

Health Insurance Options Matrix:

A Description of Coverage Options Available to Real Estate Professionals

November 8, 2023

Individual Market Health Plans

- What Are They? If you do not have access to health coverage through an employer or government program (e.g., Medicare), you can purchase a health plan from the individual market under the Affordable Care Act (ACA).
- What Type of Coverage Do They Offer? The ACA requires an individual market plan to cover “essential health benefits,” which include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; and preventive and wellness services and chronic disease management.
- Are There Protections for Pre-Existing Conditions? Yes. Individual market plans must cover pre-existing conditions. Also, premium rates may not increase if a plan-holder develops a health condition while covered under the plan.
- Are There Protections for Excessive Out-of-Pocket Expenses? Yes. An individual market plan is subject to the ACA’s out-of-pocket maximum limits, which limits how much a plan-holder may pay with their own dollars before the health plan must cover 100% of the costs. The out-of-pocket maximum limits for 2024 are \$9,450 for single coverage and \$18,900 for family coverage.
- What Type of Deductibles Do They Have? Although there are hundreds of individual market plans to choose from, the “metal level” signifies whether the plan has a high or low deductible. For example, a “bronze” level plan is allowed to have the highest deductible amount, which averages about \$7,000 for single coverage and \$15,000 for family coverage. The most popular individual market plan (“silver” level) has an average deductible around \$4,500 for single coverage and \$10,000 for family coverage.
- What Type of Premiums Do You Pay? If you purchase an individual market plan through HealthCare.gov or a State ACA Exchange, you may be eligible for a substantial government subsidy. If you have low income in a particular year, the government subsidy may cover up to 100% of the premiums or you may only be required to pay a small dollar amount for your health plan coverage.
- What Are Some of the Pros of Coverage Under an Individual Market Plan?



- **Pro:** Individual market plans provide comprehensive health coverage. You are also protected if you have a pre-existing condition or develop a health condition while covered under the plan.
- **Pro:** If you purchase an individual market plan through HealthCare.gov or a State Exchange, the government will pay a sizable portion of the cost of the plan.
- **Pro:** If you incur a catastrophic expense that requires you to pay thousands of dollars out-of-your-own-pocket, the ACA caps your out-of-pocket spending at around \$10,000 for single and \$19,000 family.
- What Are Some of the Cons of Coverage Under an Individual Market Plan?
 - **Con:** Individual market plans have high deductibles. This means that while you may only be paying a small portion of the premium cost for coverage, you could be exposed to high out-of-pocket spending.
 - **Con:** Some individual market plans may have a “narrow network,” meaning there are limited medical providers that you may access for your health needs. This means that you may not be able to see the doctors you currently see. This could also result in the need to access out-of-network care, which could result in you paying significant amounts out-of-pocket.

Short-Term Health Plans

- What Are They? A short-term health plan provides coverage for a specified period. Currently, Federal regulations allow a short-term health plan to provide coverage for 364 days, with an option to renew the coverage for 2 additional years. However, some states limit the duration of a short-term health plan to 3 months while others ban the sale of short-term health plans. Federal regulations were recently issued limiting short-term health plans to 3 months, but these regulations are not yet final.
- What Type of Coverage Do They Offer? Short-term health plans typically provide coverage only for specified medical services and are not required to cover the ACA’s “essential health benefits.”
- Are There Protections for Pre-Existing Conditions? No. Short-term health plans are not subject to the ACA, which means an insurance company may deny coverage for a pre-existing condition or raise premiums if you develop a health condition during your period of coverage. The insurance company may also refuse to renew your coverage for any health care-related reason.
- Are There Protections for Excessive Out-of-Pocket Expenses? No. Short-term health plans are not subject to the ACA, which means there are no out-of-pocket maximum limits.
- What Type of Deductibles Do They Have? The deductibles for a short-term health plan vary widely. In some cases, the deductible may be \$0, meaning the plan will pay first-dollar for the medical items or services that are covered under the plan. In other cases, a short-term health plan may have a deductible that is like an “individual market” silver level plan.



- What Type of Premiums Do You Pay? Because short-term health plans (1) only provide coverage for a specified period and (2) may only cover certain medical items or services, the premiums for these plans may be much lower than an “individual market” plan.
- What Are Some of the Pros of Coverage Under a Short-Term Health Plan?
 - **Pro:** Short-term health plans have very low premiums. While the coverage may be limited, the plan offers a base-level of coverage for certain medical items or services.
 - **Pro:** Depending on how the plan is structured, you may not have any out-of-pocket exposure for medical items and services covered under the plan.
- What Are Some of the Cons of Coverage Under a Short-Term Health Plan?
 - **Con:** Short-term health plans have limited coverage, which means the plan may not cover important medical items and services such as prescription drugs and other medical episodes or health conditions.
 - **Con:** Short-term health plans may impose dollar limits on how much the plan will cover for a particular medical item or service.
 - **Con:** Insurance companies selling short-term health plans can increase your premium based on your health conditions or deny coverage for pre-existing conditions.

Healthcare Ministry Plans

- What Are They? A health care sharing ministry plan is a member pooling arrangement and not “insurance.” Instead, members of the health care ministry “share” their health care expenses by contributing amounts to the plan, and then they are eligible for payments for incurred health claims up to a specified reimbursement amount determined by the health care sharing ministry.
- What Type of Coverage Do They Offer? Some health care ministry plans may cover a specified set of medical items or services while others cover any type of health care claim. In either case, the plan may only pay for health care expenses up to a specified amount. Because health care sharing ministry plans are not subject to the ACA, these plans are not required to cover the ACA’s “essential health benefits.”
- Are There Protections for Pre-Existing Conditions? No. Health care sharing ministry plans are not subject to the ACA, and therefore, the health care ministry may deny or refuse coverage for pre-existing conditions or raise premiums if you develop a health condition during your period of coverage.
- Are There Protections for Excessive Out-of-Pocket Expenses? No. Because health care sharing ministry plans are not subject to the ACA, these plans are not subject to the ACA’s out-of-pocket maximum limits.
- What Type of Deductibles Do They Have? The deductibles for a health care ministry plan vary widely. The deductible may range from \$0 to amounts typically found in “individual market” plans.



- What Type of Premiums Do You Pay? Because health care ministry plans (1) typically place limits on the dollar amount that the plan will pay for certain medical items or services and (2) can, for example, deny a person coverage if they have a pre-existing condition, the premiums for these plans are typically much lower than the premiums for an “individual market” plan.
- What Are Some of the Pros of Coverage Under a Health Care Ministry Plan?
 - **Pro:** Health care ministry plans have very low premiums. While the plan may limit coverage for medical items or services, the plan could offer a base-level of coverage.
 - **Pro:** Depending on how the health care ministry plan is structured, you may not have any out-of-pocket exposure for medical items and services covered by the plan.
- What Are Some of the Cons of Coverage Under a Health Care Ministry Plan?
 - **Con:** Health care ministry plans have limited coverage, which means the plan may not cover important medical items and services such as prescription drugs.
 - **Con:** Health care ministry plans may impose dollar limits on how much the plan will cover for medical services.
 - **Con:** The health care ministry may deny coverage if you have a pre-existing condition or raise premiums if you develop a health condition while covered under the plan.

Employer-Sponsored Health Plans

- What Are They? If your spouse is working for an employer as a W-2 employee, you may be eligible to participate in the health plan sponsored by your spouse’s employer.
- What Type of Coverage Do They Offer? Employer-sponsored health plans typically provide comprehensive coverage, including coverage of the ACA’s “essential health benefits.” For example, if your spouse’s employer is considered a “small employer,” the law requires the coverage of the “essential health benefits” – OR – if the employer is considered a “large employer,” virtually all large employers voluntarily cover the ACA’s “essential health benefits.” An employer-sponsored plan is also subject to the ACA’s “group health plan coverage requirements” which means that the plan must cover adult children up to age 26, must provide free coverage for certain preventive services, and cannot impose annual and lifetime limits on benefits covered under the plan.
- Are There Protections for Pre-Existing Conditions? Yes. Because an employer-sponsored health plan is subject to the ACA, the plan may not deny coverage for a pre-existing condition, refuse to renew coverage for new health conditions, or set different premium rates based on a participant’s health condition.



- Are There Protections for Excessive Out-of-Pocket Expenses? Yes. Because an employer-sponsored health plan is subject to the ACA, there are out-of-pocket maximum limits on how much a participant must pay with their own dollars before the plan must cover 100% of the costs. The out-of-pocket maximum limits for 2024 are \$9,450 for single coverage and \$18,900 for family coverage.
- What Type of Deductibles Do They Have? Deductibles for employer-sponsored health plans may range from low to high. For example, large employers will typically offer participants between two and five different plans, each with different deductibles. For example, one plan may have a low deductible, like \$1,000 for single coverage and \$2,000 for family coverage. Some employers may also offer High-Deductible Health Plans (HDHP) with deductibles ranging from \$2,500-\$5,000 for single coverage and \$4,000-\$8,000 for family coverage.
- What Type of Premiums Do You Pay? According to the Kaiser Family Foundation, the average premiums for employer-sponsored health plans in 2023 was \$8,435 for single coverage (with an employee paying \$1,400 of the cost) and \$23,968 for family coverage (with an employee paying \$6,575 of the cost). “Small employer” premium costs for both the employer and employee are slightly higher than “large employer” premium costs.
- What Are Some of the Pros of Coverage Under an Employer-Sponsored Health Plan?
 - **Pro:** Employer-sponsored health plans offers comprehensive health coverage, including coverage of the ACA’s “essential health benefits.”
 - **Pro:** Large employer plans also offer access to a broad provider network and a wide array of prescription drugs.
 - **Pro:** Employer-sponsored health plans are subject to the ACA, which means the plan may not (1) deny a person coverage if they have a pre-existing condition or (2) deny the renewal of coverage if a participant develops a health condition while covered under the plan. In addition, a plan must comply with the ACA’s group health plan coverage requirements and out-of-pocket limits.
- What Are Some of the Cons of Coverage Under an Employer-Sponsored Health Plan?
 - **Con:** If your spouse’s employer is a “small employer,” you may pay higher premiums or deductibles, and even have limited access to providers relative to a “large employer” plan.
 - **Con:** If your income is low in a particular year, you may still be required to pay a considerable portion of income on health coverage.



Association Health Plans

- What Are They? An Association Health Plan (AHP) is a plan sponsored by an association of employers that employ at least one W-2 employee. To be eligible to participate in the AHP, an employer must be a member of the sponsoring association. Once the employer member joins the AHP, the employer may offer the health coverage provided through the AHP to eligible employees. Although efforts have been made to change Federal law to allow self-employed individuals to participate in an AHP, to date, self-employed individuals are NOT permitted to participate in an AHP. However, real estate brokerages with W-2 employees would be considered an employer and if they are a member of an association that sponsors an AHP, they may be able to offer health coverage to their W-2 employees but not to the self-employed individuals contracting with the brokerage.
- What Type of Coverage Do They Offer? An AHP is considered a “group health plan,” and therefore, is subject to the ACA and other federal laws. Most AHPs voluntarily cover the ACA’s “essential health benefits.” In addition, an AHP is subject to the ACA’s “group health plan coverage requirements” which means that the AHP must cover adult children up to age 26, must provide free coverage for certain preventive services, and cannot impose annual and lifetime limits on benefits covered under the plan. Many AHPs will also offer a broad network of medical providers and cover a wide array of prescription drugs.
- Are There Protections for Pre-Existing Conditions? Yes. Because an AHP is subject to the ACA, an AHP may not deny a person coverage for pre-existing conditions. In addition, an AHP may not set different premium rates based on a health condition or refuse to renew health coverage if a participant develops a health condition while covered under the plan.
- Are There Protections for Excessive Out-of-Pocket Expenses? Yes. Because an AHP is subject to the ACA, there are out-of-pocket maximum limits on how much a participant must pay with their own dollars before the AHP must cover 100% of the costs. The out-of-pocket maximum limits for 2024 are \$9,450 for single coverage and \$18,900 for family coverage.
- What Type of Deductibles Do They Have? Like large employers, AHPs will typically offer participants between two and five different plans, each with the different deductible amounts discussed under the Employer-Sponsored Health Plan section (above).
- What Type of Premiums Do You Pay? AHP health plans typically offer premiums comparable to large employers (so, for 2023, an average of \$8,435 for single coverage (with an employee paying \$1,400 of the cost) and \$23,968 for family coverage (with an employee paying \$6,575 of the cost)).
- What Are Some of the Pros of Coverage Under an AHP?



- **Pro:** An AHP allows small employers to band together and “group purchase” health coverage, typically at a lower cost than “small employer” or unsubsidized “individual market” plans.
- **Pro:** An AHP is subject to the ACA, which means an AHP may not (1) deny a person coverage if they have a pre-existing condition or (2) deny the renewal of coverage if a participant develops a health condition while covered under the plan. In addition, an AHP must comply with the ACA’s group health plan coverage requirements and out-of-pocket limits.
- **Pro:** Most AHPs voluntarily cover ACA “essential health benefits” and provide access to broader provider network than “small employer” and “individual market” plans. AHPs also typically cover a wide array of prescription drugs.
- What Are Some of the Cons of Coverage Under an AHP?
 - **Con:** Self-employed individuals may not participate in AHPs.
 - **Con:** 13 States plus DC do NOT allow AHPs to operate in their State (these States include: CA, CT, DE, ID, MD, MA, NH, NJ, NM, NY, PA, RI, VT).

Union-Sponsored Health Plans

- What Are They? A union-sponsored health plan is a health plan sponsored by a labor union. To be eligible, an employer must employ unionized employees, agree to participate in the union-sponsored health plan through a collective bargaining or affiliate agreement, and offer health coverage to the employer’s employees through the plan. Currently, a self-employed individual is not an “employer” or an “employee” under the Federal law governing union-sponsored health plans, so questions have been raised as to whether self-employed individuals may participate in a union-sponsored health plan. However, some labor unions and service providers have argued that a self-employed individual may join the union as an “affiliate member,” and as an affiliate member, access health coverage through the union-sponsored health plan.
- What Type of Coverage Do They Offer? A union-sponsored health plan is considered a “group health plan,” and therefore, is subject to the ACA and other federal laws. Virtually all union-sponsored health plans voluntarily cover the ACA’s “essential health benefits.” In addition, these plans are required to cover adult children up to age 26, provide free coverage for certain preventive services, and they may not impose annual and lifetime limits on benefits covered under the plan. Union-sponsored health plans also offer a broad network of medical providers and cover a wide array of prescription drugs.
- Are There Protections for Pre-Existing Conditions? Yes. Because a union-sponsored health plan is subject to the ACA, the plan may not deny coverage for a pre-existing condition. In addition, a union-sponsored health plan may not set different premium rates based on a health condition or refuse to renew coverage if a participant develops a health condition while covered under the plan.



- Are There Protections for Excessive Out-of-Pocket Expenses? Yes. Because a union-sponsored health plan is subject to the ACA, there are out-of-pocket maximum limits on how much a participant must pay with their own dollars before the plan must cover 100% of the costs. The out-of-pocket maximum limits for 2024 are \$9,450 for single coverage and \$18,900 for family coverage.
- What Type of Deductibles Do They Have? The deductibles for union-sponsored health plans are typically lower than large employer-sponsored health plans due to collective bargaining. As an example, union-sponsored plans may have a \$0 to \$500 deductible limit for single coverage and a \$500 to \$1,000 limit for family coverage.
- What Type of Premiums Do You Pay? Because union-sponsored health plans typically offer more robust coverage with lower deductibles than large employer plans, the premiums are higher than employer plans. Depending on the state, the premiums for a union-sponsored plan may still be lower than ACA “small employer” or unsubsidized “individual market” plans.
- What Are Some of the Pros of Coverage Under a Union-Sponsored Health Plan?
 - **Pro:** Many union-sponsored health plans offer more robust health coverage and lower deductibles than large employer plans and AHPs. The plan also voluntarily covers the ACA’s “essential health benefits” with broad provider networks and coverage of a wide array of prescription drugs.
 - **Pro:** A union-sponsored plan may not (1) deny coverage for a pre-existing condition or (2) deny the renewal of coverage if a participant develops a health condition while covered under the plan. In addition, the union plan must comply with the ACA’s group health plan coverage requirements and out-of-pocket limits.
- What Are Some of the Cons of Coverage Under a Union-Sponsored Health Plan?
 - **Con:** Federal and state regulators have not ruled on the ability of self-employed individuals to participate in a union-sponsored health plan and questions remain on this type of structure.
 - **Con:** Because a union-sponsored health plan provides more robust coverage with lower deductibles, the premiums for the union-sponsored plan will be higher relative to other health insurance plans.

Medicare

- What Is It? If you are 65 or older, you are entitled to health coverage under Medicare, which offers coverage through Part A, Part B, Part C, and Part D. Medicare coverage is offered in two ways: Traditional Medicare (Part A and Part B) and Medicare Advantage (Part C). If you apply to receive Social Security benefits, you will be automatically enrolled in Traditional Medicare Part A and Part B. If you are enrolled in Traditional Medicare, you must enroll in Medicare Part D on your own. Medicare Advantage (or Part C) is a government-approved Medicare plan that is offered by private insurance companies. These plans include Part A, Part B, and in most cases, Part D coverage. You must enroll separately in a Medicare Advantage plan during an open enrollment period.



- *What Type of Coverage Does It Offer?* Medicare Part A (called “Hospital Insurance”) covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. Medicare Part B (called “Medical Insurance”) covers certain doctors’ services, outpatient care, medical supplies, and preventive services. Medicare Part D (called “Prescription Drug Coverage”) covers the cost of prescription drugs. Medicare Advantage (or Part C) plans cover the same benefits as Traditional Medicare, but in almost all cases, Medicare Advantage plans cover more benefits than Traditional Medicare, like vision, hearing, and dental services. In some cases, a Medicare Advantage plan may also cover benefits like transportation to doctor visits, over-the-counter drugs, and wellness programs. Typically, you must see the doctors in the Medicare Advantage plan’s provider network.
- *Are There Protections for Pre-Existing Conditions?* Yes. Medicare coverage (both Traditional and Medicare Advantage) is available to every American regardless of whether they have a pre-existing condition. In addition, Medicare (both Traditional and Medicare Advantage) will cover any health condition that you may experience while covered under Medicare.
- *Are There Protections for Excessive Out-of-Pocket Expenses?* Not under Part A or Part B. For example, once you hit your deductible under Part A, you will pay a specified amount based on the length of your hospital stay with no corresponding cap on your out-of-pocket spending. Under Part B, once you hit your deductible, you will pay a 20% co-insurance on all benefits covered by Part B with no corresponding out-of-pocket maximum limit. Starting in 2025, Part D out-of-pocket expenses are capped at \$2,000 for the year. If you are covered by a Medicare Advantage plan, the out-of-pocket maximum limit for 2024 is \$8,850.
- *What Type of Deductibles Does It Have?* Under Medicare Part A, you pay a deductible for each inpatient hospital “benefit period,” which begins the day you are admitted to a hospital or skilled nursing facility and ends when you are discharged. If you are admitted to a hospital or skilled nursing facility after a benefit period has ended, then a new one begins, and you will have to pay another deductible. For 2024, the Medicare Part A deductible is \$1,632 per benefit period. For 2024, the Part B annual deductible is \$240, and is only payable 1 time per year. If you are enrolled in a Medicare Advantage plan, each plan design will have a specified deductible for coverage under the plan. Some Medicare Advantage plans may have a deductible of \$0 while other plans will follow the \$1,632 per benefit period deductible limit. For Part D, deductibles will also vary depending on the type of plan, but your deductible can be no more than \$545 for 2024.
- *What Type of Premiums Do You Pay?* If you paid Medicare taxes for at least 10 years while working, your coverage under Medicare Part A is free. However, if you are covered under Traditional Medicare, you must pay monthly premiums for coverage under Medicare Part B. If you are single and you make less than \$97,000 or if you are married and make less than \$194,000, the monthly Part B premium for 2024 is \$174.70. If you earn more than these amounts in 2024, your Part B premium will be higher. In addition, if you are covered under Traditional Medicare and you enroll in a stand-alone Part D plan, you must pay a monthly premium of \$55.50 for 2024.



Medicare Advantage plans have different premium rates, and the amount of premiums you will pay will depend on the Medicare Advantage plan's design. For example, some Medicare Advantage plans may cost \$0 while others may require a premium of more than \$200 per month.

- What Are Some of the Pros of Medicare Coverage?
 - **Pro:** Medicare coverage is available at a very low cost, and Medicare provides coverage for most health care needs.
 - **Pro:** Medicare must provide coverage to people with any type of health condition including pre-existing conditions.
- What Are Some of the Cons of Medicare Coverage?
 - **Con:** Medicare Part A and Part B do not include out-of-pocket limits, so while Medicare coverage is available at a low cost, out-of-pocket spending may be high if a participant consumes a lot of health care in a particular year.
 - **Con:** The only people eligible for Medicare are individuals 65 or older, and many NAR members are below the age of 65.

Medicaid

- What Is It? Medicaid is a government-run program, primarily operated by a State with Federal funding. This means that to enroll in Medicaid, you must enroll through your State's Medicaid office. If your income in a particular year is below 133% of the Federal Poverty Level (FPL), you may be eligible to enroll in Medicaid, although some States have a Medicaid eligibility income threshold that is higher than 133% of FPL.
- What Type of Coverage Does It Offer? Medicaid offers coverage for most medical items or services, including coverage of the Affordable Care Act's "essential health benefits." Medicaid also provides comprehensive benefits for children, and long-term care coverage for the elderly.
- Are There Protections for Pre-Existing Conditions? Yes. Medicaid must provide health coverage to every eligible person regardless of whether they have a pre-existing condition. In addition, Medicaid will cover any health condition that you may experience while covered under Medicaid.
- Are There Protections for Excessive Out-of-Pocket Expenses? Yes. Although States are allowed to impose cost-sharing such as co-insurance, co-pays, or deductibles, any out-of-pocket spending is limited to nominal amounts that range from \$4 and \$8 for certain medical services and prescription drugs to \$75 for other medical services like inpatient hospital care, capped at 5% of income. However, there are no out-of-pocket costs for emergency services, family planning services, pregnancy-related services, or preventive services for children. In addition, out-of-pocket costs cannot be applied to children, terminally ill individuals, and individuals residing in an institution.



- *What Type of Deductibles Does It Have?* As noted above, States are allowed to impose deductibles, but these deductibles are limited to nominal amounts that range from \$4 and \$8 for certain medical services and prescription drugs to \$75 for other medical services like inpatient hospital care, capped at 5% of income.
- *What Type of Premiums Do You Pay?* Medicaid coverage is free unless your State requires premium payments. For example, Iowa, Michigan, and Pennsylvania impose a nominal premium rate on beneficiaries above 50% or 100% of FPL.
- *What Are Some of the Pros of Medicaid Coverage?*
 - **Pro:** Medicaid coverage is free for most eligible persons, and Medicaid provides coverage for most health care needs with little out-of-pocket spending.
 - **Pro:** Medicaid must provide coverage to people with any type of health condition including pre-existing conditions.
- *What Are Some of the Cons of Medicaid Coverage?*
 - **Con:** Medicaid eligibility is based on income, and your income may vary from year-to-year, which means you may be eligible for Medicaid in one year, but NOT eligible for Medicaid in another year.
 - **Con:** Medicaid reimburses medical providers at rates that are below private insurance rates, which limits the number of medical providers that are willing to furnish services to Medicaid beneficiaries, which may limit access to care

