American Bankers Association
HSA Council

J. Kevin A. McKechnie
Executive Director
The HSA Council
kmckechn@aba.com

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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue SW.
Washington, DC 20201

Submitted through Regulations.gov:
ATTN: CMS-9930-P/RIN 0938-AT12

Subject: ***Proposed Rule for 2019 Exchange "Benefits & Payment Parameters"***

Dear Administrator Verma:

The ABA's HSA Council[1] commends you for the proposed rule's new direction, clearly reflecting the change in priorities laid out by the President in the Executive Order he issued on his Inauguration Day. The individual and small group markets are collapsing; your proposal to increase flexibility and reduce regulatory burdens in the marketplace to address these problems are well-received by the Health Savings Account (HSA) industry.

The Council is very pleased that you propose to move away from the concept of standardized benefit designs for 2019 as well as the "meaningful difference" requirements. We have submitted comments expressing our concerns about the use of standardized benefit designs for the 2017 and 2018 proposed and final rules regarding benefits and payment parameters. We continue to believe that the exclusion (in 2017) and limitation (in 2018) on HSA-qualified plan designs was not consumer-friendly and antithetical to making health care more affordable.

The Council appreciates the new focus on High Deductible Health Plans (HDHPs) and HSAs. We strongly support your proposal to use plan display options to promote the availability of HSA-qualified HDHPs for 2019. In doing so, we have four recommendations we hope you will adopt:

1. We recommend that you refer to these plans as "HSA-qualified" plans instead of "high deductible health plans." In the first place, all plans in the metal tier are likely to have "high" deductibles; however, consumers need to know which of the plans makes them eligible to establish and contribute to an HSA and which would preclude them from doing so. There is currently no mechanism available to facilitate that decision.

[1] The American Bankers Association's HSA Council represents about ninety-four percent of the Health Savings Accounts (HSAs) in the United States and the millions of Americans who finance their healthcare with these plans.

2. We maintain that HSA-qualified HDHPs are likely the most cost-effective option for enrollees and would like to see them listed first in any list of available plans, by metal tier.

3. We also recommend adding information about the differences between an HSA-qualified HDHP and other non-qualified HDHPs in any coverage examples provided. There should be links to educational information to help consumers understand what an HSA is and how they might establish and contribute to an account after they complete the plan selection process.

4. It would be helpful if plan issuers would provide information about HSA account custodians and trustees – banks and TPA partners - and facilitate connecting enrollees with these partners so their account can be established in a timely manner.

If the Council can be of any service regarding any of these matters, please let us know.

Cost Sharing Subsidy Reform

For those Silver metal tier plans that provide cost-sharing subsidies, we recommend providing subsidies in the form of HSA contributions instead of reducing the cost-sharing parameters of the plan. Under the present model, the subsidies require insurance carriers to increase the actuarial value of the underlying plan by reducing cost-sharing amounts. Doing so can have the effect of making an otherwise HSA-qualified plan a non-qualified plan because the resulting deductibles and other cost-sharing amounts are lower, making them incompatible with an HSA-qualified plan.

In addition, the subsidies tend to inure to the benefit of insurance carriers rather than individuals. In many cases, the amount that could be deposited in the individual's HSA could be substantial, while producing the same actuarial value overall, according to modeling we have conducted using CMS' actuarial value calculator.

Diverging Out-Of-Pocket Maximums

We are becoming increasingly concerned about the growing gap between the out-of-pocket maximums under the Affordable Care Act (ACA) and those set by the IRS for HSA-qualified plans. In 2014, these amounts were the same, but different annual inflation adjustment factors have led to a sizable difference projected for 2019. Although the IRS will not make its determination on out-of-pocket limits for 2019 until the Spring of 2018, our current models project that the limits will vary by approximately $1,100 for self-only coverage ($6,800 for HSAs vs. $7,900 for ACA) and $2,200 for family coverage ($13,600 for HSAs vs. $15,800 for ACA). However, we note that this means HSA-qualified plans will continue to provide superior protection against high medical expenses compared to non-HSA plans that are similar in design.

Nonetheless, the higher out-of-pocket maximums under the ACA are driving the actuarial value (AV) calculator to produce progressively higher actuarial values for HSA-qualified plans. For example, although Bronze plans can have an AV ranging from 58% to 65%, it is not possible to create an HSA-qualified plan with an AV below 61% because the deductible and out-of-pocket limit cannot exceed the IRS maximums, which are lower than the ACA limits. This was not the case back in 2014 where an HSA-qualified plan could have an actuarial value as low as 58%.

On the other hand, insurance carriers can now design at least one HSA-qualified plan for the Platinum metal tier. For example, a plan using the minimum deductible for an HSA-qualified plan of $1,350 that covers 100% of expenses after the deductible is met (i.e., out-of-pocket limit also equals $1,350) would have an AV of 86.90% which qualifies as a Platinum plan according to the 2019 proposed AV calculator. This seems counter to the basic notion of having "skin in the game" that a Platinum metal tier plan would be HSA-qualified. We would prefer that more HSA-qualified plans be available in the Bronze tier with actuarial values below 61%, as these would likely offer the greatest premium savings to consumers.

Medical Loss Ratio (MLR) Flexibility

MLR regulation is firmly established in law but is just as firmly established within the Secretary's authority to modulate. Accordingly, the Council supports giving states the flexibility to lower the minimum MLR thresholds for the individual market to 75 or even 70 percent. Ideally, MLR regulation should be abandoned altogether on the grounds that it makes insurance more expensive and thwarts competition, two dynamics many observers have noted since the ACA was enacted.[2]

While policy labors to catch up to common sense, we suggest that States which adopt lower MLR levels should make it easier for HSA-qualified plans to meet these standards relative to the current 80 percent standard. We have long felt that the MLR requirements were discriminatory against HSA-qualified plans and have expressed our concerns multiple times to HHS in prior comment letters. In sum, the arguments for lower MLR levels are the following:

Generally, the ACA's requirement that insurers rebate consumers after plan years during which claims were relatively low precludes them from accumulating surplus capital, which was previously applied to claims in plan years where claims were relatively high. The possibility of either being liable to pay rebates or experiencing losses through higher than expected claims exerts upward pressure on premiums, a dynamic states (and consumers) can hardly afford.

In HSA plans, this dynamic is exacerbated by the fact that under the ACA, MLR is defined as "incurred claims," meaning that until an insurer pays a claim, the MLR is effectively zero. In a market dominated by plans that provide benefits with no cost-sharing, this definition makes some sense; in an HSA marketplace, the plans are affordable precisely because insurers don't pay claims until a high deductible is reached (with the exception of preventive care benefits).

[2] See NPCA Policy Brief, April 8, 2013

MLR is relatively much lower for plans with higher cost-sharing than plans with lower cost sharing. The federal MLR rules do not take this dynamic into account but should.

Lastly, the Council also supports giving states additional flexibility to define their benchmark plan and essential health benefits (EHB) and to do so on an annual basis. However, we urge CMS to remind states to provide appropriate exemptions for HSA-qualified plans where the absence of such exemptions would create conflict with federal HSA law and make it impossible to design HSA-qualified plans in such states. Examples of problematic state laws include: (1) benefit mandates requiring coverage below the deductible for services other than "preventive care;" and (2) any preventive care benefit mandates that exceed the IRS safe harbor definition provided in IRS Notice 2004-23.

In conclusion, the proposed rule embraces many of the changes Council members have suggested for years. Again, we commend you for including them. We look forward to working with you on this important topic in the future.

Sincerely,

J. Kevin A. McKechnie
Executive Director