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Employment, Labor & Benefits Advisory

JUNE 4, 2012

Centers for Medicare & Medicaid Services Issues Final Rule Re: Student Health Insurance Coverage under the Affordable Care Act

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Section 1560(c) of the Patient Protection and Affordable Care Act (the Act) provides that nothing in the Act "shall be construed to prohibit an institution of higher education … from offering a student health insurance plan, to the extent such requirement is otherwise permitted under applicable Federal, State, or local law." On March 21, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a final regulation implementing the provisions of Act Section 1560(c). This client advisory explains the key provisions of the final regulation.

The final regulation defines the term "student health insurance coverage" as:

> "[A] type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education … and a health insurance issuer, and provided to students enrolled in that institution of higher education and their dependents, that meets the following conditions:
>
> 1. Does not make health insurance coverage available other than in connection with enrollment as a student (or as a dependent of a student) in the institution of higher education.
> 2. Does not condition eligibility for the health insurance coverage on any health status-related factor … relating to a student (or a dependent of a student).
> 3. Meets any additional requirement that may be imposed under State law."

The final regulations apply only to fully insured student health plans, and not to self-funded plans, which are beyond the scope of the authority of the Department of Health and Human Services to regulate. CMS takes the position that, since student health plans are not employment based, they are not group health plans under the Public Health Service Act (PHS Act). They are therefore regulated under the PHS Act as individual plans. That some states regulate student health plans as types of group coverage (e.g., as association "blanket" coverage) does not change their treatment under the Act as individual plans.

Certain polices of "limited duration insurance" qualify for a regulatory exemption for "health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract." So-called "short-term limited duration insurance" is available to individuals to fill in gaps of coverage that otherwise might occur, such as when they are between jobs and without employer coverage. It is specifically excluded from the definition of individual health insurance coverage. As a consequence, the individual market protections of the Act do not apply. CMS noted in this regard, however, that —

> "these policies often — (1) Allowed students to renew coverage as long as their schools had chosen to retain the policy (and, in some cases, the issuers cooperated with the universities in

automatically renewing students who did not affirmatively opt out); (2) had significant numbers of students keep coverage for longer than one year; and (3) in some cases, even based annual and lifetime dollar limitations and preexisting condition exclusion limitation periods on students' coverage under the policies from the same issuer during prior academic years."

CMS therefore chose not to change the definition of what constitutes short-term limited duration insurance, which is defined (in 45 C.F.R. 144.103) to mean:

> "… health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract."

As a consequence, where coverage is renewable each year at the option of the student, then the coverage does not qualify as short-term limited duration insurance. Recognizing that this interpretation may require some adjustments, the preamble to the final regulation says that, "[t]he effective date of this rule is intended to provide issuers and universities that operated with a reasonable belief that their policies were short-term limited duration coverage to come into compliance …." (The rule applies to policy years beginning on or after July 1, 2012.)

The final regulation exempts student health plans from the following of the Act's insurance market reforms:

- *Guaranteed issue and guaranteed renewability*

  Guaranteed issue and renewability rules, which take effect in 2014, will not apply to student health plans. For purposes of the Act's provisions governing guaranteed issue and renewability, student health insurance coverage is deemed to be available only through a bona fide association, which is exempt from these requirements.

- *Annual limits*

  The Act generally prohibits annual limits on the dollar value of essential health benefits. An interim final rule provides for a phase-in of annual limits before 2014. Under these interim final regulations, annual limits on the dollar value of essential health benefits may not be less than the following amounts for plan years (in the individual market, policy years) beginning before January 1, 2014:

For Plan or Policy Years Beginning on or after:	Applicable Restricted Annual Limit
September 23, 2010, but before September 23, 2011	$750,000
September 23, 2011, but before September 23, 2012	$1.25 million
For plan or policy years beginning on or after September 23, 2012, but before September 23, 2014	$2 million

  The final regulation provides for a transition period for issuers of student health insurance coverage to comply with the restricted annual dollar limits requirements under the Act. Student health insurance coverage will be allowed to impose an annual dollar limit of no less than $100,000 on essential health benefits for policy years beginning before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Beginning in 2014, health insurance issuers offering student health insurance coverage must comply with the Act's bar on annual dollar limits.Where a health insurance issuer that provides student health insurance coverage fails to satisfy the restricted annual limits set out in the table above, the issuer must provide a notice informing students that the policy does not meet those requirements. The notice must include the dollar amount of the annual limit along with a description of the plan benefits to which the limit applies for the student health insurance coverage. The notice must also state that the student may be eligible for coverage as a dependent in a group health plan of a parent's employer or under the parent's individual market coverage if the student is under the age of 26. To assist with this requirement, the final regulations provide the following model language:

> "Your student health insurance coverage, offered by [name of health insurance issuer], may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage put an annual limit of: [Dollar amount] on [which covered benefits — notice should describe all annual limits that apply]. If you have any questions or concerns about this notice, contact [provide contact information for the health insurance issuer]. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information."

- *Preventive services*

PHS Act Section 2713 generally bars the imposition of cost sharing for preventive services. The final regulation exempts "student administrative health fees" from this requirement by clarifying that these fees are not considered a "cost-sharing" requirement with respect to specified recommended preventive services. A student administrative health fee is defined for this purpose to mean:

> "[A] fee charged by the institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage."

- *Minimum Loss Ratios (MLRs)*

Under the Act's provisions governing "medical loss ratios" (MLRs), in general, at least 80% (in the small group and individual markets) or 85% (in the large group market) of the premiums that issuers receive for insurance policies must be spent on reimbursement for clinical services to enrollees (such as hospital and physician payments) and activities that improve health care quality. Under final MLR rules issued by the Department of Health and Human Services, limited benefit (or "mini-med" plans) and issuers of expatriate plans are required to report their mini-med and expatriate plan experience separately from their other policies for one year, and, for that one-year period, are provided an accommodation in the formula for determining the MLR. This was done because these plans have unique characteristics or expense structures that warrant loosening of MLR requirements. The final regulations take a similar approach to student health plans. The rule provides for a transition period for issuers of student health insurance coverage to comply with the Act's MLR requirements. Issuers will be allowed to calculate their MLRs by applying a multiplier of 1.15 to the total of incurred claims and expenditures for activities that improve health care quality for the 2013 MLR reporting year. The net effect of this adjustment is to make it marginally easier for issuers to comply with the MLR rules without having to issue rebates to policyholders.

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