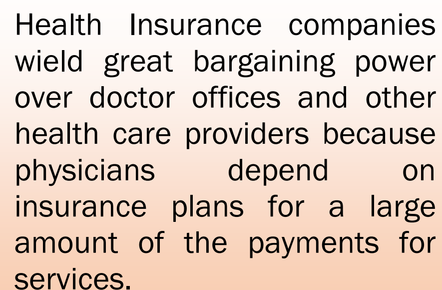
Health Care in the U.S.

A Very General Overview of How the U.S. Health Care System Works

The United States is considered a free market health care system with privatized and some government insurance providers. Basically, it is a pay-as-you-can-afford system. The private insurance industry offers individual and group policies. Health care providers (physicians, hospitals, pharmacies, diagnostic facilities, therapeutic facilities, nursing care facilities, and so on) sign contracts with insurance providers. Private insurance companies then use the volume of insured patients that they control in these plans to restrict payment to the health care providers who have agreed by contract to take a fixed fee for each service.

After a person receives care, the providers send the bill to either the patient's insurance provider, or, if the patient has no insurance, to the patient.

The insurance company will pay the provider all, some, or none of what is charged depending on the terms of the contract and other conditions. In some cases, the patient is responsible for paying the rest and/or paying a portion of the charges up front, before the insurer pays for anything.



J-1 Exchange Visitors and their J-2 dependents are required by law to have health insurance that meets specific standards. See "J-1 Health Insurance Requirement".

For those who come from countries with nationalized healthcare, or if you have purchased health insurance in your home country, please note that many medical providers in the United States will not directly bill foreign insurance entities. As such, you may be required to pay up front for the services and request reimbursement. Also, the costs of procedures may be much higher in the United States than in foreign countries. Please carefully discuss this with your foreign health insurance provider.

Medical Emergencies

In a medical emergency, please go to the nearest hospital emergency room (ER). A medical emergency is generally defined as a sudden, serious and unexpected illness, injury or condition, including severe pain, which requires immediate medical attention.

In a life threatening emergency, please call 911 for immediate assistance from a fire department, police department or ambulance/paramedics. Only use this number in TRUE emergencies.

Urgent Care centers are also available for non-life threatening or minor emergencies. If the urgent care staff judges your problem to be more critical than you estimated, they will transfer you to the closest ER.

Suggestions on How to Assess Different Health Insurance Plans

It is important to understand what is covered under the health plan and what you will pay out of pocket after the insurance company pays its part (or if the service or supply is not covered). Some examples of things to consider when looking at an insurance plan are:

- Are prescriptions included?
  - Are the prescriptions you or dependents require covered by the plan?
- Does the plan include dental expenses? Often dental insurance is separate.
- Does the plan have a *pre-existing condition clause*?
  - If you or your dependents have a continuous health condition (such as asthma, diabetes, etc), will your medications, doctor visits, and health costs related to your condition be covered by the plan?
  - Some plans may consider pregnancy a pre-existing condition.
- If you already have a specific facility or doctor selected, do they accept patients with this insurance provider?
- Does the plan allow for out-of-network reimbursement or pay a percentage of the costs? Or does the plan exclusively cover in-network healthcare providers, requiring you to pay all costs if you or your dependents need to visit an out-of-network doctor or facility?
- If you need to visit an ER or require emergency care, how much will be covered by the plan?
  - What are the differences between in-network and out-of-network emergency care coverage?
- Are eye exams and prescription lenses covered by the plan?
- Are mental and behavioral health care services covered by the plan?
- What is the yearly deductible? What services and other costs go toward meeting that deductible?
- Does the plan have a coinsurance maximum?
- Are blood work and other diagnostic tests covered?

Once you choose a health insurance company and a specific plan, you will pay a premium **every month** to the insurance company. You will receive an insurance card, which you will present to the health care provider(s) when you visit. After your visit, the insurance company will then pay what is covered in the plan to the health care providers.

Depending on your plan, you will usually be required to pay a co-pay at the time of the visit. Then the doctor's office will bill the insurance company. Once the insurance company has paid what it is going to pay, you will be responsible for the remaining balance of the bill.

Other plans may require you to pay the full amount at the time of the visit and then fill out some paperwork and submit the required documents to the insurance company for reimbursement.

Primary Care and Specialists

A primary care physician (PCP) is usually a family practice, pediatrics or internal medicine doctor who you go to for annual checkups and minor problems. He or she will then refer you to a specialist when bigger problems arise or you request one. Some insurance plans require a referral from your primary care doctor to the specialist before they will pay for the specialist's services.

How to Find Doctors

The best way to find a doctor would be through your insurance company's website. That way, you will choose an in-network doctor and will incur fewer out-of-pocket expenses.

If you already have a PCP, he or she can refer you to a specialist doctor.

Other ways include looking in directories or asking acquaintances who they would go to. There are also many websites where people rate doctors and relate experiences of their visits.

> If you ask a friend or acquaintance who is a medical doctor to recommend a specialist, he or she will most likely not answer.
>
> Instead ask:
>
> a. *If it were your son or daughter, what would you do?*
>
> b. *Who would you go to for a second opinion?*

Common Insurance Terms

- *In-Network* vs. *Out-of-Network*:
  - *In-Network*- A participating provider approved by the plan. A healthcare provider who accepts your insurance.
  - *Out-of-Network*-A provider not having a contract with the insurance company. A service or supply not covered by the plan. Such services are subject to coinsurances and deductibles.

- *Benefits (Covered benefits):* Any service (such as an office visit, laboratory test, surgical procedure, etc.) or supply (such as prescription drugs, durable medical equipment, etc.) covered by your health insurance plan in the normal course of your healthcare.
- *Coinsurance:* A form of medical cost-sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.
  - Once any deductible amount and coinsurance are paid, the insurance company is responsible for the rest of the reimbursement for covered benefits up to allowed charges: the individual could also be responsible for any charges in excess of what the insurance company does not pay.
  - Coinsurance rates may differ if services are received in-network or out-of-network and may depend on the different types of services.
- *Co-pay:* The fixed amount specified by the insurance company paid to the healthcare provider at the time of the service. The remaining amount is paid by the insurance company.
  - There may be separate co-payments for different services.
  - Some plans require that a deductible first be met for some specific services before a co-payment applies.
- *Deductible:* A specified dollar amount during the benefit period - usually a year - that you pay out-of-pocket each year before your health insurance plan begins to make payments for claims. Not all health insurance plans require a deductible. Some plans may have separate deductibles for specific services. Deductibles may differ if services are received in-network or out-of-network.
- *Drugs:* A brand-name drug and its generic counterpart are considered by the FDA to be chemically the same. Some insurance companies will only pay for generic prescription drugs.
  - *Brand Name:* Owner and manufacturer of the patent for that drug. Brand-name drugs cost more and are protected under a twenty-year patent so that the company that originally developed them can recover those development costs.
  - *Generic:* Produced and manufactured by other pharmaceutical companies. Usually less expensive than name brand. They may have different branding names, colors, and shapes, but they are required by U.S. law to be the same drug. There may be some differences among the inactive ingredients from one brand to another.
- *Emergency Care:* Illnesses or injuries which require immediate medical attention.
- *FDA:* the U.S. Food and Drug Administration. An agency of the U.S. Department of Health and Human Services, one of the U.S. federal executive departments. The FDA is

responsible for protecting and promoting public health through the regulation and supervision of food safety, pharmaceutical products, among other things.

- *Premium:* A specified amount paid to the insurance company each month unconditionally.
- *Pre-existing Condition:* A health problem that existed or was treated before the effective date of your health insurance coverage. Most health insurance contracts have a pre-existing condition clause that describes conditions under which the health insurance company will cover medical expenses related to a pre-existing condition.
- *Pre-existing Condition Exclusion:* In some cases, a health insurance company may exclude a patient's pre-existing conditions from coverage under a new health insurance plan.
- *Preventative Care:* Measures taken to prevent diseases or injuries rather than curing them or treating their symptoms. Common examples of preventative care are immunizations and yearly physicals, as well as dental cleanings and yearly eye exams. Any screening test done in order to catch a disease early is considered a preventative service, such as routine Pap tests for women or prostate exams for men. Medications, like low-dose daily aspirin therapy, and counseling services, such as nutrition and exercise guidance, are also examples of preventative care and services.
- *Urgent Care:* An injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency department. Often urgent care centers are not open 24 hours a day but they do examine and treat patients on an unscheduled, walk-in basis. If they deem your injury or illness to be more critical than you thought it, they will transfer you to the hospital emergency room.