-or-lose-it provision; unused contributions would carry over indefinitely. MSAs would belong to the employees and thus would be totally portable when people change jobs.

Proponents anticipate that employers would switch their health plans to catastrophic coverage, with a very high deductible, and contribute at least some of the savings into employees' MSAs. However, it would be possible to have MSAs without the employer contribution, and they could also be available to the self-employed or unemployed, with or without a catastrophic plan.

The arguments for MSAs

More than a decade ago, research by the Rand Corporation showed that people significantly reduce their use of healthcare services when they have to pay some of the cost. Thus, putting people at risk for the bulk of their medical care should make them more aware of cost, more careful about choosing cost-effective providers and less likely to use unnecessary or duplicate services. Greater consumer awareness should encourage greater price competition in the marketplace and induce physicians to adopt more cost-effective patterns of practice, which in turn might reduce Medicare and Medicaid costs. And research indicates that lower payments by third parties reduces medical cost inflation.

MSAs would also preserve freedom of choice of providers, encourage personal savings and reduce concerns about "job lock." They would offer the same tax advantages to everyone, thus eliminating the complaint that self-employed workers now cannot deduct their medical premiums. And MSAs should also eliminate the administrative expenses of paying many small claims.

Also in this issue . . .

3 Contract With America may affect benefits and compensation
4 DOL issues final regulations on Family and Medical Leave Act
6 Many plans not set to handle medical child support orders
7 Dunlop Commission recommends employee committees should be legal
8 Also in the news . . .

Over →
5-2

From the employer's standpoint, MSAs could lower the cost of providing health benefits, especially if provider practice patterns change. If high-deductible individual insurance policies are widely available, some employers might even be able to get out of the health benefit business entirely, confident that employees can purchase catastrophic coverage individually and do not need employer intervention to guarantee access.

The arguments against MSAs

Because healthcare costs are distributed unevenly across the population, the arithmetic of MSAs won't work out as neatly as some might wish. Older people and those with chronic illness or disabilities would bear high expenses, year-in and year-out. If illness struck before assets had built up in the MSA, they might have few resources to cover expenses below the insurance threshold.

Since more than 70% of healthcare costs are incurred by 10% of the population, the great majority of these costs would be above the catastrophic threshold — they would still be insured and thus unaffected by the Rand factor. And adverse selection would raise the cost of catastrophic insurance, since many young, healthy people would not buy coverage.

Similarly, because the bulk of employer costs are associated with high-claim individuals whose medical expenses would still be the employer's responsibility, the savings from switching to high-deductible coverage will not be as high as some MSA proponents have argued. The American Academy of Actuaries recently took public issue with Sen. Phil Gramm (R-TX), for his example of how such a plan might work. Gramm had contended that employers could switch to high-deductible coverage, deposit the difference in MSAs, and provide the same overall coverage at the same employee cost. The actuaries showed that Gramm's arithmetic was off by more than 50%, and said, "in all but a few situations, employers would save substantially less on a high-deductible insurance plan than would be needed to fully finance the new deductible."

Some are skeptical about the potential of most people to become truly educated consumers of healthcare, arguing that many employer plans have significantly raised deductibles and copayments already, without dramatic effect on consumer behavior. In addition, the Rand study showed that cost-sharing deterred people — especially poorer ones — from seeking preventive and "highly effective" care, and that once a patient decided to go to the doctor, cost-sharing had little effect on the amount or intensity of services provided.

MSAs and managed care

MSAs are designed to operate well in a fee-for-service marketplace, but their virtues are not so apparent in relation to managed care. Indeed, some employers who believe strongly in the ability of managed care to reduce costs argue that MSAs would be a big step backward. MSAs might pull people out of HMOs and would offer little leverage for employers to steer patients to cost-effective providers.

Fee-for-service medicine is rapidly losing market share, but widespread use of MSAs would probably put the brakes on that trend. Supporters of managed care argue that the fee-for-service system has failed on several counts: misallocating resources, providing few incentives for improving quality, paying insufficient attention to preventive care, not producing information to support accountability — and MSAs would do nothing to impel change. According to the Congressional Research Service of the Library of Congress, "many observers believe that people generally cannot assess the scientific or technical quality of medicine, even when it is in their self-interest to do so, and that they will always place too much emphasis on amenities and interpersonal relationships."

The outlook for MSAs

Some larger employers and large insurers who use managed care extensively plan to oppose MSA legislation. However, it's supported heavily by indemnity insurance companies and there is a great deal of interest in medical spending accounts by many conservatives in Congress. Legislation has a good chance of passage as part of an incremental health reform package. ■

KSNA
the voice of Nursing in Kansas

KSNA & You
A Powerful Match

FOR MORE INFORMATION CONTACT:
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Executive Director
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Topeka, KS 66603-3731
(913) 233-8638
March 15, 1995

HB 2010 Medical Savings Accounts

Senator Praeger and members of the Senate Public Health and Welfare Committee, my name is Terri Roberts JD, RN and I am the Executive Director of the Kansas State Nurses Association.

The Kansas State Nurses Association supports the concept of Medical Savings Accounts because they are voluntary yet they provide incentives for individuals to save money for future payment of health care needs.

Medical Savings Accounts give all Kansans the same opportunities for tax breaks to obtain and/or pay for health care coverage.

Medical Savings Accounts would also allow individuals flexibility to choose their own health care providers. The customer's could "shop" around for the best value. This would support market driven solutions for the escalating cost of health care.

Medical Savings Account participants would enjoy some assurance of portability of health care dollars, regardless of employment status. The medical account belongs to the individual. They are also more likely to encourage smarter spending for health care services.

Thank you.

b:leg95/yellow/hb2010/la

Senate Public Health and Welfare
Date: 3-16-95
Attachment No. 6

KOCH
INDUSTRIES INC

March 14, 1995

MEDICAL SAVINGS ACCOUNTS

1995 House Bill 2010

Koch Industries, Inc. believes medical savings accounts to be a step in the right direction in providing health care that is accessible, affordable, and portable. Medical savings accounts would help establish a way for consumers to make choices and to have incentives to shop for the best health care values.

This bill would allow creation of medical savings accounts to receive a state tax deduction for the money individuals put into their accounts. The money in these individual accounts would be used to cover the cost of health care in lieu of health insurance or to supplement health insurance.

Medical Savings Accounts would:

- make it possible to purchase a higher deductible, lower cost insurance plan instead of the more expensive low-deductible plans
- help keep costs down by making it possible for consumers to have more control in how they spend their health-care dollars
- provide individuals with first dollar coverage enabling them to avoid expensive deductibles and co-payments while still creating for them an incentive to purchase the most cost-effective health care plan
- make health insurance portable, thus increasing flexibility for employees to change jobs

Medical savings accounts, as part of a package of other insurance reforms, would lay a good foundation for providing universal access at affordable costs

Senate Public Health & Welfare
Date: 3-16-95
Attachment No. 7

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March 15, 1995

TO: Kansas Senate Public Health & Welfare Committee

Kansas State Legislative Committee Comments on HB 2010

WHAT IS AARP'S CURRENT POLICY POSITION?

AARP currently has no official policy on medical savings accounts. It is evident, however, that MSAs will primarily help the employed and those with financial resources and will not address some key issues of concern to AARP, such as universal coverage.

WHAT ARE THE PROS AND CONS OF MSAs?

- **Selected Arguments in Support of MSAs**

  - More Individual Responsibility. MSAs are compatible with market-based approaches that emphasize individual responsibility and reject big government. With MSAs, it is assumed that individuals would become more conscious of costs and more responsible for making wise decisions about their care. To support this decision-making, it is thought that the patient would also seek more information about cost and quality issues and become more informed about their medical care generally. Also, since Medisave accounts would be used over a period of years, supporters believe that it would encourage more people to pay attention to lifestyle choices and to plan ahead.

  - Better Cost Containment. MSAs would make consumers sensitive to prices and prudent purchasers. The money they would be spending would come from their own account. Current "first dollar" and low deductible coverage has eliminated a policyholder's incentive to restrain costs or to refrain from seeking unnecessary services. Personal control of spending is really the only way to bring costs under control. In addition, advocates contend that MSAs will also reduce administrative costs, because insurance companies will be out of the business of processing small claims. They will also be back in the business of providing "true" insurance.

Senate Public Health & Welfare
Date: 3-16-95
Attachment No. 8

- More Flexibility and Control. MSAs provide consumers with greater flexibility. Consumers can have more flexibility about which providers they want to use and services they want. The money in the account could be used for any needed care. The use of MSAs would also free people from mandated health insurance benefit laws, which drive up the premium costs, for routine medical coverage. In addition, most MSAs would allow the account holder to withdraw unspent funds at year's end, after taxes, or to accumulate savings from year to year.

- Assures Portability for Workers. MSAs would provide workers with coverage between jobs. If a consumer lost his or her job, they would not have to worry about losing their coverage. Moreover, this between-job security could be achieved without any additional cost to the U.S. Treasury.

- Assures Doctor/Patient Relationship. MSAs would shift the decision-making away from the health plan or insurer and back to the patient and his or her physician. Insurance companies would not be able to interfere as much with the services a person receives or how a doctor practices medicine.

- Provides Resources for Retirement. Supporters of MSAs contend that a relatively small proportion of people with MSAs would spend their annual account limit. Therefore, savings and interest would build over the years. As a result, MSAs could improve the national savings rate and become a valuable source of funds to help pay for medical services, or other critical services (e.g., long-term care, LTC insurance) when they get older.

- **Selected Arguments Against MSAs**

  - Loss of Revenue. Since MSA deposits by the employer, the employee, or both parties would be exempt from federal and/or state taxes, the widespread use of these plans, which would primarily benefit the non-poor, could result in large loss in tax revenue. However, without changes in the federal tax code, savings obtained from MSAs are expected to be minimal. States would run the risk of losing revenues if MSAs attract a large number of people who previously did not have insurance deduction.

  - Cost of Monitoring. Opponents contend that accurately administering and monitoring spending from medical savings accounts could be difficult and costly. These costs could increase even more if expenditures are allowed for non-medical services (e.g.,tuition, purchase of a home). As a result, MSAs could result in the creation of more bureaucratic intervention and expense.

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• Lack of Access for Uninsured. Because MSA proposals are voluntary and are closely linked to employment, there is little reason to suspect that MSAs improve access for the uninsured. Middle- and upper-income taxpayers would probably be the primary beneficiaries of MSAs-- unless public dollars are used to help provide coverage (i.e., help fund the MSA account and the premium cost of a catastrophic insurance policy) for the uninsured and unemployed. Even if individuals were provided the opportunity to fund their own plans, most people who are not covered by their employer, or who are unemployed, would have the resources to fund the MSA annually. This approach would not help the permanently unemployed, many low-wage workers, or most elderly, so it is evident that Medisave Accounts, by themselves, would not lead to universal coverage.

• Discourages Basic Care. Rather than improving access, some opponents of MSAs believe that people would skimp on preventive or routine care and save this money for other purposes. In the long run, this could increase overall health care costs.

• Provides Incentives to Spend. There is little experience with how the availability of MSAs would affect human behavior. It is feared that, for some people, the unrestricted access to a fund that is "refilled" each year will provide an opportunity to spend resources recklessly, especially since, in some proposals, all medical costs are paid by the catastrophic insurance policy after a certain level.

• Favors the Healthy. MSAs would treat all people alike which, in reality favors the healthy. For example, people with chronic medical conditions would use more services, spend more from their accounts, and accumulate less money over time.

WHEN REVIEWING MEDICAL SAVINGS ACCOUNT LEGISLATION

Assessing the various components of a MSA bill can be complex. Some of the key components/issues that should be considered when reviewing a bill include the following:

- Who will be able to have an account? An employee? Self-employed? Unemployed? Is participation in a MSA voluntary or mandatory?

- Who will be able to draw funds from the account? The employee? Spouse? All dependents?

- What is the annual contribution limit each year for the employer? The employee? Are there any estimates of how much revenue would be lost by the state?

- Will the annual MSA account limit be increased over time to keep up with inflation and/or increased medical costs?

- Are the annual contributions by the employer and/or employee deducted from gross income tax free? How about the annual and accumulated interest?

- Is the use of the account linked to the purchase of an insurance plan? What is the plan's deductible? What services does it cover? Does it cover all medical costs once the deductible is reached, or are there copayments? Can funds from the MSA be used to pay premium costs, copayments, and for any services not covered by the insurance plan?

- Are withdrawals from the account allowed for more than medical expenses?

- Are their any limitations on how MSA funds can be spent for medical care? If yes who determines which services are authorized?

- What kinds of penalties are imposed for early withdrawal or spending on unauthorized services?

- Can funds unused at the end of the year be taken out of the MSA? Taken out without penalty? Can or must these funds be "rolled over" to a person's IRA?

- How will spending from the account be tracked?

- Is there any provision in the bill to study the impact of the MSAs on individuals and on businesses? Is a report to the governor, state legislature, etc., required? How frequently?