verywell

DISCUSSION GUIDE

Obtaining Your Own Health Insurance

If you're accustomed to employer-sponsored health insurance, or if you're without coverage altogether, the idea of having to select and purchase your own health insurance might seem overwhelming. Before you begin the process, it will be helpful to understand the terminology and some basic questions that you'll want to keep in mind.

Vocabulary to Know

These common terms may come up during your search process. Here's what they mean.

Obamacare	This is another name for the Affordable Care Act (ACA). It's often used to refer to a health plan purchased in the health insurance exchange despite the fact that Obamacare/ACA rules apply to nearly all types of health insurance.
Health Insurance Exchange	A platform where you can compare various health plans and purchase the one that best fits your needs. Although there are private health insurance exchanges, if you see it written as "the exchange," it's referring to the official entity in your state where you can purchase ACA-compliant health plans and obtain premium subsidies and cost-sharing reductions if you're eligible for them. In most states, HealthCare.gov serves as the health insurance exchange, but 11 states and DC have their own exchange platforms (a few other states will join them in the next few years).
Premium	The amount you pay to purchase your health insurance. You pay it regardless of whether you receive medical care—it's completely separate from the cost-sharing (deductible, copay, coinsurance) that you'll pay if and when you need to seek medical care. When you have health insurance through an employer, the employer typically pays a large portion of the premium. When you buy your own health insurance, you might qualify for a premium tax credit (subsidy) to help pay the premiums for a plan you buy in the exchange. If not, you'll have to pay the full premium yourself, although health insurance premiums are tax-deductible if you're self-employed.
Premium Tax Credit (Premium Subsidy)	A tax credit created by the ACA in order to make individual health insurance more affordable for low-income and middle-class people. The tax credit can be taken up front (paid to your health insurer each month on your behalf). So, unlike other tax credits, you don't have to wait until you file your tax return to claim it, but you do have to reconcile it on your tax return. The tax credit is only available to offset the cost of health plans purchased in the exchange. It's only available to people who aren't eligible for Medicaid, premium-free Medicare, or an affordable employer-sponsored health plan, and whose modified adjusted gross income is between 100% and 400% of the poverty level.
Cost-Sharing Reduction (Cost-Sharing Subsidy)	Under the ACA, people who select a silver health plan in the exchange and who have income that's between 139% and 250% of the poverty level (the lower limit is 100% of the poverty level in states that haven't expanded Medicaid) are eligible for a subsidy that reduces their out-of-pocket costs. This subsidy—unlike the premium subsidy—does not need to be reconciled on your tax return.

Vocabulary to Know (continued)

These common terms may come up during your search process. Here's what they mean.

Bronze/Silver/Gold/Platinum Health Plans	Under the ACA, all new individual market health plans sold since 2014 must be either bronze, silver, gold, platinum, or catastrophic. The "metal level" distinctions are based on the actuarial value of the health plan. Bronze plans cover roughly 60% of average health care costs, silver plans cover roughly 70%, gold plans cover roughly 80%, and platinum plans cover roughly 90% (platinum plans aren't widely available). Premium subsidy amounts are based on the cost of the second-lowest-cost silver plan in each area, but can be applied to any metal-level plan. Cost-sharing reductions are only available if you buy a silver plan.
Catastrophic Health Plan	Although people often think of this as a catch-all term for any health plan with a high out-of-pocket exposure, the ACA gave it a specific definition. It's a type of individual market coverage that's only available to people under age 30 or who have a hardship/affordability exemption, and premium subsidies cannot be used to offset the cost of a catastrophic plan. The actuarial value is under 60%, and the deductible and out-of-pocket maximum are equal to the amount that the federal government sets as the highest allowable out-of-pocket maximum for that year. But catastrophic plans also cover three primary care visits before the deductible (copays can apply), and they also cover the same free preventive care that's covered under all ACA-compliant plans.
Off-Exchange Health Plans	This refers to health insurance plans that are purchased outside the official health insurance exchange. All individual major medical plans sold since 2014—including those sold in the exchange as well as off-exchange plans—are fully compliant with the ACA. Note that although short-term health plans are sometimes referred to as "short-term major medical," they are not regulated by the ACA and are instead considered an excepted benefit. However, there are no premium subsidies or cost-sharing reductions available outside the exchange, so enrollees pay full price for these plans.
Excepted Benefits	These are health plans that are not regulated by the ACA and are instead specifically exempted from ACA requirements. For the most part, these plans are not adequate to serve as stand-alone health coverage (with the exception of short-term health insurance, which can serve as stand-alone coverage for a short time, albeit without the full range of benefits that are included on ACA-compliant plans). Excepted benefits include supplemental coverage like dental and vision plans, limited benefit plans, fixed indemnity plans, and short-term health plans.
Short-Term Health Insurance	A type of health coverage that does not have to comply with the ACA's regulations, and which offers benefits for a limited time period. Under federal rules that were put in place in 2018, short-term plans can have initial terms of up to 364 days, and can be renewable for a total duration of up to 36 months. However, the majority of the states have more restrictive rules. Short-term plans use medical underwriting and do not have to cover the ACA's essential health benefits—many of these plans don't cover maternity care, mental health care, or prescription drugs.

Vocabulary to Know (continued)

These common terms may come up during your search process. Here's what they mean.

Medicaid Expansion	One of the cornerstone provisions of the ACA was to expand Medicaid to cover all adults with income up to 138% of the poverty level. Pre-ACA, Medicaid was generally only available to low-income people who were pregnant, elderly, disabled, or caring for minor children. The ACA switched to an income-based system for people ages 19 to 64, and set the upper eligibility limit at 138% of the poverty level (children were already eligible for Medicaid or CHIP with higher income limits, and the rules are different for elderly enrollees). The federal government pays the majority of the cost, but the Supreme Court ruled in 2012 that states could not be forced to expand Medicaid. The majority of the states have expanded Medicaid, but some have not. If you're in a state that has expanded Medicaid and you apply for a health plan in the exchange, you'll be enrolled in Medicaid if your income makes you eligible.
Children's Health Insurance Program (CHIP)	A state-federal program that provides health coverage to children whose families have somewhat limited income but earn too much for the children to be Medicaid-eligible. CHIP generally has fairly low enrollment fees and out-of-pocket costs. The income caps for eligibility vary from one state to another (from 170% of the poverty level in North Dakota to 400% of the poverty level in New York). If you apply for a health plan in the exchange and your kids are eligible for CHIP, the exchange will help you get them enrolled in CHIP instead of a private health plan.
PPO/EPO/HMO/POS	These are types of managed care plans. The acronyms describe the health plan's provider network and how the plan pays for care depending on whether the member sees an in-network or out-of-network provider. There are also varying requirements for specialist referrals that generally differ depending on whether the plan is a PPO, EPO, HMO, or POS, although some plans take a hybrid approach.
Health Savings Account (HSA)	If you have an HSA-qualified high-deductible health plan (HDHP), you can put pre-tax money into an HSA to use for current or future medical expenses. The IRS defines the parameters for HDHPs and how much you can put into your HAS. In 2019, the amount is $3,500 if your HDHP covers just yourself and $7,000 if your HDHP covers at least one other family member. HSAs can be established at a bank or credit union, through an insurance company that offers an HSA, or through an investment/brokerage firm. Contributions are pre-tax, the money grows tax-free (and rolls over from one year to the next), and withdrawals are always tax-free if the money is used for qualified medical expenses.
Deductible	The amount of money that you have to pay for your medical care before your health plan starts to pay benefits. Depending on your plan, you may have various services (doctor visits, urgent care visits, prescriptions, etc.) that aren't subject to the deductible, and are instead covered with a copay regardless of whether you've met your deductible. As long as you stay within your health plan's provider network, you'll pay the network-negotiated rate (as opposed to the full price that the doctor or hospital bills) during the time that you're paying your deductible. On most plans, the deductible resets annually, although Medicare takes a different approach.

Vocabulary to Know (continued)

These common terms may come up during your search process. Here's what they mean.

Copayment (Copay)	A set dollar amount that you'll pay when you receive a medical service for which your health plan offers copay coverage. Copays most often apply to office visits, urgent care visits, emergency room visits, and prescription drugs, although each health plan has a different design. Some health plans don't have copays at all, and instead count all services towards the deductible, with the patient paying full price until the deductible is met.
Coinsurance	An arrangement in which the cost of your care is split between you and your insurance company on a percentage basis. It can be 80/20, 70/30, 50/50, or some other split. Generally, the insurance company pays the larger percentage and the patient pays the smaller percentage. As long as you stay in-network, your coinsurance is based on a percentage of the network-negotiated price, as opposed to the amount that the medical provider bills. Coinsurance generally kicks in after the patient has met their deductible, and applies until the total out-of-pocket maximum is reached. After that, the health plan pays 100% of covered costs for the remainder of the year.
Drug Formulary	The list of drugs that a health plan covers. These vary from one health plan to another, but there are specific rules that health plans must follow in order to ensure that their drug formularies are adequate. There is also an appeals process that patients and their doctors can use if the patient needs a medication that's not on the health plan's formulary.
Provider Network	The medical providers that have agreed to work with an insurance company and provide services at a negotiated rate. The provider network will include doctors, hospitals, labs, device manufacturers, pharmacies, ambulance services, etc. When patients receive medical treatment outside the network (sometimes unknowingly), they'll pay a larger share of the bill or the entire bill, depending on the plan design.
COBRA	This refers to the Consolidated Omnibus Budget Reconciliation Act of 1985, which allows people with certain employer-sponsored health plans to continue their employer-sponsored coverage for a limited time (up to 18 or 36 months, depending on the circumstances) after they leave their job. The enrollee has to pay the full cost of the coverage (including the portion that the employer used to pay) plus a 2% administrative fee.
Special Enrollment Period	Most health insurance coverage—including plans purchased in the individual market and employer-sponsored plans—has limited annual enrollment windows. But people who experience various qualifying life events are granted a limited-time special enrollment period which allows them to enroll outside of the annual enrollment window.

Questions to Ask

These questions will help you select the health plan that best fits your needs.

- ❑ How much help do I need with this process. Should I use a broker, navigator, or DIY approach?
- ❑ For how long do I anticipate needing to purchase my own health insurance?
- ❑ What is the website for my state's health insurance exchange?
- ❑ How much are the individual health plans available to me?
- ❑ What are the total out-of-pocket costs for COBRA?
- ❑ What are the total out-of-pocket costs for the available individual market plans?
- ❑ How do plans with and without copays compare in price?
- ❑ Do I qualify for a premium tax credit? If so, how much does it reduce the premium?
- ❑ Do I qualify for a cost-sharing reduction? If so, how much would a silver plan cost me?
- ❑ Am I eligible for expanded Medicaid?
- ❑ Are my kids eligible for Medicaid or CHIP?
- ❑ Are my doctors in-network with the health plans I'm considering?
- ❑ Are my medications on the drug formularies of the health plans I'm considering?
- ❑ How much would my tax bill change (including potential premium tax credit eligibility) if I contributed to an HSA?
- ❑ Do I want to be able to contribute to an HSA?