REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

VIRGINIA'S MEDICAL SAVINGS ACCOUNT PROGRAM STUDY

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Preface

Section 38.2-5603 of the *Code of Virginia* requires the Joint Commission on Health Care to "monitor the development" of the Virginia Medical Savings Account Plan. Section 38.2-5600 of the *Code of Virginia* requires the establishment of the Virginia Medical Savings Account Plan and imposes specific responsibilities concerning development of the plan on four state agencies. These agencies are the Department of Taxation, Department of Medical Assistance Services, Workers' Compensation Commission, and the Bureau of Insurance. At its May 1, 2001 meeting, the JCHC directed staff to complete this review.

Based on our research and analysis during this review, we concluded the following concerning the Virginia Medical Savings Account Plan:

- A medical savings account (MSA) is a two-part individual health insurance plan, consisting of a high deductible catastrophic policy and a tax-exempt individual savings account.

- Federal law imposes limits on the number and size of tax-exempt MSAs.

- Relatively few MSAs have been established in the United States.

- Legislation (i.e., the Virginia Medical Savings Account Plan) was enacted in 1995 to promote the use of MSAs in Virginia.

- Virginia's MSA statute is based on a model (i.e., the American Health Care Plan) developed by the Jeffersonian Health Policy Foundation.

- The American Health Care Plan represents a significant departure from Virginia's current health care delivery system and marketplace.

- According to Virginia's MSA statute: 1) the Department of Taxation is required to develop a tax credit proposal for MSAs; 2) the Workers' Compensation Commission is required to utilize MSAs for the provision of health care services; 3) the Department of Medical Assistance Services is required to develop a federal waiver proposal for the use of MSAs; and 4) the Bureau of Insurance is required to monitor the availability of high deductible, catastrophic health insurance policies.

- Development and implementation of the Virginia MSA plan has not occurred, and there has been no implementation activity at all since August, 1997.

- Each of the four responsible state agencies have identified and raised implementation issues and other concerns regarding the MSA statute.

- The Department of Taxation has indicated that an MSA tax credit proposal could be developed.

- Given the passage of time since the statute was enacted in 1995 and the limited activity in implementing it, some substantive modifications to the statute may be warranted.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on page 31.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties were given the opportunity to provide written comments to us regarding this report. However, no public comments were received in response to this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Department of Medical Assistance Services, the Bureau of Insurance, the Workers' Compensation Commission and the Department of Taxation for their cooperation and assistance during this study.

Patrick W. Finnerty
Executive Director

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Background

Section 38.2-5603 of the *Code of Virginia* requires the Joint Commission on Health Care to "monitor the development" of the Virginia Medical Savings Account Plan. Section 38.2-5600 of the *Code of Virginia* (Appendix A) requires the establishment of the Virginia Medical Savings Account Plan and imposes specific responsibilities concerning development of the plan on four state agencies. These agencies are the Department of Taxation, Department of Medical Assistance Services, Workers' Compensation Commission, and the Bureau of Insurance. At its May 1, 2001 meeting, the JCHC directed staff to complete this review. This issue brief constitutes the first written report that the JCHC has issued pursuant to §38.2-5603.

Organization of Report

This report is presented in five major sections. Following this section, in order to provide some necessary background, the second section reviews the provisions of the federal Health Insurance Portability and Accountability Act pertaining to medical savings accounts, and in particular their exemption from federal income taxation. The third section describes the provisions of the Virginia Medical Savings Account Plan Act, and reviews the legislative history of the statute. The fourth section examines the extent to which the provisions of the Virginia Medical Savings Account Plan Act have been implemented thus far, and discusses various issues related to implementation. The fifth and final section presents policy options.

II.
The Health Insurance Portability and Accountability Act Provisions Concerning Medical Savings Accounts

A Medical Savings Account is, in Effect, a Two-Part Individual Health Insurance Plan Containing a Tax-Preferred Individual Account With an Accompanying Insurance Policy

Conceptually, there are many different ways to design and structure a Medical Savings Account (MSA). However, in its current form as authorized by federal law, an MSA is best thought of as having two distinct parts. The first part of an MSA is a tax-preferred individual savings account that can be used to pay insurance deductibles, copayments and other health care expenses. This part of the MSA is typically used to pay for routine health care expenses. A financial institution serves as the trustee of the account for the individual. The second part of an MSA is an individual health insurance policy with a high annual deductible. This part of the MSA is typically used to provide coverage in the event of catastrophic injury or illness. In practice, an individual must use the MSA to pay for all health care expenses until the annual policy deductible is met.

One policy objective typically ascribed to MSAs is to encourage individuals to provide for their own health care needs through personal savings. The individual holding the MSA, rather than a third-party payer, is responsible for directly paying for most health care services. If an individual MSA holder is healthy, and needs to spend relatively little money for health care, unused funds in the MSA accumulate on a tax-preferred basis and can be used for non-health care purposes upon the individual's retirement.

Federal Legislation Enacted in 1996 Contained Provisions Authorizing Tax-Exempt Treatment for Medical Savings Accounts

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorized the use of tax-exempt MSAs as a limited demonstration program beginning on January 1, 1997. The original provisions of HIPAA called for the MSA demonstration program to end in 2000, but subsequent federal legislation extended the sunset date to 2002.

Under the HIPAA provisions, MSAs are defined as trusts or custodial savings accounts that may be opened only in conjunction with the purchase of a qualifying high deductible health insurance policy. MSA holders cannot be covered by any other type of health insurance, with certain exceptions. These exceptions include:

- coverage for accidents, disability or long-term care,
- insurance relating to liabilities incurred under workers' compensation laws, and

- insurance for a specified disease or illness.

According to HIPAA, qualifying plans must be comprehensive health insurance plans with the following provisions:

- an annual deductible of at least $1,500 and not more than $2,250 for individual coverage, and an annual deductible of at least $3,000 and not more than $4,500 for family coverage;

- annual out-of-pocket maximum expenses that cannot exceed $3,000 for individual coverage or $5,500 for family coverage; and

- lower deductibles or first-dollar coverage are allowed only for state-mandated preventive care.

A key element of MSAs under the HIPAA provisions is their exemption from federal income taxation. Employer contributions to eligible employees' MSAs are not counted towards gross income, and are not subject to withholding for income tax and other federal employee taxes. In addition, contributions made by self-employed individuals or employees of small firms are tax-deductible. Furthermore, MSA funds used for qualifying medical expenses are not counted towards gross income when calculating federal income taxes. Funds that are withdrawn for non-medical expenses are taxable as income and subject to a 15 percent penalty, unless such withdrawals are made after age 65 or at the onset of a disability.

Limitations on the Availability and Size of MSAs. Under the HIPAA provisions, MSAs are available only to self-employed individuals and to employees of companies with 50 or fewer employees. Either the employee or his employer, but not both, may contribute to the same MSA

in a given year. For individual coverage, the maximum amount that may be contributed to an MSA is 65 percent of the qualifying plan deductible. For family coverage, the maximum amount is 75 percent of the deductible. A spouse of an eligible individual who is covered under the qualifying plan, but no other plan, may also open an MSA, but the combined contributions to the family's account in a year may not exceed these maximum amounts.

Cap on the Total Number of MSAs That Can Be Sold. Another key element of the HIPAA provisions was the imposition an overall cap of 750,000 MSAs that could be sold during the demonstration program. HIPAA also imposed some interim limits on the number of MSAs that could be sold:

- 375,000 MSAs by April 30, 1997,
- 525,000 MSAs by June 30, 1997, and
- 600,000 MSAs by June 30, 1998.

MSAs opened by previously uninsured individuals and by spouses of primary insured persons are not included in determining whether these statutory limitations have been exceeded. It should be noted that individuals who purchase MSAs during the demonstration period are able to keep them, along with the federal tax exemption, after the MSA demonstration period ends.

U.S. General Accounting Office Has Evaluated Medical Savings Accounts

HIPAA contained a provision requiring the U.S. General Accounting Office (GAO) to study the effects of MSAs on 1) selection, including adverse selection; 2) health costs, including any impact on premiums of individuals with comprehensive coverage; 3) use of preventive care; 4) consumer choice; 5) the scope of coverage of high-deductible plans purchased in conjunction with such accounts; and 6) other relevant items.

GAO's original evaluation design called for conducting surveys of MSA enrollees and employers to obtain a consumer perspective on MSAs, and a survey of insurers and financial institutions to obtain the perspective of suppliers. However, according to GAO, "the relatively low enrollment in MSAs made it impossible to conduct useful surveys of enrollees, employers, or financial institutions at a reasonable cost." The information

used in the study, as a result, came only from insurers. According to GAO, this limited the extent to which the evaluation could address the issues mandated for review by HIPAA.

Key findings from the evaluation included:

- Consumer demand has been lower than many in the industry anticipated. Lower demand reflects, in part, the complexity of the qualifying plan/MSA product for both agents and consumers. Sales of MSAs remain well below the HIPAA-imposed limits.

- The insurance industry responded to the legislation rapidly, with more than 50 companies offering qualifying products by the summer of 1997; but by 1998 the number of companies offering qualifying products had declined slightly.

- A wide range of insurers offer qualifying plans, and both traditional indemnity products and plans with managed care features (mainly preferred provider organizations) are available.

- A minority of insurers offering qualifying plans are marketing them aggressively and remain optimistic that MSAs will be an important option in the market; other insurers are currently more passive in the market and have more of a "wait-and-see" view of MSAs.

- Insurers report that the supply of qualifying plans available and the enthusiasm with which they are marketed has been limited by features of the demonstration design.

- A majority of insurers sell qualifying plans bundled with the Medical Savings Accounts; the accounts themselves are offering a wider variety of investment options and banking features as the demonstration matures.

- Qualifying plans have somewhat more generous benefits than other high deductible products offered by the same insurers; premiums for qualifying plans, initially set very similarly to non-

qualifying high deductible plans, have dropped in some cases between 1997 and 1998.

Relatively Few MSAs Have Been Sold. GAO found that sales of qualifying plans remained well below the legislative caps (Figure 1). According to the GAO report, the projected MSA enrollment through 1998 was 50,172, as compared to the final enrollment cap of 750,000. Subsequent to the GAO report, however, the IRS released data for tax year 1998 indicating that only 42,477 tax returns included MSA contributions. At the same time, the IRS estimated that an additional 11,727 taxpayers used MSAs in 1999. At present, 1998 is the last year for which IRS data are available concerning MSA utilization.

Figure 1

Number of Medical Savings Accounts Opened, According to IRS Reports

Counts as Of	Cumulative Number of MSAs Opened	Previously Uninsured Individuals	Spouse Also Has MSA	Total Count Against Cap	Cap
4/30/97	9,720	1,787	550	7,383	375,000
6/30/97	22,051	3,670	1,236	17,145	525,000
12/31/97	41,668	15,508	N/A	26,160	600,000

Note: Data for 4/30/97 and 6/30/97 are from medical savings account trustee reports. Data for 12/31/97 are from 1997 income tax returns.

Source: U.S. General Accounting Office, Medical Savings Accounts-Results from Surveys of Insurers (December 1998).

Pending Federal Legislation Seeks to Remove Existing Limitations on the Use of MSAs

H.R. 1524, introduced in 2001, seeks to make MSAs permanently and universally available. If enacted, this legislation would 1) eliminate the cap on the total number of MSAs that can be sold; 2) eliminate the current 2002 sunset date for the MSA demonstration; and 3) allow all companies regardless of their number of employees, and all individuals regardless of

their employment status, to purchase MSAs. Additional provisions of the bill would:

- lower the minimum deductible for qualifying insurance plans, to $1,000 for individual plans and $2,000 for family plans;

- allow annual contributions to MSAs to equal 100 percent of the qualifying plan deductible;

- allow both employers and employees to contribute to the same MSA;

- allow MSAs to be offered as part of cafeteria-style benefit plans; and

- encourage preferred provider organizations to offer MSAs.

III.
The Virginia Medical Savings Account Plan Act

Legislation Intended to Promote the Use of MSAs In Virginia Was Enacted by the 1995 General Assembly

House Bill 2337 and Senate Bill 1035 of the 1995 General Assembly Session, both of which were enacted unanimously, established the Virginia Medical Savings Account Plan (the Plan) and authorized its implementation. One of the objectives of the legislation appears to have been the promotion of greater individual responsibility, control, and cost-consciousness in the purchasing of health care services. Indeed, the preamble to HB 2337 stated that "health care reform must be focused on educating people to approach health care with the same cost-consciousness they should use to handle their other day-to-day living expenses and on motivating people to be responsible for meeting their own needs."

HB 2337 and SB 1035 were both conditioned upon Congressional authorization of the use of MSAs. However, at the time that the General Assembly was considering this legislation in 1995, the U.S. Congress had not yet enacted HIPAA. Therefore, at the time that the General Assembly enacted the statute, it was unaware whether or when federal MSA legislation would be enacted, or what the specific provisions of any federal legislation would be.

Four State Agencies Have Statutory Responsibilities Related to Implementation of the Virginia Medical Savings Account Plan

The Department of Taxation (TAX), the Bureau of Insurance (BOI), the Workers' Compensation Commission (WCC) and the Department of Medical Assistance Services (DMAS) each have specific plan development and implementation responsibilities. Section 38.1-5600 of the *Code of Virginia* states that each agency was to act "upon the passage of federal legislation authorizing the components of the Plan."

Department of Taxation. The statute requires TAX to develop a legislative proposal for a system of state tax credits, including refundable

tax credits, that will promote the use of MSAs. This is to include tax credits for:

- individuals who establish MSAs, to include a sliding scale for the working poor;

- employers who voluntarily contribute to MSAs held by their employees; and

- health care providers who provide care to MSA holders at a reduced price or without compensation.

Workers' Compensation Commission. The focus of WCC's responsibility under the statute is to develop and implement a plan to utilize MSAs "for provision of acute care to the employees who are eligible to receive services through workers' compensation insurance." In developing this plan, WCC is required to focus on cost containment for employers while ensuring adequate care for injured or sick workers. According to the statute, WCC is also to cooperate with TAX "in developing a system for voluntary employer contributions to medical savings accounts and reasonable tax deductions for these contributions."

Department of Medical Assistance Services. The statute requires DMAS to develop and implement a plan to utilize MSAs "for provision of primary and acute care to the working poor and individuals who are eligible to receive medical assistance services...." DMAS is also required to develop and apply for a waiver from the U.S. Health Care Financing Agency (HCFA) "to implement a medical savings account demonstration project to provide health care services to the working poor and certain individuals eligible for medical assistance services."

Bureau of Insurance. BOI is required to provide WCC and DMAS with a report on the "available plans/policies for high-deductible, indemnity health insurance policies or other comparable insurance mechanisms for providing low-cost catastrophic care." The statute also requires BOI to advise WCC and DMAS "on the inclusion of essential health services used as the basis for certain managed-care commercial health insurance coverage."

State Statute Specifies the Required Components of the Virginia Medical Savings Account Plan

Section 38.1-5601 of the *Code of Virginia* states that the plan shall establish the requirements for establishing MSAs in Virginia. In addition to the previously-mentioned items to be developed by the four state agencies, the plan is required to include:

- definitions of eligible participants;
- criteria for accounts, including such matters as trustees, maximum accounts, and contracts for managing debit cards;
- a system for calculating individual need for health care services in order to ensure that adequate sums are calculated for the care of individuals with greater need;
- a system for withholding the amounts to be deposited into MSAs;
- integration of existing coverage;
- a menu of insurance plans to provide high-deductible, indemnity health insurance policies;
- use of direct debit cards and methods for ensuring their use solely for payment for necessary health care services; and
- programs to educate recipients in handling health care services in a cost-effective manner while ensuring that necessary care is obtained.

The statute does not contain any requirement that the plan be developed or implemented by a certain date or within any specific period of time. In addition, the statute does not designate any state official or agency as being ultimately responsible for the implementation of the overall plan.

The 1995 Virginia Legislation Was Based on a Health Care Benefit Model Developed by the Jeffersonian Health Policy Foundation

The Jeffersonian Health Policy Foundation, based in Williamsburg, Virginia, developed a benefit model called the "American Health Care Plan" (AHCP) in the early 1990's. The Jeffersonian Health Policy Foundation, which was established by a group of Virginia physicians, describes itself as "committed to re-establishing a proper and beneficial relationship between patients and the physician of their choice through market reform." The AHCP was described by the Jeffersonian Health Policy Foundation as a comprehensive and fully integrated MSA that utilizes "a unique coordination with payments from a low cost, high deductible indemnity insurance policy." The AHCP was also described as containing a variety of unique and innovative financing mechanisms for various sectors of the population which:

- allows every American to equitably fund an MSA and purchase health insurance which is portable from one place of employment to another;

- allows all of the chronically uninsured to fully fund an MSA and pay the annual premium for the companion insurance policy, thereby enabling low-income individuals to pay market-based rates for their own health care;

- "eliminates the perverse incentives of the traditional system such as third-party reimbursement to providers which encourages overutilization and insulates patients from the true costs of services;"

- eliminates all cost shifting, while reducing paper work, overhead costs and collection difficulties;

- "eliminates the distortions of the current market and the perverse incentives, micro-management, and the third party rationing of managed care;"

- reduces total health care costs and re-establishes reasonable fees for providers; and

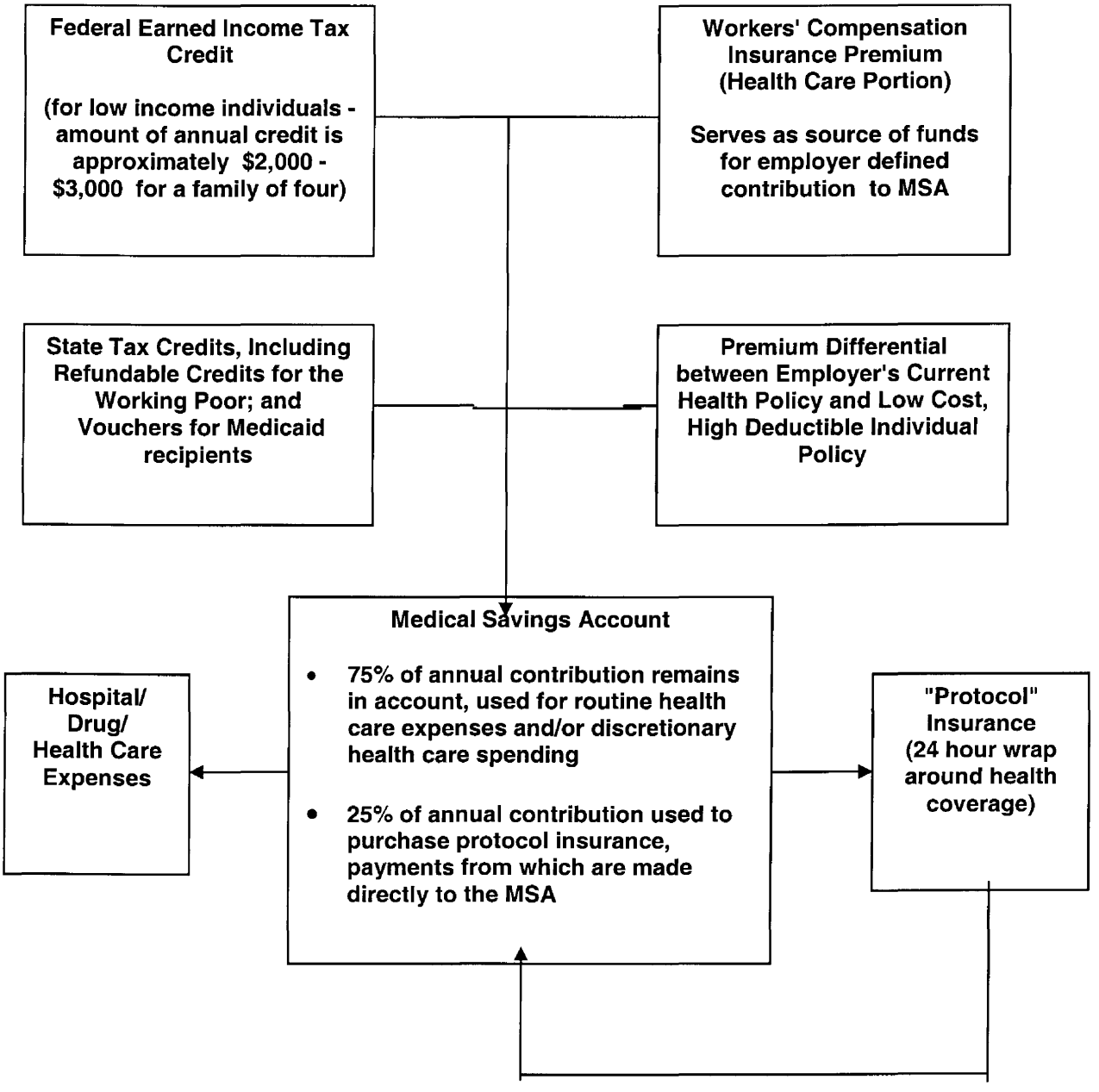
- reduces entitlement spending for Medicaid and Medicare but not at the expense of patient or provider.

American Health Care Plan is Described as a "Second Generation" Medical Savings Account. According to advocates for the AHCP, it represents a different type of MSA than that which is authorized by the HIPAA provisions. For example, the qualifying high-deductible plans authorized by HIPAA require that all of the policy deductible must be met on an annual basis before the first dollar is paid by the insurance policy. The non-insurance derived money in the MSA is used to pay for the deductible costs as well as for any discretionary medical spending. According to advocates for the AHCP, however, the poor and working poor without employer-based insurance cannot afford to pay the high deductibles contained in these qualifying policies, and therefore are unable to take advantage of MSAs. The AHCP, on the other hand, includes provisions intended to assist the working poor and other low income individuals in the utilization of MSAs. Figure 2 illustrates the major component features of the AHCP, including those components relating to the working poor.

The American Health Care Plan Envisions the Creation of a New Type of Insurance Product to Accompany the Medical Savings Account. The AHCP envisions the creation of a new type of insurance product, which is not currently available, to serve as the companion health insurance policy to the MSA. This product, which is predicted by AHCP advocates to be low cost in comparison to current health insurance products, would make payments directly into an individual's MSA rather than to the provider. Coverage provided by the policy would be limited to situations involving serious acute and chronic medical events, but would include within its scope of coverage health benefits received through workers' compensation coverage as well as benefits received through traditional employer-based health coverage. In other words, this new type of product, referred to as "protocol insurance" would provide "24-hour wraparound" coverage for health care expenses, regardless of whether or not an individual's injury or illness was causally-related to his employment.

Figure 2

Funding of Medical Savings Accounts Pursuant to the American Health Care Plan



Source: JCHC staff graphic based on review of American Health Care Plan documentation.

According to the AHCP, this type of insurance policy would avoid State health insurance benefit mandates. This is because "most benefits currently mandated under state law that do not constitute serious illness or injury or are discretionary will be paid out of MSA funds originally deposited by the individual/family and not deriving from insurance payments." This companion health insurance policy, according to the AHCP, would not be guaranteed issue and there would be no community rating. However, the AHCP envisions a high-risk pool to be shared by all insurers doing business in a particular geographic area, according to their market share.

Protocol Insurance Policy Payment System. According to the AHCP, the companion insurance policy would provide benefits limited to "medically serious events paid globally via protocol." The "protocol" is envisioned as being similar to the diagnosis-related group reimbursement methodology used by Medicare and the Virginia Medicaid program to reimburse hospitals for inpatient services, with more complex and severe diagnoses receiving higher payments. In the case of the AHCP, a similar type of approach would be used to reimburse individual physicians. According to the AHCP, an insurance company would determine its protocol payments based on "market forces and the range of actual provider costs in the geographic area of the patient." In addition, "All costs for emergency treatment shall be paid at a level of at least 95 % of costs to patient."

MSA Coordination With Companion Insurance Payments. One of the critical concepts of the AHCP is that "it is the patient's responsibility and not the insurance company's" to pay all medical and health care bills that the patient incurs out of their MSA. All insurance payments would be paid directly via electronic transfer into the MSA of the patient. The patient would then directly pay the provider market-based rates using a debit card that could be used only for such expenses. Advocates for the AHCP state that ultimately there would be a large network of debit cardholders, which would provide the necessary leverage for them to receive lower prices for health care services.

Under the provisions of the AHCP, "insurance exists only to fortify the patient's MSA when events occur that require expensive treatment in order to prevent financial catastrophe to the patient," as opposed to serving as a direct source of payment for physicians and other health care providers. Payments for low cost routine and preventive care would be

made directly from the MSA with no insurance carrier involvement up to the limit of the high deductible insurance policy. If that deductible limit is reached, then the insurance pays the protocol amount directly into the MSA, and the individual uses those funds to directly pay the provider for services rendered. When an event occurs that requires more than routine care, the AHCP states that the patient's physician would notify the insurer of the event. The insurer would then pay the global protocol amount directly into the MSA for that event, which the individual then uses to directly pay the provider. According to the AHCP, having the insurance policy pay directly into the MSA "avoids the problem of having limited insurance payments limiting the choice of the patient and the ability of the physician to privately contract with the patient for payment."

MSA Financing Sources For the Non-Poor, Employer-Based Population. For the employer-based population, the AHCP envisions a transfer of funds, currently used by the employer to purchase health insurance under a defined benefit plan, to a defined contribution plan. Under this scenario, the employer would deposit an amount equal to the premium into the employee's MSA. The employee would in turn use that amount to purchase a low cost, personal and portable companion insurance policy. The difference between the employer's former premium, and the employee's current (low-cost) premium, would remain in the MSA for the benefit of the employee.

An additional source of funding for the employer-based population, according to the AHCP, would be the employer contribution of the health portion of the Workers' Compensation premium. This would allow employers to contribute the amount of the annual premium as a defined contribution into the employee's MSA. According to AHCP advocates, "this would create a huge cost savings for the employer who has also been providing employer-based insurance since in essence he will save the dollar amount of the WC premium."

MSA Financing Sources For Low-Income Individuals. According to the AHCP, MSAs are envisioned as being a valuable public policy tool for helping low-income individuals, such as the working poor. Specifically, MSAs are described as providing a "safety net for the non-working poor and a powerful incentive to return them to the workforce." MSAs are described further as providing for health care in retirement years "without having to rely on Medicaid."

For the Medicaid population, the AHCP envisions a system of refundable tax credits, using a sliding scale means test, to fund an MSA; and a system of vouchers to pay the premium cost of the companion health insurance policy. Other potential MSA funding sources, according to the AHCP, include earned income tax credits and workers' compensation premiums. The federal earned income tax credit (EITC) is capped at $3,888 for a family with two children and $2,353 for a family with one child; the credit then phases out gradually. Low-income workers without a qualifying child may also receive a federal EITC, but the maximum credit for individuals or couples without children is $353. As a "refundable credit", a family receives the full amount of its federal EITC even if the credit amount is greater than the family's income tax liability. Sixteen states, including Virginia, provide their own income tax credit for low-income taxpayers. However, Virginia's credit and those of five other states are "non-refundable", meaning that they are limited to the amount of the family's income tax liability.

Medicaid recipients would deposit the balance of their tax-free money into their MSA accounts after their annual insurance premium is paid. The actual amount to be deposited would be determined by a means test which would also determine various categories on a sliding scale. Those categories would be indicated by color coding the MSA debit cards. The means testing would be done at local social services offices in a similar manner to Medicaid qualification.

Under the AHCP, Medicaid patients would be allowed to select the physician of their choice who would then manage their care. The patients would be required to make a nominal co-pay from their MSA according to their color code status. A patient's debit card would be checked electronically at the provider's office or a hospital. A "read/write chip" in the debit card would, according to the AHCP, keep track of the patient's MSA funds and tax credits used to pay for medical services.

A payment for each patient to pay the same fair market value for medical services as in the private sector from the MSA would be determined by a non-regressive means tested sliding scale. The balance of the fair market value of the service purchased would be paid directly to the provider in a tax credit equal to the deduction earned (the difference between the actual payment out of MSA funds and the fair market value of medical service.) According to the AHCP, "Although the public sector patient only spends a small portion of fair market value out of his MSA, he

will have paid the entire fair market value against his deductible, eliminating cost shifting." Any unused refundable tax credits at the end of the year would convert to money that remains in the MSA and continues to grow tax free from year to year.

The AHCP Represents a Significant Departure from the Current Employer-Based Health Insurance Marketplace

The AHCP currently exists only as a concept or theory, as opposed to an actual functioning health care system. The elements of the AHCP affect all of the components of the health care delivery system, including employees, employers, providers, health insurers, workers' compensation insurers and the Medicaid program. Consequently, in order to implement the various component parts of the AHCP, major system-wide changes would need to occur. At this time, it is questionable whether the AHCP could be implemented successfully in Virginia.

IV.
Implementation of the Virginia Medical Savings Account Plan

An Inter-Agency Task Force Was Established in 1997, But Plan Development and Implementation Did Not Occur

Following the enactment of HIPAA by Congress, in October 1996 the Virginia Department of Taxation (TAX) proposed to the Secretary of Finance that an inter-agency workgroup be established to "develop the required MSA plan and gain a consensus on how to proceed toward implementing a plan for consideration by the General Assembly in the 1998 session." Noting that the 1995 Virginia legislation was designed to become effective upon authorization of MSAs by Congress, TAX stated that "It is our opinion that the Health Reform Act equates to Congressional authorization as intimated by SB 1035 and HB 2337." The TAX memo to the Secretary of Finance also stated that "We do believe it is important to encourage the establishment of MSAs in order to assist Virginians in obtaining the best possible medical care at the lowest possible cost."

It should be noted that, more than a year prior to this, in June 1995, the Director of DMAS sent a memo to the Acting State Health Commissioner concerning the recently enacted Virginia MSA legislation. According to the memo, the Secretary of Health and Human Resources "has indicated that the Department of Health will be the lead entity for the Office of Health and Human Resources' efforts in developing the Virginia Medical Savings Account Plan." This was despite the fact that the Department of Health is not given any responsibilities by the statute.

April 22nd Meeting of the MSA Task Force. Representatives from TAX, the Workers Compensation Commission (WCC), the Bureau of Insurance (BOI), the Department of Medical Assistance Services (DMAS), and the Joint Commission on Health Care met initially on April 22, 1997. The Virginia Department of Health was not represented. This was primarily an organizational meeting, but even at this first meeting some of the participants had questions concerning the feasibility of Virginia's statutory provisions, and how they could actually be implemented in practice. DMAS, for example, questioned who would pay into an MSA for Medicaid recipients, since most recipients are not employed. The WCC

questioned the applicability of MSAs to workers' compensation award recipients.

At the meeting, some actions were taken to move the task force forward. For example, TAX stated that if it received estimates of the number of persons who would enroll in HIPAA-qualifying high deductible insurance plans, it could develop a range of options and cost estimates for tax credit proposals. In addition, the task force members decided that they needed to meet with a representative of the Jeffersonian Health Policy Institute, in order to learn more about the concepts and assumptions upon which the statutory provisions were based.

TAX Prepared a Memo Analyzing the Various Requirements of the Virginia Statute, and Whether or Not They Are Addressed by HIPAA. TAX sent a memo to the task force members dated May 7, 1997. The purpose of the memo was to review the requirements of the state statute found in §38.1-5601 of the *Code of Virginia*, and determine the extent to which each state requirement was addressed by HIPAA. Figure 3 summarizes some of the significant conclusions stated in that memo.

August 11th Meeting of the MSA Task Force. During this meeting the task force received a briefing from a representative of the Jeffersonian Health Policy Foundation concerning the concepts on which the state MSA legislation was based. The focus of the presentation was a discussion of the previously described American Health Care Plan. Based on JCHC staff interviews with former members of the task force who were in attendance at this meeting, it appears that some of the concepts underlying the legislation were thought to be administratively infeasible or inapplicable to the beneficiaries of programs administered by the agencies represented on the task force. On the other hand, it is possible that some of the underlying concepts may not have been fully understood by all of the task force members. In any event, there does not appear to have been any additional task force activity following the August 11th, 1997 meeting.

Figure 3

Virginia Department of Taxation Comparative Analysis of Virginia and Federal Statutory Provisions Concerning Medical Savings Accounts

Virginia Plan Requirement Found in §38.1-5601	Analysis By Virginia Department of Taxation
Definition of participants	This is defined by HIPAA. The State should not deviate from this definition, as it would create additional administrative burdens on state agencies (i.e., deviation could create situations where plans qualify for state purposes but not federal purposes, and vice versa).
Criteria for accounts (e.g., trustees, maximum amounts, and contracts for managing debit cards)	With the exception of debit cards, HIPAA defines each of these requirements. The state should not deviate from the HIPAA definitions, as it would create additional administrative burdens on state agencies.
Use of direct debit cards	HIPAA contains no provision concerning debit cards.
Programs to educate MSA recipients in handling health care services in a cost-effective manner	HIPAA contains no provision concerning educating MSA recipients. This could be incorporated as a requirement for selling high-deductible insurance plans.
Refundable tax credits for MSA holders	HIPAA contains no provision concerning state tax credits. TAX could prepare a legislative proposal for such credits but would need assistance in determining any general fund fiscal impact.
Withholding the amounts (refundable tax credits) to be deposited into MSA	HIPAA allows for payroll deductions for MSA contributions. The payroll deductions would be taken out of pre-tax earnings and not included on W-2 form. However, this requirement appears to be aimed at allowing individuals to obtain their credit during the year instead of waiting to file their return. The earned credit would be withheld by the employer and contributed to the MSA. Individuals can elect to receive the federal earned income tax credit in a similar manner.
Integration of Existing Coverage	HIPAA contains no provision concerning coverage integration.

Figure 3 (continued)

Virginia Department of Taxation Comparative Analysis of Virginia and Federal Statutory Provisions Concerning Medical Savings Accounts

Virginia Plan Requirement Found in §38.1-5601	Analysis By Virginia Department of Taxation
Calculating individual need for health care services to ensure that adequate sums are calculated for the care of individuals with greater need	HIPAA contains no provision concerning calculating individual health care needs. Insurers might have their actuaries do this as part of rate setting.
Sliding scale for refundable tax credits for the working poor	HIPAA contains no provision concerning state tax credits. TAX could prepare a legislative proposal for such credits but would need assistance in determining any general fund fiscal impact.
Voluntary employer contributions to MSAs and tax credits for such contributions	HIPAA allows employers to make contributions to an MSA on behalf of an employee. Virginia starts with federal taxable income or federal adjusted gross income in computing state income tax. As such, the deduction allowed an employer for a contribution to an employee's MSA would pass through to the Virginia return.
Tax credits for health care practitioners providing services to holders of MSAs at reduced cost or without compensation	HIPAA contains no provision concerning state tax credits. Such a credit would have to include a way to measure the reduced cost charged by a practitioner and a certification process to verify the accuracy of the credit. TAX would need assistance in devising such a credit, and in determining any general fund fiscal impact. The Bureau of Insurance would likely be responsible for administering the credit.
Cafeteria menu of insurance plans to provide high-deductible, indemnity health insurance policies	HIPAA does not appear to exclude high deductible health insurance plans from a cafeteria menu of insurance plans. In other words, an employer may offer an employee a choice of health care coverages which may include high-deductible health insurance policies.

Source: JCHC staff analysis of May 7, 1997 memo from Virginia Department of Taxation to the Virginia Medical Savings Account Plan task force.

The Workers' Compensation Commission Has Cited Several Issues and Concerns Relating to Development and Implementation of Plan

Staff at the Virginia Worker's Compensation Commission (WCC) expressed doubts and concerns, during an interview with JCHC staff, regarding the feasibility of utilizing MSAs for employees who are eligible to receive medical benefits through workers' compensation insurance coverage. As explained by WCC staff, a workers' compensation award in Virginia invariably contains a provision granting the claimant payment for 100 percent of medical expenses that are causally related to the occupational injury or illness. Under an award, such expenses are payable for as long as necessary. For a compensable claim, therefore, WCC staff state that they do not understand how an MSA would be beneficial to a successful claimant.

The medical care that the injured employee is entitled to receive pursuant to a workers' compensation award is part of the overall compensation awarded to the employee. This medical treatment and any subsequent rehabilitation services are intended to enable the injured employee to recover and return to work in an expeditious manner. Section 65.2-603 of the *Code of Virginia* states that "the unjustified refusal of the employee to accept such medical service or vocational rehabilitation services when provided by the employer shall bar the employee from further compensation...."

During an interview with JCHC staff, WCC staff identified jurisdictional issues that could arise in the event that an injured employee who had received a workers' compensation award also held an MSA with an accompanying health insurance policy. According to WCC staff, since the workers' compensation insurance carrier and the health insurance carrier could potentially contract with different medical providers, there would be a question of who would adjudicate disputes concerning medical treatment and expenses. A potential situation, according to WCC staff, could involve a workers' compensation carrier refusing to pay any additional benefits for lost earnings because of what it believed to be a lack of adequate medical treatment by a physician who is part of a separate provider network maintained by the health plan.

On the other hand, WCC staff acknowledged that injured employees who file unsuccessful workers' compensation claims can be faced with catastrophic medical expenses upon the denial of their claim if 1) their

employer does not provide health insurance benefits or if 2) coverage is provided by the employer but the employee has chosen not to enroll. In Virginia, about half of the 60,000 workers compensation claims that are filed annually are uncontested and paid by the employer. Only about 7,500 claims require an actual evidentiary hearing and ruling by the WCC in order to resolve the claim. According to WCC staff, about 50 percent of these 7,500 claims are awarded in favor of the claimant, and in about 50 percent the claim is denied.

Unsuccessful workers' compensation claimants who lack separate health insurance coverage comprise a group that could potentially benefit from an MSA. In practical terms, however, the ability of the WCC to assist such individuals is limited given current statutory provisions. Specifically, once the final workers' compensation award order has been entered concerning an employee by the WCC, the agency no longer has any jurisdiction over the employee. Therefore, according to WCC staff, the individuals that it deals with who might potentially benefit the most from an MSA are the same individuals over whom it does not have jurisdiction. This leads WCC staff to question the practical feasibility of its involvement in developing and implementing Virginia's MSA plan.

The Department of Medical Assistance Services Identified Several Issues Concerning the Use of MSAs in the Medicaid Program

During an interview with JCHC staff, DMAS staff raised various issues concerning how the Virginia MSA plan could be implemented as envisioned for Medicaid recipients and the working poor. First, DMAS believes that the state statute needs to be more specific, beyond merely referring to the "working poor," in terms of who the target population is for Medicaid MSAs. The statute, for example, could be made more specific in terms of a certain percentage of the federal poverty level, or in terms of a specific population group (e.g., uninsured parents of children enrolled in FAMIS.)

Second, DMAS is unaware of any other state ever applying to HCFA or its successor, the Centers for Medicaid and Medicare Services (CMS) for a waiver to use MSAs as part of the Medicaid program. Therefore, the likelihood of having the waiver request be approved is uncertain. Given the amount of work that is required to develop and submit a waiver request to the federal government, DMAS would first develop a concept paper and meet with CMS regional and national staff to determine if CMS

agrees with the concept. DMAS staff indicated their belief that CMS would be more receptive to a MSA waiver proposal that was targeted at a specific group not currently eligible for Medicaid, than it would be to a waiver proposal that focused on using MSAs as a substitute for Medicaid coverage currently provided to a group that is already eligible for Medicaid.

DMAS Prepared a Report Concerning MSAs in June 1995. Shortly after the General Assembly enacted the Virginia Medical Savings Account Plan Act, DMAS prepared a report concerning the potential use of MSAs in the Medicaid program. According to the report, exposing Medicaid recipients to significant financial responsibility, which is a fundamental aspect of MSAs, poses two concerns. First, the majority of Medicaid recipients live in families with income well below the federal poverty level, and financial responsibility may pose a significant barrier to medical care. For example, Medicaid recipients who deplete their MSAs before meeting their insurance deductible "generally would not be able to pay for medical care out of pocket." Instead, they would be forced to either forego needed medical care, possibly jeopardizing their health, or else seek health services from an indigent care program. Second, according to DMAS, Federal Medicaid rules generally do not allow states to expose recipients to substantial financial responsibility.

The DMAS report stated that "Designing a Medicaid MSA program that does not put recipients at financial risk, and thereby avoids access and uncompensated care problems associated with it, would require the state to ensure that recipients do not deplete their MSAs before reaching the insurance deductible." The report stated that the Virginia Medicaid program could attempt to ensure this by providing sufficient MSA funds to each participating recipient, and restricting MSA withdrawals to amounts used for qualifying expenses. According to the report, "a high level of scrutiny over account withdrawals may be needed."

The DMAS report also examined issues regarding the need for a federal waiver in order to use MSAs in the Medicaid program. The report stated that, for a waiver request to be successful, DMAS would need to demonstrate that the use of MSAs would be "budget neutral" to the federal government. However, according to the report, "it is generally expected" that in order to pay for a catastrophic insurance policy and fully fund an MSA up to the level of the policy deductible, "the state would need to increase Medicaid expenditures." On the other hand, DMAS noted that it

may be possible to design a Medicaid MSA program in which the state fully funds MSAs without increasing costs "by allowing the state to recapture a portion of any remaining MSA funds at the end of the year." However, an MSA program in which recipients keep only parts of their remaining MSA funds "would provide less of an incentive to control utilization than would an MSA in which all remaining funds go to the client." Nevertheless, even in the event the state recaptures unspent funds, the state may still need to increase Medicaid spending initially to fully fund the MSAs. The report stated that detailed actuarial analysis would be required to estimate whether or not it is possible to design a Medicaid MSA program that fully funds recipients' MSAs without increasing state Medicaid costs.

The Bureau of Insurance Appears to Have Complied With Its Statutory Responsibilities, and Has Also Identified Some Potential Implementation Issues

The BOI appears to have complied with its statutory responsibilities as stated in §38.2-5600. Specifically, BOI has tracked the availability of high deductible health insurance policies. As of September 2000, a total of 22 insurance companies licensed to do business in Virginia had high deductible accident and sickness policies that could possibly be used as vehicles for MSAs. BOI has also provided advice on the inclusion of essential health services in these plans. Regulations (14 VAC 5-210-90) promulgated by BOI governing health maintenance organizations provide definitions and requirements concerning basic health services for the following settings: inpatient hospital and physician, outpatient medical, diagnostic laboratory, diagnostic and therapeutic radiology, and preventive health.

During an interview with JCHC staff, BOI staff stated that they are not aware of any legal or regulatory barriers to MSAs being sold and marketed in Virginia. On the other hand, BOI staff are aware of the fact that Virginia is similar to the rest of the country in that relatively few MSAs have been sold thus far. BOI staff question how actively any of the previously mentioned 22 companies are actually marketing the high deductible accident and sickness policies for purposes of establishing an MSA. BOI staff did note that specific actions to make MSAs more popular with consumers, such as creation of additional tax advantages through a system of state tax credits, could potentially create additional demand in the market to which the industry might respond.

BOI staff did raise two issues which potentially affect the feasibility of implementing the Virginia MSA plan. Both of these issues concern provisions of the AHCP which, as previously discussed, served as the underlying basis for the Virginia legislation. First, as previously mentioned, the 24-hour wraparound type of health insurance policy envisioned by the AHCP is not available in Virginia. According to §38.2-3405 of the *Code of Virginia*, individual accident and sickness policies may exclude from their coverage benefits "paid or payable" under workers compensation. According to BOI staff, as a general rule all workers' compensation carriers make use of this permissible exclusion. Therefore, a 24 hour wraparound policy, which blurs the current distinction between workers compensation insurance and health insurance, would represent a significant policy change for Virginia and for the insurance industry. In fact, it might be necessary to remove the current permissible exclusion in the statute in order to create the type of environment necessary for a 24 hour wraparound policy to be viable.

The second issue raised by BOI staff concerns workers' compensation premiums. As previously mentioned, the AHCP envisions employers using the health-insurance portion of the workers' compensation premium as the source of funds for a defined contribution to an employees' MSA. In practice, however, workers' compensation premiums are not structured or billed such that there is a specific health insurance portion of the overall policy premium. While such a distinction is made for actuarial purposes, when an employer receives a bill from its workers' compensation insurance carrier, there is not a distinct health insurance portion of the total premium. This creates an obstacle to using the health care portion of the employer's workers' compensation premium to fund a defined contribution to an employee's MSA, as envisioned by the American Health Care Plan.

The Department of Taxation Has Indicated That An MSA State Tax Credit Proposal Could Be Developed

As previously mentioned, TAX was the state agency that took the initiative to recommend establishment of the inter-agency MSA taskforce subsequent to the enactment of HIPAA. Subsequent to August 1997, however, staff reductions and competing tax policy research priorities served to preclude any additional work by TAX concerning state tax credits for MSAs. Virginia currently has 25 state tax credits.

During an interview with JCHC staff, a representative of TAX stated that the department could develop a tax credit proposal along the lines envisioned by the statute. According to TAX, the existing statute is very clear in 1) establishing a new component to state tax policy; 2) defining the department's responsibilities; and 3) providing adequate direction to the department concerning how a state tax credit for MSAs should be established. The TAX representative noted, however, that the statute provides considerable latitude in what a tax credit would look like and how it would actually operate in relation to the existing federal income tax deduction for MSA contributions.

Conclusion

At the national level, MSAs have long been, and continue to be, a somewhat controversial instrument of health care policy. For example, according to some advocates at the national level, MSAs help to correct various problems that result from third-party reimbursement and excessive public sector involvement in the health care delivery system. However, also at the national level, some critics of MSAs contend that they promote adverse selection in insurance markets, and that MSAs can be used by high-income taxpayers to circumvent the income limits that currently govern tax-advantaged deposits to Individual Retirement Accounts. Nevertheless, given an appropriate set of circumstances and conditions, it appears reasonable to assume that MSAs can play a useful role in the health care delivery system. However, data concerning the relatively small number of MSAs that have been sold thus far suggests that current conditions, including the limitations imposed by HIPAA, may not be all that favorable for the widespread use of MSAs. It should be noted that the federal legislation extending the MSA demonstration program to 2002 was not signed into law until December 21, 2000. In other words, the MSA demonstration program came within ten days of expiring pursuant to its sunset provision.

In Virginia, as previously mentioned, the Virginia Medical Savings Account Plan Act was based upon the AHCP developed by the Jeffersonian Health Policy Foundation. The AHCP represents a substantial change to many aspects of the current health care delivery system, particularly as it relates to third-party reimbursement, including both negotiation of payment rates and the actual transfer of funds. While a change of this magnitude might have some beneficial aspects, the amount of work needed by Virginia state agencies to implement the type of change

envisioned by the state statute should not be underestimated. Furthermore, there are some indications that the state MSA plan statute envisions a set of circumstances concerning Virginia's workers' compensation and Medicaid programs that may in fact not be feasible, given current law. In addition, it does not appear that there are any provisions in HIPAA specifically authorizing certain components of the Virginia MSA statute (e.g., use of direct debit cards).

If the General Assembly wishes to proceed towards implementation of the state MSA plan, greater specification concerning a "lead" entity and a more certain timeframe would be helpful. Furthermore, given the passage of time since the statute was first enacted in 1995, coupled with the absence of any activity since August 1997 to develop or implement the plans, some substantive adjustments to the statute may be warranted.

V.
Policy Options

The following policy options are offered for consideration by the Joint Commission on Health Care regarding development and implementation of the Virginia Medical Savings Account Plan. They do not represent the entire range of actions that the Joint Commission on Health Care may wish to pursue regarding the use of medical savings accounts in Virginia.

Option I: **Take No Action.**

Option II: **Introduce legislation amending §38.2-5600 of the *Code of Virginia* to 1) establish a date certain for development and implementation of the Virginia Medical Savings Account Plan; and 2) designate a single state official or agency as being ultimately responsible for the final development and implementation of the plan.**

Option III: **Introduce legislation to amend the Virginia Medical Savings Account Plan (§38.2-5600 et seq. of the *Code of Virginia*) by deleting all of the provisions concerning the Virginia Workers' Compensation Commission and the Department of Medical Assistance Services. (*This option would result in the Virginia Medical Savings Account Plan consisting exclusively of a system of state tax credits for medical savings accounts. A date certain for developing a proposed system of tax credits could be included in the legislation.*)**

APPENDIX A

§ 38.2-5600. The Virginia Medical Savings Account Plan established; plan to be established upon Congressional authorization; state agency actions required.

For the purpose of providing the Commonwealth's people with a future that includes affordable health care, there is hereby established the Virginia Medical Savings Account Plan. Upon the passage of federal legislation authorizing the components of the Plan, the state agencies named in this chapter shall take action to implement the Plan as follows:

1. The Department of Medical Assistance Services shall develop and implement a plan to utilize medical savings accounts for provision of primary and acute care to the working poor and individuals who are eligible to receive medical assistance services as defined in the federal legislation or in any regulations promulgated to implement such legislation. Further, upon the effective date of this chapter, the Department shall develop a plan and apply for a waiver from the Health Care Finance Administration to implement a medical savings account demonstration project to provide health care services to the working poor and certain individuals eligible for medical assistance services.

2. The Bureau of Insurance within the State Corporation Commission shall provide the General Assembly and the Departments of Medical Assistance Services and Workers' Compensation a report on the available plans/policies for high-deductible, indemnity health insurance policies or other comparable insurance mechanisms for providing low-cost catastrophic care. The Bureau shall also, in developing this report, advise the Departments on inclusion of the essential health services used as the basis for certain managed-care commercial health insurance coverage.

3. The Department of Workers' Compensation shall develop and implement a plan to utilize medical savings accounts for provision of acute care to the employees who are eligible to receive services through workers' compensation insurance. The Department shall concentrate its focus on containing costs for employers while ensuring adequate care for injured or sick workers. The Department shall cooperate with the Department of Taxation in developing a system for voluntary employer contributions to medical savings accounts and reasonable tax deductions for these contributions.

4. The Department of Taxation shall, consistent with federal law and regulation, develop and present to the General Assembly a system for refundable tax credits which shall include a sliding scale for the working poor as defined in federal or state law and a system of tax credits, including innovative uses of such tax credits, for employers voluntarily contributing to employee medical savings accounts and health care providers who participate in providing care to medical savings account holders at a reduced price or without compensation.

§ 38.2-5601. Components of the Virginia Medical Savings Account Plan.

Upon the passage of federal legislation authorizing the components of the Plan, the Departments of Medical Assistance Services, Workers' Compensation, and Taxation and the Bureau of Insurance shall develop the Virginia Medical Savings Account Plan. The Plan shall set forth the requirements for establishing medical savings accounts, which shall include, but not be limited to:

a. Definitions of eligible participants.

b. Criteria for accounts, including such matters as trustees, maximum amounts, contracts for managing debit cards, etc.

c. Use of direct debit cards and methods for ensuring their use solely for payment for necessary health care services.

d. Programs to educate recipients in handling health care services in a cost-effective manner while ensuring that necessary care is obtained.

e. Integration of existing coverage.

f. A system of refundable tax credits, which has been coordinated with the Virginia Department of Taxation.

g. A system for withholding the amounts (refundable tax credits) to be deposited to the medical savings accounts.

h. A system for calculating individual need for health care services in order to ensure that adequate sums are calculated for the care of individuals with greater need.

i. A system for providing a viable sliding scale for refundable tax credits for the working poor.

j. A system for allowing voluntary employer contributions to the medical savings accounts and tax deductions for such contributions.

k. A system for allowing tax credits for health care practitioners providing services to holders of medical savings accounts at reduced cost or without compensation.

l. A cafeteria menu of insurance plans to provide high-deductible, indemnity health insurance policies.

m. Any other specific provisions necessary to the efficient implementation of the Virginia Medical Savings Account Plan.

38.2-5602. Operation of medical savings accounts.

Upon the authorization in federal law to establish medical savings accounts and upon development and enactment of the Plan described in § 38.2-5601 of this chapter, medical savings accounts may be established in the Commonwealth.

§ 38.2-5603. Role of the Joint Commission on Health Care.

The Joint Commission on Health Care shall monitor the development of the Plan required in § 38.2-5601 and make recommendations to the designated agencies on modifications of the Plan. Periodic reports shall be provided to the Commission by the designated agencies as the Commission may require.

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
Virginia's Medical Savings Account Program Study

Organizations/Individuals Submitting Comments

No comments were received.

Policy Options Included in the Medical Savings Account Program Report

Option I:	**Take No Action.**
Option II:	**Introduce legislation amending §38.2-5600 of the *Code of Virginia* to 1) establish a date certain for development and implementation of the Virginia Medical Savings Account Plan; and 2) designate a single state official or agency as being ultimately responsible for the final development and implementation of the plan.**
Option III:	**Introduce legislation to amend the Virginia Medical Savings Account Plan (§38.2-5600 et seq. of the *Code of Virginia*) by deleting all of the provisions concerning the Virginia Workers' Compensation Commission and the Department of Medical Assistance Services. (*This option would result in the Virginia Medical Savings Account Plan consisting exclusively of a system of state tax credits for medical savings accounts. A date certain for developing a proposed system of tax credits could be included in the legislation.*)**

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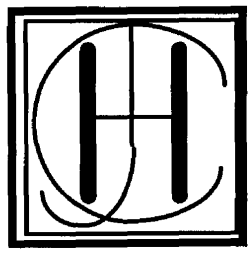

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