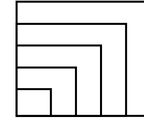

Chronic Healthcare is not an Insurable Risk

Introduction

The goal of what is written here, and of my services, is to assist in strategically designing efficient and effective systems for financing healthcare services. We will review where and why insurance fits and doesn't fit in medical and healthcare followed by an elaboration of alternatives.

Healthcare is suffering from misaligned strategy in how financing is packaged and structured. The insurance framework works fairly well for insurable risks of acute medical services even if the detailed retrospective payments, whether single payer or multiple payers, are inefficient compared to prospective payment. Insurance fails miserably for chronic healthcare which doesn't conform to an insurable risk. As you may recall from Insurance 101 an insurable risk is a loss beyond one's control having a financial component that occurs at a definable point in time and is subject to objective measurements yielding a definable claim that satisfies the insurance policy or contract. In contrast chronic healthcare conditions have a gradual onset often with significant moral hazard or personal involvement in precipitating the condition and are subjective enough as to what is sufficient to satisfy the claim that different adjudicators have low interrater reliability.

Insurance is

Insurance is for conditions over which we lack control and which are predictable by an underwriter using the laws of large numbers to cover the risk. When I walk into my clinic and am asked for my insurance card, the metacommunication is that I have no control over my health. That is mostly true if I'm coming in with an injury. However most of the factors affecting my health are influenced by what I eat and drink, how I exercise and how I manage stress and relationships, especially over time. The insurance framework gives a message contrary to overt messages about taking responsibility for our individual health.

According to my insurance professor, insurance is always for a loss and never to achieve a gain. Using the laws of large numbers to achieve a gain is called gambling. Gambling comes to play when we are balancing the downsides of various procedures against the probabilities of health or prolonging life. As much as the incentives accompanying the money itself, the framework for the payment system shapes the logic and perceptual context of decision-making. Health is a positive state of well-being and is a goal. Insurance keeps the orientation on the injury or illness rather than on health. Because of the inherent incentives physicians do well at applying guidelines and practicing medicine but fail miserably when it comes to health. Witness the diabetes epidemic and related obesity as one example. Healthcare is itself a euphemism. A parallel in education would be if we insured against ignorance and then paid teachers to eliminate ignorance. The focus on illness and injury is like driving through the rearview mirror. Prevention is still the insurance framework and very different than health promotion.

Insurance functions on objective criteria for underwriting risk and paying claims. Insurance lends itself to algorithms that produce the decisions. The roles of physicians and other medical staff are to implement the algorithms. Judgments by medical professionals may be approved or denied by the insurance adjudicator. The relationship between scientifically tested algorithms and professional judgment which should take place within the professionals' practice in conjunction with a team and organization of experts becomes conflicted between the provider and payer in a relationship with opposing financial incentives. The insurance company or third party becomes the actual customer buying services rather than the person receiving services. The medical professional has a fiduciary duty to the patient or consumer while the third-party controls who gets paid, for what and how much. Just thinking about the implicit incentives is enough to predict conflict and dysfunction.

Lee Wenzel
(952) 944-2699
Lee@WenzelAnalytics.com
www.WenzelAnalytics.com

Wenzel Analytics, Inc.
Registered Investment Advisor
8666 Westwind Circle
Eden Prairie, MN 55344

Insurance is inefficient because of the administrative complexity. The payer's revenue and profits are only part of the costs. The time and work of consumers and providers is enormous. Why is it we assume retrospective (after the fact) payments for medical services while we assume prospective (in advance) payments for both K-12 and university education? Instead of joining a plan for third-party payment, why can't I join a health and medical services system and skip the thirty percent or more we pay for the claims process?

Insurance or Entitlement?

Ironically, medical insurance works so poorly that there is very little of it around. We only call it insurance and think of it as insurance. The primary difference between insurance and an entitlement is that insurance has premiums based on risk while an entitlement has premiums, taxes or fees independent of the insured's risk. If all employees at a company have the same deduction for medical benefits, the employees have an entitlement while the employer may have insurance for all or some of the potential obligations. Most of what we euphemistically call health insurance (an oxymoron) are entitlement plans. While insurance is always for a loss, entitlements can be to cover a loss but also for goals or gains. Think about subscriptions, education or recreational facilities. Entitlements are familiar to all of us because we grow up with entitlements within the family.

The beginning step in risk management is to determine what risks or potential financial liabilities are manageable and then manage them, what risks are unmanageable but sustainable because of adequate financial resources, and what risks need to be insured. Almost by definition, most chronic healthcare conditions are amenable to being managed and are more appropriate for an entitlement program or procurement. It is difficult for an insurance underwriter to objectively project costs when the costs are determined not by arbitrary loss but by varying proactive management actions and decisions relative to ongoing coping or resolving of a health condition.

Underwriting is an essential component of insurance. Without underwriting to specific risk it is not insurance. Adverse selection is a problem unique to administering entitlements as if the entitlements were insurance but without the necessary individual underwriting. The goal of insurance is to maximize profits by setting aggregate premiums in excess of claims. An insurance company does not go looking for claims in order to lower profits. A third-party administrator, paid on a percentage of payments but not at risk, may endeavor to maximize claims in order to maximize profits. Effective insurance underwriting assumes that claims approximate incidence. Several chronic health conditions are characterized by denial with the consequence being that only a small fraction of incidents result in claims. For example, claims for chemical dependency treatment are generally less than ten percent of incidence. If the insurance premium is based on incidence it will be too high to be competitive. If the insurance premium is based on claims history, it could be far too low if claims began to match incidence due to an effective health promotion program such as education or case management interventions. The financial risk is not in the incidence but in the relation of claims to incidence. Insurance companies can produce high profits insuring chronic health conditions by the discrepancy between liberal benefits or coverage and absent or denied claims. Classic insurance may require risk minimization actions as a prerequisite to coverage, but the risk minimization or prevention is not itself a legitimate loss or claim.

Appropriate design requires being very clear about whether the program is insurance or an entitlement. Too often a review of the language, incentives and dynamics reveals an untenable convolution of insurance and entitlement.

By this point you may be thinking that I'm too rigid in my definition of insurance and that there is no harm in calling it insurance even as we adapt. To do so is to deceive ourselves. Philosophically, insurance has essence but not existence, just like the number three has essence but not existence. One can't pinpoint in time and place where three exists, or where insurance exists. While abstractions, they are real and cannot be whimsically altered. Things with existence change while things with only essence, such as insurance and the number three, cannot be changed. They have inherent immutable qualities.

Alternatives to insurance

In thinking about alternatives to insurance it is useful to think about all the possible frameworks or paradigms for economic transactions. There are only eight that I can think of. The economic transaction or exchange is the fundamental building block of economics, just as the atom is the fundamental component of chemistry and the periodic table. While both the transaction and the atom have components that can be analyzed in greater detail, they comprise a

fundamental component, each with unique characteristics.

We have already reviewed insurance, entitlements and gambling. Procurement is our most familiar transaction. We buy something or some service and hope it serves our needs. Personally, I use my health plan for acute care medical needs and procure or use cash to buy health services such as for a nutritionist, a functional medicine doctor, chiropractors, health clubs, supplements, groceries and recreation. The costs are not catastrophic, which given administrative costs is a primary purpose of insurance.

Similar to procurement is the purchase of outcomes. Instead of hiring a contractor and buying shingles, I contract for an outcome. Instead of buying groceries I buy a meal at a restaurant. Any purchase of a result rather than buying the components to produce that result is a different kind of transaction with different responsibilities and liabilities. Outcomes based medicine is paddling upstream if the payment system is insurance. Outcomes based medicine never gets very far because it is in opposition to the underlying financial paradigm focused on compliance rather than goals or outcomes.

Historically charity was the prevalent financial paradigm for hospitals and is still prevalent in financing a significant portion of medical research. Insurance has few incentives to adequately fund medical research since the premise is to insure uncontrollable events. Insurance thinks compliance, rarely cost-benefit. Try persuading an insurance company to fund something as a way to offset costs, and the proposal goes nowhere. It doesn't compute to the insurance mind.

Similar to charity is theft in that both are exchanges of something tangible for an intangible. The difference is in who has control of the transaction. A lot of invoices for medical services go unpaid, which means theft is a major way we finance healthcare.

Investments are a final mode of economic transactions. In investments we buy something such as property, stock or bond not for its immediate utility to us, but for the income or resale at a later point in time. We think of investing in our health for the long-term, or investing in public health.

Ideas for alternative designs

Each of these frameworks might have a place in designing appropriate financial systems for the delivery of medical and health services. As for some preliminary recommendations coming out of this analysis:

1. We should eliminate the term "health insurance". It is not accurate and implies that somehow I have paid for the services I receive when in fact I may have paid much more or much less than the cost of services or my risk of needing services. Why can't the term be universally replaced with "health plan"?
2. We should move toward prospective payment such as the group health plans of forty years ago rather than the retrospective payment plans. There are many arguments pro and con for such a system. A principal objection is that by choosing a provider system one is limiting the options for choosing individual providers. The consolidation of delivery systems has changed the environment. With the current scope of large delivery systems, and the expertise and team work required to deliver quality care, one rarely achieves superior services by having a half-dozen providers each providing uncoordinated care and medications.
3. We should retrieve the concept of individual risk underwriting and responsibility for one's health. For anyone who carries a smartphone, the large tech companies know our continual whereabouts and presumably where we eat, probably what we eat, and where we exercise. An independent company such as United Health Care should determine an actuarial prospective individual annual cost based on a health risk appraisal and historical medical services. A moral hazard adjustment should be made based on the degree each person takes responsibility for their health. Public policy should direct how this cost figure might be subsidized based on income and assets. Healthcare systems could then compete on offering superior services and costs at a given percentage for all enrollees of the independently determined annual cost. Such a plan would need considerable refinement but could send us thinking down a fruitful path which is strategically sound rather than continuing to adapt systems built on dysfunctional premises.
4. There is nothing wrong with promoting a procurement model where people pay cash for services and have competitive choices. Case management services, even with a budget to procure services, can be very productive in

ensuring individuals find their way through complex systems and an array of alternatives. This is particularly true for chronic health care needs such as in behavioral health where medical and social components combine. Ancillary professions and fields such as social work, psychology, nutrition, chiropractic and home health care need to develop their own systems for financing their services, independent of the strict medical systems, to preserve their professional conceptualizations and autonomy.

5. We shouldn't expect government to resolve the healthcare crises of cost, quality and access. Politicians of necessity are salespeople. We shouldn't expect them to be engineers and designers. Staff and bureaucrats are rarely engineers, innovators and designers. Creative strategy and innovation needs to come from the private sector. It shouldn't be hard, alone or in collaboration, to initiate viable solutions to compete with current inefficiencies built on insurance principles when chronic healthcare is an uninsurable risk.

Experience

I spent fifteen years setting up a managed rather than insured program for behavioral health at the Toro Company, then at Honeywell Corporate, and then consulting, speaking at conferences, writing both articles and software and implementing the thrust of this paper as applied to behavioral health. Clearly the implications extend to all chronic healthcare. With different individuals and audiences, I have found huge variations in the ability to shift paradigms. Lectures or didactic writing such as this paper are much less effective than Socratic questions and discussion. CEO's familiar with strategic thinking often get the concepts immediately and can think through implications. People working in operations typically have difficulty comprehending what this is all about and are resistive, as indeed the implications are disruptive. At the end of a three-hour seminar they might ask "So who carries the risk?" not realizing that risk is part of their glasses or perceptual apparatus. Risk from the insurance perspective becomes market from the procurement perspective or need from the charity perspective. While a lawyer's expertise is expected to be accurate and precise in the use of language, legal documents for medical disclaimers and waivers continue to make inaccurate use of the term insurance. Even the Director of Medicare and Medicaid Services referred to Medicare as an insurance program, although when brought to her attention by email acknowledged the error within an hour and corrected future publications. The debate and contrast between rights-based and needs-based programs was part of Social Security origins and is elaborated by feminist philosophers.

I would welcome the opportunity to think and work with you.