CENTER FOR HEALTH LAW & POLICY INNOVATION
Harvard Law School

Marketplace Health Plans Template Assessment Tool

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Beginning in January 2015, state and federal Marketplaces (aka exchanges) will again offer a range of insurance plans called qualified health plans (QHPs). As uninsured individuals begin to enroll in these plans in November 2014, it will be critical that each is able to select a plan that includes current health care providers and affordably meets his/her healthcare needs. This tool is designed to guide assessment of QHPs in two ways.

First, it aims to assist low-income individuals and their health and social service providers in selecting a QHP that best meets their care and treatment needs. This tool highlights areas of a QHP that will significantly affect access to and cost of care. QHPs are available on state Marketplace websites. For federally run Marketplaces, visit www.healthcare.gov to find plan offerings.

Second, this tool is meant to build capacity among advocates in assessing the adequacy of QHPs for vulnerable populations. In the past, private health plans have not met the needs of low-income individuals and families, especially those living with complex chronic health conditions or disabilities. Now that more people with lower incomes and complex health conditions will join the private market, insurance companies will need to build plans that are somewhat different from the ones in the past. For example, although the Affordable Care Act (ACA) prohibits discrimination on the basis of health status, plans may still be designed to attract the healthiest consumers. To maximize the potential of QHPs to meet care and treatment needs, advocates will need to monitor new plans to ensure their adequacy for all consumers, especially those with more significant healthcare needs. To help advocates with monitoring, this tool highlights areas where a QHP may violate the ACA's prohibition on discrimination. This is intended to help advocates identify discriminatory practices in plans in order to flag them for monitoring and enforcement by the state or federal government.

This tool is designed to guide a step-by-step analysis of the following elements in any given QHP:

1. premium and cost-sharing requirements
2. outpatient services / provider networks
3. inpatient services
4. medications
5. specialty services
6. potential discriminatory insurance practices

BACKGROUND ON HEALTH INSURANCE PLANS

Health insurance plans each have different provider networks and cover different health benefits. Plans also charge different monthly premiums and require consumers to pay different costs for healthcare services and treatments. These costs include co-pays, co-insurance, and deductibles, which can apply to provider visits, drugs, and procedures. The following terms are essential to understand as they determine the adequacy and affordability of a plan:

- **Premium:** monthly fee an insurance plan charges for plan membership
- **Co-pay:** a set fee a consumer pays for each provider visit, prescription refill, lab test, or other healthcare service (e.g., $10, $20, or more)
- **Co-insurance:** a percentage of the cost of the healthcare service that the consumer must pay (e.g., 30% of the cost of a provider visit or of a procedure)
- **Deductible:** a set annual amount of consumer spending the consumer must pay before the insurance plan pays for any of the costs of care (e.g., $2,500)
- **Out-of-pocket (OOP) maximum:** a limit on the total amount of money a plan can require the enrollee to pay for healthcare (in co-pays, co-insurance, and deductibles) during a single year
- **Subsidy:** money that the government pays directly to a health plan in order to reduce a consumer's premiums and out-of-pocket costs
- **Provider network:** the healthcare providers that a health plan contracts with, making them available to provide care to the plan's enrollees
- **Benefits:** the healthcare treatments and services a plan covers (e.g., prescription drugs, surgery, outpatient provider visits, specialty care, mental health treatment)
- **Essential Health Benefits (EHB):** a package of mandatory benefits that all QHPs (plans sold on Marketplaces) must cover

Premium and Cost-Sharing Limits

How much cost-sharing a QHP can impose on a consumer will depend on the "metal" rating of the plan. Marketplaces will sell QHPs offering four different "metal" levels of coverage: bronze, silver, gold, and platinum. Each level corresponds with a particular percentage of all enrollees' healthcare costs that plans in that level are expected to cover. Insurance plans with higher premiums generally cover a higher percentage of the cost of care. Table A lists the four metal levels that will be available on Marketplaces. Note that the percentage of healthcare costs the plan and individual are expected to pay is based on the average costs for all plan enrollees.

Table A – Plan Options in Marketplaces (Based on average % of Healthcare Costs Covered by Plan versus Consumer)

Plan Type	% Healthcare Costs Covered by Insurance Plan	% Healthcare Costs Covered by Consumer (and subsidies)
Bronze Plans	60%	40%
Silver Plans	70%	30%
Gold Plans	80%	20%
Platinum Plans	90%	10%

The ACA provides federal subsidies to make premiums for silver-level plans more affordable for individuals with income between 100-400% FPL. While people with higher incomes may buy plans with higher premiums and lower cost-sharing, most people with income up to 250% FPL will buy silver-level plans. Because this assessment tool is targeted primarily towards consumers living between 100-250% FPL, it focuses on analyzing silver-level plans.[1]

The ACA also limits out-of-pocket (OOP) costs (co-pays, co-insurance, and deductibles) for consumers purchasing a QHP. OOP caps are based on annual calculations by the Internal Revenue Service and will change each year. In 2015, OOP costs will be capped for all QHP consumers at $6,600 for an individual, or $13,200 for a family. For consumers with income greater than 100% FPL and not more than 250% FPL, the ACA further limits maximum OOP costs. Table B illustrates total caps on both premiums and OOP costs for consumers with income between 100-400% FPL. (Appendix A shows how these premium and OOP limits are calculated.) The federal government will pay the difference between the consumer's OOP cap and the QHP's unsubsidized charges directly to the plan (i.e., the consumer will not ever have to pay the difference in cost).

Table B: Total 2015 Cost-Sharing Limits/Year Based on Income (OOP + Premium Limits)

Income*	Premium Limit ($ limit)	OOP $ Limit	Total Cost-Sharing Limit/Year
100-150% FPL	$234.57 - $703.70	$2,250	$2,484.57 – $2,953.70
150-200% FPL	$703.70 - $1,479.76	$2,250	$2,953.70 - $3,729.76
200-250% FPL	$1,479.76 - $2,363.18	$5,200	$6,679.76 - $7,563.18
250-300% FPL	$2,363.18 - $,3346.96	$6,600	$8,963.18 - $9,946.96
300-400% FPL	$3,346.96 - $4,462.61	$6,600	$9,946.96 - $11,062.61

* To be in a given income category, income must exceed the lower number of each income range and not exceed the higher number. For example, an income over 150% FPL and less than or equal to 200% FPL will fall into the second-lowest income range. Then, an income over 200% FPL moves to the next range.

Finally, state-based programs may offer additional subsidies to help pay premiums, co-pays, co-insurance, and deductibles.[2] For example, if a state's AIDS Drug Assistance Program (ADAP) coordinates with private plans, it may pay the premium or deductible directly to a plan. ADAP could also pay the consumer's co-pay to a provider or pharmacy. Such programs vary widely

[1] An individual should examine his/her healthcare needs, associated costs, and available subsidies to determine whether a silver plan (with subsidies) or a gold or platinum plan results in more affordable coverage. This would most likely only be the case for people with income above 200% FPL, because those with income at or below 200% FPL receive the greatest limits on OOP costs.

[2] Note that very few state Ryan White Programs assist with provider visit co-pays, but drug co-pay assistance is common (through the AIDS Drug Assistance Program, or ADAP).

state by state, so it is important to check which types of programs (ADAPs or otherwise) that may exist in your state may provide additional financial support to low-income consumers.

QHP ASSESSMENT[3]

STEP 1: CHOOSE A QHP TO ASSESS

Issuer Name:
Product Name:
Plan name:

STEP 2: ASSESS PREMIUM AND COST-SHARING (DEDUCTIBLES, CO-INSURANCE, CO-PAYS)

As described above, the ACA limits premiums and cost-sharing for individuals with income between 100-400% FPL (Table B). For example, an individual with income at 200% FPL will not have to spend more than $1,479.76 on his/her premiums each year (the government would pay the difference if the plan charged more), and would not have to spend any more than $2,250 on other OOP costs (co-pays, coinsurance, and deductibles). This means that an individual with income at 200% FPL would spend no more than $3,729.76 on healthcare annually, including the cost of the insurance plan itself. (Note that you must select a silver CSR (cost sharing reduction) plan).

Use this space to write down the plan's OOP-maximum. Note whether your client's OOP-maximum would actually be lower than this based on Table B.

In addition, as noted above, it is important to check to see if the state offers additional financial assistance to low-income consumers. For example, in many states ADAP offers assistance to buy insurance.

Does your state offer additional financial assistance? What is the amount of financial assistance and how does it work?

[3] For simplicity, this assessment tool refers to plans for individuals, but can be used to assess a family plan as well.

STEP 3: ASSESS QHP's OUTPATIENT SERVICES & PROVIDER NETWORK

How Much Does a Provider Visit Cost the Consumer?

Use this space to write down the plan's cost-sharing rules for outpatient visits to:

Primary Care Providers:

Specialists:

Behavioral Health Providers (including mental health and substance use disorder providers):

Include Applicable Deductibles, Co-Pays, and Co-insurance

Does this plan contract with the client's current providers (both primary care and specialty)?

Continuity with healthcare providers is critical, particularly for consumers living with complex chronic disease (e.g., HIV/AIDS). A consumer enrolling in a QHP is best served if he/she can select a plan that contracts with his/her current provider(s). There are two ways to figure this out:

1. Call the provider and ask which insurance plans he/she accepts; or
2. Search for the client's current provider on the plan and/or Marketplace website.

Write down the names of each of your client's providers and whether they are in the plan's network

Does the plan consider the client's provider to be a primary care provider (PCP) or a specialist?

A consumer typically needs a referral from his/her PCP (usually a general practice or internal medicine provider) in order to see a specialist. Consumers living with HIV/AIDS tend to rely on infectious specialists as their primary source of care, and many HIV providers are actually considered infectious disease specialists by insurance plans. Because co-pays for specialist visits are generally higher than for PCP visits, seeing an HIV provider may require a higher co-pay. It will be important to know whether your client's HIV specialist (or whomever they rely on for primary care) can be considered the client's PCP by the insurance company in order to ensure a lower co-pay.

Write down the names of each of your client's providers and whether the plan considers them to be a "specialist"

Are there generally enough providers (of all kinds) in the network that are geographically accessible (including via public transportation if necessary)?

Note that this will depend on a consumer's needs and preferences.

Do consumers need referrals to see specialists? How does a consumer get a referral?

It is important to know the plan's process for allowing a consumer to see specialists, such as behavioral health (including both mental health and substance use disorder providers) and HIV providers. As stated above, consumers generally will need a PCP referral for a specialty visit. This information should be available on the Marketplace website. Some plans, such as Health Maintenance Organizations (HMOs), do not allow consumers to see out-of-network providers at all. Other plan types allow consumers to see out-of-network providers but at significantly higher cost-sharing levels. These plan types are often called Preferred Provider Organizations (PPOs) or Exclusive Provider Organizations (EPOs).[4]

Does the plan require referrals? What are the rules for out-of-network providers?

[4] EPOs do not require referrals for specialty care, whereas HMOs and PPOs do.

What are the procedures for getting outpatient mental health and substance use disorder treatment? Is the provider network for these services adequate?

If a consumer is already using behavioral health services, or would use them if they were affordable and accessible, it is important to choose a plan that his/her provider (or the provider most accessible to the consumer, whom the consumer would see if possible) accepts.

It is also critical to ensure that a QHP covers outpatient mental health and substance use disorder treatment, and to take note of any limitations on number of visits or on coverage of transitional services to assist a consumer to move back into the community, such as halfway houses or boarding houses.

Use this space to note any mental health or substance use disorder coverage limitations

Discrimination Risk Alert! Limits on mental health or substance use disorder services (both as to the type and quantity of services provided) may be discriminatory. In addition to the ACA's anti-discrimination provisions that protect against differentiating between consumers on the basis of health status, the ACA requires QHPs to follow parity laws. Parity laws require that coverage of mental health and substance use disorder services must be at least as generous as coverage of physical health services. In other words, coverage for mental health or substance use disorder visits should be the same as for all specialists. If a plan's rules vary based on the area of specialty, making it harder to see some specialists than it is to see others, these rules will likely be discriminatory in effect. For example, if a plan restricts the number of mental health visits but not other specialty visits, the plan may be discriminatory against consumers living with mental illness.

STEP 4: ASSESS INPATIENT SERVICES

What cost-sharing schedules are imposed on a consumer for inpatient care, including emergency room visits?

Use this space to write down the plan's cost-sharing rules for inpatient services, including:

Inpatient Services:

Physician and Surgical Services in the Hospital:

Urgent Care:

Emergency Department Care:

Skilled Nursing Facility:

Mental Health Inpatient:

Substance Use Disorder Inpatient:

Are there limitations on the number of days spent in inpatient care or skilled nursing facility stays?

Are there limitations on the number of days spent in a mental health or substance use disorder treatment facility?

STEP 5: ASSESS MEDICATIONS

Does the plan have your client's medications on its formulary?

Insurance companies usually offer many different health plans. It is likely that most companies will offer multiple QHPs on a Marketplace. It is important to examine the formulary that applies to the particular QHP you are assessing, because formularies vary across plans even within the same insurance company. Formularies for each QHP should be available on Marketplace websites. See Appendix B for a list of HIV medications commonly available through ADAP.

If a medication is on the formulary, the next step is to see what cost-sharing rules apply. Most plans have different cost-sharing "tiers" within their formularies, with low-cost generic medications available at the lowest cost-sharing levels while expensive brand-name medications require the consumer to pay a lot more.

Use this space to write down your client's medications. Note if the medications are on the formulary and what cost-sharing rules apply to each one.

Does the plan offer discounts at a "preferred" pharmacy? Is that pharmacy geographically accessible?

Does the plan apply utilization management techniques (e.g., prior authorization or step therapy)?

Prior authorization or step therapy may result in delayed treatment. Prior authorization requires a consumer's prescribing physician to call the insurance plan to get approval for a prescription before it will be covered. Step therapy requires a consumer to try a generic drug and prove that it is medically ineffective, meaning treatment must fail or be harmful, before coverage of a more expensive drug is approved.

Discrimination Risk Alert! Antiretroviral drugs (used to treat HIV) are often expensive. A consumer may need one or more brand-name drugs that do not have a generic equivalent. In some cases, the generic equivalent may be harmful for the consumer or require adhering to a more difficult drug dosage regimen. Insurance plans impose higher cost-sharing levels for brand-name drugs, especially when a generic is available, even if the generic is not medically effective for a particular consumer. Plans also use prior authorization or step therapy (i.e., requiring a consumer to "fail" on a less expensive drug before approving coverage of a brand-name version). If a health plan requires higher cost-sharing or more step therapy or prior authorization steps for antiretroviral drugs (and treatments of opportunistic infections commonly associated with HIV) than it does for drugs used to treat other diseases, this may amount to prohibited discrimination.

Does the state ADAP coordinate with the health plan's medication coverage?

As stated above, a state ADAP may assist with an eligible consumer's drug co-pays imposed by a private plan. If ADAP coordinates with private plans, it would pay this cost directly to a provider or pharmacy. If ADAP does not assist with private insurance affordability, a QHP may be too expensive for low-income consumers, even if subsidies apply. Note that ADAP reimbursement policies vary widely by state; it is important to check the applicable ADAP for each client.

Does your state's ADAP program assist with premiums or medication cost-sharing? If so, will it pay the health plan and/or provider/pharmacist directly?

Does the plan include the pharmacy the client already uses?

Maintaining an ongoing relationship with a pharmacist can be an important objective for some consumers. In addition, if a consumer living with HIV/AIDS is eligible for ADAP co-pay assistance, it may be important to make sure that the plan provides access to a pharmacy that participates in ADAP. This is because ADAP generally does not reimburse for drugs purchased at non-participating pharmacies.

STEP 6: ASSESS OTHER SPECIALTY SERVICES

Are there limitations on other specialty services that the client needs or might need (e.g., hospice, vision, oral health care, chiropractic, laboratory and x-ray services, durable medical equipment, home health visits, mental health or substance use disorder services, rehabilitation / habilitative services, or dialysis)?

Use this space to write down any services your client might need that are excluded from the plan's coverage. Be sure to note if the plan reserves the right to add other services to the excluded list.

Use this space to write down any services your client might need that are limited in the plan's coverage. For example, does the plan have a fixed number of allowed rehabilitation visits?

Is nutritional counseling or medical nutrition therapy available? If so, are there any limitations?

What is the scope of coverage of case management? Does it specifically include any complex treatment the client needs (e.g., for HIV, diabetes, mental health)?

ADDRESSING DISCRIMINATION

The ACA prohibits QHPs from imposing any pre-existing condition exclusions or other discrimination based on health status, race, sex, age,[5] and disability. This means that a health plan cannot refuse to provide coverage for an illness or injury that you acquired before enrolling in the health plan, or provide you with fewer benefits than it provides others.[6]

Discrimination based on health status can take several forms, and is of special concern to consumers living with complex diseases such as HIV, because treatment involves multiple (often brand-name) drugs and frequent specialist visits that tend to be expensive for insurance companies.

For example, if a plan provides different access to drug treatment based on disease status (e.g., placing all antiretroviral drugs in the highest cost-sharing tier), it may be discriminatory. Alternatively, even if a plan appears to cover all treatments equally, it may be discriminatory in practice (e.g., requiring prior authorization for certain services, medicines, or providers, and consistently denying authorization of treatment for people living with HIV or other illnesses that require expensive and frequent care).

Addressing a Discriminatory Benefit Denial

Every insurance company that sells QHPs in a Marketplace must have a process for consumers to appeal benefit denials. When a benefit is denied, the plan must send a notice to the consumer, explaining the right to appeal as well as the process for doing so (including contact information for consumer assistance or ombudsmen offices).

If an appeal is denied (i.e., the plan continues to deny the benefit after doing an internal review of the decision), the consumer can request external review (by a neutral third party) of the plan's decision. A health plan must provide notice of this process as well.

Many states also offer Consumer Assistance Programs (CAPs), funded by the ACA. CAPs provide assistance with consumers' questions or problems regarding health coverage, including filing complaints and appealing decisions made by insurance plans. Other consumer resources are also available to provide assistance (e.g., existing ombudsmen and consumer assistance agencies).

If a plan seems discriminatory, advocates should bring it to the attention of state regulators (Appendix C). States traditionally regulate insurance policies, and will continue to do so under the ACA. HHS will take enforcement action only where a state fails to intervene. Further guidance on how to report suspected discrimination that the state fails to address is forthcoming.

[5] The ACA provides specific rules for adjusting premium amounts based on age. Insurers cannot charge an older person more than three times the premium for a younger person. Patient Protection and Affordable Care Act, § 2701.
[6] Patient Protection and Affordable Care Act, § 1201, 154-56; § 1557, 260-61.

Appendix A. Calculating Cost Sharing for Consumers Living Between 100-400% FPL

Table C – Premium Limits Based on Income (Individual)[7]		
Income	**Max % Income Spent on Premium**	**Max $ Spent on Premium**
100 - 150% FPL	2.01% - .02% annual income	$234.57 - $703.70
150 - 200% FPL	4.02% - 6.34 % annual income	$703.70 - $1,479.76
200 - 250% FPL	6.34 - 8.1% annual income	$1,479.76 - $2,363.18
250 - 300% FPL	8.1 - 9.56% annual income	$2,363.18 - $,3346.96
300 - 400% FPL	9.56% annual income	$3,346.96 - $4,462.61

Table D – 2015 Yearly Out-of-Pocket (OOP) Limits Based on Income (excluding premiums)		
Income	***ACA OOP Limit for all QHP Consumers, Reduced by:***	**Estimated $ OOP Maximum (Individual)/Year**[8]
100-200% FPL	*About 2/3*	**$2,250**
200-250% FPL	*About 1/5*	**$5,200**
250-400% FPL	*No reduction*	$6,600

Table E – Total Cost Sharing Limits Based on Income (OOP + Premium Limits)			
Income	**Premium Limit ($ cap)**	**OOP $ Limit**	**Total Cost Sharing Limit**
100-150% FPL	$234.57 - $703.70	$2,250	$2,484.57 – $2,953.70
150-200% FPL	$703.70 - $1,479.76	$2,250	$2,953.70 - $3,729.76
200-250% FPL	$1,479.76 - $2,363.18	$5,200	$6,679.76 - $7,563.18
250-300% FPL	$2,363.18 - $,3346.96	$6,600	$8,963.18 - $9,946.96
300-400% FPL	$3,346.96 - $4,462.61	$6,600	$9,946.96 - $11,062.61

[7] http://www.irs.gov/pub/irs-drop/rp-14-37.pdf

[8] Individual as well as family health insurance plans will be available on marketplaces. For simplicity, this assessment tool refers to individual plans, but can be used to assess a family plan as well.

Appendix B. Drugs Covered by AIDS Drug Assistance Program Compared to Selected QHP

Table F provides a list of commonly prescribed antiretroviral therapy (ART) medications typically covered by ADAP. The table provides space to note the comparable rules for the QHP you are evaluating, including rules on prior authorization or quantitative limits.

Generic drugs typically cost much less than brand-name drugs, and therefore usually carry lower co-pays. Yet a disproportionate number of the HIV/AIDS drugs lack a generic equivalent. In many plans, then, HIV/AIDS drugs will be in higher cost-sharing tiers.

Table F – ADAP & Selected QHP Drug Formularies							
Drugs (brand name in normal type; generic in italics)	**ADAP**	**SELECTED QHP**					
		Generic	Formulary (F)/ Non-Formulary (NF)	Quantity Limit	Prior Authorization	Other Limits	Estimated Cost-Sharing Amount
Multiclass Combination Drugs:							
Atripla; ***efavirenz* + *emtricitabine* + *tenofovir DF***							
Complera; ***emtricitabine* + *rilpivirine* + *tenofavir disoproxil fumarate***							
Stribild; ***elvitegravir* + *cobicistat* + *emtricitabine* + *tenofovir disproxil fumarate***							
Triumeq; ***abacavir* + *dolutegravir* + *lamivudine***							
NRTIs							
Combivir; ***zidovudine* + *lamivude***							
Emtriva; ***emtricitabine***							
Epivir; ***lamivudine***							
Epzicom; ***abacavir, lamivudine***							
Retrovir; ***zidovudine***							
Trizivir; ***abacavir* + *zidovudine* + *lamivudine***							
Truvada; ***tenofovir DF* + *emtricitabine***							

Videx; *didanosine (buffered versions)*
Videx EC; *didanosine (delayed-release capsules)*
Viread; *tenofovir disoproxil fumarate DF*
Zerit; *stavudine*
Ziagen; *abacavir*
NNRTIs
Intelence; *etravirine*
Rescriptor; *delavirdine mesylate*
Sustiva; *efavirenz*
Viramune; *nevirapine*
Edurant; *rilpivirine*
Protease Inhibitors
Agenerase; *amprenavir*
Aptivus; *tipranavir*
Crixivan; *indinavir sulfate*
Invirase; *saquinavir mesylate*
Kaletra; *lopinavir* + *ritonavir*
Lexiva; *fosamprenavir*
Norvir; *ritonavir*
Prezista; *darunavir*
Reyataz; *atazanavir sulfate*
Viracept; *nelfinavir sulfate*
Fusion Inhibitors
Fuzeon;[9] *emfuvirtide*
Entry Inhibitors – CCR-5 Coreceptor Antagonist
Selzentry; *maraviroc*
HIV Integrase Strand Transfer Inhibitors
Isentress; *raltegravir*
"A1" Opportunistic Infection Medications
Ancobon; *flucytosine*
Bactrim; *sulfamethoxazole/trimethoprim DS*
Biaxin; *clarithromycin*
Cleocin; *clindamycin*
Dapsone

Daraprim; ***pyrimethamine***
Deltasone; ***prednisone***
Diflucan; ***fluconazole***
Famvir; ***famciclovir***
Foscavir; ***foscarnet***
Fungizone; ***amphotericin B***
Megace; ***megesterol***
Mepron; ***atovaquone***
Myambutol; ***ethambutol***
Mycobutin; rifabutin
NebuPent; pentamidine
Nydrazid; ***isoniazid, INH***
Probenecid
Procrit; ***erythropoetin***
Pyrazinamide (PZA)
Rifadin, Rimactane; ***rifampin***
Sporanox; ***itraconazole***
Sulfadiazine – Oral
Valcyte; ***valganciclovir***
Valtrex; ***valacyclovir***
Vfend; ***voriconazole***
Vistide; ***cidofovir***
Wellcovorin; ***leucovorin***
Zithromax; ***azithromycin***
Zovirax; ***acyclovir***

Appendix C. Selected State Insurance Regulators

Alabama Department of Insurance
http://www.aldoi.gov/Consumers/FileComplaint.aspx.
Phone: 334.241.4141
Hours: 8:00 am – 5:00 pm
After Hours Contact: 334.240.4431

Georgia Office of Insurance and Safety Fire Commissioner
http://www.oci.ga.gov/ConsumerService/HealthInsurance.aspx
Phone: 404.656.2070
Toll Free: 800.656.2298
Hours: 8:00 am – 7:00 pm

Louisiana Department of Insurance
https://www.ldi.state.la.us/ConsumerComplaintForm/Complaints/Welcome.aspx
Phone: 225.342.5900
Toll Free: 800.259.5300

Mississippi Insurance Department
http://www.mid.ms.gov/consumer/request_assistance_file_complaint.aspx
Phone: 601.359.2453
Toll Free: 800.562.2957
Email: consumer@mid.ms.gov

North Carolina Department of Insurance
http://www.ncdoi.com/Smart/
Phone: 877.885.0231

South Carolina Department of Insurance
http://doi.sc.gov/638/Health-Insurance
Phone: 803.737.6180
Toll Free: 800.768.3467

Tennessee Consumer Insurance Services
http://www.tn.gov/insurance/consumerRes.shtml
Phone: 615.741.2218
Toll Free: 800.342.4029

Texas Department of Insurance
http://www.tdi.texas.gov/consumer/complfrm.html.
Toll Free: 800.252.3439
Email: ConsumerProtection@tdi.texas.gov
Email: CommissionersOmbudsman@tdi.texas.gov