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THE TONIC GUIDE TO HEALTHCARE

WRITTEN SO YOU CAN ACTUALLY UNDERSTAND IT.

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0006: HEALTHCARE IF YOU NEED AN ABORTION

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IF YOU NEED AN ABORTION

BY GARNET HENDERSON

So you're pregnant and don't want to be, or you have a wanted pregnancy but the fetus has a fatal anomaly or the pregnancy could threaten your health. Whatever the case, you want an abortion. Here's how to get the care you need.

How do I find the nearest abortion provider?

The answer may seem obvious, because you can Google that, right? But crisis pregnancy centers (CPCs)—fake clinics designed to look like abortion providers that actually exist to convince pregnant people not to get abortions—have gamed the Google maps system. They may appear first in search results, and may even claim to provide abortions.

CPCs also intentionally open near real abortion clinics, and even open up in spaces formerly occupied by abortion clinics. "I once visited a clinic in Jacksonville, Florida, and there's a CPC right across the street. They used the very same language and font for their sign so they would look as much like the real clinic as possible," says Oriaku Njoku, the co-founder and executive director of Access Reproductive Care-Southeast, an abortion fund. Njoku also recalled helping a caller from South Carolina who was lied to by a CPC, where staffers told her she was only 12 weeks pregnant when she was actually 21 weeks along.

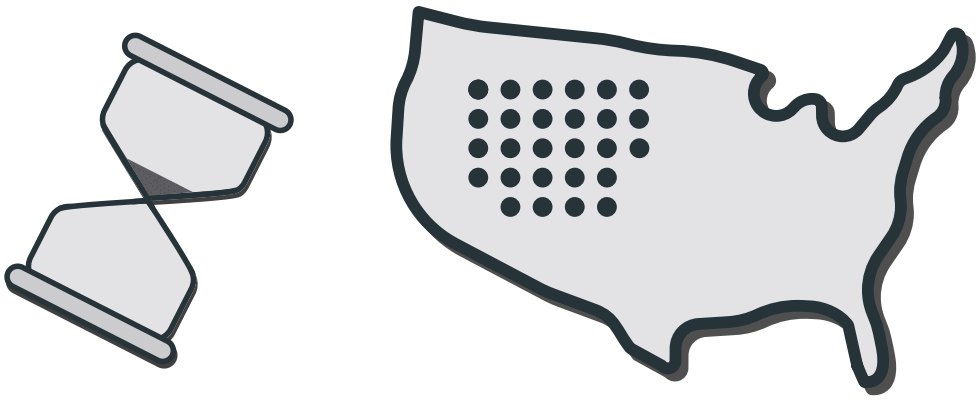
There are several ways to verify that a clinic is real in order to avoid being misled by a CPC. The National Abortion Federation (NAF) has a comprehensive directory of providers, and all Planned Parenthood health centers are listed online. However, just because a clinic isn't a Planned Parenthood affiliate doesn't mean it isn't reputable—two-thirds of abortions are performed by independent providers. In addition to the NAF directory, many independent providers are members of the Abortion Care Network, which maintains its own list. Njoku also suggests contacting your local abortion fund, which can help you find a trusted provider.

Can my regular OB/GYN do it?

In some cases, especially in major cities, you may be able to go to your regular gynecologist or at least get a referral from their office. The latter is especially true in the case of a pregnancy that is nonviable or poses a risk to your health, as some providers are more willing to offer referrals in those instances. However, fewer than two-thirds of OB/GYN residency programs offer abortion training, and only a small number of OB/GYNs in private practice perform abortions. In many places, a specialized clinic with trained, experienced providers is the best option.

Despite evidence that advance practice clinicians (APCs) like certified nurse midwives, nurse practitioners, and physician assistants can safely provide abortions, 42 states mandate that only physicians can perform procedural abortions, and 34 allow physicians only to administer medication abortion, according to the Guttmacher Institute. California is the one state with a law on the books explicitly allowing APCs to perform

Is there a waiting period for getting an abortion?



Twenty-seven states have a waiting period—most commonly 24 hours—in between counseling and the abortion itself. Fourteen of these states require that the counseling be done in person, which means you'll have to make two trips to the clinic. In other states, this counseling can be done over the phone.

What if I'm under 18?

Most states—37, to be exact—require some level of parental involvement in your decision to get an abortion if you're under 18. Most of these require parental consent, but 11 require only that parents be notified, and seven allow another adult relative (like a grandparent) to consent. Because the Supreme Court ruled that parents cannot have complete control over a minor's decision to get an abortion, most states have some way around these parental consent or notification laws. Usually this is done by judicial bypass, meaning you can ask a judge for permission to get an abortion without notifying your parents. Thirty-four of the 37 states also allow people under 18 to get an abortion without parental involvement in cases of medical emergency, and 15 the 37 states allow people under 18 to get an abortion in cases of incest, abuse, neglect, or assault.

The Guttmacher Institute has a chart to help you figure out what the laws are in your state. Your provider or local abortion fund will also be familiar with state laws and may be able to help connect you with organizations like Jane's Due Process that help with the judicial bypass procedure.

What happens during the appointment?

At your appointment, a doctor or other health professional will take your medical history, vital signs, and talk to you about the options available to you. Most providers perform an ultrasound.

Many states require it, and some even require the provider to show and describe the ultrasound image, while others simply require that the provider offer to show you the image.

What happens during the procedure itself?

The vast majority (two-thirds) of abortions in the US happen at or before eight weeks of pregnancy. Early in pregnancy, you generally have two options: medication abortion or aspiration abortion.

Medication abortion, which is FDA-approved for use up to 10 weeks after your last menstrual period, involves taking two pills. The first, mifepristone, works by blocking the hormone progesterone, which is necessary to sustain the pregnancy. Between six and 48 hours later you take the second pill, misoprostol, which causes the uterus to contract and expel the pregnancy. Cramping and bleeding usually starts within one to four hours of taking misoprostol, and lasts for several hours after that. You could experience some intermittent cramping for one or two days afterward.

Because of FDA restrictions—which are currently being challenged by the American Civil Liberties Union (ACLU)—mifepristone, the first pill, has to be dispensed by a registered provider. (It's literally not available at retail pharmacies.) Nineteen states require that the provider hand the pill to you in person, meaning a telemedicine appointment is out of the question. Though many people prefer medication abortions because they can be done at home, medication abortion is a slightly longer process and usually requires a follow-up visit to make sure the termination is complete. If you live in a state that bans telemedicine abortion, this means at least two trips to the clinic, and three if you live in a state that has a waiting period and requires in-person counseling.

Aspiration (or suction) abortion is usually done up to between 14 and 16 weeks pregnancy. In this procedure, the provider dilates your cervix and uses gentle suction to remove the contents of the uterus. This is usually done using a local anesthetic, though some clinics may offer additional anesthesia.

A dilation and evacuation, or D&E, is the most common procedure used in the second trimester of pregnancy. Because the cervix needs to be dilated further than for an aspiration abortion, the provider may start the dilation process the day before the procedure or earlier on the day of. The provider then uses suction and, if needed, other medical instruments to empty the uterus. D&E procedures are often, but not always, performed under some level of sedation. The D&E procedure is one of the latest targets of anti-abortion lawmakers, who have banned it in multiple states. Bans are in effect in Mississippi and West Virginia, but have been blocked by legal challenges in seven other states.

How far along in pregnancy can I get an abortion?

In Roe v. Wade, the Supreme Court held that abortion must be legal up to the point of fetal viability, and after viability if a woman's life or health is in danger. There is disagreement about when exactly a fetus is viable, but it is generally held to be around 24 weeks. Many states have laws on the books banning abortion at viability. Several now have laws banning abortion at 20 weeks postfertilization, or 22 weeks' gestation, based on the inaccurate claim that a fetus can feel pain at that point.

Numerous states have tried to ban abortion even earlier in pregnancy, and some of these cases could make it all the way to the Supreme Court—which now has a 5-4 conservative majority thanks to Brett Kavanaugh's confirmation. Four states have laws that would immediately ban abortion if Roe were overturned.

Even though abortions in the second trimester are generally legal, the farther along you get in pregnancy, the fewer providers there are who will be willing or able to perform your procedure. Some providers only offer medication abortion or don't offer abortions after the first trimester because unnecessary regulations make later abortions too difficult to provide.

I have health insurance. Does that cover abortion?

That depends on what kind of insurance you have—and if you have to travel out of state for the procedure. Most employer-based health insurance plans provide coverage for abortion, but how much you'll end up paying will vary (more on that later). However, 11 states have laws that limit abortion coverage in all private (aka non-government) insurance plans, which is an umbrella term for plans you get through your employer and coverage you buy online. The 11 states that limit coverage in private plans are: Idaho, Indiana, Kansas, Kentucky, Michigan, Missouri, Nebraska, North Dakota, Oklahoma, Texas, and Utah. For many of them, the only allowable exception is if the mother's life is in danger.

Nine of those 11 states allow abortion coverage through the purchase of an additional rider, but very few riders are actually available for people to buy. "Abortion riders are really a bait and switch that we see when states or federal policymakers are proposing bans on abortion. It's completely impractical. Most people are not planning ahead to have an abortion," says Megan Donovan, a senior policy manager at the Guttmacher Institute.

A whopping 26 states have abortion coverage restrictions specific to the health plans people buy through the Affordable Care Act online marketplaces. Some states do have exceptions, allowing plans to cover abortion in situations like rape, incest, or life endangerment. The Guttmacher Institute has a chart listing state restrictions for private insurance.

If you have a student health insurance plan, it may cover abortion. "Student plans are not governed by state laws. A state ban on abortion coverage doesn't necessarily mean that it impacts a student health plan," says Fabiola Carrion, senior staff attorney at the National Health Law Program.

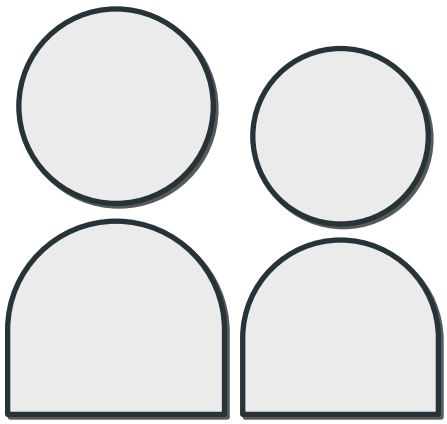
I have Medicaid. Does government insurance cover abortion?

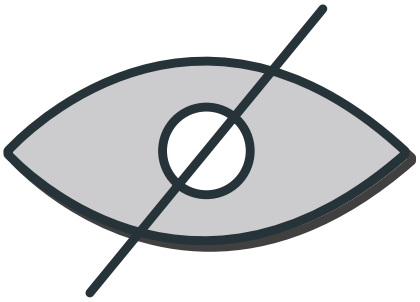
Most people seeking abortions are poor or low income, meaning they are more likely to be uninsured or have insurance through Medicaid, a government-run insurance program. Since 1976, the Hyde Amendment has blocked the use of federal Medicaid funds for abortion. Narrow exceptions were added later on, allowing coverage of abortion in cases of rape, incest, or life endangerment. (The Hyde Amendment isn't even a law: It's a rider that has been tacked on to every major spending bill since 1976.)

Medicaid is jointly funded by the federal government and the states, which means states can use their own funds to cover abortion. Seventeen states have such coverage policies in place—some by choice but most by court order. "Medicaid coverage [for abortion] is really only available in 16 states, because Arizona has a court order but doesn't actually provide the coverage," Donovan says. South Dakota only pays for abortions through Medicaid in cases of life endangerment, violating the federal standard by excluding rape and incest. Congress has control over Washington, DC, and has blocked Medicaid coverage for abortion there almost continuously since 1989.

Since the introduction of the Hyde Amendment, similar restrictions have been placed on health insurance plans other than Medicaid that are also offered through the federal government. This affects government employees, active military and veterans, Peace Corps volunteers, Native Americans, people incarcerated or detained in federal prison, and those with coverage through the Children's Health Insurance Program (CHIP). According to Guttmacher, 22 states also restrict abortion coverage for state employees.

What if I'm on a parent's or partner's insurance and I don't want them to find out about my abortion?





When you use your health insurance—whether you have coverage through an employer, a marketplace plan, or Medicaid—the insurance company sends a document, usually called an explanation of benefits or (EOB), to the policy holder explaining what the provider charged and how much insurance will pay for your care. This is a concern for many people seeking an abortion.

"Only four in 10 privately insured abortion patients use their insurance to pay for the procedure. For the other six in 10 who are privately insured but don't use their coverage, it could be that they have a plan that doesn't cover abortion, or the provider isn't in network, or they have a high deductible, or that they don't want to use their insurance. There are confidentiality concerns given the stigma around abortion. People may be concerned that an employer, partner, or family member will find out," Donovan says.

Federal law prevents your employer from accessing sensitive health information without your permission, so your employer won't find about your abortion because you used your insurance. You can also ask your health insurance company not to send your parents or partner an explanation of benefits, or to send it to a different location. Unfortunately, federal law only requires them to honor that request if disclosing the information would endanger you. However, 13 states have put stronger protections in place, according to Guttmacher.

How much will I pay out of pocket?

If you don't have insurance, or aren't able to use your insurance, the average cost of a first-trimester abortion is around $500, whether it's a medication abortion or an aspiration procedure. However, there are large variations from state to state and from clinic to clinic. "Generally, when you're between six and 12 weeks, the price is the same. But once you're 13 weeks, every week the price goes up," Njoku says. A second-trimester abortion may cost more than twice as much as a first-trimester abortion, or more. Abortion providers tend to be more transparent about cost than many other medical providers, and clinics will usually tell you up front how much they charge.

Unfortunately, even if you have an insurance plan that covers abortion, it may be difficult to figure out exactly what, or how much, is covered. "Right now, we're looking at the way in which marketplace plans describe abortion coverage [in the states where it's legal]. Plans are all over the place, from 50 percent cost sharing, to charging a $250 copay, to subjecting the abortion to a deductible, and the deductibles can be $2,000 or more," Carrion says. That's right—sometimes it may be cheaper to pay for an abortion out-of-pocket than to use your health insurance.

Your local clinic is likely to be familiar with health plans in your area, and may be able to help you figure out what is covered. "We even give patients talking points sometimes to help when contacting their insurance companies," says Tristina Fitzpatrick, director of patient services at Allentown Women's Center in Pennsylvania. This kind of guidance can be very helpful because insurers can lack understanding about what an abortion actually entails, Carrion says. "If there is a difference in coverage between medication abortion and aspiration abortion, or second-trimester abortion, often that is not explained in the policy documents. Most plans consider abortion a surgical procedure, which means that patients end up paying more than they need to, and may be under the false impression that they're having major surgery," she says.

Can I use my HSA or FSA to pay for an abortion?

Yes, funds from a health savings account (HSA) or flexible spending account (FSA)—where you set aside money tax-free for medical expenses—can be used to pay for all or part of a legal abortion. (It's considered a qualified medical expense.)

What if I have to travel out of state—will my insurance cover it?

Sometimes, the nearest clinic is across a state line, or there's not a provider in your state that offers the procedure you need. Using insurance across state lines—whether private or public—is possible, but tricky. "One big problem is that an out-of-state provider is probably out-of-network. Depending on your insurance, if you're out-of-network, you may have much worse reimbursement or none at all. Abortion providers often have trouble getting in-network in the first place," says Adam Sonfield, also a senior policy manager at the Guttmacher Institute. So you can submit receipts to your insurance company, but you might not get much money back.

What about added costs like travel, childcare, and lodging?

This is where abortion funds come in. Not only can they help cover the cost of the procedure itself, they can help with the additional expenses that now come along with abortion for many people.

"There are over 70 funds all around the country. We're all autonomous organizations and everybody does it a little differently," says Njoku of Access Reproductive Care-Southeast. "We happen to have staff, other funds are run entirely by volunteers. Some funds have a hotline, and some funds have a cold line, where you leave a voicemail and they'll call you back."

The staff or volunteers at an abortion fund will talk with you to get an idea of how much your abortion is going to cost you in total—not just what the clinic is going to charge. They will also ask how much you think you can realistically contribute, and offer what they can to help.

"There's no guarantee that we will be able to fully fund anything, but we'll do our best," Njoku says. In addition to financial support, some funds have volunteers who help provide logistical support, like giving patients a ride to the clinic or providing childcare. Some clinics may also be able to help with these extra costs, Fitzpatrick says.

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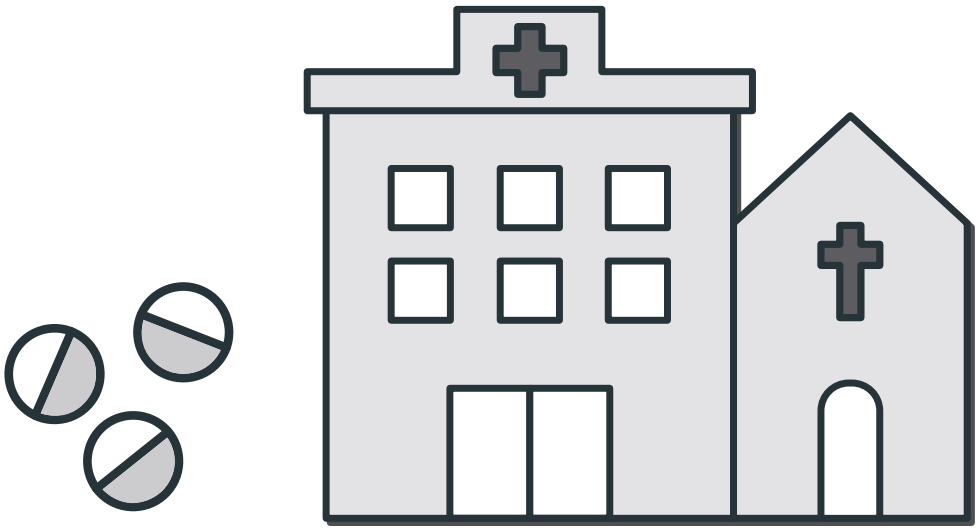
Do abortion restrictions affect miscarriage care?



Miscarriage care involves the same procedures as abortion. A doctor may prescribe you misoprostol (the second pill used in medication abortion) to help your body expel the pregnancy, or perform a vacuum aspiration, or, if you were farther along, a D&E. Bans on insurance coverage of abortion do not affect coverage for miscarriage, so if you have insurance you should be covered.

But you could still run into some problems. For example, a case in Arizona made headlines in June 2018 when a pharmacist refused to dispense misoprostol to a woman with a non-viable pregnancy that her doctor said would ultimately end in a miscarriage. A Michigan woman faced a similar issue in July 2018. Some states (and some pharmacies) require pharmacists with religious objections to have another pharmacist fill the prescription.

"Generally speaking, what happened in Arizona is rare. Catholic hospitals are a much bigger issue," Guttmacher's Sonfield says. "You don't know if the hospital will treat you if they think what you're experiencing is the aftermath of an abortion as opposed to a miscarriage. That is really hard to prove either way. And even if they believe it is a miscarriage, some of the ways in which the ethical directives for Catholic hospitals have been interpreted lead to truly substandard care for miscarriage and pregnancy complications."

Unfortunately, it can be difficult to figure out a hospital's policies regarding miscarriage and pregnancy complications. And, in many places, a Catholic hospital may be your only choice. At the very least, says Sonfield, you should be able to find out whether your local hospital follows Catholic hospital directives so you have an idea of what to expect.

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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

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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).