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Third Party Payment System In Business Healthcare

Nexhip Sheholli

PhD, Euro College, Kumanovo, North Macedonia

Abstract – Occupational health companies that do not provide products or services directly to patients generally share the same operating environment as companies in other industries. For example, machine tool makers Cincinnati Milicron and GE Medical Systems sell their products in much the same way.

Cincinnati sells its machines directly to manufacturers who use them to make other products, and GE Medical sells diagnostic equipment directly to hospitals, clinics and other facilities that use its equipment for diagnostic tests. The prices that both companies charge for their products are set in a competitive marketplace, making it relatively easy for buyers to distinguish between competing products. In general, the more expensive the product, the better the performance, and performance can be judged by more or less objective metrics. For example, in some sectors of occupational health and most other sectors of the economy, consumers of products or services have many suppliers to choose from, distinguish the quality of competing products or services, and Can (probably) act and make decisions rationally. As for the quality and price of the purchase, we will bear the full purchase cost. However, for the most part, the provision of health care in the workplace has its own way of doing things. First, there are often only a few companies offering a particular service in your neighborhood. Moreover, it is very difficult, if not impossible, to assess the quality of competing services.

Decisions about which aids to purchase are typically made by physicians or other clinicians, not by the consumer of these aids. Payments to providers are generally made by third-party payers, not by users of the assistance. Finally, for most people, third-party health insurance is fully or heavily subsidized by employers or government agencies, leaving patients largely isolated from professional medical bills. increase.

Keywords – Third party, Financing, Insurance, Health, Institutions

I. INTRODUCTION

What approach are health insurers following in practice? When health insurance first became popular after World War II, most insurers used community assessments. Here, a single premium or tariff is offered to all members of the community regardless of age, gender, health status, etc.

Thus, if a community is dominated by a single ethnic or cultural group, rates reflect geographical and perhaps even ethnic and cultural differences. However, within the community, this proportion represents an average of high-risk and low-risk individuals. However, over time, some insurers (especially commercial insurers) began offering empirical ratings that base rates on the claims experience of specific insured groups.

Another possibility for health insurers to protect themselves from negative selection is to include existing conditional clauses in their contracts. Pre-existing conditions are physical or mental conditions of the insured that existed before the insurance was issued. A typical clause stipulates that pre-existing medical conditions will not be covered until the insurance has been in force for a certain period of time (eg one or two years).

Therefore, this chapter describes the elements of the payer system that directly influence the financial management decisions of healthcare organizations. The simple example of health insurance outlined above illustrates why individuals seek health insurance and why insurance companies are set up to provide such coverage. Needless to say, the concept of insurance becomes more complicated in the real world. Insurance typically has four distinct characteristics:

Corresponding Author: PhD Nexhip Sheholli

1. Loss pool. Loss lump-sum or sharing is the heart of insurance. Pooling means that the loss is distributed over a large group of individuals, recognizing the pool's average loss (plus management costs) rather than the actual loss suffered by each individual. Additionally, when pooling, a number of homogeneous exposure units (persons or things with the same risk profile) are grouped together so that the law of large numbers can be applied. Pooling therefore means sharing losses across the group and predicting future losses with some degree of accuracy based on the law of large numbers.

2. 2. We only pay for incidental losses. Contingent loss is an unexpected and unexpected loss that occurs by chance. Insurance assumes that payment is made only for contingent losses. The issue of moral hazard when losses are not random will be discussed in a later section.

3. Risk transfer. Insurance almost always involves the transfer of risk. The only exception to risk transfer elements is self-insurance. Self-insurance occurs when a company (or individual) assumes the risk themselves, rather than insuring the risk through an insurance company. (Self-insurance is discussed in a later section.) Risk transfer means that risk is transferred from the insured to the insurer. Insurance companies are usually in a better financial position to pay claims than the insured because of the premiums they collect.

4. Indemnification. The final function of insurance is loss compensation, i.e. refinancing of the insured in the event of loss. In the case of health insurance, coverage exists when the insurance company reimburses the insured or health care provider for all or part of the costs associated with an insured illness or injury.

One of the biggest problems facing insurers is negative selection. Adverse selection occurs because individuals and businesses that are more likely to receive a claim are more likely to purchase insurance than those who are less likely to receive a claim. For example, an uninsured healthy person who needs expensive surgery is more likely to have health insurance if they can afford it, whereas the same person who is not afraid of surgery has insurance. much less likely to. Similarly, consider the likelihood that a 20-year-old will have health insurance and a 60-year-old will have health insurance. Otherwise, older people, who have much higher health risks due to their age, are more likely to seek insurance. If this tendency for negative selection is not curbed, a disproportionate number of sick people, or those most likely to become ill, will seek health insurance, and insurers will charge higher than expected claims. will be This increase in claims will lead to higher premiums, exacerbating the problem as healthier members of the plan may seek out cheaper insurance from other companies or decline the policy altogether. . (Bešvir B, (2008).

The problem of negative selection arises from information asymmetry. This happens when individual health planners know more about their health than their insurers. Insurers are trying to control the negative selection problem by underwriting reserves. Underwriting is the selection and classification of insurance candidates. From a health insurance perspective, there are two extreme positions an insurer can take with respect to underwriting. First, if an insurer offers coverage in all his 50 states, but not others, the insurer will charge premiums based on statewide average statistics, regardless of individual characteristics. can be set.

Therefore, all individuals (or employers) pay the same health insurance premiums regardless of age, gender, geographic location, occupation, smoking habits, genetics, etc. The sum of the premiums calculated for each individual is sufficient to cover all anticipated expenses and administrative costs and provide a profit for the insurer. (Bogovac J. (2007).

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Prices therefore reflect geographic differences.

II. Preventing Risks

Pre-existing conditions are a major concern for the health insurance industry and, as we have discussed, one of the key elements of insurance is randomness. In other words, insurance payouts should be made in response to random events. Anyone who has had an illness in the past is in violation of this mandatory insurance feature. As for previous illnesses, the insurer no longer takes random risks and assumes the role of payer for treatment of known illnesses.

Moral hazard issues arise because insurance assumes payment is made only for contingent losses. The most common example of moral hazard in an accident insurance company is the intentional arson of a failed company by an owner to collect insurance claims. (Bernard J. Healy, Mark C. Marchese (2017).

Moral hazard also exists in health insurance, but usually in less dramatic forms. Not many people are willing to accept injury or illness in order to obtain health insurance. However, there are undoubtedly those who purposefully use corporate health care that is not medically necessary. For example, some people visit doctors and outpatient clinics not because of medical necessity, but because of the social value of relationships. Discharge may also be delayed out of consideration for the patient rather than for medical reasons.

Finally, if your insurance covers all or most of the cost, you're often quick to agree to her $1,000 MRI scan and other expensive procedures you don't need. If the same test required full out-of-pocket costs, you would think twice before agreeing to such an expensive procedure, unless the medical necessity was clear.

Overall, the fact that “someone else” is paying for it leads to a higher industrial consumption of healthcare than if the patient were paying for it. Even more insidious is the impact of insurance on individual behavior. Individuals are less likely to take preventive action if the cost of inaction is borne by the insurer. Getting a flu shot when the financial costs associated with treatment are covered by your insurance company, or quitting smoking when someone else is paying for the costs that could adversely affect your health You don't have to worry about It is clear that the mere fact that insurance exists causes individuals to neglect precautions and engage in unhealthy behaviors that they might otherwise be able to deal with in the absence of insurance.

Apparently, just having insurance is enough to make people abandon precautions and engage in unhealthy behavior. Both could be approached differently without insurance. Insurance companies generally try to protect themselves against moral hazard claims by paying less than the full amount of the insured's occupational health insurance premium. Partially covering the cost of insurance reduces the tendency to seek unnecessary help and engage in unhealthy behavior. One way to do this is to request a deductible. Health insurance policies usually contain a certain amount that must be paid before benefits are paid. While deductibles have some positive effect on moral hazard issues, their main purpose is to prevent the payment of small claims where the administrative costs of claim processing can be greater than the claim itself. is. The Service uses only a limited number of payment methods for refunds to Providers. Payment methods fall into two broad categories: service charge and he per person. There is a wide variety of service-related payment methods, and the higher the amount of support, the higher the refinancing amount. A per capita benefit pays the company a fixed amount for each period of coverage, regardless of the amount of assistance provided. In this section, we first consider the alternative payment method mechanism. We then discuss the incentives created by alternative methods for businesses. Finally, the risk impact of alternative refinancing methods is analyzed. When paying invoiced fees, the payer will pay according to the fee schedule specified by the provider in the fee master file. The rate master file contains service codes and "list prices" for all assistance provided.

III. Efficient Management Of Risk And Return

Two of the most important concepts in operational financial management in healthcare are financial risk and required return. What is financial risk? how is that measured? And how does it affect the required return and, in turn, your business decisions? So many financial decisions involve risk and return that a solid understanding of the concept of risk and return is essential. Without it, it is impossible to fully understand corporate healthcare financial management.

If investors (individuals and companies alike) viewed risk as a harmless, real fact, it would have little impact on decision-making. But most decision makers are risk averse and believe that risk should be avoided. Moreover, if you have to take risks, there should be rewards for them. Therefore, a higher risk financial investment, whether it is a private investor's investment in safety or an investment in a radiology group's diagnostic equipment, must have a higher risk to make that investment financially attractive. You must provide a return.

Unfortunately, financial risk is such a complex subject that a complete discussion of it would require many chapters, or even a book. First, it depends on whether the investor is an individual or a corporation. If the investor is a natural person, it depends on the investment period or the period until the investment funds are required. The situation is further complicated when financial risk is difficult to define, measure and even translate into something that can be used for decision making. For example, one of the risks retail investors face when saving for retirement is that their savings may not be enough to cover

their retirement needs. Needless to say, incorporating such definitions of risk into investment decisions is not straightforward. The good news is that our primary concern is the financial risk associated with corporate decision-making. Our discussion can therefore focus on the fundamental factors that influence the risk of financial investments in tangible assets (land, buildings, equipment, etc.). Still, there are two factors that complicate the discussion of financial risk.

The first complicating factor is that financial risks are perceived by both companies and their investors. Businesses themselves carry a certain amount of risk, which largely depends on the nature of the business. For example, it is widely recognized that pharmaceutical companies are at high risk, while corporate healthcare providers are generally at low risk. Investors (such as shareholders and creditors) bear risks inherent in the enterprise, which are modified by the contractual nature of the securities they hold. (David J. Norris (2017).

For example, stocks in healthcare companies may be riskier than debt, but the risk of both securities depends on the inherent risks of companies involved in the long-term care industry. Not-for-profit corporations have similar risk sharing, but now company-specific risks are shared between creditors and implied shareholders, who are generally considered the community as a whole. (David W. Young (2014), Management Accounting in Healthcare Organizations)

A second factor complicating our discussion arises from the fact that the risk of an investment depends on the circumstances in which it is made. For example, a stock held individually is riskier than the same stock held as part of a larger stock pool. Similarly, an MRI system operated independently poses a higher risk than the same system used as part of a larger system.

IV. Conclusion

To some extent, this refinancing system puts payers at the mercy of companies regarding the cost of occupational health services, especially in markets where competition is limited. In the early days of health insurance, all payers reimbursed companies based on the amount billed. While some insurers still reimburse businesses based on the costs charged, payers tend to use other, less generous financing methods. If this trend continues, the only payers expected to pay the billed fees will be self-payers or individual patients.

Providers, such as individuals and other businesses, are responding to the incentives created by the financial environment. For example, individuals can deduct mortgage interest from their income for tax purposes, but not personal loan interest payments. Lenders are responding by offering home equity loans, a type of second mortgage.

Tax law assumed that these loans would be used to make homeownership more accessible, but in practice they are usually used for other purposes, such as financing vacations, cars, and appliances. increase. In this context, tax law created incentives for consumers to take out mortgage debt rather than personal debt, and the mortgage industry responded accordingly. It would also be interesting to briefly explore how alternative refinancing methods incentivize provider behavior.

With cost-based financing, companies receive a "blank check" that can be used to purchase assets or pay for operations. If the payer refunds all payments to the company, there is an incentive to pay. The facility is spacious, conveniently located, and staffed to ensure patients receive "luxury" care. In addition, similar to billing fee refinancing, more support means more payouts and more revenue, so you get support you don't really need. With fee-based funding, companies have an incentive to set a high fee rate, which results in high returns. (Bessie L. Marquis, Carol J. Houston (2017), Leadership and Management Roles in Nursing: Theory and Applications, Wolters Kluwer)

But in a highly competitive market, there is a limit to corporate value growth, and bargaining insurers will demand rebates. Billing is a form of refinancing, there is a strong incentive to provide the greatest possible service as there is a charge for service and more support translates into increased revenue.

Essentially, businesses can increase volume by increasing customer visits, ordering more tests, or extending hospital stays, thereby increasing volume and thus revenue. Fee-based refinancing encourages companies to hold back payments, but the incentive is weak because it is usually easier to increase fees than pay less. Note, however, that refinancing at reduced fees creates a significant incentive for companies to pay less, as it further squeezes profitability. Provider incentives for refinancing future payments are changed.

First, the profitability of individual transactions in refinancing varies from transaction to transaction depending on the relationship between the actual payments made and the payments made for that transaction. Health care providers, usually doctors, are encouraged to undertake procedures with the highest potential benefits.

Furthermore, it applies that the more procedures, the better, as each procedure typically generates an additional benefit. So are refinancing incentives per diagnosis. Health care providers, usually hospitals, seek out and discourage (or even discontinue) patients with diagnoses of greatest potential benefit. Additionally, as long as companies have some flexibility in matching diagnoses to patients, there will be incentives to upcode diagnoses from one actual diagnosis to another, allowing for greater refinancing. (Cassandra R. Henson (2022).

With fixed and independent refinancing amounts for all future payment types, businesses have an incentive to reduce payments.

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