Mandatory Health Insurance for College Students

Improving student awareness by providing detailed strategic and financial information about the health insurance policy at Rutgers University

Tag Words: Rutgers health insurance, mandatory policy

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Summary

According to NJ law, all students going to a private or a public school are required to have health insurance coverage. If a student does not have that, Rutgers automatically adds a student to a Health Insurance policy chosen by them from United Health Care. There are options to increase the plan and also a student has options to enroll his/her spouse and children. The students who are forced into this insurance are unaware of most of its benefits. The current solution of this problem is that the insurance company provides the students with the website to find the information on. The problem with that is not many students attempt to go on the website and find out about the plan. Our project is to increase the awareness among students about their plan. There are ways to save money and if they are not covered they can appeal to the insurance company asking them to reimburse the cost that the insurance company should have covered.

Video Link

http://www.youtube.com/watch?v=d7S29_Mdwt0&feature=player_embedded

What you don’t know about health insurance

Background

(BC) Health Insurance was developed in the late 1920s due to rising medical costs and a greater demand for hospitalization as opposed to house calls. As hospitals became a standard and medical advances became more costly something had to be done to ensure hospitals received payment and ensure consumers received care. Blue cross was the first group to come up with pre-paid health insurance plans. This plan was very straight forward; consumers that paid for hospital care would have a bed In the event of becoming ill. Since then health insurance has become much more complex. Initially health insurance was only for hospitals, physicians were reluctant to join this trend because they thought insurance would lower their income. Even back in the 1920-1930s you can see the root issue with health insurance, greed. To this day we have yet to develop health insurance that the provider and client are financially satisfied with. As a result, health Insurance is a constantly revolving design.
Types of Insurance Plans

Modern day health care comes in two basic categories, fee-for-service or indemnity and managed care. Fee for service is the most flexible but also the most costly. Fee-for-service plans enable you to make an appointment with the health care provider of your choice. The provider sends the claim to your insurance company and they determine how much you pay based on your deductible and co-payment terms. A deductible is the amount of money you are required to pay before insurance is obligated to make any payment. The deductible can be anywhere from $200-$4500 and is solely dependent on the plan you chose. Be aware that within your policy the deductible may vary depending on the health care service that is performed. The rest of the bill is a co-payment between you and the insurance company. The terms of the co-payment are usually 80/20 or 75/25. Meaning you pay 20% or 25% of the cost and the insurance company pays 80% or 75%. As a result this type of plan can become very expensive with increasing medical costs.2

The second category of health insurance is managed care, this option has a greater variety of plans than fee-for-service insurance. Managed care provides insurance at lower costs but has restrictions. The more restrictive the plan is the cheaper it will cost for the consumer. Managed care plans are able to offer low costs to consumers because they network with healthcare providers and restrict consumers to only use these providers. The policy holder can of course go outside the insurance company’s network of providers, however they may have to pay for all or a larger portion of the costs. Another way they keep the costs low is through what health care services are covered. For example, preventative measures, such as check-ups, are covered but specialists and medical treatments that are not accessible within their network need to be deemed necessary before being covered. There are three main types of managed care plans, Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point-of-services (POSs). HMOs require you to pay a premium each month in return for a range of health care services that are specific to the plan. The policy holder chooses a primary care physician from a list of health care providers within the specified network. The co-payment to see this primary physician is usually $5-$25 and prescription co-payments are typically $5-$10. It is essential that the consumer gets pre-approval from their primary physician for any out of the network care, otherwise he/she will not be covered by insurance. When a patient needs specialized care it is often difficult and time consuming to receive covered specialized care with an HMO, this is a major disadvantage for the consumer. PPOs in terms of restriction are between fee-for-service plans and HMOs. They have a set network of providers to choose from but a primary care physician is not necessary. If the consumer needs to see a health care provider outside the network a referral is not necessary however there will be a higher co-payment. The consumer must pay the deductible along with a higher percentage of the cost and any discrepancy between what the plan specifies as “reasonable” for the service and what the health care provider charges. The advantage is the consumer will get outside treatment in a timelier manner than an HMO. The disadvantage is it will wind up costing more for the consumer. POS plans are very similar to HMOs the difference being if you need out of the network care you will only get partial compensation even with the primary care physicians referral. The compensation amount is determined by how much the cost of the service was, how much your deductible is, and any discrepancy between what the plan specifies as “reasonable” for the service and what the health care provider charges. Each plan has there disadvantages and
advantages but not only that there are numerous health care providers all with different HMO, PPO, and POS plans. This is why health insurance companies can easily take advantage of consumers that don’t know what questions to ask before committing to a policy.

Consumers need to know what questions to ask when shopping around for insurance to make sure they get the correct policy to suit their individual needs. Health insurance policies offer a wide range of options to their policy holders but this comes with advantages and disadvantages. The advantages are that they can be tailored to meet all different needs and income levels. The disadvantages are if consumers aren’t educated they may pick a plan that will cost them a lot more money or even put a diagnosis on hold which may have a negative effect on their health. Unfortunately, more often than not, consumers don’t understand what exactly their policy covers until they need it. To prevent that from happening here are questions that should be asked and considered before agreeing to a health insurance policy. What are the deductibles and/or terms of co-payments? Will the plan cover any medication that I’m prescribed? Does the plan cover special conditions and treatments for example mental health, pregnancy, etc? Are specialists covered? Does the plan cover nursing home care? If there is a dispute regarding health care service (in or out of network), how is it handled? Do I need a primary care physician? What happens if I see a health care provider that is not a part of your network? The health insurance company should answer your questions to the fullest extent and not give you any trouble. After asking these questions to all perspective health insurance companies the consumer can compile all the answers and analyze them. This will help consumers confidently decide which type of plan will suit them best and with which health insurance company.

How health insurance companies take advantage
Health insurance companies are not always fair to all consumers. They should treat everyone the same but they have been known to discriminate against people with pre-existing conditions. They discriminate by either refusing to insure the consumer altogether or refusing to cover costs associated with the treatment of said pre-existing condition or charging them a higher premium. If a consumer doesn’t know about health insurance discrimination than they may be paying too much and not even realize. Under the new health reform health insurance companies are banned from refusing coverage due to pre-existing conditions. There will also be a yearly cap on deductibles, co-pays and out of pocket expenses. Meaning they can still charge these consumers more but there will be a maximum to the extent of how much more. The issue of discrimination is a serious problem because those people are the ones who need the coverage the most.

With health insurance it is difficult to find the right balance to make the policy fair for the consumer, insurance company, and physician. The consumer has to worry about finding the right plan with the right coverage to avoid paying more than necessary. They also have to assure they aren’t being discriminated against. When the policy holder has a HMO/PPO/POS and needs to see an out of network specialist it is crucial that they understand the policy to avoid paying for all of the costs. Many times the consumer isn’t aware that they can appeal a health insurance claim, which would save them a lot of money. Unfortunately, they make the appealing process long and not necessarily simple so many consumers won’t even bother. There is fine print to every health insurance policy that every consumer should be required to understand.
before agreeing to the policy. The difficult part is how to implement that. Currently they have all these terms in the fine print that no one ever reads. All the essential and key terms of the policy need to be more concise and presented in a way that makes the consumer more apt to read it. Insured consumers are scared that if they become seriously ill they will go bankrupt. One of the reasons for health insurance is it’s supposed to enable consumers to fairly pay for their services in return for peace of mind that they can get treatment in the event of becoming ill. They should at no point feel that if they become seriously ill they will have to pay for all costs themselves. Unfortunately, we have all heard the horror stories and this does happen to too many people. If health insurance companies aren’t going to help their customers when they need it, then what is the point of having insurance? Health insurance policies need to become more about ensuring the consumer gets proper treatment than about making money for the insurance company.5

Health Insurance vs. Customer
The health insurance company has a different mind state than a consumer. Insurance companies want money, their motives aren’t always in the best interest of the consumer. This is why health care is constantly changing and new policies are enacted to address the unfairness of the system. Sometimes in fee-for-service insurance, insurance companies will negotiate with hospitals for a reduced rate but don’t reflect this reduced rate in the consumers payment. Since the consumer pays a percentage of the cost they will wind up paying a higher percentage than in their terms of agreement. Now the insurance company pays a cheaper amount to the hospital and pockets the extra money from the consumer. Another trick insurance companies have is to put a cap on annual coverage customers are able to receive. This means that insurance companies have a maximum amount of coverage per year that the policy holder can receive. If this maximum is exceeded they will no longer cover the cost or help cover the costs of your health care. Insurance companies also tried to charge patients with known medical conditions more money because they know they’ll have to put out more money for them. They used to be able to drop consumers coverage if they became very ill and were costing them too much money. The main structure of an insurance company is the consumer pays a monthly payment regardless of if they use their services or not. So the insurance companies make a profit when more people are healthy and don’t use their services than the cost of the services needed. When you look at this as a health insurance company in an economical stand point, it makes sense to only insure healthy consumers but that isn’t what health insurance was created for. We seemed to have lost that focus and need to make health insurance more about fair compensation than a business.5,7

The uninsured
As the cost of health insurance increases, the number of uninsured citizens also increases. Having people uninsured is not good for many reasons. One of them being they aren’t able to receive preventative scans, including simple things like a check-up or blood test. This can have a detrimental effect if they have an underlying illness. Preventative scans are very important, it’s known that many health related issues have a much higher cure rate the earlier they are caught. If someone who is uninsured feels sick they fear going to the doctor because they can’t afford it, while they’re condition is getting more serious the longer it’s left untreated. They also may not fill a prescription they were prescribed because they do not have the funds for it. The uninsured are much less likely to go to a follow-up doctor’s visit, which sometimes is very important. The problem is people get sick, and if they cannot be treated they will not get better. The longer this
cycle goes on the more this person will wind up paying when they finally do go to a doctor or hospital. If the uninsured cannot pay up-front they can even be turned away and not treated. There are essentially no benefits to being uninsured so the more people we can get insured the better.  

Citizens need to protect themselves from financial hardships and also protect their health. The best way to do that is to get health insurance. In hard economic times like we are in now it is difficult for some people but health should be a priority. People need to be educated about how important health insurance is and the money they will save in the event of becoming ill. The most important education needs to be in what exactly their health insurance is covering. The lack of communication from the health insurance companies to the consumers needs to be eliminated. Consumers have every right to know about the possible extra expenses or that they can appeal claims that they feel are unfair. It is ultimately up to them to go the extra mile and do the research, but we can get the word out to encourage people and inform them as to why it will help them in the long run.  

Health insurance companies have lost sight of what their main goal is. They have changed their motives into making the most profit regardless of what it cost to the customers. The best way to stop this is to creating acts like The Patient Protection and Affordable Care Act (ACA). ACA supports greater coverage to more Americans in an effort to lessen the percentage of uninsured. This is possible by not allowing insurance companies to deny applicants due to pre-existing conditions and expanding Medicaid. New marketplaces called health insurance exchanges will be created to allow individuals and small business owners to purchase health insurance. These health insurance exchanges will hopefully guarantee a fairer competitive playing field for insurers. They are also required to inform consumers of essential information about their policies for example, any and all costs and the different plans they offer and what makes them different. While this act looks to support insuring more people, it fails to address the restrictions health insurance companies implement that interfere with how doctors treat their patients. This can be addressed by making the insurance companies cover whatever the doctor sees fit as a treatment, seeing as each and every diagnosis is different. Insurance companies cannot look at different people with the same disease and assume one treatment will work for everyone because people respond differently to treatments. By imposing these restrictions they are inevitably pushing doctors to be less honest in an effort to give their patients the same treatment they had been getting. The insurance companies put these restrictions in place to save money. They aren’t concerned about the possibility of their customers not being cured. The influences that health care companies have on doctors and doctors have on health care companies is much more difficult to regulate. It’s something that will only work if the doctors and health care companies are cooperative and have respectable motives otherwise you will see these conflicts that arise due to greed.  

The best way to deal with the current health insurance debacle is to know what you’re dealing with. We need to inform everyone we can, college students are especially important because they are almost at the point in their life were they will be picking out a health insurance plan for themselves or maybe even their family. They need to know the basics of a health insurance policy, what questions to ask, and a little bit on how they operate. Once they know that they should be aware of what health insurances hide from consumers to make money so they don’t become a victim.
Health Insurance Laws

It has been said under New Jersey Law (N.J.S.A. 18A:62-15) that all the students of a private or a public university possess health insurance that gives them at least minimum amount of benefits. If a student is enrolled in insurance then he/she needs to give proof of that to their respective university. All universities need to arrange for health insurance for their students who are not enrolled in any other healthcare plan.

This law has been designed to benefit the students. It is possible that a student might fall sick during a semester, he might get into an accident, or might need some other healthcare. If he does not have health insurance then he would not recover properly and it would affect his progress at the university. He would not be able to attend classes and would eventually fail to get good grades. This would result in failure of utilization of their complete potential. It is possible that they might even have to drop out of school in accord to their deteriorating health.

Rutgers Health Insurance Plan

Following the state requirement, Rutgers University has selected insurance plan for its students. The company that is providing the insurance to the students is United HealthCare. The students will be charged for the insurance in their term bill. They can receive maximum benefits of $50000. Prescription benefits cannot exceed $5000. Students will be required to pay 375 dollars per semester. For the students to get insurance coverage there are few requirements. They have to attend classes for at least thirty one days. Only students taking on-campus classes are covered. Students going to other types of classes such as online and home based classes are not eligible to receive coverage.

As described by the law, Rutgers University would not enforce the insurance on a student if he/she shows the university his/her enrollment in the insurance policy with minimum benefits (as per the definition of the law). That insurance policy should be valid in New Jersey and should have healthcare providers in the New Brunswick area. It has to cover medications, and prescribed medications.

If a student shows his enrollment in insurance policy he would not get enrolled in the United Healthcare policy. If a student loses his insurance coverage due to unexpected events than he has a chance to get enrolled in United Healthcare policy within 31 days of getting disqualified from his previous insurance.

Three types of policy can be chosen by Rutgers students. The one they are directly enrolled is the minimum coverage. The minimum plan covers $50000 for each injury or sickness. Students have 24 hour Mynurseline services available to them. Therefore, if a student is having problems midnight and if it does not look that serious he can take advice of a nurse. They can go over his/her symptoms and advice how to follow up for that. The number for 24/7 Nurse Advice is 180089055882. If a student has any doubts about his/her plan they can call on 18005054160 for more details or they can find out about it on www.firststudent.com. The basic plan costs $750 per year.

The best thing to do under this policy is go to a doctor that is considered as a preferred provider by United Healthcare. Insurance covers more percentage of expenses from preferred
provider as compared to out of network provider. Deductible for preferred providers is $150 and deductible for out of network providers is $300. Preferred provider Coinsurance is 80% with few exceptions and Out of network coinsurance is 60% with few exceptions. There are two kinds of care Inpatient and outpatient care. Inpatient care is when patient is admitted to a hospital or other facility. This type of care is usually long term care provided at hospitals, nursing centers or eldercare facilities. Outpatient care is when patient is not admitted to a facility. Outpatient care can be in a doctor’s office or patient’s home.  

Other important terms to have knowledge of are deductible, UCR and preferred allowance. Deductible in simple terms is the amount a student has to pay before the insurance company pays. For example, if your policy agreement says $50 deductible than you have to pay $50 before United Healthcare starts paying for your healthcare costs. Preferred allowance on the other hand is the amount that a preferred provider would consider his complete payment. UCR are the charges customary for a particular area. Let’s say that the UCR for an oncologist in New Brunswick area is $1000, but he charges you $1200. In this case scenario, United Healthcare would pay its promised percentage of $1000. The student will be responsible for the rest of the amount in addition to the deductible.

Following is the coinsurance information that the University supported plan covers:
PA = preferred allowance
U&C = Usual and Customary Charges

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<thead>
<tr>
<th>Inpatient</th>
<th>Preferred provider</th>
<th>Out of network provider</th>
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<tbody>
<tr>
<td>Hospital Expense</td>
<td>80% of PA</td>
<td>60% of U &amp; C</td>
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<tr>
<td>Surgeon’s Fees</td>
<td>80% of PA</td>
<td>60% of U &amp; C</td>
</tr>
<tr>
<td>Physician’s Visits</td>
<td>80% of PA</td>
<td>60% of U &amp; C</td>
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<tr>
<td>Psychotherapy</td>
<td>80% of PA</td>
<td>60% of U &amp; C</td>
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<th>Outpatient</th>
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<tr>
<td>Surgeon’s fees</td>
<td>80% of PA</td>
<td>60% of U &amp; C</td>
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<tr>
<td>Physician’s visits</td>
<td>100% of PA/$25 copay per visit</td>
<td>60% of U &amp; C</td>
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<tr>
<td>Physiotherapy</td>
<td>100% of PA/$25 copay per visit</td>
<td>60% of U &amp; C</td>
</tr>
<tr>
<td>Medical emergency expenses</td>
<td>80% of PA</td>
<td>80% of U &amp; C/ $100 deductible per visit</td>
</tr>
<tr>
<td>Radiation therapy and chemotherapy</td>
<td>100% of PA/$25 copay per visit</td>
<td>60% of U &amp; C</td>
</tr>
<tr>
<td>Diagnostic X-ray and Laboratory services, Test and procedures</td>
<td>80% of PA</td>
<td>60% of U &amp; C</td>
</tr>
<tr>
<td>Prescription Drugs ($5000 max) $15 copay per prescription for Tier 1 $30 copay per prescription for Tier 2 $45 copay per prescription for Tier 3</td>
<td></td>
<td>60% of U &amp; C</td>
</tr>
<tr>
<td>Psychotherapy (30 visits max)</td>
<td>100% of PA/$25 copay per visit</td>
<td>60% of U &amp; C</td>
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</table>
Other | Preferred Provider | Out of Network Provider
--- | --- | ---
Ambulance Services | 80% of PA | 80% of U & C
Durable Medical Equipment | 80% of PA | 60% of U & C
Dental Treatment, $250 maximum per tooth. For injury to Sound, Natural Teeth | 80% of PA | 60% of U & C
Preventive care $750 maximum per policy year | 100% of PA | 60% of U & C
Urgent Care Clinic Fee | 100% of PA/ $25 copay per visit | 60% of U & C

http://firststudent.com/schools/RutgersTheStateUniversityofNewJerseyNewBrunswickCampus/review_brochures.htm

In addition to this, the students can increase their benefits. They can enroll themselves in an advanced coverage plan of $100000 and $250000. Costs vary for both the plans. For the first one, students would have to pay $992 per year and for the $250000 plan, students would be paying $1073 per year.

**Increasing awareness among students**

What is our service project: For our service project we wanted to find a way to increase awareness about health insurance, in the process encouraging students to better understand their plan. We chose to add a vital FAQ that was missing from the Rutgers Health Insurance FAQ website. This is something that will affect many people as it will stay on the website indefinitely. It will reach many people as the internet is the main source of information in our era. Our FAQ was about how to appeal a denied claim. Surprisingly there was nothing on the website that even mentioned appeals which reinforces my notion that many students are not aware they have that option. I feel confident that our FAQ will be successful in helping many students. (Brittney Cook)

How was it accomplished: Once we found that this important FAQ was missing from the website, to change that became our main goal. We went to student accounting to find out if it was possible to add a FAQ. They gave us the name of someone who could further assist us. Edward Tillman helped us throughout the rest of the process. He was very helpful and got back to us in a timely manner. We sent him our FAQ, he revised it and posted it on the web! You can find it here, http://www.studentabc.rutgers.edu/faqs/studentinsurancefaqs.php. (Brittney Cook)

**References**

   <http://eh.net/encyclopedia/article/thomasson.insurance.health.us>.

Letters to the Editor

Dear Editor,

I am writing to you in concern with the awareness among students about Rutgers Health Insurance. Due to inadequate education of the insurance plan, many students end up paying most of their health care costs out of their pocket.

As required by the state law, Rutgers University enforces mandatory insurance to all the students who does not have insurance or whose insurance does not meet the requirements of state law. Rutgers University chooses the plan for the students and they are not active participant in this decision making. Every student has his/her own healthcare requirements and the university should take ample measures to inform students about best ways to utilize this plan. I myself have been a victim of being ignorant of the rules and regulations of my plan. In Fall 2011, I was suffering from sinuses and had to visit my family doctor. The insurance company denied paying my bills and I ended up paying $250 out of pocket. There is a way to get that money back if students files an appeal and can prove that he/she deserved to be covered under the rules of the plan. To spread awareness among students, I and my project partner have requested financial aid office to add the appeal process information on their website. On 4/3/2012 this request was approved and the information about appeal process is on their website now. Students should be aware that if they go to a preferred provider of the insurance company than more than 80% of
their charges will be covered by the insurance company as compared to 60% for out-of-network provider. This information will help the students to make smart decisions and will help them save some money. Most students who are enrolled in this insurance do not have good financial background to afford insurance, and losing money because of being unaware would not help their cause. Steps should be taken to educate them about the insurance plan.

Sincerely,

Shrey Shah

Send to the Targum

Dear Editor,

Health care Insurance is widely known but many people of all ages don’t know how it really works. It is very important to become aware of the insurance policy before needing to use it. My partner and I felt so strongly about this that it became the basis for a project of ours at Rutgers University. Rutgers University has implemented a new policy in regards to healthcare insurance. This mandatory policy has advantages and disadvantages. The advantages are in the event that you do get sick or injured you won’t have to pay as much for your treatment as you would without an insurance policy. The disadvantages are you have to pay for it whether you use it or not. The only way you can decline the policy is if you prove that you are insured elsewhere. Healthcare Insurance comes in a variety of different types of plans all with different rules and regulations that are extremely important to understand before agreeing to. Once you understand the plan you will find health insurance to be a good investment. There are certain things to pay special attention to, such as deductibles, monthly payments, what is covered, and what doctors you can see. If you see a doctor and are denied financial coverage you can appeal the claim denial. This is something that most people aren’t aware of and it’s unfortunate because it could save them a lot of money. If you appeal a claim the insurance company will reevaluate the claim of concern to see if it is supposed to be covered. We want people to be aware of all their options and show them that health insurance is there to help.

Sincerely,

Brittney Cook

Sent to The Argo (Rutgers Prep School news paper)