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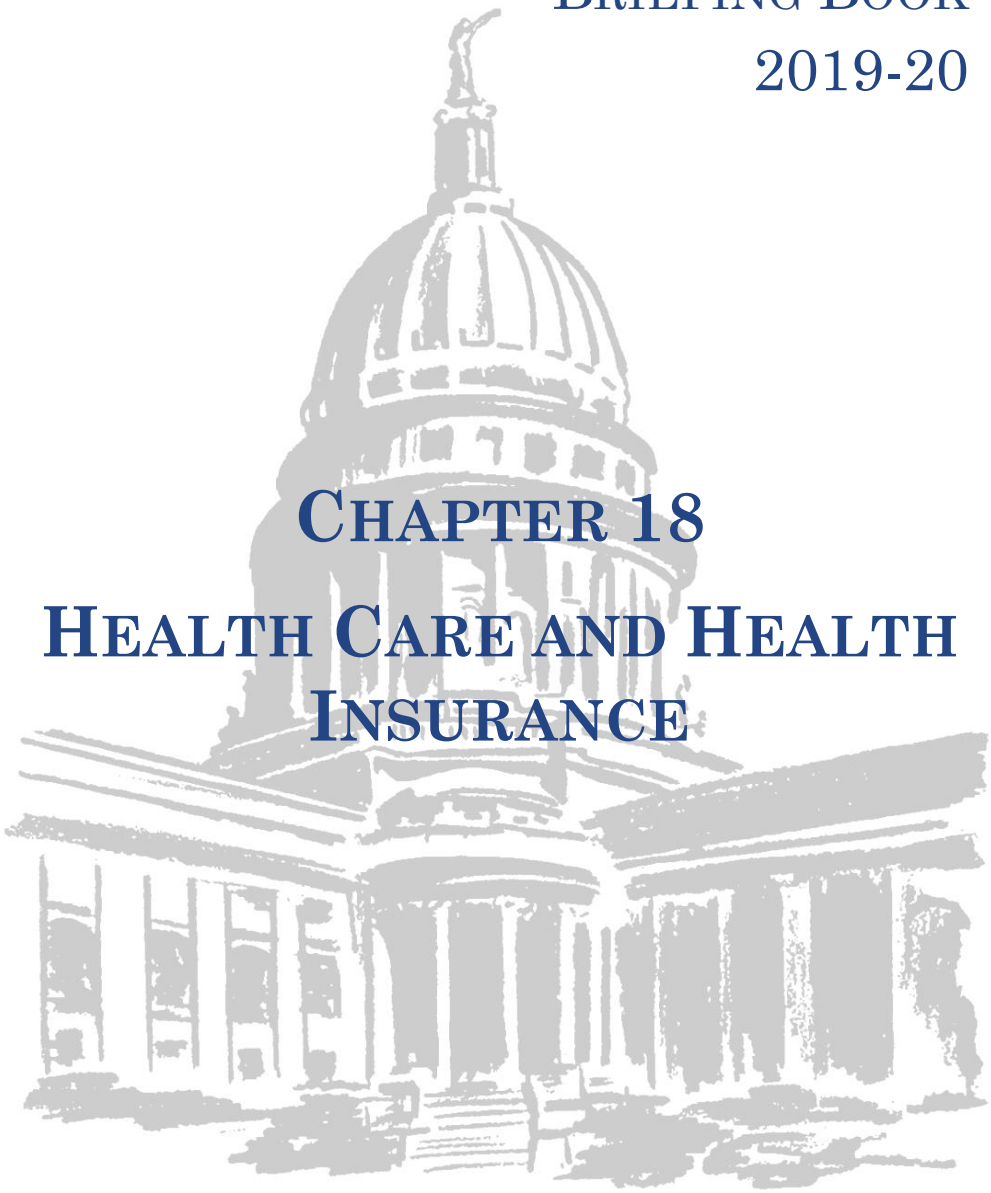

CHAPTER 18
HEALTH CARE AND HEALTH INSURANCE

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Introduction

State regulation of health care services includes oversight of professionals and caregiver background checks, credentialing of health facilities and programs, and enforcement of industry regulations and consumer protections. The state has primary responsibility for regulation of the health insurance market, subject to limitations under federal law. In addition, the state and federal government each play a role in administering major public health programs, such as Medicaid, and certain provisions of the federal Affordable Care Act (ACA), as described below.

State Regulation of Health Care Professionals, Programs, and Facilities

Health Care Professionals

The state provides credentialing and oversight of health care professionals through examining boards and affiliated credentialing boards in the Department of Safety and Professional Services. Health professions include nurses, chiropractors, dentists and dental hygienists, physicians, physician assistants, respiratory care practitioners, podiatrists, dieticians, athletic trainers, occupational therapists and occupational therapy assistants, optometrists, pharmacists, acupuncturists, psychologists, social workers, marriage and family therapists, professional counselors, hearing instrument specialists, speech-language pathologists, and audiologists. In addition, the Department of Health Services (DHS) licenses emergency personnel, including first responders and various categories of emergency medical technicians.

An examining board is a part-time body that sets standards of professional competence and conduct for the profession under its supervision; prepares, conducts, and grades examinations; grants licenses; and examines complaints. An affiliated credentialing board generally has the same authority as an examining board, but is attached to an examining board and must submit its proposed rules to the examining board to which it is attached for comment.

In addition to providing for a basic credential, such as a license or certificate, the statutes allow certain health care providers who satisfy additional requirements to engage in a higher level of practice than that provided under the basic credential. For example, a nurse who satisfies additional requirements established by the Board of Nursing is authorized to issue prescription orders and is referred to as an advanced practice nurse prescriber.

Caregiver Background Checks

Certain entities regulated under Wisconsin law are required to conduct background checks of employees who have contact with clients or vulnerable individuals. The background check involves a criminal history search from records maintained by the Department of Justice, information maintained by DHS concerning abuse of patients, and other specified information. The entities required to conduct background checks include nursing homes, community-based residential facilities (CBRFs), hospitals, home health agencies, child welfare agencies, and group homes. Consult DHS's website for a comprehensive description of entities and requirements.

More information about caregiver background checks is available at:

http://www.dhs.wisconsin.gov/caregiver/index.htm

Health Facilities and Residential Programs

State Licensing

The state licenses and certifies a number of health facilities and caregiving residential programs.

Information about facilities regulated by DHS is available at:

http://dhs.wisconsin.gov/rl_DSL/index.htm

The Division of Quality Assurance in DHS licenses adult family homes, CBRFs, and residential care apartment complexes (RCACs), as well as hospitals, hospices, and nursing homes. CBRFs are facilities that serve five or more adults who do not require care above intermediate level nursing care and who receive no more than three hours of nursing care per week. RCACs are places where five or more adults reside in independent apartments and receive supportive, personal, and nursing services not more than 28 hours per week.

Although the term "assisted living" is commonly used, this is not actually a type of licensed facility. Typically, a facility referred to as an assisted-living facility is either a CBRF or an RCAC. Residential programs that provide services to minors and that are licensed by the Department of Children and Families (DCF) include foster homes, treatment foster homes, group homes, and residential care centers for children and youth. The statutes also allow a foster home or treatment foster home to be licensed by a county human services or social services department or by a licensed child welfare agency.

[See generally, ch. 48, Stats.; and subch. I, ch. 50, Stats.]

Zoning Exceptions for Certain Residential Facilities

The statutes provide that, under specified circumstances, certain residential caregiving programs, including CBRFs for adults and group homes and residential care centers for children, may locate in areas that are locally zoned for family residences. These programs, which are referred to generally as "community living arrangements" in the statutes, may

locate in specified residential areas depending on the number of residents in the facility. The statutes provide that no community living arrangement may be established within 2,500 feet, or a lesser distance established by ordinance, of any other community living arrangement. However, a federal district court in Wisconsin has held that the distance requirement in the law is preempted by the federal Fair Housing Amendments Act and the federal Americans with Disabilities Act. Information about these facilities and programs is included in Chapter 20, *Human Services and Aging*.

Medical Malpractice

Any person, or certain relatives of a person, who is injured by the malpractice of a health care provider may sue for economic and noneconomic damages. Noneconomic damages are intended to compensate for pain and suffering, loss of companionship, mental distress, and loss of enjoyment of life. Current law limits noneconomic damages to $750,000 per occurrence of medical malpractice. [s. 893.55, Stats.] In a recent challenge to the law, the Wisconsin Supreme Court, in *Mayo v. Wisconsin Injured Patients and Families Compensation Fund*, 2018 WI 78, determined that the cap on noneconomic damage was not unconstitutional on its face or as applied in that case. This overturned the decision of the lower court, which had struck down the cap.

Wisconsin law requires specified health care providers (including physicians, nurse anesthetists, and hospitals) to carry insurance or self-insure for liability up to statutorily specified levels. The level is $1 million per occurrence and $3 million for all claims in a year. The law also requires those health care providers to pay annual assessments into the Injured Patients and Families Compensation Fund, which then provides coverage for medical malpractice claims in excess of those amounts. The Injured Patients and Families Compensation Fund is administered by OCI. [ch. 655, Stats.]

State and Federal Regulation of Health Insurance Market

Regulation of health care occurs at both the federal and state levels. Many of the regulatory functions are allocated to states, through constitutional requirements and congressional acts such as the McCarran-Ferguson Act. Credentialing and oversight of health care professionals, programs, and facilities are all primarily state government activities as described above. At the same time, some federal laws include requirements related to health care that may preempt state law in applicable cases, including the Health Insurance Portability and Accountability Act (HIPAA), Employee Retirement Income (ERISA), Emergency Medical Treatment and Labor Act (EMTALA), Controlled Substances Act (CSA), and federal statutes administered by the Food and Drug Administration (FDA).

The role of regulating health insurance has also traditionally been allocated to the states. In Wisconsin, as in other states, this activity has continued in recent years, but it has

evolved into more of a shared responsibility with the federal government since passage of the Patient Protection and Affordable Care Act, as described below.

Office of the Commissioner of Insurance

The Office of the Commissioner of Insurance (OCI) regulates health insurance with respect to issues of financial stability and consumer protection. Types of health insurance regulated by OCI include defined network plans, or HMOs, as well as plans in which an insured person may select from any health care providers to provide covered services (generally referred to as an "indemnity plan"). All insurers must be licensed in Wisconsin and meet state marketing and financial standards. OCI regulates all rate and form filings, performs financial and market conduct examinations, and responds to consumer complaints. OCI also regulates health insurance agents and licensed navigators who help consumers to find health insurance coverage.

OCI also operates the Wisconsin Healthcare Stability Plan (WIHSP), which is scheduled to begin in 2019. WIHSP is a reinsurance program authorized by 2017 Wisconsin Act 38. The Act directed OCI to apply for a waiver to operate the program under section 1332 of the ACA. If WIHSP is approved, OCI will administer a $200 million fund on behalf of carriers that issue health plans on the individual market. Carriers will receive payments to offset costs for an enrolled individual's covered benefits, if those costs exceed an anticipated amount, in a benefit year.

Mandates

State insurance laws include various types of mandates that must be met by insurance plans. These health insurance mandates generally fall into the following categories:

- Requiring coverage of a particular type of health care provider (e.g., a chiropractor or an optometrist).
- Requiring coverage for the treatment of a particular disease or condition (e.g., temporomandibular disorders or breast reconstruction).
- Requiring coverage of a particular type of health care treatment, service, or equipment (e.g., mammograms or lead poisoning screening).
- Requiring coverage for particular persons because of their relation to the insured person (e.g., newborn infants or adopted children).

[s. 601.423, Stats.]

Federal Preemption

Because of the federal Employee Retirement Income Security Act (ERISA), OCI does not regulate self-insured employee benefit plans. ERISA provides that it supersedes all state laws that relate to employee benefit plans of private employers. Therefore, a state's insurance laws, including health insurance mandates, do not apply to such plans. Because

ERISA's preemption does not apply to governmental self-insured plans, such as municipal or school district self-insured plans, the state's insurance laws apply to those plans.

Patients' Rights

Various protections exist related to patient's rights that must be followed and taken into account by health care plans. For example, plans must provide protections for insured persons relating to coverage of emergency care and experimental treatment. The statute relating to emergency care requires that if a health care plan provides coverage of any emergency medical services, it must provide coverage of emergency medical services that are provided in a hospital emergency facility and that are needed to evaluate or stabilize an emergency medical condition. The term "emergency medical condition" is defined in the statutes using a "prudent layperson" definition.

The statutes also require a health care plan that limits coverage of experimental treatment to define the limitation and disclose the limits in any policy. The disclosure must state the criteria the plan uses to determine whether a treatment, procedure, drug, or device is experimental.

In addition to the above provisions that are intended to apply in a range of contexts, state law contains various patient protections applicable to a specific type of plan or service. For example, for persons insured under defined network plans, the law sets forth duties of health plans and patients' rights in the following areas:

- Access standards.
- Continuity of care.
- Provider disclosures.
- Quality assurance.
- Use of a physician as a medical director.
- Data systems and confidentiality.
- OCI oversight.

Defined network plans are plans in which an insured person is limited to or is given an incentive for obtaining covered services from health care providers selected by the plan (also referred to as a "managed care plan"). Types of defined network plans include health maintenance organizations (HMOs) and preferred provider plans (PPPs; also referred to as "preferred provider organizations" or "PPOs").

The statutes include requirements that defined network plans include sufficient providers to meet anticipated needs; requirements regarding referrals to specialists, including referrals to obtain obstetric or gynecologic benefits; continuity of care after a provider is no longer included as a selected provider in a defined network plan; prohibitions on penalizing participating providers who discuss all treatment options with insured persons (generally

called "gag clauses"); and a requirement for developing a process for selecting participating providers and reevaluating them.

Continuation Rights

Both federal law and Wisconsin law provide that a person who would otherwise terminate coverage under a group plan may continue to be covered under the group plan for a specified period of time.

Both federal law and Wisconsin law provide that a person who would otherwise terminate coverage under a group plan may continue to be covered under the group plan for a specified period of time. In addition, Wisconsin law provides for conversion from group plan coverage to individual policy coverage. (The federal law is often referred to as "COBRA," since it was created by the Consolidated Omnibus Budget Reconciliation Act of 1985.)

Under the federal COBRA law, employees who terminate employment for any reason other than gross misconduct, persons whose hours are reduced, and dependents of those persons, may continue group coverage for up to 18 months. Dependents may continue coverage for up to 36 months if they lose coverage because of the employee's death, divorce of the employee, the dependent has reached the maximum age under the policy, or the employee becomes eligible for Medicare. Disabled employees may continue coverage for up to 29 months.

Under Wisconsin law, continuation rights are available for: (1) the former spouse of a group member who otherwise would terminate coverage because of divorce or annulment; (2) a group member who would otherwise terminate eligibility for coverage except in cases of discharge due to misconduct; and (3) the spouse or dependent of a group member if the group member dies while covered by the group policy and the spouse or dependent was also covered. Generally, the person electing continuation coverage in the group plan may continue such coverage for 18 months.

[s. 632.897, Stats.]

For more information on continuation rights, visit the DHS' *Consumer Guide to Healthcare*, at:

http://www.dhs.wisconsin.gov/guide/pay/losing.htm

Major Health Care Coverage Programs

Described below are major programs with state government financial involvement that provide health care coverage to eligible persons. The programs are administered by DHS, with claims processing done by private contractors. Medicaid, BadgerCare Plus, and SeniorCare all have income eligibility criteria, while Medicaid also has asset eligibility requirements. The federal Medicare program is also an important source of health care coverage for many Wisconsin residents.

In addition to the programs described in this chapter, DHS administers programs that provide assistance to persons with certain chronic diseases (chronic renal disease, cystic fibrosis, and hemophilia) and acquired immunodeficiency syndrome (AIDS).

Medicare

Detailed information about Medicare is included in a federal publication, *Medicare & You*, which is available at:

http://www.medicare.gov

The federal Medicare program, administered by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (DHHS), is a major source of payment for health care for elderly and disabled persons. Most U.S. citizens age 65 and older, people under age 65 with certain disabilities, and people with end-stage renal disease, are eligible for coverage under the program. Medicare has four parts:

Medicare provides coverage for citizens age 65 and older and individuals under age 65 with certain disabilities, without regard to income or assets.

Medicare Part A provides hospital insurance that includes inpatient care in hospitals, nursing homes, skilled nursing facilities, and critical care access hospitals, but does not include long-term care or custodial care. Most Part A enrollees are not required to pay a premium to receive those benefits if they or their spouse paid Medicare taxes while working.

Medicare Part B provides supplementary medical insurance that covers such services as medically necessary doctor visits, outpatient care, and other services not covered by Medicare Part A. Unlike Part A, most people are required to pay a premium to participate in Medicare Part B.

Medicare Part C combines the benefits available under Medicare Parts A and B, and does so through private health insurance plans referred to as Medicare Advantage Plans. These Medicare Advantage Plans can also offer additional benefits, including Medicare Part D prescription drug coverage.

Medicare Part D is a prescription drug benefit program. People are eligible to participate in Medicare Part D if they are entitled to Medicare Part A or they are enrolled in Medicare Part B. Generally speaking, participation in Medicare Part D is voluntary, although some individuals, such as "dual eligibles" (individuals who are eligible for coverage under both the Medicare and Medicaid programs), are automatically enrolled in a Medicare Part D plan.

Medicaid

Information about Medicaid enrollment and benefits:

http://www.dhs.wisconsin.gov/publications/p0/p00079.pdf

Medicaid, commonly referred to as Medical Assistance (MA) or Title 19, is a program that provides health care services to persons of limited resources. DHS administers Wisconsin's MA program under a framework of state and federal laws, and in conformity with the state plan it submits to CMS.

Medicaid has income and asset eligibility requirements. Medicaid laws also limit an applicant's ability to divest property in order to bring assets below the level allowed for eligibility. However, Medicaid provides spousal impoverishment protections when one spouse enters a nursing home and the other spouse remains outside of the nursing home. In that situation, the law allows the spouse outside the nursing home to retain greater assets and income than would otherwise be allowed in order for the spouse in the nursing home to be eligible for Medicaid.

Medicaid covers an array of health care services. Unlike the federal Medicare program, Medicaid is a major payer for long-term care services, including nursing home services. Included in the services covered are physician services, hospitals, rural health clinics, medical supplies and equipment, transportation to receive services, and several other health care services.

In Wisconsin, Medicaid services for individuals who are elderly, blind, or disabled (EBD) are provided through a variety of programs administered by DHS. These programs provide EBD individuals traditional MA services such as physician services, inpatient and outpatient hospital services, and nursing home care. Some EBD recipients also receive non-traditional long-term care services under Family Care and other home and community-based waiver programs.

When a spouse applies for Medicaid to cover the expenses of long-term care in a nursing home or other long-term care facility, spousal impoverishment protections allow the couple to disregard certain assets and income for purposes of Medicaid eligibility, so that the non-institutionalized spouse will not be required to deplete his or her assets in order to pay for the care of the institutionalized spouse.

During the past decade, Wisconsin's Medicaid program has grown increasingly complex. This is due, in part, to agreements between the state and the federal DHHS that waived aspects of federal Medicaid law, thereby enabling the state to expand coverage. Examples of current waiver programs are the state's home- and community-based long-term care programs (including the community options waiver program, the community integration program, and the long-term care children's waiver program),

SeniorCare, Family Care and BadgerCare Plus. Information about the MA waiver programs is also provided in Chapter 20, *Human Services and Aging*.

Medicaid is funded jointly by the federal government and the State of Wisconsin. In general, approximately 58% of the costs are paid by the federal government and 42% of the costs are paid by the state government.

[subch. IV, ch. 49, Stats.; chs. DHS 101-109, Wis. Adm. Code.]

BadgerCare Plus

BadgerCare Plus Information:
1-800-362-3002

http://dhs.wisconsin.gov/badgercareplus/

BadgerCare Plus is a Wisconsin Medicaid program that offers an array of health care services for low-income persons. Adults with household incomes at or below 100% of the federal poverty level (FPL) are eligible for BadgerCare Plus. Pregnant women with household incomes at or below 305% of the FPL and children (under 19 years old) with household incomes at or below 305% of the FPL are also eligible. Copayments for services are between $0.50 and $3 per service. There are no copayments for preventive services. [s. 49.471, Stats.]

BadgerCare Plus is funded by federal funds available under Medicaid and under the state Children's Health Insurance Program (CHIP), state general purpose revenue (GPR) funds, and premiums paid by participants.

SeniorCare

SeniorCare information:
1-800-657-2038

http://dhs.wisconsin.gov/seniorCare/index.htm

SeniorCare is a program that provides prescription drug coverage to eligible elderly persons. To be eligible, a person must be a state resident who is at least 65 years of age, does not receive Medicaid benefits, has an annual household income at or below 240% of the FPL, and pays a $30 annual enrollment fee. There is no asset limit for SeniorCare. The term "household income" is defined by DHS by rule. FPLs are calculated annually and the income eligibility limits for SeniorCare may be found at the DHS website at:
http://www.dhs.wisconsin.gov/seniorCare/fpl.htm

To qualify for coverage under SeniorCare, most participants must meet an $850 annual deductible for prescription drugs. However, the deductible is $500 for persons with a household income between 160% and 200% of the FPL, and the deductible is zero for persons with annual incomes of less than 160% of the FPL. After meeting the deductible, the participant is charged a copayment for drug purchases at the rate of $5 for a generic drug and $15 for a brand name drug. In addition, drug coverage is available under SeniorCare for persons whose household income exceeds 240% of the FPL if they spend

greater than the amount by which their income exceeds 240% of the FPL on prescription drugs.

SeniorCare is funded by state GPR, federal Medicaid dollars, and enrollment fees.

[s. 49.688, Stats.; ch. DHS 109, Wis. Adm. Code.]

The Affordable Care Act and the Federal Exchange

For more information on the implementation of the ACA in Wisconsin, see:

https://www.dhs.wisconsin.gov/publications/p0/p00634.pdf

A comprehensive health reform portal maintained by the Henry J. Kaiser Family Foundation can be found at:

http://kff.org/health-reform/

A healthcare information web portal maintained by the DHHS can be found at:

http://www.healthcare.gov

In 2010, Congress passed the Patient Protection and Affordable Care Act, often referred to as the "ACA." Almost immediately, the ACA was challenged on constitutional grounds. In June 2012, the U.S. Supreme Court upheld the ACA in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012). The Court rejected only one provision of the law, the "Medicaid expansion," which was held to be optional for the states. Subsequently, the Governor and the Legislature did not accept the Medicaid expansion funds in Wisconsin. Below is an overview of the health insurance market reforms introduced by the ACA, as they took effect in the state.

Overview of Key ACA Provisions

The ACA established new requirements for private insurance companies, including requiring dependent coverage up to age 26 for all individual and group policies, prohibiting pre-existing condition exclusions, prohibiting lifetime caps on coverage, and requiring new private plans to cover preventive services with no copayments or deductibles.

Under the ACA, all insurers must sell a health insurance policy to any person who applies for coverage unless fraudulent information is provided by the consumer. This is referred to as "guaranteed issue."

The ACA requires insurance plans that cover individuals and small businesses to spend 80% of premium dollars on health care claims and quality improvement. Insurance plans in the large group market must spend 85% of premium dollars on those services. Insurers that do not meet these thresholds must provide rebates to policyholders.

Plans are required to offer the following "essential health benefits":

- Ambulatory patient services.
- Emergency services.

- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.

Plans are categorized into one of four tiers. The tiers and the extent of coverage provided are as follows: bronze plans, on average, cover 60% of expected costs; silver plans cover 70% of these costs; gold plans cover 80%; and platinum plans cover 90%.

All plans offered on the federal exchange must limit in-network annual out-of-pocket expenses to $6,850 for individual coverage and $13,700 for family coverage.

Insurance premium credits for federal taxes are available for individuals and families with incomes between 100% and 400% of the FPL, which is $11,880 to $47,520 for individuals and $24,300 to $97,200 for a family of four.

Premium Tax Credits:
A premium tax credit calculator is available on the Kaiser Family Foundation website: http://healthreform.kff.org/subsidycalculator.aspx

The premium tax credit is refundable, which means that if a person has no tax liability, rather than receiving a credit against their taxes, the amount of the credit is paid directly to the individual's insurance company to help reduce the cost of health insurance. Premium tax credits are available only for health insurance that is purchased through a health care exchange.

The Federal Health Insurance Exchange

Federal Exchange:
The website for the federal exchange is www.healthcare.gov

Wisconsin chose not to establish a state-operated exchange, and therefore, Wisconsin participates in the federal health insurance exchange (exchange), also referred to as the "marketplace." The federal exchange operates a website designed to help consumers find and purchase health insurance.

The exchange website allows consumers to: (1) check their eligibility for government assistance programs, including any subsidies available to help pay for private health insurance; (2) compare health insurance plans based on cost; and (3) link to insurers for the purchase of health insurance after they choose a plan in which they are interested.

In general, health insurance may be purchased on the exchange only during periods of "open enrollment." Individuals and families may also qualify for special enrollment periods outside of open enrollment if they experience certain triggering events, such as: (1) loss of minimum essential coverage; (2) gaining or becoming a dependent; (3) newly gaining citizenship; and (4) becoming newly eligible for premium tax credits. Individuals and families generally have 60 days from the time of a triggering event to enroll.

Additional References

1. At the beginning of each biennial legislative session, the Legislative Fiscal Bureau publishes Informational Papers that describe various state programs, including Medical Assistance, BadgerCare Plus, and related programs. These Informational Papers are available at: http://www.legis.wisconsin.gov/lfb/.

2. More information regarding the ACA may be found on the following websites:

    - The National Conference of State Legislatures maintains a health reform implementation website at: http://www.ncsl.org/issues-research/health.aspx.
    - The Henry J. Kaiser Family Foundation maintains a comprehensive health reform web portal at: http://kff.org/health-reform/.
    - DHHS maintains a healthcare information web portal at: http://www.healthcare.gov.

3. DHS has prepared the following consumer publications related to programs and services under its jurisdiction:

    - *Consumer Guide to Health Care* http://dhs.wisconsin.gov/guide/index.htm.
    - *Choosing Wisconsin Residential Options* http://dhs.wisconsin.gov/bqaconsumer/ResidOpts/seek.htm.

4. The Board on Aging and Long Term Care operates a Medigap help line, with a toll-free number of 1-800-242-1060. The help line is designed to answer questions about health insurance, primarily Medicare supplemental policies, long-term care insurance, and other health care plans available to Medicare beneficiaries.

    The Board on Aging and Long Term Care also operates an ombudsman program that serves as an advocate for long-term care consumers who reside in nursing homes or group homes or are participating in the Community Options Program. The toll-free telephone number for the ombudsman program is: 1-800-815-0015.

    In addition to the toll-free number, persons may contact the Medigap help line or the ombudsman program at: BOALTC@wisconsin.gov or by writing to the Board on Aging and Long Term Care at: 1402 Pankratz Street, Suite 111, Madison, WI 53704-4001.

GLOSSARY

ACA: Affordable Care Act, or the Patient Protection and Affordable Care Act, passed by Congress in 2010.

APNP: Advanced practice nurse prescriber. A nurse practitioner, certified nurse-midwife, certified registered nurse anesthetist, or clinical nurse specialist who meets specified requirements and is granted a certificate to prescribe drugs by the Board of Nursing.

CBRF: Community-based residential facility. A place in which five or more adults live and receive care, treatment, or services, but only limited nursing services.

CMS: Federal Centers for Medicare and Medicaid Services in the federal DHHS.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law includes provisions for continuation of group health care coverage after a person would otherwise leave the group.

Defined network plan: A health care plan in which an enrollee's choice of health care providers is generally limited to those selected by the plan, although under some of the plans enrollees may choose other providers and pay a larger share of the cost. Types of defined network plans include health maintenance organizations (HMOs) and preferred provider plans (PPPs).

DHHS: Federal Department of Health and Human Services.

ERISA: Employee Retirement Income Security Act. This federal law preempts states from applying their insurance laws to nongovernmental self-insured plans.

Health Insurance Exchange or Marketplace: The website maintained by the federal government that facilitates the purchase of health insurance by consumers.

Federal Poverty Level (FPL): This level is set by the federal government and varies based on family size. Individuals with incomes below the poverty level are believed to be lacking the resources to meet their basic needs.

Navigator: A federally funded entity or individual who helps consumers determine their eligibility for public assistance programs. They also help consumers compare health insurance options displayed on the federal exchange website after consumers input their preferences.

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