STATE OF CALIFORNIA

PUBLIC EMPLOYEE
POST-EMPLOYMENT BENEFITS COMMISSION

PUBLIC MEETING

Thursday May 31, 2007
10:00 a.m.

Central Park Community Center
11200 Base Line Road
Rancho Cucamonga, California

Reported by: DANIEL P. FELDHAUS, CSR #6949, RDR, CRR

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A P P E A R A N C E S

PUBLIC EMPLOYEE POST-EMPLOYMENT BENEFITS COMMISSION

Commissioners Present

GERRY PARSKY, Commission Chair
Aurora Capital Group

MATTHEW BARGER
Hellman & Friedman LLC

PAUL CAPPITELLI
San Bernardino County Sheriff's Department

JOHN COGAN
Stanford University

CONNIE CONWAY
Tulare County Board of Supervisors

RONALD COTTINGHAM
Peace Officers Research Association of California

TERESA GHILARDUCCI, Ph.D.
Trustee
General Motors Retiree Health Pensions

JIM HARD
President
Service Employees International Union Local 1000

LEONARD LEE LIPPS
California Teachers' Association

DAVE LOW
California School Employees Association

CURT PRINGLE
Mayor, City of Anaheim

ROBERT WALTON
Retired (CalPERS)

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A P P E A R A N C E S

PUBLIC EMPLOYEE POST-RETIREMENT BENEFITS COMMISSION

PEBC Staff Present

ANNE SHEEHAN
Executive Director

JAN BOEL
Staff Director

TOM BRANNAN
Policy Advisor

MARGIE RAMIREZ WALKER
Office Manager

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Public Testimony

DONNA SNODGRASS
California State Employees Association

BILL KIRKWOOD
California Retired County Employees Association

HARRY H. HATCH
SEBA

PHYLLIS M. PIPES
Newport Mesa Federation of Teachers Retired and
California Federation of Teachers Retirement Committee

PAUL ROLLER
Los Angeles County Professional Peace Officers
Association

JAMES A. SPAULDING
RPEA

WAYNE PALICA
San Diego County Court Employees Association

DOUG STORM
Retired Employees Association of Orange County

BOB BLOUGH
San Bernardino Public Employees Association

A P P E A R A N C E S

Public Testimony
continued

RALPH BICKER
Retired Public Employees

MARK A. KLEIN
SEIU Local 721

LOUIS SCARPINO
Orange County Retired Employees Association and
California Retired County Employees Association

Gary Eisenbeise
Retiree

WANDA D. MALONE
California School Employees Association

DAVID A. ELDER
Dave Elder Consulting

JAMES KREG MULLER
Huntington Beach POA

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Presentations

MICHAEL CARTER
Chief Operations Officer
State Controller's Office

ALEX RIVERA
Gabriel, Roeder, Smith & Co.

JASON F. DICKERSON
Principal Fiscal and Policy
Analyst
Legislative Analyst's Office

STEVEN FRATES
Senior Fellow
Rose Institute of State and Local Government

KEN JACOBS
Chair
UC Berkeley Labor Center

A P P E A R A N C E S

Presentations

TOM SHER
1st Vice President
Public Entity Benefits Group
Alliant Insurance Services

JARVIO GREVIOUS
Deputy Executive Officer for Benefits Administration
CalPERS

JACK EHNES
Chief Executive Officer
State Teachers Retirement System

ROD DOLE
Auditor-Controller-Treasurer-Tax Collector
Sonoma County

ROBERT AGUALLO
Chief Executive Officer
Los Angeles City Employees Retirement System

TOM SMITH
Chief Financial Officer
Peralta Community College District

CRYSTAL HOVER
Chief, Human Resources Benefits
San Bernardino County

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BE IT REMEMBERED that on Thursday, May 31, 2007, commencing at the hour of 10:02 a.m., at Central Park Community Center, 11200 Base Line Road, Rancho Cucamonga, California, before me, DANIEL P. FELDHAUS, CSR 6949, RDR, CRR, in the State of California, the following proceedings were held:

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CHAIR PARSKY: Good morning, everyone. I want to welcome those of you in our audience to the third meeting of the Post-Employment Benefits Commission.

First of all, I want to thank the City of Rancho Cucamonga for letting us use this beautiful facility.

And I understand that special thanks are due to Mayor Don Kirth, as well as Mayor Pro Tem Diane Williams, City Manager Jack Lamb, and all of the members of the City Council. On behalf of all of us that are working on this commission, I want to thank you all very much.

And also, Paul, a good member of our commission for arranging this location.

Paul, thank you very much.

I think for everyone's convenience, the agenda for today has been posted and is certainly available.

Today, the Commission will hear from a variety of subject-matter experts who will provide us their views

on the costs of health care for retirees in California. We will also hear from representatives of local government on their experience at dealing with unfunded liabilities of these benefits.

We've attempted to provide some time for the Commissioners to discuss these issues at the end of the meeting. And we'll try to work as efficiently as possible.

Before we turn to the public comment period, I just wanted to remind everyone of the purpose of our commission. And it's really threefold.

It's to identify the amount of the post-retirement pension and health-care liability in California, helping the public to understand the amount that reasonably can be anticipated to need funding, to evaluate approaches for addressing these unfunded obligations, and to propose a plan to handle them.

I think it's very important to bear in mind that this commission was established on a bipartisan basis with the Governor and the legislative leaders. And all parties made it clear that promised pension health-care benefits to existing employees and retirees would be met.

One of our tasks is to begin to identify in a rational way the magnitude of this potential

responsibility and to propose ways in which those obligations can be financed, so that they can be met.

With that, we'd like to turn to the public-comment period.

I think this morning we have 15 speakers.

We have a microphone here. And we'll try to do this in a two-minute time frame. We won't be too rigid, but we'll certainly accept all of your comments in writing. But if you could try to hold your commentary to the two minutes each, it would be appreciated.

Our first three speakers in this order are Donna Snodgrass, Bill Kirkwood, and Harry Hatch.

Donna, you're first.

MS. SNODGRASS: Thank you. Good morning, Mr. Chairman and Members of the Commission. And welcome, once again, to Southern California.

I'm Donna Snodgrass, vice president, California State Employees Association. And I will be brief this morning.

Ladies and gentlemen, some people are going to be throwing around a lot of big numbers at this hearing today. Some will be doing it to frighten us and make us believe the sky is falling, to recommend radical solutions to solvable problems. But you know better. Earlier this month, State Controller John Chiang

announced a $48 billion GASB figure for health care. But he also said, and I quote, *"We need not panic or rush to judgment. This obligation was not a crisis 30 years ago, was not a crisis yesterday, and it is not a crisis today. And if we work toward a plan to pay this obligation in a reasoned manner, it will not be a crisis 30 years from now,*" unquote.

Yes, $48 billion is a big number, but we don't have to pay it this week, this month, or even this year. In fact, we have 30 years to pay for it.

Let's put it in perspective. Over in Northridge, there's a neighborhood where the cost of homes goes from $850,000 to over $1.2 million. Those are big numbers, too; but they haven't stopped people from buying houses. Why? Because they have it financed over 30 years, and they don't have to pay for that all at once.

The same is true for these health-care costs. There is no need to stop providing health care to our public servants. We could come up with a reasonable, responsible way to pay for them because we can pay for them over time. The bomb is not ticking and the sky is not falling.

Last year, the Legislature passed a bill that would have allowed the State in advance to pay for

health-care costs for future retirees. It would have meant that, ultimately, we would have had 75 percent of the cost of those health-care benefits from investment income, not from employees and not from taxpayers. And that's exactly what the CalPERS pension system does. There is no reason we can't do the same thing for health care.

Unfortunately, Governor Schwarzenegger vetoed that prefunding bill last year. This year, we have an opportunity to correct that mistake. And it's my hope that this Commission, the Legislature, and the Governor will take advantage of this new opportunity.

Thank you.

CHAIR PARSKY: Thank you very much.

Bill Kirkwood, then Harry Hatch, and Phyllis Pipes.

Bill?

MR. KIRKWOOD: Thank you.

Commission Members, I appreciate this opportunity to address you. My name is Bill Kirkwood. I'm president of the California Retired County Employees Association. That's 100,000 members in 20 counties.

I spoke to you in April in Orange County, and my background and opinions on retiree health issues are very well documented on your very excellent Web site.

Your Web site also documents actions taken by boards in various other counties. These actions appear to be quick responses to trying to do a fix on GASB. Unfortunately, retirees are the easy targets. Their health-care costs are controlled by -- usually controlled by two factors. The retirees are combined with active employees in a pool, which smoothes premiums over the entire group. This arrangement has been in existence in Orange County for over 20 years.

In addition, many '37 Act counties also grant subsidies based on years of service. I have seen reports from San Diego, San Bernardino, Contra Costa, Tulare. It would be easier to name the counties where I have not received reports, whose retirees' benefits, health benefits, have been threatened by either the retirement system or the board of supervisors.

The Orange County Board of Supervisors took the draconian action of eliminating the pool and severely reducing the subsidy. The supervisors did not require nor did county staff analyze the effects of this action on the individual retiree: Their age, income, ability to pay. And consequently, retiree associations have responded by establishing special funds to hire legal counsel. Some associations that reincorporated to facilitate PACs to start lobbying.

I'm not sure we ever wanted to get into this business when we retired.

CRCEA, my organization, has authored Assembly Bill 552, which would have reduced the effect of Orange County's action, but it has been put on hold until your report is in. So we're all holding our breath for the Commission's report.

But it's amazing that the increased benefits to active employees and the development of some accounting principles has suddenly put these older retirees in such an untenable position.

Seniors who thought they had financially provided for themselves are suddenly facing a real change in lifestyle. Older retirees on pensions of 25,000 a year are now facing financial peril or looking at Medi-Cal.

I believe this esteemed committee, with its ability to assemble large amounts of factual data, will propose solutions to resolve these issues. Retirees certainly hope so.

Thank you.

CHAIR PARSKY: Thank you.

Harry Hatch, Phyllis Pipes, and then Paul Roller.

Harry?

MR. HATCH: Good morning. My name is Harry Hatch. I am a member of the San Bernardino Sheriff's Department for the last 33 years. I've been in law enforcement for about the last 42 years. I've sat on the board of retirement for the last 12 years. However, I am not here speaking for any of those organizations today. I'm giving you a personal perspective on retirement.

In '93 I was retired, medically. I came back. I fought my way back because I am a public servant, and I have been involved in public service. This is what I do.

At the present time, I'm assigned to the Sheriff's bomb squad.

These are some of the perspectives that I want to give you from where I'm coming from.

At the present time, my wife is retired from San Bernardino County. She is on a medical program through my department because I'm still active. She is currently, as we speak, in intensive care.

I am here because this issue is important enough for all people -- not just county employees, but all people within the State of California.

In the past several years, our county has gone forward and attempted to make some changes to help on the health-care issue.

Our fund at the present time is over 90 percent funded. There is no problem with our fund in this county, nor are there any problems with any of the SEACRS counties, State Employees Association of County Retirement Systems. But the issues come up for these unfunded liabilities.

Each county has addressed the medical health-care problem differently. Our county, our boosters has stepped forward in cooperation with our association; and we are now paying our sick leave into a VEBA account for future retirees to have some medical coverage after their retirement.

But this still leaves our retirees out there who were not able to benefit from this at this time that are out in the open.

At the present time, I can retire, I can walk out the door today; however, I can't because of the medical insurance. If I leave, then it's going to hit me hard with my wife's problems.

These are the issues that come to each of us on a daily basis.

Our county again -- our county treasurer, Dick Larson, has made some efforts on Pension Obligation Bonds to limit the County's funding problems. Our board of supervisors has moved forward with the VEBA account.

Our association is paying back 2 and a half percent towards the 3 percent at 50 forever, to help offset the funds that are being paid for the 3 percent at 50.

This county has been financially and fiscally responsible in their decision-making process.

This Commission has an opportunity to look at the health-care problem; and that's where your focus really needs to be, on the health-care problem.

Our funding is good. Our association, our retirement association is in the top 10 percentile of the entire United States. We're making money. However, we're not making enough money to cover health-care costs as well as covering the benefits that people have been given.

These are the issues that you need to look at. These are the types of things that we are addressing on a day-to-day basis at the retirement boards.

You'll hear from some of our retirees today. Some of them will have problems with what is going on in our local area. But these things are being addressed. We are working on them.

The Board of Supervisors is on board, the county associations are on board, the retirement is on board, and so are our retirees. We're working together

to solve our problems. But we do need some help in the health-care area. That's where your focus should be.

Thank you very much.

CHAIR PARSKY: Thank you.

Phyllis Pipes, Paul Roller, and then James Spaulding.

Phyllis?

MS. PIPES: Hello. My name is Phyllis Pipes. I am chair of the Newport Mesa Federation of Teachers Retired and a member of the California Federation of Teachers Retirement Committee.

I retired from teaching in 1997 at age 60, after 36 years and a half of teaching in the Newport Mesa Unified School District in Orange County. The district paid my health benefits until I became 65 in 2002. At that time, I went on to Medicare, Parts A and B, since I was eligible through my husband. In 2002, Part B was $54 a month. It is now $93.50 a month.

I also went on to my husband's insurance plan for supplemental coverage. In 2002, the premium for both was $490 a month. Five years later, it is $644 a month.

Since I have been caring for my elderly mother who, by the way, is 91 and has a twin sister who is 91, and both are retired teachers from the Santa Ana Unified

School District, I decided to take out long-term care insurance so my children would not have to care for me if I became ill.

The insurance was $98 when I took it out. It is now $111 a month. And in July, it will go up 17 percent, to $131 a month.

I'm a diabetic. Although Medicare and my supplemental plan covers some of the costs, I still pay about $120 a month.

As you may know, retired teachers receive a 2 percent COLA every September. This 2 percent is on the amount received per month ten years ago. It is not compounded as it is for those retired under PERS, Public Employees Retirement System.

For many years, especially during the 1990s, when I was teaching, the teachers often took little or no salary increase, so the district could afford to pay for our health benefits. This has come back to cost us since our retirement is figured on our three highest years of salary and the number of years of employment. The total amount of COLA a month I receive after ten years is $598.18. The amount I put out each month for insurance and medication amounts to $666.50. And I have no dental or vision coverage. Every time I receive a 2 percent increase, my taxes also go up. With increases in all our

living expenses, such as fuel, food, utilities, et cetera, I am losing ground. I feel the biggest reason is what I put out for health benefits and medication.

Thank you.

CHAIR PARSKY: Thank you very much.

Paul Roller, then James Spaulding, then Wayne Palica.

MR. ROLLER: Good morning, Mr. Chairman, Members of the Commission.

I'm Paul Roller, the executive director of the Los Angeles County Professional Peace Officers Association. We have about 7,500 members, most of them sworn officers.

Since the year 2000, 11 deputies have been killed in the line of duty in Los Angeles County. That is more than virtually any other agency in the State of California, except for the Highway Patrol. It's a dangerous profession.

Every one of those deputies, when they were hired, were promised that if they did their job for a whole career, protecting the public, that they would retire with an adequate pension plan and retiree health care.

Unfortunately, those 11 officers did not make it to retirement. But as you know, most officers do make

it to retirement; but regrettably, those that do have a shorter life expectancy than the average Californian.

Specifically on today's topic, in Los Angeles County we have chosen to forgo the highest safety retirement formula in order to get the best possible retirement health care for our members, probably better than any other group that will speak today in Los Angeles County, our health-care plan.

Please, by your actions and your subsequent recommendations, don't do anything to harm or to cause LA County to go back on the promises made to those to that protect all of us.

Thank you.

CHAIR PARSKY: Thank you.

James Spaulding, Wayne Palica, and then Bob Blough.

MR. SPAULDING: Thank you very much for the opportunity to speak.

I have a report.

I'm with the Retired Public Employees Association. I'm speaking here for myself as a retiree from the City of Long Beach.

The City of Long Beach does not offer health insurance, health care when you retire. You can purchase it or you can accumulate your sick time to be able to pay

for your health insurance. When that's over, you pay for it yourself 100 percent.

Many of our problems of other public agencies, the contract agent is not paying for the insurance, but finding an avenue to pay for it -- or to find an avenue where you can buy it.

This is a very serious problem, to be able to find some insurance coverage where you can go and get decent insurance at a decent price with decent coverage.

Many of the coverage, when you go out in private, has a serious cap on it and other restrictions, many restrictions where you do not qualify for it.

I hope there is a way we could find an avenue where retirees, between the time they retire to their Social Security, can purchase health-care insurance.

Thank you very much.

CHAIR PARSKY: Thank you.

Wayne Palica.

MR. PALICA: Chairman Parsky, Members of the Commission, good morning.

My name is Wayne Palica, and I represent the San Diego County Court Employees Association, over 1,000 employees who serve the public in the courts in San Diego.

The importance of this commission cannot be

overstated. The work you've done so far and what you will accomplish over the next several months is essential to ensure that California's dedicated public servants are allowed to retire with dignity and will not be forced to become a financial drain on California's resources.

What this Commission develops over the next several months will have far-reaching impact to California's working men and women, current and future retirees, and the State's financial resources as well.

It is imperative that the retirement benefits employees have earned over the years through the give and take of the collective bargaining process are not unfairly diminished. Your recommendations must take into consideration the need for each governmental agency and the respective employee organizations to maintain local control.

Local control will ensure that what has been negotiated in good faith is not changed by those who had little or no involvement and no historical data on the collaborative efforts that led to the agreements between the parties in the first place.

For the health-insurance crisis to be fairly addressed, individual employees cannot be expected to be left holding the financial bag, nor should decisions be made by those without the knowledge of what was

sacrificed by active employees in order for them to receive the pensions and health benefits they were promised and deserved.

Your expertise, your commitment, and your diligence can help ensure that governmental agencies and employee labor organizations can continue to work together in a collaborative fashion while addressing the unique issues that they are faced with at their local level.

On behalf of the working men and women who make California the great state that it is and the dedicated public servants who make up the San Diego County Court Employees Association, thank you for your efforts and your commitment to the task.

CHAIR PARSKY: Thank you very much.

Doug Storm, then Bob Blough, and Ralph Bicker.

Doug?

MR. STORM: Good morning, Chairman Parsky and Members of the Committee.

My name is Doug Storm. I am, as of last week, co-president of the Retired Employees Association of Orange County, along with Linda Robinson, who is here in the audience this morning.

I retired after 32 years of service to the public with the Orange County Sheriff's Department and I

served at the rank of Assistant Sheriff.

I sincerely want to thank the Governor for having the insight for having this commission here and throughout the State, finding out what is occurring and what actions need to be taken.

We all want reasonable solutions to the GASB issue and to unfunded liabilities, but we don't need solutions that have unintended and dire consequences.

Orange County, as most of you know, took some action that significantly cut medical benefits to their employees and drastically increased the costs. The reason they gave was that the alleged 1.4 billion in unfunded liability would cut our credit rating and have a significant financial impact on the future of the County.

At the same time, they negotiated with current employees significantly higher rates of compensation. Those rates of compensation were traded for future retirement benefits.

Those same reductions were handed to retirees without the increased compensation, and the retirees had no input into that process other than the notice that the benefits were going to be cut.

The sad part of this effort is that if you calculate the increase in benefits, they far outweigh the 1.4 billion in unfunded liability that the County was

going to save.

Based on the testimony at the prior commission meeting, we now know that the rating agencies are not going to unilaterally reduce credit ratings. They'll look at the counties on a county-by-county basis and do what's best for each one of the counties, the way that they should be.

The consequences of a process that erode confidence in the future of those retirees erodes and undermines the public confidence in our elected representatives.

Following all of your public hearings, you will propose a plan to the Governor. My message here today is please do not pull the health-care rug out from under retirees.

What is occurring in Orange County should be a wake-up call, not only to all employees in Orange County, but to everyone here and to all of you sitting up there.

We know that Medicare and Social Security are not secure. We need to plan ahead, we need to do a good job of financially looking at these issues and taking care of them.

And if I can speak to you just real bluntly as an assistant sheriff, I had a motto for the last ten years, and I've worked for a couple of very colorful

sheriffs. And my motto was: It's not the sheriff's job to be right, it's my job to make him right.

And over the years, you've made suggestions in a very professional way, of the way something might be done. You know, two heads are better than one, even if one is a pumpkin head, and I'll represent that pumpkin head.

But if there's one thing the Commission could do today that could help us in Orange County, it might be to issue a letter from the Governor. Just that you're here, you're working, and you're taking a look. It may be like we do with our children that react and don't do things properly. We ask our elected officials that have already taken action, to take a time-out. Wait for the Commission to issue their report, and then intelligently move forward.

Thank you very much.

CHAIR PARSKY: Thank you.

Bob -- is it “Blongh”?

MR. BLOUGH: Blough.

CHAIR PARSKY: Blough?

MR. BLOUGH: Good morning again, Commissioners. My name is Bob Blough. I'm the general manager of the San Bernardino Public Employees Association, representing public employees in 28 cities, from West Covina to

Needles, and the majority of the San Bernardino County employees.

Like most public employees in this state and like many of you, these hard-working employees dedicate their careers and lives to provide important public services to Californians. Everyone has heard a lot about the health-care crisis lately. Usually, we read in the media about the uninsured because the problem is so frustrating for Californians.

Many don't realize, though, that the uninsured problem involves a significant number of retirees that simply can't afford the premiums.

We are also concerned about the health care shared by millions of people here in California who are insured. We ask that the deliberations of this Commission include consideration and recommendations to affect the global remedy of the health-care crisis here in California, addressing the crisis faced by retirees on Medicare, retirees in the gap between retirement and Medicare, and the thousands of retirees that don't qualify for Medicare, even though they gave 20, 30, or even 40 years of their lives to public service.

The best single remedy to this crisis needs to start before retirement.

We have seen how personal health issues can

turn the lives of entire families upside-down even with insurance. The majority of bankruptcies in this country are related to illness. Of those bankruptcies, over two-thirds have insurance, but it doesn't cover their needs.

Across this great state, fewer employers are offering health care to their employees. And many are reducing the coverage that they offer because the health care is becoming unaffordable to the employers as well. That means all of us end up with more costs, less care, and a growing sense of concern for the future well-being of our families.

We must make sure that the health care is affordable and covers all the basics: Preventive care, prescription drugs, and hospitalization. Otherwise, it isn't health care at all.

Individual mandates won't work. $5,000 deductibles won't work. Unaffordable premiums and prescriptions for employees, retirees, and employers won't work.

Preretirement employees are losing ground on their ability to feed and care for their families because health-care costs have been rising so fast. Post-retirement brings new choices, such as: pay for health care or eat, pay for prescriptions or cool the

house in the summer, pay the co-pay to see the doctor before your health deteriorates or die because health care is simply unaffordable.

We appreciate your work on this.

Thank you.

CHAIR PARSKY: Thank you very much.

Ralph Bicker, then Mark Kline then Louis Scarpino.

MR. BICKER: Good morning, Mr. Chairman and Commission Members. My name is Ralph Bicker. I worked for the City of Pasadena as a civil engineer almost 38 years. 1949 through '86. And I speak as an assistant area director for Retired Public Employees. I've been involved with RPEA for -- ever since I retired.

While working for the City of Pasadena, they paid the cost of my medical insurance. I always had to pay the cost for my family.

When I retired in December of 1986, the City decided that they would generously contribute $1 a month toward the cost of my medical insurance. I do not remember exactly what my coverage cost me, but I believe it was less than a hundred dollars a month.

Over the first 15 years or so of my retirement, Pasadena continued their generous contribution towards the cost of my medical coverage. In fact, they even went

so far as to increase their contribution over the 15 years by about a dollar a month, until it reached $16 by the time I retired in 1986.

My out-of-pocket cost for supplement to Medicare at that time ran around $600 a month.

At the time, Pasadena decided to pull most of its current employees, as well as all of its retirees, out of the State-sponsored PEMHCA program, health program, they offered us a supplement to Medicare program that, outside Medicare, costs an additional hundred dollars more than the plan we were under with the PEMHCA program. Then about two and a half years ago, they went back into the PERS PEMHCA program because the cost of their outside insurance rose beyond that.

Right now, I'm paying in the neighborhood of $750 a month for the PEMHCA coverage for my wife and myself. This is in addition to $172 a month I pay for Medicare, while the City contributes generously about $19 towards my coverage.

As an assistant area director for RPEA, I covered chapters of retirees from Santa Barbara, down to Long Beach, and in as far as Pomona; and I found that there were many, many of our retirees that were in a similar boat that I am in. And we really need the help of this commission to try to do whatever they can to help

the retirees out.

I have copy of this that goes into just a little bit more detail. It's on one page. And I will submit it.

CHAIR PARSKY: Please provide it to the staff, and we're happy to have it.

Thank you very much.

Mark Klein, Louis Scarpino, and then Gary Eisenbelse, I think.

MR. KLEIN: I want to thank the Chair and the Commission to this opportunity to address you today.

I am on staff in the field of political coordination for secure retirement for SEIU, Local 721.

We represent almost 90,000 members in the counties and municipalities of Los Angeles County, Orange County, San Bernardino County, Ventura, Santa Barbara, San Luis Obispo. And we are very concerned about a lot of things that are happening.

First, let me say that in the last couple of days, I believe it was, in Los Angeles County we were -- LACERA was able to disclose the GASB figures of the accrued actuarial unfunded liability for Los Angeles County. And it was slightly over $20 billion. And before anybody goes, "Oh, my God," please consider that Los Angeles County is about 40 percent of the population

of the State of California. So when you're looking at a liability -- a so-called liability in the State of California of about $48 billion, $49 billion, you know, no big surprise.

Secondly, let's look at the definitions. Los Angeles County does not owe twenty-plus billion dollars to anybody right now; okay. This is an estimate, a projected estimate over more than 30 years. It is not anything that is owed.

We have seen -- and, by the way, the other point I want to make, and you've heard story after story, and I'm sure for the life of this Commission, you will continue to hear these stories -- the problem is not the fact that people retire and expect their earned benefit; the problem is that the health-care system in this country is broken. Period. It is broken.

You have in Los Angeles County a doubling of the health-care costs of Los Angeles County in retiree health care in just the past five years.

If anybody thinks that that is sane, rational or sustainable, I suggest that you are not sane or rational.

So that is what really needs to be fixed here. And truth needs to be addressed.

We see headlines -- ever since the GASB rules

43, 45 were announced, we've seen an accumulation of newspaper articles and editorials throughout the country, saying, "Oh, my God, this train is coming down the tracks and it's going to crush the taxpayer."

Nowhere in those stories do you hear these are estimates, these are based on certain assumptions that can change over time, these are based on a health-care system that is out of control that can be solved, these are problems that can be solved. No. Instead, you have a panic and a fear that is created; and, therefore, pressure is placed on boards of supervisors and other elected officials who move precipitously to really endanger, literally, the lives of retirees and government employees.

What we need from this commission is a little bit of truth-telling. We need you to tell the truth about what these problems are, what these solutions are.

In Los Angeles County, we are working as the union representing about fifty-some odd thousand LA County employees. We are working in very active cooperation with LA County to come up with a solution.

If you took that twenty-some-odd billion dollars and you simply prefunded, that drops to about 13 billion. If you fix health care, it goes away.

So let's tell the truth and not allow

ideologues to turn this into a fight attacking the rights of public employees who perform necessary services for the public.

Thank you.

CHAIR PARSKY: Thank you very much.

Louis Scarpino, Gary Eisenbeise and Wanda Malone.

Louis?

MR. SCARPINO: Chair Parsky and Commission Members, thank you for having me.

I'm Louis Scarpino. I'm recently retired from Orange County, where I worked corporate budget policy and health-care legislation matters over the various years.

I'm also working with the Orange County Retiree Association and the California Retired Employees Association that serves 20 counties, 1937 Act counties. We're working hard to try to help you and to help ourselves craft solutions to the medical issue.

And I planned to address this committee at your last meeting, but I was thwarted by some ten days in the hospital. And I don't recommend it. You can lose a lot of weight that way, so that's a good thing.

But other than that little silver lining, I think there were some others. And that is, first, I had a firsthand reminder of what a rapid deterioration of

health can do to one's energy, spirit, and sense of well-being. It also heightened my concern for those in our retirement ranks that are in real danger of losing their medical insurance or have none, to begin with. The combination is just unimaginable and frightening.

But the last silver lining that I did get out of this, is that I got a chance to quietly -- I had a lot of time -- to review the testimony that you received to date. My only one suggestion there is if you could keep it shorter, it would be nice. 300 pages is a bit much.

CHAIR PARSKY: We'll try.

MR. SCARPINO: But having said that, it allowed me to come up with I think four hopefully useful conclusions that I'd like to share with you today. And it goes back to my trend that every Tuesday is board meeting, and you have to have solutions. So I don't think it helps to stand up here and just tell you all the things you need to do but, rather, give you some recommendations that are helpful.

So number one, I'm heartened by your commission's focus on finding ways to responsibly finance pension and OPEB obligations. However, it's clear from reading the testimony and from listening to your questions that you understand a key question is: What constitutes a current retiree medical obligation? It's

not clear how to address this question, and I think it's one that's before you.

I can tell you this: You've heard a lot of discussion about local control.

I, as many of you probably have, have worked numerous statewide budget funding policy issues. And I can tell you firsthand that crafting a one-size-fits-all solution for 58 counties, much less all the other government jurisdictions, is next to impossible, and a good percentage of the time just plain impractical.

So my conclusion and recommendation on this point is to keep it simple. You've heard conflicting solutions centered on changing local-controlled solutions. I would submit that only one major change is necessary, and that is essentially prohibit potentially very expensive cost-shifting to the State and unrepresented beneficiaries. And we can go into that at a different time for some detail.

The second area I would talk about is, you've heard a lot of testimony about setting actuarial standards. Now, my team and I in Orange County have had direct meetings with some of the same actuaries that have provided you with testimony at the last meeting. We even reached agreement on concessions that dramatically reduced the 1.4 billion-dollar medical unfunded liability

that was being pitched in the paper -- and, in fact, has been kept as the number all the way through the decision-making process.

Conclusion 2, or Recommendation 2 to you: Keep it simple. Apply the 80/20 rule strategy. Certain assumptions will be very powerful. Focus on those. An example is utilization of medical retiree.

In Orange County, it was 57 percent. I think you've heard that number before. But the number used to get to 1.4 billion was 100 percent. So you're starting with a much larger problem than you need to be starting with.

These kinds of things are not micromanaging the actuarial process, which would be, I think, a drastic mistake since it's such a complicated area, but it would be definitely an area where you can get a handle on those elements that really push these numbers up.

I think John Bartel last time had talked about an oversight committee made up in part by actuarials; and I think that's not a bad idea. That would help get into some of these issues.

Remember, this is a very new process, and they're going to be very conservative at the front end. So we want to get in here and try not to overreact to conservative numbers that will mature over time.

My third recommendation, moving on, you've heard limited testimony on investment strategies. Now, the Orange County bankruptcy -- another thing I don't recommend to anybody -- has taught me that tough times call for strength and political will to challenge the current paradigm. My conclusion is that you need to focus on changing the paradigm essentially by expanding the menu of tools, not the opposite direction of micromanaging.

Look at the massive wealth that's being invested from pension systems, set up mechanisms to focus a large portion of those investments in California and on the problem at hand. And I'll emphasize that again: In California, not in other states, where we can get the tax revenue, and on the problem at hand, specifically escalating medical costs and increasing retiree populations.

Look at reserves, potential seed money for priming the prefunding pump.

Look at incentives and remove obstacles to creation and participation in more cost-effective medical purchasing pools.

And my last recommendation, Number 4, I believe it was Dr. Ghilarducci, if I've pronounced that correctly, that expressed a need to not just inventory

liabilities, but cast them in the context of true economic models. I would absolutely encourage that, complete a multi-dimensional economic model against which proposed solutions -- that is, expanded tools -- are tested. Retirees spend in the local economy. Retirees often continue to work, enhancing the economy. Retirees generate tax revenue. It's all part of a large system.

And one thing I never hear talked about is we're always talking about the cost on the retirees' side. Well, maybe it's just my old 25 years' worth of budget experience, but there's a sponge principle in budgeting: You squeeze one end and it comes out the other.

Look at the total employer budget impact. You are spending -- a later-age retirement usually mean higher active salaries for longer periods. These higher salaries are paid at 100 percent taxpayer expense. Whether it's claimed or otherwise, it's still 100 percent taxpayer expense. There's also higher retirement amounts that have to be paid. This is opposed to substantial salary savings from new hires and lower pension payments; and these are paid in part from investment earnings. So it doesn't make sense to just look at half of the equation, because the money is still coming from the taxpayer through the employer.

And with that, I thank you and will be available later for questions, if you need to.

Thank you.

CHAIR PARSKY: Thank you very much.

Gary Eisenbeise?

MR. EISENBEISE: I'll pass.

CHAIR PARSKY: You can come to a future meeting if you want to comment. It's perfectly okay.

Wanda Malone, David Elder, and our last speaker will be James Muller, I think.

Wanda Malone?

MS. MALONE: Good morning.

Thank you for being in Southern California. And I'm glad we're not blowing you away this morning.

I am a retired classified employee from our Chaffee Joint Union High School District. And when I retired in 2003, I was told that Medi-Cal would pay -- Medicare is going to pay for my premium, because I have Kaiser insurance. That was all well and good.

And our co-pays have raised since 2003 from $10 to $30 on medical and visits.

Also, as of this January, Kaiser now is being allowed -- because they have petitioned to the federal government -- is being allowed to charge $47 a month over and above your Medicare.

I understand that that is going to be a thing from all insurances in the future. They just have to go through the process of getting it approved by the federal, so they can charge over and above the Medicare price for your premium. So that is not too bad for somebody that doesn't have to go very often; but for people that have to go a lot, it is really draining their budget. As you've heard from some of them here today, they are really in bad straits.

And I don't know how we can stop the Medi-Cal thing of going up every single month -- or every single year. And you have no control over that. And now the insurances are going to be charging you over and above the Medicare, too.

I'm very grateful my PERS retirement, that is wonderful. And I think it should be continued for anybody that's liable for it because it is -- it gives you a sense of relief when you retire that you know what's going to be there. And after you've worked all the years to get it, it's a great benefit.

I'm not objecting to what I get from my Social Security. I just wish that there was more control and you could handle it better on having some say on what they can do. We have no rights to vote on it; it is just taken from us.

Thank you very much and have a good day.

CHAIR PARSKY: Thank you very much.

David Elder.

MR. ELDER: Good morning, Commission Members and Mr. Chairman, former speaker, others assembled.

I served 14 years in the Legislature; and regrettably, that's not long enough to get a pension in the Legislature unless you're over 60. So when I retired at 56, after 16 years with Long Beach and 14 with the Legislature, I got a 1.6 percent retirement benefit for my 14 years in the Legislature, and at a much lower benefit factor.

I just want to let you know that some of the mythology that exists about pensions in the Legislature is exactly that: Mythology.

When I was in the Legislature, one of my constituents I was in a conversation with about how she dealt with medical costs, and she said to me, she says, "Well, I just don't deal with California medicine."

I said, "What?"

She says, "When I get sick, I go to the Mayo Clinic. It's a lot cheaper, and the airfare isn't that bad," you know.

So I think we have to think a little bit outside the box when it relates to some of these issues

of health care.

Clearly, the Mayo Clinic would be a desirable place to receive medical treatment.

Talking about our teachers' situation, 40 percent of them do not have health care in retirement. And one of the things that could be done, at no cost to the taxpayer, at the total cost to the teachers, is to allow a temporary annuity for members of the State Teachers Retirement System. The way that works is that for a period of time -- say, they retire at age 60, there would be an X-amount of dollars per month for five years, until they become Medicare-eligible. They pay this total cost.

I did the same thing when I retired at age 56. And I took a 2,000-dollar increase in my pension for six years, until I would be eligible for Medicare -- or for Social Security. And what happens is, the $2,000 a month that I got reduced my pension benefit by $800 a month permanently.

So in the case of teachers, they could get enough money in a temporary annuity to bridge the period of time from age 60 to age 65. And this is a way that they could pay these health costs, which the districts have to sell to them. They have to sell this health insurance to them under AB 526 which I carried and

required and was signed into law, the districts have to provide this.

Another thing that needs to happen there is those costs need to be pooled because some of these districts are very small. I mentioned this in my last presentation before your body. At which time, if these are pooled, it will not be so great a burden to each district, which may have a catastrophic occurrence in a very small labor pool.

So that's a couple things you can do that are free and will help our teachers mightily.

Health-care costs in the United States are $2.1 trillion according to a presentation I heard before the Commonwealth Club of California in March. George Halvorson, the CEO of Kaiser, mentioned that it's $2.1 trillion. So our costs in California, if we're 10 percent, are $210 billion. That's about twice the State budget. So we have some idea of how many dollars we're talking about here.

Mr. Halvorson indicated that the 75 percent of these costs are with five chronic conditions: Diabetes, asthma, congestive heart failure and coronary artery disease, and depression. Again, diabetes, asthma, coronary -- chronic -- I can't say it -- coronary heart disease, and congestive heart failure and depression.

Those five things mean 75 percent of the costs.

Cancer is 5 percent, and according to Mr. Halvorson, maternity costs are 4 percent. So we need to focus on these costs.

Another thing that needs to happen according to his presentation is that the medical mistakes that occur in this country are killing the equivalent of two 747 airline passengers a day. If he is right, that's a significant toll of human suffering. I mean, think about it, 700 people a day are dying from medical mistakes.

As an example of this, 120 doctors were given the same patient for diagnosis, and they came up with 82 separate treatments. This is pretty sad when you think that we always pat ourselves on the back as being the best in the world.

Mr. Halvorson's comments on this were -- I think the recommendations were worthy of study. And I would suggest that you get a copy, a CD of that presentation, the Commonwealth Club of California. I think it was March 17th, 2007.

This Commission needs to spearhead, in my view, the universal coverage, which according to Mr. Halvorson would be free in three years when you eliminated the cost shift. In other words, if everybody were covered, we

would not -- those of us who are paying for health insurance would not have to pay for the uninsured.

Also, another initiative that he strongly recommended is get rid of the paper records. Right now, it's impossible to keep track of what's going on with a particular patient because every time they see a provider, the records are at that provider's office, they are on paper, often illegible. And I think often in the case of doctors, proudly so, maybe help their litigation strategy, I don't know. But in any event, it's an unacceptable medical practice.

A start, which again would be free, would be the implementation of two bills which I carried and got signed in the late eighties and early '90s. AB 373 and AB -- I believe it's 1479, although I'm not quite sure. It's in the records.

It sets up a catastrophic plan in California. It's paid for by the individuals.

I stole this idea from the Wall Street Journal -- you know, a notoriously liberal newspaper. And this existed in Montgomery County, Maryland, and the District of Columbia, which is hard to think of anything starting in the District of Columbia that's worthy of emulation. But in any event --

CHAIR PARSKY: That's The Wall Street Journal

of Los Angeles or the Wall Street Journal generally?

MR. ELDER: I think it's in New York.

But, in any event, the premium for this catastrophic policy at that time was $68 a year for a family.

Now, you know, let's say it's $300 a year now. Still, we could cover -- everyone in California could have this plan. Neither Governor Wilson, nor Governor Gray Davis implemented this legislation. It's on the books.

So if any of you are close to the Governor – I assume some of you must be -- you might want to say, you don't need the Legislature for this; it's already on the books.

So with that, that's all I have as it relates to health care right now.

But I would strongly recommend you get a copy of that presentation by George Halvorson.

And I think this Commission needs to push for universal coverage and modernization of medical records.

Thank you.

CHAIR PARSKY: Thank you very much.

Our last speaker is James Mueller -- is that right?

MR. MULLER: James Muller, sir.

CHAIR PARSKY: Muller? Sorry.

MR. MULLER: Mr. Chairman and Commission Members, good morning, and thank you for allowing public input on these very important topics.

My name is James Muller, and I'm the president of the Huntington Beach Police Officers Association. I represent approximately 250 members.

I first want to make a quick comment on the hearing that took place in Orange last month. I really appreciated the Commission questioning the panel members that made presentations. It was obvious to those of us in the audience that a lot of facts and figures that Mr. Moorlach was throwing out had factual basis, and it was follow-up questions from you that made that clear.

What Supervisor Moorlach did to retirees in Orange County should be criminal.

I will also say that it is reassuring to hear from this Commission that the Governor does not want to tackle these issues on the backs of the retirees.

I've been in law enforcement for 20 years come this October. These are very interesting times we live in. The agency I work for has one of the best contracts in Orange County. We also have a great reputation as an excellent place to work. With these facts, we can't fill our positions. We desperately need officers and

dispatchers. We are not alone.

It is the same story throughout the state and across this country.

I believe one of the contributing factors is the constant attacks on our retirement system and our medical benefits that make people believe that working for the government is not a secure career.

This lack of willing and qualified candidates is not limited to public safety jobs. Our state and local governments must have the proper staffing to fulfill our missions. We also cannot settle for unqualified workers or ones with questionable backgrounds.

Public employees have great access to data and resources that could devastate our populations if it was misused.

Let me move on to the retirement issues.

I find it very interesting that there continues to be attacks on the current CalPERS retirement system. CalPERS' history shows that it is one of the most successful retirement systems in the world. The amount of money they contribute to our state's economy is huge. They also charge us very little to do it.

What is the main reason that there has been such a huge push to move away from our current system for

a 401(k)-type system is greed. If CalPERS was to go away, the major financial firms would be able to get their hands into a cookie jar with hundreds of billions of dollars in it. These are the firms that they pay CEOs millions in bonuses at our expense.

I hope this Commission takes a hard look at the PERS system and makes a report back to the Governor that PERS is not the problem.

Next, let me touch on retiree medical. Retiree medical is not the problem as many speakers have stated previously. Medical inflation is the villain here. Until this state and country take on the real issue, we will continue with double-digit medical inflation. As soon as the pharmaceuticals and major medical industry as a whole think that the government, whether it is the states or federal government, is going to make drastic changes, like moving towards a national or socialized medical programs, once that happens, they will clean up their own act.

So far, the changes that have taken place are cost-shifting, not saving.

The State of California and the citizens of California cannot afford these premiums and fees, no matter how you share the cost. Medical inflation is a root of all this evil. If it was not for these

out-of-control medical costs, this Commission would not have been convened.

I also find it very ironic that Dr. Richman, a previous speaker at this Commission and former member of the Legislature, spent so much of his time and energy claiming to be fighting for taxpayers. I truly feel that if more doctors, like Dr. Richman, would join us in fighting the real problem, medical inflation, we could get this whole issue under control. But I guess some of the doctors may actually be contributing towards the problem.

Thank you again for your time and efforts in this complex situation.

I also challenge you to bring some medical inflation experts on to future panels to get professional opinions on how to tackle the real beast here.

Thank you very much.

CHAIR PARSKY: Thank you very much.

I want to thank all of the public for your interest in our commission meeting; and we welcome all of your comments, both orally and in writing.

Just a few comments before we turn to our first panel.

Administratively, our next meeting will be in Burlingame on July 12. Lee Lipps has kindly offered to

host the hearing on that day.

The focus of the hearing will be on the public pension issue.

If any of the Commission members have suggestions for witnesses, please let Anne Sheehan, our executive director, know, and we will really try to accommodate that.

Over the course of the next week or so, I'm going to try to go through a schedule for the balance of the year. I want to try to make it possible for all Commission members to attend all of the meetings. So we finally have kind of collected everyone's conflicts between now and the end of the year, and I'll try to make sure that, to the maximum extent possible, we can accommodate that.

And we haven't decided yet on the locations, but I know that Bob and several others have suggested Los Angeles and Santa Clara. We want to try to accommodate that. And I know that there have been several suggestions about San Diego. We'll try to make sure. So any suggestions on locations for the balance of the hearings, please provide them.

I'd now like to ask Anne to just make a few comments about staff.

We've been trying to recruit for this temporary

commission really quality staff to help us as we move toward drafting our report.

And, Anne, you can introduce some of the staff, please.

MS. SHEEHAN: Thank you, Chair Parsky.

Yes, we are very excited. We have been recruiting --

CHAIR PARSKY: Your mike.

MS. SHEEHAN: Closer? Okay.

CHAIR PARSKY: It's a little heavy.

MS. SHEEHAN: It is.

We have been recruiting staff.

A couple of people I want to introduce, and then others I will just give you a heads up.

Jan Boel, who is sitting right here, has come on board as our staff director. She has worked with us in the administration, was at OPR, Office of Planning and Research, and then most recently, as the leg. director at the Department of General Services. Prior to that, she was for many years with AT&T in their Washington, D.C., office.

Margie Walker, who is standing in the back there, has come on board recently from Senator Yee's office, as our office manager and commission liaison. She will be the one helping coordinate the meetings. And

I think you all have probably interacted with her, at least by e-mail, if not by telephone.

And then next week, we're bringing on two more staff individuals. Stephanie Dougherty will come on as our research manager and help oversee the collection of a lot of the data. She comes to us from Blue Shield, and she's got a strong background in health care.

And then finally, Tom Brannan, who is here today, behind me, is coming on as our policy advisor. Tom has many years experience in this area. I think many of you know Tom from his time he worked in the Legislature and was a committee consultant for the PERS committee, I think for Mr. Elder, as I understand, for many years; and then was also publisher of The Journal, which is a retirement journal that I think many of you have seen. So we are very happy to have him and his expertise.

We will also be having some summer interns, graduate students be helping us on collecting the data.

A couple other announcements. We're trying to save trees, so we are posting the testimony on our Web site. So for any individuals who would like copies of that, that is available on our Web site.

And as you've seen, we've also posted the transcript from the previous hearing.

Any information, studies, reports that people would like us to post on the Web site, send them to me. I know many of the members have already done that, and we have put them up on the Web site.

Some of the testimony from today will be up there as soon as possible.

And, actually, we, because of the kindness of the Governor's press office, we actually are live on the Web site right now with this hearing. And it's our hope that all of our hearings, that we'll be able to do the live Web-streaming for each of the hearings, so that we will increase the access to the public of the Commission meeting.

Those are all the announcements I have, unless anybody has any questions

CHAIR PARSKY: Any questions?

(No audible response)

CHAIR PARSKY: Thank you, Anne, very much.

We're really trying to -- we recognize that this commission is temporary in nature. Many commission members, I think, are pleased with that statement.

But we really have a lot of work to do between now and the January '08 period that we are obligated to issue our report.

We'll publish publicly an update on the budget

and any of the costs that are relating to this. It will be within the indicated number that we had at the beginning.

So we want to try to be as open and as transparent as possible with respect to all the work of this commission, and any suggestions from the public are welcome.

Before we start on today's proceeding, I just want to turn to my fellow commission members, and particularly perhaps Paul, who is our host, and ask if there are any comments that anyone would like to make to date? It can be criticisms, too; because comments are welcome.

Any of the Commission members?

Paul, would you like to say anything to this group?

MR. CAPPITELLI: I just want to say welcome to Rancho Cucamonga. And since I live here in the community, if there's anything that I can assist you with while you're visiting -- and I want to echo your previous comments about the work that staff did here to make our stay today.

So thank you.

CHAIR PARSKY: Thank you all very much.

We can then turn to our first panel.

Would the panelists in our first OPEB valuation group come forward?

And I think each of you can take your turn at making your presentation.

I hope we can leave some time, as we did last time, for Commission members to raise questions.

I think we'll try to hear from all of our panelists first, and then we'll come back and ask some questions.

So please introduce yourself.

And thank you very much for participating.

MR. CARTER: Good morning, Mr. Chair, Commission Members, and audience. My name is Michael Carter, and I'm the chief operating officer for the State Controller's Office. And to my left is Alex Rivera.

Go ahead and introduce yourself.

Alex is the actuary with GRS, and he performed the actuarial study for the Controller's office.

And to his left is Jason Dickerson; and he is the principal analyst with the Legislative Analyst's Office, who has also done a tremendous amount of work on this topic.

The State Controller's Office appreciates the invitation to discuss the very important topic of funding other post-employment benefits, OPEB, for retirees of the

State of California.

The State Controller, John Chiang, wishes to convey his appreciation to the Commission for giving his office the opportunity to share our report, and for the continuing of the policy deliberation on what is certainly one of the most important topics facing California.

This presentation acknowledges that previous meetings have talked about the terminology, and so we're assuming that there is a certain amount of awareness of actuarial terms and statements. So we won't go into details in terms of educating the audience on that matter.

We are also assuming that this Commission and the audience is somewhat aware of the Controller's report and its contents, so we will focus on what we believe to be the highlights.

Of the report that was published May 7th, 2007, under the guidance of the Controller, and is the first actuarial report for the State of California, my presentation will briefly discuss the following points: First, why the Controller conducted the first annual valuation. We think that to be particularly important. And we'd like to highlight that.

We'd also like to talk about the timing of the

valuation; and, of course, the key findings of the report, which we're assuming, again, that you've already heard.

We'd also like to talk about the role the Controller's office might play in the future relative to our relationship with cities, counties, special districts, as we further deliberate on the financial reporting requirements for local government.

And then finally, policy considerations and conclusions.

Again, thank you.

The first item is why the Controller conducted the first GASB 45 valuation. And simply put, GASB 45, as you all know, is an accounting standard. And as the chief financial officer, the State Controller is responsible for reporting the financial condition of the State of California.

That mechanism is done through what's called the California Financial Report. It's the CAFR. That's produced annually. And it reports the financial status for the State of California.

And through a series of meetings beginning in mid-2005 -- and that was between the Department of Finance, CalPERS, the Controller's office -- it was decided again, as this is a financial report, that the

Controller's Office would be the appropriate entity to embark on the development of the actuarial report.

Funding was provided in the current year budget, 2006-07, for the report; and that was completed. And it should be noted that there is funding in the proposed 2007-08 Governor's budget for a subsequent valuation.

And it is particularly important to note that GASB 45 does require governments providing benefits to more than 200 plan members. They are required to have an actuarial valuation conducted every two years of the State of California, and given the fact that this is the first, we're looking at annual valuations. So there are subsequent valuations downstream, of course.

The timing of the valuation, that is proscribed in GASB 45 for government entities that have revenues over a certain amount. And in this case, for the State of California, it's over $100 million.

We are required to report our financial status in the 2007-08 financial CAFR. And that's published in -- or right around the spring of 2009. So that's when you'll get the published information.

In addition to that, as the newly elected Controller, John Chiang, thought it particularly important to get the information to individuals and

bodies such as this so that you could begin your deliberations as early as possible. And I think that, just by evidence of the deliberations today, we've met our objective of giving you baseline information upon which to deliberate further in a policy forum.

The key actuarial findings of the report, I will go slowly on them because there is an awful lot of information. And I'll try to be as clear as I can.

Under the current pay-as-you-go policy, this results in an actuarial liability of $47.88 billion. You've seen the number before. It’s a large number. But as the Controller has indicated, there's no need to panic.

And this represents the total present value of future retiree health benefits for current state retirees and employees. Based on this liability, California has an annual required contribution, commonly referred to as an “ARC,” of $3.59 billion for the 2007-08 fiscal year, or the amount that the State would pay yearly to fund these benefits.

California currently pays $1.36 billion of this requirement. Therefore, the net accounting liability for 2007-08 fiscal year is $2.23 billion.

Under a full funding policy, this results in an actuarial liability of $31.28 billion. And, of

course, this amount is lower than the actuarial liability under the pay-as-you-go policy by roughly $16.6 billion, because the costs of future benefits are fully prefunded. And this clearly shows the benefit of prefunding.

As you know, prefunding permits the State to earn investment income on the amounts set aside by fund future benefits, which help offset the costs. And that's no different than a retirement system. All of you know that.

Under this full-funding policy, the annual required contribution approach is $2.59 billion, or $1.2 billion higher than the pay-as-you-go level. This approach would fully fund the State's obligation; and there would be no accounting liability for the 2007-08 that would need to be recorded on the CAFR.

Alex will talk about some of the assumptions that are underlying the report. And, of course, I'm sure you all are interested in that. But he will go into that in more detail.

Just a couple more points on my presentation.

I would like to emphasize the SCO's role with local governments, which may be of particular interest to this commission, as well as the audience. As you know, GASB 45 impacts all government entities, including cities, states, counties, special districts, school

districts, community colleges. All are required to report under this accounting standard.

The Controller's office doesn't accumulate financial information from these entities in the form of annual reports for the various entities. And we are now looking at the best way to secure that information, and that is through an advisory committee that has been formed. And we would certainly look to any guidance that this Commission can give us relative to our financial reporting responsibility and to assist this committee to the best of our ability.

That information will be fully vetted and developed by the spring of next year; and we'll certainly stay in touch with Anne and the Commission members on any assistance we can provide you.

In conclusion, the Controller's office would like you to consider the following policy considerations. And you've heard some of that through the audience and the public testimony, but we will reiterate what's been said. Policy demands that California must prefund its state retiree health benefits within a reasonable time frame. The Controller is quite adamant about that as being fiscally prudent and something that must occur within state government in order to meet our promise to the State employees.

The prefunding pension benefits since the early 1930's has resulted in 75 percent of the benefits paid out coming from investment earnings. And that relates primarily to CalPERS. And that is further evidence that prefunding is the way to go.

Containing health-care costs must occur; otherwise, a disproportionate share of the State's budget will be spent on health care over the years.

And we'll get into more of that discussion relative to the health-care trending rate, and I'm sure you're interested in hearing how that occurs.

Collective bargaining should also play a role as employer and employee groups come together to work on ways to fund current and future benefits. As was discussed by the audience, health benefits has been a part of the compensation package for employees while they're working, and the collective bargaining process certainly has a role in forming solutions on this very important issue.

And in conclusion, for my comments, the Controller's office offers our assistance to this commission. We really do appreciate being a part of the policy deliberation, not just presenting the financial results, but also being a part of the policy deliberations.

And we would also emphasize that the State should honor its state employees who have worked very hard about the business of delivering very important services to the citizens of California.

And with that, I'd like to hand it over to Alex, and he'll talk about the actuarial assumptions.

CHAIR PARSKY: Thank you very much for that.

As I said, let's go through all of the presentations, then come back around for some questions and dialogue.

MR. RIVERA: Hello. Thank you for the opportunity to allow us to present the results of the valuation.

As Michael mentioned, I'm Alex Rivera, and we were hired by the SCO to perform the actuarial valuation for the State employees. And I'll keep my comments brief. But the basic emphasis of my presentation is really just to briefly go over the actuarial assumptions, the actuarial basis.

And the first point is, our valuation, we use what's called "best estimate assumptions." In other words, not overly conservative or aggressive. Really mainstream. We wanted to make sure that it was an unbiased estimate that didn't lean in one direction or the other. And that's consistent with actuarial

standards of practice, the so-called "best estimate assumption." So that was really the starting point, or the basic premise for the valuation.

And not to get too bogged down in the details, but for certain demographic assumptions, we used assumptions that were consistent with what the folks at CalPERS did for their pension valuation. In other words, the likelihood of retirement, disability termination, salary increases, et cetera; assumptions that would normally be used for a pension valuation, we used the assumptions produced by CalPERS. We've reviewed those assumptions, and they appear to be very reasonable and in line with other systems. So we just took them as given.

For other assumptions unique to retiree health-care valuations -- and I'll briefly go over those assumptions -- we established those assumptions under the direction of the SCO. In other words, we made recommendations, and then we jointly selected assumptions that were consistent with other similar type of programs.

And just briefly, those assumptions include the average retiree health-care cost; health-care inflation or trend, which I'll briefly discuss in a few minutes; and the participation in the health-care program.

Now, the participation in the health-care program is important. In other words, we don't assume

that all members who are currently active today will participate in the retiree health-care benefit in the future. We actually reviewed statistics and experience, and we made an assumption that a certain percentage would actually participate in the program. And what we saw was that about 90 percent of the members would participate.

The participation rate generally depends on the level of subsidy provided by the State. So the higher the subsidy, the higher the likelihood of participation in the program.

The last key point of the actuarial basis -- and this is critical -- our valuation was based on the plan provisions in effect as of March 1, 2007. In other words, we take a snapshot of the population and plan provisions as of that date, and then we determine the liabilities associated with the provisions in effect.

It's possible that plans could be changed in the near future, but our valuation does not take that into consideration. Again, we're only looking at the provisions in effect as of 3/1/2007.

As far as the economic assumptions, the most critical one, as Michael mentioned, is the discount rate. And we used three different alternatives.

Currently, the plan is being funded on a pay-as-you-go basis. And we looked at the investment

returns of assets currently available to finance the current benefit obligations. So in other words, when we set the discount rate, or interest rate, there's a relationship, or a matching of assets and liabilities. And because benefits are currently being funded or financed from the general fund, we looked at the historical returns in the State's pooled money investment account as the basis for the discount rate. And our recommendation was 4 and a half percent for the current pay-as-you-go funding policy.

We also looked at two other alternatives. One assumes that a trust would be established to fully finance retiree health-care benefits. And that trust would also include a sound investment policy that could support a long-term investment return assumption.

And given that basis, we made a recommendation of 7.75 as a starting point for the full funding scenario.

We also looked at a third scenario, which is really the mid-point of the two. And in that case, the assumption was a little over 6 percent.

And that was really the key basis for the selection of the discount rate. Again, the discount rate is the most important assumption in our valuation. That assumption really drives cost.

The second-most important assumption is the health-care trend rate. And we used what's called a select and ultimate health-care trend rate assumption. In other words, we're assuming that trend rates will gradually decline to what we would consider a sustainable level. And what we used was an initial health-care trend rate of 10 percent, declining over a ten-year period to an ultimate rate of four and a half percent.

Now, I want to emphasize that a long-term health-care trend rate assumption is not the same as a short-term assumption used for underwriting purposes.

Now, the main objective of our valuation is to project cost over a 30- to 40-year period. So we're looking at cash flows that extend over a very, very long period of time.

Now, for purposes of setting premium rates, or the underwriting process, their objective is to ensure that there's enough cash available to cover claims and expenses. So the two objectives are different. So we wouldn't use 10 percent for an extended period of time. And that's a generally accepted actuarial practice. And that has gotten some discussion.

One of the reasons why we used the selected and ultimate health-care trend rate assumption is, again, it's the sustainability of the relationship between

health care and general inflation. So in other words, if we were to assume that the health-care trend would grow at 10 percent for an extended period of time, whereas general inflation only grows at about 3 or 4 percent over a long period of time, then health-care benefits would just overtake the general economy. In other words, the GDP would be comprised of maybe 30 or 40 percent of what would be allocated to health-care benefits.

And that's consistent with what other actuaries have done for retiree health-care valuations. But that has gotten some discussion.

Another -- I just want to briefly go over what's called the “implicit” and “explicit” subsidy. And we estimated the explicit subsidy, or what the State is required to pay in cash, at about a little over a billion, $1.026 billion. But there's also what's called a "implicit subsidy," because pre-Medicare health-care costs for active members and retirees are pooled, act as -- effectively are subsidizing a portion of the retiree's cost. And that's a basic premise for the GASB 45 valuation.

And the implicit subsidy we estimated it to be roughly $336 million or so.

Now, I want to point out again that the

implicit -- or, sorry, the explicit subsidy was based on the plan provisions in effect as of March 1, 2007. So to the extent that benefits change, the explicit subsidy would be adjusted accordingly.

And I just want to briefly highlight the results of the valuation. I know Michael went over some of the results. But the unfunded actuarial liability on a pay-as-you-go basis, using a discount rate of 4 and a half percent, is roughly $48 billion or so. Using a discount rate of 7.75, it drops to $31 billion. It's a huge, huge difference. It just really emphasizes the significance or importance of funding. It really reduces the liability.

The actuarial liability, it's a disclosure item; it's not a balance-sheet liability item, but it's still very visible.

I don't have any more prepared comments.

CHAIR PARSKY: Okay, why doesn't Jason come up? And then we'll have some questions for you, I'm sure.

MR. RIVERA: Okay, thank you.

MR. DICKERSON: Thank you.

My name is Jason Dickerson. I'm the public employment and retirement analyst at the Legislative Analyst's office. Our office is the non-partisan fiscal advisor to all four caucuses, both parties and the

Assembly and the State Senate. And I also administer our Web site dedicated to retiree health issues, which is www.lao.ca.gov/retireehealth. So following the representative of the State's chief financial officer and leading actuary, I'm reminded that there are a lot of numbers that we're talking about when we consider retirement issues. So in focusing on the big picture after their comments, I want to focus on just five numbers: 80, 101.7 billion, 75, 540, and 2.

First, 80. Eighty years ago the Legislature created the Commission on Pensions of State Employees. And Governor Young appointed its members. These were your predecessors.

Like you, they were given a year to complete their report. Unlike you, I'm confident they do not appear to have met that deadline.

CHAIR PARSKY: Are they still working on that report?

MR. DICKERSON: The record shows that instead of submitting the report in 1928, one year later they submitted it in 1929, so they appear to have been a little later than their required task, if the record is any indication.

But this was a report of consequence. It led to Proposition 5 the next year which was approved by

52 percent of voters. These issues were controversial even then. And Prop. 5 authorized retirement benefits for state employees, and led in the following two years to the creation of what is now CalPERS.

That 1929 report really was one of consequence, because it shaped our state's pension policy for public employees ever since then.

In some of its language, the report wasn't like the ones that we bureaucrats often draft for committees or commissions like you today. Some of its language was passionate and it was urgent. The State had incentives and benefits to be gained from offering pensions for public employees, it said. But -- and let me quote -- it also said, *"An urgent responsibility rests upon the State to see that any retirement system which it may sponsor is placed upon a sound financial basis where liabilities are provided for as they are incurred rather than when they mature. Any system,"* it continued, *"which proposes to provide funds only as they are needed to meet disbursements is inviting disaster."* Pretty colorful language. *"The unseen liabilities continue to mount, and the time will come when they will begin to mature in such volume as to cause serious embarrassment for the State, forcing it either to make staggering appropriations or to default on its obligations to members of the system."*

The second number, 101.7 billion. We're now eight decades after that report. And our statewide retirement programs, housed in CalPERS, CalSTRS, and the University of California have unfunded actuarially accrued liabilities, that are currently estimated at $101.7 billion. The stock market is doing pretty well. That number is likely to come down a little bit in the next few years.

Most of that number does not relate to our public pension systems. Now, while the Statewide pension programs, not to mention the local pension programs, have tens of billions of dollars of unfunded liabilities, they have hundreds of billions of dollars of assets on hand that are generating investment returns that compound every day to meet those liabilities.

So these pension systems are substantially funded as quite a few witnesses have pointed out; on average, with assets with an actuarial value equal to 88 percent of accrued estimated liabilities. And those are the liabilities that have been earned to date by current and past public employees, the retirement benefits.

The third number, 75: Because the State of California -- and local governments, for that matter -- followed the advice of your predecessors eight decades

ago, those assets on hand in our pension systems, generating compound investment returns, have been sufficient to fund over the last decade 75 percent of the benefit cost for public employees in CalPERS. And that's a number that's pretty typical of most of the other public pension systems as well.

Now, think about that number. The investment returns fund 75 percent of the benefit costs. If public officials had not followed the advice in that 1929 report, perhaps three-quarters of the funds that are used today to provide retirement benefits, pension benefits to California public workers, would not be available. Three-quarters. That means that given the level of taxation that we had today and the current other public funding responsibilities, the benefits that retired public workers receive might only be one-fourth of what they are today if elected leaders had not followed the advice of that commission.

So in a real sense, 75 percent of today's pension benefits is attributable to that report.

Over time, particularly beginning in the 1950s and 1960s, public employees secured employer-provided health benefits, both during their working years and often in retirement. But for most of the last 50 years, costs for these retirement health liabilities have been

small in the whole scheme of things. But there was, it appears, no similar report of consequence, similar to the 1929 pension report, at least, as these retiree health liabilities and benefits accumulated.

Some public officials such as Mr. Elder, who discussed this a little bit today, and in Orange County, realized what was going on. And what was happening was that, as health premiums increased and our public workforce aged, the unseen liabilities described in that 1929 report for these health benefits were mounting as well.

So most of the $101.7 billion of unfunded liabilities in our statewide retirement systems, that I mentioned earlier, most of those relate to these health benefits now. $47.9 billion for the State and CSU, $7.6 billion for UC, $10 billion for LAUSD, $20 billion for LA County, and so on. Very big numbers.

But their meaning is pretty simple, these big numbers.

Public cost to provide today's level of retiree health benefits will –- will -- rise faster than the rate of public revenue and other public expenditure growth in most cases and in many years. A government spending 1 percent or 2 percent of its budget today on these retiree health benefits pretty soon will be spending

4 percent or 5 percent or more unless something changes.

So this week, in Sacramento, we're beginning the process of advising the budget conference committee as they finish crafting a budget for the people of California for the next year. And those of us who work in that process can attest, this one or two or third of the budget, that's really what all the public debate about budgets are about: Which programs –- education, prisons, CalWorks -- gets that 1 percent or 2 percent or 3 percent, and which doesn't. So these kind of numbers do matter in the scheme of things.

The fourth number is 540, and that's Franchise Tax Board Form 540. That's the California resident income tax return. So Form 540 is relevant to this discussion, too. If public leaders don’t begin to address these unfunded liabilities beginning now, the unseen liabilities will continue to mount. And in the stark words of that report from 1929, ever more staggering appropriations will be required.

Californians may have to be asked for more funds in their 540s and other taxes. Public services may have to be cut, other public services, or Californians won't get the value for their dollar that they expect when they fill out that 540 form.

There are not easy answers to this issue; and

there is not a single, simple plan that will be available for you to recommend to the Assembly and the Senate and the Governor. There just aren't.

There are two general strategies for addressing unfunded liabilities. Two.

The first is being set aside funds -- more funds -- to generate those compound investment returns over the long-term and to reduce the liabilities.

It took decades to get where we are with our pension systems. And it's likely to take it decades to fully fund or dramatically reduce a lot of the unfunded retiree health liabilities as well. That's just a fact. It's going to take a while to get there if the State begins and local governments begin to act.

The second strategy is changing benefits in some way to reduce future costs. Now, most options that are discussed along this line involve shifting cost or financial risk to public employees and retirees. These aren't easy choices. But those are the general strategies that are available to address unfunded liabilities.

Public policy and budgeting pressures may be even more challenging today than they were when your predecessors met. They met at the end of the roaring 1920s, right before the Great Depression. Probably a lot

of the challenges are tougher today.

But on a fundamental level, their charge and yours comes down to my last number, and that's “2.” Typically, what we're talking about with retirement benefits for public workers comes down to two people, a couple. An office technician who may have worked her entire life for the California State Library, and now is retired with her spouse, receiving health and pension benefits. A 56-year-old disability-retired, former member of a Sheriff's department in the County and his wife. A retired guidance counselor and her partner. These individuals today and their successors who work in those public jobs who will be retired 80 years from now, the question is, will funding be available for their pension and retiree health benefits? And if so, what benefits? And so that's really the task for you as you consider your report over the next few months.

Thanks.

CHAIR PARSKY: Thank you very much.

I thank all three of you very much for this presentation.

We're going to ask now, Commissioners who would like to raise some questions and engage in a dialogue, to begin.

I would urge we begin to try to translate some

of the numerical information into some language that our audience can comprehend and understand. And it's not that your presentation was not clear, but some of the concepts, I think, are a little bit complicated.

And one of the objectives that we have, as a commission, is to begin to shine some light that the public can understand on the magnitude of the obligation and how those obligations can be met.

And so let me start off by just -- John Cogan and I were exchanging thoughts. Let me start off by seeing if we can't understand what "full funding" means, translated into language that our audience can understand.

The numbers that you used, in terms of the actuarial estimate of liabilities relating to just state employees, 47.8, approximately, billion, and then 31.2 billion. And I think you made a reference to full funding in relationship to the 31.2. And you also seemed to indicate that if there was an annual reserve of 3.59 billion, money actually reserved on which you could earn something, that I thought that would reach full funding. But see if those numbers are right and should be translated that way or not.

MR. RIVERA: Okay, and the key to that question, the answer, really lies on the body of assets

that are available to pay benefits.

So the full funding method is actually easier to explain because the accounting and the cash requirements are the same. So I'll start there.

And the 31.28 billion, that represents a target liability for members, an actuarial liability. And if a deposit of roughly 2.6 billion -- the 2.59 billion -- were made into a qualified trust, and that trust were to earn 7.75 per year, and systematically 2.59 billion were deposited, increased with inflation, then there should be a sufficient level of funds after about 30 years or so to cover the growing liability.

So that scenario is similar to a pension system. It's virtually the same. So a target liability is determined; and then an annual contribution is determined -- the so-called normal cost, plus a 30-year amortization of the unfunded actuarial liability is calculated, and the employer makes a deposit into this qualified trust. It grows with 7.75 percent interest. After 30 years, there should be sufficient funds available to pay benefits.

CHAIR PARSKY: Just pause there for one second, then we'll turn to the other.

And I think you were saying that, currently, instead of paying that amount of money into a trust or

reserve, that it's only 1.36 billion that is being paid in?

MR. RIVERA: That's correct.

CHAIR PARSKY: Is that right?

So that is a shortfall, if you will, from what would be, quote, "fully funded"?

MR. RIVERA: Correct. And the 1.36 represents cash, actual cash that is being paid.

And the confusing term here, I think the term is called "annual required contribution."

Now, on a pay-as-you-go basis, it's not really an annual required contribution. I think a better term would probably be the "annual OPEB cost" or the "accounting expense."

The 3.59 billion represents the accrual accounting expense. And it's not an actual cash requirement.

Under the pay-go system, or funding policy, the actual cash that the employer makes is just enough to cover claims and expenses during fiscal year, which is the 1.36 billion.

But the accounting requirement dictates that an ARC, or an expense, an accounting expense be determined as though the employer were making a deposit into an account that earned 4.5 percent interest.

CHAIR PARSKY: One final, just follow-up, just so that we can again translate it. Is your message, your collective message to us and/or to the policymakers, taking all of that into account, that the prudent fiscal thing or financial thing to do is to contribute the difference between what is now being currently paid in and what you think would be on, an accounting basis, fully paid in? Is that the message that you are sending?

MR. CARTER: That is correct, Mr. Chair.

Michael Carter, again.

It would be fiscally prudent to allow the powerful impact of compounding interest to work for the taxpayers. And that's as simple as it gets.

And the concept really, as simple as it gets, is no different than putting money away for your children's college education. You can wait; but if they're going to college, you still have to pay the bill, and it's out-of-pocket. And you've not allowed compounding interest to work.

So you're absolutely correct, and that is something that the Controller strongly urges this committee to consider.

CHAIR PARSKY: Thank you.

Let me just ask other Commission members to begin. Any questions?

Yes? Matt?

MR. BARGER: The question I had was -- a couple questions I had revolved around sensitivity analyses, in terms of things like you've identified health-care costs as an example as a big assumption, that in some ways I think some people will look at and say that was fairly optimistic.

Have you done a sensitivity analysis to say, you know, what if your mortality rates, people live longer than you expect has been the trend, or health-care costs are higher, or any of those sorts of things? That would be question one.

Question two would be, you're using a closed group, as I understand it, in here. Have you looked at the sensitivity assumptions about using an open group? And just sort of size, you know, what the number is here.

MR. CARTER: We have not conducted sensitivity analysis at this point.

As indicated earlier, the Controller's office is responsible for reporting the financials. And it is a baseline report. We fully expect the sensitivity analysis and various scenarios to be run, built on the foundation that we've given today. Those are all good issues.

The issues of health-care funding and the

trending rate, all of those scenarios we expect to do further work on, or some entity as directed by this committee. And that is the importance of providing additional money in the Controller's budget for the subsequent year to continue our efforts and to build on that baseline information, again using very mainstream actuarial assumptions. We did not bury -- we did not use outlier types of assumptions. We went mainstream. And that gives you a foundation to build from there.

Does that answer your question, sir?

MR. BARGER: The answer basically is, you haven't done so but you'd be willing to?

MR. CARTER: We absolutely are prepared to do so.

MR. BARGER: Thank you.

CHAIR PARSKY: Others?

MR. DICKERSON: Actually, if I could step in, going back to the Chairman's question in particular.

To try to translate this into real numbers, we think one of the most important numbers in this valuation is 1.2 billion. Basically, what this valuation shows is that if the State of California, for its retired employees and CSU's retired employees, starts contributing $1.2 billion above what it is now in current year dollars -- so that grows over time -- but in

current-year dollars, and starts depositing those contributions for retiree health benefits irrevocably to a trust that earns 7 and three-quarters percent a year, if all the other actuarial assumptions are met, $1.2 billion is the amount to initiate a full-funding strategy, and it is estimated over 30 years, reduce the retirement -- retiree health unfunded liability to zero.

So if it's the priority of the Legislature to manage these costs over the long-term, to continue providing today's level of benefits to today's retirees and future retirees, then the Legislature needs to locate $1.2 billion and initiate –- in current-year dollars -- and initiate this prefunding strategy beginning now.

The reason that number is significant is, it certainly is a lot less than we were expecting. And while the State budget is very complex with a roughly $5 billion structural gap facing lawmakers next year, $1.2 billion is about 1 percent of the General Fund. Not easy. But also, as the Controller says, not an amount that necessarily should provoke panic. It's not a completely unrealistic amount to expect that lawmakers would set aside.

MR. LIPPS: Yes, in keeping in mind what Mr. Dickerson just explained, I'd like to go back to an analogy used by Mr. Carter about funding your child's

college education. And if I do it right and I put money -- you know, my child is born, I've got 18 years now to save for a college education. I'm going to hope it's Stanford or St. Mary's -- you know, one or the other. I like them both.

And if I do it right, when my child turns 18 and has graduated from high school, I've got a sum of money there, I've added to it, I maybe don't have to contribute as much each year because I've invested well and built up the fund, but I'm projecting. But at the age of 18, I can start drawing from that fund to pay the annual required cost of the institution that the child goes to. I can start drawing down from that.

So now if we take a look at a retiree health fund, pension fund, and getting to full funding there, at what point can you start spending out of that fund account? And what happens actuarially if you start spending it down? Is it a perpetual 30-year-out fund, or is it something that you can then, just like my child's college fund, is this something that I can start drawing from what he actually or she actually goes to college?

MR. DICKERSON: I think the answer is fairly soon. I think that the representatives from CalPERS may provide you a little bit more information on that with regard to prefunding trusts that they've set up.

But the answer is pretty soon. Compounded investment returns, assuming that they emerge as projected, start emerging pretty quickly.

MR. LIPPS: I'm sorry, I didn't understand your answer as being responsive to my question.

MR. DICKERSON: Well, pretty soon. I mean, basically if you start prefunding benefits, you're depositing the amount that the State is paying out in cash now, plus the extra amount, the 1.2 billion. You're putting it into this trust, and it's invested, and starts earning returns as soon as you put it in the trust. And pretty soon, the investment returns from that trust should start funding more and more and more of the benefit obligations that the Government has.

MR. LIPPS: Okay, but that wasn't my question.

My question is, once we get to 100 percent full funding, can I then start paying for retiree benefits out of that fully funded trust, or is it a perpetual 30-year reserve, essentially?

MR. CARTER: The amounts that we have provided in the actuarial assumptions assumes that there will be inflows and outflows. And so there are a combination of population increases, various other economic increases and changes. So you don't have to wait 30 years to start paying the bills, is the way I'm understanding it.

So as soon as you've established the fund, there is an assumption that there will be money sufficient to pay the liabilities as they occur.

The other point I'd like to make -- and I don't want to leave your point -- is that on the 1.2 billion, the Controller is recommending a reasonable plan.

And Mr. Dickerson is absolutely correct, the 1.2 billion would be the ultimate solution. But there is probably some leadway on how the commission and the State of California enters the solution to that funding scenario.

So does it have to be $1.2 billion immediately? If the money were available, that would be a nice thing.

There is probably other ways to build that solution and ultimately get to a full-funding snare.

CHAIR PARSKY: John?

MR. RIVERA: Can I add a comment to your question, sir? And it's an excellent question, and it's really a funding-policy question. And you could think of it as having two separate accounts conceptually. You have basically a cash account, and then you have another account where assets are invested in a longer term. So the cash account is used to pay current claims or premiums.

MR. LIPPS: And that would be the current

1.36 billion?

MR. RIVERA: Exactly.

MR. LIPPS: Okay.

MR. RIVERA: And then the excess is deposited into a longer-term account. That grows with interest at a much higher rate. And as the relationship of assets to liabilities -- you're really looking at the funded ratio -- as that increases, then there comes a point in time where you could start to draw down the so-called invested account.

So the policy-maker makes a decision as to what point in time they would like to start drawing down on that account.

MR. LIPPS: So let me clarify, just to make sure that I understand, and using the numbers that you used earlier -- remember, I used to just be a history teacher, you know.

CHAIR PARSKY: This is all supposed to be translated into English. You could be a history teacher or an English teacher, either one.

MR. LIPPS: I currently, with the recommendation from the LAO, is that we have a current annual funding obligation of $1.36 billion, and the recommendation is that if we start funding another 1.2 billion per year, over the course of 30 years, based

on current projections, we will have reached full funding, maybe a little bit sooner if our investment return is better, maybe a little bit longer if our investment return doesn't average this 7 and three-quarter percent.

Do I understand that correctly so far?

MR. RIVERA: Right.

MR. LIPPS: Okay, but none of that 1.2 billion that is being paid in excess of the 1.36 billion current-year obligation, none of that 1.2 billion goes to pay the current-year obligation or next year's current-year obligation; it just gets put into this irrevocable trust?

MR. RIVERA: Right.

MR. LIPPS: Now, it has to be an irrevocable trust to get the seven and three-quarter. If it's not an irrevocable trust, does it revert back to the 4.5?

MR. RIVERA: Well, that's a good question. And the key here is that when the discount rate is established, it really depends on the investment policy. So that's an excellent question.

You could actually set up another reserve and provided that the statutes allow the government to invest in -- risk your portfolio besides the General Fund, that you could actually assume a higher return.

MR. LIPPS: Okay.

MR. RIVERA: But I'm not sure if the statutes would allow that.

MR. LIPPS: At any rate, so none of the 1.2 billion additional contribution adjusted probably annually for changes in trends and assumptions -- none of that 1.2 billion, until you reach 100 percent funding, will go for the current year's obligation payment; do I understand that correctly?

MR. RIVERA: Well, that's --

MR. LIPPS: Until you've reached 100 percent?

MR. RIVERA: That's a policy decision. And, for example, you can make a policy objective that once the funded ratio reaches, let's say, maybe 60 percent or 50 percent, then maybe a certain percentage of the invested account could be used to pay cash flow. But that's really a policy objective.

So it's dynamic, and it will change year by year. So you don't necessarily have to wait until you've reached 100 percent before you start drawing down the invested account.

MR. LIPPS: But if the goal is to reach 100 percent, which is ultimately which is being recommended --

MR. RIVERA: Yes, to the extent that you have

an open group and you have new members flowing into the plan --

MR. LIPPS: Okay.

MR. RIVERA: -- you may not get to 100 percent. But if you get to, let's say, 80 percent, 90 percent, then that's a very viable and sustainable system.

MR. LIPPS: Okay, thank you.

CHAIR PARSKY: John?

MR. COGAN: You know what might be very helpful for us trying to understand this, would be if you, in addition to the material you've published, could you give us kind of an annual flow chart that looks at the liabilities each year for the next 20 or 30 years, and then looks at how those liabilities would be funded under the full funding policy? How much the fund would build up from one year to the next, and then how much would be available from return on investment? I think that would really help clarify some of the questions that people have in terms of the meaning of full funding here.

I have a question that follows up on Matthew's question. It has to do with the sensitivity of the estimates.

You've said that you assumed that health-care costs are growing now at 10 percent and that will gradually decline to about four and a half percent. So

my question is, should I think of the health-care costs as the costs of a typical premium, or should I think of it as the cost of prices in the health-care system, of services? That is, if it's a premium, then a premium increase from one year to the next is a consequence of, really, two things: One is, the prices of medical services rise; and the second is that utilization of medical services typically rise for a given individual. And so it seems to me that when you trend down to 4 and a half percent, that's a perfectly appropriate assumption for medical prices, because medical prices generally, in the last 30, 40 percent, have risen about 50 percent faster than economy-wide prices. And so if we think economy-wide inflation is three and a half percent, we would think that medical price inflation would be four and a half percent, thereabouts.

But we're talking in your terms about a four and a half percent increase in premiums from one year to the next. Given that premiums also include the increase in utilization, it seems to me to be a very, very low assumption about ultimate health-care costs. And so I'd like to see some, first, explanation as to what the costs you're talking about are, are they price inflation or health insurance premium inflation; and then two, how long would it take you to produce some

sensitivity runs that we might be able to see just how much of a difference alternative assumptions matter.

MR. RIVERA: Well, I could address the first question. And our selected and ultimate health-care trend rate, it's really the average increase on a per-unit cost. And we're looking -- when we perform a valuation --

MR. COGAN: What's the unit?

MR. RIVERA: It could be premium or what we would term the per-capita health-care cost.

MR. COGAN: Right.

MR. RIVERA: And they're roughly the same, with the exception of the blending of the pre-Medicare retiree and active.

MR. COGAN: Right.

MR. RIVERA: But we're really looking at an average health-care cost at a given age for a member.

Your question about utilization, it's an excellent question. And in the private sector, retiree health-care valuations have been around for a very long time, since the mid-eighties. And from experience, what has happened is that the select and ultimate health-care trend rates are fresh-started. So in other words, after a two- or three-year period, the actuary will fresh-start the health-care trend rate, so that --

let's say you're starting at 10 -- 9 and a half, 9, 8 and a half, after the second or third year, the actuary may decide, well, 8 and a half is not really a good indication, it should be closer to 10 and a half.

So there are ways of correcting the prior experience. And this is an assumption that actuaries have struggled with -- OPEB actuaries, not necessarily health-care actuaries that are determining premium rates, but actuaries that are determining long-term costs, is after a few years that assumption becomes a little stale, and it needs to be fresh-started.

And that goes back to your utilization question, that the experience shows that there has been increases in health-care costs because of technology, for example, that may not necessarily be reflected in the long-term ultimate health-care trend rate.

MR. DICKERSON: Let me add to that.

This assumption in the actuarial valuation is labeled -- is called health-care costs and premium increases. The valuation really ties off of the State's cost for retiree health benefits, and the State's cost in turn are basically based on premiums. It's a percentage of premiums for CalPERS's basic plans.

So that's our understanding of what we're talking about here. I think we're talking primarily

about what's going to happen to premiums in CalPERS's plans with regard to how the State will track relative to this valuation.

That is not -- that is not -- the same as medical cost inflation in the economy as a whole.

One of the things that's occurred to us is we're talking here about a subset of a subset of medical costs in the economy as a whole. First of all, employer-based health premiums tend to grow faster than health costs in the economy as a whole. Part of that is cost-shifting; part of that is, you know, people who don't have employer-based benefits are more likely to be uninsured, and so forth. We're also talking within that subset of employer-based costs about public employer-based costs.

In California, public employees, through the give and take of the bargaining table, have often -- not always, but often negotiated and placed a high value on having comprehensive health benefits and, as some of the witnesses pointed out, have made sacrifices in negotiations to preserve those comprehensive benefits.

So we're not talking about medical costs in the economy as a whole. We're talking about public employer premium increases. And that is a different factor, and one that, you know, will it eventually go down to

four and a half percent a year? Certainly we hope so. It may not. And to the extent that it doesn't, the liability figures we're seeing from around the state right now, at the state and local level, well, they may be understated.

We think that that uncertainty is one of the reasons that calls on the Legislature to begin addressing this challenge now. The sooner that these liabilities can begin to be addressed, the easier it will be for taxpayers and public employees.

MR. COGAN: It does seem to be extremely important in health care to have a range of estimates. Our level of certainty about how health-care costs and how utilization is going to change over time, is very, very suspect. We just don't have good information. And so I would -- I really do think it's very, very important to get a nice band, or a range of costs associated with both the work you do with the State Legislature and any work that you do for us.

CHAIR PARSKY: Teresa?

I'm sorry, did you -- Michael, did you want to say something?

MR. CARTER: Yes, Mr. Chair.

It is terribly important to understand that, as a part of the actuarial process, subsequent valuations

are scheduled and, in fact, are required. And it is for that very reason.

So as we look at the initial estimates and the baseline, we refine that every time this process occurs. And we will get to those issues, readdress them, utilization, economic assumptions. All of that is refined year after over.

CHAIR PARSKY: Thank you.

Teresa?

DR. GHILARDUCCI: Hi. I would like you to second-guess, or confirm my judgment that I think this is a fairly low number as well. I was quite surprised that it was a lot lower than I thought it would be. And the way I looked at it was, to compare it to the state budget, compared to the State's economy, and to compare it to the costs -- extra cost per participant. So my scratchings here, my scribblings here show that it really is equal to about $4,000 per participant per year, is what you're asking the State to contribute to. And that does not seem like a very large increase in employee costs.

Is that the way you would judge this or interpret the number?

MR. DICKERSON: They develop the actuarial valuations. I think they support it.

We think it's a solid initial estimate. All of these numbers are estimates. They're subject to change. Health-care inflation is a great, unpredictable -- and for that matter, investment earnings that retirement systems earn as well.

Just a couple of weeks ago, the State's bond-rating agency analysts were into Sacramento. And one of the discussions we had with several of them, they were looking at our unfunded liability relative to, you know, the personal income tax base, the size of the economy, and their observation was that it seemed moderate when compared to the valuations being received by some other states.

New Jersey, for instance, which is responsible for state and local and, to some extent, teacher retiree health benefits all at the State level, has as I understand it over a $70 billion liability.

So I think that, in our opinion, this is a solid initial estimate. Maybe the health-care inflation assumption is optimistic, but it is a standard actuarial assumption. And we think it's a solid initial estimate to begin taking action.

Again, as with all these retirement issues, the longer that the Legislature waits, the longer that local officials wait, the harder it will be to solve this

problem. Time is of the essence.

CHAIR PARSKY: Curt?

MR. PRINGLE: Let me -- first, I just wanted to get a little better understanding on some of the assumptions, if I could.

You say that, early on, that the assumptions in terms of where individuals expend their health-care dollars now would assume what is in effect on March 1st of this year, and all anticipated programmatic changes as well as utilization and application of Medi-Cal as of today as well; is that right?

MR. RIVERA: Well, we looked at the plan provisions in effect as of March 1st, and we took a snapshot of the liabilities based on the plan provisions in effect as of March 1st.

MR. PRINGLE: And taking into account all of the changes in terms of Medi-Cal and other types of –-

MR. RIVERA: Well, when we do our –-

MR. PRINGLE: -- systems as well?

MR. RIVERA: -- valuation, we don't -- we're looking at the experience for let's say the last two years or so in determining a per-capita cost and that based on the plan provisions in effect as of the valuation date.

MR. PRINGLE: Okay, when it comes to -- I think

I'm somewhat understanding what you're doing with the discount rate. The four and a half percent is basically the state-pooled rate that you're using for dollars that are there now, the potential of investment. And the 7 and three-quarters percent, you're using the CalPERS rate for retirement benefits, basically.

Is that what I'm assuming?

MR. RIVERA: (Nodding head.)

MR. PRINGLE: And then where does this six percent fit in? As you had mentioned, there were three separate rates.

MR. RIVERA: Well, that's just a funding policy that falls in between the pay-as-you-go and full funding.

MR. PRINGLE: Okay.

MR. RIVERA: So if the employer contributes roughly 50 percent --

MR. PRINGLE: Okay, I see.

MR. RIVERA: -- of the excess amount.

MR. PRINGLE: If tomorrow there was the pay-as-you-go funding level provided, is there the legal and structural ability to invest through a CalPERS-type system to be able to get a 7 and three-quarter percent rate? Or does that take statutory change and modification?

MR. DICKERSON: CalPERS, under a bill that was

authored by Mr. Elder, I believe, has a prefunding plan in place that is accessible to its member agencies. The state is the largest member agency in CalPERS. There is that authorization. There would also be the ability for the State to consider one or more of the other excellent public employees' retirement systems that operate in the State. So there is a statutory framework in place.

We would advise the Legislature probably to modify the current framework in the event that it decides to start a prefunding plan, to create a prefunding plan specific to the State's needs.

MR. PRINGLE: I see. And if I were to look at this, your $48 billion number and this last week or so with Los Angeles County coming forward with their $20 billion unfunded number, how are they similar? What assumptions are different between what you have in place versus what they have in place? Are interest rates the same and other elements similar or different? Where should we look to, to --

MR. DICKERSON: I'll say one thing: I haven't yet reviewed the Los Angeles actuarial valuation. But essentially, actuarial valuation assumptions for public-sector OPEB around the country are becoming pretty commonplace. These are standard assumptions. And so I am virtually certain that the major assumptions are very

similar. Basically, in just about all of the retiree health valuations you're seeing now, one of the things that can be a little bit different, depending on the valuation -- obviously, benefits are different, you might have different assumptions about the participation of people in the plan. But on investment returns, inflation, premium inflation, and so forth, the valuation assumptions are now pretty commonplace all over the country.

MR. PRINGLE: Good.

Are you, through the LAO's office, looking at that report when it's made available, since it is relatively fresh? As part of your purview, are you going to look at what comes out of L.A. County?

MR. DICKERSON: Well --

MR. PRINGLE: If you do look at what comes out of LA County within the next month, would you provide some of that information back to us in terms of comparison on the assumptions on the interest rates, on the utilization rate, on the assumption, on the trend rate of health-care costs, so that we could see what that is? Because I would like to see if, in fact, it's true that actuarially they're very similar or if, in fact, there are some, you know, substantial differences as I had been told when it comes to some of the interest rates

and discount rate formulas that are used.

MR. DICKERSON: We'll certainly look into that. And if we see something, I'm sure we'll probably comment, yes.

CHAIR PARSKY: Connie?

MS. CONWAY: Thank you. The conversation has sort of answered my question.

But when I look at this, these numbers are really just PERS numbers; correct? So it's not a -- it's not -- is it STRS? I mean, it's schools? Is it everybody? It's just the PERS system?

MR. RIVERA: State employees.

UNIDENTIFIED LADY: CSU.

MR. RIVERA: Including CSU.

MS. CONWAY: Okay, so statewide, if we looked at that statewide public employees, these would be different numbers?

MR. DICKERSON: (Nodding head.)

CHAIR PARSKY: I'm sorry, did you -- do you have a question that you wanted to ask them or not?

MS. CONWAY: I was just trying to make sure I was understanding what this was, because the system that I -- you know, I'm in a '37 Act county, but we have the same obligations. I'm just trying to get a handle on if this is a total overall number --

MR. DICKERSON: Right. This is just state government, CSU, local government, UC, cities, counties, community colleges, school districts. They'll all have their separate numbers. Your staff is working on a survey of local governments to try to assess that.

MS. CONWAY: That's what I wanted to know.

MR. DICKERSON: The total retiree health and pension liabilities combined, for what it's worth, will be a number somewhere, we expect, between $150 and $200 billion statewide. So we mentioned $101.7 billion of unfunded pension and retiree health liabilities – most of it retiree health -- for statewide programs. There's probably going to be about an equal number when you add all of the locals together with the largest being Los Angeles County.

MS. CONWAY: Thank you. That's all.

CHAIR PARSKY: Bob?

MR. WALTON: Thank you.

And I think you've clarified part of my question, but I think it's important to note -- and clarify or correct me if I'm wrong -- that the OPEB liability is the employer's share of the premium. In the State's case, that's virtually 100 percent. But for many, many local governments, that's not the case. So you can't extrapolate this to any employer and say, "It

will cost X per retiree or X per employee," because it's different. Some employers pay half the cost. Some have a fixed amount. For many school districts, they don't cover retiree health care at all.

MR. DICKERSON: Right.

MR. WALTON: And so you can't extrapolate this to other employees at all.

In the case of L.A. County, I have no idea what the employer's share is. And so there may be a reason that there's a difference there. And it could be a significant difference, depending on what they choose to pay for their retiree health.

Mr. Rivera, in an actuarial sense -- I'm very familiar with pension actuary, and I know health-care actuaries talk a different language than pension -- but is there an equivalent to a normal cost involved in these numbers?

MR. RIVERA: Yes. The calculations for a pension in an OPEB actuary -- an OPEB actuarial valuation, the mechanism, the funding methods are identical. The only difference is the cash flow, or the expected benefit payments.

So in the case of the retiree health-care valuation, we're looking at the difference between the claim versus what the retiree pays, as the net employer

cash flow.

In a pension valuation, it would be the defined benefit. For example 50 percent of final average pay for that particular year at retirement.

So the cash flows are different, and the funding methods used to develop a normal cost and an actuarial liability, they're identical. And we're using the entry age normal cost method, which is the same as what's being used for the CalPERS valuation.

MR. WALTON: The other point, again, I think utilization could drive a lot of the cost here, and more plans, such as CalPERS under the PEMHCA program used a March 1 plan date, that snapshot date.

In April, I believe, they changed their co-pays from office visits and that sort of thing -- made them higher. And we all know that co-pay changes can drive utilization changes. So that's the sort of thing that when you do the next valuation, I assume, like a pension valuation, where you say, "Well, the number was X and now it's Y," you'll show that part of this is because we earned less than what we thought or we had utilization less than what we thought. Is that correct?

MR. RIVERA: Yes, that's correct. We'll perform what's called a gain-loss analysis.

MR. WALTON: Right, okay.

MR. RIVERA: So we'll generate a reconciliation of the factors that cause the actuarial liability to change.

MR. WALTON: Go up or down?

Thank you.

CHAIR PARSKY: Yes, Paul?

MR. CAPPITELLI: Yes, I just had a quick question.

If you know, gentlemen, is this type of OPEB model that you're describing working in any other state? And if so, you know, is it successful? Or would we be the first to do this?

MR. DICKERSON: No state has a fully funded retiree health liability that I'm aware of. Every state has retiree health benefits for some segment of public employees. A few states -- Ohio is one, long ago began to set aside some funds. A number of other states are quickly beginning to adopt that strategy.

So basically there is no model for a consistent fully funded OPEB strategy that's been in place for a while; but a number of states will begin adopting them this year and a few more will probably adopt them next year. So we're going to have those models pretty soon.

At the local level, there are more models. I mean, a very small percentage of governments have been

looking at this for a long time: The City of Los Angeles you're going to hear about today, Santa Clara County, and some others, as well as others in other states. And, of course, private companies with varying degrees of success have been using an OPEB prefunding model for some time. In fact, probably the private companies are your best role models for what happens over a long period of time in a prefunding model, if you will.

MR. RIVERA: Yes, let me add to that, utility companies in the private sector have used prefunding vehicles and the reason is that they could pass the cost to the rate-payer. So it's actually -- if you were to do a survey, utility companies are a good example of prefunding of OPEBs.

CHAIR PARSKY: Last question, Dave?

MR. LOW: Mr. Dickerson, I noticed in your report you had a recommendation that part of the Prop. 98 funding should be used and directed towards paying for the OPEB. And as Mr. Walton said, about half of the school districts don't provide retiree health care. So wouldn't that result in somewhat of a disproportionate paying of Prop. 98 to those that chose to provide for retiree health care?

MR. DICKERSON: That's a great question. And one of the things that I wanted to mention to you, you

know, the issues of the State are very challenging, but the issues of school districts are probably even more challenging than any level of government. The data shows the school districts spend a greater percentage of their budget and payroll on health benefits, retiree health benefits, than any other level of government. And, of course, they operate within various funding and operational restrictions, including the funding provided by Prop. 98.

So our recommendation to the Legislature stems from the fact that over the next few years, with enrollment growth in our state's K-12 through community colleges, will start to level off for the first time in a while. And yet under Prop. 98, it's likely that funds will continue to increase. That leaves what we would call a discretionary amount above the COLA and base budget for school districts to decide on various funding priorities.

We propose that the Legislature take a portion of that discretionary funding over the next few years and Prop. 98, program it in what we call fiscal solvency block grants that would go to districts to address retiree health challenges, as well as a number of other fiscal challenges -- declining enrollment, for example -- that they face.

Our proposal, I think as you alluded to, is that districts more or less -- all districts get some share of that money.

Our thought is that districts that, to date, have been conservative in terms of the benefits that they provide to their teachers and, therefore, may not have a large, unfunded liability, we're of the opinion that they should not be penalized for that. If they don't have a large retiree health liability, they might be facing other challenges: Declining enrollment and so forth.

So that's our recommendation.

The Legislature would also have the option to direct that fund in other ways; and perhaps they would want to target it more to the districts that have some of these larger liabilities. But we do think that given where we're headed in enrollment over the next few years, now is a golden opportunity for the Legislature to think about a Prop. 98 game plan. And we think this is an important component of it. We think it's a very important issue.

MR. LOW: Last question. I'm just curious if any of you have a reaction to the recent decision in Texas to ignore OPEB liabilities?

CHAIR PARSKY: They're having enough trouble dealing with California right now.

One last question, if you would just bear with us, John.

MR. DICKERSON: A friend of mine who is an accounting professor at the University of Texas at Austin had a comment in the New York Times, and it was basically, the Texas Legislature approved a bill that allowed blind individuals to hunt. And he said this is the most stupid thing they've done since then.

So I'm not from Texas. My boss is, so I'll probably take some heat for that comment. But nevertheless, accounting reality is accounting reality. And one of the premises of Ms. Butero's argument, one of the leading forces behind this move in Texas, is that in Texas, these retiree health obligations, she says, are not vested benefits. That's one of the rationales for the not putting on the books.

I doubt very much that a lot of the public employees and retirees would have the same opinion here in California. You know, maybe these are vested benefits sometimes and maybe they aren't. It's a pretty complicated issue. But if these are vested benefits, or if they're benefits that the government expects to provide, they should be accounted for. And so the Texas Legislature, in our opinion, made a decision that's not very helpful. It doesn't appear that many other states

are going to emulate them.

CHAIR PARSKY: John?

MR. COGAN: One quick question for Mr. Dickerson.

Your agency has also recommended that the State of California begin immediately to prefund its retiree health benefits. You also mentioned that we're now engaged in a budget process leading up to the next fiscal year's budget.

Has the Legislature shown any interest in your recommendations?

MR. DICKERSON: Well, the challenge for the next couple of weeks, as lawmakers and the Governor craft a final budget, is addressing the structural shortfall that's present. We're probably going to be talking on Saturday or Monday in the conference committee about our state's annual pay-as-you-go contributions to retiree health care. And so both houses have approved budgets that basically continue that policy.

We believe that now is the time to begin ramping up, over the next several years -- and, you know, maybe it doesn't start this year, it's not going to -- but in a year or two, and then a little bit more in the year after that, now is the time to start to ramp up to that higher level of funding. It's not going to begin

this year, but it is something that the Legislature, if these benefits are a priority, we believe should look at beginning soon.

CHAIR PARSKY: Just a little bit of advice. If you're always looking for the next year to start something, it will always be the next year.

I want to thank you all very much for this presentation.

We'll take a break for lunch. We're only going to lunch for 30 minutes, so we can get through our whole agenda.

Thank you very much.

(Midday recess taken from 12:34 p.m. to 1:10 p.m.)

CHAIR PARSKY: Ladies and gentlemen, we are going to begin our afternoon now.

Those of you in the audience that would like to continue to gossip, that's perfectly okay. We'll just try to do it outside here.

Okay, so we have this afternoon three panels. We're going to try to keep to our time frame. I'll try to be the monitor in this.

And the first panel is The Rising Cost of Retirement Health Care in California and the Nation. Now, we've been talking about some of this but this will

be a little broader perspective.

So would each of you please introduce yourself? And we can leave enough time here for questions.

Thank you.

Steve, do you want to start?

MR. FRATES: Good afternoon, Mr. Chairman. My name is Steven Frates. I'm a senior fellow at the Rose Institute of State and Local Government at Claremont McKenna College, and I'm also president of the Center for Government Analysis.

MR. JACOBS: I'm Ken Jacobs. I'm the chair of the Center for Labor Research and Education at UC Berkeley.

MR. SHER: And I'm Tom Sher. I'm a partner in the Alliant Insurance Services Public Entity Benefits Group. We're consultants to cities, counties, school districts, and labor unions for public employee health-care issues.

CHAIR PARSKY: In whatever order -- you're going to start, Steve?

MR. FRATES: Sure.

CHAIR PARSKY: Okay, why don't you proceed ahead?

MR. FRATES: Thank you.

Good afternoon, Mr. Chairman and Commissioners.

It is an honor to appear before your commission.

The bulk of my testimony today is contained in a copy of the presentation that I made to the California Health Care Foundation last spring. It summarizes the findings of a research report on the cost of retiree health-care benefits for state and local government employees in California, that the Foundation commissioned my firm, the Center for Government Analysis, to produce.

I will now review those findings with you. They're up on the screen.

And before I even start that, let me sing the praises of your staff. I sent to you the wrong presentation. And by the magic of superb staff support and technical alchemy, they have produced in your packets and for me and on the screen something very close to what I was going to present to you and inadvertently did not. But before --

CHAIR PARSKY: We welcome compliments to the staff at all times. No compliments to the commissioners, just to the staff.

MR. FRATES: Well, I will compliment the Commissioners for the tolerance they have for poorly prepared witnesses.

Before I start, I think there are three key things that should be kept in mind.

First is individual governing councils and boards makes benefit decisions. And the conversations that you've had earlier this morning, and I'm sure your other testimony, there's been a macro level discussion. I'll try to bring it down a little bit more micro. Keep in mind there are 4,000 units of government in California: 485 cities, a thousand school districts, 3,000 special districts and fifty-some-odd counties. Those governing boards make the decisions on benefits. And you'll see huge differences in those benefits. They're wide variations in the many governments in California on benefit levels for retiree health-care and associated costs.

Some counsel and boards have paid in to Medicare. Remarkably enough, there were some cities, in particular, that saw this problem coming 15 years ago and subscribed to Medicare fully in the system. And basically what that means, when their employees retire, they're going to cover them for three or four years, and then Medicare is going to take over.

Those guys are sitting pretty good right now. Others have not. So you're going to see wide variations.

With that, let me just run through the executive summary. And you have it in your packet, I believe.

The mid-range estimate for it total statewide health-care benefits for current employees in fiscal year 2003-2004 was about $11.5 billion. Often helpful to keep that in mind.

Another number that I don't mention here but would be helpful for you to keep in mind, a couple of you were concerned about the relative cost of health care, retiree health care, which I'll get to in a moment. You might keep in the back of your mind that in 2003-2004, the total amount spent by cities and counties in the state of California on police services was about $10.5 billion. So when we start talking about these retiree health-care numbers, these lines are going to cross pretty quickly.

Mid-range statewide estimates for retiree health care were about $2.9 billion.

Mid-range projected total statewide cost to health-care benefit increases from $4.5 in fiscal year 2006-07 – we think it’s higher now, this report was 18 months old -- to almost $30 billion by fiscal year 2019-20 if present trends continue. And a caveat, that present trends as you've discussed this morning there's substantial difference on how quickly those health-care costs increase.

However, I do talk to people in the medical

profession and in the science research profession, one of the more sobering things that I've heard from these people is a gentleman at the National Institute of Health told me that the first person to live to be 150 years old is 50 years old today. Too late for me at 60, but somebody out in the audience has something to look forward to. But the cost of that will be quite high.

Statewide estimate cost of retiree health-care benefits for counties was over $491 million. That's hard numbers. If current trends continue, it will exceed $1 billion by fiscal year 2008-09, and $2.1 by 2002-13.

Those were actual dollars. Those are audited figures for what counties spent. Okay, out of their current operating budget, that's what they were spending.

County cost per retiree for health-care benefits grew from about $2,482 in fiscal year 2000-2002 to an estimated $4,591 in fiscal year 2004-2005. People in the health-care insurance business tell me that those numbers are probably very conservative and low; that the cost of providing retiree health care, depending upon the benefit level, is as you'll see in a moment, varies tremendously.

Expenditures for public employee pensions in California, to put that in perspective, exceeded $39 billion in the fiscal year 2004-2005. But that

increased from a little over $8.5 billion in 2001.

Now, there are vagaries of the stock market and other things involved there. But that gives you some sense of the relative size of what we're looking at.

Let's see if I do this right for the next slide. Something came up partway. Have I done something wrong?

Yes, that will work for now. If you slide down that, you'll see -- you had mentioned before -- well, just look at the graph here. Those are low, medium, and high. Dark being low; the yellow, medium; and cream-colored, high.

This is schools. These are current health-care expenditures for current employees. And the number is pretty substantial. It's around $5 million as of 2003-2004. Counties, the State -- which were some of the numbers you're talking about -- cities, special districts.

Schools have a lot of employees, many of whom are going to retire soon. That's going to be a big factor very, very soon.

Of the thousand school districts, as far as we were able to tell two years ago when we did this research, there were only two that had any actuarial funds set aside. They were providing for all retiree

health care out of current cash.

The next one, please.

And probably skip the table, which is pretty sobering. We'll go right to the chart.

Is that the next -- yes, the next one after that, I believe.

Well, I'm not seeing something there.

In your packet, you have a total statewide cost of estimated health care. The essence of it is that the total estimated cost of retiree health care in 2003-2004, we estimated, was about $3 billion. And if you look down at the bottom, if current trends continue, we went out to 2019-20, it's about 31 billion.

Now, if you keep in mind that figure that was -- the expenditure for police services, that line will probably cross in our initial calculation, 2011, 2012, if you were to ask me to kind of do a back-of-the-envelope revision, I think it's probably going to cross in the next two years.

So next slide, please.

And maybe I'm doing something wrong here. Is that -- yes, you can -- the next one after that, actually.

And we'll -- yes, now, this is kind of interesting. That's -- we'll go with that right there.

Benefits per retiree. These are just for selected counties. This is the benefit per retiree. These are hard dollars out that counties were spending in their audited statements for retiree health care in 2000-01 and then in 2004-2005.

Now, Alpine is a small county, you saw a big jump. But we slide down here to Los Angeles, 2,765.08 per retiree, okay, that number went up to $4,667.40. And this is as of 2003-2004.

If you were to ask me, I would suggest to you that these numbers over here, if we went out another two years, are going to be a good deal higher.

Some counties were noticeably lower. Some counties have fewer retirees, for whatever constellation of reasons. They just had fewer retirees. Those counties are in good shape. But if you look at some of the others, those are pretty substantial.

Next slide, please. We'll do the same thing for the total costs for cities, basically here.

And you'll get some sense. This is statewide estimated cost for retiree health care for cities. Fiscal year 2003-2004 we estimated the mid-range at four eighty-seven. You go down here to 2019-20, and it gets up to $5.2 billion. So you're talking about real money pretty quickly.

We do the same thing in the next chart for school districts, which is perhaps the most sobering one. And in that one, the mid-range expenditure -- that is current operating funds allocated to pay for retiree health-care benefits; it's not an actuarial premium payment; it's the dollars that those government agencies wrote to provide that service -- was about eight hundred twenty-one. We estimated about $821 million in 2003-2004. Current trends and demographic trends continue somewhere around 8.8.

People I have talked to -- the next slide, please -- about this, say that our numbers were inordinately conservative. They think we're low all the way, which is kind of sobering.

Now, you'll see here, these are hard dollars in 2003-2004. School district retiree health-care expenditures per retiree, Manteca Unified School District, it was 8. Santa Ana Unified School District, and this was around eight. Drops down. San Diego Unified School District, some of these were quite a bit lower.

If you were to ask me again what I think it is as of this year, I think most of these would catch up.

You see the mid-range appears to be around that $4,000-per-year figure. If you talk to people in the

health-care insurance industry, they say that's getting off cheap.

With that, I'll be glad to answer any questions.

CHAIR PARSKY: Why don't we go through each of the presentations?

MR. PRINGLE: A clarification.

CHAIR PARKSKY: I'm sorry, one quick question, certainly.

MR. PRINGLE: I want to make sure I understand what this chart is.

So on this chart here, you're saying the retiree health-care expenditure per retiree, so --

MR. FRATES: That is correct.

MR. PRINGLE: That is only the benefit provided to retirees; right?

MR. FRATES: That is correct.

MR. PRINGLE: That's not any other employees within the system and so forth --

MR. FRATES: Yes, sir.

MR. PRINGLE: -- that is taking that?

MR. FRATE: That's correct.

MR. PRINGLE: And that's the same thing as it would apply to the cities that you represented?

MR. FRATES: Correct.

MR. PRINGLE: Or counties, excuse me.

CHAIR PARSKY: Ken, why don't you go and then Tom, and then we'll come back around.

MR. JACOBS: First, I'd like to thank the Commission for inviting me to speak here today.

I'm going to talk about some of the cost trends in retiree health benefits, how private-sector employers are responding to those trends and the implications to the public. And I will conclude with a little discussion of steps that could be taken in the current health policy reform debates to control health premium inflation.

As has been discussed today quite a bit, for all but four years of the last two decades, health premium costs have risen faster than workers' earnings in overall inflation. Premium increases reached double digits, from 2001 to 2004, and began moderating the last two years. They're now, as you know, slightly above twice the rate of inflation. And as discussed earlier, most experts believe that we're in a downturn in the insurance underwriting cycle and the premium cost increases will continue to slow in the coming years.

Faced with rising health premium costs, private employers have responded in three basic ways. The most common response has been to raise retirees' share of premiums.

In the last year, three-quarters of private-sector firms with retiree health benefits increased premiums for retiree care for those under 65, and a little less than 60 percent for those who are Medicare-eligible.

The second response is to increase cost-sharing through higher deductible and greater co-insurance. Again, about a third of private-sector firms in the last year surveyed by Kaiser Hewitt raised cost-sharing requirements for those under 65 and a quarter for those over 65.

And the third response has been to restrict eligibility. Between 1988 and 2003, the share of large private-sector employers offering retiree coverage dropped by half, from about two-thirds to slightly over one-third.

This has happened primarily through eliminating coverage for new workers and through business churning. The new firms that come into the market are less likely to offer retiree coverage than firms that were there before.

The reduction in retiree health benefits is undermining the financial and health security of retirees and has important impacts on public finances. As noted earlier, increasing retirees' share of premiums can lead

to financial hardship and, in effect, take up rates of coverage. Higher deductibles, co-pays and coinsurance do reduce utilization.

And in this current health debate, there's been some suggestion by number of people that that's actually a good way to control costs. But the research is fairly clear that with higher out-of-pocket costs, consumers do forgo care, but they forgo necessary care and unnecessary care in about equal numbers. And this is especially problematic for older Americans who are in the greatest need of preventive care, and are most likely to have chronic health conditions that will tend to worsen over time.

For example, the cost-sharing for prescription drugs for seniors has a significant impact on skipping medication.

The greatest impact is on those who retire before the age of 65 and they lack retiree coverage through their previous employment.

Job-based coverage in America for people under 65, in general, fell by 5 percent points between 2001 and 2005. The fastest-growing group in America without health insurance has been over 50.

The median retirement age is 62, three years before Medicare eligibility kicks in. But workers often

retire earlier than planned due to health-related causes or job displacement.

According to a study by the Commonwealth Foundation, one in five people between 62 and 64 reports having health problems that limit their ability to work, and one in four report that they're in fair or in poor health. And Black and Hispanic workers are particularly vulnerable to losing health insurance in pre-Medicare care years as they experience higher rates of involuntary job loss.

Across the board, older displaced workers are significantly less likely to be insured than their working counterparts one year or more after losing their jobs. And so while COBRA is available for 18 months after retirement at 102 percent of group rates, it's at full cost to workers, and once COBRA expires, coverage for late middle age and elderly Americans can be prohibitively expensive on the individual market without community rating. And those with chronic health conditions are, as everyone's aware, routinely denied coverage.

So looking at the research, we find that even small breaks in coverage between leaving work and eligibility for Medicare have been shown to have long-term health consequences. Those without health

insurance for any period of time are less likely to have access to preventive services, to have a regular source of care, to receive timely care for acute medical problems or to take medications for chronic illness, both during the time they're uninsured and in the years following.

Older adults in late middle age, which is defined as those older than 51, who lack insurance for as little as two years are more likely to experience a significant decline in health or to die.

At least one-quarter of those older adults would be uninsured at some point during the years preceding Medicare eligibility.

Along with the health-care consequences, losing health benefits can have a major financial impact on retirees. It seems obvious that older Americans, older adults and their spouses would face increasing health related costs than younger adults, but the fact is that cost increases grow precipitously in the late middle-age years as chronic conditions such as diabetes, heart disease, and high blood pressure become more and more common.

Male workers older than 55 spend five times the amount on health care spent by male workers in their twenties. Even small increases in out-of-pocket costs

during this period, not to mention catastrophic spending, can have an impact on retirement savings.

Traditionally, employer-sponsored retiree plans are more generous in providing prescription drug coverage and out-of-pocket spending caps than other sources of coverage, such as private plans.

So as availability and quality of employer-provided retiree plans decline, we can expect to see these financial impacts grow.

Health cost for the uninsured are not only borne by the individual consumers. Costs of care is also shifted onto the State and onto other players. Those who are uninsured delay care until problems become acute, then rely on safety-net programs and uncompensated care. Much of this cost is borne by the State and federal governments, as well as by anyone who pays for health insurance. And as the Governor has been discussing repeatedly, the American Foundation estimated that the cost shift from uncompensated care onto health providers is about 10 percent of premium prices.

As with the increase in premium costs, these problems mirror the costs borne on behalf of the uninsured in general, but are made more acute by the greater likelihood of uninsured people in their late middle-age to have chronic health conditions.

Finally, when workers do not have retiree health coverage, they're significantly more likely to stay in their job longer, regardless of whether or not that job continues to be a good skill fit. Either through reductions in the worker's physical capacity or through technological change that shifts the skills needed for that position, without retiree coverage, workers are discouraged from changing jobs to find fits that better match their current capacities if those jobs do not offer comparable health benefits.

Most of the decline in private-sector health benefits would be felt over time as greater numbers of older workers are left without coverage. Without changes in public policy, these trends will have negative consequences for the health of older Americans and can be expected to result in greater health costs for the State and for the federal government. For the State government to follow the lead of the private sector in this regard would be largely self-defeating.

The retiree health crisis in the public sector can't be separated from the health crisis in the State and the nation overall. Had the federal government lowered the Medicare age when it was proposed in 1998, we'd be having a very different discussion today.

There is an opportunity in California this year

to address some of those issues that affect health-care costs. The health-care reform proposals under discussion in Sacramento all have important implications for retiree health-care and for health-premium costs. Senator Kuehl's proposal, of course, would replace the need for retiree benefits in the State by providing universal access to care. Each of the other major proposals would leave our job-based health-care financing system intact but with some important modifications that would affect future cost increases.

All of the proposals under discussion would expand access to care, reduce the cost shift of uncompensated health care onto premiums. Each would promote greater emphasis on prevention, wellness, and chronic-disease management, and expansion of health information technology to reduce medical errors and improve quality. These measures are not only important for the health of state residents, but they could serve to help slow the rate of growth of health premiums in the state, including retiree health premiums.

So this discussion between, is it going to grow at 4 and a half percent or I think 16 percent is what's projected in your study *(pointing to Mr. Frates)*, has a lot to do with what's done on a policy level.

Consumer organizations have proposed additional

measures that could help bring premium increases more in check. And those proposals include requiring greater transparency to health-care purchasers, from providers on cost, utilization, and quality outcomes, in order to enable purchasers to make more informed decisions, help to ensure consumers receive appropriate care, and reduce high-cost care with poor outcomes. There are proposals to increase public oversight of health premiums and their component cost to help smooth the curve on premium increases and avoid some of the shocks of recent years, and there are proposals about allowing joining the newly proposed health pools with other state purchasers to maximizing purchasing power on prescription drugs.

These and other proposals under debate in California will have an important impact on retiree health benefits and, of course, on premium prices.

In the final analysis, the crisis in retiree health in the state can't be separated from the broader health crisis. Action will be needed by the State on a policy level to both improve health-care access for older adults and to control the rate of growth in health premium costs.

CHAIR PARSKY: Thank you very much.

Tom, why don't you go ahead, and then we'll come back and ask questions?

MR. SHER: Thank you.

My perspective is a little different than any that you've had before because I spend a lot of time, as well as my colleagues spent a lot of time, in the room with members of boards of supervisors, members of city councils, trustees of labor union health benefit trusts, and especially joint labor management meetings, where labor negotiators and staff from cities and counties and schools meet with representatives of all of their bargaining units to talk about what the heck are we going to do about the increasing cost of health insurance.

So what I wanted to talk to you a little bit about today is some real numbers and how these things are seen in the trenches by the employees and the retirees and the management, and to talk about how those costs are likely to grow over five or ten years -- and my number is not 4 and a half and it's not 16; it's about 9, and we can talk about why it should be one or the other -- and to illustrate the frightening impact of the resource-allocation issues that are confronting all of the participants to the decisions.

There are -- and this is page 2 of my -- thank you.

The next page.

There are four constituencies that show up at

every one of these meetings -- at least four. And there's those who are already retired with Medicare who are by far the most vulnerable in the system. They are not represented. Typically, no one sits at the bargaining table to plead their case. They have no subsidy by federal government programs for their health-insurance costs. And they are the first, at least in the recent months and recent year and a half, for whom employers have decided not to make any more contribution for retiree health insurance.

Those already retired with Medicare benefit from Medicare Advantage and other programs which have significantly reduced the cost of care, but more importantly, guarantee its availability to them regardless of health status. So as long as they sign up within a few months of turning age 65, they could get coverage.

The soon-to-retire are the people in the room who are typically having the most influence on the decisions. These are the senior representatives of the bargaining units, the management of the cities and the counties and the schools. And all of them are trying to figure out, are we, as individuals, not just our firm or our entity, are we going to have health insurance when we retire, and who is going to pay for it?

Finally, there's those who have a long way to go to retirement. And in many scenarios addressing remedies for the cost of retiree health insurance, there's a discussion of prefunding. And prefunding typically means the employer will put some money in, but we want you, the employee, to put some money in.

The folks with ten or more years to go to retirement have a reasonable chance to set aside some money to offset the cost of retiree health insurance. But those who have already retired or have just a couple years to go obviously have no opportunity.

Employees have views of retiree health insurance that are important to how they feel about their job, to how they feel about the service they give the public. They feel it's a benefit for their loyalty and the efforts that they put out for the employer.

Often, people select public employment for a particular reason, the scheme of benefits, an opportunity to serve. All of them are frightened. You don't want to have frightened employees.

The advent of GASB 45, the nameless thing that is hard to understand in normal-speak, has made it difficult and created a lot of anxiety. I've been to countless meetings with retirees, with active employees, to try and explain what is it. It's an accounting thing.

No, you don't have to fund it. But there's a lot of anxiety, so there are morale issues that arise with that kind of situation.

It is usually seen as vested, even if it isn't. And that's one of the esoteric discussions about how big your GASB liability is. And if it's vested, it's big, and if it's not, it's not.

And then finally there's going to be people starting to retire later because they will not be able to afford retiree health insurance or it won't be there. So some of the migration, some of the normal turnover in government staff and bringing new people into jobs and new talent and so forth will be delayed because retiree health insurance is not the sure thing it used to be.

Probably the most important thing I wanted to show you is a table that I've been -- I've put this up on screens now for four or five years. And I haven't been wrong yet, although that's a dangerous thing to say. But these numbers talk about the disconnect between wages and the rate of increase in health insurance. And the top row assumes a salary in 2007 of $45,000. Now, there are a tremendous number of employees, of cities, counties, special districts, and others, who don't make $45,000. There are a lot of entry-level jobs that start at $25,000, $26,000. So this is an above-average wage in a

lot of jurisdictions.

If we assume that that rate of wage increase is 3 percent a year, well, in three years it's 49,000, and in eight years it's $57,000.

Well, my number for future health-care costs is 9 percent. And I'm basing that 9 percent on pretty much the last 20 years, as well as industry expectations. And this is based on claims cost, not insurance company profits or margins or anything else. What are the costs of the claims going to be? What is the cost of the bills that will be presented for pharmacy, for MRIs, and so forth?

Using the CalPERS single rates, the annual cost of a single rate in 2007 for Kaiser of $4,800, in eight years at 9 percent, that becomes $9,600.

The numbers that are the most concern to the folks in the room at the bargaining table are down at the bottom, and that is rates as a percentage of wages -- would you go back to the previous slide? Thanks -- rates as percentage of wages.

The Kaiser single rate today for a person making $45,000 is 11 percent of pay. By 2015, it's 17 percent of pay. But take a look at the family rate. The family rate today is 28 percent of $45,000. It would be 44 percent of the salary eight years from now.

Now, what the next pages show you is a graphic presentation of that. And the good news here about the disconnect between generally accepted accounting principles and what benefit consultants have to put on the page -- I could never put four and a half percent on the page, I'd get in a lot of trouble -- is that generally accepted accounting principles and financial modeling follow certain rules that are required for financial statements and credit risk and credit evaluation and so forth. And everyone understands that that's what they needed to be used for.

The bad news about it, when I use 9 percent, is that it is more likely from a historical perspective to be the numbers that have to be used and have to be dealt with on the ground in the room at the bargaining table, and in the room at the board of supervisors or city council meeting when the question comes down to how much do we allocate to wages, how much do we allocate to health insurance, do we offer a 3 percent wage increase this year and pay nothing for retiree health insurance, or do we offer 2 percent and pay for retiree health insurance? Those are the kind of things that I have to look at and my colleagues look at when we're advising our clients.

The next page is a picture of the percentage of

premium as a percentage of wages.

The impact on the next page, of course, the lesser-paid are the most impacted by this situation. Some individuals drop family coverage. There's beginning to be a whole phenomenon of people taking their kids off coverage. And there are some places in the state where you're better off on Medi-Cal than you are on the employer health plan, which means that we're paying for it, anyway.

Those who retain family coverage have less money to spend elsewhere.

Finally, the impact on retired employees is that they are, as we talked about, no longer represented, they're not subsidized by Medicare; and as Ken pointed out, when these folks lose coverage, it truly is a risk to life. People without health insurance coverage don't do as well.

There are a number of counties who have already either changed how they rate retirees, where the retiree rates are higher than the active rates; or where the contribution for retirees has been eliminated or reduced.

What is not in my presentation is discussion of the remedies. And we work with our clients on a range of solutions which were alluded to by Mr. Dickerson. And typically, we're on the end of talking about changing

eligibility, having to work longer to get retiree health insurance, cutting benefits, making the deductible bigger, rating the retirees separately from the actives. Things that are excruciatingly difficult to deal with at the bargaining table.

Thank you.

CHAIR PARSKY: Thank you very much.

Questions?

Maybe we'll start it off with Steve.

I think one of the messages coming out of this morning to the State Legislature was that they should establish a priority in terms of reserving for the obligations that are being assessed for the State employees.

What kind of message, based on your analysis of the school districts, would you send to the school districts?

MR. FRATES: Well, what the State Legislature could send to the school districts; is that correct?

CHAIR PARSKY: Right.

MR. FRATES: Yes, sir. There are a couple of things that the State Legislature could do.

First, the State Legislature could say that school districts should be explicit every time they make a decision about benefit levels, as to the actuarial cost

of those benefit levels going forward.

Second, I think it's always prudent to look at the actual dollar amount that's being spent per recipient. There was a brief discussion, I believe, with my colleagues, I believe, Ken and Tom, about the 4 percent, 9 percent, or 15 percent. The 15 percent number we use is not an increase in premiums at all. In fact, the 9 percent is very close to what we calculated as well. The 15 percent number we used in this particular case was based on how much actual dollars were spent per retiree, period. I mean, it's just what the math worked out. It wasn't an assumption.

So the clearer that that is made to the local decision-makers and the public at large, the better-informed the public policy decision might be, which I think would probably facilitate a very fruitful discussion amongst the people making those decisions, which are the individual school board members and city council people.

CHAIR PARSKY: Thank you.

Other questions for this august panel?

Yes, Bob?

MR. WALTON: On that last response where you say it's actual claims paid, where did you get that data?

MR. FRATES: Not actual claims. We just looked

at the dollar amount that each government was spending for retiree health care. We didn't look at claims. We didn't look at benefit levels or anything. We took the total number of retirees in each system, and then the dollar amount each year that that particular government paid to finance the retiree health-care system.

We made no analysis or assumption about claim levels or service levels.

MR. WALTON: These benefits were retiree for cities, counties, school districts, does not take into account whether the employer is paying half the premium or all the premium or whether they're covering people after 65 or not?

MR. FRATES: No, sir. That's for current employees.

When we looked at retired employees, we looked strictly at the dollar amount the government entity was paying for retiree health care. We didn't look at the whole system in that regard.

MR. WALTON: No, what I mean -- exactly. A school district in Alpine may not provide retiree health coverage once you reach age 65.

MR. FRATES: Yes, that's correct.

MR. WALTON: A school district in another county, or a county, may provide health coverage after

65.

MR. FRATES: That's correct.

MR. WALTON: So this doesn't weigh to it based on what coverage they provide or whether they provide 100 percent of their premium or --

MR. FRATES: No. No, sir, it's just it's straight up the dollar amount.

MR. WALTON: Just straight dollar?

MR. FRATES: That’s correct. Yes, sir.

MR. WALTON: And it doesn't consider, for that matter, the fact that rural health care is 15 to 20 percent higher than --

MR. FRATES: No, sir.

MR. WALTON: It's just straight costs?

MR. FRATES: Straight costs.

MR. WALTON: Okay, thank you, Counsel.

CHAIR PARSKY: Dave?

MR. LOW: I just have a question, Mr. Frates. Maybe my math is wrong here. But on your executive summary, number three, it says, "The mid-range projected statewide costs would increase from $4.5 billion in 2006-07 to almost $31.5 billion in 2019-20. So by my math, that's 13 years and a 600 percent increase in that period of time.

MR. FRATES: Yes, that’s correct.

MR. LOW: And so if you just divide 600 percent by 13 it's about 46 percent a year?

MR. FRATES: Well, what we're saying is, if you looked at the increase -- we took into account demographics, increase in demographics, number of projected retired employees that we got from the U.S. Census Bureau data. So if there was a fixed number -- and I think this gets back to Mr. Walton's question to a certain extent. If you just look at a stable population and how much retiree health-care benefit costs per retiree, for a given cohort of retirees is going through per year, it would increase,
I think Tom said, something around 9 percent per year.

But we didn't look at that as such. What we did was look at the total number of retirees, the number of people retiring, and the projected number of retirees going forward according to the U.S. Census Bureau, and their projected life spans, and the cost of providing that amount over.

So I think there's some confusion about that 16 percent per year. It's the 16 percent per year dollar expenditure for a given cohort of retirees.

But you're right, the number goes up tremendously.

Now, a caveat on that, which I didn't say here

because we glued this together, unfortunately, somewhat at the last minute, is that number could be substantially lower or higher.

We say in the full report that we get extremely uncomfortable with going out much more than four or five years for all those reasons that we've discussed.

And I believe you were present, as I recall, when we made the presentation to the California Healthcare Foundation, I think, Mr. Low?

MR. LOW: No.

MR. FRATES: I thought I saw you in the audience there.

But we did make that distinction clear, that we're not wildly enthusiastic about going out more than three or four years or five years.

CHAIR PARSKY: Lee?

MR. LIPPS: Mr. Frates, if I could clarify your expenditure per person just one more time.

MR. FRATES: Yes, sir.

MR. LIPPS: If I understand -- and my familiarity is with school district budgets. And so if there's a line item that says, "Retiree health benefits" in the 2003 account --

MR. FRATES: Right.

MR. LIPPS: -- the district, let’s say they

have a hundred retirees, and they spend a thousand dollars per retiree for retiree medical benefits --

MR. FRATES: Yes, sir.

MR. LIPPS: -- they will have an expenditure of --

MR. FRATES: Actual number of dollars, yes, sir.

MR. LIPPS: -- $100,000, or $1,000 per retiree --

MR. FRATES: Yes, sir.

MR. LIPPS: -- by your calculation?

MR. FRATES: Yes, sir.

MR. LIPPS: If the school district collects that thousand dollars from the retiree in order to pay that benefit, does it still show as a 1,000-dollar expenditure by --

MR. FRATES: Yes, it does. How it's financed, we didn't address. Your question is right.

MR. LIPPS: Okay.

MR. FRATES: If, for example, there are some government entities that require retirees to pay into providing the benefit; and we didn't.

MR. LIPPS: That is not indicated by the figures --

MR. FRATES: No, sir.

MR. LIPPS: Thank you.

CHAIR PARSKY: Yes, Teresa?

DR. GHILARDUCCI: If one is alarmed by the cost of retiree health care, this panel has maybe almost equally alarmed at the cost of not having retiree health care. And it seems as though we may be in a position to actually wonder about the costs of not having retiree health care in school districts or counties that don't offer it.

So if you wanted to delve into what those costs are a little bit more, I'd appreciate it. And I think that the distribution of the way that you account for these costs are really different. For instance, if you raise premiums, it affects everybody in the group. If you raise cost-sharing with co-pays and such, you only affect the sick people in the group, the people who need it. If you raise the working age -- the age in which you can collect the eligibility requirements, then that has a distributional affect. And it could be on young people, because the older people are hanging on for their retiree health.

So do you have any more to say about the cost of not having retiree health?

MR. JACOBS: Well, just to say beyond, as we have discussed, the very significant costs on people's

health --

DR. GHILARDUCCI: Oh, yes, that, too.

MR. JACOBS: -- we have an impact on the economy as a whole, both from people who -- when people don't have health benefits -- if you don't have retiree health benefits, you might have changed to another job where you could have been productive in that job, now you're staying in a job that you're going to be less productive in.

We did some estimates -- and this wasn't looking at retiree health benefits but health care overall -- and estimated that the lack of universal health care in California costs the economy about a billion dollars a year. So we have broad economic impacts.

Then we also have -- and I think this is the important thing to take into account as we're looking through the financial impacts on the state -- that when people don't have health coverage and they end up delaying care and going to emergency rooms or going to the county health systems, those costs fall on county government, they fall on state government, and some part falls on the federal government. And then as we know, some part goes back into other people's premiums.

So in a certain sense, you know, what we've

seen, as employers are cutting back, we've seen a major cost shift onto those employers who continue to provide coverage and a major cost shift onto the State.

Were the State to respond to the health crisis by cutting back, it's, in effect, shifting costs on to itself.

There's a certain amount you gain there because people do die earlier when they don't have health care. And so there is some potential fiscal savings, if that's the direction you want to go. But overall, that didn't strike me as a viable set of directions.

I did want to say just one last quick thing, because in reading Mr. Frates' report, my understanding was that he was looking at the top of the underwriting cycle years, whatever it was, 2001 to 2004, to get that projection forward. And there was no look at sort of how was the economy growing as a whole. Because it's true, retirees are growing but you've also got a larger population. So I'd say most of the academic literature on this in terms of looking forward would have much more conservative numbers than some of those that have been discussed today, just to --

MR. SHER: My comment on that would be that the resource allocation process depends on who has the juice at the bargaining table. And the challenge becomes how

could you have to compete, especially for safety employees, again with the jurisdictions who offer a particular retirement benefit? Everybody knows there's a lot of unfilled positions in safety across the state, partly because of the National Guard call-up.

But the allocation process results in active employees sometimes -- the cost of retiree health insurance to them is a lower wage increase.

So when you talked about the different tactics that are applied to deal with the problem, prefunding it, setting up a retiree health savings account that employees can contribute to, all of these things shake out in different ways, depending on the constituency and how well they're represented and how effective they are with lobbying the various interests groups.

CHAIR PARSKY: Curt?

MR. PRINGLE: Following up on that just real quick. Have you seen over the last couple years with the establishment of 3 at 50 retirement benefits for public safety employees, a greater obligation on the health side because many of those retirees now still have families or a larger percentage are looking at family coverage at the point of retirement? Therefore, those agencies that traditionally had provided, you know, full family and benefit coverage upon retirement, when a retiree

traditionally is in his 60's, has less of a dependent number as opposed to continuing having a family?

I mean, I know in our agency we specifically see that as that area growing. And I just wanted to know if you have taken into account, or have you, in fact, seen that additional cost?

MR. SHER: Well, Commissioner, you do see a greater propensity to retire sooner, obviously if you can take a benefit that's a meaningful benefit earlier than you could in the past. But what's bargained and what the direct cost is to each employer or to the employee, the contribution for retiree health insurance is completely separate. So employers may offer 3 at 50, but offer a flat amount per month of premium contribution for retiree health insurance. So in the employer's budget, they don't realize an ever-increasing cost.

There are some circumstances, like the State of California 190 formula, where if you have more retirees and the formula is an index of the PERS health plan rates, then you will be paying more, and you will be paying all of the premiums. So if you have more retirees, you pay more of the premium.

But in state and local government, there's a tremendous amount of variation. Some pay a percentage, although far fewer do now than used to. A non-scientific

statement would be that the prevailing model is some kind of fixed amount based on years of service. That is probably more common than anything. So that if you work for 20 years, you get $340 a month; and if you work for 10 years, you get 170.

So it doesn't directly -- the incidence of more retirees because of an early retirement age doesn't always translate directly into higher cost for the employer.

CHAIR PARSKY: I want to thank you all very much for this panel.

We'll now move to -- oh, sorry.

MR. COTTINGHAM: I had a quick question.

Mr. Jacobs, you mentioned that the lack of having universal health care in California cost California about a billion dollars a year. And when Ms. Ghilarducci asked you about the cost of not having health care for retirees, you said there would be an inherent cost back to government, but you did not put a figure with that.

Is there an estimable figure that you could put to that?

MR. JACOBS: Not that I have seen.

Most of the research we've done has looked at the uninsured overall. So I haven't seen anyone do an

analysis along those lines, just looking at retiree health care.

But, I mean, I think it's important to note, in terms of all these issues on the costs to the State, and as we've said earlier, people who are older, and especially if they're not covered by Medicare, are much more likely to have chronic diseases.

80 percent of the health costs in this state go to pay for the 20 percent of people who have chronic conditions.

This is where -- I mean, there's a reason people's health benefits cost more when they're older, right? These are where the costs are incurred. But that also means this is the age group, if they didn't have health care, where the greatest impacts are going to be felt both on the public treasury and on people's health.

So I have not seen a good quantifying of exactly how many dollars we're talking about here. But I think, you know, that's the general point.

MR. COTTINGHAM: Okay. And when we're talking about the projected rate increase, and we've heard four and a half percent, and Mr. Sher said he would figure it at 9 percent, there's a little disparity there, but is something we should be looking at is how we can ameliorate the raise in rates, what we can do to offset

those rates?

MR. SHER: There's a tremendous amount of interest in behavior modification among pubic employer unions and management where, if you can get people to behave better, better self care, more exercise, better diet, following their medical regimes and so forth, there are studies out now that seem to show that if you do enough of the right things, you can take 1 or 2 or 3 percent off the rate of increase.

But it's tough to get people to change behavior.

If I'd ask everybody in the room if they'd walk a mile a day for 500 bucks, most of the people in the room wouldn't do it.

So the challenge with the behavior modification wellness programs is to get people to comply, to participate. But there is some evidence that's beginning to show that you can make a difference in the rate of increase if you get people to manage their own health better.

CHAIR PARSKY: That section over there is ready to walk.

MR. SHER: Do I have to write them all a check?

CHAIR PARKSY: Last question, Bob.

MR. WALTON: My comment -- Mr. Jacobs, please

correct me if I misunderstood -- for a direct cost -- for direct costs for just state employees, I think most studies have accepted at least 10 percent of a premium cost is due to the uninsured. I've seen studies that go up to 15 percent. So if you just look at the premium costs the State of California is paying for its employees, if you take 10 to 15 percent of that number, that's what it's costing the State just for its employees for the uninsured. That doesn't count all the other population.

MR. JACOBS: Sure, yes. You can do that on that piece, that's right. But I'm saying that you need to add that -- you can add that, you can add on if the policies that are passed go through that include more disclosure, so we can bring some of the poor care out of the system. If we can move towards more wellness cost, that brings some piece out of the system. There's a number of measures that can be taken both on a broad policy level and in terms of the policy reform debates and in terms of the things that Tom is talking about that can really bring that number down. And I think that's that's a central -- has to be a central part of these discussions is, are we going to go in a world where the premiums increase as they have been or are we going to look at some of these kinds of reform changes that would

both lead to better health care and bring those costs down? And I think that's the important debate the State's in right now.

CHAIR PARSKY: Thank you all very much.

Oh, excuse me.

MR. COTTINGHAM: I'm sorry, just one more question.

CHAIR PARKSY: That's okay. I should look in this direction.

MR. COTTINGHAM: You're forgetting us down here.

It relates to average retirement age, and I'm not really sure -- I know Mr. Pringle asked, Commissioner Pringle, because of the ability to retire at a younger age; but have you noticed in the health care -- well, and I don't know if you would -- in the health-care industry that that has been taken advantage of as significantly as people would think? Because I think in the retirement field, that it hasn't shown that there's been a significant decrease in the age of retirement. Have you noticed that?

MR. JACOBS: I think that -- I mean, Teresa can probably answer this best; right? But I believe the age of retirement has gone down slightly. But it's around 62 years. And so what you do find is that there is –-

if people do not have retiree health benefits, there is a tendency, as we discussed, to stay in longer in order to get benefit coverage --

MR. COTTINGHAM: But I think even though we have formulas available in California specifically to retire at a younger age, I don't think we're seeing a significant amount of people -- I don't think we've seen a significant drop in the average retirement age.

MR. FRATES: I think, Commissioner, it might be helpful to keep in mind the type and character of employees. As I mentioned at the beginning of my testimony, there's huge variability amongst agencies and categories of employees.

We are seeing some decrease in public safety employee retirement age as the so-called 3 percent at 50 kicks in. We're seeing a discernible decrease in the average age of retirement, of police officers trailed, to a certain extent, by a decrease in the average age of firefighters.

For employees overall, I don't know. But we're starting to see that already.

CHAIR PARSKY: Okay, Ron, do you have another one? Is it okay?

Now, we'll move on to our next panel.

Thank you very much for that.

CHAIR PARSKY: Thank you both very much.

Please introduce yourselves to those in our audience, or those up here that don't know you, and then proceed ahead.

MR. GREVIOUS: Good afternoon, Chairman Parsky and Members of the Commission. My name is Jarvio Grevious. I'm the deputy executive officer at CalPERS for Benefits Administration. And as such, I spend most of my time overseeing the health benefits program.

So my intention today is to provide you all with an overview of the program for those that may not be familiar with how we operate, and then recap some of the recent activities undertaken by staff and the board at CalPERS to restrain as best we can the health-care costs affecting our population, and then offer some perspectives on that what we think we can do going forward.

So at CalPERS, we're generally known for our investment acumen. We're the largest investment operation in the nation. But we're also the third largest health-care purchaser in the nation. And when that is said, it means that we're the third largest commercial payer of health care in the nation. So that would exclude things like your Medi-Cal programs in the state of California.

We're second behind the federal government and General Motors. And currently, we're spending about $5 billion per year for our health-care benefits to all state government employees, including CSU employees and 1,100 contracting public agencies.

So overall, we have 1.2 million enrollees. That includes all of our active members, retiree members, and their family members. So that breaks down, as is reflected there, we have 75 percent of our population are actives, 25 percent are retirees; 61 percent are state members and 39 percent are local-agency members, including school districts.

Okay, in terms of the plans that we offer currently, we operate our program offering two -- well, "statewide" is a misnomer. I should have corrected that. That's how we've referred to them -- two broad-based HMOs, one being Kaiser, the other being Blue Shield. There's one regional HMO that operates primarily in the Sacramento area, that's Western Health Advantage; and then two self-funded preferred provider organizations.

The statutory authority for our program emanates from PEMHCA. I think you've heard that referenced a couple times by other speakers.

This program was established in 1962 by the State Legislature, amended in 1967 to allow the inclusion

of local agency members.

And one of the basic tenets of this program is that employers are required to contribute both for the health care of their active and retired employees. And that's not the case with many other programs.

I should say -- and that's redundant -- I should say that although they're required to contribute, the contribution ratios are established through their respective collective bargaining arrangements or agreements.

In terms of its history, CalPERS has a pretty well-documented history of operating its programs fairly effective. In the mid-1980s we had an access of 25 health plans that we offered. I think that was sort of the norm back then, that members were offered choice by virtue of having a number of different plans.

In the 1980s we standardized our benefit model and entered into an approach which was generally referred to as the “managed competition model.” The idea is you could standardize your benefits and have the plans compete, one against another each year, and hopefully you'd get the best price. And for a while that actually worked pretty well.

In 1999, the premiums started to rise again, indicating that that model had some flaws in it. And

in 2003 -- well, between 1999 and 2003 the premiums were increasing at about double-digit rates, culminating in 2003 when we actually experienced a 25 percent increase in premiums for that particular year.

And essentially -- let me catch up with my notes. I've gone a little far, so let me back up here.

And essentially what had happened, going into 2003, is that the nature of the health-care markets had changed substantially. Basically, in the heyday of managed care, I think consumers had less of an influence on what they were able to acquire through their benefit programs, and, secondly, the hospitals and provider organizations were not very well integrated or organized. So health plans could exert their influence. That all started to change in the mid to late nineties, and the provider community, I think, figured out how to compete effectively with the health plans.

So essentially what you were getting was sort of the same high cost across all your plans. So that's what happened. So as a result, clearly a different approach was indicated.

And what this chart shows, thanks to our Legislative Analyst, is a handy chart that reflects some of the activities or initiatives undertaken by the board to try to deal differently with the problem with

rising premiums. And essentially what it will show is that we saved, in total, $168 million. Most of that is recurring on an annual basis. And reflected on there are efforts to try to work with the provider community. Specifically, we started to identify -- we got below the plan level and started to identify who were the high-cost providers.

Am I running out of time?

CHAIR PARSKY: No, no, please go ahead.

MR. GREVIOUS: And very briefly, we stopped doing business with some of our high-cost hospitals. We were able to save some premium costs there.

We also adjusted the pricing for the CalPERS program on a regional basis, and also started to move more aggressively towards the use of generic drugs.

So as a result, we were able to drop, in 2005 and 2006, to single-digit rates.

2007, there was a bit of an aberration in -- there were some changes in the provider contracts that we had, and we experienced an increase again of over 10 percent. It's hard for me to even say “12.”

The contract negotiations for 2008 are to be concluded soon. And I do expect a result that's more akin to the 2005 and 2006 levels.

Okay, just an example of one of the provider

initiatives that we have, you know hospital costs are -- not to make them out to be the bad guys, but hospitals are the largest part of your cost portfolio in almost any health plan. So we believe that some performance transparency is important, meaning that we should know better what the quality outcomes are from a particular hospital, the relative cost efficiency from one hospital to another so that we can exercise some choice in who we do business with. So both the chart and the hospital value initiatives are cooperative endeavors geared towards producing that result.

And I think I'd like to just echo some of the things that our other speakers have said, is that the cost containment challenge is not one that even an entity as large as CalPERS can solve, and neither can the federal government, because things like the prevalence of chronic diseases as our population ages, the introduction of new technologies, drugs -- the introduction of a single drug costs $1.2 billion on average. And there are huge variations in hospitals and physician costs.

I won't go into all of this.

Obviously, the point that was raised with the last panel, the impact of the uninsured has an effect on our population as well.

If you look at this particular chart very briefly, what that is, is a cohort of hospitals doing business with Blue Shield of California. And clearly, with respect to the business they do with the uninsured, which is charitable care, with Medi-Cal and with Medicaid they lose money on all those populations that they care for. So where do they make it up? It's with the commercial payers. CalPERS is included in that group. So they need to generate about a 27 percent profit in this payer market in order to come to a 3.2 percent net profit which, you know, is not unreasonable, by any means.

All right, kind of turning our attention to retiree care specifically, we're pleased to report that CalPERS has been able to establish, starting March 1, 2007, a program to allow for the prefunding of retiree health care for any PEMHCA members that choose to take advantage of it.

As someone had indicated earlier, there's an Assembly bill, 554, currently in the Legislature, that we're working with the Administration on. We're hopeful that we can secure an agreement on the language, so that we can move that to an urgency basis. That will allow for non-PEMHCA local agencies to participate in this program, should they care to.

I won't go over the benefits of that. You've talked about that all morning.

I'm pleased to announce that the City of Thousand Oaks has been the first entity to enter into this trust arrangement. And their liabilities prior to prefunding was $25 million. So as we've talked about earlier, once you enter into a prefunding arrangement, that liability for that entity is now $17 million. Still large, but much smaller than twenty-five.

Okay, I just wanted to touch on the fact that if we're going to talk about the costs of retiree health care, it's really the talk of health care in general. So one bright spot is that the Governor, the State Legislature have introduced various opportunities for increasing access, improving performance transparency, and other means to reduce costs. So I think that these are things that we are actively involved in and would encourage the Commission members to give those their attention as well.

Likewise, even though there's not an initiative at the federal level, there are some activities at the federal level that can help in terms of this cost containment battle. One is to allow for easier entry of generics into the pharmaceutical markets. There are obviously competitive reasons why that might not happen.

Biopharmaceuticals are the next large cost pressure. There currently doesn't exist a pathway for their adoption in the generic area. Henry Waxman is carrying a bill to that effect, that would provide for that. We would support that. We would encourage you to kind of take a look at that as well.

And, obviously, supporting legislation that would promote the use of health IT and the take-up of that within the health-care markets is one that we would ask you to consider as well as we are.

So let me close with that.

We think that there are a number of things that an entity like CalPERS can do to help restrain costs. But in the end -- in the end -- I think that a broader -- the board members share this view, that in the end, a broader -- any meaningful change, I think, in terms of restraining costs require some structural changes in what is currently a dysfunctional health-care market.

So let me stop with that.

CHAIR PARSKY: Thank you very much.

Jack, I'd like you to be next. I know there are a couple of commission members that have already indicated that their travel arrangements would require them to depart a little bit early. It's perfectly okay. We understand that.

Jack, go right ahead.

MR. EHNES: Thank you, Mr. Chairman. We're just getting some slides up there. It's good to be with you.

You've all got a wealth of experience here obviously on these issues, so I think the best that I can do for you is to give you some sense of the context of the educator health-care market here in California and also the activity of the our board, because the board of trustees is very attentive to the health-care concerns of our membership.

(Dr. Ghilarducci and Mr. Lipps left the meeting room for the day.)

MR. EHNES: I would mention, in addition to the slides that we gave you in our packet, I think we gave you a four-page handout; and for the audience here as well, we released today this brochure called “Uncertain Coverage Spells an Uncertain Retirement.” And it's really the release of our survey. We'll be releasing it to the public today and tomorrow. It will be on the Web site, the actual full survey with all the data results for the media to look at. But we do think it's just another data point for you to put into your thinking, so that you can get ahold of this complex educator market.

Just to cut to the end, I want to leave you kind of with five key points and then I'll back up a little bit, but I want to make sure that I'm succinct here in leaving with you some of our impressions of the issue.

First off, unlike some of the other areas we've talked about, there are really large inequities in the educator health-care marketplace for retirees. This is a system of haves and have-nots. So I'm finding solutions where some districts are providing good, reasonable care for the retirees and some are providing nothing, makes it a complicated problem particularly, I think, in the educator market.

There are some unique factors -- and I'll show you a few nice fast facts from our system -- but there are some unique facts about educators relating to gender, mortality, that affect this challenge. And I know you've probably talked about fire and police before, too, which also have some special characteristics when we design pension and health-care benefits. But educators also do have special characteristics as well.

You're going to find that they often work longer than other public employees. They generally live longer than other public employees, and a somewhat counterintuitive comment, because our workforce for

educators is predominantly female, this particular group has a higher incidence of breast cancer than other female working forces. And there's some special issues around education and when women are in the workforce that we're finding through the sponsorship of a special study with the University of Southern California on teachers' health care.

The third point is that health care is purchased for educators through a myriad of approaches. So it's not so singular and as neat as what we've described coming from the CalPERS system. This is, as I said, a very uneven landscape of purchasing habits on the part of school districts.

Fourth, and clearly a point from the study that I'm about to show you, the employer commitment is eroding for providing retiree health care in the post-65 years. And that's going to have serious implications, which really leads to the last point.

I think we do feel at CalSTRS that we've been providing a good, a solid -- not a rich benefit, but a solid pension benefit for our membership. But to the extent that we can keep saying that, to the extent that those post-65 health-care benefits start to erode more and more, I think we're going to be unable to say so.

So those are the, I think, key points that come

from this.

Let me get going here –- there we go.

Just generally about our system. We provide retirement benefits for 800,000 active retired educators. So our core competency, to use the business term, is managing pension benefits.

I think as our board looks at health-care issues, we really need to find ways our system can complement the activities that other people are doing in this.

To use the cliché, we don't want to reinvent the wheel. CalPERS has had a long, rich history of working with their pool. So to the extent we get involved in that, I certainly don't think it's cost effective to just try to replicate other successful efforts in what we do here.

We're a very old system. I will tell you –- a lot of people don’t realize we're one of the oldest, oldest pension systems in the United States, starting in 1913.

Just take a look at some of these statistics on who the membership is, and you'll see right away that there's some things that are different here about this membership.

64 percent of them are female. Her average age

right now is 72 years old, been retired for about 11 years. 60 percent are unmarried. Interesting, huh? Obviously, affecting financial security quite a bit when you look at it that way.

The average retiring member worked for almost 29 years and retired at age 61. They expected to live about 27 years after retirement.

And these statistics, which we have to say over and over again to people, because it really is the telling comment on the adequacy of the benefit, on average, they're replacing about 63 percent of their salary.

Anyone who has been to a financial planner knows that's not the number you want to hit. So there's a gap there that has to be made up through other savings for them.

And most importantly for our story, we're not part of the Social Security system. Members do it, qualify through other employment, in many cases. There's penalties attached to those benefits. And so there are implications for that as well.

So the safety net for our workforce is very different.

You know, you've heard a lot of statistics about health trends and the costs of premiums. For me,

when I think about success, if we're doing what we need to do for our membership, you know, I really go to the end and look at what is the quality of their retiree life, are they meeting their expectations for retirement, what is that replacement ratio. That kind of tells us when we put this all together, you know, are we being successful.

Boston College has done some good retirement research at their Center for Retirement Research. And a statistic that sits with me is that they've looked at the percent of after-tax dollars retirees spend on health care and how that will change over the years. In 2000, it was around 17 percent for unmarried older adults. So that would fit our workforce. 17 percent. That is projected to go to about 30 percent in 2030. 35 percent if you're a married couple. And even worse, if you kind of slice that data in quintiles of income, looking at the very five quintiles, for one of those quintiles, the second from the bottom, that percent of available income for retirement is projected to be 40 percent of your income for your health care. So an unsustainable number, essentially, in retirement.

The second point to make, benefit adequacy. Again, we've all grown up in this model that you need to plan for retirement about 80 to 85 percent of your

income. That number probably doesn't hold true any longer given what we're seeing with retiree health care.

In the third piece, which may sound odd to mention today, but I think it's a relevant symptom of the problem, and that is home mortgages, believe it or not. More and more in financial planning, people have started looking at that home equity as an asset. And the reason is because of the concerns about funding health care. We wouldn't have done that years ago. We wouldn't have viewed the home equity as an income source for an annuity in retirement.

As a result of that, CalSTRS announced two months ago a new reverse-mortgage program.

Now, I have to tell you I have some concerns about that because you know those can be very beneficial for some but deplete a very valuable resource for others. But it is a symptom of what we're dealing with today, that the home mortgage is now on the table for financial security. So something for us all to reflect on, where we've come.

Okay, let me kind of go quickly then.

Health care is negotiated at the local level. That's what makes it so tough to have a clear discussion around schools: 1,400 school employers.

This is just a pie chart in your handout to

show there are many, many, many approaches to purchasing health care for school districts, from working through the CalPERS pool, through direct contracts with insurers, through joint powers agreements, or for trusts.

Most schools are operating, some in some economic opportunism to find the best arrangement they can and go back and forth.

There's also strong -- when you talk with schools, there's still a strong connection to some of these regional purchasing patterns. So even though we might think it always makes sense to buy through a large aggregated pool like CalPERS, I think you find when you talk to the employers, they have special commitments at times to these regional trusts, because they do feel they're making good purchases.

In our case at CalSTRS, our activities are these: We pay Medicare Part A premiums for eligible members who did not qualify for Medicare A. So that's our current financial play in the health-care area. And I guess you could say lucky for us it's a very good one because it has had a very defined economic effect and it decreases over time. Because now after 1986, everyone pays into the Medicare tax. That population definitely decreases more and more over time. So our financial liability in that area is very clearly defined.

We're conducting surveys on the state of health care in public schools every three years, and that's what we were issuing today.

We're now conducting a study with CalPERS looking again at a statewide pool. And that's not to say we would manage it, but we're certainly looking at the feasibility of the issue. And then we convened a very active task force of stakeholders and our board members. And I'm just going to highlight the very end four options they're real serious about in looking at complementing what's now available in the marketplace.

Not much to say, per se, on the Medicare A piece, other than it's currently being provided for about 6,200 members. So as you can see, that's a very small slice of our population.

We have set aside, if you want to say, $1.2 billion from the pension fund. So it's certainly not -- it's not free money by any sense. That would be money that would be otherwise used to fund the core pension. At this point, we've identified up to $700 million in total costs under the current eligibility rules. If those were extended, that would increase the liability about 840 million.

So as the board defined this program some years ago, we're operating within its financial constraints.

For GASB purposes, this program will appear to be unfunded, given the nature of the accounting rules. But, in fact, the resources have been set aside so that it's fully funded.

Hopefully, you'll get a chance in your leisure to look a little bit at the health-care survey we've provided you. But I just really brought out two tables here for the audience. Hopefully, you've grabbed the brochure as you walked in, you certainly can't see that on the screen. But the message is obvious. Employers are increasingly likely to reduce or eliminate support after age 65. We had 36, changing to 39 percent of the employers that are now providing no payment after 65, and 18, jumping up to 28 percent of the employers that were paying a partial payment, and then no payment after 65.

So sure enough, this is clear validation for those retirees after 65, that it's going to be tough going.

Again, on the new-hire side, for new employees, the data really, again, shows very clearly that there will be more responsibility for those employees to bear the costs of their health care after age 65.

Health-care task force. On that, they've been meeting monthly. We have representatives of certificated classified employees, employers, and health insurers. We

focus on opportunities to make health care more affordable for our retirees.

And I'm not sure if you've discussed these or looked at these in other parts of your testimony. In candid, these are long-term options to think about because they require funding, and they are meant to be tax-free benefits to the retirees so they require employer contributions. So to the extent these ideas can be vetted and ripened over time, hopefully they could be brought into some of the solutions that we shape here for our membership.

But real quickly, health-care security accounts is an option where the employer makes contributions to individual employee accounts. It's much like a cash balance plan, really, in the pension area but designed for health care. They earn a guaranteed interest, and the funds would have to be used for health care.

A very good approach, obviously, for prefunding and long-term savings for health care.

But we provide a table here for you to show you just what is -- for providing a benefit that would equate to about $400 a month in today's dollars. Those are the payroll amounts that would be required -- the contribution rates by age.

So those are significant, certainly, for

looking at that type of benefit.

More on the modest side is picking up the Medicare Part B premium payment. That's paying, for example, the current $93-per-month premium. Looking at that, funding something like that on a required-contribution basis on payroll is a much more modest benefit, much more defined benefit. So that's something that we want to give more serious consideration to over time, as a concept.

And one I think that particularly has the interest of the task force at this time, and we're going to dig in a little bit deeper, is just the idea of a monthly health allowance, a fixed dollar amount, essentially. The task force is focusing on a dollar -- on a sum of around $300 a month and what it would take to fund that, increasing that percentage with years of service.

And again, here's a table that shows you, again, what those percent of payroll amounts would take to fund that $300-a-month benefit based on various scenarios on plan design.

And then finally, just another approach to support here for our retirees is around purchasing power. Right now, CalSTRS essentially provides what we call 80 percent purchasing power. When the pension annuity

falls below 80 percent, then the plan steps in and provides a restoration of that purchasing power.

One option that the task force has been thinking about and looking at is actually looking at that, and whether or not when it falls below 80 percent, restoring it up to 85 percent, and using that difference, though, exclusively for health care.

Again, to the extent all of these would be using tax-free dollars, it leverages their power all the more for the benefit of our retirees.

So those are four interesting options, I think, that they've wrestled with and have been doing a lot of costing with our actuaries. And just in the next half of this year, those will come back up to our board for more vetting and consideration how to work into some type of long-term funding plan.

So those are my formal comments.

CHAIR PARSKY: Thank you very much.

We'll turn to questions.

Just to start off a little bit, if each of you had a message to give to both your constituents and to the public at large in California about the primary concerns you have or things that needed to be focused on now as opposed to delay in this area, what would each of you say?

MR. GREVIOUS: I can start with that.

I think, one, that the availability of affordable health care for our members as well as other people in this state and in this nation, I think, is fundamentally desirable. So I don't think that simply whittling away benefits is -- that we should spend much time on that sort of activity.

The other is that the health-care markets are in serious need of some structural changes. They do not operate as a normal market would.

I think long-term, that is something that needs to be addressed; and the sooner we get about agreeing on an approach to that, the better off we will all be in terms of the first principle, which is trying to maintain access to health care.

Secondly, we heartily support the notion of prefunding. It makes sense fundamentally. We have provided a vehicle to that effect, and would hope that that would be considered by all affected.

MR. EHNES: On the educator market side, the fragmented nature of the market just jumps off the page. You have some schools -- since these benefits are collectively-bargained, you have varying skills of that activity and varying resources by school district. Even on the employer's side, you certainly have varying skills

on their ability to get the best deal for the retirees. So it's a very chaotic marketplace on the educator's side for the purchasing of health care.

And then the benefit level itself, as I said, the fact -- if you look at all those charts that are in our report to you today, and if you look at the cuts that are by size of school district, always the smaller school districts in the aggregate are at a grave disadvantage relative to the larger districts.

And, you know, my concern is they get left behind, actually. I think that's what has happened over time. And now we've reached this very critical juncture, and we've got to make sure they stay in the discussion.

CHAIR PARSKY: Questions?

Yes, Ron?

MR. COTTINGHAM: On your health-care task force, your employees, is that a combination of -- do you have retired employees and active employees in that group?

MR. EHNES: Yes.

MR. COTTINGHAM: And how long has this task force been in place?

MR. EHNES: Oh, it's been going on since about the first of the year; wasn't it? Yes, around January of this year. And they've been meeting diligently --

MR. COTTINGHAM: So the first report, they haven't made their first report then; is that what you're saying?

MR. EHNES: Each month -- they've actually been vetting options and getting tighter and tighter towards some conclusions. So we're meeting here just actually within a week. And I think the one option particularly is the one they're focused most on.

So they're reporting back to the board of trustees of counselors here shortly in the next two or three months.

MR. COTTINGHAM: Okay, and as a system, are you finding this beneficial so far, from the input that you're given to this point?

MR. EHNES: Well, you know, there's been a cycle to this, honestly. When all the pension plans were in surplus positions and people looked at issues that are relative to surpluses, health care was always on the table, whether or not we could do fixes in that area. And not that much was done for the educator market. So this has lagged for some time, solutions; and now we've reached a critical situation. So the board defines -- even though our core competency is pensions, our mission of the organization is certainly securing financial security for our members. So to do so, that naturally

embraces health care. So absolutely, the board has to tackle this in some fashion, whether we do that providing some assistance to CalPERS or commissions like yourselves. But I think we realize we have to be in the play now and be active in this discussion, the board does.

So absolutely, the answer is, they've got a commitment to stay in it and to seek out some solutions.

MR. COTTINGHAM: Okay, thank you.

CHAIR PARSKY: Any further comments?

I think as we go forward, I think it will be important for this Commission to begin to differentiate recommendations that might, in this area, address structural changes or other changes in the health-care industry, and things that could have an immediate impact on providing a sense of security for the public employees of our system.

And we will, I think, attempt to take a look at both areas. But we may have a small voice in changing the entire medical health-care industry in that process.

But I really appreciate your contribution. And we'll stay in very close touch as we go forward.

Thank you both very much.

MR. EHNES: Thank you.

MR. GREVIOUS: Thank you.

CHAIR PARSKY: Okay, the third panel now could come forward, please.

The title of this panel is How Locals Are Responding to the Growing Health-Care Costs.

So the four of you represent locals, and we welcome your contribution.

Why don't you just introduce yourself as you're going forward?

Have you determined the order? I know there was one change that we wanted to make.

MR. SMITH: Yes, we have. I've moved up to first. I'm Tom Smith.

CHAIR PARSKY: Okay, Tom.

MR. SMITH: I'm the vice chancellor for the Peralta Community College District.

Peralta operates four colleges, two in Oakland, one in Berkeley, one in the City of Alameda. We're serving 27,000 students. We currently have 800 full-time employees with lifetime benefits. We have 800 retirees with lifetime benefits.

I started working on this problem in 1999-2000, before I ever heard of GASB 45.

Having been working in the private sector, I was a little astounded that we had lifetime medical benefits but we weren't putting away any kind of a

reserve. So I had an actuarial study done in 2000, and found out that we had $150 million unfunded liability. I didn't know about GASB 45, but I knew I had a problem. The problem wasn't GASB 45. The problem was a cash flow problem.

The encroachment on my budget, as we kept spending higher and higher amounts, was taking money out of the classroom to pay for my retiree medical benefits. That was an unacceptable situation for the college.

At that point in time, we started to plan how could we get out of this hole. And what we decided to do is put together a very key committee that included all of the constituent groups of my district. It included the president of the board of trustees, Bill Withrow, who is formerly the mayor of the City of Alameda. He's an MBA from Harvard. We brought in the president of our teachers' union and put him on this committee. We brought in the president of SEIU, which is our classified union. We brought in a representative from our Local 39 Operating Engineers Union. We brought in myself as CFO; and, of course, our Chancellor, Elihu Harris, is a two-term assemblyman and a two-term mayor of Oakland. That was the committee that went and put together the first OPEB bond in the State of California.

Okay, let’s see. I know it worked before, so

it must be me.

Okay, as I said, we did an unfunded liability that ranged from $132 million at 7 percent, to $196 million at 4 and a half percent. We had been funding this on a pay-as-you-go.

What we did is we worked in agreement with the unions that we would institute a two-tiered system. Employees hired after July 1st, 2004, would not get a lifetime benefit. They would get a benefit until they were Medicare-eligible.

This is kind of a picture of what the problem was for Peralta. As you can see, the annual costs were projected at double in 10 years.

My challenge -- I faced four challenges, basically:

The increased encroachments on the general fund.

The GASB 45 compliance.

I was very concerned about the bond-rating agencies' concerns over an unfunded liability.

And I certainly had public relations and political problems.

CHAIR PARSKY: That's all? And don't we all?

MR. SMITH: On a projected pay-as-you-go, you can see that the nice bell-shaped curve -- and that was

what was encroaching on the general fund, and that was unacceptable.

It was estimated that we had 5 percent of our budget was going to health care. It was going to go up to 8 and a half to 9 percent in less than 15 years.

GASB 45 said you have to do an actuarial valuation every two years. The annual required contribution for Peralta was in excess of $13 million. I could not afford $13 million.

This is just how GASB 45 envisions an irrevocable trust.

What I did was something a little bit different. I had four alternatives:

I could ignore it, because I'm getting pretty close to retirement myself.

I could eliminate the benefit and I would have significant labor issues and probably potential litigation that would probably result in the court telling me that this is a vested plan.

Funding the ARC was financially impossible.

So, really, the only alternative that we had was to issue the OPEB bonds.

The legal structure was approved by a court. The security is widely accepted by the bond market.

We went into court in Alameda County. We got a

judicial validation judgment on November of 2005.

There is no voter approval required. It's a refinancing of an existing debt.

The legal debt of the district is payable from all legally available sources. So basically what I've done is I've mortgaged the district for the OPEB bond.

It's a limited obligation bond. It's a taxable bond. And I have no additional taxing authority with respect to that bond.

What I did by borrowing $150 million, is I have basically done a remortgage of your house, let's say. I've taken a 20-year mortgage and I've basically extended it out to a 40-year mortgage, which means I'm able to remain level at 7 percent of the general fund as my expenditure for health care. That was the key to this.

Now, after I borrow $150 million, the board is naturally going to ask me, "What are you going to do with it?" What I did to give them some political cover is, we said that we were going to invest it in a PERS-like asset allocation. We did research into how PERS was allocating their assets, as well as ACERA, which is the County retirement system.

We also did the analysis that showed that PERS was earning on average a little over 12 percent, if you go back over the last 20 years. That's what we did. We

did that same asset allocation. We have stocks, we have bonds, we have emerging markets, we're international, and it has done quite well so far.

The bond that we sold was rated A+ by S&P. It was AAA insured by FGIC. Our total in costs was 5.58 percent. The initial offering was four times oversubscribed. And we had a very large global investor base.

Thank you.

MR. DOLE: If I may, my name is Rod Dole. I'm the Auditor-Controller for the County of Sonoma, up in the wine country. You'll have to come up and visit us there instead.

CHAIR PARSKY: We'll visit at our next meeting.

MR. DOLE: Yes. Well, I was here for the Orange presentation also and testimony.

Really, I want to -- the purpose of my presentation is twofold. And one is to clearly separate for the commission the difference between in Sonoma County our funding for our defined benefit package or our program, versus OPEB. And our defined benefit package is a 1937 Act. We have $1.6 billion in assets. We're 91 percent funded, actuarial value assets. I think you understand that that's the reserves that are reduced. And we're 100 percent funded -- or, actually, over

100 percent funded at the market value.

We have a 3 percent at 60 enhanced program. However, in our case, the unfunded liability, the employee contribution and employer contribution were paid for by the employees, or are being paid for by the employees. So if you will, it's sort of a defined contribution. They're picking up all the costs with the defined benefit package on the back end.

We have a strong relationship with our retirement system. I sit as a trustee on that retirement system. We support CSAC's pension principles, and I'd like to discuss that a little bit with the commission later on.

And SACRS, which is all the independent 1937 Act benefit systems, on the average is 86 percent funded.

So the point is our pension programs are well-funded in the 1937 Act. We don't feel that this needs a lot of attention by the Commission -- that's just our personal opinion -- but we do think OPEB does.

And with that, I'll jump into OPEB. OPEB, in our situation, we were pay-as-you-go, as most agencies were. This last year was about $20 million, or 7.6 percent of payroll. That cost has been jumping double-digit every year. And I'll show you a chart in a

second.

We receive no prefunded assets at this point, although with the last budget we did prefund about 7 million.

Our unfunded actual liability is $381 million. Our ARC, or annual required contribution, is $37 million, or 13.9 percent of payroll, an unacceptable situation, as Tom mentioned earlier.

I wanted to give you a sense of what we've experienced in Sonoma County in the increase in retiree health benefits. As you can see, in 2001-02, retiree health benefits was a very small percentage of payroll, 2.85 percent. And in 2006-07 we were reaching 7.6 percent.

As you can see, we were increasing in the 20 percent ranges every year.

Now, I'm pleased to announce that for 2007-08 that $20 million is flat. And I'll show you in a second what we've done to make that flat.

So our options were pay-as-you-go funding. The other was pay the ARC. However, we would have had to cut programs and services. Our third option was reduce the ARC by modifying retiree health benefits and/or OPEB bonds. And Tom just mentioned those. And we're looking in --

This gives you a sense -- you were asking about charts of future costs related to actuarial costs on health benefits, retiree health benefits. This was the chart that we shared with our employee groups and our management employees to give them a sense for what the costs would be for us as an organization in Sonoma County.

In September '06, we began discussions with our employee representatives. The idea was to educate, recognize the problem, free-think suggestions for reducing the OPEB.

In April of this year, the board of supervisors reduced the employees' contribution for health benefits for retirees and active management and confidential employees.

Basically, we have three plans that are offered, medical plans. Our current funding is 85 percent of the plan, 15 percent is picked up by the employee.

What the employees and the board agreed to is to pick up 85 percent of the lowest premium.

That resulted in about a 10 percent cut in overall costs.

If all employee groups agree to that same reduction, we will have about a 30 percent reduction in

costs.

The OPEB bonds option, Sonoma County is researching this. This could reduce our annual ARC by as much as $6 million, or 15 percent, a significant reduction. Again, our difference right now is a $37 million ARC. We're paying as you go $20 million. So we have about $17 million defined.

We feel that the OPEB bonds may be necessary in order to motivate the employees to participate in negotiating lower benefits. Again, our first priority is to make sure those health benefits are always available to those retirees, and then still make reasonable contributions or competitive contributions towards that benefit.

We've had a very positive experience in pension obligation bonds in the past in Sonoma County with significant savings in those areas. So OPEB bonds seem to make sense for us.

Our concern with OPEB bonds is sort of this soft versus hard benefit obligation. In other words, right now, it's a negotiated benefit each year. By selling OPEB bonds, do we then sort of guarantee a vested benefit? And we'd like to suggest to the Commission -- and I'll bring that up later on -- is that it's clear that the fact that we issue bonds doesn't make it a

vested benefit. It's just a tool for reducing the costs.

There are other issues. Prepayment of OPEB bonds. If you put it into an irrevocable trust, how do you pay off prepay bonds if, in fact, the costs of benefits become lower later on?

An issue that hasn't been brought up before the Commission, we'd like to ask for assistance on, is federal reimbursement.

Currently, if you take the actuarially calculated unfunded liability and turn it, the federal government will reimburse us. And this is really important for counties. I see Connie over here. It's very important for counties because of our funding from federal government.

If you then convert those to bonds, they will not reimburse you for that cost. So it doesn't make sense. So we're hoping that we can -- between the counties and the State, we can convince the feds to go in this direction and assist us with reimbursement. It is a reduction of cost to them, so it makes a lot of logical sense.

And then investment risk and opportunities. As Tom mentioned, putting these bond proceeds out in the market, making sure that you invest those wisely.

Commission's assistance. What we'd like to do

is ask for assistance in obtaining approval from the federal office of management and budget for reimbursement of OPEB Bonds debt service. We receive that -- Sonoma County issued the first POBs in 1993. And we were able to receive a letter of instruction that allowed us to be reimbursed for the debt service on POBs. So far, they are not agreeing to use that letter to extend it on OPEB bonds.

Deal with the hard and soft debt, the vested benefits issue, make it clear that we can use this as a tool but it's not a guarantee for the benefit for the future.

And then give clear guidance on prudent and balanced investment, similar to our 1937 Act programs right now.

Pension systems. We would like to ask the Commission to consider the CSAC's principles for pensions. We've all heard about a few of those systems out there that have done things outside of the norm. CSAC has issued principles that we would like to see adopted. I think they will clearly make things better for the future.

Clearly separate the issues of OPEB from our well-managed pension systems. You talk about clearly communicating to the public. I think that's essential.

And the last would be, consider issuing two reports so it's clear to the public that our defined benefit systems are -- and the issues related to that -- are very different from OPEB.

And with that, thank you.

CHAIR PARSKY: Thank you very much.

Next.

MR. AGUALLO: Thank you, Mr. Chairman and Members. I'm Robert Aguallo, general manager of the L.A. City Employees Retirement System. It's a pleasure to be here to represent LACERS and the Board of Administration.

What we want to do today is share the L.A. City story in terms of who we are, how we administer our health benefits, and some of the successes that we've had in our model.

Like our pension funds from up north, we administer three programs: Both the investment, the retirement and health benefits.

We have approximately 15,000 retirees and beneficiaries, and we annually issue around $525 million in benefit payments.

We also, as part of our system, keep records of 27,000 active city employees.

Our health benefits program is around $62 million in annual subsidies for about 15,000 retirees

and beneficiaries. And our investment portfolio is around $11 billion.

Well, I've been instructed by my staff that my presentation -- the official presentation may not exactly reflect what's up on the screen. So with that in mind, you have the presentation.

CHAIR PARSKY: Yes.

MR. AGUALLO: Well, the audience may not benefit from it, but we'll go through what you have as commissioners.

Let's talk about the retiree health-care program.

CHAIR PARSKY: We'll make available to the public the corrected version so everyone can have it.

MR. AGUALLO: Thank you. Thank you.

We are one of the few pension funds in the state of California that administers health benefits entirely. We negotiate. We do the contracts. We do the enrollment. We also make the benefit payments.

We, like most pension funds that in California have health care, we contract with medical plans, Kaiser, Blue Cross, Secure Horizons, Senior Care, which is known as SCAN, and we also reimburse those that are living outside of California.

We also have a dental plan.

And I think -- I'll move forward.

Well, we'll stop.

One of the things that -- the way we've model from the City of Los Angeles' health-care benefit program is the City requires that you have ten years of service before you're eligible for health care. And any year after that, you'll add 4 percent to the eligibility of the subsidy. For example, if you're 20 years, you get 80 percent of the subsidy; if you're 25 years, then you're eligible for 100 percent of the subsidy.

And the maximum monthly subsidy is around $983 for a two-member in the Kaiser plan.

How are we responding to the health-care program, and how are we responding to some of these issues that have been discussed by the Commission? Unlike most pension funds, LACERS does prefund post-employment health benefits. We started prefunding in 1987-88 for employees with 10 years of service -- 10 years-plus service. This was done by the City, city council, the mayor, and the CAO office. This was not -- at that time it was administered strictly by the City of Los Angeles, not LACERS. The program was later transferred to LACERS in 1999.

In 2005, through the actuarial review, we decided to prefund all active employees, even those with

less than 10 years.

How are we responding, continuation of our policies here? The new funding policy, in October 2005, increased the total actuarial contribution liability by about $132 million. It increased the City's contribution rate by 1.12 percent.

As of June 30th, we were at 57 percent funded based on the actuarial value of assets.

The City has been praised by bond rating agencies for prefunding retiree health benefits.

Now, earlier, the Commission heard different models and different approaches as to how to prefund post-employment health care. For LACERS, we basically have it as part of our entire portfolio. We don't separate health care out. It's a function of our total asset base. It's accounted within the total trust fund. And how we do that, we administer it like we'd administer any of our investment portfolio, through reducing our risk, through diversification, we reduce transaction costs and fees, and we look for superior investment returns.

I want to say also that every three years we'll do a strategic asset-liability study, and we'll actually update our actuarial valuation through an experienced study as well. So that's how we basically make sure that

we're covering all our costs.

The other part of administering a health-care program has to do with negotiating the best possible rates. We go out to RFP approximately every three years. We also negotiate with the providers, either through co-pays, deductibles. We try to negotiate the best rates. And, of course, our health-care subsidy caps are on a rolling three-year as required by the Administrative Code.

Finally, I'd like to say that based on the actuarial value of the assets, the retirement benefits funded status is around 77.8 percent. The health subsidy side, the health-care side, is around 57 percent funded status. Combined, our total funded status is around 74 percent.

It's interesting, though, if you look back over the years of 1998 to 2001, we were over 100 percent funded in both retirement and health care.

One of the things I will conclude with is that the model for the City of Los Angeles has worked very well. Those that decided to prefund in 1989 had some foresight. There was also -- it was part of a discussion that knowing that there was going to be an increase in liabilities over the next ten to 15 to 20 years, and so there were some serious actuarial discussions about that

growth.

And then secondly, there was an issue of eventually the program would be transferred over to LACERS. And at the time the City really didn't want to deal with retirees, and so they separated the two pools, and it was eventually transferred to LACERS. But the model works and we believe it's successful.

And, Mr. Chairman, that concludes my remarks.

My apologies for having the wrong slide presentation.

CHAIR PARSKY: That's okay. Thank you very much.

Crystal?

MS. HOVER: Thank you very much. I have the dubious honor of being your last speaker of the day, somebody who is not going to talk a whole bunch of numbers to you, and the person --

CHAIR PARSKY: We were counting on a lot of numbers at the stage.

MS. HOVER: I was going to go through my whole actuarial piece, but I pulled it all out just to give you some different things to ponder.

Also, thank you again for inviting the local presence to give you our thoughts about this.

We, the County of San Bernardino -- and let me

tell you, I'm the head of employee benefits and services for the County of San Bernardino. The County, we have 18,000 active employees, and we have about 8,000 retirees.

I'm going to walk through some information here, and you're going to quickly understand how many of the presentations that you heard earlier do not pertain to our situation because we're in a very unique position here. So I'm going to focus on some other things to sort of round out your thoughts for the day as opposed to a lot of the focus on the unfunded liability piece.

In the County, we have about 8,000 retirees. Of those retirees, approximately 1,500 are enrolled in the County's retiree health plans.

Today, we offer three fully insured health plans: Health Net, Kaiser and Blue Cross. And our retirees are rated as a separate group from the active employees. Their experience directly drives their costs.

And here, I'll highlight probably the big piece of this presentation, which is that the County of San Bernardino is in a very unique position relative to the rest of our colleagues that are, from a county's standpoint, represented here. We do not subsidize the retiree medical premiums. We have no GASB liability. So funded or unfunded, we have no liability, which is a

very unique place for us to sit.

You know, colleagues, when I go to different conferences and things, will talk to me and say, "Since you don't have a liability, why do you care?" And the answer to that is, we care, and I care, because of the fact that we intend to continue to offer retiree health-care solutions regardless of the fact that the County probably will not get into a position today, or certainly not in the near future, of having some type of a GASB liability.

We do offer a retirement medical trust. It's a VEBA. Eligibility and contribution rates depend -- or they vary by bargaining unit. And I'll talk a little bit more about that.

But, again, we're in a unique position because our focus is not on how do we manage how retiree medical is being paid for; our focus is really, what can we do to sort of -- to better help the cost, the actual cost of the health care that we desire to offer our retirees?

The retiree medical plan designs, our current designs are very similar to our active plans. Plan designs are very traditional, very rich plan designs.

And the cost of these plans certainly reflects how rich and traditional our offerings are. To give you an example, the range of our rates without Medicare --

and, again, this is fully retiree-paid -- vary between $578 and change, up to $3,000 a month.

With Medicare, $125 and change, for retiree only, up to $2,400 a month.

Tomorrow -- can you back up, please? I'm a step ahead of myself.

I'm sorry, back up a slide. Thank you.

Our retirement medical plans are currently out to bid. And we are seeking quotes to maintain the current benefits that we've got because many folks do desire that current plan offering.

But we're also looking for alternate plan designs, such as high deductible health plans. Potentially, we're looking -- we're evaluating this. Closed network plans brings to mind the idea of medical tourism. I heard someone speak earlier about the ability to seek treatment at the Mayo Clinic with the cost of travel, less than what we do in California.

Many med plans -- you know, maybe not desirable, but -- also a catastrophic or major medical-type coverage.

Again, our desire is to keep our retirees in our health plans and to retain them as they go or as they age by offering different plan options that will be suitable for different stages of life. And I'm going to

walk through that in a moment.

The County is launching an initiative, it's a wellness type of initiative called “My Health Matters.” We'll be launching this to our retirees later on this year. And the launch will be done in connection with the 2008 open enrollment.

We believe, in a nutshell, that –- our hope is really to create an influence –- to better inform consumers of health care.

You know, I know there's a lot of conversation relative to the health-care companies being the 800-pound gorilla, and you said earlier, Chairman, that the ability to influence these folks -- you know, you're looking at both sides: The true funding the issue; and, truly, how do we help contain the cost.

You know, our feeling is because we don't -- we're not influenced as a county by an unfunded liability situation, we have the ability to focus on the two other pieces of this puzzle that we see are critical, the retirees themselves and how they can become better consumers of health care through wellness, through other things, and also the health-care companies.

And interesting that, you know, a lot of the conversation I heard today -- I didn't hear a lot of conversation about the health-care companies.

We are in partnership with our health plans. And strangely enough, we have been able to make some headway with these folks, Health Net and Kaiser, significantly, believe it or not, on the ability to think outside the box to start to offer more cost-effective plans, and by asking the questions, because we're not, again, influenced by our liability situation, we're simply trying to come up with more cost-effective options for our retirees, we've made some very interesting progress with this.

And, you know, frankly I don't know that any legislation or any political influence, top-down, is going to change this process any more quickly; but on a one-by-one basis we, as an employer, have a very good partnership with the plans that we deal with. And we're asking them to please consider other options and things to help us continue to be able to offer retiree health care.

In summary, I want to talk about the County's focus. Our expectation is that we would increase -- again, we only have 1,500 folks enrolled in our plans. We believe that's largely due to the fact we have folks that do have health care outside, either through spouses or in other situations. But we also know that -- we're very well aware of the fact that because of the costs

associated with health care, that we have many people that don't take the retiree offering that we have because they can't afford to.

So our expectation is to increase and maintain, you know, a high level of participation in the County's health offerings. We feel a personal and probably a moral responsibility to do this.

Also, what we're calling -- we're going to offer what we're calling sort of a lifecycle style health plan piece. We'd like to get our newer retirees into something for folks that don't need a very significant coverage option, to be able to get them into maybe a catastrophic-type coverage plan initially; and then give them, through the open enrollment process, if people desire to change to more comprehensive plans, we'd like that. But we want to be able to keep people in a place that they're able to, as they get older, have different options that are suitable to their needs.

And like I said, we're making very good progress with the health plans that we partner with.

We want to increase the availability of the retirement medical trust. This medical trust, as I said, is a VEBA.

Today, for the most part, it requires ten years. The vesting requirement is ten years.

The County offers a contribution. Again, depending on the bargaining unit, it will justify the amount, or stipulate the amount.

But we'd like to see this retirement medical trust available to more folks if possible.

We want to intrinsically tie the My Health Matters Program, which is our healthy living program, to the retirees. These are the folks that certainly have enough time to do things that they'd like to do -- well, we think -- most of them, some of them -- have enough time to do things that we don't have, you know, that while we're working. These are the prime candidates for people that really want to do things; and we need to be able to help them do these things from a healthy-living standpoint, better and different.

And then we want to discuss options with other entities to determine if there are solutions or partnerships that can better help us. You know, the comment of JPA's and other types of coalitions and things. You know, given how much headway we've made with the health-insurance companies, there's certainly options by asking the questions of the health insurers, because I can't imagine a lot of us want to run out and self-fund the retiree piece -- I certainly think that if more of us were asking these questions and simply saying, strangely

enough, “Hey, what can we be doing better and different, as opposed to the traditional offering that we're trying to offer -- or give folks,” I think that the ability to partner and to make some difference is there.

Let's see, what else do we have here?

The retiree market is an untapped market from a health-insurance standpoint. We really have -- you know, folks have shied away from this. I've heard many people speak earlier about the fact that health-insurance companies, you know -- how they underwrite and what that they do and how things work relative to pricing.

You know, it's amazing when you ask people, when we talk to some of the underwriters that we deal with, and we ask them how do they come up with these rates. And this is still relatively -- this is a very new market for people. The retiree group medical is a strange situation for folks. And I think the push to get people into this market is certainly going to be helpful.

So, again, to summarize the County's position, we are in a very unique position. We do not have a liability, a GASB liability, unfunded or otherwise.

So, really, our focus is on what can we be doing to stay engaged and help this process whereby we can help influence other pieces of the process? Because, you know, the funding aspect -- how benefits are being

paid for is really irrelevant to us. It's a fact of how do we impact the cost of health care.

So we look at this as starting one employer at the time. And we're one of the people that's asking the questions. And we're certainly accountable to the retiree population that we've got, and we're here to try to find some solutions.

So thank you very much. I appreciate your time.

CHAIR PARSKY: Thank you very much.

I thought that was very well done.

I think we're going to want to follow up on the last point to see if we can't understand, are there practical ways in which this cooperation might benefit a number of different counties in the state. We don't want to overplay it, but we want to see if there are some things. And I think that's a very interesting point.

I'll ask for other questions.

But, Tom, I just wanted to make sure I understood, in your presentation, you mentioned both the two-tiered system and the issuance of OPEB bonds.

Were you indicating that both were central to getting to the point you wanted to get to; or did the bonds, in effect, make it unnecessary to have a two-tiered system?

MR. SMITH: No, what I wanted to do, if I'm going to issue bonds, I want to cap the liability --

CHAIR PARSKY: Just speak in there.

MR. SMITH: If I'm going to issue bonds, I want to cap the liability. So by putting in the two-tiered system and paying benefits only to age 65 or Medicare eligibility, I was able to cap the overall liability which took away some of the risk. Otherwise, the liability just keeps increasing.

CHAIR PARSKY: Thank you.

Any other questions?

Yes?

MR. HARD: Yes, I had a question for you, Tom.

Since you went to the bonds, and I heard you say you really had no other choice, did you go through this exercise of -- there's an article on, you know, the bonds of doing a kind of scenario test in terms of market and stuff, following a downturn? They say it can be dangerous to go to bond and then invest it?

MR. SMITH: There's some risk to this. But we have an extremely diversified portfolio of investments.

The other thing that we did in this deal is we have four years of interest-only on the front end. And I'm in the process of building up about a $12 million reserve, which would cover between three and four, five

years' worth of debt service. So if we have a market turndown, I'm going to have a reserve necessary to ride that out.

MR. HARD: Okay, thanks.

CHAIR PARSKY: Yes, Dave?

MR. LOW: I noticed, Tom, on your assumptions here, you assumed a 2 percent general fund revenue growth on your projected pay-as-you-go, general fund revenue, and a 2.5 percent growth on your OPEB bond repayment structure.

Why is there a different assumption under general fund revenue growth for these two scenarios?

MR. SMITH: Which page are you on?

MR. LOW: Page 4 and page 9. So you lay out your two scenarios, and there's a half a percent difference on the general fund --

MR. SMITH: It might be –- it's a typo. It's 2 percent is what we used.

MR. LOW: Okay. And who manages the assets?

MR. SMITH: Right now, Lehman Brothers Asset Management. The same firm that sold the bonds, is managing the assets.

MR. LOW: Thank you.

CHAIR PARSKY: Other questions?

Yes, Matt?

MR. BARGER: I was struck by the situation you were in --

CHAIR PARSKY: Grab the mike.

MR. BARGER: I was struck by the situation you were in of having no retirement liabilities. Was there a trade-off made at some point for a higher carpe or better pension? I mean, how did you end up in that situation?

MS. HOVER: I'm strictly speaking about the health-care liability piece of it, okay. And I don't have the history on that. Many years back, the decision was made to separate the actives -- the active health care from the retirees, because the retirees were heavily driving up the experience and, therefore, driving up the cost. So that was the driving factor behind this.

MR. BARGER: But you don't know why?

MS. HOVER: I don't know the specific reasons why. But interesting -- yes, again, an interesting position for us to be in.

CHAIR PARSKY: Yes, go ahead.

MR. HARD: I had a question for Ms. Hover.

So do you have any idea of what 80 percent of the retirees are doing? You said a number have alternative health care through perhaps a family member.

Do you know what the percent of these other situations are?

MS. HOVER: That's a great question. And we, as I expressed in the presentation, we are currently out to bid right now for the retiree health-care option piece. And what we're doing is we're surveying our retirees to better understand what they're doing if they're not taking our health-care situation. So I can't answer that now, but I would be able to answer that shortly.

MR. HARD: The range of those costs is pretty impressive -- you know, $456.

MS. HOVER: "Impressive" is probably not the word; but, yes, "Shocking."

MR. HARD: Very impressive to somebody that makes what I make a year.

So it doesn't -- like, intuitively, it doesn't look like you're affecting the providers, and you have a real cooperative relationship in terms of holding down prices. But that's just that range. So could you enlighten me a little bit more?

MS. HOVER: As to the cost range that you're talking about?

MR. HARD: Well, yes, an example of how you're doing well with Kaiser and others, because we're trying to work with them, too.

MS. HOVER: Newly -- I've been in my position

for about 14 months. I came to the County to take this position. And there are two things that cause me to lose sleep -- and not much causes me to lose sleep, I'll tell you that.

One of these things was the cost of retiree health care. And I can tell you that knowing that we were going out to bid this year, and really focusing on, okay, what's driving the cost, what's driving these pieces, and asking our health plans, taking them to task, of sorts, and asking them to help us better understand, you know, what can we be doing -- we, as an employer, what can we -- and we, as the provider of the plans -- what can we be doing better and different to get to where we need to get to down the road for better cost structure?

So I will tell you that prior to my coming to the County -- I can't speak to what type of partnership we've had or not had with the health insurance companies -- but certainly in the last fourteen months we've built very -- I would say much stronger partnerships, a much better alliance. And I think that going forward, we're going to see this situation positively affected. So I can't speak to prior to that.

CHAIR PARSKY: Dave?

MR. LOW: Yes, along those lines -- I have two

questions, too.

The first question is, what kind of benefit do you get for $3,000 a month?

MS. HOVER: That would be a PPO, both people over 65, not Medicare-eligible.

MR. LOW: And kind of --

MS. HOVER: Plus two, actually. Probably more than that. Three members, probably, and over 65.

Pardon me?

MR. LOW: Along the line that Jim was talking about, it seems to me that, the process of taking the retirees out and pooling them separately and then providing them a benefit that costs this much is just a formula for adverse selection. The only people that are going to go into this plan are the people that really need it.

MS. HOVER: Right.

MR. LOW: You're only going to pay that amount of money if you've got a really serious health problem. So it seems to me that you're -- how do you avoid just a death spiral in this pool?

MS. HOVER: Well, I would say that -- and your point is very well taken -- I think that we are on -- we're teetering on a potential death spiral, which is why we are focused on trying to get some better, affordable

plans.

The other thing that we're doing is we are going to, "Come one, come all," this year for open enrollment to all 8,000 folks and say, "Look, here's the offering that we're going to bring to the table. Here are the different types of options." Hopefully they're considered affordable to people and hopefully bring in more members that don't just need this insurance because they've got some type of very serious illness situation.

So your point is extremely well taken. And it remains to be seen, but we're certainly trying to get more attractive options in to attract back folks, or to attract our retirees into our -- or back into our health situation; whereas we know that they have been leaving us year over year because the cost continues to escalate. And we have not addressed it in the past as efficiently as I think we're trying to address it right now.

So your point is very well taken. Very astute.

CHAIR PARSKY: Curt?

MR. PRINGLE: To Matt's question, I know that San Bernardino probably reduced their participation in retiree health benefits longer than two years ago, because Orange County did a year ago, and they're still following us around. So there's -- to make their point. So I'm sure in San Bernardino it's been a lot longer than

a couple years.

MS. HOVER: A lot longer than a couple years, yes.

MR. PRINGLE: For all four of you, tell me if you know any ability that you have to partner with other agencies, to subcontract the management or your plans to CalPERS.

Is there anything statutorily that restricts your ability as a '37 Act county or a city that has a separate fund or a community college district? Where are those statutory limiters, or are they there at all? Have you or anyone you know of in similar positions, in other government agencies considered that?

MR. AGUALLO: Robert Aguallo, L.A. City.

There really are no restrictions other than some administrative code changes that the City Council and the Mayor would have to approve if we were to do a joint venture or part of a larger pool.

We are working much closer now with the active side of the L.A. City Retirement Program as we begin to negotiate, because we know what they're getting and they know what we're getting through Kaiser or Blue Cross/Blue Shield. And so we're working closer, so that there is a stronger bond and network within the City of L.A.; so when we do go to negotiate, we have some leverage.

But in terms of a larger pool, the CalPERS, that's something that we've talked to CalPERS about but only on a preliminary basis in terms of sharing information and networking as they proceed with their rate negotiations and their administration of the program. But we haven't pushed the issue any further than that.

MR. PRINGLE: Have you ever talked to a non-similar government entity -- not CalPERS, necessarily, as they serve cities -- but, for example, the County retirement pool, could you create a cooperative agreement in terms of managing a health benefit package?

MR. AGUALLO: We've had some discussions with L.A. County. But, again, it would be more information, network-sharing basis, so we would at least have some leverage. But not in terms of a formal affiliation.

MR. DOLE: I, too, am not aware of any restriction. In fact, when we've met with our employee groups, we've brought CalPERS estimated premiums to the table, and used those as leverage against our other plans that we offer, health plans, to keep them reasonable in their premiums. So we've used CalPERS as leverage, and also as an alternative, seriously considered that as an alternative.

MR. PRINGLE: So you'd go right now to CalPERS, if you decided to shift the management in the operation of the health-benefit side of the equation in your county, you could make that change?

MR. DOLE: That's my understanding.

MR. PRINGLE: As could San Bernardino?

MR. DOLE: Yes.

The other thing that we do is we do work with our local cities. We have a good relationship with our nine cities. And we talk about what premiums they're paying and what medical services are provided.

MR. PRINGLE: I guess that's kind of what I'm -– you know, you talk about the nine cities in your county, some of which are relatively small.

MR. DOLE: Yes.

MR. PRINGLE: Isn't there a benefit, period, to pool those -- I mean, particularly if you could, you know, pool all of those cities within one plan? I can't imagine any single one of those cities getting a better rate than you. And candidly, I don't know if many can get a better rate than CalPERS. So I'm just trying to see along the way, you know, what those limiters – other than local control, local management, more direct personal oversight and personal involvement -- other than that, I'm going to figure out what those limiters

may be.

MR. DOLE: For the most part, our jurisdictions share that information, and that is the leverage against the programs that we have available in the area.

And in Sonoma County, we have our own PPO program, we have PacifiCare and Kaiser. And by sharing that information between the jurisdictions, we're able to negotiate those premiums based on information, better information.

MR. PRINGLE: But even a strict principle, right, in terms of pooling and number of employees, a couple of your cities there have hundreds of employees, not thousands of employees or retirees; right?

MR. DOLE: I agree.

MR. PRINGLE: So they would have -- that experience rate would automatically mean that the costs would probably be higher?

MR. DOLE: I believe it has merit, yes.

MR. PRINGLE: Okay.

CHAIR PARSKY: Well, I think that's worth following up on because it obviously varies from locality to locality in terms of the ability to leverage or benefit off of the most efficient part of the system.

Connie?

MS. CONWAY: We are a ‘37 Act county, too. And

this year, CSAC Excess Insurance Authority, which is pooled risk for a lot of other things, a lot of cities in here, and the State belonged to that, we went with our health plan with them. We are the biggest member of that. It's something new. I don't know that the other cities and counties maybe weren't interested.

It did reduce our costs. A little bit of problem with the administration. We've worked that out. We told them they had to fire that administrator and get us a new one. But that opportunity does exist. The numbers may not be huge in the savings for us, but we did go with that option this year to go through a pooled bond situation, and it is available.

CHAIR PARSKY: Well, listen, I want to thank you all very much. We appreciate your contribution.

And I think if you step back and take a look at the day, I hope we're beginning to bring forward to the public some of the issues and the magnitude of the health-care retirement costs.

We thank you all very much, and we appreciate it.

Are there any other comments any commissioners have?

(No audible response)

CHAIR PARSKY: We stand adjourned.

Thank you very much.

(Proceedings concluded at 3:32 p.m.)

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REPORTER'S CERTIFICATE

I hereby certify that the foregoing proceedings were duly reported by me at the time and place herein specified;

That the testimony of said witnesses was reported by me, a duly certified shorthand reporter and a disinterested person, and was thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for either or any of the parties to said deposition, nor in any way interested in the outcome of the cause named in said caption.

IN WITNESS WHEREOF, I have hereunto set my hand on the 11th day of June 2007.

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DANIEL P. FELDHAUS
California CSR #6949
Registered Diplomate Reporter
Certified Realtime Reporter