

HSA COUNCIL

A joint effort of the American Bankers Association and its insurance subsidiary, the American Bankers Insurance Association

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January 31, 2011

Jay Angoff, 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 Angoff:

Thank you for the opportunity to comment on the Medical Loss Ratio regulations issued pursuant to the Patient Protection and Affordable Care Act (PPACA).

The HSA Council¹ submitted written comments previously on May 14, 2010, in response to the Department's request for information concerning standards for minimum medical loss ratios (MLR). In those comments we requested an exemption from the MLR regulations for HSA-qualified plans.

We believe that the interim final MLR regulations that went into effect January 1, 2011 do not address our concern that their application will negatively affect the availability and affordability of plans with lower actuarial value. Section 2718 of the PPACA provides the Secretary with the authority necessary to exercise discretion when crafting MLR standards for HSA-qualifying plans. In fact, because of the peculiar needs of small plans, that section directs the Secretary to avoid one-size-fits all rules and make exceptions.

In our opinion, the directive included in Section 2718 has been ignored. **Accordingly, we renew our request that an exemption from the MLR standards be granted to HSA-qualified plans and to plans that**

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.

are actuarially comparable to or will become “bronze” or “silver” plans under Sec. 1302 of PPACA.

Without such an exemption, the MLR formula must either be changed to more appropriately reflect the experience of plans with lower actuarial value; or other accommodations must be made.

In its current form, the MLR regulation will almost certainly incentivize insurers to offer more expensive plans that have higher actuarial value (the future “Gold” and “Platinum” plans), while discouraging the marketing of more modestly priced plans with lower actuarial value (the future “Silver” and “Bronze” plans). The likely result is a future market dominated by more expensive plans (i.e., “Gold” and “Platinum” plans), adding significantly to the costs of income-based subsidies provided under the law.

We remain very concerned that the MLR standards could have an adverse impact on the availability and affordability of plans with lower actuarial value. The interim final regulations would discriminate against and penalize plans with lower actuarial value relative to plans with higher actuarial value in several ways.

First, fixed costs represent a higher percentage of expenses for plans with lower actuarial value. Every plan has fixed costs (property rent/lease/mortgage, utilities, insurance, customer service, etc.). These costs must be incurred whether the insurance company sells plans with higher actuarial value that typically have higher premiums, plans with lower actuarial value that typically have lower premiums, or a mix of plans. However, the more plans with lower actuarial value an insurance company sells, the less premium revenue it will collect, making its fixed costs a higher percentage of revenues, all other things being equal, to plans with higher actuarial value.

Second, plans with lower actuarial value naturally have higher administrative expenses and lower claims expenses, as a percentage of premiums, relative to plans with higher actuarial value. Plans must process claims even if they are not paid by the plan so that claims are properly credited towards satisfying deductibles and limits on out-of-pocket expenses. The designs of plans with lower actuarial value typically employ higher deductibles and higher out-of-pocket limits relative to designs of plans with higher actuarial value. Therefore, compared to plans with higher actuarial value, plans with lower actuarial value will naturally have higher administrative

expenses and lower paid claims expenses as a percentage of the premiums earned.

Third, plans with lower actuarial value (primarily plans with high deductibles) will continue to have more volatile claims experience relative to plans with higher actuarial value. This phenomenon does not disappear unless all enrollees are required to enroll in plans with identical or similar actuarial value. There are two reasons for this:

- 1. Selection bias.** Individuals with poor health status and/or known diseases or conditions tend to seek coverage that will pay a greater percentage of their health care expenses (i.e., plans with higher actuarial value), even if they have higher premiums. Enrollees with high expected annual claims expenses are less likely to enroll in plans with lower actuarial value because of their higher out-of-pocket cost-sharing features. Likewise, individuals with good or excellent health status may prefer plans with lower actuarial value because they do not expect to have many out-of-pocket expenses.
- 2. Premium volatility.** Given the inherent selection bias, plans with lower actuarial value will face pressure to keep their premiums very low. But this could expose them to higher risk for unexpected increased claims due to inadequate premiums. For example, many high cost catastrophic claims come from accidents (auto accidents, head injuries, burns, etc.) where risk is unpredictable. This creates greater volatility of claims experience MLR from year to year independent of plan design selection bias. On the other hand, if plans raise premiums on their plans with lower actuarial value too fast, they could increase their risk of paying rebates because they “had a good year.”

We were pleased that the regulation recognized that plans with lower actuarial value have additional volatility of claims experience primarily resulting from their higher deductibles, as indicated by the application of a cost-sharing adjustment factor. However, this factor only applies to plans with low enrollment (under 75,000 life years) under the regulation. In addition, the impact of this factor is reduced by the co-application of the credibility adjustment factor. The regulation sets the credibility adjustment factor at 0 above 75,000 life years. We do not believe this is appropriate for two important reasons:

1. The regulation ignores the fact that the actuarial work by Milliman² shows a calculated adjustment of 0.9% (75,000 lives) and 0.8 (100,000 lives), thereby ignoring the continuing random risk variation in large blocks of business. This will make it harder for larger companies (more than 75,000 lives) to profitably sell to fully-insured large groups. The ignored credibility variation shown in the Milliman study is nearly 1% or about 33% of a typical pre-tax risk (profit) margin target.
2. The cost-sharing adjustment is lost when the underlying credibility adjustment is 0. We believe the factor should be applied to plans of all sizes because of the continued volatility in claims experience for these plans.

We believe that the current formula for adjusting plans' MLRs for credibility and cost-sharing should be modified. We believe that a plan's incurred MLR should first be adjusted by multiplying it by the cost-sharing adjustment factor, then adding the credibility adjustment factor where applicable.

For example, assume a plan with an incurred MLR of 50.00%, 10,000 life years, and average deductible of \$5,000.

The formula would work as follows:

$$\begin{aligned}
 & \text{([Incurred MLR] x [Cost-sharing Factor])} + \text{[Credibility Factor]} \\
 & \text{([50\%] X [1.402])} + \text{[2.6\%]} = 72.7\%
 \end{aligned}$$

We also believe that the cost-sharing adjustment factor should be based on the limit on total out-of-pocket costs, not just the deductible. Under the law, all plans must limit out-of-pocket expenses to meet the current statutory limit for HSA-qualified plans, those limits being no more than \$5,950 for individuals with self-only coverage and \$11,900 for family coverage.

Plans may use lower limits but not higher limits for 2011.

² Milliman, *Credibility Adjustment Factors for Use in PPACA MLR Refund Calculations*, August 31, 2010

Under the interim final regulation, plans with different deductibles but identical limits on out-of-pocket expenses would have different cost-sharing adjustment factors applied. For example, a \$5,000 deductible with no coinsurance would get a higher cost-sharing adjustment (1.402) than a plan with a \$1,000 deductible and a coinsurance of 20% up to a maximum out of pocket of \$5,000 (1.000). We believe these plans have the same total risk against out-of-pocket expenses so they should be treated equally.

The credibility adjustment factor in the interim final regulation is itself problematic for several reasons. First, it is a single credibility adjustment by life years without differentiating between adult lives and child lives, assuming their claims experience is equal. We do not agree with this assumption. In many cases, carriers do not know the exact number of member months for children. Children are often covered under family coverage without specific identification. For these plans, children are required to provide proof of dependency at time of claim. This will require carriers to change enrollment systems and/or expand surveys to estimate family size in multi-tiered coverage options.

Second, the credibility adjustment factor ignores the use of reinsurance. According to the Milliman study conducted for the National Association of Insurance Commissioners (NAIC), lower levels of individual stop loss reinsurance can significantly lower the credibility adjustment factor. If reinsurance is not counted when determining rebates, claims above the stop loss level would limit the rebate (because they are counted in the claims experience for rebate purposes) but not negatively affect operational experience (the reinsurer would suffer the loss while the carrier would avoid a potential rebate).

Finally, the regulation ignores the cost-sharing adjustment from the Milliman study to plans with deductibles below \$1,000. Ignoring this fact could encourage the sale of plans with deductibles under \$1,000 but with substantial co-insurance and high out-of-pocket limits.

The MLR requirements may have other substantial impacts on the insurance market. We believe the regulation will encourage more small employers to move to self-insured arrangements to avoid unknown consequences from any MLR requirements. To control the certainty of claims, there may be a movement to eliminate out-of-network benefits.

However, Exclusive Provider Organization (EPO) products observed in the 1990's were not successful as the network of providers was too limiting for the public. But, the regulation may force carriers to return to EPOs especially to secure higher discounts from providers receiving more in-network patients.

Failing an exemption for HSA-qualified plans or a change in the formula for adjusting an incurred MLR for credibility and cost-sharing factors, the only appropriate alternative would be to include employer allocations for health reimbursement arrangements (HRAs) and both employer and employee health savings account (HSA) contributions as "incurred claims" upon deposit. In addition, employees should be allowed the option to have any rebates automatically deposited in their HSA accounts.

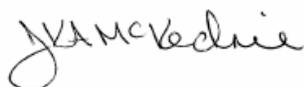
These adjustments are necessary to ensure the continuing availability of HSA-qualifying coverage while observing the requirements of the regulation.

We note that just thirty-six months from now, the exchanges go live, as does the requirements that individuals purchase insurance and businesses provide it to their employees. The President, in his March 2, 2010 letter to Congressional leaders had this to say about HSAs: *"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."*

We want to make sure his promise to the millions of Americans who finance their healthcare with an HSA is kept. Unfortunately, as written, the MLR regulation imperils both the availability of qualifying coverage and the affordability of that coverage.

We renew our request for an exemption from these requirements and look forward to working with you to achieve this goal.

Respectfully,

A handwritten signature in cursive script that reads "Kevin McKechnie".

Kevin McKechnie
Executive Director