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HDHPs AND HSAs IN STUDENT HEALTH

High-Deductible Health Plans, Health Savings Accounts and Consumer-Directed Health Plans

STEPHEN C. CAULFIELD, MSW, THE CHICKERING GROUP

Risk Managers View High-Deductible Plans With Interest, Not Concern

PATRICIA J. FOWLER, MICHIGAN STATE UNIVERSITY
VINCENT E. MORRIS, WHEATON COLLEGE
BILL PAYTON, UNIVERSITY OF MISSOURI

Consumer-Driven Health Care in a University Setting

FOREST C. BENEDICT, LOUISIANA STATE UNIVERSITY SYSTEM

High-Deductible Health Plans and the Student Health Center

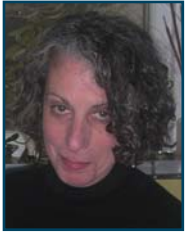
DAVID LAWRANCE, MD, UNIVERSITY OF ILLINOIS, URBANA CHAMPAIGN

HDHPs and HSAs: What's the Problem?

JOHN S. ANDREWS, JR., MD, MPH, UNIVERSITY OF CINCINNATI

A Survey of Student Health Decision Makers: HDHPs and HSAs

TIM R. GARDE, VOX MEDICA



Editorial

What Are High-Deductible Health Plans And Why Should We Care About Them?

This special issue of *Spectrum* is the result of numerous communications from leaders in college health about high-deductible health plans (HDHPs). They identified a number of concerns about how these plans will affect college health centers, including their impact on design of student health insurance plans, ability to arrange for care outside of the Student Health Service (SHS) and effect on Student Health Service revenue streams.

While high-deductible plans have been around for many years, recent changes in both tax laws and the insurance industry have fueled demand for these plans. The lead article by **Stephen Caulfield** describes what high-deductible plans are, how they work, how they have evolved over the years and projections for growth.

Most of us are familiar with the changes that have occurred in the insurance field over the past several years. Beyond the plan's historic experience, three principle components impact insurance premium costs — benefit design (namely, which benefits are covered and how much users pay for services via deductibles, co-pays and co-insurance); networks (which providers are included, as well as the cost to consumers for accessing those providers); and medical management (that is, the set of rules that determine which services are allowed).¹

Prior to the era of managed care, consumers bore a significant portion of their health care costs.² The theory underlying managed care was that medical management could control increases in health care costs through changes in providers' behavior. Instead, both insurers and providers were seen as denying access to desired services; this led to the counterrevolution for increased choice by consumers. However, another effect of managed care was the experience of decreased cost sharing and increased benefits for consumers, shielding them from considerations of cost in health care decision making. Consumers were also provided with increased access to preventive services, fueling the demand that routine medical services and preventive care be included as part of all health insurance plans (along with the expectation that the cost of those services would be paid by someone else).³

While backlash against the control of managed care plans continues, ongoing increases in medical inflation have led to renewed interest in cost control mechanisms, be they different formats for managed care products or broader choices in benefits, networks or providers. High-deductible health plans are one example of using cost sharing strategies to control increasing medical costs. In much the same way that managed care in the 1980s and 1990s was going to save us all from galloping medical inflation, the “new” HDHPs are now touted as the way to address the concerns of employers who seek the lowest possible insurance premium while still allowing consumers the freedom of choice.

We should continue to question the extent to which consumer cost-sharing serves as a long-term strategy to limit health insurance premium costs or whether it has only a short-term and modest effect on use, cost and quality of health care. While deductibles serve as a mechanism to share (or shift, or possibly delay) initial costs of care, their overall impact on reducing the ultimate amount or cost of health services received by an individual may be limited. The RAND Health Insurance Experiment explored the effect of different levels of cost-sharing on utilization for “necessary” and “unnecessary” services, and the impact on health status. For most of the study population, increasing consumer costs had a minimal impact on the health status of healthy, employed individuals; however, there was a decrease in utilization of services by the working poor and the chronically ill, with a potentially detrimental effect on health.⁴ As we assess the impact of high-deductible health plans, we need to determine whether the premises underlying cost-sharing strategies are valid in general, and whether the same principles apply to students as they do for employees, whether they are as valid for a university that subsidizes health insurance premiums as they are for an employer. We also need to keep the RAND results in mind, and consider whether students with limited income are more akin to healthy employed individuals or whether they will defer necessary care because of cost concerns.

The different entities affected by student health insurance programs have varied interests, and each group is affected differently by high-deductible health plans. The interests of students who have private or alternative health insurance may not be aligned with the concerns of students enrolled in the student health insurance plan. The focus of the SHS program may be affected — whether as a result of students on high-deductible health plans having difficulty accessing care in the surrounding community causing increased utilization of the SHS or because of the impact of high deductibles on health service revenues. Schools with insurance requirements have a number of different concerns, including the challenge of eliminating or minimizing adverse selection for the student health insurance plans, which in turn impacts the criteria used to waive the student policy as well as the administrative costs to enforce the requirement.

This issue of *Spectrum* explores the interests of different stakeholders involved with the delivery of health care to students and with the design and administration of a student health insurance plan. Two articles describe how a Student Health Service can be impacted by high-deductible health plans: **John Andrews** tells how the University of Cincinnati has been affected in the enforcement of the waiver criteria, and **David Lawrence** from the University of Illinois at Urbana Champaign looks at the issues of access to health care and whether the Student Health Service will need to be redesigned. **Forest Benedict** from the Louisiana State University System describes the attempts of the University to craft a high-deductible health plan specifically for students. A panel discussion of university risk managers looks at issues from the institutional perspective, with agreement on the importance of educating students to be informed health care consumers. Their discussion raises the broad question about how to provide that education to students in general, and the particular issues of how to and who should counsel an individual student effectively and efficiently about the costs of his or her care. Despite the readiness of students to access health information through the Internet, they have little health literacy.

Their lack of experience in health decision making is a potential concern if they are faced with the choice of cost versus care embedded in HDHPs.

The continued increases in the cost of health care are well-known. Much of the increased cost is the result of increased capabilities and technologies that people want. How much of the continued demand for high-cost services is because managed care programs shielded enrollees from cost consideration is unknown. How consumers will react to cost shifting and whether or not high-deductible health plans will have a lasting effect on spiraling health care costs is also unknown. Whether HDHPs are a long-term solution or a short-lived phenomenon, college health programs need to anticipate how they will be impacted by these plans. And if HDHPs are not the answer, we need to identify affordable long-term strategies that can enable us to meet the health care needs of our students.

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Notes:

1. Robinson, JC. "Reinvention of Health Insurance in the Consumer Era." *Journal of the American Medical Association* 2004; 291: 1880-1886.
2. Gabel, JR, Ginsburg, PB, Pickreign, JD, Reschovsky, JD, "Trends in Out-of-Pocket Spending by Insured American Workers, 1990-1997." *Health Affairs* 2001; 20:47-57.
3. Robinson, JC. "Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design." *Health Affairs* 2002; suppl Web exclusive: W139-W154.
4. Newhouse, JP. "Consumer-Directed Health Plans and the RAND Health Insurance Experiment." *Health Affairs* 2004; 23:107-113.



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High-Deductible Health Plans, Health and Consumer-Directed Health Plans

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To introduce this issue of *Spectrum*, it may be useful to lay out some basic definitions regarding consumer-directed and high-deductible health plans, the legislative and regulatory authority behind these programs, survey data and research on projected participation rates, and distinctions between Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs).

The concept of consumers playing a significant role in decisions about utilizing health care is not new. Health insurance plans common in the 1960s were called major medical and hospitalization plans and, as that name implies, left the consumer responsible for direct payment for primary care, outpatient diagnostics and prescription drugs.

A decade later, the term “Consumer Choice Health Plans” was introduced by Professor Alain Enthoven of Stanford University, who, at the time, was serving as a consultant to Department of Health and Human Services Secretary Joseph Califano.

Still later, Flexible Spending Accounts and Cafeteria Plans were offered by employers to promote prudent use of health care resources.

These, in turn, became Health Reimbursement Accounts, which, although not portable, and without investment returns, could be rolled over from year to year without the “use it or lose it” requirements of Flexible Spending Accounts.

With the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress added section 223 to the Internal Revenue Code to permit eligible individuals to establish Health Savings Accounts for the taxable years beginning after December 31, 2003. In July, 2004, the Treasury issued guidance for HSAs, too late for many large employers to adopt for their open enrollment periods in the Fall.

With the 2003 Amendments, we moved from the generic term, “consumer-directed health care,” which refers to any health insurance plan with significant point-of-purchase cost sharing, to a specific term, codified in law and tax guidance, “high-deductible health plans.”

What are HDHPs and HSAs And How Do They Fit Together?

A qualified, high-deductible health plan (HDHP) is defined based upon the plan’s deductible amount and out-of-pocket maximum. All benefits under the HDHP are subject to the deductible, except for preventive care and certain other benefits, such as dental and vision. In order to qualify for an HSA, the HDHP deductible amount must be at least \$1,000 per individual and \$2,000 per family. In addition to the deductible requirement, the sum of the deductible and required member out-of-pocket payments cannot exceed \$5,100 for an individual or \$10,200 for a family. These amounts apply for 2005, and are subject to cost-of-living adjustments (COLA) in future years. It should be noted that these requirements apply to in-network benefits, higher amounts are permitted for out-of-network services.

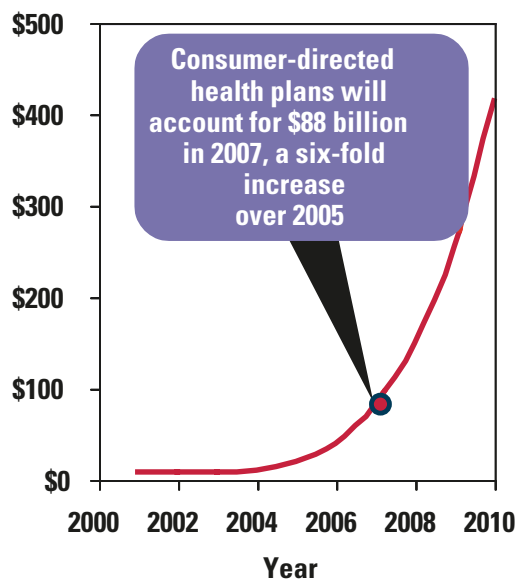
An HSA is a tax-advantaged account created to pay for qualified medical expenses as defined by IRS code section 213(d). Contributions can be made by anyone, including individuals, employers, eligible family members or a combination, up to the annual contribution maximum. The maxima are generally calculated as the lesser of the annual deductible under the HDHP or the statutory limit on contributions which, for families, is currently \$5,150. Non-qualified withdrawals by non-Medicare eligible individuals are also allowed, although subject to income tax as well as a 10% penalty tax. In addition to qualified medical expenses, individuals can use their account to pay for long-term care premiums, COBRA premiums, premiums while receiving federal unemployment compensation and some retiree health coverage, and over-the-counter drugs.

The HSA is owned by the individual and is portable. These accounts are not forfeited upon termination of student enrollment or employment. Contributions to the HSA are tax-deductible, and the accumulated HSA funds carry over into the following year. The funds can be invested and earn interest tax-free.

According to HSA guidance released by the Treasury

Savings Accounts,

Figure 1: Predicted Growth in CDHPs (2000-2010, Billions)



Source: Forrester Research

Department, pharmacy coverage must be integrated with the underlying qualified HDHP as of January 1, 2006.

In introducing the Treasury Department Guidance in July, Secretary John Snow said, "Health Savings Accounts are designed to help individuals take more control over how their health care dollars are spent and save for future medical and retiree health expenses on a tax-free basis. At a time when health care costs are rising rapidly and individuals, families and employers are struggling to find lower-cost alternatives, HSAs are a terrific option that I think every American ought to consider."¹

Despite the Secretary's

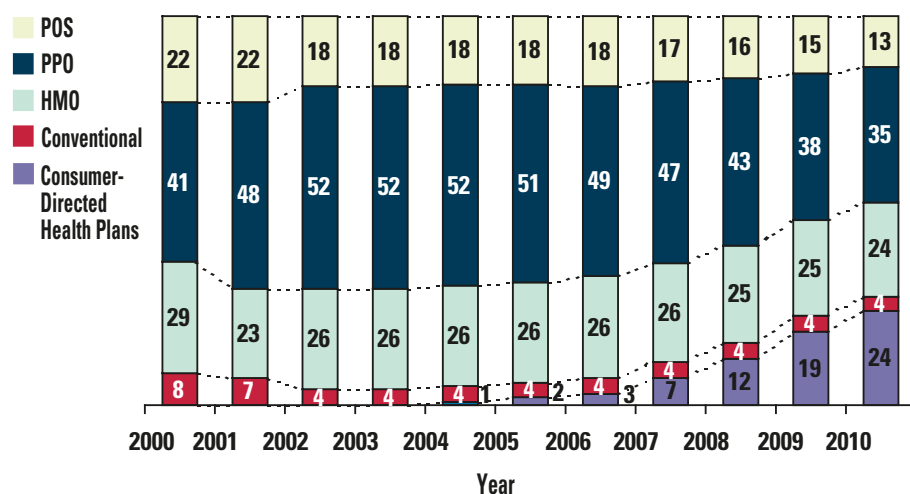
encouragement, in January of this year, only 29% of employees polled by Watson Wyatt had heard of HSAs.²

Still, despite the late issuance of guidelines from the Treasury Department, between September 2004 and January 2005, the enrollment in these plans grew from a little over 400,000 to 3.2 million.³ Recent reports from Forrester Research anticipate continuing rapid adoption of consumer-driven health plans by employers and their employees. The data in *Figure 1* suggests that CDHPs will represent over \$400 billion in premiums by 2010. *Figure 2* projects growth in these plans reaching one quarter of the eligible population by 2010.

Of interest, among the early adopters of HDHPs, 30% had been previously uninsured, according to data published by in early January by AHIP (America's Health Insurance Plans, an industry trade association).⁴

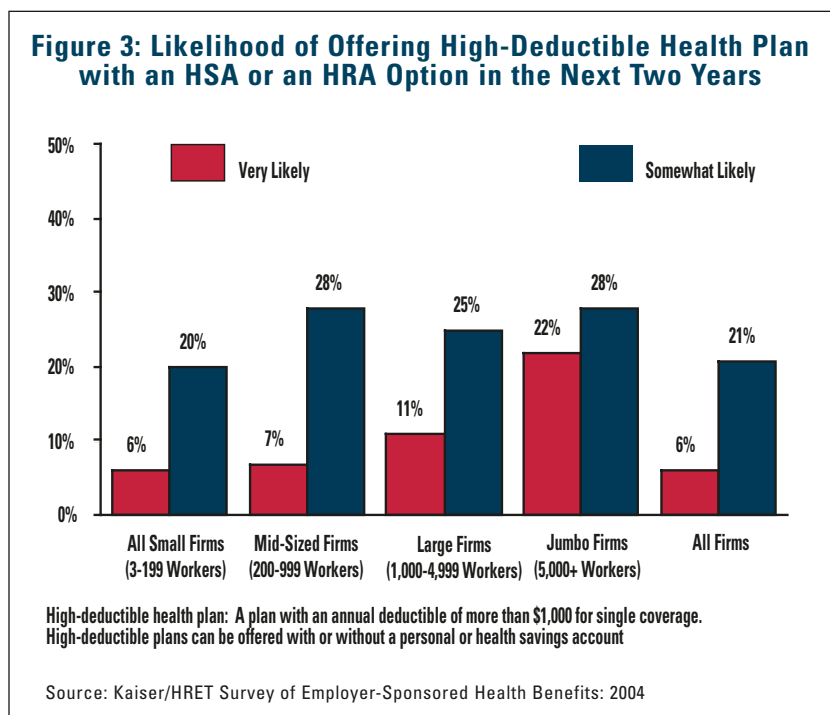
Where will the growth in high-deductible health plans come from initially? Although early adopters (2005-2006) are likely to be small- to mid-sized employers, survey data suggest the large and very large employers will become significant proponents starting in 2006 and

Figure 2: Predicted Growth in CDHPs (2000-2010, Percent of Lives)



Source: Forrester Research

“Health Savings Accounts are designed to help individuals take more control over how their health care dollars are spent and save for future medical and retiree health expenses on a tax-free basis.”



“A 30-year-old who deposits \$4,000 a year in an HSA and generates a 5% rate of return can save \$331,927 by age 65, assuming medical costs of roughly \$500 per year.”⁷

Two things are clear. In the near term, there will be significant growth in high-deductible health plans partnered with HSAs. Whether this growth will plateau in a few years or continue to grow is uncertain.

Second, outside of these HDHPs, employers will continue to shift some of the growth in health costs to employees through some combination of increased contributions for premiums, dependent coverage, increased coinsurances, co-payments, and deductibles, and greater limits on benefits.

Under either scenario, more HDHPs or more cost shifting to employees, student health programs relying on the adequacy of parental plans to provide for care not covered by the student health fee will have to rethink their student health insurance requirements.

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2007. Forrester Research projects that by the end of 2007, 12 million people will be enrolled in these plans, representing \$88 billion in premiums and 6.7% of the commercially-insured market.⁵

Figure 3 shows supporting data regarding the intent of various-sized employers to offer HDHPs.⁶

What about the older, Health Reimbursement Accounts which do not have the portability or the investment return features of the HSAs? Opinion on this issue is mixed. Many believe that HSAs and their linked high-deductible health plans will be more attractive to the individual and small employer markets, because they can dramatically lower premiums. Others see large employers moving to HDHPs and HSAs. The differences can be simply explained. The Health Reimbursement Accounts are the plans' money, the HSAs belong to the individual. As one explores the details, the HSAs offer the individual many more choices than the HRAs do, and the savings potential is significant. A recent *Wall Street Journal* article, citing the HSA Coalition, reported that,

Notes:

1. U.S. Department of Treasury, Office of Public Affairs. “Treasury Issues Comprehensive Health Savings Account Guidance.” July 23, 2004.
2. Caroll, J. “HSAs: Early Returns are In,” *Managed Care*. March 2005, pg. 28.
3. *Managed Care Week*, citing “Inside Consumer-Directed Care.” January 17, 2005, p. 2.
4. Dixon, K. “Health Savings Accounts Hurt Poor, Care-Report.” Reuters. January 27, 2005.
5. Forrester Research.
6. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2004.
7. Whitehouse, K. “Health Savings Accounts Require Investors to Shift their Approach,” *The Wall Street Journal*. March 28, 2005.

Risk Managers View High-Deductible Plans With Interest, Not Concern

Editor's Note: In February, Spectrum met with three University risk managers to discuss high-deductible health plans.

Spectrum: From your understanding of high-deductible health plans, what are your thoughts about the implications for college health and higher education's risk exposure?

Vincent E. Morris (Wheaton College): What concerns me the most about these plans — and, indeed all of our student insurance — is how little we, in higher education, do to educate our students on the principles of insurance. Education is supposed to be our business, but I question if any campus offers a program to students on personal financial management, including insurance.

We are a small college of about 2,500 students, but I assume the ratio of health staff to students is roughly comparable for schools of all sizes. Our Student Health Center staff is both concerned and committed to education in health care, particularly preventive care. We are very good at this, from explaining the risk/benefit analysis for vaccinations to the signs and symptoms of eating disorders. But, nowhere in these health education efforts is there an educational program on health insurance.

Bill Payton (University of Missouri): I think all of our Student Health Centers would agree that we have a responsibility to educate our student body on health matters. How effective we are is certainly limited by who we reach. We know that a great many students go through their years with us and never use the Student Health Service. As good as our health educators are on everything from safe sex to T.B. testing, I agree with Vince, we are not teaching our students about health insurance.

Spectrum: Since you raise the issue of educating students about insurance principles in the context of your campuses' health education programs, let me ask about students as informed health care consumers. Do they

know enough to purchase necessary and appropriate care and forgo that which may be unnecessary?

Patricia J. Fowler (Michigan State University): I don't think so. From a macro perspective, changes in the structure and financing of health insurance, typified by these high-deductible health plans, are coinciding with the other part of consumer-driven health care, which is the emphasis on safety and quality. Unfortunately, pricing, safety and quality all suffer from a lack of good, publicly available, data, so that many of the so-called "informed" decisions are really not that well-informed at all. These high-deductible health plans are part of a dynamic transition through what some call the "continuum of complexity," where we are moving from the resistance of providers and consumers to managed care to the new model of consumer-driven accountability, but one which is increasingly complex. Since this is challenging even for the experts, I think it is unrealistic to expect our students to take on this accountability for managing access and follow through, even with good, prescribed guidelines.

Mr. Morris: The smartest comment on US health care, in my opinion, was C. Everett Koop's remark when he was Surgeon General that the three things that everyone wants in health care are: immediate access, high technology, and low cost. It seems to work out that you can pick any two. In Canada, you have good technology and low cost, but you have to wait to see a doctor. In the US, you have excellent technology and immediate access, but you pay through the nose. In Mexico, you have good access and low cost, but good luck if you want a CAT scan.

In this reality, how do we educate the consumer, in general, and our students, in particular, about these trade-offs and their role in making decisions about them?

The way insurance should work is to cover catastrophic events or to smooth the budget curve. Insurance is not to pay for every health bill that comes down the pike.

“High-deductible health plans are part of a dynamic transition through from the resistance of providers and consumers to managed care to the new

I grew up in a rural setting where health insurance had meaningful co-pays. The combination of distance, convenience and cost made my parents prudent users of health care. Philosophically, I think health savings accounts (HSAs) and high-deductible health plans could bring health care back to the time when people were more aware of what things cost.

Mr. Payton: I meet every year with the graduate students. On our Columbia campus, we subsidize 100% of their health insurance premiums. We never heard from the graduate students until we started subsidizing their insurance, and now they really complain. Every year I meet with them and every year they want a full dental plan and full vision plan. My position is they should have whatever they want in terms of insurance, but that they will have to pay for some of it themselves.

Your suggestion, Vince, that these high-deductible health plans may help students become better consumers, seems to me to be optimistic. If our students are at all typical, they want everything and they want it for free.

Spectrum: If we assume that within the next two to three years, 10-15% of parental plans are high-deductible, as Risk Managers, do you anticipate the universities' risk exposure for medical costs associated with slips and falls or foodborne pathogens, etc. will increase?

Ms. Fowler: Over the years, we have had claims against the University by individuals who did not have the money to pay for their medical costs. Some were uninsured, some had let their insurance lapse, some had high deductibles. Without regard to the family's financial means, our philosophy has been to approach claims management solely on the merits of the claim. Some could argue that we should consider the facts and circumstances of the family's economic situation. These issues must be separated from claims management, which should be based on the merits of the claim.

Mr. Payton: I certainly agree, but I'm a little concerned that as these high-deductible health plans become more common, we will have many more opportunities to adhere to our claims management discipline.

Mr. Morris: I don't know how much of an increase we will see. Our experience is that deductibles have been moving up quite significantly in recent years, not to the \$1,000/\$2,000 level required for HSAs, but still pretty significant. I can't say that we have noticed an increase in claims against the college.

Mr. Payton: There have always been some number of people who think if something bad happens on campus, it's the campus' fault. The question is will high-deductible health plans cause that group to grow?

Ms. Fowler: Bill asks the right question, but you have to put into the mix the fact that folks are angry anyway about what has happened to their health plan, even before these high deductibles were introduced. Even the smallest increase to co-pays or deductibles is seen as a takeaway, and people will look for other sources of payment.

Spectrum: Let's take a specific example of the Norwalk-like virus which spreads very rapidly, often requires I.V. rehydration for a significant number of students who become ill, and where the virus is known to live for long periods of time on surfaces unless they are aggressively cleaned. Won't students covered by high-deductible health plans look to the University to cover their medical costs for these kinds of outbreaks?

Mr. Payton: I can see two approaches to handling this kind of situation. I can see some universities, particularly public institutions, saying that you have to prove negligence. I can also see institutions saying, "We have a problem here, and we should be allocating funds to take care of this problem." We have seen this happen where the institutional negligence was not proven, but where a public image problem existed and the university decided to spend some money to resolve it. The important distinction is these decisions were in no way linked to any university liability question.

Ms. Fowler: Bill is right, it's circumstantial. When we had our meningitis case, we vaccinated without cost to students and developed a comprehensive public health intervention

which went beyond the vaccinations, including education and communications to both students and parents.

Another example would be mono, where we educated our students, suggested places to go for care, and undertook measures to control infection.

Spectrum: So the consensus among you is that you don't see high-deductible health plans changing the universities' risk exposure in any appreciable way. Claims against the university will be judged solely on their merits, but the risk management function extends beyond claims into risk reduction and there, resources may be spent to promote health and prevent disease.

Mr. Morris: That's right. You have to follow the principle of risk financing. If we start deviating from that with every change in legislation or the structure of medical benefits, we are going to be chasing our tails for years. Insurance is best thought of as a very large credit card with a 30% interest rate that you use only when you are in trouble and cannot finance the loss in another way. So, in many ways, these high-deductible health plans are the right way to get people to move the catastrophic use of insurance to where it should be.

Does it change the way we handle other campus risks, like premises liability? I don't think so.

Mr. Payton: I don't think so either, but here is another concern. In talking with the physician who runs our Student Health Services, Dr. Susan Even, her concern is that students will not get the care they need. That becomes a risk management issue even though it is a very different type of risk management than we normally deal with.

Ms. Fowler: We have similar concerns. Our student health fee, which all students pay, provides for access to some number of visits to the Student Health Services, but we look to insurance to cover labs, imaging and specialty referrals which may flow from those initial visits. What then happens to our ability to provide appropriate care for a student who may refuse to get the requested lab work, imaging or specialty consult?

Mr. Morris: That leads to an interesting question about

whether or not, as these high-deductible health plans become more common, there will be a movement towards mandatory health insurance for all students. If there is, will the lower premium associated with 100% participation in the risk pool be a cheaper way to pay for health care than if we require people to pay for the first \$1,000 or \$2,000 themselves with a high-deductible health plan? The idea of financing the front end with insurance seems to me to be philosophically flawed.

Mr. Payton: We know a mandatory plan will make the insurance cheaper for the individual because it eliminates the risk selection. I'm not sure from the provider standpoint that mandatory plans would in any way change health spending. I don't see how they could. That leads to another question. Setting parental high-deductible health plans aside, what is the likelihood we will see high-deductible student plans?

Spectrum: High-deductible student plans exist and will continue to be tested. The most significant question, beyond some technical filing issues, is what can be done to ensure the student has the ability to pay for necessary and appropriate care within the deductible. Since students have little or no taxable income, the tax-advantaged financing of HSAs is not an option. Parental HSAs, however, could be used. But what happens when the parent does not have a qualified high-deductible health plan of their own? Finally, if student high-deductible health plans are offered as a choice with a more traditional plan, it is likely that anti-selection will occur, driving up the price of the traditional plan.

Mr. Morris: As much as I favor building consumerism into health insurance through high deductibles, I have concern about what these plans might mean for the Student Health Service financing that depends on recovery of insurance claims from parents. Under traditional insurance plans, we know that recovery is often less than 40% of billed charges, largely because smaller \$200-\$400 deductibles have not been met. Surely, that would be substantially less with high-deductible health plans, forcing colleges to raise their student health fee.

Spectrum: Many high-deductible health plans for students are offered on an individual basis, not as a university-sponsored plan. They usually offer good catastrophic coverage, but often exclude maternity and prescription drugs and usually have a twelve month preexisting condition exclusion. Their premiums are quite low. It is not uncommon for single male graduate students, with no preexisting conditions or significant costs for prescription drugs to elect these plans, leaving the university-sponsored plan to absorb the higher risk student population and eliminating any meaningful cross subsidies for spouses and children. This places an increased burden on universities to cover some portion of graduate student health insurance, but still leaves family coverage as an outgoing problem.

Mr. Payton: You're absolutely right. The big gap we will still have are those graduate students and international students with a spouse and dependents. That coverage is \$8,000 or \$9,000 per year, which means that many of those families go uninsured. This is an area we take very seriously, but we don't have the answer to that problem.

Mr. Morris: That raises the whole political question about the degree we can require the healthy to pay for the sick. Of course that is the basic principle of insurance, risk distribution across a large population. We have a similar problem with the affordability of our plan for graduate students. We try to moderate that by artificially lowering the graduate student (and family) premium and artificially increasing the premium for undergraduates. We make those decisions institutionally because we need to support our graduate students and we believe it is fair to more broadly distribute their risk. Unfortunately, as a society, we do not make these decisions well, allowing risk segmentation to occur. Will high-deductible health plans further drive risk segmentation?

Mr. Payton: Because of their low income, some graduate students and their families are eligible for Medicaid. We do not feel it is appropriate to encourage Medicaid participation, although we will do so for students who tell us they cannot afford the university plan.

Spectrum: Can we turn to the university policy considerations that the growth of high-deductible health plans may bring to the table?

A policy consideration under review at several universities is the qualification for waiver of the university-sponsored student health plan. A few schools now have a threshold deductible, often at the level of deductible in the university-sponsored plan. If the parental plan has a higher deductible, students are not permitted to waive without regard to other plan design features.

What is your view on the inclusion of a threshold deductible to waive off the university plan?

Mr. Payton: I am pretty much the guy on our campus who determines waiver policy. The way I think about a qualified hard waiver program is both to expand the pool of insureds on the university-sponsored plan, and to eliminate the uninsured and underinsured. Think about it — if we had all 60,000 of our students on our plan, we should be able to drop our premium from \$1,600 to perhaps \$1,200. But even at that lower premium, some number of students won't use the plans at all. So I would then try to drop the premiums further, by specifying, say, a \$400 deductible. The students who historically paid \$1,600 in premium and used the plan with a higher deductible would still come out ahead. Some of the new entrants might complain that their parental plan was still adequate, but I could sleep with that kind of policy decision.

Mr. Morris: A student health insurance plan with a hard waiver, \$400 deductible, may be less expensive than including the student on the parents' high-deductible plan, or at least a very good alternative coverage for parents to consider, to allow their HSA to grow. But, as I have said, one of the issues I am struggling with is: why is it cheaper to pay for health care through insurance than it is to have the consumer pay for it directly? Insurance companies take 20-30% overhead (retention). It would take at least equivalent discounts to offset these administrative, risk and profit charges. And shouldn't physicians and hospitals offer a cash payment discount?

Mr. Payton: The savings from in-network discounts can be very, very significant, particularly for hospital care. We had some actual bills repriced between two carriers and the differences on the hospital bills were measured in thousands of dollars, dollars which would have to be borne by the student or their family. Insurer's networks are not just discounts, but the provider credentialing

process can result in higher quality and more efficient care. Certainly, in the current environment, letting people pay retail can be significantly more expensive than using an insurance program.

Spectrum: Getting back to the policy question about hard waiver, if you were asked, would you support a deductible threshold, well below the \$1,000 individual deductible now required for HSA eligible plans, as part of your waiver requirements?

Ms. Fowler: That implies showing some proof of financial responsibility, which I think is a little more intrusive than most universities would like to be.

Mr. Morris: To answer that question I would need to know what my risk is. If we were to leave our current policy in place, which permits students whose parents have high-deductible health plans to waive, what am I worried about? Some of the risks we’ve talked about here — slips and falls and foodborne pathogens, for example — are better controlled by loss prevention measures. So why should I argue for a deductible threshold?

Mr. Payton: I agree. I can’t see university policy trying to manage a family’s budget issues.

Spectrum: Another policy question: Should universities adopt mandatory sickness and accident plans with low limits which would, in effect, fill in for high deductibles?

Mr. Payton: No, I just don’t see low-limit plans. We just had a student in the hospital one night with an appendectomy and had a \$28,000 bill. I have also had a student with cancer and, thank God he had our plan with the \$250,000 limit, because that is what it took to treat him. Here is our challenge. You meet with students who think that even a \$100 deductible is unreasonable. You can’t say to them, “You just don’t get it.”

Mr. Morris: You highlight what I started this discussion with: We in higher education have a responsibility to educate our students on how insurance works.

Mr. Payton: Exactly. Our students push for dental insurance every year. They don’t understand that dental insurance is

really only a budgeting discipline. If you just had the discipline to put that money away every month, you could easily pay for routine dental care. It’s not really insurance.

Mr. Morris: The two reasons people buy insurance for anything are catastrophic protection and smoothing the budget curve. Smoothing the budget curve is not necessarily a bad thing, but it is expensive and it is an admission of failure at budgeting.

Ms. Fowler: Not only are our students challenged to budget for routine care, but they also don’t understand the catastrophic nature of insurance.

Spectrum: Let’s raise a third policy question: A large university has suggested that we develop a student health insurance gap policy, similar to Medicare gap policies, which would fill in the gap between a lower deductible — say \$200-\$400 and the \$1,000 or \$2,000 required for HSA eligibility. The only people who could apply for these gap policies would be those with existing high-deductible health plans. Your thoughts?

Ms. Fowler: Gap coverages, aside from student health insurance, are always difficult to manage. These plans would add a level of administrative detail and complexity at a time when universities’ student health programs are strapped for resources. I just don’t think this kind of policy makes sense.

Mr. Morris: In general, I agree with Pat, but if these gap policies would help improve insurance claim recovery for the Student Health Services, then that might be a reason to consider them.

Mr. Payton: The way to improve the financing of the Student Health Service for care not covered by the student health fee is to bursar bill the student directly and let the student chase the insurance.

Whether gap insurance would solve that problem I don’t know, but on first blush it would seem to add a level of complexity and cost.

Mr. Morris: The gap insurance idea goes back to my basic theme, you generally don’t want to try to insure a budgeting problem.

“There have always been some number of people who think that if something bad happens on campus, it’s the campus’ fault. The question is will high-deductible health plans cause that group to grow?”

— *BILL PAYTON, UNIVERSITY OF MISSOURI*

Spectrum: Under the tax guidance issued last July, by 2006 all separate prescription drug programs will have to be folded under the Health Savings Accounts. Prescription drug plans are the most significant cost driver in today’s student health insurance plans. There is some evidence that in student health insurance plans — which are voluntary and offer prescription drug coverage — there is selection against the plan by students, who calculate that their prescription drug costs are greater than the premium. One possibility under the requirement to include prescription drug plans under the high-deductible plans is that this observed adverse selection would be exacerbated as high-deductible plans increase in popularity.

Mr. Morris: If you are correct about risk selection, then these high-deductible plans will increasingly be populated by people who don’t anticipate spending that deductible on health care. I presented these concepts to our HR department and afterward an employee told me that she spent more than \$1,000 on health care and couldn’t afford to pay that out of her pocket. If she were given a choice, she would clearly take the lower deductible product.

Ms. Fowler: People who have chronic or recurring conditions have a very good idea of what they spend on drugs, supplies, co-payments, etc. They’ll use that knowledge to select the plan where they are likely to get back more than they put in.

Mr. Morris: Although we discussed this before, it remains an important issue: For high-deductible health plans to attract people with anticipated health expenses, the provider world is going to have to offer discounts for cash. It can’t be done by consumers alone. Education is critical, but in the end people will usually act in what they think is their short-term economic self-interest.

Spectrum: Thank you. To summarize: The growth of high-deductible health plans among parents of college students is of interest to you as risk managers, but not of great concern. You do not anticipate a significant increase in university exposure for premises-related events. You will

continue to emphasize loss prevention and adjudicate claims on their merits.

If you do have any concerns about these plans, those concerns fall into four areas:

- Higher education could do a much better job of educating students on the principles of insurance.
- High-deductible health plans could result, over time, in unfavorable risk selection against the university-sponsored plan. Nonetheless, you do not favor waiver requirements which would prevent students with high-deductible plans from waiving off the university-sponsored plan.
- You generally do not favor insurance products which principally serve to smooth the budget process. Thus you would not favor mandatory low limit sickness and accident plans or gap plans. Your concern is that high-deductible health plans may create a demand for these plans, which could add administrative complexity.
- You, and your colleagues in Student Health, are concerned about students not getting care or being non-compliant with prescribed care because of direct, out-of-pocket costs.



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Consumer-Driven Health Care in a University Setting

Forest C. Benedict, Louisiana State University System

Today, more than half of the employees of Louisiana State University (LSU) who take health care coverage are enrolled in one of two consumer-driven health plans (CDHPs), and we are actively considering one for our students. In just three years, participation in the plans has grown to over 9,000 employees.

The questions we are often asked are these: What are we doing? Why are we doing it? What are the benefits? The concerns? What must we do to improve the health of all of our University community? And finally, why do we need to try this for students?

LSU and Health Costs

The LSU System is a large enterprise. We have 5,600 faculty, 21,500 employees, and 63,000 students, of which 13,000 are graduate students. We exist on ten campuses, primarily in Baton Rouge, New Orleans and Shreveport. The campuses are located in reasonably discrete health care markets.

The health costs associated with the LSU community have been rising at 15% or greater each year for the past five years.

In 2004, the University spent \$100 million on health benefits plans for faculty and staff. This does not include costs for lost time due to illness or injury, short-term disability, long-term disability, or worker's compensation. It does not capture lost productivity for persons at work, but who are functioning sub-optimally because of ill health, concern about another person's ill health or distractions associated with organizing health care or health reimbursement. It does include post-retirement health benefit costs, although few retirees are enrolled in our CDHPs.

In this context, it is easy to see how health costs could be viewed as a significant threat to the higher education budget in Louisiana.

Reduce Health Benefits, Shift Costs, or Introduce Consumerism?

Employers' choices in this post-managed care era

have generally been limited to either cost-shifting to employees or retirees, or reducing access.

Several years ago, some leaders in the business community raised the question of whether health plans should go the way of retirement plans — that is, shift from a defined benefit plan to a defined contribution plan. Under that approach, employers would contribute a set amount to a health benefit fund, and the employee would choose how to spend those dollars. To the degree labor relations and the maintenance of a competitive workforce permitted, the defined contribution model decoupled the employers' responsibility for increasing its contributions for health benefits from the underlying trend in health costs.

Contemporaneous with this consideration of defined contribution approaches to health benefits was a review of the employers' duty to support dependent and retiree coverage. Many employers took the position that their primary responsibility was to active employees, and reduced their support of both dependent coverage and retiree health benefits.

However, employers do have another alternative — CDHPs — which empower employees to make more informed choices about their own health care, potentially resulting in the conservation of resources and lower expenditures. This is by no means a new idea. Alain Enthoven, an economist at Stanford University, was promoting CDHPs as early as the mid-1970s.

What was new when the LSU System decided to make this type of plan available to its employees in July, 2002, was the administrative support through our third-party administrator to set up and manage employees' Personal Care Accounts (PCAs), and to provide a fully-integrated insurance feature (which is actually a self-funded LSU System plan).

CDHPs at LSU

For our employees to become informed and prudent consumers on health care, three conditions needed to be present:

“CDHPs empower employees to make more informed choices about their own potentially resulting in the conservation of resources and lower expenditures.”

- meaningful incentives had to be in place,
- accurate, timely and useful information had to be both available and understood, and,
- provider practice and compensation methods needed to be re-examined.

For the LSU System program, the incentives were the easy part. Our challenges remain education and promoting transparency in the price and quality of health care services.

How do our plans work? PCAs formed the basis for our approach to consumer-driven health care. For individuals, we allocated \$1,000 and gave the employee the choice of two plans, with the principle differences being in deductibles and employee premium share. The PCA is not a funded account, but rather a commitment by the University to cover certain eligible expenses not covered by the Health Coverage Plan (such as deductibles or an excess over the usual and customary charges). Employees can carry over the unspent portion of the PCA to a maximum of \$4,000, but lose it all if they leave the LSU System or switch to another health plan. Also, unlike an HSA (Health Savings Account), they may not contribute to their PCA.

Since its inception in 2002, the plan has been successful by two simple measurements, participation — which is now up to 9,000 employees — and the more prudent use of prescription drugs. I focus on prescription drugs because data is readily available.

Our generic substitution rate has trended up, going from 88.7% in Q3 of 2002 to 92% in Q4 of 2004. Meanwhile, pharmacy spending, as a percentage of total claims paid, declined from 26.4% for Q4 of 2002 to 19.5% for Q4 of 2004. These are significant differences, and we find no evidence of a decline in compliance levels.

Currently, we are working with our plan participants to increase their use of the prescription mail order program. Current participation in the program is in the 10% range.

Strategies to Improve Our CDHPs

This year we are targeting patients who suffer from chronic illness. Our objective is to build a health care support system that helps individuals who are at risk for chronic health conditions and have a high

rate of preventable complications. Targeted outreach efforts will focus on risk reduction, health promotion, and care management. The concept is a health care coach.

We have also have met with physician groups and hospital administrators in our various communities to try to rebuild their compensation structure from an episodic, fee-for-service basis, to a continuous care system, which would encourage physicians to spend more time with their patients, thereby becoming more knowledgeable about their patients' health status.

So, in the near term, our focus is on health care coaches for those with chronic or severe illness, health risk assessment and health care education for everyone, and a beginning look at the compensation and incentives for health care providers.

The university community may well be an ideal setting to offer a consumer model of health care. First, our workforce, faculty, staff and employees are intelligent, literate (including computer literate), and open to new ideas. Second, at LSU, as with most large universities, we have, as colleagues, a full array of health science professionals, economists, educators, marketing experts and virtually every other resource we need to make the system work.

CDHPs and Students

What about students? We believe that elements of the consumer-centric model of health care may work with students, but with many different challenges.

First, since students are not our employees, how do we fund their PCAs? One idea we are exploring is to offer students the opportunity to fund their own HSAs. Funding an HSA for students will be challenging given that IRS regulations prohibit students who still can be claimed as dependents of parents with an HSA from funding an individual HSA. A PCA, similar to a Health Reimbursement Account, may be an alternative.

Second, since most students are uninformed health care consumers, and typically want access to the best specialists or sub-specialists immediately, and for free, how do we create informed consumerism among students? Here, our best asset is our Student Health

Service. But, like the physicians in the community, most of the clinicians in student health are scheduled on 15-minute visit slots. How do we change their practice style to permit more coaching without blowing the budget? Can the coaching be done by the LSU System health plan nurses and other health care professionals?

Third, students are generally healthy. But, about 40% will use a prescription drug benefit. Ten to 15% will present with some behavioral health problem. Well-women's health and other GYN services will be used by most female students. Many seek care for dermatology lower-cost outpatient care. Other than trauma, eating disorders, and the occasional grave disease, college students are quite healthy and do not run up major health care bills.

So, a legitimate question is: Will the underlying disease burden of students lend itself to a consumer-centric model of health care? We think it will, particularly for that large amount of self-limiting disease which will resolve itself with self-care interventions (or at least with just some symptom relief).

Fourth, questions have been raised about students foregoing necessary and appropriate care when they have to spend either their own or their parents' money. Interestingly, I have heard the other argument as well — that they will spend their parents' money without a second thought. In truth, we probably have both types of students on our campuses.

Our answer has three parts. First, the PCA can only be used for health, not for other goods and services. Thus, the students' economic choices are not between things like car payments or cell phone bills and health costs. Second, studies on compliance show that the clinicians' communication about the importance of compliance is a significant variable. Improve physician-patient communication, improve compliance. Third, for students with chronic or recurring conditions, a health care coach, such as I have described for our employees, may be an appropriate use of resources.

Finally, people have suggested that the transitory nature of a student's life at college may mean they are not open to what I call "culture building" for our employee plan. My response to that is that we have the opportunity to shape our students into informed health care consumers

and we should seize that opportunity. Other sectors of the economy, which have spent a great deal of money on understanding building consumer behaviors, tell us that college campuses are the place to do this. Just look, for example, at campus advertising targeted at students for all kinds of consumer goods. Why not health care?

Our Next Steps

Whether or not we move to a high-deductible health plan for students in the 2005-06 plan year depends on our ability to resolve a few issues — such as how to create a PCA — along with other technical considerations, including the ability to offer HSA-styled plans to a large number of students who have dependent status. We also need to resolve whether a high-deductible health plan would be a total replacement for our current student health insurance plan or would be offered as a choice.

Finally, we need to revisit the University policy regarding requiring health insurance for certain students and make some decisions about how we would encourage a significant number of students to take the high-deductible consumer plans.

The LSU System's adoption of a CDHP for our employees has, at least in the short term, been a very positive step. It is obviously a work-in-progress, but we have fairly clear ideas about what we need to do to make it even more effective. We have demonstrated that these plans can work for all people regardless of health status and are not just plans for the "Healthy Wealthy" as some critics have suggested.

With regard to student health, we really want to try it. After all, our mission as a University is education and education is the key to the success of these programs. Who better to try this approach with students than a university?

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High-Deductible Health Plans and the Student Health Center

David Lawrance, MD, University of Illinois, Urbana Champaign

Students with high-deductible health plans (HDHPs) may have as much as \$2,000 to spend a year before their family's health insurance kicks in. When medical need spans coverage years (as it often does in an academic year), that amount could double to \$4,000 for an episode of illness or treatment of injury. This is a vastly greater economic exposure than the deductibles of the more traditional university-sponsored student health insurance plans, which today typically offer annual deductibles of \$200-\$300 or less. These HDHPs are also significantly different from the employer-sponsored parental coverages with which Student Health Services have become familiar. We are all entering a new era in student health insurance where some individuals and families will have a far greater direct responsibility for paying for their health care. For Student Health, this new era raises questions, concerns, and perhaps opportunities.

There is little empirical data to guide our decisions about how best to provide student health, as more and more of our students are covered by HDHPs. Absent data about health consumer behaviors in a self-pay environment, we do know far more about the health needs of our students, their risk behaviors and compliance issues than many physicians practicing fee-for-service medicine in the community know about their panel of patients. What we know should be helpful in adapting to HDHPs.

Let me raise three issues for your review:

- How can we ensure that students have economic access to all necessary and appropriate health care while in school?
- From our knowledge of the health needs of the student population (generally healthy, occasionally gravely ill or injured, and, increasingly using behavioral health services and prescription drugs), can we redesign our SHS to ensure appropriate care under HDHPs?
- What will be our responsibilities to help our students become prudent health care consumers and how might we discharge those responsibilities?

Economic Access for Students

First, let us consider how HDHPs might change economic access to health care. When high-deductible insurance is paired with an adequately-funded Health Savings Account (HSA), out-of-pocket expenses could be very easily managed. There are now strong tax incentives to encourage sheltering income in an HSA. Such consumer-directed health care coverage has the potential to lower health care costs and the rate of cost inflation by letting the consumer directly participate in the health care market as a purchaser. That assumes three conditions: informed consumers, transparency of health cost and quality data, and restructured incentives for providers. Today, these conditions are works-in-progress.

Our fear in college health care is that families choosing an HDHP might opt to minimally fund their HSAs to have maximum access to the savings achieved through lower insurance premiums. Students with inadequately-funded HSAs, who require health care, may be unable to meet the required deductible payments. This may be enough of a disincentive so that students will forgo health care that is necessary and/or preventive. Further, this cohort of students who, because of high deductibles, are at the fringes of economic access, may well be financially unable to remain in school because of large unfunded deductible costs. If this sort of plan catches on nationally, as is predicted, it could have an impact upon every campus.

There are at least three approaches to ensuring economic access that student health programs should consider: insurance standards, which might preclude HDHPs from waivers; expanding student health fees to make more primary and preventive care available to all; and education.

How will our knowledge of the health needs of students help us consider these approaches?

Here is a thought experiment. Gather the annual cost of health care of every student on campus — all costs, insurance payments to health care providers, out-of-pocket payments, and premiums. What is the median

“There is little empirical data to guide our decisions about how best to provide student health, as more and more of our students are covered by HDHPs.”

cost? What is the distribution of the variance from the median? A campus that accepts many high-deductible plans or that does not require insurance will have a somewhat lower median expense, because the healthy students will select the higher deductible, lower premium plans. But this group will also have a higher variance. The average young adult incurs few health care expenses. A few have tremendous expenses. The campus that is tightly managing its students' health coverage with a qualified hard waiver program that prohibits HDHPs will have a higher median, but a smaller variance, because the cost of its insurance will be higher. Where do we want to position our campus?

One goal of the Provost is undoubtedly to minimize the cost of insurance and health fees as a means of keeping the total college bill affordable. The goal of the health center is to minimize the variance in health care expenses through access to primary and preventive care. Somehow, we must compromise between these.

Expanding the Student Health Service

College health centers, unlike most private sector clinics, adopt a most curious business model. Rather than trying to maximize profit by discouraging care in unprofitable basic service areas and encouraging the selection of more lucrative services, our goal is to minimize the cost of health care, minimize out-of-pocket expenses, and encourage the use of basic health services. We are able to do this because much of our budget is derived from student health fees.

As students face increasing deductibles — which they will, independent of the adoption of HDHPs — Student Health Services will face increasing difficulties in referring care to the community, both from reluctant providers and non-compliant student patients. A logical and simple (conceptually) alternative is to expand the services of the SHS to include the commonly-used diagnostic, specialty and sub-specialty care. Where do we get the money, the people, and the space and equipment?

This expansion should be funded by increasing student health fees. The people, space and equipment can present a challenge, but this expansion does not have to happen overnight. Off-site resources, prepaid by the SHS and connected electronically for scheduling, EMRs, etc., might be considered.

Educating Students About Health Care and Health Insurance

Students can learn a great deal about health care, and even some things about health insurance, by using their Student Health Centers. We pay special attention to the messages that they learn when they visit us. Perhaps it sounds perverse that we are thrilled at my health center when students complain about waiting more than half an hour to get to see a doctor when they walk in for service. Why do these complaints please us? On one level, it means our staffing plan is working, permitting most patients to schedule a same-day appointment and not overload the acute care clinic by walking in. And, if they do walk in, that their waiting time was less than an hour. Lesson learned? “I can receive routine, high-quality health care on any day that I need it.” Our patients will hopefully learn to demand similar access from their future providers and their providers will listen or perish.

I have heard from others, including my colleagues at my Student Health Center, that part of the college health center's mission should be to teach our patients how to use the health care system when they graduate. I disagree. I think that it is our duty to prepare our students to seek health care that is innovative, responsive, and affordable. We want them to both demand and to design more rational methods of providing health care. Their Student Health Center should be a good model to use. We should not provide conventional care in conventional ways, we should do it in extraordinary ways.

But we also must help students understand when

“What do we want students and their families to know about their consumer-directed health plans? I think that the message could be very simple: If you have an HDHP, you need a well-funded HSA. If you cannot afford to fund the HSA, you don’t want an HDHP.”

they don’t need care. Self-limiting disease is common among students, but so too, are somatic complaints resulting from stress and anxiety. Distinguishing among patients who need no care, self-care, support and sympathy, and treatment, requires great diagnostic acumen. Helping students do that for themselves is an even more challenging, but important, part of our mission.

There cannot be a soul on Earth (outside of those few who sell it or who purchase it for their employees or campus) who really wants to know anything at all about health insurance until they need to use it. Without the willing student, what can we teach about novel forms of health insurance? Realistically, our teaching opportunities are limited. Whatever our educational content is, it must be extremely simple.

What do we want students and their families to know about consumer-directed health plans? I think that the message could be very simple: If you have an HDHP, you need a well-funded HSA. If you cannot afford to fund the HSA, you don’t want an HDHP. If you do not have a well-funded HSA and if you need health care, you are risking both your health and your college career. Is that a gamble worth taking? We get at least one chance to do that when we market the campus-sponsored plan.

The better the Student Health Center fills the gap for those with high-deductible plans, the fewer out-of-pocket expenses they will experience. Skilled generalists and evidence-based practice can keep more health care at the Student Health Center, where the cost of providing services is much less. The more we are able to provide essential health care services, the more we are reducing the variance of health care expenses.

With regard to optional services (such as massage therapy or optometry) where a Student Health Center may be charging full fee-for-service, a simple published and posted fee schedule will help patients shop for services that they can afford. The ability to produce a bill before the service or product is provided, gives the patient an opportunity to weigh their options. The ability to

advertise services with prices and produce a prospective bill demonstrates that the Health Center knows how to package and market these services. This is a major weakness of our health system. Few in the “real world” of health care can tell a patient in advance what the costs of their services will be. We should be able to do that.

Advertising our services, our prices, and our quality measures, such as access and satisfaction, are all education tools for preparing our students to be informed and demanding health care consumers.

From what I understand, we will all have students in the next academic year who have HDHPs. Probably they will be few at first, but the number will grow.

What is done will be guided by your institution’s philosophy about the importance of good health to academic success. Unlike our colleagues in the fee-for-service medical community, we have unique opportunities. We know our population at risk well, we have in place well-designed and well-run primary care organizations — our Student Health Services. And many of us, through referral management and case management, function as organized systems care.

So I am looking at some combination of these alternatives:

- Permit students to use HDHPs and try to educate them as to the importance of having resources (HSAs) to cover the deductibles.
- Rule out HDHPs for student health insurance through restrictions to the waiver process.
- Expand the prepaid service of the Student Health Center to ensure that all students have access to primary and preventive care independent of their insurance.

There is no single right answer that I can discern. But given our training in differential diagnosis, I am hopeful we can all develop a reasonable treatment plan.

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How We Do It

HDHPs and HSAs: What's the Problem?

John S. Andrews, Jr., MD, MPH, University of Cincinnati

High-deductible health plans (HDHPs) and Health Savings Accounts (HSAs) are likely to significantly change the overall health insurance environment in the next few years. Student health insurance will be no exception. The impact of these approaches will eventually be felt by every school. The University of Cincinnati (UC), is a good example of how quickly a school can feel the impact of HDHPs and HSAs. Even though these plans are relatively new, they are already sufficiently prevalent for us to understand at least the broad outlines of what they may mean for Student Health.

The history of our Student Health Program and Student Health Insurance (SHI) Program will be common to many colleges and universities. The issues we have experienced with students covered by HDHPs and HSAs offered through their parents' employers may be new to many, but in all likelihood you will be facing similar issues soon.

HDHPs and HSAs were designed to encourage "consumerism" in health care. High-deductible plans, offered previously, were not widely embraced until the amendments to the Medicare Act of 2003 provided for HSAs to have pre-tax employee contributions, carry-over provisions and tax-free investment income.

In evaluating the potential impact of these plans, staff at the University of Cincinnati revisited the core features and values underpinning our SHI plans.

UC's Hard-Waiver SHI Plan

UC is an urban research university with 34,000 students. Like most colleges and universities, UC is committed to keeping students enrolled at the University for the obvious financial reasons, but most importantly, to fulfill our commitment to provide a quality education. The causal linkage between poor health status and withdrawal rates is intuitively obvious. UC does not want students leaving school due to minor health problems purely for lack of insurance coverage.

In the 1970s, the UC Student Health Service was having difficulty obtaining specialist health care

appointments for students. An investigation revealed that many students were not paying their specialists' bills, causing the specialists to decline to see students, citing, "no available appointments."

To ensure that all our students had adequate health insurance and to improve our access to specialists, UC instituted a hard waiver SHI plan in the Fall of 1978. The plan assesses an insurance charge each quarter on all students who register for six or more credit hours and all students with "F" or "J" visas. Students with "coverage equal to or greater than that offered by UC" may waive coverage by submitting a completed waiver to the student health insurance office. Waivers submitted during Fall quarter will eliminate charges the remainder of the academic year. New waivers must be submitted each academic year.

Students with Limited Resources

The current UC SHI plan has a \$500,000 lifetime maximum, a \$200 deductible, a 10% co-pay after the deductible is met, and an annual maximum in-network, out-of-pocket of \$2,000. As recently as the Fall of 2003, the major in-network provider for the UC SHI plan said that the providers often do not get paid the deductible or co-pay money from the students. However, knowing that they will get paid the part of their bill due from the insurance company, providers continue to be willing to see UC students.

Over the past several months, UC Student Health Service physicians have encountered students who are foregoing needed medical care because they have "no money." This is reinforced by calls from in-network physical therapists who say students will not take needed post-surgery physical therapy because they can't afford the \$200 deductible and the 10% co-pay. Recently a 4th-year medical student with back pain and known fractures of his transverse processes at T1, T2, and T3 refused an MRI and an orthopedic referral because he had "no money."

Concerns of Parents with HDHPs

In the Fall of 2004, angry parents began calling the

“If all UC students were required to purchase UC SHI, it is likely that the annual premium...could be decreased by as much as 20%. This would certainly be a win-win for students who need the UC SHI.”

UC Student Health Insurance office asking why their policies with \$1,000,000 of health care benefits per family member, \$1,000 deductible per person, and a co-pay of 20% were not “good enough” to waive the UC Student Health policy. Recently a parent with a \$5,000,000 policy through his company and a \$5,000 deductible called and wanted to know why he could not waive the UC SHI plan. The answer was that they were not “equal or better than the UC plan” — the deductible was not \$200 or less, the annual maximum out-of-pocket was not \$2,000 or less.

Eligibility Complications Caused by UC’s Employee HDHP

In November 2004, UC employees received a notice that one of their possible health insurance plans for 2005 would have a \$1,000 deductible per person. Because of our SHI requirements, we will now face parents, who are also colleagues and friends, who do not meet the waiver requirement for SHI. A policy of the University is now in potential conflict with a health benefit offering endorsed by the University.

So What’s the Problem with HDHPs and HSAs?

If UC allows students with HDHPs to waive off the SHI plan, the University will no longer be able to assure providers that its students will have health insurance to pay for most of their health care. There’s no way for UC to know if a student (or his/her parents) with an HDHP have really set aside money to pay the required high deductible. Who knows whether or not the student will even tell his/her parents that he/she has incurred a medical bill?

If a bill is several thousand dollars, as might occur in hospital care, the physician or the hospital may end up with \$1,000 or more in uncollected fees. It is likely that, once again, UC will have difficulty obtaining specialist appointments for students who do not have the UC SHI.

What remains to be seen is whether providers will differentiate between the UC SHI plan, with its \$200 deductible and 10% co-pay, and the HDHP plans.

What Will UC Do Now?

Will UC allow students with HDHPs and HSAs to

waive UC SHI? Will we change our SHI policy to make it an HDHP plan? Will UC require all our students to have the UC SHI plan?

If all UC students were required to purchase UC SHI, it is likely that the annual premium (\$1,095 paid in three quarterly installments) could be decreased by as much as 20%. This would certainly be a win-win for students who need the UC SHI. It would eliminate most of the administrative efforts currently used to enforce the hard-waiver insurance plan. It would also make it easier to provide care to all UC students. It would, in effect, create a single payer plan for our entire student body, thus supporting more favorable reimbursement contracts with our academic medical center, our faculty practice plan, and other large providers. But, for students who may have comparable alternative coverage through parents or spouses, it could be argued that a mandatory plan would be duplicative coverage, adding costs.

If we do not elect mandatory coverage, it will be politically difficult for the UC SHI office to declare the \$1,000-deductible employee health plan as not “equal or better” to the UC SHI. We already know the difficulties in dealing with the very large number of different insurance plans in the market, including the new HDHPs. There is growing evidence (and much history) that students will not pay many health care bills and will forego necessary and appropriate care when self pay is involved. For these reasons, I will strongly recommend to the UC Student Health Insurance Committee that all students be required to have the UC SHI (as is done at Washington University in St. Louis and Cal Tech). Stay tuned!

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A Survey of Student Health Decision Makers: HDHPs and HSAs

Tim R. Garde, *Vox Medica*

In February 2005, Vox Medica designed and conducted 25-minute telephone interviews with 50 health insurance decision makers in small, medium and large colleges and universities.

Interviews were conducted among Vice Presidents, Deans of Student Affairs, Directors of Student Affairs, and Directors of Student Health Services.

The interview process covered four broad areas:

- The respondent's awareness level and source of awareness about HDHPs and HSAs,
- The respondent's opinion regarding the potential for HDHPs and HSAs for students,
- The advantages and disadvantages to the college and university and its constituents of HDHPs and HSAs, and,
- The likelihood that an HDHP and HSA would be offered.

The results of this kind of small sample opinion research should be viewed as qualitative and directional rather than predictive.

Awareness of HDHPs and HSAs

College Health Insurance decision makers in the study sample were generally aware of these plans. Seventy-two percent of the respondents had some knowledge of high-deductible health plans. They reported several sources of information, among the more frequent were:

- Learned about them during the renewal or rebidding process,
- Had or have a high-deductible plan themselves,
- Knew about them through their knowledge of and expertise in insurance.

The reported awareness of Health Savings Accounts was even higher — 86%. The two principle sources of information on HSAs cited were personal experience and newspapers or other media.

The Potential for HDHPs and HSAs for Students

In response to the question of whether or not these

plans could be developed for students, 58% of respondents said “yes.” The medium and large schools were more positive (76.5% and 62.5%, respectively).

The respondents attributed their positive responses to the potential attractiveness of these plans to graduate students and older students with families; to the general affordability through lower premiums; and to their appropriateness for those students who are in good health.

The reasons cited for thinking these plans would not be appropriate for students were, first, the student's ability to pay the deductible, and, second, the fact that the typical use pattern for students for basic primary and preventive care would put them below the deductible.

The Challenges in Developing, Offering and Administering HDHPs and HSAs

Only 10% of respondents felt that implementing this kind of plan would be, “not hard, not too difficult.” The 90% majority who felt it would be challenging, cited funding the HSA or otherwise having the economic resources to pay for the care within the deductible. Many cited the educational, communication and marketing challenges.

“Students budgeting, setting aside money is somewhat of an oxymoron,” was among the more colorful comments about the challenges of these plans.

Another common concern is the disconnect between a student's understanding of the plan at the time of enrollment and their understanding at the time they are ill or injured. “Students will see the low premium and get excited, but not realize what the cost will be later on.”

Finally, several expressed concern that students (and their parents) would be attracted to the low premium, but would not adequately fund the HSA or make other provisions to cover the deductibles.

Timing

Despite concerns about the complexity of offering these plans and educating students and parents about them, 34% of respondents thought these plans would be

“Not surprisingly, the key attraction for students was thought to be in were concerned about the student’s ability to afford the deductible.”

available for students in the next three years. By five years, 58% thought students would have access to these plans, although most (62%) felt these changes would be coming through parental plans. (*Editor’s note: the question did not specify whether the offering would be by the college or university or come from parental plans.*)

Advantages and Disadvantages

Respondents were asked to respond from four perspectives: the school’s, the Student Health Service’s, the student’s, and the Student Health Insurance Program’s.

Advantages for the school

The largest group of respondents (34%) said they saw no advantages for the school, with almost half (47%) of the small school respondents taking this position.

Among the positive responses, affordability was the leading answer (24%), with flexibility in recruiting (22%), options and choice (18%), and retention (18%) fairly close behind.

Disadvantages for the school

Of interest, where about a third of respondents saw no advantages for the school, a similar number (32%) saw no disadvantages.

Of considerable interest, however, the largest expressed concern (18%) was that these plans might increase drop out and withdrawal rates because of health expense.

Administrative complexity, combined with the time and energy required to educate students about these plans, was a significant downside to 24% of respondents (16% administrative, 8% education).

Advantages for the Student Health Service

As with the responses for the school (above), about one third of respondents saw no advantage for the Student Health Service.

Those who saw advantages for the SHS cited enhanced ability to refer students to the community (22%). (*Editor’s note: On the surface, this is a curious response, given the known concern of community providers about self-pay patients with high deductibles. One possibility is that these respondents felt the affordability of the lower*

premiums would bring in some number of previously uninsured students. The attraction of these plans to the employed uninsured is seen in the data on early adopters of HDHPs.)

Others saw potential revenue for the Student Health Service from HDHPs.

Disadvantages for the Student Health Service

Surprisingly, close to half (46%) saw no downside for the Student Health Service. Among expressed concerns, lost revenue from uncollected deductibles was highest (14%), with administration (8%), education and student service (phone calls) (8%), and problems of referrals, both cost and compliance (8%), being second-tier concerns.

Advantages for the students

Not surprisingly, the key attraction for students was thought to be in the lower premium costs (44%).

Other advantages were improved catastrophic coverage once the deductible was met and out-of-area access.

Only 10% of respondents cited the consumerism features of these plans, giving students more control over health care expenditures.

Among all questions, the advantages for students elicited the broadest range of responses, with eighteen different kinds of response offered.

Disadvantages for the students

Here, the responses were very tightly clustered. Sixty-eight percent of respondents were concerned about the student’s (and patient’s) ability to afford the deductible, 16% cited the complexity and educational challenge, and 14% noted these plans could be a barrier to care and/or compliance.

Advantages for the Student Health Insurance Plan

A quarter of the respondents saw no advantages for the Student Health Insurance Program. The Advantages were seen as lower premiums (16%), lower claims costs (14%), increased enrollment (12%), and more consumer choice (10%).

Disadvantages for the Student Health Insurance Plan

Forty percent of respondents saw no disadvantage. Of those who did, the high deductible feature was seen as potentially unattractive to students (20%), which could lead to reduced enrollment (12%). Of interest, there were no comments about unfavorable risk selection.

Will Colleges and Universities Consider HDHPs and HSAs for Their Schools?

A little more than one third (37%) said it was “likely” or “very likely” that they would consider these plans, with medium-sized schools being the most interested.

Half of the respondents said it was “unlikely” or “very unlikely,” with the small schools being the most negative.

Personal Use, Marketing and Internal Demand

Participants were asked several other questions, including how they would feel about HDHPs and HSAs for their personal use; whether any insurer of student health plans had offered an HDHP or HSA; and whether there had been any internal demand for these options from either students or the institution’s administration.

Regarding the attractiveness of these plans for the respondents’ own health insurance, the answers were mixed, with some interest (37%), but not strong interest. Participants from medium-sized schools were more interested, from small schools, less so.

No respondents reported any offering of these plans by student health insurers, and negligible internal demand was noted.

Waiver Requirements

Among the more interesting final questions was what might happen with waiver requirements in the face of HDHPs.

Seventy-six percent of respondents reported no current minimum plan reimbursement for waiver.

A larger group (86%) felt the introduction of those

plans would not affect their waiver requirements, but, interestingly, almost everyone said that the subject had not yet been discussed at their institution.

Conclusions

Given the small sample size and the even smaller subgroups, care must be taken not to overread the results.

It does seem clear that Student Health Insurance decision makers on campus have a growing awareness of these kinds of plans and generally understand how they might work in a campus and student environment.

It also may be appropriate to conclude that there are few strongly-held opinions among the respondents, suggesting an openness to more information and data.

The exception to the “no strongly-held opinion” conclusion is around health care costs and health insurance costs. Most felt that options that were truly lower cost would be attractive.

Finally, the survey focused narrowly on HDHPs and HSAs as defined by the 2003 Amendments to the Medicare Act. It might be useful to explore Student Health Insurance Plans with deductibles higher than is typical today, but not as high as those specified in HDHP regulations. These might also be paired with Health Reimbursement Accounts or other Flexible Spending Accounts.

Tim R. Garde is Executive Vice President and General Manager of the Vox Medica Health-care Marketing Communications Group. He has extensive experience in health care marketing within the pharmaceutical, home health care, long-term care, and managed care industries. Tim’s strengths are his expertise in strategic planning and his ability to provide creative and practical solutions to business- and marketing-related problems. He can be reached at tgarde@voxmedica.com.

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Vox Medica, the third largest independent health care marketing communications company in the country, is headquartered in Philadelphia, with additional operations in California and Europe. Comprising four business units, including the independent Institute for Continuing Healthcare Education, Vox Medica has provided its clients with strategic thinking and tactical execution since 1953, specializing in brand strategy, advertising, promotion, market research, professional and patient education, public relations, public affairs and training and development programs. For more information, visit www.voxmedica.com or call (215) 592-7500.

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