

The ACA Marketplace in Arizona

Insurer Participation, Affordability and Network Adequacy



February 2017 Since 2010, hundreds of thousands of Arizonans have obtained health insurance through the Affordable Care Act. This report takes a look at how the ACA has impacted insurer participation, affordability and network adequacy for Arizona's private Marketplace.

SPARK REPORT OVERVIEW

The ACA Marketplace in Arizona Insurer Participation, Affordability and Network Adequacy

February 2017



Since its implementation in 2010, the Affordable Care Act (ACA) has significantly changed the universe of health insurance available to individuals and families across the U.S. In 2016, more than eleven million people nationwide purchased individual (non-employer) health insurance through ACA-based electronic exchanges, known as “Marketplaces.” Approximately 180,000 of those people live in Arizona.

To recognize recent gains in coverage is also to recognize the many challenges that consumers, insurers and other stakeholders face in this arena. Since Marketplace coverage began on January 1, 2014, nine Arizona insurers have participated in providing coverage. Fast forward to January 1, 2017, and only two insurers remain. As a result, many Arizona consumers, like those in many states, have questioned why their cost-sharing requirements are unexpectedly large while their plan networks seem unexpectedly small.

This report examines the Marketplace in Arizona with regard to the interrelated concepts of insurer participation, affordability, and network adequacy. It was crafted using the most recently-available literature, along with insights gleaned from interviews with Arizona’s healthcare industry experts. It begins with an overview of applicable ACA provisions and a summary of insurer participation in Arizona’s Marketplace over its first four years. The report then discusses the constellation of factors contributing to insurance cost, highlighting Marketplace-specific cost-sharing and financial assistance standards. The crux of the report is found in its discussion of quantitative and qualitative provisions governing

network adequacy – some enacted, some proposed – which act as the building blocks of Arizona’s insurance regulatory environment. To close, recommendations are introduced to address insurance affordability and network adequacy. Such recommendations include, but are not limited to:

- Improving provider and consumer insurance literacy,
- Requiring standardized insurance plans,
- Focusing on HMO-specific consumer awareness tools,
- Developing financial and network protections for PPO enrollees,
- Optimizing utilization of telemedicine,
- Ensuring up-to-date accuracy of provider directories, and
- Providing adequate resources for regulatory enforcement.

In 2017, Arizona’s Marketplace will feature only Health Maintenance Organization (HMO) plans, thereby eliminating consumers’ option to select a Preferred Provider Organization (PPO) plan. This transition carries significant implications related to network adequacy and regulatory protections; most notably, a heavier reliance on statewide provisions protecting HMO enrollees from surprise billing and inadequate provider networks. Enforcement of these protections, however, relies on the appropriate allocation of resources to Arizona’s regulatory agencies.

(Continued on Next Page.)

(Continued from Previous Page.)

As the U.S. and Arizona health insurance markets evolve, this report highlights specific insurance provisions which will continually need to be addressed. Achievements spurred by the ACA Marketplace should continue to be championed, while shortcomings should be addressed (and prevented) by turning this report's recommendations into reality. No

individual stakeholder is solely responsible for stewarding this future. Health insurers, healthcare facilities, providers, consumers, regulators and advocates all play a critical role in developing a robust, efficient and effective insurance market – a market that optimizes affordability and access to care for all Arizonans.

Find the full report at vitalysthealth.org/publications

The Affordable Care Act: An Introduction

Since the earliest implementation of the Affordable Care Act (ACA) in 2010, as many as 20 million Americans, ages 18-64, have obtained non-employer health-care coverage they did not previously have. Millions of these ACA enrollees have obtained coverage in public programs as a result of expanded **Medicaid** funding.¹ Millions of others have purchased health insurance through ACA-based electronic health insurance exchanges usually referred to as “Marketplaces” operating in every state. In Arizona, enrollment in the Marketplace has increased every year.

Arizona Enrollment in the ACA Marketplace²

YEAR	ENROLLMENT
2014	91,529
2015	165,026
2016	179,445

Information about gains in the number of people covered under the ACA and the related advantages to consumers and communities is available from many sources, including previous Vitalyst Health Foundation analyses and reports.³ Similarly, there is abundant material available regarding the way the ACA has increased the scope of private health insurance benefits and consumer protection.⁴ Recent surveys of Marketplace enrollees by the Kaiser Family Foundation and the Commonwealth Fund indicate that more people than not are satisfied with their health plans, including the providers in their network and the time it takes them to find doctors and to receive care.^{5,6}

At the same time, however, commentators and stakeholders have raised concerns about negative consumer experiences with:

- High **deductibles** and other **out-of-pocket costs**, often in the form of **surprise billing**;
- **Narrow provider networks**; and
- Insurers facing significant financial losses and pulling out of Marketplaces, thereby reducing consumer choices and potentially increasing the cost of insurance.

This report examines the impact of the ACA on the private, individual (non-employer) health insurance market in Arizona with regard to the closely related areas of insurer participation, affordability, and **network adequacy**. The focus is on private insurance available to individual consumers through the Marketplace. We start with a summary of the ACA provisions that are most relevant to our focus. We move on to an overview of insurer participation, which shifted sharply in 2016 and will shift sharply again in 2017 when the Marketplace in Arizona will consist entirely of Health Maintenance Organization (HMO) plans. These shifts underscore the importance, often overlooked, of the difference between an HMO and a Preferred Provider Organization (PPO). We then address the cost of care for Arizonans as well as the network adequacy of Marketplace plans in Arizona. Along the way we suggest what could be done next to support Arizonans in making the most of ACA coverage when they buy individual health insurance for themselves and their families.

About This Report

- Any discussion of the ACA and health insurance requires acronyms and insurance terminology. At the end of the report you will find a list of the acronyms we use and a glossary. Every word in the glossary is in **bold type** the first time it appears in the report.
- This report addresses private, individual health insurance. It does not address the impact of the ACA on programs run by Arizona's Medicaid agency (the Arizona Health Care Cost Containment System or AHCCCS) or the impact of the ACA on employer-based coverage in Arizona. These are no less important or complicated topics, but this report focuses on private, individual insurance.
- Insurance regulated by the ACA is not limited to Marketplace coverage. This report generally does not distinguish Marketplace insurance from non-Marketplace insurance. Except for certain network adequacy requirements, the ACA healthcare reforms apply equally on and off the Marketplace. Where we have found relevant regulatory or practical distinctions, we have identified and addressed them. We explain the role of the Marketplace in more detail in the next section of the report.



RECENT SURVEYS OF MARKETPLACE ENROLLEES INDICATE THAT MORE PEOPLE THAN NOT ARE SATISFIED WITH THEIR HEALTH PLANS, INCLUDING THE PROVIDERS IN THEIR NETWORK AND THE TIME IT TAKES THEM TO FIND DOCTORS AND TO RECEIVE CARE.⁵

Key Aspects Of The Affordable Care Act

Healthcare Market Reforms

Before implementation of the ACA, health insurers controlled their costs and competed in the individual market largely by selecting enrollees based on how likely they were to use costly healthcare services (a practice known as **risk selection**). Insurers denied coverage to people who had **pre-existing conditions**. They sometimes excluded or limited benefits that were not mandated by state law and that they perceived to be costly or unpredictable, such as maternity services, prescription drugs or mental health services. They set and raised **premiums** based on an individual's age, gender, health history or previous use of healthcare services. The ACA rewrote the rules, as summarized in Exhibit 1.

EXHIBIT 1 Summary of Market Reforms

Pre-ACA Market Practices	Post-ACA Market Reforms
Insurers designed risk pools to reduce and segregate risk.	Each insurer must have a single statewide risk pool. The pool must include Marketplace plans and ACA-compliant non-Marketplace plans.
Medical underwriting was allowed.	Medical underwriting is not allowed; it is replaced by community rating .
Insurers excluded pre-existing conditions from coverage.	Insurers may not exclude pre-existing conditions. Every plan must provide essential health benefits (EHB) to every enrollee.
Insurers excluded benefits that were not mandated by law, such as maternity services, prescription drugs and mental health services.	The EHBs include a range of benefits that previously were not mandated by law. Insurers must include certain preventive service benefits without requiring any cost-sharing .
Insurers set lifetime benefit limits .	Lifetime benefit limits are not allowed.
Insurers denied coverage based on health status or claims history. Insurers were only required to issue coverage to certain individuals with prior group coverage.	Insurers must issue and renew coverage for everyone, without regard to age, sex, history or previous use of healthcare services.
Insurers did not have to set an out-of-pocket limit .	Insurers must set an out-of-pocket limit that is subject to a maximum amount. The maximum out-of-pocket limit for any 2016 Marketplace plan is \$6,850 for an individual and \$13,700 for a family. ⁷
Insurers were allowed to set an annual benefit limit .	Annual benefit limits are not allowed.
Insurers' plans were subject to rate review if required by state law.	Rates remain subject to any rate review required by state law and are subject to review under federal law. ⁸
Network adequacy was subject to review, if required by state law.	Network adequacy remains subject to any review required by state law. Network adequacy of Marketplace plans is also subject to review under federal law.
Insurers adjusted premiums based on age.	Insurers can adjust premiums based on age to a limited extent. They cannot charge the oldest enrollee more than three times as much as they charge the youngest enrollee.
Insurers adjusted premiums based on gender.	Insurers cannot adjust premiums based on gender.
Insurers adjusted premiums based on smoker status.	Insurers can adjust premiums based on smoker status by charging smokers up to 50% more.
Insurers could adjust premiums with or without regard to where the enrollee lived. There were no externally imposed geographic rating areas .	Insurers can adjust premiums based on the geographic rating area in which the enrollee lives.

EXHIBIT 2 Actuarial Values, Enrollment and Enrollee Costs in 2016

Metal Level	Actuarial Value	How Actuarial Levels Affect Enrollee Costs	Arizona Marketplace Enrollment by Metal Level* ⁹
Bronze	60%	Health Plan pays 60%; Enrollee pays 40%	39,297 (22%)
Silver	70%	Health Plan pays 70%; Enrollee pays 30%	115,708 (64%)
Gold	80%	Health Plan pays 80%; Enrollee pays 20%	19,915 (11%)
Platinum	90%	Health Plan pays 90%; Enrollee pays 10%	1,180 (1%)

* Another 3,345 (2%) of Marketplace enrollees in Arizona are enrolled in **catastrophic plans**.

In addition to the reforms listed in Exhibit 1, the ACA separates health insurance plans into four main categories, or **metal levels**, based on the percentage amount that the plan pays for the average cost of covered services. Bronze plans pay an average of 60%, silver plans pay an average of 70%, gold plans pay an average of 80% and platinum plans pay an average of 90%. These percentages establish the **actuarial value** of the plan. See Exhibit 2. In Arizona, bronze and silver plans account for 86% of Marketplace enrollment in 2016.

Because of these market reforms, health insurers preparing to offer plans effective January 1, 2014, had much less control than previously over the risk they were taking on and had little basis for predicting their costs. According to one actuary, “When we developed rates for 2014, we had no historical data. It was basically an educated guess.”¹⁰ Moreover, the Marketplace standardized the way insurers presented their plans to consumers, making it hard for insurers to differentiate their plans from those of other insurers. They could compete on very little but the things most consumers look at first: premiums and **cost-sharing**.¹¹ To the extent that this lack of data and this competition over price resulted in underpricing, subsequent premium increases across the country may reflect some over-correction. As insurers head into their fourth year of setting premiums under the market reforms, the historical data and claims experience they lacked three years ago is accumulating and available to inform future premium adjustments.¹²

The Role of the Marketplace

The ACA calls for the establishment in every state of an online health insurance exchange.¹³ In 38 states, including Arizona, the federal Department of Health and Human Services (HHS) operates the exchange, which is usually referred to as the “Marketplace” and is accessible online at www.healthcare.gov/. The remaining states operate their own version of a marketplace or share the operation with HHS.

In order to be eligible to enroll in a Marketplace plan, an individual must:

- Be a citizen or legal resident of the United States;
- Not be incarcerated;
- Live in the Marketplace service area; and
- Not be enrolled in Medicaid or the Children’s Health Insurance Program (CHIP), known in Arizona as KidsCare.¹⁴

The ACA does not require insurers to sell individual health insurance exclusively on the Marketplace. Some insurers sell individual insurance both on and off the Marketplace. Other insurers sell only on the Marketplace or only off the Marketplace. Estimates of how nationwide Marketplace enrollment compares to non-Marketplace enrollment vary from 64%¹⁵ to 83%¹⁶ on the Marketplace. Most ACA healthcare reforms apply equally to health insurance plans sold on and off the Marketplace.

One distinction is that plans sold on the Marketplace have to meet certain network adequacy standards that do not apply to plans sold off the Marketplace.^{17,18} Another distinction is that consumers who shop for insurance on the Marketplace have access to online resources, all available through one website (www.healthcare.gov/) and some available only on that website. See Exhibit 3.

The most significant distinction between Marketplace insurance and non-Marketplace insurance is that the Marketplace provides access to the ACA's financial assistance for consumers who meet two criteria:

- Their employers do not offer insurance; and
- Their incomes are below 400% of the **Federal Poverty Level (FPL)**. In 2016, for a household of four, 400% of the FPL was \$97,200.¹⁹

Consumers who meet these criteria may qualify for an **advance premium tax credit (premium tax credit)** that reduces their premiums. Consumers that qualify for premium

tax credits and have incomes below 250% of the Federal Poverty Level are also eligible to enroll in designated plans that reduce their out-of-pocket costs for **deductibles, co-payments, and coinsurance** (collectively, **cost-sharing reduction or CSR**).^{20,21} Financial assistance is only available on the Marketplace, where consumers can shop for themselves using the resources at www.healthcare.gov/ or get in-person help establishing their eligibility for a premium tax credit or cost-sharing reductions, and assistance or information about applying for Medicaid and CHIP, if applicable.

In June 2016, HHS released enrollment figures showing that more than 11 million people were enrolled in the Marketplace in March 2016. Approximately 6.4 million (57.3% of Marketplace enrollees qualified for both cost-sharing reduction and the premium tax credit. An additional 3 million qualified for only the ACA premium tax credit. Together, almost 9.4 million (84.7%) of the Marketplace enrollees received financial assistance. Arizona's Marketplace enrollment in 2016 is shown in Exhibit 4.

EXHIBIT 3 Marketplace Shopping Resources



Resource	Available on www.healthcare.gov	Usually Available on Insurers' Websites
A calculator to show how financial assistance, if available, would decrease the cost of coverage	YES	YES
Comparison tools, including a mechanism for: <ul style="list-style-type: none"> • Estimating the cost of care across plans offered by different insurers • Taking into account financial assistance across plans offered by different insurers 	YES	NO
In-person assistance from people trained to assist consumers with establishing that they are eligible to enroll in a Marketplace plan and choosing among the available plans ^{20,21}	YES	NO
A list of covered prescription drugs (a formulary)	YES	YES
A provider directory	YES	YES
A glossary and other health insurance literacy tools	YES	YES

EXHIBIT 4 Marketplace Enrollment in 2016²

	Total Enrollees	Number of Enrollees with Premium Tax Credit	Percentage of Enrollees with Premium Tax Credit	Number of Enrollees with CSR	Percentage of Enrollees with CSR
Arizona	179,445	124,346	69.3%	94,463	52.6%
Nationwide	11,081,330	9,389,609	84.7%	6,353,551	57.3%

The Difference between an HMO and a PPO

HMOs began to appear in the health coverage arena in the 1980s. Their terms of coverage contrasted sharply with traditional health insurance and the increasingly popular PPO coverage that encouraged, but did not require, enrollees to use an established **network of providers**. In addition to requiring enrollees to use network providers, early HMO plans strictly controlled access to care. They assigned every enrollee to a **primary care provider (PCP)** and used the PCPs as “gatekeepers” who decided whether their patients should see specialists. HMO plans also required that enrollees get prior authorization for many services.

From the 1990’s until 2010 when the ACA took effect, many HMO plans lifted restrictions on access in order to compete

more effectively with PPO plans for enrollment. They stopped requiring enrollees to get referrals for specialty care. They still required enrollees to stay in the provider network for services but they broadened their networks. At the same time, PPO plans began to take stronger measures to keep enrollees in the network as much as possible in order to compete more effectively with HMO plans on price.²²

Even to seasoned health insurance enrollees, the distinction between an HMO plan and a PPO plan has come to matter less and less. Many of the 179,445 Arizona consumers who have enrolled in the Marketplace probably did not understand the choice they made when they chose between an HMO plan and a PPO plan. The difference is summarized in Exhibit 5.

EXHIBIT 5 Why Product Type (HMO or PPO) Matters

Arizona HMOs^{23,24}

With two exceptions, an HMO plan must require enrollees to stay in-network as a condition of coverage. If an enrollee chooses to go out-of-network, the services are excluded from coverage. The HMO plan pays nothing.

The two **network exceptions** are triggered in two situations where an enrollee is out-of-network involuntarily.

1. In an emergency, when the member does not have time to get to an in-network provider.
2. When there is not an appropriate provider in the network to meet the enrollee’s medical needs. Usually the HMO plan pre-approves and/or arranges for anticipated out-of-network care.

Because there are no optional out-of-network benefits in an HMO plan, there is no cost-sharing structure for out-of-network services. An HMO plan enrollee who is out-of-network involuntarily and qualifies for a network exception must be treated as though the services were in-network. The out-of-pocket cost-sharing cannot be any higher than it would be if the enrollee had been in-network.²⁵ The difference (balance) between what the HMO would pay an in-network provider and what the out-of-network provider claims is a balance that the HMO, not the enrollee, has to pay. In effect, this is better protection for the HMO enrollee than the ACA provisions that apply if a PPO enrollee incurs out-of-network expenses (see the box to the right).

Arizona PPOs

Generally, a PPO plan cannot require enrollees to stay in-network as a condition of coverage. With a few exceptions, a PPO plan must pay at least some of the costs for services that an enrollee obtains from out-of-network providers.

A PPO plan may set out-of-network cost-sharing requirements that are different from its network cost-sharing. Typically, a PPO enrollee who goes out-of-network has higher copayments and a higher coinsurance percentage than an enrollee who stays in-network. Prior to 2017, many PPO plans did not apply out-of-network cost-sharing to plan deductibles or have a separate deductible for out-of-network services. Arizona legislation passed in 2015 provides that effective January 1, 2017, out-of-network cost-sharing does apply to plan deductibles.²⁵ Currently, many PPO plans do not apply out-of-network cost-sharing to **out-of-pocket maximums**.²⁶

With two narrow exceptions created under the ACA, when a PPO plan processes a claim for out-of-network services, it does not matter whether the enrollee was out-of-network on purpose or not. The exceptions are:

1. A PPO plan must treat out-of-network emergency services as if they were in-network with regard to applying coinsurance and copayments but not with regard to applying deductibles or cost-sharing limitations.²⁷
2. Effective January 1, 2018, when a PPO enrollee receiving care from a network provider in a network hospital also receives care from an out-of-network ancillary provider such as an anesthesiologist, the PPO plan must apply out-of-network coinsurance to the enrollee’s out-of-pocket maximums.²⁸ This ancillary provider exception does not apply to emergency services or to HMO plans.²⁹

“SURVEYS AND OTHER ANECDOTAL REPORTS SUGGEST THAT MANY CONSUMERS WHO SELECTED NARROW NETWORK PLANS LARGELY ON THE BASIS OF LOWER PREMIUMS WERE UNAWARE OF THE NETWORK SIZE OF THE PLAN THEY SELECTED.” *Robert Wood Johnson Foundation Issue Brief* ²⁹

Consumer Assistance and Literacy

The healthcare reforms and protections enacted under the ACA and other protections available under state law are of limited help to consumers unless the consumers understand their coverage. Nonetheless, the evidence is clear that when choosing a plan, consumers tend to focus on cost rather than coverage.¹¹

About the ACA Preventive Service Benefits

Preventive services include shots, screenings, check-ups and counseling that help to prevent illness or to detect illness at an early stage.³⁰ The ACA requires health plans to provide many, but not all, preventive services without requiring any cost-sharing, even if the enrollee has not met his or her deductible. For more information, use this link: www.healthcare.gov/coverage/preventive-care-benefits/

Network size and composition are aspects of coverage that consumers often do not understand. According to a study conducted by McKinsey & Company in 2015, 44% of those who bought an ACA plan for the first time for coverage in 2015 reported that they did not know their plan’s network configuration.³¹ Moreover, many consumers do not understand what type of **product** they are choosing (HMO or PPO) and they may not have a realistic expectation of what their out-of-pocket expenses are likely to be. They often do not know how to navigate the rules of coverage once they are enrolled and, in some cases, they do not know what benefits are covered to start with.

For example, the ACA requires health plans to provide certain (but not all) preventive services without requiring any cost-sharing, even if the enrollee has not met his or her deductible. These services include immunizations, wellness visits and screenings. A 2016 Kaiser Family Foundation survey revealed that people with individual coverage in 2016 were confused about their preventive service benefits.

- Fewer than half (47 percent) knew that their health plans covered certain preventive services completely, with no cost-sharing.
- More than half (53 percent) thought that cost-sharing did apply to those preventive services or were not sure if it applied.¹⁵

Many consumers may not know what to do if they believe their health plan has wrongly denied coverage. They may not know that Arizona law requires health plans to provide their enrollees with a way to appeal denials, first with an internal appeal to the health plan itself, and then with an appeal to an external independent reviewer.³²

In May 2015, the Consumer Reports National Research Center published the results of a nationally representative survey of consumer experiences with private health insurance.³³ Results showed:

- Two-thirds of privately insured Americans are uncertain about which state entity is responsible for resolving issues with health insurance billing.
- Most (87%) don’t know the state agency/department tasked with handling health insurance complaints.
- Many (72%) are unsure if they have the right to appeal to the state/an independent medical expert if their health plan refuses coverage for medical services they think they need.

The need for better consumer literacy about health coverage is not new under the ACA. It is, however, newly apparent in the aftermath of millions of first-time enrollments as of January 1, 2014. Drafters of the ACA anticipated the need and took a proactive approach by requiring that every Marketplace assist consumers with enrolling in Marketplace plans.³⁴ HHS promulgated an administrative rule that set standards for specially trained **navigators** as well as “non-navigator assistance personnel” such as certification application counselors (CACs) to carry out consumer assistance functions (the Navigator Rule).³⁵ The standards in the Navigator Rule focus on preparing navigators to assist consumers with obtaining coverage, for example with establishing Marketplace eligibility and choosing among the available Marketplace plans.³⁶ In March 2016, HHS amended the Navigator Rule to require that effective January 1, 2018, navigators in Marketplaces must be able to provide consumers with post-enrollment assistance, including understanding basic concepts related to using health coverage.³⁷ Navigators will also be required to provide targeted assistance to vulnerable or underserved populations.³⁸

In 2014, the Arizona legislature implemented a licensing process for navigators and CACs. Among other consumer protection measures, the Arizona law requires navigators and CACs to undergo a criminal background check and prohibits navigators and CACs from engaging in certain activities that could constitute a conflict-of-interest.³⁹

Cover Arizona, a statewide coalition of more than 1,000 member organizations and individuals, is dedicated to improving access to healthcare coverage across Arizona. The Coalition provides a forum for navigators and CACs to coordinate enrollment outreach across the state. More information is available at: www.CoverAZ.org. Navigators have been integrally involved in Arizona’s Marketplace enrollment (as well as enrollment in AHCCCS and KidsCare) since enrollment began, with Marketplace enrollment of 91,529 people in 2014, 165,016 people in 2015 and 179,445 people in 2016.²

Cover Arizona already promotes post-enrollment health coverage literacy. For example, Cover Arizona distributes HHS’s “Coverage to Care” materials (www.healthcare.gov/using-marketplace-coverage/improving-your-health/) when navigators meet with Marketplace applicants to discuss enrollment. In that setting, navigators can assist consumers in both choosing a plan and in learning how to use it. According to Allen Gjersvig, Director of Navigator and Enrollment Services at the Arizona Alliance for Community Health Centers (AACHC), navigators and non-navigator personnel in Arizona already provide post-enrollment assistance. Mr. Gjersvig says the changes to the HHS Navigator Rule are a matter of the regulations catching up to actual practice.⁴⁰



USE THIS LINK FOR ACCESS TO THE *CONSUMER GUIDE TO THE HEALTH CARE APPEALS PROCESS IN ARIZONA* FROM THE ARIZONA DEPARTMENT OF INSURANCE:

insurance.az.gov/sites/default/files/documents/files/Consumer_Guide_to_Health_Care_Appeals%207%20May%202015.pdf

Insurer Participation

Changes in the Marketplace, 2014–2017

In its first year, the Marketplace in Arizona was among the most competitive of the 36 Marketplaces then operated by HHS. The number of Arizona insurers matched the national average of eight insurers per state,⁴¹ and the predominant product in each of Arizona’s 15 counties was the PPO. In its fourth year, the Marketplace in Arizona will have two insurers. See Exhibit 6.

EXHIBIT 6 Insurers and Products Per Arizona County, 2014–2017

Insurer	Plan Type	Number of Counties Served			
		2014	2015	2016	2017
Aetna	PPO	15	15	0	0
Blue Cross Blue Shield	PPO	15	15	0	0
Cigna	PPO	15	15	0	0
Health Net	PPO	14	15	0	0
Meritus aka Compass	PPO	15	15	0	0
UnitedHealthcare	PPO	0	15	15	0
Aetna	HMO	0	0	1	0
Blue Cross Blue Shield	HMO	0	2	15	14
Cigna	HMO	0	0	1	0
Health Choice	HMO	8	15	7	0
Health Net/Ambetter	HMO	2	3	2	2
Humana	HMO	2	2	2	0
Meritus aka Compass	HMO	3	3	0	0
Phoenix Health Plans	HMO	0	1	1	0
University of Arizona Health Plans	HMO	10	9	0	0

In 2017, no insurer will offer a PPO plan in the Marketplace in any Arizona county. Blue Cross Blue Shield of Arizona will be the only insurer offering HMO plans in 13 counties. Centene (aka Health Net or Ambetter), will be the only insurer offering HMO plans in Maricopa County, and will also be offering plans in Pima County, where it will compete with BCBS-AZ.

Depending on the fate of the Marketplace following the 2016 elections, it is possible that a PPO insurer will seek to operate on the Marketplace in 2018. However, five of the PPO insurers previously on the Marketplace have taken themselves out of the running by officially withdrawing not just from the Marketplace but also from the state of Arizona. See Exhibit 7.



These companies cannot return at will. Under federal law and parallel Arizona law, an individual insurer that withdraws from the state cannot return to the individual market or the ACA Marketplace in Arizona for five years.⁴² In addition, the economic factors that motivated PPO insurers to leave the Marketplace in Arizona probably will not lift in the short term. Arizona insurers cite the need to trim losses on the Marketplace as a reason for dropping PPOs in favor of HMOs.²²

EXHIBIT 7 Marketplace PPO Exits from Arizona

PPO Insurer	Marketplace Participation	Effective Date of Withdrawal from Arizona
Aetna Life Insurance Company	2014, 2015	January 1, 2016
All Savers Insurance Company	2016	January 1, 2017
Health Net Life Insurance Company	2014–2016	January 1, 2017
Humana Life Insurance Company	2014–2016	January 1, 2017
UnitedHealthcare Life Insurance Company	2015	January 1, 2017

No PPOs and Fewer HMOs: The Impact on Affordability and Consumer Options

The HMO insurers offering plans on the Marketplace in Arizona in 2017 filed their 2017 premiums, cost-sharing requirements and network rosters with the Arizona Department of Insurance (ADOI) in Fall 2016. As a result, some impacts of the absence of PPO plans in the Marketplace will not be felt directly until 2018, at the earliest. When the effects begin to take hold, the impact on consumers will be mixed.

The one PPO insurer participating on the Marketplace in Arizona in 2016 had the largest share (35%) of the total 2016 Marketplace enrollment of 179,445.⁴³ The most immediate effect of this PPO’s departure is that in 2017, approximately 62,805 enrollees statewide will need to move to HMO coverage with a different insurer if they want to stay in the Marketplace. They will have the option to enroll in a PPO plan offered off the Marketplace. However, financial assistance in the form of premium tax credits or cost-sharing reductions is only available on the Marketplace. In the near term, many current PPO enrollees will have to choose between the greater affordability of Marketplace HMO coverage and the plan features which drew them to PPO coverage to start with.

“INSURERS OPERATING IN RURAL AREAS REPORTED LESS COMPETITION AMONG CARRIERS THAN IN URBAN AREAS; THUS, THEY HAD LESS INCENTIVE TO LOWER PREMIUMS TO ATTRACT PRICE CONSCIOUS CONSUMERS.”

Robert Wood Johnson Foundation⁴⁵

Conventional wisdom holds that HMO coverage is less expensive than PPO insurance coverage. A *Kaiser Health News* study of 2016 premiums in the 38 Marketplaces nationwide appears to validate the conventional wisdom. The study finds that the national average premium for the least expensive HMO silver plan was lower than the national average premium for the least expensive PPO **silver plan**, and had increased less since 2015. See Exhibit 8.⁴⁴

EXHIBIT 8 Comparison of 2016 HMO and PPO Premiums

	Least Expensive HMO Silver Plan	Least Expensive PPO Silver Plan
Average Premium 2015	\$274	\$291
Average Premium 2016	\$299	\$339
Percentage Change 2015-2016	9%	17%

It can be argued that Arizona consumers will be better off in 2017 with their choice limited to HMO plans, which generally have lower premiums to start with and experience smaller premium increases than PPO plans. It can also be argued that Arizona Marketplace consumers do not benefit from losing the option to select PPO coverage if that is what they want and can afford.

The nature of the HMO plan structure is likely to reduce the incidents of **surprise bills**, which in many cases result from the collision of high cost-sharing requirements and a narrow PPO network. (Narrow networks and surprise bills are explained in more detail below.) Moreover, Arizona has in place HMO network adequacy standards, provider directory standards and a **balance billing law**, none of which exists for Arizona PPO plans. If regulators have adequate resources for enforcement, this structure should give HMO enrollees regulatory protection they would not have as PPO enrollees.

Among the many factors that influence premiums, competition is known to keep prices down. As explained in a Robert Wood Johnson Foundation study of 2016 premiums for lowest-cost silver plans, “rating areas with more competitors had significantly lower premiums and lower rates of increase than those that did not.”⁴⁵

Without PPOs in the Marketplace, there can be no competition between product types, that is, between PPOs and HMOs. In 14 counties, there will be only one HMO. With the exception of Maricopa County, these counties are predominantly rural. The particular significance of rural competition was noted in the Robert Wood Johnson Foundation study referred to above. “Insurers operating in rural areas reported less competition among carriers than in urban areas; thus, they had less incentive to lower premiums to attract price conscious consumers.”⁴⁵

Finally, a trend toward less PPO participation on the Marketplace creates an opportunity to study what happens to affordability and network adequacy without PPOs and to shape policy accordingly. There is also an opportunity to look at what happens to plan compliance and how regulators respond to the relative dominance of HMO coverage. In most jurisdictions, and certainly in Arizona, HMO plans function under considerably more regulatory requirements and oversight than do PPO plans. It may follow that the more that HMO coverage dominates a market, the more likely it is that enrollees will receive the required coverage and full panoply of benefits. It may also follow that when that dominance is concentrated in the hands of just a few HMO insurers, regulators’ efforts to monitor and increase compliance can also be more concentrated and thereby more effective.



Affordability: The Impact of Cost-Sharing

Individual health insurance plans typically require cost-sharing (also called out-of-pocket costs) when enrollees receive a healthcare service covered by their plan. Cost-sharing generally consists of deductibles, coinsurance, copayments or a combination of these.^{46,47} Enrollees pay cost-sharing in addition to paying premiums. The ACA sets an annual maximum out-of-pocket limit on cost-sharing for covered services. In 2016, the limit is \$6,850 for an individual and \$13,700 for a family.⁷

Deductibles

Deductibles were common well before the ACA went into effect and are prevalent in the Marketplace. In 2016, 99.7% percent of Marketplace bronze plans have deductibles, as do 98% of Marketplace silver plans.⁴⁸ Implementation of the ACA has triggered many references to “high deductibles” but

the term is not useful as a way to define the impact of the ACA on deductibles.* Deductible amounts that some sources label as high actually are lower than the average deductible for bronze, silver or gold plans in the Marketplace. At the same time, 70% of silver plan enrollees who qualify for CSR have a deductible which is less than one-third of the average silver deductible without CSR. See Exhibit 9.

Even among silver plan members who do not qualify for CSR, thirty-two percent have deductibles of less than \$1,000.⁵² It is important to remember, however, that for consumers, especially those who do not qualify for the premium tax credit or for CSR, a low deductible is not a hallmark of affordability. In many cases, low deductibles and other low cost-sharing represent a trade-off, based on the fact that as a general rule, the lower the cost-sharing expense, the higher the premium.^{54,55,56}

* Because plan structures vary from Marketplace to Marketplace as well as within each Marketplace, nationwide study results and nationwide data are hard to put into context and hard to reconcile from one source to another. Study authors do not always clarify (1) whether an average silver plan deductible is expressed with or without CSR, (2) whether an average deductible applies to an individual or a family, (3) whether data on deductibles includes non-Marketplace plans or ACA non-compliant (“grandfathered”) plans, and (4) whether data for the individual plans is segregated from data for employer-based plans.

EXHIBIT 9 Ranges of Deductibles

“High Deductible” Examples	
The Internal Revenue Service	\$1,300 or more (2016) ⁴⁹
The Commonwealth Fund	5% or more of household income (2015) ⁵⁰
The Kaiser Family Foundation	\$1,500 or more (2016) ¹⁵
Families USA	\$1,500 or more (2015) ⁵¹
Average Deductible Nationwide, Without CSR (2016) ⁴⁸	
Bronze	\$5,724
Silver	\$3,100
Gold	\$1,527
Platinum	\$484
Median** Deductible Nationwide, With CSR (2016) ⁵²	
Silver (low CSR)	\$2,500
Silver (medium CSR)	\$500
Silver (high CSR)	\$100

** “Median” is the middle number value in a series of numbers arranged from lowest to highest. It may be higher or lower than the average of the numbers.⁵³

IT IS IMPORTANT TO REMEMBER, HOWEVER, THAT FOR CONSUMERS, ESPECIALLY THOSE WHO DO NOT QUALIFY FOR THE PREMIUM TAX CREDIT OR FOR CSR, A LOW DEDUCTIBLE IS NOT A HALLMARK OF AFFORDABILITY. IN MANY CASES, LOW DEDUCTIBLES AND OTHER LOW COST-SHARING REPRESENT A TRADE-OFF.

Copayments and Coinsurance

FROM THE GLOSSARY

COPAYMENT

A copayment is a fixed amount that a consumer is responsible for paying for a covered healthcare service, even after meeting the deductible.

COINSURANCE

Coinsurance is a percentage of costs that a consumer is responsible for paying for covered healthcare services, even after meeting the deductible.

Like deductibles, copayments and coinsurance are not new to the health insurance arena. Also like deductibles, copayments and coinsurance have an inverse relationship with premiums. As explained in the HealthCare.gov glossary, “Generally, plans with lower monthly premiums have higher copayments [or coinsurance or deductibles]. Plans with higher monthly premiums usually have lower copayments [or coinsurance or deductibles].”^{54,55,56}

While copayments and coinsurance are not innovations, they play a more prominent role in many ACA plans than they did in most pre-ACA plans. This is especially true in bronze and silver plans. For example, a broader range of services, such as lab work or x-rays, may require a copayment. A service that once required only a co-payment, such as a visit to a primary care provider or a drug prescription, may now also require coinsurance.^{46,47} Coinsurance amounts are usually presented as a percentage of the health plan’s **allowed amount**, making them difficult for the enrollee to estimate. See Exhibit 10 and Example A.

Three primary factors affect the amount of an enrollee’s coinsurance. One factor is the actuarial value of the plan. In general, the lower the actuarial value of the plan, the lower the premium and the higher the cost-sharing requirements, including coinsurance. See Exhibit 2. As a result, bronze plans usually have lower premiums

EXHIBIT 10 National Average Copayments and Coinsurance

2016 National Copayment Averages ⁴⁷			2016 National Coinsurance Averages ⁴⁷		
In-network Service	Bronze	Silver	In-network Service	Bronze	Silver
PCP Visit	\$41	\$28	PCP Visit	31%	23%
Specialist Visit	\$81	\$58	Specialist Visit	32%	24%
Emergency Room Visit	\$430	\$363	Emergency Room Visit	34%	26%
Preferred Drug	\$67	\$48	Preferred Drug	67%	48%
Inpatient Physician Visit	Not Available	Not Available	Inpatient Physician Visit	34%	26%

EXAMPLE A The Impact of Copayment and/or Coinsurance

Ms. Kahn is an Arizona resident enrolled in 2016 in a silver plan that has the cost sharing requirements illustrated in Exhibits 9 and 10. Ms. Kahn does not qualify for CSR. Having met her deductible of \$3,100, she goes to see Dr. Alvarez, a specialist in her plan network. The health plan’s allowed amount for this visit is \$150. Depending on how Ms. Kahn’s cost-sharing requirements are structured:

Ms. Kahn will pay a \$58 copayment at the time of her visit.

OR

Ms. Kahn will receive a bill from Dr. Alvarez for \$36 to cover her 24% coinsurance requirement.

OR

Both, in which case, Ms. Kahn’s total cost-share for this visit will be \$94.

and higher cost-sharing requirements than silver plans. Silver plans without CSR usually have lower premiums and higher cost-sharing requirements than gold plans.

The second factor is whether the enrollee’s plan is structured as an HMO or PPO. See Exhibit 5.

The third factor is whether the enrollee’s provider is in the plan network. A study published by the Leonard Davis Institute of Health Economics in 2015 found that nationwide, cost-sharing is twice as high in PPO plans as in HMO plans because PPO plans cover out-of-network services, for which the enrollee pays extra. According to the Leonard Davis Institute study:

- In PPO silver plans using coinsurance, the average is 50% for out-of-network services compared to 25% for in-network services.
- In PPO silver plans using copayments for in-network primary and specialty care, the copayments range from \$22-\$28 for primary care and \$55-\$60 for specialty care.

In those plans, going out-of-network also results in co-insurance rates of 50%.

- PPO silver plans have higher average deductibles out-of-network (\$6,400-\$6,500) than in-network (\$2,700).²⁹

Surprise Billing

Surprise bills usually arise when a PPO plan enrollee inadvertently obtains services from an out-of-network provider, usually in a network hospital. The key word here is “inadvertently.” In an inpatient setting, a patient often receives services from an array of providers whom the patient does not choose, or even see, such as anesthesiologists, radiologists, and pathologists. In such circumstances, a patient might be unable to make an informed or practical choice of provider based on network status. Under the terms of virtually all PPO plans offered in Arizona, however, the plan is entitled to treat non-emergency out-of-network services as out-of-network, no matter why they are out-of-network. See Example B.

EXAMPLE B How Provider Network Status and Surprise Bills Affect Cost-sharing

Ms. Jones and Ms. Garcia deliver their babies within weeks of each other at the same hospital. They are enrolled in the same Marketplace individual PPO plan, they deliver at the same network hospital, they have the same network obstetrician and they both receive epidurals during labor. Neither is told beforehand who her anesthesiologist will be.

Soon after Ms. Jones’ baby is born, she receives a bill of \$1,000 for anesthesiology services. At about the same time, Ms. Garcia receives a bill for \$250 for anesthesiology services. Why the difference? Ms. Garcia’s anesthesiologist was in her PPO provider network. Ms. Jones’ anesthesiologist was not.⁵⁷

Ms. Garcia’s Network Benefits

- The network provider submits a claim to the PPO plan for \$1,500.
- The plan processes the claim at its allowed amount of \$1,000.
- The plan applies a coinsurance rate of 25% for network anesthesiology services and pays the network provider \$750.
- The network provider accepts the allowed amount and bills Ms. Garcia \$250 for her coinsurance requirement.

Ms. Jones’ Out-of-Network Benefits

- The out-of-network provider submits a claim to the PPO plan for \$1,500.
- The plan processes the claim at its allowed amount of \$1,000.
- The plan applies a coinsurance rate of 50% for out-of-network anesthesiology services and pays the out-of-network provider \$500.
- The out-of-network provider bills Ms. Jones \$1,000 (the difference between the billed charges of \$1,500 and the plan payment of \$500).

Cost to the PPO plan: \$750, Cost to Ms. Garcia: \$250

Cost to the PPO plan: \$500, Cost to Ms. Jones: \$1,000

ARIZONA LAW PROTECTS HMO ENROLLEES FROM OUT-OF-NETWORK PROVIDER BILLS AS LONG AS THE ENROLLEE'S SITUATION IS A NETWORK EXCEPTION. FOR NETWORK EXCEPTIONS, THE HMO PLAN IS OBLIGATED TO COVER THE AMOUNT OF THE BALANCE BILL.

Emergency situations also give rise to surprise bills. Under the ACA provisions regarding emergencies, a PPO plan must treat out-of-network services as if they were in-network with regard to applying coinsurance and copayments, but not with regard to applying deductibles or cost-sharing limitations.⁵⁸ A PPO plan enrollee is still subject to a surprise bill because he or she may have to pay, in addition to the network cost-sharing, the difference between the amount the plan pays the out-of-network provider and the amount charged by the out-of-network provider.²⁸ See Example C. PPO plans usually are not obligated to pay the amount of a surprise bill.

Arizona law protects HMO enrollees from out-of-network provider bills as long as the enrollee's situation is a network exception. For non-emergency care, HMO plans are required to assist enrollees in finding network care and it is in their financial interests to do so in order to avoid the expense of covering extra out-of-network costs.⁵⁹ If Ms. Garcia and Ms. Jones were enrolled in an HMO plan, it is highly likely that the plan and the hospital and the anesthesiologists would have arranged ahead of time to have an in-network anesthesiologist available to take care of both women. If the HMO plan knew that no network anesthesiologists were available or in an emergency, the HMO plan would have to treat the out-of-network services as a network exception and ensure that they did not cost the enrollee more than in-network services. See Exhibit 5.⁶⁰ For network exceptions, the HMO plan is obligated to cover the amount of the **balance bill**.

Arizona law requires every HMO plan to have an "effective process" for handling network exceptions. See Exhibit 11.

EXHIBIT 11 Key Components of an HMO Effective Process

Arizona Administrative Code (AAC) R20-6-1910(A)

The HMO plan must assist an enrollee to obtain timely covered services when the enrollee or enrollee's referring provider cannot find a contracted provider who is timely accessible or available.

AAC R20-6-1910(B)

During normal business hours, the HMO plan must handle referrals, prior authorizations, or network exceptions as necessary for timely routine care.

AAC R20-6-1910(E)

The plan must handle network exceptions in a way that assures that the HMO plan reimburses an enrollee for any out-of-network cost the enrollee incurs that the enrollee would not have incurred if the enrollee had received the services in-network.

It is the case, of course, that HMO enrollees sometimes receive balance bills from out-of-network providers who have taken care of them. Some out-of-network providers automatically bill the enrollee instead of the HMO plan, especially after providing emergency services. Sometimes a network exception is not accurately or timely recognized in the HMO plan system. Sometimes there is a dispute between the HMO plan and the enrollee about whether out-of-network services qualify as a network exception and the HMO plan denies coverage of the out-of-network services. In that situation, the enrollee can file a healthcare appeal with the plan.^{61,62}



EXAMPLE C **How Product Type and Surprise Bills Affect Emergency Services Cost-sharing**

Mr. Smith (who is enrolled in an HMO silver plan) cuts his hand badly in the kitchen. The same day, Mr. Robbins (who is enrolled in a PPO silver plan) crushes his hand in a rock-climbing accident. Both men go the emergency room at the nearest hospital. The hospital and emergency room staff are in the provider network offered by each man’s health insurance plan. Neither man has been to the doctor yet this year.

The emergency room doctor calls in a hand surgeon to evaluate each man’s injuries. Both men are anxious and in pain; neither thinks to ask whether the hand surgeon is in-network. The surgeon decides that Mr. Robbins will not suffer medically if he waits a day or two to have his hand repaired in an out-patient setting. She thinks it is medically necessary to take care of Mr. Smith’s injuries immediately and she does so.

Mr. Smith’s HMO Benefits for Out-of-Network Emergency Services

Several weeks later after his visit to the emergency room, Mr. Smith receives a notice from his HMO plan informing him that:

- The hand surgeon, who was out-of-network, has submitted a claim for \$30,000 for the emergency services she provided to Mr. Smith.
- For purposes of determining Mr. Smith’s cost-sharing responsibilities, the HMO plan has processed the claim as in-network, as required by Arizona HMO law.⁶⁰
- Mr. Smith’s coinsurance requirement for network specialty care is 25% of the HMO plan’s allowed amount. The plan’s allowed amount for these services is \$8,000. Twenty-five percent of \$8,000 is \$2,000.
- The HMO plan has paid the hand surgeon 75% of the allowed amount, or \$6,000.
- Mr. Smith will receive a coinsurance bill from the hand surgeon for \$2,000.
- There is a difference of \$22,000 between the hand surgeon’s claim for \$30,000 and the allowed amount of \$8,000.
- Under Arizona law, the HMO must assure that the out-of-network services do not cost Mr. Smith more than he would have paid for the same services if they had been in-network. If the out-of-network hand surgeon does not accept the plan’s allowed amount of \$8,000 and bills the plan for the difference of \$22,000, the HMO plan, and not Mr. Smith, will be responsible for paying the HMO’s balance of \$28,000.

Mr. Robbins’ PPO Benefits for Out-of-Network Emergency Services

Several weeks later after his visit to the emergency room, Mr. Robbins receives a notice from his PPO plan informing him that:

- The hand surgeon, who was out-of-network, has submitted a claim for \$10,000 for the emergency services she provided to Mr. Robbins.
- For purposes of determining Mr. Robbins’ copayment or coinsurance responsibilities, the PPO plan has processed the claim as in-network, as required by the ACA.⁵⁸
- Mr. Robbins’ coinsurance requirement for network specialty care is 25% of the PPO plan’s allowed amount. The plan’s allowed amount for these services is \$3,000. Twenty-five percent of \$3,000 is \$750.
- The PPO plan has paid the hand surgeon 75% of the allowed amount, or \$2,250.
- Mr. Robbins will receive a coinsurance bill from the hand surgeon for \$750.
- There is a difference of \$7,000 between the hand surgeon’s claim for \$10,000 and the allowed amount of \$3,000.
- Neither federal nor state law requires the PPO plan to pay (cover) the difference of \$7,000 between the hand surgeon’s claim for \$10,000 and the allowed amount of \$3,000. If the out-of-network hand surgeon does not accept the plan’s allowed amount of \$3,000 and bills Mr. Robbins for the difference of \$7,000, Mr. Robbins, and not the PPO plan, is responsible for paying Mr. Robbins’ balance of \$7,000.

Cost to the HMO plan: \$28,000, Cost to Mr. Smith: \$2,000

Cost to the PPO plan: \$2,250, Cost to Mr. Robbins: \$7,750



Sometimes, for example if the enrollee has chosen to see an out-of-network provider or even inadvertently has seen an out-of-network provider without approval from the HMO plan, there is no network exception. As noted in Exhibit 5, if an HMO enrollee goes out-of-network without a network exception, the HMO plan pays nothing.

The Commonwealth Fund recently reported that nationwide, about 23% of 2016 Marketplace enrollees reported they had received a surprise medical bill.⁶³ Surprise bills have been an issue as long as coinsurance has been part of PPO plan structures, but they may cause new levels of concern under the ACA for several reasons:

- Private insurance enrollment has jumped; more people have coverage and are using it than in the past.
- Coinsurance is imposed in more plans than it used to be.
- Coinsurance percentages are higher than they used to be.
- PPO provider networks are smaller than they used to be and an enrollee is more likely to opt out of a network to find a provider who is nearby, familiar or otherwise appealing. See “Narrow Networks” below.

Comparative Approaches to Surprise Billing

Arizona’s approach to surprise bills is typical of a number of states.⁶⁴ The HMO laws protect HMO enrollees from surprise bills in network exceptions; the PPO laws do not. See Exhibit 5.

In 2015, the Arizona state legislature enacted ARS §§ 32-3216(K) and 36-437(L), which took effect January 1, 2017. These laws stipulate that if an enrollee pays any out-of-network provider directly for covered services, the provider must give the enrollee a receipt. The law states that the amount paid by the enrollee shall be applied first to the enrollee’s in-network

deductible with any remaining monies being applied to the enrollee’s out-of-network deductible, if applicable.

HMO plan enrollees do not gain protection from this law. HMO plans cannot include an out-of-network option and therefore cannot include an out-of-network deductible. HMO plan enrollees who receive covered services out-of-network because of a network exception are not responsible for any out-of-network costs. See Exhibit 5. The possible benefits of the law for Arizona PPO plan enrollees are not clear and may be misplaced in a statute that is not directed to insurers and not included in the Insurance Code (ARS Title 20).

A 2015 study by the Robert Wood Johnson Foundation provides a detailed look at the approaches in California, Colorado, Florida, Maryland, New York and Texas.⁶⁴ The most far-reaching approach with an impact on PPOs took effect in New York to hold the enrollee harmless for any cost beyond the plan’s in-network cost-sharing requirements. When non-emergency services trigger a surprise bill, patients who receive surprise out-of-network bills can assign their benefit to the provider, who can bill the health plan directly. Those enrollees are then held harmless for anything more than cost sharing at an in-network level. Out-of-network providers are prohibited from balance billing the patient. If the providers are not satisfied with the amount of the health plan payment, they may follow a dispute resolution process.^{65,66,67}

Texas does not prohibit providers from sending surprise bills for out-of-network services. Texas has taken action, however, with a twofold approach. First, in both emergency and non-emergency situations, Texas requires PPO plans to pay at least the **usual and customary rate** for the services, thereby setting a floor for reimbursement which may be higher than the plan’s allowed amount. Texas has also established a mediation process that consumers can use to seek mediation if the balance bill from a single out-of-network provider is more than \$1,000.

Second, Texas has instituted disclosure requirements, under which plans must use their provider directories to:

- Identify hospitals that have agreed to facilitate the use of in-network providers.
- Disclose the percentage of out-of-network claims filed by providers at each contracted hospital, by provider type.
- Identify all contracted providers at network facilities and specify those facilities without any contracts with a particular type of provider.⁶⁴

In November 2015, the National Association of Insurance Commissioners (NAIC) adopted the Health Benefit Plan Network Access and Adequacy Model Act (the NAIC Model Act), which includes surprise billing provisions.⁷⁰ The NAIC Model Act takes essentially the same approach to emergency surprise bills as does the state of New York.

Under the NAIC Model Act, if an enrollee receives non-emergency services from an out-of-network provider at an in-network facility, the plan must handle the cost as if the services were in-network. The provider may bill the enrollee for the amount the plan will not cover as long as the provider notifies the enrollee of his or her option to accept the charges, request assistance from their plan, or rely on any available legal rights or remedies.

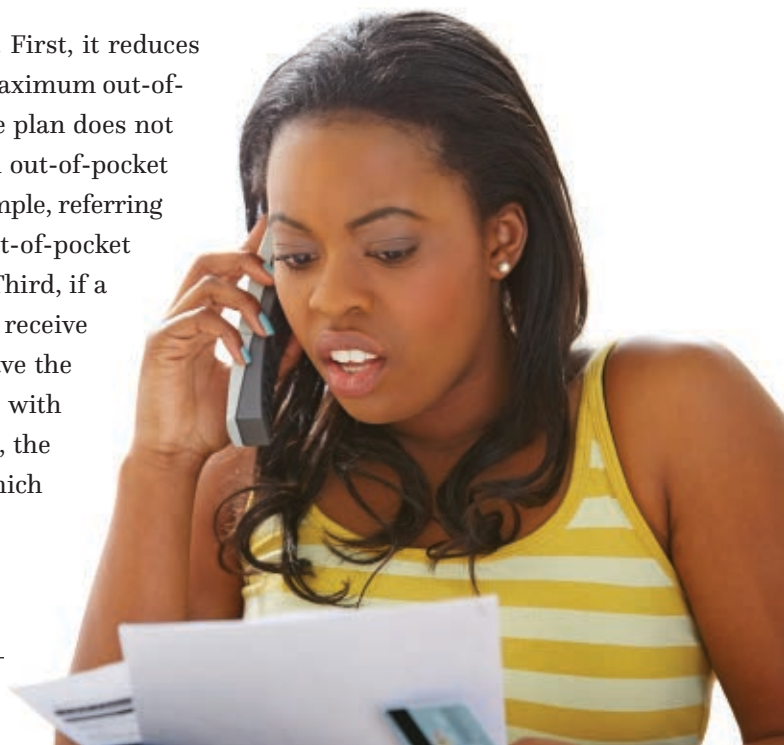
Finally, in March 2016, HHS promulgated a rule (the Ancillary Provider Rule) that takes a step toward addressing surprise bills for PPO plan enrollees.²⁶ Effective January 1, 2018, if an enrollee receives services from an out-of-network “ancillary provider” (such as an anesthesiologist or radiologist) at an in-network facility, the plan must apply the out-of-network cost-sharing to the plan’s maximum out-of-pocket limit. This provision does not apply if the plan gives notice 48 hours ahead of time or at the time of prior authorization that treatment might be received from out-of-network providers and might trigger out-of-network cost-sharing.²⁸

The Ancillary Provider Rule is meager protection for enrollees. First, it reduces the out-of-pocket cost-sharing only if the enrollee exceeds the maximum out-of-pocket limit and only for the amount over the limit. Second, the plan does not have to apply the entire out-of-pocket expense to the maximum out-of-pocket limit, only the amount the plan requires for cost-sharing. For example, referring to Example B, the plan would apply only \$500 to Ms. Jones’ out-of-pocket limit, even though her total out-of-pocket expense was \$1,000. Third, if a plan provides the optional advance notice that an enrollee may receive treatment from an out-of-network provider, the notice may leave the enrollee 48 hours away from scheduled treatment, apparently with the entire responsibility for finding a network provider. Finally, the Ancillary Provider Rule does not apply to emergency care,²⁶ which can generate very large surprise bills.

WHAT IS AN NAIC “MODEL ACT?”

The NAIC is a regulatory support organization governed by the chief insurance regulators from all 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate regulatory oversight.⁷⁸

The NAIC develops model statutes and rules that address current regulatory issues. NAIC models are not binding. They include drafting notes, guidance and alternative provisions that states can refer to when developing their own standards.⁶⁹



Cost-Sharing Financial Assistance and Protection

There are some regulatory and non-regulatory factors that can lessen the financial burden that cost-sharing can impose on enrollees:

- Consumers who meet certain income requirements have their cost-sharing obligations reduced for silver level plans. See “The Role of the Marketplace” above.
- The ACA does away with the long-standing, pre-ACA practice among plans of setting an annual benefit limit and/or a lifetime benefit limit.⁴⁷ See Exhibit 1.
- The ACA sets an annual limit on cost-sharing for covered services. See Exhibit 1. The maximum out-of-pocket limit for any 2016 Marketplace plan is \$6,850 for an individual plan and \$13,700 for a family.⁷ This benefit is particularly valuable for HMO plan enrollees and PPO plan enrollees who stay in-network. It is less valuable to PPO enrollees who go out-of-network for their services and incur costs that the PPO plan does not cover, as reflected in surprise bills. A plan must exclude certain preventive services, including specified immunizations, annual wellness

visits and cancer screening from the deductible. This means the plan must pay for those services even if the enrollee has not met the deductible amount. This does not apply to all preventive services. See *About the ACA Preventive Service Benefits*, in “Consumer Assistance and Literacy” above.

- In addition to excluding certain preventive services from deductibles, some plans offer benefits that exclude other services from the deductible.⁷¹ For example, the **second lowest cost silver plan** offered in Phoenix for 2016 covers generic drugs, primary care visits and outpatient mental healthcare before the deductible is met.⁷¹
- Paying out-of-pocket for cost-sharing expenses under an insurance plan is likely to be less expensive than paying out-of-pocket for healthcare service expenses without insurance. At least while they are in-network, insurance enrollees will pay a percentage of the discounted rate the plan has negotiated with the provider. People without insurance will pay the provider’s full, undiscounted rates unless they can negotiate a discount on their own.



What Can Be Done About Affordability and Cost-sharing?

Add HMO Focus to Consumer Literacy and Awareness

For Arizona Marketplace consumers who enrolled in coverage for 2017, plan selection is limited to HMO plans. Plan selection for 2018 probably will have the same limitation. Consumers could benefit from assistance in focusing on HMO coverage factors that are most relevant to them. These factors include:

- Who is in the network? Am I looking for any particular provider or multiple providers?
- Do I need providers who have experience treating certain illnesses or conditions?
- What happens if my doctor leaves the network?
- Does my plan require me to get a referral before I see a specialist?
- What steps can I take before getting services to be sure I am in the network and the services are covered?
- What should I do if I think I need to see a provider who is not in the network?
- Are my prescription drugs in my plan formulary?
- Under the ACA, every plan has to exclude certain preventive services from any deductible. What are those services? Does this plan exclude anything else, such as generic drugs or primary care visits or outpatient mental healthcare?
- What steps can I take if I get a surprise bill?
- What steps can I take if my plan denies coverage of a benefit?

THE LIST OF QUESTIONS TO THE LEFT CAN HELP DETERMINE APPROPRIATE HMO COVERAGE BASED ON FACTORS THAT ARE MOST IMPORTANT TO THE CONSUMER.

Increase Provider Literacy and Awareness

There are anecdotal reports that recently some Arizona hospitals have posted notices alerting hospital-based physicians to the issues that arise when they provide services to patients enrolled in plans with which the physician is not contracted. Such notices probably are too little, too late to help on an enrollee-by-enrollee basis, but they underscore the provider's ultimate responsibility for communicating with enrollees about network status and related billing implications. Insurers, provider associations, consumer groups and other providers can take steps to build awareness among providers of the negative impact that surprise bills have on patients. This approach would benefit HMO plan enrollees as well as PPO plan enrollees, by reducing the chance that an HMO enrollee would receive out-of-network services outside of a network exception.



Require Standardized Plans

With regard to cost-sharing in general, the Ancillary Provider Rule provides an option for insurers to offer standardized Marketplace plans that include:

- Standard deductibles and other cost-sharing requirements; and
- Standard exclusions from deductibles for services such as physician office visits, urgent care visits, mental health and substance-use disorder outpatient visits, and prescription drugs.^{26*}

This standardization could benefit both PPO plan enrollees and HMO plan enrollees. It might not directly lower consumers' out-of-pocket costs, but it would simplify plan choice and also allow greater certainty about the cost of services when coverage is in force. The standardized plans are optional under federal law but Arizona policy makers could require them in Arizona.

* The ACA already requires standardization and transparency for individual market coverage. For example, for every plan, insurers must publish a standardized Summary of Benefits and Coverage (SBC) that summarizes the cost-sharing requirements of the plan's required cost sharing for in-network and out-of-network services for "common medical events" that range from a doctor's visit to an ER visit. The SBC is supposed to allow consumers to compare apples to apples by standardizing plan descriptions from one insurer to the next. It does not, however, standardize the plans themselves. <http://kff.org/health-reform/issue-brief/uniform-coverage-summaries-for-consumers>

Set Out-of-Network Disclosure Requirements for PPOs

Setting out-of-network disclosure requirements for PPOs would be a step up from increasing provider literacy and awareness. PPO disclosure of the kind of information listed below would support consumer literacy and awareness. Insurers could be required to disclose the information in their provider directories (following the Texas example described above), or on their websites, or on the ADOJ website. This information could include:

- What percentage of specified services (for example, anesthesiology services in in-network hospitals) was delivered out-of-network over a specified time frame?
- What was the average coinsurance payment for the specified out-of-network services last year?
- What was the average coinsurance payment for the same services delivered in-network?
- How many enrollees over a specified timeframe filed healthcare appeals related to surprise bills? What percentage of those appeals did enrollees win?

Provide PPO Enrollees with Increased Financial Protection From the Plan-Provider Reimbursement Dispute

Some stakeholders may see improving consumer and provider literacy, implementing standardized plans or setting disclosure requirements as insufficient.

The June 2015 Robert Wood Johnson Foundation analysis of six states' surprise billing laws captures the difficulty of moving toward a hold-harmless requirement. "Passing meaningful consumer protection legislation can be challenging, particularly since legislators must balance the interests of insurers, providers, and consumers. Although all stakeholders may agree that consumers should not be caught in the middle of payment disputes between insurers and providers, they tend to disagree on how to implement that protection."

If policy makers and stakeholders take on this challenge, they might consider that consumers who want to be completely out of the middle of the insurer-provider payment dispute can enroll in an HMO plan and stay inside the network. Arguably, PPO plan enrollees relinquish that degree of protection in favor of the option to choose their own providers whenever they want to. To some extent, they accept the possibility that circumstances may propel them into the dispute. It seems a relatively simple policy question whether or not to pull them back out if the circumstances arise from a medical emergency. If the answer is yes, both the New York law and the NAIC Model Act provide a starting point for drafting an Arizona law.

The question of whether to remove enrollees from the middle of the dispute when there has been no medical emergency is more difficult. One significant concern may be the point at which the line between HMO and PPO begins to blur. This is not a matter of semantics. An HMO is legally and financially structured to take on the risk of covering a certain amount of risk for the cost of healthcare services. Arizona's HMO laws require each HMO to have a plan for dealing with the possibility of insolvency. The HMO laws also provide for continuity of care and transitioning enrollees to other insurers in the event of insolvency. Arizona law does not set the same requirements for PPO plans or protections for PPO enrollees because PPO plans have not traditionally taken on the same level of risk. If there is an imperative to hold PPO enrollees harmless from emergency surprise bills, it does not have to extend to also holding them harmless from non-emergency surprise bills.

ALTHOUGH ALL STAKEHOLDERS MAY AGREE THAT CONSUMERS SHOULD NOT BE CAUGHT IN THE MIDDLE OF PAYMENT DISPUTES BETWEEN INSURERS AND PROVIDERS, THEY TEND TO DISAGREE ON HOW TO IMPLEMENT THAT PROTECTION.

"PASSING MEANINGFUL CONSUMER PROTECTION LEGISLATION CAN BE CHALLENGING, PARTICULARLY SINCE LEGISLATORS MUST BALANCE THE INTERESTS OF INSURERS, PROVIDERS, AND CONSUMERS."

Robert Wood Johnson Foundation

Network Adequacy

Qualitative and Quantitative Standards

Recent literature on network adequacy regulations across the country generally categorizes the regulations as either qualitative or quantitative.⁶⁹ Qualitative network adequacy standards allow for subjective interpretation by plans and regulators. For example, they call for a “sufficient” number and type of providers and access to services “without unreasonable delay.”⁷² Quantitative standards, on the other hand, set specific, numerical requirements such as provider-to-enrollee ratios or maximum appointment wait times. See Exhibit 12.

EXHIBIT 12 Quantitative and Qualitative Network Adequacy Standards



Requirement	Quantitative Example
Ratios of providers to plan enrollees	<ul style="list-style-type: none"> Colorado: Provider-to-enrollee ratio of 1-to-1,000 for primary and pediatric care; obstetrics-gynecology and mental, behavioral and substance abuse care.⁷³ Maine: PCP-to-enrollee ratio of 1-to-2,000.⁷⁴
Time in which care is available	<ul style="list-style-type: none"> Montana: Enrollee must be able to get routine or preventive care from a PCP within 45 days.⁷⁵ Colorado: Enrollee must be able to get non-urgent specialty care within 60 days.⁷⁶
Geographic or “time and distance” requirements	<ul style="list-style-type: none"> New Jersey: There must be at least two primary care physicians within 10 miles or 30 minutes driving or public transit time for 90 percent of its enrollees.⁷⁷ Colorado: Maximum travel distances that vary among 50 listed specialties.⁷⁸
Adequate representation of designated specialties	<ul style="list-style-type: none"> Colorado: The network must include primary care providers, oncologists, neurologists, obstetricians, gynecologists, and psychiatrists.⁷⁹ Missouri: Mandates access to more than 20 types of specialists.^{79,80}
Requirement	Qualitative Example
Adequate representation of designated specialties	<ul style="list-style-type: none"> Maryland requires “sufficient numbers and types of available providers to meet the health care needs of enrollees.”⁸¹ Kansas requires a “sufficient” mix of network providers so enrollees can access all covered services “without unreasonable delay.”⁸²

Arizona has network adequacy standards that apply to HMO plans. These standards will be especially important in 2017, when all Arizonans in the Marketplace will be enrolled in HMO plans. They include both quantitative and qualitative standards. In some cases, Arizona takes a hybrid approach that permits the HMO plan to set its own specific, quantitative standards, subject to a more qualitative requirement such as reasonableness. For example, Arizona’s network

adequacy standards do not require that HMO plan networks include any particular physician specialties. Instead, the standards require each plan to designate no fewer than four specialties as high-profile specialties.⁸² The plan must also set and maintain its own ratios for adult PCP provider-to-adult enrollees, pediatric PCP provider-to-child enrollees and high profile specialty provider-to-enrollees.⁸⁴ See Exhibit 13.

EXHIBIT 13 Arizona HMO Network Adequacy Standards

	Standard Type	Standard
Maximum time in which care is available	Quantitative	<ul style="list-style-type: none"> An appointment for network preventive primary care services within 60 days of request.⁸⁵ An appointment for network routine primary care within 15 days or sooner if medically necessary.⁸⁶ An appointment for network specialty care within 60 days or sooner, if medically necessary.⁸⁷ Access to network urgent-care services 7 days a week.⁸⁸
Maximum time in which care is available	Qualitative	<ul style="list-style-type: none"> Timely non-emergency inpatient care services from a network facility.⁸⁹ Timely services from a network physician in a network facility. Including inpatient emergency care.⁹⁰
Geographic or “time and distance” requirements	Quantitative	<p>In urban areas, the plan must provide for:⁹¹</p> <ul style="list-style-type: none"> Network primary care within 10 miles or 30 minutes of the enrollee’s home. Network specialty care in designated specialties within 15 miles or 45 minutes of the enrollee’s home. Network inpatient care within 25 miles or 75 minutes of the enrollee’s home. <p>In suburban areas, the plan must provide for:⁹²</p> <ul style="list-style-type: none"> Network primary care within 15 miles or 45 minutes of the enrollee’s home. Network specialty care in designated specialties within 20 miles or 60 minutes of the enrollee’s home. Network inpatient care within 30 miles or 90 minutes of the enrollee’s home.⁹³ <p>In rural areas, the plan must provide for:</p> <ul style="list-style-type: none"> Network primary care services within 30 miles or 90 minutes of the enrollee’s home.⁹³
Ratios of providers to plan enrollees	Hybrid (Quantitative and Qualitative)	The plan must set a ratio for adult PCP-to-adults, pediatric PCP-to-children and high profile specialist provider-to-enrollees. ⁸⁴
Adequate representation of designated specialties	Hybrid (Quantitative and Qualitative)	The plan must designate no fewer than four specialties as high-profile specialties, which are subject to provider-to-enrollee ratios. ⁸³

EXHIBIT 14 Network Adequacy Standards in the ACA and the NAIC Model Act

Requirements	Federal Rule under the ACA	NAIC Model Act
Time in which care is available	No standard	Does not specify; says that states should determine this. NAIC Model Act § 5(B)
Geographic or "time and distance" requirements	No standard in the rule. A guidance letter from HHS to insurers (The 2017 Letter to Issuers) includes a table of time and distance standards. ⁹⁴	Does not specify; says that states should determine this. NAIC Model Act § 5(B)
Ratios of providers to enrollees	No standard	Does not specify; says that states should determine this. NAIC Model Act § 5(B)
Inclusion of specific specialties or provider types	No standard in the rule. The 2017 Letter to Issuers states that HHS will monitor networks for certain specialties. ^{94*}	Does not specify
Transition or Continuity of Care	45 CFR § 156.230(d)	NAIC Model Act § 5(B)
Essential Community Providers	45 CFR § 156.235	NAIC Model Act § 5(F)(7)

*The specialties are Hospital systems, Dental providers (if applicable), Endocrinology, Infectious Disease, Mental Health, Oncology, Outpatient Dialysis, Primary Care, and Rheumatology.

The ACA and related federal rules have qualitative network adequacy standards, similar to the standards set forth in the NAIC Model Act. See Exhibit 14.

Both quantitative and qualitative standards are necessary for network adequacy. Quantitative standards provide insurers and regulators with a black line between compliance and non-compliance. They simplify the regulator's enforcement activities. Either a network has enough PCPs to meet a PCP-to-enrollee ratio or it does not.

Qualitative standards are appropriate where a specific requirement cannot always be met as a practical matter. There is no point setting a specific time and distance requirement for specialists in rural areas when the specialists do not live or work in those areas. Qualitative standards also are appropriate where a specific standard is not in the best interest of the enrollee. An enrollee is probably better served by a requirement that the network can accommodate "timely" inpatient services than by allowing a certain number of days for admission to the hospital, regardless of the enrollee's situation.

Whatever the standards, enforcement requires resources. A study in 2015 by the Commonwealth Fund found that at least six states, including Arkansas, California, Mississippi, New Hampshire, New York, and Washington had acted to bolster the ability of regulators to oversee and enforce Marketplace plan standards.⁹⁵

Essential Community Providers

In order to provide adequate access to care for low-income and medically underserved communities, the ACA requires that every Marketplace provider network include essential community providers (ECPs).⁹⁶ ECPs often care for sick individuals with high medical expenses.⁹⁴ Many ECPs provide extra services, like care coordination and extensive language services, not usually provided in other healthcare settings.⁹⁷ ECPs included in both Marketplace and AHCCCS plans provide continuity of care for patients who move back and forth between private insurance coverage and publicly funded coverage.

A STUDY IN 2015 BY THE COMMONWEALTH FUND FOUND THAT AT LEAST SIX STATES, INCLUDING ARKANSAS, CALIFORNIA, MISSISSIPPI, NEW HAMPSHIRE, NEW YORK, AND WASHINGTON HAD ACTED TO BOLSTER THE ABILITY OF REGULATORS TO OVERSEE AND ENFORCE MARKETPLACE PLAN STANDARDS.⁹⁵

EXHIBIT 15 ECP Categories and Provider Types^{94,98}

Major ECP Category	ECP Provider Types
Family Planning Providers	Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics
FQHCs	FQHC and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Freestanding Cancer Centers, Critical Access Hospitals
Indian Health Care Providers	Indian Health Service (IHS providers), Indian Tribes, Tribal organizations and urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Program Providers
Other ECPs	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals



HHS recognizes the types of ECPs shown in Exhibit 15 above.

Health plans can locate ECPs through a non-exhaustive online list compiled by HHS and other federal agencies.^{99,100}

They must submit the ECPs in their network to HHS for approval, using an HHS template.⁹⁴ They may include or "write in" entities not already recognized as ECPs for approval.

Insurers must meet the following ECP requirements:

- Each plan network must include at least 30 percent of the available ECPs in each plan's service area in their network.⁹⁴
- Plans must offer contracts "in good faith" to all Indian healthcare providers in the plan service area and to at least one contractor in each of the six categories shown in Exhibit 15 in every county in the plan service area, where an ECP in that category is available and provides covered services. "In good faith" means that the insurance provider has offered a written contract that stipulates terms that any "willing, similarly situated ECP provider would accept or has accepted."⁹⁴

If health plans do not meet the ECP network standards, they are required to submit a justification narrative to explain how the current networks manage to provide adequate services for low income and medically underserved populations.¹⁰¹

HHS, not the ADOJ, is responsible for monitoring compliance and enforcing ECP requirements.⁹⁴

There is some evidence that Marketplace plans in Arizona may not meet the ECP requirements. For instance, Maricopa Integrated Health Systems (MIHS) is the sole Ryan White HIV/AIDS Program Medical Program Provider in Maricopa County, with the exception of Phoenix Indian Medical Center, which only provides services to Native Americans. In order to comply with the ECP requirements, every Marketplace plan in Maricopa County should have offered a "good-faith" contract to MIHS. In years past, however, during times when multiple insurers offered Marketplace plans in Maricopa County, MIHS was contracted with only one Marketplace plan and had not been provided a good-faith offer by other issuers.¹⁰²

Non-compliance in any ECP category is hard to mask when there is only one provider, such as MIHS in the category of Ryan White programs. It is possible that in the other categories there are compliance issues that are less apparent. As noted above, plans can include providers that are not on the publicly available list of recognized ECPs when they submit their roster to HHS for approval. Plan compliance with ECP standards may not be any more opaque than compliance with other network adequacy standards but it may underscore the risk of inadequate care for medically vulnerable populations among plan enrollees.

Narrow Networks

FROM THE GLOSSARY

NARROW NETWORK

A network that a health plan intentionally limits to a smaller number of providers than the plan has contracted with in the past, in an effort to lower the plan's costs.

With the implementation of the ACA, health insurers lost a number of long-standing tools for keeping their costs down. See Exhibit 1. One long-standing strategy that remains is the ability to manage the amount they pay network providers such as hospitals, primary care and specialty doctors, laboratories, and imaging centers. Health plans offering ACA-compliant plans have been employing this strategy to narrow their provider networks.¹⁰³ One 2015 study concluded that almost half of all Marketplace plan networks were “narrow” and nearly all consumers had access to buy such a plan if they chose.⁹⁵

Perhaps because it is commonly associated with surprise billings and out-of-network providers, the term “narrow network” has a negative connotation for many stakeholders. Nonetheless, a narrow network is not necessarily inadequate or harmful to enrollees. There are several factors to consider before signing on to the assumption that narrow networks cause problems.

- 1. What are the selection criteria for narrow networks and to what extent do the criteria increase or diminish access to care?** Plans may choose providers on the basis of their willingness to accept lower reimbursement than other providers or their willingness to negotiate lower reimbursement levels in return for an expected volume of patients.¹⁰⁴ Other plans may choose providers who, regardless of their reimbursement levels, provide care efficiently and consistently deliver desirable outcomes.⁹⁵ Many other plans may use both approaches.
- 2. What providers are not in the network, and why?** A so-called narrow network may be as broad as every other network in the service area with regard to certain specialties. Recalling Example B, it is usually the anesthesiologists – and seldom the obstetricians – who are out-of-network and sending surprise billings, so the problem of surprise billings probably goes beyond the relative breadth of the network overall.
- 3. Other than potential surprise billings and potential restrictions on an enrollee's freedom to choose a provider, what are the risks of narrow networks?** An immediate risk is that a network is so narrow that enrollees do not get timely access to the appropriate level of care. As described above in “Qualitative and Quantitative Standards,” many jurisdictions – including Arizona, with regard to HMOs – have established time and distance standards, appointment wait-time standards and other network adequacy measurements. These can be applied to narrow networks (or any size network) to help stakeholders assess whether a network provides enrollees with timely access to the appropriate level of care. A longer-term and less obvious risk is that a plan that offers primarily or only narrow network plans may be exercising a form of risk selection. A Robert Wood Johnson Foundation report published in 2015 is just one study to raise this specter, noting that, “market observers [have suggested] that at least some health plans will use limited networks to continue attempting to attract healthier-than-average enrollees.”^{69,106} Put another way, some health plans may use limited networks to discourage unhealthy people from enrolling.



4. Are narrow networks helping to contain costs and lower premiums for Marketplace plans? According to an analysis paid for by an insurance industry organization (America’s Health Insurance Plans) and conducted by Milliman in 2014, narrow networks (which the Milliman analysis calls “high-value networks”) resulted in lowering premiums in 2014 by 5 to 20 percent.¹⁰⁴ McKinsey & Company has published a brief that included a finding that in 2014 and 2015 median premiums were lower for narrow-network plans than for broad-network plans.³¹ As insurers head into their fourth year of designing networks and setting premiums for Marketplace plans, more information on this topic may become available.

5. How transparent are the composition of the network and the out-of-network benefits? As discussed above in “Consumer Assistance and Literacy,” recent research shows that Marketplace consumers are often willing to limit the number of providers available to them in exchange for a lower monthly premium, although many do not have enough information about their plan choices or general knowledge about health insurance or network designs to make an informed decision about what premium and network combination to select.^{29,69}

MCKINSEY & COMPANY HAS PUBLISHED A BRIEF THAT INCLUDED A FINDING THAT IN 2014 AND 2015 MEDIAN PREMIUMS WERE LOWER FOR NARROW-NETWORK PLANS THAN FOR BROAD-NETWORK PLANS.³¹

Narrow networks are prevalent in Arizona. The Leonard Davis Institute published a report in August 2015 that measured 2014 Marketplace provider networks using a “t-shirt size” model. The report assigned each network a size based on the percentage of providers participating in that network in each rating area. The sizes range from x-small to x-large. Narrow networks are those that fall into the x-small or small size. Nationally, the percentages of narrow networks ranged from 83% of plans in Georgia to 13% of plans in Idaho and North Carolina. Overall, 41% were x-small or small, meaning that they included 25% or less of the physicians in a rating area. The study found that 73% of Arizona’s plans were classified as narrow.¹⁰⁵ See Exhibit 16.

ARIZONA’S NARROW NETWORK RANKING

In 2014, Arizona tied with Texas as the state with the fifth highest percentage of narrow networks.¹⁰⁵

To the extent that narrow networks are an effective tool for keeping premiums down, in Arizona that effectiveness is probably limited to Maricopa and Pima Counties. A Robert Wood Johnson Foundation study noted that a narrow network strategy is really only possible in large urban markets with a robust supply of

EXHIBIT 16 Arizona 2014 Marketplace Networks by T-Shirt Size

T-shirt	X-Small	Small	Narrow*	Medium	Large	X-Large
Percent of providers in rating area that are in a network	< 10%	10-25%	<25%	25-40%	40-60%	>60%
Percent of networks of each size in rating area	13%	60%	73%	20%	7%	0%

* Total of X-Small and Small

providers. In rural areas where there is less provider density and less competition among providers for network contracts, networks are inherently limited in size and generally cannot be strategically narrowed.¹⁰⁷

In the 2017 Letter to Issuers, HHS announced its intention to develop a label to guide Marketplace shoppers on the narrowness or breadth of networks.^{94,108} This measure will focus on adult primary care, pediatric primary care, and hospitals. It will compare the total number of those providers in a plan's network to the total number of those providers available in all Marketplace plans in a county. HHS will label networks as "broad," "standard" or "basic," with the label "basic" standing in for the current label "narrow."¹⁰⁸

The usefulness of this proposed effort by HHS is not immediately clear. If all or most of the networks are narrow to start with, then very few of them will appear broader or narrower than the others and the majority will always be labeled as "standard." This may explain the HHS finding that nationally in 2016, about 68% of Marketplace networks were standard, 16% were broad and 16% were basic. Due to this limitation, enrollees might be better served by the development of realistic and enforceable network adequacy and transparency standards in partnership with states and the NAIC.

In August 2016, HHS announced a pilot program for labeling network breadth, to be conducted in six states during the open enrollment period for the 2017 coverage year. Marketplace consumers in the pilot states were given information about the relative breadth of plans' provider networks, as compared to other Marketplace plans in the county. According to HHS, this model tests consumer use and experience during the pilot to enhance and improve the display of QHP network breadth in the future.^{94,108}

HHS ANNOUNCED A PILOT PROGRAM FOR LABELING NETWORK BREADTH, TO BE CONDUCTED IN SIX STATES DURING THE OPEN ENROLLMENT PERIOD FOR THE 2017 COVERAGE YEAR.

Rural Area Factors

As a general matter, the rural population has lower incomes than the urban population and faces different, particularly high barriers to accessing healthcare services, such as limited provider availability, geographic distance from providers and lack of transportation.¹⁰⁹ Nonetheless, a report recently issued by HHS indicates that nationwide, rural individuals have been keeping up with their urban counterparts with regard to increasing their insurance coverage and access to care. Marketplace enrollment among both rural and urban individuals grew about 8% from before the first open enrollment period in late 2013 through early 2015. During the same time period, the share of both rural and urban individuals who reported being unable to afford needed care declined by nearly 6 percent.¹¹⁰

Not all rural Arizonans have kept up with the nationwide rural coverage gains. Across the country, rural individuals comprise nearly 20% of Marketplace plan selections.¹¹⁰ Statewide, the Arizona percentage is 10%.¹¹¹ In some rural counties, however, the percentage of Marketplace enrollees on a per capita basis is the same as, or higher than, in the state's two most urban counties. See Exhibit 17.

EXHIBIT 17 **Estimated 2016 AZ Marketplace Enrollment by County**

	Marketplace Enrollment ¹¹²	County Population ¹¹³	% Marketplace Enrollees Among County Residents
Rural Counties			
Apache	509	71,518	0.7
Cochise	3,206	131,341	2.4
Coconino	4,197	134,421	2.4
Gila	1,452	53,597	2.7
Graham	905	37,220	2.4
Greenlee	108	8,437	1.3
La Paz	331	20,289	1.6
Mohave	6,525	200,186	3.2
Navajo	2,142	107,449	2
Pinal	9,667	375,770	2.5
Santa Cruz	2,111	47,420	4.5
Yavapai	9,875	211,033	4.7
Yuma	4,558	195,751	2.3
Urban Counties			
Maricopa	126,317	3,817,117	3.3
Pima	31,161	980,263	3.2

Note: This breakdown of enrollment by county was published by HHS (ASPE) in March 2016 based on enrollment data available at the time. It does not reflect effectuated enrollment data that HHS published in July 2016. The effectuated enrollment data reduced Arizona's enrollment by approximately 14%. ASPE has not yet updated the breakdown by county. As a result, these enrollment numbers are somewhat overstated for one or more of the counties.

According to a 2015 study of provider supply and demand in Arizona, “Provider supply may not be keeping up with the burgeoning demand for services due to many factors, including the aging of the population, increasing coverage through Medicaid and the Marketplace, and rapidly changing economic, technologic, and demographic factors.”¹¹⁴ This may seem self-evident to rural Arizonans and providers. The CEO of Benson Hospital, located 45 miles east of Tucson in Cochise County, says that he does not usually think in terms of network adequacy. He says, “The problem is provider supply.”¹¹⁵

Arizona’s HMO network adequacy regulations reflect the special considerations that apply to establishing and enforcing network adequacy standards in medically underserved and geographically widespread areas. These include:

- AAC R20-6-1919 (Establishing geographic availability in a rural area),
- AAC R20-6-1920 (Establishing travel requirements), and
- AAC R20-6-1902 (Defining “rural area”).

These also include AAC R20-6-1921, which requires the Insurance Director to consider certain factors in determining compliance with the regulations. One factor is “whether market factors indicate that on a short-term basis, compliance is not possible. Market factors include shortage of providers, enrollee or provider location, and provider practice or contracting patterns.” This standard gives plans and regulators the flexibility to be realistic about enforcement and compliance.

“ PROVIDER SUPPLY MAY NOT BE KEEPING UP WITH THE BURGEONING DEMAND FOR SERVICES DUE TO MANY FACTORS, INCLUDING THE AGING OF THE POPULATION, INCREASING COVERAGE THROUGH MEDICAID AND THE MARKETPLACE, AND RAPIDLY CHANGING ECONOMIC, TECHNOLOGIC, AND DEMOGRAPHIC FACTORS.”¹¹⁴

AzCRH 2015 Supply and Demand Study of Arizona Health Practitioners and Professionals

Using Telemedicine to Expand Provider Networks and Reduce Costs

The Status of Telemedicine in Arizona

ARIZONA HAS A WELL-ESTABLISHED TELEMEDICINE INFRASTRUCTURE. THE ARIZONA TELEMEDICINE PROGRAM (ATP) IS A STATEWIDE PROGRAM INTENDED TO INCREASE ACCESS TO HEALTHCARE TO ALL RESIDENTS IN ARIZONA USING TELEMEDICINE TECHNOLOGIES.

Arizona is one of approximately thirty states that has adopted a parity law for **telemedicine** services, meaning that a plan must cover a healthcare service that is provided through telemedicine if the healthcare service would be covered were it provided through in-person consultation.^{116,117,118,119} At the same time, the Arizona law recognizes that not all services can appropriately be provided through telemedicine and specifies that telemedicine services must comply with applicable licensure requirements, accreditation standards and professional practice guidelines.

The current version of Arizona’s telemedicine law limits the parity requirement to services delivered to an enrollee in a rural area and to a specific list of services or conditions: trauma, burn, cardiology, infectious diseases, mental health disorders, neurologic diseases including strokes, and dermatology. In 2016, the Arizona legislature expanded the scope of the parity requirement. Effective January 1, 2018, the law will apply to services provided anywhere in the state, and the list of covered services will include pulmonology.¹²⁰ Some telemedicine users find the parity requirement ambiguous with regard to whether a plan must cover only the consultation services of an individual provider or also the costs associated with housing and supporting the technology required for telemedicine. Nothing prevents a plan from covering services other than those listed in the law. In addition, Arizona’s network adequacy rule for HMO plans specifically allows for telemedicine. “As an alternative to providing access to covered services from a physician or practitioner who sees an enrollee in person...an [HMO] may provide access to necessary covered services through...telemedicine.”¹²¹ The Arizona provision is consistent with the NAIC Model Act, which categorizes telemedicine as a healthcare delivery option that plans may use to meet a state’s network adequacy standard.¹²¹

Arizona has a well-established telemedicine infrastructure. The Arizona Telemedicine Program (ATP) is a statewide program intended to increase access to healthcare to all residents in Arizona using telemedicine technologies. The Program’s telecommunications network spans the entire state and is linked to other telecommunications networks in Arizona.¹²³ Use this link to see a map of the ATP system:

telemedicine.arizona.edu/sites/telemedicine.arizona.edu/files/u5/ATP%20Map%20Sept%202012.pdf

Telemedicine medical providers in Arizona include the Mayo Clinic, Dignity Health, Banner Health, and Banner University Medical Center Tucson.

The Benefits of Telemedicine

Telemedicine accommodates network providers who otherwise would not participate because of how far they are from the patient. For example, the Northern Arizona Regional Behavioral Health Authority (NARBHA, now Health Choice

Integrated Care) is responsible for patients across rural areas that cover nearly half the state. NARBHA implemented a telemedicine network in 1996 and has provided more than 166,000 telepsychiatry sessions since then.¹²⁴ This kind of arrangement also results in providers being paid for patient services, rather than for travel time and their expenses.

When the situation does not require in-person care, telemedicine can improve the quality and timeliness of care. Kingman Regional Medical Center (KRMC) has a “stroke doc” program that allows Emergency Department providers to confer with neurologists in Phoenix regarding their patients’ symptoms and immediate treatment needs.¹²⁵ Telemedicine can reduce hospital admissions and readmissions by remotely monitoring patients with chronic conditions or patients recently discharged from inpatient care.¹²⁵ It also can allow facilities to treat patients locally instead of incurring the expense of transferring them to a larger or metropolitan hospital. KRMC **hospitalists** use telemedicine to consult Phoenix neurologists regarding in-patients’ neurological symptoms and whether a patient needs to be transferred to a larger facility or can stay at KRMC.¹²⁶ CEO Brian Turney says that KRMC has seen a significant drop in transfers to other hospitals since this telemedicine service began. Patients are getting the care they need close to home and plans are saving the high cost of medical transport.¹²⁵

Are There Barriers to Insurer Use of Telemedicine in Arizona?

Telemedicine seems well suited to support three primary goals of the ACA:

- To reduce the cost of healthcare;
- To increase the quality of healthcare
- To improve healthcare outcomes

Nonetheless, a recent study by the Robert Wood Johnson Foundation on the use of telemedicine by private insurers in six states found that insurers in those states generally have not incorporated telemedicine providers into their networks, despite widespread physician shortages in some areas.¹²⁷ There is very little publicly available utilization and access data from Arizona insurers or telemedicine providers about their telemedicine activities. As a result, it is hard to gauge the pace at which Arizona health insurers are expanding telemedicine or including telemedicine providers in their networks.



ESTABLISHED, SUCCESSFUL,
LONG-TERM TELEMEDICINE
PROGRAMS IN ARIZONA OFTEN
INVOLVE AHCCCS OR ANOTHER
PUBLIC PAYER – NOT AN
INSURANCE COMPANY.

Arizona plans are required by law to pay telemedicine claims for certain services. They are permitted by law to use services from telemedicine providers to demonstrate network adequacy. That does not mean they embrace telemedicine. It is not clear whether the physician community as a whole supports telemedicine. In addition, policy makers have shown somewhat limited support for the concept. This ambiguity is illustrated by the language of Arizona’s telemedicine parity law. On the one hand, Arizona has a telemedicine law that, as of January 1, 2018, will cover eight specialties or types of service. On the other hand, the ATP supports telemedicine services for approximately 60 specialties or types of services and lists on its website the 17 specialties it most commonly supports.¹²⁸ There is a reasonable inference that some policy makers or stakeholders have reservations about letting the parity mandate go too far.

According to Don Graf, National Director of Telehealth for UnitedHealth, Community & State, Arizona leads the country in Medicaid use of telemedicine.¹²⁹ This is consistent with the fact that descriptions of established, successful, long-term telemedicine programs in Arizona often involve AHCCCS or another public payer – not an insurance company. For example, this is true of the NARBHA program referred to above and of other programs described on the ATP website, including telemedicine services at community health centers statewide and at Children’s Rehabilitative Services programs that are available through AHCCCS.¹³⁰ What is missing from the picture is data about how Arizona is doing when it comes to private insurer use of telemedicine.

Provider Directories

Consumers rely on provider directories for accurate and up-to-date information on the providers who participate in their health plan’s network. This is important when selecting a plan. Some consumers look for a plan with a particular doctor they have already seen or a hospital close to their neighborhood. It is no less important after the coverage is in effect and a medical need arises. Consumers use the provider directory to safeguard against inadvertently seeking services from an out-of-network provider and incurring surprise bills. Enrollees frequently complain that provider directories are out of date. At the same time, insurers describe the difficulty of keeping the directories updated when providers move in and out of the network daily.

Provider directory standards abound. Arizona state law contains requirements for provider network directory standards for HMOs. Provider network directories must include the “name, address, telephone number, specialty, and hospital affiliation for all in-area contracted physicians or practitioners.”¹³¹ They must clearly notify enrollees that changes may occur in the network after the provider directory is published and that a consumer’s coverage may depend on the contract status of the provider. They also must state:

- Where consumers can go to find more recent directory information;
- The effective date of the directory; and
- How enrollees can find out which primary care physicians are currently accepting new patients.¹³¹

Arizona’s online directories for HMOs must be updated at least monthly. This requirement is consistent with many other sets of standards, including the ACA, the NAIC Model Act and Georgia state regulations. New York State requires insurers to update their directories within 15 days of any change.¹³²

Arizona does not currently have any standards for PPO provider directories. The ACA standards summarized below are the only ones that apply to Arizona PPOs. HHS requires Marketplace plans to meet the following provider directory adequacy standards:

- They must be available to the Marketplace through a URL link.
- They must be up-to-date, accurate, and complete.
- They must specify what providers are accepting new patients, the location of providers, contact information, specialty, medical group, and any institutional affiliations.
- They must be accessible on the health plan’s website through a “clearly identifiable link/tab on the website without having to create or access an account or a policy number.”¹³³

There are also specific requirements in the NAIC Model Act regarding provider directory standards. The NAIC Model Act requires that insurers produce online provider directories that are current, accurate, searchable, updated monthly, and accommodate the needs of individuals with disabilities and those with limited English proficiency. The NAIC Model Act requires provider directories to include contact information, location, specialty, if the provider is accepting new patients, and if the provider speaks languages other than English.

To enforce the adequacy of provider directories, the NAIC Model Act requires that plans periodically audit a “reasonable sample” of their directories to ensure that they meet the above standards. These audits must be made available to insurance regulators upon request. Provider directories must also include either an email address and phone number or electronic link that consumers may use to report inaccuracies in the directories.¹³⁴

Georgia has standards similar to those of the NAIC Model Act. In addition, the Georgia law gives the Insurance Commissioner the discretion to require the plan to reimburse, at the in-network level, a consumer who has incurred a surprise bill as a result of relying on inaccurate directory information.¹³⁵ Texas has a similar provision for PPO plans.^{64,136}

What Can Be Done About Network Adequacy?

Add HMO Plan Focus to Consumer Literacy and Awareness

For Marketplace consumers who enroll in 2017 coverage, plan selection will be limited to HMO plans. This will allow consumers to focus on factors that shape HMO plan coverage, including the requirement that they stay in-network unless a network exception applies. These are the same as some factors they will consider with regard to the cost-sharing requirements:

- Who is in the network? Am I looking for any particular provider? What happens if my doctor leaves the network?
- What steps can I take before getting services to be sure I am in the network and the services are covered?

Optimize the Existing Regulatory Structures to Protect Consumers from Inadequate Networks

Arizona already has statutes and regulations that, when complied with by HMO plans and enforced by ADOI, can do much to protect enrollees from inadequate networks and unexpected out-of-network bills. That does not mean no action is required. On the contrary, compliance and enforcement should proceed, although inadequate regulatory resources may stymie enforcement. Policy makers have an opportunity now to take an objective look at which enforcement resources exist and which are lacking and to provide necessary resources and direction to regulators.

As compliance and enforcement move forward, stakeholders can consider whether there is a need to amend the HMO regulations and whether the benefit of the amendment will justify the resources involved for all stakeholders in seeking an exemption from Arizona’s current moratorium on rule-making and moving forward to promulgate a new rule.

Prepare for the Product Pendulum to Swing Back

Individual PPOs will probably reassert themselves as a force in Arizona, possibly in just a few years. Stakeholders have a chance now to consider whether and how to provide regula-

tory structure for PPOs in areas such as network adequacy and surprise billing. These considerations include:

- How to balance quantitative (specific, numeric) standards and qualitative (subjective) standards to achieve both accountability and enforceability.
- How to integrate transparency of network composition and out-of-network benefits with other standards.
- Whether to require prior regulatory approval of networks or network access plans.
- Whether the consumer benefits of the regulation justify the plans' costs to implement and regulators' costs to monitor and enforce.
- Whether the enforcing agency has adequate enforcement resources.

Move Forward with Telemedicine

Arizona is well-positioned from a practical and regulatory point of view for stakeholders to work together to support insurers in expanding the use of telemedicine for the benefit of Marketplace and other health insurance consumers. Steps to ensure that Arizonans get the benefit of telemedicine include the following:

- Plans and providers can participate in evaluating telemedicine gaps and removing barriers by disclosing telemedicine utilization and access data.
- Plans can move forward with telemedicine by making their use of telemedicine services transparent. They can

proactively inform providers and consumers about the situations in which telemedicine is an option. One way to do this is to integrate telemedicine providers and services into provider directories.

- Organizations providing consumer enrollment and assistance can add information about telemedicine services to their materials.
- Policy makers can amend Arizona's telemedicine law to require that plans track and disclose the telemedicine services they cover.
- Policy makers can amend Arizona's telemedicine law to clarify that plans must cover not only consultation services provided by individuals but also technical and facility-based costs.

Ensure Accuracy of Provider Directories

Arizona already has a comprehensive set of HMO provider directory standards, which is probably the only set of standards necessary for Marketplace enrollees in 2017 and even 2018.

Inaccurate information seems to be the most vexing directory problem. Arizona's requirement of monthly updates for online HMO plan directories is consistent with standards across the country. However, it may not be stringent enough to protect consumers or meet the Marketplace demand for accuracy. Moreover, plans depend on timely, accurate information from providers to update directories. That information does not arrive on a monthly schedule. A more effective measure might be the New York approach of requiring plans to update directories within 15 days of receiving any change.



Conclusion

The ACA Marketplace has significantly changed the universe of health insurance available to individuals who do not have access to employer-based coverage or publicly funded coverage.

Health insurers competing in this universe are playing on a much more level and consumer-oriented field than in the past. It should not be a surprise that some insurers are leaving some Marketplaces, switching from PPOs to HMOs or expecting enrollees to shoulder a greater share of the cost of care.

Consumers buying insurance in this universe also have to adjust to the new playing field. On one hand, they are guaranteed coverage and a comprehensive benefit package that insurers could deny before the ACA was implemented. On the other hand, they are required by law to purchase the insurance along with all the essential health benefits. In addition, some plans may be unexpectedly expensive, particularly among the 30% of all Marketplace enrollees who do not qualify for financial assistance. Consumer survey results illustrate varying degrees of consumer opinion – some which reveal consumers’ satisfaction with their health plans and providers, and others which express concern over costs and lack of choice.

This report includes a range of strategies for addressing problems with network adequacy and affordability under the ACA. The list is not exhaustive and includes strategies that borrow liberally from efforts proposed or undertaken elsewhere. There are some overarching themes to consider in developing any strategies in this arena.

First, consumers, providers and other stakeholders would benefit from greater health insurance transparency and literacy. When both consumers and providers are well-informed and able to dialogue about the parameters of health coverage, the likelihood of a positive outcome – be it health or financial – is increased. In addition, the more that stakeholders at every level, from policy maker to enrollee, understand the fundamental aspects of health insurance, including differences between an HMO and a PPO, the more successful will be the policy decisions, implementation efforts and actual access to care.

Second, as is often the case when issues are complicated, ill-defined and subjective terminology can get in the way of transparency and literacy. One such term is “high deductible.” A deductible set at \$3,000 may be a financial burden and seem high by some standards, but the same deductible may be reduced by cost-sharing to anywhere from \$0 to \$2,500. Another such term is “narrow network.” A network may be narrow, but still adequate to provide enrollees with timely access to high quality healthcare. Many consumers and other stakeholders will benefit from having an informed perspective when they consider, for example, “How high is too high?” or “How narrow is too narrow?”

Third, problems that arise in connection with Marketplace coverage, such as surprise billing or narrow networks, do not necessarily mean that the existing

IT'S NO SECRET THAT ARIZONA'S HEALTH INSURANCE MARKETPLACE, AS ENACTED THROUGH THE ACA, HAS CREATED SIGNIFICANT OPPORTUNITY AND CHALLENGES. ARIZONA'S CURRENT REGULATORY FRAMEWORK PROVIDES A SOLID FOUNDATION FROM WHICH TO CONTINUE BUILDING A ROBUST HEALTH INSURANCE MARKETPLACE.

regulatory structure is inadequate. In Arizona, the existing regulatory structure for HMOs has long been designed to protect against enrollees being liable for the unexpected costs of being inadvertently out-of-network. In practice, however, HMO enrollees may not always receive the protection the regulations afford them. This is often because effective oversight and enforcement requires resources that regulators do not have. Stakeholders may press state policy makers and regulators to protect PPO enrollees or make other local adjustments to the way the ACA affects Arizona; however, new laws or regulations must be accompanied by ample enforcement resources for regulators.

It's no secret that Arizona's Health Insurance Marketplace, as enacted through the ACA, has created significant opportunity and challenges. Those who believe this new universe should have stabilized after its first three years likely had unrealistic expectations, and those who claim the Marketplace merely needs more time to stabilize are likely being overly simplistic. Arizona's current regulatory framework provides a solid foundation from which to continue building a robust health insurance marketplace. To advance this effort, there exists a menu of policies enacted in other states and recommendations proposed by various national organizations from which Arizona may choose. In this evolving era of healthcare and health coverage, it is evermore important for all stakeholders – policy makers, providers, insurers and consumers – to consider these many options as viable tools to ensure that all Arizonans have access to high quality, affordable health coverage in the near and distant future.



Acknowledgments

It takes a constellation of many bright minds to put a report together like this, and we want to express our appreciation to everyone who provided their time and expertise. Taylor Kelly started this project as a dedicated intern, and Alix Shafer came out of retirement to get it completed. We owe a great deal of gratitude to these two authors. Kim VanPelt worked on early drafts extensively, and the Vitalyst team helped to polish and refine the content. There are also a number of critical readers and people who provided valuable information during preparation of the report.

Diane E. Brown

Executive Director
Arizona Public Interest Research Group Education Fund

Kris Erps

Associate Director, Administration
Arizona Telemedicine Program, University of Arizona

Allen Gjersvig

Director of Navigator and Enrollment Services
Arizona Alliance for Community Health Centers

Don Graf

National Director of Telehealth
UnitedHealth, Community & State

Saundra Johnson

Executive Director
Keogh Health Connection

Debbie Johnston

Senior Vice President, Policy Development
Arizona Hospital and Healthcare Association

Erin Klug

Assistant Director, Market Oversight Division
Arizona Department of Insurance

Eric Moore

Senior HIV Program Manager
Maricopa Integrated Health Systems

Jesse O'Brien

Healthcare Policy Analyst
State Public Interest Research Groups

Tara McCollum Plese

Chief External Affairs Officer
Arizona Alliance for Community Health Centers

Rich Polheber

Chief Executive Officer
Benson Hospital, Benson, Arizona

Sheri Shudde

Rate Review Manager, Market Oversight Division
Arizona Department of Insurance

Cheri Tomlinson

Vice President of Grants and Research
Maricopa Integrated Health Systems

Brian Turney

Chief Executive Officer
Kingman Regional Medical Center

Sources

- 1 Uberoi, N., Finegold, K., & Gee, E. (3 March 2016). Health Insurance Coverage and the Affordable Care Act, 2010–2016. Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services. Retrieved from: <https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf>
- 2 Quarterly Marketplace Effectuated Enrollment Snapshots by State. (1 July 2016). Retrieved from Centers for Medicare and Medicaid Services, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Effectuated_Quarterly_Snapshots.html
- 3 Vitalyst Health Foundation. Publications & Reports. Retrieved from <http://vitalysthealth.org/publications/>
- 4 *Center on Health Insurance Reforms*. (n.d.). Georgetown University. Retrieved from http://chir.georgetown.edu/#_ga=1.260477960.449203463.1462405563
- 5 Collins, S. R., Gunja, M., Doty, M. M., & Beutel, S. (2016). *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016. Issue brief (Commonwealth Fund)*, 14, 1–18. Retrieved from the Commonwealth Fund: <http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction>
- 6 Survey Finds Most Marketplace Enrollees Like Their Coverage, Though Satisfaction with Premiums and Deductibles Has Declined Since 2014. (2016, May 20). Retrieved from Kaiser Family Foundation: <http://kff.org/health-reform/press-release/survey-finds-most-marketplace-enrollees-like-their-coverage-though-satisfaction-with-premiums-and-deductibles-has-declined-since-2014>
- 7 *Out-of-pocket maximum/limit*. (n.d.). Retrieved from HealthCare.gov: <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/>
- 8 *Information about Health Insurance Rate Increases*. (n.d.). Retrieved from Arizona Department of Insurance: <https://insurance.az.gov/consumers/help-health-insurance/information-about-health-insurance-rate-increases>
- 9 *Marketplace Enrollment by Metal Level*. (March 2016). Retrieved from Kaiser Family Foundation: <http://kff.org/health-reform/state-indicator/marketplace-enrollment-by-metal-level/>
- 10 Pear, Robert (9 June 2016). *Why Do Health Costs Keep Rising? These People Know*. Retrieved from The New York Times: <http://www.nytimes.com/2016/06/10/us/health-insurance-affordable-care-act.html>
- 11 Gunja, M. Z., Collins, S. R., Doty, M. M., & Beutel, S. (2016). *Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February–April 2016. Issue brief (Commonwealth Fund)*, 17, 1.
- 12 Levitt, L., Cox, C., & Claxton, G. (2016, August 1). *How ACA Marketplace Premiums Measure Up to Expectations*. Retrieved from http://kff.org/health-reform/perspective/how-aca-marketplace-premiums-measure-up-to-expectations/?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+kff%2Fprivateinsurance+%28Private+Insurance+-+reports%2C+fact+sheets+and+explainers+-+from+the+Kaiser+Family+Foundation%29
- 13 Establishment of a State Exchange, 45 CFR § 155.100. (2012 & Supp. 2013).
- 14 Eligibility Standards, 45 CFR § 155.305(a). (2012 & Supp. 2013).
- 15 Hamel, et al. (20 May 2016). *Survey of Non-Group Health Insurance Enrollees, Wave 3*. Retrieved from Kaiser Family Foundation: <http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/>
- 16 McCue, M. J., & Hall, M. A. (2016). *Promoting Value for Consumers: Comparing Individual Health Insurance Markets Inside and Outside the ACA's Exchanges. Issue brief (Commonwealth Fund)*, 12, 1–10.
- 17 Establishment of Exchange network adequacy standards, 45 CFR § 155.1050. (2012).
- 18 Network Adequacy Standards, 45 CFR § 156.230. (2012 & Supp. 2015, 2016).
- 19 Navigator Program Standards, 45 CFR § 155.210.
- 20 Poverty Guidelines. (January 2016). Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services. Retrieved from: <https://aspe.hhs.gov/poverty-guidelines>
- 21 Federal Poverty Level. (n.d.). Retrieved from HealthCare.gov: <https://www.healthcare.gov/glossary/federal-poverty-level-FPL/>
- 22 Alltucker, K. (3 October 2015). *Why 4 major Arizona insurance carriers are dropping PPO plans in favor of HMO plans*. Retrieved from Arizona Central: <http://www.azcentral.com/story/money/business/consumers/2015/10/02/arizona-health-insurance-costs-insurers-switching-hmos/73092228/>
- 23 Definitions, ARS § 20-1051.
- 24 Health Care Services and Oversight, AAC § R20-6-1901. (2001 & Supp. 2005).
- 25 Health care providers; charges; public availability; direct payment; notice; definitions, ARS § 32-3216(K).
- 26 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters 2017. (8 March 2016). *Final Rule Federal Register 81*, 45. Retrieved from: <https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf>
- 27 Patient Protections, 45 CFR 147.138(b)(3). (2015).
- 28 Network Adequacy Standards, 45 CFR & 156.230(e). (2012 & Supp. 2015, 2016).
- 29 Polsky, D., & Weiner, J. (June 2015). *The skinny on narrow networks in health insurance marketplace plans*. Retrieved from University of Pennsylvania Leonard Davis Institute of Health Economics: <http://ldi.upenn.edu/sites/default/files/pdf/the-skinny-on-narrow-networks.pdf>
- 30 *CDC Prevention Checklist*. (23 December 2015). Retrieved from Centers for Disease Control and Prevention: <https://www.cdc.gov/prevention/>
- 31 Bauman, N., Bello, J., Coe, E., & Lamb, J. (April 2015). *Hospital networks: Evolution of the configurations on the 2015 exchanges*. Retrieved from McKinsey Center for U.S. Health System Reform: <http://healthcare.mckinsey.com/sites/default/files/2015HospitalNetworks.pdf>
- 32 Insurance, ARS § 20-2530. (2015).
- 33 Surprise Medical Bills Survey. (5 May 2015). Retrieved from Consumer Reports National Research Center: <http://consumersunion.org/wp-content/uploads/2015/05/CY-2015-SURPRISE-MEDICAL-BILLS-SURVEY-REPORT-PUBLIC.pdf>
- 34 Navigator Program Standards, 45 CFR 155.210. (2012 & Supp. 2013, 2014, 2016).
- 35 Standards applicable to Navigators and Non-Navigator Assistance Personnel carrying out consumer assistance functions under §§ 155.205(d) and (e) and 155.210 in a Federally-facilitated Exchange and to Non-Navigator Assistance Personnel funded through an Exchange Establishment Grant, 45 CFR 155.215. (2013 & Supp. 2014, 2015, 2016).
- 36 Navigator Program Standards, 45 CFR 155.210(e). (2012 & Supp. 2013, 2014, 2016).
- 37 Navigator Program Standards, 45 CFR 155.210(e)(9)(iv). (2012 & Supp. 2013, 2014, 2016).
- 38 Navigator Program Standards, 45 CFR 155.210(e)(8). (2012 & Supp. 2013, 2014, 2016).
- 39 Insurance Definitions, ARS § 20-336. (2016).
- 40 E-mail correspondence from Allen Gjersvig, Director of Navigator and Enrollment Services at the Arizona Alliance for Community Health Centers. (18 July 2016).
- 41 Health Insurance Marketplace Premiums for 2014. (2013 September 25). Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services. Retrieved from: https://aspe.hhs.gov/sites/default/files/pdf/177626/ib_premiumslandscape.pdf
- 42 Guaranteed renewability of individual health coverage, ARS 20-1380 (E).
- 43 E-mail correspondence from Erin Klug, Assistant Director, Market Oversight Division, Arizona Department of Insurance. (30 June 2016).
- 44 Appleby, J., & Rau, J. (25 November 2015). *As HMOs Dominate, Alternatives Become More Expensive*. Retrieved from Kaiser Health News: <http://khn.org/news/as-hmos-dominate-alternatives-become-more-expensive/>
- 45 Blumberg, L. J., Holahan, J., & Wengle, E. (May 2016). *Increases in 2016 Marketplace Nongroup Premiums: There Is No Meaningful National Average*. Retrieved from Robert Wood Johnson Foundation: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf429398
- 46 Centers for Medicare and Medicaid Services. (n.d.) *Cost Sharing*. Retrieved from HealthCare.gov: <https://www.healthcare.gov/glossary/cost-sharing/>
- 47 Rae, M., Levitt, L., Claxton, G., Cox, C., Long, M., & Damico, A. (13 November 2015). *Patient Cost-Sharing in Marketplace Plans, 2016*. Retrieved from Kaiser Family Foundation: <http://kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016/>

- 48 Gabel, J., Green, M., Call, A., Whitmore, H., Stromberg, S., & Oran, R. (May 2016). Changes in Consumer Cost-Sharing for Health Plans Sold in the ACA's Insurance Marketplaces, 2015 to 2016. *Issue brief (Commonwealth Fund)*, 11, 1-14. Retrieved from Commonwealth Fund: <http://www.commonwealthfund.org/publications/issue-briefs/2016/may/cost-sharing-increases>
- 49 969 Health Savings Accounts and other Tax-Favored Health Plans. (Rev. 2015). US Department of Treasury. Internal Revenue Service. Retrieved from: <https://www.irs.gov/publications/p969/ar02.html>
- 50 Collins, S. R., Rasmussen, P. W., Beutel, S., & Doty, M. M. (May 2015). The Problem of Underinsurance and How Rising Deductibles Will Make It Worse. Retrieved from The Commonwealth Fund: <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-of-underinsurance>
- 51 Mitts, L., & Fish-Parcham, C. (2015) Non-group health insurance: Many insured Americans with high out-of-pocket costs forgo needed health care. Retrieved from Families USA: http://familiesusa.org/sites/default/files/product_documents/ACA_HRMSurvey%20Urban-Report_final_web.pdf
- 52 Data Brief: 2016 Median Marketplace Deductible \$850, with Seven Health Services Covered Before the Deductible on Average. (12 July 2016). Centers for Medicare and Medicaid Services Center for Consumer Information and Insurance Oversight. Retrieved from: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-12.html>
- 53 Median [Def 2] *Merriam-Webster Online*. Retrieved from <https://www.merriam-webster.com/dictionary/median>
- 54 Centers for Medicare and Medicaid Services. (n.d.) *Copayment*. Retrieved from HealthCare.gov: <https://www.healthcare.gov/glossary/co-payment/>
- 55 Centers for Medicare and Medicaid Services. (n.d.) *Deductible*. Retrieved from HealthCare.gov : <https://www.healthcare.gov/glossary/deductible/>
- 56 Centers for Medicare and Medicaid Services. (n.d.) *Co-Insurance*. Retrieved from HealthCare.gov: <https://www.healthcare.gov/glossary/co-insurance/>
- 57 Taylor, E., & Parast, L. (n.d.). A Tale Of Two Deliveries, Or An Out-Of-Network Problem. Retrieved from Health Affairs Blog: <http://healthaffairs.org/blog/2015/11/03/a-tale-of-two-deliveries-or-an-out-of-network-problem>
- 58 Patient protections. CFR & 147.138(b)(i). (2015).
- 59 Process for Referral, Prior Authorization, Pre-certification, or Network Exception. AAC R20-6-1910(A). (2015).
- 60 Process for Referral, Prior Authorization, Pre-certification, or Network Exception. AAC R20-6-1910(E). (2015).
- 61 Denial; Levels of Review; Disclosure; Additional Time after Service by Mail; Review Process. ARS § 20-2535.
- 62 Consumer Affairs Division Arizona Department of Insurance. Consumer Guide to the Health Care Appeals Process in Arizona. Retrieved from Arizona Department of Insurance: https://insurance.az.gov/sites/default/files/documents/files/Consumer_Guide_to_Health_Care_Appeals%207%20May%202015.pdf
- 63 Rapport, R., Goyle, A., et al. (2016). Americans' Experiences with ACA Marketplace Coverage: Affordability and Provider Network Satisfaction: Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February-April 2016. Retrieved from Commonwealth Fund: <http://www.commonwealthfund.org/publications/issue-briefs/2016/jul/affordability-and-network-satisfaction>
- 64 Hoadley, J., Ahn, S., & Lucia, K. (June 2015). Balance Billing: How Are States Protecting Consumers from Unexpected Charges? Retrieved from Robert Wood Johnson Foundation: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420966
- 65 Emergency Medical Services and Surprise Bills. N.Y. Fin Serv L § 601-608. (2014).
- 66 Virtual Currencies. N.Y. Codes of R. & Regs. 23 § 200.
- 67 Disclosure of Information. N.Y. Insurance Law § 3217(a).
- 68 National Association of Insurance Commissioners. *About the NAIC*. Retrieved from National Association of Insurance Commissioners: http://naic.org/index_about.htm
- 69 Giovannelli, J., Lucia, K, et al. (28 July 2016). Health Policy Brief: Network Adequacy. Retrieved from Health Affairs: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=160
- 70 Health Benefit Plan Network Access and Adequacy Model Act § 7(3). (2015). Retrieved from National Association of Insurance Commissioners: <http://www.naic.org/store/free/MDL-74.pdf>
- 71 Beutel, S., Collins, S. R., & Gunja, M. (17 March 2016). How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016? *Issue brief (Commonwealth Fund)*, 6, 1-17. Retrieved from Commonwealth Fund: <http://www.commonwealthfund.org/publications/issue-briefs/2016/mar/deductible-exclusions>
- 72 Network Adequacy Standards, 45 CFR & 156.230(a). (2012 & Supp. 2015, 2016).
- 73 Network Adequacy Standards and Reporting Guidance for Health Benefit Plans. Colorado Dept. of Regulatory Agencies, Div. of Insurance Bulletin No. B-4.90(A)(2).
- 74 Access to Services. 02-031 Code of Maine Rule Ch. 850, § 7. (Amended 2015).
- 75 Maximum Wait Times for Appointments. Montana Admin. R. 37.108.227. (1999).
- 76 Network Adequacy Standards and Reporting Guidance for Health Benefit Plans. Colorado Dept. of Regulatory Agencies, Div. of Insurance Bulletin No. B-4.90(A)(1).
- 77 Health Care Quality Act Application to Insurance Companies, Health Service Corporations, Hospital Service Corporations and Medical Service Corporations. New Jersey Admin. Code 11.24(A). (2011).
- 78 Network Adequacy Standards and Reporting Guidance for Health Benefit Plans. Colorado Dept. of Regulatory Agencies, Div. of Insurance Bulletin No. B-4.90(A)(3).
- 79 Provider Network Adequacy Standards. Missouri CSR. 20 § 400-7.095(3).
- 80 Health Carriers and Health Plans. WAC Ch. 284-43. (2016).
- 81 Provider Panel Sufficiency. COMAR 31.10 § 34.04.
- 82 Managed Care. Kan. Stat. Ann. § 40-4607.
- 83 Definitions. AAC R20-6-1902.
- 84 Availability Ratios. AAC R20-6-1916(C).
- 85 Access. AAC R20-6-1914(1).
- 86 Access. AAC R20-6-1914(2).
- 87 Access. AAC R20-6-1914(3).
- 88 Access. AAC R20-6-1914(4).
- 89 Access. AAC R20-6-1914(5).
- 90 Access. AAC R20-6-1914(6).
- 91 Geographic Availability in an Urban Area. AAC R20-6-1917.
- 92 Geographic Availability in a Suburban Area. AAC R20-6-1918.
- 93 Geographic Availability in a Rural Area. AAC R20-6-1919.
- 94 2017 Letter to Issuers in the Federally-facilitated Marketplaces. (29 February 2016). Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. Retrieved from: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf>
- 95 Giovannelli, J., Lucia, K. & Corlette, S. (May 2015). Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks. Retrieved from The Commonwealth Foundation: http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf
- 96 Essential Community Providers. 45 CFR 156.235 (a). (Amended 8 March 2016).
- 97 Personal Interview with Cheri Tomlinson, Vice-President of Grants and Research at Maricopa Integrated Health Systems. (31 May 2016).
- 98 Essential Community Providers. 45 CFR 156.235(c). (Amended 8 March 2016).
- 99 Qualified Health Plans. (n.d.). Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. Retrieved from: <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>
- 100 Final PY 2018 ECP List. (22 August 2016). Retrieved from HealthCare.gov: <https://data.healthcare.gov/view/ecf3-gujb>
- 101 Essential Community Providers: General ECP Standard. 45 CFR § 156.235(a)(2)(ii)(3). (8 March 2016).
- 102 E-mail correspondence from Cheri Tomlinson, Vice-President of Grants and Research at Maricopa Integrated Health Systems. (6 September 2016).
- 103 Sumner, L. (10 March 2015). Health Plan Features: Implications of Narrow Networks and the Trade-Off between Price and Choice. Retrieved from AcademyHealth: <http://www.academyhealth.org/publications/2015-03/health-plan-features-implications-narrow-networks-and-trade-between-price-and>
- 104 O'Connor, J.T. & Spector, J.M. (2 July 2014). High-Value Healthcare Provider Networks. Retrieved from Milliman Report: https://www.ahip.org/wp-content/uploads/2016/02/High-Value-Provider-Networks-Issue-Paper-2014_07_01.final.pdf.pdf
- 105 Polsky, D. & Weiner, J. (August 2015). State Variation in Narrow Networks on the ACA Marketplace. Retrieved from University of Pennsylvania Leonard Davis Institute of Health Economics: <http://ldi.upenn.edu/sites/default/files/rte/state-narrow-networks.pdf>
- 106 Draper, K., Lechner, A. E. & Tu, H.T. (May 2015). Marketplace Health Plans Embrace Limited-Provider Networks to Keep Premiums Affordable. Retrieved from the Robert Wood Johnson Foundation: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420648

- 107 Ahn, S., Colette, A., & Lucia, K. (September 2014). Implementation of the Affordable Care Act: Cross-Cutting Issues Six-State Case Study on Network Adequacy. Retrieved from the Robert Wood Johnson Foundation: <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415649>
- 108 Network Breadth Pilot: CMS Bulletin on Network Breadth Information for Qualified Health Plans on Healthcare.gov. (19 August 2016). Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. Retrieved from: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Network-Classification-Pilot-Guidance-81916.pdf>
- 109 Damico, A. & Newkirk, V. (29 May 2014). The Affordable Care Act and Insurance Coverage in Rural Areas. Retrieved from Kaiser Family Foundation: <http://kff.org/uninsured/issue-brief/the-affordable-care-act-and-insurance-coverage-in-rural-areas/>
- 110 Avery, K., Finegold, K., & Xiao, X. (10 June 2016). Impact of the Affordable Care Act Coverage Expansion on Rural and Urban Populations. *ASPE Issue Brief*. Retrieved from U.S. Department of Health and Human Services: <https://aspe.hhs.gov/sites/default/files/pdf/204986/ACARuralbrief.pdf>
- 111 HealthCare.gov Marketplace Plan Selections by Rural Status. (1 February 2016). Retrieved from Kaiser Family Foundation: <http://kff.org/health-reform/state-indicator/healthcare-gov-marketplace-plan-selections-by-rural-status/?currentTimeframe=0>
- 112 Plan Selections by Zip Code and County in the Health Insurance Marketplace: March 2016. (11 March 2016). Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services. Retrieved from: <https://aspe.hhs.gov/basic-report/plan-selections-zip-code-and-county-health-insurance-marketplace-march-2016>
- 113 United States Census Bureau. Community Facts. Retrieved from American Fact Finder: https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml
- 114 Tabor, J., Jennings, N., Kohler, L., Degnan, B., et al. (February 2016). AzCRH 2015 Supply and Demand Study of Arizona Health Practitioners and Professionals. Retrieved from the University of Arizona Center for Rural Health: http://crh.arizona.edu/sites/default/files/022616_AzCRH_Supply_and_Demand_Report.pdf
- 115 Personal Interview with Rich Polheber, Chief Executive Officer, Benson Hospital. (22 June 2016).
- 116 Telemedicine; coverage of health care services; definitions, ARS § 20-841.09.
- 117 Telemedicine; coverage of health care services; definitions, ARS § 20-1057.13.
- 118 Health care plans; disclosure form; enrollee notification, ARS § 20-1076.05.
- 119 Telemedicine; coverage of health care services; definitions, ARS § 20-1406.05.
- 120 Insurance coverage; telemedicine, Arizona SB 1363, Ch 278. (2016).
- 121 Alternative Access, AAC R20-6-1915(C). (2015).
- 122 Health Benefit Plan Network Access and Adequacy Model Act § 5(b)(8). (2015). Retrieved from National Association of Insurance Commissioners: <http://www.naic.org/store/free/MDL-74.pdf>
- 123 About Us. (2015). The University of Arizona: Arizona Telemedicine Program. Retrieved from: <http://telemedicine.arizona.edu/about-us/home>
- 124 Rowe, N. (17 March 2016). Telehealth and the bottom line. Retrieved from [HealthCareBusiness Daily News](http://HealthCareBusiness.com) : <https://www.dotmed.com/news/story/28895>
- 125 Personal Interview with Brian Turney, Chief Executive Officer, Kingman Regional Medical Center. (12 July 2016).
- 126 McVeigh, J. (16 January 2014). Mayo Clinic Researchers Show Telestroke is Cost-Saving. Retrieved from Mayo Clinic New Network : http://newsnetwork.mayoclinic.org/discussion/telestroke-is-cost-saving-for-society-mayo-clinic-researchers-show/?_ga=1.109923264.472233199.1434696996,%20January%202016
- 127 Ahn, S., Colette, A., & Lucia, K. (April 2016). ACA Implementation—Monitoring and Tracking: Can Telemedicine Help Address Concerns with Network Adequacy? Opportunities and Challenges in Six States. Retrieved from the Robert Wood Johnson Foundation: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf428136
- 128 Telemedicine Specialties. (n.d.) The University of Arizona: Arizona Telemedicine Program. Retrieved from: <http://www.telemedicine.arizona.edu/clinical-services/specialties>
- 129 Personal Interview with Don Graf, National Director of Telehealth for UnitedHealth, (15 July 2016).
- 130 Arizona Telemedicine Network (2012). Retrieved from the University of Arizona: Arizona Telemedicine Program: <http://telemedicine.arizona.edu/applications-network/home>
- 131 Urias, C. (2006 August 26). Implementation of HCSO Network Adequacy Rules. *Regulatory Bulletin 2006-07*. Retrieved from Arizona Department of Insurance: <https://insurance.az.gov/sites/default/files/documents/files/2006-07.pdf>
- 132 Disclosure of Information, N.Y. Insurance Law § 3217(a)(17).
- 133 Network Adequacy Standards, 45 CFR & 156.230(b). (2012 & Supp. 2015, 2016).
- 134 National Association of Insurance Commissioners. Health Benefit Plan Network Access and Adequacy Model Act § 9(a)(2). Retrieved from [naic.org](http://www.naic.org): <http://www.naic.org/store/free/MDL-74.pdf>
- 135 Accurate Provider Directories. OCGA §33-20C-3 (d). (2016).
- 136 Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations. TAC § 3.3705(f)(1). (Amended 3 November 2016).

Appendix A: Glossary

Actuarial Value. See also **Metal Level**. The percentage amount that the insurer pays of the overall cost of providing **essential health benefits** to consumers enrolled in a plan. Placing an actuarial value on health plans is intended to make it easier for consumers to compare them to each other. The ACA provides for actuarial values of 60% (**bronze plans**), 70% (**silver plans**), 80% (**gold plans**) or 90% (**platinum plans**).

Advanced Premium Tax Credit. See **Premium Tax Credit**.

Ancillary Provider. In the context of this report, a provider of a hospital service such as anesthesiology or radiology that is ancillary to a service such as surgery that is being provided by a primary provider.

Annual Benefit Limit. The cap on the dollar amount of benefits that an insurance company will pay in a year for a consumer enrolled in a health plan. After the annual limit is reached, a consumer must pay out of pocket for all health care costs for the remainder of the year. The ACA prohibits annual benefit limits.

Balance Bill. A bill from a health care provider to a health plan or an enrollee for the difference between the health plan's allowed amount and the provider's charges for services provided, when the health plan (usually an HMO) is obligated to pay the difference.

Balance Billing Law. In Arizona, a law that establishes that if an HMO plan fails to pay an in-network provider for health care services to an HMO enrollee, the enrollee is not liable for any remaining amount (balance) that the HMO plan owes the provider. The law prohibits in-network providers from billing the HMO enrollee if the plan does not pay the provider. ARS § 20-1072.

Bronze Plan. An ACA-compliant health plan with an actuarial value of approximately 60%. The health plan must pay for an average of 60% of the cost of providing essential health benefits to an enrollee. The enrollee pays the remaining 40% through cost-sharing in the form of deductibles, copayments and coinsurance.

Catastrophic Plan. A health plan that meets all of the requirements applicable to Marketplace plans, except that the plan does not cover any benefits other than 3 primary care visits per year before the enrollee meets the deductible. Catastrophic plans have an actuarial value of less than 60% and are only available to people less than 30 years old or people who have qualified for a "hardship exemption" based on their inability to afford coverage.

Children's Health Insurance Program ("CHIP"). A federally and state funded program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. In Arizona, this program is called "KidsCare."

Community Rating. A method for setting premium rates for health insurance plans under which all policy holders are charged the same premium for the same coverage. The insurer does not vary premiums for individual enrollees based on the health status or claims history of policy holders. Under the ACA, insurers are allowed to vary premiums based only on age, tobacco use, family size, and geography.

Coinsurance. A percentage of costs that a consumer is responsible for paying for a covered health care service after they have met their deductible.

Copayment. A fixed amount that a consumer is responsible for paying for a covered health care service after they have met their deductible.

Cost-Sharing. The share of the costs for services covered by the consumer's insurance that the consumer is responsible for paying out of pocket (i.e. deductibles, coinsurance, copayments, etc.)

Cost-Sharing Reduction (CSR). A discount that lowers the amount the consumer must pay for cost-sharing. The consumer must qualify for CSR and must enroll in a Silver category plan in order to receive CSR.

Deductible. The amount the consumer must pay for health care services before the insurance plan starts to pay.

Essential Community Providers (ECPs). Providers that primarily serve low-income and medically underserved individuals.

Essential Health Benefits (EHB). Ten categories of health care services that health plans must cover to meet the requirements of the Affordable Care Act:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive services and chronic disease management,
- Pediatric services, including dental and vision care.

The EHB requirement in effect prohibits the pre-ACA insurer practice of excluding coverage for pre-existing conditions, such as diabetes, or coverage for healthcare needs that might arise in the future, such as maternity and newborn care.

Federal Poverty Level (FPL). The federal government’s working definition of poverty that is used as the reference point to determine the number of people with income below poverty and the income standard for eligibility for public programs. This level generally changes every year.

Formulary (Also called a “drug list”). A list of prescription drugs that are covered by a prescription drug plan or a health insurance plan that offers prescription drug benefits.

Gold Plan. An ACA-compliant health plan with an actuarial value of approximately 80%. The health plan must pay for an average of 80% of the cost of providing essential health benefits to an enrollee. The enrollee pays the remaining 20% through cost-sharing in the form of deductibles, copayments and coinsurance.

Health Maintenance Organization (HMO). A health insurance product that limits its coverage to services from providers that work for or contract with the HMO. HMOs generally do not cover out-of-network care except in emergencies or situations where the HMO network does not include a provider who can meet an enrollee’s medical needs.

High Profile Specialist. Under Arizona law, a provider in one of no fewer than four specialties designated by an HMO plan, not including obstetrics/gynecology. An HMO may designate a specialty as high profile on the basis of high volume or other basis the HMO reasonably determines is directly related to providing covered services to enrollees.

Hospitalist. A provider such as a physician, nurse practitioner, or physician assistant, usually specializing in internal medicine, who works exclusively in an inpatient setting to provide services for hospitalized patients.

Lifetime Benefit Limit. A cap on the total benefits an enrolled consumer may receive from his or her health insurance plan insurance company over his or her lifetime.

Lifetime Benefit Maximum A cap on the amount of money insurers will pay toward the cost of health care services over the lifetime of the insurance policy.

Maximum Out-of-Pocket Limit. See **Out-of-Pocket Limit.**

Medicaid. A federal program enacted in 1965 under the Social Security Act. Medicaid provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines.

Medical Underwriting. The process of determining whether or not to accept an applicant for health care coverage based on their medical history. This process determines what the terms of coverage will be, including the premium cost, and any pre-existing condition exclusions.

Metal Levels. A shorthand way to describe the **actuarial value** of health plans. The levels are:

Metal Level	Actuarial Value	How the Actuarial Level Affects Cost
Bronze	60%	Health Plan pays 60%; Enrollee pays 40%
Silver	70%	Health Plan pays 70%; Enrollee pays 30%
Gold	80%	Health Plan pays 80%; Enrollee pays 20%
Platinum	90%	Health Plan pays 90%; Enrollee pays 10%

Narrow Network. A **network** that a health plan intentionally limits to a smaller number of providers than the plan has contracted with in the past, in an effort to lower the plan’s costs.

National Association of Insurance Commissioners (NAIC). A regulatory support organization governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate regulatory oversight.

NAIC Model Act. A model statute developed by the NAIC that sets standards for network adequacy and related matters. NAIC model laws are not binding. They include drafting notes, guidance and alternative provisions that states can refer to when developing their own requirements.

Navigator. An individual or organization trained to help consumers enroll in a health insurance plan. Navigators can assist consumers with completing eligibility and enrollment forms. Navigators provide unbiased help and provide services at no cost to consumers.

Network. The providers, facilities, and suppliers a health insurer has contracted with to provide health care services to consumers.

Network Adequacy. The ability of a health insurance plan provider network to provide enrollees with medically necessary and adequate care within a reasonable time frame and geographic distance from the consumer.

Network Exception. A situation in which an HMO plan must cover services that an enrollee receives out of network. Network exceptions arise when: (i) an enrollee needs emergency medical care and does not have time to get to an in-network provider; or (ii) there is not an appropriate provider in the network to meet the enrollee's medical needs. Under Arizona law, an HMO plan must handle network exceptions in a way that assures that the out-of-network costs for the enrollee are no greater than the costs the enrollee would incur for in-network services.

Out-of-Pocket Costs (See also **Cost-sharing**). The costs for covered health care services that an enrollee's health plan does not pay. These include deductibles, co-payments, and coinsurance but not premiums.

Out-of-Pocket Limit (Also called "**Maximum Out-of-Pocket Limit**"). The maximum amount an enrollee has to pay for covered services in a plan year. After the enrollee reaches the out-of-pocket limit, the plan pays 100% of the costs for covered services.

Platinum Plan. An ACA-compliant health plan with an actuarial value of approximately 90%. The health plan must pay for an average of 90% of the cost of providing essential health benefits to an enrollee. The enrollee pays the remaining 10% through cost-sharing in the form of deductibles, copayments and coinsurance.

Pre-existing Condition Exclusion. An exclusion of a benefit based on an enrollee's illness or medical condition before enrollment. Before the ACA took effect, insurers could make such exclusions for a defined amount of time before they began to provide the benefit.

Preferred Provider Organization (PPO). A type of health plan that provides a network of contracted participating providers but does not limit its coverage to services from providers that work for or contract with the PPO. Enrollees have lower out-of-pocket costs for using network providers than for using non-network providers.

Premium. The monthly amount an enrollee pays for health insurance. The premium does not include cost-sharing or out-of-pocket costs.

Premium Tax Credit (Also called "Premium Subsidy" or "Tax Credit"). A tax credit that reduces an enrollee's premium. The amount of the credit is determined on a sliding scale based on income.

Preventive Service Benefits. A set of preventive services that health insurance plans must provide to enrollees without requiring any cost-sharing, even if the enrollee has not met his or her deductible. Preventive services generally include shots, screenings, check-ups, and patient counseling that help to prevent illness or to detect illness at an early stage. The ACA preventive screening benefit applies to some, but not all preventive services.

Primary Care Provider. A physician, nurse practitioner, or physician assistant, as allowed under state law, usually specializing in family practice, pediatrics or internal medicine, who provides or helps a patient obtain health care services.

Product (Also called "Product Type"). A way of describing a network-based health plan or group of health plans according to whether enrollees have to obtain health care services from network providers (an **HMO** product) or whether enrollees have the option to obtain services from out-of-network providers (a **PPO** product).

Provider. A health care professional such as a doctor, nurse practitioner, psychologist, or physical therapist or a health care facility such as a hospital, urgent care clinic, pharmacy or out-patient surgical center.

Provider Directory. A list, either on-line or on paper, of providers in a health plan network, along with the provider's address, contact information, special area of practice and other information to assist enrollees in locating providers.

Provider Network. See **Network**.

Rate Review. A process state insurance departments use to review rates (premiums and premium increases) before insurers can apply the rates to enrollees. The review looks at whether the rates are based on reasonable cost assumptions and solid evidence.

Rating Area. A geographic area within a state that all issuers in the state must uniformly use as part of setting their premiums for the insurance they offer in the area. The ACA provides that each state will have a set number of rating areas. Arizona has the following seven rating areas:

Rating Area	County Name/s
Rating Area 1	Mohave, Coconino, Apache, Navajo
Rating Area 2	Yavapai
Rating Area 3	La Paz, Yuma
Rating Area 4	Maricopa
Rating Area 5	Pinal, Gila
Rating Area 6	Pima, Santa Cruz
Rating Area 7	Graham, Greenlee, Cochise

Risk Selection (Also called “Adverse Selection”). The insurance industry practice of designing health plans to segregate less healthy, higher-risk and higher cost enrollees from more healthy, lower risk and lower cost enrollees in order to avoid the costs associated with more expensive and/or more frequent claims.

Second Lowest Cost Silver Plan. The second-lowest priced **silver plan** in a Marketplace. The premium amount for this plan is used to determine the cost of a qualifying enrollee’s premium tax credit.

Silver Plan. An ACA-compliant health plan with an **actuarial value** of approximately 70%. The health plan must pay for an average of 70% of the cost of providing essential health benefits to an enrollee. The enrollee pays the remaining 30% through cost-sharing in the form of deductibles, copayments and coinsurance.

Surprise Bill. A bill from an out-of-network provider to an enrollee for the difference between a PPO plan’s allowed amount and the provider’s charges for services provided to the enrollee. Generally, a PPO plan is not obligated to cover the amount of the surprise bill.

Telemedicine. The practice of medicine using a telecommunications system to provide clinical services at a geographically separate site. Service can be delivered in “real time” using interactive video conferencing, or through “store and forward” which relies on the transmission of images and data for review immediately or at later time.

Usual and Customary (Also called “Usual, Customary and Reasonable”). The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

Appendix B: Acronyms

AAC – Arizona Administrative Code

ACA – Affordable Care Act

AHCCCS – Arizona Health Care Cost Containment System

ARS – Arizona Revised Statutes

ATP – Arizona Telemedicine Program

CEO – Chief Executive Officer

CFR – Code of Federal Regulations

CHIP – Children’s Health Insurance Program

CSR – Cost-Sharing Reduction

ECP – Essential Community Providers

EHB – Essential Health Benefits

FQHC – Federally Qualified Health Centers

FPL – Federal Poverty Level

HHS – Department of Health and Human Services (federal)

HMO – Health Maintenance Organization

KRMC – Kingman Regional Medical Center

MIHS – Maricopa Integrated Health Systems

NAIC – National Association of Insurance Commissioners

NARBHA – Northern Arizona Regional Behavioral Health Authority

PPO – Preferred Provider Organization

2929 N Central Ave, Ste 1550
Phoenix Arizona 85012

602.385.6500
vitalysthealth.org



**The ACA Marketplace in Arizona:
Insurer Participation, Affordability
and Network Adequacy**

Author: Alix Shafer and Taylor Kelly

Editorial Team: Stan Aronovitch,
Marcus Johnson, Emily Kepner,
Sue Navran, Nicholas Olson,
Suzanne Pfister, Roy Pringle,
Kim VanPelt, Jesse Walberer

©2017 Vitalyst Health Foundation.
All Rights Reserved.

Material may be published without permission
where proper acknowledgment is made.

Improving well-being in Arizona by addressing root causes and broader issues that affect health.

Count on us to pursue the following priorities:

- Increase access to care and coverage
- Promote healthy community policies and practices
- Build community capacity to improve the effectiveness of community-based organizations
- Promote innovation and collaboration that transforms policies and systems

For more publications, news, and other education and advocacy resources, visit vitalysthealth.org.



A CATALYST FOR COMMUNITY HEALTH