A Qualitative Study of Student Health Insurance Policy Change: The Future of the Student Health Insurance Market

An Honors Thesis for the American Studies Program at Tufts University

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Abstract

Health insurance allows individuals to access and afford health care. However, not all insurance policies are comprehensive, and some can leave covered populations without sufficient protections. Historically, the student health insurance market has provided students with inadequate coverage. While a better understanding of the student health insurance market would be valuable, research on this market is largely absent from the literature. In my thesis, I use available literature on the student health insurance market combined with data from 18 key informant interviews to examine the student health insurance market, and answer the questions, *what problems exist within the student health insurance market, and how can the market be improved in light of national health care reform*? My goal was to determine the barriers and facilitators to the adoption of new student health insurance programs. I explored ways to improve the student health insurance market including primary care, on-site health centers, education, self-insurance, risk pooling, and self-insured consortiums. The information I gathered in this study points to the complex changes needed in order to initiate effective changes in the market. Key recommendations are as follows:

- School administrators need to make the sustained health of their student population a priority and an integral part of the school's mission.
- Timely and accurate information on the student health insurance market needs to be regularly collected, analyzed and distributed to interested parties.
- While complying with national health care reform, schools need take the necessary steps to ensure that their students are no longer uninsured or underinsured.
- School administrators need to provide students with the best value student health insurance plan possible; value includes both affordability and plan

design. In order to improve the value of student health insurance plans, I recommend that:

- Schools should establish robust student health services, reducing the quantity of unnecessary and expensive health care utilization in the student population.
- Schools need to ensure that their directors of student health services, and all other administrators involved in designing and purchasing student health insurance plans, are educated on the health insurance market and plan procurement.
- Schools that are able to take on the risk should self-insure their student health insurance plans.
- Certain small and medium size schools should risk-pool, and purchase health insurance as a group.

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I. Preface

The defining aspect of my college career has been my involvement with the Student Health Organizing Coalition (SHOC), a group of Tufts University students who are working to improve Massachusetts' student health insurance market. I have been working with SHOC since my first semester of college, and this thesis represents a culmination of my academic and activist work. Through meeting with key stakeholders, lobbying the state, and conducting research on student health insurance, I have learned a great deal about the student health insurance market and through this thesis I want to make this information available to others.

Aaron Marden, a Tufts University student, founded the Student Health Organization Coalition in the fall of 2008. The previous summer, Aaron had an internship with the Access Project; the Access Project no longer exists, but it was a nonprofit in Massachusetts that dealt with health insurance issues, including student health insurance plans. Aaron discovered that students on student health insurance plans in Massachusetts were often underinsured. Compared to the plans serving the general population, insurance companies were making a relatively exorbitant percentage of profit off of student health insurance plans. SHOC found that students were often purchasing inadequate health insurance plans through their schools, which offered them a false sense of security; SHOC was formed because we wanted to make sure that students were protected.

I am conducting this research because of my personal belief that school administrators and government officials should be doing whatever they can to ensure that their students have access to comprehensive and affordable health insurance. Students have a host of concerns and stresses, and it is my belief that access to effective and

affordable health care should not be one of them. A college degree is invaluable; the median weekly earnings for a full-time worker with a bachelor's degree in 2011 was 64% higher than his or her counterparts with only a high school degree; this figure was $1,053 versus $638 respectively. Additionally, children born into the lowest income level have a 45% chance of remaining there without a college degree. With a college degree, this figure drops to a less than 20% chance.[i] Both government officials and school administrators should do whatever they can to help students obtain a college degree.

This research is dedicated to all of the students who have devoted their time to SHOC, all of the school administrators and government officials who have recognized the necessity of providing students with the best health care possible, and to all of the individuals who have helped students along the way. Over the past four years, I have watched the student health insurance market develop and change. I have seen first hand many of the problems in the market, as well as improvements in the system. I am hoping that this research can provide school administrators and government officials with the information that they need to answer the hard questions involving student health insurance. Student health insurance is a largely unexplored research area, and my research will provide an analysis of the past, present, and future of the student health insurance market, in the hopes of aiding in its continuous improvement.

II. Introduction

On March 28, 2008, reacting to a Government Accountability Office report on student health insurance, Senator Edward M. Kennedy explained,

> It is unacceptable that twenty percent of college students are uninsured and that some college health plans exclude coverage for preventive services and limit payments for benefits such as prescription drugs. Students must be healthy to learn, and guaranteeing that they have quality health coverage should be a priority for our nation.[ii]

Commenting on an investigation of New York State's student health insurance market, then Attorney General Andrew Cuomo remarked:

> Many of the sponsored health care plans looked at during our investigation leave students at risk while providing massive profits for insurance companies. It is important for students to have adequate health care coverage to protect themselves during times of illness or injury, but a bad health insurance plan can have catastrophic and long-lasting effects on a young person's life. By being informed of the problematic practices that currently exist in the industry, schools can negotiate for better health plans, and students and their families can be better equipped to select the coverage that is best for them.[iii]

Student health insurance plans are the insurance policies offered to students by their colleges and universities.[iv] Colleges and universities have an interest in the health of their student population. Having good health care aids students in their educational pursuits, and student health insurance plans are a vehicle for institutions of higher education to keep students healthy and to decrease rates of uninsurance in student populations.[v] The purpose of this research is to uncover trends in and propose improvements for the student health insurance market. In the following study, I will answer the questions:

1. What are the past and present problems in the student health insurance market?
2. How can the student health insurance market be improved?

This study is guided by the conviction that school administrators and government officials should work to improve the student health insurance market, providing students with the best value student health insurance plan possible; improving the value of these plans involves both increasing benefit levels and decreasing costs. This study is one of the first comprehensive reviews on the student health insurance market. Before exploring the complexities of the market, it is important to understand why health insurance is important, and how the American health insurance system works.

Individuals purchase health insurance because of the high cost of health care. Very few Americans can afford to pay for medical care out-of-pocket if they developed a serious condition.[vi] For example, the median household income for families in the U.S. was $52,762 from 2007-2011.[vii] However, treating a stroke costs an average of $13,019 in mild cases and $20,346 in severe cases in the first 30 days, and the lifetime cost of treating a stroke is around $140,048.[viii] One study found that the per-patient lifetime costs of treating breast cancer in the U.S. ranged from $20,000 to $100,000, with individual surgeries costing between $23,000 and $31,000.[ix] In 2008, the average cost for an uncomplicated vaginal birth was around $9,600, and $15,800 for an uncomplicated cesarean section.[x] One study that looked at Emergency Room (ER) charges between 2006 and 2008, found that the median charge for one of the ten most common outpatient ER procedures was $1,233, or 40% more than the average American spends on rent every month.[xi]

With the cost of medical procedures so high, insurance is necessary to help make health care more affordable. The purpose of health insurance is to have a large population of people pool together their risk of incurring high cost medical care.

Individuals pay a certain amount for a health insurance policy, known as a premium, and this premium represents the average cost of care for a person covered in the pooled population. Some members will use more medical care than others, but health insurance enables all individuals in the insured population to afford their medical care.[xii] However, in 2011, nearly 48 million nonelderly Americans were uninsured. Because of the high cost of health insurance, many Americans have trouble affording these policies.[xiii]

Having health insurance affects an individual's ability to access health care, as well as their financial security. In 2011, 53% of the uninsured had no regular source of medical care, 30% delayed obtaining care due to cost, 26% went without needed medical care because of its cost, and 24% could not afford their prescription medications.[xiv] However, these figures were only 10%, 7%, 4%, and 5% respectively for individuals with employer or other private health insurance. Being uninsured also comes with a host of fiscal concerns, including being at a greater risk of incurring medical debt. When the uninsured receive medical care, they are often charged for their care and must pay out-of-pocket. In fact, it is common practice for hospitals to charge the uninsured two to four times what they charge private health insurers and public programs. In 2012, while comparing the uninsured and insured population between the ages of 18 and 64, 47% of the uninsured versus 23% of the insured had problems paying for their medical bills over the last year, and 46% of the uninsured versus 21% of the insured were concerned about being able to afford health care services.[xv]

The uninsured remain a vulnerable segment of the U.S. population. However, having insurance does not guarantee protection. Due to rising health care costs, insurance companies have been increasingly shifting the cost of health care onto

consumers, as well as restricting or eliminating benefits overall. Underinsurance presents another issue within the U.S. health care system. Underinsurance is typically defined based on an insured individual's susceptibility to financial risks, or measuring an individual's vulnerability to out-of-pocket medical expenses based on his or her income. Individuals are generally considered underinsured if they spend 10 percent or more of their income on out-of-pocket medical expenses.[xvi] In 2007, 20% of insured adults between 19 and 65, or 25 million people, were underinsured, and this represented a 60% increase from rates in 2003. Compared to individuals with more comprehensive insurance coverage, uninsured adults, as well as underinsured adults are significantly more likely to go without care due to financial concerns. For example, uninsured and underinsured adults are three times more likely than those with more comprehensive insurance to forgo care, fill a prescription, or get a recommended diagnostic test or treatment. At least a quarter of the underinsured reported having a cost-related access issue to necessary medical procedures, and two-thirds of the uninsured reported having this problem. While only 15% of insured (not underinsured) adults reported having problems paying medical bills, this figure was 36% and 45% respectively for underinsured and uninsured adults. The study found that having inadequate health insurance could compromise an individual's access to care, placing them in a similar position as the uninsured.[xvii]

According to the Commonwealth Fund Health Insurance Tracking Survey of Young Adults, 41% of young adults refrained from getting necessary medical care due to cost, and this statistic was 60% for young adults who were uninsured. Additionally, 36% of young adults reported having difficulty paying medical bills or that they had to pay off

their medical bills over a period of time; this rate was 51% for uninsured young adults. When further examining the young adults who reported having problems paying their medical bills, the survey found that 43% reported spending all of their savings to pay their medical bills, 33% accrued credit card debt to pay for their medical bills, 32% were unable to pay off their other debts like school loans and tuition payments, 31% delayed education or career plans, and 28% were incapable of paying for some of their other needs like food and rent.[xviii] Studying the uninsured and underinsured provides important examples of why it is not only important to have health insurance, but also to have comprehensive coverage. Having good health insurance directly impacts an individual's access to important medical care, as well as an individual's financial security.

The insured in this country obtain health insurance through a variety of private and public sources. In 2006, out of a population of nearly 300 million,[xix] around 158 million nonelderly individuals were covered by an employer-sponsored health insurance plan. Individuals without access to employer-sponsored plans can purchase health insurance through the individual health insurance market, and in some cases through a professional association; around 14 million nonelderly individuals purchased health insurance through the individual market in 2006. Additionally, there are a variety of different publicly-financed health insurance programs, including Medicare, Medicaid, the State Children's Health Insurance Program, the military, and the Veterans Administration.[xx]

Students can acquire health insurance in a variety of ways. Many students can remain dependents on their parents' health insurance plan, buy an individual policy in the general market, obtain coverage through an employer, or purchase a health insurance plan

sponsored by their university.[xxi] Currently, over 1 million college students are covered by student health insurance plans sponsored by an institution of higher education, and these school-sponsored plans will be the focus of this thesis.[xxii] However, underinsurance is a major problem in the student health insurance market, and many students covered under their school's student health insurance plans do not receive adequate coverage. As indicated by Mr. Cuomo, by informing the public on industry practices, individuals can work together to improve the system.

Health Care Reform: The Affordable Care Act and a Changing Student Health Insurance Market

The following sections explore the problems existing within the student health insurance market, many of which involve issues of uninsurance and underinsurance. However, before reviewing these issues, I want to begin my discussions on a more positive, but still cautionary note. The student health insurance market today is very different than the student health insurance market in the summer of 2011, when I started my research, and when I entered college four years ago. On March 23rd, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law. The legislation has important implications for the student population, especially with regards to access. By 2014, provisions of the ACA will allow for near-universal coverage of the student population. In 2010, the ACA required that insurance plans allow young adults to stay on their parents' health insurance plans, as dependents, until their 26th birthday.[xxiii] Additionally, the ACA allows states to expand Medicaid to all non-Medicare eligible individuals with incomes up to 133% of the Federal Poverty Line

(FPL). Subsidies are available to individuals between 133 and 400% of the FPL to purchase health insurance in state-based American Health Benefit Exchanges.[xxiv] Students now have new avenues to obtain coverage, aside from their school sponsored plans.

The ACA has important implications for the student health insurance market, beyond access. However, in the ACA, student health insurance is only mentioned once:

> STUDENT HEALTH INSURANCE PLANS. —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.[xxv]

According to this passage, the ACA permits institutions of higher education to continue offering student health insurance plans. Although the ACA designated student health insurance plans as a distinct segment of the health insurance market, the actual text of the law did not explain how health care reform would influence student health insurance plans. The ACA's influence on student health insurance plans comes from a set of regulations released by the Department of Health and Human Services (HHS).

On February 11, 2011, HHS issued a set of proposed regulations for student health insurance plans. After issuing the proposed rule, there was a comment period and over one hundred comments were submitted. These comments came from a variety of different stakeholders, including institutions of higher education, students and student organizations, faculty members, consumer organizations, health insurance issuers, and brokers. On March 21, 2012, after reviewing these comments, HHS issued the final regulations for student health insurance plans.[xxvi] The final regulations became effective on April 20, 2012, and define all ACA compliant student health insurance plans as

"individual health insurance coverage"; student health insurance plans are subject to all of the requirements of the ACA unless specifically exempted from particular provisions.[xxvii] The regulations provide a number of important protections to students enrolled in their schools health insurance plans, largely eliminating a student's risk of being underinsured.

HHS's regulations on student health insurance plans affect the benefit levels provided in a student health insurance policy, mandating the gradual elimination of plan maximums. Plans are permitted to have an annual dollar limit of $100,000 or more for 2012-2013 academic year, an annual dollar limit of $500,000 for the 2013-2014 academic year, and no annual dollar limit for all years after.[xxviii] Additionally, no internal annual limits or lifetime dollar limits can be placed on the following Essential Benefits: ambulatory patient services, hospitalizations, mental health/substance abuse, rehabilitative services, diagnostic tests, maternity and newborn care, prescription drugs, durable medical equipment/devices, and wellness/preventive care.[xxix] The regulations mandate that student health insurance plans cover contraceptives without any cost sharing, and voluntary sterilization starting in the 2012-2013 academic year. There are provisions for certain non-profit colleges and universities with religious objections who were granted a one-year exclusion from this policy until the 2013-2014 academic year. HHS will work with these schools to determine alternative measures for providing contraceptive coverage.[xxx] A major component of these regulations involve stricter Medical Loss Ratio (MLR) requirements. The Medical Loss Ratio is the percentage of total premium dollars that health plans allocate towards medical services, rather than administrative costs and profit.[xxxi] Because student health insurance plans are considered

'individual' policies, insurers are required to meet an 80% MLR or provide a rebate to students if MLRs are below this target rate.[xxxii] This means that 80 cents out of every premium dollar has to go towards students' health care needs, and the other 20 cents is permitted to go towards health insurers' profit and administrative costs.

Aside from regulating plans' benefit levels, the regulations have several other important provisions. Student health insurance plans are exempt from guaranteed availability and guaranteed renewability requirements; that is, schools do not have to offer their student health insurance plans to non-students, or past students. However, schools are permitted to temporarily extend coverage to enrollees who lost their student status. Additionally, before 2014, no student under the age of 19 can be refused access to a school's health insurance plan due to pre-existing conditions, and this provision is extended to all age groups after 2014.[xxxiii]

The remainder of this thesis will explore the past and present problems influencing the student health insurance market, and make recommendations on how the market can be improved. Many of the problems in the student health insurance market will be addressed by the ACA. However, in order to evaluate health reform's impact on the student health insurance market, we need to have an adequate understanding of the problems that the ACA is trying to address. Many provisions of the legislation are just being implemented now, and some are yet to be implemented; school administrators, government officials, and researchers need to continuously reassess the student health insurance market, and ensure that problems within the market continue to be addressed. The ACA may have unintended consequences that schools will likely have to confront. For example, student health insurance plans may become too expensive when schools try

to raise their plans' benefit levels to comply with HHS regulations. Implementing health reform is an ongoing process, and it does not end with the passage of the ACA. It is my hope that this research will convince interested parties to take the opportunities offered by the ACA, and build upon this important legislation.

III. Methods

In this thesis, I will examine past and present trends in the student health insurance market, as well as ways school administrators can improve their student health insurance programs. In order to complete this research, I used a variety of methods. This research combines a comprehensive review of literature, 18 key informant interviews, and qualitative data analysis of these interviews.

In order to determine what information is available on the student health insurance market, I used a number of different search engines and databases, including Google Scholar, Academic Onefile, Lexus Nexus, JSTOR, and the Boston Library Consortium, Scopus and Health Affairs. I used the search terms, "student health insurance," "student insurance," "college health insurance," "university health insurance," ("college students" and "health insurance"), ("college" and "student" and "health insurance"), and ("college" and "health insurance"). Additionally, I used publications from the Kaiser Family Foundation and the Commonwealth Fund to obtain statistics on the uninsured and underinsured. I also searched for government publications released by states that had studied their student health insurance markets, conducting searches on state government web pages. In addition, I looked through every volume of the *Journal of American College Health* written in the past 10 years to determine the topics covered by the journal, and whether or not issues involving student health insurance were discussed. *The Journal of American College Health* is the only scholarly publication that is specifically devoted to college students' health.

Along with a comprehensive review of literature, I conducted 18 key informant interviews with 11 school administrators, 8 from Massachusetts and 3 from other states, 2 government officials, 3 nonprofit and advocacy group workers, and 2 private consultants.

All school administrators that I interviewed were either directors of student health centers, or employees of the student health centers who were directly involved in the procurement of their school's student health insurance plans. Through these interviews, I attempted to determine key characteristics of the student health insurance market and considerations, experiences, barriers and facilitators to the adaptation of improved student health insurance programs. I conducted these interviews in the summer of 2011. To facilitate the interview process, I created a questionnaire to use as a template and guide for all interviews. I conducted the interviews in person or by phone; interviews ranged from around 15 minutes to 2 hours. All interviews were digitally recorded and transcribed. Additionally, I thematically analyzed all interviews to formulate an overarching picture of the student health insurance market based on interviewees' perspectives.

Because this research provides one of the first comprehensive reviews of the student health insurance market, many of the concepts and theories are not reflected in the existing literature. Hopefully, this research will help fill an important gap. In the following section, I will describe college student demographics, highlighting key characteristics of both college students and the student health insurance market. Next, I will discuss the literature available on the student health insurance market, analyzing the history of student health insurance market, using Texas, New York and Massachusetts as examples. These three states have collected some of the only statistics that I could find on the student health insurance market. This section will analyze existing literature to illuminate past problems, as well as future trends in the student health insurance market. In the following section, I will present the research that I obtained through my 18 key

informant interviews, discussing the problems within the student health insurance market, and how the market can be improved. Finally, in my discussion/conclusion section, I will analyze all of the materials presented in this thesis, and provide my own insights into the student health insurance market.

IV. Demographics/Features of the Student Health Insurance Market

In the following section, I will provide both an analysis of college student demographics, as well as the unique qualities of the student health insurance market to highlight its complexities. According to the Lookout Mountain Group,

> The health care and health insurance needs of college students have not been visible for many policymakers. This is partly due to the common misperception, frequently reinforced by advertising and media focus, that almost all college students have extraordinary discretionary spending, are young and exceptionally healthy, and generally represent the most privileged members of society.[xxxiv]

College students are often misrepresented as only young and healthy adults. However, this description provides an incomplete picture of student demographics.

In 2007, 10% of college students were 18 or younger, 49.7% of college students were between the age of 19 and 23, 17.3% of college students were between the ages of 24 and 29, 12.6% of college students were between the ages of 30 and 39, and 10.5% of college students were 40 or older.[xxxv] The percentage of college students age 25 and over has been increasing at a faster rate than the percentage of younger students. Between 2000 and 2010, the enrollment of students under the age of 25 increased by 34%, while the enrollment of students 25 and over rose by 42%.[xxxvi] It is clear that a large proportion of college students are young adults, but increasingly many college students are older.

However, because a large percentage of college students are young adults, studies on young adults' health care needs and health insurance status can be helpful while studying the college student population. Young adults between the ages of 18 and 24 have the highest risk of being uninsured of any age group, and college students are at a disproportionate risk for being uninsured compared to the larger U.S. population.[xxxvii] The Lookout Mountain Group's conservative estimate for the number of uninsured

college students in a four-year and graduate degree granting school is between 25% and 30%, or 2.8 to 3.3 million of the nation's 11 million college students. The group also estimates that 20 to 30% of students at four-year and graduate degree programs are underinsured.[xxxviii]

In 2006, the Government Accountability Office (GAO) conducted one of the only studies on the student health insurance market. According to the report, which studied students aged 18-23, 80% of college students had health insurance, while 20%, or 1.7 million students were uninsured. Of the 80%, 67% received health insurance as dependents on their parents' plan, which was an employer-sponsored health insurance plan, 7% were covered through private health insurance plans (ex. student health insurance plans offered by colleges), and 6% were covered by public programs like Medicaid.[xxxix] The characteristics of the uninsured students followed several trends similar to that of the general population. For example, the study found that part-time students, nonwhite students, and students from families with lower incomes were more likely to be uninsured. Thirty-one percent of part time students were uninsured, while only 18% of full-time students were uninsured. Racial minorities were also uninsured at higher rates; 38% of Hispanic, 29% of black, and 26% of Asian college students aged 18 through 23 were uninsured, while only 15% of white college students were uninsured.[xl]

Socioeconomic status also provided some indication of being uninsured. The average family income for uninsured college students aged 18 through 23 was about $52,000, while this figure was around $95,000 for insured college students. Additionally, older students aged 22 and 23 were more likely to be uninsured than their younger counterparts between the ages of 18 and 21. Thirty-five percent of college students aged

23 were uninsured and 25% of college students aged 22 were uninsured, compared with a rate of 16 to 19% in college students aged 18 to 21. Moreover, the report found that being uninsured had a negative financial impact on the health care market; the 1.7 million uninsured students utilized some $120 million to $255 million in uncompensated care for non-injury-related medical events in 2005.[xli] However, the report failed to explore both the number of students who were underinsured, as well as students over the age of 23; the study only reviewed students age 18 through 23.

College students are a diverse group of individuals with varying needs and backgrounds. In 2007, if students were dependents, 24.8% of students' parents made less than $36,000, 25.5% of students' parents made between $36,000 and $66,999, 25% of students' parents made between $67,000 and $104,999, and 24.7% of students' parents made over $105,000.[xlii] These statistics indicate that many college students do not come from wealthy backgrounds and fall below the federal poverty line. College students also come from varying racial backgrounds; in 2007, 61.8% of college students were white, 14% were black, 14.1% were Hispanic or Latino, 5.9% were Asian, .8% were American Indian or Alaska Native, .7% were Native Hawaiian/other pacific Islander, .3% were other, and 2.4% were more than one race.[xliii] Furthermore, 18% of college students were married in 2008.[xliv] Additionally, in 2007, 94.1% of college students were U.S. citizens, 4.5% were resident aliens, and 1.4% were foreign/international students.[xlv]

When discussing the student health insurance market, the GAO report found that 57% of all colleges offered student health insurance plans during the 2007-2008 academic years: 71% of four-year private nonprofit colleges, 82% of four-year public colleges, 29% of two-year public colleges. Sixty-four percent of large colleges, or

colleges with over 5,000 undergraduate students, offered health insurance plans to their students, compared to 52% of medium sized schools (1,501 - 5,000 students), and 56% of small schools (200 - 1,500 students). The benefit levels of student health insurance plans varied, and premiums ranged from $30 to around $2,400 for the 2007-2008 academic year, with an average premium cost of approximately $850.[xlvi]

States regulate their student health insurance market differently. For example, in Massachusetts, all full-time and part-time students are required to have health insurance as a condition of enrollment. In New Jersey, all full-time students are required to have health insurance, and all students attending a public 4-year college or university in Idaho are mandated to have health insurance. However, most states do not require students to obtain health insurance as a condition of enrollment.[xlvii] In fact, only six states, California, Idaho, Massachusetts, Montana, and New Jersey have a state mandate requiring all full-time undergraduate students to have health insurance as a condition of enrollment.[xlviii] Additionally, requirements involving students and their health insurance plans vary from school-to-school; colleges usually follow one of four models regarding student health insurance plans: a voluntary system, a soft waiver system, a hard waiver system, or a mandatory system.

Under a voluntary system, students are offered the opportunity to purchase their school's student health insurance plan, but they are not required to prove that they have health insurance as a condition of enrollment. In a soft waiver system, students are required to either purchase their institution's student health insurance plan, or have a comparable form of coverage. Students are expected to have health insurance, the college or university bills students, and students are asked to delete the charge if they

already have another form of insurance. Under this system students are not required to present actual evidence indicating that they have an alternative health insurance policy.[xlix] Under a hard waiver system, students must purchase their institution's student health insurance plan, or present evidence that they have a comparable form of coverage. All students are enrolled in and billed for the student health insurance plan unless they submit proof of comparable coverage to the school. Finally, under a mandatory system, all students must purchase their institution's student health insurance plan, even if they already have a comparable insurance product; students are unable to waive the student health insurance plan and expenses are included in tuition bills.[l]

Students purchase student health insurance plans for a variety of different reasons. If students are employed, they typically work in lower-wage industries, as part-time, or seasonal employees.[li] Because of this, students do not generally have access to employer-sponsored plans through their work. Additionally, students may refrain from remaining as a dependent on their parents' health insurance plan for a variety of different reasons. Parents' health insurance plans may restrict coverage for out-of-area, non-urgent care.[lii] Because of this, if a student goes to school away from home, their parents' plan may not adequately cover them in different regions of the country. Additionally, employers have increasingly been shifting the cost of insurance to their employees, and dependent coverage has become more expensive. Because of this, it may be more affordable for students to purchase their school-sponsored, student health insurance plans. Older students, and graduate students, may not even have access to their parent's health insurance coverage, and foreign students are required to purchase U.S. health insurance

policies by immigration laws. Student health insurance plans are a vital form of coverage for certain students.[liii]

Decisions on a school's student health insurance plan are typically made by a committee that includes the director of student health services, student representatives, and administrators from other departments. Schools also may contract with consultants for their expertise in designing student health insurance plans. When designing a student health insurance plan, schools need to determine who is covered under the student health insurance plan, including whether students' spouses or dependents are covered under the plan.[liv] Additionally, schools need to make decisions involving plan design and affordability. Students have limited disposable income, and either parents or students are responsible for the full premium price. Cost and plan design are directly related, and schools need to find a way to provide students with enough coverage to protect them from significant medical expenses, while also keeping plans affordable. Additionally, schools need to determine how the student health insurance will be incorporated with the student health services.[lv]

Schools need to build relationships with local providers. However, schools also need to decide how their student health insurance plans will cover students when they go home for holidays, breaks, or when students travel.[lvi] Additionally, schools need to establish enrollment periods that account for the diverse needs of its student population. Student health insurance plans can allow students to enroll in the fall, spring, or summer semesters, and they can cover students for an entire academic year, or even a semester. Some schools even allow students to enroll on a quarterly or monthly basis.[lvii] Membership in student health insurance plans is often tied to school enrollment.

Although this follows the same concept as the employer-sponsored market, tying eligibility to enrollment means that students who have to leave school for a variety of different reasons, including medical issues, are in a precarious situation. Students also lose their coverage when they graduate.[lviii]

V. Review of Literature

The American College Health Association (ACHA) guidelines for student health insurance/benefit programs recommend that:

> The student health insurance/benefits program is reviewed annually to ensure the program: (a) meets the needs of covered individuals; (b) provides desired benefits at the least possible cost; and (c) returns as much of the premium or fund contributions as possible to covered individuals in the form of benefits.[lix]

However, many colleges and universities have failed to live up to the standards set forth by the ACHA. According to a study by the University of California Board of Regents in 2000, unpaid medical bills represent the number one reason that students disenrolled from school.[lx]

Historically, many problems in the student health insurance market have involved underinsurance. When creating a student health plan, school administrators make an effort to balance the cost and coverage of the plans to fit the needs of their students. However, school administrators may concentrate more on keeping the cost of these plans down, rather than on providing important coverage and benefit levels.[lxi] Unlike employer-sponsored plans, where employers and employees share the cost of health insurance, with student health insurance plans, students and their families pay the full price of the premium. To keep the cost of student health insurance plans down, school-sponsored health insurance plans have traditionally included benefit limits and maximum annual benefit levels not typically found in the general market.[lxii] For example, in 2006 the average premium for individual coverage provided under an employer sponsored health plan in Massachusetts was $4,872. However, 80% of student health plans in Massachusetts had a premium of $2,000 or less, with 7% of premiums priced under $700.[lxiii] Affordability of a health insurance plan involves more than just premium costs;

insurance plans can place limitations and exclusions on a variety of different plan benefits, as well as include various cost sharing provisions. Underinsurance has been a major problem in the student health insurance market, placing students at an increased financial risk.[lxiv]

Bryan A. Liang, the Executive Director of the Institute of Health at the California Western School of Law, summarizes the problems existing within the student health insurance market:

> School-sponsored plans are highly variable across schools and even amongst schools within the same system. Severe limits on coverage, high ancillary plan costs, and other barriers preclude adequate access. Even in states with health insurance mandates, poor outcomes have occurred due to inattention to the details of coverage. Hence, a large fraction of the student body in the United States is one accident or illness away from losing their health, education, and a accompanying present and future opportunities.[lxv]

State reports on the student health insurance market from Texas, New York, and Massachusetts provide useful insights into the student health insurance market.

State Reports

Texas

Between July 2004 and February 2005, the Texas Department of Insurance (TDI) conducted a comprehensive review of the student health insurance market. The study found that only 63% of Texas colleges offered school-sponsored plans, and these plans covered 11% of the college student population. For the 2004-2005 academic year, premium prices ranged from $79 to $2,052; the mean premium cost was $775 and the median cost for these plans was $680.[lxvi] The report explained,

> These plans have both benefits and limitations, which make it debatable whether expanding the student health insurance market would be a good way to provide

> coverage to more college students … From an enrollee's perspective, the limitations of these plans may include affordability issues, relatively low benefit levels compared to employment-based group plans, multiple exclusions, limited eligibility for part-time students, and limited accessibility over the summer.[lxvii]

Benefit level restrictions in Texas' student health insurance plan placed students at financial risk. Over 70% of student health insurance plans had a maximum benefit per injury or illness; these benefit maximums varied from $2,000 per injury/illness to a $1,000,000 lifetime limit. The plans also included a mean maximum catastrophic coverage limit of $105,200 per accident or illness, but this figure is skewed by a few plans with much higher maximum benefits; the median catastrophic coverage level was $50,000 per illness or injury.[lxviii] However, one-third of student health insurance plans throughout the state offered their students the ability to purchase an additional catastrophic coverage option.[lxix]

Only three-quarters of Texas' student health insurance plans offered prescription drug coverage, with most having caps. Prescription drug coverage limits ranged from $50 to $6,000, with the median limit being $300 annually.[lxx] Around one-half of Texas student health insurance plans had limits on hospital expenses. For example, some plans limit hospital room and board expenses at $100 to $400 per day, and coverage for all expenses can be limited per day, per confinement, or per year from $600 to $5,000.[lxxi] Additionally, over 50% of policies had exclusions for routine exams and preventative care, injuries obtained while under the influence of drugs, injuries resulting from "high risk" activities, injuries from fighting, except for in instances of self defense, and self-inflicted injuries.[lxxii]

Two-thirds of plans contained coinsurance and deductibles. The most common coinsurance level was 80% for in-network services and 60% for out-of-network

procedures. Annual deductibles ranged from $50 to $750, with some plans having a deductible per accident or illness ranging from $10 to $150.[lxxiii] Additionally, less than 20% of the student health insurance plans in Texas had an out-of-pocket maximum, which would decrease students' financial risk. Out-of-pocket maximums would pay for 100% of covered services up to a plans benefit maximum for students after they reached some predetermined out-of-pocket amount.[lxxiv] If a plan contained these financial safeguards, they typically became effective after a student spent between $1,000 and $3,000 in out-of-pocket expenses. The report concluded that Texas' student health insurance plans are adequate for the average college student, but that the plans would not provide financial security to students who experienced serious accidents or illnesses.[lxxv]

New York

On April 8, 2010, Attorney General Andrew M. Cuomo released his report on the school-sponsored student health insurance industry. Mr. Cuomo had subpoenaed ten of the largest insurers selling in the market, as well as five insurance brokers, agents, and consultants. The investigation found that the student health insurance plans were ripe with "extremely low coverage limits, excessive costs for coverage provided, and inconsistencies with federal protections recently signed into law."[lxxvi] His office then sent a letter to over 300 colleges, universities, professional schools, and trade schools, indicating that these institutions needed to reassess their school-sponsored plans and change these plans in a manner that was beneficial for students.[lxxvii]

The investigation found that the student health insurance plans had limits that put families at risk of having to pay catastrophic medical care costs; these plans could have

annual benefit cap as low as a $25,000, and some plans had a cap per illness as low as $700.[lxxviii] Many plans in New York also failed to provide prescription drug coverage to students. Along with often providing students with inadequate coverage, these plans could also have poor Medical Loss Ratios (MLR), having insurance companies receiving an exorbitant amount of profit.[lxxix]

Aetna was found to have underpaid claims of over 73,000 students in over 200 colleges across 32 states during a 10-year period. The underpayments account for over $5.1 million from 206,000 claims that should have been paid to students or their doctors; this figure does not include interest and penalties that would augment this costs.[lxxx] The Attorney General found that Aetna owed doctors over $2 million as well as appropriate interest and penalties for over 64,000 claims. Aetna's inadequate reimbursements were due to the fact that the company failed to use current market rates to reimburse students and doctors, often using data that was five years old. The Attorney General found that the company's practices were in violation of multiple New York laws.[lxxxi]

Massachusetts

Since 1989, Massachusetts has required all full-time and part-time students enrolled in an institution of higher education to have health insurance; part-time students are those enrolling in at least 75% of full-time curriculum. Massachusetts' student health insurance plans are referred to as Student Health Programs (SHP), and the former Division of Health Care Finance and Policy (DHCFP), now the Massachusetts Health Insurance Connector, is the state agency charged with the task of providing regulatory oversight for SHPs.[lxxxii] DHCFP's regulation *114.6 CMR 3.00: Student Health*

Insurance, established the minimum benefit levels and required services that need to be included in all SHPs, as well as the criteria by which a school may waive a student's enrollment in a SHP if the student presented comparable coverage. SHPS must provide at least a $50,0000 maximum benefit per illness or injury, and plans must also include all of Massachusetts' mandated benefits. However, schools are permitted to exceed the minimum requirements, and offer more comprehensive benefit packages. Additionally, plans may vary from school to school, containing differing inpatient and outpatient benefit levels among other things.[lxxxiii]

Massachusetts has released three reports analyzing SHPs for the academic years 2005-2008, 2008-2009 and 2009-2010. These reports are known as the Student Health Plan Reports, and many of the problems existing in the student health insurance market were brought to light through DHCFP's release of the Student Health Program Baseline Reports. The first of these reports was released November 5th, 2009, and represents the first statewide investigation of SHPs.[lxxxiv] According to the second Student Health Program Baseline Report, the first report,

> Found that in many cases, students were not receiving the best value for their premium dollars and some carriers were making proportionally larger profits on SHPs than generally seen in the private market in Massachusetts. Additionally, the report highlighted that low SHP premiums are often achieved by imposing non-standard benefit limitations. These benefit limitations may leave students with gaps in coverage and exposed to potentially significant out-of-pocket expenses.[lxxxv]

Between 2005-2008, 95,000 students, or 27% of the student population, were enrolled in a SHP.[lxxxvi] In the 2008-2009 academic year, 101,685, or 26% of students enrolled in SHPs[lxxxvii], and this figure rose to over 108,553, or 27% of students during the 2009-2010 academic year.[lxxxviii] The SHP market was concentrated amongst a small

number of national insurance carriers. From 2005-2007, only 14 insurance carriers participated in Massachusetts' SHP market. Additionally, 4 schools self-funded their SHPs, accounting for 25% of Massachusetts' student health insurance market: Harvard University, Episcopal Divinity School (purchased through Harvard's self-funded SHP), Massachusetts Institute of Technology, and Northeastern.[lxxxix] Additionally, 74.9% of students enrolled in an SHP purchased their coverage through Aetna, one of the 4 self-funded schools, or Nationwide; a small number of insurance carriers dominated the market. This figure was similar in the following two reports.[xc]

The average premium for SHPs was $1,216 for the 2005-2008 academic years[xci], and this figure was $1,329 for the 2008-2009 academic year[xcii], and $1,294 for the 2009-2010 academic year.[xciii] The premiums varied widely from school-to-school; in the 2009-2010 academic year, school premiums ranged from $325 to $6,143, with some schools having lower than average premiums because of more limited benefits.[xciv]

The annual reports analyzed the Medical Expense Ratios (MER) of all SHPs. In all three reports, the MER of SHPs was generally unfavorable when compared to that of the private market. In the 2005-2008 report, the average MER for SHPs was 69%, with a 20% Administrative Expense Ratio (AER) and a 10% profit margin.[xcv] As a point of comparison to SHPs, the private market had an average MER of 88%, with a 10% AER and 2% profit margin. MERs varied for different segments of the student population and for different insurance carriers. For example, state colleges had an average MER of only 56%, with a 25% AER and 20% profit margin.[xcvi] The insurance carrier United, had an average MER of 46%, which was the lowest of all insurance carriers; the carrier had an average AER of 27% with a 27% profit margin.[xcvii] Additionally, the SHP profit margin

per member was typically higher than that of private market even though SHP premiums per member were generally lower than that of private insurance products; each month, SHPs took an average of $11 in profit per enrollee, while this figure was only $8 for the private market.[xcviii]

In the 2008-2009 academic year, the average medical expense ratio for schools was 72%, with 18% going towards administrative costs and 10% going towards profit.[xcix] Both state universities and community colleges had the lowest average MER out of all school types, with an average MER of 65%[c]; community colleges had a 15% AER and a 20% profit margin, and state universities had a 22% AER and a 13% profit margin. This compares unfavorably to private insurance products, which in 2008 had an average MER of 88%, with a 10%, AER and only a 2% profit margin.[ci] In the 2009-2010 academic year, the average MER was 81%, with a 17% AER and a 2% profit margin.[cii] Although the average MER represented an improvement from the data reported in the previous two reports, community colleges still had a MER of 53%, with a 15% AER and a 32% profit margin. In comparison, the private market had an average MER of 90% MER with a 10% AER.[ciii]

Twenty-nine students from 2005-2006, 43 students in 2006-2007, 20 students 2007-2008,[civ] 59 students from 2008-2009[cv], and 6 students from 2009-2010 exceeded their annual benefit maximums.[cvi] Only a few students exceeded their inpatient benefit limits, with 8 students from 2006-2007, 6 students from 2007-2008[cvii], 14 students from 2008-2009[cviii] and 10 students from 2009-2010.[cix] Although a small number of students exceeded their annual and inpatient benefit limits, the few students who exceeded these limits may have been exposed to high out-of-pocket costs. Additionally, many more

students exceeded their outpatient benefit limits than inpatient benefit levels; 1,539 students (1.8%) from 2005-2006, 1,523 students (1.5%) from 2006-2007, and 951 students (0.9%) from 2007-2008[cx], 1,901 students from 2008-2009[cxi], and 1,254 students (1.6%) from 2009-2010 exceeded their outpatient benefit limits.[cxii] Like inpatient benefit limits, outpatient benefit limits varied from school to school. Tables and figures indicating the average student premiums by school category, MERs by school category, and the number of students exceeding their annual, inpatient and outpatient benefit maximums by school categories from each of the Massachusetts reports can be found in *Appendix I*.

VI. Research: Key Informant Interviews

In this section, I present the perspectives of professionals involved in the student health insurance market, and identify problems in the market as well as potential solutions to these problems. This section is organized into the following thematic areas: 1) Collecting and Reporting Data, 2) The Affordable Care Act: Health Care Reform, 3) Benefit Levels and Costs: Striking a Balance, 4) Improving the student Health Insurance Market, and 4) An Uncertain Future. The 18 individuals who I interviewed were actively involved in the student health insurance market, and their perspectives provide valuable insights into the market's functioning. One school administrator explained:

> Of course you know, I'm a public health person, so I can tell you for example, last year we spent about $30,000 to buy around 3,000 flu shots, and we immunized 3,000 students, which is awesome. We had a very low flu season … what I care about, is if you don't get the flu, you don't miss classes, and you don't ruin your whole semester, and you don't say, "oh my god I am so behind, I have to take an incomplete, I got a C in a class that I should have gotten a B+ plus its because I was so sick, I couldn't catch up." So I care about flu, because my mission is to provide education support to students (School administrator, personal interview, Summer 2011).

Another school administrator remarked, "When you start looking at school health insurance plans, I think that anything that you can do to try to increase the benefits and get down the cost is … in the students best interest" (School administrator, personal interview, Summer 2011). These school administrators recognized the importance of keeping students healthy.

1) Collecting and Reporting Data

One of the most challenging aspects of conducting my research into the student health insurance market has been the lack of available information. The Massachusetts government provides some of the only information on the student health insurance

market. However, through my interviews, I discovered that information in the Massachusetts reports might not be accurate. One school administrator explained,

> And by the way, one of the things I've told the state, is you shouldn't be asking people to submit these reports in October and November about what there loss ratios are, because when we submit 71% in November, by February it was 82%. So, the state is submitting public reports, which makes it look like insurance companies are making big profits before the full year losses are actually in; so that's a piece that I talked to the state about, to say you're making it look worse than it actually is (School administrator, personal interview, Summer 2011).

This school administrator went on to say, "So that main document makes it look like all of these schools are just being fooled and taken for a ride. And, for us, I can tell you our final loss ratio this year was 82%. That's pretty damn good … and I hope next year it's 80% again" (School administrator, personal interview, Summer 2011).

In my interview with another government official, I explained what the school administrator had said to me, and I asked if the information in the Massachusetts reports were accurate. The government official commented,

> So, we actually changed our filling deadlines this year for the first time, and moved them back 4 months, 6 months … to address part of that issue … I think that they're accurate in that they're all taken from the same point in time from all the plans. So you should, more or less get the same level of claims experience, but you know it's not perfect and I think the balance that we try to strike is getting the public accurate information, timely and accurate information as well … so yes, it's a balance that we strike there and it's not always perfect (Government official, personal interview, Summer 2011).

From my interviews, it is unclear how accurate the Massachusetts reports are. With so little information available on the student health insurance market, the Massachusetts reports remain the best existing information on the topic. However, it is important to be aware that some of the information in the reports may be inaccurate.

2) The Affordable Care Act: Health Care Reform

When I began my research in the summer of 2011, HHS had just released its proposed regulations on how the Affordable Care Act would affect the student health insurance market. My interviewees explained how they believed the ACA would influence the student health insurance market. Their responses illustrate how health reform will bring new challenges to the student health insurance market.

One school administrator explained, "You know I think healthcare reform is great, and I've been advocating for it since 1993, but I think what we are setting up now may artificially raise costs for some students who don't need it to be as high as it's going to be" (School administrator, personal interview, Summer 2011). This administrator went on to say,

> I think that we still don't know all of what's going to happen, but what's already happening is that we are all starting to think about and escalate our benefits for student insurance … we know the costs of health insurance will rise because the benefit maximums are going to increase (School administrator, personal interview, Summer 2011).

Interviewees indicated that in order to comply with HHS regulations, student health insurance plans would become more expensive. Another school administrator explained that his/her school would need to think about how to make their student health insurance plan more cost effective. The administrator remarked,

> We want to increase our benefits to fully compliant plan and we're going to need to control our costs when it comes to advanced health plan practices, leveraging, where possible, on campus health services to ensure most cost effective delivery of services (School administrator, personal interview, Summer 2011).

Another school administrator explained, "But with healthcare reform, we may not have a choice and it may just be that we wind up about a 3 or 4 hundred-dollar increase, or a 5 hundred-dollar increase happens, and that means that we have a fully

comprehensive plan, and that's what it is, and people over time adjust to the cost" (School administrator, personal interview, Summer 2011). This school administrator believed that because of the ACA, cost increases were inevitable.

In a follow up email to a school administrator that I had interviewed, I asked, *are you in favor of the proposed regulations for student health insurance plans set forth in the Patient Protection and Affordable Care Act? Why or Why not?* The administrator responded,

> I'm not completely sure I like all of it. Student insurance can have increased benefits required without trying to make it like all other insurances. Without education reform to go along with health reform, I really worry about the cost of education becoming unaffordable. I really like that students can stay on their parents insurance now through age 26. That's a great provision (School administrator, personal email, Summer 2011).

School administrators were concerned with potential cost increases. When talking about health care reform, I asked one school administrator if the increased coverage mandates specified in the proposed regulations were beneficial. The administrator responded, "It's a two edged sword … I think it's great for those students that need that extra coverage … but it's going to raise the cost for everybody" (School administrator, personal interview, Summer 2011).

3) Benefit Levels and Costs: Striking a balance

When creating student health insurance plans, school administrators are faced with a very difficult task; school administrators need to determine how to best provide students with a protective student health insurance plan, while also keeping plans affordable. I asked one school administrator in Massachusetts, *what do you believe is the most pressing problem involving student health insurance in Massachusetts and at your*

university? His/her response illustrates the difficulties school administrators face, striking the right balance between costs and coverage levels:

> I guess I believe that there are a couple of issues. One is that tension between trying to meet the needs of students, some of whom have a lot of financial support and others of whom are struggling financially with higher education being as expensive as it is, and health insurance is something that's important, very important, but it adds a cost to students' overall expenses. And trying to come up with benefit levels that don't leave them vulnerable, but also address their financial restrictions so that they are not trying to make a decision between whether they can go to school or not based on an extra couple thousand of dollars a year in premiums. On the other hand, we try to point out to students is that if you have a bad insurance plan, and you wind up with an unexpected illness, there are out of pocket expenses that can impact you as well (School administrator, personal interview, Summer 2011).

This school administrator believed that if student health insurance plans were too expensive, it could deter individuals from coming to school.

Addressing both the cost and coverage concerns of students is a difficult process. One school administrator remarked,

> I have to weigh the cost to the benefits. For example we have a pharmacy benefit of a $1000, that's the maximum … that that's nowhere near adequate … But the problem is that I'm at a school that has a very middle class enrollment; these are people that do not have much money … who can't afford $1000 or $2000, or $1000 policy. So I'm providing them with a policy that covers probably 95% of their needs (School administrator, personal interview, Summer 2011).

In order to strike this balance between cost and benefit levels, students are often provided with inadequate student health insurance plans. One government official in Massachusetts remarked, "I don't think that students are getting the best deal right now" (Government official, personal interview, Summer 2011). When explaining the Massachusetts reports issued by the Division of Health Care Finance and Policy (DHCFP), the official explained,

> Actually, if you look at our report and compare SHIP plans to the private market in Massachusetts, they're exceptionally affordable … the problem, however, is they don't always have good, comprehensive coverage. So you're paying for it on the other end by putting risk on students, those students who end up being sick are going to pay more out-of-pocket than … your typical citizen with an average employer sponsored plan in Massachusetts (Government official, personal interview, Summer 2011).

One private consultant explained, "The insurance industry has basically sold what I'll call junk policies to students for years" (Private consultant, personal interview, Summer 2011). The consultant explained,

> I would say that … the fundamental problem with the contracts they've been sold is that they are not health insurance. They are accident policies written and masked to look like health insurance. For example, if you look at a typical student health insurance contract, there are 3 pages of exclusions and one page of what the contract covers. That's not health care (Private consultant, personal interview, Summer 2011).

One interviewee who worked for an advocacy group remarked, "Many of the plans are woefully inadequate at protecting people who do get sick" (Advocacy group, personal interview, Summer 2011). She/he went on to say,

> The students we've talked to who've had the misfortune of getting sick and incurring these out-of-pocket expenses, their greatest concern is that these policies were inadequate and they weren't fully aware of that before having their experience (Advocacy group, personal interview, Summer 2011).

Interviewees made it clear that the benefit levels in student health insurance plans were a major concern, as were costs.

Interviewees explained that if students had high out-of-pocket expense, they would refrain from getting necessary medical care. One school administrator remarked, "Really, for most of these kids, it just basically comes down to money … when you look at the age of these students they don't really think that insurance is important for them" (School administrator, personal interview, Summer 2011). Interviewees indicated that

students are concerned with the costs of their plans, and want them to be as inexpensive as possible. This is particularly important when combined with discussion of health care reform's impact on the student health insurance market.

However, it is important not to exaggerate the problems within the student health insurance market. When one school administrator was asked, *do you find that students are ever exceed their coverage limits*, the administrator explained,

> It happens, albeit infrequently and that's definitely one of the things that we keep in mind as we construct our plan … is that … the annual limit on coverage … is a concern because we don't want … people having bills that bankrupt them ... But it's pretty uncommon that people go over the plan max, you know in the order of one or two people every couple of years (School administrator, personal interview, Summer 2011).

One school administrator explained, that students do not typically exceed their annual limits. The administrator explained, "It is very rare that we have a student who maxes out the $25,000 … per occurrence. We did have one student diagnosed with cancer once who did" (School administrator, personal interview, Summer 2011). For the most part, even before HHS regulations, these plans provided enough coverage for the average student, and it was a rare occurrence for students to exceed their benefit levels.

Additionally, student health insurance plans are much cheaper than plans offered in the general market and one private consultant remarked,

> Well I think this idea that students can't afford real health insurance is really offensive. Because if you're at a school where your tuition and fees are $29,000 a year and you're saying, "This makes or breaks us having a plan that costs rather than $600, it costs $1600," that's just absurd … the cost benefit difference is so huge having student be able to get prescription drugs and not be limited to having huge out-of-pocket expenses if they have surgery or something on a outpatient basis. It just doesn't make any sense to me. And you hear that argument all the time, "Our students can't afford this" (Private consultant, personal interview, Summer 2011).

This consultant believed that schools should increase the price of student health insurance plans if it meant that benefit levels would be higher. The consultant rejected the argument that schools cannot make their plans more comprehensive because of affordability issues. When this consultant was asked, *do you think that students would be willing to pay a little bit higher of a premium in exchange for a better benefit package?*, the consultant explained,

> We have never had a focus group or survey with students that they weren't first and foremost being concerned with the coverage being adequate. So if you said, "Should we cover mental health care and our prescription drug program?" the answer is overwhelmingly yes (Private consultant, personal interview, Summer 2011).

By contrast, some interviewees indicated that purchasing a student health insurance plan could be burdensome for certain students. Especially on top of other student expenses, like tuition, housing and food, the cost of a student health insurance plan can act as a barrier to students pursuing an education. One school administrator explained, "A $10 co-pay might not sound like a lot for some people, but you know for some students that's the difference from being able to stay in school and not stay in school" (School administrator, personal interview, summer 2011).

One private consultant provided an important lens with which to view affordability issues in the student health insurance market. When I asked the consultant, *do you believe that student health insurance plans are typically at an affordable price?*, the interviewee explained,

> Relative to the rest of the health care spending in the United States, yes I do. Why? To just give you some examples; the typical health insurance plan for an employer in the United States, costs on average some place between 5 and 6 thousand dollars. The typical student plan in the United States costs something in the area of $1500 to $2000. So it's all relative, and when you

> say is it affordable, affordable is in the eye of the beholder. If we're dealing with low-income students … $1500 is a lot of money. But if you're dealing to an employer who's looking at a family cost that's $12000 a year, $1500 is dirt-cheap. So again, when you first wrote me I said you have to think about your perspective here. So terms like affordable has got to be phrased in the terms of in the eye of the beholder (Private consultant, personal interview, Summer 2011).

Although student health insurance plans are less expensive compared to plans in the general market, students are often in a different financial situation. School administrators are placed in a difficult situation, and balancing a student's health insurance needs with the cost of a student health insurance plan is a tremendous task. Any increase in a plan premium is potentially a hardship for students. Because of this, looking into options to improve the student health insurance market are all the more important. The following sections will provide recommendations for improving the student health insurance market, attempting to find a way for school administrators to increase benefit levels in student health insurance plan, while keeping the costs of these plans affordable.

4) Improving the Student Health Insurance Market

In this section, I explore methods to improve the student health insurance market. This section is organized into the following topics: 1) Student Health Centers and Preventive Medicine, 2) Educating Involved Parties, 3) Self-Insurance 4) Forming a Consortium: Risk Pooling, and 4) Self-Insured Consortiums.

Student Health Centers and Preventive Medicine

One private consultant explained, "The most efficient place to treat most college students is at the student health services" (Private consultant, personal interview, Summer

2011). Creating a robust student health center that offers students a variety of procedures on campus, along with the encouragement of preventive medicine, can be an effective means to lower the cost of a school's student health insurance plan. One school administrator explained, "The role of the student health services is really crucial; it's definitely a symbiotic relationship between the student health services on campuses, and the student health insurance plan" (School administrator, personal interview, Summer 2011). Another school administrator remarked, "And I think that when I look at healthcare reform, what happens at colleges, I wish it could've become a model for healthcare reform, because you have a health center, and at the health center most of what a student needs is accomplished for $600 a year" (School administrator, personal interview, 2011). The $600 a year refers to a fee that every student at this administrator's school is required to pay each year to access to the school's health services. This school administrator also explained,

> So part of the goal of everyone having health insurance is to bring the expense of healthcare out of the hospitals and emergency rooms, and put it into the outpatient clinics, the mental health clinics, and the primary care sites. I think we already do that as a college because we have a health center and a mental health center, so that's why this is such an awesome model. The only other way I think we can try to keep cost down is to provide an environment that is inviting and that educates students about the importance of taking care of themselves, and not waiting, and trusting us, and feeling safe enough to get the care that they need before something gets worse and they wind up in the hospital (School administrator, personal interview, Summer 2011).

School administrators who worked at their school's student health services believed firmly in this model, and its ability to reduce health care costs. A different school administrator commented,

> We're able to see students early and often … if someone wakes up and doesn't feel well, they can be seen that day. I mean at least here we don't make appointments; it's a walk in … what we try to explain to students is you don't

> have to wait until you are at like death's door or have an abscess in your throat. I mean, come see us and we'll put you on medication. I mean, we can see you early and often, and again, if you are not feeling better, come back and see us in a couple of days and there are no co-pays. So, I'd like to think that just the access and the availability helps keep kids out of emergency rooms, keeps kids out of specialists because we are able to deal with them here, before it becomes a major issue or an expensive problem (School administrator, personal interview, Summer 2011).

If a school establishes a comprehensive student health center, these facilities can be equipped to deal with most of a student's needs, and aside from the clear fiscal benefits of establishing an effective health center, they also have the additional advantage of keeping students healthy. One school administrator explained that student health centers could play an integral role in lowering students' utilization levels. The administrator remarked,

> For example, we have an on-call service that's run by nurses after hours so our students call in … and those nurses help manage care. So if somebody can wait till the next morning or … instead of having them run off to the ER because that's what they think they need to do, they're talking to somebody and they're getting some advice in terms of managing that particular issue in a more prudent, cost-efficient manner (School administrator, personal interview, Summer 2011).

Schools have the ability to provide students with an array of quality health care services on campus, and at a more cost-effective price. Additionally, schools can be innovative, and develop programs like an after-hours call center to further lower students' utilization levels.

Along with encouraging the development of student health clinics, schools should focus on promoting preventive medicine and public health models of care. One school administrator explained,

> I think increasing the focus on prevention and health promotion in general, including mental health, will help. I think paying attention to what we need to do as a community, in college and universities, on campus, is important that we include health as the same as, you know, academics. We have to support health to

> get people through college. I don't think it's as embraced as it needs to be. If you look at England and Australia and how far they are with health promotion and well being, they are a lot farther than we are in the United States (School administrator, personal interview, Summer 2011).

This interviewee believed that health care promotion was as important as academics on a college campus, and that schools need to start placing more of an emphasis on preventive medicine.

Other interviewees agreed that preventive medicine needs to be encouraged more on college campuses, and that it could play an important role in driving down the cost of health insurance. One school administrator explained,

> I think prevention is key … We all know these things, but it is a lot harder to sell that idea on a national level, that if we just invest a little money before the problem exists it's going to actually drive down costs … But ... I think that it makes sense if you are looking at a population of again, pretty healthy kids, you know anything that you can do from a prevention standpoint, you know whether it's screening, education, birth control … weight management, dietary counseling, nutrition counseling, all of those kinds of things … I think that helps to drive costs down in the long run (School administrator, personal interview, Summer 2011).

A student's health is integral to their success at school. Having a student health center that is focused on health promotion and provides students with affordable access to primary care can enrich the overall quality of a student's university experience, as well as drive down students' overall health care expenses.

However, there are several barriers in place that can influence a school's ability to establish a student health services. One private consultant explained:

> Now keep in mind, the student health services is part of the general operational costs of the university. So when a chancellor is looking at what is the overall record of running a university, they look at the student health services and say, "that is not our main thing in business, why are we doing this?" So the problem is that the student health services are under attack in universities (Private consultant, personal interview, Summer 2011).

The consultant went on to say,

> But if you are running a school … Let's take a very large public institution that's been in the press, University of California. University of California has a budget shortfall. They are not getting enough money from the state, they are getting half of the money from the state they were expecting to have. So if I am running the school, where do I cut? Do I cut tenured faculty? Do I increase tuition? Do I cut services (Private consultant, personal interview, Summer 2011)?

Another private consultant remarked,

> Well I think colleges and universities should have the freedom to say we're not going to have a health service, we're not going to have a counseling center. We're going to have as low a tuition and fees as we can … we're not into that game. So if you want to have those kinds of services go somewhere else. We're all about low cost. I think schools should have the flexibility to decide for themselves what is right for their students (Private consultant, personal interview, Summer 2011).

Establishing and maintaining a student health center, as well as expanding its operations, costs money and takes work. Schools that want to create a student health services need to make an investment, as well as hire staff to run the center. Additionally, if a student health center is not run effectively, it can do more harm than good. One consultant explained,

> But if you have poor quality of care, and it can be perception not, quality is both perceived and also medical delivery…if the facility isn't attractive and clean and appears professional and they don't see students on time it can be very damaging and not be cost effective. So having them function properly is important (Private consultant, personal interview, Summer 2011).

An effectively managed student health center can help keep students healthy, as well as lower the cost of student health insurance plans. However, setting up these health centers takes work and resources, and these facilities need to be managed efficiently.

Educating Involved Parties

Education can play a pivotal role in improving the student health insurance market. School administrators are often tasked with developing and monitoring a school's student health insurance plan. However, the administrators involved in this process do not always have training in procuring and designing health insurance plans. One school administrator explained,

> Personally I think the biggest problem is that a few of us, if any of us who are currently directors, have any training or experience in insurance, health insurance. We got our jobs through other ways. I got my job as a business manager of a, of a health center at ___ … Others are former nurses or practicing nurses, nurse practitioners, and deans, administrators, you know a whole gambit of people, and a few of have much information about how insurance works. I mean, it's an extremely complex business (School administrator, personal interview, Summer 2011).

I asked one government official if he/she thought there were any methods that could be used to lower the cost and increase the benefits of student health insurance plans, and his/her response explains one of the most basic and logical solutions to improve the market. The official explained, "Maybe even just educating administrators that … there are certain things in their plans that are horrible and they shouldn't stand for. You know, like some level of education might provide administrators who have no support, maybe no background in doing this kind of work." The official went on to say, "I mean it's usually you know, like .5 [%] of their job … They have a real main real job and then they just sort of, this gets thrown at them every year. And they're like, I don't know what I'm doing" (Government official, personal interview, Summer 2011). One school administrator explained:

> And again I care about my own college, but in general I do care that colleges are not taken advantage of by insurance companies when a lot of universities health services are run by physicians who may or may not have a lot of experience in the

> finance and health insurance, and they're doing their best, but this is seen as a piece of their job and not a major focus of their job so making sure that they get the information that they need, or the support that they need to make good decisions for their schools (School administrator, personal interview, Summer 2011).

While talking to interviewees, it became clear that a lack of education on the part of school administrators presented a major problem. The individuals in charge of advocating on behalf of students, and designing the student health insurance plan do not always have training that qualifies them for the job.

A school administrator's understanding of the student health insurance market is affected by where they get their information. One government official explained, "Up until state intervention of any kind, our campuses have only one source of information, their broker." The official also explained that the brokers,

> Do a very good job of convincing their clients, who are the institutions [colleges and universities], they're on their side and the insurance companies, that they're on their side. Meanwhile, a broker never really deals with students in terms of decision-making … if a broker says you have to go up in price, our institutions up until recently have lacked any tools to counter argue that (Government official, personal interview, Summer 2011).

It was not that this government official was trying to undervalue the work done by insurance brokers. In many ways, they provide a valuable service. However, these brokers should not be a school administrator's only source of information. While talking about the Massachusetts student health insurance market, the government official explained,

> At least in the public system, and often in the private system as well, the procurement … was driven by brokers, insurance brokers who get a percent of premium per student as a reward. So, there's a financial incentive for the premiums to be high, and there is a financial incentive for the premium to increase, and our institutions, especially our community colleges and state universities … lacked the real expertise and resources at their fingertips to procure

> in a way that makes sense (Government official, personal interview, Summer 2011).

It is not just school administrators who do not understand student health insurance plans; students also have a limited understanding of their health insurance plans. One school administrator explained, "You're on your own for the first time. You're dealing with health insurance that you know nothing about" (School administrator, personal interview, Summer 2011). Another school administrator explained, "They don't understand it. Even adults don't understand it until they get the bill, and then they're upset. And then they think it's, you know, those of us on site that" (School administrator, personal interview, Summer 2011). An interviewee working for an advocacy group explained,

> I mean some students just won't have a great understanding of their insurance plan unless they have to use it … I think that that's problematic … I've talked to some students who have gotten injured and didn't want to go to their plan because they have no way of knowing how much it's actually going to cost them (Advocacy group, personal interview, Summer 2011).

In order to have students understand their student health insurance plans, school administrators need to ensure that the structure of a student health insurance plan is clear. One school administrator explained,

> And students came in and said you know I have a problem with my knee, and they went for outpatient services and found out that, oh there is a $1500 maximum, but it's all the fine print and … students are smart and busy, and young, and having a lot of fine print just didn't work for them. So I would say that not having a lot of fine print restrictions that are confusing, getting clear accurate information, having something be easy to use, and not having a lot of explanation required for how to use your pharmacy card (School administrator, personal interview, Summer 2011).

The administrator went on to say,

> I think it's also helpful that students have a health services that can help them understand … health insurance is extremely confusing and sometimes they'll get

> something that they think is a bill, but it's an explanation of benefits and they don't understand it and they think they owe it. So I think what's important for students is to have a resource (School administrator, personal interview, Summer 2011).

Additionally, interviewees indicated that they believed students would be more accepting of premium increases if they had a better understanding of the student health insurance market. I asked one government official, *do you think that students would be willing to pay a little bit higher of a premium for a more comprehensive benefit package*? The official replied, "I think if they were educated they would" (Government official, personal interview, Summer 2011).

There are a variety of measures that schools can take to educate their students. One school administrator explained that his/her school was trying to set up a class to teach students about their health insurance plans. The administrator explained,

> Actually, we're doing the first week of school, what we're calling, "student health 101," or "student insurance 101," where we are bringing on our underwriter and they're going to talk about, what's co-insurance, what's co-payments, how can you best not have to utilize specialty, or when is it best to use specialty, and when is it best to use primary, so students really get a handle, because sometimes it's the first time that they've ever had their own insurance, so we can look at how can you be best consumers (School administrator, personal interview, Summer 2011).

There are a variety of different actions that school's can employ to help make their students more informed consumers of health insurance. However, not all school administrators believe that it is their job to educate their students. After I asked one school administrator, *do you think that there are any particular ways that you can make plans more understandable to people*, the administrator remarked:

> I don't think that's necessarily our responsibility … I think as consumers there's a need to be informed about, you know, buying things anywhere from a car to a health insurance plan. So I don't think that's really our responsibility, and I think that the information that we put out to the community is pretty complete and I'd say, pretty easy to understand. It's just sort of making the time to look through,

> which you know, again not just students, but most people don't do … I don't think there's much we can do to make it more understandable other than changing the whole system (School administrator, personal interview, Summer 2011).

Self-Insurance

Self-insurance is another option that schools can consider to improve the affordability of their student health insurance plans. The first self-funded employer sponsored health insurance plan was developed in the 1930s; these plans became extremely popular in the late 1970s and early 1980s. Currently, over 300,000 students, or at least 10 percent of students covered by a student health insurance plan at a four-year and graduate degree granting school, are covered by self-funded plans.[cxiii] In a fully insured plan, a school pays a fixed premium per enrollee to a health insurance company, who then bears the risk of paying for enrollee' health care expenses. Conversely, under a self-insured plan, a school would assume the risk associated with paying for their enrolled students' health care expenses, taking on the risk of incurring unpredictably large claims; schools pay students' health care claims, rather than contracting with an insurance company.[cxiv]

Self-insured plans are desirable for a variety of different reasons. For example, they are regulated differently than fully insured products and exempt from some of the ACA requirements, as well as from state insurance regulations, including state-specific benefit mandates and state premium taxes. Self-insurance can be financially appealing to schools, and can be less expensive than purchasing a fully-insured health insurance product.[cxv] For example, insurance company profits as well as premium taxes are either eliminated or reduced under self-funded plans. Furthermore, when there is money left over from the premiums collected in the previous year, it does not go to insurance

company profits. Schools can put these funds in a reserve to use in future years, and these reserve funds can even earn interest income for schools. Self-funding can be as much as 30% less expensive than fully insured plans. Additionally, schools that self-fund have greater control over their plan design.[cxvi]

However, self-insurance can be more financially risky. Schools that self-insure take on the financial risk of insuring their students, rather than an insurance company. Additionally, smaller schools will have more difficulty self-insuring, because they are at a greater risk of claim instability because of their smaller insurance pools. However, schools can purchase stop-loss insurance policies to mitigate their financial risk; stop-loss coverage is an insurance product that pays for claims above a certain cost, and can protect a self-insured plan's financial solvency.[cxvii] High cost medical claims are less of a liability when stop-loss coverage is purchased. Additionally, in most self-insured plans, third-party administrators (TPA) are contracted with to provide administrative functions to schools, including paying for claims, provider network access, analyzing a schools utilization levels, collecting premiums, and providing customer service.[cxviii]

Self-insurance is a common practice used by employers to insure their employees, and colleges and universities can also effectively self-insure their student population. One private consultant explained,

> If you brought an employee benefit manager in to a typical college or university and you said, "Here is a seven and a half million dollar fully insured health plan that returns 70 cents on the dollar", they would be appalled … They just wouldn't understand why that plan is not self-funded (Private consultant, personal interview, Summer 2011).

This consultant was a firm proponent of student health insurance plans, and thought that self-insuring could vastly improve the student health insurance market.

When I asked him/her, *why don't more schools self-insure their student health insurance plans?,* the consultant explained,

> Because they are irrationally afraid of self-funding, it sounds scary and more complex than it is. And with sixty percent of the private work force out there being covered by self-funded health plans, my gosh, if you have more than two hundred employees then the odds were over eighty percent that you'll be in a self-funded health plan so its really an irrational fear on the part of colleges and universities and I think that colleges and universities have not had enough skin in the game with their own budgets (Private consultant, personal interview, Summer 2011).

There are clear benefits to self-insuring. One school administrator explained, "You can have a lot more transparency when you're self-funded. The Medical Loss Ratio when you're working with an insurance company and they're telling you what the Medical Loss Ratio is, it can be challenging to unearth the real numbers and understand what it truly is" (School administrator, personal interview, Summer 2011). The administrator went on to say that while self-funding,

> You're in the driver's seat. You're not negotiating or dealing with the used car salesmen, the insurance company. You know your data. You understand your claims experience. You know what it takes to pay your third party administrator to pay claims. You have utter transparency in every dollar that is spent it. So that's a benefit. You have the ability to lessen that loss ratio (School administrator, personal interview, Summer 2011).

Self-insuring can help schools save money, and it also increases transparency. When working with an insurance company, you may not know exactly what your premium dollars are being spent on. In a self-insured plan, a school can know exactly how its money is being used. However, developing and running a self-insured plan can be difficult. One school administrator explained, "You can really save money on the overall loss ratio part of it. The challenge is, is you have to have the reserves in place and you need to have the management and consultant expertise to assure that you're

managing the plan appropriately" (School administrator, personal interview, Summer 2011). One private consultant commented that, "The biggest problem with self-funding is the schools that have gotten into it without appropriate controls" (Private consultant, personal interview, Summer 2011). Schools that self-fund need to make sure that their plans are set up properly. Insurance companies are indispensible for certain services. They are able to provide self-funded schools with the administrative functions they need, as well as access to their provider networks. Schools are able to contract with insurance companies for many of the services that make self-insuring difficult.

However, contracting with an insurance company does not relieve school administrators of their responsibilities. One government official explained that while running a self-insured plan, "I mean you really need to be paying attention … And like you said you'd be hiring someone to do that, but the person who's managing that contract still needs to be paying attention to what's going on" (Government official, personal interview, Summer 2011). Even when a school contracts with an insurance carrier to help them self-fund, they still need to monitor the plans and make sure that they are being run correctly. One school administrator explained,

> And it's a hard thing to manage, and it may require two staff people to do it, and I think for schools that is really hard because they see themselves in the business of higher education, and every time you ask them to be in a different business I think it requires a lot of education about how and why. So it's a challenge (School administrator, personal interview, Summer 2011).

Schools may refrain from self-insuring because of the risk involved. One school administrator explained that schools need to decide, "what kind of a stomach do people have for risk" (School administrator, personal interview, Summer 2011). Another school administrator explained,

> I think there's pros and cons to self-insurance. You have to feel comfortable enough to where you have a pot of money to where you can set aside and feel like you can afford the risk, but that's always an option and as you know, there are some schools around here that are self-insured (School administrator, personal interview, Summer 2011).

One school administrator explained,

> I think that a lot of schools need to think about self-insurance. Some schools don't want to, because they are too small … so they worry about that one big claim and not necessarily feeling like they have the resources to handle that or the knowledge about how to successfully self insure (School administrator, personal interview, Summer 2011).

However, one private consultant believed that any school could self-insure.

Although it is more difficult for a small school to self-insure, he/she explained,

> Well the smallest self-funded plan we work with is a ___ theological seminary with 350 students … it is not the size of the student population that makes self-funding work or not work, well once you get to a certain number of bodies … but it's the predictability of the risk and you can have a plan that covers ten thousand students be less predictable than a plan that covers one thousand students (Private consultant, personal interview, Summer 2011).

If you review your claims experience, and make careful predictions, this consultant believed that most schools could self-insure. The consultant went on to say, "So technically if it's done right … there is often no more risk with self-funding then there is being fully insured if you fully fund these contingent liabilities" (Private consultant, personal interview, Summer 2011). If schools are careful with how they set up their self-funded plan, they can mitigate much of the risk. One private consultant explained, "Well I mean how much stop-loss coverage you buy is also essential. As you build reserves you can buy less insurance. You can tolerate more risk" (Private consultant, personal interview, Summer 2011). In order to self-insure, it is important for some schools to buy stop-loss coverage and build up reserves. However, when talking about a client university, a private consultant remarked,

> ____ has quit buying stop-loss coverage both for their employee plan and their student plan … it took them 20 years to build reserves to the point where they can do that, but yeah often plans … can build up enough reserves that they quit buying stop-loss coverage because they can handle any bump in the road (Private consultant, personal interview, Summer 2011).

If schools carefully plan and administer their self-insured plan, they can be more stable and financially beneficial in the future, once adequate reserves are built up. However, in my interviews, there was disagreement amongst the consultants that I spoke with. One private consultant was less optimistic about all schools being able to self-insure. Although he/she thought it was an option for many schools, the consultant explained, "It's a question about what is the size, and not every school can … self-fund." He/she also explained,

> It takes a good size of risk to either self-fund or pool. For example, I'm working with 10 colleges in ___ right now; none of the colleges have more than 2,000 students. They're not large enough to self-fund on their own. They're also not politically astute enough or connected enough to self-fund as an aggregate risk (Private consultant, personal interview, Summer 2011).

The consultant also explained that even though stop-loss coverage can protect a self-insured school, if a school has a high claims experience one year, their stop-loss coverage can increase in price the next year. The consultant explained,

> Again, the insurance companies are setting the price for that aggregate stop loss. So in subsequent years there will be an increase in price of the stop-loss … And insurance companies aren't stupid, they've made a lot of money doing this stuff. And their job is to make sure that they are increasing rates and not paying all of their claims out (Private consultant, personal interview, Summer 2011).

This consultant was not trying to discourage self-funding. He/she explained, "It is a solution, it's not the only solution" (Private consultant, personal interview, Summer 2011). Additionally, the consultant explained, "A small school can self-fund, but if I were the actuary working on their plan, I would add a little extra margin to the premium

price just to make sure that I've got enough money to cover the cost of claims." He/she went on to say,

> And if you are a small school self-funding, you add extra margins to your rates to make sure that you have enough money to cover the costs of claims. So think about the self-funded plan, you only have so much money that is going in. And that's where self-funding got a very bad name in the mid 70s, where a bunch of employer groups had banded together and pooled and self-funded, but they didn't set their rates properly and the pool ran out of money (Private consultant, personal interview, Summer 2011).

Self-funding is possible for all schools, but it is more challenging for smaller schools, and possibly less financially attractive because of the extra money that these schools have to build into their premiums.

However, even with the challenges of self-insuring, many schools already have experience self-insuring. One school administrator explained, "I see it as maybe an option to be explored, because we're self-insured as employers" (School administrator, personal interview, Summer 2011). Many schools already have experience in self-insurance through the plans offered to their employees. It is possible that self-insurance is not a good option for certain schools, and it takes a considerable amount of work. However, school administrators should look into different options. One school administrator explained,

> I'm in favor of all options, so I'm looking at everything right now … I'm in favor of putting pressure on the insurance companies, researching self-insurance, and researching pooling and I haven't made any decisions yet. I'm still waiting and I'm still researching (School administrator, personal interview, Summer 2011).

Forming a Consortium: Risk Pooling

According to the GAO report, in the 2007-2008 academic year, 500 colleges jointly purchased student health insurance plans in one of 37 consortiums. Consortiums

are groups of colleges and universities that pool their resources together for a shared objective, including purchasing health insurance. For example, California's 109 community colleges purchase their student health insurance plans together as the Community College League of California.[cxix] Forming a consortium is also referred to as risk pooling.

Risk pooling, or establishing health insurance purchasing alliances, has been a component of several attempts at health care reform.[cxx] Although there is little literature on colleges' risk pooling, there is scholarship on purchasing pools in the employer and individual markets, and this data is applicable to discussions involving student health insurance. One method used to help small businesses provide health insurance to their employees is through the establishment of association health plans (AHP), which is a group purchasing alliance. When it comes to health insurance, larger groups of individuals have greater market clout and bargaining ability than small businesses and individual consumers; this is why large employers have an easier time insuring their employees.[cxxi] The idea behind purchasing pools, is that it offers lower administrative costs (because there are fewer insurance plans), and gives small groups of individuals more bargaining power because of their unification with other groups; greater collective purchasing power could lead to an increased ability to negotiate prices with insurance carriers.[cxxii] According to Wicks and Hall,

> The idea of having small employers join together to purchase health insurance has great intuitive appeal. Most small employers lack the resources, the expertise, and the inclination to cope effectively with the complex task of buying health insurance. Moreover, as separate small purchasers, they have no market power to negotiate for a better deal as large employers do. Having each insurer sell to and service hundreds of individual employers in an area also seems very inefficient. Establishing some way for

> small employers to purchase collectively seems like an obvious solution to these problems.[cxxiii]

Rather than having one school buy health insurance on its own, pooling involves multiple institutions collaborating as a group in order to spread risk over a larger population, enhance bargaining power, lower administrative costs, and negotiate better rates with insurance carriers. One government official explained,

> Academic principles indicate that the larger group you have the less likelihood there is that you are going to have severe risk fluctuations from your claims experience, and also I think market principles would indicate that a larger group can leverage better market power to leverage better prices. And to me, if you are going to have to increase premiums because you're being forced to have better coverage, which I am totally in favor of, you have to think of the students though, and their out-of-pocket costs you want to keep them as minimal as you can … So one of the ways you could hopefully mitigate would be by leveraging group purchasing power (Government official, personal interview, Summer 2011).

Some schools have already begun to form consortiums. In Massachusetts, for example, in response to the Division of Health Care Finance and Policy's reports on the student health insurance market, Governor Deval Patrick directed a multi-stakeholder collaborative to improve the student health insurance market. The Department of Higher Education formed the SHP Steering Committee in order to help establish a group purchasing initiative for Massachusetts' state colleges and universities. Through this initiative, the Commonwealth was able to get state universities to form a risk pool and community colleges to form a risk pool.[cxxiv] The report indicated that,

> In the first year of the procurement effort, the Committee succeeded in significantly improving coverage for approximately 12,000 state university and community college students, with minimal increases in premium cost. For the 2010-2011 academic year, state universities and community colleges offered SHPs without annual benefit maximums or per illness and injury caps on outpatient services. Removal of these caps will minimize coverage gaps for students. Additionally, state university and community college students have improved access to preventive care, an array of medical and disease management tools, and a broader provider network.[cxxv]

The tables in *Appendix II* show the changes in benefit levels that Massachusetts' community college and state universities were able to achieve because of the group purchasing initiative.

One school administrator, explained the problems facing small universities who want to set up a student health insurance program, "There are so few students participating that we don't have a lot of carriers interested in us" (School administrator, personal interview, Summer 2011). The administrator explained that his/her school typically had fewer than 100 students on the student health insurance plan. The administrator went on to say,

> When you have a small pool of insured students all it takes is one significant claim to drag your loss ratio up … We've had insurers just walk away and say that we don't want to be involved anymore, and when we do find an insurer who will take us, they either … eliminate the … coverage or they make the premium unmanageable (School administrator, personal interview, Summer 2011).

The school was in an extremely difficult situation, and the school was also a risky business venture for insurance companies. The administrator explained, "Because our loss ratio is so high, we have no negotiation power at all … My hands are tied in terms of really helping the students" (School administrator, personal interview, Summer 2011). For this particular school administrator, risk pooling would be an effective strategy to improve the school's student health insurance plan.

For some schools, risk pooling has the potential to allow schools to increase the benefit levels of their student health insurance plans, while controlling the rising cost of health care. While discussing Massachusetts' group purchasing initiative, one government official explained, "I think that there is power in numbers and I think that … some of the deals that we have been able to get frankly for the community college and the

state schools really demonstrates that" (Government official, personal interview, Summer 2011). However, there are several barriers in place that can inhibit the formation of consortiums, and make risk pooling undesirable for certain schools.

One school administrator from a Massachusetts state school that was involved in the Commonwealth's recent pooling initiative explained,

> So I think historically our loss ratio had been kind of low … compared to some of the other schools … I know in the beginning … the other schools are going to be benefiting from having us in their pool, which I think is one of the reasons historically that we had stayed out of the consortium because it wasn't necessarily benefiting us to be joined because we are basically taking on the loss ratios of schools that are much higher (School administrator, personal interview, Summer 2011).

This school administrator explained that his/her school has historically had good claims history; their students typically utilized less health care then the other schools that they were pooling with. Because of this, it could be financially disadvantageous for the school to enter into a pooling arrangement with schools with students that were more expensive to insure. One private consultant remarked,

> There was a move to try to get a number of schools to kind of pool their risks together. The problem is with a pool, the people who are better than average can buy it on their own for cheaper, the people who are worse than average support it. So, pooling the aggregate risk for a bunch of schools who are not affiliated is probably not a good political idea. Why? The school that can buy it cheaper, the administration is going to just get hammered by the parents and by other people involved (Private consultant, personal interview, Summer 2011).

For some schools, it may be cheaper to continue to buy health insurance independently. As this consultant explained, it can be a bad political move for schools to join with other schools if the arrangement is financially undesirable. Another private consultant believed that the savings that could be generated from risk pooling is limited. He/she explained,

> So you know to form a consortium to get that spread of risk … what you get is nominal savings in claims administration, but once you get to a group of 10 thousand plus lives there's very nominal savings above that by making it 50 thousand by having seven schools together (Private consultant, personal interview, Summer 2011).

Additionally, there are other barriers that schools need to overcome in order to form a risk pool. One government official explained,

> I think … people … loath to give away their control … Because each school is unique, and one school is going to have different claims experience then another school, some one is always going to do worse … So if you decide to group with everyone, you may have had great claims experience last year … School A and school B might have had that one student that just blew through their … hundreds and thousands of dollars of claims, and it's throwing their whole claims experience off, and by merging, school A is going to lose out. It's going to lose out in the first year, and … budget people can be very focused on the immediate and not on the long term (Government official, personal interview, Summer 2011).

Interviewees explained that schools do not like to lose control in designing and making decisions about their student health insurance plans. Additionally, negotiating plan design in a consortium can be difficult. One government official involved in Massachusetts' group purchasing initiative explained,

> The hardest part is agreeing on plan design. Because some people feel like that will be a step down for them, others feel like it is too much of a step up … It's very difficult to get people to come together around plan design (Government official, personal interview, Summer 2011).

One school administrator in Massachusetts remarked,

> II think that if you compare … Salem State, or Framingham State to like Northeastern … I think the needs of our students are different and … I think just the demographics, the history, the sort of financial situation of our students is quite different. So I think that, it might be a little tricky because … our students can't afford some of the things … that the private schools could justify (School administrator, personal interview, Summer 2011).

Interviewees explained that establishing a consortium is challenging because student populations are different and have different needs. These differences between schools can make coming together and forming a consortium difficult.

Although risk pooling makes sense from a theoretical perspective, consortiums are difficult to establish and maintain. However, these challenges do not have to prevent schools from entering into a group purchasing arrangement. One government official explained,

> The idea between consortium buying is not necessarily to always have a win right up front; it's about longevity. It's about insuring that in the long run, you don't have years where all of the sudden your premium gets spiked way up, and then plateaus, and then goes back down a little, and then way up … because the larger your pool, the more mitigated the cost increases are (Government official, personal interview, Summer 2011).

According to this government official, risk pooling can bring long-term stability to the premiums of a student health insurance plan.

Although some schools may benefit more than others at the start of the consortium, a school's claims history can change each year. Additionally, the mandated benefits for student health insurance plans established by HHS can make it easier for schools to agree on plan design. One school administrator explained,

> I mean, prevention visits are now covered … a lot of the sort of preventative stuff is being … mandated by the federal government, so as far as trying to negotiate that in the consortium is almost becoming a moot point because … the federal laws are sort of superseding … what we've been sort of fighting for in the beginning (School administrator, personal interview, Summer 2011).

Because all student health insurance plans will have to increase their benefit levels to meet federal guidelines, negotiating plan design will be easier between schools.

Additionally, one government official explained, "I think that there are a lot of administrators out there that don't want to have the responsibility that they have, and

would gratefully give it up to someone who basically they are contracting with to provide expertise and support in contract negotiations and procurement" (Government official, personal interview, Summer 2011). Risk pooling can end up reducing a school's administrative responsibilities; by joining a consortium, schools do not have to procure a student health insurance plan on their own. I asked one school administrator in Massachusetts, *Do you think that your university would be willing to join that risk pool at any time in the future*, and the school administrator explained, "I would say it would be something that we would think about every single year. Every single year that we meet to talk about insurance, we would say, well is the state offering us anything that we like right now? … why would we not do that? We wouldn't do it on principle" (School administrator, personal interview, Summer 2011). Risk pooling may not be the best financial move for a school, however, it is worth it for schools to consider and investigate the option.

Self-Insured Consortiums

Risk pooling and self-insuring are not mutually exclusive, and schools can form a consortium that is also self-funded. The University of California (UC) system recently formed a self-insured consortium, organizing all 10 UC campuses and the Hastings College of the Law under the same program. The consortium now covers around 139,000 students, and for the 2011-2012 academic year, UC estimated that it would save $8.4 million in premiums and $5.4 million in additional benefits.[cxxvi] One school administrator working for the UC system explained,

> I mean the most basic decision is do you have the volume necessary to absorb the risk associated with, or you know cushion the risk associated with insuring your

> student population … Now with the U.C. campuses consolidated, we're expecting an enrollment of about 130,000 by the end of September this year. So there's certainly enough volume there … to spread the risk of cost … Student groups I think in general are lower risks when they come to self-funding then say an aging employee population where you're going to have … a higher percentage of your population being older individuals with more chronic disease and that sort of thing … So in general I think student groups are great candidates for self-funding (School administrator, personal interview, Summer 2011).

The administrator went on to say,

> Well in self-funding you can avoid paying premium taxes in the state of California. So that can be up to two and a half percent of premiums. So right there that's a huge financial advantage to being self-funded. It also gives the university more control over plan benefit design … one of the advantages of combing self-funding and bringing together the purchasing power of all the UC campuses is … we can leverage that purchasing power with the market. So we were able to get very competitive rates for the administration of the plan … and because we're not fully insuring all of the risk associated with the plan, we're just hiring a third party administrator to process claims, and use their network, and for them to do their utilization management … So we were able to say okay, you're not taking on the risk plus we've got a huge population, give us the best deal you can give us. And so we were able to lower the costs of the plan for students on those campuses, and increase their benefits and … it's a very comprehensive plan for the cost. It's a great deal for students (School administrator, personal interview, Summer 2011).

School that form a consortium can also self-insure, and these two methods can each be used together as an effective tool to increase the value of a student health insurance plan. However, while forming a self-insured consortium, schools face the barriers associated with both risk pooling and self-insuring. The school administrator explained,

> I think the hardest part about it was the schools didn't want to give up individual control … So in the University of California system the kind of central head quarters of the President, which is in Oakland California, it didn't have the recent history of centralizing administration of system wide programs. So this student health insurance assembly is actually one of the first ones, and it has so far been successful in doing that. But some of the campuses were very, very wary of giving up their local control, or what they thought was giving up local control

However, many of these barriers can be overcome. In the UC plan, schools were allowed to add on additional benefits if they decided to. The administrator explained that they were able to establish the consortium,

> By giving them what they wanted as much as possible … But kind of my approach to quote one of our consultant partners, he said, "well you're sacrificing consistency for participation." So instead of having … the benefit structure be absolutely rock solid with no variation, we did allow campuses to buy up certain benefits that they didn't want to loose. So we had one campus that had a higher lifetime max then we had on the new plan, and … they didn't want to loose that (School administrator, personal interview, Summer 2011).

However, these systems are not without their problems. Over a year after I conducted my interviews, the UC systems self-insured consortium was in financial debt. The system is now $57 million in debt because UC did not set premiums high enough to run its plan. Because the plan is self-funded, the UC system is responsible for that debt, and student premiums might be increased as much as 25 percent next year. UC claims that its consulting/actuarial firm did not provide adequate information, and now the system needs to find ways to remediate its financial issues.[cxxvii]

5) An Uncertain Future

Although the future of the student health insurance market is uncertain, interviewees gave insights into how they felt the Affordable Care Act might change the face of the student health insurance market. One school administrator explained,

> Some schools are saying … why would we go and create a self-funded consortium when pretty soon we're going to have state exchanges, insurance exchanges that are going to be offering coverage and the federal government is going to be subsidizing that coverage for low-income individuals? … And then the schools don't have to be in the business of insurance. They can just wash their hands of it, and leave it up to the state and the feds, which is true. In a lot of states, especially where coverage isn't mandated, that is a good solution for many students (School administrator, personal interview, Summer 2011).

This school administrator also explained, "Well I feel like in the nationwide perspective, it's the health care reform question. You know how are student health insurance plans going to remain competitive under health care reform" (School administrator, personal interview, Summer 2011)? Health care reform brings up a host of issues aside from plan design and affordability of student health insurance plans. Schools will need to figure out how they can compete with other plans from the general market, and whether or not they should keep offering their student health insurance plans. One school administrator explained,

> Other schools are going to have real problems … The smaller universities who have very cheap plans that don't do much are going to, are probably going to drop out of the business and insurance companies that provide these plans are probably going to go out of business, because they cannot put together a plan that covers unlimited pharmacy, and this benefit, and that benefit that the ACA requires (School administrator, personal interview, Summer 2011).

The student health insurance market is changing, and some schools are going to have a tough time adapting to health care reform. One private consultant explained, "we predict a third to half of all student insurance plans to go away" (Private consultant, personal interview, Summer 2011). Later in the interview, the consultant remarked,

> The university plans themselves, many will say … "here we are at ___ State, we have 12,000 students, 107 are on this voluntary student insurance plan, … why bother with this? I'm not going to, as a college president, sign a request for a waiver to keep this plan after I've looked at it and it looks so bad and it only covers 107 of our students anyway and we're going to have the insurance exchanges out in 2014 if the law stays in place. That's the easier thing for us to do" (Private consultant, personal interview, Summer 2011).

One private consultant indicated that schools may drop their student health insurance plans because they want to keep the cost of education down. The consultant explained,

> When they're competing on tuition, and all of a sudden that tuition now costs another $1500 because of health care costs, that used to cost for some of them $100, it's schools that take the heat for insurance contracts. As the

> admissions counselor, I don't need more heat. What I need to do is get somebody enrolled and paying the tuition (Private consultant, personal interview, Summer 2011).

Furthermore, it is not just schools that may be affected by health care reform. One private consultant explained that the insurance carriers operating within the market might change. The consultant explained,

> I think most of the student insurance carriers are going to withdraw from the market, as we get closer to 2014. The insurance companies will make more money off of young people if they're in the insurance exchanges than if the student insurance plans (Private consultant, personal interview, Summer 2011).

However, although the student health insurance market is changing, interviewees still believed that the student health insurance market would remain viable. One private consultant explained that although some schools would drop out of the insurance business, others would make improvements to their plans. The consultant explained,

> So it'll really be a watershed where if you fall down one side, you'll be inclined to say this is something that schools, the students should buy on their own for the insurance exchanges. And if you're on the other side of the watershed you're like, "Wow we can provide a service for students that provides better coverage at a lower cost than what they can get from their parents' employer or the insurance exchanges" (Private consultant, personal interview, Summer 2011).

Although some schools may think that the state exchanges provide a better option for students to purchase health insurance, one school administrator believed that a student consortium is a better option for students. The administrator explained,

> The advantage of a consortium in college health is that … the age rating is pretty much for mostly populations between 18-24, which is cheaper. And a regular exchange is going to cover a much larger age scale, and that insurance gets expensive. The older you get the more expensive your insurance gets. So by having these, the campuses provide insurance is, I think going to be more affordable insurance (School administrator, personal interview, Summer 2011).

Student health insurance plans may remain more affordable than plans offered in the exchanges, largely because the college student population is largely young and healthy.

Additionally, one private consultant believed that the student health insurance market would continue to grow because of increased cost shifting in the employer market. The consultant explained, "So we expect in the not too distant future, student insurance plan to cover more than 80% of all students because of the employer cost shifting and more of the insurance plans are going to be so expensive" (Private consultant, personal interview, Summer 2011). Interviewees were unsure of the future trajectory of the market, and how enrollment of the market would change. However, interviewees indicated that the market was shifting, and may be very different once the provisions of the ACA go into affect.

VII. Discussion/Conclusion

The process of writing this thesis has proven to be challenging. The Affordable Care Act is changing the face of the student health insurance market, and it is difficult to reconcile recent problems within the market with its future projections. The ACA will fix some of the problems in the student health insurance market, but also may have several unintended consequences. This thesis would likely be a very different product a year from now, and even more dissimilar several years down the line. However, school administrators will be faced with a host of difficult decisions that need to be addressed, and they will have to make decisions involving the future of their student health insurance programs.

I wrote this thesis in order to compile a baseline picture with the limited information available on the student health insurance market. It is my hope that others will continue this important work. Health insurance reform is an on-going process, and the functioning of the market should always be reassessed and reformed as necessary. Throughout this final section of my thesis, I will present my own outlook on the student health insurance market, a set of viewpoints that I have challenged and reassessed throughout my college career.

In order for school administrators and policy makers to make decisions involving the student health insurance market, they have to have current information on the market readily available. There is very little data accessible on the student health insurance market. According to *The Journal of American College Health* webpage, it is "the only scholarly publication devoted entirely to college students' health." According to the journal's website:

> This prize-winning journal covers developments and research in this broad field, including clinical and preventive medicine, health promotion, environmental health and safety, nursing assessment, interventions, management, pharmacy, and sports medicine. The journal regularly publishes major articles on student behaviors, mental health, and health care policies and includes a section for discussion of controversial issues.[cxxviii]

However, an examination of the journal's sparse coverage of student health insurance plans proves an important point; if health insurance is used as a proxy for healthcare access, then the lack of scholarship on student health insurance plans is a problem. Aside from the GAO report, and a few investigations conducted by state governments, there has been virtually no discussion of student health insurance in the scholarly literature. The Massachusetts reports represent some of the best available research in an already limited area of study, but some of the interviewees suggested that at least parts of that data might be incomplete or erroneous. If the student health insurance market is going to continue to improve, it is imperative that information on the market is regularly collected, reviewed, published and disseminated to important decision makers.

In the literature review of this thesis, I presented information found from three state investigations: Texas, New York, and Massachusetts. Many of the problems indicated by these reports will be addressed by the ACA. However, I believe that having an understanding of the recent problems within the market is important. Being aware of these past problems allows us to develop an appreciation for the health care reform that is currently underway, as well as develop ideas regarding how we think the market should change. When all of the provisions of the ACA are underway, it is important that we look back at these state reports, and ask the question; *did health care reform solve the problems identified in these state investigations, and what problems remain?*

According to former Attorney General Cuomo's investigation in New York, he explained, "Students are also likely to trust health care plans sponsored by their colleges on reasonable belief that the colleges have performed due diligence concerning the plans offered and are satisfied with them."[cxxix] However, students have had little reason to trust their school sponsored plans. The Texas report explained, "These plans have both benefits and limitations, which make it debatable whether expanding the student health insurance market would be a good way to provide coverage to more college students."[cxxx] The information presented in the Texas, New York, and Massachusetts report all indicated that student health insurance plans had benefit level restrictions that placed students at risk.

For example, the Texas report pointed out that student health insurance plans in the state had an average maximum catastrophic coverage level of $50,000 per illness or injury, and some schools had benefit maximum as low as $2,000 per injury/illness;[cxxxi] plans in Massachusetts and New York followed similar trends, and these benefit level restrictions are problematic for students for several reasons. The information presented in my *Review of Literature* section should be viewed in conjunction with my discussion of underinsurance. The underinsured are far more likely to forgo necessary medical care, and are less likely to fill a prescription or get recommended tests or treatments due to cost related access issues. Being underinsured can undermine an individual's access to important medical services.

If schools view protecting the health of their students as a part of their mission, then underinsuring students directly undermines this objective. While looking at the Massachusetts reports, in the 2009-2010 academic year, although 1,254 students

exceeded their outpatient benefit levels, only 7 students exceeded their annual benefit maximums and only 10 students exceed their inpatient benefit limits.[cxxxii] Although most students did not exceed their plan limits, only 56% of students were enrolled in a student health insurance plan with an annual benefit maximum that was over $100,000, placing many students more students at risk.[cxxxiii] Additionally, while looking at the amount of students who exceeded their outpatient benefit levels, the scope of the market's deficiencies becomes clearer. Outpatient services are the medical procedures and tests that can be done without a patient having to stay in a medical facility overnight;[cxxxiv] these procedures include prescriptions drugs, as well as ambulance rides and many high-cost procedures.[cxxxv] For the most part, the average and healthy college student would be adequately covered by their student health insurance plans. Problems arise when students need expensive medial procedures, including prescription medications. Additionally, based on the research available on underinsurance, it is likely that the limited benefits provided by student health insurance plans had much more widespread negative implications on students' health care utilization, than the Massachusetts reports are able to indicate.

However, there are other options available to students when they do exceed their benefit levels. For example, Massachusetts does have a Health Safety Net (HSN), which makes payments to hospitals and community health centers to provide services to Massachusetts residents who are uninsured or underinsured. However, only individuals with an income up to 200% of the Federal Poverty Level (FPL) are eligible for full HSN coverage, and the HSN may not cover all of an individual's health care needs.[cxxxvi] Additionally, students always have access to their student health centers if their school

has one. Most likely, students are not amassing substantial medical debt, and most students were probably able to get the care that they need. However, school administrators should be trying to make the lives of their students easier and less stressful. Students may not understand what options are available to them if they exceed their coverage levels, and their medical needs will not necessarily be addressed under these alternative options. Also, shifting costs to the state and hospitals for less effective coverage is not the answer.

While looking at Medical Loss Ratios, both the Massachusetts and New York reports indicate that insurance companies are disproportionately profiting from student health insurance plans. The Massachusetts report for the 2005-2008 academic years indicated that student health insurance plans had an average MLR of 69%, while this figure was 88% for plans in the private insurance market.[cxxxvii] The Massachusetts report gives a partial explanation for these findings. The report states,

> SHP administrative expense ratios are generally higher than private insurance products. This may be due, in part, to SHP premiums being lower than private insurance products. With fewer premium dollars to pay for fixed expenses, administrative costs will account for a larger percentage of total premiums.[cxxxviii]

However, this rationale does not explain why insurance companies accrued an average profit margin of 10% from student health insurance plans, while this figure was only 2% for plans provided in the private market.[cxxxix] School administrators, policy makers, and students should view the MLRs provided in the Massachusetts reports as unacceptable. It is not that insurance companies should not be allowed to make money; they are a business and their job is to turn a profit. However, the discrepancies between MLRs in the student health insurance market student and the general market represents an inappropriate business practice.

The Kaiser Family Foundation defines 'health care disparities' as "differences between groups in health insurance coverage, access to and use of care, and quality of care."[cxl] The U.S. college student population has been suffering from 'health care disparities,' where students covered under student health insurance plans are often underinsured, and are treated unfairly by insurance companies. Although plans with more comprehensive coverage levels are more expensive, comprehensive health insurance can be used as a resource for students to stay healthy, and help them reach graduation. Although data on the student health insurance market is not available from other states, it is reasonable to assume that students across the country experienced similar problems.

It is my belief that school administrators need to make the health of their students a major priority and an inseparable part of the school's mission. While conducting my interviews, interviewees made it clear that designing a student health insurance plan was a difficult process. Administrators did not want their students to be underinsured, but they were attempting to balance the financial needs of their students with their coverage needs. When school administrators are getting pressure from the school, as well as from students to keep the cost of education down, it is difficult for administrators to justify increasing the cost of a student health insurance plan for the atypical students who need more comprehensive coverage. However, because of HHS's regulations, including minimum MLR requirements, and the gradual elimination of plan maximums and internal annual limits or lifetime dollar limits on Essential Benefits, schools that continue to offer student health insurance plans will no longer be able to underinsure their students.

Instead of worrying about plan design, administrators will be faced with a host of new challenges. Although HHS's regulations will result in beneficial market changes, the regulations will also result in a number of unintended consequences. As noted by interviewees, student health insurance plans are becoming more expensive, and these fiscal challenges will make it difficult for some schools to continue offering student health insurance plans. Schools will need to figure out a way to keep their student health insurance plans affordable.

Additionally, the ACA may result in other market changes that schools need to anticipate. For example, now that the benefit levels in student health insurance plans are increasing, the population of students enrolling in student health insurance plans may change. Before HHS's regulations, because certain student health insurance plans had limited benefit levels, it is possible that less healthy students obtained coverage through other avenues. Now that student health insurance plans have richer benefit levels, less healthy students may feel more comfortable enrolling in these plans. Because of this, it is possible that students with higher utilization levels increasingly purchase their school's student health insurance plans, making it even more costly for schools to offer a plan. It is important that schools monitor the changing population covered by their student health insurance plans, determining who leaves and who enrolls. Additionally, schools need to continue to monitor the insurance status of their students. Although the ACA will decrease the number of individuals who are uninsured, an estimated 26 million individuals will continue to be uninsured in 2016.[cxli] Schools need to ensure that their students have health insurance policies, and that the number of uninsured college students continues to drop.

While adapting to HHS regulations, increasing benefit levels in student health insurance plans does not necessarily have to coincide with an increase in plan costs. If school administrators explore options to make the system more efficient, students can have their health care needs addressed in the most affordable way possible. Robust student health services and preventive medicine, education, risk pooling, self-insurance and self-insured consortiums represent the potential solutions for improving the student health insurance market that I came across through my research. However, school administrators are not limited to these solutions, and should explore any option that they believe has the potential to improve their student health insurance plans. These options may not be right for every school, but school administrators have a responsibility to figure out the best long-term course of action for their students.

Student health centers provide an inexpensive, convenient, and accessible means for student to access health care, and these facilities can help control the rising costs of student health insurance plans. Interviewees indicated that not all student health centers are run properly, and not all schools have student health centers. However, many schools are effectively operating impressive student health centers that provide for most of their students health care needs, right on campus. With student health centers, schools are able to prevent students from unnecessarily going to more expensive health care providers, specialist, and the emergency room. Additionally, student health services are a hub for preventative medicine and health promotion campaigns on a college campus. Preventive medicine is at the forefront of health care reform options, and there has been a continued push to utilize more preventive medicine. Keeping students healthy, and preventing them from getting sick in the first place, can have beneficial implications for the student health

insurance market. Student health centers can employ a variety of techniques to alter the unhealthy behaviors of students, and promote health lifestyles throughout the campus, and there are a variety of techniques that a student health center can use to further reduce the cost of student health insurance plans. If student health centers stay open for longer hours, fewer students will need to go to the emergency room. Furthermore, student health centers can run a 24-hour hot line where students can call for medical advice.

Creating a student health center is not without costs, and it adds additional expense to a school's operating budget. However, aside from being fiscally attractive, having a student health services shows students that their schools care about their wellbeing. Schools should be establishing student health centers regardless of their financial benefits, and should use these facilities as a resource for both recruitment and retention of students.

Along with establishing a robust student health services, education is a necessary component of an effective student health insurance market. Interviewees discussed how many school administrators involved in the development of their school's student health insurance plans have little training and background in the health insurance market. In order for the market to improve, directors of student health centers and other school administrators involved in the design and procurement of student health insurance plans, need to understand how the market operates, and what options are available to them. They need to know how to negotiate with insurance companies and structure benefit levels, and they need to be aware of health care reform and other developments in the field. School administrators should not receive all of their information from private brokers and insurance companies. They should read articles on the market, speak with

other school administrators, and attend conferences if possible. Additionally, schools should hire administrators with training in the field, or find a way to train their administrators. If administrators are not aware of the options available for their student health insurance programs or what policies are in the best interest of the student, it is unreasonable to expect important changes in the market to occur.

Furthermore, students need to be educated on their student health insurance plans and involved in the decision making process so that school administrators can understand their students' concerns; if educated, school administrators could use their students as a resource. Students should be able to inform school administrators about what they want in their health insurance plans, and what avenues they want their schools to pursue. Many students come to college with no understanding of health insurance, and schools should make it a priority to educate students on their health insurance plans, why health insurance plans are important, and how to use their plans. Having an information session during freshmen orientation can be an effective means to reach students.

Risk pooling and self-insuring represent two of the most promising methods that schools could use to improve their student health insurance plans. Risk pooling is a logical course of action for many schools. Spreading the risk of insuring students over a larger population can increase schools' bargaining ability, saves schools money on administrative costs, and promote long term premium stability. Having a system where small schools purchase health insurance independently is not effective. Risk pooling is not without challenges. It is difficult to get schools to come together and agree to a uniform plan. While entering into a consortium, schools have to give up some form of independence and control. Additionally, it is unclear how much money a consortium

saves, and there are always winners and losers in risk pools. Schools have different utilization levels, and schools whose students are higher consumers of health care will save money by pooling with schools whose students are lower consumers of health care. For larger schools, there may not be a financial benefit to enter into a risk pooling arrangement.

However, if small and medium sized schools want to continue offering their students affordable student health insurance plans while complying with ACA standards, risk pooling may be their best option. Although some schools may benefit more than others in a particular year in a group purchasing arrangement, risk pooling is about long-term premium stabilization. Schools cannot anticipate what their utilization levels will look like in future years, and school administrators should recognize that although schools may lose money one year in a risk pool, they also might save money in other years. Additionally, because of HHS's regulations mandating that all student health insurance plans meet certain benefit levels, agreeing on plan design in a consortium should now be an easier process. If schools want to risk pool, and still offer unique benefit levels, schools can purchase a base plan together, and allow members to add on additional benefit levels for their own student health insurance plans.

Like risk pooling, self-insurance is another tool that schools can use to improve their student health insurance market. When a school self-insures their student health insurance plans, all of the premium dollars collected can go towards health care and administrative costs. Self-insuring removes the profit margins that insurance companies take out of student's health insurance premiums. Throughout my interviews, it became clear that school administrators were fairly apprehensive about self-insuring. A school

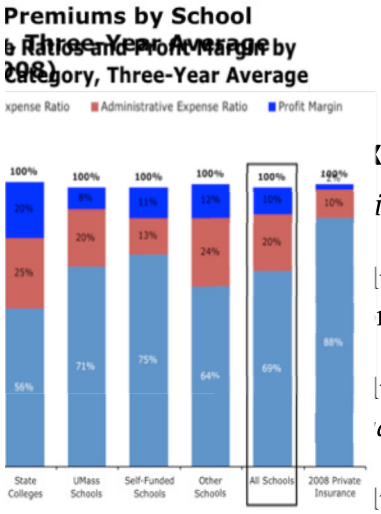
has to be willing to take on a financial risk when they self-insure, and there is a lot of work that goes into setting up and running a self-insured plan. However, it is in the best interest of students to have school administrators look into self-insuring. Self-insurance should not be a concept that makes school administrators worried. Although there is a financial risk to self-insuring, if schools are careful in how they set up and manage a self-insured plan, much of the risk can be mitigated. Schools can buy stop-loss coverage, build up reserves, and hire third party administrators to perform many of the functions needed to run the plan. Additionally, self-insuring is a common practice in the insurance market, and schools may already self-insure the health insurance plan for their employees. Like risk pooling, self-insurance may not be a good financial option for every school. If schools are getting competitive bids from insurance companies, taking the risk and switching to a self-insured plan may not be a good idea. Also, smaller schools need to be more cautious if they decide to self-insure. However, schools should look into self-insuring, and see if the practice can save the school money. Furthermore, risk pooling and self-insuring can work well together, and schools that are willing to enter into a group purchasing arrangement should consider self-insuring the consortium.

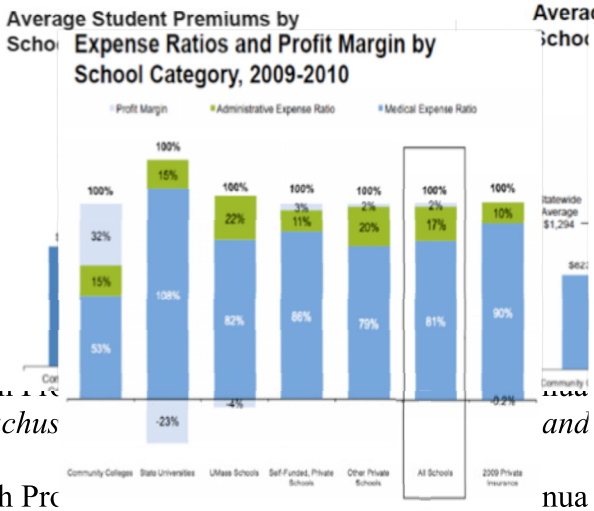
Throughout my college career I have been fighting to protect the student health insurance market, advocating for its improvements so that students can get good value health insurance plans. However, my advocacy has not been for the preservation of the student health insurance market. As discussed in my research section, the future of the student health insurance market is uncertain. Some schools may decide to get rid of their student health insurance plans, encouraging students to find health insurance on their own. Some students may stay on their parent's plan, and others may be covered under

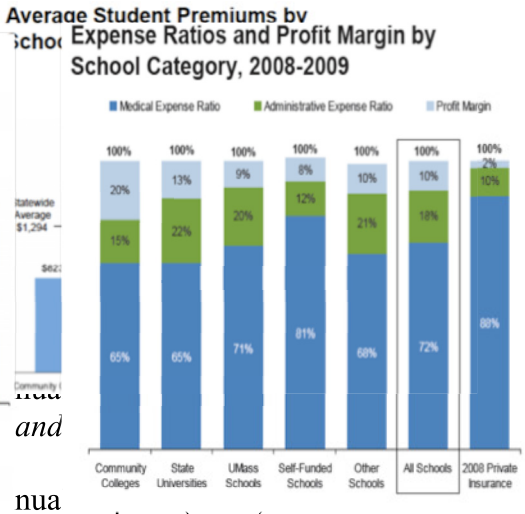
the Medicaid expansion. Additionally, some students may want to purchase health insurance through the state exchanges. The point of this thesis is not to encourage the preservation of the student health insurance market. I want students to have access to the best value plans possible, regardless of whether they get these plans through state exchanges, their universities or their families. I believe that student health insurance plans will be the most affordable health insurance options available to students. The student population is generally young and healthy, and it does not make sense for students to pool with older individuals in state exchanges. However, school administrators need to continuously reassess what the best options are for their students, even if that means getting rid of the student health insurance market.

Four years ago, when I first became involved with student health insurance, I had a much more critical view of the market. After reading the Massachusetts reports and lobbying the state government, I saw a market that I believed was taking advantage of students, and I was unsure if the market would ever move in the right direction. However, over the years my perspective has been tempered, and I see the market in a different light. My interviewees were hard working individuals who cared about the well being of students. School administrators have difficult jobs, and have a lot of factors to consider when establishing student health insurance plans. Additionally, with health care reform, I believe that the market is moving in the right direction. However, my thesis is the first piece in a much-needed evaluation of the student health insurance market. My work has several limitations. My interviews were conducted before the final regulations on the student health insurance market were released, and more work is needed to assess the ACA's impact on the student health insurance market. Furthermore, my research did

not provide much distinction between undergraduate and graduate students, and I did not interview any students. Additionally, a more in depth study is needed to analysis whether student health insurance plans are adequately addressing students' mental health needs. I challenge school administrators, policy makers, and researchers to continue my work, study the student health insurance market, and make the difficult, but necessary decisions needed to continue the markets upward trajectory.







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Section I: Student Premiums by School Category:

Section II: Expense Rations and Profit Margin by School Category

Students Exceeding Annual Benefit

Students Exceeding Annual Benefit Maximum by School Category, 2008-2009

s by School Category

	# SHP Enrolled Students Exceeding	% SHP Enrolled Students Exceeding
Community Colleges	0	0%
State Universities	6	0.2%
UMass Schools	0	0%
Self-Funded Schools	0	0%
Other Schools (total)	53	0.1%
Premium Range for Other Schools:		
Up to $1,000	*3*	*0%*
$1,001 to $1,500	*49*	*0.2%*
$1,501 to $2,000	*1*	*0%*
Above $2,000	*0*	*0%*
All Schools	**59**	**< 1%**

	# SHP Enrolled Students Exceeding Annual Benefit Maximum	% SHP Enrolled Students Exceeding Annual Benefit Maximum
Community Colleges	0	0%
State Universities	1	0.02%
UMass Schools	0	0%
Self-Funded, Private Schools	0	0%
Other Private Schools (total)	6	0.01%
Premium Range for Other Private Schools:		
Up to $1,000	*2*	*0.02%*
$1,001 to $1,500	*2*	*0.01%*
$1,501 to $2,000	*2*	*0.01%*
Above $2,000	*0*	*0%*
All Schools	**6**	**0.01%**

Students Exceeding Inpatient Benefit Limits by School Category

Section IV: Students Exceeding Inpatient Benefit Limits by School Category

	2005-2006		2006-2007		2007-2008	
	# Students Exceeding	% SHP Enrolled Students Exceeding	# Students Exceeding	% SHP Enrolled Students Exceeding	# Students Exceeding	% SHP Enrolled Students Exceeding
Community Colleges	0	0%	0	0%	0	0%
State Colleges	0	0%	0	0%	0	0%
UMass Schools	0	0%	0	0%	0	0%
Self-Funded Schools	0	0%	0	0%	0	0%
Other						

Students Exceeding Inpatient Benefit Limit by School Category, 2008-2009

	# SHP Enrolled Students Exceeding	% SHP Enrolled Students Exceeding
Community Colleges	7	0.11%
State Universities	0	0%
UMass Schools	0	0%
Self-Funded Schools	0	0%
Other Schools (total)	7	0.01%
Premium Range for Other Schools:		
Up to $1,000	*2*	*0.02%*
$1,001 to $1,500	*2*	*0.02%*
$1,501 to $2,000	*3*	*0.04%*
Above $2,000	*0*	*0%*
All Schools	**14**	**< 1%**

School Category, 2009-2010

	# SHP Enrolled Students Exceeding Inpatient Benefit Limit	% SHP Enrolled Students Exceeding Inpatient Benefit Limit
mmunity Colleges	1	0.01%
te Universities	0	0%
lass Schools	0	0%
f-Funded, Private Schools	0	0%
ner Private Schools (total)	9	0.02%
Premium Range for Other Private Schools:		
Up to $1,000	*3*	*0.03%*
$1,001 to $1,500	*3*	*0.01%*
$1,501 to $2,000	*3*	*0.01%*
Above $2,000	*0*	*0%*
Schools	**10**	**0.01%**

idents Exceeding Outpatient Benefit Limits
School Category

	2005-2006		2006-2007		2007-2008	
	# Students Exceeding	% SHP Enrolled Students Exceeding	# Students Exceeding	% SHP Enrolled Students Exceeding	# Students Exceeding	% SHP Enrolled Students Exceeding
munity ges	334	3.6%	257	3.1%	188	3.1%
ges	62	1.6%	48	1.3%	44	1.3%
ss ols	156	1.2%	155	1.2%	28	0.2%
Funded ols	185	0.9%	197	0.8%	83	0.3%
r ols	802	2.3%	866	1.9%	608	1.3%
chools	**1,539**	**1.8%**	**1,523**	**1.5%**	**951**	**0.9%**

Students Exceeding Outpatient Benefit Limits by School Category and Service, 2008-2009

	Community Colleges	State Universities	UMass Schools	Self-Funded Schools	Other Schools	All Schools
Prescription Drugs	N/A	90	72	0	394	556
Outpatient Miscellaneous	88	38	1	45	218	390
Ambulance	2	126	45	0	200	373
High-cost Procedures	18	21	7	0	75	121
Mental Health	0	4	38	0	59	101
Dental	0	3	2	0	47	52
Surgery	10	9	9	0	18	46
Physiotherapy	0	0	0	0	2	2
All Other Limits	9	67	59	0	125	260
All Limits	**127**	**358**	**233**	**45**	**1,138**	**1,901**

by School Category and Service, 2009-2010

	Community Colleges	State Universities	UMass Schools	Self-Funded, Private Schools	Other Private Schools	All Schools
Prescription Drugs	0	18	30	0	357	405
Outpatient Miscellaneous	3	0	0	0	248	251
High-cost Procedures	9	6	7	0	101	123
Ambulance	0	0	45	0	70	115
Surgery	18	2	0	0	31	51
Mental Health	0	0	10	0	26	36
Dental	0	0	0	0	25	25
Physiotherapy	0	0	0	0	0	0
All Other Limits	6	0	6	0	236	248
All Limits	**36**	**26**	**98**	**0**	**1,094**	**1,254**
Percent SHP Enrolled Students Exceeding:	0.41%	0.54%	0.70%	0%	2.03%	1.16%

	2009-2010 Community College	2010-2011 Community College	Benefit Change
Annual Premium	$823	$861	+$38
Annual Deductible	None	None	-
Out-of-pocket Maximum	None	None	-
Annual Benefit Maximum (total in-network & out-of-network services)	$50,000	None	↑
Pre-existing Condition Limitation	6 months	None	↑
Outpatient Miscellaneous Cap (total in-network & out-of-network services)	$1,500 per illness/ injury	None	↑
In-network Coverage			
Adult Routine Physical	Not covered	$20 co-pay, 100% coverage, Limited to 1 visit per year	↑
PCP Office Visit	$10 co-pay, $1,500 per illness/ injury	$20 co-pay, 100% coverage	↑
Specialist Office Visit	$10 co-pay, $1,500 per illness/ injury	$20 co-pay, 100% coverage	↑
Outpatient Mental Health (non-biologically based)	$10 co-pay, $1,500 per illness/ injury, Limited to 24 visits per year	$20 co-pay, 100% coverage, Limited to 24 visits per year	↑
Diagnostic X-rays/ Labs	$1,500 per illness/ injury	100% coverage	↑
Hospitalization Services (semi-private room and board)	$1,500 per illness/ injury	100% coverage	↑
Emergency Room	$50 co-pay, $1,500 per illness/ injury	$50 co-pay, 100% coverage	↑
Ambulance	$25 co-pay, $150 maximum	100% coverage	↑
Prescription Drugs	Not covered	Not covered*	-

Notes: * Prescription drugs will be covered, up to $5,000 per year, in the 2011-2012 academic year.
Source: The Massachusetts Community Colleges 2009-2010 Student Accident and Sickness Insurance Program brochure and summary of benefits submitted to DHCFP in Fall 2009. Blue Cross Blue Shield of Massachusetts *Proposal to provide student health insurance plans for the Commonwealth of Massachusetts College and Universities*, 3/10/10.

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State University Student Health Program
In-Network Coverage Comparison

	2009-2010 State University (Group)	2010-2011 State University	Benefit Change
Annual Premium	$1,017	$1,062	+$45
Annual Deductible	None	None	-
Out-of-pocket Maximum	None	$5,000 per member	↑
Annual Benefit Maximum (total in-network & out-of-network services)	$50,000	None	↑
Pre-existing Condition Limitation	6 months	None	↑
Outpatient Miscellaneous Cap (total in-network & out-of-network services)	None	None	-
In-network Coverage			
Adult Routine Physical	$50 co-pay, 100% coverage, Limited to 1 visit per year	$20 co-pay, 100% coverage, Limited to 1 visit per year	↑
PCP Office Visit	$25 co-pay, 100% coverage	$20 co-pay, 100% coverage	↑
Specialist Office Visit	$25 co-pay, 100% coverage	$20 co-pay, 100% coverage	↑
Outpatient Mental Health (non-biologically based)	$25 co-pay, 100% coverage, Limited to 24 visits per year	$20 co-pay, 100% coverage, Limited to 24 visits per year	↑
Diagnostic X-rays/ Labs	20% coinsurance	20% coinsurance	-
Hospitalization Services (semi-private room and board)	20% coinsurance	20% coinsurance	-
Emergency Room	$50 co-pay, 100% coverage	$50 co-pay, 100% coverage	-
Ambulance	100% coverage	20% coinsurance	↓
Prescription Drugs	Tier 1: $10 co-pay, 100% coverage, up to $3,000 per year Tier 2: $15 co-pay, 100% coverage, up to $3,000 per year	Tier 1: $15 co-pay, 100% coverage, no limit Tier 2: $30 co-pay, 100% coverage, no limit Tier 3: $50 co-pay, 100% coverage, no limit	↑

Notes: Massachusetts College of Art and Design, Westfield State University, and Worcester State College did not offer the state university group SHP.
Source: The Massachusetts State College System 2009-2010 Student Accident and Sickness Insurance Program brochure and summary of benefits submitted to DHCFP in Fall 2009. Blue Cross Blue Shield of Massachusetts *Proposal to provide student health insurance plans for the Commonwealth of Massachusetts College and Universities*, 3/10/10.

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