

April 11, 2011

The Honorable Kathleen Sebelius  
Secretary  
Centers for Medicare & Medicaid Services  
United States Department of Health and Human Services  
Attention: CMS-9981-P, P.O. Box 8010  
Baltimore, MD 21244-8010

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

Re: Comments on Student Health Insurance Coverage Proposed Rule (CMS-2011-0016-0001)

Dear Secretary Sebelius and Dr. Berwick:

As organizations dedicated to protecting the rights of consumers, and specifically the rights of students, we thank you for the opportunity to comment on the proposed regulations around the Affordable Care Act's (ACA) applicability to student health plans. Clarifying that ACA protections apply to student health plans is a huge step forward for students, many of whom have been fighting for better protections and better plans for years.

While we were generally pleased with the proposed regulations, we do have several discrete issue areas in which we would like to provide comment. Specifically, we would like to urge action to: (1) maintain a medical loss ratio (MLR) of 80%, (2) keep student health plans regulated as individual market plans, a smart choice that will benefit students immensely, (3) modify the model notice such that incoming freshman can better understand their plans' limitations, (4) affirmatively encourage states to regulate self-funded student health plans to the extent legally allowed, (5) reiterate that students health plans must permit students to designate any participating provider as a their primary care provider, and (6) implement these changes on schedule.

### **1. Maintaining an 80% Medical Loss Ratio**

By defining student health plans as individual plans, the proposed regulations set the MLR at 80%, while also asking for comments on this component. We strongly urge you to maintain the 80% MLR requirement. The generally low-quality coverage that college plans provide, including low benefit caps, has resulted in high industry profit margins. Students have been unduly burdened by benefit limitations and premium spikes while insurance companies reap the immense benefits. Requiring that 80% of student premium dollars go to medical care will go a long way to ensuring that students are protected from further profit gouging, and bring student health plans in line with the rest of the individual market.

The ability to meet an MLR of 80% is well within the capability of student insurers. In fact, some insurance companies are already close to that marker. Aetna, the largest provider of student plans, generated about \$470 million in premiums in 2009, with an MLR of 83.3%; in 2008, Aetna's MLR was 75%.<sup>1</sup> The second largest provider of student plans, UnitedHealthCare, had an MLR of 71% in 2009 (with premiums of \$390 million), and an MLR of 56% in 2008.<sup>2</sup> The MLRs of the largest student insurers are represented in Table 1.

**Table 1. Medical Loss Ratios for Student Health Plans of the Largest Student Insurers**

2009	Student Enrollees	Premiums	Medical Expenses	Medical Loss Ratio
Aetna	517,907	\$468,536,298	\$390,500,512	83.3%
United (New York)	13,921	\$13,099,006	\$7,637,078	58.3%
United	285,325	\$376,799,628	\$268,164,002	71.2%

Both companies stand to lose some premiums due the extension of dependent coverage, but the hit is expected to be minimal, given that the average age of a college student enrolling in a plan is 25 (most states already require dependent coverage for continuing students).<sup>3</sup>

Moreover, MLRs do not need to be dominated by administrative costs, as some have argued. Administering plans to a student population, one-quarter of whom are new enrollees each year, may be a slightly different task than administering individual plans to plans with a slightly higher percentage of re-enrollees each year.<sup>4</sup> However, the bulk of administrative costs for a typical plan on the private market go to marketing costs. For example, in 2006, \$69 billion was spent on administrative costs.<sup>5</sup> Of that number, almost 30%, or \$20 billion, was spent on "sales and marketing."<sup>6</sup> This type of administrative cost is unnecessary for a closed-universe student population that is easily accessible through university-provided systems, many of whom use an "opt-out" system that automatically enrolls students unless they take steps to waive participation.

Furthermore, the MLR rule by recently adopted by the National Association of Insurance Commissioners creates a calculation for MLRs that looks at the aggregate of MLRs for the same insurance company, in the same market, in the same state. In other words, the particular college plan will not have to keep a strict 80% MLR each year. Moderate fluctuations for one college

<sup>1</sup> OPPENHEIMER, *The Game Has Changed, But still Trying to Play by the Old Rules – MLR Update*, May 12, 2010.

<sup>2</sup> *Id.*

<sup>3</sup> *Bad Economy Lifts Enrollment in Student Plans, but Reform Rules are Unclear*, HEALTH PLAN WEEK, August 16, 2010, available at <http://www.aishealth.com/SampleIssues/samplemcw.pdf>.

<sup>4</sup> About one-fifth of the population as a whole changes insurance plan or status in a given year.

<sup>5</sup> CONGRESSIONAL BUDGET OFFICE, *KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS*, December 2008, available at <http://www.cbo.gov/ftpdocs/99xx/doc9924/toc.shtml>

<sup>6</sup> *Id.*

plan will be permissible, because the medical loss ratios are calculated across several individual plans—whether that is calculated across all student plans in the state or all individual plans overall.

And finally, data available for student health plans in Massachusetts show that the profit margins enjoyed by student insurers are what is really at stake when parties claim that they cannot meet this requirement. Table 2 below includes data from all Massachusetts student insurance plans.<sup>7</sup> The MLRs for these plans ranged from 65% to 81%, with an average of 72%. **The average profit margin was 10%, but ran as high as 20%.** There is plenty of room for student health insurance plans to increase their MLRs, even if administrative costs were slightly higher.

**Table 2. Massachusetts Student Health Plans Data**

2008-2009	Community Colleges	State Colleges	University of Massachusetts	Self-Funded	Other Schools	All	2008 Private Insurance
MLR	65%	65%	71%	81%	68%	72%	88%
Admin	15%	22%	20%	12%	21%	18%	10%
Profit	20%	13%	9%	8%	10%	10%	2%

Clearly, plans are able to maintain a baseline 80% MLR while maintaining profitability, given Aetna's performance in 2009. And there is also much room to improve on administrative and profit margins, as is clear from the rest of the industry and past performance by Aetna. Given the huge profit margins, it should be very feasible to hold premiums steady as they improve coverage benefits and increase MLRs. In other words, those opposing these changes may continue to claim that improving plans will raise premiums without taking into account the current high levels of profit and administrative fees. For example, if a plan currently has a 70 percent MLR and moves to the 80 percent MLR required under law, the plan will have to reduce profit and administration before they can pass on the costs of improved benefits to consumers as premium increases. Simply increasing premiums to pay for new benefits will not allow plans to meet the new MLR rule, and any analysis of likely premium impact must take this into account.

As a result, benefit improvements under the ACA can be made at current premium levels by simply complying with the required MLR improvement

## **2. Individual Categorization vs. Short-Term Limited Duration**

The proposed regulation defined student health care plans as “individual plans” for purposes of the ACA. Defining student health plans as individual health insurance brings huge benefits to millions of students, beyond just the 80% MLR. As individual market insurance, student health

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<sup>7</sup> Massachusetts Department of Health and Human Services, Division of Health Care Finance and Policy, Student Health Program: Academic Years 2008-2009 (2010).

plans must comply with the Patient's Bill of Rights, including protections such as no cost-sharing for preventive care and no lifetime limits. In 2014, these plans must offer the essential benefits package as well. As individual plans, students can have the option of purchasing an exchange plan and getting subsidies. **If these plans were not classified as individual plans, the offer of insurance would preclude students from getting subsidies for other plans under ACA.**<sup>8</sup>

Moreover, this classification makes sense in light of prior regulatory statements made by HHS in reference to HIPAA. While there is disagreement as to how student health insurance has been regulated historically, the only past HHS statements made around student health plans have indeed called them individual insurance.<sup>9</sup> And finally, as HHS stated in the proposed rule, student health insurance plans simply do not meet the definition of short-term limited duration insurance, given their timing and their renewability.<sup>10</sup>

As a practical matter, tying the regulation of student plans to the rest of the market goes a long way in protecting students, who have previously been left to fend for themselves. Until now, different actors have treated student plans differently, and as a result, market oversight has not clearly extended to these plans. Students have little experience with insurance, little time to advocate for themselves, and few resources to make their needs heard on this issue. By clarifying that individual market regulations apply to these plans, HHS is removing a huge burden from the shoulders of young students. Before, students held the burden in arguing that protective regulations should apply to them (a great example of this was in Massachusetts, where students had to fight for plans to be fully included in state health care reform—and continue to do so). Now, the burden will lay with other stakeholders to argue that student insurance plans should be exempted from regulation.

### **A. Benefit Caps**

Most college health plans have some sort of lifetime condition, lifetime, or annual benefit caps. Phasing those caps out, as is required of individual plans is both affordable and important. In a Government Accountability Office survey, 96% of student insurance plans had benefit caps and 68% of them do it on a per condition, lifetime basis.<sup>11</sup> Over half had benefit caps that were less than \$30,000.<sup>12</sup> The median for plans with annual limits, rather than condition limits, was \$50,000.<sup>13</sup> Few students exceed these caps but these caps can be devastating for those that do.

The number of students in the entire college population of the State of Massachusetts who exceeded the \$50,000 benefit cap was never more than 43 in any of the three surveyed academic

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<sup>8</sup> ACA §1401 (a)(36b)(c)2(B)(i)-(ii).

<sup>9</sup> See 62 FR 16985, 16992 (April 8, 1997).

<sup>10</sup> See 45 CFR 144.103.

<sup>11</sup> U.S. GOVERNMENT ACCOUNTABILITY OFFICE, HEALTH INSURANCE: MOST COLLEGE STUDENTS ARE INSURED THROUGH EMPLOYER-SPONSORED PLANS, AND SOME COLLEGE AND STATES ARE TAKING STEPS TO INCREASE COVERAGE (2008).

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

years.<sup>14</sup> Table 3 below demonstrates that in 2007, only three-hundredths of 1% of 18 to 30 year-olds in the country exceeded \$50,000 in medical expenditures.<sup>15</sup> Because young adults enrolled in colleges are generally wealthier and, as a result, healthier, the cost for this population is arguably even less.

Of course, for those who do exceed the limit, the consequences are dire: a lifetime of medical debt or an outright inability to gain access to care. The numbers demonstrate both that prohibiting such low benefit caps is needed, and that bringing the caps up to the \$100,000 floor, and then in line with the rest of the market improvements, will not result in huge expenditures on the part of insurance companies.

**Table 3. Medical Expenditure Panel Survey Data for Young Adults**

	\$0	\$1-5,000	\$5,000-\$50,000	\$50,000-100,000	\$101,000-500,000	\$500,000-750,000	\$750,000 and Above
Young Adults	26.24%	64.98%	8.6%	.15%	.03%	0%	0%

## **B. Pre-existing Conditions**

In discussing pre-existing conditions, the proposed rule states that Section 504 of the Rehabilitation Act does not allow for discrimination against students with disabilities when universities offer benefits. But many student health insurance plans currently have long waiting period exclusions for those with pre-existing conditions. We urge HHS to clarify that the proposed rule states that Rehabilitation Act precludes not just discrimination from enrolling in these plans, but also those discriminating waiting periods.

If HHS opts not to interpret the Rehabilitation Act in this manner, we urge the Secretary to clarify that after the individual classification takes effect, but before pre-existing condition discrimination is prohibited for individual plans, regulators and states can continue to require student plans to either prohibit waiting periods, or give an exemption to those students who have creditable coverage. In other words, for the school year 2012 – 2013, state-level regulators can and should protect students from pre-existing condition exclusions, regardless of federal classification.

## **C. Rate Review**

The proposed regulations on rate review requirements pursuant to § 1003 of ACA state that HHS will defer to state definitions used under state rate filing laws when determining whether a rate filing refers to the individual, small or large group market. For student health plans, this proposal will be insufficient, given the variance in state-level regulation of student insurance – and that in some states student health insurance are not regulated in any of those categories. As

<sup>14</sup> Massachusetts Department of Health and Human Services, Division of Health Care Finance and Policy, Student Health Program: Academic Years 2006-2007 and 2007-2008 (2009).

<sup>15</sup> Medical Expenditure Panel Survey, (2007) available at <http://www.meps.ahrq.gov/mepsweb/>.

such, as urge HHS to clarify that student health insurance rate filings must be included in individual rate filings.

### **3. Notice Requirement**

HHS has requested comment around the model notice required for all plans that do not comply with ACA requirements. Currently, the model notice references the Public Health Service Act (PHSA) when describing non-compliance. The model notice requirement language presented for compliance of Section 147.145(d)(1) should instead include a statement that it “does not meet requirements of the Affordable Care Act, commonly known as “the health care reform law.”” Enrollees not intimately familiar with health law will have little understanding as to the relationship between the Public Health Service Act and the ACA or health reform. As a result, the proposed language does not serve its stated purpose, which is to inform students that they should not expect the protections provided in the ACA if they enroll in the student plan.

Additionally, when the model notice asks insurers to list which covered benefits have annual limits, the model should include an example of benefits listed in a clear, bulleted fashion. A college student reviewing the plan is more likely to take note and comprehend materials presented in the following manner:

- This plan will pay no more than \$100,00 per year for hospitalization.
- This plan will pay no more than \$100,000 per year for prescription drugs.

Finally, the notice should be placed in large, bold type at the front of the plan. A college student, with little background in insurance, is likely to miss any notice that is provided amidst other technical details. If the notice is to serve as anything other than a formality, it must be upfront and standalone.

### **4. Self-Funded Student Health Plans**

The proposed rule specifically exempts self-funded student health plans from its purview, stating that because these plans are neither health insurance coverage nor group health insurance coverage, HHS has no authority to regulate them. HHS then goes on to conclude that, just because it is prohibited from regulating these plans, this does not mean that states cannot regulate them.

While we accept that HHS is constrained as it states, we also encourage the department to revise this section of the proposed rule to affirmatively encourage states to regulate self-funded student health plans to the extent permissible under federal and state law. As a part of this encouragement of states to regulate self-funded student health plans, HHS should specifically note that state regulatory action that would extend the regulatory framework of the proposed rule to self-funded student plans is supported by the department as a means to ensure that students enrolled in these plans receive the same protections that students across the nation will receive as a result of the proposed rule.

It is also important that HHS and states take special note of the incentives that this self-funded exemption could create. While self-funded student insurance plans tend to offer better coverage,

at least according to anecdotal accounts, actors could attempt to avoid federal regulation by moving into this type of plan. Regulators and legislators should be on notice and prepared to take further action if a trend toward this type of avoidance develops.

## **5. Choice of Health Care Professional**

College students should get the same choice of health care professional protections outlined in Section 2719A of the Public Health Service Act as all enrollees on an individual plan. The proposed rule does not specifically exempt student health plans from the choice of health care professional protection outlined in Section 2719A of the PHSA, and we see no reason to do so. The provision requires that a group health plan, or a health insurance issuer offering group or individual health insurance coverage to allow each participant, beneficiary, or enrollee to designate any participating primary care provider as his or her primary care provider if designation of a primary care provider is an available option.

While it is true that the college health service system is an unusual system and that student health plans are not structured exactly like other health plans, no disruption to the college health service system should occur from simply allowing students to designate a provider—who is otherwise available to them under the terms of their student health plan—as their primary care provider. In fact, allowing such a designation could encourage more individuals to establish robust primary care relationships during their time as students and encourage wellness as well as facilitate access to preventive services. If stakeholders representing colleges and universities are concerned that this provision would somehow lead to students being able to seek primary care from providers who would not normally be available to students under the terms of their student health plans, HHS can assuage this concern by making clear that this is not the intent of the application of this provision to student health plans while still giving students the benefit of this protection.

## **6. Timing of Regulations**

We are disappointed that HHS does not believe that these regulations can take effect any sooner than January 1, 2012, and we want to emphasize that this date should be the absolute latest date for student plans to comply with individual market requirements. Already, plans will have another full school year—the 2012-2013 school year—with only a \$100,000 annual limit requirement. This lead-time should give plans and schools plenty of time to implement these changes in a way that is least disruptive to coverage.

Additionally, the fear that insurers will attempt to collect as much profit as possible before the MLR requirement comes online, or that they will use the regulation as a pretext to raise rates, is not unfounded. Regulators at federal and state levels should use all available authority to ensure that students do not see unnecessary and unfair rate hikes until the ACA takes full effect in 2014, including rate review.

By ensuring that student health plans meet individual market requirements under the ACA, as laid out in the proposed regulations, including a minimum MLR of 80%, we can ensure that students will gain the rights guaranteed to all other insurance consumers. HHS should also

maintain a timely implementation process, provide a clearer model notice, and a clear statement of encouragement for states to regulate self-funded student health plans.

Thank you for this opportunity to comment on these proposed regulations. We are deeply appreciative of the efforts that HHS has taken on behalf of students and hope that the department addresses the areas of concern we have outlined in these comments. Please feel free to contact Jen Mishory, Deputy Director, Young Invincibles, at [Jen.Mishory@YoungInvincibles.org](mailto:Jen.Mishory@YoungInvincibles.org) or (202) 339-9365 with any follow-up questions.

Sincerely,

Campus Progress  
Community Catalyst  
Families USA  
National Women's Law Center  
Timothy Jost, Professor, Washington And Lee University School of Law  
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Young Invincibles