Individual Health Insurance in Washington State

Under the Patient Protection and Affordable Care Act (ACA), most people are now required to enroll in health insurance or pay a penalty. Washington State residents have several options for obtaining coverage. If you do not have health insurance through your employer or government programs like Medicare and Medicaid, you can buy insurance for yourself and your family as individuals.

This article provides information about applying for and comparing individual insurance products in Washington, including products sold through the Washington Health Benefit Exchange (HBE) and products offered in the "outside market." It is current as of October 2015.

General information on the ACA and government health programs can be found here.

Introduction: Do You Qualify to Enroll in Individual Health Insurance?

The ACA requires almost everyone to obtain health insurance coverage. Some of the most common sources of insurance are discussed below. If one of these options is available to you, then you do not need to keep reading; you already have access to coverage. One exception is that if your coverage does not meet minimum essential coverage requirements, you may be eligible for the cost-saving features now available to people buying individual or family health insurance coverage in the commercial market (the "individual market").

If you do not qualify for insurance through any of the sources listed in this section, continue reading to learn about how to obtain health insurance, possibly at lower cost, through the individual market.

Employer-Sponsored Insurance

If you have affordable insurance available through your work, you still can buy individual insurance, but will not qualify for government subsidies. For information on what is considered "affordable," see https://www.healthcare.gov/glossary/affordable-coverage/.

Medicaid (Apple Health)

If you are eligible for Medicaid, now called Washington Apple Health, you do not need to buy individual insurance. Apple Health now provides free coverage to individuals and families with annual incomes below 138% of the Federal Poverty Level ($16,243 for an individual, $33,465 for a family of four in 2015).[1] If you are eligible, you can keep employer or other coverage that you have and still get Apple Health. For more information on coverage options for adults, click here. Children and pregnant women are eligible for Medicaid at higher income levels (you may qualify if your

[1] For Apple Health, income maximums will use 2016 FPLs starting in April 2016.

income is slightly higher than the amounts listed because they do not reflect the automatic reduction available to everyone). To determine if you are eligible for Medicaid benefits, click here.

Medicare

If you are over the age of 65 or have qualified for Social Security Disability Insurance benefits for more than two years, you are probably eligible for Medicare. You may want to consider supplementing that policy since you are still responsible for some costs. For more detailed information on Medicare supplementary coverage for lower-income individuals, click here and here. You may also choose to buy a Medicare supplemental insurance policy from a commercial health plan or, in limited situations, the Washington State Health Insurance Pool. However, Medicare enrollees do not need to purchase full individual insurance.

What Will Happen If You Do Not Obtain Coverage?

The Affordable Care Act imposes tax penalties on individuals if they or any of their dependents do not have health insurance. For 2015, the penalty is a fee of either $325 per uninsured person ($162.50 for children under 18) or 2% of the individual's household income, whichever is higher. For example, someone who earns $60,000 could owe $1200. These penalties will increase each year. In 2016, the penalty will rise to $695 per uninsured person or 2.5% of household income; for example, someone who earns $60,000 could owe $1500.

Some people may qualify for an exemption from the tax penalty if, for example, they are uninsured for less than 3 months of the year or their income is very low. Detailed information about penalties for failing to obtain health insurance and who is exempt is available here and here. More information about how to claim an exemption through the Exchange is available here and here. However, some exemptions are only available by claiming them through the IRS form 8965.

When Should You Enroll in a Plan?

Usually, you will need to purchase health insurance during an open enrollment period. The period for purchasing coverage beginning in 2016 will start on November 1, 2015 and end on January 31, 2016.

You can only purchase insurance outside of the open enrollment period if your household has a qualifying event that makes you eligible for a special enrollment period.

How Much Will You Pay for Insurance?

Seeing a doctor or filling a prescription at a pharmacy can be very expensive. It is also difficult to know when you will need to get medical care. When you buy health insurance, you agree to pay a monthly premium, and in return, the insurance company agrees to pay part of the cost of your medical bills.

Not every health insurance plan helps you pay your bills in exactly the same way. There are differences between plans that affect how much you will need to pay for your health care, and it is important to keep track of each of them when comparing plans. These include **monthly premiums**, **cost-sharing** when you get services, and **out-of-network** charges (see discussion of "Networks" in next section).

Where you buy your insurance can also affect your healthcare costs. Shopping through the Washington Health Benefit Exchange, the state-operated insurance marketplace, can help many people save money.

Types of Plans – Networks

There are many different types of health insurance plans. Almost every plan comes with a defined network of health care providers that your insurance company prefers. These plans will make you pay much more to purchase health services from a provider who is not included in the network. These **out-of-network charges** can be very large, and some health plans don't cover out-of-network services at all. When selecting a plan, it is very important to make sure that your regular doctors or other providers are included in the network. More information about provider networks is available here. Information on Washington residents' rights to see out-of-network providers is available here.

Monthly Premiums

When you buy health insurance you will need to pay premiums each month to keep your coverage. The premiums need to be paid monthly, before the month you want coverage, regardless of whether you use the insurance or not. In general, the higher the monthly premium for a plan, the lower the average cost-sharing.

Cost-Sharing

When you buy healthcare services with insurance, the insurance company will pay a portion of the bill from your medical provider and you will be responsible for the rest of the bill. The amount of the bill that you pay is called "cost-sharing." There are three main types of cost-sharing: co-payments, co-insurance, and deductibles.

A **co-payment** (also called a co-pay) is a set amount of money you pay for a healthcare service covered by the plan, such as $20 for a prescription.

Co-insurance is the percentage you pay of the total cost of a service covered by the plan, such as 20% of the cost of an office visit.

A **deductible** is another type of cost-sharing. It is an amount of money that you must spend on healthcare in a year before your health insurance company will begin helping you pay your bills for healthcare services. For example, if your plan has a $1,000 deductible, you will be responsible for

100% of the first $1,000 that you spend on health care every year (some services are exempt from the deductible). Once you have spent $1,000, the insurance company will begin paying your bills, except for your co-payments and co-insurance amounts. Sometimes, your plan will have a deductible on certain services and not others.

The ACA requires health insurance companies to label every plan they sell with a "metal level" based on the value of the benefits in the plan. All levels include the essential health benefits (EHB) and free preventive services. The different metal levels are:

- **Bronze** – For the average customer, the insurance company pays 60% of medical costs.
- **Silver** – For the average customer, the insurance company pays 70% of medical costs.
- **Gold** – For the average customer, the insurance company pays 80% of medical costs.
- **Platinum** – For the average customer, the insurance company pays 90% of medical costs.
    - There are currently five Platinum plans offered in twelve Washington counties in 2015, but no Platinum plans will be offered in 2015.

The percentages listed above are average medical costs that each type of plan will cover based on a typical healthcare consumer. They are used to set a plan's co-payments, co-insurance, and deductible to make it easier for you to compare the total average cost of different plans. The amount that you are responsible for varies from plan to plan and depends on what services you receive.

Catastrophic plans are also available, but only to people under age 30 and those who qualify for hardship exemptions, which are available by contacting the call center at 1-855-WAFINDER (1-855-923-4633) or TTY/TDD 1-855-627-9604. In Washington, there are only three approved catastrophic plans (Group Health, Health Alliance, and Kaiser) and these are not available statewide. These plans provide coverage of the essential health benefits, but you must first meet a high deductible. In the Exchange, catastrophic plans cover three primary care visits per year at no cost, even before you've met your deductible. They also cover free preventive services. For more information about catastrophic plans, click here.

For more information about comparing the costs of different plans, click here.

Out-of-Pocket Maximums

"Out-of-pocket" refers to the amount of cost-sharing you can be required to pay for your health care coverage in a single year. The ACA requires that all health insurance plans place a cap on out-of-pocket costs for essential health benefits in a given year. If your healthcare costs for these services exceed the cap, then the insurer must pay for all of your costs for the rest of the year and may not charge you any cost-sharing as long as you get services from health care providers participating in your plan's network. This means that the lower the maximum, the less you can be forced to pay. In 2015, this cap can be no higher than $6,600 for an individual and $13,200 for a family. In 2016, the limits are $6,850 for an individual and $13,700 for a family. This maximum will be adjusted each year by the Department of Health and Human Services.

For more information on cost-sharing and out-of pocket maximums, click here.

Benefit Limits

Before the ACA, many plans had benefit limits. These were caps on the amount that the insurance company would pay for your coverage; if the amount the insurance company paid exceeded the cap, you would be forced to pay for all costs above the cap on your own.

Under the ACA, however, most plans are not allowed to have annual benefit limits and none are allowed to have lifetime benefit limits.

What Benefits Must Be Covered?

The ACA set new minimum standards for all health plans. There are no longer pre-existing condition limitations or questionnaires about your health status to complete. Insurers are required to provide their customers with a summary of their plans' coverage, which much include all services listed in the Washington State benchmark plan. To view a summary of the benefits included in the Washington State benchmark plan, click here. A new Washington benchmark plan, required by federal law, will take effect in 2017. In addition to required services, insurers can choose to include additional services in their plans. Your plan must give you a summary of benefits and coverage (SBC) and a glossary of commonly used terms before you enroll and each year when you renew your plan. State law requires your insurer to give you certain other information if you request it.

To obtain more information about plans available on Healthplanfinder, click here, click on "Find Quality Coverage," fill out the information, click on "Show Plans," then click on "More Information on this Plan" for each plan that you want to learn about. This information is basic and does not tell you everything you may need to know, such as which prescription medications are covered or which services are limited to a certain number per year. For this information, it is best to contact each plan directly.

Individual Insurance: What Are Your Choices?

Thanks to the ACA, you may now enroll in individual insurance in the Washington Health Benefit Exchange. You may also choose to enroll directly with an insurance company. Each way has advantages and disadvantages depending on your particular situation.

1. The Washington Health Benefit Exchange

Washington residents can compare and shop for health insurance through the state Health Benefit Exchange website, Washington Healthplanfinder. Though almost everyone is eligible to buy insurance through the Exchange, non-citizens without immigration documents are not. Insurance plans offered on the exchange are called Qualified Health Plans (QHPs). Even though you are no longer required to fill out a Standard Health Questionnaire to get insurance, the process of

purchasing insurance through the online marketplace can still be tricky. The technology was developed recently and has a number of glitches that still need to be fixed. Healthplanfinder has a list of Online Application Quick Tips here. If you need help completing the application or enrolling, you can search for a registered In-Person Assister (sometimes called "Navigator") here, or you can search for a health insurance broker here.

Shopping on the Exchange may help you find more affordable coverage by allowing you to take advantage of Premium Tax Credits and Cost-Sharing Reductions, government subsidies that make health insurance more affordable for most people. If you have access to affordable insurance through your employer or a government program (see above), you may enroll in an Exchange plan but you are not eligible for these cost-saving measures. If those limitations do not apply to you, then you may qualify for more affordable coverage if you meet certain criteria.

Premium Tax Credits

Under the Affordable Care Act, the federal government helps people afford their monthly health insurance premiums through tax credits. An eligible family or individual purchasing a qualified health plan through Washington Healthplanfinder with an income below 400% of the Federal Poverty Level ($47,080 for an individual, $97,000 for a family of four)[2] may be eligible for some assistance, but the lower the household's income, the larger their tax credit will be.

Washington Healthplanfinder can help you determine approximately how much you can expect to pay for coverage through each of the available plans. You have different options for how your tax credits are paid. You can choose to pay the full monthly amount of your premium tax credits sent directly to your health plan, or you can pay more each month and get some of your tax credit back at tax time. If you take the full credit up front, you must keep up with your share of the premiums, and if you fall behind, you have only a 3-month "grace period" before losing your coverage.

Cost-Sharing Reductions

In addition to the Premium Tax Credits, you may qualify for reduced cost-sharing if your household income is below 250% of the Federal Poverty Level ($29,425 for an individual, $60,625 for a family of four).[3] The coverage provided by these plans is the same as standard silver plans, but on average, enrollees pay a smaller portion of the costs when they see their doctor or buy drugs at a pharmacy. More information on Cost-Sharing Reductions is available here (navigate to the question "I qualify to get help paying for a Qualified Health Plan. How does this help work?").

Subsidies for Tribal Members

American Indians and Alaska Natives who live in Washington state and purchase insurance on Healthplanfinder may be eligible for additional subsidies. Information is available here.

[2] The Washington Health Benefit Exchange uses the 2015 Federal Poverty Levels (FPLs) shown in this publication to determine eligibility for QHP coverage during January-December 2016.
[3] See footnote 2 above.

2. Buying Coverage Directly from an Insurer

As an alternative to the Exchange, you can buy insurance directly from insurance companies that operate plans outside the Exchange.

You may wish to buy health insurance directly from an insurance company if your doctor or provider is not available through any of the QHPs in the Exchange, but is available through a plan sold directly by an insurer. If you are considering doing this, ask your provider which plans they participate in before enrolling. You can get assistance with enrollment from an insurance broker. More information on brokers is available here.

The biggest disadvantage of buying health insurance directly from an insurance company is that **you cannot receive Premium Tax Credits or Cost-Sharing Reductions unless you purchase a QHP through the Exchange**. This means that if your income is below 400% of the Federal Poverty Level, a QHP will almost always be more affordable than buying insurance directly.

Also note that if you bought individual insurance directly from an insurance company before the ACA was passed on March 23, 2010 and its benefits and costs have not changed much, you may be able to keep it if it is considered a "grandfathered plan." For more information, click here.

For a full list of plans that serve the different regions of Washington State in 2016, click here.

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