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## FEATURES OF INSURANCE IN HEALTHCARE

**Abstract:** this article outlines the relation between healthcare markets and insurance systems. Healthcare markets, including education, manpower, and pharmaceuticals, shape access to care. Health insurance is key to managing costs, but many face barriers, especially the uninsured.

**Keywords:** healthcare markets, insurance systems

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## ОСОБЕННОСТИ СТРАХОВАНИЯ В СФЕРЕ ЗДРАВООХРАНЕНИЯ

**Аннотация:** в данной статье рассматривается взаимосвязь между рынками здравоохранения и системами страхования. Рынки здравоохранения, включая образование, рабочую силу и фармацевтику, определяют доступ к медицинской

помощи. Медицинское страхование является ключом к управлению расходами, но многие сталкиваются с препятствиями, особенно незастрахованные.

Ключевые слова: рынки здравоохранения, системы страхования

The healthcare consists of several interdependent market known as education, manpower, institutional, pharmaceutical and others. The education market determines how many healthcare workers can provide services. Therefore, in this market, prices are regarded in terms of tuition and other costs to the individual seeking training to be a physician, a nurse or other professional. Manpower markets determine salaries and wages paid to professionals while institutional markets determine prices either for hospital or nursing home stays. In the pharmaceutical markets, the prices of medications are determined. Besides these markets, there are many more that one may identify themselves. Due to the nature of the product for sale and structure of healthcare markets, most of these markets unable to meet ideal conditions for efficient resource allocation [2].

Insurance in the healthcare market aims to promote health, obtain healthcare for individuals and families whilst protecting them financially from exceptional health care costs. Generally, healthcare insurance pools the risks and resources of a large group of people so that each is protected from financially disruptive medical expenses resulting from an illness, accident, or disability. Furthermore, healthcare insurance has developed as a mechanism for financing or pre-paying a variety of health care benefits, including routine preventive services, whose use is neither rare nor unexpected [3].

Generally, there are three healthcare systems which are public, private and mixed. Each type has its own way of funding, delivering care, and managing resources. The choice of system impacts access to care, quality of services, and overall costs. Public healthcare systems predominantly funded and operated by government provide universal coverage to all citizens. Private healthcare systems rely on market-driven forces with services provided by private entities and funded through insurance or out-of-pocket payments while mixed healthcare systems combine

elements of both public and private systems featuring a public baseline of care supplemented by private options [4].

Health insurance do play a role in affecting access and enhancing the quality of healthcare an individual may receive. For example uninsured adults are less likely than adults with any kind of health coverage to receive preventive and screening services and less likely to receive these services on a timely basis. Health insurance that provides more extensive coverage of preventive and screening services is likely to result in greater and more appropriate use of these services. This simply means health insurance may reduce racial and ethnic disparities in the receipt of preventive and screening services. Next, uninsured cancer patients generally have poorer outcomes and are more likely to die prematurely than persons with insurance, largely because of delayed diagnosis. Other than that, Uninsured adults with hypertension or high cholesterol have diminished access to care, are less likely to be screened, are less likely to take prescription medication if diagnosed, and experience worse health outcomes. This result is not surprising, given the strong association between having health insurance and having a regular source of care. Lastly Uninsured persons with diabetes are less likely to receive recommended services. Lacking health insurance for longer periods increases the risk of inadequate care for this condition and can lead to uncontrolled blood sugar levels, which, over time, put diabetics at risk for additional chronic disease and disability [6].

There are different types of Marketplace health insurance plans designed to meet different needs. Some examples include Exclusive Provider Organization (EPO), Health Maintenance Organization (HMO), Point of Service (POS) and Preferred Provider Organization (PPO). EPO is a managed care plan where services are covered only if one use doctors, specialists, or hospitals in the plan's network except in an emergency. HMO is type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. An HMO may require one to live or work in its service area to be eligible for coverage. POS is a type of plan where the pay is less if they use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans requires referral from

primary care doctor in order to see a specialist. PPO is a type of health plan where the pay is less if providers are in the plan's network. Individuals can use doctors, hospitals, and providers outside of the network without a referral for an additional cost [3].

The regulatory framework for private health coverage specifically in the U.S. has evolved into a complicated system of overlapping state and federal standards. This federalism framework creates a sometimes precarious “marriage” between state and federal authority in order to implement health policy goals. At a high level, key aspects of the regulatory framework include five features. Firstly, states lead on insurance regulation, but with a federal fallback for most protections. Secondly, the federal pension law limits the application of state law for those with private-employer sponsored coverage. Next, federal regulation of private health coverage can differ based on the market/source of coverage. Besides that, special exceptions in regulations allow certain types of private coverage to avoid having to meet many insurance protections. Lastly, regulation matters for cost and access to health care and private insurance coverage [1].

The Commonwealth Fund Health Care Affordability Survey, fielded for the first time in 2023, asked U.S. adults with health insurance, and those without, about their ability to afford their health care whether costs prevented them from getting care, whether provider bills left them with medical debt, and how these problems affected their lives. Difficulties affording care are experienced by people in employer, marketplace, and individual-market plans. Survey found that large shares of insured working-age adults surveyed said it was very or somewhat difficult to afford their health care (figure 1)

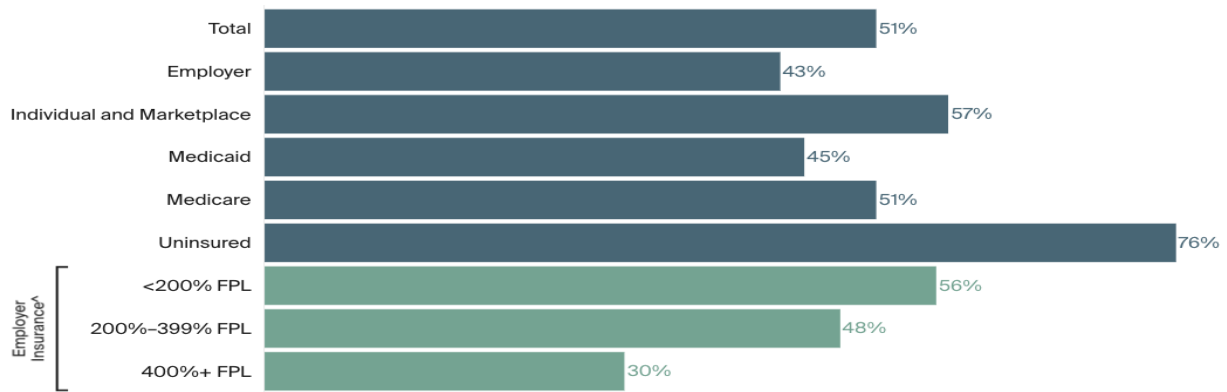


Figure 1 - Percentage of adults ages 19–64 who reported difficulty affording health care costs [2]

Nearly two of five working-age adults reported delaying or skipping needed health care or a prescription drug in the past year because they couldn't afford it.

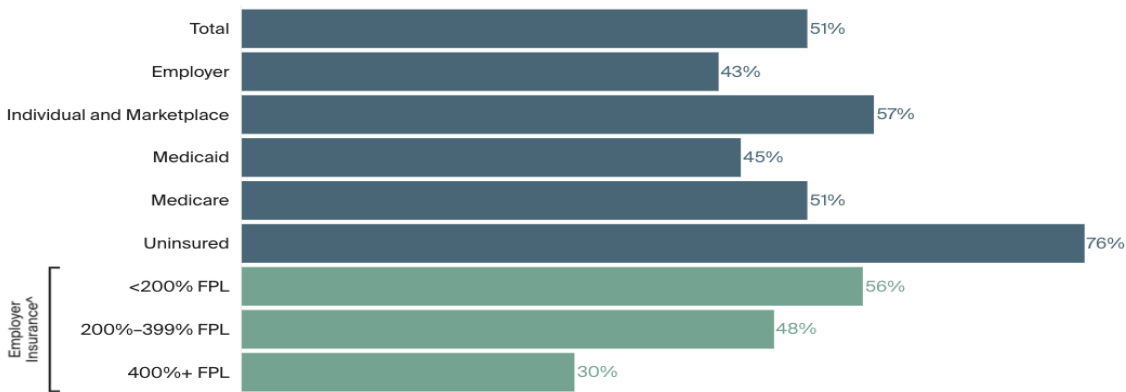


Figure 2 - Percentage of adults ages 19–64 by income who delayed or skipped any needed health care because they couldn't afford it [2]

The cost of health services is an insurmountable barrier to getting timely care for most uninsured people. Undeniably, costs are also a barrier for many people who have insurance. Nearly three in 10 people in employer plans, more than one-third in marketplace or individual-market plans, and about two of five people with Medicaid or Medicare said they or a family member had delayed or skipped needed health care or prescription drugs in the past 12 months because they couldn't afford it [3].

Despite all, the government has made an effort to lessen the burden of its citizens. For example, in the U.S. The Affordable Care Act brings an unprecedented level of scrutiny and transparency to health insurance rate increases. The Act ensures that, in any State, large proposed increases will be evaluated by experts to make sure

they are based on reasonable cost assumptions and solid evidence. This analysis is expected to help moderate premium hikes and provide those who buy insurance with greater value for their premium dollar. Additionally, insurance companies must provide easy to understand information to their customers about their reasons for significant rate increases, as well as publicly justify and post on their website any unreasonable rate increases. These steps will allow consumers to know why they are paying the rates that they are [5].

In conclusion, while health insurance is essential for improving access to care, challenges such as cost and coverage gaps persist. Continued reforms and policy improvements are necessary to ensure equitable healthcare access for all, addressing both the complexities of healthcare markets and the limitations of current insurance systems.

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