

Viewpoint: School-Sponsored Health Insurance

Planning for a New Reality

If college health services are to survive, planners must adapt to a changing healthcare environment.

by **Bryan A. Liang**

Introduction

President Clinton's attempted health reform 16 years ago included efforts to address college health services. As President Obama now tackles health care, it is an opportune time to review the state of college and university health programs and the effects of reform on them and their future. The bottom line: if college health programs are to survive, market forces and regulation will require a change from the current strategy of managed care avoidance, increased fees, limited service, and expensive programs. College and university planners must take stock and adapt to a changing health care environment if they are to fulfill the needs of their students and their institutions.

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The Historical Context

In 1993, during the height of the Clinton health care reform debate, college and university health programs were at a crossroads. Campus health center funding was being cut significantly, with a decrease in overall institutional support from 45 percent to 16 percent between 1987 and 1990. Student fees were raised in response, with revenues almost doubling from 34 percent to 63 percent of the health services budget during this same period (Brindis and Reyes 1997).

Predictably, students and their families demanded change. In fact, a *Journal of American College Health* article (Brindis and Reyes 1997, ¶ 41) asked how college health programs could continue this strategy when “students and families argue that, because they already have HMO coverage or some other insurance plan, they should not have to pay for a second, college health fee.” Parental frustrations grew further when they recognized they were actually paying three times—to keep their child on their insurance, for the health fee, and for additional expenses such as laboratory tests uncovered by campus plans (Liang, forthcoming). The article’s authors argued that “billing the managed care program for services might be more manageable and cost effective,” while the argument against billing insurers was typically based on administrative concerns (Brindis and Reyes 1997, ¶ 47).

In his reform efforts, President Clinton considered this same concept. With the growing importance of managed care came a proposal to provide employers with incentives to pay a combined student insurance plan/health services fee directly to school health plans to cover student beneficiary health needs.

Although this integration of managed care into college and university health programs was innovative, it failed when the Clinton plan failed. Ever since, managed care has grown exponentially; the integration of it into student health programs seems logical if not inevitable.

The Reform Context

Yet today, only a minority of campuses have found a way to do this, despite a U.S. Government Accountability Office (2008) report noting that two-thirds to three-quarters of students carry insurance either through a parent’s employer-sponsored managed care plan or on their own. Managed care is here to stay, and nearly everyone in the United States uses it. However, the status quo of 1993 still exists on campus—parents and students continue to pay up to three times for campus health care. To add insult to injury, those who refuse school-based insurance may pay up to five times the amount for services on campus compared with those who enroll in the school plan (Liang, forthcoming). Further, the GAO report found that school-based plans have low coverage ceilings, have “interior” caps for particular sets of services that further reduce coverage, and simply offer little for the money compared with similarly-situated managed care plans available in the community.

So while President Clinton’s reforms—albeit unsuccessfully—attempted to address college and university health, what do President Obama’s reform efforts do? At one level—perhaps most compelling—students could remain on their parent’s health insurance plan until age 27. This has broad support. Indeed, *Congressional Quarterly* noted this provision’s policy rarity: “[one] that is cheap, fairly easy to understand and universally popular” (Norman 2009, ¶ 1).

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But if college health services continue to be disassociated from managed care, this provision will simply exacerbate frustrations about multiple parent and student payments. Instead of students aged 17–23 and their families complaining, students aged 17–26 and their families will complain—and perhaps avoid certain institutions as a result.

In response to insurer profiteering, the currently proposed health reform legislation also requires that a minimum of 85 percent of premiums be spent on health care services (this figure is known as the “medical loss ratio” or MLR). But again, in comparison, college and university health programs are falling short. A recent report noted colleges and universities selling health insurance with woefully low MLRs of 55 percent and almost absurdly limited services (Liang, forthcoming; Massachusetts Division of Health Care Finance and Policy 2009). A *Business Week* investigation found even lower MLRs (Elgin and Silver-Greenberg 2008) in the context of high profits for schools and their insurer partners (Liang 2008). Indeed, a major insurance broker testified he would not buy any of the plans he and schools sell students for himself or his children (J. Boyle, pers. comm.). It is not surprising that a review of student school-sponsored health insurance program services in Massachusetts resulted in a failing grade (Rukavina et al. 2007).

Yet instead of adjusting premiums downward or increasing services, schools have taken the “cash cow” approach, either by robbing Peter to pay Paul or by vastly increasing service charges. For example:

- The University of Maryland took \$2 million set aside for the health center and used it for general budget coverage. In response, the health center attempted to increase the health fee to recover the \$2 million.

- The University of Virginia increased laboratory testing fees and now charges \$52 for a complete blood count test—a test, according to Healthcare Blue Book (2010), that should only cost \$23.

These “fixes”—and a vast majority of others (Liang, forthcoming)—breach a school’s fiduciary duty by continuing to push costs onto students and parents who already have paid separately for health insurance and are simply unsustainable.

Planning for a New Reality

Instead, by taking into account the reality of health care coverage and the needs of students and families for health care access, college and university health programs can be better stewards of their beneficiaries’ funds. Higher education planners can urge their institutions to

- *Accept managed care.* Since a vast majority of students have their own managed care health coverage, either through a parent or individually, colleges and universities must act to accept this coverage for campus health services. Planners should get their school providers into managed care networks or at least designated as accepted out-of-network providers.
- *Consider outsourcing health services billing.* Accepting managed care coverage of students provides the opportunity to bill those companies for medical services, providing funds schools otherwise would not receive. Schools that have outsourced food services, campus infrastructure support, and other facets of operations can also outsource health services billing. Public and private institutions including Arizona State University, Auburn University, Bowling Green State University, Butler University, Georgia Southern University, The University of Alabama, and Ohio University have garnered significant surpluses from outsourcing health services billing that they have used to both update hard assets and expand services. Schools adopting this approach can thus get paid by private insurance for campus health services that up until now they have attempted to cover using student health fees and general funds. This approach will also remove barriers to seeking services and reduce the likelihood that students will engage in high-risk activities such as avoiding care or buying drugs over the Internet (Liang 2008, forthcoming).

- *Terminate school-sponsored plans that focus on school and insurer profits over student welfare.* Beyond a violation of fiduciary duty, significant legal and ethical issues are associated with this practice. The conflict of interest involved (Lazar 2009) appears similar to that of the student loan scandal, in which schools pushed students to favored lenders and then split the excessive profits (Liang, forthcoming). In addition, these plans may violate public policy and consumer protection laws by charging those who do not enroll in them higher prices and by disingenuously claiming “competitive” rates in comparison to community charges. As a red flag, the Office of the New York State Attorney General has opened investigations of institutions’ school-sponsored insurance practices (Glater 2008).
- *Reallocate the student health fee.* Managed care reimburses for medical services; it cannot cover the entire health center budget. However, a health fee paid by all students could fund non-reimbursable services, such as wellness and prevention programs, as well as prepay co-payments and deductibles. This would be an appropriate use of the health fee, rather than attempting to use it to fund the lion’s share of campus health operations.

Conclusion

In their seminal work on the topic, *The History and Practice of College Health*, Turner and Hurley (2002) recognized the importance of adapting when providing student health services. As they note, “The mission of the student health service—to keep the most students at the most books the most time—can no longer be carried out in isolation. We need health care pioneers who can forge new alliances and new partnerships, who can accept the challenge of doing more with less, and do it exceedingly well” (Turner and Hurley 2002, p. 15).

If college and university health programs are to survive, they must embrace change.

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find a way to help administrative leadership work with it for the benefit of students and their families. Otherwise, students and parents may vote with their feet, leading to additional financial pressures, decreased services, and the possible extinction of college and university health programs. ❌

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