

# Archived Information

## **AFFORDABILITY: REDUCING STUDENT FEES THROUGH ALTERNATIVE REVENUE SOURCES:**

### **Billing for Office Visits in College Health Centers**

#### *Budget Challenges*

Given steady higher education enrollment increases, coupled with a sluggish economy, state appropriations to higher education cannot keep pace. Indeed, for the 2003-04 fiscal year, state appropriations for higher education fell 2.1% nationwide, marking the first spending cut since 1992-93. Remarkably, but sadly, 23 states decreased appropriations to higher education, including three states with a decrease exceeding 10%.<sup>1</sup>

Given these state funding reductions, to accommodate each university's costs of educating its students, tuition at some universities has increased 70% or more in the past three years. Last year's 7.3% median tuition increase is smaller than the previous year's 9.3%, or the previous year's 12.3%,<sup>2</sup> but the increases nonetheless continue to challenge legislators and their constituents. Without question, universities must seek all means to provide academic quality and service to students, and that requires financial resources. But alternatives to increasing tuition and fees seem to elude lawmakers and college administrators alike.

Even as state tax revenues increased last fiscal year by 6.0%,<sup>3</sup> state budget flexibility continues to decrease. Non-discretionary items, such as K-12, Medicaid, courts and prisons, garner greater dollars than higher education, principally because they collectively lack alternative revenue sources. Conversely, higher education represents the largest discretionary budget items for most state budgets. Indeed, according to the National Association of State Budget Officers, the share of general-fund revenues allocated to higher education in the current fiscal year equaled only 11.5 percent, down from 14.9 percent in 1990.<sup>4</sup> Therefore, the recent economic recovery has not boosted state support for higher education as college administrators may have expected. Moreover, the disappointing 1.1% GDP growth from 4Q 2005 does not portend the economic rebound optimistically envisioned by many. Neither does the US consumer's negative saving's rate in 2005, the first time Americans have spent more than we have saved since 1947.<sup>5</sup>

#### *The Opportunity*

Responding to limited state support, college administrators have naturally raised tuition and fees. Rising student fees that directly contribute to decreased affordability include, amongst others, the intercollegiate athletic fee, the recreation center fee, the technology fee, the student activity fee,

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<sup>1</sup> "State Spending on Colleges Drops for the First Time in 11 Years," Michael Arnone. The Chronicle of Higher Education, January 16, 2004, Volume 50, Issue 19, Page A24

<sup>2</sup> "Double-digit hikes are down; State schools' median tuition increase," Arienne Thompson and Breanne Gilpatrick. USA TODAY. McLean, Va.: Oct 5, 2005. pg. D.7

<sup>3</sup> <http://www.coe.ilstu.edu/grapevine/50state.htm>

<sup>4</sup> "State Appropriations: Still More Money Needed," Karin Fischer. The Chronicle of Higher Education, January 6, 2006, Volume 52, Issue 18, Page A14

<sup>5</sup> "Economic Growth Slowed to 1.1% in Fourth Quarter," Greg Ip, The Wall Street Journal, January 28-29, 2006, Vol. CCXLVII, No. 23, Page A2

and the health fee. These rising fees have been most prevalent in student health services (“SHS”), the on-campus health clinics available to students. SHS embodies the ill-fated department caught in a nexus of both (i) limited state support for higher education and (ii) the corresponding increase in the cost of delivering health services. Indeed, 30% annual SHS fee increases in recent years have been commonplace, with some SHS increasing annual student fees by 50%. Overall, of the fees noted above, the annual SHS fee increase often represents a greater increase than all other student fees *combined*. Yet within these very SHS exist an unprecedented opportunity to generate significant incremental revenue. The purpose of this paper is to address that opportunity, an opportunity available to SHS at both public and private universities.

### ***Student Health Service Insurance***

SHS by and large do not accept student’s private insurance, despite, according to the American College Health Association, 83% of students having private health insurance coverage, typically through their parents. Notwithstanding carrying private insurance, students at a majority of institutions pay SHS out of pocket for most ancillary charges, such as labs or x-rays, which represents a hidden and unpublished cost of higher education. Granted, students and parents may seek reimbursement from their insurance company, but reality dictates a poor outcome. Most students and parents possess neither the time nor the intricate understanding of insurance reimbursement to receive repayment from their insurance company.

While most SHS receive revenue for ancillary charges from their students (rather than the student’s insurance company), SHS have historically not charged for office visits. In fact, the only place in American medicine where a patient visits a physician but the insurance company receives no claim for an office visit is in college health. With SHS either unable or unwilling to accept private health insurance, two results emerge. First, as noted, students pay out of pocket dollars for ancillary charges their private insurance should, and would generally, cover. And second, SHS forego a considerable potential revenue stream by not billing insurance for office visits.

Envision a primary care clinic not charging an office visit fee, yet striving nonetheless to have revenues equal or exceed expenses. Survival would presumably entail government intervention in the form of increased taxes, much akin to the SHS fee increases at universities. As it is, keeping the doors open for a primary care clinic remains a challenge...even *when* billing insurance for office visits. Similarly, SHS could take steps towards self-sufficiency and less reliance on state or university appropriations by charging office visits to students’ private health insurance. Positive student and parent reaction at the few SHS that accept private insurance evidences not only the benefits of the foregoing, but the constituent satisfaction as well.

### ***The Opportunity Nationwide***

According to the Chronicle of Higher Education, 7,305,000 full-time undergraduate students attended four-year institutions in Fall 2003. Including the 4,948,000 part-time undergraduate and graduate students at four-year institutions, that number equals 12,253,000.<sup>6</sup> Four-year institutions typically include comprehensive SHS, centers with at least one physician, whereby

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<sup>6</sup> Those numbers have increased in two years, but Fall 2003 is the latest accurate data.

the framework exists for successful insurance billing. Therefore, for purposes of the calculations below, the 4,384,000 total students attending two-year institutions are excluded in the following assumptions.

- 83% of students have private health insurance, or 10,169,990 of the 12,253,000 students attending four-year institutions.
- The average visit per student per year to a student health center exceeds 1.5 visits.
- Conservatively, at 1.35 visits per student, or 90% of 1.5 visits, 10,169,990 insured students make a cumulative 13,729,487 office visits.
- Based on the typical lower level visits seen on a college campus, Medicare would repay an average of \$61.02 per visit (see chart below).

CPT Code	Description	Ratio (IOV and EOV)	Projected Allowable	Projected Gross Revenue
99201	IOV - Level I	2.0%	\$36.50	\$0.73
99202	IOV - Level II	6.0%	\$64.00	\$3.84
99203	IOV - Level III	13.0%	\$95.00	\$12.35
99204	IOV - Level IV	3.0%	\$135.24	\$4.06
99205	IOV - Level V	1.0%	\$171.00	\$1.71
<b>SubTotal</b>		<b>25.0%</b>		<b>\$22.69</b>
99211	EOV - Level I	3.0%	\$21.50	\$0.65
99212	EOV - Level II	18.0%	\$38.00	\$6.84
99213	EOV - Level III	47.0%	\$52.00	\$24.44
99214	EOV - Level IV	5.0%	\$81.00	\$4.05
99215	EOV - Level V	2.0%	\$118.00	\$2.36
<b>SubTotal</b>		<b>75%</b>		<b>\$38.34</b>
<b>Total Projected Gross Collections</b>		<b>100.0%</b>		<b>\$61.02</b>
			<b>Deductions: 20%</b>	<b>\$12.20</b>
			<b>Adjusted Gross Collections:</b>	<b>\$48.82</b>

\* Note: IOV: Initial Office Visit; EOV: Established Office Visit

- Insurance companies sometimes do not allow payments for various reasons, and in order to project a more conservative number, assume a 20% reduction from the \$61.02, to \$48.82.
- 13,729,487 visits multiplied by \$48.82 equal gross collections of \$670,273,531.
- With approximately 95% of SHS not accepting private health insurance, **\$636,759,854 of gross revenue in US college health centers remains uncollected.** That equals **0.96%** of

**total** state appropriations to higher education in the United States in FY2006, <sup>7</sup> from only one department, and one typically considered a cost center.

### ***Benefits of Third Party Billing***

Despite these rapidly increasing SHS fees, many SHS have nonetheless curtailed services. Specialties such as gynecology, physical therapy, radiology and dermatology have been eliminated. These eradicated services, coupled with higher fees, have hardly ingratiated SHS to the student population. However, third party billing for office visits would permit retention of many foregone SHS services. And third party billing would also produce a plethora of additional benefits, financial and non-financial, for students, parents, legislators and college administrators alike.

Financially, charging insurance companies, standard practice in every clinical setting save college health, supports SHS in their efforts to become self-supporting auxiliary enterprises. As such, college administrators may eliminate the largest fee increase imposed upon their student body. Moreover, the incremental dollars generated from insurance billing could not only eliminate SHS fee increases, but possibly *exceed* SHS fee increases. That in turn could facilitate the retention of the aforementioned foregone services and/or an increase in SHS cash reserves. Finally, because reimbursement typically rises linearly along with increased student demand, administrators need not respond to greater demand with rising fees. Reimbursement from insurance companies satisfies these increased costs, as it does in private practice.

From a non-financial perspective, students deem the SHS that conducts third party billing as more “mainstream,” akin to their primary care provider from high school. Moreover, perception immediately improves, as third party billing necessitates SHS providers becoming “in-network” with insurance companies. Students visiting (i) “in-network” providers and (ii) reimbursed providers (from the insurance company, not the student or parent), versus those providers today perceived to “give away” services, are unsurprisingly viewed with higher regard. Indeed, in SHS that conduct third party billing, usage typically increases significantly. Increased usage leads to greater revenue. And that is a sustainable financial model.

### ***Questions***

Notwithstanding the benefits of a third party billing model, questions persist, most often with respect to the 20% or so uninsured students. For instance, some SHS directors question, ethically speaking, the procedure of insured students effectively subsidizing the uninsured students. However, this practice is analogous to the students who pay “sticker price” for tuition. These wealthier students subsidize the students who receive financial aid in the form of tuition discounts, in part through publicly funded grants. The concept of charging the uninsured student a lower rate than a student whose insurance company can afford the “sticker” price is philosophically comparable.

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<sup>7</sup> According to a survey conducted by James C. Palmer at the Center for the Study of Education Policy at Illinois State University, state appropriations to higher education from all 50 states totaled \$66,642,898,000 in FY2006.

This philosophical shift also addresses SHS director concerns that the SHS fee has historically covered office visits. In a SHS third party billing model, the health fee continues to cover wellness and education programs, prevention, infrastructure and other non-reimbursable items critically important to a SHS model. However, office visits shall be billed to the student's private health insurance. To reiterate, the only place in American medicine where a patient visits a physician but receives no bill for that visit is in college health. Given recent and anticipated increased student demand, foregoing an office visit charge will necessarily reduce health services, increase the SHS fee, or both. Conversely, billing an office visit -- to a health insurance company that receives a monthly premium and expects to pay office visit reimbursement -- mitigates fee increases, while simultaneously augmenting financial resources to enrich health services.

Some SHS directors express concern that charging an office visit fee, albeit to the insurance company and not to the student or parent, nonetheless creates a barrier to entry. However, if the insurance company does not pay for an office visit, the health center does not need to "balance bill" the student's bursar account. Therefore, the student is not adversely affected by office visit billing. Conversely, *today's* model creates the barrier to entry, as students generally pay for ancillary services their insurance should cover. And for SHS whose large fee permits students to pay little or nothing for ancillary services at time of service, the students nevertheless pay through their ever increasing SHS fees. Moreover, the SHS that charges a large health fee in lieu of charging ancillary services effectively taxes the approximately 50% of the student body that never visits SHS. On the other hand, billing an office visit generates incremental revenue to SHS, reduces student and parent expenses and eliminates the unnecessary taxing of the healthy student who rarely, or never, visits SHS during his or her four years on campus.

Moreover, with respect to ancillary services, some students actually evade SHS to avoid paying a substantial x-ray or lab fee their insurance should cover. Instead, they visit a local clinic or emergency room, both of whom accept insurance, despite the relative logistical inconvenience of visiting an "off-campus" provider. And insurance companies hardly welcome the latter option, as an emergency room bill is exponentially higher than a SHS office visit bill. Worse, because of the inconvenience of the off-campus physician or hospital, some students avoid treatment altogether. That benefits no one.

### ***Summary***

If health insurance had predated the era when universities began constructing on-campus health facilities to improve student retention, third party billing as the financing mechanism in college health would presumably be a widespread model today. However, the financing of college health has typically included three sources of funding: (i) institutional funding, (ii) fee for service (for ancillary care), and (iii) the rapidly increasing student health fee. With limited state funding, institutional funding has plummeted. Fee for service costs, while rising, cannot increase disproportionately vis-à-vis community rates. That has left increased student health fees as the primary mechanism to fund any SHS financial shortfall.

However, with the third party billing model having recently proved successful when introduced into college health, another financial model exists. Its relative infancy in college health, though,

requires a cultural shift. This culture change -- not for students and parents, but for college health administrators -- is one which some college administrators have embraced, especially given positive student and parent feedback. Notwithstanding the benefits, though, change can prove daunting, and therefore, any change, whether in college health or another area of higher education, requires patience.

Overall, the lack of state appropriations has forced universities to seek alternative revenue. Additional revenue, irrespective of the industry, habitually requires increased costs, and hence, risk. The switch to third party billing at SHS, however, represents the unusual scenario whereby revenue is already being generated -- every time a student visits a provider. Missing is merely the *collection* of that revenue from the insurance company.

Headlines for a December 2003 article in the Arizona State University student newspaper read: "Student Fees Contribute to Rising Tuition Costs." ASU, the largest university in the country by virtue of Fall 2005 enrollment data, responded in part by outsourcing third party billing in their SHS. Dr. Michael Crow, ASU's President since July 2002, encourages entrepreneurial leadership in all departments, presumably with the goal of averting the aforesaid headlines. And in today's economic environment, where higher education foregoes dollars to non-discretionary items, higher education officials should capitalize on all financial opportunities that do not include raising tuition and fees. And the easiest one awaits on campus in their student health center.