HB 843

Department of Fiscal Services

Maryland General Assembly

FISCAL NOTE
Revised

House Bill 843 (Delegate Kelly, *et al.*)
Economic Matters — Referred to Finance

Health Insurance - Small Group Market - Medical Savings Account

This amended bill requires the Health Care Access and Cost Commission (HCACC) to develop a modified health benefit plan for medical savings accounts (MSA) that qualify under the Federal Health Insurance Portability and Accountability Act of 1996, including a waiver of deductibles as permitted under federal law. The modified health benefit plan will be offered to small employer groups who offer the Comprehensive Standard Health Benefit Plan (CSHBP). There will be minimum funding standards for an MSA. In addition, a carrier may not impose minimum participation requirements for a small employer group if any member of the group participates in an MSA.

Fiscal Summary

State Effect: General fund expenditures could increase by an estimated $32,900 in FY 1998, which reflects the bill's October 1, 1997 effective date; future year expenditures reflect annualization and inflation. General fund revenues could decrease by an indeterminate but significant amount as discussed below.

(in dollars)	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
GF Revenues	---	---	---	---	---
GF Expenditures	$32,900	$38,000	$39,400	$40,800	$42,300
Net Effect	($32,900)	($38,000)	($39,400)	($40,800)	($42,300)

Note: ( ) - decrease; GF - general funds; FF - federal funds; SF - special funds

Local Effect: Potential significant decrease in local piggyback tax revenues as discussed below.

Small Business Effect: Potential meaningful effect on small businesses as discussed below.

Fiscal Analysis

Background: The Federal Health Insurance Portability and Accountability Act of 1996 established a four-year pilot program for MSAs. MSAs are tax-favored accounts holding funds to be used in combination with a high-deductible medical plan coverage (such as an indemnity health insurance plan). A high-deductible health plan is a plan with an annual deductible of at least $1,500 and no more than $2,250 for an individual and at least $3,000 and no more than $4,500 for a family. The maximum out-of-pocket expenses allowed (including deductibles) cannot exceed $3,000 for an individual and $5,500 for a family.

Aside from the high-deductible health plan, the individual cannot be covered under any other health plan (except for other incidental health coverage, such as vision). Contributions to an MSA can be made by either the employer or the employee, but not by both. Federal law specifies a maximum cap on the annual contribution and this bill provides for a minimum contribution level. The maximum annual contribution to an MSA for an individual is 65% of the deductible under the high-deductible plan and 75% for family coverage.

Distributions from an MSA are generally excluded from income, for tax purposes, if used to pay for unreimbursed medical expenses of an employee or dependent. Funds remaining in the MSA may be rolled-over to the following year.

Federal legislation limits the number of taxpayers participating in an MSA. The program limit will start with 375,000 taxpayers as of April 30, 1997 and will increase to 750,000 taxpayers in 1999. If a proportionate number of people from each state participates in the program, this amounts to about 14,250 Maryland taxpayers in 1999.

State Effect: Since contributions to MSAs are tax deductible and earnings and distributions from MSAs are not taxed as income if spent on certain unreimbursed medical expenses, State income tax revenues would decrease. General fund revenues could decline by, at most, $861,700 in fiscal 1998 assuming: (1) 7,125 Maryland taxpayers participate in MSAs as of July 1997; (2) half are family plans and half are individual plans; and (3) they each contribute the maximum amount to their MSA. If all 14,250 Maryland taxpayers participate in 1999 and the above assumptions continue to hold, general fund revenues would decline by $1.7 million in fiscal 1999.

General fund expenditures could increase by an estimated $32,903 in fiscal 1998, which reflects the bill's October 1, 1997 effective date. This estimate accounts for the cost of hiring one Contract Analyst to review the contracts for the new modified plan and ensuring that they comply with federal regulations. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$27,883
Operating Expenses	5,020

Total FY 1998 State Expenditures $32,903

Future year expenditures reflect (1) full salaries with 3.5% annual increases and 3% employee turnover; and (2) 2% annual increases in ongoing operating expenses.

In addition, the effect on State expenditures would depend on how MSAs affect people's behavior regarding health care. The advantages and disadvantages of an MSA discussed below highlight some of the possible consequences to State expenditures.

Advantages:
(1) Expenses not covered under the indemnity plan may be covered under MSAs.
(2) MSAs could be used to cover preventive care, so it may encourage early intervention.
(3) Since employees keep the balance in MSAs, they may shop for more efficient forms of care and reduce unnecessary tests and procedures.

As a result, the health status of individuals may improve and medical care costs or uncompensated care may decrease. This could lead to reduced expenditures for: (1) the Medicaid program and the State employee health benefit plan due to lower hospital rates; (2) health services funding to local health departments which serve the "grey-area" population (those who have too much income to be eligible for Medicaid but cannot afford health insurance); and (3) the Primary Care for the Medically Indigent program which serves those not eligible for Medicaid. Any such decrease, however, cannot be reliably estimated at this time.

Disadvantages:
(1) Healthy individuals may enroll in this plan, leaving the less healthy in the CSHBP. Since the CSHBP is community-rated, a less healthy pool of individuals in the CSHBP would raise premiums on the plan and may affect the insurance status of some people.
(2) The incentive of keeping the balance in an MSA may cause people to avoid office visits for minor illnesses and preventive care.
(3) People will use MSAs for services not covered under the indemnity plan and will not understand that these expenses do not satisfy the deductible. As a result, if they incur high medical expenses, they may not have sufficient funds in their MSAs to pay those medical expenses.

As a result, the amount of uncompensated care may increase. This could lead to increased expenditures for: (1) the Medicaid program and the State employee health benefit plan due to higher hospital rates; (2) health services funding to local health departments which serve the "grey-area" population (those who have too much income to be eligible for Medicaid but cannot afford health insurance); and (3) the Primary Care for the Medically Indigent program which serves those not eligible for Medicaid. Any such increase, however, cannot be reliably

estimated at this time.

Local Revenues: Assuming a loss in State income tax revenues of $861,700 and $1.7 million in fiscal 1998 and 1999, respectively, local tax revenues would decline on average by $469,600 and $939,200 in fiscal 1998 and 1999, respectively.

Small Business Effect: Currently, employers are not required to subsidize the CSHBP for its employees. The new modified plan with the MSA will permit either the employer or the employee to contribute to the MSA (but not both); however the employer may still elect not to subsidize the health coverage. For these employers, the bill's effect would be negligible.

The MSA will, however, affect the premiums of the CSHBP. This is because premiums for CSHBP are community-rated, meaning that the rates are set based on the expected medical care cost of a large pool of individuals. It is expected that healthier individuals would prefer the high-deductible catastrophic plan because their expected medical care costs are low. If healthier individuals leave the pool of the CSHBP, the remaining individuals with the higher expected medical care costs will drive up premiums for the CSHBP. As a result, for the small employer who subsidizes health insurance coverage, health insurance costs will increase. According to a Foster Higgins analysis, if an MSA is introduced with a high-deductible catastrophic health benefit plan, premiums for the CSHBP could increase by between 0.2% to 0.4% (about $6.39 to $12.78), depending on the size of the deductible allowed by the plan. Currently, the average cost of the CSHBP is $3,195.

Information Source(s): Insurance Administration; Department of Health and Mental Hygiene (Health Care Access and Cost Commission); Foster Higgins; Department of Fiscal Services

Fiscal Note History: First Reader - February 12, 1997
nrd Revised - House Third Reader - March 25, 1997

Analysis by: Lina Walker
Reviewed by: John Rixey

Direct Inquiries to:
John Rixey, Coordinating Analyst
(410) 841-3710
(301) 858-3710