**Task Force on Student Health Insurance**

**Report and Recommendations**

The Task Force on Student Health Insurance was charged by Provost Jones to examine the current state and future of student health insurance at Penn State. Specifically, we were asked:

 *(1) To explore the interpretation of how the Affordable Care Act (ACA) applies to the Penn State student health insurance plan, using information provided by our insurer, Aetna, our consultant, Towers Watson, and, if necessary, other sources internal and external to the University.*

*(2) To examine factors that contribute to the rising costs of coverage independent of ACA, including plan utilization, review the short-term cost mitigation strategies proposed by the University and others, and recommend approaches to control costs and ensure equity and prevent hardship during the life of the existing student insurance contract with Aetna and that may be appropriate for future contracts.*

*(3) To review the longer term challenges and opportunities facing student health insurance at Penn State linked to rising health care costs and health reform, and to identify recommendations for the University to implement or explore with the goals of ensuring access to quality, cost-effective care for current and future students.*

During the course of our meetings, we have had the opportunity to review extensive information and discuss the recent events and future of student health insurance with representatives from University Health Services (UHS), the University’s benefits consultant from Towers Watson and representatives from Aetna, our current insurance provider. We have had the opportunity to examine survey results and other information provided by our student members and provided an opportunity for anyone in the University community to submit questions for us to review and study.

To explore aspects of the three charges more deeply and especially to respond to the critical third part of our charge, the Task Force decided to work as six committees to address the following areas:

 (1) Mental Health

 (2) Provider Network and Relationships

 (3) Health Insurance Requirements and Waivers

 (4) Process, Organization, and Engagement

 (5) Premiums and University Contributions

 (6) Plan Structure, Benefits and Coverage

Each committee was asked to provide a summary of the problem, a statement of recommendations for the University, and an explanation for the recommendations. The full Task Force held formal votes on the final draft of each recommendation and in areas where we do not find consensus, those holding minority views on the recommendations were given the opportunity to provide a short dissenting statement of opinion.

Our report provides an Executive Summary of the recommendations of the Task Force, followed by the full reports of each committee. Supplemental materials are available in appendices and/or on the web site established for the Task Force (<http://sites.psu.edu/tfonshi/>).

All members of the Penn State community should understand that the landscape for student health insurance, as for all health insurance in the United States, has fundamentally shifted with the passage and implementation of the ACA. In fact, it continues to shift; even as we completed our final report, the state of Pennsylvania announced its new agreement to expand public coverage for low income individuals through a Medicaid waiver expansion of subsidized private health insurance options. Young adults, once a group that had one of the highest levels of uninsurance and underinsurance in our nation, now have many new options available to purchase insurance. Some have new subsidies available to them to assist in the purchase of that insurance. All individuals are mandated by the law to have insurance or pay a penalty.

These changes have had and will have important impacts on students and families, UHS, and student health insurance at Penn State. The changes created by the ACA are just beginning and will play out over a decade or more as the health insurance exchanges and state Medicaid options develop, and additional aspects of the law are implemented. The recommendations provided are merely a start to what must be an ongoing process of monitoring the developments in health care and health insurance, assessing how Penn State’s UHS and Student Health Insurance office can best serve the needs of our students, and working with students, faculty, staff, and others to create and sustain a culture of health, transparency, and engagement in this area of our University.

**Executive Summary of Task Force Recommendations**

**Mental Health Committee Recommendations**

*Approved unanimously by the Task Force*

Penn State should pursue a public-health stance vis-à-vis student mental health concerns, at all campuses, to facilitate academic success and provide for the health and safety of the individual and community. This stance requires a multi-faceted approach involving multiple stakeholders that actively work to ensure access to a wide-range of services.

* Student health insurance plan: A proportion of Penn State students seek mental health care using the Penn State student health insurance, currently contracted through Aetna. To ensure access to mental health care via this mechanism, Penn State should:
	+ Eliminate hurdles to mental health care by pursuing a contract that minimizes out-of-pocket expenses. Specific attention should be paid to eliminating the mental health deductible and minimizing copays/coinsurance.
	+ Ensure that the provider network is sufficient to meet peak-period demand (during the academic year) by actively advocating for an accessible, clinically appropriate, and robust provider network of professionals known to work with students
	+ Ensure access to specialty care, such as psychiatry, by advocating for inclusion of providers who serve students and are within walking distance to campus
* Counseling and Psychological Services (CAPS): Although access to mental-health services via personal health insurance will continue to be a viable treatment option for some students, campus-based mental health services (e.g., crisis response, assessment, consultation, counseling, psychiatry, groups, referral services, case management, community education, etc.) with minimal hurdles to care, remains a critically important service option for all students.
	+ To ensure rapid access to short-term campus-based mental care (crisis response, evaluation, and time-limited treatment) for all when needed, we recommend that Penn State University expand CAPS services by implementing a Student Mental Health Fee to augment existing centralized funding. This fee should be applied/utilized at each campus and overseen by a committee of stakeholders.
	+ The expansion of campus-based mental health services (e.g., CAPS) will require additional office space that is easily accessible to students, facilitative of mental-health services, and near existing CAPS offices. We recommend that Penn State prioritize a flexible space solution for this purpose.
	+ To enable the recruitment and retention of qualified mental health providers, representative of the Penn State student population, in a competitive market and relatively isolated location, we recommend that Penn State perform a salary survey along with indicated salary adjustments for all current and future mental health providers employed by Penn State.

**Provider Network and Relationships Committee Recommendations**

*Approved unanimously by the Task Force*

The current recommendations pending approval from Penn State University, Hershey Medical Group (HMG) and Aetna are two-fold:

* Penn State and Aetna designate HMG as a preferred provider for primary care of Penn State student dependents (children under age 16 only) covered under the Aetna Student Health Plan. This designation would be similar to Aetna’s designation of UHS and Fishburn Clinic at Hershey as preferred providers for students and spouses and could provide 100% coverage for primary care visits for children.
* Penn State and Aetna should explore altering the coverage for pediatric visits so that dependent coverage is at 100% or as close as possible. Altering the plan structure to 100% coverage for primary care pediatric visits would be ideal; however, if that is not possible, Penn State should look into instituting a mechanism to achieve a similar result.

**Health Insurance Requirements and Waivers Committee Recommendations**

*Approved by a 16-1 vote of the Task Force*

Penn State should institute and enforce a requirement for adequate student health insurance such that all full-time students are required to enroll in the student health insurance plan or provide proof of health insurance with coverage in their Penn State community (i.e., “opt out”). The details of this policy, and its implementation, should be carefully developed over the next several years and coordinated with stakeholders and the ongoing Lion Path transition as the implementation will include data collection to identify those with insurance who would be waiver-eligible and *could* include Bursar Account charges for insurance premium costs.

**Process, Organization, and Engagement Committee Recommendations**

*Approved 15-0, with 2 abstentions, by the Task Force*

The committee has three primary recommendations for the University.

* The University should work to improve student knowledge and understanding of health insurance:
	+ Provide educational workshops to students and parents during orientation or other key periods (e.g. the commencement of each academic year or semester) to help them understand their insurance options, how student or other insurance works at the University, and the coverage and costs of the student health insurance plan
	+ The Student Insurance Administrative Council (SIAC) should provide at least two annual town hall meetings, one for undergraduates and one for graduate students, to share information, gather feedback, and answer questions concerning student health insurance.
	+ The SIAC should provide electronic updates of agenda and minutes on a Penn State public access website after each of their meetings
	+ Student and administrative representatives should plan at least one meeting with student government organizations, including, but not limited to University Park Undergraduate Association (UPUA), Graduate and Professional Student Association (GPSA), Commonwealth Campus Student Government (CCSG), and International Student Council (ISC) each year to discuss the progress of negotiations and any expected changes to student health insurance
	+ The University and Student Health Insurance office should seek to post costs and coverage details of the plan on their website by June 1st  of each year
	+ The Student Health Insurance office should use the document created by the Task Force on “[Guide to the Affordable Care Act and Health Insurance for Penn State Students](http://sites.psu.edu/tfonshi/wp-content/uploads/sites/13271/2014/06/ACA-Info-for-students.docx)”, and regularly update and make it available to students and parents electronically and in print form (see Appendix C).
	+ The University should either regularly communicate information to students about health insurance issues or should enable student government organizations to be able to communicate more easily to students via email
* The University should work to improve student engagement in the decision-making process regarding student health insurance.
	+ The University should improve involvement on and input to the SIAC through the development of formal appointments for representation of key groups on the SIAC. For example, the Office of Student Affairs might work with UPUA, CCSG and the ISC to appoint undergraduate student representatives and international student representatives; the Graduate and Professional Student Association might appoint graduate and professional student representatives in consultation with the Dean of the Graduate School.
	+ SIAC should meet monthly to review data from the insurer and address any ongoing student health insurance issues
	+ The University and SIAC should require that monthly premium, claims, cost, and other insurance data be archived under The Pennsylvania State University archival requirements
* The University should improve organizational structure and processes in the following manner:
	+ The University should contract on an ongoing basis with a health insurance consultant for contract and annual rate and benefit negotiations, allowing the SIAC to focus on assessing the proposals and taking advantage of the greater expertise of the consultant
	+ The University should require the consultant and insurer to present at least 2 options for contract and annual rate and benefit plans to SIAC no later than October 15
	+ The University should have student representatives from the SIAC share information on those proposals for discussion; student organizations may choose to express a preference for proposals through consensus, vote, or other forms
	+ The University should have SIAC make a final decision and forward a recommendation simultaneously to the Vice-President of Student Affairs, The Dean of the Graduate School and Senior Vice-President for Finance and Business by December 15. The Senior Vice-President for Finance and Business would be responsible for seeking budgetary and risk management consultation to be shared with the Vice-President of Student Affairs, who may also seek further consultation with the SIAC, student organizations, the Graduate School, and the health insurance consultant, as needed. The final decision on the insurance plan should be made by the Vice-President of Student Affairs no later than February 15 and communicated to all interested groups (UPUA, GPSA, CCSG, ISC, all undergraduate and graduate students, The Graduate School, UHS, the Student Health Insurance office, the SIAC, and the Vice-President for Business and Finance) as soon as possible following the decision.

**Premiums and University Contributions Committee Recommendations**

*Approved unanimously by the Task Force*

In order to mitigate students’ costs, the committee recommends that the University maintain, rather than decrease, contribution levels for students on graduate appointments moving forward.

Moreover, this committee recommends that graduate student organizations be consulted during the decision making process if contribution levels will be reevaluated in the future. Any decisions and/or information should be communicated to students in a timely fashion.

The committee further recommends that students’ experiences be incorporated to approach a plan design that minimizes future premium increases while limiting potential costly surprises in the form of coinsurance and emergency department costs.

**Plan Structure and Benefits Committee Recommendations**

*Approved unanimously by the Task Force*

* Decisions about the plan structure, benefits, and coverage would best be made with the help of consultants with the needed expertise. Penn State should obtain bids with various contract durations and coverage options such as coinsurance, copayments, deductibles, out-of-pocket limits and compare combinations of these coverage options in light of their corresponding premiums.
* Since insurance is so specialized, a consultant specializing not just in health insurance, but in student health insurance should be chosen by Penn State for designing and negotiating student health insurance.
* Since self-funding of student health insurance appears to be complex due to Pennsylvania law, Penn State should seek to obtain expert advice on how this would be accomplished and the costs and benefits of such an approach. This may include determining whether it could be in the University’s best interest to join other universities to encourage changes in Pennsylvania law to make self-funding easier.
* Annual decisions about plan benefits should not be made until the coverage and premium options obtained by the consultants are known and vetted through the SIAC and others. Penn State should maintain the current plan while exploring other options with consultants. Longer term, the University should continue to monitor the developments of the ACA market to assess whether offering student health insurance remains a sustainable approach.

**Report and Recommendations of the Task Force on Student Health Insurance**

**Background on Student Health Insurance Challenges**

In examining the reasons for the recent rise in costs and the application of the ACA to Penn State health insurance coverage, there appear to be a combination of events that led to the dramatic changes for 2014-15.

Penn State negotiated a new three year plan with Aetna covering the 2012-13, 2013-14, and 2014-15 years. The plan offered very comprehensive coverage for students and limited any premium increase in 2013-14 to less than 10 percent. To secure the comprehensive coverage and the limit on the rate increase for the second year, the University had to provide some contract flexibility for Aetna. That flexibility is in the form of what is known as “experience rating”, which means that Aetna can adjust Penn State’s premium based on the history of spending at Penn State. While the ACA restricts the factors that can be used to set insurance rates, student health insurers are permitted to base rates on “…a school-specific group community rate…” (78 FR 13424, February 27, 2013, <https://www.federalregister.gov/articles/2013/02/27/2013-04335/patient-protection-and-affordable-care-act-health-insurance-market-rules-rate-review>

Another reason for the change is the way the federal government has chosen to regulate student health plans under the ACA. The law requires that student health plans be regulated as individual health plans and meet the guidelines for actuarial value (AV), which represents the share of health care expenses the plan covers on average for a typical group of enrollees.

Penn State’s student health insurance plan was so generous that it exceeded the allowable AV under the ACA. The ACA requires plans to fall in one of four metallic tiers: Platinum (with AV between 88 and 92), Gold (AV between 78 and 82), Silver (AV between 68 and 72), and Bronze (AV between 58 and 62). Penn State’s plan was estimated to have an AV of more than 98 by the AV calculator that the federal government requires insurers to use to assess their plans. Thus, the law requires Aetna to reduce how comprehensive the benefits are in the plan. Benefits must comply with the requirement that the plan be designed to pay on average no more than 92 percent of an individual’s health care costs.

Ultimately, the cost increases are driven by a combination of ACA regulations, health care market trends, and Penn State experience, as shown in Table 1.

**Table 1**

Sources of premium increases for Penn State's Student Health Insurance Plan

|  |  |
| --- | --- |
| **Source of Premium Increases** | **Increase %** |
| New PPACA Taxes, Fees, and Mandated Benefits | 8% |
| Overall Health Care Cost Trend | 5-9% |
| Penn State Experience Rating | 15% |
| TOTAL | 28-32% |
| (Less benefit reductions required by PPACA) | (-10%) |
| FINAL PREMIUM INCREASE | 18-22% |

The ACA adds four taxes or fees to the cost of insurance. In addition, the ACA has required that new benefits be added to health plans. In addition to maintaining the preventive benefits added to the student health insurance plan last year, the 2014-15 plans adds pediatric dental and vision benefits and removes day/visit maximums from substance abuse treatment to comply with mental health parity requirements. The taxes, fees, and new mandated benefits represent an 8 percent increase in costs.

Industry analysts see underlying health care costs rising in 2014 and 2015, leading most insurers to assume cost trends in the 5-9 percent range in creating premiums for upcoming years (see Table 2).

Finally, student health care costs at Penn State have been higher than projected by Aetna. The experience rating in the contract allows Aetna to adjust the premium for that higher than projected level of costs and adds about 15 percent to the cost of our insurance. Factoring in the benefit reductions required by ACA, the estimated increase in costs due to the factors outlined falls in the range of 18 to 22 percent.

**Table 2**

Projections of 2014 Health Care Cost Increases

|  |  |
| --- | --- |
| **Organization** | **Projection** |
| [Center for Medicare and Medicaid Services1](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html)  | 6.7% |
| [Milliman Medical Index](http://www.milliman.com/mmi/http%3A/) | 5.4% |
| [Altarum Institute](http://altarum.org/health-policy-blog/why-health-spending-is-not-on-a-10-growth-path-for-2014) | 6-7% |
| [PwC](http://www.pwc.com/us/en/health-industries/behind-the-numbers/key-findings.jhtml) | 6.5% |
| [Towers Watson](http://www.towerswatson.com/en-US/Insights/IC-Types/Survey-Research-Results/2013/09/2013-Health-Care-Changes-Ahead-Survey) | 6.7% |
| [Buck's](http://www.reuters.com/article/2014/05/15/ny-buck-consult-xerox-idUSnBw155153a%2B100%2BBSW20140515) | 8.7% |
| [Mercer](http://www.mercer.us/press-releases/1557830) | 7% |
| [Aon Hewitt](http://aon.mediaroom.com/2013-10-17-Aon-Hewitt-Analysis-Shows-Lowest-U-S-Health-Care-Cost-Increases-in-More-Than-a-Decade) | 6.5% |

Many of the recent forces driving the changes in student health insurance are not easily within our control. However, there are a number of steps that can be taken by our University community to better address the challenges in this area. For example, as the Task Force noted on its web site, other universities anticipated the many questions that students and parents would have regarding the ACA, their employer plans, the health exchanges, and the student health insurance plan. These universities created print and web media to address frequently asked questions related to the law and how it impacted students. Penn State provided no guidance to students and their families in this way.

Using resources from these other universities and from other sources, the Task Force developed an FAQ to help guide students and families on the complex issues surrounding health insurance. The document, “Guide to the Affordable Care Act and Health Insurance for Penn State Students”, is incorporated on our web page at <http://sites.psu.edu/tfonshi/information/> and included here as Appendix C; it can serve as a draft for UHS and the Student Health Insurance office to revise further for Penn State students and families. While providing information like this will not solve the problem of rising health care costs, assisting families and students in understanding these choices is part of our mission and support that should be provided.

The next section of our report provides the report of each of our six committees on their identification of the problem, their recommendations for addressing the problem, and an explanation of that recommendation.

## Mental Health Committee

**Problem:**

The mental health of college students is critical to their academic success as well as the health and safety of the Penn State community. The supply of appropriate, accessible, and affordable mental health services is currently insufficient to meet the demand at Penn State – both at University Park and many commonwealth campuses. Students require access to a wide variety of mental health services including campus-based services (i.e., CAPS), insurance-based community services (counselors, psychologists, psychiatrists), county/state/federal programs (e.g., Medicaid, medical assistance, etc.), and county-based crisis services (e.g., CAN Help, emergency room, etc.).

**Recommendations/Explanations:**

Penn State should pursue a public-health stance vis-à-vis student mental health concerns, at all campuses, to facilitate academic success and provide for the health and safety of the individual and the community. This stance requires a multi-faceted approach involving multiple stakeholders that actively work to ensure access to a wide-range of services.

* Student health insurance plan: A proportion of Penn State students seek mental health care using the Penn State student health insurance, currently contracted through Aetna. To ensure access to mental health care via this mechanism, Penn State should:
	+ Eliminate hurdles to mental health care by pursuing a contract that minimizes out-of-pocket expenses. Specific attention should be paid to eliminating the mental health deductible and minimizing copays/coinsurance.
	+ Ensure that the provider network is sufficient to meet peak-period demand (during the academic year) by actively advocating for an accessible, clinically appropriate, and robust provider network of professionals known to work with students
	+ Ensure access to specialty care, such as psychiatry, by advocating for inclusion of providers who serve students and are within walking distance to campus
* Counseling and Psychological Services (CAPS): Although access to mental-health services via personal health insurance will continue to be a viable treatment option for some students, campus-based mental health services (e.g., crisis response, assessment, consultation, counseling, psychiatry, groups, referral services, case management, community education, etc.) with minimal hurdles to care, remains a critically important service option for all students.
	+ To ensure rapid access to short-term campus-based mental care (crisis response, evaluation, and time-limited treatment) for all when needed, we recommend that Penn State University expand CAPS services by implementing a Student Mental Health Fee to augment existing centralized funding. This fee should be applied/utilized at each campus and overseen by a committee of stakeholders.
	+ The expansion of campus-based mental health services (e.g., CAPS) will require additional office space that is easily accessible to students, facilitative of mental-health services, and near existing CAPS offices. We recommend that Penn State prioritize a flexible space solution for this purpose.
	+ To enable the recruitment and retention of qualified mental health providers, representative of the Penn State student population, in a competitive market and relatively isolated location, we recommend that Penn State perform a salary survey along with indicated salary adjustments for all current and future mental health providers employed by Penn State.

**Provider Networks and Relationships Committee**

**Problem:**

University Health Services (UHS) can only accept patients who are 16 years of age or older, which means that students with dependents must seek healthcare outside of UHS for their children. Given the structure of the Aetna student health insurance plan, where visits at UHS are covered at 100% and do not apply to the deductible, students and dependents age 16 and over can obtain healthcare at substantially lower costs than the younger dependents of students. Since dependents under the age of 16 must be seen at primary care offices outside of UHS, their healthcare costs will only be covered at 90% (except for preventive services that are covered at 100%) and those costs must first go toward the family deductible of $500 before 90% is covered. Due to the new plan structure, students with dependents under age 16 will have significantly higher healthcare costs for the upcoming 2014-2015 plan.

**Recommendation**:

The current recommendations pending approval from Penn State University, Penn State HMG and Aetna are two-fold:

* Penn State and Aetna designate HMG as a preferred provider for primary care of Penn State student dependents (children under age 16 only) covered under the Aetna Student Health Plan. This designation would be similar to Aetna’s designation of UHS and Fishburn Clinic at Hershey as preferred providers for students and spouses and could provide 100% coverage for primary care visits for children.
* Penn State and Aetna should explore altering the coverage for pediatric visits so that dependent coverage is at 100% or as close as possible. Altering the plan structure to 100% coverage for primary care pediatric visits would be ideal; however, if that is not possible, Penn State should look into instituting a mechanism to achieve a similar result.

**Explanation:**

The goal is to provide an option for students with dependents under age 16 to obtain 100% coverage for those dependents regardless of where they are seen, just as is available at UHS for dependents and spouses age 16 and over. Penn State HMG in State College is fully staffed to handle the influx of approximately 400 dependents covered under the Aetna student health insurance plan. Penn State HMG has 12 Family Physicians (care of newborn to elderly), 1 pediatrician (care of newborns to 21 with 20% of time devoted to general pediatrics and 80% to eating disorders), 3 family nurse practitioners (care of newborn to elderly) and 1 physician assistant (care of newborn to elderly).

This recommendation requires additional research, legal clarification, and specific discussions with Aetna to determine how any changes in plan structure may alter the AV of the plan. The incorporation of 100% coverage for primary care pediatric visits may alter the AV of the plan too much. Some options have already been explored by the Task Force, such as the provider (HMG) waiving deductibles, co-insurance, and/or copayments; however, waiving out-of-pocket fees is not a viable alternative.

Additional research needs to be undertaken, including Aetna modeling this new plan structure to determine the impact to the metal tier threshold. If changing dependent coverage to 100% alters the AV value too much, then other alternatives for dependent coverage and care can be explored, such as incorporation of co-pays for primary care pediatric visits. Furthermore, the incorporation of co-pays in lieu of deductibles and coinsurance for primary care pediatric visits may help lessen the financial burden and uncertainty for all, including those students who choose to have their children seen elsewhere. Many students may not be willing to switch to Hershey Medical Group due to prior relationships established with a different pediatrician/pediatric group. An insurance consultant will have expertise in plan design and can help craft an ideal plan.

**Problem:**

When the task force began its work, UHS only accepted the Aetna student health plan insurance, and did not accept other insurance plans. Healthcare for students who did not have the Aetna plan could have been limited due to out-of-pocket expenses. Since that time, UHS has contracted with many of the large carriers and will accept health care insurance from Aetna, Cigna, United Health Care, and Highmark Blue Shield. UHS will also bill PA Medical Assistance and TriCare. They are still working on a contract with UPMC.

**Recommendation:**

No recommendation needed as problem has been resolved.

**Student Health Insurance Requirement and Waiver Committee**

**Problem**

* Uninsured and underinsured – Rapid and reliable access to health/mental health services is dependent on each student securing health insurance that (a) covers the needed services via (b) a sufficiently large provider network within the Penn State community of residence. Penn State and State College health/mental-health-care providers struggle each year to help a set of students who have no insurance, or insufficient insurance, and are unable to access necessary medical services as a result. The lack of appropriate health insurance is a potentially serious problem that can be easily identified and pro-actively remedied prior to matriculation. This remains true even with the ACA because students can elect to pay a fine rather than purchasing insurance or may purchase health insurance that does not provide adequate coverage in Penn State communities.
* Premium costs – Many factors contribute to health insurance premium costs. However, the number of students covered by a student health insurance plan is one of the few factors that can substantively decrease premiums for all while also stabilizing premium levels from year to year. The Penn State student health insurance premiums have gone up, in part, due to unstable and/or relatively low overall enrollment levels, as a percentage of the total student population.

**Recommendation:**

Penn State should institute and enforce a requirement for adequate student health insurance such that all full-time students are required to enroll in the student health insurance plan or provide proof of health insurance with adequate coverage in their Penn State community (i.e., “opt out”). The details of this policy, and its implementation, should be carefully developed over the next several years and coordinated with stakeholders and the ongoing Lion Path transition as the implementation will include data collection to identify those with insurance who would be waiver-eligible and *could* include Bursar Account charges for insurance premium costs.

**Explanation:**

Many universities require that all students purchase the student health insurance plan or provide proof of an alternate/adequate health insurance (i.e., a student health insurance requirement) to avoid the problem of uninsured or underinsured students experiencing serious academic/health/financial consequences from unexpected medical expenses.

The task force discussed a wide variety of ideas to ensure that all students have the necessary coverage while avoiding undue burdens on students. While exact numbers of uninsured or underinsured students cannot be known from currently available data, there is no question that this problem exists (via the experience of Penn State health care providers and administrators) with very serious (and usually unexpected) financial/academic consequences for some students and the community resources required to assist those impacted by health events.

Current Penn State policy already implements a student health insurance requirement for F-1 and J-1 international students and College of Medicine students. Enforcement is accomplished via registration holds and retroactive billing for the insurance premiums. Graduate assistants are enrolled automatically in the health plan, but most domestic graduate assistants have the choice to opt out. Other students, including domestic undergraduate and professional students, are not subject to a student health insurance requirement (absent the existence of program-specific requirements). In sum, insurance requirement policies already exist at Penn State, but they are implemented in an inconsistent manner and only for a subset of students.

In addition to ensuring access to necessary health care for those without sufficient health insurance, a student health insurance requirement has the added benefit of reducing premium expenses for both individual students and the University. Both Aetna and Towers Watson have indicated that increased enrollment in the student health insurance plan and the reduction in the relative risk pool with a strict requirement can reduce premiums. Aetna has indicated that other universities which instituted a student health insurance requirement commonly saw substantial reductions in premium rates as a result of increased enrollment.

Implementing a student health insurance requirement will entail additional administrative resources (proactive education for all affected, billing, and opt-out verification procedures). However, student health insurance requirements are in widespread use at other institutions, Penn State can benchmark with peer institutions, and can rely on both consultants and insurance providers who have years of experience managing such policies and plans.

If this recommendation is implemented, Penn State should continue to monitor the student health insurance situation. The insurance requirement and waiver process could be used to gather information on student insurance coverage, providers, and network access to better understand the problem of uninsured and underinsured students. Penn State should also seek full actuarial estimates of the likely premium reduction from an insurance requirement and waiver policy. In addition, because of the implementation of the ACA, a monumental change to the landscape of health insurance, Penn State also should undertake a campaign aimed at educating students about their options and raising awareness of potential costs of being uninsured or underinsured.

In developing the new insurance requirement and waiver policy, Penn State should seek consultation with student government representatives of the affected populations (e.g., UPUA, CCSG, ISC, and GPSA). Other universities have developed excellent resources for students to use in providing proof of adequate health insurance (e.g., see Ohio State’s page on adequate insurance <https://shi.osu.edu/coverage-comparison-tools/>) and can offer good models for students and administrators to consider in the development of a Penn State solution.

**Student Health Insurance Requirement and Waiver Dissenting Opinion**

Spencer Carran

Imposing a new requirement that students be automatically enrolled in PSU’s plan unless they are able to demonstrate coverage elsewhere is both unnecessary and harmful.

There is little indication that there is a large population of uninsured Penn State students posing a burden to local emergency services, and with the multiple avenues of expanded insurance coverage under the ACA this problem, to the extent that it exists, is indisputably going to grow smaller, not larger, in the coming years even without intervention by Penn State. Therefore, the additional bureaucratic imposition of a new insurance requirement is unnecessary. Further, it is irresponsible to recommend sweeping new policies aimed at a addressing a problem whose scope is currently unknown.

By automatically enrolling students in the Aetna plan, there is the risk that many students will be enrolled in, and charged for, insurance that they do not need. Many new students, particularly first generation college students, may not have a sufficient understanding of insurance to complete the opt-out process or adequate support in navigating their options. Given that Penn State has recently received negative attention in the national press for high levels of graduate indebtedness and is the second most expensive public university in America, any policy that increases the cost of attendance further must be regarded as highly undesirable. Particularly for unsubsidized students (undergraduate, professional, and some graduate), the high cost of the student insurance plan through Aetna relative to alternatives available on the ACA Marketplace make the recommendation to, by default, enroll all students in a much more expensive plan than most are likely to need, and which may be redundant with coverage they already have, highly inappropriate. The impact of a hard waiver policy will be to impose a substantial new financial burden on students for uncertain gains.

**Process, Organization and Engagement Committee**

The Committee reviewed the recent events related to Penn State’s student health insurance, benchmarked against peer institutions, and gathered information from University officials to seek an understanding of the organizational structures and processes related to student health insurance and the engagement of key stakeholders in the decision-making.

**Problem**

*General Process and Structure*:

At Penn State, the organization and process for the student health insurance plan is similar to one model used by some – not all – of our peer institutions. The office with formal responsibility for the student health insurance plan, the Student Health Insurance office is a unit within UHS. Student Health Insurance reports to a Senior Associate Director within UHS, who reports to the Director of UHS, who in turn, reports to the Vice President of Student Affairs. Finally, two groups with student representation are, potentially, part of the organization and process: the Student Insurance Advisory Board and the Student Insurance Administrative Council.

The Student Insurance Advisory Board (SIAB) is a group invited by the Student Health Insurance office to participate in regular meetings with the office. Those invitations are sent to student groups at the beginning of each semester. A second group, the Student Insurance Administrative Council (SIAC), has administrative representation from the University Office of Global Programs, the Corporate Controller’s Office, the Registrar’s Office, the Office of Risk Management, the Office of Employee Benefits from the Office of Human Resources, the Dickinson School of Law, the Graduate School, and the College of Medicine. Student representatives are invited from the Graduate and Professional Student Association (GPSA)[[1]](#footnote-1), the University Park Undergraduate Association (UPUA), the International Student Council (ISC), the College of Medicine Student Assembly, and other international clubs at the University Park campus to participate on the Student Insurance Advisory Board (SIAB) and the SIAC.

While the opportunity for students to participate in an advisory role is present through the SIAB and SIAC, most student organizations invited to participate do not respond. Since there is no formal appointment or election of an individual to the role of representative to the SIAB in most organizations, the organizations must actively seek a volunteer. Effectively, the SIAB is inactive. In addition, the GPSA is the only organization that has regularly participated in the SIAC, with little participation by UPUA representatives or other student groups. Thus, while students are invited to participate, there are few formal mechanisms to ensure that students are involved, and in practice, only GPSA has consistently represented students. The lack of broader student interest in these groups has been suggested to be the result of students benefiting from a robust plan. Involvement was not seen to be necessary, as there were minimal complaints from the student body.

For most decisions, the Student Health Insurance office operates similar to other units in the university. Budget, human resources, etc. plans and decisions were made in the unit, reviewed and approved by the Senior Associate Director, then the Director, and then the Vice-President for Student Affairs, and incorporated in plans for Student Affairs for central administration.

The decisions about the student health insurance plan, on the other hand, follow a different process. The manager of the Student Health Insurance office and the Senior Associate Director were responsible for negotiating the details of the student health insurance plan with outside insurers. They relied on consultation with the SIAC during that process, allowing them to gather feedback from the GPSA representative, as well as others at the University who could provide perspectives from international students, expertise on financial, budgetary, human resources, graduate and professionals school and risk issues.

After review and approval by the Vice-President of Student Affairs of the preliminary plan and premium, the initial goal of the process was the delivery in December to the University’s administration of an estimated premium for use in preliminary University budgets to assess the cost of the subsidy for insurance for Graduate Assistants. An estimated premium was usually delivered by the insurer to the Student Health Insurance office by November, leaving a small amount of time for adjustments to the plan design and premium prior to the deadline for the University’s administration.

Once the University’s administration provides guidance on the premium estimate, the Student Health Insurance office would finalize contract details with the insurer. The contract would be reviewed and signed by the Office of Risk Management. The process was usually targeted to be completed by April, leaving the office approximately 2-3 months to prepare materials for student arrivals in July and August, and allowing academic units to finalize their budgets for Graduate Assistant support over the summer. Other than what is described, there is no formal role for or approval of the student health insurance plan by the leadership in UHS, Student Affairs, the Graduate School, or other units. There is also no other role for or consultation with students or student groups.

*Weaknesses:*

Some of the weaknesses of this structure and process are evident through a review of the timeline during the 2013-14 period (see Appendix A). The Student Health Insurance office had negotiated a three-year contract with Aetna for the period covering academic years 2012-13, 2013-14, and 2014-15. Aetna provides monthly reports to the Student Health Insurance office tracking premiums, spending, and other data. Late in the 2012-13 period, medical spending, which had shown a medical loss ratio (MLR, or the percent of the premium paid that is spent on health care) of under 80% as late as April 2013, began to outpace significantly the premiums collected. Higher levels of spending in a health insurance plan will generally trigger a premium increase. By this time, however, Aetna and Penn State had already negotiated premiums and benefits for 2013-14, and Penn State was already preparing materials for students.

While Aetna had sought a premium increase greater than 10 percent for 2013-14 because of new ACA taxes and fees, Penn State held the Aetna contract premium increase to under 10% for the second year of the contract, a limit that the original contract allowed. If information about the high level of medical spending were evident sooner, it’s possible that Penn State could have negotiated a reduction in benefits or a greater increase in premiums for the 2013-14 plan year to begin to address the issue. At the time decisions were made, however, that information was not available, and Penn State chose to enforce the negotiated limit on the premium increase and to maintain the comprehensive benefit levels.

While the high level of spending toward the end of the 2013-14 plan year signaled the possibility of a higher premium for 2014-15, a number of factors, in addition to the underlying variation in number of persons covered by the plan and medical spending, made for great uncertainty about the complete impact of that information, including the following:

* This was the first contract Penn State had held with Aetna, after many years where student health insurance was provided by United HealthCare Student Resources (UHCSR).
* This was the first time under the new Aetna contract that Penn State’s actual medical spending experience would factor into determination of the premium.
* This was a new type of student health insurance contract, with more comprehensive coverage than the former contract with UHCSR, which was classified as accident and sickness insurance.
* New ACA regulations were mandating new benefits to be covered and adding new taxes and fees with uncertain impact on the premium costs.
* There was uncertainty about whether student health insurance plans had to comply with metallic tier levels in ACA, and what their impact would be on benefits and costs.
* Decisions on claims and payment of claims often extend several months after the end of the plan year, as insured individuals and their health care providers submit information on the care received. With a student insurance plan-year ending in August, the insurer is still resolving claims often through the end of the calendar year.

While the detailed impact of these uncertainties may not have been completely predictable, the University also did not appear to prepare for the important changes from ACA that were clearly developing or seek professional consultation on student health insurance about the potential effects and possible strategies to deal with those effects. As a result, the full dimension of the problem, a 40 percent increase in premiums to maintain the current benefits, initially became evident to the Student Health Insurance office, the SIAC, and the GPSA only during the fall semester of 2013. During the next 2-3 months, those three groups shared information with each other and tried to work together to have Aetna estimate the impact of various changes in student health insurance benefits to reduce the overall premium increase, while still protecting students from health care cost burdens.

While there was no effort to hide information (the issue was openly discussed at GPSA Assembly Meetings, open to students, in November, December, January and February and at the SIAC meeting, where student representatives attend), all three groups (Student Health Insurance office, SIAC, and the GPSA) chose to wait to communicate the information more actively and publicly to others, except through the premium estimate needed for preliminary University budget estimates, until more details about the final contract structure, including benefits and premiums, were received. With few student groups well represented at these meetings and a clear set of challenging problems coming to a head, an earlier effort to engage student leaders and student groups and communicate about these issues was needed.

The insurance plan information was finalized and communicated by Aetna in February, at which point GPSA shared the details by email with all graduate and professional students. No administrative group or student organization took on leadership for communicating about the issue with undergraduate students or other key student constituencies. At this point the Student Health Insurance office was still waiting on the University’s administration for guidance on the premium increase; hence, no communications were planned by them until that information was received. Student Health Insurance office materials and web site information are typically revised in the April-June period for communication to students arriving in July and August. This process of communication was one that had been followed in past years, but the unusual events clearly necessitated something other than business as usual.

The subsequent concerns that were raised by students after GPSA’s communication led to the involvement of senior University leadership in mid-March. The GPSA organized a Town Hall meeting with relevant senior administrators for students to learn more about the changes and ask questions. In response to concerns raised by students, the Graduate School, Office of Budget and Finance, and Student Affairs worked with Provost Jones and then President Rodney Erickson to put together a response that included the involvement of the University’s current benefits consultant, Towers Watson, to assist in final contract negotiations; guaranteeing a 3 percent increase in Graduate Assistant stipends and increases in premium subsidies for dependents; efforts to identify additional funding for mental health services; cost mitigation for hardship situations; and finally, the creation of a Task Force to examine student health insurance.

At the town hall, in later communications, and at the May Board of Trustees meeting students asked for further information on the reasons underlying the changes, details on the current contract, as well as, the ongoing contract negotiations. While information on some issues, like the ACA impact, was communicated well, other information was not communicated clearly, if at all.

Perhaps the best example of this lack of communication was the frequent student requests for information about the timeline for when plans needed to be finalized. Individuals not deeply involved in the process may assume that everything needs to be ready by early August, when international students begin to arrive for the fall semester and undergraduate students arrive shortly after that time. But, plan materials and documents need to be ready no later than mid-July to be ready for the arrival of medical school students also covered under the plan. And staff in the Student Health Insurance office estimate 45-60 days are needed to prepare materials, meaning benefits and premiums need to be finalized in the contract no later than mid to late May.

That timeline, although not the exact dates, appears to have been communicated between the Student Health Insurance office, SIAC, and GPSA. The February minutes for the GPSA Assembly indicate decisions must be made by the end of the semester. Penn State senior leaders, however, seemed unaware of this timeline at the March Town Hall and nearly 6 weeks later at the Board of Trustees meeting. At the Town Hall, a student asked a question about the timeline, and none of the panel members were able to answer the question. The Student Health Insurance manager responded from the audience reminding everyone that the plan needed to be in place for the College of Medicine students by mid-July, but no one clarified what this meant for signing the contract. Similarly, the question regarding the timeline was raised during the public comment at the Board of Trustees, and a response was given that the deadline was August 1. Some students then sent a letter on May 12 requesting clarification to the Office of Student Affairs. One day later, the rate binder, establishing benefits and premiums for 2014-15, was signed by the Office of Risk Management.

The absence of timely, clear, reasonably complete communication of information creates an environment where rumors flourish and distrust grows. Individual students and student groups may begin to try to fill information gaps, which could result in inaccurate, misleading, or incomplete information reaching the student population. This happened with regard to the contract timing, the multiplier adjustment to the medical loss ratio, the self-funding of employee versus student benefits, the ability of students to access ACA exchanges and other topics, and the University either did not have or did not share information as quickly, as clearly, or as completely as students would have liked.

In some cases, this may have been because the University could have better prepared for the ACA changes and did not have complete information. In others, there may have been uncertain information and a dynamic environment that made communication challenging. In some areas, confidentiality and disclosure agreements may have limited what the University can communicate. In some cases, the division of responsibility across multiple University offices and the lack of familiarity with the overall process for student health insurance may have made it unclear who or what should be communicated by which office. No matter the reasons, the organization, process and engagement weaknesses should be addressed.

**Research and Outreach:**

*Comparison to our peers:*

Student members of the Task Force sampled some of the Big 10 schools to find out:

* What is their general process for choosing a contract and what offices and groups are involved?
* How are students engaged in the process of choosing a contract?
* And what timeline is used for choosing a contract?

At Michigan State University, the Office of Human Resources contracts with an insurer (currently, Aetna Student Health) to provide student health insurance. A Base Plan is available to students who are not Graduate Assistants and their dependents. A Graduate Assistant Plan is available to graduate assistants and their dependents. The Graduate Employees Union at Michigan State engages in collective bargaining with the University to establish certain aspects of coverage and University contributions to premium costs. Michigan State pays for 100 percent of the Graduate Assistant’s premium, 64.9% of a child dependent’s premium, 41.5% of the premium for multiple child dependents, 35.6% of a spouse dependent’s premium, 20.2% of the premium for a spouse and child dependent, and 17.9% of the premium for a spouse and multiple child dependents.

Ohio State University utilizes a Student Health Insurance Advisory Committee (SHIAC), which contains students and administrators. The SHIAC makes recommendations for the student health insurance plan to the student health insurance office. They use Aetna Student Health. This committee falls under the purview of the Office of Student Life. Student Life assigns student representatives to the SHIAC. The committee meets starting in late September through mid-Spring semester. Ohio State tried to stay abreast of the changes related to the ACA early on so that they could make slower - less abrupt - changes over time (so as to not experience a major dramatic change this year). This committee also has subcommittees that look at specific issues. They utilize actuarial and medical students to assist with these subcommittees.

Purdue University has a contract negotiated by the Office of Human Resources with United Healthcare offering three plans for students—a plan for undergraduate students and unfunded graduate students, a plan for funded graduate students, and a plan for graduate students on fellowships. According to the Graduate Student Government president, students are very satisfied. The process for choosing a contract for funded graduate students begins when Human Resources (HR) meets with the Graduate Student Government (GSG) in February and tells them the rates they expect to see in the coming year, and asks the GSG for input. GSG uses their executive board and other committee representatives to look at the plan and tell the University what they want. They can consult with a legal team through the University, if needed. HR will put whatever GSG wants into the plan as long as they are willing to pay for it. The GSG also passes endorsements of what they want changed each year. Students bring concerns before the GSG senate for consideration (e.g. birth control, transgender surgery, pet insurance). An annual town hall forum is held near the beginning of the year to explain health insurance to new students (this is open to all students, not just new graduate students).

At the University of Illinois at Urbana-Champaign, graduate students belong to a union, called the Graduate Employees' Organization (GEO).  The main focus of the GEO during the last contract negotiation was to receive health insurance premium subsidies for students and their dependents, which they received.  Unfortunately, the union has been largely unsuccessful in being incorporated into decision processes regarding the student health insurance plan.  They have participated in gathering concerns through self-distributed surveys that they share with the University, and they participate in organizing annual town hall meetings to relay information to and from the administration on health care issues.  Both of these processes are only informal, though, and final decisions of insurance providers and plan structures are made solely by University administration.  By all accounts, UIUC students feel that this current structure provides ineffective communication and plan design for them.  Obtaining formal representation on decision-making committees is a primary goal for the GEO's next contract.

In addition to these efforts to contact student organizations at other universities, UHS provided a table comparing Penn State’s student health insurance to plans at other Big Ten universities. Towers Watson also provided a table comparing Penn State’s student health insurance to other universities with whom they consult. These tables are available in our appendices.

*Internal information gathering:*

The Graduate and Professional Student Association has been meeting with students informally, as well as collecting feedback through a survey posted by the GPSA. Students have voiced the following main views:

* Desire for more email communication with more thorough updates regarding changes to their health insurance (coverage, costs, etc.),
* Strong interest in wanting students to be a bigger part of the process,
* Educational/information session at the start of each year for all students who are interested in learning about how their insurance works and what is covered,
* Disappointment in administration and the GPSA not informing students earlier.

A final issue is the process for approving the student health insurance contract. Policy FNG02 of the Penn State Policy Manual (found in GURU) allows for limited delegation by the Corporate Controller’s office of the authority to approve contracts. The Controller has delegated responsibility for approving insurance policy documents including, applications, endorsements, coverage, and proof of loss, to the University Risk Officer. Although the University Risk Officer is a member of the SIAC, he is not involved in negotiating the student health insurance contract and typically receives requests from the Manager of Student Health Insurance to sign contracts and other documents. Recently, the Risk Management Officer has requested that he receive confirmation from the Vice President of Student Affairs that he concurred in the Student Health Insurance office’s decision to renew/modify a plan which required the Risk Management Officer’s delegated signature.

**Recommendations:**

The committee has three primary recommendations for the University.

* The University should work to improve student knowledge and understanding of health insurance:
	+ Provide educational workshops to students and parents during orientation or other key periods (e.g. the commencement of each academic year or semester) to help them understand their insurance options, how student or other insurance works at the University, and the coverage and costs of the student health insurance plan.
	+ The SIAC should provide at least two annual town hall meetings, one for undergraduates and one for graduate students, to share information, gather feedback, and answer questions concerning student health insurance.
	+ The SIAC should provide electronic updates of agenda and minutes on a Penn State public access website after each of their meetings.
	+ Student and administrative representatives should plan at least one meeting with student government organizations (including, but not limited to UPUA, GPSA, and CCSG) each year to discuss the progress of negotiations and any expected changes to student health insurance.
	+ The University and Student Health Insurance office should seek to post costs and coverage details of the plan on their website by June 1st  of each year.
	+ The Student Health Insurance office should use the document created by the Task Force on “Insurance Information for Penn State Students”, and regularly update and make it available to students and parents electronically and in print form.
	+ The University should either regularly communicate information to students about health insurance issues or should enable student government organizations to be able to communicate more easily to students via email.

**Explanation**:

A number of the problems from the past stem from a lack of ongoing and timely communication between those involved in negotiating the student health insurance contract and students. These recommendations outline some basic expectations for units in the University to maintain regular communication with a wider group of students to ensure that important information is shared in both directions.

* The University should work to improve student engagement in the decision-making process regarding student health insurance.
	+ The University should improve involvement on and input to the SIAC through the development of formal appointments for representation of key groups on the SIAC. For example, the Office of Student Affairs might work with UPUA, CCSG, and the ISC to appoint undergraduate student representatives and international student representatives; the Graduate and Professional Student Association might appoint graduate and professional student representatives in consultation with the Dean of the Graduate School.
	+ SIAC should meet monthly to review data from the insurer and address any ongoing student health insurance issues.
	+ The University and SIAC should require that monthly premium, claims, cost, and other insurance data be archived under The Pennsylvania State University archival requirements.

**Explanation**:

The current informal process of soliciting student involvement in the SIAB and SIAC has not garnered adequate representation and engagement of important student groups. Having appointments come through important student groups and confirmed by senior levels of administration may create a stronger environment for engagement. Access to key data will improve the ability of students involved in the process to participate in meaningful ways.

* The University should improve organizational structure and processes in the following manner:
	+ The University should contract on an ongoing basis with a health insurance consultant for contract and annual rate and benefit negotiations, allowing the SIAC to focus on assessing the proposals and taking advantage of the greater expertise of the consultant.
	+ The University should require the consultant and insurer to present at least 2 options for contract and annual rate and benefit plans to SIAC no later than October 15.
	+ The University should have student representatives from the SIAC share information on those proposals for discussion; student organizations may choose to express a preference for proposals through consensus, vote, or other forms.
	+ The University should have SIAC make a final decision and forward a recommendation simultaneously to the Vice-President of Student Affairs, The Dean of the Graduate School, and Senior Vice-President for Finance and Business by December 15. The Senior Vice-President for Finance and Business would be responsible for seeking budgetary and risk management consultation to be shared with the Vice-President of Student Affairs, who may also seek further consultation with the SIAC, student organizations, the Graduate School, and the health insurance consultant, as needed. The final decision on the insurance plan should be made by the Vice-President of Student Affairs no later than February 15 and communicated to all interested groups (UPUA, GPSA, CCSG, ISC, all undergraduate and graduate students, The Graduate School, UHS, the Student Health Insurance office, the SIAC, and the Vice-President for Business and Finance) as soon as possible following the decision.

**Explanation**:

The primary weaknesses in the current approach identified by the committee included the lack of ongoing expertise through consultation and the lack of a clear process for decision-making and communication regarding a decision. To address these concerns, the committee proposes that the consultant be the University’s primary representative in negotiations with health insurers. Other University’s use their Office of Human Resources or a combination of Human Resources and Student Insurance Office for negotiations, which also may be an approach to consider; however, the expertise of a consultant with broad experience across the industry specializing in student insurance may be the best approach.

Ideally, the consultant and insurer can present at least two options to the SIAC early enough in the fall semester to allow student representatives to consult with their broader organizations. The current time frame, with contract information often not available until November for SIAC, makes it difficult to engage students during the busy November-December period. Student representatives and organizations then would have up to 2 months for consultation and feedback prior to a recommendation.

The lack of clear formal authority for approval also represents a current weakness in the system. The committee believes that final authority rests with the Office of Student Affairs, since the Student Health Insurance office, as part of UHS, rests under the control of the Vice-President of Student Affairs. SIAC, as the administrative body responsible for examining the options, should forward their recommendation to the Vice-President for Student Affairs. Because the insurance choices have implications for both graduate programs and the University budget, that recommendation should be simultaneously communicated to the Graduate School and the Senior Vice-President for Finance and Business. The Dean of the Graduate School would then be expected to gather any input from graduate programs, while the Senior Vice-President for Finance and Business would address any budgetary or risk management issues. In addition to this information, the Vice-President for Student Affairs would be able to seek consultation from other groups in making a final decision by the deadline.

**Premiums and University Contributions Committee**

**Problem**:

Penn State has historically subsidized the health insurance premium costs of Graduate Assistants and fellows and trainees on University appointments. Prior to 2014-15 the subsidy had been set at 80% for the student and 70% for dependents and families. Beginning in 2014-15, the subsidy level for dependents was increased to 75% and to 76% for family coverage.

**Recommendation**:

In order to mitigate students’ costs, the committee recommends that the University maintain, rather than decrease, contribution levels moving forward.

Moreover, this committee recommends that graduate student organizations be consulted during the decision making process if contribution levels will be reevaluated in the future. Any decisions and/or information should be communicated to students in a timely fashion.

The committee further recommends that students’ experiences be incorporated to approach a plan design that minimizes future premium increases while limiting potential costly surprises in the form of coinsurance and emergency department costs.

**Explanation:**

Penn State subsidy contribution levels are comparable to similar institutions (see data in Appendix B). While some institutions offer higher contributions for student premium costs, this is commonly in lieu of offering substantial contributions to dependents. In the event that the University was to allocate a meaningfully larger proportion of subsidy contributions to graduate assistants, contributions for dependents could potentially decrease dramatically since dependents comprise a relatively smaller proportion of the plan. The recent increase in contributions for dependents was instated to mitigate costs and financial risk to students with families, and the committee does not recommend reversing this decision.

The maintenance of a high subsidy level for both graduate assistants and their dependents has both benefits and costs. The benefits include not just the affordability of insurance for these students and their dependents. The greater subsidy levels may reduce adverse selection in this group, since it encourages healthier graduate assistants and their dependents to enroll in the student health plan.

There are, however, consequences of this approach. Most labor economists argue that employers recruit workers through their offer of total compensation (the value of both salary and benefits) and that there are tradeoffs between salary and benefits; the same principle applies for graduate students who receive funding. Higher premium subsidies may limit the ability of graduate programs at Penn State to offer competitive stipend levels. Those potential graduate students who value direct salary more than subsidized health insurance or who have health insurance options alternative to the Penn State student health insurance plan, may find offers from other programs more attractive.

In addition, graduate students value the division of total compensation differently. Single graduate assistants get little to no direct value from the subsidy to dependents. Penn State’s current subsidy structure is more attractive to those graduate students with dependents in comparison to some peer institutions. Whether this impacts the stipend offers departments make or how this influences the overall distribution of total compensation among graduate students is unknown.

The overall goal should be for Penn State graduate programs to be able to make competitive total compensation offers-graduate student support that meets or exceeds that of our peer institutions. Internally, graduate program leaders and students should maintain an ongoing dialogue on the appropriate division of that total compensation between salary, student health insurance subsidy and dependent health insurance subsidy, especially as the health insurance market evolves under the ACA.

**Plan Structure, Benefits & Coverage Committee**

**Problem:**

What provisions should Penn State make for student health insurance? Should Penn State remain with Aetna or obtain bids from other insurers?

**Recommendation:**

Decisions about the plan structure, benefits, and coverage would best be made with the help of consultants with the needed expertise. Penn State should obtain bids with various contract durations and coverage options such as coinsurance, copayments, deductibles, out-of-pocket limits and compare combinations of these coverage options in light of their corresponding premiums.

**Explanation:**

Given changes in the laws and in the market for student health insurance, there appears to be a consensus that Penn State should obtain quotes from competing insurers for the 2015-2016 student insurance plan. One perceived barrier to doing this on a more regular basis is the length and complexity of the request for proposals (RFP) process. This can make it appear difficult or impossible to shop around in response to undesirable terms being offered by a current insurer for an upcoming contract period.

Currently, the student health insurance contract is negotiated directly through the Office of Student Health Insurance and this office typically would expect to put out an RFP in order to begin the process. It is unclear whether this approach is necessary and advisable. The Office of Human Resources (OHR) has a list of prequalified benefit consultants that have already gone through the RFP process and could be used in negotiations for the student health insurance plan. The RFP process could be shortened by having the consultant obtain quotes from several insurers and present the information to the Manager of Student Insurance, the Senior Associate Director of UHS, and the SIAC. The appropriate parties at Penn State can decide which, if any, of the insurers they would like to interview by phone or invite to give presentations on campus regarding plan benefits, networks, claims handling, pricing, customer service, administration, etc.

It would be advisable to use a consultant for reasons beyond the advantages associated with minimizing the RFP hurdle. A consultant who specializes in student health insurance plans will have experience negotiating with the insurers in that market, will have knowledge of the laws, both state and federal, governing such contracts. In addition, they could be helpful in interpreting contract language, such as clarifying whether Penn State was locked into the third year of the Aetna contract. Even more important, a consultant will bring extensive knowledge of what other universities are doing in the student insurance space; this is critical to Penn State since we tend to rely on our insurers to provide this critical information instead of an independent third party. The Employee Benefits Division recently engaged an external consultant for the employee benefit program for this exact reason.

**Problem:**

What consultant should Penn State use for help in designing and negotiating for student health insurance?

**Recommendation:**

Since insurance is so specialized, a consultant specializing not just in health insurance, but in student health insurance should be chosen by Penn State for designing and negotiating student health insurance.

**Explanation:**

The current list of OHR preapproved consultants likely contains firms with units experienced in employee health plans that can be used by OHR, but some will also have separate units focusing on student health insurance plans. That list should be combed through for firms with such specialized units. In the event that consultants with better expertise in student health insurance than those on our preapproved list are desired, an RFP process can be initiated for additional pre-approved consultants which will not have to be repeated in future years when student insurance contracts need to be renegotiated and quotes from additional insurers are desired.

**Problem:**

Should Penn State consider self-funding its student health insurance plan?

**Recommendation:**

Since self-funding of student health insurance appears to be complex due to Pennsylvania law, Penn State should seek to obtain expert advice on how this would be accomplished and the costs and benefits of such an approach. This may include determining whether it may be in the University’s best interest to join other universities to encourage changes in Pennsylvania law to make self-funding easier.

**Explanation:**

The issue of self-funding has been raised and the information we have to date on that comes from legal counsel that represented the University of Pennsylvania in 2008 when they made a request to the PA Department of Insurance to self-fund their student health plan. Self-funding can reduce costs and give students and the University greater flexibility than is allowed under state regulations for health insurance plans. It does have risks, since self-funded plans are not subject to some consumer protection laws and any errors in estimating costs can create financial problems for the self-funded plan (the University of California system faced a $57 million dollar shortfall in its plan in Spring of 2013--<http://www.dailycal.org/2013/01/31/uc-ship-considers-raising-premiums-to-close-57-million-deficit/>).

There appear to be two main options under current Pennsylvania law, 1) creating a new captive insurer in Pennsylvania (we currently have one for property-casualty insurance domiciled in Vermont) or, 2) creating a RANLI (risk-assuming – not a licensed insurer). Some information about becoming a RANLI can be found at <http://www.pacode.com/secure/data/031/chapter152/chap152toc.html>. It is unlikely that the benefits of creating a second captive insurer for the purposes of a student health insurance plan would outweigh the significant costs and creating a RANLI appears to be both burdensome and beyond the scope of the current expertise at Penn State. Due to the lack of such expertise in the Student Health Insurance Office, this responsibility would likely fall on the Risk Management Office which has expertise in property-casualty insurance, not health insurance.

The University should inquire about this issue when consultants are engaged to look at options for 2015-2016, but this is not likely to be something that would be implemented in the short-run even if it were desirable. At least one other university in Pennsylvania is seeking to have the Pennsylvania Department of Insurance review its current policy on self-funding student health insurance plans, and Penn State may consider participating in this effort. Universities in New York were able to work with the state legislature to create a self-funding option (<https://www.governor.ny.gov/press/08012012Affordable-College>).

**Problem:**

What is the optimal combination of coverage options (coinsurance, copayments, deductibles, and out-of-pocket limits) for the various parties involved in student health insurance at Penn State? What options other than the current plan for student health insurance should be considered?

**Recommendation:**

Annual decisions about plan benefits should not be made until the coverage and premium options obtained by the consultants are known and vetted through the SIAC and others. Penn State should maintain the current plan (Option 2 below), and explore Options 3-5 with consultants. Longer term, the University should continue to monitor the developments of the ACA market to assess whether offering student health insurance remains a sustainable approach (Option 6).

**Explanation:**

There are several general approaches that can be considered for the future direction of coverage options for Penn State students (see Appendix B for a comparison of Penn State plan coverage to coverage at other universities). The table below outlines general approaches, with a brief narrative following:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Option 1: Full Coverage (Former Plan) | Option 2: Current Plan | Option 3: Public Health Plan | Option 4: VBID plan | Option 5: Multi-plan | Option 6: No Plan |
| Premiums | High | High | Moderate to High | Moderate to High | Can offer low and high premium options | Depends on insurance options in ACA plans |
| Cost-sharing for students | Low, less than 5 percent | Low, 8-12 percent (ACA Platinum level) | Low to Moderate, could be set at 8-12 percent (ACA Platinum level) or 18-22 percent (ACA Gold level); may vary by service | Low to Moderate; could be set at 8-12 percent (ACA Platinum level) or 18-22 percent (ACA Gold level); varies by service | Varies by plan type; high premium could be set at 8-12 (ACA Platinum level) percent, low premium at 18-22 (ACA Gold level) or 28-32 percent (ACA Silver Level) | Depends on ACA plan selected. |
| Sustainability | Low | Low | Low to Moderate | Unknown | Low to Moderate |  |

The graduate students on our committee report that they have received feedback from students indicating support for the following general philosophy: lean toward spreading the costs of health care more evenly over those in the insurance plan rather than much more heavily on those who end up using health care services. Although that philosophy implies less cost sharing through coinsurance, copayments and deductibles, the requirements of the ACA include at least a minimum amount of cost sharing through the metal level policies. In addition, this general philosophy does not give clear guidance on how graduate students view the fundamental trade-offs in the insurance plan.

Every health insurance plan faces a basic trade-off among several key elements. A first important trade-off is between coverage and premium. Higher levels of coverage come with a higher premium cost. A second important trade-off, however, is between different types of coverage. First dollar coverage (low deductibles, coinsurance, copayments, etc.) lowers the cost of accessing services for everyone; however, that first dollar coverage means that less protection can be provided for catastrophic costs, holding the health insurance premium level. Alternatively, better protection against the catastrophic costs, holding the health insurance premium constant, can only happen with less first dollar coverage.

So, the more comprehensive coverage in Option 1 (Former Penn State student health insurance plan) and Option 2 (Current Penn State student health insurance plan) comes at a price—they have to skimp on protection against catastrophic costs or they have to have higher premiums. Those students who face the full cost of those higher premiums may have different opinions on the value of those trade-offs than students who do not pay that full cost. Healthier students, too, may value that tradeoff differently than those students who have a chronic illness or regular medical costs.

While providing protection for students with chronic illnesses or high medical costs is fundamental, every health insurance plan depends on having a reasonable group of healthy individuals in the plan. In our discussion with Towers Watson, they noted the growing problem created for comprehensive student health insurance plans under the ACA. The increased options that the ACA provides to students (coverage under parental plans, Medicaid expansion, state or federal exchange plans, etc.) can create a selection spiral—healthier students who do not wish to pay the high premiums associated with a comprehensive coverage plan can select alternative coverage. This leaves a smaller, riskier, unhealthier pool of students remaining in the student insurance plan. As a result, premiums rise even higher and, consequently, even more students leave the pool. Eventually, the student health insurance plan may become unsustainable at any reasonable premium.

Options 1 and 2 are the plans most at risk for a selection spiral. Option 1, of course, does not meet the requirements for metallic tiers under ACA because it pays for more than 92 percent of health care costs. Some students have suggested that Penn State request a clarification from the Department of Health and Human Services to determine whether student health plans must meet those tiers. The American College Health Association (ACHA) has already issued a letter seeking an interpretation that student plans should be exempt from the metallic tier requirements. Our discussions with both Towers Watson and Aetna suggested this request would not result in a change in this requirement. The administration and Department of Health and Human Services want students to be able to compare the price and coverage of their health insurance options, and allowing variation from the metallic tiers would make it harder for students to compare student health insurance plans to other plans available through the state and federal exchanges. Option 1 may not be an option for the future.

Option 2 represents the current plan at Penn State for 2014-15. While less comprehensive than the coverage under Option 1, it represents the highest level of coverage available in the ACA marketplaces. As the University community is now well aware, it also represents a high premium policy. It remains at risk for a selection spiral unless the number of enrollees increases.

To prevent that selection spiral, other universities have been moving over the last few years to explore Options 3 through 6. At least one university, the University of Washington, has eliminated their student health insurance plan for domestic students (Option 6) and encouraged their students to purchase individual health insurance through ACA insurance exchanges (<http://www.washington.edu/ship/>). Since the ACA has provided alternative means for obtaining health insurance in the individual market, with generous subsidies for low income purchasers, Penn State should monitor the options on the health insurance exchanges and through Medicaid to determine if the maturation of these markets makes them more advantageous than a student health insurance plan.

As the market stabilizes, if Penn State concludes that ACA Marketplace coverage will serve the student population well, it should maintain a list of informational resources and provide assistance to students in enrolling for subsidized Marketplace plans. Given how new these markets are, it seems premature to consider such an approach at this point in time, but it would be advisable to monitor the options available through this alternative in future years to determine if this becomes a viable long-term approach.

In addition, it is not clear that ACA Marketplace plans will be available to all students or will not leave gaps remaining for some students. In particular, some questions remain about the eligibility of international students; while the current interpretation by DHHS is that students on F and J visas are eligible to purchase insurance and received subsidies through the ACA, it is unclear how immigration authorities view this, or the complications this might cause for claiming subsidies through the IRS. The National Association of Foreign Student Advisers encourages students to seek immigration and tax legal advice on this. In addition, many ACA exchange, Medicaid and employer plans have narrow networks of physicians, which may leave students that have insurance coverage through these sources underinsured at Penn State campus locations. Such students may need wrap-around coverage—a supplemental insurance plan--available through a student health insurance plan or directly through UHS.

While the uncertainties around the ACA changes become clearer, Penn State could explore Options 3 through 5 as alternatives to Option 2, the current plan. Option 3, which Towers Watson describes as a “Public Health Approach” that some universities are adopting, would maintain a single student health insurance plan, perhaps with slightly higher deductibles, coinsurance or copayments in its first dollar coverage. A student health fee is added and paid by all students, not just those in the health plan. The student health fees are used to provide a set of services that students and the university agree are highly valued and important for students; often, these include direct funding for mental health services, services related to substance use or abuse, and/or basic primary care services for all students through the UHS. A student health fee could be added to any of the Options noted above, and this may be something to consider regardless of which option is ultimately chosen.

Option 3 does expose students in the student health insurance plan to higher costs for some services. By lowering the cost of the premium, it attempts to retain a pool of healthier students in the plan and offer an insurance plan that will be less subject to the selection spiral. It tries to mitigate the impacts of the higher cost-sharing by making available key services directly, not just to students in the health plan, but to all students. This can help address access problems that go beyond just the cost of services. All access problems are not simply the result of cost and insurance. For example, the mental health access problem on many campuses includes a lack of providers in the area. More comprehensive insurance coverage does not directly solve that problem. Universities that adopt the Option 3 approach can use student health fees to hire mental health or other health professionals and provide more services at the University to students. Thus, the recommendation made by the mental health committee could be extended to include other important health services, and Penn State could use the student health fees to complement the services available in the student health insurance plan and try to mitigate the impact of higher cost sharing.

Another complication for adopting Option 3 is that Penn State’s UHS just recently began contracting with and billing other insurers. A student fee-based structure would disrupt the funding model of UHS. Additionally, it would add difficulties in ensuring adequate access to healthcare at commonwealth campuses and while students are travelling, since those fee-based services would not be accessible away from the campus.

Option 4 represents a more privatized version of Option 3 in some ways. Some employer plans are moving to a more “value-based” insurance design (VBID). In VBID, the insurer links the level of cost-sharing to the estimated “value” of the service. Health services that have demonstrated strong impacts on health have low levels of cost-sharing. Those services that have less of an impact may have higher levels of cost-sharing. Effectively, this is akin to the public health approach, which raises cost-sharing, but then provides some services at much lower cost or for free by direct service provision. Sometimes, though not always, the VBID plan is also coupled with a higher deductible and possibly, a health savings account.

A well-designed VBID plan could offer a better combination of appropriate priced services for students for a lower premium, lowering coinsurance for certain services and raising it for others. The lower premium might also reduce the chances of a selection spiral. There do not appear to be many universities moving in the direction of Option 4. VBID plans can be complex, increasing administrative costs. There’s a thin body of evidence to identify even which services are high-value or low-value, much less what is the “right” level of coinsurance for each. Many individuals are still uncomfortable with higher deductible plans, and it is not clear that students in a plan would see the same benefits that an employee might from a longer-term health savings account.

Option 5 represents an option in place at several universities, where it can be used to provide different options to different groups of students (graduate assistants offered one plan, other students offered a different plan) or to provide multiple options to all students (e.g., low premium/low coverage and high premium/high coverage options). In fact, Penn State previously had multiple plans, but many students expressed an interest in joining the higher coverage plan that was only offered to graduate assistants. The plans were combined under the Aetna contract for clarity in advising students and to gain the stability of a larger pool of insured students. Offering different plans within the University may establish what insurance economists call “a separating equilibrium” which can minimize additional selection spirals to outside alternatives, while giving students with different preferences toward the tradeoffs mentioned above the opportunity to select the plan that best fits their needs.

Offering two different plans may come with higher administrative costs, so less of the premiums go to paying for medical care. In addition, there is no guarantee that a separating equilibrium, even if initially established, can be maintained over the longer term. This requires regular monitoring and can require changes in the health plan to maintain stability. Furthermore, splitting the students across multiple pools could also lead to greater instability in each pool. Sustaining a multi-plan system of student health insurance may require the adoption of a strict insurance requirement policy, discussed in our other recommendations. Nevertheless, several peer institutions take this approach.

Ultimately, the premium and cost sharing options in the plan represent a trade-off between the possible benefits of cost sharing by students (reducing overuse, lowering premiums) and the risks of cost sharing (relatively low income students forgoing needed care) that should be considered when choosing coinsurance, copayments, deductibles, and out-of-pocket maximums, and the optimal mix of these features may vary among insurers and over time. It would be premature to choose the mix of these features without first seeing how they would alter premiums and how they may relate to different insurer networks. This is why the input of student groups and others on the SIAC will be important when various options are being discussed over the next few years

**APPENDIX A**

**Student Health Insurance Timeline, 2013-14**

**March 2013**

Federal Government issues final rule governing benefit and payment provisions for individual health insurance market, including 2014 Actuarial Value (AV) calculator

**July 2013**

First year of Aetna contract ends. Renewal with 9.9% increase negotiated in Spring 2013 implemented

Federal government issues final rule determining self-funded student health insurance plans will count as minimum essential coverage and guidance making students eligible for subsidies under the ACA.

**August-October 2013**

Student Insurance Office sends their annual invitations to GSA, UPUA, and other student groups asking for their participation on the Student Insurance Administrative Board (GSA has been the lone group that has regularly responded and participated.)

Aetna completes processing and payment of 2012-13 claims, analyzes claims data and applies new ACA rules, including AV calculator. Aetna informs Penn State that current plan structure would require 40% premium increase. Penn State asks Aetna to develop benefit options with lower premium increases.

**November 2013**

Student Insurance Administrative Council met and reviewed Aetna's options to reduce premium increase to 30 percent. The committee made recommendations for changes in options and asked Aetna work up 2 major options with a 30 percent increase in premiums. (November 11)

SIAC Liaison reports to GSA on the issues facing the student health insurance plan. (November 20)

**December 2013**

SIAC continues to review possible benefit change options from Aetna to reduce premium increase projected.

GSA is updated on benefit changes being considered (December 4)

**January 2014**

Updated Aetna proposal for 2014-15 was received, indicating 30% premium increase and two plan options.  University becomes aware that previous benefit structure is not allowed by AV rules under ACA. Email was sent from the Student Health Insurance office to the Student Insurance Administrative Council on January 6, 2014 with this information:

“All,

Aetna Student Health has worked up premium options for the 2014-15 student insurance plan. As discussed at our last administrative council meeting, premium increases are due to several factors, including:

1) Last year's plan experiencing a loss ratio of 105.7%

2) Increased Essential Health Benefits (EHB) next year.

3) Addition of Affordable Care Act (ACA) taxes.

4) Getting the plan to meet an actuarial value of 92%

It was not made clear at the time of our meeting that, under the ACA, plans as rich as ours can no longer exist.  Our current plan has an actuarial value of 98% and Aetna proposed two options to achieve the target of 92%.  Under both options all the EHBs are included and UHS charges are paid at 100% for covered services.

Option 1 changes:

In-network reimbursements are at 90% and out-of-network reimbursements are at 70% with a maximum out-of-pocket of $3250 for an individual and $6500 for a family.

Annual deductible is $75 for individual and $150 for family.

$150 emergency room copay.

Premiums for this options are:  Student - $3208, Spouse - $8000, Child(ren) - $4810

Option 2 changes:

In-network reimbursements are at 90% and out-of-network reimbursement are at 70% with a maximum out-of-pocket of $1350 for an individual and $2700 for a family.

Annual deductible is $250 for individual and $500 for family.

$150 emergency room copay.

Premiums for this options are:  Student - $3131, Spouse - $7806, Child(ren) - $4693

I believe option 2 is the best choice.  This information has been sent to Joe Doncsecz, Corporate Controller and Damon Sims, Vice-President for Student Services for review and approval.

If anyone would like to review the documents from Aetna Student Health or if you have any questions, please do not hesitate to contact me.”

Graduate students are updated on student health insurance plan issues at GSA meeting (January 22)

**February 2014**

Student Health Insurance office begins to make plans for communicating insurance changes with Graduate School and students, as graduate assistant subsidy information is finalized.

Proposed plan shared with GSA and discussed at their Feb 19 meeting. GSA leadership meets with administrators to discuss impact.

GSA sends email communicating information to graduate students. This is first communication by anyone to broader set of students.

**March 2014**

GSA communicates student concerns to administration and town hall arranged.

University administration begins work on plans to mitigate cost increases, communicated to students at Town Hall at end of March.

Penn State arranges consultation with Towers Watson to negotiate with Aetna

Town Hall (March 27)

**April 2014**

Executive Vice President and Provost requests that the Interim Dean of the Graduate School and Vice President for Student Affairs work together to form a Task Force on student insurance, identifying members to represent stakeholders.

Towers Watson and Student Health Insurance office explore plan alternatives to continue reducing costs and maintain benefits.

Task Force appointed and holds first meeting on April 29

**May 2014**

Board of Trustees meeting held; three students address the Board on student health insurance (May 9).

Rate binder contract with Aetna signed with 21% increase in premium (May 13).

**APPENDIX B**

**Data and Benchmarking**





Source: Towers Watson















**APPENDIX C**

The first part of the Task Force on Student Health Insurance’s charge asked us “to explore the interpretation of how the Affordable Care Act (ACA) applies to the Penn State student health insurance plan, using information provided by our insurer, Aetna, our consultant, Towers Watson, and, if necessary, other sources internal and external to the University.”

Examining these materials, especially information that other universities have distributed to students, the Task Force has put together a draft guide to how ACA applies to Penn State students and their health insurance choices, including the Penn State student health insurance plan. A guide such as this is available at many universities and could become part of regular web and print media for use of students and families.

**WHAT STUDENTS NEED TO KNOW ABOUT THE AFFORDABLE CARE ACT and STUDENT HEALTH INSURANCE**

**Health care reform makes important changes to the health care system. Health insurance exists to protect people from the financial consequences of a serious illness or injury. Before the ACA, some Americans were denied health insurance because they had pre-existing health conditions which insurers refused to cover. As of January 1, 2014, nearly everyone (including students) must get medical coverage or pay a fine. Enrolling in the student health plan at Penn State is one way of meeting that requirement. This guide tries to help students understand the issues and their options.**

**How are college students affected by the ACA?**

* Under the new law, most people over age 18 (this includes nearly all college students) must purchase health insurance or pay a penalty.
* The ACA provides affordable ways for some students to get quality health insurance coverage that meets their specific needs.

**Are there any exceptions to the ACA’s individual mandate that students have health insurance?**

* There are few exceptions to this rule, and they include students:
	+ Whose household income is so low that their family unit does not have to file federal income tax;
	+ Who qualify for a hardship or affordability exception when they apply for coverage on their state’s health insurance exchange;
	+ Who are members of a recognized Indian tribe, health care cost-sharing ministry, or religious group that objects to health insurance; or
	+ Who are in the U.S. illegally.
* Check with your state’s health insurance exchange if you believe that you may qualify for an exception and do not wish to enroll in a health plan.

**What are my options for getting insurance if I am covered by ACA’s individual mandate?**

* Most students will have several options, including:
	+ If you are age 26 or younger, you may be able to continue to be covered as a dependent by a plan from a parent;
	+ Purchasing coverage through the Penn State student health insurance plan;
	+ Purchasing ACA coverage as an individual or under a family plan, if you are a dependent, through one of the ACA exchanges/marketplace, where you may be eligible for a premium tax credit, or subsidy, if income requirements are met;
	+ If your income or your family’s income is low enough, you may qualify for Medicaid
	+ A catastrophic or “young invincible” plan offered through the Exchange/Marketplace
	+ Purchasing an Individual Health Plan offered outside of the Exchange/ Marketplace

**What is the Exchange/Marketplace?**

* The Exchange or Marketplace is a new source of health coverage, which may offer lower costs based on your income. Each state has one, either set up on their own or through the federal government.

**What kinds of health insurance options are available through the Exchange/ Marketplace?**

* There is a menu of plan designs based on levels of benefits offered through the Marketplace. These plans are called: Bronze, Silver, Gold and Platinum. Bronze plans are designed to pay 60 percent of your health care costs; Silver plans are designed to pay 70 percent; Gold are designed to pay 80 percent; Platinum are designed to pay 90 percent. Plans can achieve those percentages in many different ways
* Individuals with low and moderate incomes may be eligible for an upfront premium tax credit (subsidy) when purchasing insurance through the Marketplaces in order to reduce their monthly premiums. Premium tax credits (subsidies) will be based on the lowest cost “Silver Plan” in the state. That amount can be used to purchase any plan on the exchange, however, the individual will be responsible for any additional premium.
* Once enrolled in a Marketplace plan, you must continue enrollment in the same plan throughout the policy year unless a qualifying life event occurs, such as moving to a new state, certain changes in income, or changes in family size (i.e., marriage, divorce, or birth of a child).

**How does the Penn State student health insurance plan compare to the plans available through the Exchanges/Marketplace?**

* The Penn State student health insurance plan equates to Platinum level coverage on the Marketplace, the highest level of coverage.

**Who is eligible for a premium tax credit, or subsidy, through the Marketplace?**

* Eligibility for premium tax credit (subsidy) is based on the Tax Filing and Social Security data provided by the applicant to verify household income. Therefore, if a student is considered a dependent on their parents’ tax return, their eligibility for a subsidy is based on their parents’ income.
* To qualify for a premium tax credit (subsidy) to purchase insurance through the Marketplace in a State that has not expanded Medicaid like Pennsylvania, one must be a member of a household with earnings between 100% and 400% of the Federal Poverty Level, with no access to affordable employer-sponsored coverage.
* To determine your eligibility for a premium tax credit (subsidy) go to www.healthcare.gov

**Will I be able to see my current doctor if I purchase coverage through the Marketplace?**

* It depends on whether you select a plan that has your doctor in its network. Some plans in the Marketplace achieve their cost savings by having narrow doctor networks. You should look closely while shopping on the Marketplace to determine if your doctors and hospital are included in the network.

**What if I live out-of-state?**

* If you do not consider yourself a Pennsylvania resident (think about where you pay taxes, have your driver’s license, etc.), you should look into the health insurance exchange in your home state. You can find information about your state’s exchange on the federal ACA website, where there is a list of state Marketplaces, visit [https://www.healthcare.gov/whatis‐the‐marketplace‐in‐my‐state/](https://www.healthcare.gov/whatis%E2%80%90the%E2%80%90marketplace%E2%80%90in%E2%80%90my%E2%80%90state/)
* Out-of-state students considering coverage under a parent’s plan or on the ACA exchanges should closely examine the physicians and hospitals that are considered “in-network” and “out-of-network”. Some plans would not provide “in-network” coverage for medical received from University Health Services or doctors and hospitals around the Penn State campus.
* When you consider plans in your home state, you may be able to find a “multi-state” plan that has a national or regional provider network that includes Pennsylvania.

**How are international students affected by the ACA?**

* International students at Penn State have had to demonstrate adequate insurance coverage for many years. International students can continue to enroll in Penn State’s Student Health Insurance Plan or can demonstrate comparable insurance coverage and be granted a waiver out of that plan. Information on waiver requirements for Penn State can be found at <http://studentaffairs.psu.edu/health/services/insurance/international.shtml>.
* The ACA exchanges provide another option for international students to explore for their health insurance needs, but international students should discuss that option with someone familiar with immigration and tax law. The Department of Health and Human Services has interpreted the ACA to mean that international students can purchase insurance on the exchanges and possibly even receive subsidies, if they qualify because of low income (<https://www.healthcare.gov/immigration-status-and-the-marketplace/>). However, at this point it is not clear whether there may be complications related to verification of their resident status or completing tax documents for international students to be able to take advantage of the exchanges. The current immigration reform bill under consideration in Congress proposes to remove ACA eligibility for international students.
* If international students choose to purchase insurance through the exchanges, they should make sure that the plan they choose meets the Penn State waiver requirements and any requirements from their visa. For example, J-visa students must have medical evacuation and repatriation coverage as part of their insurance, and this may not be commonly included in insurance policies through the ACA exchanges.

**How are families impacted by ACA? Children cannot be seen at UHS and have no option for full coverage of covered pediatric care.**

New mandates under the ACA require 100 percent coverage for pediatric dental and vision care, as well as for a host of preventive services such as vaccinations, well-child checkups, autism screening, and more. So even when families have to go out of UHS for care, they may find many services they use are fully covered.

**What is the penalty if I do not enroll in a health insurance plan?**

* In 2014, the penalty is $95 per individual adult or 1 percent of your income, whichever is higher.
* Penalties increase annually after 2014. In 2015, the penalty will rise to $325 or 2 percent of your income; in 2016, these numbers increase to $695 or 2.5 percent of your income.

**What will an insurance plan cost?**

* The cost of a plan for an individual student depends on a number of factors. For example:
	+ Costs for the Penn State Student Health Insurance plan can be found here: <https://www.aetnastudenthealth.com/>
	+ If you are under age 26 and eligible for coverage under a parent’s plan or are a dependent of another individual, your coverage will depend on their plan. Costs of dependent coverage can vary a great deal, as some plans make this more expensive than others.
	+ If you are financially independent and your income is very low, you may qualify for Medicaid, which does not require you to pay premiums and has minimal out-of-pocket costs. Medicaid plans may limit your choice of providers.
	+ If you are financially independent and have income that is too high for Medicaid coverage, you may qualify for subsidies and credits for the cost of your insurance through an ACA exchange. Healthcare.gov allows you to enter information on your residence, income and other characteristics and find out the plans that are available for you, as well as their costs, including any estimated subsidy. Make sure you search for plans under the state where your residence is established. You can see what’s available here: <https://www.healthcare.gov/how-much-will-marketplace-insurance-cost/>
	+ If you are under age 30, you can enroll in a “Young Invincible Plan.” This plan has a very low premium but high deductibles and other cost-sharing if and when you do use health services.

**What are Young Invincible Plans?**

* Young Invincible Plans are catastrophic plans available to people under age 30. They are designed for healthy young people who do not anticipate needing many health services, but who want protection against having to bear the full cost of a major medical emergency.
* These plans typically have very low premiums, often in the $40-$60 per month range, but their annual deductibles can be several thousands of dollars.
	+ On the exchanges, these plans must cover three primary care visits per year at no cost to the enrollee.
	+ With the exception of the three annual primary care visits, you will be responsible for the full cost of all health services up to the deductible amount.
* There are no subsidies or tax credits available for Young Invincible Plans. If your income is low, you may want to compare the subsidized costs of Bronze and Silver plans, which have lower deductibles, against the unsubsidized premiums of a Young Invincible Plan.

**My health plan requires me to pay for deductibles, coinsurance, and other costs. How can I make sure I spend my money effectively?**

For many years it has been close to impossible to comparison shop in health care to make sure you get a fair price. New resources for health care consumers, however, are giving everyone new tools. If you have time to decide about a health care service, you can consult some of these resources:

* Our Aetna student health plan at Penn State provides the Aetna Navigator, which you can use to estimate costs and save money
* The Health Care Blue Book and Fair Health have tools that allow you to search for an estimate of fair prices for many different services in your location. (<https://www.healthcarebluebook.com/>) and (<http://fairhealthconsumer.org/>)
* Choosing Wisely provides a list of services and procedures that physicians have developed that offer little or no value to patients (<http://www.choosingwisely.org/>)

**Where can I get more information?**

* For more info on the exchanges and subsidies, go to [www.healthcare.gov](http://www.healthcare.gov).
* For more info on the Penn State student health insurance plan go to <http://studentaffairs.psu.edu/health/services/insurance/>
* The “Young Invincibles” [web site](http://health.younginvincibles.org/) provides some good information for students and they also provided a guide for students: <http://health.younginvincibles.org/wp-content/uploads/2013/09/ACA-Toolkit_Helping-Students-Understand-Health-Care-Reform-and-Enroll-in-Health-Insurance.pdf>
* NAFSA, an association of international educators, provides resources for international students and scholars: <https://www.nafsa.org/findresources/Default.aspx?id=35008>
* The American College Health Association provides resources on how ACA is impacting student health insurance: <http://www.acha.org/Topics/affordablecareact.cfm>
* The U.S. Government also issued a toolkit for colleges and universities that has helpful information for students: <http://www.acenet.edu/news-room/Documents/ACA-Toolkit-100213.pdf>

In addition to these resources, information in this guide was drawn from helpful resources developed by the Texas A&M University, University of Miami, University of California, University of Maryland, and the University of Wisconsin.

**APPENDIX D**

**Membership of the Task Force on Student Health Insurance**

Administrative/Faculty:

1. **Chair**: Dr. Dennis Shea, Professor of Health Policy and Administration and Associate Dean for Undergraduate Studies and Outreach, College of Health and Human Development. Expertise in health economics; health insurance policy.
2. **Faculty Member**: Dr. Lisa Posey, Associate Professor of Business Administration, Dept. of Risk Management, Smeal College of Business. Expertise in risk management.
3. **University Health Services** – Doris Guanowsky, Sr. Associate Director.
4. **Counseling and Psychological Services (CAPS)**: Ben Locke, Associate Director.
5. **Clinical provider**: Dr. Michael Flanagan, Family and Community physician and head of PSHMG Family Physicians in State College.
6. **Human Resources**: Robin Haas, Director of Employee Benefits.
7. **Graduate School**: Barbara Struble, Director of Fellowships and Awards Administration.
8. **Budget Office:** Andy Reisinger, Asst. Director, Analytical Budget Studies.
9. **Office of Global Programs, Directorate of International Student and Scholar Advising** **(DISSA):** Masume Assaf, Director and member of the Student Insurance Administrative Council.
10. **Financial Reporting Office, Corporate Controller:** Nancy Ondik, Assistant Manager

Students:

11) **UPUA/CCSG Undergraduate student:** Emily McDonald, newly elected UPUA Vice President.

12) **GSA/Graduate Student**: Scott Rager, immediate Past President of GSA.

13) **GSA/Graduate Student**: Danielle Rhubart, newly elected President of GPSA.

14) **GSA/Graduate Student**: Katherine Kragh-Buetow, immediate past GSA liaison to the Student Insurance Administrative Council.

15) **GSA/Graduate Student**: Alison Franklin, incoming liaison to the Student Insurance Administrative Council.

16) **Graduate Student**: Spencer Carran, Ph.D. student in the Intercollege Graduate Degree Program in Ecology.

17) **Graduate Student:** Naomi Zewde, Ph.D. student in Health Policy and Administration

Committee Organization

Mental Health: Ben Locke and Katie Kragh-Buetow (co-chairs); Michael Flanagan, Doris Guanowsky (members)

Provider Network and Relationships: Alison Franklin and Michael Flanagan (co-chairs); Naomi Zewde, Robin Haas (members)

Health Insurance Requirements and Waivers: Scott Rager, Masume Assaf and Barb Struble (co-chairs); Dennis Shea, Emily McDonald, Spencer Carran (members)

Process, Organization, and Engagement: Danielle Rhubart and Dennis Shea (co-chairs); Lisa Posey, Scott Rager (members)

Premiums and University Contributions: Andy Reisinger and Naomi Zewde (co-chairs); Alison Franklin, Barb Struble, Nancy Ondik (members)

Plan Structure, Benefits and Coverage: Spencer Carran and Lisa Posey (co-chairs); Katie Kragh-Buetow, Doris Guanowsky, Masume Assaf, Robin Haas (members)

1. The Graduate and Professional Student Association (GPSA) adopted its new name on July 1st, 2014. Prior to July 1st, the GPSA was called the Graduate Student Association. For simplicity and clarity, the organization will be referred to as the GPSA for the remainder of this section. [↑](#footnote-ref-1)