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A COMPARATIVE STUDY OF HEALTH INSURANCE IN IRAN AND THE UNITED STATES: PRESENT SOLUTIONS

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ABSTRACT

This paper is a documentary study that investigates the literature in the field of health insurance system in Iran and the United States. The research population is collection of writings and documents related to this study subject and the sampling has been targeted based on dependence, relation to the subjects under study and including the relevant keywords. In this study, in addition to describe the health insurance system in Iran and the United States, health services presentation has been compared as well. The most significant finding in comparison between these two systems is powerful and varied social security system in the United States known as "Medicare" and "Medicaid". Emphasis on long-term care services, short-term care coverage and diversity in the care system services on the community in the US is significant. Results show that insufficient universal health insurance coverage has been the most important factor in choosing supplemental health insurance, at the meantime the Supreme Council of Health was determined to be responsible for supplemental health insurance services approval. While the organizational structure of provider systems of supplemental health insurance were decentralized on the run but centralized in planning and policy maiking, the cost of its services was also determined based on real price of services as well as the principle of competition. Taking adavantage of insurances in the form of public and private complementary health and creating competition among them can play an important role in enhancing the quality of health insurance services, improving the level of consumer satisfaction of services and ultimately improving the health of society.

Keywords: Health insurance, comparative study, insurance in Iran, insurance in the US.

INTRODUCTION

Today healthcare is considered as a natural right for the nations socially and as a strategic issue for the states economically. The health care generalization purpose to the public must be determined based on discrimination elimination between different social groups, at the meantime, the range of health care services is considered as a basic right rather than a commercial instrument. So the community is committed to orovidebe the minimum health care services for all people. People's health is part of the national capital which is constantly exposed to environmental risks, and the profit or loss due to the presence or absence would be imposed on all members of the community. So even though individuals of the community should strive to maintain their health, the community is responsible for maintaining its own individuals' health and it should accept responsibility against the risks that threaten the health. In recent decades the structure of social security systems, in particular in the field of health insurance, has undergone changes that is still continuing. The organizational structure of health insurance in selected countries has its specific features and there are various plans to establish the systems. However, the overall structure has not been apart from any country's current public insight and its type of government and the government intervention in the implementation of projects and the role given to the private sector is closely related with the type of governments as government efforts can be seen to expand health insurance services in selected countries and all countries aim to make treatment options for all individuals in the society. Today, many social services and institutions are available based on private and employment-based plans or insurance programs. In insurance affairs (supplemental health insurance) is a specific sample of such cases. Since the the scope and level of based insurance (public) is decreasing and the need are increasing, to study the supplemental health insurance is significantly important. Services in supplemental health insurance are determined with a wide variety of products, services and providers. This article aims to conduct a comprehensive review of a number of supplemental insurance institutions and services in the United States, and subsequently it will have an analysis of the supplemental insurance system in Iran, and finally, some recommendations are provided to improve the current status. In order to understand the scope of complementary programs, first the basic health insurance plan has to be examined. It's important because the basic health insurance is usually considered as a

deflection point for the supplemental health insurance.

Basic concepts and structure of the insurance market can be explained in terms of evolution of the industry in response to new events. The insurance industry development has been the result of important impacts of international trade, urban development, an increase in catastrophic events such as fires and industrial revolution. For historical reasons, the insurance industry has been developed in the UK since the seventeenth century onwards. The insurance development also took place in North America and other British colonies with the establishment of British insurance corporates agencies and the colonies' comprehensive compliance with all policies of England.

It was mainly in the first half of the twentieth century that insurance become an institutionalized activity. Development of insurance activity brought the industry out of the form of just a series of contracts between individuals and it was takan into account by all countries.

Insurance that is a part of the overall development of economy can have a good quality growth like \ other financial services. Many developing countries in Asia have had the fastest economic growth. In line with economic development, they have also experienced rapid growth in insurance activities. In contrast with developing countries, Africa and Latin America have still negligible share in the global insurance market. In developing countries, major restrictions on the establishment of insurance companies are continuous deterrent factors ruling the exclusive markets.

METHODOLOGY

This is a documentary study that investigates the literature "in the area of health insurance system in the United States and Iran".

The study population is the set of the writings and documents related to the study subject and a sampling has been conducted purposefully based on dependency, relationship to the subjects under study including related keywords as: health insurance, comprehensive study, Iran, the United States among the resources available in articles, writings and reliable documentation. In this regard, national databases of the Ministry of Health of America and Iran, as well as books and periodicals were used.

Data were collected with noting from writings and documents introduced in sampling and it was then under content analysis and was classified.

Health insurance system in the country:

Iranian health insurancesystme, like many developing countries, is a universal insurance. Among the characteristics of the country, there are various developments

leading to the lack of formation and stability of the health care system. In other words, countries are still unable to identify and find their appropriate organization structure. On the other hand, the extent and diversity of population in the country has always created access difficulty and equity establishment to having resources for people, especially in rural areas. Constant development of health systems in different parts of the country, despite population growth, has made Iranians suffering from physical, geographic, and financial access problems whether in the health sector or in the treatment sector, causing many costs of the people.

Iranian public and private sectors together are responsible for providing various health care services but mainly the public sector, and especially the Ministry of Health and Medical Education take more responsibilities in this area. Social developments and health services have been taken into consideration at least since three decades ago and they have been considered as the obligations of insurance companies. It is also stipulated in the constitution of Islamic Republic of Iran (Articles 6 and 10) and in legislation such as the Third Development Plan its full implementation has been emphasized as well.

High costs of diagnosis and treatment and totally the increasing growth of the costs in on hand, and a large difference between the tariffs of medical services in governmental and non gevernmental sectors on the other hand, have created conditions that reduce social motivation in the field of activity in health insurances sector; because if individuals tend to use the supplemetal health insurances, because of the demand for receiving services with higher quality and along with other extra services and not requiring to wait in line and conditions like that, the services are more in the private or non governmental sector and services tariff in this sector is much higher than the public sector.

Our country, like all countries in the world is facing with the issue of limited resources in the health sector. Basic health insurances in Iran, despite their strengths in comparison with many countries under studiy have considerable strenghts as well. All outpatient services and a fully broad range of insurance services in Iran are much more than many countries around the world. But the main point is the feasibility of the country's success in continuing the current level according to deep changes occur in technologies and expensive methods of diagnosis and treatment every day.

Opportunities in the current situation to implement the supplemental insurances are as follows:

1. Several years of experience in a variety of supplemental insurance achieved by business insurance companies
2. Governmental and non-governmental organixzations' and institutions' serious tendency to cover employees in supplemental insurance
3. Predict legal problems solving of private insurance activity in the near future
4. Activate the private sector in providing health care services in many cities of the country
5. Lack of coverage of many services in the forms of basic insurance
6. Inability to use many health services for people due to economic reasons
7. Lack of support systems for the elderly and persons with disabilities
8. Reject health insurance books in many clinics and medical centers
9. Patients' uncertainty for costly surgeries like organ transplantation
10. The inability of public sector in providing healthcare costs of population.
11. The need for community participation in the use of dairy supply management costs.

International experiences have shown that with the use of supplemental insurance, the demand for medical services has significantly increased and the rate of using them has remarkablely grown.

In the country, supplemental insurance have been defined with different and sometimes various definitions based on the perception of provider system from the supplemental insurance and based on the tangible needs in special conditions that are briefly provided in the following formats.

1. Supplemental insurance provided by commercial insurance covered by Central Insurance of Iran The main philosophy in the definition of this type of supplemental insurance is to enable the insured people using healthcare services of the private sector and mainly non-governmental hospitals. So that on the entrance head of health damage insurance sector of each of the four companies, the name of their contract hospitals, that are mainly private and sometimes specialized hospitals like Rajayi Cardiac Hospital can be seen.

The insurance first generally covers hospitalization services and defined and specific criteria have been also presented for costly diagnostic services. Type of insurance services coverage is the cost by determining specific payment and for higher coverage above the payment, higher insurance premiums have to be paid (even if a person suffers from a chronic and costly illness, and his annual cost of treatment is above the specified insurance coverage, the cost should be inevitably paid by the person.

In this format, supplemental insurance will be the costs supply in excess of the payment by governmental insurance; the

insurance company has no obligation to pay for outpatient services and in the case of insured hospitalization for surgery, the insurance pays the costs based on the tariffs inserted in the contract, but the maximum payable costs for per person within one year from the insurance company are determined by the number of groups and certain insurance premium. In Iran, insurance companies, to provide insurance services are not individual therapeutic Only in those acts. The general conditions of group insurance cost Hospital treatment in the insurance business, insurance, compensation costs Hospital and surgery may be due to disease and accident insurance in accordance with the conditions set out in And takes a pre-determined period of insurance, insured Shall pay the premium to cash.

Iranian insurance companies have not provided individual health insurance services and they are merely acting in group fields. In general conditions of group insurance of hospital costs in commercial insurance, the insurance take the responsibility of compensating hospital costs and surgery due to possible disease and accidents in accordance with the conditions set out in the insurance and the period of insurance is pre-determined; the insured is obliged to pay insurance premium in cash.

Hospital and surgical expenses in cases such as beauty, birth defects, miscarriages, addiction, suicide, natural disasters, war, nuclear interactions, private rooms, eliminate refractive defects and fourth childbirth are not covered by the insurance.

The insured is free to choose any of the hospitals in the country and the insurer requires to be informed about hospitalization up to 3 days after postpartum to be admitted to. Maximum age of insured is 60 years and in case of death, the dependents will receive benefits until the end of the contract period. Male children up to the age of 20, and if student up to the age of 25 and female ones until their first marriage are covered by the insurance.

Strengths and weaknesses

Strengths

Main strengths of this package of the supplemental insurance are as follows:

1. The expansion of health insurance coverage in the country,
2. Create more choice for the insured to choose the doctor and place of treatment (public or private sector)
3. Reduce the costs imposed on the insured,
4. The expansion of services used by the insured followed by the increase of accessing to services.

Weak points

1. Covers only costly diagnostic inpatient and outpatient services,
2. Insurance coverage with cost recovery system with specified payment above which must be paid by the insured.
3. Classification of services based on unproven assumption that high quality services will be certainly provided in private hospitals,
4. Strengthen incentives for service providers in the private sector to provide detailed invoices based on conservative payment system,
5. Provide limited services packages of supplemental health insurance without competition among rival insurance institutions,
6. Organizations, rival insurer,
7. Health insurance activity only in the form of commercial insurance only in the public sector,
8. Inability to cover certain patients in this typy of insurance coverage,
9. The lack of a strong legal base for the supplemental insurance services,

According to the existing laws and regulations in the country, currently doing any private activity in the insurance sector, including health insurance is prohibited, and no private institution is allowed to act in the sector.

Now some insurance institutions in the country such as aid insurance, whose treatment activities were mentioned in the research, does not provide insurance services themselves, but they get members as an intermediary between Iran insurance company and individuals and insurance servicea are actually offered by Iran Insurance Company. The legal problem is now the main obstacle to private sector activity in the field of health insurance including supplemental insurance.

High costs of diagnosis and treatment, and increasing growth of the costs in one hand, and a large difference between the tariffs on medical services in both public and private sectors on the other hand, have created conditions that enhance economic incentive for activity in the health insurance sector, because if people want to use private health insurance, due to the demand to receive services with higher quality along with other extra services, they will search some services more in the private sector than the public sector, the conditions such as lack of commitment to waiting in line and etc. and the services tariff in this sector is much higher. Therefore, if any tendency towards privatization of health insurance and supplemental insurance, it will first need an active private sector in the provision of high quality medical services and on the other hand it should create a reasonable balance between health insurance premiums per capita with real medical tariffs. Public and private

institutions tendency to supplemental insurance in order to create more incentives is one of the positive points for the implementation of the project in the country.

2. Supplemental insurance provided by governmental insurance agencies

The main objective of the implementation and development of this type of insurance coverage has been to cover part of the healthcare costs of the target population in order to increase their job satisfaction and motivation.

Strengths and weaknesses

Strengths

1. Success in increasing job motivation and satisfaction of insured and employees,
2. Increase individuals' accessibility to healthcare services,
3. Enter the field of supplemental insurance by the public sector and individuals' competition in the country,
4. Expand the scope of healthcare insurance coverage in the country,
5. Create more choice for the insured,
6. Reduce costs imposed on the insured,
7. Expand services used by the insured followed by the increase of accessibility to the services.

Weaknesses

1. The lack of a firm legal base with a spesific definition of supplemental insurance coverage in the public sector,
2. The lack of an integrated system to cover all persons based on the principle of justice,
3. Exclusive provision of supplemental insurance by the providers to the target population and the lack of individual choice,
4. Supplemental insurance funds' economic dependence on subsidies,
5. Supplemental insurance systems design based on other materials, regardless of the precise economic principles and Actuary,
6. Non-comprehensive definition of covered services in each of supplemental packages only based on the existing facilities, the lack of full compliance of the defined packages with the definition of supplemental insurance.

Researchers in Medical Services Insurance Organization (MSIO) according to the survey of experts and specialists in this field, suggest a model for supplemental insurance in Iran as follows:

The general principles

Basic services: include all services lack of which will damage the patients' health (regardless of the maximum costs payment).

Complementary services: include insurance coverage of services and costs out of the basic insurance coverage.

Covering principles: occupational or geographical area, depending on the conditions and in a competitive manner.

Type of coverage: coverage is optional, the way of implementation is the issuance of long-term insurance that in the case of the insured tendency and with the same conditions of the previous insurance (if the previous insurance provisions are met) it can be extended to the end of life and the prerequisite to use the services is competitive and it depends on the insurance choice.

Performance guarantee: approving the supplemental health insurance law in the parliament and issuing implementing regulations by the Cabinet.

Organization and management: different providers of supplemental insurance in the public and private health care sectors under the supervision of the Supreme Council of healthcare insurance that is required to comply with guidelines issued by the Supreme Council.

Franchise: considering the franchise for covered services in a competitive form between the insurance companies to control the consumption model and prevent unnecessary requests and pay subsidies for the services franchise to those need service providers.

Goals

Increasing the level of satisfaction of insured; compensating current failure of basic insurance by providing more diverse services and doing more freely activities with more maneuverability to maintain the public insurers ' dynamism.

Procedure

The need to gradually expand covered services and gradual coverage of population with two parallel procedures to begin a certain credit program of existing resources to be considered for that.

The method of determining premiums

1. Different service packages are defined by priority,
2. For each service package, a separate premium is specified,
3. To complement the supplemental insurance premium, basic insurance premium receipt mechanism is used,
4. Premium rates are determined according to the public insured ability to pay,
5. Insurance premiums are paid as the state subsidies for needed people.

Private sector providers

The way to run

1. Provide clear and unambiguous definition of key words and terms of health insurance,
2. Provide favorable conditions for the establishment and operation of private

insurance companies with new legislation of supplemental insurance,

3. Develope supplemental health insurance standards and they have to be implemented for all insurance companies,

4. In order to respect the rights of the insured and the insurer, develope standard forms for insurance contracts,

5. Determine the specific and impartial regulatory authority to implement these agreements and pursue possible violations.

6. Determine the precondition of using services competitively.

How to calculate insurance premiums

Appropriate to the age and individual and group health status competitively and freely in determining the amount and its payment jointly between the insured and the insurer that the government pays a fixed amount in the form of subsudes by as the right of needed people.

Definition of service package or packages

Different service packages with a priority of need and necessity for everyone to purchase more urgen packages according to its needs and economic power.

Insurance system in America

America's health care system is explained with a complex collection where there is a suitable access for those who are covered by the insurance for a variety of services, but the access is difficult for other people who are denied to be covered by the insurance for some reasons. Thus the system coul not be considered to be reliable. The reason is that the system acts as a multiple system that the population in any form of it covered is different from the other forms, and each form is also pursuing its own specific goals.

In this system, Medicare covers the elderly and disabled population, private insurance covers people of up to 65 years; Medicaid establishes health coverage for poor and vulnerable groups and separate systems are established for both veterans and employed military personnel.

In this situation for people under 65 who are not covered by private insurance and others who rely on the conditions of health care system in the public sector, there is no insurance coverage guaranteed. The health policies of any states have some complications as well that are along with difference in priorities for establishing the coverage of remainder groups of the insurance coverage sustems. The complexities are mainly due to differences in the payment system, the burden of diseases and the usage pattern of care. Among the insured groups there are also a lot of problems evident for those who have inadequate insurance services.

In health system of the United States of America, sources of costs financing are mainly funded from direct payment by consumers, sources of private insurance

and public insurance sources for Medicare, Medicaid and children's health insurance plan. Private insurance including health insurance institutions and commercial insurance institutions, generally co-payment of contributions by employees and employers or individual insurance premium to provide the required financial resources.

Private insurance institutions including health care insurance and commercial insurance institutions generally provide required financial resources from common premium payments by employees and employers or individual insurance premium.

This insurance due to the need to control their costs, have to develop and continually refine their methods of payment. Payment methods known in private insurance mainly consists of three methods of (DRG). Despite controlling costs, especially by insurance as fee-for-services, capitation, and private prospective payments, total health expenditures in 2000 and 2005 have a growth of 52 percent. The reason generally has refered to the growth of wages for health care, the use of expensive technology, demand trends towards more expensive insurance, and regulations that increased the cost of Medicare.

In the public Medicare insurance it's tried to control payment system to doctors and hospitals. In addition, in this type of insurance, disease management along with clinical treatment manual and transmission of the additional costs to consumers is considered in the ways to control costs. In Medicaid insurance, finding physicians and institutions that accept the low insurance reimbursement rates is a concern. Moreover, the services of this type of insurance vary from state to state and the increase in its cost is always expressed as a concern.

Payments for health care in America can be seen as a combined method of several different methos. Payment to hospitals in the past three decades is observed as a set of refund on the basis of prospective-payment system of DRG, Pay-for-Performance and funding for medical education. Payments to physicians can be also seen in varous forms as fee-per-service, per-capita rate, salary, and "resource-based relative value scale» that in the Medicare insurance it determines that how much must be paid to providers.

Two important issues in determining the payment systems include:

A) Payments for physicians' fees are more in the type of contract payments that can not be determined or accepted regardless of the resources allocated to services.

B) Payments for physicians' fees should be considered to motivate them.

Now with this explanation, it can be accepted that fee-for-services system leads to costly and unnecessary treatment (over

reat). Systems based on prepayment such as per capita rate lead to reduce costs, maily due to limited or incomplete treatment (under treating), avoid high costs of treating patients and focus on prevention. The salary payment system doen not provide doctors with any financial incentives.

American experience has also shown that hospitals can easily react against their reduced income. I.e. hospitals simply can show their balance profit low with shifting their accounts, reduce their costs in cases where their income would not be damaged, for example, with the discharge of patients, increase their emergency treatment cases and increase the rate of referrals from outpatient to inpatient treatment.

In America's health care system it has been accepted that any method of payment is absolutely correct. Payment systems in any structural situation should be set accordance with the realities of supply and demand. Policymakers need to worry about the effects of a payment method on other payment methods at the same time in other parallel structures.

Policymakers should review the effects of payment methods to service providers on costs, accessibility and quality of services continually. The purposes of this system have been explained as the tendency to pay for functions in recent years.

In this type of payment, it's tried to make it possible to increase service providers' incentives to increase the quantity and quality of services, to quantitative objectives and functions to enable their comparison and to exchange between costs, quality and access. Principles of payment system for functions for present and future years have included the following items: increased efficiency for the supply of services, create incentives for service providers, increase consumers' choices, increase the sensitivity of the doctors to the patients' status, cost control, guidance funds to the needs for costs, create transparency and proportionality in payments to service providers, encourage cost-effective methods of treatment, transfer of service in a different direction from its current difficult path and improve the quality of supply and access to services.

At the present, payment systems in America is trying to development based on salary paymet system combined with necessary conditions to motivate the doctors, combined fee for service with restrictions to increase costs by doctors and combined per capita rate with the favorable situation in terms of patients.

On the payment system to hospitals the important issue is that the inpatient treatment payments must be measured against payments of outpatient treatment. The way of amortization of capital costs,

they have to be properly distinguished from operating costs and required differences need to be established between the three sets of public, specialized and educational hospitals. In addition, payments to doctors have to be considered in hospital costs and additional payments of paitients should be properly identified.

Currently, the peyment system to hospitals contains a series of payments that include: a) the reimbursement of expenses made, b) the prospective payments for any service or item, including fee-for-services, pay-per-day hospital stay, payment based on patient records at the time of acceptance, and payment of DRG, c) payment based expenses on components including payroll, materials and supplies, cost of medication and other costs which are calculated and paid as global, and d) payment with per capita rate. Managed care system also makes a relationship between funding costs and supply of health services based on a contract between registrants and service providers.

In this system, the insurance premiums are adjusted with the risk related to them and the package of service benefits is determined based on participating in costs for the consumer. In this system, the quality and usage of services are under supervision and control as well and selection of service providers' network is possible in accordance with the opions of insured people. In the system, participation of service providers can be considered possible at risk. Totally in policy-makers's idea, payments system, especially for the pyment to private sector, need to legality, and costs control in it is of particular importance. This legality can be effective to control the rate of inflation, inefficiencies, inequities and transfer costs to the public sector.

America's health care system consists of three main sections:

1. Private sector insurance
2. Public sector insurance
3. Retirement and disability insurance of the military

Totally, 25 percent of the US insurance is public and 70 percent of health insurance is private which covers a total of 85 percent of the population.

- 10 percent of people are simultaneously covered by both types of insurance
- 14 percent of America's population is without any coverage.

Private Sector Insurance:

With more than 100 private insurance companies that cover about 74 percent of the population among which 62 percent are workers who have been insured by their employers.

The insured pays 10 percent of the cost of hospital and 26 percent of doctors' payments as franchise.

Private insurance includes:

- ❖ Commercial Insurance
- ❖ Personal insurance
- ❖ Employer-based insurance

Public Sector Insurance:

For those who are not covered by private insurance and it's funded by the federal government.

Medicare insurance program: for the elderly, disabled, patients with kidney diseases and specific groups

It's the largest insurance network in the country. It covers around 13 percent of the total country's population.

It has been taken into more consideration since 1950.

Part A Medicare program: inpatient services, home services and nursing homes.

Part A Medicare is considred as central program of Medicare because the main benefits designed in program A are considered in other three programs as well.

Part B: doctors' services and other outpatient services.

• Public Sector Insurance: MEDICAID health insurance program covers about 10 percent of the total population for low-income groups whose income is lower than poverty line and its resources are provided jointly by the federal and local government and its administration is by state governments. Covered groups are as:

• Poor elderly, blind, disabled, pregnant women and those who have accepted the guardianship of orphans.

Retirement and disability insurance of the military:

- ➢ It covers 3 percent of the country's total population. The plan's budget is from the government's general revenues.
- ➢ 43 million of this country's population is not covered by any insurance.
- ➢ The satisfaction of health system among American citizens is very less than other nations.
- ➢ Coordination between the private and public sector is very weak.
- ➢ The price of services is determined by the free market. (Supply, demand, competition)
- ➢ Health care services are organized and provided by a defective system locally.
- ➢ America has the highest per capita cost of health care services in the world.
- ➢

It is estimated health share of GNP would reach to 37 per cent in by 2030.

The supplier organizations of health insurance:

- ➢ blue shield

- blue cross
- commercial care
- Health maintain organization
- preferred provider organization

Financing insurance in America:

• 33 percent of premium
• 24 percent of taxes
• 28 percent of private insurance sources
• 20 percent cash
• 5 percent of other private resources

Patients in the healthcare systems studied only require to direct payment in the pharmaceutical sector and all other services are made for free or with partial payments. What can be seen in the pharmaceutical services is to determine maximum range for direct payments, so that for the low cost drugs the insurance has fewer shares of payment, but on the specific range of expensive drugs the insurance will pay the most.

Most laboratory and diagnostic services in the two countries surveyed are offered in the outpatient department of more specialized services in hospital wards. Institutions providing social services work through a referral, which means they temporarily admit the patient and, if necessary, and after performing the necessary services they refer them to day-care centers.

FINDINGS

The comparative study showed that the organizational structure of the supplementary health insurance in the United States and Iran are devided into two private (independent) and public (government dependent) insurance.

Current models for the structure of insurance

Iran	**Public**
United states	**Private**

The supplementary health insurance services are in two forms of cost supplementary health insurance and service supplementary health insurance, in other words some forms of the cost and service supplementary health insurance are available.

Some advantages provided by cost and service supplemental insurance in the United States

Country	Cost supplemental insurance	Service supplemental insurance
United states	**Dental Services / Ophthalmology / home care / nursing care**	**Cover medical costs / cover travel expenses, consulting / cover the cost of the income losses**

Organization and management of health insurance in Iran

How to reimburse (reimburse to the insured(	The basis for calculating premiums and population coverage	The status of services coverage by supplementary health insurance	Type of insurance organization
No	**No**	**No**	**Social security organization**

In referring to any units on behalf of the contracting no payment is done by insured. In other cases, reimbursement	**The coverage is provided as group without consideration of factors such as gender, age, and health status.**	**Atiyehsaz Hafez company directly provides the employees of medical services insurance organization with supplementary helath insurance services.**	**Medical services insurance organization**
Like Atiyehsaz Hafez	**It's acted like commercials insurance.**	**It has signed a contract with Iran insurance and indirectly provides this coverage.**	**Army forced medical services insurance organization**
Like Atiyehsaz Hafez	**The coverage is provided as group with consideration of such as health status.**	**Dana, Iran, Asia and Alborz**	**Commercial insurance**
Reimbursement (guaranteed)	**Dental supplementary**	**Shamim Kowsar insurance companies**	**Other**

Organization and management of health insurance in the United States

Considerations	Basic health insurance	Supplementary health insurance	Country
Monitoring and evaluation system is done through independent non-profit organizations	**Except the Medicaid and Medicare, the basic health insurance coverage is also provided by the private sector**	**It's entirely provided by the private sector**	**America**

CONCLUSION AND RECOMMENDATIONS

People's expectations of supplemental health insurance is different, insufficient coverage of the basic health insurance and poor macro management of health insurance and the inability of government to fully health cover the health insurance on the one hand, the expectation to receive better quality services, providing greater benefits from insurance organizations and rising cost of health sector are the causes of tendency towards supplemental health insurance. Taking the necessity infrastructures into account and laying the grounds to do this is an imporat factor to improve the current situation.

In our country the public sector, especially the Ministry of Health is responsible for a large volume of health services. Using an institution as the council of determination of supplemental health insurance services as a special council under the supervision of the Supreme Council of Health can be useful to develope external relations and the withdrawal of unilateralism in the development and evaluation of services being provided in the form of supplemental health insurance.

In this area, policy development and its implementation by the government, the extent of the duties and services of the organization may leads to disturbances in the performance of the organization. On the other hand ignoring facilities in each region will make the other institutions unable providing solutions and new ideas.

Hence the creation of a decentralized organizational structure in the implementation and focus on policymaking

and macro planning for private sector involvement under the supervision of competent centers could be effective in decreasing executive functions of government, running a competition and consequently impriving the quality of services and creating employment.

Studies conducted suggest that the reimbursement is a type of guarantee; this means that the consumer after paying the cost refers to the insurer to receive the agreed amount.

The use of insurance in the form of public and private supplemental health insurance and creating competition between them, they can play an important role in promoting the quality of health insurance services, consumer satisfaction and finally the development of public health, taking the following issues into account will be useful:

The Supreme Council of the national health shall determine the packages of basic and supplemental health insurance according to the public coverage principles by considering the available resources in the health sector and consumer's ability to pay.

The Supreme Council of the national health while considering the approach of decentralization on providing supplemental health insurance after policymaking at the national levels by the Supreme Council of the Health, should have reginal and decentralized supervision on the implementation of supplemental health insurance on an adjunctive treatment for regional and regulate is decentralized.

In providing the methods of supplemental health insurance, some principles should be considered including creating a competitive environment for services with high quality and with reasonable prices and the individuals' freedom of choice to select insurance companies.

Strengthening the private sector for more activities in providing supplemental health insurance and developing appropriate services with the consumption pattern and needs of the community and separating and making specific boundaries of basic health insurance from supplemental health insurance

With regard to the legal status of Medical Services Insurance Organization, the organization can be the main provider of supplemental insurance services to the poor by receiving relevant insurance premium from the government.

The extent of population covered by the organization in the country is as a strong point in its activity in the supplemental insurance, because many of the individuals will be undoubtedly volunteers to purchase supplemental healthcare service packages too.

Providing supplemental insurance by Medical Services Insurance Organization (MSIO) can promote the level of

satisfaction and it also allows insurance institutions to be unified in basic and supplemental insurance for the insured.

With regard to freedom of choice of the insured in selecting an insurance company in the third five year plan, the supplemental insurance in the organization activities description will lead to attract more people to buy basic and supplemental insurance of the organization in the competitive market between insurance institutions.

Definition of different service packages of supplemental insurance by the priority of need increases the choice for people in registeration. According to certain legal restrictions that exist when implementing the supplemental healchcare insurance plan, the organization can pioneer in providing a draft bill of supplemental insurance to the government.

The comparative study showed that in supplemental insurance discussion in the world, the private sector activity for enrichment and further development of supplemental insurance has an undeniable role that the organization may play a more effective role in eliminating legal obstacles and strengthening the role of the private sector in this area.

In the implementation of supplemental insurance, there is a threat to take the risk of social justice that prediction of all the necessary strategies in the prevention of these conditions can be also of national responsibilities of the organization.

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