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Stephen W. Robertson, Commissioner

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Via Email to ActuarialValue@cms.hhs.gov and CostSharingReductions@cms.hhs.gov
The Honorable Kathleen Sebelius
United States Department of Health & Human Services
Secretary of Health & Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: Actuarial Value and Cost-Sharing Reductions Bulletin

Dear Secretary Sebelius:

Thank you for the opportunity to provide comment regarding the Actuarial Value and Cost-Sharing Reductions Bulletin (AV-CSR Bulletin) released by the Department of Health & Human Services (HHS) on February 24, 2012. I write to provide comment on a significant aspect of Indiana's health insurance market, consumer-driven health plans (CDHPs), also known as high-deductible health plans (HDHPs), and their relationship to the AV-CSR Bulletin. Specifically, this letter discusses the method by which HHS intends to address the actuarial value (AV) of plans paired with Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs) under the proposal put forth in the bulletin.

Indiana has a robust CDHP market. According to a report issued by America's Health Insurance Plans (AHIP), CDHPs have increased 25% since 2009. Currently, Indiana has the sixth highest percentage in the nation; 10.6% of the State's population, or 384,772 people under age 65 with private insurance, utilize CDHPs with a HSA[1].

While CDHPs with HSAs are currently thriving in Indiana's individual health insurance market, these plans have historically and continue to play a significant role in the State's small group market as well. Small employers were the earliest advocates and purchasers of the HDHP-HSA options. Small businesses are keenly aware of the necessary trade-offs when resources are finite: wages versus benefits. This analogy is clearly evident in employee healthcare benefits: low deductibles with high premium versus high deductibles with low premium. Often the employers' premium savings are shared with employees in the form of a pre-tax contribution to an HSA[2] or HRA[3]. Proper reflection of both the AV of HDHPs with HSAs and the combined employer benefit plans with HRAs in the small group market is essential for their continued utilization and success in the small group market.

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[1] http://www.ahipresearch.org/pdfs/HSA2011.pdf.
[2] Medicare Modernization Act of 2003
[3] U.S. Department of the Treasury Revenue Ruling 2002-41

Indiana agrees with HHS that "simply calculating the AV of the HDHP based on the insurance product could understate the value of coverage and some HDHPs could fall below the level of a bronze plan based on the HDHP alone", as stated in the AV-CSR Bulletin. This sort of calculation would inaccurately reflect the true value of the HDHP with the HSA or an employer benefit plan with an HRA. However, Indiana does recommend changes to the proposed AV calculation to better reflect the full value of employer HSA and HRA contributions.

The current proposal, for the purpose of calculating AV, would discount the employer contribution to suggest that the employee will spend only a portion of the employer contribution amount within the benefit year. As stated in the AV-CSR Bulletin, "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." This is inconsistent with a covered employee's ability to roll forward unused funds from an employer contribution into a HSA or HRA for use in the next benefit year. By not counting a portion of the employer contribution in the AV calculation, HHS is asserting unused HSA or HRA funds rolling over to the next plan year have no actuarial value. The State disagrees that accounting for the entire value of the HDHP with an HSA or employer benefit plan with an HRA could overstate the actuarial value.

Further, the AV should measure the richness of the benefits as seen through the eyes of the insured individual. If an employer provides a very rich HSA contribution, this is a meaningful component of the richness of the total benefit package, irrespective of whether the full amount is anticipated to be applied to current year healthcare costs.

In conclusion, as HHS works toward a determination of employers' plan AV, Indiana urges HHS leaders to include in its formulation the full value of employer HSA and HRA contributions (not discounted/adjusted) because the contributions are *pre-payment* for medical claims whether or not they are first dollar. If these contributions are not provided credit for their full value, employers will not see the value in making these contributions, and employees could potentially end up with higher exposure to out-of-pocket costs.

Should you have any questions regarding these comments, please contact Chief Deputy Commissioner Logan Harrison at 317.234.7734 or lharrison@idoi.in.gov. Thank you for your time and consideration to this matter.

Sincerely,

Stephen W. Robertson

Stephen W. Robertson
Indiana Insurance Commissioner