

# **Student Health and Student Expatriate Plans FAQs**

Last Updated 11/1/2015

## **Student Health Plans**

### **How is “student health insurance coverage” defined in the final rule?**

Student health insurance coverage is defined 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.

### **To whom can student health insurance be offered?**

Student health insurance coverage may be issued to students enrolled in an institution of higher learning and their dependents. The coverage cannot be offered to individuals other than students and their dependents.

### **Can student health insurance coverage be underwritten based on health status?**

No, issuers may not condition eligibility based on health status.

### **Does student health coverage have to cover the Essential Health Benefits (EHB)?**

Yes. Nothing in the regulation exempts student health plans from the EHB requirements.

### **Will student health plans be sold through the Marketplace?**

No, institutions of higher learning will continue to market student health plans in the traditional way. Issuers of student health plans are not required to offer a choice of plans. Neither the student health plan issuer nor the educational institution has to offer multiple plans / multiple metal levels.

### **Are student health plans required to meet actuarial value metal levels?**

Yes, these plans are subject to the AV standards that are required of all individual market plans. (Changes have been proposed by the Centers for Medicare & Medicaid Services (CMS) for 2017.)

### **Are student health plan issuers required to file CMS templates in binder filings?**

No, student health plans are not sold on the Marketplace, therefore, issuers of these plans are not required to file binders that include state or federal data templates. However, we will need to see how the benefits/plans offered are categorized/fit into the tiered-levels i.e. Platinum, Gold, Silver and/or Bronze. An institution does not have to offer multiple plans/levels. However, DIFS does need to know in a filing which metal level(s) is/are being submitted. The Unified Rate Review Template (URRT) should not be used for student health plans. (Changes have been proposed by CMS for 2017.)

### **Are there restrictions on how student health plans are rated?**

Student health plans can be rated based on their own experience or the experience of another relevant credible source. This also extends to subgroups within the school, such as domestic and international, undergraduate and graduate, etc., as long as these pools are not discriminatory based on health status. Premiums at the individual family or member level are subject to the Federal market rules for the individual market. Community rating is allowed with family tiers, as long as it is done uniformly. Dependents 21 or older, including spouses, must be rated the same as the student. Dependents under the age of 21 must be charged a uniform rate, but in no case at a level higher than the student or adult dependents and dependent premium must be capped at 3 times the student premium. Rating may also be performed on a

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per member basis, but the corresponding rates must follow the Federal age curve and the tobacco surcharge must be no greater than 50%. No other adjustments to rates are permitted (e.g. health status).

### **Is student health insurance considered to be short-term, limited duration coverage?**

No, short-term limited duration coverage is not considered student health plan coverage. Short-term limited duration coverage cannot exceed a coverage period of more than 180 days and is not renewable after that term, it also does not provide coverage for preexisting conditions. Student health plans are designed to provide 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.

### **Can student health insurance impose dollar limits on essential health benefits?**

No, dollar limits on essential health benefits in student health plans have not been permitted since January 1, 2014.

### **Must student health insurance plans provide preventive services?**

Yes, student health insurance plans must provide preventive services with no cost-sharing as required under PHS Act section 2713 and the implementing regulations.

### **What other individual market protections apply to student coverage?**

Along with no lifetime or annual limits and coverage for preventive services, student health plan issuers are prohibited from rescinding coverage, must allow dependents under the age of 26 to remain on their parents' health plan, and are subject to the patients' bill of rights.

### **Which provisions of the PHS Act do not apply to student health plans?**

The exemptions for the PHS Act include requirements for guaranteed availability (guarantee issue) of coverage and the guaranteed renewability requirements.

### **Can issuers of student health insurance plans enter into agreements with providers at student health centers?**

Yes, PHSA section 2713 and the implementing regulation do not prevent student health insurance coverage from coordinating with student centers to ensure the provision of preventive services. An issuer can arrange for a student health center to serve as its in-network provider provided that the centers have sufficient provider capacity and range of services available to support the designation as an "in-network provider."

### **Can a student health plan be considered "grandfathered" coverage?**

Grandfathered status is determined by 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.

### **Are issuers of student health plans subject to the federal rate review process?**

Yes, issuers must comply with the federal rate review process in 45 CFR Part 154 for non-grandfathered health insurance coverage.

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### **Are issuers of student health plans subject to the Medical Loss Ratio (MLR) standards?**

Yes, however, an amendment to 45 CFR Part 158 provides that the experience for student coverage is to be reported separately from other individual market coverage, with national aggregation of student health insurance coverage data rather than on a state-by-state basis, and credibility adjustments are permitted in the student health insurance market.

### **Will student coverage MLR reporting be on a plan year basis or a calendar year basis?**

MLR reporting for student health plan coverage has been required on a calendar year basis since January 1, 2013.

### **Are students eligible for MRL rebates?**

Yes, rebates will be distributed directly to the student in the same manner as rebates for other individual market coverage.

### **Are student administrative health fees considered cost-sharing under the regulation?**

No, student administrative health fees are not considered cost-sharing.

## **Expatriate Student Health Coverage**

### **Can student health plans be covered under the [Expatriate Health Coverage Clarification Act of 2014 \(EHCCA\)](#)?**

Yes, the EHCCA includes a student who is studying abroad as a qualified expatriate.

### **Would these student health plans covered under EHCCA of 2014 be subject to ACA?**

In general, no. The provisions of (including any amendment made by) the Patient Protection and Affordable Care Act ([Public Law 111-148](#)) and of title I and subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 ([Public Law 111-152](#)) shall not apply with respect to—

- expatriate health plans;
- employers with respect to any such plans for which such employers are acting as plan sponsors; or
- expatriate health insurance issuers with respect to coverage offered by such issuers under such plans.

### **Are there any standards that these student health plans covered under the expatriate health plans must meet?**

Yes, the standards for expatriate health plans specified in the EHCCA are as follows:

- all of the primary enrollees in such plan or coverage are qualified expatriates, with respect to such plan or coverage. In applying the previous sentence, an individual shall not be taken into account as a primary enrollee if the individual

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is not a national of the United States and resides in the country of which the individual is a citizen.

- all of the benefits provided under the plan or coverage are not excepted benefits described in [section 9832\(c\)](#) of the Internal Revenue Code of 1986.
- the plan or coverage provides benefits for items and services, in excess of emergency care, furnished by health care providers—
- the plan sponsor also offers a qualifying minimum value domestic group health plan, the plan sponsor reasonably believes that the benefits provided by the expatriate health plan are actuarially similar to, or better than, the benefits provided under a qualifying minimum value domestic group health plan offered by that plan sponsor; or
- the plan sponsor does not also offer a qualifying minimum value domestic group health plan, the plan sponsor reasonably believes that the benefits provided by the expatriate health plan are actuarially similar to, or better than, the benefits provided under a qualifying minimum value domestic group health plan.
- if the plan or coverage provides dependent coverage of children, the plan or coverage makes such dependent coverage available for adult children until the adult child turns 26 years of age, unless such individual is the child of a child receiving dependent coverage.
- the plan or coverage is issued by an expatriate health plan issuer, or administered by an administrator, that maintains, with respect to such plan or coverage has licenses to sell insurance in more than two countries
- maintains network provider agreements with health care providers that that provide for direct claims payments, directly or through third party contracts, with health care providers in eight or more countries
- maintain call centers, directly or through third party contracts in three or more countries and accepts calls from customers in eight or more languages
- processes (in the aggregate together with other plans or coverage it issues or administers) at least \$1,000,000 in claims in foreign currency equivalents each year
- offers reimbursements for items or services under such plan or coverage in the local currency in eight or more countries
- makes available (directly or through third party contracts) global evacuation/repatriation coverage; and
- maintains legal and compliance resources in three or more countries
- the plan or coverage, and the plan sponsor or expatriate health insurance issuer with respect to such plan or coverage, satisfies the fair health insurance premium provisions of title XXVII of the Public Health Service Act ([42 U.S.C. 300gg et seq.](#)), chapter 100 of the Internal Revenue Code of 1986, and ERISA under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 ([29 U.S.C. 1181 et seq.](#)), which would otherwise apply to such a plan or coverage, and sponsor or issuer, if not for the enactment of the Patient Protection and Affordable Care Act and title I and subtitle B of title II of the Health Care and Education Reconciliation Act of 2010.