Controlling Health Care Costs with Medical Savings Accounts

by

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Executive Summary

Health care costs are rising in the United States for the same reason they are rising in every developed country: most of the time when we consume medical services we are spending someone else's money. Currently:

- About 95 percent of all hospital bills and more than 80 percent of physicians' fees are paid by private and public third-party payers.
- On the average, every time a patient spends a dollar in the medical marketplace, 76 cents is paid by someone else.
- Since we pay only 24 cents out-of-pocket for every dollar of medical care we consume, we have an incentive to continue consuming until medical services are worth only 24 cents on the dollar to us.

When health care is virtually "free," there is almost no limit to how much we can spend on it — even if we are not sick. In recognition of this fact, other countries have limited access to technology and forced hospitals and doctors to ration health care. In the United States, we are moving in the same direction, as third-party payers attempt to limit physician choice and hospital access, and increasingly dictate the practice of medicine and interfere in other ways with the doctor-patient relationship. Yet experience shows that no country has succeeded in controlling health care costs from the top down without severely reducing the quality of patient care.

Fortunately, there is a better way — one which has already been adopted in Singapore.

- Instead of having third parties pay for all medical bills, most bills could be paid by patients themselves — using health care debit cards to draw on funds in individual medical savings accounts.
- Instead of 100 percent reliance on third-party insurance, about half the nation's medical expenses could be covered by individual self-insurance.
- Instead of depending on health care bureaucracies to control costs, we could depend on the self-interest of individuals acting as prudent buyers in a competitive medical marketplace.

In substituting self-insurance for wasteful third-party insurance, people should have the opportunity to choose higher deductibles and to place the premium savings in individual medical savings accounts. Medisave accounts would grow tax free and could be used only to pay medical expenses. During retirement, Medisave balances could either be used to pay medical expenses not paid by Medicare or rolled over into an individual's pension plan.

Under the current tax law, third-party insurance is subsidized and self-insurance is penalized. Every dollar an employer pays for third-party insurance is excluded from employee income. Every dollar an employee tries to save is taxed — at rates as high as 50 percent. To correct this distortion, we should

give just as much tax incentive to deposits to Medisave accounts as we give to third-party health insurance premiums.

For individuals and families shopping for health insurance, high-deductible policies are often a much better buy even without the opportunity to establish a Medisave account:

- Increasing the deductible from $250 to $1,000 results in annual premium savings of about $400 for a middle-aged male — a good deal even if he has a $1,000 medical expense every third year for the rest of his life.

- Increasing the deductible from $250 to $2,500 results in annual premium savings of about $1,750 on a family policy — which is about equal to the insurance coverage they would forego, considering the 20 percent copayment provision in most low-deductible policies.

Although the premium savings from higher deductibles tend to be smaller for group insurance, they are still substantial. Most companies could cut health insurance premiums by one-third by moving to a $2,500 deductible — even if employees' medical care consumption did not change.

If most medical expenses were paid by people using their own Medisave funds, patients would have a financial self-interest in eliminating waste and reducing costs in the medical marketplace. Patients would acquire greater control over how their health care dollars were spent. Third-party payers would interfere in the doctor/patient relationship far less. And health insurance companies could specialize in what they do best: managing risks for rare, expensive, catastrophic medical events.

If all U.S. citizens had catastrophic health insurance for large medical bills and Medisave accounts for small medical bills, administrative costs and wasteful health care spending would be reduced significantly.

- The widespread use of Medisave accounts would reduce the administrative costs of the U.S. health care system by as much as $33 billion.

- More prudent buying on the part of patients could reduce health care spending by as much as $147 billion.

- Overall, universal catastrophic health insurance combined with Medisave accounts could reduce total U.S. health care spending by as much as one-fourth.

Self-insurance for medical bills is not a new idea. Singapore has built an entire health care system around the concept by requiring workers (and their employers) to deposit 6 percent of annual salary into Medisave accounts. Only recently has Singapore introduced third-party insurance for catastrophic medical expenses. Most of the time, people in Singapore are spending their own money rather than someone else's money when they enter the medical marketplace. And Singapore's decision to privatize its public hospitals will encourage a competitive market for medical services.

We do not have to follow Singapore's precedent of *requiring* the use of Medisave accounts. We should give people the *opportunity* to do so, however.

Introduction:

Why Health Care Costs Keep Rising[1]

The reason why health care costs keep rising is clear. When we enter the medical marketplace, most of the time we are spending someone else's money rather than our own. If we paid for food, clothing, housing and life's other necessities the way we pay for health care, the cost of those items also would soar.

"We could spend half the GNP just on diagnostic tests and the other half on minor ills."

Under most employer-provided health insurance plans, employees effectively have a company credit card allowing them to spend freely in the hospital equivalent of a shopping mall. There are plenty of experts ready to help shoppers learn what is available. The shoppers enjoy the benefits of the spending spree, and employers get the bill.

It would be a mistake to believe that employers ultimately pay this bill, however. Health insurance is a fringe benefit which substitutes for wages in the total employee compensation package. The more costly health insurance becomes, the smaller the remaining funds available for wage and salary increases. The ultimate victims of waste in the medical marketplace are employees. This is one reason why take-home pay has been relatively stagnant over the past two decades, even though total compensation has been rising.

Third-Party Health Insurance

Many people believe that health care spending should be determined by medical "needs." Yet if we followed the practice of spending health care dollars whenever a need was being met (or a medical benefit created), we could easily spend our entire gross national product (GNP) on health care. In fact, we could probably spend half of the entire GNP on diagnostic tests alone.

The Potential Demand for Health Care. What prevents medical costs from being even higher is that patients are constrained by obstacles such as time, money and inconvenience. For example, medical science has identified 900 tests that can be done on blood.[2] Except for the cost and inconvenience, why not make all 900 part of our annual checkup? Similarly, an annual checkup could include a brain scan, a full body scan and numerous other tests — all of which are valuable even to people who appear healthy.

As an example of how the demand for the services of primary care physicians could soar, consider:[3]

- In any given year, Americans make about 472 million office visits to primary-care physicians.
- If only 2 percent of nonprescription drug consumers sought professional care rather than self-medicating, the number of patient visits would climb to 721 million.
- The number of primary-care physicians would need to increase by 50 percent to meet the increased demand.
- If every person who now uses nonprescription drugs chose professional care over self-medication, we would need 25 times the current number of primary-care physicians.

"If every purchaser of a nonprescription drug stopped by the doctor's office first, we would need 25 times more primary care physicians."

How Third-Party Insurance Increases the Demand for Health Care. The vehicle by which we spend other people's money in the medical marketplace is third-party health insurance (provided by an employer, an insurance company or government). Prior to 1965, increases in health care costs were relatively modest because a large part of the payment was made out-of-pocket by patients. Since then, Medicare and 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 I shows:

- About 95 percent of the money Americans now spend in hospitals is someone else's money at the time they spend it.
- Four-fifths of all physicians' payments are now made with other people's money, as are three-quarters of all medical payments for all purposes.

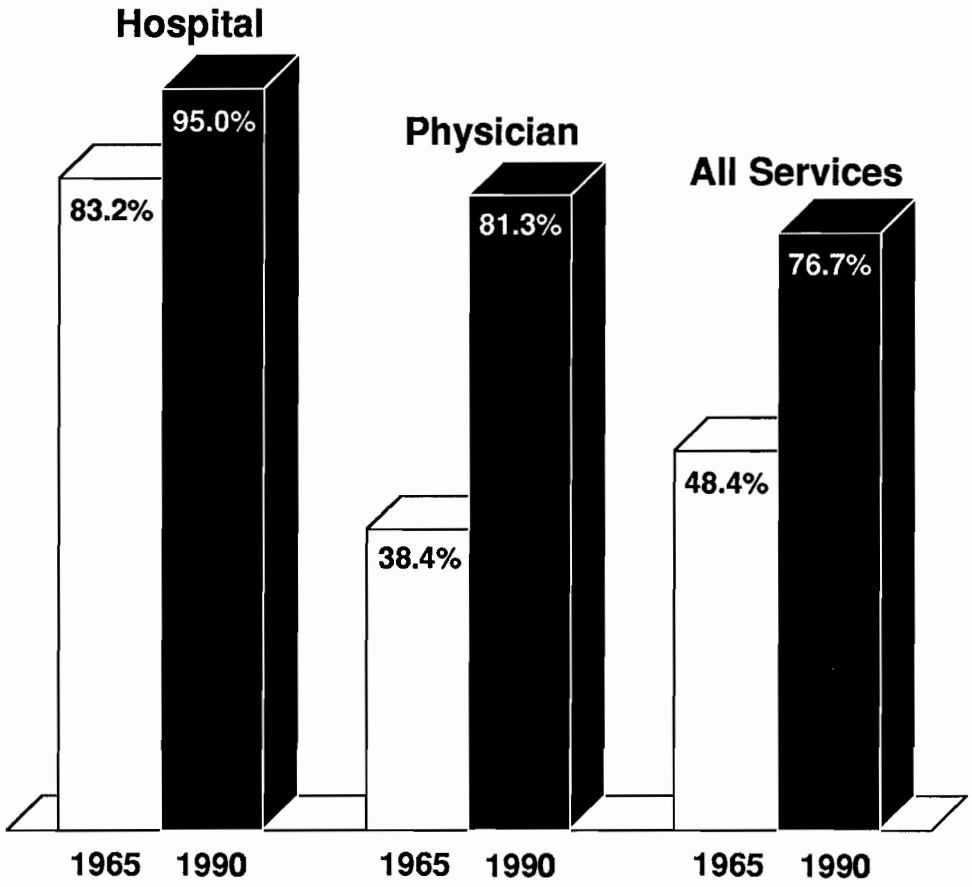
When patients pay only a fraction of the real cost of the health care they receive, they have an incentive to over-consume. Since we pay only 23 cents out-of-pocket for every dollar of medical care we receive, we have an incentive to continue consuming until medical care is worth only 23 cents on the dollar to us.

The expansion of third-party insurance coverage since 1965 has had a predictable consequence: health care spending has soared from 6 percent to 12 percent of GNP, and the rate of increase shows no sign of abating.

"Three-fourths of the money we spend on health care is someone else's money."

FIGURE I

Percent of Personal Health Expenses Paid by Third Parties



Source: Health Care Financing Administration, Office of the Actuary.

Numerous studies have shown that the amount of medical care people consume varies with the out-of-pocket price they have to pay — often with no effect on health. For example:[4]

- A Rand Corporation study found that people who had access to free care spent about 50 percent more than those who had to pay 95 percent of the bills out-of-pocket (up to a maximum of $1,000).

"A reasonable deductible can cut health care spending by one-third with no adverse effects on health."

- People who had free care were about 25 percent more likely to see a physician and 33 percent more likely to enter a hospital.

- Despite these differences in consumption, there were no apparent differences between the two groups in health outcomes.[5]

The Rand study was conducted from 1974 to 1982. A $1,000 deductible over that period would be equivalent to a deductible between $1,380 and $2,482 today.

Third-Party Payment of Small Medical Bills. Using insurers to pay small medical bills is especially wasteful. It is comparable to using an insurance company to pay monthly utility bills. That might be convenient, but the convenience would be costly.

● Studies show that physicians spend an average of $8 for each insurance claim they submit.

● Most employers and insurance companies spend another $8 for every check they write.

"Third-party payment of small medical bills can double their cost."

● If the third-party payer investigates the legitimacy of a claim, a $25 physician's fee can easily generate another $25 in administrative costs — thus doubling the cost of medical care.

Considering that a substantial portion of insurance claims are for small-dollar expenses, using third parties to pay small medical bills adds substantially to the nation's annual health care costs.

The Self-Insurance Alternative

People familiar with insurance have always known that it creates perverse incentives for the insured. In order to take advantage of the benefits under a policy, the beneficiaries do things they would not otherwise do.

In recognition of this fact, insurance in most fields is restricted to risks beyond the control of the insured. (For example, automobile casualty insurance does not pay for oil changes, tire rotations, break adjustments and other routine maintenance — even though these activities are important for the *health* of a car and the safety of the driver.) Financial advisers almost always recommend high-deductible policies because small-dollar claims are the ones where the most abuse is likely to occur, and the premiums needed to cover these claims are often much too high relative to the extra coverage. The same principles apply to health insurance.

The alternative to third-party insurance is self-insurance. Rather than relying on insurers to pay every medical bill, we could put money aside in personal savings for the small expenses and use insurance only for rare, high-dollar medical episodes. As we shall see, such a practice would result in much lower premiums and curtail a great deal of wasteful spending.

Yet instead of exploiting opportunities for self-insurance and taking advantage of its benefits, in health care we have moved in the opposite direction — with insurers paying for all manner of routine expenses, including checkups and diagnostic tests, even when there is no illness and no risky event has occurred. Why have we failed to apply the lessons learned in other insurance fields to health insurance? The most important reason is the tax law.

How the Tax Law Encourages Third-Party Insurance and Penalizes Individual Self-Insurance

One strange feature of the tax code is that a physician's fee paid by an employer (or an employer's insurance carrier) is paid with pretax dollars, whereas fees paid out-of-pocket by employees must be paid with aftertax dollars. As a result, the tax law encourages (subsidizes) 100 percent health insurance coverage (with no deductibles and no copayments) for all medical expenses.

"People prefer more health insurance to wages because taxes can take up to half of an additional dollar of wages."

Federal tax law has an enormous impact on employee benefit plans because individual marginal tax rates are so high. Even a moderate wage earner in the U.S. economy gets to keep less than 70 cents out of each *additional* dollar earned. As Table I shows:

- For an employee facing an income tax rate of 15 percent and a combined (employer plus employee) Social Security tax rate of 15.3 percent, federal taxes take 30.3 cents out of each additional dollar of wages.

- If the employee faces a 6 percent state and local income tax, the marginal tax rate is 36.3 percent, leaving the employee with less than two-thirds of a dollar of wages in the form of take-home pay.

The results are even worse for employees in higher tax brackets:

- Workers in the 28 percent federal income tax bracket face a marginal tax rate of 43.3 percent — leaving them with less than 57 cents in take-home pay out of each additional dollar of earnings.

- If state and local income taxes apply, these workers take home only 51 cents of each additional dollar of earnings.

"Health insurance need only be worth half its actual cost in order to remain attractive."

TABLE I

Aftertax Value of a Dollar of Money Wages

Federal Tax Category[1]	No State and Local Income Tax	State and Local Income Tax
FICA Tax Only	**85¢**	**81¢[2]**
FICA Tax Plus 15 percent Income Tax	**70¢**	**64¢[3]**
FICA Tax Plus 28 percent Income Tax	**57¢**	**51¢[3]**

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

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

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

Because wages are taxed and health insurance benefits are not, health insurance is more valuable to employees than additional wages. As Table II shows:[6]

- For an employee in the 15 percent tax bracket (and facing a 15.3 percent FICA tax), federal tax law makes $1.44 of health insurance benefits equivalent to a dollar of take-home pay — because $1.44 in gross wages will be reduced by 44 cents in taxes.

- For an employee who is in the 28 percent bracket, $1.76 of health insurance benefits is equivalent to a dollar of take-home pay.

- For a higher-paid employee also facing a 6 percent state and local income tax rate, $1.97 of health insurance benefits is equivalent to a dollar of take-home pay.

Table II also shows how much waste can be present in the purchase of health insurance and still allow health insurance to be preferable to wages. [See Figure II.] For example, if an employer attempted to give the higher-paid employee $1.97 in wages, the employee's take-home pay would be only $1.00 after taxes are paid. As a result:

- For a highly paid employee, $1.97 spent on health insurance need only be worth $1.01 to be preferable to $1.97 of gross wages.

TABLE II

The Amount of Health Insurance That is Equivalent To a Dollar of Take-Home Pay

Federal Tax Category	No State and Local Income Tax	State and Local Income Tax
FICA Tax Only	$1.18	$1.24[1]
FICA Tax Plus 15 percent Income Tax	1.44	1.56[2]
FICA Tax Plus 28 percent Income Tax	1.76	1.97[2]

Note: Table shows the amount of taxable wages that are equivalent to a dollar spent on an employee benefit and includes the employer's share of FICA taxes.

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

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

- Thus, 96 cents of $1.97 (or 49 percent of the premium) can represent pure waste and still leave health insurance preferable to wages for the employee.

This is why employees tend to prefer generous (and wasteful) health insurance coverage — coverage that they would not buy out-of-pocket without tax subsidies. Note also that the higher the tax bracket, the greater the economic incentive to purchase more health insurance. Higher-paid workers tend to dictate the contents of employee benefit plans and impose their choices on all other workers. Moreover, many current employee benefit plans were shaped decades ago, when marginal tax rates were much higher and the incentives for waste even greater.

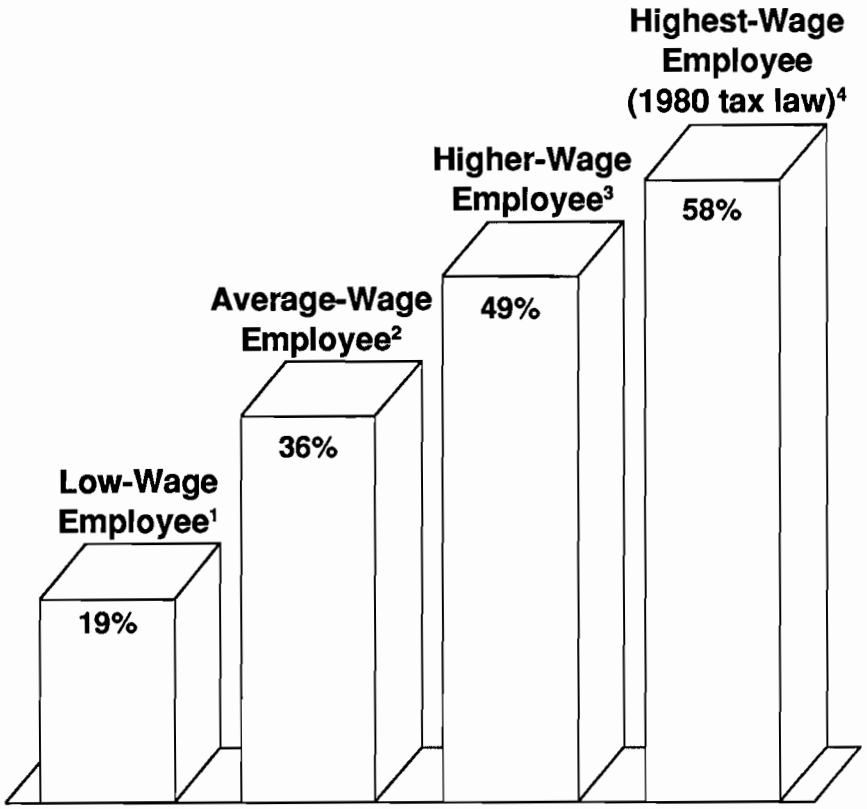
"Although Americans receive $60 billion worth of tax deductions for third-party insurance, no deduction is allowed for individual self-insurance."

The total tax deduction for employer-provided health insurance is about $60 billion per year — roughly $600 for every American family. Although this system may appear to benefit large companies with more generous employee benefits, in many cases these companies are trapped by benefit plans that are eating into company profits, raising production costs and keeping wages lower than they otherwise would be. The current system not only encourages and subsidizes rising health care costs, it also harms the very industries and companies which are subsidized the most.

"Higher income employees have the strongest incentives to prefer overly wasteful health insurance."

FIGURE II

How Much Waste Can Be Present in Health Insurance and Still Leave Health Insurance as Valuable as Wages?



[1]Employee faces a 15 percent FICA tax and a 4 percent state and local income tax.

[2]Employee faces a 15 percent FICA tax, a 15 percent federal income tax and a 6 percent state and local income tax.

[3]Employee faces a 15 percent FICA tax, a 28 percent federal income tax and a 6 percent state and local income tax.

[4]Employee faces a 50 percent federal income tax and an 8 percent state and local income tax.

Why Low-Deductible Health Insurance is Wasteful

Because employees (through their employers) are able to purchase health insurance with pretax dollars, but individuals are not allowed to self-insure (personal savings) for small medical expenses with pretax dollars, people often buy low-deductible health insurance and use insurers to pay for small medical bills that would be much less expensive if paid out-of-pocket.

The Cost of a Low-Deductible Policy in Cities With Average Health Care Costs. The cost of catastrophic health insurance is usually quite low. Consider a standard individual health insurance policy for a middle-aged male in a city with average health care costs, such as Indianapolis. [See Table III.] If the policy has a $2,500 deductible, the policyholder is at risk for $2,500. The insurance company, on the other hand, is at risk for $1 million. Given an average premium, this health insurance costs the policyholder about 6/100th of one penny in premiums for each dollar of coverage.

Now contrast this policy with a $1,000-deductible policy which has a 20 percent copayment for the next $5,000 of expenses. In theory, the $1,000 deductible gives the policyholder $1,500 of extra insurance coverage. But because of the 20 percent copayment, the additional coverage actually is only $1,200.[7] People who choose the $1,000 deductible will pay about $255 in additional premiums in return for $1,200 of additional insurance coverage. As a result each additional dollar of insurance coverage costs the policyholder 14 cents.[8] Table III also shows the marginal cost (premium increase per additional dollar of coverage) of buying down the deductible even further. As the table shows:

- Lowering the deductible from $1,000 to $500 costs 64 cents in additional premiums for each additional dollar of insurance coverage.
- Lowering the deductible from $500 to $250 costs 77 cents in additional premiums for each additional dollar of insurance coverage.

"In an average city, lowering the deductible from $500 to $250 costs 77 cents for each dollar of extra coverage."

TABLE III

Cost of Lower Deductibles In a City with Average Health Care Costs

(Male, Age 40)[1]

Lowering the Deductible[2]			Additional Annual Premium	Cost of Each $1 of Additional Coverage[3]
$2,500	→	$1,000	$168.84	14¢
$1,000	→	$500	$255.12	64¢
$500	→	$250	$153.24	77¢

[1]Figures are for 1991.

[2]For deductibles of $1,000 or less, the policy has a 20 percent copayment up to a maximum of $1,000.

[3]Because the policy has a 20 percent copayment, additional coverage is 80 percent of the difference between the two deductibles.

Source: Golden Rule Insurance Company

In general, buying a $250-deductible policy rather than a $500 deductible is a good deal provided that the policyholder is confident he will have at least $500 in medical expenses. Even in that case, the gain is a small one — a dollar's worth of medical expenses for each 77 cents in premiums. For the vast majority of people, however, a low-deductible policy is quite wasteful. Considering the administrative expenses, insurers on the average will pay out only 54 cents in claims for each 77 cents in premiums. Policyholders as a group, therefore, will pay far more in premiums than they will receive in benefits.

The Cost of a Low-Deductible Policy in Cities with High Health Care Costs. In general, the higher the health care costs in an area, the more expensive low-deductible health insurance becomes. Table IV, for example, shows the costs of a lower deductible for a middle-aged male in a city such as Miami. As the table shows:

- Lowering the deductible from $2,500 to $1,000 is quite expensive — 33 cents for each additional dollar of coverage.
- Lowering the deductible from $1,000 to $500 is inherently wasteful — costing $1.79 for each additional $1.00 of coverage.
- Lowering the deductible $500 to $250 costs $2.20 for each additional $1.00 of coverage — $1.20 more than any possible benefits the policyholder could derive.

"In a city with high health care costs, lowering the deductible from $500 to $250 costs $2.20 for each $1.00 of extra coverage."

TABLE IV

Cost of Lower Deductibles In a City with High Health Care Costs

(Male, Age 40)[1]

Lowering the Deductible[2]			Additional Annual Premium	Cost of Each $1 of Additional Coverage[3]
$2,500	→	$1,000	$389.64	33¢
$1,000	→	$500	$715.44	$1.79
$500	→	$250	$440.28	$2.20

[1]Figures are for 1991.

[2]For deductibles of $1,000 or less, the policy has a 20 percent copayment up to a maximum of $1,000.

[3]Because the policy has a 20 percent copayment, additional coverage is 80 percent of the difference between the two deductibles.

Source: Golden Rule Insurance Company

The Cost of a Low-Deductible Policy Under Blue Cross Plans in California. Southern California has among the highest health care costs in the nation. As a result, Californians who buy low-deductible policies are being especially wasteful. Table V shows what policyholders would pay to reduce the deductible under Blue Cross plans currently sold for individuals and families in different age groups. Even lowering the deductible from $2,000 to $1,000 is a bad buy in many cases. A deductible of less than $1,000 is always a bad buy:

- A California couple with no children will pay from $1.00 to $2.63 (depending on their age) for each dollar of additional insurance if they choose a $500 rather than a $1,000 deductible.
- If they further lower the deductible to $250, they will pay from $1.92 to $9.54 for each additional dollar of coverage.

"In Southern California, some policyholders pay as much as $9.54 for a dollar's worth of health insurance."

Opportunities for Premium Savings. Because low-deductible health insurance is so wasteful, in most places people would realize substantial premium savings if they increased the deductible. For example, the average employee in the U.S. economy has a deductible of about $250.[9] If it were increased to $1,000, the employee would lose $600 worth of coverage (80% x $750). Figure III shows the potential premium savings based on individual policies sold in Indianapolis (an average health care cost city), Dallas (an above-average-cost city) and Miami (a high-cost city). As the figure shows:

- In return for giving up $600 of coverage, policyholders would realize immediate savings of more than two-thirds that amount in Indianapolis and 90 percent in Dallas through lower premiums.
- In Miami, policyholders would save $1,156 in reduced premium payments — $556 more than the coverage they would forgo.

In most places, the savings for families who choose higher deductibles are even greater:

- In a city with average health care costs, families can save about $1,315 by choosing a $1,000 deductible rather than a $250 deductible — savings that are more than twice as much as the value of coverage foregone.
- By choosing a $2,500 deductible rather than a $1,000 deductible, families can save $1,749 — $51 less than the value of the coverage they forego.[10]

Yet under current tax policy, if such policies are purchased by employers who attempt to pass the savings on to employees in the form of higher wages, up to half the premium savings will go to government in the form of taxes.

"In Southern California, almost any deductible below $1,000 is a bad buy."

TABLE V

Blue Cross Plans in Southern California[1]

Costs Per Dollar of Additional Insurance Coverage:

	Lowering Deductible From $2000 to $1000	Lowering Deductible From $1000 to $500	Lowering Deductible From $500 to $250
Single Person			
Under 30	$0.14	$0.72	$1.80
30-39	0.20	1.05	1.02
40-49	0.27	1.20	1.80
50-59	0.42	0.99	2.82
60-64	0.51	1.08	3.84
Subscriber & Spouse			
Under 30	$0.29	$1.44	$2.28
30-39	0.24	2.52	1.92
40-49	0.51	2.07	4.62
50-59	0.77	2.64	5.64
60-64	1.02	1.71	9.54
Subscriber & Child			
Under 30	$0.15	$0.96	$1.62
30-39	0.23	1.14	1.74
40-49	0.24	1.86	2.58
50-59	0.38	2.55	3.18
60-64	0.53	1.05	5.34
Family			
Under 30	$0.42	$2.52	$2.22
30-39	0.56	2.16	3.60
40-49	0.62	2.82	4.68
50-59	0.87	3.90	5.04
60-64	1.16	2.04	10.14
Subscriber &Children			
Under 30	$0.27	$1.38	$2.52
30-39	0.29	0.96	3.90
40-49	0.30	1.44	4.62
50-59	0.44	1.44	6.96
60-64	0.62	1.23	6.18

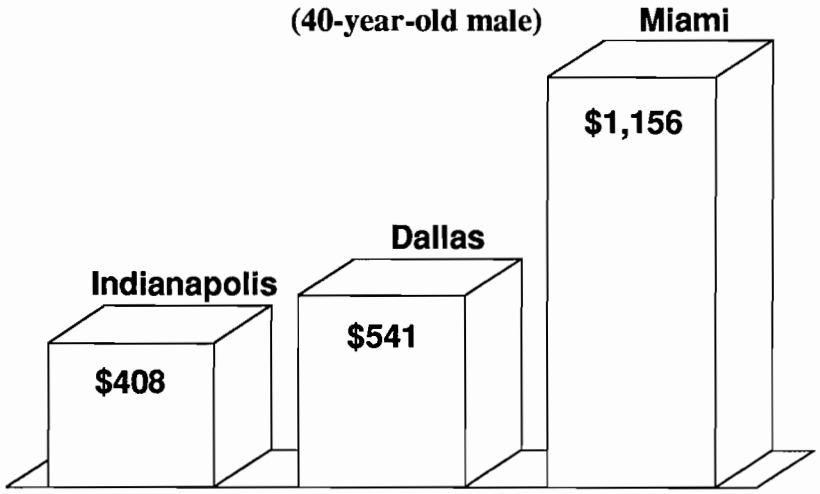
[1]For Orange, Santa Barbara and Ventura counties in California in 1991.

Source: Blue Cross

"In return for giving up $600 of coverage, a middle-aged male would save two-thirds that amount in Indianapolis, 90 percent in Dallas and make a $556 profit in Miami — in terms of reduced premiums."

FIGURE III

Annual Premium Savings If the Deductible is Increased From $250 to $1,000[1]



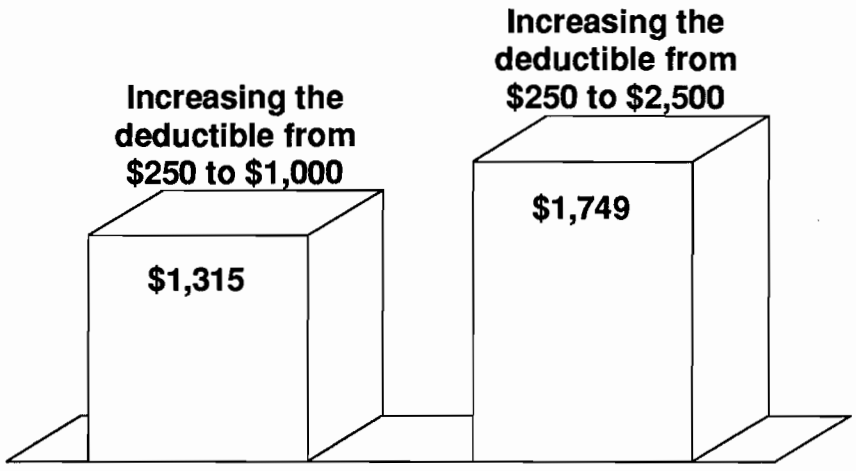
[1]Figures are for an individual policy for a male, age 40 in 1991. Because the policy has a 20 percent copayment, the increase in the deductible eliminates only $600 of health insurance coverage unless the policyholder has medical expenses in excess of $5,000.

Source: Golden Rule Insurance Company

"By increasing the deductible from $250 to $2,500, the average family would save as much in premiums as the coverage it foregoes."

FIGURE IV

Annual Premium Savings From Higher Deductibles For Families in Cities With Average Health Care Costs[1]



[1]Figures are for two adults and two children in a city with average health care costs. For deductibles less than $2,500, policyholders face a 20 percent copayment up to $1,000. Unless policyholders have medical expenses of $5,000, they forego $600 of coverage by moving from a $250 deductible to a $1,000 deductible and $1,800 of coverage by moving from a $250 deductible to a $2,500 deductible.

Source: Golden Rule Insurance Company

Opportunities for Premium Savings in Large Groups

Considerable savings are possible for individuals and families who choose higher deductible policies for two reasons. First, when policyholders spend more of their own money on small medical bills, they are more prudent consumers — holding down medical costs and, therefore, health insurance premiums. Second, when people have the choice between higher and lower deductibles, healthy people tend to choose high-deductible policies while less healthy people choose low deductibles. Thus, those who choose high deductibles are a less risky group.

Suppose, however, that an employer with a large group of employees increased the deductible for every member of the group — the healthy as well as the sick. In this case, any reduction in total medical expenses would be due solely to changes in the employees' consumption behavior. But even if there are no behavior changes, health insurance premiums can be cut substantially.

The Experience of Large Groups. Many people — including representatives of large employers and large insurance companies — question whether there are substantial savings in raising the deductible. On the other hand, the claims experiences of large groups show that substantial savings occur. The reason for the confusion is that apparently contradictory statements can be made about the distribution of claims. Consider the following statements:

- About 4 percent of the people account for 50 percent of health care spending and 20 percent of the people account for 80 percent of the spending.
- About two-thirds of all health care spending is on medical bills of $5,000 or less.

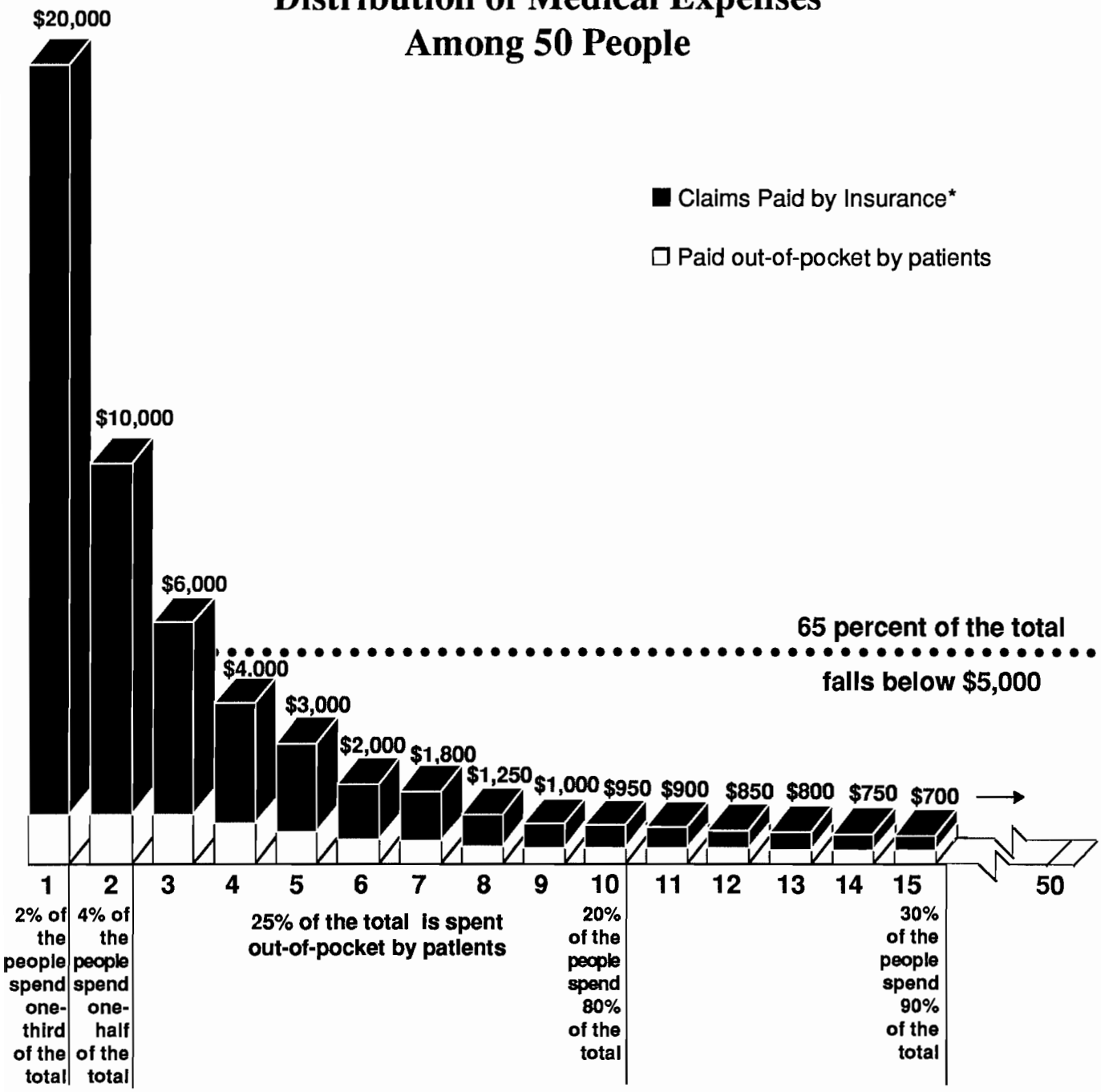
The first statement, popularized in a widely distributed Blue Cross-Blue Shield publication,[11] implies to many people that most of the money is spent on people who are very sick. By contrast, the second statement implies that most medical bills are small bills. As Figure V shows, both statements are correct.

The distribution of medical expenses in Figure V is a reasonable representation of what happens in both large groups. In this case, 50 people spend

$60,000, or $1,200 per person on the average. A small percentage of people spend most of the money and at the same time two-thirds of spending is on medical bills below $5,000. If the example were broadened to include a much larger group, the extremes of the distribution would become more evident. A few people would have medical expenses of several hundred thousand dollars, and many others would have no medical claims. The characteristics of the distribution, however, would be about the same as those shown in Figure V.

FIGURE V

Distribution of Medical Expenses Among 50 People



**Assumes a $250 deductible and a 20% copayment on the next $5,000 of expenses. Period of coverage is one year.*

Figure VI shows that when individuals are given a choice, those who choose a $1,000 deductible rather than a $250 deductible can expect a one-third reduction in health insurance premiums. A one-third reduction in claims costs (and therefore in premiums)[12] is possible for a large group if the deductible is increased from $250 to about $2,500. Considering that higher deductibles cause people to change their behavior, however, a one-third reduction in premiums for a large group will probably occur at a deductible between $1,000 and $2,500.

Winners and Losers With Higher Deductibles

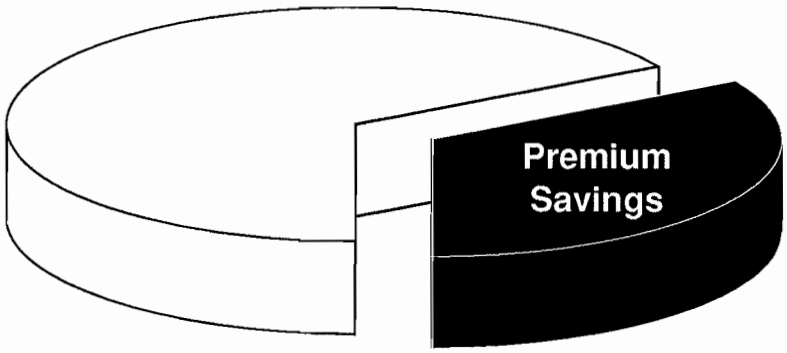
Except in those instances where people pay more in premiums than the value of coverage they receive, higher deductibles represent a gamble. On the one hand, a higher deductible results in premium savings. On the other hand, it puts policyholders at greater risk. Thus, some people will gain from a higher deductible and others will lose. *A priori,* most people won't know which group they are in.

As Figure V shows, the vast majority of people would gain from a higher deductible. In any one year, about 70 percent will have very few medical

"A large group can cut premiums by one-third with a deductible between $1,000 and $2,500."

FIGURE VI

Two Ways To Cut Health Insurance Premiums By One-Third



- **For individuals, choose a $1,000 deductible rather than a $250 deductible.**
- **For large groups, a $2,500 deductible will usually cut premiums by one-third— even if there is no change in consumption behavior of employees.**

expenses — accounting for only 2 1/2 percent of all health insurance claims. Those who have large medical bills, on the other hand, will be worse off. Yet as we show below, even people who have high medical expenses in any one year will be better off with a high deductible, *provided they do not have recurring large medical bills over many years.*

Take a leukemia patient, for example, who faces large medical expenses indefinitely into the future. With a high annual deductible, the out-of-pocket costs for this patient simply rise over time.

"Many problems could be avoided by having a 'per condition' deductible rather than an annual deductible."

Yet there are ways of structuring health insurance so that even potential leukemia patients are better off with a high deductible. Instead of the annual deductible which is common these days, health insurance could have a *per condition deductible* as was common earlier. With a per condition deductible, a person diagnosed with cancer would pay the deductible only once, and insurance would pay all of the remaining costs of the cancer treatments — even if those costs were incurred over many years.

Allowing People to Self-Insure Through Medical Savings Accounts

To help eliminate the perverse incentives in the current system, we should allow individuals to make tax free deposits each year to individual Medisave accounts. These accounts would serve as self-insurance and as an alternative to the wasteful use of third-party insurers for small medical bills. Funds in the accounts would grow tax free, and withdrawals would be permitted only for legitimate medical expenses. Funds not spent during a person's working years could be spent on postretirement health care or rolled over into a pension fund.

Medisave accounts would be the private property of the account holder and become part of an individual's estate at the time of death. If created by an employer, they would be personal and portable for the employee. Medisave contributions should receive at least as much tax encouragement as payments for conventional health insurance.[13]

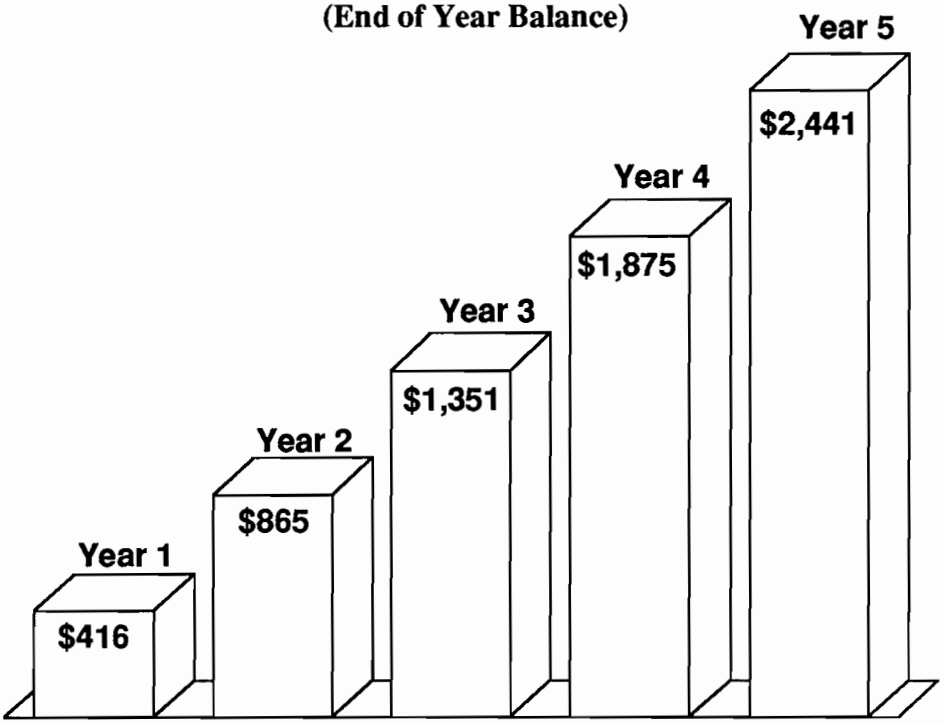
Medisave Accounts With a $1,000 Deductible. Most people have no medical expenses in any given year, and it is not uncommon for people to go for several years without incurring medical costs. Figure VII shows how Medisave balances would grow if not spent in the case of an individual who switches from $250 deductible to a $1,000 deductible, with $400 in premium savings each year. Let's compare benefits of the two alternatives:

"After five years of savings, a middle-aged male would be better off with a $1,000 deductible — even if he had a $1,000 medical expense every year for the next 48 years."

FIGURE VII

Growth of Medisave Accounts With $400 Annual Deposits[1]

(End of Year Balance)



[1]Assumes 8 percent interest.

- With a $250 deductible and a 20 percent copayment, the policyholder would pay $400 out of the first $1,000 of medical expenses and health insurance would pay 80 percent of the remainder.[14]

- With a $1,000 deductible, the policyholder would be at risk for $600 more each year.

"As Medisave account balances grow, people can choose even higher deductibles over time."

- With a $1,000 deductible and a Medisave account, however, the policyholder could have at least $400 additional cash each year — so at worst would pay an additional $200 in medical expenses out of personal funds.

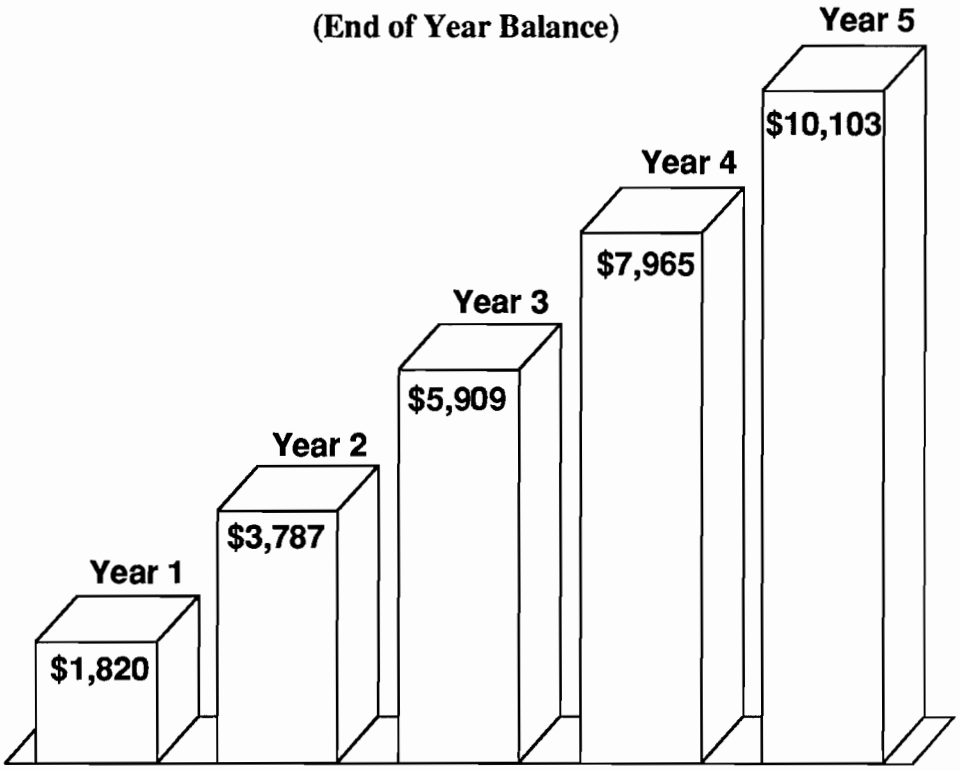
- On the other hand, if the policyholder makes it through the first 18 months without any medical expenses, he is clearly better off with a Medisave account even if he has $1,000 of medical expenses in year two.[15]

- If the policyholder has no medical expenses for five years, he will have accumulated $2,441 in his Medisave account — enough to make the Medisave option profitable even if he then has a $1,000 medical expense for each of the next 48 years!

"After one year of savings, the average family would be better off with a $2,500 deductible — even if they had a $2,500 medical expense in every succeeding year."

FIGURE VIII

Growth of Family Medisave Accounts With $1,750 Annual Deposits[1]



[1]Assumes 8 percent interest.

Medisave Accounts With a $2,500 Family Deductible. As noted above, a family in a city with average health care costs can expect to save about $1,749 in insurance premiums if they choose a $2,500 rather than a $250 deductible. Figure VIII shows how Medisave account balances would grow over time if none of the money were spent. Let's compare this Medisave option with a conventional health insurance policy:

- A family with a $250 deductible and a 20 percent copayment (up to $1,000) is at risk for $700 on the first $2,500 of medical expenses in any given year.[16]

- With the Medisave option, the family will have $1,750 in their account the first year, leaving them at risk for an additional $750 — only $50 more than under a conventional policy.

- Allowing for interest accumulation, this family will be better off with a Medisave account even if they have $2,500 of medical expenses at the end of each year, every year, indefinitely into the future.

Encouraging Self-Insurance: A Revenue Neutral Proposal. One way to encourage Medisave accounts without any loss of revenue to the federal government is to allow employers and employees to choose higher-deductible policies and place the untaxed premium savings in Medisave accounts.[17] For employees, there would be no change in the amount reserved for health care benefits or in the total tax subsidy for employee benefits. Yet the change would encourage prudence, eliminate waste and give employees greater control over their health care dollars.

Currently, many large employers maintain flexible spending accounts (FSAs) for their employees under Section 125 of the Internal Revenue Code. Under this arrangement, employees can reduce their salaries and make contributions to an individual FSAs with pretax dollars. The funds are then used to purchase medical expenses at the employee's discretion. The only difference between an FSA and a Medisave account is that FSA funds are governed by a "use it or lose it" requirement. If employees fail to spend the entire amount in their FSAs in one year, they forfeit the balance.[18] Thus, FSAs create the opposite incentives of Medisave accounts — employees are penalized for not spending FSA funds. A small change in the tax law could change this perverse incentive into a positive incentive: "use it or keep it."

"Instead of the current policy of 'use it or lose it,' people should be able to 'use it or save it'."

Extending Medisave Accounts to Others: A Non-Revenue Neutral Proposal. Although the federal government grants generous tax subsidies to employer-provided health insurance, only a 25 percent deduction is given to self-employed people who purchase their own health insurance. No deduction is given for the purchase of health insurance by the unemployed, employees of firms which do not provide health insurance or employees who must pay for health insurance coverage for their dependents with aftertax dollars.

Most of the 33 million Americans who lack health insurance have no tax encouragement to obtain it. One of the most effective ways to increase the number of people with health insurance would be to grant a tax deduction (or tax credit) to individuals who purchase health insurance with aftertax dollars. Since the choice to purchase health insurance would remain voluntary, this would create far fewer distortions in the labor market than would employer mandates.[19] At the same time we extend tax encouragement for third-party insurance to all Americans, we should also establish tax incentives to self-insure for small medical bills.[20]

Creating Medisave Accounts in Public Programs. Under the current system, the political pressures governing Medicare (for the elderly) and Medicaid (for the poor) are to expand benefits and refuse to pay for them. One consequence is that most doctors won't see a pregnant woman on Medicaid and there is increasing evidence of health care rationing for other Medicaid services. There is also increasing evidence of rationing under Medicare.

Medisave accounts could solve problems in both programs. For example, pregnant Medicaid women might have an account to draw on which they could freely spend in the medical marketplace. This would empower patients and expand the number of providers to whom they have access. Similarly, the elderly could choose higher Medicare deductibles and make deposits to their own Medisave accounts.

Medisave Accounts in Singapore. Medisave accounts have been in existence in Singapore since 1984. Unlike the proposals made here, in Singapore contributions to Medisave accounts are mandatory — part of the government's program of insisting that people save to meet needs that might otherwise have to be met by the state. Not only are the accounts mandatory, they are the principal form of health insurance in a country that only recently encouraged third-party insurance for catastrophic medical expenses. A more extensive discussion of the Singapore system is contained in Appendix B.

"Medisave accounts would give individuals control over how their health care dollars are spent."

Advantages of Medical Savings Accounts

Creating individual and family Medisave accounts would represent a major departure from the current system of paying for health care. These accounts would have immediate advantages which would become even more important over time.

1. Lowering the Cost of Health Insurance. Medisave accounts would allow people to substitute less costly self-insurance for more costly third-party insurance for small medical bills. To the degree they are 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. Lowering the Administrative Costs of Health Care. 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 administra-

tors and insurers. By one estimate, as much as $33 billion a year in administrative costs could be saved by the general use of Medisave accounts. (See the discussion below.)

3. Lowering the Cost of Health Care. Medisave accounts would institute the only cost control program that has ever worked — patients avoiding waste because they have a financial self-interest in doing so. When people spent money from their Medisave accounts, they would be spending their own money, not someone else's — an excellent incentive to buy prudently. By one estimate, the general use of Medisave accounts would reduce total health care spending by almost one-third. (See the discussion below.)

4. Restoring the Doctor-Patient Relationship. Medisave accounts would give individuals direct control over their health care dollars — freeing them from the arbitrary, bureaucratic constraints often imposed by third-party insurers. Physicians would see patients rather than third-party payers as the principal buyers of health care services and would be more likely to act as patients' agents rather than agents of an institutional bureaucracy.

5. Giving Patients More Control Over the Services They Are Insured For. Every group health insurance plan includes some services and providers, and excludes others. But the preferences of the group may not necessarily be those of the individual. In addition, state legislators are increasingly imposing their views on private group policies through mandated health insurance benefit laws. To the extent that individuals were self-insured, they would make these decisions for themselves.

6. Enjoying the Advantages of a Competitive Medical Marketplace. In most places, a patient cannot discover the cost of even routine surgery prior to entering a hospital. At the time of discharge, patients are confronted with lengthy, line-item statements not even their doctors can read. Thus, the people who make the purchasing decisions cannot find out what the price is in advance and cannot understand what they were charged afterward. The evidence suggests that these problems are created by our system of third-party payment and are not natural phenomena of the marketplace. When patients pay with their own money (e.g., 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.

"The doctor-patient relationship would be restored — as doctors became agents of patients rather than agents of third-party payers."

7. Enjoying the Advantages of Real Health Insurance. Because third-party insurance pays almost all U.S. medical bills, to a large extent health insurance is not really insurance. Instead, it is *prepayment for consumption of*

medical care. One consequence of this situation is that people with preexisting health problems often cannot buy insurance to cover other health risks. A system of Medisave accounts would encourage a market for genuine catastrophic health insurance and would make such insurance available to more people.

8. Expanding the Benefits of Self-Insurance Over Time. The funds in most Medisave accounts would grow over time, allowing people to choose higher deductible policies — thus relying less on third-party insurers and increasing their control over their health care dollars.

9. Creating Incentives for Better Lifestyle Choices. Since Medisave accounts would last over an individual's entire life, they would allow people to engage in lifetime planning — recognizing that health (and medical expenses) are related to their lifestyle choices. People would bear more of the costs of their bad decisions and reap more of the benefits of their good ones. Those who don't smoke, who eat and drink in moderation, refrain from drug use and otherwise engage in safe conduct would realize financial rewards for their behavior.

10. Expanding Health Insurance Options During Retirement. Medisave accounts would eventually become an important source of funds from which to purchase health insurance or make direct payments for medical expenses not covered by Medicare during retirement. Such funds would help America solve the growing problem of long-term care for the elderly.

Using Medisave Accounts to Lower the Administrative Costs of Health Insurance

"If medical bills were paid by patients with health care debit cards, administrative costs would be less than 2 percent."

Health insurance not only creates perverse incentives but its overuse also leads to high and unnecessary administrative costs. For example, the cost of marketing and administering private health insurance averages between 11 and 12 percent of premiums.[21] Dealing with private and public third-party payers also creates administrative burdens for physicians. A study by the American Medical Association estimates that a physician spends an average of six minutes on each claim and the physician's staff spends an average of one hour. Those physicians who contract with outside billing services pay about $8 per claim.[22]

Medisave accounts offer a way of cutting these costs dramatically while at the same time maintaining — and even improving — the quality of care.

Health Care Debit Cards. A general system of Medisave accounts would lead naturally to the use of health care debit cards. Patients could, for example, pay for physician visits by using their cards just as people now pay for merchandise at retail stores. Several health care debit card companies already exist, including Pulse Card, headquartered in Kansas City, Kansas and Security Plus, headquartered in Newport Beach, California.[23]

With an increase in volume and with increased competition, the administrative costs of using health care debit cards would be quite low, relative to the cost of using third-party payers. Currently, the overhead cost for credit card companies is as low as 1.29 percent. Moreover, for most transactions between patients and physicians, this would be the only administrative cost other than paperwork deemed necessary for purely medical reasons. Private and public insurers would not need additional paperwork except when total costs exceeded high patient deductibles.

Health Care Debit Cards and Medical Records. Health care debit cards could be combined with another technological innovation to reduce other costs and improve the quality of care. Several companies are experimenting with technology that would put a patient's entire medical record on a credit card.[24] This would allow physicians immediate access to each patient's complete medical history. Putting medical records on a credit card could be costly. But it might be less costly than the current system under which physicians treat patients about one-third of the time without access to their records.[25]

"Health care debit cards could contain a patient's entire medical records."

The Benefits of the Canadian System Without the Costs. Advocates of the Canadian system of national health insurance cite two principal benefits: (1) patients entering the health care system need produce only a national health insurance card in order to receive care, and (2) the administrative costs of the system are lower because the paperwork is reduced and other costs — such as marketing — are eliminated.

Against these advantages, there are severe disadvantages. Because patients are spending other people's money at the time they consume "free" health care, the potential demand is unlimited and Canadian provincial governments control costs by limiting technology and forcing physicians and hospitals to ration health care. As Canadian waiting lists grow longer, there are increasing reports of unnecessary patient deaths and increasing numbers of Canadians crossing the border for U.S. medical care. In addition, because of the perverse incentives the system creates for providers, physicians often

over-provide some services while hospital managers try to avoid the costs of acute care by housing chronic patients who use the hospitals as expensive nursing homes.[26]

A system of Medisave accounts plus health care debit cards could produce the benefits of the Canadian system without the adverse side effects. A valid health care debit card would be proof that a patient could pay small medical bills and had third-party insurance to pay large ones. Unlike the Canadian system, however, patients using debit cards would have strong incentives to purchase care prudently because they would be spending their own money.

A Ballpark Estimate of the Economic Effects of Medisave Accounts

"Medisave accounts can cut administrative costs and preserve the benefits of private sector medicine."

A number of studies have compared administrative costs of health insurance in the United States with those of Canada's national health insurance. For example, Table VI shows three estimates of the administrative savings that could be realized by adopting the Canadian system as well as an estimate of the costs of eliminating out-of-pocket charges. The potential savings in administrative costs range from a Lewin/ICF estimate of $34 billion to a General Accounting Office (GAO) estimate of $67 billion.[27] However, the effect of eliminating all deductibles and copayments swamps these savings and leads to a net increase in costs.

We believe the estimates of potential savings from reduced administrative costs are much too high for three reasons. First, government accounting practices always lead to underestimates of the real cost of government provisions of goods and services. Second, these estimates completely ignore all indirect costs (e.g., the costs of rationing and of physician and hospital responses to perverse incentives) caused by Canada's method of paying for health care. Third, many of the administrative activities in the U.S. health care system are not designed merely to control spending; they also are designed to prevent inappropriate medical care and maintain quality. The United States is not likely to follow the Canadian practice of giving hospitals global budgets and forcing physicians to ration health care with few questions asked.[28]

Nonetheless, Table VI is interesting for a different reason. What the GAO calculates as the rock-bottom cost of administering a health care system is probably on the high side when compared to a system of Medisave accounts

"Adopting the Canadian system would raise costs, not lower them — even according to the most favorable estimates."

TABLE VI

Estimates of the Economic Effects of Adopting the Canadian System in the United States

($ billions)

	Lewin/ICF	Physicians for a National Health Program	General Accounting Office
Insurance Overhead	-$22	-$27	-$34
Physician Administrative Expenses	-1	-9	-15
Hospital Administrative Expenses	-11	-31	-18
Total	-$34	-$67	-$67
Expansion of Coverage for the Currently Insured (Based on Rand estimate)[1]	+$54	+$54	+$54
Expansion of coverage for the Currently Uninsured (Based on Rand estimate)[1]	+$19	+$19	+$19
TOTAL EFFECT	+$39	+$6	+$6

[1]Based on GAO estimates for increased hospital spending and GAO estimates increased to reflect the Rand results for physician spending.

Source: General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, June 1991, pp. 62-67; L.S. Lewin and J. Sheils, *National Health Spending Under Alternative Universal Access Proposals* (Washington, DC: Lewin/ICF, October 26, 1990). Prepared for the AFL-CIO; and K. Grumbach et al., "Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal," *Journal of the American Medical Association*, Vol. 265, No. 19, May 15, 1991, pp. 2549-2554.

and health care debit cards. We used the GAO method to estimate the potential reduction in administrative costs under a system of Medisave accounts and health care debit cards, and the Rand Corporation's method to estimate the likely reduction in health care spending if people had high-deductible health insurance. Table VII shows the probable effects of a generalized system under which everyone (including Medicaid and Medicare patients) has third-party catastrophic insurance and uses health care debit cards, drawing on individual Medisave accounts to pay small medical bills. As the table shows:

TABLE VII

Economics Effects of Combining Universal Health Insurance with Medisave Accounts and Health Care Debit Cards

($ billions)

Adjustment	Change in Costs	
	Low Estimate	High Estimate
Savings in Administrative Costs:[1]		
Insurance Overhead	- $8	- $17
Physicians Administrative Expenses	- 5	- 10
Hospital Administrative Expenses	- 3	- 6
Total	- $16	- $33
Coverage for the Currently Uninsured[2]	+ 12	+ 12
Behavioral Response[3]	- 90	- 147
TOTAL EFFECT	- $94	- $168

[1]Based on GAO estimates of the potential savings in administrative costs with the following adjustments. For high estimate, one-half of savings attained in reduced insurance overhead, two-thirds of savings attained in reduced physician administrative costs and one-third of savings attained in reduced hospital administrative costs. For low estimate, one-half of those amounts. See GAO, *Canadian Health Insurance,* Table 5.1, p. 63.

[2]Based on GAO and Lewin/ICF estimates. See J. Needleman, et al., *The Health Care Financing System and the Uninsured* (Washington, DC: Lewin/ICF, April 4, 1990). Prepared for the Health Care Financing Administration.

[3]Based on Rand estimates. For high estimate, 23 percent reduction in total health care costs excluding insurance overhead, research and public health expenditures. For low estimate, spending is reduced by 45 percent for physicians and 10 percent for hospitals.

"Medisave accounts combined with health care debit cards would cut health care costs by almost one-third."

- A system which combines catastrophic third-party insurance with Medisave accounts should reduce administrative costs by as much as $33 billion.

- Because the presence of high deductibles would make patients more prudent purchasers of health care, total spending should go down by as much as $147 billion.

- After extending catastrophic health insurance to the currently uninsured, the net total savings are $168 billion — almost one-fourth of what the United States now spends on health care.

Conclusion

"No one should be forced to self-insure; but they should have the opportunity to do so."

Primarily because of U.S. tax law, most Americans are overinsured. People use health insurance to pay for non-risky medical episodes, including diagnostic tests and routine checkups. They also use health insurance to pay small medical bills they could pay more economically from personal funds. As a consequence, the administrative costs of the U.S. health care system are much too high and patients and physicians are often wasteful.

Health care costs in the United States could be reduced substantially if people relied on third-party insurance for catastrophic expenses only and paid small medical bills with health care debit cards, drawing on individual savings accounts. No one should be forced to self-insure for small medical bills. But Congress should create the opportunity for people to do so by giving just as much tax encouragement for deposits to individual medical savings as it currently grants to employer payments for third-party insurance.

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Appendix A

Twenty Questions and Answers About Medisave Accounts

1. How would Medisave accounts be administered?

Medisave accounts would be administered by qualified financial institutions in much the same way as Individual Retirement Accounts (IRAs). Individuals could exercise choice over the investment of account balances, but with the same restrictions on the type of instruments the accounts could own as now apply to IRAs.

2. How would funds from Medisave accounts be spent?

The simplest method would be by a debit card. Patients would use their debit cards to satisfy payment at the time medical services were rendered. At the end of each month, the 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?

In order to receive Medisave funds, a provider of medical services would have to be "qualified" under IRS rules. Qualifying should be a simple procedure, involving little more than the filing of a one-page form. But if IRS auditors discovered fraudulent behavior, the provider would lose the right to receive Medisave funds and might be subject to criminal penalties.

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

In general, any type of expense considered a medical expense under current IRS rules would qualify, including postretirement health insurance and COBRA health insurance payments during periods of unemployment.

5. What tax advantages would be created for Medisave deposits?

Medisave deposits would receive the same tax treatment as health insurance premiums. Thus, under employer-provided health insurance plans, Medisave deposits would escape federal income taxes, FICA 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 Medisave accounts would receive the same tax treatment. Medisave balances would grow tax free and would never be taxed if the funds were spent on medical care.

6. What about low-income families who cannot afford to make Medisave deposits?

If low-income families can afford to buy health insurance, they can afford to make Medisave deposits — since the primary purpose of the Medisave option is to allow individuals to divide their normal health insurance costs into two parts: self-insurance and third-party insurance. Currently, the tax law discriminates against people who do not have employer-provided insurance by failing to subsidize those who purchase health insurance on their own. Health insurance would become more affordable for the currently uninsured if they could deduct some or all of their premiums from their taxable income. It would become even more affordable through a system of refundable tax credits, which grants greater tax relief to low-income people.

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

One way would be to choose a higher deductible insurance policy and deposit the premium savings in the Medisave account. For most people, a year or two of such deposits would exceed the amount of their insurance deductible. Young people and people in low-cost areas might be allowed to make even larger deposits. An alternative (which tends to be revenue neutral for the federal government) is to allow people to reduce the amount of their annual, tax-deductible contributions to IRAs, 401(k) plans and other pensions and deposit the difference in a Medisave account.

8. What if medical expenses not covered by health insurance exceeded the balance in an individual's Medisave account?

One solution would be to establish a line of credit so that individuals could effectively borrow to pay medical expenses. Repayment would be made with future Medisave deposits or other personal funds. Another solution would be to adopt the Singapore practice of allowing family members to share their Medisave funds. This would become much less of a problem as Medisave balances grew over time.

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

Since family members often are covered under the same health insurance policy, it seems desirable to allow couples to own joint Medisave accounts and for parents to own family Medisave accounts. In these cases, more than one person could spend from a single account. But even if family members maintained separate accounts, this 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?

These people might be harmed by a sudden increase in the health insurance deductible unless transitional arrangements are made. Most would benefit from a high deductible in the long run but suffer financially at the outset.

One solution is for employers to extend credit to employees who are especially disadvantaged, with the loan to be repaid from future Medisave contributions. Another solution is for employers to bear part of the burden of these expenses (in the case of special hardship) during the transition period.

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

Most of these people would be disadvantaged if they have an annual deductible. A better form of health insurance is one with a per condition deductible, in which case the deductible would be paid only once for an extended illness.

12. Are there circumstances under which individuals could withdraw Medisave funds for non-medical expenses prior to retirement?

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

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

We don't. The theory behind Medisave accounts is that people should have a store of personal funds with which to purchase medical care. But since the money they spend is their own, they have strong incentives to make prudent decisions. Undoubtedly some of these decisions will be wrong. But many decisions made under the current system also are wrong.

Since we cannot spend our entire GNP on health, health care has to be rationed in some way. Under the current system we are moving toward the European solution — with rationing decisions made by a health care bureaucracy. The alternative is self-rationing, with individuals making their own choices between money and medical services.

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

One thing people can do is solicit advice from others who claim to 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 should be performed.

These experienced professionals might play an important role in helping patients make decisions about complicated and expensive procedures. But the professionals' role as advice-givers should not include decision-making power. We should let the experts advise and the patient decide.

Moreover, the fact that individuals maintain Medisave accounts does not preclude their taking advantage of employer-negotiated price discounts from providers or managed care programs.

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

The reason large institutions have so much difficulty negotiating with hospitals is precisely because the institution is not the patient. And the reason why patients spending 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. In the field of cosmetic surgery, for example, consumers can obtain package prices that are well below the prices charged for comparable procedures at institutions dependent on third-party reimbursement. Moreover, the fact that individuals maintain Medisave accounts does not prevent them from using employers as bargaining agents.

16. What would happen to Medisave account balances at retirement?

People should be able to roll over their Medisave 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. Alternatively, Medisave balances could be maintained to purchase postretirement health care, long-term care or long-term care insurance.

17. What would prevent wealthy individuals from misusing Medisave accounts to shelter large amounts of tax-deferred income?

An individual's total tax-advantaged expense for health insurance plus Medisave deposits could not exceed a "reasonable" amount. One definition of "reasonable" is an annual Medisave deposit which equals the deductible for a standard catastrophic health insurance policy.

18. What about people who join HMOs?

They would have the same opportunities as those who join conventional, fee-for-service health insurance plans. Note that because many HMOs are now instituting deductibles, HMO members will have additional incentives to acquire Medisave accounts. Their HMO premiums plus their deposits to Medisave accounts could not exceed a reasonable amount, however.

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

Allowing employees to make individual choices makes sense. Over time, different people will have different accumulations in their Medisave accounts and, thus, will likely have different preferences about health insurance deductibles. However, under current law, employers have the option of fashioning employee benefit plans, and it is in their self-interest to create a plan that is most pleasing to employees. As a practical political matter, it seems wise to continue that feature of the current system.

20. What would happen to the Flexible Spending Accounts now available to some employees?

Medisave accounts would replace Flexible Spending Accounts (FSAs) under employee benefits law. Currently, employees who make deposits to FSAs must "use it or lose it," typically within twelve months. Similar deposits made to Medisave accounts would have no such restrictions.

Appendix B

Medisave Accounts in Singapore[29]

In 1955, Singapore introduced a compulsory savings program that covers about three-fourths of all Singapore workers.[30] Employer and employee contributions are made to the Central Provident Fund (CPF), which is controlled by the government and has a monopoly status. In the beginning, the CPF invested its funds entirely in government securities, and withdrawals were essentially limited to lump sum retirement benefits or survivor benefits. Over the years, however, the program has acquired flexibility. Workers can now direct the investment of up to 40 percent of their CPF funds[31] and withdraw funds to purchase a house, buy life or home mortgage insurance or borrow funds from their accounts to pay college expenses for a family member.[32]

The required rates of contribution to CPF accounts over the past 25 years are shown in Table B-1. Remembering that employer contributions on behalf of employees are undoubtedly made in lieu of the payment of wages, the table shows that the forced savings rates in Singapore have been quite high — totaling 50 percent of the first $41,000 of wages (in U.S. dollars) in 1985.[33] For the future, the government is committed to gradually move toward a contribution rate of 40 percent, 20 percent each for employees and their employers.[34]

All employees in Singapore have a private property right to the funds which accumulate in their individual CPF accounts. These funds may be withdrawn at retirement, in the event of permanent disability or if the individual emigrates from Singapore or Malaysia. At the account holder's death, the funds are payable to the individual's heirs.

Prior to 1987, funds were withdrawn as a lump sum at the time of retirement. Beginning in 1987, however, the government required retirees to use the first US$18,600 (single) or US$27,900 (couple) to purchase a monthly retirement annuity equal to $143 (single) or $214 (couple). Retirees can use the balance of their fund for any purpose. However, as Table B-2 shows, the bulk of CPF withdrawals have been used to purchase a home — usually well before the time of retirement. About 86 percent of the housing in Singapore has been built by the government and of these units, 70 percent have been purchased by their occupants — with CPF money.

Beginning in 1984, the government of Singapore extended its program of forced savings to require that a certain portion of CPF contributions be put into "Medisave accounts" to provide a source of funds for hospitalization expenses. The funds may be used only for treatment at a government hospital or an approved private hospital.[35] Strangely, Medisave funds cannot be used to purchase outpatient care, including physicians' services or expensive outpatient renal dialysis and long-term care. People also cannot borrow against future Medisave deposits to pay current bills at private hospitals, although family members can pool their Medisave balances to pay another member's hospital bill, and people who enter some government hospitals can settle their bills from future Medisave deposits.

TABLE B-1

Forced Savings in Singapore: Features of the Central Provident Fund

(Financial totals in Singapore dollars)

	Required Contribution:			Size of Maximum Taxable	Fund at End of Year	Members at End of Year
Beginning	Employer	Employee	Total	Wage	($Millions)	(Thousands)
July 1955	5.0%	5.0%	10.0%	$ 6,000	$ 9	180
Sept 1968	6.5%	6.5%	13.0%	27,692	540	505
Jan 1970	8.0%	8.0%	16.0%	22,500	777	639
Jan 1971	10.0%	10.0%	20.0%	18,000	988	715
July 1972	14.0%	10.0%	24.0%	18,000	1,316	855
July 1973	15.0%	11.0%	26.0%	18,000	1,771	962
July 1974	15.0%	15.0%	30.0%	18,000	2,414	1,042
July 1975	15.0%	15.0%	30.0%	24,000	3,235	1,104
July 1977	15.5%	15.5%	31.0%	24,000	4,954	1,251
July 1978	16.5%	16.5%	33.0%	36,000	5,981	1,341
July 1979	20.5%	16.5%	37.0%	36,000	7,516	1,436
July 1980	20.5%	18.0%	38.5%	36,000	9,551	1,519
July 1981	20.5%	22.0%	42.5%	36,000	12,150	1,650
July 1982	22.0%	23.0%	45.0%	36,000	15,656	1,725
July 1983	23.0%	23.0%	46.0%	48,000	19,505	1,779
July 1984	25.0%	25.0%	50.0%	60,000	22,670	1,847
July 1985	25.0%	25.0%	50.0%	72,000	26,829	1,892
April 1986	10.0%	25.0%	35.0%	72,000	29,341	1,932
July 1988	12.0%	24.0%	36.0%	70,000	32,529	2,063
July 1989	15.0%	23.0%	38.0%	72,000	36,052	2,126
July 1991	17.5%	22.5%	40.0%	72,000	42,000	2,200

Source: Central Provident Fund, *Annual Report*, various years.

TABLE B-2

Uses of Withdrawals From Forced Savings Accounts

(Millions of Singapore dollars)

Year	Total	Approved Housing Schemes	Reached 55 Years of Age	Leaving Singapore & Malaysia Permanently	Medisave	Death	Others[1]
1968	$30.7	$6.3	$14.9	$5.0		$1.8	$2.7
1969	42.4	21.7	13.3	4.2		2.0	1.1
1970	45.7	22.9	15.4	4.2		2.0	1.1
1971	56.4	23.2	22.1	7.0		3.2	0.9
1972	57.9	25.1	23.8	4.1		3.8	1.2
1973	93.5	50.6	31.4	5.7		4.7	1.0
1974	154.3	92.8	46.4	8.1		5.5	1.6
1975	216.9	134.8	60.9	11.2		8.4	1.5
1976	377.7	275.2	76.2	14.1		9.3	2.9
1977	503.5	383.5	90.0	14.1		12.6	3.4
1978	657.8	488.4	123.1	15.7		13.8	16.8
1979	629.3	438.6	150.7	18.2		15.1	6.7
1980	779.1	520.9	213.9	23.2		15.6	5.4
1981	1,067.6	691.1	294.5	33.0		19.5	29.5
1982	1,241.2	796.3	322.9	56.4		27.1	38.5
1983	1,717.9	1,122.4	437.8	104.3		31.3	22.1
1984	3,509.3	2,692.9	606.0	96.4	$17.6	35.6	60.8
1985	3,359.7	2,566.4	506.2	146.3	43.9	40.5	56.4
1986	3,823.8	2,647.3	666.3	156.8	104.8	44.4	204.2
1987	3,697.2	2,647.5	548.0	143.9	140.5	48.6	168.7
1988	4,010.2	2,776.1	573.5	151.7	169.9	52.2	286.8
1989	3,663.3	2,415.1	619.4	161.5	178.2	54.2	234.9

[1]Includes withdrawals for physical and mental disability, for purchase of home mortgage insurance and for investments in non-residential real estate and approved shares of stock and gold.

Source: *Economic and Social Statistics of Singapore 1960-1982*, Department of Statistics 1988; and *Singapore Yearbook of Statistics 1988*; and Central Provident Fund, *Annual Report 1989*.

Currently, 6 percent of an employee's salary is placed in a Medisave account until the balance reaches approximately US$8,522. Once that total is reached and maintained, any additional contributions are automatically placed in an individual's ordinary account. In Singapore, $8,522 would be sufficient to cover hospitalization expenses except in very rare catastrophic cases. The Singapore government currently is negotiating with private health insurance companies and is apparently committed to allowing some portion of the Medisave account funds to be used for the purchase of health insurance coverage. In 1985, 145,000 members of the CPF (out of a total Singapore population of 2.6 million) made Medisave withdrawals averaging about US$171 per person. As Table B-2 shows, between 1985 and 1988 the use of Medisave funds quadrupled.

Funds in a Medisave account are self-insurance for hospitalization throughout the employee's working life. At retirement, people are required to leave about US$4,830 in their Medisave account to cover medical expenses after age 55.[36] Singapore's Medisave program, therefore, is a more general application of the concept of the medical IRA, which has been proposed in various forms in the United States.

Like most other provident fund systems around the world, the Singapore system forces people to save but allows them to make withdrawals for many of the purposes for which people ordinarily engage in private, voluntary savings — retirement, disability, death expenses, medical expenses and the purchase of a home. Singapore's provident fund differs from others in that there is very little insurance (and therefore no pooling of risks) for adverse contingencies such as hospitalization, disability or death. What individuals receive in the event of these contingencies is based solely on their own contributions. An exception is compulsory mortgage insurance, for which the premium is paid from the buyer's CPF account.

The Singapore system is far from perfect. Restrictions on the use of Medisave funds encourage people to over-use hospital care and under-use less expensive alternatives. Certain restrictions favor public over private hospitals (although Singapore is privatizing its public hospitals) and discourage the development of a competitive market for hospital care. And some restrictions against borrowing from future Medisave deposits to pay current expenses seem unwise. The timing of medical expenses over a person's working life may not match the timing of the buildup of Medisave funds.

On the other hand, Singapore has established one of the most innovative ways of paying for health care found anywhere in the world — a vast system of individual self-insurance. The philosophy of the government of Singapore is "no subsidies." Each individual is expected to pay his or her own way, and the government forces people to save for the needs that are often met by government in most other countries. The program has been highly successful. The Singapore welfare state has steadily shrunk over the past two decades and is now largely devoted to helping the low-income elderly, who participated in the program for only a few years. As the Singapore program has matured and the savings requirements increased, only among older workers are there many who have failed to accumulate substantial savings. For example, about 70 percent of all middle-aged workers have savings of more than $17,000.

Footnotes

[1] For a more complete discussion of the issued covered in this report, see John Goodman and Gerald Musgrave, *Solving America's Health Care Crisis* (Washington, DC: Cato Institute), forthcoming.

[2] Glenn Ruffenbach, "Medical Tests Go Under the Microscope," *Wall Street Journal*, February 7, 1989.

[3] Simon Rottenberg, "Unintended Consequences: The Probable Effects of Mandated Medical Insurance," *Regulation*, Vol. 13, No. 2, Summer 1990, pp. 27-28.

[4] See Robert Brook et al., *The Effect of Coinsurance on the Health of Adults* (Santa Monica, CA: Rand, 1984); and Willard Manning et al., "Health Insurance and the Demand for Health Care: Evidence from a Randomized Experiment," *American Economic Review*, June 1987. For a survey of economic studies of the demand for medical care, see Paul Feldstein, *Healthcare Economics* (New York: Wiley, 1988).

[5] The one exception was vision care, which is not surprising — since eyeglasses are often viewed as a marginal health care expenditure. Sometimes mentioned is high blood pressure, since it was close to being statistically significant. Researchers could find no other significant differences in health outcomes. See Joseph Newhouse et al., "Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance," *New England Journal of Medicine*, Vol. 305, No. 25, December 17, 1981, pp. 1501-1507; and Robert Brook et al., "Does Free Care Improve Adults' Health," *New England Journal of Medicine*, Vol. 309, No. 23, December 8, 1983, pp. 1426-1434.

[6] The value of the benefit equals 1/(1-t), where t is the marginal federal income tax rate plus the combined employer-employee Social Security payroll tax rate. For a worker in the 15 percent bracket, t = 0.15 + 0.153. For a worker in the 28 percent bracket, t = 0.28 + 0.153.

[7] Unless the policyholders have reached the cap on their copayment ($1,000), they must pay 20 percent of medical expenses above the deductible. Thus, if policyholders with a $1,000 deductible have medical expenses of $2,500 they must pay the first $1,000 plus 20 percent of the next $1,500 (or $300). The insurance company, in this instance, will pay $1,200.

[8] These calculations are based on policies sold by Golden Rule Insurance Company, the largest seller of individual and family policies in the country. Other insurance companies sell similar policies at similar prices. See John Goodman and Gerald Musgrave, "The Cost of Low-Deductible Health Insurance," National Center for Policy Analysis, forthcoming.

[9] See John Goodman, Aldona Robbins and Gary Robbins, "Mandating Health Insurance," National Center for Policy Analysis, NCPA Policy Report No. 136, February 1988.

[10] The foregone coverage is 80% x ($2,500 - $250) = $1,800.

[11] Blue Cross and Blue Shield System, *Reforming the Small Group Health Insurance Market*, March 1991, p. 6.

[12] Assumes that administrative costs are proportional to claims, which is consistent with the industry's experience.

[13] The concept of medical savings accounts was originated by Jesse Hixson, currently a health policy economist with the American Medical Association. The idea first appeared in print in John Goodman, Peter Ferrara, Gerald Musgrave and Richard Rahn, "Solving the Problem of Medicare," National Center for Policy Analysis, NCPA Policy Report No. 109, January 1984. The idea achieved further impact through John Goodman and Richard Rahn, "Salvaging Medicare with an IRA," *Wall Street Journal*, March 20, 1984. That same year Singapore introduced the program discussed in Appendix B.

[14] The employee's expenses would be the $250 deductible plus a coinsurance payment of $150 (20% x $750).

[15] Under a conventional policy, the insured would have to pay $400 out of personal funds. When insurance is combined with Medisave funds, however, the insured would have to pay less than $400 out of other personal funds.

[16] The family's expenses would be the $250 deductible plus a copayment amount of $450 [20% x ($2,500-$250)].

[17] Under the current budget rules, any change in policy proposed in Congress must not cause a net loss of federal revenue. The forecasting techniques used to estimate revenue effects are "static" rather than "dynamic," however. Thus, forecasters tend to ignore any behavioral economic responses that would result from a change in the composition of the total amount of non-taxed employee benefits.

[18] See Alain Enthoven, "Health Policy Mismatch," *Health Affairs*, Winter 1985, pp. 5-13

[19] See Goodman, Robbins and Robbins, "Mandating Health Insurance."

[20] For example, individuals might be given a tax deduction for the amount of money that would be necessary to purchase a standard $250 deductible policy. For the purchase of higher deductible policies, taxpayers could be granted the right to deposit the premium savings in Medisave accounts.

[21] According to estimates by Hay/Huggins Company, the "load factor" for private health insurance ranges from 5.5 percent for groups of 10,000 or more to 40 percent for groups of less than five people. See Uwe Reinhardt, "Breaking American Health Policy Gridlock," *Health Affairs*, Summer 1991, Exhibit 1, p. 100.

[22] American Medical Association Center for Health Policy Research, "The Administrative Burden of Health Insurance on Physicians," *SMS Report*, Vol. 3, No. 2, 1989.

[23] See Burt Sims, "Cutting Health Care Costs: A Major Breakthrough," *US Business to Business*, Winter 1991.

[24] Currently, there are three competing technologies: magnetic striped cards, smart cards (with integrated circuits) and optical memory (laser) cards. See C. Peter Waegemann, "Patient Cards — The Promise of the Future?" *Medical Practice Management*, Spring 1990, pp. 264-268.

[25] Ibid., p. 264.

[26] For these and other defects of Canadian national health insurance, see John Goodman and Gerald Musgrave, "Common Myths About National Health Insurance," National Center for Policy Analysis, forthcoming.

[27] See General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, June 1991.

[28] See Patricia M. Danzon, "The Hidden Cost of Budget-Constrained Health Insurance," paper presented to an American Enterprise Institute conference on "American Health Policy," Washington, DC, October 3-4, 1991.

[29] For general descriptions of the Singapore system, see John Goodman and Peter Ferrara, "Private Alternatives to Social Security in Other Countries," National Center for Policy Analysis, NCPA Policy Report No. 132, April 1987; and "The Report of the Central Provident Fund Study Group," *Singapore Economic Review*, Vol. 31, No. 1, April 1986. We are indebted to Armina Tyabji for collecting some of the material used in this section.

[30] The program does not include people who are self-employed and people covered by separate plans such as university employees and pensionable civil servants.

[31] Investments may be made in real estate, in approved shares of stock in Singapore companies and in gold. People are not allowed to purchase bonds or shares of stock in foreign countries.

[32] These loans must be repaid.

[33] All figures expressed in U.S. dollars in this section are based on a conversion rate of S$1.76=US$1

[34] Currently, the maximum taxable wage is $72,000. The average wage was $28,684 in 1990.

[35] Hospital patients also face copayments, which they must make with out-of-pocket funds, in addition to payments from Medisave accounts.

[36] When Medisave accounts were started in 1984, the required balance was S$5,000 or the actual balance, whichever was lower. That amount has increased by S$500 per year and will continue to increase until it reaches S$10,000 in 1994.

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- Man-made food additives, pesticides and airborne pollutants are much less of a health risk than carcinogens that exist naturally in our environment.

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