House
Legislative
Analysis
Section

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MEDICAL CARE SAVINGS ACCOUNT

House Bill 4878 as enrolled
Sponsor: Rep. Terry London
House Committee: Insurance
Senate Committee: Commerce

Senate Bill 926 as enrolled
Sponsor: Sen. John Pridnia
Senate Committee: Commerce
House Committee: Insurance

Second Analysis (8-2-94)

THE APPARENT PROBLEM:

It is a common observation that one root cause of the high rate of increase in the cost of health care, and in the price of insurance to cover health care expenses, is the lack of cost consciousness by consumers. Consumers of health care, it is said, are often "spending someone else's money" or at least do not perceive the money they are spending as their own because they are relying on insurance. This means, the argument goes, that there are few incentives to seek out less expensive services and products and few incentives to decide to forego care entirely in marginal cases. The result is over-utilization of the health care system and a lack of price discipline, together leading to ever-increasing expenditures on health care. Among some who emphasize this point-of-view, one new proposal deemed encouraging is the "medical care savings account," sometimes known as a "medical IRA" or "medisave" account. The basic elements of this concept are a high-deductible, catastrophic health insurance policy and money set aside in a tax-free savings account to pay smaller bills and deductibles. One form of this would have an employer switch from its current health insurance to a high-deductible catastrophic policy and deposit the savings into a tax-free account for an employee's use. If the employee did not use the money in a given year it could be withdrawn. (Early withdrawals of money, however, would be subject to penalty.) The money also could be allowed to accumulate, in anticipation of special health care expenses or to be used to purchase health insurance if the employee lost his or her job. In other words, the money in the medical savings accounts would belong to the employees to use as they saw fit and would be portable from one employer to another or to self-employment. This kind of benefit plan is already possible, and is being marketed, notably by Golden Rule Insurance Company, but without tax exemption for the contributions to the accounts. Legislation is being promoted at the national level to provide the necessary special tax treatment. Proposals also are being made at the state level for exemptions from state tax.

THE CONTENT OF THE BILLS:

The bills, taken together, would provide tax-exempt medical care savings account programs. House Bill 4878 would create a new act, the Medical Care Savings Account Act, to describe the features of such programs, which would include the purchase of a health plan with a deductible up to $3,000 and contributions into a special account up to the amount of the deductible in the plan. The new act would be repealed effective January 1, 1999. Senate Bill 926 would amend the Income Tax Act (MCL 206.30) to provide for a credit in an amount equal to 3.3 percent of the amount contributed by a taxpayer or on behalf of a taxpayer. The bills are tie-barred to one another. The bills would apply to tax years beginning after 1993.

Under House Bill 4878, medical care spending accounts could be established 1) by employers that previously had provided another form of health coverage; 2) by employers that had not previously provided health coverage; and 3) by or for "resident individuals," (rather than employers), who would be known as account holders. The bill says that an employer could offer a spending account program "except as otherwise provided by statute, contract, or a collective bargaining agreement." It also would

provide that upon an agreement between an employer and an account holder, an account holder could have the employer either contribute to his or her medical care savings account or continue to make contributions under the employer's existing health insurance policy or program.

The bill would define a medical savings account program so as to require the inclusion of the following elements.

-- The employer (or account holder) would purchase "a qualified higher deductible health plan" for the benefit of an employee (or account holder) and his or her dependents. (This plan would involve a health policy, certificate, or contract that covered benefits exceeding the "higher deductible", which would mean for 1994 a deductible of not less than $1,000 and not more than $3,000, with the amount adjusted annually based on changes in the consumer price index.)

-- Employers that had previously provided health coverage would contribute all or part of the premium differential (i.e., savings from the lower cost policy) into a medical care savings account on behalf of an employee. The minimum contribution, however, would be $1,000. An employer that had not previously provided health coverage could contribute all or part of the plan's deductible (with no minimum specified). A contribution by either kind of employer could not exceed $3,000 for 1994, to be adjusted annually based on the consumer price index.

-- Under an employer program, an employee could make a contribution to the medical care savings account beyond the employer's contribution, up to the contribution limit ($3,000 in 1994, with annual adjustments). The term "employee" in the bill would include a self-employed individual. Under a program established by an account holder, the account holder could contribute up to $3,000 in 1994 (with annual adjustments).

An employer would have to inform employees in writing before making any contributions of the federal tax status of the contributions. An employer that made contributions on a periodic installment basis could advance, interest free, an amount necessary to cover expenses that exceed the amount in the savings account if the employee agreed to repay the amount from future installments (or when he or she ceased to be an employee).

A medical care savings account would have to be administered by an account administrator, who would have a fiduciary duty to the person for whose benefit the account was administered. The bill lists those eligible to be an administrator, including financial institutions, insurance companies, trust companies, persons registered under the Uniform Securities Act, third party administrators, certified public accountants, licensed attorneys, self-insured employers, and employers participating in a medical care spending program.

An account administrator could only use the funds in such a medical care savings account to pay the eligible medical expenses of the employee or account holder (and any dependents) or to purchase a health coverage policy, certificate, or contract. An employee or account holder would submit documentation of medical expenses paid in the tax year, and the administrator would provide reimbursement for eligible medical expenses.

Funds from an account could not be used to cover medical expenses of the employee or dependents otherwise covered, including expenses covered by an auto insurance policy, worker's compensation policy or self-insured plan, or another health coverage policy, certificate, or contract.

An employee could withdraw money from the account on the last business day of the administrator's business year without penalty. (Not more than 30 days after beginning to administer an account, an administrator would have to notify in writing each employee and account holder of the date of the last business day of the business year.) Withdrawals at other times of the year (except for permitted reimbursements) would be subject to a penalty of 10 percent of the amount of the withdrawal, to be paid to the Department of Treasury. However, disbursement of assets of an account pursuant to a bankruptcy filing would not be considered a withdrawal and would not be subject to penalty. Upon the death of an employee or account holder, the account administrator would distribute the principal and accumulated interest of an account to the deceased's estate.

If an employee left the employ of a participating employer, he or she would have 60 days to transfer the account to a new administrator or request in writing that the account remain with the former employer's account administrator. (That administrator would decide whether to agree to

retain the account.) Not more than 30 days after the expiration of the 60 days, if no account administrator had accepted the former employee's account, the former employer would mail a check to the employee for the amount in the account on that day. If an employer joined another employer with a medical savings account program, he or she could transfer the account to the new employer's account administrator. Further, if an account holder became employed by an employer participating in such a program, the account holder could transfer his or her account to the employer's account administrator.

House Bill 4878 also would require the insurance commissioner to report on or before January 1, 1998, to the standing committees in the House and Senate on insurance and health legislation on the availability of health care coverage under and market share of medical care spending account programs; the results of a survey of employer and employee satisfaction with the programs; and the results of a loss ratio study relative to the programs.

Senate Bill 926 would amend the Income Tax Act to permit a taxpayer, for the 1994 tax year and thereafter, to credit against the tax an amount equal to 3.3 percent of the amount contributed in the tax year by the taxpayer or on behalf of the taxpayer to a medical care savings account. For a joint return, each joint filer could take the credit if each qualified. A taxpayer could only take the credit if he or she had coverage only under a qualified higher deductible plan purchased as part of a medical care savings account. program. If the amount of the credit exceeded the taxpayer's tax liability, the portion that exceeded the liability would not be refunded. (In other words, the credit would not be a refundable credit.) The credit could not be taken in a tax year in which a federal income tax deduction or credit became available for contributions to a medical care savings account or any similar federal program (or in any subsequent year).

A taxpayer would have to deduct from the contribution amount used to calculate the credit any amount withdrawn from the account other than for purposes specifically permitted under the Medical Care Savings Act (for care-related reimbursements or for distributions or transfers related to bankruptcies or changing jobs), but a taxpayer would not have to deduct amounts withdrawn on the last business day of the account administrator's business year.

FISCAL IMPLICATIONS:

The Department of Treasury does not yet have realistic estimates of what the cost of the income tax credit would be. It is difficult to know how many people will participate in these programs. It should be noted that the credit falls away if federal legislation addresses these kinds of accounts. Special federal tax treatment would provide a greater incentive to participate. A Senate Fiscal Agency analysis of a slightly different version of the legislation said the reduction in state revenue from a deduction (available to households with income under $40,000) would be about $60 million if every potentially eligible household took maximum advantage of it, and about $25 million if only households that itemized deductions participated. The credit is worth about three-quarters of the deduction. The SFA also said, in its 6-1-94 analysis, that without a federal tax exemption for these plans, "it would seem extremely unlikely that a household would forgo the significantly higher federal marginal tax offset on current employer-based health insurance premiums just to gain the bill's state tax credit."

ARGUMENTS:

For:

The bills would provide an additional option for employers who want to provide health care coverage to their employees and, at the same time, would offer a means to restrain health care costs by providing incentives for health care consumers to be cost conscious. Under this proposal, employers could switch to cheaper high-deductible health insurance coverage and put some or all of the savings into a special savings account for use by an employee in paying for uncovered medical expenses. Other employers who had not been providing health coverage to employees could use it as a way to begin providing such benefits. And individuals could choose a spending account as an alternative way of buying health insurance. In each case, a percentage of the money going into an employee's or individual's account could be taken as a credit against the state income tax.

For example, a company might purchase a policy with a $3,000 deductible and put $3,000 into each employee's account. If the company put less money in, the employee could contribute up to the limit of

the deductible. The account would be under the control of the employee. Money unused at the end of the account administrator's business year could be withdrawn without penalty. Or, it could be left in the account if some large medical bills were anticipated. (There would be a penalty for unauthorized early withdrawals.) These accounts would make people more aware of how their health care dollars were being spent and would encourage more cost-conscious behavior in determining whether to seek care, how much care to buy, and from whom. Additionally, it would permit people temporarily unemployed to use dollars from their medical savings accounts to purchase insurance coverage while between jobs.

Supporters of this approach point to other benefits as well. It works against the bias that all dollars to pay for health care need first be sent to insurance companies or similar entities in premiums. It eliminates the relatively high administrative costs to insurance companies associated with small medical bills. Further, it tends to promote healthier lifestyles and provide incentives to reduce health risks. Employees and others who have these accounts will know they can benefit financially by staying healthy. The state income tax credit will provide additional incentive for the creation of these plans. Proponents say they are fairly confident of a federal income tax exemption for the accounts in the near future (in which case the state credit would come to an end).

Response:

It ought to be made clear that contributions to medical care savings accounts by employers are not now exempt from federal income tax and would be treated as income to the employees.

Against:

A number of concerns have been raised. One is that approaches of this kind could discourage more comprehensive reform. By itself, this concept cannot address the many problems associated with the current health care insurance system, such as selection biases, cost-shifting, administrative inefficiency, and ever-increasing costs.

The medical care savings account concept could lead to a segregation of insureds or employees by health risk. If employees are offered a choice between a comprehensive plan and a savings account plan, those with fewer health problems will tend to choose the latter, due to the financial incentives, while those with more health problems would take the comprehensive coverage. This will make any comprehensive coverage more expensive (since the cost is likely to be based on the experience of the group as a whole). Further, if employees were allowed to switch plans annually, it could lead to people using the comprehensive plan in years when medical expenses were anticipated and taking the savings account in other years, further segregating by risk. Instead, reform of health care coverage should focus on greater pooling of risks and more affordable coverage for all state residents.

Also, the concept could lead to an increase in uncompensated care for hospitals and other providers, to the extent that those with large deductibles are unable to cover all of their costs (due to underfunded or inadequate savings accounts). Some in the health field caution that, while this approach is to be applauded for its emphasis on cost consciousness and personal responsibility by health care consumers, there are better ways to reduce costs due to unhealthy behavior and wastefulness. Insurers and similar entities can do so, without risk segregation, through benefit plan designs, co-payments, designation of eligible providers and facilities, caps on annual out-of-pocket expenses, and other means.

It is also fair to ask whether health care consumers have the information, or the time and means, that they need to be "cost conscious" about health care decisions.

Response:

It is not clear that the plans envisioned by this legislation would lead to an increase in uncompensated care. They would, in some cases, replace policies that already have various deductibles and co-pays. Companies that go to the trouble of initiating such plans will likely fund them properly, and the accounts grow over time. Also, the proposal permits interest-free loans (or advances) to employees by employers to cover shortfalls, with the loan to be paid back out of future installment payments by the employer to the account. This may encourage some employers who cannot now afford health care benefit plans to establish one, which would, if anything, reduce problems of uncompensated care. While this approach is not the sole and exclusive solution to health care financing, it is a positive step.

Against:

It should be noted that the bills do not require that all savings to employers from switching plans go into a medical care savings account, only that "all or part" of the premium differential must go into an account. Although there is a $1,000 minimum contribution for employers who previously had health plans, there is no minimum contribution for employers who did not. Employees could be forced to absorb very high deductibles. Also, there are no standards for the "higher-deductible" policies as regards the scope of coverage. Plans of this kind do not emphasize preventive medicine or "wellness" approaches, which some people believe lead to greater eventual savings to the system. Also, there is the danger that employees will be tempted, if they have other pressing financial needs or problems, to withdraw the money from the account and incur the penalty, and then not be able to pay for needed treatment. Further, one could ask, what the need (and justification) is for a tax credit for these accounts.

Response:

Granting some flexibility to employers on the amount to be deposited in a medical savings account would permit some companies to offer these plans who otherwise could not afford to. A shared contribution plan between employer and employee would be better than not having a benefit plan and would be better than many of the other low-cost alternatives that provide deductibles and co-pays. The tax credit allows contributions to a medical care savings account by an employer to be given treatment similar to that provided payments by an employer for insurance to an insurance company, and thus counteracts that bias.

Against:

With a tax credit available to any individual who establishes a medical care spending account, the state stands to lose revenue. As first proposed, this legislation would have applied to companies offering these accounts as an alternative to existing health insurance. Thus, there would have been no state revenue lost because the dollars flowing into those accounts would be dollars that otherwise would have been sent to insurance companies by employers on behalf of employees. Now, the legislation applies to employers who had not previously provided health benefits and to any individual who wants to use this kind of program as a means of obtaining health insurance.