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Review of the American College Health Association's Standards for Student Health Insurance/Benefits Programs (SHIBPs)

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Last updated: December 14, 2009 (original publication: July 1, 2002)

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Introductory notes

The American College Health Association (ACHA) first issued standards for Student Health Insurance/Benefit Programs (SHIBPs) in 1986. The standards were updated in June, 2000, and again in March, 2008. A growing number of colleges and universities are publishing their compliance commitment in their annual SHIBP program brochures, an indication that the importance of the standards is increasing. A desire to be fully compliant with ACHA's standards is often a key component of institutional decisions to require health insurance as a condition of enrollment. As the cost of SHIBPs has increased, many colleges and universities are increasing the amount of time and resources devoted to effective program management. Unfortunately, there is still widespread lack of compliance with the requirement for providing catastrophic coverage (first introduced in 2000), for providing plan benefits that meet the fiduciary responsibility to manage programs in the best interest of covered students (see Standard III), and for having coverage that is consistent with common practices of the group health insurance field (see Standard II).

This document provides the rationale for each standard and example applications. Although this article was reviewed by numerous student affairs and college health administrators, as well as by several national health insurance/managed care experts (including legal counsel), the content of this paper is not endorsed or approved by the American College Health Association and solely reflects the opinions of Stephen L. Beckley and Associates, Inc (SLBA). Nothing in this article should be construed to be legal advice or legal opinion from SLBA.

The use of the term "Insurance/Benefits" in the title for the standards is an acknowledgement of the significant amount of self-funding that is occurring for the management of student health programs for college students. More information about self-funding may be obtained from SLBA's web site under Research, Resources, and Downloads.

The importance of ACHA's insurance standards for providing guidance to SHIBP managers/committees cannot be overstated. These standards recognize many of the common strengths and long-standing challenges for effective management of SHIBPs. SLBA's article entitled "Health Insurance Choices for College Students" provides additional perspective on SHIBPs and provides links to numerous informational sites and resources that may be helpful to readers in understanding the operation of insurance/benefit programs.

Questions regarding this article will be answered under an FAQ section of SLBA's web site at faq-acha.html.

Standard I (*mandatory insurance*)

As a condition of enrollment, the college or university requires students to provide evidence that they have health insurance coverage.

Rationale:
Colleges and universities often have a compelling institutional interest for requiring health insurance as a condition of enrollment. Moreover, compliance with the SHIBP standards endorsed by ACHA is not likely to occur if the college or university does not require health insurance as a condition of enrollment. Commonly recognized student health insurance enrollment system definitions may be found at SLBA's web site: www.slba.com/enrollment.html

There appears to be agreement that colleges and universities have an institutional interest in health insurance since almost all four-year degree granting institutions endorse a SHIBP. Extending this involvement to require students to have health insurance is appropriate because:

1. students who are uninsured or under-insured often do not have appropriate access to health care, especially mental health care services and prescription medications;
2. employer-sponsored health insurance through parents is becoming less available because of increasing cost and reduced eligibility;
3. colleges and universities that require health insurance as a condition of enrollment are usually able to obtain coverage at a much lower cost and provide greater benefits than students can obtain on an individual, voluntary purchase basis;
4. large uninsured student populations often create inequities among students relative to access and funding for on-campus health care services (including mental health care); and
5. there are direct institutional interests associated with students' insurance status, including risk management concerns (particularly campus safety), relationships with community health care providers and governmental agencies, and protection of the institutional investment made in

student recruitment and academic success. This last point is becoming increasingly important as funding for public colleges and universities continue to transition from substantial state funding to publicly assisted status.

Other factors for mandatory health insurance are discussed at SLBA's web site.

Although over 80 percent of private colleges and universities, and approximately one-third of major public universities, require health insurance as a condition of enrollment, college students comprise one of the nation's single largest identifiable groups of uninsured persons (when loss of health insurance is for more than a six month period).

Voluntary SHIBPs have generally failed to provide effective health insurance/benefit programs because such programs often:

1. provide inadequate insurance coverage and cover less than 10 percent of the eligible student population (often leaving large numbers of students uninsured);
2. cost more than other individual market alternatives;
3. have inappropriate cost subsidization of domestic students by international students (who are often required to have health insurance); and
4. are not in compliance with the benefit and program management standards adopted by ACHA for SHIBPs.

Comments:

- ACHA's standards do not require colleges and universities to provide student health insurance/benefit programs. This first standard for requiring health insurance can be implemented without institutional endorsement or administration of a student health insurance/benefit program. To the extent a college or university does not endorse or administer a specific student health insurance/benefit program, all other standards are not applicable.
- The evidence of insurance provision provides wide latitude to colleges and universities in determining the requirements for health insurance coverage for their respective institutions and the type of evidence that must be provided by students who assert the existence of personal health insurance coverage.
- The insurance requirement standard provides support to colleges and universities trying to develop or maintain an institutional requirement for health insurance. Colleges and universities that have voluntary insurance programs might consider either adopting some form of mandatory insurance (refer to SLBA's enrollment system definitions) or terminating their insurance programs for domestic students if they cannot otherwise meet the standards endorsed by ACHA.
- Unfortunately, voluntary SHIBPs among public colleges and universities continue to exist primarily where there are relatively large numbers of uninsured persons (e.g., states with more than 18 percent of their population uninsured - Arizona, New Mexico, Nevada, Texas, Oklahoma, Louisiana, Mississippi, Georgia, and Florida).
- Colleges and universities have wide discretion in determining eligibility for their SHIBPs, as well as which classes of students should be required to have health insurance as a condition of enrollment. For example, the mandatory requirement may not be applied to part-time students, distance learners, or non-degree seeking students.

Standard II (*scope of coverage*)

The college or university recognizes that students rely upon its student health insurance/benefit programs for their primary source of health insurance protection. An appropriate scope of coverage is provided, including, but not limited to:

- Coverage for preventive health services.
- Coverage for catastrophic illness or injury.
- Coverage for prescription medications, including coverage for psychotropic medications.
- Minimization, or ideally elimination, of pre-existing condition exclusions/waiting periods.
- Coverage for dependents of covered students including children, spouses, and domestic partners.
- Continuity of coverage up to plan limits for students requiring a medically-necessary leave-of-absence.
- Continuity of coverage for previously insured students in plan renewals or with new carriers (i.e., no gain/no loss provision), subject to RFP provisions and final negotiations.
- Program benefits, limitations, exclusions, special provisions, and definitions are reviewed to assure they are consistent with common practices of the group health insurance field and/or there is a compelling reason for the college or university to have a provision that is unique for its SHIBP.
- The program encourages use of campus health and counseling services, where doing so provides cost effective and high quality care for students.

Rationale:
Student health care insurance/benefit programs must provide a scope of coverage that reflects the need for health insurance in the eligible student population. Many programs do not presently provide coverage that is sufficient for students relying on it as their sole source of health insurance protection and/or have major gaps in coverage that are inconsistent with providing appropriate access to care (especially in benefit areas that are closely associated with campus safety).

Almost all students purchasing SHIBPs are doing so for their sole source of health insurance protection. Even those students with other health insurance are often primarily relying on the student program because their other insurance provides only emergency care while they are in college, or the plan has some other significant benefit limitation.

Many student health insurance/benefit plans do not provide catastrophic coverage. SHIBP coverage should include at least a $1 million lifetime maximum benefit. Even a lifetime maximum benefit of $1 million may not be sufficient if a significant number of potential plan participants perceive this level of coverage to be inadequate protection. In many environments, the plan maximum should be no less than the amount common for employer-sponsored plans ($2,000,000 to unlimited coverage).

It is important to note that colleges and universities cannot comply with this standard by offering optional catastrophic coverage. Catastrophic protection must be included in the program in which students are enrolled if they do not complete a waiver/refund petition. Also, programs providing a maximum benefit of $50,000, $100,000, or $250,000 per year or per accident or injury do not meet this standard because there is an extraordinarily low probability of a student incurring separate illnesses or injuries that would equal a $1 million lifetime maximum (or incurring

large expenses for the same illness or injury over many years).

Successful SHIBP management requires balance be struck between the cost of coverage and benefits. The optimum balance point between benefits and cost varies significantly among colleges and universities based on the characteristics of the student population, scope of care available on-campus, and other environmental factors. Nonetheless, after the program provides appropriate catastrophic coverage and satisfies all applicable state and federal benefit mandates, there should be a hierarchy for providing coverage that is based on a careful assessment of the needs of a specific student population and students' financial resources. In general, the following process is recommended as a basis for developing a student health benefits plan.

1. To the maximum extent possible, primary health care needs and short-term counseling services should be funded through either health fees or institutional funds rather than insurance benefits. Such institutional funding arrangements are often more fiscally efficient than common insurance plan arrangements. It is usually appropriate, however, to cover the fee-for-service charges for on-campus health care providers through student health insurance/benefit programs (particularly if the claims liability is self-funded by the college or university). The SHIBP coverage should be designed to assure appropriate access to on-campus services and to facilitate referral access to community health care providers. This is particularly true for crisis intervention and mental health care services.

2. It can be appropriate for student health centers to move to an insurance reimbursement funding model if:
    - many students are covered by employer-sponsored health plans which provide nominal copayments for primary care services;
    - it is possible for the student health service to become a participating provider with major insurance/HMO/managed care organizations, and successfully obtain reimbursement for primary care services;
    - responsibility for funding of mental health care services and health education programs (which are least likely to be adequately reimbursed by employer-sponsored plans) is shared across the entire student population through health fees or institutional funding;
    - concerns, such as patient confidentiality, are clearly explained to students relative to their choice of health insurance options;
    - the college or university does not charge the SHIBP for costs of operation of the student health service, or other institutional costs, that do not fairly reflect the value of the services provided to students covered by the SHIBP (refer also to Standard III pertaining to fiduciary responsibility); and
    - the importance of the insurance choices students will be making under this kind of health care funding system is clearly communicated (program communications must be accurate and fair, e.g., no use of fear tactics).

3. Copayments and coinsurance, which are used to help assure health care services are consumed responsibility and to have users pay an appropriate share of the cost, must be balanced against creating barriers to care.

4. Once catastrophic coverage is established, as much additional coverage should be purchased as possible up to the point that the students' perception of cost of coverage becomes excessive, and students either try to go without health insurance or choose less costly benefit alternatives.

5. Comprehensive mental health care benefits and prescription drug coverage are essential to augment the services provided on a pre-funded basis by the college or university. Mental health care benefits, particularly services related to crisis intervention and emergency hospitalization, are required for effective SHIBP management.

6. Pre-existing condition exclusions should be eliminated, or be narrowly defined, and have limited waiting periods. Colleges and universities should advocate that SHIBPs be regulated on the same basis as employer-sponsored group health insurance programs under the Health Insurance Portability and Accountability Act of 1996.

7. Continuity of coverage is a major concern for effective management of SHIBPs. Assuring students do not lose immediate access to health care because an illness or injury precludes ongoing enrollment is addressed in the 2008 version of the standards. This responsibility reasonably ends at some point for each college or university, and students would be expected to transition to personal insurance (using HIPAA certificates of creditable coverage) if they are not able to return to the college or university following a leave of absence.

8. Eligible expenses/covered services, and all other plan provisions (e.g., definitions and limitations and exclusions) generally should be consistent with provisions that are common among large employer-sponsored health insurance plans. Certain exclusions or plan provisions unique to college programs are appropriate (e.g., exclusion of medical expenses resulting from the practice or play of intercollegiate sports) to the extent they are meaningful. This means the exclusion must provide substantive fiscal protection for the program and be reasonable given the circumstances of the institution.

Comments:

- The college or university should control the plan of benefits for the student health insurance/benefit program under a mission, vision, and values statement that has been developed (and periodically revised) in consideration of the specific needs of a student population and available health care resources. Generally speaking, students are not well-served by purchasing turn-key products designed by health insurance companies/agents/brokers.
- Obtaining catastrophic coverage is becoming increasingly affordable as the number of colleges and universities that provide this coverage has grown, and there has been more favorable catastrophic claims experience than expected.

Standard III (*fiduciary responsibility*)

The college or university acknowledges it has a fiduciary responsibility to manage student health insurance/benefits programs in the best interests of students covered by the programs.

Rationale:
Student health care benefit/insurance programs must be managed solely in the best interests of the students participating in the program. Many SHIBPs are not managed under this standard because of purposeful or inadvertent management actions on the part of plan administrators.

To fully comply with Standard III, management of Student Health Insurance/Benefit Programs (SHIBPs) requires both expertise and a strong

commitment to work in the best interests of student consumers. The standard for fiduciary responsibility should be construed to be the same requirement private sector employers, subject to the Employee Retirement Income Security Act of 1974 (ERISA), must meet in managing their employee benefit programs. This is a valid standard as there is no other fiduciary responsibility requirement that would be as meaningful in providing guidance for management of SHIBPs.

There are numerous court decisions, textbooks, articles, and research papers available to SHIBP managers that provide a detailed explanation of the fiduciary requirements that are applicable to ERISA-governed employer-sponsored health plans. One key aspect of fiduciary responsibility is to have program management at the highest possible level of effectiveness, including the financial arrangements for providing coverage. Specific components of compliance with Standard III include, but are not limited to, the following:

- **The college or university does not comingle funds for operation of the SHIBP with other institutional funds.** SHIBP funds must be separate from health service funds or any other college or university accounts. Any reserve funds for SHIPB must earn a fair market, long-term leve of interest income and be maintained in an account which is fully protected from speculative short-term financial loss. Under no circumstance may funds collected under the SHIBP be used for any purpose other than the benefit of SHIBP participants. In the event the college or university decides to discontinue its SHIBP, any remaining funds should be used for health care and/or health education services for student consumers.

- **Institutional charges for support of the SHIBP reflect the fair market value for the services or supplies provided**. Since there is a compelling institutional interest in having an insurance requirement and a highly effective SHIBP, some costs for program operation should probably be borne by the University or the entire student population (e.g. the costs associated with enrollment/waiver processes) rather than being charged exclusively to SHIBP participants. Fees assessed as part of the SHIBP enrollment should reflect actual costs of administering the program and/or providing direct SHIBP support to enrollees. Excessive and inappropriate institutional charges may be considered an illegal form of rebating.

- **The college or university does not allow the SHIBP to be influenced by other financial concerns, either internal or external to the institution.** For example, sole source purchasing arrangements should be permitted only under highly unusual circumstances (e.g., a vendor withdraws from the market, and there is not sufficient time to conduct a complete request for proposal process). A policy requiring competitive vendor selection processes, which is compliant with regulatory and/or institutional purchasing processes, is particularly important for academic health center environments or other situations where the college or university has a financial and/or controlling interest in a hospital, physician network, or other health care providers. A competitive request for proposal process should assure that the SHIBP is affiliating with the health care organizations that can provide the best value for student consumers. If a sole source purchasing arrangement for the managed care network or individual health care providers is required, this should be supported by an independent study confirming the students are receiving favorable treatment (both cost and quality of care) that could not be replicated by other potential vendors. Readers should note that competitive request for proposal processes are also required under Standard VIII.

- **The selection of an agent, broker, or consultant is not influenced by gifts or other support for the institution** (see also the discussion of rebating under Standard IV for legal compliance and discussion of purchasing rules under Standard VIII). For example, a SHIBP management committee is asked during an RFP process to give special consideration to an insurance agent who is a consistent donor for the college or university. Institutional interests may appropriately influence the program under only narrow circumstances that are fully disclosed to the college or university community, student consumers, parents, and other interested parties. For example, an institution with a religious affiliation may determine it is impermissible for the program to provide coverage for voluntary termination of pregnancy. Even though it may be arguable that this kind of exclusion is not in the best interests of all of the participating students, the exclusion is permissible because it is at the core of the institution's values and would probably mean the program would not otherwise be provided if the college or university could not have this exclusion. Any compromise for ACHA's SHIBP standards should involve a careful decision making process. It is recommended that any area of the standards that may require explanation or limitation be fully discussed in a mission and management parameters statement for the SHIPB that is available to students, parents, and other interested parties.

- **There is no inappropriate financial subsidization of the health service, counseling center, or other health care providers serving the general student population.** Since many SHIBPs will make special benefit arrangements with student health services, counseling centers, and other university-owned or -affiliated health care providers (often including plan provisions that pre-fund care for SHIPB participants), it is arguable that SHIPB participants should receive the most favorable cost schedule for services provided. This statement is particularly true when the health service or counseling center is a participating provider with managed care plans or prescription drug programs.

- **Concerns for the institution's employee benefit plan do not influence SHIPB management.** Negotiating a preferred provider network, conducting a request for proposal process, or other plan management functions for the SHIBP must not be influenced by concerns for management of the institution's employee benefit plan. Joint purchasing arrangements for program services or vendors may be appropriate (as long as there is no commingling of funds or joint indemnification of risk between the SHIPB and the employee benefit plan). Conversely, if the employee benefit program is governed by ERISA (almost all private college and university employee benefit programs that are not located at church-owned colleges and universities will be subject to ERISA), the employee health plan must be managed for the sole benefit of employees, and its management must not be influenced by concerns for the SHIBP.

- **Ancillary components for the program are also managed in the best interests of student consumers.** For example, an optional program that allows students to pre-fund care at a student health service for radiology and laboratory services would not be acceptable if the rationale for doing so is simply that it is proven to be a good additional revenue source for the student health center. This kind of program would have to be a good insurance value for student consumers and take into consideration factors such as the cost of the program compared to the probability of receiving a financial benefit, the need for indemnification of this kind of risk (i.e., even if there is a good financial return for students, it may not be the kind of risk that warrants insurance protection), and whether the program can be marketed without using fear tactics or other impermissible marketing methods under the state's insurance advertising code (even if the code does not apply to self-funded programs).

- **The college or university understands that meeting the fiduciary responsibility standard requires both special expertise and proactive program management from administrators and management committees responsible for its SHIBP**. The requirement under the fiduciary responsibility for ERISA pertaining to expertise is commonly referred to as the prudent expert rule and should be viewed as being applicable to ACHA's insurance standards. The ERISA prudent expert rule is most often associated with investment of pension plans and other plan assets under a standard of special expertise rather than the simple best judgments of a lay person. This requirement, however, also extends to the decision making processes for all facets of plan management. For example, the prudent expert requirement would not be satisfied by haphazardly conducting vendor selection processes (e.g., providing inadequate data or providing insufficient time for vendors to respond

properly to a request for proposals), failing to evaluate each cost components for a SHIBP under a "fair market value" standard, or failing to devote sufficient resources to assure the most effective use of the students' fund contributions (e.g., not using a partial self-funding arrangement or risk sharing method for a large SHIBP when it is both legally permissible to do so and there are compelling cost advantages). Lack of institutional resources or expertise among management committee members would not be a viable defense for failing to meet the institution's fiduciary responsibility requirements. In regard to this last point, given the widespread involvement of major benefit consulting/actuarial firms in providing advisory services for SHIBPs, as well as the internal expertise of many colleges in managing their employee benefit programs, there is no valid reason for a college or university to not meet the prudent expert requirement for SHIBP management.

The SHIBP should be periodically audited and reviewed by external agencies/consulting firms to assure it is in compliance with ACHA's standards and to assure it is meeting the needs of student consumers (see Standard VI). There should also be full compliance with the public disclosure requirements for plan operation noted in Standard VII.

Standard IV (*legal compliance*)

The student health insurance/benefit program is annually reviewed to assure it is in full compliance with all applicable federal and state statutes and regulations.

Rationale:
There are three distinct components for the regulatory environment for student health insurance/benefit programs (SHIBPs): federal law, state law, and general liability. Legal compliance for SHIBPs must not be entrusted solely to an insurance carrier indemnifying the risk or other program vendors. Many of the compliance penalties for federal mandates apply only to the college or university, and there are student health insurance carriers underwriting and administering programs have been found not to be in full compliance with either federal civil rights laws or state mandated coverage.

Colleges and universities should take four actions to achieve federal and state legal compliance (recommendations for minimizing general liability are provided at the end of this section):

1. If an external broker or consultant is utilized, the program manager or management committee should select a firm that is familiar with the regulatory environment for SHIBPs.

2. The college or university should have the program periodically reviewed by legal counsel (this is especially important prior to request for proposal processes). If internal legal counsel is not comfortable performing this service (or available), an outstanding resource for legal research is the Federation of Regulatory Counsel (FORC). FORC members spend at least 50 percent of their practice doing insurance regulatory law work, and the organization includes member attorneys in most states.

3. For fully insured programs, the college or university should include a provision in its request for proposals (RFP) document requiring the insurance carrier to hold harmless and indemnify the college or university for compliance with all federal and state rules and regulations, regardless of whether or not the mandated coverage or plan management requirement is applicable to the insurance carrier or the college or university.

4. A campus-wide audit should be conducted to make sure the college or university has not inadvertently either administered or endorsed a student health insurance program that is not compliant with applicable federal civil rights laws. This last point includes programs for international students, programs available to currently enrolled students sponsored by alumni associations, and programs offered by various student associations. Many of these programs do not comply fully with the federal civil rights laws that are applicable to SHIBPs endorsed or administered by colleges or universities that are recipients of federal funding.

   The following is a general discussion of each of the major legal compliance components for SHIBPs under federal law, state laws and regulations, and general liability.

   - Three federal civil rights laws are applicable to SHIBPs for colleges and universities that are recipients of federal funds: Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973; and the Age Discrimination Act of 1975, as all three laws were amended by the Civil Rights Restoration Act of 1987. These federal civil rights laws apply to colleges and universities that are recipients of federal funds, regardless of whether or not there are any federal funds used to support the operation of the SHIBP. The mandates for federal civil rights laws apply exclusively to colleges and universities, and there are no liabilities for health insurance carriers or HMOs for failed compliance.

     Title IX mandates colleges and universities not discriminate on the basis of sex for specifically identified programs and policies. In regard to SHIBPs, there are two specific mandates under Title IX: (1) the cost of coverage cannot be different based on the sex of the student or the sex of the student's spouse; and (2) pregnancy benefits must be provided on the same basis as any other temporary disability for both student and spouse coverage. This means that pregnancy benefits must be provided at a level that is neither less than nor greater than coverage for other conditions. Readers should note there is an exception for no pre-existing condition exclusion for pregnancy, discussed later in this section, for the majority of states that have implemented the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for SHIBPs on the same basis as employer-sponsored programs. Also, a provision in the Civil Rights Restoration Act of 1987 removed the original requirement in Title IX for providing coverage for voluntary termination of pregnancy.

     Section 504 mandates that colleges and university not discriminate on the basis of covered handicapping conditions. There are two levels of impact for Section 504 on SHIBPs. First, the program cannot deny access to either students or dependents who have handicapping conditions. This means, for example, that no medical underwriting procedures can be used that might deny a person (either a student or dependent) eligibility based on a covered handicap (e.g., physical impairment, communicable diseases, mental health conditions, or major chronic conditions such as diabetes or HIV). This medical underwriting is also impermissible for evaluating whether qualified late enrollees may be allowed to participate in a SHIBP. The second level of compliance relative to Section 504 occurs when exclusions are so injury or illness specific that they are tantamount to denial of access to the program. For example, a SHIBP that excludes medical expenses resulting from a sexually transmitted disease is likely to be found by either the United States Department of Education's Office for Civil Rights (OCR) or a federal court not to be in compliance with Section 504. The American College Health Association's advice to its member institutions is to provide benefit levels that are adequate for Section 504 covered conditions and review all program limitations and exclusions for Section 504 compliance. OCR has ruled that pre-existing condition exclusions will not be reviewed under Section 504

because such provisions broadly apply to both handicap and non-handicap covered conditions.

Note: This section pertaining to the Age Discrimination Act of 1975 was updated in July, 2003.
The Age Discrimination Act of 1975 (ADA) does not have specific mandates for SHIBP management or benefit levels. Although there is no case law or OCR rulings relative to the Age Discrimination Act, the United States Department of Education's Office for Civil Rights (OCR) has confirmed that age-rated student health insurance/benefit programs do not violate the Age Discrimination Act of 1975 if such policies: (1) do not exclude access to the program based on age; and (2) the age-rating practice falls within the normal operations exception for the Age Discrimination Act of 1975. More specifically, there must be a sound actuarial standard as the basis for the age rating.

- **The Health Insurance Portability and Accountability Act of 1996 (HIPAA)** required state implementing legislation. A discussion of all of the various permutations for implementation of HIPAA for SHIBPs is beyond the scope of this article. Providing advice about HIPAA compliance is particularly difficult because various states have chosen to interpret HIPAA differently as it applies to student plans. The possible implementation options include, but are not limited to: regulation as "individual" plans, regulation as an "association" plan, and regulation as a "group" plan (i.e., regulation on the same basis as employer-sponsored health plans). Each of these designations has particular HIPAA compliance ramifications.

  For states regulating student health plans on a group basis, it is common to find that some student health plans are not reducing or waiving the pre-existing condition exclusion for students who have previous creditable coverage. Some programs in these same jurisdictions have not completely removed the pre-existing condition exclusion for pregnancy, regardless of the existence of any previous creditable coverage. The compliance penalties for HIPAA under group programs fall solely upon the college or university as the plan sponsor. Again, it is essential SHIBP managers consult with legal counsel, who has experience in the insurance regulatory law environment, regarding compliance requirements for their particular state.

- **The Mental Health Parity Act of 1996** amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act to prohibit health plans and health insurers from setting lower lifetime or annual dollar limits for mental health coverage than is applicable to medical and surgical benefits. While the Mental Health Parity Act does not permit lower annual dollar limits for mental health care coverage, the law does allow insurers and health plans to continue to use different benefit levels between physical conditions and mental health conditions. Lifetime maximum benefits for mental health care and visit maximums (either per year or per lifetime) are permissible.

- **The Newborns' and Mothers' Health Protection Act of 1996** requires group health plans and health insurers (including those offering individual policies) to allow mothers and their newborns to remain in the hospital for at least 48 hours (96 hours for cesarean delivery). Earlier discharges are allowed only if the decision is made by the attending physician.

- **Regulations issued in 1993 by the United State Information Agency** require colleges and universities to make a good faith effort to make certain J1 and J2 (i.e., visiting scholars and their dependents) visa recipients have health insurance. As of the date of the publication of this article, these mandates have not been extended to all F visa recipients under the proposed regulations issued for the Illegal Immigration Reform and Immigrant Responsibility Act of 1996. Specific coverage requirements include a per illness or per injury maximum benefit of $50,000, repatriation coverage providing at least $7,500, medical evacuation coverage providing at least $10,000, and medical expense deductible not greater than $500 per illness or injury.

- **State regulation** of SHIPs is complex and often difficult to follow. Unlike private employer-sponsored health plans that are governed by ERISA, there is no federal preemption of state regulation for self-funded SHIBPs (except in the areas noted above). This simply means that in most states there can be significant regulation of SHIBPs, regardless of the funding arrangement. Common mandated benefits for SHIBPs include coverage for mental and nervous conditions (often including parity legislation and coverage for biomedical conditions), coverage for treatment of alcoholism and chemical dependency, and mandated coverage for many other specific conditions and program operation. A summary of mandated benefits is available from the National Association of Insurance Commissions or from individual state insurance regulatory agencies. Given the wide variety of possible mandates and the differences between state jurisdictions, it is not surprising to find that many SHIBPs do not fully comply with state mandated coverage.

  The problem of legal compliance is worsened by the numerous state insurance regulatory agencies that do not have the resources to fully examine insurance company applications, policy forms, and program marketing material and certificates of coverage. For example, many SHIBPs continue to take always secondary payor status in coordinating benefits with other group health insurance programs even though most states have adopted coordination of benefit rules (based on model legislation endorsed by the National Association of Insurance Commissioners) precluding always secondary payor positions for SHIBPs that cover both illness and injury conditions.

  Although the penalties for failure to comply with state mandates usually apply to only the insurance company underwriting the coverage (or the college or university under self-funding arrangements when state regulations and mandates apply), periodic review of mandated coverage by legal counsel retained by the college or university is recommended. An especially good time for this kind of review is prior to periodic request for proposal processes. This review should also pay particular attention to health maintenance organizations and other managed care organizations that are likely to be subject to additional state mandates. One area of state regulation that varies significantly based on jurisdiction is the permissibility of self-funding. Legal research should be conducted before any component of a SHIBP is self-funded, including internal claims liability at a student health service or student counseling center.

  Health insurance, including managed care programs, is one of the most heavily regulated products in our society. As is the case with most consumer protection legislation, it followed a period of widespread abuse by the least reputable parts of the industry, and acknowledgment by legislators and regulatory agencies that consumers were often irreparably harmed by inappropriate practices. Each state extensively regulates advertising for health insurance products. Most states prohibit the use of fear tactics (e.g., statements suggesting that failing to have health insurance may jeopardize an uninsured person's ability to access health care services), testimonials, and misleading use of statistics. The advertising codes also specify that negative features cannot be stated positively (e.g., the program includes a "favorable pre-existing condition exclusion"), and that all terms and conditions of the coverage must be included in marketing materials providing any explanation for the schedule of benefits. Many SHIBPs do not comply with one or more aspects of state advertising code regulations.

  Another aspect of state regulation for public universities is compliance with purchasing rules and regulations for state agencies. As noted under the discussion of Standard VIII, sole source selections (e.g., changing insurance carriers without a formal request for proposal

process) of student health insurance vendors should occur only under highly unusual circumstances, and agents/brokers or other parties should not be allowed, under any circumstance, to control (or inappropriately influence) the selection of the insurance carrier for the college or university.

- **General liability** is the final area of regulatory concern. The legal and regulatory environment has been addressed extensively in the revised standards for Student Health Insurance/Benefit Programs. Standard II requires that the scope of coverage for SHIBPs be sufficient for students to rely on the program as their sole source of health insurance protection. This is important for management of general liability for colleges and universities sponsoring SHIBPs because they could be liable for failing to provide a program reflecting the need for coverage in the eligible student population. This is particularly true when: (a) plan managers are clearly aware that they are providing a program which is the sole source of health insurance for the majority of covered students; and (b) the program is promoted as providing comprehensive coverage.

  Standard III establishes a fiduciary requirement for SHIBPs to be managed in the best interests of the covered students. General liability could evolve for a college or university under numerous circumstances for failing to act in the best interests of covered students. Examples under this area of general liability include:

  - inappropriate financial subsidization from the SHIBP for operation of the student health service or other on-campus programs;
  - directing care to university-owned or -operated health care providers which may be more expensive than other local-area providers;
  - gross negligence on the part of the college or university in providing routine oversight of the program, including review of all program expenditures and vendor relationships; or
  - a request for proposal process that is influenced because of gifts to an athletic department or institutional entity.

  Regarding the last point, readers should note that rebating, i.e., providing gifts by insurance carriers or insurance agents to influence the sale of an insurance product, is expressly illegal in all state jurisdictions.

  Although there does not appear to be any specific case law for general liability for SHIBPs, each of the examples noted has occurred recently in actual program management. Management of this kind of liability can be reduced by complying with Standard VII specifying an annual report of program income and expenditures and periodic, independent audits, and with Standard VIII pertaining to compliance with institutional and/or governmental purchasing policies.

  Another concern for general liability is SHIBPs that have exclusions that are arbitrary or capricious (i.e., clearly outside the norm for the group health insurance field). A common inappropriate provision for SHIBPs is exclusion for attempted suicide or self-inflicted injury. In addition to being a concern for compliance with Section 504, these provisions are now being called into question by various state regulatory agencies. The Colorado Division of Insurance has noted the following in regard to these plan provisions:

  > "Health policies cannot exclude benefits based on suicide attempts or self-inflicted injuries if the circumstances are such that the covered person was unable to form intent for those actions. For example, if the person were unable to control his actions due to severe mental illness, attempts to harm himself would be accidental, not intentional. Case law has supported this position of requiring intent in order to apply exclusions for self-inflicted injury. This limitation on exclusions applies to all health policies, including disability income and long term care."

  Source: *The Colorado Regulator*, Spring, 2000, page 13

  Other examples of arbitrary and capricious plan provisions include moral turpitude exclusions (e.g., expenses resulting from consumption of alcohol or illicit drugs), exclusions for treatment of non-malignant lesions (or other conditions where a negative medical finding is covered but a positive medical finding is excluded) and exclusions for perceived high risk behaviors (e.g., hang gliding or operating a motorcycle or three-wheeled vehicle). As noted under the rationale discussion for Standard II, all plan limitations and exclusions should be evaluated to make sure they are meaningful (i.e., they provide substantive protection for the program).

Standard V (*student consumers, student health services staff, and expert involvement in SHBIP management*)

Student consumers, student health program staff, and other internal or external experts, as appropriate, are involved with the selection, monitoring, and evaluation of the student health insurance/benefits program.

Rationale:
Several surveys conducted by Stephen L. Beckley and Associates during the 1990s confirmed that compliance with ACHA insurance/benefit program standards are highly correlated with program influence/control vested in student consumers and leadership from student health services, counseling centers, and other stakeholders who have expertise in health care delivery and insurance program management. This standard was revised in 2008 to reflect the necessary involvement of internal or external professionals with expertise in insurance plan management.

1. Successful student health service management is rooted in the same management and funding principles as operation of health maintenance organizations. On most college campuses, this expertise is often uniquely possessed by college health administrators.
2. Many college health administrators recognize that an effective student health program cannot exist without a high quality SHIBP which is coordinated with other components of the institution's overall student health program (e.g., primary care, short-term mental health care services and crisis intervention services, and health education and wellness programs). Effective integration of the student health service, counseling center, and insurance program benefits requires the involvement of student health center and counseling center leaders in the management of the SHIBP.
3. Almost all of the funding for SHIBPs is derived from participating students. Students rightfully should have a significant voice in the

management of the program. Student members of management committees are often asked to communicate the perspective of the overall student community. Of course, students who participate on SHIBP management committees should also be free from any real or perceived conflicts of interest. All management committee members should be given guidance in ethical decision making and not be devoted to advocating for benefits or program management methods solely on behalf of a particular group of student consumers.

Standard VI (*annual program review*)

The student health insurance/benefits program is reviewed annually to ensure the program: (a) meets the needs of covered individuals; (b) provides desired benefits at the least possible cost; and (c) returns as much of the premium or fund contributions as possible to covered individuals in the form of benefits. Reserve funds may also be maintained to assure short- and long-term financial viability for the program.

Rationale:
Even though program managers and other stakeholders are aware that the need in the student population has evolved in different forms, many SHIBPs have not evolved over a protracted period. The most common problem associated with this lack of program evolution is that many program managers do not have basic knowledge of insurance funding mechanisms and of how to evaluate cost factors on both a short- and long-term basis.

This standard speaks to the need for annual review of SHIPBs, and the requirement for program managers and management committees to have a basic understanding of the factors that influence both short- and long-term costs.

1. The first component of the annual review should be assessing the needs of covered individuals. This does not mean trying to determine how the program can provide 100 percent coverage for any potential claimant under the SHIPB. The annual assessment is primarily concerned with: (a) the insurance status of the entire student population (i.e., well-insured, under-insured, and uninsured); (b) the benefit and cost position of the SHIBP compared to other private sector alternatives available to students; (c) assessment of changes related to medical care technology, health care practices and procedures, new medications, and trends in the managed care field that could suggest changes to the benefit design or plan management; and (d) changes among students, parents, and other stakeholders that could affect the cost and quality perceptions of the SHIBP.

2. One of the keys to effective SHIPB management is to understand that most health insurance programs, particularly employer-sponsored group health insurance programs, strive to achieve an equity balance between the overall covered population and the smaller, constantly changing group of covered individuals who will incur eligible health care expenses. Generally speaking, most employer-sponsored group health insurance plans expect that the individuals who will incur health care expenses will pay (i.e., coinsure) a portion of their health care expenses through copayments, deductibles, coinsurance, and certain excluded or limited services. Although it is often argued that students have lower financial resources than employees, and therefore need higher levels of insurance protection, there is no empirical data to support this contention. College students, as an overall class, seem to have a high level of discretionary income compared to many other groups in the general population. Putting this issue aside, it is still an equity concern that should drive balance between the cost of the program and the scope of coverage. Thus, after assuring the program provides catastrophic coverage and complies with state and federal rules and regulations, it is the responsibility of program managers to determine how program benefits can be designed to appropriately share the risk between the overall insured population and individual claimants. A key aspect of this determination is finding which services and supplies (e.g., prescription medication) is in the commonweal of need for the student population and should be provided through the student health center and the counseling center, versus services and supplies that should be indemnified jointly by the insurance/benefit program and the covered individuals.

   Generally speaking, the current student health insurance/benefit field does not provide sufficient catastrophic coverage and often has too much first dollar/100 percent coverage for minor health care conditions. Excessive coverage for relatively minor health care conditions can greatly increase the overall cost of the program. Again, as a general rule, providing 100 percent coverage for services should usually be a result of either special negotiations with health care providers who are providing extraordinary discounts/cost reductions or concern for access to essential services that affect campus safety (e.g., prescription drug coverage for psychotropic medications and/or mental care benefits).

3. While Standard VI makes it clear that a program management objective should be to obtain the least possible cost and return as much of the premium/fund contributions as possible in the form of benefit payments, nothing in this text should be construed to mean that colleges and universities should not develop reserve funds to facilitate alternative funding arrangements and/or to promote long-term cost stability. The appropriate development and maintenance of reserve funds is beyond the scope of this article, but the subject is discussed at length in SLBA's primer on self-funding .

Standard VII (*review of retention expenses, program audits, and annual public reporting*)

Commercial insurance carriers, agents, brokers, and all others providing services to the student health insurance/benefits program are required to provide a full description of estimated claims, reserve estimates, administrative expenses, and all other fees. The student health insurance/benefits program is audited periodically and the results are provided to appropriate university or college officials and student consumers. Each year, a summary financial report for the program is published and made available to student consumers and campus officials responsible for management of the student insurance/benefits program.

Rationale:
The rationale for this standard is two-fold: (1) many student health insurance/benefit program managers do not require vendors to provide sufficient information, in both request for proposal processes and renewal negotiations, to understand the basic financial operation of a fully insured program; and (2) the likelihood of overall compliance with the SHIBP standards is greatly increased by public disclosure of a periodic independent audit and publication of an annual summary financial report.

1. It is important for plan managers and other stakeholders to understand the common differences among agents, agents of record or brokers, and consultants. Under most circumstances, the difference among these three entities is a function of how they are compensated, and on whose behalf they are legally obligated to serve:

Agents are legally obligated to work in the best interests of the insurance carrier they represent. Their compensation is a commission that is not subject to review or approval by the college or university. Agents who refer to themselves as brokers, however, may be doing so in the context that they represent more than one insurance vendor rather than having a formal brokerage appointment from the college or university.

Agents of Record or Brokers are legally obligated to work in the best interest of the college or university. They receive a commission that is agreed upon by the college or university. The agent of record or broker often prepares request for proposal documents and helps obtain proposals from insurance carriers. They then often assist the college or university in reviewing the proposals, conducting vendor interviews, assisting with program implementation program, conducting annual renewal negotiations, and often providing routine daily services that would often otherwise be provided by an agent of the insurance carrier.

Consultants are legally obligated to the work in the best interests of the college or university and are usually compensated on a fee basis. The consultant should not have any other financial relationships with insurance carriers or other potential vendors (including acting as an agent for insurance carriers at other locations). Consulting services may be expanded to include actuarial and/or legal work (often through sub-contractors of the consultant) for assistance in managing partially self-funded programs or other alternative funding arrangements.

2. Periodic program audits/reviews are an integral part of successful SHIBP management. The auditing process should be conducted by an entity that is completely independent of the program, although a companion report from consultants or program managers can be an important part of the audit/review process. Generally speaking, these audit/program reviews should be conducted at least once every five years.
3. SHIBP management committees should be aware that most state insurance regulations specifically preclude any form of rebating on the part of agents, brokers, or consultants. Rebating means providing gifts or other compensation to the purchasers of insurance to influence the selection of an insurance product.
4. It is important to publish annually a summary financial report for the program to help assure overall compliance with the standards for SHIBPs endorsed by ACHA. Student consumers should be aware of the financial condition for the program and how program surpluses or deficits are managed by the institution.

Comments: The concepts under this standard generally follow the requirements for program disclosure and fiscal management that are required for employer-sponsored health insurance programs under the Employee Retirement Income Security Act of 1974 (ERISA).

Standard VIII (*selection of vendors*)

The selection of vendors for the student health insurance/benefits program adheres to institutional and/or applicable governmental requirements relative to competitive vendor selection processes.

Rationale:
The rationale for this standard is rooted in a finding that inadequate student health insurance/benefit program management is often linked to inappropriate influence/control by entities having a vested financial interest in the program, and that competitive vendor selection processes are not used for program management. This problem is so strongly correlated to the long-standing problems associated with SHIBP management that vendor selection processes are addressed by ACHA under several components of the standards.

Comments:

- Inappropriate program management is a major concern for the entire college health field because it has historically resulted in a reduction of the number of high quality vendors that are active in the college health field, resulting in long-term harm to both institutions and student consumers. The harm to student consumers is manifest in both excessive cost and poor quality service. As noted elsewhere in this article, there should be a strong presumption against any sole source purchasing arrangements.
- Although selection of attorneys, consultants, actuaries, and other professional advisory entities, are often not subject to state agency requirements for competitive vendor selection processes, these entities should be selected with a high degree of concern for independence and freedom from conflict of interest. For example, a consultant should not be retained by a college or university if the consultant also acts as agent for insurance companies elsewhere (refer to Standard IX).

Standard IX (*conflicts of interests*)

Agents, brokers, consultants, and program managers do not have relationships that could be construed to be a real or potential conflict of interest. Agreements with consultants or brokers are fully disclosed and clearly define the services to be performed and the compensation to be received.

Rationale:
The rationale for this standard is fundamentally the same as noted for Standard VIII. Historically, there is inappropriate management of SHIBPs that is long-standing and has caused significant harm to the college health field and student consumers. In regard to compensation, colleges and universities should be aware of the scope of services provided by all program vendors in relation to the level of compensation.

Comments:

- Widespread problems for SHIBPs remain a major concern even though there has been extraordinary improvement in the quality of many SHIBPs in recent years (e.g., increased numbers of major public universities requiring health insurance as a condition of enrollment, improved fiscal efficiency of programs through self-funding and other alternative funding mechanisms, improved program communication materials, reduction/elimination of pre-existing condition exclusions, and increased adoption of catastrophic coverage). Inappropriate control of programs by agents and brokers is among these major problems, as are as excessive agent commissions.
- Conflicts of interest for program managers (including institutional conflicts of interest) remain a significant concern for SHIBP management. Program managers should not have financial relationships (including receipt of gifts) with entities that provide services for SHIBPs they are responsible for managing.

- As was noted under the discussion of Standard V, students who participate on SHIBP management committees should also be free from any real or perceived conflicts of interest. All management committee members should be given guidance in ethical decision-making and not be devoted to advocating benefits or program management methods solely on behalf of a particular group of student consumers.

Standard X (*program access*)

The student health insurance/benefit program is available to all eligible students regardless of age; gender identity, including transgender; marital status; psychological/ physical/learning disability; race/ethnicity; religious, spiritual or cultural identity; sex; sexual orientation; socioeconomic status; veteran status.

Rationale:
The rationale for this standard is based on the American College Health Association's non-discrimination policy that is applicable to all programs, guidelines, and standards endorsed by ACHA.

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