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SELF-INFLICTED INJURIES: DESIGNATION FOR RISK ASSESSMENT OR COST AVOIDANCE

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ABSTRACT

This paper considers the denial of health insurance benefits based on a participant's high-risk behaviors such as self-inflicted injuries. In many instances, healthcare benefits can be denied if patients are injured while engaging in criminal activities, from a self-infliction, and from injuries relating to the consumption of alcohol. With increases in healthcare expenditures and government regulation, the necessity for benefit reductions is directed at individuals engaging in high-risk behaviors. The belief is that high-risk behaviors can be modified by individuals. Unfortunately, modification of behaviors may not be available to everyone.

Keywords: *injuries, risk assessment, cost*

1. INTRODUCTION

Profit and sustainability of an organization are contingent upon the acquisition of resources that exceed disbursements. In most instances, incomes must exceed expenditures with liquidity of resources being essential for ongoing operations and future strategic endeavors. For the health insurance industry, this translates to reductions in medical disbursements.

In an effort to reduce medical disbursements, health insurance providers are using economic and financial incentives to encourage participating members to engage in behaviors that are consistent with reductions in medical payouts. Some examples include differences in premiums based on tobacco-free participant status, special educational programs targeting high payout participants, and decreased participant benefits for self-inflicted injuries. In this paper, we discuss high-risk behaviors of participants and the decisions to reduce medical benefits contingent upon injuries and treatments sought. The scope of this paper is limited to organizations operating within the United States of America. In the subsequent section, high-risk behaviors are presented.

2. DISCUSSION

High-risk behaviors primarily include self-inflicted injuries, but these behaviors may extend to an individual's ability to influence his or her future health position. These insurance participant behaviors and insurance provider demands for cost minimization are likely to result in conflicts. Fortunately, many consumers obtain health insurance benefits from employer plans as these benefit plans are regulated by *The Employee Retirement Income Security Act of 1974* ("ERISA") (Wibers, 2006). ERISA mandates that regulated employee benefit plans must provide participants written notification concerning the denial of benefits and a reasonable opportunity to appeal denials. ERISA must be considered when evaluating decisions that can result in the denial of coverages to participants. Also, ERISA is significantly complex and therefore is beyond the scope of this paper as it is the authors' intention to highlight trends in high-risk behaviors.

An example of high-risk behaviors are criminal acts. Individuals that have been injured while engaging in criminal acts may be denied benefits from healthcare insurance (Chezem, 2005). As society has deemed criminal acts to be illegal, then the denial of healthcare insurance benefits is also permissible. This is a logical conclusion that has transferred to other types of high-risk behaviors such as traffic accidents.

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Commonly, injuries sustained as a result of traffic accidents are scrutinized by insurance carriers for high-risk behaviors (Wibers, 2006). Injured parties failing to wear proper safety equipment (e.g. seat belts and helmets) may be deemed not eligible for benefits. Likewise, alcohol-related injuries may be considered a high-risk behavior; and, as such, denial of health insurance benefits for individuals that have engaged in consuming alcohol is likely (Wibers, 2006). Hence, healthcare providers have reported hesitation and ethical dilemmas about screening for high-risk behaviors (i.e. alcohol and illegal substances in patients during emergency room admissions) as the identification of these behaviors may trigger denial of medical reimbursements to the healthcare organization (Chezem, 2005). Therefore, the possibility that costs associated with treating a patient may not be recouped through insurance or the patient. Thus, discrimination in treatment may exist.

Evidence of discrimination, according to Olfson et al. (2005b), does exist within patient admissions and patient treatments. Specifically, similar diagnosis reduced hospital stays when considering the patient's age, gender, and cognitive disorder. Additionally, cognitive disorders are linked to self-harm visits to the emergency room (Olfson et al., 2005a). Thus, high-risk behaviors can be tied to violent attitudes and actions such as *"...suicide, attempted suicide, self-mutilations, homicide, [and] domestic violence"* (Conso et al., 2007). Medical care costs associated with these attitudes and actions are underreported by the healthcare providers. Underreporting may likely occur in relation to the potential denial of healthcare benefits and the future perceptions from insurance carriers and healthcare providers of the patient. In essence, any medical treatment may be scrutinized for high-risk behavior which may cause delays in benefits. For example, Smith et al. (2015) found that repeated visits to emergency facilities increased when patients had cognitive disorders (e.g., autism, dementia, impulse control disorders, and personality disorders) or substance abuse (i.e. alcohol and drugs) issues. Substance abuse being a greater factor in determining trauma and visits to emergency facilities (Brattström et al., 2015). Both cognitive disorders and substance abuse issues are linked to socio-economic factors (Barnes et al., 2016; Brattström et al., 2015). Therefore, poverty becomes a greater barrier in obtaining health benefits as poverty is linked to high-risk behaviors that may warrant, by health insurance providers, the denial of health insurance benefits.

Consequently, instances of self-harm may be reduced by psychosocial therapies (Erlangsen et al., 2015). Considering that economic issues are underlying roots that trigger self-harm (Barnes et al., 2016), holistic treatments should include analyzing patient resources, providing financial literacy, and life planning to mitigate against trigging events. Without therapies and treatment of the underlying issues, an individual is likely to suffer in silence and not seek medical attention as financial obligations without insurance may be perceived as too great (Cherry, 2015). Moreover, insurance providers may deny coverages based upon the potential of the insured to self-harm. In the U.S., this may directly conflict with Federal Laws (cf. §54.9802-1 *et seq.*; 29 USC 1182) that generally prohibit discrimination of individuals based on such issues as health factors, health status, disability, genetic information, health claims, and medical history.

To profile participants in health insurance programs, genetic testing may offer insight into patient risk factors such as future chronic and catastrophic illnesses: both physical and cognitive. Consequently, Billings et al. (1992) suggest that discrimination will play a role in the denial of medical benefits and potentially employment if genetic testing does not include patient rights. Heuristics would trigger denials of benefit decisions centering on probabilities, perceptions, and stereotypes. These decisions would likely adversely affect individuals with differences emerging based on gender and mental health diagnosis.

The Genetic Information Non-Discrimination Act of 2008 ("GINA") was passed to address issues of patient privacy and mitigate against discrimination (Prince & Roche, 2014). The purpose of GINA is *"To prohibit discrimination on the basis of genetic information with respect to health insurance and employment."* Hence, Billings et al.'s (1992) earlier concerns concerning employment discrimination have been partially addressed. Prince and Roche (2014) note that individuals must be familiar with Federal and State protections to properly ensure medical privacy. In some instances, the full realization of privacy has yet to occur.

An individual's genetic code can help facilitate a chronic medical condition such as obesity, cancer, and diabetes (Finkelstein et al., 2003). Is it fair to deny health insurance benefits to individuals based on

his/her weight? An argument is that the individual should eat healthier and consume less. Consequently, not everyone's metabolism processes food (i.e. calories) the same. In some instances (i.e. diabetes), fruits and vegetables may increase the blood sugar. Similarity, decreases in an individual's food consumption can trigger the body to conserve calories by reducing the metabolism. Hence, an individual's weight may increase. Obesity is considered a high-risk behavior and health insurance providers are increasing premiums and decreasing benefits. Another high-risk behavior is smoking (Asaria et al., 2007). Many health insurance programs include benefits to reduce tobacco use since tobacco use has been linked to chronic illness. The cost of these tobacco-free programs has been questioned. Should healthcare insurance benefits extend to individuals that targets the modification of high-risk behaviors?

3. CONCLUSION

Is general question, *"Are the long-term strategic plans to reduce health care expenditures better by targeting the individuals that present high-risk behaviors or engage in self-harm?"*, a better approach in stabilizing increased healthcare costs? According to Porter and Teisberg (2004), no. The primary problem in the U.S. healthcare system results from a combination of incorrect decisions, healthcare industry practices and changes, and public policy (Porter & Teisberg, 2004). The U.S. healthcare system is inferior and expensive. Competition is actually increasing costs as healthcare is based on geographic markets. The incentives for providers do not correspond to a healthier outcome. Providers should focus on *"...prevention, diagnosis, and treatments..."* of patients. This translates to more expensive testing during diagnosis and not a subsequent series of lower cost tests that bleed time and that are more costly in the aggregate.

Based upon Porter and Teisberg's (2004) analysis, we can conclude that healthcare practices may create socioeconomic discrimination for individuals that exhibit or are deemed to exhibit high-risk behaviors. Although Billings et al.'s (1992) concerns that genetic testing would be a tool that may displace individuals from participating within the healthcare insurance programs, Prince and Roache (2014) identified that GINA has an established framework to deter medical discrimination. Consequently, GINA is not enough.

We recommend that a comprehensive review (e.g. a meta-analysis of literature) of high-risk behaviors and healthcare insurance policies be conducted. Subsequently, the addition of quantitative research that focuses on high-risk behaviors and the decisions to deny benefits to plan participants be undertaken to illustrate the relationship between financial decisions and healthcare consequences.

We further recommend that health insurance providers, after a review of current laws and public policy, enhance benefit programs through a holistic approach of treatment. By treating the whole person, the underlying issues associated with self-harming behaviors may result in significant savings through a "cost avoidance" of trauma and emergency medical treatments.

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Lawrence P. Shao is Professor of Finance and Dean of College of Business at Slippery Rock University. He has travelled extensively abroad and has lectured in Canada, England, India, Mexico, Taiwan and the Czech Republic. Dr. Shao has authored numerous refereed journal articles and books dealing with international business and finance.