1. What is the difference between co-pay and co-insurance?

2. What characterizes a Platinum, Gold, Silver, Bronze plan?

3. What characterizes catastrophic coverage plan?

4. What is the origin of tying health insurance to employment?

5. Describe the difference between capitation and fee-for-service

6. What is cost shifting?

7. What is Medicare part A?

8. What is Medicare part B?

9. What is Medicare part D?

10. Who is eligible for Medicaid in WI?

11. Define the term “Allowable Costs”

12. What is a MOOP or Out-of-pocket Maximum/Limit?
1. Co-pay is a fixed amount; co-insurance is a percentage

2. The difference among these coverage tiers rests with their "actuarial" value -- in other words, how much a plan will cover before the patient must chip in for co-insurance, deductibles and co-payments.

According to the Kaiser Family Foundation, the actuarial values for the four levels of coverage are:

- Bronze: 60 percent.
- Silver: 70 percent.
- Gold: 80 percent.
- Platinum: 90 percent.

For example, someone who gets a silver plan would have to pay 30 percent of health care costs, while the plan covers 70 percent. Most Americans will be required to get at least a bronze-level plan, according to Kaiser, unless they're eligible for a religious or hardship exemption.

3. Catastrophic health plans generally have low premiums, high deductibles, and high cost sharing amounts. Catastrophic plans typically won’t pay any out-of-pocket costs like copays and coinsurance. Deductibles on catastrophic plans will tend to be equal to out-of-pocket maximums, this essentially means coinsurance and deductibles will never factor into what you pay. Often this means you pay a premium simply to get the same deals on care your insurer gets and to know you’ll never pay more than your out-of-pocket maximum in an emergency. Under the ACA, you’re only eligible for catastrophic plans if you’re under 30 or have obtained a “hardship exemption.” Of note:
   - You are under 30 and healthy and it is cheaper than the least expensive marketplace plan.
   - You don’t qualify for Medicaid because your state didn’t expand coverage.
   - You’re employer based coverage as a dependent will cost more than 8% of your household income.

4. In 1940s, wages were frozen so health benefits were a way for unions to get more from employers and employers to incentivize positions.

5. Capitation is a set amount to be paid per patient, fee for service charges per service preformed.

6. Compensating for payors that pay less by charging others more.

7. Part A covers hospital care
8. Part B covers physician services [Part B covers all out patient care (professional and facility)]

9. Drugs are covered by Part D

10. People at or below the poverty line (including childless adults). Others in WI get insurance through the exchange or private market. Federal expansion would have meant Medicaid for people at 133% of poverty.

11. Allowable costs are the total payments for services a payor negotiates. For example, a provider may have a list price of $1,000 for a visit but a commercial payor may have negotiated that down to $400. Medicare and Medicaid set the amounts they will pay (by region) without such negotiations and are typically lower than commercial insurers.

12. The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include your monthly premiums. It also doesn't include anything you spend for services your plan doesn't cover.