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THE TONIC GUIDE TO HEALTHCARE

WRITTEN SO YOU CAN ACTUALLY UNDERSTAND IT.

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0002: HEALTHCARE IF YOU'RE ON BIRTH CONTROL

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IF YOU'RE ON BIRTH CONROL

BY JESSICA MIGALA

You don't want babies right now. Or any more babies than you currently have. Or any babies ever. Whatever your exact situation, getting the right birth control is critical.

"We know when women are using the method that's not the best match for them, they're less likely to use it correctly or consistently," says Mara Gandal-Powers, director of birth control access and senior counsel for the National Women's Law Center. Incorrect or inconsistent use can lead to an unintended pregnancy, and nearly half of all pregnancies in the US are unintended. The average American woman who has two kids will still spend about three decades trying to avoid unintended pregnancy, says the Guttmacher Institute.

The Affordable Care Act (ACA) has been a game-changer when it comes to women's ability to control if and when they get pregnant. The law required most plans to cover birth control with no out-of-pocket costs and also led to millions more people getting health coverage. In 2013, 12.5 million reproductive-age women didn't have insurance; and thanks to Medicaid expansion and gains in private insurance, that number fell to 7.4 million in 2016, according to data from the Guttmacher Institute.

But the ACA isn't perfect and there are still people who don't have insurance. Here's what you need to know.

I have insurance. What family planning services are covered?

Again, birth control is covered at no cost, but we'll get to that in a minute. Whether you're covered under Medicaid, a plan you bought on the ACA Marketplace, or insurance you get through an employer or school, here is what's covered with no out-of-pocket costs (that is, without a copay, coinsurance, or deductible). If you wrongly get charged for any of these things, you can push back on your insurance company—more on how to do that below.

AN ANNUAL WELL-WOMAN EXAM

Even if you don't need a Pap smear or HPV test this year, you should still go in for this exam. This is essentially a physical, though it needs to be billed as a "well-woman visit" to be fully covered. There, you'll chat about your medical and family health history, sexual health concerns, lifestyle habits, mental health, and relationship safety. You'll also receive a pelvic exam (if you're over 21), and you may get a breast exam as well. Any immunizations and other screenings will also be given depending on your health needs. Cervical cancer screening through a Pap smear is recommended for women every 3 years starting at age 21. The HPV test can be done along with a Pap every five years starting at age 30.

STD SCREENINGS

As part of preventive care benefits for women, all Marketplace plans are required to cover certain STD screenings for people at a higher risk without a copay or coinsurance when you see an in-network doctor. (This applies to many insurance plans as well. Ask yours what they cover.) The covered tests include HIV tests for all sexually active women, chlamydia and gonorrhea screenings for all sexually active women younger than 25, or women over 25 who who have new or multiple sex partners, or a sex partner who has an STD, or people who use condoms inconsistently in relationships that aren't mutually monogamous. Insurance plans also have to cover syphilis tests for women with HIV and women who are pregnant. If you're not in any of these groups and you want an STD test, ask your doctor if your insurance will cover it.

HPV VACCINE

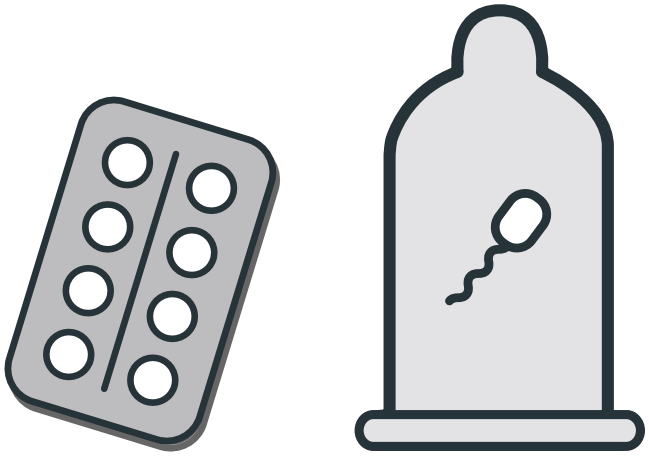
One in four people have HPV (human papillomavirus), a virus that can cause cancer in both men and women. The ACA requires most private insurance plans to cover vaccination at no cost for people ages 9 through 26 (both men and women), though following FDA approval for people ages 27 to 45, insurance plans might start covering the vaccine for this group as well. Preteens and teens ages 9 through 14 need two doses, while those ages 15 to 26 need three doses. If you received Medicaid through the ACA expansion, the HPV vaccine is covered; otherwise, Medicaid coverage of the vaccine is state-dependent, though most states offer coverage for women, according to the Kaiser Family Foundation.

BIRTH CONTROL

This is one of the reasons why the ACA is so critical for women's health when it comes to their reproductive decisions. "There are 62.4 million women who are eligible for birth control without out-of-pocket costs thanks to the ACA. That's huge," Gandal-Powers says. "For the vast majority of people who have birth control coverage due to the ACA, they're experiencing good coverage." But that's not always true across the board, and "when it doesn't work, it's extremely frustrating," she says.

There are some common loopholes and roadblocks you may need to clear to get free birth control. We've all heard stories of friends whose insurance wouldn't cover such-and-such brand name or who were charged for an IUD when they shouldn't have been. Keep reading to fully equip yourself with what you need to know.

Which birth control methods does insurance cover?



The ACA requires that 18 methods of contraception for women (the 20 types listed on FDA.gov minus vasectomies and male condoms) are covered for free, without co-pay or co-insurance, when prescribed by a doctor in your insurance network. This includes pills, patches, rings, diaphragms, sponges, the implant, intrauterine devices (IUDs) with and without hormones, emergency contraception (e.g. Plan B), and female sterilization. (Note: The sterilization implant is on the FDA's list but the only one sold in the US, Essure, will be taken off the market by 2019 following lawsuits.)

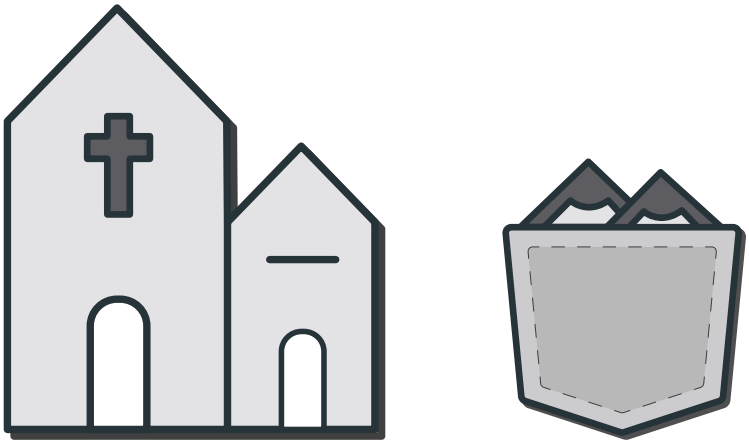
This birth control benefit applies to most private health insurance plans, as well as plans people buy themselves. We say "most" plans because a small number of employer plans remain grandfathered under the ACA, so they don't have to comply with this benefit, and if your employer is religiously affiliated, there are other exemptions (more on that below).

The office visit to get the prescription and counseling on the right method for you are also fully covered—and it's important that you take advantage of this benefit, since, as mentioned above, women who have the birth control that best suits them are more likely to use it and use it correctly, Gandal-Powers says. The ACA's contraceptive coverage provision allows you to pick which method works best for you without having to worry how much it will cost. So, for instance, if you know you're not consistent at taking the pill, maybe you'll opt for a long-acting device that might have been too expensive for you before the ACA required it to be covered. (Power to Decide also offers a Bedsider tool that explains your range of contraceptive choices and helps you compare multiple methods.)

However, as the Guttmacher Institute points out, there are certain loopholes that can saddle you with an unexpected bill, writing that "under the guarantee, health plans may apply formularies, prior authorization requirements, and similar restrictions within a method category." This may be to influence patient choice, which isn't very helpful since drugs within the same category—like birth control pills, for example—can cause different side effects or may not be right for every woman.

Some states may have even more generous coverage than what the ACA offers, like covering a full year's supply of contraception at once or even vasectomies. Check out Guttmacher's site to see what your state specifically covers.

What religious exemptions do I need to know about?



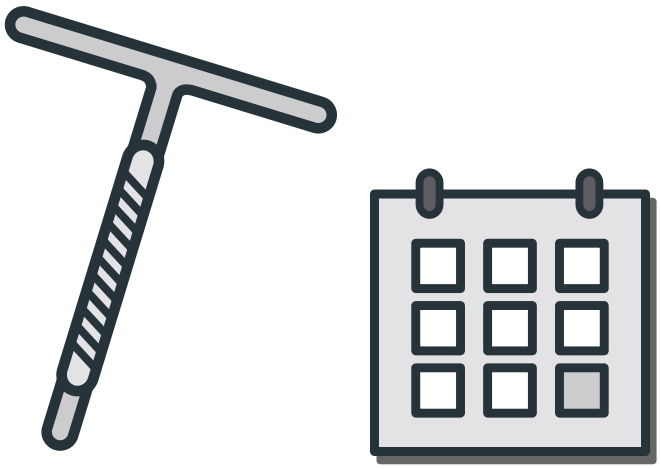
If your employer is a religious institution like a church, they don't have to cover contraception and you may have to pay out of pocket. If you work for a non-profit religious hospital, university, or other organization, they also don't have to pay for contraception—but the insurance company does so you can still get it at no cost anyway. The insurance company is supposed to step in and arrange birth control coverage on your plan, Gandal-Powers says. (If not, check out the section below on what to do if you get charged.)

Now, let's talk about something that happened in October 2017. A mandate from the Trump administration expanded employer's rights to deny insurance coverage for birth control for any ethical, religious, or moral objection, and it extends to for-profit companies. "This would have basically driven a Mack truck through the contraceptive accommodations," says Gandal-Powers. However, she notes that these rules are currently stalled by two nationwide injunctions in the circuit courts. Right now, they are not in effect—a very good thing for your health.

I don't trust my insurance company. Can I just ask my doctor if it's covered?

Yup. It's easy to assume that they're there for your physical care, but they can also help with insurance concerns. So, don't be afraid to ask them if the prescription is covered under your plan. "If I don't know the answer, I know someone in my office does. At every office there is usually a point person to talk to about insurance issues and logistics," says Kristyn Brandi, an OB/GYN in New Jersey and board member with Physicians for Reproductive Health.

I think I want an IUD or implant. Anything else I should know about getting one of those?



Yes, glad you asked. Some clinics and doctor's offices carry these super-effective, long-acting methods—which last between three and ten years—and some don't, Brandi says. If yours doesn't, the office will have to order it and you'll need to come back to get it inserted. If you think you may be interested in an IUD or implant, ask the doctor's office while making your appointment if they stock those.

For these more expensive devices or sterilization procedures, it's always a good idea to call your insurer to ask if the specific one you're getting is covered. Ask the administrative team in the office for the insurance codes (for the counseling, the device itself, and the insertion procedure) and call your insurance company to double check your coverage. You have a right to your Summary of Benefits, which outlines these details. This small amount of work on your part can save you from a surprise bill.

While we're talking about these devices, you should ask yourself if you want to get pregnant within the next year or so—and share this info with your OB/GYN so they can help counsel you on what method is best. If you do want to get pregnant in the near future, then a hormonal or barrier method (like the pill or diaphragm) may be best for you. An IUD or implant can still work in this case, but be prepared that there's legwork to get the device put in and taken out, and you have to decide if that's worth it for you, Brandi says. (She, however, does not recommend the birth control shot, brand name Depo-Provera, if you're planning on getting pregnant soon. "Studies show that it can take up to a year to return to fertility after the shot," she says.)

Ugh, my insurance sent me a bill. What now?

You thought that the Rx your doctor gave you would naturally be covered. But now you went to the pharmacy and they asked you to pay up. Or you got an IUD and then were sent a bill for it in full. Don't stand for it. "If you're new to insurance coverage, it can be daunting to take on your insurance company, or you might not know you can. But it's worth it," says Gandal-Powers.

Because of the ACA, you should be able to get the method of birth control the doctor prescribed. If it's a brand name, insurance plans have a process in place to get you this prescription (versus them trying to stick you on a generic). While it should be covered, "we know this doesn't always work perfectly with insurance companies," Gandal-Powers says. In that event, the National Women's Law Center has their free CoverHer hotline (phone or email). The CoverHer site also outlines what your rights are and includes templates of appeal letters to send to your insurance.

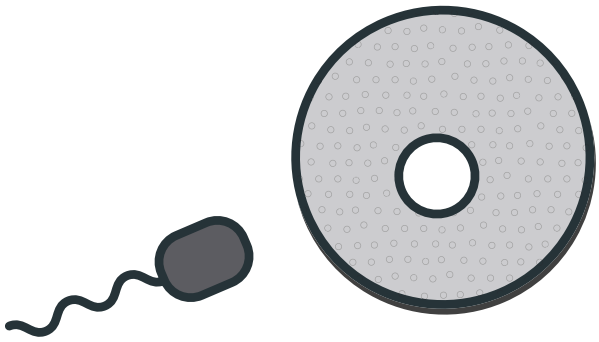
The good news is that since the NWLC published a report in 2015 detailing problems with insurance companies not complying with the ACA (like only covering the pill or the ring, not both, since both are hormonal options), additional guidelines circulated at the end of the Obama administration that made insurance companies more accommodating, Gandal-Powers explains.

What if I want my tubes tied?

The official name for this is a tubal ligation, a surgical female sterilization procedure where the two fallopian tubes are blocked or cut so sperm can't reach an egg. The surgery is fully covered by insurance thanks to the ACA. While it can be reversed in some instances with another surgery, a tubal ligation is usually permanent. For that reason, some women report that their doctors sometimes won't do the procedure, warning them that they may change their mind.

"It personally makes me very angry when I hear those stories," Brandi says. "If a woman decided she doesn't want children or more children, that's it. End of conversation—regardless of her age or partner status." Of course, your doctor may give their medical opinion on your specific case. If your doctor is pushing back based on their views on your family wants (rather than if, say, it wouldn't be medically safe for you), seek a second opinion.

If you're unsure if it's right for you, you can reach out to the office of a doctor who does tubal ligations of people your age and ask if you can talk to a similar patient, Brandi suggests. It can be a little tough to coordinate, but sometimes they will refer to another patient so you can understand the procedure in a new way.



All this is nice, but I don't have health insurance. How can I get low-cost birth control?

If you don't have insurance, the difficult reality is that you have to be your own advocate, says Jennifer Johnsen, senior director of digital programs and education at Power to Decide, a non-profit that works to prevent unplanned pregnancy. This can be tough depending on your job, access to transportation, and availability of health clinics that provide contraceptive services at low or no cost.

Power to Decide's Bedsider database can help you find a health center near you to get birth control, and they also have a tool to help you determine if you qualify for free contraception. According to Planned Parenthood, you may be able to get it for free if you qualify for Medicaid or state programs even if you're not enrolled in them. Both Planned Parenthood health centers and health clinics that get federal family planning funds known as Title X grants will provide low- or no-cost birth control, cancer screenings, and STD tests depending on your income. You can search for Planned Parenthood health centers and Title X health centers online. You can also search "sliding scale birth control" and your city name. (If you just need STD testing, you can search the database at gettested.cdc.gov and select "show only free or low cost providers.")

Before you go, know that it may not be as simple as going in for an appointment and walking out with birth control. Some health centers will dispense prescriptions on site, while others require you to make a separate trip to a pharmacy to fill it. And if it's a long-acting method like the shot, implant, or IUD, you may have to go back to the center to get it administered or implanted.

This large amount of commitment can be a deterrent to going, but knowing what you're in for first can help you make arrangements for transportation and time off. If you have children but are hesitant to go because you don't have childcare available, some of these centers have accommodations that you can bring your kids.

From there, you can call the clinic and ask about their birth control options and how they can help you get the method you want without health insurance. (They may say they can't, and you'll have to look at another center.) Johnsen also notes that a telemedicine provider, who prescribes birth control through an app or online video consultation, can be a more accessible way for some people to get birth control. Some will require a flat fee of as low as $15 a month without insurance (and many do take insurance).

The Affordable Care Act has done a lot of good but, yes, there are still many people without insurance. The 7.4 million women of reproductive age without insurance fall into a "coverage gap," Johnsen says.

"[Many of] these women do not have children, they have incomes below 138 percent of the poverty line, and they live in one of the 17 states that have not yet expanded Medicaid," she says. Johnsen adds that 11 of these states have Medicaid Family Planning Waivers, which allow women with low incomes to qualify specifically for family planning coverage, rather than full health insurance. The Kaiser Family Foundation has a list of states that allow women to get Medicaid coverage for birth control.

Additional coverage gaps include legal immigrants (some green-card holders have to wait 5 years before enrolling in Medicaid) and undocumented people. Then, there's geographical concerns. So-called "contraceptive deserts" leave 19 million women without access to health clinics that provide the full range of FDA-approved birth control methods.

0008: HEALTHCARE GLOSSARY

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).