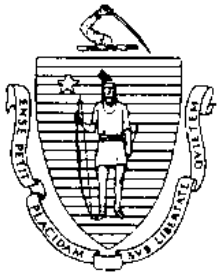

Commonwealth of Massachusetts
Special Commission to Study Retiree Healthcare and Other Non-Pension Benefits

Final Report
Submitted January 11, 2013

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I. Introduction

The special commission to investigate and study retiree healthcare and other non-pension benefits was established by Chapter 176 of the Acts of 2011 to address the growing cost and unfunded liability of state and municipal retiree healthcare benefits. The cost of providing health care and other non-pension benefits for retirees, collectively referred to as "other (than pension) post-employment benefits," (or OPEB), has become an increasing focus of state and municipal governments throughout the United States since the Governmental Accounting Standards Board (GASB) mandated public disclosure of OPEB costs and liabilities beginning in 2008.[1] This disclosure has focused the attention of public policy makers and financial analysts on the financial sustainability of current governmental practices in funding retiree healthcare benefits. The scope of this challenge is well documented in national and local research studies, and some financial analysts suggest that liabilities such as any unfunded OPEB liabilities should be added to bonded debt when considering the financial stability of a state or municipal government. [2]

In Massachusetts, the unfunded OPEB liability for state and local government amounts to approximately $46 billion—a liability larger than the unfunded pension

[1] GASB Statement 43, "http://www.gasb.org/st/summary/gstsm43.html" issued April 2004 and Statement 45, http://www.gasb.org/st/summary/gstsm45.html, issued June 2004.
[2] Pew Center on the States, "The Trillion Dollar Gap: Underfunded State Retirement Systems and the Road to Reform," http://www.pewstates.org/research/reports/the-trillion-dollar-gap-85899371867, February 2010 and Massachusetts Taxpayers Foundation, "Retiree Health Care: The Brick That Broke Municipalities' Backs," http://www.masstaxpayers.org/publications/public_finance/budget/fy_2012/20110215/retiree_health_care_brick_broke_municipalities%E2%80%99, February 2011.

liabilities in the Commonwealth[3] - and budgetary spending for retiree health benefits exceeds $1 billion. In contrast to pension obligations, the Commonwealth and local governments have not set aside significant resources to prefund their OPEB liabilities.[4] Moreover, municipalities shoulder a proportionally larger share of increased retiree healthcare costs, in comparison to pensions, because they are responsible for providing health benefits to retired teachers (who participate in the state teachers public employee system for pensions).

OPEB liabilities are a function of health care costs, the size of the eligible population and the level of benefits offered. Massachusetts, like the rest of the country, has been affected by dramatic increases in the cost of healthcare and an aging population. These trends, when coupled with relatively low eligibility requirements and high benefit levels, have created the large OPEB liability now faced by the state and local governments in the Commonwealth. The recommendations of the Commission seek to balance the financial implications of OPEB obligations with the equally important goals of equitable and fair treatment of current retirees, as well as attracting and retaining high-quality state and municipal career employees.

The remainder of this report is organized as follows. Sections 2 and 3 provide background on the challenge of OPEB costs and the drivers of OPEB liabilities. Sections 4 and 5 provide an overview of the OPEB Commission and its work. Sections 6, 7, and 8 summarize the principles, potential strategies, and fiscal sustainability

[3] This is in part a function of the fact that the discount rate used to calculate OPEB liabilities, typically 4.5 to 5% for most government entities in the Commonwealth, is substantially lower than the rate used for calculating pension liabilities.

[4] Total funding for OPEB in the Commonwealth is equal to roughly 1% of OPEB liabilities according to the Health Care Security Trust Board of Trustees. The Commonwealth has set aside over $400 million of invested assets in the State Retiree Benefits Trust Fund to fund future obligations. Municipalities have invested assets of approximately $50 to $75 million, based on information provided by over 25 municipalities.

analysis that guided the Commission as it developed its recommendations. Section 9 presents the Commission's recommendations.

II. The Challenge

The January 1, 2012 Actuarial Valuation by Aon Hewitt valued the Commonwealth's OPEB liability at $16.7 billion. In Fiscal Year 2013, retired state employee health care costs are budgeted at $415 million, while funding the state's actuarial Annual Required Contribution (ARC) would require $1.3 billion annually. The ARC, a standard measure of financial adequacy for the funding of retirement income obligations, represents both the value of benefits earned during the year (the Normal Cost) and an amortization of the Unfunded Actuarial Accrued Liability over a 30-year period.

The estimated municipal unfunded liability is approximately $30 billion.[5] Funding the ARC for the Commonwealth's 50 largest municipalities would cost approximately $1.2 billion, and these communities pay $500 million annually for retiree health care benefits.[6] As a consequence of underfunding and the concentration of OPEB obligations at the local level, municipal budgets have been particularly hard hit by growing retiree healthcare costs, with total health benefit costs increasing from 13.5% to 20% of budgets from 2001 to 2010.[7]

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[5] This does not include the potential impact of new accounting standards which can allow for the use of a higher discount rate that results in a material reduction in the reported liability.

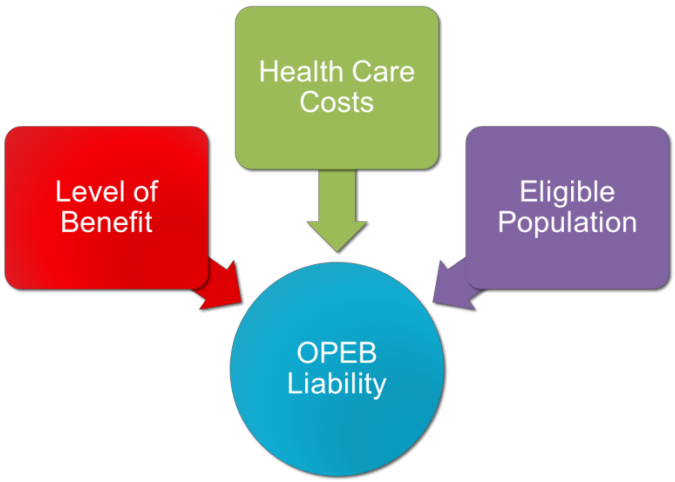
[6] Massachusetts Taxpayers Foundation, "Retiree Health Care: The Brick That Broke Municipalities' Backs," http://www.masstaxpayers.org/sites/masstaxpayers.org/files/The%20Brick%20That%20Broke%20Municipalities%27%20Backs_Feb%2025%202011.pdf, February 2011.

[7] Massachusetts Municipal Association, "The OPEB Challenge for Municipalities," Presentation to the OPEB Commission, April 2012.

Without further action, the Commonwealth and its municipalities will have increasing difficulty paying for retiree health benefits while adequately funding other investments, including transportation infrastructure and education. The Commission recognizes that this problem was not caused by retirees and believes that retirees should have access to quality and affordable health care coverage. In the spirit of fairness and cooperation, the Commission has agreed to recommend changes to the benefits provided to future retirees and to the practices of the Commonwealth and its municipalities.

III. Drivers of OPEB Liabilities

OPEB liabilities and costs are driven by the cost of providing health care, the eligible population, and the level of benefit provided. Health care cost inflation, an aging population, and longer life expectancies are among the factors that have impacted these cost drivers in recent years. Eligibility for benefits in retirement is determined by an individual's age and years of service in public employment. In the Commonwealth, the level of benefit provided by the government employer is typically expressed as a percentage of health care premiums.



Health Care Costs

Over the period FY2007 to FY2011, the Group Insurance Commission's average per enrollee increase of 26.4% was lower than the national average of 35.0% but nevertheless outpaced growth in state revenues, which increased by 15% over this same period.[8] The GIC's average cost for non-Medicare retirees increased by 23.8% and average costs for Medicare enrollees increased by 16.3%.[9] Health care costs for the state's 50 largest municipalities grew 85% from 2002 to 2009.[10] This compares to property tax revenue growth over this period of 42%.

The Eligible Population

According to the Commonwealth's 2012 actuarial valuation, 75,041 retirees, spouses, and survivors receive retiree health coverage through the GIC, and it is estimated that at least twice as many retirees receive municipal health coverage. The number of public retirees receiving health care benefits is expected to grow over the next decade, due primarily to demographic trends, including the retiring of the baby boom generation and increased life expectancies. Aon Hewitt, for example, projects annualized growth in the number of state retirees receiving health care coverage of 2.1% over ten years, compared to projected growth in the Massachusetts population of

[8] The Group Insurance Commission, "FY 2011 Age and Sex Report," February 2012.
[9] The Group Insurance Commission, "The GIC's Retiree Population," Presentation to the OPEB Commission, April 2012.
[10] Analysis by the Massachusetts Taxpayers Foundation, using municipal data reported to the Department of Revenue's Division of Local Services, provided to the OPEB Commission.

0.4%.[11] The impact of increased life expectancies is also reflected in ongoing changes to actuarial standards, which will increase pension and OPEB liabilities.[12]

Eligibility for retiree health benefits in the Commonwealth is currently linked to eligibility for pensions. Group 1 employees hired before April 2, 2012, for example, become eligible for retiree health benefits after 10 years of service and may begin receiving benefits upon retirement at age 55 or older. The OPEB Commission's review of other state plans found that 18 states require a higher age or minimum years of service than Massachusetts. Massachusetts, moreover, does not require employees to retire directly from state and local government in order to be eligible for retiree health benefits, as required in 16 other states. Additionally, while the Commonwealth pro-rates part-time work, such that an employee working half-time must work at least 20 years to become eligible for benefits, some municipalities provide full-time credit for part-time service.

Most private sector employees are able to access post-retirement income and benefits at comparatively later ages. The minimum age for accessing 401(k) savings is 59 ½, the minimum age for receiving Social Security benefits is 62, and the minimum age for Medicare eligibility is 65. Retiree health benefits are becoming increasingly rare

[11] ANF analysis of vendor forecasts.
[12] A recent change to the Actuarial Standards of Practice requires actuaries to consider future mortality improvement ("fully generational" mortality) in determining the mortality assumption. An updated experiences analysis, while not yet finalized, projected mortality improvement from the level used in the 2011 actuarial valuation of an additional 5 years for retirees and ten years for active members. See PERAC, "Commonwealth Actuarial Valuation Report," http://www.mass.gov/perac/valuation/2012commonwealth.pdf, January 2012.

in the private sector. In 2011, only 8.2% of private employers in Massachusetts offered health benefits to retirees below age 65 and 7.4% to Medicare-eligible retirees.[13]

The Level of Benefit

The Commonwealth pays for 80% of premiums for retirees who retired after October 1, 2009. Municipalities vary in the level of benefit they provide; however, no municipality pays less than 50% of retiree health care premiums, and on average municipalities pay for about 75% of premiums.[14] National data shows that most private sector employers that offer retiree benefits require their retired employees to pay the full cost of their premiums or to pay for any increases in premiums above a fixed dollar cap.[15] It is difficult, however, to compare only this benefit without considering the total compensation package.

As of January 2012, the annual cost of retiree health care for former state employees was $10,620 for those under age 65 and $4,780 for those over age 65 and eligible for Medicare. As a result, a disproportionate share of OPEB liabilities is associated with the cost of health insurance for pre-Medicare retirees. The present value at retirement of this medical benefit for a single male, retiring at age 62 with Indemnity coverage, is $114,000, which represents approximately $200,000 in post-retirement benefit payments.

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[13] Medicare Expenditure Panel Survey Table II.A.2.e, "Percent of Private-Sector Establishments that Offer Health Insurance by Plan Options and Insurance Offerings to Retirees by State," http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2011/tiia2e.pdf, 2011.
[14] Retired State, County and Municipal Employees Association of Massachusetts, "Retirees Surveys & Studies," Presentation to the OPEB Commission, May 2012.
[15] Paul Fronstin, "Implications of Health Reform for Retiree Health Benefits," http://www.ebri.org/pdf/briefspdf/EBRI_IB_01-2010_No338_RetHlth1.pdf, January 2010.

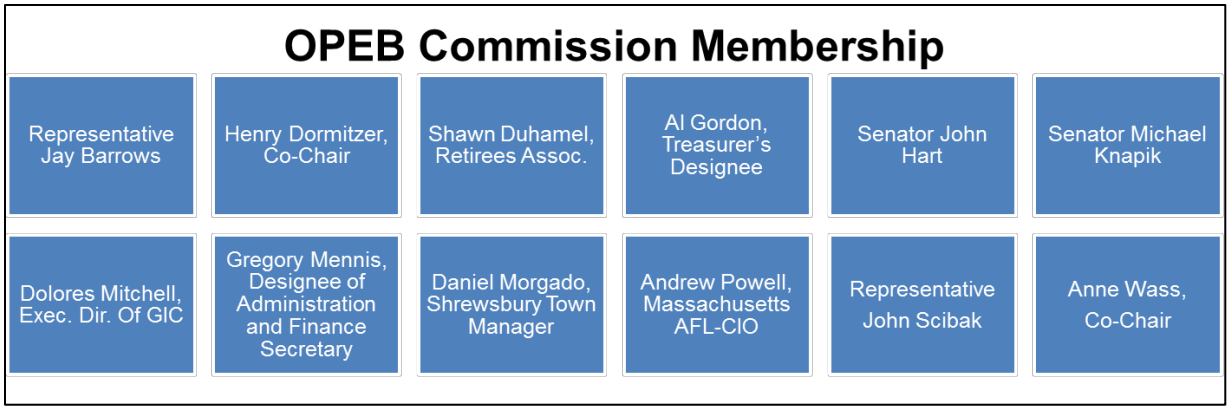
Unlike pensions, retiree health benefits do not vary with length of service. An employee who works for the Commonwealth or one of its municipalities for 10 years becomes eligible for the same retiree health benefits as a career employee who has served for 30 years.

IV. The Commission

The Commission was established by Chapter 176 of the Acts of 2011 to:

- *Consider the range of benefits that are or should be provided as well as the current and anticipated future cost of providing them;*
- *Consider and may make recommendations on how best to divide the costs between the commonwealth and employees;*
- *Study the operation and structure of the Group Insurance Commission or any other aspects of employee healthcare the commission deems appropriate; and*
- *Upon appropriation of sufficient funds, engage professional advisors as needed to accomplish its purposes.*

The Commission's membership, listed in the table below, includes two private citizens, four members of the legislature and representatives of the Secretary of Administration and Finance, the Treasurer, the Group Insurance Commission, the Massachusetts AFL-CIO, the Massachusetts Municipal Association, and the Retired State, County and Municipal Employees Association of Massachusetts.



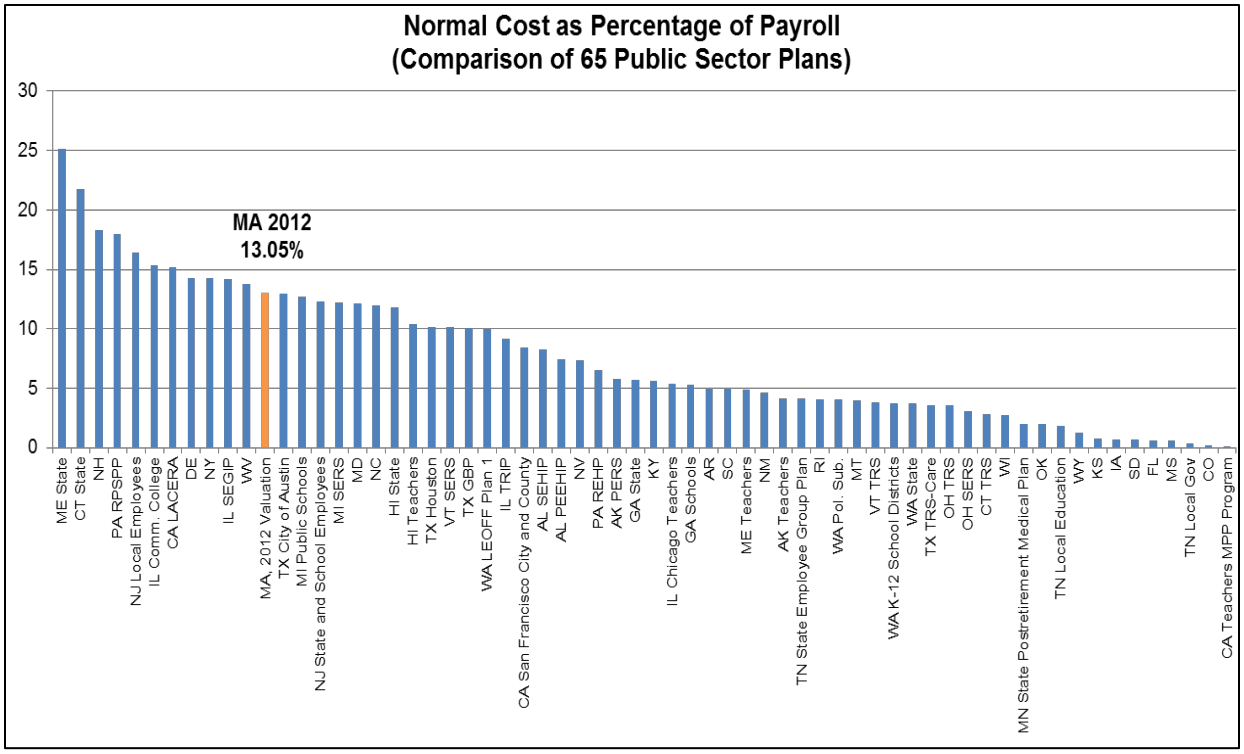
The Commission held nine meetings between April and December of 2012 and heard presentations from a diverse group of stakeholders. The Commission's members agreed to a set of guiding principles, conducted comparative research of benefit polices in all 50 states and the private sector, engaged two actuarial firms to perform analysis of potential changes, and developed a list of recommendations for the Commonwealth and municipalities.

V. Research

State Comparative Analysis

The cost of retiree health care in Massachusetts is among the highest in the 50 states. According to data from the Boston College Center for Retirement Research and the Commonwealth's most recent valuation, it would cost the Commonwealth 13.05% of existing payroll to pre-fund commitments for retiree health benefits being promised to current state employees—putting Massachusetts in the top 15 of the 64 public plans studied.[16]

[16]Alicia H. Munnell et. al, "Comparing Compensation: State-Local Versus Private Sector Workers.", http://crr.bc.edu/wp-content/uploads/2011/09/slp_20-508.pdf, September 2011. This report includes data from Massachusetts' 2010 valuation, which shows normal cost as a percent of payroll of 16.41% and places Massachusetts in the top six of the plans studied. The FY2012 result cited above is more accurate and reflects accounting adjustments made in the most recent valuation.



The Commission undertook research to understand what other states have done in order to control their retiree health care costs. At least 40 other states have enacted one or more cost containment measures that fall into three broad categories.

Benefit Eligibility: According to the Commission's review of state plans, at least 18 states have higher minimum age and/or minimum years or service requirements than Massachusetts.

At least 16 states have "continuing service" requirements that limit retiree health coverage for individuals who were not in state service at the time of retirement.

Level of Benefit: At least 19 states pro-rate the employer's premium contribution based on years of service and/or other characteristics, such as age.

Cost Reduction: According to an Aon Hewitt survey of private and public plan sponsors, 61% anticipate changing their Medicare Part D or broader post-65 retiree strategy, and 62% of those who have already changed their strategy have adopted an

Employee Group Wavier Plan (EGWP).[17] An EGWP involves contracting directly with a prescription drug plan especially to provide at least Part D-level prescription drug coverage to Medicare-eligible participants. Retiree health plan sponsors who adopt an EGWP strategy are eligible for enhanced federal payments, as well as favorable accounting treatment.

Cost Containment: Nine states contribute a fixed dollar amount rather than a percentage of the premium, with these contributions typically indexed to inflation. In addition, 12 states provide either no retiree health coverage or unsubsidized coverage only.

Pre-Funding Strategies: Washington State uses a voluntary employees' beneficiary association (VEBA) to offer a health reimbursement arrangement (HRA) to former employees of participating public employers. Funding sources vary by employee and include unused sick, vacation or personal leave; mandatory employee contributions; and all or part of future pay raises or cost-of-living allowances.[18] In Connecticut, health care eligible state employees are required to contribute a percentage of their compensation to a Retiree Health Fund, and the state has committed to contributing an equal amount beginning in 2017.[19]

Recent Legislation

The Commission also considered the impact of recent state and federal legislation on state and municipal retiree health care costs.

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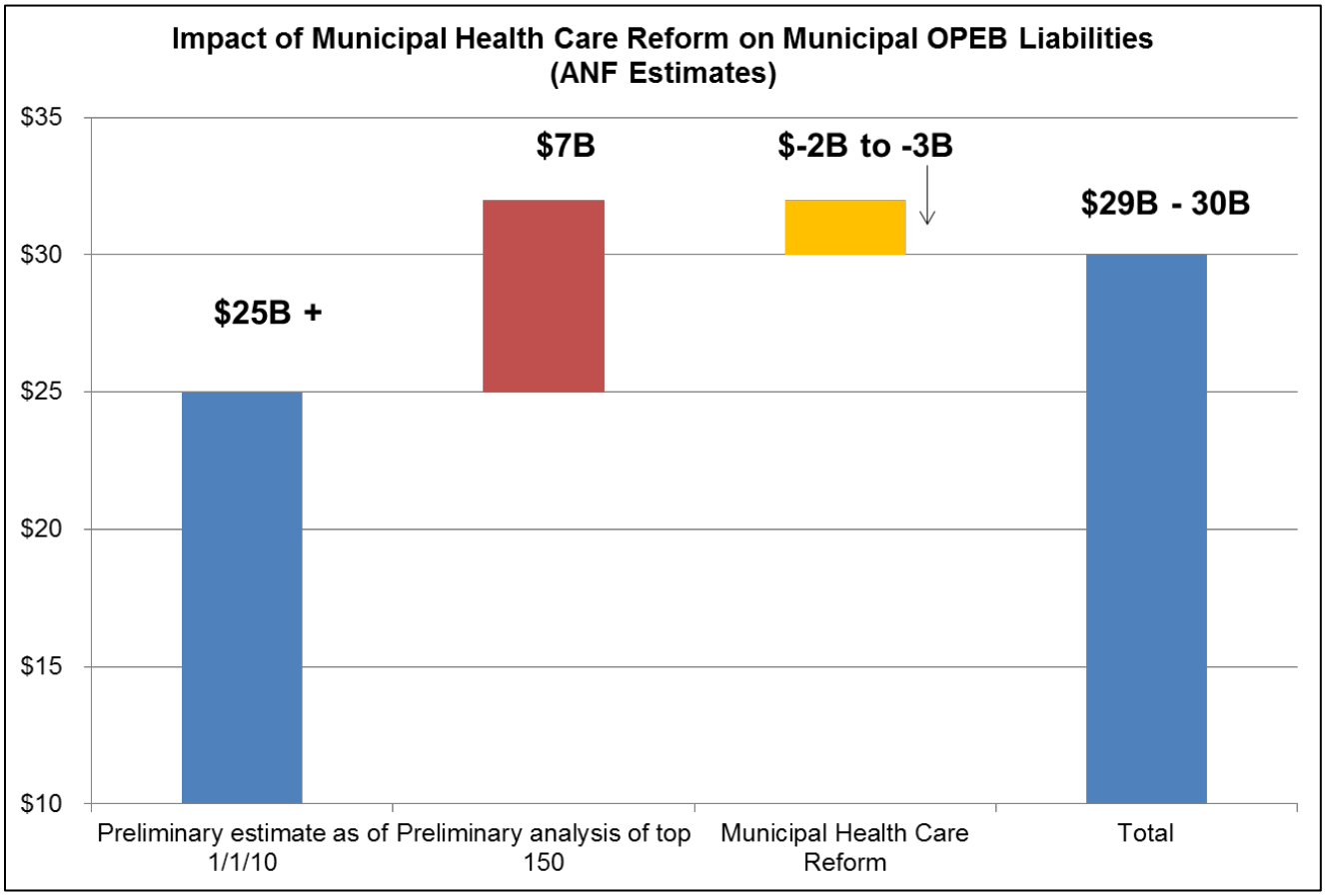
[17] Aon Hewitt, "Medicare Part D: EGWP Feasibility Study," Presentation to the OPEB Commission, October 2012.
[18] VEBA Trust, www.veba.org.
[19] Connecticut Office of Legislative Research, "OLR Backgrounder: The 2011 SEBAC Agreement," http://www.cga.ct.gov/2012/rpt/2012-R-0032.htm, February 2012.

Municipal Health Care Reform: Municipal health reform became law in July 2011 and is expected to reduce municipal OPEB liabilities by an estimated $2-$3 billion, or approximately 6% to 9%, as a result of lower health care premiums and other plan design changes.[20] The success of municipal health reform is evidence of the commitment from state and municipal governments, public employees, and retirees to work together to address health care costs.



Pension Reform: Because of increased retirement ages, pension reform legislation passed in November 2011 is projected to lower OPEB liabilities. However,

[20] Estimates reflect latest projected savings from municipal health care reform, including $175M in premium savings and other assumptions regarding employer cost share, rate of adoption to date, etc. Does not include the impact of accounting changes, now being used by some municipalities, that allow for using a higher discount rate and which can decrease liabilities by about one-third.

because new pension rules apply only to employees hired after April 2012, the resulting savings in retiree health care costs will not begin for at least a decade.

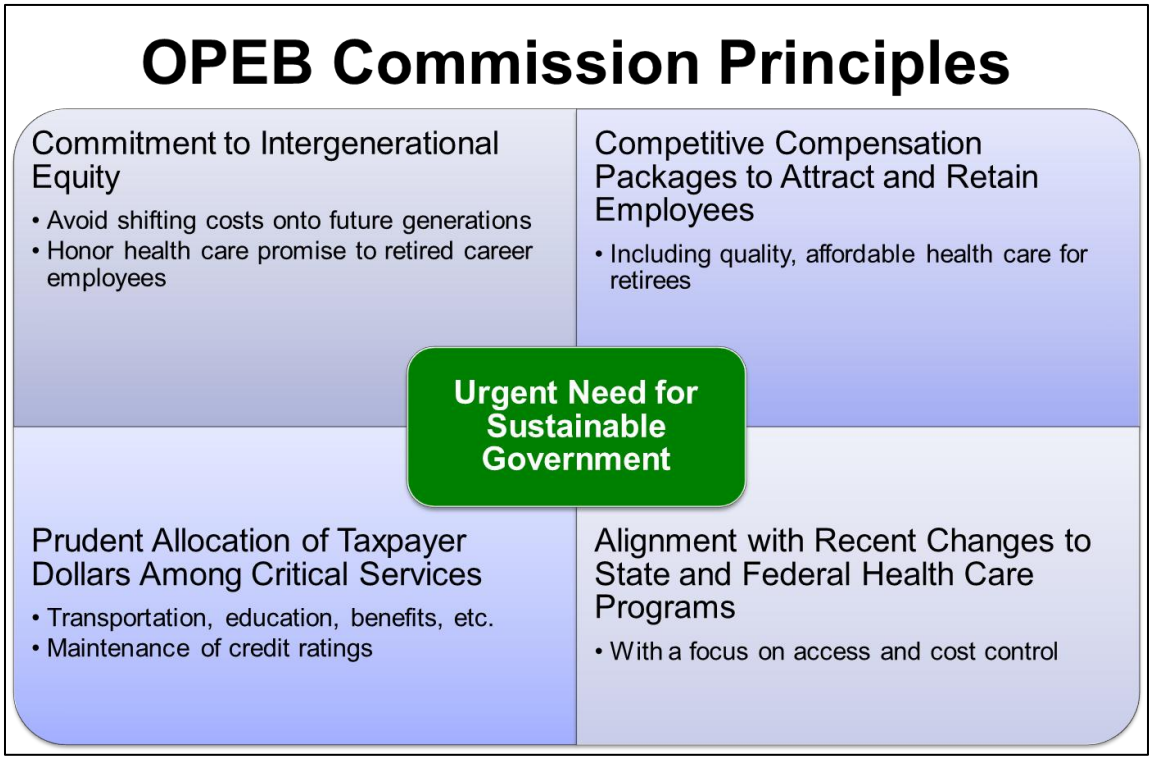
Health Care Cost Containment: Health care cost containment legislation passed in August 2012 is intended to limit health care cost growth, a major driver of growing OPEB liabilities. The OPEB Commission's analysis included the impact of this legislation both separately and in combination with other changes. In addition, because this legislation provides tools to address high rates of health care cost growth, the Commission decided not to pursue other cost containment or cost shifting strategies, such as indexing employer contributions to inflation.

Patient Protection and Affordable Care Act (ACA): Starting in January 2014, under the ACA, eligibility for subsidized health care will change. Individuals with incomes between 133% and 400% of the federal poverty line without insurance, or whose employer-subsidized insurance is not considered affordable, will become eligible for federal subsidies to offset the cost of purchasing insurance through a Health Insurance Exchange. Currently, subsidized insurance through Commonwealth Care is available only to those under 300% of the federal poverty line. In addition, eligibility for Commonwealth Care is more restrictive in that individuals who receive employer premium contributions of 20% (individual coverage) or 33% (family coverage) are not eligible for state subsidies. The consequence of this for the OPEB Commission is that the ACA offers a broader safety net for early retirees who may be impacted by benefit design changes. The Commission recommends that in the future, retirees are provided with the information necessary to determine whether coverage under the ACA exchange may be of comparable quality at a lower price.

VI. Principles

The Commission's work was a response to the urgent need for financial sustainability in government arising both from the growth in retiree health care costs and from other challenges, including revenue challenges and a need for additional investment in other areas of government.

At the same time, the Commission expressed a commitment to considering not only the savings associated with changes to the current benefit structure, but also the impact of these changes on people: taxpayers, future public employees, current employees, and retirees. This commitment is reflected in the following principles, which guided the Commission's work:



Commitment to Intergenerational Equity: Avoid shifting costs onto future generations. Honor health care promise to retired career employees.

Competitive Compensation Packages to Attract and Retain Employees: Provide quality, affordable health care for retired career employees.

Prudent Allocation of Taxpayer Dollars Among Critical Services: Balance the need to maintain transportation, provide education, offer employee benefits, and offer other important governmental services while preserving credit ratings.

Alignment with Recent Changes to State and Federal Health Care Programs: Focus on supporting access to quality, affordable health care and controlling growth in health care costs.

VII. Potential Strategies

Based on its research from other states, the Commission considered a range of potential strategies, including:

Benefit Eligibility: Increase the minimum age and/or minimum years of service; implement continuing service requirements; mandate provision of survivor benefits

Level of Benefit: Pro-rate the level of subsidy based on years of service; change policies for crediting part-time service

Cost Reduction: Employer Group Waiver Plans (EGWP) and procurement

Cost Containment: Establish metrics with an automatic alarm or mechanism if cost growth becomes unsustainable

Pre-Funding Strategies: Set aside funds to pay for future retiree health benefits

The Commission engaged two actuarial firms, Aon Hewitt and Segal Co., to provide estimates of the savings associated with a number of benefit design changes at the state and municipal levels. In Phase 1 of their analysis, the actuaries reviewed the individual impact of seven changes to the minimum age or years of service, two

changes to pro-rate retiree premiums based on service, and four changes to limit cost growth. Each change was considered separately if applied to new retirees only and to new hires only. The actuaries estimated the impact of the changes on 30-year projections of cash flow, normal cost, and liabilities. In Phase 2 of their analysis, the consultants reviewed scenarios reflecting combinations of proposed reforms and various grandfathering provisions. The firms' scopes of services are attached as Appendix A and B.

The Commission performed additional analysis, supported by information from Commission members and from the Public Employee Retirement Administration Commission and the State Board of Retirement, to inform its recommendations on part-time service, continuous service requirements, and survivor benefits.

VIII. Fiscal Sustainability Analysis

The Commission used a benchmark of "sustainable spending growth" to evaluate the impact of potential strategies to manage retiree health costs on the Commonwealth and municipalities. Sustainable spending growth, one of the three goals of the Commonwealth's Long-Term Fiscal Policy Framework,[21] is achieved when the projected growth in spending is less than or equal to the government's projected sustainable rate of revenue growth. In addition to evaluating sustainable spending growth, metrics for cash flow savings, net present value savings, and reductions in liabilities over both 10- and 30-year time horizons were measured.

[21] Commonwealth of Massachusetts, "Long Term Fiscal Policy Framework," http://www.mass.gov/anf/docs/anf/long-term-policy-framework.pdf, May 2012.

Achieving sustainable spending growth will have the effect of reducing OPEB liabilities, which is necessary to protect intergenerational equity and to maintain the Commonwealth's credit ratings. While achieving sustainable spending growth in the future does not address the appropriateness of the level of spending on retiree healthcare costs today, ensuring sustainable spending growth in retiree healthcare costs is necessary both to preserve the benefit for public employees in the future and to prevent budget cuts in other areas.

IX. Recommendations

The Commission has adopted a set of recommendations to refer to the Governor and the Legislature. These recommendations will provide quality retirement benefits to career employees while taking a significant first step toward ensuring fiscal sustainability for compensation packages offered by the Commonwealth and its municipalities. It should be noted that Commission's recommendations are the result of a collaborative and productive 10 months of deliberation and each of its members appreciates the professionalism and dedication shown by other members.

The table below summarizes the recommendations of the Commission, but the table is intended solely as a quick reference. Please refer to the detailed descriptions of each consideration that follows the table.

Item	Recommendation
Minimum Age	+5 years for all groups (e.g. 60 for Group 1)
Minimum Years of Service to receive minimum benefit (50%)	+10 years for all groups
Pro-Rating of Benefits	Prorated from 50% premium contribution after 20 years to maximum current retiree benefit at 30 years
Affected Population	All future employees. All current employees except (i) those with 20 years of service and within 5 years of pension eligibility at the time of enactment; (ii) those within 5 years of Medicare eligibility and within 12 months of pension vesting at the time of enactment; and (iii) teachers enrolled in Retirement Plus, upon reaching age 57 and the statutory maximum of 80%.
Phase-In of New Requirements	Any current employee who, at the time of the legislation, is at least age 50 and has completed 15 years of service, shall be eligible to receive a 50% premium contribution upon retirement; Any current employee who, at the time of enactment, is at least age 55 and has completed 10 years of service, shall be eligible to receive a 50% premium contribution upon retirement
Disability Retirements	Accidental disability retirements exempted from any recommendations of this Commission. Ordinary disability retirements will be exempt from the reform until the 2014 Affordable Care Act exchange is available. At that time, ordinary disability retirees shall receive a 50% premium contribution for 10 to 20 years of service. Beyond 20 years, prorating will apply.

Item	Recommendation
Future Changes to Premium Contributions	Municipal retiree contributions are "frozen" at levels as of 1/1/2013 for a period of three years from the effective date of the OPEB Reform Law, provided that changes adopted locally before 1/1/2013, shall be honored. Following the moratorium, the ability to reduce contributions shall be returned to local option given, however, that any municipality that exercises this right shall hold harmless (grandfather) existing retirees at their current level of contribution at the time of implementation.
Employee Group Waiver Plan	Recommend adoption after a reasonable period of preparation, if feasible.
Part-Time Service	Recommend municipalities adopt the Commonwealth's policy of providing pro-rated credit for part-time service based on the number of hours employees work each week.
Continuing Service	Recommend a continuing service requirement.
Employer Funding	Recommend changes to make the SRBTF more accessible to municipalities and other government entities and continued review of the state's funding plan.
Procurement	Suggest the study of the requirement that, as best practices, municipalities periodically competitively procure health coverage.
Survivor Benefits	Recommend future surviving spouses eligible for a minimum of 50% premium share; current surviving spouses now paying 100% eligible for minimum of 50% premium contribution.
Amendment to 32B 9A ½	Recommend changes to make legislation more useful to municipalities.
Employee Funding	Recommend future study.
Roadmap to Sustainability	See below.

Minimum Age

The Commission recommends increasing the minimum age at which former employees become eligible for retiree healthcare by five years. Group 1 employees would have a minimum age of 60. Group 2 employees would have a minimum age of 55. Group 4 employees would have a minimum age of 50.

This change is intended to align the Commonwealth's eligibility standards with improvements in health and life expectancy that allow employees to continue working later in their lives, with policies in other states, and the age at which retirement income benefits are available by law in the private sector. In addition, this requirement is consistent with increases in the minimum age for pension benefits which apply to current employees hired after April 2, 2012 and new employees.

This change would produce savings by reducing the period of time for which former employees may receive retiree healthcare. In particular, this change would reduce coverage prior to retirees' eligibility for Medicare, which is the period during which their coverage is most expensive.

Minimum Years of Service

The Commission recommends increasing the minimum years of service required to receive retiree healthcare from 10 to 20 years. This change is intended to preserve retiree healthcare benefits for career employees while aligning the Commonwealth's eligibility standards with policies in other states. This change would produce savings by reducing the number of former employees who are eligible for retiree healthcare.

Pro-Rating of Benefits

The Commission recommends pro-rating benefits based on retirees' years of service. Under this new policy, retirees with a minimum of 20 years of service would be eligible to receive a 50% employer premium contribution. This premium contribution would increase to the maximum available benefit (e.g. 80% employer premium contribution for state retirees) for retirees with 30 or more years of service. The employer contribution would increase by one-third of the difference between 50% and the maximum available benefit at 23 years of service (e.g. to 60% for state retirees) and by two-thirds of the difference at 27 years of service (e.g. to 70% for state retirees).

This change is intended to provide a full retiree healthcare benefit to retirees who spent full careers in public service, while providing a proportionally smaller benefit to retirees who worked in public service for only a portion of their careers. This change would produce savings by reducing the employer premium contribution for those employees with less than 30 years of service.

Affected Population

The Commission recommends that existing retirees be exempt from the benefit design changes described above. This recommendation is consistent with the Commonwealth's recent practice of applying changes to new retirees only. Benefit design changes would apply to all future employees and to current employees, with the following exceptions:

- Current employees within five years of retirement age (e.g. 50 or older for Group 1) with 20 or more years of service as of the effective date of the legislation.
- Current employees within five years of Medicare age and 12 months of vesting (e.g. 60 or older with nine or more years of service) as of the effective date of the legislation.
- Current teachers participating in Retirement Plus who are at least 57 and who are eligible for the maximum pension benefit of 80%.

In addition, two groups of current employees would be exempt from changes to the minimum age and years of service but would receive a pro-rated benefit.

- Current employees who are age 50 with 15 or more years of service or age 55 with 10 or more years of service as of the effective date of the legislation would receive a minimum employer premium contribution of 50%. In the event these employees work beyond 20 years of service, they would be eligible for an increased contribution according to the pro-rating rules described above.

The recommendations set out by the Commission are designed to address an urgent need for sustainable government and to produce significant savings in both the medium- and long-term. If these benefit design changes were applied only to future employees, there would be no resulting savings within the first 10 years after enactment and the full impact of the changes would not be felt for 30 years or more.

At the same time, the Commission recognizes that some current employees approaching retirement are not able to extend their careers and may not have sufficient

time to prepare for a loss of retiree healthcare coverage or a reduction in their expected employer contribution.

Disability Retirements

The Commission recommends that accidental disability retirements be exempt from the benefit design changes proposed in this report. The Commission recommends that ordinary disability retirements with 10 to 19 years of service receive a minimum employer premium contribution of 50%. In the event these employees work beyond 20 years of service, they would be eligible for an increased contribution according to the pro-rating rules described above.

Future Changes to Premium Contributions

The Commission recommends that municipal retiree contributions be "frozen" at levels as of 1/1/2013 for a period of three years from the effective date of the OPEB Reform Law, provided that changes adopted locally before 1/1/2013, shall be honored. Following the moratorium, the ability to reduce contributions shall be returned to local option given, however, that any municipality that exercises this right shall hold harmless (grandfather) existing retirees at their current level of contribution at the time of implementation. This recommendation is designed to ensure sufficient time to observe the impact of changes to retiree healthcare benefits, particularly in light of other recent changes to municipal health care, pensions, and health care cost containment, as described above. This recommendation is consistent with the Commonwealth's recent practice of applying changes to new retirees only.

Employee Group Waiver Plan (EGWP)

The OPEB Commission recommends that the Group Insurance Commission investigate the adoption of an EGWP beginning January 1, 2015. An EGWP involves contracting directly with a prescription drug plan especially to provide at least Part D-level prescription drug coverage to Medicare-eligible participants. Part D-level coverage is a minimum requirement; there is no intention to lower the GIC's prescription drug coverage. According to Aon Hewitt, adopting an EGWP would result in enhanced federal subsidies, with associated savings to the Commonwealth equal to approximately $20 million in year one.

To achieve these savings, the GIC would have to enroll members on a calendar year as opposed to a fiscal year basis. In addition, the GIC would have to create a completely new drug plan for retirees who are Medicare eligible, separate from the current prescription drug plan, which would continue to operate for employees and non-Medicare eligible retirees. This schedule change would double the GIC's annual enrollment efforts, as the rest of the GIC would still be on a fiscal year basis.

The proposed January 1, 2015 date is intended to provide adequate time for the GIC to address this and other operational concerns. In addition, the Commission recommends that the administration estimate and allocate to the GIC sufficient resources for this project. As this represents a major benefit change, this proposal would require a vote by the GIC Commissioners.

Part-time Service

The OPEB Commission recommends that when determining eligibility for retiree health benefits, municipalities adopt the Commonwealth's policy for crediting part-time service. Currently, a number of municipalities provide full-time credit for part-time service to employees who work part-time for some or all of their careers. In contrast, the Commonwealth pro-rates part-time service based on the number of hours employees work each week. This policy would produce savings by limiting eligibility for retiree health benefits. If municipalities begin to pro-rate employer contributions based on an employee's years of service, this policy would produce additional savings from lower employer contributions.

Continuing Service

The OPEB Commission recommends that the Commonwealth and municipalities develop a policy that would limit eligibility for retiree health benefits to individuals who were employed at the time of their retirement, except that those who have worked a substantial career before leaving service would remain eligible for coverage if they retire within a reasonable number of years after leaving state or municipal service. At least 16 other states have policies that limit retiree health coverage for individuals who were not in state service at the time of retirement. Seven of these states require state employment immediately or shortly before retirement; seven require enrollment in the state plan for a specified period prior to retirement; and five require retirees to receive an immediate retirement benefit (some states have instituted more than one of these

requirements). This policy would produce savings by limiting eligibility for retiree health benefits.

Employer Funding

The OPEB Commission recommends changes to the State Retiree Benefit Trust Fund (SRBTF) to make this a more accessible vehicle for municipalities and other government entities seeking to prefund their retiree health costs. These changes could include providing a standard trust document; allowing investment in the SRBTF to be overseen by the local retirement board or other appropriate local authority; and streamlining the existing statutory language governing investment in the SRBTF. The Commission also recommends that the Commonwealth continue its current policies around liability valuation and allocation of funding for retiree health benefits (e.g. from Tobacco Settlement Proceeds) and that these policies be reviewed to ensure that they are aligned with best practices for financial reporting of OPEB liabilities.

The Patrick-Murray Administration proposed legislation in 2010 that was enacted by the legislature to phase-in a dedicated source of revenue from the Tobacco Settlement Trust to the State Retiree Benefits Trust Fund in order to fund OPEB liabilities. This was informed by the recommendations of The Special Commission to investigate and Study the Commonwealth's Liability for Paying Retiree Health Care and Other Non-Pension Employee Benefits in its July 2008 report. ANF estimates that the combined impact of this policy and the recommendations of the OPEB Commission, if adopted, would result in the Commonwealth's OPEB liabilities being approximately 80%

funded in 2040. This analysis also assumes that health care cost containment targets are met.

Procurement

Currently, municipalities are not required to hold competitive procurements for their health plans. In contrast, the Group Insurance Commission puts its health plans out to bid every five years. The AFL-CIO representative to the OPEB Commission recommends that municipalities put their health plans out to bid on a similar schedule.

Survivor Benefits

While the Commonwealth provides a 90% contribution for the surviving spouses of retirees, municipal contributions for surviving spouses are a local option. While most municipalities provide surviving spouses with the same contribution as they offer to retirees, some municipalities offer a lower subsidy or no subsidy to surviving spouses. The Commission recommends requiring all municipalities to contribute not less than 50% premium for future surviving spouses. Current surviving spouses, who are enrolled in a municipal health insurance plan and contributing a premium in excess of 50%, would be kept at the same premium contribution as future surviving spouses (not greater than 50% of premium). Those who are currently enrolled in a municipal insurance plan and pay less than 50% of the premium would be kept at the same level of premium contribution as they are now paying. In order to avoid an unfunded mandate in communities where this survivor benefit will result in increased costs that

exceed ½ of the savings generated by the reform, the Commonwealth will reimburse those communities for the portion of those costs in excess of half the savings.

State surviving spouses, who are currently enrolled in the Group Insurance Commission (GIC), would be kept at the same level of premium contribution as they are now paying. Those who enroll in the GIC in the future would be kept at the same level of premium contribution as their deceased spouse at the time of his or her death. Upon remarriage, in order to continue enrollment, a surviving spouse would be required to provide proof that he or she is not otherwise eligible for an employer sponsored retiree health insurance plan.[22]

Chapter 32B Section 9A ½

Chapter 32B, Section 9A ½, passed in 2010, allows municipalities to charge back other governmental units for a portion of retirees' health insurance. Municipalities have encountered challenges in implementing this law. The Massachusetts Municipal Association representative to the OPEB Commission has proposed changes, including: making billing a local option; standardizing the chargeback rate; and mandating that retirement boards send out standard creditable service notices by a certain date annually; and enabling municipalities to chargeback the Commonwealth.

Employee Funding

Other states, including Connecticut and Michigan, have recently implemented employee contributions to pre-fund retiree health benefits. In Connecticut, health care

[22] Under present law, surviving spouses of state and municipal retirees who remarry lose eligibility for survivor coverage,

eligible employees are required to contribute 3% of their compensation on a pre-tax basis. Employees must make contributions for 10 years or until retirement, whichever is sooner, and contributions are refundable to employees who leave prior to completing 10 years of state service. The state has committed to contributing an amount equal to the employees' contributions beginning in 2017.

The ANF representative to the OPEB commission has proposed that employee contributions be a future consideration for policymakers, provided that the high rate of employee contributions to state and local pension plans is factored into any supporting analysis. Implementation would require analysis to ensure that the investment trust conforms to section 115 of the IRC and the potential need for an IRS ruling, depending on the proposed design.

Roadmap to Sustainability

The OPEB Commission is hopeful that together with other recent reforms — including municipal health care reform, pension reform, and health care cost containment legislation — its recommended changes to retiree health benefits will enable the Commonwealth and its municipalities to manage this large liability for many years.

The Commission also recognizes the need to monitor and manage the budgetary cost of retiree health benefits in the future and recommends the development of a sustainability roadmap for this purpose. The roadmap would consist of three components: (1) periodic analysis of metrics to assess the cost of retiree health care benefits and to establish the sustainable level of public sector revenue available to pay

for government services; (2) an alarm if the level of spending for retiree health benefits is growing faster than sustainable rates of growth; and (3) a sustainability response, if the alarm is triggered, to provide government officials and legislators with the information required to consider solutions to the fiscal challenges that levels of spending growth above the sustainable rate may present.

Sustainability Roadmap Overview

Should the costs of these benefits or the actuarial assessment of the unfunded OPEB liability continue to grow in excess of the growth rate of potential gross state product, the Commission recommends that the executive director of the GIC identify additional cost saving strategies that would cause the rate of growth for the costs of these benefits and the OPEB liability to meet benchmarks for sustainability. This would apply even to those municipal governments that do not participate in the GIC. While such modifications would be non-binding and ultimately subject to a public process, the presentation of such an alternative plan by the GIC executive director would help public policy makers at both the state and local government level to understand the types and magnitude of potential cost saving strategies they might consider.

Implementation of these components will require coordination among four state agencies.

- Administration and Finance (ANF), as the executive office responsible for implementation of budgetary policies, will provide oversight and ensure intergovernmental coordination.

- The Department of Revenue's Division of Local Services (DLS), which conveys taxing authority on municipal governments through an annual review and approval process, will incorporate investigation of municipal OPEB liabilities and costs into its annual review and data collection process.
- The Group Insurance Commission (GIC), which procures and manages health plans for the Commonwealth and some municipal entities, will offer insight and analysis regarding best practices and benefit construction.
- The Public Employee Retirement Administration Commission (PERAC) will provide actuarial and administrative guidance as needed, in addition to collecting OPEB liability reports from municipal governments.

These entities will work together and in ongoing partnership with the legislature, retirees, public employee and municipal leaders to implement the sustainability road map - an essential component in support of the OPEB Commission's central objective of ensuring a financially sustainable government that adheres to its four principles.

Periodic Analysis

The proposed analysis would compare the growth in OPEB liabilities and annual OPEB budgetary spending (the "OPEB metrics") to the growth in the state's potential gross state product (PGSP) and tax levies for municipalities (the "sustainable growth benchmarks"), as an extension to fiscal budgeting policies currently used by ANF and DLS. The analysis would be performed bi-annually beginning in 2017 and compare the compounded annual growth rate (CAGR) for each of the OPEB metrics, from 2013 (the

baseline) through the preceding calendar year, to the CAGR for the sustainable growth benchmarks over the same time horizon.

OPEB metrics would be collected by DLS based on information requirements defined by PERAC and ANF, using reasonably consistent assumptions across government entities to the extent practicable. The state analysis would rely on the calculation for PGSP that is included in the recent health care cost containment legislation and agreed to as part of the consensus revenue process. The growth metrics for municipalities would be based on aggregate and individual municipal property tax revenue data that is currently collected by DLS.

Alarm

The calculations would be performed by ANF and DLS on a biannual basis to compare the CAGR for the OPEB metrics to the CAGR for the sustainable growth benchmarks. The process would also recommend that the Commonwealth and municipalities project the rate of growth in the metrics and the benchmarks over five years as a component of the long-term fiscal policy framework used by ANF and the five-year fiscal budget planning tool that has been developed by DLS to the extent municipal or state OPEB metrics exceed sustainable growth benchmarks, a sustainability analysis would be performed.

Sustainability Response

To the extent any municipality's or the state's OPEB metrics exceed sustainable growth benchmarks the executive director of the GIC must recommend potential cost

savings strategies that could curb the growth of OPEB metrics. This would apply even to those municipal governments that do not participate in the GIC. The GIC director's recommended changes are not binding upon either the state or any municipal government but form a public record and source of information for policy makers to evaluate whether and how to manage OPEB cost growth. Under current law, municipal government tax levies must be approved by the Commissioner of Revenue acting through DLS. The Commission recommends that the DLS be empowered to withhold approval of a tax levy until it receives adequate documentation from a municipal government regarding that government's plan regarding its growing OPEB costs.

The Need for Sustainability

The implementation of the roadmap is particularly important for municipalities based on recent research that the level and growth of retiree health care benefits does not appear to be sustainable for a number of cities and town in the Commonwealth. The recommendation of the OPEB Commission, if adopted, in combination with municipal health care reform and health care cost containment legislation, should provide these municipalities with significant budgetary relief. A process to continue monitoring the impact of the measures, however, is required to ensure that the Commission's central objective is achieved over time.

X. Savings

The OPEB Commission compared actuarial projections of the level and growth of retiree healthcare spending to sustainable rates of revenue growth. Sustainability was

measured over ten years—an extension of the standard five-year time horizon[23]—given that most reform measures would take several years to generate savings.

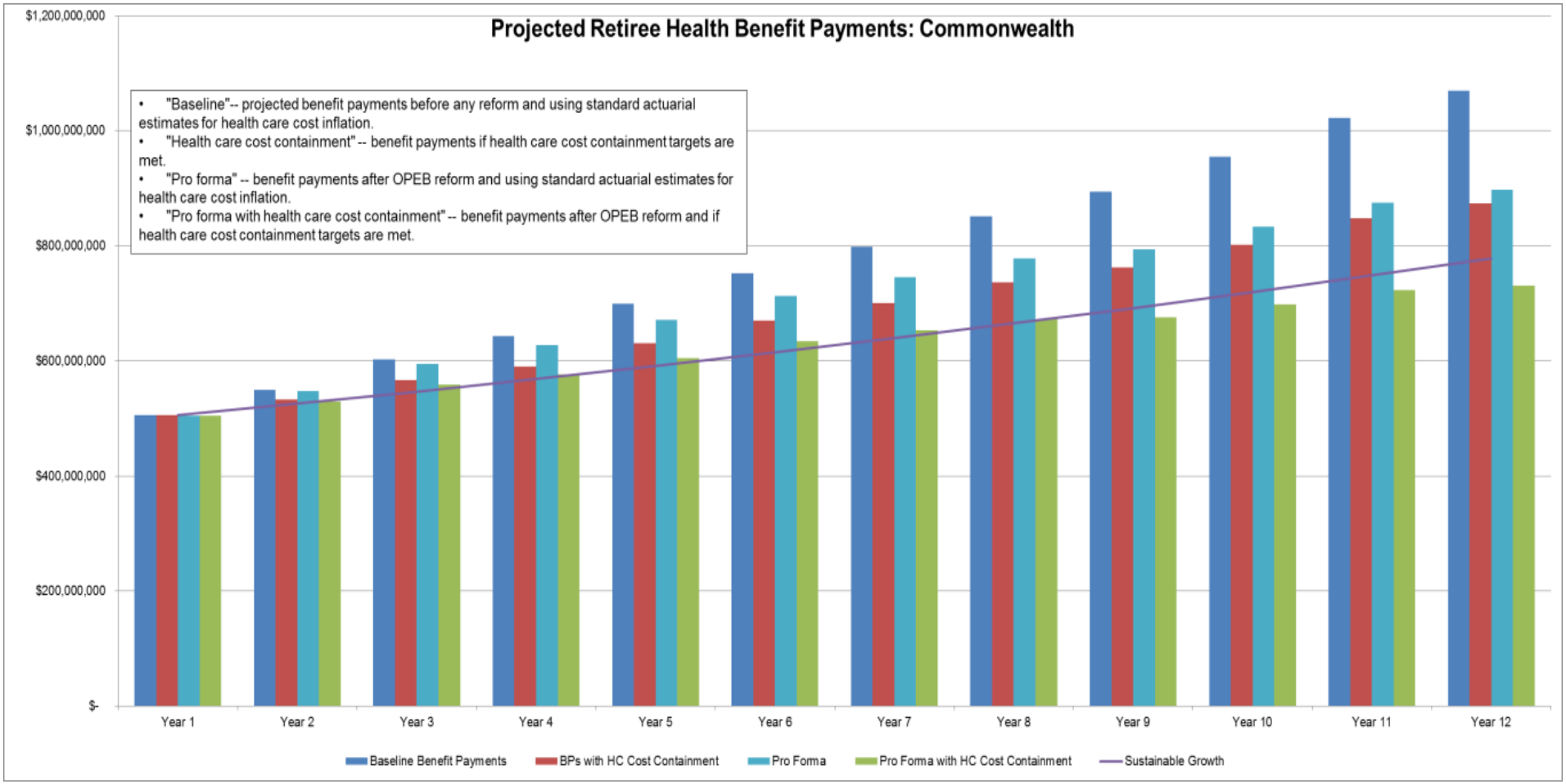
The purple lines in the following charts represent benchmarks for sustainable spending growth. Sustainable spending growth for the Commonwealth Commonwealth's represents ANF's standard benchmark of approximately 4%, based on long term trends for revenue growth.[24] Sustainability spending growth for municipalities is believed to be in the range of 3.25% — well below that of the Commonwealth— due to differences in service delivery models and in revenue streams. For municipalities, the primary revenue stream is real and personal property taxes, for which increases are capped at 2½% per year plus new growth. In Fiscal Year 2012, real and personal property taxes comprised 57.5% of the total revenue stream for Massachusetts municipalities.[25] Increases in special education, public works infrastructure, pension funding and health insurance costs all must be contained within the revenue limitations of municipalities.

The dark blue bars show the actuary's projections of annual retiree health benefit payments, and the red bars show annual benefit payments if health care cost containment targets are met. These health care cost containment targets tie annual growth in health care spending to the growth in the state economy, excluding fluctuations due to the business cycle. Meeting these targets would result in a substantial reduction in retiree health benefit payments as compared to the actuary's

[23] See Page 3 of the Commonwealth of Massachusetts, "Long Term Fiscal Policy Framework," http://www.mass.gov/anf/docs/anf/long-term-policy-framework.pdf, May 2012.
[24] ibid.
[25] Massachusetts Taxpayers Foundation, "Municipal Financial Data 42nd Edition," http://www.masstaxpayers.org/publications/public_finance/municipal/20121213/municipal_financial_data_42nd_edition, December 2012.

current projections. These reductions, however, are not sufficient to meet the sustainable spending growth target described above, because of an expected rapid increase in the number of new retirees. If health care cost containment is not successful, the Commonwealth would need additional savings from other changes in order to remain on a sustainable spending path.

The light blue bars show projections of annual benefit payments after the OEPB reforms identified in the recommendations section above. The green bars show projections of annual benefit payments after the OPEB reforms and if health care cost containment targets are met.


Projected Retiree Health Benefit Payments: Commonwealth
• "Baseline"-- projected benefit payments before any reform and using standard actuarial estimates for health care cost inflation.
• "Health care cost containment" -- benefit payments if health care cost containment targets are met.
• "Pro forma" -- benefit payments after OPEB reform and using standard actuarial estimates for health care cost inflation.
• "Pro forma with health care cost containment" -- benefit payments after OPEB reform and if health care cost containment targets are met.
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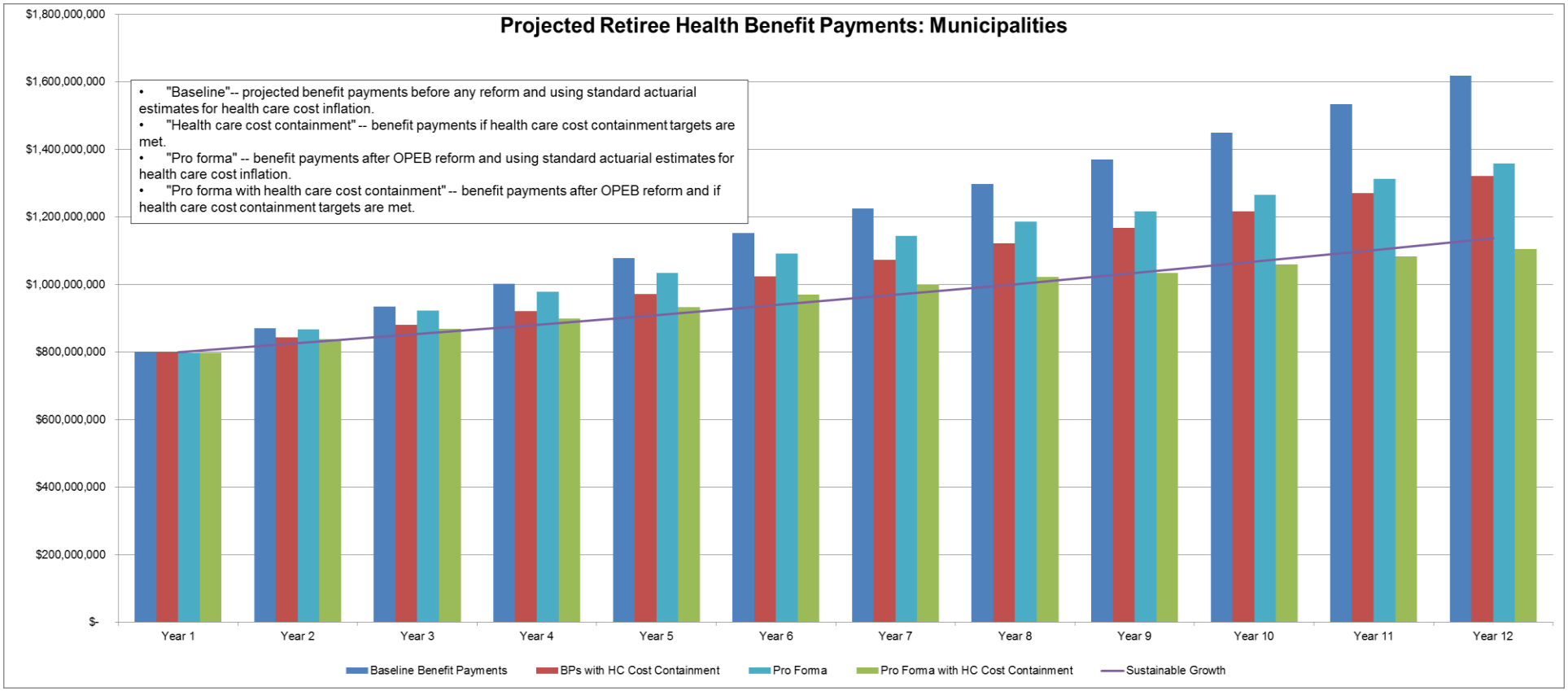
Year 7
Year 8
Year 9
Year 10
Year 11
Year 12
Baseline Benefit Payments
BPs with HC Cost Containment
Pro Forma
Pro Forma with HC Cost Containment
Sustainable Growth

Special Commission to Study Retiree Healthcare and Other Non-Pension Benefits



The savings that would result from the OPEB Commission's recommendations are summarized below. The upper bound of these savings estimates reflects the actuaries' projections. The lower bound of these savings estimates reflects adjusted baseline and pro forma projections that assume health care cost containment targets are met.

Total	Commonwealth	Municipalities
• Savings of $15-20 billion over 30 years	• Savings of $6-8 billion over 30 years • Greater than 30% reduction in year 30	• Savings of $9-12 billion over 30 years • Greater than 30% reduction in year 30
• Savings of $1 billion over 10 years	• Savings of over $400 million • 12-13% reduction in year 10	• Savings of over $600 million • 12-13% reduction in year 10
	• Meets ANF sustainable spending threshold in year 9 (year 3 with EGWP)	

These results show substantial savings over both 10- and 30-year time horizons as a result of the proposed OPEB reform.

XI. Additional Materials

Presentations to the OPEB Commission, including actuaries' analysis and other background materials, are available on the Commission's website: http://www.mass.gov/anf/opeb-commission.html.

January 9, 2013

Mr. Greg Mennis
Assistant Secretary for Fiscal Policy
Executive Office for Administration and Finance
State House, Room 373
Boston, MA 02133

Re: OPEB Commission Report – State Report

Dear Greg:

Aon has completed work on the costing of different plan design and structural changes for the Commonwealth of Massachusetts Retiree Benefit (Other than Pensions) Plan. We have presented the results of the study to the OPEB Commission and are in the process of completing the final report. The presentations can be found on the OPEB Commission website. The information in the final report will be consistent with the information we presented to the OPEB Commission, used by the Commission in their report. We anticipate the final reports being completed and published by January 15, 2013.

Please let us know if you have any questions or want to discuss any aspects of the reports.

Sincerely,

Tom Vicente
Partner

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Senior Vice President and Actuary
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January 10, 2013

Mr. Greg Mennis
Assistant Secretary for Fiscal Policy
Executive Office for Administration and Finance
State House, Room 373
Boston, MA 02133

Re: OPEB Commission Report – Municipal Report

Dear Greg:

Segal has completed work on the costing of different plan design and structural changes for the retiree health plans for selected municipalities (and one regional school district.) We have presented the results of the study to the OPEB Commission and are in the process of completing the final report. The presentations can be found on the OPEB Commission website. The information in the final report will be consistent with the information we presented to the OPEB Commission, used by the Commission in their report. We anticipate the final reports being completed and published by January 15, 2013.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Kathleen A. Riley, FSA, MAAA, EA