Medical insurance and how they work research paper examples

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Healthcare is one of the most important or essential needs that often, an individual has to pay a steep price for, especially in developed or highly industrialized countries such as the United States. In this country, the United States, for example, roughly 46 million Americans have been considered as insurance holders in 2006 alone. As more reforms are set to take place in the U. S. healthcare coverage and policies in the next years to come, that number is set and expected to increase as well. Estimates suggest that by 2016, more than 20 percent of the American population will already be covered by a public or private insurance company .

This can be considered as a good thing, especially for the majority of the Americans since a huge portion of which are still recovering from the aftermaths of the Great Recession of 2008 and the fact that healthcare costs can expensive. To give the readers of this paper some idea how much money the U. S. government is spending on healthcare and just how expensive it is, let us compare the U. S. government’s budget for national defense and its budget for healthcare. Rough estimates suggest that the U. S. government spends about four times resources as much as they do on national defense. The U. S. national defense is the most heavily funded among all countries’ national defense.

The Health Insurance Association of America defines a health or medical insurance as a “ coverage that provides for the payments of benefits as a result of sickness or injury; includes insurances for losses from an accident, medical expense, disability, or accidental health and dismemberment” . Before an individual or any members of his family gets covered by medical insurance, an agreement with a company or a public government-related

entity often has to be made first. During the formation of such agreement, the company or entity that will provide for the medical insurance will have to estimate the overall potential risk of having to pay for medical or healthcare expenses for the applicant in the future. Based on the insurance provider’s assessment of risk, an insurance can develop a payment scheme or financing structure that an individual has to strictly follow and pay so that there will be a source of financing available in case a medically related event that would prompt the insurance provider to pay the expensive cost of healthcare happens. The rule often goes like this: the higher the overall potential risk that the insurance company will have to pay for an individual’s healthcare cost in the future, the more likely that that individual will have to pay for a higher monthly insurance premium or payroll tax deduction.

Any health insurance agreement between an individual and an insurance coverage provider has to be composed of a contract—between the insurance company or government entity and an individual or that individual’s sponsor (e. g. a family member), and an Employer-sponsored and self-funded Employee Retirement Income Security Act (ERISA) plan, especially in the case of large corporations . There are corporations that depend on private insurance companies. This is usually a more expensive option. There are also companies that depend on government-issued insurance offers. The employer-sponsored self-funded ERISA plan is one of the government-issued insurance offers. It is the government, under the jurisdiction of the Department of Labor that provide for the payment of medical expenses and other healthcare related costs. Private insurance companies also play a major role in the administration of coverage in such insurance plans. As

mentioned, they are not the ones that provide for the medical expenses although they are the ones that handle such agreements.

In exchange of being covered by a medical insurance, an insured person is often given financial obligations which can take various forms. The most common form of financial obligation bestowed upon insured individuals is an insurance premium. Based on the agreement between the insurance provider and the insured individual or his sponsor (e. g. employer or any public government-related entity, the latter has to pay for a certain amount, monthly or annually, in exchange for being medically insured.

One of the most common questions about medical insurance in the past was this: will they work? In most cases, medical insurance have worked. The mere expensiveness of medical and healthcare costs in developed and highly industrialized countries such as the United States have made it impossible for average tax-payers to pay for such costs directly in cash out of their pockets. A cash payment scheme for medical and healthcare services may work in some countries but whether this scheme would work is highly influenced by the average costs of medical and healthcare services. Naturally, the lower costs of such services, the more likely that a cash payment scheme would work, and clearly, that is not the case with the U. S. healthcare system. The one that has worked in the U. S. healthcare system was an insurance-based payment scheme. For the most part, it has worked.

This leads us to the next question: will they continue to work? The answer is it depends because there is really no one hundred percent guaranteed correct answer to this question.

Firstly, it depends on the ability of the private and public, government-

related insurance providers to cover the medical and healthcare costs of their respective insurance holders. Healthcare costs keep on increasing and the same goes for the number of people applying for a medical insurance coverage. This combination of factors can be a potential risk for both private and public insurance providers because this means that they will have larger medical and healthcare costs to cover for an often disproportioned premium. In most cases, it is not the hospitals that carry the risks, specifically financial risks, in an insurance-based healthcare payment scheme. It is the private and public insurance providers that do.

Hospitals will be paid, either directly by the recipient of the medical and or healthcare services in an out of pocket payment scheme; or by the insurance providers. No matter what the case is, the hospitals will still end up the winner because they will get paid regardless. In an insurance-based healthcare system, a continuously increasing percentage of the population covered by insurance would actually mean larger revenues and profits for hospitals.

Individuals covered by a medical insurance plan can indeed be more confident to pay hospitals a visit for a medical checkup or basically any healthcare service or procedure because they know that they do not have to pay for anything (except in co-payment-based insurance plans). Imagine the majority of medical insurance-covered individuals doing this. What the hospitals can expect in that scenario would be a sharp surge in the number of people visiting their medical facilities which can be equated to higher revenue and profit figures.

A single insurance plan should be enough for most people. The only

acceptable reason to subscribe for a second medical insurance plan is if the initial plan fails to cover all or at least majority of the medical and healthcare cost of an individual or his dependents (e. g. family members). Cases like these exist. Suppose Mr. X has been assessed by an insurance company and significant risks were seen and considered in the formulation of his insurance plan which resulted to only fifty percent coverage of all his and his dependents' medical expenses. Now, Mr. X has the option to accept such insurance proposal, try his luck with other medical insurance providers, or he can take the current offer and apply for a secondary insurance.

The general rule when it comes to medical insurance applications suggest that as a person's risk of getting sick and thus incurring higher medical and healthcare related costs in the future, the lesser the insurance benefits become. Of course, there are things that a medical insurance applicant can do to make sure that insurance benefits would remain the same: pay higher insurance premiums or allow higher monthly or annual wage deductions. Some of the factors that increase the risk of getting sick and of incurring higher medical and healthcare related costs include but are not limited to the following: older age, genetic problems, lifestyle (sedentary or active, smoking habits, alcohol consumption), and past and existing illnesses. This principle is what keeps the entire medical insurance system financially stable . As the risks go higher, the higher the payment or the lower the value of the insurance benefits should be. If private and public insurance providers would follow the opposite of this principle, that could certainly lead to bankruptcy and instability in the medical insurance industry .

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