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>> Matt Loesch: Good morning. If I could please I'd like to call to order the November 17th meeting of the board of administration for the Federated city employees retirement system. Under orders of the day. There's several things mostly just getting shifted around as far as placement in the agenda. As noted on the agenda, we're going to have our closed session time-certain at 10:00 a.m. And do I need to detail now what's in that closed session?

>> Mollie Dent: No, when we go out to the closed session I'll do the order in which we'll do that in.

>> Matt Loesch: And we'll take a quick break. Do we need to convene before we do the quick break?

>> Mollie Dent: You can go directly in. I'll announce it before you take the break.

>> Matt Loesch: To be clear we have two disability hearings today, one that is to be heard in closed session, another one that is in open session. And -- but we can take the open session one depending how the actuarial stuff, we can do that before the 10:00 a.m. break. I just don't know if staff -- if Eliza Zimmerman -- (inaudible).

>> Matt Loesch: Did we reach out at all on the one that was not listed as closed session so we could hear it at any time?

>> She's coming around 9:30.

>> Matt Loesch: 9:30. We will have a quasi-soft time of 9:30. We are going to move 5.1 and 5.2 to the front of the meeting. We have the actuaries present. Other than that anything other than that on orders of the day that you see need to be brought up? Otherwise I'll entertain a motion on those.

>> Edward Overton: So moved.

>> Second.

>> Matt Loesch: All in favor, opposed, 5.1, discussion and action regarding Cheiron's July 30, 2011 valuation for Federated city employees retirement system.

>> Good morning, I'm Bill Hallmark. I apologize you do not have a final report but all the aggregate results are here in the PowerPoint. With the decision last time to -- for the city to contribute an additional \$8.1 million we had to go back and get revised asset statements and adjust everything and in the aggregated level is a very simple adjustment but getting all the details of how that flows through the Val report took us some additional time. So that's why that's not available today. We're going to talk briefly about the valuation process. And then the results looking at the historical trends and some of the key things that happened this year. Some of this is a review of things that we talked about in the prior meeting. And then, we're going to look forward-looking and show our projections. And you have not seen projections based on the new data, so this is really where you'll see some new information. As a reminder, we usually start with this graphic on how the valuation works. The tank on the right represents the liabilities. And the green in the tank represents the asset level. And that asset level goes up and down. There are a couple items that come out, but the benefit payments come out the bottom and the expenses come out the bottom. And then there are three different sources of income for that fund. The employer contributions, the employee contributions, and the investment earnings. And so largely, what you control is those valves on the top through either investment policy or the contribution policies built through our actuarial valuation. And so the valuation is the annual assessment of where this system sets. As of a point in time. And so it's always important to put that point in time in perspective, both looking back, and looking forward. The valuation results we've prepared are used to determine the contributions for the fiscal year ending 2013. Both the city and member contributions the members are set as rates and the city we set both raids and amounts. And the city ends up paying the greater of the two based on the policy adopted last year. Usually this is also produced the accounting numbers. The pension expense for the fiscal year ending 2013 and I just wanted to warn you with GASB's proposed changes they would be effective 2013. So these might not be the numbers that actually go into the City's pension expense next year if, as expected, GASB issues final proclamations. And retains the same effective date. So we've expecting those to come out next June. So we won't know until then but in the interim in terms of accounting expense these would be the numbers.

>> In graph shows the asset and liability relationship. This graph shows the asset and liability relationship. The gray bars are the 1977 and the yellow line is the actuarial value of assets or our smooth assets. The green line shows the assets at market value. And the reason the green line starts in 2003 for the market value is, that's the first year that the health benefits and retirement benefits were separated. So that's the first year we have data on that. The funded ratio which is based on the smooth assets, the actuarial value of assets, started at 92% in 1997, and stayed steady until about 2005, where there was a big drop due to the 2001 bear market. And then it stayed steady for a couple more years and dropped again with the 2008 market crash. And it's been steadily decreasing as the -- as we smooth-in those losses from 2008. So the funded ratio for this valuation is 64.6. And you can see the unfunded went at the beginning of this time frame from about 57 million to 982 million. This graph shows the contribution rates for both the city and the members. And it stayed steady at about 15% up until about 2005 and increased to 18% and jumped again in 2011 with the market crash in 2008 to about 26%. And has been rising steadily the last three years. And the large jump from 2012 to 2013 is going to be explained later in the presentation by Bill, so he can explain the factors that go into the large increase there. And these, just want to note, these are fiscal year end rates, when the rates become effective to the city. This next chart shows historical gains and losses which are created for your plan when the actual experience differs from the actuarial experience. And there are two main categories, investment gains and losses and liability gains and losses. And the last seven years the plan has accumulated net loss due to both the assets and the liabilities. And this has been the impetus for us justifying several of the actuarial assumptions during the experience study we did last year, so that we can align the actual experience more with the -- or we can align the assumptions with the actual experience of your plan. So you can see, for the liabilities -- or for the investments which are the yellow bars, we've seen losses in four out of the -- four out of the five years. Actually, this is a seven year period so during that time four of the five times that we've measured it. And liability losses also in the time -- only time we had liability gains were in the last two valuation cycles and that's due to salary gains.

>> So this table shows a quick summary of the key valuation results comparing last year to this year. In the last valuation all of those numbers were calculated using a discount rate of 7.95. And we have the new numbers calculated with the newly adopted discount rate of 7.5. So even with that change, you're seeing the actuarial liability go from just 2.5 billion up to 2.8 billion. And the actuarial value of the assets stayed relatively level, as

we're phasing in recognition of the 2008 losses still, even with the good investment return, the actuarial value of assets is higher than we expected because of the good return in the last year, but it's still lagged our assumption. I think one of the things to note, however, is how much the market value -- the relationship between the market value and the actuarial value. The past couple valuations, the actuarial value has been significantly greater than the market value. Because we were smoothing in those losses. Now, with the investment gains this last year, and all the recognition, they're almost identical, we're almost in the same place, that really affects our outlook going forward. The numbers at the bottom show the change in the contribution rates, broken out. And there's a significant increase in the contribution rates. At the very bottom though, you see the change in the contribution amount. And the contribution amount went from 87 million up to 103 million at the beginning of the year when the city pays its contribution. That is a significant increase, but it's actually less than what we anticipated. I think we showed this slide last month. But just to refresh everyone, what is driving the demographic gains that Ann showed us and the numbers here is a 14% drop in the number of active members and a 24% drop in active member payroll. So the changes in just the number of people accruing benefits and their pay level has had a dramatic impact on the liabilities. The gains and losses are broken out as follows: The key gain was the salary gain of about \$127 million in terms of the reduction in pay that we saw, reduced the liabilities by \$127 million. Now, with the reduction in the active members, we had a lot of retirements. And that actually added an additional \$35 million to our liabilities over what we had expected. In general, earlier retirements than expected will add a cost to the system. The -- and then the investment loss, again that's on the actuarial value, not the market value. So that loss was less than we -- or it was a greater loss than we expected. But the combination of the investment loss and the retirement -- and the retirement loss offset the salary gain. So in aggregate we ended up with a very small change in liabilities. Here, we break down each piece from how -- what the contribution rate in dollar amount for the city was, and the contribution rate for the member. And then the experience during the year. And so you can see that the investment loss added about \$6 million to the City's contribution, and the demographic gains reduced cost by about 5.5 million. And then the payroll decreasing reduced cost by almost 12 million. Those changes were offset by the assumption changes. Now, one thing I want to clarify here is, last time we showed the assumption changes based on the -- based on a comparisons to the board's previously adopted change in assumption for 2011 of moving the discount rate to 7.75. Here, we're comparing to actually last valuation, which was at 7.95. So some of the numbers are slightly different. The key number that's different is line

3 D, the change due to economic assumption changes. That 11.6 breaks out roughly 50-50 between the two steps. After the assumption changes, we end up with a contribution rate of \$103 million which compares to our projected \$105 million, the member contribution increases to 5.4% largely due to those assumption changes and their effect on the normal cost. This exhibit shows the SRBR calculations for this year. There were \$213 million in earnings in the retirement fund. The calculations go down to that primary interest crediting line where we show \$88 million. That means, after crediting all of the reserves, the employee reserves, the SRBR and the general, with the primary interest credit, which is for the SRBR in general, it's the assumed rate of 7.95, the employee, it's the 3%, that uses up 88 million of the 213 which leaves us with 125 million of excess earnings and 10% of that is transferred to the SRBR. And so you're seeing a transfer of 12.5 million to the SRBR this year. Now, I want to show you some projections here. And we're going to start with the graph showing percent of pay. So to orient, I think most of you have seen this graph before but let me orient everyone to it. The top graph shows the projection of the funded status and the actuarial liability. The gray bars represent the liability of the plan. The green line is the market value of assets. And the orange line that you can't see is the actuarial value. And the reason you can't see it, except in the first couple years there's a little shading of it, is because we're starting so close together that there's just some minor differences, and then we assume they merge together. And so there -- you're not seeing a difference. If we look at different economic scenarios you'll see the difference. The bottom graph shows in the teal bars are the member contribution rate. The gold bars are the City's contribution rate. The black bar that goes across is the normal cost. And so that's the rate at which new benefits are being accrued. So any contribution above that black bar is going to pay off the unfunded liability. The red line shows the projection from last year. And so, as a percent of pay, the projection has gone up. It's gone up you know a fair amount. But part of that is driven by the reduction in payroll. The percent you have to go to pay off that unfunded liability goes up. I'm just going to change the bottom graph to show the dollar projection. So now, the teal bars are still the member contributions, but showing expected dollar amounts. And the gold bars are the City's expected dollar liabilities. The red shows the prior projection. And so last year we were projecting higher dollar amount increases. Now, even reflecting all the assumption changes, what's happening here is that good year of investment performance, we had an almost 19% return, gets phased in over five years. And as we recognize that, that has a significant impact on the projection. The other thing is, the assumption changes we made, one of them was to reduce the wage inflation rate to 3.25%. So in our projection, we are now assuming that normal cost increases as the dollar amount

by 3.25%. And the payments on the unfunded liability increases the dollar amount by 3.25%. In the past it was 3.83%. So that flattens the projection out, and the projected dollar amount payments follow a much flatter pattern. At the end of the 20-year period, that makes about a ten to 12% difference in the contribution rate. Now, just want to show, we're not -- we're assuming right now 7.5% is exactly earned every year. And because of that I've turned off a calculation of a gain-loss on the SRBR. Turn it on, and look at a historical period. So you can -- what this is doing is, taking historical investment returns for right now I'm at the period starting in 1943, and reproducing it as if it goes forward, based on just a simple 70% equity, 30% bond portfolio. And so you can see some of the volatility that you would get in contributions. Particularly if we get into some of the bad scenarios. And on the top line, you see how the orange actuarial asset line smooths the changes in the market value of assets. And then on the bottom, you'll see the contribution rates fluctuating. Now, I think it's important to understand that those investment returns have a dramatic impact on those contributions. So we got a really good return this last year, which drove the projections down. I know so far this year, the investment returns have not been what we would hope for. So we do need to have some caution. I mean, this is good news about the projections. But we should take it with a little bit of caution. Any questions or scenarios?

>> Matt Loesch: Inquiries from the board?

>> Just to understand what the model was. Are you just changing one year of returns to the 1931 year returns or -

>> No projecting forward.

>> Okay.

>> I can change -- do you know what your return was for the first quarter of this year?

>> Carmen Racy-Choy: Approximately negative 9.75.

>> So let me just put in minus 10. Minus 10% if that held for the year, that kind of puts you back where you were.

>> Pete Constant: What if we had another (inaudible) clearly this (inaudible).

>> Um -- so I don't remember the returns from the tech bubble off the top of my head. Do you --

>> Carmen Racy-Choy: Three years of 19% return.

>> Before the bust?

>> Carmen Racy-Choy: Going forward.

>> Pete Constant: I'm talking about (inaudible) we had another double-dip --

>> He's talking about the 2001-2002.

>> Carmen Racy-Choy: Oh, the bust side, maybe negative 15 for two years.

>> That was just the equity, though, wasn't it?

>> Carmen Racy-Choy: Um -- negative 10? It's going to be bad.

>> Yeah. Okay, let's put in negative 10 for two years. Now, you know, with the tech, then you followed that with a fairly quick recovery. So you get -- I don't remember what they were. But I remember they were pretty good. So you can get these balancing out, if you're lucky, they might balance out. And you can see here, the market value of assets changes significantly. And actually, with the smoothing, the contributions stay fairly level, if you get that kind of pattern. That's really the idea of the smoothing is to deal with that kind of pattern.

>> Arn Andrews: And June one question so I understand the model correctly. Up at the top where you show an historical, going forward aren't you already putting in some sense of market fluctuations to predict going forward?

>> To develop the assumption of 7.5%, yes.

>> Arn Andrews: Okay.

>> But not -- when we're doing the projections here, we're actually assuming all of our assumptions come true.

>> Arn Andrews: Gotcha. Okay, so going forward you're not assuming market fluctuations?

>> Not on this. If we go to the historical returns then we are.

>> Arn Andrews: Right.

>> Okay.

>> Matt Loesch: I think the quick summary is if we have hellacious returns it's bad for us. If we have good returns it's good for us. We expect if we have bad returns more contributions would be sought, if it's good returns it would be tampered down. If we plug in any number we want, 1980 forward, we would have a positive scenario. If we plug 2000 we would probably have a pretty negative scenario.

>> The point is to understand what the magnitude of that scenario is for you.

>> Matt Loesch: It's massive. Question?

>> Edward Overton: I wanted to understand the magnitude of the payroll contribution. The city is looking at growth in what do you think of that?

>> Between the prior projection and the current projection, reflects a --

>> Edward Overton: On a go-forward basis?

>> On a go-forward basis we're assuming that all assumptions are met on the liability side and we have not projected variability in the demographics, beyond what's already embedded in the assumptions so if you -- if you went through another round of cuts, like you just went through, you'd see a similar reduction. If you have just flat payroll, you have kind of offsetting impacts. The normal cost is less, the liability growth is less. But if all those people are still employed the UAL is fairly much intact. It gets adjusted slightly but you're spreading it over a smaller payroll. Again the dollar amount of the payroll goes down but the percent of payroll may go up.

>> Matt Loesch: Mr. Armstrong.

>> Michael Armstrong: So as I'm looking at this, the percent of payroll jumps rather dramatically in 2014, and you're looking at 48, 49% almost in perpetuity?

>> Yeah, that's essentially the design of the funding method, is to get to a level percent of payroll and hold it there at least for the duration of the amortization period which is 20 years. So that just runs to the end of our graph here. So once you've paid off some of those amortizations you would drop down.

>> Michael Armstrong: Okay.

>> Matt Loesch: Further questions?

>> Arn Andrews: Just going forward in future presentations I find the dollar amount and the compare and contrast to the previous valuation very helpful. The slide you just put on this screen, if they could be embedded in the packet, especially with the new floor methodology, the dollar amount as contribution amount.

>> I agree, and we made that adjustment more at the last minute, which is why it's in the dynamic model and not in the presentation. We'll get that in, in the future.

>> Arn Andrews: Great.

>> Pete Constant: I have a question. (inaudible) what if (inaudible).

>> You have the dollars?

>> Pete Constant: Yes, the dollars.

>> Matt Loesch: And the assumption would be, if it's 8% it would be even less than that.

>> Pete Constant: Right.

>> Yeah, I mean, it's the same dynamic. It's just getting --

>> Matt Loesch: I have a question here on slide 11. Only because this goes to how it would be broken down and who's paying what. Has it been resolved yet from the attorneys what the SRBR and normal costs you said that would be looked at? It's included here that the city is paying the entirety of the SRBR costing that we've -- method.

>> Mollie Dent: So yeah, we've looked at that and we think the cost could be shifted to the employees but it would need to be bargained for, so I guess that's up in the air whether it will be or not.

>> Matt Loesch: So basically as currently constructed the plan would have all of those costs as it's listed here on the chart?

>> Mollie Dent: I would assume the SRBR is kept and there's no bargaining over it.

>> Matt Loesch: If it is, there's nothing that's listed here, that's one of the pending questions last time. My recommendation, not to accept the report, there is no report to accept today to wait until December to look at that and maybe have that comment about the SRBR in your report as well. Because I think -- it was a question that came up in our review and make sure that's covered as to why that's broken down the way it is. So my recommendation was, to move out just to December and we actually have the report to review and actually accept, unless you have further questions or comments or thoughts.

>> Arn Andrews: Just one other question. On slide 7 where we show the historic gains and losses, knowing that we have two years of losses and two years of gains, is the expectation provided, the GL bar is going to start to be flattened out and mitigated?

>> Yeah.

>> Arn Andrews: Okay.

>> And you saw that.

>> Carmen Racy-Choy: Let me maybe add some color since this is a forward-looking question. Currently the median -- you'd expect that the bars, the yellow bars would offset over a long period of time to the extent at least the median return of the asset mix is at the actuarial discount rate. Currently, the -- given the most recent capital market assumptions that the investment committee set, the net discount rate is, on a 30-year basis approximately 7.4. That's 10 basis points short of the actuarial rate. So you're still going to see a little bit of -- as opposed to it being flat you're going to see a little bit of losses. That's kind of the baseline expectation.

>> Arn Andrews: Thanks and I -- perhaps flat was the wrong word. What I meant was you know, because of the losses we experienced we've been so used to having our discussion centered around the deferred losses that are still in the pipeline but now we also have two years of gains in the pipeline. So I'm just trying to get a better sense of expectation of that yellow bar heading into next year if we did meet our actuarial assumed return.

>> Yes, so if you look at the top chart here and the difference between the green and the orange line you can kind of see that next year we'd expect over the next two years we'd expect a very small loss as the smaller pieces are of the big loss are phased in but offset by pieces of the last two years' gains. And then we'd expect some gains to get us back to market value and then continue.

>> Arn Andrews: Good, thank you.

>> Edward Overton: Do you produce any information that shows what those gains and losses are from an accounting standpoint?

>> Yes, they are in the full valuation report, itemized by year so you can look at the historical numbers.

>> Matt Loesch: Any further comments or questions on this one? Otherwise, the action will be nonaction until December. Item 5.2, discussion and action regarding Cheiron's assumptions for June 30, 2011, other postemployment benefit plan, OPEB, actuarial valuation.

>> The other valuation we do is for the retiree health care plan. And we're going to talk about some of the background for that program. The health care assumptions and expected return assumptions that go into that valuation. So one of the key things to understand is that there is a delineated contribution strategy in the collective bargaining agreements. The transitions from a program that was in the historically pay as you go, meaning you just contributed what the benefits were that year, to one that is fully prefunded, using the arc as the annual required contribution under GASB, statements 43 and 45. And the contribution strategy calls for that to be phased in over five years, starting in 2009. With a straight-line phase-in except that the city and member rates can't

increase by more than .75% of pay each year. And then the full arc would be contributed in 2013-14. I'll come back to this again, a couple of times in the presentation. But with that limit on the increase on the city and member contribution rate we're essentially locked in until we reach the end of our phase-out period, unless we get some dramatic gains that change as a percent of payroll, the reduction in payroll is not going to help us there. We use the entry age normal cost method. The initial unfunded liability was amortized over 30 years and then subsequent gains and losses and changes are amortized over 20-year periods just like in the pension plan. The contributions are split differently than in the pension plan. The retiree medical benefits, the cost is split evenly, 50-50, between members and the city. And then the dental, the retiree dental benefits followed the same 8-3 ratio as the pension plan. Last year, this was our projection. Just to kind of put what we were looking at in context. On the left-hand side assets and liabilities, the other side is the changes, we use the market value of assets. The net is the NOO, the balance that shows on the city's financial statements as their liability for the plan. And under GASB, that liability is essentially an accumulation of the difference between the annual required contribution and what the city actually contributes. The right-hand side shows the projected funding and the gray shaded is the percentage of payroll and the teal bars are the City's contribution, and the gold bars are the employee's contribution. And the red shows the annual required contribution. And so you can see, for the phase-in period the annual required contribution is greater than the City's contribution, and then when we phase-in fully it matches the City's contribution. Now, the other thing to note here is in an OPEB valuation, if you are not making a contribution equal to the arc, we have to use a blended discount rate. And we'll get to the assumption later here. But last year we were using 6.71, that's a blended return between the expected assets which we assumed last year was 7.95 and the return on the City's general investments which is generally invested in very short-term fixed income securities. For the OPEB valuation we use the applicable valuations from the pension valuation. So the expected return of assets because they are invested in the same trust, the retirement rates, mortality rates, termination rates, all of those kinds of assumptions. And then we have to look at some specific suggestions for the OPEB. And the most critical are the claims costs, for the health benefits, the trend rates for future health benefits and the participation. Participation has a dramatic impact because only half the people take your retiree benefit is a lot cheaper than if all of them take it. And then we look at the plan elections that people are making. And the expected return on the employer assets. The claims this year actually were lower for pre-65 retirees than expected. So we saw a 2.2% increase in the claims cost in aggregate, across all of your plans. For pre-65 retirees

and the Medicare eligible retirees, the increase was about on what we had expected with our trend. We had projected a 7% increase and it was 7.3. And then, for dental, the claims costs actually went down and we had projected a 5% increase.

>> Matt Loesch: When you say claims cost, for clarification, that means the paid out for the funds to pay for those individuals? We pay premium, don't necessarily pay a claim. Just trying to make sure I understand the difference.

>> That's a good one. Thank you for backing me up. We'll get to an illustration of the difference in a minute. Claims cost is an assessment of the actual claims that would you receive, incur for retirees and it varies by age. So here you're seeing the ages over there on the left, 40, 50, 60, so forth, and increasing claims costs. So we generally expect the cost of providing medical benefits to increase with age.

>> Matt Loesch: So these are -- okay, these assumptions, these are not an experience, we have a 40-year-old getting \$220 --

>> Right. These are.

>> Matt Loesch: Okay.

>> These are assumptions based on an analysis of your claims experience, and the key assumption becomes how you spread those by age. So we get your actual total claims, and then analyze those. And fit them to age curves and compare.

>> Matt Loesch: And the premiums that get paid out for those individuals, we don't get a claim for medical experience. We get a premium. Usually they are the base premium --

>> The low 65, the premium covers the claims cost for all your retirees and actives under age 65. So let me come back to this discussion. I have a chart talking about the implicit subsidy and the difference.

>> Russell Richeda: I'm confused, Matt keeps saying premiums, you keep saying actual -- are you getting actual claims that the insurers pay or do you mean premiums that we pay the insurers?

>> We are analyzing claims here based on -- yes. But they're aggregate claims.

>> Russell Richeda: I know they are aggregate claims. But they are actual claims.

>> They are actual claims.

>> Carmen Racy-Choy: The pension that you expect a specific retiree will be earning at a specific point in time. Based on that you can project the premiums that the individuals will end up paying. So you kind of need to start with a claims projection to get to the premium.

>> Matt Loesch: The key thing I missed at the top of the chart is, these are the assumptions. Looking forward to that experience, I wanted to make sure this wasn't experience of premiums, something that didn't make sense to me. Now it does.

>> Is the experience after 65 due to Medicare kicking in?

>> Exactly.

>> Thank you.

>> This year there were some \$25 co-pay plans added to the menu of options. And the \$25 co-pay plan is the basis for the explicit subsidy that resulted in the smaller increase both in the aggregate projected claims and you'll see the explicit subsidy then was anticipated so --

>> Carmen Racy-Choy: Bill, since we have a lot of new trustees can you give a short definition of what is the implicit subsidy?

>> I should -- let me go -- let me go here. The way the plan works is, we provide a subsidy for retiree health care cost, equal to the lowest premium of all the plans offered, which is the Kaiser plan, with a \$25 co-pay. And so the gray area here represents that premium amount. And so that's the subsidy that -- that's what we refer to as the explicit subsidy that is provided. Now, the gold line represents our projected claims cost by age. So the bottom access is age, I'm showing 45 to 85. It extends down to your youngest employee. Youngest active employee. And so the big drop you're seeing at age 65 is when they become Medicare eligible then Medicare picks up a bunch of the claims. So the area between that gold bar and the Kaiser premium is called the implicit subsidy. Which is a cost that you incur for retirees but is actually embedded in the premiums for active employees. So that if you extend the claims line all the way to the left, the aggregate area under that line is the same as the area under the premium. So the insurance company is collecting enough premiums to pay all the claims. It's just how it's weighted between the premium for the active employees and the premium for the retirees. So we pay -- so this is the subsidy we pay. Now, if someone elects something else besides the Kaiser plan then there's a retiree premium. What we are showing here is that red area is the premium that the retiree would have to pay. And this is for the PPO plan and the Kaiser represents the specific subsidy. Those two areas add up to the total premium for the PPO plan. And then there's still that implicit subsidy on top which is the difference again between the orange line and the solid areas. And I changed the color of the line because this is the projection of the PPO claims and not the Kaiser claims. So they're different for each plan. So that's the basic structure of how the plan works and where the subsidies come. So in the valuation, we have to project the cost and the liability as both the sum of all the explicit subsidies that Kaiser 25 premium, that the city would pay, and the implicit subsidy. When the city pays their active premiums, they are paying that implicit subsidy as part of the active premiums and they get credit for that in their accounting.

>> So if we have a spaller employee base for the city, I'm trying to think through how the implicit subsidy is -- how this is working out.

>> The implicit subsidy dynamics can be quite complex. Yeah, you end up with a smaller active base and actually we also end up with the healthier employees going into the higher deductible plans and so that changes the expected claims for those plans versus the lower deductible plans. And so you get -- there's a whole host of factors that go through this and change it. But in general, if you have fewer, younger active employees compared to your retirees, you would expect the premiums to go up, to reflect an even spreading of those costs. Which would cause the implicit subsidy to go down. Because you'd be getting closer to the -- the average cost per employee would be closer to the cost for our retiree.

>> Matt Loesch: And again, the implicit subsidies hit the folks before they hit 65, so the pool, the quantity of people in that is fairly small compared to the quantities on either end of it, right?

>> Right.

>> A lot of moving parts pulling us underground.

>> There are lots of moving parts here.

>> Matt Loesch: Make sure you understand or having to ferret it out now. Okay.

>> Part of what we're seeing from last year is the addition of these new plans and that is changing the overall aggregate claims cost we're projecting, changed overall premiums and in particular, changed the premium for the explicit subsidy. And we are seeing, there's a dynamic of the \$25 co-pays tending to attract the younger healthier people compared to the \$10 co-pay. I don't think it's a huge flood but it's something to monitor going to see if we get an antiselection effect here.

>> Matt Loesch: Again for clarification, it's easier to tell if they are younger. How can you tell if they're healthier?

>> Individuals make their own assessment. You can't and that's part of the dynamic. The only way we can tell is by looking at the total claims that are filed under that, compared to the total claims filed you know per capita under the other plan. So we can tell --

>> Matt Loesch: So in your experience you have all the claims --

>> Looking back you can tell what happened.

>> Matt Loesch: You have all the claims for the individuals in the plan?

>> I believe in this plan we just have the aggregate claims by plan.

>> Matt Loesch: So you don't have claims cost by individuals?

>> No.

>> Matt Loesch: That's my question, so you don't know -- I just wanted -- I'm not trying to challenge your assumption.

>> We don't have claims cost by individual but we know which individuals are in which plan and we know the total claims for each plan.

>> Arn Andrews: Just a point of reference and maybe someone from HR in the administration might be here but I believe the city's currently in the process of eliminating the \$10 co-pay plan. I just have a recollection of that.

>> Donna Busse: For retirees yes.

>> Mollie Dent: For retirees it's not going to be available.

>> Matt Loesch: Does that change any assumptions then?

>> No, not at this point.

>> Matt Loesch: At what point would there be changes?

>> We have to look at how the plans are rated and how that affects the premiums versus claims relationship. So it could have an effect over time on what the implicit subsidy is. But you know, we'll have to see.

>> Edward Overton: I think it's the City's plan to eliminate the \$10 co-pay for everybody. Is that accurate? Staff?

>> Donna Busse: I think it's already been eliminated for the active, but it's been eliminated for all retirees including the Medicare groups for retirees in January.

>> That will eliminate this concern in the bottom bullet. That's the primary thing that it would do. Now one of the very powerful assumptions in this valuation is what we expect health care trends to be in the future. How much do we expect costs of health care to increase. The general approach that's used is to start in the short run look at rates and see what they are in the marketplace and grade that down over a period of years to an ultimate trend rate. The reason it grades down is the concept that health care expenditures cannot grow indefinitely as a percentage of our GDP. So we can't -- 100 years from now we can't be spending 80% of our GDP on health care. Most of the models have it grade down and end up as a constant percentage of GDP. So it will grow as a percentage of GDP for a period of time and then constant. There's debate, as you might imagine, over what the ultimate percentage of GDP is that we can spend on health care and how long it will take us to get there. Last year, we extended that grade-down period from 8 to 9 years to 15 years. And we're not suggesting any change to

that this year. For Medicare, they assume a GDP, long term GDP assumption of 4.1% in their intermediate projections, and short term they grade down to GDP plus 1, hold that for a while and then go to GDP. Our trend outlook has not changed, we're not recommending any changes, just wanted to give you that background on how we developed that. And we and I think all of the other firms and Medicare are continuing to evaluate what the appropriate grade-down period is, and what the ultimate long term cost is. For this plan, we assume the ultimate long term rate of 4.5%, for the health care and 4% for dental. But again we're not -- this is not a change from last year, and the experience, other than the plan change, seemed to follow our short-term trends. I went through these. This just shows where people are -- people's current elections are in the data we received. We assume that they continue in those plans, pre-65, and then migrate to the associated plan for post-65. Spousal coverage, one key to the cost is how many people actually take you up on the retiree medical benefits. We assume 100% of eligible retirees take coverage. And we also assume that since there's no additional cost for covering a spouse under the dental plan, that everyone takes spousal dental coverage. For the health plan, not everyone covers their spouse or domestic partner under their retiree health plan. So this data is showing the number of retirees, male and female, and then applying our assumption from the pension plan, about how many are married, and that assumption is built off of the joint and survivor annuity data in the pension plan. Because spouses get covered automatically under the joint and survivor annuity. And so we use that as our marker for developing that for the pension plan. And so if we apply that here, we have an estimated number of retirees with spouses that could be covered and then we look at how many are covered. And so we are recommending that we use a 90% assumption for males, covering their spouse and 70% for females covering their spouse. And typically the reason they may not cover their spouse is their spouse may have coverage elsewhere. So that's usually the most significant factor in that decision.

>> Edward Overton: Bill, when you say we assume 100% of retirees elect coverage, are you making a distinction between the retirees who do not have paid medical and those who do?

>> Yes, the retirees who are eligible for the retiree medical benefit.

>> Edward Overton: Which looks like about half of them.

>> I didn't look at the numbers but you may be right. It's a different number that are eligible for the OPEB benefit than are eligible for a pension benefit. You're correct.

>> Matt Loesch: The effect of lowering, instead of 100% participation, would be that -- if you're not covering your spouse then the premium, the subsidy actually is smaller, right? Because you only get coverage for a single as opposed to a family. So there's reduction of what the premium paid out would be, right?

>> Correct.

>> Matt Loesch: So if assumption is that would be --

>> Reduces your cost.

>> Matt Loesch: Would reduce the cost.

>> Yeah.

>> Donna Busse: Can you tell me again how you come up with the assumption of 90% of married males and 70% of married females are covering their spouses? I didn't get that.

>> The chart, the actual calculation comes out to 88% of married males cover a spouse based on the data and the assumption of the number that are married.

>> Donna Busse: This is -- whatever you were saying about the joint and survivor benefit that was the part that was confusing to me.

>> That's how in the second line there we have the assumed percentage married, so for males it's 80%. That's based on an analysis in the pension plan of the pension data, and the percentage of males -- male retirees who are married.

>> Donna Busse: But the joint and survivor only?

>> Which is -- that analysis was based on the joint and survivor benefits paid in the pension plan.

>> Donna Busse: But also including people who selected options?

>> Yes.

>> Donna Busse: Okay.

>> So if you multiply those together, what we would be assuming is that 72% of male retirees cover a spouse. So that's kind of where it all comes out. So the last item is the expected return on employer assets. The discount rate we have to use for the accounting, not the funding. So for funding we use the expected return on plan investments of 7.5% and the funding calculations are all based on that. But then we do separate accounting calculations and we have to use a blended discount rate which is a blend between the 7.5% assumption and the expected return on the City's unrestricted assets which are typically fixed income securities of short duration. Last year our assumption was 4.5%. Looking at the capital market assumptions, the Barclays capital 1 to 5 year government credit rate assumption is 4%. So we're suggesting reducing that to 4%. Now, the one thing that's a little bit, sometimes confusing is, I don't think anyone is getting 4% on their one to five year investments today. We have to make a very long term assumption about what those investments would return. So it's -- there's an obvious adjustment for what you're getting but you're going to be reinvesting those every 1 to 5 years and we're trying to look out over a 30 or longer period of time. So that's why the 4% is significantly more than what you're getting today.

>> What's the rationale behind incorporating the return from city assets?

>> Okay, now you're asking me to explain GASB and their thinking. I mean, my rationale is, that's the rule that I have to follow. [ Laughter ]

>> I think the rationale GASB has expressed is that the invested assets are going to earn the expected return. But you're not fully funding this. So some of the money is coming out of the City's unrestricted assets. Whatever those may be. And so they're trying to find an appropriate discount rate for the unfunded portion of the plan. And so in the current GASB 43-45 we settled on this expected return on unrestricted assets. If you look at what they've done in the new proposed pension statements they seem to be going towards an index bond rate, municipal bond rate as the appropriate bond rate. So we might see that change come into the OPEB. But right now, this is the way they've structured it.

>> So we might anticipate that the returns will be coming down? If that's what they do?

>> Well, it's more complicated than that unfortunately. We should -- there's a lot to the new GASB statements. But they actually loosen things up in some ways. And allow you to use the expected return on investments for as long as your contribution strategy keeps the plan solvent. And so, under the current -- I haven't actually run the test on the OPEB. But under the current amortization structure we're doing a 30-year closed amortization of the unfunded liability and 20-year closed on any gains and losses. I think if you project that amortization out, the plan would not run out of money, and if that's true, under the new proposed GASB, you would just use 7.5%. But they have not applied that to OPEB yet. They're going to start looking at that after they issue the final pension statements. And so there's an awful lot of ifs in my statement.

>> I guess sort of where my question is going is, we are sort of essentially employing the same investment strategy as we are for our health care as we are for our pension liabilities. That appropriate?

>> Matt Loesch: Did you read my notes?

>> Carmen Racy-Choy: I'll give you the short answer, which is, health care liabilities tend to be short term in nature. And typically a lot of the contribution, especially over the coming years that is going into the fund is being used up. So is the pension asset allocation appropriate for health care? No. I think at some point in time, the trustees need to sit down and establish an independent asset allocation. However, currently, there isn't enough money in the fund to really make an impact. And the reality is, it was so hard to actually get the money invested, that necessarily doing something different from the trust would be very difficult. In two, three years we need to reevaluate the strategy as the fund grows and we start to have a little bit of money that would give you the flexibility that would allow you to hire the type of managers and the type of mandates that you would like to have.

>> This is showing how that blended discount rate is calculated using the methodology that's in place. So last year, we had a blended discount rate of 6.17% under the recommended assumptions we dropped to 6.1. Part of that is drop in the assumption from 7.75 to 7.5 and 4.5 to 4. Another part is the limit on the increase in the employee and employer contributions, were actually contributed a smaller percentage of the arc than we were a year ago. So as I said, at the outset, we don't expect a change in the contribution rate. I emphasize rate, because with the payroll dropping, the rates that we calculate will go up. The dollar amount, however, when you apply the rate, is likely to go down. The new claims assumption and the new -- the lower premium for the explicit subsidy plan, we expect to reduce the liabilities. The proposed spousal coverage assumption we expect to increase liabilities slightly. And the -- for GASB purposes, the reduction in the blended discount rate will increase liabilities. We don't have actual calculations prepared for you at this time to let you know how all those things balance out, and how the demographic changes balance out. So I can't -- I can't give you those estimates at this time.

>> Matt Loesch: So one of my thoughts in general is similar to Mr. Armstrong's, as we balance these things and the health trust grows and we deplete the 401, and should this whole conversation really have happened under the health care trust, that might be appropriate we should consider moving forward, because it's in the health care assets and health care plan, that conversation should be thought of. But then the asset allocation, is it what is happening with the liabilities, large scale as the layoffs that happened last year, our people that aren't vested in

health care plan and what are the consequences there? I can't remember, if we don't do payouts on people that don't vest under 15 year right and the health care contributions they make, right? If someone's not vested in the pension plan and less than five years, they get paid out or the money sent into a retirement account they don't hang onto it.

>> Mollie Dent: If if a person asks for a return on contributions they will get a return on contributions that go to their health care. If they decide to go on vested, they won't receive any of their -- deferred vested they won't receive any of their pension contributions back.

>> Matt Loesch: This is not like an experience study on the pensions, right, at what time will we be doing a experience study on what's been happening the many years, as many of the young people have been laid off, contributing to health care, but quite likely won't be receiving retiree benefits because we won't be paying those out, the large preponderance of people who get laid off are under 15 years. What are the implications of that?

>> Can I just clarify that if there is someone who is -- takes a return of contributions, they're together. You're doing a return of contributions, you can't leave your health and take your pension, or you can't take your pension and leave your health. Both health and pension are leaving at the same time. Any of the members that would be laid off that wouldn't be getting the health care benefits and didn't return the contributions on pension would be taking health care as well.

>> Matt Loesch: Someone vested on pension would decide to take their money out?

>> You would take both.

>> Mollie Dent: I would only be people who decided to leave their pension contribution on deposit.

>> Matt Loesch: Right. Those folks between five and 15 years would get no health care benefits from it but still get their pension when they become eligible?

>> That's correct.

>> Matt Loesch: How are we accounting for that? There are people that we would potentially be paying out benefits for but they wouldn't be.

>> Because they are linked, who takes a refund, who terminates, I think all of that applies to the health as well. What's different is what benefit gets paid once they've done that. So -- and that piece is part of our programming. So I don't think -- I don't think in terms of the experience study that there's a difference on that particular assumption. Because they're going to -- we're just looking at whether they leave employment or not. And that's not going to be different for retirement or health. Same as whether they retire or not. That's not going to be different.

>> Matt Loesch: Even if there's a larger amount of people? Because there's more people between zero and 15 than there are between zero and five, right? Zero and five would get paid out than both, someone who's more than five but less than 15 will never get retiree benefits, contributed, get --

>> So let's just say you know, we had 5%, the assumption is 5% of the people in that 5 to 15 leave. We would apply that 5% to both plans. But in the pension plan we'd say there's a 5% chance you're going to get this deferred vested benefit. In the health care plan, we'd say there's a 5% chance you'd get nothing.

>> Russell Crosby: So there would be small occasions all the way through (inaudible).

>> Yes, it's like how the plan provisions itself are programmed.

>> Matt Loesch: I'm tracking but when we do this experience to see what's happening in the current environment we're in it's going to have an effect on our liabilities and what we'll be paying out.

>> Yes, that's going to have a different effect on your liabilities, that's correct.

>> Matt Loesch: Right, okay.

>> And the other thing that should be clear is the reductions in pay affect your pension benefits. But that has no impact on the value of the health benefits you'd receive because your health benefits are not tied to pay.

>> Matt Loesch: But our health benefits have been reduced, our active benefits have been reduced and once they are reduced they trickle into in theory --

>> Right, that's a different dynamic we're looking at through the premiums and the claims and how those are affected by having the lower plans. As opposed to just a direct reduction due to a reduction in pay. The dynamics are going to be different.

>> Matt Loesch: At this time when all this stuff is in flux. at what point will we take a snapshot and look at assumptions?

>> The key assumptions that underlie both plans I think are really covered in the pension experience study. It's the implication of variations on those -- on the cost that's going to differ. But the assumption itself is not going to differ. The special assumptions that affect retiree health are the ones that we laid out here. So you're looking at you know tracking the history of claims and those costs and premiums increases, changes in plans. There's a lot of different pieces. And the spousal coverage. So we look at those things, every year, really. The claims are looked at every year. The health care trend is looked at every year. But it becomes a forward-looking adjustment. And it's not like we can just locate your last five-year history and say, you know, we expect retirement -- we expect retirement rates to follow the same pattern as the last five years so we expect claims to follow the same pattern as the last five year or premiums the same pattern as the last five years. The historical view has less applicability to those assumptions than it does to the demographic assumptions. The analysis is more -- is similar to what we do for the investment return. Where you're looking forward-looking and making adjustments

based on how you see the capital markets looking forward, we're looking at the health care market going forward and trying to assess how that works.

>> Matt Loesch: Well and the big driver here is we know what the contribution rates are going to be because they were agreed to in a contract.

>> Right.

>> Matt Loesch: Regardless of the assumptions and the changes it's not irrelevant. But they are locked in because of the contribution rate increases that were agreed to in the last contract. On employee health care. So any further discussions? You're on board decisions I believe is the next.

>> Arn Andrews: And just one question on board decisions. Since we don't actually have numbers, is there a reason why we need to make a decision today with the numbers? Because you said you don't actually have the numbers available, would that be relevant to us making a decision?

>> Russell Crosby: It's actually similar to what you did last meeting in order to get the pension valuation done, they need to have the assumptions approved to go forward. For the next step.

>> Arn Andrews: Okay. That being the case, I make a motion to adopt the health care trend assumptions, the participation and spousal coverage assumptions and the expected return on employer asset assumption.

>> Second.

>> Matt Loesch: Further comments or questions? All those in favor? Opposed? Thank you Tom.

>> All right, thank you. Could I do the favor of -- can we get a couple of items done? Dispose of the consent calendar and then we'll do our quick break. If you would allow me that liberty I'd appreciate that. So on the

consent calendar that's items 2.1 to 2.8 is there anything that needs to get pulled? Otherwise I'll entertain a motion.

>> Edward Overton: Move approval.

>> Second.

>> Matt Loesch: All those in favor, opposed, none. Item 3 please death notification.

>> Arn Andrews: And actually on item 3 I would just like to say, Gordon worked in the finance department. The gentleman was a pleasure to be around. And he'll be missed in the finance department, he'll be missed in the city, he provided a lot to the city over the years.

>> Matt Loesch: So in that regard, Gordon being a fine man and recently passed. Ask for a moment of silence, please. [ Moment of silence.]

>> Matt Loesch: Okay, thank you.

>> Edward Overton: Do we need a motion to approve survivorship benefits to his spouse?

>> Donna Busse: Notification on (inaudible).

>> Matt Loesch: Okay, so we're going to take a quick break here but before the break we're going to talk about Ms. Dent is going to do a notice on closed session.

>> Mollie Dent: Proceed into closed session first with conference with legal counsel, under government section 54956.9, subsection a, for existing litigation to discuss the following cases: Raul Guerrero versus board of administration of the Federated city employees retirement system, and second case, Meyers versus Board of

Administration of Federated City Employees Retirement System; third case, in re the retirement funds for the members of the Federated city employees retirement system for the City of San José. And after, discussing the existing disability retirement, pursuant to government code section 54957, upon the request of the applicant Emily Briggs.

>> Matt Loesch: Thank you, we'll take a break and then retire into closed session, thank you. [ Recess followed by closed session ]

>> Matt Loesch: Like to call back to open session please under item 1.1A, for eliza Zimmerman, latent fingerprint examiner, police department, request for non-service-connected disability retirement, effective September 8th, 2011, 19.78 years of service. Staff (inaudible) for identification.

>> Donna Busse: Eliza Zimmerman is requesting a nonservice connected disability based on degenerative disk, disk protrusion, (inaudible) spondylosis of cervical spine at three levels, she's 46 years old with 19.78 years of service. Medical reports are listed in your packet. There were no work restrictions provided by the medical director. Her status is that she's currently separated. At the time of separation she was on loss time. At the time of application she was on disability leave. Committee summary: The application withdraw her request for service connected disability so board does not need to consider work relatedness. The committee is recommending a denial of nonservice connected disability based on the fact that we did not think that the work restrictions provided by the treating physician would preclude her from doing her job and that the applicant had other treatment options available to deal with her pain. The committee was not persuaded by consulting physician Dr. Carlson's response to questions regarding validity of work restrictions on 11-17-2009, we were more persuaded by consulting physician Dr. Shey's report, from 3-7-10 indicating that there were minimal degenerative findings that only supported prophylactic restrictions of generally avoiding overhead work although it could be done on occasional basis and avoidance of constant cervical flexion and extension and rotation although it could be done on a frequent basis. The committee was persuaded by the report from Dr. Rollins dated may 12th, 2010. Dr. Rollins states that he believes the patient is not permanent and stationary and recommends evaluation by neck specialist to discuss new treatments and the potential benefit of those treatments. In addition, the statement of medical addition from Dr. Flap dated February 17th, 2011 indicates that the applicant is not maximally medically improved from her neck.

>> Matt Loesch: Dr. Das would you like to review the medical summary please?

>> Dr. Das: Yes. Ms. Zimmerman has arthritis in her neck, which may cause symptoms and cause pain, and it's reasonable for those findings to cause pain. The issue is for the severity and the functional restrictions. There is no cervical instability identified, there is no nerve root compression identified. There is no spinal cord compression identified. There are no physical exam findings in the medical record that support a nerve root compression or spinal cord compression or cervical instability. Therefore, the restrictions provided by her treating physicians are entirely based on her reported levels of pain and this is a completely subjective measure. There is no objective way to measure the severity of the sometimes. There is no reason why she cannot perform the stated activities and the restrictions provided her by her treating physicians are reasonable to prevent pain. However, they do not represent a limitation in actual physical function based on a mere physiologic or anatomic finding.

>> Matt Loesch: Thank you. Ms. Zimmerman would you confirm that you received the staff letter dated November 4th, 2011, with medical and other report attached?

>> Yes.

>> Matt Loesch: Would you stipulate to the relevance of the disability retirement reports and would you provide anything further for the board's consideration?

>> Yes.

>> Matt Loesch: You would like to provide further for the board?

>> Yes -- well no.

>> Matt Loesch: That's fine. Are there any witnesses that will be testifying in your behalf besides yourself? Is anyone here from the department that's going to speak on behalf of any memos at a were presented here? Don't see any. Ms. Zimmerman would you please present your testimony in support of your application?

>> First of all, Dr. Das said I don't have any nerve root compression --

>> Matt Loesch: Pull the microphone real close to your mouth. Be sure we can hear, thank you.

>> I did have a nerve conduction test. And it did show that I have a nerve root compression at C-5 and 6. That's why I have numbness down my arms and in my neck.

>> Matt Loesch: Is the data presented -- is that presented in the packet?

>> Yes.

>> Matt Loesch: Would you happen to know what page that is, please?

>> It's page 50 and 51.

>> Matt Loesch: Thank you. Would you like to present your testimony in favor of your application, please? You will have a chance to ask questions of Dr. Das or other staff, after you present your testimony.

>> Okay. So basically, I have art arthritis in my neck and I also have stenosis, which means the nerve space that my nerve is in, it's narrowing and it's pinching my nerve. Imagine if you are wearing shoes that are too small and your feet are irritated, the more your feet will swell and cause pain. And this is what's going on in my neck with my nerve. And then my arthritis, there are three joints in my neck that are affected. And it's -- it's causing me pain and numbness on an everyday basis. It's tolerable, but if I do activities such as repetitive neck movement or sitting in the wrong posture, it aggravates my neck. And I do take medication to help with the pain and numbness. But when I was working, as an examiner, because of the duty that I do, the physical part where I would have to lean over and magnifying glass between maybe two prints, it's causing a lot more irritation, causing more pain. And with the medication, with the injection, it's not effectively relieving my pain. And when I get the pain, it's so severe that I just -- I can't even do anything. It's not -- to say that my restriction from my doctor, it's just prophylactic

because it's to prevent pain, it's true. But I feel that it should be viewed case by case, because in my case, the work that I do require me to do this over a long period of time. It's not just back and forth between two, for like an hour or -- it could be up to five, six hours doing comparison. And I would be leaning over and doing that type of work, kind of like looking into microscope. And you just have to go back and forth. And I can do a lot more active work, get up and do things and I do take breaks. I do everything that I'm supposed to do to try to relieve my and help with my symptoms but it's too much of the head movement and bad posture and I can't manage that pain. And my work require me to have concentration, when I get these pains, I can't even concentrate. I can't do my work. So my doctor as part of the treatment, it's to rest, and not try to do anything to aggravate my pain, along with the medicine, and so it's just that the type of work that I do with my arthritis is just happened that with my arthritis I can't do that type of work. If my arthritis is in my knee, in my hip, I could still do the same work. But it's just that this work require me to do a lot of head movement and I can't do it. I mean I physically, yes, I can move my head. But after five, ten, you know continuously doing it I cannot. Just the pain is just so great that even if I wanted to continue working, I can't.

>> Matt Loesch: Thank you. Would you like to -- I'm sorry, ask any questions of -- I'm sorry, Dr. Das, would you like to rebut any comments that were made by the applicant?

>> Dr. Das: Yes, please. Ms. Zimmerman have you received any trigger point injections or into the muscles to try to help with the pain?

>> I have epidural injection into the space in the neck and it didn't work. It was just momentarily for two weeks.

>> Dr. Das: So you've had the epidural steroid injection. Have you had any intramuscular trigger point injections to help with the pain at all?

>> No.

>> Dr. Das: What medications are you currently taking?

>> Lodine.

>> Dr. Das: Lodene?

>> Lodine.

>> Dr. Das: And it's not effective?

>> It's only when I -- along with some ice and resting, with the neck brace. But if I do things and not rest, it barely helps.

>> Dr. Das: And you're taking the medication when you're doing activities you take it every day or just as needed?

>> As needed right now.

>> Dr. Das: I have no other questions. With respect, just to clarify the record as far as the presence of the radiculopathy and the nerve root compression, reviewing the interpretation by Dr. Suzani for the radiculopathy, I'm a physical medicine and rehabilitation specialist and perform electrodiagnostic studies myself. And therefore there are certain studies that we do to identify a pinched nerve in the neck or a radiculopathy. And one of the findings that's typically seen in an acute injury is fibrillation potentials and there's also positive sharp waves. In a chronic injury typically the nerve reheels and even with arthritis, there can be some ongoing damage to the nerve, however, after a long term -- a long time of damage to the nerve there will be weakness in the muscle and noticeable atrophy. And those findings haven't been really noted in the report. The second issue is in these types of studies when you diagnose someone with a chronic radiculopathy, the criteria typically is something called polyphasic potentials which refers to the reinnervation of the motor unit of the muscle by the nerve that's damaged. So even though there's an initial damage to the nerve what happens is there's a healing process that

occurs, that causes -- that the nerve attaches to a new motor unit or a muscle unit. And therefore, that muscle unit becomes a little bit bigger. So one nerve may innervate four muscle fibers, but after an injury like a radiculopathy, that one nerve root will innervate six muscle fibers so it becomes a little bit bigger and it has what is called a little more phases. The way I have to discount the findings by Dr. Suzani, is with respect to the -- referring to the imaging study, the MRI interpretations, which show narrowing and stenosis of the canal but do not show nerve root compression. In order to have a radiculopathy show up on a muscle test with an EMG you need to have Axomal degeneration or for an interruption of Axomal flow. The analogy of values is like a tree root or a tree where you have the nutrition going through the -- nutrition going through the inside of the roots kind of going to the muscle. And it's interrupted. And then once -- and then so these imaging studies do not show that level of compression, that would result in the findings described in the EMG study. And so therefore even though the electrodiagnostic study diagnoses her with a cervical radiculopathy or a chronic one I disagree with that diagnosis based on the imaging studies which do not show a corresponding nerve root compression that would cause those kinds of findings and more importantly the physical exam findings do not support a chronic radiculopathy. Where if there was continuous loss of muscle fiber and weakness you would have atrophy, which is not described in the medical record.

>> Matt Loesch: Ms. Zimmerman would you like to have any comments bam from Dr. Das's comments?

>> Well the fact that I still have tingling numbness feeling down my arm, does that mean I am still trying to feel or if I have little or no damage? The EMG nerve test is just another report, even though the X ray or the MRI does not show the degree of the narrowing, this is another -- this is to show -- could this be something that is shown that what the MRI doesn't show? I'm sorry.

>> Dr. Das: Go ahead, go ahead.

>> Then what's the point of sending me to get a nerve test, if you can't even count (inaudible) then maybe nobody should be doing this test.

>> Dr. Das: It's a very painful test, I know.

>> It is painful.

>> Dr. Das: And just for information it involves inserting a needle into the muscle and listening and looking at the wave potential after initiating movement. And it can be quite uncomfortable as I'm sure Ms. Zimmerman can attest to. Ms. Zimmerman continues to report a symptoms in a radicular pattern or in the pattern of a nerve root injury and you have two components. There's one where we can call it a radiculitis, where there is irritation of the myelin surrounding the nerve. So if you compare it to an electrical wire you have the metal component which is like the axon sending the signal and then you have the myelin which contributes resistance around the electrical wire to stop the signal from dispersing. When you damage the myelin where there's some type of injury to the myelin you can have symptoms that we would call a radiculopathy. And in Ms. Zimmerman's case she does have arthritis present which can be a source of irritation to the myelin without frank nerve root compression. But the EMG does not test for the phenomena that Ms. Zimmerman describes. What it tests for is a reason for a muscle weakness or to find out if there are imaging studies there, is there a physiologic evidence of that kind of problem, is that a significant finding? And in the absence of frank nerve root compression, Ms. Zimmerman is right, the EMG is not a very valuable tool.

>> Matt Loesch: Okay. Any further testimony, or anything you'd like to add before I ask the board members to ask some questions? Okay, any else to ask staff?

>> Dr. Das: I don't.

>> Matt Loesch: Board, do you have any questions, comments?

>> Arn Andrews: I just have one question and I guess it's probably to both the doctor and to yourself. It sounded like what you were saying is because you didn't have faith in the efficacy of the EMG the way it was conducted you discounted that medical portion. Is that correct?

>> Dr. Das: In terms of number one, that there wasn't any reason for those findings. That's why -- yeah.

>> Arn Andrews: And so then I guess the question is, the applicant -- and I appreciate it sounds like it's not a pleasant test. But if the applicant wanted to try to get a more robust EMG where the doctor would be willing to evaluate those results whether positive or negative but at least it would attest that it was done in a manner you would be able to entertain whatever the evidence was, one way or the other, I would ask if you wanted that option provided to you.

>> (inaudible) test and I have done it twice. And um -- probably --

>> Arn Andrews: It's your option. I'm not suggesting you do it or not do it. I just wanted to understand why the doctor disallowed that evidence, basically. So it's your choice. I was just saying --

>> Yeah, I don't think it would change his mind. I have seven doctors that said the same thing. Two of them are not even my own doctors. They are doctors from the insurance company and they review my case and reasonably, they look at the type of work that I do, that they said reasonably I shouldn't be doing this much movement to my neck. So my feeling is, I have to take care of myself. And I'm the only one who can feel the tingling. Every night I go to bed but if I do more stuff I can feel a tingling going down my arm. So I don't feel it will change my mind unless they modify my position, limit the hours that I should be doing this. It won't change my mind. I can't be doing this type of work, and just keep damaging my nerve, and my neck. So even if the test come out I -- I --

>> Arn Andrews: And the doctor can speak for himself. I don't think he disavowed the fact that you are experiencing tingling. I think what he's trying to do is use the medical evidence that's presented to try to determine causation. That's why I wanted to present you with an opportunity, if you saw reason to.

>> So what kind of test would you be recommending?

>> Dr. Das: Actually, there is no test. The EMG would not dis-- a negative EMG would not say that you don't have those symptoms. I -- I believe that you experience those symptoms. That -- that's not the issue.

>> And if I were doing everything correctly, why do I still feel the pain when I'm working, and it's just so -- it's so great that -- what else can you recommend me to do, if --

>> Dr. Das: As I'd mentioned before one of the options is in terms of trying to determine what the, quote unquote, what the primary and secondary pain generators are. Arthritis, an epidural steroid injection is not going to treat osteoarthritis very well, especially in the facets. So if there is -- there are injections and procedures that can be done to decrease the pain on the facet joints in different parts of the vertebral column. And I'm not suggesting that you get those done necessarily, the efficacy of those procedures is not necessarily great, either. So I don't necessarily advocate that. There are procedures and things that can be done to address secondary pain sites like the muscle. And I suggested trigger point injections and those kinds of things. I don't know if ergonomic adjustments had been attempted at your workplace in terms of doing different things. Once again I don't want to discount the pain that you're reporting and you certainly have the right to choose to obtain whatever treatment or not obtain whatever treatments you want. But it goes -- it goes back to the issue of incapacity and inability. And that's where my restrictions in the way -- that is why I have provided the restrictions that I have, or the lack of restrictions because there is no incapacity or inability to perform those based on the objective information that's there. And I believe that do you have pain, I'm not discounting that you have arthritic findings that will cause pain in people. I do not discount that at all.

>> Matt Loesch: Further comments or questions of the board?

>> Edward Overton: I would like to ask Dr. Das, in the report of May 12th, 2010 from Dr. Rollins on page 23, bottom paragraph, he states that the report of Dr. Das dated March 23rd, 2010 indicates that the patient does have cervical degenerative disk disease and is not related to her work duties and that she is permanent and

stationary at this time. Patient disagrees with this and so do I. I believe that the patient is not permanent and stationary. Now, if that's true, why has this taken forward?

>> Dr. Das: Because she was permanent and stationary before he made the opinion and then after that he said that she -- we obtained the paperwork from her primary care provider saying she was maximally medically improved and then I did the evaluation and submitted the report. And then I believe it was after the committee hearing or after my report was read, that Dr. Rollins responded and stated she needs surgery or at least an evaluation. So I -- so I -- you know, I -- and you are correct. I maybe should not have brought this before the board for an evaluation since we had opinions stating that she was not maximally medically improved, I believe there were also opinions stating that she was. And so I felt it was fairer for the patient just to bring it to the board to make the assessment rather than me make -- rather than myself making the determination .

>> Russell Richeda: Who is Dr. Rollins? Is he a treating decision or --

>> Dr. Das: I believe that her primary care doctor is Dr. ReneÉ Olmby who is a chiropractor and Dr. Rollins is an orthopedic surgeon, a general orthopedic surgeon, not a spine surgeon that she was referred to.

>> Russell Richeda: By?

>> Dr. Das: By Dr. Olmby I'm going to presume.

>> No, it's actually my -- I was going through workmen comp and it was the -- he is -- he referred -- he was referred by the --

>> Dr. Das: Adjustor?

>> Not the adjustor but when you go through the --

>> Dr. Das: QME qualified medical examiner?

>> With his finding he found I did not reach my maximum, that's when I find out I have shoulder problem, I have neck problem. And Dr. Rollins is one of the doctors that treated my shoulder.

>> Matt Loesch: So that being said?

>> Mollie Dent: So just so maybe that the applicant understands for the record, the legal requirement for the board to consider your disability retirement, nonservice connected or service connected, is that it be of permanent duration.

>> Ed Overton: Permanent or uncertain.

>> Mollie Dent: Uncertain duration. So if there is -- if the -- if it's not of permanent and uncertain duration, they can't grant the application.

>> What is considered permanent then? I'm all the time --

>> Mollie Dent: Permanent would mean not capable of being ameliorated or improved.

>> Edward Overton: And then the new term that the medical profession has put out is, maximally medically improved. In other words, it is at best. And so that's a pretty good substitute for permanent, it won't get any better.

>> I don't think I'll get any better. It is arthritis, it is degeneration.

>> Edward Overton: Is there medical evidence that supports that?

>> Russell Richeda: On the pages 52 to 54, are those standard forms where the treating chiropractor indicated Ms. Zimmerman (inaudible).

>> Edward Overton: And to give more weight to the orthopod?

>> Mollie Dent: It's just that the applicant needs to understand that if the board moves forward with the hearing today, that is a requirement, if the applicant herself thinks that --

>> Matt Loesch: Is her analyst here to council her on patient decisions?

>> Mollie Dent: Yes.

>> Matt Loesch: Think we ought do that? Or could we go on to a few other items and he can council her on it? If we make the decision today, say it was in one way or the other, or if she retracted her application we don't make the decision today, then --

>> Mollie Dent: Well if she wanted to put her application on hold and defer it to consult further with her doctor about whether she is truly permanent and stationary then that --

>> Matt Loesch: Speak to her analyst about possible outcomes before we make decision, basically, put it on hold for a few more moments, we'll go on to a few more things then we can come back today and you can tell us whether you want us to proceed with the decision or not or what you would like us to do, is that okay? Because your analyst is behind you. You can talk offline and we'll go on to a couple of things, and then you can come back. Sound good?

>> Uh-huh.

>> Matt Loesch: Okay. But that on hold, we've done the consent calendar. Item 4.1, discussion and action on conflict counsel's memorandum concerning trustee's role in an environment of discussion and negotiations on vested benefits. Mr. Odell.

>> Stuart Odell: Can I make a suggestion here? I have a number of questions on this. But I think it would be valuable if we could add two of our missing trustees in on that session. Because I think this is a really critical important -- so I wonder if we might --

>> Matt Loesch: Table this until December?

>> Stuart Odell: Correct.

>> Matt Loesch: Is that of interest to the rest of the board? Hold on to it to December. I apologize for the urgency in our work being put into the research. That's fine.

>> Arn Andrews: I agree the other members of the board should participate in the discussion.

>> Matt Loesch: Especially if we set board policy. So table until December time. 4.2, update on legal request for proposal.

>> Mollie Dent: I'll be very brief. We did receive 11 proposals. Quite a few from investment -- for investment, a fair sampling for the general counsel services. We're going through screening them now to make sure they all meet minimum qualifications. And then we'll be distributing packets to the evaluators. Hopefully early next week, and give people a week to ten days to score the firms.

>> Matt Loesch: Will be provided those scores?

>> Mollie Dent: We'll be putting packets together so you'll have scoring sheets for everyone. And we'll probably try to fill in some of the information on the scoring sheet off of the proposals like costs so you don't have to go through all of them. But part of the evaluation, except for the cost element, is a little more subjective in terms of their qualifications. So we are not going to fill that out for the evaluators.

>> Matt Loesch: The stuff's coming out early next week, that would be the week of the 21st, Thanksgiving week, and week to ten days, one technical concern on my part. I'm on that panel. Technically, my term ends November 30th and I would not be up for reappointment if I'm successful, until the 6th, which is when the council meeting is.

>> Mollie Dent: So we're -- the timing now on the RFP is that I doubt that we will be scheduling any interviews before the 6th of December. I doubt it.

>> Matt Loesch: Hope it's not until after the 13th, (inaudible) come back to the (inaudible).

>> Mollie Dent: It -- I think it's more important for us to do a thorough process. Once we get the scores back, we're going to take a look at the scores in terms of whether or not there is a way, through the written scores, to narrow the list down.

>> Matt Loesch: Right. I'm not trying to make this a personal conversation, I can work out scheduling with you.

>> That sounds like it.

>> Matt Loesch: I'm trying to make it so can I work within your time line. If not, I think we should make it so someone else should be on.

>> Mollie Dent: So I think we will be definitely expecting the participants on the panel to give us their scores back before November 30th. So that piece of it we will be asking to have back. I don't anticipate needing to schedule anything in between December 1st and December 15th. But I think we would have to substitute someone else

then if you were not reappointed, we would have to substitute someone else in your place to do the interviews, so --

>> Matt Loesch: Does that concern anyone?

>> So when do we cease to receive legal services from the city?

>> Mollie Dent: Well, the goal had been the end of this year. But I don't think we're going to achieve that goal. I think given -- well, especially given the Police and Fire board's December 1st take it, unless they wanted to hold a special meeting later in December, we're not going to be able to get a proposal to them.

>> Matt Loesch: It will probably be the 1st of February.

>> Mollie Dent: Probably hopefully January we would be bringing them -- bringing it forward.

>> Matt Loesch: Effective date by the time we get too far forward --

>> Mollie Dent: Your meeting date in January -- your meeting date in December is the 15th.

>> Matt Loesch: Yes, it's the 15th.

>> Mollie Dent: If we wanted to meet that we would have to have someone else other than you look at these.

>> Matt Loesch: Right. I just -- I wanted to present this board so I didn't want it to be an issue.

>> Mollie Dent: It could be that the panel will actually not have to do much more than the written screening. We may drop out of the written screening that you've got three strong firms and we're going to move all three firms forward. With them ranked --

>> Matt Loesch: And provided they're not successful they can look at my scores in the event they're not given (inaudible) sound fair?

>> Arn Andrews: I think we should do anything we can to facilitate your schedule so you remain on that panel. [ Laughter ]

>> Matt Loesch: I'm not entertaining that motion, okay. Number 4.3. Discussion and action on the review of retirement services staffing. I just wanted that on the docket because we talked about last time there was a letter included in your packet and just to note I did have a discussion with Mr. Gurza of the City Manager's office, subsequent to the letter being sent, just notifying that we are interested in engaging in useful conversation in possible remedies and hopefully we'll have some ideas back in the next while, you know, comments or questions on that? 4.4 Update on electronic board pacts.

>> Donna Busse: Okay, we have the RFP out, they're scheduled to come back on December 2nd, our staff is really trying to do an accelerated schedule so we can bring a recommendation back to you in January. We are going to set up a demo -- demos of the finalists most likely December 12th. And we will send a notification out to trustees to see if anyone wants to see the demos.

>> Matt Loesch: Any questions on that? 5.1, 5.2, 6.1 is nothing. 6.2 is investment committee meeting minutes.

>> Arn Andrews: Just one comment on the minutes. I know that it references a discussion on the probability assumption. Will those be coming back to the board? They will?

>> Matt Loesch: Any other comments or questions on the minutes that are there? Okay. I'll entertain a motion.

>> Move approval.

>> Arn Andrews: Second.

>> Matt Loesch: All those in favor? Aye, opposed, ad hoc governance committee, it is listed here as to be determined, I believe someone scheduled it on December 8th. Okay, so still to be determined. We'll note and file. Number 7, education and training. Any future agenda items? Seeing none, public or retiree comments? Okay. And any other items -- we go with 1.1A. Do we have a decision?

>> Donna Busse: The applicant would like to move forward on the -- I'm not sure how many remaining body parts that were MMI. I believe only the neck was the one that was not MMI.

>> Matt Loesch: All right.

>> Donna Busse: Is the only body part?

>> Matt Loesch: Can we clarify?

>> Mollie Dent: So once we clarify though, the question is going to be is the applicant dropping the request for disability retirement on the neck or not?

>> No, I'm going to move forward with my application, and because I feel this is -- I'm as good as I can get.

>> Mollie Dent: So you're moving forward with your application on all body parts?

>> Dr. Das: They're all neck and --

>> Mollie Dent: You don't want the opportunity to consult with the doctor about it?

>> I have actually -- Dr. Rollins referred me to a neck specialist and he -- at first he said I'm a candidate for surgery but then ultimately he referred me to a chiropractor -- no acupuncturist to relieve the symptoms and because surgery is the last option. And because other -- other treatment are actually effective, as long as I stay away from doing too much of the neck movement, he doesn't feel that I need surgery at the moment.

>> Matt Loesch: Any comments or questions from the board? Reopen the hearing? Any other comments or questions? Other than that I'll entertain a motion.

>> Arn Andrews: Based on medical evidence that's before us, which at best, either doesn't confirm or seem to be ambivalent on whether or not you've achieved maximum medical improvement, I'd like to thank you for your time with the city but I will make a motion to accept staff's recommendation to deny the application for a nonservice connected disability.

>> Edward Overton: Second.

>> Matt Loesch: Any further comments or questions on that? All those in favor? Aye, opposed? None. Thank you for your service. So there are no public or retiree comments, meeting's adjourned.