Individual Health Insurance for Washington State Residents

Under the Patient Protection and Affordable Care Act (ACA), most people are currently required to enroll in health insurance or pay a penalty. However, as of January 1, 2019, Congress removed the penalties to being uninsured, with some exceptions, though the requirement to have insurance remains.

Washington State residents are fortunate to 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 August 2019.

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.

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 ($17,236 for an individual, $35,535 for a family of four in 2019).[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 at higher income levels. To find out more about whether you are eligible for Apple Health 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 previously imposed tax penalties on individuals if they or any of their dependents did not have health insurance. As of 2019, Congress has eliminated these tax penalties**.**

When Should You Enroll in a Plan?

Usually, you will need to enroll in health insurance during an **open enrollment** period. The period for state residents to enroll in 2020 coverage through the Washington State Health Benefit Exchange is **November 1, 2019 – December 15, 2019**. Open enrollment no longer extends to the end of December as in past years.

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

Important information when enrolling in 2019 coverage:

*As of January 2018, silver plan premiums in the Washington Health Benefit Exchange have increased due to the stoppage of certain federal funds. If you currently have a silver plan and are **not** eligible for a premium tax credit, then make sure to compare and consider all metal plans. In the Exchange, gold plans may now be comparable in price to the increased silver plan cost, but you will get more coverage with a gold plan. Silver plans outside the Exchange may also be worth considering. Make any change during open enrollment (see above). You must enroll by this date unless you are eligible for special enrollment.*

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 and the New Balance Billing Protection Law

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. **Out-of-network charges** can be very large, and some health plans don't cover out-of-network services at all. These "balance bills" can come as a shocking surprise to patients after receiving services either for emergencies or for procedures in which they weren't aware that one or more providers were out-of-network.

When selecting a plan, it is very important to make sure that your regular doctors or other providers are included in the network. To shop for plans, click here to use Healthplanfinder. The website has a "Smart Planfinder" tool to help you choose a plan by searching for your providers, facilities and prescriptions. More information about using this tool is in "What Benefits Must Be Covered?" below.

In 2019, the Washington State Legislature enacted the Balance Billing Protection Act, which protects consumers in many insurance plans from the most frequent kinds of surprise bills beginning January 1, 2020. Insurance companies must tell you whether this law applies to your plan. It generally applies to individual health insurance plans. However, some employers' health insurance plans are not included in the law unless the employer chooses to participate. If the law applies to your plan, you cannot be billed more than the in-network cost-sharing amount (see **Cost Sharing**, below) for care you receive in two kinds of situations: (1) **emergency** services from an out-of-network facility or provider, and (2) **non-emergency** surgical**,** anesthesia, pathology, radiology, lab, or hospitalist services from an out-of-network provider while you are at an in-network hospital or outpatient surgical facility.

Insurance companies and providers are required to post information about their networks on their websites. They must also post a notice that describes your rights under this law. If you get a surprise medical bill for services provided before January 1, 2020, the OIC advises contacting the

provider directly, telling them you know the law is changing soon, and asking them to reconsider and reduce the charge.

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.

No Platinum plans are offered on the Washington Exchange in 2019 and it is unlikely that any such plan will be offered in 2020.

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 two approved catastrophic plans (Kaiser Foundation of Washington and Kaiser Foundation Health Plan of the Northwest) 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 2018, this cap can be no higher than $7,350 for an individual and $14,700 for a family.

For more information on cost-sharing and out-of-pocket maximums, click here and 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. 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, 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. For more information on what each plan covers based on your household needs, like prescription medications you take, select "Smart Planfinder" on the left side of the page, answer a few short questions, and then click "Calculate Smart Choice Plans." Each plan will now display with a "green check" or "red x" next to each item entered in the previous questionnaire indicating whether or not the plan covers that item. For more detailed information, such as which services are limited to certain number per year, it is best to contact each plan directly.

Individual Insurance: What Are Your Choices?

The ACA allows most Washington residents to enroll in individual insurance through 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.

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. 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 ($49,960 for an individual, $103,000 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 ($31,225 for an individual, $64,375 for a family of four).[3] You must enroll in a silver plan to get reduced cost-sharing. The coverage provided is the same, 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.

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. See "When Should You Enroll in a Plan" regarding differences in the open enrollment dates.

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 likely 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." Currently, only LifeWise has individual market grandfathered plans in Washington State. For more information, click here.

For a full list of plans that serve the different regions of Washington State in 2020 and information about the individual and family premiums, click here.

[1] For Apple Health, income maximums will use 2019 FPLs for the 2020 plan year.

[2] The Washington Health Benefit Exchange will use the 2019 Federal Poverty Levels (FPLs) shown in this publication to determine eligibility for QHP coverage during January-December 2020. The 2018 FPLs used for 2019 coverage are slightly lower.

[3] See footnote 2 above.

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