Understanding Private Health Insurance

First in the Series
MANAGING MEDICAL BILLS
Strategies for Navigating
the Health Care System



Contents Include...

NATIONAL ENDOWMENT FOR FINANCIAL EDUCATION

Understanding Private Health Insurance

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Contents

Introduction

In the United States, we rely on health insurance for our ticket to health care. Unfortunately, millions of Americans are uninsured or underinsured. Some may be eligible for private or government insurance programs but have difficulty navigating the maze of complex rules and insurance jargon. Many more may not have any affordable coverage options or may not be eligible for any. Without health coverage for an illness or disability, the challenge of paying for necessary medical care can be daunting. Bills can accumulate. Access to health care can suffer.

This booklet is the first in a series on strategies for navigating the health-care system. Two other booklets in this series may also be of interest to you. *Understanding Private Health Insurance* was written to help you make the most of private coverage and navigate transitions that can make it hard to get and keep health insurance. The second booklet, *Medicare and Medicaid: A Health Care Safety Net for People with Serious Disabilities and Chronic Conditions,* provides an introduction to the two largest government programs offering safety-net health coverage. A third booklet, *Options for Avoiding and Managing Medical Debt,* gives an overview of programs and strategies for seeking free or reduced-cost health care and for managing medical debts.

To help you understand how health insurance works and options for getting and keeping coverage, this booklet provides information about private health insurance, which is the main source of coverage for Americans under the age of 65.[1]

Everyone needs health insurance. Health insurance companies provide an important service by helping to pay for their policyholders' health care. Because thousands of different health insurance policies are available in the United States, this booklet offers only general information to help guide your inquiries. You should also ask questions of your human resources department, a licensed insurance agent, or other experts available to you. Additional sources of help and information are listed in the back of this book.

Most people with private health insurance get coverage through an employer—their own, a spouse's, or a parent's. Job-based health insurance is most popular because it usually offers the most comprehensive coverage and it is subsidized, with employers and tax breaks paying some or most of the premium on your behalf.

Not everybody has job-based coverage, however. People who own their own business, work in a job with no health benefits, work part-time, or don't work at all, may have to buy their own coverage in the individual health insurance market.

[1] Medicare is a federal program providing health coverage to nearly all Americans who are age 65 or older. For more information about Medicare, visit www.medicare.gov.

Some people get health coverage from government programs. Usually, people can only get public coverage if they qualify based on age, income, family status, or health status.

This booklet is organized in five chapters. The first discusses the adequacy of health insurance coverage with some cautionary words about products that may not provide adequate protection. The second chapter reviews steps you can take to get the most out of your insurance protection. The third chapter describes some basic legal protections that may apply to you as a health insurance consumer. The fourth chapter lists options that can help you navigate transitions that may cause loss or change in your health insurance coverage. The fifth chapter contains resources that provide more information. Web site addresses mentioned in chapter five may be accessed by following the instructions provided. For more extensive and direct URLs, please see the references provided in the End Notes at the back of the booklet.

Chapter 1

Elements of Good Health Insurance Coverage

Many kinds of private health insurance policies are for sale, though not all offer the same protection. Sometimes it can be difficult to recognize good coverage or compare the pros and cons of different policies.

The most obvious feature of any policy is the premium. Many people look for the cheapest health-care coverage available. Just as important, however, is the comprehensiveness of the coverage. Often, there is a direct tradeoff between the cost of health insurance and the level of protection it provides.

As you weigh this tradeoff, keep in mind: you buy health insurance in case you get sick—not in case you stay healthy. Most people who declare bankruptcy because of high medical bills have health insurance. Buying inadequate coverage can be risky.

Key questions to ask

To evaluate how well a health insurance policy might protect you when you need it most, ask yourself the following key questions.

What services are covered?

Look at the list of benefits and services the policy covers to see whether it includes the basics, such as:

» Hospital and doctor care.

» Lab tests.

» Medical equipment.

» Prescription drugs.

» Rehabilitation following illness or injury (for example, physical therapy).

» Mental health care.

Many policies have a lifetime limit on covered benefits—for example, $1 million or higher. Some may have an annual maximum on covered care. As you consider these maximums, remember that care for a serious illness (such as a heart attack or cancer diagnosis) or traumatic injury could easily cost $100,000 or more.

Look also for limits on covered services, especially those that will leave you without coverage for catastrophic health-care costs. For example, some policies may only cover four doctor visits per year, only $5,000 for chemotherapy, or only $800 per year for prescription drugs. These policies could leave you facing tens of thousands in medical bills if you become seriously ill.

An insurance contract may exclude coverage of some types of claims in advance. Review the list of items and services that are excluded from coverage. There could also be exclusions that apply specifically to you. Many policies temporarily exclude services relating to a medical condition you have now or had in the past. Some policies add riders (amendments) that permanently exclude services relating to your specific condition or the organ system or body part it affects. (See chapter three, section "What about pre-existing conditions" on page 17 for more information on rules governing these exclusions.)

Some coverage limits will be harder to recognize or evaluate. For example, most policies restrict coverage for prescription drugs to those on a *formulary* (approved list). You can ask the insurer if drugs you take are on the formulary, though often the lists are not made public. The insurer should at least disclose whether exceptions can be made if patients need a drug not on the formulary. Other care, such as surgery or mental health care, may require prior authorization to be covered. A policy should state whether prior authorization is required, but generally consumers will not be able to tell ahead of time whether prior authorization will be granted. You may want to contact your state insurance department to find out how many complaints have been lodged against an insurer for refusing to authorize care.

From whom can I get care?

Most private health insurance policies have networks of hospitals, doctors, pharmacies, and other health-care providers. Depending on the type of policy purchased, care may be covered only when received from a network provider. Traditional HMOs (health maintenance organizations) may restrict coverage in this way. Other policies give you a choice of receiving care within or outside their provider network, although the portion of health costs covered by insurance may be much lower for out-of-network care. Plans like these may be called PPOs (preferred provider organizations) or POS (point-of-service plans). Whatever the acronym, review the list of participating providers. If staying with your current doctors is important to you, check to see if they are included. In addition, look for names of other respected physicians—such as cardiologists, surgeons, and oncologists—even if you may not need them today, as another indication of the protection the health plan offers.

How much will I pay for covered services?

Many policies impose an annual *deductible*—an initial amount of costs you must pay yourself before the insurance will pay. Usually, choosing a higher deductible will result in a lower monthly premium. The deductible might not apply to all covered services, such as preventive care. Some policies have separate deductibles for certain services, such as hospital care or prescription drugs. In addition, insurance will typically require you to pay for a portion of covered services after you've met your deductible. Co-payments (flat dollar fees, such as $25 per visit) or co-insurance (a percentage of covered charges, such as 20%) may apply. What you pay for covered services may depend on whether you seek care in or outside the insurer's provider network.

Increasingly, health insurance policies have *tiered* (multiple levels of) cost sharing. The deductible, co-pays, and co-insurance that apply depend on the particular item or service you need or the type of provider you see. For example, a policy might charge a $10 co-pay for generic drugs, a $50 co-pay for some brand name drugs, and 50 percent co-insurance for very expensive injectible drugs (to treat diabetes or multiple sclerosis, for example). Care in community hospitals may be subject to a co-pay of $250, while care in specialized academic medical centers may be subject to 20 percent co-insurance.

It is important that a policy have an annual *out-of-pocket maximum*, or limit on what you will pay for covered care. Without this cap, you could end up paying most of the cost of a catastrophic illness. Also keep in mind, even if there is a cap, not all costs may apply to this out-of-pocket limit. Co-pays for prescriptions, for example, often do not count against the out-of-pocket limit. In addition, the policy probably won't limit the amount you have to pay for doctor or hospital fees beyond a level recognized as reasonable by the health insurer. Usually,

providers in the insurer's network are not allowed to charge more than the insurer's recognized charge, but care by out-of-network providers may result in large out-of-pocket bills.

Typical Hospital Charges*

Medical observation following heart attack	$ 2,800
Cardiac bypass surgery	$17,000
Heart Transplant	$51,000

* Based on Medicare hospital payments, 2006. Physician/surgeon charges additional.

Some policies impose a cap on what they will reimburse for certain kinds of health care. For example, a policy that pays no more than $650 per day for hospital care could leave the policy-holder owing thousands of dollars in hospital bills.

Is the policy renewable?

If you buy your own health insurance, it is important to get coverage that is renewable, meaning you have the right to continue the policy as long as you pay your premiums, even if your health status changes. Even if a policy is *guaranteed renewable*, the price of coverage can increase from year to year. Ask the insurer or agent about renewal premiums. In particular, ask whether renewal premiums are based on how long you've been covered under the policy. So-called *durational rating* discourages consumers from renewing coverage. Also, ask whether premiums will increase if you make a lot of claims under the policy.

Tony compared insurance policies and picked a short-term policy that was cheapest. Four months later, Tony took a bad fall, injured his back, and needed surgery and physical therapy. His claims were covered for two months until the policy expired. The insurer refused to renew, leaving Tony uninsured and still in need of care.

Not all health insurance sold to individuals is guaranteed renewable. Short-term policies are widely marketed as an affordable health insurance option. As the name implies, short-term policies offer coverage only for a limited time (for six months, for example). The policy can be renewed, but usually just a few times and only at the insurer's option. A key reason why short-term policies tend to be cheaper is that insurers don't have to continue coverage after you get sick. If you make a claim, the insurer can, and probably will, refuse to renew coverage. Short-term policies can help bridge a gap in insurance coverage and may be an option if you are very certain another, more stable source of coverage will be available in the near future. However, these policies should not be mistaken for comprehensive health insurance that is guaranteed renewable.

Recognizing products that are *not* health insurance

Among the many kinds of private health coverage sold today, you may encounter products that look and sound like health insurance, but do not, in fact, provide comprehensive

It was hard for Audrey to afford her insurance premium, which was over $300 per month. Because she had diabetes, she worried she'd have trouble buying other coverage. Then she saw an ad promising "affordable health care," including hospital, doctor care, and prescription coverage. The ad also promised "all pre-existing conditions accepted" for a monthly premium of only $89. So Audrey dropped her insurance and bought the new plan. Once she realized the difference in protection provided by the "discount plan," it was too late to get her original policy back. A few months later, Audrey was hospitalized and now she owes more than $20,000 in bills.

health insurance protection. Be careful. These products are not a substitute for comprehensive coverage.

Dread disease policies

Dread disease policies pay only for costs related to treatment for specific diseases, such as cancer. One state has banned their sale and other state insurance regulators have posted advisories cautioning consumers about these policies.[2] Most insurance experts recommend buying a good comprehensive policy instead. Dread disease policies tend to be a poor value and some sellers try to mislead consumers and prey on their fears about cancer or other diseases.

Accident-only policies

Accident-only coverage pays for care you need as a result of an accident that is not due to illness. Since a good comprehensive policy will cover costs associated with accidents as well as illness, accident-only policies generally are not a good value.

Supplemental policies

Supplemental policies (sometimes called hospital indemnity policies) pay cash benefits for each day you are in the hospital. Usually, however, the cash benefit will be nowhere near the cost of hospital care. Still, these policies can be popular because they are inexpensive in relation to comprehensive coverage and can be simple to buy. Supplemental policies may be an option if you want to cover "extras" that can come up when you get sick. But they usually are not a good buy and they should not be confused with comprehensive coverage.

Discount plans

Discount plans are not health insurance, and they will not protect you from high medical expenses. Some people may mistake discount health plans for health insurance because of insurance-like features of these products. For example, discount plans charge a monthly premium, issue an ID card, and offer "coverage" for a broad range of health services. Discount plans also typically advertise a network of providers who will discount charges by, say 25 or 30 percent to patients who are cardholders. Some consumers have reported problems obtaining promised discounts even on smaller-ticket health-care services.

[2] See, for example, advisory of Wisconsin Department of Insurance (oci.wi.gov/pub_list/pi-001.htm), Alabama Department of Insurance (www.aldoi.org/Consumers/Cancer Insurance.aspx), and North Carolina Department of Insurance (www.ncdoi.com/Consumer/Publications/Health_Insurance_and Managed_Care/A_Consumer_Guide_To_Cancer Insurance~.pdf)

Unfortunately, because discount plan cards are not health insurance, insurance regulators often cannot help in these circumstances. A number of state insurance regulators and attorneys general have issued alerts warning consumers away from discount medical plans.[3]

"Stacked" policies

A number of licensed insurers sell products that have been described by regulators as *stacked* policies. These join together several limited coverage products—for example, an accident-only policy combined with a supplemental hospital policy or dread disease policy and a discount medical plan. The combination may sound similar to comprehensive health coverage, but it is not.

In summary, it can be a challenge to find coverage that meets your health-care needs and fits your budget. Health insurance that covers more tends to cost more. Do your best to balance the cost (monthly premium) of a policy against the protection it offers. Try to determine what you will have to pay for covered services (deductible, co-insurance, co-pays, out-of-pocket limit). Also estimate costs for non-covered care (services excluded or limited by the policy) and charges (fees above what the plan recognizes). The Evaluating Health Insurance Choices Worksheet on the following two pages can help you keep track of this information. Avoid policies that do not have some kind of maximum out-of-pocket limit on covered charges. Do not mistake insurance-like products for comprehensive coverage.

[3] Britton, G., "Discount Medical Plans and the Consumer: Health Care in a Regulatory Blindspot," *Loyola Consumer Law Review,* Volume 16, Number 2, 2004, 97-118.

Evaluating Health Insurance Choices Worksheet

This two-page worksheet helps you evaluate the types of health-care coverage available. Gather as much information on each policy as you can, and then use this worksheet as a checklist to compare key features as well as premiums.

Do you need more copies of this worksheet? You can download it online at www.healthinsuranceinfo.net/nefe/worksheet.pdf.

Health Insurer: _____ Phone: _____

Plan Name: _____ Web site: _____

Annual deductible: $ _____ Annual out-of-pocket limit: $ _____

Monthly premium: $ _____ Lifetime limit: $ _____

Limit	Disease/Condition
$ _____	_____
$ _____	_____
$ _____	_____
$ _____	_____

	Covered?	Annual Deductible Applies?	Out-of-pocket Max. Applies?	Cost Sharing		Special Limits	
				In-network	Out-of- network	Number of Days, Visits, etc.	$ Covered
INPATIENT FACILITIES							
Hospital	☐	☐	☐				
Skilled Nursing Facility	☐	☐	☐				
INPATIENT PROFESSIONAL SERVICES							
Medical	☐	☐	☐				
Surgery	☐	☐	☐				
Anesthesia	☐	☐	☐				
Lab and Radiology	☐	☐	☐				
OUTPATIENT FACILITIES							
Hospital	☐	☐	☐				
Clinic	☐	☐	☐				
Ambulatory surgical center	☐	☐	☐				

	Covered?	Annual Deduct-ible Applies?	Out-of-pocket Max. Applies?	Cost Sharing		Special Limits	
				In-network	Out-of- network	Number of Days, Visits, etc.	$ Covered
OUTPATIENT PROFESSIONAL SERVICES							
Medical	☐	☐	☐				
Surgery	☐	☐	☐				
Anesthesia	☐	☐	☐				
Lab and Radiology	☐	☐	☐				
Emergency care	☐	☐	☐				
PREVENTIVE CARE							
Checkups	☐	☐	☐				
Immunization	☐	☐	☐				
Screening (Mammogram, etc.)	☐	☐	☐				
Maternity care	☐	☐	☐				
PRESCRIPTION DRUGS							
Generic	☐	☐	☐				
Brand name (on formulary)	☐	☐	☐				
Brand name (off formulary)	☐	☐	☐				
MENTAL HEALTH/CHEMICAL DEPENDENCY							
Inpatient Treatment	☐	☐	☐				
Outpatient Treatment	☐	☐	☐				
Rehabilitation care (physical, speech, occupational therapy, etc.)	☐	☐	☐				
Medical equip. & supplies	☐	☐	☐				

Chapter 2

Be an Informed, Proactive Policy Holder

To get a policy to pay for necessary care, it's important to understand how your insurance works — what responsibilities are required of you and your insurer — and follow some basic common-sense strategies.

Read and keep your policy or benefits handbook

The policy or benefits handbook should be kept with other important financial records. Familiarize yourself with plan rules and follow them. For example, your insurance may require prior authorization (permission) for surgery or other care, or it may require a referral from your primary care doctor in order to see a specialist. Double check your plan's list of participating providers to make sure the ones you need are still in-network. Doctors sometimes change networks; often, updated lists are available online. Pay attention to deadlines and procedures. For example, a referral may be good for only two visits, may expire after 30 days, or may be invalid if faxed.

Keep your doctor informed about the policy, too

Your doctor and other providers can help you follow insurance procedures. Ask for their help in obtaining referrals or other authorization for medical care and choosing among providers. Their billing staff may be especially helpful at navigating the system. Keep them in the loop and ask for help when you need it.

Keep good records

Keep track of all the care you receive, when, from whom, and why. Also, keep copies of bills, *explanation of benefit* statements (EOBs) from the insurance provider, and all other written correspondence from doctors, hospitals, other providers, and insurers.

Call member services at your health plan

Whenever you have a question or problem, call the insurer directly for guidance. Try to be polite and calm—always—even if you feel frustrated. If necessary, ask to speak to a supervisor. Write down the date and time of your call, the name of the person(s) you spoke with, and what they told you. If you don't get the help you need, make your request in writing and keep a copy of the letter you send.

Don't take "no" for an answer

Insurance companies can make mistakes. If the health plan won't cover care you think it should, question the decision to see if they'll correct it. Contact your human resources department (for job-based coverage) or your insurance agent (for individual coverage) to see if they can intervene on your behalf. If that doesn't work, consider a formal appeal. All health insurers have procedures for appealing denials and resolving other disputes. Your handbook should explain what those are and how to pursue them. If you exhaust your appeals within the plan and still are not satisfied, contact federal or state authorities to lodge a complaint. In many states, you may also be able to appeal to an independent external review program. (See chapter five, section "Appealing disputes with health plans" on page 33 for more information.) This can take some time, but remember that research shows consumers who vigorously appeal health plan denials win at least half the time.[4]

[4] Pollitz, K., et al, "Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation," Report to the Kaiser Family Foundation, March 2002.

Chapter 3

Know Your Rights

As a health insurance consumer, you have rights under federal and state laws. These legal protections vary depending on what kind of health-care coverage you have (job-based group health insurance, individual coverage, or coverage through an association), where you live, and other factors.

Employer-sponsored group health plans

The basic rules governing employer-sponsored group health-care plans are set by the federal government and so will be similar no matter where you live. Sometimes, additional state law protections will apply. Each employer's human resources department is supposed to be familiar with these rules and is a good place to start when you need help or information.

When does an employer-sponsored health plan have to let me in?

First, you have to be eligible for health benefits. Not all employers offer health benefits, and when they do, it's up to the employer to decide which employees are eligible. However, eligibility for group health plan coverage cannot be based on your health status. Health status means your medical condition or history, genetic information, or disability. This protection is called *nondiscrimination*. Employers can refuse or restrict coverage for other reasons (such as part-time employment), as long as these reasons are unrelated to health status and apply to all employees.

Employers can also decide when health benefits are offered. Usually, you will be offered benefits when you're first hired. However, employers can require *waiting periods* (sometimes called probationary periods) before health benefits begin. These waiting periods also must be imposed without regard to health status.

Thereafter, employers might offer annual open seasons when you can join or change health coverage. In addition to any regular enrollment period or open season, you must be offered a special, 30-day *special enrollment period* to enroll in your group health plan after certain events. Changes that can trigger a special enrollment period are:

» Birth, adoption, or placement for adoption of a child.

» Marriage.

» Loss of other health insurance (for example, due to death, divorce, legal separation, termination, retirement, or reduction in hours worked).

You and your eligible dependents can elect health-care coverage during a special enrollment period.

What will an employer-sponsored health plan cover?

It depends. Employers can decide what their health plan will cover. However, the *nondiscrimination* rule says you cannot be offered different coverage because of your health status. In addition, there are laws requiring group policies to cover certain benefits. For example, most employer-sponsored health plans must cover maternity care.

What about pre-existing conditions?

Although employer-sponsored group health plans can't refuse to cover an individual or charge more because of a health condition, they are allowed to impose temporary *pre-existing condition exclusion periods* (or *pre-ex*, for short).

There are rules governing when these can be imposed and for how long. In general, a pre-ex cannot be longer than 12 months. If your employer requires a waiting period before health benefits begin, the pre-ex must start on the first day of the waiting period. (So, for example, if there is a three-month waiting period and the health plan imposes a 12-month pre-ex, only nine months of the pre-ex will remain once your coverage begins.) These exclusion periods can only limit coverage of conditions for which you actually received medical treatment, advice, or diagnosis within six months prior to enrolling in the group health plan. Employer-sponsored group health plans cannot apply a pre-ex to pregnancy, newborns, or genetic information.

In addition, you may be able to reduce a pre-ex if you had other health coverage prior to joining a group health plan. Prior coverage can be *credited* against a pre-ex provided you did not have a break in coverage of 63 consecutive days. Your prior insurer should have given you a *certificate of creditable coverage* that documents your past coverage. Show your certificate(s) to your new health plan provider and ask for prior coverage to be credited against a new pre-ex. If you lost your certificate, you can request a new one. In addition, you can submit other forms of proof of prior coverage, such as old ID cards or statements from insurers or providers indicating insurance payment.

What can I be charged for group health plan coverage?

It depends. Employers can decide how much of the group health plan premium they will pay on your behalf. Often, employers will contribute less toward the premium for dependent coverage than they will for the employee. Whatever your employer decides you must pay toward your health benefits, that amount cannot be based on your (or your dependents') health status.

What if the group health plan won't pay a claim?

Call member services or check with your employer's human resources office to see if a mistake has been made. If the problem persists, check your benefits handbook. All employer-sponsored health plans must have procedures for considering appeals when a claim is denied. In addition, you may be able to appeal to an independent external reviewer if your dispute still is not resolved by the plan's internal appeals process. See chapter five, section "Appealing disputes with health plans" on page 33 for more information.

If you have other questions about your rights under your employer-sponsored health plan, contact the U.S. Department of Labor. See page 32 for more information.

Individual health insurance

Compared to job-based health coverage, far fewer people have individual health insurance. It tends to be more expensive, especially since employers

don't help pay for it. Insurers feel pressure to lower premiums, but usually do so by limiting covered benefits or increasing deductibles. In addition, in most states, your health status can affect whether you can buy individual health insurance, what you pay for it, and what it covers.

People often buy individual health insurance with help from a licensed insurance agent. Agents can help you find and compare insurance policies and understand what's covered. If you have a dispute with an insurer after you buy a policy, your agent may be able to help resolve it. It's important to know that agents are paid by insurance companies, regardless of whether they are independent or employees. However, to keep their license, agents must also be honest and disclose important information. Any problems or concerns about an insurance agent should be reported to your state insurance department.

Increasingly, people also shop for individual health insurance on the Internet. A number of Web sites let you compare costs and coverage under various policies. Remember, the premiums posted on these sites are for the healthiest individuals. Your own health status may determine whether you can buy a policy, at what price, and with what restrictions.

Individual health insurance is regulated by states; the rules will depend on where you live. For more information about laws that protect you in your state, see health insurance consumer guides at www.healthinsurance info.net. In most states, you have far fewer protections under individual health insurance than you do under an employer-sponsored group health plan.

When does an individual health insurer have to sell me coverage?

In most states, individual health insurance is medically underwritten. That means you can be turned down based on your health status or health history. It's hard to know in advance whether you will be able to buy medically underwritten individual health insurance. If you have a serious health condition, such as cancer or diabetes, you will likely be denied coverage, and less serious health problems may also result in a denial of your application. However, in some states, individual health insurers must sell coverage to all residents, regardless of health status. This is called *guaranteed issue.*

What will individual health insurance cover?

It depends. In most states, insurers can decide what to cover under their policies. In general, individual health insurance tends to cover less than job-based coverage. For example, individual policies usually don't cover maternity care, and many don't cover prescription drugs or they strictly limit drug coverage (for example, to $500 per year). Many individual policies impose high annual deductibles of $1,000 or more per person. However, some states require all insurers to offer a standard policy covering basic benefits. Many states require policies to

cover specific benefits or services, such as mammograms.

What about pre-existing conditions?

Individual health insurance might turn you down if you have a pre-existing condition. Or, the insurer might add an *exclusion rider* to your policy that excludes coverage for your pre-existing condition—or for the body part or system the condition affects. If the insurer offers you a policy with a rider, your agent is required to explain the rider to you prior to sale. Make sure you understand whether the exclusion is temporary or permanent or if the exclusion means the carrier will not pay for doctor treatment or for prescription drugs. Some states prohibit the imposition of exclusion riders in individual health insurance.

Insurers can also make decisions about pre-existing conditions after you buy a policy. When you make a claim, the insurer may investigate your past medical records for evidence that your health problem existed before you bought your policy. Even if you didn't know you were sick, but had some symptoms, the insurer may decide your condition was pre-existing and exclude coverage. Most states have rules governing the imposition of pre-existing condition exclusions after a policy is sold. For example, states may limit the length of exclusion periods or the period of time prior to purchasing the policy the insurer can investigate. In addition, some states require that prior health coverage be credited against pre-existing condition exclusion periods in individual health insurance.

What can I be charged for individual health insurance?

In most states, individual health insurance premiums are based on your age and gender. In addition, in most states, insurers are allowed to charge more if you are sick. However, in some states, premiums are not allowed to vary based on health status. This is called *community rating*. In states that do not require community rating, your health insurance premiums may also increase at renewal simply because you have held the policy for a while. This is called *durational rating*, and it can make it hard for people to renew coverage. Occasionally, policies will also increase premiums at renewal if you get sick. This is called *re-underwriting*. Finally, some insurers will only sell a policy to new customers for a few years. After that, they *close* a policy to new customers and sell other policies, instead. Premiums for old, closed policies tend to increase much more dramatically, making it hard for these policyholders to afford premiums at renewal. Ask the insurer or your agent about these renewal practices before you buy coverage. In addition, contact your state insurance regulator to see what complaints have been filed against insurers based on their rating practices.

What if my individual policy won't pay a claim?

Call member services to see if a mistake has been made. If the problem persists, check your policy or hand-

book. States require individual insurance companies to have procedures for considering appeals when a claim is denied. In addition, in most states you may be able to appeal to an independent external reviewer if your dispute still is not resolved by the plan's internal appeals process. See chapter five, section "Appealing disputes with health plans" on page 33 for more information.

Health insurance sold through associations

Many individuals and small employers consider purchasing health insurance through associations, such as the chamber of commerce, alumni associations, or professional associations, hoping to get better coverage, lower prices, or stronger legal protections by joining with a large group. However, it is important to understand that the rules protecting consumers in job-based health insurance or individual health insurance may not be the same under coverage bought through an association. For example, the association or its insurer may be headquartered in another state with different rules.

In general, if your employer buys an employer-sponsored health plan through an association, the same rules (nondiscrimination, special enrollment periods, limits on pre-existing condition exclusion periods, and credit for prior coverage) are supposed to apply. However, if you buy individual coverage through an association, you cannot necessarily count on having the same protections that would apply in the individual health insurance market in your state.[5] For example, an out-of-state association's policy might not have to cover all the benefits otherwise required to be covered where you live. Contact your state insurance department for more information before buying health coverage through an association. Ask whether any state protections do not apply. Also, ask if any complaints have been filed against the association or its insurer.

[5] Kofman, M., et al., "Association Health Insurance: Is it time to regulate this product?" *Journal of Insurance Regulation*, October 1, 2005.

Chapter 4

Navigating Health Insurance Transitions

People can be vulnerable to health insurance problems during transitions—job changes, changes in family status, moves, etc.—that may also change or disrupt health coverage. Every month, an average of two million Americans lose their health insurance. Some will transition smoothly to the next coverage; others will be uninsured for at least a month. Most transitions involving private health insurance begin with a loss of job-based group coverage.

If you find yourself facing a health insurance transition, you may have legal rights. It's important to know when you qualify for protection and what procedures and deadlines you must observe. Any time you anticipate a transition may be likely, advance planning can help increase the odds you will navigate it successfully. The following laws and programs can help you remain covered through health insurance transitions.

Special enrollment periods in job-based plans

If you are about to lose your job-based group coverage and you are married, find out whether your spouse's employer offers health benefits. If so, you can ask to sign up during a special enrollment period (see chapter three, section "When does an employer-sponsored health plan have to let me in?" on page 17). You do not have to wait until the next regularly scheduled open season to join a job-based health plan if you qualify for a special enrollment opportunity.

Regular health insurance enrollment periods/open seasons for job-based plans

Typically, employers that offer health benefits will give you an opportunity to enroll in the health plan when you are first hired. Thereafter, the employer may offer annual open seasons when you can elect to change health plans or enroll in coverage that you previously declined. If you begin a new job with new benefits, keep in mind important rights you have, especially regarding nondiscrimination in benefits and limits on pre-existing condition exclusion periods (see chapter three, section "What about pre-existing conditions?" on page 17). Pay attention to deadlines for electing coverage.

Family and medical leave

If you need to take leave from a job due to illness, the birth or adoption of a child, or to care for a seriously ill family member, you may be able to keep your group health coverage for a limited time. A federal law called the Family and Medical Leave Act (FMLA) guarantees you up to 12 weeks of job-protected leave if you work at a company with 50 or more employees. If you qualify for leave under the FMLA, your employer must continue your health benefits and contribution toward your premium during your leave. You will have to continue paying your share of the premium.

If you decide not to return to work at the end of the leave period, your employer may require you to pay back the employer's share of the health insurance premium. However, if you don't return to work because of factors outside your control (such as a need to continue caring for a sick family member, or because your spouse is transferred to a job in a distant city), you will not have to repay the premium.

For more information about your rights under the FMLA, contact the U.S. Department of Labor. (See chapter five, section "U.S. Department of Labor", page 32)

COBRA

If you are leaving your job and you had group health coverage through your employer, you may be able to stay in the plan for an extended time through COBRA coverage. Your covered health benefits under COBRA will be the same as those you had before you qualified for COBRA. However, the employer no longer has to contribute toward the premium. Instead, you must pay the entire premium (the employer and employee share) plus a 2 percent administrative fee. For many people, this makes COBRA coverage quite expensive. On the other hand, continuing group coverage under COBRA may be especially important if you think you might have trouble buying medically underwritten individual health insurance. (Remember, medically underwritten means you can be turned down based on your health status or health history.) Also, remaining covered under COBRA can be important if you're in the middle of treatment for a health condition and don't want to change doctors or other covered benefits.

To qualify for COBRA continuation coverage, you must meet three criteria:

1. You must work for an employer with 20 or more employees.
2. You must be covered under the group health plan as an employee or as the spouse or dependent child of an employee.
3. You must have a *qualifying event* (see the following lists) that would cause you to lose your group health coverage.

Qualifying events for employees include:

» Voluntary or involuntary termination of employment for reasons other than gross misconduct.
» Reduction in number of hours worked.

Qualifying events for spouses include:

» Loss of coverage by the employee because of one of the qualifying events listed previously.
» Covered employee becomes eligible for Medicare.
» Divorce or legal separation from the covered employee.
» Death of the covered employee.

Qualifying events for dependent children include:

» Loss of coverage because of any of the qualifying events listed for spouses.
» Loss of status as a dependent child under the plan rules (for example, 19th birthday or graduating from college).

To qualify for COBRA continuation coverage, you must meet the criteria listed in the box above. Often, you can anticipate a qualifying event, get in touch with the human resources department, and arrange for COBRA coverage in advance. Otherwise, federal law requires employers to notify you about your COBRA rights soon after the qualifying event. If the qualifying event is employment-related (job loss, retirement, etc.), the employer has 30 days to notify you that you can elect COBRA coverage. If the qualifying event is related to a change in depend-

ent status (divorce, graduating from college, etc.), *you* must notify the employer of the qualifying event within 60 days; then the employer has 14 days to notify you of your COBRA rights. Once you've been notified, you have up to 60 days to elect COBRA. Your dependents have their own right to elect COBRA, independent from you, assuming they were covered under the plan before the qualifying event.

If you elect COBRA during the 60-day election period, your coverage must resume retroactive to the date of your qualifying event. You will have another 45 days to pay the premium dating back to that date. Thereafter, you will have to pay premiums according to the schedule set by the employer's health plan (usually monthly). Be sure to pay the premiums on time. Employers are obligated to grant a grace period of at least 30 days for late payment, but your coverage can be terminated immediately thereafter if you haven't paid premiums.

COBRA coverage generally lasts for 18 months (following job-related qualifying events) or 36 months (following qualifying events related to change in dependent status) and cannot be renewed. Your right to COBRA coverage ends if you join a new group health plan. However, if the new plan imposes a pre-existing condition exclusion period, you can keep COBRA during the new plan pre-ex. COBRA will also end if the plan you are continuing in ceases to exist—for example, if the former employer drops health benefits for all employees.

Contact the U.S. Department of Labor to find out more about your rights under COBRA. (For more information, see chapter five, section "U.S. Department of Labor", page 32.)

State continuation laws

Most states have laws requiring group health insurers to offer continuation coverage that is similar to COBRA. If you were covered under a group health plan sponsored by an employer with fewer than 20 employees, you may be able to elect state continuation coverage and temporarily remain in your former plan. Contact your state insurance regulator for more information about state continuation and whether this protection applies to you.

When access to employer-sponsored health insurance ends

Once access to job-based health insurance ends, you may be faced with buying individual health insurance. Remember, individual health insurance is medically underwritten in most states, so you may have difficulty buying coverage if you are sick. If you don't live in a state where individual insurers must sell guaranteed issue coverage to all residents regardless of health status, two other protections may be available: HIPAA and high-risk pools.

HIPAA

In every state, you must be offered some type of individual health insurance when you are *HIPAA eligible*. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. To be HIPAA eligible, you must meet all of the requirements in the box at right.

To be HIPAA eligible, you must meet all of the following requirements:

- You must have had 18 months of continuous prior coverage, at least the last day of which was under a group health plan.
- You must have used up any COBRA or state continuation coverage for which you were eligible.
- You must not be eligible for Medicare, Medicaid, or a group health plan.
- You must not have health insurance.
- You must apply for health insurance for which you are HIPAA eligible within 63 days of losing your prior coverage.

HIPAA coverage must be sold on a guaranteed issue basis (meaning you cannot be turned down based on health status) and it cannot impose a pre-existing condition exclusion period. Depending on where you live, you may be able to apply for HIPAA coverage from one insurer or from all the insurers in the individual market. Or, you might have to apply for HIPAA coverage from the state high-risk pool (see the following section). Also, depending on where you live, there may be limits on how much you can be charged for HIPAA coverage. In states that do not limit premiums, HIPAA coverage can be very expensive. Finally, depending on where you live, there may be rules about what HIPAA policies have to cover. Contact your state insurance department or see your state-specific health insurance consumer guide at www.healthinsuranceinfo.net for more information about HIPAA coverage.

High-risk pools

More than 30 states have programs called high-risk pools that will sell individual health insurance to people who have trouble buying medically underwritten coverage. Most state high-risk pools also offer HIPAA coverage. High-risk pools charge premiums for health insurance coverage, and the premiums tend to be much higher than those charged for medically underwritten coverage in the private market. A few states subsidize high-risk pool premiums for low-income residents. Most pools offer covered benefits similar to what you would find in the individual health insurance market. Most pools will also impose pre-existing condition exclusion periods (unless you are HIPAA-eligible). In a few states, there may be a waiting list to join the high-risk pool (unless you are HIPAA-eligible).

If you apply for individual health insurance and are turned down, charged more, or offered a policy with an exclusion rider, the insurer will probably notify you that you are eligible for high-risk pool coverage. To find out whether your state has a high-risk pool, see chapter five, section "State high-risk pools," page 34. For more information about the program, contact your state insurance department or

check your state health insurance consumer guide at www.healthinsuranceinfo.net.

When protections apply

To understand when you might need the protections described here, consider the case of this hypothetical family: Frank (58), his wife Rosa (50), and their son Alex (17). The following examples describe common events that can trigger health insurance transitions and protections that may help in those circumstances. The options are not listed in a particular order. Frank, Rosa, and Alex will need to weigh them in light of their own needs and costs. For example, COBRA premiums may be higher than individual health insurance premiums, but COBRA is available regardless of health status and won't impose a new pre-ex.

Job loss

Frank was laid off from Acme Widget, a large company that offers group health benefits. Rosa also works for an employer that offers health benefits, though their family has always been covered through Frank's job. The family's options for remaining covered could include:

» *Special enrollment opportunity in Rosa's job-based plan.* Within 30 days following the loss of coverage under Frank's plan, the entire family can enroll in Rosa's job-based plan, Rosa can also enroll alone, but she must elect coverage for herself in order for Frank and Alex to sign up as her dependents.

» *COBRA continuation under Frank's plan.* Frank, Rosa, and Alex can elect coverage independently or together for 18 months.

» *HIPAA coverage.* This option will be available for 63 days after COBRA expires. To be eligible for HIPAA coverage, Frank and Alex would need to be ineligible for coverage as dependents under Rosa's job-based health plan.

» *Other job-based coverage*. If Frank finds a new job offering health benefits, he can enroll. If there is a waiting period or a pre-ex, he and the family can elect COBRA until full coverage begins to avoid a gap in coverage.

» *Individual health insurance.* This could be an option for family members who are healthy enough to qualify for medically underwritten coverage, or if the family lives in a state that requires individual insurance to be sold on a guaranteed issue basis. Pre-existing conditions may be excluded, especially if there is a gap in coverage.

» *High-risk pool*. If Frank or his family members have trouble getting individual coverage and live in a state with a high-risk pool, they may be able to buy coverage from that state program. Pre-existing conditions may be excluded, especially if there is a gap in coverage.

» *Medicaid and S-CHIP*. If the family's income is very, very low following Frank's layoff, Alex (and possibly his parents) might qualify for cover-

age under Medicaid or the State Children's Health Insurance Program. See the second booklet in this series, *Medicare and Medicaid: A Health Care Safety Net for People with Serious Disabilities and Chronic Conditions* for more information about qualifying for coverage under state Medicaid and S-CHIP programs.

Employer bankruptcy

Acme Widget goes bankrupt, laying off most of its workers, including Frank, and closing the group health-care plan. Health insurance options for Frank and his family are similar to those options under "Job loss" on page 27, with certain differences:

- *Special enrollment opportunity in Rosa's job-based plan.*
- *Health Coverage Tax Credit (HCTC).* If Acme receives special certification from the federal government that its financial problems are due to foreign trade and imports, Frank may be eligible for special *trade adjustment assistance* (TAA) benefits and special health insurance coverage options. He also may be eligible for a special federal income tax credit, called the HCTC, to cover 65 percent of the premium for certain health insurance coverage options. More information about the HCTC is available at www.irs.gov.
- *HIPAA coverage.* Since COBRA is not available (no group health plan exists to continue in), HIPAA eligibility will begin the day Acme group health coverage is lost and will be available for 63 days.
- *Other job-based coverage.*
- *Individual health insurance.*
- *High-risk pool.*
- *Medicaid and S-CHIP.*

Retirement

Frank retires from Acme Widget but is too young to qualify for Medicare, which begins at age 65. The same health insurance options listed under "Job loss" on page 27 could apply.

Eligibility for Medicare

Imagine Frank retires from Acme as he turns 65 and becomes eligible for Medicare. Rosa and Alex will no longer qualify for dependent coverage as a result. Their coverage options could be similar to those listed under "Job loss" on page 27 with certain differences:

- *Special enrollment opportunity in Rosa's job-based plan.* Within 30 days following the loss of coverage under Frank's plan, Rosa and Alex can both enroll in Rosa's job-based plan or Rosa can enroll alone. Rosa must elect coverage for herself in order for Alex to sign up as her dependent.
- *COBRA continuation under Frank's plan.* Rosa and Alex can elect coverage independently or together for 36 months.
- *HIPAA coverage.*
- *Individual health insurance.*
- *High-risk pool.*
- *Medicaid and S-CHIP.*

Divorce

Say that Frank and Rosa are divorcing. Usually, the custody agreement or a court order will specify which parent is responsible for Alex's health insurance. Assuming Frank continues to be responsible for Alex's health insurance coverage, Alex can remain eligible for dependent coverage under his father's plan. However, Rosa will no longer qualify for spousal health insurance under Frank's job-based plan. Her coverage options could be similar to those listed under "Job loss" on page 27 with certain differences:

- *Special enrollment opportunity in Rosa's job-based plan.* Within 30 days following the loss of coverage under Frank's plan.
- *COBRA continuation under Frank's plan.* Rosa can elect coverage, independently or together, for 36 months.
- *HIPAA coverage.* This option will be available for 63 days after COBRA expires.
- *Individual health insurance.*
- *High-risk pool.*
- *Medicaid and S-CHIP.*

Widowhood

Frank passes away, so Rosa and Alex are no longer dependents of an Acme employee. Their coverage options could include:

- *Special enrollment opportunity in Rosa's job-based plan.*
- *COBRA continuation under Frank's plan.* Rosa and Alex can elect coverage independently or together for 36 months.
- *HIPAA coverage.* This option will be available for 63 days after COBRA expires.
- *Individual health insurance.*
- *High-risk pool.*
- *Medicaid and S-CHIP.*

Illness or leave

Frank falls seriously ill—too sick to work—so he must take extended leave from his job. Coverage options for Frank and his family might start with the Family and Medical Leave Act. Frank is entitled to up to 12 weeks of job-protected leave because of his illness. Depending on his benefits, this may or may not be paid leave, but he must be allowed to continue his job-based health insurance for the entire family during the protected medical leave and Acme must continue to pay the employer share of the premium. If he is still too sick to work after 12 weeks, Frank could lose his job, in which case the following coverage options could be considered:

- *Special enrollment opportunity in Rosa's job-based plan.*
- *COBRA continuation under Frank's plan.* Frank, Rosa, and Alex can elect coverage independently or together for 18 months.
- *HIPAA coverage.* This option will be available for 63 days after COBRA expires.
- *Other job-based coverage.* If Frank can manage to work in a different job

that offers health benefits, he can enroll. If there is a waiting period, he and the family can elect COBRA until full coverage begins to avoid a gap in coverage.

» *Individual health insurance*. This could be an option for family members who are healthy enough to qualify for medically underwritten coverage (Frank may not in light of his recent illness), or if the family lives in a state that requires individual insurance to be sold on a guaranteed issue basis. Pre-existing conditions may be excluded, especially if there is a gap in coverage.

» *High-risk pool.*

» *Medicaid/S-CHIP.*

Chapter 5

For More Information

U.S. Department of Labor

The Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor has authority over all private-sector employer-sponsored health plans, including COBRA continuation rights under these plans. If you have questions or concerns about your employer-sponsored job-based health coverage or COBRA, contact the EBSA regional office nearest you.

STATE(S) SERVED	ADDRESS	PHONE	FAX
Alabama Northern Florida Georgia Mississippi North Carolina South Carolina Tennessee	Atlanta Regional Office 61 Forsyth St., SW, Suite 7B54 Atlanta, GA 30303	404-562-2156	404-562-2727
Connecticut Maine Massachusetts New Hampshire New York Rhode Island Vermont	Boston Regional Office JFK Building, Room 575 Boston, MA 02203	617-565-9600	617-565-9666
Northern Illinois Northern Indiana Wisconsin	Chicago Regional Office 200 West Adams St., Suite 1600 Chicago, IL 60606	312-353-0900	312-353-1023
Southern Indiana Kentucky Ohio	Cincinnati Regional Office 1885 Dixie Highway, Suite 210 Ft. Wright, KY 41011-2664	859-578-4680	859-578-4688
Arkansas Louisiana New Mexico Oklahoma Texas	Dallas Regional Office 525 South Griffin St., Suite 900 Dallas, TX 75202-5025	214-767-6831	214-767-1055
Michigan	Detroit District Office 211 West Fort St., Suite 1310 Detroit, MI 48226-3211	313-226-7450	313-226-4257
Colorado Southern Illinois Iowa Kansas Minnesota Missouri Montana Nebraska North Dakota South Dakota Wyoming	Kansas City Regional Office 1100 Main St., Suite 1200 Kansas City, MO 64105-5148	816-426-5131	816-426-5511

STATE(S) SERVED	ADDRESS	PHONE	FAX
Arizona Southern California Hawaii	Los Angeles Regional Office 1055 East Colorado Blvd., Suite 200 Pasadena, CA 91106-2341	626-229-1000	626-229-1097
Southern Florida	Miami District Office 8040 Peters Rd., Bldg H, Suite 104 Plantation, FL 33324	954-424-4022	954-424-0548
Northern New Jersey Eastern New York	New York Regional Office 33 Whitehall St., Suite 1200 New York, NY 10004	212-607-8600	212-607-8681
Southern New Jersey Pennsylvania Delaware	Philadelphia Regional Office The Curtis Center 170 S Independence Mall West, Suite 870 West Philadelphia, PA 19106-3317	215-861-5300	215-861-5347
Northern California Nevada Utah	San Francisco Regional Office 71 Stevenson St., Suite 915 San Francisco, CA 94105	415-975-4600	415-975-4589
Alaska Idaho Oregon Washington	Seattle District Office 1111 Third Avenue, Room 860 Seattle, WA 98101-3212	206-553-4244	206-553-0913
Maryland Virginia Washington, DC West Virginia	Washington District Office 1335 East-West Hwy., Suite 200 Silver Spring, MD 20910	301-713-2000	301-713-2008

State health insurance regulators

State insurance departments regulate health insurance companies that sell policies to individuals and to employers, including state continuation rights (similar to COBRA continuation rights) under small employer health insurance policies. The National Association of Insurance Commissioners (NAIC) has a Web site with links to each state's insurance department at www.naic.org. Contact your state insurance department if you have questions or concerns about your health insurance policy or for more information (including previously filed complaints) about a policy you are considering.

Appealing disputes with health plans

You can find consumer guides explaining your rights to appeal disputes with health plans at www.kff.org (search for Consumer Guide).

State high-risk pools

Thirty-two states operate high-risk pool programs for people who have trouble buying individual health insurance because of their health. Eligibility for these programs varies, as do premiums and covered benefits. Contact the program in your state for more information.

PROGRAM	WEB SITE	PHONE
Alabama Health Insurance Plan	www.seib.state.al.us	1-800-513-1384 or 334-833-5900
Alaska Comprehensive Health Insurance Association	www.achia.com	1-888-290-0616
Arkansas Comprehensive Health Insurance Pool	www.chiparkansas.org	1-800-285-6477
California Major Risk Medical Insurance Program	www.mrmib.ca.gov	916-324-4695
CoverColorado	www.covercolorado.org	1-877-461-3811
Connecticut Health Reinsurance Association	www.hract.org	1-800-842-0004
Florida (not open for new enrollees)	none	850-309-1200
Illinois Comprehensive Health Insurance Plan	www.chip.state.il.us	1-800-367-6410 or 217-782-6333
Indiana Comprehensive Health Insurance Association	www.ichia.org	1-800-552-7921 or 317-614-2000
Iowa Comprehensive Health Association	www.onlinehealthplan.com	1-877-793-6880
Kansas Health Insurance Association	www.benefitmanagementks.com	1-800-290-1368 or 620-792-1779

PROGRAM	WEB SITE	PHONE
Kentucky Access	www.kentuckyaccess.com	1-866-405-6145
Louisiana Health Plan	www.lahealthplan.org	1-800-736-0947
Maryland Health Insurance Plan	www.marylandhealthinsuranceplan.state.md.us	1-866-780-7105
Minnesota Comprehensive Health Association	www.mchamn.com	952-593-9609
Mississippi Comprehensive Health Insurance Risk Pool Association	*Visit www.doi.state.ms.us and search "Chirpa," then click "Consumer Information" and select "Mississippi Comprehensive Health Insurance Risk Pool Association."* [a]	1-888-820-9400 or 601-899-9967
Missouri Health Insurance Pool	www.mhip.org	1-800-821-2231 1-800-843-6447 (all but NW Missouri) 1-800-645-8346 (NW Missouri)
Montana Comprehensive Health Association	www.mthealth.org	1-800-447-7828, ext 8537 406-444-8537 (Helena only)
Nebraska Comprehensive Health Association	*Go to www.doi.ne.gov and click "Consumers," then "Brochures." Select the "Comprehensive Health Insurance Pool (CHIP)" brochure.* [b]	1-800-356-3485 (outside of Omaha) 402-390-1814
New Hampshire Health Plan	www.nhhealthplan.org	1-800-578-3272 or 1-877-888-6447
New Mexico Medical Insurance Pool	www.nmmip.com	1-800-432-0750 or 505-622-4711
Comprehensive Health Association of North Dakota	www.chand.org	1-800-737-0016 or 701-277-2271

PROGRAM	WEB SITE	PHONE
Oklahoma Health Insurance High Risk Pool	www.okhrp.com	1-800-255-6065, ext. 4767 or 913-362-0040
Oregon Medical Insurance Pool	www.omip.state.or.us	1-800-542-3104 (local) 1-800-848-7280 503-373-1692
South Carolina Health Insurance Pool	none	1-800-868-2500, ext. 42757 803-788-0500, ext. 42757 803-264-6401
South Dakota Risk Pool	www.state.sd.us/bop/riskpool.htm	605-773-3148
Texas Health Insurance Risk Pool	www.txhealthpool.org	1-888-398-3927
Utah Comprehensive Health Insurance Pool	*Go to www.fritzfx.8m.com and search for "Utah Comprehensive Health Insurance Pool." Click on the #3 entry.* [c]	1-800-538-5038
Washington State Health Insurance Pool	www.wship.org/Default.asp	1-800-877-5187
West Virginia – AccessWV	www.accesswv.org	1-866-445-8491
Wisconsin Health Insurance Risk Sharing Plan	*Go to www.dhfs.state.wi.us and click on "Health Insurance Risk Sharing Plan (HIRSP)" from the list of most requested pages.* [d]	1-800-828-4777 608-221-4551
Wyoming Health Insurance Pool	*Go to insurance.state.wy.us and click on "Consumer Assistance," then scroll down to "Wyoming Health Insurance Pool (WHIP)" and click on the downloadable brochure.* [e]	1-800-442-2376 307-634-1393

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End Notes

This section provides complete URLs for selected cited listings within this publication.

[a] http://www.doi.state.ms.us/htm_files/mchirpa.html

[b] http://www.doi.ne.gov/brochure/b_chip.htm

[c] http://www.oid.state.ok.us/consumer/hrp.html

[d] http://www.fritzfx.8m.com/hiputah/index.html

[e] http://www.dhfs.state.wi.us/hirsp/index.htm

[f] http://www.insurance.state.wy.us/consumer.html#8

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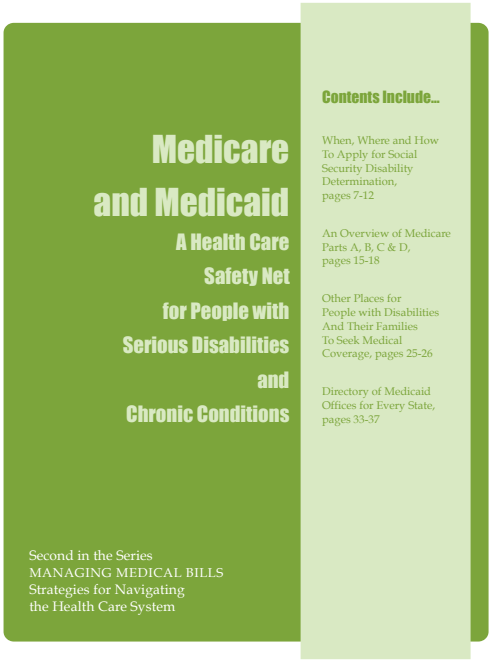

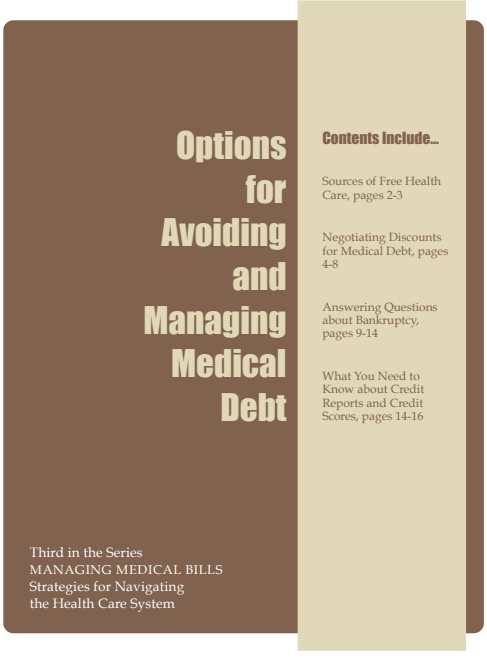

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