

SIXTH EDITION

ESSENTIALS OF MANAGED HEALTH CARE

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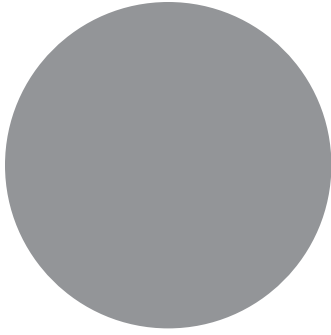
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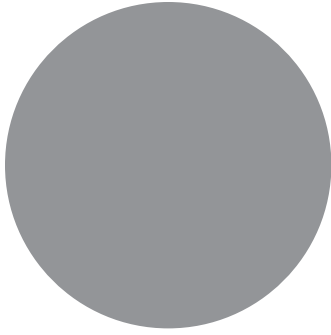
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Introduction

The sixth edition of *Essentials of Managed Health Care* is the most significant structural overhaul since the second edition morphed into the third back in 1996. And while it is a hefty volume at just under a half a million words, it remains svelte in comparison to the fourth and, as of 2001 the last edition of its antecedent, *The Managed Health Care Handbook*, which was three times the size. This does not reflect a shrinking healthcare sector nor a movement from complexity to simplicity, since neither is the case. It does reflect the commitment of the book's contributors to providing a broad and sufficiently detailed overview of the key elements of health insurance and managed health care to meet the needs of one or more of its types of readers. At the same time, it means that some things are left out. As the editor, I bear full responsibility for any decisions about what to include and what to exclude, as well as any errors that may be contained in this text.

■ WHO BENEFITS FROM THIS BOOK

This book is much like the original Swiss Army Knife® designed by Karl Elsener in 1891, which had a cutting blade, a screwdriver, a can opener, and a reamer (or awl).¹ That tool served four different purposes depending on the needs of the user, and this book also serves four different purposes, depending on the needs of the reader. Unlike the knife, however, there is considerable overlap in how those purposes are served. The four primary users of this book also overlap in many ways, and are loosely categorized next.

Teaching and Academics

This represents the largest number of users, but there are differences in how it might be used in a graduate program. Some topics will be of considerable use for classroom teaching, such as the chapters on history, the types of payers and integrated health systems, network structure, payment, care management, and so forth. But even the operational chapters can be useful since even now it is easier to think we know how these things are done and why, when in fact what we “know” are assumptions, not reality.

Day-to-Day Payer Operations and Administration

Those who work in the payer industry or in other industries that provide services to payers benefit the most from those chapters that focus on operations. As becomes quickly apparent, all operations are interconnected and what affects one part of a payer organization often ripples out to exert an effect on other parts. For example, errors in eligibility affect claims payment, provider services, consumer services, and financial management. Beyond the “tab A goes into slot B” descriptions of operational business processes, knowing as well the background about why operations are carried out as they are will go a long way in understanding the business as a whole. This is especially the case for those in management, where understanding the whole is a requirement for assuming greater responsibilities.

Health Policy

Certain sections of the book are right in the middle of the world of health policy, and overlap with those most useful in academics and teaching. But the book provides something else, something often missing in health policy resources, and that's a picture of what this sector actually looks like *as a whole*. Policy and theory are valuable and critical for our future, but policy that ignores the incredibly messy and complex reality of the sector, or that is built upon assumptions that are “widely understood” but are in fact thoroughly misunderstood, will produce elegant but ultimately useless results—much like a hand-carved, solid walnut SCUBA tank. The systems and operational processes we have today were not found under a loose board; they all came about in direct or indirect response to policy decisions, including policy omissions, whether intended or not.

Health Administration

Those who are preparing to enter the world of health administration or are already working in it, regardless of type of provider, public health or private, and whose organization in any meaningful way interacts with commercial payers will benefit from knowing how payers actually operate, why they do what they do, and under what circumstances. Just as there

is great heterogeneity in types of providers and provider organizations, even when they fall under the same descriptive type, there is equal heterogeneity not only between payers but between the different business units within any payer organization. By understanding the payer environment better, and knowing at least the basics of certain operations, legal requirements, and constraints, the business-to-business relationship has a better chance of working at least a little better.

There is another reason for those in health administration to know more about the payer sector, and that is the continually evolving sector itself. At the height of the managed healthcare boom in the late 1980s through the late 1990s, providers sought to take on more risk, and even to “cut out the middle man.” Many did not survive that decision, although some did quite well. Those times are not likely to be repeated, but recently we’ve seen a stronger push to make providers more accountable for costs, and costs are related to risk.

Health systems, especially those with regional market strength and those that now employ a large number of physicians, have been able to negotiate higher prices and not worry much about cost control. That is ultimately an unsustainable model, though, and with Medicare leading the charge, the flow of money will over time be affected more and more by overall performance (which is not the same as pay for performance, discussed in Chapter 5). And it is managed healthcare methodologies that will be used to do it, even if they are referred to under a kinder and gentler name.

Others Who May Benefit

The book has been useful beyond the four primary constituencies noted previously. The legal profession has often turned to it to be better informed both in matters involving litigation or arbitration, and in constructing legal agreements that encompass specific operational aspects between a payer and other parties. Regulators have also used the book, particularly when looking at regulations with a potential impact beyond the intended target. Journalists and nonacademic writers may turn to it to gain a better understanding of some aspect of the industry that is the subject of an article or story. It is fair to say that the book has been used by individuals in all parts of the health sector, not just those noted here. It has also been used in a number of other nations around the globe as they look to addressing issues similar to our own, even if their overall system differs.

■ HOW THIS BOOK IS STRUCTURED

The book has 30 chapters, divided into six parts.

Part I: Introduction to Health Insurance and Managed Health Care

The three chapters that open the book provide a broad overview of the historical roots of health insurance and managed health care in the United States; the different types

of insurers, managed care organizations, and integrated delivery systems; and their basic governance and management structure. They are all updates of prior versions, but the updates found in the first two of these are considerable.

Part II: Network Contracting and Provider Payment

Part II underwent a major structural overhaul for this edition, and is composed of three long chapters that describe in some detail how payer networks are structured; the astonishing array of provider payment methodologies and payment modifiers, and how different providers respond to them; and the core structural elements of a contract between a payer and a provider that support all of those elements. These topics no longer completely separate facilities, professionals, and ancillary services, but look at common elements first, and those specific to type of provider second. It also separates payment from all the other aspects of network development, structure, and management in order to keep the focus on each. The content within each chapter has been updated as appropriate, and expanded considerably to address new elements and new dynamics because when it comes to payment, we are all endlessly inventive. Finally, the chapters may address these topics from a payer point of view, but in our currently evolving system, much of what they cover may migrate to new types of organizations, including provider organizations.

Part III: Management of Utilization and Quality

Along with Part II, Part III makes up what is generally considered to be managed health care. It addresses basic utilization management (UM), a topic that has been significantly restructured and expanded in order to illuminate the varied elements of UM that are interconnected, but often treated as though they are not. Part III also addresses the more advanced and specialized forms of UM, including those focused on specific types of utilization such as behavioral health and the prescription drug benefit.

Part III also sees a new contributor addressing a topic that last appeared in the fourth edition, which is changing physician behavior, something that has taken on renewed relevance as physicians are employed increasingly by health systems and payers. It concludes with a chapter focusing on quality management (QM) in payer organizations and on accreditation of health plans and related services, something that is tied deeply to QM.

As in Part II, the topics are addressed from a payer point of view, but they all are relevant to providers and others as our system evolves and greater accountability—and financial performance—are diffused out into the health sector.

Part IV: Sales, Finance, and Administration

The eight chapters of Part IV are the most operationally oriented chapters in the book, describing the nuts and bolts of nonclinical administration. It also includes two entirely new

topics never before addressed in this book: enrollment and billing, and fraud and abuse. The chapter on information technology has been completely rewritten and expanded in scope to better cover multiple elements of what can only be described as the backbone of any payer organization. The material covered in this section may not make up the bulk of the book, but these chapters describe what makes up the bulk of all payer operations.

Part V: Special Markets

Where the book overall looks at the why and how of managed care, Part V looks at four specific and unique market segments for payers, which are health plans and Medicare, managed Medicaid, military managed health care, and managed health care in a global setting. Of particular importance, the chapters on health plans and Medicare and Medicaid managed health care have been completely rewritten by new authors, and both are expansive in scope to address all of the most important elements of managed health care in those programs.

Part VI: Laws and Regulations

The three chapters here have been entirely rewritten by a new author, and provide a succinct review of the state and federal legal and regulatory underpinnings affecting health insurance and managed health care, including the Patient Protection and Affordable Care Act (ACA), a law passed but not yet fully implemented at the time this is being written. At nearly 1,000 pages, the ACA affects all health sectors, but its impact on health insurers and health benefits plans is far greater than its impact on any other sector, so that chapter is confined to just those portions of the ACA.

■ **WHERE TO FIND CURRENT INFORMATION**

Before this book is even printed, something in it will be outdated. The topic at greatest risk for this is the ACA, but it can and does occur for other topics as well. Even when the basic information does not change, metrics and other data do. Rather than attempt to provide individual sources for updated information, data, and analyses here, they are all available through a page on my website devoted to useful links, where you can find a brief description of each useful website as well as an active link. If you find any of those links to be dead or now redirected, please contact me at the e-mail address provided on that page.

The Useful Links page may be accessed at www.kongstvedt.com/useful_urls.html.

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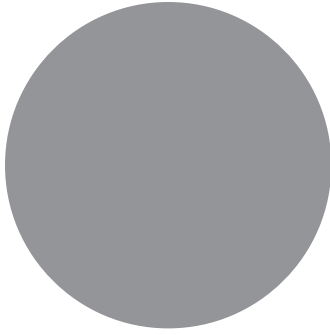
It is no hyperbole to express my deepest thanks and appreciation to my wife Emily and my stepsons Aaron and Benjamin for not only resisting the justifiable and well-deserved urge to regularly beat me with sticks, but to actually support me in a hundred different ways. It is one thing to read *Dr. Jekyll and Mr. Hyde*, it is quite another to live with Mr. Hyde for the 6 months in which Dr. Jekyll vanished without a trace. Fortunately, he's back, albeit with his arm in a sling, a glazed look in his eyes, and a noticeable limp.

Finally, thank you. If you were not reading this book, or at least those parts of it that you find valuable enough to take the time to read, there would be no reason to write this Introduction and write or edit the half a million words that now follow. Thanks again, and don't be a stranger.

Peter R. Kongstvedt

Endnote

1. www.victorinox.com/us/content/history_page. Accessed October 18, 2011.



Preface

Is Health Insurance?

PETER R. KONGSTVEDT

The easy answer is mostly no. For one thing, as discussed in Chapter 2, the majority of individuals covered under commercial health benefits plans are in employer self-funded plans, not in fully insured benefits plans. But that is a technical distinction, and while it is important for several reasons that are addressed in the book, it is not the reason to ask the question, “Is health insurance?” The reason to ask it is to illuminate the underlying dynamics in health insurance in order to better make sense of it. Because on its surface it looks like chaos—which it is*—but it is also a very rational system, although not always rational in a good way.

For half a century, the cost of health insurance has stubbornly increased faster than the general rate of inflation. There are myriad reasons why this occurs, many of which are addressed in Parts II and III of the book as well as extensively in published articles.¹ But there are also attributes intrinsic to health insurance itself that contribute to cost inflation. But it is not profits. As shown in Chapter 5, margins for health insurers and hospitals are nearly the same, and well below other health sector industries. One can argue about health insurer profit motives, but it is now moot. As discussed in Chapters 21 and 30, the Patient Protection and Affordable Care Act (ACA) singled out the health insurance industry to control profits indirectly through minimum medical loss ratio requirements, allowing only a narrow margin for administration, marketing, and profits.

These intrinsic attributes are directly related to its being treated as insurance in the first place. All insurers face these attributes all the time, regardless of type of insurance such as property/casualty, life, annuity, and health insurance. All have developed methods to reduce their impact on cost increases, although health insurers have been more limited than other types of insurers and will be markedly limited under the ACA.

Going under the semantically misleading terms “moral hazard” and “inherent vice,” these interrelated principles are

* In the sense that the entire health sector conforms to complexly adapting systems theory, also known as chaos theory, which is why pundits must continually rewrite speeches about what the future will hold for the healthcare sector.

not difficult to understand in isolation, though regrettably they are often approached that way. But they do not exist in isolation; they exist as a set of related but differing expressions. Moral hazard and inherent vice are not totally ignored in the ACA, but there is considerable variation in what and how effectively they are addressed.

In his landmark 1963 paper, economist and Nobel laureate Kenneth Arrow addressed moral hazard and its application to health insurance, including the pooling of unequal risks, asymmetric knowledge, and issues of trust and delegation.² Writing before the passage of Medicare and Medicaid, Arrow argued that the lack of a truly competitive market for health insurance (i.e., no market to insure sick older adults and poor people) means society must fill the void. Two years later, economist Mark Pauly argued that the existence of health insurance must lead to an increase in demand as the direct cost to an individual of an episode of care goes down, and that some things are simply not insurable.³

Since then, moral hazard has traditionally been the domain of economists, and they have written extensively on the topic, including further excellent detailed discussions specifically about health insurance.⁴ But it is important for noneconomists to understand the concepts as well, particularly for those involved in health policy. The goal of this preface therefore is to illustrate the core concepts of moral hazard and inherent vice as applied to health insurance now and under the ACA, and to do so using plain English, without the use of such terms as price elasticity, welfare losses, marginal utility, or redistributive policy. And there will be no math.

■ MORAL HAZARD

Moral hazard is not a synonym for Las Vegas or the wages of sin. It is usually thought of that way when discussed in the popular press,⁵ but it actually has nothing to do with morals as we commonly use the term. It’s uncertain when it first came into use, although several researchers found publications from the 19th century associating it with good and bad behavior, such as a person who deliberately burns down an insured building.⁶ Others also placed it in

the 19th century, but only through recognition that having insurance can itself create a motive to behave differently.⁷

Still others, including this author, believe it appeared earlier, perhaps as early as the 18th century, with the word “moral” referring only to a state of mind.⁸ This is similar to one aspect of its current definition in the *Oxford English Dictionary* as “. . . psychological rather than physical or practical: *moral support*.”⁹ The word “hazard” may have referred to the familiar definition of “. . . a danger or risk,” but it’s more likely it referred to a popular form of gambling, a dice game called “hazard” that is a forerunner of today’s craps.¹⁰ This is further supported by the origin of the word “hazard” from the “. . . old French *hasard*, from Persian or Turkish, ‘dice’.”¹¹ In other words, moral hazard means the outcome is influenced more by the insured’s state of mind than by the random chance of a roll of the dice.

In simplest terms, moral hazard means that the presence of insurance changes the behavior of the insured party in a way that increases an insurer’s risk because the insured party no longer bears the full cost. For example, a shipping company that is fully insured may be more willing to order its ships to sail through pirate-infested waters because quicker arrival means more profit, but losses to pirates are covered by the insurer, at least until such time as the insurer wises up and boosts the premium.

Beyond this general concept, the expression of moral hazard is seen in four interrelated ways. While each is an expression of a single principal, it is highly instructive to examine all four separately, since addressing one does not equate to addressing them all, and ameliorating one does not ameliorate the others. They are:

- The pooling of unequal risks,
- Asymmetric knowledge and purchasing behavior,
- Induced demand (which has two expressions), and
- The agent–principal problem.

Inherent vice is similar in concept and related to moral hazard, but it refers to physical properties rather than direct behaviors, so it is discussed separately.

The Pooling of Unequal Risks

In an ideal insurance market, all who are insured in a single risk pool have an equal risk of incurring losses. While a perfect market does not exist for any type of insurance, insurers typically identify substantial risk differences and place customers into risk-similar pools; for example, individuals with poor driving records are in a higher risk pool and pay more for their auto insurance, or a malpractice carrier will place all neurosurgeons in a state into a different risk pool than it will place family physicians. In this way, the cost of insurance is related to the level of risk. If significantly unequal risks are pooled, premium costs go up for lower-risk individuals or groups, and they are more likely to exit the risk pool altogether.

Insurers also avoid pooling unequal risks by simply refusing to insure high-risk individuals or organizations. For example, a life insurance company typically will not insure the life of somebody with widespread cancer, or a property/casualty insurer will not insure a coastal home built on a sandbar jutting into the Atlantic.

In health insurance, unequal risk may be separated through age-banding (younger people are in a different risk pool than older people) or categories of products (e.g., a very costly high-risk pool for individuals with high health needs). Experience rating is another way of separating unequal risks, in which employer groups with high costs also have higher premiums. Medical underwriting is another way health insurers avoid pooling unequal risk by not insuring high-risk individuals.

Beginning in 2014, the ACA requires complete pooling of unequal risks in the small group and individual markets, and insurers must charge the same premium rates to individuals or to small employer groups whether they purchase through an exchange or a broker or through direct sales.* Many states have required community rating for small groups for many years, so that is not different. Risk pools for individuals and small groups are not comingled, however, unless a state chooses to do so. Any insurer’s risk pool may be sicker or healthier on average, but the exchange will be able to offset this through risk adjusters to premiums. The ACA also creates temporary risk corridors for insurers in an exchange, giving them a few years to address disparities.

The ACA does allow some age-banding for individuals, but limits it to a threefold difference, not eight or tenfold differences found today. This will necessarily increase the premium cost to younger and healthier individuals. The ACA recognizes this by allowing for a less expensive high-deductible “catastrophic” plan with preventive benefits and a small number of office visits for individuals under the age of 30.

The real impact of the ACA on the pooling of unequal risk is guaranteed issue, meaning an insurer must sell coverage to any individual or group that wants it, meaning the least insurable individuals or groups will now be able to have coverage, and for individuals and small groups at least, pay the same price as everyone else. This is a laudable goal, but it also means higher premium costs, which in turn affects purchasing behavior, discussed next.

Asymmetric Knowledge and Purchasing Behavior

Asymmetric knowledge means that one party, the insured, knows something that the other party, the insurer, does not know. The first place this occurs is the decision to purchase insurance. Because the decision to purchase occurs before coverage is in effect, this type of moral hazard is sometimes

* All of the elements in the ACA discussed in this Preface are described in detail in Chapter 30 as well as throughout the book.

referred to as “ex ante,” meaning “before the event.” The other three expressions of moral hazard are referred to as “ex post,” meaning after the event.

To illustrate this, imagine an 18th century shipping company learns of an increased density of Jolly Rogers in the Caribbean. The company buys insurance but does not tell the insurer about seeing the pirates and thus obtains a favorable rate because the insurer is unaware of the recent increase in risk. This concept is equally applicable to chronically heightened risk such as driving a truck load of unstable nitroglycerin across rough terrain, or to a single event such as wrecking your car yesterday or a recent diagnosis of cancer.

All insurers address this in several ways. Underwriters require prospective customers to submit all relevant information to allow them to determine risk or even decline coverage. Policies are written to negate coverage if the insured failed to disclose relevant information. An insurer may also directly obtain it; for example, by inspecting ship’s logs, obtaining medical records as part of a life insurance evaluation, or requiring an applicant to undergo a physical examination. And coverage is almost never provided for anything occurring prior to applying for it; for example, no auto insurer is required to cover you for yesterday’s car wreck. Health insurers accomplished this through medical underwriting by evaluating a group’s prior claims or an individual’s medical history.

The ACA will not prohibit medical underwriting for experience rating in large groups, but does prohibit rescissions and exclusions for preexisting conditions and, as already discussed, requires guaranteed issue regardless of medical condition. In other words, in 2014 health insurers lose all ability to reduce the impact of asymmetric knowledge except for calculating rates in large insured groups.

Combined with community premium rating requirements in the individual and small group markets, meaning no variations in rates, those facing high medical expenses will be able to buy health insurance for less than the cost of care. This is justifiably the most socially important aspect of the ACA, and has also been the most contentious. But as is now widely understood, if the only individuals or groups who purchase coverage are the sickest, their added high costs will accelerate premium cost inflation since more money goes out than comes in.

Worse, healthy individuals could afford to go without insurance until such time as they needed it, knowing they couldn’t be turned down. Barely sustainable right now, the costs for the newly aggregated risk pool would rise so dramatically that it would rapidly become unsustainable, a dynamic that insurers refer to as a “death spiral.”

To offset it, the ACA contains requirements on employers to offer coverage or face fines, with exemptions and subsidies for some. The ACA also has an individual “mandate,” which, as a result of political compromise, is actually a structured series of modest and slowly increasing fines

for not having coverage. Some people would be exempt from these fines, and low-income individuals will receive subsidies.*

Purchasing behavior needn’t be confined to an up-front decision by someone who is currently uninsured. The ACA will allow individuals (or employers) to opt in and back out of the insurance pool with no penalty beyond the fines. If there is no mechanism to prevent opting in and out at will, it sharply increases the impact of moral hazard on purchasing behavior. But the ACA allows each state to determine when an individual or small group may apply for and obtain guaranteed coverage, referring to special-enrollment periods as defined under the Employee Retirement Income Security Act (ERISA) as well as a general open-enrollment period. Should states use the strictest approach, meaning allowing purchase only after a qualifying event such as losing group coverage or getting married, and otherwise limit open enrollment to 1 month per year, this would offset this problem, but only for 11 months or less. A state allowing continuous open enrollment would actually encourage this form of moral hazard.

Professor Paul Starr of Princeton University suggested an alternative to an individual mandate, allowing individual adults to opt out without facing a fine, but doing so would subject them to exclusions on preexisting conditions for 5 years.¹² This may have mitigated the risk of this form of moral hazard more effectively than the relatively modest fines defined in the Act, although it is difficult to know how the two compare. Nevertheless, this or a similar concept may yet come into play.

Induced Demand

Induced demand means that having insurance actually encourages its use. The amount of induced demand varies widely, and most types of insurance have natural limits on induced demand. For example, moral hazard may lead a shipping company to be more willing to sail vessels through risky waters if they are insured, but not to the point of losing half their fleet. And absent felony fraud, the existence of homeowner’s insurance does not induce people to burn their houses down. And generally speaking, induced demand in insurance is typically confined to a single or a few events.

Health insurance is exactly the opposite. Having health insurance may not induce you to break your leg, but it does result in increasing the amount of healthcare services received, and the less one pays out of pocket the more healthcare services are used.¹³ This is not necessarily a bad thing since the uninsured do not get the care they need and suffer poorer outcomes. Also at some point, increasing

* At the time of publication, the individual “mandate” was the subject of conflicting judicial rulings, and the U.S. Supreme Court had not yet heard the case, so it may or may not be a moot point by the time you are reading this.

usage drives up costs while providing diminishing returns. But the heart of induced demand is this: you are supposed to use health insurance to pay for medical services on an ongoing basis, not just when you break your leg.

There are two distinct pathways for induced demand: demand induced by consumers and demand induced by providers. Consumer-induced demand is described here. Provider-induced demand, which is more important, is discussed in combination with the next form of moral hazard, called the agent–principal problem.

While there is no question that the existence of health insurance leads to an increase in consumers' demand for healthcare services, it is unclear how important that is. For example, consumer-induced demand is the precise focus of direct-to-consumer (DTC) advertising by pharmaceutical manufacturers. While there is evidence that DTC increases consumer demand,^{14,15,16} it may be offset by physicians' advice.^{17,18} Furthermore, as has been argued in the popular press,¹⁹ except for a small number of troubled individuals, nobody really wants to go to the doctor to have a colonoscopy or get stuck with a needle. On the other hand, in today's medicalized society it is not uncommon for a patient to begin an office visit with a request for a diagnostic procedure. In the end, it is difficult to really gauge the impact of consumer-induced demand since a desire to avoid an unpleasant medical intervention must compete with a desire to be healthy.

One way insurers address induced demand is through cost-sharing via deductibles. Losses that are less than the deductible do not result in a claim, and a loss that is only slightly higher than the deductible is unlikely to generate a claim either. For example, if there was no deductible on an auto policy, car owners would have every scratch and ding removed.*

Health insurers do the same via copayments, coinsurance, and deductibles. This reaches its peak in high-deductible health plans (HDHPs), including consumer-directed health plans (CDHPs) with associated pretax funds, as described in Chapter 2. The new standardized benefits plans required under the ACA and described in Chapters 16 and 30 allow for the same significant level of cost-sharing as a typical CDHP, so little changes there.

Health insurers can also use a reduction in cost-sharing to deliberately induce demand, as does the ACA by removing cost-sharing for wellness and preventive care, with the deliberate goal of increasing consumer demand for prevention. Similar approaches to selectively increasing consumer demand have been used recently by insurers as well, using value-based insurance benefits design to lower economic barriers for preventive services, and sometimes for certain drugs and interventions in order to increase compliance in chronically ill individuals.²⁰

*They would also pay very high premiums!

The Agent–Principal Problem

This fourth major expression of moral hazard occurs when the financial interests of a principal's agent are not aligned with those of the principal and as a result, the agent's behavior may increase the principal's costs. Non-health insurers address this by requiring certain functions to be done by their own employees or an agent with aligned incentives. For example, a disability insurer might pay a private detective 10% of a recovered fraudulent payout, or an auto insurer will employ a damage assessor to determine exactly what repairs will be covered rather than having the body shop make that determination.

In health care, we typically think of physicians acting as their patients' agent, looking out for their patients' best interest. And that is certainly true, using the broad concept of an agent. In insurance, and in moral hazard in particular, the physician is also the *health insurer's* agent because the physician (or other professional, really) makes decisions that use the insurer's money. This is the result of the third-party payment system in which there is no alignment at all between the insurer's (the principal's) financial interests and those of the physician (the agent). It is made far worse by the fee-for-service (FFS) system that rewards providers for doing and charging more, at little perceived cost to themselves or their patients. It is also a primary reason physicians have turned away from relatively low-paid primary care and toward more highly paid procedure-based specialties.

The impact can be exacerbated by provider-induced demand. Not only does FFS reward providers for doing more, it rewards them for inducing demand that might not otherwise have existed. As discussed extensively in Chapters 5 and 7 for example, physician ownership of costly devices (e.g., cardiac imaging) is associated with significantly higher levels of utilization when compared to physicians with no ownership interest.

In health care, as prepayment to providers in early 20th century models gave way to insured products, alternate payment models such as capitation were designed to align incentives, but as HMOs declined in popularity, so did capitation. Prospective payment methods such as diagnosis-related groups (DRGs) were also designed to better align incentives, but as discussed in Chapter 5, charge-based outlier payment diminished its impact. Recent approaches such as shared savings and value-based payment for accountable care organizations (ACOs) are another example of attempts to realign incentives between the agent and the principal.

Health insurers, and HMOs in particular, also address the agent–principal problem through utilization management for the most costly types of clinical services. The use of clinical algorithms for precertification of coverage for elective procedures or high-cost drugs are examples, as is the capitated primary care gatekeeper model found in most HMOs, as discussed in Chapters 2 and 7. And on a broader basis, most large insurers use their claims database to look

for patterns of regular overutilization, irregular billing, or other expressions of the agent–principal problem.

The ACA essentially ignores the agent–principal problem, except for a few provisions applicable to Medicare and Medicaid. It calls for the collection of hospital charge data, although it is not clear how that would differ from chagemaster data currently collected by Medicare, and the relationship between cost and charges in the chagemaster is loose, at best.²¹ More encouraging is the creation of an Independent Advisory Board to provide recommendations to Congress on pricing, and which go into effect unless Congress passes legislation for an alternative with equivalent savings. But how such a board will operate is yet to be defined, and it is confined to Medicare, so will have little impact on commercial insurance except to further increase cost-shifting to private payers, as described in Chapter 5.

■ INHERENT VICE

Inherent vice is more than the title of Thomas Pynchon’s fine 2009 novel.²² Inherent vice is an insurance term used most often, but not exclusively, in marine insurance. It refers to an inherent physical property that may cause deterioration or damage, for example, rotting fruit, a truck full of unstable nitroglycerine, or 3 tons of metallic sodium on a leaky ship. Even if discovered after the policy has been issued, a marine insurer will not pay for losses incurred as a result of undisclosed or undetected inherent vice. Inherent vice is simply the other side of the moral hazard coin—where moral hazard refers to a willful behavior, inherent vice refers to a physical state (i.e., structure rather than process).

If it were confined to that, it would not be worth discussing. But inherent vice is a broader concept because life itself is ultimately a fatal condition. As we age, we accumulate more clinical events and conditions, even if we were perfectly healthy when we were first insured. At some point that risk passes from a commercial insurer to Medicare, but the underlying dynamics do not change.

Health insurers address inherent vice through several mechanisms. For reasons discussed earlier, all-or-none approaches such as medical underwriting, exclusions of pre-existing conditions, and rescissions may be used. Experience rating of groups at least partially reflects actual and predicted costs, but it doesn’t work for individuals. The individual market therefore typically uses age-banding as a proxy for actual inherent vice, but this will be limited under the ACA.

Inherent vice also increases risk through real vice, for example, smoking, obesity, alcohol and drug abuse, reckless driving, and so forth. To its credit, the added risk caused by unhealthy behavior is recognized in the ACA, and a strong emphasis has been put on wellness and prevention, including in the benefits designs and funding for prevention programs. The ACA even addresses it in a way that is stronger than what is currently permitted by allowing for significant

“incentives” for participation in preventive services. These incentives may take the form of premium contribution, in effect allowing for differences of up to 30% (or even 50% if allowed by the Secretary). Furthermore, premium rate adjustments of up to 1.5 for individuals and small groups will be allowed based on tobacco usage.

These measures will certainly improve health, but will not offset the increased risks created by removal of the more traditional approaches of medical underwriting and coverage limitations. In counterpoint, a recent analysis of prevention concluded that “less than 20 percent of the preventive options (and a similar percentage for treatment) fall in the cost-saving category—80 percent add more to medical costs than they save.”²³ In this way, the effect of inherent vice on costs will actually be amplified. Prevention is important and the right thing to do, but not because it will lower costs.

■ INSURANCE VERSUS FINANCING

Moral hazard and inherent vice are insurance terms, and broadly speaking, insurance means indemnifying a person or company against unanticipated or unlikely financial losses from a one-time or rare event or cost, for example, a house fire, a sinking ship, or hurricane damage. It can also refer to premature loss or damage when the risks are highly predictable in large populations, for example, life, disability, and long-term care insurance.

Conversely, services that are used repeatedly are often financed, even if their use varies by individual. In some cases, this is through taxation, for example, property taxes to pay for public schools or income tax to pay for police and fire departments. In other cases, it is done through private subscription, for example, monthly payments for telephone service, cable television, or Internet access. Most individuals do not see a doctor as often as they watch television or use online social media each day, but they do see a doctor far more often than they wreck their car or lose a ship to pirates. In this way, health care more closely resembles goods and services that are financed, not insured.

As described in some detail in Chapter 1, the origin of health insurance and managed health care in the United States was also through financing, not through insurance. The earliest forms of coverage were all prepaid plans, including prepaid group practice plans similar to modern group model health maintenance organizations, and prepaid service plans that were the forerunners of today’s Blue Cross and Blue Shield plans. That financing of health services became an insurance product is at least in part due to its inclusion as an employee benefit under the 1942 Stabilization Act that imposed wage and price controls on businesses.

Many nations finance health care by using a combination of taxation and fees. In most cases of financed services, the entities collecting the taxes or subscription fees also provide the service directly or strictly control its delivery.

For example, the school district owns the building and hires the teacher; or the cable company owns the copper, fiber, and descrambler box, and sells only prepackaged bundles of cable channels. The same often applies in other nations, where the state owns the hospitals and employs hospital-based specialists. In this way, they are less subject to cost and revenue fluctuations because those facilities operate under a budget, distribution of high-cost services is centrally planned, and governments are better positioned to demand favorable pricing on devices and drugs.

Governments that finance health benefits and in which at least some healthcare services are provided by private providers also usually attempt to offset at least some of the impact of moral hazard through price controls on providers, blunting the capacity for price inflation. Medicare does this in the United States, and a recent analysis of Maryland's all-payer hospital rate setting system concluded that for the commercial sector it was an "enduring and successful cost containment program."²⁴ Government can also blunt the impact of moral hazard through cost-sharing or other means, since anything in finite supply may be considered in economic terms; for example, time is in limited supply, so queuing is a form of cost-sharing.

Other nations are far from immune to increasing health-care cost pressures, of course. They face the same issues of new technology, aging populations, new procedures, and so forth. As a result, while other nations spend far less per capita than the United States does for healthcare services, they too face inflation rates above their general rates of inflation. The response by other nations is a combination of greater spending and greater queuing, while spending increases are the primary response in the United States.

It would be misleading, though, to simply conclude that the answer to "Is health insurance?" to be "It is health financing." Financing is applied more easily to regular services for most individuals. It is more easily budgeted and resources may be more fairly allocated. But as discussed in Chapter 7, a small percentage of unfortunate individuals experience medical problems that generate catastrophic levels of cost, and in those cases it is the insurance aspect that protects them from losses. By eliminating annual* and lifetime benefit maximums, the ACA will finally reduce or end the serious medical debt and bankruptcies we have today,²⁵ although it increases the insurance aspect of protection that indemnifies individuals from catastrophic financial exposure.[†] In any event, as demonstrated during the rancorous debate culminating in passage of the ACA, our

society is not ready to embrace approaches used by other industrialized nations to finance their healthcare systems.[‡] That being the case, the insurance elements will continue to exert significant influence.

■ CONCLUSION

So the answer to "Is health insurance?" is "Sometimes it is, most of the time it is not." As necessary as reform is, focusing only on health insurance *as insurance* will have the unintended effect of increasing the impact of moral hazard, potentially accelerating cost inflation in the commercial sector. Having a healthier population and reducing human suffering is important, humane, and long overdue. But the cost of doing so will increase under the provisions in the ACA due to perfectly rational economic behaviors of patients and providers that are in no way "immoral." But health insurance reform is insurance reform, not health reform, which is yet to come.

Endnotes

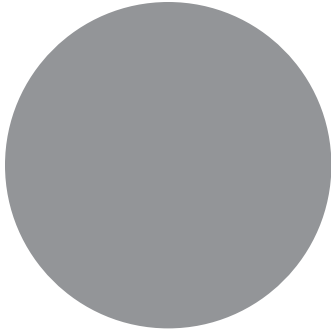
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†Of course, it is possible to separate the two elements; for example, the government providing reinsurance (presumably through Medicare or Medicaid) while the private sector undertakes the financing for routine health care, as proposed by Senator John Kerry in his 2004 presidential bid.

‡I am well aware that many nations finance their systems through "insurance premiums," including two that come closest now to what will exist in the United States after 2014 (Switzerland and the Netherlands), but reject the notion that generally speaking, "health insurance" in a European nation is the equivalent of health insurance in the United States.

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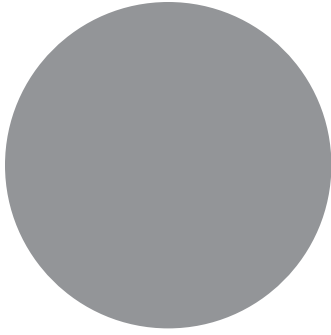


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