European Journal of Innovation in Nonformal Education (EJINE)
Volume 4 | Issue 6 | June - 2024 ISSN: 2795-8612

Models of Medical Insurance Development

Olmosova Munisa Sherkhan kizi
Tashkent State University of Economics 3 rd grade student

A B S T R A C T
This article deals with significant data about models of medical insurance development and its importance for today. Furthermore, basic historical information according to background of medical insurance were given.

A R T I C L E I N F O
Article history:
Received 08 Apr 2024
Received in revised form
09 May 2024
Accepted 10 Jun 2024

Keywords: Health insurance, finance structure, not-for-profit entity, dismemberment, private insurance, "accident insurance", employer-sponsored group, for-profit corporations.

Hosting by Innovatus Publishing Co. All rights reserved. © 2024

INTRODUCTION

Health insurance or medical insurance (also known as medical aid in South Africa) is a type of insurance that covers the whole or a part of the risk of a person incurring medical expenses. As with other types of insurance, risk is shared among many individuals. By estimating the overall risk of health risk and health system expenses over the risk pool, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to provide the money to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization, such as a government agency, private business, or not-for-profit entity. According to the Health Insurance Association of America, health insurance is defined as "coverage that provides for the payments of benefits as a result of sickness or injury. It includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment"[1].

LITERATURE ANALYSIS

A health insurance policy is a contract between an insurance provider (e.g. an insurance company or a government) and an individual or his/her sponsor (that is an employer or a community organization). The contract can be renewable (annually, monthly) or lifelong in the case of private insurance. It can also be mandatory for all citizens in the case of national plans. The type and amount of health care costs that will be covered by the health insurance provider are specified in writing, in a member contract or "Evidence of Coverage" booklet for private insurance, or in a national [health policy] for public insurance. In the U.S., there are two types of health insurance – tax payer-funded and private-funded. A private-funded insurance plan example includes an employer-sponsored self-funded ERISA plan. Typically, these companies promote themselves as having ties to major insurance providers. However, in the context of an ERISA plan, these insurance companies do not actively participate in insurance practices; instead, they handle administrative tasks. Consequently, ERISA plans are exempt from state regulations and fall under federal jurisdiction, overseen by the US Department of Labor (USDOL). Specific details about benefits or

coverage can be found in the Summary Plan Description (SPD). Should there be a need for an appeal, the process typically involves initiating it through the insurance company and then reaching out to the Employer's Plan Fiduciary. If a resolution is still not achieved, the decision can be escalated to the USDOL for review to ensure compliance with ERISA regulations, and, if necessary, legal action can be taken by filing a lawsuit in federal court[2].

If we go back to the history, in the late 19th century, "accident insurance" began to be available, which operated much like modern disability insurance. This payment model continued until the start of the 20th century in some jurisdictions (like California), where all laws regulating health insurance actually referred to disability insurance. Accident insurance was first offered in the United States by the Franklin Health Assurance Company of Massachusetts. This firm, founded in 1850, offered insurance against injuries arising from railroad and steamboat accidents. Sixty organizations were offering accident insurance in the U.S. by 1866, but the industry consolidated rapidly soon thereafter. While there were earlier experiments, the origins of sickness coverage in the U.S. effectively date from 1890. The first employer-sponsored group disability policy was issued in 1911.

Before the development of medical expense insurance, patients were expected to pay health care costs out of their own pockets, under what is known as the fee-for-service business model. During the middle-to-late 20th century, traditional disability insurance evolved into modern health insurance programs. One major obstacle to this development was that early forms of comprehensive health insurance were enjoined by courts for violating the traditional ban on corporate practice of the professions by for-profit corporations. State legislatures had to intervene and expressly legalize health insurance as an exception to that traditional rule. Today, most comprehensive private health insurance programs cover the cost of routine, preventive, and emergency health care procedures. They also cover or partially cover the cost of certain prescription and over-the-counter drugs. Insurance companies determine what drugs are covered based on price, availability, and therapeutic equivalents. The list of drugs that an insurance program agrees to cover is called a formulary. Additionally, some prescriptions drugs may require a prior authorization before an insurance program agrees to cover its cost.

Hospital and medical expense policies were introduced during the first half of the 20th century. During the 1920s, individual hospitals began offering services to individuals on a pre-paid basis, eventually leading to the development of Blue Cross organizations[3]. The predecessors of today's Health Maintenance Organizations (HMOs) originated beginning in 1929, through the 1930s and on during World War II. The Employee Retirement Income Security Act of 1974 (ERISA) regulated the operation of a health benefit plan if an employer chooses to establish one, which is not required. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives an ex-employee the right to continue coverage under an employer-sponsored group health benefit plan.

Through the 1990s, managed care insurance schemes including health maintenance organizations (HMO), preferred provider organizations, or point of service plans grew from about 25% US employees with employer-sponsored coverage to the vast majority.[89] With managed care, insurers use various techniques to address costs and improve quality, including negotiation of prices ("in-network" providers), utilization management, and requirements for quality assurance such as being accredited by accreditation schemes such as the Joint Commission and the American Accreditation Healthcare Commission. Employers and employees may have some choice in the details of plans, including health savings accounts, deductible, and coinsurance. As of 2015, a trend has emerged for employers to offer high-deductible plans, called consumer-driven healthcare plans which place more costs on employees, while employees benefit by paying lower monthly premiums. Additionally, having a high-deductible plan allows employees to open a health savings account, which allows them to contribute pre-tax savings towards future medical needs. Some employers will offer multiple plans to their employees. ‘

RESULT AND DISCUSSION

The four basic designs healthcare systems follow are:

- Beveridge model
- Bismarck model

- National health insurance model
- Uninsured model.

All these models differ in both how they are funded and how healthcare is delivered. Publicly funded systems are paid for with taxation, while privately funded systems are paid for with individual contributions to a collective fund, like an insurance company[4]. Facilities that deliver healthcare can be either owned by the government or privately owned by an organization, like a corporation or a nonprofit. In the Beveridge model, funding and delivery is primarily provided by the government, whereas both are provided privately in the Bismarck model. In the national health insurance model, funding is public but facilities are private. And in the uninsured model, only those who are able to pay out of pocket receive care.

In all of the models, there is a role for private insurance, private healthcare practices, or both. Regardless of the model a country follows, though, universal coverage lays the foundation for effective price control and improves access to low-cost, high-benefit preventive care. In the U.S., where universal coverage is not ensured, up to half of uninsured patients have delayed preventive care because of cost.

Beveridge model

The Beveridge model is named after Sir William Beveridge, a British economist who in 1942 published his most famous work, a government report entitled Social Insurance and Allied Services. In this report, he proposed a national healthcare system that would provide free medical treatment for all and that would be paid for through taxation. This report was part of a longstanding, broader movement to reform welfare services in Britain, which began with the publication of the Minority Report of the Royal Commission on the Poor Law in 1909.

However, these reports would not have led to policy changes without the work of Nye Bevan, a politician who served as minister of health and is widely credited with founding the National Health Service (NHS). He served under the Labour Party's Clement Attlee, who won the election over Winston Churchill largely due to campaign promises based on the Beveridge report. After taking office, Bevan faced fierce opposition from other politicians as well as the British Medical Association (BMA). But, after lengthy negotiations and campaigning, the National Health Service Act was passed in 1946, establishing the NHS. With the creation of the NHS, the U.K. gave birth to the first of the four major healthcare models. In this model, healthcare is paid for almost entirely with taxation and delivered through the government. Healthcare facilities are government-owned and healthcare providers are employed by the government. Healthcare is seen as a responsibility of the government, in the same way that tax-funded roads and schools are. It's important to note, though, there are exceptions to this model in British healthcare. One of the most notable is that the majority of primary care providers, called general practitioners (GPs), own their own practices or are employed by private practices. The majority of community pharmacies are also privately owned. In addition to the U.K., other countries that follow the Beveridge model include New Zealand, Finland, and Spain.

Bismarck model

Otto von Bismarck was the founder and first chancellor of the German Empire, now Germany. He served as chancellor from 1871 to 1890. And the healthcare system now named after him grew out of a series of economic crises that the German Empire faced during his tenure. These crises led to harsh living conditions, especially among the urban poor, which prompted Bismarck to suggest a national health insurance system in 1881. The system was passed by the legislature in 1883. Under this system, both the financing and delivery of healthcare are privately funded, as opposed to using public funds received through taxation and government-owned clinics to deliver care. In Germany, employees and employers pay premiums to insurance companies, termed "sickness funds," through mandatory payroll deductions. Those sickness funds then reimburse the facilities that deliver care. While Germany developed the original Bismarck healthcare system, other countries that use this model include Japan, France, the Czech Republic, and South Korea.

National health insurance model

The national health insurance model is somewhat of a mixture between the Beveridge and the Bismarck model. In this type of system, the government funds healthcare services, which are paid for through taxation, similar to the Beveridge model. The delivery of healthcare services is provided, however, mostly through private organizations, similar to the Bismarck model. Perhaps the most notable example of a country using this model is in Canada. There, residents receive provincial insurance plans funded by both the federal government and provincial governments, which are used at mostly private clinics and hospitals.

Uninsured model

With the uninsured model, healthcare services are provided to people who can pay for those services out of pocket. Residents and citizens who can afford to pay receive healthcare, while those who cannot afford care do not receive it. Like with the other models, there can be exceptions to these basic principles within different healthcare systems. For example, depending on the country, nonprofit institutions might provide charitable care to the uninsured, or the government might provide vaccines free of charge. Comprehensive care, however, goes primarily to those who can afford to pay. This system is found in many low-income countries that lack the resources to fund a strong healthcare system.

CONCLUSION

To sum up all given facts above, it should be noted that health insurance provides financial support to pay for healthcare expenses during a medical emergency, illness or accident up to the sum insured by a person. It covers the medical expenses of an individual or family members included in the plan without depleting one's savings. No one plans to get sick or hurt, but most people need medical care at some point. Health insurance covers these costs and offers many other important benefits. Health insurance covers essential health benefits critical to maintaining your health and treating illness and accidents. Health insurance protects you from unexpected, high medical costs. You pay less for covered in-network health care, even before you meet your deductible. You get free preventive care, like vaccines, screenings, and some check-ups, even before you meet your deductible.

REFERENCES:

1. Pekerti, Andre; Vuong, Quan-Hoang; Ho, Tung; Vuong, Thu-Trang (25 September 2017).
2. https://en.wikipedia.org/wiki/Health_insurance#cite_note-3
3. Fundamentals of Health Insurance: Part A, Health Insurance Association of America, 1997, ISBN 1-879143-36-4.
4. https://www.goodrx.com/hcp/providers/healthcare-system-designs