MONEY MAN 4 Integrity®

"Annuity, Life and Health Insurance"

FREE GUIDE · 2026 EDITION

The Smart Health Insurance Playbook

How professionals, business owners and pre-retirees can compare plans, control costs and build a healthcare bridge to Medicare.



Plan Types | Metal Tiers | COBRA & ACA | HSA Strategy | Medicare

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About This Guide

The Smart Health Insurance Playbook is a free educational resource from Money Man 4 Integrity, built from our Health Insurance article library and organized into one practical, step-by-step guide.

Inside you will find plain-language explanations of how health plans are built, what really drives your annual costs, and the questions to ask before you enroll, whether you are changing jobs, running your own business, retiring early, or getting ready for Medicare.

Who this guide is for: professionals, executives, consultants, self-employed business owners and pre-retirees, especially those aged 45–65 who are planning the move from employer coverage to individual coverage and, eventually, Medicare.

Important Educational Disclaimer

This guide provides general educational information only. It is not individualized financial, tax, legal, medical, or insurance advice. Premiums, deductibles, subsidies, eligibility rules, networks, formularies and plan designs vary by person, state, ZIP code, income, age, household and insurer, and they change from year to year. Figures quoted in this guide (for example from KFF, CMS, HealthCare.gov and the IRS) are averages or published limits for the years stated and are not personal quotes. Always verify current information with official sources and a licensed professional before making a decision.

Sources Referenced

HealthCare.gov · Centers for Medicare & Medicaid Services (CMS) · Medicare.gov · Internal Revenue Service (IRS) · KFF (Kaiser Family Foundation) Marketplace and Employer Health Benefits research · Fidelity retiree healthcare cost estimate · USHealthCosts audit framework.

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Welcome: Healthcare Is a Financial Decision

Most people shop for health insurance the same way: they sort by monthly premium and pick the lowest number they can live with. That habit can be expensive.

A premium is only the price of admission. What you actually spend in a year depends on the deductible, copays, coinsurance, the out-of-pocket maximum, the provider network, how your prescriptions are covered, where you live, how much care you use and how much income you report. Two plans with nearly identical premiums can produce very different totals once real life happens.

For more than 19 years, Money Man 4 Integrity has helped American families plan smarter. This playbook brings that same discipline to health insurance. Our goal is simple: help you understand the full cost of coverage so you can choose with confidence instead of guessing.

19+
Years helping American families plan smarter

10
Practical chapters with checklists

1
Goal: understand your total annual cost

How to Use This Playbook

- Read Chapters 1–3 first. They explain the building blocks every plan shares.
- Jump to the chapter that fits your situation: leaving a job, retiring before 65, running a business, or approaching Medicare.
- Use the worksheets and checklists near the end to compare real plans side by side.
- Bring your notes to a licensed advisor for a personalized review.

> **The one question that matters:** not “Which plan is cheapest?” but “Which combination of premium and expected out-of-pocket spending fits my household and my risk tolerance?”

Contents

01 The Healthcare Bridge: Why Total Cost Matters 5
02 HMO, PPO, EPO and HDHP Explained 9
03 Bronze, Silver and Gold: Choosing a Metal Tier 14
04 Health Insurance After Leaving Your Job 19
05 Retiring Before 65: Budgeting the Gap 23
06 HSA Strategy After 45 28
07 Why Your ZIP Code Matters 32
08 Prescription Drug Coverage 36
09 Self-Employed and Small Business Coverage 39
10 Medicare: Supplement vs. Advantage 42
Your Plan Comparison Worksheet 44
Health Insurance Glossary 45
About Money Man 4 Integrity 47

CHAPTER 01

The Healthcare Bridge

Why the monthly premium is only the beginning, and how to think about the full cost of coverage.

IN THIS CHAPTER

- Why employer coverage hides the real price
- The eight components of total healthcare cost
- Premium cost vs. total cost
- Expected, high-use and worst-case years

Why Employer Coverage Feels Cheaper Than It Is

When you are employed, healthcare often looks predictable. A modest payroll deduction appears on each paycheck and the rest is handled for you.

What many people do not see is that employers usually pay a significant share of the premium. When employment ends, through a job change, a business sale, early retirement or a move to consulting, that contribution typically disappears, while your medical needs stay exactly the same.

Medicare generally does not begin until age 65. Anyone who leaves employer coverage before then has to arrange coverage on their own. For a professional who retires at 55, that gap can last roughly a decade. Even modest annual costs, repeated for ten years, add up to a substantial total.

Think of it as a bridge. Your retirement and career plans need a healthcare bridge that carries you from employer coverage, through individual or Marketplace coverage, all the way to Medicare without a break.

The Typical Coverage Journey

Employer coverage → COBRA or ACA Marketplace → Pre-Medicare planning → Medicare at 65

Each stage has a different cost structure. Planning the transitions in advance, rather than reacting when a paycheck stops, is what keeps healthcare from derailing a retirement or business plan.

Common Life Events That Trigger the Question

- Changing careers or taking a break between jobs
- Selling a business or becoming an independent consultant
- Retiring early, before Medicare eligibility
- Relocating to a new state or ZIP code
- A spouse losing or changing employer coverage

The Eight Components of Total Cost

A realistic healthcare budget looks at every way money leaves your pocket, not just the monthly bill.

Cost component	What it means	Question to ask
Premium	Monthly payment to keep coverage active	What will coverage cost every month and every year?
Deductible	What you pay before broader benefits begin	How much must I spend before the plan shares costs?
Copayments	Fixed dollar amount for a covered service	What will routine visits and services cost?
Coinsurance	Your percentage share after the deductible	What percentage remains my responsibility?
Out-of-pocket max	Annual cap on covered, in-network costs	What is my maximum exposure in a bad year?
Network	Doctors, hospitals and pharmacies in the plan	Are my preferred providers included?
Prescriptions	How the formulary and tiers price your drugs	Are my medications covered affordably?
Utilization	How much care your household actually uses	What healthcare pattern am I insuring against?

Premium Cost vs. Total Cost

Consider a plan with a $500 monthly premium. That is $6,000 a year, but it tells you nothing about your maximum exposure. Add the deductible, coinsurance and prescription costs and the real annual figure may be far higher, especially in a year with a surgery, hospital stay or new diagnosis.

> **Rule of thumb:** the cheapest plan is not necessarily the least expensive plan. A low premium can cost more when you need care, while a higher premium can buy predictability.

Plan for Three Kinds of Years

Insurance exists to protect against uncertainty, so your budget should never assume only a “normal” year.

Low-use year	Moderate year	High-use year
Routine checkups, preventive care, few or no prescriptions. Premiums make up most of your spending.	A typical planning case: some specialist visits, regular prescriptions, an urgent-care trip or two.	A stress test: surgery, hospitalization or ongoing treatment. Costs climb toward the out-of-pocket maximum.

Two Formulas Worth Remembering

Expected annual cost = Annual premiums + expected prescription costs + expected medical cost-sharing

Worst-case exposure = Annual premiums + potential prescription costs + medical cost-sharing up to the out-of-pocket maximum

The first number tells you what you will probably spend. The second tells you what you could spend. A household with strong cash reserves may be comfortable with a large gap between the two. A household on a tighter budget may prefer to pay more in premiums to narrow it.

Stress-Test Questions

- What if premiums rise next year?
- What if my healthcare use increases substantially?
- What if my investment or business income changes?
- What if I relocate to a different state or rating area?
- Could I cover the full out-of-pocket maximum without selling investments at a bad time?

CHAPTER 02

HMO, PPO, EPO and HDHP

Plan labels describe how you access care and how costs are structured. Here is what each one really means.

IN THIS CHAPTER

- How each plan type works
- Side-by-side comparison
- What the deductible data shows
- Matching a plan type to your needs

HMO and PPO: Coordination vs. Flexibility

HMO · Health Maintenance Organization

Coordinates care through a defined network. Non-emergency care outside the network is generally not covered, and a primary care physician often guides referrals.

Works well when: your preferred doctors and hospitals are in the network and you value simple, coordinated care.

Did you know? In KFF's 2025 employer survey, 47% of covered workers in HMOs had no general annual deductible for single coverage, compared with 12% of PPO enrollees.

PPO · Preferred Provider Organization

Offers broader provider choice. Out-of-network care is covered at a higher cost, and referrals are generally not required.

Works well when: you travel often, keep homes in more than one place, or are tied to particular specialists.

Did you know? PPOs were the most common plan type among covered workers in 2025 at 46% of enrollment, and their average premiums ran above overall employer-plan averages.

Not every HMO is cheaper. The label alone does not determine cost. The specific plan contract, including deductible, copays and network, decides the economics.

Is Flexibility Worth the Price?

Paying more for a PPO makes sense only if you will actually use the flexibility. If every doctor you see is already in an HMO network, you may be paying for options you never exercise. On the other hand, a single out-of-network specialist you depend on can make a PPO worth every dollar.

EPO and HDHP: Networks and Deductibles

EPO · Exclusive Provider Organization

Covers care only within the network, except emergencies, but usually avoids many referral requirements.

Works well when: you are comfortable staying inside one health system. Frequent travelers or people who need out-of-network specialists may find it limiting.

HDHP · High-Deductible Health Plan

Carries a higher deductible and usually lower premiums. It may qualify you for a Health Savings Account (HSA).

Key point: an HDHP describes a deductible structure, not a network. It can be paired with an HMO, PPO or EPO network design.

Side-by-Side Comparison

Plan	Provider flexibility	Out-of-network	Financial emphasis
HMO	More restricted	Usually not covered except emergencies	Coordinated care
PPO	Greater flexibility	Covered at higher cost	Access and flexibility
EPO	Network-focused	Generally not covered except emergencies	Network efficiency
HDHP	Depends on network	Depends on underlying plan	Lower premium potential, HSA opportunity

HealthCare.gov Marketplace plans can use HMO, PPO and EPO structures across every metal tier, so you will often see combinations such as a “Silver HMO” or a “Bronze HDHP PPO.” Always read the specific plan details.

What the Numbers Say About Deductibles

Employer-plan averages from KFF's 2025 survey show how much deductibles vary by plan type.

$1,886
Average single-coverage deductible (all plan types with a deductible)

$2,609
Average deductible, HDHP with savings option

33%
Covered workers enrolled in an HDHP with a savings option

Plan type (with a deductible)	Average single deductible
HMO	$1,649
PPO	$1,337
HDHP with savings option	$2,609

Average annual premiums for HSA-qualified HDHP coverage were about **$8,575** for single coverage and **$25,303** for family coverage. These are employer-plan averages, not individual quotes, but they show an important trade-off: lower premium potential comes with more upfront spending when care is needed.

Where to Start: Matching Needs to Plan Type

If your priority is...	Starting point
Coordinated in-network care	HMO
Broader provider flexibility	PPO
Strong network discipline at lower cost	EPO
Lower premium potential and an HSA strategy	HDHP
Frequent out-of-network care	Take a closer look at PPOs
Ability to absorb upfront costs	Consider an HDHP

There is no universally best plan. Start with your healthcare pattern, then choose the structure that fits it.

Risk Capacity vs. Risk Tolerance

Two people with identical incomes can rationally choose very different plans.

Risk capacity is what your finances can absorb. A high-income household may easily be able to pay a $5,000 medical bill. **Risk tolerance** is how much uncertainty you are comfortable living with. That same household may still prefer the predictability of a lower deductible.

The right plan respects both. Choosing a high-deductible plan simply because you can afford a large bill ignores the stress and disruption that bill could cause. Choosing a rich plan you cannot comfortably pay for every month creates a different kind of risk.

Verify the Network Before You Compare Prices

A cheap plan becomes expensive if your doctors are out of network. Provider directories can be outdated, so call offices directly and confirm:

- ✓ Primary care physicians
- ✓ Specialists you see regularly
- ✓ Major hospitals near you
- ✓ Urgent care centers
- ✓ Preferred pharmacies
- ✓ Coverage for your prescriptions

Questions to Map Your Healthcare Pattern

- How many primary care and specialist visits do you expect this year?
- Which prescriptions does your household take regularly?
- Are any procedures planned or likely?
- Does anyone need ongoing treatment?
- How would you handle a hospitalization financially?

> Network fit can matter more than a modest difference in premium.

CHAPTER 03

Bronze, Silver and Gold

Metal tiers describe how costs are shared between you and the insurer. They do not rate the quality of care.

IN THIS CHAPTER

- What the 60/70/80 split means
- Why Bronze enrollment surged in 2026
- Silver and cost-sharing reductions
- Calculating total annual cost

What the Metal Levels Really Mean

Choosing a Marketplace plan is not a contest between Bronze, Silver and Gold. The tiers describe how costs are divided, not how good your doctors are.

BRONZE

60 / 40

Plan pays ~60%
You pay ~40%

Lower premiums, higher cost-sharing

SILVER

70 / 30

Plan pays ~70%
You pay ~30%

Moderate premiums and cost-sharing

GOLD

80 / 20

Plan pays ~80%
You pay ~20%

Higher premiums, lower cost-sharing

These percentages, published by HealthCare.gov, are actuarial estimates for a standard population. They are not guarantees for any individual. Your personal split depends on which services you use and when.

> **Bronze is not inferior coverage.** It simply places more financial responsibility on you when you use care, while Gold shifts more of it to the insurer. Doctors, hospitals and quality are not determined by the metal level.

Why Risk Tolerance Drives the Choice

A financially comfortable person with substantial liquid savings might happily accept a high deductible, because a large unexpected bill would not disrupt their retirement plans. Another person with a similar income might prefer predictable costs and pay higher premiums to limit their exposure. Neither choice is automatically right. The decision should reflect how much uncertainty your household budget can absorb.

Bronze, Silver and Gold Up Close

Bronze: Lower Premiums, Higher Exposure

Bronze usually has the lowest premiums but the highest deductibles. You save while healthy and pay more when care is needed. It can be a reasonable fit for someone who rarely uses care and has strong emergency reserves.

Silver: The Balanced Middle, With a Hidden Benefit

Silver offers a balance between monthly affordability and protection against large bills. It also carries a key feature: eligible lower-income enrollees generally must choose a Silver plan to receive **cost-sharing reductions**, which lower deductibles, copays and coinsurance. If your household income may qualify, Silver deserves a careful look.

Gold: Pay More Monthly, Spend Less When Care Is Needed

Gold makes sense for people who expect regular specialist visits, costly prescriptions or planned procedures. Higher premiums can reduce out-of-pocket exposure throughout the year.

2026 Shift: Bronze Enrollment Jumped

Metal level	2025 share of selections	2026 share of selections
Bronze	30%	40%
Silver	57%	43%
Gold	13%	17%

KFF attributes much of the shift to consumers chasing lower premiums after enhanced premium tax credits expired. The trade-off was significant: average Marketplace deductibles rose from **$2,759** in 2025 to **$3,786** in 2026, a 37% increase.

> Lower premiums can quietly shift risk onto you.

2026 Pricing and Total Annual Cost

KFF's 2026 data for a 40-year-old shows national average monthly premiums for the lowest-cost plan at each level:

$456
Bronze · lowest-cost plan per month

$611
Silver · lowest-cost plan per month

$615
Gold · lowest-cost plan per month

Notice how close Silver and Gold are. In some markets Gold costs barely more than Silver, so never assume a predictable price step between tiers. These are national averages that vary widely by location, so always compare your actual local marketplace.

Total Annual Cost Framework

Factor	Bronze	Silver	Gold
Monthly premium	Lower	Moderate	Higher
Deductible	Usually higher	Moderate	Usually lower
Copays & coinsurance	Generally higher	Moderate	Generally lower
Financial exposure	Higher	Moderate	Lower
Best fit	Low use, high risk tolerance	Balanced approach	High use, values predictability

HealthCare.gov recommends looking at total healthcare spending rather than premiums alone. The better comparison is not “Which plan has the lowest premium?” but “Which combination of premium and expected out-of-pocket spending fits my household?”

Emergency Reserves and Choosing Your Tier

Liquid savings can help you handle a high deductible without selling investments at the wrong time. But having savings does not automatically make Bronze the right choice.

The real question is whether your household can absorb potential costs without compromising other goals. Weigh these factors together:

- ✓ Emergency savings
- ✓ Retirement assets
- ✓ Expected care use
- ✓ Prescription costs
- ✓ Upcoming procedures
- ✓ Monthly cash flow
- ✓ Other coverage
- ✓ Debt obligations

Don't Choose Based Only on Today's Health

Expected utilization should be one of the strongest variables in your decision, but insurance exists to cover uncertain future needs. Feeling healthy this year is not a guarantee about next year.

Three Questions Before You Pick a Tier

1. How much healthcare will you likely use?
2. How much financial risk can you comfortably absorb?
3. How much predictability do you value?

> **Bottom line:** a lower premium preserves cash now. A higher premium buys predictability later. The right choice depends on which kind of uncertainty you are better positioned to carry.

CHAPTER 04

After Leaving Your Job

Leaving a job changes more than your paycheck. Here is how to compare COBRA, the Marketplace and your other options.

IN THIS CHAPTER

- COBRA vs. ACA Marketplace
- The 60-day Special Enrollment Period
- How income and MAGI affect subsidies
- The ten factors to compare

Your Options When Employer Coverage Ends

Whether you are changing careers, selling a business, becoming independent or retiring early, the core question is the same: what will healthcare actually cost after employment?

Option	Main advantage	Keep in mind
ACA Marketplace	Potentially lower premiums through financial assistance	Network and formulary may differ from your old plan
COBRA	Continuity with your existing employer plan	You pay the full premium plus an admin fee
Medicaid / CHIP	Possible coverage for eligible households	Income and state rules apply
New employer plan	Employer may share the premium	Can affect Marketplace credit eligibility

The Special Enrollment Period

According to HealthCare.gov, losing job-based coverage can qualify you to enroll in a Marketplace plan outside Open Enrollment, generally **within 60 days** of losing coverage. Mark the date. Missing the window can leave you without options until the next Open Enrollment.

Understanding COBRA

The Consolidated Omnibus Budget Reconciliation Act lets eligible workers and their families temporarily keep employer coverage after a qualifying event. The catch: you generally pay the full premium, including the share your employer used to pay, plus an administrative fee. COBRA can cost far more than your old payroll deduction suggested.

When COBRA can make sense: during active treatment, when you depend on established physicians, or right before an important procedure. Continuity has value, just compare it against Marketplace alternatives first.

How Income Shapes Your Marketplace Cost

The Premium Tax Credit can reduce what eligible households pay for Marketplace coverage. Its amount depends on household income, family size and access to other qualifying coverage.

$113 → $178
Average monthly Marketplace premium payment, 2025 to 2026 (+58%)

$2,759 → $3,786
Average Marketplace deductible, 2025 to 2026 (+37%)

2026 rule: under general federal rules, Premium Tax Credit eligibility is limited to households with income between 100% and 400% of the federal poverty line, subject to other requirements. The temporary expansion that removed the upper income limit applied through 2025.

Income Doesn't Stop When the Paycheck Does

The IRS uses modified adjusted gross income (MAGI) to determine household income for Marketplace purposes. Investment income, retirement distributions, business income and capital gains can all count.

EXAMPLE

An executive leaves employment at 57 with substantial retirement assets but little earned income. If she funds living expenses with IRA withdrawals or by realizing capital gains, her MAGI rises, and that can change her subsidy eligibility. Where the money comes from, and when it arrives, both matter.

Report Changes Promptly

Update your Marketplace information whenever employment or income changes. If your actual income differs from your estimate, your final Premium Tax Credit can differ from the advance payments you received, which can create an unexpected tax bill. Never understate income to lower a premium.

The Ten Factors to Compare

The best decision compares expected annual costs, not premiums alone. Use this checklist for every plan on your shortlist.

#	Factor	Why it matters
1	Monthly premium	Your recurring cash expense
2	Deductible	Your initial healthcare spending
3	Out-of-pocket maximum	Your major annual exposure
4	Copayments	Cost of routine care
5	Coinsurance	Shared costs after the deductible
6	Provider network	Practical access to your doctors
7	Prescription formulary	Your medication expenses
8	Premium tax credit	Can change your net premium
9	Plan type	Flexibility and cost-sharing design
10	Geographic availability	Affects plan options and pricing

Watch for Separate Deductibles

Some plans have one deductible for medical care and a separate one for prescriptions. A plan with a low premium and high deductible may look attractive while you are healthy but become costly during surgery, a hospital stay or extended treatment.

> **Never budget from averages alone.** Market-wide figures are useful context, but your own quote depends on your age, location, household, income and plan choice.

CHAPTER 05

Retiring Before 65

Early retirement is achievable, but healthcare must be treated as a core financial obligation, not an afterthought.

IN THIS CHAPTER

- Modeling the years until Medicare
- Building a three-scenario budget
- 2026 cost benchmarks
- Planning the handoff to Medicare

Modeling the Years Before Medicare

Retiring at 55 leaves Medicare roughly ten years away. Pre-Medicare coverage becomes a long-term budget item, not a one-year expense.

No single premium represents the cost of early-retiree coverage. Age, location, household size, income, plan type, coverage level and eligibility for financial assistance all play a role. That is why premiums should be **modeled, not guessed**, and why the assumptions behind any estimate (average, median or estimate) should be clearly stated.

Don't Assume One Year Repeats Ten Times

Premiums change, your age changes, your health changes and your income changes. Model several scenarios rather than multiplying today's quote by the number of years until 65.

What Healthcare Pattern Are You Insuring Against?

Someone expecting minimal care may prefer a different cost structure than someone expecting specialist visits, costly prescriptions or procedures. Consider:

- ✓ Routine doctor visits
- ✓ Regular prescriptions
- ✓ Specialist care
- ✓ Planned procedures
- ✓ Chronic conditions
- ✓ Ongoing treatment

Retirement Income and Subsidies Are Linked

The IRS lists IRA distributions and capital gains as relevant income considerations for the Premium Tax Credit. How you draw down your savings in early retirement can directly change what you pay for health coverage. Coordinate your withdrawal strategy with your healthcare plan.

Build a Three-Scenario Budget

For each scenario, estimate every cost category below, then compare the totals against your liquid retirement assets.

Category	Low use	Moderate use	High use
Annual premiums	✓	✓	✓
Deductible	Partial	Likely met	Fully met
Copays & coinsurance	Minimal	Some	Up to out-of-pocket max
Prescriptions	Few or none	Regular	Regular + specialty
Other / out-of-network	—	Occasional	Possible
Reserve for surprises	✓	✓	✓

Your Pre-Medicare Budget Checklist

- Monthly premiums for the chosen coverage
- Annual deductibles and out-of-pocket maximums
- Routine medical and prescription costs
- Healthcare needs of everyone in the household
- Potential Marketplace financial assistance
- Multiple income scenarios
- Every year until Medicare eligibility
- A reserve for unexpected expenses

The key test: can the full healthcare obligation be absorbed without forced asset sales or major lifestyle changes? If not, the retirement date may need adjusting.

2026 Benchmarks to Keep in Mind

These published figures help frame your planning. They are averages and limits, not personal quotes.

$625
National average benchmark premium per month, age 40 (KFF 2026)

$202.90
Standard Medicare Part B premium per month (CMS 2026)

$283
Annual Medicare Part B deductible (CMS 2026)

The Out-of-Pocket Maximum as a Stress Test

The out-of-pocket maximum generally limits what you pay for covered in-network services in a plan year. Use it to separate four levels of spending: **expected, likely, high-utilization and maximum exposure**. A household planning on $8,000 a year could face much more after a serious medical event.

Copays and Coinsurance Continue After the Deductible

Meeting your deductible does not end your spending. Many plans still require copayments or coinsurance until you reach the out-of-pocket maximum. Preventive services may receive special treatment under federal rules.

Medicare Changes the Structure, Not the Need

Reaching 65 does not eliminate healthcare costs. Higher-income beneficiaries may pay additional income-related amounts for Medicare. A complete retirement model has two phases: pre-Medicare coverage and Medicare-era spending.

Bridging Smoothly to Medicare

Medicare generally becomes available at 65, subject to enrollment and eligibility rules published on Medicare.gov. The goal is continuous coverage with no gap.

Before you leave work
Price Marketplace and COBRA options, estimate income for next year, and confirm your doctors' networks.

Within 60 days of losing coverage
Enroll through the Special Enrollment Period so there is no break in coverage.

Every year until 65
Re-shop during Open Enrollment. Networks, premiums and formularies change. Don't auto-renew blindly.

Months before 65
Plan your Medicare enrollment, Part D drug coverage and Supplement or Advantage decision (Chapter 10).

At 65 and beyond
Budget for Part B premiums, supplemental coverage and remaining out-of-pocket costs.

Healthcare uncertainty becomes manageable when it is properly modeled. A 55-year-old retiree shouldn't budget for ten years of Marketplace coverage and stop there; the plan must continue into Medicare.

CHAPTER 06

HSA Strategy After 45

A Health Savings Account paired with the right high-deductible plan can become a dedicated retirement healthcare reserve.

IN THIS CHAPTER

- How HSAs work and who qualifies
- 2026 contribution and plan limits
- The triple tax advantage
- What changes at age 65

HSA Basics and 2026 Limits

An HSA is a tax-advantaged account for qualified medical expenses. Unused money rolls over year after year, and the account stays with you if you change jobs or retire.

To contribute, you generally need coverage under an HSA-eligible high-deductible health plan (HDHP), must meet other IRS requirements, and generally cannot be enrolled in Medicare.

2026 HDHP Requirements

	Self-only	Family
Minimum deductible	$1,700	$3,400
Maximum out-of-pocket	$8,500	$17,000

2026 HSA Contribution Limits

	Self-only	Family
Annual limit (incl. employer)	$4,400	$8,750
Catch-up, age 55+	+$1,000	+$1,000 per eligible spouse

Married couples must make catch-up contributions to each spouse's own HSA, not into one shared account. The years after 45 are a valuable window to build a healthcare reserve before Medicare begins.

Why it matters: Fidelity estimates a 65-year-old retiring in 2025 could spend about **$172,500** on healthcare throughout retirement. Individual experience varies, but a dedicated HSA reserve can keep medical costs from draining general retirement savings.

The Tax Advantage and Smart HSA Habits

1 · Contributions	2 · Growth	3 · Withdrawals
May be deductible even if you don't itemize. Employer contributions may be excluded from income.	Investment earnings generally grow tax-free while held in the account.	Distributions for qualified medical expenses are generally tax-free.

Pay Today's Bills From Other Savings

If you have adequate cash, you might pay current medical costs from regular savings and leave your HSA invested for later. Fidelity identifies this as a potential long-term approach. Keep careful records, confirm each expense qualifies, and remember that an HSA is not an emergency fund.

Investing HSA Assets

Many providers allow investing once a minimum balance is met. Long-term HSA money can be viewed as part of your overall retirement allocation, but investments carry market risk. Keep money for near-term bills separate in purpose from money intended for future care.

What Happens at Age 65

- Contributions generally stop with your first month of Medicare enrollment, including retroactive coverage.
- Your account and funds remain available to you.
- Qualified medical withdrawals stay generally tax-free.
- Non-qualified withdrawals are taxable, but the extra 20% tax generally no longer applies after 65.

Is an HSA Strategy Right for You?

The goal is coordination, not maximum contributions at any cost. Work through these nine questions:

1. Is the HDHP affordable in a high-expense year?
2. Do you have enough cash to cover the deductible?
3. Does your employer contribute to the HSA?
4. Can your household contribute consistently?
5. Are your current medical costs predictable?
6. Does the HSA provider offer suitable investments?
7. How much emergency liquidity exists outside the HSA?
8. When do you expect to enroll in Medicare?
9. How will future healthcare costs fit your retirement income?

How an HSA Fits Your Balance Sheet



An HSA sits alongside your 401(k), IRA, taxable accounts and emergency reserve. It cannot replace retirement savings, because retirement also requires money for housing, food, transportation, taxes, travel and family. The HSA addresses healthcare only.

CHAPTER 07

Why Your ZIP Code Matters

Where you live shapes which insurers compete, which plans exist, which doctors participate and what coverage costs.

IN THIS CHAPTER

- The five factors insurers can use
- Insurer competition by county
- 2026 state benchmark examples
- Comparing two potential locations

Location Is a Pricing Factor

Under the Affordable Care Act, insurers can set Marketplace premiums using five factors: **location, age, tobacco use, plan category and whether dependents are covered**.

Geographic differences come from insurer competition, local healthcare markets, state rules, provider concentration and cost of living. Your ZIP code is not your price by itself, but it is your gateway to a local market: it determines which insurers operate, which plans are available, which benchmark applies and which hospitals are realistically accessible.

$401
New Hampshire avg. benchmark, age 40

$625
National avg. benchmark, age 40

$1,299
Vermont avg. benchmark, age 40

Insurer Competition Is Shrinking

According to KFF, the average number of Marketplace insurers per state fell from 9.6 in 2025 to 9.0 in 2026. One-third of U.S. counties lost participating insurers, and **165 counties had only one Marketplace insurer** in 2026. Fewer insurers can mean fewer plan designs, fewer networks and less flexibility.

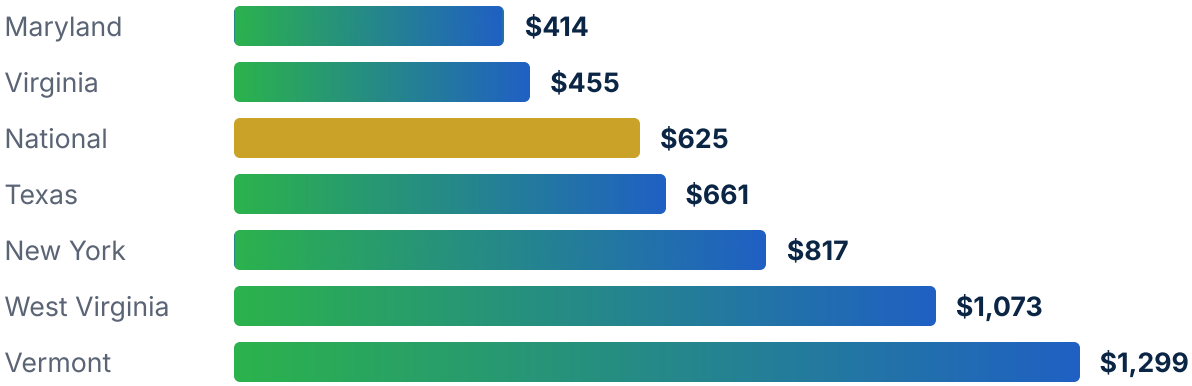
Neighbors Can Have Different Choices

Insurer footprints change every year. Some expanded into new counties in 2026 while others withdrew. Two nearby households can face very different options, so compare at the ZIP level rather than relying on statewide averages.

Should Healthcare Influence a Retirement Move?

Professionals aged 45–55 often have more freedom to relocate. The best location on paper may not have the best healthcare costs.

2026 State Benchmark Examples (age 40, monthly)



Source: KFF 2026 benchmark averages. These are not what a specific household will pay; income, age, household and subsidies change the final premium.

The Layered Path to Your Real Premium

Location → Available plans → Household details → Financial assistance → Actual premium

Before a move becomes irreversible, weigh housing, taxes, transportation and healthcare together.

Comparing Two Potential Locations

Factor	Location A	Location B
Benchmark premium	Compare	Compare
Lowest-cost plan	Compare	Compare
Number of insurers	Compare	Compare
Preferred doctors in network	Check	Check
Major hospitals accessible	Check	Check
Prescription access	Check	Check
Out-of-pocket exposure	Compare	Compare
Subsidy estimate	Calculate	Calculate
Expected healthcare use	Estimate	Estimate

Network Questions for Any New Area

- ✓ Are my preferred physicians included?
- ✓ Are major hospitals accessible?
- ✓ Are specialists available locally?
- ✓ Does coverage work while traveling?
- ✓ Are pharmacies convenient?
- ✓ Could relocating change network access?

Hospital prices also vary between metro areas and even between hospitals in the same region. A cheaper insurance market may come with fewer providers, while a pricier one may offer stronger networks and more competition. Start with the ZIP code, then review insurers, specific plans, networks, deductibles, out-of-pocket limits, prescriptions and your expected use.

CHAPTER 08

Prescription Drug Coverage

Shoppers usually compare premiums first, then deductibles and networks. For anyone taking several medications, prescription coverage deserves equal attention.

In KFF's 2025 employer survey, nearly 99% of covered workers were at firms that offered prescription coverage, yet the structure of that coverage varied widely. A plan can look inexpensive until regular prescriptions generate significant cost-sharing.

What Is a Formulary?

A formulary is the plan's list of covered drugs and the rules for covering them. Drugs are usually grouped into tiers with different cost-sharing. In 2025, 92% of covered workers were in plans with tiered cost-sharing.

Tier	Typical drugs	Avg. copay*	Avg. coinsurance*
Tier 1	Generic drugs	~$12	19%
Tier 2	Preferred brands	~$40	25%
Tier 3	Non-preferred drugs	~$71	35%
Tier 4 / Specialty	High-cost drugs	~$123	31%

*KFF 2025 averages for employer plans with three or more tiers. Not a prediction for any individual plan.

Copay vs. coinsurance: a copay is a fixed dollar amount. Coinsurance is a percentage of the drug's cost, which can be much larger for expensive medications.

Check Your Actual Medications

Build a medication inventory before you compare plans. HealthCare.gov's tools can show whether specific drugs are on a plan's formulary.

- ✓ Drug name and dosage
- ✓ How often you take it
- ✓ Generic or brand
- ✓ Current pharmacy
- ✓ Expected annual use
- ✓ Available alternatives

Pharmacy Networks and Specialty Drugs

A covered drug can still cost more depending on where it is filled. Confirm your preferred pharmacy (and any mail-order option) participates on favorable terms. Specialty drugs deserve extra scrutiny: in 2025, the average specialty copay was **$111** and the average specialty coinsurance was **27%**.

When a Drug Isn't Covered

Marketplace consumers can request a formulary exception for a medically necessary drug. If approved, the plan generally covers it, though you may pay highest-tier cost-sharing. Appeals may be available if an exception is denied, but this process should not replace choosing the right plan up front.

Prescription Comparison Framework

Factor	Question to ask
Formulary	Are my medications covered?
Drug tier	Which tier holds each medication?
Deductible	Must it be met before drug coverage starts?
Pharmacy network	Is my preferred pharmacy included?
Out-of-pocket max	How do drug costs count toward the limit?
Alternatives	Are generic or preferred options available?

Chronic Medications and Long-Term Planning

For multi-medication users, the formulary can matter as much as the deductible. For specialty-drug users, it can matter even more.

KFF reported that 45% of covered workers at firms with 50 or more employees were in plans that reduce or waive cost-sharing for drugs used to manage chronic conditions. Availability varies, so check your specific medications.

Prescription prices also push premiums higher for everyone: in 2025, 36% of large employers said drug prices contributed “a great deal” to rising premiums, and another 35% said “somewhat.”

Ten Questions for Ages 45–55

1. Are my current medications covered?
2. Could my medication needs increase?
3. Are preferred pharmacies convenient?
4. How are specialty drugs handled?
5. Do deductibles apply to prescriptions?
6. What happens if a drug changes tiers?
7. Are generic alternatives available?
8. What is my potential annual exposure?
9. Will coverage stay practical after employment?
10. How will drug costs fit my retirement budget?

Know the medications. Then compare the plans.

CHAPTER 09

Self-Employed Health Insurance

Without an HR department to choose or subsidize coverage, self-employed people must weigh coverage, cash flow, tax rules and medical risk together.

Start With Your Business Structure

Per HealthCare.gov, self-employed people with no employees generally use the individual Marketplace, not the small-business SHOP program. Owners, partners and owners' spouses don't count as employees. Growing businesses may need to compare small-group options, reimbursement arrangements or SHOP.

Estimate Income Honestly

Marketplace savings depend on projected household income, and the IRS reconciles premium tax credits against actual income. Update the Marketplace when income changes materially to avoid a tax surprise.

The Self-Employed Health Insurance Deduction

IRS Form 7206 calculates the deduction for eligible taxpayers. It can cover medical, dental, vision and qualified long-term care premiums for you, your spouse and dependents, subject to limits. It is a deduction, not a credit, and it should be coordinated with premium tax credit rules.

Protect Business Cash Flow

Premiums are monthly, but claims are unpredictable and can land in a month with slow receivables or a tax payment. Set aside a medical reserve the way you set aside money for taxes. For 2026, HealthCare.gov notes more Bronze and Catastrophic plans are HSA-eligible, which can help disciplined savers.

Treat coverage like a business expense: it must be sustainable in both strong and slow months. Keep plan documents, premium invoices, Marketplace notices and Form 1095-A together.

Small Business Health Insurance

A health plan affects hiring, retention, morale and tax planning, not just the HR budget. Start with your workforce: who is eligible, how they work, and whether they need family coverage.

1–50
Employees: generally eligible for SHOP small-group coverage

Up to 50%
Of premiums: Small Business Health Care Tax Credit (35% for tax-exempt)

50+
Full-time employees: employer responsibility rules generally apply

Key Points for Employers

- SHOP coverage can usually be started any time of year if requirements are met; states may define small group differently.
- The IRS tax credit is generally available for two consecutive taxable years and depends on employee count, average wages and premium contribution.
- Employer shared-responsibility rules generally apply to applicable large employers with 50+ full-time employees, including equivalents. Track headcount as you grow.
- A plan can be affordable for you but too costly for workers through payroll deductions. Model individual and family costs.
- Compare carriers on networks, claims processes, digital tools, formularies and renewal history.

Communicate the Value

Employees judge jobs by total compensation. Give them a plain-language sheet showing their premium share, common visit costs, prescription tiers, deductible and out-of-pocket maximum, plus how to find in-network providers before they need care.

The One-Page Plan Review

Whether you are a solo consultant or an employer, put these items on a single page before every enrollment or renewal decision.

Monthly and annual premium .....

Deductible (medical and prescription) .....

Likely prescriptions and their tiers .....

Preferred doctors and hospital in network? .....

Expected routine visits .....

Maximum exposure in a difficult year .....

Coverage start date .....

What Could Change at Renewal

Premiums, provider participation, drug tiers, formularies, cost-sharing amounts and benefit rules can all change from year to year. Auto-renewal is convenient, but it can lock you into a plan that no longer fits.

Ask for Plain-Language Reasoning

A good recommendation explains **what problem the plan solves, what trade-off it creates, and when a different option would be better**. Labels like “cheap” or “best” are not enough. At renewal, compare your actual spending with your original assumptions and adjust.

CHAPTER 10

Medicare Supplement vs. Medicare Advantage

At 65, the core choice is between Original Medicare plus supplemental coverage, or a private Medicare Advantage plan with a network and an annual out-of-pocket limit.

Original Medicare + Medigap

Private Medigap policies help pay costs Original Medicare leaves behind, such as copayments, coinsurance and deductibles. Usually paired with a separate Part D drug plan.

Strengths: broad provider flexibility and predictable cost-sharing, valuable for travelers and those seeing specialists across regions.

Trade-off: premiums may be higher; Medigap generally excludes long-term care, most dental and vision, hearing aids and eyeglasses.

Medicare Advantage

Medicare-approved private plans that cover Part A and Part B and often include Part D drug coverage, sometimes with extra benefits.

Strengths: integrated coverage and an annual out-of-pocket limit for covered Part A and B services, which Original Medicare alone lacks.

Trade-off: networks, referrals, prior authorization and annual plan changes require more attention.

You cannot hold both. Medigap works only with Original Medicare and generally cannot pay Medicare Advantage cost-sharing. Every option still requires the Part B premium.

Timing, Switching and the Multi-Year View

The Medigap Open Enrollment Window

Medigap open enrollment generally lasts **six months**, starting when you are 65 or older and enrolled in Part B. During this window, insurers generally cannot use medical underwriting. Returning to Medigap later may not be easy in every state, so this first decision carries extra weight.

Think Before Switching

Moving from Medigap to Medicare Advantage can look appealing during one enrollment period. Before switching, weigh what you would lose, what you would gain, and whether you could return on similar terms if your health changed.

Look Beyond One Year

A single-year premium comparison can miss long-term issues like travel, specialist access and network management. Ask how each choice would work if your health declined. Medigap policies sold today generally exclude drug coverage, so budget for a separate Part D plan; Advantage plans often include drugs, but the formulary still needs review.

Medicare Decision Checklist

- ✓ Monthly and annual premiums
- ✓ Deductibles and cost-sharing
- ✓ Expected prescriptions
- ✓ Preferred doctors and hospitals
- ✓ Worst-case annual exposure
- ✓ Travel and second-home needs

> Neither option is automatically better. Compare total annual cost and risk, then re-check every year when new plan documents arrive.

Your Plan Comparison Worksheet

Fill in up to three plans side by side. Use the numbers from each plan's Summary of Benefits and Coverage.

Item	Plan A	Plan B	Plan C
Plan name & type			
Metal tier			
Monthly premium			
Annual premium (×12)			
Medical deductible			
Drug deductible			
Primary care copay			
Specialist copay			
Coinsurance %			
Out-of-pocket maximum			
My doctors in network?			
My hospital in network?			
My drugs covered / tier			
HSA-eligible?			
Est. premium tax credit			
Expected annual cost			
Worst-case exposure			

Expected annual cost = annual premium + expected prescriptions + expected medical cost-sharing. Worst-case = annual premium + out-of-pocket maximum (plus any non-covered costs).

Health Insurance Glossary

Key terms used throughout this playbook, explained in plain language.

Actuarial value
The approximate share of covered costs a plan pays for a standard population, e.g. 60% for Bronze.

Benchmark plan
The second-lowest-cost Silver plan in your area, used to calculate premium tax credits.

COBRA
Federal law allowing eligible workers to temporarily continue employer coverage, usually at full cost plus a fee.

Coinsurance
Your percentage share of a covered cost after meeting the deductible.

Copayment
A fixed dollar amount you pay for a covered service, such as a doctor visit.

Cost-sharing reductions
Extra savings on deductibles and copays for eligible enrollees, generally only on Silver plans.

Deductible
The amount you pay for covered services before the plan begins sharing costs.

EPO
A plan covering care only within its network, except emergencies, usually without referrals.

Formulary
A plan's list of covered prescription drugs and the rules and tiers that apply.

HDHP
High-deductible health plan; may qualify you to contribute to an HSA.

HMO
A plan that coordinates care within a defined network; out-of-network care generally not covered.

HSA
Health Savings Account: a tax-advantaged account for qualified medical expenses, paired with an HDHP.

Glossary (continued)

MAGI
Modified adjusted gross income, used to determine Marketplace financial assistance.

Marketplace
The ACA exchange (HealthCare.gov or a state site) for buying individual coverage.

Medicare Advantage
Private Medicare plans covering Parts A and B, often with drug coverage and an out-of-pocket limit.

Medigap
Medicare Supplement insurance that helps pay costs left by Original Medicare.

Network
The doctors, hospitals and pharmacies contracted with a plan.

Open Enrollment
The annual period when anyone can enroll in or change Marketplace coverage.

Out-of-pocket maximum
The most you pay for covered in-network services in a plan year.

PPO
A plan with broader provider choice and out-of-network coverage at higher cost.

Premium
The monthly amount you pay to keep coverage active.

Premium Tax Credit
A federal credit that lowers Marketplace premiums for eligible households.

SHOP
The Small Business Health Options Program for employers, generally with 1–50 employees.

Special Enrollment Period
A window, often 60 days, to enroll after a qualifying event such as losing job-based coverage.

Tip: every Marketplace plan publishes a Summary of Benefits and Coverage (SBC) using these terms. Keep it next to your worksheet when comparing plans.

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