TONIC

THE TONIC GUIDE TO HEALTHCARE

WRITTEN SO YOU CAN ACTUALLY UNDERSTAND IT.

- 00001: HEALTHCARE: IF YOU’RE PREGNANT
- 00002: HEALTHCARE: IF YOU’RE ON BIRTH CONTROL
- 00003: HEALTHCARE: IF YOU HAVE A MENTAL HEALTH ISSUE
- 00004: HEALTHCARE: IF YOU’RE A COLLEGE STUDENT
- 00005: HEALTHCARE: IF YOU’RE ADDICTED TO OPIOIDS
- 00006: HEALTHCARE: IF YOU NEED AN ABORTION
- 00007: HEALTHCARE: IF YOU’RE TRANS
- 00008: HEALTHCARE: GLOSSARY

0004: HEALTHCARE

IF YOU’RE A COLLEGE STUDENT

- 00001: HEALTHCARE: IF YOU’RE PREGNANT
- 00002: HEALTHCARE: IF YOU’RE ON BIRTH CONTROL
- 00003: HEALTHCARE: IF YOU HAVE A MENTAL HEALTH ISSUE
- 00004: HEALTHCARE: IF YOU’RE A COLLEGE STUDENT
- 00005: HEALTHCARE: IF YOU’RE ADDICTED TO OPIOIDS
- 00006: HEALTHCARE: IF YOU NEED AN ABORTION
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HEALTHCARE IF YOU'RE A COLLEGE STUDENT

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- MY SCHOOL IS CHARGING ME A STUDENT HEALTH FEE. WHAT DOES THAT COVER? DO I STILL NEED INSURANCE?
- WHAT ARE THE PROS AND CONS OF BUYING A PLAN MY SCHOOL SELLS?
- CAN'T I JUST STAY ON MY PARENT'S PLAN?
- IS THERE A WORLD IN WHICH HAVING BOTH PLANS IS A GOOD IDEA?
- WHAT DO I DO IF I DON'T HAVE THE OPTION OF A PARENT'S PLAN OR BUYING A STUDENT HEALTH PLAN?
- I CAN'T AFFORD ANY OF THESE OPTIONS. I'LL JUST HAVE TO RISK IT AND BE UNINSURED, RIGHT?
- WHAT ABOUT THOSE CHEAP, SHORT-TERM HEALTH PLANS THAT TRUMP APPROVED?
- WHAT'S THE DEAL WITH MENTAL HEALTH CARE ON CAMPUS?
- WHAT CAN I KEEP CONFIDENTIAL FROM MY PARENTS EVEN IF I'M ON THEIR INSURANCE?
- SHOULD I REALLY BE CONSIDERING HEALTHCARE WHEN I'M CHOOSING A SCHOOL?

IF YOU'RE A COLLEGE STUDENT

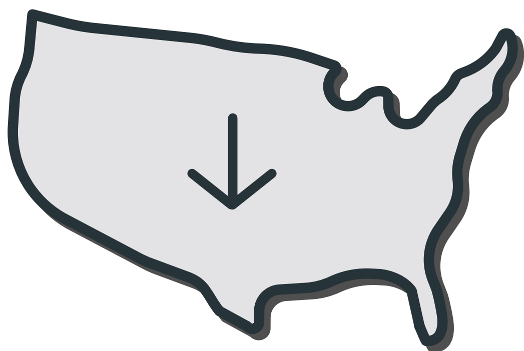
BY JESSICA MIGALA

Even if you're feeling great now, you're going to get sick, trust us. Not to be a downer, but you may also face other health challenges in college besides a bad cold or the flu, like mental health issues, car accidents, STDs, problems with alcohol, or unexpected emergencies. No one wants to rack up huge medical bills, especially if they're already facing absurd student loans. In short: make sure you have some kind of insurance.

About 13 percent of people ages 18 to 24 don't have health insurance, according to the National Center for Health Statistics 2014 survey. But you need it, whether that's through a plan you buy on the Affordable Care Act marketplace, a student health plan, or through the insurance your parents get from work. (Plus, if you're uninsured in 2018, you'll have to pay a penalty on your 2019 taxes—assuming you make enough money to file.)

Here are some common questions about getting covered.

My school is charging me a student health fee. What does that cover? Do I still need insurance?



Yes, you still need insurance for things like emergency room care and services the health center doesn't cover. The student health center fee ensures that students who pay it have access to many health services on campus. (Most full-time students are required to pay this fee, if not, you'd have to pay per visit.) While some services, like routine doctor visits, vaccinations, or short-term counseling may be covered by this fee, others, like X-rays, prescriptions, or visits to specialty doctors, may not be. The price of non-covered services will depend on your health insurance.

Look at the details about what's covered at your school and what's not—this should be outlined on the school website. (Side note: One benefit of the health fee, as explained later, is that it means you can use health services—mental health, too—and your parents won't know any of the specifics.)

What are the pros and cons of buying a plan my school sells?

We'll talk about your parents' insurance in a second, but first it's worth considering school plans. "Most major four-year colleges offer student health insurance," advises Erin Hemlin, the national director of training and consumer education at Young Invincibles, a young adult research and advocacy group. These plans usually count as qualifying health coverage to avoid the tax penalty.

It's likely you can use the school's health resources for things like check-ups or gynecological exams, STI screenings, treatment for illnesses, sleep issues, lab work/X-rays, regardless of having a student plan or not. The clinic may offer services on a sliding fee scale or for cheap, but find out what those costs are before you get sick, says Cheryl Fish-Parcham, director of access initiatives at Families USA.

However, the benefit of a student health plan is that they're often inexpensive and good quality, something that radically changed after the passage of Affordable Care Act (ACA). "Before the ACA, more than half the student plans were dangerous," says Stephen L. Beckley of Hodgkins Beckley Consulting LLC, a healthcare management and benefit consultant group that specializes in higher education. (Previously, many had "gotchas" like excluding coverage of pre-existing conditions, he says.) Today, luckily, things are different. "Student health plans can be exceptional value, even if you still have eligibility under your parent's employers plan," Beckley says. "It's not uncommon to hear from parents they're saving significant dollars going to a student plan." (Yes, you can stay on a parent's plan until age 26, but it's not free; more on that later.) Sometimes students are automatically enrolled in student healthcare plans—and thus charged for them—unless they specifically opt out of coverage. For some schools that is true when it comes to full-time students, and you'll have to fill out a waiver to opt out. In other schools you'll go through an enrollment process where you either choose to enroll or waive coverage. Either way, it's not some sneaky system to insure you, Beckley says, but rather to make sure that you have a health plan in place. Anticipate what your health needs may be. Then, check out the Summary of Benefits Coverage to determine exactly what the plan covers and what the deductible is. (In schools that offer excellent health programs, this will easily be found on their website). Does it cover doc visits? Prescription drug coverage? X-rays? Lab tests? Vision and dental? And check out the coverage dates, if it's full-year, school year, or what happens if you're not enrolling until the spring semester.

Next, learn about what the copays are for medical and mental health visits at the Student Health Center and other in-network providers, as well as for emergency room visits. (While the campus health center may be the main resource, student health plans don't limit you to only campus care.) You'd need to compare these all of these costs—copays, deductibles, and premiums, or the cost of the plan—to whatever a parent's plan charges to find out if a student plan is truly a better deal.

Most school plans are also designed to cover you when you return home (even if it's in another state) or go abroad. "These often cover better than employer plans, providing worldwide coverage, including medical evacuation back home if you're in another country," Beckley says.

Can't I just stay on my parent's plan?

If your parent is insured through their employer, the ACA says you can stay on their plan until you're 26. (And you can stay on it even if you get married, have a child, move out of their house, or—yep—start school.) All your parent has to do is add you on their application during open enrollment to get you covered, and then they'll pay a higher amount from their paychecks. Open enrollment usually starts in November, so if you're not already on their plan, coverage wouldn't kick in until January of the following year.

However, know that while the law says young adults can remain on their parent's plan, there's no requirement that employers need to make a contribution to coverage for dependents, Beckley says. "Over the last two decades, many employers have quit funding dependent coverage," he says.

That means your coverage could be a lot more expensive than theirs is. Have your parents look at their paycheck, which should list how much each family member's health insurance costs. (During open enrollment, the employer should also have information on costs for dependents.) Another thing to check: if you're on your parent's plan, are you insured by the same company? Some employers offer different coverage for their employees and their family members, he says.

If your school is in another state, call the insurance company to make sure that you'll have a network of providers accessible in the area, Hemlin says. It's possible you're on a state- or regional-based network that's more restricted. And it will hardly do you any good if you have insurance but there are no doctors or hospitals you can go to near your school.

Is there a world in which having both plans is a good idea?

If you're covered under your parent's plan, you're likely better off making a choice between a student plan or staying on their employer plan. Having both probably doesn't make sense for most young people, Beckley says, unless you have a chronic health condition that's managed with a lot of routine doctor's visits and expensive medications. In that instance, the student plan would pay for your services first and then the employer plan would kick in. "For the most part, you'd wind up with 100 percent coverage," he says.

What do I do if I don't have the option of a parent's plan or buying a student health plan?

If your school doesn't offer insurance and getting on a parent's plan isn't an option for you, you can buy your own insurance. As Healthcare.gov points out, you can either get this on your own or be included on your parent's application if you're under 26. Most likely, you or your parents will sign up during Open Enrollment, unless they qualify for a special enrollment period for certain life events. For instance, if you lose student health insurance for whatever reason, get married, or have a baby, you can buy a Marketplace plan in a special enrollment window.

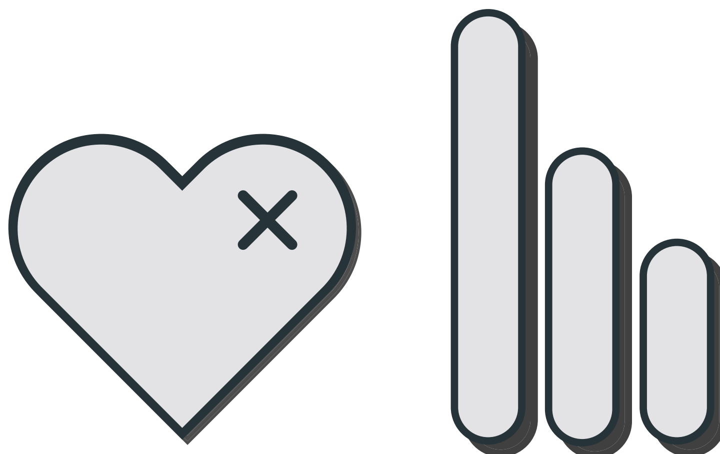
When you're shopping for insurance, Hemlin says to consider these three things: 1) What's the benefit package? Make sure the services covered are what you need—and what you anticipate you may need. Marketplace plans have to cover things like prescription drugs, mental health services, and maternity care, and, but you'll have to check to see if they offer additional benefits like dental or vision, or medical-management programs if you're treating specific conditions like diabetes. 2) Check out the network of providers. Can you actually access the doctors based on geography or your personal circumstances? If you're spending summers back home in one state and going to school in another, make sure there are providers in both areas. 3) Cost. If you're working part time and aren't eligible for insurance through your employer, you may be able to get a discount plan. Or you may be able to qualify for Medicaid in your state if you can establish permanent residency.

As Hemlin points out, you shouldn't just go for the cheapest plan. "Even if you consider yourself young and healthy, we know people can get into an accident at any time and have to pay thousands of dollars in a deductible," she says.

That's why people are overwhelmingly enrolled in Silver Health Plans, a mid-range plan with moderate monthly premiums. You may also be able to save on out-of-pocket costs if you qualify for extra savings based on your income. These savings are known as "cost-sharing reductions" and basically they're a discount that lowers what you pay for deductibles, copays, and coinsurance—but only for silver plans, she says. Need help? Check out the Get Covered Connector tool from Young Invincibles, which will help connect you to local aids who can help you with your application.

This probably goes without saying, but if you're new to buying your own insurance, you want to make sure that you keep up with paying the premiums. If you have a break in payments (usually up to 90 days) and are dropped from your plan, you will have to wait until the next open enrollment period to get insured again, says Fish-Parcham.

I can't afford any of these options. I'll just have to risk it and be uninsured, right?

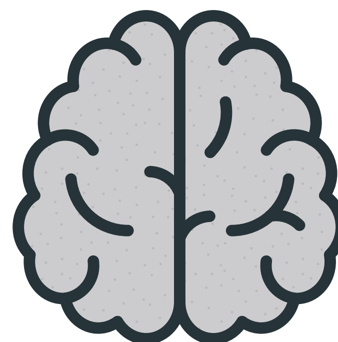


There are other ways to get covered. If you make less than $16,573 a year (138 percent of the federal poverty level), you're eligible for Medicaid in more than 30 states as long as you're not a dependent on someone else's insurance, Fish-Parcham says. If you have Medicaid and your school is in another state, you may consider transferring Medicaid coverage to the other state, but first, consider if you're planning on going home during the summer and also look at what your new state's income guidelines are for Medicaid.

What about those cheap, short-term health plans that Trump approved?

Short-term health plans offer coverage for limited periods of time (three months), though Fish-Parcham says that new rules may make them available for longer. "We caution people to be very wary of these. They do not include mental health coverage or sports injuries of the most part. There are many holes that would be especially problematic for a young person," she says. (They're already effectively banned in five states and restricted in others.)

What's the deal with mental health care on campus?



College may be the first time you're managing and responsible for your own health and mental health without involvement from your parents, notes Victor Schwartz, a clinical associate professor of psychiatry at the NYU School of Medicine and chief medical officer at The Jed Foundation, a nonprofit dedicated to promoting mental health and suicide prevention for teens and young adults.

"The demand for mental health care services is exploding. Having a student plan with strong long-term counseling is integral, but not all colleges offer this," Beckley says. Schwartz adds, "The most serious problems that emerge in students is more likely to be in the mental health arena, and these are fairly common. According to data from the National College Health Assessment, 40 percent say they experienced anxiety or depression significant enough to interfere with their functioning."

It's critical to know how and where to get support. Thing is, Schwartz adds, there is no national standard that enforces the type and availability of services on campus. Rather than assume what your school provides, you should just ask about their counseling services.

The benefit to getting counseling on campus is that "their services may allow you to see a practitioner sooner and with the same level of quality as in the local community," Schwartz says. The on-campus center can also coordinate with the school if you need specific accommodations or need to take a leave of absence for mental health reasons.

However, if you have an existing mental health issue, you should know that school resources are designed to provide short-term care, he says, meaning they're not intended for people who are already diagnosed. In that case, you should work out a plan with your current mental health team about how to best continue your care (where to go, how often, etc) before arriving on campus.

Ideally, the health center and counseling center at a university are integrated, Beckley says. "This is a standard in primary care that college health has been slow to adopt," he says, noting that Colorado State University, Cornell University, and the University of Minnesota are all examples of schools that provide excellent integrated care. Ask your school if that's the case and how these services work together.

What can I keep confidential from my parents even if I'm on their insurance?

If you're over 18, you're an adult. Know that health privacy and confidentiality laws protect your health and mental health records, according to a 2016 report from the National Alliance on Mental Illness (NAMI) and the JED Foundation. (The laws in question are the Family Educational Rights and Privacy Act, or FERPA, and the Health Insurance Portability and Accountability Act, or HIPAA).

There's an exception, though. If you use your parents' insurance to get healthcare, your parents will probably receive an explanation of benefits (EOB) that outlines which services were provided and how much the insurance company covered. Schwartz says this is one of the reasons most colleges charge student health fees rather than a fee for each health or counseling visit—if no bill is generated, then the visit can remain private.

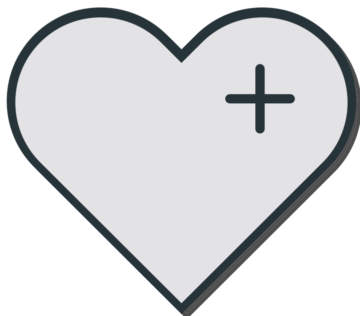
But that privacy protection could work against you in certain cases. "These laws safeguard your information, but they can also prevent colleges from contacting your parents if you are facing significant challenges or a serious mental health condition," the report states.

Before getting any type of care, it's a good idea to write directives out ahead of time by completing an authorization form that instructs providers when they can contact your parent or guardian about a health or mental health problem, Schwartz says. Your school may have one of these forms available, but you can also find one on page 23 of the NAMI/JED report.

If you experience a health or safety emergency or mental health crisis, your provider can independently decide to communicate the issue with your parents, based on the severity of the situation, and also taking into account the climate at home. If the counselor has reason to believe that this information would be damaging to you if your parents were involved, then they may opt to not contact them. State laws can also kick in and prevent this communication, which is why you'll need to fill out that authorization form if you want your parents to be informed in case of emergency.

If your parent is worried about you and calls the counseling center asking if you've recently been seen (or, likewise, wants information from the health center), the school won't release that info without consent from you. They may instead speak to your parents in more general terms, e.g. that school health staff have been in contact with you and you are okay. That said, your parents can share any information with the school's health center or Dean of students that they deem helpful—like prescription medications and past treatment—and the school can "accept" it.

Should I really be considering healthcare when I'm choosing a school?



It may be too late to say this but, if you're still choosing a school (or will be next semester/year), consider the robustness of the health and counseling services when making your decision, Beckley says. "How well a college provides for health will vary dramatically from campus to campus, and it speaks to how they value the wellbeing of students," he says.

On campus tours, they should stop at the health center and emphasize the great services it provides. You can also get a feel for this by looking at a school's website, which should outline the student health benefits.

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HEALTHCARE GLOSSARY

- AFFORDABLE CARE ACT (ACA)
- ANNUAL AND LIFETIME LIMITS
- COINSURANCE
- COPAY
- DEDUCTIBLE
- ESSENTIAL HEALTH BENEFITS
- FLEXIBLE SPENDING ACCOUNT (FSA)
- HEALTH SAVINGS ACCOUNT (HSA)
- HIGH-DEDUCTIBLE HEALTH PLAN
- INDIVIDUAL MANDATE
- INSURANCE NETWORK
- MARKETPLACE
- MEDICAID
- MEDICARE
- MEDICARE FOR ALL
- OPEN ENROLLMENT
- OUT-OF-POCKET COSTS
- OUT-OF-POCKET MAXIMUM
- PREMIUM
- PREEXISTING CONDITION
- PRIVATE HEALTH INSURANCE PLAN
- PUBLIC HEALTH INSURANCE PLAN
- SINGLE-PAYER HEALTHCARE
- UNIVERSAL HEALTHCARE

HEALTHCARE GLOSSARY

BY SUSAN RINKUNAS

Let's be honest: Health insurance is confusing, so let's start at the beginning. Health insurance is a contract you buy that requires an insurance company to pay for some or all of your medical expenses. Some employers offer (heavily subsidized) insurance to their employees, some people buy their own plans, and the government provides insurance for older people as well as for low-income people and those with disabilities. Still, some people in the US go without insurance.To help you understand how it all works, here's a list of the terms you need to know, explained in plain English.

Affordable Care Act (ACA)

Really, its full name is the Patient Protection and Affordable Care Act (PPACA) and it was passed in early 2010 and fully implemented as of January 2014. It's also known as Obamacare, after the President who shepherded it and signed it into law.

People in the United States aren't guaranteed to get health insurance. They have to get coverage from their employer or spouse's employer, buy it themselves, qualify for a government program, or go without. The ACA sought to get more people covered by insurance and protect people from going bankrupt from medical bills. It did that in a few ways: It said young people could stay on their parents' plans until age 26, it expanded the eligibility requirements for Medicaid, and it banned insurance companies from discriminating against people for having preexisting conditions [see " preexisting conditions"], which range from having given birth via C-section to having diabetes and other very basic, common things.

The ACA required insurance companies to cover everyone, and charge them the same rates no matter their health history. It also mandated that plans cover, at minimum, the same set of essential services [see "essential health benefits"], including preventive care at no cost, like vaccines and a set of benefits specific to women. The ACA also banned annual or lifetime caps on those essential services.

In 2010, 48.6 million Americans, or 16 percent of the population, didn't have health insurance. In 2017, the number of uninsured had fallen to 29.3 million people (or 9 percent of the US). That's still a sizeable chunk of people without health insurance, and that's why people want to improve upon Obamacare or replace it with universal coverage.

Annual and Lifetime Limits

These are caps on the benefits your insurance a company will pay in a given year or over a lifetime; after you hit the number, they stop paying and you're on the hook.

Annual limits can be dollar amounts or a number of visits. Obamacare banned annual and lifetime limits for a set of 10 essential health benefits. [see "essential health benefits"].

Coinsurance

The percentage of costs you have to pay for a service after meeting your deductible [see "deductible"]. Your plan will either charge a copay or coinsurance, not both. Coinsurance matters a lot if you see providers that aren't in your plan's network [see "insurance network"].

Say your copay for an in-network specialist is $25 and your coinsurance for out-of-network providers is 30 percent. If your therapist charges $250 a visit and they take your insurance but are considered "out of network" (as is common with therapists), you'll first have to pay in full out of pocket until you hit your deductible, then pay $75 a visit (30 percent of $250) after that. If you see an in-network therapist, you'd owe a $25 copay, and might not even have to pay the deductible first if your plan says office visits aren't subject to the deductible.

Copay

Short for copayment, it's a flat fee you pay for seeing a doctor or filling a prescription. Copays typically don't count toward your deductible [see "deductible"]. Usually you only pay a copay if you've already hit your deductible, but many employer plans cover things like office visits and trips to the emergency room before you meet the deductible and so, voila, you only get charged a copay. It's common to have different copays for primary care providers and specialists, so you might pay $25 to see a doctor about a suspected case of bronchitis and $50 to see a specialist like a podiatrist.

There's usually an inverse relationship between your monthly premium (the cost of a plan) and your copays: Plans with lower premiums tend to have higher copays, and plans with higher premiums usually have lower copays.

Deductible

The amount you have to pay out of pocket for medical care before your plan will start footing the bill. Unfortunately, the deductible starts over every year. Many plans cover office visits before you've hit your deductible, so you may only have to pay a copayment for those visits rather than the full cost. After you've hit your deductible for the year, you usually only pay a copay or coinsurance for care [see "copay" and "coinsurance"].

Similar to a lot of employer plans, Obamacare plans provide certain preventive health services for free, even if you haven't hit your deductible yet. These services include vaccines and certain medical tests for all adults, and a special set of services for women including birth control and an annual well-woman visit. (Contrary to popular belief, an annual physical with a primary care doctor is NOT one of the things that's required to be free, and it will cost you at least a copay. For many employer-sponsored plans, both the annual physical and also the well-woman visit are free.)

Essential Health Benefits

A set of ten services that all health insurance plans on the Marketplace [see "marketplace"] must cover as a result of the Affordable Care Act. Insurers also can't place annual or lifetime limits on these services. The ten categories are: doctors' services, prescription drugs, hospitalization including surgery, outpatient hospital care, pregnancy and childbirth, emergency room care, mental health and substance use disorder services, laboratory services, rehabilitative services, and pediatric oral and vision care.

Flexible Spending Account (FSA)

If you have employer-based insurance, you can have money taken out of your paycheck before taxes and use it to pay for approved medical expenses including deductibles, copayments, and coinsurance. It's often loaded onto a prepaid card that you can swipe at a doctor's office or the pharmacy. You can also use an FSA account to pay for other expenses like glasses, contact lenses, dental care, and health products sold on FSAstore.com, like bandaids, pain relievers, and sunscreen. In 2018, the most you could contribute to an FSA was $2,650 a year, and you can roll over $500 to the following year.

Health Savings Account (HSA)

This is similar to a flexible spending account (FSA) in that it's pre-tax money that can be used to pay for deductibles, copayments, and coinsurance. But you can only put money in an HSA if you have what's considered a high-deductible health plan (HDHP), which is generally any plan that has a deductible of at least $1,350 for one person. For 2019, you can contribute up to $3,500 to an HSA for individual health coverage. Some insurance companies offer these accounts, or you can open one with a bank. And unlike an FSA, you can roll over the account's entire balance from year to year and the funds may earn interest, which isn't taxable.

High-deductible Health Plan

An insurance plan that requires you to pay at least $1,350 out of pocket for an individual (or $2,700 for a family) before the plan starts to pay its share, though the monthly premium (or cost of the plan) is usually lower than plans with lower deductibles. Some plans sold on the insurance marketplace have deductibles over $5,000 for one person.

Individual Mandate

This is one of the linchpins of the Affordable Care Act. In order for insurance companies in the Marketplace not to be saddled with only people who have preexisting conditions—people who buy health insurance because they need to use it and cost the insurance companies more money than people who don't require a lot of care—the law required everyone in the US to either have health coverage or pay a tax penalty.

Importantly, it doesn't say that everyone has to buy a plan from the ACA Marketplace, just that they need to have coverage that meets the law's minimum standards—so getting insurance through work means you're good. The idea is that having "healthy" people in the pool of insured people helps keep costs down, but a lot of those people were mad that they suddenly had to get insurance. (Truth is, without insurance, healthy people are one accident or diagnosis away from big, big problems, physically and financially.)

Republicans effectively ended the individual mandate for 2019 in their tax bill. They couldn't erase it altogether, but they made the tax penalty for not having insurance $0. Experts believe that healthier people will be less likely to buy insurance in 2019 and premiums for others will go up as a result.

Insurance Network

A group of providers and facilities that contracts with your insurance company to provide services at a discounted price. A doctor might accept your insurance and be considered in-network, and your insurance company will incentivize you to use providers like this by charging, say, a $25 copay for visits. Other providers may accept your insurance but are out-of-network and your insurance company may charge you more money to see them, for instance by subjecting the visit to your deductible and charging coinsurance, or a percentage of the cost rather than a flat fee.

Marketplace

The health insurance marketplace, also known as the "exchange," is the service available in every state that helps people shop for and enroll in health insurance. People who are buying their own coverage (i.e., not getting it through their job, spouse, or the government) can shop for plans online, by phone, or in person. In most states, the federal government runs the marketplace and you sign up at HealthCare.gov. But 11 states and Washington DC have their own sites.

■ Medicaid

A government-run insurance program that provides low- or no-cost health insurance to some low-income people, low-income or uninsured pregnant women and children, people with disabilities, the elderly, and more. People can apply for Medicaid at any time; it doesn't have to be during the open enrollment period [see "open enrollment"]. Under the Affordable Care Act, more than 30 states expanded eligibility for Medicaid to include all adults below a certain income level—138 percent of the federal poverty level. (This is known as "Medicaid expansion.") The states that have resisted thus far tend to be in the South and Midwest.

■ Medicare

A government-run insurance program for people 65 and older and some younger people with certain disabilities and conditions. Some politicians want to make Medicare available to more people by letting them buy into it before age 65, aka a "public option," or turn it into our nation's one health insurance program [see "Medicare for all"].

■ Medicare for All

One way to achieve universal coverage is to make Medicare the insurer for everyone—not just people over 65 or people with certain conditions. Medicare allows both the government and private insurance companies to pay for care, so it's not a single-payer system. Vermont Senator Bernie Sanders has a plan that he calls Medicare for All, but if you want to get technical, his plan is actually single-payer healthcare because it would eliminate all private insurance companies, which isn't how Medicare operates now.

■ Open Enrollment

The period when you can sign up for health insurance for the following year. Each employer has its own window, but for people buying their own plans, open enrollment has run from November 1 to December 15 the past two years in the 39 states that sell their plans on Healthcare.gov. (Most of the 11 states that run their own sites have longer enrollment periods.) You can sign up for or change your insurance outside of that period if you have what's known as a qualifying life event. Examples include if you get married or divorced, have a baby, lose your health coverage, or if you move.

Out-of-pocket Costs

Also known as "cost-sharing," this is the total of what you, not the insurance company, spend for medical care. It includes deductibles, copays, and coinsurance, but not the monthly premium since that's the cost of having insurance, not for getting care.

Out-of-pocket Maximum

Yes, there is a limit to how much the insurance company can make you pay in one year. After your out-of-pocket costs hit whatever that amount is, the insurance company picks up 100 percent of any costs for covered services thereafter. And while copays don't usually count toward your deductible, they DO count toward your out-of-pocket max.

Premium

The amount you pay just to have an insurance plan, even if you never set foot in a doctor's office. If your insurance comes from your employer, the premium gets deducted from each paycheck throughout the year. (This isn't the true cost of the plan—your employer pays for some of it.) If you buy your own plan, you pay the insurance company directly every month.

Preexisting Condition

Before the Affordable Care Act, people who bought their own insurance could be denied coverage for having a preexisting condition like diabetes and Crohn's disease. Some insurers would cover you if you had a preexisting condition, but they'd charge you more than other people. The ACA banned insurance companies from asking people about their health history and required them to accept everyone and charge them the same rates.

■ Private Health Insurance Plan

A health plan that isn't "public," that is, paid for by the federal government. Private plans include those offered by employers and ones people buy themselves. The majority of Americans have private insurance: In 2016, 49 percent of Americans had insurance through work and another 7 percent bought their own coverage.

■ Public Health Insurance Plan

A health plan that's operated by the federal government—so, Medicaid and Medicare.

■ Single-payer Healthcare

One type of universal healthcare. The payer in this case is the government, rather than a for-profit insurance company. A single-payer system would make health insurance companies obsolete: You'd get health coverage from the government and the government would pay doctors a set price for medically necessary care. You, the user, would have no premiums or deductibles, but there would likely be some out-of-pocket costs, and not every country with single payer covers vision or dental care.

■ Universal Healthcare

A system that guarantees that everyone in a country, or even a single state, gets health insurance, no matter their ability to pay. The system is funded by taxes. There are several types of universal healthcare, including single-payer, where the government pays for care provided by private companies (see: Canada), or socialized medicine, where the government pays for and provides the care (see: the UK).