INSURANCE REGULATION AND INSURANCE EXCHANGES

Bradford Kirkman-Liff, DrPH

The Patient Protection and Affordable Care Act (Act) will affect the regulation of health insurance in Arizona. There will be new consumer protections and new oversight mechanisms. The Act in 2014 will create health insurance exchanges in which individuals and small employers will have choices among many different health plans and will receive subsidies to cover part of the cost of these plans. This section of the report describes the new consumer protections, the new oversight mechanisms and the new insurance exchanges.

KEY REFORM CHANGES

- **Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges through which individuals and small businesses can purchase qualified coverage beginning in 2014. States may form regional exchanges. Creates four benefit categories and a separate catastrophic plan.**
- **Creates the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of nonprofit, member-run health plans in all states.**
- **Requires health plans to report the proportion of premium dollars spent on clinical and related costs (medical loss ratio) and provide rebates to consumers if they don't meet required standards. Establishes a process for reviewing and justifying increases in health plan premiums at the federal and state levels.**
- **Disallows plans to impose pre-existing condition exclusions for children under 19. Allows adult children up to age 26 to be covered under their parents' plan. Prohibits lifetime limits on dollar value of coverage.**
- **Develops a uniform insurance disclosure form to allow consumers to understand and compare policies. Establishes various consumer protection and review processes.**

WHAT ARE THE NEW CONSUMER PROTECTIONS?

After October 1, 2010, several new consumer protections go into effect:

- Health plans will cover essential preventive services without cost sharing. National panels of physicians will determine these essential preventive services. Currently, the only preventive services that Arizona law requires insurers to cover are immunizations and mammograms according to defined age guidelines.[1] There can be cost-sharing for these preventive services under current Arizona law. Under the reforms there will be greater financial access to preventive care, which in the long-run should reduce healthcare costs.
- Individual and group health insurers cannot impose pre-existing condition exclusions for children under 19. Arizona law does require immediate coverage for 31 days for newborn children, adopted children or children placed for adoption. It also requires continued coverage for a child with disabilities until it reaches the limiting age for dependent children. Arizona law currently does not prohibit pre-existing condition exclusions for children under 19, but health insurers may not impose a pre-existing condition waiting period of more than 12 months on any person in a group plan.[2] Reform will mean that children with pre-existing conditions will be covered from their first day of enrollment.
- Adult children up to age 26 can be covered under their parents' coverage. Arizona law currently does not regulate extension of dependent coverage. The reform should reduce the number of uninsured Arizona adults under the age of 26, which is estimated to be 280,000.[3]

- Insurers will be allowed to rescind coverage (cancel health insurance when claims from the covered patient are received) only in instances of fraud. Arizona law currently does not regulate rescission and other post-claim underwriting practices.

Employer-sponsored and individual health plans that had been in place prior to the enactment of health reform ("grandfathered") are exempt from several of the new consumer protections. However, if the plan significantly decreases the covered benefits or increases the deductibles and cost sharing by members, the plan has to comply with all of the new consumer protections. Estimates vary as to what percentage of plans are likely to lose their "grandfather" status over the next several years, ranging from 50 percent to 90 percent.[4,5]

Consumer Information and Assistance

The U.S. Department of Health and Human Services (HHS) is providing states grants to establish and operate independent offices of health insurance consumer assistance or health insurance ombudsman programs. The grants are aimed at helping states assist consumers with complaint filing and appeals. These grant monies will also help states collect and track consumer problems and inquiries, educate consumers on their rights and responsibilities and assist consumers with health coverage enrollment.

Unfortunately, Arizona is not pursuing such grant opportunities. The state recently chose not to submit a grant application that was due September 10th. It is unclear whether additional funding opportunities will occur. Such support could be useful, given recent state budget cuts. The Arizona Department of Insurance in 2009 eliminated 10 positions in the Consumer Affairs Division. Currently, it takes an average of five to six months for written complaints to be resolved.

As part of healthcare reform, HHS will also develop a uniform insurance disclosure form to help consumers understand and compare health insurance policies, including cost-sharing and covered benefits. In Arizona, statistics on enrollment, market share, complaints, enforcement actions and healthcare appeals are publicly available.[6] There is not, however, a uniform insurance disclosure form.

The Act also provides all health plan members nationally with standard protections to ask for a review of any unfavorable decision. Many Arizona residents already have this protection. According to state law, all fully-insured health plans are required to follow Arizona's uniform Health Care Appeals Process. In Arizona, insurers distinguish between "denied services" (care that the patient has not received) and "denied claims" (for care that the patient has received). To appeal either, the patient must start with an internal appeal.

Arizona's uniform Health Care Appeals Process is not currently available to residents with coverage through a Medicare HMO, Medicare supplement plan, long-term care coverage, multi-employer plans under ERISA, a federal employee plan, or any self-funded or self-insured plan. All of those plans are exempt from state legislation and can have their own appeals processes. Thus, health reform will create a uniform appeals process used by all plans with greater transparency.

KEY TAKEAWAYS:

- Arizona's residents covered by employer-sponsored health insurance will start to see stronger protections in fall 2010.
- The Arizona Department of Insurance will need to become extensively involved in consumer appeals, consumer assistance and consumer disclosure. This will require an infusion of resources into the Department of Insurance, which may (at least initially) be obtained through federal grants, if additional federal monies become available. However, it is unclear whether the state will pursue such funding.

WHAT ARE THE NEW OVERSIGHT MECHANISMS?

Under the Act, the U.S. Department of Health and Human Services, in conjunction with the states, will establish an annual premium review process. This will require health insurers to publicly disclose and justify their premium increases on their websites.

Currently, the state plays some role in overseeing insurance premium rate setting. Arizona law establishes a rating band for small group insurance and sets out factors that insurers can take into account within the band, including scope of coverage, family size or composition, geographic area or demographic characteristics. However, Arizona does not review rates for large indemnity groups or HMO groups or individual coverage, as Arizona law does not establish any rate-setting requirements nor require insurers to file such rates. The law does require insurers to submit annually an actuarial certification that their small group rates comply with the law. However, these certifications have limited value, as they do not have a common format, and there are varying interpretations about what constitutes compliance in each actuarial certification.

In the individual health insurance market, Arizona law currently requires insurers to file initial rates with every new policy form submitted for approval. The Arizona Department of Insurance relies on a checklist to determine whether the filing is complete and on an actuary's certification of compliance to determine whether the rates comply with the law. No initial filing has ever been disapproved. Arizona law also requires the insurers in the individual market to file each rate revision. The insurers submit information about the methods used to calculate the rate, including its "anticipated loss ratio" for the policy.

Health Reform Will Require Changes

Unlike some states, Arizona law currently does allow for some oversight of insurance companies and the rates they charge. However, health reform will require additional changes to Arizona laws, increasing the authority of the Arizona Department of Insurance. Rate review will become far more extensive. Federal law will require public comment and public hearings to be held, and formal hearings prior to enforcement actions will be a distinct possibility.

These changes will expand the Department of Insurance's workload. The Department of Insurance has received a $1,000,000 grant from the Department of Health and Human Services for health insurance premium review. Arizona will improve the filing review process by hiring an actuarial consultant to review 95 percent of submissions for compliance and make recommendations regarding whether filings are unjustified or excessive. Grant funds will be used to create a consumer-friendly website for publication of information for consumers on health insurance as well as easy-to-read information on filings and justifications by insurance companies for health insurance premiums increases. The state will also use the grant to improve efficiency and data-sharing in reviewing health insurance premiums.[7]

The Act also requires health insurers to show the percentage of premiums spent on clinical services and activities that improve healthcare quality. It also requires insurers to provide rebates to enrollees if this spending does not meet minimum standards. This percentage is known as the "Medical Loss Ratio" – 85 percent in the large group market and 80 percent in the small group/individual market. The National Association of Insurance Commissioners is involved in establishing uniform definitions of medical expenses and standardized methodologies for calculating measures of these activities. Arizona law currently does not regulate medical loss ratios and has no standards defining what costs are assigned to medical care and what costs are considered administrative. Predictably, health plans and regulators disagree about what "counts" as medical care.

KEY TAKEAWAYS:

- Unlike some states, Arizona does regulate the health insurance industry. However, statutory changes will likely be needed for it to conduct the expanded oversight required through healthcare reform.

- Arizona will need to expand the capacities of the Department of Insurance. Health reform will require it to conduct rigorous rate reviews and oversee whether insurers allocate adequate funds for clinical services and quality improvement activities. This will require an infusion of resources into the Department of Insurance, which should (at least initially) be obtainable through federal grants. However, the state may need to commit additional resources over the long term.

WHAT ARE THE NEW HEALTH INSURANCE EXCHANGES?

A health insurance exchange is an organized marketplace operated by a government agency or non-profit offering consumers information and a variety of health insurance purchase options.

All of the different insurance plans sold through the exchange have uniform consumer protections, and there is a standardization of deductibles and co-payments into tiers of plans that enable easy premium comparisons.

Under healthcare reform, each state will have an option to create two state-based exchanges: one for individuals ("American Health Benefit Exchanges") and one for small businesses ("Small Business Health Options Program," or SHOP Exchanges). A second option for a state is to establish a single exchange that serves both individuals and small businesses, allowing for some administrative efficiency to be realized.

Exchanges will open in 2014 and be administered by a governmental agency (either an existing agency or one newly created to administer the exchanges) or a non-profit organization. Between 2014 and 2016, states can limit the small business exchanges to firms with 50 or fewer employees. In 2017, states will have the option to open the exchanges to businesses with more than 100 employees. It is estimated that 746,000 Arizonans will obtain health insurance through the exchanges and receive various levels of subsidies to support their purchase of insurance.[8]

The exchanges will offer coverage from at least two federally-qualified multistate plans, a federally-supported non-profit "consumer operated and oriented plan" (CO-OP) as well as offerings from existing insurers in the state. There will be five standardized products in the market for each offered plan (Platinum, Gold, Silver, Bronze and Young Adult). These products will differ in their level of deductibles, co-payments, co-insurance, in-network and out-of-network coverage and prescription drug coverage.[9] The plans with the highest level of deductibles will meet the requirements for the plan to qualify as a High Deductible Health Plan. Individuals who select that type of plan will be eligible to open a Health Savings Account.[10]

INSURANCE EXCHANGE FEATURES

Benefits

- **Ambulatory patient services**
- **Emergency services**
- **Hospitalization**
- **Maternity and newborn care**
- **Mental health benefits and substance use disorder services**
- **Prescription drugs**
- **Rehabilitative and habilitative services and devices**
- **Laboratory services**
- **Preventive and wellness services**
- **Chronic disease management**
- **Pediatric oral and vision care**

Levels of Coverage

- **BRONZE: The plan pays 60 percent of the full actuarial value of benefits; the individual is at risk for 40 percent of the costs.**
- **SILVER: The plan pays 70 percent of the full actuarial value of benefits; the individual is at risk for 30 percent of the costs.**
- **GOLD: The plan pays 80 percent of the full actuarial value of benefits; the individual is at risk for 20 percent of the costs.**
- **PLATINUM: The plan pays 90 percent of the full actuarial value of benefits; the individual is at risk for 10 percent of the costs.**
- **CATASTROPHIC COVERAGE: Coverage set at the level for Health Savings Account rules, except that prevention benefits and three primary care visits are covered. Only available for young adults.**

Individuals wanting coverage for themselves and family members or small employers wanting coverage for their employees will have to provide information to prove that all persons covered by the plans are U.S. citizens or legal alien residents.

Those purchasing coverage through the exchange will be able to receive premium subsidies based on their income. Cost-sharing subsidies will also be available (again based on income). Individuals and employers who want to purchase insurance outside of the exchange can do so, but they will not then receive the subsidies.

Federal grants have been made available to states to establish insurance exchanges starting in 2011. The Governor's Office recently applied for a grant, and received nearly $1 million for planning of the exchange beginning October 1, 2010.

Arizona Choices

Arizona has several choices regarding the administration of small business and individual insurance exchanges:

- Arizona could decide not to create health insurance exchanges. Individuals and small employers would then use the multi-state exchanges that the federal government will establish to provide access to coverage and the subsidies for individuals and employers in states without exchanges. This would probably result in that segment of Arizona's population being insured by multi-state for-profit health plans, regulated by federal agencies.
- Arizona could build on its experience with Health Care Group, which is a nascent health insurance exchange. Health Care Group, a division of the Arizona Health Care Cost Containment System (AHCCCS), has been in existence for more than 20 years and makes available to businesses with two to 50 employees two different health plans that operate in nine Arizona counties. Each health plan offers five different levels of front-end deductibles ranging from $500 to $3,000. The plans offered in Health Care Group use modified community rating, similar to what is proposed for the health insurance exchanges, rather than experience underwriting for each small group.

  Health Care Group has developed a website that provides information for employers on the different plans and options. The website allows employers and employees to make premium payments and to renew their coverage. Health Care Group also administers the Health Coverage Tax Credit Program (HCTC), which pays 80 percent of qualified health insurance premiums for trade-affected workers, retirees, and their families. Health Care Group is currently the only HCTC-qualified program for Arizona. Health Care Group has the electronic infrastructure and the organizational experience to be considered as the small group health insurance exchange. It has extensive experience with marketing health insurance to small employers. There would be no need to create a new organization and develop new software or websites. In fact, with minor modifications, the same site could serve as the individual insurance exchange.
- Another option would be for a different government program or agency to establish the health insurance exchanges. For example, the Arizona Department of Administration has managed a self-insured health coverage program for state employees for several years, known as Benefit Options. It has developed a website, enrollment procedures and monitoring mechanisms for the contracting health plans. The website provides extensive information on the different health plans and their provider networks. Such a site could serve especially well for the individual insurance exchange and, with modifications, could also serve for the small group exchange.
- Yet another option would be to have Health Care Group serve as the small group insurance exchange and the Department of Administration serve as the individual insurance exchange. Here, each agency focuses on those areas in which it has the greatest knowledge and expertise. The drawback is that this divides the exchanges between two government agencies, which may be less efficient than having one agency operate both exchanges.
- Arizona could contract with a quasi-governmental authority or a non-profit organization to obtain the federal grant funds to start up the Arizona Health Insurance Exchange. This non-profit organization would need to develop websites, purchase information technology for enrollment management, and develop the organizational capabilities to operate the exchanges

for both the individual and small group markets. The state could contribute some of its expertise from Health Care Group and the Department of Administration to this effort. By creating a quasi-governmental authority or a non-profit organization to obtain the federal grant funds to start up the exchange and to retain administrative fees from the operation of the exchange, the exchanges could have additional flexibility in contracting. They would also avoid the issue of yearly state budget deliberations, which could affect the stability of their operations. The exchange has to be a stable marketplace in which consumers and insurers can meet with transparent information on prices and benefits.

- Arizona could work with other states to develop a multi-state exchange. Developing a multi-state exchange would require deciding on a number of further questions: Which states should be involved in the multi-state exchange? Should the states contract with an existing government agency in one of the states to develop the exchange, or should they contract with a new non-profit organization that would create the multi-state exchange? How would the insurance plans sold through the multi-state exchange be regulated? How would the multi-state exchange be governed? A multi-state exchange would be a complex undertaking, but could provide greater financial stability and lower administrative costs.

Costs and Benefits

Each of these options has different costs and benefits. Upfront funding to establish an exchange in each state is part of the health reform legislation. Federal officials have expressed a preference that each state develop its own exchange or work with other states to develop a regional exchange, rather than have the federal government directly operate exchanges. If Arizona defaults to the federal government to operate an exchange, there will be no Arizona oversight of the plans offered in the exchange. Medical decision-making might end up being done by out-of-state medical directors working for multi-state plans, although, even with plans nominally based in Arizona, medical decision-making may be contracted to out-of-state physicians.

If Arizona were to create its own exchange, it could capitalize on the experience of Health Care Group and the self-insured Benefit Options program in developing the exchange. Although the exact level of federal funding for startup has not yet been defined, it appears that the intent is to provide sufficient federal up-front funding (such as it did when Massachusetts established its exchange) that the exchanges (through fees) would be self-sufficient (as required by the new law) by 2016. Whatever option is selected, it is important that the accumulated knowledge with operating different employee-choice programs should be used in designing these exchanges.

If Arizona were to work with other states to create a multi-state exchange, complex issues about governance, ownership and regulation of the health plans would have to be established. However, the lower cost of having several states to share the information technology infrastructure and the ability to negotiate lower contracts for insurance premiums could be worth the additional complications.

One important decision in the design of an Arizona exchange is to determine the rules that define which plans will be allowed to be offered to the individuals and small employers. One approach is to have a competitive process in which health insurers provide their rates for the five different levels of coverage, and those plans with the lowest cost and highest measures of access and quality are offered by the exchange. This is the method that has been used by Massachusetts. A second approach is to set a minimum standard for quality and access, and all insurers that meet those standards can offer their plans, regardless of their initial rates. The first approach would provide individuals and small employers with choices from five different health insurers for five different levels of coverage (for 25 insurance options), and the risk of not being selected would result in lower premiums than the second approach. The second approach would provide individuals and small employers with more choices, as there would not be any selection of insurers based on their premium price, but the lack of competition to have access to this market would result in higher premiums.

These are important decisions, and in several states the Governor has appointed a task force to review the issues and make a recommendation to the Governor and the Legislature. In some states, the Governor and Legislature have asked external consultants to provide recommendations. In other states decisions have already been made to move forward with creating state-level exchanges. At a minimum, policy leaders in Arizona have to make a decision as soon as possible about the process they will follow in deciding which option(s) to pursue.

The Importance of Linking the Exchange(s) and AHCCCS

Regardless of who operates the exchange, it is important that there be strong linkage between the exchange and AHCCCS. Part of the work of the individual insurance exchange will be the determination of the subsidy level, which is based upon income. The exchanges will be required to determine if an individual is eligible for coverage by AHCCCS, and if so, provide them with information on how to complete the AHCCCS enrollment process. It would be helpful if individuals who were found to be AHCCCS-eligible could be directly enrolled by the exchange, rather than having to re-apply at an AHCCCS eligibility office. By the same logic, AHCCCS eligibility workers who determine that an applicant is not eligible for enrollment due to their income should be able to do more than simply refer them to the insurance exchange with their income information that has already been examined. They should be able to determine their subsidy level and assist the applicant in choosing a health plan. In an ideal situation, every AHCCCS eligibility office or outreach worker would also be an officer or outreach worker for the insurance exchange, and every insurance exchange office would also be tied to AHCCCS eligibility. This is the model followed in Massachusetts, where the insurance exchange contracts with the organization that conducts Medicaid eligibility to also do subsidy determination for those who are not eligible for Medicaid and so are mandated to obtain coverage through the exchange.

Participation in the Health Insurance Exchange(s)

The most recent publicly available data on the fully insured health insurance market for Arizona (December 31, 2007) can be used to examine if a sufficient number of insurers would likely be able to participate in an exchange.

As seen in Table One, Blue Cross/Blue Shield of Arizona is the dominant plan in the fully insured individual health insurance market, with 71 percent of the market, followed by HealthNet at 12 percent and Aetna at 6 percent. Many of the for-profit health insurers have very small numbers of individual policyholders. These data indicate that there is a risk of a lack of competition in the individual health insurance market. It will be critical to determine if the individual mandate and subsidies attract at least one large multi-state firm to vigorously compete in Arizona within the exchange against the current market participants.

There are two alternatives to creating an Arizona individual health insurance exchange and hoping that strong competition will emerge. First, Arizona could choose not to establish an individual insurance exchange and wait for the federal government to create a multi-state exchange in which multiple insurers vigorously compete to serve clients. However, the federal government has indicated that it would prefer that states operate exchanges. The second alternative would be for Arizona to work with an adjoining state or multiple adjoining states (Utah, New Mexico, Nevada and Colorado) to have a multi-state exchange. This could be the easiest way to bring strong price competition to the Arizona market. A multi-state exchange could attract an insurer who has high market share in an adjoining state in the individual insurance market to enter Arizona through the multi-state exchange. Depending on the regulatory rules, an insurer who was not in the individual

Table One: Fully Insured Individual Health Insurance Market for Arizona from 12/31/07

INDIVIDUAL HEALTH ENROLLEES AS OF 12/31/07	ENROLLMENT	MARKET SHARE
Aetna[11]	12,644	6.3%
Blue Cross & Blue Shield of Arizona	142,097	71.0%
CIGNA[12]	8,269	4.1%
HealthNet[13]	24,133	12.1%
Humana[14]	4,866	2.4%
Assurant Health[15]	2,535	1.3%
Lifewise	4,435	2.2%
Other Insurers[16]	1,206	0.6%
Total Fully-Insured Enrollees	200,185	

insurance markets in any of these states might attempt a major expansion through a multi-state exchange.

Table Two shows that for the small group market there is no single dominant insurer as there is in the individual insurer market. The six different carriers that are part of UnitedHealthcare account for 41 percent of the market, followed by Blue Cross and Blue Shield of Arizona with 21 percent of the market. Aetna and Humana each have over 10 percent of the market. There appear to be sufficient firms competing in the small group health insurance market to promote vigorous price competition.

Table Two: Fully Insured Small Employer Group Health Insurance Market for Arizona from 12/31/07

SMALL EMPLOYER GROUP (2-50) ENROLLEES AS OF 12/31/07	ENROLLMENT	MARKET SHARE
Aetna[17]	49,801	12.6%
Blue Cross & Blue Shield of Arizona	83,162	21.0%
CIGNA[18]	11,264	2.8%
HealthNet[19]	29,798	7.5%
Humana[20]	39,529	10.0%
Lifewise	8,394	2.1%
UnitedHealthcare[21]	164,007	41.4%
Other Insurers[22]	10,614	2.7%
Total Fully-Insured Enrollees	396,569	

Lessons from Massachusetts

Lessons can be learned from the operation of the Massachusetts Connector, which operates the individual and small employer exchanges in that state under its innovative health reform program.[23] Massachusetts has had a mandatory individual purchase of health insurance since July 2007, and those three years of experience can be useful for Arizona.[24]

The Connector is a quasi-public authority, with 10 members appointed by the Governor and the Attorney-General. The Board of Directors of the Connector operates on a consensus basis. While unconventional in most organizations, this approach was adopted by the Chair and the Finance Secretary in order to keep all 10 members in agreement and ensure credibility for future decisions. As described in one report:

> *The practice of building consensus for earlier decisions built a culture both of compromise as well as an atmosphere of wanting the program to succeed. As the decisions became more difficult, this culture of consensus helped keep all the players in the room. No one wanted to be the first to vote "no." This gave advocates and progressives more say in the final decision than originally expected. In turn, it meant progressives had to compromise and accept ideas such as deductibles with which they were not comfortable.*[25]

The Connector itself is a small organization of 35 employees. Many of the operational functions have been contracted out to governmental agencies or private firms:

- State Medicaid employees do eligibility screening. Individuals who are interested in subsidized insurance and are of such low income that they qualify for Medicaid are referred to that program.
- The Connector uses a private vendor for customer service and health plan enrollment. This same vendor was already contracted by Massachusetts to provide these functions for Medicaid enrollees.
- In 2004, the Massachusetts Executive Office of Health and Human Services created the Virtual Gateway to provide the public, medical providers, community-based organizations and EOHHS staff with online access to health and human services. The Connector uses the Gateway to speed enrollment into the various health plans, and health providers can verify eligibility and enrollment through the same network.[26]
- Massachusetts has determined that controlling the cost of health insurance was more important that offering the widest possible range of choices to individuals. Individuals were offered five different levels of coverage by each of four insurers, for a total of 20 different health plan options. When other health insurers wanted to gain access to this population, the Connector required that there be a competitive bidding process, and took the four lowest bids. This restrained cost increases and kept insurance affordable.

This approach – having a limited number of employees for the exchange, building on existing Medicaid eligibility and enrollment systems, contracting to use Medicaid eligibility workers to do the assessment of income eligibility for insurance subsidies for the exchange and contracting with plans by competitive bidding to restrain cost increases – is an approach that Arizona should consider. These ideas can apply regardless of the agency or non-profit organization that operates the exchange and solicits the bids from different insurers to be offered to the population.

KEY TAKEAWAYS:

- Arizona will have to decide whether it wants to merge its individual and small group exchanges.
- Arizona will face interesting choices related to how Arizona's health exchange(s) will be operated:
  - Arizona could leave it to the federal government to create regional exchanges offering multi-state health plans.
  - Arizona could form a regional exchange with one or more states.
  - Arizona could build on the experience of the Health Care Group and the Department of Administration, managing and operating the exchange through one or more state agencies.
  - Arizona could have AHCCCS operate the exchange, allowing eligibility and subsidy determinations to be performed internally (as it currently performs for some programs such as KidsCare) or by contractors (DES or private contractors).
- Arizona will have to decide whether it wants to offer a wide array of health insurance choices through the exchange, or whether it wants a more centralized approach (emulating Massachusetts's experience) where health plans compete to be allowed to offer their product through the exchange, potentially driving down costs for consumers and improving quality.

ABOUT THE AUTHOR

Bradford Kirkman-Liff, DrPH is a Professor in Health Policy at Arizona State University. After 30 years in the W. P. Carey School of Business at the Tempe campus of ASU, he moved in 2010 to the College of Nursing and Health Innovation at the Downtown Phoenix campus. His extensive published research focuses on health system reform in industrialized nations, the use of collaboration and knowledge sharing methods in healthcare organizations, and entrepreneurship in the biotechnology and medical device sectors.

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