Reporting on Consumers’ Health Insurance Problems: 50-State Media Guide

A comprehensive resource for journalists seeking to understand the uniquely American interplay of federal and state laws and market forces that shape consumers’ experiences with health insurance coverage and their access to health care.

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Health Insurance Primer: Types of Insurance Coverage

The United States has a patchwork system of health insurance coverage, in which people’s access to services and level of financial protection — not to mention whether they have coverage at all — can vary depending on their birthplace, age, job, income, location, and health status. This primer provides a high-level overview of the main types of insurance coverage available to U.S. residents.

Types of Health Insurance – Basics

Approximately 92% of the U.S. population has some form of insurance coverage. The largest single source of coverage in the U.S. is employer-based insurance (covering 49% of the U.S. population in 2022). Medicare and Medicaid combined cover 36% of the U.S. population. See Figure 1.

![Figure 1. Health Insurance Coverage in the U.S., 2022](source)

Medicare

Nationwide, 47.3 million people are enrolled in coverage through the Medicare program, approximately 15% of the U.S. population (2022 data).
Medicare is a federal program that provides insurance coverage to eligible individuals aged 65 or older. Some people under 65 may qualify for Medicare if they have a disability, end-stage renal disease (ESRD), or Amyotrophic Lateral Sclerosis (ALS, also called Lou Gehrig’s disease).

Medicare coverage has several parts, sometimes referred to as Parts A, B, C, and D.

- **Part A** helps cover inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care.
- **Part B** helps cover services from doctors and other clinicians, outpatient care, home health care, durable medical equipment, and many preventive services.
- **Part C** is also called “Medicare Advantage” and provides Medicare benefits through private insurance companies. Medicare Advantage plans must provide Part A and Part B benefits and many also cover Part D benefits (prescription drugs).
- **Part D** helps cover prescription drug costs. Medicare beneficiaries either sign up for a separate Prescription Drug Plan or receive Part D benefits through a Medicare Advantage plan.

In 2023, just over half (51%) of Medicare beneficiaries are enrolled in the Medicare Advantage program. For individuals enrolled in the traditional Medicare program, many also purchase additional insurance policies (called Medicare supplemental plans) to help defray their out-of-pocket costs. These plans are offered by private insurers and come with standardized benefits. Although Medicare is a federal program, Medicare supplemental plans are state-regulated insurance products.

**DIG DEEPER: MEDICARE BASICS**

U.S. Centers for Medicare & Medicaid Services (CMS):
[Medicare and You Handbook](#)

Medicare Payment Advisory Commission (MedPAC):
[Medicare 101](#)

KFF: [A Medicare Primer](#)
Medicaid and the Children’s Health Insurance Program (CHIP)
Medicaid is a jointly financed state-federal program that provides insurance coverage for low-income children and families, low-income seniors, and low-income people with disabilities. In most states, the benefits are provided via private insurance companies called managed care organizations or “MCOs.”

The Affordable Care Act gave states the option to expand Medicaid to individuals up to 138% of the federal poverty level (FPL), with enhanced federal matching funds as an incentive to do so. To date, 41 states (including D.C.) have adopted the Affordable Care Act’s Medicaid expansion.

CHIP is also a jointly financed, state-federal program that covers low-income children above the state’s Medicaid eligibility threshold. States may choose whether to run the CHIP program as either an expansion of their Medicaid program or as a separately run program.

DIG DEEPER: MEDICAID AND CHIP BASICS

Medicaid Payment Advisory Commission (MACPAC):
Medicaid 101

KFF: Medicaid, A Primer

Texas Health & Human Services Commission:
Medicaid & CHIP Reference Guide

Employer-sponsored Insurance (ESI)
Nationally, 158 million people are covered by employer-sponsored insurance (ESI), or 49% of the population (2022 data). ESI is the main source of insurance coverage for people between the ages of 19-65. In 2022, slightly less than half of U.S. firms offer health insurance to their employees (48.3%), but offer rates vary significantly by the size of firm. Among large firms (over 50 employees), 97.3% offer health insurance, while only 32.5% of small firms do.

Employers’ contributions to group health plan premiums are exempt from federal taxes. Employers can choose to self-fund their ESI, meaning that they are financially responsible for covering enrollees’ costs. Such plans are called self-funded or self-insured. Employers can also choose to purchase a group health insurance policy from an insurance company. In such a case the employer pays a fee to the insurer (a premium), and in turn the insurer bears the financial risk of covering enrollees’ health costs. Such a plan is called fully insured. The distinction is important because under a federal law known as ERISA (the Employee Retirement Income Security Act), self-funded plans are exempt from state insurance regulation. Fully insured group
plans are subject to both state and federal law. Nationally, approximately 38.2% of private sector businesses that offer health insurance self-fund at least one health plan. For large firms (over 50 employees), 59.9% that offer health insurance self-fund at least one plan.

Small-group (up to 50 employees), fully insured health plans are subject to more insurance regulation than large-group health plans. For example, small-group fully insured plans must comply with minimum federal standards governing the scope of benefits they must cover (called “essential health benefits”), and limiting the extent to which premium rates can vary based on health risk.

Individual Market Insurance

Individuals who are not eligible for Medicare or Medicaid/CHIP, or who do not have an offer of ESI, may instead choose to purchase a health insurance plan in the individual market. Approximately 6% of U.S. residents (20.3 million) are enrolled in the individual market (2022 data). There are three main types of individual market insurance:

**Health Insurance Marketplace Plans**

The health insurance Marketplaces were created under the 2010 Affordable Care Act. The Marketplaces are organized, state-based, online markets for buying health insurance. They offer a choice of health plans that have been certified as meeting certain minimum federal standards. Through the Marketplace, individuals and families can qualify for federal premium and cost-sharing subsidies to reduce the cost of coverage, based on their income. In 2023, nearly 16.4 million people enrolled in Marketplace coverage.
Nineteen states operate their own Marketplaces, three states operate a federal-state hybrid Marketplace, and 29 are operated by the federal government. Regardless of their state, people can access Marketplace plans by visiting HealthCare.gov.

Off-Marketplace Plans (ACA-compliant)
People can also buy a health insurance policy directly from an insurer or broker. Health insurance sold through the individual market must comply with federal and state consumer protections, such as requirements to cover a minimum set of health benefits and prohibitions on discrimination against applicants based on pre-existing conditions. However, individuals who purchase health insurance “off-Marketplace” do not qualify for federal premium or cost-sharing subsidies. Individual market health insurance (both on- and off-Marketplace) is primarily regulated under state law.

Off-Marketplace Insurance (non-ACA compliant)
Many states allow the sale of different types of insurance products that are often marketed to consumers as health insurance but are not regulated as such, and are in fact exempt from most federal and state consumer protections. These products come in multiple forms and are sponsored by different types of organizations. They include: short-term, limited duration insurance, Farm Bureau plans, fixed indemnity products, and health care sharing ministry arrangements. Although these products are often able to offer a lower premium than Affordable Care Act-compliant products, they are not subject to the same level of regulatory oversight, and can often leave enrollees, particularly those with pre-existing health conditions, exposed to unexpected health costs.

Other Coverage
Many U.S. residents are enrolled in other forms of insurance coverage, such as coverage for the military (TRICARE or U.S. Veterans Administration), which covers 1%, or 4.22 million Americans (2022 data). Colleges and universities may also offer school-sponsored health insurance to actively enrolled students.

DIG DEEPER: INDIVIDUAL MARKET BASICS

Health Affairs: The ACA’s Effect on the Individual Insurance Market

CMS: The Health Insurance Marketplace

Congressional Research Service: Health Insurance, A Primer
The Uninsured

Approximately 8%, or 26.1 million U.S. residents are uninsured (2022 data). However, this masks significant state variation, from an 16.6% uninsured rate in Texas to a 2.4% uninsured rate in Massachusetts. States that have chosen not to expand their Medicaid programs have a higher uninsured rate than those that have expanded Medicaid. Additionally, states with a high population of individuals who are not legally present have more uninsured. These individuals are not eligible for government programs such as Medicaid, Medicare, or the health insurance Marketplaces. In general, most uninsured people are in low-income families with at least one family member working. People of color are at higher risk for being uninsured than white people.

DIG DEEPER: THE UNINSURED

KFF: A Closer Look at the Remaining Uninsured Population Eligible for Medicaid and CHIP

HHS: State and Local Estimates of the Uninsured Population in the U.S. Using the Census Bureau’s 2022 American Community Survey

Institute of Medicine: Consequences of Uninsurance
The Regulators: Oversight, Enforcement, and Sources of Health Plan Data

Most private health insurance is regulated by the federal government, the state government, or both. There are several state and federal agencies responsible for interpreting and enforcing standards and requirements for health insurers and health plans.

Federal Regulators

The Centers for Medicaid & Medicaid Services (CMS)

CMS is an agency within the U.S. Department of Health & Human Services. It is responsible for administering the Medicare program, and ensuring that Medicare Advantage and Medicare Prescription Drug Plans comply with program rules and standards. If these plans are out of compliance, CMS may issue warning letters, Corrective Action Plan requests, or monetary penalties.

CMS also partners with states to administer Medicaid, CHIP, and the health insurance Marketplaces. In five states, it directly enforces some or all federal insurance standards for individual and fully insured group health plans.

In addition to its national office, CMS maintains regional offices around the country.

CMS maintains multiple databases with plan-specific information. These include:

* Medicare Advantage and Medicare Prescription Drug Plans
  CMS provides data about Medicare Advantage and Medicare Prescription Drug plans on the agency’s website, including:

  - Enrollment data by state, county, plan, and contract, and additional information such as market penetration data and contract state service areas are available here.
  - Reports with company-specific data on plan coverage determinations, enrollee grievances and appeals, and more is available here.
  - Performance data (based on a star ratings system) is available here.
  - Plans that have received Corrective Action Plan requests from CMS, as well as results from CMS’ Performance Reviews (including plans identified as “poor performing” or “outlier” organizations) can be found here.

* Medicaid MCOs
  CMS does not collect or provide any plan-specific information about Medicaid MCOs.

* Health Insurance Marketplace
  CMS provides Public Use Files on plans that participate in the Marketplaces. These files include data on enrollment, benefits, rates, cost-sharing, plan business rules, numbers of denied claims, service areas, networks, prescription drug formularies, quality rating, numbers of enrollee benefit appeals and decisions on those appeals, as well as data from enrollee surveys, all available here. CMS also maintains files with insurer-level enrollment data, available here.
ACA-regulated Insurance

Medical loss ratio reports: These files include insurer’s medical loss ratio filings, annual public use files containing the raw data underlying the medical loss ratio filings, and a list of insurers owing refunds by year, available here.

Rate review: These files include some rate filing justification information, by state and insurer, available here.

Risk Adjustment reports: These annual reports include data on payment transfers among insurers based on the health status of their enrollees (called relative risk scores), available here.

U.S. Department of Labor’s Employee Benefits Security Administration (EBSA)
The U.S. Department of Labor’s EBSA has regulatory jurisdiction over employer-sponsored group health plans. For self-funded group health plans, it has exclusive jurisdiction because state regulation is preempted under ERISA. The agency promulgates regulations and standards for group health plans, provides oversight, and conducts enforcement when a violation of federal rules is found. EBSA maintains regional offices around the country.

Employers that sponsor group health plans must file an annual Form 5500 with information about the number of plans offered, number of enrollees, income and expenses, and premiums paid. A database of Form 5500s is available here.

U.S. Security and Exchange Commission (SEC)
The SEC regulates public companies, including health insurance carriers to protect investors and ensure the fair functioning of markets. Publicly traded health insurers are required to regularly disclose financial and other information through quarterly financial reports and earnings calls for investors and the public. To obtain financial reports, you can search by company name on the SEC’s website. For a schedule of earnings calls and recordings or transcripts, each publicly traded insurer should have a website providing this information. Information about SEC enforcement actions (investigations, administrative proceedings, litigation) is available here.

U.S. Department of Justice, Anti-trust Division and Federal Trade Commission (FTC)
Health insurers are subject to federal anti-trust laws. The U.S. Department of Justice (DOJ) and the FTC investigate anti-trust concerns about health insurers and enforce federal laws. DOJ and FTC anti-trust actions can be found via searchable databases. The DOJ database is available here and the FTC database here.
Sources of Coverage Information for Plan Enrollees and Where They Can Go for Help

Explanation of Benefits (EOB)
After an insured person receives health care services, their health plan will send them information about the claims for reimbursement they received from the health care provider. This is called an Explanation of Benefits (EOB). The EOB will include information about how payment for the services is shared between the health plan and the enrollee. The EOB should show the enrollee a list of the services they received, the dates of service, the amount the provider or facility billed the health plan, the amount the plan paid the provider, and the amount the enrollee owes to the provider. If payment for a service is denied, the EOB should include a reason. There is no standard format for health plan EOBs, so each one may look different.

Note: A federal law enacted in 2021 requires commercial health insurers to provide enrollees with an “Advance” EOB (AEOB) before they receive services. The AEOB would include an estimate of the enrollee’s out of pocket costs. However, the federal government has delayed implementation of this requirement and AEOBs are not yet available to most consumers.

Summary of Benefits and Coverage (SBC)
Consumers trying to choose among commercial health plan options (individual market, Marketplace, or ESI) may use a plan’s Summary of Benefits and Coverage (SBC). The SBC is a publicly available, standardized form that displays a snapshot of a plan’s cost-sharing, covered benefits, and any significant coverage limits or exceptions.

Summary Plan Description
Employers who offer group health insurance are required under federal law to provide plan enrollees with a “Summary Plan Description” (SPD). This document may not be publicly available, but employers must provide one, upon request, within 90 days of enrollment. The SPD includes details about what the health plan covers and how it operates.

Sources for Consumer Assistance
Internal and external appeals
Federal law requires all commercially insured consumers to have the right to appeal denied claims. First, enrollees must seek an internal appeal (operated by their health plan). If the plan upholds its decision, the enrollee may seek an independent, external appeal.

Consumer complaints and hotlines
Depending on the issue and type of insurance, several federal and state agencies can provide consumer assistance:
For people with self-funded employer plans:
U.S. Department of Labor Employee Benefits Security Administration: 
https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa

For people with other forms of health insurance:
State department of insurance and/or State Attorney General. Some states may also have an
executive branch office or official tasked with helping to resolve consumers’ insurance
problems.

For HealthCare.gov enrollees: https://www.healthcare.gov/contact-us/ for the call center or
find local, in person assistance at https://localhelp.healthcare.gov/.

What’s in a Name? The Different Legal Forms of Entities Involved in the Business of Insurance

Quite often, a consumer will have an insurance card with the name of an insurance company
that is different than the name of the parent or holding company. When researching insurance
companies, it may be important to know the different legal forms and names under which they
operate. For example, one parent company may have subsidiaries that offer Medicare
Advantage, Medicaid managed care, and individual market policies, each with different
marketing names.

- **Holding company.** The corporate holding company may be engaged in capital-raising
  activities on behalf of its subsidiary insurance companies, but does not take on
  insurance risk or engage in the business of insurance.

- **Parent company.** Like a holding company, the parent company owns other businesses,
  but unlike a holding company the parent company runs its own operations in addition to
  running the other businesses.

- **Issuing insurance company.** An insurance company may operate in multiple states, but
  will have one issuer per state that is licensed to do business. The issuing insurance
  company has the legal obligation to pay claims under the policies that it issues.

- **Marketing entity.** The issuing insurance company may market different insurance
  policies under different marketing names.
Other (non-government) Sources of Data on Health Insurance Companies

National Association of Insurance Commissioners (NAIC)
The NAIC is the national association of state insurance regulators. They maintain a database that allows users to search for complaint data about insurance companies, by state. The NAIC also maintains a “complaint index,” that allows users to see how insurers compare to a national index on the volume of complaints. [https://content.naic.org/cis_consumer_information.htm](https://content.naic.org/cis_consumer_information.htm)

National Association of Attorneys General (NAAG)
NAAG is the national association of state attorneys general. It maintains a database of multistate settlements between attorneys general and private entities. [https://www.naag.org/news-resources/research-data/multistate-settlements-database/](https://www.naag.org/news-resources/research-data/multistate-settlements-database/)

Robert Wood Johnson Foundation “HIX Compare”
The Robert Wood Johnson Foundation provides a free database of comprehensive plan information for the ACA-compliant individual and small-group health insurance markets. The database also includes files on Medicare Advantage and Medicaid Managed Care plans. It is accessible [here](https://www.naag.org/news-resources/research-data/multistate-settlements-database/).

Good Jobs First “Violation Tracker”
The Violation Tracker is produced by the Corporate Research Project of Good Jobs First. It provides a searchable database of enforcement actions from more than 400 federal, state, and local regulatory agencies. The tracker includes aggregated data for more than 3,000 parent companies, including health insurers. It is available [here](https://www.naag.org/news-resources/research-data/multistate-settlements-database/).

KFF, Did Your Plan Rip Off Medicare?
KFF, through a Freedom of Information Act request, in 2023 obtained and published the results of Medicare Advantage plan audits, covering billings from 2011 to 2013.
Appendix A: Glossary

**Centers for Medicare & Medicaid Services (CMS):** The Centers for Medicare & Medicaid Service (CMS) is a federal agency that administers Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Health Insurance Marketplace.

**Children’s Health Insurance Program (CHIP):** The Children’s Health Insurance Program (CHIP) is an insurance program that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance.

**Coinsurance:** Coinsurance is the percentage of the cost of a health care item or service that a plan enrollee must pay, after the deductible.

**Copayment:** A copayment is a fixed dollar amount that a plan enrollee must pay for a health care item or service, after the deductible.

**Deductible:** A deductible is the amount that an individual or family must pay out-of-pocket for health care before their insurance starts to cover the costs.

**Durable medical equipment (DME):** DME is equipment ordered by a health care provider for everyday or extended use.

**Employer-sponsored Insurance (ESI):** Employer-sponsored insurance is health insurance that is offered to employees and their dependents as a benefit of employment.

**Essential health benefits:** Essential health benefits are a set of services certain health insurance plans must cover under the Affordable Care Act. Examples include doctors’ services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, behavioral health services, and more.

**Explanation of Benefits (EOB):** An Explanation of Benefits (EOB) shows enrollees the total charges for health care visits. This explanation shows what their health plan covers and how much the enrollee will end up paying.

**External appeals:** Health plan enrollees have the right under federal law to appeal a denial of payment from an insurance company. These appeals are adjudicated by an independent third-party.

**Farm Bureau health plans:** Some state Farm Bureau associations offer health plans to their members. A few states exempt these health plans from the laws and regulations that apply to traditional health insurance.

**Federal poverty level (FPL):** The federal poverty level is a measure of income issued every year by the Department of Health and Human Services (HHS). This measure is used to determine eligibility for certain benefits.
**Federal Trade Commission (FTC):** The U.S. Federal Trade Commission is a federal agency whose mission is to protect the public from unfair or deceptive acts or practices and promote fair competition in the marketplace.

**Fixed indemnity insurance:** Fixed indemnity insurance is a type of medical insurance that pays a predetermined amount on a per-period or per-incident basis, regardless of the total charges incurred.

**Fully insured health plan:** A fully insured health plan is an insurance option in which the policyholder, either an individual or an employer, pays monthly or yearly premiums to the insurance company. The individual or employer purchases the policy directly from the insurance company, and the insurance company bears the financial risk of paying the claims costs incurred by the policyholder.

**Health Care Sharing Ministry:** A Health Care Sharing Ministry is a group whose members share religious or ethical beliefs and contribute a monthly amount that is used to pay for medical costs of other members.

**Individual market insurance:** Individual market insurance is health coverage that an individual purchases on their own, on an individual or family basis, as opposed to through an employer or from a government-run program like Medicare, Medicaid or CHIP.

**Inpatient care:** Inpatient care refers to health care services that a patient receives when they are admitted as a patient to any health care facility for at least one night.

**Internal appeals:** If an enrollee’s health plan won’t provide or pay for a covered item or service, the enrollee can appeal the health plan’s decision. The initial, internal appeal is adjudicated by the health plan, without an independent decision maker. If the enrollee is not satisfied with their health plans’ decision after the internal appeal, they may seek an external review (see above).

**Managed Care:** Managed care is a health care delivery system organized to manage costs, utilization, and quality.

**Managed Care Organization (MCO):** Managed Care Organizations (MCOs) are organizations that contract with a state on a capitated basis (usually a per member-per month fee) to deliver managed care services to Medicaid and/or CHIP enrollees.

**Medicaid:** Medicaid is an insurance program that provides free or low-cost health coverage to eligible low-income people, families and children, pregnant women, the elderly, and people with disabilities.

**Medical loss ratio (MLR):** The medical loss ratio (MLR) is the share of health insurance premiums that a health insurance company spends on medical claims and efforts to improve the quality of care, a financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees.
**Medicare:** Medicare is a federal health insurance program for people 65 and older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

**Medicare Part A:** Medicare Part A helps cover the cost of inpatient care in hospitals, critical access hospitals, skilled nursing facilities, hospice care and some home health care.

**Medicare Part B:** Medicare Part B helps cover medical services like doctors’ services, preventive care, outpatient care, and other medical services that part A doesn’t cover.

**Medicare Advantage (Medicare Part C):** Medicare Advantage (MA) is a type of Medicare health plan offered by a private company that contracts with Medicare to provide Medicare eligible populations with all their Part A, Part B, and often Part D benefits.

**Medicare Part D:** Medicare Part D is a program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage.

**Off-Marketplace plans:** Off-Marketplace plans are individual health insurance plans sold outside of the Affordable Care Act (ACA) Health Insurance Marketplace. Some may comply with the ACA’s insurance market reforms, others may not.

**Out-of-pocket costs:** Out-of-pocket costs are the expenses for health care, not including premiums, that aren’t reimbursed by insurance. These include deductibles, coinsurance, and copayments.

**Outpatient care:** Outpatient care is any health care service that does not require a patient to be held overnight/for an extensive amount of time. Outpatient care patients are free to leave the facility once the procedure is completed.

**Pre-existing condition:** A pre-existing condition is a health problem an enrollee had before the date that new health coverage starts. Under the Affordable Care Act, individual market health insurance companies cannot refuse to cover treatment for a person’s pre-existing condition or charge them more.

**Prescription drug formulary:** A prescription drug formulary is a list of prescription drugs covered by someone’s health insurance plan.

**Rate review:** Rate review is an annual process that allows state insurance departments to review, and in many states require adjustments to, health insurance rate changes before insurance companies can apply them to consumers.

**Risk adjustment:** Under risk adjustment, insurers that enroll a relatively larger share of high-risk enrollees receive payments from those insurers with a relatively low share of high-risk enrollees. Insurers in the individual and small group markets, Medicare Advantage, and Medicaid managed care participate in risk adjustment to reduce the incentive for plans to avoid enrolling sicker people.
**Self-funded health plan:** A self-funded health plan is a type of plan in which an employer takes on most or all of the cost of benefit claims. The majority of large employers (with more than 50 employees) self-fund their health plans.

**Short-term plans:** A short-term health plan is a type of plan that can provide individuals with temporary medical coverage when they are between health plans, outside enrollment periods, or need some coverage in case of an emergency. Under federal and most state laws, short-term plans do not have to comply with the Affordable Care Act’s insurance market reforms.

**Small-group market:** The small-group market is where individuals can obtain health insurance through a group health plan maintained by a small employer. Most states define a “small employer” to be one with up to 50 employees.

**Summary of Benefits and Coverage (SBC):** A summary of benefits and coverage is an easy-to-read summary that lets enrollees make comparisons of costs and coverage between health plans.

**Summary plan description (SPD):** A summary plan description is a document that tells participants what the plan provides, how it operates, when an employee can begin to participate in the plan and how to file a claim for benefits.

**Supplemental plan:** A supplemental plan is an insurance policy that supplements an enrollee’s primary health insurance coverage.
Appendix B: Federal Poverty Level (FPL) Table (2023)

<table>
<thead>
<tr>
<th>% of FPL</th>
<th>Annual Income for Household Size:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>100% FPL</td>
<td>$14,580</td>
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<tr>
<td>138% FPL</td>
<td>$20,120</td>
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<td>$43,740</td>
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<tr>
<td>400% FPL</td>
<td>$58,320</td>
</tr>
</tbody>
</table>


*The Department issues separate federal poverty guidelines for Alaska and Hawaii.