January, 2013

Considering Insurance Billing for College Health and Counseling Services

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Abstract

A combination of decreased funding and increased demand for services has necessitated a transition from pre-paid funding to substantial fee-for-service charges and insurance reimbursement for many college health and counseling services. The Patient Protection and Affordable Care Act (ACA) is a contributing factor for this trend because it creates an opportunity to obtain 100 percent insurance reimbursement for preventive care services.

Some colleges have rushed to take advantage of insurance billing revenue opportunities without carefully considering the regulatory requirements for health care providers relative to insurance billing and charges for patients. This paper addresses the concern that college health and counseling services may inadvertently engage in impermissible billing practices if they, without first making individual patient ability-to-pay allowance determinations, (1) waive charges for uninsured students and/or (2) do not collect insurance copayments, deductibles, and coinsurance charges from insured students.

This paper explains the opportunity to obtain secondary payor status for health fees and other institutional funding arrangements in the coordination of benefits (COB) process with students' personal health insurance. While the net financial result might be the same, obtaining secondary payor status for health or counseling center funding is not the same as simply waiving charges as described in the preceding paragraph.

For many colleges and universities, the possibility that almost all students ultimately may be enrolled in a student health insurance benefit/program (SHIBP) is a major factor determining whether insurance billing is a worthwhile endeavor. The likelihood that states will consider formalizing the regulation and/or licensing of self-funded student health plans, as suggested by the regulations for student health insurance plans finalized under the ACA in March 2012,[1] may create an opportunity for also considering the permissibility of secondary payor status for college health service funding arrangements. Several states presently allow secondary payor status for health service funding arrangements.

Keywords: Patient Protection and Affordable Care Act (ACA), College Health and Counseling Services, Coordination of Benefits (COB), Primary and Secondary Payor, and student health insurance/benefit programs (SHIBPs).

Historical Values for Pre-Funding of College Health and Counseling Services

Providing unfettered access to health and counseling services, regardless of students' insurance status or ability-to-pay, is a recognized best practice for the college field.[2] This was a cornerstone of the rationale for colleges to charge designated prepaid health fees and/or use other institutional funding arrangements to pre-fund primary care visits and counseling services. Confidentiality of care was another imperative. Confidentiality may be diminished if visit or other charges are submitted through a parent's employer-sponsored group insurance or a parent's individual policy that covers family members.[3] A common third rationale for health fees and other institutional funding was that public health services and health promotion and wellness programs could not be funded adequately either from direct health insurance reimbursements or from fiscal surpluses derived from the operation of health and counseling services.

The Shift Away from Pre-Paid Funding for College Health Services

The majority of residential private colleges and universities have maintained pre-funding of their health and counseling services through designated health fees and/or institutional funding allocations. Generally, these private institutions assure students and parents that there will be no charges for medical or counseling visits, and that ancillary services (e.g., laboratory and radiology, prescription medication, and specialty services such as minor surgical procedures, dermatology, or physical therapy) will be provided with nominal costs. Although less common, many prominent public universities have maintained pre-funding of health service care by achieving long-term support among students, parents, and senior institutional leadership, resulting in consistent increases in health fee and/or institutional funding support.

In contrast to the situation described in the preceding paragraph, the adverse cost trend for higher education over the past three decades and the recent economic downturn, combined with the increased demand for services discussed in the following section, have resulted in the diminution of the historical linkage between pre-funding of services and unfettered access to care.[4] In 2000, surveying by Hodgkins Beckley Consulting (HBC) found there were only four major college health services that derived more than 60 percent of annual revenue from fee-for-service charges and insurance reimbursements.[5] By 2007, an extrapolation of a national survey by the **American College Health Association** (ACHA) suggested that more than 150 colleges were in the so-called "60% + Club" relative to health service funding.[6] This projection was affirmed by the 2011 Sunbelt survey, showing that 25 percent of public universities had fee-for-service revenue that accounted for 50 percent or more of total operating budgets.[7]

These data are in stark contrast to those of the late 1980s when Dr. Kevin Patrick's overview article for the college health field in the *Journal of the American Medical Association* reported that less than 15 percent of college health service revenue was derived from fee-for-service among major public universities and less than eight percent among private colleges and universities.[8] It is likely

that from the 1950s through the 1970s, major college health services had only nominal charges for ancillary services[9] and many also provided 24-hour care and infirmary services without charge.

Increased Utilization of College Health and Counseling Services

The trend towards adopting substantial fee-for-service charges was necessitated by more than just institutional concerns for reducing tuition and fee increases. Over the past three decades, both increased demand for services and increased utilization of services (including a broad spectrum of high-cost prescription medications and immunizations) were additional major causes for the shift in the source of programmatic funding for many college health services. As explained below, the increased demand for services includes a sustained, widespread increase in need for mental health care services. Demand for services was also affected by the emergence of college students as one of the single largest cohesive groups of uninsured and under-insured Americans.[10]

Increased societal acceptability for using mental health care services,[11] more severe mental health conditions (a national survey of college counseling directors reported a 16 to 44 percent increase in severe psychological disorders from 2000 to 2010),[12] and proliferation in the use of depression screening[13] have required significant expansions of counseling staffs. For example, at colleges and universities with enrollment between 7,500 and 25,000 students, there was a 33.5 percent increase in the number of counselors from 2007 to 2011.[14]

The ACA and Full Coverage for Preventive Care Services

The preventive care benefits mandated in the Patient Protection and Affordable Care Act (ACA) are a major new driver for college health service leaders to consider shifting funding resources to visit and ancillary service charges. There is a broad spectrum of preventive care services that must now be covered for adults, children, and women/pregnant women, without any out-of-pocket expense for the covered person. Covered services for adults include depression screening, alcohol misuse screening and counseling, obesity screening and counseling, routine immunizations, sexually transmitted infection prevention counseling for adults at higher risk, and numerous other services that would commonly be provided by college health and counseling services.[15]

One hundred percent coverage for preventive care services is required for all health insurance/benefit plans, including plans with high deductibles. Generally, college health and counseling services cannot be excluded or limited from receiving ACA mandated preventive care benefit payments to the extent in-network participating provider status is obtained.

Increased Enrollment in Student Health/Insurance Benefit Programs

Contrary to expectations for the impact of the ACA's age 26 mandate for dependent eligibility, for a second consecutive year almost all colleges and universities providing comprehensive coverage experienced either stable or increased student health insurance/benefit program (SHIBP) enrollment.[16] This is primarily due to the cost advantage of these SHIBPs over employer-sponsored and individual health plans, and it is increasingly likely that SHIBPs will have favorable costs compared to options available to students on insurance exchanges created under the ACA.[17] Alternatively, many low cost SHIBPs did not experience enrollment gains because they provided inadequate plan year or lifetime maximums and/or had severe internal plan limits.

If, as a result of comparably favorable benefits and costs, a college or university can project that almost all students will enroll in its SHIBP, it may not be worthwhile to incur the costs to change to a funding model based in large part on insurance reimbursements. If almost all students are covered by the SHIBP, a cost component (i.e., capitation) in the SHIBP could replace health fees and/or institutional funding, and there would be no reason to bill charges on a fee-for-service basis for a relatively small number of students covered by other insurance plans. This long-term view for the favorability of SHIBPs for almost all students may be contingent on (1) the ACA being implemented with funding for health insurance for low income students and (2) such funding being available to pay for the cost of SHIBPs.

For other colleges that do not anticipate the majority of students will soon be covered by a SHIBP, the health service becoming a participating provider and developing new revenue streams for preventive care services could still provide important transitional funding. For colleges that discontinue providing a SHIBP, new insurance billing revenue may be essential for adequate health service funding.

Variable Success for Developing Insurance Billing Revenue

College health and counseling services that have adopted visit charges and ancillary fee-for-service charges are experiencing varying success for maintaining an open access objective for providing care to students. Most have found that access to services is best assured when there is an effective insurance requirement as a condition of enrollment, when the SHIBP provides comprehensive benefits (including full coverage for health service charges) and has a favorable cost, and when the health service is able to be a participating provider with almost all students' personal health insurance plans. Success in developing insurance billing revenue is optimal if the college or university is located in a geographic area where employer-sponsored health plans have relatively low copayments for primary care visits for illness or injury (even if there is a high deductible health plan) and the participating provider reimbursement rates for primary care visits are favorable.

For some colleges and universities that have joined the "60% + Club," the overall experience has not been favorable. The **Lookout Mountain Group** noted in its major 2009 report on health care

reform for the college student population that ". . . [the movement away from pre-paid funding] has been adopted imprudently relative to environmental conditions, and/or implemented without appropriate understanding of insurance participating provider contracts, and many students were disenfranchised from access to health care services."[18] Disenfranchising students from access to care has occurred through several different scenarios. In most instances, the health service effectively participates with only the SHIBP, resulting in most of the students with other private health insurance either seeking services off campus or forgoing care. The increased trend, particularly since the passage of the ACA, for employers to adopt high deductible health plans[19] greatly increases the concern for access to care because of students' increased out-of-pocket expenses.

Even if there is a considerable increase in new revenue derived from insurance coverage, and no overall decrease in utilization is attributable to a specific funding model, or if any decrease in utilization is offset with operational cost reductions, a much more subtle question remains: Do overall campus health utilization statistics mask underlying access issues for lower income students? Cornell University found this to be the case and reported their findings at the American College Health Association's (ACHA) 2012 annual meeting.[20] Cornell provides access to professional services (primary care, psychiatry, and counseling visits) as a tuition benefit, but its health service charges for all other services and is a participating provider only with Cornell's student health insurance program. Cornell has tracked its utilization data according to students' financial and insurance status since 2006, and these data have consistently demonstrated that as a students' financial resources decline, a growing gap in access to care emerges for those students who waived enrollment in Cornell's student health insurance program. Cornell has evaluated the option of insurance billing and found that, without being able to waive remaining balances, out-of-pocket costs would increase for approximately 60 percent of students, worsening access issues.

Waiving Insurance Copayments, Deductibles, and Coinsurance Charges

As was noted in numerous open discussion comments at the 2012 ACHA meeting in Chicago and in regional college health meetings in the fall of 2012, some college health services have obtained participating provider status with students' personal health insurance and are automatically waiving insurance copayments, deductibles, and coinsurance charges without completing individual ability-to-pay allowance determinations. The open discussion comments suggest many of these college health services have simply adopted a policy to automatically waive charges for uninsured students and/or for students who have remaining balances from their insurance coverage.

As shown in a 2010 advisory publication issued by the Minnesota Medical Association (refer to Appendix A), there are both federal and state laws that affect the permissibility for waiving charges in excess of small gift and service allowances. Generally, the only way for a health care provider to permissibly waive insurance remaining balances is to document that the patient has limited financial resources and that the charges, if not waived by the health care provider, would create a substantial financial hardship for the patient.[21] Thus, while there are exceptions in varying states, health care providers can waive charges for patients only when detailed financial information supports reduction or elimination of charges based on the provider's completion of an individual ability-to-pay determination. This financial hardship assessment must be periodically updated to remain valid. Based on a review of literature and case law in preparation for this paper, there is

no reason to believe college health and counseling services are not under the same constraints for waiving insurance charges as private-sector health care providers.

In addition to states having anti-fraud and false claim statutes and regulations, participating provider contracts usually stipulate that all copayments, coinsurance, and deductibles must be collected, absent an ability-to-pay allowance determination for the patient. There are no state insurance regulatory authorities that have issued interpretive bulletins allowing waiving of student health service charges without following ability-to-pay determinations. While the net financial result might be the same, obtaining secondary payor status for health or counseling center funding, as discussed in this paper, is not the same as waiving copayment, coinsurance, or deductibles for insured students or waiving charges for uninsured students.

Understanding Coordination of Benefits

Coordination of benefits (COB) refers to the process for determining the order in which payments will be made when a person is covered by two or more health plans. On its website, one prominent multi-state Blue Cross and Blue Shield plan provides this explanation of COB for employers providing group health insurance coverage:

> "When a member of your group is covered by more than one health plan (for example, when one of your employees is covered under your group plan as well as a spouse's health plan), one plan is considered to be the primary carrier and the other is considered to be the secondary carrier. The primary carrier covers the major portion of the bill according to plan allowances, and the secondary carrier covers any remaining allowable expenses. The COB provisions of your policy or plan determine which plan is primary. That plan's benefits are applied to the claim first. The unpaid balance is usually paid by the secondary plan to the limit of its responsibility. Benefits are thus "coordinated" among all of the health plans, and payments do not exceed 100% of charges for the covered services."[22]

A common example of COB occurs when both of a child's parents cover him or her through each of their respective employer-sponsored group health insurance plans. When the child incurs health care expenses, the parent's plan that is required to pay first is referred to as the primary plan, and the plan that covers the remaining balance is the secondary plan.

Most states have adopted some form of the model coordination of benefits statute endorsed by the **National Association of Insurance Commissioners (NAIC)**. The NAIC's model statute is available at its web site at **http://www.naic.org/store/free/MDL-120.pdf.** Finding a specific state's COB statute is relatively easy with a Google® search (statutory citations by state can also be obtained at: **http://www.askmariatodd.com/resources/articles/state/163-sbscob.html**).

Secondary Payor Status for Health Fees and Institutional Funding

Even though college health fees are not a form of health insurance, and do not constitute health insurance premiums, state insurance regulatory authorities often conclude that health fees and other institutional funding arrangements fall within the definition of a "plan" in their COB statutes (refer to Appendix B) and are precluded from automatically covering remaining balances for copayments, deductibles, and coinsurance under students' personal health insurance plans. More specifically, some state insurance departments have found that health fees and other institutional student health care funding arrangements constitute "Group Type Contracts" (refer to Appendix B). Having found that health fees and other institutional funding arrangements are a form of "plan" under COB, they also find student health care funding arrangements are not listed in the plans/funds that are excluded from the COB statute (refer to Appendix B). It is noteworthy that student health insurance plans that provide accident-only coverage (e.g., plans that cover only intercolle-giate sports injuries) are permitted to take secondary payor positions by being excluded from their state's definition of "plan" under COB.

Several states (e.g., Minnesota, Massachusetts, and Florida) either directly or indirectly permit college health and counseling services to establish their funding systems as secondary payors in coordinating benefits with students' personal health insurance. In these states, colleges can use a funding model in which medical expenses are submitted to students' personal health insurance before their health fees or other institutional health funding arrangements provide coverage. In other words, health fees and other institutional funding are able to take a secondary payor position in coordinating benefits with students' personal health insurance (see examples below for health fees covering copayments, deductibles, and coinsurance). In such states, college health services have developed new insurance revenue streams that often exceed one-third of operating budgets. This substantial revenue may increase significantly as ACA preventive care services are expanded and appropriately charged to students' personal insurance.

Colleges and universities in Minnesota, Massachusetts, and Florida have successfully contracted with insurance companies and health plans and are obtaining insurance reimbursements for office visit charges, ancillary services, and preventive care services that would have otherwise been funded by the college or university and/or direct charges to students. This requires health services to become participating providers with the health insurance plans that cover their students, develop electronic billing systems/processes, insure accurate service coding, and engage in other practices that are common for community health care providers. As is the case with community health care providers, small college health services with limited administrative capability may choose to retain a third party to submit medical claims to students' insurance plans.

In summary, having a definitive statutory or regulatory authorization that establishes that health service funding arrangements may take secondary payor positions is the only certain path to having health fees or other student health care funding arrangements cover the expenses not paid by students' private health insurance.

Common Components for a Secondary Payor System

When allowed by state statute, regulation, or regulatory ruling, the following are common components for a secondary payor system college health service funding (the same components would apply if counseling is provided or if there is a separate counseling service).

- The health service enters into participating provider agreements with the major insurance carriers/health plans covering its students. It is often advantageous for a health service to join a local independent provider association (IPA) or a physician hospital organization (PHO) to obtain participating provider status through a single contracting entity. Various commercial billing services may also be available to assist with obtaining participating provider status. Many large college health services have sufficient resources to obtain participating provider status without having to use an IPA, PHO, or commercial billing service.

- The health service develops fee-for-service charges for all medical services, including office visits. Counseling services usually continue to be pre-funded for students, regardless of whether they have personal health insurance coverage. Visit costs and other fee-for-services are typically set at a level that is above the highest participating provider reimbursement rates (i.e., participating provider contractually allowed charges).*

- If not already in existence, the college health service enters into a direct participating provider agreement with the college- or university-provided SHIBP. The reimbursement system can be based on either capitation or fee-for-service charges, but the total reimbursement must reflect the fair market value of the services provided. While the allowed charges can be at the lowest level of reimbursement among all participating provider agreements, some state insurance regulatory authorities will require the SHIBP's reimbursement level be generally comparable to the aggregated reimbursement (as a percentage of charges) from other private insurance plans. For example, the average total reimbursement from insurance plans other than the SHIBP could be 45 percent of billed charges (net of copayments, coinsurance, deductibles, and exclusion of services not covered), and the SHIBP capitation or fee-for-service charge system could be set to result in 40 percent of charges being covered.

  Conversely, fiduciary responsibility requirements for the operation of SHIBPs[23] compel that reimbursements to college health services reflect fair market value, and that there are appropriate monitoring and controls for both utilization and cost of services received at health services. Using the preceding example, having the reimbursement level result in 55 percent of billed charges being covered by the SHIBP would raise concerns. Questions might be raised even if the reimbursement level is set to be at the average of other private insurance plan reimbursements if the SHIBP is the single largest third party payor for the health service. As is suggested in this discussion, the potential conflict of interest for college administrators and management committees being responsible for both health services and SHIBPs is a long-standing concern.

- The health service defines the services for which it will use health fees or other institutional funding to cover (i.e., covered services) what students' primary health insurance plans do not reimburse. For example, covered services could include charges for office visits, procedures,

allergy injections, flu shots, radiology, and lab tests (including certain reference lab tests). The scope of covered services typically excludes travel medicine services/immunizations, employment physicals, and other services routinely excluded by health insurance/benefit plans.

- The health service bills students' health insurance plans using its electronic health record/practice management systems. These systems typically have billing capability through the use of an electronic billing clearing house. Alternately, the health service may bill insurance plans directly or contract with a commercial billing service.

- Health fees or other institutional funding continue to cover health education and promotion services which are generally excluded by health insurance plans (i.e., no charges rendered for these services). Most colleges also continue to cover counseling services to insure there are no confidentiality barriers for students to access care (e.g., concern that explanation of benefits statements will be sent to parents when students are covered under a parent's group health insurance plan or individual family policy).*

  * *A discussion of the validity of the concern for confidentiality for counseling services versus medical care services is provided in point D on page 15.*

Secondary Payor System Example Charges and Out-of-Pocket Expenses

Health fees or other institutional funding would cover any copayments, deductibles, coinsurance, or excluded charges for covered services not paid by students' primary insurance plans.

- **Example 1:** Health center office visit charge = $125, participating provider allowed amount = $125, health center is participating provider, insurance pays 80% in-network:
  The student's insurance pays $100 and the college health fee covers the remaining $25. Student out-of-pocket expense = $0.00.

- **Example 2:** Health center office visit charge = $125, usual and customary allowance (U&C) = $100, health center is not a participating provider, insurance pays 60% of U&C:
  The student's insurance pays $60 and the college health fee covers the remaining $65. Student out-of-pocket expense = $0.00.

- **Example 3:** Health center office and laboratory service charges = $200, student covered by SHIBP, SHIBP pays 40% of eligible charges:
  SHIBP pays $80.00 (payment is consistent with net reimbursements from other private health insurance) and $120 balance is covered by health fee. Student out-of-pocket expense = $0.00

- **Example 4:** Health center office visit charge = $125, student has not met her annual deductible (or she has an HMO with no coverage in the local area):
  The student's insurance pays nothing and the college health fee covers the entire $125. Student out-of-pocket expense = $0.00.

- **Example 5:** Health center non-preventive immunization charge (excluded service from health fee funding, not a covered service) = $50, student's personal health insurance excludes this service:
  The student's insurance pays nothing and the balance is put on student's account. Student out-of-pocket expense = $50.00.

Secondary Payor System Example Communications

The following are example communications of the secondary payor system for colleges and universities in Massachusetts, Minnesota, and Florida.

Wentworth Institute of Technology
Student Health Services uses an insurance-based model. The SHS will bill students' insurance plans for all services rendered. Students must present their student identification cards and also their health insurance cards at every appointment, just as they do when accessing their physicians at home.

The college will pay for any co-payments, co-insurance or deductibles due for primary care services after the student's insurance plan has been billed. Students will not be responsible for co-payments, co-insurance or deductibles due for primary care services.

University of Minnesota
The Student Services Fee is not health insurance and does not apply to visits at University of Minnesota Medical Center, Fairview, Hennepin County Medical Center, or any other facility . . . Students who are assessed the Student Services Fee and have health plan coverage will receive most services at Boynton Health Service subsidized after their insurance has been billed and their insurance responds to the claims.

University of Florida
The per-credit-hour student health fee, paid as part of tuition, covers any patient responsibility associated with most SHCC office visits and with telephone or online services initiated by the patient . . . Charges are assessed for things like medical equipment, X-rays, laboratory work, procedures and visits with specialists, which are first sent to the insurance company if the patient has provided their insurance information and card for verification. Any applicable charges are then billed directly to the patient's UF account . . . Charges for patients without insurance coverage are billed directly to the patient's UF account.

Concerns for a Secondary Payor System

The following are common concerns or challenges for college health and counseling services considering a secondary payor system for health fee/institutional funding in coordinating benefits with students' health insurance coverage.

- **Confidentiality:** Although there is increased confidentiality of care for dependents age 18 or older, under many health plans confidentiality of care remains a major concern for young adults who are covered by a parent's employer-sponsored health insurance or an individual policy under family coverage (e.g., direct explanation of benefit forms go to the dependent's home address).[24]

  The common practice of not billing for counseling services is based on a concern that students would be reluctant to use the services if explanation of benefit forms or other insurance billing information were available to parents/guardians. This distinction is often based on an assumption that students have a lower level of concern for confidentiality of primary care and other medical services (refer to point D on page 15).

  Some college health services that have secondary payor status have experienced a slightly lower overall level of utilization. This may be due to communication challenges, or it could be a concern for confidentiality of care (especially for alcohol/drug related illnesses and injuries, sexually transmitted diseases, and contraceptive services). Students and parents can make informed choices when the college highlights the importance of the insurance waiver process, emphasizing that all charges submitted to the SHIBP are confidential and cannot be accessed by parents, potential employers, graduate schools, or other entities/individuals. Likewise, communication of privacy rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may also be helpful.[25]

- **High Deductible Health Plans:** The trend for adoption of high deductible health plans for employer-sponsored plans and individual health plans raises equity concerns for the value of health fees or general tuition/fees for funding college health services. In other words, should students receive significantly different financial values for their college health service funding contributions based on the health insurance plans that cover them? At least one college is considering having the secondary health fee arrangement pay for 50 percent of the remaining cost not paid by personal insurance if the student did not receive a Pell Grant or other limited income designation from the colleges' financial aid office. This action would address the concern that secondary payor status may inadvertently infer to students or parents that it is advantageous to be enrolled in a high deductible health plan.

- **Long-Term Value:** The major trend for employer cost-shifting has resulted in large increases in student health insurance plan enrollment over the past decade for colleges that provide comprehensive benefits that comply with standards endorsed by ACHA.[26] For example, Dartmouth College went from covering less than one-quarter of its students in 2000 to covering more than 55 percent by 2009.[27] The expansion of coverage to age 26 did not result in major decreases in enrollment (in fact, many colleges experienced increased SHIBP enrollment over the past two years), further reinforcing the value of SHIBPs with comprehensive coverage.[28]

For colleges that have already experienced significant growth in SHIBP enrollment, the decision to pursue secondary payor status for students' personal health insurance may have substantial financial value for only a brief period. For these colleges, growth in SHIBP enrollment will reach a point where a capitation to fund services for SHIBP enrollees can largely replace health fee and institutional funding allocations.

- **State Regulations and Provider Contracts:** Some states have preferred provider organization regulations, and/or common participating provider contracts issued by insurance plans, precluding health care providers from limiting access to certain insured persons. For example, a health care provider could not limit access to insured persons who reside in a specific zip code area. In these states and/or participating provider contracts, college health services would have to see any plan member, student or community member, who requests services. This is a concern for private colleges that have liability coverage requirements that limit their health services to seeing only students and providing only urgent medical care to campus visitors. Some public universities also have restrictions for the use of student fee funded facilities, precluding providing care for community members.

- **Increased Cost for SHIBPs:** Moving to insurance billing and a secondary payor system can have adverse impact on SHIBPs, since new charges (e.g., office visit charges) will be submitted by the health service. Having a fee schedule for the SHIBP that is close to the range of reimbursement rates common for participating provider agreements will be required in most regulatory environments.

  In some instances, the cost impact to the SHIBP can be offset by moving to partial self-funding arrangements, direct provider contracting, or other advanced management practices. SHIBP enrollment can also be positively impacted, since more students will choose not to waive SHIBP coverage because their concerns for confidentiality and certainty of coverage can be guaranteed.

- **Viability for Laboratory Services:** Moving to an insurance billing model will likely be a catalyst for colleges and universities to evaluate the financial viability of continuing to operate **CLIA** complex or moderately complex clinical laboratories on campus and/or continuing to bill for outside reference lab tests. Since participating provider insurance reimbursement rates are often very low for clinical/reference laboratory tests, many health services will find their laboratories will experience significant financial losses and require substantial subsidies to continue operating. Colleges and universities will have to weigh these losses against non-financial factors such as clinical practice preferences and convenience for access to services for students.

- **Increased Probability for Outsourcing:** Particularly in urban areas, many private physician practices have been purchased by hospitals or large practice corporations. The economies of scale and purchasing power of these large organizations are often necessary to address the regulatory complexity and technology costs for practice management, billing, and electronic health records systems; and to optimize negotiations with payors. For small college health and counseling services, and sometimes for larger facilities, consideration of a secondary payor system may require or increase consideration of community partnering or outsourcing. Some of the concern for increased potential for outsourcing can be mitigated by joining a local IPA or by retaining a third party billing service, but the conditions that are driving the trend

for moving to hospital-owned and large corporate physician practices could portend major changes for college health and counseling services.

- **HIPAA/FERPA:** Some colleges and universities have perceived advantages in configuring their health and counseling service operations to preclude regulation under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Their operations are only subject to privacy and confidentiality requirements of the Family Educational Rights and Privacy Act (FERPA). While engaging in insurance billing will cause HIPAA to attach due to required electronic billing processes, many college health services fully comply with HIPAA and have found the requirements not to be overly burdensome.

Typical Steps for Considering a Secondary Payor System

Given the challenges and uncertainty of the current environment, college health and counseling program administrators would be well served to carefully consider alternatives to historically ideal pre-paid funding arrangements. The following process is recommended for a formal study and report.

Step One: Engage legal counsel with insurance regulatory law expertise to assess whether state laws and regulations allow health fees or other institutional funding arrangements to take a secondary payor position in coordinating benefits with students' personal health insurance. Having external legal counsel who routinely works with the state's insurance department may be required to explain the functions and funding systems for college health and counseling services, the applicability of their existing statutes and regulations, and the regulatory approaches and practices of other states.

A state's adoption of the NAIC model statute for coordination of benefits does not inherently mean that secondary payor status for college health and counseling services funding arrangements is impermissible. Other statutes or regulations could be important variables in reaching a determination for the permissibility of secondary payor status. Working collaboratively with other colleges may be beneficial.

If a secondary payor position is not permissible, legal counsel and governmental relations leadership should identify the best approach for obtaining a statutory change or regulatory clarification. This step could include obtaining enabling legislation that is part of a regulatory clarification for self-funding of student health plans, as suggested by the regulations issued on March 22, 2012, by the U.S. Department of Health and Human Services for student health insurance plans.[29]

Step Two: Develop a financial projection for the operation of the college health and/or counseling services under a secondary payor system. This will usually require the following:

A. INSURANCE STATUS: Assess the insurance status for the student population. This will generally result in a four-tier categorization.

- Students enrolled in the SHIBP or the college or university provided employer-sponsored health plan.
- Privately insured students with first-dollar coverage for both primary care and preventive care services.
- Students who are insured with high deductible health plans, HMO coverage, or limited coverage that would result in only preventive care benefits being covered.
- Students who are uninsured. For projections for 2014 and beyond, the estimate of the uninsured would be based on students exercising religious exemptions/ministry sharing plans, students paying the tax penalty rather than complying with the ACA's federal mandate, and international students who are not subject to the ACA's federal mandate. There could be almost no uninsured students if the college has a strong insurance requirement as a condition of enrollment, especially one that exceeds the ACA's individual health insurance mandate.

If there is a large uninsured population, develop analysis for the impact of requiring health insurance as a condition of enrollment in compliance with ACHA's standards. If there is an existing insurance requirement, reconsider the minimum coverage and benefit conditions required for waiving enrollment in the SHIBP.

A key element of this step is to project short- and long-term enrollment trends for the SHIBP. An important question is whether Medicaid funding can be used to pay for the cost of the SHIBP, and/or technical corrections legislation for the ACA includes the ability to have low-income subsidies be used for SHIBP costs. Long-term cost advantages for SHIBPS will result from continued employer cost-shifting for dependent coverage and the cost surcharge in the insurance ex-changes for young adults who are ineligible for a low income subsidy. Effectively managing SHIBPs, particularly focusing on the use of **partial self-funding** and direct health care provider contracting, and working to assure overall quality and cost effectiveness of the college health and counseling services will be essential.

B. REIMBURSEMENT RATES: Assess third party payor reimbursement rates for primary care, preventive care services, and ancillary services. Identify areas where reimbursement rates will require reconsideration of delivery of the service and/or institutional cost subsidy.

C. ADMINISTRATIVE ASSESSMENT: Evaluate current administrative capability and determine the best option for obtaining participating provider status and insurance billing systems. Identify staff training needs for coding, processes for obtaining insurance information (possibly linked to the SHIBP enrollment/waiver process), criteria for special exceptions not to bill students' insurance, new facility space requirements for billing services, and other administrative/system modifications. HIPAA compliance must be included if the organization is presently operating only under FERPA compliance. Finally, develop a direct and indirect cost projection for required changes.

This step should include modeling options for outsourcing of services and/or community partnering. Additionally, performance-based compensation for staff should be considered, especially if this is a key element of compensation packages for not-for-profit and for-profit community based clinics in the area.

D. COUNSELING: Although most colleges currently engaged in insurance billing exclude counseling services from this system, the revenue projection should include, at minimum, analysis and discussion of this matter. Given that primary care services routinely include care that is highly sensitive, the philosophical distinction for excluding counseling relative to confidentiality is questionable. Excluding counseling might also perpetuate the common misunderstanding that insurance billing for mental health care services can create a discoverable record that will affect future employment or graduate school opportunities.

These four research steps (A through D) should facilitate developing short- and long-term net-revenue projections for billing insurance and having secondary payor status in coordination of benefits and for identification of major administrative and operational changes.

Step Three: COMMUNICATION: If moving to insurance reimbursement is economically viable, the best practices for communication used by peer institutions should be identified and modified as necessary. Some colleges currently engaged in insurance billing report that parents and students are better able to understand this college health and counseling services funding model.

If the conclusion of the study is that insurance reimbursements are not economical, communication strategies should be developed for students and parents to respond to questions of whether the health fee and/or institutional funding duplicates their personal insurance.

Step Four: REPORT: The final step is preparation of a report for student affairs and other senior leadership. Engaging senior leadership at the beginning of the process is important as it may be necessary to convene stakeholders external to the college health and counseling services to participate in the development and implementation of the study.

SUMMARY

- Colleges and universities that have already decided to automatically waive insurance charges for uninsured students and waive copayments, deductibles, coinsurance and other charges for insured students should reconsider the permissibility of these practices.

- Billing insurance and having secondary payor status for health fee and other institutional funding is not a panacea for health and counseling service funding. There may be legitimate environmental and operational factors that make insurance billing inadvisable, even when the regulatory environment is favorable. It is, however, likely that obtaining secondary payor status for college health fees and other institutional funding may be an important short-term strategy for enhancing the operating revenue for many college health services.

- The long-term success of SHIBPs in covering almost all college students is a factor that suggests secondary payor status may be important for a relatively short period. Some colleges and universities will find the insurance billing revenue to be significant, and a viable transition funding system to capitation funding from SHIBPs.

- The passage of the ACA, particularly the new preventive care benefits, suggests that most college health services should develop an analysis for moving to an insurance reimbursement system.

- Many states will reconsider the regulation of SHIBPs under their respective insurance codes, including whether self-funding enabling legislation is needed. This reevaluation of the regulatory position for SHIBPs may be an opportune time for colleges and universities to obtain secondary payor status if state regulations do not presently allow this practice for college health and counseling services.

Waiving Copays and Reducing Fees

NOTE: The following information is intended only as general information and should not be used as a substitute for legal advice. The legality of waiving co-payments and reducing medical fees can and will vary depending on the facts of each situation. Physicians and clinic managers with specific legal questions should seek the advice of their attorney.

LEGAL ISSUES AND OPTIONS ASSOCIATED WITH WAIVING COPAYMENTS FOR UNDERINSURED PATIENTS AND REDUCING FEES FOR UNINSURED PATIENTS

INTRODUCTION

Given the current economic climate, many health care providers are looking for ways to help make medical treatment more affordable for their patients. Some wonder if they can legally waive an insured patient's copayments or reduce their fees for the uninsured. The answer to these questions depends on the type of insurance that the patient has (public versus private); the frequency with which the physician seeks to reduce the copayments and/or fees; and the physician's reason for making the waiver or reduction.

CAN PHYSICIANS WAIVE COPAYS FOR PATIENTS WITH PUBLICALLY-FUNDED INSURANCE?

Patients who receive insurance through a federally-funded program (i.e., Medicare or Medicaid) generally may not be granted a copayment waiver except under limited circumstances. There are several laws that prohibit routine waivers of this type, including:

- The federal and state anti-kickback statutes;
- The federal and state false claims laws;
- The Civil Monetary Penalties law; and
- HIPAA.

■ Violation of Anti-kickback Statutes

Physicians who receive payment through the Medicare or Medicaid programs and who routinely waive copayments and/or deductibles may be held in violation of federal and state anti-kickback statutes.

The federal anti-kickback statute prohibits the payment of remuneration (meaning any kickback, bribe, or rebate) when it is knowingly used to induce business paid for with federal money.1 By routinely waiving copayments or deductibles (i.e., without taking each individual patient's financial situation into account2), physicians could be providing an incentive for patients to choose their practice over another one at the expense of the Medicare and Medicaid systems and, thus, they would be in violation of the federal (and state) anti-kickback statutes. These types of violations can result in significant civil and criminal fines, imprisonment, and/or both.[3]

That being said, the Office of the Inspector General stated that waiving Medicare and Medicaid copays or deductibles would not violate the Anti-kickback Statute if:

- The waiver is not offered as part of any advertisement or solicitation;
- The provider does not routinely waive coinsurance or deductibles; and
- The provider waives the coinsurance and deductibles after determining in good faith that the individual is in financial need or reasonable collection efforts have failed.4

With regard to state law, the Minnesota Provider Conflict of Interest law makes the same prohibitions that the federal anti-kickback statute provides, and it extends the federal statute to all persons in the state, regardless of whether they participate in any state health care program.[5]

■ False Claims Act

The federal False Claims Act is a whistleblower law for employees, patients, and other individuals who suspect that false or fraudulent claims are being submitted to the government.

The U.S. Department of Health and Human Services Office of Inspector General has stated that a routine waiver of copayments and/or deductibles is equivalent to misstating charges to government programs including Medicare and Medicaid.[6]

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1 *42 U.S.C. § 1320a–7b(b)*

2 *See Addendum to "Hospital Discounts to Patients Who Cannot Afford to Pay their Hospital Bills (02/02/2004)" (6/18/07). The beneficiary's "financial need" will depend on the individual's circumstances. Providers should consider factors such as the local cost of living, the patient's income, assets and expenses, and the scope and extent of the patient's medical bills. Providers are encouraged to establish an indigency policy, make an individualized determination of financial need consistent with that policy, and then document the financial need.*

3 *42 U.S.C. §1320a-7a(a)(7)*

4 *http://oig.hhs.gov/fraud/docs/safeharborregulations/072991.htm and http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html*

5 *Minn,. Stat. § 62J.23, subds. 1 and 2*

6 *Department of Health and Human Services Office of Inspector General 1991 Special Fraud Alert: http://oig.hhs.gov/fraud/docs/safeharborregulations/072991.htm visited July 29, 2009. http://oig.hhs.gov/fraud/*

MMA
Minnesota Medical Association

These types of waivers would, therefore, constitute a violation of the federal False Claims Act.

Persons found to be in violation of the federal False Claims Act will be assessed a civil penalty in addition to three times the amount of damages that the government sustains due to the submission of the fraudulent claim.[7] Private parties who suspect a violation of the federal False Claims Act may also bring a lawsuit against the suspected violator. If the private party proves that an illegal violation of the Act occurred, they may be awarded up to 30 percent of the proceeds of the lawsuit.

Minnesota adopted a false claims statute[8] in 2009 that will become effective July 1, 2010. The Minnesota statute is similar to the federal Act in that the damages are identical, and a whistleblower who files a lawsuit can obtain up to 30 percent of the recovery, depending on whether the state intervenes in the action. Given the recent adoption of this law, it is undetermined whether a routine waiver of copayments and/or deductibles would constitute a violation of the statute. That seems likely, however, given the Office of Inspector General Opinion stated above.

■ Civil Monetary Penalties Law

Under the Civil Monetary Penalties Law, a physician may not offer or transfer remuneration (including the waiver of coinsurance and deductible amounts, and the transfer of items or services for free or for other than fair market value[9]) to a patient who is eligible for Medicare or Medicaid if the physician knows or should know that the waiver is likely to influence the patient to order or receive an item or service that will be paid by a government program.[10]

A violation of this law can result in fines for each wrongful act.11

There are some exceptions to this rule. Remuneration will not be found if the waiver meets the following three criteria:

1. It is not offered as part of an advertisement or solicitation;
2. The physician does not routinely (i.e. more than 50% of the time) waive co-insurance or deductible amounts; and
3. The waiver is granted after a good faith determination has been made that the patient has a financial need (or the physician is otherwise unable to collect coinsurance or deductible amounts after making reasonable collection efforts).[12]

■ Health Insurance Portability and Accountability Act (HIPAA)

The relevant portions of the HIPAA law are identical to the Civil Monetary Penalties Law, listed above.[13]

In terms of exceptions, according to an Office of Inspector General Special Advisory Bulletin published in August 2002, gifts and services (other than cash or cash equivalents) with a retail value of no more than $10 individually and no more than $50 in the aggregate annually per patient may be provided by physicians to patients without being in violation of the HIPAA statute.[14]

CAN PHYSICIANS WAIVE COPAYS OR REDUCE FEES FOR PATIENTS WITH PRIVATELY-FUNDED INSURANCE?

Physicians may routinely waive co-pays, deductibles and/or reduce fees for patients with privately-funded insurance provided that the insurance carrier knows of the waiver and/or reduction, and agrees to it. If the insurance carrier does not agree to it, a physician risks being accused of insurance fraud.

For example, assume that a physician's usual and customary fee for a particular procedure is $100. If an insurance company agrees to pay 80 percent of that fee ($80.00) with the understanding that the remaining 20 percent will be paid by the patient, and then the physician routinely waives the patient's portion of the bill, the insurance company could claim that the physician was acting fraudulently because the usual and customary fee actually charged was 80% of the price originally quoted. This could result in the insurance company making the accusation that the it had been defrauded out of $16.00 and that it only owes 80% of the $80.00 it originally agreed to pay ($64.00).

Health insurance companies are likely to be more lenient if the waiver of copayments and deductibles is only done on occasion to address the special financial needs of a particular patient, or when a good faith effort to collect the deductibles and copayment has been made.

CAN PHYSICIANS REDUCE FEES FOR UNINSURED PATIENTS?

The answer to this question depends on what your contracts with insurance carriers say. Some contracts contain clauses that prohibit providers from charging the insurance company more than what physicians charge other payers (including uninsured patients). Providers are encouraged to review their contracts for this type of provision prior to reducing their fees.

CONCLUSION

Physicians may on occasion waive copayments and deductibles for insured patients as well as reduce fees for uninsured patients. It is important that in doing so, they stay within the parameters of the laws and contracts summarized above.

docs/alertsandbulletins/121994.html visited August 5, 2009.

7 31 U.S.C. § 3729 (a)

8 Minn. Stat. §§ 15C.01 – 15C.16

9 42 U.S.C. § 1320a-7a(i)(6)

10 42 U.S.C. § 1320a–7a (a)(5)

11 42 U.S.C. § 1320a–7a (a)(7)

12 42 U.S.C. § 1320a-7a(i)(6)(A)

13 1128A(i)(6) of the Act; 42 CFR 1003.101.

14 http://oig.hhs.gov/authorities/docs/FRversionofSABonOfferingGifts.pdf (site visited August 17, 2009).

LAST UPDATED JANUARY 2010

Appendix B

National Association of Insurance Commissioners

www.naic.org

Refer to: http://www.naic.org/store/free/MDL-120.pdf

Excerpts from Coordination of Benefits Model Regulation, #120

Section 3. Definitions

H (1) "Group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a

K (2) If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this subsection. The definition of "plan" in the model COB provision in Appendix A is an example.

(3) "Plan" includes:

(a) Group and nongroup insurance contracts and subscriber contracts;

(b) Uninsured arrangements of group or group-type coverage;

(c) Group and nongroup coverage through closed panel plans;

(d) Group-type contracts;

(e) The medical care components of long-term care contracts, such as skilled nursing care;

(f) The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts; and

(g) Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4)(h). That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(4) "Plan" does not include:

(a) Hospital indemnity coverage benefits or other fixed indemnity coverage;

(b) Accident only coverage;

(c) Specified disease or specified accident coverage;

(d) Limited benefit health coverage, as defined in [insert reference in state law equivalent to Section 7 of the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act];

(e) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(f) Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit

(g) Medicare supplement policies;

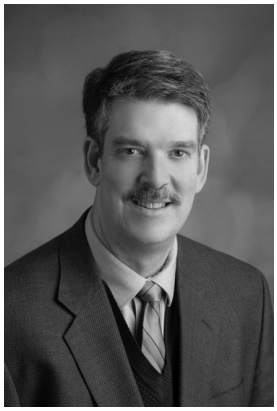
(h) A state plan under Medicaid; or

(i) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

APPENDIX C

Credentials for Report Authors

Stephen L. Beckley, CEBS



Stephen Beckley has over 25 years of experience working with student health care financing and insurance programs, and he has 20 years of experience conducting program reviews for college and university student health services and counseling centers.

Mr. Beckley was employed as a consultant for a major employee benefits consulting firm prior to founding Stephen L. Beckley & Associates (SLBA) in 1991 and Hodgkins Beckley Consulting (HBC) in 2006. As a team leader for HBC consultations, he specializes in conducting environmental assessment studies and managing student/parent surveys.

Mr. Beckley has served as a consultant to the America College Health Association's Task Force on Insurance, and he was the primary author of several ACHA publications relating to student health care financing and insurance. ACHA's standards for student health insurance benefit plans were reauthorized in 2000 and 2008. He has written articles and provided presentations at national meetings for compliance with ACHA standards and best practices for student health insurance/benefits plans. He is nationally recognized as one of the foremost authorities on student insurance programs and health service funding.

Mr. Beckley is one of the co-organizers for the **Lookout Mountain Group**, a non-partisan organization devoted to considering health care reform for the college student population. Mr. Beckley has conducted seminars and workshops on student health care delivery and financing for ACHA, the National Association of Personnel Administrators (NASPA), and other meetings of university business officers, risk managers, and legal counsels.

Education: Bachelor of Arts degree in Rhetoric and Public Address, Idaho State University

Certified Employee Benefit Specialist (CEBS) designation from the International Foundation of Employee Benefits Plans and the Wharton School of the University of Pennsylvania

Doreen Hodgkins

Doreen Hodgkins has over 30 years of experience in college and academic health and is a Fellow of the American College Health Association. Ms. Hodgkins is a principal in Hodgkins Beckley Consulting, LLC. Prior to joining HBC-SLBA in 2002, she served as the chief operational, administrative, and fiscal officer of the Olin Health Center at Michigan State University.

At Michigan State, she implemented strategic planning processes and organizational redesign, reduced University subsidy, increased ancillary profits, implemented MGMA accounting standards, and achieved initial and continuing JCAHO accreditation. She spent two years as Special Projects Consultant for the Vice President for Health Services and Facilities at Michigan State University, where she assessed, established, and implemented accounting, statistical, and cost allocation systems for the medical schools' outpatient facility.

Ms. Hodgkins is known for her unique combination of strong analytical abilities and creative talent. Her operational expertise includes strategic planning, organizational development, team facilitation, and process analysis and design. Her fiscal expertise includes financial and business design and analysis, data analysis, cost allocation methodologies, office and facility reimbursement, and student health insurance/benefits program management.

Ms. Hodgkins is a member of the **Lookout Mountain Group**, the Medical Group Management Association (MGMA), and the American College Health Association (ACHA). For ACHA, she served as Chair of both the DataShare Task Force and the Administrative Program Planning Committee. She serves as a member, technical advisor, and data analyst on the ACHA Benchmarking Committee for utilization, productivity, finance, and insurance. She has given numerous presentations on issues concerning college health.

Education: Masters in Business Administration (Phi Kappa Phi, Beta Gamma Sigma), Michigan State University; Bachelor of Arts, Mathematics, Montclair State College

Marc M. Tract

Marc M. Tract, a partner at Katten Muchin Rosenman LLP, concentrates his practice in the areas of corporate and regulatory matters for the insurance and reinsurance industries, as well as the organization and licensing of health maintenance organizations.

Mr. Tract was instrumental in the development of statutory authority in New York state for self-funded university student health plans. Mr. Tract has represented clients before state insurance departments and counseled clients on public offerings, private placements, domestications, redomestications, demutualizations, mergers, acquisitions, and divestitures. He is a member of the Boards of Directors of several national and international insurance companies, for whom Katten Muchin Rosenman LLP acts as counsel. He regularly advises clients on a variety of general corporate matters, including investment limitations, holding company compliance, licensing, and the organization of subsidiaries and US branches. He had primary responsibility for the first listing of an alien insurance company on the New York Stock Exchange.

Mr. Tract also handles a variety of private client matters, including the separation of business interests and multi-generation planning.

Mr. Tract is listed in *The World's Leading Insurance and Reinsurance Lawyers, Who's Who in America, and Who's Who in American Law*. Mr. Tract is a member of the Economic Club of New York and the American Council on Germany. Mr. Tract has also lectured and written extensively on insurance law and regulation and the responsibilities of directors of insurers.

Mr. Tract received his undergraduate degree (BA) from Ithaca College and his law degree (JD) from Pepperdine University School of Law. He is admitted to practice in the District of Columbia, New Jersey, and New York.

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