

**A Proposal
for
Averting
Future Crises
in Delaware's
Medicaid Funding**

**C. D. Casscells, M.D.
Policy Director
Center for Health Policy
The Caesar Rodney Institute**

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Finally, I extend many thanks to Scott Atlas, M.D., Robert Wesson Senior Fellow at Stanford University's Hoover Institution. His book, *Restoring Quality Health Care: A Six-Point Plan for Comprehensive Reform at Lower Cost*, inspired the analysis presented here.

C. D. Casscells, M.D.
Policy Director
Center for Health Policy
The Caesar Rodney Institute
Newark, Delaware

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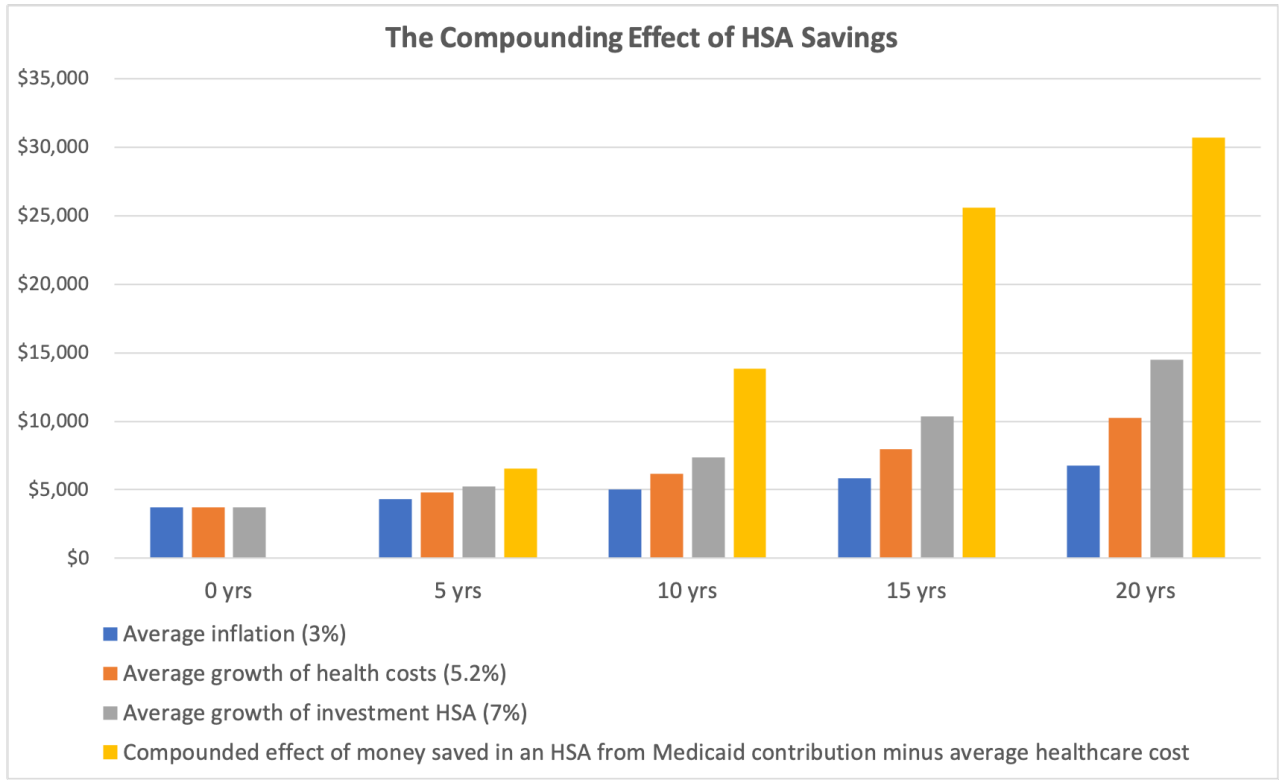
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Executive Summary

The State of Delaware's budget trajectory is unsustainable. With a stagnant economy and shrinking tax base, its obligations to provide healthcare to its employees, pensioners, and Medicaid are steadily rising and risk a balanced budget. The rising healthcare costs exceed that of inflation and vastly exceeds the state's GDP growth. One in four Delawareans is now a recipient of government-funded programs. The following is a proposal for a demonstration project for the age of birth to 20-year-old demographic in the Medicaid program. The project is designed to increase access to medical care, lower healthcare costs while increasing the quality, and lower the cost and risk to the state's budget. The basic mechanism is the use of health savings accounts, giving purchasing power back to the individual, encouraging savings, and capitalizing on the compounding effect of the invested money. Should the demonstration project in this demographic be successful, the issues of pre-existing conditions would cease to exist, and the model could be expanded to the other demographics in the medical assistance population.

A Proposal for Averting Future Crises in Delaware's Medicaid Funding

Below is a graphic representation of the effect of relative growth rates and the effect of compounding on the difference in dollar growth after inflation, even subtracting the initial average Medicaid enrollee cost in this demographic. In a short while, the State of Delaware's contribution to Medicaid would disappear.



The Larger, National Dilemma

In the United States, there is a broad consensus that the rising cost of health care, led by Medicare and Medicaid, poses a huge fiscal challenge.¹

Some consider it a long-term threat to this country's global economic preeminence, given foreseeable problems with annual budget deficits and ballooning national debt.²

But at the federal level, we behave as though we believe that the fiats of the Federal Reserve System and the printing presses of the United States Treasury Department can cope indefinitely with spending obligations and huge annual budget deficits.³

A very few voices, despite the evidence of history and the best available computations, have even been heard to express the hope that a booming national economy could somehow outgrow the problem.⁴

Most would regard that hope as a triumph of fantasy over reality.⁵

The President, to his credit, did announce a "Price Transparency" regulation to take effect Jan. 1, 2021, much to the dismay of the hospital lobby.

That is a critical first step to true reform.

¹ <https://khn.org/morning-breakout/impending-insolvency-of-medicare-may-hit-sooner-due-to-pandemic/>
<https://www.advisory.com/daily-briefing/2020/09/11/weekly-line>
https://www.bls.gov/spotlight/2009/health_care/

² <https://www.brookings.edu/policy2020/votervital/how-worried-should-you-be-about-the-federal-deficit-and-debt/>

³ <https://www.wsj.com/articles/how-washington-learned-to-love-the-deficit-11560436380>

⁴ <https://www.baconsrebellion.com/wp/can-the-u-s-outgrow-its-national-debt/>

⁵ <https://www.nevadaappeal.com/news/opinion/jim-hartman-unsustainable-federal-deficits-and-debt/>

Delaware's Troubling Outlook

Individual states must deal with constraints that play no role in decisions made in Washington, D.C.

State governments cannot print money and are usually obligated to run on balanced annual budgets.

For Delaware, the problem of state spending on health insurance is especially pressing. The state is experiencing successive years of no-growth economy (2019's rate of expansion was 0.0%)⁶ in tandem with rapidly growing budgets for its Medicaid program and for the health insurance benefits extended to State employees, both active and retired. COVID lockdown recession notwithstanding.

Delaware's government is the state's largest employer. State employees, active and retired, enjoy Platinum-level coverage, the most expensive of the five tiers of coverage available in the state.⁷

Delaware also has an expanding Medicaid obligation as the lower-income population seeking the program's coverage increased under the effects of the Affordable Care Act (ACA) and the insurance exchange marketplace it created.⁸

Data generated by the Kaiser Family Foundation show that the percentage of the state's budget taken up by Medicaid expenditures rose from its historic norm of about 17% to 19.2% by 2015 and to 21% in 2018, as 90% of the funding for Delaware's Medicaid program from the Federal Government decreased to 59%.⁹

⁶ <https://www.bea.gov/news/2020/gross-domestic-product-state-third-quarter-2019>

⁷ <https://dhr.delaware.gov/benefits/agencies/index.shtml>

⁸ <https://www.dhss.delaware.gov/dmma/fpl.html>

⁹ <http://files.kff.org/attachment/fact-sheet-medicaid-state-DE>
<https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22delaware%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Delaware's Troubling Outlook *(continued)*

That percentage of federal support is programmed to decline in the coming years, putting far greater pressure on the state's resources.¹⁰

Although precise figures do not yet exist for how much of Delaware's 2021 budget will go toward Medicaid, the best sources agree that in the fiscal year 2019, the number was close to 30%.¹¹ The historic national figure is 17%. As reported by the US Dept of Health and Human Services, Delaware 2020 Federal Financial matching rate for Medicaid was 59% and is scheduled to decrease by 1% in 2021.

The end to this climb in Medicaid dominance of the budget in future years is not in sight, but the trend is not sustainable.

In the fiscal year 2021, Delaware's aggregate spending on health care has been estimated at nearly 40%.¹¹

There are projections that by 2025 over 50% of Delaware's annual state budget will go toward health insurance.¹²

Major shortfalls and paralyzing funding crises lie ahead.

¹⁰ <https://www.macpac.gov/subtopic/state-and-federal-spending-under-the-aca/>

¹¹ https://dhss.delaware.gov/dhss/files/dmma2021presentation_02262020.pdf

¹² <https://news.delaware.gov/2018/12/19/health-care-spending-benchmark/>

Inflation vs. Stability and Falling Prices

The Federal Bureau of Labor Statistics estimates that inflation in the nation's health care sector will average 5.2% per year.¹³

Without going into the several forces and complex, perverse incentives that drive that inflation, one cause that virtually no economist would deny is that those who receive health care rarely pay most of the cost for it in any direct way.¹⁴ Relying on third parties, public or private, to attend to the details, they are in the unusual position of being customers who do not question pricing; they don't comparison shop; they have no reason to ask for a lower price. They regard these matters as utterly beyond their control. In short, the buyer of the service has been uncoupled from, even insulated, and anesthetized against, the price.

What would happen if that changed? What if consumers of medical services cared about the price, knew how it would affect them, and knew that their choices could cause prices to move in a direction favorable to them?

There are many medical procedures that exist largely outside the sphere of the third-party payer system that dominates the American system of health care. For one thing, the beneficiary of and payer for those procedures almost always knows what they will cost ahead of time. These are often cosmetic, highly elective, and generally discretionary.

The history of those procedures, a history shaped by certain "natural laws" of economic behavior, is instructive. For example, discretionary cosmetic

¹³ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0459>
https://www.bls.gov/spotlight/2009/health_care/

¹⁴ <https://www.jpands.org/vol19no3/buff.pdf>

Inflation vs. Stability and Falling Prices *(continued)*

surgeries—facelifts, eye lifts, breast implants, liposuction, the Lasik procedure to improve vision—***ALL*** have been accompanied by significant drops in price over the last 20 years,¹⁵ while the safety and reliability of the outcomes have measurably improved. Lower prices. Higher quality.

Again, those procedures are not covered by health insurance—private or taxpayer-funded.

Instead, they have been subjected to “market discipline.” The interactions of countless buyers and sellers have created a supply and demand profile in the marketplace, exerting a powerful restraint or even downward pressure on the prices of those procedures.

Our investigations at the Caesar Rodney Institute have led us to conclude that the extension of this same discipline across the health care marketplace would be enormously helpful in averting the budgetary crises that are assuredly ahead if we do not change course.

¹⁵ <https://www.aei.org/carpe-diem/what-economic-lessons-about-medical-costs-can-we-learn-from-the-market-for-cosmetic-procedures/>

Our Proposal: An Experiment in Delaware's "Laboratory"

We propose an experiment to address the cost of Medicaid, the most troubling feature of Delaware's fiscal future.

Observations Leading to a Testable Hypothesis

- The average cost per Medicaid enrollee is \$8,875 per year. At the moment, that adds up to roughly 62% of the annual budget for Delaware's Health and Human Services.¹⁶
- About one-tenth of that 62% is "overhead."¹⁷ (Medicaid and Medicare are reputedly low in overhead relative to private insurance. Although government opacity makes it difficult to assess, the consensus is the average is 10%. Commercial health insurance margins vary widely. By contrast, administrative overhead costs for hospitals and physicians range from 20% to 27%. Assignment of overhead cost for actual delivery of healthcare is difficult but is generally assumed to be over 70%. The point is that neither Medicaid nor health insurance actually provides healthcare service, only manage it financially.
- One in four Delawareans are enrolled in one of the several DMMA programs of Delaware Department of Health and Human Services, according to Director Stephen Groff, in his budget address to the Joint Finance Committee. That 2020 DE budget for HHS was \$2.4 billion, 54% of the total \$4.4 billion DE budget, of which \$1.5 billion was provided to DE from the Federal Government, FMAP.

¹⁶ <https://www.investopedia.com/articles/personal-finance/082015/how-much-medicaid-and-medicare-cost-americans.asp>
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>

¹⁷ <https://www.americanprogress.org/issues/healthcare/reports/2019/04/08/468302/excess-administrative-costs-burden-u-s-health-care-system/>

Observations Leading to a Testable Hypothesis (continued)

- Expansion of Medicaid under the ACA was initially associated with a Federal Medical Assistance Percentage (FMAP) of 90%; it is now 59%.¹⁸

- Of those who rely on Medicaid in Delaware, those who generate the least cost are those under the age of 20.¹⁹ At present, they cost the program \$3,745 per year, about 22% of the state's total annual expenditure for Medicaid. There is considerable potential for savings with this group. They enter as CHP, Children's Health Program, and often proceed into Medicaid. They have difficulty accessing quality healthcare because low reimbursement rates cause fewer participating practitioners. There is a supply problem.

- We have another existing instrument that an individual can use to pay for medical services—the Health Savings Account (HSA). While it was designed in the 1980s as Medical Savings Account, primarily as a tax device, it is uniquely adept at introducing supply and demand principles to the healthcare market. There are limitations, most related to federal tax policy.
 - An HSA is an instrument only available to those who have insurance coverage featuring a high deductible.
 - Contributions to an HSA are capped annually but slowly rising.
 - Contributions to an HSA are tax-deductible up to a point.
 - The HSAs funds can be invested in the market.
 - IRA funds can be converted into an HSA with limits

¹⁸ <https://fas.org/sgp/crs/misc/R43847.pdf>, pages 5 and 6

¹⁹ <https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/>

Observations Leading to a Testable Hypothesis (continued)

- When HSA funds grow through investment, there is no tax on the gain.
 - HSA purchases can be made with an HSA debit card through which the available dollars can be certified electronically at points of purchase and transaction data gathered and maintained.
 - When HSA funds are spent, there is no redemption tax.
 - HSA funds can be used for dental and eye care, as well as a broad range of approved health-related expenditures not usually covered by conventional insurance.
 - HSA funds cannot be spent on just anything, such as clothing, jewelry, alcohol, or other non-health-related items.
 - Unused HSA funds (unlike the money in Flexible Spending Accounts) can roll over from year to year. They do not expire.
 - Unused funds in an HSA are inheritable, tax-free, by a spouse.
 - But, unused funds in an HSA inherited by heirs other than a spouse are taxable as part of the estate tax and treated as IRA money.
-
- Delayed or absent attention to the day-to-day basics of personal care, notably for teeth and general hygiene, are the most-frequent gateways to greater health problems in the materially disadvantaged under the age of 20.²⁰

²⁰ <https://www.cdc.gov/nchs/fastats/dental.htm>

Observations Leading to a Testable Hypothesis (continued)

- Under existing IRS regulation, although one may continue to own an HSA, contributing to it is prohibited ***unless*** one also has a “High Deductible Catastrophic Health Insurance Policy” (a deductible of at least \$1,400 for an individual, or \$2,800 for a family). Contributions are therefore prohibited if one is enrolled in Medicare, Medicaid, or has employer-sponsored health insurance.²¹
- Over the last 140 years, the overall stock market index has risen by 10% per year, ranging from an average low of 9.2% per year in some decades to an average high of 13.6%.²²
- And throughout its 99-year history, the S&P index has risen an average of 10% per year.²³
- As stated earlier, the Federal Bureau of Labor Statistics (FBLs) has found that healthcare costs rise by 5.28% per year, almost twice the rate of inflation in the rest of the economy, and will continue to do so.²⁴

²¹ <https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/irs-2021-hsa-contribution-limits.aspx>

²² <https://www.businessinsider.com/personal-finance/average-stock-market-return>

²³ <https://www.investopedia.com/ask/answers/042415/what-average-annual-return-sp-500.asp>

²⁴ https://www.bls.gov/spotlight/2009/health_care/

Further Assumptions and Reasoning Underlying the Hypothesis

Below, we discuss certain assumptions and reasoning that take into account the foregoing observations that lead to the testable hypothesis.

HSA money can be spent, as needed, on any form of health care, including dental work, eyeglasses, prescription medications, or sundries, such as hygiene products and appropriate analgesics. What if they could be spent on High Deductible Catastrophic Health Policies, say, at an average of \$99 per month?

BECAUSE THE MONEY IS THEIRS, and because the behavior of people who have choices and responsibility for their own money is affected in certain predictable ways, the population participating in the experiment will, over time, develop the habits of spending the money more judiciously, seeking out better prices from providers of products and services, and preserving as much of their funding as possible so that it can be rolled over to the next year. There would be no reason to exhaust the funds simply because they would be lost if unused—an unfortunate feature of Flexible Spending Accounts, disincentivizing saving.

Given (a) an ***average*** annual inflation rate of 5.28% in the costs of health care, and (b) and an assumed inflation rate of 2.64% (half of 5.28%) in the rest of the economy, the inflation-adjusted annual rate of growth for the invested money would be 7%, a figure often attributed to Warren Buffett.

Using that conservative estimate of growth, we calculate the difference between the growth in the invested money and the rate of inflation in the cost of health care to be 1.72%. That is the rate by which the invested portion of HSA funding would grow per year. That figure, compounded over the 20 years of an individual's participation in the experiment, would yield ***about \$80,000 more than*** the total cost of Medicaid for that individual under the existing scenario.

***Further Assumptions and Reasoning Underlying the Hypothesis
(continued)***

And it could still be accompanied by the guarantee that expenses from catastrophic health events and developments would be covered. **NOTE:** This calculation does ***not*** even include the net effect of choices made in a competitive market that is disciplined toward lower prices, nor does it assume the elimination of any part of the 10% overhead—alluded to earlier—for the administration of the State's Medicaid program.

Under these assumptions, a child at age five who had benefitted annually from \$3,745 of supported spending on health care would retain more than \$4,000 in an HSA while having had in place throughout this period catastrophic coverage with an annual deductible of \$1,400. If less than \$3,745 were spent each year, the amount of money retained in the HSA could be substantially higher than \$4,000 if the money was spent carefully.

The Experiment's Hypothesis

By granting the use of HSAs with the characteristics described in the preceding pages to citizens (a) enrolled in Delaware's Medicaid program and (b) under 20 years of age, two things should occur.

- (1) Delaware should realize significant savings— when compared to continuing with its current policies for funding Medicaid.*
- (2) The population participating in the experiment should experience improvements in access to actual care and in the quality of that care.*

Essential Ground Rules

Under this experiment, control of HSA funds and choices related to health care would rest with parents or guardians, or even with the young individuals, if necessary, to incentivize saving, comparison shopping for the best prices, and personal behaviors that maintain good health.

Through monthly contributions by the State of \$312, the population to be studied would receive \$3,745 into their HSAs to cover out-of-pocket health care expenses for one year. Of that monthly \$312 deposited into the Health Savings Account, \$99 would be used to purchase a Catastrophic Insurance Policy, with the remainder being invested in a low-overhead index fund. Excluding the investment results, the actual monthly increase to unused money in the HSA would be \$213. Since there is ongoing insurance coverage from birth, there would be no opportunity for a denial of coverage based on pre-existing conditions. The problem of insurance companies denying coverage to patients because of these conditions would disappear necessarily by mandating continued coverage.

If the Hypothesis is True, the Results to Expect

- **Through tax-free compounding, the growth of unused funds in the HSA would average 10% per year.**
- **We believe that the experiment should lead to substantially better access to actual medical care.** While millions have ACA exchange insurance policies or coverage under Medicaid, many have come to realize that there are fewer and fewer providers who accept patients who rely on these programs.²⁵ For that population, health insurance does NOT translate into conveniently accessible medical care and does NOT eliminate large out-of-pocket expenses. For example, policies available through the ACA exchange carry high copayments and high deductibles, making them effectively of little use. Consequently, access to actual medical care is severely limited. Under the HSA experiment proposed here, this would not be the case. Practical barriers to actual medical care should fall.
- **The State of Delaware would save that part of its overhead cost normally incurred for the population participating in the experiment.**
- In the best case imaginable—no money spent from the HSA and investment returns consistent with the averages cited earlier, a participant in the program through the first 20 years of life would have accumulated \$270,000 in a Health Savings Account. Going forward, that money could fund quite a lot of health purchases and Catastrophic Insurance policies.

²⁵ https://www.cms.gov/mmrr/Downloads/MMRR2011_001_02_A01.pdf
<https://health.usnews.com/health-news/health-insurance/articles/2015/05/26/youve-got-medicaid-why-cant-you-see-the-doctor>
<https://www.hhs.gov/answers/medicare-and-medicaid/where-can-i-find-a-doctor-that-accepts-medicare-medicaid/index.html>

If the Hypothesis is True, the Results to Expect *(continued)*

- Assuming that a participant in the program through the first 20 years of life spent the full amount (\$3,745) of Medicaid contributed annually by the State, the HSA would have accumulated \$80,000 in the account.
- The worst-case scenario would be defined as someone spending ALL of the money contributed to the HSA and the money realized from the investment over the 20 years. We would expect this to be a statistical rarity. In that case, the individual would be covered under the catastrophic policy.

A True Hypothesis and the Bigger Picture

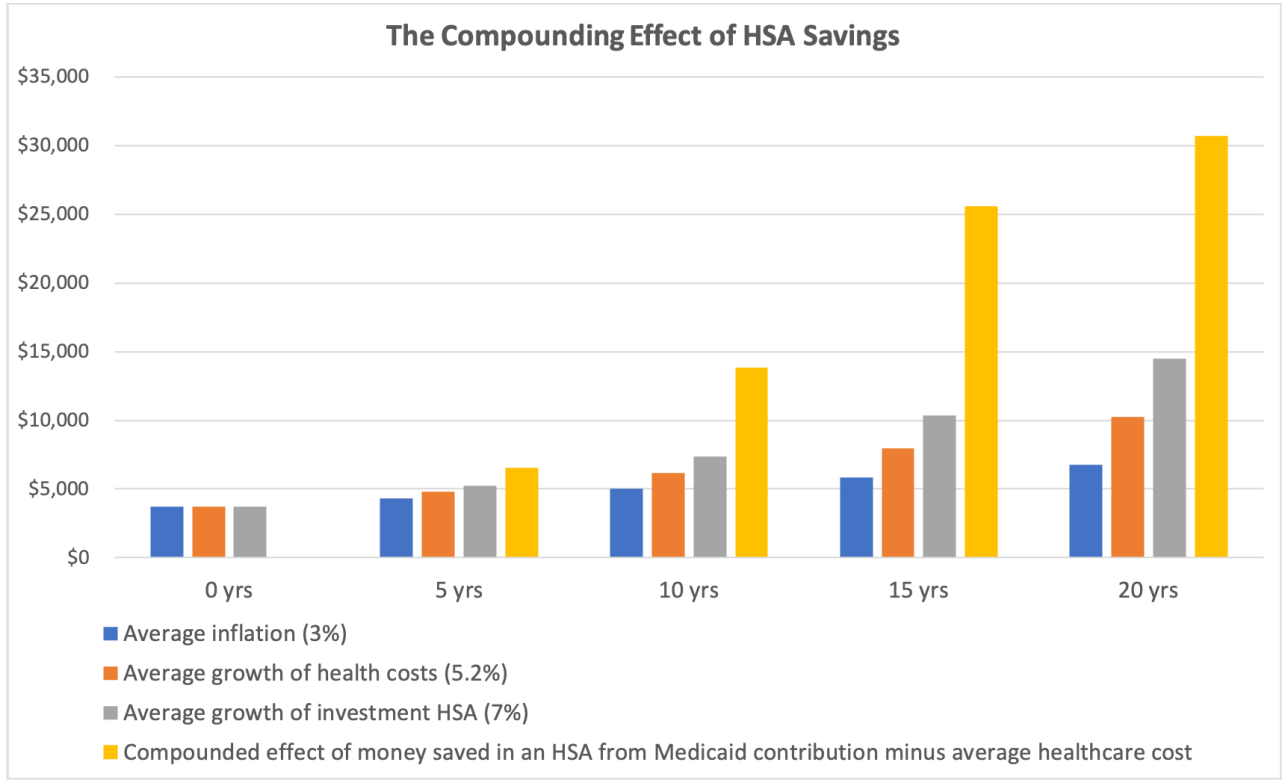
If the hypothesis proved to be valid, what results could be expected from applying the ground rules of the experiment to, say, people from birth to age 80, with the State's annual contribution being increased at age 21 to \$8,875, or perhaps increasingly gradually through the years in a way that is consistent with changing health profiles as people age?

In calculating the results, we note that the most expensive population is the long-term recipient of Medicaid, the program relied upon by the sickest among us in their middle and later years. That subset of the population would be associated with the highest expenditures and would likely have the pre-existing conditions, which, historically, would have led to denials of coverage. However, under guarantees of continuing coverage, this would no longer be a concern.

Our calculations show that the assumptions informing the HSA experiment proposed in this document would yield the following result for an 80-year-old who died after having incurred average annual Medicaid expenses from birth to age 80: **that individual's HSA would contain \$1,328,000 that could be passed to heirs.** The inherited money would be subject to the inheritance tax, except in the case of an inheriting spouse. But that could be changed to provide for health care expenditures for future generations.

A Proposal for Averting Future Crises in Delaware's Medicaid Funding

Below is a graphic representation of the effect of relative growth rates and the effect of compounding on the difference in dollar growth after inflation, even subtracting the initial average Medicaid enrollee cost in this demographic. In a short while, the State of Delaware's contribution to Medicaid would disappear.



Reasonable Questions

Q. What would happen if someone involved in this experiment became employed and no longer eligible for Medicaid?

A. The employer could either assume from the State the monthly responsibility for contributing \$312 to the HSA **or** offer to the new employee the same health insurance coverage offered to other employees. This would eliminate the economic disincentive of losing Medicaid coverage upon becoming employed. We believe that most employers would be pleased to make the monthly \$312 contribution. Some young people on the Medicaid rolls could find their attractiveness to employers enhanced because that relatively small amount would predispose the employers to hire them.

Q. In the case of individuals under the age of 20 with pre-existing conditions who wish to become involved in this experiment, what would be expected of private insurers who provide coverage for catastrophic health events or developments?

A. This assumes that coverage was started some time after birth, not the experimental group, such that continued coverage was not in effect. For those who would wish to convert from traditional Medicaid to a health savings policy coverage, there would need to be guidelines developed to protect those individuals from discrimination based on those conditions. There is clearly a small subgroup in the 0 to 20 demographic, which will need to be addressed outside of this proposal. But it is important to note that there would be no further growth of that subgroup as continued coverage from birth took hold. The problem of pre-existing conditions would go away.

Summing Up

Delaware is a small state with a big problem that will only grow bigger. Our leadership has every reason to be open to bold experimentation to avert the budgetary crises that lie ahead.

The Caesar Rodney Institute is fully persuaded that innovative experimentation based on well-established market disciplines has the greatest hope of success.

Writing an opinion on a case before the United States Supreme Court in 1932, Associate Justice Louis Brandies said the following as he pondered the implications of the Constitution's Tenth Amendment: "... a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." His words in the early years of the Great Depression gave rise to the concept of "the states as laboratories."²⁶

After more than 50 years of experience in working with a system for funding health care coverage for the least affluent—a system increasingly marked by perverse incentives and squandered public money, a system posing a future chronic threat to Delaware's fiscal health and flexibility—the time has come to take a different road.

This document proposes testing a hypothesis through the creative use of Health Savings Accounts to achieve savings and sustainability for the state's Medicaid program.

It is a promising place to start.

²⁶ https://en.m.wikipedia.org/wiki/Laboratories_of_democracy

APPENDIX

The Author's Personal Experience

In 1999, when I left one large corporate medical practice to become independent, I needed to set up health insurance for a new and much smaller professional corporation.

Blue Cross/Blue Shield of Delaware was familiar, so we talked to them first.

As in most medical offices, most of my employees were married females covered by their spouses' health insurance.

We decided to put three choices before the employees. They could receive the cost of health insurance in the form of:

- Health Insurance;
- Money deposited in a flexible spending account; or
- A cash bonus.

All of the employees chose the cash bonus, leaving only my family in the group to buy health insurance.

At the time, small group insurance rates were rising sharply.

My wife and I investigated what was out there and discovered something called a Medical Savings Account (MSA)—also called an Archer Account, for the congressman from Texas who had sponsored the legislation to create such an instrument.

We set up our MSA and backed it up with an inexpensive catastrophic insurance coverage plan with a high deductible from Golden Rule.

MSAs eventually became Health Savings Accounts (HSAs) under HIPAA legislation.

I remember once speaking with Janet Reznicki, Delaware's insurance commissioner, and mentioning that we had an MSA. She replied that no such instrument was authorized in Delaware.

I explained to her that it was offered by a company called Golden Rule. She verified what I was saying and was surprised to discover that Golden Rule could offer that product in Delaware. (When the state's insurance commissioner is surprised on a matter like that, you know that it's a very complex world out there.)

Slowly, over time, the allowable annual contribution to an HSA increased. It now stands at \$7,100 per family per year.

APPENDIX
The Author's Personal Experience
(continued)

HSA's have been described as "IRAs on steroids." The contributions are tax-deductible; growth in the account is tax-free; no tax is imposed when the HSA's funds are used for health expenditures; the accumulated money in an HSA can be passed, tax-free, to a surviving spouse.

From time to time, for various reasons, operating a small business, we have re-entered the health insurance market. But it finally became exorbitantly expensive.

By 2015, the annual premium for just my wife and me was \$17,000, with a deductible of \$15,000. That meant that we would be out \$32,000 **before** we even began to receive any benefit from our health insurance policy.

At that point, we had no dependent children. It was just the two of us. So we rolled the dice and did without health insurance.

In the meantime, our HSA has grown steadily and has remained relatively untouched. It has been invested in index funds. The money accumulated in the HSA is now substantial.

Some of the regulation restricting the use of HSA's has been eased in recent years, making the instrument more attractive.

In 2016, Scott Atlas, M.D., a scholar from Stanford University's Hoover Institute, published a book entitled ***Restoring Quality Health Care: A Six-Point Plan for Comprehensive Reform at Lower Cost***, which laid out a plan to improve access and the quality of care delivered by the troubled health care delivery system in this country. The book supports the idea of HSA's as one way to bring sanity to the tortured issues of pricing and access. His book resonates with everyone who knows what has become of the health care sector of our economy, what is still happening, and what will continue to happen if we do not change course.

The proposal advanced in this document for an experiment focused on Delaware's Medicaid-covered population between birth and their 20th birthday owes much to Dr. Atlas's book.