



American College Health Association

▲ 891 Elkridge Landing Road, Suite 100
Linthicum, MD 21090
Tel: (410) 859-1500
Fax: (410) 859-1510
www.acha.org

April 12, 2011

Donald M. Berwick, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9981-P
P.O. Box 8010
Baltimore, MD 21244-8010

**Re: Student Health Insurance Coverage under the Public Health Service Act and the Affordable Care Act
45 C.F.R. Parts 144 and 147 – Comment
File Code CMS-9981-P**

Dear Mr. Berwick:

On behalf of the American College Health Association (“ACHA”), I write in response to the Notice of Public Rule Making (CMS-9981-P) in which the Centers for Medicare & Medicaid Services (“CMS”) solicited comments on its proposed rules concerning college student health insurance coverage under the Public Health Service Act and the Affordable Care Act. Founded in 1920, ACHA is a non-profit national health association that represents multidisciplinary college health professionals and their student health centers. ACHA represents the interests of more than 2,500 physicians, physician assistants, nurses and advanced practice nurses, nurse-directors, mental health professionals, health promotion professionals, health administrators, pharmacists, and support staff, as well as over 900 student health centers nationwide. We thank you for the opportunity to share our perspectives on these proposed regulations.

First, we applaud the release of these proposed regulations implementing provisions of the Public Health Service (“PHS”) Act and the Affordable Care Act (“ACA”) as they relate to the continued operation of college student health insurance plans, and we appreciate this opportunity to provide input. ACHA acknowledges the thoughtful and extensive work undertaken to craft these regulations, and we are pleased that the proposed rule maintains a specific category of “student health insurance coverage” (as a type of individual health insurance coverage) in the newly mandated health insurance marketplace. We commend the Department of Health and Human Services (“HHS”) for developing an approach that will enable colleges and universities to continue offering high quality student health plans, while encouraging improvement in the insurance coverage currently provided by some lower quality student health insurance plans.

We are concerned however that: 1) the regulations do not *clearly* set forth that premiums for college student health insurance plans may continue to be determined based on the unique populations

covered by the plans; 2) self-funded plans are left unaddressed; and, 3) choice of primary care provider may be too broadly interpreted. Therefore, we offer the following comments in response to the Notice of Proposed Rulemaking.

1. Guaranteed Availability and Guaranteed Renewability

ACHA is concerned that the regulations only imply that premiums for student health insurance coverage may continue to be determined based on their unique college populations. While the intent is clear from the discussion of construing student health insurance coverage as bona fide association plans (“...for purposes of Federal law, intended solely to allow student health insurance coverage to be limited to students and their dependents, without imposing availability requirements for non-students, or renewability requirements after an individual has ceased to be a student...”), ACHA strongly believes that the Department should make a more definitive statement declaring that issuers offering student health insurance coverage may continue to determine premiums based on the unique college population covered by the plan. The provision in the regulation (“This construed status does not require health insurance issuers offering student health insurance coverage to revise or amend their current business or marketing agreements and practices.”) clearly implies no change in rating requirements, but ACHA strongly recommends that the Department include an unambiguous statement that premiums for student health insurance plans may continue to be determined based on their unique college populations.

2. Definition of Student Health Insurance Coverage

The Department proposed that “student health insurance coverage” would be defined to include only insurance provided pursuant to a written agreement between an institution of higher education and a health insurance issuer. Furthermore, the Department invited comments on self-funded plans.

ACHA is very concerned that an opportunity to include quality coverage provided by self-funded plans has been omitted from these rules. While we acknowledge that the HHS has no authority to regulate self-funded student health plans as explained in the regulations, ACHA encourages the Secretary to use her authority (from the ACA) to designate other types of coverage as “minimum essential health coverage”, to so designate that self-funded plans having all of the compliance features as set forth in the regulations would be another form of “minimum essential health coverage” (like Medicare, Medicaid, Children’s Health Insurance Program, and TRICARE have been designated), thereby satisfying the individual mandate. ACHA strongly recommends that these regulations provide a mechanism for self-funded student health plans to be recognized as “minimum essential health coverage”.

Furthermore, ACHA recommends that the regulations address models if there is an institution, broker, and issuer relationship, and further clarify the definition when an insurance broker is involved.

Additionally, ACHA recommends that:

- Nothing in the final regulations should prevent a college or university from offering student health insurance as part of a customized student insurance program that may offer other coverage such as dental insurance; and,

- Nothing in the final regulations should prevent a college or university from participating in a consortium student insurance plan.

3. Choice of Health Care Professional

The Department requested comments on the applicability of the requirements for choice of health care professional to student health insurance coverage and the interaction with the college health service system.

The proposed rule cites the provisions of section 2719A of the PHS Act permitting each plan participant, beneficiary, or enrollee to designate *any participating* primary care provider who is available as their provider if the plan is one that requires or provides for designation of a participating primary care provider. However, the regulations themselves acknowledge the concerns of colleges and universities that the provisions relating to choice of health care professional “could be disruptive to the college health service system since it is a unique system”. Notwithstanding, the proposed rule does not provide that the requirements of section 2719A of the PHS Act would be inapplicable to student health insurance plans.

An overbroad interpretation of “any participating primary care provider” can be harmful to the institution’s student health service. It could be construed to mean other participating primary care providers in the community within a given commercial insurance issuer’s network, but not necessarily within the student health center. The final regulations should clarify that, for purposes of college health insurance coverage, the *participating* primary care provider may be more narrowly defined as being a provider within the institution’s student health service. This clarification is important to enable many student health centers to continue their important role of triage and referral for students who require services that fall outside of the scope of services provided at the institution’s health center.

For decades, college health centers have operated from a multidisciplinary and collaborative model. With clinicians, mental health professionals, health educators and others using principles of the patient-centered medical home, and keenly focused on both adolescent health and academic success in higher education, primary care providers *within* the network of the institution’s student health center are best suited to provide both the continuum of care and the continuity of care so important to students’ success. Basic tenants of this model include: coordination of care, whole person orientation and enhanced access. The model effectively addresses same-day access demand, coordination of care, and seeks to avoid the more expensive alternative for students, i.e., seeking care at a local emergency room or urgent care clinic.

Student health insurance plans work in partnership with the campus college health service to coordinate the overall delivery of health care services to students. Costs are kept lower than traditional health plans through effective referral coordination and care management by the college health service.

This intricate fabric of support services provided by colleges and universities, which includes on-campus primary care, mental health, public health and health promotion, should not be dismissed. ACHA is confident that both access to care and quality of care can be sustained when colleges and universities offer plans where enrollees designate a participating primary care provider *within the*

institution's college health insurance plan if that is the plan design preferred by the institution. Therefore, ACHA strongly recommends continuation of this type of plan design option in the final rules for student health insurance coverage.

Additional Comments/Concerns:

Student Health Insurance Coverage and Short-Term Limited Duration Insurance

The Department invited comments on the prevalence of existing student health insurance plans that meet the definition of short-term limited duration insurance and whether such plans should be subject to certain requirements of the PHS Act and the Affordable Care Act.

ACHA supports the designation of student health insurance coverage as individual health insurance coverage generally subject to the individual market requirements of the PHS Act and the ACA. However, ACHA remains concerned about the continued availability of short term, limited duration policies in the private market that may be marketed to students specifically, and sold as primary, sole source coverage. ACHA recommends provisions in the regulations setting forth that these limited duration plans should carry a mandated notice requirement stating that the plan does not meet the ACA requirements.

Annual Limits

The Department requested comments on the applicability of the annual dollar limits requirements to student health insurance coverage, and the proposed phase-in of the annual dollar limits requirements.

ACHA supports the phase-in methodology incorporated in these regulations. It acknowledges and concurs that without such a transition period (wherein the annual limit for student health insurance coverage would be no less than \$100,000 instead of \$1,250,000), an immediate increase in the floor amount to \$1,250,000 could prevent many institutions from continuing to offer student health insurance coverage, contrary to the Congressional intent expressed in the Section 1560(c) rule of construction.

However, ACHA remains sensitive to the increased cost of insuring students as a result of ultimately removing annual limits. We therefore request that HHS collaborate with the Department of Education to recognize student health insurance as a cost of attendance, and consider the increased cost burden when factoring and funding federal student aid award packages.

Coverage of Preventive Services

The Department requested comments on the applicability of section 2713 of the PHS Act to student health insurance coverage and the interaction of the college health fee and the no cost-sharing requirement for preventive services.

ACHA supports the provisions in the regulation that define and distinguish a student administrative health fee from insurance premiums and cost-sharing, thereby allowing administrative health fees to continue to be charged by colleges and universities.

These administrative fees are often essential in enabling an institution to provide critical public health, as well as campus health and safety, services to its students. The public health role of colleges and universities in administering immunization requirements, preventing communicable diseases, and responding to disease outbreaks (e.g. HINI, mumps, meningococcal disease, etc.) is vital to community and national health. These fees enable the campus health service to employ prevention strategies as they relate to alcohol and other drug issues and mental health challenges facing college students. In summary, institutions of higher education utilize administrative health fees in a variety of ways to ensure that all students -- even those without coverage -- have access to individual or group prevention programs. It is therefore critical that these administrative fees be allowed to continue, separate and apart from premiums and cost-sharing.

Affordable Care Act Provisions Effective in 2014

The Department requested comments on sections 2702 and 2703 of the PHS Act, and other 2014 Affordable Care Act provisions to student health insurance coverage as defined in the proposed regulation. It also requested comments on the interaction of student health insurance coverage with the health insurance Exchanges that will be created in States beginning in 2014.

PHS Act, Sections 2702 (Guaranteed Issue) and 2703 (Guaranteed Renewability)

ACHA concurs with the Department that the general policy rationales used to make sections 2741 (guaranteed availability) and 2742 (guaranteed renewability) inapplicable to student health insurance coverage, should and would apply to sections 2702 and 2703 for policy years beginning on or after January 1, 2014. The same concern would apply on January 1, 2014 and beyond, namely avoiding the disruption of the design of student health insurance coverage which is intended to be available and renewable only to college students (and their dependents). This would be contrary to Congressional intent expressed in the ACA section 1560(c) rule of construction.

ACHA is concerned that this section of the regulation unnecessarily introduces ambiguity for student health insurance coverage when clarity is the intent. If this proposed regulation will *not* address ACA provisions effective in 2014 and beyond, ACHA strongly encourages the department to sustain its already developed policy rationale in future regulations addressing 2014 and beyond.

Interaction of Student Health Insurance Coverage with Health Insurance Exchanges

Student Health Insurance Coverage is an affordable option for a significant number of individuals who would otherwise, not have access to coverage through a group health plan, or would have coverage that is limited in first dollar benefits when the student is away from home. ACHA is concerned about ensuring that ACA compliant student health insurance remains affordable for students. To address this concern, we recommend permitting institutions of higher education to offer student health insurance to their eligible students and dependents through the state exchanges, and therefore providing students and their dependents one means for accessing premium tax credits and an electronic mechanism to

compare and enroll in coverage. We also recommend ensuring that this option is available for both state and out-of-state resident students.

Several key parameters of the exchange program are dependent on state residency and income, including eligibility for the subsidy. Defining eligibility for students could be complex and problematic for the individual who attends school out-of state. Income criteria based on residency and dependency status may vary for purposes of income tax, federal financial aid and health insurance as a dependent. ACHA recommends that HHS collaborate with the Department of Education to explore ways to provide the federal subsidy or a credit of similar value for students who enroll in a qualified student health plan. In addition, to ensure adequate first-dollar coverage for students who are attending school beyond their Medicaid coverage network, a strategy to direct Medicaid funding to offset the cost of a qualified student health plan should be developed and implemented, with oversight responsibility delegated to the state exchange of the students' permanent residence.

Medical Loss Ratio

The Department requested comments on the PHS Act section 2718 (medical loss ratio provisions) as it relates to student health insurance coverage.

ACHA acknowledges concerns regarding the application of the medical loss ratio (MLR) provisions of section 2718, PHS Act to student health insurance plans. There are several factors that may influence the MLR for student health insurance plans. Therefore, ACHA recommends further study of the cost of compliance for student health plans. Perhaps accommodation similar to those offered to expatriate and "mini-med" plans may be advisable, including, postponing the rebate provisions for issuers of student health plans until the 2013-2014 plan year; redefining reporting dates to coincide with policy years; requiring issuers to separate student health plan reports from their other policies for the 2012-2013 plan year; and, directing an analysis of medical care and administrative expenses to determine if student health insurance plans warrant special methodologies. The Department should consider following the approach it applied with respect to the aforementioned "mini-med" plans, utilizing the expertise of the National Association of Insurance Commissioners (NAIC) to assess whether student health insurance plans have such unique administrative expenses that they warrant development of other methodologies that take such expenses into account when calculating the MLR requirements. Key factors would be as follows:

- Expansion of benefits to meet all of consumer protection provisions will result in higher claims for the majority of student health plans for the 2012-2013 policy year. A regulatory impact analysis was not conducted to estimate the cost of removing lifetime benefit limits and pre-existing condition waiting periods, nor the cost of requiring preventive care benefits with no cost share, which stakeholders have reported may create a cost burden on students, and/or disrupt the student health insurance market.
- The January through December reporting period and monthly lives calculations do not align with student health insurance plan coverage periods and enrollment cycles that span two calendar years.

- Typically, student health insurance plan enrollment and benefits coverage cycles commence in August/September. The cost of the coverage is annualized, however the actual premium charged to the student may vary in the number of months included within the coverage period. For example, fall and spring premium charges are billed in equal amounts, however the autumn coverage period includes 5 months, and the spring coverage period includes 7 months. There is potential for claims/premium ratios to be over or understated, especially during a calendar year in which the institution changes insurers.
- The May 31st reporting requirement with rebates paid by June 30th also does not align with standard policy year models.
- Given the transient nature of the student population and the common practice of billing premium charges through institutional student accounts, the administrative burden and cost of refunding directly to the individual, in many instances would exceed the value of the rebate.

Notice Requirement

The Department requested comment on the notice requirement for student health insurance coverage.

ACHA is supportive of this provision but is concerned that issuers of student health insurance coverage may move to shift the burden of providing this notice to the institutions of higher education and their student health centers. We respectfully request clear reinforcing language in the regulations indicating that the notice requirement is solely a responsibility of the issuers of student health insurance coverage, and that no costs or burden would be borne by the college or university. Furthermore, ACHA recommends discontinuance of the notice requirement on September 23, 2012 when the annual dollar limit amount becomes \$2 million, consistent with all other individual plans.

Notice Model Language

The Department requested comments on the model language for the notice requirement.

While the proposed rule provides model language for the notice, ACHA's view is that the language is unnecessarily negative and there is an opportunity for the Department to re-write the model language in a manner that reflects that student health plans (by issuance of these regulations) *are* compliant with the provisions of the ACA and PHS Act, and then noting the few exceptions. ACHA requests the Department reconsider its approach to the model language.

Regulatory Impact Analysis

The Department invited comments on the regulatory impact analysis and its determination that the proposed regulations would have "minimal effect" on premiums.

ACHA recognizes that moving plans that already have annual limits to the phased threshold will most likely not cause disruption to the market. However, while the rules are clear that the effect of imposing the ACA provisions on overall student health insurance plans was not included in this analysis, since the individual market rules comment period has passed, ACHA is sensitive to the impact on cost to students that will result when plans remove their lifetime maximums and full compliance is achieved.

Domestic Partner Coverage

There are no provisions addressing domestic partner coverage.

If there is any decision to address domestic partner coverage within these or other insurance regulations, ACHA recommends that the proposed rules clarify that student health plans are permitted to allow students to enroll their domestic partners (as defined in the individual institution's plan terms) as dependents.

Waivers

There are no provisions for a waiver of the requirements of these regulations for student health plans prior to 2014.

It is ACHA's opinion that there is significant potential for pushback from some institutions of higher education and insurance carriers for a waiver option in order to prevent market disruption. If the final regulations include an option for waivers of the regulations prior to 2014, we urge that the waiver must be submitted by the college or university chief executive officer on the institution's behalf, and that the required notice on the plan brochure, web site, and in other materials must include a prominent statement that the program applied for and received a waiver. Furthermore, these waiver requests should not be allowed from insurance carriers; instead, they should originate from the institution.

We thank the Department for the opportunity to comment and would be pleased to provide any additional information that would be helpful to HHS as final regulations are developed. Thank you in advance for your attention to these views.

Sincerely,


Alan I. Glass, M.D.
President
American College Health Association