

The Impact of the Affordable Care Act on Campus Healthcare Services



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This policy memo provides information on the Patient Protection and Affordable Care Act (ACA) and its effect on how healthcare is provided to students on campus. As campus-wide leaders, chief student affairs officers (CSAOs) must understand the ACA and prepare to engage the campus community in a broad discussion about its implications. That discussion will ensure that the institutional response benefits students and reflects the campus culture. Many campus health centers may need to change traditional processes or risk students leaving campus for healthcare. This brief was created to assist NASPA members in understanding the law as it relates to providing healthcare to students and to offer NASPA members a resource guide for related campus-based discussions¹.

The Importance of Campus Health Centers

Campus health is a specialized field of medicine. Students have unique life stressors and medical conditions, and campus healthcare providers are trained and experienced in managing

these issues. By offering the most acute healthcare treatments and by adjusting the traditional healthcare model to the unique needs of students, campus health centers keep students on campus and in the classroom. A 2006 study conducted at Bowling Green State University, for instance, demonstrated that 82 percent of student respondents reported their visits to the campus-based Student Health Service helped them avoid missing classes to receive medical treatment².

Regarding student retention, a 2012 study by Farmingdale State College (State University of New York) demonstrated that if students had not sought treatment at the campus Health and Wellness Center, 10.5 percent *might not* have completed the semester and 16 percent *would not* have completed the semester.³ Campus health centers help keep students in the classroom and are instrumental in CSAO efforts to engage and retain students. Given the central roles that individual student health, campus healthcare provision, and overall campus wellness play in supporting the educational mission of

postsecondary institutions, it is important to consider how recent statutory changes impact the administration of student health centers.

The Affordable Care Act and Campus Health Centers

The Traditional Campus Health Funding Model

Traditionally, student health centers have been funded by a health fee (or a portion of a general fee) that covers services offered at the center. During the last 10 to 15 years, as higher education budgets tightened and healthcare costs increased, campus health centers began to add fees for certain services. These additional fees include billing students for an office visit fee similar to the co-payment at a physician's office or, most commonly, billing students for incidental expenses like vaccinations, medications, PAP tests, laboratory and radiology studies, and other tests. Most campus health centers have limited infrastructure or expertise to supporting billing health insurance companies, leaving students to cover costs that can be quite significant, depending upon treatment received.

If a student seeks insurance reimbursed for incurred fee expenses, he or she often

¹ The ACA also has affected student health insurance plans and, per federal statute, most institutions already have adapted their plans in compliance with the law. This brief focuses on healthcare delivered on campus and does not address student health insurance plans directly.

² Bowling Green State University Student Health Service 2006–07 Annual Report.

³ Krapf, Casserly and Van Tassel. Farmingdale State College: The Impact of the Health and Wellness Center on Attendance and Retention – Phase II.

discovers that most campus healthcare providers are not *in-network* with insurance companies, resulting in negligible expense coverage at best, or no reimbursement at worst.

Despite the historic infrequency of *in-network* campus health centers, most insurance companies permit these healthcare providers to become *in-network*; insurance companies typically appreciate the early intervention, low cost, and coordination of care provided by campus health. For example, as of fall semester 2011, Bowling Green State University Student Health Service was *in-network* with 92 percent of insurers, despite enrolling students from 40 states⁴. Despite the ability to become *in-network*, for a variety of reasons many campus healthcare providers have voluntarily remained *out-of-network*.

Impact of Legislation on Providing Campus Health

The distinction of being an *in-network* or *out-of-network* campus healthcare provider has taken on greater significance since passage of the ACA. Specially, the cost of many basic and frequent health services for traditional college age students are impacted by statutory changes.

Among other things, Section 2713 of the Public Health Services Act (as added by the ACA) states that for most new

health insurance plans or insurance policies beginning on or after September 23, 2010, an extensive number of preventive healthcare services *must* be covered by health insurance without requiring patients to make a co-payment, have co-insurance, or meet a deductible. In other words, there are no out-of-pocket costs for common preventive healthcare services, which include women's health care, alcohol misuse screening and counseling, depression screening, vaccinations, tobacco screening and cessation intervention, obesity screening and counseling, and sexually transmitted disease screening and counseling – just to name a few. PAP tests, HIV tests, contraception, and more were similarly covered starting August 1, 2012. (See the complete list in **Table 1**).

This list of services reads like a textbook on campus health; the services are the bread and butter of campus healthcare⁵. They are integral to maintaining the public health of the campus, educating students to lead productive and healthy lives, and ensuring students remain engaged in the classroom and in co-curricular experiences.

However, Section 2713 of the Public Health Services Act also notes that the above services are *only free* from out-of-pocket costs when they are “delivered by a network provider.” In addition, the ACA includes what has been dubbed the “under 26 initiative,” by which students up to age 26 are eligible to remain on parental health insurance

policies unless offered health insurance through an employer. It is estimated that upwards of 3.1 million people under age 26 already have received health insurance through this provision.⁶

The ACA also significantly expands Medicaid eligibility. Starting January 1st of 2014, all students with financial resources up to 133 percent of the federal poverty level will be eligible for free or low cost healthcare (from participating *in-network* healthcare providers) through the federally funded Medicaid expansion. Students with financial resources from 133 percent to 400 percent of the federal poverty level will be eligible for discounted health insurance through state and/or federal exchanges. As noted previously, these insurance plans will only cover preventive services provided by *in-network* healthcare providers.

Although these initiatives will not fully eliminate the concerns about uninsured students on campus, they will significantly reduce the number of uninsured students. Most students under 400 percent of the federal poverty level will be insured through Medicaid or a state/federal exchange, while students with greater financial resources likely will be covered by a parental policy or a campus-sponsored student health insurance plan. In summary, by 2014, the vast majority of students will have health insurance; bringing into sharp contrast the difference

⁴ Bowling Green State University Payor Mix Analysis Report. Fall 2011.

⁵ Turner and Hurley, *History and Practice of College Health*, University of Kentucky Press, 2010

⁶ <http://www.hhs.gov/news/press/2012pres/06/20120619b.html>

between *in-and-out of network* campus health providers.

Potential Implications for Chief Student Affairs Officers

As enacted, the ACA drastically expands the free-from-fee services that healthcare providers are to make available to insured individuals. However, this expansion creates significant incentives for patients to pursue treatments from providers who are *in-network*. Although the majority of students will have quality health insurance by January 1, 2014, this health insurance will cover out-of-pocket costs for preventive and women's healthcare services for students only if students are seen by an *in-network* healthcare provider.

Accordingly, if campus healthcare providers do not become *in-network* with health insurance companies, students will learn quickly that staying on campus for common healthcare needs, including immunizations, means paying for related services. If they go off campus to a healthcare provider who is *in-network*, students will not incur out-of-pocket costs.

On most campuses then, the status quo gives students financial incentives to leave campus for healthcare, which will contribute to classroom absenteeism and treatment by healthcare providers who are neither expert in nor dedicated to the health and well-being of students. Antidotal evidence suggests that with enactment of the "under 26 initiative," many

Sidebar: Being 'In-Network' and Insurance Bill: An Overview

Campus healthcare providers can become *in-network* with the vast majority of insurance companies that represent the student population. Although hundreds of different health insurance plans are represented on any one campus, national plans such as Aetna and United Healthcare, state-to-state reciprocity with Blue Cross and Blue Shield, and the proliferation of rental networks such as MultiPlan, minimize the actual number of applications necessary for an institution to complete.

To become an *in-network* provider, institutions must complete substantial paperwork and submit documentation of academic and professional credentials. Then, the healthcare providers need to negotiate and sign contracts with the individual health insurance carriers, which is the most challenging aspect of becoming *in-network* and a key reason that most campus health centers have traditionally not been *in-network*.

Insurance billing requires healthcare providers to code office visits – assign numbers to diagnoses and services provided. Healthcare providers must be educated about the process and compliance checks must be conducted to ensure that coding is correct. Once an office visit is coded, the information needs to be transmitted to the correct insurance company, typically through a clearinghouse, for collection. This transmission is primarily an electronic communication that requires the appropriate information technology infrastructure. Accounts receivable, follow up, reconciliation, and payment posting are tasks that also require infrastructure to complete.

Campus health centers can bill insurance companies for services even if the center is not *in-network*. Unfortunately, most insurance plans have separate, high deductibles and do not pay for *out-of-network* care. As previously noted, the ACA does not cover preventive services and women's healthcare services for *out-of-network* care. Therefore, billing as an *out-of-network* provider does not financially benefit the campus, generate significant revenue from insurance companies, or keep students on campus for these services. Students are still required to pay for services that insurance would cover.

If a campus health center bills the insurance company as an *in-network* provider, the student experience is similar to a visit to a primary healthcare provider. The student brings an insurance card to the campus health center, and the health center staff gains an opportunity to educate students on health insurance. The business aspect of medicine is essentially invisible to the student if the visit is handled correctly.

In-network insurance billing for services provided at campus health centers can be highly lucrative. While reimbursement for some services simply shifts from the student to the insurer – a benefit for the student but no difference to the health center – the primary incremental revenue comes from reimbursement for office visits. However, insurance billing is fraught with the challenges. Although some campuses may have the space, knowledge, information technology and human resource capabilities to perform these functions, others

campus healthcare providers have witnessed a decline in demand for preventive services.

Considerations for Chief Student Affairs Officers

Under the ACA, the majority of students will have quality health insurance that will fully cover the costs of *in-network* preventive healthcare services, which previously were the bread and butter of campus health centers. CSAOs need to assess if it is still feasible to provide healthcare on campus given that many students will be using off-campus healthcare providers at no cost to them. How can campus health services best be structured to meet the healthcare and financial needs of both the campus and students? CSAOs should consider the following four potential institutional responses as a foundation for discussion in their specific context:

Eliminate on-campus health centers

If it is in students' best financial interests to leave campus for healthcare, then some campuses might choose to eliminate on-campus health centers. This option removes potential malpractice risks to the campus and is budget-friendly (exclusive of financial repercussions from potential retention implications). However, not all local communities can absorb student healthcare, and on-campus public health issues are left unaddressed. In addition, a campus health center supports campus engagement and

retention, as noted by the Bowling Green and Farmingdale studies. The Farmingdale study also found that if the Health and Wellness Center was not located on campus, 55.6 percent of students would have incurred higher costs, 24.2 percent of students would have difficulty in accessing transportation to another facility, and 32.4 percent of students would have experienced a delay in receiving treatment and/or a worsening condition. The Farmingdale researchers concluded that "attendance and retention, while critical in this setting, are therefore only two of several areas impacted by have on-campus health services."⁷

Outsource campus health services

If a campus does not have the resources to meet the increased demand for on-campus healthcare, it may choose to outsource the health center to a local hospital or physician network. This option shifts some, but does not remove all, potential malpractice risk from the campus.

On-campus healthcare offerings are different from community healthcare offerings. Local healthcare providers may operate under a rapid-pace model (10 minutes per patient) and may be financially incentivized to treat a high volume of patients. In addition, these providers may not appreciate students' unique life stressors and medical

conditions. Campus experience demonstrates that the average on-campus healthcare provider is scheduled for 15- to 20-minute visits per patient, and many campus providers include an educational component in the student visit.

With outsourcing, the campus loses control of the management and culture of the health center, and financial challenges will remain for an outside contractor. Experience has shown that many private companies and local hospitals have abandoned campus health centers as unprofitable, contrary to pre-acquisition analyses.^{8,9}

Redefine the health fee to cover preventive and women's health services and stop billing students for these services, eliminating the financial incentive to leave campus for healthcare

If a campus health fee is generous, it may cover many services without any substantial financial impact. Since this is not the case at most campuses, institutions could estimate the costs to provide such ACA-mandated preventive and women's health services and raise the health fee accordingly. However, many of these services, including PAP tests, immunizations, and contraception are very costly. For example, according to the Centers for Disease Control and Prevention, the average cost of the HPV vaccine series was \$390 in July 2011; according to

⁷ Krapf, Casserly and Van Tassel. Farmingdale State College: The Impact of the Health and Wellness Center on Attendance and Retention – Phase II.

⁸ Moore, Brian. College Health Care Company Goes Out of Business. College Heights Herald. March 2001.

⁹ Dunn, Conor. Colleges Experience Mixed Results in Health Center Outsourcing. Daily Nebraskan. September 2012.

Planned Parenthood, the cost of birth control pills ranges from \$15 to \$50 per month or an annual cost of \$180 to \$600 per female student using the pill. Raising the campus health fee to cover preventive services could ensure continued access to an on-campus healthcare facility staffed by providers with expertise in campus health. However, as healthcare costs rise, the health fee would need to increase accordingly.

Implement insurance billing for healthcare services provided at campus health centers

This option requires campus healthcare providers to become *in-network* with insurance companies, allowing students to receive the ACA benefits while remaining on campus for treatment and preventative service (see **Sidebar**). If campus healthcare providers are *in-network* and the health center can bill students' insurance companies, then the financial incentive to leave campus for healthcare is removed. In addition, the campus remains in control of an on-campus healthcare facility and access to providers with expertise in campus health. At the same time, a significant new and sustainable revenue stream – from insurance companies not students – is created. This non-tuition based revenue stream, unlike health fee increases, is sustainable.

However, most campus health centers do not have the financial, physical, information technology and/or human resources capacity and expertise

to easily become *in-network* with insurance companies and to bill health insurance companies directly. Additionally, many campus healthcare providers joined campus health services to remove themselves from the business aspect of medicine, and this option may not appeal to them. Some campuses are choosing to outsource the business aspect of medicine to private companies, while retaining control of how healthcare is provided on campus.

Recommendations and Potential Next Steps

The Patient Protection and Affordable Care Act is changing how healthcare is provided nationwide, including at college campus health centers. When healthcare reform is fully implemented, campuses will undoubtedly feel the effects of these significant changes. Many institutions appreciate the importance of providing healthcare services on campus and the impact of such services on campus engagement and retention. Now is the time for CSAOs and campus constituents, including senior leadership, to discuss how campuses provide healthcare to ensure that students do not delay treatment and/or leave campus for healthcare services because of insurance payment concerns.

The four previously discussed options provide some context for deliberations at the institutional-level about the

provision of student healthcare. Each institution will ultimately chart a path that is most appropriate for their campus and community healthcare needs and ecology. Regardless of the final outcome, NASPA seeks to support CSAO's grappling with these critical issues (see **Resource List** at end of brief). To facilitate a continued and effective dialogue on campus, below we offer several recommendations for CSAOs as they design and implement a campus response to the changing landscape of student healthcare.

- ☑ Convene a working group to review the ACA's impact on your campus healthcare services. Potential group members could include the CSAO, the health center director and/or the counseling center director, the campus CFO and/or the student affairs budget analyst, student representatives, and other campus constituents and the community.
- ☑ Expand the working group's body of knowledge by reviewing the attached resources and government publications.
- ☑ Consider the four potential institutional responses to the ACA. Contemplate others that may be most appropriate for your campus.
- ☑ Determine if your healthcare provider should become *in-network* with insurance plans. If so, how will you accomplish this on your campus?

- ☑ Determine if you will bill insurance plans for office visits. If so, how will you accomplish this on your campus?
- ☑ Communicate with other campuses to see if a coalition would benefit your institution. For campuses that wish to outsource the business processes of becoming *in-network* and bill insurance companies, rates are likely to be more favorable if campuses join together, which is

particularly important for smaller colleges and universities.

- ☑ If you are a member of a state system, engage with your central offices to see how you could work with sister institutions. For example, the University System of Georgia recently completed an insurance billing services contract through an RFP process for all campuses in the system. This collaboration garnered favorable rates and eased

the administration for the individual campuses.

- ☑ Contact NASPA if you have questions or require additional resources.

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Resources and Suggested Reading

American College Health Association's National College Health Assessment. Includes aggregated survey data on student health -- <http://www.achancha.org/>

Liang, Bryan. *Crisis on Campus: Student Access to Health Care*. University of Michigan Journal of Law Reform. Vol 43.3. Spring 2010.

Liang, Bryan. *Viewpoint: School-Sponsored Health Insurance – Planning for a New Reality*. Society for College and University Planning. April – June 2010.

Munro-Prescott H. *Student Bodies -The Influence of Student Health Services in American Society and Medicine*. University of Michigan Press. 2007

"Sunbelt" surveys of campus health center administration and management -- <http://studenthealth.uncc.edu/general-information/sunbelt-surveys>

Turner S. and Hurley J. *History and Practice of College Health*, University of Kentucky Press, 2010.

United States Department of Health and Human Services website on the Patient Protection and Affordable Care Act --<http://www.healthcare.gov/>

United States Government Accountability Office. "Report to the Committee on Health, Education, Labor, and Pensions, U.S. Senate. HEALTH INSURANCE -- Most College Students Are Covered through Employer-Sponsored Plans, and Some Colleges and States Are Taking Steps to Increase Coverage". <http://www.gao.gov/assets/280/274105.pdf>

Table 1: Preventive Services Covered under the Affordable Care Act

If students have a new health insurance plan or insurance policy beginning on or after September 23, 2010, the following preventive services must be covered without a copayment or co-insurance or meet the deductible. This applies only when these services are delivered by an *in-network* provider.

Covered Preventive Services for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines --doses, recommended ages, and recommended populations vary:
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus
 - Influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella
- **Obesity** screening and counseling
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

Continue Table 1: Covered Preventive Services for Women, Including Pregnant Women

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women*
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs*
- **Domestic and interpersonal violence** screening and counseling for all women*
- **Folic Acid** supplements for women who may become pregnant
- **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes*
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women*
- **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older*
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI)** counseling for sexually active women*
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Well-woman visits** to obtain recommended preventive services for women under 65*

*Source: Services marked with an asterisk (*) must be covered with no cost-sharing in plan years starting on or after August 1, 2012.*