How U.S. Health Insurance Works

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Health care in the United States can be very expensive. A single doctor's office visit may cost several hundred dollars and an average three-day hospital stay can run tens of thousands of dollars (or even more) depending on the type of care provided. Most of us could not afford to pay such large sums if we get sick, especially since we don't know when we might become ill or injured or how much care we might need. Health insurance offers a way to reduce such costs to more reasonable amounts.

The way it typically works is that the consumer (you) pays an up front premium to a health insurance company and that payment allows you to share "risk" with lots of other people (enrollees) who are making similar payments. Since most people are healthy most of the time, the premium dollars paid to the insurance company can be used to cover the expenses of the (relatively) small number of enrollees who get sick or are injured. Insurance companies, as you can imagine, have studied risk extensively, and their goal is to collect enough premium to cover medical costs of the enrollees. There are many, many different types of health insurance plans in the U.S. and many different rules and arrangements regarding care.

Following are three important questions you should ask when making a decision about the health insurance that will work best for you.

Key Question 1

Where can I receive care?

One way that health insurance plans control their costs is to influence access to providers. Providers include physicians, hospitals, laboratories, pharmacies, and other entities. Many insurance companies contract with a specified network of providers that has agreed to supply services to plan enrollees at more favorable pricing.

If a provider is not in a plan's network, the insurance company may not pay for the service(s) provided or may pay a smaller portion than it would for in-network care. This means the enrollee who goes outside of the network for care may be required to pay a much higher share of the cost. This is an important concept to understand, especially if you are not originally from the local Stanford area.

If you have a plan through a parent, for example, and that plan's network is in your hometown, you may not be able to get the care you need in the Stanford area, or you may incur much higher costs to get that care.

Key Question 2

What does the plan cover?

One of the things health care reform has done in the U.S. (under the Affordable Care Act) is to introduce more standardization to insurance plan benefits. Before such standardization, the benefits offered varied drastically from plan to plan. For example, some plans covered prescriptions, others did not. Now, plans in the U.S. are required to offer a number of "essential health benefits" which include

Emergency services
Hospitalization
Laboratory tests
Maternity and newborn care
Mental health and substance-abuse treatment
Outpatient care (doctors and other services you receive outside of a hospital)
Pediatric services, including dental and vision care
Prescription drugs
Preventive services (e.g., some immunizations) and management of chronic diseases
Rehabilitation services

For our international population of students who might be considering coverage through a non U.S. based plan, asking the question, "what does the plan cover" is extremely important.

Key Question 3

How much will it cost?

Understanding what insurance coverage costs is actually quite complicated. In our overview, we talked about paying a premium to enroll in a plan. This is an up front cost that is transparent to you (i.e., you know how much you pay).

Unfortunately, for most plans, this is not the only cost associated with the care you receive. There is also typically cost when you access care. Such cost is captured as deductibles, coinsurance, and/or copays (see definitions below) and represents the share you pay out of your own

pocket when you receive care. As a general rule of thumb, the more you pay in premium up front, the less you will pay when you access care. The less you pay in premium, the more you will pay when you access care.

The question for our students is, pay (a larger share) now or pay (a larger share) later? Either way, you will pay the cost for care you receive. We have taken the approach that it is better to pay a larger share in the upfront premium to minimize, as much as possible, costs that are incurred at the time of service. The reason for our thinking is that we don't want any barrier to care, such as a high copay at the time of service, to discourage students from getting care. We want students to access medical care whenever it's needed.

Important Insurance Terms and Concepts

- **Out-of-pocket expenses**: The terms "out-of-pocket cost" and/or "cost sharing" refer to the portion of your medical expenses you are responsible for paying when you actually receive health care. The monthly premium you pay for care is separate from these costs.
- **Annual deductible**: The annual deductible is amount you pay each plan year before the insurance company starts paying its share of the costs. If the deductible is $2,000, then you would responsible for paying the first $2,000 in health care you receive each year, after which the insurance company would start paying its share.
- **Copayment (or 'Copay')**: The copay is a fixed, upfront amount you pay each time you receive care when that care is subject to a copay. For example, a copay of $30 might be applicable for a doctor visit, after which the insurance company picks up the rest. Plans with higher premiums generally have lower copays and vice versa. Plans that do not have copays typically use other methods of cost sharing.
- **Coinsurance**: Coinsurance is a percentage of the cost of your medical care. For an MRI that costs $1,000, you might pay 20 percent ($200). Your insurance company will pay the other 80 percent ($800). Plans with higher premiums typically have less coinsurance.

- **Annual out-of-pocket maximum**: The annual out-of-pocket maximum is the most cost-sharing you will be responsible for in a year. It is the total of your deductible, copays, and coinsurance (but does not include your premiums). Once you hit this limit, the insurance company will pick up 100 percent of your **covered** costs for the remainder of the plan year. Most enrollees never reach the out-of-pocket limit but it can happen if a lot of costly treatment for a serious accident or illness is needed. Plans with higher premiums generally have lower out-of-pocket limits.
- **What is means to be a 'Covered Benefit'**: The terms 'covered benefit' and 'covered' are used regularly in the insurance industry, but can be confusing. A 'covered benefit' generally refers to a health service that is included (i.e., 'covered') under the premium for a given health insurance policy that is paid by, or on behalf of, the enrolled patient. 'Covered' means that some portion of the allowable cost of a health service will be considered for payment by the insurance company. It does not mean that the service will be paid at 100%.
    - For example, in a plan under which 'urgent care' is 'covered', a copay might apply. The copay os an out-of-pocket expense for the patient. If the copay is $100, the patient has to pay this amount (usually at the time of service) and then the insurance plan 'covers' the rest of the allowed cost for the urgent care service.
    - In some instances, an insurance company might not pay anything toward a 'covered benefit'. For example, if a patient has not yet met an annual deductible of $1,000, and the cost of the covered health service provided is $400, the patient will need to pay the $400 (often at the time of service). What makes this service 'covered' is that the cost counts toward the annual deductible, so only $600 would remain to be paid by the patient for future services before the insurance company starts to pay its share.