Healthcare Navigation, LLC

October 19, 2020

**Individual Health Insurance and You**

Maura Carley, Founder and President

Individual insurance is coverage you buy for yourself and/or your dependents. It is not tied to an employer or union.

The reforms of the individual health insurance marketplace under the Affordable Care Act took effect for individual coverage beginning January 1, 2014. Nonetheless far too many people remain uneducated about how the individual health insurance marketplace works – and to their peril.

**Pre-Existing Conditions**

Prior to 2014, most states allowed insurers to deny individual coverage to those with pre-existing conditions. The Affordable Care Act reforms prevent pre-existing conditions from being a factor in obtaining any Affordable Care Act compliant plan, including individual insurance. This is an extremely important protection.

**Your State Matters**

Although the Affordable Care Act is federal legislation, how implementation has played out in the states varies widely. Coverage in the individual market is state-specific and you must become familiar with the options in your state of residence.

**The Timeframes**

Prior to the ACA reforms, one could apply for individual coverage throughout the year. Since 2014, however, there is an Annual Open Enrollment Period from November 1st through December 15th for a January 1st effective date for anyone who wants to obtain or change coverage. Some states which operate their own state-based exchanges have longer enrollment periods which allow for a February 1st or March 1st effective date. One objective in obtaining new coverage is to do so without a gap in coverage. If you apply during the Annual Open Enrollment Period you ordinarily need no documentation associated with past coverage but there are some exceptions.

If you lose group coverage involuntarily or your COBRA ends or you move to another area where you are no longer eligible for your individual coverage, you have the right to apply for coverage outside the open annual enrollment period. You must act timely. You have 60 days from the loss of coverage to apply for individual coverage. Often it is to your great advantage to plan ahead and apply for new coverage three or four weeks before your requested effective date to avoid any gap in coverage. We recommend applying no later than the 15Th of the month preceding your requested effect date. Applying early

optimizes receiving your new identification cards before your coverage begins and provides some additional time in case there is a glitch in the enrollment process.

In some situations, the end of subsidized COBRA by a former employer also provides an opportunity to apply for coverage outside the annual enrollment period.

When you lose coverage involuntarily and apply outside the annual enrollment period the Plan requires documentation of loss of coverage to accompany the application for new coverage.

**Medicaid Eligibility vs Subsidized Coverage On Exchange**

For the lowest income Americans, those eligible for Medicaid, enrollment is continuous. That means that those qualifying for Medicaid may enroll any month of the year. A person is eligible for Medicaid in the states which expanded Medicaid when income is below 138% of the federal poverty level. When income is between 138% and 400% of the federal poverty level in those states, one is no longer eligible for Medicaid. Subsidized coverage through premium tax credits is available for those with incomes between 138% and 400% of the federal poverty level.

In those states that have not endorsed the Affordable Care Act Medicaid expansion, there are people who might earn too much to be eligible for Medicaid but not enough to be eligible for subsidized coverage through the ACA.

**The Health Insurance Marketplace or Exchange**

Those who are entitled to a subsidy or premium tax credit (income between 138% and 400% of federal poverty level) must buy their coverage through either healthcare.gov, the federal site, or their state-based exchange for those states who do not use the federal marketplace. Marketplace and Exchange are synonymous terms. If you go to healthcare.gov and input your zip code, you will see whether your state uses the federal or a state-based marketplace. The healthcarenavigation.com web site under the Education tab also lists all the state-based exchanges.

If your income exceeds 400% of the federal poverty level, then you can choose other ways to apply for coverage – directly from the plan, through a broker or using a health insurance consultant. Remember that there may be on and off exchange options for coverage. At that income level, you are no longer eligible for a premium tax credit which would lower the cost of your premium.

**Often Not Like Group Coverage Options**

The individual marketplace has been somewhat tumultuous since 2014. Insurers have entered and dropped out of the market. State environments vary. The only available product options in some markets are Health Maintenance Organizations with a so-called “narrow” network which require you to designate a primary care provider who must refer you to any specialist for care. Some plans have limited hospital networks and it is not unusual for there to be no out-of-network benefit or an out-of-network benefit where the deductible is so high that it’s not a meaningful protection. However, some markets continue to offer products with national networks and open access plans. It is important that you become familiar with your state environment and understand that your options can even vary depending on your county of residence.

**Select the Best Plan for You**

Determine if you will apply for coverage on exchange or off-exchange. Those eligible for a subsidy through the Affordable Care Act MUST buy on-exchange. Those who are not subsidy-eligible can buy on or off exchange. In some states, plans are available off-exchange that might have a broader hospital network or out-of-network benefits. Your state's Insurance Department web site is often a good place to determine which insurers offer individual coverage in your state.

If you are eligible for a subsidy or premium tax credit then you should definitely make contact with an individual at healthcare.gov or a state-based exchange as applicable or use the on-line system as the information here is primarily for the benefit of those who are NOT eligible for a premium tax credit.

Before the Enrollment Period begins, compile and/or update your list of your doctors, your preferred hospitals and the prescription drugs you take on an ongoing basis and as needed. The objective is to optimize your preferred hospitals and doctors being in-network and that your drugs are on the Plan's formulary. In our opinion, the best way to conduct this exercise is on the Marketplace web site for those who must purchase through the Marketplace or the web site of the Plan for those who can buy off-exchange. Check in October to see if information is available about the next plan year.

**Metal Tiers**

Note that insurance companies are required to categorize their offerings into metal Tiers – Bronze, Silver, Gold and Platinum. There can many offerings in a given category. Also, many insurers do not offer Platinum plans. A Bronze plan will have a high deductible and relatively low premiums, a Platinum or Gold plan will have higher premiums but lower deductibles and a Silver Plan is in-between Bronze and Gold or Platinum. Clearly the monthly premium of the plan and the deductibles are key factors in any decision. If your income qualifies you for a premium tax credit, know that your subsidy will be based on the second lowest priced silver plan offered in your area.

**The Deductible**

The deductible is the amount you must pay out of pocket before your plan is obligated to pay. There are exceptions. Well-care is considered paid by the premium for the plan so one doesn't have to meet the deductible for an annual physical, mammography, colonoscopy and other well care services.

**Out-of-Network Benefit**

Another factor to include in your research is whether you have an option for a Plan that has out-of-network benefits, a national network, or any access to providers outside your immediate geographic area. Urgent and emergent care must be covered by any Plan when you are outside your Plan's area.

**Rules**

Also review the Rules of the Plan. Does the Plan require you to have a Primary Care Physician and to obtain referrals to see a Specialist through a Primary Care Physician you select who is in-network with your plan?

**Narrow the Process to Manageable Project**

Our advice is to work to reduce Plan choices to two insurance companies when there are many choices. In some states there are only two insurance companies to choose from. You want to see that your preferred hospitals and doctors are in-network, that your prescription drugs are on the Plan's formulary and how the drug benefit is structured which can vary by how the company categorizes the drug.

There are times that options in the individual marketplace disappoint those who have enjoyed richer coverage through an employer or union. Even if you are choosing among options that disappoint, educating yourself about the options and deciding which is best for you is important.

**Apply for Coverage**

No matter how you apply for coverage, aim to apply no later than three or four weeks before the effective date. Never leave anything to chance. Obtain confirmation of your application and follow-up if you do not. In spite of your best efforts, it is not unusual for there to be a delay in receiving new i.d. cards in the beginning of January. As long as you have confirmation that your Application was complete and received timely, try to be patient and give the plan an extra week or so before calling for your new identification number. With the new identification number, you should be able to create an on-line account and download a temporary i.d. card if one hasn't arrived in the mail.

Once your coverage is effective, remember to bring your new i.d. card to all medical appointments so your coverage information can be updated and claims processed accordingly.