Brandeis University

Administrative Review of the Health Center and the Psychological Counseling Center

Volume Two: Report Attachments, Section VI

October 14, 2013
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Attachment A
ACHA Medicaid Advocacy Primer¹: A Proposal for Providing Medicaid Eligible Students with an Option for Student Health Insurance Coverage

Background

American College Health Association began exploring issues related to Medicaid coverage, eligibility, portability and use of Medicaid dollars to purchase student health insurance plans (SHIPs) in 2011. The opportunity for states to participate in Medicaid expansion under the Affordable Care Act (ACA), which would result in over 5 million students meeting Medicaid eligibility, raised the importance of this issue for several reasons, including recognition that Medicaid may not be the best option for coverage for college students given shortcomings in portability and provider network limitations. Because Medicaid typically offers ‘emergency only’ coverage for students studying outside the state, the coverage may not meet benefit criteria for schools that require students to carry health insurance. This is especially problematic for students who are studying outside of their home state. Moreover, Medicaid-covered students studying at in-state institutions that are located in rural areas with limited health care provider networks may also be negatively impacted due to lack of access to mental health providers or specialists.

There is interest on the part of some schools to advocate for payment for SHIP and student health benefit plan (SHBP) premiums with Medicaid dollars as a reasonable option for Medicaid eligible college students, as well as interest for this option on the part of some state legislators looking for more cost-effective coverage options for their state’s Medicaid beneficiaries. Although it appears, following the Supreme Court ruling in June 2012, that fewer states may opt into Medicaid expansion, which would have significantly increased the number of students eligible for Medicaid, the idea continues to present as one worth exploring. Since advocacy efforts for applying Medicaid funds to the payment of SHIP/SHBP premiums will be primarily focused at the state level, the purpose of this primer is to raise awareness of this potential opportunity for expanding meaningful student health insurance coverage, and to provide interested members with information that may be helpful to their advocacy efforts.

¹ This primer serves as a guide to assist members who are interested in engaging in state advocacy on the issue of providing Medicaid eligible students with an option for coverage through a student health insurance program using Medicaid dollars. The information provided is not intended to serve as legal advice. College and university administrators responsible for student health plans should assess, with their campus insurance administrators, financial aid officers and legal counsel, the impact this proposal may have on their student population. The viability of this proposal may vary from state to state as well as institution to institution.
Frequently Asked Questions

Q1. What is the status of Medicaid Expansion?

A1. As a result of the ACA, beginning in January 2014, Medicaid will increase its national eligibility limits for adults at or below 133 percent of the Federal Poverty Level (ex. 2012 - $14,856 for one person) and open coverage to include childless adults age 19 through 64 years of age. The original ACA legislation would have required states to participate in the expansion or risk losing federal funding for their current program. The Supreme Court ruled in June 2012 that states could not be punished for refusing to participate in Medicaid expansion thereby giving states the option to opt in or out of this provision of the ACA without penalty.

As of February 14, 2013, 23 states and the District of Columbia have opted to participate in the expansion, 13 states have elected not to participate, three are leaning toward participating, five are leaning toward not participating and seven are undecided/have no comment. There is no deadline for states to make a decision on whether to opt in or out of Medicaid expansion. In fact, the states can decide to opt in or opt out at any time. A regularly updated map showing each state’s position with respect to Medicaid expansion may be viewed at www.advisory.com/MedicaidMap. Another helpful link on Medicaid expansion is provided via the American Public Health Association at: www.apha.org/advocacy/Health+Reform/ACAbasics/medicaid.htm

Q2. How does a state’s decision to opt into Medicaid expansion affect insurance coverage for the college population?

A2. If a state opts in, the number of college-aged students who are eligible for Medicaid coverage will significantly increase. Therefore, the impact on managing health care for
students would likely shift to consideration of coverage under Medicaid which may or may not meet schools’ health insurance coverage requirements or may present barriers to care because of network restrictions. Given the concerns regarding access to care for any student with Medicaid, another coverage option like student health insurance is worth considering even if the Medicaid covered student is in a state that has opted out of the expansion.

Q3. How do I determine how many students attending my institution are Medicaid eligible?

A3. Since Medicaid eligibility is primarily based on family income, the financial aid office on your campus may be in the best position to assist you with this calculation.

Q4. Are states permitted by law to use Medicaid funds to purchase SHIPs/SHBPs?

A4. It appears that states are able to make the determination that an alternate insurance plan can be considered an acceptable option. Section 1905(a) of the Social Security Act provides a pathway to premium assistance allowing states to enroll Medicaid eligible persons in individual insurance market plans that are “cost-effective” (See Q/A9). Since the students would still be considered Medicaid beneficiaries under this option, they would remain entitled to all benefit and cost-sharing protections for Medicaid Beneficiaries. States may have to provide additional (i.e. wrap around) benefits to ensure cost-sharing is not above Medicaid requirements and, for example, ensure that Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) benefits are available to those under 21. States may apply for a Section 1115 waiver to exempt a premium reimbursement program from some or all of these requirements. Additionally, the benchmark benefits statute described below provides authority to actually enroll people in plans that are deemed to meet the alternative benefit plan requirements.

Q5. If student health insurance appears to be a better coverage option for Medicaid eligible students, is there a way to offer that option to students while not disadvantaging them from a financial or benefits standpoint?

A5. ACHA is aware of two states, Montana and Minnesota, that determined it was cost-effective for Medicaid dollars to be used to purchase the institution’s student health insurance for a student while providing secondary coverage (commonly referred to as “additional” or wrap around coverage) to the student for services not covered by the SHIP/SHBP. In the case of Montana, payment is issued directly from the State Medicaid Office to the institution. In Minnesota, students can petition their State Medicaid Office to pay for the SHIP/SHBP with the student receiving reimbursement from the state for payment of the plan.
Q6. What are “Alternative Benefit Plans” under the benchmark statute and do such plans offer additional opportunities for state Medicaid funding of SHIPs/SHBPs?

A6. The benchmark statute was added by the Deficit Reduction Act of 2005 to provide states flexibility to amend their state Medicaid plans without obtaining a waiver to offer different coverage options to targeted populations consisting primarily of healthy adults and children. (See 42 U.S.C.A. 1937). The ACA made several changes to the benchmark statute, including designating the benchmark packages as “Alternative Benefit Plans”. Any Alternative Benefit Plans proposed by a state for a targeted population must provide benefits at least equal to or actuarially equivalent to one of the three commercial insurance products\(^2\) or a fourth “Secretary-approved” benchmark package identified in the benchmark statute.

To provide states flexibility to design benefits based on the special needs of the target population, Alternative Benefit Plans are exempt from Medicaid “comparability” and “statewideness” requirements. This allows the Alternative Benefit Plan to provide different benefits to the target population than to other Medicaid beneficiaries and to utilize managed care or services that are geographically limited within the state. However, Alternative Benefit Plans must meet other Medicaid requirements for coverage, including transportation services, care in rural health clinics and federally qualified health centers, and Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) services for children under 21 either as part of the benefit package itself or through a combination of the benefit package and “additional services” provided by the state (i.e. wrap around coverage). (See 42 U.S.C.A Section 1937 and 42 C.F.R. Sections 345, 365, and 390).

Beginning in 2014, all Medicaid benchmark and benchmark-equivalent plans must include the ten categories of “essential health benefits” (“EHBs”) under the ACA. The proposed regulations, issued on January 14, 2013 by HHS (“Proposed Regulations”), also clarify that Alternative Benefit Plans must cover family planning services, mental health benefits, prescription drug coverage, and comply with provisions of the Mental Health Parity and Addiction Equity Act beginning in 2014. In addition, states will have additional flexibility in 2014 to designate an EHB package that is benchmarked to private plans in their state, or design their own EHB benefit package, subject to HHS approval. Alternatively, a state may select any of the three commercial plans designated by HHS as an EHB benchmark reference plan.

The proposed regulations address application of EHBs to Alternative Benefit Plans, define the states’ role and two-step process for designating EHB benchmarks for Alternative Benefit Plans, and streamline eligibility, enrollment and appeals among Medicaid, the Children’s Health Insurance Program (“CHIP”) and available federal assistance for low-

\(^2\)The three commercial insurance “benchmark” or “benchmark-equivalent” packages are as follows:

1. The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program;
2. State employee coverage that is offered and generally available to state employees; and
3. The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state.
income persons obtaining coverage through an exchange. (See Proposed 42 C.F.R. 335, 345, 347, and 435).

**Q7. Under what circumstances could a SHIP/SHBP be considered an Alternative Benefit Plan?**

**A7.** For a state to designate a SHIP/SHBP as an Alternative Benefit Plans, such plans would need to meet the minimum coverage requirements under the ACA and Medicaid, including wrap around coverage, and provide EHB benchmark or benchmark equivalent coverage. The extent to which SHIPs/SHBPs offering lesser coverage could successfully obtain HHS approval as an Alternative Benefit Plan is unclear. There does not appear to be any precedent for designating lesser coverage as a benchmark or benchmark equivalent package by HHS since states have historically used the Alternative Benefit Plan option sparingly and in most cases for the purpose of providing additional services to adults in special needs categories such as those with diabetes or heart disease. However, HHS does have limited authority to approve an Alternative Benefit Plan deviating from the otherwise applicable Medicaid requirements if a state can satisfactorily demonstrate that implementing such required provisions would be directly contrary to their ability to implement Alternative Benefit Plans. (See 42 U.S.C.A. Section 1937).

**Q8. Do the proposed regulations impact the appropriateness of advocacy for states to subsidize SHIPs/SHBPs under CHIP when the student is eligible for Medicaid?**

**A8.** The proposed regulations make many modifications streamlining eligibility, enrollment and appeals to coordinate the federal insurance assistance provided under Medicaid, CHIP and the premium assistance and cost-reduction subsidies available for certain low-income individuals purchasing insurance through an exchange beginning in 2014. (See Proposed 42 C.F.R. 431 and 435). However, it does not appear that the proposed regulations would impact the current provisions under Medicaid and CHIP that permit Medicaid funds to provide premium assistance for individual health policies not offered through an exchange by a state plan amendment or Section 1115 waiver from HHS. (See 42 U.S.C.A. 1905(a) and 2105(c)(3)). HHS is expected to issue additional guidance regarding simplification of the waiver process and addressing ACA changes to Medicaid.

**Q9. Is there a standard formula that states use to perform a cost-effectiveness test between SHIP/SHBPs and Medicaid?**

**A9.** No. Each state uses its own formula to make a determination of cost-effectiveness. The Proposed Regulations that would apply to premium assistance for individual market plans under Section 1905(a) authority align the cost effective determination for those plans with the current requirements for premium reimbursements under group health plans. Specifically, the Proposed Regulations provide that “the cost of purchasing such coverage, including administrative expenditures and the costs of providing wraparound benefits for items and services covered under the Medicaid State plan, but not covered under the
individual’s health plan, must be comparable to the cost of providing direct coverage under the State plan.” (See Proposed 42 C.F.R. 435.1015). The comparison may also include any assistance with cost-sharing that the Medicaid program had to provide as well.

**Q10. What are the benefits of using Medicaid funds to purchase SHIPs/SHBPs for both the Medicaid eligible student and the state?**

**A10.** Benefits would include:

- Affordability³ (student insurance costs may be lower than Medicaid costs)
- Improved access to care for low income families using health insurance that is designed to provide comprehensive coverage tailored to address issues prevalent in the college population (e.g. mental health, alcohol and other drugs)
- Improved access to local provider networks with reasonable co-payments and deductibles as well as access to worldwide coverage including medical evacuation and repatriation of remains
- Decreased financial burden for students who have Medicaid coverage but find that they must purchase a SHIP/SHBP anyway because the Medicaid plan does not meet the institution’s health insurance requirements
- Decreased burden to state Higher Education Opportunity Programs (HEOPs) and universities for financial aid costs related to paying for student health plans for low-income students

**Q11. What data should I gather to better understand how this issue impacts students on my campus?**

**A11.** Consider the following:

- Partner with financial aid office to determine an estimate of number of students on your campus that may be eligible for Medicaid.
- Prepare a cost/benefit analysis to aid in the discussion with university government relations about the size and scope of the concern.
- In addition to providing the cost and benefit structure of your student insurance program, provide a comparison between the benefits provided by the SHIP/SHBP and Medicaid.

**Q12. Who should I approach to advocate on this issue?**

**A12.** Consider the following contacts:

- A good place to start is to speak with the government relations staff of your institution. They will be able to tell you which department/person in state

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³ A comparison should be done between the institution’s student health plan coverage and cost compared to the state Medicaid program.
government is responsible for managing the issue, such as, the state Medicaid Director.
• Approach other institutions in the region to identify those with shared interest.

Q13. How should I approach an advocacy issue with state legislators/officials?

A13. Your approach should consider and incorporate the following:
• Prepare ahead of time for the meeting. If you are going with a group, decide on the role each person will play.
• Establish relevance – make sure the person understands how this issue impacts the people they represent.
• Be specific about the issue. Use case examples when possible to illustrate your rationale.
• Be specific about how you would like the person to support your position.
• Provide briefing materials that you can leave behind.
• Be patient – do not expect an immediate response.
• Let the person know how you can help (provide more information, data, speak with others)
• Consider various options which may ultimately result in Medicaid payment for SHIP/SHBP programs (ex- possibly begin the process with advocating for a cost benefit analysis and/or feasibility study)

Q14. What language might be helpful in advocating for a cost benefit analysis and/or feasibility study?

A14. The first step may be to suggest to your state legislator(s) that your state calculate the cost of providing Medicaid versus using Medicaid dollars to purchase a student insurance plan to determine the cost-effectiveness of the idea.

An example of language that has been used in one state to advance a resolution designed to require that the calculation be determined is below:

Referred to Committee on HIGHER EDUCATION AND
EMPLOYMENT ADVANCEMENT

Introduced by:

(HED)

AN ACT CONCERNING THE USE OF MEDICAID FUNDS TO PAY HEALTH INSURANCE COSTS FOR MEDICALLY INDIGENT STUDENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. () The Commissioner of Social Services and the president of the Board of Regents for Higher Education shall study the effectiveness of requiring state Medicaid to pay the cost of
premiums for health insurance sponsored by a constituent unit, as defined in section 10a-1 of the general statutes, and provide supplemental health insurance coverage for students enrolled in a constituent unit who are (1) not covered by any other health insurance plan, and (2) eligible for state Medicaid benefits. Not later than (date), the commissioner and president shall report on such study, in accordance with the provisions of …… of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to higher education and human services.

Statement of Purpose:

To require a study of the effectiveness of requiring state Medicaid to pay the cost of institution-sponsored health insurance premiums and provide supplemental coverage to medically indigent students enrolled in a constituent unit.
Doreen and Steve:

I’m writing in response to your request for changes that we would like to see Brandeis consider as it reviews its health and counseling services. I’ve outlined our recommendations and have added our responses to Doreen’s other questions below.

**Recommended changes:**

- Addition of an experienced part-time clinical nutritionist based at the Health Center. Job description should include:
  - Consultation with individual students re: sports nutrition, management of eating disorders, obesity, celiac disease, diabetes, etc.
  - Involvement in health and wellness educational programming

- Coordination of health and wellness educational programming at Brandeis
  - Currently several staff members and student groups do health and wellness programming on campus without formal collaboration/coordination

- Co-location of the Health Center with the Psychological Counseling Center
  - Shared office suite, waiting room, reception, conference room
  - Consideration of shared practice management system, electronic health record

- Redesign of reception/waiting room area to improve patient privacy and flow
- Utilization of BID Needham Hospital for referral services
  - Would facilitate coordination of care
  - Transportation is a key issue

- Purchase and implementation of a practice management system and electronic health record

**Also for consideration (no recommendation at this time):**

- Further reduction in Health Center hours
- Moving the administration of the insurance waiver process out of the Health Center
- Third party billing for Health Center visits
- Promotion of enrollment in the QSHIP among undergraduates and graduate students
BIDMC's vision for major trends/opportunities for the short- and long-term future operation of college health programs in the Boston area:

- We see opportunity for college health programs to offset a portion of the costs of operating on-campus health services through third party billing. This would also improve access to on-campus services for some students.

Text redacted by HBC pertaining to other data requests.

Cost for the BIDMC HER and ability to change the contract so that it can be used at Brandeis

- Use of the BIDMC Online Medical Record (OMR) would probably be without charge if the Brandeis Health Center became a practice of the Harvard Medical Faculty Physicians (HMFP) and instituted third party billing. This would be contingent upon approval by HMFP.

Text redacted by HBC pertaining to other data requests.

Please let us know if you need anything else.

Kay
Attachment  C
Integration of Behavioral Health and Primary

Among both governmental and community-based health centers, as well as many large employer-based work-site clinics, integrating behavioral health care specialists into primary care is a definitive best practice. HHS and several major association web sites provide on-line resources explaining key concepts and evidence-based results:

- [http://www.ahrq.gov/research/jan12/0112RA1.htm](http://www.ahrq.gov/research/jan12/0112RA1.htm)
- [http://www.pcpcc.net/content/why-primary-care-needs-behavioral-health-services](http://www.pcpcc.net/content/why-primary-care-needs-behavioral-health-services)

* Refer to Section IV, Attachment B-2, American Psychological Association’s Health Care Reform Priorities.

There are also numerous resources explaining the value for integrated care under the patient-centered medical home model that is advanced under the ACA. Several college health programs are advancing this concept and academic journal articles have been published. College health programs at Syracuse University, Colorado State University, and Cornell University, and the University of Texas at Austin are recognized leaders.
Attachments
D-1, D2, and D-3
DeSoto Memorial Hospital in Arcadia, Fla., faces numerous financial issues. Dan Hogan, the 49-bed rural hospital’s CFO, says the facility struggles with uncompensated care in particular.

"It's a nightmare for us," he says. "We have drug companies, the electric company and the water company, among other vendors, expecting payment for services rendered to the hospital. If we're not collecting for healthcare services we provide, I don't have a money tree out back for us."

Although many of those unpaid bills come from people who don't have insurance coverage at all, there are also people who have coverage but still can't pay. The reason: growing high-deductible health plan enrollment, a trend Mr. Hogan says he saw developing about a decade ago, before he joined DeSoto.

That growth has sped up significantly in recent years, with employers looking to contain health benefits spending as healthcare costs continue to increase and the Patient Protection and Affordable Care Act enacts new fees and revamps the health insurance landscape.

Ideally, the high-deductible, or consumer-directed, plans would lead to consumers making smarter choices, opting to visit their physician instead of going to the emergency room for minor ailments. However, research shows that while shifting more responsibility onto consumers works out well for employers, it can lead to financial troubles for consumers and for hospitals when patients who don't understand their plans end up facing a bill they can't pay.

The reason behind the rise: Employers turn to more consumer control to cut costs
According to the Kaiser Family Foundation 2013 Employer Health Benefits survey, 23 percent of companies offering health benefits offer a high-deductible health plan, with 17 percent providing health savings account-qualified high-deductible plans and 6 percent opting for coverage with a health reimbursement account.

Health savings and health reimbursement accounts are both tax-exempt accounts people can use to pay for current or future qualified healthcare costs, according to Kaiser. An HRA can be paired with a high-deductible plan but isn't required to go along with one. However, in order to open an HSA, a person must have coverage under an HSA-qualified high-deductible plan, meaning the plan meets the premium minimums federal law sets for high-deductible plans.

Federal law requires a deductible of at least $1,250 for single coverage and $2,500 for family coverage for HSA-qualified high-deductible plans in 2013, according to Kaiser. There is no legal requirement for a minimum deductible in a plan offered with an HRA. For plans with an HRA, Kaiser has defined high-deductible plans as those with deductibles of at least $1,000 for single coverage and $2,000 for family coverage.

The number of workers enrolled in high-deductible plans has risen significantly in recent years. In 2013, 20 percent of covered workers were enrolled in high-deductible plans with savings options such as an HRA or HSA, up from 13 percent in 2010.

It seems like that number will continue its upward trajectory as the pressure to contain healthcare costs grows, and the Patient Protection and Affordable Care Act continues to alter the healthcare landscape. Starting in 2014, the healthcare reform law might increase benefit costs for employers through a handful of new fees.

One is the traditional insurance fee, a three-year fee levied on health plan sponsors to help fund state-based health exchanges. The rate for 2014 is set at $63 per worker. Plan sponsors of group health plans must also pay a seven-year fee to fund the Patient Centered Outcomes Research Institute. The rate for that fee is $1 per worker in 2014.

A survey conducted in June by the National Business Group on Health — a nonprofit employer association — found large employers expected their healthcare benefit costs to increase by 7 percent on average in 2014 (Note: The survey was conducted before the Obama administration announced it was delaying the employer mandate until 2015).

Concerning how they plan to respond to the increased expense, 36 percent of respondents viewed high-deductible health plans as the most effective strategy for containing costs. National Business Group on Health President Helen Darling says the desire to control spending on benefits is the main reason behind the rise in employers offering their workers high-deductible plans.

"The belief is high-deductible health plans cost employers less," she says. Employers see almost immediate savings from high-deductible health plans because of the lower claims costs or premiums, she says.
Research suggests that high-deductible plans can lead to very significant employer savings. A study released in August by the Employee Benefit Research Institute confirmed that high-deductible plans associated with savings account options to cover out-of-pocket costs reduced one large Midwestern employer's healthcare spending by 25 percent, or $527 per person, in the first year following the high-deductible plan's adoption.

Another factor driving the shift to consumer-directed plans is the idea that people who have more fiscal responsibility for their healthcare costs make smarter decisions about their care, Ms. Darling says.

"We think that people who are in high-deductible health plans tend to be wiser about how they spend money," she says. "They're more likely to call a nurse advice line about whether they should see a doctor. They use more tools and resources when they are available, and they use services less."

If employees are careful and take what they save through their lower contribution, Ms. Darling says they can also save money if they don't end up using their coverage. If they do need treatment, they can put the money they saved from the lower premium contributions toward their care. In that scenario, she says they won't save extra money, but they won't be worse off than they would be if they had a plan with a lower deductible.

Anthony Fioretti — the chief benefits officer for insurance broker HNI Risk Services — says he's seen more and more clients offering high-deductible plans as a way to rein in their spending on benefits. HNI itself offers its employees the option of enrolling in high-deductible plans, and its plan costs have been reasonably stable. "Eighty percent of our people are in those qualified high-deductible plans," he says.

Mr. Fioretti says he's observed employers having "tremendous success" in keeping their spending on health benefits stable through high-deductible health plans. Employees can benefit too if they become "good consumers and savers," he says.

**How high-deductible can hurt hospitals and patients**

However, the reality of high-deductible plan use isn't as simple and rosy as employers saving money while employees make smarter healthcare decisions and potentially add to their own savings. "The obvious question is, 'Are they not getting care they should be getting?'" Ms. Darling says of high-deductible plan enrollees. "The answer is actually very complicated."

Patients with high incomes and women will probably differentiate between necessary and unneeded care no matter what their deductible is, Ms. Darling says. Low-income patients and people who aren't well-informed about their benefits are a different story.

Patients with low socioeconomic status enrolled in a high-deductible health plan may skip needed emergency care due to high out-of-pocket costs, which may lead to higher rates of hospitalization, according to a study published in *Health Affairs*. Men are also more likely than women are to delay treatment for serious ailments under high-deductible plans, forgoing emergency room visits even for severe conditions such as irregular heartbeat, according to a report from *The New York Times*. Not seeing a physician or going to the emergency room for unneeded treatment saves money, but going without crucial healthcare services could lead to more serious health problems — and more spending — down the road.

Furthermore, a recent study published in the *Journal of Economics* found most people in the U.S. don't understand health insurance plans. The study drew on two surveys of Americans between the ages of 25 and 64 who had private health insurance and were the primary healthcare decision makers for themselves or their families. Of those surveyed, only 14 percent understood all four of the four traditional insurance concepts of deductible, copay, co-insurance and out-of-pocket maximums, according to research led by George Loewenstein, a professor of economics and psychology at Carnegie Mellon University.

These findings suggest that instead of promoting more prudent healthcare decision making, high-deductible plans can lead people to avoid necessary and unneeded treatment alike or to not understand that their plan doesn't cover their care until they come face-to-face with the hospital bill.

Hospitals seem to be encountering that scenario more and more in association with high-deductible plans. According to the American Hospital Association, hospital owners such as Dallas-based Tenet Healthcare Corp. have reported more bad debt tied to patients with high-deductible insurance coverage.

"We're hearing from our members that the number of patients who are unable to pay their bills resulting in bad debts for hospitals because of these plans is increasing," says Caroline Steinberg, AHA's vice president of health trends analysis. "Hospitals tell us around a quarter of bad debt comes from patients who are actually insured."

Patients' misconceptions about their health insurance are often responsible for their ultimate inability to pay for their care, Ms. Steinberg says. "A lot of times, people don't understand their benefit package," she says. "They thought they were insured, but they don't understand what their insurance is covering."

Regardless of the reason, more patients are finding it harder to cover the high deductibles and other out-of-pocket medical bills. CarePayment, which offers flexible patient financing programs to help hospitals cope with bad debt and rising patient balances, has seen rapid expansion in recent years. Its market has expanded beyond its initial client base of uninsured patients, says Craig Froude, CEO of the Lake Oswego, Ore-based company. For CarePayment's programs that let patients pay their out-of-pocket costs over time, "we've seen a pretty significant shift to more accounts from people who have insurance coverage but with a much higher deductible," he says.
Ms. Darling of the National Business Group on Health agrees that high-deductible health plans are indeed a factor driving bad debt, but she doesn't think the plans are the sole cause of patients failing to fulfill their cost-sharing obligations. "I think it's also true that we have more and more people who are either unemployed or in jobs that pay less," she says. "We've had a big drop-off in household income since the recession. I think part of what they're seeing is the impact of that."

With more provisions of the healthcare reform law kicking in and rising healthcare costs still presenting a pressing economic conundrum, it seems likely that hospitals will continue to grapple with bad debt, and high-deductible health plan enrollment will keep rising.

"Healthcare costs are going to continue to escalate, and reform will continue to drive the penetration of high-deductible health plans," Mr. Froude says. "Hospitals need to have proactive strategies in place to protect their financial health and help their patients."

How hospitals and employers can fight bad debt

With a growing number of patients heading to the hospital with high-deductible coverage, what can healthcare providers — and employers — do to prevent a corresponding flood of unpaid bills? Ms. Steinberg of the AHA recommends educating the patient population, something hospitals are already doing.

"They're trying to work with the patients up front so they'll understand what their financial obligations will be and developing strategies to help their patients pay their bills over time," she says.

Employers can ease the burden on healthcare providers by making sure their workers understand their benefits before they even show up at the hospital, she says. "The education should be occurring when the person signs up for the plan, not when they show up for services," she says.

Hospitals, too, can play a vital role in ensuring patients understand their financial obligations. "Our hospital clients are increasingly spending time educating their patients about their financial liabilities even prior to admittance and providing ways for them to cover their costs so they can get the care they need," Mr. Froude says.

Mr. Fioretti of HNI agrees employers have to educate their employees in order for the high-deductible plans to have an optimal effect. "You can't just slap on a high-deductible plan," he says. "You have to surround it with a strong enough support system to teach people how they can be good consumers and provide other incentives for them to maintain their health."

Ms. Darling suggests that hospitals and other care providers work hard to stop providing services that don't have clinical value through efforts such as the "Choosing Wisely" campaign, an initiative launched by the American Board of Internal Medicine Foundation to encourage conversations between physicians and patients about necessary and appropriate care.

One other option is setting up payment programs to let patients pay their bills over an extended period of time, a strategy Mr. Hogan of DeSoto Memorial Hospital opted for by using CarePayment. "That helps us to get a little more smoothing of the cash flow curve," he says.

Conclusion

In the end, it appears that high-deductible health plan enrollment will keep growing along with the need to contain healthcare costs, adding to the assortment of challenges hospitals will continue to face in an industry in the midst of significant reform and upheaval.

"There's a lot going on right now," Mr. Hogan says. "I've been in healthcare for over 40 years, and it's probably the most changes in a small amount of time and the most pressures in a small amount of time I've ever seen in my career. Every day is a challenge."

More Articles on High-Deductible Plans:

- The One Thing Scarier Than Exchanges for Healthcare Providers — Employers Offering Only High-Deductible Plans
- Survey: Big Employers Expect Health Benefit Costs to Go Up 7% in 2014

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FROM WIRE REPORTS
Published: 04 October 2013 08:55 PM
Updated: 04 October 2013 09:53 PM

A lot of attention has been given to the health insurance exchanges opening this month. But if you're like most Americans, you'll still get your insurance through an employer. And that means the annual open enrollment period, when you choose your benefits for the coming year, will soon be upon you.

Almost anyone can shop on the new exchanges, or marketplaces. But if your job comes with affordable coverage, you're ineligible for any subsidies and you probably won't need to shop there.

A few companies have made headlines with big changes to their employee health plans for next year. Walgreen Co., for instance, is shifting workers to a private health care exchange — separate from the state-based marketplaces created by the Affordable Care Act — where they can shop for plans with a contribution from the company.

And United Parcel Service recently told white-collar workers it would eliminate coverage for spouses who are eligible for insurance through their own jobs.

So far companies making such major changes remain in the minority. But benefits experts caution that with so much in flux, it's wise to carefully review the options your employer is offering for next year.

"The overarching theme this year is that you have to pay attention," said Jody Dietel, chief compliance officer at the benefits management firm WageWorks.

Trends to watch

Higher costs for covering your spouse and children.

If you don't already, you may pay a surcharge for covering your spouse if your spouse's job offers coverage. Under the health overhaul, companies that offer insurance to workers must also offer it to their children, but you may pay more for covering them, too.

Higher deductibles are here to stay.

The trend toward "consumer-driven" plans with high deductibles is continuing, as employers shift costs to workers. Usually, high-deductible plans are offered along with a health savings account, which employees can use to help pay for out-of-pocket medical costs. The idea is that if you are responsible for more of your medical spending, you'll pay more attention to the cost. Most companies will now offer at least one such high-deductible plan as an option, and more are offering them as the sole plan.

"Our best indication is that they'll be fairly universally offered in the next few years, and in some cases, exclusively offered," said Christopher Ryan, vice president of ADP's Strategic Advisory Services, a benefits consultant.

Carrots and sticks to influence employee health behavior.

Companies are encouraging workers to improve their health, either by offering payment as an incentive for losing weight or exercising, or higher insurance premiums as a punishment.

"Lots of companies are getting aggressive around wellness and health promotion," said Tom Billet, a health care consultant at Towers Watson.

For instance, your employer may ask you to complete a personal health assessment, or undergo some sort of health screening, like a blood pressure or cholesterol test. As a reward, the company may deposit a bonus into your health savings account.

Questions to consider
Why did my employer gave me information about the state health insurance exchanges if I don’t need to use them?

The law requires employers to inform workers about the marketplaces. But for the vast majority of employees with workplace coverage, no action is warranted, Billet said.

Should I choose coverage under my employer’s plan, or the one offered by my spouse’s employer?

If you and your spouse have coverage available through your respective jobs, you’ll have to do the math both ways to see which option makes the most sense financially, said Helen Darling, president of the National Business Group on Health, which represents large employers.

You’ll also want to take into account any restrictions the plans impose. If your spouse’s plan is less expensive but your family’s doctor isn’t in the plan’s network, for instance, you might want to go with your employer’s plan, even if it costs more.

Is there any upside to high-deductible plans?

They plans usually are paired with a health savings account, which can be financed with pretax dollars by you, your employer or both of you. You can use the money to pay medical costs that fall under your deductible (and keep in mind that most preventive care is covered outside of the deductible, meaning you shouldn’t have to tap the account to pay for it). If you don’t spend the money, it can be rolled over to the next year.

Ann Carm, Times reporter

Questions and Feedback

ps to help you face open enrollment:

Do your homework. Evaluate all benefit options and weigh them against your specific needs.

Look over your benefits selections from last year and assess what worked and what didn’t.

Think about any life changes — such as marriage, divorce or childbirth — that may affect the benefits you select.

Take advantage of health savings accounts, flexible spending accounts and dependent care spending accounts your employer may offer.

Consider participation in health and wellness programs such as smoking cessation, weight management or physical fitness.

The Associated Press

Did you see something wrong in this story, or something missing? Let us know.

Comments

To post a comment, log into your chosen social network and then add your comment below. Your comments are subject to our Terms of Service and the privacy policy and terms of service of your social network. If you do not want to comment with a social network, please consider writing a letter to the editor.

Login to post a comment

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4 Comments

Darrell Seybold 6 days ago

Why would I need to watch anything when Obama clearly stated, “If you have company provided benefits now, uh well, nothing is going to change for you.”

Could he have been lying?? Nah.........

2 replies 1 like

Cestos Jack 6 days ago

Maybe the Liberal writers should have researched a little more. Maybe they should have asked the employees of Delta and several other major companies about healthcare changes.

3 replies 2 likes

Paula Schlinger 6 days ago

Maybe those who blame all changes in corporate health care coverage should look a little deeper and realize that these changes have been happening for a long time and were one of the primary reason that then-candidate Obama ran and was elected on a platform of reforming health care.
Maybe such folks, like Mr. Cestos, would learn that health insurance premiums rose 97% from 2000 to 2008, and that the rise in premiums has actually slowed thanks to Obamamcare. But in order to do so they would have to reject the many lies and distortions being fed to them by rightwing media and get real facts.

They can start here:


If I remember correctly, delta went bankrupt. Then merged with another airline...the changes were due to that incident. A little tough to offer benefits, when you are struggling to have a profit. After a bankruptcy.

Delta also dumped their pensions...

You and I picked up the slack.....doggone Obamacare....

Obama was also the reason Delta went under...

---

Pete 6 days ago

If I remember correctly, delta went bankrupt. Then merged with another airline...the changes were due to that incident. A little tough to offer benefits, when you are struggling to have a profit. After a bankruptcy.

Delta also dumped their pensions...

You and I picked up the slack.....doggone Obamacare....

Obama was also the reason Delta went under...
United Parcel Service got attention by dropping some working spouses from its health plan and partly blaming the Affordable Care Act. But UPS's move is only one among many changes in employer health insurance, most of them having little to do with the health law.

Employers are raising deductibles, giving workers health savings accounts that look like 401(k) plans, mimicking the health law's online insurance marketplaces and nudging patients to compare prices and shop around for treatments.

Together the moves could eventually affect far more consumers than the law's Medicaid expansion or health exchanges aimed at the uninsured and scheduled to open Oct. 1. Here's a rundown.

Q. The Affordable Care Act required fewer changes in employer coverage than in plans sold directly to consumers. Why are employers overhauling their benefits?

A. They cite rising costs. Although overall medical expenses are rising at the slowest pace in decades, they're still going up at twice the rate of inflation. Some analysts doubt the deceleration is permanent.

At the same time, employers say health law requirements such as covering dependents to age 26 and banning annual and lifetime limits on benefit payouts also increase their costs. However, some analysts portray what's going on as part a long-term trend of employer benefit redesign that has little to do with the health law.

Q. What are employers doing?

A. There are two themes. In trying to control their own spending, employers often are shifting health costs to employees. So the average annual deductible for an individual — what consumers pay before insurance kicks in — nearly doubled in the past seven years, from $584 in 2006 to $1,135 this year, according to the Kaiser Family Foundation. (KHN is an editorially independent program of the foundation.)

But employers aren't just making workers pay more. They're trying to make them think more about health-related expenses and behavior.
Companies such as grocer Kroger Co. pay only a fixed amount for particular drugs or procedures, giving patients incentive to shop around for the best price. IBM started giving rebates to workers who adopt healthy lifestyles. Penalizing smokers with surcharges is one of the few discriminatory measures the health act allows.

Q. All that will save employers money. Will it keep workers healthy?

A. The law requires insurance to pay for recommended preventive services without cost sharing. Even so, some worry that the increasing number of plans with high deductibles will cause consumers to avoid seeking treatment when they might need it. Many patients don’t realize the deductible doesn’t apply to preventive care.

At the same time, critics say the veil around the health industry’s costs and prices makes smart shopping all but impossible. Companies such as Castlight are trying to change this by listing prices and information on quality in accessible ways, such as through smartphone apps and easily searchable web sites.

Q. How can workers afford the extra costs of higher deductibles?

A. Proponents of making patients share more costs and shopping — it’s been dubbed “consumer-directed insurance” — say it’s the best way to control the soaring medical spending that strains not just household budgets but corporate and government accounts, too. But some patients with high-deductible plans have trouble paying the bills when they seek care.

Key to giving consumers more responsibility are savings plans known as health savings accounts or health reimbursement arrangements that employees use to pay for the deductibles, co-pays and other expense.

Employers and workers fund the accounts with pre-tax dollars. Unlike the better-known flexible spending accounts for medical costs, money in HSAs can build up, earn investment returns and roll over from year to year.

Q. If having employees shop for doctors and hospitals makes sense, why not give them more power to shop for health insurance, too?

A. That’s the idea behind “private exchanges,” so called to distinguish them from the ACA’s public exchanges that will sell subsidized coverage directly to individuals starting Oct. 1.

In both cases the consumer gets what’s basically a voucher to buy coverage. With the public exchanges it’s an instantly spendable tax credit. With private exchanges it’s employer dollars.

Software guides the consumer through a menu of comparable plans and helps pick the best one for her. Companies steering workers to private exchanges include Darden Restaurants and Sears. IBM and other corporations are putting retirees into private exchanges.

Private and public exchanges are likely to have something else in common: plans with closed, narrow networks of doctors and hospitals that promise lower costs through discounts and better control of care.
Some see private exchanges and HSAs nudging aside traditional health insurance much as 401(k) plans replaced traditional pensions. Whereas employers used to promise health care and retirement income no matter the cost, increasingly they cap contributions for both benefits and let workers bear the risk.

Q. I heard Washington delayed the requirement for large employers to offer health insurance. How is that affecting coverage?

A. The delay is for one year, and most employers already offer coverage. The requirement applies to employers with at least 50 workers. Stores and restaurants, less likely to offer health insurance in the past, may be most affected. The coverage mandate doesn’t affect workers who put in less than 30 hours a week, and some employers have talked about cutting hours.

Q. Are other companies following UPS in how they handle spouses and dependents?

A. UPS decided to stop covering working spouses if they have access to coverage at their own jobs. The health law does not require employers to cover spouses, but surveys show that only a minority of companies have implemented a UPS-style “spousal exclusion.”

However, employers increasingly offer incentives to get spouses off their plans. They may charge workers extra if a covered spouse has access to other insurance, or they may pay bonuses when spouses are not on the company policy.

The health law does require large employers to offer coverage to dependent children as well as employees or pay a penalty.

Q. What are small employers doing?

A. The Affordable Care Act does not require companies with fewer than 50 workers to offer coverage. It does create online marketplaces, scheduled to open in October, for small employers to buy insurance similar to policies offered there for individuals. But the ability for small-business workers to choose from multiple plans will be delayed in most states until 2015.

Small employers are less likely to offer coverage. This year 57 percent of firms with 199 or fewer workers provided health insurance, according to KFF.
Attachment E
The Future of U.S. Health Care

What Is a Hospital? An Insurer? Even a Doctor? All the Lines in the Industry Are Starting to Blur

By ANNA WILDE MATHEWS

Call it the united state of health care.

Amid enormous pressure to cut costs, improve care and prepare for changes tied to the federal health-care overhaul, major players in the industry are staking out new ground, often blurring the lines between businesses that have traditionally been separate.

Hospitals are bulking up into huge systems, merging with one another and building extensive new doctor work forces. They are exploring insurance-like setups, including direct approaches to employers that cut out the health-plan middleman.

On the other side, insurers are buying health-care providers, or seeking to work with them on new cooperative deals and payment models that share the risks of health coverage. And employers are starting to take a far more active role in their workers’ care.

Such shifts have been gathering force for a while, but the economic downturn has accelerated the push for efficiency. The federal legislation, which creates new health-insurance marketplaces and requires most people to carry coverage, may unleash additional demand for health care once it fully takes effect in 2014.

Even if the Supreme Court unwinds part of the law, the changes occurring now aren’t likely to stop because the pressure to reduce the price of health coverage won’t go away.

"We're seeing a marketplace reacting to an economic imperative," says Michael O. Leavitt, a former U.S. Secretary of Health and Human Services who is now chairman of a health-information company. "The new delivery models are far more integrated."

The trends have crystallized over the past year in a series of high-profile deals and quiet, under-the-radar developments. For a close look at what they mean, here...
are snapshots of five people—a doctor, a hospital CEO, an insurance-company official, a human-resources executive and a patient—on the front lines as much of the $2.6 trillion U.S. health-care industry tries to remake itself.

Their stories show where health care is trying to go. The picture wouldn't be complete without a reminder of where it has been. Many of these same efforts were attempted in the 1990s, and they often failed. Experts caution that there are many signs the current flurry of activity could result in the same problems, with less margin for error in today's unforgiving economic environment.

**Getting the Doctors On Board**

Ultimately, the success or failure of efforts to change the health-care system may hinge largely on doctors like Dan McCullough.

As a family physician, Dr. McCullough, who works for a hospital system in Beverly, Mass., is on the front lines of efforts by health-care providers and insurers to boost preventive care and rein in costs. Hospitals and insurers are both rushing to employ and ally with primary-care doctors in all of their new schemes to blend their various functions and integrate the health-care system.

But doctors, the gatekeepers of the system, often react sharply to efforts to control their practice styles. A survey this spring of medical administrators and doctors by health-staffing firm AMN Healthcare found that doctor and staff cooperation was the most frequently cited "serious obstacle" to creating accountable-care organizations.

In Dr. McCullough's case, around 28% of his pay for the fiscal year ended in September was tied to patient-satisfaction, quality and efficiency goals, a mix of his own results and those of the entire physician group affiliated with the hospital. The quality portion involves measures like patients' blood-pressure control and preventive care like mammograms. The efficiency part is tied to statistics including how often doctors refer patients to specialists outside the system and how often their patients go to the emergency room. But much of the rest of Dr. McCullough's pay is still tied to his productivity, a typical style of doctor compensation that parallels the traditional fee-for-service model.

Dr. McCullough's current pay structure took effect last year, when he started working under a contract with the state's biggest insurer, Blue Cross Blue Shield of Massachusetts, that enables providers to effectively earn more if they keep costs down and meet quality goals. Upping the ante, Dr. McCullough's employer, Northeast Health System, ties an additional chunk of his pay to quality and patient-satisfaction measures.
Dr. McCullough, 44 years old, says he likes the incentives. It used to be true that "quality doesn't pay the bills," he says. Now he focuses more on closely tracking the care of patients with chronic conditions, including hiring a new case manager. He says the new payment method also makes him think twice about allowing some services or specialty care from doctors outside his hospital's network. In the past, he "would just rubber-stamp the referral," he says."

Recently, he got a call from a doctor's office because one of his patients had gone there seeking surgery for chronic heartburn. Dr. McCullough refused to sign off. Instead, he called the patient and asked him to come in for an appointment. After he prescribed a stronger heartburn medication, the man, who had seen the surgery advertised, decided he no longer needed the procedure.

Dr. McCullough, who has a master's degree in medical ethics, says he doesn't skimp on care that he believes will help patients. Indeed, many aren't even aware that his compensation has changed. Sometimes, though, patients question his motives. One woman wanted an ovarian-cancer test because a friend of hers had suffered from the disease, but Dr. McCullough refused to order it. The patient was "a little miffed," and she said "it's because the insurance company doesn't want to pay for it," Dr. McCullough says. He responded that there was no evidence she needed it. Still, he says, such encounters are "not the highlight of my day."

An older, recently widowed patient who kept going to the emergency room when he ran out of his asthma medication got a house call from Dr. McCullough, whose office then helped get the man into adult day care. The traditional fee-for-service model has no reward for that, he says. But "we got really aggressive with him not just because it's the right thing to do, but because we were incentivized to do it."

**Mergers Help Hospital Bulk Up**

Jim Taylor, the chief executive of the University of Louisville Hospital, says his institution's future depends on an ambitious statewide merger with two other hospital systems. Now, he has to persuade others that he's right.

In June, Mr. Taylor helped unveil a plan to merge with nearby competitor Jewish Hospital & St. Mary's HealthCare and Saint Joseph Health System, an eight-hospital group based in Lexington, Ky., that is part of Catholic Health Initiatives of Englewood, Colo.
If the deal is approved by the state's governor and the local Catholic archbishop, the nonprofit Catholic Health Initiatives will provide a $320 million infusion of cash and will hold 70% of the combined system. The merger would create Kentucky's biggest hospital network, with 14 facilities stretched across the state and $2.5 billion in annual revenue. It would also account for 22% of the acute-care beds in Louisville and 13% of those statewide.

Mr. Taylor says the money, along with the better bond rating the merged combination will get because of Catholic Health's backing, will provide a vital buttress for University Hospital. "We couldn't grow, and our role was going to decline as we face revenue pressures" from declining government reimbursement, says Mr. Taylor, 64, a second-generation hospital executive.

Mr. Taylor says University is in the black now but can't afford to buy advanced electronic medical records or upgrade and expand its main facility, built in 1980. University, which is the region's only adult trauma center and main safety-net hospital, is routinely overcrowded, particularly its emergency department, a spokesman says. Over the years, executives have drawn up plans to build a new $150 million patient tower and spend $33 million to expand emergency capacity, among other options, but had to shelve them. Mr. Taylor and other executives say the merger will achieve savings when duplicated functions are consolidated.

Nonprofit hospitals had their slowest revenue growth in at least two decades last year, according to Moody's Investors Service. The financial challenge is leading many to merge in hopes of cutting expenses and gaining leverage in negotiations with insurers. In the first three quarters of this year, there were 71 hospital mergers, compared with 53 at that point last year. The full number for 2010, 75, was already the highest since 2001.

Hospital deals can touch a nerve, because of the institutions' central economic and emotional position in their communities. Often, the debate centers around whether a for-profit company based elsewhere will continue to provide charity care and meet other local needs.

In Mr. Taylor's case, the controversy has mostly focused on whether University Hospital will be affected by Catholic care guidelines, which ban or restrict various reproductive procedures including abortion and sterilization. The buzz-saw of resistance has put Mr. Taylor in an unaccustomed spotlight after 15 years as the hospital's CEO. A community forum on the deal drew more than 200 questions. There are
also dueling lawsuits over whether University Hospital merger documents are covered under state public-records laws.

"I don't think a hospital that belongs to the people of Kentucky should be merged and be dictated to by people who put restrictions on certain procedures," says Rep. Tom Burch, a Democrat who chairs the health and welfare committee in the state's House of Representatives. "It has hit a sore spot with people."

Mr. Taylor says the merger won't significantly affect service offerings at his hospital, which doesn't currently provide elective abortions. University Hospital has made arrangements for women who want tubal ligations to get them at a different facility, he says.

The new network will have more than 3,000 doctors. Though University Hospital doesn't employ its own physicians, the other two merger partners have significantly expanded their employed doctor staffs in recent years, including primary-care doctors, a common pattern in U.S. hospitals recently.

The new system will be able to integrate patients' care and to take on the financial risk tied to overseeing groups of patients, says Paul Edgett III, a Catholic Health Initiatives senior vice president. It will look at "warranty"-style payments, he said, under which a set sum is paid for an episode of care, including any complications. Such setups, under which hospitals can sometimes lose money if costs run too high, move hospitals into a space that has largely been the purview of health insurers.

Mr. Taylor said that on its own, his hospital is "poorly positioned" to do such deals, because it's "too small, too limited."

An Insurer Partners With Hospitals

Negotiations between health insurers and hospitals typically focus on clashes over payment rates. Chris Day, an executive with Aetna Inc., is supposed to change that.

Mr. Day, 36, spearheads Aetna's efforts to create new cooperative deals with health-care providers. The details vary, but the main idea is that Aetna and the provider try to work together to trim costs and track the quality of care. In the most ambitious cases, they are creating jointly marketed health plans that effectively blur the line between insurer and provider.

Instead of Aetna simply paying the hospital for services, the two exchange patient data and may share the risk of coverage, acting more like an integrated company. These plans aim to leverage the hospital's local brand-name recognition and the insurer's back-office know-how.

They also may be the insurer's best shot at competing in many of the new state-based health-insurance marketplaces where some 24 million people are eventually expected to buy coverage. Chief Executive
Mark Bertolini recently highlighted the new "HMOs on steroids" as a key Aetna initiative at an investor conference.

Accountable Care

<table>
<thead>
<tr>
<th>Currently have an ACO in place</th>
<th>Likely to have an ACO in place by</th>
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<tr>
<td>2011</td>
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<td>15%</td>
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Note: May not add up to 100%, due to rounding.

But after years of head-butting between the two industries, a warm-and-fuzzy partnership isn't always an easy sell. "When I walk in that room, I'm seen as a health-plan person," says Mr. Day, who estimates that he has met with more than 100 medical providers around the country. Sometimes he breaks the ice by referring to his own background, which includes running a sleep clinic and an early stint as a hospital data-entry clerk.

Aetna recently unveiled a jointly marketed health plan with Banner Health, a not-for-profit 23-hospital system based in Phoenix, Ariz., after more than a year of talks. At one point early on, Mr. Day had to keep some locally based Aetna executives out of key strategy meetings with Banner. After one of them raised the idea that Banner might need to grant some rate discounts, a Banner official suggested "we needed to find ways to keep the conversations strategic," Mr. Day says.

On the other side, Chuck Lehn, vice president of managed care for Banner Health, says Mr. Day earned his trust by sharing closely held information, including certain details of how the insurer sets premiums. Aetna also agreed it wouldn't build a guaranteed profit margin into providing administrative services for the new product, he says, though both sides will share its earnings.

"We shared a lot more information than we normally would" with an insurer, including detailed cost and utilization data, Mr. Lehn says. "I remember thinking, 'I'm putting my total trust and faith that they're not going to use this!'" against Banner to winch down rates.

The two sides zeroed in on areas where they could potentially shave costs and improve care, such as relatively high use of imaging scans by some Banner doctors, Mr. Lehn says.

During a different effort to strike a deal with a provider, Mr. Day's talks broke down for months because a separate contract-rate negotiation between the hospital system and local Aetna executives got so contentious that details leaked to the local media. In another case, a mistrustful hospital executive demanded written pledges that his...
company's patient information wouldn't be used in setting the patients' insurance rates.

Like other insurers, Aetna is making moves into the business of providing services to providers partly to prepare for another change tied to the federal overhaul law. It requires health plans to spend a set share of premium dollars on health-care expenses, which can crimp insurance profits.

**An Employer Gets Into Health Care**

A few years ago, Robert Jacobs, a human-resources executive at MasterBrand Cabinets, felt he was running out of options to blunt annual double-digit health-coverage price increases. Employees had already shouldered as much as they could bear, he felt. He had hit the limit of discounts from health providers. Wellness programs like free health-club memberships had shown little impact.

Then Mr. Jacobs read a research report that said about three-quarters of health costs are linked to lifestyle-related conditions. That persuaded him to try a radical new tack: Last year, MasterBrand, which has some 7,000 U.S. employees, started tying their insurance-premium contributions to their health-risk factors. Those who score poorly on measures such as cholesterol, blood pressure, body-mass index and tobacco use pay more each week.

"We had to do something more," Mr. Jacobs says. After wood and salaries, health care is the company's third-biggest expense, and "I can't pass that along to my customers in prices on kitchen cabinets."

The program at MasterBrand, a unit of Fortune Brands Home & Security Inc., is an example of companies' growing willingness to push workers toward better health, a role once left to health-care providers. MasterBrand, like others, offers the health tests right at the offices and factories where its employees work.

A survey this year by consulting firm Towers Watson and the National Business Group on Health found that 13% of U.S. employers are tying financial incentives to health outcomes like cholesterol-test results, and another 33% plan to do so. Forty-three percent of the biggest employers are taking an even more direct path into health care by offering onsite clinics, according to a survey by Mercer.

Some of these efforts are controversial. In a letter to federal regulators in March, groups including the American Heart Association, the American Diabetes Association and the American Cancer Society's advocacy arm said such programs were backed by little evidence and risked discrimination against people based on their health.

Mr. Jacobs, a blunt-spoken 60-year-old who himself is managing elevated blood pressure, says he is giving employees accountability. "It's almost like going to a risk-based insurance like automotive," he says. "If you have a health risk you're not managing, you'll pay a little more."
So far, MasterBrand hasn’t set very stringent standards, he says. Also, the most a worker has to pay extra based on test results is $10.50 a week, while a person with the best health indicators gets a $2-a-week discount.

The program is administered by Bravo Wellness LLC, a vendor that oversees an appeals process that is supposed to let workers opt out without penalty or aim for alternative goals if they have a medical condition that makes it impossible to achieve the targets. Those who choose not to participate without a medical excuse pay an extra $37.50 a week in premiums.

Around a half-dozen workers got urgent calls after they took the health tests, warning they were in imminent danger of heart attacks, Mr. Jacobs says, and a couple had heart-related surgery.

He also points to employees like Sandra Kaufman, 47, who works in shipping at a MasterBrand facility in Goshen, Ind. She says she initially thought the program was "an invasion of my privacy." But she couldn’t afford the penalty for refusing to participate, so before it launched two summers ago, she went to a doctor for the first time in years. When she learned she had high blood pressure, elevated cholesterol and diabetes, Ms. Kaufman started dieting and exercising, and she says she has lost about 50 pounds.

Mr. Jacobs says he fielded complaints when the program was started. One man asked him angrily, "Why are you doing this to us?" The worker didn’t think the company should be imposing health standards. "That's personal," he said, according to Mr. Jacobs, who says he responded that MasterBrand had a stake as well, since it was paying around 80% of the cost of workers’ health coverage.

The worker is now a "willing participant" in the program, Mr. Jacobs says.

A Patient Gets Care From His Insurer

On a recent day, Louis E. Kauder Jr., an 86-year-old suffering from advanced diabetes, arrived at a storefront clinic in La Mirada, Calif., for his weekly checkup.

Nurse Eugenia Chang looked at his blood-sugar result and started quizzing him. What had he eaten? Mr. Kauder confessed to a dinner the night before of macaroni and cheese and chocolate chips. "Your sugar is a lot higher than normal," she chided, urging him to avoid desserts and eat more protein.

Then she zeroed in on his toe, which had a small sore. Was he wearing the protective shoes the clinic provided? She painted the toe with a disinfectant and wrapped it in gauze.

Finally, she examined a gaping six-inch-long wound on Mr. Kauder's left calf. That was improving, she said, and she would continue the daily home visits from a nurse to dress it.

Hospitals and doctors are increasingly promoting this type of health care – close, constant monitoring, with strong efforts to push preventive measures – as the best way to treat chronically sick patients.
But Mr. Kauder's clinic is different: It's owned by a health-insurance company, CareMore Health Group, that offers Medicare Advantage plans. CareMore says it can improve patients' health and save money in the long run by taking an active hand in their care.

It's a bet that more insurers are making, hoping to trim costs and lock in some doctors in case the influx of newly insured consumers leads to a shortage. CareMore was bought in August for slightly less than $800 million by WellPoint Inc. The big insurer said it plans to more than double the number of "care centers" that CareMore operates and spread it across the country.

Last December, Humana Inc. spent $790 million for Concentra, an operator of urgent- and occupational-care clinics. And Humana late last month announced it would buy SeniorBridge, which focuses on care for complex chronic conditions.

UnitedHealth Group Inc.'s Optum health-services arm recently purchased the operations of Monarch HealthCare, an Irvine, Calif., association that includes some 2,300 doctors, the latest of several doctor groups in which the company has taken ownership stakes. Cigna Corp. announced in October that it would spend $3.8 billion to buy HealthSpring Inc., a Medicare Advantage carrier that works closely with doctors and owns some of its own clinics.

CareMore says the heavy upfront investment it makes in preventive care for patients like Mr. Kauder pays off because its members end up spending less time in the hospital than most traditional Medicare beneficiaries. They have fewer readmissions and lower rates of events like heart attacks, says the company's chief medical officer, Ken Kim.

A hospital stay can run $3,000 or more a day, Dr. Kim says. Amputation of a limb for a patient with advanced diabetes like Mr. Kauder can cost about $16,000, he says, and CareMore's amputation rate is about 60% lower than the average for traditional Medicare.

"We get to them at the front end" and keep medical conditions from worsening to catastrophic levels, he says. As a result, CareMore is more profitable than many rival Medicare plans, he adds.

Mr. Kauder started with CareMore last October. "They really take care of me," he says. He doesn't pay a premium for the CareMore Medicare Advantage plan, and he doesn't have out-of-pocket fees to see CareMore staff, though he does pay charges for some other things, like certain medications.

His case illustrates many of the challenges of managing chronically ill patients. After repeated medication tweaks and sessions with a nutritionist, Mr. Kauder's blood sugar level has improved, but it's
still not at CareMore’s target. The retired auto mechanic also has heart problems, and he had a bypass operation a few years ago.

A CareMore staffer asked a visiting wound-care nurse whether his home, where he lives alone, showed signs of neglect such as rotting food. On another occasion, when a visiting nurse spotted Mr. Kauder trying to clamber over a wall in his backyard, she informed clinic personnel. A case manager phoned Mr. Kauder to make sure he wasn’t showing signs of dementia and booked him for an immediate checkup.

Still, Mr. Kauder’s major leg lesion has lingered since February, a common circumstance for someone with advanced diabetes. It became infected, and his home-visit nurse started administering an intravenous antibiotic. In June, he ended up in the emergency room after he tripped and opened up the wound, which bled heavily. Doctors at the hospital urged him to consider amputating the limb below the knee.

"I said, no way," says Mr. Kauder, whose mother lost a leg to diabetes. After a night in the hospital, where CareMore doctors visited him, he returned home. Since then, he hasn’t been in the hospital, and the wound has improved. He’s off the IV antibiotic. The clinic tracks the wound’s progress with weekly digital pictures.

Dr. Kim, the CareMore chief medical officer, who wasn't personally involved in Mr. Kauder’s case, says the care almost certainly saved his leg.

Write to Anna Wilde Mathews at anna.mathews@wsj.com
Attachment F
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Mission Statement

Mission

The mission of Emory University Student Health and Counseling Services is to empower students to take responsibility for their health and to complement the academic mission of the university by providing unified medical, counseling and health promotion services that result in a healthy campus culture. Student Health and Counseling Services is committed to providing caring professional clinical services to a diverse student body and to reducing the stigma associated with seeking mental health services.

Vision

The vision of Emory University Student Health and Counseling Services is to help students to excel, both while at the University and beyond, by promoting wellness as a state of optimal human functioning.

Emory University Student Health Services is very proud to be fully accredited by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). Emory University Student Counseling Centers Psychologist Training Program is fully accredited by the American Psychological Association (APA).
Overview of EUSHCS 2011-12 Accomplishments

Significant EUSHCS Accomplishments for 2011-12 included:

- EUSHCS met all Annual Report organizational goals for 2011-12 (see EUSHCS Goals and Results 2011-12).
- EUSHCS continued to meet the primary care, nursing, counseling, psychiatric and health promotion/wellness needs of over 13,500 Emory students, offering state of the art and evidence-based services and programming.
- EUSHCS created a multidisciplinary Strategic Planning Task Force in Fall 2011 and completed the 2012-16 EUSHCS Strategic Plan in February 2012. The EUSHCS strategic plan includes five major strategic goals with detailed objectives, implementation strategies, timelines, process owners and financial implications. The EUSHCS Strategic Plan was presented to Campus Life Deans and Directors in April 2012.
- EUSHCS successfully implemented the Fall 2011 American College Health Association National College Health Assessment (NCHA), analyzed data, and disseminated findings to stakeholders. Emory University received recognition at the American College Health Association annual meeting as a prime example of a well executed National College Health Assessment (NCHA). Emory’s response rate in November 2011 was 31.5%. The ACHA-NCHA dataset helps EUSHCS set priorities and spark campus dialogue around students’ health attitudes and behaviors. Wide-scale dissemination of results will begin in fall 2012.
- EUSHCS spearheaded another highly contentious but ultimately highly successful renegotiation of the Aetna Student Health Insurance Plan for 2012-13. By successfully fighting to reduce the rate increase from over 24% to 7.9% (including mandatory national healthcare reform plan enhancements), 5,800+ Emory students enrolled in the plan (and/or their academic departments) will save nearly $2 million in premiums paid in 2012-13.
• EUSHCS successfully advocated with Ways and Means Committee and the Board of Trustees to increase the Mental Health and Counseling Fee from $50 to $58 in FY13, which will sustain personnel and programming funded by the fee and continue the most effective intervention programs currently funded by the Garret Lee Smith SAMHSA Suicide Prevention Grant.

• EUSHCS initiated an Emory Healthy Campus Coalition in collaboration with the University Senate and conduct a needs assessment for sexual and relationship violence prevention and response, using findings to integrate primary prevention into program components. Marc Cordon, MPH chaired the Campus Life committee of the University Senate in the first of a three-year term focusing on the development, operationalization and sustainability of a student-run Healthy Campus Coalition. Year one focused on a literature review, building a theoretical foundation and beginning to engage students, staff and faculty on the steering committee.

• EUSHCS completed the final moves to new primary care clinical facilities in the 1525 Clifton Road building, gaining an additional 2,000 sq. feet of clinical, waiting room and administrative space. Erna Wilkerson, MHA and Business Office staff redesigned the EUSHCS waiting room to make it more welcoming and student-oriented, including a video screen with health enhancing messages.

• EUSHCS had another successful year financially, with nearly $2 million in patient care revenue for FY 12.

• Primary care and women’s health clinical providers, nurses, counselors and psychiatrists at the 1525 Clifton facility saw over 19,000 individual patient visits in 2011-12.

• Emory University was recognized as a “Safe Community” due to the collaborative work of the Emory Safety Alliance, of which EUSHCS is an active member. Michael Huey is co-chair of the Safety Alliance. Emory is only the second campus in the United States to receive this designation.

• Counseling Center and Psychiatric staff continued to deal with very serious mental illnesses among our student population. Data from clinical assessments estimate that 24% of students using Counseling Center services this year reported having had some kind of suicidal ideation; 10% reported having these thoughts more than rarely, and about 4% reported having these thoughts frequently.

• The Sexual and Relationship Violence Prevention Education and Response program re-launched under a new name, the Respect Program, in July 2012. Lauren Bernstein, MSW worked with several student volunteers at the undergraduate and graduate level
to conduct formative research informing the strategic plan for violence prevention. The Respect Program will continue to provide crisis intervention, individual consultations, and education while expanding on its successes over the past year in student mobilization and leadership as well as population-level prevention.

- In Spring 2012, EUSHCS received a $1000 grant from the Emory College Center for Creativity & Arts to host the Water Gives Life; Water & Soap Saves Lives Video Contest. Emory students were encouraged to create short digital videos to increase hand hygiene awareness. The first and second place videos debuted at the Center for Ethics’ Free Speech Art Café. The winning video was also featured in the May 2012 edition of Student Health 101.

- EUSHCS worked with Emory Healthcare Administration to maintain Emory Clinic Radiology services in the 1525 Clifton Road building.

- Business Office staff completed a final transition to a fully electronic medical records system. In summer 2012, over 9,000 paper medical records of graduated Emory students were electronically imaged for future reference and access.

- EUSHCS Nursing Staff created new patient care protocols for the Travel and Immunization Clinic. The highly utilized EUSHCS Travel Clinic provided comprehensive risk assessment, immunizations and travel education to Emory students studying abroad.

- EUSHCS participated in the planning and successful implementation of the 2012 Emory Campus-wide “Active Shooter” Emergency Drill. The drill was a centerpiece of the successful site visit for Emory’s Safe Community designation.

- EUSHCS Nursing and Business Office Staff implemented another successful Flu Shot Campaign, giving close to 2500 flu shots to the Emory students.

- EUSHCS continued participation in Emory’s Enterprise Risk Management process, as a process owner for 4 of the 50+ identified major risks.

- In Fall 2011, OHP launched a unified social media experience for students, incorporating a blog site and Twitter feed as well as photos, videos, direct access to the Student Health 101 online magazine and incorporating our existing Facebook page. Our Be Well Excel listserv continued to grow and numbers over 1500 students even after many members graduated.

- Dana Wyner, PhD’s two year assessment study of the EUSHCS Stress Clinic received a national honorable mention from the AAAHC Institute of Quality Improvement.
- Michael Huey, MD was honored as the Emory University 2012 LGBT Ally of the Year.

- OHP planned, implemented and evaluated campaigns and awareness weeks including: National Collegiate Alcohol Awareness Week; Take Back the Night; National Nutrition Month and Sexual Assault Awareness Month.

- Counseling Center staff saw 1031 new clients, representing a 15% increase from the previous year. Center professional staff provided 8777 therapy hours, or a 14% increase compared to the previous year and a record for the Center. Despite these significant increases in students served, 96% reported having been seen in a reasonable amount of time.

- Counseling Center staff continued to supervise and support two marquee student-run groups over the past year: Helpline and Active Minds. Active Minds’ marquee event was the first-ever Active Minds Southeastern regional conference.

![National Nutrition Month with President Wagner](image-url)
EUSHCS 2011-12 Clinical Provider Accomplishments

In 2011-2012, EUSHCS Clinical Providers enjoyed delivering high quality health services to Emory students while participating in campus life activities and educational programs. Accomplishments included:

- Completion of more than 300 hours of continuing medical education concerning topics such as emergency medicine, primary care updates, contraceptive technology, wilderness medicine, and women’s health

- Completion of quarterly peer reviews and annual HIPAA privacy compliance and blood borne pathogens /OSHA training for clinical providers

- Participation in new student orientation events

- Participation in the educational mission of the University by presenting lectures to students, faculty and the community. Betsy Rothschild served as a course module director for Fundamentals of Endocrinology, served as a Learning Society Leader, and lectured on urinary tract infections for students in the physician assistant program.

- Mike Huey continues to serve as a team physician for Varsity Athletics at Emory. He provides care at the on-site training room clinic and during athletic events.

- Clinical providers continue to create and revise policies, procedures and forms to facilitate high standards of care for our students.

- Michael Huey served on numerous Emory committees such as the Emory University Administrative Counsel, Emory University CEPAR Operations Group, the Disaster Drill Planning Committee, the Emory Healthcare Influenza Operations Group, the Emory College Orientation Planning committee, and the Emory Athletics Athlete Wellness Committee. Michael Huey is Co-chair of the Emory Safety Alliance and is Chair for both the Emory Student Health Insurance Advisory Committee and the Emory University Student Insurance Requirement Appeals Committee. He is a member of Emory’s Occupational Medicine Steering Committee and Occupational Medicine Executive Director Search Committee.
• Ray Jarvis directed the American Heart Association CPR training for members of the EUSHS medical staff in January, 2012.

• Mike Huey continues to serve as a surveyor for the Accreditation Association for Ambulatory Health Care.

• Betsy Rothschild attended the American Association of Physician Assistants National Conference in May 2012 and made a presentation on The Clinical Preceptor’s Tool Kit. Betsy also served as a project leader at the Clinical Coordinator Workshop for the Physician Assistant Education Association in March 2012.

• Ray Jarvis continues to enhance the Student Health website by serving as a manager and editor.

• Theresa Berry and Betsy Rothschild continue to volunteer at the Good Samaritan Clinic in Atlanta.

• Theresa Berry served as an attending for the Physician Assistant Program during their work with the South Georgia Farm Worker Health Project in June 2012.

• Theresa Berry received certification for Advanced Wilderness Life Support (AWLS).

• Dawn Mielke received certification for Adult Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS).

• Eleanore Reiss initiated a support group for students with diabetes.

• Michael Huey, MD was honored as the Emory University 2012 LGBT Ally of the Year.
EUSHCS 2011-12 Nursing Staff Accomplishments

EUSHCS Nursing Staff continued to focus on assisting in providing excellent care to our Emory University students. 2011-12 accomplishments included:

- Continued to communicate with hundreds of students offering timely medical advice through Point -N-Click, EMR, via secure e-mail, and the medical information phone line.
- Provided nursing support and assistant to EUSHS providers and in-house specialty clinics (Dermatology and Colposcopy) in the care of our students.
- Provided Travel Consultations to hundreds of students traveling out of the country and administered required vaccines which included Yellow Fever and Japanese Encephalitis.
- Developed a new nurse protocol for the Travel Clinic.
- Continued to administer various vaccines to students through the Immunization Clinic. Also, coordinated many mass immunization sessions with the Medical, Allied Health, and Nursing Schools.
- Assisted in tracking over 1300 pap smears and follow up to students with abnormal pap smears.
- Collaborated with non-EUSHS doctors to provide services for student requiring blood drawn and administering injections for chronic illnesses.
- Continued to provide desensitization services to over 50 patients receiving from 1-4 allergy shots weekly.
- Continued to coordinate and manage a successful contraceptive program completing hundreds of refill requests and offering up-to-date methods and information.
- Worked with staff to implement a successful Flu Shot Campaign, giving close to 2,500 flu shots to the Emory students in a newly renovated nursing triage area.
- The nursing staff attended numerous conferences, seminars and in-house in-services such as MSM, Sexual Violence and Safe Space. Gertrude Thompson attended the American College Health Conference in Chicago. Molly Mitchell attended the PnC Conference in South Carolina.
Molly Mitchell and Gertrude Thompson were members of the EUSHCS Strategic Planning Task Force.

Continued to have a nurse representative on Executive, Core Group, Women Health and Safety Committees.

Continued to actively participate in developing and updating policies and procedures.

Several nurses were recertified in CPR and renewed their Defensive Driving privileges, which aids in transporting students to the ER and sometimes their residence hall.

Two nurses, Marlene Tessler and Dawn McJenkin, retired after a cumulative 55 or more years of nursing experience.
Highlights

- We welcomed Sue Gloor as our 2010-2011 RHD Fellow.

- Emory was recognized as a “Safe Community” due to the collaboration of the Emory Safety Alliance of which OHP is an active member. Emory is only the second campus in the United States to receive this designation.

- Spring 2012 marked our first semester as a tobacco-free campus. We provided Freedom from Smoking courses as well as individual consultations to assist students who wanted to quit.

- Emory University received recognition at the American College Health Association annual meeting as a prime example of a well executed National College Health Assessment (NCHA). Our response rate in November 2011 was 31.5%. The ACHA-NCHA dataset helps us set priorities and spark campus dialogue around students’ health attitudes and behaviors.

- Willie Bannister, Virginia Plummer, and students Uduak Bassey, Danielle Kuykendall, Kristen Bell, Alexis Ritvo and alumna Andrea Stokfisz collaborated on a two year project to develop a comprehensive plan for ATOD Prevention and Risk Reduction at Emory.

- The Sexual and Relationship Violence Prevention Education and Response program relaunched under a new name, the Respect Program, in July 2012. The Respect Program will continue to provide crisis intervention, individual consultations, and education while expanding on its successes over the past year in student mobilization and leadership as well as population-level prevention.

- In summer 2012, we had 16 volunteer interns who developed a wide array of projects to enhance individual and community wellbeing including program planning, curriculum design, video production, independent study in the connections between student affairs and health promotion, campaign development, research, and marketing. See photo.
Health Promotion Goals and Outcomes 2011-2012

**Goal One: Build Individual and Community Capacity through Education and Training**

**Summary**

We provided 156 educational programs totaling 217 hours of instruction and resulting in 3,868 student contacts, 380 staff contacts and 38 faculty contacts. Of these total educational programs, we provided 8 mini-courses and micro-courses reaching a total of 95 participants.

We also participated in 21 outreach events reaching over 600 students.

**Mini-Course and Micro-Course Outcomes**

**Healthy Sustainable Eating on a Budget - Fall Micro Course Summary:**
Evaluations from the three classes showed improvement in knowledge scores and positive feedback regarding student experience in the classes. Goals of the lesson plan were accomplished in all three classes. The instructors concurred that the depth of class discussions was excellent. All students collaboratively prepared, cooked and ate together.

**Healthy Sustainable Eating on a Budget - Spring Micro Course Summary:**
Three distinct sections were provided: “Grains and Greens”, “The Pros and Cons of Chocolate” and “Meet Meat”. Goals of the lesson plans were again accomplished in all three programs. Participation in all three programs was excellent as was feedback from students.

**SleepWell**
The majority of participants responding at each interval met the learning outcomes. The majority of participants that could be matched from time 1 to time 3 showed an improvement in sleep quantity or maintained an appropriate sleep quantity. This was the first department self-sponsored iteration of SleepWell. Thus, there were no meals or snacks provided. Retention was comparable to other cohorts and the initial registration exceeded any other cohort (no limitations to registration based on sponsor or class year). The class will be continued.

**Curriculum Infusion**
OHP staff partnered with faculty in the Rollins School of Public Health to provide learning experiences for MPH students in seven courses. Results of these projects were a) used to strengthen The Respect Program; b) shared with the national publishers of Student Health 101 e-magazine to improve its features for graduate students; c) used to revise the LeadWell series; and d) used to inform development of an online wellness map (in development ‘12-’13).
Student Practica and Practical Experience

- Heather Zesiger mentored 4 students for year-long public health practicum experiences:
  - Jenna Lupi – long-term retrospective assessment of the SleepWell mini-course
  - Heather Marsh – creating supplemental interventions to complement AlcoholEdu
  - Alice Byrd – Tobacco Free Emory Task Force evaluation and social marketing (Dooley Quits!)
  - Amy Goodman – converting SleepWell to an online course

- Lauren Bernstein mentored Sara Millimet, an RSPH student, in a practicum project benchmarking other institutions’ sexual violence prevention programs and their educational programming offered during new and transfer student orientation.

- Marc Cordon supervised two RSPH practical experience interns. Kirsten Bondalapati was our data analyst for the NCHA; Maral Banan joined us for part of the year as the Healthy Campus Coalition intern.

- Willie Bannister and Virginia Plummer co-advised two RSPH practicum students, Uduak Bassey and Danielle Kuykendall, in the summer, preparing internal benchmarking report and Alcohol and Other Substance Abuse Prevention and Intervention Strategic Plan.

- Willie Bannister supervised, with support from Lauren Bernstein, Anjali Desai, an RSPH intern developing curricula to highlight the intersections of sexual assault and alcohol abuse prevention in summer 2012.

Goal Two: Provide Clinical and Consultative Services and Case Management to Enhance Health and Reduce Risk

Clinical and consultative service visits August 2010 - July 2012:

<table>
<thead>
<tr>
<th>Sexuality Counseling and Confidential HIV Testing in OHP</th>
<th>Nutrition Counseling</th>
<th>Alcohol &amp; Other Drug Risk Reduction</th>
<th>Sexual Assault Prevention &amp; Response</th>
<th>Sleep Consultations</th>
<th>Stress Reduction (at the Counseling Center)</th>
</tr>
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<tr>
<td>62</td>
<td>468</td>
<td>291</td>
<td>196</td>
<td>24</td>
<td>123</td>
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Virginia Plummer augments Stress Clinic staffing for a second year
Gini taught 18 Stress Clinic classes at the Counseling Center.
Goal Three: Perform Assessment and Evaluation to Inform Practice

Willie Bannister submitted a quality assurance study on the AlcoholEdu program. This report as well as other indicators will be considered in 2012-2013 to determine whether to renew the contract for this service or to seek an alternative.

Carol Kelly submitted Campus Life Needs Assessment, Assessment 2011-2012, Nutrition Factors Which May Affect Athletic Performance, Phase II (with Joyce Jaleel and Susan Johnson). Results will be used to inform future nutrition education interventions with student athletes and may be published.

Carol Kelly submitted 6 micro-courses: 2 cohorts of each of the following: Grains & Greens, Pros and Cons of Chocolate and Meet Meat. Results will be used to inform future nutrition education interventions.

Virginia Plummer submitted StressLess for Success Mini Course QA Report; Benchmarking Study on 2011 Education Advisory Board Custom Research Brief: Alcohol and Drug Education and Prevention Programming at Seven Private Institutions; and Emory University Office of Health Promotion Benchmarking Survey Summary Report. Results were used to inform the strategic plan for ATOD prevention and the recommendation for qualified prevention personnel to be hired to implement the plan.

Heather Zesiger submitted 5 quality assurance studies: SleepWell cohort 7; WVU Benchmarking Study; USC Benchmarking Study; Students in Distress Needs Assessment update (on behalf of an RSPH class); evaluation of Student Health 101 (on behalf of an RSPH class). Results of the benchmarking studies were used to inform a strategic realignment of the OHP department in August 2012. Results of the needs assessment will be shared with the new suicide prevention coordinator in the Counseling Center and results of SleepWell were used to enhance the new online version.

Emory University received recognition at the American College Health Association annual meeting as a prime example of a well executed National College Health Assessment (NCHA). Our response rate in November 2011 was 31.5%. The ACHA-NCHA dataset helps us set priorities and spark campus dialogue around students’ health attitudes and behaviors.

Goal Four: Contribute to Community and Diversity

Programs and Partnerships

- Lauren Bernstein and Willie Bannister led a roundtable discussion on Negotiating Difficult Conversations at the NASPA AOD Conference.
- Lauren Bernstein was a guest lecturer on the Intersections of LGBTQ and Anti Violence Agends in Reproductive Justice Work at the University of Waterloo, Canada
- Willie Bannister served on the LGBT Life Advisory Committee
- Carol Kelly participated in National Nutrition Month with FSAP, Dining and Emory Hospital
• Virginia Plummer was a Guest panelist for *Alcohol Prevention and Recovery on College Campuses* statewide conference held at Georgia Tech

**Other Service**

• Carol Kelly supervised 8 Emory University Hospital dietetic interns
• Virginia Plummer advised one MD/MPH intern, one community volunteer, and one RSPH student volunteer preparing external benchmarking report, 2011-2012.

**Student Organization Advising**

• OHP staff coordinate the Student Health Advisory Committee (SHAC)
• Lauren Bernstein advises the Alliance for Sexual Assault Prevention (ASAP); Sexual Assault Peer Advocates (SAPA); and Grads Against Violence (GAV)
• Marc Cordon advises the Healthy Campus Coalition

**Professional Development, Continuing Education, Awards and Publications**

• Professional development activities are logged on the Campus Life Professional Development form. OHP staff presented at conferences, published an article, were interviewed by the media, won awards, and attended several continuing education seminars in 2011-2012.

**Goal Five: Provide Outreach and Marketing to Promote Services and Raise Awareness**

We provided 21 outreach events. These events included information tables at Wonderful Wednesdays and in the lobbies of graduate and professional schools.

We also guest lectured in classes in the PA program, Dietetics Intern program, School of Nursing, RSPH, Emory College, Goizueta Business School and School of Medicine.

We planned, implemented and evaluated campaigns and awareness weeks including:
National Collegiate Alcohol Awareness Week; Take Back the Night; National Nutrition Month and Sexual Assault Awareness Month.

We continued our online program request forms and an online safer sex supply request form.

In Spring 2012, EUSHCS received a $1000 grant from the Emory College Center for Creativity & Arts to host the Water Gives Life; Water & Soap Saves Lives Video Contest. Emory students were encouraged to create short digital videos to increase hand hygiene awareness. The first and second place videos debuted at the Center for Ethics’ Free Speech Art Café. The winning video was also featured in the May 2012 edition of Student Health 101.
The 2011-12 annual report summarizes another year of progress towards fulfilling the mission of the Student Counseling Center: providing first-rate mental health care, prevention and education to the Emory University community. Particularly significant were the continued efforts of the “Emory Cares 4 U” program funded by the Garrett Lee Smith Memorial Campus Suicide Prevention Grant that Emory University was awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Spearheaded by Drs. Kaslow (Department of Psychiatry), McLeod and Yang (Campus Life, Counseling Center), major grant related accomplishments included expanding gatekeeper training efforts, continuing the internet-based outreach program developed and supported by the American Foundation for Suicide Prevention, and further development of an Emory Cares 4 U web site which includes links to materials developed specifically through grant-related activities. In addition, a diverse and representative coalition of stakeholders representing many of Emory’s constituencies continues to function as an advisory group as the Center prioritizes and develops programs designed to sustain efforts that were previously grant funded. The staff at the Center has devoted a large amount of time to grant activities, time that has been well worth the effort and which should eventually facilitate the development of more grant funded interventions. In addition, this past year Center staff participated fully in the very important process of developing a new strategic plan for Student Health and Counseling Services.

As noted in last year’s report, obtaining approval and funding for a viable sustainability plan was a major goal for the past academic year. Fortunately, a proposal to raise the Mental Health and Counseling Fee an additional $3 greater than cost of living was approved by President Wagner and the Board of Trustees. This increase has been used to fund a full-time Suicide Prevention Coordinator, Dr. Mahlet Endale, who is already planning efforts to continue the grant’s most effective programs (e.g., gatekeeper training) as well as considering new interventions and funding sources (e.g., federal, state and foundation based grants).

These new accomplishments, taken together with previous accomplishments at the university,
position Emory on the forefront of university-based efforts to develop and implement effective prevention-focused programming while also providing effective short-term mental health care and referral services for students. Dr. McLeod will give a presentation on the history and sustainability of these efforts at this fall’s meeting of the Association of University College Counseling Center Directors in Newport, Rhode Island.

Counseling Center staff continued to supervise and support two marquee student-run groups over the past year: Helpline and Active Minds. Helpline staff responded to 149 calls representing a 12% increase from the previous year and a 75% increase over the past 2 years. These numbers document the accomplishments of a longstanding (for over 30 years) student group that continues to be superbly trained by Counseling Center professional staff (this year by Dr. Yang) to provide confidential after-hours help and intervention to fellow students. Helpline students represent the very best of our very talented student population.

This past year another student group that is advised by the Counseling Center (by Dr. McLeod), Active Minds, was truer than ever to its name as it became extremely active in its efforts to reduce stigma at Emory. The group’s marquee event was the first-ever Active Minds Southeastern regional conference. The conference featured a motivational speaker provided by the Active Mind’s national office. In addition, Drs. Elaine Walker and Corey Keyes, both members of the Emory faculty, gave informational and inspirational presentations. Perhaps the most impactful presentation at the conference was provided by the students themselves: a panel of three students publicly sharing courageous personal stories and answering questions from the audience. This last event was a stunning reminder of what our community could be like without stigma. It also demonstrated the powerful role that students, with some assistance, can play in that effort.

On a somewhat more challenging note, the Counseling Center’s outreach activities were reduced by about 30% compared to the previous year. We believe that this reduction was the result of a significant decrease in professional time available by Counseling Center staff due to the need to provide more clinical hours (which increased by 14%), as well as professional staff turnover and the loss of a half-time social worker position. In addition, some outreach activities were provided by grant-funded staff whose activities are not included in this report. Certainly we are going to continue to be faced with the challenge of allocating finite resources towards efforts to reduce stigma, provide students with both relevant and effective prevention programs as well as with effective, timely counseling services. One of the most important tasks of our new Suicide Prevention Coordinator, who is working with Dr. Jane Yang, our new Assistant Director of Outreach, will be to prioritize our efforts to continue and, where possible, expand the most effective programs of the suicide prevention grant.

Despite these challenges, clients at the Center continued to report a high degree of satisfaction and symptom relief as a result of the services they received. In addition to our own clinical outcome measures, the Counseling Center participated in the Healthy Minds Study this past year and continues to participate in the Center for the Study of College Mental Health (Penn State).
As a whole, these assessments demonstrate that the Emory community, like other American universities, has a student body that struggles with mental health issues, particularly depression, stress and anxiety. There are also some preliminary indicators that our attempts to improve the culture here may be having a positive impact (e.g. improved measures of flourishing, reductions in levels of stigma).

The continued development of the Stress Management Clinic, directed by Dr. Dana Wyner, was once again a highlight this past year. Dr. Wyner’s program won an Honorable Mention award in a competitive quality improvement program sponsored by AAAHC. Stress is consistently one of the most prevalent complaints among our students and among students assessed in national cohorts (e.g. NCHA annual survey). This past year, 63 students participated in Relaxation Skills and/or Biofeedback Training Classes (compared to 48 students last year). We expect these numbers to increase consistently in future years.

An important administrative change took place this past year, perhaps symptomatic of the challenges faced by any organization that is situated in two different locations and consequently separated along disciplinary lines. This past year it was determined that Psychiatry would return to reporting directly to our Executive Director, Dr. Huey. The “two sides of the street” continue to work towards developing legal and ethical ways to share important health care information and have plans to give trainees in all disciplines opportunities to work and train together. In addition, consideration is being given to a site visit by an interdisciplinary team that will give us objective guidance about how to best meet the challenges associated with being in separate locations.

In summary, we believe that, despite many challenges along the way, Emory University, with its many health care resources and centers of excellence in the area of mental health, remains in a unique position to provide leadership in developing innovative university-based mental health services. Emory’s Active Minds, Helpline, gatekeeper training program and Emory Cares 4 U coalition, as well as other important work by students, faculty and staff, continue to put Emory in the forefront of national efforts in this area.

ACCOMPLISHMENTS AND CHALLENGES

CRISIS INTERVENTION

1. Crisis appointments during office hours continued to occur at a high rate of frequency (129, compared to 122 last year). Dealing with each crisis represents our most urgent, and consequently, most time consuming service. Crisis appointments often involve life-threatening situations, necessitating consultation with a wide range of offices on and off
campus (e.g. Residence Life, Greek Life, Student Health, EUH Emergency Room, Threat Assessment Team, academic offices and professional schools, as well as private therapists and parents). Crisis appointments had been declining slowly over the past two years. We will continue to monitor the data to see if this latest increase becomes a trend. Student hospitalizations for psychiatric emergencies (e.g. suicidal, psychotic) remained at a very high level (39 hospitalizations versus 31 the previous year).

2. Data from clinical assessments estimate that 24% of students using our services this year reported having had some kind of suicidal ideation; 10% reported having these thoughts more than rarely, and about 4% reported having these thoughts frequently.

3. Counseling Center after hours on call staff responded to 10 emergency calls this past year compared to 6 the previous year. Of these 10 calls half were related to suicidal students. These numbers do not capture the many after hours consultations provided by professional staff when they were not on call. Planning and coordination of emergency services and data keeping for mental health emergencies/crises continues to be managed through the Campus Life Crisis Committee, chaired by the Director of the Office of Student Conduct. The Counseling Center Clinical Director is a member of this committee. The Counseling Center Director serves on the Threat Assessment Team which is charged with reacting to and preventing crises across the entire Emory University community. We continue to work with the new Emory Center for Injury Control to better coordinate record keeping for mental health emergencies, particularly suicides.

4. The Counseling Center Director, along with the Director of the Faculty Staff Assistance Program, continues, to participate in the University’s Emergency Response Protocol process as the owners of the “Students or staff harm to self or others” protocol (ASA7).

**CLINICAL SERVICES**

1. This year Counseling Center staff saw 1031 new clients, representing a 15% increase from the previous year and consistent with past years’ increases. Center professional staff provided 8777 therapy hours, or a 14% increase compared to the previous year and a record for the Center. These increases are based upon therapy hours provided by Counseling Center staff and do not account for additional hours provided by psychiatric staff who now report through the health services clinic.

2. Data from the Counseling Center Assessment of Psychological Symptoms (CCAPS) demonstrated that being seen at the Counseling Center resulted in a reduction of students’ mental health symptoms and complaints (including social anxiety, generalized anxiety, depression and academic distress). Clients also continued to report very positive subjective experiences at the Center. Of particular note is that 99% of students who completed evaluation forms reported that they would recommend our services to a friend. In addition, 78% of these clients reported that their therapy resulted in an improvement in
their academic performance, and 96% reported having been seen in a reasonable amount of time. This latter statistic simply would not have been possible without additional resources provided by the Mental Health and Counseling Fee.

3. The Counseling Center continued to purchase low cost services from the training clinics operated by the Departments of Psychology and Psychiatry. The Counseling Center pays for students to be seen in these on campus clinics when they are in need of brief counseling but would have to wait for therapy services at our center. All three agencies have found the arrangement to be a positive one. This past year 54 students were served in this manner, a slight decrease from the previous year when 59 students were served.

4. This past year the Counseling Center continued to assess a “no show” fee to students who failed to call ahead to cancel their appointments. The fee was instituted because clients who do not call ahead are essentially “taking away” a much needed appointment from a fellow student. This past year saw an 11% reduction in the number of “no shows,” following a 23% reduction last year. We hope that this trend will continue in the future. In fact, our hope would be to never have to levy the no show fee because all available appointments are being used.

5. Groups are an effective and efficient way to provide appropriate treatment to college students and are often the treatment of choice for many students. This past year Dr. Ben Stillman, the current Group Therapy Coordinator, engaged in an assessment project of the program. His results (available upon request) mirror those reported for individual therapy; significant symptom improvement and very positive subjective experiences reported by participants. The Counseling Center offered the following groups to students last year:

   - Eating Disorders Group,
   - Interpersonal Process Group for Undergraduates and Graduate students
   - Getting in Touch with Emotions (DBT or Dialectical Behavior Therapy)
   - Relaxation/Biofeedback Class

   Together these groups served 134 students, a 31% increase over last year’s numbers. A goal for next year is to continue to increase participation in the group therapy programs.

6. Under the direction of Dr. Pam Epps, the Counseling Center continued to operate a nationally recognized pre-doctoral internship program in psychology (recently re-accredited by the American Psychological Association), an APPIC (Association of Psychology, Postdoctoral and Internship Centers) postdoctoral fellowship program in Psychology and a new fellowship program for training Post- MSW clinical social workers. The Center also provides a practicum program for psychology graduate students attending Atlanta area doctoral programs, including Emory’s program in Clinical Psychology. Interns and other trainees provide cost effective, high quality clinical services and educational programming to the Emory community. Counseling Centers with training
programs tend be able to hire and retain more high quality professional staff than centers without training programs.

**PREVENTION AND OUTREACH**

1. During the 2011-12 year, Counseling Center staff conducted a total of 184 orientations, trainings and workshops, with a total of 6,494 students served. This represents a 30% decrease in the number of outreach programs conducted and a 29% decrease in the number of students served when compared to 2010-11. The decrease in the number of outreach programs likely reflects the increased demand for clinical services during the 2011-12 year, which subsequently limited staff availability for outreach activities, as well as the fact that some staff provided grant supported outreach programs that were not counted as part of their Counseling Center work (see below). Still this reduction in outreach programs is of particular concern given the results of the Center’s Campus Life Assessment Project on outreach (see Challenges Section below).

2. As in 2010-11, the Counseling Center continued its extensive involvement in activities related to the Garrett Lee Smith Suicide Prevention Grant. Counseling Center staff attended 41 grant-related meetings. This number represents 41 meetings apart from the total number of outreach programs reported above.

3. As in previous years, the Counseling Center continued to advise student groups such as Active Minds and Helpline.

4. Emory Helpline continued to serve as a valuable resource for the Emory community. This academic year, Helpline received a total of 149 calls, which represents a 12% increase from 2010-11 and a 75% increase from 2009-10. Furthermore, in 2011-12, Helpline received a total of 36 suicide-related calls. This represents a 177% increase from 2010-11, during which the Line received 13 suicide-related calls.

5. In addition to the quantity of calls, Helpline volunteers continued to voice their awareness that this year’s calls involved more complicated and serious concerns, which was reflected in the increase in suicide-related calls, as well as the consistency in the total number of calls exceeding 30 minutes in duration.
In 2011-12, EUSHCS Business Office accomplishments included:

- Erna Wilkerson, Mary Primm and Donna Weaver participated in the EUSHCS multidisciplinary Strategic Planning Task Force in Fall 2011, which completed the comprehensive 2012-16 EUSHCS Strategic Plan in February 2012.

- In Summer 2012, Business Office staff successfully completed the final transitioned to a fully electronic medical record system.

- Worked with nursing staff to implement a successful Flu Shot Campaign, giving close to 2,500 flu shots to the Emory students. For the first time, Emory student flu shots were given four-days a week at our 1525 Clifton Road facility.

- Emory University had a highly successful third year of the Aetna Student Health Insurance Plan Emory Core Network, with 100% coverage for students at all Emory Healthcare sites. As part of the 2012-13 Aetna negotiation, Emory Core coverage will be reduced to 95%.

- Via the $30 per enrollee administrative charge for the management of the Aetna Student Insurance Plan for 2011-12, realized over $150,000 in revenue to support EUSHCS business and Insurance functions and staffing. This administrative charge will be maintained in the 2012-13 plan, even in the face of several other plan cuts.

- EUSHCS completed the final moves to new primary care clinical facilities in the 1525 Clifton Road building, gaining an additional 2,000 sq. feet of clinical, waiting room and administrative space. Erna Wilkerson, MHA and Business Office staff redesigned the EUSHCS waiting room to make it more welcoming and student-oriented, including a video screen with health enhancing messages.

- EUSHCS had another successful year financially, with nearly $2 million in patient care revenue for FY 12.
EUSHCS 2011-12 Quality Improvement - Assessment Program

In 2011-12, the EUSHCS Quality Improvement Program continued to be actively engaged in ongoing monitoring of patient care and administrative activities, patient satisfaction, patient outcomes and utilization issues. EUSHCS’s many assessment and quality improvement activities in 2011-12 included (but was not limited to) the following:

- Laboratory Proficiency Testing, provider/nurse training and competency testing, and ongoing quality control activities
- Quarterly Peer Reviews for nurses, nurse practitioners, clinical providers, psychiatrists, counselors and nutritionist
- Biweekly Core Group (QI Committee) Meetings
- Dana Wyner, PhD’s two year assessment study of the EUSHCS Stress Clinic received a national honorable mention from the AAAHC Institute of Quality Improvement.
- *Hand Hygiene in Primary Care, Part II*, Quality Improvement Project (Campus Life Assessment Project), 2011-12
- *Identification of University Service Utilization and Optimal Methods for Mental Health Outreach to Students from Historically Marginalized Populations: A Pilot Study* (Campus Life Assessment Project), 2011-12
- Evaluation of mental health consultation services provided to faculty, staff, and the community (Campus Life Assessment Project), 2011-12
- *Nutrition Factors Which May Affect Athletic Performance, Phase II* (Campus Life Assessment Project with Department of Athletics and Recreation and Dining Services), 2011-12
- *Primary Care/Women’s Health Patient Satisfaction Survey*, Spring Semester 2011
- *Needs Assessment of Student Veterans, Summer 2010-Spring 2011*
- *Wellness and Health Promotion Benchmark Survey 2011 Summary*, May 2012
- *Community Needs Assessment of Students in Distress*, May 2012
- *Benchmarking Survey of Alcohol and Drug Education and Prevention Programming at Seven Private Institutions*, May 2012
- *AOD Services Benchmarking Survey at Ten Institutions*, May 2012
- *Healthy, Sustainable Nutrition, Sessions One, Two and Three*, 2011-12
- *West Virginia University’s Wellness and Health Promotion Director Benchmarking Survey*, February 2012
- *SleepWell Mini-Course Report*, Fall 2012
- *Health Promotion Passive Programming*, Fall 2011
- *ACHA 2012 Pap and STI survey*

EUSHCS also participates in several national consortiums and data surveillance networks, including:

- The **College Health Surveillance Network** (University of Virginia and the CDC), which maps illness and diagnosis (ICD-9) trends across the nation
- The **Healthy Minds Study**, a long-term research project that uses rigorous scientific methodology to assess mental health, stigma and flourishing at campuses across the United States.
- The **Center for the Study of Collegiate Mental Health**, a data bank for clinical data collected from all colleges and universities across the country use the same counseling software program, Titanium.
- The **Research Consortium** (Association of University and College Counseling Center Directors), an assessment instrument that looks at mental health issues among college students in the U.S.
Annual Report 2011-12

EUSHCS Goals and Results for 2011-12

EUSHCS Departmental Goals for 2011-12 included the following:

1. Creation of an updated, unified strategic plan for Student Health and Counseling Services and a new strategic plan for alcohol and other drug programming and services.

   ✓ **Accomplished.** EUSHCS created a multidisciplinary Strategic Planning Task force in Fall 2011 and completed the 2012-16 EUSHCS Strategic Plan in February 2012. The EUSHCS strategic plan includes five major strategic goals with detailed objectives, implementation strategies, timelines, process owners and financial implications. The EUSHCS Strategic Plan was presented to Campus Life Deans and Directors in April 2012.

2. Continue to meet the medical patient care increases likely to result from the continued increased enrollment in the Emory Aetna Student Health Insurance Plan (4,800 in 2009-10 → 5,600 in 2010-11 → 6,500 in 2011-12) and our ongoing PPO agreements.

   ✓ **Accomplished.** 2011-12 EUSHCS medical patient flow was nearly identical to 2010-11 numbers, with 19,300 patients seen in our 1525 Clifton practices. 19,380 patients were seen in 2010-11. We were able to meet these patient care needs with high levels of patient satisfaction in our Spring 2012 EUSHCS Primary Care Patient Satisfaction Survey.

3. Successfully implement the Fall 2011 American College Health Association National College Health Assessment (NCHA), analyze data, and disseminate findings to stakeholders.

   ✓ **Accomplished.** Emory University received recognition at the American College Health Association annual meeting as a prime example of a well executed National College Health Assessment (NCHA). Our response rate in November 2011 was 31.5%. The ACHA-NCHA dataset helps us set priorities and spark campus dialogue around students’ health attitudes and behaviors. Wide-scale dissemination of results will begin in fall 2012.
4. Create a successful proposal for President Wagner that will sustain the most effective intervention programs currently funded by the Garret Lee Smith SAMHSA Suicide Prevention Grant.

- **Accomplished.** In Spring 2012, the Emory Board of Trustees approved a proposal to raise the Mental Health and Counseling Fee an additional $3 per student per semester in 2012-13 and beyond (the total fee increase will be $8, with the remainder used to fund current programming and personnel under the fee). This increase has been used to fund a full-time Suicide Prevention Coordinator, Dr. Mahlet Endale (joined EUSHCS staff in August 2012), who has already begun efforts to continue the grant’s most effective programs, as well as considering new interventions and funding sources going forward.

5. Following the blueprint created by the 2005-06 President’s Task Force on Mental Health, work with the Departments of Psychiatry and Psychology and the Division of Campus Life to plan the creation of an EUSHCS-based, nationally recognized multidisciplinary center for mental health patient care, teaching and research.

- **In process.** In late Fall 2011 and early Spring 2012, the Committee on Student Mental Health Services met to explore the feasibility of a recommendation by the December 2005 President’s Task Force on Mental Health to create a center of excellence for student mental health services. The President’s Task Force had a focus on the entire Emory community, including students, faculty and staff. However, for purposes of this committee, the focus was on mental health services for students. The scope of the committee deliberations was to review possible options and make recommendations, but not to specifically set policies and procedures. The report was presented to President Wagner in April 2012 and the committee met with him in June 2012. At President Wagner’s request, the report is currently under revision.

6. Increase OHP’s web presence by integrating various social media (Twitter, Facebook, blogs) into one online Office of Health Promotion experience.

- **Accomplished.** In fall 2011, OHP launched a unified social media experience for students, incorporating a blog site and Twitter feed as well as photos, videos, direct access to the Student Health 101 online magazine and incorporating our existing Facebook page. Our Be Well Excel listserv continued to grow and numbers over 1500 students even after many members graduated.

7. Initiate an Emory Healthy Campus Coalition in collaboration with the University Senate and conduct a needs assessment for sexual and relationship violence prevention and response, using findings to integrate primary prevention into program components.

- **Accomplished.** Marc Cordon, MPH chaired the Campus Life committee of the University Senate in the first of a three-year term focusing on the
development, operationalization and sustainability of a student-run Healthy Campus Coalition. Year one focused on a literature review, building a theoretical foundation and beginning to engage students, staff and faculty on the steering committee. Year two will focus on recruitment and retention of student leaders and operationalization of key coalition building constructs, as well as grant applications. Year three will culminate in a sustainability plan for continuing the movement beyond the three-year senate term.

Lauren Bernstein, MSW worked with several student volunteers at the undergraduate and graduate level to conduct formative research informing her Summer 2012 strategic plan for violence prevention and the launch of The Respect Program.
Table 1: Summary of Primary Care Patient Medical Visits

<table>
<thead>
<tr>
<th>Year</th>
<th>Visits to primary care providers (excludes health promotion, psychiatry and specialist consultants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>15,869</td>
</tr>
<tr>
<td>2008-09</td>
<td>15,514</td>
</tr>
<tr>
<td>2009-10</td>
<td>15,150</td>
</tr>
<tr>
<td>2010-11</td>
<td>15,214</td>
</tr>
<tr>
<td>2011-12</td>
<td>15,613</td>
</tr>
</tbody>
</table>

Notes: EUSHCS achieved our highest primary care numbers in history in 2007-08, with a slight drop off in 2008-09 (-2.2%) and 2009-10 (-2.3%), a minor increase in 2010-11 (+0.4%) and a further increase in 2011-12 (+2.6%).

Building a Healthier Student Body, Mind and Spirit
Table 2: Office of Health Promotion: Clinical Visits for 2011-12

Overview of Service Utilization 2003-2012

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</tr>
</thead>
<tbody>
<tr>
<td>Confidential HIV</td>
<td>209</td>
<td>172</td>
<td>136</td>
<td>117</td>
<td>99</td>
<td>150</td>
<td>98</td>
<td>62</td>
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<tr>
<td>Testing and Sexual</td>
<td></td>
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<tr>
<td>Health Counseling</td>
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<tr>
<td>Nutrition Counseling</td>
<td>767</td>
<td>617</td>
<td>539</td>
<td>531</td>
<td>741</td>
<td>763</td>
<td>623</td>
<td>504</td>
</tr>
<tr>
<td>Alcohol and</td>
<td>180</td>
<td>149</td>
<td>189</td>
<td>221</td>
<td>483</td>
<td>516</td>
<td>287</td>
<td>308</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
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<tr>
<td>Counseling</td>
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</tr>
<tr>
<td><strong>Total Health</strong></td>
<td><strong>1,156</strong></td>
<td><strong>938</strong></td>
<td><strong>864</strong></td>
<td><strong>869</strong></td>
<td><strong>1,323</strong></td>
<td><strong>1,429</strong></td>
<td><strong>1,008</strong></td>
<td><strong>874</strong></td>
</tr>
<tr>
<td>Promotion Clinical</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td><strong>Visits</strong></td>
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</tbody>
</table>

The Office of Health Promotion saw a decrease in clinical visits in 2011-12, mirroring the trend in 2010-11. In Summer 2012, a decision was made to cease confidential HIV testing and sexual health counseling in Health Promotion, at least at this time.
Table 3: Psychiatry Services at EUSHCS

<table>
<thead>
<tr>
<th></th>
<th>2007-08</th>
<th>2008-09</th>
<th>2008-09</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Visits to Psychiatry Services</td>
<td>2,268</td>
<td>3,179</td>
<td>3,757</td>
<td>3,571</td>
<td>2,924</td>
</tr>
</tbody>
</table>

Notes: In 2011-12, disruption in both faculty psychiatrist staffing and third year resident psychiatrist staffing led to a 22% decrease in patient visits. Efforts were made to identify affordable on- and off-campus psychiatric care options for students while recruiting additional staff.
Table 4: Student Counseling Center Statistics (excludes Psychiatry Services)

<table>
<thead>
<tr>
<th></th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Requests for Counseling</td>
<td>735</td>
<td>925</td>
<td>966</td>
<td>1,031</td>
</tr>
<tr>
<td>% of CC Clients Referred</td>
<td>17%</td>
<td>15%</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>% of Clients Referred after CC Treatment</td>
<td>3%</td>
<td>8%</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>Therapy Appointments</td>
<td>6,334</td>
<td>7,245</td>
<td>7,681</td>
<td>8,777</td>
</tr>
<tr>
<td>Average Length of Treatment</td>
<td>5.77 visits</td>
<td>6.4 visits</td>
<td>6.72 visits</td>
<td>6.74 visits</td>
</tr>
</tbody>
</table>
**EUSHCS Goals for 2012-13**

EUSHCS Departmental Goals for 2012-13 include:

1. Successful completion of the December 2011 Accreditation Association for Ambulatory Health Care (AAAHC) re-accreditation survey with a full three-year term. This is EUSHCS’s fourth survey and the second to include both the 1525 and 1462 facilities.

   
   Accredited by
   
   Accreditation Association for Ambulatory Health Care, Inc.

2. Establish mechanisms for continuing the most effective elements of the Suicide Prevention Program and for the Emory Cares 4 U website and coalition.

3. Implement and monitor progress of the EUSHCS 2012-16 unified strategic plan for Student Health and Counseling Services.

4. Successfully continue the Emory Healthy Campus Coalition in collaboration with the University Senate. Year Two will focus on recruitment and retention of student leaders and operationalization of key coalition building constructs, as well as grant applications.

5. Continue to meet the medical patient care needs of 13,500 Emory students and their dependents with state-of-the-art primary and women’s health care and high levels of patient satisfaction.

6. Find mechanisms to improve communication, cooperation and patient care systems between EUSHCS mental health and counseling disciplines on both sides of Clifton Road. Seek the input of a consulting college health interdisciplinary team.
Attachment G
INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name ____________________________ Date of Birth _____________________

ID# ______________________________

I understand that as a subscriber to the University of Rochester Student Health Program I am eligible to receive a range of services at University Counseling Center (UCC). The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks. Please Note: If you No Show or Cancel your appointment with less than 24 hours notice, this will count against your total number of sessions.

I understand that all information shared with the clinicians at UCC is confidential and no information will be released without my consent. During the course of treatment at UCC, it may be necessary for my therapist to communicate with providers at the University Health Service (UHS). While written authorization will not be requested, prior to any discussion with UHS providers, I understand that my therapist will discuss UHS communications with me. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, provides UCC services. All professionals-in-training are supervised by licensed staff. See reverse page for a listing of all UCC supervisors.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

I understand that UCC routinely videotapes therapy sessions. I understand that such recording(s) will be used only for educational purposes and that the professionals involved will respect and protect the confidential nature of the sessions. I understand that the tapes will be the property of the University Counseling Center. I also understand that if I object to be videotaped, it will in no way jeopardize my relationship with the University Counseling Center.

If I have any questions regarding this consent form or about the services offered at UCC, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by UCC. I understand that I may stop treatment at any time.

Please see other side of this form if referred by a Member of the Uof R Faculty/Staff.

Signature ____________________________________________ Date ________________
This Box is For Use ONLY If You Were Referred by a Member of the Uof R Faculty/Staff:
May we notify the person who referred you to Counseling Services that you followed through with the referral? If so, sign below to grant us permission to inform this person that you attended an initial appointment at Counseling Services. Please note the following: 1) you may choose not to sign and this will in no way influence any treatment which you might receive here, and 2) other than a letter confirming that you attended an initial appointment, no additional information will be shared without your consent. Complete the area below ONLY if you agree to provide us with consent to inform the faculty/staff member who referred you; be sure to fill in both the contact information and to sign your name.

Name of Faculty/Staff Member: __________________________________________________
Department:_________________________________ Phones Number ___________________

I have read the above and agree to release this information to the person named here.

_____ YES  Your Signature: _____________________________________________

University Counseling Center’s Supervisors

Joellen Popma, Ph.D., Director
Brigid Cahill, Ph.D., Associate Director
Dagmar Kaufmann, Ph.D.
Mike Kemp-Schneider, LMSW
Felicia Reed, LMSW
Allan Schwartz, Ph.D.
Ronke Tapp, Ph.D.
Kelly Willson, Ph.D.

revised 08/27/13
Attachment H
Patients' Rights and Responsibilities

Your Rights as a Patient

At Beth Israel Deaconess Medical Center, we support your right to know about your health and illness, and your right to participate in decisions that affect your well-being. Our own statement of patients' rights, incorporating state and federal law, describes the medical center's commitment to protecting your rights.

1. You have the right to receive medical care that meets the highest standards of BIDMC, regardless of your race, religion, national origin, any disability or handicap, gender, sexual orientation, gender identity or expression, age, military service, or the source of payment for your care.

2. You have the right to receive visitors of your choosing that you (or your support person, where appropriate) designate, including a spouse, domestic partner (including same-sex domestic partner), or another family member or a friend. You also have the right to withdraw or deny consent to receive such visitors. You have the right to visitation privileges regardless of race, religion, national origin, any disability or handicap, gender, sexual orientation, gender identity or expression, age, military service, or the source of payment for your care. Depending on clinical situations, personal safety risk, or security issues, BIDMC reserves the right to place restrictions on visitation as outlined below and as necessary. BIDMC limits visitation when it would interfere with the care of the patient and/or other patients based on a health care provider's best clinical judgment. Limitations on the number of visitors, the age of visitors, and the times at which visitors may be present are reasonable and necessary measures dependent on the particular setting or circumstance. Examples of circumstances that could provide a basis for restricting visitation include, but are not limited to: where infection control is an issue; when visitation may interfere with the care of the patient or of other patients; when the hospital becomes aware of a court order restricting contact; if
7. You have the right to privacy within the capacity of the medical center. If you are being cared for in a setting where there are others present, you can expect a sincere and reasonable attempt to keep all conversations confidential within the capacity of the medical center. When you are examined, you are entitled to privacy - to have the curtains drawn, to know what role any observer may have in your care, and to have any observer unrelated to your care leave if you so request.

8. You have the right to seek and receive all the information necessary for you to understand your medical situation. You have the right to know the name and specialty of the doctors and other health care providers who are responsible for your care and to talk with these providers. You are entitled to know fully about the planned course of diagnosis and treatment (including an explanation of each day's procedures and tests), and your likely future medical course and prognosis. This is true regardless of your diagnosis. In addition, the law requires that you receive specific information in certain circumstances. For example, if you are receiving mammography services, you will receive specific information about this procedure. If you are suffering from breast cancer, you have the right to receive complete information on all alternative treatments that are medically viable. If you are having breast implant surgery, your surgeon will inform you of the risks associated with this procedure no later than ten days in advance of surgery. You will be given a written summary of this information. Prior to admission as a maternity patient, you will receive information regarding labor and delivery care specific to BIDMC, including the rate of cesarean section and the types of anesthesia administered at the medical center. If you are a victim of rape and are of childbearing age, you have the right to receive written information about emergency contraception, and to be offered and provided emergency contraception if you so request.
You are entitled to seek and receive adequate instruction in self-care, prevention of disability, and maintenance of health. You have the right to ask your doctor or nurse any question about your health that concerns you. You have the right to have all reasonable requests responded to promptly and adequately within the capacity of the medical center.

You have the right to know who will perform an operation or a test and to receive a full explanation of the details in advance, in order for you to exercise your right to give informed consent or elect to refuse. If you agree to the diagnostic and therapeutic procedures recommended by your doctor, you may be asked to sign a consent form. If you refuse, you may expect to receive the best help that the medical center can still offer under the circumstances.

You have the right to request and to receive additional medical consultation on your medical condition if you desire. You have the right to be fully informed of the nature and extent of the plan of treatment developed for you by your doctor and nurse, and the right to define any limits on that treatment when fully informed, should you desire to do so. You have the right to be informed about the outcome of care you receive.

7. **You have a right to know the identity and the role of individuals involved in your care.** Because this is a major teaching hospital, there are many members of the health care team participating in your care and treatment. You may request that an individual not be assigned to your care and may expect that this request will be honored whenever this is possible without jeopardizing access to medical or psychiatric attention.

8. **You have a right to a full explanation of any research study in which you may be asked to participate.** You also have the right to refuse to participate in research. Your refusal will not affect your access to care at BIDMC. BIDMC respects the rights of all individuals who choose to participate (or not participate) in research at BIDMC. For more information about BIDMC's human subjects' research program and your rights as a research participant, you may contact the human subjects protection office at 617-667-4524.

9. **You have the right to leave the medical center even if your doctors advise against it,** unless you have certain infectious diseases that may influence the health of others, or if you are incapable of maintaining your own safety or the safety of others, as defined by law. If you decide to leave before the doctors advise, the medical center will not be responsible for any harm that this may cause you, and you will be asked to sign a 'Discharge Against Medical Advice' form.

10. **You have the right to access your medical record.** As a general rule, we do not recommend that you review your medical record in the midst of a hospital stay because, while you are an inpatient, your medical record is incomplete; it serves as documentation by your physicians and nurses of your current treatment. During your hospitalization, we urge you to direct questions to your physicians and nurses, but if you still wish to see your record, you have the right to do so. Patients who are no longer in the hospital and outpatients wishing to obtain copies of their medical record may make arrangements by calling the correspondence section of the medical records department at 781-234-0850. For your protection, we require signed authorization and positive identification to release medical record information. If you have questions about the information you acquire from your medical record, they should be directed to your physician. Records will be maintained in accordance with applicable laws and regulations, accreditation standards, and other requirements.
governing record retention. Records will not be destroyed before the appropriate retention period has expired.

11. You have the right to inquire and receive information about the possibility of financial assistance. As there are many different options for assistance, the BIDMC financial assistance office will work with you to obtain the most suitable assistance available to you. You may request an itemized bill for the services you have received. You may also ask for an explanation of that bill. For inquiries related to financial assistance, please contact the financial assistance office at 617-667-5661. Financial information provided to the medical center will remain confidential.

12. You are entitled to know about any financial or business relationships the medical center has with other institutions, to the extent the relationship relates to your care or treatment.

13. You have the right not to be exposed to the smoking of others. Because smoking is a health and safety hazard to smokers and to others, BIDMC is a smoke-free hospital. Smoking is not permitted anywhere in the medical center, including public areas, private and open offices, rest rooms, patient rooms, and outside areas in the immediate vicinity of medical center entrances and exits. Smoking materials are not for sale anywhere on medical center property.

14. You have the right to take part in decisions relating to your health care. This includes participation in the development and implementation of your plan of care. You have the right to make informed decisions regarding your care, to receive information about your health status, and to request or refuse treatment. Upon admission to the medical center, you have the right to have a family member or personal representative and your own physician notified promptly. In accordance with Massachusetts law, you have the right to formally designate a substitute decision-maker who, in a situation in which you cannot make your own health care decisions, will be legally authorized to make these decisions for you. (For more information please read our pamphlet on the Massachusetts Health Care Proxy and talk with your physician, nurse, social worker, or pastoral services representative.)

15. You have the right to appropriate assessment and management of pain. Your doctor and nurse will assess your pain and involve you in decisions about managing pain effectively.

16. You have the right as a patient who may have limited English proficiency to have access, free of charge, to meaningful communication via a qualified interpreter either in person or by phone, as deemed appropriate. If you are a Deaf or hard of hearing patient, BIDMC will provide a certified interpreter either from the BIDMC staff interpreter service or the Massachusetts Commission for the Deaf and Hard of Hearing.

17. You have the right to receive information about how you can get assistance with concerns, problems, or complaints about the quality of care or service you receive, and to initiate a formal grievance process with the medical center or with state regulatory agencies. Should you have concerns, problems, or complaints about the quality of care or service that you are receiving, you are encouraged to speak to the providers directly involved in your care. If the issue is not resolved to your satisfaction, or if you would like the help of an independent person to assist you, you may contact the Patient Relations Office. If you have specific concerns about Medicare, you can also contact the Medicare ombudsman at 617-667-5661. Patient Relations is available to assist you Monday through Friday, 8:30 AM to 4:30 PM (EST).
of someone not immediately involved, patient relations staff are available to help resolve the problem. Staff from patient relations can be reached using the contact information in the box above. If you find the above avenues unsatisfactory, you may choose to file a formal grievance with the medical center (via the patient relations office) or you may contact any of the following agencies:

Massachusetts Board of Registration in Medicine  
200 Harvard Mill Square  
Suite 330  
Wakefield, MA 01880  
781-876-8200  
Fax number: 781-876-8381  
Online: www.massmedboard.org

Massachusetts Department of Public Health  
Division of Health Care Quality Complaint Unit  
99 Chauncy Street, 11th Floor  
Boston, MA 02111  
800-462-5540  
617-753-8150  
Fax number: 617-753-8165  
Online: www.mass.gov/dph/dhcq

[Or, if you have Medicare]  
MassPRO  
245 Winter Street  
Waltham, MA 02451  
800-252-5533  
Online: www.masspro.org

The Joint Commission  
Office of Quality Monitoring  
One Renaissance Boulevard  
Oakbrook Terrace, IL 60181  
800-994-6610  
Fax number: 630-792-5636  
Online: www.jointcommission.org

18. You have the right to have your spiritual and cultural needs addressed within the capacity of the medical center.

19. You have the right to obtain a copy of the rules and regulations of the medical center that apply to your role as a patient.

Your Responsibilities as a Patient
To ensure the medical center's ability to provide you with the best care possible, we ask that you accept the responsibility to:

1. Provide accurate and complete information regarding your identity, medical history, hospitalizations, medications, dietary supplements (herbal and other nutritional supplements), and current health concerns. Report any changes in health to care providers.

2. Follow treatment plans recommended by physicians and other health care providers working under the attending physician's direction. Let care providers know immediately if you need clarification or do not understand your plan of care or the health instructions you are given.

3. Participate and collaborate in your treatment and in planning for
Patients’ Rights and Responsibilities

4. Be part of the pain management team. If you are receiving pain medications, ask your medical team about pain management options. Use pain medication as prescribed and provide feedback if certain methods are not working well for you.

5. Be considerate and respectful of other patients and medical center personnel. Do what you can to help control noise, and ensure that your visitors are considerate as well. Be respectful of medical center property.

6. Follow medical center rules and regulations, including those that prohibit offensive, threatening, and/or abusive language or behavior, and the use of tobacco, alcohol, or illicit drugs or substances. Help ensure that your visitors are aware of and follow these rules.

7. Provide the medical center with a copy of any advance directive or health care proxy designation you have prepared.

8. Provide accurate and complete financial information and work with the medical center to ensure that financial obligations related to your care are met. Notify the medical center promptly if there is a hardship so that we may assist you as needed.

Other languages versions:
- Sus derechos y responsabilidades como paciente (Spanish)
- Ваши права и обязанности как пациент (Russian)
- Os seus direitos e responsabilidades enquanto paciente (Portuguese)
- 患者權利及責任 (Chinese)
Welcome to the Psychological Counseling Center. This document (the Agreement) contains important information about the Counseling Center’s professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which has been given to you, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures when we meet. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES
Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and outside of that time.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS
I normally conduct an evaluation that will last for several sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to attend unless you provide advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment, although this is not guaranteed.
CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. My hours on campus vary and I am not always available to answer the phone. When I am unavailable, you may leave a message on my voice mail at X: __________ or you may call the Counseling Center secretary at X-63730 during regular business hours. I will make every effort to return your call as soon as I can. You may also contact me through e-mail at _____________________. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me when the center is closed and feel that it is an emergency and that you can’t wait for me to return your call, you may reach the therapist on call by calling the Counseling Center answering service at 781-239-8312. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

Various laws protect the privacy of communications between patients and their therapists. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don’t object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called “PHI” in my Notice of Policies and Practices to Protect the Privacy of Your Health Information). Interns at the Psychological Counseling Center are also supervised by senior staff members and share information with their supervisor(s).

- You should be aware that I practice with other mental health professionals at the Counseling Center and that the Counseling Center has an administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- The Counseling Center also has contracts with a billing service that is used when students are billed for time which exceeds the allotted free sessions. As required by HIPAA, the Counseling Center has a formal business associate contract with this business, in which it promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of this organization and/or a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law or by laws governing other mental health professionals. I cannot provide any information without your (or your legal representative’s) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

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• If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

• If a patient files a worker's compensation claim, I must, upon appropriate request, provide appropriate information, including a copy of the patient's record, to the patient's employer, the insurer or the Department of Worker's Compensation.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual at the Counseling Center and happen rarely.

• If I have reasonable cause to believe that a child under age 18 is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect (including malnutrition), the law requires that I file a report with the Department of Social Services. Once such a report is filed, I may be required to provide additional information.

• If I have reason to believe an elderly or handicapped individual is suffering from abuse, the law requires that I report to the Department of Elder Affairs. Once such a report is filed, I may be required to provide additional information.

• If a patient communicates an immediate threat of serious physical harm to an identifiable victim or if a patient has a history of violence and the apparent intent and ability to carry out the threat, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.

• If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. You may examine and/or receive a copy of your Clinical Record if you request it in writing unless I believe that access would endanger you. In those situations, you have a right to a summary and to have your record sent to another mental health provider or your attorney. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon your request.

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In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that it would adversely affect your well-being, in which case you have a right to a summary and to have your record sent to another mental health provider or your attorney.

PATIENT RIGHTS
HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record, requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS
Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child’s treatment records, unless I believe this review would be harmful to the patient and his/her treatment. Because privacy in psychotherapy is often crucial to successful progress, it may sometimes be necessary to request an agreement from parents that they consent to give their access to their child’s records. If they agree, during treatment, I will provide them only with general information about the progress of your treatment, and your attendance at scheduled sessions. Any other communication will require your authorization, unless I feel that you are in danger or are a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have.

TREATMENT POLICIES AT THE COUNSELING CENTER
All students who have paid the Student Health Fee are entitled to 12 sessions of counseling or psychotherapy in each year of their attendance at Brandeis. This will ensure that care will be possible throughout the time you are attending Brandeis.

If you choose to engage in longer-term counseling, the Counseling Center now provides the option of using your health insurance to defray the cost of continuing beyond 12 sessions. After two consecutive years, you may choose to continue with me on a private basis or be referred to another therapist or treatment modality. All of these options will be considered on a case-by-case basis, with primary importance placed on your well-being.

Psychiatric consultations, aftercare, continuing medication consultations, and emergency consultations will be billed. It is the Counseling Center’s expectation that you will utilize your health insurance for these costs, and you should not incur any substantial out-of-pocket expense.

Students who come to Brandeis with medication prescribed by an out-of-area physician and who wish to use Center psychiatrists to monitor and provide collaboration with the out-of-area physician will be required to utilize their insurance from the first session. Medication will be prescribed by Counseling Center psychiatrists only if you are in ongoing counseling at the center.
The fee structure for reimbursement from insurance carriers is set by each carrier. The Center will bill the usual and customary charge accepted by the insurance companies. In the rare instance that a student does not have coverage and wishes to pay directly, the Counseling Center can, by arrangement, set a fee that is appropriate for his or her income level. Please discuss this with me if necessary.

INSURANCE REIMBURSEMENT FOR EXTENDED TREATMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled, however, you (not your insurance company) are responsible for full payment of the Counseling Center fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.]

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information database. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services from the Counseling Center yourself to avoid the problems described above [unless prohibited by contract].

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

________________________________________________________________________

(Name) (Date)

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Attachment J
CONSIDERING INSURANCE BILLING FOR COLLEGE HEALTH AND COUNSELING SERVICES

By Stephen L. Beckley, Doreen Hodgkins, and Marc M. Tract
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The information in this document is for informational purposes only and is not legal advice. No responsibility is assumed for the accuracy or timeliness of any information in this document. The information in this document is not intended as a substitute for legal counsel, and is not intended to create, and receipt of it does not constitute, a lawyer-client relationship. The impact of the law for any particular situation depends on a variety of factors; therefore, colleges and universities should not act upon any information in this document without seeking legal counsel.

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

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

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

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

Keywords: Patient Protection and Affordable Care Act (ACA), College Health and Counseling Services, Coordination of Benefits (COB), Primary and Secondary Payor, and student health insurance/benefit programs (SHIBPs).
Providing unfettered access to health and counseling services, regardless of students’ insurance status or ability-to-pay, is a recognized best practice for the college field. This was a cornerstone of the rationale for colleges to charge designated prepaid health fees and/or use other institutional funding arrangements to pre-fund primary care visits and counseling services. Confidentiality of care was another imperative. Confidentiality may be diminished if visit or other charges are submitted through a parent’s employer-sponsored group insurance or a parent’s individual policy that covers family members. A common third rationale for health fees and other institutional funding was that public health services and health promotion and wellness programs could not be funded adequately either from direct health insurance reimbursements or from fiscal surpluses derived from the operation of health and counseling services.

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

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

These data are in stark contrast to those of the late 1980s when Dr. Kevin Patrick’s overview article for the college health field in the Journal of the American Medical Association reported that less than 15 percent of college health service revenue was derived from fee-for-service among major public universities and less than eight percent among private colleges and universities. It is likely
that from the 1950s through the 1970s, major college health services had only nominal charges for ancillary services and many also provided 24-hour care and infirmary services without charge.

**INCREASED UTILIZATION OF COLLEGE HEALTH AND COUNSELING SERVICES**

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

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

**THE ACA AND FULL COVERAGE FOR PREVENTIVE CARE SERVICES**

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

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

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

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

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

Variable Success for Developing Insurance Billing Revenue

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

For some colleges and universities that have joined the “60% + Club,” the overall experience has not been favorable. The Lookout Mountain Group noted in its major 2009 report on health care
reform for the college student population that “... [the movement away from pre-paid funding] has been adopted imprudently relative to environmental conditions, and/or implemented without appropriate understanding of insurance participating provider contracts, and many students were disenfranchised from access to health care services.”

Disenfranchising students from access to care has occurred through several different scenarios. In most instances, the health service effectively participates with only the SHIBP, resulting in most of the students with other private health insurance either seeking services off campus or foregoing care. The increased trend, particularly since the passage of the ACA, for employers to adopt high deductible health plans greatly increases the concern for access to care because of students’ increased out-of-pocket expenses.

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

**Waiving Insurance Copayments, Deductibles, and Coinsurance Charges**

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

As shown in a 2010 advisory publication issued by the Minnesota Medical Association (refer to Appendix A), there are both federal and state laws that affect the permissibility for waiving charges in excess of small gift and service allowances. Generally, the only way for a health care provider to permissibly waive insurance remaining balances is to document that the patient has limited financial resources and that the charges, if not waived by the health care provider, would create a substantial financial hardship for the patient. Thus, while there are exceptions in varying states, health care providers can waive charges for patients only when detailed financial information supports reduction or elimination of charges based on the provider’s completion of an individual ability-to-pay determination. This financial hardship assessment must be periodically updated to remain valid. Based on a review of literature and case law in preparation for this paper, there is
no reason to believe college health and counseling services are not under the same constraints for waiving insurance charges as private-sector health care providers.

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

**Understanding Coordination of Benefits**

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

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

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

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

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

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

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

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

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

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

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

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

Conversely, fiduciary responsibility requirements for the operation of SHIBPs23 compel that reimbursements to college health services reflect fair market value, and that there are appropriate monitoring and controls for both utilization and cost of services received at health services. Using the preceding example, having the reimbursement level result in 55 percent of billed charges being covered by the SHIBP would raise concerns. Questions might be raised even if the reimbursement level is set to be at the average of other private insurance plan reimbursements if the SHIBP is the single largest third party payor for the health service. As is suggested in this discussion, the potential conflict of interest for college administrators and management committees being responsible for both health services and SHIBPs is a long-standing concern.

- The health service defines the services for which it will use health fees or other institutional funding to cover (i.e., covered services) what students’ primary health insurance plans do not reimburse. For example, covered services could include charges for office visits, procedures,
allergy injections, flu shots, radiology, and lab tests (including certain reference lab tests). The scope of covered services typically excludes travel medicine services/immunizations, employment physicals, and other services routinely excluded by health insurance/benefit plans.

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

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

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

SECONDARY PAYOR SYSTEM EXAMPLE CHARGES AND OUT-OF-POCKET EXPENSES

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

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

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

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

- **Example 4:** Health center office visit charge = $125, student has not met her annual deductible (or she has an HMO with no coverage in the local area): The student’s insurance pays nothing and the college health fee covers the entire $125. Student out-of-pocket expense = $0.00.
Example 5: Health center non-preventive immunization charge (excluded service from health fee funding, not a covered service) = $50, student’s personal health insurance excludes this service:
The student’s insurance pays nothing and the balance is put on student’s account. Student out-of-pocket expense = $50.00.

Secondary Payor System Example Communications

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

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

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

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

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

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

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

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

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

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

• Long-Term Value: The major trend for employer cost-shifting has resulted in large increases in student health insurance plan enrollment over the past decade for colleges that provide comprehensive benefits that comply with standards endorsed by ACHA.26 For example, Dartmouth College went from covering less than one-quarter of its students in 2000 to covering more than 55 percent by 2009.27 The expansion of coverage to age 26 did not result in major decreases in enrollment (in fact, many colleges experienced increased SHIBP enrollment over the past two years), further reinforcing the value of SHIBPs with comprehensive coverage.28
For colleges that have already experienced significant growth in SHIBP enrollment, the decision to pursue secondary payor status for students’ personal health insurance may have substantial financial value for only a brief period. For these colleges, growth in SHIBP enrollment will reach a point where a capitation to fund services for SHIBP enrollees can largely replace health fee and institutional funding allocations.

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

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

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

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

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

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

### Typical Steps for Considering a Secondary Payor System

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

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

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

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

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

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

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

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

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

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

This step should include modeling options for outsourcing of services and/or community partnering. Additionally, performance-based compensation for staff should be considered, especially if this is a key element of compensation packages for not-for-profit and for-profit community based clinics in the area.
D. **COUNSELING:** Although most colleges currently engaged in insurance billing exclude counseling services from this system, the revenue projection should include, at minimum, analysis and discussion of this matter. Given that primary care services routinely include care that is highly sensitive, the philosophical distinction for excluding counseling relative to confidentiality is questionable. Excluding counseling might also perpetuate the common misunderstanding that insurance billing for mental health care services can create a discoverable record that will affect future employment or graduate school opportunities.

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

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

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

**Step Four:** **REPORT:** The final step is preparation of a report for student affairs and other senior leadership. Engaging senior leadership at the beginning of the process is important as it may be necessary to convene stakeholders external to the college health and counseling services to participate in the development and implementation of the study.
• Colleges and universities that have already decided to automatically waive insurance charges for uninsured students and waive copayments, deductibles, coinsurance and other charges for insured students should reconsider the permissibility of these practices.

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

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

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

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

Waiving Copays and Reducing Fees

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

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

INTRODUCTION

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

CAN PHYSICIANS WAIVE COPAYMENTS FOR PATIENTS WITH PUBLICLY-FUNDED INSURANCE?

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

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

Violation of Anti-kickback Statutes

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

The federal anti-kickback statute prohibits the payment of remuneration (meaning any kickback, bribe, or rebate) when it is knowingly used to induce business paid for with federal money. By routinely waiving copayments or deductibles (i.e., without taking each individual patient’s financial situation into account), physicians could be providing an inducement for patients to choose their practice over another one at the expense of the Medicare and Medicaid systems and, thus, they would be in violation of the federal (and state) anti-kickback statutes. These types of violations can result in significant civil and criminal fines, imprisonment, and/or both. That being said, the Office of the Inspector General stated that waiving Medicare and Medicaid copays or deductibles would not violate the Anti-kickback Statute if:

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

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

False Claims Act

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

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

1. 42 U.S.C. § 1320a–7(b)
2. See Addendum to “Hospital Discounts to Patients Who Cannot Afford to Pay Their Hospital Bills (02/02/2004)” (6/18/07). The beneficiary’s “financial need” will depend on the individual’s circumstances. Providers should consider factors such as the local cost of living, the patient’s income, assets and expenses, and the scope and extent of the patient’s medical bills. Providers are encouraged to establish an indigency policy.

3. 42 U.S.C. § 1320a-7(a)(7)
These types of waivers would, therefore, constitute a violation of the federal False Claims Act.

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

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

### Civil Monetary Penalties Law

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

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

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

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

### Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

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

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

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

### CAN PHYSICIANS REDUCE FEES FOR UNINSURED PATIENTS?

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

### CONCLUSION

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

National Association of Insurance Commissioners

www.naic.org

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

EXCERPTS FROM COORDINATION OF BENEFITS MODEL REGULATION, #120

SECTION 3. DEFINITIONS

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

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

(3) “Plan” includes:

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

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

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

(d) Group-type contracts;

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

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

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

(4) “Plan” does not include:
(a) Hospital indemnity coverage benefits or other fixed indemnity coverage;

(b) Accident only coverage;

(c) Specified disease or specified accident coverage;

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

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

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

(g) Medicare supplement policies;

(h) A state plan under Medicaid; or

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

Credentials for Report Authors

Stephen L. Beckley, CEBS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


5 Ibid.

6 Ibid.


9 Ibid.


22 Anthem Blue Cross and Blue Shield, Coordination of Benefits, “How COB Works.” http://www.anthem.com/wps/portal/ahpemployer?content_path=employer/va/f5/s1/t0/pw_034763.htm&state =va&rootLevel=4&label=Coordination%20of%20Benefits%20%28COB%29


25 Ibid.


27 Ginger Farewell-Lawrence, e-mail to Lookout Mountain Group, May 15, 2009.


29 *Federal Register* 46 CFR Parts 144, 147 and 158 (21 March 2012). 16455