



PROCEED WITH CAUTION

**PROPOSED HEALTH INSURANCE MERGERS COULD
HARM GEORGIA CONSUMERS**



A PUBLICATION BY

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INTRODUCTION

Two of the nation's largest health insurance companies announced proposed mergers in 2015 that would drastically change the health insurance market in Georgia and other states. Aetna has proposed a merger with Humana, while Anthem (the parent company for Blue Cross Blue Shield of Georgia) has proposed a merger with Cigna. If finalized, 90 million Americans would have health insurance either through Aetna-Humana or Anthem-Cigna. The scope and size of these proposed mergers and the impact they would have on competition raise concerns about affordability, choice, and access to care for health care consumers in Georgia.

Before the proposed mergers can go into effect in Georgia, both must be approved by the Georgia Office of Insurance and Safety Fire Commissioner (DOI). This means that Georgia regulators have the opportunity to assess the merits of the proposed Aetna-Humana and Anthem-Cigna mergers. The DOI has the power to deny them, approve or approve with conditions that can mitigate consumer harm.

THE GOALS OF THIS POLICY BRIEF ARE TO:

- » Summarize current insurance market concentration in Georgia
- » Outline the impact of mergers on premiums and access to providers
- » Explain the role of regulators in approving mergers and Georgia's review process
- » Provide policy recommendations to protect consumers

PROPOSED MERGERS

CURRENT "BIG 5" HEALTH INSURANCE COMPANIES



PROPOSED MERGERS



"BIG 3" HEALTH INSURANCE COMPANIES AFTER MERGERS



Nationally, the five biggest health insurance companies are Aetna, Anthem, Cigna, Humana and United Healthcare. Proposed mergers to combine Aetna with Humana and Anthem with Cigna would reduce the "Big 5" to a "Big 3," with United Healthcare being the third company.

BACKGROUND

Our nation's health system has undergone major changes in recent years, many of which have been accelerated by the Affordable Care Act. Over the past two and a half years, millions of Americans and approximately 500,000 Georgians have enrolled in health insurance, many of whom were previously uninsured. This phenomenon is having positive effects on access to care and financial security for individuals, families, and communities in Georgia and across the nation. At the same time, health insurance companies and health care providers are adapting to the changing health care landscape by implementing new market reforms and payment models. Consolidation is a strategy that both insurance companies and health systems are deploying to gain market power and jockey for leverage with each other. This phenomenon places consumers at risk, and state and federal regulators have a responsibility to ensure any harm to consumers is avoided or minimized.

In the case of insurance mergers, a large payer could achieve greater administrative efficiencies and drive down prices by negotiating lower reimbursement rates with providers. For dominant provider entities, consolidation could afford them more tools, resources and coordination to improve clinical care. However, mergers and acquisitions can negatively impact consumers. A dominant insurer could use its market power to increase profits by narrowing networks, raising premiums and using other cost-containment strategies that are not in the best interests of consumers. Additionally, large provider entities can set higher prices and compel plans to pay because insurers that do not include them in their networks will not be attractive to consumers. Absent any regulatory oversight and protections, consumers suffer the most by paying more for fewer options.

Thus, the impact of the proposed Aetna-Humana and Anthem-Cigna mergers on Georgians is an important issue for regulators, health advocates and consumers to understand and assess in the merger review process.



INSURANCE MARKET CONCENTRATION IN GEORGIA

The proposed Aetna-Humana and Anthem-Cigna mergers would increase market concentration and further limit existing market competition and choice for consumers in Georgia. Market concentration is the degree to which a small number of companies control a large part of a market.

How is Market Concentration Calculated?

Market concentration is calculated using the Herfindahl-Hirschman Index (HHI). The HHI is used as a measure of the size of a company in relation to the industry and as an indicator of the amount of competition among them. The HHI is calculated by determining the percentage of the market each company has, then squaring each percentage. For example, a market that includes four companies with shares of 30, 30, 20, and 20 percent would have an HHI of 2,600 ($30^2 + 30^2 + 20^2 + 20^2 = 2,600$). The HHI ranges from 0 to 10,000, and based on their HHI scoring, markets are classified as (1) unconcentrated, (2) moderately concentrated, and (3) highly concentrated¹.

Regulators use HHI and the Competitive Standard when assessing market consolidation and determining whether or not to approve mergers between insurers. The Competitive Standard relies on HHI as part of a larger calculation. Under Georgia law² a merger substantially lessens competition in a market that is highly concentrated when the two merging insurers have the following shares of the existing market:

Insurer A	Insurer B
4 percent	4 percent or more
10 percent	2 percent or more
15 percent	1 percent of more

Market Concentration is the degree to which a small number of companies control a large part of a market

When the market is not highly concentrated, a merger will substantially lessen competition if the merging insurers have the following share of the market:

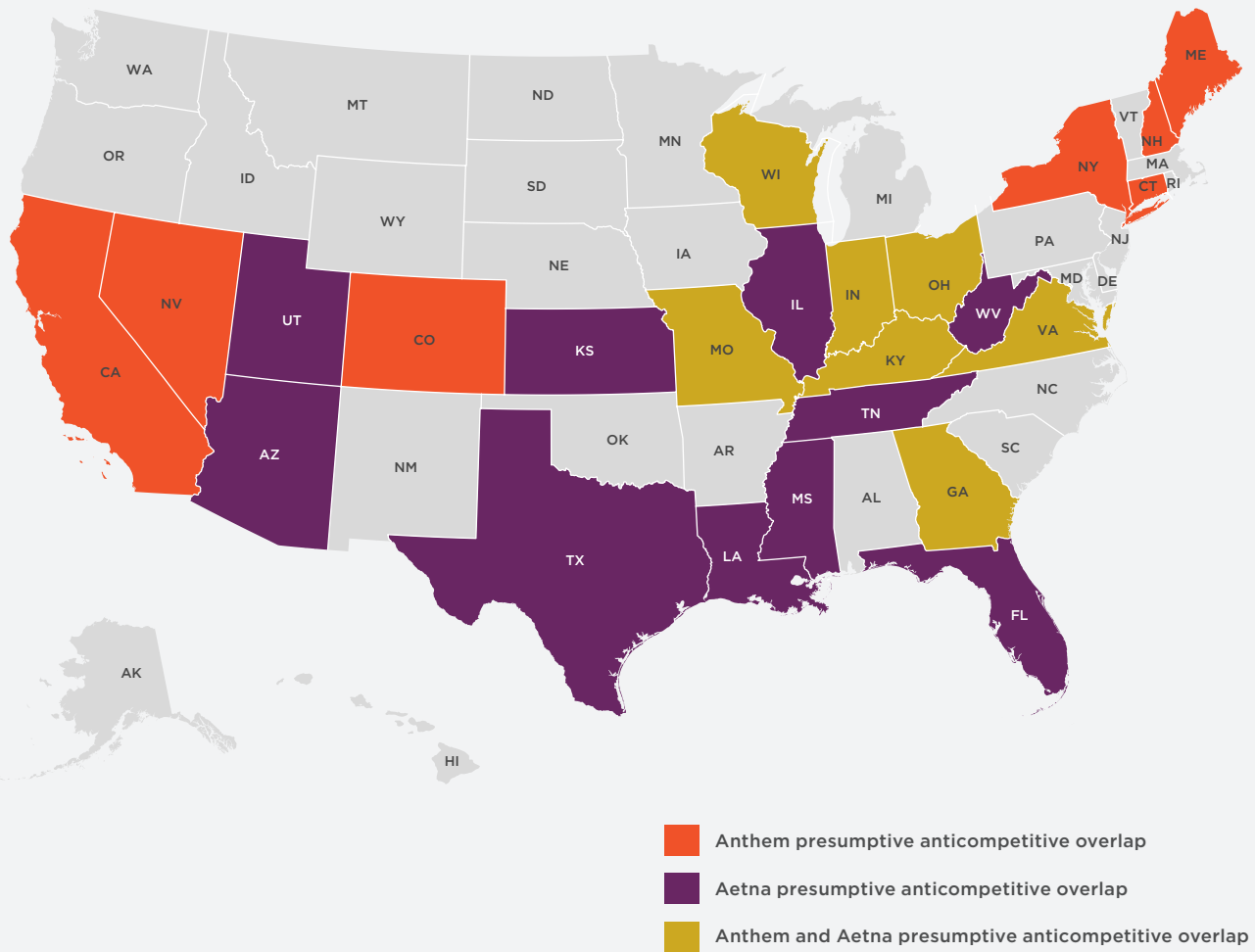
Insurer A	Insurer B
5 percent	5 percent or more
10 percent	4 percent or more
15 percent	3 percent or more
20 percent	1 percent or more

The insurance markets for individual, small group, large group, and Medicare plans sold in Georgia are already highly concentrated. Currently, the top four insurers in Georgia control over 75 percent of the market. The proposed Aetna-Humana merger violates the anti-competitive standard under Georgia law in the individual, small group, and Medicare Advantage markets. The proposed Anthem-Cigna merger would violate the anti-competitive standard under Georgia law for the individual and large group markets.

Highly concentrated markets rarely benefit consumers because they stifle competition. Consumers benefit from competition, as competition encourages companies to offer lower prices, increase quality, and spur innovation. New companies that try to enter into highly concentrated markets experience difficulties because they have less influence to negotiate lower prices with providers to position themselves at a competitive advantage. Also, in competitive markets consumers have more companies to choose from when shopping for coverage.

The Georgia Department of Insurance (DOI) estimates that Aetna would control close to 58 percent of the market for individual plans, 49 percent of the small group plans, and 35 percent of the market for Medicare Advantage plans sold in Georgia³ if it is allowed to acquire Humana. Department of Insurance analysis for the market share impact of the Anthem-Cigna merger is pending.

STATES THAT WILL HAVE LESS COMPETITION DUE TO HEALTH INSURANCE MERGERS



LESS COMPETITION INCREASES PREMIUMS AND DECREASES CHOICE

Greater insurer consolidation will likely lead to higher premiums for Georgians. While insurers argue that the mergers will give them greater ability to negotiate lower prices with hospitals, providers, and drug makers to decrease costs, analyses of previous mergers show that any such cost savings were not shared with consumers. In fact, to date insurers have offered no evidence that any health insurance merger savings achieved through lower negotiated payments with providers are passed on to consumers.

Analyses of previous national mergers found that:

- Premiums went up in 139 separate geographic markets after Aetna purchased Prudential in 1999⁴
- Small group premiums increased by 13.7 percent in markets a year after the Sierra-United merger in 2008⁵

More recently, several economic studies have found that mergers and other consolidation activity do not result in savings for consumers. One study found a direct relationship between concentrated insurance markets and greater premium increases in large employer plans⁶. Another study researched the potential impact of the Aetna-Humana merger on the Medicare Advantage market. The study found that:

- Aetna's annual premiums are \$155 lower and Humana's premiums are \$43 lower in counties where they compete head-to-head than premiums in counties where only one of the companies offers plans
- The average premium of the second lowest silver plan sold on the Marketplace would increase by \$335 in Georgia

The findings of this study⁷ are of particular importance for consumers who are enrolled in Medicare Advantage and Marketplace plans because Aetna and Humana currently compete in the Medicare Advantage market in 96 Georgia counties⁸. In addition, Humana recently proposed a 65 percent increase to the average rate of plans sold on the Georgia marketplace in 2017⁹. Decreased competition would likely result in even less incentive for insurers to set reasonable rates in the future. This underscores the importance of preserving competition in Georgia markets to safeguard consumers from higher costs.

In fact, to date insurers have offered no evidence that any health insurance merger savings achieved through lower negotiated payments with providers are passed on to consumers.

Proposed mergers would drive premium increases in Marketplace plans:
A recent study found that the proposed Aetna-Humana merger would increase the average premium of the benchmark plan for Marketplace coverage by \$355 in Georgia

PLANS ARE INCREASINGLY LIMITING ACCESS TO PROVIDERS

Mergers may also worsen current market conditions that limit consumer choice. Current market trends are shifting more towards plans that offer limited out-of-network benefits and restrict access to providers through narrower networks. Historically, insurers have offered a variety of plan types that consumers could choose from based upon their health needs and willingness to pay for more benefits. Two common ones are platinum tiered plans sold on the marketplace and Preferred Provider Organization (PPO) plans. Platinum plans cover generous benefits at a higher premium and feature lower out-of-pocket costs (deductibles, co-pays, etc). Platinum plans are appealing to consumers who have chronic conditions or high annual health care costs or who value the security of a more comprehensive plan. Preferred Provider Organization plans provide consumers with the choice to get care from in-network or out-of-network providers. An individual pays less for care from an in-network provider and more if care is received from an out-of-network provider. In Georgia, all insurers have stopped offering platinum plans¹⁰ and the number of PPO plans has been greatly reduced¹¹. If insurers consolidate consumers may find that they have even less access to needed providers or out-of-network benefits required to cover their care because the consolidated companies would have more leverage over providers in their negotiations on provider networks and reimbursement rates.

THE PROBLEM OF NETWORK ADEQUACY

Another pivotal concern about insurance companies getting bigger is their ability to create more narrow and restrictive provider networks. Narrow networks in theory offer limited provider choice in exchange for lower premiums. They are defined as 25 percent or less of all providers in participating rating areas within a state that participate in the network¹². Tiered networks rank providers based on cost and quality. Big insurance companies can use their market power to exclude providers from their network or place a provider in a higher cost-sharing tier and consequentially reduce the number of patients who will seek care from that provider.

Narrow networks are becoming more common in Georgia: Georgia has the highest percent of narrow networks among all states with 83 percent of marketplace plans defined as narrow¹³. Narrow and tiered networks can sometimes be advantageous, especially for price conscious consumers, but only if they provide meaningful access to care. To ensure true network adequacy is achieved, meaningful access standards must be defined and enforced.

Georgia's current network adequacy standards are based in part upon the previous National Association of Insurance Commissioners (NAIC) model act dating back to 1996. These standards do not specify clear, quantitative requirements, which leaves consumers with no guaranteed benchmark for services and enforceable rights. To assist states in developing new standards or bringing their existing standards up to date, the NAIC updated its network adequacy model act in November 2015¹⁴. The model act creates a framework that states can tailor to accommodate certain variations in insurance markets and regulatory authority among states and enact into law if they choose. To date, there has been state legislative interest in reviewing the recent NAIC model act to inform future revisions to Georgia's network adequacy standards but no new policies have been set. As provider networks narrow and the number of insurance companies shrink, the need to assess and monitor the adequacy of these networks has increased.

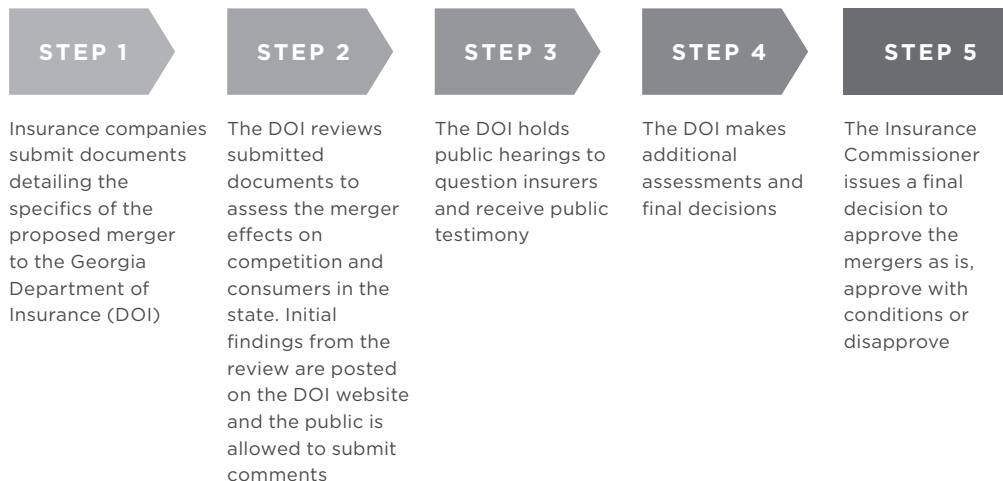
GOVERNMENT AGENCIES AND POLICYMAKERS PLAY A CRITICAL ROLE IN ENSURING CONSUMERS BENEFIT

There are three separate levels of review for proposed mergers: the Federal Department of Justice (DOJ), state Attorneys General (AG), and state Insurance Commissioners. Each regulator assesses the impact of the mergers on competition in markets but state Insurance Commissioners have greater expertise and final authority to investigate a broader range of competition and consumer protection concerns. Insurance Commissioners are authorized to approve or disapprove a merger independent of DOJ and/or AG review. So, before the Aetna-Humana and Anthem-Cigna mergers can go into effect in Georgia, both must be approved by the Georgia Department of Insurance (DOI).

To obtain approval the insurers must submit specifics of proposed mergers to allow the DOI to assess how these deals reduce competition or create a monopoly. In July 2015, Aetna began the review process with the Georgia DOI for the Aetna-Humana merger. The DOI review found that the proposed Aetna-Humana merger violated the anti-competitive standard under Georgia law in the individual, small group, and Medicare Advantage markets. Further, the DOI found that the proposed merger would be a major concern for future competition in the large group market if the Anthem-Cigna merger is approved¹⁵. The DOI requested additional explanation on how Aetna's network adequacy standards, provider network designs, and out-of-network benefits would change post-merger, and how those changes would be communicated to consumers. In August 2015, Aetna responded to the DOI's inquiries but their follow-up was insufficient for the department to proceed with further review.

The DOI review found that the proposed Aetna-Humana merger violated the anti-competitive standard under Georgia law in the individual, small group, and Medicare Advantage markets

HOW MERGERS ARE REVIEWED IN GEORGIA



Anthem also filed an application for review of its proposed merger with Cigna in September 2015¹⁶. The DOI found that the proposed Anthem-Cigna merger would violate the anti-competitive standard under Georgia law for the individual and large group markets. To date the DOI has not published any further review documents for either merger. The merger proposals are still under review by the DOI and documents for both proposed mergers are posted on the DOI website.

As part of its review, the DOI may consider remedies that would protect consumers from anti-competitive effects and ensure that consumers' interests are protected. The purpose of a remedy is to fully restore the competition that would otherwise be lost, or to otherwise effectively prevent the harm that would result.

After the review process is completed, the DOI will publish the findings of the review for each proposed merger. This triggers a 30-day public commenting period, which includes a public hearing. During the public comment period, anyone can submit comments to the DOI. The public hearing provides the opportunity for stakeholders, consumer advocates, and the public to question the insurers. No later than 30 days after the hearing, the Commissioner will issue a final decision to approve the mergers as is, approve with remedies, or disapprove. The state Attorney General may also review the merger for antitrust concerns.

At the national level, the Department of Justice is conducting a separate review of these mergers. Federal regulators' determination focuses on whether or not the proposed mergers create companies that would substantially lessen health insurance competition nationally. Additionally, in the summer of 2015, policymakers in the U.S. Senate subcommittee on Antitrust, Competition Policy, and Consumer Rights and the House subcommittee on Regulatory Reform, Commercial and Antitrust Law began questioning insurers and allowing groups opposed to the mergers to share their concerns. While Congressional members have no power to approve or reject mergers, they can be influential in opposing large merger deals.

The purpose of a remedy is to fully restore the competition that would otherwise be lost, or to otherwise effectively prevent the harm that would result.

POLICY RECOMMENDATIONS TO PROTECT CONSUMERS

Mergers, once approved, cannot be reversed. Ensuring that consumers experience real benefits from the mergers and are protected from harm are the highest priorities to consider in the merger review process. Should the mergers be approved, regulators have a menu of remedies to choose from that give consumers some assurance that benefits promised will be realized and enforceable safeguards.

While the DOJ traditionally has relied on divestitures as a remedy to restore competition in markets, there is little evidence that this method is effective. Divestitures occur when a company sells off assets such as operational business units and/or policyholder contracts to another insurance company that is capable of restoring pre-merger market competition.¹⁷ Divestitures in Georgia markets could be difficult to execute because the market shares of the merging companies are significant in the individual, small group, large group and Medicare Advantage markets. Selling off assets in these markets means selling a large number of contracts of policyholders to another insurer. In the next open enrollment period, a divested policyholder may return to the previous insurer, which would negate the intent to restore competition in the market. Also, insurers that purchase the divested policyholder contracts will have to adequately replace the competitive provider and hospital networks of the merging insurer. Lastly, divestitures do not prevent insurers from raising premiums.

Divestitures may address some competition issues resulting from mergers, but relying on this one remedy will not fully address consumer concerns. Additional remedies are needed to mitigate some of the cost, network adequacy, and consumer protection issues in Georgia markets. Several other states have approved the mergers with remedies and their approaches offer promising policies for Georgia to consider in its review of the mergers.

Suggested remedies

PREMIUM STABILITY

Current market regulations do not protect consumers from unreasonable premium increases. While the Medical Loss Ratio (MLR) is a good tool to ensure insurers are efficient in their spending of premiums on medical services and quality improvements, it does not cap prices and premium increases. Rate review is a tool that can help protect consumers from unjustified increases in health insurance rates. It enables state insurance departments to review proposed rate increases charged by health insurance companies that sell plans in the state. Rate review requires insurers to openly explain how they determine the amount they charge for rates, on which health insurance premiums are based. Often, insurers also must justify proposed increases to these rates, documenting why an increase is both necessary and appropriate.¹⁸ Absent a more robust rate review process, the decreased competition resulting from insurance mergers would provide less incentive for insurers to set reasonable rates in the future. If the Aetna-Humana merger is approved, a stronger rate review process would be needed to help ensure any future premium increases are justified. Approaches that have been utilized in other states when approving mergers include insurer commitment to:

- Contribute funding that would provide regulatory agencies with more resources the state's rate review process to improve consumer interfaces and education
- Implement rate increases that are deemed reasonable by state regulators. In the event an insurer implements an unreasonable rate, regulators would set appropriate conditions
- Not pass any merger associated costs onto enrollees, including any and all executive compensation, pay-outs, bonuses, interest on loans one company may use to purchase another, legal fees, etc.
- Pass cost savings associated with merger efficiencies on to consumers in the form of lower premium increases and reduced cost sharing

NETWORK ADEQUACY

Network adequacy serves as an important link between having health insurance and accessing health care services. Provider networks must be adequate to ensure consumers enrolled in the plan have meaningful access to all covered benefits. The risk of big insurers merging and continuing to reduce network sizes and plan options is concerning in terms of whether consumers, and especially rural consumers, will have access to the care they need. If state regulators approve the mergers, they should consider requiring insurers to take the following steps to ensure access and consumer choice are improved:

- Publish and maintain printed and online provider directories in compliance with provisions in SB 302¹⁹
- Submit provider networks to DOI for review for compliance with state or DOI-specific standards, and resolve existing network problems prior to merger approval
- Build more robust provider networks that include specialties and services for the medically underserved (e.g. essential community providers, substance use, mental health, pediatricians, etc.) in the state
- Continue participation on the Marketplace and expand offerings into counties not currently served
- Offer the same plans both on and off the Marketplace

VALUE-BASED COVERAGE

Insurers claim that mergers will enable them to offer more value-based insurance design (VBID) options. These have the potential to improve health and lower health care costs but they must be driven by high-value care at the best prices. Improving the quality of care in plans is critical to ensuring consumers experience value in their coverage. One way to measure the realization of this benefit is to closely monitor plan quality ratings. The National Committee for Quality Assurance (NCQA) rates health insurance plans based on customer satisfaction and clinical measures. For 2015-2016, Aetna, Humana and Cigna received “average performance” ratings for commercial plans in Georgia²⁰. To enhance quality for enrollees, and make certain that plans improve based on a measurable metric, state regulators should consider requiring insurers to improve any substandard and/or average quality ratings by a set time.

CONSUMER ASSISTANCE

The health insurance market is rapidly changing and consumers report difficulty navigating the market. Millions of Georgians impacted by the proposed mergers will need help understanding their rights and responsibilities regarding their insurance plans. Consumer Assistance Programs (CAPs) and ombudsman offices provide one-on-one services to help consumers understand and use their health insurance. Georgia had a CAP operated by the DOI until 2013²¹. The Georgia CAP was instrumental in building capacity and expertise to assist consumers and strengthen regulatory oversight and would be invaluable in Georgia if proposed mergers occur. Regulators and policymakers will also need to increase their capacity to closely monitor post-merger market activities. Through interactions with consumers, these CAPs are able to collect and analyze valuable data on the trends and issue areas in the health insurance market at the ground level, all of which can be reported back to the DOI and policymakers.

Consumer assistance programs provide a direct benefit for consumers and regulators. If the mergers are approved, regulators should consider requiring insurers to make community investments in consumer assistance. These contributions should be sufficient to establish a grant program to support non-profit organizations and/or public-private partnerships in providing direct consumer assistance to seniors and individuals enrolled in Medicare Advantage, Marketplace and other plans that are subject to regulatory oversight by the DOI.

ACCOUNTABILITY AND ENFORCEMENT

Insurers should be accountable to consumers and regulators. Close monitoring and oversight are needed to ensure insurers comply with all merger approval conditions. Regulators should consider requiring insurers to commit to the following if the mergers are approved:

- Provide the DOI with annual reports detailing the realization of estimated merger efficiencies, savings, how savings are passed on to consumers, and any cost containment and quality improvement efforts undertaken
- Meaningful penalties and sanctions by the DOI for non-compliance with merger approval conditions

CONCLUSION

If approved, the proposed Aetna-Humana and Anthem-Cigna mergers will lessen competition across markets and impact the price, access, and quality of care for millions of consumers and the health system as a whole in Georgia. History and research have shown that large mergers of this size do not create greater efficiency, lower costs, or increase quality of care despite insurers' claims to the contrary. Mergers, once approved, cannot be unwound. Therefore, extreme caution should be taken in reviewing whether the mergers should be approved at all.

If, at the end of the comment and review period, the DOI has a high degree of certainty that the merger does contain net benefits for consumers, the DOI should write into the consent order enforceable conditions to ensure consumers realize these benefits. The Georgia State Insurance Commissioner has the power to impose remedies to protect consumers and hold insurers accountable for the positive effects they claim are only attainable through consolidation. Georgia regulators should carefully consider whether or not to approve each merger and which remedies best address the expected concerns of and effects on consumers.

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