INTRODUCTION:

The Patient Protection and Affordable Care Act ("Affordable Care Act" or "the Act"), enacted on March 23, 2010, has dramatically changed the landscape for any discussion of health insurance. Last October, NACUANOTES examined the initial impact of the Act on college and university-sponsored employee health care plans [1]. This Note examines a second important impact of the Act: how the Affordable Care Act affects college or university-sponsored student health plans ("SHPs").

After the Affordable Care Act was enacted, many within the higher education community expressed concern that certain reforms within the Act could make it impossible for colleges and universities to continue offering high-quality, low-cost SHPs to their students. For example, certain provisions of the Act, such as those requiring guaranteed issue and guaranteed renewability, directly conflict with the nature of SHPs, which are intended to provide health coverage only to students and their dependents while the students are enrolled in the college or university. Other provisions, such as the prohibition on annual limits, would require such a drastic change to many existing policies that it is unclear whether such policies would continue to be affordable for students.

While President Obama's administration indicated that the Act was not intended to eliminate SHPs, it appeared that legislative changes or regulatory guidance would be necessary in order for these plans to survive. In response to the many questions that were raised regarding the applicability of the Act to SHPs, the Department of Health and Human Services ("HHS") published a Proposed Rule on student health insurance coverage on February 11, 2011 ("Proposed Rule") [2]. The Proposed Rule answers many questions with respect to how SHPs will be treated under the Public Health Service Act and the Affordable Care Act. The Proposed Rule attempts to strike a balance between ensuring that SHPs provide students and their dependents with meaningful coverage and maintaining SHPs as a viable, affordable form of coverage that can be offered by colleges and universities.

This NACUANOTE (1) provides an overview of SHPs, (2) discusses the impact of the Proposed Rule on the treatment of SHPs, and (3) highlights the sections of the Affordable Care Act that will apply to SHPs.

DISCUSSION:

I. An Overview of SHPs and the Historical Statutory Framework Governing SHPs

Many colleges and universities sponsor SHPs to provide their students access to affordable health coverage, usually in coordination with existing student health clinics or university medical centers. Some institutions sponsor a SHP but do not require students to enroll in the plan nor show proof of
other health coverage through their parents or employment. To ensure that students have adequate coverage, other institutions require that students enroll in the college or university’s SHP unless the students show proof of other health coverage. A few institutions require students to enroll in the SHP regardless of whether the student is covered by, or has access to, other health coverage, perhaps to control costs by ensuring sufficient participation in the SHP. While most colleges and universities contract with an insurance carrier to offer SHP coverage, a small number of institutions self-insure their SHPs [3]. Although the American College Health Association has established standards to guide colleges and universities in establishing SHPs [4], the benefits covered by SHPs and the cost of such plans can vary considerably from institution to institution [5].

The Public Health Service Act (“PHSA”) has historically provided the statutory framework in which fully-insured group and individual health plans must operate. The Affordable Care Act amends the PHSA and builds on the existing rules and definitions. The PHSA – and the Affordable Care Act – regulate two categories of health insurance coverage: (i) group health insurance coverage offered through the small group market and the large group market, and (ii) individual health insurance coverage offered through the individual market [6].

- “Group health insurance coverage” is defined as health insurance coverage offered in connection with a “group health plan,” [7] which in turn is defined as a plan established or maintained by an employer or employee organization for the purpose of providing health care insurance or reimbursement to employees or their dependents [8]. Group health insurance coverage is made available through the “group market,” which is the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves and their dependents through a group health plan maintained by an employer [9]. A SHP is not group health insurance coverage within the meaning of these definitions, because there is no employer-employee relationship between the institution and the student.

- “Individual health insurance coverage,” on the other hand, is defined as health insurance coverage offered to individuals in the individual market, but does not include short-term limited-duration insurance [10]. Individual health insurance coverage is made available through the “individual market,” which is the market for health insurance coverage offered to individuals other than in connection with a group health plan [11].

Since a SHP is not group health insurance coverage for purposes of the PHSA and the Affordable Care Act, it is regulated as individual health insurance unless it is short-term limited-duration insurance. The Department of HHS has defined “short-term limited-duration insurance” in its regulations as follows:

*Short-term, limited-duration insurance* means 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 [12].

Many fully-insured SHPs have historically been treated as short-term limited-duration insurance within the meaning of these regulations. Accordingly, these SHPs have been treated as exempt from much of the regulation under the PHSA applicable to the individual and group markets [13]. Since the Affordable Care Act amends the PHSA and adopts these definitions in large part, it follows that SHPs that are treated as short-term limited-duration insurance are also not subject to many of the provisions of the Act. The application of the short-term limited-duration insurance exemption to SHPs, therefore, gained newfound significance and focus when the Affordable Care Act became law [14].

Although self-insured SHPs are much less common than fully-insured SHPs, self-insured SHPs are
not subject to the PHSA requirements relating to “health insurance coverage” since the coverage is not extended under a policy or contract issued by a “health insurance issuer.” [15] As such, self-insured SHPs have historically been treated as exempt from most federal (but not state) regulation.

II. The Department of HHS Weighs In On SHPs

Congress clearly stated that the Affordable Care Act is not intended to preclude a college or university from offering a SHP. Section 1560(c) of the Act provides:

Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State or local law.

(“Savings Clause”). The term “student health insurance plan” was not defined by the Act, and until the Proposed Rule was issued by the Department of HHS, there was significant debate as to what exactly this Savings Clause meant for SHPs [16]. The Proposed Rule interprets the Savings Clause and provides significant guidance to colleges and universities that offer fully-insured SHPs. Specifically, the Proposed Rule:

- Defines “student health insurance coverage” as a specific type of individual health insurance coverage;
- Clarifies that SHPs that permit students to renew their coverage each year in which they continue to be enrolled as a student do not qualify as short-term limited-duration insurance;
- Provides that certain requirements of the Affordable Care Act and the PHSA are inapplicable to a SHP that is student health insurance coverage;
- Requires health insurance issuers to disclose to students and their dependents that the student health insurance coverage policy being issued does not meet all of the requirements under the Affordable Care Act; and
- Provides that student health insurance coverage must comply with the PHSA and Affordable Care Act applicable to coverage in the individual market, as modified by the Proposed Rule, for policy years beginning on or after January 1, 2012.

Each of these items is discussed below.

1. **Student Health Insurance Coverage.** The Proposed Rule defines “student health insurance coverage” as a type of individual health insurance coverage that is governed by a written agreement between an institution of higher education and a health insurance issuer and which is provided to students enrolled in that institution of higher education and their dependents. The written agreement could be the master insurance policy issued to the college or university or, if the policy is issued to the individual students, an agreement between the insurer and college or university that indicates the institution’s role in selecting, terminating, and replacing the insurer; negotiating policy terms; setting student and dependent eligibility terms; publicizing, endorsing or recommending the policy to students and dependents; and/or providing students and dependents with assistance with obtaining benefits or appealing denials under the coverage. Student health insurance coverage must also satisfy the following conditions:

   i. it cannot make health insurance coverage available other than in connection with enrollment
as a student or dependent of the student in the institution;

ii. it cannot condition eligibility for the coverage on any health status-related factor of the student or dependent of the student; and

iii. it must meet any additional requirement that may be imposed under State law.

The preamble to the Proposed Rule states that the Department of HHS proposes that coverage that satisfies the definition of student health insurance coverage could meet this definition even if it provides coverage for limited periods of time to students on break between academic terms or on temporary leaves of absence for medical or other reasons, or to students who have recently graduated or ceased enrollment in the college or university, which should be specified in the policy or written agreement governing the coverage. The preamble also states that the Department of HHS intentionally did not set any minimum threshold for determining student status, but left this to be determined by each institution.

A fully-insured SHP that meets the definition of student health insurance coverage is exempt from several requirements under the Affordable Care Act under the Proposed Rule, as discussed below. Fully-insured SHPs that do not satisfy the Proposed Rule’s definition of “student health insurance coverage” and that do not qualify for treatment as short-term limited-duration insurance, appear to be subject to all of the individual market requirements under the PHSA and the Affordable Care Act and also do not qualify as minimum essential health coverage that satisfies the individual mandate, as discussed below.

Self-insured SHPs do not fall within the scope of the definition of student health insurance coverage. The preamble to the Proposed Rule confirms that because self-insured SHPs are neither health insurance coverage nor group health plans, as those terms are defined by the PHSA, the Department of HHS has no authority to regulate them. Self-insured SHPs may, however, be regulated by the States. The Department of HHS invited comments on the prevalence, structure, and State regulation of self-funded SHPs.

2. Short-Term Limited-Duration Insurance. The preamble to the Proposed Rule addresses the historical practice of treating SHPs as “short-term limited-duration insurance.” The preamble confirms that the individual market protections of the PHSA and the Affordable Care Act do not apply to short-term limited-duration insurance. However, the preamble also makes clear that SHPs do not qualify as short-term limited-duration insurance if the coverage is renewable each year at the option of the student as long as the student remains in school. This interpretation of short-term limited-duration insurance squarely excludes any fully-insured SHPs that permit students to renew their coverage each year while still enrolled at the university or college, or that automatically renew coverage for students who do not affirmatively elect to cancel their policies. The Department of HHS has invited comments on the prevalence of existing SHPs that meet the definition of short-term limited-duration insurance, as clarified, and whether such plans should be subject to certain requirements of the PHSA and the Affordable Care Act.

3. Certain PHSA and Affordable Care Act Provisions Are Inapplicable to Student Health Insurance Coverage. The Proposed Rule provides that a limited number of requirements under the PHSA and the Affordable Care Act are inapplicable to SHPs that qualify as student health insurance coverage. The Department of HHS interpreted the Savings Clause as precluding or limiting application of any such requirement to fully-insured SHPs if the requirement would as a practical matter have the effect of prohibiting an institution of higher education from offering a student health plan otherwise permitted under Federal, State or local law.

a. Guaranteed Issue and Guaranteed Renewability
Significantly, the Proposed Rule exempts student health insurance coverage from the guaranteed issue and guaranteed renewability requirements set forth under the PHSA that apply to health insurance issuers that offer coverage in the individual market [19]. The Department of HHS found application of these provisions to be inconsistent with the provision of SHPs, which are limited by definition to a defined pool of beneficiaries (students and their dependents). Therefore, for purposes of guaranteed issue and guaranteed renewability requirements, student health insurance coverage is construed to be available through a bona fide association [20], for which there is an existing exception to the application of these requirements [21]. As a result, student health insurance coverage can be limited to students and their dependents, and does not have to be offered to individuals who have ceased to be students, at least through 2014.

In 2014, two new provisions under the Affordable Care Act become effective that impose similar guaranteed issue and guaranteed renewability requirements applicable to the individual health insurance market [22]. The Proposed Rule did not exempt student health insurance coverage from these two Affordable Care Act mandates. However, the preamble to the Proposed Rule states that the general policy rationale behind exempting the PHSA guaranteed issue and guaranteed renewability requirements would apply to the Affordable Care Act mandates and that this issue could be addressed in future regulations.

b. Annual Limits on Essential Health Benefits

The Proposed Rule also provides transitional relief for application of the Affordable Care Act’s prohibition on annual limits [23]. The Affordable Care Act prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from establishing lifetime limits on the dollar value of essential health benefits [24]. The Act further restricts annual limits on the dollar value of such benefits before 2014 [25]; for plan years beginning on or after January 1, 2014, annual limits on the dollar value of essential health benefits are also no longer permissible [26]. The Department of HHS recognized that SHPs typically impose low annual limits on student health insurance coverage, and that this practice has generally continued after the enactment of the Affordable Care Act due to the treatment of the SHPs as short-term limited-duration insurance not subject to the Act [27]. The Proposed Rule, therefore, provides for transitional relief with respect to the restricted annual dollar limits. Student health insurance coverage can establish an annual limit of no less than $100,000 on essential health benefits for policy years beginning on or after January 1, 2012, but before September 23, 2012 (compared to the $1.25 million minimum that would otherwise apply to plans covered by the Act). The transitional relief ends for policy years beginning on or after September 23, 2012. At that time, the annual limit may be no less than $2 million. No annual limits may apply for policy years beginning on or after January 1, 2014.

c. Preventive Care

The Proposed Rule specifically provides that student administrative health fees are not considered prohibited cost-sharing requirements (e.g. deductibles, co-pays, co-insurance, etc.) with respect to specified recommended preventive services. The Proposed Rule defines student administrative health fees as fees that are periodically charged to students 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.

4. Notice Requirement. The Proposed Rule requires health insurance issuers that provide student health insurance coverage to provide a notice informing students that the policy does not meet all of the requirements under the Affordable Care Act. This disclosure is similar in nature to the disclosure that “grandfathered health plans” are required to provide in their plan materials. The notice must be prominently displayed in a clear, conspicuous 14-point bold type on the front of the insurance policy.
or certificate and on any other plan materials. The Proposed Rule provides model language that health insurance issuers can use to satisfy this notice requirement.

5. **Delayed Effective Date.** The coverage mandates under the Affordable Care Act generally became applicable to group health plans and health insurance issuers offering group or individual health insurance coverage for plan or policy years beginning on or after September 23, 2010. However, the Proposed Rule provides that student health insurance coverage is required to comply with the PHSA and the Affordable Care Act provisions applicable to individual coverage, as modified by the Proposed Rule, effective for policy years beginning on or after January 1, 2012. Therefore, colleges and universities that offer a SHP that qualifies as student health insurance coverage that is currently not in compliance with the PHSA or the Affordable Care Act are provided some extra time to transition their student health insurance coverage to comply with the PHSA and the Act. The Department of HHS states in the preamble to the Proposed Rule that the delayed effective date is provided to avoid disruption to the student health insurance market and to maintain the offering of SHPs to students.

**III. Effect of the Affordable Care Act on SHPs**

1. **Coverage Mandates Applicable to Student Health Insurance Coverage**

SHPs that meet the definition of “student health insurance coverage” under the Proposed Rule are subject to the Act's individual health insurance coverage mandates, as modified by the Proposed Rule, effective the first policy year beginning on or after January 1, 2012. The following coverage mandates will apply:

- **No Lifetime or Annual Dollar Limits.** Plans cannot have any lifetime limits on the dollar value of essential health benefits for any participant or beneficiary. Plans can only have restricted annual limits on the dollar value of such benefits until 2014. As discussed in the previous section, the Proposed Rule provides transitional relief for student health insurance coverage with respect to the restricted annual limits.

- **No Rescissions.** Plans may not rescind coverage once an individual is enrolled, except in cases of fraud or intentional misrepresentation of a material fact or nonpayment of premiums.

- **Pre-Existing Condition Exclusions.** Plans are prohibited from imposing pre-existing condition exclusions for individuals enrolled in the plan who are under 19 years of age. The Department of HHS has invited comments with respect to the application of this provision on student health insurance coverage.

- **Preventive Health Services.** Plans must provide certain preventive services, such as tests, screenings, and immunizations, at no cost. As discussed above, student administrative health fees are not considered cost-sharing requirements for purposes of applying this provision. The Department of HHS has invited comments with respect to the application of this provision on student health insurance coverage.

- **Extension of Dependent Coverage.** Plans that provide dependent child coverage must make coverage available to an adult child regardless of marital status, student status, residency or any other condition until the child turns age 26.

- **Emergency Room Services.** Plans that provide coverage for hospital emergency department services must do so without requiring prior authorization, regardless of whether the service provider is a participating provider, and without imposing requirements or costs different
from those imposed on in-network participating providers [34].

- **Provider Choice.** Plans that require a participant or beneficiary to affirmatively designate a primary care provider or a pediatrician must permit the participant or beneficiary to designate any participating primary care provider or pediatrician who is available to accept the participant or beneficiary and who is in the plan’s network. If such plans also provide coverage for obstetrical and gynecological care, they must permit women participants to have direct access to such care without referral or authorization from a primary care physician [35].

- **Internal Review and External Appeals Processes.** Plans must implement minimum internal claims and appeals processes and external review processes [36].

- **No Discrimination on the Basis of Health Status.** Plans are prohibited from discriminating against an individual with regard to eligibility or coverage based on factors including health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, and any other factor as determined by the Department of HHS [37]. This provision applies to student health insurance coverage and forms a part of the definition of student health insurance coverage.

- **Minimum Loss Ratios and Rebates.** Fully-insured group and individual plans must submit reports to the Department of HHS for each plan year concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. The plan must generally provide an annual rebate to each enrollee on a pro-rata basis if the loss ratio is less than 80 percent (85% for group coverage) [38]. The Department of HHS stated in the preamble to the Proposed Rule that there may be unique administrative expenses for student health insurance coverage that warrant developing methodologies that take such expenses into account in calculating the measure of activities to be reported as part of the MLR requirements. The Department of HHS has invited comments with respect to the application of this provision on student health insurance coverage [39].

- **Uniform Notice.** By March 23, 2012, plans must provide a uniform summary of benefits and coverage explanation that accurately describes benefits and coverage under the plan to participants prior to enrollment. The summary must be presented in a culturally and linguistically appropriate manner utilizing terminology understandable by the average plan enrollee. The content and format will be prescribed by statute and standards developed by the Secretary of the Department of HHS [40].

These requirements will likely increase the cost of SHPs, and may make it difficult for some SHPs to continue to exist. However, the relief provided under the Proposed Rule with respect to certain provisions help to allay some of the concerns held by those in the higher education community [41].

Additional coverage mandates and market reforms under the Affordable Care Act take effect for policy years beginning on or after January 1, 2014. These include restrictions on waiting periods, limits on deductibles and out-of-pocket expenses, guaranteed issue and renewability, rating for establishing health insurance premiums, and requirements that the coverage satisfies the rules for an "essential health benefits package." The Proposed Rule did not address the applicability of 2014 requirements on student health insurance coverage. The Department of HHS has invited comments on the impact 2014 requirements would have on student health insurance coverage, and the Department has indicated that it may address the applicability of those provisions in future regulations. Given the interpretation of the Savings Clause adopted by the Department of HHS in the Proposed Rule, it seems likely that student health insurance coverage would be exempted from any provision that is contrary to the nature of a SHP, or that would effectively prohibit colleges and
universities from being able to offer SHPs.

The Department of HHS has also invited comments regarding the interaction of student health insurance plans and state exchanges that become effective in 2014. At least one comment letter has requested that the final rules permit eligible students and their dependents to take advantage of the premium tax credits and cost sharing subsidies available through the state exchanges in order to purchase student health insurance coverage from their institution [42].

2. The Individual Mandate

The Proposed Rule would appear to qualify many SHPs as “minimum essential coverage” through which students can satisfy their individual responsibility to maintain health coverage under the Affordable Care Act. The Act requires that most U.S. citizens and residents [43] either secure “minimum essential coverage” or pay a tax beginning January 1, 2014 [44]. Individuals who fail to comply with this mandate, or whose tax dependents fail to comply with this mandate, are generally subject to a tax penalty for each month without coverage [45]. Accordingly, to the extent that a student remains a dependent of his or her parents, the parent would be responsible for paying the tax penalty on the part of the student [46].

“Minimum essential coverage” includes coverage under:

- Government-sponsored programs such as Medicare, Medicaid, CHIP, TRICARE, veterans coverage, or Peace Corps coverage;
- Eligible employer-sponsored plans [47];
- Health plans offered in the individual market within a State;
- Grandfathered health plans; and
- Such other health benefit coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services recognizes for purposes of this rule [48].

SHPs that meet the definition of “student health insurance coverage” under the Proposed Rule would be treated as a type of individual health insurance coverage, and would, therefore, clearly qualify as minimum essential coverage. However, it remains unclear as to how colleges and universities provide documentation for students to prove they have minimum essential coverage.

It does not appear that SHPs that satisfy the definition of short-term limited-duration insurance would qualify as minimum essential coverage. Moreover, self-insured SHPs do not appear to fall within any category that would qualify as minimum essential coverage. However, while the Department of HHS states in the Preamble to the Proposed Rule that it has no authority to regulate self-insured SHPs, it could issue guidance that would recognize self-insured SHPs as minimum essential coverage if they satisfied the requirement of student health insurance coverage as defined under the Proposed Rule [49].

Prior to issuance of the Proposed Rule, several interest groups requested that the Secretary of the Department of HHS use her authority under the Affordable Care Act to issue regulations clarifying that SHPs qualify as minimum essential coverage [50]. This direct clarification may no longer be necessary for the vast majority of SHPs that will satisfy the requirements of “student health insurance coverage.” However, to the extent colleges and universities continue to offer self-insured SHPs or SHPs that meet the definition of short-term limited-duration insurance, the qualification of such coverage as minimum essential coverage will continue to be a question.
CONCLUSION:

The future for SHPs under the Affordable Care Act is still not completely clear, but the Proposed Rule released by the Department of HHS answers a number of questions. The Proposed Rule specifically determined that SHPs are a form of individual health insurance coverage. In clarifying the definition of short-term limited-duration insurance, the Department of HHS eliminated a long-held view that many SHPs were short-term limited-duration insurance even when students were permitted to renew their coverage year after year. The Proposed Rule also began to answer the question of how the Affordable Care Act applies to student health insurance coverage. The Department of HHS’ interpretation of the Savings Clause permits it to take a fairly flexible approach with SHPs. Rather than finding that the Savings Clause exempted SHPs from the Affordable Care Act altogether on the one hand, or finding that SHPs were fully subject to the Act's provisions on the other, the Department is instead evaluating the Act's applicability to student health insurance coverage on a provision-by-provision basis to determine whether a requirement would effectively prohibit colleges and universities from being able to offer SHPs.

Further regulatory clarification will be necessary to understand the extent of the Affordable Care Act's application to SHPs in 2014 and beyond, and changes may still be necessary in order for many SHPs to survive when forced to compete with State-run exchanges. Until such guidance is issued, colleges and universities sponsoring SHPs will need to consider how the Affordable Care Act impacts their program as it is uniquely designed, and what changes it will need to implement in order to comply with the applicable Affordable Care Act provisions that will become effective in 2012.

FOOTNOTES:


FN4. See American College Health Association, Standards for Student Health Insurance/Benefits Programs (March 2008).


FN8. See 42 U.S.C. § 300gg-91(a)(1). The term "group health plan" means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. § 1002(1)]) to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance,
reimbursement, or otherwise. Section 3(1) of the Employee Retirement Income Security Act defines “employee welfare benefit plan” as “any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both . . . .”


FN12. 26 CFR § 54.9801.2; 45 CFR § 144.103.

FN13. SHPs are still regulated at the state level, however, as group health insurance, blanket coverage, or otherwise under the insurance code.

FN14. Some interest groups and observers took issue with the short-term limited-duration insurance exemption, arguing that it does not apply to the vast majority of SHPs and that the Affordable Care Act should apply to SHPs either as group or individual health insurance plans. See Letter from Young Invincibles to Kathleen Sebelius, Sec’y of Dept. of HHS, and Nancy-Ann DeParle, Dir. of White House Office of Health Reform (Sept. 10, 2010); Bryan Liang and Tim Mackey, Health Care Mandates: A Reply, INSIDE HIGHER ED, Nov. 17, 2010. Even those interest groups and observers that supported the continuing application of the short-term limited-duration insurance exemption, however, have conceded that SHPs should be subject to some requirements under the Affordable Care Act. See Letter from Molly C. Broad, President of American Council on Education, to Kathleen Sebelius, Sec’y of Dept. of HHS, and Nancy-Ann DeParle, Dir. of White House Office of Health Reform (Aug. 12, 2010), enclosing June 2, 2010 Memorandum entitled “Preserving Affordable College Student Health Insurance: Group-Like Rating Status;” Letter from Jim Mitchell, Lookout Mountain Group, to Kathleen Sebelius, Sec’y of Dept. of HHS, and Nancy-Ann DeParle, Dir. of White House Office of Health Reform (Aug. 20, 2010) (“August 20, 2010 LMG Letter”).

FN15. 42 U.S.C. §§ 300gg-91(b)(1) & (2).

FN16. There were two competing views regarding the Savings Clause prior to the publication of the Proposed Rule. One interpretation held that SHPs were completely exempt from the Affordable Care Act, and could continue to operate as they have historically operated as short-term limited-duration insurance or self-insured plans outside of federal regulation. An alternative interpretation focused on the phrase “otherwise permitted under applicable Federal, State or local law,” to mean that SHPs must comply with the Act’s requirements otherwise applicable to health plans.

FN17. “Health status-related factor” under the Proposed Rule has the same meaning as applies to group health insurance, and includes health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. See 45 CFR § 144.103, 45 CFR § 146.121(a).

FN18. For example, the preamble to the Proposed Rule states that if there were no written agreement between the institution of higher education and the health insurance issuer, such coverage would be subject to all of the individual market requirements in the PHSA and the Affordable Care Act.

FN19. Prop. Reg. at 45 CFR §§ 147.145(b)(1) & (2); PHSA §§ 2741(a) and 2742.

FN20. 45 CFR § 144.103.
FN21. PHSA § 2741(e)(1).

FN22. PHSA §§ 2702, 2703.

FN23. PHSA § 2742(b)(5).

FN24. Essential health benefits include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and pediatric services. Affordable Care Act § 1302(b).

FN25. Under the interim final rules, annual limits on the dollar value of essential health benefits generally cannot be lower than: $750,000 for plan/policy years beginning on or after September 23, 2010 but before September 23, 2011; $1.25 million for plan/policy years beginning on or after September 23, 2011 but before September 23, 2012; and $2 million for plan or policy years beginning on or after September 23, 2012 but before January 1, 2014.

FN26. PHSA § 2711, as added by Affordable Care Act §§ 1001(5) and 10101(a).

FN27. The GAO study found annual limits under SHPs ranging from $15,000 to $250,000, with the median being $50,000. See 76 Fed. Reg. 7769 (Feb. 11, 2011).

FN28. For additional information regarding each of these mandates, see Tara Sciscoe, NACUANOTES: Health Care Reform and College and University Employee Health Care Plans: The Initial Impact (October 26, 2010).

FN29. PHSA § 2711, as added by the Affordable Care Act §§ 1001(5) and 10101(a).

FN30. PHSA § 2712, as added by the Affordable Care Act § 1001(5).

FN31. PHSA § 2702, as added by the Affordable Care Act § 1201.

FN32. PHSA § 2713, as added by the Affordable Care Act § 1001(5); see HHS Interim Final Regulations, 45 CFR § 147.130.

FN33. PHSA § 2714, as added by the Affordable Care Act § 1005(5), and revised by Section 2301(b) of the Health Care and Education Reconciliation Act of 2010; see HHS Interim Final Regulations, 45 CFR §§ 147.100 to 147.120.

FN34. PHSA § 2719A, as added by the Affordable Care Act § 1001(5); see HHS Interim Final Regulations, 45 CFR § 147.138.

FN35. PHSA § 2719A, as added by the Affordable Care Act § 1001(5); see HHS Interim Final Regulations, 45 CFR § 147.138. See American Council on Education April 12, 2011 Comment Letter to Department of HHS requesting that final rule clarify that, for purposes of student health insurance, the participating primary care provider can be defined as being a provider within the institutions’ student health service (“ACE April 12, 2011 Comment Letter”).

FN36. PHSA § 2719, as added by the Affordable Care Act §§ 1001(5) and 10101(g); see HHS Interim Final Regulations, 45 CFR § 147.136.

FN37. PHSA § 2705, as added by the Affordable Care Act § 1201.

FN38. PHSA § 2718, as added by the Affordable Care Act §§ 1001(5) and 10101(f); see
FN39. See ACE April 12, 2011 Comment Letter.

FN40. PHSA § 2715, as added by the Affordable Care Act § 1001(5).


FN42. See ACE April 12, 2011 Comment Letter.

FN43. There are exemptions from the individual mandate for individuals with certain religious beliefs, illegal aliens, incarcerated individuals, low income individuals who cannot afford coverage, individuals with income below the filing threshold, and members of Indian tribes. 26 U.S.C. § 5000A(d), (e).

FN44. 26 U.S.C. § 5000A(a), as added by the Affordable Care Act § 1501(b); but see *Virginia ex rel. Cuccinelli v. Sebelius*, 702 F. Supp. 2d 598 (E.D. Va. 2010) (finding the Affordable Care Act § 1501 to be an unconstitutional extension of the Interstate Commerce and Tax Clauses of the U.S. Constitution); but see, e.g., *Liberty Univ., Inc.*, No. 10 Civ. 00015 (W.D. Va. 2010) (upholding the constitutionality of the Affordable Care Act § 1501); *Thomas More Law Center v. Obama*, No. 10 Civ. 11156 (E.D. Mich. 2010) (same).

FN45. 26 U.S.C. § 5000A(b)(1), as implemented by the Affordable Care Act § 1501(b).

FN46. Dependent means a tax dependent within the meaning of Code Section 152. 26 U.S.C. § 5000A(b)(3).

FN47. “Eligible employer-sponsored plan” is defined to mean, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is a governmental plan or any other plan offered in the small or large group market within a State, including a grandfathered health plan offered in a group market. 26 U.S.C. § 5000A(f)(2).


FN49. See ACE April 12, 2011 Comment Letter.

FN50.Specifically, the American Council on Education, along with several other higher education associations, submitted a comment letter to the Secretary in August 2010, requesting that she designate, by regulation, that student health coverage constitutes “minimum essential coverage” under the individual mandate if it: (1) is offered by an eligible educational institution; (2) is made available to students and their dependents without regard to health status or pre-existing conditions; and (3) meets the actuarial standards for a “bronze plan” under the rules applicable to state-based exchanges. The Lookout Mountain Group submitted a comment letter shortly thereafter, also asking the Secretary to use her discretion to allow SHPs to qualify as minimum essential coverage, but modifying the last requirement to provide that the SHP “include the essential benefits required for group health plans” that meet the actuarial standards for a bronze plan.” See August 20, 2010 LMG Letter.
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