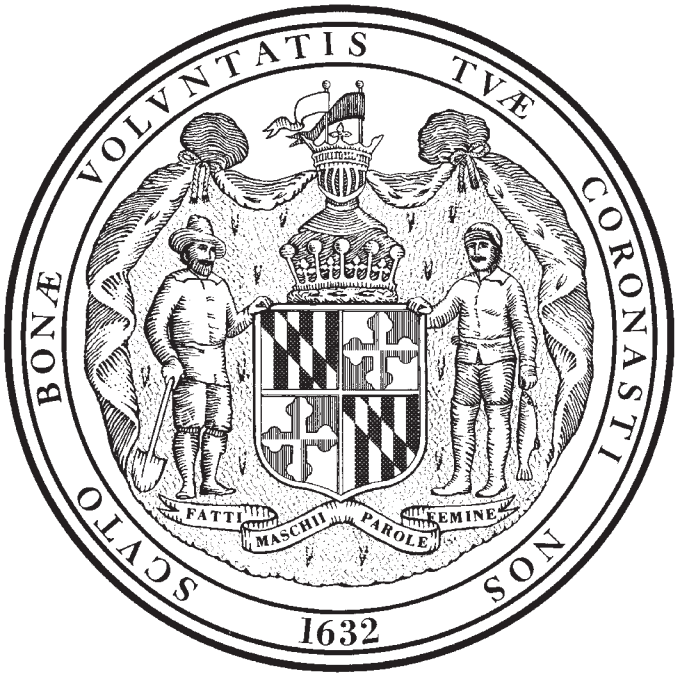
Blue Ribbon Commission To Study Retiree Health Care Funding Options

2008 Interim Report



Annapolis, Maryland
December 2008

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December 31, 2008

The Honorable Martin J. O'Malley
Governor, State of Maryland

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate of Maryland

The Honorable Michael E. Busch
Speaker of the House of Delegates

Gentlemen:

On behalf of the Blue Ribbon Commission to Study Retiree Health Care Funding Options established by Chapter 433 of 2006, we respectfully submit this interim report. Pursuant to the requirement for an interim report included in Chapters 228 and 229 of 2008, this report summarizes the commission's work to date, leading to a final report by December 31, 2009. It reflects commission members' hard work and commitment to tackling the challenge of developing a strategy to address the State's growing retiree health liabilities.

Over the past 18 months, through full commission meetings and smaller workgroups, the commission has worked to become familiar with the magnitude of the liability facing the State, the root causes of that liability, and potential funding solutions. Through these efforts, the commission has learned that Maryland offers retirees among the most generous health benefits available in either the public or private sectors. That level of benefits has generated a long-term liability of more than $15 billion, roughly the current size of the State's general fund. Under new rules promulgated by the Governmental Accounting Standards Board, the State would have to begin recognizing a portion of those liabilities on its annual financial statements unless it makes annual contributions to a trust fund to offset them. The annual required contribution necessary to fully fund the State's liability is between $809 million and $1.2 billion, of which the State already pays $314 million in pay-as-you-go costs.

Given the magnitude of the State's liability, combined with severe strains on the State's fiscal condition prompted by the current recession, it is clear to members of the commission that Maryland cannot sustain the current level of retiree health benefits into the future. At the same time, the commission recognizes that retiree benefits are an important component of the State's overall strategy for attracting the best possible employees to public service on behalf of the citizens of Maryland. Therefore, the commission has begun exploring options for redesigning retiree health benefits and/or the way the State pays for them to arrive at a solution that is both fiscally sound and fair to current and retired State employees.

Thank you for the opportunity to serve the citizens of Maryland in this important capacity. We look forward to continuing to serve for another year as we come together to craft an equitable plan. We would like to thank our fellow commission members for their dedication and Michael C. Rubenstein and Anne E. Gawthrop of the Department of Legislative Service for their dependable service.

Sincerely,

Edward J. Kasemeyer
Co-Chair

Melony G. Griffith
Co-Chair

EJK:MGG/MCR:AEG/eck

Maryland General Assembly
Blue Ribbon Commission
to Study Retiree Health Care Funding Options
2008 Membership Roster

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Michael C. Rubenstein

Anne E. Gawthrop

Contents

Blue Ribbon Commission
to Study Retiree Health Care Funding Options

Legislative Authority

Chapter 433 of 2006 established the Blue Ribbon Commission to Study Retiree Health Care Funding Options. The commission was charged with the following seven tasks:

1. Contract with an actuarial consulting firm to conduct an actuarial valuation that illustrates the State's annual required contribution as both a fixed dollar amount and also as a percentage of payroll.

2. Review the specific legal obligations of the State to provide retiree health benefits to existing retirees, fully vested employees, active employees, and new employees.

3. Study the cost drivers associated with the State's unfunded retiree health care liabilities which provide the basis for the unfunded accrued liability as well as the ongoing normal costs associated with the retiree health care liabilities.

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

5. Review the eligibility requirements for State retiree health care benefits with a particular emphasis on whether the requirements are appropriate and equitable.

6. Review alternative vehicles for providing health care benefits to State retirees, including Voluntary Employee Beneficiary Accounts (VEBAs), Section 401(h) accounts, Section 115 trusts, health reimbursement arrangements, and health savings accounts.

7. Recommend a multi-year implementation plan to address fully funding the obligations of the State as set forth in the Governmental Accounting Standards Board's (GASB) Statement 45 as soon as practicable.

With regard to the commission's first responsibility to contract with an actuarial consulting firm, the Department of Legislative Services (DLS) conducted a competitive procurement to secure the services of an actuarial firm. Five firms submitted proposals, which were reviewed and graded by DLS staff and commission members. Buck Consultants received the highest overall grade and was selected to serve as the commission's actuarial consultant.

Originally, the commission was to submit its final report to the Governor and the General Assembly by December 31, 2008. However, Chapters 228 and 229 of 2008 extended the commission's authority and delayed submission of the final report until December 31, 2009. This report fulfills a statutory requirement for an interim report by December 31, 2008, included in Chapters 228 and 229.

Membership of the commission, as set forth in Chapter 433 and later amended by Chapter 355 of 2007, includes the following individuals:

- Five members of the Senate
- Five members of the House of Delegates
- State Treasurer or designee
- State Comptroller or designee
- Chancellor of the University System of Maryland or designee
- Executive Director of the State Retirement Agency or designee
- Secretary of Budget and Management or designee
- Three members of the public with expertise in either funding retiree health benefits, the economics of affordable retiree health programs, or investing pension fund assets. One member each is appointed by the Governor, President of the Senate, and Speaker of the House.

Background and History

In 2004, GASB issued new standards that require State and municipal governments to recognize liabilities for post-employment benefits other than pensions (OPEB) on their balance sheets as they accrue rather than on a pay-as-you-go (PAYGO) basis. In effect, the new standards require public employers to account for OPEB benefits (typically health insurance coverage for retirees) in the same way that they treat pension benefits. The standards require Maryland to conduct an actuarial valuation of its OPEB liabilities at least every two years, and to reflect any unfunded portion of those liabilities on its annual balance sheet beginning in fiscal 2008.

GASB does not have the authority or mechanism to enforce its standards, but state compliance with the standards is considered by the bond rating agencies. All three rating agencies have indicated that they will examine states' compliance with the GASB standards during their reviews. However, they have all acknowledged that states will have a few years during which to develop a plan to comply with the new standards before there are any rating implications. Moreover, they acknowledge that OPEB liabilities, like pension liabilities, are considered "soft" debt and will be treated differently than bonded debt.

Like almost all states, Maryland funds and accounts for its retiree health benefits on a pay-as-you-go basis. Current PAYGO costs, based on medical claims data, are estimated by the

actuary to be $314 million. The 2007 valuation of the State's OPEB liabilities put them at $15.2 billion, with an annual required contribution (ARC) of $1.2 billion. The ARC represents the sum of the 30-year amortization payment of the accrued liabilities and the normal cost, or the liabilities accrued by active employees in the current year. If the State funds the ARC by paying the full amount into an irrevocable trust for the purpose of paying future retiree health care costs, it will have no net OPEB obligation under the GASB standards. Any portion of the ARC that is not funded on an annual basis appears as a liability on the State's balance sheet and accrues interest. To the extent that the State's unfunded OPEB liability multiplies at a rapid pace, it could, eventually, negatively affect the State's AAA bond rating.

If the State fully funds the ARC, GASB allows it to use a higher discount rate in projecting its liabilities. The unfunded discount rate used by the actuary is 4.25%; the full funding discount rate is the same rate used by the State pension fund, or 7.75%. Under the full-funding scenario, the State's OPEB liabilities drop to $9.2 billion, with an ARC of $809 million.

In an effort to begin pre-funding its OPEB liabilities, the State began setting aside funds in fiscal 2007, 2008, and 2009. The fiscal 2007 budget set aside $100 million into the Dedicated Purpose Account, which was later transferred to the OPEB trust fund once it obtained the necessary IRS clearance as an irrevocable trust. The fiscal 2008 budget as enacted also set aside $100 million in general funds in the Dedicated Purpose Account toward pre-funding the State's liabilities. During the 2008 legislative session, however, the General Assembly cut that figure in half. The Governor's fiscal 2009 allowance included a $210 million contribution, all funds, to the OPEB trust fund. As enacted, the fiscal 2009 budget contained half that amount. In October 2009, the Board of Public Works cancelled the remaining $46 million that had yet to be paid into the trust fund as a cost containment measure. As of October 2008, the OPEB trust fund held $148 million.

Maryland retirees are eligible to retain the same health care coverage they had when they were active employees if they satisfy any of the following criteria:

- retire directly from State employment with a State retirement allowance and at least 5 years of creditable service;
- leave State employment with at least 16 years of creditable service;
- leave State employment with at least 10 years of creditable service and within five years of the age at which a vested retirement allowance would begin; or
- retire directly from State employment with a State disability retirement allowance.

The State subsidizes up to 80% of the health insurance premiums paid by retirees for themselves and their spouses. Retirees with at least 16 years of service qualify for the full 80% subsidy; retirees with between 5 and 16 years earn a pro-rated subsidy. Retirees of the Optional Retirement Plan (primarily university and community college faculty) must have 25 years of service in order to earn a full subsidy for their spouses.

Commission Meetings

The full commission met twice during the 2007 interim and once during the 2008 interim to hear presentations by Buck Consultants, DLS staff, and various experts in the area of retiree health care. The special legislative session held during November 2007 disrupted plans for at least one additional meeting during the 2007 interim. In addition, the commission formed three working groups in the areas of finance, benefits, and legal requirements. Each working group met once during the 2007 interim, and the benefits workgroup met once during the 2008 interim. Agendas for full commission and workgroup meetings are attached as **Appendix 1**.

Actuarial Valuations

Buck Consultants conducted and presented to the commission two actuarial valuations of the State's liability for retiree health care costs, one for fiscal 2006 and one for fiscal 2007. The most recent valuation is attached as **Appendix 2**. The fiscal 2007 valuation estimated the State's total liability for retiree health care costs to be $15.2 billion on an unfunded basis, with an estimated annual required contribution (ARC) of $1.2 billion. On a fully funded basis, those figures were $9.2 billion and $809 million, respectively. Expected pay-as-you-go costs for retiree health were $314 million, resulting in a gap of $495 million between current expenditures and fully funding the State's liabilities on an annual basis.

Consistent with the requirements of Chapter 433, the fiscal 2007 valuation highlighted several factors driving the high cost of Maryland's retiree health care costs. Retirees eligible for Medicare account for 76% of the State's total liability, compared with 24% for retirees who are not eligible for Medicare. Prescription drug costs account for 59% of the total liability, compared with 41% for other medical costs. Spouses account for 37% of the total liability, compared with 63% for members. Finally, current retirees account for 48% of the liability, compared with 52% for future retirees.

A third valuation, for fiscal 2008, is expected to be completed in January 2009.

Benefit Comparisons

The commission heard two presentations comparing Maryland's retiree health benefits to those in other states with AAA bond ratings and to private sector employers. The first presentation, conducted by DLS staff, examined retiree health benefits in the six other states with AAA ratings from all three rating agencies and three additional states with AAA ratings from at least one rating agency. A copy of the DLS report is attached as **Appendix 3.** Overall, the report found that Maryland offers among the most generous package of health benefits to its retirees compared to the benefits offered by the 10 states in the DLS analysis. Of the 10 states examined, Maryland offers the shortest vesting period, the lowest prescription drug co-payments,

the second most plan options, and the second highest premium subsidy. As a result, Maryland has the highest retiree health liability per covered retiree and spouse among these 10 states.

The commission also heard a presentation by Dr. Frank McArdle of Hewitt Associates on recent trends in retiree health benefits among private sector employers. A copy of Dr. McArdle's presentation is attached as **Appendix 4**. Dr. McArdle demonstrated that the percentage of large private employers providing retiree medical benefits has declined steadily from 66% in 1988 to 33% in 2007. By contrast, approximately 90% of state governments continue to offer retiree medical benefits. Almost half of private employers that provide retiree medical benefits have placed a cap on their share of the cost of those benefits. Between 2005 and 2006, more than half of private employers increased retirees' share of premium costs, and between one-quarter and one-third increased cost sharing requirements for retirees.

On behalf of the commission, DLS is currently conducting a survey of retiree health benefits among Maryland counties. Data collection is almost complete and results should be available in January 2009.

Legal Obligation to Provide Retiree Health Benefits

As required by Chapter 433, the commission's legal workgroup received a briefing on an opinion by the Attorney General regarding the State's legal obligation to provide and maintain retiree health benefits. The opinion was originally issued in 2005 in response to a request from a legislative task force that pre-dated the commission. At the commission's request, the Office of the Attorney General reviewed the original opinion to determine if subsequent case law or other developments required any changes and determined that no substantive changes were necessary. A copy of the original Attorney General's opinion is attached as **Appendix 5**.

The Attorney General's opinion concluded that Maryland has a statutory obligation to provide retiree health care, but that the statutory obligation does not create a contractual obligation. Consequently, the State has the flexibility to modify or rescind retiree health benefits through statutory or administrative means.

Medicare Options

Prescription Drugs

Medicare Part D, established by the Medicare Modernization Act of 2003, provides a prescription drug benefit for Medicare participants. To dissuade employers that already provide prescription drug benefits to their retirees from terminating those benefits, Medicare provides a subsidy to employers that offer an actuarially equivalent benefit to that provided by Part D. Maryland, like the vast majority of employers, accepts the subsidy in exchange for maintaining its prescription drug benefit for Medicare eligible retirees. In fiscal 2008, the subsidy totaled approximately $19 million; State law requires that the subsidy be deposited in the OPEB trust fund.

Under GASB rules, however, employers cannot apply the Part D subsidy payments as a credit against the retiree health liabilities they must calculate under GASB 45. If GASB allowed employers to reflect these payments in calculating their actuarial liabilities, the State's liabilities would decrease by approximately $1.5 billion. Under GASB guidelines, the State can apply the Part D subsidy as a credit against its liabilities if it opts for one of two alternative benefit designs. The first, known as the Employer Group Waiver Plan (EGWP), allows the employer to apply to become a qualified insurer of its prescription drug benefit. The State would continue to receive Part D subsidies, which would be reflected in its GASB 45 valuation of retiree health liabilities. The second option would be to contract with a drug benefit manager to create an EGWP. The private contractor would collect the subsidy from Medicare and pass it on to the State in the form of reduced premiums. Once again, federal subsidies collected in this manner would be reflected in GASB 45 valuations in the form of reduced liabilities.

At the direction of the commission, Buck Consultants analyzed the advantages and disadvantages of all three approaches and concluded that the State would be best served by continuing to accept the Part D subsidy. A copy of Buck's presentation is attached as **Appendix 6**. Based on its analysis, Buck concluded that the State would incur additional administrative costs and lose considerable flexibility and control in administering its prescription drug benefit if it opted for either EGWP option. These disadvantages, it concluded, outweighed any potential reduction in the State's retiree health liability that would result.

In a November 2008 meeting of the benefits workgroup, DLS staff introduced members to an approach taken by Raytheon Corp., which shifted its Medicare-eligible retirees to Part D but provided supplemental coverage to cover certain out-of-pocket costs not covered by Part D. DLS and Buck are collecting additional information on this approach, which could dramatically reduce the State's retiree health liabilities, and will present that information at a future meeting of the full commission.

Medicare Advantage

Also at the commission's request, Buck examined the potential benefits of shifting Medicare-eligible retirees to Medicare Advantage plans. Under current rules, State retirees must enroll in Medicare when they are first eligible, and Medicare becomes their primary insurer. State health plans provide supplemental coverage to Medicare-eligible retirees, often compensating them for out-of-pocket expenses such as deductibles and co-payments not covered by Medicare. Medicare Advantage plans, which were significantly expanded by the Balanced Budget Act of 1997, combine traditional Medicare coverage and supplemental coverage into a seamless package, often providing additional benefits such as prescription drug coverage or dental care. While traditional Medicare coverage is administered by the federal government, Medicare Advantage plans are administered by private insurers that contract with Medicare. Medicare Advantage plans may be preferred provider organizations (PPOs), health maintenance organizations (HMOs), private fee-for-service plans, and other types of plans found in the private health insurance market.

To encourage Medicare participants to join Medicare Advantage plans, the federal government subsidizes those plans, paying between 12 and 20% more to Medicare Advantage plans than for traditional Medicare. The commission was informed that at least two states, West Virginia and Pennsylvania, took advantage of the federal subsidy and shifted their Medicare-eligible retirees to Medicare Advantage plans to reduce their costs and future liabilities. At the commission's request, Buck examined whether Maryland could incur any savings by shifting retirees to Medicare Advantage private fee-for service plans. These plans mirror traditional fee-for-service insurance plans, allowing participants to choose their own doctors and minimizing managed care restrictions.

In its analysis, which is also included in Appendix 6, Buck concluded that shifting Medicare-eligible retirees to Medicare Advantage private fee-for-service plans could generate approximately 15% savings in the short run but posed significant long-term risks. Buck noted that approximately 5% of health care providers do not accept Medicare Advantage members (but do accept traditional Medicare), so some State retirees could be forced to find new health care providers. Buck also reported that some Medicare Advantage plans provide lower reimbursement levels than traditional Medicare, deny more claims, and are slow to pay reimbursements. Of greatest concern, however, was the uncertain future of the federal subsidy for Medicare Advantage plans. Democratic leaders in Congress had made public statements indicating that they wanted to repeal the subsidy for Medicare Advantage, and then-presidential candidate Barack Obama had targeted the subsidy for elimination in his proposal to expand health coverage. In light of those developments, Buck recommended against shifting Medicare-eligible retirees to Medicare Advantage plans.

Debt Financing of OPEB Liabilities

The commission heard a presentation by Public Financial Management (PFM), the State Treasurer's financial advisor, on the advantages and potential risks of using debt to finance a portion of the State's OPEB liabilities. PFM's presentation is attached as **Appendix 7.** The potential advantage of using debt in the form of OPEB bonds is the opportunity for interest arbitrage. That is, the State may earn a greater return by investing the proceeds of the sale of OPEB bonds than it needs to pay in interest on the bonds and other related expenses. In turn, it can use the principal from the sale of the bonds to pay at least a portion of its ARC. This approach would convert the "soft" OPEB liability into a "hard" liability requiring the full faith and credit of the State to back the new debt. The main risk inherent in this approach, therefore, is that investment returns would fall short of the level necessary to pay the interest on the bonds, requiring an influx of general funds to fill the gap. Given current market conditions and the long-term investment scenario, it is quite possible that the arbitrage assumptions would not be met, either in specific short-term periods or over the life of the debt.

PFM's presentation demonstrated that if the State used OPEB bonds to finance 35% of its accrued liability, and if the arbitrage assumptions were realized, the State could save approximately $1.0 billion over 30 years compared with simply paying the ARC without debt financing. This assumes a $10.00 per bond in underwriter's discount and cost of issuance, a true interest cost of 5.92%, and annual investment returns of 7.75%.

In addition to the inherent risk associated with debt financing that relies on interest arbitrage, another factor could restrict the State's ability to rely on this approach. The Maryland Constitution does not allow the State to issue debt for longer than 15 years, so a 30-year funding scenario for OPEB bonds would require a constitutional amendment.

Benefit Redesign

In its most recent meetings, the commission has turned its attention to options for redesigning retiree health benefits in ways that would reduce future liabilities without placing undue financial burdens on current or future retirees. Its first step was to invite the Employee Benefits Division of the Department of Budget and Management (DBM), which administers the health plan for employees and retirees, to present a summary of mechanisms it has in place to ensure that the plan is administered in a cost-effective manner. DBM's presentation noted that the State health plan requires extensive documentation to ensure that new spouses and dependents are eligible for coverage. It also carries out regular dependent audits to ensure that covered dependents remain eligible to participate. In this regard, the State is more vigilant than many private employers, which do not carry out regular dependent audits. However, while DBM can determine when a dependent reaches the age of 25 and, therefore, is no longer eligible for coverage, it has no independent means of knowing when a spouse is no longer eligible for coverage due to divorce.

DBM reported that the Maryland health plan covers 94% of covered charges submitted by plan members. By contrast, DBM noted that the average coverage ratio for state health plans is between 80 and 85%, again highlighting the fact that Maryland's plan is one of the most generous in the country.

Remaining Agenda

In the upcoming year, the commission will carry out its statutory responsibility to develop a comprehensive, multi-year plan to fully fund the State's OPEB obligation. In doing so, it will draw on the extensive knowledge and information that its members have gained throughout the past two years, which is summarized in this report. It will also call on DLS staff and Buck Consultants for further analysis and presentation of options for funding or reducing the State's OPEB obligations. Specific tasks that will be carried out in the intervening period include:

- completion of the July 1, 2008 actuarial valuation
- compilation of retiree health benefits in Maryland counties
- analysis of the fiscal effects on the State and on current and future retirees of benefit redesign options, including changes to eligibility requirements, subsidy amounts, and benefit levels
- testimony by State employee collective bargaining representatives
- preparation of implementation plan and submission of final report

The commission expects to meet in January 2009 prior to the start of the 2009 legislative session to begin consideration of benefit design options. It will schedule subsequent meetings as needed during the 2009 interim to complete its work.

Blue Ribbon Commission to Study Retiree Health Care Funding Options

Senator Edward J. Kasemeyer, Senate Chair
Delegate Melony G. Griffith, House Chair

Thursday, August 2, 2007, 9:00 a.m.
House Appropriations Committee Hearing Room

Agenda

I. Call to Order and Chairmen's Opening Remarks

II. Overview and Implications of GASB 45

Michael Rubenstein, Department of Legislative Services

III. Presentation of Actuarial Valuation of Maryland's Retiree Health Liabilities

- Introduction to Actuarial Valuation Methodology
- Comparison of 2005 and 2006 Valuations
- Review of GASB 45 Liabilities
- Preliminary Discussion of Cost Saving Strategies

Stephen Oates, Buck Consultants
Hope Stevenson, Buck Consultants

IV. Retiree Health Benefits and Liabilities in Other AAA-rated States

Michael Rubenstein, Department of Legislative Services

Blue Ribbon Commission to Study Retiree Health Care Funding Options

Senator Edward J. Kasemeyer, Senate Chair
Delegate Melony G. Griffith, House Chair

Thursday, September 27, 2007, 1:00 p.m.
House Appropriations Committee Hearing Room

Agenda

V. Call to Order and Chairmen's Opening Remarks

VI. OPEB Liabilities in Maryland Counties and Municipalities

Michael Sanderson, Legislative Director, Maryland Assoc. of Counties

Keith Dorsey, Director of Budget and Finance, Baltimore County

Ted Zaleski, Director of Management and Budget, Carroll County

Elaine Kramer, Chief Financial Officer, St. Mary's County

Lawrence Ulvila, Jr., Chief Executive Officer, Insurance Solutions, Inc.

VII. Health Benefits for Maryland Retirees

Cindy Kollner, Executive Director for Personnel Services and Benefits, Department of Budget and Management
Anne Timmons, Director of Employee Benefits Division, Department of Budget and Management

VIII. Medicare Part D – Prescription Drug Benefits

Stephen Oates, Director, Buck Consultants
Hope Stevenson Manion, Senior Consultant, Buck Consultants

IX. Retiree Health Benefits in the Private Sector

Frank McArdle, Principal, Hewitt Associates

X. Legal Status of Retiree Health Benefits

Bonnie Kirkland, Assistant Attorney General, Attorney General's Office

VII. Chairmen's Closing Remarks and Adjournment

Blue Ribbon Commission
to Study Retiree Health Care Funding Options

Benefits Workgroup

Senator Edward Kasemeyer, Workgroup Leader
December 12, 2007, 1:00 pm
3W Miller Senate Building

Agenda

I. Call to Order and Workgroup Leader's Opening Remarks

II. Presentation of 2007 Actuarial Valuation

- Buck Consultants

III. Briefing on Ohio's Health Care Preservation Program

- Department of Legislative Services Staff

IV. Discussion of Fiscal Estimates of Benefit Adjustments

- See Attached

V. Workgroup Leader's Closing Remarks and Adjournment

Blue Ribbon Commission
to Study Retiree Health Care Funding Options

Finance Workgroup

Delegate Melony Griffith, Workgroup Co-Leader
Delegate Murray Levy, Workgroup Co-Leader

December 12, 2007, 10:00 am
120 Lowe House Office Building

Agenda

I. Call to Order and Workgroup Leader's Opening Remarks

II. Report on Alternatives to Medicare Employer Subsidy

- Buck Consultants

III. Discussion of Funding Options

- See Attached

IV. Workgroup Leader's Closing Remarks and Adjournment

Blue Ribbon Commission to Study Retiree Health Care Funding Options

Legal Workgroup

Senator Rona Kramer, Workgroup Leader

Monday, December 17, 2007, 10:30 a.m.
Room 111, Department of Legislative Services

Agenda

XI. Call to Order and Workgroup Leader's Opening Remarks

XII. Presentation of 2007 Actuarial Valuation Results

Department of Legislative Services

XIII. Legal Status of Retiree Health Benefits

Ms. Bonnie Kirkland, Assistant Attorney General, Attorney General's Office

XIV. Collective Bargaining Process

Mr. Bruce Martin, Assistant Attorney General, Attorney General's Office

XV. Workgroup Leader's Closing Remarks and Adjournment

Blue Ribbon Commission to Study Retiree Health Care Funding

Delegate Melony G. Griffith, House Co-Chair
Senator Edward J. Kasemeyer, Senate Co-Chair

Wednesday, September 3, 2008, 1:30 p.m.
Room 120 House Office Building

Agenda

I. Call to Order and Chairmen's Opening Remarks

II. Report of the Legal Workgroup

- Senator Rona Kramer, Work Group Leader

III. Report of the Benefits Workgroup

- Senator Edward Kasemeyer, Workgroup Leader

IV. Analysis of Benefit Redesign Options

- Mr. Stephen Oates, Buck Consultants

V. Report of the Finance Workgroup

- Delegate Melony Griffith, Workgroup Co-leader
- Delegate Murray Levy, Workgroup Co-leader

VI. Presentation on OPEB Financing

- Ms. Nancy Winkler, Managing Director, Public Financial Management

VII. Discussion

VIII. Chairmen's Closing Remarks and Adjournment

Blue Ribbon Commission to Study Retiree Health Funding Options

Benefits Work Group

Senator Edward Kasemeyer, Workgroup Leader

November 13, 2008, 11:00 am
3W Miller Senate Building

Agenda

VI. Call to Order and Chairman's Opening Remarks

VII. Cost and Quality Controls Within the State Health Plan

- Anne Timmons, Director, Employee Benefits Division, Department of Budget and Management

VIII. Presentation of Benefit Design Options

- DLS Staff

IX. Discussion of Alternative Benefit Designs

- DLS Staff

X. Chairman's Closing Remarks and Adjournment

GASB 45 – July 1, 2007 Actuarial Valuation (Draft)

The Maryland Blue Ribbon Commission to Study Retiree Health Care Funding Options

December 2007

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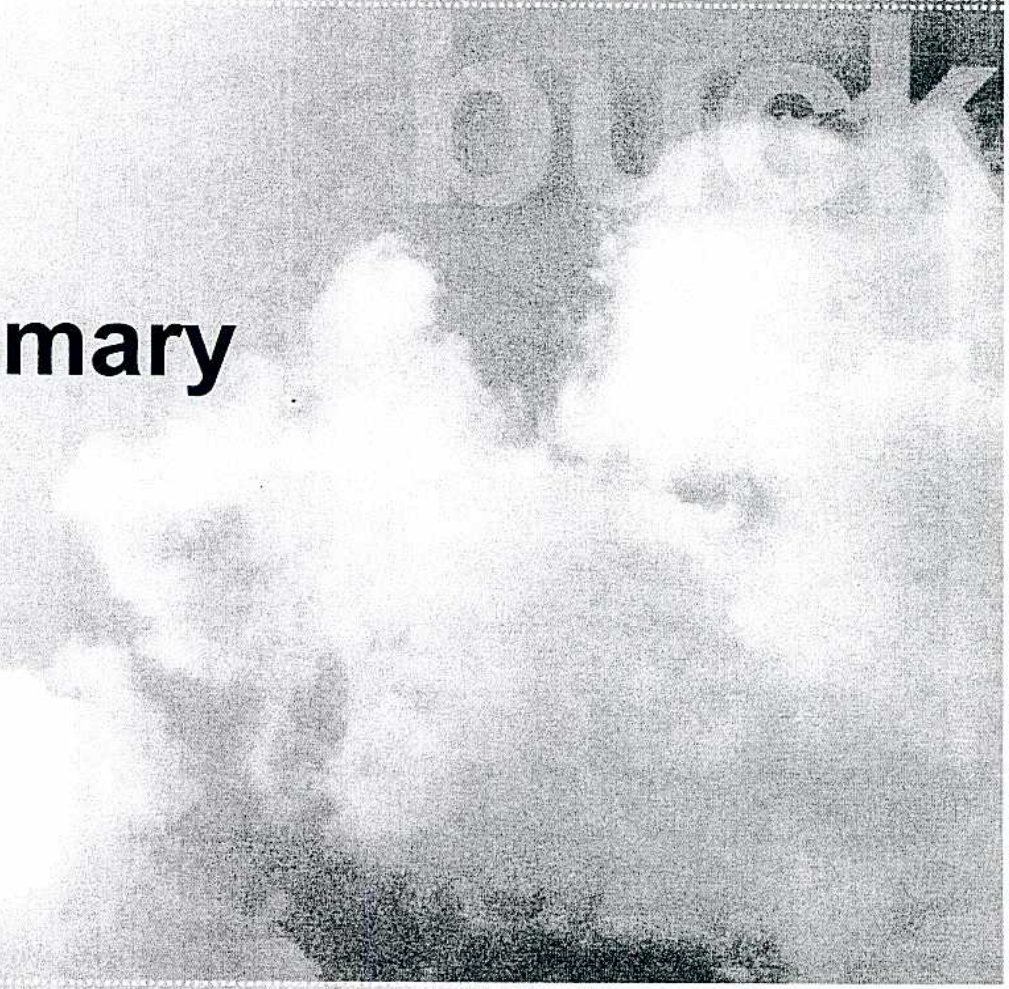
Executive Summary



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Executive Summary – Plan

- The State of Maryland Retiree Health Plan:
  - Benefits include medical, dental, vision, prescription drug and behavioral health.
  - Participants include retirees, disabled retirees, and their eligible dependents. Current active employees and deferred vested participants may be eligible for health benefits in retirement, provided that age and service criteria are met.
  - Amount of State health subsidy is based on service (typically a "full subsidy" is provided after 16 years), but there are specific differences between pension systems (MSRS or ORP). A full subsidy constitutes a cost-sharing arrangement whereby the retiree pays approximately 15% to 20% of premiums (which for pre-Medicare coverage is a blended active/retiree rate).

Executive Summary – Census

- GASB 45 valuation census data by status:

	7/1/2006[1]	7/1/2007
– Active	76,993	84,425
– Deferred Vested	4,398	4,468
– Retirees[2]	35,831	36,913
– Covered Spouses[2]	15,956	16,722
– Total	133,178	142,528

[1] Actuarial results for the 7/1/2006 valuation were adjusted (+4% for active and +1% for inactive) to account for known gaps in census data. No adjustments were made for the 7/1/2007 valuation. Counts shown are unadjusted and reflect complete data only. It is our understanding that the 7/1/2007 census is complete.

[2] Counts of retirees and covered spouses reflect those with medical and/or Rx.

Executive Summary – Assumptions

- Discount Rate
  - Funded rate: 7.75% (same as pension plan)
  - Unfunded rate: 4.25%
    - GASB 45 stipulates that this rate be based on general assets
    - 25% of general assets invested in repurchase agreements, with maturities of 90 days or less ("REPOs")
    - 75% is invested in 1-3 Year Treasuries or Agencies
    - Average return for general fund from FY1996-2006: 4.20%
      The asset mix was recently flipped. Previously the fund was 75% in REPOs and 25% in 1-3 year treasuries.

Source: Maryland State Treasurer's Office

Executive Summary – Assumptions

- Baseline Per Capita Costs
  - Initial health care costs per retiree / dependent
  - Based on analysis of recent plan experience
  - Sample ages with 7/1/2006 costs in parentheses:

	Age 60	Age 65
– PPO:	$7,305 ($7,119)	$1,469 ($1,349)
– POS:	$6,412 ($6,244)	$1,243 ($1,281)
– HMO:	$5,888 ($5,685)	$1,797 ($1,719)
– Rx:	$2,306 ($2,398)	$2,833 ($2,935)
– Dental:	$ 229 ($223)	$ 229 ($223)

Executive Summary – Assumptions

- Healthcare Cost Trend Rates – Baseline Assumption

  More or less conservative alternatives are provided for health plans and Rx, which start at +/- 1.0% for initial rate and grade down to +/-0.5% at ultimate

	Health Plans	Rx	Dental
FY 2008	10.0%	11.0%	5.0%
FY 2009	9.0%	10.0%	4.5%
FY 2010	8.0%	9.0%	4.5%
FY 2011	7.5%	8.0%	4.5%
FY 2012	7.0%	7.5%	4.5%
FY 2013	6.5%	7.0%	4.5%
FY 2014	6.0%	6.5%	4.5%
FY 2015	5.5%	6.0%	4.5%
FY 2016	5.0%	5.5%	4.5%
Ultimate	5.0%	5.0%	4.5%

Executive Summary – Assumptions

- Demographic: generally use pension assumptions
  - Mortality, turnover, retirement, disability
  - Demographic assumptions have been updated since the last valuation at 7/1/2006, due to changes adopted for the State Retirement and Pension System of Maryland.
  - Updated assumptions were based on a study of plan experience from July 1, 2002 to June 30, 2006.
  - Updated mortality tables reflect anticipation of longer life expectancies. This translates into increased plan costs.

Executive Summary – Assumptions

- Health care specific assumptions
  - Elect to Participate in the Health Plan at Retirement
    - Direct Retirement
      - » 87%, if have 16 or more years service
      - » 65%, if have 10 -15 years of service
      - » 35%, if have < 10 years of service
    - Retire as Eligible Deferred Vested
      - » 40%, if have 16 or more years of service
      - » 20%, if have less than 16 years of service
  - Plan Choice at Retirement: POS: 31%, PPO: 57%, HMO: 12%
  - Cover a Spouse at Retirement: Male: 70%, Female: 40%
    Husbands are assumed to be 3 years older than their wives

Executive Summary – Assumptions

- Actuarial Cost Method
  - Entry Age Normal ("EAN") cost method (percent of pay)
    - For active employees, this method is intended to allocate costs evenly on a level percent of pay basis
    - This method is common in the governmental sector. Nearly 80% of large state plans use the EAN method.[1]
  - Sensitivity results provided under Projected Unit Credit (PUC) method
- Amortization of unfunded actuarial liability (UAL)
  - Percentage of pay basis, with 30 year amortization
  - Assuming 3.5% aggregate growth in salary
- Valuation Date: July 1, 2007

[1] Source: 2004 Comparative Study of Major Public Employee Retirement Systems; Wisconsin Legislative Council; December 2005

Executive Summary – GASB 45 Results

- Actuarial Accrual Liability (Gain)/Loss (in billions)

Discount Rate	Unfunded (4.25%)
Healthcare Cost Trend Rate	Baseline
Funding Method	EAN (level %)
Actuarial Accrued Liability (AAL) at July 1, 2006	**$14.543**
Normal cost	$0.567
Expected pay-go costs	($0.304)
Interest on AAL, normal cost and pay-go costs	$0.636
Expected Actuarial Accrued Liability (AAL) at July 1, 2007	**$15.442**
Actual Actuarial Accrued Liability (AAL) at July 1, 2007	**$15.193**
(Gain) / Loss in AAL = Actual AAL minus Expected AAL	**($0.249)**

Economic and demographic assumption changes approved by the State Retirement and Pension System of Maryland were incorporated into the July 1, 2007 GASB 45 valuation and resulted in roughly an 8% actuarial loss. While numerous assumption changes were made, the loss was driven largely by anticipated mortality improvement. Better than expected claims experience resulted in nearly an 8% actuarial gain, which offset the assumption change loss. The plan also enjoyed a modest census data gain.

Executive Summary – GASB 45 Results

- Funding Methods: Entry Age Normal (EAN) vs. Projected Unit Credit (PUC)

Discount Rate	Unfunded (4.25%)		Funded (7.75%)	
Funding Method	EAN	PUC	EAN	PUC
Actuarial Accrued Liability (AAL)				
Current Retirees	$7.000	$7.000	$4.668	$4.668
Current Deferred	$0.342	$0.342	$0.187	$0.187
Active Employees	$7.851	$7.635	$4.317	$3.811
TOTAL AAL	**$15.193**	**$14.977**	**$9.172**	**$8.666**
Present Value of Future Normal Costs				
Normal Cost (this year)	$0.583	$0.568	$0.235	$0.250
Normal Cost (following years)	$5.982	$6.213	$1.767	$2.258
TOTAL PV of Future Normal Costs	$6.565	$6.781	$2.002	$2.508
Actuarial PV of Total Projected Benefits	**$21.758**	**$21.758**	**$11.174**	**$11.174**
Unfunded Actuarial Liability (UAL)	**$15.193**	**$14.977**	**$9.172**	**$8.666**

Executive Summary – GASB 45 Results

- Funding Methods: Entry Age Normal (EAN) vs. Projected Unit Credit (PUC)

Discount Rate	Unfunded (4.25%)		Funded (7.75%)	
Healthcare Cost Trend Rate	EAN	PUC	EAN	PUC
Amortization of UAL				
Current Inactives (incl. Deferred)	$0.283	$0.283	$0.294	$0.294
Active Employees	$0.302	$0.294	$0.262	$0.231
TOTAL UAL Amortization	$0.585	$0.577	$0.556	$0.525
Normal Cost (with interest)	$0.608	$0.592	$0.253	$0.269
TOTAL ARC	**$1.193**	**$1.169**	**$0.809**	**$0.794**
Expected pay-go costs	$0.314	$0.314	$0.314	$0.314
Ratio of ARC to pay-go-costs	3.8	3.7	2.6	2.5

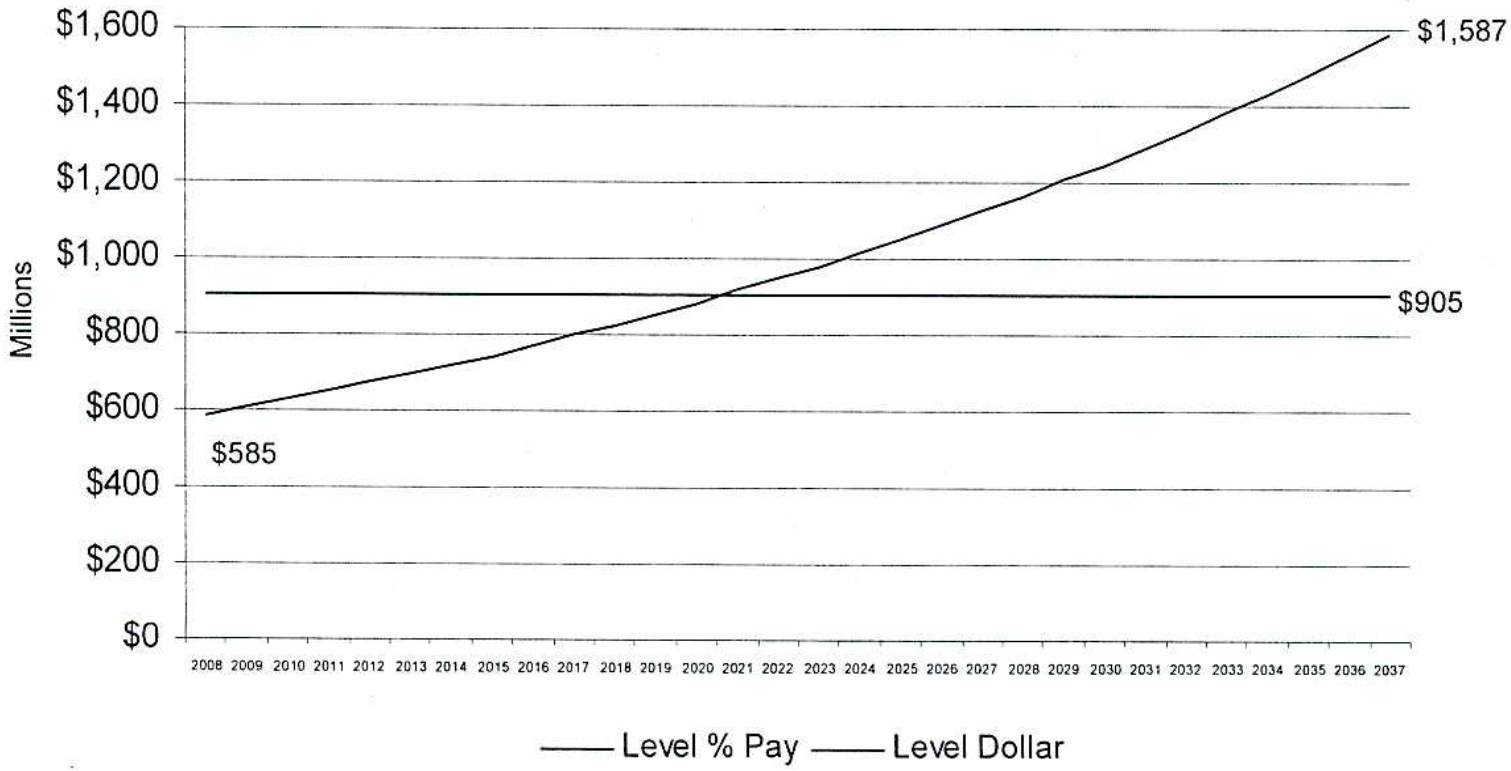
Executive Summary – GASB 45 Results

- Actuarial Present Value of Total Projected Benefits (in billions)

Discount Rate	Unfunded (4.25%)			Funded (7.75%)
Healthcare Cost Trend Rate	Lower	Baseline	Higher	Baseline
Actuarial Accrued Liability (AAL)				
Current Retirees	$6.495	$7.000	$7.594	$4.668
Current Deferred	$0.308	$0.342	$0.379	$0.187
Active Employees	$6.920	$7.851	$8.976	$4.317
TOTAL AAL	**$13.723**	**$15.193**	**$16.949**	**$9.172**
Present Value of Future Normal Costs				
Normal Cost (this year)	$0.506	$0.583	$0.680	$0.235
Normal Cost (following years)	$5.097	$5.982	$7.080	$1.767
TOTAL PV of Future Normal Costs	$5.603	$6.565	$7.760	$2.002
Actuarial PV of Total Projected Benefits	**$19.326**	**$21.758**	**$24.709**	**$11.174**
Unfunded Actuarial Liability (UAL)	**$13.723**	**$15.193**	**$16.949**	**$9.172**

Executive Summary – GASB 45 Results

- Comparison of Unfunded Actuarial Liability Amortization Approaches
  [Discount rate of 4.25%, Baseline Trend, Aggregate Salary growth of 3.50%]



Executive Summary – GASB 45 Results

- Annual Required Contribution (ARC) (in billions)

Discount Rate	Unfunded (4.25%)			Funded (7.75%)
Healthcare Cost Trend Rate	Lower	Baseline	Higher	Baseline
Amortization of UAL				
Current Inactives (incl. Deferred)	$0.262	$0.283	$0.307	$0.294
Active Employees	$0.266	$0.302	$0.346	$0.262
TOTAL UAL Amortization	$0.528	$0.585	$0.653	$0.556
Normal Cost (with interest)	$0.528	$0.608	$0.709	$0.253
TOTAL ARC	**$1.056**	**$1.193**	**$1.362**	**$0.809**
Expected pay-go costs	$0.314	$0.314	$0.314	$0.314
Ratio of ARC to pay-go-costs	3.4	3.8	4.3	2.6

Executive Summary – GASB 45 Results

- Annual Required Contribution (ARC)

Discount Rate	Unfunded (4.25%)			Funded (7.75%)
Healthcare Cost Trend Rate	Lower	Baseline	Higher	Baseline
Active Compenents of ARC				
Normal Cost (with interest)	11.8%	13.6%	15.9%	5.7%
Amortization of UAL for Actives	6.0%	6.8%	7.7%	5.9%
TOTAL Active ARC Components	17.8%	20.4%	23.6%	11.6%
Amortization of UAL for Inactives	5.9%	6.3%	6.9%	6.6%
TOTAL ARC as a percent of payroll	**23.7%**	**26.7%**	**30.5%**	**18.2%**
Total Covered Payroll (in billions)	$4.469	$4.469	$4.469	$4.469

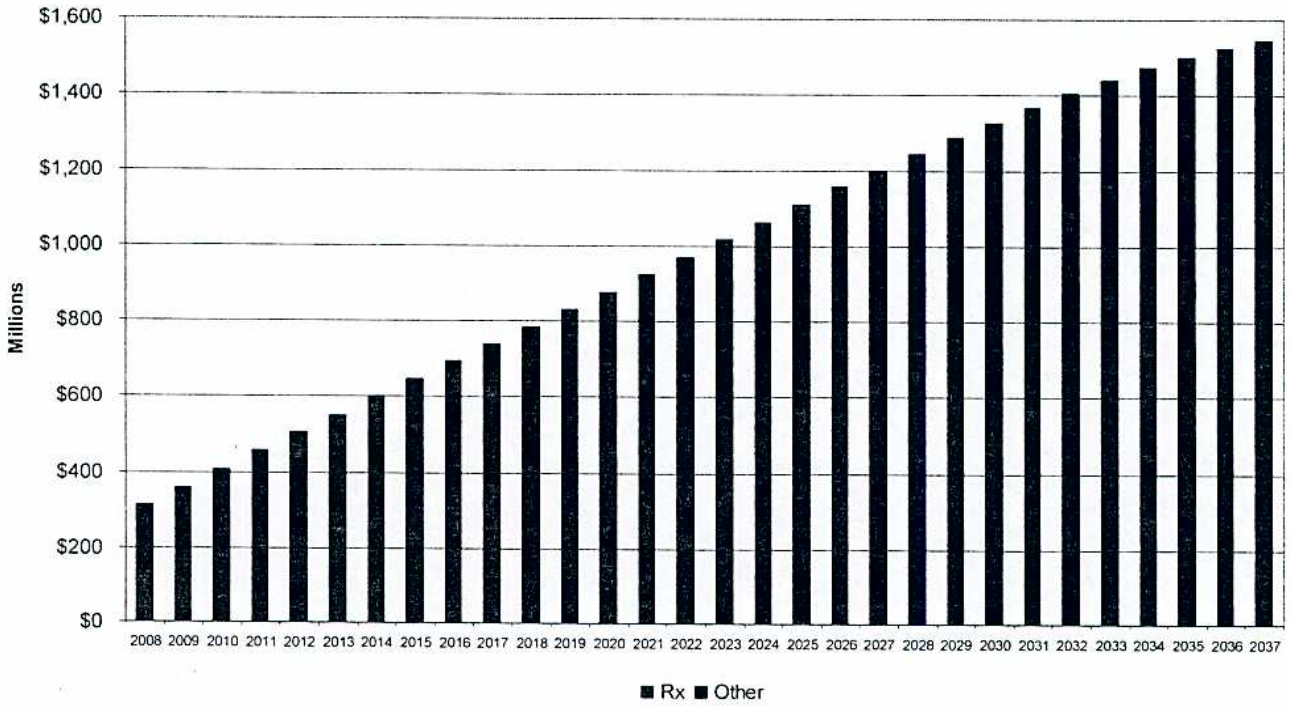
Executive Summary – GASB 45 Results

- Balance Sheet Information: Net OPEB Obligation (NOO) (in billions)

Discount Rate	Unfunded (4.25%)			Funded (7.75%)
Healthcare Cost Trend Rate	Lower	Baseline	Higher	Baseline
Net OPEB Obligation (NOO) - 6/30/2007	$0.000	$0.000	$0.000	$0.000
Annual OPEB Cost (AOC)				
ARC	$1.056	$1.193	$1.362	$0.809
Interest on NOO at beg. of year	$0.000	$0.000	$0.000	$0.000
TOTAL AOC	$1.056	$1.193	$1.362	$0.809
Contributions				
Pay-go costs	$0.314	$0.314	$0.314	$0.314
Pre-funding	$0.000	$0.000	$0.000	$0.495
TOTAL Contributions	$0.314	$0.314	$0.314	$0.809
Net OPEB Obligation (NOO) - 6/30/2008	$0.742	$0.879	$1.048	$0.000

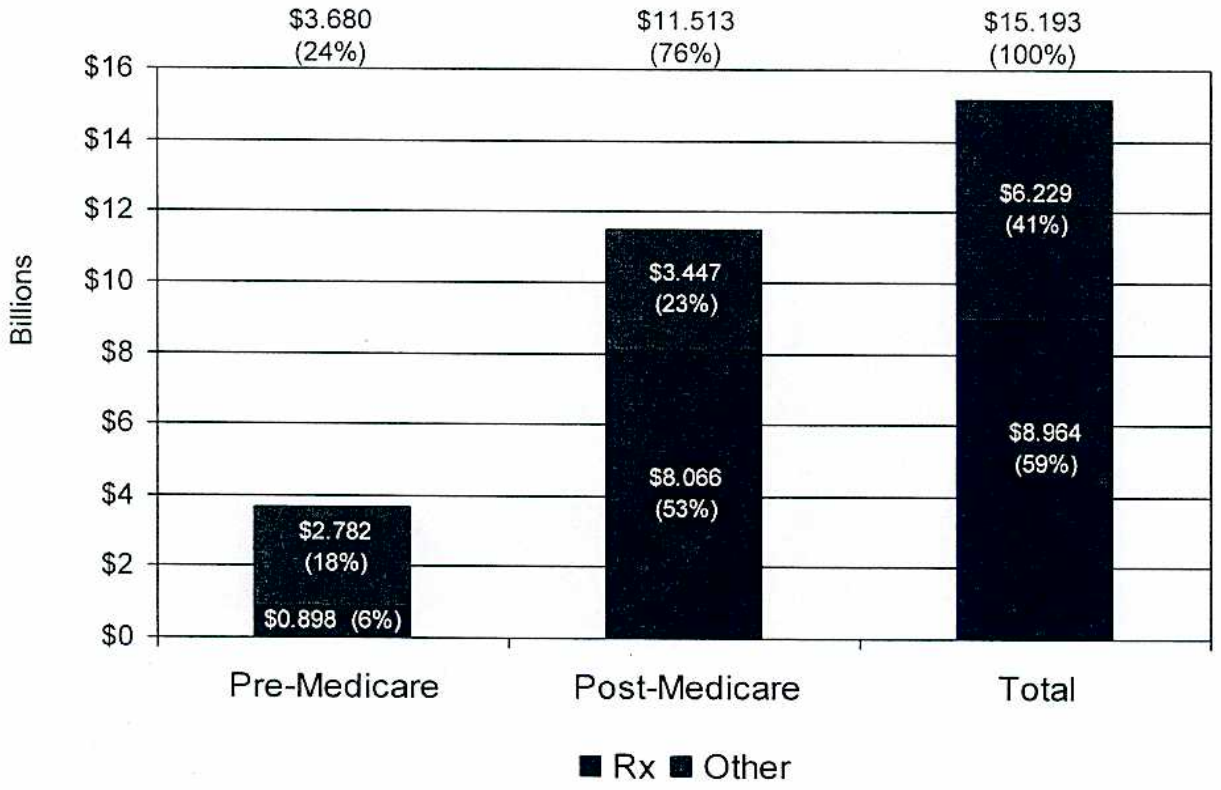
Executive Summary – GASB 45 Results

- Projected cash benefit payments for Retiree Health Care
  [based on a closed valuation of current retirees and employees at baseline trend]



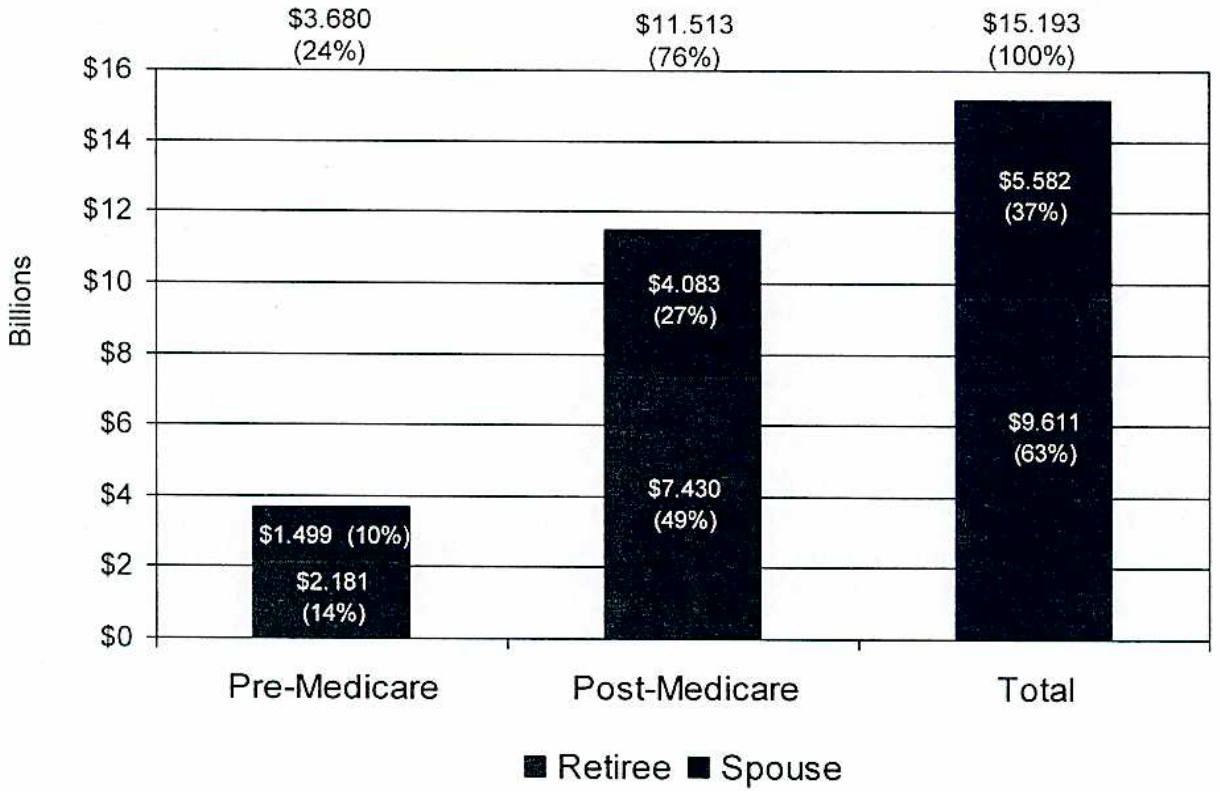
Executive Summary – GASB 45 Results

- Actuarial Accrued Liability Cost Drivers:
  Pre/Post Medicare – Rx



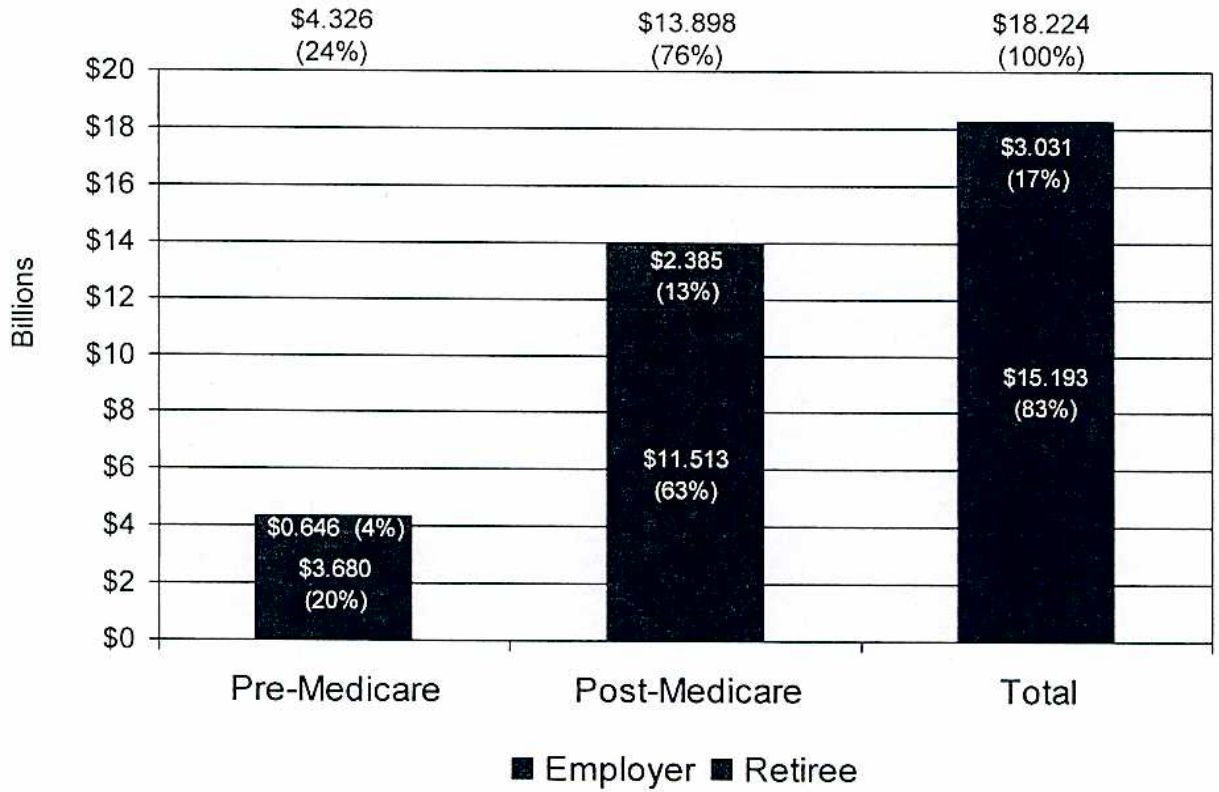
Executive Summary – GASB 45 Results

- Actuarial Accrued Liability Cost Drivers:
  Pre/Post Medicare – Spouse Cover



Executive Summary – GASB 45 Results

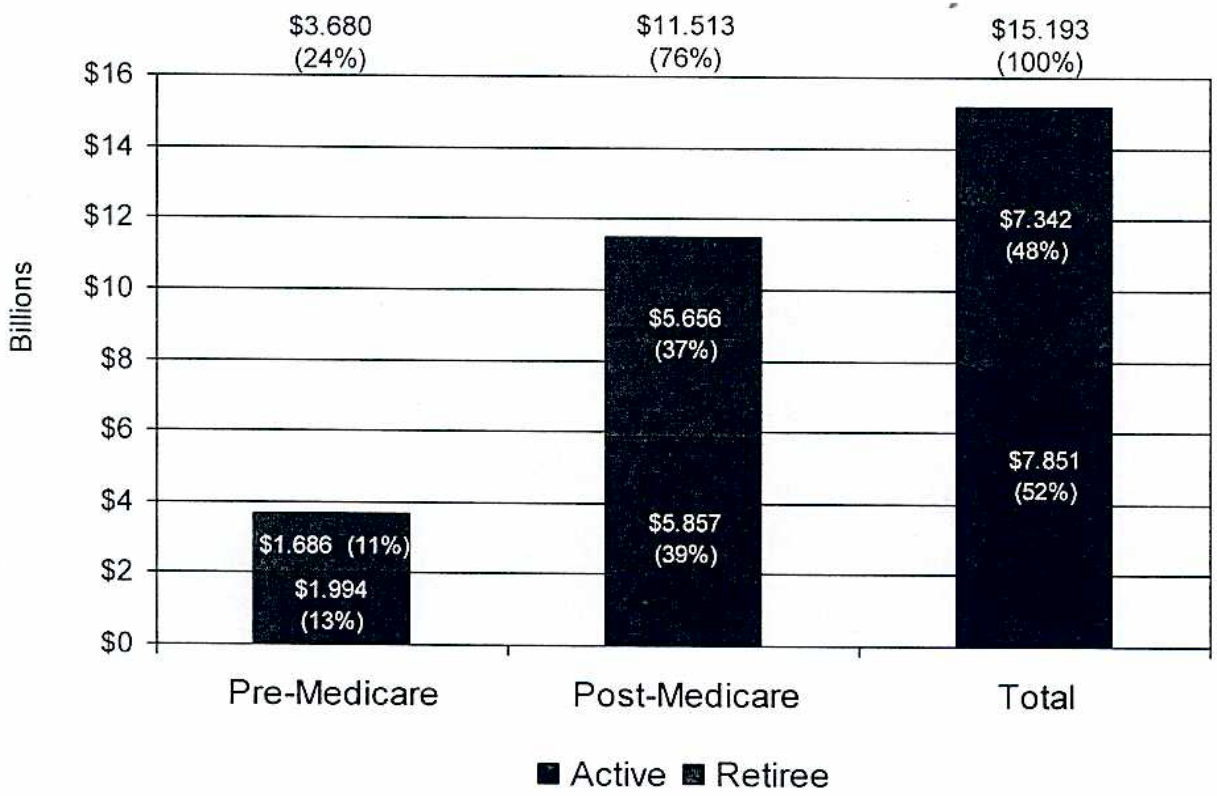
- Actuarial Accrued Liability Cost Drivers:
  Pre/Post Medicare – Employer/Retiree Share



* Note that retiree share reflects premium only. Out-of-pocket costs are not reflected.

Executive Summary – GASB 45 Results

- Actuarial Accrued Liability Cost Drivers:
  Pre/Post Medicare – Participant Status



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Comparison of Retiree Health Benefits and Liabilities in AAA-rated States

Presentation to the

Blue Ribbon Commission to Study
Retiree Health Care Funding Options

Department of Legislative Services
Office of Policy Analysis
Annapolis, Maryland

August 2, 2007

Comparison of Retiree Health Benefits and Liabilities in AAA-rated States

Besides Maryland, there are six other states with AAA bond ratings from all three rating agencies. They are:

- Delaware
- Georgia
- Missouri
- North Carolina
- Utah
- Virginia

In addition, there are three states with AAA bond ratings from at least one rating agency. They are:

- Florida
- Minnesota
- South Carolina

To place Maryland's liabilities for other post-employment benefits (OPEB) in context, this report compares Maryland with these nine states along the following dimensions:

- Retiree health benefits
- OPEB liabilities (overall and per capita)
- Measures taken to address OPEB liabilities

Retiree Health Benefits

Exhibit 1 compares retiree health benefits in all 10 AAA-rated states. Overall, Maryland's benefits are among the most generous offered to retirees in these states.

Exhibit 1
Retiree Health Benefits in AAA-rated States

State	Non-Medicare Plan Options	Medicare-eligible Plan Options	Vesting Period	State Share of Premium	Prescription and Dental Coverage	Prescription Drug Co-payments
Maryland	**2 PPOs; 3 POSs; 3 HMOs**	**2 PPOs; 3 POSs; 3 HMOs**	**5 years for partial benefit; 16 years for full benefit**	**Full subsidy given for 16 years of service; subsidy pro-rated for 5 to 16 years of service PPO – 80% POS – 83% HMO – 85%**	**Prescription and dental coverage available as add-ons, with 80% subsidy for premiums**	**$5 generic $15 formulary $25 non-formulary**
Delaware	1 basic plan; 1 traditional indemnity; 1 PPO; 2 HMOs (Indemnity plan dropped in 2007)	2 Medicare supplements; 1 HMO (Only 1 Medicare supplement available in 2007)	10 years for partial benefit; 20 years for full benefit	For basic plan: <10 years – 0% 10 years – 50% 15 years – 75% 20 years – 100% For all other plans, retirees pay difference between the premium for their selected plan and the basic plan premium	Prescription coverage included in all plans; Dental coverage available as add-on, with retiree paying 100% of premium	$8.50 generic $20 formulary $45 non-formulary

State	Non-Medicare Plan Options	Medicare-eligible Plan Options	Vesting Period	State Share of Premium	Prescription and Dental Coverage	Prescription Drug Co-payments
Florida	1 standard PPO; 1 high-deductible PPO; Regional HMOs	1 standard PPO; 1 high-deductible PPO; Regional HMOs	6 years for partial subsidy; 30 years for full subsidy	Retirees earn state health insurance subsidy of $30 per month for 6 years of service, which can be applied toward premium for medical coverage; subsidy increases $5/month for each additional year of service, up to $150/month for 30 or more years of service	Prescription and dental coverage included in all plans	$10 generic $25 formulary $40 non-formulary
Georgia	1 Indemnity; 1 PPO; 4 HMOs; 4 high-deductible	1 Indemnity; 1 PPO; 4 HMOs; 4 high-deductible	At age 60 with 10 years of service, or any age with 25 years.	State pays 85% of PPO coverage for a single retiree and 76% of PPO coverage for a family plan	Prescription coverage in all but some high-deductible plans; Dental coverage available as add-on with retirees paying full cost	$10 generic (PPO) $30 formulary (PPO) $100 non-formulary (PPO)

State	Non-Medicare Plan Options	Medicare-eligible Plan Options	Vesting Period	State Share of Premium	Prescription and Dental Coverage	Prescription Drug Co-payments
Minnesota	3 PPOs	3 Medicare supplements	15 years	State does not subsidize premiums for retirees or their dependents	Prescription coverage included in all plans; Dental coverage available as add-on, with retirees paying full cost	$15 formulary $30 non-formulary
Missouri	1 Statewide PPO; Regional HMOs	1 Statewide PPO; Regional HMOs	Age 60 with 15 years; Age 65 with 4 years	Variable, depending on years of service: Up to 65% for 30 years of service for lowest-cost plan available in your region	Prescription coverage included in all plans; Dental coverage available as add-on, but retiree pays full premium.	$8 generic $35 formulary $55 non-formulary
North Carolina	1 Indemnity; 3 PPOs	1 Indemnity; 3 PPOs	Current employees receive full subsidy after 5 years; new hires receive full subsidy after 20 years	State pays 100% of premiums for eligible retirees but does not subsidize spousal coverage for retirees	Not available	$10 generic $25 formulary $50 non-formulary
South Carolina	1 standard PPO; 1 high-deductible PPO; Regional HMOs	1 Medicare supplement; Regional HMOs	10 years if retire from state; 20 years if leave employment before retirement	State pays 72% of premiums for eligible retirees	Prescription coverage included in all plans; Dental coverage available as add-on with subsidy	$10 generic (PPO) $25 formulary (PPO) $40 non-formulary (PPO)

State	Non-Medicare Plan Options	Medicare-eligible Plan Options	Vesting Period	State Share of Premium	Prescription and Dental Coverage	Prescription Drug Co-payments
Utah	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 Medicare supplement	n/a	No state subsidy Cash value of retiree's unused sick leave deposited into health savings account	n/a	Medicare supplement: 10% generic 25% formulary 50% non-formulary
Virginia	1 standard PPO; 1 high-deductible PPO; 1 Regional HMO	1 Medicare supplement	15 years for partial benefit; 30 years for full benefit	Retirees earn state health insurance credit of $60 per month for 15 years of service; credit increases $4/month for each additional year of service, up to $120 per month for 30 years of service	Prescription coverage included in all plans; Dental coverage included in non-Medicare plan; Dental coverage available as add-on to Medicare supplement with retiree paying full premium	$15 generic $20 formulary $35 non-formulary

HMO: Health Maintenance Organization
POS: Point of Service
PPO: Preferred Provider Organization

Source: Department of Legislative Services' Review of Government Accounting Standards Board Valuations and Benefit Summaries

Plan Options (Non-Medicare eligible)

With a total of 8 plan options and 3 plan types – preferred provider (PPO), point of service (POS), health maintenance organization (HMO) – Maryland offers the second most options to its retirees. Only Georgia, with a total of 10 plan options and 4 plan types (indemnity, PPO, HMO, and high-deductible plans), offers more options to retirees. However, 4 of the plans available to Georgia retirees are high-deductible plans that require high out-of-pocket payments by members before the plan begins reimbursing health costs. Otherwise, most of the remaining AAA-rates states offer between 2 and 4 plans to retirees who are not Medicare eligible.

Plan Options (Medicare Eligible)

Once again, Maryland trails only Georgia in the number of plans available to Medicare-eligible retirees. Unlike Maryland, several states reduce the number of plan options available to Medicare-eligible retirees compared to the number of plans available to those who retire before they are eligible for Medicare. For instance, Delaware offers five different plans to retirees who are not eligible for Medicare, but beginning in 2007, it offers only one Medicare supplement plan and one HMO to Medicare-eligible retirees.

Vesting Period

All states require employees to accrue a minimum number of years of service before they qualify for retiree health benefits and state subsidies. Maryland's service requirements are comparable to those in other AAA-rated states. Certain Maryland retirees are eligible for a partial, pro-rated subsidy after 5 years of service; most retirees earn a full subsidy for themselves and their spouses after 16 years of service (Optional Retirement Program retirees must have 25 years of service before qualifying for a spousal subsidy). Until recently, North Carolina had the most liberal vesting period (5 years) for a full subsidy, but only subsidized retiree premiums (not spouses). However, North Carolina recently increased its service requirement to 20 years for new hires. The most stringent service requirements are in Virginia, which requires 15 years for a partial benefit, and 30 years before earning the full benefit.

State Subsidy

A majority of AAA-rated states (including Maryland) pay a portion of retiree health benefit premiums. Maryland's share of retiree health benefit premiums (80 to 85 percent) is among the highest of its AAA-rated peers. Only Delaware, which offers a 100 percent subsidy for both retirees and spouses after 20 years of service, has a more generous subsidy. Minnesota offers no explicit subsidy, and three states (Florida, Virginia, and Utah) provide modest cash benefits that vary with length of service, which retirees can use toward paying for health premiums. However, these four states offer implicit subsidies by allowing retirees to pay the

same group rates as active employees. Otherwise, explicit subsidies in the remaining states range from 50 to 100 percent of premium costs, often depending on length of service. North Carolina provides a 100 percent subsidy for retirees, but no subsidy for spouses.

Availability of Prescription and Dental Benefits

Every AAA-rated state except Maryland includes prescription coverage as a component of their retiree health plans. Therefore, retirees in each of those states enjoy subsidized prescription benefits only to the extent that the state subsidizes the plan premiums (see previous section). Maryland allows retirees to elect to purchase prescription coverage as an add-on benefit; the State subsidizes 80 percent of the premium for retirees who elect that coverage.

Along with South Carolina, Maryland offers the most generous dental benefit to its retirees. Maryland retirees may elect to purchase dental coverage as an add-on, with the State paying 80 percent of the premium, which is similar to the dental benefit available to South Carolina retirees. Five states make dental coverage available to retirees but require the retirees to pay the full premium. Retirees in these states enjoy an implicit subsidy by paying the same premiums as active employees. Florida includes dental coverage in its health plans but provides only modest premium subsidies (as noted above).

Prescription Co-payments

Maryland's prescription drug co-payments are the lowest among the 10 AAA-rated states. Maryland retirees pay $5 for a 30-day supply of a generic drug, $15 for a preferred name-brand drug, and $25 for a name-brand drug that is not on the preferred list. Each of those co-payments is the lowest among the 10 states in this analysis. By comparison, Georgia has the highest co-payments ($10, $30, $100, respectively).

OPEB Liabilities

Exhibit 2 presents total and percapita OPEB liabilities for each of the AAA-rated states. Maryland has the third highest total OPEB liability of the 10 states in this analysis, but the highest perretiree/spouse liability of all of the states.

Exhibit 2

OPEB Liabilities in AAA-rated States

State	OPEB Liability	Population (2005)	OPEB Liability Per Resident	Covered Retirees and Spouses	OPEB Liability Per Retiree/Spouse
Maryland	**$14.5 billion**	**5,600,000**	**$2,589**	**51,787**	**$279,993**
Delaware	4.4 billion	844,000	5,213	18,250	241,096
Florida	3.6 billion	17,790,000	202	42,085	85,541
Georgia	19.6 billion	9,073,000	2,160	*122,980	159,375
Minnesota	No valuation	5,133,000	n/a	n/a	n/a
Missouri	2.2 billion	5,800,000	379	15,379	143,052
North Carolina	23.8 billion	8,683,000	2,740	*191,618	124,205
South Carolina	10.0 billion	4,255,000	2,350	59,397	168,358
Utah	500 million	2,470,000	202	n/a	n/a
Virginia	1.3 billion	7,567,000	172	**72,387	17,959

OPEB: Other Post-employment Benefit

* Includes retired teachers

**Includes some retired teachers ($105/month maximum benefit) and local government employees ($45/month maximum)

Source: Government Accounting Standards Board Valuations; U.S. Bureau of the Census

Measures Taken to Address OPEB Liabilities

Maryland has taken several steps to address its OPEB liability. Chapter 355 of 2007 designated Maryland's Postretirement Health Benefits Trust Fund as a trust fund for the purpose of pre-funding its OPEB liabilities. In addition, the fiscal 2007 and 2008 budgets, as enacted, each included $100 million contributions to the Dedicated Purpose Account to begin pre-funding the State's OPEB liabilities. Finally, Chapter 433 of 2006 established the Blue Ribbon Commission to Study Retiree Health Care Funding Options. The commission is charged with reviewing the health benefits offered by the State to its retirees and identifying potential cost savings. Pending the commission's findings, Maryland has not made any changes to its retiree benefit structure.

Exhibit 3 shows that the responses of other AAA-rated states to their OPEB liabilities have been mixed. Like Maryland, eight of the remaining nine states have conducted an actuarial valuation of their OPEB liabilities to gauge the size of their accrued liabilities; only Minnesota has not. Five of the nine states have established trusts for the purpose of pre-funding their OPEB liabilities, and two additional states are in the process of establishing those trusts.

Seven of the nine states have joined Maryland in setting aside money in their budgets toward pre-funding their OPEB liabilities. Of those, three states (Delaware, Utah, and Virginia) have implemented plans to fully fund their Annual Required Contributions (ARC). Utah is already paying its full ARC ($48 million annually). Delaware's plan anticipates fully funding its ARC in six years, while Virginia's plan anticipates reaching full funding in five years.

Two states (Utah and North Carolina) have reduced retiree health benefits to lower their future liabilities. In 2005, Utah began phasing out its subsidy for pre-Medicare retiree health benefits and replaced that defined benefit program with a defined contribution plan. The previous program enabled employees who retired before being eligible for Medicare to exchange eight hours of unused sick leave for one month of extended health coverage for up to five years or until age 65, whichever came first. Under the new plan, unused sick leave will be converted to a cash equivalent based on each retiree's final salary, and the balance will be deposited into a health savings account. This move eliminates Utah's future OPEB liabilities, leaving only $500 million in accrued liabilities to fund.

In 2007, North Carolina raised its vesting period for fully subsidized retiree coverage from 5 years to 20, but only for new hires. State employees or teachers employed prior to 2007 are still eligible for a 100 percent subsidy of retiree health care premiums if they retire with at least 5 years of service. Because these changes affect only future hires and not current employees, North Carolina is lowering its future OPEB liabilities, but has not reduced its current accrued liabilities.

Exhibit 3

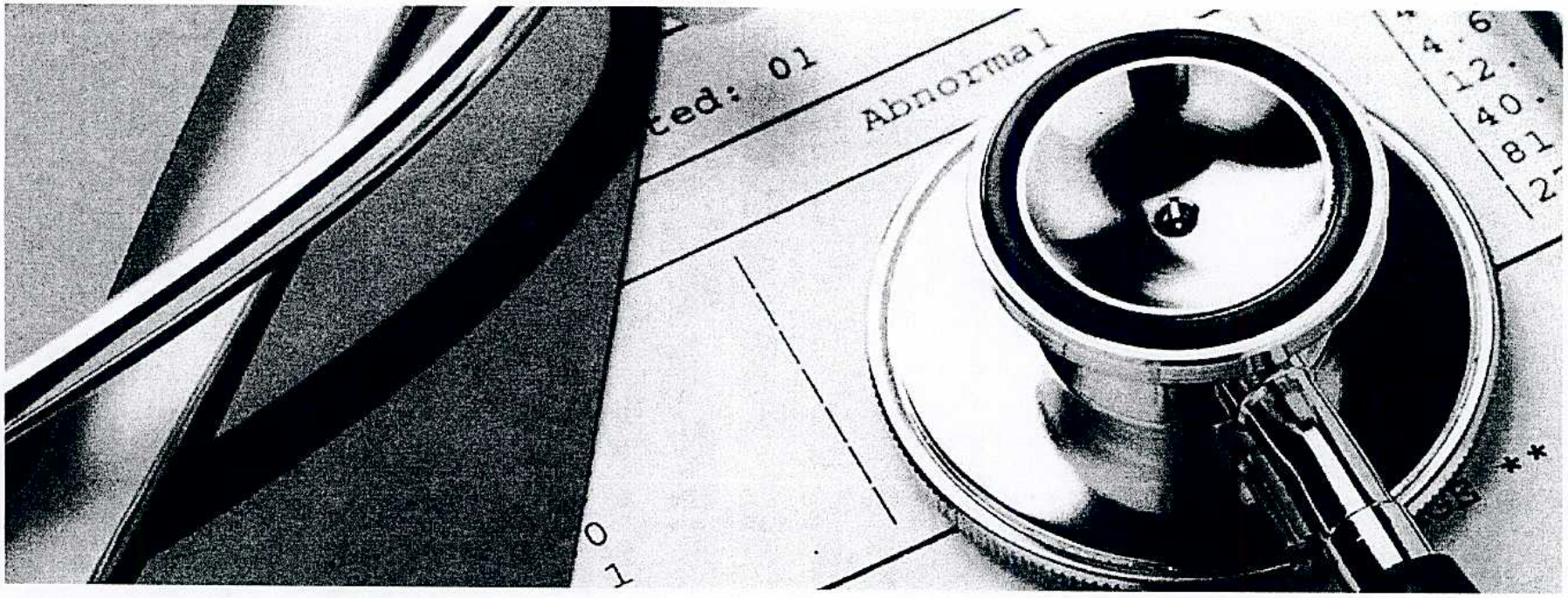
Response to OPEB Liabilities in AAA-rated States

State	OPEB Liabilities	ARC	Trust Fund	Pre-funding	Benefit Changes
Maryland	**$14.5 billion (4.25%) $9.0 billion (7.75%)**	**$1.11 billion $772 million**	**Yes**	**$100 million in each of fiscal 2007 and 2008**	**None yet**
Delaware	$4.4 billion (5.5%) $3.2 billion (8.0%)	$475 million $342 million	Legislation pending	$40 million in fiscal 2008; increasing by $40 million each year for 6 years	None yet
Florida	$3.6 billion (4.0%) $2.1 billion (7.75%)	$213 million $162 million	No	No	No
Georgia	$19.6 billion (4.5%) $15.0 billion (6.0%)	$1.59 billion $1.26 billion	Yes	$100 million in fiscal 2008	None yet
Minnesota	No valuation	n/a	n/a	n/a	n/a
Missouri	$2.2 billion (4.5%) $1.3 billion (8.5%)	$159 million $103 million	In process	$15 million in fiscal 2008	None yet
North Carolina	$23.8 billion (4.25%) $15.5 billion (7.0%)	$2.39 billion $1.63 billion	Yes	No	Increased vesting period for new hires from 5 to 20 years for full subsidy; gradual transition from indemnity plan to HMO

State	OPEB Liabilities	ARC	Trust Fund	Pre-funding	Benefit Changes
South Carolina	$10.0 billion (4.5%) $7.6 billion (6.0%)	$777 million $640 million	No	$249 million in fiscal 2008 ($47 million recurring annually)	Legislation failed; would have raised vesting period for new hires from 10 to 25 years
Utah	$500 million	$48 million	Yes	$48 million in each of fiscal 2007 and 2008	Yes, converted from defined benefit to defined contribution plan for new hires
Virginia	$1.3 billion (4.0%) $890 million (7.5%)	$128 million $107 million	Yes	$20 million in fiscal 2008 (five-year phase-in to fully fund the ARC)	No

ARC: Annual Required Contribution
HMO: Health Maintenance Organization
OPEB: Other Post-employment Benefit

Source: Government Accounting Standards Board Valuations; Legislative Staff



Maryland Blue Ribbon Commission to Study Retiree Health Care Funding Options

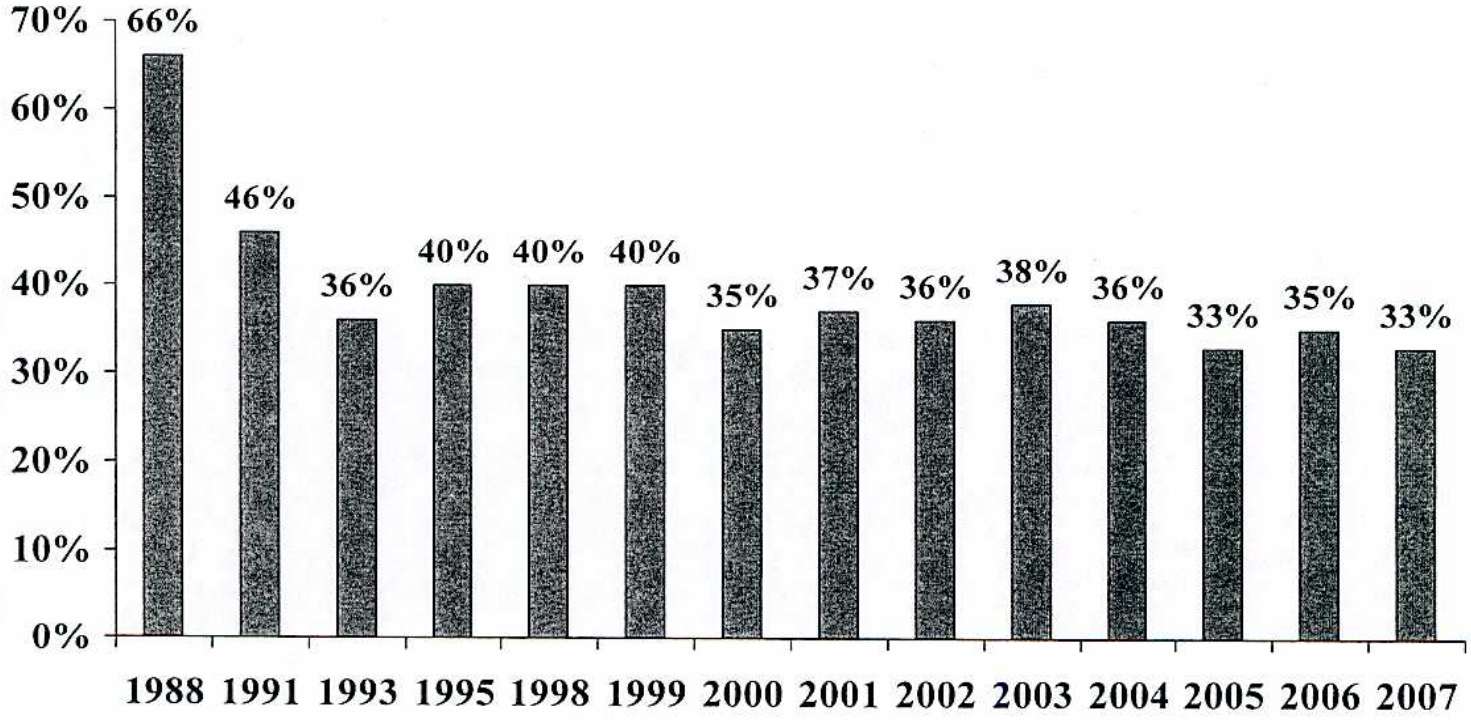
Retiree Health Benefit Trends Among Private Employers

Frank B. McArdle, Ph.D.
September 27, 2007

Hewitt

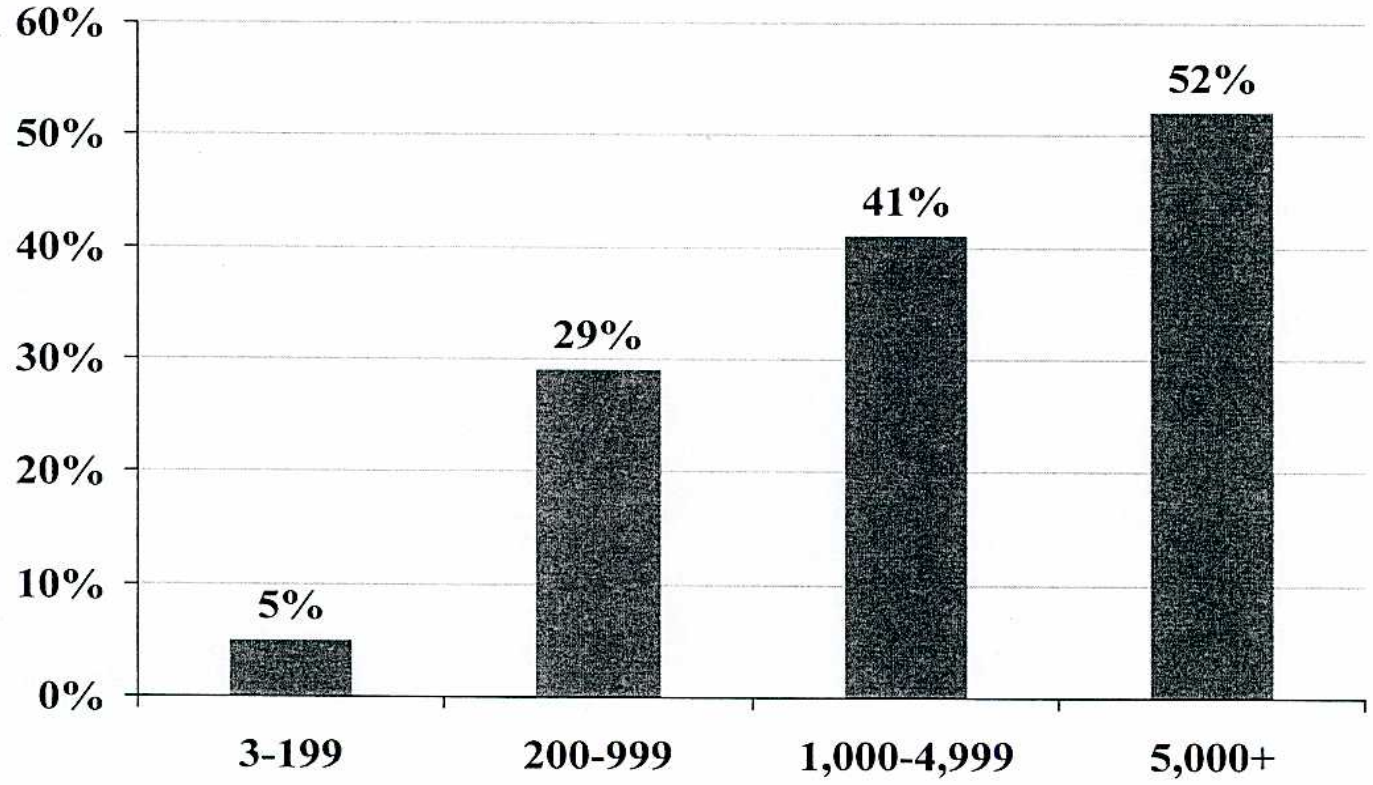
Trends in Employer Retiree Health Coverage

Percentage of All Large Firms (200 or More Workers) Offering Retiree Health Benefits, 1988-2007



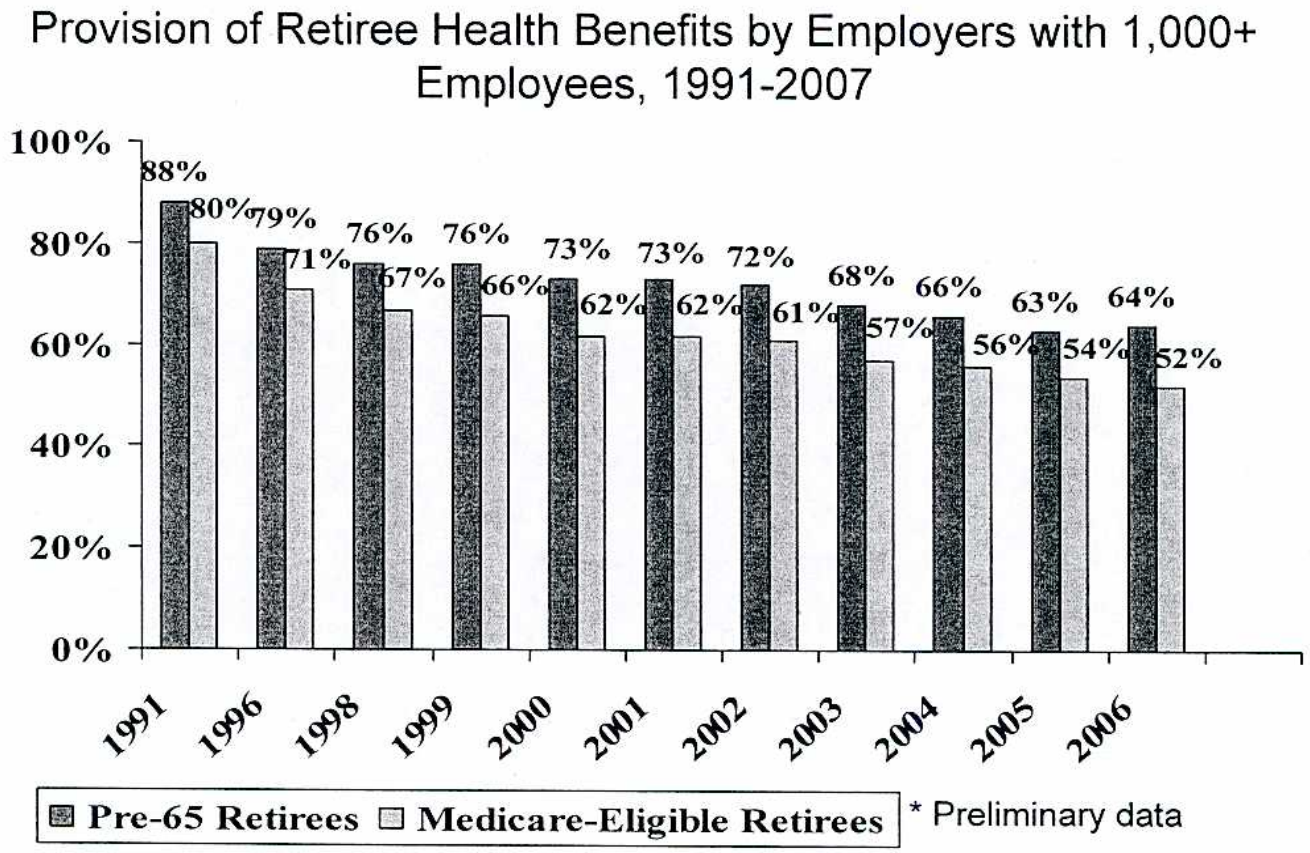
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007

Employers Offering Retiree Health Benefits
Percentage Offering by Size of Employer



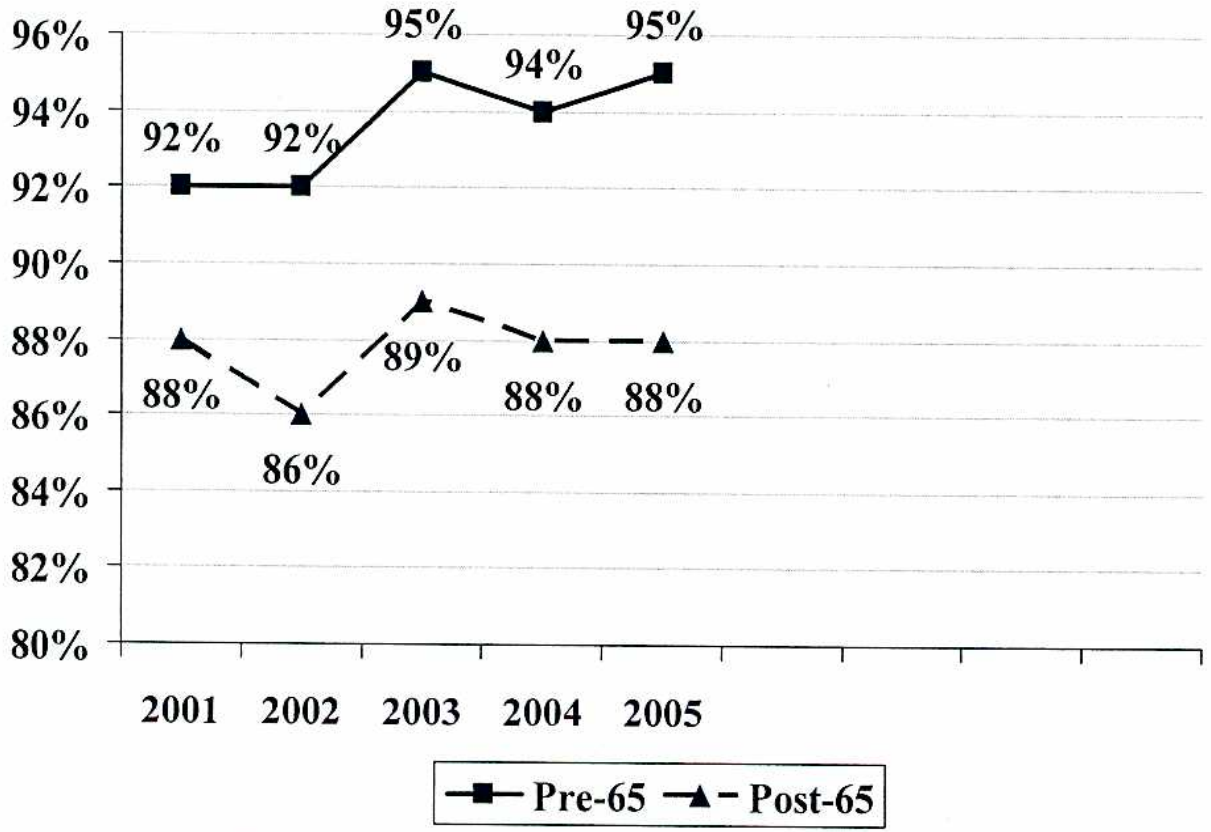
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007

Retiree Health Trends: Large Private Employers 1991-2006



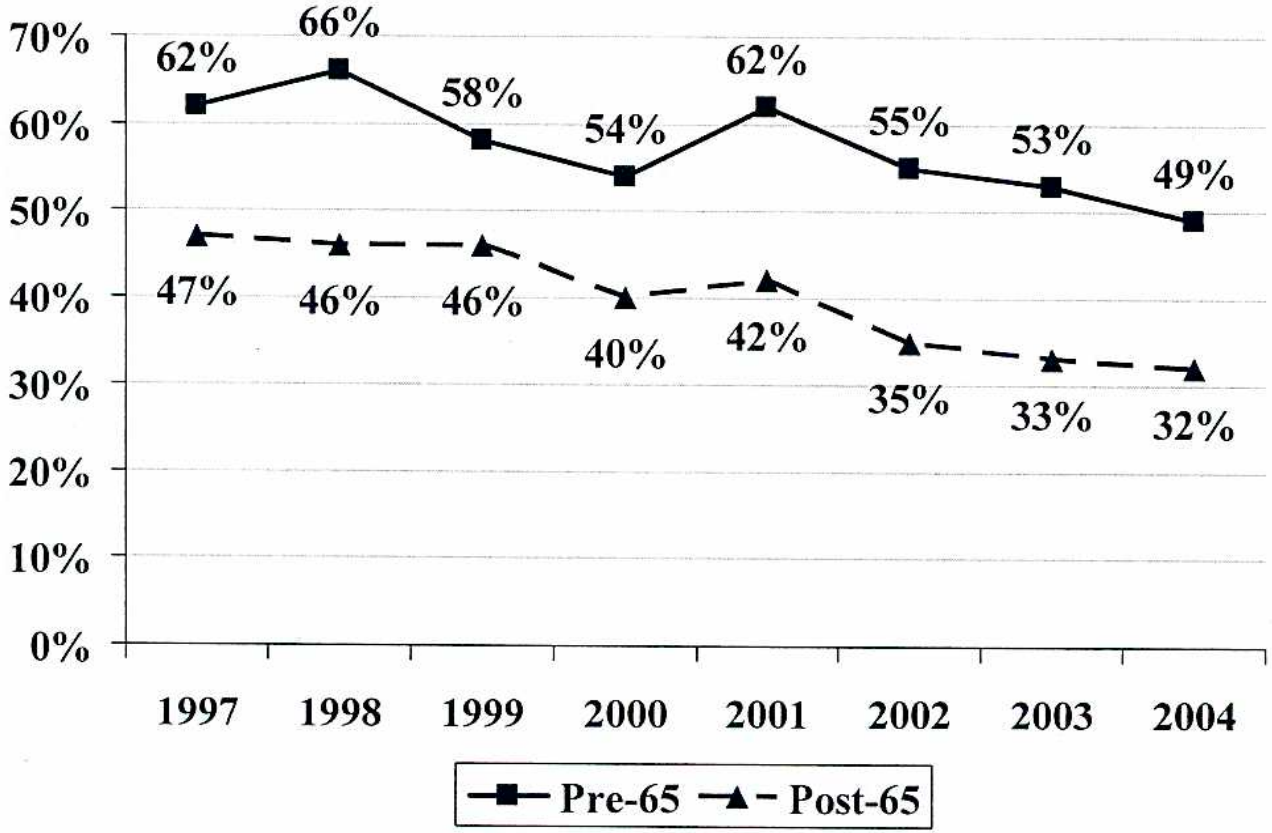
Source: Hewitt Associates

State Governments
Percentage Offering Retiree Health Benefits



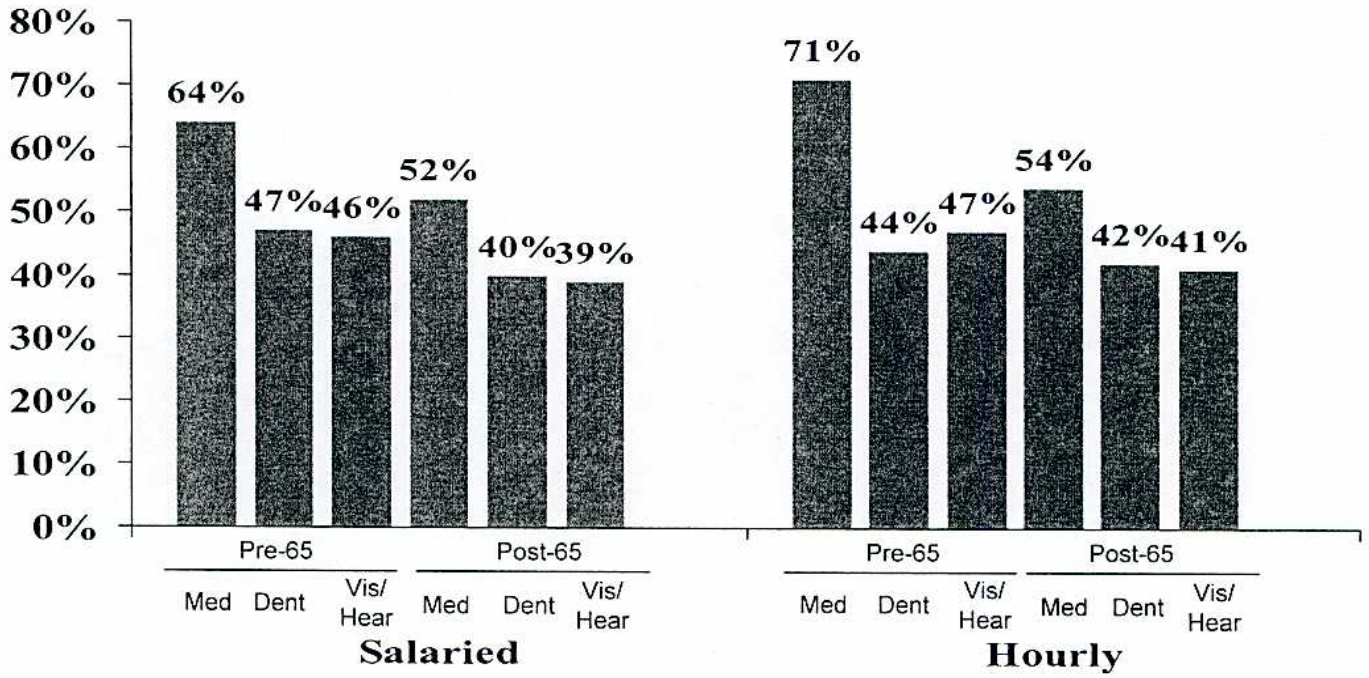
Source: Medical Expenditure Panel Surveys

Local Governments (250-999 ees)
Percentage Offering Retiree Health Benefits



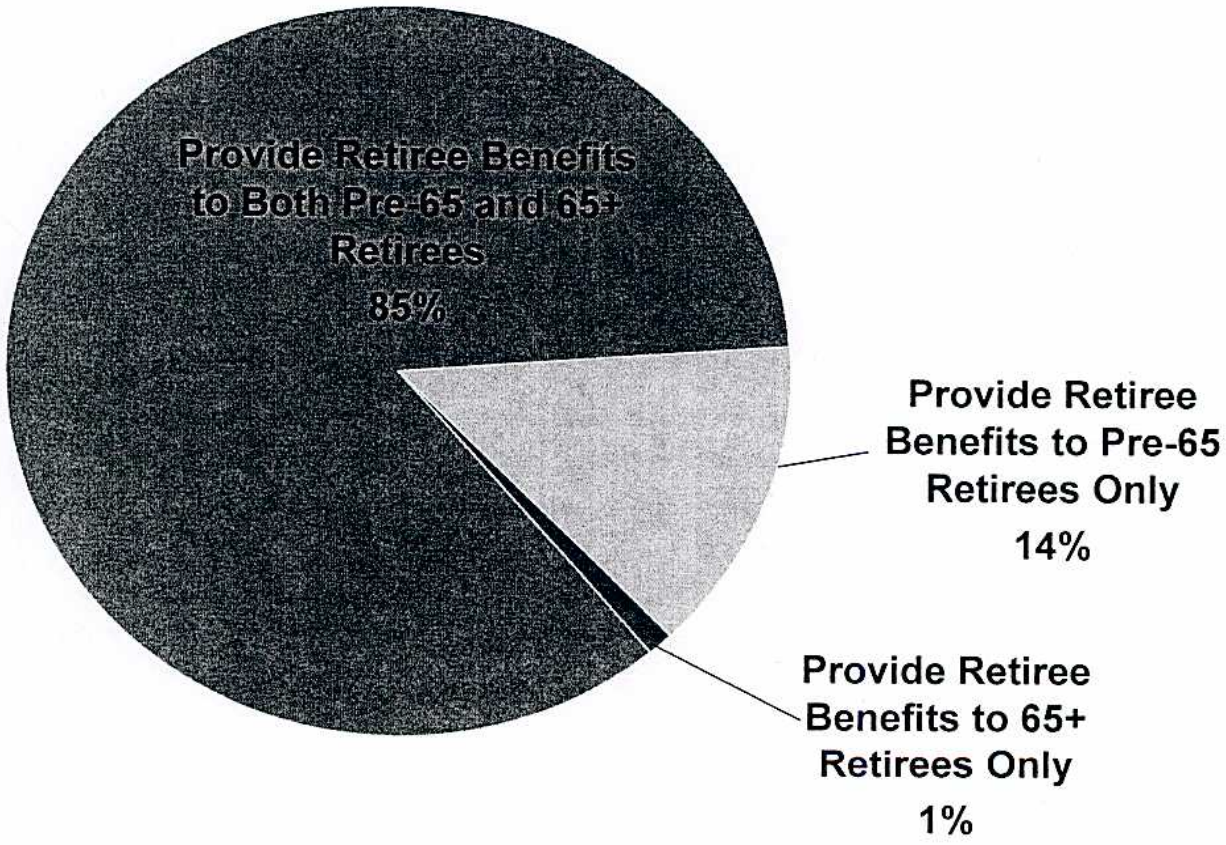
Source: Medical Expenditure Panel Surveys

Retiree Benefits Provided for Private Sector Salaried and Hourly Employees



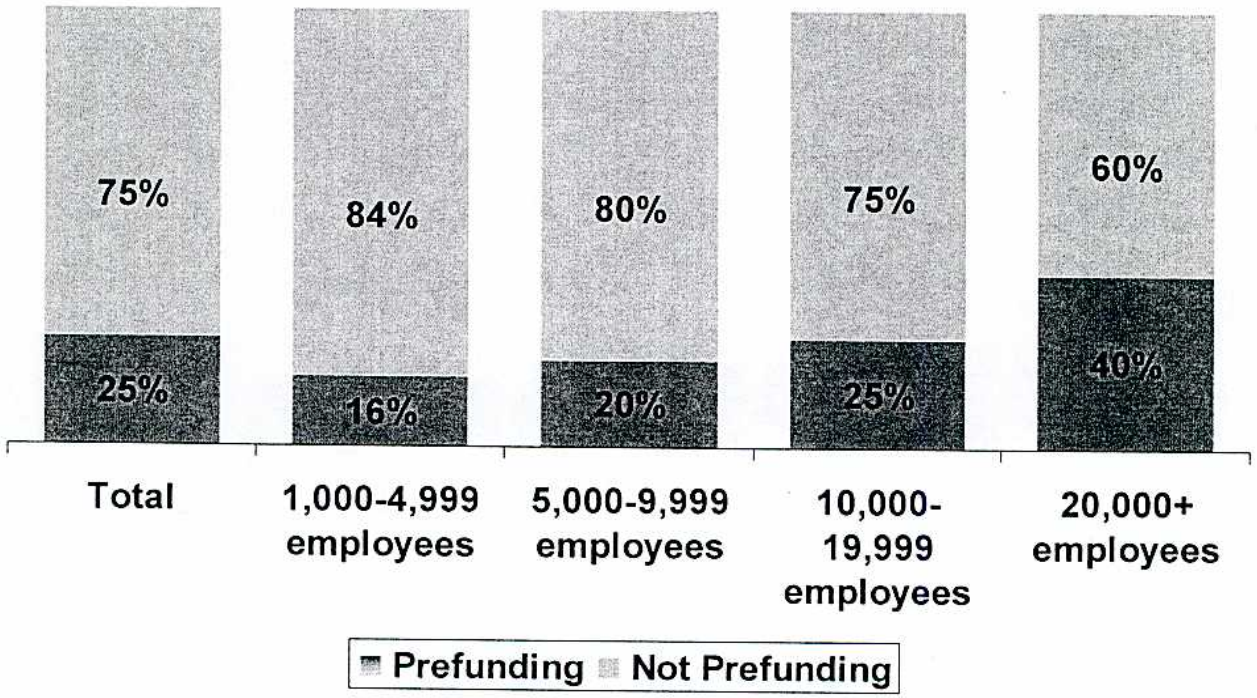
Source: Hewitt Associates, 2006

Most Private Employers Offering Retiree Coverage Do So for Pre-65 and 65+ Retirees



SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006

Most Private Employers Do Not Pre-Fund and What They Can Pre-Fund is Limited by Federal Tax Law

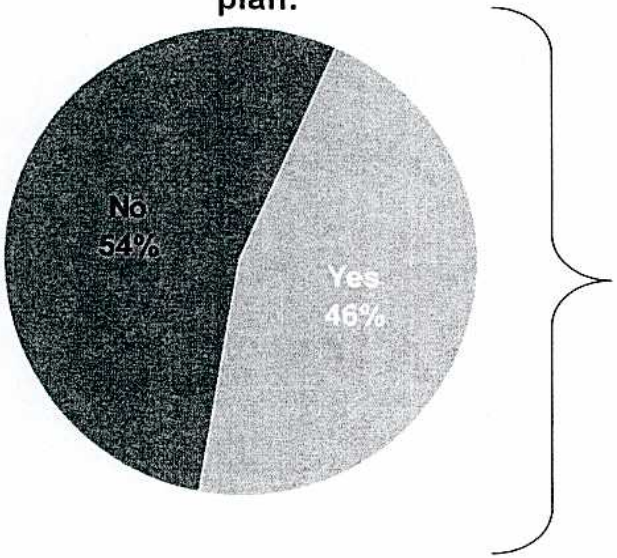


Note: Firms that report pre-funding have made contributions to the fund within the last three years.

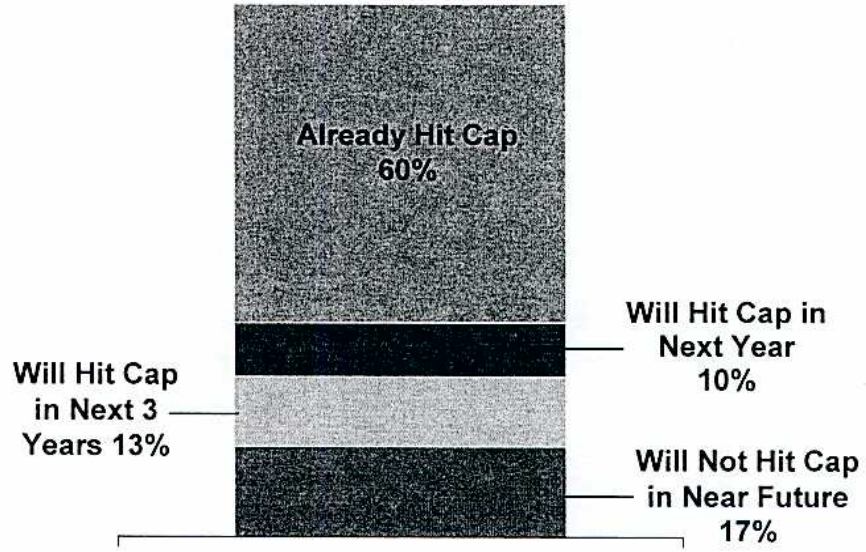
SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

Large Employers Typically Impose a Financial Cap on Their Retiree Obligation

Of large private-sector employers, percentage with a cap on their largest pret-65 plan:



Of large private-sector employers with a cap on their largest pre-65 plan, percentage that anticipate hitting the cap:



SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

Wide Variation Exists in the Share of the Total Premium Paid by Retirees

Distribution of Employers by Share of Premium Paid by New Pre-65 Retirees:

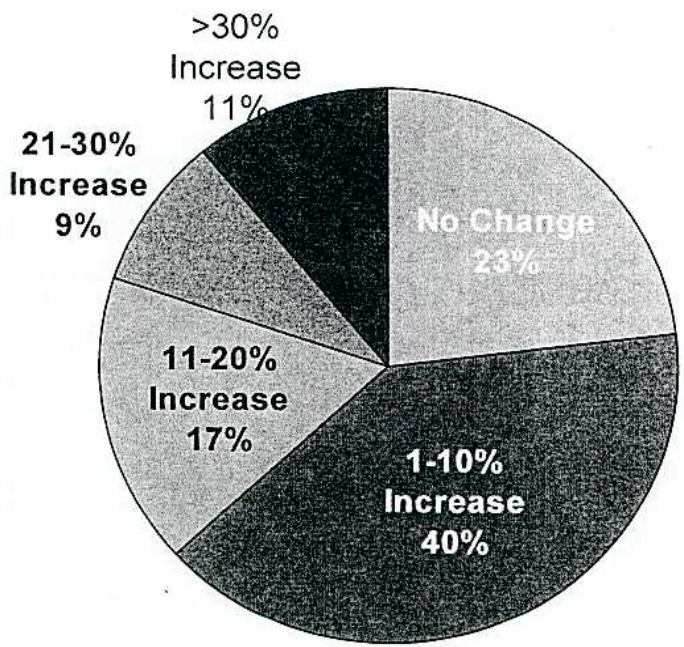
Distribution of Employers by Share of Premium Paid by New 65+ Retirees:

Note: Premiums for retiree-only coverage for full-time employees retiring on or after January 1, 2006, in plans with the largest number of enrolled retirees. Based on responses from private-sector firms with 1,000 or more employees that offer retiree health benefits.

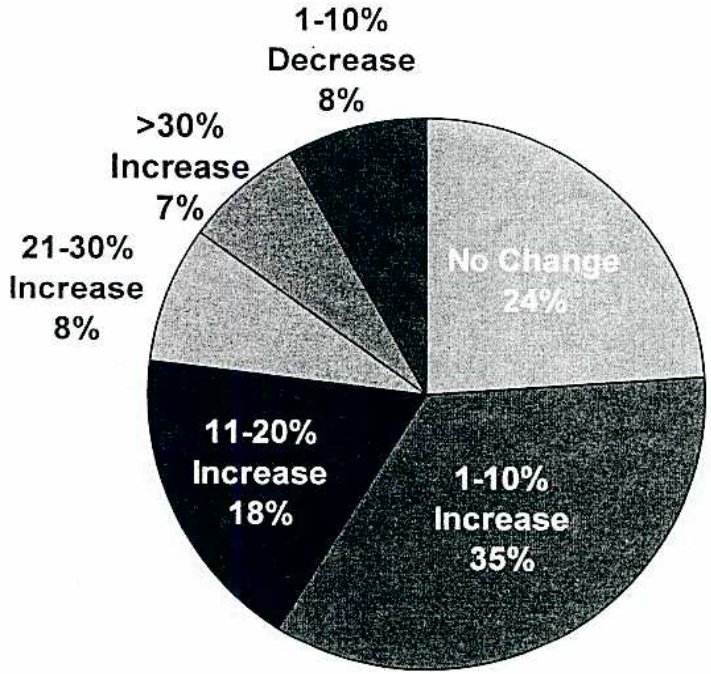
SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

Annual Increases in Retiree Contributions Also Vary Widely

% Change in Pre-65 Retiree Contributions, 2005 to 2006:

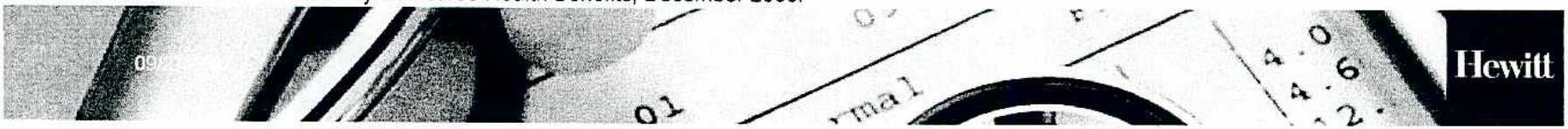


% Change in Age 65+ Retiree Contributions, 2005 to 2006:

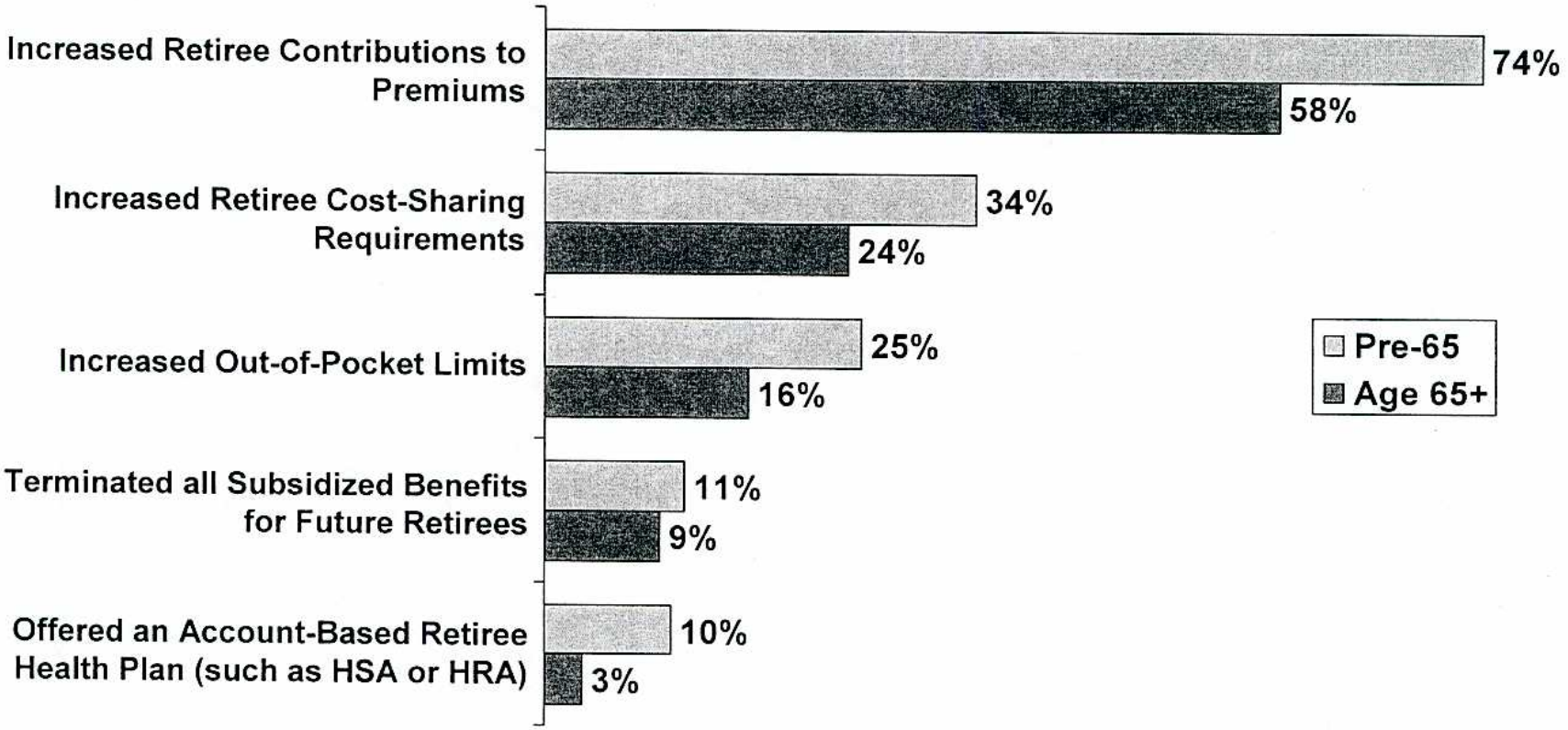


Note: Retiree contributions to premiums for retiree-only coverage for full-time employees retiring on or after January 1, 2005 and January 1, 2006, respectively, in plans with the largest number of pre-65 and age 65+ retirees. Based on responses from private-sector firms with 1,000 or more employees that offer retiree health benefits.

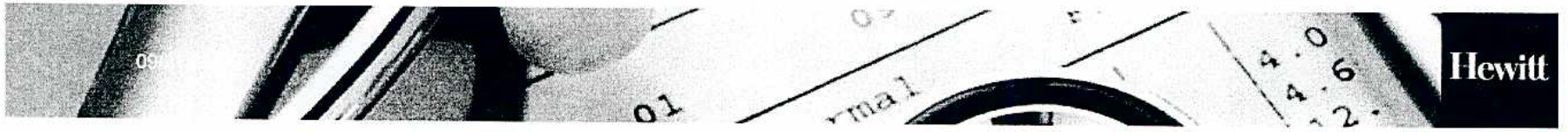
SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.



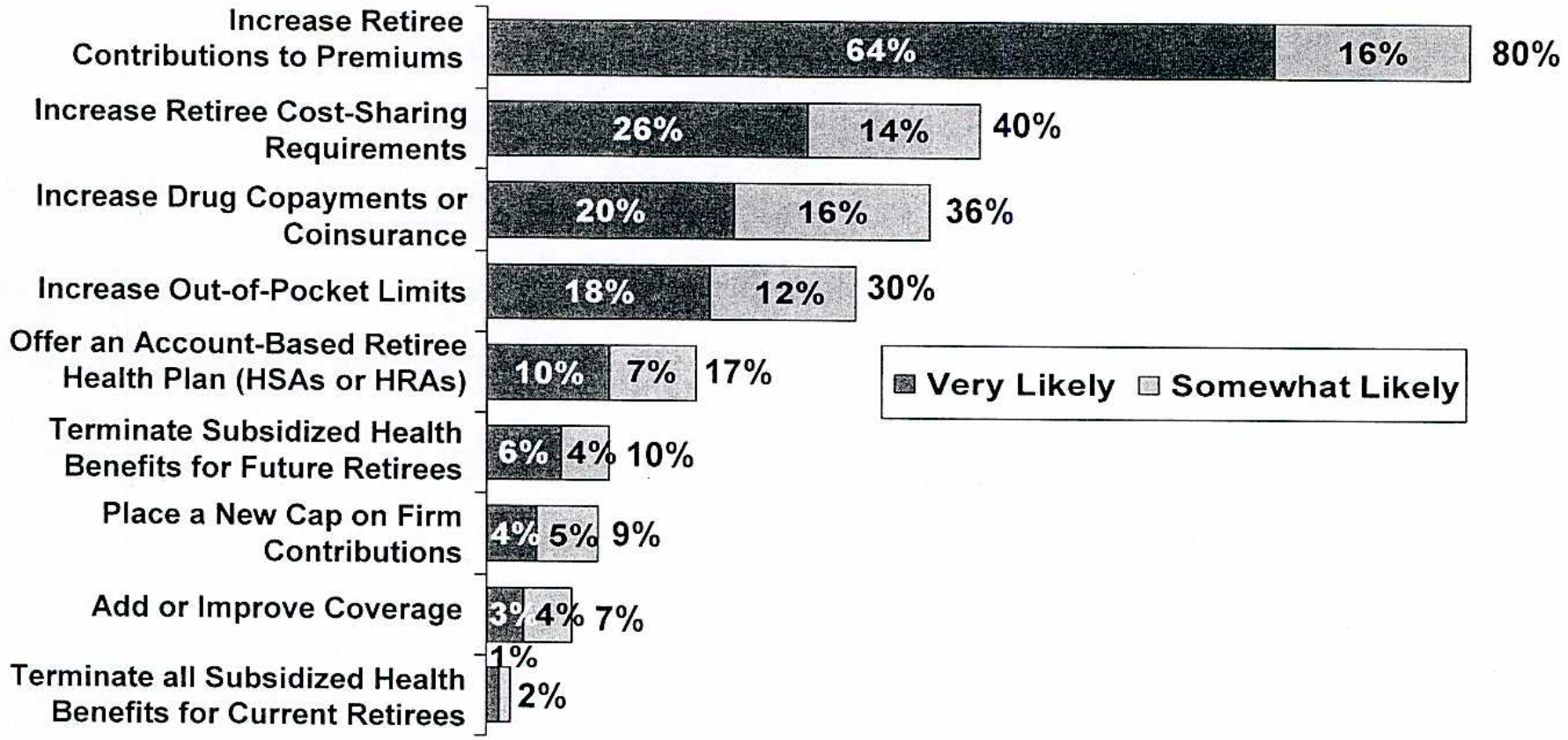
Large Private Employers Often Make Changes to Retiree Health Benefits: % Making Changes between 2005 and 2006



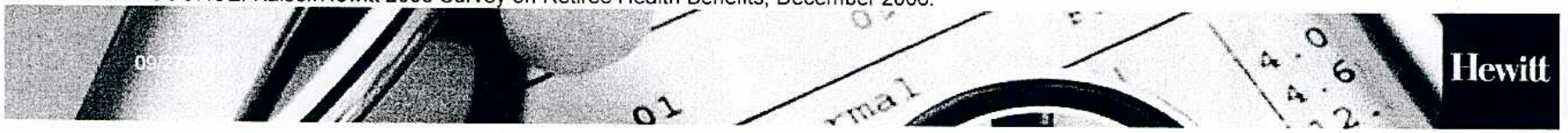
Note: Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits.
SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.



And Will Continue to Do So: Likelihood of Making Changes to Retiree Health Benefits for the 2007 Plan Year

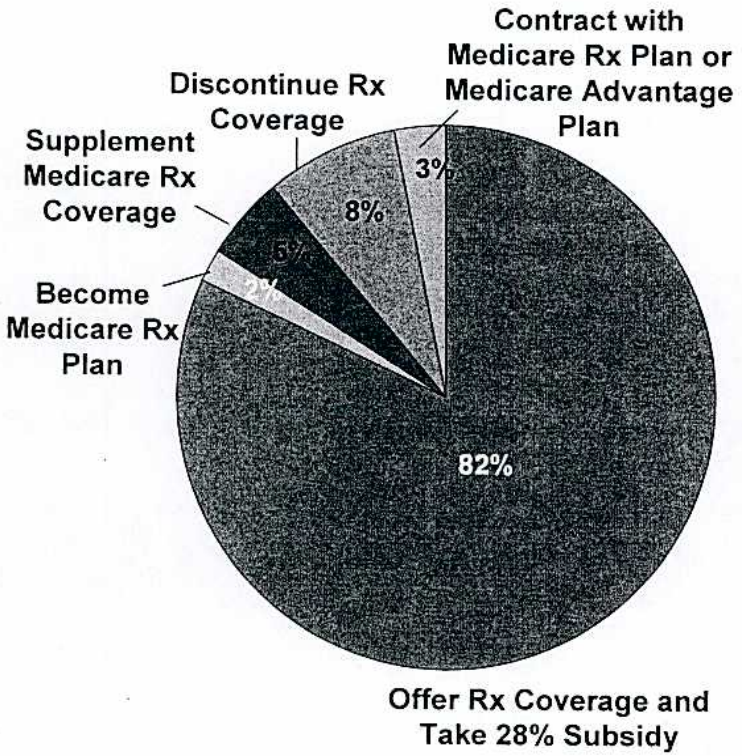


Note: Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits.
SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

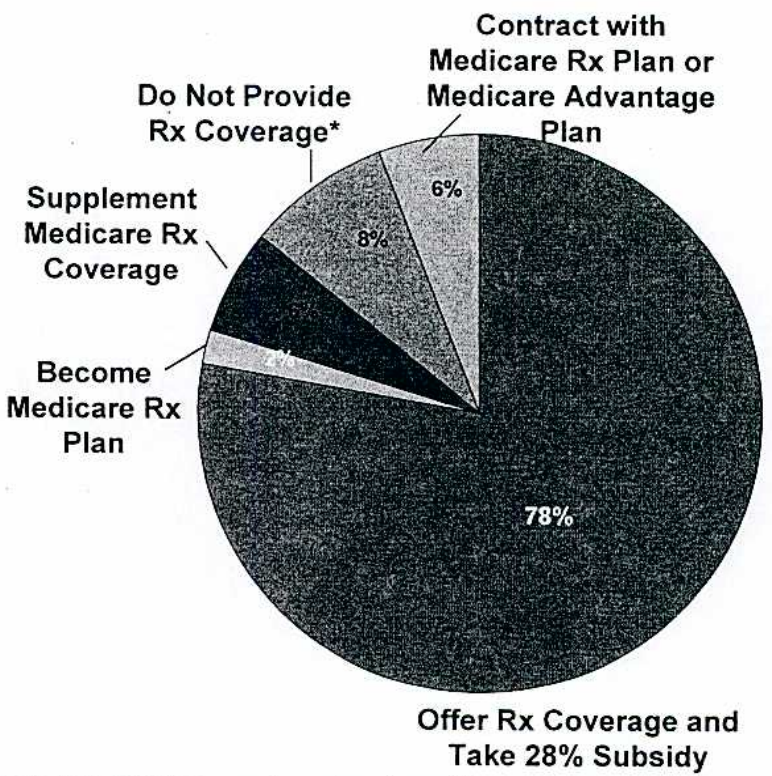


Employers' 2006 and Expected 2007 Medicare Drug Benefit Strategies for the Largest Age 65+ Plan

2006 Medicare Strategies:



Expected 2007 Medicare Strategies:



Note: *Virtually all of these companies discontinued drug coverage in 2006. Applies to plan with the largest number of age 65+ retirees. Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits.
SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

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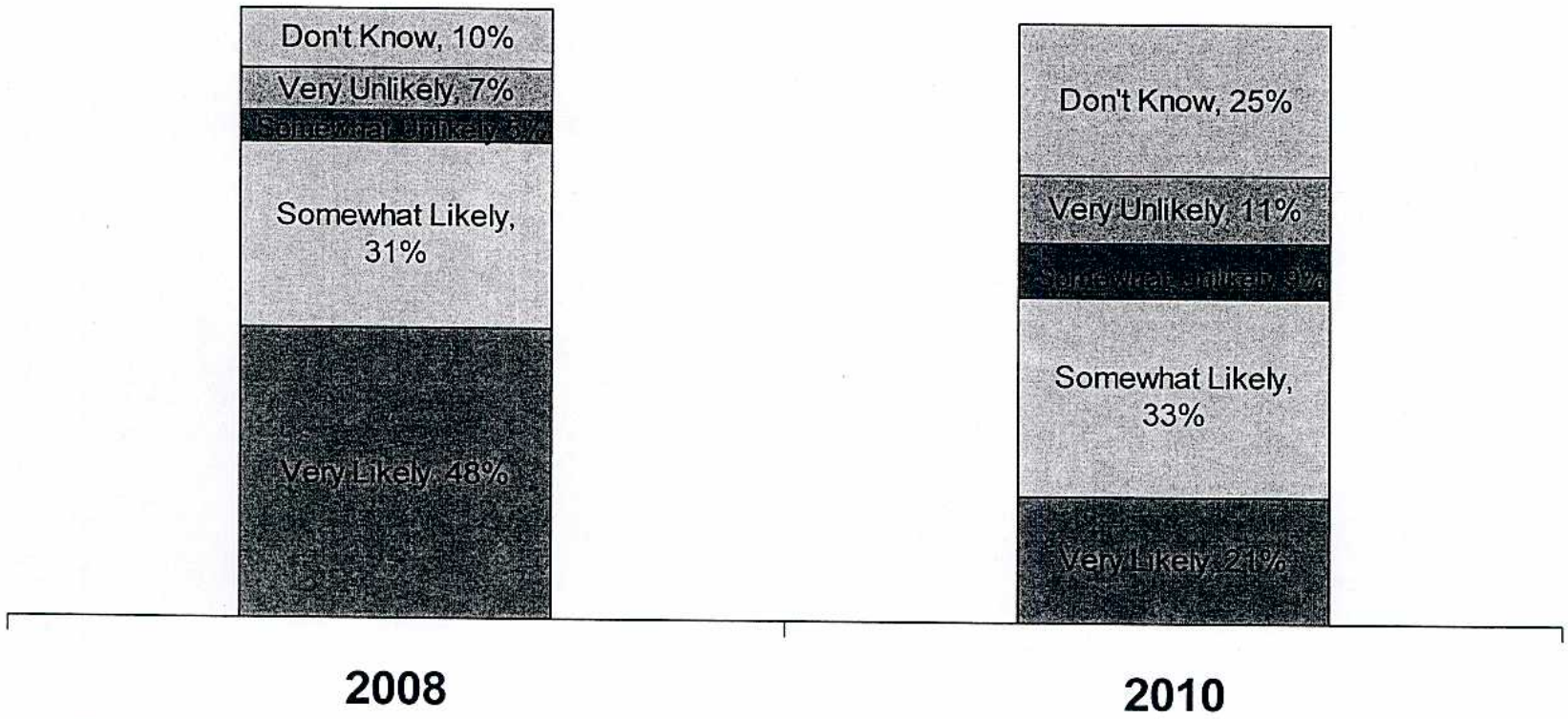
Likelihood of Continuing Drug Benefits and Accepting Employer Subsidy in the Future



Note: Numbers do not add to 100% due to rounding. Data are for firms maintaining drug benefits and accepting the employer subsidy in 2006. Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits.
SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

Conclusions

Most surveyed private employers are maintaining retiree benefits, but many are shifting costs onto retirees

- Retirees can expect more premium and cost sharing increases in the future
- Also growing interest in using account-based plans

Some employers are eliminating retiree coverage for new hires and for groups of current workers

- Current retirees are largely shielded from plan terminations

Employers will re-assess their current Medicare coordination strategies as they gain greater comfort with alternative options

- Public employers may have even more reason to do so

Early retirees are considered the most vulnerable because they do not have Medicare coverage

Conclusions

Private sector trends are instructive for governmental employers but key differences also exist

- Pre-funding reduces governments' reported liability under GASB rules due to use of higher discount rate; pre-funding under FASB does not
- Under federal tax rules government entities can pre-fund more of the obligation than can private employers and the earnings are not assessed Unrelated Business Income Tax as it can be for corporate entities
  - But GASB requires that monies be segregated, protected from general creditors, and funded amounts are irrevocable
- GASB does not reduce liability to reflect Medicare 28% drug subsidy but FASB does; other Medicare strategies under GASB do reduce liability
- Since cash compensation paid by private employers is often higher, retiree health benefits can help state governments attract & retain employees
- Governments have longer-tenure employees and more long-term "business" stability than private employers facing global competition

Consider how plan design changes coupled with employee population trends affect long-term projections of future liability

Appendix

Plan Design Changes and Employee Population Trends

Design Changes Affect Long Term Projections of liability

- Consider how design changes coupled with employee population changes affect long-term projections of future liability
  - Incorporate recent & expected future trends in State hiring patterns
- For example, consider three types of liability projections based on availability of retiree medical benefits for different populations
  - *Closed Group*: Assumes newly hired employees do not participate in plans (i.e., only current population included in projections)
  - *Open Group (Constant Employees):* Number of employees remains constant over projection period
  - *Open Group (Increasing Employees):* Active population grows based on historical experience and expected future trends

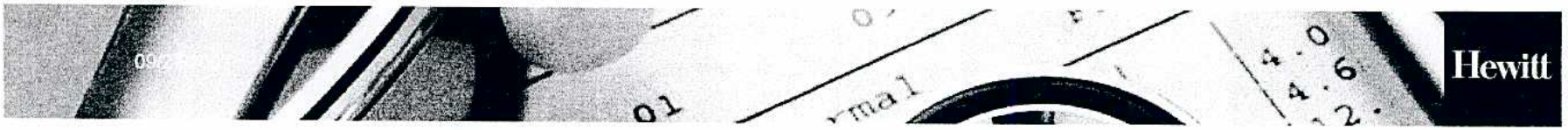
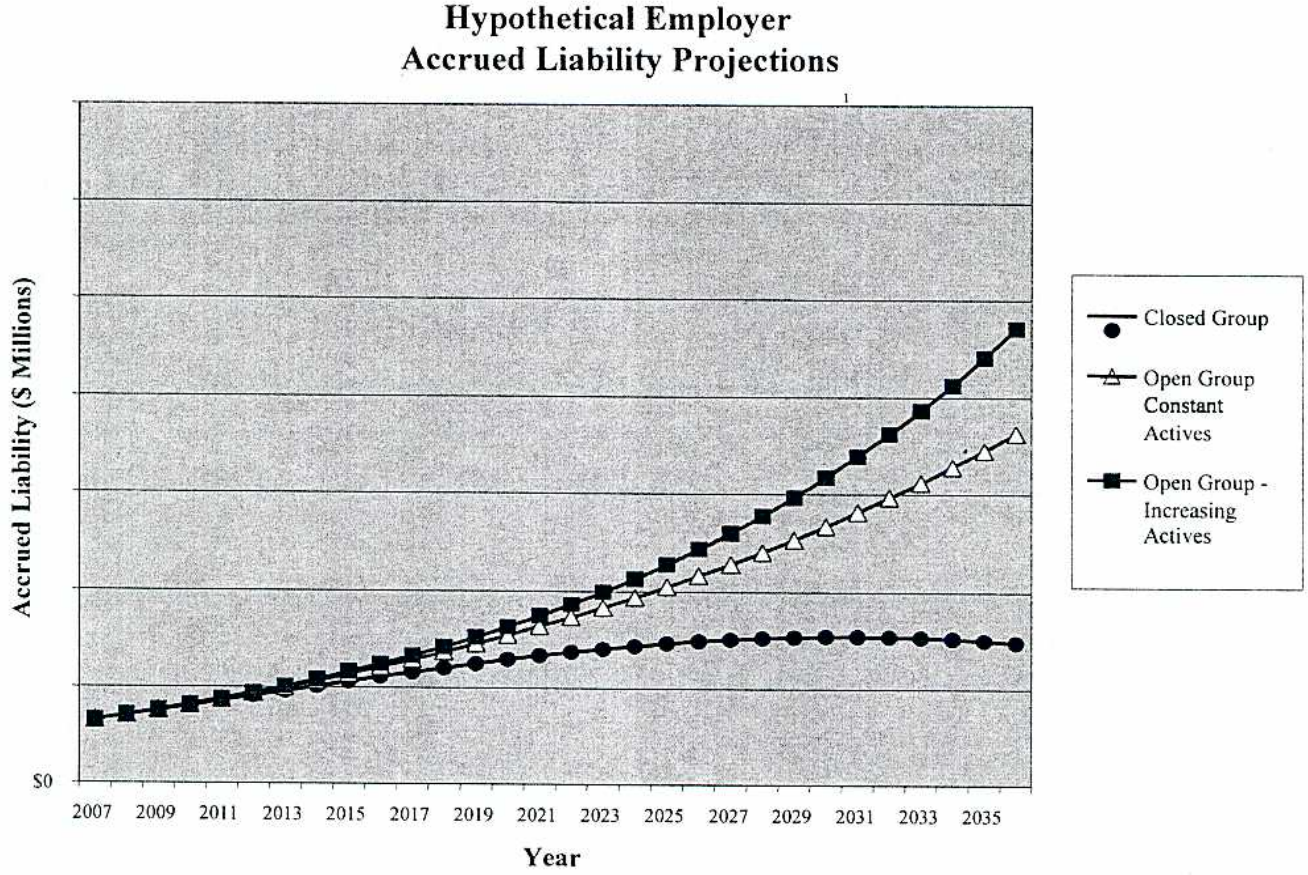
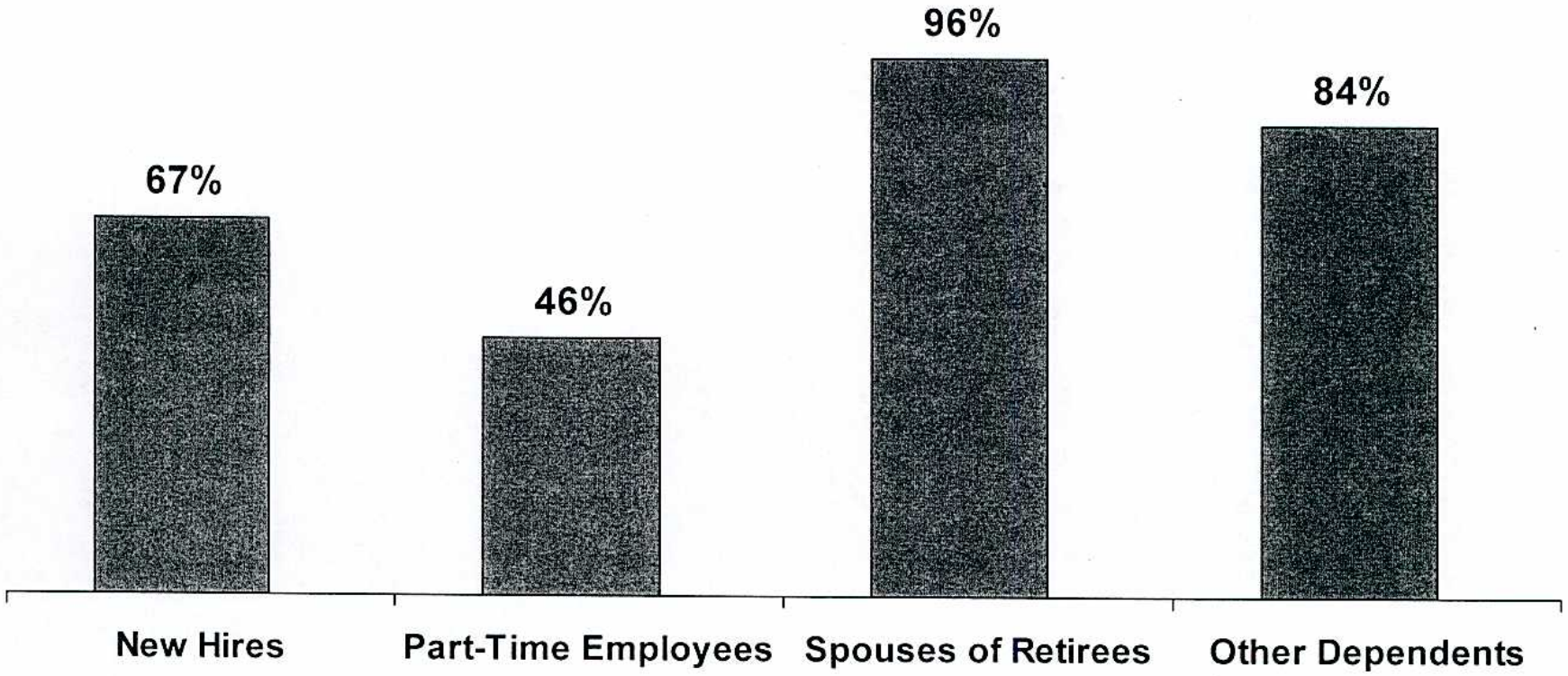


Illustration of Restricting Eligibility for New Hires vs. Continuing Benefits for an Increasing Workforce

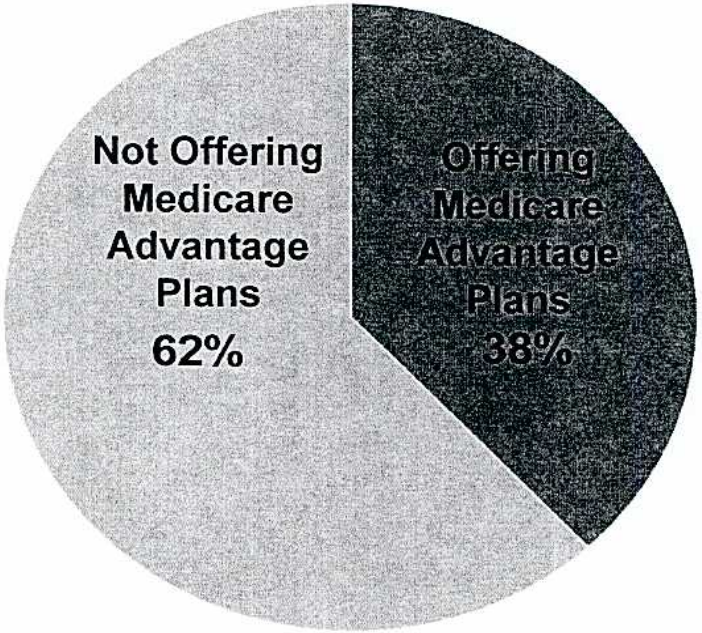


Percentage of Surveyed Large Private-Sector Employers Providing Retiree Health Benefits to Selected Groups



Note: Based on responses from private-sector firms with 1,000 or more employees that offer retiree health benefits. New hires are employees hired as of January 1, 2006.
SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

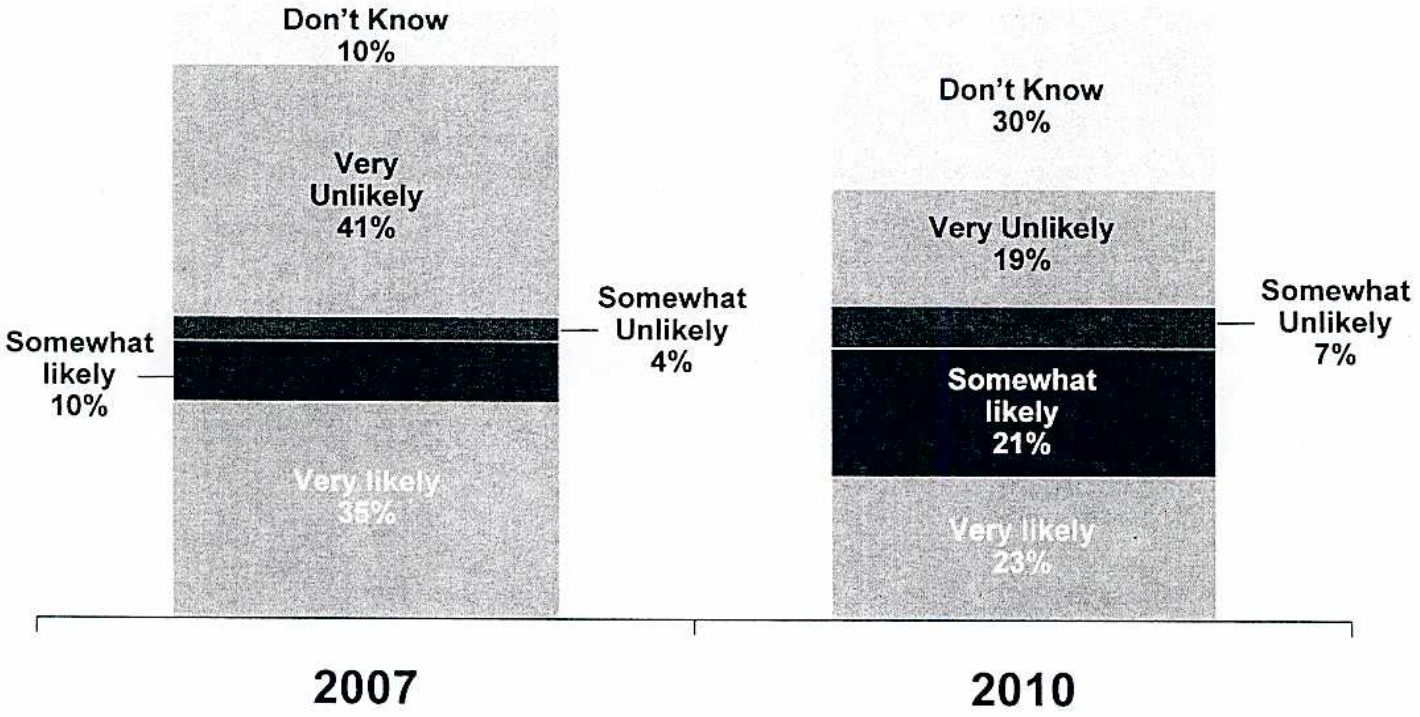
Private-Sector Employers Offering Medicare Advantage Plans



Medicare Advantage plans may include Medicare Health Maintenance Organization (MHO) plans, Medicare Preferred Provider Organization (PPO) plans or Medicare Private Fee-for-Service (PFFS) plans.

SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

Likelihood of Offering Medicare Advantage Plans

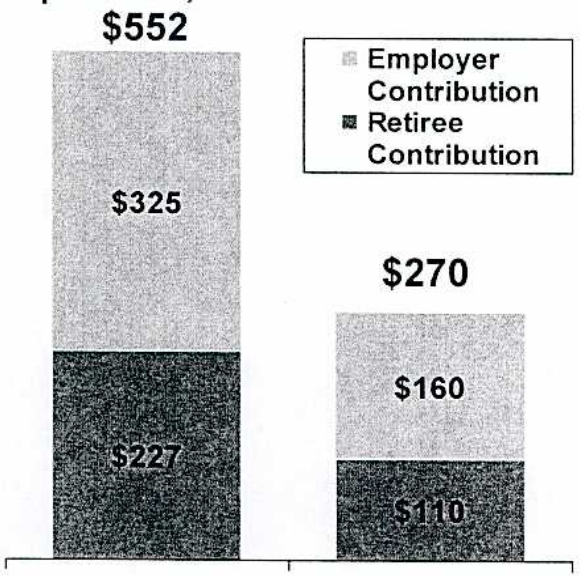


Medicare Advantage plans may include Medicare Health Maintenance Organization (MHO) plans, Medicare Preferred Provider Organization (PPO) plans or Medicare Private Fee-for-Service (PFFS) plans.

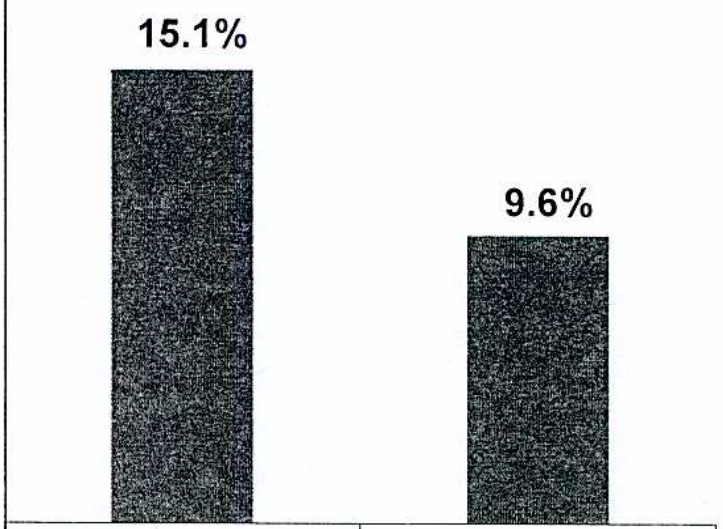
SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

Average Monthly Premiums For New Retirees in 2006

Weighted average monthly premium, 2006:



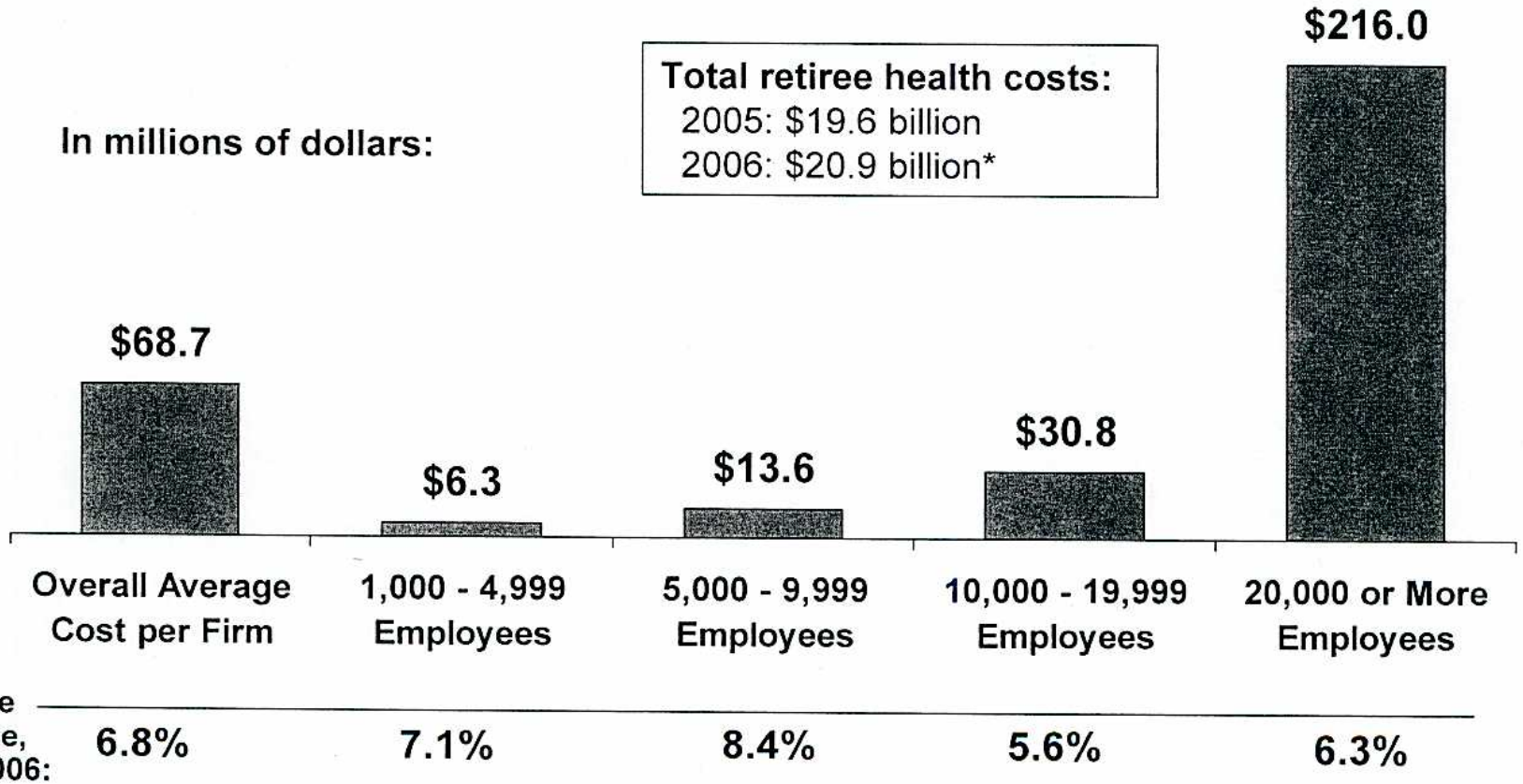
Weighted average increase in retiree contributions to premiums, 2005-2006:



Note: Premiums for retiree-only coverage for full-time employees retiring on or after January 1, 2006 in plans with the largest number of enrolled retirees. Includes firms that do not require retiree contributions.

SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

Average Total Retiree Health Costs, by Firm Size, 2005
Average Increase in Retiree Health Costs, 2005-2006



Note: *2006 estimate based on actual costs in 2005 increased by employers' estimates of total cost increases between 2005 and 2006.
Based on responses from private-sector firms with 1,000 or more employees offering retiree health benefits.
SOURCE: Kaiser/Hewitt 2006 Survey on Retiree Health Benefits, December 2006.

OFFICE OF THE ATTORNEY GENERAL OF THE STATE OF MARYLAND
2005 Md. AG LEXIS 14
[NO NUMBER IN ORIGINAL]
December 16, 2005

Request By:

The Honorable Edward J. Kasemeyer
301 James Senate Office Building
Annapolis, Maryland 21401-1991
The Honorable Mary-Dulany James
326 Lowe House Office Building
Annapolis, Maryland 21401-1991

Opinion

Opinion by: J. Joseph Curran, Jr., Attorney General; Bonnie A. Kirkland, Assistant Attorney General; Robert N. McDonald, Chief Counsel, Opinions and Advice

You have asked for our opinion on several issues related to the State's funding of retiree health benefits. Your questions are prompted by new standards recently adopted by the Government Accounting Standards Board ("GASB") that affect how a government employer is to account for liabilities related to employee benefits. In particular, GASB Statement 45 ("GASB 45") requires that a government employer accrue liabilities associated with the employer's commitment to retiree benefits and recognize them on its balance sheet.

You have asked:

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. 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 of 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?

Our answers to your questions are explained below. In summary, it is our opinion that:

1. The State currently has a statutory obligation to provide health care benefits to certain retirees; however, the statute does not create a contractual obligation and the General Assembly remains free to amend the law that provides such benefits. Although the General Assembly may choose to confer a vested right in retiree health care benefits, it has not done so. Even a contractual right to health care benefits would be subject to modification if reasonable and necessary to serve an important public purpose.

2. With respect to other states that, like Maryland, enjoy the highest credit rating from the bond rating agencies, we found no relevant case law. There are cases in other states that have reached various conclusions; some of those decisions recognize a contractual obligation to provide health care benefits to retirees. However, those cases are of limited value in construing Maryland law as they are based on the particular state constitution, statute, collective bargaining agreement, or other circumstances peculiar to the case.

3. In contrast to retiree health care benefits, pension benefits are contractual in nature. The statutes creating the various retirement systems explicitly vest certain rights in retirees with respect to the type and level of benefits, while the statute concerning retiree health care benefits does not. Prior opinions of this Office and court decisions confirm that the pension benefits are a contractual obligation. The fact that the amount of a retiree's subsidy for health care benefits may be related to length of State service does not alter this essential distinction.

4. Collective bargaining negotiations could result in changes in the State's legal obligations concerning retiree health benefits, but only if the General Assembly specifically adopted those changes.

5. GASB 45, as an accounting standard issued by a private entity, does not itself impose any legal obligation on the State concerning the level or funding of retiree health care benefits. Nor does it express a preference for or prescribe the timing or the method of financing retiree health care benefits. The creation of an irrevocable trust to fund retiree health care benefits could be part of a contractual undertaking of the State to provide those benefits. If the trust fund consisted in part of employee contributions, there may be a stronger argument that the State had undertaken to devote the funds in the trust to retiree health care benefits.

I

Background

A. Retiree Health Care Benefits

1. State Employee and Retiree Health and Welfare Benefits Program

The General Assembly has provided for health care benefits for retired public employees in Maryland as part of the State Employee and Retiree Health and Welfare Benefits Program ("Program").

Annotated Code of Maryland, State Personnel and Pensions Article ("SPP"), § 2-501 *et seq.* The Program is to be available to employees in all units of State government, including units with independent personnel systems. SPP § 2-502(b) .

The Department of Budget and Management ("DBM") is charged with administration of the Program. SPP §§ 2-502 , 2-503 . The Legislature has given the Secretary of DBM broad discretion to design the type and level of benefits available through the Program. SPP § 2-503(b) ("the Secretary may arrange as the Secretary considers appropriate any benefit option . . ."). In exercising that discretion, the Secretary may consider recommendations from the Health Insurance Advisory Council, an advisory body consisting of representatives of various State entities, employee organizations, and the public. SPP §§ 2-505 , 2-506 , COMAR 17.04.13.02 .1 The Secretary also is to specify by regulation the eligibility of various categories of employees for the Program and the extent of any State subsidy provided in connection with the Program. SPP § 2-503(c) .2 The Secretary has adopted regulations specifying the eligibility standards for benefits, among other things. COMAR 17.04.13 .

On an annual basis, the Secretary is to recommend to the Governor the State's share of costs of the Program for inclusion in the State Budget. SPP §§ 2-503(a)(3) , 2-504 . Finally, the Secretary is charged with ensuring that the Program complies with federal and State laws governing employee benefit plans. SPP § 2-503(a)(2) .

During its past two sessions, the General Assembly limited the Secretary's discretion in some respects. In 2004, in the wake of federal legislation that created prescription drug coverage under Medicare Part D, it directed that the Program is to include a prescription drug benefit plan, although it did not specify any particular elements of that plan. Chapter 296, Laws of Maryland 2004, *codified at* SPP § 2-509.1 .3 In 2005, the Legislature gave the Secretary specific criteria for designing the Program for fiscal years 2006 and 2007. Chapter 444, § 7, Laws of Maryland 2005. In particular, the Legislature directed that the Program provide "the same health insurance benefits options, prescription drug benefits options, co-premiums and co-payments" as were provided by the Program on January 1, 2005. SPP § 2-502(c) . That legislation also limited the increase in a participant's share of premiums in the point-of-service health plan and specified certain parameters for pharmaceutical benefits.4

In 2005, the General Assembly also created a special fund called the State Employees and Retirees Health and Welfare Benefits Fund to help finance health care benefits. Chapter 444, § 1, Laws of Maryland 2005, *codified at* SPP § 2-516 . This fund is to consist of moneys appropriated for the fund or authorized to be transferred to it in the State budget. SPP § 2-516(c)(2) . For fiscal years 2006 and 2007, any federal subsidy received with respect to Medicare Part D also is to be deposited in the fund. SPP § 2-516(c)(1) .5 Moneys in the fund are to be retained in reserve and used only to fund the Program pursuant to budget amendment. SPP § 2-516(d) .

2. Provisions Related to Retiree Benefits

The statute governing the Program provides that certain categories of retirees "may enroll and participate in the health insurance benefit options established under the Program." SPP § 2-508(b)(1) .6 While the General Assembly has accorded the Secretary of DBM considerable discretion in designing the Program, it has established certain criteria for the participation of retirees in the Program that relate to the length and dates of State service. *Id.* Further, a retiree who chooses to participate in the Program is entitled to a State subsidy of the benefits if the retiree has five or more years of "creditable service."7 SPP § 2-508(c) . The amount of the subsidy increases with each additional year of creditable service up to 16 years, when it is to equal the subsidy provided to current employees. *Id.* A retiree who receives a disability retirement allowance is also entitled to a subsidy equal to that of a current employee. SPP § 2-508(c)(1) ; COMAR 17.04.13.05A(5) . In addition, under the DBM regulations, a retiree who retired prior to July 1, 1984,8 and an individual who receives a special death benefit under the State Police Retirement System9 are also entitled to equivalent

subsidies. COMAR 17.04.13.05A(1) , (6).

If a retiree is eligible for Medicare Parts A and B, the benefits are converted to a Medicare Supplemental Program; any benefits provided by that program are reduced by the amount that would be provided by Medicare, regardless of whether the retiree has actually enrolled in Medicare. COMAR 17.04.13.08 . As noted above, since 2004, the Legislature has also directed that "the State shall continue to include a prescription drug benefit plan in the health insurance benefit options established under the Program and available to retirees . . . notwithstanding the enactment of [Medicare Part D] or any other federal law permitting states to discontinue prescription drug benefit plans to retirees of a state." SPP § 2-509.1 .

The State currently finances retiree health care benefits in the same way as employee benefits -- through the annual budget process. *See* SPP § 2-504 ; Joint Committee on Pensions, 2004 Interim Report, *Report on State's Unfunded Retiree Healthcare Liability,* pp. 178-79. Recently, the Legislature created the Postretirement Health Benefits Trust Fund ("Trust Fund") to assist in the future financing of the retiree health insurance subsidy provided by the Program. Chapter 466, Laws of Maryland 2004, *codified at* SPP § 34-101 . The Trust Fund is to consist of any federal moneys received by the State as a result of the Medicare Part D program or any similar federal subsidy related to the State's prescription drug program for fiscal year 2008 and later. SPP § 34-101(d) . Any moneys deposited in the Trust Fund are to accumulate and no payments may be made until after fiscal year 2017. SPP § 34-101(g) . Thereafter, moneys from the Trust Fund are to be transferred to the State's general fund on an annual basis to help finance the subsidy for retiree health care benefits according to a formula. SPP § 34-101(h) .10 If the State discontinues that subsidy, any moneys in the Trust Fund are to be transferred to the general fund. SPP § 34-101(i) .

B. GASB 45

GASB was created in 1984 by the Financial Accounting Foundation to establish and improve standards for financial accounting and reporting for state and local government entities. *See* Facts About GASB, <<*www.gasb.org/facts/mission.html*>. As an independent, not-for-profit, private organization, it has no power to impose its standards on government entities. However, GASB standards are considered part of generally accepted accounting principles (GAAP).11 Government auditors and other oversight officials, as well as the municipal bond industry and other users of government accounting and financial reports, look to compliance with GASB standards as a benchmark for financial reporting. GASB describes its authority as follows:

> The GASB is not a federal agency. The federal government does not fund GASB, and its standards are not federal laws or rules. The GASB does not have enforcement authority to require governments to comply with its standards. However, compliance with the GASB's standards is enforced through the audit process, when auditors render opinions on the fairness of presentations to conformity with GAAP, and through the laws of individual states, many of which require local governments to prepare GAAP basis financial statements. In addition, the municipal bond industry prefers that governments issuing debt prepare their financial statements on a GAAP basis.
>
> GASB, *GASB at a Glance,* Question 8.

In 2004, GASB *issued Accounting and Financial Reporting by Employers for Postretirement Benefits Other than Pensions, Statement on Governmental Accounting Standards No. 45* (2004). GASB 45 applies to government employers who provide post employment benefits in addition to pensions -- referred to as Other Post Employment Benefits or "OPEB." OPEB includes health care benefits, and also may include other benefits provided separately from pension benefits. GASB, Summary of Statement 45 (June 2004), <<www.gasb.org/st/index.html>. Under the theory that OPEB are part of the compensation earned by employees for services rendered, benefits are earned and employers incur a cost for those benefits as services are rendered. *Id.* GASB 45 requires that the liability for such

obligations be accrued to provide a more accurate accounting of the cost of OPEB at the time services are performed. *Id.* GASB 45 provides for implementation of the standard by a government entity such as the State in fiscal year 2008.12

To comply with GASB 45, a government employer will have to report OPEB costs on an accrual basis. In order to do that, it will have to obtain an actuarial valuation of OPEB costs. Such a valuation involves a projection of future cash outlays for benefits, based on various assumptions, the discounting of those outlays to a current present value, and the amortization of that sum over a period that approximates the anticipated years of the average worker's employment. The result is referred to as the government employer's "annual required contribution" or "ARC". The ARC should be sufficient to fund the benefits expected to be earned in the future, as well as to amortize unfunded benefits attributed to the past. GASB, *Guide to Implementation of GASB Statements 43 and 45 on Other Postemployment Benefits,* p. 29.

GASB believes that this method of reporting will provide "more accurate information about the *total cost of the services* that a government provides . . . " GASB, GASB *Statement 45 on OPEB by Governments -- A Few Basic Questions and Answers,* p.1 (emphasis in original). In addition, it will make clear whether a government has covered its OPEB cost for the year; to the extent that a government chooses to defer that cost, "the higher will be (a) its unfunded actuarial accrued liability and (b) the cash flow demands on the government and its tax or rate payers in future years." *Id.*

C. Task Force and Valuation Study

During its most recent session, the Legislature created the Task Force to Study Retiree Health Care Funding Options, which you co-chair. Chapter 298, Laws of Maryland 2005. We understand that, in accordance with the 2005 legislation, the Task Force commissioned through DBM an actuarial study of the State's OPEB obligation in connection with the Program. *See* Aon Consulting, *State of Maryland Postemployment Benefits other than Pension Actuarial Valuation* (October 2005). That study analyzed data provided by the State and, based upon the consultant's understanding of the GASB standards, concluded that the ARC for the State's Fiscal Year 2006 would be $ 1.959 billion if GASB 45 were currently in effect. *Id.,* p.6.

II

Analysis

A. The State's Legal Obligation to Provide Retiree Health Care Benefits

You ask whether the State has "a statutory, contractual, or other legal obligation" to provide health care benefits to current retirees and several different categories of future retirees. We address this question with respect to benefits provided under the Program, which were the subject of the recent valuation study.

1. Statutory Obligation

As outlined above, State law currently requires the Secretary of DBM to administer the Program for the benefit of retirees, as well as current employees. The statute does not specify the type or level of benefits that the State is to provide, but delegates that determination to the Secretary, except in two respects. First, the Legislature has required the Secretary to include the same benefit options for fiscal years 2006 and 2007 as were part of the Program on January 1, 2005. Second, there must be a prescription benefit plan as part of the Program, although the Legislature has not specified any particular elements of that plan except for fiscal years 2006 and 2007.

While the statute provides for a State subsidy of the costs of the Program -- a subsidy that is to be pro-rated for most employees who retire after July 1, 1984 -- it does not set the level of the State subsidy of these benefits. Rather, it contemplates that the Secretary, with the advice of the Health

Insurance Advisory Council, will make an annual recommendation to the Governor as to the extent of the State subsidy of those benefits and, accordingly, the amount to be dedicated to that purpose in the State budget. However, the 2005 legislation did place some constraints on the Governor's discretion in this area,13 as it required the provision of certain benefit options and set a cap on the increase of the employee or retiree share of some premiums for fiscal years 2006 and 2007. *See* SPP § 2-502(c)(2) .

In sum, at present, the State has a general statutory obligation to make available health care benefits for certain retirees and to provide a partial subsidy of those benefits as specified in statute and regulation. The Secretary of DBM and the Governor enjoy relatively unfettered discretion to set benefit and subsidy levels in the proposed budget submitted to the General Assembly for fiscal years subsequent to 2007. While the Legislature may under the State Constitution mandate the inclusion of particular expenditures in the State budget under certain conditions, it has generally not done so with respect to the Program.14

Of course, in general, a statute may be amended by the General Assembly. Thus, the General Assembly could alter this statutory obligation at any time, unless there were a constitutional limitation on the Legislature's power to do so. The federal Constitution would limit alteration of the Program by the General Assembly if the amendment of the statute was a "law impairing the obligation of contracts." *See* United States Constitution, Article I, § 10, cl. 1 ("Contract Clause").

2. Contract Clause Analysis

To assess whether a legislative action impairs contract rights, the first question is whether a contractual obligation exists. There is a strong presumption that statutes do not create contractual rights. *Nat'l R. Passenger Corp. v. Atchison, Topeka & Santa Fe. R. Co.,* 470 U.S. 451, 465-66 (1985). "The principal function of a legislature is not to make contracts, but to make laws that establish the policy of the state." *Id.* In determining whether a statute creates a contractual obligation, there must be "an adequate expression of an actual intent" of the state to bind itself. *Id.* at 466-67. Thus, "a statute is itself treated as a contract when the language and circumstances evince a legislative intent to create private rights of a contractual nature enforceable against the State." *United States Trust Co. v. New Jersey,* 431 U.S. 1, 17 n.14 (1977). This power is subject to the proviso, under what is known as the reserved powers doctrine, that a state cannot enter into a contract that "surrenders an essential attribute of its sovereignty." *Id.* at 23.

If there is a contract, the next question is whether the State's action impairs private rights under the contract. *United States Trust Co.,* 431 U.S. at 19-21. Even if it does, it may not violate the federal Constitution, as not every impairment by a state of its contractual obligations is prohibited by the Contract Clause. Not all impairments of contractual obligations are unconstitutional; an impairment is constitutional if it is reasonable and necessary to serve an important public purpose. *Id.* at 21-26. In that regard, the courts accord a degree of deference to a legislative judgment of reasonableness and necessity. *See Baltimore Teachers Union v. Mayor and City Council of Baltimore,* 6 F.3d 1012, 1019 n.10, 1022 (4th Cir. 1993), *cert. denied,* 510 U.S. 1141 (1994); *Maryland State Teachers Association, Inc. v. Hughes,* 594 F.Supp. 1353, 1360-62 (D.Md. 1984), *aff'd,* No. 84-2213 (4th Cir. 1985), *cert. denied,* 475 U.S. 1140 (1986); 68 *Opinions of the Attorney General* 366 (1983).

In *Hughes,* the federal district court applied the analysis outlined above and concluded that State legislation reforming the State *pension law* did not amount to an unconstitutional impairment of contractual rights. In that case, State employee groups challenged the 1984 Pension Reform Law arguing that it unconstitutionally impaired contract rights conferred by a 1979 pension law. The court assumed, without deciding, that the 1979 law created a contractual right to certain pension benefits. 594 F.Supp. at 1362-63. Even under that assumption, the court found that the State retained the power to amend or alter the contract to enhance the actuarial soundness of the plan. *Id.* The court then turned to the question of impairment. It first concluded that the 1984 law did not deny vested or

earned pension rights retroactively and allowed employees to protect pension benefits earned up to the effective date of the law by selecting a particular option from the "menu" offered by the 1984 law. *Id.* at 1363-64. Relying on *City of Frederick v. Quinn,* 35 Md. App. 626, 371 A.2d 724 (1977) 15 and a prior opinion of this Office, the court held that "Maryland law would not extend unalterable contract protection against change in pension benefits which were to be earned on a pro rata basis by employment service in the future." *Id.*

Finally, the court held that, to the extent that the 1984 law did in fact impair any contract right, it was supported by "an important and legitimate public purpose" -- *i.e.,* protecting the soundness of the retirement system that had been created by the 1979 legislation. 594 F.Supp. at 1364-70. The court found that the 1984 law was a reasonable and necessary response to problems that had surfaced since 1979. Accordingly, the 1984 law did not violate the Contract Clause of the federal Constitution, regardless of whether it had impaired a contractual obligation of the State. *Id.* The court deferred to the General Assembly's judgment in determining how best to preserve the stability of the State pension systems. *See also 76 Opinions of the Attorney General* 351, 354-56 (1991)(applying analysis described in *Hughes* and concluding that proposed legislation imposing benefits limits in order to allow the pension system to retain tax-qualified status with the IRS did not violate Contract Clause).

3. Whether the Health Benefits Statute Creates a Contractual Obligation

As noted above, there is a presumption that statutes do not create contractual rights unless there is a clear legislative intent to do so. The State statute that extends employee health benefits to certain classes of retirees does not expressly create a contractual right. Apart from certain provisions relating to fiscal years 2006 and 2007, it does not purport to promise any particular level of benefits or subsidy to employees. The benefits and subsidy made available to retirees are keyed to those to which current employees are entitled.16 The statute does not appear to confer any greater right to benefits and a State subsidy to retirees. Nor is there any clear and express language that vests retirees with benefits. We are not aware of any Maryland cases that hold that State retiree health care benefits authorized by statute generally are a contractual right.

Thus, in our view, there is no contractual right to retiree health care benefits that could be impaired if the General Assembly were to amend the statute to change the level of benefits or subsidy or were to continue to leave the extent of benefits to the Secretary's and Governor's discretion.17 On the other hand, the General Assembly could confer a contractual right to health care benefits by enacting legislation to that effect, if it chose to do so. However, such a commitment would be subject to modification in the future by the General Assembly under the standards set forth in *Hughes* and other cases construing the Contract Clause.

B. Case Law in Other States Concerning Retiree Health Care Benefits

You have asked whether there is any case law concerning alteration of retiree health care benefits, particularly in other states whose bonds have received the highest rating from the rating agencies. We are not aware of any case law that construes or applies GASB 45 -- which is not surprising, as GASB 45 was only recently issued. Nor are we aware of any case law concerning the alteration of retiree health care benefits in other states whose bonds have been given the highest rating by the bond rating agencies.18

Courts in other states have rendered opinions concerning the alteration of health care benefits of retired public employees. Most of those opinions are of limited value in answering the questions you have raised, as they construe state constitutional provisions, statutes, or contracts peculiar to the particular state.

Some courts have looked to the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.,* for guidance. ERISA, which applies to private employers,19 distinguishes pension plans from "welfare benefit plans" (defined to include retiree health insurance benefits). 29

U.S.C. § 1002 (1), 2(a). In particular, it excepts welfare benefit plans from its vesting requirements. 29 U.S.C. § 1051 (1). The exclusion of welfare benefit plans from the ERISA vesting requirement has been attributed to the fluctuating and unpredictable nature of the costs of such plans:

> Actuarial decisions concerning fixed annuities are based on fairly stable data, and vesting is appropriate. In contrast, medical insurance must take account of inflation, changes in medical practice and technology, and increases in costs of treatment independent of inflation. These unstable variables prevent accurate predictions of future needs and costs.
>
> *Moore v. Metropolitan Life Ins. Co.,* 856 F.2d 488, 492 (2d Cir. 1988). Under ERISA, an employer may voluntarily create a vested right in retiree health care benefits.20

In *Davis v. Wilson County,* 70 S.W.3d 724 (Tenn.S. Ct. 2002), the Tennessee Supreme Court relied on an analogy to ERISA to hold that employees do not automatically have a vested interest in welfare plan benefits -- such as retiree health care benefits. Rather there must be "clear and express language" indicating an intent to confer a vested benefit. 70 S.W.3d at 727-28. In the case before it, the court found no evidence of such intent.

Similarly, in *Colorado Springs Fire Fighters Ass'n v. City of Colorado Springs,* 784 P.2d 766 (Colo.S. Ct. 1989) (en banc), plaintiffs argued that a 1966 municipal ordinance that provided for full payment of retiree health insurance costs amounted to a "contractual, quasi-pension benefit" and that a subsequent ordinance reducing that benefit was an unconstitutional impairment of contract rights. However, in concluding that the program was not a "pension benefit", the Colorado Supreme Court found that the municipal program was similar to a state retiree health benefit program, under which the amount of the health benefit premium subsidy was determined on an annual basis, the cost and design of the program was subject to change, and employee participation was optional. 784 P.2d at 771. The court also drew an analogy to ERISA's exclusion of welfare plan benefits, such as health insurance, from mandatory vesting. *Id.* at 772. The court held that the municipal ordinance did not otherwise create an enforceable contract because, among other things, it did not address the level of benefits.

Without making an explicit analogy to ERISA, some courts have looked to the use of elective language in a statute conferring health care benefits and the unpredictable costs of such benefits to conclude that a legislature did not intend a contractual obligation. For example, *Bernstein v. Commonwealth,* 617 A.2d 55 (Pa. Cmwlth. 1992), involved an interpretation of a Pennsylvania statute that provided for an "election" by retirees of State health care coverage. The case arose after Pennsylvania changed the health care options for its retirees to eliminate coverage duplicative of Medicare Part B. Some retirees challenged this change in benefits, arguing that it amounted to an unconstitutional impairment of their contract rights. The court held that the statutory language merely gave a retiree an option to participate in the employee health coverage. It also concluded that the state legislature, recognizing the practical reality of fluctuating health care costs, had not committed the state to any particular plan. The court noted that the amount of the state share of the costs of the health insurance program had changed over the period that the plaintiffs had been active employees, thus undermining any contention that they had an expectation of a particular level of benefits upon retirement. 617 A.2d at 59-60. *But see Thorning v. Hollister School District,* 15 Cal.Rptr.2d 91, 94-95 (Ct.App. 1993) (although both statute allowing for retiree health care benefits and local policy under that statute were phrased in elective language, retired school board members who had elected those benefits had vested right because elements of compensation for elected officers became contractually vested upon acceptance of employment).

Several states have constitutional provisions that protect the "accrued" benefits of retirees. However, courts have reached differing conclusions about whether health care benefits fall within that category. In *Duncan v. Retired Public Employees of Alaska, Inc.,* 71 P.3d 882 (Ak. S. Ct. 2003), the Alaska Supreme Court held that health insurance benefits were part of the "accrued benefits" of the state

employee retirement systems. Accordingly, they were subject to a state constitutional provision that specifically prohibited the diminishment or impairment of such benefits. However, the court held that the prohibition did not prevent the state from modifying retiree health care benefits so long as the modifications were reasonable and any disadvantageous changes were offset by beneficial changes from a group perspective.21

Like Alaska, Michigan also has a provision in its state constitution that protects "accrued financial benefits" of public employees from impairment or diminishment. In *Studier v. Michigan Public School Employees' Retirement Board,* 698 N.W.2d 350 (Mich.S. Ct. 2005), the Michigan Supreme Court held that the phrase did not encompass retiree health care benefits.22 In addition, the court also held that the statute creating retiree health care benefits did not establish a contractual obligation and that modification of the prescription drug benefits -- increasing co-payments and implementing monetary incentives to encourage the choice of formulary drugs -- would not implicate the contract clauses of the state or federal constitutions. Rather, the court found that the Michigan legislature had simply made a policy decision that there would be a subsidy for a retiree who chose to participate in whatever plan the state authorized; the statute did not require that any particular plan be developed or that the plan could not be later amended. *Id.* at 363-64.

Some court decisions relate to the public collective bargaining law of the particular state, as well as particular collective bargaining contracts. In *Poole v. City of Waterbury,* 831 A.2d 211 (Conn.S. Ct. 2003), a city confronted with a financial crisis entered into a new collective bargaining agreement that replaced a prior indemnity plan for employee and retiree health care benefits with a managed care plan. Retired municipal firefighters challenged that modification, arguing that they had a vested right in the medical benefits provided by the collective bargaining agreement with the city at the time of retirement. In construing ambiguous language in particular collective bargaining contracts, the Connecticut Supreme Court held that, although the plaintiffs had a vested right to retiree medical benefits generally, they did not have a vested right in the particular menu of benefits provided in an expired collective bargaining agreement. 831 A.2d at 231-32. Rather, the court would look to whether the benefits provided to retirees were "reasonably commensurate" with the benefits afforded by an agreement, when viewing the group of retirees as a whole. 831 A.2d at 234. In discussing whether there should be a presumption in favor of vesting of retiree health care benefits, the court contrasted the inability to predict or control health insurance costs with the more predictable nature of pension benefits. *Id.* at 223. The court also noted that it would be "counter to all of the parties' interests" to construe the collective bargaining agreements to freeze benefits in the exact plan provided at the time of retirement. *Id.* at 233.

On the other hand, in *Roth v. City of Glendale,* 614 N.W.2d 467 (Wis.S. Ct. 2000), the Wisconsin Supreme Court interpreted a series of limited term collective bargaining agreements between a city and union that included provisions for subsidizing retiree health care benefits and adopted a presumption that such benefits vest unless the language of the contract provided otherwise. The Court treated those benefits as part of the package of retirement benefits that ordinarily last beyond the life of the contract, in the absence of contract language or extrinsic evidence demonstrating a contrary intention. *Id.* at 471-74.

As this brief summary of case law in other jurisdictions illustrates, there is no consensus in the courts that retiree health care benefits are a vested or contractual right. The cases concerning public employees in other jurisdictions reach various conclusions, depending on the particular constitutional provisions, statutes, or collective bargaining agreements that govern the benefits at issue.

C. Distinction Between Pension Benefits and Health Care Benefits

You have asked whether there are legal distinctions between a retiree's right to pension benefits and to health care benefits. A key distinction is that retirees have a contractual right to pension benefits, but not to health benefits. This distinction is borne out in a number of ways.

Pension statutes refer to membership in the pension system as a "condition of employment." *See, e.g.,* SPP §§ 23-203 (Employees' Pension System), 23-208 (Teachers' Pension System), 22-202(a)(Employees' Retirement System), 22-206(a)(Teachers' Retirement System), 24-202 (State Police Retirement System), 25-202 (Correctional Officers' Retirement System). Citing similar language in a prior version of the State retirement law, Attorney General Sachs concluded that the law created a contractual obligation, although benefits were subject to reasonable modification by the General Assembly for the purpose of maintaining the financial flexibility and integrity of the retirement systems. 68 *Opinions of the Attorney General* 366 (1983);23 *see also* 61 *Opinions of the Attorney General* 746, 747-51 (1976)(concluding that earlier version of pension law demonstrated intent to create contractual rights).

The retirement law specifically refers to the "vesting" of pension benefits. *See, e.g.,* SPP § 20-101(tt) (definition of "vested allowance"); § 21-112(2)(ii)(members of retirement systems entitled to annual report showing "vested benefits"); § 22-213 (transfer of vested rights between systems); § 23-501 (continuation of benefits for "former vested members"); §§ 29-302, 29-303 (computation of vested allowance); §§ 29-304, 29-305 (immediate vesting for heads of units and other officials). In addition, the State retirement law explicitly guarantees the payment of retirement allowances and other benefits provided by the pension laws. SPP § 21-302 . The statute provides that "the following are obligations of the State":

(1) the payment of all allowances and other benefits payable under . . . [the State pension laws];

(2) the creation and maintenance of reserves in the accumulation funds of the several systems;

(3) the crediting of regular interest to the annuity savings funds of the several systems; and

(4) the payment of expenses for administration and operation of the several systems.

SPP § 21-302(a) .24

Maryland courts have adopted the view that government pension plans are contractual in nature, "but under certain circumstances the government may unilaterally modify them so long as any changes do not adversely alter the benefits, or if the benefits are adversely altered, they are replaced with comparable benefits." *Davis v. City of Annapolis,* 98 Md. App. 707, 715, 635 A.2d 36 (1994) (Cathell, J.)(police officer entitled to disability pension benefits under the statute in effect at the time of injury). *See also Board of Trustees of Employees' Retirement System v. Mayor and City Council of Baltimore City,* 317 Md. 72, 100, 562 A.2d 720 (1989), *cert. denied,* 493 U.S. 1093 (1990) ("There is no doubt that, by establishing the pension systems, the City imposed contractual obligations on itself"); *Quesenberry v. Washington Sububran Sanitary Commission,* 311 Md. 417, 423, 535 A.2d 481 (1988) (stating that rights conferred by a public pension plan are contractual in nature, although they may be modified by unilateral action of the employer in certain circumstances); *City of Frederick v. Quinn,* 35 Md. App. 626, 629-31, 371 A.2d 724 (1977) (holding that government pensions are "more contractual than gratuitous" and citing a "reserved legislative power" to make reasonable modifications in a pension plan).25 Courts in other states have also concluded that state and local governments have undertaken contractual obligations in creating pension plans. *See* 16B Am.Jur.2d, *Constitutional Law,* § 721 .

By contrast, as noted above, retirees do not have a contractual right to health care benefits. SPP § 2-508 , in providing retiree health care benefits, neither states that a retiree "vests" in Program or subsidy eligibility, nor characterizes any portion of the Program as an "obligation of the State" to retirees. Rather, there is a statutory right, the delineation of which has been largely delegated to the Secretary of DBM and the Governor, and which is subject to change by the General Assembly.

The distinction between pension benefits and health care benefits is also borne out by the method of funding chosen by the Legislature. The State retirement law provides for advance funding of pension

benefits with government and employee contributions and creates specific funds for each of the State's retirement systems. SPP § 21-301 *et seq.* By contrast, with limited exceptions, the funding of the subsidy of benefits in the Program is left to the judgment of the Secretary of DBM and the Governor in devising an amount to include in the proposed budget. SPP § 2-503(a)(3) . There is no suggestion that this estimate must satisfy a pre-existing obligation.

It is true that the Legislature has created two special funds to help finance retiree health care benefits in the future. SPP §§ 2-516 (State Employees and Retirees Health and Welfare Benefits Fund); 34-101 (Postretirement Health Benefits Trust Fund). However, the first fund is specifically identified as a "special reserve fund . . . to retain certain State revenues and State general and special funds for the purpose of funding the [Program]." SPP § 2-516(b)(1) . This reserve fund would help finance health care benefits of current employees, as well as retirees. The statute establishing the reserve fund does not create any specific obligation to retirees.

In addition, when it created the second fund -- the Trust Fund -- the Legislature did not commit to provide health care benefits to retirees. The implementing law for the Trust Fund provides that, "if for any reason the State discontinues the postretirement health insurance subsidy specified in [SPP § 2-508], the assets of the [Fund] shall be transferred to the General Fund." SPP § 34-101(i) . This provision recognizes the possibility that the subsidy for retiree health care benefits could be eliminated in the future; in that event, retirees would have no special claim on the moneys in the Trust Fund, indicating that the Legislature did not intend to create a contractual obligation to retirees in creating the Trust Fund.

The General Assembly has specifically distinguished health care benefits from pension benefits. The statute that establishes the Program, including health care benefits, states that the Program "may not contain any of the benefits provided under Division II . . ." -- *i.e.,* pension benefits. SPP § 2-502(b)(2) .

Finally, consistent with the statutory provisions, the materials published to employees and retirees concerning health care benefits have explicitly disclaimed any intention to create a contractual obligation to provide health care benefits. The booklet that summarizes State benefits for employee and retirees prominently states, on its inside cover: *"This Book is Not a Contract."* DBM, Summary of Benefits for Active & Retired Employees (July 1, 2005 -- June 30, 2006). Similarly, the summary of health insurance benefits published by the State Retirement Agency states:

> Membership in the State Health Program does not constitute a contract. The provisions of the program are subject to annual review and modification. Costs may vary each year.
>
> State Retirement Agency, Benefits Handbook for the Employees and Teachers Pension Systems (Rev. July 2004), p.46; see also *id.,* p.47 (disclaimer paragraph concerning retiree health benefits entitled "This is Not a Contract")

You note that the State subsidy of health care benefits provided to retirees under SPP § 2-508 increases to a certain extent with the length of service of the retiree. You ask whether the relation of the subsidy to length of service results in a contractual obligation. It is true that the statute does not provide all retirees with the same subsidy as current employees, but allocates the amount of the State subsidy to a retiree in relation to some extent to the individual's years of service. In doing so, the statute incorporates the concept of "creditable service" and certain time periods from the pension statutes. However, they are used in SPP § 2-508 to compute a particular retiree's share of whatever subsidy is provided to current employees under the Program, not to set a particular benefit or subsidy level.26 In our view, this does not change the nature of the benefits provided. As noted above, the statute generally does not establish any particular level of benefits or subsidy and, indeed, contemplates that they will ordinarily depend on annual budget decisions.

In summary, while pension benefits under the State retirement law may be considered a contractual obligation of the State, retiree health care benefits provided through the Program are not. *Cf.* 78

Opinions of the Attorney General 296 (1993)(distinguishing group health insurance benefits from pension benefits for purposes of the prohibition against in-term increases in "compensation" in Article III, § 35, of the State Constitution).

D. Effect of Collective Bargaining Agreements on Retiree Health Care Benefits

You have asked whether the State's legal obligations regarding retiree health care benefits can be altered as a result of a collective bargaining agreement between the Administration and employee organizations. The short answer is that a collective bargaining agreement can affect retiree health care benefits, but only if the change is adopted by the General Assembly.27

The State collective bargaining law sanctions collective bargaining for many, but not all, employees of the executive branch. SPP § 3-101 *et seq.* The statute contemplates that representatives of the State will negotiate with the exclusive representatives of various categories of employees. SPP § 3-501 . The negotiations are to include "all matters relating to wages, hours, and other terms and conditions of employment." SPP § 3-502 . Any agreement resulting from the negotiations is to be incorporated in a memorandum of understanding ("MOU"). An MOU is not effective unless it is ratified by the Governor, as well as a majority of votes cast by employees in the bargaining unit. SPP § 3-601(c) ; *see also Ehrlich v. Maryland State Employees Union,* 382 Md. 597, 856 A.2d 669 (2004). 28

The statute contemplates that Governor will include any additional costs resulting from a ratified MOU in the proposed budget for the relevant departments. SPP § 3-501(c)(2)(ii) .29 Pursuant to the State Constitution, the General Assembly remains free to reduce or strike those appropriations when it considers the Governor's proposed budget. Maryland Constitution, Article III, § 52(6). In addition, to the extent that negotiations result in an MOU that has terms inconsistent with current law, those terms become effective only if the General Assembly amends the applicable law. SPP § 3-502(c) .

In our view, retiree health care benefits would be encompassed within "wages, hours, and other terms and conditions of employment" and thus can be a subject of collective bargaining under the State collective bargaining law. The Administration could negotiate with employee representatives concerning the types and level of health care benefits to be included in the Program designed by the Secretary for employees and, by operation of SPP § 2-508 , certain classes of retirees. However, the costs associated with any such agreement would be subject to reduction or elimination as part of the General Assembly's budget process. In addition, to the extent that the MOU embodied an agreement for retiree health care benefits different from those in current law, the change could not become effective until the General Assembly amended the law.

Thus, a collectively bargained MOU could only change the nature of retiree health care benefits if the General Assembly incorporated that change in the law.30 As we understand it, none of the collective bargaining MOUs to date between the State and recognized representatives have specifically addressed the subject of retiree health care benefits. To the extent that MOUs have referred to employee health care benefits, they have not deviated from the existing statutory provisions.

E. GASB 45 and the Use of a Trust to Fund Benefits

Finally, you ask several questions related to the creation of a trust to fund retiree health care benefits.

1. Whether GASB 45 Creates Legal Obligations

You ask whether GASB 45 creates any legal obligations for the State to treat retiree health care benefits in the same manner as pension benefits. As noted above, GASB is a private organization that develops accounting standards. It has no authority to impose legal obligations on the State and does not purport to do so. Moreover, GASB 45 itself was not intended to mandate any particular level of benefits or method of financing those benefits. GASB has explained:

> Q -- Does Statement 45 require that an employer change its method of financing OPEB . . . to begin paying the ARC or otherwise accumulate plan net assets in order to fund the actuarially

accrued benefits in some manner?

A -- No. Statement 45 establishes standards for an employer's *accounting and financial reporting* of OPEB. The ARC is used in the measurement of . . . OPEB expense . . .

See GASB, *Guide to Implementation of GASB Statements 43 and 45 on Other Postemployment Benefits,* p. 30 (emphasis in original). Accordingly, GASB 45 imposes no legal obligations on the State with respect to the level or types of health care benefits accorded to retirees or the financing of those benefits. 31

2. Effect of Creation of Irrevocable Trust

Under GASB 45, assets transferred to an irrevocable trust "or equivalent arrangement" that dedicates those assets to the financing of retiree health care benefits and protects them from the employer's creditors are considered a payment in relation to the employer's ARC. (Other payments in relation to the ARC include funds actually paid for health benefits and premiums paid to an insurer for that year). GASB, *Guide to Implementation of GASB Statements 43 and 45 on Other Postemployment Benefits,* p. 32 (Question and Answer 100).

You asked whether the creation of a non-revocable trust fund in response to GASB 45 would create a legal obligation to provide retiree health care benefits. It is difficult to answer this question in the abstract without the terms of a specific proposal.32 If the State were to create an irrevocable trust for retiree health care benefits, particularly one that consisted in part of employee contributions, there may be a stronger argument that the State had undertaken a contractual obligation to provide retiree health care benefits -- or at least to devote the funds in the trust to that purpose. *Cf.* 66 *Opinions of the Attorney General* 56 (1981)(statute creating Fair Campaign Financing Fund with voluntary contributions of taxpayers established a trust and a contractual obligation of the State).

III

Conclusion

In summary, it is our opinion that:

1. The State currently has a statutory obligation to provide health care benefits to certain retirees; however, the statute does not create a contractual obligation and the General Assembly remains free to amend the law that provides such benefits. Although the General Assembly may choose to confer a vested right in retiree health care benefits, it has not done so. Even a contractual right to health care benefits would be subject to modification if reasonable and necessary to serve an important public purpose.

2. With respect to other states that, like Maryland, enjoy the highest credit rating from the bond rating agencies, we found no relevant case law. There are cases in other states that have reached various conclusions; some of those decisions recognize a contractual obligation to provide health care benefits to retirees. However, those cases are of limited value in construing Maryland law as they are based on the particular state constitution, statute, collective bargaining agreement, or other circumstances peculiar to the case.

3. In contrast to retiree health care benefits, pension benefits are contractual in nature. The statutes creating the various retirement systems explicitly vest certain rights in retirees with respect to the type and level of benefits, while the statute concerning retiree health care benefits does not. Prior opinions of this Office and court decisions confirm that the pension benefits are a contractual obligation. The fact that the amount of a retiree's subsidy for health care benefits may be related to length of State service does not alter this essential distinction.

4. Collective bargaining negotiations could result in changes in the State's legal obligations concerning retiree health benefits, but only if the General Assembly specifically adopted those changes.

5. GASB 45, as an accounting standard issued by a private entity, does not itself impose any legal obligation on the State concerning the level or funding of retiree health care benefits. Nor does it express a preference for or prescribe the timing or the method of financing retiree health care benefits. The creation of an irrevocable trust to fund retiree health care benefits could be part of a contractual undertaking of the State to provide those benefits. If the trust fund consisted in part of employee contributions, there may be a stronger argument that the State had undertaken to devote the funds in the trust to retiree health care benefits.

Footnotes

Footnotes

1 The Advisory Council is to advise the Secretary concerning:

(1) health insurance benefit options that should be included in the Program;

(2) types of health care providers that should be used to provide health insurance benefits under the Program;

(3) procedures for soliciting bids or requesting proposals from health care providers for contracts for the Program;

(4) the implementation, maintenance, and administration of the health insurance benefits under the Program; and

(5) negotiations involving health insurance benefits under the Program.

SPP § 2-506(a) .

2 Separate sections of the statute set forth the eligibility standards and benefits for employees of institutions of higher education who retire under the optional retirement program (SPP § 2-509), retired Baltimore City jail employees (SPP § 2-510), employees and retirees of the Maryland Environmental Service and Northeast Maryland Waste Disposal Authority (SPP § 2-511), employees of certain not-for-profit organizations (SPP § 2-512), county and municipal employees (SPP § 2-513), and employees of regional economic development councils (SPP § 2-515).

3 The federal legislation also provided for a federal subsidy of employers who continue to provide prescription drug coverage for retirees. 42 U.S.C. § 1395w -132; *see also* Fiscal and Policy Note for Senate Bill 614 (March 15, 2004). The federal subsidy is designed to encourage group health plans to provide retiree prescription drug coverage that is at least actuarially equivalent to Medicare Part D. *See* Joint Committee on Pensions, 2004 Interim Report, *Report on the State's Unfunded Retiree Healthare Liability,* p. 184; see also Fiscal and Policy Note (Revised) for Senate Bill 548 (March 30, 2004).

4 The statute places the following limitations on changes in benefits for fiscal year 2006 and 2007:

(2) In fiscal years 2006 and 2007:

(i) the employee or retiree share of the premium for the employee or retiree and their dependents for the point of service health plan may increase to 17%;

(ii) the Program may include disease management programs;

(iii) the Prescription Drug Benefit Plan shall offer a voluntary mail order option and the Prescription Drug Benefit Plan may charge enrollees the following co-payments for prescription drugs:

1. $ 5 for generic drugs;

2. $ 15 for preferred drugs on the State formulary; and

3.$ 25 for drugs that are not preferred drugs on the State formulary;

(iv) the Prescription Drug Benefit Plan may charge a co-payment as provided in item (iii) of this subsection for each 45-day prescription;

(v) for each fiscal year, the total amount of co-payments charged the employee or retiree and their dependents as provided in item (iii) of this subsection may not exceed $ 700; and

(vi) the Prescription Drug Benefit Plan may include the following programmatic changes:

1. implementation of a step therapy program to assure that lower cost alternatives are used first;

2. changes in the pharmacy network;

3. limitations on the first prescription for a maintenance drug;

4. limitations on the quantity of drugs dispensed to reduce inappropriate or excessive drug usage;

5. requirements for prior authorization of drugs to ensure that they are medically necessary; and

6. implementation of a drug utilization review program.

SPP § 2-502(c)(2) . With respect to fiscal year 2006, these provisions would be regarded as directory, rather than mandatory. See Letter of Attorney General J. Joseph Curran, Jr., to Governor Robert L. Ehrlich, Jr., concerning House Bill 147 (May 19, 2005) p.4 n.4.

5 Any subsidies received after fiscal year 2007 are to be deposited in the Postretirement Health Benefits Trust Fund. *See* Part I.B.2 below.

6 In some cases, such benefits are also available to the spouse and dependent children of deceased retirees. SPP § 2-508(b)(2) .

7 "Creditable service" is specifically defined in the statute. SPP § 2-508(a)(2) .

8 This subsidy is not specifically authorized in the language of SPP § 2-508 itself, which sets out a pro-rated subsidy based on years of service. The regulation apparently reflects the agency's understanding of legislative intent. Prior to the enactment of the predecessor of SPP § 2-508 in 1984, there was a "custom" of providing retirees with subsidized health care benefits equivalent to those of active employees, although the custom was not reflected in statute. The Joint Legislative and Executive Committee on Pensions recommended, among other things, that employees who retired prior to July 1, 1984, be grandfathered under that custom. Report of the Joint Legislative and Executive Committee on Pensions (January 1984), pp.37-40. The legislation that emanated from that report -- the predecessor of SPP § 2-508 -- was explicitly intended to incorporate the Joint Committee's recommendations. *See* Chapter 290, Preamble, Laws of Maryland 1984. The language of the statute that was enacted failed to explicitly reflect that intent with respect to the grandfathering of those who retired prior to July 1, 1984. However, the understanding that those retirees were grandfathered under the prior practice was described in a memorandum of the Secretary of Personnel to all State employees shortly after the 1984 bill was enacted. Memorandum of Theodore E. Thornton, Sr., Secretary of Personnel, to All State Employees (May 15, 1984).

9 This subsidy was originally provided by statute. *See* Chapter 745, Laws of Maryland 1985, *then codified at* Article 64A, § 48B(c)(2)(ii). However, the reference to the subsidy was apparently inadvertently dropped from the statute during code revision. Chapter 10, § 2, Laws of Maryland 1993.

10 The amount transferred each year is to equal the lesser of: (1) one-quarter of the Trust Fund's investment gains for the prior year; and (2) the annual cost of the retiree health care benefits provided under SPP § 2-508 .

11 The American Institute of Certified Public Accountants requires auditors to note non-compliance

with GASB standards when an auditor expresses an opinion on whether an entity's financial reports are presented in accordance with generally accepted accounting principles ("GAAP"). AICPA, Rules of Professional Conduct, §§ 203, 203-2.

12 GASB 45 is being phased in, beginning with the largest governments, and is effective for the fiscal year beginning after December 15, 2006 for governments with annual revenues in excess of $ 100,000,000. GASB, Summary of Statement 45 (June 2004).

13 To some extent these constraints are directory rather than mandatory. *See* footnote 4 above.

14 Under certain conditions, the General Assembly may mandate the inclusion of a particular expenditure in the State budget. Maryland Constitution, Article III, § 52(11). The Legislature has generally not exercised this authority in establishing a subsidy for employee and retiree health care benefits, presumably to allow the Secretary flexibility in responding to the evolving market for health care benefits.

15 In *Quinn,* the Court of Special Appeals held that, even though municipal employees had vested rights in a pension plan, those rights were subject to the power of the city to make reasonable and necessary modifications.

16 It is also notable that the statute states that a retiree "may enroll and participate" in the Program -- clearly indicating that the retiree has a choice. By contrast, employees are automatically enrolled in pension programs. *See* Part II.C. of this opinion, below.

17 Nor do we believe that modification of SPP § 2-508 would affect a property interest or vested right protected by the Due Process Clause of the federal Constitution or Articles 19 and 24 of the Maryland Declaration of Rights. *See Flemming v. Nestor,* 363 U.S. 603, 610 (1960) ("To engraft upon the Social Security system a concept of 'accrued property rights' would deprive it of the flexibility and boldness in adjustment to everchanging conditions which it demands.").

18 We understand that the other states, in addition to Maryland, whose bonds have achieved the top rating from all of the major rating agencies are: Delaware, Georgia, Missouri, Utah, and Virginia.

One case in Georgia held that a life insurance benefit provided to retirees was not vested. *Wilson v. City of East Point,* 360 S.E.2d 254 (Ga.S. Ct. 1987). However, that case involved construction of a municipal ordinance that explicitly limited the benefit "for such time as may be determined by the City Council."

19 ERISA does not apply to government retirement and benefit plans. 29 U.S.C. § 1003 (b).

20 There is some variation in the cases as to how explicitly that intent must be expressed. *See Poole v. City of Waterbury,* 831 A.2d 211, 221-22 (Conn.S. Ct. 2003).

21 The court rejected the plaintiff's argument that the issue of impairment should be measured from the perspective of an individual employee. 71 P.3d at 889.

22 In concluding that retiree health care benefits were not "accrued financial benefits" for purposes of the Michigan constitution, the court noted that, unlike pension benefits, the amount of health care benefits did not increase with the retiree's years of service and therefore "they are not accrued." 698 N.W.2d at 358. It also reasoned that health care benefits are not "financial" benefits as they do not consist of monetary payments. *Id.*

23 Attorney General Sachs' opinion anticipated the Legislature's subsequent enactment of pension reform legislation in 1984 and the federal district court's decision upholding that legislation against a Contract Clause challenge. *See Maryland State Teachers Ass'n, Inc v. Hughes, supra.*

24 The statute further specifies that the assets of the pension systems are to be used to pay these obligations and that the State is to make up any amount each year in the accumulation fund of each

system necessary to pay allowances and other benefits out of the fund for the year. SPP § 21-302(b) -(c).

25 In *Quinn,* Judge Lowe summarized the circumstances under which a government pension plan could be altered:

> Each case where a changed plan is substituted must be analyzed on its record to determine whether the change was reasonably intended to preserve the integrity of the pension system by enhancing its actuarial soundness, as a reasonable change promoting a paramount interest of the State without serious detriment to the employee. In short, the employee must have available substantially the plan he bargained for and diminution thereof must be balanced by other benefits or justified by countervailing equities for the public's welfare.
>
> 35 Md. App. at 631.

26 Even in a state with a constitutional provision protecting "accrued" financial benefits, this factor would not be conclusive on whether health care benefits fall within that phrase. *See* note 22 above.

27 We address only retiree health care benefits that were the subject of the recent actuarial valuation study and that may be affected by agreements under the State's collective bargaining law. We do not address retiree health care benefits that may be provided under other collective bargaining regimes, such as agreements between the Maryland Transit Administration and its employees. *See* Annotated Code of Maryland, Transportation Article, § 7-601 *et seq.*

28 In the case of an institution of higher education, the MOU must be ratified by the institution's governing board, as well as a majority of employees in the bargaining unit. SPP § 3-601(c)(2) .

29 The statute states:

> In the budget bill submitted to the General Assembly, the Governor shall include any amounts in the budgets of the principal units required to accommodate any additional cost resulting from the negotiations, including the actuarial impact of any legislative changes to any of the State pension or retirement systems that are required . . .
>
> SPP § 3-501(c)(2)(ii) .

30 There is case law in other states holding that promises made in a collective bargaining agreement may confer a vested right to retiree health care benefits. *See Poole v. City of Waterbury,* 831 A.2d 211, 222 n.10 (Conn.S. Ct. 2003) (collecting cases); *see also* Minnesota Op. Atty. Gen. 125 A-28, 2001 WL 505668 (2001) (provision of state statute governing collective bargaining limited duration of promise of retiree health care benefits to term of agreement; however, promise of lifetime coverage made in collective bargaining agreement prior to enactment of that provision remained in effect).

31 This does not mean that GASB 45 may not have a significant impact on states and their finances. States will likely feel compelled to comply with the accounting and disclosure standards established in GASB 45. To the extent that compliance with GASB 45 results in a large liability being added to a state's balance sheet, the state may try to reduce that liability in various ways to avoid adverse action by bond-rating agencies. *See Solomon, State, Local Officials Face Looming Health-Care Tab,* Wall Street Journal (November 23, 2005), p.A1; Fitch Ratings, *The Not So Golden Years -- Credit Implications of GASB 45* (June 22, 2005), p.2.

32 As outlined above, the General Assembly has created the Postretirement Health Benefits Trust Fund to help finance retiree health care benefits in the future. However, that Trust Fund is not irrevocable, as its implementing law contemplates a possible termination of benefits and reversion of funds to the general fund.

Discussion of State Options Regarding Medicare Subsidies

The Maryland Blue Ribbon Commission to Study Retiree Health Care Funding Options

September 27, 2007

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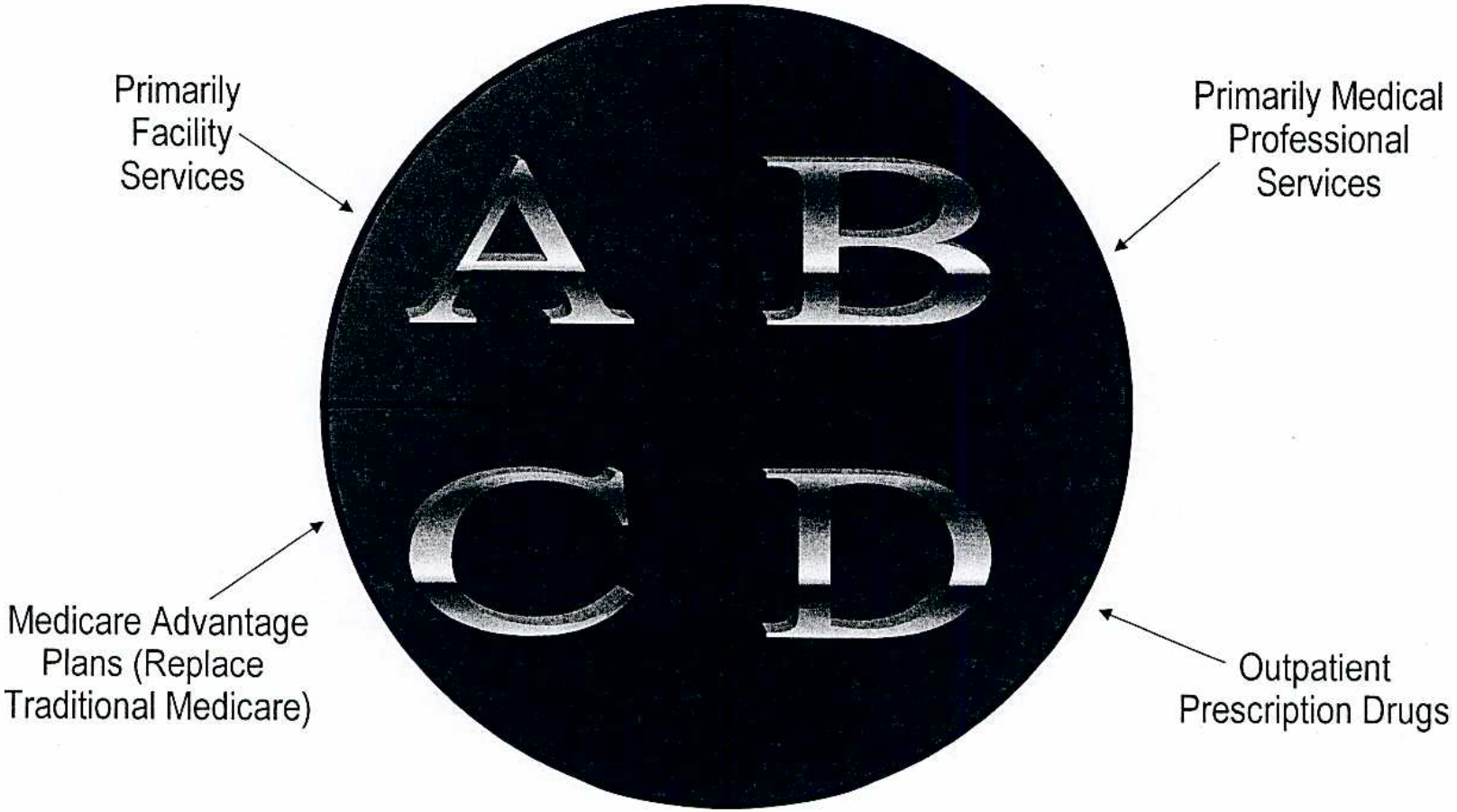
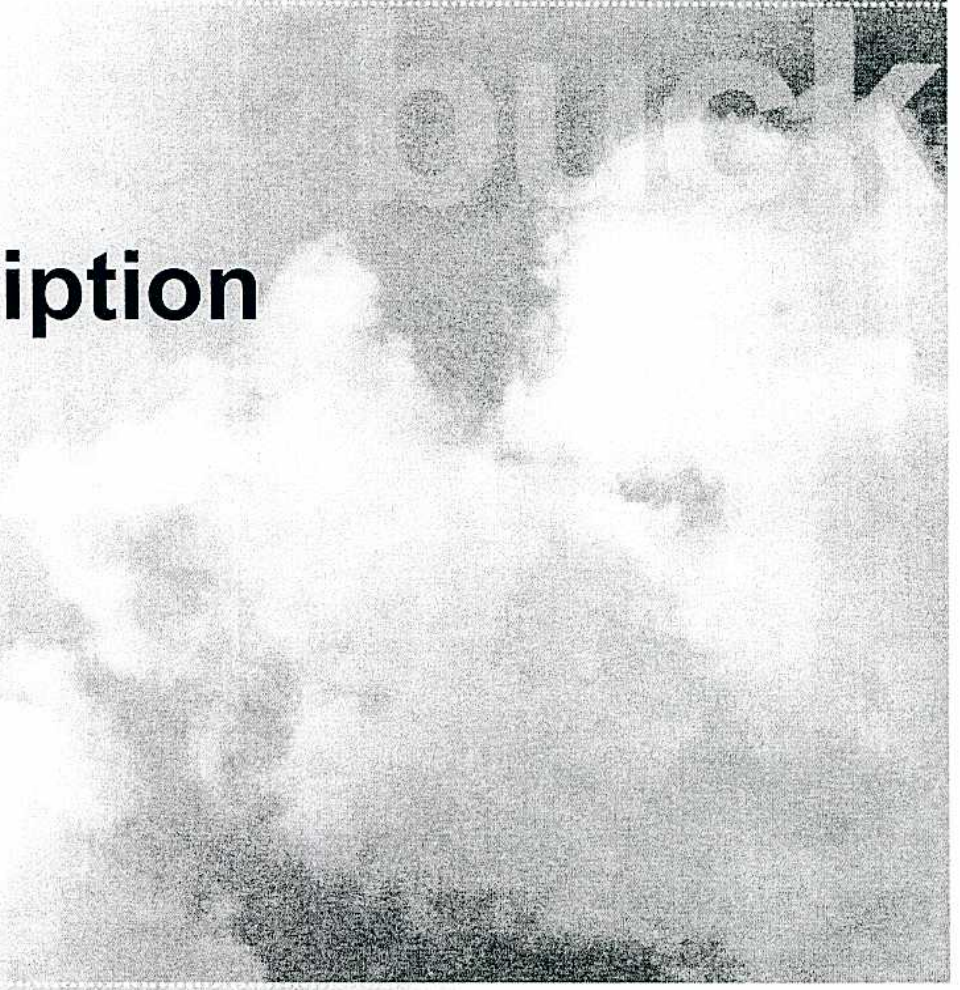
Contents

Medicare's Component Parts



Focus on Prescription Drugs



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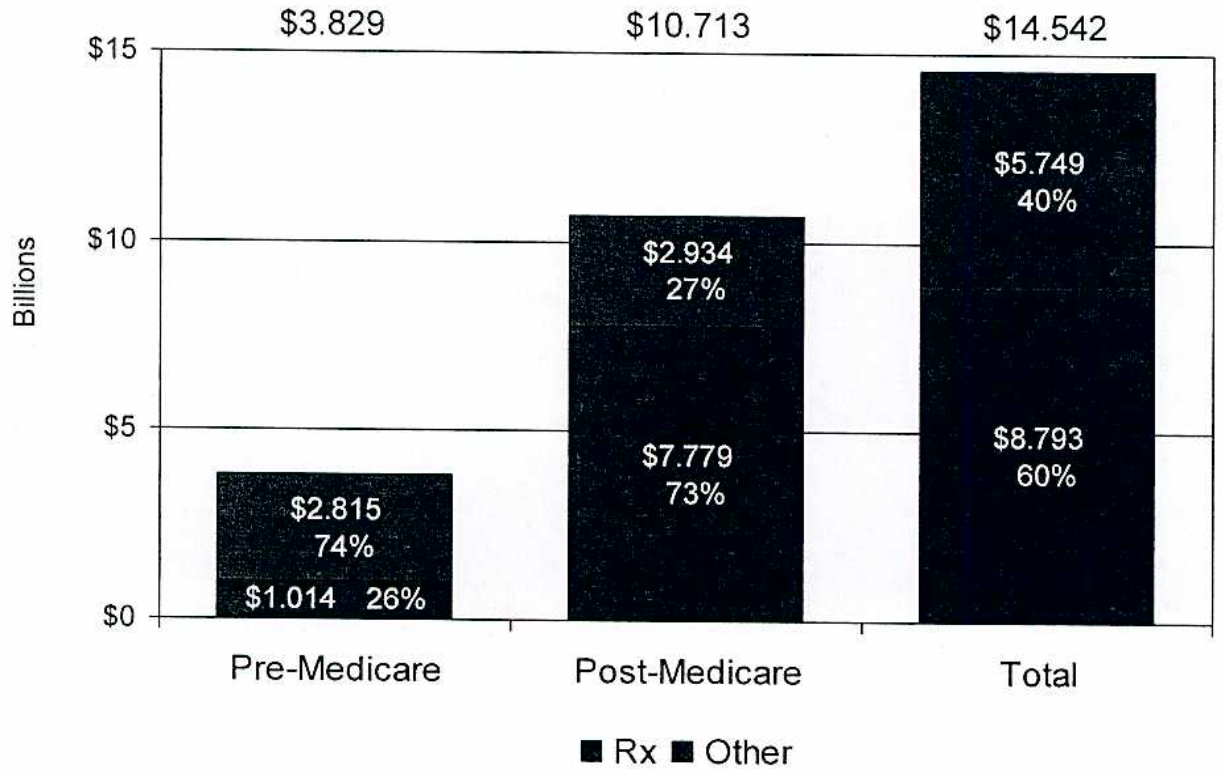
Focus on Prescription Drugs

- Post-Medicare Rx is biggest OPEB cost-driver
  - State's current plan is generous: $5/$15/$25 co-pays to $700 annual out-of-pocket maximum
- Preliminary Rx strategies:
  - #1 – Maximize plan efficiency and RDS subsidy
  - #2 – Employer Group Waiver Plan
  - #3 – Eliminate State Rx program, retirees enroll directly in Medicare Part D Plan
  - #4 – Eliminate State Rx program, but provide Medicare plan premium support

Executive Summary – GASB 45 Results

- Actuarial Accrued Liability Cost Drivers:
  Pre/Post Medicare – Rx



Medicare Part D Basics

- Medicare Modernization Act of 2003 created federal Rx benefit for retirees ("Medicare Part D")
- Provided several alternatives for employers/plan sponsors
- Coverage commenced 2006

Standard Part D Plan Design

Claim Level	Retiree Pays	Plan Pays
Up to Deductible	100%	0%
Deductible to Initial Coverage Limit	25%	75%
Initial Coverage Limit to OOP Threshold ("Doughnut Hole")	100%	0%
Catastrophic Coverage Over OOP Threshold	Approx. 5%*	Approx. 95%*

* Retiree Pays 5% or a minimum co-payment: $2.15/$5.35 in 2007, $2.25/%5.60 for 2007

Source: Kaiser Foundation Report: "Medicare Payments and Beneficiary Costs for Prescription Drug Coverage," March 2007

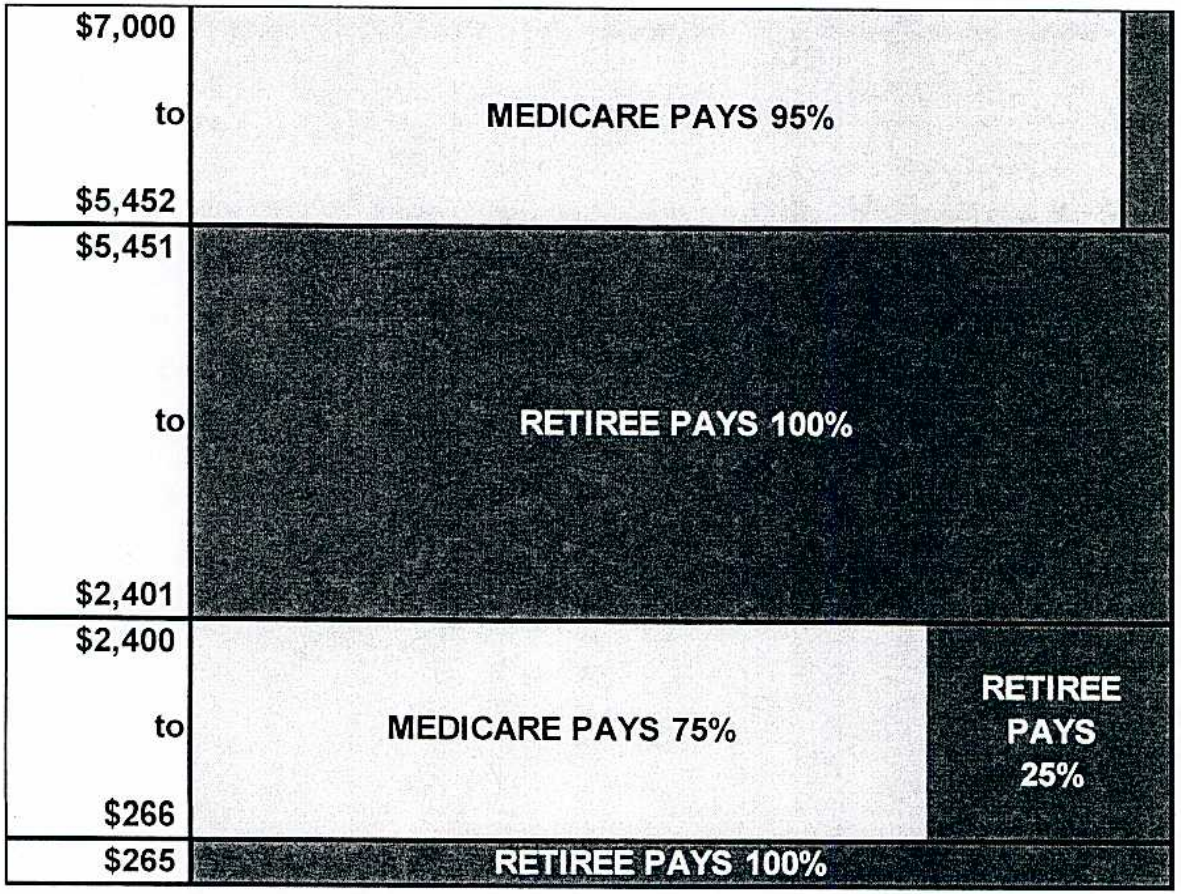
Medicare Part D Limits and Thresholds

	2006	2007	2008
Deductible	$250	$265	$275
Initial Coverage Limit	$2,250	$2,400	$2,510
OOP Threshold	$3,600	$3,850	$4,050
Covered Part D Rx Spend at OOP Threshold	$5,100	$5,451.25	$5,726.25

Source: CMS Memo from Abby L. Block, April 2, 2007

Standard Plan – Graphical Representation

For a claimant with $7,000 in Rx claims in 2007:



Emerging Part D Rx Plan Market

- Currently, Part D Rx Plans ("PDPs") available to employer groups and individuals vary widely
- 55 PDPs available in Maryland
- Premiums vary per benefit richness versus Standard Part D Plan Design as well as geographic cost differences
  - In Maryland, monthly premiums range from $12.20 to $103.20
- Later in this discussion, we'll review two specific plans available in 2007:
  - AARP MedicareRx Enhanced ($43.70)
  - SierraRx Plus ($103.20)

Retiree Drug Subsidy ("RDS")

- Employers may be eligible to be reimbursed a portion of their retirees' Rx claims
- Called the Retiree Drug Subsidy or RDS program
- Reimbursement is equal to 28% of each retiree's claims within a certain range:
  - $265 and $5,350 for 2007
  - $275 and $5,600 for 2008

Source: CMS Memo from Abby L. Block, April 2, 2007

Strategy #1 – Increase Plan Efficiency, Maximize RDS

- State Impact:
  - Possible modest reductions in cash costs and GASB liabilities from increasing plan efficiency
  - Possible modest increases in RDS reimbursement collected by State (but no effect on GASB valuation)
- Retiree Disruption:
  - Least disruptive – retirees continue in current plan
  - No additional retiree cost
- Administrative Considerations:
  - Effectiveness of this strategy depends on vendor flexibility and cooperation

Strategy #2 – Employer Group Waiver Plan

- State Impact:
  - Medicare subsidies potentially decrease cash costs and GASB liabilities
  - No longer able to collect RDS
    - Potential savings from subsidized plan costs may offset loss of RDS
- Retiree Disruption:
  - Minimal disruption – likely enjoy the same design as Current Plan
  - May see formulary changes
- Administrative Considerations:
  - Potential savings may be offset by increased administrative costs
  - In order to estimate possible savings, need to collect and analyze diagnostic codes and detailed claims data

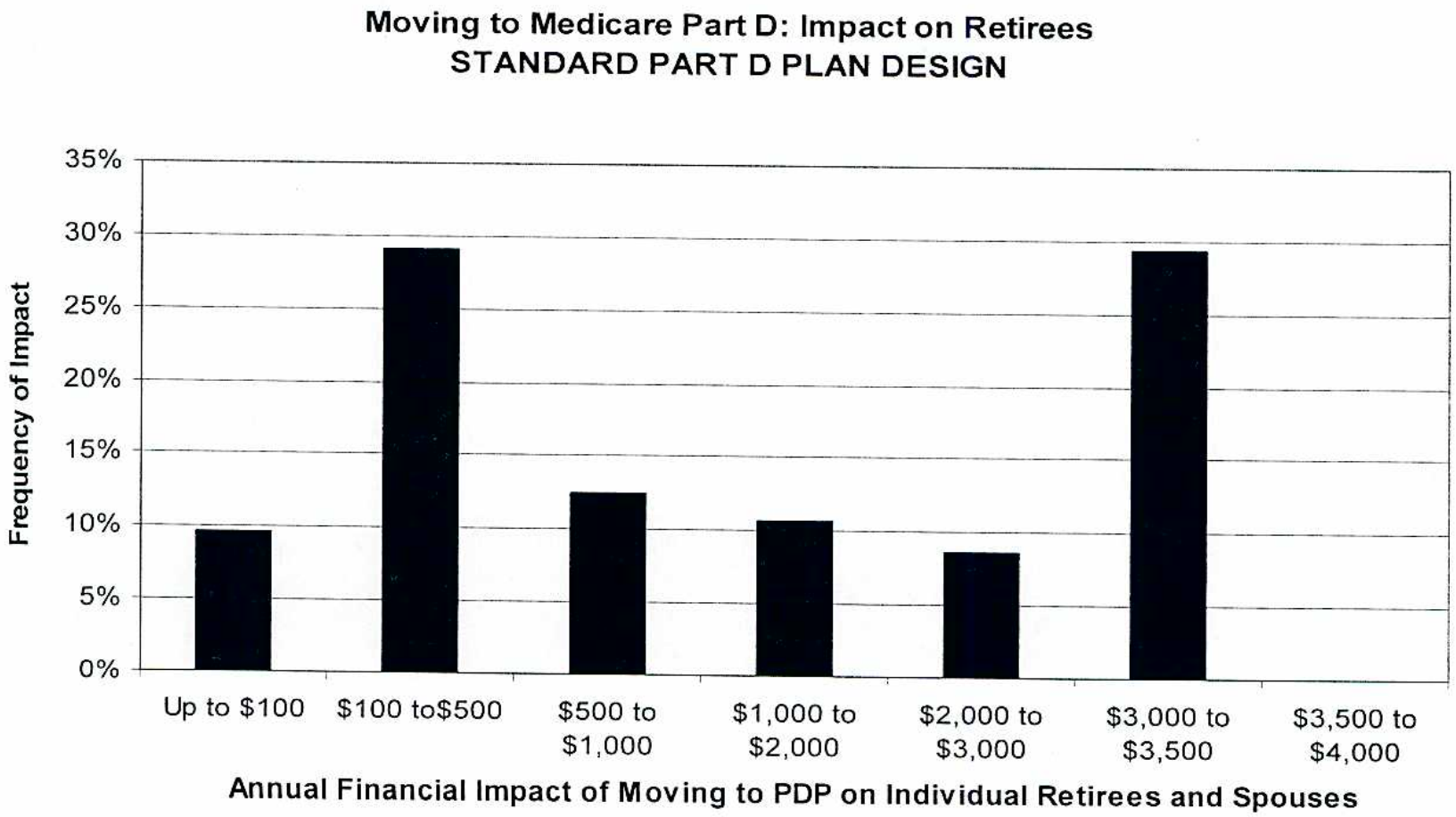
Strategy #3 – Terminate State Rx Plan

- State Impact:
  - Maximum savings: employer cost for Medicare-eligible Rx is $0 (both cash cost and GASB liabilities)
  - Potential litigation risk
- Retiree Disruption:
  - Considerable disruption (subsequent slides provide details)
  - Must shop for new Part D Rx plan ("PDP")
- Administrative Considerations:
  - After initial communication, no ongoing administration

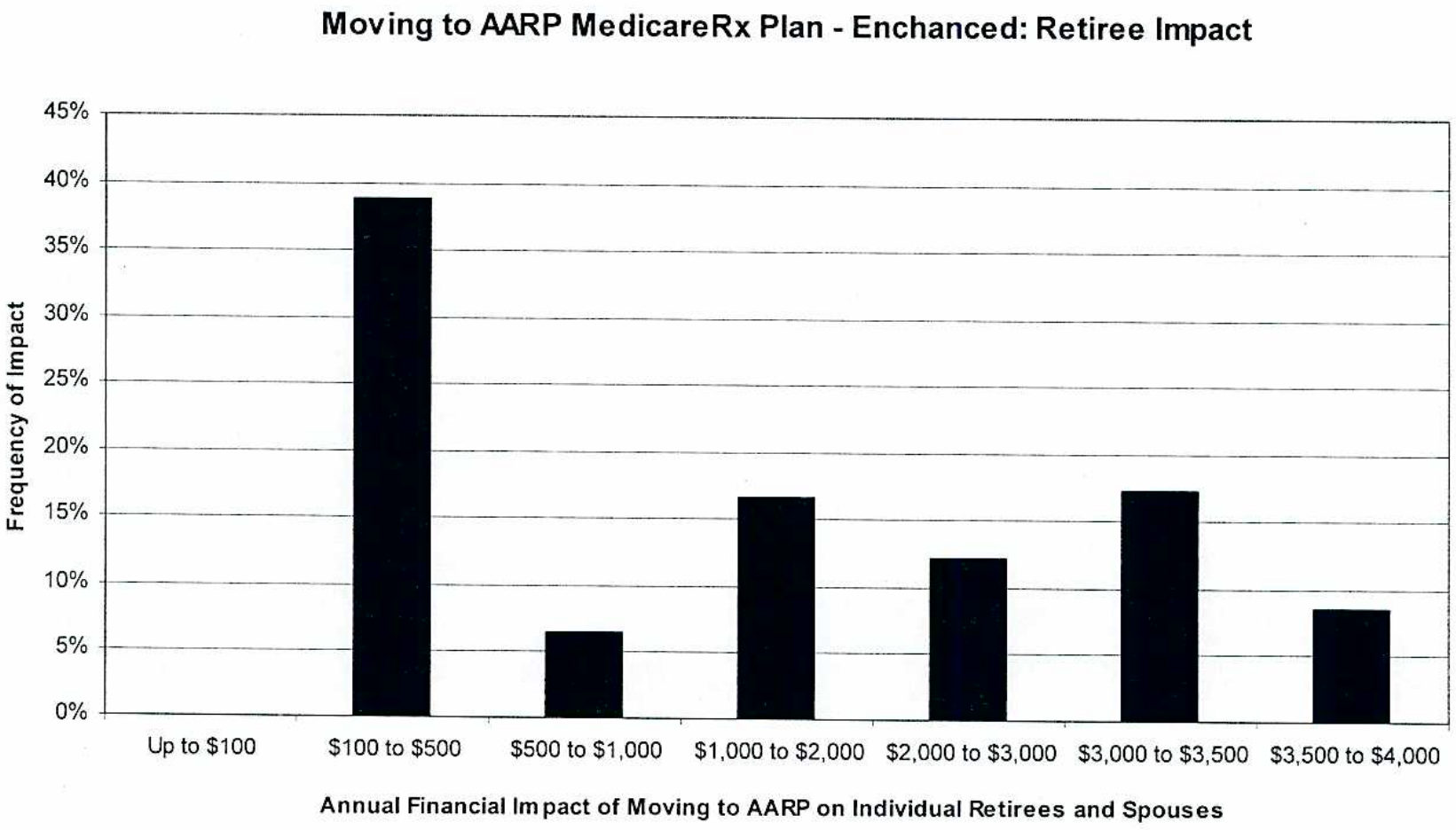
Strategy #3 – Sample Part D Plan Designs

	Current Maryland Plan	Medicare Part D Standard Design	AARP MedicareRx - Enhanced	SierraRx Plus
Average Annual Plan Premium Paid By Retirees	$430.00	$328.20	$524.40	$1,238.40
Deductible	N/A	$265	N/A	N/A
Coverage to Initial Coverage Limit ($2,400 claims per Part D Standard Plan)	Plan pays all cost in excess of $5/$15/$20 copays	Medicare Pays 75%, Retiree pays 25%	Plan pays all costs in excess of $6/$28/$69.10 copays (33% retiree coinsurance for "tier 4 specialty drugs")	Plan pays all costs in excess of $5/$30/$60 copays (30% retiree coinsurance for "specialty drugs")
Coverage in "Gap"	N/A (no "Gap")	Retiree pays 100% until Retiree OOP Max is reached	Retiree pays $6 copay for "tier 1" (assumed to be generics), 100% of cost for all other drugs until Retiree OOP Max is reached	N/A (no "Gap")
Retiree Out-of-Pocket Maximum	$700	$3,850	$3,850	$3,850
Catastrosphic Coverage (After OOP Max reached)	Plan pays 100%	Medicare pays approximately 95% coinsurance	Plan pays approximately 95% coinsurance	Plan pays approximately 95% coinsurance

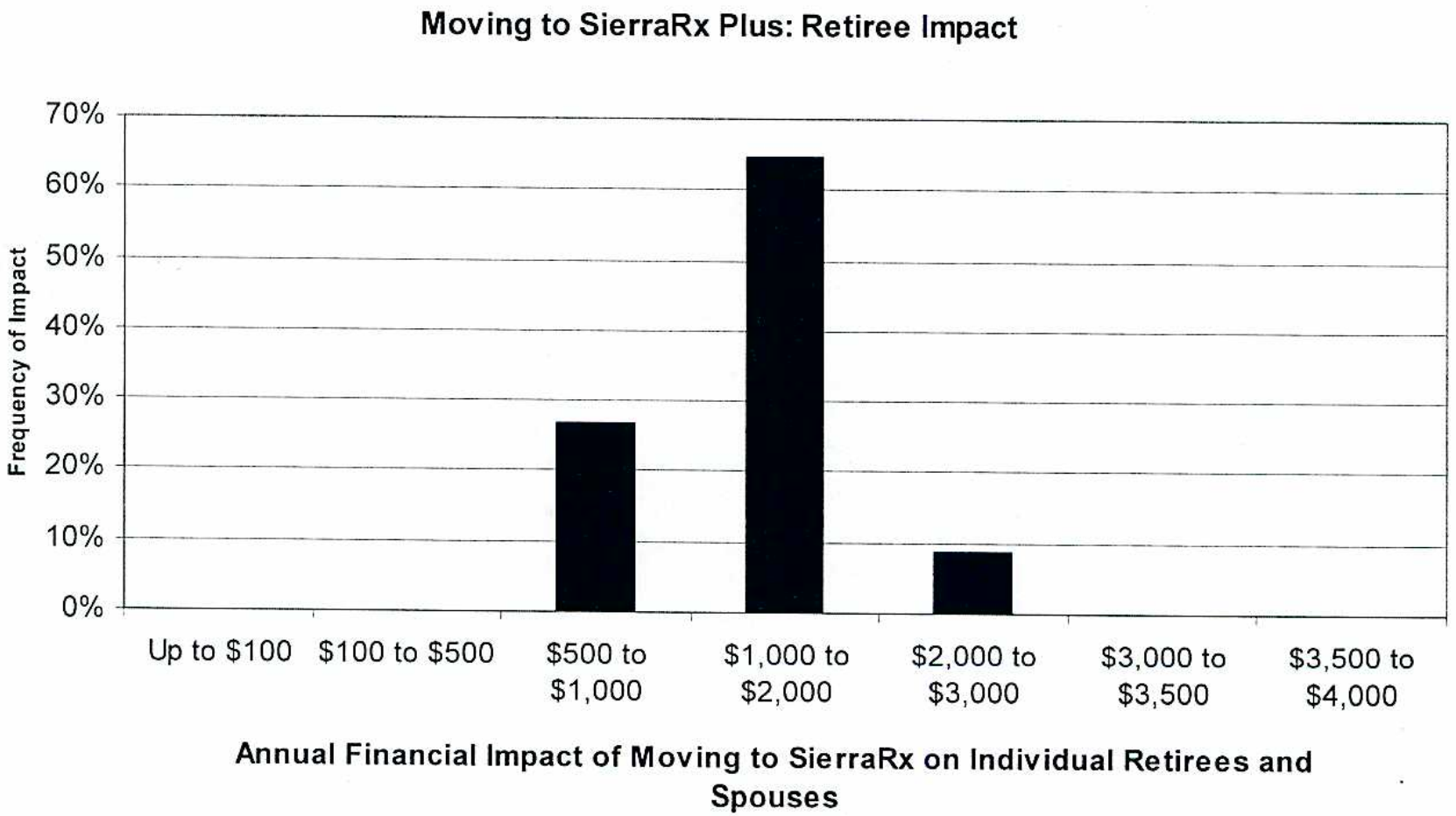
#3 Impact on Retirees – Standard Part D



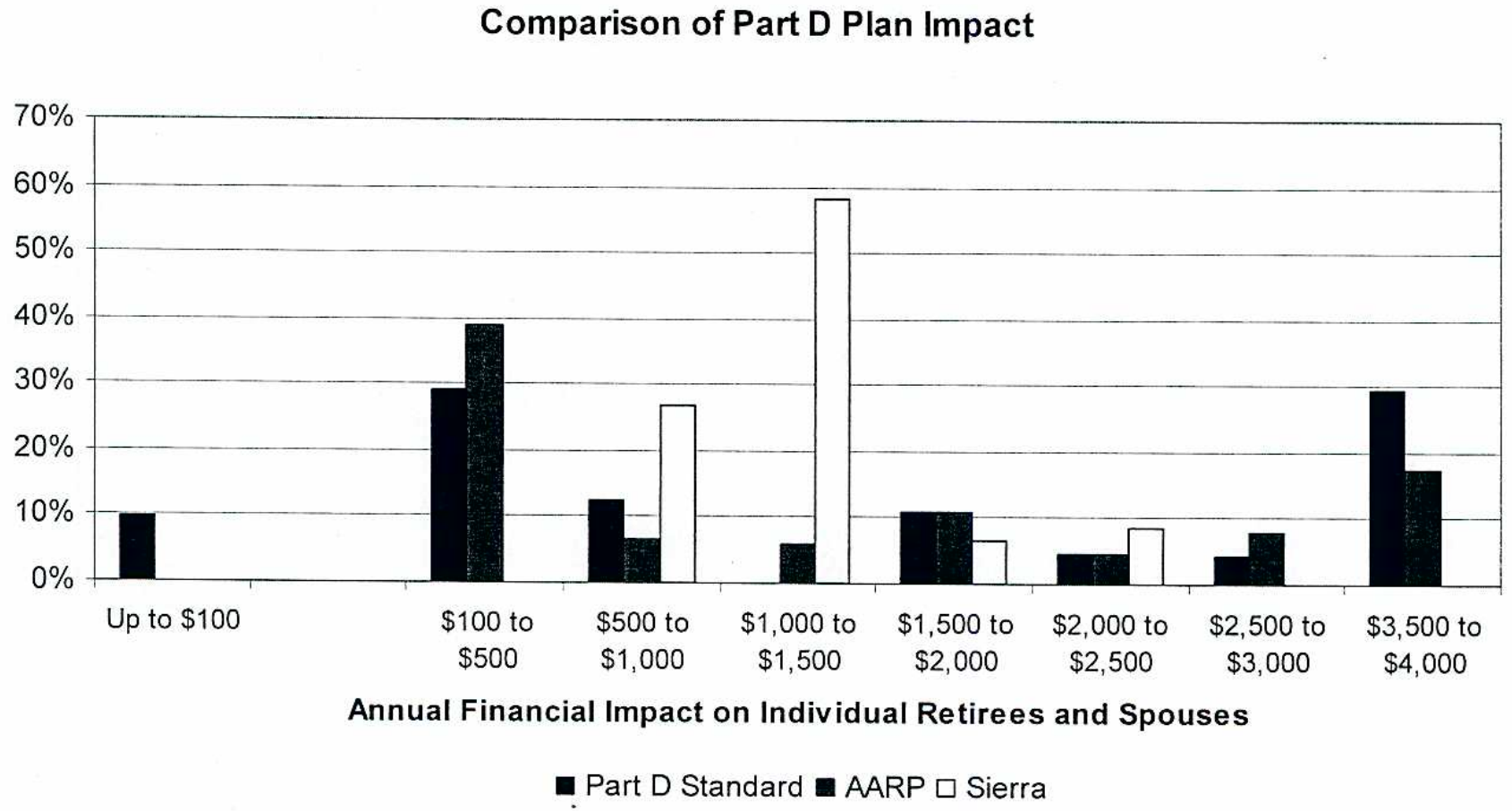
Impact of #3 – AARP MedicareRx Enhanced



Impact of #3 – SierraRx Plus



Impact of #3 – Comparison



Strategy #4 – Eliminate State Rx Plan, but Provide Some PDP Premium Support

- State Impact:
  - Considerable cash and GASB liability savings
  - State can choose level at which it will support retiree premium payments
  - State can choose to eliminate health care cost inflation risk
- Retiree Disruption:
  - As with #3, but cost impacts are smaller
- Administrative Considerations:
  - State will need to administer reimbursements
- This is similar to the State of Virginia's design
  - Retirees earn fixed-dollar state health insurance credit
  - $60 per month for 15 years of service, increasing $4 per month for each additional year of service to a maximum of $120 per month

Focus on Medicare Private Fee-For-Service Plans

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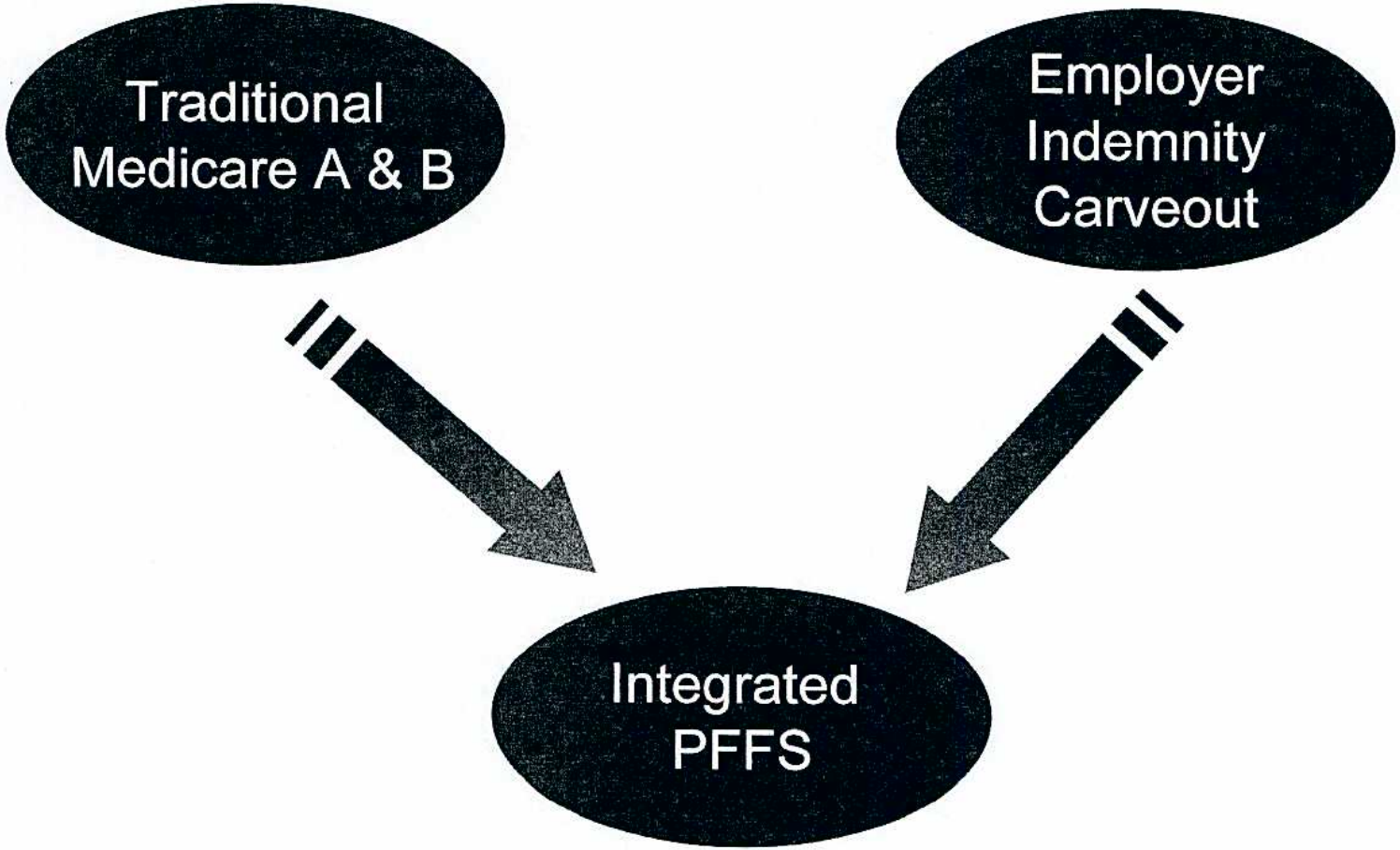
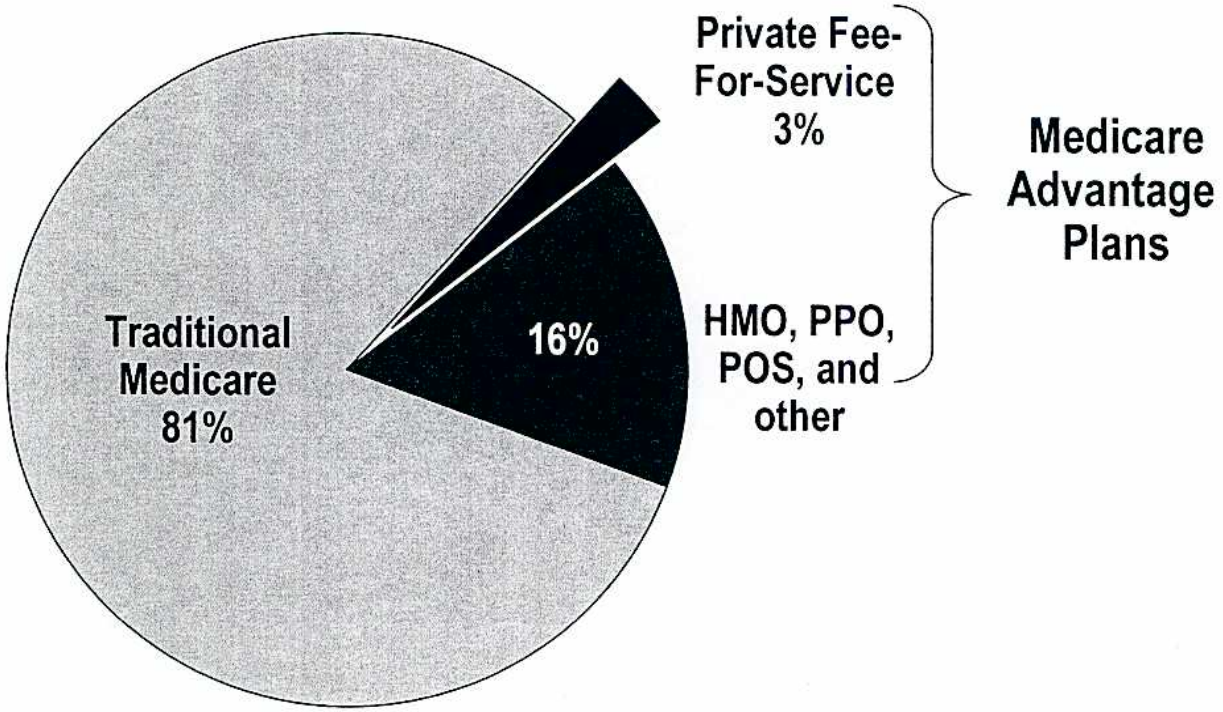
Plan Design


Traditional
Medicare A & B
Employer
Indemnity
Carveout
Integrated
PFFS

U.S. Congress' Goals

- Provide beneficiaries with a wider range of choice
- Begin to privatize traditional Medicare and infuse some "managed competition"
- Reduce beneficiary confusion with Medigap (secondary payer) market
- Extend more private plans into rural areas
- Respond to objections to managed care constraints

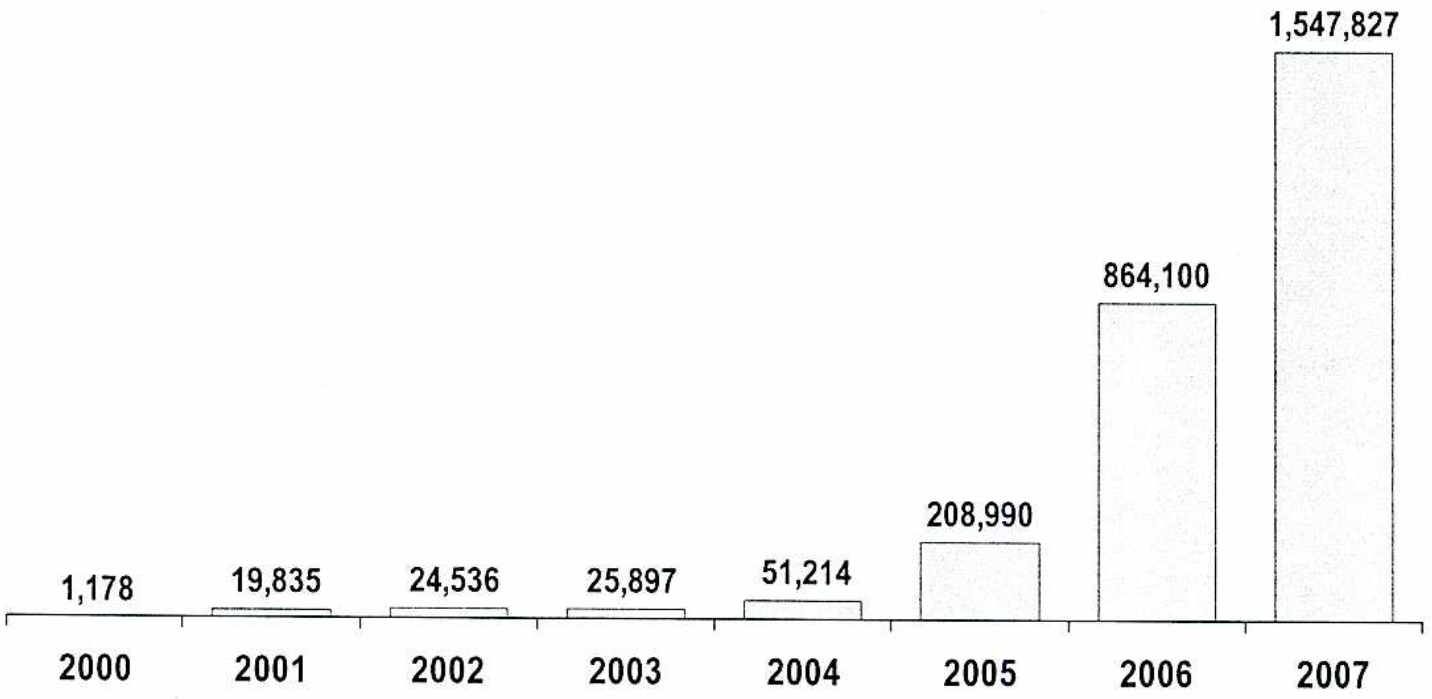
Medicare Enrollment, 2007



Total Medicare Beneficiaries = 44 million

Source: Centers for Medicare and Medicaid Services, Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan Contract Report – Monthly Summary Report (data as of May 2007) as reported by Kaiser Family Foundation.

Private Fee-For-Service Enrollment
2000 – 2007



Source: Avalere Health analysis of Centers for Medicare and Medicaid Services, Medicare Managed Care Contract Report (2000 – 2005); Centers for Medicare and Medicaid Services, Monthly Summary Report (2006 – 2007). Figures are year-end for 2000 – 2006 and as of May 2007 as reported by Kaiser Family Foundation.

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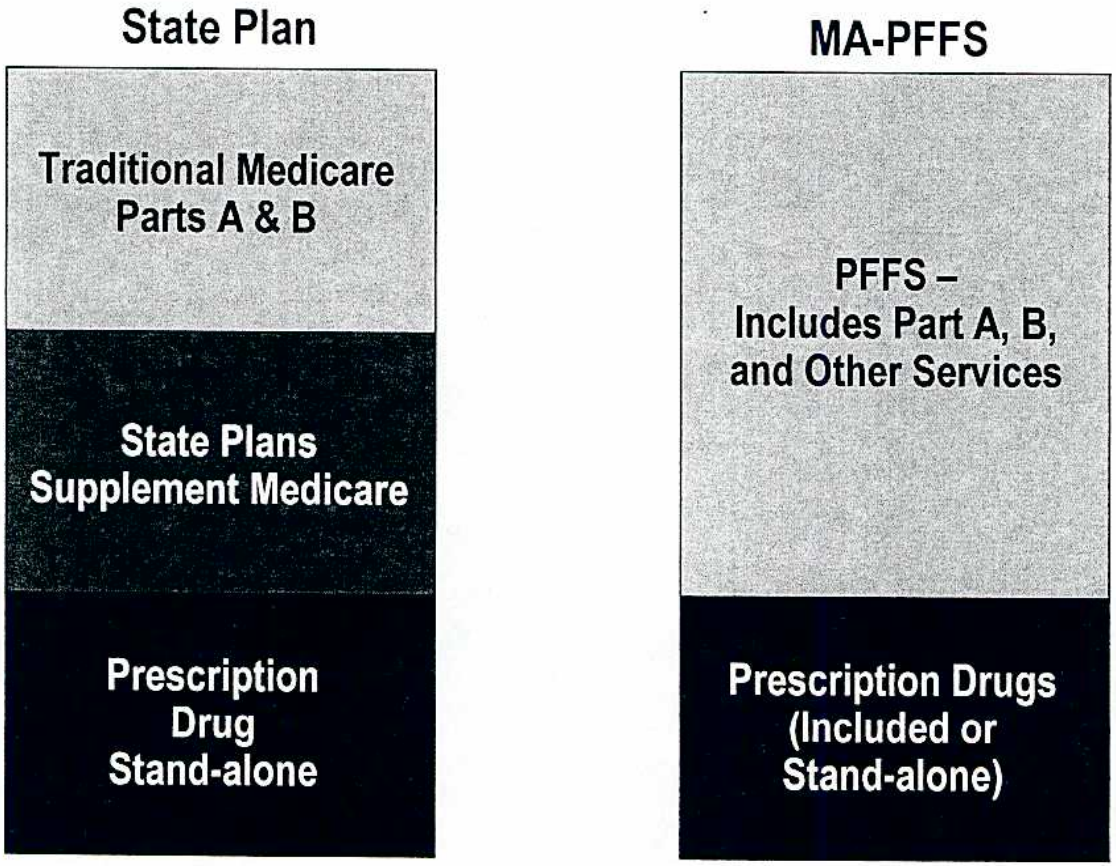
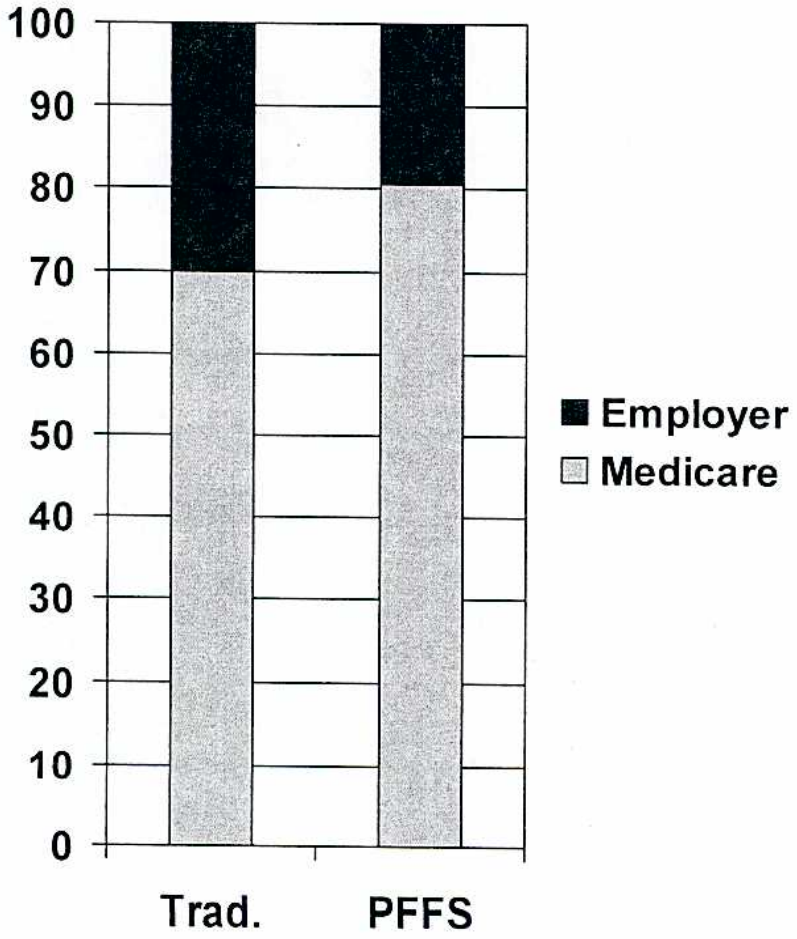
Program Comparison



The Good, The Bad and the Uncertain



- Financial Savings Example
  - Assume 15% CMS "subsidy"
  - Employer savings of 35%
  - Administrative savings
- Nationwide Medicare Advantage
- Rx flexibility

The Good, *The Bad* and The Uncertain

- Some providers won't treat PFFS patients
  - Lack of (or too much?) familiarity with PFFS plans
    - Lower reimbursement levels
    - Claim denials
    - Slow payers
- Uncertain provider "network"
- The possibility of balance billing
- Marketing abuses and bad press

The Good, The Bad and *The Uncertain*

- How long will Medicare continue to subsidize MA plans?
  - Significant changes unlikely with current administration
  - New administration would likely phase in transition
- And at what level will they be subsidized?
  - Current average payment is 119% of Traditional Medicare
  - To fully eliminate could affect several million retirees
    - Congressional support for rural areas

Exit Strategy

- Continue to offer any group PFFS program
- Offer any other Part C plan (e.g. HMO or PPO) on a group basis
- Let retirees choose any individual plan (Part C or Medigap) and provide a fixed dollar stipend
- Return to old-style, 2-tier coverage supplementing traditional Medicare

Issues for Maryland

- Plan Design
  - Replicating existing benefits
  - Prescription drugs – included or carved out
  - Potential application of health management and wellness initiatives
  - Retiree contribution strategy
  - Split contracts
- Implementation
  - Timing
  - Communication – retirees and providers
  - Vendor capacity / resources

Issues for Beneficiaries

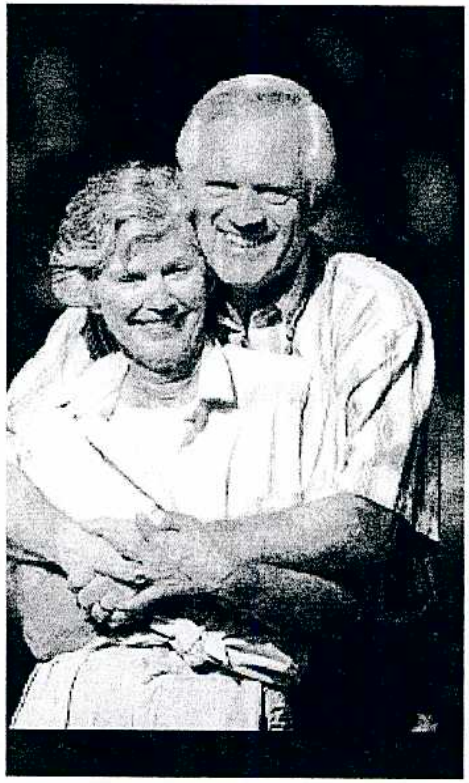
- Balance Billing
  - Under federal law, PFFS plans can determine whether or not to allow balance billing
  - Some vendors do; some don't
  - Any balance billing regulations in Maryland?
- Provider access and acceptance
  - No formal network – participants can go to any provider
  - Providers are not obligated to accept PFFS, even if they accept assignment under traditional Medicare

Example – West Virginia

- Initial GASB 45 liability = $7.8 billion
- Adopted MA-PFFS (including PDP) plan July 1, 2007
- Revised GASB 45 liability = $3.4 billion
- Projected cash savings of $50 million for first year

Key Communications Messages

- Its very close to what you've got now but not exact
- You need to confirm provider participation in PFFS
- You no longer have traditional Medicare benefits
- You always retain the right to drop out of the employers plan and return to traditional Medicare
- Part B premiums remain deducted from SS check
- You MAY be exposed to balance billing
- This is NOT an HMO
- The financial windfall from CMS might only be temporary
- You now have OnePay for simplified claim filing



Your Guide to

Private Fee-for-Service Plans

This official government booklet has important information about

- Understanding Private Fee-for-Service Plans
- Joining and Leaving Private Fee-for-Service Plans
- Other Important Information on Private Fee-for-Service Plans

CMS

Observations on Current Plan Design

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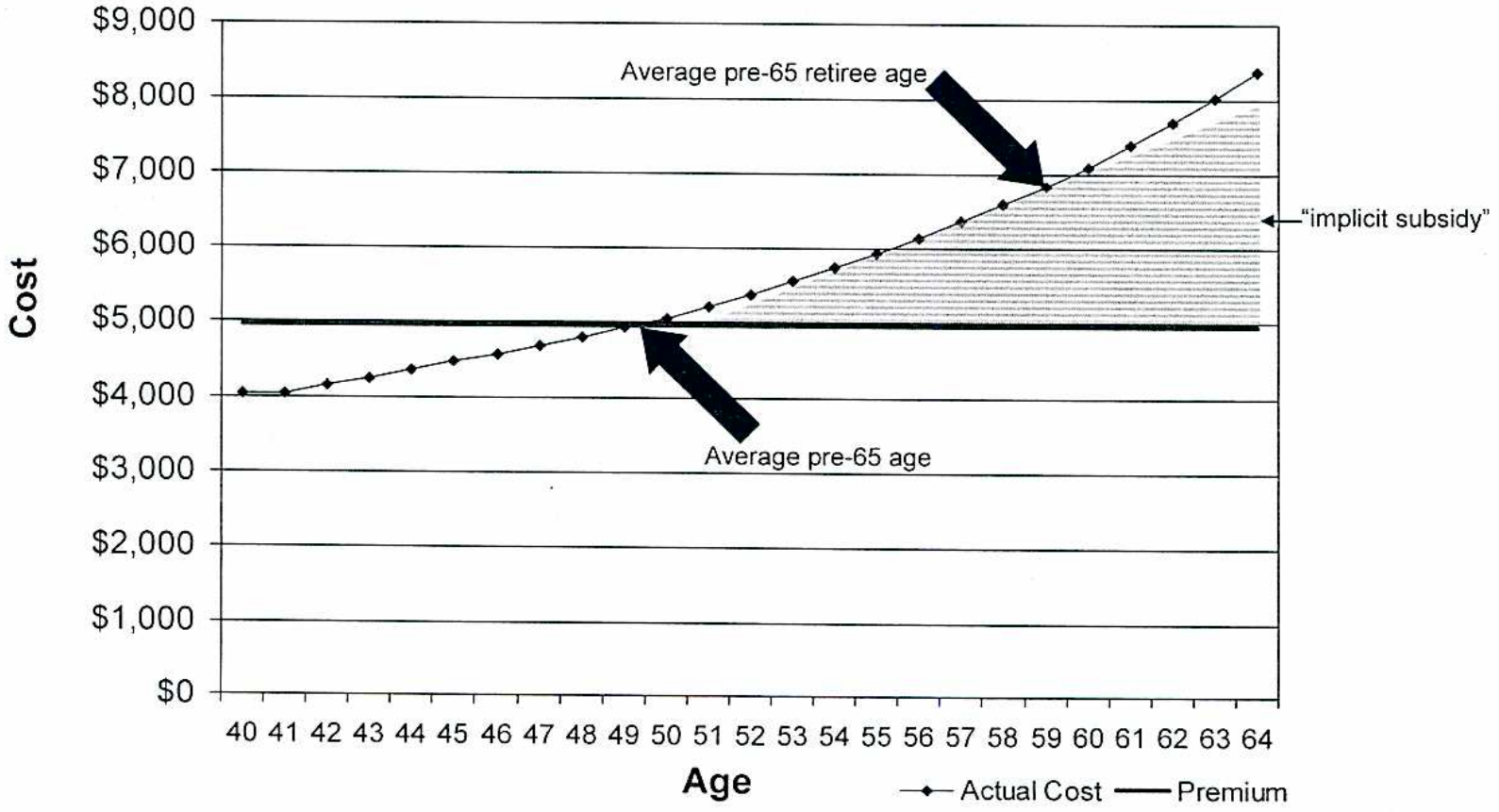
Observations on Current Plan Design

- Implicit Subsidy
- Married versus Single
- Early Retirement

Blending Active and Retiree Experience Creates Additional "Implicit" Pre-Medicare State Subsidy



This is a simplified example, which is intended to communicate graphically certain OPEB concepts.

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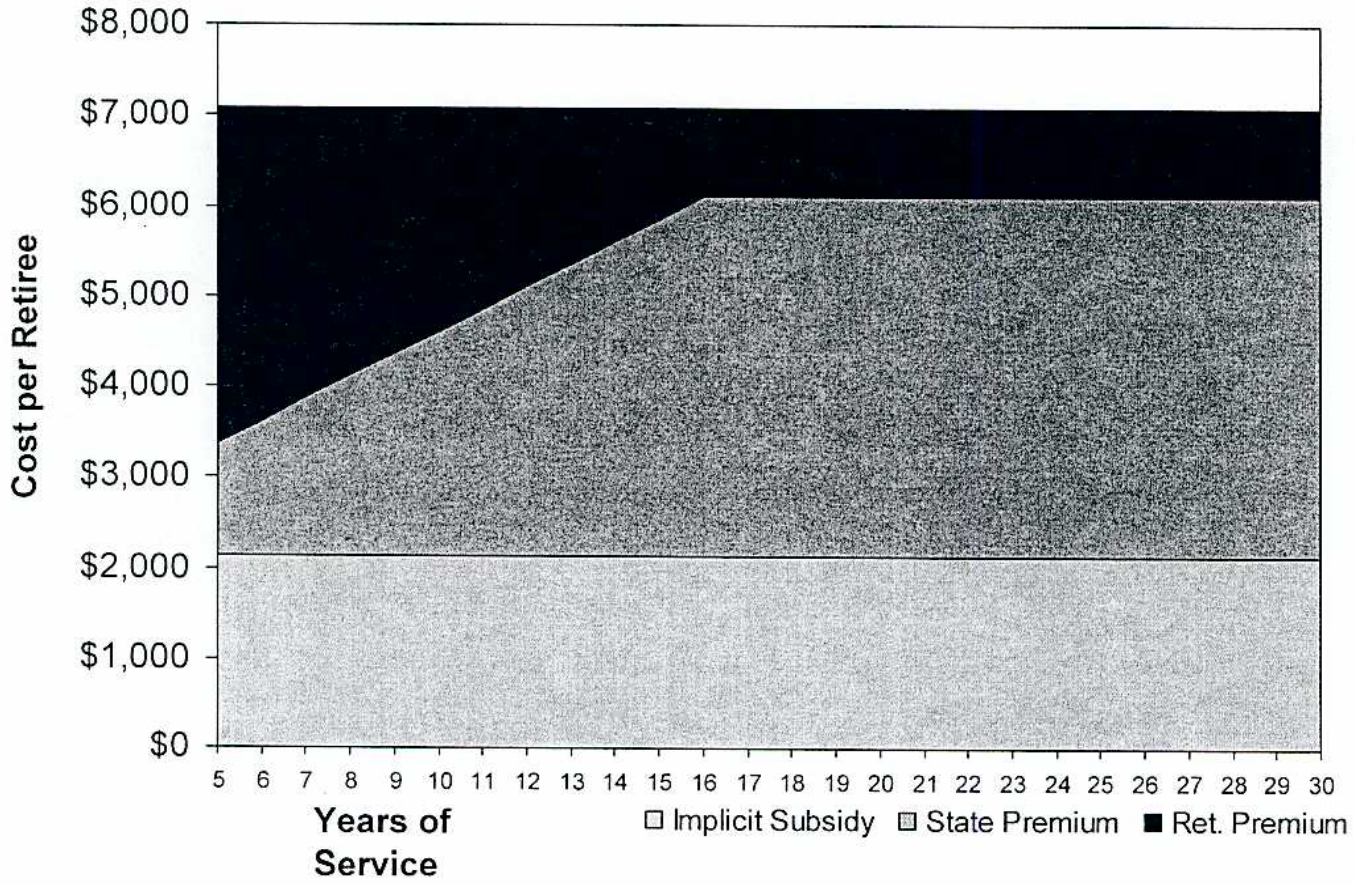
Blending Active and Retiree Experience Creates Additional "Implicit" Pre-Medicare State Subsidy



This is a simplified example, which is intended to communicate graphically certain OPEB concepts.

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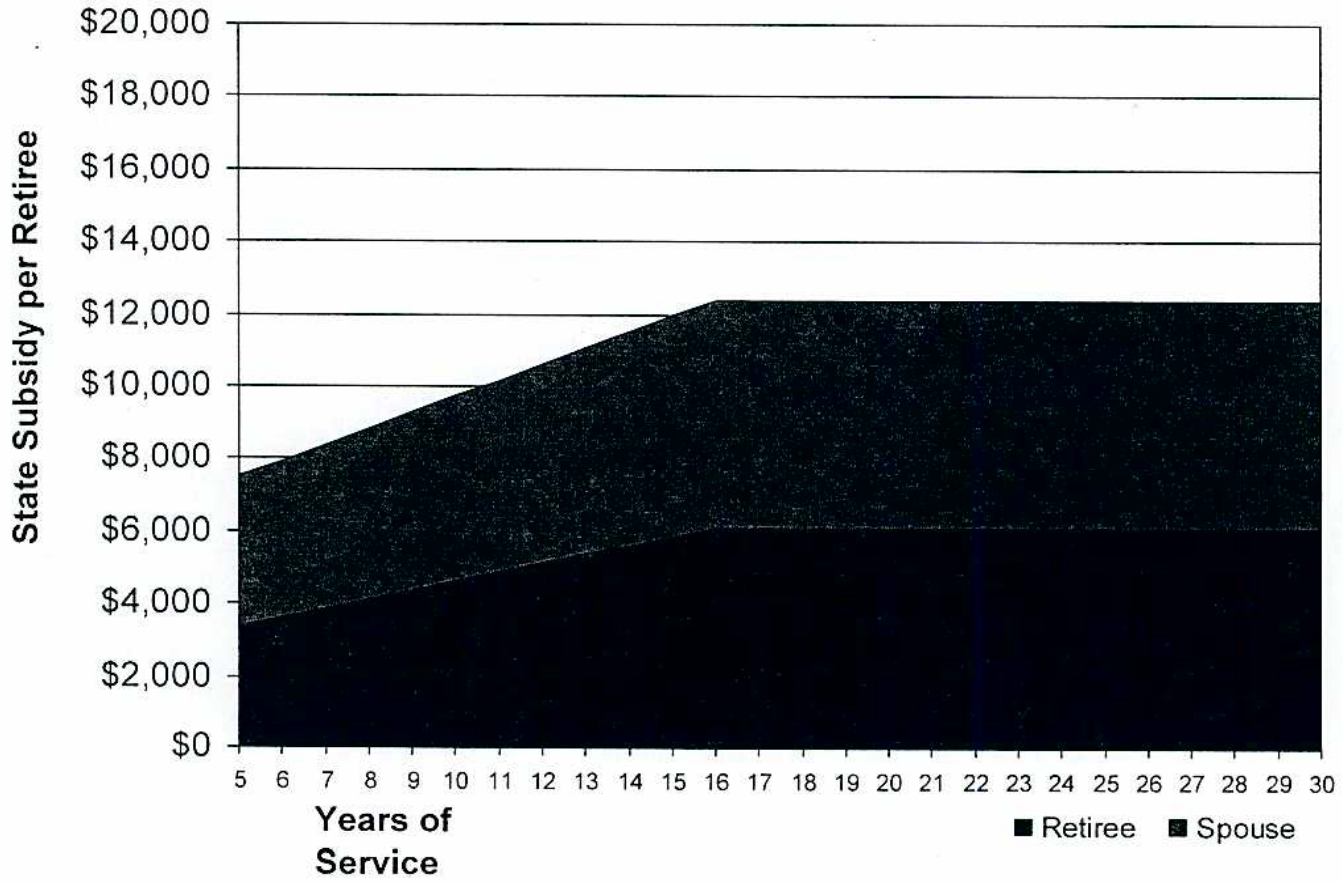
Pre-Medicare (Medical Only)
Comparison of State Subsidies – Single vs. Married



This is a simplified example, which is intended to communicate graphically certain OPEB concepts. Includes "implicit subsidy."

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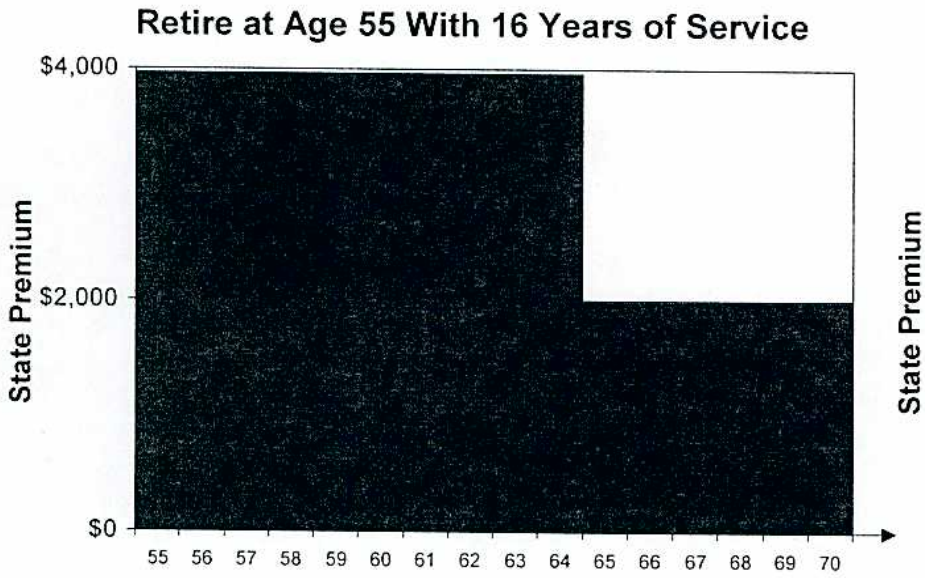
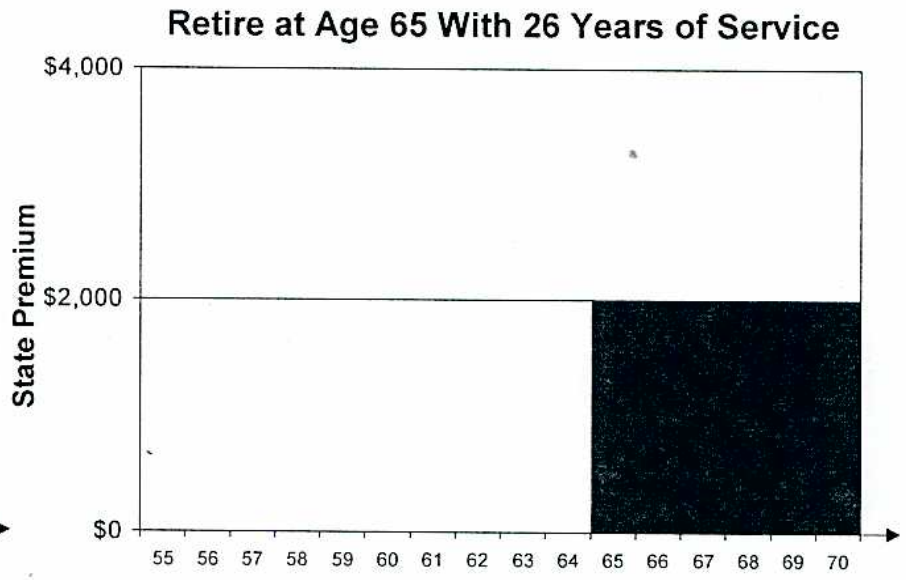
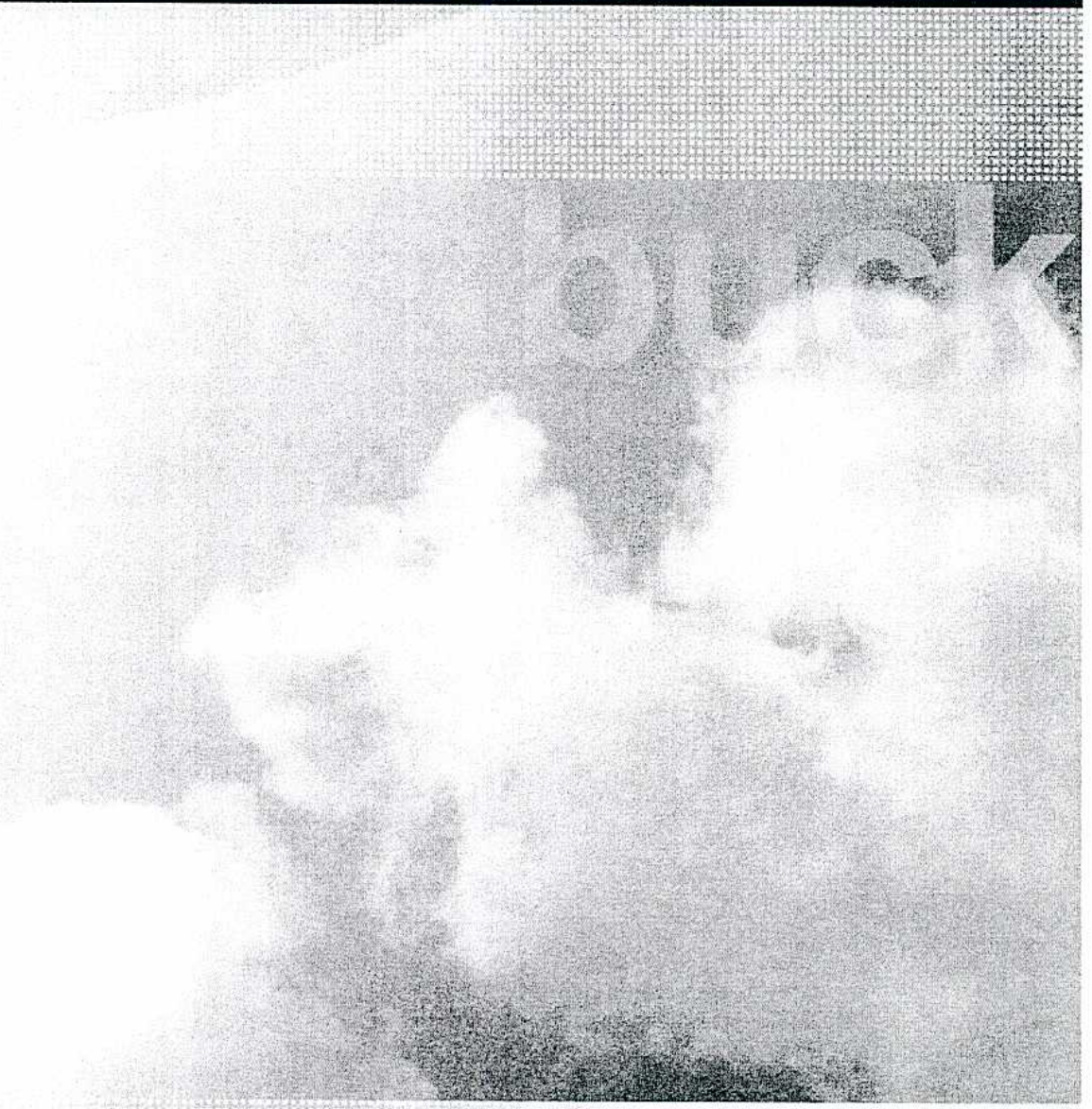
Impact of Early Retirement on OPEB Costs





This is a simplified example, which is intended to communicate graphically certain OPEB concepts.
Does not include "implicit subsidies."

Appendix



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Appendix

http://www.medicare.gov/pdphome.asp

www.cms.hhs.gov/privatefeeforserviceplans/downloads/benqa.pdf

www.medicare.gov/publications/pubs/pdf/10144.pdf

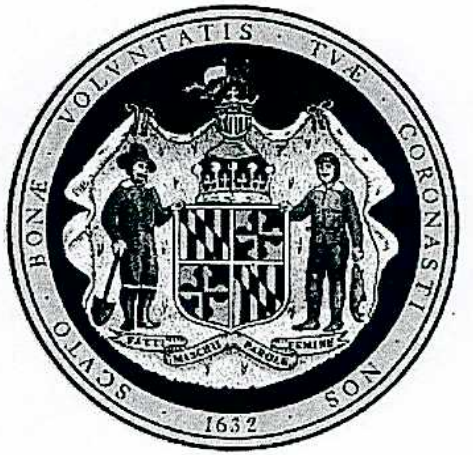
Options for Debt Financing of Other Post Employment Benefits (OPEBs)

Discussion with

Maryland Blue Ribbon Commission

September 3, 2008

Nancy Winkler
Managing Director
Public Financial Management, Inc
Philadelphia, PA
215-567-6100
winklern@pfm.com



PFM
The PFM Group
Public Financial Management, Inc
PFM Asset Management LLC
PFM Advisors

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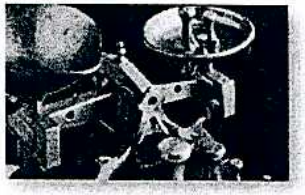
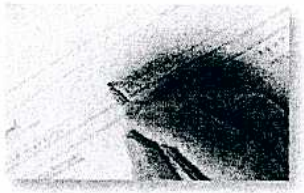
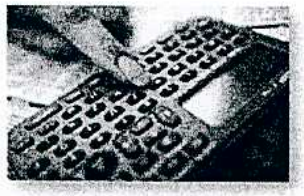
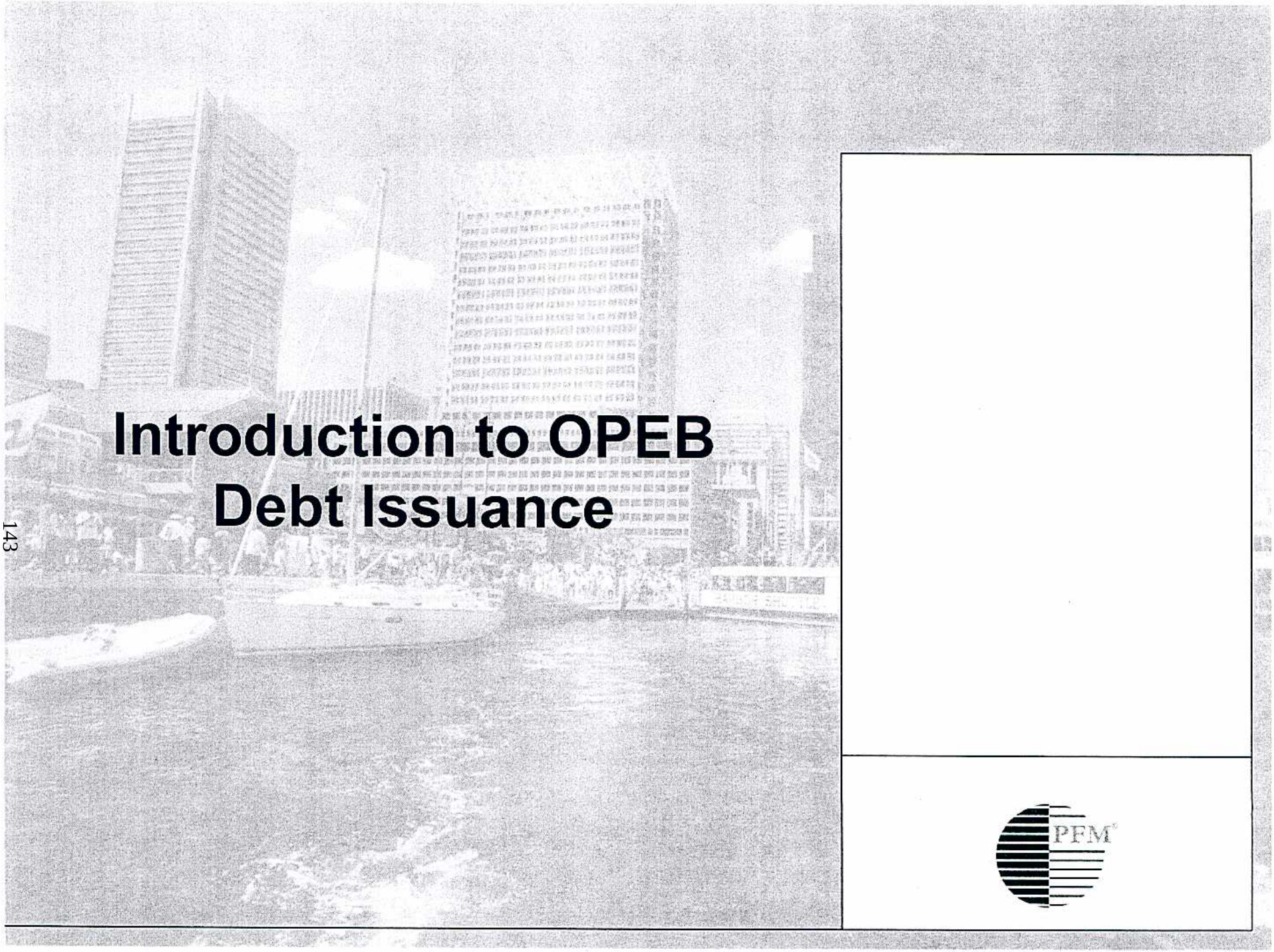






Our Mission is to Add Value for our Clients by Creating Sound, Innovative Strategies for Solving Financial Problems.



Introduction to OPEB Debt Issuance

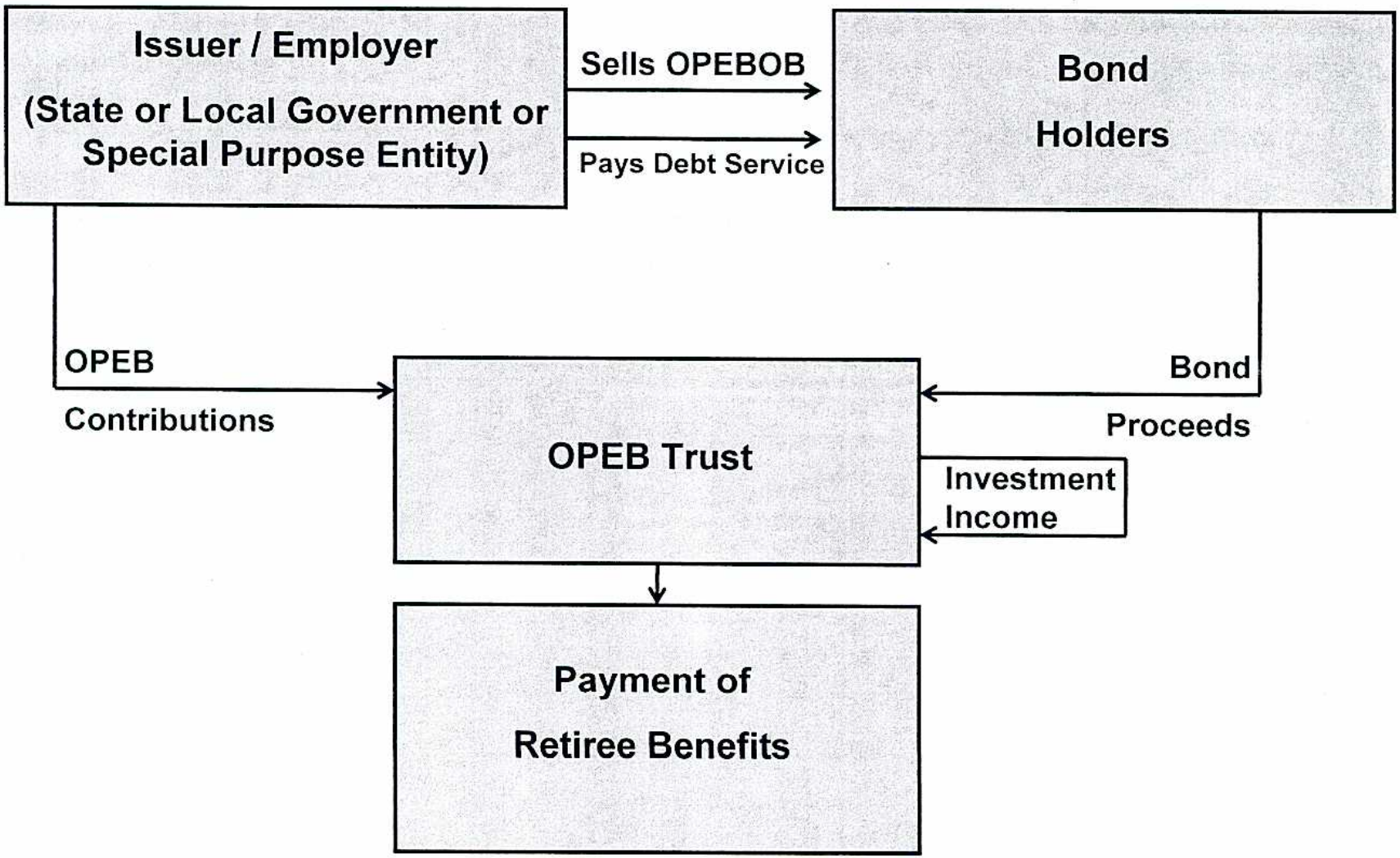
Definitions

- **Unfunded Actuarial Accrued Liability (UAAL)**
  - The existing unfunded liability for OPEB which is amortized over a period of years.
- **Normal Cost**
  - The cost of future benefits earned by employees in the current year.
- **Annual Required Contribution (ARC)**
  - Amortized Unfunded Actuarial Accrued Liability + Normal Cost.
- **Net OPEB Obligation (NOO)**
  - Amount stated on balance sheet of the extent that actual aggregate OPEB contributions are less than cumulative ARC.
- **Present Value**
  - The amount of cash today that is equivalent in value to a stream of payments to be made in the future.

POBs: An Antecedent to OPEB Obligation Bonds

- **Pension Obligation Bonds (POBs)** – Over the past ten years, there have been over 25 issues of POBs on the state agency level and many more at the local level.
- **Interest Arbitrage: the Objective of POB and OPEBOBs** – Interest arbitrage is accomplished when the issuer earns, over time, a higher yield on the investment of the bond proceeds net of expenses than it pays for the taxable interest expense on the OPEBOBs.
- **Interest Arbitrage can be a Powerful Funding Tool** – Assuming that the expected interest arbitrage is realized, then OPEBOBs are a cost effective method of funding an Unfunded Accrued Actuarial Liability (UAAL). OPEBOBs allow faster funding of UAAL than would occur if the state made the same payments equivalent to debt service into an OPEB Trust.

OPEB Obligation Bond Mechanics



Size and Structure Considerations for OPEBOBs Differ From POBs

- **Nature of the Liability is Different** – Since OPEBs are not statutory guarantees, from a practical perspective, substantial but not full funding may be the primary consideration.
- **Actuarial Valuation of Medical Costs is Less Certain Than Pension Costs —** Actuarial valuations are likely to be volatile because of medical inflation and benefit changes. Many valuations have rates ranging from near term rates of 8 to 12% to longer term rates of 4 to 7%. There have been numerous years recently with double digit overall medical inflation rates.
- **Funding Less Than 100% of the UAAL May Be Desirable** – As a result of valuation volatility, full funding in the short term may equate to overfunding in the mid to long term. Because of the irrevocability of the assets, full funding may be undesirable.

Other Size and Structure Considerations for OPEBOBs

- **Asset Allocation Impacts Sizing** – If the optimal full funding asset allocation is 70% equities/ alternatives and 30% allocation for fixed income, no more than roughly 70% of the UAAL should be funded using debt. If there is negative arbitrage, then issuing debt would be tantamount to paying extra to fund the OPEB obligation.
- **OPEB Trusts May Earn Less Than POB Trusts** – Due to the nature of the cash flows and the investment asset allocation, OPEB Trusts may have lower investment returns than pension funds, narrowing the arbitrage earnings opportunities. Based on the actuarial discount rate and the modeled bond costs, there are limited arbitrage earnings benefits in the Partial PreFunding scenario presented.
- **OPEBOBs Would Be Issued at a Taxable Rate** – The planned use of bond proceeds – to invest and earn arbitrage – is not a permitted federal tax-exempt use.
- **Consider a Single Purpose Entity** – To enable a 30 year maturity and to maximize potential savings.

Sizing: Impact of Maryland Affordability Criteria

- **Maryland Debt Affordability Criteria –**
  - **Personal Income:** Debt outstanding / total personal income ≤ 3.2%

    and
  - **Debt Service Affordability:** Debt service/ revenues ≤ 8%

Current baseline projections indicate that the 3.2% personal income cap will be surpassed beginning in 2010. Therefore, no additional capacity is available.

OPEB obligation bonds could only be considered if the current cap of 3.2% of debt outstanding to personal income were modified or surpassed, or if the current Capital Improvement Program were reduced.

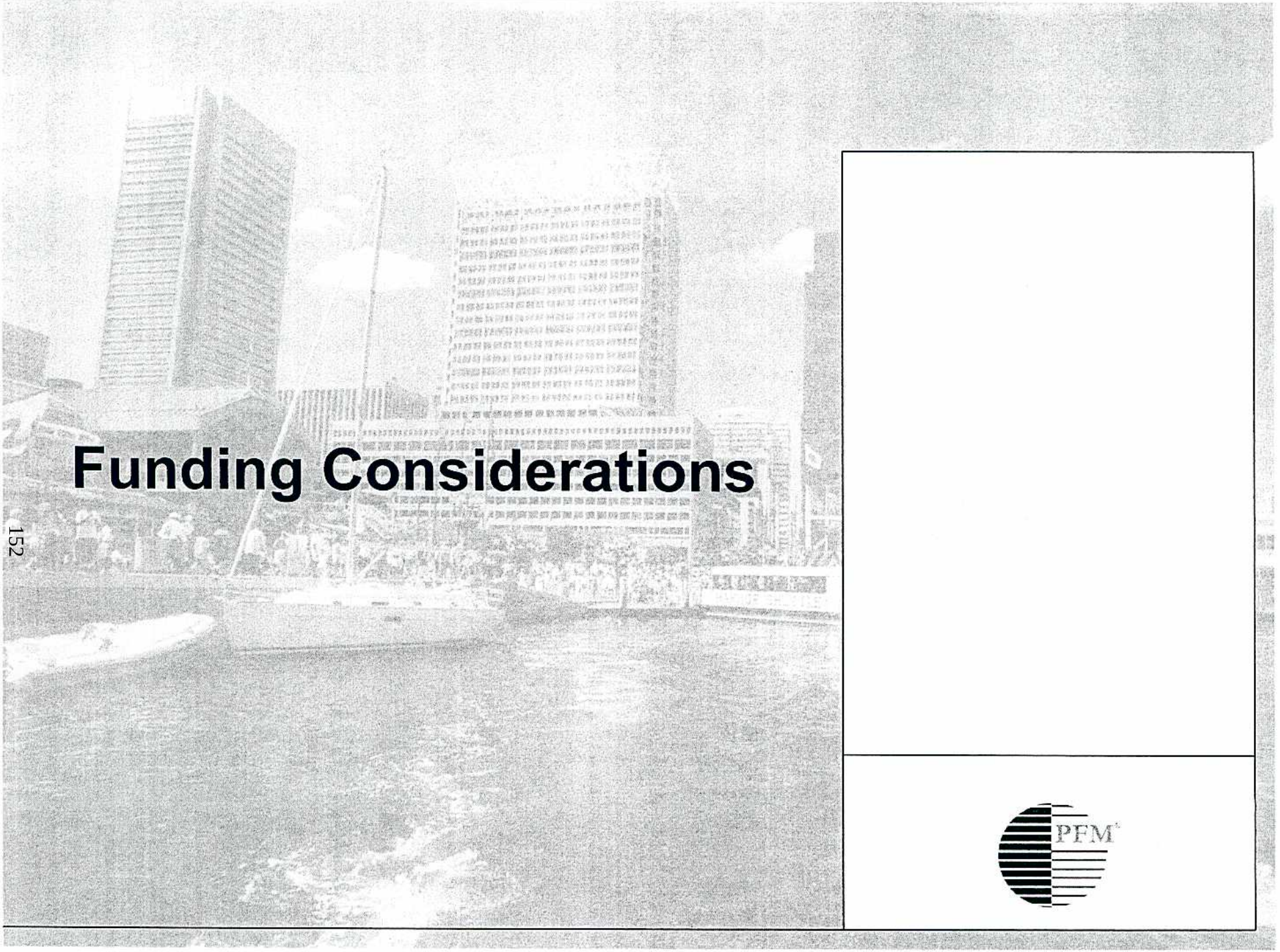
Central Risks of OPEB Obligation Bonds

- **Bonds Are a Hard Liability** – Issuing OPEBOBs would eliminate flexibility and create a mandatory schedule for the State to repay the debt service.
- **Actual Returns on the Trust Assets May Fail to Exceed the Cost of Debt Service** – The size of the OPEB bonds should reflect a manageable debt service in case the investment returns of OPEB proceeds do not achieve projections.

Rating Considerations for OPEBOB's

- **Debt Structure –** Rating agencies will analyze how the OPEBOB fits into the issuer's total debt structure, including a review of future capital requirements that may require bonding, as well as other long-term liabilities.
- **Overall OPEB Management Plan –** Dealing with cost containment, workforce issues, structure of a trust, supplemental annual funding, and policies to address future shortfalls.
- **Budget Impact –** Budgetary affordability is a factor.
- **Amount and Timing of Expected Savings –** Is there front-loading of contribution savings and, if so, could this lead to higher, unsustainable contribution rates in later years?
- **Prudence –** Do potential savings from the OPEBOB outweigh the risks involved?

Source: Standard & Poor's Ratings Time May Be Right for a POB Revival, Peter Block and Robin Prunty, January 23, 2008



Funding Considerations

Funding Scenarios
Actuarial Valuation Data

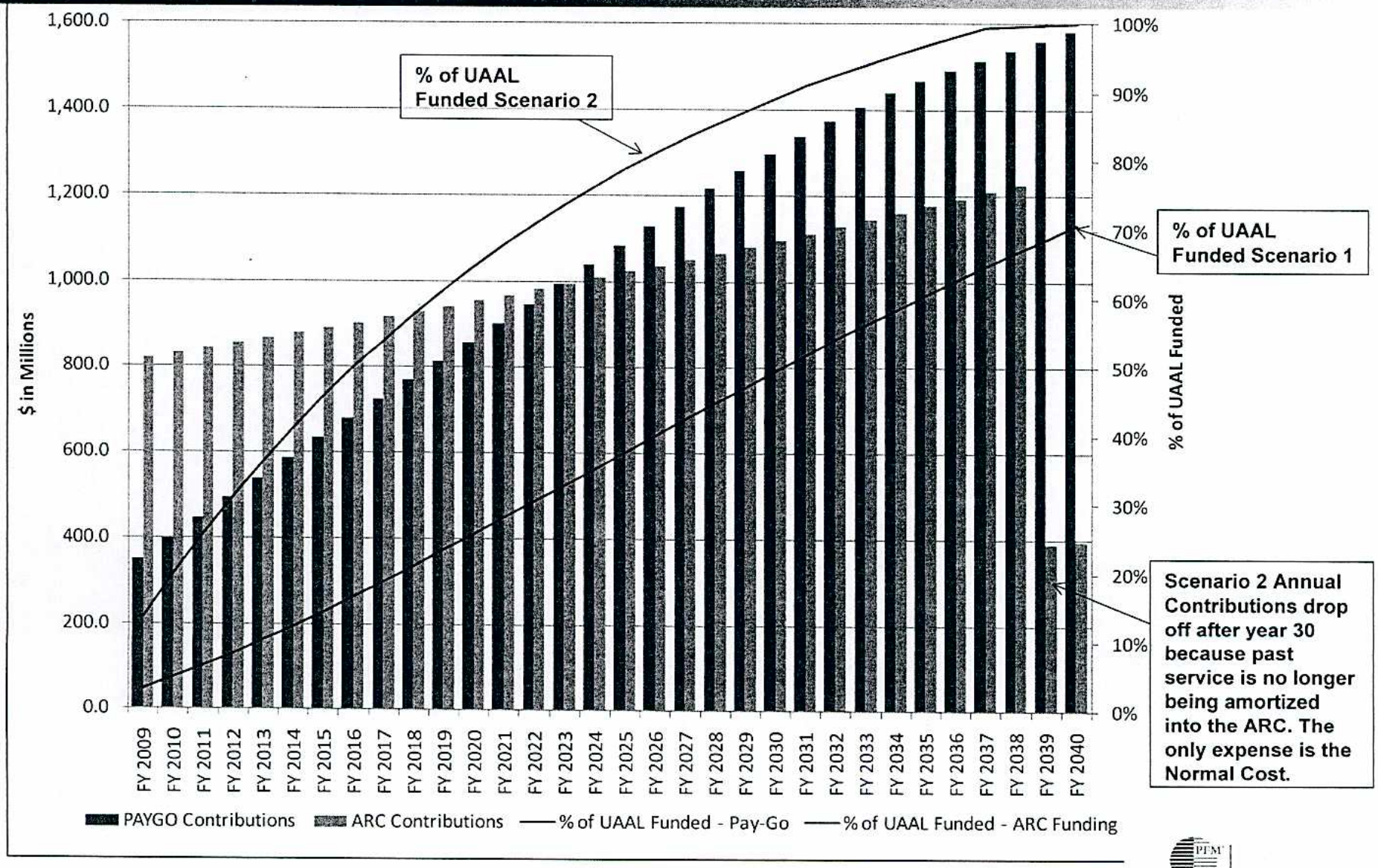
- **Actuarial Valuation Method**
  - Entry Age Normal
- **Discount Rates**
  - 4.25% for Unfunded Plan
  - 7.75% for Funded Plan
- **OPEB Present Value of Benefits (PVB) Liability**
  - $21.758 billion at 4.25% discount rate
  - $11.174 billion at 7.75% discount rate
- **Baseline Annual Required Contribution (ARC)**
  - $1.193 billion at 4.25% discount rate
  - $809 million at 7.75% discount rate
- **Cumulative Benefit Payments over 30 Years**
  - $29.296 billion

Source: Buck Consultants, December 2007

PFM Evaluated Three Scenarios

- **Scenario 1** – PAYGO
  - State pays annual benefits on a Pay as You Go basis.
  - No long-term investment earnings.
- **Scenario 2** – Constant ARC
  - State begins funding at the ARC in 2009.
  - Long-term investment earnings equal $22.8 billion.
- **Scenario 3** – Partial Pre-Funding
  - Prefund by funding 35% of the accrued actuarial liability with debt and paying normal cost and the remaining amortized actuarial accrued liability annually. The size of the pre-funding could be adjusted upward or downward.
  - At a 35% pre-funding level, long-term investment earnings equal $28.1 billion.

Scenario 1 (PAYGO) and Scenario 2 (Constant ARC)



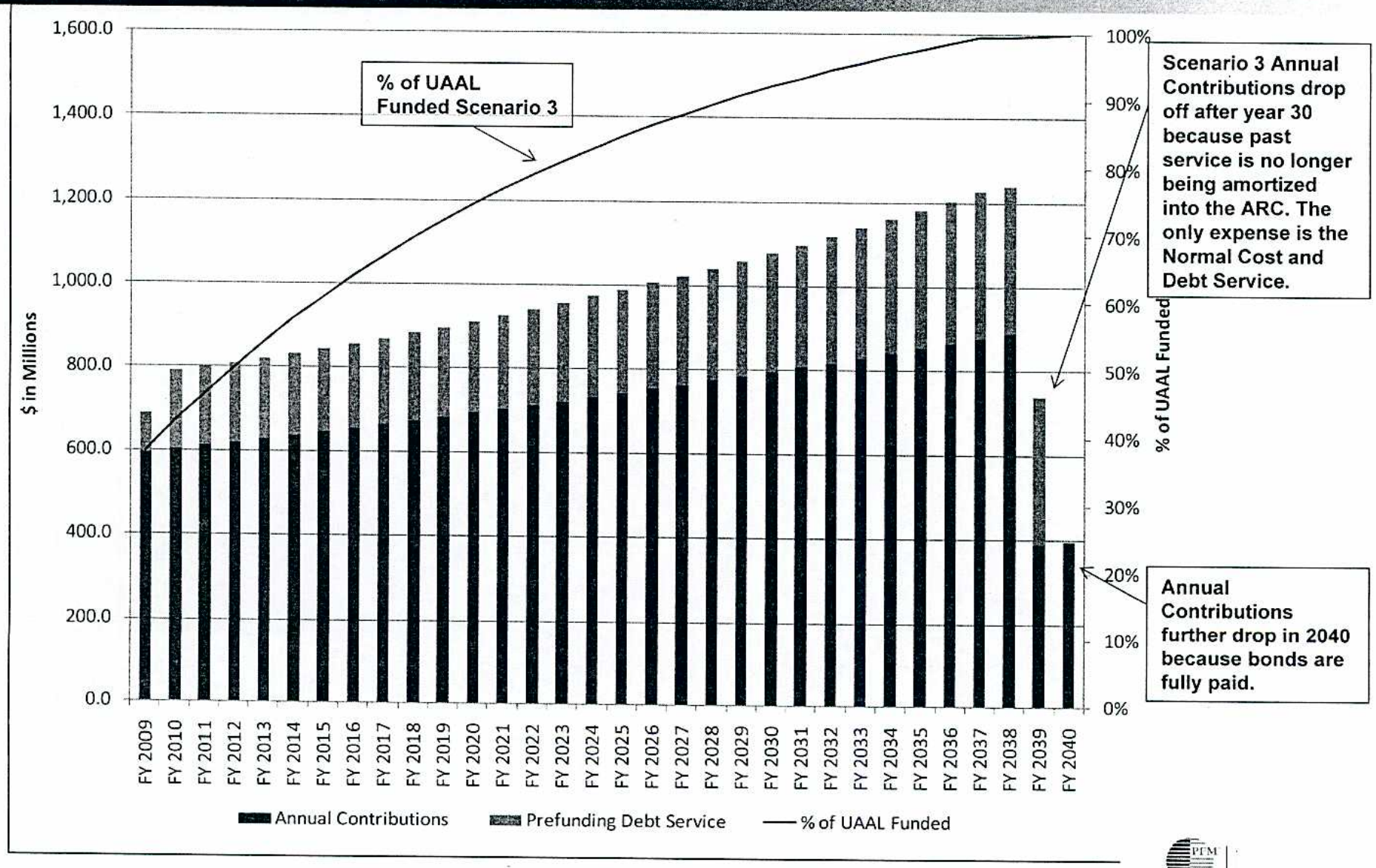
Scenario 3 – Partial Pre-Funding of UAAL

- Based on Buck Consultants GASB 45 projections as of July 1, 2007, the State's AAL, if fully funded, is assumed to be $9.172 billion (net of the normal cost).
- Below is an estimated bond sizing, provided bonds are issued for approximately 35% of the unfunded liability.
- The sizing assumes $10.00 per bond in underwriter's discount and costs of issuance. True interest cost is 5.92%.

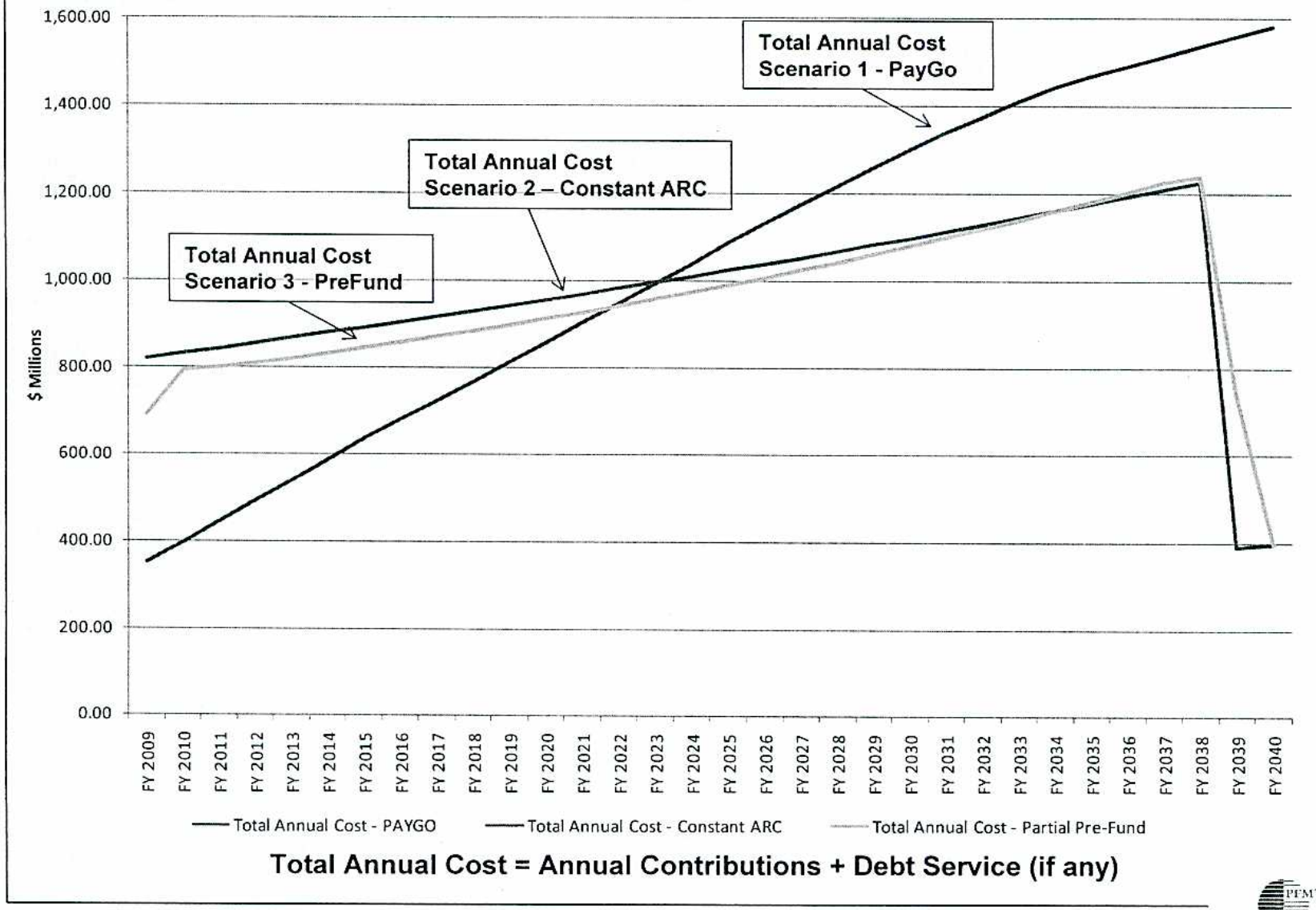
Actuarial Data ($ Billions)	Unfunded	Funded
Discount Rate Assumption	4.25%	7.75%
Actuarial Accrued Liability (AAL)		
Current Retirees	$7.000	$4.668
Current Deferred	$0.342	$0.187
Active Employees	$7.851	$4.317
TOTAL AAL	**$15.193**	**$9.172**
Present Value of Future Normal Costs		
Normal Cost (this year)	$0.583	$0.235
Normal Cost (following years)	$5.982	$1.767
TOTAL PV of Future Normal Costs	**$6.565**	**$2.002**
Actuarial PV of Total Projected Benefits	**$21.758**	**$11.174**

Bond Sizing Assuming Funding of 35% of UAAL	
Sources:	
Par Amount	**$3,217,175,000**
Uses:	
Deposit to Trust	$3,185,000,000
Cost of Issuance	$32,171,750
Additional Proceeds	$3,250
Total Uses:	**$3,217,175,000**

Scenario 3 (Partial Pre-Funding) Estimated Annual Contributions

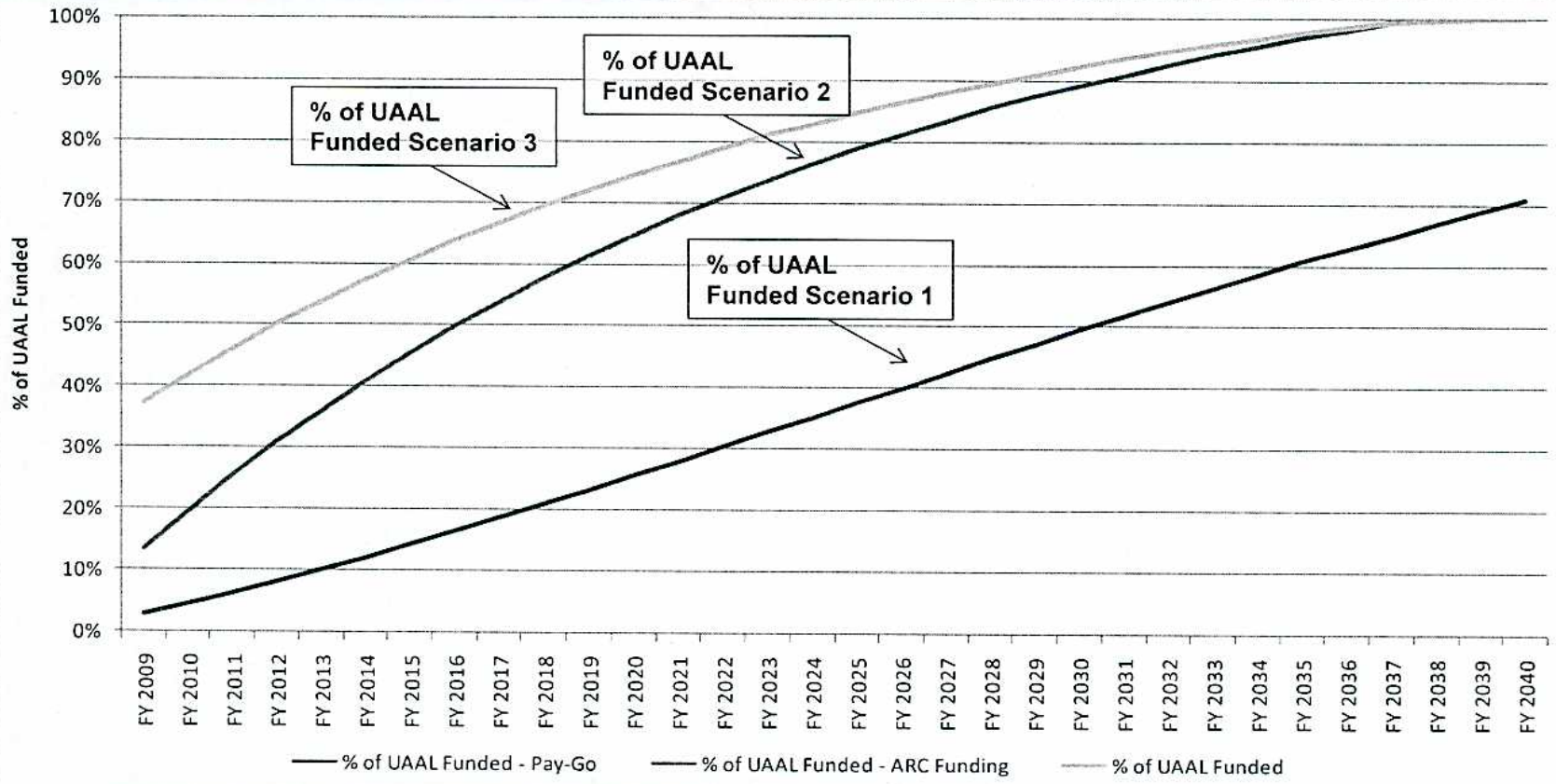


Cost Comparison Scenarios 1-3



Total Annual Cost = Annual Contributions + Debt Service (if any)

Comparison of Funded Status Scenarios 1-3



Residual Trust Value ($Billions)				
	Year 10		Year 30	
	Cash	Present Value	Cash	Present Value
Scenario 1	$0.00	$0.00	$0.00	$0.00
Scenario 2	$5.58	$3.68	$23.44	$6.72
Scenario 3	$8.57	$5.65	$23.63	$6.77

Note: Present value is computed using a 4.25% discount rate.

Financial Comparison of Scenarios at Year 30

	Scenario 1 PAYGO		Scenario 2 Constant ARC		Scenario 3 Partial Pre-Funding	
	Cash	Present Value	Cash	Present Value	Cash	Present Value
Total Contributions - Sum of Contributions and Debt Service	$28.69	$13.82	$29.91	$16.02	$28.73	$15.17
Residual Trust Value	$0.00	$0.00	$23.44	$6.72	$23.63	$6.77
Contributions less Trust Value	$28.69	$13.82	$6.47	$9.30	$5.10	$8.40

Residual Trust Value will help pay future benefits for current and future employees

Note: Present value is computed using a 4.25% discount rate.

Balance Sheet Impact

- The State will have a significantly different Balance Sheet after thirty years under the Pay-Go scenario versus the ARC and Partial Pre-Fund Scenarios.

- Net OPEB Obligation:

Net OPEB Obligation ($Billions)				
	Year 10		Year 30	
	Cash	Present Value	Cash	Present Value
Scenario 1	($8.24)	($5.43)	($26.61)	($7.63)
Scenario 2	$0.52	$0.34	($0.74)	($0.21)
Scenario 3	$3.50	$2.31	($0.55)	($0.16)

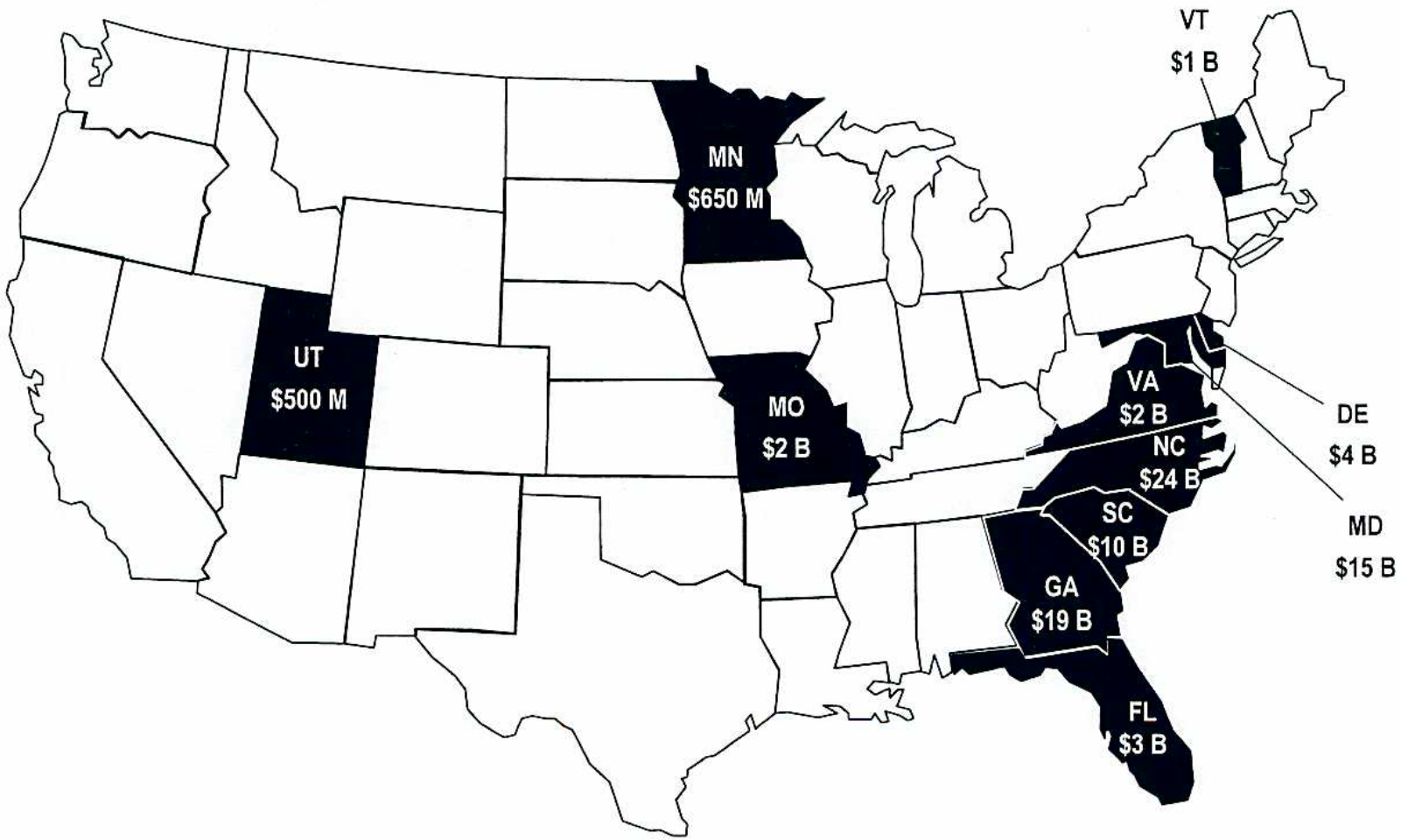
Note: Present value is computed using a 4.25% discount rate.

Scenario Analysis
Accounting, Financial and Benefit Results

- Scenario 1 (PAYGO) net financial results are the weakest of the three scenarios at 30 years.
- Over the long term, Scenario 2 (ARC) and Scenario 3 (Partial Prefunding) generate positive results with significant residual assets at the end of 30 years to mitigate future benefit liabilities.
- Thirty-year savings generated by issuing debt to fund 35% of UAAL are $5.4 billion on a present value basis compared to Scenario 1 (PAYGO).

Appendix A: AAA State OPEB Funding Experience

State OPEB UAAL* – AAA-Rated States



Source: Standard & Poor's

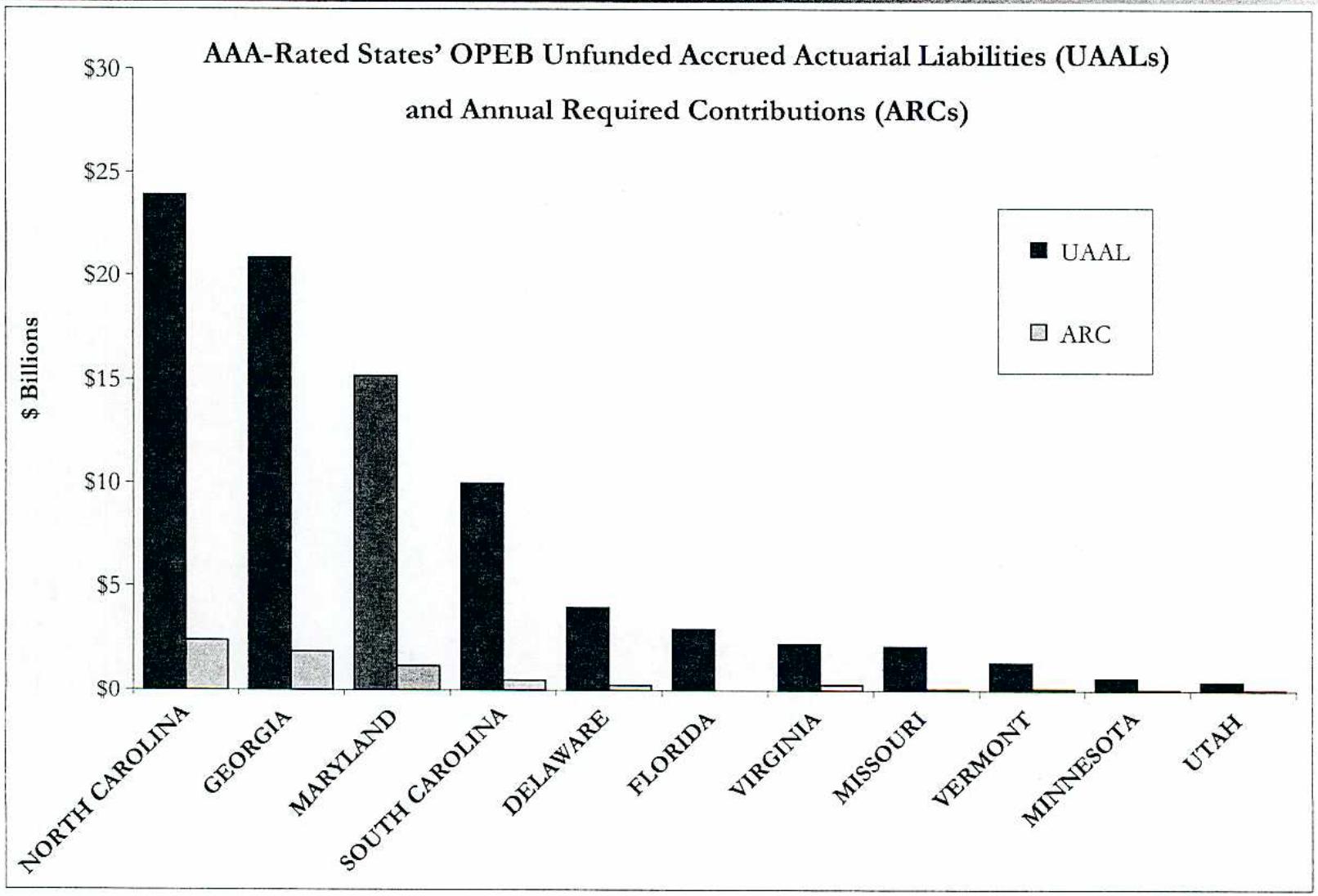
*Unfunded Accrued Actuarial Liability (UAAL) numbers are rounded.

State OPEB UAAL – Detailed Information

Summary of State OPEB Funding and Liabilities ($ Billions)						
	S&P	Moody's	Fitch	UAAL	ARC	Value of Trust(s)
Maryland	AAA	Aaa	AAA	$15.193	$1.193	$0.128
Delaware	AAA	Aaa	AAA	$4.000	$0.286	$0.070
Florida	AAA	Aa1	AA+	$2.1 - $3.6	N/A	$6.2
Georgia	AAA	Aaa	AAA	$20.850	$1.890	$0.147
Minnesota	AAA	Aa1	AAA	$0.654	$0.066	
Missouri	AAA	Aaa	AAA	$2.186	$0.103	
North Carolina	AAA	Aaa	AAA	$23.900	$2.400	
Ohio	AA+	Aa1	AA+	$21.875	N/A	$15.500
South Carolina	AA+	Aaa	AAA	$10.000	$0.536	$0.063
Utah	AAA	Aaa	AAA	$0.488	$0.047	$0.025
Vermont	AA+	Aaa	AA+	$1.400	$0.107	Trust not yet funded
Virginia	AAA	Aaa	AAA	$2.100	$0.295	Trust not yet funded

Sources: Maryland - Buck Consultants, December 2007 and MSRA, August 2008; Virginia – VA CAFR, June 30, 2007; Other States – Standard & Poor's: "U.S. States Are Quantifying OPEB Liabilities And Developing Funding Strategies As The GASB Deadline Nears", November 12, 2007

Maryland Has the Third Highest UAAL and ARC of all AAA-Rated States



Highlights of "AAA" States

- **Delaware** established OPEB trust in 2000 and plans to fund it with 0.3% of payroll. The fund is expected to have $70 million by FY 2008.
- **Florida's** State Pension Fund is over-funded by $6.2 billion in excess of liabilities. Florida funds a health insurance subsidy with 1% of payroll.
- **Georgia** is implementing a partial funding strategy for its UAAL, setting aside 4% of payroll towards state employee OPEBs. That contribution is expected to generate $147 million in FY 2008.
- While it does not have formal OPEB funding plans at this time, **North Carolina** has increased vesting levels and changed benefit levels for new employees in order to manage future liabilities.
- **South Carolina** is also considering changing its benefit levels – from 100% after 10 years of service to 50% after 12.5 years of service and 100% after 25 years. The 2008 Appropriation Act will create and fund an OPEB trust with recurring and non-recurring monies if passed.
- **Utah** has capped and eliminated certain benefits reducing its liability. The state has also moved to full ARC payments, with $47 million already set aside for FY 2007-08.
- **Vermont** established an irrevocable OPEB trust in 2007.
- **Virginia** has five OPEB-related trusts, plans to contribute 0.3% of payroll to the trusts starting in 2008. Also, annual savings from health care cost containment are deposited into the trust.

Non Triple A State OPEB Points of Interest

- **Ohio**, although not AAA-rated, is noted as the only large state that has actively engaged in managing its OPEB costs and liabilities.
    - Ohio has accumulated $15.5 billion in OPEB trust monies, including $12 billion for the Public Employees Retirement System and $3.5 billion for the State Teachers' Retirement Plan.
- The states with **the highest OPEB liabilities are New York, New Jersey and California.**
- **New Jersey, with a $58.1 billion liability, is funding OPEBs on a pay-go basis only.** In FY 2007 the state spent $1.03 billion on benefits, and $1.13 billion has been budgeted for 2008.
- **California has a $47.88 billion liability and a $3.59 billion ARC.** A commission is currently evaluating decreasing benefits or increasing OPEB contributions to deal with rising costs. The state intends to continue funding OPEB on a pay-go basis.
- **New York has a $47 billion liability and a $3.7 billion ARC.** However, $858 million was appropriated for OPEB costs in 2006 and $1 billion is expected to be spent in FY 2007 and 2008. The state's Health Insurance Council is currently reviewing options, with a formulated approach to OPEB costs expected for FY 2009.

Selected OPEB Bond Issuers Have Maintained Strong Ratings

- **Oakland County, Michigan** – Had historically funded OPEB. At the time of bond issuance, had $303 million in a Employee Benefits Trust versus an AAL of $829 million, resulting in $527 million unfunded liability. The County created an intermediate Retiree Medical Benefits Funding Trust which sold in 2007 $557 million Taxable COPS with a 20 year final maturity. The County contractually agrees to pay lease payments to the Intermediate Trust which has assumed the Health Care liabilities and makes annual payments to the Employee Benefits Trust. The Bonds were rated Aaa (Moody's) and AA+ (S&P). The County's obligations are not subject to appropriation.
- **Chicago Transit Authority** – The Illinois General Assembly passed PA95-0708 which created a retiree Health Care Trust to separate health care benefits from the retirement system. The Act requires the Health Care Trust Board to establish an appropriate funding level for the trust; if the funding level falls below projections, a 10 year remedial plan must be proposed. Retiree contributions going forward are statutorily limited to 45% of premiums, while retirees currently contribute 3% of compensation.
  - The CTA sold $640 million in Taxable Sales and Transfer Tax Bonds to fund Retiree Health Care in August of 2008. The bonds were structured with a 2040 final maturity.
  - The bonds, which were part of a larger transaction that included Pension Bonds, were rated AA3(Moody's)/AA+(S&P). A Mortgage Transfer tax was added to supplement the sales tax revenue credit.

Scenario 3 (Partial Pre-Funding) – Estimated Debt Service

- Debt service is proportional to the annual ARC payment
- Rates are general market AAA-rated taxable rates
- Alternate Credit – not a Maryland general obligation (GO) bond
- A 30 year amortization is necessary to achieve any substantial savings levels
- PFM has used a conservative debt structure for the purpose of this analysis. Other structures could improve projected arbitrage earnings and the relative benefit of the Partial Prefund Scenario

Estimated Debt Service Assuming Funding of Approx. 35% of UAAL

Year Ending	Principal	Coupon	Interest	Debt Service
12/31/2009		3.280%	$94,487,626	$94,487,626
12/31/2010		4.100%	188,975,252	188,975,252
12/31/2011		4.370%	188,975,252	188,975,252
12/31/2012		4.620%	188,975,252	188,975,252
12/31/2013	2,265,000	4.840%	188,975,252	191,240,252
12/31/2014	5,485,000	5.010%	188,865,626	194,350,626
12/31/2015	9,140,000	5.170%	188,590,827	197,730,827
12/31/2016	13,270,000	5.270%	188,118,289	201,388,289
12/31/2017	17,900,000	5.360%	187,418,960	205,318,960
12/31/2018	23,070,000	5.440%	186,459,520	209,529,520
12/31/2019	28,815,000	5.510%	185,204,512	214,019,512
12/31/2020	35,185,000	5.580%	183,616,806	218,801,806
12/31/2021	42,220,000	5.640%	181,653,483	223,873,483
12/31/2022	49,965,000	5.690%	179,272,275	229,237,275
12/31/2023	58,475,000	5.740%	176,429,266	234,904,266
12/31/2024	67,800,000	5.780%	173,072,801	240,872,801
12/31/2025	78,000,000	5.820%	169,153,961	247,153,961
12/31/2026	89,145,000	5.850%	164,614,361	253,759,361
12/31/2027	101,280,000	5.870%	159,399,379	260,679,379
12/31/2028	114,485,000	5.880%	153,454,243	267,939,243
12/31/2029	128,810,000	5.890%	146,722,525	275,532,525
12/31/2030	144,340,000	5.900%	139,135,616	283,475,616
12/31/2031	161,150,000	5.910%	130,619,556	291,769,556
12/31/2032	179,340,000	5.920%	121,095,591	300,435,591
12/31/2033	198,990,000	5.930%	110,478,663	309,468,663
12/31/2034	220,210,000	5.940%	98,678,556	318,888,556
12/31/2035	243,105,000	5.950%	85,598,082	328,703,082
12/31/2036	267,785,000	5.960%	71,133,334	338,918,334
12/31/2037	294,380,000	5.970%	55,173,348	349,553,348
12/31/2038	311,955,000	5.980%	37,598,862	349,553,862
12/31/2039	330,610,000	5.980%	18,943,953	349,553,953
TOTAL:	**$3,217,175,000**		**$4,530,891,029**	**$7,748,066,029**

Disclaimers

- Any investment advice in this document is provided solely by PFM Asset Management LLC. PFM Asset Management LLC is an investment advisor registered under the Investment Advisors Act of 1940. PFM Advisors is a division of PFM Asset Management LLC. Public Financial Management Inc. is not providing and is not responsible for any investment advice herein.