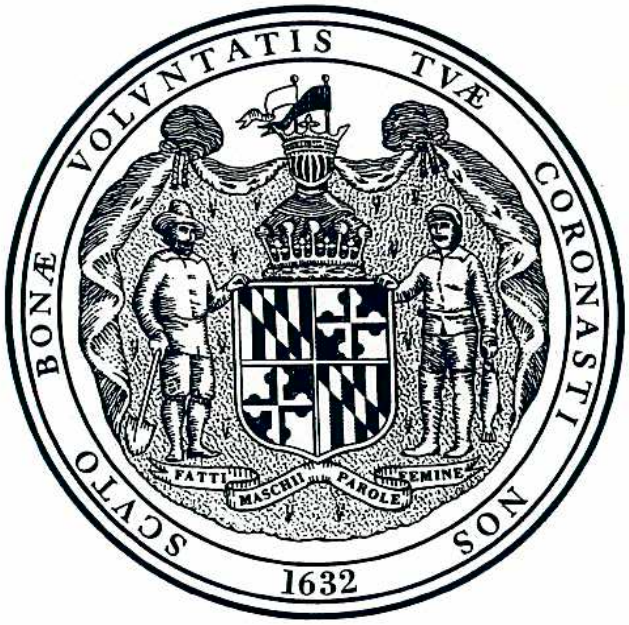
Task Force to Study Retiree Health Care Funding Options

2005 Interim Report



Annapolis, Maryland
December 2005

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF POLICY ANALYSIS
MARYLAND GENERAL ASSEMBLY

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December 23, 2005

The Honorable Robert L. Ehrlich, Jr.
Governor of Maryland
100 State Circle
Annapolis, Maryland 21401-1991

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, Maryland 21401-1991

The Honorable Michael E. Busch
Speaker of the House
101 State House
Annapolis, Maryland 21401-1991

Gentlemen:

On behalf of the Task Force to Study Retiree Health Care Funding Options created under Chapter 298 of the Acts of 2005, we respectfully submit this final report. This report completes the interim work of the task force to fulfill its broad charge to develop options for addressing the unfunded liability associated with retiree health benefits under Governmental Accounting Standards Board (GASB) Statement 45.

The task force held three meetings at which significant information was provided. This information included the valuation commissioned by the Department of Budget and Management as required by Chapter 298. The valuation performed by Aon Consulting showed that the unfunded accrued liabilities for State retiree health benefits are over $20 billion. The task force learned that to fully fund the GASB 45 requirements, the State would need to pay an additional amount of between $1.1 and $1.6 billion each year beginning in fiscal year 2008.

The task force recognizes that the magnitude of these liabilities are tremendous and that it will be difficult for the State to maintain the current level of retiree health benefits for all employees and retirees into the future. We further realize that significant additional study must be done to examine and evaluate all of the issues surrounding this problem as well as the potential solutions. At the same time, the State's historical approach to fiscal prudence which has resulted in Maryland's AAA bond rating was an important consideration to the task force.

For these reasons, a large majority of the task force members voted to support the following recommendations:

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- fiscal planning to address retiree health care liabilities should begin in fiscal 2007 through reserving approximately one half of the total funds that would be necessary to fund the normal costs associated with retiree health benefits by fiscal 2008; and

- because this addressing this issue will require serious and comprehensive additional study, a Blue Ribbon Commission should be established to further examine all of the issues so that a well reasoned and carefully drafted multi-year plan can be put into place as soon as is practical.

Thank for the opportunity to serve the citizens of Maryland in this important work. We would also like to thank the members of the task force and the staff at the Department of Legislatives for their hard work.

Sincerely,

Senator Edward Kasemeyer /NTW

Senator Edward Kasemeyer
Senate Chairman

Delegate Mary-Dulaney James /NTW

Delegate Mary-Dulaney James
House Chairman

Contents

Task Force to Study Retiree Health Care Funding Options

2005 Membership Roster

Senator Edward J. Kasemeyer, Co-Chair
Delegate Mary-Dulaney James, Co-Chair

Senator Patrick J. Hogan

Senator Donald F. Munson

Delegate Murray D. Levy

Delegate Susan L. Aumann

William Donald Schaefer, Comptroller of Maryland

Nancy K. Kopp, State Treasurer

Cecilia Januszkiewicz, Secretary of Budget and Management

John Kenney, the Comptroller's designee

Department of Legislative Services Staff
Anne E. Gawthrop
Victoria L. Gruber
Susan D. John
Elizabeth H. Moss
Michael C. Rubenstein

Summary and Recommendations

Background

Chapter 298 of the Acts of 2005 created the Task Force to Study Retiree Health Care Funding Options. The nine task force members were designated as follows:

- three members from the House of Delegates appointed by the Speaker of the House from among the members of the Joint Committee on Pensions;
- three members from the Senate appointed by the President of the Senate from among the members of the Joint Committee on Pensions;
- the Secretary of Budget and Management, or the Secretary's designee;
- the State Treasurer, or the Treasurer's designee; and
- the State Comptroller, or the Comptroller's designee.

Chapter 298 required the task force to commission an actuarial valuation through the Department of Budget and Management (DBM) of the liabilities associated with Government Accounting Standards Board (GASB) Statement 45. Chapter 298 provides that the task force is specifically charged to:

> develop options for addressing the unfunded liability associated with State retiree health care that will have to be included on the State's financial statements ... as a result of Governmental Accounting Standards Board Statement 45, and evaluate the costs associated with each option.

The Act provides that the Department of Legislative Services will provide staffing for the task force. Finally, Chapter 298 requires the task force to report to the Governor and the General Assembly by December 31, 2005. The task force is scheduled to terminate under Chapter 298 on December 31, 2005.

Task Force Meetings

The task force held three meetings at which significant information was provided. The agendas for these meetings are attached as **Appendix 1**. The subject matter discussed at the meetings included presentations on: requirements of GASB Statement 45; the State's financial

statement and the impact of GASB Statement 45; the State's Other Post Employment Benefits Actuarial Valuation; the State's legal obligations regarding retiree health benefits; retiree health benefits and the effect on local governments; health and prescription drug benefits in AAA-rated states; and the retiree health care liabilities prefunding status of other states.

State Retiree Health Benefits

The State of Maryland offers its retired employees a range of paid health insurance options. Benefits are available for retirees and their dependents both before and after they are eligible for Medicare. **Chapter 1** of this report provides an overview of the retiree health benefits currently provided, funding of retiree health care in recent years, and the recent response by the State. Additionally, the provisions of Maryland law regarding eligibility for retiree health benefits are outlined in **Appendix 2** of this report.

GASB Statement 45

Specifically, the GASB standards will require governmental employers to account for liabilities associated with the employers' commitment to what is referred to as Other Post Employment Benefits (OPEB) such as retiree health insurance. Moreover, under these standards, Maryland will be required to account for these OPEB liabilities on its balance sheets in fiscal 2008.

The benefits to be valued for the purposes of OPEB liabilities are the retiree health benefits as understood by the State and the employees. The financial reporting under GASB 45 provides that employers must commission an actuarial valuation of OPEB liabilities every two years. Once a valuation is done, an Annual Required Contribution (ARC) amount will be calculated that represents the annual payment by the employer that would be necessary to fund the normal costs accrued for that year (liability for current and future benefits earned by employees in that year) in addition to an amount that represents the amortization of any unfunded OPEB liabilities (benefits earned to the date of the valuation).

GASB 45 provides that the maximum amortization period for funding any unfunded OPEB liabilities is 30 years. GASB 45 does not require employers to make ARC payments to a trust similar to a pension trust fund. At the same time, however, to the extent that an employer makes contributions to an irrevocable trust similar to a pension trust fund, a long-term interest rate assumption can be used in calculating the liabilities instead of short-term rates. The effect of utilizing a long-term rate is a significant reduction in both the unfunded liabilities and the amount of the ARC.

The financial reporting required under GASB 45 provides that the difference between the employer contribution towards retiree benefits (including pay-as-you-go funding) and the ARC in a given fiscal year will establish a "Net OPEB Obligation" (NOO). The NOO will be included

on the employer's financial statement of net assets for that fiscal year. Once the NOO is established, an annual OPEB cost is calculated which represents the ARC plus interest on the NOO. This annual OPEB cost will be also be reported on the employer's financial statement as an expense.

The task force was provided with information on the specifics of the GASB 45 Statement in a presentation made by John Muehl and John Garrett, consulting actuaries with Milliman, USA. A copy of their presentation is attached as **Appendix 3**.

Actuarial Valuation of Retiree Health Liabilities

In compliance with the provisions of Chapter 298, the Department of Budget and Management contracted with AON Consulting for the actuarial valuation. The actuarial valuation completed by AON indicated that the State of Maryland's liabilities with respect to retiree health care under the GASB 45 are quite extensive. A copy of the actuarial valuation and the AON presentation are attached to this report as **Appendix 4**.

Specifically, in the report submitted by AON, the liabilities estimated for the actuarial accrued liability for retiree health benefits, defined as benefits earned as of the valuation date of July 1, 2005, is approximately $20.4 billion. AON also estimated that the $20.4 billion liability amortized over a 30-year period plus other specified costs required under the GASB standards will result in an ARC amount of $1.96 billion. This number incorporates the approximately $311 million in costs that the State would have been obligated to fund for retiree benefits. This means that the NOO, which is the additional amount that will appear on the State's financial statement, is $1.65 billion.

It should be noted that the $1.96 billion ARC estimate is based on a 5 percent rate of return. GASB 45 provides to the extent that a governmental employer prefunds the ARC for retiree health care liabilities in a trust fund similar to how Maryland funds the State Retirement and Pension System (SRPS), that the rate of return used can be the rate assumed by the trust fund. Accordingly, if the full ARC payment were made, the rate of return used by Maryland for retiree health care liabilities could be set at the 7.75 percent rate used in the SRPS which would lower the ARC to $1.45 billion.

While GASB 45 does not require prefunding, as stated above, the liabilities shown on the State's financial statement are significantly lower if there is a prefunding mechanism in place. Additionally, as discussed above, if the State fails to make the full ARC payment in a given year, the deficit will be added to the NOO discussed above and will appear on the State's financial statement.

The State's Financial Statement

The task force was briefed on the State's financial statement and health care costs by John Kenney, Director of the General Accounting Division in the State Comptroller's Office. The accounting for OPEB will be similar to the current accounting for pension benefits and liabilities. Mr. Kenney's presentation is attached as **Appendix 5**.

GASB 45 will require certain information to be reported by employers in the notes to the financial statements or as required supplemental information. Maryland has a single-employer plan and will be required to include the types of benefits provided to retirees, the authority under which the benefits are established (*i.e.*, State law), and whether the plan issues a separate set of financial statements. In most cases, a plan that issues its own financial statements would be a cost-sharing, multiple-employer plan as opposed to Maryland's single-employer plan.

The notes to the State's financial statements must include the required contribution rates of plan members and employer, either as a rate per member or as a percentage of payroll. For the current year and the two preceding years, the notes should include the current annual OPEB cost and the actual contributions made, the increase or decrease in the net OPEB obligation, and the net OPEB obligation at the year's end. Information about the funded status of the plan must also be disclosed, including the actuarial value of assets, accrued liability, and the value of assets as a percentage of the liability.

Legal Obligations of the State Relating to Retiree Health Care Benefits

The chairs of the task force requested a formal opinion of the State Attorney General on the obligations of the State regarding retiree health benefits. A copy of the request is attached as **Appendix 6**.

The task force was briefed by Assistant Attorney General Bonnie Kirkland who stated that her initial research of the issue indicates that the State has no contractual legal obligation to provide retiree health benefits. Therefore, it appears the advice of the Attorney General will be that if the State desired to change the level of retiree health benefits provided, the current statute could be amended to do so.

Retiree Health Benefits in Other States and Maryland Local Governments

As a governmental employer, Maryland is not alone with respect to the OPEB liabilities to be recognized under GASB 45. Any governmental employer who provides a commitment for a retiree health care benefits subsidy will be in a similar position. The task force was briefed by representatives of Howard County, the City of Hagerstown, and the City of Annapolis on their efforts to identify and address liabilities for retiree health care. **Appendix 7** provides the results of a Department of Legislative Services' survey of retiree health benefits offered by each county.

To allow comparison of the current position of the State of Maryland, particularly relative to other AAA-rated states, **Chapter 2** of this report provides a review of: retiree health benefits provided in other AAA states; the status of prefunding of retiree health benefits in other AAA states; as well the status of prefunding of retiree health benefits across the country.

Six states currently have a AAA bond rating – Delaware, Georgia, Missouri, Utah, and Virginia. Of the five AAA states surveyed by DLS, the level of benefits provided to retirees differs significantly with only one of the states, Delaware, offering retiree health benefits comparable to those offered by Maryland. Delaware offers a range of plan options similar to Maryland's, and its premium subsidy equals or exceeds Maryland's depending on length of service. DLS also surveyed Michigan which is a state with liabilities for retiree health that are similar to Maryland's. Michigan offers a more limited range of plan options, but the percentage of premium subsidy exceeds the Maryland subsidy.

Two AAA states, Virginia and Utah, offer a minimal subsidy for retiree health coverage, and therefore have negligible OPEB liabilities. Finally, Missouri's retiree health benefits fall between the generous benefits offered by the three AAA states and the minimal benefits offered by two AAA states. It offers a limited range of plan options and a variable premium subsidy that tops out at 65 percent.

The status of efforts to address prefunding retiree health benefits in other AAA states is quite varied. Delaware and Utah have commissioned an actuarial valuation of the liabilities associated with the GASB 45 standards. In Delaware, the actuarial valuation estimated the actuarial accrued liability for retiree health benefits is approximately $3 billion. A task force established by Executive Order in Delaware issued a report in October indicating a lack of consensus on the issue and recommending additional study.

Utah reported unfunded actuarial liabilities of $500 million. Virginia indicated that they have not commissioned an actuarial valuation relating to the GASB 45 requirements. Neither Missouri nor Virginia currently report the actuarial accrued liability for retiree health benefits. Virginia informally estimated that its liability would be less than $1 billion, while Missouri provided only the pay-as-you-go costs for 2005 – $54 million for retirees and $350 million for active employees. Michigan officials stated that the state has been reporting its actuarial accrued liability for retiree health benefits for the past five years, with liabilities for 2005 equal to approximately $18 billion.

Alternative Plans to Provide Retiree Health Benefits

The task force reviewed the various vehicles that can be used by employers to prefund the liabilities associated with retiree health benefits, to provide retiree health benefits, and to allow employees to save funds for health care expenses in retirement. **Chapter 3** of this report provides a brief summary of some of the most widely proposed alternatives for providing or funding retiree health benefits. These plan structures include: Voluntary Employee Benefit Associations (VEBAs) established under § 509 (c)(9) of the Internal Revenue Code (IRC);

accounts established under § 401(h) of the IRC; trusts established under § 115 of the IRC; Health Reimbursement Arrangements (HRAs); and Health Savings Accounts (HSAs).

Perspective of the Bond Rating Agencies – Presentation by Standard and Poor's

Mr. Parry Young, Public Finance Director at Standard and Poor's, presented the perspective of one of the bond rating agencies as to liabilities established under GASB Statement 45. Mr. Young indicated that while immediate rating changes are not anticipated, the bond rating agencies will be reviewing a number of factors after the effective date of the GASB 45 requirements. These factors will include: OPEB managerial credit factors; OPEB financial credit factors; and OPEB debt credit factors. The managerial factors will include a review of the methodology used for determining OPEB liabilities, whether the liabilities are a surprise to the employer, and whether the obligation to pay retiree health benefits is a firm legal obligation. Mr. Young also indicated that "once the OPEB liability and ARC numbers are known, management's plan to deal with them going forward will be of the utmost importance".

In terms of financial credit factors, the concern will be whether the government employer's budget can afford the OPEB ARC and whether the financial flexibility of the employer will be limited as a result. Finally, the debt credit factors will include evaluating whether the total cost for bond debt service, pension liabilities, and OPEB liabilities are sustainable.

Conclusions and Recommendations

Maryland's AAA debt rating stems from the State's historical fiscal prudence. Part of this prudence relates to the General Assembly's proactive approach to impending fiscal obligations and liabilities. The bond rating agencies have indicated that any new OPEB liability disclosures are not likely to result in any immediate changes in bond ratings, but it is clear that this issue will be one that the agencies will be watching. The State's long record of fiscal prudence has been an important consideration for the members of the Task Force on Retiree Health Care Funding in addressing this matter.

The task force recognizes that the magnitude of the liabilities associated with retiree health benefits is tremendous and it will be very difficult for the State to sustain the current level of retiree health benefits for all employees and retirees into the future. At the same time, although a clear legal obligation may not exist, great consideration should be given to perceived promises made by the State particularly with regard to the level of benefits provided to existing retirees or employees that have fully qualified for retiree health benefits under the current law.

The Spending Affordability Committee (SAC), which recommends to the Governor and the General Assembly a level of spending for the operating budget, included the following recommendation in the annual SAC report relating to retiree health care liabilities:

> The committee encourages the Governor to expeditiously develop a plan for reducing the State's retiree health insurance liability and allocate fund in the fiscal 2007 budget to begin resolving the problem. At a minimum, it is recommended that the Governor implement any recommendations of the Task Force to Study Retiree Health Care Funding Options.

The task force is cognizant that SAC has also recommended an 8.9 percent increase in spending, which is estimated to be sufficient to fund the baseline budget of the State as well as an increase in the Rainy Day Fund balance from 5 to 7.5 percent of general fund revenues. At the same time, the task force believes addressing OPEB liabilities can be accomplished in concert with the SAC recommendations and will require significant fiscal planning that should begin as soon as possible. To assist in this effort, SAC supports excluding funds allocated to address OPEB liabilities from the affordability calculations. Additionally, an extensive review should be undertaken that examines all of the issues affecting the problem and potential alternatives and solutions. **For these reasons, the task force makes the following recommendations to the Governor and General Assembly:**

Begin to Address the Issue by Prefunding the Normal Costs

The task force recommends that the State set a goal of funding normal costs for retiree health benefits beginning in fiscal 2008. To accomplish this goal, the task force recommends that the State set aside approximately one-half of the total funds required to meet this goal in the fiscal 2007 budget, approximately $161 million. Of this amount, $97 million would be General Funds and the remaining $64 million would be from Federal and Special Funds. This will allow the State to fund annual normal/service cost beginning in fiscal 2008, the first year GASB 45 liabilities will appear on the State's financial statement. The total normal/service cost in fiscal 2008, which includes retiree PAYGO costs, is approximately $650 million. This would fund the actuarial cost of all future retiree health benefits earned by current State employees in each fiscal year, but not the approximately $20 billion in unfunded accrued liabilities for benefits earned by State employees prior to fiscal year 2008.

As shown in **Exhibit 1**, the estimated normal/service cost for fiscal 2008 is $650 million, of which it is estimated that the State would already be paying approximately $320 million for current retiree health PAYGO costs. Of the remaining $329 million necessary to meet normal costs, $209 million would be General Funds, with Federal and Special Funds making up the remaining $120 million. It should be noted that the costs in Exhibit 1 are estimates based on payroll data and information provided in the valuation performed by Aon Consulting. The actual amounts may vary somewhat when the fiscal 2007 and 2008 budgets are introduced.

Because retiree health benefits accrue at a faster rate than the State payroll increases, the task force recommends that the State phase in annual increases in the percentage of payroll necessary to fully fund normal/service cost in fiscal 2008 and beyond. Exhibit 1 shows the estimates of the amounts necessary to cover normal/service costs through fiscal 2011 as well as the balance in the trust fund at the end of the period.

Exhibit 1

Begin by Funding Normal Costs
DLS Pro Forma Analysis

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Surcharge for GASB 45					
State Employee Salaries	4,029	4,190	4,358	4,532	4,713
GASB 45 Surcharge Rate	4.0%	4.0%	8.0%	8.0%	8.0%
Surcharge Amount	161	168	349	363	377
Additional Annual Costs					
Total Cost					
Additional for GASB	161	168	349	363	377
General Funds (60%) Cost					
GASB 45 Reserve	97	101	209	218	226

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Funding Model					
FY 2007 GASB Appropriation		161			
FY 2008 GASB Appropriation		168	349	363	377
Appropriation for Benefits Paid		320	350	380	400
Payment to Benefits Account		649	699	743	777
Payments from Account		320	350	380	400
Available to invest		329	349	363	377
Principal Balance			678	1,041	1,418

Source: Department of Legislative Services

Establish a Blue Ribbon Commission to Study the Issue Further

The task force also recommends legislation be introduced establishing an ongoing blue ribbon commission to further study the issue. Due to the complexity and high importance of this issue, the blue ribbon commission should be charged with considering the cost drivers of the liabilities as well as various alternatives to address the costs and alternatives which would allow the State to prefund the large liabilities while balancing the needs of State employees and retirees. The commission should also be charged with considering approaches with varied solutions that may be different for: employees who have already retired; fully vested employees; active employees who have not vested; and new employees who will be hired in the future.

The task force recommends that the commission be guided by a set of principles including:

(1) Recognition that the current method of funding retiree health benefits – funding solely on a PAYGO basis – is no longer a viable solution. At the same time, any solution, funding or otherwise, should treat employees, retirees, and taxpaying citizens fairly.

(2) In light of the enormity of the State's projected unfunded accrued liability for retiree health care of $20.4 billion and the potential effect on the State's bond rating, the ultimate goal should be to fully fund the obligations set forth under GASB 45.

(3) A clear message should be sent to the bond rating agencies that the State is taking this issue seriously and a multiyear plan that clearly articulates the State's commitment to address this issue should be put into place as soon as is practical.

(4) Any funding solution proposed by the commission will likely include some direct State appropriation. At the same time, however, the commission should pursue any and all viable funding sources, including the possibility of employee contributions during active service.

(5) The commission should consider the actual impact any changes in the employee and retiree health care program will have on the ARC and should look for appropriate cost efficiencies that maintain the quality health care coverage the State provides for retirees.

(6) Special consideration should be given to retirees who are already receiving benefits or employees who have already qualified (vested) for a full retiree health benefit under current law. Although it appears no legal obligation exists on the part of the State to provide retiree health benefits, the commission should view the commitment to provide retiree health benefits to these individuals as a moral one.

Membership

The task force recommends that the blue ribbon commission retain the same membership as established by Chapter 298 for the task force and recommends that the Governor and the General Assembly consider including the following individuals as members:

(1) members currently serving on the task force;

(2) the executive director of the State Retirement and Pension System;

(3) representatives from various State employee union groups; and

(4) members of the public with expertise that would assist in the commission's deliberations.

Duties and Responsibilities

The task force recommends that the blue ribbon commission be charged with continuing the study of the many challenges facing the State with regard to the GASB 45 standards, taking into account the fiscal, workforce, and bond rating implications. To accomplish this goal, the task force recommends that the commission contract with an actuarial consulting firm to provide ongoing services to the commission throughout its existence. Additionally, the task force recommends that DBM gather any data regarding health benefits and health benefit costs for employees and retirees that the commission requests to accomplish the duties charged to the commission.

The task force recommends that the commission be charged with the following duties:

(1) commissioning another actuarial valuation that illustrates the ARC as both a fixed dollar amount and also as a percentage of payroll;

(2) reviewing the specific legal obligations of the State to provide retiree health benefits to existing retirees, fully vested individuals, active employees, and new employees;

(3) studying the cost drivers associated with the State's unfunded retiree health care liabilities which provide the basis for the unfunded accrued liability of $20.4 billion as well as the ongoing normal/service costs;

(4) reviewing the current health care benefit levels for both employees and retirees and how the benefits compare to benefits provided under Medicare, by private employers and other public employers, with a particular emphasis on whether the various levels are appropriate, equitable, and sustainable;

(5) reviewing the eligibility requirements for retiree health benefits with a particular emphasis on whether the requirements are appropriate and equitable;

(6) reviewing alternative vehicles for providing health benefits to retirees including VEBAs, Section 401(h) accounts, Section 115 trusts, HRAs, and HSAs; and

(7) recommending a multiyear implementation plan to address fully funding the obligations of the State as set forth is GASB 45 as soon as is practical.

Chapter 1. State Retiree Health Benefits and Funding and GASB 45 Requirements

Introduction

In June 2004, the Government Accounting Standards Board (GASB) issued Statement No. 45 (GASB 45) requiring public employers to account for liabilities associated with subsidizing retiree health insurance. Maryland will be required to implement GASB 45 by fiscal 2008 when it must begin accounting for these liabilities on its financial statements. GASB 45 does not, however, require public employers to prefund retiree health benefits. This paper discusses the health benefits supplied to State retirees and the associated costs with Maryland's current funding method, the requirements of GASB 45, and the fiscal impact of moving to an actuarially funded plan.

Overview of Retiree Health Benefits in Maryland

Current Structure of Retiree Health Benefits

The State of Maryland offers its retired employees a range of paid health insurance options (see **Exhibit 1**). Benefits are available for retirees and their dependents both before and after they are eligible for Medicare.

State retirees and spouses must enroll in Medicare Parts A and B as soon as they are eligible, whether through age or disability. The State retiree benefit plan is a supplemental plan to Medicare when the retiree or spouse turns 65 or through certification of disability. The State plan covers only that portion of the hospital and medical bills not covered by Medicare. If the retiree or spouse does not enroll in Medicare, they are responsible for the claims costs that Medicare would have paid. A person who is certified by the Social Security Administration (SSA) and becomes eligible for Medicare 24 months after a disability also must enroll in Medicare Parts A and B as soon as that person is eligible.

Premium rates for medical coverage vary according to whether the retiree or the retiree's dependents are eligible for Medicare. For those not eligible for Medicare, the State retiree benefit is considered primary coverage, and the retiree is responsible for the same portion of the total monthly cost of coverage or the premium level as are active employees.

Exhibit 1
Retiree Benefit Options
July 1, 2005 through June 30, 2006

Plan Type	Benefit Options	State Subsidy
Medical Plan	2 Preferred Provider Organization (PPO) Plans 3 Point-of-service (POS) Plans 3 Health Maintenance Organization (HMO) Plans All medical plans include vision benefits but do not include either dental or prescription benefits.	PPO Plans: 80% of Monthly Cost POS Plans: 83% of Monthly Cost HMO Plans: 85% of Monthly Premiums
Prescription Plan	Available	80% of Monthly Cost
Dental Plan	2 Dental Health Maintenance Organization (DHMO) Plans 1 Dental Preferred Provider Plan (DPPO)	50% of Monthly Premiums
Mental Health/ Substance Abuse Plan	1 PPO Plan 1 POS Plan Mental health coverage is included in the HMO medical plans.	PPO Plans: 80% of Monthly Cost POS Plans: 83% of Monthly Cost
Term Life Insurance	Retirees can continue their coverage if they had already been enrolled in term life insurance as active employees.	Varies with age.
Long-term Care	Coverage for nursing home care, assisted living care, adult day care, etc. for covered members with activities of daily living or ADL certified disabilities.	Premiums are paid entirely by the retiree.

Source: Department of Budget and Management

"Pay-As-You-Go" Funding Approach to Retiree Health Insurance

The State's current practice is to finance the cost of retiree health benefits on a "pay-as-you-go" basis. That is, the funds necessary to cover the cost of the State subsidy for retirees' health, prescription, and dental insurance are budgeted in much the same way that active employee expenditures are budgeted. Each year, the State estimates and budgets the funds necessary to fully cover the cost of the State's share of health insurance for both retired and active employees.

Each budget year, agencies are instructed to calculate the amount charged for the State retiree health subsidy. Agency accounts are "billed" by the Central Payroll Bureau, and the funds are transferred to the Department of Budget and Management's (DBM) nonbudgeted account for health insurance. The funds budgeted for retirees are calculated as a percentage of active employee expenditures. In recent years, budgeted retiree health expenditures have been approximately 30 percent of active employee budgeted health expenditures. However, this budgeted State retiree health insurance subsidy is misleading.

As demonstrated in **Exhibit 2**, actual payments made to providers for claims made on behalf of retirees are higher than the 30 percent budgeted and are growing at a faster pace than active employees' claims payments. The actual State retiree total health subsidy, as a percentage of the actual total active employee subsidy, has increased from 41.1 percent in calendar 1999 to 48.7 percent in calendar 2004. Additionally, total payments made on behalf of active employees have grown approximately 11.6 percent annually since calendar 1999, while total payments made on behalf of retirees have grown approximately 15.4 percent.

The faster pace of growth for retiree payments is driven primarily by the growth in prescription insurance spending. Spending in calendar 2004 on retiree prescription insurance ($134.7 million) is almost as high as spending on retiree health insurance ($135.9 million). Further, since calendar 1999, the State is paying $79.6 million more (19.6 percent average annual increase) on behalf of retirees and $87.7 million more (18.1 percent average annual increase) on behalf of active employees for prescription insurance. In contrast, since calendar 1999, State spending for retiree health insurance has increased by $58.6 million, less than half the $138.3 million increase for active employee health insurance over the same period of time. Finally, Exhibit 2 reveals that in calendar 2004 the State paid more for retiree prescription insurance than it paid for retiree prescription, health and dental insurance *combined* in calendar 1999.

Exhibit 2
Active Employee and Retiree Health Insurance Payments to Providers
Calendar 1999 through 2004
($ in Millions)

	CY 1999	CY 2000	CY 2001	CY 2002	CY 2003	CY 2004**	Avg. Annual Growth Rate CY 1999-2004
Active Employee Payments							
Health*	$251.6	$260.2	$292.8	$334.3	$358.1	$389.9	9.2%
Prescription	67.7	83.7	100.5	118.8	134.1	155.4	18.1%
Dental	7.0	15.7	17.3	18.8	19.5	19.2	22.2%
Total	**$326.3**	**$359.5**	**$410.7**	**$471.9**	**$511.7**	**$564.5**	**11.6%**
Retiree Payments							
Health*	$77.3	$80.5	$93.3	$106.8	$118.3	$135.9	12.0%
Prescription	55.1	67.4	81.3	96.2	112.0	134.7	19.6%
Dental	1.7	2.7	3.1	3.4	3.9	4.3	20.5%
Total	**$134.1**	**$150.5**	**$177.6**	**$206.4**	**$234.2**	**$274.9**	**15.4%**
Retiree Payments, As a Percent of Active Employee Payments							
Health*	30.7%	30.9%	31.9%	31.9%	33.0%	34.9%	2.6%
Prescription	81.4%	80.5%	80.9%	81.0%	83.5%	86.6%	1.3%
Dental	24.0%	17.0%	17.6%	18.4%	20.1%	22.4%	-1.4%
Total	**41.1%**	**41.9%**	**43.3%**	**43.7%**	**45.8%**	**48.7%**	**3.5%**

* Includes mental health and vision coverage.

** Projected expenditures.

Source: Department of Budget and Management

GASB Statement No. 45

In General

GASB Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*, establishes standards for reporting of other post employment benefit (OPEB) plans. OPEB plans refer to the healthcare benefits provided to retired public employees. These standards include assets and liabilities, as well as disclosure of information about the funded status and funding progress of benefits of the plan.

GASB 45 is intended to improve the usefulness of financial reporting in two ways. First, it requires a systematic measurement and recognition of OPEB costs over a period that approximates employees' years of service (i.e., 30 years). Second, it requires employers to provide information about actuarial accrued liabilities associated with OPEB plans and whether progress is being made in funding the costs. The approach followed in GASB 45 is generally consistent with the current requirements of accounting and reporting for pension plans.

From an accounting perspective, the cost of OPEB plans, like the cost of pension benefits, should be associated with the periods in which the exchange of salaries and benefits for employee services are rendered, regardless of when those benefits are paid. Like Maryland, most state OPEB plans are currently financed on a pay-as-you-go basis. This means that the cost of benefits are not recognized when earned, and that there has traditionally been a lack of information about future liabilities and an employer's future cash flow demands.

Actuarial Measurements

Employers that participate in a single-employer defined benefit OPEB plan, which is the current structure in Maryland, will be required to have biennial actuarial valuations to determine the present value of total projected benefits, the employer's annual required contribution (ARC) to the plan, and any unfunded accrued liability. The present value of total projected benefits will include benefits to current retirees and beneficiaries, terminated employees entitled to benefits but not yet receiving them, and current active employees. Present value of total projected benefits is the initial investment at a prescribed investment return rate that provides sufficient assets to pay total projected benefits when due. This figure is the actuarial accrued liability (AAL). The actuarial value of plan assets is the actuarial value of assets (AVA). An unfunded accrued liability will result if the actuarial liabilities are greater than actuarial assets.

An unfunded accrued liability could result for several different reasons: (1) when transitioning to actuarial or prefunding methods, any benefits not fully pre-funded become unfunded; (2) actuarial gains and losses on assets; and (3) effects of changes in benefits structure provided to retirees. The annual required contribution to the OPEB plan is made up of a component for normal cost (costs of all benefits absent any unfunded accrued liability), and a component to amortize the unfunded actuarial liability over a period no more than 30 years.

Part of the normal costs of benefits included in the ARC will be the calculation of an implicit rate subsidy. An implicit rate subsidy occurs when the health insurance carrier charges the government a common or "blended" premium – the same premium for both active and retired employees. Normally, retired employees' premiums, if age adjusted, would be higher than the premium charged for active employees. Since the same rate is charged for both, active employees' premiums are actually subsidizing a portion of the higher retiree premium. The implicit rate subsidy will allocate a portion of this subsidy for retirees' premiums to the ARC.

Standards of Accounting

There is significant difference between the actuarial determined liability and assets of OPEB and any accounting liability, net OPEB obligation, recorded on the financial statements. In the first year of implementing the standard, the beginning liability recognized on the financial statements will be zero. The actuarially determined amounts will be disclosed in the notes of the financial statements. The only time that an accounting liability will be recognized on the government's financial statements will be when the government does not fully fund the ARC. Therefore, at the end of the first year of implementation, the liability will be the difference between the ARC and the government's actual contributions to the plan. Actual contributions to the plan will consist of (1) employer payment of benefits directly to or on behalf of retirees; (2) premium payment to an insurer; and (3) irrevocably transferred assets to a trust in which plan assets are dedicated to providing benefits and are legally protected from creditors of the employer, such as the accumulation of funds to be provided as required by Chapter 466 of 2004.

Annual OPEB expenditures will be recognized in the financial statements based on the ARC, one year's interest on the net OPEB liability, and an adjustment to the ARC for interest already included in that calculation for amortization of past contribution deficiencies. The expenditures should be charged to the appropriate funds depending on the distribution of retirees. That is, a portion of expenditures could be charged to general funds, special revenue funds, or enterprise funds depending on the funding arrangement when the retiree was an active employee.

Required Note Disclosures

GASB 45 also requires certain information to be reported in the notes to the financial statements or as required supplemental information. A plan description must include the types of benefits provided to retirees, the authority under which the benefits are established (i.e., state law), and whether the plan issues a separate set of financial statements. In most cases, a plan that issues its own financial statements would be a cost-sharing multiple employer plan as opposed to Maryland's single-employer plan.

The notes to the financial statements must include the required contribution rates of plan members and employer, either as a rate per member or as a percentage of payroll. For the current year and the two preceding years, the notes should include the current annual OPEB cost and the actual contributions made, the increase or decrease in the net OPEB obligation, and the net OPEB obligation at the year end. Information about the funded status of the plan must be disclosed including the actuarial value of assets, accrued liability, and the value of assets as a percentage of the liability. Finally, the notes to the financial statements must include a variety of information about the actuarial methods and assumptions used in the valuations.

Costs of Prefunding Retiree Health Benefits

The Department of Budget and Management (DBM) contracted with AON Consulting this year to perform an actuarial valuation of the liabilities for retiree health care benefits that would be faced by the State under GASB Statement 45. Maryland will be required to account for these liabilities on its balance sheets in fiscal 2007.

AON's report estimates retiree health benefits liabilities at approximately $20.4 billion. AON also estimated that the $20.4 billion liability amortized over a 30-year period plus other specified costs required under the GASB standards will result in an Annual Required Contribution (ARC) among of $1.96 billion. This number incorporates the $311 million in costs that the State would have been obligated to fund for retiree benefits. This means that if no additional contributions are made, the net obligation that will appear on the State's financial statement is $1.65 billion. This estimate is based on a 5 percent rate of return.

This estimate is significantly higher than the State's last estimate. In 2000, the State's pension actuary, Milliman, USA, preliminarily estimated that the actuarial liabilities associated with retiree health benefits in Maryland totaled approximately $3 billion. These cost estimates were derived from a 1998 study conducted by the Segal Company that provided 20-year cash flows for State spending on retiree health care.

In response to the escalating cost of the State's subsidy for postretirement health insurance, legislation was enacted in 2004 (Chapter 466) that established a special, off-budget retiree health insurance trust fund for the purpose of prefunding postretirement health insurance costs paid by the State. Initial funding for the trust will be provided by anticipated federal revenues associated with employer subsidies for retiree prescription drug insurance subsidies.

Anticipated Federal Revenues

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 established a voluntary prescription drug benefit as Medicare Part D. It is slated to begin providing comprehensive drug coverage in January 2006. Until then, the plan provides a discount prescription drug card, giving all Medicare enrollees a discount on prescription drugs and providing a subsidy to certain low-income enrollees.

Medicare Part D, a comprehensive drug coverage plan that begins in 2006, includes a $35 monthly premium, a $250 annual deductible, and 25 percent cost-sharing up to the initial $2,250 coverage limit. If an enrollee purchases additional drugs beyond the $2,250 limit, the enrollee must pay all costs of drugs between $2,250 and $3,600 the first year. If an enrollee spends more than $3,600, the enrollee is subject to 5 percent cost-sharing or certain low co-payments.

In an attempt to encourage group health plans to provide prescription drug coverage, plans that provide employment-based retiree health care coverage with a drug benefit at least

actuarially equivalent to the Medicare Part D plan will receive a federal subsidy per qualified employee. The subsidy is 28 percent of costs for coverage above $250 and up to $5,000 in 2006 for each individual who participates in the employer's retiree prescription drug benefits, and who is eligible but not enrolled in a Medicare prescription drug plan or Medicare Advantage (formerly Medicare+Choice) drug plan. The federal subsidy is 28 percent in 2006, and then indexed in out-years to the annual growth in average per capita spending by Medicare beneficiaries for Part D drugs. The federal subsidy to group health plans is intended to maximize employer-based prescription drug plan coverage. Group health plans may also pay Medicare Part D premiums for its retirees, or supplement Part D coverage.

Maryland's Response

To take advantage of this new federal subsidy, Chapter 466 of 2004 (SB 548) created a Postretirement Health Benefits Trust Fund under the direction of the Board of Trustees of the State Retirement and Pension System. Beginning in 2006, any subsidy received by the State that is provided to employers as a result of the federal Medicare Modernization Act or other similar federal subsidy must be deposited into the fund. For fiscal 2006 through 2016, no payments may be made from the fund. For fiscal 2016 and each fiscal year thereafter, the board must transfer monies to the general fund to defray the State's share of health benefit costs.

Chapter 444, the Budget Reconciliation and Financing Act of 2005, shifted the allocation of the federal revenue, for fiscal 2006 and 2007 only, from the Postretirement Health Benefits Trust Fund to a new special reserve fund for the purpose of funding the State Employee and Retiree Health and Welfare Benefits Program. Currently, approximately 21,975 Medicare-eligible retirees and dependents are enrolled in the various health plans. The federal Centers for Medicare and Medicaid Services (CMS) estimate that the average subsidy will be $611 per qualified enrollee. The State expects to receive $17 million in calendar 2006 from the federal subsidy. While it is anticipated that the federal subsidy to the State will continue beyond fiscal 2006, at this time it is uncertain if the subsidy will continue to be set at 28 percent or be adjusted from year to year.

Chapter 2. Overview of Health Care Benefits, Liabilities, and Prefunding Status in Other States

Background

Governmental Accounting Standards Board (GASB) Statement No. 45 will require the State to apply an accounting methodology similar to the one used for pension liabilities to Other Post Employment Benefits (OPEB), including retiree health benefits, beginning in fiscal 2008. For Maryland, the liabilities estimated for the actuarial accrued liability for retiree health benefits, defined as benefits earned as of the valuation date of July 1, 2005, is approximately $20.4 billion. This $20.4 billion unfunded actuarial liability amortized over a 30-year period plus other specified costs required under the GASB standard will result in an Annual Required Contribution (ARC) amount of $1.96 billion. This number incorporates the approximately $311 million in costs that the State would have been obligated to fund for retiree benefits. This means that the Net OPEB Obligation (NOO) which is the additional amount that will appear on the State's financial statement is $1.65 billion.

While GASB 45 does not require prefunding, as stated above, the liabilities shown on the State's financial statement are significantly lower if there is a prefunding mechanism in place. Additionally, if the State fails to make the full ARC payment in a given year, the deficit will be added to the NOO discussed above and will appear on the State's financial statement. There has been much discussion of the fact that Maryland is not alone among other states and governmental entities with respect to the OPEB liabilities to be recognized with respect to retiree health benefits under GASB 45. Any state or local governmental employer that provides a commitment for a retiree health care benefits subsidy will be in a similar posture. The bond rating agencies have indicated that these new liability disclosures are not likely to result in any immediate changes in bond ratings but it is clear that this issue will be one that the agencies will be watching. Further, as Maryland is one of six AAA-rated states, it is likely that Maryland's response will be compared to that of the other AAA-rated states.

To allow comparison of the current position of the State of Maryland, particularly relative to other AAA bond rated states, the Department of Legislative Services (DLS) has prepared this report which will provide overview of retiree health benefits provided in other AAA-rated states; the status of prefunding of retiree health benefits in other AAA-rated states; as well as some general information on the status of prefunding of retiree health benefits across the country.

Health Benefits in Other AAA-Rated States

As mentioned above, six states, including Maryland, currently have a AAA bond rating – Delaware, Georgia, Missouri, Utah, and Virginia. All of these states are currently funding retiree health benefits on a pay-as-you-go basis. In terms of a starting point for comparing the position

of Maryland to other AAA-rated states, DLS has surveyed the retiree health benefits level in five of these states and Michigan (which is reported as having liabilities similar to Maryland's), as this is the key component driving the liabilities for retiree health under the standards established by GASB 45.

As shown in **Table 1**, only Michigan and Delaware offer retiree health benefits comparable to those offered by Maryland. Delaware offers a range of plan options similar to Maryland's and its premium subsidy equals or exceeds Maryland's depending on length of service. Michigan offers a more limited range of plan options, but the percentage of premium subsidy exceeds the Maryland subsidy.

Two AAA states, Virginia and Utah, offer a minimal subsidy for retiree health coverage, and therefore have negligible OPEB liabilities. Virginia's retiree health benefit has not increased since 1992 and provides credit of between $60 and $120 per month depending on length of service. The $120 monthly amount is the maximum retiree health benefit that can be earned in Virginia after 30 years of service. Virginia retirees can apply the subsidy received toward health insurance premiums upon their retirement .

Prior to 2005, Utah's retiree health benefit consisted of "bridge" coverage provided to state employees who retire before Medicare eligibility. To reduced the liabilities associated with this retiree health benefit, Utah is phasing out its five-year "bridge" and replacing it with a defined contribution plan, making the state the only AAA-rated state that has taken steps to reduce OPEB unfunded liability by reducing retiree health benefits. In terms of the specific actions taken by Utah, under the state's former system, retiring employees received 25 percent of the value of unused sick leave in cash. From the remaining balance, retirees could then purchase health insurance from the state at the rate of 8 hours of unused sick leave for one month's premium. This benefit lasted five years or until Medicare eligibility, whichever came first. As health care costs increased, the state was unable to sustain its commitment to pay for retiree health benefits in exchange for unused sick leave. Under the changes enacted in 2005, the state deposits 25 percent of the value of unused sick leave into the retiree's 401(k) account, assigns a dollar value to the remaining unused sick leave based on the retiree's final salary, and deposits that amount into an interest-earning health savings account.

Finally, Missouri's retiree health benefits fall between the generous benefits offered by the three AAA-rated states and the minimal benefits offered by two AAA-rated states. It offers a limited range of plan options and a variable premium subsidy that tops out at 65 percent.

Prefunding Survey of AAA-rated States

The status of efforts to address prefunding retiree health benefits in other AAA-rated states is quite varied. Delaware and Utah have commissioned an actuarial valuation of the

liabilities associated with the GASB 45 standards. Appendix 1 also shows the liabilities estimated by each of the AAA-rated states, and Michigan.

In Delaware, the actuarial valuation estimated the actuarial accrued liability for retiree health benefits is approximately $3 billion. In May of this year, the Governor of Delaware established a task force by executive order. The task force concluded its study in September of this year but was unable to produce a consensus around any of the funding options that were considered.

Utah reported unfunded actuarial liabilities of $500 million. At this time, Michigan, Missouri, and Virginia indicated that they have not commissioned an actuarial valuation relating to the GASB 45 requirements. However, Michigan officials stated that the state has been reporting its actuarial accrued liability for retiree health benefits for the past five years, with liabilities for 2005 equal to approximately $18 billion. These liabilities include both state employees and teachers. Neither Missouri nor Virginia currently report the actuarial accrued liability for retiree health benefits. Virginia informally estimated that its liability would be less than $1 billion, while Missouri could only provide the pay-as-you-go costs for 2005 – $54 million for retirees and $350 million for active employees.

Comparative State Overview

Workplace Economics, Inc. is a Washington, DC economics consulting firm specializing in the application of economic and quantitative analysis to employment, compensation and benefits, and pension and retirement issues. To assess the potential impact of the new GASB standards, Workplace Economics examined retiree health care benefits currently provided in state government employment by the 50 states and practices employed by state governments to account for and finance their retiree health benefit obligations. The results of the study conducted by Workplace Economics are found in Appendices 2-4 and are summarized below.

Table 2 illustrates that while most states stipulate that their state employees are entitled to retiree health care coverage if they meet the service requirements to receive a retirement benefit, 17 states have additional requirements such as some minimum number of years of active service with the state or prior coverage in the health plan as an active employee. States also differ as to when a retiree may begin receiving health care coverage. For example, a dozen states require an individual to enroll within a limited time period, usually 30 to 90 days, surrounding the retirement date.

To develop a picture of the current size, funding, or costs of state retiree health care benefit plans, Workplace Economics reviewed each state's most recently available comprehensive annual financial report (CAFR) with respect to OPEB reporting. Each state's relevant annual reports were examined for the following categories of information:

1. the number of eligible retirees reported (generally as of mid-year 2001);[1]

2. the scope or nature of the retiree health care benefit program, particularly in terms of eligibility;

3. the reported percentage of employer contributions;

4. whether the state finances its retiree health care insurance obligations on a pay-as-you-go or prefunded basis; and

5. the most recent annual total cost reported by the state in connection with providing retiree health care insurance.

Table 3 details items 1-3 and **Table 4** details items 4-5.

At the time Workplace Economics conducted its study, 42 states reported providing some contribution towards defraying the cost of state retiree health insurance through programs covering more than 1.7 million retirees, with nine states not providing any information. (see **Table 4**). Appendix 4 illustrates that of these 41 states, 32 states financed these costs on a pay-as-you-go basis, while only 10 states reported a prefunding arrangement. **Exhibit 1** summarizes Appendix 5.

Exhibit 1
Summary of State Financing of Retiree Health Benefits
Fiscal 2001

Financing Method		States
Pay-as-you-go (no prefunding)	**32**	AL, CA, CT, DE, GA, HI, ID, IL, KS, LA, ME, MD, MS, MI, MN, MT, MO, NV, NJ, NM, NY, NC, OK, PA, RI, SC, TN, TX, UT, VA, WA, WV
Prefunding	**10**	AK, AZ, CO, FL, KY, NH, ND, OH, OK, WI
No data	**8**	AR, IN, IA, MS, NE, SD, VT, WY

Source: Workplace Economics, Inc.

[1] Data reported in state CAFR typically follow a fiscal year format; not every state or relevant reporting entity follows the same fiscal year.

Table 1.
Retiree Health Benefits in AAA-Rated States

Table 1. Retiree Health Benefits in AAA-Rated States

	Maryland	Delaware	Michigan*	Missouri	Utah	Virginia
Number of Retirees (2004)	31,539	18,374	41,397	15,995	30,292	65,153
Plan Options	2 PPO 3 POS 3 HMO	1 Basic plan; 1 traditional FFS; 1 PPO; 2 HMO	1 PPO Regional HMO	1 PPO Regional HMO	2005 Legislation phased out guaranteed five-year health coverage for retirees under age 65; replaced with defined contribution plan funded by unused sick leave	1 PPO, 1 Regional HMO
Vesting	5 years for partial benefit; 16 years for full benefit	10 years for partial benefit; 20 years for full benefit	10 years	Age 62 with 5 years of service	4 years	15 years for partial benefit; 30 years for full benefit
State Share of Premiums	Variable, depending on years of service and plan selected: Full subsidy given for 16 years of service; subsidy pro-rated for 5-16 years of service PPO-80% POS-83% HMO-85%	Variable, depending on years of service and plan selected For Basic Plan: <10 years-0% 10 years-50% 15 years-75% 20 years-100% For all other plans, retirees pay the difference between the premium for their selected plan and the	95% Medical 90% Vision 90% Dental	Variable, depending on Years of Service: Up to 65% for 26 years of service	Under former plan, retirees under age 65 exchanged 8 hours of unused sick leave for one month of health coverage paid for by the state, for up to 5 years or age 65, whichever came first; under new plan, unused sick leave is assigned a cash value based on retiree's final pay and deposited into his/her	Retirees earn state health insurance credit of $60 per month for 15 years of service, which can be applied toward premium for medical coverage; Credit increases $4/month for each additional year of service, up to $120/month for 30 years of service

*Michigan is not a AAA-Rated state but has liabilities similar to Maryland's

	Maryland	Delaware	Michigan *	Missouri	Utah	Virginia
		Basic Plan premium			health savings account	
Dental, Vision, and Prescription	Prescription coverage with low co-payments and Dental coverage available as add-ons, with 80% subsidy for premiums; Vision coverage included with all plans	Prescription coverage with variable co-payments included in all but the Basic plan; Dental and Vision coverage included in all plans	Prescription coverage with low co-payments included; Dental and Vision coverage available as add-ons with subsidized premiums	Prescription coverage with moderate co-payments included; Dental coverage available as add-on, but retiree pays full premium; Vision coverage not available (except COBRA for 18 months)	N/A	Prescription coverage with low co-payments is included; Dental and Vision coverage are available as add-ons for slightly higher premium
Post-Medicare Coverage	Coverage continues as Medicare supplement with subsidized premiums; Prescription and Dental available with subsidized premiums	3 Medicare supplements available; Same benefit rate applied (i.e., State pays full premium for retirees with more than 20 years of service)	1 Medicare supplement available; state pays full premium	Coverage continues as Medicare supplement; same subsidy applied	2 Medicare supplements available; Retiree pays full cost	1 Medicare supplement available; Dental and Vision continue to be available as add-ons; Retiree pays full cost, except for state credit ($60-120 per month)
Unfunded Liability (estimate)	$20.3 billion	$3 billion	$18 billion	Not available	$500 million	Less than $1 billion

Sources: DLS Review of Various State CAFRs and Retirement System Internet Sites

*Michigan is not a AAA-Rated state but has liabilities similar to Maryland's

Table 2.
Eligibility Requirements for Plan Participation Fiscal 2003

Table 2: Eligibility Requirements for Plan Participation, Fiscal 2003

State	Eligibility Requirements
Alabama	Those with 10 yrs. state service and receiving monthly benefit from Employees' Retirement System, Teachers' Retirement System or Judicial Retirement System.
Alaska	PERS retirees only. No cost to retiree if hired before 7/1/86 or to anyone age 65 or greater. Retirees first hired after 6/30/86 who retire prior to age 60 (or prior to age 65 with less than ten years of credited service for those first hired after 7/1/96) may receive retiree health care insurance by paying the full cost of the premium. Retirees first hired after 6/30/86 who retire at age 60-64 (or prior to age 65 with more than ten years of credited service) may receive retiree health insurance by paying half of the premium cost.
Arizona	Those retired and collecting a pension from an Arizona state retirement system.
Arkansas	State retirees.
California	Those retired within 120 days of separation from state job in which were employed at least ½ time for at least 6 months and one day. Retirees hired before 1/1/85 or retiring with at least 20 years service receive 100% of the state subsidy.
Colorado	Those receiving a benefit from the Colorado Public Employee Retirement System.
Connecticut	Health care benefit provided to all retirees.
Delaware	State pays 100% for retirees hired before 7/1/91. For those hired 7/1/91 or later, state pays portion based on service at retirement; retirees with less than 10 years service pay 100%.
Florida	Retirees eligible upon retirement from state service and enrollment in retire health plan. Eligible for subsidy upon proof of insurance coverage, which can include Medicare.
Georgia	Retired teachers, school personnel, state employees and dependents.
Hawaii	Retired members of state employee retirement system
Idaho	State employees eligible to retire under Public Employee Retirement System of Idaho (PERSI), whose unreduced regular retirement allowance at the time of retirement must equal or exceed the single retiree health insurance premium. Must enroll within 60 days of retirement.
Illinois	Those retired from state service with at least 8 years creditable service. State pays 100% of premium for retirees with at least 20 years service, and pays 5% per year of service for those retiring with less than 20 years.
Indiana	Pre-Medicare retirees may purchase continued coverage in state plan. No coverage in state plan past age 65.
Iowa	State retirees
Kansas	Recipients of retirement benefit through State of Kansas.
Kentucky	Retirees drawing a check from the KY Retirement Systems, Teachers Retirement System, Judicial Retirement Plan or Legislators Retirement Plan
Louisiana	Retirees of participant employers. Retirees must be vested in health insurance plan prior to retirement to receive maximum state subsidy of 75%.
Maine	State funds postretirement health care benefits for most state employees, legislators and portion of teachers' premium. State pays 100% of premium for retirees hired before 7/1/91 or for those with 10 or more years coverage in the state health plan.
Maryland	Health care coverage for those retired before 7/1/84, or those retired 7/1/84 or later with at least 5 years creditable service. State subsidy for retirees with at least 16 years creditable service, for those who directly retire from the state with at least 5 years and for employees who leave state service within 5 years of normal retirement age and with at least 10 years of creditable service. For less than 16 years, state pays 0.52% of subsidy for each month of creditable service; for 16 or more years of service state pays full subsidy equal to the amount of subsidy paid by the state for active employees.
Massachusetts	State retirees.
Michigan	Retirees of State Employee Retirement System, Judges Retirement System, State Police Retirement System and Legislative Retirement System. State pays 100% for retirees who were hired before 4/1/97 and are Medicare-eligible; 95 % if under 65. State pays 3% per year of service for retirees hired 4/1/97 or later. State pays 100% of premium for pre-Medicare retirees in the Legislative Retirement System.
Minnesota	State retirees. Must enroll within 60 days preceding retirement date.

Table 2: Eligibility Requirements for Plan Participation, Fiscal 2003

State	Eligibility Requirements
Mississippi	Retirees who, as active employees enrolled in plan, participate in retirement plan approved by Public Employees' Retirement System and have at least 25 years of creditable service, or are at least age 60 with 4 or more years service, or are approved for disability retirement benefits. Must enroll within 31 days of retirement date.
Missouri	Retirees who, at time of termination of state employment, were eligible to receive retirement benefit from Missouri State Employees' Retirement System or Public School Employees' Retirement System for State Employees, and have been covered under the state plan at least since the last enrollment period or have proof of coverage elsewhere for the prior 6 months. Must enroll no later than 31 days after retirement date.
Montana	Any employees eligible to retire from the Montana Public Employees Retiree Administration.
Nebraska	Pre-Medicare retirees may purchase continued coverage in state plan. No coverage in state plan past age 65.
Nevada	Retired state employees receiving a benefit from the Public Employees' Retirement System, Retirement Plan Annuities, Judges Retirement, Legislative Retirement, LTD plan, or their surviving dependents. Must enroll within 60 days.
New Hampshire	Those retired with at least 30 years of service at any age, or retired with 10 or more years of service if at least age 60, or retired from vested deferred retirement and are at least age 60, or attained age 60 after early retirement. For certain employees, retired from vested deferred retirement, at point when 20 years of service would have been completed but not before the age of 45. Effective 7/1/02, post-retirement medical plan subsidy was extended to state retirees age 60 with 20 or more years of service, or age 55-59 with 30 or more years of service.
New Jersey	State retirees. Retirees with 25 or more years of service receive 100% premium subsidy.
New Mexico	Those retired with normal or disability pension from public service before employers' effective participation date in the NM Retiree Health Care Authority, or with retiree and/or employer contribution to NM Retiree Health Care Authority for at least 5 years before retirement date, or retiree and/or employer contribution to NM Retiree Health Care Authority from date of employer's participation in program until retirement date. Must enroll within 31 days of retirement date.
New York	Those qualified to retire as member of a retirement system administered by NY State, with minimum 5 years state service if hired before 4/1/75 or minimum 10 years state service if hired 4/1/75 or later, and enrolled in state health plan at time of retirement. May defer coverage and reenroll later.
North Carolina	Retired state employees.
North Dakota	State pre-Medicare retirees can continue coverage in EPO through COBRA, then participate in state PPO at basic level if receiving retirement benefits. Medicare-eligible retirees may participate in ND Public Employee Retirement System Retiree Health Plan. Retirees with PERS, Highway Patrolman's Retirement System or the Defined Contribution Retirement Plan are eligible for credit.
Ohio	State retirees with at least 10 years service.
Oklahoma	Former employees already enrolled in one of the health plans. Must apply 90 days before retirement
Oregon	Pre-Medicare individuals receiving or eligible to receive a service retirement allowance may enroll in health plans through the Public Employee Benefits Board or PERS. Pre-Medicare state retirees may receive subsidy based on years of service. Upon attaining Medicare eligibility, retirees may enroll in a health plan through PERS within 90 days following retirement or after date of Medicare eligibility, or after 24 months of consecutive coverage under another group plan. Medicare-eligible recipients of PERS pension benefit with at least 8 years service at retirement may receive subsidy from Retirement Health Insurance Account.

Table 2: Eligibility Requirements for Plan Participation, Fiscal 2003

State	Eligibility Requirements
Pennsylvania	State annuitants who were covered under the health plan as an employee or dependent on his/her last day of work may enroll in the Retired Employees Health Program. State annuitants who become dependent subscribers under a spouse's coverage may re-enroll if the spouse's coverage ceases. Most state retirees with 25 years service and those retiring at the normal retirement age with 15 or more years of service qualify for 100% state subsidy.
Rhode Island	Retired state employees. State subsidy depends on age and service at retirement. Pre-Medicare subsidies: retirees with less than 28 years service must be age 60 to receive any subsidy; retirees with 28 years but less than age 60 receive 90% subsidy. 100% subsidy for retirees with at least 28 years and age 60 or older, or for retirees with 35 years service at any age. Medicare-eligible retirees receive full subsidy at age 65 with 28 or more years.
South Carolina	Covered employees may enroll within 31 days of retirement or during later open enrollment periods. To receive state funded benefits, must be eligible to retire with at least 5 years service with a participating state entity.
South Dakota	Former employees covered under the state health plan and who are entitled to immediate retirement benefits may continue coverage in the state health plan until age 65, then they may convert to the state sponsored Medicare supplement plan.
Tennessee	State retirees may retain coverage until age 65. At age 65, retirees may enroll in state sponsored Medicare supplement plans. For Medicare-eligible retirees, state pays $40/month for retirees with 30 or more years service, $30/month for retirees with 20-29 years service, $20/month for retirees with 15-19 years service and $0 for retirees with less than 15 years. Pre-Medicare retirees receive state contribution on same basis as active employees.
Texas	Retirees with at least 10 years of state service; state subsidizes full cost for individual coverage.
Utah	Retirees under 65 may continue coverage on same basis as active employees; coverage ends when retiree attains age 65 or after 5 years. Retirees attaining age 65 may enroll in high- or low-option Medicare supplement plan for which retiree pays full premium. Medicare members may only switch between low- and high-option every 2 years.
Vermont	Retiring employees may continue coverage by paying 20% share of premium.
Virginia	Retiring state employees who are eligible for annuity and will receive annuity immediately upon retirement may enroll in health plan within 31 days of retirement. Retirees are automatically enrolled in Advantage 65 Medicare supplement plan upon attaining age 65. Minimum 15 years of service at retirement required to receive commonwealth subsidy.
Washington	Retiring state, higher education, school district or political subdivision employees. Employees retiring under most state retirement plans must immediately begin receiving a retirement allowance. Employees retiring under PERS III, TRS III or SERS III must be age 55 with 10 years of service, and higher education employees must be age 55 with 10 years or age 62 or immediately begin receiving a retirement benefit in order to enroll in a state health plan.
West Virginia	Those meeting minimum eligibility requirements for retirement of applicable state retirement system, and whose last employer prior to retirement was participant in state health plan. Must enroll within 2 months after retirement. Maximum state subsidy for retirees with 25 or more years of service or those retiring before 7/1/97. Retirees with 20 or more years service may defer enrollment in health plan for up to 2 years following separation, but will be required to pay 105% of premium upon reenrollment.
Wisconsin	State retirees participating in a health plan at the time of retirement and who receive an annuity within 30 days of retirement will be automatically enrolled for continued coverage. Insured employees who terminate service with 20 years of creditable service but who are not immediately eligible for a retirement annuity, or who defer their retirement annuity may enroll by submitting an application with 90 days of termination of state service.
Wyoming	Retirees who had medical coverage under the state employer's plan for at least one year prior to retirement, and either: are at least age 50 on the retirement date, or have at least 20 years of service, or are eligible for state retirement benefits.

Source: Workforce Economics, Inc., 2004

Table 3.
Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Alabama	9,018 for age 65+ enrollees; 4,463 for retirees under 65	All retired state employees covered by the State Health Insurance Plan.	100% of the premium for retirees over age 65 and eligible for Medicare; portion of the premium for a retiree who is under 65.
Alaska	Number of state government employee retirees receiving health care benefits not reported in state CAFR. The number of PERS retirees and beneficiaries reported in PERS CAFR as of 6/30/01 was 14,185.	Health care benefits provided to retirees without cost for all employees hired before 7/1/86 and all employees who are disabled or age 65+, regardless of initial hire date; employees first hired after 6/30/86 (or those with less than 10 years of credited service if hired after 7/1/96) may receive postemployment health care benefits prior to age 60 by paying the full monthly premium; and by paying half of the monthly premium if they are between the ages of 60 and 65.	100% of the premium for retirees over age 65 and eligible for Medicare; portion of the premium for a retiree who is under 65.
Arizona	State CAFR reported approximately 38,000 coverage agreements for retired and disabled members and their families; group health insurance made available through Arizona State Retirement System (ASRS), a consolidated retirement system covering state employees, teachers, and local public employees. (It is estimated from ASRS's data that state employee retirees make up less than 1/3 of the system's total retirees).	Not reported in state CAFR. However, ASRS reports that for ASRS members electing ASRS health insurance coverage (only eligible for coverage and subsidy if retiree health insurance not available from former employer and retiree elects ASRS coverage), state retirement system offers a subsidized plan. Health insurance subsidy is graded depending on the retiree's length of service.	Not reported in state CAFR. Percentage subsidy reported by ASRS varies with employees' length of service, with highest amount paid for those retirees with 10 years or more of service—such retirees receive $150/month for retiree-only pre-Medicare coverage and $260/month for pre-Medicare family coverage (but rural, non-HMO accessible members receive $300/month and $600/month respectively) and $100/month for retiree-only Medicare coverage and $170/month for family Medicare coverage (but rural, non HMO accessible members receive $170/month and $350/month, respectively).

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Arkansas	Not reported in state CAFR, but state does subsidize retiree health care benefits for state employees.	Not reported in state CAFR, but state does subsidize retiree health care benefits for state employees.	Not reported in state CAFR, but state does subsidize retiree health care benefits for state employees.
California	110,132 annuitants are enrolled to receive health benefits and 89,134 annuitants are enrolled to receive dental benefits. In addition, 35,900 retirees of the University of California, receive University of California contributions for retiree medical and dental benefits.	Health care and dental benefits are provided by the primary government to annuitants of retirement systems to which the primary government contributes as an employer (CALPERS). To be eligible, first-tier plan annuitants must retire on or after age 50 with at least 5 years of service and second-tier annuitants must retire on or after age 55 with at least 10 years of service.	In FY2001 the state CAFR reported that the primary government generally paid 100% of the health insurance cost for annuitants, plus 90% of the additional premium required for the enrollment of family members and 100% of the dental insurance premium for annuitants.
Colorado	State retirees, together with the retirees of the other public employers such as schools and municipalities, participate in the Colorado Pubic Employees' Retirement Association (PERA), a statewide multi-public employer pension system that also provides a health care program, primarily to annuitants. At year-end 2001, the health care program had 35,235 enrollees of whom 10,798 were under age 65 and 24,437 were over age 65.	Enrollment is voluntary for PERA benefit recipients and includes all contributors to the plan, whether members of the state and school division of the Colorado PERA, the municipal division, or the judicial division. The Health Care Trust Fund of PERA provides a health care premium subsidy to participating PERA benefit recipients and their eligible beneficiaries who choose to enroll in the program.	The PERA Health Care Trust Fund provides a subsidy of up to $230/month for pre-Medicare enrollees and $115/month for Medicare enrollees. The maximum subsidy is based on the recipient having 20 years of service credit and the subsidy is reduced by 5% for each year of service credit under 20 years.
Connecticut	32,101 retirees of the State Employees Retirement System	Health care benefits provided to all retirees; amount of state payment determined by plan chosen by retiree; state also pays 100% of premium cost for a portion of employees' life insurance if continued after retirement.	State may pay up to 100% of retiree health care insurance premium, including dependent's coverage, based on the plan chosen by the retiree and the date of retirement.

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Delaware	16,308 state retirees	State reimburses substantially all validated claims for medical and hospitalization costs incurred by pre-Medicare retirees and their dependents. The state also paid a fixed amount of $237.37/month in 2001 for Medicare supplements for Medicare-eligible retirees.	State pays 100% for pre-Medicare retirees who retired prior to 7/91 and a portion that varies with length of on service for pre-Medicare retirees who retired after 7/91; those retirees who retired with 10 years or less of service credit are allowed to participate in the plan, but state pays no part of their premium costs.
Florida	166,111 Health Insurance Subsidy (HIS) recipients are retirees of the Florida Retirement System, a cost-sharing, multiple-employer pension system administered by the state that covers state employees, teachers, and other participating local public employers.	Retirees may participate in their former employers' group health insurance programs; in general, premiums are paid by retirees but retirees receive Health Insurance Subsidies of at least $50 but not more than $150 per month ($5/month for each year of creditable service at retirement to maximum of 30 years). Retirees are eligible for HIS upon proof of health insurance, which can include Medicare.	Percent varies with plan to which fixed dollar amount of subsidy is applied.
Georgia	60,935 retired employees received postretirement health care benefits through the State Health Benefits Plan.	A retiree is eligible for post-retirement health care benefits if he/she was a full-time employee at the time of retirement of either the state or a county social service agency and is receiving monthly benefits from either the Employees' Retirement System of Georgia or a county employees' retirement system.	Employees and retirees subject to the State Health Benefits Plan contribute amounts determined by the State Personnel Board for various insurance plans. The various agencies of the state contribute to the health insurance fund based on amounts recommended by the State Personnel Board and set forth in the Appropriations Act.

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Hawaii	State CAFR reported 22,100 state retirees receiving benefits.	State CAFR reported that as of 2001, the state paid all or a portion of pre-Medicare and Medicare-eligible health insurance premiums for retirees, depending on the retirees' retirement dates and length of active service.	For employees hired before 7/1/96, the state pays 100% of the monthly health care premium (Medicare or pre-Medicare) for retirees with 10 or more years of credited service, and 50% of the monthly health care premium for retirees with less than 10 years of credited service. For employees hired after 7/1/96, the state pays 100% of the monthly health care premium for retirees with 25 or more years of credited service, 75% for employees with at least 15 years of service but less than 25 years, 50% for employees with at least 10 years of service but less than 15 years, and 0% for employees with less than 10 years. Retirees covered by the medical portion of Medicare are also eligible to receive a reimbursement of the basic medical coverage premium .
Idaho	2,885 retired state employees receive retiree subsidies for health insurance	State employees who are eligible to retire under the Public Employee Retirement System of Idaho, and whose unreduced monthly pension benefit at the time of retirement would meet or exceed the monthly cost of single retiree health insurance may elect to have the state's retiree health insurance coverage for themselves and eligible dependents. There is also a separate sick leave/insurance conversion program available to reduce retiree costs.	Retirees pay the majority of the premium costs (unless they are participating in the sick leave/insurance reserve fund). For the subsidy program, the state contributes $7 per active non-retired employee per month and active employees contribute an equal amount that goes to a reserve to offset the monthly costs of the retirees' benefits. A separate benefit is available to retirees based on unused accumulated sick leave at retirement and is financed by state employer contributions of 0.65% of payroll to cover future insurance premiums.

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Illinois	79,300 state employee annuitants	State Employees Group Insurance Act requires that the state pay the cost of basic noncontributory health, dental, and life insurance benefits to annuitants who are former state employees; this includes annuitants of all of the state's retirement systems, except the non-state employee members of the Teacher's Retirement System (TRS). Although, since 1996, the state has contributed to a separate subsidy program available for TRS annuitants.	State pays for 100% of the cost of basic health and dental insurance. Retirees with less than 20 years of service receive 5% per year of service.
Indiana	Not reported in state CAFR.	Not reported in state CAFR.	Not reported in state CAFR. State does contribute 0% for retiree health care coverage.
Iowa	Not reported in state CAFR	Not reported in state CAFR.	Not reported in state CAFR. State does contribute 0% for retiree health care coverage.
Kansas	9,400 retirees	Benefits provided in accordance with rules and regulations of the Kansas State Employees Health Care Commission (HCC).	The HCC is responsible for the determination of the allocation of premium costs between participants and the state each contract year. In plan year 1996, the HCC made the decision that retiree participants should pay 100% of the costs of coverage; however, in view of rate increases assessed to participants, the HCC continued to use plan excess reserves to provide subsidies in-plan year 2001 ranging from $0 to $115 per month, depending on the level of coverage selected.

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Kentucky	7,744 pre-Medicare and 13,683 Medicare hospital and medical contracts were reported in Kentucky Retirement Systems 2001 CAFR.	The Kentucky Retirement Systems Insurance Fund provides insurance for members receiving benefits from the Kentucky Employees Retirement System, the County Employees Retirement System, and the State Police Retirement System.	The Kentucky Retirement Systems Insurance Fund pays a prescribed contribution for whole or partial payment of required premiums to purchase retiree health insurance. The amount of contribution paid by the Fund is based on years of service, with 100% paid for retirees with 20 or more years of service; 75% paid for retirees with 15 through 19 years of service; 50% paid for retirees with 10 through 14 years of service; 25% paid for retirees with 4 through 9 years of service; and 0% paid for retirees with less than 4 years of service.
Louisiana	26,840 retirees	State provides retiree health care benefits largely through the self-insured and self-funded State Employee Group Benefits Program (SEGBP). The SEGBP provides health care insurance or HMO coverage for both active and retired employees; it is financed by contributions from the state and participating employees. Upon retirement, substantially all employees become eligible for continuing health care benefits if they reach normal retirement age while working for the state.	Not reported in state CAFR. Estimated at approximated 75% in 2001.
Maine	7,039 retired eligible state employees and 6,027 retired eligible teachers	The state funds postretirement health care benefits for most retired state employees and legislators and for a portion of the premiums of teachers. Retirees eligible for Medicare are covered under supplemental insurance policies; retirees must pay for Medicare Part B coverage to be eligible to participate in the state-funded plan; coverage for retirees who are not eligible for Medicare includes basic hospitalization, supplemental major medical and prescription drugs, and costs for treatment of mental health problems, alcoholism, and substance abuse.	The state pays 100% of the health insurance premiums of state retirees who were first employed before 7/1/91 and, for retirees first employed after 7/1/91, a pro rata portion is paid, ranging from 0% for retirees with less than 5 years of service to 100% for retirees with 10 years or more of service. The state pays 30% of the health insurance premiums of retired teachers.

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Maryland	29,792 total participants reported	Health care benefits provided to employees who retired before 7/1/84, employees who retired on or after 7/1/84 with at least 5 years of service, and employees who receive disability retirement allowances or special death benefits.	The state subsidizes approximately 50% to 90% of covered medical and hospitalization costs, depending on the type of insurance plan.
Massachusetts	46,000 participants eligible to receive benefits	The Commonwealth is required to provide certain health care benefits for its retired employees; substantially all of its employees may become eligible for these benefits if they reach retirement age while working for the Commonwealth.	Eligible retirees are required to contribute a specified percentage of the health care benefit costs, which is comparable to contributions required from active employees. State pays 90% of premiums for retirees before 7/2/94 and more than 80% for retirees thereafter.
Michigan	40,369 total eligible state retiree participants	Health, dental, and vision benefits provided to retirees of the State Employees Retirement System (SERS), the Judges' Retirement System (JRS), the State Police Retirement System (SPRS), and the Legislative Retirement System (LRS).	The state CAFR reports that the state pays 95% of the pre-Medicare premiums for SERS, JRS, and SPRS retirees and 100% of the pre-Medicare premiums for LRS retirees. For employees hired before 4/1/97, the state pays 95% of the pre-Medicare premiums and 100% of the premiums for retirees who are over the age of 65 and Medicare-eligible; for retirees hired after 4/1/97 the state pays 3% of the premiums for each year of credited service at retirement.
Minnesota	1,100 former employees	For certain employees, post-retirement benefits are available upon retirement at age 55 under the terms of their employment contracts, other employees are eligible for limited window early retirement incentive programs; the state pays the employer's share of health insurance benefits until employees reach age 65.	Not reported in state CAFR. Other than in the case of early retirement incentive plans, the state contributes 0% for retiree health care coverage.

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Mississippi	Not reported in state CAFR. Estimated 14,000 retirees covered by Mississippi State and School Employee's Health Insurance Plan.	State law mandates that all state, public education, library, junior and community college, and retiring employees be offered health and life benefit coverage through MSSEHIP. In addition, the state's consolidated PERS offers a separate Medicare supplement plan.	Retirees and beneficiaries have option of maintaining health coverage at their own expense; the state incurs no expense for retirement health benefits according to state CAFR --the state contributes 0%.
Missouri	2001 Annual Report of the Missouri Consolidated Health Care Plan (MCHCP) showed 13,111 retirees meeting eligibility requirements.	Retirees who have state-sponsored medical insurance coverage for at least 2 years (or since first eligible) before they are eligible to retire may continue coverage into retirement.	Actual dollar amount of premiums paid varies by regional plan and length of employee service.
Montana	3,156 state retirees	State provides optional postemployment health care benefits to retirees and surviving dependents of deceased employees who elect to continue coverage and pay administratively established premiums that vary with the medical and dental plan selected.	0% premium contribution, but state does reimburse all validated medical claims less the annual deductibles and coinsurance of the plan selected.
Nebraska	Not reported in state CAFR.	Not reported in state CAFR.	Not reported in state CAFR, but state contributes 0% for retiree health care coverage.
Nevada	5,181 retirees covered	Any retiree of the state who meets the eligibility requirements for retirement and at the time of retirement is covered, or has dependents covered by any group insurance or medical and hospital service, has the option upon retirement of continuing that group insurance. The employer may pay all or any part of the cost of retiree health care coverage, but may not pay more than it does for its active employees.	State and retiree contributions varied in 2001 by years of service and plan selected; for retirements prior to 1/1/94 state paid 100% of the "base" state contribution rate; for subsequent retirements, the state paid 25% of the base amount for a retiree with 5 years of service plus 7.5% for each additional year of service to a maximum of 137.5% of the base rate; the retiree paid the remainder

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
New Hampshire	7,465 state retirees and covered dependents	Substantially all of the state's employees may become eligible for retiree health care insurance if they reach normal retirement age while working for the state (age 60) and receive their pensions on a periodic basis rather than in a lump sum. The state recognizes the cost of providing these benefits by paying the entire annual insurance premiums, with a portion paid by the New Hampshire Retirement System's (NHRS)medical premium subsidy.	State pays 100% of the premium; any payment of the subsidy may be "invisible" to the retiree as it is a transaction between the state and NHRS. Effective 7/1/02, the NHRS postretirement medical plan subsidy is extended to state retirees who retire at age 60 with 20 or more years of service, or who retire at ages 55 through 59 with 30 or more years of service; this subsidy is a fixed dollar amount that is greater for pre-Medicare retirees than for Medicare-eligible retirees and the premium subsidy increases by 8% each July 1.
New Jersey	51,482 retirees of the Public Employees Retirement System (PERS) and the Teachers' Pension and Annuity Fund (TPAF) retirees eligible for postretirement medical benefits; 4,236 state retirees who do not have their retiree health care benefits financed through PERS or TPAF; and 6,917 members of PERS and the Alternate Benefit Program who retired from a board of education or county college.	PERS and TPAF are required to fund postretirement medical benefits for those state employees who retire after accumulating 25 years of credited service or on a disability retirement. State law also requires coverage for those state retirees with 25 years or more of service who are not covered by PERS and TPAF funding. In addition, the state is responsible for providing free health benefits to members of PERS and the Alternate Benefit Program who retire from a board of education or county college with 25 years of service.	Generally 100% for employees with 25 or more years of service.
New Mexico	N/A	Retiree health care insurance provided through New Mexico Retiree Health Care Authority (NMRHCA). Eligible retirees are those who retired prior to 7/1/90 or those whose employer contributed to NMRCHA for at least 5 years prior to their retirement.	Subsidy for retirees with 20 or more years of service covers 50% to 78% of retiree-only premiums, depending on plan selected. Retirees receive prorated percentage of subsidy depending on their length of service (20 or more years of service qualifies retirees for full subsidy amount).

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
New York	113,888 retirees and dependents	Substantially all of the state's employees become eligible for retiree health insurance if they reach normal retirement age while working for the state.	For employees retiring prior to 1/1/83, the state pays 100% of retiree-only coverage and 75% of the cost of dependent coverage; for employees retiring after 1/1/83, the state pays 90% of retiree-only coverage and 75% of dependent coverage.
North Carolina	44,459 members of the Teachers' and State Employees' Retirement System and the Disability Income Plan of North Carolina, 258 members of the Consolidated Judicial Retirement System, 129 members of the Legislative Retirement System, and 705 members of the University Employees' Optional Retirement Program.	The state health plan provides postemployment health insurance to former employees of the state, the University of North Carolina system, community colleges, certain proprietary component units, and local education agencies that are not part of the reporting entity. These former employees are eligible to participate in either the self-funded comprehensive medical plan or one of the HMO plans. The health insurance is the same as for active employees, except that coverage becomes secondary when the former employees become eligible for Medicare.	State pays 100% of the premiums for pre-Medicare and Medicare retiree-only coverage, while the retiree pays for entire cost of spouse and dependent care coverage.
North Dakota	3,306 retirees receive benefits.	A retiree who is receiving benefits from the PERS, the Highway Patrolmen's Retirement System, or the Defined Contribution Retirement Plan is eligible to receive a credit based upon the retiree's years of service toward his/her monthly health insurance premiums under the state plan. The retiree health insurance credit is also available for early retirement.	Varies by length of retiree's service; benefits are equal to $4.50 per month for each year of credited service, not to exceed the premium in effect for the selected coverage.
Ohio	Number of state retirees receiving retiree health care benefit was not reported 2001 state CAFR. The number of PERS members eligible for OPEB as of 12/31/00 was 122,343.	All state age and service retirees with 10 or more years of service credit qualify for health care coverage under PERS. In addition, the State Highway Patrol Retirement System pays health insurance claims on behalf of all persons receiving monthly pensions or survivor benefits.	PERS plan pays 100% of the least expensive plan offered for pre-Medicare and Medicare retirees and most of the cost of spouse or dependent coverage.

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Oklahoma	13,543 eligible participants of the Oklahoma Public Employees Retirement System (OPERS), 402 eligible participants of the Oklahoma Law Enforcement Retirement System (OLERS), 90 participants of the Uniform Retirement System for Judges and Justices (URSJJ), 24,708 eligible participants of the Teachers Retirement System (TRS)of Oklahoma, and 2,142 eligible participants in 17 Higher Education institutions.	OPERS, OLERS, and URSJJ pay an amount equal to the Medicare supplement premium or $105 per month, whichever is less, for all retirees (pre-Medicare and Medicare-eligible) who elect coverage at the time of retirement through the Oklahoma State and Education Employees Group Insurance Board. TRS pays between $100 and $105 per month for each retiree, depending on the member's service.	Percentage varies by plan selected, inasmuch as state generally pays a fixed amount ($105)
Oregon	32,716 Retirement Health Insurance Account (RHIA) participants and 739 Retirement Health Insurance Premium Account (RHIPA) participants.	Oregon PERS members and their dependents are eligible for health coverage if they are receiving retirement allowances or benefits under PERS. To qualify for the RHIA premium subsidy, members must: (1) have 8 or more years of qualifying service in the PERS system at the time of retirement, (2) have coverage under both Medicare Part A and B, and (3) enroll in a PERS-sponsored health plan. State retirees, depending on length of service, who are not Medicare-eligible may receive a RHIPA premium subsidy equal to the average difference between the health insurance premiums paid by retired state employees and active state employees.	RHIA subsidy varies by plan selected, inasmuch as the state generally pays a fixed amount ($65 per month). RHIPA subsidy also varies by plan selected inasmuch as the state pays the average difference between the health insurance premiums paid by retired state employees and active state employees.
Pennsylvania	State provides retiree health care benefits for retired employees who meet certain specified length of service and age requirements. State CAFR reported that approximately 84,000 individuals were covered by these benefits in fiscal 2001.	State retirees are generally eligible for fully paid retiree health care if retired at age 60 with 15 years of service or if retired at any age with 25 years of service. Retiree health care program provided through Pennsylvania Employees Benefit Trust Fund.	State pays 100% of the cost for retirees at age 60 with 15 years of service or retirees at any age with 25 years of service.

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Rhode Island	3,517 retirees receiving benefits	Benefits cover medical and hospitalization costs for pre-Medicare retirees and Medicare supplements for Medicare-eligible retirees (retired state employees who are members of Employees' Retirement System of Rhode Island).	State share varies with years of service and ranges from 50% for retirees with 10 to 15 years of service to 100% for retirees with 35 years of service.
South Carolina	22,000 eligible retirees	Retirees are generally eligible for pre-Medicare and Medicare health benefits if they have established at least 5 years of retirement service credit. The state also provides postretirement dental benefits	Percentage varies by retiree health care plan, inasmuch as state generally pays a fixed amount; however, state contribution generally exceeds 85% of the cost of retiree-only premiums.
South Dakota	Not reported in state CAFR	Not reported in state CAFR	Not reported in state CAFR, but state contributes 0% for retiree health care coverage.
Tennessee	5,918 pre-Medicare retirees and 20,739 Medicare retirees	Retirees not eligible for Medicare may continue participation in state's Employee Group Insurance Fund (EGIF) plan covering active employees. Upon Medicare eligibility, the retirees are afforded the opportunity to participate in Medigap plans offered through a separate Medicare Supplement Insurance Fund.	For pre-Medicare retiree members of EGIF plan, percentages vary because retiree premium amounts vary by health care plan selected and retiree length of service, while state contribution is fixed at same dollar amount as for active employees, estimated to cover 60% to 80% of retiree-only premiums. For Medicare supplement, percentages vary because state contribution varies by retirees' length of service and retirees' premiums vary by plan selected ($40 per month maximum state contribution for retirees with 30 or more years of service).

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Texas	57,953 Employee Retirement System (ERS) retirees, 10,990 University of Texas System retirees, 5,119 Texas A&M University retirees, and 138,040 Teacher Retirement System (TRS) retirees	The state contributes a monthly amount for health care and life insurance for state (not school district) employee retirees covered by ERS or TRS; retirees with at least 10 years of state service are eligible for health and life insurance benefits. The University of Texas System and the Texas A&M University System provide separate postemployment health care and life insurance coverage to their retirees, surviving spouses, and beneficiaries. TRS administers a program that provides benefits to school district retirees with at least 10 years of service.	Generally, state pays 100% of retiree-only coverage for state employee retirees. TRS school district employee retiree-only coverage is fully covered at a basic level of coverage through contributions based on active payroll shared by the state and active school district employees. FY2001 state contribution rate was 0.50% of school district payroll and the active school employee contribution rate was 0.25% of school district payroll.
Utah	State CAFR reports 1,387 individuals in the program	If retired before age 65, the state continues to pay health insurance costs on same basis as for active employees until age 65 or for 5 years, whichever comes first; retirees may then use accumulated sick leave to pay for retiree-only health insurance coverage until age 65, spouse health insurance coverage until age 65, or after age 65, Medicare supplemental insurance for retirees or spouses.	State pays substantial portion of pre-Medicare premiums, but 0% of Medicare premiums.
Vermont	N/A	A retiree (disability, early, or normal) is entitled to receive medical coverage for himself/herself and their dependents over the lifetime of the retiree, with a portion of the cost paid by the retiree. If the retiree chooses the joint and survivor pension option and predeceases his/her spouse, the medical benefits also continue for the spouse along with the pension, however, the surviving spouse must pay 100% of the cost.	State pays 80% of the premium for both pre-Medicare and Medicare retirees.
Virginia	25,813 state retirees receive health insurance credits	The Retiree Health Insurance Credit Plan provides health insurance credits against the monthly health insurance premiums for pre-Medicare and Medicare-eligible retired state employees, state police officers, and judges with at least 15 years of creditable pension service.	Percentage varies by retiree. State contributes $4 per month per year of service for a retiree with at least 15 years of service, up to a maximum of 30 years of service (or $120 per month).

Table 3. Covered Retirees, Scope/Nature of Retiree Health Benefits Program, and Percentage State Contributed in Fiscal 2001 for Retiree Health Insurance Benefits

State	Number of Eligible Retirees Reported	Scope/Nature of State Retiree Health Benefits Program	Percentage State Contributed in FY2001
Washington	Not reported in state CAFR. Approximately 8,848 pre-Medicare and 24,300 Medicare estimated non-K-12 Public Employee Benefit Board (PEBB) plan members and 9,819 pre-Medicare and 21,406 Medicare K-12 retiree members.	Retirees "self-pay" their insurance premiums for plans provided by the PEBB, a part of the Washington Health Care Authority. However, eligible Medicare retirees (generally vested state retirement system members) receive fixed subsidies from the state towards the cost of premiums, while pre-Medicare employees receive "implicit subsidies" from pooling with active employees.	State pays 0% for pre-Medicare retirees. For Medicare retiree members of PEBB plan, percentages vary because retirees' premium amount vary by health care plan selected, while state contribution is a fixed dollar amount.
West Virginia	2,200 eligible retirees	State provides health care credits against the monthly health insurance premiums of certain retirees based on various factors (including unused sick leave at the time of retirement). Substantially all employees may become eligible for these benefits if they reach normal retirement age while working for the state.	Not reported in state CAFR. In addition to the sick leave conversion program, there is a varying amount of state subsidy depending on length of service and retirement date.
Wisconsin	8,754 annuitants receive health insurance coverage through sick leave conversion credits	At the time of eligibility for an immediate pension, the employee's accumulated sick leave balance may be converted at his/her current rate of pay to credits for the payment of health insurance premiums for the employee or the employee's surviving dependents. The program also provides partial matching of sick leave accumulation depending on years of service and employment category.	Not reported in state CAFR. However, generally 0%, except for application of sick leave conversion program.
Wyoming	Not reported in state CAFR.	Not reported in state CAFR.	Not reported in state CAFR, however, generally 0%.

Source: Workforce Economics, Inc., 2004

Chapter 3. Alternative Plans to Provide Retiree Health Benefits

There are a number of vehicles that can be used by employers to prefund the liabilities associated with retiree health benefits, to provide retiree health benefits, and to allow employees to save funds for health care expenses in retirement. Health care expenses at retirement have grown to become one of the largest areas of postretirement expenditures. Retirement planning companies have estimated that an individual who retires in 2005 at age 65 and lives to age 90 will need approximately $143,000 in assets to pay for Medicare Part B premiums and employment-based health benefits to supplement Medicare. This amount increases to $210,000 to cover approximately $1,800 of out of pocket expenses each year.[1]

Each of the different vehicles an employer considers to assist in funding retiree health benefits must be carefully structured to ensure compliance with relevant federal tax provisions in order to maximize the benefits of each option. The following is a brief summary of some of the most widely proposed alternatives for providing or funding retiree health benefits. These plan structures include Voluntary Employee Benefit Associations (VEBAs) established under § 509(c)(9) of the Internal Revenue Code (IRC); accounts established under § 401(h) of the IRC; trusts established under § 115 of the IRC; Health Reimbursement Arrangements (HRAs); and Health Savings Accounts (HSAs).

Voluntary Employee Benefit Associations

A VEBA is a trust created by an employer under § 509 (c)(9) of the IRC for the purpose of creating accounts for employees for the payment of life, health, or similar benefits. VEBAs may be structured in a number of fashions. Employers may choose to offer the ability to contribute to a VEBA as an option for employees to save in an account for retirement health expenses without any employer contributions. In some instances, VEBA accounts for employees have been funded with money equal to the cash-out of a certain percentage of unpaid sick leave at retirement.[2] VEBAs may also be structured as accounts on behalf of employees containing only employer contributions that will be used for the purpose prefunding employer retiree health obligations. Contributions by an employer to a VEBA must inure to the benefit of the employees and cannot be removed by the employer once they are made. The IRC prohibits the commingling of employer and employee contributions in a VEBA except for tax-exempt employers such as the State of Maryland.

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[1] *"Options and Alternatives to Fund Retiree Health Care Expenditures"* , TIAA-CREF Institute. Paul Fronstin and Paul Yaboski. July 2005.

[2] Washington State VEBA Program Overview, www.washington.edu/admin/hr/benefits/veba.html. The VEBA includes higher education librarians, professional staff, and staff represented by unions voting to join the plan.

For employees, their contributions to VEBAs are made with after-tax dollars which creates a disincentive for these types of plans; however, earnings on the contributions are not subject to tax and payments from the VEBA for health related expenses are tax free on distribution. There are limitations on employer contributions to VEBAs that include a requirement that contributions for benefit costs be made over the career of the employee and that contributions cannot include amounts for medical inflation. There is an unusual exception to these limitations that allows for medical inflation to be included if the plan is established under collective bargaining.

Additional IRC requirements related to VEBAs include a requirement that the trust be controlled either by employee members, by an independent trustee, or by a board of trustees that has employee members. Finally, the VEBA plan must receive approval from the IRS, and funds in a VEBA cannot be commingled with pension funds for investment purposes.

401(h) Accounts

Section 401(h) of the IRC allows employers with an established pension plan to establish a 401(h) account within the pension plan for the payment of retiree health benefits. Although the fund is separately accounted for within the pension fund, one advantage is that the funds in the § 401(h) account do not have to be segregated from pension funds and may be invested together with the pension fund assets.

Similar to pension fund assets, contributions to the § 401(h) account are deductible for the employer and earnings accumulate on a tax-free basis. Additionally, unlike distribution of pension benefits, the distribution of funds from the § 401(h) account to pay for health benefits for retirees are not taxable under the IRC. No funds from a § 401(h) account may be used to fund benefits for active employees.

The funds in a § 401(h) account do not have to be used solely to fund a traditional defined benefit plan for retiree health care. Funds from the § 401(h) account could also be used to make employer contributions for retiree health benefits under a defined contribution structure. This approach would allow an employer to use funds from the account to pay a specified annual amount towards a plan such as a flexible spending account (FSA) that allows reimbursement to the retiree for specified health expenses.

There are some technical limitations on § 401(h) accounts. One of the most complicated limitations is that contributions to the account must be "subordinate" to contributions with respect to the pension plan. This is specified under the IRC to limit the total employer contribution in the aggregate to the retiree health account to no more than 25 percent of the aggregate contributions to the pension plan. This subordination requirement clearly limits the ability of an employer with a fully funded or near fully funded pension plan to utilize a § 401(h) account to prefund retiree health benefits.

Section 115 Trust

A § 115 trust under the IRC is a trust that may be established by a governmental employer for the purpose of holding assets that are related to the exercise of an essential government function. The income on the assets in these trusts is tax exempt and the Internal Revenue Service has indicated that holding funds for the purpose of providing retiree health benefits is an acceptable use of a § 115 trust. A § 115 trust is revocable by the governmental entity and the amount of contributions are discretionary. Unlike VEBAs, these trusts do not have special requirements as to membership on the board of trustees.

In Maryland, Chapter 466 of 2004 (SB 548) created a Post Retirement Health Benefits Trust Fund which was designated as a § 115 trust under the direction of the Board of Trustees of the State Retirement and Pension System. The legislation provided that beginning in 2006, any subsidy received by the State that is provided to employers as a result of the federal Medicare Modernization Act or other similar federal subsidy must be deposited into the trust fund. The legislation also specified that for fiscal 2006 through 2016, no payments may be made from the fund and that for fiscal 2016 and each fiscal year thereafter, the board must transfer monies to the general fund to defray the State's share of health benefit costs.

Chapter 444, the Budget Reconciliation and Financing Act of 2005, shifted the allocation of the federal revenue, for fiscal 2006 and 2007 only, from the Postretirement Health Benefits Trust Fund to a new special reserve fund for the purpose of funding the State Employee and Retiree Health and Welfare Benefits Program. Currently, approximately 21,975 Medicare-eligible retirees and dependents are enrolled in the various health plans. The federal Centers for Medicare and Medicaid Services estimate that the average subsidy would be $611 per qualified enrollee. The State expects to receive $17 million in calendar 2006 from the federal subsidy. While it is anticipated that the federal subsidy to the State will continue beyond fiscal 2006, at this time it is uncertain if the subsidy will continue to be set at 28 percent or be adjusted from year to year.

Health Reimbursement Arrangements

Section 105 of the IRC provides a method for employers to contribute annually towards an account on behalf of employees that may be used for the tax free reimbursement of health expenditures postretirement or postemployment. Referred to as Health Reimbursement Arrangements (HRAs), these arrangements provide for the reimbursement of specific annual amounts for health expenses of eligible employees as defined by the employer based on age, length of service, or additional criteria.

The amounts allocated by the employer are not actually set aside in an account but are reimbursed by the employer when the employee incurs the expense up to the allocated amount each year. The employer does have the discretion, however, to provide that funds allocated under the arrangement that are not used at the end of each year may be rolled over and

accumulated over time. This would permit the amounts allocated by the employer to increase over time.

One significant limitation on HRAs is that employees are not permitted to make contributions. Prefunding of HRAs has not been fully investigated with the IRS; however, a HRA could be used to provide a defined benefit for retiree health care in conjunction with the establishment of prefunded retiree health care trust such as the ones described above. Fund from the trust could be distributed to HRAs on behalf of retirees based on years of service. The funds available in the HRA would then be used for reimbursement of a specified dollar amount of a retiree's health care premiums each year.

Health Savings Accounts

The federal Medicare Modernization Act of 2003 allowed for the creation of Health Savings Accounts (HSAs). These accounts are trust accounts to which an employee and employee may make tax-free contributions. Earnings on the amounts in the HSAs and distribution for qualified medical expenses are also not taxable.

These accounts are limited, however, to individuals who are covered under a "high-deductible health plan" defined as a plan with a deductible of at least $1,000 for an individual or $2,000 for a family. Additionally, contributions to the account are limited to the plan deductible amount and may not exceed $2,650 for individual coverage and $5200 for family coverage in 2005. Catch-up contributions of $600 are permitted in 2005 if an individual is at least 55 and not enrolled in Medicare.

Funds in an HSA are portable and may be rolled over from year to year to pay health expenses. However, payment of expenses for employment-based retiree health care premiums may not be made until age 65. Because these plans are often utilized by employees to assist in meeting high deductibles, it is not clear whether they will serve as an efficient vehicle to fund the payment of health expenses after retirement.

Appendix 1. Agendas

Task Force to Study Retiree Health Care Funding Options

Senator Edward J. Kasemeyer, Co-Chair
Delegate Mary-Dulany James, Co-Chair

Thursday, November 3, 2005, 1:00 p.m.
Senate Budget and Taxation Committee Room

Agenda

I. Call to Order and Chairmen's Opening Remarks

II. Overview of Retiree Health Care Benefits

- Vicki Gruber, Department of Legislative Services

III. Requirements of General Accounting Standards Board (GASB) Statement 45

- John Garrett, Consulting Actuary, Milliman USA
- John Muehl, Consulting Actuary, Milliman USA

IV. Briefing on the State's Financial Statement and the Impact of GASB Statement 45

- John Kenney, Director, General Accounting Division, Comptroller's Office

V. Report on the State's Other Post-employment Benefits (OPEB) Actuarial Valuation

- The Honorable Cecilia Januszkiewicz, Secretary, Department of Budget and Management
- Andrea Fulton, Executive Director, Department of Budget and Management's Office of Personnel Services and Benefits
- Catherine M. Furr, Senior Vice President, Aon Consulting
- David S. Boomershine, Senior Vice President, Aon Consulting
- Vicki L. Winters, Vice President, Aon Consulting

VI. Chairmen's Closing Remarks and Adjournment

Task Force to Study Retiree Health Care Funding Options

Senator Edward J. Kasemeyer, Co-Chair
Delegate Mary-Dulany James, Co-Chair

Thursday, November 21, 2005, 10:00 a.m.
Senate Budget and Taxation Committee Room

Agenda

I. Call to Order and Chairmen's Opening Remarks

II. Overview of legal obligations with regard to prefunding retiree health care benefits

Bonnie Kirkland, Attorney General's Office

III. County survey of health/prescription drug benefits

Sharon Greisz, Director, Office of Finance, Howard County
Timothy Firestine, Director, Department of Finance, Montgomery County
Alfred Martin, Finance Director, City of Hagerstown
Tim Elliott, Director, Department of Finance, City of Annapolis

IV. Overview of health and prescription drug benefits and the prefunding status of AAA-rated states

Michael Rubenstein, Department of Legislative Services
Anne Gawthrop, Department of Legislative Services

V. Alternative Plans to Provide Retiree Health Benefits

Vicki Gruber, Department of Legislative Services

VI. Chairmen's Closing Remarks and Adjournment

Task Force to Study Retiree Health Care Funding Options

Senator Edward J. Kasemeyer, Co-Chair
Delegate Mary-Dulany James, Co-Chair

Monday, December 12, 2005, 10:00 a.m.
Senate Budget and Taxation Committee Room

Agenda

I. Call to Order and Chairmen's Opening Remarks

II. Report on Various Options for the Task Force to consider with regard to prefunding retiree health care benefits

- Warren G. Deschenaux, Director, Office of Policy Analysis, Department of Legislative Services
- Anne E. Gawthrop, Department of Legislative Services

III. Briefing by Standard & Poor's on the position of bond rating agencies

- Parry Young, Director, Public Finance, Standard & Poor's

IV. Decisions

V. Chairmen's Closing Remarks and Adjournment

Appendix 2. Eligibility for State Retiree Health Benefits

Appendix 2. Eligibility for State Retiree Health Benefits

Relevant Definitions and Meanings in the State Personnel and Pensions Article:

- "Creditable service" means the service credit of a member that is recognized for computing a pension benefit in one of the State systems and for the purposes of retiree health benefits also includes:
  - service while employed by the Domestic Relations Division of Anne Arundel County prior to transfer into the State Personnel Management System; and
  - service while a member of the Maryland Transit Administration Retirement Plan.
- "Full State subsidy" means that an individual who qualifies is "entitled to the same State subsidy allowed a State employee".
- "Normal retirement age" in the State retirement system means:
  - age 62 in the Teachers' and Employees' Pension Systems;
  - age 60 in the Teachers' and Employees' Retirement System, Correctional Officers' Retirement System, Judges' Retirement System; or
  - age 50 in the State Police Retirement System or the Law Enforcement Officers' Pension System (LEOPS).
- "Retiree" does not include:
  - member of faculty or staff of a community college; or
  - teacher or staff member employed by a county board of education.
- "State service" means service with the State by:

- an employee while a member of the Employees' Retirement or Pension System or the Teachers' Retirement or Pensions System;
- a member of the Judges Retirement System;
- a correctional officer while a member of the Correctional Officers' Retirement System;
- a member of University of Maryland Medical System Corporation while a member of the Employees' Retirement or Pension System;
- a State police officer while a member of the State Police Retirement System or a law enforcement officer while a member of the State Law Enforcement Officers' Pension System; or
- an employee while a member of the Mass Transit Administration Plan.

Members of the State Retirement and Pension System:

Eligibility for the Full State Subsidy

Retiree is eligible for the full State subsidy if the retiree:

- left State service with at least 16 years of creditable service with the State;
- retired directly from the State with a disability retirement allowance; or
- left State employment prior to July 1, 1984.

Partial Pro-Rated Subsidy

Retiree is eligible for 1/16 of the State subsidy allowed a State employee for each year of the retiree's creditable service up to 16 years if the retiree:

- retired directly from State service with at least five years creditable service with the State; or

- left State service with at least 10 years State creditable services and within five years or normal retirement age.

Dependent Subsidy

The subsidy for a dependent of a retiree of the State Retirement and Pension System is the same full or partial subsidy as the retiree receives.

Members of the Optional Retirement Plan (ORP)

Eligibility for Full State Subsidy

Retiree is eligible for full State subsidy if the retiree was in service with a Maryland State institution at time of retirement and have at least 16 years of service

Partial Pro-Rated Subsidy

Retiree is eligible for partial pro-rated subsidy if the retiree was in service with a Maryland State institution at time of retirement and:

- had at least 5 years' State service with a Maryland State institution of higher education; or

- had at least 10 years of service and was a least age 57.

Optional Retirement Plan Dependent Subsidy

Full State subsidy for eligible dependents of the ORP if the retiree has at least 25 years of service with the State in the Executive, Judicial or Legislative Branch

ORP retirees with less than 25 years of service may enroll eligible dependents but must pay the entire cost between the individual coverage premium and the full premium for the higher level of coverage.

Appendix 3. GASB Statement No. 45. Overview and Considerations

State of Maryland
Task Force to Study Retiree Health Care Funding Options

GASB Statement No. 45
Overview and Considerations

November 3, 2005

State of Maryland
Task Force to Study Retiree Health Care Funding Options

GASB Statement No. 45
Overview and Considerations

Milliman, Inc.

John Muehl, Consulting Actuary
John Garrett, Consulting Actuary

Topics

- Overview of GASB #45
- Actuarial Valuations
- Financial Reporting
- Key Considerations

GASB #45 Overview

What **benefits count as OPEB?**

- Postemployment benefits other than pension benefits
  - Medical, dental, hearing, vision
  - Life insurance, long-term care
- Benefits as understood by employers and employees (Substantive Plan)

GASB #45 Overview

What is the objective of GASB #45?

- Accrual basis recognition of OPEB costs
- Disclosure of OPEB actuarial accrued liability
- Provide information on funding progress

When is GASB #45 effective?

- Fiscal year beginning after 12/15/2006 (FYE 2008)

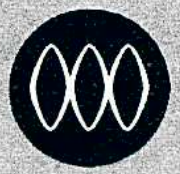
Plan Structures for GASB #45

- **Single Employer**
  - Formal Trust or not
- **Agent Multiple-Employer**
  - Formal Trust or not
- **Cost-Sharing Multiple-Employer**
  - Formal Trust required

Note: Plans without formal trusts will have $0 valuation assets

Actuarial Valuations

- **If plan administered through a formal trust**
  - Plan performs valuation
  - Plan assets can accumulate in the trust
  - Interest assumption based upon plan investments (if employers policy is to continually contribute the ARC)
- **If no formal trust –**
  - Employer performs valuation
  - No plan net assets
  - Interest assumption based on return of employer assets used to pay for OPEB – Short term rate



GASB #45 Financial Reporting

- **Annual Required Contribution (ARC)**
  - In accordance with valuation parameters
  - Normal cost plus amortization of unfunded accrued liability
- **Employer contributions toward the ARC**
  - Employer payments for benefits or premiums
  - Amounts transferred to an irrevocable trust

GASB #45 Financial Reporting

- **Net OPEB Obligation (NOO)**
  - Accumulated differences in ARC and actual employer contributions
  - Recognized as year-end liability
- **Annual OPEB cost equals:**
  - ARC plus interest on NOO plus an ARC adjustment

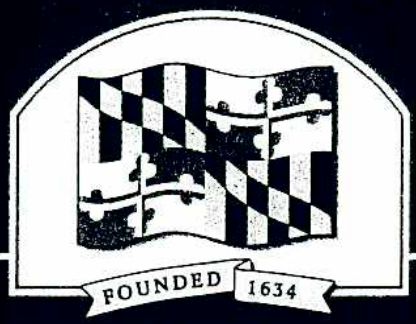
Key Considerations for GASB #45

- **Is the plan administered by a formal trust?**
  - Investment return assumption
  - Plan Assets vs. Employer Assets
- **What is the plan's structure?**
  - Cost-Sharing Multiple-Employer advantage
    - ARC is the contractual (statutory) required contribution
    - If contracted amount paid, net OPEB obligation is zero
    - Cost-sharing pools risks and administrative costs

Additional Considerations

- **What type of formal trust?**
  - IRC 401(h), VEBA, Section 115
  - None are perfect
- **Long Term Strategy**
  - Long term problem needs long term solution
  - Important to bond ratings agency

Appendix 4. State of Maryland GASB Valuation



MARYLAND

STATE OF MARYLAND

Postemployment Benefits
other than Pension
Actuarial Valuation

October 2005

Submitted by:
Aon Consulting
111 Market Place
Baltimore, Maryland 21202

AON

AON

October 14, 2005

The Honorable Cecilia Januszkiewicz
Secretary of Budget & Management
Office of Secretary
Department of Budget & Management
45 Calvert Street
First Floor
Annapolis, Maryland 21401-1907

This report presents the July 1, 2005 Actuarial Valuation results for the retiree health benefits (medical, prescription drug, behavioral health, dental and vision) provided through the ***State Employee Health Benefits Program ("the Plan").*** The purposes of this report are to:

(1) Determine the Plan's July 1, 2005 obligations;

(2) Determine the State's 2006 Fiscal Year accrual as if the *Governmental Accounting Standards Board (GASB)* standard is adopted for this Fiscal Year based on GASB Statements 43 and 45; and

(3) Provide information that may be helpful in future planning for the Plan.

A summary of the major results is shown in the Executive Summary, while the Principal Valuation Results Section provides more detail.

The Accounting Information Section summarizes GASB Other Postemployment Benefit (OPEB) accounting treatment including the 2006 fiscal year Annual Required Contribution (ARC), Annual OPEB Cost (AOC) and projected June 30, 2006 Net OPEB Obligation (NOO).

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This report's costs and liabilities are based upon the data and Plan Provisions provided by the State, as summarized in the Demographic Information and Plan Provisions Sections, respectively, and the funding method and actuarial assumptions outlined in the Methods and Assumptions Section of this report. This report presents our best estimate of the costs of the Plan in accordance with accepted actuarial principles and our understanding of GASB Statements 43 and 45.

Respectfully,

Aon Consulting, Inc.

David S. Boomershine
Member of the American
Academy of Actuaries
Senior Vice President
Consulting Actuary

Catherine M. Furr
Member of the American
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/vjh

Table Of Contents

Executive Summary

The ***State of Maryland ("the State")*** provides medical, prescription drug, behavioral health, dental and vision benefits to retirees and their covered dependents. The State pays a portion of the cost for retirees, disabled retirees, spouses and dependents. All active employees who retire or are disabled directly from the State and meet the eligibility criteria will participate.

The State also offers life insurance and long term care to retirees. Since these benefits are completely paid by the retirees, there is no GASB 45 liability for the State.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 was enacted on December 8, 2003. As a result of this legislation, employers providing drug coverage to Medicare eligible members, that is at least actuarially equivalent to the standard benefit provided by Medicare, will receive a federal subsidy, starting January 1, 2006.

Aon has determined that the State's drug coverage for retirees is better than actuarially equivalent to Medicare's standard coverage in 2006. A reduction in liability for the subsidy is reflected in the results.

This summary identifies the value of benefits at July 1, 2005 and costs for the 2006 Fiscal Year:

	July 1, 2005		
	Initial Results ($ billions)	**Medicare Prescription Savings ($ billions)**	**Final ($ billions)**
Present Value of all Projected Benefits	27.406	2.980	24.426
Present Value of Benefits Earned to Date (Actuarial Accrued Liability)	22.903	2.528	20.375
2006 FY Annual Required Contribution (ARC) * +			1.959
2006 FY Annual OPEB Cost +			1.959
2006 FY Expected Benefit Premiums +			0.311

* **The Annual Required Contribution reflects a 30-year, level amortization of the Unfunded Actuarial Accrued Liability.**

\+ **Reflects reduction in cost due to Medicare Part D subsidy, starting January 1, 2006.**

Executive Summary (continued)

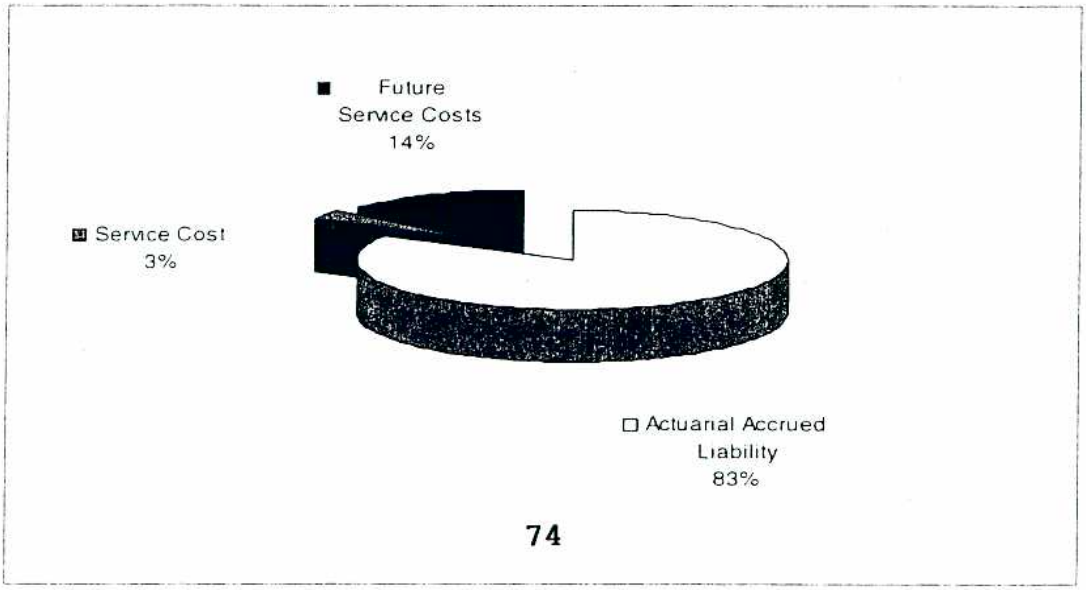
This section presents detailed valuation results for the State's Plan.

- The ***Present Value of all Projected Benefits*** is the total present value of all expected future benefits, based on certain actuarial assumptions. The Present Value of all projected benefits is a measure of total liability or obligation. Essentially, the Present Value of all projected benefits is the value (on the valuation date) of the benefits promised to current and future retirees. The Plan's present value of all projected benefits (at July 1, 2005) is $24.426 billion. The majority of this liability is for current active employees (future retirees).

- The ***Actuarial Accrued Liability*** is the liability or obligation for benefits earned through the valuation date, based on certain actuarial methods and assumptions. The Plan's Actuarial Accrued Liability (at July 1, 2005) is $20.375 billion. The majority of this obligation is for active employees. The Actuarial Accrued Liability represents approximately 83% of the present value of all projected benefits.

- ***Service Cost*** is the value of benefits expected to be earned during the year, again based on certain actuarial methods and assumptions. The 2006 Fiscal Year Service Cost is $633.7 million.

The following graph illustrates the Present Value of all Projected Benefits, the yellow area representing the Actuarial Accrued Liability in total:



Executive Summary (continued)

The results were calculated based upon plan provisions, as provided by the State, along with certain demographic and economic assumptions as recommended by Aon with guidance from the GASB statement.

Demographic Assumptions

Data was provided by the State as of July 1, 2005. Demographic assumptions used to project the data are the same as those used to value the pension liabilities under GASB 27. There is no assumption for future new hires.

Economic Assumptions

The GASB statement requires that the discount rate used to determine the retiree healthcare liabilities should be the estimated long-term yield on the "investments that are expected to be used to finance the payments of benefits". Since the State does not pre-fund the retiree healthcare liabilities, the discount rate should be based on the portfolio of the State's "general assets" used to pay healthcare benefits:

Asset Class	Target Allocation %
Repurchase Agreements (Repos)	75
1 - 3 Year Treasuries or Agencies	25

This portfolio could suggest a 3.0% to 4.0% discount rate (actual return for the period July 1, 2004 through June 30, 2005 was 2.26%). However, Aon recommends using a rate closer to the required rate under the Financial Accounting Standards Board No. 106 (FAS 106) to value postretirement healthcare benefits for private employers. FAS 106 discount rates as of July 1, 2005 were 5.0% to 5.25%. Aon recommends the lower end of this range, 5.0%, to be conservative.

The trend assumption is used to project the growth of the expected claims over the lifetime of the healthcare recipients. The GASB statement does not require a particular source for information to determine healthcare trends, but it does recommend selecting a source that is "publicly available, objective and unbiased".

Executive Summary (continued)

Aon developed the trend assumption utilizing the short term rates expected on the State plan along with information in published papers from other industry experts (actuaries, health economists, etc.) suggesting a 5.0% long term trend rate for all healthcare benefits except dental.

The balance of this report provides greater detail for the above results.

Principal Valuation Results

The following highlights the State's recognition of the above amounts:

- The July 1, 2005 assets are $0.
- The 2006 FY Annual Required Contribution (ARC) is $1.959 billion. *
- Expected 2006 FY benefit payments are $311million. *

**** Reflects reduction in cost due to Medicare Part D subsidy, starting January 1, 2006***

The following table shows results by active, deferred vested and retired employee groups:

	Initial Results ($ billions)	Medicare Prescription Savings ($ billions)	Final ($ billions)
Present Value of Projected Benefits			
Actives	17.904	1.821	16.083
Deferred Vesteds	2.758	0.428	2.330
Retirees	6.744	0.731	6.013
Total	**27.406**	**2.980**	**24.426**
Actuarial Accrued Liability			
Actives	13.401	1.369	12.032
Deferred Vesteds	2.758	0.428	2.330
Retirees	6.744	0.731	6.013
Total	**22.903**	**2.528**	**20.375**
Assets			0.000
Unfunded Actuarial Accrued Liability			20.375
Service Cost			0.634

Accounting Information

The effective date for the new GASB OPEB Accounting Standard is the Fiscal Year beginning July 1, 2007. Adoption before the 2008 Fiscal Year is optional. The following shows the Annual Required Contribution (ARC), Annual OPEB Cost (AOC), and projected June 30, 2006 Net OPEB Obligation (NOO), assuming the accounting standard is first adopted for the 2006 Fiscal Year.

Annual Required Contribution (ARC)

The proposed Standard sets the method for determining the State's postemployment benefits accrual, the Annual Required Contribution (ARC), to include both the value of benefits earned during the year (Service Cost) and an amortization of the Unfunded Actuarial Accrued Liability. Accordingly, the following table shows the State's 2006 Fiscal Year Annual Required Contribution (ARC) based on a 30-year amortization of the Unfunded Actuarial Accrued Liability as a level dollar amount.

Fiscal Year Ending June 30, 2006	
	($ billions)
Service Cost	0.634
Unfunded Actuarial Accrued Liability Amortization	1.325
Annual Required Contribution (ARC)	1.959

Accounting Information (continued)

Annual OPEB Cost (AOC)

If there is no OPEB obligation on the State's financial statements at transition, then the Annual OPEB Cost is equal to the Annual Required Contribution. However, if there is an initial obligation at transition, the Annual OPEB Cost should reflect an adjustment for the transition obligation. Note that the GASB OPEB Statement, in general, directs sponsors to set their Initial OPEB Obligation to zero at transition. However, this may result in inconsistent accounting results. We recommend you discuss this issue with your auditors if an obligation is currently recorded on your financial statements.

	($ billions)
Annual Required Contribution (ARC)	1.959
Adjustment to Annual Required Contribution	0
Total Annual OPEB Cost (AOC)	1.959

Annual OPEB Cost Summary (After adoption, a 3-year display will be shown):

Fiscal Year Ending	Annual OPEB Cost ($ billions)	Percentage of Annual OPEB Cost Contributed *	Net OPEB Obligation ($ billions)
6/30/2006	1.959	15.88%	1.648
* Based on expected benefit payments for the applicable fiscal year end.			

Accounting Information (continued)

Projected June 30, 2006 Net OPEB Obligation (NOO)

Based on the Annual OPEB Cost developed above, the following is the projected June 30, 2006 Net OPEB Obligation (NOO):

	Total ($ billions)
July 1, 2005 Net OPEB Obligation (NOO)*	0.000
Annual OPEB Cost (AOC)	1.959
Expected Premium Payments	0.311
Expected June 30, 2006 Net OPEB Obligation (NOO)+	1.648

*** Assumes July 1, 2005 Net OPEB Obligation is $0.**
+ Actual reserves would use actual 2006 FY benefit payments.

Required Supplementary Information

Below is the projected schedule of funding progress:

Valuation Date	Actuarial Value of Assets ($ billions) (a)	Actuarial Accrued Liability – Projected Unit Credit ($ billions) (b)	Unfunded Actuarial Accrued Liability ($ billions) (b) – (a)	Funded Ratio (a) / (b)	Covered Payroll (c)	Unfunded Actuarial Accrued Liability as a Percentage of Covered Payroll (b) – (a) / (c)
7/1/2005	0	20.375	20.375	0.00%	Not Available*	Not Available*

* *Required disclosure at adoption of standard. Covered payroll not collected from the State for this initial analysis.*

25-Year Payout Projection

Annual payments expected based on assumptions and contributions detailed in the Methods and Assumptions Section.

Year Ending	Total ($ billions)
6/30/2006	0.311
6/30/2007	0.369
6/30/2008	0.442
6/30/2009	0.526
6/30/2010	0.621
6/30/2011	0.722
6/30/2012	0.823
6/30/2013	0.919
6/30/2014	1.018
6/30/2015	1.116
6/30/2016	1.208
6/30/2017	1.289
6/30/2018	1.367

Year Ending	Total ($ billions)
6/30/2019	1.444
6/30/2020	1.521
6/30/2021	1.595
6/30/2022	1.667
6/30/2023	1.736
6/30/2024	1.799
6/30/2025	1.858
6/30/2026	1.914
6/30/2027	1.963
6/30/2028	2.008
6/30/2029	2.044
6/30/2030	2.076

Sensitivity Analysis

Results in this report are based on a 5.0% discount rate. This rate was selected based on the long-term expected returns on Funds. The following shows the impact of a 0.5% increase and a 0.5% decrease in the discount rate (i.e. discount rate increase/(decrease) to 5.5%/4.5%).

	5.0% Discount Rate ($ billions)	Impact of 0.5% Interest Rate	
		Increase - 5.5% ($ billions)	Decrease - 4.5% ($ billions)
Present Value of Projected Benefits	24.426	22.129	27.073
Funded Status:			
Actuarial Accrued Liability	20.375	18.651	22.337
Assets	0.000	0.000	0.000
Unfunded Actuarial Accrued Liability	20.375	18.651	22.337
Annual Required Contribution (ARC):			
Service Cost	0.634	0.557	0.724
Unfunded Accrued Liability Amortization	1.325	1.283	1.371
Annual Required Contribution (ARC)	1.959	1.840	2.095

Demographic Information

The following table summarizes active, deferred vested and retiree demographic information.

	Participants	Dependents	Total
Actives:			
Currently Receiving Healthcare Benefits	66,420	59,778	126,198
Not Receiving Healthcare Benefits	11,357	10,222	21,579
Deferred Vested	18,315	13,738	32,053
Retirees:			
Currently Receiving Healthcare Benefits	34,432	21,208	55,640
Not Receiving Healthcare Benefits	8,112	5,479	13,591
TOTAL	**138,636**	**110,425**	**249,061**

Summary Of Principal Plan Provisions

MARYLAND STATE RETIREMENT SYSTEM RETIREES

Retiree Healthcare Eligibility Criteria

Maryland State employees are eligible to continue health insurance coverage after retirement if they are receiving a monthly State Retirement allowance, and meet one of the following criteria:

- Left State service with at least 16 years of Creditable Service with the State;
- Retired directly from State service with at least 5 years of Creditable Service with the State;
- Left State service (with a deferred retirement allowance) with at least 10 years of State Creditable Service and within 5 years of Normal Retirement age;
- Retired directly from State service with a Disability Retirement allowance; or
- State employment ended prior to July 1, 1984.

Full State Subsidy (Retirees and Dependents)

A State employee who retires with 16 or more years of Creditable Service or who receives a Disability Retirement, or who left State service prior to July 1, 1984 receives the full State subsidy provided to an active employee.

Partial State Subsidy (Retirees and Dependents)

A State retiree otherwise eligible for health benefits with at least 5 years, but less than 16 years of Creditable Service receives a pro-rated subsidy.

Summary Of Principal Plan Provisions (continued)

MARYLAND STATE RETIREMENT SYSTEM RETIREES

Coverage of Spouse and Dependent After Death of Retiree

Surviving beneficiaries and dependents of deceased State retirees who are covered under any of the State sponsored health plans have the right to continue coverage upon the death of State employee/retiree providing they:

- Are receiving a monthly State retirement allowance as the surviving beneficiary of a deceased retiree who had selected Retirement Option 2, 3, 5 or 6; and
- Meet the dependent eligibility criteria for health benefits.

The eligible beneficiary will be provided the same state subsidy that was provided to the retiree.

Summary Of Principal Plan Provisions (continued)

OPTIONAL RETIREMENT PROGRAM RETIREES

Retiree Healthcare Eligibility Criteria

There are special rules governing the eligibility and costs of health benefits for the Optional Retirement Plan retirees, including Teachers Insurance and Annuity Association – College Retirement Equities Fund (TIAA-CREF), Valic, Aetna and American Century.

Optional Retirement Program employees are eligible to continue health insurance coverage after retirement, if they retired directly from a Maryland State Institution of higher education and:

- Had at least 5 years of State service with a Maryland State Institution of higher education; or
- Ended State services with a Maryland State Institution of higher education with at least 10 years of service and were at least age 57; or
- Ended service with a Maryland State Institution of higher education with at least 16 years of service.

Optional Retirement Plan retirees who did not retire directly from a Maryland State Institution of higher education, but meet other eligibility requirements above, may participate in the State Retirees Health Benefits Program, but with no State subsidy. Optional Retirement Plan retirees with at least 25 years total years of service with the State, in the Executive, Judicial or Legislative Branch, are not required to retire directly from a Maryland State Institution of higher education in order to participate in the Health Benefits Program with full State subsidy.

Summary Of Principal Plan Provisions (continued)

OPTIONAL RETIREMENT PROGRAM RETIREES

Full State Subsidy (Retirees Only)	Available to retirees who have at least 16 years of service with a State Institution of higher education, and retire directly from service with the State Institution of higher education.
Partial State Subsidy (Retirees Only)	Available to retirees who have at least 5, but less than 16 full years of service with a State Institution of higher education, and retire directly from service with a State Institution of higher education.
Dependent Subsidy	Full State subsidy for eligible dependents is available for retirees who have at least 25 years of service with the State in the Executive, Judicial or Legislative Branch.
Coverage of Spouse and Dependent After Death of Retiree	Upon the death of an Optional Retirement Plan retiree with at least 25 years of State service, the named beneficiary may continue coverage with the State subsidy, provided that the beneficiary continues to receive a periodic distribution under an Optional Retirement Plan and meets dependent eligibility requirements for health benefits.

Summary Of Principal Plan Provisions (continued)

MEDICAL PLANS

Benefit	PPO		POS		HMO Coverage (All care must be preauthorized)
	In-Network Coverage	Out-of-Network Coverage	In-Network Coverage	Out-of-Network Coverage	
Deductibles					
Individual	None	$250	None	$250	None
Family	None	$500	None	$500	None
Out-of-Pocket Maximums					
Individual	None	$3,000	None	$3,000	None
Family		$6,000		$6,000	
Lifetime Maximums*	***Any fees above the Plan Allowed Amount are not counted toward the Out-of-Pocket** The Lifetime Maximum per each covered individual (i.e. per employee or retiree, spouse, and child) is $2 million per lifetime, for PPO and POS membership. Unlimited for the HMOs.				
Physicians					
Primary Care Office Visit	100% after $15 co-pay	80% after deductible	100% after $15 co-pay	80% after deductible	100% after $15 co-pay
Specialist Office Visit	100% after $25 co-pay	80% after deductible	100% after $25 co-pay	80% after deductible	100% after $25 co-pay
Routine Annual GYN Exam (including Pap test)	100% after $15 co-pay	80% after deductible	100% after $15 co-pay when preauthorized by Plan	80% after deductible	100% after $15 co-pay when preauthorized by Plan
Inpatient Care (Requires Preauthorization)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

Summary Of Principal Plan Provisions (continued)

MEDICAL PLANS

Benefit	PPO		POS		HMO
	In-Network Coverage	Out-of-Network Coverage	In-Network Coverage	Out-of-Network Coverage	Coverage (All care must be preauthorized)
Outpatient Care (may require Preauthorization)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Hospitalization	100% for 365 Days	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan
Surgery (subject to Preauthorization)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Anesthesia Services	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Maternity Benefits	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Newborn Care	100%	80% after deductible	100% for enrolled newborn when preauthorized by Plan	80% after deductible	100% for enrolled newborn when preauthorized by Plan

Summary Of Principal Plan Provisions (continued)

MEDICAL PLANS

Benefit	PPO		POS		HMO
	In-Network Coverage	Out-of-Network Coverage	In-Network Coverage	Out-of-Network Coverage	Coverage (All care must be preauthorized)
Diagnostic Lab and X-Ray	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Urgent Care Centers	$20 co-pay	80% after deductible, plus $20 co-pay	$20 co-pay	80% after deductible, plus $20 co-pay	$20 co-pay
Emergency Room (ER) Services – Inside and Outside of Service Area	100% after $50 co-payment for ER Facility Care and $50 co-payment for ER Physician services. Co-payments are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus the two $50 co-payments.	100% after $50 co-payment for ER Facility Care and $50 co-payment for ER Physician services. Co-payments are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus the two $50 co-payments.	100% after $50 co-payment for ER Facility Care and $50 co-payment for ER Physician services. Co-payments are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus the two $50 co-payments.	100% after $50 co-payment for ER Facility Care and $50 co-payment for ER Physician services. Co-payments are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus the two $50 co-payments.	100% after $50 co-payment for ER Facility Care and $50 co-payment for ER Physician services. Co-payments are waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus the two $50 co-payments.

Summary Of Principal Plan Provisions (continued)

MEDICAL PLANS

Benefit	PPO		POS		HMO Coverage (All care must be preauthorized)
	In-Network Coverage	Out-of-Network Coverage	In-Network Coverage	Out-of-Network Coverage	
Mental Health/Substance Abuse * *Of APS's negotiated fee maximun*	100% * for inpatient care preauthorized by Plan. Outpatient care - 80% * visits 1-5; 65% * visits 6-30, 50% * visits 31 + per calendar year.	80% * for inpatient care preauthorized by Plan. Outpatient care - 40% * visits 1-5; 32.5% * visits 6-30, 25% * visits 31 + per calendar year.	100% * for inpatient care preauthorized by Plan. Outpatient care - 80% * visits 1-5; 65% * visits 6-30, 50% * visits 31 + per calendar year.	80% * for inpatient care preauthorized by Plan. Outpatient care - 40% * visits 1-5; 32.5% * visits 6-30, 25% * visits 31 + per calendar year.	100% care up to 365 days for inpatient care preauthorized by Plan. Outpatient care - 80% visits 1-5; 65% visits 6-30, 50% visits 31 + per calendar year.
Mammography	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Immunizations	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Physical Exams: 1 every 3 years for all members and their dependents age 13 and older	100% after $15 co-pay	80% after deductible	100% after $15 co-pay if preauthorized by Plan	Not Covered	100% after $15 co-pay for exam when preauthorized by Plan

Summary Of Principal Plan Provisions (continued)

MEDICAL PLANS

Benefit	PPO		POS		HMO
	In-Network Coverage	Out-of-Network Coverage	In-Network Coverage	Out-of-Network Coverage	Coverage (All care must be preauthorized)
Vision – Medical	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist)	80% after deductible	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist) when preauthorized by Plan	80% after deductible	100% after $15 co-pay (primary care physician) or $25 co-pay (specialist) when preauthorized by Plan
Vision – Routine	Plan pays up to: ➢ Exam - $45 (available once every plan year) ➢ Prescription Lenses (per pair) – (available once every plan year) ⇒ Single Visions - $28.80 ⇒ Bifocal, Single - $48.60 ⇒ Bifocal, Double - $88.20 ⇒ Trifocal - $70.20 ⇒ Aphakic: Glass - $54.00 ⇒ Plastic - $126.00 ⇒ Aspheric - $162.00 ➢ Frames - $45 (available once every plan year) ➢ Contacts (per pair, in lieu of frames and lenses) – (available once every plan year) Medically necessary - $201.60 ⇒ Cosmetic - $50.40				

Summary Of Principal Plan Provisions (continued)

PRESCRIPTION DRUG PLAN

	$
Annual Out-of-Pocket Maximum (Family)	700
Generic	
Retail (up to 45 day supply)	5
Retail (46-90 day supply)	10
Mail Order (up to 90 day supply)	10
Preferred Brand Name	
Retail (up to 45 day supply)	15
Retail (46-90 day supply)	30
Mail Order (up to 90 day supply)	30
Non-Preferred Brand Name	
Retail (up to 45 day supply)	25
Retail (46-90 day supply)	50
Mail Order (up to 90 day supply)	50

Summary Of Principal Plan Provisions (continued)

DENTAL PLANS

Dental HMO

Service Type	
Class I (Diagnostic and Preventive)	100%
Class II (Basic)	Schedule copayment
Class III (Major)	Schedule copayment
Class IV (Orthodontic for Adults and Children)	Schedule copayment
Orthodontic Lifetime Maximum	None
Deductible	
Contract Year Deductible	N/A
Family Deductible	N/A
Maximum Benefit per Contract Year	N/A

Dental PPO

Dental PPO benefits are provided according to the following Schedule of Benefits.

Annual Maximum (paid by the Dental PPO Plan per participant) = $1,500.

Class I (Preventive)	Class II (Basic Restorative)	Class III (Major)	Class IV (Orthodontia) CHILD ONLY
Coverage: 100% Allowed Amount **Deductible:** None	**Coverage:** 70% Allowed Amount **Deductible:** Yes; $50 per individual; 3 deductibles per family per year.	**Coverage:** 50% Allowed Amount **Deductible:** Yes; $50 per individual; 3 deductibles per family per year.	Lifetime maximum per child $2,000

Methods and Assumptions

Actuarial Method

Projected Unit Credit Cost Method.

Service Cost

Determined for each active employee as the Actuarial Present Value of benefits allocated to the valuation year. The benefit attributed to the valuation year is that incremental portion of the total projected benefit earned during the year in accordance with the plan's benefit formula. This allocation is based on each individual's service between date of hire and date of full benefit eligibility.

Accumulated Post-Retirement Benefit Obligation

The Actuarial Present Value of Benefits allocated to all periods prior to the valuation year.

Discount Rate

As of July 1, 2005 - 5.0%.

Medical Trend

Annual Rate of Increase			
To Fiscal Year	PPO %	POS %	HMO %
2007	14.0	13.5	15.0
2008	14.0	12.5	15.0
2009	13.0	11.5	14.0
2010	12.0	10.5	13.0
2011	11.0	9.5	12.0
2012	10.0	8.5	11.0
2013	9.0	7.5	10.0
2014	8.0	6.5	9.0
2015	7.0	5.5	8.0
2016	6.0	5.0	7.0
2017	5.0	5.0	6.0
2018 and Later	5.0	5.0	5.0

Methods and Assumptions (continued)

Prescription Drug Trend

Annual Rate of Increase	
To Fiscal Year	**%**
2007	15.0
2008	15.0
2009	14.0
2010	13.0
2011	12.0
2012	11.0
2013	10.0
2014	9.0
2015	8.0
2016	7.0
2017	6.0
2018 and Later	5.0

Dental Trend

Annual Rate of Increase*	
To Fiscal Year	**%**
2007	6.0
2008	6.0
2009 and Later	4.4

* **Blend of PPO and HMO Plans.**

Mortality Annual rates of mortality are shown on pages 28 through 30.

Retirement Age Retirement rates are shown on pages 31 through 33.

Turnover Turnover rates are shown on pages 34 and 35.

Disability Disability rates are shown on pages 36 and 37.

Methods and Assumptions (continued)

Morbidity

Medical

Expected medical claims are assumed to increase as participants age as follows:

Age	Annual Increase %
18 - 48	5.0
49 - 54	3.3
55 - 59	3.6
60 - 64	4.2
65 - 69	3.0
70 - 74	2.5
75 - 79	2.0
80 - 84	1.0
85 - 89	0.5
90 or Older	0.0

Prescription Drug

Expected prescription drug claims are assumed to increase as participants age as follows:

Age	Annual Increase %
18 - 54	5.0
55 - 74	1.0
75	0.0
76	(1.0)
77	(2.0)
78 - 84	(3.0)
85 or Older	(2.0)

Methods and Assumptions (continued)

Initial Baseline Costs (Fiscal Year 2006)

Age	Blended PPO $	Blended POS $	Blended HMO $	Prescription Drug $	PPO/HMO Blended Dental $
25	1,526	1,228	1,444	658	194
30	1,949	1,568	1,844	840	194
35	2,487	2,002	2,355	1,072	194
40	3,173	2,555	3,005	1,368	194
45	4,050	3,260	3,834	1,746	194
50	5,170	4,161	4,893	2,229	194
55	6,080	4,894	5,756	2,844	194
60	7,257	5,841	6,869	2,989	194
65	1,459	1,294	1,421	3,142	194
70	1,691	1,500	1,648	3,302	194
75	1,914	1,696	1,864	3,471	194
80	2,113	1,873	2,058	3,168	194
85	2,220	1,969	2,163	2,721	194
90 or Older	2,277	2,018	2,217	2,459	194

Annual Baseline Retiree Contributions * (Fiscal Year 2006)

Group	Blended PPO	Blended POS	Blended HMO	Prescription Drug	PPO/HMO Blended Dental
Retirees less than 65	980	627	508	424	100
Retirees over 65	488	315	272	424	100

* Employee Only coverage assuming 16 years of Creditable State Service.

Methods and Assumptions (continued)

Data Assumptions

Satellite Employees

Participants not currently in the State Retirement System active database are assumed to have the same demographic assumptions as members of the *"Employee Pension System"*.

Optional Retirement Plan Employees

Active participants follow the same demographic assumptions as members of the *"Employee Pension System"*.

Data for St. Mary's College was unavailable. It was assumed there were 125 active participants similar to the average Optional Retirement Plan employee.

Age Difference/ % Married

Males are assumed to be 4 years older than females. 90% married.

Coverage

We have assumed that:

- 100% of all retirees who currently have healthcare coverage will continue with the same coverage.
- 75% of all deferred vesteds and retirees without current healthcare coverage will elect healthcare benefits at age 62, or current age if later.
- 100% of all State Retirement System actives who currently have healthcare coverage will continue with that same coverage upon retirement.
- 75% of all Optional Retirement Program actives and State Retirement System actives without current healthcare coverage will elect healthcare benefits upon retirement.

Valuation Methodology and Terminology

We have used GASB accounting methodology to determine the postretirement medical benefit obligations.

Amortization Period

The period used to determine amortization costs for the initial Unfunded Actuarial Accrued Liability is a level period of 30 years.

Methods and Assumptions (continued)

The following table shows annual rates of mortality at selected ages:

RATES OF MORTALITY – Active Members
(Number of Deaths per 10,000 Members)

Active Members	AGE 25	30	35	40	45	50	55	60	65	69
Teachers' Retirement										
Male	9	9	10	13	21	34	55	89	148	230
Female	3	5	7	10	15	24	38	59	92	136
Teachers' Pension										
Male	9	9	10	13	21	34	55	89	148	230
Female	3	5	7	10	15	24	38	59	92	136
Employees' Retirement										
Male Regular	9	10	12	17	28	46	73	120	206	317
Female Regular	9	9	10	13	19	31	50	81	133	206
Correctional	9	12	17	26	38	55	80	107	107	107
Legislative	7	10	15	24	38	61	96	140	140	140
Employees' Pension										
Male Members	9	10	12	17	28	46	73	120	206	317
Female Members	9	9	10	13	19	31	50	81	133	206
State Police Retirement										
Ordinary Death	6	9	13	20	30	46	71	103	103	103
Accidental Death	2	3	3	3	4	6	2	1	1	1
Judges' Pension										
Male	6	8	13	20	33	54	85	133	213	315
Female	4	5	8	12	19	31	50	79	124	182
LEOPS										
Ordinary Death	6	9	13	20	30	46	71	103	103	103
Accidental Death	2	3	3	3	4	6	2	1	1	1

Methods and Assumptions (continued)

The following table shows annual rates of mortality at selected ages:

RATES OF MORTALITY – Retired Members (Number of Deaths per 10,000 Members)	AGE							
	45	50	55	60	65	70	75	80
Teacher's Retirement and Pension								
Inactive Members								
Male	13	18	31	57	108	189	322	547
Female	10	14	23	43	83	142	239	390
Inactive Disabled Members								
Male	432	496	784	992	1,168	1,424	1,696	2,304
Female	162	186	294	372	438	534	636	864
Employees' Retirement and Pension (including Correctional)								
Inactive Members								
Male	19	31	53	96	174	285	447	744
Female	11	17	27	51	97	167	281	459
Inactive Disabled Members								
Male	226	290	354	420	502	626	821	1,094
Female	202	231	266	298	333	370	443	671
Legislative Inactive Members								
Male	13	18	31	57	108	189	322	547
Female	10	14	23	43	83	142	239	390
Legislative Inactive Disabled Members								
Male	432	496	784	992	1,168	1,424	1,696	2,304
Female	162	186	294	372	438	534	636	864
State Police Retirement								
Inactive Members								
Male	17	24	40	74	140	244	416	708
Female	13	19	31	58	112	193	323	528
Inactive Disabled Members								
Male	81	93	147	186	219	267	318	432
Female	95	109	172	217	256	312	371	504

Methods and Assumptions (continued)

The following table shows annual rates of mortality at selected ages:

RATES OF MORTALITY – Retired Members (Number of Deaths per 10,000 Members)	AGE							
	45	50	55	60	65	70	75	80
Judges' Pension								
Inactive Members								
Male	13	18	31	57	108	189	322	547
Female	10	14	23	43	83	142	239	390
Inactive Disabled Members								
Male	432	496	784	992	1,168	1,424	1,696	2,304
Female	162	186	294	372	438	534	636	864
LEOPS								
Inactive Members								
Male	17	24	40	74	140	244	416	708
Female	13	19	31	58	112	193	323	528
Inactive Disabled Members								
Male	81	93	147	186	219	267	318	432
Female	95	109	172	217	256	312	371	504

Methods and Assumptions (continued)

The following table shows annual rates of retirement at selected ages:

RATES OF RETIREMENT (Number Retiring per 1,000 Members)	AGE					
	45	50	55	60	65	70
Teachers' Retirement						
Early						
First Year Eligible						
Male	30	35	70	--	--	--
Female	10	30	100	--	--	--
Subsequent Years						
Male	10	20	30	--	--	--
Female	10	20	50	--	--	--
Normal						
First Year Eligible						
Male	300	300	300	300	300	300
Female	350	350	350	350	350	350
Subsequent Years						
Male	170	170	170	200	300	250
Female	150	150	200	220	350	250
Teachers' Pension						
Early						
First Year Eligible						
Male	--	--	30	100	--	--
Female	--	--	50	150	--	--
Subsequent Years						
Male	--	--	--	40	--	--
Female	--	--	--	80	--	--
Normal						
First Year Eligible						
Male	150	150	250	300	300	300
Female	150	150	250	400	200	200
Subsequent Years						
Male	120	120	120	200	220	220
Female	100	100	150	200	250	220

Methods and Assumptions (continued)

The following table shows annual rates of retirement at selected ages:

RATES OF RETIREMENT (Number Retiring per 1,000 Members)	AGE					
	45	50	55	60	65	70
Employees' Retirement						
Early						
First Year Eligible						
Male	55	80	80	--	--	--
Female	80	100	100	--	--	--
Subsequent Years						
Male	30	30	40	--	--	--
Female	40	50	50	--	--	--
Normal						
First Year Eligible						
Male	270	270	270	270	270	270
Female	300	300	300	300	300	300
Subsequent Years						
Male	50	150	100	150	300	200
Female	100	100	120	250	450	250
Correctional						
Early	--	--	--	--	--	--
Normal						
First Eligible	400	400	400	500	1,000	1,000
Subsequent	120	150	150	200	500	1,000
Legislative						
Early	--	--	--	--	--	--
Normal	--	--	--	1,000	1,000	1,000

Methods and Assumptions (continued)

The following table shows annual rates of retirement at selected ages:

RATES OF RETIREMENT (Number Retiring per 1,000 Members)	AGE					
	45	50	55	60	65	70
Employees' Pension						
Early						
First Year Eligible						
Male	55	80	60	60	--	--
Female	80	100	40	100	--	--
Subsequent Years						
Male	30	30	40	40	--	--
Female	40	50	50	60	--	--
Normal						
First Year Eligible						
Male	150	150	250	250	250	250
Female	150	150	250	300	300	300
Subsequent Years						
Male	50	50	70	120	250	200
Female	50	50	70	100	250	220
State Police Retirement						
First Year Eligible	200	200	200	1,000	1,000	1,000
Subsequent Years	200	200	400	1,000	1,000	1,000
Judges' Pension						
First Year Eligible						
Male	100	100	100	100	100	100
Female	300	300	300	300	300	300
Subsequent Years						
Male	100	100	100	100	100	1,000
Female	200	200	200	200	200	1,000
LEOPS						
First Year Eligible	350	150	150	150	150	150
Subsequent Years	150	150	200	300	1,000	1,000

Methods and Assumptions (continued)

The following table shows annual rates of withdrawal for the first 10 years of service:

RATES OF WITHDRAWAL FOR FIRST 10 YEARS OF SERVICE
(Number Of Withdrawals Per 1,000 Members)

	YEARS OF SERVICE									
	0	1	2	3	4	5	6	7	8	9
Teachers' Retirement										
Male	149	149	116	99	81	78	56	54	45	39
Female	128	128	106	93	74	70	63	51	49	49
Teachers' Pension										
Male	149	149	116	99	81	78	56	54	45	39
Female	128	128	106	93	74	70	63	51	49	49
Employees' Retirement										
Regular										
Male	161	161	111	99	92	76	76	60	60	53
Female	150	150	106	100	78	78	64	60	51	45
Correctional										
Male	134	134	96	93	63	63	52	39	35	29
Female	151	151	82	82	70	70	53	53	45	45
Legislative	*	*	*	*	*	*	*	*	*	*
Employees' Pension										
Male	161	161	111	99	92	76	76	60	60	53
Female	150	150	106	100	78	78	64	60	51	45
State Police Retirement	86	86	57	29	14	14	8	8	7	7
Judges' Pension	0	0	0	0	0	0	0	0	0	0
LEOPS	86	86	57	29	14	14	8	8	7	7

* 200 withdrawals per 1,000 members are assumed after 8 years of service and each fourth year thereafter.

Methods and Assumptions (continued)

The following table shows annual rates of withdrawal at selected ages:

RATES OF WITHDRAWAL
(Number of Withdrawals per 1,000 Members)

	AGE					
	30	35	40	45	50	55
Teachers' Retirement						
Male	39	27	16	11	14	24
Female	49	36	16	13	15	26
Teachers' Pension						
Male	39	27	16	11	14	24
Female	49	36	16	13	15	26
Employees' Retirement						
Regular						
Male	52	46	34	27	28	33
Female	44	34	25	22	21	28
Correctional						
Male	29	27	24	12	12	12
Female	45	33	32	27	27	27
Legislative	*	*	*	*	*	*
Employees' Pension						
Male	52	46	34	27	28	33
Female	44	34	25	22	21	28
State Police Retirement	7	7	7	7	7	7
Judges' Pension	0	0	0	0	0	0
LEOPS	7	7	7	7	7	7

* **200 withdrawals per 1,000 members are assumed after 8 years of service and each fourth year thereafter.**

Methods and Assumptions (continued)

The following table shows annual rates of disablements at selected ages:

RATES OF DISABILITY
(Number becoming disabled per 10,000 Members)

	AGE						
	25	30	35	40	45	50	55
Teachers' Retirement							
Male	1	1	1	4	9	13	18
Female	2	2	4	8	14	21	36
Teachers' Pension*							
Male	3	3	3	10	20	31	41
Female	3	3	6	13	22	32	55
Employees' Retirement							
Ordinary Disability							
Regular							
Male	8	8	14	27	34	41	54
Female	5	5	9	16	24	34	47
Correctional							
Male	30	36	45	57	71	101	131
Female	46	46	46	51	59	77	117
Legislative	0	0	0	0	0	0	0
Accidental Disability							
Regular							
Male	2	2	3	4	3	3	3
Female	1	1	2	2	2	2	2
Correctional							
Male	5	6	8	10	13	18	23
Female	8	8	8	9	10	14	21
Legislative	0	0	0	0	0	0	0

* **It is assumed that 1.0% of disability retirements is due to accidents in the performance of duty.**

Methods and Assumptions (continued)

The following table shows annual rates of disablements at selected ages:

RATES OF DISABILITY (Number becoming disabled per 10,000 Members)	AGE						
	25	30	35	40	45	50	55
Employees' Pension							
Ordinary Disability							
Male	12	12	21	40	51	61	82
Female	9	9	15	27	41	58	81
Accidental Disability							
Male	3	3	4	6	5	4	4
Female	2	2	3	4	4	4	4
State Police Retirement							
Ordinary Disability							
Male	35	44	56	74	99	142	183
Female	108	116	117	136	165	217	332
Accidental Disability							
Male	23	25	30	35	39	54	71
Female	72	64	63	64	65	83	128
Judges' Pension							
Male	3	3	3	10	21	31	41
Female	3	3	6	13	22	32	55
LEOPS							
Ordinary Disability							
Male	34	43	54	71	96	137	176
Female	55	59	60	70	85	111	170
Accidental Disability							
Male	22	24	29	34	37	52	68
Female	37	33	32	33	33	43	66

GASB OPEB Summary

The Government Accounting Standards Board (GASB) has issued Statements No. 43 and 45 for the recognition and disclosure for public entities sponsoring other (than pensions) post-retirement benefit plans.

This Exhibit summarizes pertinent issues from the above statements and includes comments about GASB's OPEB standard.

Why Pay-As-You-Go Accounting Will Be Unacceptable

The GASB believes, like the FASB, that other post-retirement benefits, like pensions, are a form of deferred compensation. Accordingly, GASB is saying these benefits should be recognized (in an organization's financial statement) when earned by employees, rather than when paid out. Under SFAS 106, pay-as-you-go accounting is replaced with accrual accounting for these benefits. *This approach is similar to (although more restrictive than) GASB's approach under Statements No. 43 and 45.*

Allocating Costs (Attribution)

The FASB defines attribution as the process of assigning other post-retirement benefit cost to periods of employee service. SFAS 106 specifies how (the attribution method) and over what accounting periods (the attribution period) the postretirement benefits promise must be allocated.

The attribution (actuarial cost) method specified by SFAS 106 is the "projected unit credit actuarial cost method". This method attributes an equal amount of the total postretirement benefit to each year of service during the "attribution period".

The attribution period is the period over which the total postretirement benefit is earned. Unless the plan states that post-retirement benefits are not earned until a later date, the attribution period is from the employee's hire date until the employee is first eligible for the benefit. *The GASB Statements do not restrict entities to a single attribution method, but instead allows sponsors (and actuaries) to choose from several acceptable methods (similar to GASB 27).* GASB allows six funding methods and also allows attribution to the expected retirement age rather than the earliest eligibility age.

GASB OPEB Summary (continued)

Defining the Plan

SFAS 106 refers to the substantive plan as the basis for accounting. The substantive plan may differ from the written plan in that it reflects the employer's cost sharing policy based on past practice or communication of intended changes, or a past practice of cost increases in monetary benefits. Under SFAS 106, the substantive plan is the basis for allowing recognition of potential future changes to the plan. *GASB follows FASB's lead on this issue, requiring entities to recognize the underlying promise, not just the written plan*

.

One GASB requirement relates to the implied subsidy when retirees participate in the active healthcare plan, but are charged a rate based on composite active and retiree experience. Under the GASB standard, even if an organization does not otherwise subsidize the benefit, then the organization will have to recognize an OPEB obligation for the implied subsidy.

Actuarial Assumptions

SFAS 106 says actuarial assumptions should be explicit. This means each individual assumption should represent the actuary's best estimate. GASB also, generally, requires explicit assumptions.

GASB requires the discount rate be based on the source of funds used to pay the benefits. This means the underlying expected long-term rate of return on plan assets for funded plans. However, since the source of funds for unfunded plans is usually the organization's general fund, and organizations are usually restricted by State law as to what investments they can have in their general fund, unfunded plans will need to use a relatively low discount rate.

Transition Issues

Because historical annual required contribution information will rarely be available, *GASB is taking a prospective approach on transition issues.* This means there will be no requirement for any initial transition obligation.

GASB OPEB Summary (continued)

Effective Dates

The new standard will have staggered effective dates, similar to GASB Statement No. 34, as follows:

	Annual Revenue	Effective for Fiscal Years Beginning After
Phase I	$\geq$ $100 million	December 15, 2006
Phase II	$\geq$ $10 million but < $100 million	December 15, 2007
Phase III	< $10 million	December 15, 2008

GASB OPEB Summary (continued)

Differences Between SFAS 106 and GASB 43 and 45

Conceptually, GASB No. 43 and 45 are similar to SFAS 106. They require current recognition of the promise to pay future benefits. However, they differ somewhat in how that recognition should occur. Specifically:

		SFAS 106	GASB 43 and 45
(1)	Attribution Method	Mandates use of a particular method, regardless of method used to determine contribution.	Allows sponsor to use same method used to determine contribution, provided it meets certain criteria.
(2)	Assumptions (excluding discount rate)	Requires each assumption stand on its own - Explicit assumptions.	Requires each assumption stand on its own and, in addition, meet certain other criteria.
(3)	Discount Rate	Long term high quality bond rates (e.g., Moody Aa).	Expected long-term rate of return on source used to pay benefits (e.g. sponsor's general fund).
(4)	Benefit Cost	Mandates use of a specific method, regardless of method used to determine contribution.	Provides that if entity always contributes Annual Required Contribution, then benefit cost equals Annual Required Contribution. If entity does not contribute Annual Required Contribution, then benefit cost equals Annual Required Contribution, adjusted for the difference.
(5)	Annual Required Contribution	N/A	The Plan's funding contribution, with actuarial assumptions and methods (including amortization periods) restricted as indicated above.
(6)	Liability Recognition	The historical difference between actual contributions and benefit costs become an accrued liability (or prepaid asset) on the sponsor's financial statement.	If sponsor consistently contributes the Annual Required Contribution, then no recognition is required. However, if sponsor has not historically contributed the Annual Required Contribution, then difference becomes a Net Obligation on the sponsor's financial statement.

State of Maryland

GASB Valuation

(REVISED)

November 3, 2005

AON

Agenda

- ✓July 1, 2005 GASB 45 Valuation Results
- ✓Data / Assumptions

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GASB Plans

- State of Maryland Retiree Healthcare and Other Postemployment Benefits
  - Healthcare Plans required to be valued under GASB 45 since subsidized by the State of Maryland
    - Medical
    - Prescription Drug
    - Dental
    - Vision
  - Life Insurance & Long Term Care paid in full by retirees so no GASB 45 liability for the State of Maryland

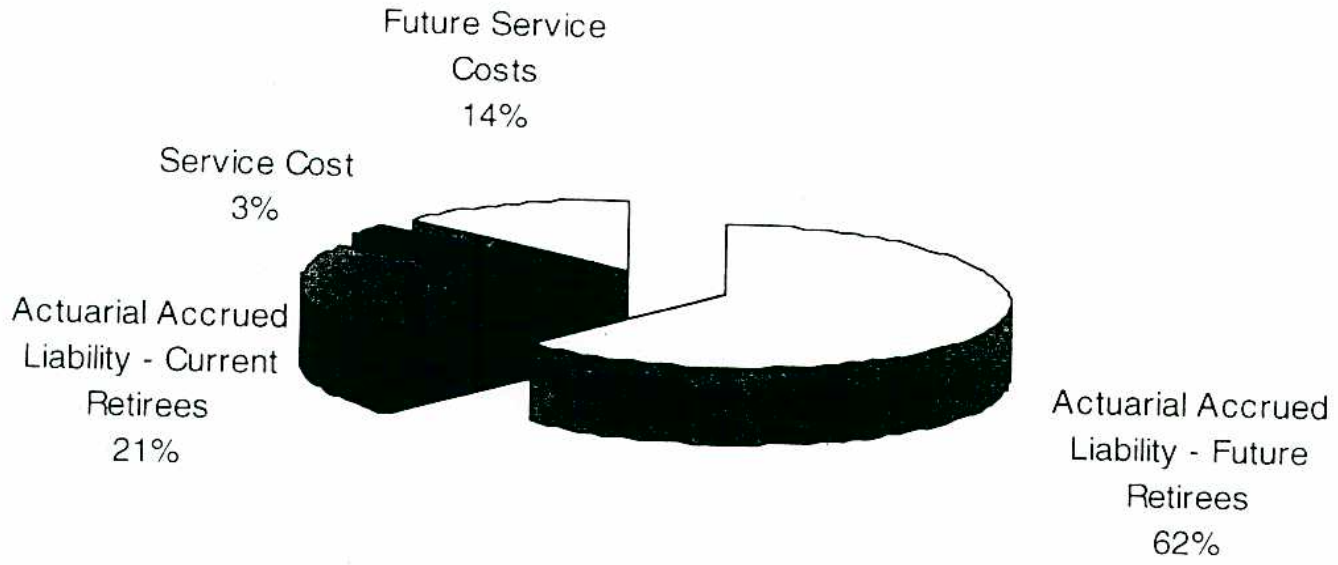
July 1, 2005 GASB Results

	Initial Results ($ billions)	Medicare Rx Savings ($ billions)	Final ($ billions)
Present Value of all Projected Benefits	27.406	2.980	24.426
Present Value of Benefits Earned to Date (Actuarial Accrued Liability)	22.903	2.528	20.375
2006 FY Annual Required Contribution (ARC) * +			1.959
2006 FY Annual OPEB Cost (AOC) +			1.959
2006 Expected Benefit Premiums +			0.311

** The ARC reflects a 30-year, level amortization of the Unfunded Actuarial Accrued Liability.*
+ Reflects reduction in cost due to Medicare Part D subsidy, starting January 1, 2006 .

July 1, 2005 GASB Results

- **Present Value of all Projected Benefits -**



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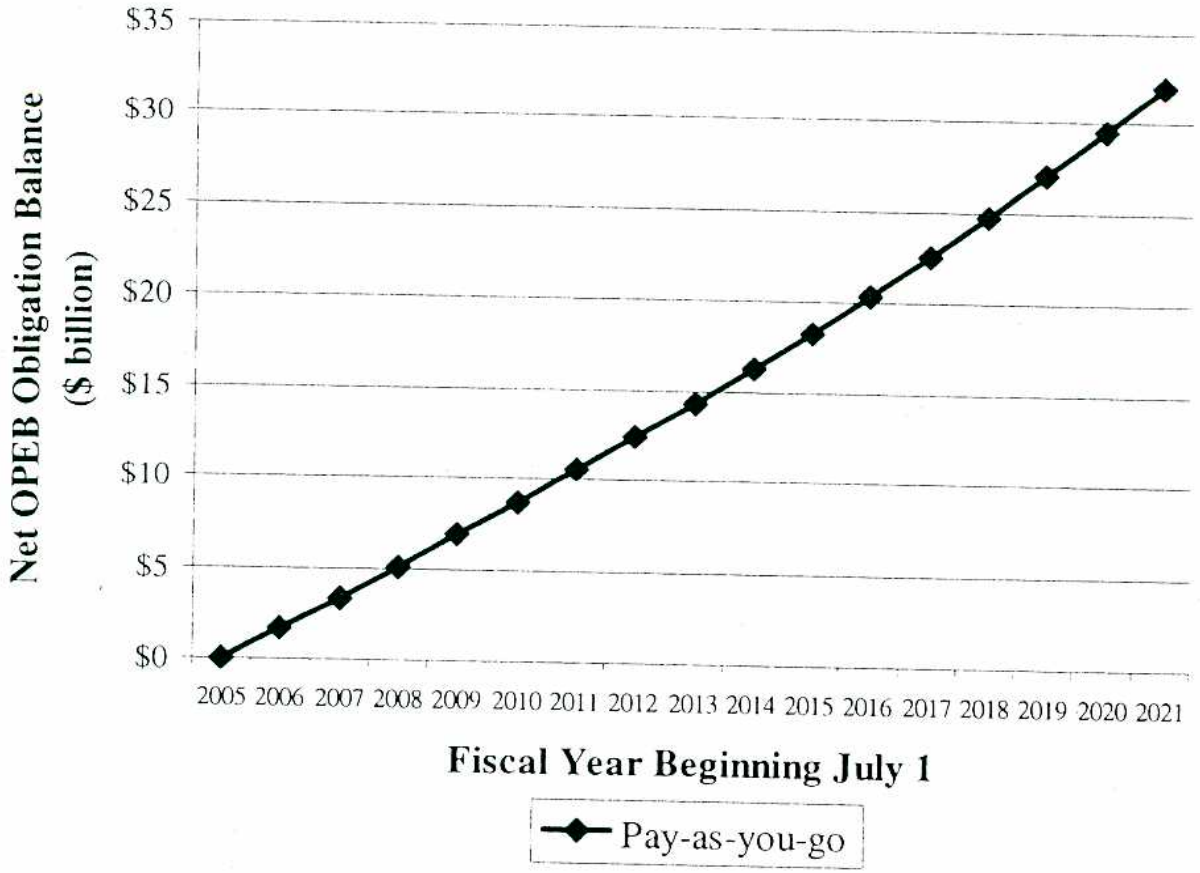
July 1, 2005 GASB Results

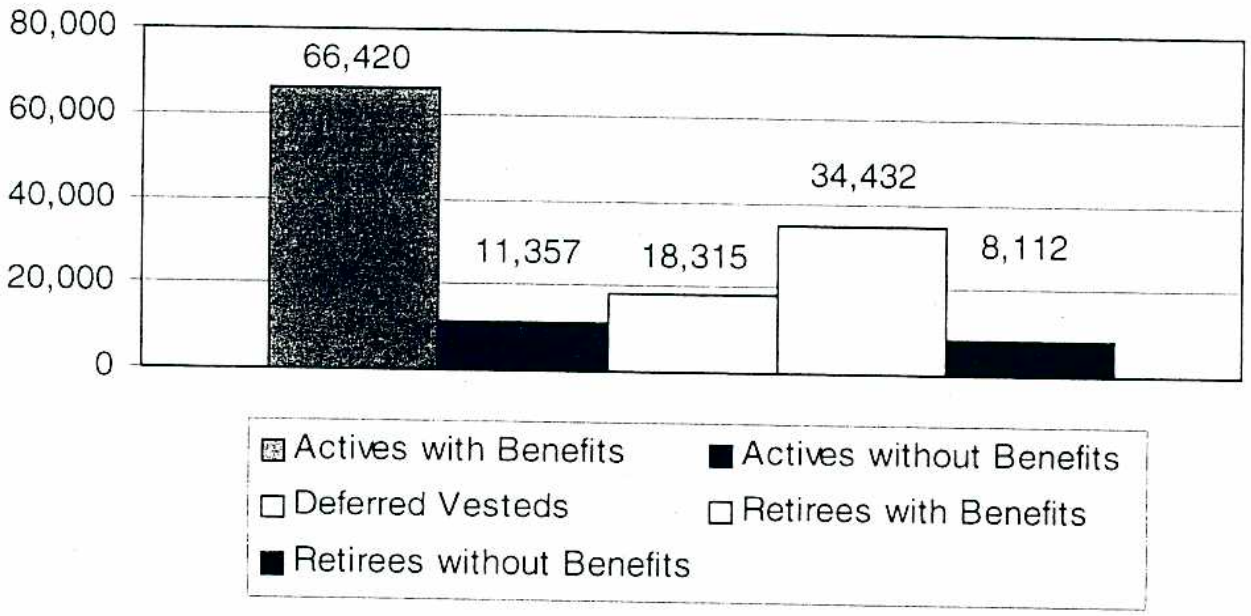
- **Projection of Net OPEB Obligation (Current Plan) -**



Current Demographics

- Participant data as of July 1, 2005 (no dependents)
  - No assumption for future new hires
  - Demographic assumptions same as pension plans
  - Actual dependent data used for retirees only

July 1, 2005 Participant Counts (138,636 total)



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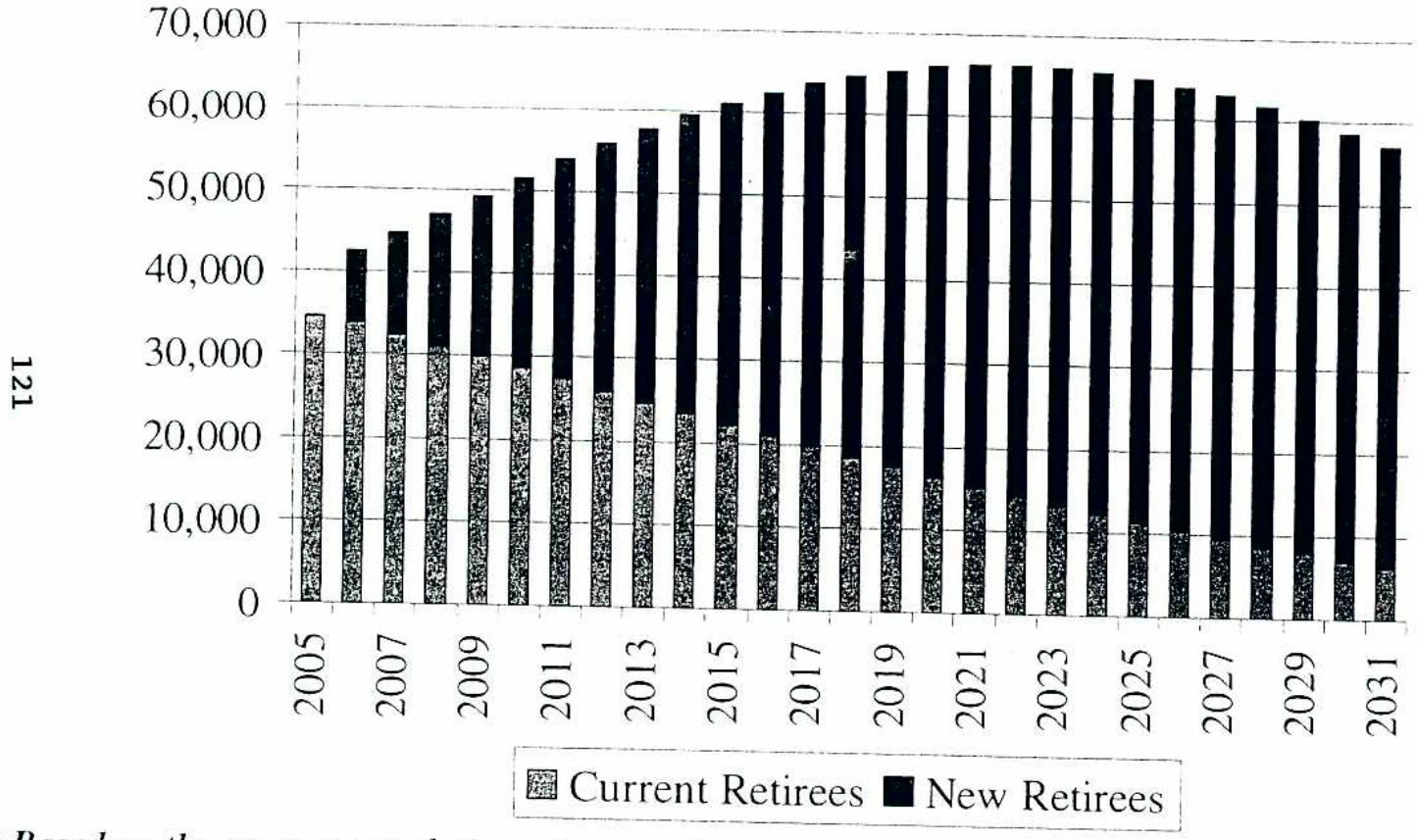
Projected Demographics

- **Projection of Growth in Number of Retirees* -**



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** Based on the current population. Does not include any assumption for future hires.*

Assumptions - Economic

- Discount Rate
  - Discount rate based on returns on assets used to pay benefits
    - Unfunded plans generate greater liabilities than identical funded plans
    - State Plan is not prefunded - base on the portfolio of the State's "general assets" used to pay healthcare benefits:

Asset Class	Target Allocation
Repurchase Agreements (Repos)	75%
1 - 3 Year Treasuries or Agencies	25%

Provided by Don Walton (Investment Manager for the Maryland State Treasury Department)

Assumptions - Economic

- Portfolio suggests a 3%-4% discount rate
  - Actual return 7/1/04 through 6/30/05 - 2.26%
- Recommend a rate as required under FAS 106 used to value postretirement healthcare benefits for private employers.
  - FAS 106 discount rates as of July 1, 2005 were 5.0% - 5.25%.

Aon recommends the lower end of this range, 5.0%, to be conservative.

Assumptions - Economic

Discount Rate – Sensitivity :

Discount Rate	5.0% ($ billions)	5.5% ($ billions)	4.5% ($ billions)
Present Value of Projected Benefits	24.426	22.129	27.073
Actuarial Accrued Liability	20.375	18.651	22.337
Annual Required Contribution (ARC)	1.959	1.840	2.095

Assumptions - Economic

Assuming the Plan is funded:

- Investment portfolio similar to pension plans
- Pension valuation interest rate – 7.75%

Discount Rate	5.0% ($ billions)	7.75% ($ billions)
Present Value of Projected Benefits	24.426	14.855
Actuarial Accrued Liability	20.375	13.022
Annual Required Contribution (ARC)	1.959	1.455

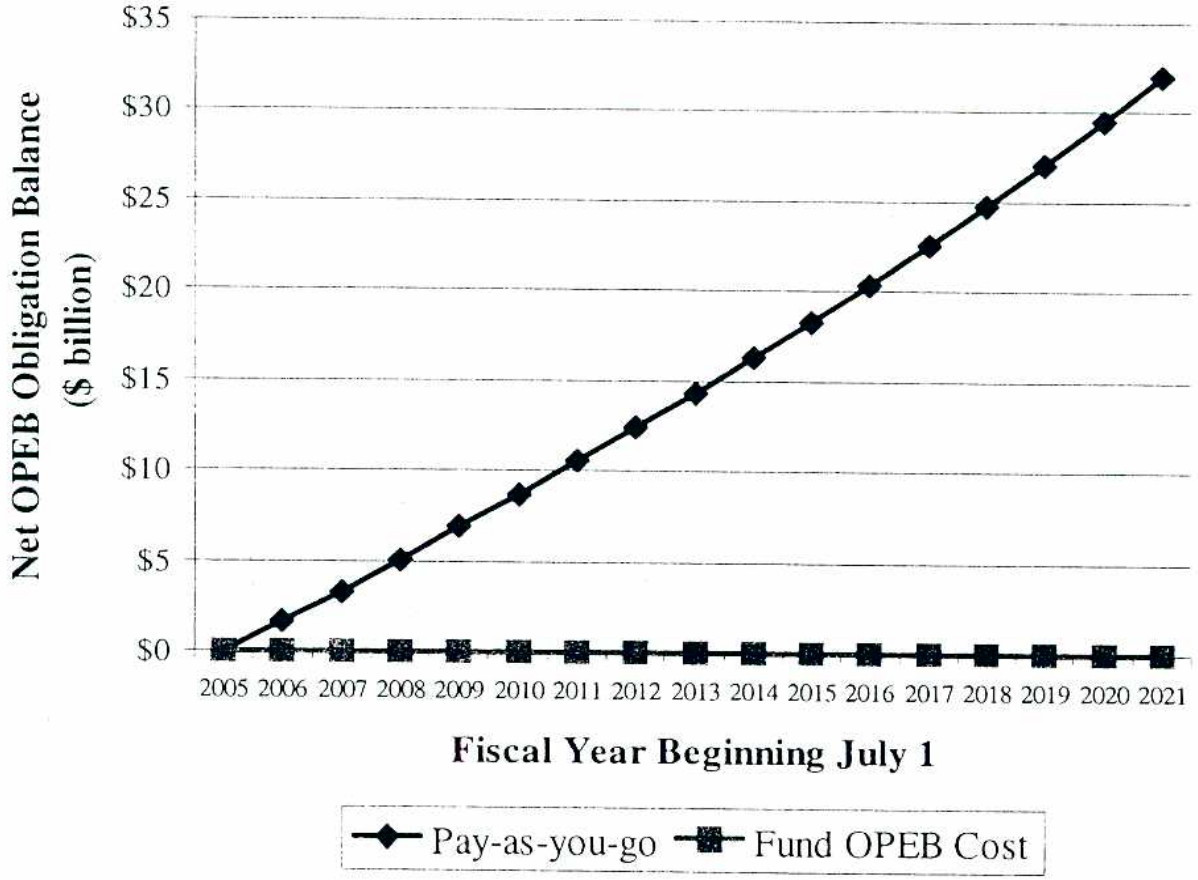
Assumptions - Economic

Projected June 30, 2006 Net OPEB Obligation (NOO):

Balance Sheet - Fiscal Year Ending June 30, 2006 ($ billions)	
June 30, 2005 Net OPEB Obligation (NOO)	$0.000
Annual OPEB Cost (AOC)	$1.455
Contribution	$1.455
Expected June 30, 2006 Net OPEB Obligation (NOO)	$0.000

Assumptions - Economic

- **Projection of Net OPEB Obligation -**



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Assumptions - Economic

- Medical Trend and Morbidity
  - Medical costs increase as an employee ages
  - After 65, cost offset by Medicare

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Aon developed the trend assumption utilizing the short term rates expected on the State plan along with information in published papers from other industry experts (actuaries, health economists, etc.) suggesting a 5% long term trend rate for all healthcare benefits except dental (4.4% long term rate). Morbidity rates were selected based on published studies in actuarial journals.

Assumptions - Economic

Recommended trend rates:

	Annual Rate of Increase				
To Fiscal Year	PPO	POS	HMO	Rx	Dental
2007	14.0%	13.5%	15.0%	15.0%	6.0%
2008	14.0%	12.5%	15.0%	15.0%	6.0%
2009	13.0%	11.5%	14.0%	14.0%	4.4%
2010	12.0%	10.5%	13.0%	13.0%	4.4%
2011	11.0%	9.5%	12.0%	12.0%	4.4%
2012	10.0%	8.5%	11.0%	11.0%	4.4%
2013	9.0%	7.5%	10.0%	10.0%	4.4%
2014	8.0%	6.5%	9.0%	9.0%	4.4%
2015	7.0%	5.5%	8.0%	8.0%	4.4%
2016	6.0%	5.0%	7.0%	7.0%	4.4%
2017	5.0%	5.0%	6.0%	6.0%	4.4%
2018	5.0%	5.0%	5.0%	5.0%	4.4%

Assumptions - Economic

Historical Trend Rates for specific healthcare coverage:

- Medical, Prescription Drug, Dental

Period	PPO	POS	HMO	MH/SA	Rx	Dental	Combined Average
CY 2001	13.9%	28.3%	(3.0%)	75.8%	20.7%	14.5%	18.0%
CY 2002	11.3%	27.7%	6.4%	2.5%	18.3%	12.6%	16.2%
CY 2003	8.8%	17.4%	6.6%	6.9%	16.4%	13.6%	13.5%
CY 2004	21.7%	4.0%	6.0%	26.3%	18.5%	12.9%	17.0%
Short CY 2005*	10.0%	10.9%	20.2%	5.0%	9.7%	12.9%	10.3%
FY 2006	11.8%	10.2%	6.4%	7.0%	(3.2%)**	4.0%	4.0%

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* *Annualized increase based on comparison of estimated CY 2005 costs to actual CY 2004 costs. CY 2005 costs for PPO, POS & HMO reflect plan changes effective January 1, 2005, including increased copays for physician office visits, emergency room visits and services, and therapy services.*

** *Reflects decrease in Rx costs due to increase in copays with implementation of an out-of-pocket family maximum, effective July 1, 2005.*

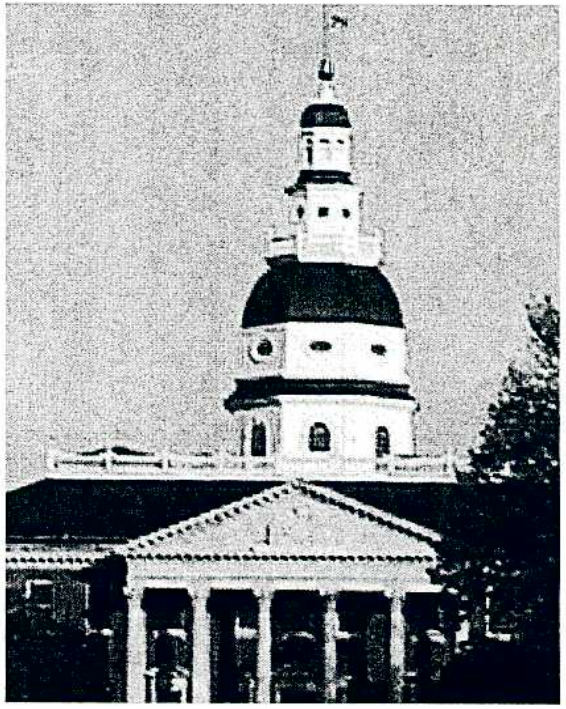
Appendix 5. Financial Statements and Health Care Costs

Financial Statements and Health Care Costs

John Kenney, Director
General Accounting Division
Comptroller of Maryland

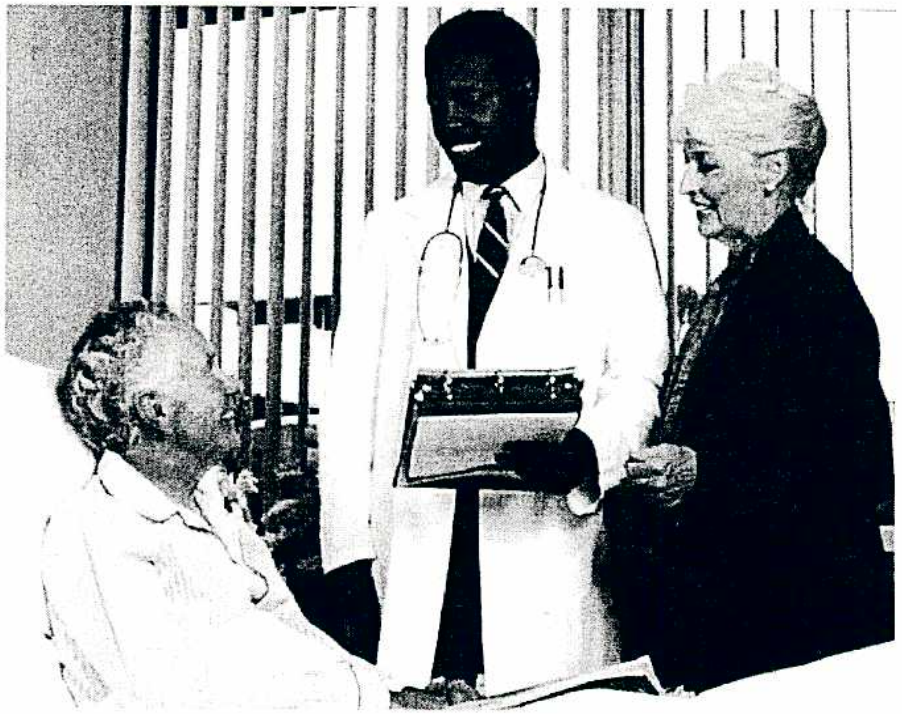
Introduction

- ✓Maryland has prepared independently audited financial statements for 26 years. (1978 – 2004)
- ✓Earned Certificate of Achievement for Excellence in Financial Reporting from GFOA for the last 25 years.



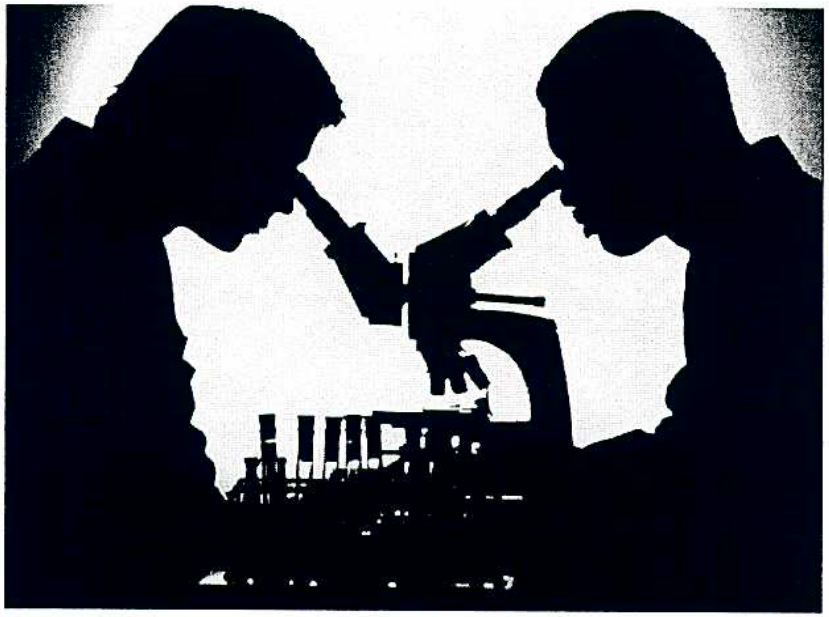
GASB Statement 45

- ✓In fiscal year 2008, Maryland must implement GASB Statement 45 - "Accounting and Financial Reporting by Employers for Post-employment Benefits Other Than Pensions."



Post Employment Benefits

- ✓Accounting for post-employment benefits is generally consistent with current accounting for pensions.



Post Employment Benefits *cont'd*

- ✓GASB Statement 45 requires recognition of post employment benefits during periods that employees render their services - when the benefit is earned - as opposed to the period when benefits are paid.
- ✓Funding – Advanced vs. Pay-as-You-Go.

Recording Post-Employment Benefits

- ✓Unfunded health care benefits at transition date are disclosed in the notes but not recorded in the state's financial statements.

Recording Post-Employment Benefits *cont'd*

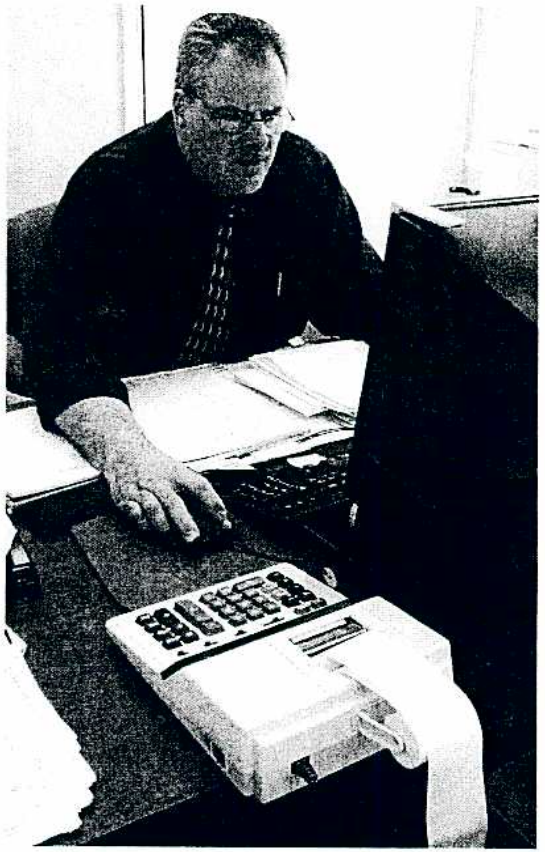
- ✓No liability is recorded in future years provided that the actuarial required contribution is made each year.
- ✓Maximum amortization period for unfunded liability is 30 years.

Post-Employment Costs in F/S

- ✓ Actuarial Required Contribution = Postemployment expense in financial statements.
- ✓ Actuarial Required Contribution = Value of benefits earned during the year (Service Cost) plus the amortization of the Unfunded Actuarial Accrued Liability.

Post-Employment Costs *cont'd*

- ✓A liability is recorded in the F/S to the extent that the actuarial required contribution exceeds actual contributions made.



State of Maryland Financial Statements

- ✓Review government-wide financial statements and effect on auditor's opinion.
- ✓Deficits in Unrestricted Net Assets.
- ✓Schedule of Funding Progress.
- ✓Schedule of Employer Contributions.

Auditor's Opinion on the F/S

- ✓Independent Auditor can still issue an unqualified opinion if post-employment benefits are not funded.

Auditor's Opinion *cont'd*

- ✓Decision to ***not*** fund post-employment benefits will result in recording a liability in state's financial statements and an increase in the deficit in unrestricted net assets ($1.64 billion in the first year).

Why Government-Wide Statements?

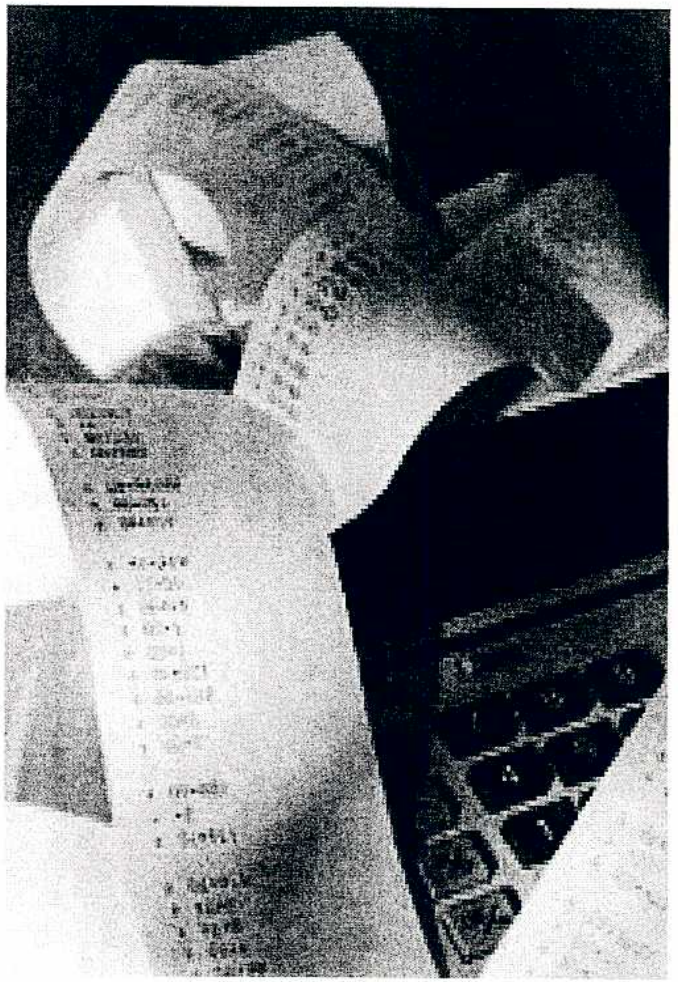
- ✓Focus on the "big picture."
- ✓Report all assets and liabilities.
  - Both financial assets and capital assets.
  - Both current and long-term liabilities.
- ✓Difference = "Net Assets."

Reporting Net Assets

- ✓Presentation based on accessibility of underlying assets.
  - Net investment in capital assets.
  - Restricted.
  - Unrestricted.
- ✓Businesses base equity presentation on basis of source of capital (stock, retained earnings).

Negative Unrestricted Net Assets

- ✓Accounting vs. financing.
  - Accounting – focus on when liability is incurred.
  - Financing – focus on when liability is paid.

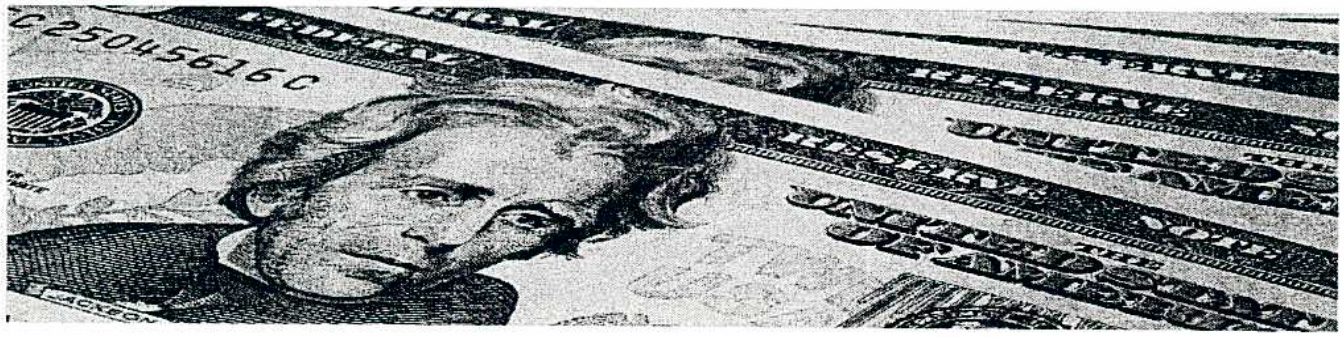


Negative Unrestricted Net Assets *cont'd*

- ✓State typically focuses on financing.
  - Resources are raised when needed for payments.
- ✓Deficit in unrestricted net assets = commitment of future taxing power.

Unrestricted Deficit June 30, 2004

- ✓June 30, 2004 balance in unrestricted net assets: deficit of $1.5 billion.
- ✓Outstanding general obligation bonds and capital leases for local governments and private organizations: $2.4 billion.

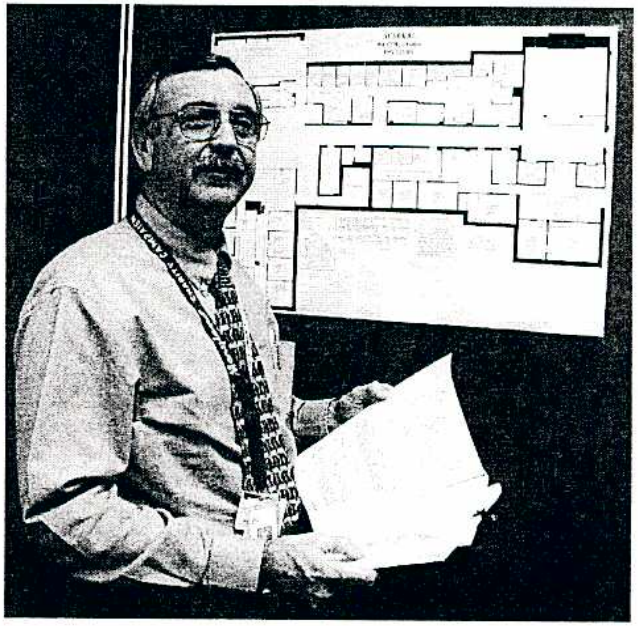


Unrestricted Deficit *cont'd*

- ✓Unfunded pension plan liability: $142 million.
- ✓Deficit will grow significantly if post-employment benefits are not reduced or funded - or some combination of both.

Disclosure of Funding Progress

- ✓Required Supplementary Information.
- ✓Information about the funding progress for the plan similar to the disclosures for Pension and Retirement Systems.
  - CAFR - June 30, 2004, page 85.



Disclosure of Funding Progress *cont'd*

- ✓ Actuarial value of assets, actuarial accrued liability, funded ratio (assets/liabilities) and the unfunded actuarial liability as a percentage of annual covered payroll.

Schedule of Employer Contributions

- ✓Required Supplementary Information.
- ✓All acceptable actuarial funding methods lead to the same point.
- ✓Need to compare annual required contribution (ARC) and actual contributions over time.
- ✓Full funding = pattern of 100% funding of ARC.

Appendix 6. Attorney General's letter and Opinion

THE MARYLAND GENERAL ASSEMBLY

ANNAPOLIS, MARYLAND 21401-1991

November 8, 2005

The Honorable J. Joseph Curran, Jr., Attorney General
Office of the Attorney General
200 St. Paul Place, 17th Floor
Baltimore, Maryland 21202-2021

Dear Attorney General Curran:

The purpose of this letter is to request an Opinion of the Attorney General relating to retiree health benefits. As you may be aware, Maryland currently funds the costs of State retiree health benefits on a pay-as-you-go basis in the State budget each year. However, based on new standards established in the Government Accounting Standards Board (GASB) Statement 45, governmental employers will be required to account for liabilities associated with the employers' commitment to what is referred to as Other Post Employment Benefits (OPEB) such as retiree health insurance. Maryland will be required to account for these liabilities on its balance sheets by fiscal 2008. If the State intends to continue providing retiree health benefits, implementation of GASB 45 will likely require the State to identify an actuarial means to prefund these benefits in order to maintain the State's reputation for fiscal prudence. The cost of prefunding will be in addition to the pay-as-you-go costs associated with existing retirees receiving benefits.

Chapter 298 of the Acts of the 2005 General Assembly created a Task Force to Study Retiree Health Care Funding Options that we have been appointed to co-chair. Chapter 298 also required the Department of Budget and Management to commission an actuarial valuation of the liabilities associated with the GASB 45 standards. This actuarial valuation indicated that the liabilities estimated for the actuarial accrued liability for retiree health benefits, defined as benefits earned as of July 1, 2005, is approximately $20.4 billion. Amortized over a 30-year period, this $20.4 billion liability will result in an Annual Required Contribution (ARC) amount of $1.96 billion. This number incorporates the approximately $311 million in costs that the State would have been obligated to fund for retiree benefits in fiscal 2007. Taking that into account, if no additional contributions are made, the Net OPEB Obligation (NOO) which will appear on the State's financial statement at the end of fiscal 2008 is $1.65 billion. While GASB 45 does not require prefunding, the liabilities shown on the State's financial statement are significantly lower if there is a prefunding mechanism in place. Additionally, if the State fails to make the full ARC payment in a given year, the deficit will be added to the NOO discussed above and will appear on the State's financial statement.

Specifically, we request your opinion on the following questions:

1. Does the State have a statutory, contractual, or other legal obligation to provide or to continue to provide health benefits to any of the following groups: current vested retirees receiving health benefits; employees or former employees that have fully vested with 16 years of creditable service (deferred vested individuals); current employees with less than 16 years of State service who may vest at a later date; or future employees?

2. Maryland is not alone among other State and local entities with respect to the OPEB liabilities to be recognized with respect to retiree health benefits under GASB 45. In terms of other states and local governments, particularly with regard to other AAA bond-rated states, does any relevant case law exist regarding the provision or alteration of retiree health benefits, and if so, how are these cases distinguishable from the situation in Maryland?

3 Are there any legal distinctions between the contractual rights that exist for pension benefits and promised retiree health benefits? Specifically, does the fact that the health insurance benefit accrues over the career of an employee similar to pension benefits create a similar contractual right to those benefits? Because current case law in Maryland indicates that the contractual right to pension benefits accrues over the career of an employee, does the fact the health insurance benefits accrue over the career of an employee result in a similar contractual right to those benefits? Additionally, since case law indicates that the contractual right to pension benefits is created at the time the employee vests in the pension system, if there is no contractual right to health insurance benefits, how is vesting for pension benefits distinguished from vesting for retiree health insurance benefits?

4. Can the State's legal obligations regarding retiree health care for any of the enumerated groups in question one be altered as the result of a collective bargaining agreement entered into by the Administration and employee representatives?

5. GASB Statement 45 will require the State to report liabilities and obligations for retiree health care in the same way as pension liability. Does GASB 45 create any legal obligation for the State to treat promised retiree health benefits the same as promised pension benefits? Additionally, GASB 45 strongly encourages prefunding or retiree health liabilities in the same manner as pensions are prefunded. If the State were to create a non-revocable trust fund in response to the GASB 45 requirements, does this action create any legal obligation to provide retiree health benefits to any of the groups enumerated in the first question and if so, at the current level or some other level? Does this change if the employees are required to make a contribution towards retiree health care similar to the employee pension contribution?

The bond rating agencies have indicated that these new liability disclosures are not likely to result in any immediate changes to bond ratings, but it is clear that this issue will be one that these agencies will be watching and, therefore, cannot be ignored or deferred indefinitely. We are requesting an Opinion of the Attorney General because we believe it is necessary that the task force fully understand the obligations of the State in the matter and any implications of actions that may be proposed in response to the requirements of GASB 45.

If you have any questions relating to this request or need additional information, do not hesitate to contact the Department of Legislative Services staff to the task force, Victoria Gruber, Anne Gawthrop, or Elizabeth Moss.

Sincerely,

Senator Edward J. Kasemeyer
Senate Chairman

Delegate Mary-Dulany James
House Chairman

EJK:MDJ/jhf

Appendix 7. Survey of County Retiree Health Benefits

County Retiree Health Benefits Survey – 2005

County	Eligibility/Subsidy Under 65	65 and Over	Yrs. Service & Age	Dependent Coverage	Medical	Dental	Vision	Rx	Rx Copay
Allegany	X – 96%	X – 100%	25 years (10 years if age 62)	X	PPO/HMO	X	X	X	$100 ded/$10/$20/$35
Anne Arundel	X – 80%	X – 80%	5 years	X	HMO/Triple Choice	X	X	X	$5/$15/$25 or $10/$30/$50
Baltimore									
Baltimore City	X – 50%	X – 50%	5 years	X	Trad/PPO/HMO			X	$10/$60
Calvert	X – 90%	X – 90%	25 years	X	PPO/HMO/MS	X		X	$10/$20/$35 or $8/$15/$30
Caroline	X – 100%	X – 100%	20 years	X	MS			X	$10/$20/$35 $5000 max
Carroll	X	X – 100%	Age +Yrs Service = 75	Spouse Only	MS			X	$10/$15 no deductible
Cecil	X	X – $75/mo.	25 (public safety), 30	X	PPO	X	X	X	$10 gen., 25% brand
Charles									
Dorchester	X – 85%	X – 85%	16 years	X	HMO/POS/PPO	X	X	X	$5/$15/$25 or $10/$30/$50
Frederick	X – 50%	X – 50%	10 years	X	HMO/PPO	X		X	$5/$10/$25
Garrett									
Harford[1]	X – $275/mo.	X – $275/mo.	25 years	X	PPO/HMO	X	X	X	$10/$20/$30
Howard									
Kent[2]	X – 100%	X – 100%	30 years	X	HMO		X	X	$5/$10/$25
Montgomery[3]	X – 70%	X – 70%	5, 15, or 20 years, dep. on age.	X	POS/HMO/Indem.	X	X	X	$10/$20/$30
Prince George's	X – 80%	X – 80%			PPO/POS/HMO	X	X	X	
Queen Anne's	X – 54-90%	X – 54-90%	15 yrs, max benefit at 25 yrs.	X	PPO/EPO	X	X	X	$10/$20/$35
Saint Mary's	X – 85%	X – 85%	16 years	X	Trad/PPO/HMO/MS	X	X	X	$5/$10/$25
Somerset	X – 90%	X – 90%	20 or 30 yrs., dep. on age.	X	HMO/MS	X	X	X	$0/$25/$50 or $10/$20/$35
Talbot	X – 66%	X – 66%	16 years		PPO/POS/HMO/MS			X	$10/$20/$35
Washington	X – 50%		5 years	X	POS/HMO	X	X	X	$10/$20/$30
Wicomico[4]	X – 85%	X – 85%	25 years or age 55	X	PPO/EPO	X	X	X	$10/$25/$35
Worcester	X – 90%	X – 90%	5 years if direct retire	X	Traditional	X	X	X	$10/$10/$20

Definitions:

EPO = Exclusive Provider Option
MS = Medicare Supplement Policy
PPO = Preferred Provider Option
Indem. = Indemnity or Fee-for-service
POS = Point of Service Option
Traditional = Fee-for-service

[1] If dependent coverage is desired, retiree must choose a higher-cost plan.
[2] Indemnity plan open to current members only.
[3] 55% subsidy provided for dependents.
[4] 75% subsidy provided for dependents

County Board of Education Retiree Health Benefits – 2005

County	Eligibility/Subsidy[1] Under 65	Eligibility/Subsidy[1] 65 and Over	Minimum Service Requirement	Medical	Dental	Vision	Rx	Dependent Coverage
Allegany	X – FR	X – FR	15	HMO/MS			X	X
Anne Arundel	X – %	X – %	5	Indem./PPO/HMO/MS	X	X	X	X
Baltimore	X – %	X – %	10	Indem./HMO/MS				X
Baltimore City	X – FR	X – FR	5	Indem./HMO/PPO			X	X
Calvert	X – %	X – %	5	Indem/HMO	X	X	X	
Caroline	X – %	X – %	5	PPO/MS	X	X	X	X
Carroll	X – FR	X – FR	10	PPO/POS/HMO/MS				X
Cecil	X – FR	X – FR	8	PPO	X	X	X	X
Charles	X	X	10	Indem./POS/HMO/MS	X	X	X	X
Dorchester	X – FR	X – FR	15	HMO/PPO/MS		X	X	
Frederick	X – %	X – %	5	POS/MS	X	X	X	X
Garrett	X – FR	X – FR	15	PPO/POS/HMO/MS			X	
Harford	X – %	X – %		Indem./PPO/MS	X			X
Howard	X – %	X – %	10	PPO/MS	X	X	X	
Kent	X – %	X – %	30	HMO/MS	X	X	X	
Montgomery	X – %	X – %	3	Indem./PPO/POS/MS	X	X	X	X
Prince George's	X – %	X – %	12	POS/MS	X	X	X	X
Queen Anne's	X – FR	X – FR	15	HMO/PPO/MS	X	X	X	X
Saint Mary's	X – %	X – %	15	Indem./PPO/MS	X	X	X	X
Somerset	X – %	X – %	10	PPO/MS	X	X	X	X
Talbot	X – %	X – %	8	PPO/HMO/MS			X	X
Washington	X – FR	X – FR	5	PPO/POS/MS	X		X	X
Wicomico	X – %	X – %	5	Indem./POS/MS	X	X	X	X
Worcester	X – %	X – %	5	Indem./HMO			X	

Definitions:

% = Percentage Subsidy
EPO = Exclusive Provider Option
MS = Medicare Supplement Policy
PPO = Preferred Provider Option
FR = Flat Rate Subsidy
Indem. = Indemnity or Fee-for-service
POS = Point of Service Option
Traditional = Fee-for-service

[1] There are two typical cost-sharing mechanisms for retiree health benefits. Some county boards provide a fixed amount of money (flat rate) to offset retiree costs. Some county boards subsidize a percentage of retiree costs. The flat rates and subsidies vary greatly by county depending on the number of years of service, age, and type of coverage.

Appendix 8. Credit Implications of Retiree Health Care Costs and GASB 45 Reporting – Parry Young, Director, Standard and Poor's

STANDARD
&POOR'S

Setting the Standard

Maryland Legislative Task Force on Retiree Health Care

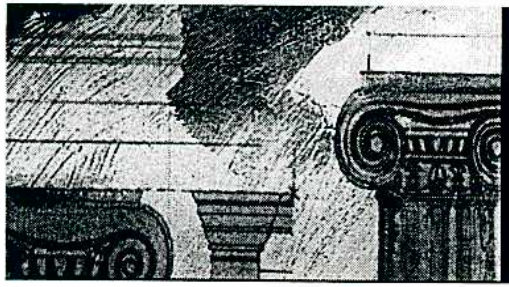
Credit Implications of Retiree Health Care Costs and GASB 45 Reporting

Parry Young, Director

Standard & Poor's

December 12, 2005

The McGraw-Hill Companies



GASB Statement No. 45 – June 2004

Accounting and Financial Reporting by Employers for Postemployment Benefits Other than Pensions

OVERVIEW

- What is OPEB?
- When will new reporting be implemented?
- Why did GASB do this?
- How will reporting/funding be affected?

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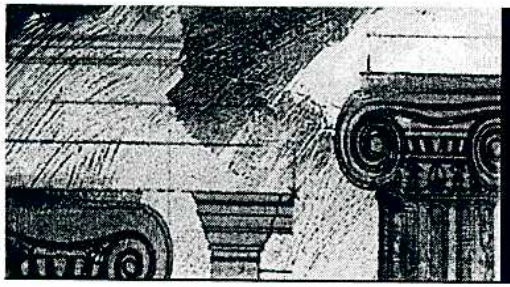
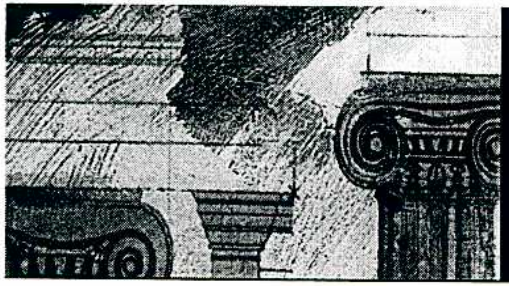


GASB 45 – OVERVIEW (cont'd)

- General outlook for OPEB reporting
- Specific OPEB cases
- Options for managing OPEB liabilities
- Credit implications of GASB 45

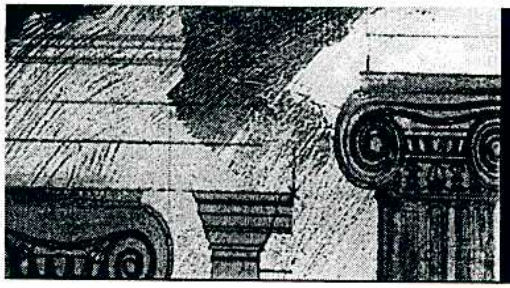
161



OPEB - What?/When?

- What? - Other Postemployment Benefits (OPEB) – largely healthcare related – are part of an exchange of salaries and benefits – like pensions – for employee services rendered

- When? - GASB 45 will be implemented for phase 1 governments for fiscal periods beginning after 12/15/06



GASB 45 – WHY?

GASB said that from "an accrual accounting perspective, the cost of OPEB … should be associated with the periods in which the exchange occurs……

Current {OPEB} financial reporting generally fails to:

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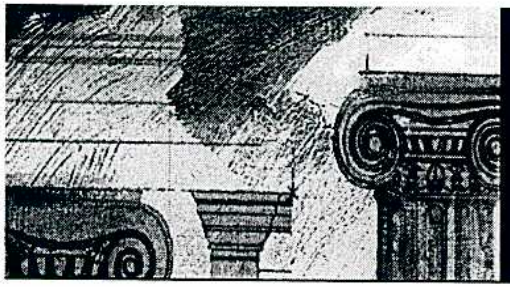
- "Recognize the cost of benefits in periods when the related services are received by the employer
- Provide information about actuarial accrued liabilities for promised benefits associated with past services and… to what extent those benefits have been funded
- Provide information useful in assessing potential demands on the employer's future cash flows"



GASB 45: How will reporting be affected?

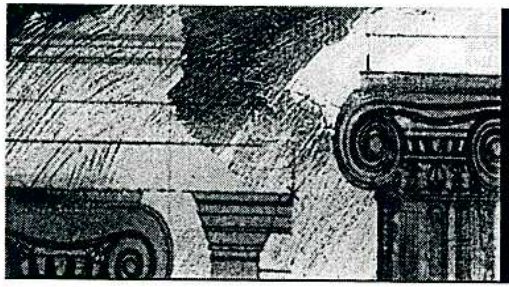
Major Requirements of the Statement for Employers--

- Conduct actuarial valuation of retiree health care plan which would include actuarial accrued liabilities (and assets, if any)

- Determine Annual Required Contribution (ARC)--adjusted annual OPEB cost on an accrual basis

- Report the net OPEB obligation—the cumulative difference between the ARC and the employer's actual contribution

Note: GASB does not require funding of OPEB—only reporting/accounting



Specific OPEB Cases

Selected unfunded OPEB liabilities reported so far…

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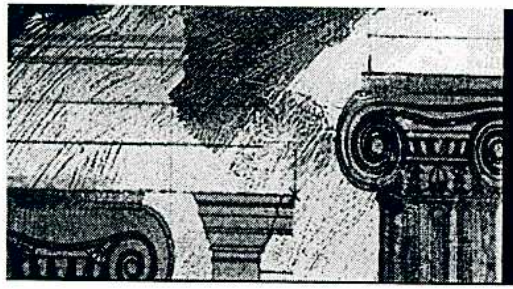

Managing OPEB: What are your options?

OPEB obligations, like pension obligations, may be managed by affecting either:

- Liabilities, or

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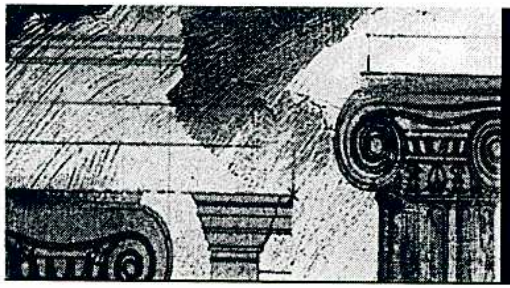
- Assets



Managing OPEB: Strategies to Mitigate Liabilities

Options may include--

- Close existing plan
- Reduce retiree healthcare benefits outright
- Offer new employees (or new retirees) a lower benefit level

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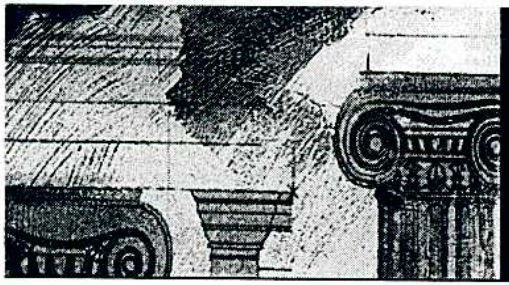

Strategies to Mitigate Liabilities (continued)

Additional options--

- Cap employer-provided benefits

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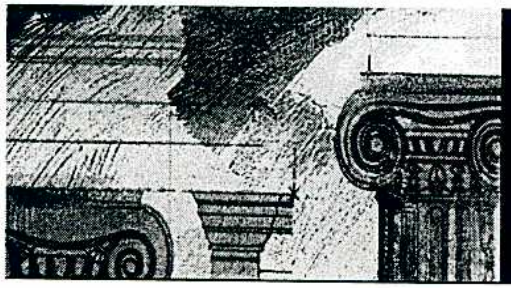
- Convert defined benefit plan to a defined contribution plan



Managing OPEB: Strategies to Enhance Assets

Increase payments for retiree healthcare

- Employer may pay full GASB 45 ARC thereby funding an OPEB trust

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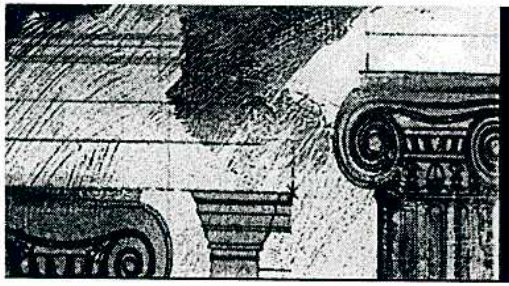
- Employee contributions may be initiated or increased



Managing OPEB: Strategies to Enhance Assets (continued)

If the employer chooses to pay the full ARC, it then:

- Takes advantage of investment earnings (and a higher discount rate under GASB 45)
- Increases benefit security
- Includes a commitment of higher costs

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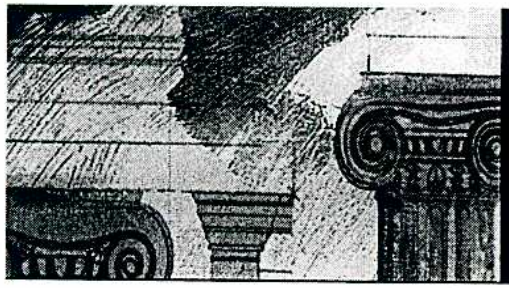

Enhancing OPEB Assets (continued)

Is funding a portion of the unfunded liability with OPEB Obligation Bonds an option?

- Similar in concept to Pension Obligation Bonds
- May be greater legal hurdles… initially
- Fast injection of assets into OPEB trust
- Same risks as POBs, including investment risk

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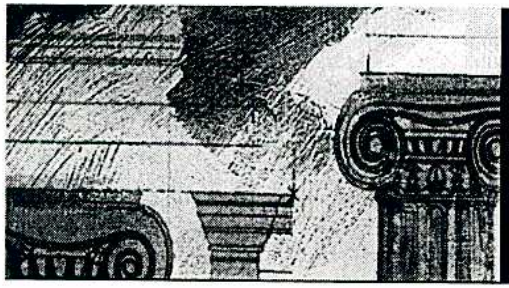

Credit Implications of Retiree Health Care/GASB 45

View from 30,000 feet -

a. As part of our credit analysis, S&P is always looking for factors that could adversely affect a government's ability to pay bond debt service

b. OPEB liabilities, like pension liabilities, are considered debt-like in nature

c. While similar to pension liabilities, they are harder to measure, and may be more volatile and more susceptible to exogenous events

d. The big question: might OPEB liabilities endanger creditworthiness?

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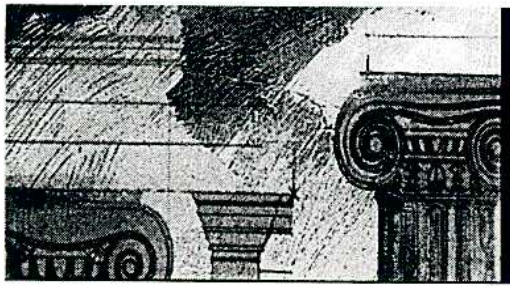

OPEB Credit Implications (continued)

OPEB Touches Ratings in Three Major Areas

- Managerial
- Financial
- Debt

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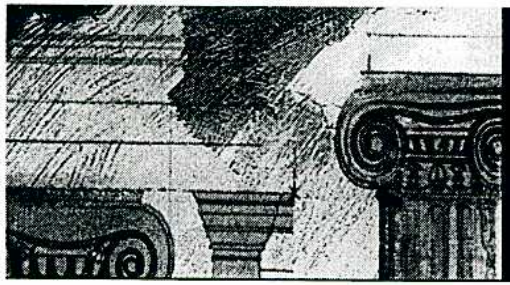

OPEB Managerial Credit Factors

GASB 45 Management Issues

- How well understood are the liabilities associated with specific benefits?
- What methods and assumptions are being used to determine liabilities?
- Are the GASB 45 actuarial valuation results going to be complete surprise?

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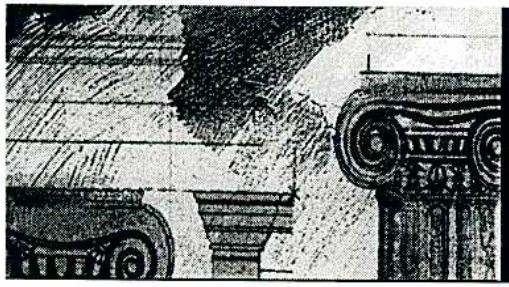

OPEB Managerial Credit Factors (continued)

Once the OPEB liability and ARC numbers are known, management's plan to deal with them going forward will be of the utmost importance

- Are the current level of benefits sustainable – economically and politically?
- If not, what can be done to lighten the burden?
- What are the employer's most likely alternatives to reduce liabilities or increase assets?

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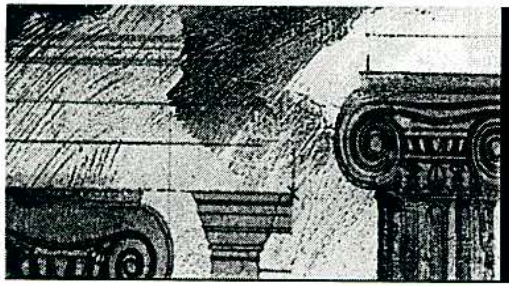

OPEB Financial Credit Factors

Public Policies and Financial Policies must be balanced

- Can the budget afford the OPEB ARC (or even an escalating PayGo scenario)?
- Are there other areas to cut to make room?
- How/when will it compromise financial flexibility?
- Will creditworthiness be jeopardized?

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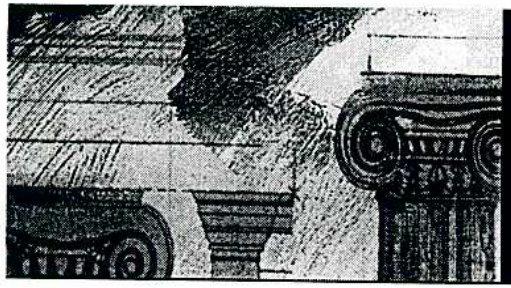

OPEB Debt Credit Factors

In that OPEB Liabilities are debt-like—

- How does OPEB alter the long-term liability landscape for the employer?
- How does the employer stack up to its peers?
- Will total carrying charges of bond debt service, pension contributions, plus OPEB contributions be sustainable given existing (or projected) resources?

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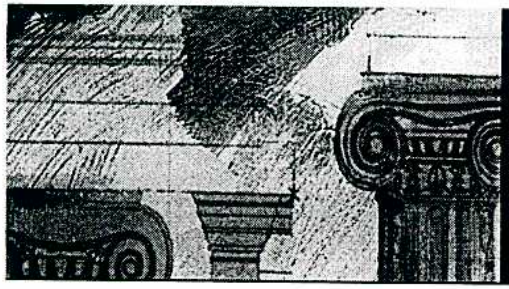

Summary/Conculsions

- Many governments will be able to assimilate GASB 45 without disruption, while for others it will cause a catharsis

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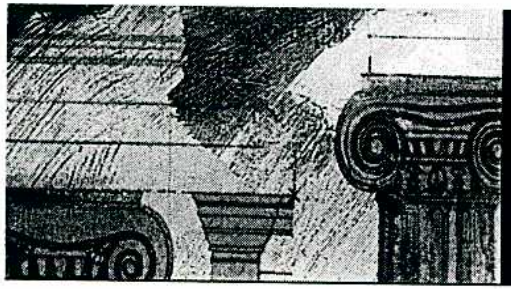
- In the latter cases, painful decisions will have to be made and acted upon

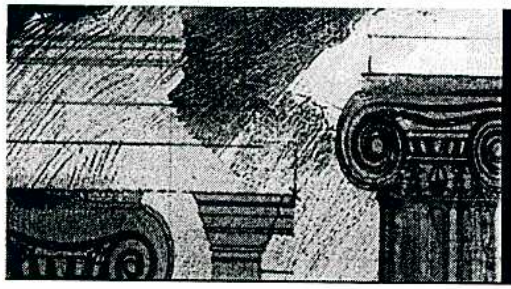


Summary/Conclusions (continued)

To date, we have observed the beginnings of two significant trends related to the new OPEB reporting:

- The liabilities are going to be huge--in some cases
- There will be a wide range of liabilities from government to government—from little or no liabilities to significant amounts

These disparities may be large enough to cause rating distinctions



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