

UNIVERSITY OF MAINE SYSTEM

Report of the

Retiree Health Plan Task Force II

Submitted to

Chancellor Richard Pattenau

September 24, 2008

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Executive Summary

At the appointment of the Chancellor, a Task Force (referred to as Retiree Health Plan Task Force II, or RHPTF II) representing employees of the University of Maine System, convened in the spring of 2008 to explore the feasibility of establishing a defined contribution retiree health plan. The charge for this Task Force grew out of earlier work by a similar Task Force formed in the spring of 2007 to review approaches to mitigate the impact of the cost of retiree health benefits under GASB 45.

Among the recommendations of the 2007 Task Force was the following: “The University consider the establishment of a defined contribution program for the financing of retiree health benefits for new employees,” with the hope that such a plan might be able to provide the same level of benefits as the current plan but at some cost savings to the University of Maine System. It was with that recommendation in mind, and a clearly defined “charge” to the committee (see page 3) that RHPTF II began its work.

The Task Force members launched their efforts by reviewing the outcomes of the 2007 Task Force and gaining a shared understanding of the features of the very limited number of defined contribution retiree health plans currently available within this emerging market. Representatives from Emeriti and TIAA-CREF provided details on the aspects of their plans, shared data (where available) on the experience of their clients, and helped the Task Force members gain a reasonable level of familiarity with defined contribution retiree health plans.

As the Task Force conducted its work, there was extensive discussion about the pros and cons of the current retiree health plan, as compared to either of the defined contribution options, particularly as the latter was perceived to shift greater risk to the retirees. Despite this, the Task Force agreed upon a basic set of criteria to be used in the development of financial models, and it was the review of those models that ultimately moved the Task Force to a final set of recommendations.

In short, an actuarial review of the numbers presented to us by Emeriti (the only current vendor able to provide financial models) led the Task Force to the conclusion that there is no financial advantage to moving to a defined contribution retiree health plan at this time, nor was there agreement among the Task Force members that any perceived benefits resulting from the defined contribution plan would outweigh the financial difference between the two types of plans.

What follows is a more detailed report on the work of RHPTF II, our findings, and our recommendations.

Introduction

In March of 2007, Chancellor Terrence MacTaggart established a Retiree Health Plan Task Force to make recommendations as to how the University of Maine System (UMS) could comply with GASB 45 accounting requirements while maintaining a meaningful retiree health benefit. A Task Force of faculty and administrators, staff employees, retirees, representatives of the Board of Trustees, and the System's bargaining agents was appointed and co-chaired by Gino Nalli and William Sullivan. The result of their work was a set of recommendations included in a report titled "Report of the Retiree Health Plan Task Force" and submitted to the Chancellor on June 30, 2007.

As a result of those recommendations, the Board of Trustees took the following actions:

- Approved retiree contributions for those who retire on 7/1/10 or later, ranging from 7% to 15%, depending on service
- Approved an option to opt-out of the plan and re-enroll within 90 days of Medicare eligibility
- Approved establishment of a trust fund for post-employment medical benefits funding
- Approved the revision of eligibility rules for full-time employees to require 10 years of service after age 45
- Modified the definition of retirement to require 10 years of service, regardless of age at separation, for those who retire on 7/1/10 or later.

Guided by the Board of Trustees' decisions, UMS adopted a Medicare Advantage Health Plan for Medicare eligible retirees. This step, and the impact of the actions of the Board of Trustees, resulted in the following:

- Reduction in accrued liability from \$330 million to \$153 million
- Reduction in the FY08 annual required contribution from \$42 million to \$17 million
- 2/3rd reduction in the "pay-as-you-go" cost in calendar year 2008.

By all measures, the recommendations of the Task Force and the actions taken by the Board of Trustees and the System had an immediate and very positive financial impact and were well received by bond rating agencies. The June 6, 2008 issue of Standard & Poor's "Ratings Direct" newsletter included the following comment: "Funding its OPEB liability is not mandatory and places the system ahead of its peers in terms of responding to this liability."

While six of the seven recommendations made by the Task Force could be implemented immediately, the seventh recommended that:

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.

In response to this recommendation, the following “charge” was developed by the Chancellor and ultimately presented to a Task Force (referred to as Retiree Health Plan Task Force II, or RHPTF II) representing employees of the University of Maine System in the spring of 2008:

Charge: To explore the feasibility of establishing a defined contribution retiree health plan and to make recommendations to the chancellor by June 30, 2008 regarding design of a program that will provide a competitive retiree health benefit for employees who spend a major portion of their career at UMS and that will not increase costs of retiree health coverage over the amount that would be required for accrual accounting of the current plan for the covered employees.

The Task Force is asked to develop a plan that meets the following parameters; the Task Force is free to recommend additional alternate designs. The defined contribution retiree health plan will provide high quality retiree health coverage for UMS retirees under the following situations:

- A benefit that is targeted to provide for 90% of the cost of a comprehensive health insurance plan after a career of 30 years at UMS, with optional dependent coverage available at the retiree’s cost.
- Designed to apply to new hires effective January 1, 2010.
- Transition provisions may be recommended so that the plan may be offered to employees hired before January 1, 2010, with the goal of achieving a benefit of 90% of the cost of a comprehensive coverage for the career retiree with dependent coverage available at the retiree’s cost.
- Estimate projected costs of the proposed program to both UMS and the employee.
- The cost to UMS should not exceed the cost of the current plan on an accrual accounting basis for the covered group of employees.

Process

Task Force composition

Chancellor Pattenaude used the following criteria to select the membership of the Task Force:

- Two employee members representing each bargaining unit that represents UMS employees
- Two non-represented employees (one hourly employee named by the USCEAC and one salaried)
- One Faculty Representative to the Board of Trustees
- One president
- Two chief financial officers
- Two human resource directors
- Chief Human Resources and Organization Development Officer

In addition, each bargaining agent was encouraged to have a non-voting staff observer attend. Staff support was provided by Tom Hopkins, Tony Richard, Frank Gerry, Kay Saucier and the System's actuary, Stuart Rubinstein of Hilb Rogal Hobbs (HRH). Rather than select a chair or co-chair to lead the process and serve as facilitator(s), a decision was made to contract with Jeff Wahlstrom, of Starboard Leadership Consulting, to fill that role. A full list of the Task Force membership, support staff and observers is included in exhibit 1.

Defined contribution plans defined

While many of the members of RHPTF II also served on the original Task Force and brought a solid understanding of the issues related to GASB 45 and a beginning level of understanding about defined contribution plans, the Task Force also included several new members who needed to catch up on some of the background. An initial orientation session was conducted for all of the new members, and the first meeting of the full Task Force focused much of its time on gaining a shared vocabulary and a shared understanding of what a defined contribution plan was and how it differed from a defined benefit plan. The following description proved helpful to the Task Force:

What do we mean by Defined Contribution?

1. Defined Benefit: Employer provides access and contributes towards a specific medical plan design.
 - Based on age and service
 - Retiree makes decision to join or decline coverage
 - No benefit if the employee leaves before retirement
2. Defined Contribution: Employer (and possibly employee) contributes to a fund in the employee's name during the period of active employment.
 - Subject to vesting schedule
 - All employees receive the same contribution amount, regardless of compensation level
 - Invested in manner similar to a 403(b) retirement account
 - Portable at termination (after vesting)
 - Retiree decides how to use the funds and can purchase a health plan, pay Medicare premiums, pay for health care related expenses, etc.
 - Decision making, control and risk (investment and medical trend) are with the retiree

Framing the issues

As the Task Force began to gain greater familiarity with the basics of defined contribution retiree health plans, an effort was made to identify the key issues/questions facing the Task Force as it considered the options before them. A listing of those issues and questions is included here:

- What are the investment options available within these plans, and are there specific requirements or restrictions?
- How much risk should we allow employees to take in their investments, and are we able to help limit the risk?
- What level of control over their investments will future employees expect?
- What are the most common vesting requirements and options, and what are some of the advantages and disadvantages of those options?
- Will the benefits be portable and to what degree?
- What are the advantages and disadvantages of employee mandated contributions?
- If employee contributions are required, are there 'opt out' options for those who don't want to contribute to the plan?
- What happens upon the death of the retiree (both when there are living dependents and when there are not)?
- When do funds (employee and employer) revert to the plan, and what are the options for how those funds are used?
- How can we protect people if future healthcare costs skyrocket well above our projections? Will long range projections be sufficient to provide a lifetime benefit?
- What are the tax/legal implications of a defined contribution option?
- Is there a guaranteed insurance partner, and can UMS retirees be sure that they can get insurance in retirement?
- What are the common entry/eligibility requirements (age, service, fulltime/part time etc.)?
- Are there any guarantees that the funds will be there (that retirees don't outlive coverage)? Are there any 'annuity like' options or other approaches to this issue?
- Who else is participating in these plans, what are the common plan designs, and what has been the experience?
- What options might exist for employees in the current plan to opt in to the defined contribution plan?
- What role should UMS assume, or might we expect from the vendor, in ensuring that employees and retirees make appropriate choices, on-time, and get the support they need both prior to retirement and in retirement?
- Compared to our current plan, how big of a nest egg would someone need to accumulate in order to be assured of a similar benefit?

Vendor presentations

With the list of issues and questions in hand, it was determined that representatives from Emeriti Retirement Health Solutions and from TIAA-CREF would be invited to meet with the Task Force and describe their products. It is important to note here that defined contribution retiree health plan products are very new and, as far as we can determine, only Emeriti has a product on the market at this time. TIAA-CREF is hurrying their own product to market, and they were selected to give a presentation

because they appeared to be closer than others to launching a product and because of UMS's extensive and positive experience with TIAA-CREF.

Emeriti is a consortium of colleges, universities, and other higher education-related tax-exempt organizations that was established to "leverage collective buying power, shared resources and economies of scale to secure well-designed, competitive benefits and deliver them in a cost-effective manner." As of January 1, 2008, they had implemented plans with 45 institutions, had \$35.2 million under management and were working with 18,841 participants.

TIAA-CREF is a \$400 billion, full-service, financial services group of companies that serves those in the academic, medical, cultural, and research fields. They have a 90+ year history and over 3 million participants in their plans. As noted earlier, when the Task Force met with them, they were moving quickly to launch a defined contribution savings vehicle, with the hope that they would have implementation plans in place with, what they described as, "Phase One clients" by the end of the 3rd quarter of 2008 and with open enrollment underway by the 4th quarter of 2008.

As the Task Force listened to both presentations, it became obvious that the basic framework and features of both vendors' products were very similar. IRS regulations, tax law, and accepted accounting practices largely define the delivery of these products, and the differences appeared to be primarily in their claims about customer service and administration, fees, the investment options available, and the health plans with which each was affiliated. The Task Force did not explore the claims about customer service and administration, and while Emeriti had a clearly defined fee schedule, TIAA-CREF's fees were still under discussion. Emeriti partners with Aetna in offering health insurance (medical, prescription drug, and dental) and with Fidelity to offer a selection of mutual fund options from the "Fidelity Freedom Funds." TIAA-CREF does not have a health insurance partner at this time and is considering whether to have one partner or to provide access to insurance through multiple providers. For investment of funds, their current plan is to offer the TIAA-CREF "Lifecycle Funds" for investment.

The general consensus of the Task Force, upon hearing both presentations, was that it was extremely helpful to meet with the vendors and have an opportunity to look at their models in greater depth and ask questions. Everyone expressed a regret that there were not more options to consider at this time and that TIAA-CREF really was not far enough along in the development of its product to be considered a viable option for UMS at this point in time. The general sentiment of the Task Force was that it might, ultimately, be advantageous to wait until TIAA-CREF and others have products on the market (ideally with some client history) before moving ahead with the selection of a plan. However, for purposes of meeting our charge and the timeline, it was agreed that we would work with Emeriti to develop some financial models for comparison purposes.

Development and review of plan options

As a follow-up to the presentations by Emeriti and TIAA-CREF, we asked the System's actuary, Stuart Rubinstein, to conduct a comparison between the current retiree health plan provided by Anthem and the Emeriti plan that most closely resembled the current plan. That comparison resulted in a determination that the Emeriti health plan had 95.3% of the value of the current plan. With that in mind, it was agreed that any financial models or calculations would need to compensate for that differential.

Before asking Emeriti to present plan options for the Task Force to review, discussions took place among the Task Force to more clearly define the range of acceptable options that would be used to

develop plans for our review. For comparison purposes, we reviewed Emeriti's experience with 38 of its current clients to see what criteria others have used in developing their plans. They presented us with data on items such as the average age of eligibility, length of contribution period, definition of retirement age and years of service, vesting criteria, employer contribution levels to the plans, etc.

As the Task Force moved through the process of developing plan criteria, there was considerable discussion and concern voiced regarding the issue of dependent coverage. The Chancellor's "charge" called for "optional dependent coverage available at the retiree's cost." This was in contrast to the current retiree health plan, which pays half of dependents' premiums. As a result, there was strong interest in examining plans that would provide funding for dependent coverage, so the Task Force looked at funding accumulation targets of 120 and 150% of the cost of individual coverage. The 120% level would, in the aggregate, reflect a contribution by UMS equal to the current plan (based on the proportion of retirees who have dependents). The 150% level would provide an individual with the estimated amount needed to provide coverage for himself/herself and half of coverage for a spouse.

Ultimately, the Task Force developed a set of criteria that resulted in 9 plan models for review. The selected criteria used were as follows:

- Contribution starting ages of 25, 35 and 40
- Target funding of 90%, 120% and 150%
- Funding over 25 or 30 years
- Retirement age of 65
- Annual contribution increase of 3%
- Investment return of 7%

Findings

While the review of potential plan models was helpful in further focusing the discussion of the Task Force, there was agreement that the essential information required in order to make a “go or no go” decision for our process would be a financial analysis of the cost to UMS of transitioning to a defined contribution plan.

Stuart Rubinstein, the System’s actuary, was asked to analyze and present a report on the projected annual cost of transitioning from the current plan to a defined contribution plan. Stuart presented two financial comparisons, one using a funding target of 95% and one using a funding target of 125%. The 95% figure was used (rather than the 90% in the Chancellor’s charge) to bring the Emeriti plan to the equivalent of the current plan. The 125% figure that was used in the second calculation is 5% to account for that same adjustment and 120% to account for dependent coverage.

Both comparisons shared the assumption of a current program cost based on an 8.5% discount rate, assuming full prefunding to the trust of the annual required contribution. Both also used the following criteria for a defined contribution option:

- Funding start age of 40
- Funding years – 25
- Vesting – 10 years
- Annual investment return assumption of 7%

See exhibits 2 and 3 for both financial comparisons

What became apparent as the Task Force reviewed the models was that if UMS were to adopt a defined contribution program for *new* employees that met the target of 125% (with current employees and retirees remaining in the current retiree health plan), UMS’s total costs would increase in each of the next ten years. In the first year, the increase would be approximately \$700,000, and by the tenth year the added costs would be appropriately \$1.6 million. If the university were to adopt a defined contribution program for *new* employees with a target accumulation of 95% (with current employees and retirees remaining in the current retiree health plan), UMS’s total costs would increase for the first four years before experiencing lower costs in subsequent years. The added costs in early years would begin at approximately \$500,000, reducing to less than \$100,000 by the fourth year. The savings in subsequent years would start at \$13,000 per year and increase to almost \$600,000 in the tenth year of the program.

While a plan built on the 95% target (which the Task Force believes is consistent with the Chancellor’s charge) would likely result in cost savings over time, employee members of the Task Force did not believe that the cost savings presented would justify the loss of a benefit, and they would not recommend adopting a plan that provides no consideration for dependent coverage.

Recommendations

Following extensive discussion and review, financial modeling by actuary Stuart Rubinstein of HRH, and consultation with potential vendors, the Task Force forwards the following recommendations to the Chancellor:

Continue with the current retiree health plan and fully fund it through a trust. While the Task Force recognizes the challenge UMS may have in pre-funding the trust on an ongoing basis, the current reality is that there are not meaningful, if any, savings at this time in moving to a defined contribution retiree health plan that maintains the benefit for retirees at its present level.

Pre-funding a trust provides advantages to employees, retirees and UMS:

- Assets are assured to be available for post-employment benefits;
- Accounting rules allow use of a higher discount rate because of the long-term investment horizon for the trust, which, in turn, lowers the accrued liability;
- UMS may include the amount funded as a benefits expense in calculating the federal reimbursement rate for grants and contracts;
- Pre-funding the full amount keeps the cost relatively stable;
- In the long run, fully funding each year will result in a strong funding ratio for the plan;
- And, the result is a lowering of the annual required contribution that must be recognized on financial statements, which will contribute to a continued strong rating by credit agencies.

In attempting to summarize and write-up the work of the Task Force, one of the most significant challenges came in trying to reach agreement on the *emphasis* that should be used in describing the value of pre-funding the trust (despite the fact that the topic of whether or not to pre-fund the trust was outside of the Chancellor's charge). Opinion on the emphasis to be used ranged from those who see it as highly desirable to those who see it as the only reasonable approach. While one member of the Task Force made the point that "not prefunding is not a reasonable decision," and that "full funding the trust reduces cost per retiree substantially," another member of the Task Force made the observation that "while funding the plan *does* reduce the cost of health insurance, it comes at another cost to the University—that is, the loss of unrestricted investment income, because unrestricted dollars will be funding this plan with the return going to it." It is important to note, however, that no matter where Task Force members fell in regard to the amount of emphasis to be applied, all agreed that prefunding the trust provides advantages to employees, retirees and UMS.

If UMS finds itself unable to fully fund the trust, then the economic model upon which the Task Force makes these recommendations will change, and it may then make sense to, once again, examine the value of a defined contribution retiree health plan. Keep in mind, however, that any examination will need to address the strong concerns, voiced by many members of our Task Force, about the shift in risk from the employer to the employee in adopting a defined contribution retiree health plan.

Be attentive to the developing market for defined contribution plans and the potential for more competitive alternatives in the future that could be financially advantageous to UMS and still maintain, or even enhance, the benefit for retirees. Looking to the future, members of the Task Force acknowledge that the environment for healthcare, insurance products, investments, and our economy are

going to continue to change and to challenge some of the assumptions that were made during this process. Within this rapidly changing environment, we anticipate that there will continue to be new retiree health products developed to meet the needs of organizations like UMS, and we hope that there will be continued efforts to explore both the potential for cost savings and the opportunity to maintain and enhance this important benefit for UMS employees. While the Task Force resisted setting a firm timeline or outlining a process for a review of options, it was suggested that not more than two years go by without taking at least a preliminary view of new options that may be available.

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**University of Maine System
Retiree Health Plan Task Force II
July 18, 2008**

Cost Impact of Transition to Defined Contribution Program Option 1

Projected Annual OPEB Cost

Year Beginning July 1	OPEB Cost Current Program Continues	OPEB Cost Current Program Closed to New Hires	Proposed Defined Contribution Program Cost	Total Proposed Program Cost	Proposed Program Cost Savings
2008	\$17,975,000	\$17,975,000	\$702,000	\$18,677,000	(\$702,000)
2009	\$17,353,000	\$16,453,000	\$1,445,000	\$17,898,000	(\$545,000)
2010	\$17,525,000	\$15,937,000	\$2,231,000	\$18,168,000	(\$643,000)
2011	\$17,636,000	\$15,377,000	\$3,062,000	\$18,439,000	(\$803,000)
2012	\$17,798,000	\$14,770,000	\$3,940,000	\$18,710,000	(\$912,000)
2013	\$17,970,000	\$14,159,000	\$4,867,000	\$19,026,000	(\$1,056,000)
2014	\$18,160,000	\$13,505,000	\$5,845,000	\$19,350,000	(\$1,190,000)
2015	\$18,295,000	\$12,763,000	\$6,876,000	\$19,639,000	(\$1,344,000)
2016	\$18,262,000	\$11,802,000	\$7,963,000	\$19,765,000	(\$1,503,000)
2017	\$18,439,000	\$10,892,000	\$9,109,000	\$20,001,000	(\$1,562,000)

Notes:

Current Program cost based on 8.5% discount rate assuming full prefunding of Annual Required Contribution.

Proposed Defined Contribution Program

- Funding Target – 125% of cost of Emeriti Medicare Supplement Plan 1 plus Emeriti Rx Plan 1 at age 65 .
- Funding Start Age – 40
- Funding Years – 25
- Vesting – 10 Years
- Annual Investment Return Assumed – 7%

**University of Maine System
Retiree Health Plan Task Force II
July 18, 2008**

Cost Impact of Transition to Defined Contribution Program Option 2

Projected Annual OPEB Cost

Year Beginning July 1	OPEB Cost Current Program Continues	OPEB Cost Current Program Closed to New Hires	Proposed Defined Contribution Program Cost	Total Proposed Program Cost	Proposed Program Cost Savings
2008	\$17,975,000	\$17,975,000	\$538,000	\$18,513,000	(\$538,000)
2009	\$17,353,000	\$16,453,000	\$1,106,000	\$17,559,000	(\$206,000)
2010	\$17,525,000	\$15,937,000	\$1,708,000	\$17,645,000	(\$120,000)
2011	\$17,636,000	\$15,377,000	\$2,344,000	\$17,721,000	(\$85,000)
2012	\$17,798,000	\$14,770,000	\$3,015,000	\$17,785,000	\$13,000
2013	\$17,970,000	\$14,159,000	\$3,723,000	\$17,882,000	\$88,000
2014	\$18,160,000	\$13,505,000	\$4,471,000	\$17,976,000	\$184,000
2015	\$18,295,000	\$12,763,000	\$5,259,000	\$18,022,000	\$273,000
2016	\$18,262,000	\$11,802,000	\$6,089,000	\$17,891,000	\$371,000
2017	\$18,439,000	\$10,892,000	\$6,964,000	\$17,856,000	\$583,000

Notes:

Current Program cost based on 8.5% discount rate assuming full prefunding of Annual Required Contribution.

Proposed Defined Contribution Program

- Funding Target – 95% of cost of Emeriti Medicare Supplement Plan 1 plus Emeriti Rx Plan 1 at age 65 .
- Funding Start Age – 40
- Funding Years – 25
- Vesting – 10 Years
- Annual Investment Return Assumed – 7%