Historical Medical Plan Renewal – 2004 to Present

Pace Healthcare Cost 2004 to 2014

- In 2007, the plans were consolidated from several regional HMOs and a self-funded plan to a fully funded plan.
Affordable Care Act Timeline

<table>
<thead>
<tr>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015 &amp; beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adult child coverage until age 26</td>
<td>• Annual fee on pharmaceutical manufacturers begins</td>
<td>• 60-day advance notice of material modifications</td>
<td>• Administrative simplification begins</td>
<td>• Clinical trials coverage*</td>
<td>• Employer mandate for 100+ (2015)</td>
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<tr>
<td>• Annual dollar limits restricted</td>
<td>• Annual rate review process</td>
<td>• Accountability Care Organization requirements</td>
<td>• Annual fee on medical device sales begins</td>
<td>• Coverage for all adult children until age 26 including those that have employer coverage (formerly not covered for grandfathered plans)</td>
<td>• Employer mandate for 50-99 (2016)*</td>
</tr>
<tr>
<td>• Early retiree reinsurance program (ERRP)</td>
<td>• Appeals ombudsman and process documentation*</td>
<td>• Appeals provision fully implemented*</td>
<td>• Deduction for expenses allocable to the Part D subsidy for &quot;qualified prescription drug plans&quot; eliminated</td>
<td>• Essential health benefits required for small employers*</td>
<td>• High-value plan excise tax begins (2018)</td>
</tr>
<tr>
<td>• ER coverage as in-network, no prior authorization*</td>
<td>• Auto-enrollment for groups with 200+ FTEs*</td>
<td>• First medical loss ratio rebates to be paid by August</td>
<td>• Employee notification of access to Exchanges</td>
<td>• Health Insurance Marketplaces (Exchanges)</td>
<td>• ICD-10 code adoption</td>
</tr>
<tr>
<td>• Initial appeals review standards*</td>
<td>• Discounts in Medicare Part D &quot;donut hole&quot;*</td>
<td>• New women's preventive services with no cost sharing*</td>
<td>• FSAs contributions limited to $2,500</td>
<td>• Guaranteed issue and renewability*</td>
<td>• Medicare Part D &quot;donut hole&quot;* closed by 2020</td>
</tr>
<tr>
<td>• Lifetime dollar limits prohibited</td>
<td>• HSAs/HRAs/FSAs: limitations for OTC medications</td>
<td>• Patient-centered Outcomes Research Institute (PCORI) fee ($1 per member/year)</td>
<td>• FSAs allow carryover up to $500 of unused amounts into next plan year</td>
<td>• Individual mandate</td>
<td>• Reporting requirements (6055, 6056) (2016)</td>
</tr>
<tr>
<td>• Medicare Part D rebate for beneficiaries in the gap</td>
<td>• Increase penalty for non-qualified HSA withdrawals</td>
<td>• Quality bonus begins for Medicare Advantage plans</td>
<td>• High earner tax begins (applies to individuals)</td>
<td>• Insurer fee – permanent</td>
<td>• States can open Exchange to CHIP eligibles (2015) and all employers (2017)</td>
</tr>
<tr>
<td>• No pre-existing conditions for kids until age 19</td>
<td>• Minimum medical loss ratio (MLR): 85% for large group, 80% for small group and individual</td>
<td>• Quality of care reporting requirements*</td>
<td>• PCORI fee increases to $2 per member/year</td>
<td>• Integrated HRA (permanently opt out of and waive future HRA reimbursements at least annually and upon termination of employment)</td>
<td>• Implementation delayed until regulations are released:</td>
</tr>
<tr>
<td>• Online consumer information at healthcare.gov</td>
<td>• Non-discrimination rules apply to insured plans*</td>
<td>• Summary of benefits and coverage (SBC) and the Uniform Glossary</td>
<td>• W-2 reporting of the value of employer-sponsored health benefits</td>
<td>• Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)</td>
<td>• Auto-enrollment for groups with 200+ FTEs</td>
</tr>
<tr>
<td>• Pediatricians as PCPs, direct access to OB/GYNs*</td>
<td>• Preventive services with no cost sharing*</td>
<td>• Recession prohibited except for fraud or nonpayment</td>
<td>• QOP limits established*</td>
<td>• No annual dollar limits</td>
<td>• Health Plan Identifier required for self-funded health plans</td>
</tr>
<tr>
<td>• Preventive services with no cost sharing*</td>
<td>• Rescissions prohibited except for fraud or nonpayment</td>
<td>• Small business tax credit</td>
<td>• Provider scope of license (Provider non-discrimination)</td>
<td>• No pre-existing condition exclusions</td>
<td>• Non-discrimination rules apply to insured plans*</td>
</tr>
<tr>
<td>• Temporary high-risk pool</td>
<td>• Small business wellness grants</td>
<td>• Transitional reinsurance fee (2014-2016)</td>
<td>• Rating restrictions* / Adjusted community rating</td>
<td>• Quality of care reporting requirements</td>
<td>• Small business wellness grants</td>
</tr>
</tbody>
</table>

Pace has complied with all required provisions.
Medical Plan Renewal

- Still early in the process but preliminary information indicates CIGNA opening bid in the high single digits.

- 2018 Cadillac Tax Driving Change
  - Forcing paradigm shift to higher point of service costs

- Some plan changes are being considered to integrate inflation into some of the point-of-service costs

- Plan Year change from fiscal year (July-June) to calendar year (Jan-Dec) to better align with FSA, deductibles, and make HDHP more attractive.

- Consideration to discontinue the 100/70 plan
2018 - Excise Tax - “Cadillac Tax”

- 40% nondeductible tax on the annual value of health plan costs that exceed $10,200 for single coverage or $27,500 for family coverage in 2018.

- Potential Impact to Pace in 2018

<table>
<thead>
<tr>
<th>Average Renewal Rate (2014-2018)</th>
<th>Expected Annual Excise Tax (million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>4.2</td>
</tr>
<tr>
<td>7%</td>
<td>2.9</td>
</tr>
<tr>
<td>5%</td>
<td>2.0</td>
</tr>
<tr>
<td>2.5%</td>
<td>1.0</td>
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<tr>
<td>1%</td>
<td>0.4</td>
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</tbody>
</table>

- Keep renewals as low as possible – each year below the average has a significant future impact
- Make plan design changes that keep up with inflation/medical trend
Post Retirement Plan
Proposed Change
Post Retirement Plan Background*

- Plan provides medical, prescription drug and life insurance benefits to retirees.
  - Pre-1996: Medical Coverage for Individual at Rate

- In 2001, the plan was amended to eliminate benefit coverage for employees hired after October 1, 2000.

- The plan has 944 participants, which cannot be expanded:
  - 461 are retired;
  - 483 are active employees (355 can retire now; 72 more by 2020)

- The plan’s post retirement obligation and net periodic benefit costs are actuarially determined annually.
  - Pace retains Sibson Consulting as actuaries to perform annual valuation.

* See pages 9 & 10 for further plan details
Plan Assumptions & Accounting Summary

• Plan assumptions that significantly affect the recorded obligation and the annual net periodic benefit cost include:
  ▪ Life expectancies (mortality)
  ▪ Interest/discount rate
  ▪ Benefit expense, including actual claim experience and changes in medical costs
  ▪ Plan services costs

• Assumptions, estimates and calculations are subject to audit by KPMG

  ▪ Balance Sheet Liability: Accrued Postretirement Health Benefits Obligation
    ▪ Unfunded: annual contributions = benefits paid.
    ▪ Liability = the present value of expected future future contributions.

  ▪ Operating Statement:
    ▪ Actual benefits paid (cash) recorded in Benefits expense.
    ▪ Accrual for net periodic benefit costs, to reflect the excess of actuarially computed benefits expense over actual cash benefits paid in the period.
    ▪ Changes in the balance sheet liability will affect the accrual in the following year
Impact of Liability

• The liability has increased significantly over the past five years
  – June 30, 2009 - approximately 60 million dollars
  – June 30, 2014 - approximately 87 million dollars
  – 2015 & Beyond - Society of Actuaries released in October, 2014, updated mortality tables which reflect longer lifespans; as such, the Plan liability is expected to rise to approximately 95 million (with all other factors remaining constant)

  ▪ The liability impacts several of the University’s financial measures (Unrestricted Net Assets, the Department of Education Financial Responsibility Ratio, Standard & Poors credit rating).

  ▪ Options to reduce the plan liability were developed
Plan Change Options

• For Active employees hired before January 1, 1996, reduce the life insurance coverage amount from $100,000 (maximum, decreasing 10% per year for 6 years) to a flat $25,000 - **NOT RECOMMENDED**

• Increase annual retiree contributions with trend. This change would apply an annual increase percentage to retiree premiums (which are now fixed for pre 96 and 96-00 with 25+ YOS) based on Plan annual trend (increase in renewal cost). The retirees would share in the annual increase of the cost of the Plan (like 96-00 with less than 25 YOS) - **NOT RECOMMENDED**

• Eliminate Medicare Part B reimbursement for all retirees (does not impact 96-00) - **NOT RECOMMENDED**

• Discontinue offering medical coverage and instead provide a $4,000 per year per retiree payment and continue Part B Subsidy (where applicable) or $5,200 per year and discontinue both coverage and Par B reimbursement. Retirees would purchase a supplemental plan on the secondary market - **NOT RECOMMENDED**

• Integrate retiree health plan with Medicare Part D in 2020 to take full advantage of ACA change to retiree costs. Discontinue prescription coverage in 2020 and provide $100 per month ($1,200 per year) retiree payment to purchase Medicare D prescription coverage plan on the secondary market – **RECOMMENDED – SEE FOLLOWING PAGES**
Proposed Change – Summary Statement

The proposed modification to the post-retirement medical plan is to take advantage of a legislative change taking full effect in the year 2020, that would allow the Pace to integrate the post retirement health plan (much like is already done with Medicare Parts A & B) with Medicare Part D, which is the federal prescription drug plan administered by private insurance companies.

The impact of the integration to retirees would be on and after the year 2020, and it would provide them similar prescription drug coverage at generally the same or in many cases, lower cost when the $1,200 per year annual Pace subsidy is included (which will be indexed 3% per year).

The impact of the integration would also have a positive impact on both the University’s post-retirement balance sheet liability (actuarially calculated to be an estimated 95 million – this change would have an estimated effective of reducing the liability by approximately 21 million) and annual operating budget, both non-cash accruals starting in FY16 (estimated to be a reduction from 7 million to 3 million in FY16) as well as annual actual real dollar expense reduction beginning in 2020.
Recommendation

Eliminate Prescription Coverage for age 65 Retirees in 2020 and Provide $100/mo subsidy

- Prescription coverage currently provided by the Plan would be replaced by Medicare Part D, which in 2020 (due to changes brought on by the Affordable Care Act) will be reasonably equivalent to current coverage. Plan prescription coverage and cost to the retirees
  - Pace would provide retirees with a subsidy of $1,200 per year in 2020
  - In certain cases, the retirees cost for coverage would be reduced as a result of the monthly subsidy to be provided to retirees.

- The adoption of the Plan change will have no change to the following:
  - Continued medical coverage for life at a cost equal to the amount prescribed by the plan based on retirees hire and retirement costs
  - No change to the reimbursement of Medicare Part B monthly premium for pre January 1, 1996 hires only.
  - No change to retiree life insurance in the amount equal to the amount prescribed by the plan at the retirees hire date

- There will be no change to retirees for the Plan change until 2020.
- Liability reduced by approximately 21 million
Medicare Part – D

- In 2006, The U S Federal Government enacted Medicare Part - D to subsidize the costs of prescription drugs and the related insurance premiums for Medicare beneficiaries – which only can be obtained through private insurance companies.

- While Medicare Part - D subsidized these costs previously not covered prior to 2006, no coverage was provided to retirees for prescription coverage cost between the “initial coverage limit” ($2,960 in 2015) and the “catastrophic coverage limit” ($4,700 in 2015). This gap in coverage is referred to as the “donut hole.” (See chart on page 7)

- Under the Affordable Care act (ACA), effective in the year 2020, Medicare Part D will increase prescription drug coverage, reducing the “donut hole” by reducing the amount retirees are required to pay from 100% to 25%.

- This change in Medicare Part  D coverage effective in 2020 will be reasonably equivalent to the prescription drug coverage and cost currently provided by the Plan. (See chart on page 8)
Medicare Part D - Explained

Retirees in 2015 pay 100% of the cost up to the first $320.

Retirees pay 25% of the cost between $320 and $2,960 (Initial Coverage Limit).

Retirees pay 100% of the cost between $2,960 (Initial Coverage Limit) and $4,700 (Catastrophic Limit).

Retirees pay 5% of the cost after $4,700.

In 2020, retirees pay 25%.
### Medicare Part D – Expected Costs in 2020

#### Comparison of Alternative Rx program for Retirees vs the Medicare Part D Program in 2020

<table>
<thead>
<tr>
<th></th>
<th>Low Utilizer</th>
<th>Medium Utilizer</th>
<th>High Utilizer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Retiree Annual Cost Under Pace Plan</strong></td>
<td>$500(^1)</td>
<td>$3,500(^2)</td>
<td>$10,000(^3)</td>
</tr>
<tr>
<td>Employee Out of Pocket (deductible, copays and coinsurance)</td>
<td>$280</td>
<td>$965</td>
<td>$1,765</td>
</tr>
<tr>
<td><strong>Total Retiree Cost Under Alternative Plan Change</strong></td>
<td>$501</td>
<td>$501</td>
<td>$501</td>
</tr>
<tr>
<td>Part D Premiums</td>
<td>$498</td>
<td>$1,334</td>
<td>$2,353</td>
</tr>
<tr>
<td>Employee Out of Pocket (deductible, copays and coinsurance)</td>
<td>$999</td>
<td>$1,835</td>
<td>$2,854</td>
</tr>
<tr>
<td>Difference Between Pace Plan Cost and Alternative Part D Cost:</td>
<td>$719</td>
<td>$870</td>
<td>$1,089</td>
</tr>
<tr>
<td>Monthly Subsidy ($100)</td>
<td>$1,200</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td><strong>Net Reduction in Retiree Cost</strong></td>
<td>$481</td>
<td>$330</td>
<td>$111</td>
</tr>
</tbody>
</table>

*Please refer to Appendix B (page 11 for footnotes)
Appendix A: Summary of Post Retirement Plan Provisions (1 of 2)

Pre 1996 Hires
Age plus a minimum of 10 years of full-time service must total 75 years in order to be considered a qualified retiree. Qualified Retirees are eligible for the following benefits:

The University will provide supplemental coverage for our retirees. Medicare coverage will become primary (if age 65 or over) while University coverage will become secondary. The retiree is required to contribute towards medical coverage for oneself while in retirement. The retiree’s contribution will be the same cost share dollar amount as immediately prior to retirement without being subject to future increases in premium. If a retiree desires coverage for a spouse, he/she may do so by continuing family coverage and paying the required premiums.

Medicare - Part B
The University will reimburse qualified retirees, age 65 or over, for the standard monthly Medicare Part B premium upon receipt of the Medicare Part B card. In 2015, the standard monthly Part B premium is $104.90.

Life Insurance
Non-Contributory Life Insurance is provided to qualified retirees at an amount equal to their last full time base annual salary up to $100,000. The amount of the policy will decrease by 10% of the original amount on the first of each July following the date of retirement. It will continue to decrease until the amount is equal to 40% of the original amount, or $2,500, whichever is greater.
Appendix A: Summary of Post Retirement Plan Provisions (2 of 2)

Post January 1, 1996 Hires
For employees hired on or after January 1, 1996, age plus a minimum of 15 years of full-time service must total 75 years in order to be considered a qualified retiree.

Medical Coverage
The University provides supplemental coverage for qualified retirees. Medicare coverage will become primary (if age 65 or over) while University coverage will become secondary. The retiree is required to contribute towards medical coverage for oneself while in retirement. The retiree’s contribution will be based on the schedule below:

<table>
<thead>
<tr>
<th>Full-Time Service</th>
<th>Employee Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19 years</td>
<td>50% of total premium subject to annual increases</td>
</tr>
<tr>
<td>20-24 years</td>
<td>25% of total premium subject to annual increases</td>
</tr>
<tr>
<td>25 + years</td>
<td>Will contribute the same premium cost share dollar amount as immediately prior to retirement without being subject to future increases in premium.</td>
</tr>
</tbody>
</table>

Medicare - Part B
No reimbursement.

Life Insurance
$10,000 upon retirement
Appendix B: Footnotes for Medicare Part D – Expected Costs in 2020

1 **Low Utilizer:** Assumes average of: 4 generic scripts and 2 formulary brand scripts.

2 **Medium Utilizer:** Assumes average of: 24 generic scripts, 10 formulary brand scripts, 1 non-formulary brand script; 4 generic scripts, 1 formulary brand purchased through mail.

3 **High Utilizer:** Assumes average of: 32 generic scripts, 20 formulary brand scripts, 2 non-formulary brand script purchased at retail; 10 generic scripts, 3 formulary brand, and 1 non-formulary brand script purchased through mail.