



**Professional Caregiver Insurance Risk
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Risk Induced Professional Caregiver Despair
A Learning Module
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This is being revised as of June, 2009. Some sections are very sloppy at this time - I hope to complete revisions by April 16, 2046... As with all enterprises there are risks related to prematurity and other risks related to tardiness. I have chosen an early release because I think that the majority of the content is critically misunderstood by health care professionals, educators, and policy makers.

It is also true that my interpretation of PCIR has advanced some since this document was originally prepared. Chief, in this regard, is the awareness that the early formulation only dealt with variation about a stable process mean. Figure 1 and Table 1 discuss this. However, the impact of PCIR is really through the combination of shifts in the process mean and variation around the shifted process mean. This combination is far more problematic than mere variation around a stable process mean. This aspect has been explored more recently on materials available at my website:

For academic purists - I apologize for the lack of the references. Haven't created that file yet

`http://drtcbear.servebbs.net:81/~PCIR`

Abstract

This is a learning module on Professional Caregiver Insurance Risk. It describes the theoretical background of PCIR and the implications, the impact on operations of insurance risk assumption on health care providers.

The purpose of the module is to make material available to nurses, nursing students, nursing educators, and administrators that will help them understand the fundamental shift in the health care environment caused by PCIR. The most intimate professional relationship - that between a patient and nurse has been severely affected by the altered financial landscape currently existing in health care.

Health insurance is not, as most readers will believe, the payment of the average claim costs, but the management of the risk that the costs will exceed the average. The advantage that an insurer brings to managing risk is that by accumulating many risks together, its average costs will more and more closely match the population average cost. Writing more policies makes the insurer's operating results more stable and this is the true benefit of insurance.

In fact, when claim costs do not vary very far from average insurance is a very inefficient mechanism since all policyholders must pay the average costs plus the operating costs of the insurer. Insurance is valuable only when there is great variability in claim costs, because the Central Limit Theorem means that the insurer can charge a small amount in excess of the average cost, provide a useful service, and save policyholders far more money than setting aside funds to cover the full magnitude of possible losses.

The current paper requires a limited amount of understanding of Probability Theory and Statistics beyond what is possible to present here, so the reader may be well served if they read this along with a text on statistical sampling theory. However, the impact of these unsound finance mechanisms has shifted the ethical relationship between nurse and patient in ways that are still unfolding. Gone are the duties to treat each patient the same, to provide service independent of a client's ability to pay, to diagnose and treat each patient in the same manner, simply no longer exists. Instead, health care professionals, who have a vested interest in lowering the financial costs of the services they offer, make decisions that maintain or increase their wealth by reducing the amount of service they provide to clients. Not all nurses are comfortable with this as demonstrated from the interviews with Carol and Gloria (fictitious names).

1 Introduction

Nurses and the nursing profession face extraordinary challenges as a result of the aging of the population, the high costs of acute, chronic, and extended care, and the challenges imposed by rapidly shifting economic conditions, changes in corporate policies, and changes in health care financing mechanisms. In particular, nurses are often compelled to balance the fiscal consequences of care with the clinical consequences of care, making decisions about what services to provide for specific clients who are covered by many different 'insurance' policies and/or managed care plans, while being held accountable for the financial and clinical outcomes of their decisions.

Implicit in these situations is the assumption that the clinical and financial decisions are either compatible, or at the very least, not mutually incompatible: This assumption that nurses can efficiently deliver clinical care at costs that will not, on average, exceed the reimbursements received by their employers, or the revenues allocated to individual divisions, departments, units, or individual nurses, deserves to be challenged. This core assumption is fundamentally incorrect as detailed in the theory of Professional Caregiver Insurance Risk. Nurses individually and as a profession, need to understand the true nature of current reimbursement mechanisms and the constraints they impose on clinical settings and health care professionals, if they and the nursing profession are going to preserve the core values and ethical standards that have guided professional nursing since the days of Florence Nightingale. In particular, nurses need to understand the fiscal and clinical constraints under which care decisions are being made and they must be able to articulate the duties and responsibilities of their organizations/employers to their clients when their organizations wish to limit their clients' access to services. Understanding these tangled obligations is critical if nurses are going to serve as effective advocates for their clients and the nursing profession.

2 Goals and Objectives

The purpose of this module is to explain how various mechanisms used to reimburse health care providers affect caregiving environments, caregivers, and clients. In particular, this module addresses finance mechanisms that involve either implicit or explicit transfers of insurance risks to health care providers. These mechanisms occur in two very distinct ways. First, and of primary concern, financial entities such as insurers or non-service providing managed care organizations may contract with health care providers, paying them a fixed, prospective amount, per covered client, to provide services in the future that are not known at the time of contract negotiation or inception. Second, service providing organizations may transfer clients from one unit to another or from one organization to another. In the latter case the usual characterization is that the transfer primarily

involves clinical responsibilities and the financial implications are often veiled, ignored, or unrecognized.

Transferring a medical surgical client, to a cardiology unit, because the client had a heart attack after surgery for an unrelated problem is one example of the latter case. When the patient is transferred, the cardiology unit will assume clinical risks, financial risks, and a revenue stream from the payor, and the medical surgical unit will replace that client with another client, therefore losing the clinical risks, financial risks, and revenue stream attributable to their former client, and assuming clinical risks, financial risks, and a revenue stream attributable to their new client. In some cases the transfer might be between two similar units and the revenue streams will be for the same DRG codes, but in general, intra-organizational transfers will involve different diagnostic classifications, different clinical risks, different financial risks, and different revenue streams. Astute nurses, managers, and executives will, over time, adopt practices and policies that are informed by their assessments of the clinical and financial consequences of their actions. In some cases this may result in better management of their domains, but there is a tangible risk that this will ultimately occur at the expense of clients whose clinical needs may be sacrificed to achieve better financial outcomes.

Depending on the degree to which the receiving and sending units are aware of the revenue differences, it is possible that one unit may skim the patients with the highest reimbursement rates and the lowest clinical demands, while less aware units will see no difference between a client on Medicaid and a client with a generous insurance plan. Another example would be the transfer of a medical surgical client from a hospital to an extended care facility. In each of these cases the sending unit is relieving itself of both the clinical and the financial responsibilities that previously existed, while the receiving entity is assuming both the clinical and financial implications. When service providing entities effect such transfers they do not, in general, play a continuing role in the receipt of or payment for health care services. The continuing financial responsibilities are generally in the hands of third parties to the clinical transfer, but the financial risks do move along with the client. A long-term care facility that consistently accepts Medicaid clients will experience different financial outcomes than a similar facility that accepts only private pay, or a mix of private, Medicare, and Medicaid clients.

When finance or reimbursement mechanisms involve the transfer of uncertain financial liabilities that accompany clinical transfers, in lieu of fixed, prospective, or fixed retrospective payments, the mechanisms are properly classified as Professional Caregiver Insurance Risk transfers. When health care providers assume insurance risks they must function as small insurers and they have to perform the same functions as any insurer: Solvency management; Insuring premium adequacy; and Claims management. Unfortunately, these insurance functions involve activities that are counter-productive at the bedside or at the point of care because caregivers are supposed to function as client advocates not as claims managers or advocates for their employing organizations. Under most circumstances the role disparity is not an issue. As long as a client's care fits in a narrow

range around the expected level, clinical and financial needs are either synchronous or at least not dramatically mismatched.

However, not all clients will fit in a narrow range around the average. Some clients will require far less care, generating a surplus of revenue during their stay. The problem that comes into play is when the client demands a far higher level of clinical care than incorporated in the expected financial reimbursement. That is, the care of such a client is problematic when the costs of care are high. In insurance companies, high value claims receive special attention - often resulting in delayed claim resolution and payment while the insurer determines whether they are really obligated to pay for the claim. Insurance companies and specifically insurance claims agents maintain a very safe distance from clients on such high cost claims. The role of the claims agent is to hold the line on the payment of benefits for which the insurer may not be liable. In the clinical setting the opposite treatment is required. High cost treatments are often needed immediately and delays in treatment may be life threatening or result in less than optimal outcomes for clients.

Nurses, particularly bedside caregivers and unit managers, are in pivotal positions on this issue and they are being asked to fill two fundamentally antithetical roles. The better caregivers understand the conflicted roles that exist and their implications, the more capable they will be to serve as client advocates in situations in which there are inappropriate efforts to constrain the costs of critically needed care. The subtle fact of insurance risk assumption by health care providers is that they are obligated to meet the needs of high cost clients, from the excess of revenues generated from their low cost clients. Few health care providers have a concrete grasp of this obligation, tending to see high cost clients as exceeding the revenues they generate and therefore not covering their costs. In a fee for service system this may appear an acceptable view, though the ethical flaws are part of the rich tradition of nursing as a profession. When health care providers assume insurance risks such feelings and their attendant actions to reduce the level of care provided are unacceptable. Still, few health care providers are sufficiently knowledgeable to advocate against the prevailing ideology that these "medical outliers" are entitled to the full standard of care. There is however, another subtle problem that arises. Clients come with a variety of benefit plans, each one involving differing obligations on the part of the health care plan organization and the insurance risk assuming health care provider. When a client needs treatment X but their plan does not cover this, nor does the capitation contract cover such services, what are the duties of the nurses, physicians, and health care organizations to deliver the clinically appropriate standard of care?

This module includes an explanation of the theoretical basis of this work, common financial mechanisms that transfer insurance risks from one entity to another, a detailed explanation of the differences in risk management efficiency between large and small insurers, descriptions of how registered nurses feel insurance risk transfers have impacted their work, and a brief discussion of the implications of insurance risk assumptions on health care environments, providers, consumers, the nursing profession, and the public

health.

3 Theoretical Foundations

Nursing theory and nursing science distinguish nursing from other disciplines, establish core phenomena of concern to nurse researchers and theorists, delineate content, and provide guidelines for professional practice, while informing and directing the activities of researchers, practitioners, and educators (Fawcett, 2000; Meleis, 1997). Nursing science and nursing theory provide frameworks within which nursing practitioners and researchers define areas of interest and expertise, develop theory-generated propositions about the state of the world, and develop specific research trajectories and agendas. The premises drawn from a particular nursing science theory provide a context within which one may guide and evaluate the results of research endeavors.

Developing a better theoretical understanding of RNs' responses to changing finance mechanisms may be critical to understanding the complex nature of the work and working environments of RNs. Rogers (1994), in her science of unitary human beings, describes the core phenomenon of nursing science to be irreducible, unitary human beings. According to Rogers, unitary human beings are irreducible wholes different from and not determined in their wholeness by their parts. Rogers advocated the study of the whole and the integrality of human and environmental energy fields. This view is particularly appropriate to this study because extant analyses of the impact of finance mechanisms have been too narrow, resulting in fragmented bodies of knowledge concerning the impact on health care organizations and providers of health care of changes in health care financing mechanisms.

Economists may study inter-industry relationships, individual firms, health care as a sector of the economy, or cross-country approaches to health care economics. Accountants may study organizational cash flows and profitability. Nursing managers may be concerned with meeting the need for different levels of care and different types of staffing. Sociologists may engage in studies of the behaviors and social interactions of health care professional's under the influence of risk transfers. Risk managers may be concerned with managing the risks of unpleasant outcomes and protecting health care providers from legal and financial harms. However, little attention has been devoted to an examination of how RNs, *qua* unitary human beings, experience, perceive, and express what it is like to work in caregiving environments influenced by professional caregiver insurance risk transfers.

Resource inadequacy and the managerial imperatives of risk transfers are not identical. Predictable resource inadequacies exist in all health care settings and RNs quickly respond to the environmental constraints that result (Kritek, 2001). However, hospitals

function best when redundant resources are available to meet the unexpected demands that are common on most nursing units. For example, if operating costs are known with 100% certainty and are under-funded, productivity imperatives may not be met, but new work routines will develop to deal with the consequences of persistent and predictable under-funding. A more serious problem occurs when uncertainty exists in both resources and service demands. The combined effect of accepting professional caregiver insurance risk transfers, reducing redundant resources, and increasing client acuity levels may have negative, synergistic, effects on the ability of RNs to deal with workplace demands for equipment, supplies, time, and services.

Change, according to the science of unitary human beings, is continuous and is one of the core aspects of Rogerian nursing practice. This study recognized two levels of change that were particularly important. First, there are the changes that have occurred, and continue to occur, in registered nurses' working environments as health care organizations respond to changes in reimbursement mechanisms. Second, change manifests as the potential for transformation and growth on the part of participants, and other caregivers, the researcher, and health care organizations. Later in this module I will describe a research project devoted to working with registered nurses experiencing Risk Induced Professional Caregiver Despair. This project was a participatory action research program wherein I worked with registered nurses to help them sort out their experiences and they helped me to better understand the impact of risk transfers on clinical environments and registered nurses. As well, the objectives included the potential for healing and transformative experiences on the part of the participants. A common problem experienced by nurses is that they experience so many traumas that it is hard for them to ever express all of it, or to unburden themselves of it. An important component of this project was to allow the registered nurses to fully describe and explore their myriad experiences. By listening to these RNs, providing them an opportunity to share and reflect on their experiences, and extending an opportunity for personal and professional transformation, healing, and growth the project met its healing objectives as well as its informational imperatives.

Rogers's (1992) fundamental premises for the science of unitary human beings are: energy fields, pattern, openness, and pandimensionality. Energy fields are infinite, i.e., pandimensional, dynamically fluctuating, and open. The patterns of these energy fields are identified by their manifestations. Pattern continuously changes and is not directly observed, although there are manifestations of the field that may be observed and which do reflect the dynamic nature of the underlying field. A good example of this is the way physicists demonstrate the existence of a magnetic field by sprinkling iron filings on a sheet of paper placed on top of a strong magnet. Under the influence of the magnet, the iron filings will coalesce, forming curved lines. The curved lines themselves are not the energy field. The magnetic field, like pattern, is conceived as continuous, ever changing, and dynamic. However, we see evidence for the magnetic field by abstracting from the way the iron filings coalesce and conceptualizing the continuity and dynamic nature of the energy field that is manifest in the alignment of the iron filings. In the same way, when we observe the pattern manifestations of a unitary human being, we have data about

the underlying human energy field pattern, through the manifest experiences, perceptions, and expressions. To grasp the true nature of human beings as energy fields, we have to appreciate what we experience and extend our understanding beyond the discrete nature of the observable pattern manifestations to arrive at an appreciation of the whole.

According to Rogers (1992), openness refers to the a-causal nature of the universe and postulates a universe of commingling energy fields that are continuously open to dramatic change, including unexpected change, which manifests in innovative and diverse ways. Pandimensionality refers to a multi-faceted, non-linear domain in which our usual notions of time and space do not necessarily hold. This concept was likely created in response to the tendency in the social and human sciences to conduct research, which either explicitly or implicitly assumes linearity in conceptualization, design, or analysis.

Abbott (1998) describes how uni-dimensionality and by extension, any limited, finite-dimensional worldview, restricts our understanding of complex phenomena. Phillips (1991) suggests that the assumption of pandimensionality is a non-linear awareness that transcends three-dimensional reality. By employing the concepts of pandimensionality and openness, Rogers (1970) effectively rejects premature conclusions drawn from cause and effect relationships.

Broad (1949; 1953) proposes the existence of a constantly unfolding universe and suggests that synopsis, the intentional effort to view phenomena normally viewed as separate, as connected and compatible, is fundamental to philosophical inquiry. In this research inquiry, synopsis occurs on many levels. The researcher views registered nurses performing their normal duties and roles and also functioning, on behalf of their employers, as insurance claims agents, an unexpected and seemingly unlikely role for nurses. This research also embraces Rogers (1970) openness and acausality with a theoretical description of common health care finance mechanisms as insurance risk transfers. Unitary researchers and practitioners recognize the need to maintain openness in order to develop a more comprehensive understanding of complex phenomena such as the experiences, perceptions, and expressions of RNs in mutual process with their working environments.

Professional Caregiver Insurance Risk is a nursing theory based on actuarial risk theory. Unlike the perspectives usually taken by insurance companies, Professional Caregiver Insurance Risk incorporates nursing paradigms, values, and perspectives, and focuses on explicating the problems that insurance risk assumption causes in the nurse-client environment: the context of clinical service delivery. There are different perspectives and paradigms that best highlight different facets of PCIR. Bertalanffy's General Systems Theory, and its various implementations in core nursing theories is excellent for understanding the intricate causal web that connects insurance risk assumption with dwindling profit margins for health care providers. Rogers' SUHB addresses the subtle forces and acausal aspects that come with the uncertainties faced in clinical environments. A smoothly running nursing unit can be thrown into chaos at any moment if a client codes, has a bad reaction to medications or blood products, or if family dysfunctions get out

of hand. A nursing unit that functioned efficiently and safely can become disorganized, chaotic, and dangerous simply by implementing a change in patient admissions or increasing client/nurse ratios. What central administrators see as slack in an entirely predictable environment is all too often the reserve necessary to ensure smooth operations during periods of both predictable and unpredictable demands. The core theoretical basis of PCIR is actuarial risk theory applied to the effect of insurance risk transfers such as capitation contracts, managed care programs, prospective payment systems such as the Diagnosis Related Groups (DRG) financing mechanisms, and intra-organizational insurance risk transfers on caregiving environments, staff, and clients. The central arguments of PCIR are easily demonstrated using actuarial risk theory, utility theory, and elementary statistical sampling theory. The empirical aspects of the impact of PCIR on registered nurses are elaborated in the theory of Risk Induced Professional Caregiver Despair (RIPCD). The empirical description of the main features of the theory of RIPCD was derived from a participatory action research program involving the collaborative investigation of registered nurses' experiences of the effect of insurance risk transfers such as capitation contracts, managed care programs, Diagnosis Related Groups (DRG) financing mechanisms and intra-organizational insurance risk transfers, on themselves, their caregiving environments, their peer registered nurses, and their clients.

Exploring RIPCD with caregivers involved a collaborative, participatory, qualitative, descriptive, exploratory design, using Cowling's unitary appreciative inquiry (UAI). UAI was particularly well suited to facilitating collaborative relationships with registered nurses in the development of seven appreciative profiles of their experiences of risk induced professional caregiver despair. The eight registered nurses participating in the project revealed serious problems they believed resulted from the impact of insurance risk transfers on their workplace settings, and the availability of equipment, and material resources. The data derived from these collaborations was processed using synopsis and synthesis to fill in empirical data and rich aesthetic detail for the theory of risk induced professional caregiver despair, expanding the science of unitary human beings, and explicating the theories of PCIR, and RIPCD.

This module both explains and reveals the impact of insurance risk transfers on bedside nurses and the care they are able to render to their clients in insurance risk assuming environments. This module helps learners develop an understanding of the experiences of these registered nurses and sets the stage for the development of strategies to improve the situations bedside caregivers increasingly face in the workplace. At the conclusion of this module the learner will be able to identify and describe critical features of the impact of insurance risk assumption, the resulting cost-constraints, and how this affects registered nurses, nursing environments, and clients.

4 Prelude

4.1 NURSING TRAUMA

The critical and traumatic care theaters aren't the only places where nurses witness the horrific effects of abuse, neglect, and other forms of inhumanity ('Understanding Secondary Traumatic Stress,' July). My work takes me into the lives of people receiving state-and federally supported care in their homes, where I see the insidiously slow destruction of human bodies, minds, and spirits and the ways in which poverty, substance abuse, and capricious state and federal funding obstruct the effective provision of care.

My work doesn't include the clamor of a trauma ED, or the tension and sorrow of a neonatal intensive care unit, but nonetheless it takes place in a "battle zone." Patient advocacy is won in increments so small and so hard fought that the effort leaves my heart battered and my mind a blur. I, too, fight for sleep. I, too, have fits of anger, no, rage, that evolve into episodes of bitter weeping followed by mute depression. I, too, have developed cardiac arrhythmias brought on by the stresses of my nursing job.

Nursing practice takes place in one type of war zone or another, and the resulting stress plagues us all (Stevens, 2001, pp.14-15).

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5 Professional Caregiver Insurance Risk

Insurance risk transfers can be beneficial or harmful. When an adequately capitalized insurance company writes insurance policies, aggregating and retaining these risks, there are benefits for both the insurer and its policyholders (Bowers, Gerber, Hickman, Jones, & Nesbitt, 1986). On the other hand, transferring insurance risks to inadequately capitalized operations, such as health care organizations, can be very harmful. Gold, Lake, Hurley, and Sinclair (2002) distinguish between three types of risk transfer arrangements: Global capitation, Professional service capitation, and Hospital services capitation, noting that the difference corresponds to the degree of exposure to risk.

Global capitation agreements transfer most or all of the risk from health maintenance organizations to other entities and may include the costs associated with prescription medi-

cations. Professional services capitation involves the transfer of risks associated with the customary services provided to health care consumers by health care professionals and may include radiology and laboratory services. Hospital services capitation involves risk transfers that cover hospital-based services, some professional, and additional services.

Gold et al. point out that risk assuming entities are regulated in some states, such as California that limits health care providers to risk-assumption for services they normally provide. Gold et al. also report findings related to the functioning of intermediary risk assuming organizations, suggesting that these organizations often accept a great deal of risk.

The assumption of 'risk' is well acknowledged but the characterization of the risk transfers is incomplete in material ways. When health maintenance organizations or other policy aggregators (See definitions) transfer risks to health care providers and organizations, it is more accurate to call these insurance transfers and to explicitly analyze the behavior of health care providers and organizations that assume insurance risks as though they are insurers, exploring their financial viability, surplus, service quality, and claims management practices in particular.

The recognition that health care providers and organizations are engaged in the insurance business also has implications for insurance regulation at the state and federal levels. The theory of professional caregiver insurance risk assumes that risk assuming health care providers and organizations are engaged in the insurance business and analyzes premium adequacy and claims handling implications of health care providers and organizations serving as quasi-insurers.

Global capitation agreements (Gold et. al., 2002) are the clearest example of the entry of health care providers and organizations into the insurance business. However, other forms of insurance risk transfers occur as well. When a health care organization assumes responsibility for a specific client's care and delegates the responsibility for care to a budgeted nursing unit, the transfer of responsibility for clinical care comes with financial risks for the receiving unit, which may then be viewed as an insurance risk transfer and the ability of the nursing unit to manage the resource demands that result may be analyzed in ways analogous to the analysis of an insurer's capacity, albeit unique to nursing. Another commonly used financing mechanism, Diagnosis Related Groups (DRG) also involves insurance risk transfers to health care providers and organizations.

6 Benefits of Insurance Risk Transfers

Insurance policyholders may be individuals, groups, families, organizations, or government. A well-run insurance operation significantly reduces risk for itself and its policy-

holders for complicated and complex reasons. The full explication and appreciation of the benefits of insurance require understandings of the law of large numbers (LLN), philosophical and mathematical utility theory, the central limit theorem, actuarial risk theory, finance, portfolio theory, interest rates, mortality, and a host of other theoretical disciplines (Bowers et al., 1986; Dorfman, 1998; Schmitt, 1969; Stone, 2000; Webb, Harrison, & Markham, 1997).

Despite the theoretical complexity of the topic, insurance has been practiced for thousands of years and some of the core ideas can be grasped and the implications understood. However, the reader is warned that misunderstanding of insurance is so pervasive that it will take great care to avoid imposing popular misconceptions about insurance to the explanation.

In essence, as insurers write more policies, both their estimates of the average cost of paying claims and expenses on those policies and their actual financial experiences converge toward the true loss ratios for the population insured. The popular misconception is that the benefit of insurance is achieved by lowering claims costs when the reality is that the benefit of insurance is the approach to the true population loss ratio as portfolio size increases. All insurers expect to pay the average loss, in the aggregate, for each policy they write. Efficient insurers do this by reducing the spread of their operating results around the true population loss ratio.

Some insurers also operate more efficiently by having more productive staff, using technology to improve efficiency, reduce costs, and manage their policies and claims more efficiently. But the core virtue of insurance is the convergence to the mean loss ratio. It is this convergence that represents risk reduction. As late as the 1980s the actuarial and underwriting professions were still confusing risk and convergence - viewing them as fundamentally different characteristics, when they are, in fact, identical.

Insurance companies use many mechanisms to insure their well being, including: writing many different types of insurance policies, writing policies in geographic regions that are remote from each other (Stone, 2000; Webb et al., 1997), establishing financial reserves that allow them to weather extremely bad years, and establishing rates for their products that are adequate to meet the costs of their insurance operations.

Insurers avoid unnecessary risk by engaging in non-correlated lines of business, remote geographical distribution of policies, and other methods to ensure that they will not go bankrupt, depriving policyholders and claimants of the benefits they paid for and deserve to receive (Larkin & Casscles, 2003). An insurer may write homeowners or health insurance policies in many different states, so that the losses it incurs as a result of an industrial accident, natural calamity, or localized epidemic will be offset by far lower than expected losses in a state 1,000 miles away. Likewise, an insurer may write workers' compensation insurance, general liability insurance, health, and life insurance in the same state, relying on large losses in one line of business to be offset by low losses in another line of business.

There are also state specific regulations regarding entry into and continued insurance operations. New and continuing insurers are obligated to demonstrate that they possess significant financial resources to support their operations, and insurers must report their financial operations according to the Generally Accepted Accounting Principles (GAAP) and the Statutory Accounting Principles. In both cases, the insurer is obligated to maintain adequate resources to pay all their liabilities, even those that may extend decades in the future.

However, despite significant regulatory control (Nordman, 2000; Pickens, 2003), detailed financial accounting procedures, and highly skilled personnel such as actuaries, accountants, attorneys, and underwriters (Davidson, 2001) insurance companies do fail (Harrington & Niehaus, 1999). Even very large, well-respected, and long established companies fail, such as Reliance, Mutual Benefit Life, and Executive Life. In some cases, insurance companies are rehabilitated when they fail, as happened with Metropolitan Life Insurance. In other cases, such as Reliance and Mutual Benefit Life, the companies are so lacking in the operating capital and the technical and professional infrastructure needed to operate that their assets and obligations are sold off to other insurance companies or liquidated, with policyholders, beneficiaries, and claimants bearing the ultimate costs of the insurer's poor business operations.

Multi-line insurance operations, geographic risk spreading, and special relationships between insurers, known as reinsurance, link the entire planet together financially (Michelbacher, 1957; Strain, 1997). The extent of this inter-relatedness became apparent after the loss of life and property accompanying the destruction of the Twin Towers in New York City, the attack on the Pentagon, and the plane that crashed in Pennsylvania on September 11, 2001. Insurers and reinsurers around the world soon realized that the insurance covering the planes, the buildings, and the people in the planes and the buildings represented a monumental loss financially, in addition to the social and personal losses involved. What appeared to be a closed and bounded system of insurers and insureds, operating in a fixed, closed; deterministic model of highly predictable events, predictable revenues, expenses, and losses was anything but that. Instead, events never fully considered, suddenly came together and changed the landscape for insurers, reinsurers, and people all over the planet. Those events had always been possible, however unlikely they were to occur at that particular moment. Rogers's science of unitary human beings, incorporating pandimensionality, open systems, and unpredictability took on new relevance on the morning of September 11, 2001.

7 Harms of Insurance Risk Transfers

The dramatic increases in the aggregate costs and demands for health services between the 1960s and the present have generated a desire to reduce health care costs in private

and public health insurance programs. Reductions in costs affect different organizations, service providers, or clients in different ways. What may be benign in one setting may be very harmful and disruptive in another. Some organizations and professionals adjust to reductions in income by changing service priorities to better align with current or anticipated funding opportunities, while other organizations have great difficulty adjusting to changing financial exigencies, opportunities, and risks. In health care, unlike many other enterprises, the easiest path to cost reduction is not the elimination of rare, high cost services. Rare high cost services are precisely the situations for which health insurance is the appropriate method of risk management. However, health care providers who do not understand insurance operations, may be tempted to eliminate high cost, rarely used services, or restrict access to care by the small number of high cost clients, threatening the core relationships between health care providers and clients. In business, a low return service or product can usually be eliminated, without adversely affecting consumers. This is not the case in health care services and the elimination of rarely used services has broader implications: a net reduction in security, peace of mind, and financial stability for individuals, families, and communities. Average cost based reimbursement plans (Cox, 2001a) exist in one form or another in most private and public sector health care operations. Insurance risk transfers to health care providers and organizations can cause significant problems if providers react by reducing client care services rather than achieving greater efficiencies. The theory of professional caregiver insurance risk (Cox, 2002c) suggests that insurance risk transfers will result in financial problems for health care providers and organizations that repeatedly engage in such agreements because reimbursement levels in average cost based reimbursement plans cannot adequately compensate health care providers for the risks that they are assuming.

PCIR theoretically demonstrates that financial and actuarial problems exist even if health care providers and organizations streamline operations, reduce inefficiencies, and reduce the use of defensive diagnostic testing procedures (Cox, 2001a; 2002b; 2002c). The reason for this is that competitive pressures in the marketplace will eventually force PCIR reimbursement schedules to the average cost for providing service, meeting expenses, and small margins of profitability for insurers and health care providers (Samuelson, 1964). Since the average cost of providing health care services is the most an efficient insurer, operating in an efficient insurance market, can pay to health care providers, 50% of health care providers and organizations will spend more to provide these services than they receive in the form of capitation or prospective payments. There are two alternatives, both of which are unsustainable in the market place: Insurers could charge substantially more for their products than the average costs, passing the additional revenues to health care providers. That would mean that the market place would have to be willing to tolerate considerable inefficiency. Alternatively, health care providers could reduce poorly funded services to levels that are consistent with available, profitable, and sustainable operations.

At first, this may seem avoidable. Most analysts, consumers, and payors believe that the health care delivery system is wasteful, inefficient, and redundant. This is true. However, even a perfectly efficient health care delivery system cannot survive sustained insurance

risk assumption. The reason average cost based reimbursement plans must reach this equilibrium condition is that it is the only stable configuration in competitive insurance markets and this is exacerbated when health care cost reduction becomes the primary objective of economic, social, and health policy (Samuelson, 1964). If any insurer consistently pays more to health care providers and organizations than the average cost to supply services, they would have to charge their policyholders more. In competitive or efficient insurance markets another insurer will see an opportunity to profit by offering similar financial services at lower cost to their inefficient competitor's policyholders. If the first insurer continues to pay out more to providers than it can take in, it will eventually become insolvent. If it modifies its operations to match the rates of the new competitor, it will have to be rate competitive - offering similar services for the same price. Hence, competitive pressures in the marketplace require a gradual movement to either insurer insolvency or risk assuming health care provider or organization insolvency as insurers and health care providers and organizations continue these necessarily inadequately funded professional caregiver insurance risk transfer relationships. Why is this the case? The critical flaw affecting insurance risk assumption by health care providers is the diminution or elimination of the statistical benefits of insurance risk aggregation when health care providers and organizations accept insurance risk transfers. There are six main reasons for the loss of financial benefit typical in insurance risk transfers to health care providers.

First, properties such as statistical averages for a population are not necessarily true about any of the individuals in that population. This means that average costs for services based on millions of similar cases are, with statistically negligible exceptions, either lower or higher than the costs for each individual. Put another way, the costs of providing services to any particular client will either exceed or fall below the average. When these costs exceed the expected revenues for that client, it may be difficult for relatively small health care providers and organizations to distinguish between what is clinically appropriate for the individual client in the consultation room and what is fiscally sound for the health care provider and organization. Insurers and their claims staff are usually insulated from the lives of the policyholders and claimants, while health care provider and organizations often have long-standing relationships with the clients they insure and must make clinical decisions that are based, in part; on the financial impact they will have without the ability to be dispassionate. The same issue of generating higher or lower costs than average is true when the unit of focus is any subgroup of the whole population, such as a particular health care organization's portfolio, a geographic region, or any specific time interval, operating division, or unit.

Second, insurance companies perform many specialized functions, developed and refined over many centuries. These special functions include: underwriting, loss control, claims adjustment, ratemaking, accounting, and marketing. Insurers rely on skilled professionals such as underwriters, claims managers, and actuaries to steward their operations and insure their long-term viability. These insurance functions often conflict with the clinical roles of health care providers or organizations, imposing ethical and fiduciary conflicts into professional relationships between clients and their health care providers and orga-

nizations (American Nurses Association, 2001). The theory of professional caregiver insurance risk demonstrates that health care providers and organizations accepting insurance risks must perform these insurance functions (Cox, 2001a). The issue is not whether most health care providers and organizations will attempt to perform these functions ethically, but whether all health care providers and organizations can, or will do so, at all times, if their own financial well being is at risk.

Third, the variability in estimates of the average cost of health services and the deviation from the true underlying average costs for health care services becomes higher as sample sizes decrease (Bowers et al., 1986; Dorfman, 1998; Stone, 2000; Webb et al., 1997). Health care providers and organizations serving small numbers of clients may have dramatically different results than the average for the whole population, or the average for larger health care providers. This increasing variability with decreasing portfolio size is particularly troublesome as the effects of insurance risk transfers to health care organizations move to the level of a specific nursing unit, a single registered nurse, or single client. At the level of the individual doctor, nurse, or nursing unit the variation in demand and costs for providing client care may exhaust the available resources. At this level there is no benefit of averaging, clients either receive the services they need and are entitled to receive, or they do not on any particular nursing shift. A client that should be ambulated two times per shift and is ambulated only once on a given shift because the staff are too busy, cannot be compensated for by the fact that another client was ambulated three times, on another shift, or on another unit.

This problem of increased variability also thwarts efforts to mediate the effect of insurance risk transfers because carve-outs, and risk-adjustments all assume that equity can be achieved by distinguishing groups with higher risk or demand characteristics (Finkelman, 2001). However, each of these groupings results in smaller numbers of clients, higher variability, and the potential for decreased access to the services needed. When mental health services for chronically ill clients are carved out of the customary managed care services will there actually be providers available that are willing and able to handle these higher risk clients? As insurance transfers, these higher variability clients pose greater financial risks once they are identified and removed from the general population since their needs are no longer compensated for by the lack of need for the overwhelming majority of clients.

Fourth, the timing of costs and revenues in average cost based reimbursement plans is also problematic. Insurers would be guilty of financial impropriety if they disbursed the full amount of the prospective payments in advance of the performance of the insurance and clinical services health care providers and organizations provide. This is not a matter of choice for insurers; it is a requirement under the Statutory Accounting Principles. If the insurer did fully fund the expected liabilities of health care providers and the health care providers and organizations became insolvent or neglected their duties, the insurer would lose the money that it had transferred to the provider and would have to find and fund another provider to meet the client's needs. As well, under the SAP guidelines funds

disbursed to entities that are not state licensed insurers or reinsurers, are offsets to the capital requirements of insurers.

One consequence of this is that insurers often provide health care providers and organizations with amounts lower than the expected cost of providing the related services, promising additional payments at contract end. They may also promise substantial performance bonuses to risk assuming health care providers and organizations who achieve significant cost efficiencies. Naturally, the funds to pay these performance bonuses come from the same pool used to fund service costs. Hence, health care providers and organizations that exceed average service costs are likely to fail to meet the standards for performance bonuses. This means that they may receive less than average levels of reimbursement and fail to obtain performance bonuses precisely when they are needed most, when the costs of client care exceed revenues.

Fifth, unlike insurers, health care providers and organizations must anticipate needs and maintain resources in advance of their use. Offices and beds must be available, staff present, utilities available, and supplies stocked before the professional caregiver insurance risk transfer occurs. Traditional insurers collect premiums long before claims arrive and claims processing may take days, weeks, months, or years before the insurance benefits are paid (Bowers et al., 1986; Stone, 2000; Webb et al., 1997). Insurers typically get premiums before the coverage begins and the premiums may be paid far in advance of the end of the policy period. Insurance risk assuming health care providers have to provide the services before the full amount of the payment is known and they may not be fully reimbursed until months or years later. As well, retrospective auditing may also impact how much the health care provider received for the services they rendered. In some case, the needs of the client may fall outside of the terms governing the insurance risk transfer - the client may need specific diagnostic procedures or treatments that are not covered by the client's elected health plan, but the standard of care for the client's condition may dictate that those procedures or treatments be made available by the provider.

Sixth, the sub-portfolios of clients transferred to health care providers and organizations are not, in general, random selections from the populations upon which the actuarially sound premium rate is based. Self-selection biases (Pauly & Nicholson, 1999), geographic, or occupational risk factors may all increase or reduce the costs for each health care provider or organization's portfolio. Some health care providers and organizations may profit greatly, while other health care providers and organizations may lose substantial sums under such conditions.

8 Public Health Effects of Professional Caregiver Insurance Risk Transfers

There are consequences of requisite reductions in health care benefits that affect communities rather than specific individuals or organizations. Shortly after September 11, 2001, while speaking at the American Public Health Association (Cox, 2001c), this researcher remarked that September 11, 2001 was notable for having avoided one such outcome. Very few people were injured because of the events of that day. Either people died or they escaped with little physical trauma. The health care system, as a whole, was untested that day. If, this researcher speculated, there were thousands, or tens of thousands of victims critically injured, it is unlikely that the New York City and surrounding area health care providers and organizations would have been able to meet the needs for such catastrophic, unexpected, and unanticipated health care services. It is difficult to imagine meeting everyone's needs in such a catastrophe. However, every community has an actual capacity to meet some portion of victim's needs in a catastrophe. Should this figure be 1%, 5%, 10%, ... 50%, 75%, or perhaps 95%? This ominous foreboding was tested in less than four years when Hurricane Katrina created precisely these conditions.

Furthermore, who really decides what this capacity should be? Where is the centralized funding and decision-making that guarantees the community-wide versus individual institutional capacity to respond in a catastrophe? When communities rely on hospitals and hospitals cut costs, staff, and resources to insure profitability, or stop offering unprofitable services such as emergency rooms, maternity, neurology, or orthopedic services, communities lose the ability to handle both expected and unexpected demands for health care services. There are many factors that contribute to the inability of the health care system, as a whole, to respond to serious epidemics, biological, or meteorological events. Poor planning, inadequate resolve, competitive pressures, and profit motives all contribute, but insurance risk transfers to health care providers and organizations may underlie and exacerbate the effects of these other factors. As the work on Risk Induced Professional Caregiver Despair was being completed, during an unusually virulent influenza season and an inadequate supply of vaccine, there was mounting concern that the health care system, individual health care organizations and providers, may not be able to respond to anticipatable increases in demand for primary, secondary, and tertiary preventive health care services. The following sections explore the quantitative implications of transferring insurance risks to health care providers and organizations.

9 Probability Theory and Insurance

Insurance works for the same reason that statistical estimates become more accurate as the number of units in the sample increases. The Central Limit Theorem and the Law

of Large Numbers explain this effect and make it easy, with a few reasonable and conservative assumptions, to explain why insurance risk transfers being shifted away from insurers and to health care providers and organizations are inappropriate. Statisticians and insurers can accurately determine population parameters, such as average expenditures per policyholder for health services, because most measurements follow the normal distribution. The higher the number of units in the sample, the more accurate the estimate of the population average value, such as a loss ratio, will be (Borowiak, 2003; Hogg & Craig, 1984). This is the major reason that insurance works.

The second element that makes it possible to sell insurance at an attractive price for both the insurer and the policyholder is due to an effect described as the theory of utility (Bowers et al., 1986; Friedman & Savage, 1948; Markowitz, 1952; Mosteller & Noguee, 1951). The theory of utility suggests that the more units we have of any good, the less dearly we hold the last unit. If I have two cabbages I may not want to give either of them up. On the other hand, if I have many cabbages, I may be very happy to trade one cabbage for a roast beef sandwich. If I can find someone with many roast beef sandwiches who wants cabbage, we may each be able to acquire something we both value highly for something else we value less. Insurers can charge a premium low enough that policyholders are willing to pay it because the alternative for policyholders is to risk the loss of many dollars. At the same time, since the insurer has a very accurate estimate of the costs of providing insurance services, it can price its policies high enough to cover claims, expenses, expected and unexpected losses, and profits.

However, when an insurer redistributes the insurance policies it has written to many different health care providers or organizations, the mathematical bases that support insurance risk transfers reverses. The failure to characterize risk transfers to health care organizations and providers, as insurance risk transfers is a serious omission. These risk-transferring arrangements are only superficially different from insurance. Characterizing these risk transfers as "risk sharing," "profit sharing," "purchase of services," or describing them as intrinsically different than insurance based on the capability of providers to manage service demands as opposed, for example, to a health care provider's lower ability to manage pharmaceutical costs is a misunderstanding. The central premise of professional caregiver insurance risk is consistent with the shift to dollar-denominated market economies (Samuelson, 1964). The essential feature achieved through the introduction of currency is that goods and services have values in terms of the currency. Maintaining the premise that the costs and value of professional services to be provided in lieu of a prospective premium achieves considerable economy of thought in analyzing risk transfers to health care providers and organizations. Insurance protection has value. People pay more than their expected losses for insurance protection. The difference between the expected value of losses and the amount the insured pays the insurer, exclusive of non loss related expenses, is a risk premium, the value of the insurance protection to the insured.

The benefit of risk aggregation by insurers is lost when organizations that seem to be insurers pass insurance risks to health care providers and organizations. This can be

demonstrated very easily on the basis of statistical sampling theory. If we assume that an insurance company's losses per dollar of premium income are correctly modeled by a normal distribution with a mean value \$0.85 and a Standard Error of the Estimate of the Mean (se) of \$0.05, we can model what will happen when exactly 1/20th of these risks are passed to each of twenty health care providers or organizations.

Figure 1

**Compare National Insurer vs Two Risk Assuming Health Care Providers
0 Million Insureds - Small Risk Assuming HCPs Accept 10% & 1% Sha**

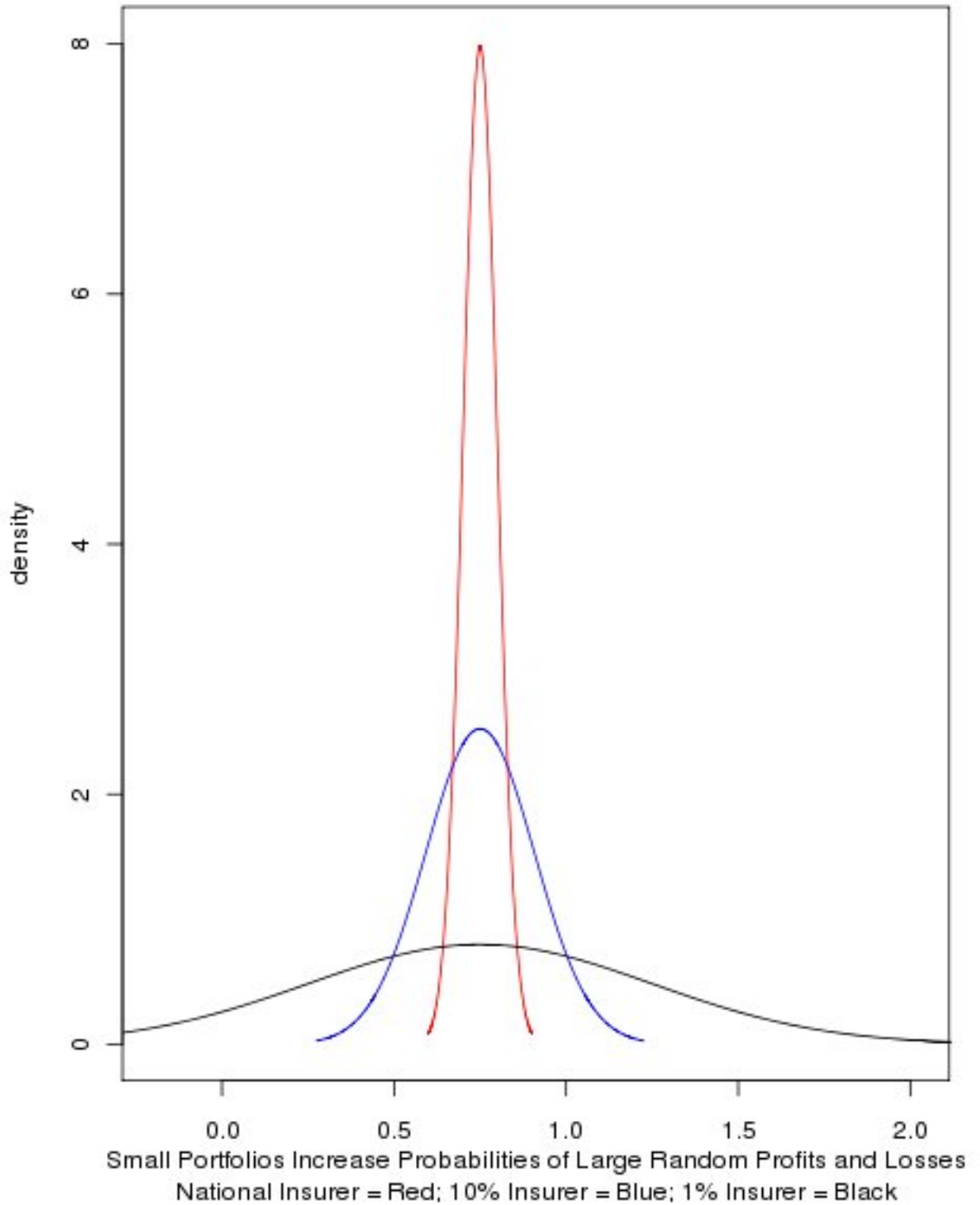


Figure 1 showed that smaller insurers and risk-assuming Providers have greater variability on loss ratios when they underwrite portions of a larger insurer's insurance policies. The following tables put some numbers on this to facilitate understanding. Once a capitulation agreement is negotiated, Providers are responsible for the financial consequences of illness, injury, diagnosis and treatment for their portfolio of risks. Many events effect the experiences of the Providers and their clients. A bad cold or flu season, an industrial accident, food poisoning, adverse weather, or environmental catastrophe may radically alter the demands on the Provider. Clearly, while these tables address higher than expected losses, the variation around the mean loss ratio can go either lower or higher. If the actual loss ratio falls below the expected loss ratio, the Insurer and the Provider make far greater profits than anticipated.

In addition, there is a more severe problem of conflagration risk due to the geographic concentration of risk portfolios ceded to a Provider who will generally be located closer to the population being served. The tables below do not address these issues specifically. These tables simply rely on the increased spread around the population loss ratio due to the smaller sample size of Provider portfolios and the known behavior of sampling from normal distributions.

Table 1 details the profitability of an insurer and a Provider when the insurer has two cushions against underwriting losses. The insurer has a 5% profit margin built into the rate it charges for insurance and a 5% risk premium for its insurance services. The Provider has a 5% profit margin but no risk premium. As we shall see below, the insurer cannot transfer an adequate risk premium to Providers because Providers require a larger risk premium than under risk retention for the insurer. The implication of this is that the insurer would have to transfer more risk premium to its contracting Providers than it could collect in a competitive, efficient insurance market when competing with risk retaining insurers.

This table does not take into account the smaller portfolio size, concentrating only on the fixed revenue the Provider gets and the impact of higher than predicted demand for health services. We shall address the profitability implications of smaller portfolio size below.

How Are Provider Profits Affected By Extreme Underwriting Losses
 Insurer Profit Margin of 5% and Provider Profit Margin of 5% Insurer Risk Premium 5%
 - No Risk Premium For Provider

Insurer Loss Ratio On Premiums of \$1,000 Per Insured	Profits of Insurer If Risks Are Retained and Insurer Has a 5% Profit Contingency + 5% Risk Premium Based on \$1,000 of Insurer Premium	Actual Provider Costs Assuming 5% Profit Margin Per \$1,000 On Revenues From Insurer Premium	Risk Assuming Health Care Provider Profits Per \$1,000 of Insurer Premium
0.7500	100.00	712.50	37.50
0.7600	940.00	722.00	28.00
0.7700	830.00	731.50	18.50
0.7800	720.00	741.00	9.00
0.7900	610.00	750.50	-0.50
0.8000	50.00	760.00	-10.00
0.8100	40.00	769.50	-19.50
0.8200	30.00	779.00	-29.00
0.8300	20.00	788.50	-38.50
0.8400	10.00	798.00	-48.00
0.8500	0.00	807.50	-57.50
0.8600	-10.00	817.00	-67.00
0.8700	-20.00	826.50	-76.50
0.8800	-30.00	836.00	-86.00
0.8900	-40.00	845.50	-95.50
0.9000	-50.00	855.00	-105.00

As we can see, the insurer has two hedges against underwriting losses, the profit margin and the risk premium. The insurer does not hit an underwriting loss until the loss ratio shifts by more than ten points from 0.75 to above 0.85. The Provider, however, only has the profit margin to cushion the impact of shifts in the loss ratio, losing profitability at a loss ratio just below 0.79. This greater vulnerability to fluctuations in the actual loss ratio is a consequence of risk assumption, no portfolio size. When portfolio size is added to the analysis the probability of underwriting losses for Providers rises dramatically.

How Are Provider Profits Affected By Extreme Underwriting Losses
Insurer Profit Margin of 5% and Provider Profit Margin of 10%

Insurer Loss Ratio On Premiums of \$1,000 Per Insured	Profits of Insurer If Risks Are Retained and Insurer Has a 5% Profit Contingency + 5% Risk Premium Based on \$1,000 of Insurer Premium	Actual Provider Costs Assuming 10% Profit Margin Per \$1,000 On Revenues From Insurer Premium	Risk Assuming Health Care Provider Profits Per \$1,000 of Insurer Premium
0.7500	100.00	675.00	75.00
0.7600	90.00	684.00	66.00
0.7700	80.00	693.00	57.00
0.7800	70.00	702.00	48.00
0.7900	60.00	711.00	39.00
0.8000	50.00	720.00	30.00
0.8100	40.00	729.00	21.00
0.8200	30.00	738.00	12.00
0.8300	20.00	747.00	3.00
0.8400	10.00	756.00	-6.00
0.8500	0.00	765.00	-15.00
0.8600	-10.00	774.00	-24.00
0.8700	-20.00	783.00	-33.00
0.8800	-30.00	792.00	-42.00
0.8900	-40.00	801.00	-51.00
0.9000	-50.00	810.00	-60.00

In Table 2 we assume a more generous profit margin for the Provider, 10% vs 5% in Table 1. As expected the insurer has the same results, but the provider has an additional hedge against underwriting losses. For every point rise in the loss ratio the providers net income declines by \$9.00. The Provider remains profitable until the loss ratio exceeds 0.83. Is a 10% profit margin realistic? Probably not. If the Provider's profit margin is this high there will likely be much competition for these contracts. However, it is easier to do this table than to have multiple readers working through such an example. Table 3 makes an even more generous and more unrealistic assumption that the Provider profit margin is 25%.

How Are Provider Profits Affected By Extreme Underwriting Losses
 Insurer Profit Margin of 5% and Provider Profit Margin of 25% Insurer Risk Premium
 5% - No Risk Premium For Provider

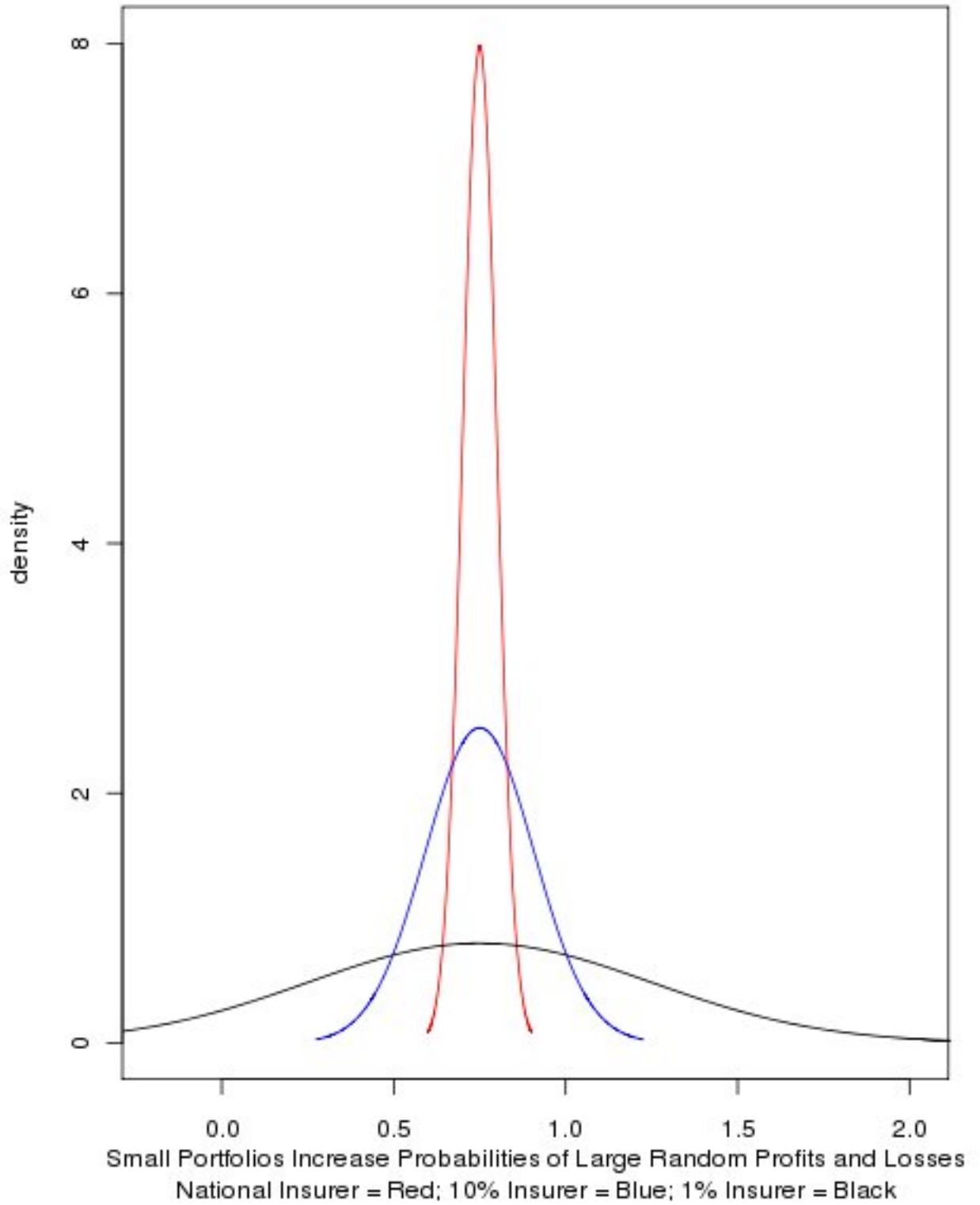
Insurer Loss Ratio On Premiums of \$1,000 Per Insured	Profits of Insurer If Risks Are Retained and Insurer Has a 5% Profit Contingency + 5% Risk Premium Based on \$1,000 of Insurer Premium	Actual Provider Costs Assuming 25% Profit Margin Per \$1,000 On Revenues From Insurer Premium	Risk Assuming Health Care Provider Profits Per \$1,000 of Insurer Premium
0.7500	100.00	562.50	187.50
0.7600	90.00	570.00	180.00
0.7700	80.00	577.50	172.50
0.7800	70.00	585.00	165.00
0.7900	60.00	592.50	157.50
0.8000	50.00	600.00	150.00
0.8100	40.00	607.50	142.50
0.8200	30.00	615.00	135.00
0.8300	20.00	622.50	127.50
0.8400	10.00	630.00	120.00
0.8500	0.00	637.50	112.50
0.8600	-10.00	645.00	105.00
0.8700	-20.00	652.50	97.50
0.8800	-30.00	660.00	90.00
0.8900	-40.00	667.50	82.50
0.9000	-50.00	675.00	75.00

In Table 3 we assume a far more generous profit margin for the Provider, 25% vs 5% in Table 1 and 10% in Table 2. The insurer has the same results, but this Provider has a substantial hedge against underwriting losses. For every point rise in the loss ratio the providers net income declines by \$17.50. The Provider would remain profitable until the loss ratio exceeds 0.95. Is a 25% profit margin realistic? No. If Provider profit margins were this high there would be massive competition for these contracts and the profit margins would re-correct in the marketplace.

10 Discussion of Figure 1

Figure 1

**Compare National Insurer vs Two Risk Assuming Health Care Provid
0 Million Insureds - Small Risk Assuming HCPs Accept 10% & 1% Sha**



As we look at figure 1 it is important to recognize the three normally distributed curves we are analyzing. The first curve we shall consider is the red curve. This is a normally distributed random variable reflecting the variation in loss ratios for a large insurer. We can think of this as a national health insurance program with 300,000,000 people insured or we might think of it as a large managed care or capitation using insurer with a far smaller number of insureds, say 100,000 subscribers.

The second curve is blue and we can think of this as either a smaller (10% as large), private insurer, choosing its insureds randomly from the pool of all 300,000,000 insureds, or as a capitated health care provider servicing a random selection of 10% of the insurer's (Red curve) portfolio. The black curve is then either a smaller (1% as large), private insurer, choosing its insureds randomly from the pool of all 300,000,000 insureds, or as a capitated health care provider servicing a random selection of 1% of the insurer's (Red curve) portfolio.

black and we can think of this as either a smaller, private insurer, choosing its insureds randomly from the pool of all 300,000,000 insureds, or as a capitated health care provider services to a random selection of 10% of the insurer's portfolio.

We should immediately note that the red curve is the highest and thinnest of the three, that the blue curve is in the middle on both dimensions, and that the black curve is the shortest and widest. It is this information that will drive the rest of our analysis. As a preview for where we we arrive, the broader the curves the more variability there are in the loss ratios that result from portfolios of the assigned size. Small insurers and capitated providers have far more variation in their actual loss ratios than large insurers and the entities that parse out sub-portfolios to health care providers. This difference in variability is a result of the portfolio size, and we ought not assume that either smaller insurers or risk assuming health care providers have any special ability to moderate this increased variability imposed by portfolio sizes.

This deserves more explanation. The implicit assumptions that have led to a thirty year long failure to correctly analyze and correct a fundamentally flawed health care finance system are the untenable assumptions that health care providers are absolutely inefficient and if only they could become more efficient, the health care finance system would work to their advantage and the advantage of their clients. To demonstrate that this reasoning is in error we need only make the counter-assumption. Rather than assuming health care providers are inefficient, we assume that both the insurer and health care providers are already as efficient as they can be over the short term. The insurer's charges for its policies are market and experience based. This means that the insurer operates efficiently and its rates for policies identical to those offered by other similarly sized insurers are the same

and that policy buyers know what they are buying. Likewise, we assume that health care providers clinical and financial operations are as efficient as they can be given the size of their portfolios. We will also assume that the profit goals for both the insurers and the health care providers operations are both market driven. In particular, we will assume that each entity seeks to achieve a 5% profit margin on its management of its portfolio.

Given these assumptions, what becomes immediately clear is that smaller insurers and risk-assuming health care providers cannot manage their insurance operations as well as larger insurers can. In fact, we can, with the few assumptions we have made, quantitatively evaluate the discrepancy between the abilities of large insurers and smaller risk-assuming health care providers.

Continuing with our analysis, we can use our customary information about the normal curve to note the following points. First, the expected loss ratios for all three curves are exactly the same. The loss ratios however have different meanings for the insurer and the risk-assuming health care providers. The loss ratio for the insurer is the portion of its premiums expended for claims on the health care policies it has issued. For the risk-assuming health care providers the loss ratio is the amount of money they receive from the insurer for providing the clinical services the insurer has bought.

It would be easy to just gloss over this but it is critical that we grasp the full significance of our insight. The large insurer is competing with other insurers in offering insurance. It cannot consistently pay all of its risk-assuming health care providers more than the expected value of the claims to be covered for the policies it has issued policies. If it did this it would lose money because it has only 75% of its premiums available.

For the risk assuming health care providers we must recognize that the payments they receive must be adequate to meet their operating costs for their clinical services, and the 5% profit they want to make. In short, the actual costs for providers are assumed to be 95% of the revenue they derive from the insurer, the balance being their profit on their total revenues.

We shall not pursue this in too much detail. We could parse this a dozen more ways. While more faithful, we would lose ourselves, among the branches and leaves of the forest, as analysts have for the last 30 years. We must sharpen our focus on the forest and the general pattern. This is where the powerful insights lie.

What we should immediately acknowledge is that if the loss costs assumed in the insurer's rate are achieved exactly by each party: The insurer and the risk-assuming health care providers, the insurer makes a profit of 5% and the health care providers make a profit of 5%. But, if the losses are higher or lower, the insurer and the providers will either make greater profits or suffer more severe losses. We can quantify the impact of changes in the loss ratios and we shall do so shortly, but before we do that we should also note that the insurer may achieve its expected loss ratio while the health care providers may not. Half the health care providers may experience higher costs than anticipated in the insurers loss costs, while the other half may experience lower costs. The net effect would be neutral for the insurer but potentially very severe for some of the individual health care providers.

As our next step in trying to understand the impact of insurance risk assumption by health care providers, we shall consider the impact of five different levels of actual losses on the insurer and on the providers. First, we should note that we only need to discuss one side of the normal curve. We shall concentrate on the situation that exists as losses rise above 0.75 and simply note that there are symmetric effects below except that when losses are below the target level, the insurer and the providers will, in general, reap larger profits. Losses will vary for many reasons. New technologies that speed up diagnosis of expensive conditions may lead to expensive treatments that occur earlier than they otherwise would. A severe flu season will certainly affect health costs nationwide. Environmental conditions such as natural disasters may increase or reduce costs. Some clients will suffer injury and disease in natural disasters driving costs up. Other clients may die during a natural disaster thereby incurring no additional costs. We shall not try to resolve this, assuming that the cause of shifts in the loss ratio are not as significant as the difference in financial effects on insurers and health care providers.

So, let us analyze the impact of a shift of 1, 2, 3, . . . , 15 points in the loss ratio the insurer will report when it prepares its rate filing for the next premium period. The insurer's loss ratio will incorporate the customary profit margin for the health care providers but the contract for the current year do not guarantee provider profits. The rates for the current year were already fixed when the current contract period started.

We should emphasize at the moment that such a shift will be reflected in future periods by rate adjustments. The insurer will seek approval for rate increases that will allow it to reach a target loss ratio of 0.75. As costs rise, health care providers will seek, during future negotiations, larger capitation payments to assure them that their operations will be profitable. However, over the short term, the rates of reimbursement in capitation contracts are set, and they will not, in general, increase just because current year losses are higher than anticipated. If the health care providers were being paid more when their costs

rise, there would be absolutely no incentive for insurers to enter such contracts. Capitation contracts, at their core, are desirable for insurers because they limit loss exposure, supplanting the free-wheeling blank checks of the indemnity insurance system.

We assume that the actual costs, when fully analyzed at the end of the calendar year, are 0.76, 0.777, 0.78, . . . , 0.90 per dollar of premiums earned by the insurer during that calendar year. The amount that all the providers combined, actually have available to cover their costs is 95% of 75% of the insurers premium revenues, or \$0.7125 per premium dollar if we assume that the profit margin is 5%.

Likewise, the amount that all the providers combined, actually have available to cover their contract costs is 100% of their premium derived 90% of 75% of the insurers premium revenues, or \$0.675 per premium dollar if we assume that the profit margin is 10%. Last, the amount that the providers combined, actually have available to cover their contract costs is 100% of their premium derived 75% of 75% of the insurers premium revenues, or \$0.675 per premium dollar if we assume that the profit margin is 25%.

If the target loss ratio is exactly 0.75, the providers make a profit of 5, 10, or 25%. But if the losses are above 0.75, the providers profits will fall, eventually becoming losses if the loss ratio is high enough.

This is so because the profit contingency for the health care provider is fixed, in advance, at 5% of 75% of the insurer's premium revenues. We can now In short, If the actual cost ,, and earlier, expensive, the as need to understand losslevels of variability in losses and

The standard error rather than the variance of the distribution is used in this description. The variance remains stable for a population while the standard error is a function of sample size. When we discuss the population of insureds we want to concentrate on samples from the entire universe of insureds. Each insurer selects a sample from the population of all possible insureds every time it writes insurance policies. If the competition and regulatory environment is well managed, the selections are random samples from the population of all possible insureds. Based on the size of the sample, we can calculate the standard error of different sample sizes. Two different sized samples n_1 and n_2 will have standard errors that follow a specific ratio according to the square root of the ratio of the sample sizes. If the standard error ($s_{e_N} = \frac{\sigma^2}{\sqrt{N}}$) of n_1 is $\frac{\sigma^2}{\sqrt{N_1}}$ and the standard error of n_2 is $\frac{\sigma^2}{\sqrt{N_2}}$, the standard error for the second sample, n_2 , is 10 times larger than the standard error for the first sample, ie,

$$\frac{\sigma^2}{\sqrt{N_2}} = 10 \times \frac{\sigma^2}{\sqrt{N_1}}. \quad (1)$$

The most important thing to grasp is that the relative size of the se changes with the size of the sample. In particular, Table 1 presents the probability that an individual health care provider or organization will experience any pre-set level of loss if an insurer passes on the full risks, global capitation, associated with policies it randomly assigns to the health care provider. Table 1 also shows the probability of a loss as far from average for the insurer and the relative disadvantage of the health care providers and organizations in the form of a relative risk of a higher than expected loss compared with the original insurer.

Several points are important. The value of the mean is not as important as the value of the se because the premium charged is determined by the expected losses for the population insured. If we assume that the premium is adequate, on average, to cover the losses, the actual experiences of individual health care providers will vary around the true population average in predictable ways. Second, insurers base their estimates of losses per dollar on historical averages, after adjustment for future cost trends (Borowiak, 2003; Hogg & Craig, 1984; Salzman, 1984). Trends in health care costs may mean higher or lower future service provision costs than anticipated, during the contract. Third, the ability of a well operated insurer to withstand unusually high losses is higher than a health care provider or organization that accepts sub-portfolios of insureds from the insurer, because of regulations requiring the insurer to maintain adequate resources to meet both anticipated and unanticipated past and future obligations. The most critical point however, is that the data in Table 1 are based solely on the differences in size of the portfolios transferred from insurers to health care providers and organizations, holding true regardless of the specific values of the mean and standard error.

11 Implications of Professional Caregiver Insurance Risk

This researcher's explicit characterization of common health care finance mechanisms as insurance risk transfers is important because it allows a dispassionate analysis of different funding mechanisms. In general, funding mechanisms that aggregate small numbers of clients are inefficient compared with funding mechanisms that aggregate the experiences of large numbers of otherwise identically distributed health care loss exposures. This runs exactly counter to many current proposals for reforming health insurance, which tend to focus on encouraging individually funded health care accounts and other mechanisms that segregate risks into small cohorts. If every American were to adequately fund an individual health care account, they would have to do so by diverting more money to individual accounts every year than by purchasing health insurance, particularly if the costs of health insurance are evenly spread across all citizens. This is confusing so it deserves further explanation.

Let's discuss a particular easy assumption. We will assume that every person has a 1/1000 chance of having a loss of 1,000 during the next year. 999 people will have no loss. 1

person will lose 1,000. The expected loss per person is \$1. We assume that an insurer is available who will write insurance policies for \$1.10 such that the person who experiences the loss will get \$1,000. Every person has to pay \$1.10 to be fully covered against the rare but high losses they face. In this situation, every person is protected for the full amount of his or her possible loss for \$1.10. This is a very easy situation to grasp. Under this model there is only one loss per 1,000 insureds per year. Nobody knows, in advance, whether they will be the unlucky person, but they do know that if they are, they will be reimbursed for their loss. Suppose no insurance is available. In order to be protected from the loss, each of the 1,000 potential insureds would have to set aside \$1,000. If they fail to do this, they will not be able to cover the full amount of their possible loss. In fact, no amount of reserve assets less than \$1,000 will work. If the only way to be restored to the condition they were in prior to the loss is to have \$1,000 any amount less, even \$999.99 will be inadequate. To achieve the same degree of security, peace of mind, and protection from the financial consequences of loss, each potential insured would have to set aside \$1,000.

From a macro-economic perspective this is wasteful and inefficient compared to insurance. With insurance, the consumers can all go out and buy a TV that costs \$998.90, invest that money in a new car, or perhaps spend it on additional, elective, health maintenance services, devoting the other \$1.10 to their insurance purchase. The entire economy benefits by not having the \$998.90 set aside. This means higher employment in the economy as TV, auto manufacturers, of health maintenance suppliers, wholesalers, and retailers benefit from the increased economic activity. If all 1,000 potential insureds have to set aside \$1,000 to protect themselves, the TV, auto, and health maintenance industries will have fewer sales, some production and service operations may be forced to close down, and others will operate less efficiently than they might with higher volumes of activity. Individually funded health care or retirement accounts are all inefficient mechanisms compared to risk aggregating through insurance.

There are similar problems with individual health savings accounts (HSAs) as there are with health insurance. Many people cannot afford to fund the HSAs. Many people cannot afford health insurance. Not surprisingly, it is the same group of people in both cases. The poor, the unemployed, welfare clients, the elderly, and most importantly, people with chronic health problems are rarely able to finance their own health care needs. Neither the free market insurance model nor HSAs meet the needs of these people, leaving them to government sponsored programs, such as Medicaid, Medicare, charity care, bankruptcy, or delayed, deferred, denied, or inadequate care.

As well, communities tend to be stratified by income, race, illness status, and some communities carry a double burden: high numbers of high intensity, health utilization, and limited resources to fund these services. The closer the locus of health care cost risk management moves to individuals, the more difficult it is to maintain a functional health care system because individuals rarely have the resources available to meet unexpected costs.

12 Insurance Risk Transfer Impacts on Health Care Providers

Trying to fund uncertain costs as insurance risk transfers permeate through health care organizations, different operating units may experience profoundly different effects (Cox 2001a, 2002c). One unit may have far lower costs than the revenues available while another unit may have costs that dramatically exceed the resources it has available. Insurance companies can shift funds from one operating unit to another quite easily merely by allocating additional resources from one bank account to another. Hospitals and nursing units will only rarely be able to match the efficiency of insurer financial transfers with their ability to shift staff, equipment, and supplies in time to meet unexpected demands during a single nursing shift which is when the needs of clients will either be met or not met.

Much information suggests that professional caregivers, and in particular, RNs, are very dissatisfied with their roles, status, and perquisites (Aiken, Clarke, Sloane, Sochalski et al., 2001; Boyle, Grap, Younger, & Thornby, 1991). Manifestations of this dissatisfaction are documented in surveys of RNs, and research on substance abuse and suicide among nurses. (Blythe et al., 2001; Buxton 1985; Clark 1988b; Crowley 1984; Feskanich, Hastrup, Marshall, Colditz, Stampfer et al., 2002; Finke, Hickman, & Miller, 1993, Finke, Williams, & Stanley, 1996; Hawton & Vislisel, 1999; Hawton, Simkin, Rue, Haw, Barbour et al., 2002; Lillibridge, Cox, & Cross, 2002; Molassiotos 1996; Payne, 2001; Poissonnet & Veron, 2000; Laschinger 1997).

Nursing Units, Budgets, and Intra-organizational Risk Transfers. RNs usually work in environments with fixed operating budgets, the impact of which is similar to a capitation agreement. A fixed budget for a nursing unit represents an attempt to meet the highly variable demand for nursing services with a budget that is, on average, adequate (Cox, 2002c). However, the demands on a nursing unit may vary dramatically by time within shift, shift within day, day within week, unit, budget period, and by unit within hospital. Efforts to substitute average costs for highly variable service demands may leave some nurses and nursing units inadequately resourced at any given time. While insulated from the direct, personal, financial consequences of insurance risk transfers, RNs may experience unpleasant consequences of risk transfers as the effects filter through their worksites. RNs may be unable to find the medications, supplies, or a physician to order a treatment their client needs in a timely manner. RNs may have to work unexpected overtime shifts, or there may be fewer RNs and paraprofessionals to handle both routine and unexpected client needs. RNs risk their licenses to practice or may be subject to malpractice litigation if they work in environments that are later determined to have violated norms and standards for the profession. RNs may experience emotional trauma, ethical conflict, or financial jeopardy when their clients suffer because of inadequate material and non-material resources that result in unmet standards of care. RNs who work in consistently under-resourced environments may encounter high levels of stress and other negative effects or may simply feel unfulfilled.

The level of funding and the predictability of adequate funding influence the way nursing units and nurses operate and the experiences nurses have in health care organizations. The severity of the current situation may vary by institution and even units within an institution. Some organizations may thrive when they participate in risk transfers while other organizations do not. Even within a single organization, some units could be well funded while the adjacent unit is under-funded. Depending on reimbursement opportunities, some organizations may concentrate their attention on profitable services, de-emphasizing, withdrawing support from, or shutting down unprofitable operations. General medical-surgical care units in inner city, urban areas may have high numbers of clients with inadequate personal resources and insurance to meet their expenses. Another unit, coronary care, might only admit and treat well-insured clients. The hospital could conceivably shift the additional revenues from one unit to another unit with inadequate revenues, the same way an insurer efficiently shifts assets from one line of business to another. However, this may not occur in practice. Cost-shifting from one unit to another, less profitable unit may be difficult to implement since such decisions are political as well as economic decisions. The ability of health care providers and organizations to fluidly transfer assets from profitable units to unprofitable units is yet to be proved.

13 Participants

Eight RNs, self-identifying as experiencing risk induced professional caregiver despair who were working in acute care hospitals in the Middle Atlantic region, participated in this unitary appreciative inquiry into risk induced professional caregiver despair. Their employing organizations either had participated in, or were currently participating in, many financial relationships with insurers, state, and federal government programs that meet the definition of average cost based reimbursement plans and professional caregiver insurance risk. Each of the RNs in the study identified constraints they felt resulted from these financial relationships, which they believed affected their employers, their work-sites, and them, as caregivers. These risk transfer mechanisms are common in health care organizations such as hospitals, nursing homes, or group health care practices. Specific examples of risk transfer mechanisms include: Diagnosis Related Groups (DRGs), Medicaid and Medicare payment limitations, and other prospective payment contracts with policy aggregators (see definitions below). In addition, intra-organizational risk transfers arise in the prospective budgeting of nursing units. This is especially likely in situations where organizations exert pressure to remain within prospective budgets rather than using prospective budgeting as flexible guides in decision-making and resource allocation.

14 Visions of Risk Induced Professional Caregiver Despair

Each if the nurses had poignant stories about their experiences of risk induced professional caregiver despair. However, some of the nurses' stories were particularly helpful in understanding the impact of professional caregiver insurance risk at the level of the individual nurse-client level. The following two appreciative profiles are particularly rich in practical and aesthetic detail.

14.1 Carol

Carol was an operating room (OR) nurse. She had over twenty years of experience in OR settings. She was married with two children and her husband also worked in health care services. She invited the researcher to her home in a nice, quiet, residential setting. The house was a beautiful oasis of calm despite the fact that they were in the middle of a renovation on the kitchen. She shared information that was quite unexpected by the researcher. The researcher's a priori expectation was that the OR would be immune from many of the effects of financial risk transfers because of the potential severity of the impact on the quality of care and the inherent dangers of surgery. Instead, Carol revealed that this was not the case and that resource shortages, poor staffing, and deficient equipment and supplies affected employees and clients alike. Carol's revelation that a new, multi-facility contract for acquisition of supplies from a company several hours distant was having a negative effect on the quality and availability of supplies contributed heavily to this researcher's development of the theory of professional caregiver insurance risk and nursing capacity.

14.2 Gloria

Gloria was educated in oncology and transplant services. She was married with two children, lived in a nice residential neighborhood several miles from the hospital she described. She had an associate degree in nursing and had been a registered nurse for more than ten years. Gloria chose nursing to develop a stable, secure income after her divorce. Potentially thwarted in her efforts to enter nursing school, she asked permission to take an extremely difficult pre-entry requirement for which she did not have appropriate preparation. The likelihood of completing was very low. An administrator told her that if she passed the course he would admit her to the program without the other pre-requisites. She earned an A. Gloria's story continues to be one of the most compelling stories related by any participant, and among the most vivid and memorable experiences of the

researcher. Gloria, too, contributed important details during her interview that profoundly influenced the researcher's work on professional caregiver insurance risk and risk induced professional caregiver despair.

15 Carol's Story

operating room is really costly... supplies...
we exist on supplies we use to do the surgery
operating room... negotiate their own contracts... different companies...
different types of supplies
what has changed is, it's not our surgery, it's parent corporation
big contract... one company... lower rates.
what we're finding now is... inferior quality products coming in
no recourse... not something the OR... can change
go through parent... it's very hard... it's dollars and cents
get the most for their dollar... best contract... larger bulk... lower rate
drapes... take them off... strikethrough... blood has soaked through
onto the patient
asepsis... you can't let things soak through... germs...
dangerous to the patient... danger to me
I take off a gown and I have strikethrough here on my arms
write up Incident Reports... complain... big frustration and fear
have your Director come in... look at the drapes... the strikethrough
"Oh well, did you have it on upside down?"
I've only been doing this for 20+ years. That's a big frustration...
that's difficult.
medical costs... just escalating out the ceiling...
something needed to be done... bring them back...
But I think the pendulum has swung too far in the opposite direction
run out of real basic things, prep kits... they haven't ordered enough
some that are disposable... meant to be one time use, scissors, grafts...
one time use, disposable instruments... recycled
recycled, re-sterilized, repackaged, sent back... to use again...
don't work... scissors... don't cut
running around... trying to find a new package of scissors... we didn't have any open up
a
kit... gastric by-pass...
don't know how much it costs...
to get one pair of new scissors out for him
grafting instruments, they're not holding tissue
laparoscopic... release button... makes it lock... makes it unlock...
see whether its containing tissue or not

The button broke off
things are just not there... don't have availability of things that you used to...
We even have the times... had to send a courier to another hospital to get one...
one or two instances... in the middle of things... not good for the patient Prolonging
their OR
time, their anesthesia time
big frustration
over the past few years working in the OR..
have absolutely no control over what's coming in...
the supplies... what is stocked
I'm having trouble with my despair. You want to talk about my despair
lack of control
I'm finding in my nursing practice all over... all around in the operating room
the feeling of lack of control over what I can and cannot do
the doctor's right there... in the middle of surgery... wants something...
you haven't got it
You're right there, you're the one he's gonna vent on
more friction... Why can't I have this? Why isn't it working?
You have to use what supplies and materials they have
I have no choice. I have no choice as to what I use
don't know whether it's... going back to school... getting older, being so long...
But I'm starting to feel that I want to go beyond what I'm doing now
You feel like your banging head up against a brick wall
this has been set and this is what's dictated...
Why isn't it working?
so strapped for people... to staff... people say there just aren't any OR nurses
people aren't going into nursing... best and brightest aren't doing floor nursing
There are a lot of unhappy people right now in the OR
you would think someone... would get a clue... treat us a little better...
more respect. And it doesn't happen
they keep adding rooms on
pushing my patients from recovery... pushing my instruments to wash them
Charge Nurse would tell me, "Oh, go to room, they're ready for you there"
I still do handle instruments... it's just another dollars and cents issue
you can hire a tech for a lot less than a nurse
We're all dealing with turn over times...
the time in between when one patient leaves and the next one comes
get our patients on to the stretcher... take them to the recovery room
ship 'em in, and ship em out'
we supposedly have a team of attendants to come in and clean the room
they do a pretty decent job...
A lot of times... they're talking, leaning on a box, telling jokes...
listening to... music you can't get anybody... I need help...
check my patient into the Recovery Room, collect my OR record... Sign it

Sign in the specimen. Put in the implant sheets. . . .
do an implant. . . make a separate sheet.
a lot of times, they'd be halfway through cleaning the room or. . . nobody there
you have to go turn over your own room
turn over your own room
The computers for all the OR rooms and the front desk
connected with the two printers in the Recovery Room
printer won't work, it malfunctions. . . can't get your oral record back up to sign
they try to get it fixed. . . like going to fix your car
You take it in to get it fixed and. . . something else is wrong
fix the printer and a week later, it's doing the same thing
Or it spit out papers, just spit out paper
you have a ream of paper the thing is just spitting out
you try to put in more paper
and it won't stop
two other nurses running around looking for supplies. . . I needed
weren't on the cart
trying to open up this room. . . big case. . . get everything counted
I never delayed the room. . . never asked anesthesia not to bring them back
we were sitting there waiting for the doctor
But he was upset because his room started late
Well, you know get a grip!
another thing that has changed. . . last six months. . .
used to get our case cart; the rolling carts. . . filled with all the sterile supplies
the packs, the towels, the basin, everything
used to come from Medical Supply. . . right here in Richmond
they would deliver the case carts to the OR
either evenings or nights shift. . . have a list of instruments. . . to be picked
attendants are supposed to have a list of equipment. . . microscopes, headlights. . .
they should be brought to every room. . .
in a perfect world, everything would be there when you walked in
because of Parent Corp. . . contract dropped. . . gone to Other state
So, they drive down the truck every day
make do as best you can. . . pull from what you have there in the hospital
run and borrow things. . . make do with something else
it's the doctor's decision. . . make do with something else or not
woman was supposed to have a breast implant. . . literally asleep on the table
doctor came in. . . his office. . . ordered the wrong size implants
brand we did not carry. . . why they were ordering. . . woke her and rescheduled
A bad day is. . . "The Scream" . . . or, I guess it's a take off. . . "Home Alone"
"I've seen better days. I've seen better days and then the bottom falls out."
you think, you just think things are bad now. . .
Insurance stinks. . . I don't carry that insurance. . . I have my husband's insurance
not as good as it used to be, but it's better than a lot

it's just. . . we don't even have an HMO we have Preferred Provider
can only go to certain doctors. . . always have to go to your Primary Care Doctor
you want to see a specialist, you've got to get a referral
they're only going to pay X amount
have a drug card, thank goodness. . . deductible goes up every time you go back
Days off are another thing. . . used to give you X amount of vacation days
X amount of holidays
keep your sick days separate
now they've combined it all...
even worked. . . where they combined the sick days too. . . paid time off
I can't tell you why, but once they went to the paid time off,
you never seemed to have enough time for anything
It always seemed like it dropped
Frustration. . . anxiety. . . out and out fear about the quality of nursing...
Not being able to provide things for my patients
not being able to. . . protect my patients... not being adequately protected myself
I understand that my director is management, and she has to. . .
she's getting it from both ends. She sees our frustration.
People are trying to get things as cheaply as possible
that's not always what needs to be done
nothing changes even though you try to go up the ladder..
show people what's wrong and what's happening
You're a little bitty cog in a great big wheel
We always hear from the charge nurses: "they" are looking at turnover times
You call out two or three times to get people come move the patient
come clean the room
they're always looking at your turnover time
In spite of what I said, for the most part, I enjoy very much what I do.
I like where I work too
I think overall, for a hospital, for an OR, I feel I've been treated pretty well
have enjoyed what I'm able to do
It's been very therapeutic
It does help to talk and to vent about your frustrations with someone
sometimes it just really does help you. . .
to get these things off your chest
verbalize them

16 Gloria's Story

I felt like so much pressure.
It had changed so drastically in five years

Average. . . two patients per nurse. Occasionally you would pick up a third an in-patient
 and out-patient... when they were coming for their initial consult, and... we would take
 care of them, all the way
 huge consulting group come in and looked...
 at ways of cutting...
 corners...
 decided that our nurse patient-ratios weren't...
 as critical as some
 So our nurse patient-ratio started to go up, and up, and up
 Five years ago. . . two, maybe three patients. . . now four and five patients.
 Supplemental staffing. . . more like a nursing assistant...
 vital signs...
 linens. . .
 can't give Treatment Protocol X unless you've been trained. . .
 extra RN. . .
 but she's not carrying her weight
 nurse manager came. . . think of ways...
 start taking on four and five patients
 I felt like so much pressure
 Insurance. . . Alpha,
 they pay lump sum. . .
 Beta pay per day
 if they're another day, oh let them stay on. . .
 the insurance company would no longer pay for his in-patient hospitalization...
 we were, we literally thought that we were kicking them out...
 that was such a hard thing for us to do as nurses. . .
 we don't think they're ready
 I never thought I'd have to deal with insurance companies...
 you have to notify the insurance company,
 are you willing to...
 pay. . .
 fought round and round...
 had the space. . .
 they didn't want to pay. . .
 first time I became involved. . .
 it was like
 I don't think they actually realized what amount of care he was going to be needing
 It was a learn by day experience. . .
 letters need to be written
 do you really understand, would you like me to read you the definition. . .
 talking to a non-medical person
 They didn't care. . .
 reading to you what their coverage was
 what they were, and what they weren't going to cover

that was difficult. . .
 working with the insurance
 I felt like so much pressure
*Tc So, you know, there's always the question, like to what degree are nurses in a setting,
 aware of the financial constraints on care with their patients? And it sounds like what
 you are saying is that you were very, very aware*
 Yes, very aware, very aware
 If you worked overtime your nursing supervisor was written up
 you were written up
 Your nurse manager was written up, and so were you
 the nurse manager would say. . . "just justify why you were staying over."
 Not only had to change them, bathe them, change their beds
 I felt like so much pressure
 I remember. . .
 staff meeting. . .
 talking about 4 or 5 patients...
 been told. . .
 have to take care of four patients. . .
 "What can I do to take you away from the patients. . .
 so that you can charge more?" . . .
 we said, "You're taking us away from our patients...
 What do you mean you want to figure out ways to take us away from bedside nursing?
 That is nursing."
*nursing manager suggested that secretaries and unlicensed assistive personnel can do
 bedside care. . .*
 telling things that, you know, the secretaries and the UAPs can do. . .
 these patients,
 they don't want secretaries.
 They don't want UAPs.
 Did I clock out on time?
 when you are in charge. . . you get the same patient load,
 maybe. . . one patient less. . .
 you handle the call-ins,
 you handle any problems. . . got a call-in for tomorrow morning. . .
 trying to find coverage for that
 three people calling, asking questions about their medications. . .
 go pull charts from the clinic and care for my patients.
 our unit, used to be stocked every day
 one time we had a guy in here who. . .
 could not pass any water whatsoever. . .
 he probably had a clot. . .
 the patient was in there, in pain, hurting. . .
 we don't have the supplies to put a Foley in
 to get the fluids running, to relieve him

I'm the nurse, and she's the nurse manager. But, the person that orders not a nurse...
this clerical person and the nurse manager determined
without even consulting the nurses
and getting the nurse's opinion on it...
to configure all our supply carts
the nurses were... not at the table
we were saying if they're not going to re-stock for three days
we need larger quantities
the patient was in pain, hurting because we don't have the supplies
I remember...
we ran out of Betadyne swabs...
a lot of patients had central line dressings
per protocol those dressings are changed every three days
there was a little package of Betadyne and it had three large like Q-tips...
we ran out of those...
they started dispensing the actual bottle of Betadyne...
we would order a bunch of Q-tips...
we ran out of Q-tips
They were on back order...
we improvised.
We got ...4X4s and the 2X2s and opened them up ...
sparingly
because we might run out of these 4X4s ...
I left before we ever actually got those Betadyne swabs in ...
I wonder if we ever did ...
we're going to order everything out of city 200+ miles away...
only order on Tuesdays and Fridays ...
shipments only come in on Tuesdays and Fridays
we're supposed to save 10% ...
by Monday you're almost out of everything
Bye...
Some agency nurses come in and tell you
days they will and will not work,
which shifts they will and will not work...
I would look at the days...
there were certain individuals you didn't want to work with...
because they weren't...
team players...
hate working night shifts...
nurse manager would know that day RN was going to call-out...
beautiful workschedules ...
certain people ...
called-out frequently...
didn't want to offend them ...

would put us into another nursing shortage . . .
 you feel like there's a warm body there
 but not necessarily a team player
 sometimes, it was like, is anything really looked at?
 Is my work, is my extra work, my extra burden
 Is anything ever really looked at . . . and appreciated?
 I remember that day that I keep going back . . .
 nurse manager did go get me...
 a specialty coffee.
 one time... in a storm... three of us... all worked on unit... and we had a storm...
 we got to work . . .
 the supervisor called and said, "Everybody get to work?" . . .
 "Yeah," and she was like
 "Ok, thank you, bye."
 dock thirty minutes . . . for lunch,
 whether I actually got that
 sometimes it upset me . . .
 no meal taken . . .
 came down from management
 now you . . . *Tc New requirement , you have to take meals.*
 Yeah, you have to take your meal
 sometimes I'm like, but you don't understand, but you know, that's a whole. But, uh . . .
 Tc You have to sign off on taking your meal. . . .
 right.
 it was just easier to take on the burden and just do it . . .
 less resistance, less frustration.
 You just did it, and you went on
 I like getting in there and being a patient advocate . . .
 I don't care if you've got a PhD...
 are you really listening to your patients?
 You got a 72-year-old woman that wants to be at home with her children, grandchildren,
 great-grand children . . .
 you keep wanting her to do chemo?
 She doesn't want to feel like crap any more, *raised voice*
 DID YOU HEAR?
 Then go listen to her again . . .
 I also think that there are some people that shouldn't be in nursing...
 They're so not a compassionate person...
 And you've got to be
 health care . . .
 its only gonna get worse
 It's gonna drive good people out of nursing, or away from bedside nursing
 patients are . . . more critically ill.
 You need those good nurses in there

don't feel the support,
 not only of the staff but definitely of our management...
 one time when my nurse manager...
 did come in and I remember thanking her
 so outdated in her clinical skills,
 the only thing she can do is
 sit and answer the phone
 she said, "I know."
 I at least appreciate her coming in and acknowledging that
 "... I can't do anything but answer the phone, but I'm here so that at least maybe I can
 take that off of you."
 I absolutely love nursing. would I ever change my profession? No!
 Do I get on these little, s'cuse my expression, bitch sessions. Yeah
 I've been back to former unit
 I love the in-patient setting...
 I feel bad sometimes when I say I like that adrenaline rush ...
 Its just part of me, its in me
 I actually love gettin' up and goin' to work every day ...
 came home exhausted...
 I always was able to look back and say, I made a difference
 Even though you gave me 4,000 pounds worth of crap...
 I made a difference ...
 in my patient's lives
 They're pulling back on how many nurses that they're dumping that load on
 I think its driving ... me out of the hospital but I will
 I'll go back to that probably
 I think I just needed a break, like right now ...

17 Risk-Induced Professional Caregiver Despair: Nursing at the Crossroad of Finance and Caring

17.1 Learning Objectives

1. Describe and discuss risk-induced professional caregiver despair Learning Objective
2. Give two examples of how the transfer of insurance risk to health care providers affects the quality and quantity of care provided

Professional Caregiver Insurance Risk (PCIR) describes the impact on nurses and other healthcare professionals of capitation contracts, prospective payment plans, and other

insurance risk transfers to healthcare providers. Cowling's Unitary Appreciative Inquiry (UAI) was used in collaboration with eight registered nurses, enabling them to draw from their experiences in dealing with risk induced professional caregiver despair. Using unstructured interviews and imposing no time limits facilitated this collaboration and allowed participants to share their experiences, perceptions, and expressions until they felt the experience was complete. Several participants engaged in intense collaborations to shape their stories into aesthetically pleasing narratives. Cowling suggests that UAI, a Rogerian praxis method counters the tendency toward diagnosis, behavioral objectification, time-limited, and inappropriately directed nursing care by renewing our focus on wholeness. These collaborations demonstrated the utility of UAI as a research, practice, and theory generative nursing method, by generating rich detail on the experiences of registered nurses who stand, often alone, at the crossroads of insurance claims management and clinical care, as insurance risk transfers impact the nursing unit.

Nurses are increasingly facing situations where insurance claims management functions have shifted to the bedside with doctors, practitioners, and bedside caregivers making combinations of clinical and financial decisions when their employers are financial interesees in the outcomes. These stories of the experiences of registered nurses facing caregiving situations with inadequate resources, staff, and equipment, are visions of an avoidable future, if registered nurses and other healthcare professionals press back against the tide of the intrusion of financial eligibility for services.

This researcher, a psychiatric nurse, is developing new strategies and tools for detecting, quantifying, and correcting inadequate 'nursing capacity' resulting from cost-cutting and failures to adequately staff and supply nursing units in order to manage the insurance risks that healthcare providers are increasingly assuming.

18 Definitions

The following terms are used throughout this document, and are defined here for the convenience of the reader.

Adverse selection: Any situation in which a particular cohort of beneficiaries, either through poor randomization or self-selection, includes higher numbers of high-risk beneficiaries than is true for the general population of insureds. Adverse selection may result in increased use of health care services and higher expenses than assumed in the premiums for the coverage.

Admission certification: Utilization reviews of the medical necessity of client admissions to health care organizations designed to maintain standards for when clients require hospital and to reduce inappropriate or unnecessary hospitalizations. This review

may include the assignment of anticipated lengths of stay and may be conducted before or soon after admission.

Average Cost Based Reimbursement Plan: An average cost based reimbursement plan is any financial relationship that substitutes a fixed, prospective payment for the unknown costs of providing future services. One example is a capitation contract where a health care organization agrees to provide care for a cohort of clients for a fixed, prospective, monthly payment. However, the customary methods of funding nursing units also involve a fixed, prospective budget for equipment, material supplies, and staff despite the fact that the actual resources needed may vary greatly depending on the client load, client diagnoses, season, day of the week, shift, and staffing patterns. The less flexible the budgeting pattern, the more closely such arrangements approach insurance risk transfers. While there may be no direct financial impact on nurses or nursing managers, the indirect effect may be to constrain resources and make the responsibility for managing the variable demands for service and supplies increasingly difficult for nurses and nursing managers at the unit, staff, and client level. Between these two extremes lie many other forms of financial risk transfers. Medicaid and Medicare payment limitations, Diagnosis Related Groups (DRG) financing of health care services, and other contractual relationships between insurers and health care providers may also represent insurance risk transfers. Depending on the underlying variability in demand for health services of the specific DRG category, the unique circumstances of the individual client, the adequacy of the reimbursement rate for that particular unit or hospital, and the ability of the health care organization to manage the service and financial risks involved, the risk transfer may or may not be actuarially sound. However, since the relative size of the portfolios transferred by insurers to providers tends to be small, many of the benefits of risk aggregation are lost and the prospective payments may prove to be inadequate due to fluctuations in cost at the provider level. Hence, although some providers may operate profitably during short periods, the long-term effect may be unprofitable operations for many health care providers.

Capitation: Prospective payments for health services in which health care providers or organizations receive a fixed, per capita amount to cover each client for a specified period of time, regardless of the volume of service required.

Case management: This may involve managing care for serious conditions that will require advanced levels of treatment or it may be the review of all care being provided or limitations on care that will be provided. Case managers may handle a small number of cases and assist clients to get the most effective and efficient care or they may impair the ability of clients to get responsive and individually appropriate care.

Certificate of Authority (COA): State sponsored authorizations for licensing health care organizations.

Coinsurance: Amounts, usually in the form of a percentage of total fees, paid by policy

beneficiaries for care received. Coinsurance tends to reduce use of policy benefits. Coinsurance may be in the form of per-visit costs or as in fee-for-service/indemnity plans, a stated percent. (See co-payment).

Class ratemaking: Ratemaking system in which insurers establish insurance premiums on the basis of the combined claims experiences of defined demographic characteristics such as age, gender, or prior status. The class plan distinguishes between higher and lower risk policyholders. (See Community Ratemaking).

Community ratemaking: Ratemaking systems that set insurance premiums on the basis of the combined claims experiences of a defined geographic area. Similar to Class Ratemaking whereby specific demographic characteristics are used to distinguish between higher and lower risk policyholders. The more finely tuned a community or class rating plan is the more equitable are the costs for members of the defined group but the greater the insurance costs may be for higher risk policyholders because some of the benefits of risk aggregation are lost the more homogeneous the community or class. (See Experience Rating).

Co-payment: A type of coinsurance often employed in managed care plans where beneficiaries pay specified amounts per unit of service or time and insurers pay the remainder. The co-payment usually does not vary with the cost of the services provided to beneficiaries.

Credentialing: Validation of health care provider's qualifications prior to being granted status with a health care facility or health care plan. The review usually includes obtaining references, validating training and experience, verifying current licensure and malpractice insurance. Some health care providers believe that credentialing may also incorporate economic profiling, reviewing their expenditures and excluding health care providers serving more seriously ill or costly clients.

Deductible: A fixed amount that beneficiaries must pay, out-of-pocket, before becoming eligible for insurance benefits for the balance of costs for covered health care services, usually under an indemnity insurance policy.

Diagnosis Related Group: The DRG system is a classification system for inpatient care based on several factors: principal diagnosis, secondary diagnosis, surgical factors, age, gender, and discharge status. The Medicare prospective payment system went further than this, paying hospitals a set fee for client treatment within a single DRG category, regardless of the actual cost of care provided for multiple treatments. DRG financing mechanisms exist in most industrialized countries and may actually increase costs by encouraging inefficient service delivery. Since DRG payments are for specific services, collateral treatments that could be provided simultaneously may be deferred in favor of a second treatment at a later date and under a different DRG category.

Diagnostic Related Groups (DRG): Classification system used by the Department of Health and Human Services (HHS) and Health Care Financing Administration (HCFA) to set prospective hospital reimbursement rates for Medicare clients. The DRG system classifies clients with similar diagnoses, treatment patterns, and comparable expected lengths of stay, setting reimbursement rates for each individual category. Some managed care plans use the DRG system for setting payment reimbursement rates. The DRG system bases rates on several factors: principal diagnosis; secondary diagnosis; surgical factors; age; sex; and discharge status.

Employee Retirement Income Security Act (ERISA): The Employee Retirement Income Security Act of 1974. ERISA reserves the power to enact any laws or regulations related to employer-sponsored benefit plans to the federal government. While the states are left free to regulate commercial health insurance plans many legal issues have arisen where the rights of states to regulate insurance have been questioned.

Exclusive provider organization (EPO): An exclusive provider organization more tightly controls the use of health care providers than do preferred provider organizations. Beneficiaries use only designated providers or sacrifice reimbursement for health care services they seek from outside the exclusive provider organization network. (See Preferred provider organization). Experience Rating: Insurance premium rates are based on prior claims and expenses by a specific insured or group of insureds.

Fee-for-service: Traditional method of paying for medical services. Health care providers bill for each encounter or service rendered. This form of payment pre-dated insurance plans and fee for service payment was the dominant form of payment provision in traditional Blue Cross/Blue Shield indemnity insurance plans. Fee for service plans contrast with salaried, per capita, or prospective payment systems in which a fixed payment may cover all services rendered.

Group model: A type of health maintenance organization with medical centers where many different health services are provided in a central location. Paid staff of group model health maintenance organizations treat only health maintenance organization clients.

Group practice: The joining of health care providers working together, using the same offices, staff, equipment, and technical personnel, often with centralized administrative and financial support services.

Health maintenance organization: Comprehensive health care financing and delivery organizations that provide covered health care services to specific beneficiaries, for a fixed prospective payment. Four types of health maintenance organization models are:

1. Staff model - Medical doctors and other health care providers are salaried employees

2. Group model
3. Independent Practice Associations (IPA) contract with the health maintenance organization and with independent physicians
4. Network models contract with two or more independent group practices or IPAs. Health maintenance organizations may be sponsored by government, medical schools, hospitals, employers, labor unions, consumer groups, or insurance companies.

Indemnity plan: Defined benefits are available for reimbursement up to predetermined policy limits in the event of beneficiaries experiencing a covered loss. (See Fee for service).

Indemnity benefits: Insurers make cash payments rather than provide services. Indemnity payments used to be made as reimbursements for out-of-pocket expenses but may also be paid directly to health care providers. These latter arrangements helped ease the burden of making out-of-pocket payments when beneficiaries do not have the resources to make these payments.

Individual practice association (IPA): Partnerships, corporations, or associations enter into contracts with health maintenance organizations to provide services in their own offices and serve the health maintenance organization beneficiaries as part of their regular practices.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): A private, non-profit organization, which accredits hospitals and other health care providing facilities. JCAHO promulgates national standards, surveys facilities, and accredits facilities that comply with the standards. JCAHO accreditation, while voluntary, is required for participation in Medicare.

Managed care: Health care systems that integrate the financing and delivery of health care services to covered beneficiaries by contracting with health care providers to deliver comprehensive health services, evaluate and select health care providers, have established programs for quality assurance and utilization review, and may offer financial incentives to beneficiaries who use plan providers and procedures.

Managed competition: A theory about consumer impacts on health care delivery in which it is assumed that large numbers of consumers choosing among health care plans offering similar benefits. The theory assumes that competition is based on cost and quality. However, this also assumes that consumers are able to evaluate cost and quality, which may not be true.

Medicaid: Age independent state health insurance programs for eligible beneficiaries whose financial resources are insufficient to cover their health care needs. Title XIX of

the federal Social Security Act, passed into law in 1965, provides matching federal funds for state Medicaid programs. Medicaid covers many services and most beneficiaries are low-income women and children. About 70% of Medicaid funds pay for nursing home and long term care services for the elderly and disabled.

Medicare: Federal health insurance program for beneficiaries 65 and older and certain disabled people., Medicare was created in 1965 under Title XVIII of the Social Security Act and covers costs for hospitalization, medical care, and related services independent of ability to pay. **Physician-Hospital Organization (PHO):** Organizations of physicians and hospitals that join together to negotiate rates for services with third party payers.

Point-of-service (POS): Also known as open-ended health maintenance organizations or preferred provider organizations, point of service plans encourage beneficiaries to use network providers but beneficiaries may use providers outside the plan.

Policy Aggregators: Policy aggregators are organizations that appear to be engaged in the health insurance business, aggregating and managing risk exposure for policyholders, but are only nominally insurance organizations since they deviate from traditional insurers by transferring much, if not all, of the risks in the policies they write to health care organizations. Since they do not retain risk, they may have a competitive advantage over traditional risk assuming and retaining insurers because the ultimate financial risks are borne by professional caregivers who become responsible for unknown future costs and the policyholders who may be denied access to needed health care services.

Examples of policy aggregators are large managed care organizations or health maintenance organizations that contract with and transfer risk to hospitals, nursing homes, and group or individual caregivers, using agreements in which they pay a fixed amount in lieu of future unknown costs. This same basic analysis extends to risk transfers that occur within organizations that assign clients to nursing units. Insurance risk management emerges if the budgets for those units are inadequate to provide care for the clients assigned at the time the clients need services. Traditional insurers may not be able to compete with Policy Aggregators (e.g. organizations such as health maintenance organizations, insurers that transfer risks to health care providers and organizations, and government programs such as Medicare and Medicaid) that pass some or all of their insurance risks to professional caregivers, and indirectly, back to the insured policyholders because the policy aggregators eliminate some of their risk and can offer seemingly similar products at lower cost. However, the products they offer may not be comparable.

When the needs for nursing services vary widely from day-to-day the ability of the nursing unit to plan for and meet these demands may become more difficult. As is the case with insurance company employees, staff members who implement policies and procedures in health care organizations may not suffer personal economic loss based on their decisions regarding a particular client. However, there still remain subtle and overt pressures regarding resource use in health care organizations that may mirror the

situations that insurance claims agents respond to in their work environments. This study is unique in exploring the impact of professional caregiver insurance risk transfers on RNs. Exploring this impact is critical to determining to what degree financial risk and consequential resource inadequacies affect nursing care, RNs, and their clients.

Pre-admission certification: Pre-admission determination of the need for in-patient service to assess the appropriateness of the facility, the utility and appropriateness of the anticipated services, and to establish the authorized length of stay. Pre-admission certification seeks to reduce inappropriate hospitalizations and services.

Preferred provider organization (PPO): Third-party payers contract with a group of "preferred" health care providers who agree to provide their services at fees lower than standard and in return for more rapid payment. Preferred provider organizations also provide health care providers with access to large numbers of clients.

Premium: Amount paid by a policyholder or beneficiary for insurance. In professional caregiver insurance risk transfers the fixed prospective payments to health care providers that agree to provide services is assumed to be an insurance premium rather than a payment for services.

Primary care: Primary care providers are typically nurse practitioners, internists, general practitioners who are the first providers seen by clients and may serve as referral agents or gate-keepers as clients seek to access specialist care or more sophisticated services. Primary care also refers to the source of care for common illnesses and preventive health maintenance services.

Prior authorization: Requirements that health care providers document and justify beneficiary's needs for health care services before providing service or risk not being reimbursed for those services.

Professional Caregiver: Professional Caregiver refers to trained and licensed healthcare providers including registered nurses gainfully employed in the capacity of providers of health services. RNs are exemplars of professional caregivers based on their extended contact with clients, their dedication to service provision, and their willingness to attempt to meet the needs of their clients.

Professional Caregiver Insurance Risk: Professional Caregiver Insurance Risk is the financial risk or other consequences of risk assumptions that exist when professional caregivers (either individually, in groups, or as corporate entities) accept prospective payments in lieu of unknown future costs. The obligation to provide unknown professional services, at unknown costs, to a defined cohort of clients for a specified period of time in return for the prospective premium, or for fixed resources in a particular unit or division, mirrors the role of an insurer (or reinsurer) for a policyholder (or insurer) transferring insurance risks. While RNs may not be responsible for the financial

loss, efforts to control costs may influence the quality and quantity of nursing services they provide to clients. Such resource limitations may lead some nurses to dissatisfaction with their own professional performance and may result in their failure to meet professional standards of practice. Nurses may also face threats to their nursing licenses as they supervise less-skilled paraprofessionals and assume responsibility for more clients or more acutely distressed clients than they can manage. Professional caregivers possess professional skills, competency, and credentials to provide health care services, but they may be performing more than these circumscribed duties. In effect, professional caregivers become responsible for underwriting or managing health insurance risks, while they may possess neither the professional skills nor the resource capacity under statutory requirements to perform these insurance functions.

There are two major forms of risk involved in accepting professional caregiver insurance risk transfers. First, there is the actual financial risk for the caregiver that may occur when a hospital or group practice, or home health nurse agrees to accept the responsibility for unknown costs of services in lieu of a fixed, prospective payment. Second, there are consequential risks that accrue to caregivers related to the impact of insurance risks on their work and their caregiving environments. If staffing levels are trimmed, resources reduced, and mandatory overtime enforced, the risks of accident or injury to clients may increase and the satisfactions derived from professional activities may decline. While the impact of financial risk is the most obvious effect, the emotional and professional risks may be equally important to professional caregivers who may feel they are insulated from the actual financial risks. **Quality management:** The review of a provider's attainment of care standards, to improve care and outcomes or achieve other standards such as cost-control. **Reinsurance:** Insurance, usually between two insurers that protects against excessive losses spreads risk, or which allow insurers or other parties to achieve stable operating results despite financial risks they face.

Risk: Risk refers to the uncertain financial outcomes resulting from injury, loss of life, illness, theft, or accidental losses. Risk also refers to the risks insurers, whether insurance companies or health care providers assume when they accept premiums in lieu of uncertain financial obligations.

Risk Induced Professional Caregiver Despair: Risk induced professional caregiver despair refers to the dysphoric experiences of participating RNs when they are involved in rendering services to their clients as employees of health care organizations, operating under the influence of professional caregiver insurance risk transfers.

Risk management: The effort to identify, evaluate, and correct situations that may result in client or employee injuries, property loss or damage, and financial loss or legal liability. Risk management also includes the development of plans to achieve financial risk reduction by using insurance to cover the financial consequences of loss.

Risk retention: Risk retention refers to the tendency for risk management to be

incomplete. Despite the purchase of insurance, not all exposure to financial loss may be covered. Companies and individuals may select risk-retention intentionally or it may result from inadequate identification of and planning for risk management services.

Self-insured: Self-insured health insurance programs include individuals who do not elect to purchase health insurance and to companies that choose to pay for employee's health expenses. Risk-retaining employers may profit if employee utilization is reduced but may also face high losses if utilization is increased, such as might happen as a result of an industrial accident. Risk-retaining self-insurers often contract with third party administrators, or insurance companies through Administrative Services Only (ASO) arrangements that include plan administration, claims handling, and other traditional insurance functions.

Staff model: Health maintenance organizations that, like the group model, use salaried health care providers who provide services exclusively to health maintenance organization beneficiaries.

Third-party administrator: A person or organization who provides administrative services to benefit plans, including premium accounting, claims review and payment, utilization review, maintains employee records, and may negotiate with insurers for stop-loss protection through reinsurance for excessive claims. Third party administrators offer many functions normally provided by state-regulated commercial insurance companies.

Third party payment: Payment for health care services made by a party that is neither providing nor receiving the care for which payment is made. Typically third party payment refers to payment made to a health care provider on behalf of a beneficiary, by an insurer.

Traditional Insurers: Traditional insurers are risk aggregating and retaining organizations, providing a benefit to society by managing financial risk and funding needed health care services for their policyholders. In providing the social and financial benefits of insurance, these organizations use the central limit theorem and the law of large numbers to manage their exposure to risk, protecting their policyholders and themselves from the adversities associated with illness, accident, and unexpected financial loss. By retaining risks, traditional insurers face difficulties competing with entities that transfer these risks, since those entities do not face the same extremes in cost as traditional insurers. Unlike health maintenance organizations and managed care programs, traditional insurers have few controls on demand for health care services.

Indemnity insurance policies such as those issued by Blue Cross - Blue Shield companies are examples of traditional insurers.

Utilization review: Programs that evaluate the provision of health care services on the basis of appropriateness, necessity, and quality. Utilization review may include

pre-admission certification, concurrent review with discharge planning, and retrospective reviews. Concurrent review may present difficulties to health care providers because it means that services deemed necessary may not be provided at the bedside because permission may be withdrawn or clients may be deemed ineligible.