

**Minutes
of the
Second Meeting
of the
Retirement Systems Solvency Task Force
Room 307, State Capitol
August 10-11, 2009**

The second meeting of the retirement systems solvency task force was called to order on August 10, 2009 at 10:10 a.m. by Representative Mimi Stewart, co-chairwoman, in Room 307, State Capitol.

Present were:

Rep. Mimi Stewart, co-chairwoman
Mr. Tito Chavez, co-chairman
Mr. Diego Arencon
Rep. Richard J. Berry
Mr. Charles Bowyer
Ms. Jan Goodwin
Rep. John A. Heaton
Mr. David Heshley
Ms. Emily Kane
Ms. Michelle Lewis
Ms. Alexis Lotero
Mr. Bruce Malott (8/10)
Mr. Andrew Padilla
Mr. Wayne Propst
Mr. Ronald Sanchez (8/10)
Mr. Terry Slattery (8/10)
Mr. Jeff Varela
Rep. Luciano "Lucky" Varela

Absent were:

Mr. Oscar Arevalo
Sen. Pete Campos
Mr. William F. Fulginiti
Sen. Phil A. Griego
Sen. Steven P. Neville
Sen. John Arthur Smith
Ms. Christine Trujillo

Legislative Guests: Rep. Miguel P. Garcia (8/10); Sen. Carlos R. Cisneros (8/10-11); Sen. Dianna J. Duran (8/10); and Sen. Timothy Z. Jennings (8/10)

Staff:

Raul Burciaga, Jonelle Maison, Tom Pollard, Josh Sanchez — Legislative Council Service (LCS)
Michelle Aubel — Legislative Finance Committee (LFC)

Guests: The guest list is in the meeting file.

Copies of all presentations and handouts are in the meeting file.

Minutes of the first meeting were approved as submitted.

Monday, August 10

Retiree Health Care Authority (RHCA) Report of Annual Meeting — Mr. Wayne Propst, Executive Director

Mr. Propst reported there was good news in that RHCA is in a better financial position than it was three years ago. In 2007, House Bill 728 required the appointment of a task force to study retiree health care fund solvency, and RHCA has been implementing its recommendations since then. The following recommendations have been implemented:

- (1) focus on pre-funding and unfunded liability, not just solvency;
- (2) increase employer/employee contributions (beginning in FY 2011);
- (3) remove the sunset of the \$3 million suspense fund contribution;
- (4) adjust retiree, spouse and dependent subsidies to 50% average;
- (5) institution of regular governmental accounting standards board (GASB) and solvency evaluations;
- (6) regularly adjust premiums to track medical inflation; and
- (7) review and rationalize plan design.

Two recommendations, to adjust age and service eligibility requirements and initiate disease management and health promotion programs, are still to be implemented. The wellness program has been instituted for medicare recipients, and other retirees should have a program within the next year.

The June 30, 2008 GASB valuation found that RHCA's unfunded liability decreased to \$2.9 billion from \$4.1 billion and the annual required contribution to fully fund the benefit decreased to \$273 million from \$373 million. The June 30, 2009 solvency report found that solvency has been extended from FY 2014 to FY 2028, with deficit spending projected to begin in FY 2018. The effect of FY 2010 plan changes include:

- (1) three non-medicare plans (gold, silver and bronze) collapsed into two (premier and plus);
- (2) overall premium increases across plans at 8.3%;
- (3) 88% of pre-65 retirees may choose a lower premium plan;

(4) 90% of 65+ retirees may choose a lower premium plan;

(5) non-medicare retirees have a deductible choice of \$300 or \$800, with out-of-pocket maximums at \$3,000; and

(6) an additional medicare option for low-income seniors was added.

Mr. Propst noted that RHCA cannot go another 10 years without employer/employee contribution increases. The future priorities for RHCA include:

(1) focusing on pre-funding and moving beyond year-to-year budgeting;

(2) identifying additional revenue streams and ensuring adequacy of current revenue sources;

(3) growing the investment fund;

(4) focusing on strengthening disease management and health promotion provisions for all participants; and

(5) focusing on innovations in the private sector, such as lower premiums for healthier lifestyle choices.

Pointing out that the state was essentially in limbo until the health care reform debate was resolved at the federal level, Representative Heaton asked if the board had considered penalizing participants who have made bad lifestyle choices. Mr. Propst said there had been some discussion, but no action as yet. He noted that he is interested in learning more about the Safeway program, which has differential premiums for lifestyle, because people who are outside the health ranges are driving the cost and perhaps should pay more. The RHCA actuary has pegged the cost of smoking at \$10 million. Mr. Malott, a former RHCA board member, said the authority needs to understand the magnitude of premium increases for under-65 participants.

Senator Jennings initiated a discussion of the problems participants outside the Albuquerque metropolitan area and Santa Fe have in finding adequate care because of the scarcity of specialists who take medicare and medicaid patients.

Mr. Varela pointed out that when the under-65 plans are collapsed from three to two, some participants will see a 40% increase in premiums. Representative Stewart requested that RHCA provide illustrations of the new plans and a comparison with the gold/silver/bronze plans. Mr. Propst said the gold plan is similar to the new premier plan and premiums will go down 20%; silver participants who move to premium plus may see premiums increase as much as 40%. The premier plan is essentially the current bronze plan. Representative Stewart reiterated her request for illustrations and comparisons.

Mr. Chavez asked if the over-65 wellness program includes incentives for participation. Mr. Propst answered in the negative. RHCA pays the full cost of the program, but there are no incentives otherwise. Representative Stewart asked for details of the program.

On further questions from Representative Stewart, Mr. Propst said the reported 8.3% overall premium increase was based on the assumption that some participants will stay in the more expensive plan. In 2008, a 70% premium increase did not compel participants to change plans. Senator Jennings again noted that participants who live in some parts of the state cannot switch and end up buying something they cannot use. He asked RHCA to consider a premium differential based on geographic availability of services.

After a discussion of House Bill 573 and the increased contributions required by that bill, Representative Stewart asked the members for suggestions as to other areas the task force should consider. Mr. Bowyer said the task force should compare RHCA with other states and consider pay-as-you-go or pre-funding. Mr. Varela said the task force should consider full insurance or self-insurance and requested staff to provide information on the topic. Mr. Chavez said he wants to know where any information came from and hoped staff would provide as much objective information as possible. Mr. Arencon asked for information on plans such as Safeway that provide incentives for healthy behavior. Mr. Sanchez said his organization does this for healthy lifestyles with a plan that gives points for participants to buy down their premiums. He also thought the program could be tiered with respect to geography. Representative Heaton noted the federal Employee Retirement Income Security Act of 1974 (ERISA) prevents the states from doing anything substantial, and, if a national plan is not provided, ERISA should be repealed.

Actuarial Information Overview — J. Chris Conradi, Senior Consultant, Gabriel, Roeder, Smith & Company (GRS)

Mr. Conradi has been the lead actuary for the educational retirement board (ERB) since 1991. His company is also the actuary for the public employees retirement association (PERA), but uses another team of actuaries.

Mr. Conradi began by providing an overview of the kinds of retirement plans used in the various states and the risk characteristics of defined benefit (DB), defined contribution (DC) and hybrid plans.

Defined contribution: a DC plan defines employer and sometimes member contributions that are put into an account with actual fund earnings credited to the account. Employees often direct the investment of their accounts. The balance in the account is usually distributed as a lump sum at termination. Examples of DC plans are private sector 401(k) plans, profit-sharing plans and employee stock option plans; Section 457 plans; 403(b) plans for teachers and health care workers; IRAs; and health savings accounts.

DC public sector coverage:
mandatory for new hires: Michigan (state employees since 4/1/1997); and Alaska (all new public employees, 7/1/2006).

optional programs: Florida, South Carolina, Ohio (three choices), Colorado, Montana and some local governments. New hire election rates when optional: Florida, 21%; South Carolina, 13% (excluding higher education); Montana, 10%; and Colorado, 12%.

West Virginia went to a DC plan 12 years ago, but has since returned to a DB plan. Nebraska is a cash balance plan.

Defined benefit: a DB plan, like PERA and ERB, makes a promise to pay benefits in the future. The benefits are usually a function of the member's pay, service, etc., not an account balance. The amount and form of payment depend on future contingencies such as salary increases; length of service; and whether the employee dies, retires, becomes disabled or leaves for another reason. DB plans are uncertain future financial events. Retirement benefits are defined by a formula that usually involves years of service and final average salary. For example, $2.35\% \times 30 \text{ years} \times \$50,000 =$ a benefit of \$35,250 a year, which is usually paid as a monthly lifetime benefit. There are also DB medical plans, which promise to pay medical benefits in the future or pay a benefit used to pay for medical insurance. Contributions by employers and sometimes employees are based on needs of the fund. Most states and local governments have DB plans; others include RHCA, federal civil service employees hired before 1984, teamsters' central states pension fund and Mr. Conradi's own company plan.

The key differences between a DB and DC plan are that the value of benefits received by a member in a DB plan is not a function of contributions made on the member's behalf and the employer's obligation is not fulfilled until the last benefit recipient dies.

Hybrid plan: a hybrid plan combines features of both DB and DC plans. There are only a few hybrid plans in the public sector. Ohio has an optional combination plan, one DB and one DC, and Nebraska has a cash balance plan.

Risk Characteristics	
Defined Benefit Plans	Defined Contribution Plan
investment risk (poor performance)	investment risk (poor performance)
mortality risk (long lives)	mortality risk (long lives)
inflation risk (pay increases, COLA)	inflation risk (no COLA)
employer nominally bears the risks	employee bears the risks
benefits are predictable (defined)	benefits are not predictable

If the employer bears the risk, does that mean taxpayers will foot the bill for higher costs? Perhaps, but that is not the only answer. Increased costs could be covered by lower future salary increases for active members, reductions in other benefits for active members, reductions in work force and reductions in taxpayer services. The ways to explicitly share the

risk between employer and employee include having member contributions tied to funded status (Arizona); cost-of-living allowances (COLAs) dependent on "excess" returns (e.g., a return greater than the mandated actuarial return could be set aside for COLA); the Dutch system, with benefits and COLAs dependent on funding status; and the use of hybrids, especially combinations. The states are about evenly split on fixed COLAs (New Mexico) and consumer price index (CPI)-based COLAs.

Approximately 86% of the public sector, including both state and local governments, provides retirement benefits, 79% through a DB plan and 18% through a DC plan. DC use is usually secondary, except for colleges and universities and the few states with mandatory or optional DC plans.

Mr. Conradi presented a primer on the role of the actuary in retirement plans and actuarial mathematics. The actuary reviews data, past experience and plan provisions and based on these selects appropriate assumptions and estimates liability of the plan at a given point and determines employer contribution requirements. If contributions are set by statute, the actuary determines the annual required contribution (ARC) to compare to the statutory contributions. The actuary monitors several actuarial measurements and ratios, watches trends, determines the actuarial effect of proposals and provides factors for option and service purchase calculations.

The basic retirement funding equation is $C + I = B + E$, where C is contribution income; I is investment return; B is benefits paid; and E is expenses. Another way to express the equation is "money in = money out". The trick is to balance the equation. B depends on plan provisions and experience; C depends on the short term on actuarial assumptions and actuarial cost method; in the long term, C depends on I, B and E.

On the question of why to pre-fund, Mr. Conradi noted that a few plans pay benefits when they are known and due, but such a method is not recommended. In most situations the payment requirement will start small, when there are few retirees, but then grow exponentially to a point that the employer may not be able to pay the amounts due without pre-funding. Pre-funding allows a significant part of the plan's cost to be met by investment earnings, which reduces the amount the employer must contribute. Funding in a trust provides security to the members, and some kind of fund is necessary when there are member contributions. Bond rating agencies expect money to be set aside for future liabilities.

Actuarial calculations almost always begin with the calculation of a present value, which is the amount needed to make a series of payments in the future. The calculation assumes there will be investment income earnings until the payment is made. For example, Mr. Conradi said, you could promise to pay someone \$1,000 tomorrow, which would mean you would need that amount tomorrow. But if you promise to pay the \$1,000 in two years, you could invest \$907 now at 5% to generate \$1,000 in two years. The more you can earn while you have the money, the less you need to start with because higher expected returns mean lower present value. Actuarial present values also reflect the probability the payments will be made. The actuary must project the future benefits a member might receive at each age, factoring in future salary

increases and service, retirement benefits at different ages, refunds and death benefit at each age. The actuary must estimate the probability that each active member will retire, die or become disabled in each future year; then the actuary must determine how the benefit will be paid and, in most cases, the probability that the member is alive at any point in the time after retirement. The actuary then must discount all of these contingent benefits back to today, reflecting the time value of money. This is the actuarial present value of future benefits and, in practice, requires complex computer modeling software.

Actuarial assumptions are needed to determine the probability and timing of various life events in the future, such as death in service, disability, retirement and other termination. Assumptions are needed to determine the kind of benefit and what payment period will be needed for each retirement, based on post-retirement mortality. Assumptions are also needed to determine the amount of the benefit at future dates, which includes making salary increase assumptions. An assumption is needed for future investment returns to discount the expected payments back to the present. The actuary studies a plan's experience to assist in setting assumptions. For some assumptions, recent past experience is an important guide to the future, e.g., post-retirement mortality. For other assumptions, recent experience must be weighed against other factors, e.g., salary patterns in governmental plans often reflect tax receipts, which in turn follow the general economy. The plan's own experience is sometimes the best guide, but an actuary also looks at national statistics, e.g., inflation and investment return. Plan provisions affect the assumption-setting process. If assumptions are too optimistic, the long-term ability to meet the liabilities may be compromised, e.g., if the assumed return is 9.5% but the actual return is only 8%, the true value of liabilities is greater than assumed. More money than planned will be required, and the system may have problems paying benefits in the future. If the assumption is that members will retire at 63, but they actually retire at 60, the benefit will be less, but it will be payable for more years and the system has lost three years of contributions it had been counting on, which probably will require an increase in the contribution rate. If assumptions are too pessimistic, taxpayer funds are tied up unnecessarily in trust funds, creating tension between employees and other needs such as roads, prisons, parks and education. The consequences if the actuary is wrong are generally worse if the actuary has been too optimistic.

The actuary helps find a "rational" funding pattern, which is the function of an actuarial cost method that determines the year-to-year incidence of employer/state contributions. There are different methods, just as there are different accounting methods for handling depreciation or for determining the value of inventory. Mr. Conradi noted that Utah does not have a statutory contribution rate; contributions are actuarially determined. Different actuarial cost methods spread incidence of costs in different ways, such as based on a benefit formula or based on costs (dollars or percentage of pay). Key considerations are: (1) whether the method produces relatively level costs; and (2) whether the method allocates contributions to successive generations of taxpayers equitably. The entry-age actuarial cost method is the most common for public plans because it meets the key considerations. Most methods produce two pieces used in determining the employer contribution rate, normal cost and amortization charge for unfunded actuarial accrued liability (UAAL). Normal cost is the basic cost for the current year, which may be determined by actual benefits earned or may be a theoretical level contribution amount, and

depends on the actual cost method. In contributory plans, member contributions usually are treated as covering part of the normal cost, with the employer covering the rest.

The components of contributions are:

- ▶ actuarial accrued liability (AAL), which is the theoretical liability associated with prior years under the method. It may reflect actual benefits earned or may be a theoretical amount;
- ▶ actuarial value of assets (AVA) could be the plan's market value, but is usually a smoothed value tied to market. Smoothing is needed because results are too volatile otherwise; and
- ▶ UAAL is the difference between the AAL and the AVA. It may be positive or negative (overfunded); the balancing item and the liability are not accounted for by future member contributions, future employer normal costs or by the AVA.

The second component of annual cost is the amortization of the UAAL. Usually, this is an annual payment designed to increase with payroll, although it could be a level amount like a traditional home mortgage. When the system is overfunded, this is a credit. The amortization period is set by the plan trustees or statute, unless the contribution is fixed. Using the home mortgage analogy:

Retirement System	Home Mortgage
unfunded liability	outstanding loan balance
normal cost	taxes and insurance payment
amortization charge to fund the unfunded liability	principal and interest portion of loan payment
change in contribution rate due to assumption changes	refinancing existing mortgage
experience loss creates an increase in unfunded liability and therefore in contribution rate	take out a second mortgage to pay for new roof
benefit change increases normal cost, unfunded liability and contribution rate	an addition to the home increases taxes and insurance, second mortgage increases principal and interest payments

UAAL is **not** an accounting liability; it is always off the employer's balance sheet. It is not a liability if the plan is terminated or frozen. The term "liability" is misleading; different cost methods produce different UAALs. UAAL **is** a step in computing contribution rate. It is a "liability" associated with prior years. It assumes the plan continues, and it reflects expected future pay increases and, in some methods, expected future service. Sources of unfunded liability include when actual experience differs from assumptions, when granting benefit credit

for service before the system was created and granting retroactive credit for benefit enhancements.

Mr. Conradi pointed out that nothing is wrong or bad about having an unfunded liability if systematic progress is being made in amortizing it over a reasonable time period. Nothing is wrong with a benefit enhancement that increases unfunded liability if it is funded properly.

The reasons to have actuarial valuations are to: (1) provide an annual snapshot of the system; (2) determine the required employer contribution rate if not set by statute; (3) monitor experience; (4) monitor various funding measures; and (5) calculate gains and losses for the year from investment, liability, benefit changes and assumption changes. Key measurements include:

- ▶ employer contribution rate, unless set by statute;
- ▶ funding period, if contributions are set by statute, which is the number of years theoretically required to reduce UAAL to zero;
- ▶ normal cost and UAAL;
- ▶ funded ratio (AVA/AAL), which if over 100% is overfunded;
- ▶ UAAL as percentage of payroll;
- ▶ gains and losses, which is the difference between assumptions and actual experience; and
- ▶ external cash flow as a percentage of assets, which are member and employer contributions, less benefits, refunds and administrative expenses.

When monitoring trends, Mr. Conradi said the actuary looks for consistent patterns of actuarial experience gains and losses and consistent patterns of deterioration in funding levels. In the former, the system may need to have an actuary do an experience study and may be a sign of the need to change assumptions; in the latter, the trustees need to begin educating legislators and members of potential dangers. Deterioration in funded levels, increases in funding period or contribution rates, etc., are a natural consequence of benefit improvements and are not a sign of a problem by themselves if due to such. Mr. Conradi pointed out that even with a smoothed AVA, year-to-year results can be volatile, so it is important to focus on trends, remaining aware of changes in the plan during the period in question.

Explaining the process for costing a benefit enhancement, Mr. Conradi said the actuary analyzes whether the proposed enhancement would change any existing assumptions, e.g., moving from 30 and out retirement to unreduced 25 and out would be expected to change the pattern of retirements. The actuary develops new assumptions to reflect the incidence of

expected changes; calculates a new normal cost and UAAL; and determines the increased contribution rates needed to support the enhancement.

Mr. Conradi made the following observations about cost studies:

- ▶ when new benefits are being considered, policymakers need to be aware of potential assumption changes that may be needed to reflect fully the total effect of a proposal on the cost of the system;
- ▶ many changes may have a dramatic impact on not only the amount of the benefit, but also on the probability of when it will be paid; and
- ▶ to ignore potential assumption modifications can materially understate the actuarial impact of the change and may even hide an actuarially unsound proposition until it is too late to bring about a reasonable corrective action.

There are legal issues to be considered when contemplating changing from a DB to a DC plan. Changing benefits for current members might violate the constitution of New Mexico (Article 2, Section 19 and Article 20, Section 22). In addition, there are political ramifications to be considered. The probable approach to changing to a DC plan would be to make it a requirement only for future new members. The legislature could create an optional DC plan, but there have been low election rates in other governmental plans in which this has been tried, and the internal revenue service has held that members must leave contributions in the DB plan. This would mean no transfer to a DC plan of the member's or the employer's money, and the member would receive a DB benefit when eligible; therefore, DB liability for current members does not disappear. UAAL must still be paid off, and since it does not include liability for future members, there would be no reduction when the DC plan is created. There are also actuarial issues. Part of the employer's contribution is used to amortize the UAAL, but without inflow of new members, less revenue will be received, and contributions from current members may be insufficient. Insufficiency was the case in 2005 when ERB asked Mr. Conradi to look at the question. To make up the resulting shortfall, the employer (state) must contribute more than the current scheduled statutory rates; this would be done by raising contribution rates, paying a contribution on the pay of future new members covered under the DC plan or by finding other contribution sources. GASB allows amortization as a level percentage of payroll so that smaller amortization payments are required initially and they rise over time as payroll increases. Both PERA and ERB do this. However, if the DB plan is closed, GASB requires computing amortization like traditional home mortgage, with level payments. This may knock the plan out of compliance with GASB or make the plan look worse. Without the inflow of new members, the active membership will shrink, and, eventually, covered payroll and contributions will shrink even though payouts will continue to increase. Mr. Conradi noted that when Alaska moved to a mandatory DC plan for new hires, its costs jumped significantly. Negative external cash flow will become a significant issue. External cash flow equals contributions minus benefits; as it becomes more and more negative, the plan must draw on investment return to pay benefits and

eventually must sell investments to meet benefits. Negative external cash flow forces the plan trust to hold more cash or more fixed income and less equities, which lowers expected return.

Representative Stewart requested information on GRS's return to work actuarial assumptions for PERA and ERB. Mr. Varela asked if the recession would require actuarial changes. Mr. Conradi replied that inflation is negative, but GRS is still comfortable with 3%. As for investment return, if the plans could make 8% before, they can do that in the future, so there will not be dramatic changes in the assumptions.

On questions from Representative Berry, Mr. Conradi indicated that a DB-to-DC shift was not really related to issues around a generational shift as it affects retirement plans.

Representative Heaton discussed whether the plans need to reduce their income assumptions since their portfolios were reduced by bigger-than-expected losses. Mr. Conradi said that to squeeze the risk out, the plans would have to go to fixed income. On another question, Mr. Conradi said the question of who could be moved to a DC plan is one for the attorney general's office, not an actuary. Representative Heaton acknowledged the difficulty and complexity of switching from DB to DC and noted there were "lots of moving parts" in the plans that all play a role. He said the task force must struggle with what pieces to change to ensure fund adequacy and it would be helpful if it had an actuary to develop a matrix of possible changes, along with projections of the results of those changes. Mr. Conradi advised that it is not realistic to have significant actuarial work accomplished by the next session. Representative Heaton asked how to ramp up a change to DC to avoid the problems Mr. Conradi had discussed in his presentation. Mr. Conradi said DC could be offered as an option or the state could use a hybrid program, including retirement at age 65 and using the ERB COLA instead of PERA's. Another option would be not to eliminate DB entirely, but to reduce it for new hires and combine it with DC.

Senator Duran asked why people would choose DC if they were offered an option between DB and DC. Mr. Conradi said DC is attractive to employees who do not think they will retire from government, e.g., university faculty, political appointees and term employees.

Mr. Malott pointed out that it is important for the task force to be able to define success for itself and that it must know its goal. He noted that even fixed income investments were doomed in the recent financial crash and that there had been no place for investors to hide. Representative Stewart reminded the members that the task force's task is spelled out in HB 573.

On questions from Senator Jennings, Mr. Conradi said that under a DC plan, if an employee leaves before the five-year vesting period, the plan returns the employee's contribution; if the employee is vested, the employee would receive all of the employee's account. He said it would be hard to determine whether retirement plans affect public employment turnover rates. As for return to work, Mr. Conradi noted the issue often makes news when people violate the purpose of the provision by retiring and immediately returning to

their jobs; in California, it is known as "chief's disease". Massachusetts, this year, passed reforms pegged to abuses of return-to-work provisions.

Asked if there is a greater migration to DC plans on the health care side of benefits, Mr. Conradi said some plans are moving to a type of DC in which the employer contributes to a fund so retirees can buy coverage.

Ms. Kane observed that at least on the issue of spiking, New Mexico does not have the same problems as other states because it does not have the loopholes other states have. Representative Stewart asked how spiking, return-to-work and other issues relate to solvency. Mr. Conradi pointed out that "solvency" is not an actuarial term. Referring to page 70 of the handout, which shows examples of the funding ratios of two hypothetical plans, he said the more a plan is funded, the less contributions are needed, but if contributions are sufficient, the plan needs less funding. He considers the question of solvency to be one of whether the state is able to make sufficient contributions to make the funding ratio over time. Mr. Slattery said that PERA's 80% funding ratio is due to the four-year smoothing, which helps manage contribution increases.

Representative Garcia asked for an example of a successful hybrid plan. Mr. Conradi replied that he could not provide one. One reason for that answer, he said, is that there are not that many hybrids. Ohio's plan has a reduced DB and optional DC. While DC looks good on paper, it draws less than 5% of participants.

Senator Jennings suggested the task force look at 30-year retirement and the coordination of benefits with return to work. Mr. Conradi said Nevada has a "30 and out" plan for police and firefighters.

Legal Issues of Changing from Defined Benefit to Defined Contribution Plans — Doris Faust, LCS Staff Attorney

Ms. Faust said there are constitutional ramifications to be considered in a discussion of changing from a DB to DC plan. Limiting the choice of new employees to a DC plan and offering it as an optional plan for any employee would not invoke constitutional concern. However, there are two constitutional obstacles to changing the DB plan for current employees. Article 2, Section 19 of the constitution of New Mexico provides in part that "[n]o. . .law impairing the obligation of contracts shall be enacted by the legislature". If the issue were brought before the court, it would look to determine: (1) is there a contract; (2) if so, what are the terms and what is the change; and (3) what is the impairment. On a case on point, in its May 2009 decision in *Beggs v. City of Portales*, the New Mexico supreme court reversed a summary judgment ruling of the district court and court of appeals, saying the circumstances of the case present genuine issues of material fact as to whether the city's offers and retirees' acceptances constituted binding contracts. The case involves retirees who relied on the city's personnel policy manual that provided that retirees could pay the same health care premiums as employees. In addition, Article 20, Section 22 of the constitution, which establishes protections for PERA and ERB and property rights for vested members, might come into play in a legal challenge.

Representative Varela suggested that rather than looking at issues with constitutional problems, such as changing from DB to DC, the task force look at statutory changes it can recommend to the legislature. Representative Stewart said any recommendations the task force considers will likely need to be vetted by the actuary and the task force is operating without a research budget.

Representative Heaton inquired as to when contract is made, whether hire date or vesting date, and noted that teachers sign annual contracts. Ms. Faust explained that an implied contract could be created at any point in a relationship. Mr. Padilla said the best position would be to look at only changing benefits for new hires. Ms. Faust said in that instance, there would be no contrary contract right established. In answer to another question by Mr. Padilla, Ms. Faust said prior to vesting, an employee might make contract arguments against changes to the employee's plan.

The task force recessed at 4:10 p.m.

Tuesday, August 11

The second day was called to order by Representative Stewart, co-chairwoman, at 9:10 a.m.

Roundtable Discussion — Task Force Expectations and Direction

The co-chairwoman introduced the item, saying she wanted to hear the members' ideas for the task force and hoped they could talk to one another about issues of concern.

Mr. Arencon began the discussion by stating his interest in the task force pursuing prevention and wellness programs as incentives to control costs in RHCA. He asked for information of such programs in other states.

Ms. Lotero would like any actuarial study commissioned by the task force to include projections due to increases in minimum retirement age.

Mr. Chavez asked staff to look at what most states are doing relative to ideas postulated by the members. He also asked the task force to pursue other issues such as an irrevocable trust for health and minimum retirement age. He expressed support for the concepts in HB 573. He agreed that the task force needs funding for its own actuarial study, including cost effects of proposed changes.

Mr. Bowyer said it is vital that the task force know where it is going and when it arrives there. He did not have the sense that this had been determined. Noting that Mr. Conradi had said solvency is not an actuarial term, he wondered if PERA and ERB are solvent and if people confused annual return with performance over time. He agreed that RHCA is not solvent as a prepaid plan. He also cautioned the task force not to confuse solvency issues and a perception that some provisions may be unfair. For example, return to work does not affect solvency,

particularly with the HB 573 fix. As for minimum retirement age, there can be actuarial adjustments for underage retirement. He opined there are ways other than draconian to consider changes, that he preferred incentives over punishment. For example, the law could provide incentives for staying longer rather than penalizing those who did not stay longer. The state should be able to develop strategies to convince employees to stay until they are closer to the age for social security and medicare benefits.

Representative Heaton noted that any discussion of health care may be premature, given the debate in congress about health care reform. There are discussions of eliminating medicare advantage and filling the prescription drug donut hole. He said he was shocked that Mr. Conradi said unfunded liabilities do not matter. He stressed that he believes the public employer has a financial and moral obligation to ensure that it can pay for what it has agreed to do. He concurred with Representative Stewart and other members that the task force needs its own actuarial advisor; it needs to know how changes to system provisions, such as minimum age, vesting term, age and service, contributions and others, will affect the trust funds and which would be significant players. He said the task force needs to understand more about the contractual rights and obligations of public employers and employees, and he would like to know what is included in teacher contracts. What would be the effect of changing the vesting provision from five to eight years, for example? What effects do spiking and return to work have on the funds? He expressed concern about the larger ups and downs of the economy and investment returns and said fund managers need to be on the conservative side.

Mr. Chavez commented on Representative Heaton's point of underfunding and noted that while RHCA is underfunded by \$2.9 billion, it was underfunded at one point by \$4.1 billion, which means that recent measures have helped to shore up the fund.

Mr. Heshley pointed out that collective bargaining agreements could forestall changes affecting current PERA members. He wanted to be sure the task force considers the impact of DC for new hires on the DB plan. He also said PERA is looking at return to work and whether it affects the trust fund and that spiking is no longer a problem because of collective bargaining.

Representative Berry observed that after listening to the discussions on unfunded liabilities, it seemed there was no consensus about the size of the problem and wondered if UAAL does create a bonding problem. He thought the task force should determine if it could come to agreement about plan changes for new hires. He asked for a compilation of information on the per capita income, salary and benefits of teachers, police, firefighters, state employees and others and asked that it be compared to surrounding states.

Mr. Varela said the earlier presentation did not answer the question of how serious the market has been on funds and the annual assessment that is still to be done. He expressed reservations about DC plans and said ERB has agreed there needs to be eligibility changes, e.g., loopholes need to be closed and consideration should be given to years of service, COLAs and return-to-work changes.

Mr. Bowyer reiterated that the task force needs not only to know where "there" is to get there, it needs to know what "there" is as well. He said Mr. Conradi had presented another view by saying that money lost will be made up over time and that it is not necessarily the issue to worry about. He said he hoped the task force would not rush to present recommendations since it has until October 2010 to complete its work.

Ms. Kane noted that members who retire early receive less benefits and said she would like to see incentives for those members who choose to stay in the system longer.

Mr. Padilla expressed the belief that return to work does affect solvency. Referencing Senator Jennings' concern about the difficulty of recruiting specialists, he suggested the employer will have to prove need when hiring a retiree. He noted there is no silver bullet, no one change, that will fix all three systems. He said DC does not sound like a solution to the problem of fund solvency.

Mr. Propst pointed out that the three plans are different. RHCA does have solvency problems, and it will be in deficit spending by 2018. He said the under-65 retirees are the real problem and he does not expect RHCA to be there when he retires in 25 years. He stressed that revenue and contributions must increase and the board has significant power to manage the program. He said RHCA can issue a request for proposals (RFP) for medicare services but not for non-medicare services; the authority must use consolidated purchasing as required by the Health Care Purchasing Act, which is not always the most efficient or effective. [Note: This is also referred to as IBAC, the interagency benefits advisory committee, composed of the RHCA; the Public School Insurance Authority; the Risk Management Division and the Group Benefits Committee of the General Services Department; and the health care program of the Albuquerque Public Schools.] Upon a question from Representative Heaton, Mr. Propst explained that the agencies do not buy together, but they are required to issue an RFP together. One agency cannot issue an RFP unless all agencies do; he would like the authority to have more flexibility.

Ms. Goodwin said RHCA does need to be pre-funded and it should strive for that going forward. She noted there needs to be intergenerational fairness, and one way to drive down pre-medicare costs is to have a healthier work force. Seventy percent of health care costs derive from lifestyle choices, she said. She requested the task force to look at the Safeway program and what other states are doing.

Representative Varela asked for a breakdown of premium increases from RHCA. He indicated that IBAC has not been proactive enough and the task force should look at its legislation.

Ms. Lewis suggested the task force look at the actual number of retirees under 50 and under 60 and whether they are state, municipal, firefighter or police members. She also suggested a threshold be established for contribution increases. Mr. Padilla said there are 2,000 state and 1,000 county corrections officers on 20-year retirement. He cautioned the other members that recruitment and retention of corrections officers are difficult.

Representative Stewart observed that the economy has complicated an already complex topic and the task force may need to take all the time allowed by statute to complete its task. She stressed the need for good data and actuarial projections.

There being no further business, the task force adjourned at 10:45 a.m.