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June 30, 2007

Terrence MacTaggart
Chancellor
University of Maine System
16 Central Street
Bangor, Maine 04401

The University of Maine

University of Maine
at Augusta

University of Maine
at Farmington

University of Maine
at Fort Kent

University of Maine
at Machias

University of Maine
at Presque Isle

University of
Southern Maine

Dear Chancellor MacTaggart:

On March 6, 2007, you established the Retiree Health Plan Task Force to make recommendations for the University of Maine System (UMS) to comply with GASB 45 accounting requirements while maintaining a meaningful retiree health benefit program.

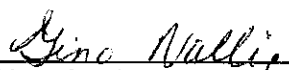
The Task Force membership included faculty and administrators, staff employees, retirees, representatives of the Board of Trustees and the System's bargaining agents. We had a series of meetings with presentations on technical matters, a full exchange of views, and discussions aimed at reaching a consensus on the options and recommendations related to the UMS retiree health program.

This is our report.

The members of the Task Force appreciated the opportunity to serve and contribute to the discussion of this important issue. We also underscore our appreciation for the support provided by UMS staff. Tracy Bigney and Tom Hopkins provided invaluable expertise and counsel to our deliberations. And the administrative support that was generously provided by Kay Saucier made our job as co-chairs far easier.

We hope this report will assist the UMS as it formulates the crucial balance between its use of scarce resources and the interests of its employees and retirees.

Respectfully submitted,


Gino A. Nalli, co-chair


William J. Sullivan, co-chair

University of Maine System



Report of the

Retiree Health Plan Task Force

Submitted to

Chancellor Terrence MacTaggart

June 30, 2007

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Executive Summary

At the appointment of the Chancellor, a team representing employees and retirees of the University of Maine System convened in the spring of 2007 to review approaches to mitigating the impact of the cost of retiree health benefits as recently projected under GASB 45. This liability is estimated at \$330 million, representing an annual liability of \$42 million. The UMS current annual, pay-as-you-go costs total \$9 million. While GASB 45 requires public entities to disclose this liability, its funding is not mandated. For purposes of maintaining a favorable bond rating, however, and other considerations, the Task Force deemed it appropriate and necessary for the UMS to address this liability.

The task force reviewed a number of options including increasing retiree contributions to premium costs, changing eligibility requirements, requiring greater cost sharing and other approaches. Based on its review of options and within the context of the Chancellor's charge to maintain meaningful benefits while addressing the GASB liability, the Task Force recommends that the UMS modify eligibility rules to begin accrual for this benefit at age 45, impose an aggregate 10% premium contribution by future retirees in any Medicare supplemental plan, establish a trust for funding this liability, adopt a Medicare Advantage plan and consider a defined contribution strategy for new employees. The Task Force also recommends that retirees younger than 65 who leave the plan be provided a one-time opportunity to resume coverage when they become Medicare eligible.

The above steps are estimated to reduce the annual GASB contribution by \$14.5 million and – if an acceptable defined contribution plan can be fashioned – to ultimately eliminate the GASB 45 liability entirely.

I. Introduction

During the next 10 years, 60 million Americans will move from work into retirement, including 1,800 or so members of the faculty and staff of the University of Maine System. How well our retirees adjust to – and enjoy – their retirement will depend heavily on their sense of economic security and on their health and that of their family.

As they look forward to retiree health coverage, however, they see that a plan long considered to be excellent is under careful review because of spiraling health costs and new accounting rules which require an examination of - and perhaps change in - present programs and practices. We have studied many of the issues surrounding retiree health coverage, and found them complex. We have tried to lay them out in as clear and as balanced a way as we could.

In his charge, the Chancellor asked the Task Force to make recommendations by June 30, 2007 that will provide for “a meaningful retiree health benefit program for the future, maintain the financial integrity of UMS and meet the GASB 45 requirements.”

We begin by setting forth the underlying principles that frame our study and relating them to the Chancellor's charge. We then state our understanding of the problem and present the findings which emerged from our meetings and discussions, and we set forth the significant choices surrounding the UMS health plan. Our recommendations are intended to balance the interests of UMS employees and retirees with the financial constraints operating on any organization, no matter how important its mission or enlightened its intentions.

A. Principles

As our discussions progressed it was clear that there was agreement among the participants on several key matters, which became the principles which underlie our recommendations.

I The UMS retiree health plan is not only vitally important to today's retirees, but is of growing concern to current employees. The UMS should continue its commitment to a meaningful health plan for retirees.

II Health coverage provided retirees should be comparable to that offered active employees.

III We recognize that in order to keep its commitments to retirees (and indeed to its students and to its faculty and staff) the UMS must remain financially healthy. It must continue to demonstrate to the people of Maine, and to grantors, lenders and others, that it is managed with fiscal responsibility, and that in its financial reporting to its stakeholders, it follows generally accepted accounting principles.

IV The size of the liability GASB 45 places on the UMS financial statements has appropriately focused attention on the long-postponed issue of funding retirement health insurance. Although none of the new accounting rules themselves mandate any change in the terms of the retiree health program, it is timely to examine the retirement program and the trend of its costs and to put into place – sooner rather than later – responsible provisions to assure its continuing viability.

The first two of these principles provide context for our recommendations intended to **'provide for a meaningful retiree health benefit program for the future.'** The last two track our proposals to **'maintain (the) financial integrity of UMS and meet the GASB requirements'** by significantly reducing the size of the GASB 45 liability.

Finally, with respect to our process, the Task Force decided that we would shape our recommendations, and the content of our report, insofar as possible, by consensus. A more complete description of the Task Force's process is described in Appendix 1.

B. Statement of the Problem

Retiree health insurance has traditionally been paid for as a current operating expense. Years ago the cost of providing such insurance, especially for those covered by Medicare, was a minor cost to the UMS budget. For FY08, however, UMS premium payments for post-retirement health insurance, including coverage for those on long-term disability, will have risen to \$8.5 million, or about 2.7% of the total cost of all compensation and benefits. With rising health costs, the upsurge in the number of retirements expected in the near future, and higher life expectancy, that percentage is expected to rise significantly during the next decade.

The "pay-as-you-go" method of funding retiree health insurance, commonly used for decades in both the public and private sectors, pays only the current year's retirement health costs. This method does not take into account that the costs of retiree health insurance will continue well into the future as retirees live longer and current employees age into retirement and the promise that the UMS has made to pay a portion of these costs. By ignoring how those costs are growing, or the total liability they represent, the "pay/go" approach is now recognized as a serious fiscal problem, threatening, over the long term, both institutional financial integrity and the continuation of the health coverage provided retirees by their former employers.

Institutions faced a similar financial issue with pensions. Once treated in a similar pay-as-you-go fashion, the passage of federal ERISA legislation required pension programs to fully recognize their current and future liabilities. One common approach, including the one in use at the UMS since 1961, is to fund pensions through regular payments to an external retirement account during the course of an employee's career. This practice complies with a basic principle of accrual accounting that all of the costs incurred in a fiscal year should be reported in the financial statements for that year. Consequently, the UMS costs are limited to the annual funding and there is no liability associated with this benefit beyond the current year.

C. GASB 45

Given the liability represented by retiree health benefits, the two organizations establishing reporting standards in the private and public sectors, the Financial Accounting Standards Board (FASB), and the Governmental Accounting Standards Board (GASB), now require employers to estimate and report in the employer's financial statements both the expected long-term cost of providing retirement health insurance for current retirees and active employees, and the amount of that cost attributable to the current year. For private organizations, this requirement was articulated in FAS 106 more than ten years ago. The UMS will be required to report its retiree health benefit liability under GASB 45, effective with the fiscal year beginning July 1, 2007, i.e. FY08.

The preliminary actuarial valuation prepared for UMS [described further in Appendix 2] projects that the present value of future costs already accrued under the current health plan is about \$330 million. The 'annual required contribution' to the plan needed to amortize this amount over 30 years and to remain on a solid footing from now on is about \$42 million, or an increase of \$33 million over what the UMS now pays under the pay-as-you-go approach.

Comprehensive though its requirements are, GASB 45 essentially requires only the disclosure of the liability. It does not:

- Create any new costs for the employer but simply requires that certain expected future costs be explicitly recognized and shown as a fiscal liability.
- Require that this liability be funded, now or in the future.
- Require any change in the level of health benefits provided present or future retirees, nor in the premium cost, if any, passed along to the individual for those benefits.

While GASB 45 does not prescribe a particular remedy, it is nonetheless a call to action to an organization to measure, report and ultimately manage its retiree health benefit program.

D. Implications of a large GASB liability

The size of the FY08 estimated annual expense for UMS is \$42 million; larger than the budgets of five of the seven Universities in the UMS.

Even if not funded, furthermore, a large liability shown on an institution's financial statements can create serious problems. It can convert a positive or break-even year-end result into a loss, showing that the institution 'ran a deficit' and potentially creating problems with rating agencies, donors or grantors who prefer to deal only with institutions that are effectively managing their financial affairs.

Having to report an annual deficit, furthermore, could induce an institution to reduce significantly or even eliminate benefits traditionally provided to present or future retirees, creating obvious morale and public confidence difficulties.

Our Task Force has explored these issues thoroughly and has concluded that certain steps should be taken to address the problem stated above ... and that others, in our judgment, should be avoided.

E. The UMS Retiree Health Plan

UMS employees with 10 years service may retire at any time after they reach age 55. Part time employees must have the equivalent of 10 years full time service and the same minimum retirement age. Except for those on long-term disability, Individuals leaving University employment before becoming retirement eligible receive no post-employment health benefits. New retirees must continue their health coverage immediately or permanently lose access to the plan.

Retirees under age 65 have 'access only' use of the UMS plan. They may remain in the active employee group plan but must pay 100% of the per-capita premium charged to the UMS by Anthem/Blue Cross. This monthly premium is currently \$433 for one adult, \$952 for two adults, and \$1,211 for family coverage. (Rates are slightly lower if one adult is over 65 and covered by Medicare.) If a retiree leaves the plan, he or she is not permitted to return and loses permanently access to the UMS plan, which is much less expensive to the retiree at age 65 and older.

Retirees over age 65 must be enrolled in Medicare, including Part B Medical Insurance, to be eligible for the UMS Medicare Supplement Plan. This plan is intended to bring coverage available under Medicare to the level of the comprehensive plan offered active employees, including the prescription benefit. Retirees with the requisite service pay no premium for the supplemental plan, apart from the required Part B Medicare premium, currently \$93.50 per month. Dependent coverage requires payment of 50% of the premium paid by UMS, currently \$183 per month for those covered by Medicare and paying a separate part B premium. For dependents who are not yet eligible for Medicare the premium contribution is \$260 per month.

Employees on long-term disability, regardless of age or length of service, continue to participate in the active employee health plan if they are not Medicare eligible and are covered by the Medicare supplement plan if they are. They pay no premium for themselves, and their dependents, like those of Medicare retirees, pay one half the University's premium costs. Additional discussion on disability coverage is described in Appendix 3.

Table 1 - Retiree Health Plan Current Statistics
(from HRH Valuation for FY08)

Enrollment	<i>Retiree or Former EE</i>	<i>Their Dependents</i>	<i>Total Enrollment Covered Distribution</i>	
Retirees under 65	118	33	151	6%
Retirees over 65	1523	573	2096	88%
Disabled Former EE's	100	25	125	5%
Totals	1741	631	2372	100%
Pay/Go Cost to University (\$000)	<i>Annual Premium</i>	<i>Paid by Participant</i>	<i>Paid by UMS Cost UMS Distribution</i>	
Retirees under 65	\$613	\$613	\$0	0%
Their Dependents	\$206	\$206	\$0	0%
Retirees over 65	\$6,689	\$0	\$6,689	78%
Their Dependents	\$2,644	\$1,322	\$1,322	15%
Disabled Former EE's	\$520	\$0	\$520	6%
Their Dependents	\$156	\$78	\$78	1%
Totals	\$10,828	\$2,219	\$8,609	100%
		20%	80%	
Per Capita Pay/Go Cost to University	<i>Annual Premium</i>	<i>Paid by Participant</i>	<i>Paid by UMS</i>	
Retirees <65	\$5,195	\$5,195	\$0	
Their Dependents	\$6,242	\$6,242	\$0	
Retirees >65	\$4,392	\$0	\$4,392	
Their Dependents	\$4,614	\$2,312	\$2,312	
Disabled Former EE's	\$5,200	\$0	\$5,200	
Their Dependents	\$6,240	\$3,120	\$3,120	

Participant Costs in addition to premiums

Anthem/Blue Cross provided information that in Calendar 2006 co-pays and deductibles paid by participants in the Medicare eligible retiree health plan averaged \$83 per month, per person covered, representing \$1,974 per year for the average couple in the plan. This reflects a significant cost shift from UMS to plan participants made in recent years. Since 2000, the annual deductible has doubled to \$300 per individual and \$600 per family, and the non-prescription out-of-pocket limit has risen from \$750/\$1,500 (individual/family) to \$1,100/\$2,200.

Prescription drug co-pays moved from \$5/\$15 (generic/brand name) to a 3-tier \$10/\$25/\$40 monthly cost. (The co-pays for 90-day prescription orders are 33% less.) The out-of-pocket maximum for prescription drugs, originally \$300 per family, then \$1,800, was removed entirely in 2006 for retirees (but not for active employees)

While such cost shifts are not unique to the UMS retiree plan, they should be recognized, along with premiums, in weighing the costs paid by UMS retirees for their health coverage.

II. FINDINGS

A. The Initial Options

The Task Force recognized that the \$42 million annual cost needed to provide permanent funding for the retiree health plan - \$33 million above today's cost of pay-as-you-go financing – was not a realistic sum to suggest be simply added to the UMS budget. Instead we examined ways that the liability itself might be reduced and began by considering 20 options that are listed in Appendix 4. These options may be categorized into four groups.

- Four related to changing current eligibility rules for retiree health benefits.
- Seven related to changes in plan design, generally, involving higher co-payment or deductibles.
- Six related to increasing the participant's share of the premium costs for the retiree health plan.
- Three were approaches outside the above categories.

For each option, our consulting actuary, Stuart Rubinstein of Hilb, Rogal and Hobbs (HRH), was asked to assess the impact of the option on the size of the annual liability calculated under GASB 45.

The HRH report characterized the fiscal impact of each option as either:

- 1) **Low**, i.e., expected to reduce the UMS annual liability by less than 10%,
- 2) **Medium**, reducing it by between 10% and 20%, or
- 3) **High**, reducing it by more than 20%.

The Task Force reviewed this information and evaluated each option within the context of its guiding principles noted above and the reduction in liability offered by the particular option. For example, the Task Force rejected several of the possible plan design options because they were not consistent with the principle that the resulting benefit plan for retirees should not offer less coverage than that provided to active employees. Similarly and with regard to many of the eligibility changes, the small fiscal impact of the proposed savings was considered to be outweighed by the adverse effects on plan participants.

These deliberations, in turn, led to a set of options for which more specific information was requested with regard to the details, impact on employees and retirees, and reduction in the annual liability value.

B. Discussion of Options

Option 1 Change in the Eligibility Rules

If employees did not begin to accrue credit for retiree health benefits until age 45, all the employees younger than that age could be excluded from the GASB calculation, for a substantial reduction in the total liability. Retiree health benefit 'credit' would be earned during the next ten years of service. This option would not affect full-time employees who already need to be at least age 55 with 10 years service to retire. For part time faculty and staff the rule would have to be modified, for example by allowing them an earlier starting age.

Option 2 The Defined Contribution Approach

Some colleges and universities are beginning to use defined contribution plans to finance the retiree health benefit for their employees. The plans are analogous to the defined contribution annuity programs offered by TIAA-CREF and others. Retirement health benefit costs are paid by the employer in the year they are earned, thus fulfilling the underlying GASB 45 principle that future costs are not left unrecorded. Employees are assured that a monthly contribution to their retiree benefit has actually been paid into a fund that can be used only for their own retirement health care. Employer contributions are a flat amount per employee, not related to compensation level, and employees may also contribute.

Under the vesting rules adopted by the Plan Sponsor, the fund at some point becomes the property of the employee and can move with the employee to any new job, or can simply be allowed to grow to provide funds for insurance premiums or other medical expenses in retirement. Both employer and employee contributions to the fund receive favorable tax treatment upon withdrawal.

A University which adopts a defined contribution plan for retiree health benefits – even one limited to new hires - has, in one sense, 'solved' the GASB 45 dilemma, because eventually all of its post-retirement health costs will be funded on a current basis. Its existing pay/go plan becomes a 'closed plan' which will eventually disappear. Even if the institution has to continue an unfunded liability for current retirees and active employees not in the plan, that liability is diminishing each year. Financial markets are able to see that the institution has not only complied with the new GASB reporting requirements but that it has adopted a long-term funding mechanism reflecting prudent financial management.

As with some of the issues the Task Force discussed, there were strongly held differences of opinion on the value to employees of a defined contribution plan for retiree health care.

- Those with reservations asked whether the funds available when a covered employee was ready to retire would be adequate to pay premiums for all the years left to the employee. In a defined contribution plan, they observed, these risks are borne by the retiree, rather than the employer. An annuity option is one approach that is suggested to address this 'longevity risk', although no assurances can be made that the annuity payments will be sufficient to meet future premium and health costs.

- There was also concern about those employees who had already qualified for the existing health plan and might not have enough service time left to build an adequate fund under a new plan.
- Those favoring the plan argued that any adjustments necessary to cope with rising premium costs could be made in a timely manner as the employer contributions to the plan were reviewed every few years through existing procedures for reviewing all current employee benefits.
- Some employees may feel more secure that their retiree health benefit will be there at the time of retirement because it is in a dedicated account and because they have contributed to it over the years of their career.

In light of these differing views, there was not sufficient support for a finding that current employees would be better off with a defined contribution health plan. New employees, however, each of whom would need at least ten years service before earning the retirement health benefit would be at less risk than, for example, a 49-year-old current employee brought into the plan. It was recognized, however, that should a plan for new employees have features attractive to current employees, they should have the option of switching to the new plan.

The benefits associated with this option are significant. As employees grandfathered under this provision age out, the UMS post retiree medical liability – as calculated by GASB would be ultimately eliminated. The UMS, of course, would incur, as a current expense, the annual cost of funding the defined contribution plan.

Option 3 Premium for Medicare Retirees

Consistent with the Task Force's principle of comparability between health benefits for employees and retirees, the third option proposes to establish a monthly premium for the retiree health plan. Current retirees, many of whom retired years ago with pensions that seem small today, would be exempted from the requirement. To provide adequate notice for current employees, the premium would not become effective until 2010. The proposed contribution, 10 percent of the premium paid by the UMS, is comparable to the current premium contribution made by active employees with single coverage. No change in the dependent premium is proposed.

Option 4 Medicare Advantage Plan

The present Medicare supplement plan would be replaced with a Medicare Advantage plan. With benefit coverage levels and participating provider networks comparable to current arrangements, these plans afford savings by better coordinating Medicare Part A, B and prescription drug coverage with the supplemental coverage enjoyed by UMS retirees. Certain rebates that the UMS is entitled to receive as a result of its prescription drug program will be more efficiently captured through a Medicare Advantage plan.

Option 5 Establishment of a Trust

The Task Force identified the establishment of a formal program to pre-fund post retirement health benefits as a possible source of further reductions in the unfunded liability. Funds segregated from any use other than post-retirement health services would allow a higher discount rate to be used in the valuation. This higher rate results in a reduced present value in the calculation of the UMS liability. In addition, the establishment of a Trust provides the UMS the opportunity to increase its indirect cost recovery rate from grants and contracts. This additional recovery was estimated to be nearly \$1 million for fiscal year 2008 had UMS funded a trust with \$5 million. The risk of this approach is the additional budgetary commitment each year and the strict prohibition imposed on any use of the funds for other than post retirement health. It is presumed that trust provisions can be established for the dissolution of the program in the event that post retirement health benefits were no longer provided by the UMS, e.g. under a national health care program which relieves employers of retiree health liability.

Each of these options are to some extent interdependent and the savings shown cannot be simply added together to determine the impact of multiple options. This effect has been recognized in the final set of recommendations discussed in the next section.

C. Further Findings

The participant premium for retiree health coverage is dramatically different for early retirees and those covered by Medicare. For a UMS employee, retirement before age 65 results in an immediate 7-fold increase in premium cost. At current rates the participant's share moves from approximately \$50 to \$433 per month. Retirees with a second person in the plan move from about \$120 to \$952 per month. Whether or not the participant desires pre-Medicare coverage, he or she must remain in the plan, paying those rates, until age 65 when the plan UMS employees look forward to becomes available

In order to establish a better context around this issue, the Task Force commissioned a small survey of other Universities (see Appendix 5). The highlights of this survey regarding premiums charged to early retirees include:

- Five of the six institutions responding to the survey by HRH reported they charged early retirees either no premium or a maximum of 20% of the premium cost. The sixth did not answer the question.
- The University of New Hampshire (one of the surveyed institutions) doesn't allow early retirement until age 62, but during the 3 years before Medicare eligibility charges retirees the active employee contribution to the retiree and an adult dependent.
- The University of Vermont bases premiums for active employees on salary, and charges early retirees the premium corresponding to 85% of their highest 3 years

of salary. Retirees hired before FY92 receive the full benefit after age 55 with 10 years of service (i.e. continue to pay what actives pay); those hired during the next 5 years will need a total of 75 years age-plus-service for the full benefit, and those hired after FY97 will need 15 years of service to retire with the full benefit at age 60.

- The University of Connecticut (also in the HRH survey) is covered by the state employee plan and the state pays 100% of the cost of 'certain medical plans' for both the retiree and spouse. (The state also reimburses retirees for the full cost of the Medicare Part B premium.) Retirees may leave the plan and return during any annual retiree open enrollment.

The degree to which the long-standing UMS policy of requiring pre-Medicare retirees to pay 100% of the University's premium charge has affected retirement decisions cannot be known with certainty. It should be noted, however, that while 16% of the US workforce is over age 55, and less than 25% of higher education workers are above that age, 38% of today's UMS active employees are over age 55.

Our review of this issue also included the question of an "implied subsidy" of the premium costs associated with the pre-65 retiree. GASB 45 requires that age-based rates be imputed for retirees under 65 years old for valuation purposes, even when the premium actually paid for them by the employer is the same as that paid for active employees. Because post-55 retirees may be expected to utilize more medical services than the average employee in a large workforce with a wide range of ages, premium costs for a tiny separate plan covering those retirees would indeed be significantly greater than the 'blended' rate which includes all employees. GASB does not require, of course, that such retirees be charged that imputed premium, simply that it be used in the liability calculation. UMS currently continues the 118 retirees under 65 in the same insurance pool as the 4700 active employees, a common practice, based on the insurance principle of sharing risk, but, as noted above charges them the full premium paid by the UMS.

The survey conducted for the Task Force seems to indicate that other universities provide health care to early retirees on a more favorable cost share than UMS. On the other hand, other universities appear to provide less favorable terms to retirees once they become eligible for Medicare. The Board of Trustees may want at some time to review the policy of requiring pre-Medicare retirees to pay 100% of the premium and its impact on retirement patterns. In view of the fact, however, that our objective is to seek ways to reduce the GASB liability, we have chosen not to make that recommendation. The Task Force would however, especially in light of the fact that UMS pre-Medicare retirees already pay more than their counterparts at institutions we surveyed, urge that no increase in premium be made for early retirees to reflect this implicit subsidy.

III RECOMMENDATIONS

Following extensive discussion, the Task Force forwards seven recommendations to the Chancellor for the consideration by UMS. We believe most of these recommendations could be directly implemented and will reduce the UMS GASB 45 liability. The seventh recommendation is for a new defined contribution program for retiree health benefits. While a consensus existed within the Task Force to investigate a defined contribution program, additional analysis is needed to fashion a viable mechanism and that work could not be completed by the Task Force.

The Task Force recommends that:

- 1. Eligibility rules for retiree health benefits for full time employees be revised to require 10 years of service after age 45.**
- 2. Eligibility rules for retiree health benefits for part-time employees be revised to require the equivalent of 10 years of full-time service.**
- 3. For employees retiring on or after July 1, 2010, a premium contribution should be established for these retirees when they reach age 65 in order to capture, in the aggregate, 10 percent of the UMS' premium costs for these retirees. Current retirees and those who retire before July 1, 2010 will be grandfathered and exempted from this premium contribution. For reasons of time, the Task Force could not devise a specific contribution schedule but recommends an approach that provides a lower relative contribution based on longer service and/or lower income levels at time of retirement. The current premium contribution of 50% for dependents should not be modified.**
- 4. Retirees under age 65 should be allowed to "opt-out" of the University retiree health program but remain eligible to rejoin the University plan, with their dependents, provided the retiree:**
 - Provides evidence of continuous health insurance coverage during the "opt-out" period.**
 - Rejoins the University retiree program no later than 90 days after becoming Medicare-eligible.**
- 5. The present Medicare supplement plan for UMS retirees be replaced by a Medicare Advantage Plan covering the same participants, with comparable benefits.**
- 6. The establishment of a trust and a pre-funding schedule for benefits.**
- 7. The University consider the establishment of a defined contribution program for the financing of retiree health benefits for new employees. It is recommended that a second, broad based study group be convened to explicitly address this issue. This recommendation is grounded in the understanding that the funding levels provided**

to any defined contribution approach would finance 100% of the retiree's cost for the same benefit levels as those currently provided to retirees. And finally, current employees would be provided the option to participate in the defined contribution plan and waive their eligibility for the current plan.

The impact of the above recommendations (except recommendation 7) is estimated to reduce the University's FY08 Annual Required Contribution from \$42 million to \$27.6 million, or by approximately 35%.

Current FY08 Actuarial Accrued Liability:	\$329,955,000
Actuarial Accrued Liability with Recommendations:	\$198,482,000
Current FY08 Annual Required Contribution:	\$42,143,000
Annual Required Contribution with Recommendations:	\$27,616,000
Reduced Annual Required Contribution:	\$14,527,000
Reductions as Percentage Change	(34.5%)

Given the absence of specificity around a defined contribution approach, no savings are projected. However, and as discussed earlier, a defined contribution approach will ultimately result in the total elimination of the GASB 45 liability as the "closed group" of current employees and retirees age and the University's commitment to future employees is limited to annual funding contributions.

Appendix 1 - Task Force Process

The Retiree Health Plan Task Force established by Chancellor MacTaggart has two co-chairs (one active faculty member and one retiree), representatives of all bargaining units and non-represented employees, two retirees, one faculty representative to the Board of Trustees, two trustees, one President, and one chief financial officer. A list of the Task Force members, union staff observers and staff who supported the work is included as Appendix 5.

The Retiree Health Plan Task Force carried out its deliberations over six meetings between March and June 2007. Meetings were five hours in length in order to provide ample time for presentations and discussion. The Task Force recognized the need for members to have solid information about the GASB rules, the valuation, and options they might consider in making recommendations. In order to provide that information the Task Force reviewed materials from a variety of sources and invited experts to participate in meetings.

The work of the Task Force moved from information gathering to analysis and assessment of alternatives to making recommendations. Each meeting had several major objectives:

- Meeting 1
 - Introductions, charge, background, discussion, norms, logistics
- Meeting 2
 - Brainstorm to develop a “catalog” of possible approaches and actions to reduce the liability; drill down to more specific information on issues such as age-based premiums, integration with Medicare and funding in a trust; review actuarial assumptions
- Meeting 3
 - Develop packages of possible actions for modeling of cost impact, presentation of information about defined contribution plans for retiree health, discussion with UMS bond advisors
- Meeting 4
 - Review results of modeling of cost impact; discuss refinements; begin to discuss recommendations
- Meeting 5
 - Review and refine draft recommendations
- Meeting 6
 - Review final recommendations and report for submission to the Chancellor

A ground rule adopted at the start of our work was that members would not send substitutes in their absence. Attendance was excellent with most members attending all

sessions, demonstrating the serious commitment members made to the process, and assuring that members remained well-informed on the issues.

The Task Force first received a thorough overview of the issues related to retiree health care and GASB 45 from **Tom Hopkins**, Director of Compensation and Benefits. **Stuart Rubinstein** of Hilb, Rogal and Hobbs (HRH), the actuary who conducted the UMS valuation, attended most meetings and assisted the Task Force in understanding the valuation process. Mr. Rubinstein explained the concepts underlying the valuation and the assumptions used for health care trend, discount rate, turnover and retirement rates. He also provided information about the “exclusion” method used by UMS to integrate with Medicare and the alternative “carve out” method and the “implicit subsidy” created by using active employee premium rates for early retirees.

Mr. Rubinstein also worked with the Task Force to identify a wide range of options to be considered including changes in eligibility, plan benefits, integration with Medicare, retiree contributions, and funding. He conducted a preliminary review of the impact of these options on the amount UMS must show as the yearly cost of meeting its expected payments and amortizing its past unfunded liability. This information allowed the Task Force to review each option in depth and narrow the range of options for forming recommendations.

Other experts were invited to provide information about specific issues. **Ms. Barbara Perry**, of *Emeriti Retirement Health Solutions*, presented information about defined contribution retiree health plans. **Ms. June Matte** and **Mr. Jeremy Bass** of *Public Financial Management*, the university's bond advisors, discussed issues related to bond ratings, funding through a trust, and bonding to fund the OPEB cost.

Task Force members contributed information from outside sources including the National Education Association, the State of Maine, and the California public pension system (CALPERS). These materials were distributed and placed on the Task Force website so that members could further educate themselves on the issues.

Early in its work the Task Force determined that it would be helpful to have information from other higher education employers to answer two questions:

- How does the UMS retiree health plan compare to plans of other universities?
- What are other universities doing in response to the GASB rules?

In order to collect this information, Stuart Rubinstein conducted a survey of colleges and universities, including New England public universities, Maine's major private colleges, and several other universities similar to UMS or that we understood to be actively dealing with the issues we were discussing. Thirteen institutions were asked to respond to the survey and 8 responded. The results of this survey are included in Appendix 3.

For much of its work the Task Force met as a full group. In order to allow all members to actively participate in generating ideas for further consideration, the Task Force broke into small groups for discussions during several meetings. The small groups discussed options

and reported back to the full Task Force with proposals for options to be assessed by the actuary for their fiscal impact.

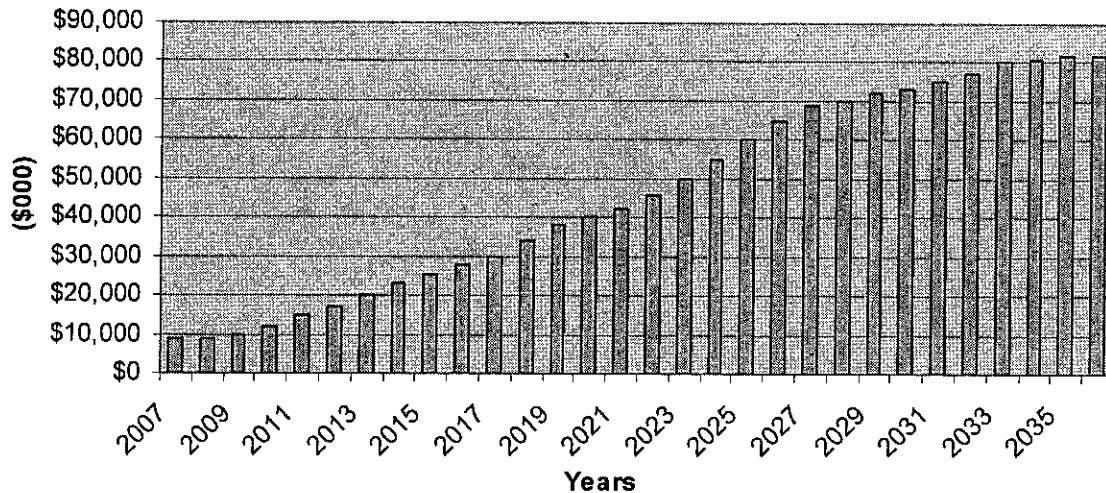
This process encouraged a diversity of viewpoints to be considered. Small groups were asked to guide their discussions by the Task Force charge to “Make recommendations . . . that will provide for a meaningful retiree health benefits program for the future, maintain financial integrity of UMS, and meet the GASB 45 requirements.” Each group was asked to consider the impact of actions on retirees 55-64, retirees age 65 and older, current employees less than age 45, current employees age 45 and older, and future employees. Groups were also asked to propose actions that would “make a substantial difference in the retiree health plan costs for the future as measured by the GASB accrued actuarial liability and annual required contributions and/or the projected pay- as-you- go cost.”

The Task Force strove throughout to work through consensus. In developing norms for our work we decided that a simple majority would not be adequate support for any recommendation made to the Chancellor. We had considerable discussion on what level of supermajority would be required for a formal recommendation, recognizing that unanimity might not be possible. We decided that in our report recommendations that were not unanimous would be presented with the level of support indicated.

Appendix 2 - Description of Preliminary FY08 Actuarial Valuation

The starting point in determining the valuation is projecting the cost – in current dollars at the time of payment – of future health benefit payments for present and future retirees. The annual payments under the current plan, as of July 1, 2007, are estimated to be:

Projected Retiree Health Costs



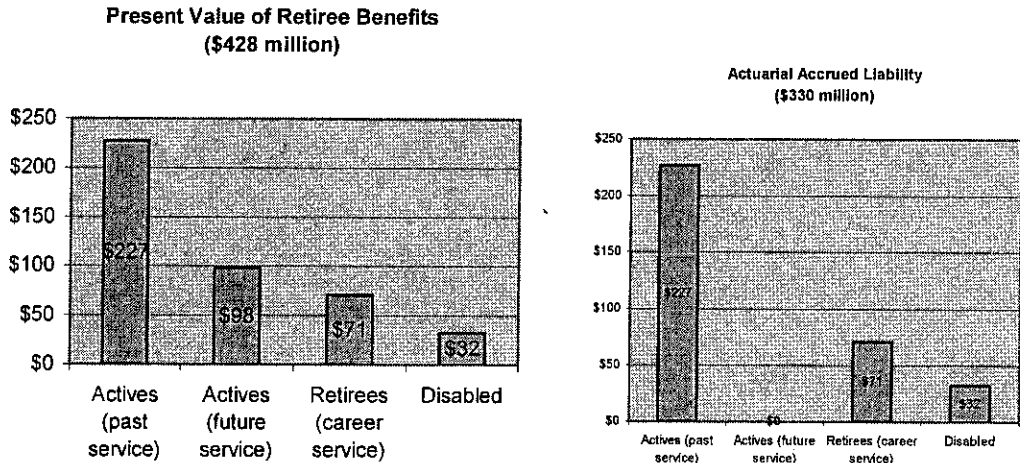
The total of this stream of payments over 30 years is \$1.388 billion, with about 12% being spent for the retiree group (current retirees, dependents and disabled former employees) and 88% expended for today's active employees when they retire.

The 'Present Value' Calculation

Dollars to be paid out in the future are not as 'costly' as dollars paid out today, since the funds can be earning interest before they need to be disbursed. Future streams of funds, whether payments or income, are therefore routinely 'discounted' to reflect the time value of money. The farther out in the future a payment, the less it is worth in today's dollars. The assumed rate at which the funds could theoretically be invested before they need to be spent, called the 'discount rate,' has an important impact on the final figure: the higher the discount rate assumed in the calculation, the smaller the amount required today to fund a given stream of future payments. Present Value is a convenient way to deal with, and compare, streams of payments occurring over a period of time. The present value may be described as the amount the University would need to invest today with a single payment, at a given earnings rate, to provide the year by year funds as they are needed to cover retiree health benefits over the next 30 years.

The equivalent 'present value' of the 30-year payment stream shown, as calculated by the actuarial consultant, is \$428.2 million. It is made up of \$70.8 million to fund benefit costs for present retirees, \$32.4 million for current disabled participants and

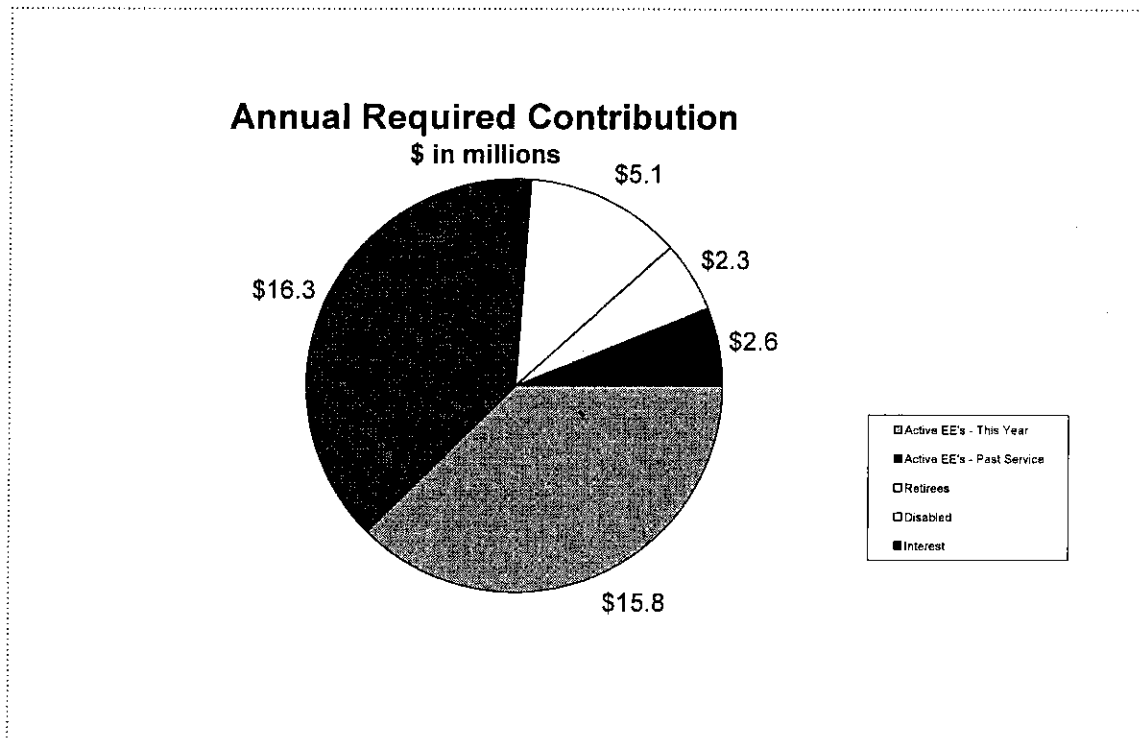
\$324.8 million for the projected costs of retirement benefits for active employees. Employee attrition and historic age-at-retirement patterns at UMS, as well as mortality tables, are used in the calculation, which established present value with a discount rate of 6.5%.



The actuarial valuation process used with GASB 45 divides the \$325 million shown for active employees into two parts shown in the first two columns: \$227 million to reflect the amount of the retirement benefit earned by active employees during their past service, and \$98 million they will earn in the future before they become eligible to retire. The graph on the right shows, for GASB 45 purposes, only the liability accrued to date: the health benefit 'credit' employees will earn in future years is not included.

Determining the Balance Sheet Liability

The amount required each year to keep the retirement pre-funding current and to amortize any benefits earned in years past is called the Annual Required Contribution.



For the University of Maine UMS, that pre –Task Force value is \$42.1 million, consisting of:

- **\$15.8 million representing what active employees earned in the current year toward their post-retirement health benefit**
- **\$16.3 million to amortize, over 30 years, the retirement benefit earned by today’s employees during their past service**
- **\$ 5.1 million to amortize, over 30 years, the retirement benefit earned by current retirees during their years with the University**
- **\$ 2.3 million to amortize, over 30 years, the expected benefit to be paid to disabled employees**
- **\$2.6 million for interest on the above items**

The \$42.1 million is the calculated accrued liability figure for the University using standard valuation techniques. GASB 45 allows it to be reduced, however, by anything paid out for the retiree benefit during the current year, \$8.8 million for UMS. (The full retiree health benefit cost was \$13.0 million in FY07, partially offset by participant premium contributions of \$4.2 million.)

Thus the ‘bottom line new’ GASB liability for UMS is \$33.0 million.

Appendix 3 - Retiree Plan Coverage for the Disabled

UMS grants former UMS employees on long-term disability lifetime coverage in the University's health plan, regardless of their age or length of service. Newly disabled former employees are covered under the active employee plan for two years until they qualify for Medicare and receive coverage under the UMS Medicare supplement plan. Like others in the UMS retiree health plan, they pay no premium for themselves and 50% of what it costs UMS for spousal coverage.

Disabled former employees and their dependents represent 5% of the total number of participants in the Retiree health plan. As might be expected, they represent a slightly higher share (7%) of the plan's annual pay-as-you-go costs.

Surprisingly, however, in the GASB 45 valuation, those in the disabled category account for 30% of the total annual liability in the 'retiree plan'. This occurs because on the average they are 16 years younger than the retirees in the plan and they are projected to be drawing benefits for a substantially longer time.

Appendix 4 - Options Reviewed by Task Force

Category	Fiscal Impact	Task Force Disposition
Eligibility		
1. Require 15 years of service for eligibility.	Low	Table
2. Increase early retirement age to 60 or 62.	Low	Table
3. Spouses whose employers offer medical benefits are not eligible.	Low	Table
4. Change eligibility to "10 years of service after age 45."	Medium	Consider
Plan Design		
1. Increase HMO Choice office visit co-pays and out-of-network deductibles, participant co-insurance and out-of-pocket limits.	Low	Table
2. Increase Comp-Care deductibles, participant co-insurance and out-of-pocket limits.	Low	Table
3. Implement separate deductible for imaging tests.	Low	Table
4. Implement separate outpatient and inpatient deductibles.	Low	Table
5. Implement separate prescription drug deductible and/or increase prescription drug co-pays.	Low	Table
6. Change integration with Medicare from "Exclusion" to "Carve-Out" basis.	Low	Not Applicable if #7 Adopted
7. Replace Comp-Care Carve Out Plan for Medicare participants with national PDP (Prescription Drug Plan) or Medicare Advantage plan.	Medium	Consider
Cost Allocation		
1. Develop premiums for non-Medicare eligible retirees on claim experience for that group and require contributions based on these premiums.	Medium	Table
2. Implement contributions for retirees over age 65.	Medium	Consider
3. Increase contributions for spouses over age 65.	Low	Table
4. Employees hired on or after certain date are not eligible for postretirement medical benefits.	Low in early years High in later years	Table
5. Require 25 years of service for full employer subsidy, with UMS contributions proportionately reduced down to 10 years of service.	Medium	Table
6. Cap UMS contributions at fixed dollar amount or allowed increase in some future year.	High	Table
Other Approaches		
1. Establish a trust and adopt pre-funding schedule for benefits.	Low in early yrs. Med. in later yrs.	Consider
2. Require contributions from active employees to pre-fund portion of obligation.	Low-Medium	Table
3. Implement a "defined contribution" program under which UMS makes a contribution to accounts for eligible active employees to prefund their postretirement medical benefits.	Low in early years High in later years	Consider

Appendix 5 – Survey Results

UNIVERSITY OF MAINE SYSTEM
2007 RETIREE MEDICAL BENEFITS & GASB 45 SURVEY



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101 FEDERAL STREET
BOSTON, MA 02110

APRIL 2007

INTRODUCTION

HRH drafted a Retiree Medical Benefits Survey in conjunction with the University of Maine System. Thirteen (13) higher education institutions were asked to participate. A copy of the survey instrument is included in **Attachment A**.

Eight (8) colleges and universities submitted responses. The participants included:

- Colby College
- Michigan State University
- Pennsylvania State System of Higher Education
- Pennsylvania State University
- University of Connecticut
- University of Kentucky
- University of New Hampshire
- University of Rhode Island

Detailed survey responses are included in **Attachment B**.

The following colleges and universities did not provide a response: Bates College, Bowdoin College, UMASS Boston, University of Vermont and State University of New York.

Note: For the purpose of this executive summary, the term “university” will be used to describe both universities and colleges.

EMPLOYER PROFILE

- The combined populations of the eight (8) colleges and universities responding represent approximately 65,092 full-time employees and 9,764 part-time employees.
- Four (4) universities had a full-time employee definition of 35 hours or more per week. Only one (1) university had a 30 hour per week definition and three (3) did not provide this information.
- Six (6) of the universities have union representation.
 - Two (2) of the bargaining units negotiate retiree benefits.
 - One (1) union bargains for future retiree benefits, but not for current retirees.
 - Three (3) unions do not negotiate retiree benefits.

Retiree Medical Benefits

- All eight (8) universities offer medical benefits to their **under age 65 retirees**. Five (5) universities offer the same plan(s) as they offer to active employees. One (1) university offers the same Indemnity plan as their active employees but does not offer their HMO plan to retirees. One (1) university does not offer their **under age 65 retirees** the same plan design as their active employees. In this case, the plan offered is determined by the date of the employee's retirement.
- Four (4) universities base retiree contributions on the blended cost for active employees and retirees under age 65. One (1) university bases retiree contributions on the cost for retirees under age 65 retirees only, and one (1) university is changing to this method effective 7/1/2007.
- Seven (7) universities offer medical benefits to their **over age 65 retirees**. One (1) university offers medical benefits to a grandfathered class of **over age 65 retirees** only. Two (2) universities offer the same plan designs as they offer active employees. One university offers the same Indemnity plan as their active employees but does not offer their HMO plan to their **over age 65 retirees**. Five (5) universities offer different plans to **over age 65 retirees** than they offer active employees. Of these five (5) universities, three (3) offer a Medicare Advantage plan, one (1) offers a Medigap plan and one (1) offers plans that vary based on retirement date.

- The Age and Service requirements to receive retiree benefits vary between universities:
 - The most common age requirement is 60 years old (4 universities). However, the age requirement ranged from 55 to 62.
 - Two (2) of the universities also allowed for eligibility regardless of age after 25 years of service.
 - One (1) university uses the “Rule of 75” – Years of service + age = 75, with at least 15 years of service.
 - The most common year of service requirement was 10 years (5 universities). One university specified the 10 years of service had to be after age 40. Three (3) universities required 15 years of service to satisfy the eligibility requirement.

- All eight (8) universities responding allow **under age 65** and **over age 65 retirees** to cover dependents. One (1) university requires dependents of retirees to be covered under a separate plan.

- The contribution basis for **under age 65 retirees** varies among the respondents:
 - Five (5) of the universities require **under age 65 retirees** to contribute to their medical benefits.
 - Additionally, two (2) universities offer a no cost plan option to **under age 65 retirees** with buy-up plans available.
 - One (1) university requires contributions at the same rate as active employees.
 - One university (1) is changing from a fixed percentage contribution to a contribution schedule based on age and years of service for **under age 65 retirees**, effective 7/1/2007.
 - Two (2) universities have a grandfathered group of **under age 65 retirees** who do not contribute to their medical plans.
 - One (1) university requires **under age 65 retirees** to pay 100% of the premium.

- The contribution basis for **over age 65 retirees** varies among the respondents as well:
 - Five (5) of the universities require **over age 65 retirees** to contribute to their medical benefits.
 - Additionally, two (2) universities offer a no cost plan option with buy-up plans available.
 - Only one (1) university provides medical coverage free of charge to all **over age 65 retirees**.
 - Two (2) universities have a grandfathered group of **over age 65 retirees** who do not contribute to their medical benefits.
 - One (1) university requires **over age 65 retirees** to pay 100% of the premium.

- Six (6) universities give retirees annual open enrollment rights and six (6) universities allow their retirees qualifying event rights.

Retiree Medical Benefits – Plan Designs

Under Age 65 Retirees Plan Designs

- Three (3) universities offer 2 plan designs to **under age 65 retirees**. Additionally, two (2) universities offer 1 plan design and two (2) universities offer 3 plan designs to retirees **under age 65 retirees**.
- Of the six (6) universities that provided information on the types of plans offered, all offer either a PPO or Indemnity plan, and three (3) offer both. Three (3) universities offer an HMO plan in conjunction with the PPO and/or Indemnity plan(s).

Over Age 65 Retirees Plan Designs

- Three (3) universities offer a Medicare Advantage plan to **over age 65 retirees**.
- One (1) university offers a Medigap plan.
- One (1) university offers the same HMO/PPO/Indemnity triple option to **over age 65 retirees** as they offer to their under age 65 retirees and active employees.
- One (1) university offers the same Indemnity option to **over age 65 retirees** as they offer to their under age 65 retirees. (Active employees also have an HMO option that is not available to either retiree group.)
- One (1) university offers an Indemnity plan to its **over age 65 retirees** but the benefits vary based on retirement date.

Retiree Prescription Benefits

- All eight (8) of the universities offer prescription drug coverage. One (1) university offers prescription drug coverage only for certain plans.
- Four (4) universities maintained their current plan and applied for the federal subsidy (RDS) for 1/1/2007. Three (3) of the four said they will likely do the same for 1/1/2008.
- One (1) university maintained its current plan and did not take any additional measures for 1/1/2007. They are not planning on making any changes for 1/1/2008.
- One (1) university replaced one of their current benefit plans by contracting with a PDP plan as of 1/1/2007. They plan to continue the PDP arrangement for 1/1/2008.

- One (1) university did not provide information on their response to Medicare Part D for 1/1/2007 and three (3) did not provide information on their intentions for 1/1/2008.

Medicare Coordination

- Four (4) universities use the Exclusion Method
- Three (3) universities offer Medicare Advantage plans and one (1) university offers a Medigap plan.

GASB 45

- Two (2) universities have a FASB accounting requirement.
- Five (5) universities have a GASB accounting requirement.

Eligibility:

- Two (2) universities have made changes to retiree eligibility in response to the GASB accounting standards. Of these two universities, one (1) is considering the Emeriti program for future eligibility changes.
- Additionally, two (2) universities have made changes to their eligibility requirements for retiree medical benefits but not in response to GASB.
- One (1) university is still discussing possible changes to eligibility. No changes have been made as of yet.

Contributions:

- One (1) university has made changes to retiree contributions in response to the GASB accounting standards. Retirees are now in separate risk pools (under age 65 vs. over age 65). As of 7/1/2007, retiree contributions will change from a fixed percentage to being based on age and service at retirement.
- Additionally, one (1) university has made changes to their retiree contributions but not in response to GASB.
- One (1) university is still discussing possible changes to retiree contributions. No changes have been made as of yet.

Plan Design:

- One (1) university has made changes to their medical plan design in response to the GASB accounting standards. In 2007, they changed to a Medicare Advantage plan and adopted a PDP for Medicare eligible retirees. They noted they will continue to watch Medicare programs for sustainability.

- Additionally, one (1) university has made changes to their retiree medical plan designs but not in response to GASB. They are considering making changes to their retiree prescription benefits in the future.
- One (1) university is still discussing possible changes to retiree medical plan designs. No changes have been made as of yet.

Funding:

- One (1) university is pre-funding their retiree medical benefits through a trust. Pre-funding is under review at one (1) other university.
- One (1) university has adopted a defined contribution approach. This was adopted in 1994 in response to FAS 106. At that time, all employees were given the option to remain the defined benefit plan or convert to the defined contribution plan.
- Two (2) universities are considering adopting a defined contribution plan. Four (4) universities said it is not under consideration.

Appendix 6
Retiree Health Plan Task Force Membership

Jerry Ashlock
Part-time Faculty Association
AFT/AFL-CIO

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V.P. for Administration and Finance
University of Maine at Presque Isle

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Oil Burner Mechanic
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