CONCESSIONS RELATIVE TO THE CLEAN "SENATE BILL":

1. Any MSA at all. (The Senate passed the health insurance reform initiative by a 100 - 0 vote without any MSA provision.)

2. No geographically-based demonstration.

3. Experiment open to all employees in firms with 100 or fewer employees (and only limited to the amount of participants that the Treasury currently projects will opt for MSAs.)

4. Experiment open to all self-employed individuals (and only limited to the amount of participants that the Treasury currently projects will opt for MSAs.)

5. No requirement for a cap on build-up of the MSA account during the experiment.

6. No requirement that insurers and plans must offer employees the choice of a traditional plan if they offer an MSA option.

7. No requirement that a state-passed risk adjustment mechanism be in place in order to sell MSAs in a state.

8. No requirement that MSA account spending be solely limited to benefits covered by the catastrophic benefit plan.

9. Acceptance that penalty for withdrawal of funds for non-medical purposes be set at 15%, and not a higher amount (experts advising us have suggested 20%).

10. Elimination of requirement that the tax treatment for the self-employed be consistent with their treatment for traditional, comprehensive health plans.

11. The elimination of all mental health parity requirement provisions originally included in the Senate-passed version of the Domenici/Wellstone bill (such as copays, deductibles, inpatient/outpatient limits, chemical and substance abuse, etc.) other than the requirement for equal treatment of lifetime and annual payment limits.

MSA Reporting Models

o Since CHI/MSA plans are new products for the small group market, they will be introduced into that market in a manner parallel to the introduction of other new product lines. This means that like all small group products, they will be subject to state regulation. Typically, state regulation in this area covers consumer protections such as marketing and disclosure requirements. All CHI plans would have to be approved by the state, consistent with current practice, before being sold as an MSA product. These products would also be subject to all the insurance reform requirements in H.R. 3103.

Due to the newness of CHI/MSAs, states would look to the NAIC to provide potential models for regulating these products as they have with prior new products. Alternatively, states would provide their own regulations.

o A study of CHI/MSAs requires that a sufficient, yet manageable number of accounts be identifiable. Thus there will be reporting of information 1) to support the study and 2) permit the implementation of a constraint on the number of accounts available. Such a constraint may be necessary to allow until sufficient information to be collected and analyzed on the effects of CHI/MSAs on national and state revenue, and the availability and cost of health insurance.

There are three models of implementing a constraint on the number of policies until the study results have been submitted to Congress. All three share the following characteristics:

- A fixed or target number of policies is available
- Reporting of minimal data elements to support the study (limited to 5-6 key variables such as number of policies sold, firm name, industry and size).
- Reporting mechanism and schedule to parallel current small group market reporting within states to the extent possible.

1. Prospective Model: In a prospective model, a maximum number of CHI/MSA policies would be set based on Treasury's estimate. Thus, there would be a fixed number of certificates for establishing a CHI/MSA, and MSAs could not be established without a certificate.

There are two options for distributing these certificates throughout the nation:

1) allocate the number of policies ('certificates') by state according to an agreed upon calculation (proportional to general population)

   -- states would devise an allocation plan for those instances where demand outstripped supply (probably based on date of application from employer or "first come, first served)

-- there would be no reallocation of certificates across states

-- states would report information on plans quarterly (firm identification, size, and industry code) to the federal government (needed to establish the sampling frame for the study).

2) allocate certificates to employers as they sign up to offer this new product to their employees. Employers would register their intent to offer in the state, which would then receive MSA certificates from the federal government. (An eligible employer with multi-state employees could file with one state.)

o Once the full quota has been allocated, no new certificates would be available. The certificates would be "owned" by the employer; if an employee dropped an MSA, an employer could enroll another employee. If an employer dropped MSAs entirely, the certificates would become invalid.

2. Passive Model: In a passive model, the objective is to have sufficient reporting so that the sale of MSA/CHI plans can be terminated when a target is reached. The margin of error is potentially greater than the prospective model but it may entail less government interference in the market.

o On a quarterly basis, the insurance carriers would report policy sales and other information to state insurance commissioners, who, in turn, would report to HHS.

o After each quarter, HHS would report on MSAs/CHI plans sold. If the target number of plans had been reached, HHS would inform the states that no further plans could be sold. If the target had not been reached but is expected to be reached in next quarter, there could be three options:

a. based on previous quarters' sales experience, HHS could issue a target for each state to assure that the target is not exceeded [there would necessarily have to be some margin of error, but this approach would prevent the number the number from rising from just below the target to some level significantly above the target if sales in the next quarter were unconstrained]; or,
b. sales could continue unhindered and a freeze would not occur until quarterly reports indicated that the target had been exceeded.
c. when the target appears to be near (i.e., the following quarter), HHS would project a date at which sales likely would reach the target and announce, in advance, that as of that date no more plans could be sold.

o Once the target has been reached, no new plans would be sold. Policies could be renewed, and an employer could reassign a policy from an employee who dropped an MSA to another employee in the firm. If an employer dropped MSAs entirely, an insurer could not resell them to another firm.

POSSIBLE HEALTH INSURANCE REFORM COMPROMISE
6/24/96

MSA Experiment

A. A 4-year MSA experiment, evaluated by an independent, nationally-recognized body. Requires an affirmative vote (under regular order procedures) to expand the experiment. Continuation of MSA experiment requires an affirmative vote under regular order. Preliminary report due after third year, leaving a full year while the experiment is still running for the Congress to consider a continuation of the program.

B. Study: An independent, nonpartisan organization would be selected to study the effect of MSAs in the self-employed and small group market. The study would focus on a number of issues including: the number and demographic characteristics of MSA users, the impact of MSAs on cost containment and consumer choice for users and the entire market, the cost of MSAs (in terms of revenue loss to the Treasury), the correlation, if any, of MSAs to positive/negative health insurance coverage rates, the effect of MSAs on the insurance market (including risk selection issues and their potential impact on premiums of non-MSA users), the impact of MSAs on the use of preventive care services and on the health care delivery system in general, and the advisability of capping the build-up of the account and, if so, what the amount should be.

C. Populations eligible to participate in the experiment:

1. The self-employed; and

2. Businesses with 50 and fewer employees.
(Utilization of MSAs by businesses and the self-employed is limited to the number of users projected by the Treasury Department).

MSA Structure

A. Republican MSA tax policies and insurance provisions included in 6/20/96 offer, including:

1. The assumption that MSAs insured products that comply with state insurance laws and the insurance reform provisions in H.R.3103, as well as the provision that directs NAIC to develop a consumer protection model -- including a risk adjustment recommendation.

2. The limitations on tax treatment of MSAs, including provisions regarding medical withdrawals from MSAs, non-medical withdrawals, and estate tax treatment of MSAs.

B. Catastrophic benefit package designed to be consistent with RAND study recommendations to avoid risk selection. Maximum deductibles and stop loss for individuals and families are set consistent with RAND recommendations (i.e., $2,000/$4,000) and the minimum deductible and stop loss is set at one-half of the maximum deductible (i.e., $1,000 for individuals and $2,000 for families.) [Almost every insured and self-insured plan in the nation has stop loss protection].

C. To assure equitable tax treatment between MSAs and traditional plans, contributions to MSAs can be made only by employers and the amount of the contribution is limited to the lower of the plan's deductible OR the difference in the cost of the premium between the catastrophic benefit plan and the traditional plan.

D. Protections for employees of the self-employed to address incentives to disproportionately use MSAs during the experiment by the employers. (The self-employed participating in their own employment group plan could not contribute more to their MSA account than they contribute to their employees.)

E. Revised mental health provision (see attached).

Other Issues:

A. Pending review of statutory language, assume Senate-passed provisions of Medicare fraud and abuse and insurance reform.

B. Adequate consumer protections for policies that duplicate Medicare and for long-term care private insurance.

C. Provisions that are significantly inconsistent with Administration positions outlined in the June 4th list provided to Republican staff.

MSA Allocation Method: Option A Sunday, June 23, 1996

- **MSA Guidelines**

  - States develop their own guidelines and requirements for catastrophic insurance policies.[1] Treasury also determines a set of guidelines related to the tax structure of MSAs, similar to those for IRAs.

  - In States which do not adopt their own guidelines, HHS (in consultation with NAIC and others) would develop guidelines to be used. Such guidelines would stipulate that HHS must certify policies sold in such states within a certain, limited time frame (e.g., 90 days of submission).

  - Insurers that meet both Treasury and State (or HHS) requirements would be permitted to offer catastrophic policies in conjunction with MSAs.

- **Insurance Reform**

  - All catastrophic plans would be subject to all the insurance reform requirements in H.R. 3103.

- **Reporting**

  - The number of participants in the demonstration would be determined based on a Treasury estimate of the number of individuals that might be expected to purchase catastrophic/MSA policies in the absence of a limited, demonstration program (e.g., available to all individuals in all markets). This estimate would become the soft target of the number of participants that would be allowed to participate in the MSA demonstration.

  - On a quarterly (or semi-annual) basis during the first year of the demonstration, employers would report to Treasury the number of individuals for whom they purchased catastrophic policies and opened MSAs. Treasury will track the total number of MSAs opened.

  - At the end of the first six months of the demonstration, Treasury would determine how many MSAs had been opened relative to the target number. If the target has been exceeded, no more MSAs could be opened. ***Question: How does Treasury notify eligible employers that cap has been reached/exceeded?***

---

[1]If the NAIC develops a model act for catastrophic policies, States, of course, would be free to adopt the model act.

If the target has not been reached, employers would continue to open MSAs. In this case, Treasury would make a semi-annual determination, based on the employers' reports, of when MSAs may no longer be opened.

- Beginning, in Year 2 of the demonstration, Treasury would submit an annual report to Congress which contains the following information: (1) the number of participants and (2) the revenue loss due to MSAs. These figures would be based on the tax returns filed for the previous year of the demonstration.

- **Redistribution**

  - Once the target number has been reached or exceeded, no new MSAs could be opened.

  - Employers could use policies that have been dropped by their employees (either voluntarily or because the employee has left the firm) to offer another employee (e.g., a new hire or an old employee who had previously declined the MSA option) an MSA policy.

  - If, in subsequent years, an employer does not use all of their original MSA policies (e.g., employees drop the MSAs), other employers could open new MSAs.

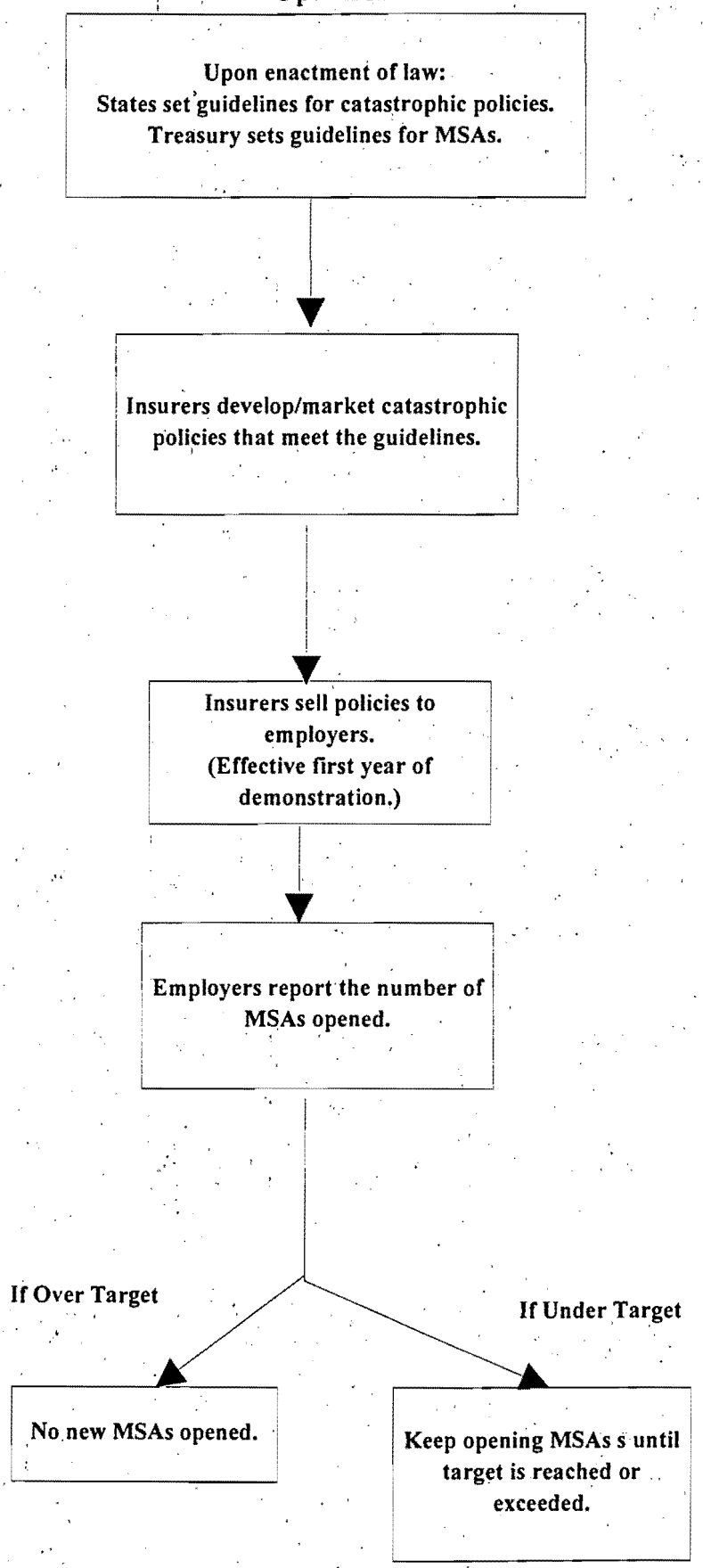
  - If a firm goes out of business, the MSAs used by its employees would not be reallocated to a new firm. Instead, the aggregate number of available MSAs would simply decline.

    Alternatively, these MSAs could be made available for use by other firms.

- **Guaranteed Renewal**

  - Firms that had purchased policies in the first year would have guaranteed renewal (consistent with H.R. 3103).

Option A


Upon enactment of law:
States set guidelines for catastrophic policies.
Treasury sets guidelines for MSAs.
Insurers develop/market catastrophic policies that meet the guidelines.
Insurers sell policies to employers.
(Effective first year of demonstration.)
Employers report the number of MSAs opened.
If Over Target
If Under Target
No new MSAs opened.
Keep opening MSAs s until target is reached or exceeded.

MSA Allocation Method: Option B Sunday, June 23, 1996

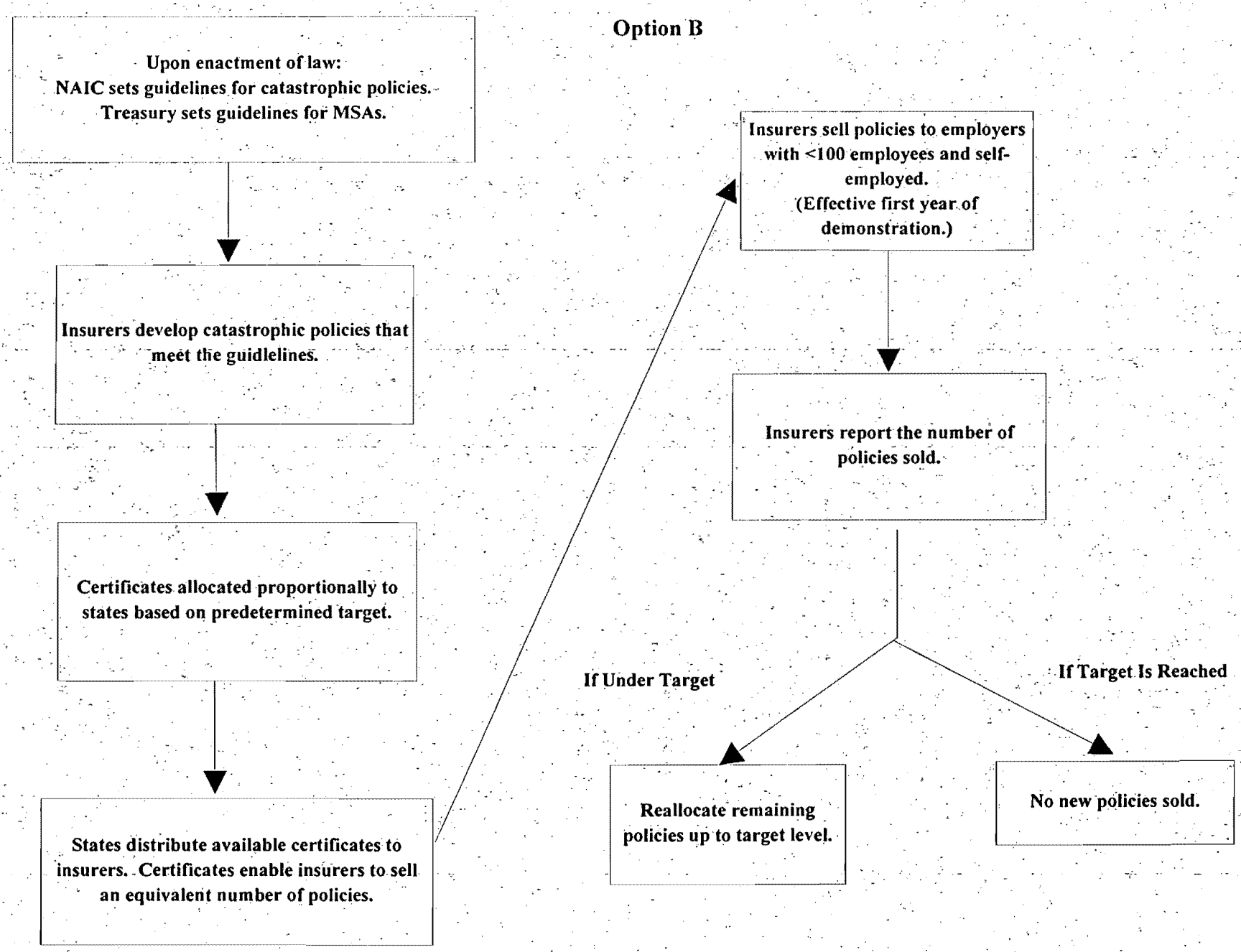
- **MSA Guidelines**
  - The NAIC would develop guidelines and requirements for catastrophic insurance policies. A state must adopt the NAIC model before MSAs/catastrophic plans could be sold in the state.
  - HHS would have the authority to approve state laws that vary from NAIC model.
- **Insurance Reform**
  - All catastrophic plans would be subject to all the insurance reform requirements in H.R. 3103.
- **Reporting**
  - Treasury provides HHS with a number of policies that may be sold, and HHS allocates a certain number of policies (i.e., certificates) to each state. HHS could withhold some percentage of policies for subsequent allocation based on initial (e.g., 6 months) sales. States distribute certificates to insurers.
  - On a quarterly basis, insurers must report policy sales and any other required information to State insurance commissioners, who, in turn, must report to HHS within 60 days. HHS would track the total number of policies sold.
  - After the second quarter, HHS would release any policies withheld if a certain percentage of existing certificates have already been sold. HHS could also withdraw unused certificates from a State if some minimum level (e.g., 30-40 percent) of policies have not been sold and other States are above a threshold (e.g., 60 percent).
  - In the second through fourth years of the demonstration, States would be given new certificates based on first year distribution. If a State had sold less than a certain percentage (e.g., 75-90 percent), some portion of these could be reclaimed by HHS and redistributed to other States.
- **Redistribution**
  - Once all of the policies have been sold, no new policies would be offered.
  - Employers could use policies that have been dropped by their employees (either voluntarily or because the employee has left the firm) to offer another employee (e.g., a new hire or an old employee who had previously declined the MSA option) an MSA policy.

- A State, or a insurer, could redistribute certificates that had been dropped by employees/employers.

- **Guaranteed Renewal**

  - Firms that had purchased certificates in the first year would have guaranteed renewal (consistent with H.R. 3103).

Option B


Upon enactment of law:
NAIC sets guidelines for catastrophic policies.
Treasury sets guidelines for MSAs.
Insurers develop catastrophic policies that meet the guidlelines.
Certificates allocated proportionally to states based on predetermined target.
States distribute available certificates to insurers. Certificates enable insurers to sell an equivalent number of policies.
Insurers sell policies to employers with <100 employees and self-employed.
(Effective first year of demonstration.)
Insurers report the number of policies sold.
If Under Target
If Target Is Reached
Reallocate remaining policies up to target level.
No new policies sold.

POSSIBLE HEALTH INSURANCE REFORM COMPROMISE
6/21/96 -- 10:50 am

MSA Experiment

A. A 4-year MSA experiment, evaluated by an independent, nationally-recognized body. Requires an affirmative vote (under regular order procedures) to expand the experiment. Continuation of MSA experiment requires an affirmative vote under regular order. Preliminary report due after third year, leaving a full year while the experiment is still running for the Congress to consider a continuation of the program.

B. Study: An independent, nonpartisan organization would be selected to study the effect of MSAs in the self-employed and small group market. The study would focus on a number of issues including: the number and demographic characteristics of MSA users, the impact of MSAs on cost containment and consumer choice for users and the entire market, the cost of MSAs (in terms of revenue loss to the Treasury), the correlation, if any, of MSAs to positive/negative health insurance coverage rates, the effect of MSAs on the insurance market (including risk selection issues and their potential impact on premiums of non-MSA users), the impact of MSAs on the use of preventive care services and on the health care delivery system in general, and the advisability of capping the build-up of the account and, if so, what the amount should be.

C. Populations eligible to participate in the experiment:

1. The self-employed; and
2. Businesses with 50 and fewer employees.
   (Utilization of MSAs by businesses and the self-employed is limited to the number of users projected by the Treasury Department).

MSA Structure

A. Republican MSA tax policies and insurance provisions included in 6/20/96 offer, (including the assumption that MSAs are an insured product that complies with state insurance laws and the insurance reform provisions in H.R.3103 as well as the directive that NAIC develops a consumer protection model -- including a risk adjustment recommendation), and limitations on tax treatment of MSAs including provisions regarding medical withdrawals from an MSA, non-medical withdrawals from an MSA, and estate tax treatment.

B. Catastrophic benefit package designed to be consistent with RAND study recommendations to avoid risk selection. Maximum deductibles and stop loss for individuals and families are set consistent with RAND recommendations (i.e., $2,000/$4,000) and the minimum deductible and stop loss is set at one-half of the maximum deductible (i.e., $1,000 for individuals and $2,000 for families.) [Almost every insured and self-insured plan in the nation has stop loss protection].

C. To assure equitable tax treatment between MSAs and traditional plans, contributions to MSAs can be made only by employers and the amount of the contribution is limited to the lower of the plan's deductible OR the difference in the cost of the premium between the catastrophic benefit plan and the traditional plan.

D. Protections for employees of the self-employed to address incentives to disproportionately use MSAs during the experiment by the employers. (The self-employed participating in their own employment group plan could not contribute more to their MSA account than they contribute to their employees.)

E. Revised mental health provision (see attached).

Other Issues:

A. Pending review of statutory language, assume Senate-passed provisions of Medicare fraud and abuse and insurance reform.

B. Adequate consumer protections for policies that duplicate Medicare and for long-term care private insurance.

C. Provisions that are significantly inconsistent with Administration positions outlined in the June 4th list provided to Republican staff.

June 26, 1996

MSA Demonstration Cap

- Reporting

  - The number of participants in the demonstration would be _____.* This number is the target for the cap limiting the number of participants in the MSA demonstration.

  - On a semi-annual basis during the first year of the demonstration, sellers/marketers of MSAs (e.g., financial institutions such as banks, insurers, mutual funds that are qualified to sell MSA products) would report to an entity designated by each state the number of individuals residing in that state for whom they opened MSAs. States would forward this information to HHS.

  - At the end of the first six months of the demonstration, HHS would determine how many MSAs had been opened relative to the target number and supply this information to Treasury. If the target has been exceeded, the MSA demonstration cap would be triggered and Treasury would notify the sellers/marketers of MSAs, through the applicable state entities, that no more MSAs could be opened until further notice.

    If the target has not been reached, sellers/marketers of MSAs could continue to open MSAs on behalf of employers. HHS would make a semi-annual determination, based on the states' reports, of the number of MSAs that have been opened and would notify Treasury accordingly.

- Enforcement

  - If Treasury notifies the sellers/marketers of MSAs, through the applicable state entities, that the cap has been triggered, no new MSAs can be opened. If a seller/marketer of MSAs opens an MSA for an employer after such notice has been given, the seller/marketer would be subject to penalties.

  - Insurers selling catastrophic policies would <u>not</u> be subject to penalties if they sell a catastrophic policy to an employer after Treasury has announced that the MSA demonstration cap has been triggered, and the employer decides to open an MSA.

  - Employees would <u>not</u> be subject to penalties if an employer opens an MSA on their behalf after Treasury has announced that the MSA demonstration cap has been triggered.

* This number will be Treasury's estimate of the number of individuals that it expects to choose the MSA/catastrophic health insurance policy option.

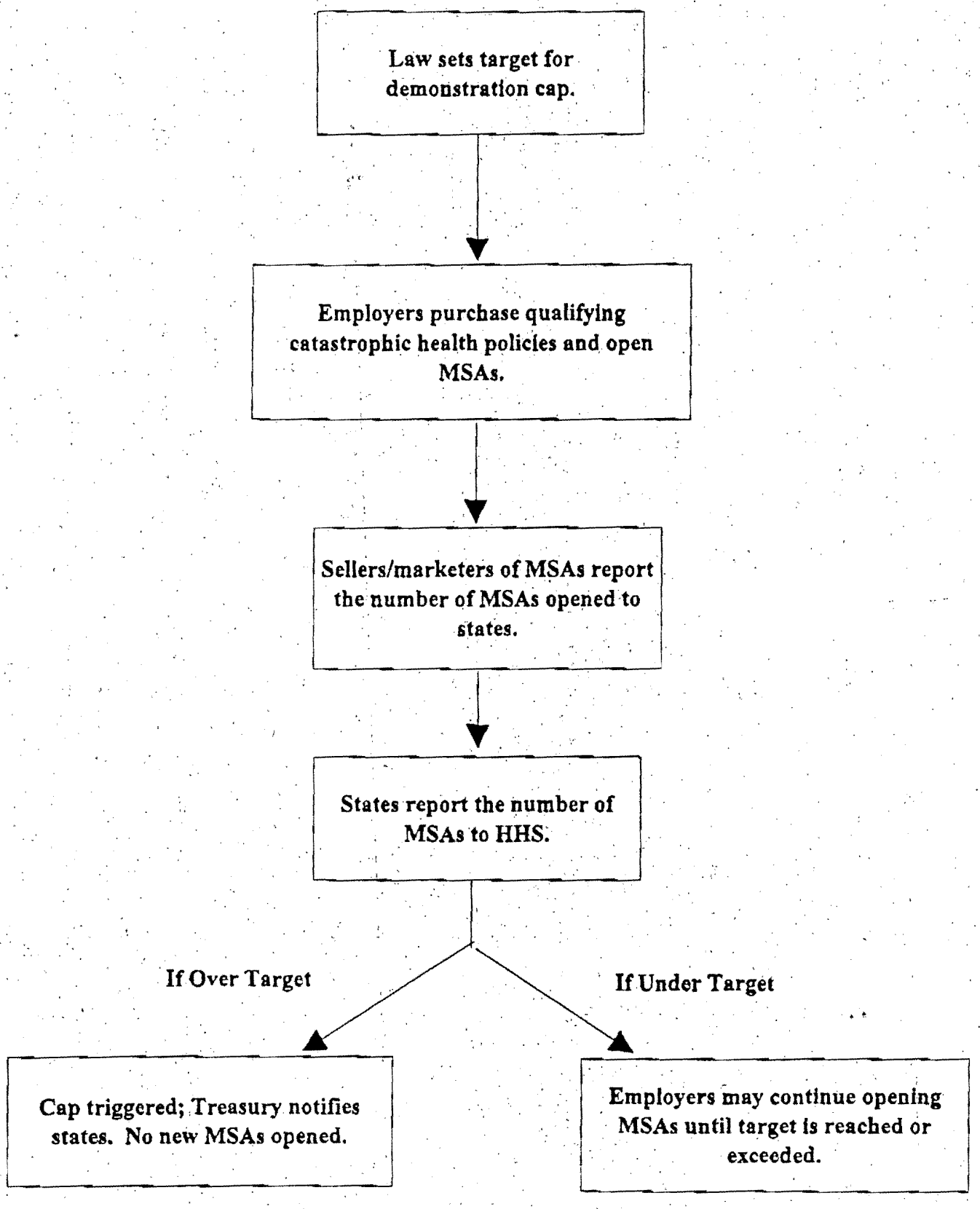
- Employers would not be subject to penalties if a seller/marketer opens an MSA for an employer once Treasury has announced that the MSA demonstration cap has been triggered.

- **Redistribution of MSAs**

  - If employees (either voluntarily or because the employee has left the firm) decide to drop the MSA/catastrophic health insurance option, employers would be allowed to offer it to another employee (e.g., a new hire or an old employee who had previously declined the MSA option).

  - If, in subsequent years, the number of MSAs declines (e.g., because employers or their employees drop the MSA/catastrophic health insurance option), and the cap is not exceeded, other employers could open new MSAs.

  - Similarly, if a firm goes out of business, the MSAs used by its employees could be made available for use by other employers.


Law sets target for demonstration cap.
Employers purchase qualifying catastrophic health policies and open MSAs.
Sellers/marketers of MSAs report the number of MSAs opened to states.
States report the number of MSAs to HHS.
If Over Target
If Under Target
Cap triggered; Treasury notifies states. No new MSAs opened.
Employers may continue opening MSAs until target is reached or exceeded.

CONCESSIONS RELATIVE TO THE CLEAN "SENATE BILL":

1. Any MSA at all. (The Senate passed the health insurance reform initiative by a 100 - 0 vote without any MSA provision.)

2. No geographically-based demonstration.

3. Experiment open to all employees in firms with 50 or fewer employees (and only limited to the amount of participants that the Treasury currently projects will opt for MSAs.)

4. Experiment open to all self-employed individuals (and only limited to the amount of participants that the Treasury currently projects will opt for MSAs.)

5. No requirement for a cap on build-up of the MSA account during the experiment.

6. No requirement that insurers and plans must offer employees the choice of a traditional plan if they offer an MSA option.

7. No requirement that a state-passed risk adjustment mechanism be in place in order to sell MSAs in a state.

8. No requirement that MSA account spending be solely limited to benefits covered by the catastrophic benefit plan.

9. Acceptance that penalty for withdrawal of funds for non-medical purposes be set at 15%, and not a higher amount (experts advising us have suggested 20%).

10. Elimination of requirement that the tax treatment for the self-employed be consistent with their treatment for traditional, comprehensive health plans.

11. The elimination of all mental health parity requirement provisions originally included in the Senate-passed version of the Domenici/Wellstone bill (such as copays, deductibles, inpatient/outpatient limits, chemical and substance abuse, etc.) other than the requirement for equal treatment of lifetime and annual payment limits.

Republican Offer

June 27, 5:00pm

BIPARTISAN MSA COMPROMISE

MSA Pilot Program:

- Extent of Pilot: During an initial test period of 4 years, MSAs coupled with high-deductible health coverage would be limited to a pilot group consisting of employer-sponsored health plans if the employer has 50 employees or fewer, and the self-employed.

- There would be no explicit cap on the number of MSA participants, but the Secretary of the Treasury would be required to monitor the program's enrollment during the initial test period, report to Congress annually on the number of active MSAs, and make appropriate recommendations to Congress.

- Study: An independent, nonpartisan organization chosen by relevant congressional committees would be required to study the effect of MSAs in the small group market. The study would include adverse selection, health costs, use of preventive care, and consumer choice. The study would be due by January 1, 2000.

- Continuation and expansion after initial test period: The pilot program would continue unless Congress affirmatively votes to discontinue. An affirmative vote would be required to expand the program to individuals and larger employers. No expedited procedures.

Consumer Protections

The favorable tax treatment of MSAs would be conditioned on the high-deductible health coverage meeting certain consumer protections. States could require additional consumer protections.

- Disclosure: MSA plans would be required to disclose information about cost-sharing requirements, deductibles, and limitations on coverage.

- Deductibles: The annual deductible would be required to be in the following ranges:

  Single coverage: Not less than $1,500 and not more than $4,000.
  Family coverage: Not less than $3,000 and not more than $6,500

- Cost-sharing: During the first 5 years, the annual cost sharing cannot exceed an average of 30 percent of the allowable costs for covered services. The NAIC would be directed to develop, within 5 years, model standards for cost-sharing that States could voluntarily adopt.

- Meaningful health coverage: The statements of managers would reflect Congressional intent that the high deductible coverage is intended to provide meaningful health care coverage and the legislative language would specifically direct the Secretary of the Treasury to monitor the high deductible coverage and report to the Congress if the need for additional anti-abuse rules develops.

Structural Changes to the MSA Proposal:

- Who can contribute to the MSA: Contributions to MSAs may be made either by employers or employees who have high-deductible coverage, but not both.

- Maximum annual contribution to an MSA: The annual contribution to an MSA cannot exceed the lower of the annual deductible amount for high-deductible coverage or $1,700 for individuals and $3,700 for families.

- Medical withdrawals from an MSA: Tax-free medical withdrawals from an MSA may be made only for the medical expenses of an individual who has high-deductible coverage.

- Nonmedical withdrawals from an MSA: Penalty-free nonmedical withdrawals from an MSA would be allowed on or after age 65 (instead of age 59 1/2 in the House bill). The penalty on nonmedical withdrawals before age 65 would be 15 percent (instead of 10 percent in the House bill).

- Estate tax: MSA account balance would not be exempt from the estate tax. Instead, MSAs would be subject to the estate tax under rules similar to IRAs (i.e., if the beneficiary is not the decedent's spouse, the MSA balance would be includible in the taxable estate, and an income tax deduction would be allowed for estate tax paid with respect to the MSA).

Republican

DRAFT

POSSIBLE COMPROMISE ON MEDICAL SAVINGS ACCOUNTS

House bill, with the following modifications: (1) medical savings accounts would be available only to employees in an employer-sponsored high deductible plan through December 31, 1999; beginning January 1, 2000, medical savings accounts would be available to all individuals enrolled in a high deductible plan (i.e., employees with employer-provided insurance, self-employed, and other individuals); in the Senate, expedited procedures would apply with respect to a bill to delay or repeal the application of the provision to individuals other than employees if offered within a certain time period; (2) the exemption from the estate tax would be deleted; medical savings accounts would be subject to estate tax under rules similar to individual retirement accounts (i.e., if the beneficiary is not the decedent's spouse, the medical savings account balance be includible in the taxable estate, and an income tax deduction would be allowed for estate tax paid with respect to the medical savings account); (3) the additional tax on withdrawals for nonmedical purposes would be increased from 10 percent to 15 percent; (4) penalty-free withdrawals for nonmedical purposes could be made after age 65 (instead of after age 59-1/2); (5) in any year in which a contribution is made by an individual to a medical savings account, withdrawals from medical savings accounts maintained by that individual would not be includible in income only if they are for medical expenses of the individual, and the individual's spouse and dependents, who are covered by a high deductible plan; (6) the statement of managers would reflect Congressional intent that a high deductible policy is intended to provide meaningful health care coverage and would direct the Treasury Department to monitor the market for high deductible policies and report to the Congress if the need for anitabuse rules develops (i.e, if individuals are obtaining high deductible polices that do not provide meaningful health care coverage); and (7) the Chairmen of the House Ways and Means Committee and the Senate Finance Committee would be directed to request the American Academy of Actuaries to prepare a study regarding the effects of medical savings accounts on adverse selection, if any, among health plans, to be submitted to such Chairmen by January 1, 1999.

premium increase

BIPARTISAN MSA COMPROMISE

→ Dem Offer
Kennedy/Dorgan
7:00 PM

MSA Pilot Program:

- Extent of Pilot: During an initial test period of 4 years, MSAs coupled with high-deductible health coverage would be limited to a pilot group consisting of employer-sponsored health plans if the employer has 50 employees or fewer, and the self-employed.

- There would be no explicit cap on the number of MSA participants, but **policies sold to businesses and the self-employed who currently provide insurance would be limited to the number of participants projected by the Department of Treasury or 500,000, whichever is less.** The Secretary of the Treasury would be required to monitor the program's enrollment during the initial test period, report to Congress annually on the number of active MSAs, and make appropriate recommendations to Congress.

- Study: An independent, non partisan organization chosen by **the Majority and Minority leaders of the House and Senate with advice from** relevant congressional committees would be required to study the effect of MSAs in the small group market. The study would include adverse selection, health costs, use of preventive care, consumer choice; **proportion of families experiencing high out-of-pockets costs and cost to the United States Treasury.** The study would be due by January 1, 2000.

- Continuation and expansion after initial test period: The pilot program would **not** continue unless Congress affirmatively votes to continue. An affirmative vote would be required to expand the program to individuals and large employers. No expedited procedures. **Individuals enrolling in an MSA program during the initial test period would be allowed to retain the funds deposited in their MSA account on a tax free basis. Participants would also be guaranteed portability to non high deductible plans as provided under the general insurance reform provisions.**

Consumer Protections

The favorable tax treatment of MSAs would be conditioned on the high-deductible health coverage meeting certain consumer protections. States could require additional consumer protections.

- Disclosure: MSA plans would be required to disclose information about cost-sharing requirements, deductibles, and limitations on coverage.

• Deductibles: The annual deductible would be required to be in the following ranges:

Single coverage: Not less than $1,500 and not more than [~~$4,000~~] **$2,000.**

Family coverage: Not less than $3,000 and not more than [~~$6,500~~] **$4,000.**

• Cost-sharing: During the first 5 years, the annual cost sharing cannot exceed an average of 30 percent of the allowable costs for covered services. The NAIC would be directed to develop, within [~~five~~] **one** year, model standards for cost-sharing that States could voluntarily adopt. **No cost sharing would be allowed for out-of-pocket spending for covered services in excess of $2,500 for individuals and $5,000 for families.**

• Meaningful health coverage: The statements of managers would reflect Congressional intent that the high deductible coverage is intended to pride meaningful health care coverage and the legislative language would specifically direct the Secretary of the Treasury, **in consultation with the American Academy of Actuaries,** to monitor the high deductible coverage and report to the Congress if the need for additional anti-abuse rules develops.

Structural Changes to the MSA Proposal:

• Who can contribute to the MSA: Contributions to MSAs may be made [~~either~~] **only** by employers [~~or employees~~] who have high-deductible coverage. [~~but not both~~.]

• Maximum annual contribution to an MSA: The annual contribution to an MSA cannot exceed the lower of **the savings in the premium from offering a high-deductible plan pursuant to guidelines promulgated by the Secretary of the Treasury in consultation with the American Academy of Actuaries, or** the annual deductible amount for high-deductible coverage or $1,700 for individuals and $3,700 for families.

• Medical withdrawals from an MSA: Tax-free medical withdrawals from an MSA may be made only for the medical expenses of an individual who has high-deductible coverage.

• Nonmedical withdrawals from an MSA: Penalty-free nonmedical withdrawals from an MSA would **not** be allowed. [~~on or after age 65 (instead of age 59 1/2 in the House bill).~~] The penalty on nonmedical withdrawals [~~before age 65~~] would be 15 percent (instead of 10 percent in the House bill).

- Estate tax: MSA account balance would not be exempt from the estate tax. Instead, MSAs would be subject to the estate tax under rules similar to IRAs (i.e., if the beneficiary is not the decedent's souse, the MSA balance would be includible in the taxable estate, and an income deduction would be allowed for estate tax paid with respect to the MSA).

- **Self-employed participating in an employment group plan may not contribute more to a personal MSA than to an employee MSA.**

- **Non-discrimination requirement for MSAs, i.e., contribution to MSAs for highly paid employees could not be greater than for other employees.**

- **NAIC development of model risk adjustment mechanism/states adopt mechanism in conjunction with sale of MSAs**

Rep. offer

June 27, 5:00pm

BIPARTISAN MSA COMPROMISE

MSA Pilot Program:

- Extent of Pilot: During an initial test period of 4 years, MSAs coupled with high-deductible health coverage would be limited to a pilot group consisting of employer-sponsored health plans if the employer has 50 employees or fewer, and the self-employed.

- There would be no explicit cap on the number of MSA participants, but the Secretary of the Treasury would be required to monitor the program's enrollment during the initial test period, report to Congress annually on the number of active MSAs, and make appropriate recommendations to Congress.

- Study: An independent, nonpartisan organization chosen by relevant congressional committees would be required to study the effect of MSAs in the small group market. The study would include adverse selection, health costs, use of preventive care, and consumer choice. The study would be due by January 1, 2000.

- Continuation and expansion after initial test period: The pilot program would continue unless Congress affirmatively votes to discontinue. An affirmative vote would be required to expand the program to individuals and larger employers. No expedited procedures.

Consumer Protections

The favorable tax treatment of MSAs would be conditioned on the high-deductible health coverage meeting certain consumer protections. States could require additional consumer protections.

- Disclosure: MSA plans would be required to disclose information about cost-sharing requirements, deductibles, and limitations on coverage.

- Deductibles: The annual deductible would be required to be in the following ranges:

  Single coverage: Not less than $1,500 and not more than $4,000.
  Family coverage: Not less than $3,000 and not more than $6,500

- Cost-sharing: During the first 5 years, the annual cost sharing cannot exceed an average of 30 percent of the allowable costs for covered services. The NAIC would be directed to develop, within 5 years, model standards for cost-sharing that States could voluntarily adopt.

- Meaningful health coverage: The statements of managers would reflect Congressional intent that the high deductible coverage is intended to provide meaningful health care coverage and the legislative language would specifically direct the Secretary of the Treasury to monitor the high deductible coverage and report to the Congress if the need for additional anti-abuse rules develops.

Structural Changes to the MSA Proposal:

- Who can contribute to the MSA: Contributions to MSAs may be made either by employers or employees who have high-deductible coverage, but not both.

- Maximum annual contribution to an MSA: The annual contribution to an MSA cannot exceed the lower of the annual deductible amount for high-deductible coverage or $1,700 for individuals and $3,700 for families.

- Medical withdrawals from an MSA: Tax-free medical withdrawals from an MSA may be made only for the medical expenses of an individual who has high-deductible coverage.

- Nonmedical withdrawals from an MSA: Penalty-free nonmedical withdrawals from an MSA would be allowed on or after age 65 (instead of age 59 1/2 in the House bill). The penalty on nonmedical withdrawals before age 65 would be 15 percent (instead of 10 percent in the House bill).

- Estate tax: MSA account balance would not be exempt from the estate tax. Instead, MSAs would be subject to the estate tax under rules similar to IRAs (i.e., if the beneficiary is not the decedent's spouse, the MSA balance would be includible in the taxable estate, and an income tax deduction would be allowed for estate tax paid with respect to the MSA).

HEALTH INSURANCE REFORM COMPROMISE OFFER
6/28/96

MSA Experiment

A 4-year Medical Savings Account (MSA) experiment that limits participation to 400,000 individuals and whose eligible participants are drawn from businesses with 100 and fewer employees and the self-employed. After receipt of the findings from a non-partisan, objective third party (such as RAND or the American Academy of Actuaries), an affirmative vote (under regular order procedures) would be needed to expand utilization of MSAs.

Design of the Study:

1. **Tax Structure and Insurance Oversight.** Accept the Republican MSA tax policies and insurance provisions included in 6/20/96 offer, including (a) the assumption that MSAs are insured products that comply with state insurance laws and the insurance reform provisions in H.R.3103, (b) the provision that directs NAIC to develop a consumer protection model -- including a risk adjustment recommendation, and (c) the limitations on tax treatment of MSAs, including provisions regarding medical withdrawals from MSAs, non-medical withdrawals, and estate tax treatment of MSAs.

2. **Equitable Tax Treatment Between Plans.** To assure a level playing field between MSAs and traditional plans, the third party would set the maximum contribution by the employer to the MSA at the level it determines accurately reflects the difference in the cost of the premium between the high deductible plan and the traditional plan.

3. **Adverse Selection Protections.** The third party would set the level of the deductible and appropriate out-of-pocket cost liability that is necessary to guard against adverse selection while also allowing consumers a range of choices of high deductible plan designs.

Evaluation of the Study:

The mutually agreed upon third party would be directed to study the effect of MSAs in the self-employed and small group market. The study would focus on a number of issues including: the number and demographic characteristics of MSA users; the impact of MSAs on cost containment and consumer choice for users and the entire market; the cost of MSAs (in terms of revenue loss to the Treasury); the correlation, if any, of MSAs to positive/negative health insurance coverage rates; the effect of MSAs on the insurance market (including risk selection issues and their potential impact on premiums of non-MSA users); the impact of MSAs on the use of preventive care services and on the health care delivery system in general, and the advisability of capping the build-up of the account and, if so, what the amount should be.

Other Issues (pending review of final statutory language):

A. **Mental Health Provisions.** Assume revised Domenici mental health compromise that drops all parity provisions other than those related to annual and lifetime caps. (See attached.)

B. **Insurance Reform Provisions.** Assume Senate-passed provisions of insurance reforms. If compromises are made in the regulation of the individual market, insurers should be not be permitted to direct individuals seeking portability protections to a product that is marketed and sold solely to them and, as a result, is much more expensive that any other product in the individual market.

C. **Duplicative Medigap and Long-Term Care Provisions.** Assure that language provides for adequate disclosure information to consumers purchasing Medigap plans that duplicate Medicare coverage. All sellers should have to provide this information BEFORE individuals choose to purchase these plans. In addition, no state law should be preempted in its regulation of these or any other Medigap or long-term care product.

D. **Medicare Fraud and Abuse.** Assume Senate-passed provisions that provide guidance to providers to make certain that they do not unintentionally run afoul of new Medicare fraud and abuse enforcement. (See attached for explanation of position.)

NANCY LANDON KASSEBAUM, KANSAS, CHAIRMAN

JAMES M. JEFFORDS, VERMONT
DAN COATS, INDIANA
JUDD GREGG, NEW HAMPSHIRE
BILL FRIST, TENNESSEE
MIKE DEWINE, OHIO
JOHN ASHCROFT, MISSOURI
SPENCER ABRAHAM, MICHIGAN
SLADE GORTON, WASHINGTON

EDWARD M. KENNEDY, MASSACHUSETTS
CLAIBORNE PELL, RHODE ISLAND
CHRISTOPHER J. DODD, CONNECTICUT
PAUL SIMON, ILLINOIS
TOM HARKIN, IOWA
BARBARA A. MIKULSKI, MARYLAND
PAUL WELLSTONE, MINNESOTA

SUSAN K. HATTAN, STAFF DIRECTOR
NICK LITTLEFIELD, MINORITY STAFF DIRECTOR AND CHIEF COUNSEL

United States Senate

COMMITTEE ON LABOR AND HUMAN RESOURCES

WASHINGTON, DC 20510-6300

TO: Chris Jennings

FR: David Nexon

DATE & TIME:

NUMBER OF PAGES: COVER + 3

RETURN FAX NUMBER: (202) 224-3533

IF THERE IS TROUBLE RECEIVING THIS FAX, PLEASE CALL (202) 224-7675.

MESSAGE:

FAX NUMBER: 456-5542

THE IMPACT OF THE DEMOCRATIC OFFER ON THE ATTRACTIVENESS OF MSAs

1. The allowable deductibles ($2,000 per individual and $4,000 per family) and stop-loss ($2,500/$5,000) under the Democratic offer are far above the typical conventional plan. The typical small business plan has a deductible of $200 (1/10th of that allowed under the Democratic offer) and a stop-loss of $1,000 (40% of the Democratic offer).[1]

2. Most individuals have medical costs each year that are below the Democratic deductible level. Seventy eight percent of all adults have medical costs of less than $2,000 in a given year.[2]

3. The Democratic deductible and stop-loss level results in major savings in premiums. Raising the deductible further does not produce a proportionate additional reduction. According the American Academy of Actuaries, the family plan premium under the Democratic MSA deductible and stop-loss would be $4,385--a savings of $2,182 (33%) compared to the conventional plan. By the time the Democratic deductible level is reached, the law of diminishing returns sets in on further increases in the deductible. Going to a $6,000 deductible, a 50% increase in the deductible, increased savings by only one-third ($724).[3]

4. The Democratic deductible is at the level that the market has already established as the norm for high deductible, MSA-type plans. According to experts at the American Academy of Actuaries, in general, MSA/high deductible plans today do not impose any additional cost-sharing after the deductible is reached. Moreover, individual deductibles are generally in the $1,500-$2,000 range, rarely higher. Family plans are typically $2,000 to $3,000.

4. Changes in the stop-loss, the most important consumer protection feature, make only a very minor difference in premium savings, according to experts on the American Academy of Actuaries MSA task force. An increase in the stop-loss of $1,000 saves only about 3.7% in premium costs.

---

[1] BLS. This is also the level that the American Academy of Actuaries uses to model the typical conventional plan (Medical Savings Accounts: Cost Implications and Design Issues).

[2] American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, p. 6.

[3] american Academy of Actuaries, p. 8.

Analysis of Workers Eligible for MSAs During 1997-99 Start Up Period Under H.R. 3103 Compromise

	Number of Workers	Percent of Total Workforce
Employees in firms with 50 or fewer employees and self-employed	41.8 million	32.9%
All others	85.2 million	67.1%
TOTAL	**127 million**	**100%**

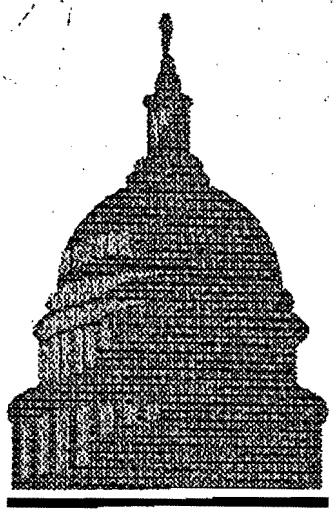
Analysis of Potential Users of MSAs During Start-Up Period Under H.R. 3103 Compromise That Currently Have Health Insurance Coverage → 15% of eligibles

	Number of Workers With Health Insurance	Percent of Workforce With Health Insurance
Eligible for MSAs in 1997 – Employees in firms with 50 or fewer employees with employer-provided insurance and self-employed	6.1 million	**7.66%**
Not eligible for MSAs until 2000	73.5 million	92.3%
TOTAL	**79.6 million**	**100%**

Survey of Selected MSA Plans: Summary of Cato Institute Policy Analysis no. 220

Amount of Deductible	Percent of Plans
More than $2,000	17%
$2,000 or less	83%
$1,500 or less	25%

Source: Cato Institute Policy Analysis no. 220: More Than a Theory: Medical Savings Accounts at Work



NAIC Washington Counsel
444 N. Capitol Street, NW
Washington, DC 20001

Facsimile Cover Sheet

To:	Chris Jennings
Organization:	White House
Phone:	
Fax:	456-7431
From:	Nicole Tapay
Organization:	NAIC-DC
Phone:	202-624-7798
Fax:	202-624-8579
Date:	June 28, 1996
Document:	
Pages including this cover page:	

Comments: Attached is a chart through Missouri which I have double-checked with the statutes. It appears that the max. contributions and max. deductibles are more parallel than in the scheme you described as a possible (Republican?) proposal. I need to look @ remaining states

DRAFT

Quick Response to Inquiry re: state regulation of Medical Savings Accounts

For the states of Arizona - Missouri, a * indicates that eligible medical expenses are defined as those defined in Section 213 (d) of Internal Revenue Code. Will make calls to learn of other restrictions that may apply to benefit packages.

Arizona*

-Total Deposits made to the account from either the account holder or employer are limited to $2,000/account holder and $1,000 per dependent up to 2 dependents
-No specification re: benefit packages but presumably state law applicable to high deductible insurance policies applies
-Statute states that upon agreement between employer and employee an employer may contribute to employee's MSA exclusively or in addition to medical coverage

Colorado*

-Maximum contribution $3,000. (Employer and employee contribution combined)
-"Qualified higher deductible plan" is defined as policy that provides for payment of covered benefits that exceed the **deductible (which shall not exceed $3,000)** that is purchased by employer for the benefit of employee who makes deposits into medical savings account.
-Employer or employee may establish MSA

Idaho*

- Maximum contribution (employer and employee combined) $2,000
-No specifications on benefit package for insurance policy used with MSA
-Employer may offer to establish MSAs for employees or may contribute to employee's existing MSA

Illinois*

-Maximum contribution of $3,000 per taxpayer ($6,000 only in case of two account holders filing joint return), adjusted annually for CPI
-"Qualified higher deductible health plan" means a health coverage policy or contract that provides for payments for covered benefits that exceed the "higher deductible" and that is purchased by employer for employee for whom employer makes deposits into a msa ("higher deductible" defined as $1,000 and $3,000, to be adjusted by CPI)
-Group high deductible policies must comply with group health insurance requirements
-MSA program includes an employer purchase of a "qualified higher deductible plan" or employer contribution into MSA.

Indiana*

-Deductibles must be between $1,000 and $5,000-figures to be adjusted
-"Qualified higher deductible health plan" means a health policy that provides for payment of eligible medical expenses (defined in tax code) after "higher deductible" (Defined as $1-5,000) is exceeded
-Contributions must not exceed $5,000.
-MSA programs to be established by employer and employee may contribute but may not contribute an amount larger than necessary to make balance in account equal to the deductible

Michigan*

-Maximum contribution $3,000, minimum deductible for higher deductible plan $1,000 and max. deductible is $3,000, (As of '94) to be adjusted annually according to general price level
-"Qualified higher deductible health plan" means health coverage policy that pays for covered benefits in excess of deductible and that is purchased for benefit of MSA account holder
-Employer or resident of state may establish MSA

Mississippi*

-Deductibles between $1,250 and $2,500 for individuals, between $1,750 and $3,500 for health coverage provided to individual and dependents
-"Qualified higher deductible plan" is health policy that provides for payment of covered expenses in excess of the higher deductible
- MSA can be established by employer or resident
-MSA program includes employer purchase of qualified higher deductible plan and employer or individual payemnt into a msa an amount equal to at least 66⅔% of premium reduction realized by purchase of higher deductible plan

Missouri

-Benefit package must include a contribution level that will be in lieu of premiums that would have been charged for standard small group plan
-Regulation specifies that 50% of the employer's contribution level shall be used by insurer or self-funded plan to purchase a major medical policy.
-Employer contributions to individual MSA are tax exempt
-Dept. of insurance in consultation with Dept. of Health to define "bona fide medical and health care expenses"

Sec. 2. Section 43-1028, Arizona Revised Statutes, is amended to read:

~~§ 43-1028. Individual medical savings accounts; definitions~~

A. For taxable years beginning from and after December 31, 1994, a resident may establish an individual medical savings account. An individual medical savings account is a trust created or organized to pay eligible medical expenses. The account holder may subtract the amount of deposits to an individual medical savings account during the taxable year in computing Arizona adjusted gross income under section 43-1022.

B. On agreement between an employer and employee an employer may either:

1. Contribute to the employee's individual medical savings account. Employer contributions to an employee's account are not considered to be income to the employee until they are withdrawn from the account.

2. Make or continue to make contributions toward the employee's medical coverage.

3. Contribute a combination of monies to the employee's individual medical savings account and medical coverage.

C. In each taxable year, total deposits made to the account from either the account holder or the account holder's employer shall not exceed the following:

1. For the 1995 taxable year, either:

~~(a) Not more than~~ Two thousand dollars for the account holder.

~~(b) Not more than~~ Two thousand dollars for the account holder plus ~~not more than~~ one thousand dollars for each of the account holder's dependents up to a maximum of two dependents.

2. For subsequent taxable years, the department shall adjust the maximum amounts prescribed by paragraph 1 of this subsection according to the annual change in the GDP price deflator, as defined in section 41-563.

D. For the 1995 taxable year, no ~~household~~ taxpayer is eligible to subtract, from Arizona gross income, deposits to individual medical savings accounts totaling more than four thousand dollars with respect to the taxpayer's household. For subsequent taxable years, the department shall adjust this maximum amount according to the annual change in the GDP price deflator as defined in section 41-563.

E. The individual medical savings account shall be established as a trust under the laws of this state and placed with a trustee. At the time the medical savings account is established the trustee shall notify the account holder of potential federal income tax liability that may be associated with the account. The trustee shall use the monies in an individual medical savings account solely to pay medical expenses of the account holder and the holder's spouse and dependents that are not otherwise covered under the holder's existing medical coverage. After submitting appropriate documentation to the trustee, the holder may also be reimbursed by the trustee out of available account monies for eligible medical expenses paid directly by the holder during the taxable year.

F. The account holder may withdraw monies from the individual medical savings account for purposes other than those expenses allowed pursuant to subsection E of this section on the last business day of a calendar year without incurring a withdrawal penalty. Money withdrawn pursuant to this subsection is considered income for the purposes of computing Arizona adjusted gross income. If an account holder withdraws money at any other time for purposes other than those expenses allowed pursuant to subsection E of this section or as provided by subsection G of this section, all of the following apply:

1. The amount of the withdrawal is considered income for the purpose of computing Arizona adjusted gross income.

2. The ~~employee~~ account holder shall pay a penalty, equal to ten per cent of the amount of the withdrawal, to the department at the same time as the ~~employee~~ account holder files the income tax return under this title for the taxable year. The state treasurer shall credit penalty monies to the state general fund.

G. If an account holder withdraws all or part of the monies from an individual medical savings account and does not deposit the amount withdrawn in another individual medical savings account, the amount that is not deposited is considered to be a withdrawal for purposes of subsection F of this section except that:

1. If an interest in an individual medical savings account is transferred or distributed to the account holder's spouse or former spouse under the terms of a legal separation or dissolution of marriage and the spouse or former spouse fails to deposit the full amount in another individual medical savings account within sixty days, the amount that is not deposited is considered to be income to the spouse or former spouse for the purpose of computing Arizona gross income but is not subject to a penalty under subsection F, paragraph 2 of this section.

2. If, pursuant to a written request by a former employee to the current trustee to retain the monies in the current individual medical savings account, the current trustee fails or refuses to retain the former employee's individual medical savings account, the trustee shall mail a check for the full amount of the balance in the individual medical savings account on that date to the former employee's last known address. The amount of the check is considered to be income for the purpose of computing Arizona gross income but is not subject to a penalty under subsection F, paragraph 2 of this section. The written request from the former employee to the current trustee must be made within sixty days of the final date of employment.

H. On the death of the account holder, the trustee shall distribute the principal and accumulated interest of the individual medical savings account to the estate of the account holder.

~~G.~~ I. The trustee of an individual medical savings account shall make such reports regarding the account to the department and the account holder with respect to contributions, income earned during the taxable year, distributions and such other matters as the department may require by rule. The report shall be:

1. Filed with the department at the time and in the manner prescribed by the department.

2. Furnished to the account holder in the manner prescribed by the department on or before January 31 of the calendar year following the calendar year to which the report relates.

~~H.~~ J. For purposes of this section:

1. "Account holder" means an individual on whose behalf an individual medical savings account is established.

2. "Eligible medical expense" means expenses paid by or on behalf of an account holder for medical care that is described in section 213(d) of the internal revenue code.

3. "Household" means the taxpayer, the spouse and those persons that the taxpayer claims as dependents pursuant to this chapter ~~10 of this title~~.

4. "Trustee" means:

(a) A financial institution that is authorized to conduct business in this state as a fiduciary.

06/28/96 FRI 14:16 FAX 202 624 8579 NAIC 006

provide for himself or herself.

(2.4) "Eligible medical expense" means any medical expense that is deductible for purposes of section 213(d) of the internal revenue code.

(2.5) "Employee" means the individual for whose benefit a medical vings account is established.

(2.6) "Employer" means a person or entity employing one or more persons in this state, excluding the federal government.

(3) "Medical savings account" means an account established to pay the eligible medical expenses of an account holder and his or her spouse and dependent children, if any.

(3.5) "Qualified higher deductible health plan" means a health coverage policy, certificate, or contract that provides for the payment of covered benefits that exceed the deductible, which shall not exceed three thousand dollars, and that is purchased by an employer for the benefit of an employee who makes deposits into a medical savings account.

(4) (Deleted by amendment, L. 94: p. 2840 § 7, effective January 1, 1995.)

HISTORY L. 86: p. 1121, § 1; L. 88: p. 419, § 16; L. 89: p. 622, § 19; L. 94: p. 2840, § 7.

DATE NEW 1986

DATE AMENDED 1988; 1989; 1994

SUBJECT CATEGORY 060 - Health insurance / insurers
080 - Group insurance (all lines)

DEFINITIONS < Account administrator > < Account holder > < Dependent child > < Eligible medical expense > < Employee > Employer > < Medical savings account > Qualified higher deductible health plan >

INFORMATION TYPE TEXT

DOCUMENT ID CO STAT RL 39-22-504.6

==========

Colorado Statutes - Insurance Related Laws
TITLE 39-- TAXATION
Article 22 -- INCOME TAX
Part 5. Special Rules

39-22-504.7 Medical savings accounts -- establishment -- contributions -- distributions -- restrictions -- taxation -- portability

(1)(a) Establishment of accounts. On and after January 1, 1995, an employer may offer to establish medical savings accounts.

(b) An employee on whose behalf a medical savings account has not been established by his or her employer may establish such an account on his or her own behalf.

(2)(a) Each year an employer may contribute to an employee's medical savings account an amount that does not exceed three thousand dollars.

(b) If an employer establishes a medical savings account for an employee but contributes less than the maximum set forth in paragraph (a) of this subsection (2), the employee may contribute the difference in accordance with the provisions of paragraph (d) of this subsection (2).

(c) An employee who establishes his or her own medical savings account may contribute to such account an amount that does not exceed the maximum set forth in paragraph (a) of this subsection (2). Any such contribution is to be made in accordance with the provisions of paragraph (d) of this subsection (2).

(d) Employee contributions -- pretax. (I) All employee contributions

another permanent home or principal establishment is established.

Illinois

"Eligible medical expense" means an expense paid by the taxpayer for medical care described in Section 213(d) of the Internal Revenue Code.{Footnote 6}

"Employee" means the individual for whose benefit or for the benefit whose dependents a medical care savings account is established. ployee includes a self-employed individual.

"Higher deductible" means a deductible of not less than $1,000 and not more than $3,000 for 1994. This minimum and maximum shall be adjusted annually by the Department of Revenue to reflect increases in the consumer price index for the United States as defined and officially reported by the United States Department of Labor.

"Medical care savings account" or "account" means an account established in this State pursuant to a medical care savings account program to pay the eligible medical expenses of an employee and his or her dependents.

"Medical care savings account program" or "program" means a program that includes all of the following:

(1) The purchase by an employer of a qualified higher deductible health plan for the benefit of an employee and his or her dependents.

(2) The contribution on behalf of an employee into a medical care savings account by his or her employer of all or part of the premium differential realized by the employer based on the purchase of a qualified higher deductible health plan for the benefit of the employee. An employer that did not previously provide a health coverage policy, certificate, or contract for his or her employees may contribute all or part of the deductible of the plan purchased pursuant to paragraph (1). For 1994, a contribution under this paragraph may not exceed $6,000 for 2 taxpayers filing a joint return, if each taxpayer has a medical care savings account but neither is covered by the other's health coverage, or $3,000 in all other cases. These maximum amounts shall be adjusted annually by the Department of Revenue to reflect increases in the consumer price index for the United States as defined and officially reported by the United States Department of Labor.

(3) An account administrator to administer the medical care savings account from which payment of claims is made. Not more than 30 days after an account administrator begins to administer an account, the administrator shall notify in writing each employee on whose behalf the administrator administers an account of the date of the last business day of the administrator's business year.

"Qualified higher deductible health plan" means a health coverage policy, certificate, or contract that provides for payments for covered benefits that exceed the higher deductible and that is purchased by an employer for the benefit of an employee for whom the employer makes deposits into a medical care savings account.

HISTORY P.A. 88- 648, § 5.

FOOTNOTE {Footnote 1} 215 ILCS 125/1- 1 et seq.

{Footnote 2} 815 ILCS 5/1 et seq.

{Footnote 3} 215 ILCS 5/511.100 et seq.

{Footnote 4} 225 ILCS 450/0.01 et seq.

{Footnote 5} 29 U.S.C. § 1001 et seq.

{Footnote 6} 26 U.S.C. § 213(d).

E NEW 1995

SUBJECT CATEGORY 060 - Health insurance / insurers
065 - Health service corporations
080 - Group insurance (all lines)
300 - The policy

06/28/96 FRI 14:17 FAX 202 624 8579 NAIC 009

ilve: September 18, 1994

INSURANCE—MEDICAL CARE SAVINGS ACCOUNT ACT

PUBLIC ACT 88-648

H.B. 1065

concerning insurance matters.

enacted by the People of the State of Illinois, represented in the General Assembly:

[S.H.A. 820 ILCS 152/1]

Short title. This Act may be cited as the Medical Care Savings Account Act.

[S.H.A. 820 ILCS 152/5]

Definitions. In this Act:

"unt administrator" means any of the following:

A national or state chartered bank, a federal or state chartered savings and loan ation, a federal or state chartered savings bank, or a federal or state chartered credit .

A trust company authorized to act as a fiduciary.

An insurance company authorized to do business in this State under the Illinois ance Code[1] or a health maintenance organization authorized to do business in this under the Health Maintenance Organization Act.[2]

A dealer, salesperson, or investment adviser registered under the Illinois Securities of 1953.[3]

An administrator as defined in Section 511.101 of the Illinois Insurance Code who is ed under Article XXXI ½ of that Code.[4]

A certified public accountant registered under the Illinois Public Accounting Act.

An attorney licensed to practice in this State.

An employer, if the employer has a self-insured health plan under the federal oyee Retirement Income Security Act of 1974 (ERISA).[5]

An employer that participates in the medical care savings account program.

ctible" means the total deductible for an employee and all the dependents of that e for a calendar year.

endent" means the spouse of the employee or a child of the employee if the child is the following:

Under 19 years of age, or under 23 years of age and enrolled as a full-time student at credited college or university.

Legally entitled to the provision of proper or necessary subsistence, education, al care, or other care necessary for his or her health, guidance, or well-being and not wise emancipated, self-supporting, married, or a member of the armed forces of the d States.

Mentally or physically incapacitated to the extent that he or she is not self-sufficient.

icile" means a place where an individual has his or her true, fixed, and permanent al principal establishment, to which, whenever absent, he or she intends to return. e continues until another permanent home or principal establishment is established.

ble medical expense" means an expense paid by the taxpayer for medical care d in Section 213(d) of the Internal Revenue Code.[6]

ployee" means the individual for whose benefit or for the benefit of whose dependents al care savings account is established. Employee includes a self-employed individual.

"Higher deductible" means a deductible of not less than $1,000 and not more than $3,000 for 1994. This minimum and maximum shall be adjusted annually by the Department of Revenue to reflect increases in the consumer price index for the United States as defined and officially reported by the United States Department of Labor.

"Medical care savings account" or "account" means an account established in this State pursuant to a medical care savings account program to pay the eligible medical expenses of an employee and his or her dependents.

"Medical care savings account program" or "program" means a program that includes all of the following:

(1) The purchase by an employer of a qualified higher deductible health plan for the benefit of an employee and his or her dependents.

(2) The contribution on behalf of an employee into a medical care savings account by his or her employer of all or part of the premium differential realized by the employer based on the purchase of a qualified higher deductible health plan for the benefit of the employee. An employer that did not previously provide a health coverage policy, certificate, or contract for his or her employees may contribute all or part of the deductible of the plan purchased pursuant to paragraph (1). For 1994, a contribution under this paragraph may not exceed $6,000 for 2 taxpayers filing a joint return, if each taxpayer has a medical care savings account but neither is covered by the other's health coverage, or $3,000 in all other cases. These maximum amounts shall be adjusted annually by the Department of Revenue to reflect increases in the consumer price index for the United States as defined and officially reported by the United States Department of Labor.

(3) An account administrator to administer the medical care savings account from which payment of claims is made. Not more than 30 days after an account administrator begins to administer an account, the administrator shall notify in writing each employee on whose behalf the administrator administers an account of the date of the last business day of the administrator's business year.

"Qualified higher deductible health plan" means a health coverage policy, certificate, or contract that provides for payments for covered benefits that exceed the higher deductible and that is purchased by an employer for the benefit of an employee for whom the employer makes deposits into a medical care savings account.

[1] 215 ILCS 5/1 et seq.
[2] 215 ILCS 125/1-1 et seq.
[3] 815 ILCS 5/1 et seq.
[4] 215 ILCS 5/511.100 et seq.
[5] 29 U.S.C.A. § 1001 et seq.
[6] 26 U.S.C.A. § 213.

[S.H.A. 820 ILCS 152/10]

§ 10. Program offer; tax treatment.

(a) For tax years beginning after 1993, an employer, except as otherwise provided by statute, contract, or a collective bargaining agreement, may offer a medical care savings account program to the employer's employees.

(b) Before making any contribution to an account, an employer that offers a medical care savings account program shall inform all its employees in writing of the federal tax status of contributions made pursuant to this Act.

(c) Except as provided in Section 20, principal contributed to and interest earned on a medical care savings account and money reimbursed to an employee for eligible medical expenses are exempt from taxation under the Illinois Income Tax Act[1] as provided in that Act.

[1] 35 ILCS 5/101 et seq.

[S.H.A. 820 ILCS 152/15]

§ 15. Use of account moneys.

(a) The account administrator shall utilize the moneys held in a medical care savings account solely for the purpose of paying the medical expenses of the employee or his or her

06/28/96 FRI 14:18 FAX 202 624 8579 NAIC 010

INDIANA

(3) is part of a medical care savings account program established under this chapter.

Sec. 9. (a) Except as otherwise provided by statute, contract, or a collective bargaining agreement, an employer may establish a medical care savings account program for the employer's employees.

(b) An employer that establishes a medical care savings account program under this chapter shall, before making any contributions to medical care savings accounts under the program, inform all employees in writing of the federal tax status of contributions made under this chapter.

(c) Except as provided in sections 17 and 23 of this chapter, the:

(1) principal contributed by an employer to a medical care savings account;

(2) interest earned on money on deposit in a medical care savings account; and

(3) money:

(A) paid out of a medical care savings account for eligible medical expenses; or

(B) used to reimburse an employee for eligible medical expenses;

are exempt from taxation as income of the employee under IC 6-3-2-18.

Sec. 10. (a) A medical care savings account program established by an employer under this chapter must include all of the following:

(1) The purchase by the employer of a qualified higher deductible health plan for the benefit of one (1) or more employees and dependents of the employees.

(2) The contribution by the employer, and the deposit into the medical care savings account established on behalf of each employee, of all or part of the difference between:

(A) the cost to the employer of purchasing a qualified higher deductible health plan for the benefit of the employee; and

(B) the cost previously incurred by the employer to pay the eligible medical expenses of the employee through a health coverage policy, certificate, or contract.

(3) The designation of an account administrator to administer the medical care savings accounts of employees.

(b) Notwithstanding subsection (a)(2), if an employer, before establishing a medical care savings account program under this chapter, did not pay the eligible medical expenses of the employer's employees through a health coverage policy, certificate, or contract, the employer's employees may contribute all or part of the deductible of the qualified higher deductible health plan purchased by the employer to establish the medical care savings account program.

(c) The contribution under subsection (b) must not exceed the following:

(1) For 1996, five thousand dollars ($5,000).

(2) For calendar years after 1996, the figure set forth in subdivision (1), adjusted under subsection (d).

(d) The adjustments referred to in subsection (c):

(1) may reflect increases in the general level of prices since 1995; and

(2) must be based on:

(A) the Consumer Price Index updated monthly by the Bureau of Labor Statistics of the United States Department of Labor; or

(B) other figures issued by the government of the United States to indicate increases in the general level of prices in the United States.

Sec. 11. (a) A medical care savings account program established by an employer under this chapter may allow an employee to contribute money to the medical care savings account established for the employee. However, an employee may not contribute an amount larger than necessary to make the balance in the account equal the deductible.

(b) Notwithstanding sections 17 and 23 of this chapter, if an employee contributes money to an account under this section:

(1) the money may be withdrawn from the account by the employee at any time and for any purpose without a penalty;

(2) the withdrawal of the money by the employee is not income to the employee that is subject to taxation under IC 6-3-1 through IC 6-3-7; and

(3) income earned on the money while it is in the account is not income to the employee that is subject to taxation under IC 6-3-1 through IC 6-3-7.

Sec. 12. The following may be an account administrator under this chapter:

(1) A federal or state chartered:

(A) bank;

(B) savings and loan association;

(C) savings bank; or

(D) credit union.

(2) A trust company authorized to act as a fiduciary.

(3) An insurance company or health maintenance organization authorized to do business in Indiana under IC 27.

(4) A broker-dealer, agent, or investment advisor registered under IC 23-2-1.

(5) A person:

(A) that holds a certificate of registration as an insurance administrator; or

(B) for whom the insurance commissioner has waived the requirement of a certificate of registration as an insurance administrator;

under IC 27-1-25-11.

(6) An employee welfare benefit plan that is governed by the federal Employee Retirement Income Security Act, 29 U.S.C. 1001 et seq.

(7) An employer that participates in the medical care savings account program.

Sec. 13. An account administrator shall use the funds held in a medical care savings account exclusively for the purpose of paying the eligible medical expenses of the employee or the employee's dependents.

Sec. 14. (a) Funds held in a medical care savings account shall not be used to cover medical expenses of the employee or the employee's dependents that are otherwise covered.

(b) Medical expenses that are "otherwise covered" for the purposes of this section include expenses covered by:

(1) an automobile insurance policy;

(2) a workers compensation insurance policy or self-insured plan; or

(3) another health coverage policy, certificate, or contract.

Sec. 15. If an employee submits documentation to the account administrator concerning eligible medical expenses that the employee has incurred and paid for medical care for the employee or a dependent of the employee, the account administrator shall reimburse the employee from the employee's account for the eligible medical expenses paid by the employee.

Sec. 16. An employer that makes contributions to a medical care savings account program on a periodic installment basis may advance to an employee, interest free, an amount necessary to cover unpaid eligible medical expenses that exceed the amount in the employee's medical care savings account if the employee agrees to repay the advance:

(1) from future installments; or

(2) when the employee ceases to be an employee of the employer.

Sec. 17. (a) An employee may, under this section, withdraw money from the employee's medical care savings account for a purpose other than the purposes set forth in section 13 of this chapter.

(b) Except as provided in section 11(b) of this chapter, if an employee withdraws money from the employee's medical care savings account on the last business day of the account administrator's business year for a purpose not set forth in section 13 of this chapter:

08/28/96 FRI 14:18 FAX 202 624 8579 NAIC 011

(1) a stock bonus, a pension, a profit sharing, an annuity, or a similar plan or arrangement, including a retirement plan for self-employed individuals or a simplified employee pension plan;

(2) a government or church retirement plan or contract; or

(3) an individual retirement annuity or individual retirement account;

that is intended in good faith to qualify as a retirement plan under applicable provisions of the Internal Revenue Code of 1986, as amended.

SECTION 5. [EFFECTIVE JANUARY 1, 1996] This act applies to taxable years beginning after December 31, 1995.

Approved May 16, 1995.

HEALTH INSURANCE

P.L. 93-1995

S.E.A. No. 576

AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 6-3-2-18 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1996]:

Sec. 18. (a) As used in this section, "eligible medical expense" has the meaning set forth in IC 6-8-11-3.

(b) As used in this section, "medical care savings account" has the meaning set forth in IC 6-8-11-6.

(c) The amount of money deposited by an employer in a medical care savings account established for an employee under IC 6-8-11 is exempt from taxation under IC 6-3-1 through IC 6-3-7 as income of the employee in the taxable year in which the money is deposited in the account.

(d) The amount of money that is:

(1) withdrawn from a medical care savings account established for an employee under IC 6-8-11; and

(2) either:

(A) used by the administrator of the account for a purpose set forth in IC 6-8-11-13; or

(B) used under IC 6-8-11-13 to reimburse an employee for eligible medical expenses that the employee has incurred and paid for medical care for the employee or a dependent of the employee;

is exempt from taxation under IC 6-3-1 through IC 6-3-7 as income of the employee.

(e) Except as provided in IC 6-8-11-11, in each taxable year, the amount of money that is:

(1) withdrawn by an employee from a medical care savings account established under IC 6-8-11; and

(2) used for a purpose other than the purposes set forth in IC 6-8-11-13;

is income to the employee that is subject to taxation under IC 6-3-1 through IC 6-3-7.

(f) If an employee withdraws money from the employee's medical care savings account under the circumstances set forth in IC 6-8-11-17(c), the interest earned on the balance in the account during the full tax year in which the withdrawal is made is subject to taxation under IC 6-3-1 through IC 6-3-7 as income of the employee.

SECTION 2. IC 6-8-11 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 1996]:

Chapter 11. Employee Medical Care Savings Account Plans

Sec. 1. As used in this chapter, "deductible" means the total deductible for an employee and all dependents of the employee for a calendar year.

Sec. 2. As used in this chapter, "dependent" means any of the following:

(1) The spouse of an employee.

(2) An employee's child who is one (1) of the following:

(A) Less than nineteen (19) years of age.

(B) Less than twenty-three (23) years of age and enrolled as a full-time student at an accredited college or university.

(C) Legally entitled to the provision by the employee of proper or necessary subsistence, education, medical care, or other care necessary for the child's health, guidance, or well-being, and not otherwise emancipated, self-supporting, married, or a member of the armed forces of the United States.

(D) Mentally or physically incapacitated to the extent that the child is not self-sufficient.

Sec. 3. As used in this chapter, "eligible medical expense" means an expense paid for medical care (as defined in Section 213(d) of the Internal Revenue Code).

Sec. 4. As used in this chapter, "employee" means the individual:

(1) for whose benefit; or

(2) for the benefit of whose dependents;

a medical care savings account is established.

Sec. 5. (a) As used in this chapter, for calendar year 1996, "higher deductible" means a deductible of:

(1) not less than one thousand dollars ($1,000); and

(2) not more than five thousand dollars ($5,000).

(b) For calendar years after 1996, the term means a deductible of:

(1) not less than the figure set forth in subsection (a)(1), adjusted under subsection (c); and

(2) not more than the figure set forth in subsection (a)(2), adjusted under subsection (c).

(c) The adjustments referred to in subsections (b)(1) and (b)(2):

(1) may reflect increases in the general level of prices since 1995; and

(2) must be based on:

(A) the Consumer Price Index updated monthly by the Bureau of Labor Statistics of the United States Department of Labor; or

(B) other figures issued by the government of the United States to indicate increases in the general level of prices in the United States.

Sec. 6. As used in this chapter, "medical care savings account" or "account" means an account established in Indiana under a medical care savings account program to pay the eligible medical expenses of an employee and dependents of the employee.

Sec. 7. A "medical care savings account program" means a program established under this chapter to pay the eligible medical expenses of employees and dependents of employees through medical care savings accounts.

Sec. 8. As used in this chapter, "qualified higher deductible health plan" means a health coverage policy, certificate, or contract that:

(1) provides for the payment of eligible medical expenses that exceed a higher deductible;

(2) is purchased by an employer for the benefit of employees and dependents of employees; and

(vii) An employer that participates in the medical care savings account program.

Michigan

(b) "Account holder" means the resident individual who establishes a medical care savings account or for whose benefit a medical care savings account is established.

(c) "Deductible" means the total deductible for an employee or account holder and all the dependents of that employee or account holder for a calendar year.

(d) "Dependent" means the spouse of the employee or account holder or a child of the employee or account holder if the child is any of the following:

(i) Under 23 years of age and enrolled as a full-time student at an accredited college or university or under 19 years of age.

(ii) Legally entitled to the provision of proper or necessary subsistence, education, medical care, or other care necessary for his or her health, guidance, or well-being and not otherwise emancipated, self-supporting, married, or a member of the armed forces of the United States.

(iii) Mentally or physically incapacitated to the extent that he or she is not self-sufficient.

(e) "Domicile" means a place where an individual has his or her true, fixed, and permanent home and principal establishment, to which, whenever absent, he or she intends to return. Domicile continues until another permanent home or principal establishment is established.

(f) "Eligible medical expense" means an expense paid by the taxpayer for medical care described in section 213(d) of the internal revenue code.

(g) "Employee" means the individual for whose benefit or for the benefit of whose dependents a medical care savings account is established. Employee includes a self-employed individual.

(h) "ERISA" means the employer retirement income security act of 1974, Public Law 93-406, 88 Stat. 829.

(i) "Higher deductible" means a deductible of not less than $1,000.00 and not more than $3,000.00 for 1994. This minimum and maximum shall be adjusted annually by the department of treasury to reflect increases in the general price level as defined in section 33 of article IX of the state constitution of 1963.

(j) "Medical care savings account" or "account" means an account established in this state pursuant to a medical care savings account program to pay the eligible medical expenses of an employee or account holder and the dependents of the employee or account holder.

(k) "Medical care savings account program" or "program" means 1 of the following programs:

(i) A program established by an employer that previously provided a health coverage policy, certificate, or contract or self-insured health plan that includes all of the following:

(A) The purchase by an employer of a qualified higher deductible health plan for the benefit of an employee and his or her dependents.

(B) The contribution on behalf of an employee into a medical care savings account by his or her employer of all or part of the premium differential realized by the employer based on the purchase of a qualified higher deductible health plan for the benefit of the employee but not less than $1,000.00. The employee may contribute into the account in addition to a contribution by the employer all or part of the difference between the employer's contribution and the maximum contribution as determined pursuant to this sub-subparagraph. A contribution under this sub-subparagraph shall not exceed $3,000.00 for 1994. For each year after 1994, this maximum shall be adjusted annually by the department of treasury to reflect increases in the general price level as defined in section 33 of article IX of the state constitution of 1963.

(ii) A program established by an employer that did not previously provide a health coverage policy, certificate, or contract or self-insured health plan that includes all of the following:

(A) The purchase by an employer of a qualified higher deductible health plan for the benefit of an employee and his or her dependents.

(B) The contribution on behalf of an employee into a medical care savings account by his or her employer of all or part of the deductible of the plan purchased pursuant to subparagraph (ii)(A). The employee may contribute into the account in addition to a contribution by the employer all or part of the difference between the employer's contribution and the maximum contribution as determined pursuant to this sub-subparagraph. A contribution under this sub-subparagraph shall not exceed $3,000.00 for 1994. For each year after 1994, this maximum shall be adjusted annually by the department of treasury to reflect increases in the general price level as defined in section 33 of article IX of the state constitution of 1963.

(iii) A program established by an account holder that includes all of the following:

(A) The purchase by the account holder of a qualified higher deductible health plan for the benefit of the account holder and his or her dependents.

(B) A contribution by the account holder not to exceed $3,000.00 for 1994 into a medical care savings account. For each year after 1994, this maximum shall be adjusted by the department of treasury to reflect increases in the general price level as defined in section 33 of article IX of the state constitution of 1963.

(1) "Qualified higher deductible health plan" means a health ~~coverage~~ policy, certificate, or contract or health plan that provides for payments for covered benefits that exceed the higher deductible and ~~that~~ is purchased or established by an account holder or by an employer for the benefit of an account holder or employee for whom the account ~~holder~~ employer makes deposits into a medical care savings account.

HISTORY P.A. 1994, No. 289, § 2.

DATE NEW 1994

SUBJECT CATEGORY 060 - Health insurance / insurers
080 - Group insurance (all lines)

DEFINITIONS < Account administrator > < Account holder > < Deductible > < Dependent > < Domicile > < Eligible medical expense > < Employee > < ERISA > < Higher deductible > < Medical care savings account > < Account > < Medical care savings account program > < Program > < Qualified higher deductible health plan >

INFORMATION TYPE TEXT

WHATSNEW

DOCUMENT ID MI STAT IC 550.982

==========

Michigan Statutes - Insurance Laws
CHAPTER 550-- GENERAL INSURANCE LAWS
" Medical Care Savings Account Act"

550.983 Medical care savings account program

Sec. 3. (1) For tax years beginning after 1993, both of the following apply:

(a) An employer, except as otherwise provided by statute, contract, or a collective bargaining agreement, may offer a medical care savings account program to the employer's employees.

(b) A resident individual may establish a medical care savings account program for himself or herself or for his or her dependents.

(2) Before making any contributions, an employer that offers a

(f) "Higher deductible" means a deductible of not less than One Thousand Two Hundred Fifty Dollars ($1,250.00) but not more than Two Thousand Five Hundred Dollars ($2,500.00) for individual health coverage, and not less than One Thousand Seven Hundred Fifty Dollars ($1,750.00) but not more than Three Thousand Five Hundred Dollars ($3,500.00) for health coverage provided to an individual and his or her dependents, in tax year 1994. Such deductible limits thereafter shall be adjusted annually for increases in the cost of living, as measured by the medical costs component of the Consumer Price Index.

(g) "Medical savings account" means an account established to pay eligible medical expense of the account holder and his or her dependents.

(h) "Medical savings account program" means a program that includes all of the following:

(i) The purchase by an employer of a qualified higher deductible health plan for the benefit of an employee and his or dependents or the purchase by a resident individual of a qualified higher deductible health plan for his or her benefit or for the benefit or his or her dependents, or both;

(ii) The payment on behalf of an employee into a medical savings account by his or her employer or payment into a medical savings account by a resident individual on his or her behalf of at least sixty-six and two-thirds percent (66 2/3%) of the premium reduction realized by the purchase of a qualified higher deductible health plan; and

(iii) An account administrator to administer the medical savings account and the reimbursement of eligible medical expenses therefrom.

(i) "Qualified higher deductible health plan" means an accident and health insurance policy, certificate or contract that provides for payment of covered expenses that exceed the higher deductible and that is purchased by:

(i) An employer for the benefit of an employee; or

(ii) A resident individual for his or her benefit.

(j) "Resident individual" means an individual who has a domicile in this state.

HISTORY Laws, 1994, ch. 468, § 2.

DATE NEW 1994

SUBJECT CATEGORY 060 - Health insurance / insurers
080 - Group insurance (all lines)
300 - The policy
560 - Finance and investments

DEFINITIONS < Account administrator > < Account holder > < Dependent > < Domicile > < Eligible medical expense > < Higher deductible > < Medical savings account > < Medical savings account program > < Qualified higher deductible health plan > < Resident individual >

INFORMATION TYPE TEXT

DOCUMENT ID MS STAT RL 71-9-3

==========

Mississippi Statutes - Insurance Related Laws
TITLE 71-- LABOR AND INDUSTRY
Chapter 9 -- MEDICAL SAVINGS ACCOUNT ACT

71 5 Voluntary medical savings account program

Text of section repealed effective January 1, 1998

(1) Each employer shall be permitted to offer voluntarily the following programs:

(a) Continued coverage under the employer's existing health coverage

MO.

Title 20—DEPARTMENT OF INSURANCE

Division 400—Life, Annuities and Health
Chapter 9—Individual Medical Accounts

20 CSR 400-9.100 Eligibility

PURPOSE: This rule implements section 143.999, RSMo, relating to individual medical accounts.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) Eligibility for Tax Exemption. Employer contributions to an individual medical account (IMA) shall be exempt from state income tax under Chapter 143, RSMo, to the extent that such contributions are not excluded from gross income under 26 U.S.C. sections 105 and 106 and regulations promulgated thereunder, only if the IMA and the contributions made to it meet all provisions of section (2) of this rule.

(2) An individual medical account must comply with each of the following standards in order for employer contributions to such account to be exempt from state income tax under section 143.999, RSMo:

(A) Health Insurance Benefit Package. The employer shall annually determine a contribution level to be expended for coverage of an insured person and any dependents. Such contribution level shall be in lieu of the premiums which would have been charged to the employer for a health insurance benefit package at least equivalent to the standard health benefit plan established under section 379.944.3, RSMo. The employer must retain written confirmation from the insurer of such premiums in order to verify the contribution level.

(B) Minimum Contribution. At least fifty percent (50%) of the employer's contribution level shall be used by the insurer, health maintenance organization, health services corporation, or as a self-funded employer plan to purchase or provide a policy or plan of major medical health care benefits for the insured person and any dependents. The remainder of the employer's contribution level not used to provide major medical coverage shall be used to fund an IMA. Funds in the account shall be used by the insured person or his/her dependents, if any, to pay for that portion of bona fide medical and health care expenses not covered by the policy or plan of major medical health insurance coverage, including any deductible, copayment, or coinsurance requirements 1) established in the major medical health insurance benefit plan which is established by the employer, and 2) authorized by law, regulation of the Department of Insurance. Funds in the IMA shall be spent for no other purpose except as otherwise provided by section 143.999, RSMo, and this rule.

(C) Minimum Balance after Employee Withdrawal. After expenditures authorized under subsection (2)(B) of this rule the employee insured through an IMA may withdraw at the end of the year any moneys remaining in the IMA to the extent that the remaining IMA balance exceeds the amount of the highest applicable deductible under the major medical coverage purchased by the employer's contribution or five hundred dollars ($500), whichever is greater. Such withdrawals are subject to taxation under Chapter 143, RSMo.

(3) As used in this rule, "bona fide medical and health care expenses" shall mean "medical care" as defined in *Internal Revenue Code* section 213(d)(1), 26 U.S.C. section 213(d)(1).

Auth: sections 143.999 and 374.045, RSMo (1994). Original rule filed March 23, 1995, effective Nov. 30, 1995.*

**Original authority: 143.999, RSMo (1993) and 374.045, RSMo (1967), amended 1993.*

Mo. Statute

tions
enue
s al-

excluded by statute or rule held invalid by supreme court, no deficiency to be charged.—Any provision of law to the contrary notwithstanding, where a statute or a rule promulgated by the director has excluded any income from the computation of tax imposed under this chapter and is thereafter held by a final decision of the Missouri supreme court to be invalid, the director shall not be entitled to serve a notice of deficiency of taxes which result from such court decision for any period occurring prior to the date of the court's mandate or the implementation of regulations interpreting such court decision, whichever is later.

(L. 1990 H.B. 1554 § 1)
Effective 6-12-90

143.998. Tax return to contain number assigned by director to school district.—Every person filing an individual income tax return form under this chapter shall place in the space provided on said form the number assigned by the department of revenue to the school district of which the person filing is a resident.

(L. 1977 H.B. 131 § 2)

143.999. Exclusion of employer contributions to individual medical accounts—requirements for eligibility of exclusion—rules, procedure, review.—1. Employer contributions to an individual medical account which are used to pay for health care expenses of the employee in accordance with this section shall be exempt from state income tax under this chapter, to the extent such contributions are not excluded from gross income under 26 U.S.C. 105 and 26 U.S.C. 106 and regulations promulgated thereunder. In order to qualify for such an exemption from taxation under this chapter, such contributions shall be made in accordance with health care coverage arrangements which contain at a minimum the following components:

(1) The employer shall annually determine a contribution level to be expended for coverage of an insured person and any dependents, which shall be in lieu of any standard indemnity or health insurance provided under a health insurance benefit package which is established by the department of insurance. Such a benefit package may be offered as an individual or group policy or other insurance arrangement by an insurer, health maintenance organization, health services corporation, or as a self-funded employer plan. A percentage of the employer's designated contribution level as established by rule and regulation of the department of insurance shall be used by the insurer, health maintenance organization, health services corporation, or as a self-funded employer plan to purchase or provide a policy or plan of major medical health care benefits for the insured person and any dependents. The remainder of the employer's contribution level not used to provide major medical coverage shall be used to fund an individual medical account. Funds in the account shall be used by the insured person or his dependents, if any, to pay for that portion of bona fide medical and health care expenses not covered by the policy or plan of major medical health insurance coverage, including any deductible, copayment, or coinsurance requirements established by regulation of the department of insurance to discourage unnecessary use of health care services. Funds in the individual medical account shall be spent for no other purpose except as otherwise provided by this section;

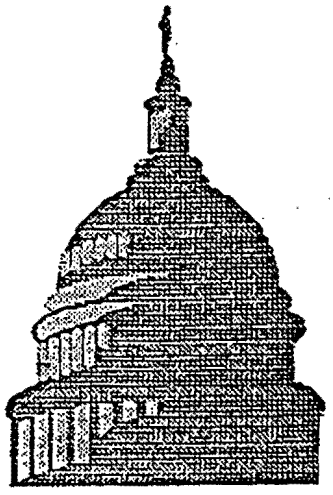
(2) Any amount in the insured's individual medical account that is unspent at the end of the year shall remain in the account. The director of the department of insurance shall by rule and regulation establish a balance for the account which, if exceeded, shall allow the insured to withdraw any moneys in excess of such balance. Any moneys so withdrawn from the account and interest earned on such moneys shall be subject to state income taxation;

(3) The amount in an individual medical account shall not be subject to state income taxation while it remains in the account. Any amount spent from the individual medical account on medical and health care expenses and interest accrued on such amount shall be totally exempt from state income taxation;

(4) The insurer, health maintenance organization, health services corporation, or employer which sponsors or provides health insurance coverage as authorized by this section shall administer the account on behalf of the insured person and any dependents.

2. As used in this section, bona fide medical and health care expenses shall be those medical and health procedures as defined by regulation of the department of insurance. Such

Dup



NAIC Washington Counsel
444 N. Capitol Street, NW
Washington, DC 20001

Facsimile Cover Sheet

To: CHRIS JENNINGS

Organization: WHITEHOUSE
Phone:
Fax: 456-7431

From: NICOLE MMM/ STEPHANIE LEWIS
Organization: NAIC
Phone: 202/624-7790
Fax: 202/624-8579
Date: 6/28/96
Document:

Pages including this cover page:

Comments:

In the process of calling each state for additional information on state regulation of medical savings accounts

Montana

- Maximum contribution $3,000.
- Account can be established either by the employer, the employee, or an individual state resident.
- Eligible medical expenses means an expense paid by the employee or account holder for medical care defined by 26 USC § 213 (d) for the employee or account holder or a dependent of the employee or account holder.

Nevada

- Account established by employer.

New Mexico

- Account established by the employer in which the employer provides a qualified higher deductible plan, contributes to a MSA, and appoints an account administrator to administer the plan.
- For 1995, the maximum deductible shall not be less than $1,000 and not be more than $3,000. The department may adjust annually the maximum employer contribution to reflect the last known increase in the medical care component of the consumer price index. For 1995, the employer's contribution shall not exceed $3,000.
- Qualified higher deductible plan is a health coverage policy, certificate or contract that provides for payments for covered health benefits that exceed the policy, certificate or contract deductible that is purchased by an employer for the benefit of an employee.
- Eligible medical expense means an expense paid by the employee for medical care described in section 213(d) of the Internal Revenue Code of 1986 that is deductible for federal income tax purposes.

Oklahoma

- Individuals or employers can contribute to a medical savings account. An individual or employer can purchase a qualifeid higher deductible health benefit plan approved

by the state offered by an entity regulated by the state for the benefit of an individual or employer and dependents. An individual can deposit into a MSA or the employer can make a contribution on behalf of the employee all or part of the premium differential realized by the employer based on the purchase of a qualified higher deductible plan. An employer that did not previously provide a health plan or health coverage policy, can contribute all or part of the deductible of a qualified higher deductible plan.

- The amount of deposit for the first taxable year shall not exceed $2,000 for the account holder and spouse and $1,000 for each dependent child of the account holder. The maximum allowable amount of deposit for subsequent years shall be increased annually by a percentage equal to the previous year's increase in the national consumer price index.

- An eligible medical expense is an expense paid by the taxpayer for medical care described in section 213(d) of the Internal Revenue Code.

Utah

- Account can be established by employer or individual. The program can be established by an employer in which the employer purchases a qualified higher deductible plan and contributes to the MSA. Or alternatively, the account holder can purchase a qualified higher deductible plan and contribute to the MSA.

- A contribution into an account made by an employer on behalf of an employee, or made by an individual account holder may not exceed the greater of $2,000 in that tax year, or an amount equal to the sum of all eligible medical expenses paid by the employee or account holder in that tax year. In this latter circumstance, eligible medical expenses are expenses in that tax year that an insurance carrier has applied to the employee or account holder's deductible.

- Qualified higher deductible plan means a health coverage policy, certificate, or contract, that provides for payments for covered benefits that exceed the higher deductible and that is purchased by an employer for the benefit of an employee for whom the employer makdes deposits into a MSA or by an account holder.

- Eligible medical expense means any expense paid by the taxpayer for medical care described in section 213 (d) of the Internal Revenue Code.

Virginia

Statute authorized development and establishment of a plan upon Congressional authorization (includes MSAs for medical assistance and workers'compensation programs).

West Virginia

- Any individual resident of the state can establish a medical savings account.

- Medical expenses means the amounts paid for services for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, which expenses may be included in calculating the federal deduction for medical and dental expenses for federal income tax purposes; for insurance premiums for combined plans issues pursuant to this section, but exlcuding expenses for cosmetic surgery as defined in section 213 of the Internal Revenue Code of 1986, as amended.

- Insurance Commissioner directed to promulgate regs re: annual contribution minimum and maximums.Any individual resident of the state or employer can establish a medical savings account

- Medical expenses means the amounts paid for services for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body, which expenses may be included in calculating the federal deduction for medical and dental expenses for federal income tax purposes; for insurance premiums for combined plans issues pursuant to this section, but exlcuding expenses for cosmetic surgery as defined in section 213 of the Internal Revenue Code of 1986, as amended.

- Insurance Commissioner directed to promulgate regs regarding the annual minimum and maximum contributions among other items.