Average Cost Based Reimbursement Plans (ACBRPs) And Risk Theory: Implications For Health Care Policy And Practice

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What are the essential tools for this exploration?

Stand things on their head a few minutes

View common experience in uncommon ways

Look at what things are vs what we expect

Exaggerate some things to see them clearly

Examples of Average Cost Based Reimbursement Plans:

- Capitation agreements
- Diagnosis Related Groups financing

Risk, Profit and Insurance

The essence of an insurance contract is that one entity (the insured) enters into a contract with another entity (the insurer) and for an agreed fee, the insured transfers their exposure to uncertain loss to the insurer.

Ideal Insurance

A large entity (Insurer) writes a large number of identical insurance contracts with small entities (Insureds) and the huge volume of business allows the insurer to manage the risk effectively, charge a relatively small risk premium in addition to the loss and expense costs, be profitable, and provide a public service by reducing risk for all concerned. e.g.:

Homeowners

Automobile

Life insurance

Less than Ideal Insurance

Insurer writes few and dissimilar contracts

Poorly predicted/anticipated risk characteristics and increased expenses are more like gambling

Premiums: insured's are low; insurer's are too low

Correct premium may be unknown at signing or ever

Potential for large losses is high and the solvency of the insurer is put at risk

e.g. Lloyds of London

Event insurance

Insuring an athlete's/models legs

Business interruption insurance

How are ACBRPs like insurance?

One entity: government, policy aggregator, funnels risk exposure to another entity – performing a solely sales agent function

Average cost premium to cover losses, expenses, and profits

Actual portfolio outcomes are random and unknown to parties

Some years/contracts will be profitable and some unprofitable

Difficult, not impossible, to legally/ethically alter outcomes

Success in any period may be due to design or random

Acceptor of risk has limited (even if large) liability to loss

Parties harmed by malfeasance may be third parties (like auto ins)

Relatively large portfolio size

How are ACBRPs unlike insurance?

Agent ceding the risk is larger than the agent accepting the risk

No clear risk premium involved

Exposure to risk increases as a contract consequence

Agent accepting risk has little or no capital to back risk assumption

Risk acceptors have little understanding of insurance

Timing of payments exacerbates financial problems

No state/federal regulation of the insurance provisions

No accounting standards in place

Risk is actually being transferred back to the original insureds

Non-performance is difficult to detect

What is wrong with ACBRPs? 1

The transfer of risk goes from larger entities (HMO/INSURER) to smaller entities/providers

The plans are priced, and payments timed, for profitability and risk avoidance by the aggregator

Risk transfer to providers means greater cost variability and lower or negative profit margins for service providers.

Small providers encounter more variability in losses hence loss position is less predictable than for aggregator

Poorly timed cash flows hamper financial stability

What is wrong with ACBRPs? 2

Provider incurs costs in advance to deliver services and losses may exceed operating capital entailing borrowing money

Providers unaware or may have miscalculated how much it costs to provide the services required under the contract

Providers entered contracts believing they were not insurers

Providers cannot manage multi-plan operating requirements

Providers feel ethically compromised

May incur unanticipated costs deferred by former providers

Statistical Problems with Disaggregation

Process mean shifts due to region, severity, capacity, time, technology, competence

Greater variability in experience solely due to inverse effect of the law of large numbers

Conflagration hazards due to concentration of risk

- Influenza
- Accident
- Environmental problems

Using normal distribution – ACBRP providers have fatter tails than aggregators – opposite of insurance

What if providers cannot perform? 1

If the provider cannot meet its responsibilities under the contract - one of the following may happen:

The provider may:

Be vulnerable to “buy out” by the aggregator or others

Engage in ‘belt-tightening’ to try to curtail costs

Limit access to diagnostic services

Deny patients’ true conditions and appropriate treatment

Shut their doors

What if providers cannot perform? 2

If the provider cannot meet its responsibilities under the contract - one of the following may happen:

The insurer may:

Tell the consumer that they chose the provider and not let them switch

Say that patients have to deal with their primary providers

Make it financially advantageous - through incentive plans - to have providers deny benefits to consumers

Purchase provider entities to cover service obligations

What is clear about ACBRP financing?

The risk transfer goes in the wrong direction.

If correctly viewed as insurance, these agreements violate state/federal insurance regulations

ACBRPs are insurance agreements that insulate the aggregator against its manageable risks and costs

Under the pretense of financial advantage, the unwary provider is lulled into a false sense of enrichment.

In the end, the exigencies, the risks, the losses, and the harms extend in only one direction - through the practitioner - to the patient

“The pump don't work 'Cause the vandals took the handles”

SUBTERRANEAN HOMESICK BLUES

ACBRPs like spider webs catch the unwary

What to do about health care?

Separate diagnosis and cost

National primary care service: exams, shots, preventive care – using insurance for universal costs is inappropriate

Let insurance manage risk

Extend practice privileges to lower cost providers for routine care – NPs, PAs

Reduced end/beginning of life care

Increased funding on prevention activities

Take responsibility for rationing access to health care