

CALIFORNIA—OZONE—Continued
[8-Hour standard]

Designated area	Designation ^a		Classification	
	Date ¹	Type	Date ¹	Type
That portion of San Bernardino County which lies north and east of a line described as follows: Beginning at the San Bernardino-Riverside County boundary and running north along the range line common to Range 3 East and Range 2 East, San Bernardino Base and Meridian; then west along the Township line common to Township 3 North and Township 2 North to the San Bernardino-Los Angeles County boundary; And that portion of San Bernardino County which lies south and west of a line described as follows: latitude 35 degrees, 10 minutes north and longitude 115 degrees, 45 minutes west.				
San Diego County, CA:				
San Diego County (part) That portion of San Diego County that excludes La Posta Areas #1 and #2, ^b Cuyapaibe Area, ^b Manzanita Area, ^b and Campo Areas #1 and #2. ^b	Nonattainment	.....	Subpart 1.
San Diego County (part) La Posta Areas #1 and #2 ^b	Unclassifiable/Attainment		
Cuyapaibe Area ^b	Unclassifiable/Attainment		
Manzanita Area ^b	Unclassifiable/Attainment		
Campo Areas #1 and #2 ^b	Unclassifiable/Attainment		

^a Includes Indian Country located in each county or area, except as otherwise specified.

^b The boundaries for these designated areas are based on coordinates of latitude and longitude derived from EPA Region 9's GIS database and are illustrated in a map entitled "Eastern San Diego County Attainment Areas for the 8-Hour Ozone NAAQS," dated March 9, 2004, including an attached set of coordinates. The map and attached set of coordinates are available at EPA's Region 9 Air Division office. The designated areas roughly approximate the boundaries of the reservations for these tribes, but their inclusion in this table is intended for CAA planning purposes only and is not intended to be a Federal determination of the exact boundaries of the reservations. Also, the specific listing of these tribes in this table does not confer, deny, or withdraw Federal recognition of any of the tribes so listed nor any of the tribes not listed.

^c The use of reservation boundaries for this designation is for purposes of CAA planning only and is not intended to be a Federal determination of the exact boundaries of the reservations. Nor does the specific listing of the Tribes in this table confer, deny, or withdraw Federal recognition of any of the Tribes listed or not listed.

¹ This date is June 15, 2004, unless otherwise noted.

² This date is June 4, 2010.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 147, and 158

CMS-9981-F

RIN 0938-AQ95

Student Health Insurance Coverage

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule establishes requirements for student health insurance coverage under the Public

Health Service (PHS) Act and the Patient Protection and Affordable Care Act (Affordable Care Act). The final rule defines "student health insurance coverage" as a type of individual health insurance coverage, and specifies that certain PHS Act requirements are inapplicable to this type of individual health insurance coverage. This final rule also amends the medical loss ratio and annual limits requirements for student health insurance coverage under the PHS Act.

DATES: *Effective Date.* This rule is effective on April 20, 2012.

Applicability Dates. The amendment to 45 CFR Part 147 applies to student health insurance coverage for policy years beginning on or after July 1, 2012. The amendments to 45 CFR Part 158 apply beginning January 1, 2013, to

health insurance issuers offering student health insurance coverage.

FOR FURTHER INFORMATION CONTACT: Robert Imes, (410) 786-1565.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act (Pub. L. 111-148) was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) was enacted on March 30, 2010. We refer to the two statutes collectively as the Affordable Care Act. The Affordable Care Act reorganizes, amends, and adds to the provisions of Part A of Title XXVII of the Public Health Service (PHS) Act relating to group health plans and health insurance issuers in the group and individual markets.

Section 1560(c) of the Affordable Care Act provides that “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.”

On February 11, 2011, we published a proposed rule (76 FR 7767) regarding section 1560(c) entitled “Student Health Insurance Coverage.” In the preamble of the proposed rule, we explained that we interpreted section 1560(c) to mean that if particular requirements in the Affordable Care Act would have, as a practical matter, the effect of prohibiting an institution of higher education from offering a student health plan otherwise permitted under Federal, State or local law, such requirements would be inapplicable pursuant to section 1560(c). Accordingly, the proposed rule defined “student health insurance coverage” and specified that a small number of individual market requirements in the PHS Act and the Affordable Care Act would not apply to student health insurance coverage. We also asked for comments on how other Affordable Care Act requirements should apply in the case of student health insurance coverage. We received approximately one hundred comments in response to the proposed rule. They include comments from institutions of higher education and their associations, students and student organizations, faculty members, consumer organizations, health insurance issuers, and brokers.

II. Provisions of the Proposed Rule

The February 11, 2011 proposed rule included the following:

Definition. The proposed rule defined student health insurance coverage as a type of individual market health insurance coverage offered to students and their dependents under a written agreement between an institution of higher education and an issuer. Student health insurance coverage could not be offered to individuals other than students and their dependents, could not condition eligibility based on health status, and had to satisfy any additional requirements imposed under State law.

Exemptions from the PHS Act. The proposed rule would exempt student health insurance coverage from the guaranteed availability requirement of PHS Act section 2741(e)(1) and the guaranteed renewability requirement of PHS Act section 2742(b)(5). The proposed rule also would provide that

student health insurance coverage could not establish an annual dollar limit on coverage lower than \$100,000 for policy years beginning prior to September 23, 2012. The proposed rule would apply the generally applicable annual dollar limit requirements for individual health insurance coverage for subsequent policy years.

Student Administrative Health Fees. The proposed rule would clarify that student administrative health fees were not cost-sharing for purposes of PHS Act section 2713, which requires that certain preventive services be covered without cost-sharing. Student administrative health fees were defined as fees charged by institutions of higher education on a periodic basis to provide health care through school clinics, regardless of whether students utilize the clinics or enroll in student health insurance coverage.

Notice. The proposed rule would require that issuers give students a notice informing them of their coverage’s exceptions from the specified PHS Act requirements. The notice would have to be prominently displayed in 14-point bold type on the front of the insurance policy or certificate and any other plan materials. Model language was provided.

Applicability. The proposed rule would be applicable to student health insurance coverage for policy years beginning on or after January 1, 2012.

III. Analysis of and Responses to Public Comments

We carefully considered all of the comments in drafting this final rule. The major comments are summarized below with our responses.

A. Definition of Student Health Insurance Coverage (§ 147.145 (a))

Comment: We received several comments concerning the proposed definition of student health insurance coverage in § 147.145(a). An issuer, a college association and a student advocacy group noted that, in addition to individual universities, consortia of universities and State boards of regents sometimes sponsor student health insurance coverage plans. In addition, they noted that student associations have sponsored insurance plans. A broker asked for clarification whether student health insurance coverage could encompass coverage sold to students attending high school. A college association requested clarification on what individuals can be included as dependents under student health insurance coverage. Lastly, an issuer proposed that temporary continuations

of coverage following loss of student status be limited to 90 days.

Response: The proposed definition of student health insurance coverage would not prevent consortia of universities or State boards of regents from acting on behalf of an institution of higher education in entering into a written agreement with an issuer to provide student health insurance coverage since those bodies are either a collection of universities or part of the university system. Student associations sponsoring insurance plans are not institutions of higher education under the Higher Education Act of 1965, and therefore such coverage would not be student health coverage within the meaning of the proposed rule. However, depending on their circumstances, student associations may qualify as bona fide associations under § 144.103 which would allow them to be exempt from the current PHS Act guaranteed availability and guaranteed renewability requirements. The proposed definition would not include coverage provided under an agreement between an issuer and a high school, as the definition of an institution of higher education under the Higher Education Act does not include secondary institutions.

As discussed in the proposed rule’s preamble, student health insurance plans have flexibility in determining which dependents, if any, are eligible for coverage under their plan terms. Similarly, student health insurance plans would have discretion under the proposed rule to allow temporary continuations of coverage upon events such as the loss of student status. For example, while a 90-day extension would be reasonable to allow a graduating student to transition to other coverage, a very lengthy extension, such as a 12-month extension, would not be consistent with the proposed requirement of § 147.145(a) that eligibility for student health insurance coverage be limited to students and their dependents. We are therefore adopting the proposed definition of student health insurance coverage in the final rule without change.

Comment: Nine colleges and universities urged that we allow student coverage, at least in some instances, to continue to be offered as short-term limited duration coverage. These commenters noted the temporary nature of student coverage, the fact that universities generally were issued a new policy each year, and the cost of compliance with the Affordable Care Act. Further, some universities and issuers asserted that student coverage

was not intended to provide comprehensive coverage and should rather be seen as part of the universities' risk mitigation strategies. A consumer group supported defining student health insurance as individual health insurance and noted the definition's consistency with past CMS statements. A higher education association recommended that any short-term limited duration policies issued to students be required to disclose that they do not comply with Affordable Care Act provisions.

Response: As discussed in the proposed rule's preamble, we understand that in the past many issuers have claimed that student health insurance coverage was short-term limited duration coverage and have not complied with the PHS Act. To that effect, issuers sometimes included coverage terms that were only minutes short of one year and placed disclaimers on the front pages of policies asserting non-renewable and short-term limited duration status. However, in practice, 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.

The 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 with the Affordable Care Act and the PHS Act. While there may be instances where short-term limited duration coverage is appropriately sold to students—for instance, foreign students studying for only one semester in the United States or U.S. citizens studying abroad for one summer—the short-term limited duration model does not apply to coverage that a student could have through the same health insurance issuer for one or more years during the course of his or her undergraduate or graduate education. CMS, along with the States, will monitor issuers' compliance with properly classifying student health insurance coverage following the effective date of this rule. Further, we point out that CMS has authority to impose penalties on health

insurance issuers for failures to comply with the requirements of the PHS Act.

Comment: In the proposed rule, we specifically requested comments on the prevalence, structure, and State regulation of self-funded student health plans, given that the PHS Act does not provide authority for HHS to regulate such plans. In response, three consumer advocacy groups asked that we affirmatively encourage States to regulate self-funded student health plans to the extent permissible under Federal and State law. One issuer asserted that colleges would self-fund student health plans in response to a determination that insured student health plans fall under the Affordable Care Act, in order to avoid some of the requirements of the Affordable Care Act.

Response: From the comments to the proposed rule, it appears that there are approximately 200,000 students covered through student health plan arrangements that are self-funded through colleges and universities. While some commenters would prefer uniform regulation of all student plans; as stated in the proposed rule's preamble, however, we do not have the authority to regulate self-funded student health plans. The PHS Act and the Affordable Care Act give HHS regulatory authority over health insurance issuers in the group and individual markets and over non-Federal governmental group health plans, but self-funded student health plans do not fit into these categories. The proposed rule acknowledged that because self-funded student health plans are neither health insurance coverage nor group health plans, as those terms are defined in the PHS Act, HHS has no authority to regulate them, including extending Affordable Care Act policies to them. As explained in the proposed rule, these self-funded student health plans may be regulated by the States.

B. Exemptions From the Public Health Service Act (§ 147.145(b))

Comment: Nine issuers and four universities were concerned that eliminating annual and lifetime dollar limits would result in dramatic premium hikes for student plans and that many students will not be able to afford insurance. As a result, some commenters asserted that this elimination would cause universities to stop sponsoring student health insurance plans. An issuer opined that smaller schools would not have sufficiently large enrollments that could generate the premiums necessary to cover the risk exposure from unlimited maximums on plan dollar limits. These commenters proposed alternatives such

as a slower phase-in of the annual limits rules, a permanent exception from these rules, and a waiver program under which universities could request exceptions from the generally-applicable rules.

Conversely, seven commenters, including some universities and consumer interest groups, supported the elimination of annual and lifetime dollar limits on student health insurance plans without a phase-in. Two commenters noted that while few students even come close to meeting these limits, the uncovered medical expenses could be catastrophic for those that do.

Response: In recognition of the considerable increase from \$100,000 to \$2 million in one year and in response to these comments, we have modified the proposed rule to the following schedule for restrictions on annual dollar limits—(1) annual limits of no less than \$100,000 for policy years beginning on or after July 1, 2012 but before September 23, 2012; (2) annual limits of no less than \$500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014; and (3) consistent with section 2711, no annual dollar limits for policy years beginning on or after January 1, 2014. The \$500,000 annual dollar limit requirement for policy years beginning on or after September 23, 2012 provides student health insurance coverage a more gradual transition to full compliance with PHS Act section 2711 in 2014 but also protects students from catastrophic claims except in extreme cases. This schedule ensures persons with student health insurance coverage will be more fully protected from catastrophic claims within a few years, while allowing any costs associated with this important protection to be incorporated gradually. We point out that the student policies likely to see premium increases from this requirement are those policies that currently leave students with very significant financial exposure in the event of illness or accident.

Comment: Commenters, including universities, brokers, and issuers, generally recommended that preventive service coverage be provided at student health centers, unless referrals were needed to other providers. Industry and university commenters noted that student health insurance coverage benefits typically coordinate with services offered at the student health center and that this coordination eliminates duplication of benefits and makes student plans more affordable. Industry commenters noted that student health fees, separate from the student

health insurance coverage premiums, often cover access to certain preventive services from campus providers for both students enrolled in student health insurance coverage and other students who may have other or no coverage.

Response: Student health insurance coverage must include the preventive services specified under PHS Act section 2713 and the implementing regulations (45 CFR § 147.140). However, PHS Act section 2713 and the implementing regulations do not prevent student health insurance coverage from coordinating with student health centers to ensure the provision of these services. For example, an issuer can arrange for a student health center to serve as its in-network provider where students could receive preventive services without cost-sharing. This final rule also retains the clarification that student administrative health fees are not cost-sharing under section 2713 of the PHS Act. Student administrative health fees are those that are charged to all students enrolled at a college or university, regardless of whether a student enrolls in student health coverage or utilizes any services offered by the clinic, which gives all students access to a student health clinic's services and supports a number of services and activities that foster a healthier campus community.

Comment: Most commenters asserted that it would be inappropriate to apply section 2719A, which allows choice of certain health care professionals, to student health insurance coverage because of the unique nature of the student health system environment. More than two dozen commenters, including industry, university and consumer interest groups, noted the need to preserve the student health centers' role in providing care to students. Commenters emphasized the fact that student health insurance coverage's benefits are customized to take into account the services available from campus providers. Commenters also noted that campus providers serve as gatekeepers for care and as medical homes. Conversely, one consumer group asserted that it was not necessary to grant an exception from section 2719A to student health insurance coverage because students already are incentivized to use the geographically closest providers. Additionally, a consumer advocacy group noted that students would also need adequate access to health care when away from campus.

Response: The proposed rule does not prevent a student health insurance plan from designating providers at a student health center as its in-network providers

and allowing students to choose from among those providers for purposes of satisfying section 2719A, provided that the centers have sufficient provider capacity and range of services available to support this designation. We believe that this provides an adequate incentive for students to obtain health care at the student health clinic while they are on campus, while also providing them with choice of providers when away from campus. We also note that student health centers vary in capacity and design, and some are not equipped to provide emergency services. Therefore, the final rule does not modify the proposed rule to grant student health insurance coverage exceptions from the provider choice requirements of section 2719A.

Comment: Commenters offered various approaches concerning how grandfather status should apply to student health insurance coverage. A university proposed that grandfather status apply to student health insurance coverage in the same manner that it applies to other individual health insurance coverage. Other commenters including issuers and brokers asserted that special treatment regarding grandfather status was advisable because issuers and universities were not able to predict the direction of this rule in advance and because the effective date of this rule as proposed (that is, policy years beginning on or after January 1, 2012) is much later than the Affordable Care Act's general date (March 23, 2010) for determining grandfather status. Commenters requested accommodations such as—(1) assessing grandfather status based on the student plan in place for the academic year 2011–2012; (2) setting grandfather status based on whether a university had the same or a similar policy within the parameters of the grandfather rule, not on a student-by-student basis, as a straight-forward application of the individual market rules would dictate; and (3) allowing issuers and universities a limited opportunity to revoke benefit changes that otherwise would trigger loss of grandfather status.

Response: While we understand the unique issues regarding grandfather status of student health insurance coverage, we do not have the legal discretion to alter the generally applicable grandfather rules. Grandfathering rules apply to health insurance issuers and plans across all markets. The rule defines student health insurance coverage to be a form of individual market coverage, and as such, grandfather status is determined as to the coverage in which each

individual student was enrolled on March 23, 2010. Any coverage in which an individual student is newly enrolled after March 23, 2010 is non-grandfathered.

Comment: In response to the NPRM, a public health group, a women's rights organization, a student organization from a religiously-affiliated university, and an individual student commented on the importance of student health insurance coverage including benefits for contraception. The student organization and the individual student specifically noted that their schools' plans excluded coverage for contraceptive methods.

Subsequent to the NPRM on student health insurance coverage, on August 3, 2011, CMS, along with the Department of Labor and the Department of the Treasury (the Departments), published interim final rules (IFR) with request for comments (76 FR 46621) amending the Interim Final Rules Relating to Coverage of Preventive Services, codified at 45 CFR § 147.130. The August 3, 2011 amended IFR provided the Health Resources and Services Administration (HRSA) authority to exempt group health plans established or maintained by certain religious employers (and group health insurance coverage provided in connection with those group health plans) from any requirement to cover contraceptives required as a result of any HRSA guidelines.

In response to the August 3, 2011 amended IFR, the Departments received comments from a council of religiously-affiliated schools and from numerous religiously-affiliated colleges and universities requesting that, among other suggestions, the exemption be broadened to include plans that meet the definition of a church plan under section 414(e) of the Internal Revenue Code and also to include student health insurance plans facilitated by religiously-affiliated colleges and universities. Conversely, the Departments received comments from women's advocacy organizations and from a constitutional rights organization requesting that the exemption either be stricken from the IFR or at least narrowed.

Response: With respect to certain non-profit institutions of higher education with religious objections to covering contraceptive services whose student health insurance plans are not grandfathered health plans, if the college or university and its student health insurance plan satisfy the terms applicable to an employer and its group health plan (and group health insurance coverage provided in connection with

that group health plan) under the Guidance released on February 10, 2012, establishing a temporary one-year enforcement safe harbor for group health plans established or maintained by certain non-profit, non-exempt employers with religious objections to covering contraceptive services (and group health insurance coverage provided in connection with those group health plans),¹ the college or university and the issuer of the student health insurance coverage will also be subject to the temporary one-year enforcement safe harbor, and contraceptive benefits will not have to be provided in its student health insurance plan until policy years beginning on or after August 1, 2013. Satisfaction of such terms includes sending the requisite notice to the students enrolled in the student health insurance plan and the institution of higher education maintaining on file the requisite self-certification.

Before the end of the temporary enforcement safe harbor, the Departments will work with stakeholders to develop alternative ways of providing contraceptive coverage without cost-sharing to students of non-profit religious institutions of higher education with religious objections to such coverage. Specifically, the Departments plan to initiate rulemaking to require issuers to offer student health insurance plans without contraceptive coverage through such an institution and simultaneously to offer contraceptive coverage without cost-sharing directly to the student health insurance plan enrollees (and their dependents). Under this approach, the Department also will require that, in this circumstance, there be no charge for the contraceptive coverage. Actuaries, economists and experts have found that coverage of contraceptives is at least cost neutral when taking into account all costs and benefits in the health plan.

C. Notice (§ 147.145(d))

Comment: While commenters uniformly supported a notice requirement concerning how student health insurance coverage differs from other individual market coverage, they had various recommendations concerning the notice's content and

appearance. Some consumer groups agreed with the proposed rule's specific approach. Other commenters, including provider associations, consumer advocacy groups and issuers, submitted a range of proposed changes to the notice, including that it—(1) Use terms likely to be understood by enrollees, such as using “new health reform law” in place of “PHS Act”; (2) provide contact information for State or local consumer assistance services; (3) clearly list exceptions from the PHS Act and the Affordable Care Act in a bulleted fashion; (4) be limited to one sentence in length; (5) use a conspicuous font and display; (6) permit font and display to conform more to the style of the document into which it is incorporated; (7) be provided in languages other than English; and (8) be allowed to be posted on schools' intranets. One consumer group suggested that notice regarding the special rules on guaranteed availability and renewability are unnecessary. In addition, two commenters recommended that the notice requirement sunset when the annual dollar limit requirement for student health insurance becomes consistent with that for all other individual health insurance coverage.

Response: While we retain the proposal that a notice should be provided to a student and any dependents describing how their coverage differs from other individual market coverage, and that the disclosure should be provided in the insurance policy or certificate and any other written materials for the coverage (for example, enrollment information), we include some modifications in the final rule in response to comments. We note that the proposed rule set out a model notice, with the intent of allowing health insurance issuers flexibility to create their own notice, provided that it met certain criteria.

In response to recommendations from commenters, the final rule modifies the content of the notice requirement, as well as simplifies the model notice. The content criteria was modified by removing the notice regarding guaranteed availability and guaranteed renewability, leaving only the content to inform students if the policy does not meet the annual limits restrictions. Additionally, the revised model notice in the final rule uses the term “health care reform law,” given that this phrase may be more understandable to consumers. Required language was also added advising students that they may be eligible for coverage under their parents' employer group health plan or a parent's individual market coverage if they are under the age of 26. This is

important because coverage under a parent's employer or a parent's individual market plan may contain all of the protections of the Affordable Care Act, including adherence to the annual dollar limits requirements. In addition, we clarify that the notice must be provided in the insurance policy or certificate and in any other plan materials summarizing the terms of the coverage (such as a summary description document). Finally, the final rule sunsets the notice requirement when the annual limits requirement is consistent with other individual health insurance coverage.

D. Applicability (§ 147.145(e))

Comment: One consumer advocacy group recommended that January 1, 2012 be the latest date for student health insurance coverage to comply with the individual market requirements. This commenter expressed concern that by establishing policy years beginning on or after January 1, 2012 as the effective date for the rule, most students will have to wait until the 2012–2013 school year to benefit from the rule. A related concern of the commenter was that this effective date allows issuers to increase premiums and collect as much profit as possible before the Federal MLR requirements take effect.

One issuer urged HHS to issue a final rule no later than August 1, 2011 or otherwise delay the effective date so that issuers have adequate time to prepare for compliance. The commenter explained that negotiations for and sales of 2012–2013 academic year policies will occur in the Fall of 2011.

Response: We recognize the concerns of issuers regarding timing, but we had to ensure that the final rule is consistent with other policies. We believe that the timing of this final rule provides sufficient time for issuers to comply with the new provisions for the 2012–2013 academic year.

Comment: Issuers and brokers raised several general issues concerning the applicability of the PHS Act and the Affordable Care Act to foreign students studying in the United States. They asserted that plans for inbound foreign students have unique administrative cost structures, benefit designs, and medical utilization patterns, which differ substantially from plans for domestic students. These commenters suggested that, because of these differences, schools should be allowed to offer separate plans for international students that are subject to different requirements than domestic health plans. One commenter asked that we exempt health plans for students who are not United States citizens from the

¹ “Guidance on the Temporary Enforcement Safe Harbor for Certain Employers, Group Health Plans and Group Health Insurance Issuers with Respect to the Requirement to Cover Contraceptive Services Without Cost Sharing Under Section 2713 of the Public Health Service Act, Section 715(a)(1) of the Employee Retirement Income Security Act, and Section 9815(a)(1) of the Internal Revenue Code”, February 10, 2012, which can be found at: <http://ccio.cms.gov/resources/files/Files2/02102012/2012010-Preventive-Services-Bulletin.pdf>.

PHS Act and the Affordable Care Act. In contrast, a consumer group and a school interest group urged HHS to subject international student plans to the same rules as all other individual market coverage.

Response: Health insurance coverage issued in a State, as that term is defined by the PHS Act and the Affordable Care Act, must comply with the applicable provisions of such Acts, without regard to the individuals being insured. However, as previously discussed, there may be circumstances where student coverage appropriately may still be sold on a short-term limited duration basis to foreign students, and thus the issuer would not have to comply with the PHS Act and the Affordable Care Act.

Comment: Issuers noted that the State Department's Bureau of Educational and Cultural Affairs requires students on J-1 Exchange Visitor visas to maintain health insurance coverage that includes medical benefits of at least \$50,000 per accident or illness, includes a deductible of not more than \$500 per accident or illness, and meets other requirements (22 CFR 62.14). One commenter requested that we ensure that our final rule and 22 CFR 62.14 do not conflict.

Response: We reviewed the requirements under 22 CFR 62.14 and believe that issuers will be able to comply both with those rules and this final rule.

Comment: Commenters offered a range of comments on the rule's interaction with State laws. A State insurance department requested a clarification that States could impose more stringent standards on student health insurance coverage than those under this rule. The State insurance department offered an example of a State requiring more detailed disclosures. One issuer requested this rule preempt State laws imposing additional standards on student health insurance coverage. On the other hand, several universities submitted a form letter urging that student health insurance coverage be subject only to State laws. A broker asserted that most States regulate student health insurance coverage as a form of blanket or group health insurance and urged that CMS allow States to continue to regulate student health insurance coverage in that fashion. Finally, several consumers expressed concern that student health insurance coverage would not be subject to rate review under PHS Act section 2794, as added by Affordable Care Act section 1003.

Response: As discussed in the preamble to the proposed rule, the PHS Act only preempts State standards and

requirements to the extent that they prevent the application of a PHS Act requirement. (PHS Act sections 2724 and 2762). States may impose additional requirements on student health insurance (for example, additional disclosure requirements) and States may continue to regulate student health insurance coverage as a form of group or blanket health insurance, provided these standards do not prevent the application of the relevant individual market provisions of the PHS Act.

Section 1560(c) permits limited exemptions for student health insurance coverage from those generally applicable Affordable Care Act requirements that, as a practical matter, would prohibit the offering of student health insurance coverage. Section 1560(c) does not allow CMS to except student health insurance coverage from compliance with all Federal requirements. Further, many commenters pointed out the inadequacy of many current student health insurance plans, which suggests that compliance solely with State laws has failed to ensure that students had access to comprehensive coverage in the past.

Issuers must comply with the Federal rate review process in 45 CFR Part 154 for non-grandfathered health insurance coverage that is included under a State's definition of individual market coverage or small group market coverage.

E. Issuer Use of Premium Revenue: Reporting and Rebate Requirements (Part 158)

Comment: While the proposed rule did not include a specific proposal as to how Federal medical loss ratio (MLR) requirements in PHS Act section 2718 would apply to student health insurance coverage, we specifically requested comments on this issue. Section 2718 provides for the calculation of an issuer's MLR based on the percentage of premium revenue that is spent on health care claims and quality improvement, and directs that rebates be paid if this amount does not meet the minimum standard. We specifically invited comments on whether to make an adjustment to the MLR methodology to reflect the "special circumstances" of student health coverage, as allowed under PHS Act section 2718(c). Pursuant to our request in the proposed rule, we received several comments on the Federal MLR requirements as they relate to student health insurance coverage.

One university and student advocates strongly supported applying Federal MLR requirements to student health insurance coverage in the same manner as they apply to individual market

insurance generally. This would mean using the standard methodology for calculating the MLR and applying the 80 percent standard for individual market insurance to the MLR produced by this standard methodology.

A majority of the brokers, agents, TPAs and issuers, however, asserted that applying the Federal MLR requirements to student health coverage without any special circumstances adjustment would be inappropriate and would force issuers to leave the student health insurance market. These commenters asserted that it would be difficult for student coverage to meet the Federal MLR requirements because of the unique operational and administrative nature of such plans. Most issuers stated that if the standard method for calculating the Federal MLR were applied, their MLRs would be between 65 percent and 82 percent. One issuer commented that only large issuers would be able to fold student insurance into their overall individual market blocks of business and continue to operate at the required Federal MLR standard if no adjustment were made to the methodology for calculating the MLR.

Specific examples of the unique administrative costs cited by several commenters include—(1) The transient nature of the student population, leading to high turnover; (2) more frequent enrollment periods; (3) the level of plan design customization required by different schools; (4) the operation and administration of student waiver programs; and (5) special billing practices related to student health centers. Additionally, one issuer asserted that college students' unfamiliarity with the health care system increases the cost of administrative expenses for student health plans.

Several issuers also provided specific recommendations to address the application of the Federal MLR requirements. A majority of these commenters proposed developing a special MLR methodology for student coverage. Two issuers recommended that student coverage in effect should be held to no higher than a 70 percent or 75 percent MLR. Several commenters suggested that student plans should be aggregated nationally as their own pool, and a few requested that the MLR reporting year should be based on an academic year or a policy year because this is how student plans are sold. One issuer specifically noted that it does not sell other individual health insurance coverage and, therefore, would not have any other individual market business to aggregate with the student experience.

Another issuer had specific comments regarding when rebates should be due, and who should receive them.

Lastly, two commenters including an educational association recommended that HHS research, either independently or through an independent organization, whether student health plans have unique administrative expenses that warrant special treatment.

Response: We considered the comments and have reviewed additional data that supports the claim that student health plans have special circumstances specifically relating to their administrative cost structures. Accordingly, this final rule amends 45 CFR Part 158 by expressly stating that issuers of student health insurance coverage are subject to the individual market reporting and rebate requirements of the MLR rule. While some commenters requested modifying the Federal MLR percentage standard for student plans, HHS does not have the authority to change the MLR percentage standard for plans. HHS does have authority under PHS Act section 2718(c), however, "to take into account the special circumstances of smaller plans, different types of plans, and newer plans" in determining the methodology for calculating an issuer's MLR. This amendment to Part 158 exercises this authority by recognizing the special circumstances of student plans for purposes of the application of the Federal MLR requirements. The amendment to Part 158 provides that the experience for student coverage is to be reported separately from other individual market coverage. Further, given that student health insurance coverage is provided a separate pool, apart from other individual market coverage, the amendment provides for national aggregation of student health insurance coverage.² In addition, by taking into account the special circumstances of student health insurance coverage and helping to ensure continued access to student health insurance coverage, this amendment to Part 158 comports with section 1560(c) of the Affordable Care Act, which provides that nothing in Title I of the Affordable Care Act (or any amendments) be construed to prohibit universities from offering student health insurance plans.

Also in response to comments from issuers, universities and student advocates and data from issuers and the NAIC, this amendment to Part 158

provides that the calculation of incurred claims and quality improving activities is to be multiplied by 1.15 in 2013. HHS has determined that this phased-in adjustment to the numerator for student health insurance coverage for the MLR requirements is sufficient to account for the special circumstances of student health plans, specifically their unique administrative costs. As mentioned above, issuers of student health insurance coverage commented that, based on current operations and unique costs associated with student coverage, they currently meet a 70 percent to 75 percent MLR standard and, therefore, would need an adjustment to meet the 80 percent MLR standard and place them on a glide path to compliance in 2014. The student health plan-specific MLR methodology is in effect for MLR reporting year 2013, and no special treatment is provided in MLR reporting year 2014 and beyond. As mentioned above, issuers provided many examples of the unique administrative expenses in the student market. While some of the expenses are inherent in the nature of student coverage (such as, high enrollee turnover and manual claims processing for student clinics), there are other administrative costs where issuers can potentially gain efficiencies in their operations (such as, marketing and plan customization). The phase-in of the MLR requirements is intended to provide issuers additional time to become more efficient in their operations and meet the individual market MLR requirement of 80 percent. We believe that this policy is responsive to the concerns of commenters, while still maintaining the protections under the Affordable Care Act. The rule also provides that the MLR reporting year for student coverage will be on a calendar year basis, beginning January 1, 2013. We maintained the calendar year MLR reporting structure for student coverage because, under Part 158, issuers currently report other individual market coverage on a calendar year basis. In addition, issuers of student health insurance coverage will be subject to the rebate provisions in Part 158, consistent with other individual market coverage. Since student health insurance coverage is individual market coverage, the rebates will be distributed directly to the student in the same manner as rebates from other individual market coverage. Lastly, the amendment to Part 158 includes conforming changes clarifying how life-years and credibility adjustments are applied to the student market.

F. Provisions of the Public Health Service Act Effective in 2014

Comment: Pursuant to our request in the proposed rule for comments on the applicability of other Affordable Care Act provisions, we received a large number of comments on the interaction between student health insurance coverage and various Affordable Care Act reforms effective in 2014.

Five commenters argued that PHS Act section 2702 and 2703, the 2014 guaranteed availability and renewability provisions, should not apply to student health insurance coverage, consistent with the proposed rule's exemption from PHS Act section 2741 and 2742, the current HIPAA guaranteed availability and renewability requirements. One commenter further pointed out the need to have flexibility to limit guaranteed availability to open enrollment periods.

Three universities and a consumer advocacy group expressed concern that universities would stop sponsoring student health insurance due to coverage being available through the Affordable Insurance Exchanges. One university asserted students are better served purchasing coverage while enrolling for classes, while another university expressed concern that provider networks could be inadequate for students with coverage through an out-of-state Exchange. Four commenters requested that the subsidies available through the Affordable Insurance Exchanges be available for use with student health insurance coverage and self-funded student plans. On the other hand, three commenters opposed the offering of student health insurance coverage through the Affordable Insurance Exchanges, arguing that this would interfere with the administration of colleges' mandatory insurance requirements and that, in any event, most students' family income levels would disqualify them for subsidies.

Several commenters requested that student health insurance coverage and self-funded student health plans be specifically recognized as minimum essential coverage. Two commenters suggested that self-funded student health plans be required to meet the same coverage requirements as student health insurance coverage in order to be deemed minimum essential coverage.

Lastly, two commenters proposed that student health insurance coverage continue to have its experience separately pooled, notwithstanding the single risk pool requirement that otherwise goes into effect for the individual market in 2014, and one commenter proposed that student health

² Because student health insurance plan data will be aggregated nationally, a single 80 percent MLR standard will apply in determining rebates, even if some of the aggregated data come from States with adjusted individual market percentages.

insurance coverage be deemed large group coverage and therefore exempt from the essential health benefits package requirements.

Response: We considered the comments concerning those Affordable Care Act provisions that become effective in 2014 and have decided to address these issues with respect to student coverage in conjunction with final regulations concerning the Affordable Insurance Exchanges, the market requirements of the PHS Act, the definition of minimum essential coverage, tax credits for premium assistance, and other 2014 issues.

As noted, the proposed rule included exemptions for student health plans from the current guaranteed issue and renewability requirements of PHS Act sections 2741 and 2742 for policy years beginning on or after July 1, 2012.

IV. Provisions of the Final Regulations

For the most part, this final rule incorporates the provisions of the proposed rule. The provisions of this final rule that differ from the proposed rule are:

- *Annual limits.* We modified the phase-in schedule so that student health insurance coverage cannot have annual dollar limits on essential health benefits less than \$500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014.

- *Notice Requirement.* We streamlined the content of the notice requirement by removing notice of the exemption regarding guaranteed availability and guaranteed renewability and simplified the model notice by using terms more easily understood by students and their dependents. Required language was also added advising students that they may be eligible for coverage under their parents' employer or individual market coverage if they are under the age of 26. In addition, we added a sunset provision to the notice in 2014 for when the annual limits requirements become consistent with other individual health insurance coverage.

- *Medical Loss Ratio.* We amended 45 CFR Part 158 by expressly stating that issuers of student health insurance coverage are subject to the reporting and rebate requirements of the MLR rule. However, as allowed by PHS Act section 2718(b)(1)(A)(ii), adjustments to the

MLR numerators are provided for MLR reporting year 2013 due to their unique circumstances. In addition, we added specific provisions to § 158.120 providing that student coverage will be aggregated nationally as its own pool rather than on a State by State basis, and its experience will be reported separate from other policies. Lastly, the rule includes conforming changes regarding how credibility adjustments are applied to the student health insurance market.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for 45 CFR 147.145(d), which contains information collection requirements (ICRs). Section 147.145(d)(1) requires issuers of student health insurance coverage to provide notice to enrollees that the policy does not meet the minimum annual limits requirement of the Affordable Care Act. In addition, the final regulation requires that the disclosure must be prominently displayed in clear, conspicuous 14-point bold type. Additionally, the final regulation provides model language that issuers of student health insurance coverage can use in order to be in compliance with the notice requirement. The model language is provided in 45 CFR 147.145(d)(2).

In order to provide the notices, the issuers of student health insurance coverage will need to review the model

language or draft their own language, incorporate the plan or issuer's name into the model notice (or a notice that is similar to the model), and print the notice in any plan or policy documents that are regularly sent to student enrollees.

Minor changes in the notice requirement from the proposed rule create no additional burden beyond that calculated in the proposed rule. The final rule modifies the content of the notice requirement, as well as simplifies the model notice. The content was modified by removing the notice regarding guaranteed availability and guaranteed renewability and by using the term "health care reform law." Required language was also added advising students that they may be eligible for coverage under their parents' employer or individual market coverage if they are under the age of 26. In this final rule, we are adopting the burden estimate in the student health insurance coverage proposed rule. This burden estimate encompasses the entire notice process which includes assembly of the notice. It is estimated that approximately 75 student health insurance coverage issuers will have to provide such notice.³ We estimate that it will take approximately 2 minutes per student enrollee or approximately 1,000 hours per student health insurance issuer to prepare and mail the notices to students. Including hourly wage and printing and mailing costs, we estimate the annual cost burden will be \$40,840 per affected issuer for a total cost of \$3,063,000. In some cases, actual burden per notice (for example, postage) may be lower because we expect that many issuers will insert the model language into the existing plan materials that they were already intending to send to enrollees each year.

³ This estimate is based on data from the 2009 National Association of Insurance Commissioners (NAIC) Annual Accident and Health Policy Experience Exhibit and the American Council on Education (ACE). The 2009 NAIC filings show that there are 58 health insurance issuers offering student health coverage; however this data does not include managed care plans in California, and may include some issuers offering K-12 student accidental health coverage. In addition, data from the American Council on Education suggests that there are several smaller plans offering student health plans.

TABLE 1—ANNUAL REPORTING, RECORDKEEPING AND DISCLOSURE BURDEN

Regulation section(s)	OMB Control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)	Hourly labor cost of reporting (\$)	Total labor cost of reporting (\$)	Total capital/maintenance costs (\$)	Total cost (\$)
§ 147.145	0938—New	75	2,250,000	.0333	75,000	26.14	3,063,000	0	3,063,000
Total .....	.....	75	2,250,000	.....	75,000	.....	.....	.....	3,063,000

For purposes of MLR and rebate reporting under Part 158, this final rule generally conforms the requirements for issuers of student plans to the requirements for the individual market under the MLR interim final regulation. One exception is that health insurance issuers that sell student plans will report the experience separately from other coverage. In addition, such experience will be aggregated on a national basis. Because the MLR interim final rule accounted for health insurance issuers for individual market coverage reporting on an annual basis, we are not imposing any additional requirements for health insurance issuers. In fact, as a result of the national aggregation of these plans, the burden on health insurance issuers of complying with this final rule will decrease.

We have submitted an information collection request to OMB for review and approval of the information collection requirements contained in this final rule. The requirements are not effective until approved by OMB and assigned a valid OMB control number.

VI. Regulatory Impact Analysis

In accordance with the provisions of Executive Order 12866, this rule was reviewed by the Office of Management and Budget.

A. Summary

As stated earlier in this preamble, this final rule is designed to address several issues that have arisen regarding the applicability of the Affordable Care Act to student health insurance coverage, including how this coverage is categorized under the PHS Act. Specifically, the provisions in this final rule clarify which protections of the PHS Act and the Affordable Care Act apply to student health insurance coverage, and to what extent students and their dependents enrolled in these plans have the benefit of these consumer protection provisions. This final rule defines student health insurance coverage as a type of individual health insurance coverage and specifies certain PHS Act and Affordable Care Act provisions as inapplicable to this type of individual health insurance coverage. These

provisions are generally effective for student health insurance policy years beginning on or after July 1, 2012.

CMS has crafted this rule to implement the protections intended by Congress in the most economically efficient manner possible. We have examined the effects of this rule as required by Executive Order 12866 (58 FR 51735, September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)). In accordance with OMB Circular A–4, CMS has quantified the benefits, costs and transfers where possible, and has also provided a qualitative discussion of some of the benefits, costs and transfers that may stem from this final rule.

B. Executive Orders 13563 and 12866

Executive Order 12866 (58 FR 51735) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 (76 FR 3821, January 21, 2011) is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a final rule—(1) Having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement

grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year), and a “significant” regulatory action is subject to review by the OMB.

As discussed below, we have concluded that this final rule would likely not have economic impacts of \$100 million or more in any one year or otherwise meet the definition of an “economically significant regulation” under Executive Order 12866. Nevertheless, CMS has opted to provide an assessment of the potential costs, benefits, and transfers associated with this final rule. This assessment is based primarily on the estimated administrative costs to issuers associated with providing the required notifications to student health plan enrollees. As discussed below, we believe that this final rule will have a minimal effect on premiums.

1. Need for Regulatory Action

In order to address several issues that have arisen regarding the applicability of the Affordable Care Act to student health insurance coverage, including how this coverage is categorized under the PHS Act, this final rule specifies that student health insurance coverage will be defined as a type of individual health insurance coverage and, with the exception of certain specific provisions, be subject to the individual market provisions of the PHS Act and the Affordable Care Act. As discussed elsewhere in the preamble, in clarifying the general applicability of the PHS Act and the Affordable Care Act to student health insurance coverage, this final rule also specifies that a limited number of provisions of the PHS Act and the Affordable Care Act are inapplicable to student health insurance coverage. Section 1560(c) of the Affordable Care Act provides that “[N]othing 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.” CMS interprets this provision of the Affordable Care Act to mean that if particular requirements added by the Affordable Care Act would have, as a practical matter, the effect of prohibiting an institution of higher education from offering a student health plan otherwise permitted under Federal, State or local law, such requirements would be inapplicable pursuant to the rule of construction in section 1560(c). As discussed elsewhere in the preamble, based on data provided by stakeholders representing colleges and universities and students, CMS has determined that if student health insurance coverage were required to comply with certain provisions of the Affordable Care Act, this would be the functional equivalent of “prohibiting” the educational institutions from making such coverage available to students. Therefore, this final rule clarifies that student administrative health fees are not cost-sharing requirements under section 2713 of the PHS Act; and provides for a transition period for issuers of student health insurance coverage to comply

with the restricted annual dollar limits requirements and methodology for calculating the MLR under the Affordable Care Act. The final rule also announces a temporary one-year enforcement safe harbor with respect to certain non-profit colleges and universities with religious objections to covering contraceptive services. CMS believes that the clarifications that are included in this final rule are necessary to facilitate the offering of student health insurance plans, consistent with the requirements of section 1560(c) of the Affordable Care Act.

2. Summary of Impacts

In accordance with OMB Circular A–4, Table 2 below depicts an accounting statement summarizing CMS’s assessment of the benefits, costs, and transfers associated with this regulatory action. CMS has limited the period covered by the regulatory impact analysis (RIA) to 2012–2013. Estimates are not provided for subsequent years because there will be significant changes in the marketplace in 2014 related to the offering of new individual and small group plans through the Affordable Insurance Exchanges. Additionally, because this final rule clarifies that student health insurance coverage is subject to the provisions in the Affordable Care Act, including how these plans are categorized under the PHS Act, the RIA does not estimate the

overall effect of imposing the Affordable Care Act provisions on these plans. Instead, the RIA focuses on the modifications to the applicability of individual market requirements that would have a potential impact during the years 2012 to 2013. That is, providing for a transition period for issuers of student health insurance coverage to comply with the restricted annual dollar limits policy of section 2711 of the PHS Act and the MLR calculation methodology of section 2718 of the PHS Act, and announcing a temporary one-year enforcement safe harbor with respect to certain non-profit colleges and universities with religious objections to covering contraceptive services. These modifications are designed consistent with section 1560(c) of the Affordable Care Act. Because some final rule provisions are modified from the proposed rule, the RIA has been revised to reflect these changes.

CMS anticipates that the provisions of this final rule will help ensure that institutions of higher education can maintain the offering of student health insurance coverage by clarifying the inapplicability of certain requirements of the PHS Act and Affordable Care Act that would prohibit the offering of such coverage. In accordance with Executive Order 12866, CMS believes that the benefits of this regulatory action justify the costs.

TABLE 2—ACCOUNTING TABLE

Benefits:
Qualitative:

- * Continued coverage, access to preventive services and other Affordable Care Act patient protections, and continuity of care for students.
- * Increased transparency relating to benefits offered in student health insurance coverage.

Costs and Transfers:	Estimate	Year dollar	Discount rate percent	Period covered
Annualized Monetized (\$millions/year)	3.1	2011	7	2012–2013
	3.1	2011	3	2012–2013

Annual costs related to providing notifications to enrollees.

Qualitative:

- * Reduced rate of premium growth for student health insurance coverage from 2012 through 2013 than would have occurred under immediate compliance with the restricted annual dollar limit requirements.
- * Increased out-of-pocket costs for a small number of enrollees.
- * Reduced rebate receipts for a small number of enrollees.

3. Estimated Number of Affected Entities

Comprehensive sources of data concerning the number of persons covered by student health insurance plans and the benefit structure of those plans are not readily available. Additionally, available survey data do not adequately capture this population due to small sample sizes and the

difficulty of differentiating student health insurance coverage from other individual market coverage. However, we were able to develop some estimates based on a Government Accountability Office (GAO) report and data provided by the American Council on Education (ACE).

a. Estimated Number of Plans Offering Student Health Insurance Coverage

There were 4,409 degree-granting institutions in 2009, including two-year and four-year institutions.⁴ The GAO found that 57 percent of colleges and

⁴ U.S. Department of Education, National Center for Education Statistics. (2010). *Digest of Education Statistics, 2009 Table 265*. http://nces.ed.gov/programs/digest/d09/tables/dt09_265.asp.

universities offered student insurance plans from 2007 to 2008,⁵ suggesting that approximately 2,500 colleges and universities offered such an insurance plan. According to industry sources, approximately 1,500 to 2,000 institutions offer student health plans, and the vast majority of these plans are insured (rather than self-funded) plans.⁶

In a survey of colleges with student health plans, GAO found that all but 4 percent established some maximum benefit amount during the 2007 to 2008 academic year. Most (68 percent of plans) defined the maximum in terms of per condition per lifetime. Approximately 24 percent of the plans defined an annual limit (including plans with a per year or per condition per year limit).⁷

Additionally, as discussed earlier in the Collection of Information Requirements section, CMS estimates that there are approximately 75 health insurance issuers that offer student health insurance coverage that is provided to eligible students and their dependents through written agreements that are negotiated with the abovementioned colleges and universities that offer such coverage.

b. Estimated Number of Individuals Enrolled in Student Health Insurance Coverage

The GAO has estimated the percentage of college students aged 18 through 23 years old who are insured through non-employer-sponsored private health insurance programs, including student health insurance programs. GAO found that 7 percent of college students aged 18 through 23 were covered by non-employer-sponsored private health insurance programs, including student health insurance programs.⁸ However, almost one-half of all college students are not in this age group.

The National Center for Education statistics (NCES) has projected that there will be 19.0 million college students in 2012, including both undergraduate and graduate, approximately one-half of

whom will be in the 18–23 age range.⁹ Based on the previous GAO findings, a reasonable estimate of the total number of persons with student health insurance is approximately 1.3 million (approximately 7 percent of the estimated 19.0 million total college students). A separate source of information estimates that the five largest carriers offering student health insurance account for approximately 1.2 to 1.5 million undergraduate and graduate enrollees; in addition, industry sources estimate that approximately 200,000 students are covered through student health plan arrangements that are self-funded through colleges and universities, and a relatively small number by insurers beyond the five largest carriers.¹⁰ By comparison, 2009 data from the National Association of Insurance Commissioners' (NAIC) Accident and Health (A&H) Policy Experience Exhibit suggest that health insurance issuers offered college student policies with approximately 1.1 million enrollees (based on estimated member years, including dependents).¹¹ There is clearly some uncertainty about the number of people enrolled in student health insurance coverage, but it appears likely that there are between 1.1 million and 1.5 million enrollees.

Table 3 presents the estimated distribution of persons covered by student health insurance according to the annual limits of their policies, based on two different data sources. Regardless of which data source is used, the estimated number of students affected by this rule is small. The first data source represents the distribution of annual limits in the individual

market, as presented in Table 3.3 of the interim final rule relating to section 2711 of the Affordable Care Act, regarding lifetime and annual dollar limits on benefits (75 FR 37188, June 28, 2010). Because that table did not use the annual limits thresholds relevant to this rule, the estimated number of persons in each cell was prorated. Because the Affordable Care Act prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from establishing lifetime dollar limits, for purposes of this analysis we assume that the plans with such limits (for example, 71.9 percent of the 199 plans in the GAO survey) have no annual limit. Another 4.0 percent of plans have had no limit of any type. Of the plans with per condition per year limits (13.6 percent), none had limits exceeding \$100,000. The distribution of the remaining 10.6 percent of plans was estimated based on three statistics reported in the GAO report.¹²

The second data source represents the findings from the 2008 GAO report. According to the GAO's analysis, only 24 percent of student health plans had an annual limit of any sort. Although the GAO found that most student health insurance coverage included lifetime benefit limits during the 2007 to 2008 academic year (for example, per condition per lifetime), such limits are prohibited under current law and hence are not relevant to this analysis.

A commenter expressed concerns about the data in Table 3, that it was inconsistent with the finding from the GAO study that annual limits ranged from \$15,000 to \$250,000, with the median being \$50,000. We would like to clarify that this statement applies to only the plans that had annual limits. The preceding paragraphs explain how the data from the GAO study was used to estimate the distribution in Table 3. In the GAO study, only 24 percent of the plans had annual limits, 71.9 percent of the plans had lifetime limits but no annual limit and another 4 percent had no annual or lifetime limits. As explained previously, for the purpose of this analysis, plans with lifetime limits only were treated as having no annual limits.

The GAO estimate suggests that approximately 300,000 students would potentially be affected by the rule to allow student health insurance coverage to have annual dollar limits on essential health benefits lower than the \$750,000 that would be required in the absence of this rule.

¹² These four percentages do not sum to 100 percent due to rounding.

⁹ U.S. Department of Education, National Center for Education Statistics. (2009). *Digest of Education Statistics, 2008, Table 190*. <http://nces.ed.gov/fastfacts/display.asp?id=98>.

¹⁰ Based on information compiled by the American Council on Education, primarily from the American College Health Association and the health insurance industry, September 2010.

¹¹ This represents data for 32 health insurance issuers (for example, licensed entities with unique NAIC company codes) that reported earned premiums and enrollment for student business in the individual or group markets on the NAIC Accident & Health (A&H) Policy Experience Exhibit for 2009, and excludes experience for companies regulated by the California Department of Managed Health Care. These issuers represent a subset of the 58 total issuers who reported any kind of student business on the NAIC A&H Policy Experience Exhibit for that year. CMS estimates that 16 issuers whose average premium per enrollee was approximately \$200 or less were primarily reporting data for K–12 student accidental health coverage, which is not subject to the provisions of this rule. CMS also excluded 10 issuers that did not report valid premium and/or enrollment data for student business from this analysis. In cases where data for member years were unavailable for certain issuers, CMS used data that were reported for covered lives or number of policies/certificates as a proxy.

⁵ Government Accountability Office, "Health Insurance: Most College Students Are Covered through Employer-Sponsored Plans, and Some Colleges and States Are Taking Steps to Increase Coverage," March 2008, GAO-08-389, p. 17.

⁶ It is estimated that approximately 200,000 students (less than 1 percent of the market) are enrolled in coverage offered through self-funded health plans. As discussed earlier in the preamble, these self-funded student plans are not subject to the requirements of the PHS Act because they are neither health insurance coverage nor group health plans, as those terms are defined in the PHS Act.

⁷ Government Accountability Office, March 2008, pp. 24, 27.

⁸ Government Accountability Office, March 2008, p. 10.

TABLE 3—ESTIMATED NUMBER OF PERSONS WITH STUDENT HEALTH INSURANCE COVERAGE SUBJECTED TO ANNUAL LIMITS, BY DATA SOURCE

Annual limit	CMS estimated distribution for all plans offered in the individual market		GAO distribution for student health plans with annual limits, 2007–2008	
	Percent	Number (in thousands)	Percent	Number (in thousands)
Less Than \$100,000	0.2	3	21.6	281
\$100,000–\$499,999	1.4	18	2.5	33
\$500,000–\$1,999,999	13.6	177	0.0	0
\$2,000,000 or Higher (including no annual limit)	84.8	1,102	75.9	986
Total	100.0	1,300	100.0	1,300

Note: The estimated number of persons in each cell has been prorated.

Sources: The CMS distribution was derived from CMS, 75 FR 37188, Table 3.3; the GAO distribution was derived from GAO, March 2008, GAO–08–389, pp. 24, 27.

Given that provisions of this final rule would be applicable for policy years beginning on or after July 1, 2012, and assuming that most students enrolling in student health insurance coverage do so at the beginning of the fall semester, we believe that this final rule is not likely to impact a significant number of students until late summer of 2012, at which point approximately 280,000 enrollees will see their annual limits increase to no less than \$100,000 on essential benefits (for student health insurance coverage policy years beginning on or after July 1, 2012, but before September 23, 2012), according to the GAO-based results.

Because this final rule includes a phased transition to the restricted annual dollar limits thresholds that are required under the Affordable Care Act, some students that would have otherwise experienced increases in their annual dollar limits for policy years beginning before September 23, 2012 under current law will not experience those increases. This includes an estimated 33,000 persons with coverage offering annual limits between \$100,000 and \$499,999. In the late summer of 2013, approximately 314,000 persons enrolled in coverage with annual dollar limits below \$500,000 will experience an increase in their annual dollar limits (to no less than \$500,000 for essential health benefits). Consistent with the provisions of the Affordable Care Act, no non-grandfathered student health insurance coverage will be allowed to have annual dollar limits for policy years beginning on or after January 1, 2014. These estimates are different from the proposed rule, which had different annual dollar limit thresholds.

The final rule also specifies a phased-in transition to the methodology for MLR calculation, authorized by section 2718 of the PHS Act. Section 2718(b) of the PHS Act requires issuers to provide an annual rebate to each enrollee if the

ratio of the amount of premium revenue expended on reimbursement for clinical services and activities that improve quality is less than the applicable minimum standard and also specifies how the rebate is to be calculated. For the MLR reporting year 2013, the total of incurred claims and expenditures for activities that improve health care quality is multiplied by a factor of 1.15 for student health insurance coverage. Limited data for student business in the individual and group market is available for 29 health insurance issuers in the 2009 NAIC Accident and Health (A&H) Policy Experience Exhibit.¹³ Of these, 10 issuers had less than 1,000 life-years¹⁴ each and thus, as provided by 45 CFR 158.230(c)(3) and (d), would be presumed to meet or exceed the 80 percent MLR standard. For the remaining 19 issuers, the estimated unadjusted MLRs for student health insurance plans range from approximately 12 percent to 125

¹³ This represents data for 29 health insurance issuers (e.g., licensed entities with unique NAIC company codes) that reported earned premiums and enrollment for student business in the individual or group markets on the NAIC Accident & Health (A&H) Policy Experience Exhibit for 2009, and excludes experience for companies regulated by the California Department of Managed Health Care. These issuers represent a subset of the 58 total issuers who reported any kind of student business on the NAIC A&H Policy Experience Exhibit for that year. The Department estimates that 16 issuers whose average premium per enrollee was approximately \$200 or less were primarily reporting data for K–12 student accidental health coverage, which is not subject to the provisions of this rule.

The Department also excluded 10 issuers that did not report valid premium and/or enrollment data for student business, and 2 issuers that reported anomalous combinations of premiums and claims (e.g., zero premiums and positive claims or negative claims and positive premiums) from this analysis. In cases where data for member years were unavailable for certain issuers, the Department used data that were reported for covered lives or number of policies/certificates as a proxy.

¹⁴ Life-years are the total number of months of coverage for enrollees whose premiums and claims experience is included in the data reported, divided by 12.

percent. Of these, only 3 issuers have sufficient numbers of enrollees to have fully credible experience. The remaining 16 issuers would receive a credibility adjustment, or boost, to their MLR to take into account the fact that their experience is not large enough to be fully credible. In the absence of data required for calculating the adjusted MLRs, the unadjusted MLR has been used to estimate the impact of the transitional phase in. Table 4 presents the estimated total rebates and the number of issuers and enrollees affected under the provisions in this final rule and under the methodology used to calculate an issuer’s MLR without any adjustment for the special circumstances of student health insurance coverage or credibility. It is estimated that 14 issuers will be required to pay approximately \$53,000,000 in rebates if the special circumstances of student health insurance coverage are not taken into account. Rebates owed by individual issuers range from \$34,000 to over \$33 million. High rebate amounts could affect the viability of some of the affected issuers and cause them to withdraw from the market, thereby reducing access to student health insurance coverage. If the total of incurred claims and expenditures for activities that improve health care quality are multiplied by a factor of 1.15, then it is estimated that 7 issuers will not meet the MLR requirements and will be required to pay approximately \$7,000,000 in rebates. This is a high range estimate and once all the adjustments consistent with the provisions of section 2718 of the Affordable Care Act are applied, the number of issuers affected and the amount of rebates will likely be reduced. It is also possible that issuers will undertake quality improvement activities and operational changes and efficiencies that will further increase

their MLRs and reduce the rebate amounts.

TABLE 4—ESTIMATED NUMBER OF ISSUERS OF STUDENT HEALTH INSURANCE COVERAGE AFFECTED BY PHASED TRANSITION OF MEDICAL LOSS RATIO CALCULATION METHODOLOGY

MLR calculation methodology (MLR requirement—80%)	Number of affected issuers	Total rebate amount
MLR calculated without any multiplier	14	\$53,460,000
MLR calculated with a multiplier of 1.15	7	7,115,000

While the final rule also announces a temporary one-year enforcement safe harbor with respect to certain non-profit institutions of higher education with religious objections to covering contraceptive services we have insufficient information with which to estimate its effect.

4. Anticipated Benefits, Costs and Transfers

As discussed earlier, because this final rule clarifies that student health insurance coverage policies are subject to the provisions in the Affordable Care Act, the RIA does not estimate the overall effect of imposing the Affordable Care Act provisions on these plans. Therefore, the discussion of anticipated benefits, costs and transfers focuses on the impacts associated with the clarification in this final rule that a limited number of requirements of the PHS Act and the Affordable Care Act are inapplicable to student health insurance coverage, in order to facilitate the offering of student health insurance plans, consistent with section 1560(c) of the Affordable Care Act.

a. Benefits

The final rule defines student health insurance coverage as a type of individual health insurance coverage and specifies certain PHS Act and Affordable Care Act provisions as inapplicable to this type of individual health insurance coverage. One such provision of this rule is to provide for a transition period for issuers of student health insurance coverage to comply with the restricted annual dollar limits requirements under the Affordable Care Act. For example, 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 on or after July 1, 2012, but prior to September 23, 2012 and \$500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014.

Another provision of this rule is to provide for a transition period for issuers of student health insurance

coverage to comply with the MLR requirements of the Affordable Care Act. For example, 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. Aside from these adjustments to the annual dollar limits and MLR requirements, students enrolled in student health insurance coverage will benefit from the other Affordable Care Act individual market protections, including the prohibition against rescissions, the prohibition against lifetime dollar limits, the dependents under 26 coverage requirements, preventive services and the patients' bill of rights.

While we cannot quantify them at this time, we believe there would be economic benefits to this rule resulting from improved coverage and access to health services for students because in the absence of the provisions in this rule, it is likely that there would be some reductions in student health insurance availability—for example, due to the more restricted annual dollar limits and MLR methodology requirements that otherwise would have applied in these years.

One rationale for the provision of a transition period for issuers of student health insurance coverage to comply with the restricted annual dollar limits requirements is that many student plans currently have annual limits substantially lower than the \$1.25 million requirement that will be in effect for plan years beginning on or after September 23, 2011. Concerns have been expressed that some institutions of higher education would not be able to offer student health insurance coverage if the annual dollar limits were immediately increased by those amounts. Similarly, many student plans currently have unadjusted MLRs that are significantly lower than the 80 percent requirement. According to issuers of student health insurance coverage, these plans have significantly higher administrative costs due to factors such as high rates of manual claims processing, low persistency rates,

multiple enrollment periods in a year and varied network and referral requirements. If the issuers are required to comply with the MLR methodologies applicable to traditional health insurance immediately, it might lead to reduced access to student health plans. While some students have access to dependent coverage through their parents' health insurance plans up to age 26, this may not be an option for older students and students whose parents do not have coverage.¹⁵ Some students may be able to find coverage in the medically underwritten individual market in the absence of a student health plan, and others may be able to access the Pre-existing Condition Insurance Program if they meet other eligibility criteria. However, in the absence of the provisions of this final rule, it is likely that some affected students would not be able to find affordable alternative coverage and become uninsured. To the extent that the transition period for issuers of student health insurance coverage to comply with the annual dollar limits and MLR calculation methodology applicable to other types of individual market coverage results in institutions of higher education continuing to offer coverage, benefits are realized. Students who otherwise might have been uninsured will have continued access to coverage.

Several other provisions in this final rule will also help colleges and universities to continue offering student health insurance coverage by maintaining current industry practices—including the temporary one-year enforcement safe harbor with respect to certain non-profit institutions of higher education with religious objections to covering contraceptive services, clarifications relating to the inapplicability of the current guaranteed availability and renewability requirements in the PHS Act (in order to allow student health insurance

¹⁵ Andrews, Michelle, "Health-Care Overhaul Offers Insurance Benefits to Young Adults," *The Washington Post*, May 25, 2010, accessed at <http://www.washingtonpost.com/wp-dyn/content/article/2010/05/24/AR2010052403141.html>.

coverage to be limited to eligible students and their dependents), and the clarification that student administrative health fees are not cost-sharing requirements under section 2713 of the PHS Act. Additionally, the notice requirements in this final rule will provide increased transparency relating to the benefits that are offered in student health insurance coverage. This will assist students in making the best selection among their available coverage options.

b. Costs and Transfers

In addition, as discussed earlier in the preamble, for plan years beginning after September 23, 2011, the minimum annual limit under the Affordable Care Act is \$1.25 million. This level is higher than many of the current annual dollar limits for student health plans. The required 80 percent MLR is also higher than the MLRs currently observed for student health plans. If the higher annual dollar limits and MLR methodology requirements are applied immediately, without adjustment, to student health insurance coverage benefit designs, and issuers are not able to adjust their operations quickly enough, it could require large premium increases or high rebate payments that could effectively “prohibit an institution of higher education * * * from offering a student health insurance plan.” (Affordable Care Act section 1560(c)).

However, at the same time, a small number of student enrollees are likely to face higher out-of-pocket costs than they would have faced if there were no transition period for issuers of student health insurance coverage to comply with the restricted annual dollar limits. Thus, there is a small transfer from this group which would have had higher out-of-pocket costs to the population of students purchasing student plans through lower premiums. Similarly, a small number of enrollees will not receive rebate payments that they would have received if there was no transition period for calculating the components of the MLR. Thus, there is a transfer from this group to the issuers of student health plans. In addition, a small number of enrollees will be affected by the temporary enforcement safe harbor with respect to contraceptive services.

Finally, CMS estimates that there will be some administrative costs to issuers associated with the notice requirements. As discussed in the Collection of Information Requirements section, we estimate that approximately 75 student health insurance issuers will have to provide notices to students and any dependents indicating that the coverage

does not meet all of the requirements of the Affordable Care Act. We estimate that it will take approximately 2 minutes per student enrollee or approximately 1,000 hours per student health insurance issuer to prepare and mail the notices to student enrollees. In other words, it would take a team of ten individuals 2½ weeks to prepare and mail the notices. Including hourly wage and printing and mailing costs, we estimate the annual cost burden will be \$40,840 per affected issuer, for a total cost of \$3,063,000. We believe that these cost estimates represent the upper limit, as most issuers are likely to insert the model notice language into the existing plan documents that they distribute to their enrollees, thus reducing their estimated costs.

C. Regulatory Alternatives

Under the Executive Order, CMS is required to consider alternatives to issuing rules and alternative regulatory approaches. CMS considered the two regulatory alternatives below.

1. Require Student Health Insurance Coverage To Be Offered Through a Bona Fide Association

CMS considered requiring student health insurance coverage to meet the definition of a bona fide association, as that term is defined at 45 CFR 144.103, in order to be exempt from guaranteed availability and guaranteed renewability requirements under current law provisions before 2014. This approach would have required issuers of student health insurance coverage to comply with all of the individual market requirements of the PHS Act and the Affordable Care Act, except for current guaranteed availability and guaranteed renewability provisions. However, the approach would have been cost-prohibitive on some institutions of higher education, causing them to drop coverage since student health insurance coverage today rarely is offered through associations (that is, student associations). In addition, associations affiliated with newly-established institutions of higher education would have been unable to satisfy the requirement that a bona fide association be in existence for five years.

2. Change the Definition of Short-Term Limited Duration Coverage

CMS also considered modifying the definition of short-term limited-duration insurance in 45 CFR 144.103 to make it more difficult for student health insurance coverage to qualify as such (for example, shorten the time limit from 12 months to 6 months). However, this change would have had broader

implications for the health insurance market because there are currently health insurance policies being offered in the general market that meet the current definition of short-term limited duration insurance. As indicated earlier, these products serve as stop-gap coverage for individuals who need health coverage for short periods of time. To change the definition of short-term limited duration insurance would have implications for this type of coverage.

CMS believes that the option adopted for this final rule (defining student health insurance coverage as individual health insurance coverage and limiting the applicability of the PHS Act and the Affordable Care Act through its authority under Affordable Care Act section 1560(c)) strikes the best balance of extending certain protections of the Affordable Care Act to students and their dependents enrolled in the student health insurance plans while preserving the availability and affordability of such coverage.

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) requires agencies that issue a rule to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The RFA generally defines a “small entity” as— (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000 (States and individuals are not included in the definition of “small entity”). CMS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 percent to 5 percent.

As discussed in the Web Portal interim final rule (75 FR 24481), we examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the final rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis we determined that there were few if any insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for “small” business established by the SBA (currently \$7 million in annual receipts for health insurers, based on North American

Industry Classification System Code 524114).¹⁶

Additionally, as discussed in the Medical Loss Ratio interim final rule (75 FR 74918, December 1, 2010, as modified by technical corrections (75 FR 82277, December 30, 2010)), CMS used a data set created from 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, CMS used total A&H earned premiums as a proxy for annual receipts. CMS estimated that there were 28 small entities with less than \$7 million in A&H earned premiums offering individual or group comprehensive major medical coverage; however, this estimate may overstate the actual number of small health insurance issuers offering such coverage, since it does not include receipts from these companies' other lines of business.

As discussed earlier in this regulatory impact analysis, comprehensive sources of data concerning the student health insurance market are not readily available. However, for purposes of this regulatory flexibility analysis, CMS has used data for issuers who reported offering student coverage on the 2009 NAIC Accident & Health Policy Experience exhibit as a proxy for estimating the potential number of small issuers that could be affected by the provisions in this final rule. Based on these data, CMS estimates that there are 4 small entities with less than \$7 million in A&H earned premiums that offer student health insurance coverage that is the subject of this final rule. These small entities account for 13 percent of the estimated 32 total issuers who reported offering such coverage.¹⁷

CMS estimates that 100 percent of these small issuers are subsidiaries of larger carriers, and 100 percent also offer other types of A&H coverage. On

average, CMS estimates that student health insurance coverage in the group market accounts for approximately 29 percent of total A&H earned premiums for these small issuers. Additionally, CMS estimates that the annual cost burden for these small entities relating to the notice requirements in this final rule will be \$40,840 per issuer (accounting for 2.3 percent of their total A&H earned premiums). As discussed earlier, CMS believes that these estimates overstate the number of small entities that will be affected by the requirements in this rule, as well as the relative impact of these requirements on these entities because CMS has based its analysis on issuers' total A&H earned premiums (rather than their total annual receipts). Therefore, the Secretary certifies that this final rule will not have a significant impact on a substantial number of small entities.

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a final rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. This final rule would not affect small rural hospitals. Therefore, the Secretary has determined that this final rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any final rule that includes a Federal mandate that could result in expenditure in any one year by State, local or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2011, that threshold level was approximately \$136 million.

UMRA does not address the total cost of a final rule. Rather, it focuses on certain categories of cost, mainly those "Federal mandate" costs resulting from—(1) imposing enforceable duties on State, local, or tribal governments, or on the private sector; or (2) increasing the stringency of conditions in, or decreasing the funding of, State, local, or tribal governments under entitlement programs.

This final rule includes no mandates on State, local, or tribal governments. Under the final rule, issuers will be required to provide important Affordable Care Act and PHS Act protections for students enrolled in

student health insurance coverage. Further, the estimated annual costs associated with the provisions of this final rule are approximately \$40,840 per affected entity (or approximately \$3,063,000 per year across all affected entities). Thus, this final rule does not impose an unfunded mandate on State, local or tribal governments or the private sector. However, consistent with policy embodied in UMRA, this final rule has been designed to be the least burdensome alternative for State, local and tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. In CMS' view, while the requirements specified in this final rule would not impose substantial direct costs on State and local governments, this final rule has federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to the rule of student health insurance coverage.

As discussed earlier in the preamble, some States do not regulate student health insurance as individual health insurance coverage, but rather as a type of association "blanket coverage" or as non-employer group coverage. Under this final rule, student health insurance coverage will be defined as a type of individual health insurance coverage, and will therefore be subject to the individual market provisions of the PHS Act and the Affordable Care Act, with the exception of certain specific provisions that are identified in the final rule. States would continue to apply State laws regarding student health insurance coverage. However, if any State law or requirement prevents the application of a Federal standard, then that particular State law or requirement would be preempted. Additionally, State requirements that are more stringent than the Federal requirements would be not be preempted by this final rule. Accordingly, States have significant latitude to impose requirements with respect to student health insurance coverage that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policymaking discretion of the

¹⁶ "Table of Size Standards Matched To North American Industry Classification System Codes," effective November 5, 2010, U.S. Small Business Administration, available at <http://www.sba.gov>.

¹⁷ As discussed earlier in this regulatory impact analysis, these 32 health insurance issuers are licensed entities with unique NAIC company codes that reported earned premiums and enrollment for student business in the individual and group markets on the NAIC Accident & Health Policy Experience Exhibit in 2009, and exclude companies regulated by the California Department of Managed Health Care. This represents a subset of the 58 total issuers who reported any kind of student business on the NAIC A&H Policy Experience Exhibit for that year (including some that CMS estimates are primarily offering K-12 student accident health coverage that is not subject to the provisions of this final rule).

States, CMS has engaged in efforts to consult with and work cooperatively with affected States, including consulting with State insurance officials on an individual basis.

Throughout the process of developing this final rule, CMS has attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform protections to consumers in every State. By doing so, it is CMS' view that it has complied with the requirements of Executive Order 13132. Under the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this rule, HHS certifies that the CMS Center for Consumer Information and Insurance Oversight has complied with the requirements of Executive Order 13132 for the attached final rule in a meaningful and timely manner.

G. Congressional Review Act

This final rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

List of Subjects

45 CFR Part 144

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

45 CFR Part 158

Administrative practice and procedure, Claims, Health care, Health insurance, Health plans, Penalties, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR Subtitle A, Subchapter B as set forth below:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ 1. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

- 2. Section 144.103 is amended by:
 - a. Revising the introductory text.
 - b. Adding the definition of “student health insurance coverage” in alphabetical order.

The revision and addition read as follows:

§ 144.103 Definitions.

For purposes of parts 146 (group market), 147 (health reform requirements for the group and individual markets), 148 (individual market), and 150 (enforcement) of this subchapter, the following definitions apply unless otherwise provided:

* * * * *

Student health insurance coverage has the meaning given the term in § 147.145.

* * * * *

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 3. The authority citation for part 147 continues to read as follows:

Authority: Sections 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 4. Add § 147.145 to read as follows:

§ 147.145 Student health insurance coverage.

(a) *Definition.* Student health insurance coverage is a type of individual health insurance coverage (as defined in § 144.103 of this subchapter) that is provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) 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 (as defined in § 146.121(a) of this subchapter) relating to a student (or a dependent of a student).
- (3) Meets any additional requirement that may be imposed under State law.

(b) *Exemptions from the Public Health Service Act.* (1) *Guaranteed availability and guaranteed renewability.* For

purposes of sections 2741(e)(1) and 2742(b)(5) of the Public Health Service Act, student health insurance coverage is deemed to be available only through a bona fide association.

(2) *Annual limits.* (i) Notwithstanding the annual dollar limits requirements of § 147.126, for policy years beginning before September 23, 2012, a health insurance issuer offering student health insurance coverage may not establish an annual dollar limit on essential health benefits that is lower than \$100,000.

(ii) Notwithstanding the annual dollar limits requirements of § 147.126, for policy years beginning on or after September 23, 2012, but before January 1, 2014, a health insurance issuer offering student health insurance coverage may not establish an annual dollar limit on essential health benefits that is lower than \$500,000.

(iii) For policy years beginning on or after January 1, 2014, a health insurance issuer offering student health insurance coverage must comply with the annual dollar limits requirements in § 147.126.

(c) *Student administrative health fees.*

(1) *Definition.* A student administrative health fee is 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.

(2) *Preventive services.* Notwithstanding the requirements under section 2713 of the Public Health Service Act and its implementing regulations, student administrative health fees as defined in paragraph (c)(1) of this section are not considered cost-sharing requirements with respect to specified recommended preventive services.

(d) *Notice.* (1) *Requirements.* (i) A health insurance issuer that provides student health insurance coverage, and does not meet the annual dollar limits requirements under section 2711 of the Public Health Service Act, must provide a notice informing students that the policy does not meet the minimum annual limits requirements under section 2711 of the Public Health Service Act. 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.

(ii) The notice must 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.

(iii) The notice must be prominently displayed in clear, conspicuous 14-point bold type on the front of the insurance policy or certificate and in any other plan materials summarizing the terms of the coverage (such as a summary description document).

(iv) The notice must be provided for policy years beginning before January 1, 2014.

(2) *Model language.* The following model language, or substantially similar language, can be used to satisfy the notice requirement of this paragraph (d): “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.”

(e) *Applicability.* The provisions of this section apply for policy years beginning on or after July 1, 2012.

PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

■ 5. The authority citation for part 158 continues to read as follows:

Authority: Section 2718 of the Public Health Service Act (42 USC 300gg–18), as amended.

■ 6. Section 158.103 is amended by adding the definitions of “student

administrative health fee,” “student health insurance coverage,” and “student market” in alphabetical order, to read as follows:

§ 158.103 Definitions.

For the purposes of this part, the following definitions apply unless specified otherwise.

* * * * *

Student administrative health fee has the meaning given the term in § 147.145 of this subchapter.

Student health insurance coverage has the meaning given the term in § 147.145 of this subchapter.

Student market means the market for student health insurance coverage.

* * * * *

■ 7. Section 158.120 is amended by adding paragraph (d)(5) to read as follows:

§ 158.120 Aggregate reporting.

* * * * *

(d) * * *

(5) An issuer in the student market must aggregate and report the experience from these policies on a national basis, separately from other policies.

■ 8. Section 158.140 is amended by adding paragraph (b)(3)(iv) to read as follows:

§ 158.140 Reimbursement for clinical services provided to enrollees.

* * * * *

(b) * * *

(3) * * *

(iv) Amounts paid to a provider for services that do not represent reimbursement for covered services provided to an enrollee and are directly covered by a student administrative health fee.

* * * * *

■ 9. Section 158.220 is amended:

■ a. In paragraph (b) introductory text by removing the reference “paragraph (c)” and adding in its place the reference “paragraphs (c) and (d).”

■ b. Adding paragraph (d).

The addition reads as follows:

§ 158.220 Aggregation of data in calculating an issuer’s medical loss ratio.

* * * * *

(d) *Requirements for MLR reporting years 2013 and 2014 for the student market only.*

(1) For the 2013 MLR reporting year, an issuer’s MLR is calculated using the data reported under this part for the 2013 MLR reporting year only.

(2) For the 2014 MLR reporting year—

(i) If an issuer’s experience for the 2014 MLR reporting year is fully

credible, as defined in § 158.230 of this subpart, an issuer’s MLR is calculated using the data reported under this part for the 2014 MLR reporting year.

(ii) If an issuer’s experience for the 2014 MLR reporting year is partially credible or non-credible, as defined in § 158.230 of this subpart, an issuer’s MLR is calculated using the data reported under this part for the 2013 MLR reporting year and the 2014 MLR reporting year.

■ 10. Section 158.221 is amended by adding paragraph (b)(5) to read as follows:

§ 158.221 Formula for calculating an issuer’s medical loss ratio.

* * * * *

(b) * * *

(5) The numerator of the MLR for policies that are reported separately under § 158.120(d)(5) of this part must be the amount specified in paragraph (b) of this section, except that for the 2013 MLR reporting year the total of the incurred claims and expenditures for activities that improve health care quality is then multiplied by a factor of 1.15.

* * * * *

■ 11. Section 158.231 is amended by adding paragraphs (d) and (e) to read as follows:

§ 158.231 Life-years used to determine credible experience.

* * * * *

(d) For the 2013 MLR reporting year for the student market only, the life-years used to determine credibility are the life-years for the 2013 MLR reporting year only.

(e) For the 2014 MLR reporting year for the student market only—

(1) If an issuer’s experience for the 2014 MLR reporting year is fully credible, the life-years used to determine credibility are the life-years for the 2014 MLR reporting year only;

(2) If an issuer’s experience for the 2014 MLR reporting year only is partially credible or non-credible, the life-years used to determine credibility are the life-years for the 2013 MLR reporting year plus the life-years for the 2014 MLR reporting year.

■ 12. Section 158.232 is amended by adding paragraph (e) to read as follows:

§ 158.232 Calculating the credibility adjustment.

* * * * *

(e) *No credibility adjustment.*

Beginning with the 2015 MLR reporting year for the student market only, the credibility adjustment for an MLR based on partially credible experience is zero

if both of the following conditions are met:

(1) The current MLR reporting year and each of the two previous MLR reporting years included experience of at least 1,000 life-years; and

(2) Without applying any credibility adjustment, the issuer's MLR for the current MLR reporting year and each of the two previous MLR reporting years were below the applicable MLR standard for each year as established under § 158.210 in this subpart.

Dated: October 11, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 3, 2011.

Kathleen Sebelius,

Secretary.

[FR Doc. 2012-6359 Filed 3-16-12; 4:15 pm]

BILLING CODE 4120-01-P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 1

[WT Docket No. 05-211; FCC 12-12]

Implementation of the Commercial Spectrum Enhancement Act and Modernization of the Commission's Competitive Bidding Rules and Procedures

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Federal Communications Commission removes two modifications to its competitive bidding rules pursuant to a mandate by the U.S. Court of Appeals for the Third Circuit.

DATES: Effective March 21, 2012.

FOR FURTHER INFORMATION CONTACT: Wireless Telecommunications Bureau, Auctions and Spectrum Access Division: Audrey Bashkin at (202) 418-0660.

SUPPLEMENTARY INFORMATION: This is a summary of an *Order* released on February 1, 2012. The complete text of the *Order*, including an attachment and related Commission documents, is available for public inspection and copying from 8 a.m. to 4:30 p.m. Eastern Time (ET) Monday through Thursday or from 8 a.m. to 11:30 a.m. ET on Fridays in the FCC Reference Information Center, 445 12th Street SW., Room CY-A257, Washington, DC 20554. The *Order* and related Commission documents also may be purchased from the Commission's duplicating contractor, Best Copy and Printing, Inc.

(BCPI), 445 12th Street SW., Room CY-B402, Washington, DC 20554, telephone 202-488-5300, fax 202-488-5563, Web site <http://www.BCPIWEB.com>. When ordering documents from BCPI, please provide the appropriate FCC document number, for example, FCC 12-12. The *Order* and related documents also are available on the Internet at the Commission's Web site: <http://wireless.fcc.gov/auctions>, or by using the search function for WT Docket No. 05-211 on the Commission's Electronic Comment Filing System (ECFS) Web page at <http://www.fcc.gov/cgb/ecfs/>.

I. Background

1. In *Council Tree Communications, Inc. v. FCC*, 619 F.3d 235 (3d Cir. 2010), *cert. denied*, 131 S. Ct. 1784 (2011), the U.S. Court of Appeals for the Third Circuit vacated two modifications the Federal Communications Commission (Commission) had made in 2006 to its competitive bidding rules for designated entities on the ground that the Commission had failed to provide the public an adequate opportunity for notice and comment. The Commission removes the two modifications in accordance with the Third Circuit's mandate.

2. The Third Circuit held that the Commission's impermissible material relationship rule in 47 CFR 1.2110(b)(3)(iv)(A) and its extension of the unjust enrichment period from five years to ten years in 47 CFR 1.2111(d)(2) had been adopted without the notice and opportunity for comment required by the Administrative Procedure Act. The Court thus vacated the impermissible material relationship rule and ordered reinstatement of the Commission's previous five year unjust enrichment payment schedule. The Court also denied Council Tree's petition for review with respect to the attributable-material-relationship rule articulated in 47 CFR 1.2110(b)(1) and (b)(3)(iv)(B).

II. Discussion

3. The *Order* conforms Part 1 of the Commission's rules to the Court's mandate by amending 47 CFR 1.2110 to remove paragraph (b)(3)(iv)(A) and 47 CFR 1.2111 by removing paragraph (d)(2)(i) as no longer applicable and reinstating the previous version of the payment schedule in 47 CFR 1.2111(d)(2). The *Order* also conforms other Part 1 rules, as necessary, to remove several references to impermissible material relationships.

4. The Commission finds that notice and comment are unnecessary for these rule amendments under 5 U.S.C. Section 553(b), because this is a

ministerial order issued at the direction of the United States Court of Appeals for the Third Circuit.

III. Congressional Review Act

5. The Commission will send a copy of the *Order* to Congress and the Government Accountability Office pursuant to the Congressional Review Act, *see* 5 U.S.C. 801(a)(1)(A).

List of Subjects in 47 CFR Part 1

Administrative practice and procedures, Auctions, Licensing, Telecommunications.

Federal Communications Commission.

Bulah P. Wheeler,
Deputy Manager.

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 CFR part 1 as follows:

PART 1—PRACTICE AND PROCEDURE

■ 1. The authority citation for part 1 continues to read as follows:

Authority: 15 U.S.C. 79 *et seq.*; 47 U.S.C. 151, 154(j), 160, 201, 225, 303, and 309.

■ 2. Section 1.2110 is amended by removing paragraph (b)(3)(iv)(A) and redesignating paragraphs (b)(3)(iv)(B) and (C) as paragraphs (b)(3)(iv)(A) and (B) and by revising newly redesignated paragraph (b)(3)(iv)(B) and revising paragraph (j) to read as follows:

§ 1.2110 Designated entities.

* * * * *

(b) * * *

(3) * * *

(iv) * * *

(B) *Grandfathering (1) Licensees.* An attributable material relationship shall not disqualify a licensee for previously awarded benefits before April 25, 2006, based on spectrum lease or resale (including wholesale) arrangements entered into before April 25, 2006.

(2) *Applicants.* An attributable material relationship shall not disqualify an applicant seeking eligibility in an application for a license, authorization, assignment, or transfer of control or for partitioning or disaggregation filed before April 25, 2006, based on spectrum lease or resale (including wholesale) arrangements entered into before April 25, 2006. Any applicant seeking eligibility in an application for a license, authorization, assignment, or transfer of control or for partitioning or disaggregation filed after April 25, 2006, or in an application to participate in an auction in which bidding begins on or after June 5, 2006, need not attribute the material