

Professional Caregiver

Insurance Risk: A Brief Primer for Nurse Executives and Decision-Makers

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Health care providers, administrators, and patients and their families have expressed concern and frustration with managed care and various aspects of current health care financing and insurance schemes. As it turns out, prospective payment plans and insurance are areas I know a little bit about. In addition to my bachelor's, master's, and doctorate degrees in nursing, I also earned a bachelor of arts degree in pure mathematics and a master of science degree in applied mathematics and statistics. My master's degree in social work plays a role as well. In addition to my nursing activities, I have also worked in a variety of actuarial settings for a number of years, and I am a chartered property casualty underwriter, an insurance designation certifying my knowledge of insurance principles and policies and insurance company operations.



PROFESSIONAL CAREGIVER INSURANCE RISK AND AVERAGE COST-BASED REIMBURSEMENT PLANS

Over the past few years, I have been refining my analysis and descriptions of what I term *professional caregiver insurance risk* (PCIR) and *average cost-based reimbursement plans* (ACBRPs). These are aspects of the insurance risk transfers to health care professionals and providers made under the premise that prospective payment plans are purchases of well-defined future services rather than risk portfolio transfers or insurance risk transfers. I have suggested at many conferences that the differential in size between insurers or the government (Medicare and Medicaid) and risk-assuming health care providers means that the law of large numbers and the central limit theorem work in reverse of traditional insurance transfers and statistical sampling.

ELEMENTARY PROBABILITY AND STATISTICAL THEORY

Statistical sampling is based on two fairly simple propositions from probability theory and statistics that most nurse executives and leaders have encountered in school or on the job. The central limit theorem and the law of large numbers imply that as the number of items or people in a random sample increases, the accuracy of the estimate of the average value of a parameter (such as age, batting average, birth weight of full-term babies, or the costs associated with health insurance claims) increases.

So if we want to know whether consumers will use planned alternative health programs, we can mail questionnaires to a small fraction of the residents in our catchment area and ask them if they will use such services. Based on their responses, we can make fairly accurate predictions of future utilization. If we reduce the

size of our sample, our estimates get more and more inaccurate. We may overestimate or underestimate utilization rates far more than the larger sample size estimates would, but we will not know which until we actually open the doors and start serving patients.

Using this same insight, it is possible to understand why managed care, capitation contracts, Diagnosis Related Groups (DRGs), and other prospective payment schemes have had such a dangerous—even deadly—effect on health care providers and consumers. In simple terms, the smaller the cohort of patients in a portfolio (a collection of patients' health care costs during a specified period transferred from a quasi-insurer to a health care provider), the greater the variability in costs for providers compared with that of insurers or government programs that avoid these risks. The quasi-insurers and the government (including managed care organizations, Medicaid and Medicare, and other prospective payment systems) avoid these underlying financial risks by "selling" them to providers at discounted rates—the prospective payment or, for short, the "premium."

GAMBLER'S RUIN

This greater variability in costs increases providers' vulnerability to *gambler's ruin*, a statistical term that refers to the likelihood that a gambler with finite resources will lose all his money by repeatedly making identical bets. Health care providers who may have very little liquid operating capital are far more likely to lose money on contracts than insurers who benefit from large aggregates of risk portfolios that make it possible to predict their costs very accurately. While the insurer will face many very costly claims, they will also have many very low-cost claims or even policyholders who make no demands at all that will balance out. Providers, because of their smaller numbers of insureds, do not benefit as much from risk aggregation because of the reverse effect of the central limit and large numbers propositions.

One aspect that has led to a great deal of confusion about prospective payment plans is that although some providers will suffer extremely high costs, others will have better luck and will make a profit on lower than expected utilization costs. Because some providers profit, the dangers and obvious flaws of ACBRPs and PCIR have been kept from intense public scrutiny.

Of course, ethically challenged health care providers can profit simply by delaying or denying services to their patients, just as unethical insurers can profit when they deny legitimate claims of their policyholders, a serious problem for people with homes destroyed by Hurricane Katrina's high winds, hours before the storm surge, being cited to support denying legitimate wind damage claims. Such behavior, although rare, puts the overwhelming majority of ethical health care providers at greater financial risk.

Patients who were receiving care from unethical providers will turn elsewhere when their condition becomes more severe and they realize that their needs have not been met.

FAIR MARKETS AND COST COMPARISONS OF QUASI-INSURERS AND REAL INSURERS

As a long-term strategy, the mechanism of delay or denial of services is flawed. Competitive pressures in the insurance marketplace, assuming an efficient market exists, would drive the price quasi-insurers could charge for their services to the price that real, risk-aggregating and retaining insurers ask for equivalent benefits. A quasi-insurer looks just like an insurer except that it has no intention of retaining insurance risks. Quasi-insurers write policies just as insurers do, but they avoid the financial risks in those policies by transferring them to providers through capitation contracts, DRG schedules, and managed care contracts. Quasi-insurers may also limit their exposure to risk by buying health care providing organizations or by hiring health care providers who will arbitrarily limit access to care according to the quasi-insurer's policies and procedures.

But the simple truth is quite clear. When quasi-insurers offer the same benefits as real insurers, they cannot fairly compensate the providers and organizations to which they transfer their insurance risks and remain competitive and solvent themselves. Why? Because insurers should actually pay each provider the expected amount of the benefits and expenses, plus a risk premium adequate to compensate providers for the insurance risks they are assuming. Since no provider knows in advance whether it will be lucky or unlucky, it ought to be given an incentive for assuming the uncertain outcome. This is standard, everyday Insurance 101 course content. Insurers make money by being paid for the service they provide—period!

When insurers assume risks, they ask for and receive an amount that is adequate to cover their losses, expenses, reasonable profits, and a risk premium. That is how insurers manage their affairs and stay in business, and it makes all the sense in the world. Any insurer that sells its insurance products without getting all the pieces of a legitimate and fair premium will eventually go bankrupt. However, this means that quasi-insurers would need to charge more for the same benefits offered by a real insurer because the real insurer benefits from risk aggregation and does not transfer its risks to third parties. By retaining risks, the real insurer does not need to pay health care providers a risk premium above and beyond the cost of the benefits to be provided and the expenses to manage those benefits.

Hence, in an efficient insurance marketplace and as efficient enterprises, quasi-insurers would not be able to pay an amount higher than the pure premium or pure loss component of their risk-aggregating competitors' premiums to the health care providers and organi-

zations assuming their insurance risks. Simply put, for the same benefit costs to policyholders, quasi-insurers have to charge their policyholders more or deliver lower benefits. This makes them unable to compete in a market in which everyone knows the true value of what they are selling.

INSURER COSTS, EXPENSES, PROFITS, AND RISK ASSUMPTION INCENTIVES

So, for the same premium income from policyholders, the quasi-insurer furnishes lower benefits to patients. This assessment does not represent my political or social bias; it is a simple consequence of economic and statistical principles regarding market behavior, finance, and insurance. In the final analysis, there is a disparity between the true pure premium plus risk premium plus expenses plus profits that providers should receive for the small portfolios they accept and the amount that quasi-insurers can actually provide and remain price competitive with real insurers. This difference is seen in reduced service provision levels at bedside, by home health, health suppliers, and in health care providers' offices for you, me, our families, friends, and colleagues.

If health care providers do not reduce the level of services they deliver in line with the actual amounts they are being paid by quasi-insurers, they increase their probability of financial loss under risk transfers such as DRGs, capitation contracts, managed care agreements, and prospective payment plans. This simply must happen because providers are not being paid enough to cover the benefits available through risk-retaining insurers. In short, PCIR is the answer to why so many nurses and other health care professionals feel so squeezed at bedside, why hospitals have had to close their doors, and why hallways are being used to seat emergency room patients waiting for services. Alternatively, it is the up-river answer to the question from Weinberg's book, *Code Green Money-Driven Hospitals and the Dismantling of Nursing*:¹ "Why are the nurses crying?"

INEFFICIENCIES AND PROFESSIONAL CAREGIVER INSURANCE RISK

Inefficiencies abound in health care settings that have allowed these plans to remain in place for decades, while in an efficient market they would have failed almost immediately. However, most nurse executives and leaders are familiar with inefficiencies such as time value of money considerations that further exacerbate the potential harms of such plans. Monumental inefficiencies as a result of different benefit provisions among very different insurers and quasi-insurers also hamper efficiency in providers' offices, home health settings, equipment providers, and health care organizations.

The unfair competitive advantage that quasi-insurers obtain over real insurers by selling something they have no intention of providing has all but destroyed the legitimate health insurance market.

PCIR is a fundamental breakthrough in understanding what has gone wrong in the past couple of decades. During this period, health maintenance organizations, unethical managed care plans, and unintentional although no less harmful policies and practices of otherwise ethical insuring entities have consistently shifted the management of health insurance financial risks to health care providers and organizations. When health

care providers find themselves managing insurance risks, they have no alternative but to act the same way insurers do—trying to limit their costs, denying questionable claims, and refusing to provide services they believe they are not required to provide under their extant contracts. However, this pattern of behavior violates the most sacred principles and duties of health care providers and limits the trust patients need to have in their diagnosticians and caregivers.

The problems that have resulted from this chaos-inducing system of transferring uncompensated and impossible to compensate insurance risks below the costs of managing those risks have caused endless problems for patients, families, and ethical health care providers. The unfair competitive advantage that quasi-insurers obtain over real insurers by selling what they have no intention of providing has all but destroyed the legitimate health insurance market.

CAN REINSURANCE FOR HIGH CLAIMS HELP HEALTH CARE PROVIDERS?

One way of managing the insurance risks of ACBRPs that has been promoted is reinsurance contracts, which are really just a bad joke. This is how they work: Quasi-insurer A transfers the risks presented by 5,000 policyholders to Health Care Provider X. In the process, Quasi-insurer A pays Provider X less than the policyholders ought to receive in health care services. Provider X, recognizing almost immediately that it may be liable for some very high patient care costs, asks Insurer B, a reinsurer, to write a policy to cover high-cost policyholders' needs. Insurer B agrees to do this for a small premium adequate to cover its expected costs, expenses, profits, and a risk premium for the risk it is assuming. Oops! Insurer B is going to assume responsibility for the risks that Quasi-insurer A did not want? What is wrong with this picture? The money that the health care provider has, after paying the reinsurer, is even less adequate than it was before it bought reinsurance. Quasi-insurer A makes money because it has little or no risk and accurately predicted the costs of doing business. Insurer B makes money because it wrote a lot of expected costs plus expenses plus profits plus risk premium reinsurance policies for health care providers. Who loses? Health care providers that get less money than required to provide services to their patients and health care con-

sumers who get fewer services than they need and have paid the quasi-insurer to provide.

IMPLICATIONS FOR NURSE EXECUTIVES AND LEADERS

Nurse executives and nurses in caregiving or policy-making roles in business and government organizations need to understand how these unethical and irresponsible insurance risk transfers arise, and they must lead their organizations away from such policies and practices. While managed care is on its last legs, nurse executives and leaders can be sure that the same problem will reappear under the guise of new provider compensation plans, provider incentive plans, and service performance enhancement programs. But it will be the same wolf in sheep's clothing, because quasi-insurers are not yet satisfied that they have squeezed every drop of profit they can out of this game. Nurse executives and leaders must remain ever vigilant for risk transfers in seemingly common settings or they and their organizations may suffer harm, and their patients may be harmed as well.

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