January 12, 2010

The Honorable Nancy Pelosi
Speaker, House of Representatives
H-232 Capitol Building
Washington, DC 20515-6501

The Honorable Harry Reid
Senate Majority Leader
S-221 Capitol Building
Washington, DC 20510-7020

The Honorable John Boehner
House Minority Leader
H-204 Capitol Building
Washington, DC 20515-6537

The Honorable Mitch McConnell
Senate Minority Leader
S-230 Capitol Building
Washington, DC 20510-7010

Dear Speaker Pelosi, Majority Leader Reid, Minority Leader Boehner, and Minority Leader McConnell:

On behalf of the members of the American Council on Education (ACE), the Association of American Universities (AAU), and the Association of Public and Land-grant Universities (APLU), we appreciate that Congress is working on health care, one of the most pressing and difficult issues of our time. As you work to reconcile differences between the House-passed “Affordable Health Care for America Act” (H.R. 3962) and the Senate-passed “Patient Protection and Affordable Care Act” (H.R. 3590), we ask for your careful attention to and consideration of some key issues affecting research universities, including academic medical centers. These institutions play a unique and essential role in the provision of health care in our country.

Teaching and research are people-intensive endeavors. Research universities depend on the people they educate and employ to achieve their missions. Consistent with their missions of teaching, research, and public service, research universities take seriously their responsibility to ensure the well-being and health of the people they educate and employ, and of their surrounding communities as well. In addition to offering or providing health insurance to students, faculty, and staff, many institutions are home to academic medical centers and teaching hospitals that advance medical care and serve many beyond their campuses.

Rising health care costs increase the costs of education and research at these institutions. In fact, the unabated growth in health care costs is among the most significant drivers of tuition prices. We applaud the efforts in both bills to help reduce the growth rate of health care costs. Moreover, we appreciate that both bills will enhance access and improve health care over the long term through new programs supporting innovative medical research.

We particularly appreciate two provisions in the Senate-passed bill. One (Section 1560) would explicitly permit colleges and universities to continue to offer health insurance plans to their students. The other (Section 10602) pertains to the publication of comparative effectiveness research and potential conflicts of interest. We urge that both of these provisions be included in the final bill.
With any legislation that seeks to address a complex system such as health care, there are elements that would produce unintended consequences. As you negotiate the final version of the legislation, we ask you to consider a few issues that raise serious concerns for research universities and academic medical centers.

First, as we recently wrote in a letter from a broader group of higher education associations, the Senate-passed bill threatens the ability of all colleges and universities to continue to offer students group-like health insurance plans that are both high-quality and low-cost because it applies the individual market reforms to such plans. While we previously offered a proposed solution to this problem (attached), it was not included in the Senate-passed version. We respectfully request that you preserve the current exemption that protects the ability of colleges and universities to offer high-quality and low-cost coverage for students as specified in our proposal. Moreover, we raised concerns about the impact that future increases in states’ Medicaid costs could have on state funding for higher education and state-based student financial aid programs. We recognize the importance of Medicaid expansion to many, particularly low-income Americans, and we applaud the new mechanisms to help fund such an expansion through 2016. We urge you to consider additional alternatives to insulate states from future increased Medicaid costs, including increases in the Federal Matching Assistance Percentages (FMAP).

Second, we are deeply concerned about provisions added in the Manager's Amendment to the Senate-passed bill that would modify the recently amended False Claims Act. To be clear, we strongly support mechanisms to prevent and pursue fraud. The provisions in the Senate bill, however, would substantially weaken the existing public disclosure bar and its original source exception. These new provisions would apply to any whistleblower lawsuit filed under the statute, regardless of whether the government program at issue is a health care program. Our greatest concern is that if these provisions are enacted, they would make research universities (among others) far more vulnerable to unfounded and unnecessary qui tam lawsuits—highly expensive litigation prosecuted not by the government, but private parties. Additionally, we are troubled by the provisions that expand the application of the False Claims Act beyond government-funded programs, like the National Institutes of Health, Medicare, and Medicaid, to include private health insurance plans to be offered on the proposed new Health Insurance Exchanges. Congress amended the False Claims Act just seven months ago, significantly expanding its reach in ways that government attorneys and courts are only now beginning to implement. Further modification of the False Claims Act—particularly when such changes are so sweeping in nature—should involve the congressional committees of jurisdiction to consider how to balance carefully the risk of unintended consequences against the putative rewards of more litigation. We urge you to exclude these provisions from the final legislation.

Finally, with respect to academic medical centers, our organizations support the recommendations made by the Association of American Medical Colleges (AAMC) in its December 30, 2009, letter to Congress. Our associations are particularly concerned about the number of Graduate Medical Education (GME) training slots and proposed reductions in Disproportionate Share Hospital (DSH) payments. As AAMC and others have noted, our nation already faces a shortage of primary care physicians, and with additional population growth, an aging population, and the likely increase in the number of individuals with health insurance, the shortages will become more acute in the coming years. Neither the House nor the Senate version increases the number of GME training slots sufficiently to meet the future demand for physicians. We support the proposal offered by Majority Leader Reid during consideration of H.R. 3590 to increase the number of GME slots by 15 percent.
With respect to DSH payments, both versions of the legislation would reduce DSH payments in future years. These proposed reductions would disproportionately affect teaching hospitals. Though relatively few in number, teaching hospitals provide approximately 40 percent of indigent care in the United States. We support the AAMC recommendation that the proposed cuts in DSH payments be limited in the absence of evidence demonstrating that future expanded health care coverage will alleviate the need for DSH payments.

We are hopeful that the final legislation will make lasting improvements that will serve not only college and university students, faculty, and staff, but all citizens. We appreciate your consideration of our views.

Sincerely,

Molly C. Broad  
President, ACE

Robert M. Berdahl  
President, AAU

Peter McPherson  
President, APLU

Attachment
Preserving Affordable Student Health Insurance

SUMMARY: The Patient Protection and Affordable Care Act, H.R. 3590 (“PPACA”) should preserve high quality, cost effective student health insurance/benefit plans (“SHIBPs”) offered by colleges and universities.

BACKGROUND

Many colleges and universities currently provide health insurance for their students. Nationwide, approximately 3 million students are enrolled in SHIBPs. In addition to fully insured programs, many institutions use cost-effective self-funded arrangements.

SHIBPs are typically regulated at the state level as either group health insurance (i.e. on the same basis as employer-sponsored health insurance) or under the blanket and franchise section of the insurance code as a form of group insurance. SHIBPs are also subject to certain federal laws. Between state and federal laws, SHIBPs are not a form of individual health insurance coverage from either a regulatory or operational perspective.

SHIBPs are currently defined to be a “limited duration” form of coverage under the Public Health Service Act (“PHSA”). The provision exempts SHIBPs from the definition of “individual health insurance coverage” under the PHSA, which exempts SHIBPs from certain individual market requirements. Among other things, this exception permits colleges and universities to offer students high quality low cost group-like coverage that sets premiums as a large group would.

ANALYSIS

The PPACA states that nothing in the Act should be construed to prohibit institutions of higher education from offering a student health insurance plan. See section 1560 (pg 372). This language is a helpful recognition of the important role that universities play in providing student insurance. It appears, however, that even though colleges and universities can continue to offer coverage, their ability to offer effective SHIBPs may be threatened because the bill applies the individual market reforms to SHIBPs. This is problematic because:

1 See 42 USC 300gg-91. “The term “individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.”
• Non-Students- requires SHIBPs sold in the individual market to be offered to anyone who applies regardless of university affiliation and

• Loss of Group Rating Benefits- precludes the ability to continue the beneficial practice of group rating.

The individual market reforms apply to health plans “offered in the individual market.” Under the PPACA, the “‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.” See sec. 1304(a)(2) (pg 125).

Consequently, even though SHIBPs are not per se “individual health insurance coverage,” it seems that SHIBPs may nonetheless be considered in the PPACA as “coverage offered to individuals other than in connection with a group health plan,” which would prevent colleges and universities from offering high quality, cost advantageous SHIBPs on a group basis. This would appear to eliminate university based SHIBPs.

PROPOSAL

Remove current 1560(c) and replace with the following rule:

For purposes of this Act, and any subsequent amendments, college or university sponsored student health insurance coverage shall not be considered to be coverage offered in the individual market, provided that such student health insurance coverage meets the following requirements. Student health insurance coverage:

(1) must be offered by an “eligible educational institution” as defined in sections 101, 102(a)(1) and 102(b) of the Higher Education Act of 1965 (20 U.S.C. 1001 and 1002),

(2) is made available to eligible students and their eligible dependents as defined by the policy without regard to health status,

and

(3) must meet, at a minimum, the actuarial standards for the Bronze Plan as defined in this Act.

Student health insurance coverage that meets the previous three requirements shall be considered minimum essential coverage for the purposes of satisfying the individual responsibility requirements of this Act.