Medical Savings Accounts:

Background Information and Regulatory Concerns of the National Association of Insurance Commissioners
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1996

NAIC
National Association of Insurance Commissioners
MEDICAL SAVINGS ACCOUNTS

The use of Medical Savings Accounts (MSAs) as a strategy to control medical care costs has become an increasingly popular concept. A great deal of debate exists about the effectiveness of an MSA in achieving cost control. This paper provides background information on the key issues related to MSAs, the strengths and weaknesses of the use of MSAs to control costs, the various potential design elements of MSAs, and the impact of MSAs on the insured marketplace. Regulatory concerns regarding MSAs are discussed as well.

Introduction

MSAs couple a savings account concept with a high-deductible or catastrophic health care plan. In a typical MSA, the employer will establish an MSA account for each employee and purchase a high-deductible/catastrophic insurance plan. The employee will draw from this account to pay for unreimbursed health care expenses. Once the cost of the employee’s health care reaches the deductible limit, the catastrophic plan becomes effective for those services which it covers.

At present, any employer may offer an MSA option to employees as its health benefit package. For special consideration for MSAs, such as tax treatment, legislation is required. Integral to current MSA proposals is tax-favored treatment for funds in the savings accounts.

MSAs are attractive to various constituencies, including many employers, employees, and public officials, not only because they help reduce health care utilization and costs, but because they resolve other health care reform challenges, such as “job-lock” as a result of the current non-“portability” of health care coverage. At the same time, others believe that MSAs will greatly exacerbate the difficulties involved in achieving the broader health care reform objective of access to health care coverage. Parties on both sides of the debate concede that MSAs will not provide essential coverage to the poor and many of the currently uninsured.

Legislative Activity

Both the federal government and the states have responded to the increased interest in MSAs through the introduction of MSA legislation. Fourteen states have enacted MSA legislation: Arizona, Colorado, Idaho, Illinois, Indiana, Michigan, Mississippi, Missouri, Montana, New Mexico, Oklahoma, Utah, and West Virginia. The Commonwealth of Virginia has passed legislation tying the implementation of MSA legislation to the passage of federal legislation. Many states have also adopted resolutions advocating that the United States Congress enact MSA legislation and adopted legislation requiring a study of MSAs.

Several proposals have been introduced in the 104th Congress. At the time of this writing, no MSA legislation had been enacted at the federal level.
Key Structural Issues

Within the broad confines of the typical MSA plan are a variety of structural decisions which determine the attractiveness of MSAs to consumers and employers. How the MSAs are structured will also have a direct impact on whether cost savings will actually be achieved. Key issues which must be considered in the design of an MSA include:

1. Who is eligible for an MSA?
2. Who establishes and administers the plan?
3. What kind of health care coverage is required with an MSA?
4. What is the required amount of contribution into an MSA?
5. Who makes the contributions, and, are they voluntary or mandatory?
6. What is the tax treatment of the contributions?
7. What is the tax treatment of earnings of the contributions?
8. For what may the contributions be used?
9. What is the relationship between MSAs and other health care plans?
10. To what extent should MSAs be regulated?

1. Who is eligible for an MSA?

The most commonly discussed MSA is one in which the employer establishes an MSA for its employees and their dependents. Some proposals also allow employees to establish an MSA for themselves.

All individuals could be made eligible for an MSA. The drawback to this broader approach, however, is reduced tax revenue if the contributions to all individuals receive tax-favored treatment. A document prepared by the United States Congress Joint Committee on Taxation notes, however, that tax benefits for individuals outside of the employment context may have only a minimal distortional effect on health care consumption since non-employed individuals receive less of a subsidy than those who receive contributions from an employer.

While this paper focuses on the relationship between the employer and its employee, the issues discussed could pertain to an MSA program which involves the government and beneficiaries or other relationships.

2. Who establishes and administers the plan?

MSAs are typically established, but need not be administered, by the employer. Unless the MSA is to be a blank check for the accountholder, there will need to be an administrator. An insurance company, third party administrator (TPA), certified public accountant, attorney, investment advisor, trust company, bank, or other financial institution may be responsible for handling the account. What types of rules will apply to the administrator? Should the Unfair Claims Settlement Practices Act apply to the administrator? Should the administrator be required to have a license of some kind (i.e. under a state TPA law)?
3. What kind of health care coverage is required with an MSA?

Most MSA proposals couple the savings account with a high-deductible, catastrophic health care plan. Some people believe the MSA dollars should not be allowed to be used to purchase a comprehensive health insurance plan.

4. What is the required amount of contribution into an MSA?

A threshold question in MSA design is the contribution level provided by the employer. The Congressional Research Service believes that one of the most important questions on MSAs is whether they will be adequately funded. Much of the literature assumes that the employer contribution toward a traditional plan today will be enough money to purchase the catastrophic plan and fully, or almost fully, fund the deductible. The American Academy of Actuaries, however, reached a different conclusion.

Proposals differ on how the contribution should be set. Some proposals suggest that the contribution be the difference between the premium cost of a low-deductible and high-deductible plan. Others suggest that the contribution be the level of the deductible. Alternatively, the maximum level could be a flat dollar amount unrelated to the deductible. Some state statutes set a minimum or maximum contribution level or both.

Whether the employee will find the MSA option attractive will depend, in part, on if the contribution is sufficient to cover anticipated medical expenses for the year. The ability to spend the funds based on need as opposed to the timing of the contribution is also another factor important to the account holder. If employees must wait to tap into the savings account until after the contribution is deposited, irrespective of the timing of their medical needs, it will be less attractive. Many state MSA statutes permit employers to give advances to MSA funds so that employee medical expenses may be paid for on a timely basis.

5. Who makes the contributions, and, are they voluntary or mandatory?

Under the typical scenario, MSA contributions are provided by the employer. In some proposals, employees may also contribute to the MSA. The contributions of the employer and employee are typically voluntary, although the maximum contribution level is specified in most state statutes.

The American Medical Association (AMA) and others are actively advocating that MSAs be an option, not only for the employed marketplace, but also for the Medicare program through a specific government contribution. The beneficiary would be required to use a part of the government contribution to purchase a high-deductible, catastrophic insurance policy. Under the AMA’s proposal, the contribution would be tax-deductible and money spent from the fund for medical expenses or catastrophic, long-term care insurance premiums would be tax-exempt. The AMA asserts that this strategy has the advantage of privatizing long-term care insurance, and at the same time, reducing the public sector’s burden for financing the health care of the growing elderly population.
6. What is the tax treatment of the contributions?

Another factor which will determine the attractiveness of MSAs to employees and affect the level of cost savings is the tax treatment of MSAs. The level of the contribution is linked to the tax treatment. Tax-favored treatment for the entire deductible as opposed to the difference between the high-deductible and low-deductible premium costs are far more attractive to employees. Again, the downside to this approach is the foregone revenue associated with more generous tax treatment.

Tax-favored status for these funds provides incentives which may or may not be attractive from a public policy perspective. If funds are permitted to accumulate on a tax-free basis, employees may be reluctant to use the MSA funds and either avoid meeting their health needs or use funds from other sources. In addition, while tax-free MSAs encourage savings, it may not be appropriate to dictate that employees save specifically for medical expenses instead of for those expenses they determine to be appropriate to their circumstances.

7. What is the tax treatment of earnings of the contributions?

Similar concerns arise when considering the tax treatment of earnings on the contribution. Tax-free earnings on unspent funds encourage the use of MSAs but also decrease revenues. As mentioned in the section above, it also provides an incentive for medical savings, potentially at the expense of other necessary forms of savings.

8. For what may the contributions be used?

MSA proposals have outlined a variety of options for how the accounts may be used and have provided various tax incentives along these lines. Some proposals only permit withdrawal of funds for medical expenses. Medical expenses may either be defined broadly, linked to those services eligible for a deduction under the Internal Revenue Code, or limited to services either covered under the accompanying catastrophic health plan or not covered under the accompanying catastrophic health plan.

This is a key issue and its resolution may have discrete ramifications for state insurance departments. For instance, if the expenses for which the MSA may be used were tied to the catastrophic plan benefits, consumers may incur medical expenses which are both unreimbursed and do not count toward satisfaction of the catastrophic deductible. If the MSA is allowed to be a blank check to the consumer, the consumer may spend those dollars on items which the catastrophic plan insurer does not allow, thus not counting toward the deductible, or may pay charges which are in excess of the insurer’s allowed charge, also resulting in paid charges not counting toward fulfillment of the deductible. If there were an MSA administrator, and the administrator is not the insurer of the catastrophic plan, payments made by the administrator may result in the same problems regarding allowable expenses as in the situation where the MSA is a blank check to the consumer. In any event, this issue could result in consumer complaints to the insurance department over what counts toward the deductible in an MSA/catastrophic plan scheme.

Other proposals permit withdrawal for expenses other than medical expenses. However, some of these proposals limit tax-favored treatment only for withdrawals for medical expenses. Proposals may also permit withdrawal for any expenses after a certain age or period of time. While penalty taxes and
regular income tax rates may be imposed on prohibited withdrawals, the Joint Committee on Taxation 
noted in its report that experience with individual retirement accounts demonstrate that a minimal 
penalty tax does not serve as a strong deterrent to withdrawals.

Funds which are left at the end of the year could either be withdrawn or rolled over into the next 
year’s account. When an employee runs out of funds, the program designer has several options. The 
employee may have the ability to draw on future contributions, similar to a line of credit. Employees 
also may be able to tap into the MSA funds of family members. Or, the employee may be forced to 
use other personal sources.

When an employee leaves an employer through which he or she has an MSA, the former employee 
may seek approval from the account administrator for continued administration of the funds, move the 
funds to another account administrator, or cash in the account. Upon the death of the accountholder, 
the funds typically become a part of the estate or go to the designated beneficiary.

9. What is the relationship between MSAs and other health care plans?

The relationship between MSAs and other health care plans is a significant factor in program design. 
The availability of coverage through other health care plans for the purpose of supplementing the 
MSA will decrease the overall level of savings which can be derived from an MSA. By doing so, the 
goal of decreased utilization will not be achieved. Many state statutes prohibit the use of MSA funds 
for services covered under other plans such as automobile insurance policies, workers’ compensation 
policies, self-insured, or other health insurance policies.

Whether an MSA approach would be compatible with a state’s reform plans is another significant 
factor to consider. For example, the State of Minnesota, in its 1994 review of MSAs, concluded that 
the approach would be inconsistent with the state’s plans for comprehensive health care reform and 
the significant managed care presence in the state. The study did note that in states with lower 
managed care penetration and little movement towards comprehensive health care reform, MSAs may 
be more beneficial.

There is also the issue of switching plans back and forth from an MSA/catastrophic plan to a 
comprehensive plan when the insured perceives it is to his or her economic benefit to have 
comprehensive coverage. Many believe this ability to switch plans should be strictly curtailed to limit 
the adverse selection impact. Because many MSA bills at the federal level amend the Internal 
Revenue Code, this issue is not effectively addressed in those bills. Also, this issue is affected in some 
states by small group and individual insurance laws which require annual open enrollment periods.

Last, in general, it should be noted that requiring an MSA option may run counter to state small group 
and individual insurance laws which are built on the standard and basic plans scheme embodied in the 
NAIC Small Employer Health Insurance Availability Model Act.

10. To what extent should MSAs be regulated?

How the plans are regulated will also greatly affect the extent of savings derived from MSAs. A 
minimalist approach to regulation would involve setting up a tax framework and allowing employers 
and employees to make their own choices related to design within that framework. Limited regulation
in this manner will not address, however, concerns related to selection bias which increases costs for those who remain in traditional health insurance plans.

Regulating for selection bias will assist in attaining savings goals. Unfortunately, instituting regulations to limit selection bias reduces the spectrum of choice available to both employers and employees and increases administrative costs due to the need to conduct enforcement.

Other areas where regulation may be considered include standards for account administrators and fiduciary standards for the management of account funds.

**Strengths and Weaknesses**

The few states that have considered and passed MSA legislation have done so only recently and little objective evaluation has been published on MSA plans developed by employers. The resulting insufficient experience and objective analysis of actual MSA policies make it difficult to assess fully the strengths and weaknesses of MSAs. Analysis has been limited to the few employment settings studied which have implemented MSAs as an option for employees and from current understanding of the principles of insurance. In undertaking this analysis, proponents and opponents have offered a variety of grounds for furthering the implementation of MSAs or for questioning the true value or effectiveness of MSAs in achieving cost control or improving access to health care.

1. **Cost Control**

While proponents do not claim that MSAs are the panacea for all problems associated with the health care system, they do believe that MSAs serve as a useful mechanism for helping to control utilization of medical services. It is argued that because an employee will own the MSA fund, the employee will have an incentive to use the funds more wisely, thus becoming a more active health care consumer and more prudent shopper. In addition, MSAs offer employees an incentive to make healthier lifestyle choices.

Employers, physicians, and others claim very tangible reductions in health care expenditures. Several of the employers that have instituted MSAs report significant decreases in health care costs because of reduced employee utilization. Decreases in health care expenditures are also said to result from reductions in administrative costs for both insurers and providers. The American Academy of Actuaries’ workgroup on MSAs found that administrative expenses under the typical MSA would decrease by about 20 percent.

Others question whether in fact MSAs really do conserve overall medical costs since the majority of health care costs are for individuals whose episodes of care reach beyond the catastrophic deductible. The utilization incentives under the MSA concept do not affect services sought under the high-deductible plan. Furthermore, while current administrative expenses may decrease substantially, skeptics contend that monitoring expenses will remain to ensure that the funds are being used for permissible purposes and that appropriate taxes are imposed and paid. (The permissible purposes aspect is actually twofold: permissible under the MSA law and permissible with regard to what counts toward the deductible of the catastrophic plan.) Administrative expenses will also be high for the claims submitted under the high-deductible plan.
Another concern is that the high-deductible policy does not provide the types of utilization control incentives that the MSA provides. In addition, it has been argued that MSAs do not prevent providers from increasing volume or raising prices to make up for the decreased utilization. Nor do MSAs provide a disincentive for insurers to raise premium rates. Finally, the MSA concept places bargaining responsibility in the hands of consumers, who have reduced bargaining power as individuals and less information and expertise available to them. Effective MSAs would, among other things, require the greater availability of objective information so that consumers can make effective choices.

2. Access to Health Care Services

The portability of MSAs improves access by eliminating at least some of the obstacles employees currently face when they desire to move to another job. Employees can take their MSAs with them. They can also be used by individuals who are temporarily unemployed as stop-gap coverage until employment resumes with another job. Furthermore, MSAs provide an opportunity for consumers to have access to a broader range of medical services traditionally not provided, such as long-term care (if the account has been built up substantially). And, because high-deductible policies are more affordable than low-deductible policies, small employers in particular may be more likely to offer some type of coverage to their employees.

Despite the advantage of portability and other cited benefits, MSAs only seek to address one aspect critical to true health care reform -- cost reduction. MSAs leave unresolved the challenges related to increasing access to care by providing coverage for the uninsured and adequate coverage for the underinsured. Furthermore, MSAs may severely restrict the ability to improve access to care by increasing premium costs for those most in need of health care, reducing utilization for necessary services, and reducing employer subsidization for health care costs. Both proponents and skeptics agree that supplemental policies would be required to cover the poor and uninsured under the MSA concept. It should also be noted that MSA plans need not be totally portable. The program could be designed to be shared property between the employer or government contributor and the employee.

The undesirable effect of encouraging adverse selection is of utmost concern to those who question the wisdom of MSAs. Sicker patients will likely remain or rejoin traditional health insurance plans and healthy patients will likely select MSAs. The effect of this adverse selection will be to increase premiums for members with the highest health care costs -- principally the elderly, pregnant women, and chronically ill or disabled populations. The withdrawal of the healthy population from traditional indemnity and managed care plans will undermine the primary concept of insurance, the spreading of risk. Premium costs for those persons selecting options other than MSAs may be significantly higher, and potentially out of reach. In addition, some MSA proposals would increase the federal tax subsidy by calling for efforts that would help lower income citizens make their deductible payments.

Some opponents also claim that MSAs create a disparity in benefits between the wealthy and less wealthy that result in incentives not to obtain needed preventive care. The Rand Health Insurance Experiment was conducted from 1974 to 1982, and the medical expenditures of 2,500 families were studied. It demonstrated that cost-sharing strategies discourage both necessary and unnecessary utilization of medical services. The incentives provided by MSAs to control utilization of health care services may result in consumers skimping on needed preventive care to save money. In particular, it is feared that lower income families might forego necessary care to avoid drawing down on their accounts or to avoid paying out-of-pocket if the account is insufficiently funded.

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Commentators are also unclear about whether savings to employers from the purchase of a high-deductible plan would be large enough to fund sufficiently an MSA. Insufficient funding of the accounts could leave employees, particularly lower-middle income and low income employees without an adequate reserve to cover non-catastrophic expenses.

3. Fairness

In addition to the portability of MSAs, proponents tout the advantage of individuals only paying for what they need as opposed to seeking care because of the availability of insurance or because of less healthy lifestyle choices, resulting in the subsidization of those choices by others.

Opponents believe that MSAs disproportionately benefit the wealthy. Under a tax-favored MSA approach, those employees who make the most get the largest tax breaks, thus receiving a subsidy at the expense of sicker members of the population. MSAs also provide another potential tax shelter for the wealthy. For these reasons, some consider MSAs to be an unfair approach to providing health care coverage. MSA proponents contend that the wealthy will not be able to abuse the system because the tax advantages offered will only be for a “reasonable” amount.

4. Compatibility with the Health Care Delivery System

MANAGED CARE

Whether MSAs are offered as an alternative to or as a framework for managed care, the managed care community and others claim that MSAs are inconsistent with current managed care initiatives. The perceived incompatibility derives from the removal of the healthy population from the managed care population, the lack of controls to ensure the provision of primary and preventive care, the inability to maintain capitated systems, and the legal structure developed to encourage managed care development.

The American Academy of Actuaries discussed potential options and effects related to MSAs and managed care. In its publication, “Medical Savings Accounts: Cost Implications and Design Issues,” the authors made the following observations:

1. If MSAs are offered as an alternative to health maintenance organizations (HMOs), then the healthy may opt for the MSA, resulting in higher costs to managed care entities.

2. Employers who support an HMO option in addition to contributions to an MSA may see their health care costs remain the same or increase, particularly if the cost of the HMO is lower than the cost of the low-deductible policy. The outcome under this scenario would depend upon employee selection patterns which are extremely difficult to predict.

3. Integration of managed care plans into an MSA concept would require changes in federal and state law and would likely undermine the purposes of both HMOs and MSAs. For example, the authors note that an all-purpose deductible is not currently permitted under federal HMO law. In addition, they observe that closed panel HMOs limit the freedom implicit in the MSA design.
Integration options considered by the Academy include:

1. HMO utilization of a schedule of charges set below traditional fee-for-service charge schedules to control utilization of office visits and outpatient services. The savings realized from the reduced utilization can be used as contributions to an MSA fund. Unknown, however, is whether the amount of savings would be sufficient to fund an MSA and whether such a schedule would be to the advantage of an MSA.

2. For managed care options which reimburse on a fee-for-service basis, such as individual practice associations, the use of an MSA as an “exclusive provider organization” might be considered. Again, the funds could not be used freely by the employee because the funds would only be available for covered, authorized services. This option also precludes the use of capitation, seen as an effective tool in controlling physician use of resources, unless a portion of the MSA funds were to be earmarked for capitation.

3. A preferred provider organization or point-of-service option might be compatible with an MSA because it provides the employee with the option of seeking care outside of the network. This option would require unbundled care, making it potentially impossible for a fully integrated network to participate. This approach, however, is likely to become so complicated for patients and providers that it would be unattractive from a practical standpoint.

4. An additional option to consider is to pay a premium to the HMO for expensive services and allow the employee to utilize the MSA for care related to outpatient services.

HOSPITALS AND PHYSICIANS

Hospital providers also fear that MSAs, which in essence make consumers self-payors of care, will increase the uncompensated care rate for the industry. Those who fall in the self-pay category often fail to pay for the services rendered. Physicians support MSAs as beneficial to the health care delivery system because of the option’s ability to enhance the physician-patient relationship. For routine treatment decisions paid for by an MSA, the deliberations on how to proceed will not involve the insurance company, which has become an overriding presence in treatment decisions. The management of care will be done by patients and doctors.

Proponents concerned with the economics of health care assert that MSAs encourage true cost competition between doctors and hospitals. It also provides developers of medical technology with incentives to not only develop technology which improves the provision of care, but reduces costs as well.

It is possible that many of the concerns expressed above can be alleviated through structure and design of MSAs. It is clear, however, that a careful balancing act must be maintained to achieve cost savings. The balancing act becomes even more difficult when attempting to reach successfully, or at least not undermine the ability to achieve, broader reform objectives as well.
**Impact on the Insured Marketplace**

In summary, MSA penetration into the marketplace has not been extensive enough to permit objective evaluation of its impact on the insured marketplace. Commentators agree that the MSA approach will not comprehensively cover the uninsured population, but may, in some circumstances, provide coverage for individuals between jobs who have balances in their accounts.

As mentioned previously, it is strongly believed by many that MSAs will skim the healthiest population from the insured marketplace, thus leaving the more costly members of the employed population—principally pregnant women, employees with a chronically ill or disabled family member, and the older worker—with higher, and potentially unaffordable, premium costs. Whether this is the case will depend upon the extent to which today’s traditional insurance coverage adequately protects sicker employees. If the high-deductible policy is designed to provide coverage which is more appropriate to the medical needs of employees with higher health care costs, the out-of-pocket differential between an MSA and the traditional plan may not be significant.

Finally, a commitment to MSAs may be incompatible with a commitment to managed care. The MSA strategy may undermine the ability of managed care entities to lower costs because healthier workers will finance their care through MSAs instead of joining plans.

MSAs are an enticing option for many employers, employees and providers. They offer an element of control over resources and decisions about the course of care that have been lacking in the insured environment. On the other hand, MSAs threaten the ability to care for those employees most in need of insurance by eliminating the ability to spread the risk of insurance. A commitment to both controlling costs and maintaining, as well as increasing, access to care will require that the potential design options for MSA programs undergo careful scrutiny to ensure that MSAs do not impair the ability to reach these objectives.
Appendix A

Employer Activity

Despite the lack of tax incentives, many employers have implemented MSAs as an option for their employees. MSAs take various forms and few plans are exactly alike. Some of these plans have been showcased in the literature.

The most widely touted plans include those established by the Golden Rule Insurance Company, Forbes, Inc., and Dominion Resources. A plan marketed by Plan 3 Insurance provides another interesting option.

GOLDEN RULE INSURANCE COMPANY

Golden Rule began offering an MSA option to its employees in 1993. In 1994, about 90 percent of Golden Rule’s employees chose the MSA instead of traditional insurance coverage.

For family coverage, the company purchases a catastrophic policy that pays all medical expenses which exceed $3,000 per year and deposits $2,000 in the MSA for the employee and his or her family. For individual coverage, the company purchases a catastrophic policy which pays medical expenses which exceed $2,000 per year and deposits $1,000 in the employee’s MSA. At the end of the year, any unused funds may be withdrawn from the account by the employee to be used for any purpose. Golden Rule notes the following results:

1. Employees used funds to pay for care that traditional insurance often did not cover or discouraged through the imposition of deductibles and coinsurance fees, such as preventive care.

2. MSAs decreased costs above the deductible by 40 percent from previous projections in 1993.

3. The sickest employees had less exposure for out-of-pocket costs under the MSA, than under the traditional health insurance plan.

FORBES, INC.

Under Forbes, Inc.’s MSA health benefit plan developed in 1991, the company sets aside $1,000 per employee annually. In addition, Forbes has established a deductible equal to one percent of an employee’s annual salary. At the end of the year, employees who file under $600 worth of claims receive a bonus equal to twice the difference between $600 and the dollar amount of the claims. No limits are placed on how employees spend or save the money. Forbes reports significant reductions in health costs and premiums.

DOMINION RESOURCES

In 1992, Dominion developed a plan that provides its employees with incentives to choose a high-deductible plan. It contributes the same amount of dollars towards an employee’s plan regardless of
the different premium costs of the three plans offered by the company. For the high-deductible plan, the premium is less than the company’s contribution. An employee could receive the difference directly or have it placed in a personal savings account. Furthermore, if the company’s total health care costs for the year come in below budget, the savings are shared with employees whose claims for the year were less than the deductible for their plan.

PLAN 3 INSURANCE

Plan 3 Insurance sells a different version of MSAs than that established by Golden Rule, Forbes or Dominion Resources. Under Plan 3’s MSA option, an employer would purchase a high-deductible catastrophic policy and place the savings achieved through the purchase of the catastrophic policy into a fund used to pay for all employee medical expenses below the deductible. Employees who utilize fewer medical costs than an amount specified by the employer, such as the deductible amount, may withdraw the difference from the fund after three years. Over the three year period, the fund grows, allowing the level specified by the employer to be set higher, resulting in higher rebates to employees over time.
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Burry, Jr., John, Medical Savings Accounts: Bad Medicine for the U.S. Healthcare System.


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<td>Arizona</td>
<td>§ 43-1028, 43-1331</td>
<td>Trust established as an individual MSA shall not add the amount of interest income received on obligations of the state. Employer may contribute to the employee’s individual MSA exclusively or in addition to medical coverage. For each taxable year, deposits may not exceed $2,000 for account holders and $1,000 for each dependent up to 2 dependents. Funds used solely for medical expenses are not taxable. Funds can be withdrawn without penalty on the last business day of a calendar year but are subject to income tax. Withdrawals for non-medical expenses are considered taxable income and incur a penalty equal to 10 percent of the withdrawal amount.</td>
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<td>Colorado</td>
<td>§§ 39-22-504.5 to 39-22-504.7</td>
<td>Employer or employee may establish MSA. Maximum contribution $3,000. All contributions are on a pre-tax basis. Funds exempt from income tax if used to pay eligible medical expenses.</td>
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<td>Idaho</td>
<td>§§ 63-3022J</td>
<td>MSAs may be established and contributed to by individuals or employers. Maximum annual contribution $2,000. Annual contributions and interest earned are deducted from taxable income. Funds used for purposes other than for eligible medical expenses considered taxable income. Account holder shall pay income tax and a penalty equal to 10% of money withdrawn if funds used for purposes other than eligible medical expenses. When account holder reaches 59 1/2 years of age, withdrawals may be made for any reason without penalty.</td>
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<td>Illinois</td>
<td>820 ILCS 152/1 to</td>
<td>MSA is an account established to pay eligible medical expenses of an employee and dependents. MSA programs include all of the following: purchase by an employer of a higher deductible health plan; contribution into a medical care savings account. Maximum amounts are adjustable based on consumer price index; principal contributed to and interest earned on MSA and money reimbursed to an employee for eligible medical expenses are exempt from taxation under IL Income Tax Act; money withdrawn for other purposes considered income and is taxable.</td>
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<td>820 ILCS 152/20,</td>
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<td>ILCS 152/85</td>
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<td>Indiana</td>
<td>IC 6-8-11, IC 6-3-</td>
<td>Employers may establish MSA for employees and dependents of employees. Employer must purchase a qualified higher deductible health plan, make a contribution that equals all of part of the difference between the cost of the higher deductible health plan and the employer’s previously incurred health coverage costs, and designate an account administrator. Maximum amounts are adjustable based on the consumer price index or other federal indicator of general price levels. Funds withdrawn for purposes other than payment of eligible medical expenses shall be subject to taxation. Effective January 1, 1996.</td>
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<td>Michigan</td>
<td>§§ 550.981 to 550.988</td>
<td>Employer or resident of state may establish MSA. MSA is one of the following: program established by an employer that previously provided a health coverage policy that includes all of the following: purchase of a higher deductible health plan; maximum contribution $3,000; amounts adjusted annually based consumer price index; if funds withdrawn for purpose other than payment of eligible medical expenses, administrator shall withhold 10% of amount withdrawn as penalty.</td>
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<td>Mississippi</td>
<td>§§ 71-9-1 to 71-9-9</td>
<td>MSA can be established by employer or resident. MSA program includes all of the following: purchase by an employer or resident of a qualified higher deductible health plan; payment into the MSA at least 66 2/3 of the premium reduction realized by the purchase of a qualified health plan; and an account administrator. Principal and earned interest shall be excluded from tax; money withdrawn and not used to pay eligible expenses shall be taxable income.</td>
</tr>
<tr>
<td>Missouri</td>
<td>§ 143.999</td>
<td>Employer contributions to Individual Medical Account for health care expenses shall be exempt from income tax. Annually employer shall determine contribution level to be expended for coverage which shall be in lieu of any standard indemnity or health insurance provided. Percentage of employer’s contribution shall be used by the insurer, HMO etc. to provide benefits. Remainder will be used to fund an IMA to pay for health care expenses not covered by the policy. Funds in account spent on health care are exempt from MO state income tax.</td>
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<td>STATE</td>
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<tr>
<td>Montana</td>
<td>HB 560 (1995)</td>
<td>Employer may establish MSA for an employee or employee's dependent. Resident of state may establish an MSA. Contribution and interest are tax exempt. Amounts withdrawn from account not tax exempt and subject to 10% penalty of withdrawn amount if used for other than payment of eligible medical expenses. Max. annual contribution $3,000, but no limit on amount maintained in account.</td>
</tr>
<tr>
<td>Nevada</td>
<td>AB 592 (1995)</td>
<td>If an employer elects to provide health care benefits through an MSA, the program must be administered by an approved entity. Funds can be withdrawn to pay eligible medical expenses not otherwise paid by a third party, to reimburse employee for eligible medical expenses or by the employee on the last business day of the year.</td>
</tr>
<tr>
<td>New Jersey</td>
<td>AB 635 (1994)</td>
<td>The feasibility of permitting the use of MSA plans under the state’s small employer health benefit program shall be studied by the program’s board of directors.</td>
</tr>
<tr>
<td>New Mexico</td>
<td>59A-23D-1 to</td>
<td>Employer may establish an MSA for employees. The employer must provide a qualified higher deductible health plan, contribute to the MSA and appoint an account administrator. Funds used for eligible medical expenses are exempt from taxation.</td>
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<td>59A-23D-7, 7-2-</td>
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<tr>
<td>Oklahoma</td>
<td>Tit. 63 §§ 2621 to 2623</td>
<td>MSA shall be an account to pay eligible medical expenses of an account holder. The program shall include the purchase of a qualified, approved health plan or the deposit by an individual on behalf of an employee into a medical savings account of all or part of the premium differential realized by the employer based on the purchase of a qualified health plan for the benefit of the employee. Beginning 1/1/96 the amount of deposit shall not exceed $2,000 for the account holder, $2,000 for the spouse of the account holder and $1,000 for each dependent child of the account holder. The maximum deposit for subsequent years shall be based on the CPI. Contributions and interest earned are tax exempt.</td>
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<tr>
<td>Texas</td>
<td>SB 604 (1995)</td>
<td>The Health and Human Services Commission shall develop a plan for a pilot program that uses Medicaid funds to establish an MSA for recipients of acute care services under the Medicaid program.</td>
</tr>
<tr>
<td>Utah</td>
<td>§ 31A-32-101 to 31A-32-106, 63C-3-104</td>
<td>MSA can be established by employer or resident. The contribution into the account may not exceed the greater of either $2,000 in any tax year or an amount equal to the sum of all eligible medical expenses in that tax year which an insurance carrier has applied to the employee or account holder’s deductible. Contributions, interest earned and reimbursement made for eligible medical expenses are tax exempt. The Health Policy Commission will evaluate MSAs.</td>
</tr>
<tr>
<td>Virginia</td>
<td>38.2-5600 to 38.2-5603</td>
<td>Dept. of Medical Assistance Services to develop a plan to use MSAs for the working poor. Dept. of Workers Compensation shall create and use medical savings accounts and work in cooperation with the Dept. of Taxation. Dept. of Taxation to develop a system of refundable tax credits. Joint Commission on Health Care to monitor the plan. Implementation of plan contingent upon passage of federal legislation authorizing plan components.</td>
</tr>
<tr>
<td>West Virginia</td>
<td>§§ 33-15-20, 33-16-15</td>
<td>Resident may establish a medical savings account. A percentage may be designated that may be withdrawn if not needed for medical expenses. Any amount used for other than to pay medical expenses shall be taxed as income of the payee. Withdrawal requirements applicable to insurers offering group A/H, public employee insurance agency and ERISA health plans.</td>
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</tbody>
</table>

Every effort has been made to make this information as correct and complete as possible. For further information about Medical Savings Accounts, please consult the laws listed above.

* Although the statutory framework exists for MSAs in these states, the NAIC has no statistical information with respect to the number of persons who have utilized these plans.