Solano Community College District
Health Care Reform Strategic Impact Study
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Contents

I. INTRODUCTION AND PROJECT SCOPE 1

II. PLAY - PLAN COST PROJECTIONS 2

III. PAY - PLAN TERMINATION ANALYSIS 7

IV. ALTERNATIVE CONTRIBUTION SCENARIOS 9

V. TECHNICAL DISCUSSION 10

VI. CAVEATS AND LIMITATIONS OF USE 22

VII. METHODOLOGY AND ASSUMPTIONS 23

VIII. ABOUT MILLIMAN 25

APPENDIX

A PPACA PROVISIONS AND TERMINOLOGY

I. INTRODUCTION

Keenan & Associates (Keenan) retained Milliman, Inc. (Milliman) to analyze the potential impact of the Patient Protection and Affordable Care Act (PPACA) on the future financial viability of Solano Community College District's (Solano) employee health plan. The project scope includes analyses of cost and migration projections based on PPACA, as well as recommendations regarding potential directional changes for Solano to consider with respect to the future of its health plan.

This report details the results of our analysis for Solano (referred to as "group" or "this group" herein). The results and findings in this report, as well as references to costs and the plan, pertain only to the plan covering this group and would not represent other groups or plans.

OBJECTIVES

The objectives of this report are to:

- **Provide** data and information that can be used in the development of a multi-year strategic response plan to mitigate the financial impact of Health Care Reform on the active employee health plan,
- **Project** how the moving and interrelated provisions of PPACA may impact the intended result of certain changes made (e.g., plan design or employee contribution changes) to protect the financial viability of the plan,
- **Estimate** the number of employees who could be eligible for Medicaid or Federal Premium Subsidies in the State or Federal Health Plan Exchanges,
- **Analyze** the potential impact of the health plan's in and out-migration due to PPACA, and the potential change it could have on the volume of employees and dependents participating, as well as the relative health risk of the participant pool, and
- **Identify** potential strategic opportunities.

The various projections included in this report are provided under a combination of assumptions that we believe are most likely to occur due to PPACA and are referred to as *Most Likely Scenario* throughout the report.

HEALTH CARE REFORM TERMINOLOGY

Please note that PPACA may also be referred to as Health Care Reform, or HCR, in this report.

Health Care Reform provisions mentioned in this report are often referenced in an abbreviated format. The Appendix to this report identifies key provisions, effective dates, and Milliman abbreviations.

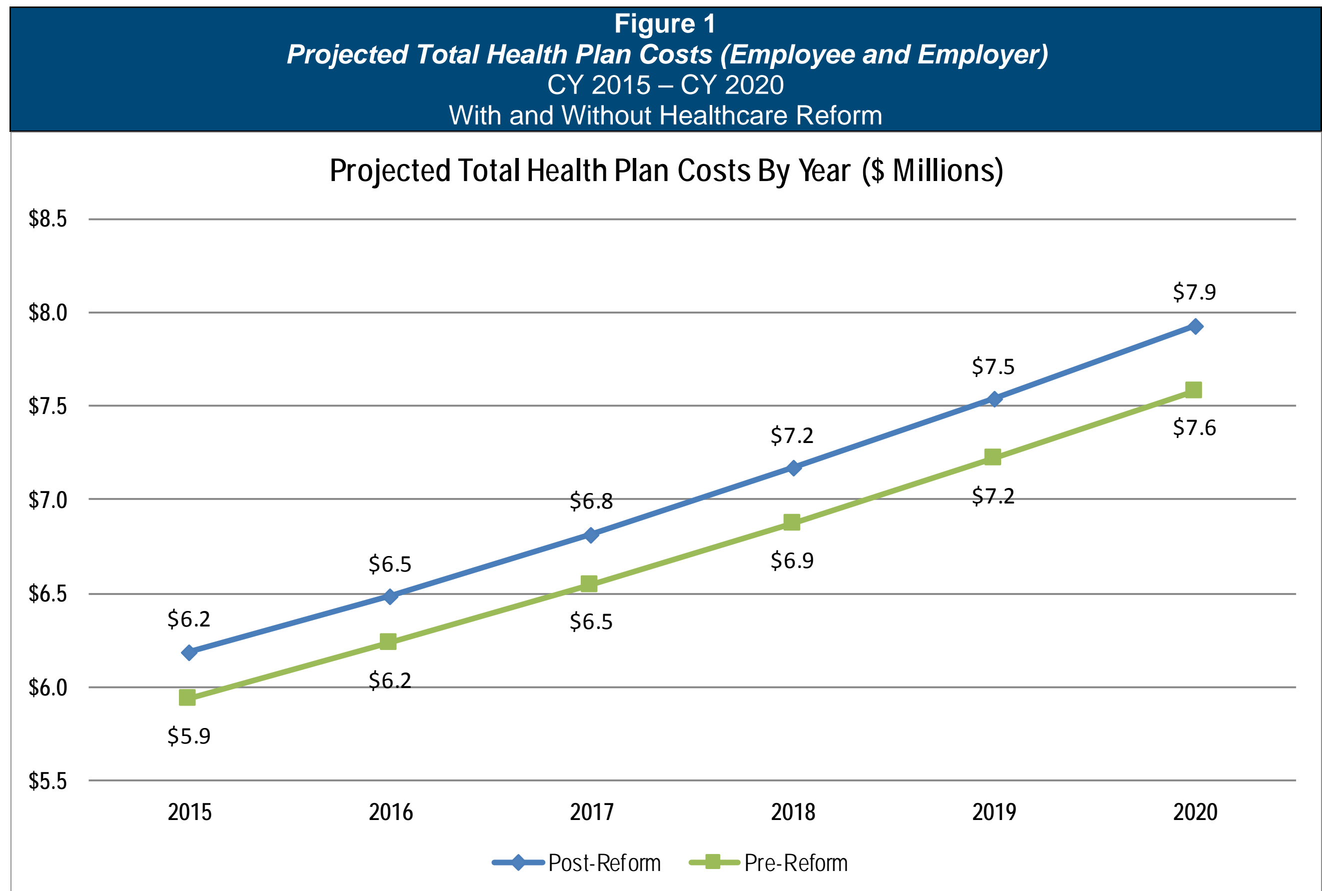
II. PLAY - PLAN COST PROJECTIONS

The risk and opportunity assessments identified in this report are made from a financial perspective only to assist Solano in understanding the potential impact of Health Care Reform on its current health plan offering. These assessments may be viewed differently from an employee attraction / retention, business philosophy, or cultural viewpoint. Solano should consider the balance among all of these factors in developing its strategic response to Health Care Reform. **Costs illustrated in this report do not reflect any expenditures for the cash-in-lieu benefit provided to certain employees not participating in the plan.**

TOTAL PLAN COST SUSTAINABILITY

Without the impact of Health Care Reform, Solano's **total health plan** costs are expected to increase from **$5.9 million in 2015** to **$7.6 million in 2020** (5.0% annual medical trend). Health Care Reform will increase these costs further. Under the *Most Likely Scenario*, the additional costs of Health Care Reform and the associated trend will increase the **2020 costs to $7.9 million**. Solano will need to assess the financial sustainability of these projected cost increases. Costs related to Solano's cash-in-lieu benefit have been excluded from Figure 1 and elsewhere in this report, unless specifically noted.

Figure 1
Projected Total Health Plan Costs (Employee and Employer)
CY 2015 – CY 2020
With and Without Healthcare Reform



Note: Certain HCR related costs have been assumed to be embedded in 2015 premium rates.

EMPLOYER COST PROJECTIONS

The following section contains projected costs assuming Solano continues to offer employer sponsored insurance at the current level of benefits (defined by the actuarial value, or the percentage of healthcare expenses paid by the plan on average for enrolled participants) and employee contributions (i.e. the share of plan expenses paid by employees does not change).

Figure 2 illustrates projected costs for 2015, 2016, 2018, and 2020. Descriptions of the line items can be found on the following page.

Figure 2
Employer Cost Projection Under Health Care Reform

	2015	2016	2018	2020
Total Plan Costs w/o HCR	$5,940,800	$6,237,800	$6,877,200	$7,584,300
Employee Contributions	$4,700	$4,900	$5,500	$6,000
Net Employer Cost (w/o HCR)	**$5,936,100**	**$6,232,900**	**$6,871,700**	**$7,578,300**
HCR Cost Drivers				
Exchange – Out-Migration Savings	$0	$0	$0	$0
Medicaid – Out-Migration Savings	$0	$0	$0	$0
Dependents to Age 26	$0	$0	$0	$0
Enrollment In-Migration	$33,500	$35,100	$39,000	$43,200
Adverse Selection	($14,400)	($15,200)	($16,800)	($18,700)
Employer Penalties	$0	$0	$0	$0
Administrative Costs and Benefit Mandates	$17,800	$18,700	$20,600	$22,700
HCR Pass-Through Fees and Taxes	$182,200	$161,300	$163,000	$167,900
Cadillac Plan Excise Tax	na	na	$0	$0
Cost Shifting	$29,700	$46,900	$86,300	$133,600
Net HCR Cost Impact – Employer	**$248,800**	**$246,800**	**$292,100**	**$348,700**
Projected Employer Cost With HCR Impact	**$6,184,900**	**$6,479,700**	**$7,163,800**	**$7,927,000**
HCR as % of Pre-Reform Costs	**4.2%**	**4.0%**	**4.3%**	**4.6%**
Employee Participants	355	355	355	355
Plan Participants	865	865	865	865
Employer Cost per Enrolled Employee	**$17,400**	**$18,300**	**$20,200**	**$22,300**

Note: Change in costs illustrated on pre-tax basis.

As Figure 2 shows, HCR adds **$248,800 in plan costs during 2015** and **$348,700 in 2020**. With respect to the portion of total cost paid by the employer, the top three HCR cost drivers for Solano in 2015 are:

1) HCR Pass-Through Fees and Taxes
2) Enrollment In-Migration
3) Cost Shifting

As illustrated in Figure 2, Solano is not estimated to be impacted by the Cadillac Plan Excise Tax during the projection period.

Below are detailed descriptions of each HCR cost driver.

Figure 3 - HCR Cost Driver Description	
Subsidy – Out-Migration Savings	○ Health plan costs are likely reduced by employee out-migration to the Exchange.
Medicaid – Out-Migration Savings	○ Health plan costs are reduced by employee out-migration to Medicaid.
Dependents to Age 26, In and Out-Migration	○ Represents savings or additional costs as Dependents under age 26 join your plan or employees under age 26 migrate out to become dependents of their parents' plan.
Enrollment In-Migration	○ Additional costs to the plan due to in-migration of employees and dependents that are not currently enrolled in the plan. ○ In-migration may be driven by compliance with the individual mandate and other employers terminating their sponsored health plans. ○ In-migration costs will decrease as employee contributions increase, for employees are paying an increased share of total costs.
Adverse Selection	○ Costs can increase if net migration creates a less favorable health risk pool. ○ Can also have a favorable impact if positive selection results. ○ Costs can also increase if net migration increases the number of members per contract.
Employer Penalties (Delayed Until 2015)	○ Employer penalties occur whenever a Subsidy eligible employee joins an Exchange. ○ Penalties offset savings related to Subsidy out-migration.
Administrative Costs and Benefit Mandates	○ Additional costs due to HCR prescribed benefit mandates and HCR-related administrative expenses.
HCR Pass-Through Fees and Taxes	○ Projected pass-through costs to employers associated with HCR taxes for insurers, durable medical equipment manufacturers, pharmaceutical companies, transitional reinsurance program, and comparative research effectiveness fee.
Cadillac Plan Excise Tax	○ Non-deductible excise tax if health plan costs exceed HCR prescribed amounts starting in 2018. ○ Since the Excise Tax is based on Total Costs, increasing employee contributions does not reduce the Tax by itself. ○ Benefit design changes could reduce Excise Tax costs.
Cost Shifting	○ Represents costs due to additional cost shifting and the less visible costs of HCR. ○ Can include both employer and provider cost shifting.

Figure 4 illustrates the number of estimated plan participants (employees and dependents) in 2015 through 2020. In 2015, 371 employees are eligible for coverage, with 355 employees (or 96% of eligible employees) estimated to participate in the plan. Employee participation is projected to remain flat relative to 2015.

Figure 4
Estimated Number of Plan Participants

	2015	2016	2018	2020
Participants	865	865	865	865
Employees Enrolled	355	355	355	355
Employees Eligible	371	371	371	371
Employee Participation	96%	96%	96%	96%

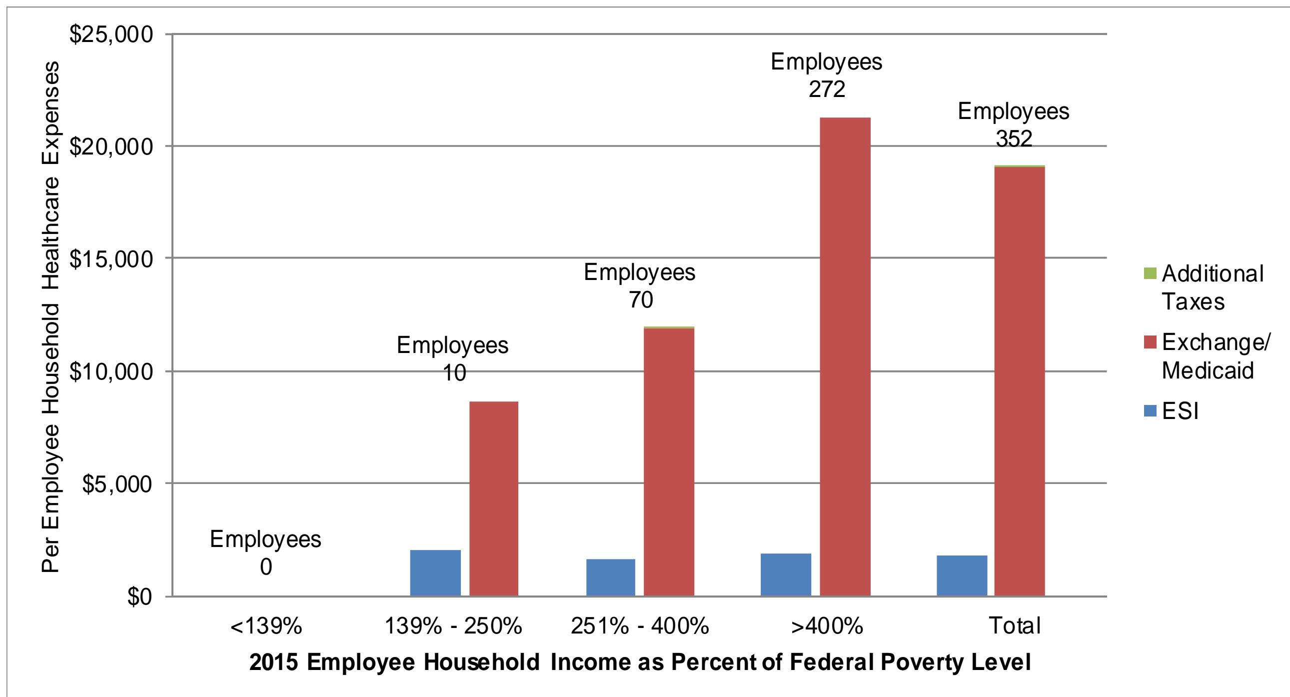
Note: 2014 census data indicated 352 employees participating on the plan. We estimated three additional employees would enroll in the plan in 2015.

Actual costs may differ significantly if future enrollment differs significantly from these enrollment estimates. Enrollment estimates assume that Solano does not modify hiring practices.

WHAT IS THE VALUE OF EMPLOYER SPONSORED INSURANCE?

Expenditures on Solano's plan should also be evaluated with respect to the employee cost in relation to health insurance that will be offered through Medicaid or the state insurance Exchange. As Medicaid eligibility and the premium subsidy tax credit for Exchange coverage are tied to employee household income, the value or benefit of employer sponsored insurance may differ significantly amongst employees. Figure 5 illustrates a comparison of employee healthcare expenses (premium contributions and cost sharing) under Solano's plan relative to either Medicaid or the individual Exchange (net of the premium subsidy tax credit and additional taxes on an employee's contribution to Solano's plan). The employees are grouped according to their household income as a percentage of the Federal Poverty Level (FPL). Household income in dollars in relation to a percentage of the FPL can be found in Figure 11 on page 10.

Figure 5
Projected Employee Healthcare Expenses – Employer Plan vs. Exchange
Currently Enrolled Employees (2014 Census Data)
CY 2015



Notes:

1. **Exchange coverage reflects purchase of silver level coverage and applicable cost sharing Subsidies. No adjustment has been made for the difference in benefit levels between the different sources of insurance. Estimated Exchange rates based on published premiums for 2015.**
2. **Reflects California expanding Medicaid.**
3. **Healthcare expenses reflect both premiums and estimated cost sharing amounts for both ESI and Exchange coverage.**
4. **Additional taxes reflect federal, state, local, and payroll taxes applied to employee plan contribution amounts.**

Figure 5 offers the following key observations regarding currently enrolled employees:

- **Potential Subsidy Eligible Employees**. 80 employees are estimated to be eligible for a premium subsidy tax credit if Solano was to terminate its plan (i.e. employees with income between 139% and 400% of the FPL). 272 employees have estimated household income above 400% FPL and would not be eligible for a premium subsidy tax credit.

- **Value of Employer Sponsored Insurance**. The value of employer sponsored insurance relative to individual market coverage available through the state insurance Exchange grows quickly relative to household income.

  For all of Solano's eligible employees, individual market insurance is expected to be more expensive than participating in Solano's plan. Individual market insurance will increase personal healthcare expenses for employees with household income between 139% and 250% of FPL from $2,000 per year to approximately $8,500. For employees with household income between 251% and 400% FPL, the increase is from approximately $1,500 to near $12,000. For employees over 400% FPL, the disparity in personal healthcare expenses grows to about $19,500. For all eligible employees, it is likely that Solano's plan will continue to be an attractive employee benefit, as significantly higher out-of-pocket costs would be incurred if insurance coverage was purchased on the Exchange.

MINIMUM VALUE

Keenan provided information relating to the actuarial values of Solano's current benefit offerings to Milliman for this study. Keenan's analysis, based on the federal minimum value calculator, estimated the following actuarial value for Solano's plan designs:

Anthem Select HMO: 92%
Anthem Traditional HMO: 92%
Blue Shield Access+ HMO: 89%
Blue Shield NetValue HMO: 89%
Kaiser HMO: 92%
PERS Choice PPO: 87%
PERS Select PPO: 87%
PERS Care PPO: 88%
UnitedHealthcare HMO: 92%

Based on the federal minimum value calculator, for a standard employer population, the benefit options are estimated to cover a percentage of health coverage costs of each participant indicated by the actuarial value (ex. the **Anthem Select HMO** plan is estimated to cover 92% of costs). The employee pays the remaining amount through some combination of deductibles, copayments, and coinsurance. Employer Health Reimbursement Account (HRA) or Health Savings Account (HSA) contributions are included in the actuarial value estimate to the extent an employer makes such contributions. Actuarial value estimates do not take into account any premiums the employee paid in order to enroll for coverage. Actuarial value and its application to employers is discussed in the technical discussion section of this report on page 15.

III. PAY - PLAN TERMINATION ANALYSIS

Large employers will be assessed penalties beginning in **2015** if they do not provide group health coverage to full-time employees. Our analysis reviewed the potential savings to Solano if the plan were terminated effective January 1, 2015 and the estimated salary increase necessary to make employees whole for the loss of coverage.

PLAN SPONSORSHIP PENALTY

The plan sponsorship penalty would not apply unless a decision was made ***to terminate the plan for active employees or if fewer than 95% (70% in 2015) of full-time employees were offered coverage***. Figure 6 shows projected high level net savings of discontinuing the health plan after accounting for the penalties that would be incurred. Under current law, if the health plan would be terminated, the employer will be required to annually pay $2,000 (indexed by the 'premium adjustment percentage' in calendar years beginning in 2015) per full-time employee (FTE), less the first 30 (80 in 2015) full-time employees. HCR defines a full-time employee as those working at least 30 hours per week.

Figure 6
Impact of Ending Health Plan Sponsorship – Without Salary Adjustment
Estimated Net Change in Annual Health Plan Costs

Year	2015	2016	2018	2020
Employer's Contributions (Pre-Reform)	($5,936,100)	($6,232,900)	($6,871,700)	($7,578,300)
Healthcare Reform Costs	($248,800)	($246,800)	($292,100)	($348,700)
Employer Costs with HCR Impact	**($6,184,900)**	**($6,479,700)**	**($7,163,800)**	**($7,927,000)**
Penalty for Not Offering Coverage	$515,800	$643,700	$700,300	$771,800
Total Change in Costs Pre-Tax	**($5,669,100)**	**($5,836,000)**	**($6,463,500)**	**($7,155,200)**
Change in Payroll Taxes	$400	$400	$400	$500
Total Change in Costs without Salary Adjustment	**($5,668,700)**	**($5,835,600)**	**($6,463,100)**	**($7,154,700)**

Note: Tax amounts reflect new employer payroll taxes attributable to employees no longer making exempt contributions for health insurance coverage.

The above table summarizes the costs that Solano would incur if they simply ended plan sponsorship without making employees' salaries 'whole'. Figure 7 below illustrates the costs for 2015, 2016, 2018, and 2020 if Solano were to increase the salaries or wages of currently enrolled employees enough to cover the cost of acquiring insurance from the Exchange, if eligible, in addition to the applicable taxes assessed on salary increases. **The salary or wage adjustment for each employee reflects both changes in out-of-pocket premium or contribution expenses, as well as cost sharing changes between the employees' current plan and second lowest cost silver plan offered in the Exchange.**

Figure 7
Impact of Ending Health Plan Sponsorship – With Salary Adjustment
Estimated Net Change in Annual Health Plan Costs

Year	2015	2016	2018	2020
Total Change in Costs without Salary Adjustment	**($5,668,700)**	**($5,835,600)**	**($6,463,100)**	**($7,154,700)**
Change in Salary	$8,098,000	$8,853,600	$10,011,800	$11,098,300
Change in Payroll Taxes	$522,800	$571,900	$653,100	$731,500
Total Change in Costs Post-Tax	**$2,952,100**	**$3,589,900**	**$4,201,800**	**$4,675,100**

Notes:

1. **Change in taxes reflects additional payroll taxes generated by salary increases.**
2. **Estimated salary increases provided to current participating employees only.**
3. **Salary increase provides Exchange silver coverage.**

From a financial standpoint, ending plan sponsorship may not deliver cost savings under Solano's current business model. Additional costs could be incurred if current eligible employees were made 'whole' for the loss of employer sponsored coverage through a salary adjustment. **Since current plan designs are estimated to be significantly above the federal minimum actuarial value of 60%, plan design modifications may reduce the cost of Solano's sponsored health plan in relation to terminating coverage.**

It should be noted that the Department of Labor has ruled that offering employees cash to specifically purchase an individual policy would violate the group market reform provisions of the ACA because the arrangement would still be considered a group health plan, and therefore by default, have an annual limit which is prohibited. Employer payment plans or Health Reimbursement Arrangements (HRAs) can only be offered if integrated with a traditional group health plan[1].

Figure 8 provides the estimated salary increase by FPL range to make employees 'whole' for the loss of employer sponsored coverage in 2016. For the purposes of determining the breakeven salary, it is assumed that salary increases are not provided to Medicaid or Medicare eligible employees.

Figure 8
Impact of Ending Health Plan Sponsorship – CY 2016
Estimated Salary Increases Needed for Employees to Breakeven

FPL Range	Number of Employees In FPL Range	Average Salary Increase	Total Aggregate Salary Increase
<139%	0	$0	$0
139% - 250%	10	$12,300	$122,800
251% - 400%	68	$21,000	$1,426,900
>400%	250	$29,200	$7,303,900
Total	**328**	**$27,000**	**$8,853,600**

Notes:

1. **Salary increases provided only to employees currently participating in the plan.**
2. **Salary adjustments not provided to Medicaid or Medicare (over age 65) eligible employees. Therefore, aggregate employee counts may be inconsistent with Figure 5.**

Before making a decision to end plan sponsorship, we recommend that serious consideration be given to the potential impact on attraction and retention of needed employees.

[1] Please see http://www.dol.gov/ebsa/faqs/faq-aca22.html for more information.

IV. ALTERNATIVE SCENARIOS

Based on discussion with Keenan, we have modeled two alternative scenarios. **Alternative Scenario 1 increases the share of total plan costs paid by employees by 5%.**

Figure 9
Comparison of Baseline and Alternative Scenario 1

	Baseline Scenario			Alternative Scenario 1		
	2016	**2018**	**2020**	**2016**	**2018**	**2020**
Enrolled Employees	355	355	355	355	355	354
Change from Baseline	-	-	-	0	0	(1)
Employer's Annual Healthcare Cost per Employee (w/HCR)	$18,300	$20,200	$22,300	$17,300	$19,200	$21,300
Change from Baseline	-	-	-	($1,000)	($1,000)	($1,000)
Net Employer Cost (w/HCR)	$6,479,700	$7,163,800	$7,927,000	$6,154,900	$6,803,200	$7,526,300
Change from Baseline	-	-	-	($324,800)	($360,600)	($400,700)

As illustrated in Figure 9, Alternative Scenario 1 results in cost savings for Solano, increasing from $324,800 in 2016 to $400,700 in 2020. Due to the increase in employee contributions, one part-time employee is estimated to migrate to the Exchange starting in 2019.

Alternative Scenario 2 increases the assumed annual premium trend rate from 5% to 8%.

Figure 10
Comparison of Baseline and Alternative Scenario 2

	Baseline Scenario			Alternative Scenario 2		
	2016	**2018**	**2020**	**2016**	**2018**	**2020**
Enrolled Employees	355	355	355	355	355	354
Change from Baseline	-	-	-	0	0	(1)
Employer's Annual Healthcare Cost per Employee (w/HCR)	$18,300	$20,200	$22,300	$18,800	$22,000	$25,800
Change from Baseline	-	-	-	$500	$1,800	$3,500
Net Employer Cost (w/HCR)	$6,479,700	$7,163,800	$7,927,000	$6,664,100	$7,796,900	$9,135,300
Change from Baseline	-	-	-	$184,400	$633,100	$1,208,300

As illustrated in Figure 10, the increase in premium trend results in greater costs for Solano. Similar to Alternative Scenario 1, one part-time employee is estimated to migrate to the Exchange starting in 2019 as a result of higher required employee contributions. The higher trend rate assumption is estimated to result in Solano being impacted by the Cadillac Plan Excise Tax beginning in 2018.

V. TECHNICAL DISCUSSION

The remainder of this report provides a technical overview of cost drivers and assumptions used to develop our analysis. **All values in the technical discussion reflect that California expanded Medicaid to 138% FPL.**

A. PLAN DEMOGRAPHICS

Under HCR, eligibility for Medicaid and the premium subsidy tax credits available in the state or federal insurance Exchange are defined by a household's income level, measured as a percentage of the federal poverty level. The federal poverty level is adjusted by family size and is indexed by the Consumer Price Index. Figure 11 illustrates the household income in dollars in relation to a percentage of the federal poverty level based on calendar year 2015 guidelines.

Figure 11
2015 Federal Poverty Level Guidelines

FPL %	Single	2-Person	4-Person
100%	$11,770	$15,930	$24,250
138%	$16,243	$21,983	$33,465
250%	$29,425	$39,825	$60,625
400%	$47,080	$63,720	$97,000

Figure 12 illustrates the current distribution of employees by those participating and not participating in the plan, split by marital status and household income level (defined as a percentage of the federal poverty level).

Figure 12
Employee Demographics and 2014 Plan Participation – Estimated 2015 Income Levels

	Participating			Non-Participating			Total			Participation Rate		
Income (FPL Percentage)	**S**	**M**	**Tot**	**S**	**M**	**Tot**	**S**	**M**	**Tot**	**S**	**M**	**Tot**
<100%[1]	-	-	-	-	-	-	-	-	-	0%	0%	0%
Potentially Subsidy Eligible												
100% - 138%[1]	-	-	-	-	-	-	-	-	-	0%	0%	0%
138% - 200%	1	1	2	-	1	1	1	2	3	100%	50%	67%
200% - 250%	4	4	8	1	-	1	5	4	9	80%	100%	89%
250% - 300%	10	10	20	-	-	-	10	10	20	100%	100%	100%
300% - 350%	7	11	18	-	-	-	7	11	18	100%	100%	100%
350% - 400%	10	22	32	-	-	-	10	22	32	100%	100%	100%
Subtotal	**32**	**48**	**80**	**1**	**1**	**2**	**33**	**49**	**82**	**97%**	**98%**	**98%**
400%+ (Not Subsidy Eligible)	**74**	**198**	**272**	**1**	**16**	**17**	**75**	**214**	**289**	**99%**	**93%**	**94%**
All Employees	**106**	**246**	**352**	**2**	**17**	**19**	**108**	**263**	**371**	**98%**	**94%**	**95%**

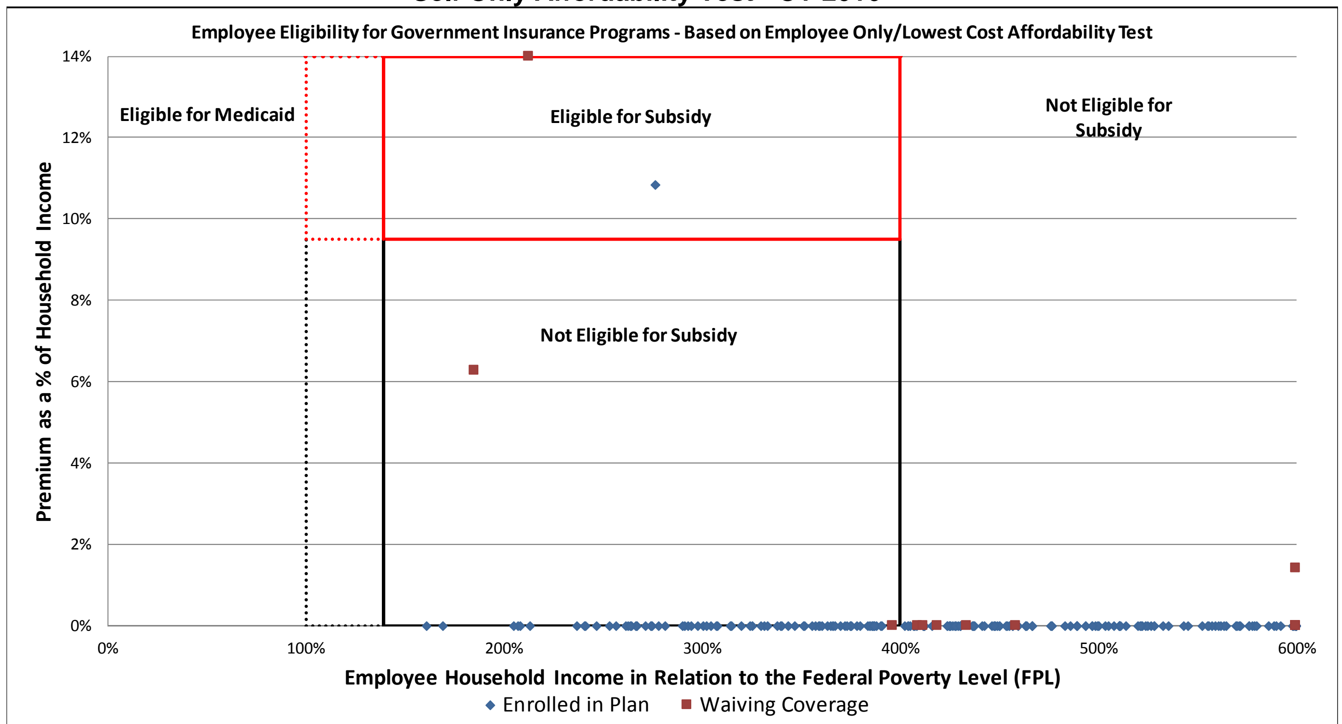
Notes:
1. Population under 138% FPL is eligible for Medicaid as a result of California's decision to expand Medicaid.
2. S = Single, M= Married, Tot = Total.
3. Includes only employees eligible for the plan as of December 2014.

B. AFFORDABILITY OF EMPLOYER SPONSORED COVERAGE AND SUBSIDY ELIGIBILITY

PPACA defines eligibility for Medicaid and Federal Subsidies (Subsidies) based on employee household income. Under HCR, there are three tiers of household income to understand, all of which are based on a percent of the Federal Poverty Level (FPL). Milliman analyzed the salary and demographics data provided and used proprietary census-based projection tables to correlate that data to the likely household income for each Solano employee.

According to PPACA, individuals with household income at or below 138% of FPL are eligible for Medicaid, while those with household income of 400% or more of FPL are not eligible for Medicaid or to receive any financial assistance to join the State (or Federal) Health Plan Exchanges (Exchange(s)). Employees with household income between 139% and 400% of FPL are potentially eligible for some financial support from the government to join the Exchanges in the form of premium and / or cost sharing Subsidies. For the purposes of this report, we define a Subsidy as a payment from the government toward the cost of an Exchange plan or specific cost sharing protections for the individual within the Exchange plan they choose. In addition to FPL, Subsidy eligibility is also dependent upon the contributions the employee must pay to participate in their employer health plan, as a percentage of household income. That percent needs to be at or above 9.5% of an employee's household income for Subsidy eligibility in calendar year 2014. After 2014, the affordability test will be indexed as defined in PPACA based on "*the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year".* For 2016, based on currently published regulations, we estimate the affordability index will set at 9.66% of an employee's household income. The scatter diagram below shows the distribution of employees by FPL and premium contribution percent based on the affordability test being applied to contribution rate for self-only coverage for the lowest cost plan.

Figure 13
Estimated Employee Household Income Relative to Plan Contributions
Self Only Affordability Test - CY 2016



Note: If California had not expanded Medicaid, the subsidy affordability test would have extended to 100% FPL, as indicated by the dotted lines on the graph above.

We estimate 2 employees, both part-time employees working under 30 hours per week, will be potentially eligible for a Subsidy. For the purposes of penalty exposure, ***it is also important to understand an employer is only assessed the penalty if a full-time employee actually leaves the employer plan and receives a premium subsidy on the Exchange.***

Under Health Care Reform, if an employee must contribute 9.5% (subject to indexing after 2014) or more of household income to participate in the health plan and his/her household income is between 139% (100% without a Medicaid expansion) and 400% of FPL, the employee is eligible for some form of subsidization in the Exchanges. The amount of subsidization is based on the specific percent of household income the employee must pay to purchase the second lowest cost silver plan on the Exchange.

Figure 14 below displays when an employee might be eligible for Medicaid or a Subsidy under Health Care Reform, assuming current employee contribution levels and the ***affordability test based on self-only premium contributions***. ***Figure 14 excludes all employees defined as part-time (average less than 30 hours per week and are not currently eligible for the plan).***

Figure 14
Estimated Employees Eligible For Financial Incentives To Join Medicaid/ Exchange Plan
2016 Estimated Employee Contribution Levels

HCR Benefits	Employees Currently In Health Plan	Employees Who Currently Waive or Not Currently Eligible	Total Eligible Employees
Subsidies	1	1	2
Medicaid	0	0	0
Not Eligible	351	18	369
Total	**352**	**19**	**371**

Note: Employees currently in health plan defined by 2014 census data.

The above table shows 2 current employees, including both those currently enrolled and waiving benefits, are estimated to be eligible for a Subsidy to join an Exchange plan under the plan's projected contribution rates and benefit design for 2016.

C. OUT MIGRATION ANALYSIS

Under Health Care Reform certain employees and dependents may leave the health plan because of eligibility for Medicaid, due to a government Subsidy to join an Exchange, or to be covered under a parent's health plan up to age 26.

Milliman researched the likely migration of eligible employees to an Exchange or a parent's plan under various scenarios. Our research includes estimates of the potential cost of the health plans that will be offered by insurance carriers in the Exchanges.

Figure 15 summarizes the estimated number of eligible employees in 2016 and 2020 who are likely to leave the health plan to obtain coverage through an Exchange or Medicaid based on current employee contribution levels.

We estimate that no employees or dependents are going to leave the health plan to obtain coverage through an Exchange plan or enroll in Medicaid in 2016 or 2020. Additionally, no employees are estimated to leave to join a parent's plan or go without coverage and pay a penalty.

Figure 15
Estimated Employees Moving Out Of Health Plan In 2016 and 2020
Assuming Current Employee Contribution Levels

HCR Migration Reason	Employees Currently In Health Plan		Dependents Currently In Health Plan		Total	
	2016	2020	2016	2020	2016	2020
Subsidies	0	0	0	0	0	0
Exchange	0	0	0	0	0	0
Medicaid	0	0	0	0	0	0
Parents' Plan or No Coverage	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

D. IN MIGRATION ANALYSIS

Under HCR, more employees and dependents could potentially join the health plan due to the individual mandate starting. As the individual mandate is strengthened (from 2014 through 2016) and Solano is required to auto-enroll (assumed beginning in 2017) employees into the plan, it is expected that previously uninsured employees may auto-enroll in the plan. To a small degree, this may have already taken place with 2014 and 2015 open enrollment. Some employees may also join the health plan due to changes to or elimination of a spouse's employer health plan. In addition, more children under the age of 26 could also join under a parent's plan for financial reasons, but that risk may be limited since the plan already covers children to age 26.

Figure 16 provides an estimate of potential in-migration in 2016 and 2020 due to Health Care Reform. Related costs are shown in Figure 2 titled "Employer Cost Projection Under Health Care Reform".

Figure 16
Estimated Employees Moving Into Health Plan In 2016 and 2020
Assuming Current Employee Contribution Levels

Year	Employees Currently Waiving Coverage or Not Eligible	Dependents	Total
2016	3	1	4
2020	3	1	4

3 employees, plus 1 dependent, who currently waive coverage or who are currently not eligible, are expected to join the health plan in 2016 through 2020. In-migration from other health plans could increase, however, as more employers reduce or eliminate health coverage due to the impact of Health Care Reform. This will add costs to the health plan. We estimate many of the individuals currently waiving coverage are insured through a spouse's employer's plan.

E. NET MIGRATION ANALYSIS

For Figure 17 below, the related net costs/ savings are shown in Figure 2 titled "Employer Cost Projection Under Health Care Reform". Figure 17 estimates the net impact of in and out-migration assuming the *Most Likely Scenario* in **2016 and 2020**.

Figure 17
Net Impact of In and Out-Migration Analysis
Under Current Employee Contribution Scenarios

Year	Net Employees In	Net Dependents In	Total Participant Change
2016	3	1	4
2020	3	1	4

The counts shown in Figure 17 are the net impact of expected out-migration and in-migration under the assumption that Solano does not increase their employee contributions (beyond aggregate premium trends). In 2016 through 2020, the plan is expected to gain 3 employees and 1 dependent due to net migration under HCR.

F. ADVERSE SELECTION ANALYSIS

Along with estimating the net migration of employees and dependents to and from the health plan, it is also important to know the impact of adverse or positive selection (e.g., any increase or decrease in higher cost individuals in the plan due to migration). The estimated impact of selection, which is calculated based on the demographic characteristics of the groups, is translated into gross savings or costs in the table below.

Figure 18 compares the health risk demographics of the employees and dependents currently enrolled in the health plan (value of 1.0) relative to the health risk pool after net migration of employees and dependents.

Figure 18
Estimated Impact of Adverse Selection on Gross Employer Costs
Under Net Migration Assumptions

Year	Current Health Risk	Health Risk under HCR	Cost
2016	1.000	0.998	($15,200)
2020	1.000	0.998	($18,700)

Net migration under HCR generates favorable selection for the health plan in 2016 and 2020. This is because the employees expected to enroll in the plan have lower estimated claims expenses on average relative to existing plan participants.

G. PENALTIES

Several potential penalties exist for employer health plan sponsors under HCR. Employers may be assessed penalties if:

- The employer does not sponsor a health plan or does not offer coverage to at least 95% (70% in 2015) of full time employees.
- A health plan is sponsored, but it is not considered qualified and affordable. This occurs if a plan does not have a minimum actuarial value of 60% or the employee share of self-only total premium costs exceed 9.5% (indexed thereafter) of household income in calendar year 2014.

AFFORDABLE PLAN PENALTY

Under HCR, if the employee premium contribution to the health plan exceeds 9.5% (indexed in years after 2014) of their annual household income, the plan is considered not affordable. In that situation, if employees eligible for Subsidies purchase coverage through an Exchange, an employer will incur a penalty. The penalty is $3,000 (indexed in years after 2014 by the ‘premium adjustment percentage’) per employee joining the Exchange with a Subsidy, not to exceed $2,000 times all full-time employees (minus the first 30 FTEs, 80 FTEs in 2015).

Figure 19 summarizes the potential penalties the employer is likely to face under their current employee contribution levels in 2016 and 2020 due to full-time employees using a Subsidy to purchase coverage on the Exchange. We do not estimate any full-time employees will be eligible for a Subsidy in 2016 or 2020.

Figure 19
Estimated Affordable Plan Penalty

Year	Number of Full-Time Employees Eligible for Subsidy	Estimated Number of Full-Time Employees to Join Exchange	Estimated Penalty
2016	0	0	$0
2020	0	0	$0

Note, based on discussion with Keenan, Milliman assumed 1.0% salary/wage increase from 2015 through 2020. To the extent salary/wages were modified from this assumption, the number of affordable plan penalties may change.

QUALIFIED PLAN PENALTY

Actuarial Value

Figure 20 also shows an approximate estimate of the actuarial value of each current health plan option based on modeling by Keenan. These estimates are based on your plan design features (deductible, coinsurance, co-pays, etc.).

Figure 20
Actuarial Value of Current Plan Designs in 2015

Plan Option	Actuarial Value of Plan Option
Anthem Select HMO	92%
Anthem Traditional HMO	92%
Blue Shield Access+ HMO	89%
Blue Shield NetValue HMO	89%
Kaiser HMO	92%
PERS Choice PPO	87%
PERS Select PPO	87%
PERS Care PPO	88%
UnitedHealthcare HMO	92%

Qualified Plan

Under HCR, if the actuarial value of a health plan is below 60%, and / or the plan does not meet minimum benefit standards, the plan sponsor is subject to penalties. In that situation, if employees eligible for a Subsidy purchase coverage through an Exchange, an employer will incur a penalty of $3,000 (subject to indexing) per each full-time employee. The total penalty for full-time employees joining the Exchange cannot exceed $2,000 (subject to indexing) times all full-time employees (minus the first 30 FTEs, 80 FTEs in 2015).

- Since the actuarial values of the health plan options are above the required minimum of 60%, no qualified plan free rider penalty is expected.

We assumed that the health plan options meet minimum benefit standards outlined in PPACA in 2015 and beyond for our projections.

Another Reason Why Actuarial Values are Important

HCR requires a state or federally facilitated Exchange to market qualified benefit plans to individuals and small groups (i.e., those with fewer than 100 employees) starting in 2014 (a state is permitted to limit the small group market to groups with 50 or fewer employees until 2016). The health plans offered, which will be fully insured, must meet certain criteria, including actuarial value standards.

Five health plans could be offered through an Exchange. Each has a separate actuarial value so that participants can have a choice with respect to how much the plan will cost and what level of benefits will be provided. The Exchange plans are as follows:

- ***Platinum*** Plan – Actuarial value of 90%
- ***Gold*** Plan – Actuarial value of 80%
- ***Silver*** Plan – Actuarial value of 70%
- ***Bronze*** Plan – Actuarial value of 60%
- ***Catastrophic*** Plan – Currently undefined, but only individuals under 30 or those meeting the individual mandate's affordability exemption are eligible.

Figure 21 illustrates sample plan designs at each Exchange plan level based on the federal minimum value calculator.

Figure 21
Metallic Tiers – Sample Plan Designs

Tier	Plan	Deductible	Coinsurance	Out-of-Pocket Maximum	Actuarial Value
Platinum	1	$250	80%	$1,000	90%
	2	$500	90%	$1,000	90%
	3	$750	100%	$750	90%
Gold	4	$1,500	80%	$2,000	80%
	5	$1,500	90%	$2,500	80%
	6	$2,000	100%	$2,000	80%
Silver	7	$2,500	80%	$4,500	70%
	8	$2,750	90%	$5,500	70%
	9	$3,500	100%	$3,500	70%
Bronze	10	$5,000	80%	$6,400	60%
	11	$5,500	90%	$6,400	60%
	12	$6,350	100%	$6,350	60%

Employers who have health plan options with high actuarial values may become more attractive relative to the Exchange plans and/or relative to other employers that may reduce the actuarial value of their plans over time. Reducing the actuarial value of your plans will help reduce the costs related to adverse selection and in-migration that might otherwise occur if plan changes are not made.

H. GRANDFATHERING

Under HCR an employer may avoid or delay certain provisions of the law by maintaining Grandfathered Status. To do so, the employer must be willing to accept prescribed limits on the nature and extent of changes that may be made to the plan on an annual basis. These limits include prohibition against certain plan changes listed below:

- Elimination of benefits for a specific condition or illness, which includes the elimination of benefits necessary to diagnose or treat a particular condition
- Increasing a participant's cost sharing requirement (i.e., the deductible or out-of-pocket amount) by more than medical CPI plus 15%
- Decreasing employer contribution for any tier of coverage by more than 5% (using COBRA rates as basis of calculation)
- Implementation of the annual limit on the dollar value of benefits

As this plan is not grandfathered, it is assumed that all required benefit mandates to date have been made to the plan and that the related costs are already included in the premium rates provided. The estimated additional cost of benefit mandates (e.g. those not coming into effect until 2014) were shown in Figure 2 of this report. The benefit mandate cost shown in Figure 2 represents the estimated costs of various HCR-related administrative tasks. These administrative tasks are described in Figure 24.

I. HCR FEES AND TAXES

PPACA implements a number of fees and taxes that result in additional costs for the commercial health insurance market. These costs are summarized in Figure 22 and described more fully below. 2014 estimates are assumed to be included in the plan's fully insured premium rates.

Figure 22
HCR Pass-Through Fees and Taxes

	2015	2016	2018	2020
Health Insurer Assessment	$124,700	$118,400	$137,400	$151,600
Tax on Pharmaceutical Manufacturers	$16,200	$16,200	$21,900	$14,500
Tax on Medical Device Manufacturers	$1,400	$1,400	$1,600	$1,800
Comparative Effectiveness Research Fee	$1,800	$1,900	$2,100	$0
Transitional Reinsurance Program	$38,100	$23,400	$0	$0
Total Pass-through Fees and Taxes	**$182,200**	**$161,300**	**$163,000**	**$167,900**

- **Health Insurer Assessment** - Beginning in 2014, Section 9010 of PPACA imposes an assessment on health insurers. In 2014, the total assessment was $8.0 billion, increasing to $14.3 billion in 2018, and indexed thereafter. Each insurer is assessed based on its premium market share. However, self-funded / ASO business is not included in the premium market share calculation and therefore exempt.

- **Tax on Pharmaceutical Manufacturers** - Imposes a non-deductible fee on brand drug manufacturers based on market share from 2011 through 2019. Manufacturers with annual sales under $5 million are excluded.

- **Tax on Medical Device Manufacturers** - 2.3% excise tax on sale price of devices for device manufacturers. Does not apply to eyeglasses, contact lenses, hearing aids, and other items as defined by Secretary of HHS.

- **Comparative Effectiveness Research Fee** - Insurers and sponsors of self-funded health plans pay annual comparative effectiveness fee of $1 per participant beginning in 2013; rising to $2 in 2014, with adjustments for healthcare inflation through 2019 for the Outcomes Research Trust Fund.

- **Transitional Reinsurance Program** - The transitional reinsurance program will assess fees on the individual and group (including self-funded) health insurance markets. Self-funded and self-administered plans are exempt from the fees in 2015 and 2016. The funds will be used to make reinsurance payments to the individual insurance market during calendar year 2014 through 2016. A portion of the funds will go directly to the Department of Treasury. The federal government has announced this assessment will be $63 per plan participant in 2014, $44 per plan participant in 2015, and $27 per plan participant in 2016.

J. CADILLAC PLAN EXCISE TAX ANALYSIS

HCR imposes an Excise Tax on employers starting in 2018 if their total health benefit costs (i.e. including medical, HSA contributions, etc.) exceed prescribed amounts. This tax equals 40% of the cost in excess of those amounts, which are currently defined as $10,200 for individual coverage and $27,500 for family coverage. Please note that we adjusted the Excise Tax thresholds for the age/gender of Solano's employees based on assumptions from the Milliman *Health Cost Guidelines,* as regulations have not yet defined the specific adjustments to be used. Should the adjustments under final regulations materially differ from our assumptions, the results of this analysis could change, including the potential for a Cadillac Excise Tax. The prescribed cost limits can also change prior to 2018 based on some national health plan cost benchmarking prescribed in the law.

Figure 23 includes projections of the 2018 through 2020 Cadillac Plan Excise Tax for Solano.

Figure 23
Projected 2018 - 2020 Cadillac Plan Excise Tax – Current Plan Design

		2018 Estimates		2019 Estimates		2020 Estimates	
Health Plan	**Coverage Type**	**Average Plan Cost**	**Excise Tax**	**Average Plan Cost**	**Excise Tax**	**Average Plan Cost**	**Excise Tax**
Anthem Select HMO	Single	$0	$0	$0	$0	$0	$0
	Family	$0	$0	$0	$0	$0	$0
Anthem Traditional HMO	Single	$12,300	$0	$12,900	$0	$13,600	$0
	Family	$28,300	$0	$29,800	$0	$31,300	$0
Blue Shield Access+ HMO	Single	$12,700	$0	$13,300	$0	$14,000	$0
	Family	$29,200	$0	$30,700	$0	$32,300	$0
Blue Shield NetValue HMO	Single	$0	$0	$0	$0	$0	$0
	Family	$0	$0	$0	$0	$0	$0
Kaiser HMO	Single	$9,800	$0	$10,300	$0	$10,900	$0
	Family	$23,000	$0	$24,200	$0	$25,500	$0
PERS Choice PPO	Single	$9,700	$0	$10,200	$0	$10,700	$0
	Family	$22,700	$0	$23,800	$0	$25,100	$0
PERS Select PPO	Single	$0	$0	$0	$0	$0	$0
	Family	$0	$0	$0	$0	$0	$0
PERS Care PPO	Single	$10,800	$0	$11,300	$0	$11,900	$0
	Family	$22,400	$0	$23,600	$0	$24,800	$0
UnitedHealthcare HMO	Single	$11,800	$0	$12,500	$0	$13,100	$0
	Family	$25,700	$0	$27,000	$0	$28,400	$0
Estimated Excise Tax (5.0% Trend)			$0		$0		$0
High Scenario (8.0% Trend)			$1,600		$5,100		$11,700

Given the current plan design and employee contribution levels, we anticipate the plan will incur no additional costs related to the Excise Tax in 2018 under the *Most Likely Scenario* (5.0% annualized healthcare trend). After 2018, the Excise Tax thresholds are scheduled to be increased by the Consumer Price Index (CPI), plus 1% in 2019, and by only the Consumer Price Index thereafter. Because forecasted CPI trends are below estimated future healthcare trends, costs related to the Excise Tax remain at $0 in 2020.

Additionally, Figure 23 illustrates the sensitivity of the Excise Tax projected amounts to healthcare trend rates that are higher than the *Most Likely Scenario*. If annualized healthcare trend is 8.0% from 2015 through 2020, projected Excise Tax amounts increase to $11,700 in 2020.

Please note that the Excise Tax thresholds in this study were adjusted, by plan, to account for the age/gender distribution of Solano's benefited employees. If we had not used these age/gender adjustments, the total estimated Excise Tax would have been $45,500 in 2018 and $81,100 in 2020.

K. COST SHIFTING AND ADMINISTRATIVE COSTS

In addition to the more transparent costs under HCR, other potential costs could have a material impact on some employers. The sections below identify some of those less transparent costs which should be considered for strategic planning purposes. These costs would be in addition to the cost projections already discussed in this report and why we recommend that Solano develop a Contingency Plan as part of its strategic response to HCR. This plan would assume additional trend starting in 2015 to cover additional cost shifting and administrative costs.

Cost Shifting

Health Care Reform may exacerbate cost shifting to employers from a number of sources. Because of these issues, we have included an additional cost shifting line item in your projections equal to 0.3% of annual trend.

Provider Cost Shifting. With the expansion of Medicaid, the growing number of baby boomers becoming eligible for Medicare, along with potential reductions in Medicare reimbursement levels, providers will be under pressure to increase their reimbursement per service unless significant changes are made to the delivery of health care. Milliman published a research report[2] on this topic and found that these pressures could cause a significant increase in commercial provider payment levels through 2020 if significant changes are not made to provider delivery systems.

Employer Plan Sponsor Termination Cost Shifting. Some employers, particularly those in the small employer market where play-or-pay penalties are not in effect, may eliminate employer-sponsored health plans. A majority of other employers maintaining coverage may reduce benefit levels to offset the impact of HCR. Some employers may elect to not cover any employee's spouse under their plans (which is permitted under HCR) or carve-out spouses with access to other employer sponsored coverage. The combination of these issues will result in more exposure for employer plan sponsors that do not make similar changes to their own plans because more employees and/or dependents will migrate to such subsidized employer plans.

Administrative Costs

HCR adds additional reporting and administrative requirements on employers. Two key administrative requirements that begin for the 2015 coverage year (including non-calendar year plans) are form 6055 and 6056 reporting:

> *Form 6055:* This reporting requirement mandates that group health plan sponsors report information on employees who have minimum essential health coverage. This information will be used by the IRS to determine if individuals are in compliance with the individual mandate. For plans that are fully insured, the insurer will transmit the required information to the IRS. For self-funded plans, the employer is responsible for reporting the required information (or the entity responsible for managing the plan (labor union, board of trustees, etc.)). For every member of the plan (employees, spouses, children, retirees, COBRA beneficiaries), the months for which a member had health insurance coverage through the plan must be reported. Statements must be provided to individuals by January 31st following the coverage year (January 31, 2016 for the 2015 coverage year). Employers with more than 250 employees are required to file the information electronically with the IRS by March 31st following the coverage year.
>
> *Form 6056:* This reporting requirement mandates an employer report a monthly list of full-time employees who were offered minimum essential coverage. This information is used by the IRS to determine if the employer was complying with the employer mandate, and whether employees were eligible to receive a premium Subsidy in the Exchange. Additionally, information related to the monthly employee contribution for the lowest cost plan meeting minimum value standards must be provided. A plan administrator may be designated to report this information to the IRS.

Failure to comply with either Form 6055 or Form 6056 reporting requirements may result in a penalty of up to $1.5 million for an employer. For more information, please read: http://www.milliman.com/uploadedFiles/insight/Periodicals/cab/pdfs/CAB_14-4_ACA_InfoRept_TRRP.pdf.

Figure 24 below provides a high-level list of the provisions that will possibly lead to additional administrative costs. Solano should review these additional requirements and determine the potential cost and staffing impact. Legal counsel should be consulted to assess the potential impact of these provisions.

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[2] See: http://publications.milliman.com/publications/healthreform/pdfs/why-hospital-cost-shifting.pdf

Figure 24
Possible Additional Administrative Costs

HCR Administrative Provision	Effective Year
Administration of Benefit Mandates	Plan years beginning on or after September, 2010
Disclosure of Transparency in Coverage Data under Section 2715A to Health and Human Services (HHS), state insurance commissioner(s) and public	Plan years beginning on or after September, 2010 (subject to issuance of guidance by HHS)
Quality of Care and Wellness reporting to HHS under Section 2717	HHS to publish regulations no later than 3/23/2012 for reporting requirements (Delayed)
Second level external appeal process	Plan years beginning on or after September, 2010 (Grandfather rules apply)
W2 disclosure of health plan cost	Benefits payable during taxable years beginning January 1, 2012
Provision of health plan summary of benefits and a coverage explanation	Health Plans and employer groups must notify enrollees for plan years beginning after September 23, 2012
Plan change notices 60 days in advance	Health Plans and employer groups must begin notifying enrollees within two years of enactment beginning after March 23, 2012
Comparative Effectiveness research fee administration	First plan year ending after September 30, 2012; ends after 2019
Payroll change for FSA $2,500 cap	Applies to taxable years beginning after December 31, 2012
Free Rider penalty administration – if applicable	January 1, 2015
Auto enrollment administration (If 200 or more full-time employees)	January 1, 2016 (Subject to issuance of regulations)
Cadillac plan excise tax administration – if applicable	Taxable years beginning after December 31, 2017
Administrator and service provider fees and fee increases for additional HCR work	Employer Dependent
Elimination of employer deductible 28% Subsidy under Medicare Part D. Medicare Part D "donut hole" keeps shrinking until closed in 2020.	Applies to taxable years beginning after December 31, 2012
New Employer Disclosure Obligation re: (Exchange Notice) (Employers subject to Fair Labor Standards Act)	October 1, 2013

VI. CAVEATS AND LIMITATIONS OF USE

A few caveats and limitations apply to this report and the work performed by Milliman:

- Milliman's work was performed under the signed Project Agreement with Keenan & Associates dated March 7, 2013 and is under the signed Healthcare Reform Impact Study Purchase Agreement between Keenan and Solano signed June 17, 2014.

- This report is intended for the internal use of Solano and it should not be distributed, in whole or in part, to any external party without the prior written permission from Milliman. We do not intend this information to benefit any third party even if we permit the distribution of our work product to such third party.

- During the course of the analysis, Milliman relied on information from Keenan & Associates. The information was checked for reasonableness, but we did not independently audit any information for accuracy. The conclusions documented in this report could change, and may not be appropriate, if the information on which we relied is incomplete or inaccurate.

- This report includes various health plan cost projections. Our projections are only estimates. Solano's actual costs will vary from our estimates and should be monitored closely. Our estimates assumed no growth in employment from current levels or any changes in the composition of Solano's workforce. Additionally, Healthcare Reform variables and values utilized in this analysis may not be appropriate, if any amendments to the PPACA vary greatly from what is currently proposed, and if future Healthcare Reform regulations alter the interpretation of Healthcare Reform impact. Solano should consider these circumstances when interpreting its 2014 through 2020 cost projections.

- For the purposes of the figures illustrated in this report, Milliman has assumed that Solano passes Internal Revenue Code Section 105(h) non-discrimination testing. **Milliman has not reviewed or determined whether Solano's plan design and projected enrollment would meet the requirements of Section 105(h).**

- Data was provided to Milliman through the use of the Milliman Employer HCR Data Input Tool. Milliman assumes no liability for the results presented in this report since Milliman did not audit the data inputted into the HCR Impact Tool.

VII. METHODOLOGY AND ASSUMPTIONS

The Milliman HCR Impact Tool develops estimated annual medical benefit costs before and after the impact of PPACA. The model calculates these costs using the following methodology:

- Premium costs for each employee are trended forward to each projection period to develop the baseline health plan costs before considering the impact of PPACA.
- Actuarial value for each of the employer's plans was provided by Keenan. An official actuarial certification is outside the scope of this project; however, Milliman can perform this type of certification upon request.
- The HCR Impact Tool projects migration in and out of the plan based on a number of employee specific metrics such as age, gender, salary, premium, and plan selection.
- The total annual compensation of each employee is grossed up using published U.S. census data and other proprietary data sources and algorithms to calculate a total expected household income.
- Employees are grouped into categories based on their eligibility for financial assistance in obtaining health care coverage. Eligibility is based on each employee's household income in relation to the Federal Poverty Level (FPL) and their premium in relation to estimated household income.
- Estimated cost of the health plans that will be available in the Exchanges are based on Milliman's internal studies and the publicly available 2015 Exchange rates.
- The HCR Impact Tool calculates the expected total out-of-pocket cost to each employee for the different options available to obtain health care coverage beginning in 2014. The model considers the costs of the premium and cost sharing as well as any premium or cost sharing Subsidies based on employee's eligibility for financial assistance.
- Employees are projected to continue to waive coverage, enroll in Medicaid, join or continue to be enrolled on the employer's plan, or move to the Exchange with or without any financial assistance.
- The change in expected costs due to migration in and out of the group is produced based on age/gender factors from Milliman's *Health Cost Guidelines®* that are the basis for calculating an overall risk score for the employees covered on the employer's plan. We calculated this risk score before and after any employee estimated migration to determine the change in the risk mix.
- Taxes and penalties associated with the provisions of PPACA were added to the employer's total cost, as applicable.
- If relevant, the Excise Tax thresholds have been adjusted for the group's specific age and gender characteristics based on assumptions from Milliman's *Health Cost Guidelines®*. However, those assumptions may not be the same as what is published in final regulations, if any.
- Premium tax credit percentages, the affordability test, and employer penalties have been indexed beyond 2014 based on the methodology outlined in PPACA and federal government estimates of per capita commercial premium increases and general inflation. To the extent that actual national future healthcare trends deviate from these projections, actual values for these indexed amounts after calendar year 2014 will differ from those estimated in this analysis.

In developing our projected costs, we relied on the following data provided by Keenan:

- Employee level census as of December 2, 2014 containing the age, gender, salary, medical plan selected, and marital status.
- Medical premium paid by each employee enrolled in Solano's health plan for the plan year effective January 1, 2015.
- Total medical premium for each employee enrolled in Solano's health plan for the plan year effective January 1, 2015.
- Medical plan designs for Solano's benefit options for the plan year effective January 1, 2015.
- Actuarial value determinations for each of Solano's plan offerings.
- Identification of employees eligible for the cash-in-lieu benefit.
- 5.0% annual medical trend.
- Annual salary inflation of 1.0%.
- Solano is Tax Exempt.

As with any projection, results are naturally sensitive to different assumptions used in the model. Some key assumptions we used in our projections are as follows:

- We do not assume any aging in the workforce in our projections; thus, any major shifts in the employee demographics would produce different estimates.
- There were employees listed in the data provided with unreasonably low annual compensation figures. For those who were listed as Early Retirees, we assigned salary equal to 60% of the average salary of employees over age 55 for whom salary information was provided. For those who were listed as Board Members, we assigned a salary of $50,000.
- For employees with unknown marital status, we estimated marital status based on research conducted related to the marital status rates of the employer sponsored insurance population.

Qualification

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The analytics in this report were produced by Paul Houchens and Jason Clarkson. Paul is a Principal & Consulting Actuary in the Milliman Indianapolis Health Practice. Jason is a Consulting Actuary in the Milliman Indianapolis Health Practice. Paul and Jason are Fellows of the Society of Actuaries and members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

VIII. ABOUT MILLIMAN

For more than 60 years, Milliman has pioneered strategies, tools, and solutions around the globe. One of the world's largest independent actuarial and consulting firms, we are recognized leaders who have helped shape significant changes in the markets we serve. Set apart by our independent ownership, we deliver unbiased advice based solely on what is best for our clients.

Milliman insight reaches across global boundaries and multiple industries, offering specialized consulting services in healthcare, employee benefits, investment, life insurance and financial services, and property and casualty insurance. Our consultants serve a wide range of clients, with highly personalized service and a unique combination of actuarial and business expertise. With offices in over 50 key locations worldwide, Milliman combines global experience with local knowledge. We can help you be prepared to operate in new markets, expand beyond your boundaries, and understand how your industry is affected by developments around the world.

Our unique perspective, by serving all sectors of health plan sponsorship, provides a value add to our clients. Particular to this report, our analyses utilized what we have learned about Exchange plans by serving our insurance company clients.

APPENDIX A

PPACA Provisions and Terminology

APPENDIX A

	PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) PROVISIONS AND TERMINOLOGY (Enacted in March 23, 2010)			
	CATEGORY / REQUIREMENT	**PROVISION SUMMARY DESCRIPTION**	**CALENDAR PLAN EFFECTIVE YEAR**	**GRANDFATHERED PROVISION**
1	Adult Children to age 26	Adult children covered to age 26, regardless of marital status. Benefits non-taxable regardless of Code §152 dependent status. For grandfathered plans only until 2014, child is not eligible for parent's coverage if child is eligible for employer coverage through another source (i.e., child's or spouse's employment).	2011	Y if have other coverage
2	Annual Limits	Only restricted annual dollar limits on essential benefits as determined by Health and Human Services (HHS) secretary. Cannot be < $750k for plan years beginning after September 23, 2010. Those limits increase to $1.125 million September 23, 2011 and $2 million September 23, 2012. By 2014, no annual dollar limits on essential benefits are allowed.	2011	
3	Claim Appeals	Must include and communicate defined internal and external claim appeal process according to specified requirements on culture, language, etc. Can provide testimony. If insured, also comply with state.	2011 Some portions postponed to 2012	Y
4	CLASS - Long Term Care	Voluntary Community Living Assistance Services & Support (CLASS) benefit for active workers only. Will cost about $123 per month starting in 2011. $50 per day benefit, deduct from paychecks. 5 year vesting for benefits. Auto enroll with opt-out, if offer. (NOTE: THE CLASS ACT HAS BEEN SUSPENDED.)	2011	
5	Emergency Care Coverage	No prior authorization required for ER Services. Cover out-of-network same as in-network.	2011	Y
6	Non-Discrimination	Fair Labor Standard Act (FLSA): No employment terms & conditions, compensation, or privileges discrimination based on eligibility for premium tax credit or insurance subsidies; no retaliation for whistleblower activities.	2011	
7	FLSA Breastfeeding Breaks	Employers must provide break time and place for breastfeeding mothers up to 1 year after childbirth. Employers < 50 need not comply if "undue hardship."	2011	

APPENDIX A

	PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) PROVISIONS AND TERMINOLOGY (Enacted in March 23, 2010)			
	CATEGORY / REQUIREMENT	**PROVISION SUMMARY DESCRIPTION**	**CALENDAR PLAN EFFECTIVE YEAR**	**GRANDFATHERED PROVISION**
8	Reporting of Employer Plan Study Information	Group Health Plan disclosure to HHS and public on claim payment policies and practices, financial disclosures, enrollment and disenrollment data, claims denied, rating practices, cost sharing and out-of-network coverage, enrollee and participant rights.	2011 Timing based on government rules	Y
9	Health Savings Account (HSA) Penalty	HSA non-medical withdrawal penalty increased from 10% to 20% for those under age 65.	2011	
10	Lifetime Limits No lifetime limits	No lifetime coverage limits on dollar value of benefits with respect to essential benefits. Can have for non-essential.	2011	
11	Loss Ratio	Insurers in individual and small group markets must maintain a medical loss ratio of not less than 80% (85% for large groups). Thus, must spend more of revenue on clinical services and less to admin costs and profits, or pay rebates to policyholders. Applies to all insured plans, including grandfathered plans.	2011	
12	Medicare Savings Account (MSA) Penalty	Archer MSA non-medical withdrawal penalty increased from 15% to 20%.	2011	
13	Insured Plan Non-Discrimination	New non-discrimination rules on insured plans, similar to those imposed on self-funded plans under Code §105(h)(2).	Originally 2011; postponed pending further IRS guidance	Y
14	OB-GYN - No prior authorization	No prior authorization or referral for Obstetrics / Gynecology services.	2011	Y
15	RX OTC Drugs Only	Over the counter drugs no longer eligible for FSA, HRA, or HSA reimbursement without prescription. OTC Insulin and devices still eligible.	2011	
16	Non-Compliance Penalty	$100 per day per individual for whom mandated benefit provision is not complied with.	2011	
17	Pre-Existing Exclusion < 19	No pre-existing condition exclusions on enrollees under age 19.	2011	

APPENDIX A

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18	Preventive Care Coverage	Category A and B Preventive care, and certain child and women's preventive care, covered at 100% for in-network providers. Plans may exclude coverage or impose cost-sharing for out-of-network providers.	2011	Y
19	Primary Care Provider Choice	Participant can choose any participating primary care provider, including pediatricians and OB-GYN.	2011	Y
20	Coverage Rescission	Cannot rescind group health coverage by individual except for fraud or misrepresentation.	2011	
21	Pharmaceutical Manufacturer Tax RX Maker Tax	Tax on pharmaceutical manufacturers with branded products. Starting with 2010 sales payment in 2011.	2011	
22	Small Employer Wellness Grants	$200 million, 5 year grant program for small businesses to put in place qualified wellness program.	2011	
23	60 Day Advance Summary of Material Modifications	Must begin notifying employees of material health plan changes at least 60 days in advance (tied to Uniform Summary of Coverage).	2012 [Delayed until 2013]	
24	Uniform Summary of Coverage	Coverage summary defined by Secretary must be provided to all eligible new hires and at time of open enrollment; also by March 23, 2012 for all participants. Be linguistically and culturally appropriate. Up to $1,000 fine for each failure to disclose.	2012 [Delayed until 2013]	
25	Pay Based Non-Discrimination	Employers may not base eligibility on salaries or wages, or any rule in favor of higher paid employees.	2012	
26	Quality Of Care and Wellness Reporting	Secretary develop quality of care reporting requirements - quality, case management, care coordination, chronic disease management, medication, and care compliance; as well as activities to prevent hospital readmissions, reduce medical errors, improve patient safety, and promote health and wellness. Thereafter, plan must disclose to HHS and participants and also provide at open enrollment.	2012 Timing based on government rules	Y

APPENDIX A

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27	Employer Research Fee	Insurers and sponsors of self-funded health plans pay annual comparative effectiveness fee of $1 per participant; rising to $2 through 2019 for Outcomes Research Trust Fund.	2012	
28	W2 - Health Plan Value	Addition of value of employer subsidized health coverage on W2. 2011 in 2012 and annual thereafter.	2012 (IRS made reporting for 2011 optional)	
29	Admin Simplification - Eligibility & Claims	Rules on health plan eligibility and claim status rules from Secretary take effect.	2013	
30	CDC Wellness Program Promotion	Center for Disease Control & Prevention (CDC) finished evaluation of wellness best practices and starts educational campaign promoting worksite wellness.	2013	
31	Coverage Availability Notice	Provide new hires, and current employees at open enrollment, certain required information about the plan, health insurance exchanges, health care reform (HCR) benefits, etc. Style and format to follow certain rules.	2013	
32	Device Manufacture Tax	2.3% excise tax on sale price of devices for device manufacturers. Does not apply to eyeglasses, contact lenses, hearing aids and other items as defined by Secretary.	2013	
33	Health FSA Contributions Limit	Salary reduction contributions to health FSAs capped at $2,500 per year, indexed to CPI in $50 increments.	2013	
34	Medicare Payroll Tax	Tax increased from 1.45% to 2.35% for employees with income above $200k single & $250k family. The 0.9% increase only affects employees, not employers.	2013	
35	Medicare New Investment Income Tax	3.8% tax on unearned income for employees with income above $200k single and $250k family. Unearned income includes interest, dividends, annuities, royalties, rents, and capital gains.	2013	

APPENDIX A

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36	Individual Medical Tax Deduction	Employee medical tax deduction on excess above 10% of adjusted gross income (AGI).	2013 (2017 for individuals >65)	
37	Annual Limits	No annual limits on dollar value of benefits, with respect to essential benefits. Can have for non-essential.	2014	
38	Auto Enrollment	Employers with 200+ employees must auto enroll in plan, with sufficient time to opt out of the plan enrolled in. Compliance not required until after regulations come from Secretary of Labor. (DEPARTMENT OF LABOR HAS POSTPONED UNTIL AT LEAST 2015.)	2015	
39	Cafeteria Plan (Pre-Tax Exchange Premiums)	Employers of 100 employees or less may offer all full-time employees option to pay or reimburse exchange premiums under a 125 plan. Only for large employers if allowed into exchange after 2017.	2015	
40	Clinical Trial Coverage	Must cover approved clinical trials for life-threatening diseases and no out-of-network restriction.	2014	Y
41	Individual Coverage Mandate	Individual must have qualified coverage (certain exceptions) or pay greater of flat dollar ($95 in 2014 - $695 in 2016) or % of income penalty that will increase over time. Tied to bronze plan premiums. Exemption for those below tax filing income threshold (e.g., $18,700) and other specified reasons. CPI increases for penalties starting 2016. No penalty if least expensive plan available exceeds 8% of household income. Other exemptions for religious reasons, hardship waiver, or not covered for less than 3 consecutive months during the year. No penalty if enrolled in grandfathered plan even if not qualified coverage.	2014	

APPENDIX A

	PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) PROVISIONS AND TERMINOLOGY (Enacted in March 23, 2010)			
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42	Employer Free Rider Penalties	50+ employers subject to "free rider" penalty if at least one full-time employee receives a premium tax credit for exchanges and employer does not offer minimum essential coverage, the coverage is unaffordable or actuarial value less than 60%. Pre-tax contributions are employee payments for calculation of affordability. Full-time is 30 hours per week or more, determined monthly. No penalty for waiting period. If offer no coverage, pay $2,000 for everyone with 30 hours or more per week, less first 30 full-time (FT) employees (80 employees in 2015), if at least one full-time receives premium tax credit (100% to 400% of Federal Poverty Level (FPL)). If provide coverage, but unaffordable (contributions more than 9.5% of household income), or actuarial value less than 60%, then $3,000 for those receiving premium tax credit. The maximum penalty is $2,000 times total number of FT employees, less the first 30 FT (80 FT in 2015). (NOTE: THERE IS A PROPOSED SAFE HARBOR THAT WOULD PERMIT EMPLOYERS TO DETERMINE WHETHER COVERAGE IS AFFORDABLE BY USING THE EMPLOYEES W2 WAGES, RATHER THAN HOUSEHOLD INCOME. THIS SAFE HARBOUR WOULD ONLY BE FOR PURPOSES OF THE EMPLOYER PENALTY. HOUSEHOLD INCOME WOULD STILL BE USED THE PREMIUM TAX CREDIT.)	2015	
43	Essential Benefits	Insurers must provide essential benefit plans in individual and small markets, whether through Exchange or not. Standards for qualified plan include mandated benefits, cost sharing rules, OOP limits based on HSA and 60% actuarial value minimum. Essential benefits, including key items within these categories, include: Ambulatory services, Emergency services, Hospitalization, Maternity and newborn care, Mental health and substance abuse, RX, Rehab services and devices, Lab, Preventive and wellness, Pediatric - including oral and vision.	2014	
44	Minimum Essential Coverage Reporting	Employer must actuarially certify plan meets qualified coverage standards, minimum essential benefits and at least a 60% payment plan.	2015	

APPENDIX A

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45	Quality / Affordable Coverage Reporting	Reporting to government on coverage and play or pay mandates. Must inform if will provide FT a minimum essential coverage plan, waiting period length, lowest cost option, employer share of total allowed costs, number and names of FT receiving coverage.	2015	
46	Guaranteed Coverage	Insurers must accept all individuals and groups during open enrollment period.	2014	
47	Guaranteed Renewal	Insurers must continue coverage in force for individuals and plan sponsors.	2014	
48	Premium Tax Credit	Federal premium tax credit for household income 100% to 400% of FPL to use with exchanges. Not available if employer offers affordable minimum essential coverage or if individual eligible for Medicaid or Medicare. Subsidy on sliding scale based on income.	2014	
49	Cost Sharing Subsidies	Federal cost sharing subsidy for household income 100% to 250% of FPL for participation in exchanges. Not available if employer offers affordable minimum coverage. Subsidy on sliding scale based on income.	2014	
50	Insurer Premium Tax	New tax on health insurers with premiums written > $25 million.	2014	
51	Medicaid Expansion	Expanded Medicaid for those with household income up to 133% of FPL (currently $31,700 for family of 4). Does not apply to over age 65. Note that States are required to use a corridor of 5% of adjusted gross income in determining Medicaid eligibility, so 133% may effectively become 138%. Based on June 28, 2012 Supreme Court decision, this expansion is optional for states.	2014	
52	Medicare Reimbursements Reduction	Reduce annual market basket updates for inpatient, home health, skilled nursing, and hospice. Reduce hospital payments for excess admissions. 2014 reduce Disproportionate Share Hospital payments by 75% and increase based on uncompensated care.	2014	
53	Non-Discrimination	No discrimination due to health, claims experience, receipt of care, medical history, genetics, disability, etc.	2014	

APPENDIX A

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54	Cost Sharing Limits	For all group health plans: Out-of-pocket limits no higher than high-deductible health plan (HDHP) to 2014; premium adjustment percentage increases thereafter. Lower in exchange plans for those under 400% FPL. 2014 limits are $6,350 single and $12,700 family. Deductibles no greater than $2,000 / $4,000 (limited to fully insured small groups); amounts; premium adjustment percentage increases thereafter.	2014	
55	Removal of Pre-Existing Exclusion	All pre-existing condition exclusions removed on all participants.	2014	
56	Insured Premium Rates Rules	For individuals and small group (up to 50 or 100 employees based on state law), insurers must offer guaranteed issue qualified health plan to age 65 with no health underwriting or pre-existing conditions - premiums must be within rate bands. Rates can only adjust for tobacco use (1.5:1), age (3:1), family composition, and geographic location. Large groups in exchanges must follow these same rules.	2014	
57	Provider Selection	Group Health Plan not required to contract with any willing provider; however may not discriminate if operating within scope of license.	2014	
58	State Exchanges	States establish exchanges, marketplace for private insurers to offer qualified plans to individuals and small employers. Administer subsidies also. Individuals or employers with 100 or less employees can purchase coverage. State can limit to employers with 50 or less until 2016, and can open to large employers in 2017. Must offer four levels of actuarial value based on % of covered expenses paid by plan (e.g., Bronze = 60%, Silver = 70%, Gold = 80% and Platinum = 90%). Must also offer lower cost catastrophic health plan with preventive benefits, to individuals age 30 and under or those who are exempt from individual responsibility penalty due to hardship or unaffordability.	2014	
59	Catastrophic Coverage <30 Exchange Plan	Include a catastrophic option in exchanges for those under age 30 or those who are exempt from individual responsibility penalty due to hardship or unaffordability.	2014	
60	Subsidized State Program Plan	State can create federally funded non-Medicaid plan for those with FPL between 133% and 200% if person does not have access to affordable employer coverage and would otherwise be subsidized through the exchange.	2014	
61	Waiting Period	No waiting period longer than 90 days.	2014	

APPENDIX A

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62	Wellness Incentives	Can provide incentives up to 30% (50% for tobacco related programs) of COBRA rate for those who achieve certain health status targets related to a wellness program. Must offer reasonable alternative to satisfying a health status factor. Secretary can increase to 50%. Wellness incentives other than tobacco are excluded from affordability testing beginning in 2015.	2014	Y
63	Transitional Reinsurance Fee	Additional fee for a three year period beginning in 2014, charged to insurance carriers and third party administrators on behalf of self-funded employer health plans. Reinsurance contributions will be used to make reinsurance payments to health insurance issuers that cover high risk individuals in the individual market (excluding grandfathered health plans) for the three-year period beginning January 1, 2014. The estimated fee for 2014 is $63 per member.	2014	
64	State Exchanges Exchange Eligibility	State exchanges become available to employers of up to 100 employees.	2016	
65	Cadillac Plan Excise Tax	40% excise tax, non-deductible, on employer high cost health plan - paid by employer or insurer. Insurer can pass through tax. Applies to excess over $10.2k single and $27.5k family, but higher for retirees and certain high risk professions ($11,850 single and $30,950 family). Indexed to general inflation only. Dental and Vision not included, FSA, HRA, and HSA are included. May start at higher initial amounts based on actual results of the Federal Employees Health Benefits (FEHBP) standard BC / BS option, if increases more than 55% between 2010 and 2018. Can also be adjustments to cost thresholds based on age or gender relative to a national pool. Costs based on COBRA rates.	2018	
66	Employer Research Fee	Employer research fee for Outcomes Research Trust Fund discontinues after 2019.	2020	
67	Medicare Part D "Donut Hole"	Medicare Part D "donut hole" (i.e., coverage gap for Part D medications, when the beneficiary is responsible for paying 100% of drug costs) is closed.	2020	