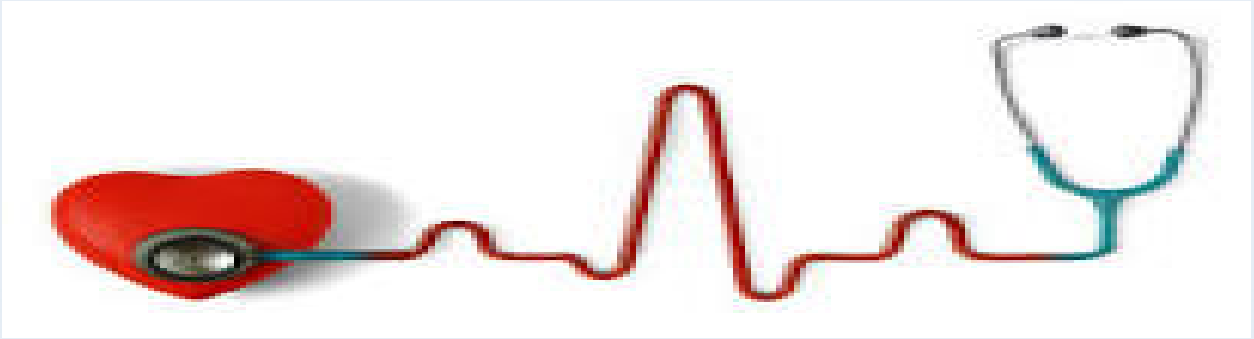


Discussion on the ACA-2016

Nebraska Health Underwriters

May 12, 2016

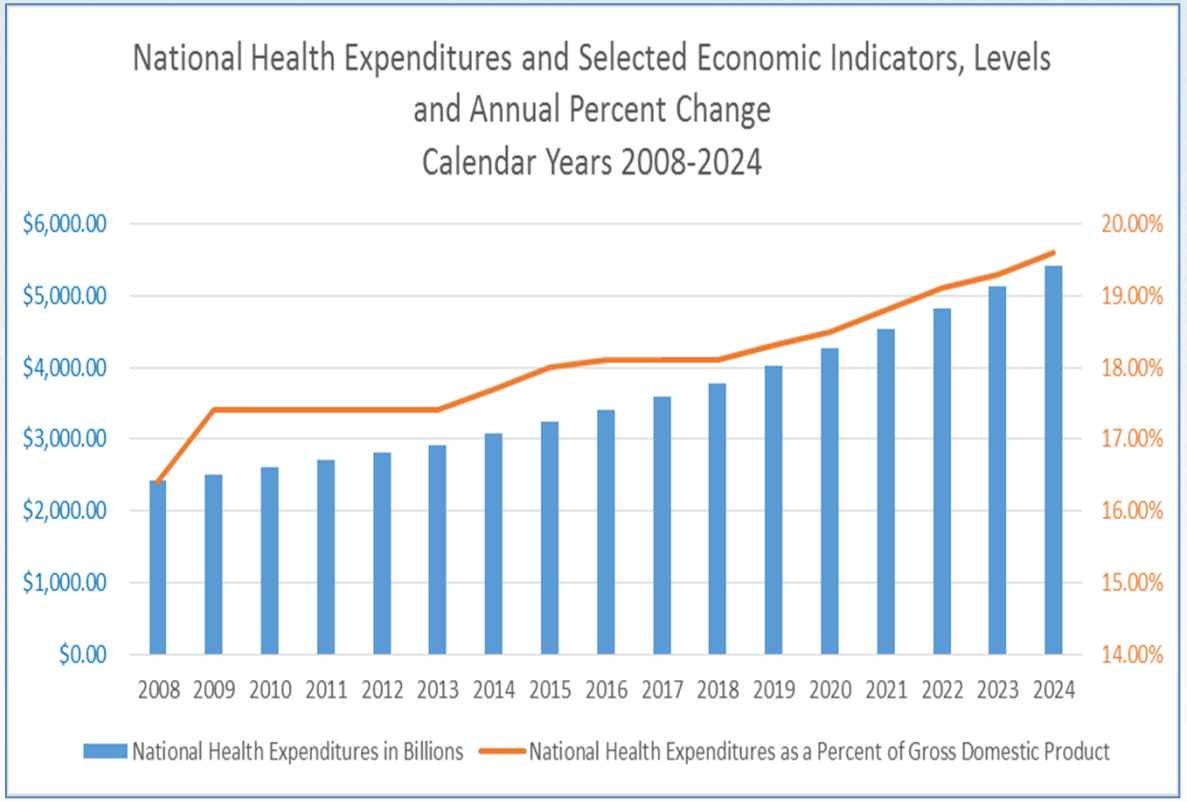
Jesse A Patton *LUTCF, HIA, MHP, FAHM, HIPAAA, EHBA, PHIAS, DBA*

PROTECTING THE CONSUMER'S FUTURE
NAHU
National Association of Health Underwriters
AMERICA'S BENEFITS SPECIALISTS

Healthcare Costs & the Economy

Projected 2024 U.S. healthcare spending = $5.46 trillion, 19.6% GDP

Up, Up and Away: U.S. Healthcare Spending Projections



Centers for Medicare and Medicaid Services

What Do We Get For All This Spending?

- U.S. ranks **last** in efficiency
- U.S. ranks low on safe and coordinated care and patient access to primary care
  - However, the U.S. ranks best on:
    - Provision and receipt of preventive and patient-centered care.
    - Rapid access to specialists.

Employers Foot the Bill

Employers paid **58%** of employees' healthcare costs in 2014.

- A typical family of four has **$23,215** in medical costs each year
  - Employer pays **$13,520**
  - Employee pays **$9,695**
    - *($5,908 in payroll deductions and $3,787 in out-of-pocket costs.)*

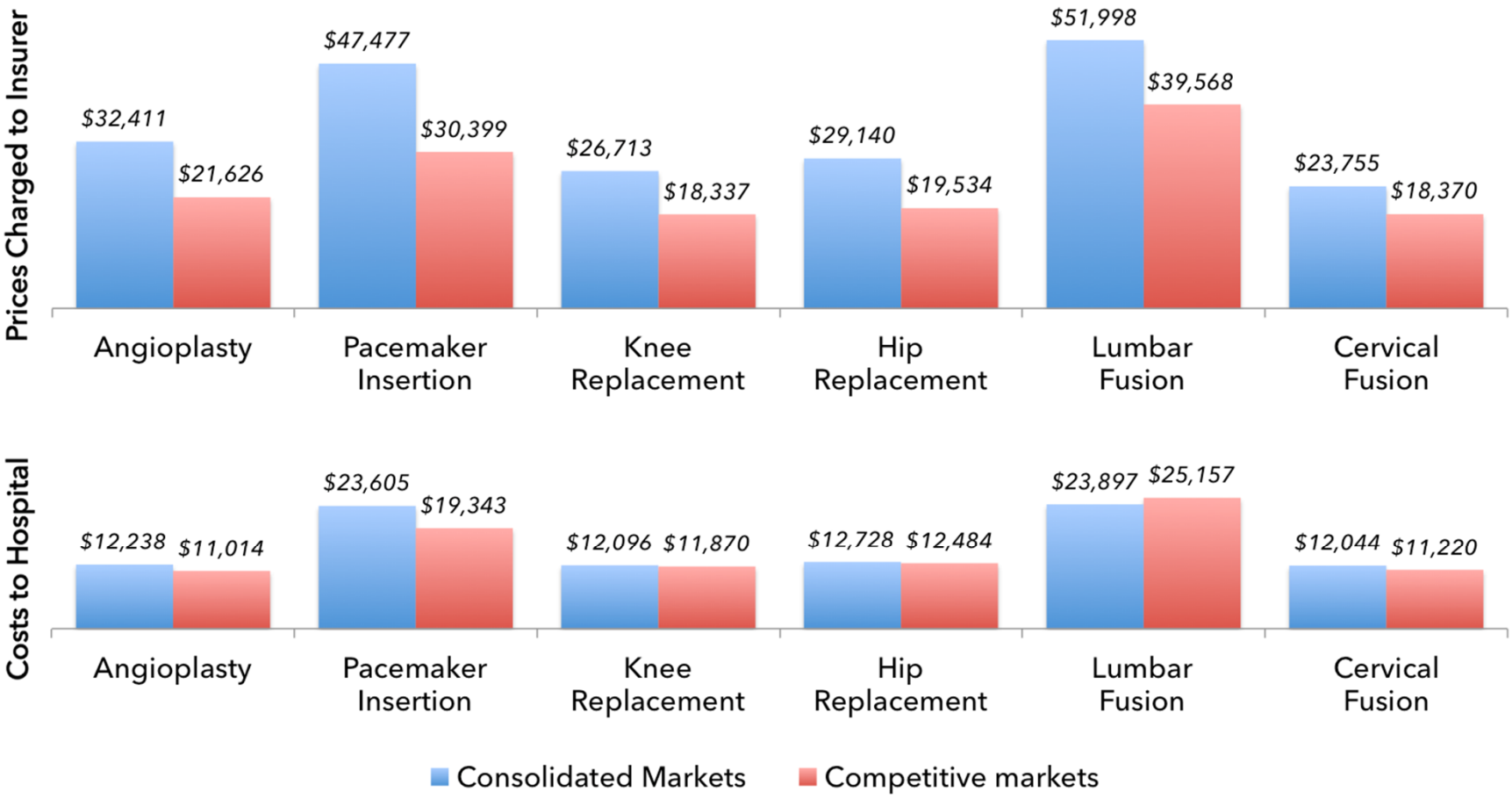
What Is Driving Healthcare Costs?

- Fee-for-service reimbursement
- Fragmentation in care delivery
- Administrative burden
- Population aging, rising rates of chronic disease and co-morbidities
- Advances in medical technology
- Lack of transparency about cost, quality
- Tax treatment of health insurance

- Insurance benefit design
- Cultural biases influencing care utilization
- Healthcare market consolidation
- High unit prices of medical services
- The health care legal and regulatory environment
- Structure and supply of the health professional workforce

Hospital Concentration = 44% Higher Prices

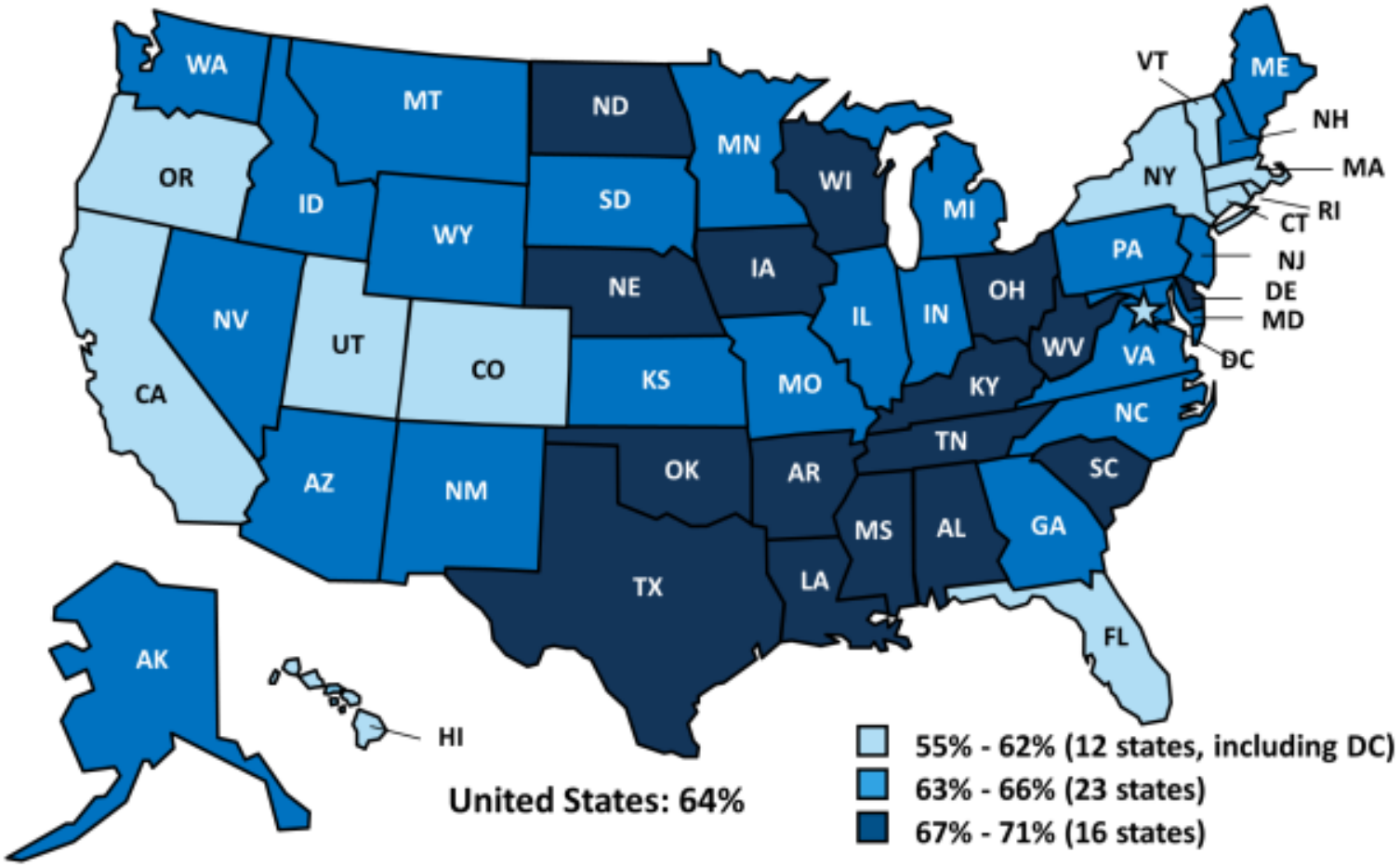
Source: Robinson, AJMC 2011



CENTER FOR MEDICAL PROGRESS
AT THE MANHATTAN INSTITUTE

Figure 6

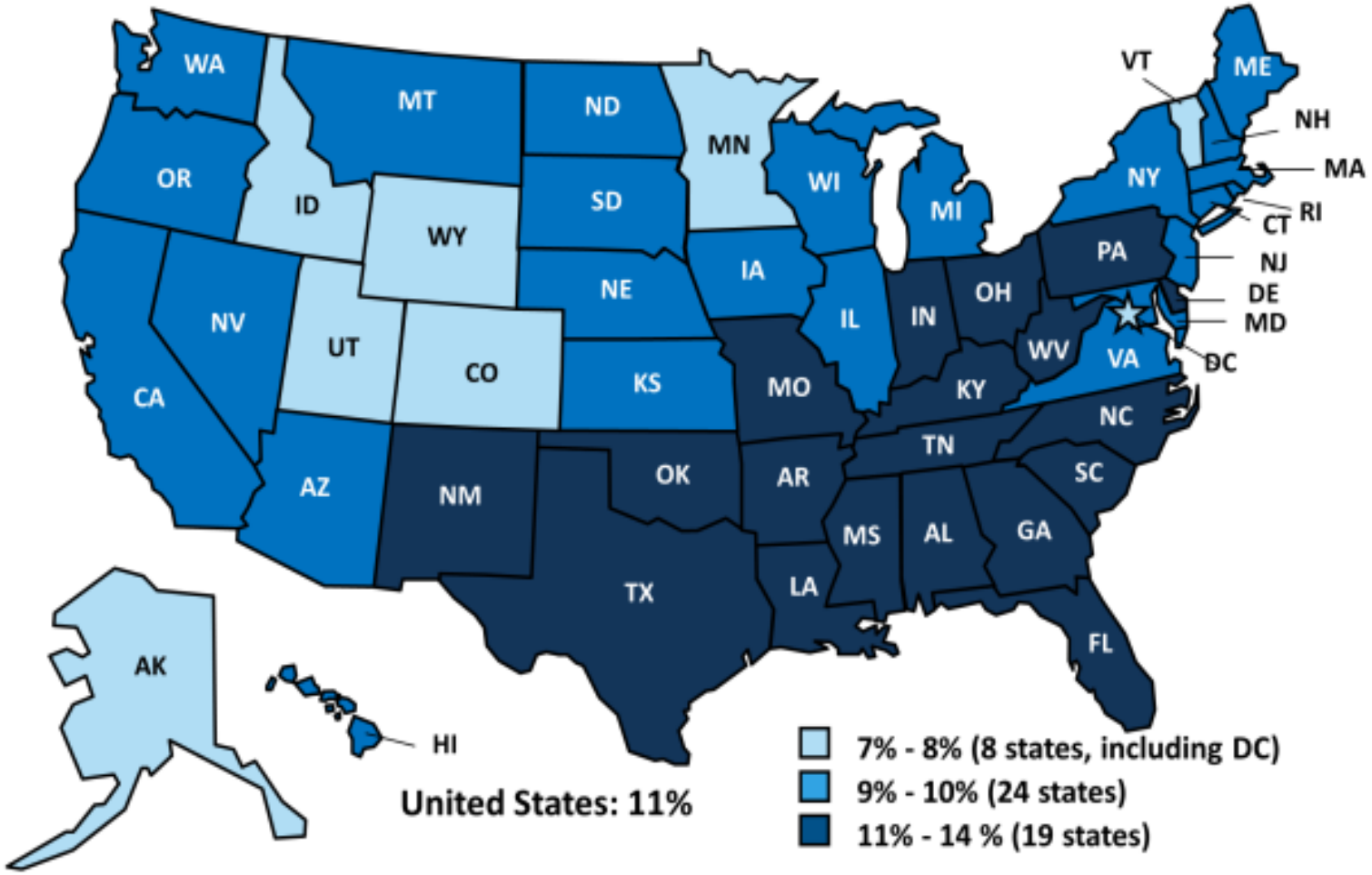
Percent of Adults Who are Overweight or Obese, 2014



Source: KCMU analysis of the Center for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) 2014 Survey Results.

Figure 5

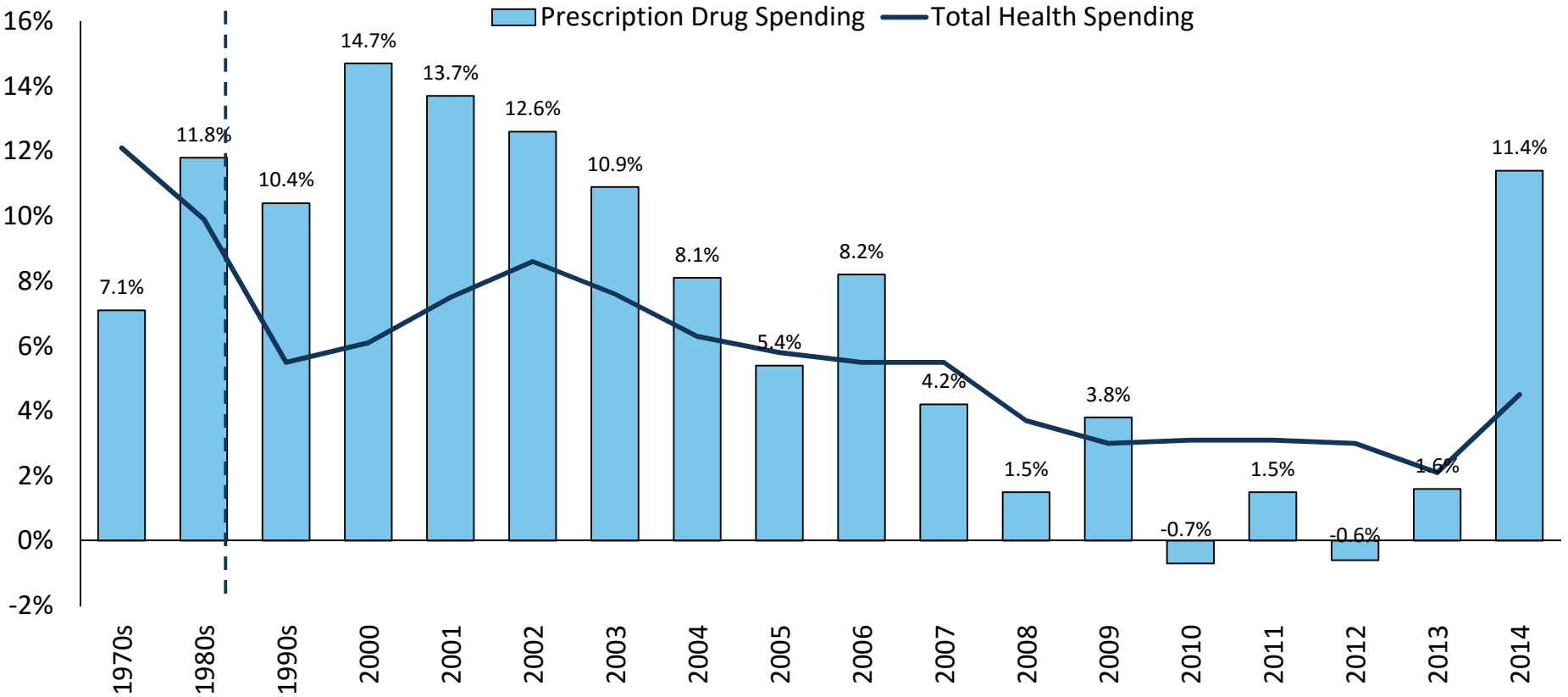
Percent of Adults Who Have Ever Been Told by A Doctor that They Have Diabetes, by State, 2014



Source: KCMU analysis of the Center for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) 2014 Survey Results.

After several years of modest growth, prescription drug spending rose sharply in 2014

Average annual growth rate of prescription drug spending per capita for 1970's – 1990's;
Annual change in actual prescription drug spending per capita 2000 – 2014



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) Historical (1960-2014) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group (Accessed on December 7, 2015)

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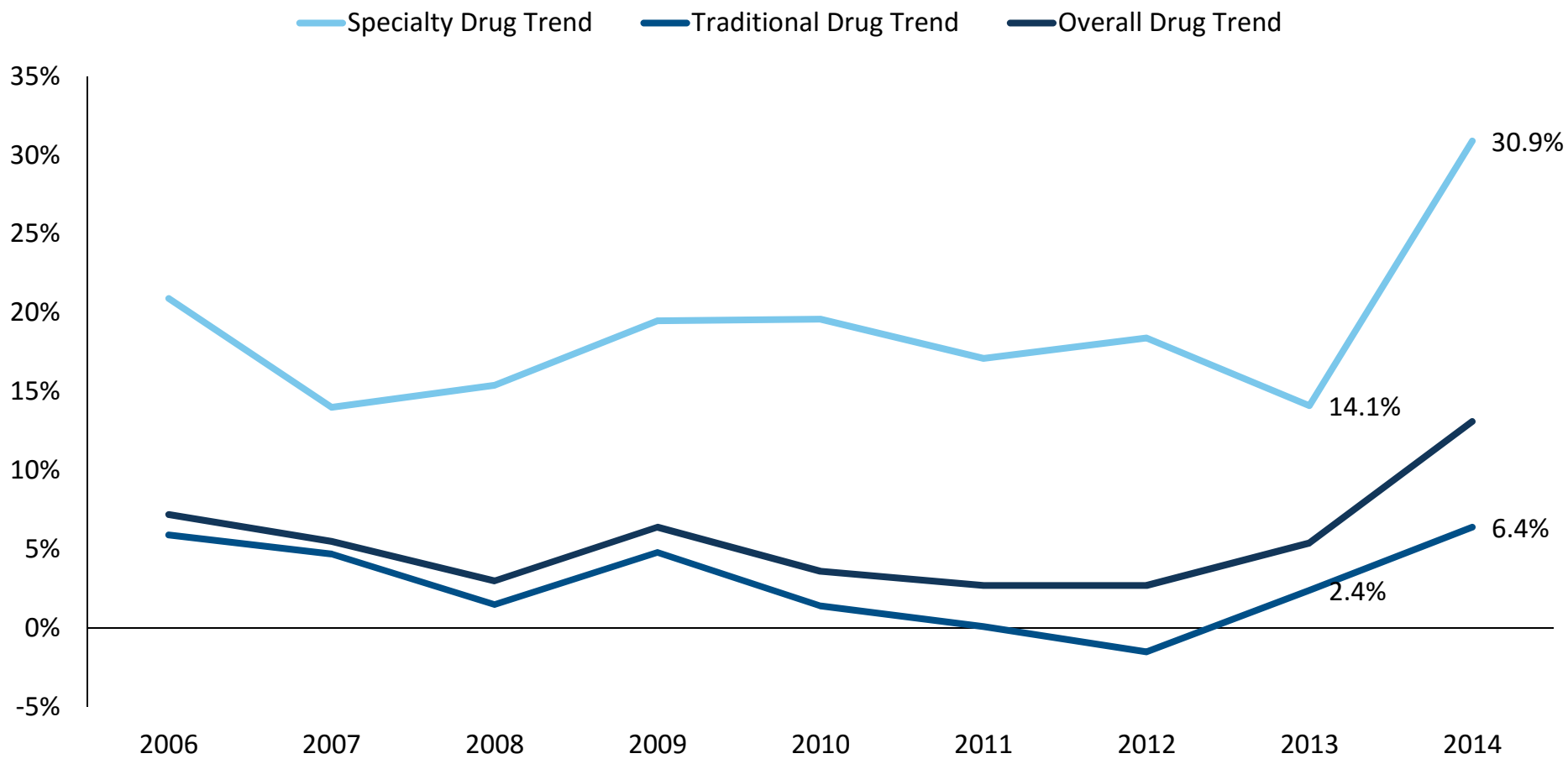
Costly new specialty drugs are a major driver of increased health spending

Express Scripts drug spending growth trend by therapy class, 2006 -2014



Source: Express Scripts 2014 Drug Trend Report and Year in Review. Available at http://lab.express-scripts.com/drug-trend-report/ and http://lab.express-scripts.com/drug-trend-report/introduction/year-in-review

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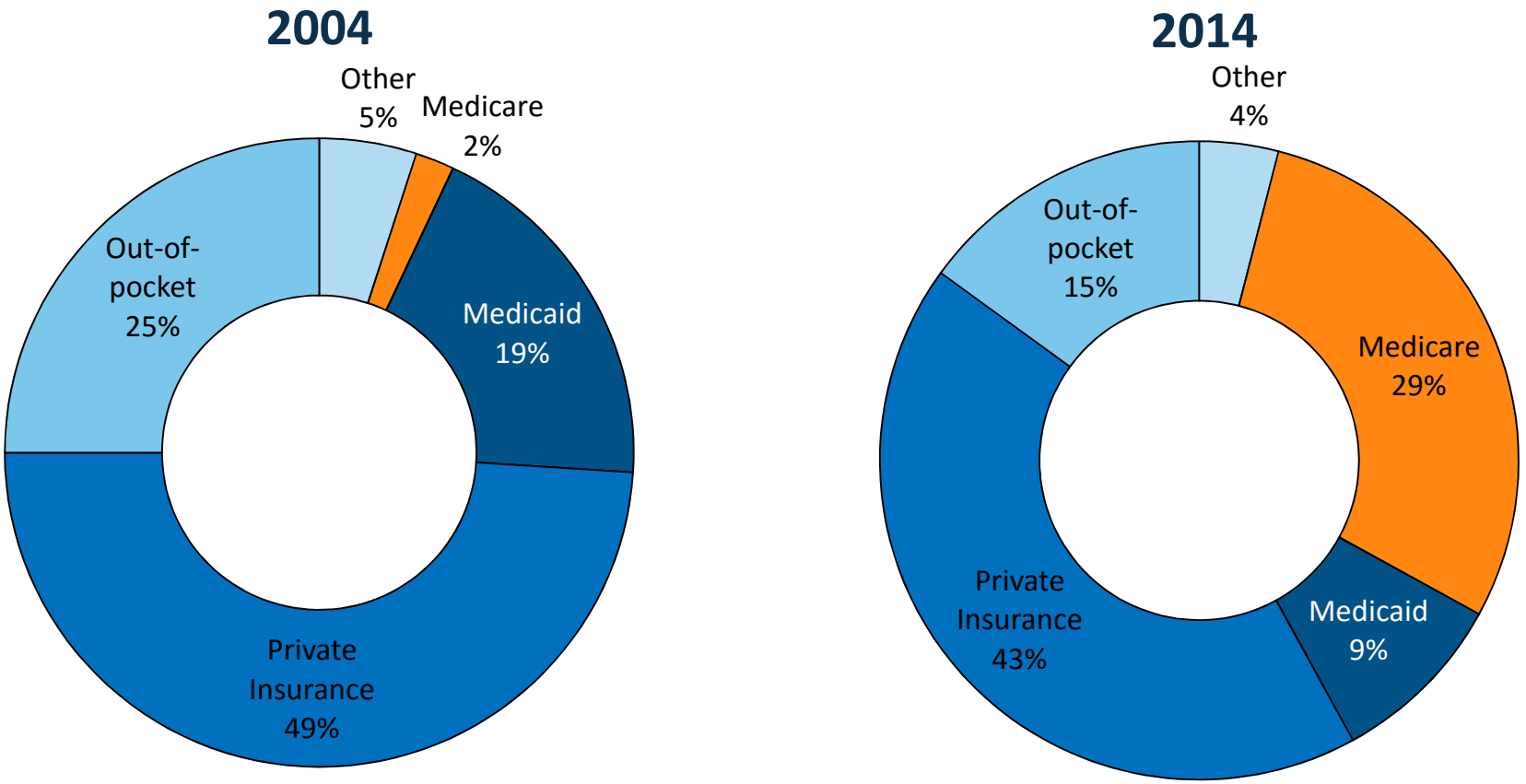
Medicare has become a major payer for prescription drugs

Distribution of total national health expenditures on retail prescription drugs, by payer, 2004 and 2014



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group **Note:** The increase in Medicare spending on prescription drugs is largely due to the 2006 addition of the Medicare prescription drug benefit.

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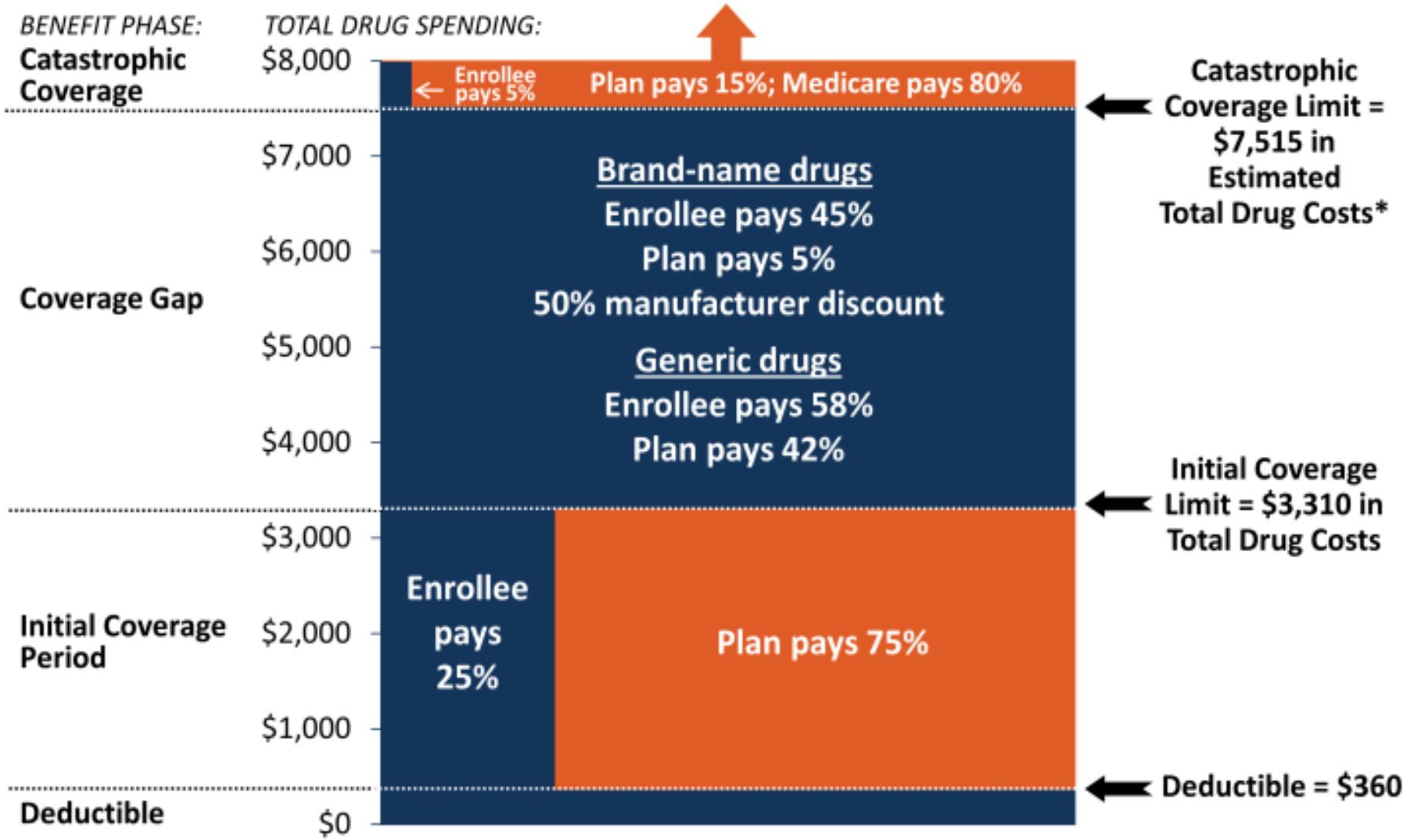
Figure 5

Standard Medicare Prescription Drug Benefit, 2016



NOTE: Amounts rounded to nearest dollar. *Amount corresponds to the estimated catastrophic coverage limit for non-low-income subsidy enrollees ($7,062.50 for LIS enrollees), which corresponds to True Out-of-Pocket (TrOOP) spending of $4,850 (the amount used to determine when an enrollee reaches the catastrophic coverage threshold.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2016.

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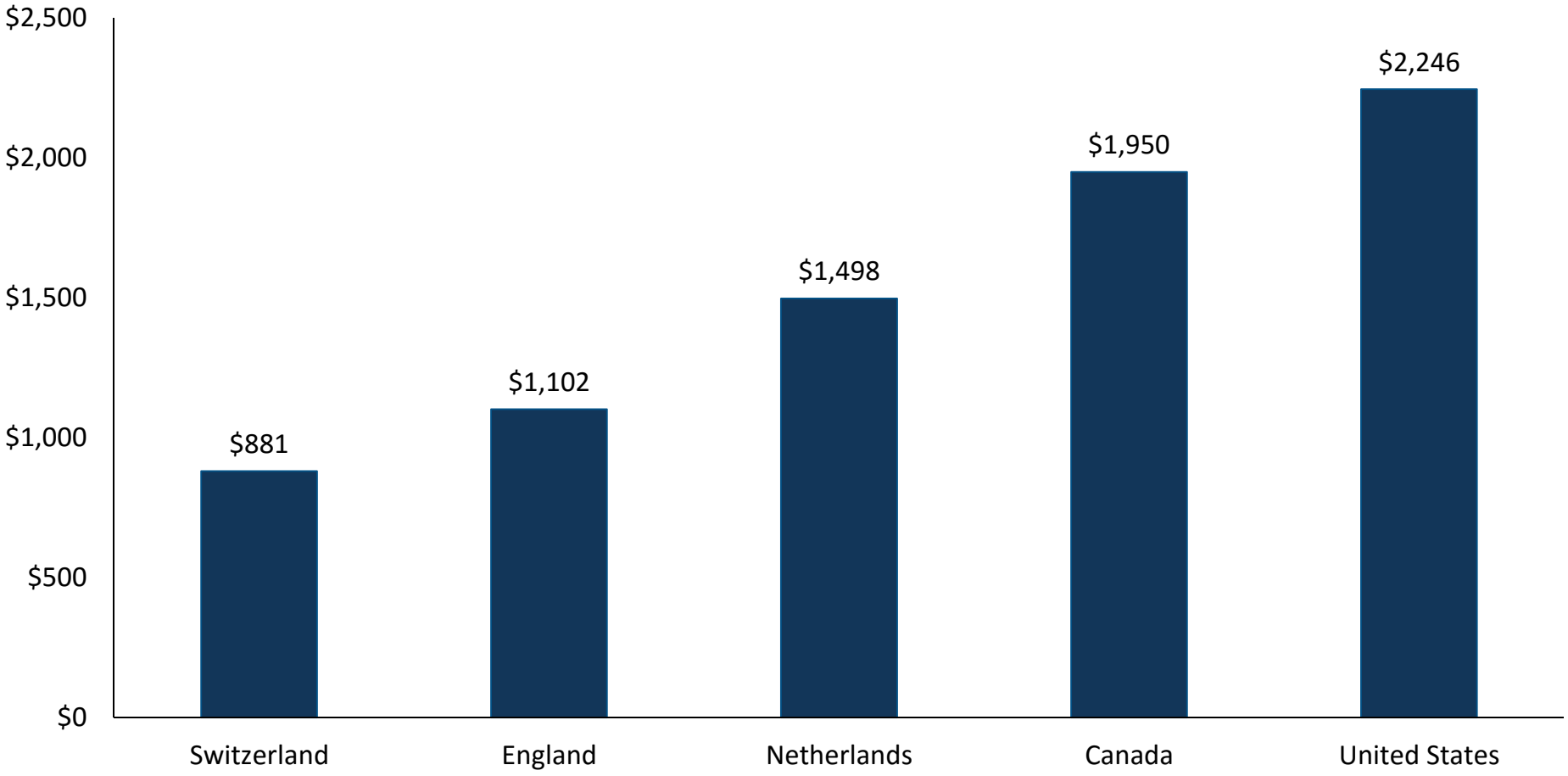
The average price of Humira is about 15% higher in the U.S. than in Canada

Average price for 1-month supply, 2013

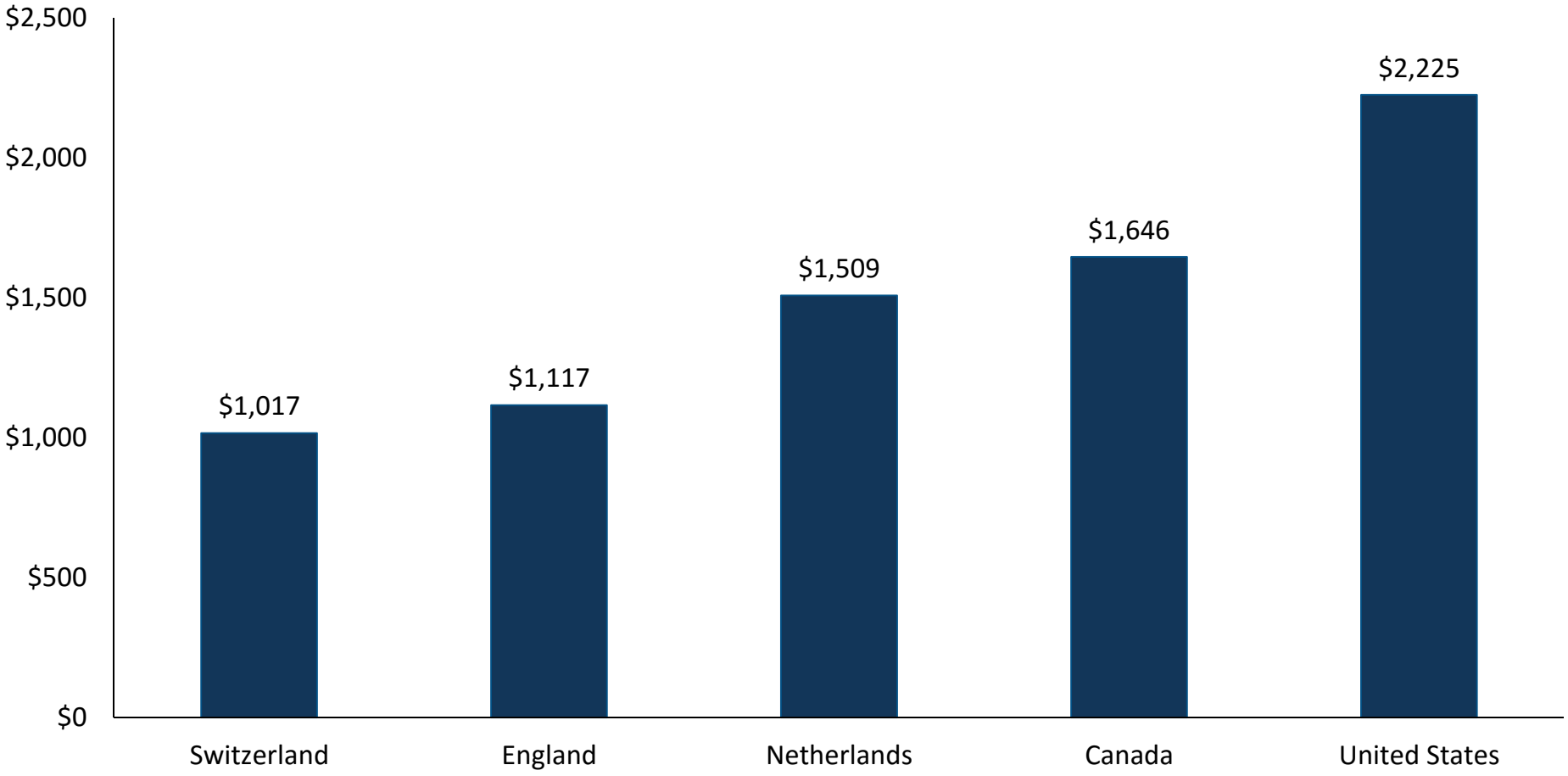


Source: International Federation of Health Plans **Notes:** U.S. average prices are calculated using commercial claims data from Truven MarketScan Research databases. Methods and sources for comparable countries can be found here: http://www.ifhp.com/1404121

THE HENRY J. KAISER FAMILY FOUNDATION

The average price of Enbrel in the U.S. is about 35% higher than in Canada

Average price for 1-month supply, 2013



Source: International Federation of Health Plans **Notes:** U.S. average prices are calculated using commercial claims data from Truven MarketScan Research databases. Methods and sources for comparable countries can be found here: http://www.ifhp.com/1404121

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Enbrel Sales in U.S.

3.8 million prescriptions for Enbrel issued in the U.S.

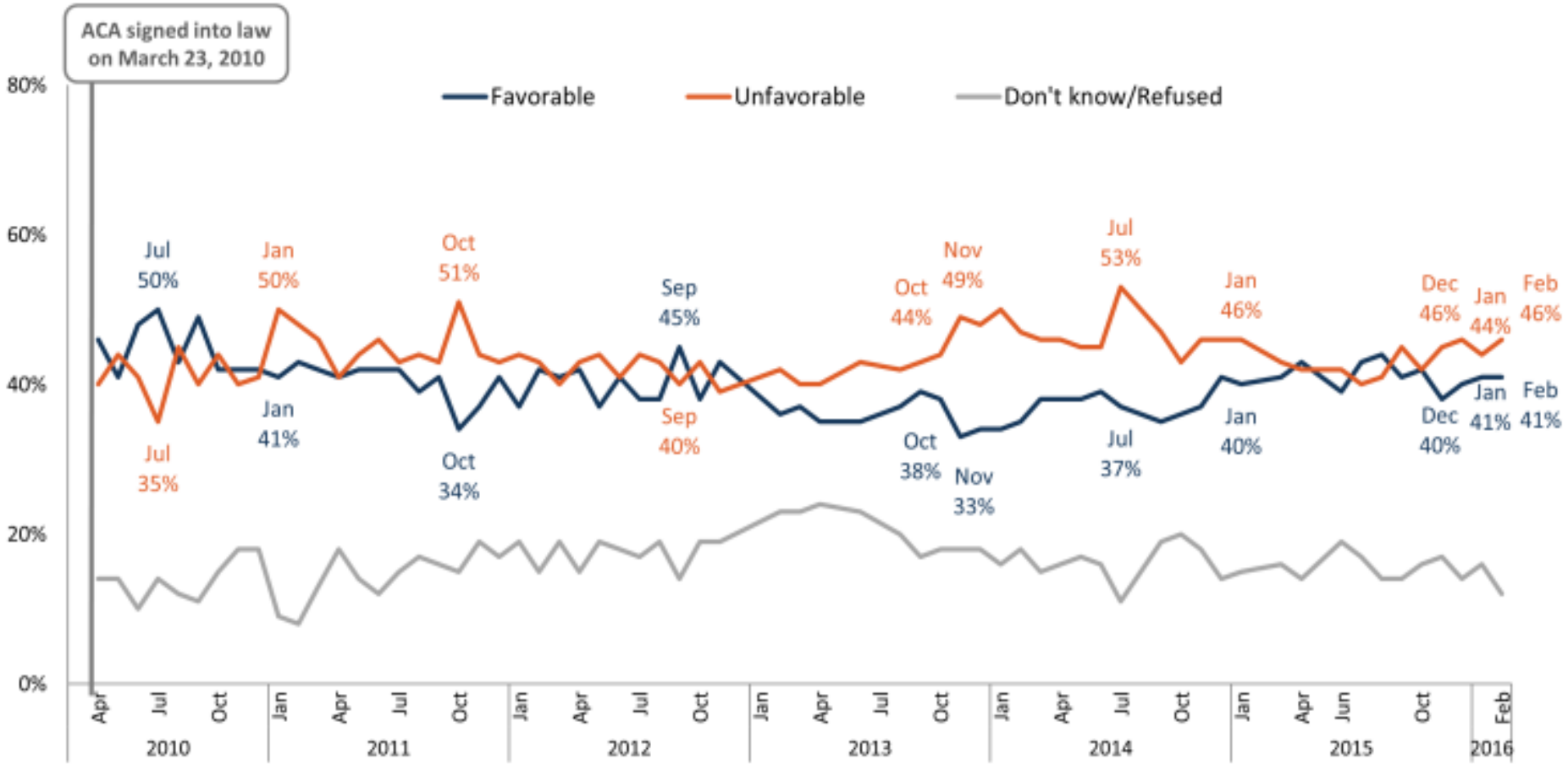
- Cost to United States system $8.5 Billion dollars
- Cost in the Switzerland $3.9 Billion dollars

Potential Cost savings on One drug to U.S. system $4.6 billions dollars

Figure 9

Public's View of the Health Care Law Remains Divided

As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?



NOTE: Data not collected for Dec 2012, Jan 2013, May 2013, Jul 2013, Aug 2014, Feb 2015, May 2015, and Jul 2015.
SOURCE: Kaiser Family Foundation Health Tracking Polls

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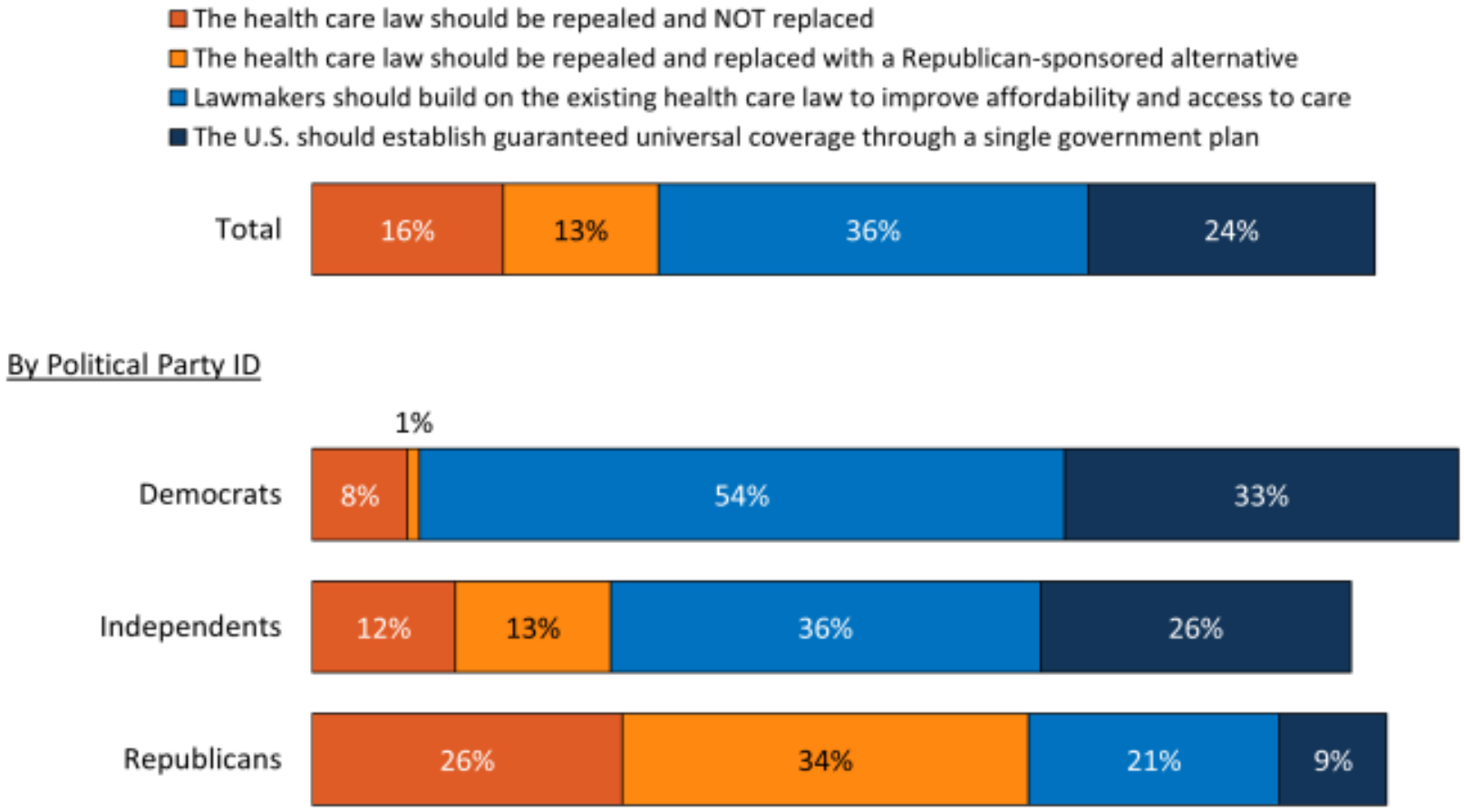
Happy 6th Birthday ACA-Speaker Pelosi stated

- "The United States will finally join the rest of the civilized world in achieving universal coverage…
- "Families will save thousands of dollars on premiums…
- "No one will be denied care because they can't afford to pay…
- "Passage of this law will reduce the federal budget deficit…"

Figure 2

Views of the Future of the U.S. Health Care System

Which of the following comes closest to your view of the future of the U.S. health care system?



NOTE: None of these/ Something else (Vol.) and Don't know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 10-18, 2016)

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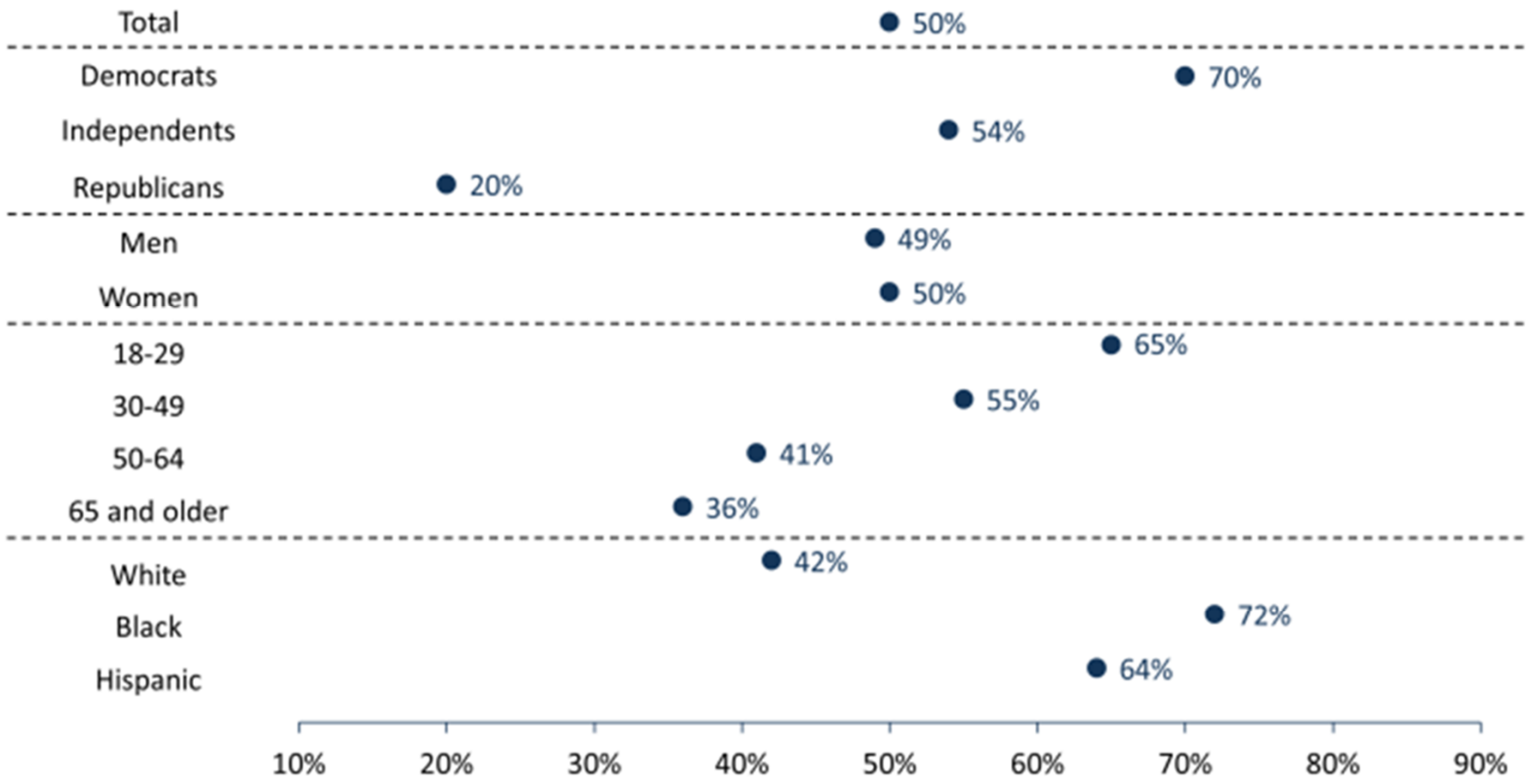
Figure 3

Views of Universal Coverage

Percent who say they strongly or somewhat favor having guaranteed health insurance coverage in which all Americans would get their insurance through a single government health plan:



SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted February 10-18, 2016)

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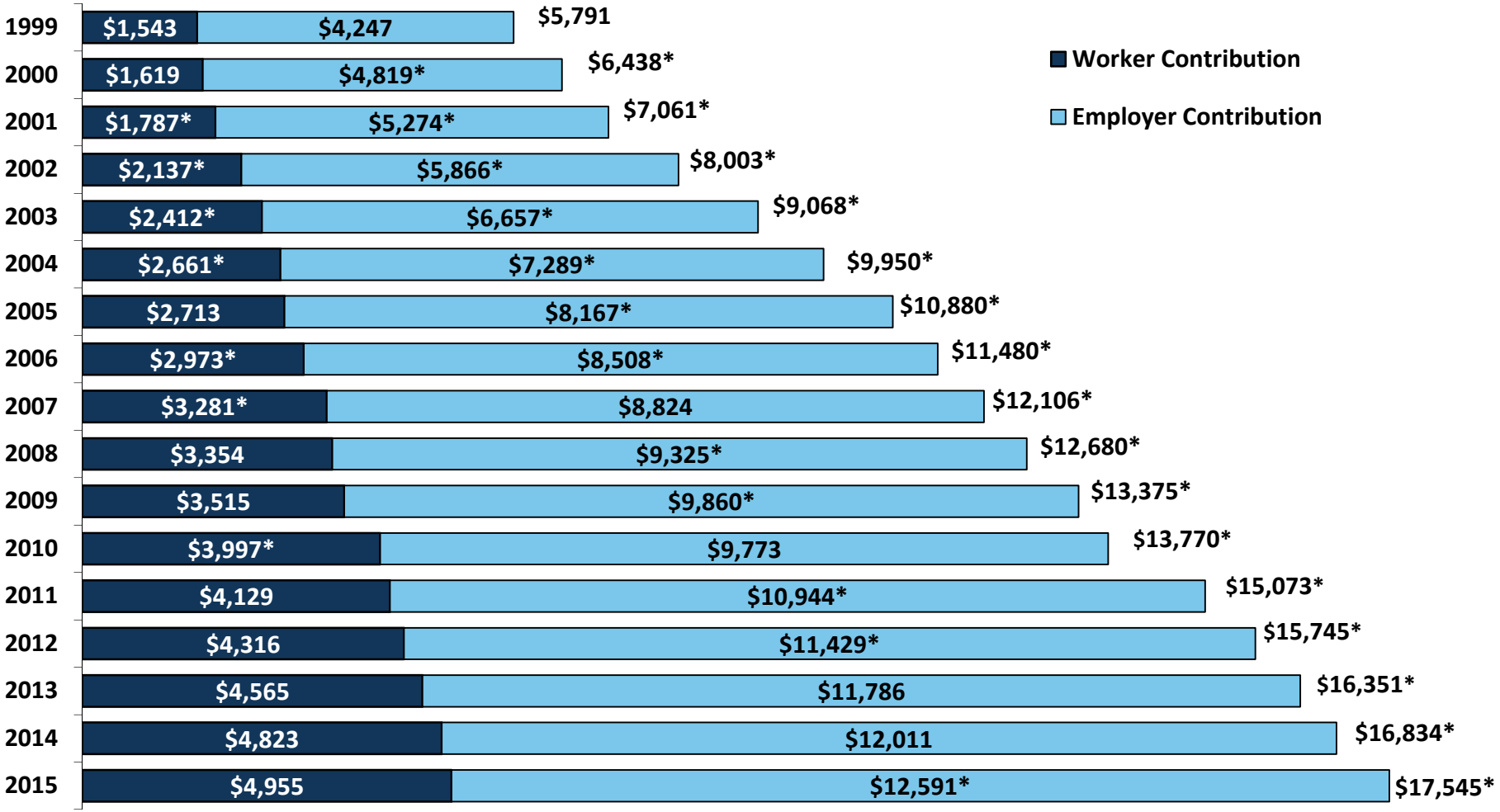
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2015



* Estimate is statistically different from estimate for the previous year shown (p<.05).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015.

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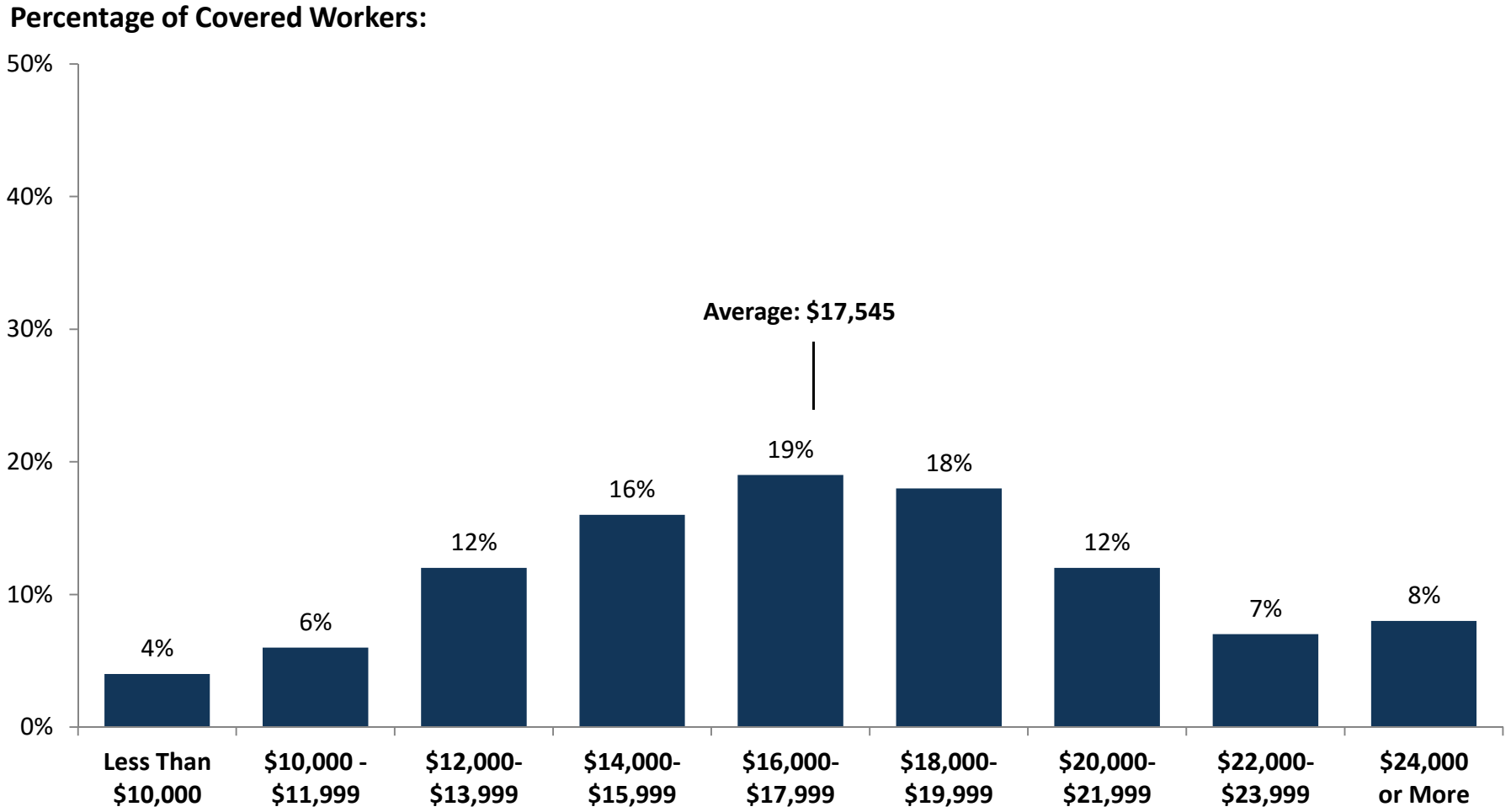
Distribution of Annual Premiums for Covered Workers with Family Coverage, 2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015.

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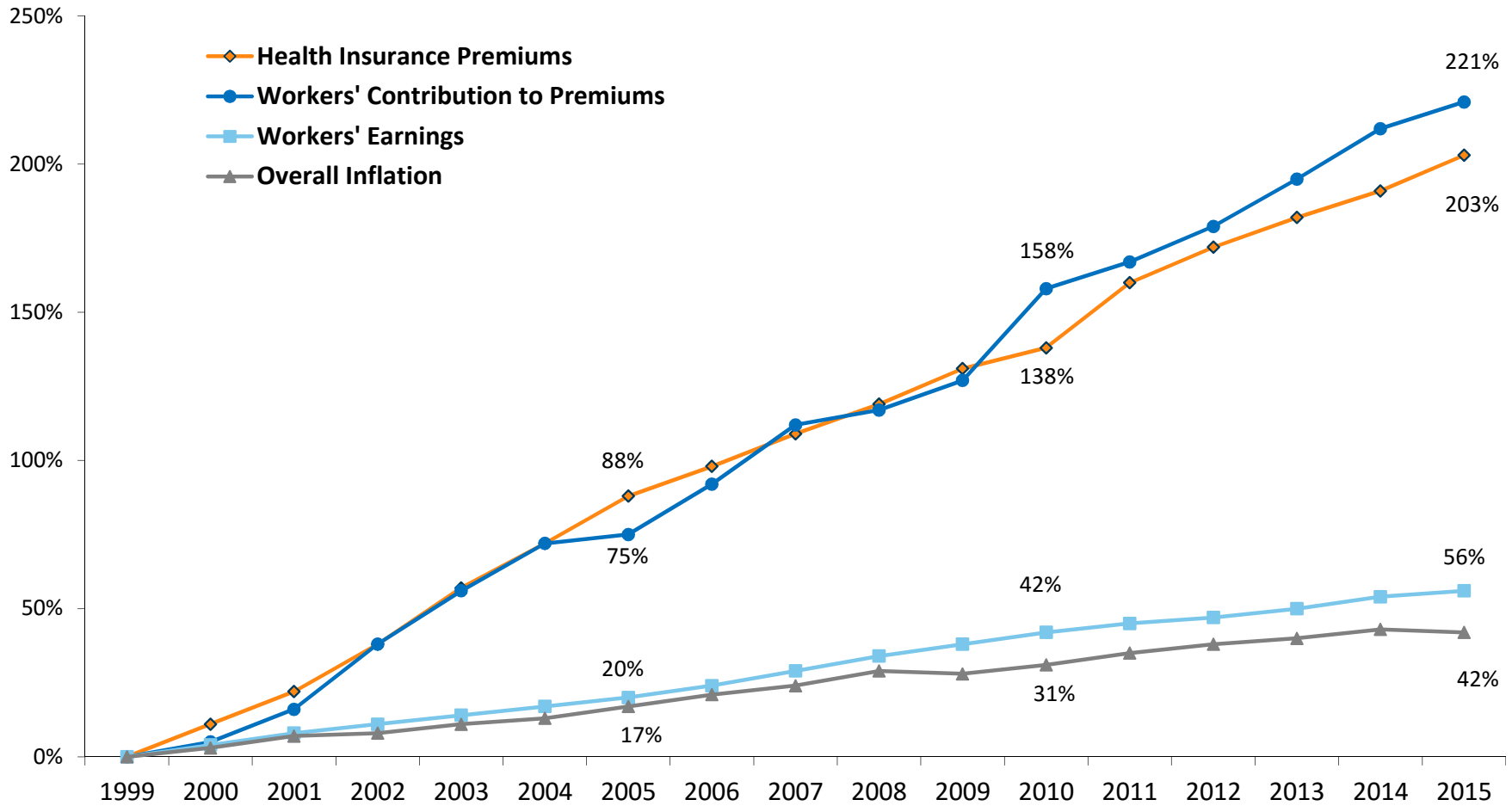
Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2015 (April to April).

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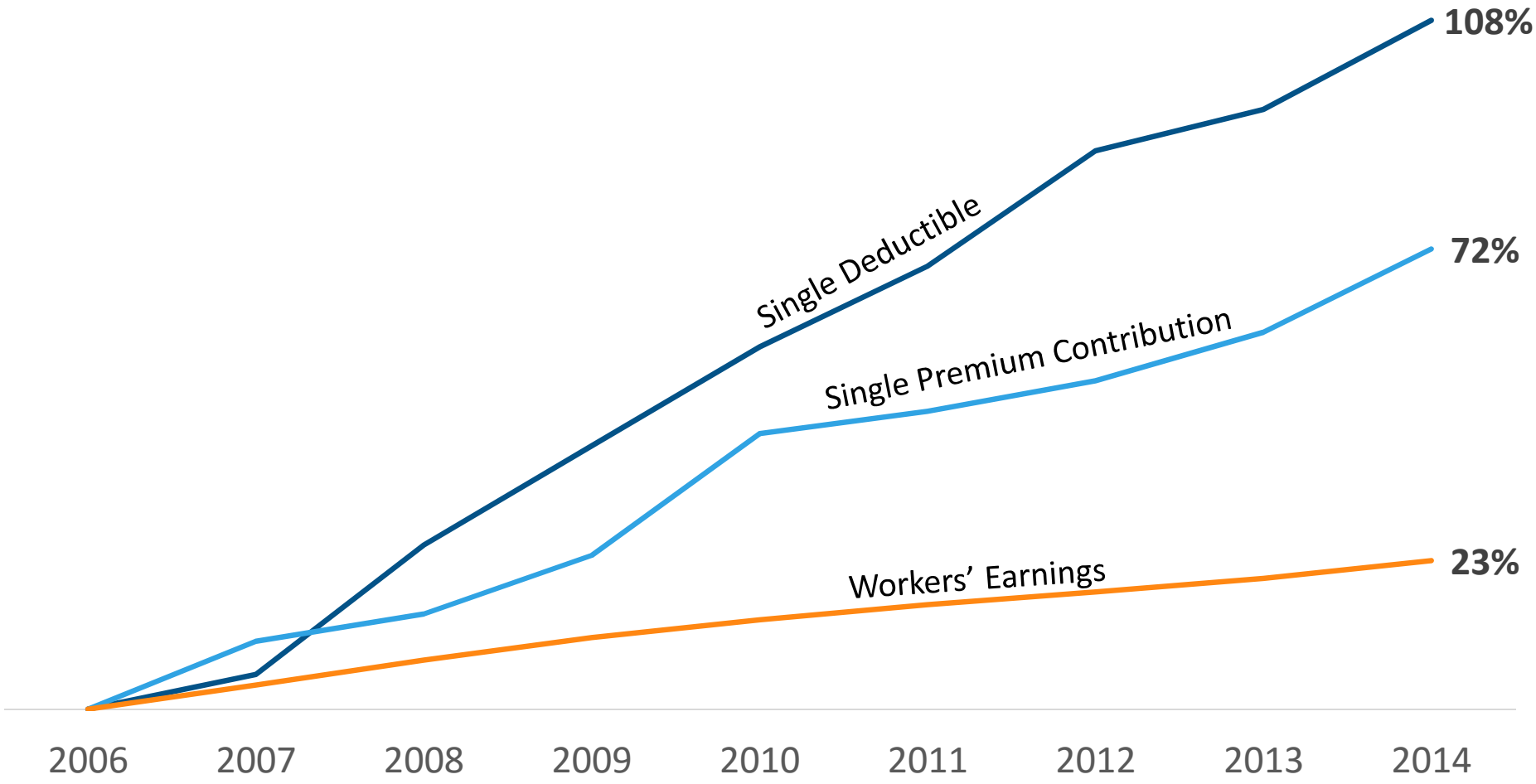
Out-of-Pocket Pain

Cumulative Growth in Worker Health Expenses vs. Earnings



Source: Analysis of Kaiser/HRET Employer Health Benefits Survey and BLS data.

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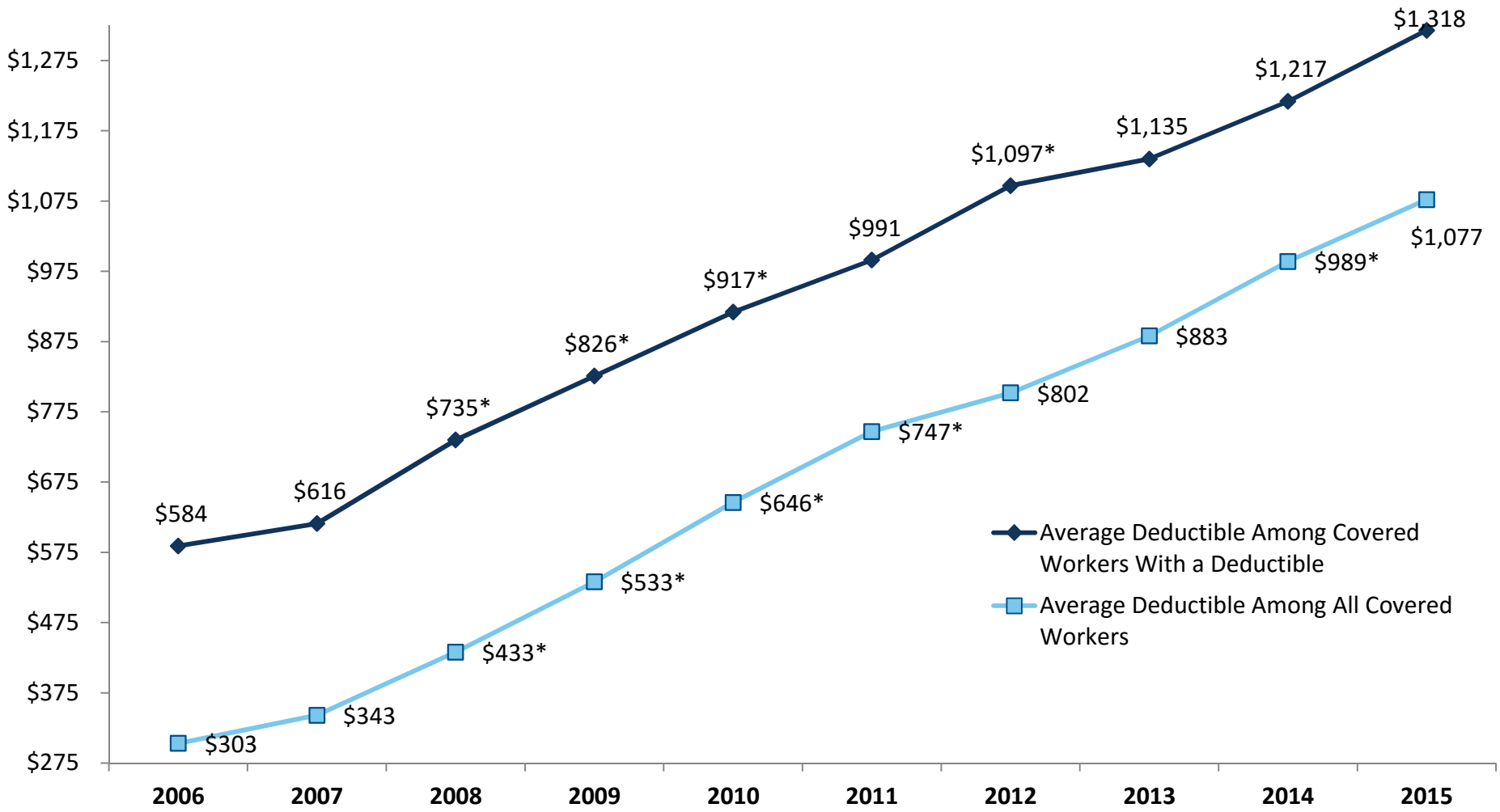
Average General Annual Deductible for Covered Workers Enrolled in Single Coverage, 2006-2015



* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTES: Average general annual deductible is among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.

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Market Landscape in 2016

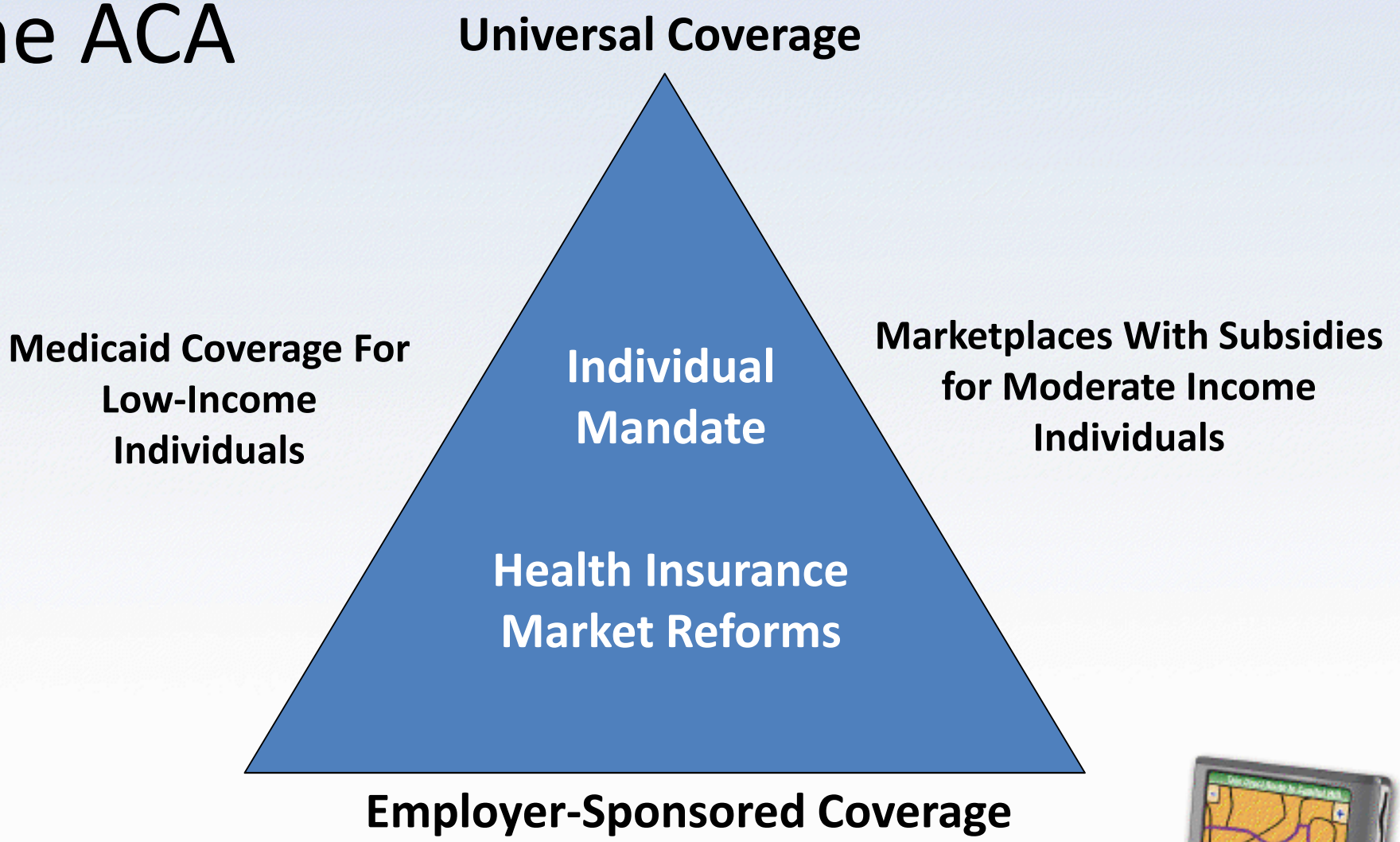
- Everyone must enroll in one of these plans or programs

<table>
<tr><td colspan="2">Individual or Small Group Plans</td><td rowspan="2">Large Group Plans</td><td rowspan="3">Government Programs

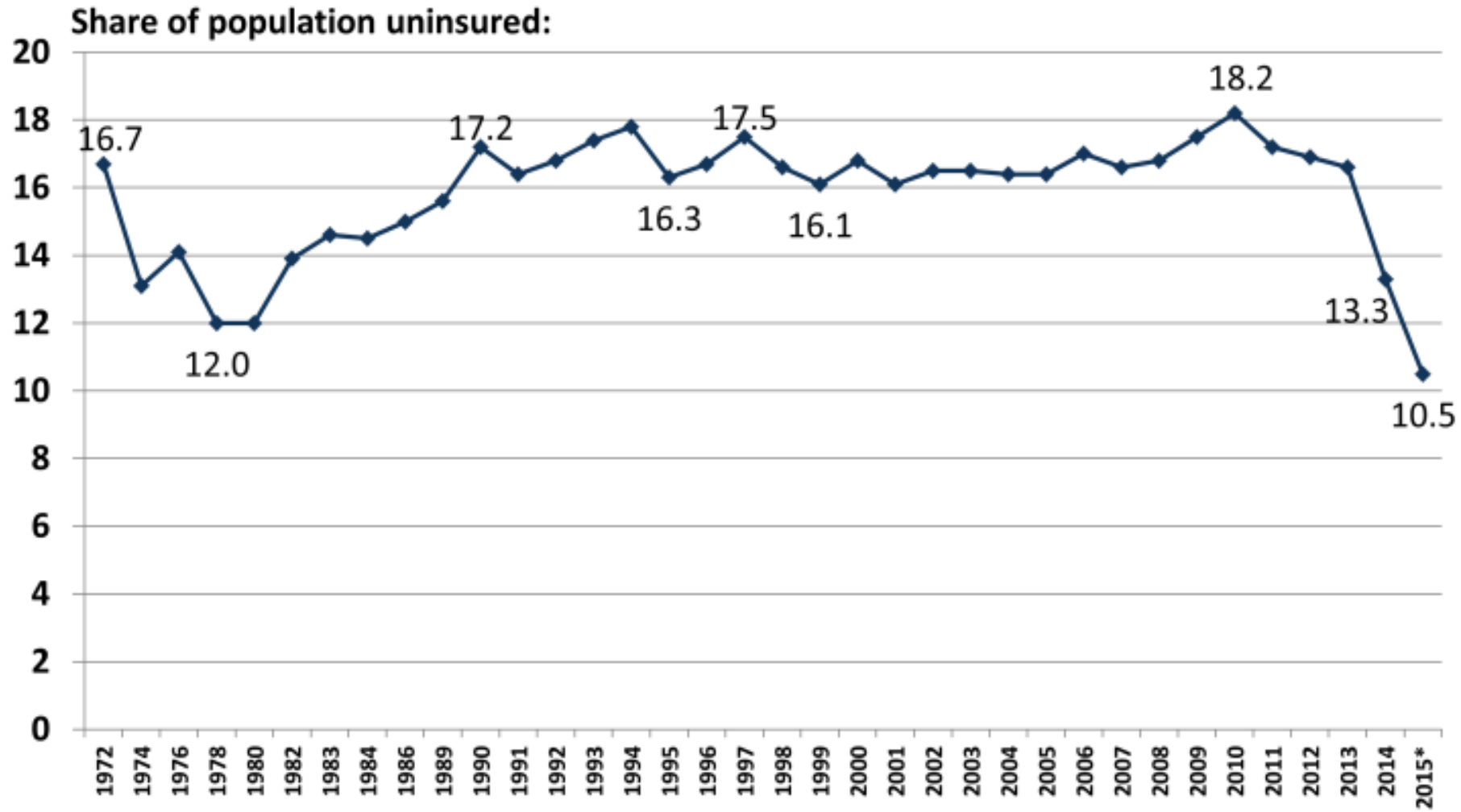
• Medicare
• Medicaid
• CHIP
• Tricare
• Veterans</td></tr>
<tr><td>Offered in Exchange</td><td>Offered Outside Exchange</td></tr>
<tr><td colspan="3">Grandfathered Plans*
(Individual, Small or Large Group)
Grand-mothering</td></tr>
</table>

* Existed 3/23/10, with minor changes allowed under ACA. Added employees and dependents OK.

Promoting Health Coverage through the ACA



Uninsured Rate Among the Nonelderly Population, 1972-2015



Note: 2015 data is for Q1 and Q2 only.
Source: CDC/NCHS, National Health Interview Survey, reported in http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm#table01 and http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201511.pdf.

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Enrollment as Share of Potential

Location	Marketplace Type	Total Enrollment	Estimated Number of Potential 2015 Marketplace Enrollees	Percent of Potential Marketplace Population Enrolled
United States	13 State-based Marketplaces; 4 Federally-supported Marketplaces; 7 State-Partnership Marketplaces; 27 Federally-facilitated Marketplaces	8,780,545	27,438,000	32%
Iowa	State-Partnership Marketplace	36,085	247,000	15%
Nebraska	Federally-facilitated Marketplace	59,348	221,000	27%

Marketplace Enrollment and Financial Assistance

Location	Total Marketplace Enrollment	Marketplace Enrollees Receiving Advance Premium Tax Credits (APTCs)	Percent of Total Marketplace Enrollees Receiving APTCs	Marketplace Enrollees Receiving Cost-Sharing Reductions (CSRs)	Percent of Total Marketplace Enrollees Receiving CSRs
United States	8,780,545	7,375,489	84.0%	4,955,281	56.4%
1. Nebraska	59,348	52,603	88.6%	29,585	49.9%
2. Iowa	36,085	31,039	86.0%	17,726	49.1%

Enrollment by Metal Level

Location	Bronze	Silver	Gold	Platinum	Catastrophic	Total
United States	1,788,315	5,993,766	645,390	310,784	42,290	8,780,545
Iowa	10,791	21,423	3,846	NSD	NSD	36,060
Nebraska	19,877	35,234	3,690	116	431	59,348

Medicare Access and CHIP(MACRA)H.R.2

MACRA signed into law April 16, 2015

- SGR repealed-21% cut proposed 2015
- 0% through June 2015-0.5% July 15-Dec. 2019
- 2017 Physicians subject to Adjustments based on Value-Based Payment Modifier(VBM)
- 2018 Medicare Means testing changes for Part B & D.
- 2020 Medigap plans for new enrollees may not offer “first dollar” coverage. Plan F moves to G and Plan C moves to D.

Part B (Voluntary Medical Insurance)

Taxable Income from 2014

2016 Part B Premiums	Individual Income	Couple Income
$121.80	<$85,000	<$170,000
$170.50	$85,000-$107,000	$170-001-$214,000
$243.60	$107,001-$160,000	$214,001-$320,000
$316.70	$160,001-$213,000	$320,001-$426,000
$389.80	>$214,000	>$428,000

2018 MACRA Changes to Means Testing

- **2018 premium thresholds for individuals:**
- If MAGI is: Percentage
- > $85,000 but not > $107,000 35%
- > $107,001 but not > $133,500 50%
- >$133,501 but not > $160,000 65%
- >$160,000 80%

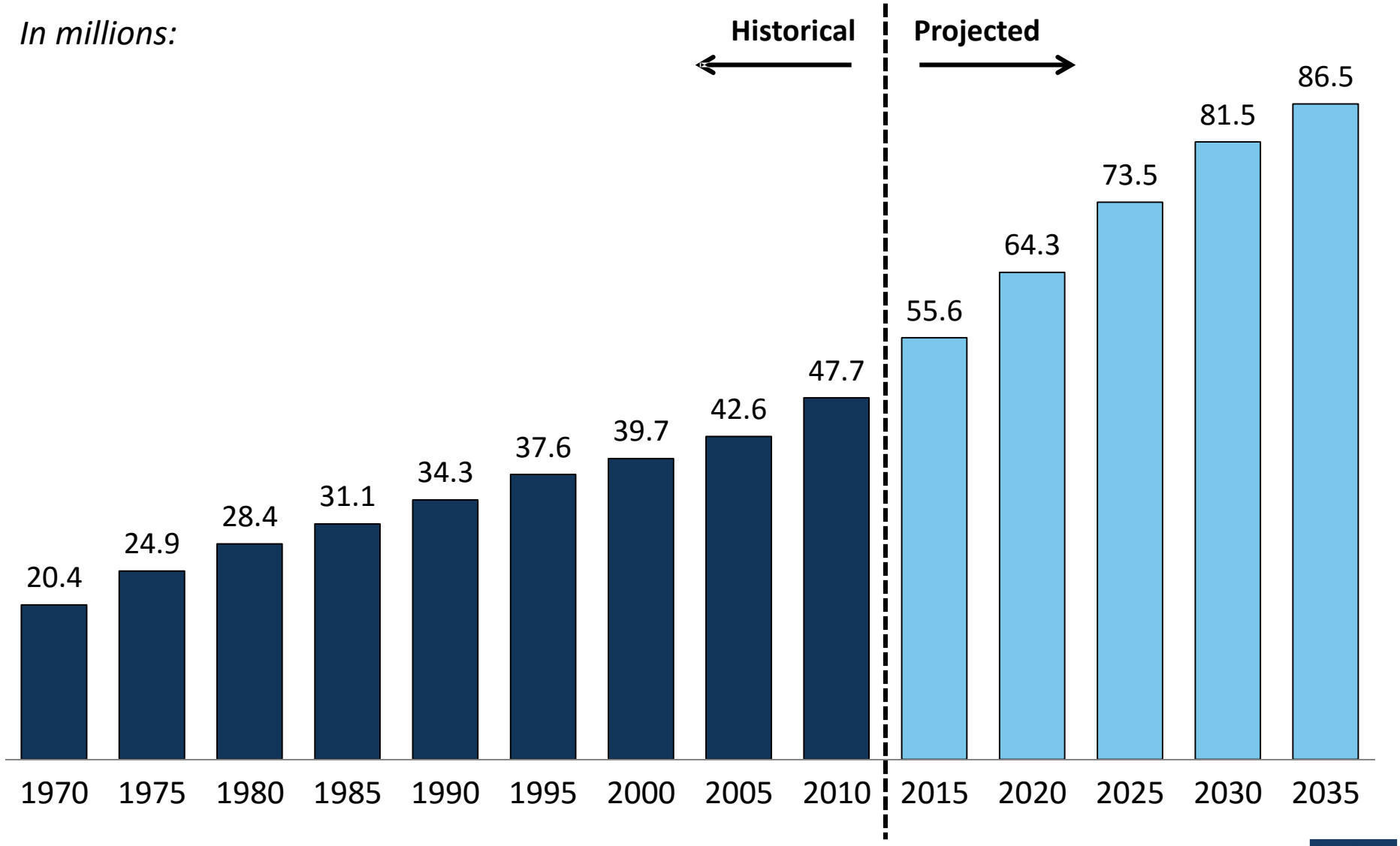
- **2018 premium thresholds for couples:**
- If MAGI is: Percentage
- >$170,001 but not > $214,000 35%
- > $214,001 but not> $267,000 50%
- >$267,001 but not > $320,000 65%
- >$320,000 80%

Importance of Medicare Market

Who Are The Baby Boomers?

- Born between 1946 - 1964
- 78 million baby boomers
- $13 trillion in assets
- January 1st 2011
  - 10,000 a day will reach age 65
  - Will continue for the next 19 years

Medicare Enrollment, 1970-2035



SOURCE: 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

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2016 Projections CMS Actuary

- Benefits will amount to $627.6 Billion Dollars on 57 Million Medicare Beneficiaries

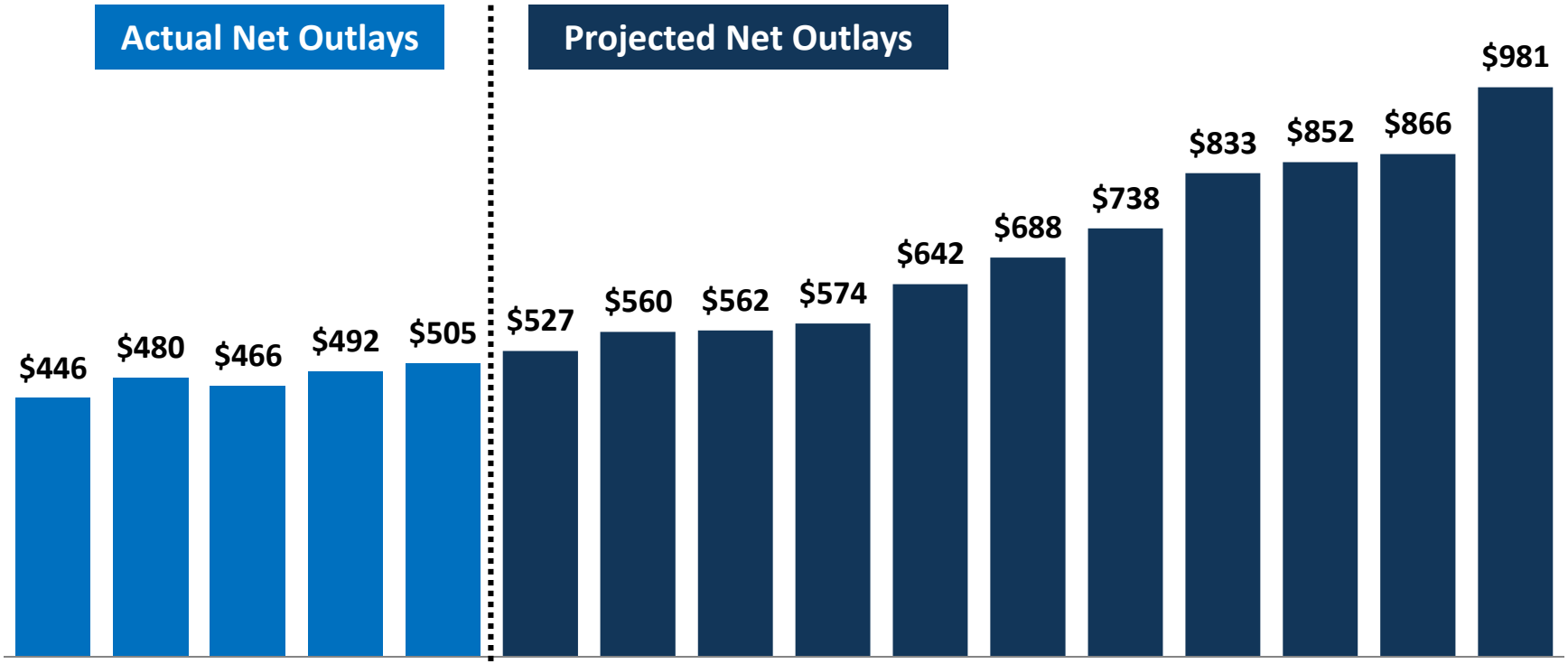
Part A: Financed on 2.9% Payroll Tax on both Employer & Employee

Part B: 25% Premium Collected Beneficiaries

75% General Revenue Funds

Figure 38

Medicare Spending and Percent of Federal Outlays and GDP, 2010-2025



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Share of: Federal Outlays	*12.9%*	*13.3%*	*13.2%*	*14.2%*	*14.4%*	*14.3%*	*14.3%*	*13.9%*	*13.6%*	*14.3%*	*14.5%*	*14.8%*	*15.8%*	*15.8%*	*15.2%*	*16.2%*
GDP	*3.0%*	*3.1%*	*2.9%*	*3.0%*	*2.9%*	*2.9%*	*3.0%*	*2.9%*	*2.8%*	*3.0%*	*3.1%*	*3.2%*	*3.4%*	*3.4%*	*3.3%*	*3.6%*

NOTE: All amounts are for federal fiscal years; amounts are in billions and consist of Medicare spending minus income from premiums and other offsetting receipts.

SOURCE: Kaiser Family Foundation based on data from Congressional Budget Office, Updated Budget Projections: 2015 to 2025 (March 2015); The 2014 Long-Term Budget Outlook (July 2014).

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Medicare– 50 Years Later

- July 22, 2015 memo to Senate Budget Committee staff, Medicare's Office of the Actuary reports that Medicare's debt—the program's long-term unfunded liability—ranges from $27.9 to $36.8 trillion.

Income-related Medicare Part B premiums

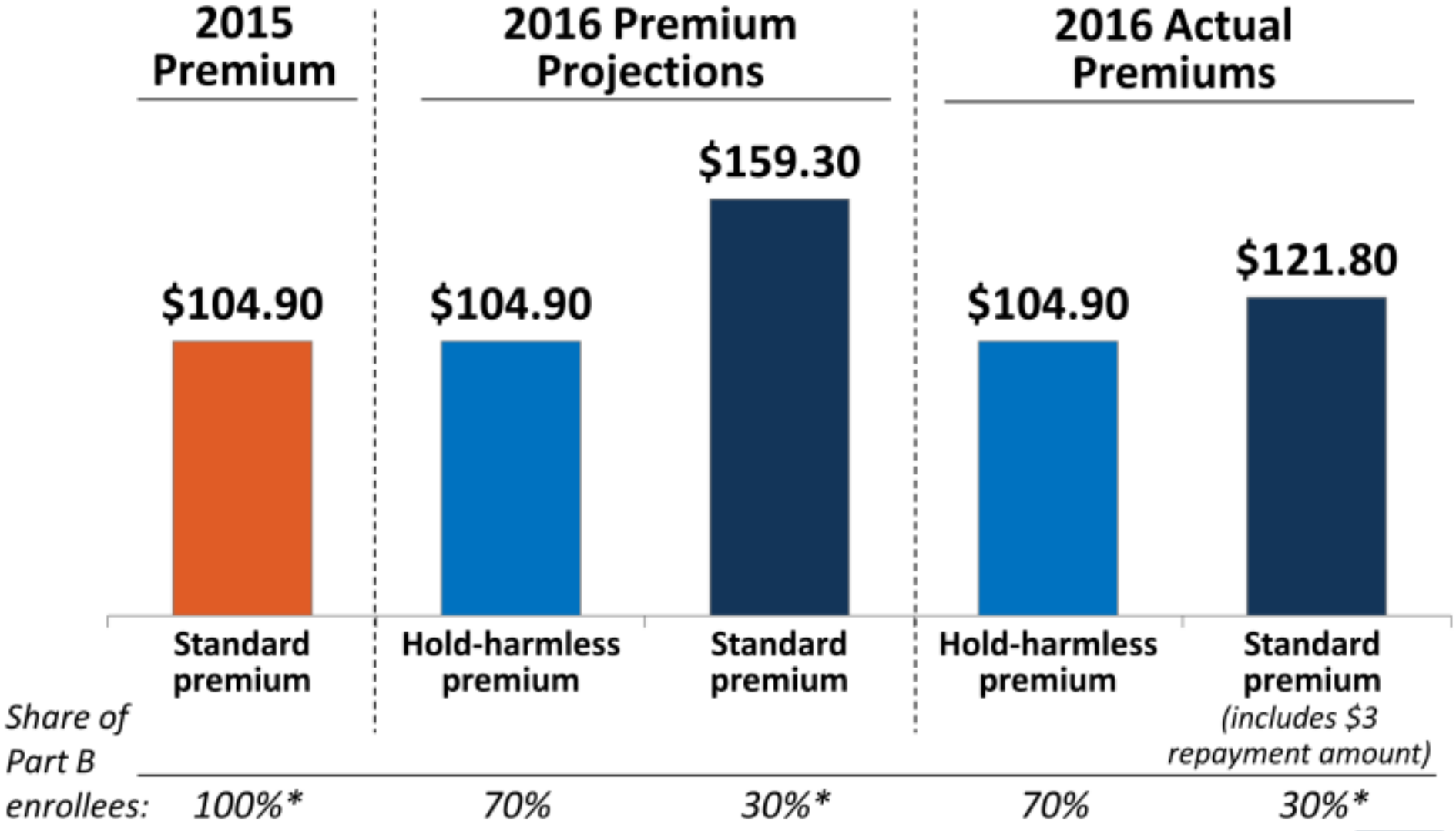
2016 premium projections based on 2014 MAGI

	Income thresholds				
Single	<$85K	$85K-$107K	$107K-$160K	$160K-$214K	>$214K
Married	<$170K	$170K-$214K	$214K-$320K	$320K-$428K	>$428K
2015	$104.90	$146.90	$209.80	$272.70	$335.70
2016-Held harmless	$104.90				
2016-Not held harmless	$159.30	223.00	318.60	414.20	509.80
Premium level	Standard premium	1.4 x standard premium	2.0 x standard premium	2.6 x standard premium	3.2 x standard premium

Sources: Centers for Medicare and Medicaid Services as compiled by the Centers for Retirement Research at Boston College

Figure 1

Medicare Part B Monthly Premiums, 2015-2016



NOTE: *Around 6 percent of Part B enrollees pay income-related premiums that are higher than the standard monthly premium.
SOURCE: Kaiser Family Foundation; data from CMS and 2015 Medicare Trustees report.

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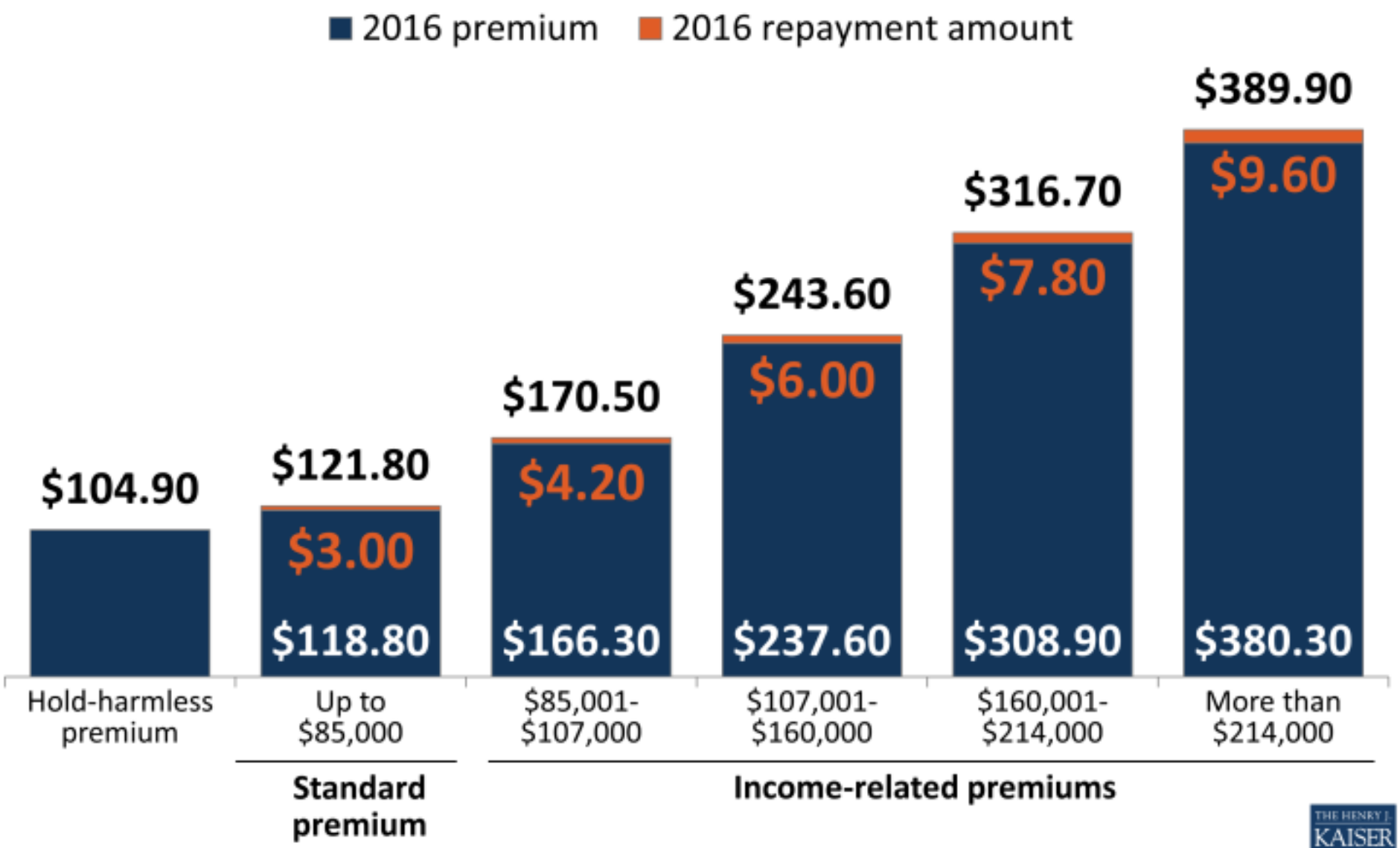
Figure 3

Medicare Part B Premiums and Repayment Amounts, 2016



SOURCE: Kaiser Family Foundation; data from CMS and 2015 Medicare Trustees report.

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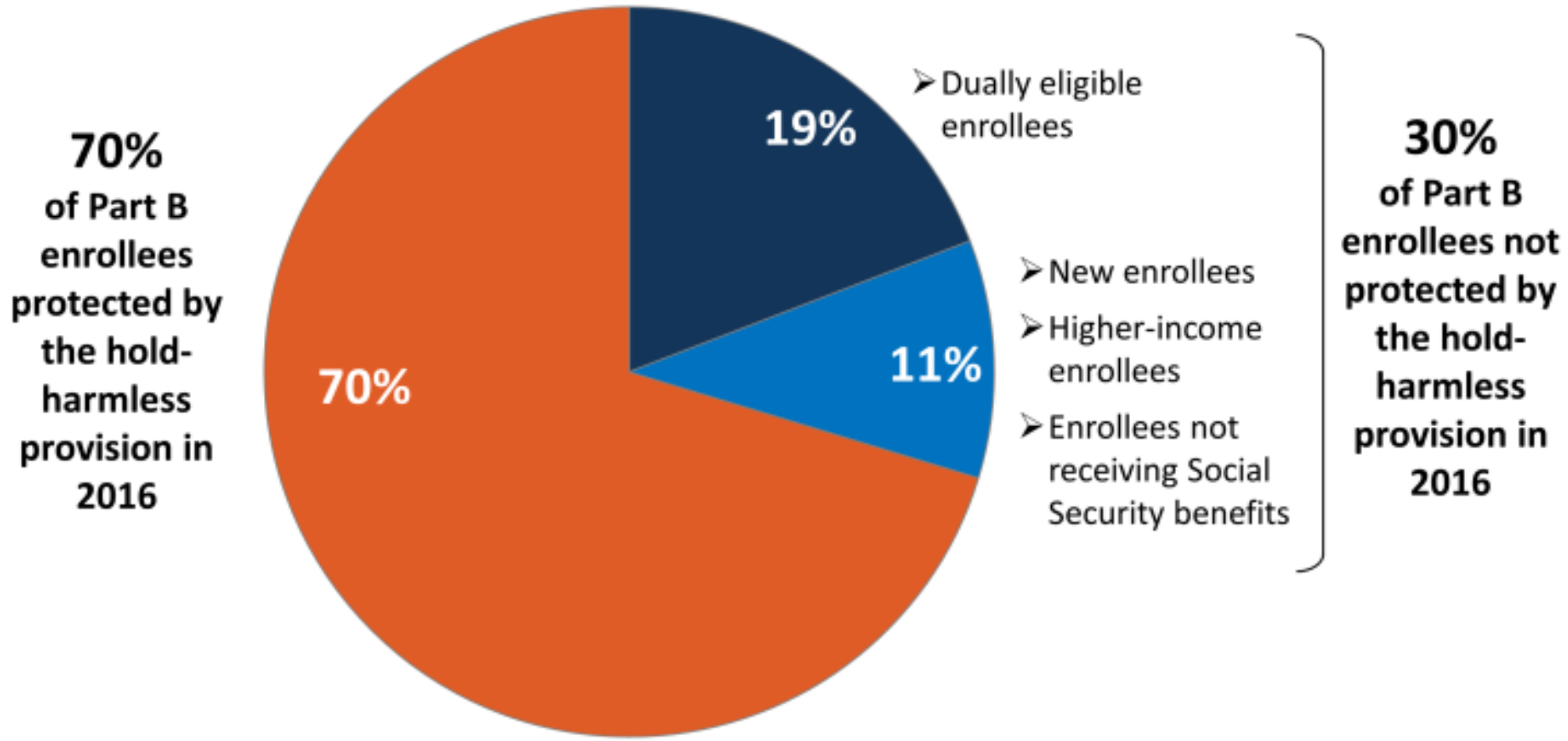
Figure 2

Distribution of Medicare Part B Enrollees Affected by the Hold-Harmless Provision in 2016



Total Medicare Part B Enrollment, 2016 = 52 million

SOURCE: Kaiser Family Foundation; data from CMS and 2015 Medicare Trustees report.

Basis for Determining the Part A Amounts

Inpatient Hospital- First 60 Days	Deductible applicable equal to national average cost per day
Inpatient Hospital- 61st thru 90th Day	Coinsurance per day always equal to 1/4 of inpatient hospital deductible
Inpatient Hospital- 60 Lifetime Reserve Days (nonrenewable) - 91st thru 150th day	Coinsurance always equal to 1/2 of inpatient hospital deductible
Skilled Nursing Facility 21st thru 100th Day	Coinsurance always equal to 1/8 of inpatient hospital deductible

Tax Relief afforded 12-18-2015

- Two-year delay (2018 and 2019) of the Excise (Cadillac) tax on high-cost plans. It also makes the tax deductible to the employer,
- A one year suspension (tax applies in 2016 and suspended for 2017 premium) of the Health Insurance Tax (HIT) and,
- A suspension of the medical devices tax until December 31, 2017.

AFFORDABLE CARE ACT CADILLAC TAX

Purpose of Tax

- Reduce tax preferred treatment of employer provided health care
- Reduce excess health care spending by employees and employers
- Help finance the expansion of health coverage under the Affordable Care Act (ACA)

Cadillac Tax

Amount of the Tax

- The tax is 40% of the cost of health coverage that exceeds predetermined threshold amounts.
- Cost of coverage includes the total contributions paid by both the employer and employees, but not cost-sharing amounts such as deductibles, coinsurance and copays when care is received.
- For planning purposes, the thresholds for high-cost plans are currently $10,200 for individual coverage, and $27,500 for family coverage.
- For pre-65 retirees and individuals in high-risk professions, the threshold amounts are currently $11,850 for individual coverage and $30,950 for family coverage.

Who calculates and pays

•**Insured:** Employers calculate and insurers pay
•**Self-funded:** Employers calculate and "the person who administers the plan benefits" pays
•**HSAs and Archer MSAs:** Employers calculate and employers pay

- The tax is based on the total cost of each employee's coverage above the threshold amount.
- The cost includes contributions toward the cost of coverage made by employers and employees.
- The statute states that costs of coverage will be calculated under rules similar to the rules for calculating COBRA premium.

While the tax was originally non-tax deductible, the December 2015 changes make it tax deductible for employers who pay it.

Applicable types of coverage

- Insured and self-insured group health plans (including behavioral, and prescription drug coverage)
- Wellness programs that are group health plans (most wellness programs)
- Health Flexible Spending Accounts (FSAs)
- Health Savings Accounts (HSAs), employer and employee pre-tax contributions*
- Health Reimbursement Accounts (HRAs)*
- Archer Medical Savings Accounts (MSAs), all pre-tax contributions*
- On-site medical clinics providing more than de minimis care*
- Executive Physical Programs*
- Pre-tax coverage for a specified disease or illness
- Hospital indemnity or other fixed indemnity insurance
- Federal/State/Local government-sponsored plans for its employees
- Retiree coverage
- Multi-employer (Taft-Hartley) plans

Excluded types of coverage

- U.S.-issued expatriate plans for most categories of expatriates
- Coverage for accident only, or disability income insurance, or any combination thereof
- Supplemental liability insurance
- Liability insurance, including general liability insurance and automobile liability insurance
- Worker's compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance
- Other insurance coverage as specified in regulations under which benefits for medical care are secondary or incidental to other insurance benefits
- Long Term Care
- Standalone dental and vision*
- Coverage for the military sponsored by federal, state or local governments*
- Employee Assistance Programs*
- Employee After-Tax Contributions to HSAs and MSAs*

How it works

Self-only coverage
A $12,000 individual plan would pay an tax of $720 per covered employee:
$12,000 - $10,200 = $1,800 above the $10,200 threshold
$1,800 x 40% = $720

Family coverage
A $32,000 family plan would pay an excise tax of $1,800 per covered employee:
$32,000 - $27,500 = $4,500 above the $27,500 threshold
$4,500 x 40% = $1,800

Threat to Retiree Health Plans

Tax will hit 81% of early retiree plans

- "Early-retiree plans are projected to incur the tax at a much higher rate than active employees, with 81% of early retiree plans expected to trigger the tax in 2018, according to a 2014 study by Truven Health Analytics."
- New Jersey estimated that it will owe $40 million in 2018 because of the 40% tax just for its retired teachers who don't yet qualify for Medicare. Because the 40% tax is not indexed to health care inflation, the amount of tax owed for pre-Medicare retired teachers in 2022 will rise to $129 million.

2016 Max Out of Pocket

- Insurers must limit out-of-pockets costs to the individual limit, regardless of if the enrollee is in a family plan with a higher out-of-pocket cap. The maximum out-of-pocket spending in 2016 will be **$6,850 for individuals and $13,700 for families**. The guidance also clarified how plans can offer a family deductible of $10,000 and remain in compliance with the requirement; so long as each individual is not subjected to more than the $6,850 out-of-pocket maximum as the limit applies to each person individually.
- 2017 OOP limits are **$7,150 for individual and $14,300 for families**
- NOTE that for HSA compatible plans the 2017 MOOP is $6,550/$13,100

Annual HSA Contribution Limits

- In 2017 the annual contribution limit will be **$3,400** for single coverage.
- The 2017 annual contribution limit for **family** coverage will be unchanged at **$6,750**.
- The annual **catch-up contribution** amount for account holders 55+ years old also remains unchanged at **$1,000**.

Health Savings Accounts Under Attack In Exchanges

- March 8 rule regarding the requirements for health plans that will be offered on the insurance exchanges for 2017, based on 500-page-long rule.

1) Plans must apply specific deductibles and out-of-pocket limits that are outside the requirements for HSA-qualified plans.
2) Plans must cover services below the deductible that are not considered "preventive care."

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- Because of a different inflation-adjustment factor applied to these limits than for HSA-qualified plans, the gap between the annual limits has and will continue to grow.
- Bronze standardized plans will be required to have a deductible of $6,650. This amount is $100 above the projected maximum deductible of $6,550 for HSA-qualified plans for 2017.
- Gold standardized plans will be required to have a deductible of $1,250. This amount is $50 below the projected minimum deductible for HSA-qualified plans for 2017.
- Bronze and Silver standardized plans will be required to have out-of-pocket of $7,150, well above the projected out-of-pocket limit of $6,550 for HSA-qualified plans for 2017.

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- Regarding the second reason, HHS is requiring plans to cover a variety of services below the deductible in an attempt to make them more appealing to consumers. These services include:
- a limited number of primary-care visits
- specialty-care visits
- mental-health and substance-use-disorder
- outpatient services
- urgent-care visits
- drug benefits

But for those who are unfamiliar with HSAs, HSA-qualified plans are not permitted to cover any services below the deductible except for preventive services. Since HHS did not provide any exceptions for HSA-qualified plans, covering these services will also prevent plans covering these services from being HSA-qualified.

CMS 2016 small group guidance

On February 29, 2016 the Center for Medicare & Medicaid Services (CMS) issued guidance related to the extended transition of pre-Affordable Care Act-Compliant policies. CMS has said:

"States and issuers will have the option to renew non-grandfathered individual and small group health policies, but these policies must end no later than December 31, 2017."

Changing deadlines from October 1, 2017 to December 31, 2017 allows small groups with any renewal date in 2016 to remain on their current plan until their 2017 renewal.

Small v Large Employer Defined 2016

- With the PACE Act, a State may elect to define small employer by substituting “100 employees” for “50 employees.”
- At this time, CA, CO, NY, VA and VT are using up to 100.

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html

- In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

- A complicated factor is that not all states with use the same counting methodology i.e. ATNE (average total number employees) v FT employee plus equivalents v eligible

- NOTE: this count is not the same as the counting methodology to determine ALE status under the Employer Shared Responsibility/Play or Pay/ 4980(H).

End of Transitional Relief

- All employers with at least 50 FT including FT equivalents will be subject to the Employer Shared Responsibility(ESR) in 2016. Note Union employees are included in group size determination.
- Affiliated companies (controlled groups), as defined under IRC 414 (b), (c), (m), or (o), are included as well.
- Non calendar year relief for employers with 100 or more Ft including equivalents expires at the employer's 2016 ERISA plan year renewal.
- The safe harbor affordability was indexed and is 9.56% for 2015 (retroactive to Jan 1, 2015) and 9.66% beginning January 2016.
- Employers who want to avoid any tax assessment /penalty will have to offer coverage to at least 95% of FT employees in 2016. Offering to 70% is now over.
- Employers will have to offer to DU26 as well as FT employees. There is no mandate to offer to spouses in order to avoid penalty.
- Transitional relief codes used to complete form 1095C will no longer apply for employer reporting 2016 date in 2017. We anticipate that there will be updated instructions for reporting 2016 data.

ESR Penalties

- IRS aligning affordability safe harbors with marketplace affordability
- 9.56% for plan years beginning in 2015
- 9.66% for plan years beginning in 2016
- Employer mandate penalties

	2015	2016
A Penalty	$2,080	$2,160
B Penalty	$3,120	$3,240

Reporting Relief

Notice 2016-4

- The notice extends due dates for both furnishing to individuals and filing with the IRS for insurers, employers and other providers of minimum essential coverage (MEC) and information reporting by applicable large employers (ALEs).
- There is an automatic extension for furnishing 1095s (B and C) to individuals from February 1, 2016 to *March 31, 2016*.
- If not filing electronically, there is an automatic delay from February 29, 2016 to *May 31, 2016* .
- There is an automatic extension to file electronically with the IRS from March 31, 2016 to *June 30, 2016*.
- The notice also provides guidance to individuals who might not receive Forms B or C by the time they file their 2015 tax returns.

Price Varies Widely

Price for service in the U.S. can vary as much as

600%

Facility costs vary so dramatically that discounts become less important than directing patients

Look at the difference between facilities for the same types of procedures!!!

MRI Brain with and without dye	Colonoscopy	C-Section without complications
43 locations	71 locations	56 locations
facility payment range $425 to $3,900	facility payment range $479 to $3,528	facility payment range $5,165 to $16,966

Source: Rates taken from one of the CUBA's (Cigna, United, BCBS, Aetna) contracted rate schedule in Chicago, IL

Look at the difference between facilities for the same types of procedures!!!

Some hospitals cost more than others, which renders discounts meaningless.

KANSAS CITY INPATIENT - TOTAL KNEE REPLACEMENT

Geographic Area (Clay, Jackson and Wyandotte Counties)

	Length of Stay		Charges		Index		
Facility	Actual	Expected	Actual	Expected	Severity	LOS	Charge
1	4.30	4.64	$ 50,528.64	$ 34,024.94	122%	92%	149%
2	4.22	4.46	$ 50,170.44	$ 31,849.39	114%	95%	158%
3	4.46	4.60	$ 49,574.13	$ 33,992.80	122%	97%	146%
4	3.94	4.63	$ 47,060.24	$ 34,631.41	124%	85%	136%
5	3.74	4.68	$ 44,824.95	$ 34,248.57	123%	80%	131%
6	3.54	4.50	$ 40,504.05	$ 35,663.90	128%	79%	114%
7	4.50	4.63	$ 39,593.16	$ 33,369.40	119%	97%	119%
8	4.51	4.61	$ 38,710.51	$ 33,920.65	121%	98%	114%
North Kansas City Hospital	4.98	4.62	$ 33,883.59	$ 33,702.13	121%	108%	101%
10	3.68	4.60	$ 29,961.93	$ 33,454.92	120%	80%	90%
11	3.47	4.56	$ 26,798.53	$ 33,432.44	120%	76%	80%
12	4.90	4.61	$ 24,523.45	$ 33,583.06	120%	106%	73%
13	7.50	5.25	$ 24,436.79	$ 35,748.41	129%	143%	68%
14	4.67	4.62	$ 21,238.73	$ 34,233.37	123%	101%	62%
15	5.00	4.57	$ 20,149.96	$ 33,363.96	119%	109%	60%

Regional Norm

Even within the hospital, the right physician is KEY to lowering the cost despite the charge structure.

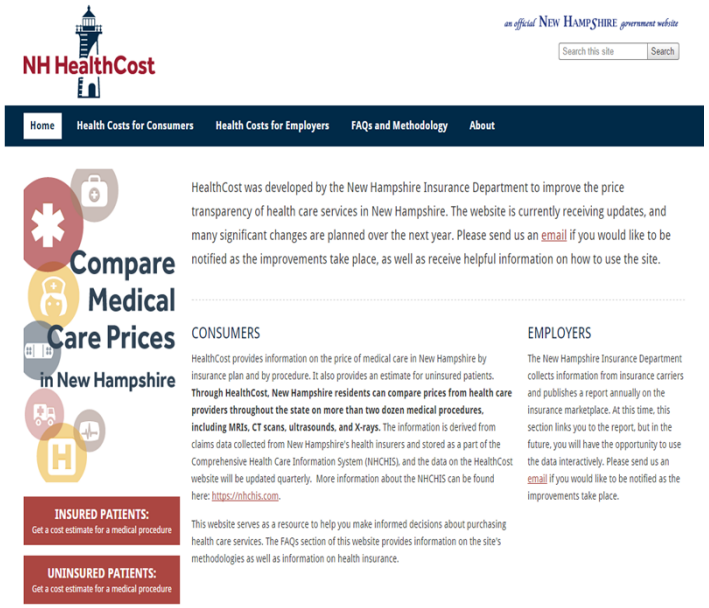
NORTH KANSAS CITY HOSPITAL INPATIENT - TOTAL KNEE REPLACEMENT

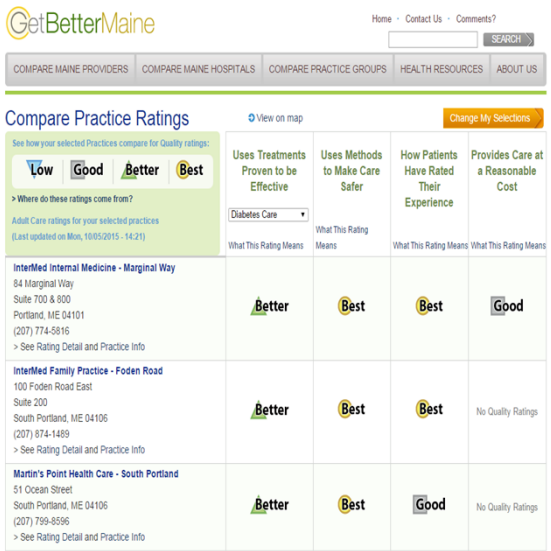
Sorted by Physican Cost

Facility	Physician ID	Length of Stay		Charges		Index		
		Actual	Expected	Actual	Expected	Severity	LOS	Charge
North Kansas City Hospital-MO	375242	6.17	4.60	$ 43,282.07	$ 33,270.17	119%	134%	130%
North Kansas City Hospital-MO	488954	4.43	4.56	$ 41,318.08	$ 33,307.66	119%	97%	124%
North Kansas City Hospital-MO	1024680	4.13	4.57	$ 35,916.90	$ 33,463.19	120%	90%	107%
North Kansas City Hospital-MO	155683	8.80	4.89	$ 35,384.91	$ 33,982.52	121%	180%	104%
North Kansas City Hospital-MO	567446	3.77	4.53	$ 34,737.20	$ 33,562.29	121%	83%	104%
North Kansas City Hospital-MO	156264	4.92	4.61	$ 33,842.83	$ 33,608.79	120%	107%	101%
North Kansas City Hospital-MO	488134	5.00	4.53	$ 33,513.99	$ 33,747.12	124%	110%	99%
North Kansas City Hospital-MO	314150	4.64	4.68	$ 31,695.72	$ 33,796.55	121%	99%	94%
North Kansas City Hospital-MO	377457	4.57	4.61	$ 29,698.55	$ 33,224.08	119%	99%	89%
North Kansas City Hospital-MO	86302	4.20	4.59	$ 29,266.46	$ 33,512.29	119%	91%	87%
North Kansas City Hospital-MO	155910	4.00	4.49	$ 28,913.96	$ 33,240.06	117%	89%	87%
North Kansas City Hospital-MO	312968	5.23	4.67	$ 28,708.37	$ 35,230.15	126%	112%	81%
North Kansas City Hospital-MO	573849	5.00	4.66	$ 28,674.49	$ 32,947.52	118%	107%	87%
North Kansas City Hospital-MO	443366	3.00	4.49	$ 28,617.00	$ 33,240.06	117%	67%	86%
North Kansas City Hospital-MO	1019971	4.50	4.56	$ 27,834.54	$ 33,459.56	120%	99%	83%
North Kansas City Hospital-MO	1038991	4.67	4.50	$ 27,732.73	$ 33,409.08	119%	104%	83%
North Kansas City Hospital-MO	400237	4.50	4.54	$ 27,704.23	$ 33,515.67	119%	99%	83%
North Kansas City Hospital-MO	155697	6.00	4.53	$ 26,517.59	$ 33,747.12	124%	132%	79%
North Kansas City Hospital-MO	996643	4.00	4.53	$ 26,295.09	$ 33,747.12	124%	88%	78%
North Kansas City Hospital-MO	570843	4.00	4.57	$ 23,115.55	$ 33,318.93	119%	87%	69%
			Average	$ 33,884.00				

Price and Quality Transparency

- Transparency is important to:
  - Create educated healthcare consumers
  - Create accountability for price and quality variation among providers
  - Enable purchasers to judge value

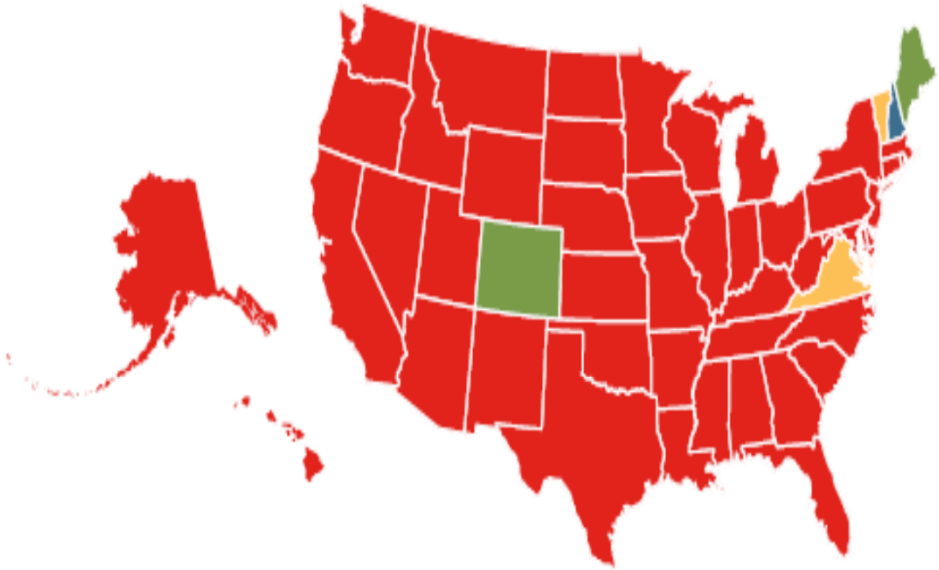




Source: National Association of Health Underwriters Education Foundation

States Are Not Filling the Void…

2015 Report Card on State Price Transparency Laws



STATE	GRADE	STATE	GRADE	STATE	GRADE	STATE	GRADE
Alabama	F	Indiana	F	Nebraska	F	South Carolina	F
Alaska	F	Iowa	F	Nevada	F	South Dakota	F
Arizona	F	Kansas	F	New Hampshire	A	Tennessee	F
Arkansas	F	Kentucky	F	New Jersey	F	Texas	F
California	F	Louisiana	F	New Mexico	F	Utah	F
Colorado	B	Maine	B	New York	F	Vermont	C
Connecticut	F	Maryland	F	North Carolina	F	Virginia	C
Delaware	F	Massachusetts	F	North Dakota	F	Washington	F
Florida	F	Michigan	F	Ohio	F	West Virginia	F
Georgia	F	Minnesota	F	Oklahoma	F	Wisconsin	F
Hawaii	F	Mississippi	F	Oregon	F	Wyoming	F
Idaho	F	Missouri	F	Pennsylvania	F		
Illinois	F	Montana	F	Rhode Island	F		

1-A 2-Bs 2-Cs 45-Fs

CATALYST FOR PAYMENT REFORM

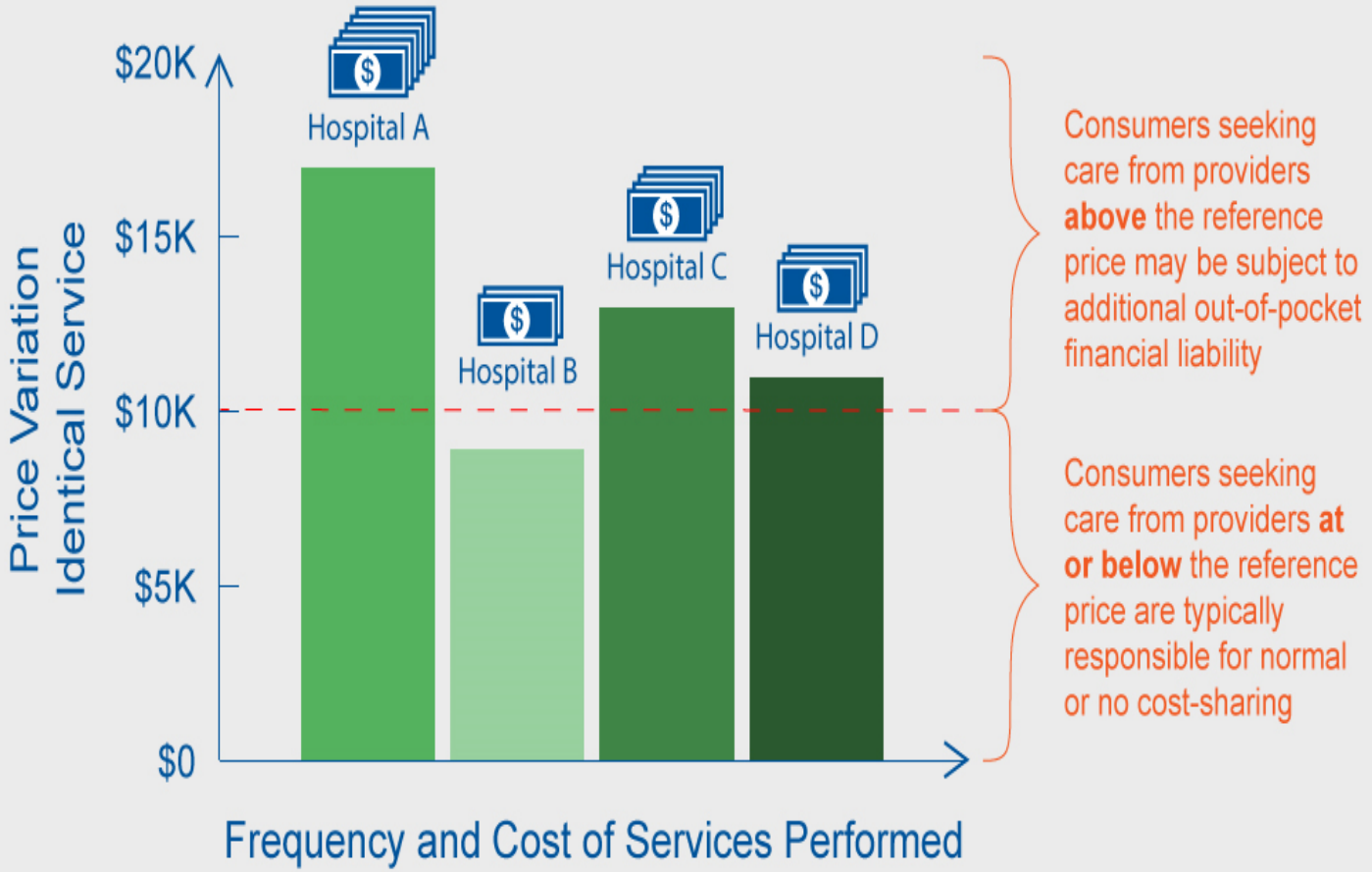
HEALTH CARE INCENTIVES IMPROVEMENT INSTITUTE℠

Your Logo Here

Source: National Association of Health Underwriters Education Foundation

REFERENCE PRICING

AMGI



Source: Catalyst for Payment Reform

Reference pricing establishes a standard price for a drug, procedure, service or bundle of services and generally requires that health plan members pay any allowed charges beyond this amount.


Prepare. Innovate. Win.
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