www.mnindependentscholars.org

Minnesota
Independent Scholars
Forum

Practical Thinking

Volume 6 Number 1 September 2010

Table of Contents

Yes, But Is It Health Insurance? *by Lee Wenzel* *p. 1*

ACLU in Minnesota *p. 6*

Forgotten Churches *p. 7*

African-Americans & the CCC *p. 8*

Islam 101 *p. 9*

The Idea of God *p.10*

Radical Christianity *p. 10*

Editor's Note *p. 11*

Upcoming Meetings *p.12*

Practical Thinking is published semi-annually and distributed by mail to members of MISF and to selected institutions. The return address for this publication is PO Box 80235, Lake Street Station, Minneapolis, MN 55408-8235.

Yes, But Is It Health Insurance?

by Lee Wenzel

The problems of access, quality, and cost inherent in the current healthcare delivery system are a direct result of using the insurance framework or paradigm for a set of services that mostly do not conform to being an insurable risk. We blame insurance companies when we should blame insurance itself. There is a strategic misalignment between the inherent nature of the form of finance, that being insurance, and the inherent nature of health and more narrowly, even most medical services. These strategic problems will not be resolved by tactical maneuvers and adaptations. Fortunately, insurance is only one of eight paradigms available in our toolbox for forms of finance governing all financial transactions. The strategic task is to open the toolbox and design a viable way to finance healthcare.

The purpose of this article is to make explicit the implicit abandonment of insurance implied in the recently enacted national healthcare legislation. When everyone can obtain coverage and premiums are not related to risk, that is no longer insurance. To the extent that the concepts of insurance guide implementation, the system might well implode for lack of outcomes and uncontrollable costs. Reform is to move into alternative forms or paradigms.

Clean up our language

We need an accurate use of terms and a solid and logical conceptual base before economic science and business expertise can bring to bear alternatives and data to design and implement a viable system. Health insurance is an oxymoron that desperately needs elucidation if we are to design an adequate system to finance medical and broader healthcare services.

To take the first term, the *health* in health insurance usually refers only and primarily to medical services under the control of physicians. Health clubs obviously provide health services or they wouldn't be called health clubs, but most health club revenue does not come from health insurance. Nursing homes and custodial care provide healthcare services, but have only minimal financing from what we refer to as health insurance. Instead they are mostly financed by procurement (people buying directly), Medicaid (an entitlement, not insurance), Medicare for a short time (also an entitlement and not insurance), and increasingly long-term care insurance.

One would think that health insurance would provide financial compensation for the financial risks attendant to loss of health. In addition to paying for required medical services, this would include inability to work (disability), chronic and long-term nursing and healthcare services, and of course the ultimate loss of health which is death.

An entitlement plan that had financial liability for situations when a cure is not

continued on page 2

available, such as for ALS or Alzheimer's, would provide necessary ongoing care and have financial incentives to invest in critical research. Our insurance system has provider incentives for expensive treatments, if approved by the claims process, but no incentives for medical research.

The nature of insurance makes insurance most appropriate for medical cure in contrast to health care. Health services are broader than medical services. In addition, services oriented to care, rather than cure, generally do not conform to being an insurable risk.

What makes this matter of being an insurable risk so important is that the paradigm rules. Systems built on the principals of insurance tilt towards paying for insurable services and tend to deny or limit uninsurable services. This tilt happens despite the best intentions of providers, consumers, and public policy.

The good news is that most medical insurance plans and companies long ago abandoned medical insurance. They function mostly as third-party administrators (TPAs) and do not underwrite risk. The bad news is that even as we have shifted mostly from insurance to entitlements, we still call it insurance and apply many of the concepts and principles that are ill-suited to financing healthcare services.

An insurable risk

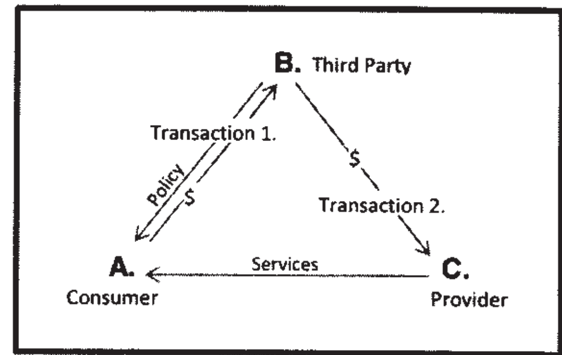
And what is an insurable risk? Think about insurance. Insurance is a way to have the money we need when improbable catastrophes occur. Using the laws of large numbers, a premium is charged when the policy is sold based on the probability of the undesirable event and the amount of money needed should that happen. Insurance is always for undesirable events and to compensate for a loss.

Insurance is always a conditional contract. If this happens, then that is what will be paid or provided. For insurance to work there has to be an objective and legally definable basis for a claim and for the consequent benefits or obligations of the insurance provider.

Third-party transactions

To understand how this works, one must dissect the dynamics of any third-party payment design.

As shown in the accompanying diagram, the first transaction between parties A & B is the purchase of a policy. In exchange for a premium, a contractual guarantee is made to pay for or provide "medically necessary" services that are usually limited by a specified list. As it has evolved, the second transaction is usually between parties B &C. In



order to fulfill its contractual obligations to A, the third party B buys services from C, the provider, which are delivered to A, the consumer. The consumer could submit a claim to B and receive payment which is then sent to C, although that is rarely done in practice as it creates uncertainties for the provider and more bookkeeping and work for the consumer. The provision of services by C for A is not an economic transaction in itself, but a consequence and the completion of the other two transactions.

These two transactions are in very different markets. Transaction One (A to B) is insurance. Transaction Two (B to C) is procurement.

Note that the consumer is not buying healthcare or medical services. The consumer is buying coverage for the possibility of being eligible for services. In practice, the services are purchased by the third party who becomes the provider's customer. The incentives for the consumer are to pay as little for coverage and get as much as possible from the provider or plan. The incentives for the third party are to collect as much in premium as possible and pay out in claims as little as possible. One lucrative way to do this is to make the policy commitments to the consumer as vague or buried as possible, or deny the providers' judgment as to necessity. This is particularly easy to do in areas such as need for psychotherapy. The incentives for party C, the provider, are to provide the maximum volume of services and at the highest price that the third party will tolerate. Of course there are other tactics in how B treats C such as those related to claim denial, difficulties in filing claims, or timeliness of payments.

Note from the diagram that a third party payment preempts a financial transaction between the consumer and the provider. As a consumer I'm left out of weighing cost-to-benefits and excluded from service considerations and decisions based on cost. What about deductions and copayments? Deductions and copayments are not insurance; they are exemptions from insurance. They define risk that is not covered. The result is that the consumer's health and welfare are dependent upon the negotiations between these

two other parties, the third party payer and the provider, each with their own financial incentives.

In this tripartite arrangement, who decides medical necessity and the services I should receive under the terms of the policy? If the services are indeed medically necessary, then I shouldn't be asked about my insurance when I go to the clinic or hospital. By definition, I need necessary services and should get them regardless of who is paying or how much is paid. If the services are contingent upon who is paying and how much, then they are contingent services and not medically necessary services.

The original meaning of a professional service is that because of the nature of the services and the technical knowledge and trustworthiness of the provider, the provider decides what I need and what I will pay. The professional has a fiduciary responsibility for the economic transaction to be in my best interest. Under this meaning of professional, every bankruptcy from medical costs is prima fascia evidence of non-professional conduct.

More about insurable risk

Insurance pushes to take medical providers out of the diagnosis process. The consumer or a technician could feed the objective data into a computer which contains algorithms to determine the diagnosis, the course of treatment, and automatically send prescriptions to the pharmacist. Doctors are only needed for interventions requiring specialized skills, such as surgeons. Insurance doesn't support the importance of personal relationships for most chronic health conditions. The insurance problem with chronic conditions is that they begin so gradually that it is difficult to determine eligibility for a claim. Moreover, they are often not cured.

Some naïve people argue that insurance should cover prevention as a way to avoid costly acute interventions. Such arguments fail to understand the pervasive influence of the financial paradigm, and how prevention is antithetical to insurance. Insurance pays for claims and loss, not prevention. Things that are preventable should be managed and prevented, not insured. Insurance is for events over which we do not have control.

In a similar naïve vein, some argue for outcomes-based medicine. Insurance is based on compliance and is indifferent to outcomes. Ask any life insurance company about the outcomes of the claims they have paid and they would be hard pressed to provide any data beyond the timeliness and accuracy of sending checks.

Professionals are paid independent of outcome. Doctors are paid whether their treatments work or not. Indeed, mortality amongst doctors' patients is one hundred percent, although we still pay in hopes of postponing the event.

Any serious move towards outcomes in healthcare is paddling upstream if insurance is the finance paradigm.

Why insurance?

So why is our society fixated on medical insurance? The most obvious reason is that insurance provides the cash flow when services are needed. However, there are lots of other ways to accomplish the same thing. The function of insurance is for cost not to be an issue should the catastrophe occur. Since insurance is designed precisely to remove the cost issue, why are we surprised when health insurance costs move up without apparent constraint?

Ignorance insurance?

The arbitrariness of using the insurance paradigm to finance medical and health services can be revealed by a hypothetical proposal to use insurance to fund education. We could insure against ignorance, since learning is essential to individual career advancement, and if we don't get rid of ignorance our economy is going down the tubes! The way it would work is that education professionals could do assessments in their private clinics, and then refer to the institutions where they have staffing privileges (schools, as opposed to hospitals). Claims could also be based on standardized tests, such as those done for No Child Left Behind. Claims could then be submitted for each educational intervention, whether it was tutoring, web-based instruction, or classroom instruction. Defining the interventions very specifically and for brief discrete time periods could produce more claims and more income. The insurance could be purchased by individuals, families, corporations, or any other public or private entity. The third party administrators would love all the new business, and a lot more teachers would be making $200,000 a year. A lot of people and organizations would be relieved to have the focus shift away from outcomes and towards instruction delivered. You say it is different from health care? How and why?

Insurance claims, whether for ignorance, illness, or injury, are for what we want to get rid of, not for learning and health which we desire. Insurance implements an avoidant rather than a goal-oriented endeavor. The shift from obsessing about illness, aches, and pains to enjoying positive health practices is a challenge for more than a small minority of hypochondriacs. Insurance puts the providers' and consumers' focus in the wrong direction.

So what are the alternatives to health insurance?

There are eight alternative paradigms that govern

continued on page 4

Health Insurance, continued from page 3

economic transactions. Each has its own language and dynamics and is more or less appropriate for different situations. Economists talk about rational economics as if there is only one rational way to make an economic decision. In reality what is rational is configured and determined by the specific paradigm. I will review possible applications for healthcare financing.

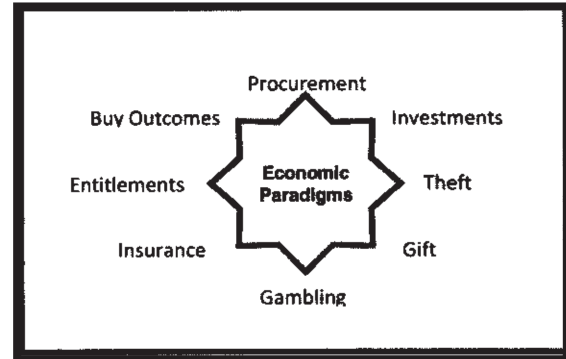
1. Entitlement

The most common alternative to insurance is entitlement. If an employer offers a health plan to its employees, and all employees pay the same fee (technically not a premium), the employees have an entitlement plan and not health insurance. Insurance always has individual underwriting where the premium is adjusted to the statistically calculated risk of benefits or claim payment. The employer may have an insurance plan to cover the cost liabilities attendant to the offered entitlement plan. We then have a significant private or employer form of socialism.

In contrast to insurance, for an entitlement the cost to the specific individual is unrelated to the entitled benefits. Entitlements are often goal- or service-oriented, and may or may not be contingent upon a loss, such as is the function of insurance. So we are entitled to go to the library and drive on most public roads. We buy a membership to a health club, or any other association, and are then entitled to the benefits of that membership. I buy an online subscription and pay the same whether I use the subscription or not. Our earliest and most primal economic experiences are with entitlements, as most of us are born into families where we are provided with food, clothing, housing, and a whole host of entitlements.

There can be limits to entitlements or forms of rationing according to rules, although entitlements work best in situations where there is a natural satiation—such as the public library. To avoid stigma, a third or so of a population must perceive a service or program as something they will or potentially might use. While entitlements provide security, as does insurance, excessive entitlements inhibit the motivation to conserve scarce entitlement resources. Since the demand for medical and health care services is highly elastic, any entitlement system needs some form of rationing just as every family rations who gets what and when. Don't be alarmed. The rationing of scarce resources is a primary function of all economic transactions. It just happens differently under different economic paradigms.

The biggest challenge in designing an entitlement plan is how to balance a rights-based system and leave room for judgment and discretion in determining access and availability of services. This dichotomy between rights and needs is sometimes referred to as the hard versus soft. To illustrate the contrast, retirement benefits under Social Security are a right while social work and children's rights activists argued successfully that caseworkers should provide services and use their discretion in determining eligibility for financial help to needy children and their families. The result some seventy-five years later is that I make a good living and collect Social Security without social stigma, while many poor, hungry children and their parents in our country collect limited benefits accompanied by considerable stigma, or receive no benefits at all.



Any entitlement program based strictly on rules or rights is going to tilt towards acute cure medicine, to the neglect of chronic healthcare where the determination of need requires individual judgment and flexibility.

Isaac Rubinow was the brains behind Social Security, our first significant entitlement program. Rubinow was not only the pioneer in actuary science, but a pioneer in understanding the psychology and sociology of how people and peoples handle and mishandle their needs for economic security. In 1917 he was employed by the American Medical Society, speaking to large groups around the country promoting national health insurance. He wrote in a weekly magazine that we were within six months of making such insurance a reality. Of course health insurance at that time would be more like disability insurance today, and the window of opportunity closed with World War I. Rubinow was writing books in the 1920s about the reasons why people were not financially prepared for disability or old age, and the same remains largely true today. It is interesting that while many bemoan big government and deficits, only a few people advocate dismantling Social Security or refuse on principle to take the checks.

Personally, I see little reason for employers to be involved in medical or health plans apart from workplace safety and health promotion. The annual rotation in and out of plans is particularly destructive of any longer-term investment

in an individual's health. The expenses detract from the employer's world competitiveness, too many people are self-employed or don't have an employer, and few employers have the expertise or motivation to design and implement state-of-the-art health plans.

2. Insurance

A second paradigm, which I would rather see, is large group health plans, perhaps with geographic boundaries like large school districts. The primary alternative to the tensions and dysfunctions of any third party payment system as outlined above is to merge parties B & C and make it an entitlement instead of insurance. This may have been the intent of Health Maintenance Organizations (HMOs), although for the most part they have not escaped the linguistics and baggage of the insurance paradigm. The model holds promise if some of the insurance mentality could be monitored and removed, if incentives could be controlled by controls on things like executive compensation and what happens to profits (or fund balances in the case of nonprofits), if adverse selection and annual membership rotations were limited, and if the boundaries between medical and broader health services could be appropriately managed. One move in that direction might be financial responsibility for total outcomes such as disability, long-term care, and death

3. Procurement

A third paradigm is procurement, the way we go to a store and buy something because we would rather have the object than the money. Veterinary services are mostly purchased by procurement, and it seems to work. Procurement could be supplemented by a large deductible or sliding copayment for catastrophic costs. Leaving off the psychological and political realities, financially it makes sense for anyone with financial means enough to retire or aspire to retire without a pension to buy a $10,000 or $20,000 deductible medical plan and purchase the balance of needed medical services. However, this option makes sense only if there were a fair and open market and providers were prohibited from having under-the-table preferred provider rates.

4. Purchase of outcomes

A fourth paradigm is the purchase of outcomes, rather than the components to accomplish the outcomes as in procurement. I can purchase the outcome of a roofing job for our house, or I can purchase the shingles and labor.

Last summer I went to a pain clinic for a pain in my hamstring that prevented me from running. After an MRI and two epidurals, the pain was still there. When I stopped taking the statin medication, the pain went away. If compensation was based on outcomes, the doctor might have told me to discontinue the statin and I could have saved myself the discomfort—and Medicare—the costs of the MRI and epidurals.

5. Charity

A fifth paradigm is charity. Many of our major medical institutions still carry the legacy names from charities that were part of their founding. Many churches have nurses delivering health services that are largely charitable. Research organizations devoted to specific disorders are often funded as charitable organizations. Whether charity is adequate to provide the continuity and advances in science that we need is perhaps questionable.

6. Theft

The flip side of charity is theft, in that the recipient rather than the giver is the primary decision maker for the transaction. Medical services are frequently funded by unpaid bills, a form of theft.

7. Gambling

A large proportion of health and even medical interventions are done without a solid probability that they will be efficacious. Even where we do have the benefits of good research, many interventions are a gamble. The odds might be seventy percent that it will work, or even ten percent, but given the alternatives, we take the gamble. Insurance systems pay or provide what is specified in the policy. An entitlement program might provide services based on a ratio of probabilities to cost. For example, should a procedure costing $500,000 be supplied when the probabilities of extending life up to six months are ten percent? Or are those resources better deployed in a children's health program that improves health status by ten percent for a thousand children? These are gambling decisions in that they are not just about compensating for loss, but about odds to achieve goals. Honeywell pioneered an employee organ transplant benefit that selected providers on a national level for each organ transplant and then only paid based on patient survival. The provider then had to set rates based on probabilities and take the gamble.

8. Investments

The final paradigm, investments, is when we buy something not to use it or benefit directly, but to have it produce income or increase in value for a consequent sale. We often refer to health promotion as an investment in our health. Endowments and foundations can produce a significant source of revenue for healthcare services.

What's wrong with calling it health insurance?

Calling it insurance perpetrates the illusion that my health is beyond my control. I'm passive and need to be (a) patient. My health is determined by the doctor who

concluded on page 6

Health Insurance, continued from page 5

"treats" me. My health must be a matter of fate, since the purpose of insurance is to provide financial protection for improbable and uncontrollable events. Health promotion programs are undermined by the implicit premises of the insurance paradigm.

Insurance pays what is required by contract and is not responsible for achieving specific outcomes. Outcomes are discredited. Outcomes-based medicine is contrary to the financial incentives and framework of the primary funding mechanism.

Conclusion

In summary, we need more strategic thinking to lay a solid foundation for how medical and health services should be financed. Instead of blaming insurance companies for adhering to the principles of insurance, we need to examine the applicability of insurance. The paradigm of insurance has significant negative implications for providers, consumer, and payers. Yet, it is the paradigm which then frames all the other choices. We need to think creatively about how to frame a system based primarily on entitlements and procurement.

While a relatively small number of individual medical insurance policies exist in the United States, most of what passes for health insurance is in reality a medical entitlement plan. An important step towards creating a workable delivery system is to not call insurance that which isn't insurance. This means precision in not using many insurance-related words and concepts, such as premiums, risk, claims, and underwriting. Journalists, politicians, and legislative authors need to be more precise in their use of language. When I check in at a clinic, they might ask about my medical plan and not mention the word *insurance*. The term *insurance* should not be used for what is not insurance. The term *health* should not be used to refer only to medical services. The use of language defines the discourse and the framework for how people think, what they expect, and how they decide.

The people designing administrative rules and mechanisms to implement healthcare reform need to be clear as to the paradigms being deployed. If it is entitlement rather than insurance, then abandon the insurance language and principles. The effectiveness of programs, to say nothing of their efficiencies, is going to be dependent upon a level of implementation below the radar of political euphemisms.

Remember, the paradigm rules.

In the 1980s, Lee Wenzel, then working for Toro, designed alernatives to medical coverage. He is now all-but-dissertation for a PH.D.in the area of alternatives to medical coverage. He is also a registered investment advisor with his own company, Wenzel Analytics.