

# CRS Report for Congress

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## Medical Savings Accounts: Legislation in the 105<sup>th</sup> Congress

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### Summary

Medical savings accounts (MSAs) are tax-advantaged personal savings accounts for unreimbursed medical expenses. In the 105<sup>th</sup> Congress, a number of bills have been introduced to expand the MSA demonstration that Congress authorized in 1996 for employed individuals not yet eligible for Medicare. Bills have also been introduced to authorize MSA plans under the Federal Employees Health Benefits Program (FEHBP).

The Balanced Budget Act of 1997 (P.L. 105-33) authorized a limited number of Medicare MSAs under a demonstration beginning in 1999. One of several new options to traditional Medicare, "Medicare+Choice MSAs" will be coupled with health insurance that has a high deductible but could offer additional benefits such as prescription drugs. Both the health insurance premiums and MSA contributions will be paid from Medicare capitation rates that vary by county and are adjusted for age, gender, and other risk factors. One bill has been introduced to remove limitations on participation in Medicare+Choice MSAs.

Medical savings accounts are tax-advantaged personal savings accounts for unreimbursed medical expenses. They can be used to pay health insurance deductibles, coinsurance, and copayments as well as medical expenses that the insurance does not cover. The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) authorized a limited number of MSAs under a demonstration beginning in 1997. Eligibility for these MSAs is restricted to individuals who have qualifying high deductible insurance and who are either self-employed or employees covered by small employer plans. Individuals eligible for Medicare may not participate in the HIPAA demonstration.

In the 105<sup>th</sup> Congress, a Medicare MSA demonstration was authorized during the budget reconciliation process. Medicare MSAs were first approved by the House Committee on Ways and Means on June 9, 1997, and the House Committee on Commerce on June 12, 1997; the House approved them as part of H.R. 2015 on June 25, 1997. The Senate Finance Committee approved similar provisions on June 17, 1997; the Senate

approved them as part of S. 947 on June 25, 1997. The conference agreement on H.R. 2015 was approved by the two chambers on July 31, 1997, and was signed by President Clinton on August 5, 1997.<sup>1</sup>

## Medicare Medical Savings Accounts

**Eligibility and Enrollment.** Under the Balanced Budget Act of 1997, individuals eligible for Medicare Part A and enrolled in Part B may elect an MSA as one of several new private plan options under Medicare. The “Medicare+Choice MSA” will be coupled with an “MSA plan” that provides high deductible health insurance.<sup>2</sup> Coverage will first be available in 1999. Enrollment can occur upon initial eligibility for Medicare or during annual election periods; it can be changed to other options during these periods and at certain other times. Transition enrollment rules apply through 2000.<sup>3</sup>

Medicare+Choice MSAs are limited to a demonstration: new enrollments cannot occur after 2002 or when the number of enrollees reaches 390,000, whichever happens first.<sup>4</sup> (H.R. 2668 (Representative Salmon) would remove this sunset and numerical limitation.) MSA plans cannot be chosen by certain low-income or disabled individuals, among others. When enrolled in an MSA plan, individuals may not have other health insurance (including Medigap policies), with some exceptions, and they have to reside in the United States for at least half the year.

**Contributions to Accounts.** For all private plan options, the Secretary of Health and Human Services will make monthly advance payments to the health plan based upon annual capitation rates for the enrollees. These rates will vary by county and be adjusted for age, gender, disability status, institutional status, and other risk factors that the Secretary determines are appropriate. For individuals electing an MSA plan, the Secretary will deposit the difference between one-twelfth of the annual capitation rate and the monthly insurance premium into the MSA; the deposit for the first month of eligibility will include sums for all successive months in the year. Contributions cannot be made by individuals or employers.

**Insurance Coverage.** An MSA plan will provide reimbursement for items and services covered under Parts A and B of Medicare, though only after the enrollee incurs *countable* expenses equal to the annual deductible. The deductible cannot be more than

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<sup>1</sup> One Medicare MSA bill had been introduced prior to budget reconciliation: S. 246, the Medicare Improvement and Choice Care Provision Act (Senator Gregg).

<sup>2</sup> In the House legislation, the MSAs were called “MedicarePlus MSAs,” while in the Senate amendment, they were called “Medicare Choice MSAs.”

<sup>3</sup> For additional information about Medicare changes made by the Balanced Budget Act of 1997, see CRS Report 97-640, *Medicare: Budget Reconciliation Action in the 105<sup>th</sup> Congress*, by Jennifer O’Sullivan, Celinda Franco, Beth Fuchs, Bob Lyke, and Richard Price.

<sup>4</sup> In the House legislation, the numerical limit was 500,000, while in the Senate amendment it was 100,000.

\$6,000, indexed for inflation.<sup>5</sup> Countable expenses include at least those payable by Medicare under Parts A and B as well as the deductibles, coinsurance, and copayments the individual would have paid under those parts. At a plan's option, other expenses (such as prescription drugs) may also be counted. After the deductible is met, the plan must reimburse at least 100% of Parts A and B expenses (the provider charges) or 100% of what Medicare would have paid for these expenses without regard to Medicare deductibles or coinsurance, whichever is less. MSA plans are not subject to balance billing limitations, nor will they have to pay balance billing charges, though some might do so. (Balance billing refers to the additional amount that is charged by physicians or medical suppliers who do not accept assignment. By accepting assignment, physicians and suppliers agree to accept the Medicare-approved amount as full payment under Part B. They bill patients only for coinsurance and any unmet deductible. There are limitations on how much physicians can charge over the approved amount if they do not accept assignment.)

**Account Withdrawals and Taxation.** Contributions to Medicare+Choice MSAs will be exempt from taxes, as will account earnings. Withdrawals will likewise not be taxed nor subject to penalties if used to pay unreimbursed medical expenses deductible under the Internal Revenue Code. However, qualified withdrawals cannot be used to pay insurance premiums other than for long-term care insurance, continuation coverage (such as COBRA), or coverage while an individual is receiving unemployment compensation.

Non-qualified withdrawals will be included in the individual's gross income for tax purposes; they will also be subject to an additional 50% penalty to the extent they exceed the amount by which the account balance on December 31<sup>st</sup> of the prior year was greater than 60% of the MSA plan deductible for the year of withdrawal. For example, if the account balance on December 31<sup>st</sup> were \$3,500 and the plan deductible the next year were \$5,000, the amount that could be withdrawn for non-qualified purposes without the penalty would be \$500 (i.e., \$3,500 minus 60% of \$5,000). The 50% penalty will not apply in cases of death or disability. Account balances at death will be subject to various tax treatments depending on their disposition.

If MSA plan enrollees switch to another private plan option or traditional Medicare, they can maintain their account and use it to pay qualified medical expenses. No additional contributions can be made unless they chose an MSA plan again.

**Issues.** Medicare+Choice MSAs could be attractive to some beneficiaries. In contrast to traditional Medicare, they could provide first dollar coverage for health expenses, provided there were sufficient funds in the accounts. Enrollees would not have to purchase Medigap policies to cover these expenses or obtain additional benefits. (To prevent enrollees from reducing the deductible for their insured expenses, they would not be allowed to purchase Medigap or other insurance anyway, with some exceptions.) Enrollees in good health might be able to accumulate sufficient funds in their accounts that they could use some for non-medical purposes. In contrast to health maintenance organizations (HMOs) and some other managed care options, Medicare+Choice MSAs

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<sup>5</sup> The conference agreement adopted the House provision regarding the deductible. In the Senate amendment, the deductible could not have been less than \$1,500 nor more than \$2,250, indexed for inflation, and annual out-of-pocket expenses could not have exceeded \$3,000.

will not restrict choice of doctors or other providers. The MSAs might make enrollees more prudent consumers, possibly reducing what they spend on health care.

However, MSA plans will shift more risk for paying typical health care expenses onto the beneficiaries who choose them. If account balances were depleted, perhaps due to hospitalization or chronic illness, enrollees may have greater out-of-pocket expenditures than under traditional Medicare. Doctor charges may be higher since balance billing limitations do not apply. Even considering savings on Medigap premiums, some enrollees could be worse off financially. Because of these possibilities, MSA plans are likely to be attractive mostly to people who are healthy, particularly if they have ample savings or are willing to take a chance.

If MSA plans attract healthier people, the average cost of other Medicare plans might rise. This divergence in costs, resulting from what is called adverse selection, could lead to financing problems and diminished public support for those plans. In the view of some people, the common insurance pool principle of Medicare could be diminished. However, the extent to which adverse selection will actually occur and result in diverging costs is not known.<sup>6</sup>

One critical question is how large Medicare+Choice MSA contributions will be relative to the insurance deductible. If they are relatively small (several hundred dollars, for example), even healthy enrollees will face financial risk for a number of years until substantial balances accumulate in their account. This would discourage enrollment in an MSA option. If instead contributions are relatively large in relation to the deductible, it is possible that federal payments for MSA plans exceed their true actuarial cost. (As described above, federal payments for MSA plans will be based on capitation rates for enrollees that vary with age, gender, and other factors. MSA contributions will equal the difference between the capitation payment for the individual and the cost of the high deductible insurance.) In this case, the Medicare program would be paying more for MSA plan enrollees than it would pay for them in the traditional program. This would increase overall Medicare costs to the federal government. Without reliable methods of adjusting payments to reflect actuarial cost, it may be difficult to avoid one or the other of these problems.

Whether enrollees ought to be able to withdraw Medicare+Choice MSA funds for non-medical purposes has also been questioned. To some people, it is difficult to justify using Medicare funds for anything but health care. But if non-qualified withdrawals represent savings from more prudent health care use, it might be appropriate to allow enrollees to spend them as they please. (Non-qualified withdrawals would be subject to income taxes, unlike sums spent on health care.) Not allowing non-qualified withdrawals may even create incentives for enrollees to increase health care spending. However, limitations on non-qualified withdrawals would seem appropriate to the extent they represent Medicare payments that exceed the MSA plans' actuarial cost.

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<sup>6</sup> For a discussion of adverse selection and other issues raised by MSAs, see CRS Report 96-409, *Medical Savings Accounts: Background Issues*, by Bob Lyke.

## Medical Savings Accounts Outside of Medicare

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorized a limited number of tax-advantaged MSAs under a demonstration for employed individuals who are not yet eligible for Medicare.<sup>7</sup> These MSAs are similar to the Medicare MSAs described above in that account owners must have qualifying high deductible insurance (and none other, with some exceptions) when contributions are made. However, HIPAA demonstration MSAs differ with respect to eligibility, insurance requirements, contribution sources and limitations, penalties for non-qualified withdrawals, and other matters. HIPAA demonstration MSAs are tax-advantaged in that employer contributions are excluded from gross income, individual contributions are deductible, and account earnings are tax-exempt. Withdrawals are not taxed nor subject to penalties if used to pay unreimbursed medical expenses deductible under the Internal Revenue Code.

**Eligibility Restrictions.** HIPAA included two broad restrictions on MSA eligibility. First, eligibility is limited to individuals who are either self-employed or are covered by small employer plans. (Small employers are generally defined as having an average of 50 or fewer employees, with some exceptions.) Second, eligibility will be restricted after the earlier of (1) December 31, 2000, or (2) specified dates in the years 1997-1999 following a determination that the number of taxpayers who have MSAs exceeds certain thresholds. Once eligibility is restricted under the latter tests, tax-advantaged MSAs generally will be limited to individuals who either were active participants (had contributions to their accounts) prior to the cut-off date or become active participants through a participating employer.

The thresholds were not exceeded in 1997. By April 30, 1997, only 9,720 taxpayers had established MSAs, of which 7,383 were taken into account with respect to the threshold of 350,000. (The others were not to be considered for purposes of the cut-off: 550 taxpayers had a spouse who also had established an MSA, and 1,787 had been uninsured 6 months prior to obtaining coverage under a high deductible policy.) By June 30, 1997, only 22,051 taxpayers had established MSAs, of which 17,145 were taken into account with respect to the threshold of 525,000. (Of the rest, 1,236 had a spouse with an MSA and 3,670 had been uninsured.)<sup>8</sup> For 1998, the thresholds are 600,000 and 750,000 (depending on different estimate procedures); while for 1999, the threshold is 750,000.

The MSA eligibility restrictions were controversial when HIPAA was enacted and remain a matter of debate. In general, MSA proponents favor lifting the restrictions and allowing MSAs to be established by employers and individuals generally. MSA opponents prefer keeping the restrictions as long as any MSAs are authorized.

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<sup>7</sup> For a summary of the MSA provisions enacted in 1996, see CRS Report 96-805, *The Health Insurance Portability and Accountability Act of 1996: Guidance on Frequently Asked Questions*, by Beth C. Fuchs, Bob Lyke, Richard Price, and Madeleine Smith. p. 21-24. Several technical amendments to the HIPAA provisions were made by section 1602(a) of the Taxpayer Relief Act of 1997 (P.L. 105-34).

<sup>8</sup> The MSA counts were announced in Internal Revenue Service announcements 97-79 (issued August 15, 1997) and 97-96 (issued September 12, 1997), respectively.

**Legislation.** In the 105<sup>th</sup> Congress, five bills have been introduced that would amend or otherwise eliminate the restrictions just discussed.

- H.R. 1068 (Representative Lipinski) would eliminate restrictions on the number of MSAs that could be established, including the December 31, 2000 cut-off.
- H.R. 1490 (Representative Cooksey) would eliminate the restriction based on employer size. In addition, it would delete a provision restricting contributions to compensation from employment (though other contribution limits would remain). The bill would also reduce the capital gains tax on individuals.
- H.R. 1582 (Representative Cooksey) would eliminate restrictions on the number of MSAs that could be established, including the December 31, 2000 cut-off. It would also eliminate the restriction based on employer size. In addition, it would delete a provision restricting contributions to compensation from employment (though other contribution limits would remain).
- H.R. 1743 (Representative Salmon) would eliminate restrictions on the number of MSAs that could be established, including the December 31, 2000 cut-off. It would also eliminate the restriction based on employer size.
- S. 572 (Senator Allard) would eliminate restrictions on the number of MSAs that could be established, including the December 31, 2000 cut-off. It would also eliminate the restriction based on employer size. In addition, it would delete a provision restricting contributions to compensation from employment (though other contribution limits would remain).<sup>9</sup>

In addition, three bills have been introduced in the 105<sup>th</sup> Congress that would authorize MSAs and qualifying high deductible insurance plans under the Federal Employees Health Benefits Program (FEHBP):

- H.R. 1574 (Representative Salmon)
- H.R. 2465 (Representative Salmon)
- H.R. 3166 (Representative Burton)

H.R. 2100 (Representative Stearns) would require the Secretary of Defense to conduct a two-year demonstration project in which certain military health care system beneficiaries have the option to enroll in FEHBP; it would authorize a federal income tax credit of 25% for demonstration participants for amounts paid for medical savings accounts.

At this writing, none of the above bills has been reported by a committee.

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<sup>9</sup> During the June 25, 1997 Senate debate on S. 947 (the budget reconciliation legislation), Senator Allard proposed and then withdrew an amendment to authorize families with uninsured children to deposit money in an MSA.