

# student health SPECTRUM

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## Performance Improvement in Student Health Centers: Effective Use of Peer Review

by Eleanor W. Davidson, M.D.  
Case Western Reserve University

As the director of a health service in a university with an academic medical center, I have tried to integrate the peer review strategies of both academic medicine and other organized systems of care to the unique requirements of student health.

One might think about this in two ways:

1) the informal process, which is often characterized as 'coaching' or 'friendly advice,' but often may involve formal presentations at staff meetings, and 2) the formal process which fulfills the requirements of accreditation bodies, such as the Joint Commission on Accreditation of Health Care Organizations (JACHO) and Accreditation Association for Ambulatory Care, Inc (AAAHHC). Included in the latter are random chart reviews, targeted reviews, occurrence screens (e.g. review of records for all admitted students), sentinel events (e.g. review of records for all students withdrawing for medical reasons), and negative outcomes (e.g. hospitalization, death, litigation).

My colleagues in student health who participated in this year's Chickering Leadership Forum spoke about current practices in peer review during an informal discussion the evening before the Forum. Some of the key points from that discussion are:

- Peer review in student health is as critical, or more so, than in private practice because students often see multiple clinicians during the same episode of illness or injury. Peer review serves here to decrease intra-practice pattern variability in order to achieve high quality, cost-effective and consistent practice.
- Peer review is often resisted because of fear of criticism; in fact, the very term may evoke negative feelings and uneasiness that could interfere with its effectiveness. To minimize this, peer review should be made regular and routine. Also, care should be taken to avoid judgmental comments directed at individuals. Negative comments should be directed at a problem not a 'problem person' (ad hoc, NOT ad hominem). Whenever possible, the positive should be emphasized.
- College health medicine is difficult for several reasons that are not always obvious to the casual observer. First, much of the clinical content consists of routine, self-limited illness. The difficult part comes in finding the one sore throat and fatigue that is really leukemia, or the one fever and malaise that is meningococcal disease, or the one cough that is tuberculosis. Second, the present complaint is often NOT the real reason for visit. Adolescents are taking steps towards individual adulthood and often find it hard to ask for help with issues they are trying to sort out; the very things they most want our help with.

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Attention to interviewing skills which create the therapeutic alliance are a must. Building trust and safety in a relationship with an adolescent is difficult at best, greatly rewarding at its finest.

- Peer review goals in college health can be difficult to set, and more difficult to measure. Said another way, it is easier to make the chart 'look good' than the patient interaction worthwhile. Care should be taken to avoid choosing endpoints that, while appealing in their measurability, do little to improve the real quality of the care.
- Early case finding among students with significant underlying problems (be they drug/alcohol related, psychological, developmental, or otherwise) is clearly important. Peer review goals should target the appropriate discussion of these issues as much as (or more) than the easier ones to discuss, such as immunization. One cannot emphasize enough the strategic position of the caring, ready, and trained clinician who can say: "I am ready to hear what you have to say" (no matter how difficult or upsetting it is). "It has to be at your own pace." (I will not force you to talk about what you are not yet ready to discuss.)
- Introducing the concept of Grand Rounds on a monthly basis (or the in-house equivalent of Morbidity / Mortality Conference) with occasional outside presenters can be effective in elevating the status of peer review.
- The SHS director should be open and available to discuss current cases with colleagues, and encourage a collaborative model of practice. This person should be able to act as a mentor for new clinicians, a support to those more seasoned, and a sounding board for all, ready to admit his/her own past mistakes and lessons learned.
- The SHS director should seek peer review of some of their own cases. If any work is done involving the more psychodynamic aspects of adolescent issues, consultation should be sought from colleagues in the mental health arena. A wise director will develop good working contacts with these professionals, and any time a case with significant mental health dimensions is encountered, these cases MUST be discussed with a mental health professional and the discussion documented in the chart (much as mental health professionals obtain their own consults from colleagues in cases where severe depression or suicide is an issue).
- When the SHS director does not have clinical responsibilities, he/she should seek peer review for management decisions. (Of note, many management texts use the medical model of decision making as a preferred management technique.) By seeking his/her own review, the director can send the valuable message to staff that seeking advice and consultation does not diminish one's stature.
- Because college health is multi-disciplinary, the best practice of peer review involves the full clinical team.
- Medical directors have a responsibility to determine the most effective forum for peer review. Where an individual might be embarrassed, private review is desirable. When a close judgment call is involved, a broader process may contribute to the improvement of the whole team.
- In larger student health services, the use of clinical teams can build trust and promote peer review within the team.
- When peer review processes become more rigorous in preparation for accreditation, staff may focus on these as 'compliance driven' rather than motivated by professional growth and devel-

opment needs. When 'fixing' things for accreditation, try to keep them 'fixed' thereafter.

- In busy clinical settings, peer review must be carefully balanced with productivity requirements. It must be seen as equal to or of higher importance than seeing more patients.

In summary, college health differs from private practice in many ways. For various reasons, discontinuous, episodic care may be the norm. Attention to mental health issues (including quite normal developmental tasks) of this age group must be part of the work. The legal posture of the individual school must be factored in to certain clinical settings. All of these differences must be acknowledged and supported by the peer review process.

Nonetheless, the similarities to group practice settings are also important. Here, the establishment and maintenance of a routine, high-value peer review program will provide quality leadership and will balance productivity needs with continuing clinical improvement. ■

*The editors are grateful to Dr. Davidson for preparing this article and also wish to acknowledge the contributions of Dr. Richard Piech, Director of the Student Health Services at Rutgers University who both suggested and led this discussion at the Leadership Forum.*

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Spectrum, please visit  
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# The Attributes of a High Performance Student Health Insurance Program

by Stephen Caulfield

Business and management consultants and writers have used "spider-web" diagrams to identify critical success factors as a way to quantify current performance against best practices. Because all human enterprise is dynamic, it is important to step back and take a fresh look at each of your activities to achieve excellence. Continuous Quality Improvement (CQI) or Total Quality Management (TQM) are other names for this process. What is important is to balance improvement on existing programs with a fresh look at the whole enterprise.

At Chickering, we have recently taken a hard look at the entire student health insurance business using a twelve axis spider web model. A significant insight for us was the critical importance of the applications of information technology to the service components of our business.

However important service and technology are, price is still regarded by many as the most important factor. Indeed, thought leaders in student health have suggested that within a given plan design, student health insurance is a **commodity**, differentiated only by price, particularly multiple-year price guarantees. This assumes all insurers are similar in financial stability, services, and provider relationships.

Our work on this particular project, supported by input from many in the field, certainly supports the primacy of price. But, recent events within the insurance industry and the managed care industry, resulting in altered ratings by A.M. Best Company, Duff and Phelps, and Moody's, underscores the fact that not all insurers are created equal for all time. State receiverships of managed care plans in California, New Jersey and, most recently, in Massachusetts have raised substantial consumer concerns.

Listening to the marketplace, particularly Student Health Service (SHS) Directors, students and parents, we have maintained our focus on plan design and price, continuing to emphasize partnership with the stu-

dent health service, but we have added greatly to service programs enhancing them through technology, much of it web-based.

On the next page is the spider-web diagram of our current view of the twelve attributes of a high performing student health insurance program. Although price is very important, the web moves clockwise tracking the logical steps in the decision making process, only reaching price after starting with eligibility, plan design and verifying the insurer's reputation.

What follows is a discussion of seven of the twelve attributes of a high performance student health insurance program, those dealing with plan design, eligibility, insurance quality, value, and partnership. The remaining five, those that are service related and technology-driven, will be discussed in the next issue of *Spectrum*.

First, it is noteworthy that the five most important issues (at the top) center around eligibility, plan design, insurance quality, and financing the student health center. The critical underpinnings of the program (literally, at the bottom of the diagram) are all service-related and technology driven. The "shoulder" or transitional issues between service and program value are early case findings on one side and managed care strategies on the other.

The value for us in this diagrammatic representation is that it allows for a quick, visual "gap analysis" between current program and best practice. Where large gaps exist and where resources may be constrained or the political realities limiting (as in hard waiver), it may be possible to sketch in interim achievable goals between current program and best practice.

## What Constitutes Good Plan Designs?

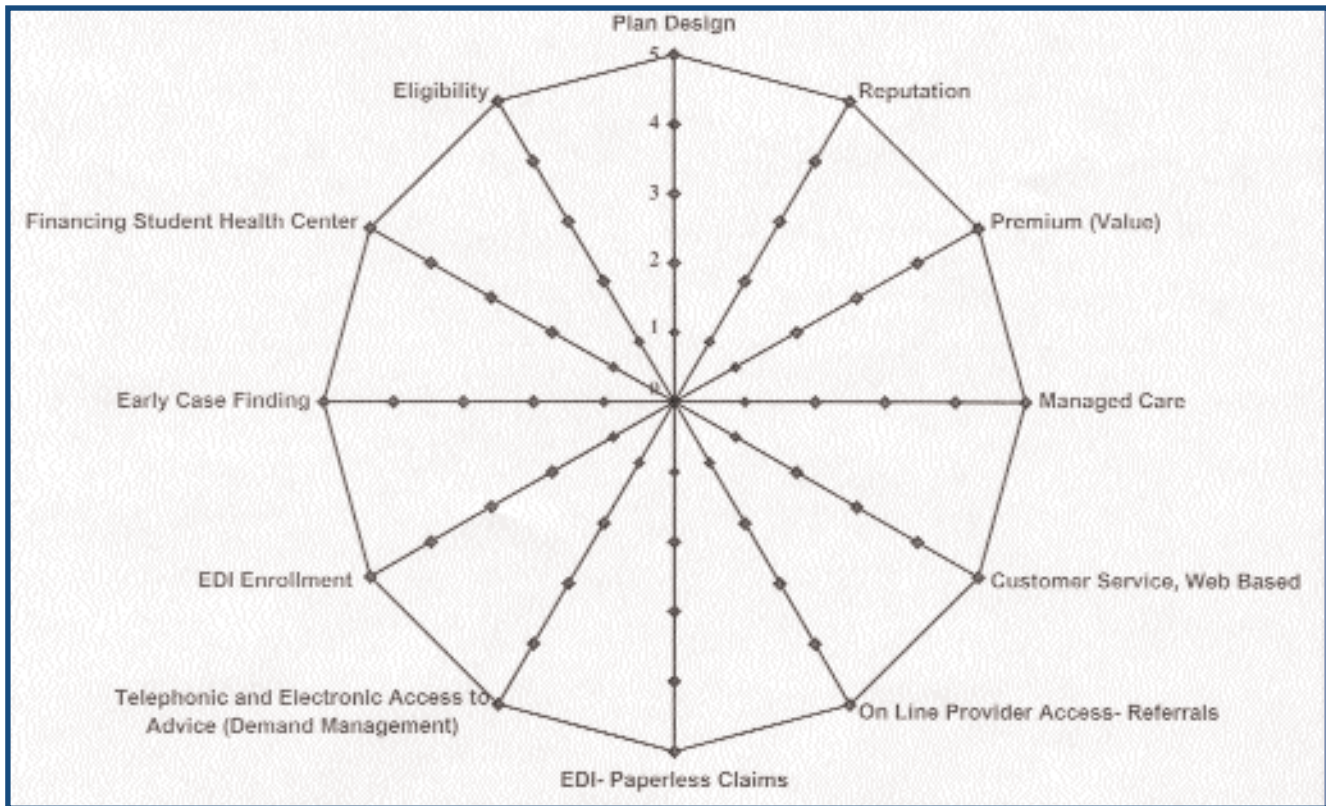
College health insurance plan designs tend to track those benefits offered by employers, even though the needs of the student population are significantly different. The trend in employer-sponsored health insurance has been to add benefits that are frequently used by most of those insured, such as dental care,

prescription drugs, and vision benefits. Although the unit costs of the services are not prohibitive, the high utilization rates of these kinds of benefits adds significantly to premium costs. But when someone else pays the premium (the employer), the demand for these benefits is high. In college health insurance, the premium is usually paid by parents, making price critical, requiring that the costs of these popular coverages be offset in other ways- deductibles, coinsurances (or copayments), and plan limits. A well-designed plan must, of course, have adequate protection against significant economic costs because of a major illness or injury, not just the popular coverage for benefits like prescription drugs. Two strategies are often used to resolve the inherent tension between cost-sharing and economic protection. The first is the out-of-pocket maximum (OOPM) meaning when the combination of deductibles, copayments or plan maxima reach a threshold, the insurer pays 100% thereafter. Like an automobile or homeowners insurance deductible, the higher the OOPM, the lower the premium.

The second strategy is to avoid plan limits and/or exclusions that can lead to significant financial burdens for the seriously ill or injured student. Unfortunately, it is not uncommon to see low limits on surgery, mental health and prescription drug benefits. It is also common to see exclusions for alcohol-related injury or treatment resulting from an attempted suicide or other self-inflicted injury. Because these are the types of claims that occur in student populations, such plan limits can leave some students and their parents with very significant uncovered costs.

Chickering writes plans to the specifications suggested by each school, but where possible we try to balance coverage of high frequency care (e.g. office visits, Rx's etc.) with deductibles and copayments. We advise against most narrow internal plan limits, because it places the insured at significant economic risk.

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## 12 Attributes of a High Performance Student Health Insurance Plan

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While there is no "ideal" plan design for student health insurance, the better plan designs will meet five tests.

- Coverage will offer solid economic protection against significant unanticipated medical costs.
- Coverage for anticipated medical costs (Rx, routine office visits, labs, etc.) will be good value for premium.
- Coverage will follow the student as they leave school on holidays and breaks, and as they travel and provide medical evacuation and repatriation coverage.
- Coverage will fit hand-in-glove with the programs of the SHS.
- Provider contracts will allow broad geographic access without balance billing and without paper claim forms.

Unfortunately, there is high variability among colleges and universities in their plan designs. This makes comparisons difficult and adds costs to plan administration.

### Should Student Health Insurance Be Mandatory?

The evidence is mounting that students are increasingly ineligible for parental insurance because of lower age limits or because employers are charging employees substantially more for dependent coverage. Further, under-insurance is a growing problem as parental insurance limits out-of-area, non-urgent care; care rendered by non-network providers; or because plans are imposing higher deductibles.

Students without insurance or with inadequate insurance represent 25-40% of the undergraduate population, with a much higher percentage applying to graduate students. Virtually all international students will need the college-sponsored plan, except those with Embassy-sponsored plans.

While many schools are reluctant to move to "hard waiver", it is likely that ACHA's new guidelines will strongly suggest that all students should have adequate health insurance. It is our belief that mandatory, hard waiver programs now represent "best practice".

### How Do You Determine What Is the Best Premium? Is It Generally the Least Costly?

Premium is primarily a function of plan design, historic experience and provider networks. Plan design provides information on what is covered, but more importantly, what levels of cost sharing exist. Historic experience will reflect the specific demographics of the insured population (male vs. female, undergraduate vs. graduate, domestic vs. international), the medical cost in that area, and likely patterns of utilization (which may be modestly altered by cost sharing). Provider networks will reflect the health center's effectiveness to steer and manage utilization and cost. Three other factors are also very important in evaluating premium: annual trend projected (change in costs and utilization), pooling or reinsurance levels, and the target loss ratio the insurer wishes to achieve.

If one assumes actuarial science and underwriting methodologies are based on well established and broadly accepted assumptions, then it is likely that multiple insurers with the same plan design, historical claims experiences and comparable provider networks will rate the case to the same, or similar premium. Indeed this happens, often within a few dollars. Where premiums differ more substantially, the insurer with the lower premium may have discounted some recent large claims hoping they will not re-occur (an actuarial sin!); may have lower trend assumptions; may have more favorable provider arrangements; or may be willing to assume a higher loss ratio. In some cases it appears that some insurers will deliberately try to "buy" the business with unrealistically low premiums, hoping for substantial premium increases in future years.

Best performing premiums reflect the anticipated costs of specified plan design according to accepted underwriting practices, which combine historic utilization with future price expectations or trend. The trend assumption will incorporate all the "guesswork" of how the future will play out relative to the historical experience and, at best, is an extrapolation of everything known to date. The "trend" assumption thus is judgmental, but can be checked against a variety of credible surveys that should provide a confluence of values. Trend assumptions that are outliers on either side of the average should be questioned.

Provider arrangements require the most careful analysis. An insurer paying a percentage of Usual Customary and Reasonable charges (UCR) is a risky proposition for two reasons. First, charges are determined only by the provider, without any negotiation with the insurer or managed care organization. Thus, the difference between charges and UCR can change at any time and is often considerable. Worse, it may be billed directly to the student. This practice is called "balance billing".

A more significant risk, however, is that the provider may not accept the insurance at all because the percentage of UCR is too low, requiring the student to pay the entire bill directly and then seek reimbursement. (Insurers may wish to encourage direct payment for benefits like prescription drugs where costs are raising rapidly. The direct payment focuses the student on price, which is important, but also it is known that many students lose the bills or fail to file for reimbursement for other reasons. This "shoebbox effect", as it is known, can save the insurer significant numbers of claims.)

Far preferable to UCR are provider arrangements where the provider and insurer agree contractually to a payment program with no balance billing and open access for the insured.

In the end, "value" is determined by adding to the premium, the expected out-of-pocket costs for deductibles, co-pays, and plan limits, and any balance billing, the sum of which might be called the "full price". What you purchase for this "full price" is plan design, geographic access, the ratings and reputation of the company(ies), the service levels to both the student and the university. Lowest premium is often not the best value, because it may have hidden, higher out-of-pocket expenses to the student, limited access to preferred specialists, disjointed service, and higher than average premium rate adjustments in the future.

#### **The Ratings and Reputation(s) of the Companies Involved; Are These Important?**

Student health insurance has several component parts:

- The relationship with the college and university
- The relationship with students and parents
- The paying of claims (often called the TPA or third party administration function)
- The assumption of risk and the adequacy of compliance with insurance regulation, reporting, reserving and financial disclosure.
- The relationship with providers.

Different groups are qualified to provide these functions and are often discreet corporate entities that have partnered only to serve a specific school. In the most disaggregated model, a broker, a TPA, an insurer and a network manager will be four separate entities servicing a single school's student health insurance program. Among these components, only the insurer has a publicly available rating through A.M. Best Company, Duff and Phelps, Moody's and/or Standard and Poor's. Brokers and TPA's are usually licensed and regulated by the states in which they do business. Provider contracting companies, sometimes called managed care organizations (MCO's), are generally not licensed although the Divisions of Insurance in several states, most notably California and New Jersey, oversee providers and MCO's which take "down stream insurance risk" (e.g. risk capitation).

Two issues intersect here: responsibility / accountability, and reputation. Our prejudice is clearly toward a fully integrated, single corporate entity. Our thinking is straightforward: If one entity controls the entire service and insurance function, the level of responsibility and accountability will be the highest. Conversely, the old adage, "what's two people's responsibility is nobody's responsibility" wouldn't be an old adage if it weren't true.

This leads to the second issue, reputation. Reputation is discoverable at three levels- publicly available ratings, retention of clients, and written or oral testimony. All three should be examined. Unfortunately, human nature is such that if the premium is competitive and stable, if claims get paid, and if customers are happy, the soundness of the insurer is rarely questioned. Recent failures of managed care organizations and insurers in several states and receivership and government oversight of plans in other jurisdictions have made the careful examination of the financial health of the insurers, a critical and necessary part of every student health insurance program. The line from Gilbert and Sullivan is apt: "All is not what it seems when the milk masquerades as cream."

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Moving from the four "insurance" issues to the three "care management" or partnership issues, it is important to emphasize a key distinction between student health insurance and employer-sponsored plans. That difference is that virtually all student plans are centered around a campus-based student health service which offers a number of health education and screening programs, as well as primary care and some frequently used specialty care. The employees and clinical staff of student health services (SHS) are typically salaried or fee-for-time (sessions pay) and thus look like a staff model HMO. (For a more detailed discussion of financing student health centers, see *Spectrum*, Fall 1999, Vol 3, Number 2.)

In reviewing the critical components of the partnership between student health insurance programs and student health insurance centers, experts in the field identified three: first, early case finding, health education and prevention programs; second, contributing to the financing of the SHS; and third, managed care strategies, including demand management and disease management. Each will be briefly discussed.

#### The Importance of Early Case Finding, Health Education and Prevention Programs.

Insurers have been somewhat reluctant to pay for these kinds of "soft" services for several reasons, including the difficulty in projecting costs and, more importantly, the inability to measure benefit in any reasonable time period. Over the past several years, as employers have pushed for plans to provide pediatric immunizations, pap smears, mammography and other proven case finding and screening mechanisms (HEDIS-Health Plan Employer Data Information Set), insurers are now covering a broader range of these procedures. For students, however, beyond vaccine preventable disease and pap smears, much of the early screening and case finding should focus on life-style risk behaviors, such as alcohol and other substance abuse, eating disorders unprotected sex, and aggressive behaviors. These risk factors do not lend themselves to simple clinical procedures or lab tests, but involve carefully designed, multidisciplinary human interventions. (Surveys have utility in defining the population at risk, but are limited in helping individuals or groups modify behaviors.) It is typical for student health centers to fund these early case-finding programs through student health service fees, university funds or special grants. It is clearly difficult to build these kinds of programs into premiums, but nonetheless stu-

dent insurers should actively support any direct clinical interventions that flow from early case finding. Further, if the student health insurance enrollment is large enough to represent a significant subset of the total population, say 1/3 or greater, and the university is willing to build these costs into the premium, the insurer should consider supporting these activities on a capitated basis. (For a more detailed discussion on early case finding, see *Spectrum*, Fall 1999, Vol. 3, Number 2.)

#### The Insurer's Role in Financing Student Health Centers.

Student health centers are increasingly limited in their ability to raise student fees or increase their allotment of university funds. Because they function as the primary care center for the campus, the student health center is uniquely positioned to help the insurer keep costs down by both the care they render and by rationalizing and coordinating much of the care which is delivered in the surrounding community. Given this important role in both care and cost management, logic would suggest that the insurer's self-interest is in supporting an adequately funded student health center. The reality however is different. Parental insurance rarely covers services in the SHS. Therefore for student health insurance to provide general support for the student health center would be to subsidize parental insurance and unfairly burden the student insurance premium.

The solution is for the student health insurance program to work closely with the student health center to pay for all covered benefits provided by the SHS, which are not covered by the student fee. And, to encourage the SHS to add capacity to move some specialist care from the fee-for-service community to a prepaid student health service program (or to the SHS on a sessions basis). The two keys to this successful partnership are flexibility and data. "Best practice", then, is to know on a real time basis what care, which could be rendered in the SHS, is actually finding its way into the community (this is facilitated by Chickering's web-based referral system) and then creating a financial partnership to bring that care back to the student health service.

#### What Are Best Practices For Managed Care Strategies For Student Health Insurance?

The core of managed care is, theoretically, "evidence-based medicine" or following the most effective known course of treatment.

Unfortunately, much of what is called managed care is actually "managed fee" medicine or "cost-shifting" medicine. Exceptions are in the management of certain high frequency, high cost diseases such as asthma, diabetes, hypertension, and congestive heart failure. Most of these conditions, however, have a low prevalence among college students.

Students typically have three areas of high utilization which may be amenable to "evidence-based medicine" types of managed care interventions: prescription drugs (See *Spectrum*, Spring 1999, Vol.2 Number 1 for a more detailed discussion of prescription drug cost management); ambulatory surgery; and behavioral health.

Best practices in bringing evidence based medicine to these three areas involve a close working relationship with the student health center to identify practitioners who treat students appropriately, achieve good outcomes and conserve resources. The role of the insurer is two-fold: first, to provide a broad network of providers who have agreed to economically fair provider contracts; and second, to identify significant practice pattern variations which persist over time to the SHS directors. Our view is that it is not the insurer's role to tightly restrict a network, but that the SHS should have its own preferred providers. Most SHS directors confirm this by telling us, "We know to whom to refer within your network".

Insurers should also bring to each school current information on best practices in plan design, which also can support managed care by creating some economic incentives for the student to use our preferred providers through different levels of co-payment.

In summary, best practices in student health insurance yield **real economic protection to all students without adequate insurance**, through a **broad network of providers** at a **competitive and stable price**. This insurance program should be a **close working partner** with the student health service to **support early case finding**, to provide **appropriate financial support** and to identify best practices in **evidence-based medicine**. ■

# In the SPOTLIGHT

## Graduate Student Health Insurance: Why Graduate Students are Different from Undergraduates

by Mary Beth Pierog

Graduate student health insurance is increasingly a topic of concern among student affairs officers, deans, risk managers, and student health center directors. The growing competitiveness among R-I universities (The Carnegie Foundation's highest classification for universities engaged in sponsored research, currently 89 in number) for graduate students has been one factor in raising the issue. Graduate students themselves have advocated for different and richer benefits, while risk managers, concerned about institutional risk for the uninsured and underinsured, have also expressed concern.

What is driving these concerns? Basically, it is that graduate students are different.

### Consider these six differences:

- 1. Age and eligibility for coverage under parental plans.** Most graduate students are (or will become) ineligible for parental coverage by virtue of age. Thus, while a small percentage of undergraduates must purchase health insurance, virtually all graduate students will have to do so prior to completing their terminal degrees, either as students or under a spouse's plan.
- 2. Marital status and dependent children.** Many more graduate students are married and have children. The higher fertility rates, higher number of eligible dependents, and higher pediatric visits increase expected plan utilization and costs.
- 3. Access to and appropriateness of campus-based student health centers.** Graduate students may be geographically distant from the student health center. Further, most student health centers do not have significant pediatric capacity for preschool age dependents. Further, graduate students may not wish to use a facility that has an "undergraduate" constituency.
- 4. Most graduate students receive some university support,** through a stipend and /or grant and contract support. Many graduate students are economically independent, supporting themselves through spousal employment, part time employment and student loans. By contrast, undergraduate students are less economically independent, and, therefore, less cost-sensitive, although their parents may be.
- 5. Graduate students typically have a more intimate and more collegial relationship with senior faculty** than undergraduates, and, therefore, a stronger "political voice" for issues that concern them.
- 6. Universities compete more aggressively for the best graduate students** and are interested in providing an attractive program, including health insurance.

In the context of these six differentiating factors, universities must address five issues regarding graduate student health insurance: Plan Design, Delivery Systems (SHS- Networks, etc.), Premium(s), University Contribution to Premium (including the university's position on uniformity of contribution, both within programs and across programs), and Choice.

In facing these issues, universities usually adopt a "reference view point", e.g. graduate students are students; graduate students are Junior Faculty; or graduate students are a class unto themselves.

Some universities even divide their graduate student groups into subgroups such as Health Sciences, Other Professional Schools, Hard Sciences, Arts and Letters. These subdivisions are explained by virtue of geography, financing, or competitive practices.

Those universities that integrate graduate student health insurance into their undergraduate program often offer the health insurance at the same premium. In virtually all cases, this results in the undergraduate population subsidizing the graduate population. This may not be an undesirable outcome, but it should be done with a clear understanding by all key decision makers.

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Often, combining graduate and undergraduate students is done to create a larger, more credible group. In those instances where the undergraduate students electing the plan are largely international or non-traditional students, the risk pools may be similar and no significant cross-subsidy will exist.

A second model uses the faculty plan as its point of departure, which establishes a plan design, delivery system, and choice of options which many graduate students find more attractive than the undergraduate student health insurance program. Using the faculty plan for graduate students in no way obligates the university to subsidize the premium at the same level as faculty and staff. Indeed, many university administrators would argue that a separate premium program is not only appropriate, but necessary to make it clear that graduate students are not faculty.

As a third option, some universities offer a unique plan to graduate students and price it on its own experience. Premium costs may be partially offset by stipends and are usually incorporated into all calculations for student aid.

In summary, graduate students represent a significantly different, and more costly, health insurance risk pool than undergraduates.

In many instances graduate students express dissatisfaction with the undergraduate health insurance plan design, the requirement to use the student health service, premium costs, and the lack of choice.

Universities find themselves caught between a reluctance to move graduate students to the faculty plan\* and the considerable competitive and political influence graduate students have (including threats of and/or actual unionization).

While no single "best practice" has emerged among the variety of programs in place, several guiding principles appear to have utility.

Acknowledge the legitimacy of the different needs of graduate students and their dependents.

Consider designing programs which address these needs. One size will not fit all without some tailoring.

Political "clout" usually reflects some market reality. This is not inappropriate, because realistically, universities are "market economies". The importance of graduate students to their program and the university should be reflected in how their health benefits are organized.

If decisions are made on a school by school, or program by program basis, then knowledge of all current practices regarding graduate student stipends and benefits should reside in one office. "Rogue" or ad hoc arrangements should be discouraged. Avoid extremes in plan design, financing, and particularly cross-subsidies. Pure equity is not necessary to have a fair and equitable program.

Be clear about the decision making process. This issue should not be an open agenda group decision matter. The corollary is keep key constituencies informed. ■

\* This reluctance often is expressed as the "slippery slope" problem of parity with faculty on other matters of compensation and benefits.

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