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Regulation of Student Health Insurance/Benefit Programs (SHIBPS)
under the
Patient Protection and Affordable Care Act (PPACA)

The Lookout Mountain Group's Analysis and Recommendations
for Regulations Proposed by the
United States Department of Health and Human Services

45 CFR Parts 144 and 147
CMS-9981-P
RIN 0950-AA20
Student Health Insurance Coverage
http://www.gpo.gov/fdsys/pkg/FR-2011-02-11/pdf/2011-3109.pdf

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Section I
Overview Comments

The Lookout Mountain Group (LMG) is highly supportive of the overall objectives of the proposed regulations for student health insurance/benefit programs (SHIBPs). High quality, cost effective SHIBPs are currently being provided by four-year and graduate degree institutions in all areas of the country. They are provided in highly diverse situations (e.g., public and private governance, urban and rural locations, and in areas where health care costs are exceptionally high).

Of equal importance for preserving the availability of these programs, the proposed regulations will result in dramatic improvement for the low quality programs that New York Attorney General's 2010 report called "dangerously insufficient." Although the LMG estimates the aggregate cost of SHIBPs will increase between 54 and 68 percent (assuming all colleges continue to offer programs), under no circumstances should colleges be allowed to endorse health insurance plans for students that do not meet the minimum scope of coverage outlined in the proposed regulations before 2014 and the same scope of coverage as all other forms of health insurance after January 1, 2014. The increase in cost appears dramatic because of the large number of programs that provide nominal coverage. For the more than one-third of students covered by SHIBPs that provide comprehensive coverage or near-comprehensive coverage, the cost for compliance with the proposed regulations will not cause significant cost increases or market disruptions.

The LMG is a non-partisan study group that is not affiliated with any colleges or universities, associations, or other organizations. The members are primarily composed of a diverse group of college health professionals from over 40 campuses. Student representatives, student affairs leaders, and experts in health care reform, employee benefits, and insurance regulatory law are also a part of the LMG. The opinions and positions stated in document are solely those of the individual members of the LMG and do not represent the position of the institutions or organizations by which they are either employed or associated. Though the LMG operates by consensus, there may be members of the group who disagree with certain findings or recommendations in this document.

Inquiries regarding this document should be directed to the spokesperson for the LMG.

Jim Mitchell
Director, Student Health Service
Montana State University
(not representing the university)

Email: jimm@montana.edu
Phone: 406-994-5901

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Item A **SHIBPs Are Not Short-Term/Limited Duration Policies**	**Analysis** The US Department of Health and Human Services (HHS) presented convincing reasons why SHIBPs endorsed by colleges and universities do not operate as short-term limited duration policies and should therefore be subject to regulation under the PPACA. **Recommendation** 1. The LMG strongly supports the analysis for student health insurance plans complying with the provisions of PPACA. There is no basis for concluding that SHIBPS endorsed by colleges and universities are a form of short-term limited duration coverage and should not be regulated under the PPACA. Importantly, the LMG does not believe Congress intended to exempt SHIBPs from PPACA under the Section 1560(c) rule of construction. The LMG participated with the American Council on Education and the American College Health Association (ACHA) in the meetings and discussions with the Senate Finance Committee in the fall of 2009 where the rule of construction that became Section 1560(c) was proposed and drafted. The intent was clearly to assure that student plans were covered by PPACA. There was much concern expressed about the poor quality of many student plans and the need to address those plans. 2. HHS rightfully pointed to the 2010 report of the New York State Attorney General which identified serious shortfalls of many SHIBPs. This report, which appropriately characterized many SHIBPs as being "dangerously insufficient," is also supported by a 2009 review of SHIBPs by the Massachusetts Division of Health Care Finance and Policy, health care advocacy groups such as the Student Health Advocacy Coalition (a group of university students in the Boston area), the Young Invincibles, and The Commonwealth Fund. 3. These serious deficiencies are documented in detail in the LMG's major report of June 2009, available at the LMG's web site. As noted in this document, the substantial advantages and cost effectiveness of high quality SHIBPs should be promoted, but the termination of many low quality programs should not be viewed as a major loss of access to health insurance. Better quality plans already exist in the individual market. There is no evidence to suggest that students enrolled in low quality SHIBPs are making conscious choices to enroll in these plans versus a comparison of individual market options. Rather, it is likely that students and parents place an understandable trust in programs that are endorsed by colleges and universities. They often do not have an appropriate *caveat emptor* perspective because of such institutional endorsements. 4. HHS should issue final regulations that treat self-funded and fully insured student insurance programs on the same basis relative to benefit mandates

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	under the PPACA. The LMG also suggests that the Section 1560(c) rule of construction provides ample authority for HHS to regulate self-funded student health benefit plans. The use of the term "student health insurance plans" in the rule of construction should not be narrowly construed to mean only products offered by insurance companies or fully insured programs. Self-funded programs are commonly included in this definition. As noted in Section III, Item A, the LMG has updated its analysis to show that more than 300,000 students are presently covered by self-funded student health benefit plans. This number could easily increase to more than 400,000 by 2012, and 500,000 prior to 2014.
Item B **Long-Term Viability of SHIBPs**	**Analysis** Beyond nominal compliance with the Section 1560(c) rule of construction, there is a compelling rationale for why regulations should facilitate the long-term existence of SHIBPs. These programs can provide effective benefit integration with campus based health and counseling services, access to services to best assure personal safety and campus safety, and cost advantages for student consumers and parents, including the not-for-profit operation of self-funded programs. It is likely that continued employer cost shifting, and relative cost disadvantages for insurance exchange products, will result in almost all students being covered by SHIBPs on campuses where they are provided.* This consolidation of students into a single, college- or university-provided student health plan will increase campus safety and provide the opportunity for highly effective pre-funding arrangements for on-campus services and opportunities for maximum financial return and health care delivery/purchasing effectiveness. ** The LMG recognizes that many colleges, particularly colleges that have highly transient, local student populations, are likely to discontinue endorsing SHIBPs because their respective student populations will be better served by insurance exchange products and health insurance options under parents' dependent coverage.* **Recommendation** 1. HHS is correct in concluding that the provisions in the proposed regulations for removing requirements for guaranteed issue and guaranteed renewability are essential for the viability of SHIBPs. 2. Students enrolled in SHIBPs must be deemed to have satisfied health insurance requirements so that federal tax penalties (Internal Revenue Code [IRC §5000A(f)(1)]) will not apply under the individual coverage mandate. 3. Financial subsidies for low income students in the insurance exchanges for 2014 must be extended to the purchase of SHIBPs on the same basis as such student might have otherwise qualified for premium credits by purchasing health insurance via the insurance exchanges. 4. States should be required to provide the option for students qualifying for

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	access to Medicaid to use a funding allowance to enroll in a SHIBP (refer to 42 U.S.C., §1396e and 1396e-1). 5. It is crucial that the provisions outlined in this section should be applied to self-funded student health benefit plans to the extent such plans meet the benefit requirements specified for fully insured student health insurance programs. In particular, self-funded plans must be an option for students in the exchanges, and eligible students must have access to subsidies. Otherwise, student plans are likely to be at a cost disadvantage with respect to exchange plans that will threaten the existence of a self-funded SHIBP.
Item C **Waivers for SHIBPs Prior to 2014**	**Analysis** 1. The LMG anticipates that agents, brokers, and other advocates for the existence of low quality SHIBPs will request either delay of the proposed regulations until 2014 or request a relatively easy process for obtaining a compliance waiver. Credible analysis, including the LMG's analysis in Section III, item A, will confirm that there will be substantial cost impact on almost all low quality SHIBPs that cannot be mitigated by reduction of insurance company profits, elimination or reduction of agent or broker commissions, or other non-claims costs. 2. Analysis suggesting that requiring students to have health insurance with appropriate coverage levels will deter students from attending college because of cost concerns is not supported by the national experience of both public and private colleges providing SHIBPs that fully comply with the standards for health insurance endorsed by the American College Health Association. Almost all colleges and universities now have peer institutions that are providing high quality SHIBPs and requiring health insurance as a condition of enrollment. Only two colleges (University of Utah and Rochester Institute of Technology) are known to have adopted an insurance requirement since 1980 and then later rescinded this action. Alternatively, hundreds of colleges and universities have adopted insurance requirements and provided meaningful insurance coverage without experiencing any loss of low income students or enrollment from "at risk" student populations. **Recommendation** We do not believe waivers for student plans are necessary or good public policy. However, should HHS consider them, we feel strongly that because of the unique nature of the college or university endorsement of SHIBPs, waiver requests must be signed and submitted by the college's or university's CEO. To assure college and university accountability, waiver requests should not be allowed to be submitted from any entity other than the CEO of the college or university endorsing the SHIBP.

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Item A **Definition for Essential Benefits**	**Analysis** There is speculation that the proposed regulations would allow colleges and universities latitude in deciding whether to provide all essential benefits prior to 2014. More specifically, some entities have suggested that a SHIBP could completely exclude an essential benefit (e.g., prescription drugs); however, if such a benefit is provided, there must be no internal dollar limit under the mandate for the annual limit proposed for the 2012-13 plan year of $100,000. **Recommendation** 1. HHS should provide as much detail as possible regarding the requirement for essential benefits effective for 2012-13 and subsequent plan years. Given the possibility that a waiver process may be adopted, the LMG suggests that the definition of essential benefits should be as restrictive as required for all other forms of insurance subject to regulation under the PPACA. 2. Any options for using alternative service limits rather than dollar maximums should be explained by HHS (e.g., a $5,000 plan year for physical therapy might not be a permissible limit for rehabilitation services, but a limit of 50 visits per year for these services would be permissible).
Item B **Applicability of Federal Civil Rights Laws**	**Analysis** The proposed regulation does not address the application of existing federal civil rights law to SHIBPs: (1) Title IX of the Education Amendments of 1972 (P.L. No. 92-318, 86 Stat. 373); Section 504 of the Rehabilitation Act of 1973 (P.L. No. 93-112); and the Age Discrimination Act of 1975 (P.L. No. 94-135) as all three laws were amended by the Civil Rights Restoration Act of 1987 (20 USC §1688). **Recommendation** The final regulations issued by HHS should confirm that all three federal civil rights laws and the provisions of the Civil Rights Restoration Act of 1988 remain in effect for SHIBPs. This will resolve questions about whether coverage for the voluntary termination of pregnancy can be included as a benefit. This also assures that other key mandates will continue to apply to SHIBPs (e.g., age rating systems must have actuarial validity, and exclusions and limitations must not be so injury/illness specific that they violate Section 504 of the Rehabilitation Act of 1973).
Item C **Fiduciary Responsibility**	**Analysis** Many of the historically inappropriate practices and limited scope of coverage noted by HHS in the proposed regulations clearly result from inadequate institutional oversight. Beyond the highly important mandated coverage, effective operation of SHIBPs will best be achieved by requiring that colleges and universities recognize they have a fiduciary responsibility to

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	manage these programs for the benefit of their respective student subscribers. A broad, explicitly stated fiduciary responsibility requirement, which probably already implicitly exists to the extent that colleges and universities do not disclaim such responsibility, would place SHIBPs on the same operating plane as most employer-sponsored group health insurance plans This requirement would have more impact (e.g., application of prudent expert requirements for selection of funding systems) than adoption of medical loss ratio requirements, which will invariably require accommodation for current business models. **Recommendation** As the LMG has already advocated, and as stated in the ACHA's SHIBP Standards, colleges and universities providing SHIBPs should be required to manage their programs solely in the best interests of covered students under a fiduciary responsibility requirement. This requirement should be explicitly stated by HHS in the final regulations.
Item D **Medical Loss Ratios**	**Analysis** 1. Determining an appropriate medical loss ratio scheme will be an extremely difficult task because of the lack of credible industry data and the historically poor financial return for consumers for the operation of most fully insured SHIBPs. It is likely that any uniform minimum medical loss ratio requirement will create a *de facto* standard for the operation of SHIBPs. This will become an unfortunate ethical and legal safe harbor that will retard innovation and adoption of best practices that might otherwise occur. 2. The adoption of minimum medical loss ratios based on the insurance book of business by state (i.e., comingling student health insurance with other individual health insurance products) is likely to have significant disruptive results for the availability of various insurance organizations. **Recommendation** 1. The application of minimum medical loss ratios is only appropriate for SHIBPs with relatively small premium volume. The LMG suggests this annual premium volume threshold should not be greater than $750,000. For SHIBPs with greater premium volume, the fiduciary responsibility requirement recommended in Section III, Item C would be the most effective option. Otherwise, a graduated medical loss ratio must be developed based on premium volume. It would make no sense to have the same medical loss ratio for a plan with $500,000 in annual premium volume and a plan with $20 million in annual premium vo-

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	lume. 2. The LMG supports a provision allowing for national aggregation of student health insurance claims experience for calculation of medical loss ratios. Insurance companies should not be required or allowed to calculate medical loss ratios by commingling claims experience for non-student group or individual health insurance programs. 3. As is the case for self-funded employer-sponsored health plans, self-funded SHIBPs should not be subject to the minimum medical loss ratio requirements because of their not-for-profit status.
Item E **Preventive Care Mandate**	**Analysis** Many of the mandated preventive care benefits are already provided by colleges and universities through pre-funding arrangements collected under health fee funding arrangements. Including these benefit mandates for SHIBPs will result in a net cost increase for many students because the SHIBP funding system, in which full insured programs often return 80 percent or less of premium dollars in the form of benefit payments, is not as cost efficient as health fees or other pre-funding allocations. **Recommendation** 1. SHIBPs should be exempted from providing mandated preventive care benefits that are otherwise provided under pre-funded benefits from student health fees or other pre-funding arrangements. 2. SHIBPs should be allowed to contract for delivery of preventive care benefits with on-campus health and counseling services.
Item F **Status of Student Health Fees**	**Analysis** The proposed regulations include a discussion of the status of student health fees assessed to all students to cover the cost of student health clinic operations. The concern expressed by HHS is that these may be construed as "insurance" and thus would not permit cost sharing for the preventive services outlined in PPACA. **Recommendation** While there may be some value in a declaration that health fees are not insurance, the reality is that there is little reason for a student health service to charge co-pays for preventive services because a student faced with co-pays for preventive services will have a strong incentive to go off campus to receive these services that will be 100 percent covered by their insurance plan. Alternatively, a student health service could choose not to cover preventive services with health fee funding but instead have this covered by the student's insurance plan. The LMG recommends that the term "health fees" be broadened to include all sources of funding a university provides to operate a student health clinic

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	including a portion of tuition revenue, comprehensive fees, etc.
Item G **Choice of Health Care Professional**	**Analysis** PPACA and regulations already issued require that a participant in a health insurance plan be allowed to choose and use any health care professional on that plan's provider panel. The draft regulations concluded in the discussion of this issue that stakeholders representing colleges and universities believe this requirement would be disruptive to the current system in which choice of provider is limited. HHS has asked for comment on whether SHIBPs should be permitted to restrict the choice of health care professional. The LMG speculates that some stakeholders want to preserve arrangements that require plan participants to use student health service providers for primary care services, for example, and not permit use of other local primary care providers who are also in the insurer's PPO network. **Recommendation** Generally, the LMG does not support restricting the choice of health care providers for college students covered by SHIBPs. College health services already have a convenience advantage, and quality student health services should not have difficulty attracting patients. SHIBPs could also not charge co-pays or not apply deductibles if a plan member uses a college health provider for non-preventive care services, thus providing a financial incentive for a plan member to use the student health service provider. Note: This is one area in which the LMG was not able to reach consensus. There are LMG members who believe that having the student health service in a gatekeeper role is important for the financial stability of their student health service, their SHIBP, or both.
Item H **International Student Plans**	**Analysis** There is no mention of regulating how insurance companies will market plans with no college or university affiliation to international students. Since these non-citizens, non-taxpayers will not be affected by the mandate, there doesn't appear to be any incentive or requirement for insurance carriers to provide coverage that meets the requirements of PPACA. **Recommendation** Plans marketed to provide coverage for international students should be subject to the same benefit requirements as all other individual coverage.

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Item I College Control Requirement	**Analysis** The draft regulations state that in order to be considered a SHIBP, the plan must be under the direct control of a college or university. This means that plans under control of student governments or other groups affiliated with, but not controlled by, a university may not continue to sponsor SHIBPs. Plans that have contracts with brokers or agents rather than insurance companies may also not be permissible under this provision. **Recommendation** The LMG supports this provision in the proposed regulations.
Item J Notice Requirement	**Analysis** HHS proposes that students be informed in the years prior to 2014, if a SHIBP does not meet all the requirements of PPACA. In addition, it's likely that this provision will also apply after 2014, particularly with respect to the guaranteed issue and guaranteed renewability provisions from which SHIBPs are exempt. **Recommendation** 1. The LMG strongly supports a prominent notice requirement for SHIBPS that apply for a waiver of the mandated coverage for 2012-13 and subsequent plan years up to 2014. 2. Notice requirement pertaining to lack of guaranteed issue or guaranteed renewability would not be appropriate for SHIBPs to the extent that employer-sponsored health plans are not required to make the same notice. To the extent a college or university clearly communicates that its SHIBP is provided exclusively for its students and their eligible dependents, there is no substantive advantage for students in seeing a notice pertaining to the guaranteed issue and guaranteed renewability provisions. Students will have the unfettered choice of transitioning to employer-sponsored coverage or insurance exchange individual coverage upon loss of eligibility for SHIBP coverage.

The following points of information are presented by the LMG to clarify or question data and findings included in the proposed regulations. These items are presented in the order in which they appear in the proposed regulations.

<table>
<tr><th>Point of Information or Finding</th><th>LMG's Response</th></tr>
<tr><td><u>Item A</u>
Annual Limits (Financial Impact)
Page 7772</td><td>
HHS states on page 7772 of the proposed regulations that ". . .issuers of student health insurance coverage should be able to fully comply with the annual dollar limits requirements of not lower than $2 million for policy years beginning on or after September 23, 2012, without incurring undue hardship or without disruption to the student health insurance market given the period of time provided under the proposed rule for them to comply with the requirements."

<u>LMG's Concern or Question of Data and Findings</u>
As noted in Section II, Item C, Waivers for SHIBPs Prior to 2014, the LMG anticipates HHS will receive information from some insurance carriers that there will be a major cost impact to the student health insurance field. The following table shows the LMG's current analysis for the 2.4 million students that we presently estimate to be covered by SHIBPs (refer also to Appendix A), estimated premium volume for the 2009-10 plan year, and the impact on premium volume for compliance in 2012-13 with the essential benefits and $100,000 maximum annual benefit.
<table>
<tr><th>Number of Colleges and Universities Endorsing SHIBPs</th><th>Scope of Coverage Relative to Compliance ACHA Insurance Standards</th><th>(1) Number of Students Enrolled, (2) Average Annual Student Cost, and (3) Total Premium Volume</th><th>(1) Average Annual Student Cost after PPACA Compliance for 2012-13 @ $100,000 and (2) Total Premium Volume</th></tr>
<tr><td>200</td><td>Fully ACHA Compliant-SHIBPs</td><td>1) 500,000
2) $1,700 to $1,900
3) $850 to $950 million</td><td>1) $1,785 to $1,995
2) $893 to $998 million</td></tr>
<tr><td>200</td><td>Near ACHA-Compliant SHIBPs</td><td>1) 400,000
2) $1,100 to $1,300
3) $440 to $520 million</td><td>1) $1,200 to $1,400
2) $480 to $560 million</td></tr>
<tr><td>1,100 to 1,500</td><td>Low Quality SHIBPs</td><td>1) 1,500,000
2) $400 to $620
3) $600 to $930 million</td><td>1) $1,200 to $1,400
2) $1.8 to $2.1 billion</td></tr>
<tr><td>1,500 to 2,500*</td><td colspan="2">1) Current Total students covered by SHIBPs = 2,400,000
2) Current Average Annual Student Cost = $788 to $1,000
3) Current Average Annual Market Premium Volume: $1.9 to $2.4 billion</td><td>Premium Volume if all colleges maintain SHIBPs for 2012-13 at Proposed Benefit Level: $3.2 to $3.7 billion (54% to 68% increase)</td></tr>
</table>
</td></tr>
</table>

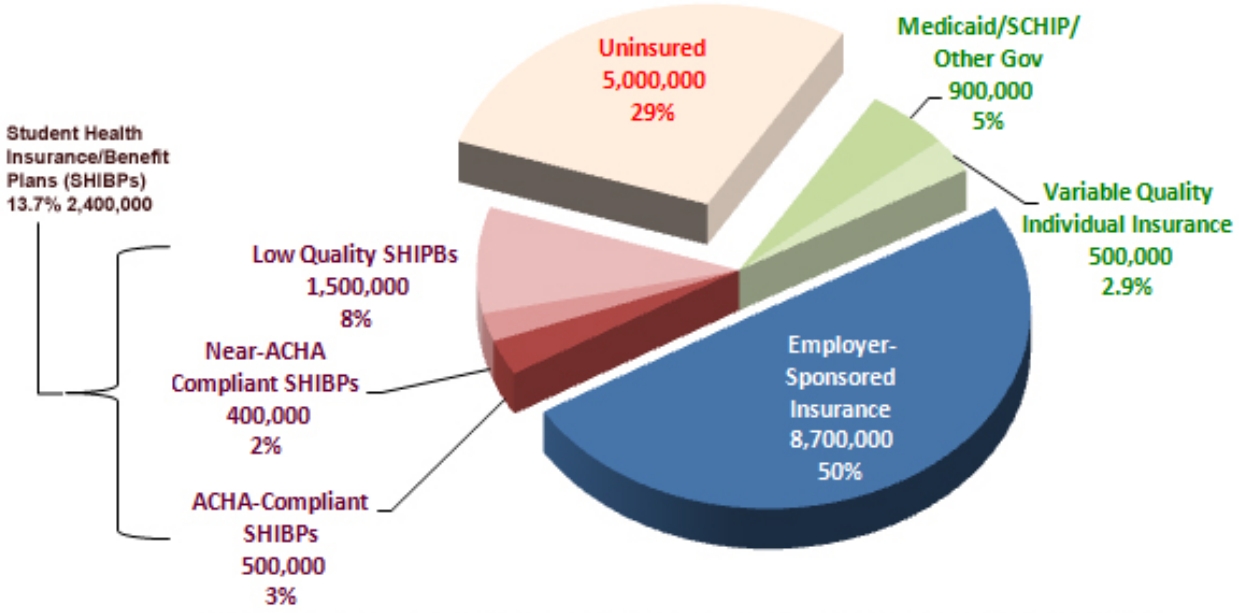
Point of Information or Finding	LMG's Response
	*The LMG does not have access to credible survey data for the number of community college SHIBPs. Accordingly, all calculations are based on survey data, largely from the American College Health Association's 2007 survey, suggest approximately 1,500 four-year and graduate-degree colleges and universities endorse SHIBPs. Total premium volume projection and the projection of 2.4 million students covered by SHIBPs includes community colleges. Increasing the plan maximum requirement from $100,000 to $2 million for the 2013-14 plan year is estimated by the LMG's consultants to add less than seven percent to premiums. Subsequent increases to unlimited coverage maximums will have nominal cost impact.
Item B **Medical Loss Ratio** Page 7773	HHS suggests there is no public data available for medical loss ratios. While these data may not be available through peer reviewed journals or other research sources, publicly issued request for proposal documents, a 2007 survey by the American College Health Association, and the experience of the LMG's diverse consultants allow the LMG to state with confidence that medical loss ratios for SHIBPs with annual premium volume in excess of $2 million are well below the fiscal effectiveness of self-funded employer-sponsored health plans. Even when state premium taxes are taken into consideration, most large fully insured SHIBPs do not have an appropriate medical loss ratio. Many programs have targeted MLRs at 80 percent or less of total premium. The LMG questions the credibility by industry stakeholders that costly enrollment/waiver processes, program marketing costs, special coordination of benefit requirements, and administration of pre-existing condition exclusions are key factors in the relatively low fiscal effectiveness of SHIBPs. The LMG suggests that lack of institutional oversight to control excessive agent/broker commissions, lack of institutional insistence on controls to capture unexpended claim funds (e.g., retrospective reserve funds and dividend account systems), and appropriate focus on long-term cost factors are primary causes for the fiscal ineffectiveness of many fully insured SHIBPs. While HHS concluded the legal basis for regulation of SHIBPs requires a determination that they are a form of individual coverage, they actually operate as group health insurance programs. The disparity in the size of premium volume also makes a medical loss ratio mandate questionable for plans with premium volume of more $750,000. The Kaiser Foundation's Employer Health Benefits 2010 Annual Survey shows that self-funding becomes prevalent for employer-sponsored health plans with 200 employees. If we assume a composite single/family paid claims level of $8,000 per employee, self-funding becomes viable by paid claims volume for employers at approximately $1.6 million. Accordingly, the LMG suggests that a premium volume-based schedule for SHIBPs with less than $1.5 million in paid claims should be considered (e.g., 80

Point of Information or Finding	LMG's Response
	percent for plans with less than $750,000 and 85 percent for plans with paid claims between $750,000 and $1.5 million. As noted in Section II, Item C, the LMG has substantial reservations about the long-term impact of any mandated target loss ratio to the operation of large SHIBPs. A much more effective method for best assuring fiscal efficiency of large SHIBPs is to formally mandate acceptance of fiduciary responsibility to manage the programs in the best interest of student consumers. This mandate would include, in part, operation of the program under a prudent expert rule. As previously noted in Section II, Item C, the LMG has concluded that national aggregation of student business will be an important option for calculation of medical loss ratios to maintain as many insurance plan vendor choices as possible for fully insured SHIBPs.
Item C **Estimated Number of Individuals Enrolled in Student Health Insurance Coverage** Page 7777	The GAO study used by HHS to conclude that only seven percent of college students are covered by SHIBPs is seriously flawed by the data limitations of the Current Population Survey (CPS) and other factors. HHS appropriately noted that almost half of all college students are not included in the CPS questionnaire, and it does not ask about student status for survey participants age 24 or older. The extrapolation of seven percent enrollment in SHIBPS to older college students is highly questionable. There are also major concerns with developing an insurance status picture based on national surveys. Given the fractured nature of the SHIBP marketplace, it is likely that the five largest carriers cover approximately 50 percent of students enrolled in SHIBPs. This would yield a result similar to the LMG's enrollment estimate of 2.4 million students covered by SHIBPs. The LMG acknowledges that national survey data for SHIBP enrollment is problematic as there is no published data for SHIBP enrollment for the more than three million students enrolled at two-year degree granting institutions.
Item D **Prevalence of Catastrophic Coverage** Page 7777	The GAO's methodology for selecting its sample for its colleges and universities SHIBP survey is unknown; however, the data extrapolation concluding that 84.8 percent of student health plans have a maximum benefit of $2 million or higher is implausible. The LMG's consultants, ACHA's 2007 survey, and any informal survey of plans at the state or regional level would show that no more than ten percent of SHIBPS provided by four-year degree granting intuitions provide this coverage level (no community colleges are known to provide this level of protection). While the number of SHIBPs providing catastrophic coverage protection has grown significantly since 2000, as reflected in the growth of colleges complying

Point of Information or Finding	LMG's Response
	with ACHA's insurance standards, from three to 15 percent from 2000 to 2010 (refer to the LMG's major report from June 2009), it is likely that more than 70 percent of all SHIBPs will have to increase the maximum benefit to comply with the $100,000 mandate for the 2012-13 plan year.

Appendix A

Insurance Status for the Nation's 17.5 Million College Students (2010)



Estimates derived from analysis of 2006 Current Population Survey (GAO report, 08-389) and insurance market surveys conducted by Hodgkins Beckley Consulting