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# Opportunities and Threats for College Women's Health: Health Care Reform and Higher Education

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*The Patient Protection and Affordable Care Act (PPACA) of 2010 (P.L. 118-148) has already changed college students' health care options and has a larger impact on women as they outnumber men in college enrollment and require unique services. Through a feminist policy framework, we discuss how the PPACA impacts college women's health and reproductive rights with a call for higher education to proactively develop policies and standards that focus on the health of women students without limiting access to a range of reproductive health care options.*

The Patient Protection and Affordable Care Act (PPACA) of 2010 (P.L. 118-148) is changing college students' health care options, especially women's due to the unique health services they require. National data indicate that a higher percentage of women than men enroll in higher education. With over 10 million women enrolled in postsecondary education (National Center for Educational Statistics, 2009), health care legislation and related policies can affect overall collegiate success. College women utilize health care services more often than men (American Association of University Women [AAUW],

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n.d.), and they pay 18% more out-of-pocket medical expenses while making 58% more annual physician- or provider-related trips (DeLorey, 2006). This makes affording quality health care a challenge. The new health care law requires higher education's policies to respond to the specific interests of women because the PPACA alters basic health care access and cost for comprehensive sexual and reproductive health as well as education affecting the psychological, medical, and academic experiences of college women.

In this paper, we use a feminist policy framework (Bensimon & Marshall, 1997) to guide an examination of health care policy and the potential impact on college women. We posit that the current health care system and the PPACA may continue to restrict middle-class and lower-income women's access to comprehensive and affordable reproductive services, unless higher education responds with proactive policies that prioritize women's reproductive rights and keep health care services on college campuses. Some provisions in the PPACA will benefit college women; however, there are provisions with the potential to limit women's health and reproductive rights.

We suggest that public higher education administrators develop policies and standards for the health of women students without limiting access to a range of affordable reproductive health care options. Higher education has a role in the development of health care provisions and education, especially because college students are increasingly engaging in first-time and regular sexual intercourse and report inconsistent to no contraceptive use (Kang & Moneyham, 2008; National Campaign to Prevent Teen and Unplanned Pregnancy [NCPTUP], 2009). Within this analysis, we focus intentionally on the implications of the health care reform for college women and their reproductive rights, because as a population college women generally are in their main reproductive years and will be impacted by the changes. We conclude with policy and research recommendations for higher education administrators and policy makers focusing on protecting and promoting women's health throughout the college years.

## An Overview of the PPACA

Overall, the PPACA makes specific changes to health care for the college student population. Some of the provisions related to our discussion are

- the ability to remain on parents' insurance until age 26;
- the requirement that all U.S. citizens must obtain health insurance by 2014, with a few exceptions;

- the removal of insurance companies' ability to use gender rating or to limit coverage for pre-existing conditions; and
- the ability to visit an obstetrician/gynecologist without previous referral from a primary care physician.

New regulations for insurance companies will increase insurance coverage for women who did not have access before and will change the ways women think about and pay for health care. While we view many of the new provisions as positive steps, the new law ignores women's right to affordable, comprehensive health care and prevention that is equal to that of men in terms of reproductive rights. The PPACA works against reproductive health by continuing funding for abstinence-only education, by limiting or denying access to elective termination coverage and care, and birth control availability based on employers' and private institutions' religious or moral beliefs. We discuss these issues to alert higher education administrators and researchers that these factors create negative implications for college women. Based on advocacy and dialogue, campus leaders should devise solutions to provide college women with access to services that foster their persistence and academic success.

### **A Feminist Framework Grounded in Reproductive Rights**

We use a women-centered policy framework to guide our discussion of the health care reform's influence on college women and how higher education institutions should consider policies that transform institutions for the betterment of women students' overall health. Conventional policy analysis views structures, actors, and culture as genderless; however, a feminist policy framework examines women as a conceptual category and uses gender as an analysis lens (Acker, 1990; Bensimon & Marshall, 1997; Ng, 2000; Rich, 1979).

Our application of a feminist policy framework views reproductive rights as a woman's lifelong commitment to her body. A commitment to reproductive rights requires comprehensive education and fiscal awareness that extends far beyond legalized birth control and elective termination debates to include the right to education, access, and affordable costs for quality reproductive health care. Women deserve freedom in making personal decisions based on sexual preferences, childbearing, and personal welfare. Women should also have the right to make informed choices based on knowledge of reproductive health regardless of surrounding societal or political belief systems. These rights impact a woman's ability to be successful in higher education.

Therefore, through a feminist lens, we review PPACA policies that control the content of sexual education, and limit access to affordable birth control and gynecological care and safe termination of pregnancy. Women's reproductive care begins before college and should include comprehensive educational programs rather than focusing solely on abstinence-only (AAUW, n.d.; Advocates for Youth, 2007; Douglas, 2007; Strong, 2010). Abstinence-only programs "censor information on contraception, pregnancy prevention, and sexually transmitted infections, and are a disservice to our nation's youth" (AAUW, n.d.) and thereby work against the foundations of reproductive rights. Without comprehensive sex education in high school, young women and men enter higher education lacking the most current and accurate information for making decisions about their reproductive health. Inaccurate or missing information is detrimental to the college student experience and hinders students' ability to persist and graduate.

In addition to comprehensive education and information, the 1973 Supreme Court case *Roe v. Wade* legalized elective termination of pregnancy as an option for women. In 1976, Congress passed the Hyde Amendment to prohibit the use of federal funds to pay for elective terminations with the exception of rape or incest and in cases of immediate threat to the woman's life. The Hyde Amendment is not a permanent law and must be reinstated annually (Center for Reproductive Rights, n.d.), but current legislation has made annual reinstatement easier.

Regardless of an individual's personal belief system, through a reproductive rights framework, all women should have comprehensive knowledge and access to all options. Women require regular reproductive health care during their college years (Kaiser Family Foundation, 2010), including access to annual gynecological exams, contraception, sexual health education, emergency contraception, maternity care, treatment for sexually transmitted diseases, and the choice to terminate pregnancy through Mifepristone (RU-486) or in-clinic surgical elective termination. Due to these needs, we discuss the PPACA and issues of access, cost, gender rating, pre-existing conditions, abstinence-only education, and elective termination.

## **The PPACA and College Women's Health Care Discussion**

### **Access to Health Care**

Currently, health insurance coverage for college students varies greatly across the United States. Approximately 80% of higher education students be-

tween the ages of 18 and 23 have some type of health insurance (U.S. Government Accountability Office [GAO], 2008). According to the American College Health Association (ACHA), 57% of colleges and universities offer Student Health Insurance/Benefit Plans (SHIBPs) funded through student fees and available only to students, but 70% of the schools with SHIBPs do not require students to be enrolled in their SHIBP (as cited in Mills, 2007). Most students (67%) ages 18 to 23 obtain health insurance through their parents' employer-sponsored plans (GAO, 2008) and the remaining insured college students rely on individual or group plans (7%), such as SHIBPs or Medicaid (6%) (GAO, 2008). One threat to the continuation of campus health care is the rising costs of comprehensive and preventative care (Grasgreen, 2012; Mole, 2012).

One of the PPACA's greatest positive provisions is the option to remain on parents' insurance plans until the age of 26. The change allows an alternative health care option for nontraditional age students or those in graduate school. Students who do not qualify for coverage through their parents' insurance or whose institution does not offer a SHIBP would, because of unemployment and low incomes, likely receive government subsidies to help pay for individual health insurance, possibly even Medicaid (Kaiser Family Foundation, 2010). One significant population group missing from the age benefit is college students in the United States who are 25 years or older, which is 40% of the enrolled higher education population (Lookout Mountain Group, 2009). Thus, the age provision omits a significant portion of the college population and identifies a reason for higher education leaders to consider its ramifications on college completion.

### Cost of Health Care

The PPACA mandates that all U.S. citizens must obtain health insurance by 2014 unless the cost of the insurance is more than 8% of the individual's income. However, there have been state court cases to challenge this provision. The law expands Medicaid and offers federal premium and cost sharing credits to those whose income is up to 400% of the federal poverty level (Harrington, 2010). Yet, the PPACA creates potential problems for college women who risk losing health care coverage either during or directly after attendance. Many students who rely on their parents' insurance can only do so as dependents. If for any reason a student's status (such as age, marriage, or voluntary independence to increase financial aid opportunity) changes, the student loses coverage (Lookout Mountain Group, 2009). This result could impact persistence across terms.

Part-time students, older students, and low-income students are less likely to be insured (GAO, 2008); and within the broader U.S. population, more women ages 19 to 24 are uninsured (Kaiser Family Foundation, 2009c). Uninsured individuals are less likely to seek medical care (Kaiser Family Foundation, 2009b). Becoming uninsured and not seeking medical care could negatively affect students' academic success and institutions' budgets due to unexpected costs of reactive care rather than preventive care (Blom & Beckley, 2005; Liang, 2010; Wagner, 2006). Additionally, during the first year after graduation nearly one-third of college students become uninsured (Nicholson, Collins, Mahato, Gould, Schoen, & Rustgi, 2009), which will leave them in violation of the mandate, add cost to the Medicaid system, and impact students' loan repayments. Avoidance of health care services can result in hospitalization or long-term care for issues preventable through regular check-ups and preventative care (Kaiser Family Foundation, 2009a).

### **Insurance Companies and Gender Rating**

Currently, insurance companies in most states have the right to limit coverage and control costs based on age, gender, and health status (U.S. Department of Health and Human Services, n.d.). Insurance companies providing individual insurance justify charging women higher premiums for coverage because women necessitate more health care services, which penalizes women for their biological reproductive system. Insurance provided to groups that are likely to have more women (for example, health care providers and child-care workers) often has an increased premium for the entire group (Courtot & Kaye, 2009; National Women's Law Center [NWLC], 2010b). Research does not cite a specific correlation, but sex-based rating practices could increase the premium for students who use SHIBPs because women are 57% of enrollment in higher education institutions (American Council on Education [ACE], 2010; Diprete & Buchmann, 2006). Insurance companies that provide SHIBPs could view the larger number of women participants as a risk and raise the cost to universities, thereby passing costs to students or forcing universities to reduce their health services due to budget constraints.

For individual insurance coverage identical to that of a man (without maternity coverage), insurance companies charge a 25-year-old woman 84% more (Courtot & Kaye, 2009). The PPACA ends gender rating, but only limits gender rating for groups with less than 100 participants. Higher education could see the continuation of women being penalized for their reproductive needs (NWLC, 2010b).

## Pre-existing Conditions

In most states, insurance companies have had the right to charge higher premiums or deny coverage based on pre-existing conditions. Insurance companies were able to consider domestic violence, cesarean section, or pregnancy as pre-existing conditions (Courtot & Kaye, 2009). Based on these conditions, women can end up paying one and a half times more for health insurance than men (U.S. Department of Health and Human Services, n.d.). Starting in 2014, the law prohibits increased premiums or denial of coverage for pre-existing conditions and patients will no longer require referrals for obstetrician and gynecologist care (NWLC, 2010a).

Effective July 2010, the government established a requirement that states must offer insurance coverage to those with pre-existing conditions until 2014 when insurance companies no longer can deny coverage because of an individual's health history. States will either provide this coverage to citizens or opt in to a federal government option. While this provision does offer more affordable health care options for many women, it also denies elective pregnancy termination procedures for enrolled women.

## Abstinence-Only Continuation

Title V, introduced by Congress in 1996, focuses on abstinence-only sexual education and limits information on other types of education that students receive. Sections 2953 and 2954 of the PPACA continue supporting and funding abstinence-only education with the main message that sex should wait until marriage. The abstinence-only message ignores the fact that many teenagers have already engaged in intercourse before the introduction of abstinence-only education (Strong, 2010) and the "waiting for marriage" message ignores nonheterosexual relationships. Additionally, limited education ignores the presence of rape and incest in society (Advocates for Youth, 2007).

Abstinence-only education has not been proven effective (AAUW, n.d.; Douglas, 2007; Strong, 2010), yet will continue to receive \$50 million in grant funding per year (Kennedy, 2010). Abstinence-only education discriminates against gay, lesbian, bisexual, and transgender (GLBT) students as well as other minorities (Gilliam, 2002). The program disregards pertinent information about sex, contraceptives and preventive treatments, such as the human papillomavirus (HPV) vaccine (AAUW, n.d.; Strong, 2010). Sex education should be comprehensive and include information on nonheterosexual sexual health. The lack of a comprehensive curriculum leaves youth searching for alternative

sources or ignorant of their sexual responsibilities. Possible outcomes include placing them at risk for STD/STI transmission, unwanted pregnancies, rape, and other negative experiences. The lack of information at the secondary education level creates a critical burden for higher education wellness and health centers to address with incoming students.

With the health care reform's continued commitment to Title V, students will not receive adequate education about sex. Since many students use their college time to "explore and solidify their sexual values, needs, and attitudes" (Evans, Forney, Guido, Patton, & Renn, 2010, p. 306), higher education will need to implement and offer more programs and services for college students to gain appropriate information. This initiative is essential for college student's sexual development and personal safety. The goal of these educational initiatives would be to decrease college students' potential for sexual diseases, risky sexual practices, and unplanned pregnancies.

Rape and sexual assault are silent epidemics on college campuses and can have a negative impact on enrollment. Campus rapes are underreported, falsely implying that they are not an epidemic (Littleton, Tabernik, Canales, & Backstrom, 2009; Sampson, 2002). Sampson (2002) found that campus police feel pressure from administrators to remain silent about rape incidents because of the reputation of the institution, which leaves students and parents with a false sense of safety. "Women between the ages of 16 and 24, experience rape at rates four times higher than the assault rate of most women" (Sampson, 2002, p. 2). Although both genders report rape, women are raped at much higher rate than men (Eshbaugh & Gute, 2008; Sampson, 2002). For example, "a college with 10,000 women students would experience 350 rapes a year" (Sampson, 2002, p. 3). A culture of abstinence-only education could inhibit rape and sexual assault reporting as well as documenting pregnancy and sexual diseases. Low reporting means victims do not receive assistance and that college administrators are not informed about the issues.

### **Birth Control Funding and Access**

Over 38 million women use some form of birth control or contraception (Planned Parenthood, 2010). In addition to birth control's proven effectiveness against unplanned pregnancies, it can prevent the need for elective termination procedures. When comprehensive birth control is not made affordable or available to women, policymakers impose values on what is "acceptable" birth control (Lerner, 2009). In some cases, physicians and pharmacists deny medications, such as emergency contraception or the abortion



pill, due to conflicting beliefs (National Organization for Women, n.d.). For example, Mississippi law allows pharmacies and pharmacists to deny dispensing contraceptives to individuals based on their religious views (Aaron & Dreier, 2009). Birth control remains a controversial subject for many policymakers and religious leaders, yet the refusal to consider birth control costs impacts women, specifically college-enrolled women, who may not be able to afford it along with the costs of tuition and related expenses (Richards, 2012).

Since we began this policy analysis, birth control availability and affordability continues to be a contested issue. On July 14, 2010, the Obama administration determined that contraception was not a free preventative service. That decision would have placed birth control options out of reach for many low-income women since it is a significant financial burden that primarily women bear. For example, in 2007, birth control that previously cost \$3 to \$10 a month increased to as much as \$30 to \$50 a month (Maloney, 2007) and a woman could pay upwards of \$1,800 to \$3,000 during the average 5-year undergraduate degree experience. About 58% of sexually active college women utilize birth control as an option in their reproductive health (ACHA, 2009b). Fortunately, effective August 1, 2012, all companies must include birth control as a preventative measure except for religious employers. The availability of birth control continues to be contested in courts by private universities (“Contraception and insurance coverage [religious exemption debate],” 2012). As birth control continues to be battled in court, it will be a concern to follow because if reversed it will not only be a financial burden on college women, but could also lead to unplanned pregnancies.

With the PPACA's age limit change, if a young woman is on her parents' health insurance, her parents may gain access to information about her birth control choices. While this may seem to be a parents' right, once a child is over 18, it is her legal right to make these decisions. If a student who is on her parent's health insurance plan gains access to birth control at an on-campus health clinic, institutions may have to concern themselves with Family Educational Rights and Privacy Act (FERPA) regulations as well as Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. While FERPA was designed to protect academic records, this is untested territory especially at institutions where students sign FERPA waivers and permit their parents access. A university could respond by allowing a woman patient to not file on her parents' insurance, but then she would be responsible for the full contraception cost. Students will continue to utilize contraception if it is affordable and available. If not, they may turn to other alternatives, such as

less effective birth control or nothing at all, increasing unwanted pregnancies (Maloney, 2007).

### **Elective Termination Restrictions in Insurance Plans**

The PPACA includes additional language that further codifies the restrictions on elective termination funding in the Hyde Amendment. The law requires that insurance companies that provide elective termination coverage and receive tax credits or subsidies from the federal government separate funds that pay for elective termination coverage. Individuals seeking insurance through an exchange will be required to choose a plan that covers elective termination, if available in that state, and to pay for the elective termination coverage separately, with personal funds (PPACA, 2010). A woman would have to decide when she enrolls with an insurance company whether she intends to acquire elective termination coverage. In most cases, women do not plan or elect to have a termination procedure until faced with extenuating circumstances.

In addition, the law mandates that any plan offered in an exchange covering elective termination must also have an identical plan that does not cover elective termination (PPACA, 2010). The law does not require the opposite to be true, meaning that a plan that does not offer elective termination coverage does not have to have an identical plan that does (PPACA, 2010). In order to gain the number of votes needed for the bill to pass in the House of Representatives, President Barack Obama issued an executive order reiterating that the Hyde Amendment would still stand and that the status quo would be maintained (Ambinder, 2010). This action could have a negative effect on women's reproductive rights and access (NARAL, 2010).

The new legislation could negatively influence individual states', institutions', or SHIBPs' abilities to provide additional Medicaid coverage for elective termination. Guided by the Hyde Amendment, 32 states provide some Medicaid funding for related services in cases of life endangerment, rape, and incest (Guttmacher Institute, 2014). However, only 17 states allow the use of state funds to cover all medically necessary termination costs, with 13 of these requiring a court order to release monies (Guttmacher Institute, 2014). Furthermore, there could be damaging outcomes from forcing insurance companies to carry elective termination coverage separately. The determination of the necessity of a medically indicated elective termination would require individual case-by-case evaluation. The administrative burden and cost of separating elective termination coverage from general health coverage is not economically beneficial for insurance companies, and they may choose not to

offer elective termination coverage at all. Eventually, if this trend spills over into larger group markets, elective termination coverage would become more limited, especially for college women and those in rural locations (Rosenbaum et al., 2009).

### **Elective Termination Restrictions on Women's Reproductive Rights**

Almost one half of pregnancies in the United States are unintended; and by age 45, 30–40% of women will have had an elective termination (Chavkin & Rosenbaum, n.d.; Guttmacher Institute, 2014; Jones & Kavanaugh, 2011). As of 2000, 64% of insurance plans provided elective termination coverage (Brittle & Bird, 2007), but the expectation is that this percentage will decrease with the new bill. Of college women, 62% intend to utilize elective termination services if needed, yet only 10% receive information on emergency contraceptives from their providers (Hickey, 2009). A study found that when a campus health center was not available, women had a harder time knowing where or how to obtain emergency contraception, which can be detrimental given the time-sensitive nature of this medication (Hargittai & Young, 2012).

Wording in the PPACA limits the use of federal funds to provide subsidies for elective termination care (NWLC, 2010a). PPACA language restricts women's access and coverage since the government's temporary high-risk pools do not cover elective termination procedures (Galewitz, 2010). States that currently use local and state funds to supplement elective termination coverage under Medicaid may no longer be able to do so (Rosenbaum et al., 2009). The requirement for women to opt in and pay for elective termination coverage with a separate check creates additional administrative cost for insurance companies and may lead to insurance companies discontinuing elective termination coverage altogether (Rosenbaum et al., 2009). If a young woman is on her parents' insurance due to the expanded age range, then this requires the legal adult student to gain parental approval in order to purchase an abortion rider or to file an elective termination procedure with the insurance company.

While *Roe v. Wade* (1973) determined that elective termination was a woman's legal right (Center for Reproductive Rights, n.d.), the current health care reform does not allow any federal monies to be used for elective termination and would require women to pay for a separate, private rider if the state they live in even allows for that option. The implications of the elective termination language in the Senate Bill reverses previous advances for safe, affordable elective termination coverage to American women. While the Hyde

Amendment restricts only federal funds for women's reproductive rights, states may institute their own laws to limit or prohibit elective termination. According to the Guttmacher Institute (2010), "43 states allow individual health care providers and institutions to deny women of elective termination services" (p. 1). The Center for Disease Control cites "a decline in the availability of abortion providers" and "the adoption of state regulations, including mandatory waiting periods and parental involvement laws" as reasons for the declining number of elective terminations (Pazol, Gamble, Parker, Cook, Zane, & Hamdan, 2009).

Attempts to thwart access to elective termination have been effective as there were 38% fewer abortion providers in 2005 than in 1982, even though the population of women of childbearing age increased. By further limiting insurance companies' ability to provide elective termination coverage with the implementation of PPACA, more clinics are in jeopardy of closure, and fewer women will have access to comprehensive reproductive health care. Further, clinic closure negatively impacts college women at rural institutions since not only would the elective termination be expensive, but the nearest clinic could be hundreds of miles away, especially when combined with mandatory wait times between consultation and procedure. Consequences of the lack of access may include later-term abortions or dangerous illegal abortions.

If a college woman decides to follow through with pregnancy, it may cause a discontinuation of education as single mothers are less likely to persist in higher education due to added financial, child care, and work responsibilities (Adair, 2001; Cook & King, 2004; Fenster, 2004; Goldrick-Rab, 2009). In a University of Illinois study, students with children were three times more likely to drop out of college compared to students who did not have children due to the financial burden and a lack of familial support (Mulroy, 2010).

Unwanted pregnancy is an issue for higher education institutions as well as for students. For example, recent statistics and research report that community college students have higher rates of unintended pregnancies than 4-year university students (Trieu, Shenoy, Bratton, & Marshak, 2011). The National Campaign to Prevent Teen and Unplanned Pregnancy (NCPTUP) has focused on the community college population because 48% of community college students reported getting pregnant or getting someone else pregnant. The NCPTUP's focus is to increase retention rates because 61% of women who have children after enrolling will drop out (2009). The correlation between unintended pregnancy and dropping out affects higher education's retention rates and a loss of tuition revenue. Since "states spend over 7.6 billion dollars on freshman dropouts" (Williams, 2010, p. 1), students who do not enroll or

continue enrollment cost institutions time and money. This issue alone should be a compelling reason to focus on reproductive health and education.

Without arguing a moral or personal belief position on the sensitive issue of elective termination, a feminist analysis argues that it is the government's and public higher education's responsibility to protect women's reproductive rights and freedom to choose. Between 1997 and 2006, 56.8% of elective terminations were performed on women between the ages of 20 and 29 (Pazol et al, 2009). Hence, access to elective termination care is particularly important for college-aged women in terms of reproductive justice and the right to have control over their own futures and bodies.

## Considerations and Recommendations for Higher Education

This article's analysis serves as a discussion with recommendations for higher education institutions to respond proactively to the PPACA. First, we recommend that institutions consider how to develop policies that protect and promote college students' reproductive health. The second recommendation encourages practitioners and researchers to initiate studies that explore the ways the PPACA influences women in the higher education setting. This paper advocates for a focus on the areas of college success, retention, graduation rates, and time to degree.

## Institutional SHIBPs and Health Care Standards

The wide range of insurance types and higher education organizations will make it difficult to enforce a standard policy for college women's health. From a feminist policy perspective, administrators should be knowledgeable of the PPACA's implications for their student populations and women's health issues. Without specific language regarding women's health, institutions can determine individual policies and standards for women's health based on their institutional needs and contexts. However, Section 1560(a) of the PPACA allows for higher education institutions to offer their own student health insurance plans; however, the plans must follow applicable federal, state, and local laws.

The PPACA allows for the continuation of SHIBPs as individual health insurance policies for those ineligible to remain on their parent's insurance plan. The ACHA provides a set of standards for over 900 institutional members to choose insurance providers and maintain health care for students. Beyond stating that SHIBPs must be eligible to all students regardless of gender, these standards do not specifically provide criteria for women's health (ACHA, 2009a, 2009b). It is critical as the specifics are determined by higher educa-

tion practitioners and members of the ACHA to maintain a focus that holds women's health rights at the forefront of the conversation.

Higher education, heavily influenced by government and state funding, needs to have consistency in its policies and procedures. Brian Liang (2010) suggests that the government amend the Higher Education Opportunity Act (HEOA) to address concerns about inconsistency of insurance coverage for college students. Liang's proposed bill mandates that all college students have either institutional or private health insurance coverage with a set minimum of requirements for treatment, aligning with the PPACA. In addition, the proposal requires that on-campus clinics accept and bill private insurance, which is not the case today. Ten percent of all excess funds generated from billing private insurance would go toward subsidies for uninsured students. To keep the cost of campus premiums down, the bill would require that institutions use 75% of all premiums on medical care.

While Liang's (2010) proposal does include mandates that student insurance cover newborn children, well-woman care, and mammograms, it may prove integral to include more provisions for the specific and unique medical needs of college women that we have discussed. The proposal should include the requirements that mandatory health insurance cover the HPV vaccine, treatment of STDs/STIs, maternity care, elective termination of pregnancy, and birth control. Based on the average age of college women, mandatory coverage of all reproductive health care is imperative to retention and graduation.

While developing a standard is the focus of the ACHA, there is not one particular group that works to set standards specifically for college women. As new federal health care laws influence higher education, institutions need to influence policy as a collective group. We recommend that the ACHA focus on the health of college women and work to add standards that address the need for equality in health care coverage.

In addition, we recommend that the ACHA, along with other higher education associations, continue to work with the federal government to ensure that institutions are able to maintain affordable institution-based health care coverage. The wording of the PPACA defines group plans as "employer-based." On the basis of this wording, and the lack of wording clarifying that SHIBPs will remain group-like plans, the possibility is raised that there will be higher premiums for SHIBPs because they will be included in individual market ratings (ACHA, 2010). Clarification of the classification of SHIBPs is imperative to providing affordable health care.

## Recommendations for Higher Education Administrators and Researchers

While the reform presents an opportunity for college health care and medical professionals to create the most beneficial insurance coverage for students, specifically women and their unique health concerns, there is a broader imperative directed at senior administrators who offer vision and budgetary direction to institutions. Without campus-wide attention to college women's health care, women face an inability to afford and access full reproductive health care that could interfere with completing a higher education degree, which would have a ripple effect of limiting economic attainment, educational level, and career opportunities. Also, higher education has experienced increased costs and decreased funding, that impact the resources of campus-based health care centers. Senior administrators' budgetary decisions impact the delivery of comprehensive health care to women students and access to health care centers for all students.

In a time when women are the majority of student enrollment in higher education, feminist policies support reproductive rights and affordable campus-based women's health care. These principles communicate a campus culture of care and create an environment in which women's enrollment and success matters. For administrators and practitioners in higher education who believe in advancing women's collegiate success, there should be an awareness of the consequences for college women beyond campus health care professionals. The first step towards creating college women's equal access is educating administrators, policy makers, and students. Costly or limited reproductive health care can limit a woman's ability to persist in higher education, which is why a full range of reproductive health services should be available without filing an insurance claim or without additional cost passed onto the woman.

Realizing that legislators likely have not considered Liang's proposal of amending the HEOA, institutions can take steps to create policies for the specific health care of college women. Health care professionals and administrators should evaluate and revise current university policies on college student health insurance coverage and services in terms of women's health care, specifically reproductive health. Universities must take an active role in developing specific standards and stances on health education, prevention, and care. Examining current policy and developing new standards can help institutions take a role that is proactive rather than reactive.

The continuation of abstinence-only education requires higher education departments and student affairs practitioners to develop more comprehen-

sive sex education workshops targeted at first-year and transfer students. The NCPTUP (2009) cites that “only two out of ten students at two-year institutions report receiving information from their college on pregnancy prevention, compared to 33% of students at four-year institutions” (p. 2). Health centers partnering with orientation and first-year success courses can develop a comprehensive sex education program to counter abstinence-only programs and to make students aware of services and information that are available to them in a safe environment.

The lack of higher education’s research on this subject allows for multiple opinions and views of insurance coverage. Without proactive discussions, higher education risks delayed policy revisions as the lack of research may cause anxieties in current institutional policies. Reactive policy development and budgetary cuts have potentially negative consequences for limiting comprehensive and affordable education and health care services for women. An absence of proactive planning could lead to mistakes in procedures and administration that could cause detrimental outcomes for institutions as well as FERPA or HIPAA violations. Administrators should develop policies to protect the confidentiality of reproductive services when students choose to remain on their parents’ insurance plans during college. While colleges revisit their current health care policy, students face a dilemma about their coverage and how they will afford health care in the next few years.

## Conclusion

A feminist policy framework highlights that women deserve the right to equal opportunities in higher education, and maintaining the health of college women is one important role that institutions can play in students’ lives. While some provisions in the PPACA are positive, some implications have the potential to be destructive to women’s reproductive rights and access. This article’s discussion and recommendations are only a start to evaluating and addressing a very complex problem for women in higher education.

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