Health Care Vocabulary

premiums: The amount you pay (usually every month) to purchase an insurance policy. It is not cheap! Best is to get a job where your employer provides it. (Starbucks does. Also most union jobs.) But even then, money your employer spends on your policy is money they would be willing to give you in salary if they didn't have to pay for health care for employees. So it's not really free.

There are usually three levels of cost: for one person, two people, or a family of three or more.

Policies with better coverage (and lower out-of-pocket expenses) cost more.

out-of-pocket expenses: The expenses you have to cover yourself, that your insurance does not pay. Including:

deductibles: This is how much you have to pay each year, before your insurance will start paying for anything. (There can be exceptions, for example for COVID-19 testing they will pay even if you have not met your deductible.) If there are multiple people on your policy (a family) there is usually a per-person deductible and a family deductible. (So if one person goes over that amount, the plan will start paying for them. If the total for multiple people goes over the family deductible, the plan will start paying for everyone, even if some have not met their individual deductibles yet.)

More expensive policies usually have lower deductibles, so they start paying sooner.

copays: This is the amount you pay for a visit, prescription, or service, every time you use your plan. For example, you might pay $20 each time you go for a doctor's visit. (The insurance will pay the rest. Most doctor visits cost $80-$120.) Or you might pay $10 for a prescription. (The insurance pays the rest. Prescriptions can be as cheap as $50, or can cost several hundred dollars per month.) Emergency room visits often have $100 copays, to discourage using them instead of just going to the doctor, as they are extremely costly. Same with ambulances. But if you end up being admitted to the hospital (and didn't just use the ambulance as a taxi), they will waive the copay usually.

More expensive policies usually have lower copays, since you are paying more up front.

annual caps: This is the maximum an insurance plan will pay for a member in any given year. So if you need a lot of expensive care, after you reach the cap they will stop paying! (Think heart attack, stroke, cancer, kidney failure...) *This is one of the things that Obamacare changed.*

lifetime caps: The same as annual caps, but lifetime. So if you have an ongoing expensive condition, that requires ongoing treatment (like dialysis), after a few years you will reach your cap and they will cut you off! *This was also changed by Obamacare.*

preexisting conditions: These would be ANY medical conditions you had when you applied for your policy. Including anything you avoided going to the doctor for, because you didn't want it to be identified before you had an insurance policy. In the U.S., preexisting conditions would typically not be covered by your insurance for at least a year after you got your policy. This would even apply to babies born with medical conditions, and added to your family policy when they were born. If you get a group policy (like through your employer, where all employees are automatically part of the plan) these exclusions would often be waived. Because they charged their premiums based on the overall historical health of the employee group. *Obamacare also addressed the topic of preexisting conditions, in stages.*

junk policies: These are very cheap health insurance policies, that provide very little coverage and exclude many conditions, even those that were not preexisting. They have huge deductibles and copays. They might only cover you if you get a catastrophic condition (and even then, they would have caps). *Obamacare banned these policies, so some people got mad that their insurance rates went up when they had to buy better policies. Sometimes for their employees.*

individual mandate: Insurance companies complained that if they could not reject people who had preexisting conditions, no one would buy insurance until they were already sick. That would make it impossible to pay for the care everyone would need. (They were right.) So they insisted that if the preexisting condition exclusions were eliminated, there should be an individual mandate that requires everyone to buy insurance.

public option: This is an idea where the government offers insurance policies for a cheaper price (because they are not for profit) to those who do not want to buy private insurance, or can't afford it, or have been rejected by private insurance

companies. This is like public schools as an option to private schools. Private insurance companies said it was not fair, because they could not compete with what the government could offer. In the end, a modified version of this became part of Obamacare, through the exchanges. (See the next term.)

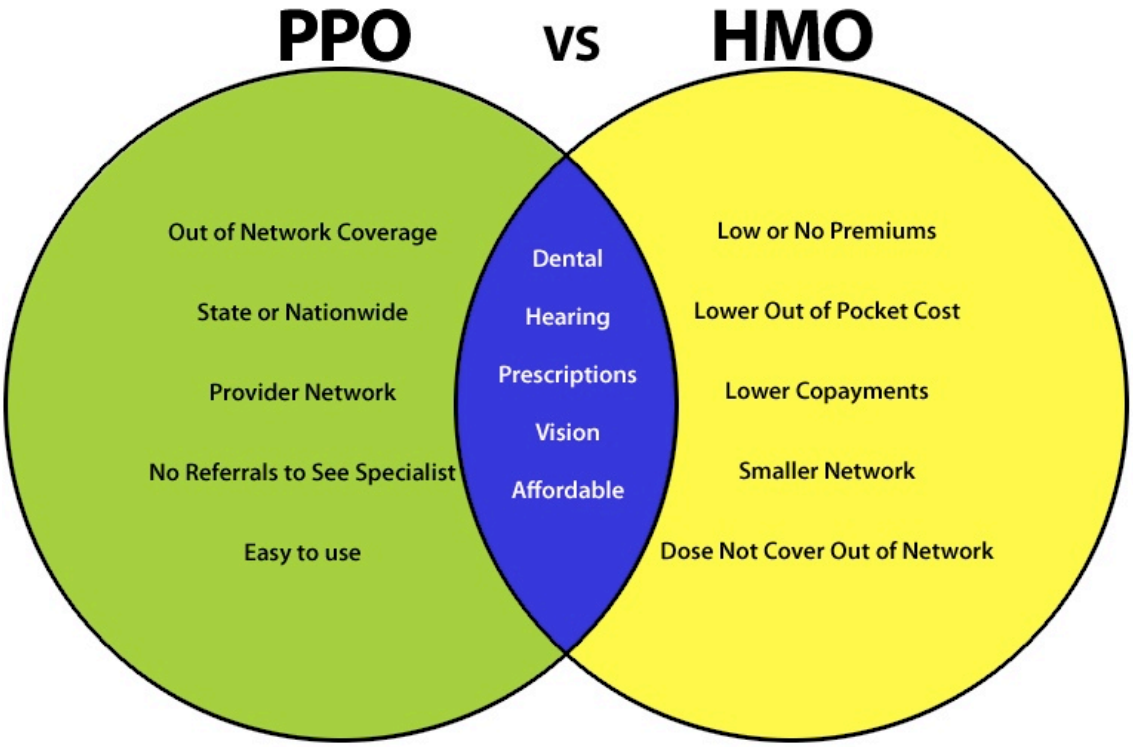
insurance exchanges: These are online insurance "marketplaces," offered to individuals by those states that choose to participate. In California, the program is called "Covered California." The insurance is a lot cheaper than private plans. This is how the public option (see above) was incorporated. The compromise with insurance companies was that these exchanges cannot cost insurance companies any customers. So only low income people who cannot afford private insurance, or those with preexisting conditions that the insurance companies don't want to insure, can participate. If you already have a policy, you cannot replace it with one of these to save money.

Medicare: This is the federal government's health care plan for those over 65 and those with disabilities (such as blindness or being in a wheelchair). It was first proposed during FDR's New Deal, but was not passed until 1965, as part of LBJ's Great Society. Medicare covers doctor visits, hospitalization, and a host of procedures. But people on Medicare have to buy supplemental insurance to cover their prescriptions.

Medicaid: This is the federal government's health care plan for people who are low income. It was also passed in 1965, as part of the Great Society. Unlike Medicare, Medicaid is managed by the states. Each state receives funds from the Medicaid program, and they they set up their own system to deliver services. The program has a different name in every state. In California, it is called MediCal.

PPOs: This stands for Preferred Provider Organization. It is a health care plan where you go to providers (such as doctors) who join the organization, usually referred to as a "network." To join the network, doctors/providers agree to accept payment from the PPO (such as Blue Cross), and to only charge the amount that the PPO allows. In exchange, the PPO sends its customers their way, and guarantees payment. (No bouncing checks.) You can also go to out-of-network providers, but the insurance company will pay a smaller portion of the cost (maybe 50%), and the charges are often higher. People like these policies because they can choose their own doctors, but they are more expensive plans.

HMOs: This stands for Health Maintenance Organization. This is a health care plan which operates its own hospitals and medical offices, and hires its own doctors, nurses, and other staff. You must go to the HMO's own facilities, and receive care from their own providers (unless you are away from home and they don't have a facility where you are). They will not pay if you go elsewhere. (Kaiser is an example.) People like HMOs because they offer one-stop-shopping (you can often get everything taken care of in the same facility), and they are cheaper than PPOs (because they have control over all the costs). But you do have to accept the care that is offered in-network. (You can usually choose your doctors from among the ones they have.)



single-payer / universal health care / "Medicare for All": This is the plan that Bernie Sanders has been promoting. (It is a plan that many people have been promoting, for a good long time. Like decades. It was also the plan that Elizabeth Warren was calling for, until she was pressed to explain how we would pay for it all, and then she changed her mind and said maybe we should get to it more gradually.) Under this plan, everyone in the country is covered by the government. (Think public education. But for all ages.) Some people find it easier to understand if they think of it as extending Medicare to everyone. It is called universal because everyone is covered. It is sometimes referred to as single-payer

because one entity (the government) pays all the bills. (Just like the government pays all teacher salaries, and the utility bills for schools, and buys the books, etc.) It is actually because it is single-payer that the system can be affordable. When a single payer negotiates prices for a needed medication, for example, they can get a much better price than when smaller organizations try to make purchases. And, like HMOs, they can control salaries and other costs. Proponents of this plan point out that the U.S. as a society spends more per capita on health care than any other country, and yet we are the only major industrial country that does not cover everyone. Opponents argue that their tax dollars should not go to pay for other people's health care, and maintain that capitalism produces higher quality of care. (Universal health care is essentially socialism. Again, like public education.) Just as with education, if this system is adopted people could still retain their private insurance. But they would still be paying taxes to support the public plan.