Covered Clips

A Weekly Summary of News and Activities for the Cover Arizona Coalition[](http://stylegirlfriend.com/wp-content/uploads/2012/04/paper-clips-style-girlfriend.jpg)

Weeks of October 5th – 26th

**2016 Arizona Silver-Level Plans and Sample Premiums**

**Lowest Premium by Plan, 40 Year Old, Single, Non-Smoker, Maricopa County**

|  |  |  |
| --- | --- | --- |
| **Company** | **Plan Type** | **Premium** |
| **Phoenix Health Plans, Inc.** | **HMO** | **$204.09** |
| **Health Choice Insurance Co, Inc.** | **HMO** | **$206.91** |
| **Meritus Health Partners** | **HMO** | **$209.22** |
| **All Savers Insurance Company (United)** | **PPO** | **$248.69** |
| **CIGNA Healthcare of Arizona** | **HMO** | **$259.21** |
| **Blue Cross Blue Shield of Arizona** | **HMO** | **$268.79** |
| **Humana Health Plan Inc.** | **HMO** | **$269.15** |
| **Aetna Health Inc.** | **HMO** | **$277.00** |

**Source: SLHI and Arizona Alliance of Community Health Centers Analysis of Arizona Department of Insurance Report, 10/1/15**

**HHS: Arizona Health Plan Set for 17.5% Rate Hike**

The Arizona Republic

Arizonans who buy health insurance from the Affordable Care Act marketplace next week will see that the key benchmark plan raises monthly rates 17.5 percent — more than twice the national average rate increase, according to figures released Monday by the U.S. Department of Health and Human Services.

The benchmark plan is the second-lowest-cost silver plan in any geographic region and is used to calculate subsidy rates for low- and middle-income consumers. The average benchmark plan across the 37-state federal marketplace will increase 7.5 percent next year, HHS said.

The amount  people pay depends on age, residence, whether they smoke and the type of plan they choose. The three-month open-enrollment period begins Nov. 1 for health coverage that begins in 2016.

Several health insurers that sell plans in Arizona will raise average rates in excess of 10 percent, and many insurers are converting to health plans that offer smaller networks of doctors and hospitals.

Experts say that 2016 rates likely will be more realistically priced than those of the first two years of the  ACA marketplace because health insurers have a better idea of how often the newly insured consumers are using medical care. Before the marketplace launched in January 2014, health insurers could deny or limit coverage based on a person's health, a major tool to keep costs lower.

During the first two years of the federal marketplace, Arizona's benchmark rates were far lower than those of most other states that used the federal marketplace. Consumers benefited from cheaper plans, but the lower-priced benchmark rates also limited tax-credit subsidies for some younger and middle-income consumers.

"We know Phoenix had some of the lowest premium rates in the whole country," said Allen Gjersvig, the Arizona Alliance for Community Health Centers' director of health-care innovation. "It is not shocking that it will go up."

For example, figures provided by the Arizona Department of Insurance show there will be 41 silver plans with average monthly premiums that range from $204 to $328 for a single, 40-year-old Maricopa County resident who does not smoke.

The HHS report issued Monday did not provide monthly premium rates for states or cities, only percentage increases for benchmark plans.

The average benchmark plan in metro Phoenix will charge 19 percent more in 2016 compared to this year. The benchmark plan in Tulsa, Okla., had the highest rate increase, 35 percent, while the benchmark rate in Indianapolis will drop nearly 12 percent.

Most people who buy plans over the federal marketplace get subsidies to offset their monthly premium. Nearly eight in 10 people who buy a plan through healthcare.gov will pay less than $100 month in 2016, after subsidies are calculated, HHS said.

About 165,000 Arizona residents purchased health insurance through the federal marketplace as of March 31. Arizona's Medicaid expansion, funded largely through the  ACA, had extended coverage to more than 364,000 Arizonans as of last month.

The uninsured who don't qualify for an exemption must pay a penalty that equals the greater of 2.5 percent of household income or $695 per  adult and $347.50 per minor. The penalty is assessed when a person or family files their federal income tax return.

"We are hopeful that more and more people will understand the importance of shopping around for coverage as well as the implications for not having coverage," said Kim VanPelt of St. Luke's Health Initiatives, which helped organize a coalition of mainly non-profit groups to encourage insurance sign-ups.

VanPelt said people who need enrollment assistance can visit [www.coveraz.org](http://www.coveraz.org) and request in-person appointment.

**http://www.azcentral.com/story/money/business/consumers/2015/10/26/hhs-arizona-health-plan-set-175-rate-hike/74651446/#**

**Improving the Consumer Experience at HealthCare.gov**

**CMS**

Open Enrollment is just around the corner, and we’re ready to welcome consumers back to HealthCare.gov. Over the last few months, our team has been hard at work, applying lessons learned and taking steps to make enrollment quicker and smoother for both returning and new customers. Ahead of Open Enrollment 2016, new features were added to HealthCare.gov based on consumer feedback about previous experiences with the site and the type of additional information they want in order to pick the right plan. Over the next several weeks, we’ll be rolling out additional features to provide consumers with even more information about their plan choices.

Take a look at just some of the improvements for 2016 Open Enrollment:

·         Streamlined Navigation: Directions, buttons, and page designs were improved to better communicate information and next steps to people visiting the website.

·         Consumer-Specific Information: We’ve tailored information specific to whether a consumer is new or is returning so that consumers will have an experience that matches their unique situation. New information has been added to the website to help each consumer understand exactly where they are in the enrollment process and what steps remain.

·         Simplified Re-enrollment: When returning consumers come back to HealthCare.gov, they will be able to easily find their current plan if it is available again for next year and compare it with other available plans in their area without having to manually search by entering a 14-digit plan identification number.

·         Understanding Marketplace Eligibility: This year, instead of needing to open their eligibility notice, consumers will immediately see on the screen the type of coverage they qualify for, how much financial help they are eligible for, and whether they need to submit additional information because there was a data matching inconsistency.  After seeing a summary on screen, consumers still will be able to view full details by downloading a PDF of their eligibility notice, which brings with it content enhancements and an improved section layout to increase awareness of key takeaways and next steps.

·         Reducing Data-Matching Issues: Additional prompts have been added to encourage people to enter a Social Security Number or an immigration document information if they are requested to and fail to do so initially. The prompt includes reminder messaging that explains that if they do not enter this information now they may have to provide additional documentation later.

·         Improvements to Log-In: We made it easier for consumers to reset passwords if they no longer have access to the email they used to create their HealthCare.gov account. If a consumer forgets her password and is unable to retrieve it, representatives at the Marketplace Call Center will be able to help her change her email address and reset her password to make sure consumers have access to their accounts.

·         Understanding True Costs: A new Out of Pocket Cost feature has been added to the website this year that will help consumers better estimate the cost of their health insurance based on their own personal situation. The new feature has been added to the Window Shopping tool and provides consumers with an opportunity to get an estimate of what their premiums, deductibles, and co-pays may be for each specific plan prior to enrolling based on a low/medium/high anticipated health care service utilization.

·         Searching for Providers and Prescriptions: In the coming weeks, two additional beta features will be launched – the new Doctor Lookup feature and the Prescription Drug Lookup feature when viewing plans and pricing. These features, which are in development, will provide consumers with easily searchable information about the doctors and prescriptions plans may cover as consumers shop and enroll in coverage.

·         Adding new decision support features and making consumer-facing fixes represent one side of the improvements we made this year. Improvements to our information technology infrastructure and “back end” have enhanced the website’s stability and performance compared to last year and will provide a faster and smoother experience for consumers when they visit the website.

·         Faster experience. We’ve made simplifications to our system that resulted in a reduction of hardware on the website by 40 percent. While visitors to the website will not see evidence of these improvements on their computer screen, users should find the website to be faster and more responsive than previous years.

·         Updated account management system. We completely replaced the technical underpinnings of how consumers create accounts and log-in online. While the user will ultimately notice nothing different on screen, the simpler architecture we put in place is now faster, more stable, and allows for an increasing number of users to visit the website at the same time.

·         Improved ability to identify problems. The simplifications we made make it easier for us to address bumps along the road - we’ll be able to find and fix system errors faster.

**Insurers Find Out-Of-Network Bills as Much as 1,400 Percent Higher**

**Kaiser Health News**

It’s common knowledge that consumers have to pay more money if they choose doctors or hospitals outside of their insurance plan’s network. But [a new analysis](http://www.ahip.org/epub/OON-Report-2015/) prepared by the insurance industry seeks to show just how much more in each of the 50 states.

Out-of-network providers charged patients on average 300 percent more than the Medicare rate for certain treatments or procedures, according to the analysis of 2013 and 2014 claims data released Thursday by the America’s Health Insurance Plans. The industry group, which supports limiting out-of-network charges, found that some treatments were even more exorbitant — with out-of-network providers charging nearly 1,400 percent more than what is reimbursed by Medicare.

Charges for an MRI of the brain, for example, cost on average $2,929 with an out-of-network provider, compared to the Medicare rate of $405, according to the report. And patients who needed a one-hour chemotherapy infusion paid on average $437 while Medicare reimbursed $136, the group found.

The study found significant differences among providers for the same treatments and wide geographic differences. California had some of the largest gaps between out-of-network charges and Medicare rates. For example, out-of-network providers billed an average of 626 percent higher than Medicare for a brain MRI.

Other states also saw out-of-network charges that far exceeded the Medicare rates, the study found. In New York, providers charged on average 1,100 percent more than the Medicare fee for low back disc surgery. And emergency care in Florida cost about 700 percent higher for out-of-network care.

“This is the blueprint to show that there is more work to be done and that we have to fix this problem for patients,” said Clare Krusing, spokeswoman for America’s Health Insurance Plans. “There needs to be much more disclosure from hospitals and doctors and specialists.”

Krusing said limits should be set on charges that out-of-network providers can bill. The report is based on 18 billion claims covering about 100 medical procedures performed in 2013 and 2014 in all of the states.

In a prepared statement, Dr. Steven J. Stack, president of the American Medical Association, called the insurance industry report “grossly misleading.”

He said the report features a handful of extreme examples and compares them to Medicare payments that have lagged behind inflation for years. The report also provides no information on how much patients actually paid for care, he said. And the study does not address the role of the insurance industry in pushing costs upward, he said.

“If there is a growing problem with out-of-network billing, it’s because the insurance industry has created it with ever more restrictive provider networks, “Stack said.

Betsy Imholz, director of special projects for Consumers Union, agreed with the report’s finding that providers are charging too much — but she said it is hardly surprising.

“Some providers will take whatever they can get,” she said. “If there is no limitation … they will ask for the most they can.”

The bigger problem, Imholz said, is when patients get stuck with surprise bills. That happens when they go to an in-network hospital but are unknowingly treated by anesthesiologists or other specialists not in the plan’s network.

“The rude awakening is that when they get home … there are these huge other bills that come filing in,” she said. “The Affordable Care Act was aimed at making care affordable, and we want it to remain that way.”

A few states, including New York, have passed laws to protect patients from higher surprise bills. Proposed legislation that would have done so in California recently died in the legislature.

Imholz said consumer advocates would try again. “We are not giving up on this,” she said.

<http://khn.org/news/insurers-find-out-of-network-bills-as-much-as-1400-percent-higher/>

**Practices See Minor Economic Gain from ACA Coverage Expansion**

Medscape

Total revenue collections of physician practices increased from 2013 to 2014 in states that expanded their Medicaid programs as a result of the Affordable Care Act (ACA) and in states that did not, says a [new report](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf423784) from ACAView, a joint project of electronic health record vendor athenahealth and the Robert Wood Johnson Foundation.

But overall, the ACA has not had much effect on practice revenues, according to the report.

Athenahealth has a quantity of data on the billing and collection of its customers because it provides them with a cloud-based practice management system. The new research shows the impact of the ACA on 19,600 physicians who began subscribing to athenahealth software before 2012.

According to ACAView, collections by primary care practices increased 3% in states that expanded Medicaid eligibility and 3.3% in nonexpansion states. Surgeons increased collections by 2% and 4% in expansion and nonexpansion states, respectively.

The greater increase of collections in nonexpansion states might seem counterintuitive, considering that more people have insurance coverage in the expansion states than in the nonexpansion states. But a number of other factors were involved in the growth of practice revenues across the country.

Higher reimbursement rates were a factor in the 3.3% rise of collections across primary care practices in nonexpansion states, counterbalancing a 1.3% decrease in visit volume, ACAView shows. In a separate article in *Health Affairs*, the ACAView researchers show that commercial insurance payments for office visits by new and established patients to primary care doctors and ob/gyns increased from 2013 to 2014. (Payments to general surgeons and orthopedists dropped.)

The new ACAView report also shows that primary care practices in nonexpansion states benefited from an increase of 1.6% in work complexity (relative value units [RVUs] per visit) and a 3% rise in collections per RVU. Primary care practices in expansion states saw a similar pattern, but their visit volume decreased only 0.3%.

In nonexpansion states, 57% of the PCPs' collection increase was attributed to commercially insured patients aged 41 to 64 years. This was consistent with the increase in the percentage of PCP visits from commercially insured adults from 2013 to 2014, the report shows.

In expansion states, by contrast, 46% of the increase in collections in expansion states came from Medicaid patients aged 41 to 64 years.

Medicare was the other main driver of increased PCP collections, accounting for 50% of the growth in nonexpansion states and 44% in expansion states. Currently, Medicare patients account for a quarter of visits to doctors' offices, and that percentage is expected to increase, according to the report.

ACAView attributed the 4% increase in collections for surgeons in nonexpansion states to a 3.5% increase in visit volume and a small increase in acuity. There was also a slight decrease in collections per RVU. The 2% increase in collections in expansion states was driven by a 2% increase in collections per RVU and a 1% increase in visit volume, the report shows.

In nonexpansion states, 51% of the surgeons' increased collections were from commercially insured patients aged 41 to 64 years, and 40% was attributed to Medicare. In expansion states, nearly all of the increase came from Medicaid. Medicaid patients aged 18 to 40 years accounted for 34% of the growth, and those aged 41 to 64 years generated 73% of the increased revenue.

"This suggests that Medicaid expansion may be tapping into a previously unmet need among the poor for surgical services," the report's authors write.

A "Nonevent"

"Overall," they concluded, "our data suggest that the coverage expansion provisions of the ACA have not had a negative financial effect on medical practices. An increase in reimbursement rates has offset a slight reduction in visits to PCPs, while surgeons in our sample are seeing more patients."

The data also show that although millions of Americans have gained insurance under the ACA, the number of physician office visits has not increased dramatically. The number of primary care visits has actually dropped, and the number of surgical encounters has risen only slightly.

"Despite the many disruptive changes associated with health reform, these data suggest that in terms of revenue growth for office-based physicians, so far it is largely a nonevent," said Kathy Hempstead, who directs coverage issues at the Robert Wood Johnson Foundation, in a news release.

http://www.medscape.com/viewarticle/852177

**Obamacare Open Enrollment: eHealth Report Finds Out-of-Pocket Prescription Drug Costs Have Highest Impact on Satisfaction with Obamacare Plans**

Arizona Republic

Today eHealth, Inc. ([NASDAQ: EHTH](http://finance.azcentral.com/azcentral/quote?Symbol=537%3A2546545)) ([eHealth.com](http://ctt.marketwire.com/?release=11G069369-001&id=7504663&type=0&url=https%3a%2f%2fwww.ehealthinsurance.com%2f%3fallid%3dPre32944)), the nation's first and largest private online health insurance exchange, published two reports suggesting how strongly consumers' personal expenditures for prescription drugs and other medical care correlate to dissatisfaction with their health insurance. The reports also shed light on just how much of a burden some consumers face in out-of-pocket costs for prescription drugs and other medical care.

eHealth's [Consumer Satisfaction & Spending for Prescription Drugs and Medical Care](http://ctt.marketwire.com/?release=11G069369-001&id=7504666&type=0&url=https%3a%2f%2fwww.ehealthinsurance.com%2fresource-center%2fwp-content%2fuploads%2fCSI-Survey-Report-2016-FINAL.pdf) report and its [Coverage Satisfaction & Utilization Snapshot](http://ctt.marketwire.com/?release=11G069369-001&id=7504669&type=0&url=https%3a%2f%2fwww.ehealthinsurance.com%2fresource-center%2fwp-content%2fuploads%2fCSI-Utilization-Snapshot-FINAL.pdf) found that the largest factors predictive of a consumer's satisfaction with their health coverage relate to how much money they spend out of pocket (e.g. in copayments or deductibles) on prescription drugs and medical care.

eHealth's [Utilization Snapshot report](http://ctt.marketwire.com/?release=11G069369-001&id=7504672&type=0&url=https%3a%2f%2fwww.ehealthinsurance.com%2fresource-center%2fwp-content%2fuploads%2fCSI-Utilization-Snapshot-FINAL.pdf) provides a glimpse into how many health insurance consumers face unexpected out-of-pocket costs and what they are actually spending when it comes to prescription drugs and medical care.

On spending for prescription drugs:

* 35% said they faced unanticipated prescription drug costs in 2015
* $848 was the average estimated amount spent out of pocket among those with unanticipated drug costs
* 22% said they spent more than $1,000 out of pocket on prescription drugs

On spending for medical care:

* 35% said they used their health coverage for non-preventive medical care in 2015
* 91% of those receiving non-preventive medical care paid out-of-pocket costs in the form of deductibles, co-pays, coinsurance and/or out-of-network charges, etc.
* $2,380 was the average estimated amount spent among those who reported paying out-of-pocket for medical care

Average estimated out-of-pocket costs by medical care received:

* $3,738 for a major surgery
* $3,101 for maternity care
* $2,723 for a minor surgery
* $2,696 for an unexpected illness
* $2,042 for emergency care
* $1,989 for mental health care
* $1,798 for chronic disease management

eHealth's Consumer Satisfaction Index Demonstrates Effect of Costs on Satisfaction

eHealth's [Consumer Satisfaction & Spending for Prescription Drugs and Medical Care](http://ctt.marketwire.com/?release=11G069369-001&id=7504675&type=0&url=https%3a%2f%2fwww.ehealthinsurance.com%2fresource-center%2fwp-content%2fuploads%2fCSI-Survey-Report-2016-FINAL.pdf) report reveals how personal expenditures for prescription drugs and medical care can affect consumers' satisfaction with their health plan and their sense of being valued as a customer by their insurer (as recorded by a "strongly agree" or "agree" response to that survey item):

On satisfaction and prescription drug costs:

* 23% of those who spent more than anticipated on prescription drugs felt valued by their insurer
* Only 15% of those who spent more than $2,000 on prescription drugs felt valued by their insurer

On satisfaction and out-of-pocket spending:

* 44% of those who spent up to $1,000 toward medical care felt valued by their insurer
* Only 28% of those who spent more than $2,000 toward medical care felt valued by their insurer

On satisfaction by type of medical care received:

* 60% of those who had major surgery felt valued by their insurer
* 39% of those who received maternity care felt valued by their insurer
* 38% of those who received only preventive medical screenings felt valued by their insurer
* 37% of those who received emergency care felt valued by their insurer
* 35% of those who received care for chronic disease management felt valued by their insurer
* 29% of those who reported receiving out-of-network care felt valued by their insurer
* 40% of those who only saw network medical providers for care felt valued by their insurer

On satisfaction and access to government subsidies:

* 52% of those who said they were receiving government subsidies felt valued by their insurer
* 29% of those who said they were not receiving subsidies felt valued by their insurer

"No one loves spending money out of pocket toward prescription drugs or medical care, but this survey suggests just how big a role personal expenditures play in consumer satisfaction with health coverage," said Gary Lauer, Chairman and CEO of eHealth, Inc. "Too many health insurance shoppers ignore deductibles and copayments, which can be a major burden for many consumers, and focus only on monthly premiums. If you want to be happier with your coverage over time, we recommend that you work with a licensed agent in the upcoming 2016 open enrollment period to help you choose the plan best suited for you."

eHealth's reports are based on a nationwide online survey of eHealth customers conducted in July and August of 2015. More than 6,500 responses were collected. All respondents had previously purchased individual or family health insurance plans through eHealth.com, the company's private online marketplace. Respondents were invited to rate their agreement with five satisfaction criteria defined by eHealth. Additional questions were asked about coverage utilization and out-of-pocket costs. For more information about the survey, refer to the Methodology section at the end of each report.

http://finance.azcentral.com/azcentral/news/read/30913976/obamacare\_open\_enrollment

**Some Health Plans Have No In-Network Doctors in Key Specialties**

NPR

Say you bought health insurance through the federal health exchange, paid the premiums and followed the rules.

And then say you start having pain in your hands. Your doctor refers you to a rheumatologist to test for arthritis.

But when you search for the specialist, there isn't one there.

That happens more often than you'd think. In fact, as many as 14 percent of health plans sold on the federal government's insurance exchange are missing doctors in at least one common specialty from their networks, according to a [study](http://jama.jamanetwork.com/article.aspx?articleid=2466113&resultClick=3) published Tuesday in *JAMA,* the journal of the American Medical Association, by researchers at Harvard's T.H. Chan School of Public Health.

The means patients may find themselves facing big medical bills for care they thought they had bought insurance to cover.

The researchers reviewed 135 health plans in the 34 states that sell health insurance through the [federal marketplace](https://www.healthcare.gov/) and found that 19 of them lacked in-network specialists in some areas. The most common missing specialties were psychiatry, rheumatology and endocrinology.

"If somebody needed to access a psychiatrist or a rheumatologist, or they had a thyroid disorder and needed an endocrinologist, they would not be able to find an in-network specialist to care for them," says [Stephen Dorner](http://www.hsph.harvard.edu/diversity/student-ambassadors/stephen-dorner/), a medical student who was an author of the study while he earned his master's degree at Harvard.

Dorner and his colleagues searched for specialists within 50 miles and 100 miles of the most populous city where each plan was offered. Some plans lacked specialists such as dermatologists and oncologists in the narrow radius but included them farther away.

The Affordable Care Act requires that health insurance plans have enough doctors in their networks to ensure that their customers can get the health care they need.

"From where we were sitting, in our analysis, having no access to an in-network specialist didn't seem like sufficient access to us," Dorner says.

People who buy insurance without access to specialists can face unexpected costs. The study showed that five of the 19 plans that lacked at least one specialist do not cover any expenses from out-of-network doctor visits. An additional 11 require the patient to pay at least half.

The study was actually designed to be easy on health plans. Dorner says the researchers focused on the most populous areas in the 34 states so they would be more likely to find doctors located nearby. He said it's likely the health insurance plans in rural areas lack even more specialists, simply because there aren't any located within 100 miles of the customers.

The deficient health plans were all found in just nine states, the study says. However, the researchers declined to name those states.

<http://www.npr.org/sections/health-shots/2015/10/27/452254106/some-health-plans-have-no-in-network-doctors-in-key-specialties>

**Obama Signs Law Preventing Premium Hikes under Health Law**

Associated Press

President Barack Obama has signed legislation aimed at preventing premium increases that some smaller businesses were expecting next year under his signature health care law.

The White House says Obama signed the bill into law Wednesday. It represents an uncommon instance in which both parties rallied behind an effort to revamp part of the Affordable Care Act.

Under Obama's health care law, companies considered small businesses must offer certain required benefits. Business groups had complained that many employers' health care costs would increase.

Previously, small businesses were defined as those having up to 50 employees. But that number was set to expand to 100 on January 1.

The new law keeps the small business definition at 50 workers but allows states to increase the number if they choose.

<http://news.yahoo.com/obama-signs-law-preventing-premium-hikes-under-health-234846944--politics.html?utm_campaign=KHN:+First+Edition&utm_source=hs_email&utm_medium=email&utm_content=22683659&_hsenc=p2ANqtz-_sSqYzr-_-s1Hz3XD3mLJRW4EY2xoXNoyl3LrrTjYE&tr=y&auid=16082367>

**Why Four Major Arizona Insurance Carriers Are Dropping PPO Plans**

The Arizona Republic

Four major health insurance companies will discontinue preferred-provider plans for tens of thousands of Arizonans next year on the federal marketplace.

Instead, they’ll sell pared-down, health maintenance organization plans that limit the doctors and hospitals that consumers can visit at lower, in-network rates.

Erin Klug, of the Arizona Department of Insurance, said that Aetna, Blue Cross Blue Shield, Cigna and Meritus won't offer PPO plans on the federal marketplace in Arizona next year. However, Health Net and UnitedHealthcare's All Savers Insurance have filed paperwork to sell PPO plans in2016, pending federal approval, Klug said.

HMOs dominated Arizona’s insurance market in the 1990s, before consumer backlash over these more restrictive plans fueled the popularity of PPO plans. PPOs gave consumers a broader choice of doctors, hospitals and specialists but also coincided with an era of inflated medical spending.

As Arizona insurers seek to trim losses on Affordable Care Act marketplace plans but still keep plans affordable for consumers, they increasingly are dropping PPOs in favor of HMOs that are often paired with smaller networks of doctors and hospitals.

Blue Cross Blue Shield of Arizona already has mailed out notices to the first wave of about 37,000 PPO customers explaining that they'll be assigned to new HMO plans beginning next year. Blue Cross Blue Shield officials said they tried to match their customers to plans that were a good fit with price, doctors and hospitals. Consumers will have the option to shop for other plans during the three-month open enrollment, which begins next month.

“We need to make changes in the individual market that reflects what our consumers demand,” said Jeff Stelnik, Blue Cross Blue Shield of Arizona's senior vice president of strategy, sales and marketing.

Health insurers are operating in a different market than the pre-2014 days. Then, they could protect their profits by denying or limiting coverage for those with chronic health conditions. The federal health law forbids insurers from denying coverage based on an individual’s health. Insurers say that has created insurance pools with some consumers who heavily use medical care, whether a specialist, a hospital or expensive prescription drugs.

Many companies that sold health insurance plans through the federal marketplace in Arizona reported substantial financial losses in 2014, according to filings with the National Association of Insurance Commissioners.

Blue Cross Blue Shield of Arizona reported an underwriting loss of more than $33 million. The insurer’s losses on individual plans — those sold on or off the federal marketplace — reached about $90 million in 2014, company officials said. Those losses were offset by plans sold to businesses, federal employees and seniors. Even though the insurer had an underwriting loss, it made a profit of $4 million due to returns on investments.

Other Arizona insurers had larger losses in 2014. Health Net reported a net loss of nearly $79 million in Arizona, Cigna lost $16.9 million and the startup, non-profit health insurance cooperative Meritus lost more than $16 million, according to the NAIC report. The report did not provide separate financial figures for different areas of an insurer's business, such as individual marketplace plans or larger group plans sold to businesses.

The federal health law has three programs — called reinsurance, risk adjustment and risk corridor — designed to help stabilize premiums for consumers and discourage insurers from dropping out of the market.

Some health insurers will get lucrative payments from these programs designed to counter the extra cost from taking on high-risk patients.

The federal Centers for Medicare and Medicaid Services announced in June it would pay $7.9 billion to 437 insurers nationwide under the reinsurance program, which collects funds from all insurers and distributes money to insurers to offset the medical costs of patients whose claims exceed $45,000. Insurers that signed up more high-risk patients in 2014 expected to get tens of millions of dollars in reinsurance payments, CMS records show.

Even with these federal risk programs in place, health insurers are trying to stabilize their finances through a combination of rate increases and a shift toward lower-cost plans like HMOs, which typically charge lower monthly premiums than PPOs.

“Insurers are recognizing that in order to be competitive, they have to offer lower-cost plans,” said Cynthia Cox, associate director of health reform and private insurance for Kaiser Family Foundation. “It’s much easier for insurers to contain cost when there is an HMO plan.”

That is one reason why health insurers may be scaling back networks by shifting from PPOs to HMOs and increasing rates for 2016.

The Arizona Department of Insurance already has reviewed and approved plans and rates for next year, but the details on these won't be known until the federal government signs off on all marketplace plans, likely before mid-October. The three-month enrollment period begins Nov. 1.

Health insurers say that because the marketplace did not start until Jan. 1, 2014, there has been an element of guesswork in establishing plans and setting rates. Arizona had some of the lowest-priced plans among states that use the federal marketplace.

"It's really hard to price," said Tom Zumtobel, CEO of the Meritus, which launched with the financial backing of federal loans. "You have to assume what your risk is going to be. You have to do your best to figure out who will be attracted to your plan."

Meritus is an example of the frenzied nature of marketplace pricing over the first two years, and the market changes that consumer will see next year.

The non-profit's plans were priced higher than many other insurers' in 2014 and it signed up fewer than 3,600 people that year. Meritus slashed its rates this year, and enrollment soared to nearly 58,000 as of mid-September, according to Zumtobel.

Meritus initially decided to keep rate increases for 2016 to less than 10 percent for all of its plans, assuming it would receive financial relief from the federal government's "risk corridor" program.

"We booked a significant amount of receivables to come in under the risk corridor," Zumtobel said. "We started to lose faith in the credibility of that. We increased rates to offset that."

The Centers for Medicare and Medicaid Services said last month that it would delay the public release of the risk-corridor payment data until it verifies figures are correct. The federal agency has not said when the payment information will be released.

Meritus will try to stabilize finances by eliminating its marketplace PPO plans next year and implementing rate hikes ranging from 10.5 percent to 27.6 percent for 26 HMO offerings, Zumtobel said.

Health insurance cooperatives such as Meritus were established by the federal health-care law and backed by federal loans to provide competition to private health plans. But the vast majority have struggled to meet enrollment and profit projections, according to a Health and Human Services Inspector General report issued in July.

Zumtobel said Meritus' biggest challenge has been managing a startup that had relatively little enrollment during the first year and explosive growth during the second year.

"We have to figure out a way to grow more conservatively," said Zumtobel.

Other insurers, too, are taking a close look at the types of health insurance plans that resonate with customers.

Cigna won't sell PPO plans on the federal marketplace in 2016, but those plans will be sold to customers who buy plans outside the marketplace. Consumers must use the marketplace if they want to collect federal subsidies to offset monthly premiums. Those subsidies are based on a person's income, with more generous subsidies for lower-income earners. People who earn more than four times the federal poverty level are not eligible for subsidies.

Cigna will sell HMO plans in Maricopa County that include Cigna's medical providers to "offer competitively-priced plans and also provide quality, integrated care and service," spokesman Joseph Mondy said.

Blue Cross Blue Shield will route its customers to HMO plans that have distinct networks of doctors, hospitals and other health providers. One HMO network includes doctors and hospitals from two health systems, Banner Health and HonorHealth. The other network includes a network of providers fromAbrazo Health, Dignity Health and IASIS Healthcare.

Those two networks represent about 90 percent of all doctors, hospitals and other providers in Maricopa County, and the insurer will attempt to pair customers with plans that include their doctors, Stelnik said.

Some health insurance brokers expect there will be some angst among consumers who prefer the flexibility of PPO plans but will be routed to HMO plans with smaller networks.

Michael Malasnik, a broker who is familiar with the marketplace plans, said consumers should scrutinize plan details to find a plan that fits their needs. He added that some HMO plans are "open network" plans that allow patients to see a specialist without a referral from a primary-care doctors, while some HMO plans require a referral.

"If you are stuck in an HMO but you want to have freedom, you may want to look into an open-access HMO," he said.

<http://www.azcentral.com/story/money/business/consumers/2015/10/02/arizona-health-insurance-costs-insurers-switching-hmos/73092228/>

**Republicans: Are PPACA Exchange Plans Good for Kids**

LifeHealthPro

Three Republican lawmakers are asking the U.S. Department of Health and Human Services (HHS) for a comparison of exchange plan and [**Children's Health Insurance Program (CHIP)**](http://www.lifehealthpro.com/2014/07/15/cbo-chip-has-no-magic-pot-of-gold) benefits.

Section 2101 of the Patient Protection and Affordable Care Act of 2010 (PPACA) requires the HHS secretary to complete an exchange plan-CHIP comparison by April 1, 2015, and to certify which of the exchange "qualified health plans" (QHPs) are comparable in terms of benefits and out-of-pocket costs to CHIP coverage.

Rep. Fred Upton, R-Mich., chairman of the House Energy & Commerce Committee, has joined with Sen. Orrin Hatch, chairman of the Senate Finance Committee, and Rep. Joseph Pitts, R-Pa., chairman of the House Energy & Commerce health subcommittee, to ask HHS Secretary Sylvia Burwell where the children's coverage analysis is.

The lawmakers note in a [letter to Burwell](http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/CHIP/20151005-HHS-CHIP.pdf) that PPACA lets states enroll children eligible for CHIP in HHS-certified QHPs after Sept. 30, 2015.

Bigger kids have been getting fewer brand-name drugs, but more generics.

The lawmakers ask Burwell about the status of the HHS CHIP-exchange QHP comparison process.

"Has HHS determined which, if any, qualified health plans are comparable to CHIP?" the lawmakers ask. "If so, why wasn't a list of such plans released by the April 1, 2015, deadline mandated by PPACA? When will HHS release this list?"

The lawmakers point out that CHIP funding is set to expire Sept. 30, 2017.

"What is HHS' position on the extension or termination of CHIP?" the lawmakers ask.

<http://www.lifehealthpro.com/2015/10/06/republicans-are-ppaca-exchange-plans-good-for-kids?eNL=56143d06160ba0f521a1c65f&utm_source=LHPro_Daily&utm_medium=EMC-Email_editorial&utm_campaign=10072015&_LID=139512914>

**Obamacare Mandated Better Mental Healthcare Coverage. It Hasn’t Happened.**

The Washington Post

A trio of Washington Post stories this week detail the horrible toll of rising heroin addiction, along with the very much related issues of limited access to substance-abuse treatment and other forms of mental health care.

Among the saddest takeaways: People with means can send their kids to rehab, try to get them clean and sometimes shelter their public reputations. Sometimes, all of that fails; young people die.

Sometimes when the funds exist, as [Patrick Kennedy wrote in his new book released this week](https://www.washingtonpost.com/news/reliable-source/wp/2015/10/05/former-rep-patrick-kennedys-tell-all-memoir-causes-family-rift/), the honesty required to get help is not there or is too slow in coming. And for everyone else, access to drug detox and rehabilitation treatment -- the gold standard for addiction management -- are only as accessible as what their insurance companies and charity will cover. The odds of survival and recovery for these people are even slimmer. The most recent federal data indicates the number of people who overdosed and died due to heroin grew 39 percent between 2012 and 2013. In the latter year, [more than 8,000 people died](http://www.cdc.gov/vitalsigns/heroin/).

But wait, you might say, isn't there [a 2008 law that was supposed to address this](http://www.nytimes.com/2008/03/06/washington/06health.html)? Yes. But, it seems it did not. What about the [mental health care parity mandates](http://www.nytimes.com/2014/01/10/your-money/understanding-new-rules-that-widen-mental-health-coverage.html?ref=topics) that went into effect in January 2014, [under Obamacare](http://www.theatlantic.com/health/archive/2013/03/since-2008-insurers-have-been-required-by-law-to-cover-mental-health-why-many-still-dont/273562/)? Well, results there can at best be described as mixed.

The Affordable Care Act has boosted the number of Americans with health insurance coverage but has not resolved the disparate way in which many insurers treat the costs of mental and physical health care, according to an April report released by the National Alliance on Mental Illness. The report found that federal changes (part of the Affordable Care Act) mandating so-called parity between mental and physical health-care benefits do not, in practice, exist for the vast majority of Americans who are insured.

The Alliance study surveyed nearly 3,000 people living with mental illness, addiction or family members trying to access care. And the Alliance's researchers dug deep into the details -- co-pays, what is an is not covered, deductibles and medication -- available to people enrolled in 84 health insurance plans offered in 15 states.

And what the research team found should be truly disturbing in a country in the throes of a heroin crisis.

It turns out that people across the country are struggling to find therapists and psychiatrists who participate in their health insurance plans. They also face more frequent coverage and treatment denials from their health insurance companies for mental health care than for other services and must clear multiple hurdles to maintain a steady supply of mental health care medication. Sometimes, they pay higher out-of-pocket costs for these drugs when compared to others.

On top of that, information about which services and treatments are covered and which medical providers participate in mental health care networks is often difficult to find before one is actually enrolled. And those determined to get some kind of mental health care or substance abuse treatment must often pay so much out of pocket that treatment becomes impossible.

Perhaps most troubling of all,  it seems that on some of those fronts, the problems are actually slightly worse for those covered by the sometimes-subsidized plans created under the Affordable Care Act than for those obtaining coverage the more conventional way -- through employers.

<http://www.washingtonpost.com/news/the-fix/wp/2015/10/07/obamacare-mandated-better-mental-health-care-coverage-it-hasnt-happened/?tr=y&auid=16077386>

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Have something you want us to possibly add to next week’s newsletter? Email Kim VanPelt at [kim.vanpelt@slhi.org](mailto:kim.vanpelt@slhi.org).