South Dakota Legislative Research Council

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MEDICAL SAVINGS ACCOUNTS

The Time Has Come?

The Generic Medical Savings Account

Attempts to control medical costs take many forms. One of these is the medical savings account, also known as MSA, medisave account, medical IRA, and individual medical account. An individual would pay for medical bills not covered by insurance from funds kept in a tax-free account owned by the individual. The individual and the individual's employer would make regular contributions to the account.

At the end of the year, the money not spent for medical services could either be left in the account to accumulate tax free or could be withdrawn and used for other purposes. Money withdrawn would be taxed as income to the individual.

Medical savings accounts are intended to be tied to a health insurance plan with a large deductible. The individual would pay for small medical expenses, up to the deductible, and the insurance plan would pay for the larger medical expenses

Proponents believe that an individual in control of personal funds for medical expenses would make prudent, cost-effective choices if he has to pay for medical services himself. A tax credit or exemption from state or federal income taxes is considered an incentive for individuals to choose to use an MSA and a high-deductible health plan.

Background

The idea of medical savings accounts surfaced about twenty years ago in a proposal by health economist Martin Feldstein for "major risk insurance" that would have made families responsible for the first ten percent of medical expenses. Miron Stano proposed "individual health accounts" in 1981. These accounts would be handled by an administrator and would replace health insurance entirely. Once accounts were exhausted, however, funds for health care would come from a public "National Health Fund."

Medical IRAs were advocated in 1984 by the National Center for Policy Analysis in Dallas and a bill was introduced in Congress by Rep. D. French Slaughter, Jr., to implement the idea. The same year, Rep. Claude Pepper introduced a bill that would have allowed $2,000 to be deposited in a tax-deferred medical IRA account. The first bill would have replaced Medicare, and the second would have funded health services not covered by Medicare. Neither bill passed.

Private Industry Action

Without waiting for favorable tax treatment from the federal government or most state governments, Golden Rule Insurance Co. and Dominion Resources, Inc., offered their employees the option of a health plan that includes a medical savings account and a high-deductible health insurance plan. Forbes magazine, Quaker Oats, and Knox Semiconductor, along with other companies, offer health plans that use elements of the medical savings account. The MSA plan has been chosen by ninety percent of Golden Rule employees.

Action in Other States

A flurry of state actions since 1993 have resulted in authorization of MSAs by eighteen states: Arizona, Colorado, Idaho, Illinois, Indiana, Louisiana, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, Ohio, Oklahoma, Utah, Washington, West Virginia, and Wisconsin. Most states with income taxes have either set limits on the amounts that can be contributed to the accounts yearly or have set limits on the amounts that are tax deductible. The limits range from $2,000 to $5,000 annually.

States that set no limits on contributions are Idaho, Missouri, Montana, Nevada, Ohio, and Washington; however, Idaho, Montana, and Ohio set limits on the amounts that are tax deductible. Missouri will set its limits by regulation. Nevada and Washington have no income taxes.

A few states have considered using MSAs in conjunction with Medicaid. A study in Texas concluded that there would be significant cost overruns if MSAs were used for Medicaid. Montana and Oregon are studying the feasibility of using MSAs for Medicaid. Virginia has enacted legislation directing the Department of Medical Assistance Services to develop a plan for using MSAs to provide primary and acute care to the working poor and individuals who are eligible for medical assistance. The legislation is contingent on federal legislation.

Minnesota published a formal feasibility study of MSAs in February 1994 and concluded that the program was not feasible in Minnesota, partly because of the high degree of development of managed care in that state. The report found that the goals of individual autonomy and personal economic gain emphasized in MSAs were incompatible with the goals of universal health coverage and managed care.

Some states are cautious in their acceptance of MSAs. The authorizing legislation in Idaho, Illinois, Michigan, and Mississippi will expire before the year 2000 if it is not extended by those legislatures. Idaho, Illinois, and Michigan require a report on the program's impact to be submitted to the legislature before the date of expiration.

South Dakota Action

South Dakota has begun to recognize the issue. The South Dakota Legislature in 1995 adopted House Concurrent Resolution No. 1007 memorializing Congress to pass legislation to allow Americans to establish medical savings accounts. In 1996, House Bill No. 1317, An Act to provide for medical savings accounts by granting property tax credit to employers, employees, and the self-employed, was introduced, but it did not survive its first committee hearing.

Recent Action in Washington

The issue has captured the interest of Congress. Beginning in 1991, several unsuccessful bills that would have created MSAs were introduced in the Congress. Twenty-four different bills with MSA components were introduced in the 103rd Congress during 1993-94. The Gephardt version of the Clinton health bill in 1994 included MSAs; and MSAs for most Americans, including those under Medicare, were part of the Budget Reconciliation Bill passed in 1995. President Clinton vetoed the latter bill.

After passage in the House, the Health Insurance Portability and Accountability Act of 1996 (H.R. 3103), also known as the Kassebaum-Kennedy health reform bill, passed the Senate on August 2, 1996, and was sent to the President for signature. President Clinton signed the bill on August 21, 1996.

In addition to other health insurance reforms, this bill provides for a pilot program that will allow 750,000 self-employed persons, employees of small companies, and uninsured individuals to establish tax-deductible medical savings accounts if they also purchase high-deductible catastrophic health insurance policies. The pilot will run for four years.

Questions and Concerns

Who will administer medical savings accounts? Idaho has an extensive list of persons eligible to be account administrators. Most states require a trustee or an administrator to assure that withdrawals from an account are for legitimate medical expenses. An area of concern is a process by which an individual could appeal the denial of a request for withdrawal of funds.

What is an eligible expenditure? Most legislation to date defines eligible expenditures to be those medical expenditures eligible for federal tax deductions under § 213(d) of the Internal Revenue Service Code. Some states allow the account to pay for health insurance premiums in certain instances; others prohibit this.

How will withdrawals be handled? Withdrawals not for medical purposes are subject to taxation. Some states also provide for a penalty of ten percent for withdrawals. If an individual dies, will the account become part of the individual's estate?

Will there be minimum standards of coverage required of the catastrophic health insurance? The Minnesota feasibility study noted that individuals may have more out-of-pocket expenses than the balance in the MSA will cover and that these expenses may not be covered by catastrophic health insurance.

Will there be a required minimum contribution from employers? Without a requirement that the employer contribute an amount equal to the savings realized by choosing the higher deductible plan, the employee may lose a benefit formerly available. With such a requirement, the employer's incentive to offer MSAs as an option may disappear.

One of the criticisms of MSAs is that they have great appeal for individuals who do not get sick or who can afford illness--the young, the healthy, and the rich. How will the states even the playing field for low-income persons, part-time or seasonal workers, and persons with chronic illnesses or disabilities who may have difficulty in making contributions or who

use up all the funds in the MSA each year and can never accumulate a surplus?

How equitable to families is a limit placed on contributions to the MSA? Is there a gap between the limit and the application of the insurance deductible to family members?

What effect do MSAs have on managed care? MSAs work for services provided on a fee-for-service basis. Can they be made to mesh with the more controlled environment of managed care? Medicaid and workers' compensation are moving toward managed care. Even Medicare patients are being offered a managed care option. Will MSAs and managed care be an either/or option or can they be made to work together?

How much monitoring of the MSA program will be required? The state may have to set minimum requirements for administrators and minimum standards for the accompanying catastrophic health insurance. Someone will have to make sure that account administrators do their jobs and that someone is available to hear appeals. Someone will need to make sure that employers make their fair contributions to the MSAs and that low-income, sick, or elderly residents receive fair treatment. Someone will have to determine the fiscal impact of the program and the relationship between cost and benefits.

Conclusion

The picture regarding medical savings accounts is far from clear. Theoretically, they will be one of the ways to control health care costs, but they have not been tried long enough to know if this is a reality. More will be known when the studies and reports required by the states are published near the end of this decade and when the trial period for the federal MSA pilot program ends. A long list of questions remains to be answered.

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This issue memorandum was written by Rosemary Quigley, Administrative Rules Analyst for the Legislative Research Council. It is designed to supply

background information on the subject and is not a policy statement made by the Legislative Research Council.