

CONSUMER GUIDE TO INDIVIDUAL HEALTH INSURANCE

Courtesy of the National Association of Healthcare Underwriters (NAHU)

How is individual insurance different from group insurance?

Individual health insurance is, quite simply, coverage that an individual purchases for himself and/or his family. The Affordable Care Act (ACA) has made significant changes to how individual insurance policies are rated and the benefits that these policies provide. Individual insurance policies and provisions are also regulated by the state where the policy is purchased.

Individual policies are often purchased with the advice of a professional insurance producer due to the complexity of coverage offerings and the premium cost. With the advent of the ACA, a professional insurance producer's expertise may be even more critical since insurance policies have changed so dramatically.

Whether or not a person has a pre-existing medical condition is no longer a factor when purchasing individual coverage. Since a person's medical condition is not a factor, individuals are limited to certain times when they can enroll in coverage. A person must enroll during an open enrollment period to gain coverage for the year. There are limited opportunities to purchase coverage at other times during the year as a result of a special enrollment right.

Individual insurance policies in 2014 may be purchased through an exchange or "marketplace" or they may be purchased outside of the exchange. Irrespective of whether a policy is purchased inside or outside the exchange, policies must cover the same set of Essential Health Benefits. The richness of the benefits under the plan is defined by a metal tier. These tiers are based on the percentage the plan pays of the average overall cost of providing essential health benefits to members:

- **Platinum plans** are the most generous and more expensive. These are designed to pay as much as 90% of medical expenses
- **Gold plans** are designed to pay 80% of medical expenses
- **Silver plans** are expected to pay 70% of medical expenses
- **Bronze plans** are expected to pay 60% of medical expenses.

It's important to note that the metal tiers reflect what the plans will pay on average. These percentages are not the same as coinsurance, which calls for an individual to pay a specific percentage of the cost of a specific service.

Another category of individual plan is the **catastrophic plan**. A catastrophic plan must meet the requirements of the metal plans, but benefits are very limited. Catastrophic plans are an option for individuals under the age of 30 or others who have received a "hardship exemption" from the exchange due to other health coverage being deemed unaffordable.

Since medical services can be quite costly, the insurance premium for individual coverage is small compared to the amount an insurer may have to pay for claims. For example, a comprehensive individual insurance policy may cost \$4,000 for a 30-year-old male for a year (actual premium costs vary by geographic area, metal tier selected and other factors, this is an estimate for comparison purposes only). Treatment costs for a broken leg that needs surgery (lower leg fracture surgery) are estimated to cost a total of \$15,581 by the [Healthcare Blue Book](#).

How are premium rates determined?

Premium rates both on and off of the marketplace are determined by the age of each individual who will be covered by a plan. Other factors that affect the premium for coverage include where a person lives and the level of plan (metal tier) that they select.

Individuals may be eligible for government subsidies to help pay for premiums. Subsidies are available only for coverage purchased through the exchange. Subsidies are calculated based on the modified adjusted gross income for the year and the household size. Subsidies may be available to individuals with incomes between 100% of the Federal Poverty Level (FPL) and 400% of the FPL. More information on qualifying for premium assistance can be found at <https://www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/>.

Individuals may also qualify for savings on out-of-pocket costs when they obtain medical care. These savings are called "cost-sharing reductions." Cost-sharing reductions reduce the amount an individual pays for out-of-pocket costs such as deductibles, coinsurance and copayment. They are available for Silver plans purchased through the exchange for individuals with incomes no higher than 250% of the FPL.

Can I still buy individual insurance if I have a very serious pre-existing medical condition?

Under PPACA, as of March 23, 2010, health plans can no longer exclude, limit or deny coverage to a child under age 19 solely on the basis of a pre-existing condition. Beginning in 2014, insurers providing individual insurance will no longer be able to, in most cases, exclude, limit or deny coverage for any American solely on the basis of a pre-existing condition. There may be some limited situations where a plan has maintained special "grandfathered" status where this limitation would not apply.

What benefits will an individual health policy cover?

Health insurance plans offered through the exchange or outside of the exchange will offer the same essential health benefits. Each plan or insurance company may add items or services to these minimum essential benefits and may vary the hospitals and doctors that are part of the network so it is important to compare plans.

The essential health benefits include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services
- Prescription drugs
- Laboratory services
- Preventive and wellness services
- Pediatric services
- Rehabilitative and habilitative services and devices.

When can I enroll in an individual plan?

Because there are no longer any restrictions on coverage for pre-existing conditions, coverage is generally available for purchase only during open enrollment periods. The limitation to purchase coverage during open enrollment is a mechanism to avoid "adverse selection" and is needed to help keep health insurance premiums more affordable. Adverse selection occurs when someone can purchase insurance only after they know that they need it.

The open enrollment period for coverage to be effective in 2014 began on October 1, 2013 and ended on March 31, 2014. The open enrollment period for coverage to be effective in 2015 will begin on November 15, 2014 and end on February 15, 2015.

Enrolling in coverage outside of the open enrollment period generally requires that someone have a qualifying life event that triggers a special enrollment right. A qualifying life event is typically marriage, divorce, birth or adoption of a child or a change in income, among others. It is not a voluntary loss of employer coverage.

Some states or some insurance companies may offer coverage at times other than the open enrollment period. You should check with your state Department of Insurance, the exchange marketplace in your state or an insurance producer licensed to sell insurance in your state to see if there are exceptions.

Where can I get more information?

An insurance producer licensed to sell insurance in your area is one of the best resources for information on coverage that meets your needs. You can find an agent in your area that is qualified to sell insurance through the exchange or outside of the exchange at www.nahu.org under the consumer information tab.

You may also find a helpful glossary of insurance terms and other marketplace information at www.healthcare.gov.

This information can be found online at: <http://www.nahu.org/consumer/IndividualInsurance.cfm>