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Healthcare Insurance Provider's Mitigation of Risk

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Fee-for-service Method

There is risk everywhere. That is why, in the medical field, much more focus is given on risk mitigation to maintain patient's, caregiver's safety and limit overspending on medical services on the insurer. It is worth noting, however, that risk cannot be eradicated, but any work that goes to reducing risk can be highly beneficial. Dorn (2017) argues that the issue is that the alternatives for mitigating risk in health insurance are limitless. Someone somewhere is doing it faster and more effectively. Also, fees for medical services from insurance firms are based on deficit allocation, arbitrary loss compensation, risk sharing, and indemnities. Consequently, health insurance companies employ a variety of strategies to reduce risks and set premium costs. This paper evaluates two global payment systems in healthcare insurance while focusing on the financial risk for the insurance providers and the pros and cons of each model.

One of the approaches used by healthcare insurance providers to mitigate their financial risks and set premium rates is the fee-for-service approach (FFS). This is an approach where a physician and other healthcare professionals are paid a premium for each specific service given, primarily benefiting healthcare experts for the capacity and level of services offered regardless of any outcome (Dowd & Laugesen, 2020). Before the value-based care approach, the traditional medical health care coverage was a fee-for-service care plan. FFS insurance, also known as liability insurance plans, is the most expensive, notwithstanding those who can afford it. It provides complete flexibility and autonomy. FFS allows a client select their health care providers unreservedly, with hardly any involvement from the health insurer. Fee-for-service medical insurance necessitates significant out-of-pocket expenditures because patients may be obligated to pay their medical costs in advance and present bills for refund. In recent years, multiple

healthcare reform reviews have called for the phase-out of the FFS scheme, arguing FFS is one of the reasons for inequitable care, increased services, and rising health insurance prices. Healthcare providers encounter hospital billing hurdles as the framework transitions from a conventional FFS method to an entirely new model of value-based treatment.

The Advantages of FFS

People receive a highly prized level of care, and the practitioner can propose recommendations. Doctors can charge a decent fee for the scheme and be flexible in providing real help and support to their clients. Health care providers are also compensated for providing the best possible care to their patient populations per their high practice (Dowd & Laugesen, 2020). Furthermore, doctors can revoke fees for those unable to pay by delivering free care, covered by billing wealthy clients. Those who can afford to pay can forgo huge waits, enjoy better facilities, and have healthcare access that is interpreted to be of excellent quality.

The Disadvantages of the FFS

Some specialists like Zuvekas and Cohen (2016) believe that the advancement of modern healthcare, the issues of the existing health framework, and the health needs of chronically ill demography have rendered fee-for-service in medical insurance obsolete. Medical advancements have jeopardized the FFS framework. Insurance payers have encouraged the overuse of FFS, and FFS has encouraged the lower financial obligation of both providers and clients. "Pay the physician first," was the guiding principle for paying the general practitioner under the FFS model. Such was the price of the support provided for the client, and exercising caution for the unknown required again. The FFS is a framework for compensating physicians based on the level of work done. It was basic and straightforward. Then came a shift in healthcare. In the last century, practitioners billed what they thought their offerings were worth, and clients

compensated them, resulting in more lavish healthcare spending because practitioners charged what they thought was proper. Fee-for-service payment offers almost no incentive to provide comprehensive and value-based treatment. It motivates doctors to request unneeded examinations to increase their revenue and start practicing preventive care.

The fee-for-service method has come under fire for excessive usage of solutions and overstretched third-party insurers such as healthcare companies or government assistance initiatives (Zuvekas & Cohen, 2016). Despite policymakers and regulatory agencies favoring a transition away from fee-for-service to a value-based model of care, it is unlikely that insurers will abandon the FFS model entirely in the long term.

Risk Pooling Approach

According to Ahangar et al. (2018), risk pooling in healthcare coverage guarantees that the vulnerability of funding treatment programs is shared by all pool participants rather than being borne independently by every subscriber. Its primary aim is to share the potential losses linked to health treatments with unsure needs. The aspect of risk pooling is central to the health coverage idea. A health cover risk pool is a group of persons whose health care costs are merged to determine premium rates. By consolidating uncertainties, the increased costs from the less healthy can be counterbalanced by the relatively lower prices of the healthy subscribers, in either the overall plan or in a high price rating class (Ahangar et al., 2018). The wider the risk pool, overall, the far more reliable and foreseeable the insurance costs can be, and the insurance providers will have mitigated their risks.

Even though big risk pools are generally stable, a significant risk pool often does not imply cheaper insurance. The typical health spending of the pool's subscribers is the most crucial component. Just like a pool of healthy individuals can lead to lower-than-average health care

costs, a significant proportion with a high proportion of high-risk populations can lead to higher health care insurance costs. Pooling structures open up the possibility of redistributionist healthcare expenditures on the insurer's part. According to Ahangar et al. (2018), the magnitude to which a specific pooling arrangement future efficiency improvements is recognized in practice as determined by its engagement and consistency with other health care financing capabilities. The capabilities include raising revenue and making purchases, including links between subscribers and services benefiting communities they cover.

Improving fairness in service use and financial assistance necessitates broadening risk pooling, which is a policy goal in itself. Risk pooling essentially implies that the healthy continue to fund the ill, and the youths help finance the elderly by inference owing to reduced health concerns. In the absence of risk pooling, expenses for health care services will be directly linked to the person's medical needs, and the insurer will have to pay more since their financial risk is not adequately covered. Risk pooling is useful since health care costs are generally unpredictable and, at times, prohibitively expensive. Individuals cannot predict when they will become ill and require medical attention. When this occurs, the fees of medical care can be substantial. In addition, risk-pooling increases the chances of those in need of medical services to access them at a reasonable cost and in a timely fashion. It enables the transfer of funds from the healthy to the ill. According to Bazyar et al. (2016), amounts paid during times of excellent health can be channeled to cover medical expenses in the event of an ailment, without insurance companies using additional resources for the same according to the individual's perspective and families.

Advantages of Risk Pooling

As previously stated, one of the benefits of consolidating risks is that the high prices of the less healthy can be mitigated by the significantly lower costs from contributions made by those enjoying good health, in either the overall plan or in a luxury segment. The bigger the risk pool, in particular, the more predictable and consistent the insurance costs will be. In addition to that, on the insurer's part, risk pooling leads to reduced costs of health premiums since resources are redistributed from those who do not need them to those in urgent need without any additional expenses (Bazyar et al., 2016). Another advantage on the insurance company's side is that the insured who do not necessarily need to pay the total cost of medical services may feel inclined to do so. In contrast, insurance companies will be happy to let them overuse these services. In the end, insurance companies earn more though there is the question of moral hazard to address when insurance companies make money using this method.

The Disadvantage of Risk Pooling

Lesser risk pools of undesirable characteristics will remain passive consumers of health services, with little power to affect provider conduct or enter into value-based agreements with health insurance companies. Also, splitting risk pools will keep creating opportunities for unjustly denying availability to prescribed minimum advantages or shifting these costs into self-insurance streams. Disparate risk pools will also continue to draw adverse selection conduct from some members, who will purchase less coverage when in good health and more coverage once they are ill (Bazyar et al., 2016). They sign up and deactivate their beneficiaries as and when they need the health care coverage. Some healthcare arrangements will continue to ignore poor risks but only attract better risks, partly to prevent undesirable classification but to compete

directly with other plans for equivalent levels of cover, thereby changing their economic placement.

Furthermore, Ahangar et al. (2018) suggest that depending on how the policy is structured, a health care insurance company might be forced to take some risks for certain pool members. If an insurance company pools high-risk participants who incur additional claims, its costs will increase in the years ahead, even if no huge claims occur.

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