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

April 2, 2012

Steve Larsen, Director
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO–9998–IFC
Room 445–G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Director Larsen:

On behalf of the members and Board of Directors of The HSA Council[1], thank you for the opportunity to comment on the guidance bulletin on Actuarial Value (AV) and Cost-Sharing Reductions (CSR) issued pursuant to the Patient Protection and Affordable Care Act (PPACA).

To ensure that HSAs are available, we believe that the AV rule for HSA-qualified plans should be constructed so that:

1. All employer contributions are counted at 100%, not "adjusted;"
2. All individual contributions are counted at 100%, not "adjusted;" and,
3. All insurance carrier contributions are counted at 100%, not "adjusted."

Our concerns also extend to the following statement included in the bulletin:

> "However, because generally only a portion of an HSA is used in a year for health services, HSA contributions would be adjusted so that the employer receives the same credit for HSA contributions in the numerator of the AV calculation as it would receive for the same amount of first-dollar insurance coverage."

We disagree with the assumption that "only a portion of an HSA is used in a year for health services." The HSA Council represents the overwhelming majority of this industry and our data suggests that between 92% and 98% of all HSA transactions are for "qualified medical expenses" as this term is defined in section 213(d) of the IRS code. To assume the contrary is to misstate publically available IRS data.

[1] The HSA Council is made up of FDIC insured depository institutions, health insurers and their technology partners. The HSA Council advocates on behalf of account-based health care financing solutions in the United States and is part of the American Bankers Association.

While the HSA Council has attempted to speculate what the referenced passage actually means, the absence of clear guidance makes that impossible. We respectfully request that HHS issue a clarification about exactly what type of "adjustment" this proposed rule contemplates. Until we receive clarification, our ability to comment further is impeded.

However, with the information at hand, our conclusion is that the proposed rule would unfairly and irrationally devalue HSA contributions for the purposes of calculating the AV of HSA-qualified plans through an undefined "adjustment" based upon an inaccurate assumption about the manner in which these accounts are used.

If this interpretation is correct, we find the rule in direct opposition to both the President's promise of a role for HSAs in the Exchanges and the methodology for calculating the AV of HSA-qualified plans issued by the Congressional Budget Office (CBO).

CBO said that[2]:

> ". . . the actuarial value of consumer-directed plans would include the expected value of any contributions that an insurer or employer sponsoring the plan would make to an enrollee's account—so that contribution could be set to make the overall actuarial value of the consumer-directed plan equal to the value of a conventional health plan."

Our understanding at time of PPACA's enactment mirrors the explanation for AV calculation given by the CBO. AV regulation should treat dollars contributed to the account in exactly the same manner as dollars spent on premium, whether by the individual or the employer.

The view of the American Academy of Actuaries (AAA) is the following:

> "If the contributions are automatic, it may be appropriate to simply add the value of the contribution to the actuarial value of the high-deductible health plan. However, if contributions are voluntary, it may be more appropriate to discount the value of the potential contribution to reflect that not everyone will contribute or exclude contributions from the actuarial value altogether."

The proposed AV rule ignores the issue of automatic contributions to the account made by individuals or small business. While we believe contributions should be treated the same as premium payments, we request that HHS issue clarification around the issue of automatic vs. voluntary contributions.

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[2] December 2008 CBO report, "Key Issues in Analyzing major Health Insurance Proposals" http://www.aba.com/aba/documents/ABIA/CBO_KeyIssuesAnalyzingMajorHealthRefor%20ProposalsDec2008.pdf

The stakes are high for the HSA industry, since we know of not a single insurer who will be offering bronze plans for the exchanges, or for outside the exchanges, for the small group and individual markets impacted by the Minimum Loss Ratio and the Actuarial Value rules.

It is our view that the discrimination against HSAs in the MLR rule has already made offering HSA-qualified plans impossible. HHS's "adjustment" rule on AV will only further push insurers out of offering bronze plans.

Regarding the "national claims data set" proposed for use to determine plan Actuarial Values, we believe that all population types--not just employer plans--but also individual plans, plans covering those with pre-existing conditions (e.g., PCIP) and state high-risk pool populations, as well as currently uninsured individuals, should be included. If all these populations are not included in the data set, it will not be truly representative of actual health care utilization patterns across the country.

Regarding cost-sharing reductions, we believe that HHS should not develop reduced annual out-of-pocket limits for individuals with income below 250 percent of the Federal poverty level that would fall below the minimum deductible for HSA-qualified "high deductible health plans." For 2012, that would mean no annual out-of-pocket limits below $1,200 for individuals with self-only coverage and $2,400 for individuals with family coverage. If HHS reduces the out-of-pocket limits below these levels, then some individuals will lose their HSA eligibility. We believe there are other ways to meet the AV levels stated in the bulletin without precluding HSA eligibility for any individual.

One potential way to avoid HSA eligibility problems would be to count HSA contributions towards the actuarial value instead of requiring reductions in out-of-pocket expenses like copays, coinsurance, and deductibles. And, as stated previously, counting HSA contributions "in full," without adjustment, would meet the goal of increasing AV for lower income individuals without forcing them to have fewer plan choices.

The intent of the 2003 legislation that created HSAs was to redirect dollars that would have otherwise been spent on health insurance premiums to an individual's account. The only difference between the HSA funds and premium dollars is the transfer of risk to the consumer. HSA balances are held for future health expenditures just as insured premium is designed to cover current and future liabilities (especially in a small population). An HSA is like insurance for a population of one, so the risk is quite variable and must address more than one year at a time. The HSA funds are "insurance" for payment of claims beneath the deductible of the HSA-qualified health plan; in essence, pre-paid claims.

Our objection to the proposed rule is that it ignores the treatment of IRS-qualified claims and the treatment of contributions to the HSA as pre-paid claims or, in the alternative, does not treat the contribution as payments in lieu of payments that would otherwise have been

paid premiums. Absent changes, the AV rule discriminates against HSAs generally, but fully insured HSA-qualified plans in the individual and small group markets in particular.

As you are aware, these markets are precisely the segments in need of the most relief and HSAs offer the only proven cost reductions in the marketplace. Where the MLR rule threatens the financial ability and incentive of insurers to offer fully insured HSA-qualified plans, the proposed AV rule threatens to exclude them from being offered in the Exchanges, an outcome the President specifically told the industry he would avoid.

In his March 2, 2010 letter[3] to Speaker Pelosi, Majority Leader Reid, Minority Leader McConnell and Minority Leader Boehner, the President assured Senator Barrasso about the viability of HSAs in the Exchanges and said,

> "I believe that high-deductible health plans could be offered in the exchange under my proposal, and I'm open to including language to ensure that is clear. This could help to encourage more people to take advantage of HSAs."

The availability of HSA-qualified plans in the Exchanges is essential if individuals and small businesses are to have the ability to purchase affordable coverage when they are ordered to do so, or face penalties commencing in 2014.

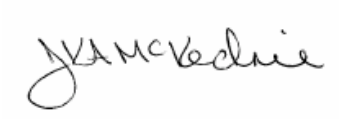
If we consider this issue from the perspective of premium, if left as is, the proposed rule does not "adjust" the AV of a plan simply because there are excess premium dollars not spent on claims in any given plan year. Why, then, does the rule treat unspent HSA contributions differently?

Further, the proposed rule penalizes HSA owners by creating perverse incentives to spend more money per medical good or service. HSA owners have a lower utilization rate because of the simple fact that they are spending their own money, so they spend it more prudently. An unavoidable conclusion of the rule's effect, therefore, is that the proposed AV rule intends to penalize prudent spending.

[3] March 2, 2010 Letter from President Obama to Majority Leader Harry Reid, Minority Leader Mitch McConnell, Speaker, Nancy Pelosi and Minority Leader John Boehner; found at: http://www.whitehouse.gov/blog/2010/03/02/president-obama-follows-thursdays-bipartisan-meeting-health-reform-0.

We understand the complexity of the task before HHS and look forward to working constructively with you to ensure that the greatest number of Americans possible have access to health insurance they can afford. Preserving HSAs seems the best way to do that.

Respectfully,



Kevin McKechnie
Executive Director