

**ALASKA STATE LEGISLATURE
HOUSE STATE AFFAIRS STANDING COMMITTEE**

April 5, 2005

8:02 a.m.

MEMBERS PRESENT

Representative Paul Seaton, Chair
Representative Jim Elkins
Representative Bob Lynn
Representative Jay Ramras
Representative Berta Gardner
Representative Max Gruenberg

MEMBERS ABSENT

Representative Carl Gatto, Vice Chair

COMMITTEE CALENDAR

CS FOR SENATE BILL NO. 104(JUD)

"An Act relating to the crimes of unsworn falsification in the first and second degrees and false information or report; requiring the establishment of a permanent fund dividend fraud investigation unit in the Department of Revenue; and providing for an effective date."

- MOVED CSSB 104(JUD) OUT OF COMMITTEE

HOUSE BILL NO. 238

"An Act relating to contribution rates for employers and members in the defined benefit plans of the teachers' retirement system and the public employees' retirement system and to the ad-hoc post-retirement pension adjustment in the teachers' retirement system; requiring insurance plans provided to members of the teachers' retirement system, the judicial retirement system, the public employees' retirement system, and the former elected public officials retirement system to provide a list of preferred drugs; relating to defined contribution plans for members of the teachers' retirement system and the public employees' retirement system; and providing for an effective date."

- HEARD AND HELD

HOUSE BILL NO. 177

"An Act relating to employee and employer contributions to the teachers' retirement system and the public employees' retirement system; and providing for an effective date."

- SCHEDULED BUT NOT HEARD

HOUSE BILL NO. 191

"An Act relating to defined contribution systems for members of the teachers' retirement system and the public employees' retirement system; and providing for an effective date."

- SCHEDULED BUT NOT HEARD

PREVIOUS COMMITTEE ACTION

BILL: SB 104

SHORT TITLE: PERMANENT FUND DIVIDEND FRAUD

SPONSOR(S): SENATOR(S) SEEKINS

02/14/05	(S)	READ THE FIRST TIME - REFERRALS			
02/14/05	(S)	STA, JUD			
02/22/05	(S)	STA AT 3:30 PM BELTZ 211			
02/22/05	(S)	Heard & Held			
02/22/05	(S)	MINUTE(STA)			
02/24/05	(S)	STA AT 3:30 PM BELTZ 211			
02/24/05	(S)	Moved CSSB 104(STA) Out of Committee			
02/24/05	(S)	MINUTE(STA)			
02/28/05	(S)	STA RPT CS		4DP	
		SAME TITLE			
02/28/05	(S)	DP: THERRIault, ELTON, HUGGINS, DAVIS			
03/01/05	(S)	JUD AT 8:30 AM BUTROVICH 205			
03/01/05	(S)	Heard & Held			
03/01/05	(S)	MINUTE(JUD)			
03/02/05	(S)	JUD RPT CS		3DP	2NR
		NEW TITLE			
03/02/05	(S)	DP: SEEKINS, THERRIault, HUGGINS			
03/02/05	(S)	NR: FRENCH, GUESS			
03/02/05	(S)	JUD AT 8:30 AM BUTROVICH 205			
03/02/05	(S)	Moved CSSB 104(JUD) Out of Committee			
03/02/05	(S)	MINUTE(JUD)			
03/07/05	(S)	TRANSMITTED TO (H)			
03/07/05	(S)	VERSION: CSSB 104(JUD)			
03/09/05	(H)	READ THE FIRST TIME - REFERRALS			
03/09/05	(H)	STA, JUD			
04/05/05	(H)	STA AT 8:00 AM CAPITOL 106			

BILL: HB 238

SHORT TITLE: PUBLIC EMPLOYEE/TEACHER RETIREMENT
SPONSOR(s): STATE AFFAIRS

03/30/05	(H)	READ THE FIRST TIME - REFERRALS
03/30/05	(H)	STA, FIN
03/31/05	(H)	STA AT 8:00 AM CAPITOL 106
03/31/05	(H)	Heard & Held
03/31/05	(H)	MINUTE(STA)
04/02/05	(H)	STA AT 10:00 AM CAPITOL 106
04/02/05	(H)	Heard & Held
04/02/05	(H)	MINUTE(STA)
04/05/05	(H)	STA AT 8:00 AM CAPITOL 106

WITNESS REGISTER

SENATOR RALPH SEEKINS
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Presented SB 104 as sponsor.

SHARON BARTON, Director
Permanent Fund Dividend Division
Department of Revenue
Juneau, Alaska
POSITION STATEMENT: Testified on behalf of the division during the hearing on SB 104.

DANIEL J. BOONE, Investigator III
Permanent Fund Dividend Division
Department of Revenue
Juneau, Alaska
POSITION STATEMENT: Testified on behalf of the division during the hearing on SB 104.

MELANIE MILLHORN, Director
Health Benefits Section
Division of Retirement & Benefits
Department of Administration
Juneau, Alaska
POSITION STATEMENT: On behalf of the division, presented a proposed medical program prepared by Mercer Human Resource Consulting, during the hearing on HB 238.

BRAD LAWSON
Mercer Human Resource Consulting
Seattle, Washington

POSITION STATEMENT: Testified as a representative of Mercer Human Resource Consulting, on behalf of the Division of Retirement & Benefits, during the hearing on HB 238.

KATHY LEA, Retirement Manager
Division of Retirement & Benefits
Department of Administration
Juneau, Alaska

POSITION STATEMENT: Answered questions from the committee during the hearing on HB 238.

ACTION NARRATIVE

CHAIR PAUL SEATON called the House State Affairs Standing Committee meeting to order at [8:02:48 AM](#). Representatives Elkins, Lynn, Gardner, and Seaton were present at the call to order. Representatives Ramras and Gruenberg arrived as the meeting was in progress.

SB 104-PERMANENT FUND DIVIDEND FRAUD

[Contains discussion of HB 127.]

[8:03:12 AM](#)

CHAIR SEATON announced that the first order of business was CS FOR SENATE BILL NO. 104(JUD), "An Act relating to the crimes of unsworn falsification in the first and second degrees and false information or report; requiring the establishment of a permanent fund dividend fraud investigation unit in the Department of Revenue; and providing for an effective date."

[8:03:32 AM](#)

SENATOR RALPH SEEKINS, Alaska State Legislature, presented SB 104 as sponsor. He said the bill would strengthen the Department of Revenue's ability to investigate fraud associated with making false applications for the Alaska permanent fund dividends (PFDs). Under the proposed bill, the submission of a fraudulent PFD application would become a Class C felony. He reported that in 2004, the Department of Revenue examined over 1,600 fraud tips and audited over 1,700 PFD applications suspected of being fraudulent, which resulted in \$1.4 million in denied or assessed dividends. Furthermore, there were three federal indictments and one conviction for crimes involving PFD fraud.

SENATOR SEEKINS said currently, under state law, Alaska cannot prosecute for fraud, but the federal government can. Senator Seekins revealed that the most common fraud offense involves persons who forge the signature of another on the PFD application or related documents with the intent of receiving a dividend to which they are not entitled. He noted that the bill is not intended to capture cases, for example, where husbands and wives sign for each other; the provision of SB 104 would apply in cases where the individual is attempting to steal from another person or from the state.

[8:05:26 AM](#)

SENATOR SEEKINS discussed categories of offenses. He reiterated that the bill would make unsworn falsification, as it relates to a person making an application for a permanent fund dividend, a violation in the first degree punishable as a Class C felony.

[8:06:51 AM](#)

SENATOR SEEKINS said he introduced the bill because he thinks "we all" know people who are trying to tap into the PFD illegally. The bill would codify in statute a fraud investigation unit within the department. He anticipated that by having the unit in statute, it will be possible to access the national crime computer system in order to find people who may be trying to hide.

[8:07:35 AM](#)

SENATOR SEEKINS, in response to a question from Representative Lynn, said the current fraud unit does not have the necessary statutory authority to be able to [access the national crime computer system] and would have to "apply to do so."

[8:08:02 AM](#)

REPRESENTATIVE GARDNER noted that the House just passed HB 127, which will allow Peace Corps Volunteers to receive the PFD. One of the provisions of the bill reduced the fine for fraudulent claims from \$5,000 to \$3,000. She offered her understanding that "it had to do with our ability to actually collect on that." She observed that SB 104 "addresses that in a much more severe way."

[8:08:49 AM](#)

SENATOR SEEKINS responded that it is a stronger way. He said he applauds any effort to collect; however, in this case, "it's not a collection issue; it's a felony."

[8:09:07 AM](#)

CHAIR SEATON clarified that the idea behind lowering the fine [in HB 127] was not to lessen the impact, but to make it so that it was worth enforcing, because at the higher amount a public offender had to be provided, which was not always cost effective for the state. He added that lowering the fine also made prosecution more likely.

[8:10:20 AM](#)

SENATOR SEEKINS said the intention of the bill is to be able to go after the most serious offenders. He said a warning would be clearly printed on the application. He stated, "A felony conviction has a whole lot more ramifications than a misdemeanor conviction."

[8:10:47 AM](#)

REPRESENTATIVE ELKINS asked for an example major fraud.

[8:11:04 AM](#)

SENATOR SEEKINS deferred to the Permanent Fund Dividend Division.

[8:11:19 AM](#)

SHARON BARTON, Director, Permanent Fund Dividend Division, Department of Revenue, testifying on behalf of the division, stated that the PFD program is particularly vulnerable to fraud. She said there are 635,000 applications "to shove through the pipe in just a few months of considerations." She noted that the division began "beefing up" its investigations of fraud two years ago, and last year the legislature authorized subpoena powers for the division, which has helped substantially with audits.

[8:13:05 AM](#)

DANIEL J. BOONE, Investigator III, Permanent Fund Dividend Division, Department of Revenue, testifying on behalf of the

division, stated that the division is encouraging the public to file online applications, use an electronic signature - for those who have "been in the system," and receive a direct deposit. When everything is done electronically, he said, it makes it difficult to identify someone who has moved out of the state. He reported that the division is currently working on new technology that will help in identifying outside "IP" [Internet Protocol] addresses in order to tell if the person is actually in the state. The focus, he indicated, is to work to find the individuals who are "going after one PFD after another, year after year" He offered examples.

[8:16:24 AM](#)

MR. BOONE said the current fine is not a deterrent. The subpoena power is a help. He stated that approximately 64 percent of the fraud cases are related to dealing with individuals out of the state. He offered more examples. He said, "There is no forgery, per se - ... as far as a [PFD] application - that puts teeth in anything." He said the same applies to criminal impersonation. He said, "With the [attorney generals (AGs)] and everything that they're under, it's really been difficult ... for them to take a Class A misdemeanor versus a felony case."

[8:18:10 AM](#)

CHAIR SEATON noted that the committee is currently considering another bill which would allow the use of a power of attorney to submit the [PFD] application. He said, "Under a power of attorney you can't really tell somebody's intent to return to Alaska and, therefore, ... basically the intent to return to Alaska provision is made void by the use of a power of attorney." He asked if the unsworn falsifications being discussed under SB 104 often relate to the intent to return to Alaska, or if that is a totally separate issue.

[8:19:12 AM](#)

MR. BOONE answered that that's a totally separate issue. He said he deals with individuals who have deliberately and recklessly disregarded material facts pertaining to their eligibility or the eligibility of others for whom they are applying. He offered examples. He said, "The ... way we pursue our cases criminally ... [is] definitely more cut and dry than in intent, which is a lot of grey area"

[8:20:10 AM](#)

REPRESENTATIVE GRUENBERG stated his concerned about a possible constitutional challenge on the basis of equal protection regarding setting up "this particular type of fraud as a felony." He stated his strong support of the bill and explained that he wants to protect it against such a challenge. He asked, "Is there specific legislative history explaining why this is a felony and other types of unsworn falsification for similar types of benefits are only Class A misdemeanors?"

[8:22:00 AM](#)

SHARON BARTON recommended asking that question of Chris Poag.

[8:22:16 AM](#)

REPRESENTATIVE GRUENBERG directed attention to page 4, [lines 4-5], which read:

(2) on a form bearing notice, authorized by law, that false statements made in it are punishable.

REPRESENTATIVE GRUENBERG asked if the language would be changed so that it would apply to all PFD applications and would be "punishable as unsworn falsification in the first degree." He explained, "Because an argument could be made if you don't that it would only be [a] misdemeanor."

[8:23:10 AM](#)

MS. BARTON said that the division has not drafted that language but would certainly take it under advisement.

[8:23:25 AM](#)

CHAIR SEATON noted that the bill would be heard by the House Judiciary Standing Committee; therefore, he said he would like most of those [kinds of questions] asked at that time.

[8:23:40 AM](#)

REPRESENTATIVE GRUENBERG asked if the attorney general would testify.

[8:23:57 AM](#)

CHAIR SEATON answered yes.

[8:24:01 AM](#)

REPRESENTATIVE GRUENBERG recommended inserting some findings in the bill. He talked about the federal implications and mentioned the unlawful flight to avoid prosecution (UFAP). He asked Ms. Barton if one of her intentions was to be able to "get federal assistance in the enforcement of this."

[8:25:37 AM](#)

MS. BARTON said most of the cases have not "flown before they've perpetrated the crime," but rather have moved out of state first. In response to a question from Representative Gardner, she said the division's approach generally has been conservative; it imposed fines just this year and the five-year forfeiture for the first time only a year ago. She said the division proceeded carefully with the first cases to determine where it was appropriate to apply the civil penalties. She said, "Now that we are looking at a Class C felony, we will certainly consult with our good [attorney general (AG)] support before we ... proceed with any ... action." She offered further details.

[8:27:23 AM](#)

REPRESENTATIVE LYNN moved to report CSSB 104(JUD) out of committee with individual recommendations and the accompanying fiscal notes.

[8:27:55 AM](#)

REPRESENTATIVE ELKINS interjected that he has first-hand knowledge of fraud regarding dividends and there is a surprising amount of money involved. He offered examples.

[8:28:43 AM](#)

CHAIR SEATON stated that, there being no objections, CSSB 104(JUD) moved out of the House State Affairs Standing Committee.

HB 238-PUBLIC EMPLOYEE/TEACHER RETIREMENT

[8:29:04 AM](#)

CHAIR SEATON announced that the next order of business was HOUSE BILL NO. 238, "An Act relating to contribution rates for employers and members in the defined benefit plans of the teachers' retirement system and the public employees' retirement system and to the ad-hoc post-retirement pension adjustment in the teachers' retirement system; requiring insurance plans provided to members of the teachers' retirement system, the judicial retirement system, the public employees' retirement system, and the former elected public officials retirement system to provide a list of preferred drugs; relating to defined contribution plans for members of the teachers' retirement system and the public employees' retirement system; and providing for an effective date."

CHAIR SEATON clarified that the committee would hear a presentation of the tier task force regarding the medical portion of HB 238.

[8:30:23 AM](#)

MELANIE MILLHORN, Director, Health Benefits Section, Division of Retirement & Benefits, Department of Administration, on behalf of the division, presented a proposed medical program prepared by Mercer Human Resource Consulting ("Mercer"). She said the material was worked on extensively by the tier proposal committee for a number of months. She told the committee that Mercer engaged in a great deal of analysis by asking Aetna - the state's third party administrator - to provide the actual claims experience, from which Mercer analyzed the cost to the system and redesigned those costs going forward with a new tier medical plan design. A survey was sent out to "all employers," and those employers emphasized the importance of the medical component of the retirement benefits package.

MS. MILLHORN noted some key elements from the feedback of the employers. She specified that she would be referring to presentation material dated November 19, 2004, that was provided to the full Public Employees' Retirement System (PERS) and Teachers' Retirement System (TRS) Boards; that material is found in the survey information [included in the committee packet].

MS. MILLHORN listed some of the key elements as follows: One, members should bear a greater share of the cost of medical benefits; two, members should have to retire from the system in order to be eligible for medical benefits; and three, system benefits should favor longer service members. Regarding the third element in the list, she explained that the criteria for

medical coverage can be satisfied after an employee vests and is age eligible. For the current Tier I, that would mean after five years and at age 55. In contrast, the proposed medical plan design would recognize the years of service of the member and would provide a greater benefit based on "greater years of service."

[8:34:15 AM](#)

MS. MILLHORN continued with the list as follows: Four, employer contributions should be predictable and stable; five, health care inflation risk should not be borne solely by employers; six, benefits must take the form of new tiers; and seven, the annual cost of benefits should not be designed to exceed current systems' normal cost rates. In response to a question from Chair Seaton, she confirmed that number seven means that the medical component should not exceed the current medical component.

[8:35:59 AM](#)

MS. MILLHORN turned to a Power Point presentation, [hard copy included in the committee packet, entitled, "State of Alaska PERS & TRS Proposed Medical Program, House State Affairs" and dated April 2, 2005]. She directed attention to Slide 2, which lists the key features of the proposed post-retirement medical program as follows [original punctuation provided with some formatting changed]:

Members must retire directly from the System to be eligible

System sponsored health plan with varying levels of subsidy or cost to members

Early retirees get "access only" prior to normal retirement eligibility

Defined dollar benefit from normal retirement to Medicare eligibility (currently age 65)

Defined health benefit after Medicare eligibility, similar to the current program with the following key exceptions:

Method of coordination with Medicare

Retired members share in the cost through premium contributions

MS. MILLHORN explained that "access only" means that the member can apply [prior to normal retirement eligibility], but would have to pay 100 percent of the medical premium costs in order to receive the medical coverage.

8:38:32 AM

MS. MILLHORN directed attention to Slide 3, which shows the system sponsored health care plan under the proposed bill. She explained that the slide compares medical, prescription drug, and dental, vision, and audio costs under the current and proposed "alternative" plans. She said other states' medical plans were studied in order to "compare and contrast." Alaska's medical plan costs are one of the primary drivers for the retirement systems' underfunded status; however, the studies done show that Alaska's medical plan benefits are rich compared to other [states'] medical plans. She offered some examples.

MS. MILLHORN turned to Slide 4, which shows eligibility criteria of the proposed medical program and read as follows [original punctuation provided with some formatting changes]:

Normal retirement eligibility for medical benefits will be defined as the earlier of

- (1) age 60 with 10 years of service
- (2) 25 years of service (30 years for PERS "others" retirees).

Disabled participants will be eligible

Terminated vested participants are not eligible. A member must retire directly from active service in order to receive coverage

MS. MILLHORN explained that the 25 years of service pertains to police, firefighters, and teachers, and the 30 years pertains to all other PERS employees who retire. She opined that an important feature of the plan design is that terminated vested participants would not be eligible. Currently, the Division of Retirement & Benefits covers 54,000 members and its claims cost for 2004 was \$225 million. She said:

If you just look at the parties that are eligible for our medical plan right now and you project into the future, and you expect that all of those ... individuals will receive a benefit, there's

approximately 90,000 members and the dependent ratio is 1.9. So, if you were to look into the future to do some projections, you would be able to see that there would be a population if there's some ... vested members here who will receive that benefit. But there's also members who have to satisfy some ... additional service in order to be eligible. But you could be easily looking at a population in the future of 180,000 members.

[8:43:18 AM](#)

MS. MILLHORN directed attention to Slide 5, which shows details of early retirement under the proposed medical program. Slide 5 read as follows [original punctuation provided with some formatting changed]:

Early retirees who have not reached normal retirement eligibility

Receive "access only" plan

Will not be eligible for subsidized retiree health plan costs

Pay 100% of the pre-Medicare eligible (currently pre-age 65) per member per year (PMPY) claim costs

Dependent spouses of early retirees will pay 100% of the appropriate pre-Medicare or Medicare eligible PMPY claim cost

MS. MILLHORN explained that "access only" means that [the retiree] would pay the full premium to receive coverage. She said it's important to note that that is still a very good benefit. She explained that there are a lot of people who may leave their employment or have breaks in their health insurance, and having access to health care can be cost prohibitive.

[8:44:36 AM](#)

MS. MILLHORN highlighted the key points of Slide 6, which shows normal retirement to Medicare eligibility as follows [original punctuation provided with some formatting changed]:

Members who retire directly from the Systems will be eligible for a "defined dollar" benefit upon reaching eligibility for normal retirement

Fixed dollar subsidy toward system sponsored health coverage

Access to system sponsored retiree medical plan as outlined above

Subsidy amount is based on length of service

Subsidy amount indexed each year by healthcare inflation up to a maximum of 5 percent

[8:46:05 AM](#)

MS. MILLHORN, in response to a question from Chair Seaton, referred back to Slide 4 and explained that there are two ways a person can be eligible for medical benefits: one is to be age 60 with 10 years; or two is to be of any age as long as the retiree has 25 years of service for police, firefighters, and teachers or 30 years of service in PERS.

[8:46:48 AM](#)

MS. MILLHORN returned to discussion of Slide 6. She said, "The employers wanted to build in recognition for long service, and this medical plan does that."

[8:48:49 AM](#)

MS. MILLHORN turned to Slide 7, the second component addressing normal retirement to Medicare eligibility, which read as follows [original punctuation provided with some formatting changed]:

Upon becoming eligible for Medicare, such members will become eligible for the "defined health" benefit

Pre-Medicare dependent spouse is eligible for the same subsidy as retiree

Medicare eligible dependent spouse is eligible for the Medicare eligible benefit level, with contribution percentage based on retiree length of service

MS. MILLHORN continued:

If you look at those segments for a member, it's pre-65 and post-65. And the post-65 portion is a defined health benefit, and that includes that the members

will make a contribution based ... on their years of service. But I think we all recognize that the cost to the system, pre-65, is much higher. What the research and analysis has shown through the tier study is that 75 percent of our medical cost are attributed to and can be allocated to pre-65 members, and 25 percent of those costs are allocated to post-65 members, because there is a coordination with Medicare that occurs on the post-65 period of a member's health care coverage. And that cost is quite a bit different, because Medicare's primary and the Alaska Care plan is secondary. So, the costs are reduced to 25 percent for that segment.

[8:49:56 AM](#)

CHAIR SEATON queried:

Although we have higher expenses currently ... projected in the pre-65 - those five years ... - that's a defined dollar amount. And yet, on the post Medicare eligibility we're talking about defined benefit amount. And though we're identifying 25 percent, if Medicare eligibility changes, if Medicare reimbursement rates change, we could be looking at an unfunded liability on the post-65 or post-Medicare eligibility that we don't have ... control over, whereas with the defined dollar contribution on the pre-Medicare eligibility, haven't we contained that growth, especially with the 5 percent escalated?

[8:50:50 AM](#)

MS. MILLHORN responded as follows:

The premium amount - when there's not a coordination with Medicare we bear all of those costs. So, right now, when you look at the existing claims cost and you look at the premium amounts that we established for that, 75 percent of the costs are allocated there. There could be some changes in Medicare that would change the post-65 cost and could increase those costs to the system, depending on those changes - Medicare reform in 2006, for example.

[8:51:52 AM](#)

CHAIR SEATON stated that the intent of going through this whole process is to get the state "out of the prospect of having unfunded liabilities." He offered his understanding that Ms. Millhorn is saying, "It's really not a defined dollar contribution; it's a defined percentage of an unfixed premium." He stated concern that "we're back to a defined benefit post-65." He said at some point in time it will be necessary to get clarification regarding "what we're calling a defined dollar amount when I'm not sure it's defined."

[8:52:44 AM](#)

BRAD LAWSON, Mercer Human Resource Consulting, offered to address Chair Seaton's concerns. He said there's a lot of risk and volatility associated with the defined benefit plan, primarily driven by fluctuations in interest rates. He said "the medical side of the current benefit" not only has that interest rate volatility and risk, but also has a "trend volatility and risk." He explained that the latter is the risk that the medical benefits will grow at a greater or even lesser rate than has been presumed in projections. He explained that a defined dollar approach is a defined benefit component because it does have the same interest rate risk. He said, "So, what we have done by having a fixed escalator of 5 percent, we've eliminated ... what we would call the trend risk, or the health inflation risk. So, in one sense we have contained that component of the risk; that health inflation risk then is being borne by the retiree versus by the system at that point."

[8:54:33 AM](#)

CHAIR SEATON said he thinks there is still a question among committee members regarding "why we're calling it defined dollar amount ahead of pre-65 when actually what we've got is a percentage of premium"

[8:54:43 AM](#)

MR. LAWSON explained as follows:

The defined dollar terminology comes from the fact that, while we start with a premium base, that base actually does not grow as a premium would, or a health cost would. It grows in a defined manner of 5 percent or less. And in our current environment, it's unlikely that health inflation will be less than the 5 percent. So, we can actually go forward maybe 10

years and, based on a member's years of service, we can have a very accurate picture or a defined amount that the system will be contributing towards their health cost. So, even if health inflation was 15 or 20 percent - heaven forbid - ... in 10 years we could still predict or define the amount of premium dollars that the state would be subsidizing that individual. And that's why we call that a defined dollar approach.

[8:55:48 AM](#)

CHAIR SEATON, regarding post-Medicare eligibility, asked:

If ... Medicare melts down and the rates increase significantly, or their contribution rates or their payment rates decrease, are we - with the plan as suggested - looking at a defined benefit unfettered above that in ... post-Medicare eligibility?

[8:56:31 AM](#)

MR. LAWSON proffered that in an extreme scenario in which Medicare fails and provides no benefits, health costs would increase substantially because the system would then be responsible for providing the medical benefits for which Medicare had previously paid. He added, "Probably an unfunded liability would be generated from that scenario."

[8:57:19 AM](#)

MS. MILLHORN requested that Mr. Lawson continue with her presentation because she had to leave to give another presentation.

[8:57:41 AM](#)

MR. LAWSON revisited Slide 7.

[8:59:50 AM](#)

MR. LAWSON directed attention to Slide 8, the third component addressing normal retirement to Medicare eligibility, which read as follows [original punctuation provided with some formatting changed]:

Apply percentages to the applicable subsidy base to arrive at the appropriate subsidy amount.

Defined Dollar Subsidy Base Annual PMPY for fiscal year 2004:

Pre Medicare \$5,962*

Subsidy Percentage

<u>Service (yrs)</u>	<u>Subsidy %</u>
10-14	30%
15-19	45%
20-24	60%
25-29	75%
30+	90%

Member contributions are determined by subtracting the annual subsidy amount from the annual claims cost for a given year.

*Equivalent to FY2004 pre-Medicare projected claim cost.

MR. LAWSON said it's important to note that the subsidy base of \$5,962 will grow only at 5 percent; it will not grow as actual claims costs grow. He explained, "If claims costs are going to grow at 10 or 15 percent, and the subsidy base only grows at 5 percent, the retirees will be responsible for a larger and larger portion of their health care expenses."

[9:02:27 AM](#)

CHAIR SEATON said the grouping of service years in five-year increments concerns him, because that may raise issues such as an employee quitting earlier because the next jump up in subsidy doesn't happen soon enough or working longer than desired to get to the next level. He noted that HB 238 would increase the subsidy by 3 percent a year from 30 percent to a maximum of 90 percent and asked Mr. Lawson if he perceives any problem with that plan.

[9:03:28 AM](#)

MR. LAWSON responded that there are two considerations in going to that valid approach. The first consideration is an administrative one: the more details that are inserted, the more administratively challenging it will be. The second consideration he described as follows:

As you ... add a 3 percent subsidy for somebody with 11 years and add another 3 for someone with 12 years, you are increasing the overall subsidy that's provided to retirees in the system. And I think that's probably not a huge impact, but it will increase the cost somewhat from the numbers we've presented here today and the numbers that were looked at in the tier redesign project.

MR. LAWSON added that he does not think there is anything that would "stop or hinder you from going to an approach of 3 percent per year of service."

[9:05:15 AM](#)

MR. LAWSON referred to Slide 9, which highlights the aspect of the proposed medical program after Medicare eligibility as follows [original punctuation provided with some formatting changed]:

Defined health benefit similar to current program

Retirees who were previously eligible for 100% subsidy of retiree health plan costs will now participate in the premium cost.

Contributions are per covered individual

Pre-Medicare dependent spouses are eligible to receive a defined dollar subsidy with percentage based on retiree length of service

Medicare eligible dependent spouses are eligible to receive the same defined health benefits as the retiree and pay the same contributions

MR. LAWSON, regarding contributions, explained that a person paying for two participants will pay twice as much as someone paying for a single person. Regarding dependents, he said the intent is to recognize the fact that "if there is a pre-Medicare spouse, they're going to have a lot higher claims cost than that Medicare eligible retiree and they ... will receive benefits under the ... defined dollar component until they reach Medicare eligibility age."

CHAIR SEATON asked if the "5 percent escalator" has "gone away."

MR. LAWSON answered that's right.

9:07:19 AM

MR. LAWSON moved on to Slide 10, which shows information regarding contributions after Medicare eligibility as follows [original punctuation provided with some formatting changed]:

Contribution Base PMPY for fiscal year 2004:
Medicare Eligible \$2,667

Contribution Percentage

<u>Service (yrs)</u>	<u>Contribution%</u>
10-14	30%
15-19	25%
20-24	20%
25-29	15%
30+	10%

Apply percentages to the contribution base to arrive at the applicable contribution amount

MR. LAWSON stated, "To me it's very striking that even though ... these individuals are, on average, quite a few years older than those individuals in the pre-Medicare group, their claims costs are still well under half of that pre-Medicare group."

CHAIR SEATON added that that's because Medicare "picks up the primary health care." In response to a remark from Chair Seaton, he reiterated that the intent is to have each individual covered under the program to be paying a contribution amount - even those who are participants of the program, but not members [such as spouses or dependents]. He added, "We do not want to penalize those individuals who are only covering themselves to be subsidizing those individuals who cover multiple dependents." He continued as follows:

While we have not eliminated the trend risk and volatility as we have with the ... defined dollar component, retirees will still be sharing in that trend component to the amount of the percentage that they're paying. So, an individual with 10-14 years of service will be absorbing essentially 30 percent of that trend risk. So, in here we meet the objective of the redesign of sharing that trend risk somewhat with those retirees.

Here it was also felt that, due to the lower claim volume, ... about 25 percent, it was desired to give retirees a larger benefit in this category and to maybe offer a little bit more subsidy in the Medicare eligible stages of retirement.

[9:10:26 AM](#)

CHAIR SEATON asked if a 5 percent escalator could be applied in this category.

[9:10:40 AM](#)

MR. LAWSON replied that it could be applied. He continued:

The thinking here was that they actually wanted to provide additional subsidy to those Medicare eligible individuals; the thought being that the second component - going from normal retirement to Medicare eligibility - was going to kind of provide a bridge into an area that -- you know, if an individual retires before Medicare eligibility, it's often very difficult for them to find coverage. And that was the access issue that ... [Ms. Millhorn] was referring to. And if they do find coverage it's often very expensive. So, the individuals here have the opportunity, no matter when they retire, to have guaranteed access to that health coverage with no penalty for their own particular health status, as they would if they went out and bought insurance on an individual basis.

... The second component was designed to provide more of a bridge; ... if an individual chose to retire before their Medicare eligibility, we would offer them access and offer them some subsidy, but not a particularly large subsidy. The ceiling for the Medicare eligible individual was that there was a desire to provide an additional benefit or to provide ... additional levels of subsidy there and not tie that to a fixed dollar approach.

MR. LAWSON, regarding the fixed dollar approach, stated that as the years project into the future, retirees will be covering a larger and larger percentage of the premium costs due to the fact that the premium cost is growing at a larger rate - the

trend rate at 10-15 percent - versus the subsidy base which would only grow at 5 percent.

MR. LAWSON indicated that Mercer ran some scenarios with a fixed dollar approach for Medicare eligible individuals and the final recommendation of the tier committee was to merge a defined benefit and defined dollar approach.

[9:13:18 AM](#)

CHAIR SEATON asked if it was estimated that a 5 percent escalator would actually limit the amount that would be paid by the system or if, after Medicare eligibility, the 5 percent would not be reached.

[9:13:50 AM](#)

MR. LAWSON answered that [the 5 percent] would be reached and would result in an elimination of dollars paid by the system. He said there was a feeling that the medical component was being cut so much and the cost of that program was being reduced substantially, and there was not a desire to reduce it further.

[9:15:03 AM](#)

MR. LAWSON directed attention to Slide 11, which shows the types of Medicare integration, with the headings of "Traditional," "Exclusion," and "Maintenance of Benefits" - three widely accepted methods of coordination of benefits. He explained that coordination of benefits is a process of integrating a planned benefit package with the benefits that Medicare will pay. The process is used to determine how much the plan sponsor and plan participants will pay and how much will be paid by Medicare. All three methods are designed to ensure that at no point is more than 100 percent of the claims cost paid. Mr. Lawson provided examples of the three plans, which Slide 11 defines as follows [original punctuation provided with some formatting changed]:

Traditional - Calculates what the plan would have paid as sole provider and adds what Medicare pays. If the total is more than 100% of the bill, the plan pays only enough to total 100%. The retiree often pays no deductible or coinsurance.

Exclusion - Determines the total expenses covered under the plan, reduces them by Medicare benefits and

then applies the deductibles, coinsurance and other plan limits.

Maintenance of Benefits - Calculates the plan's payment as if there were no Medicare coverage, applies the deductibles, coinsurance and other plan limits and pays the remaining amount minus what Medicare pays. Also call [sic] Carve-Out.

[9:21:13 AM](#)

REPRESENTATIVE GRUENBERG stated, "This looks like it's fantastically more expensive for the retiree than what we've had before, isn't it?"

[9:21:14 AM](#)

MR. LAWSON stated his belief that "this was the same cost share design prior to ... 2000 or 2001." He said he thinks the system went from a Maintenance of Benefits to a Traditional approach about 3-5 years ago.

[9:21:57 AM](#)

MS. MILLHORN said Kathy Lea, [Retirement Manager, Division of Retirement & Benefits] confirms that is correct.

MR. LAWSON said he does not have the background on why it was changed. However, he said it's clear there's an impact from going from a pre-Medicare status where the individual would have paid \$300 and would have been used to the cost sharing element to a Medicare eligible status when all of a sudden the cost sharing is eliminated. He said, "It really removes them from feeling the pain of their healthcare cost."

[9:23:00 AM](#)

REPRESENTATIVE GRUENBERG offered his understanding that "all these people at the time they were paying this were getting longevity bonuses."

MS. MILLHORN interjected, "Some of them ..."

[9:23:29 AM](#)

MR. LAWSON stated that another important consideration is that there is an out of pocket maximum for these charges; therefore,

the charges would not be indefinite. He offered an example, referring back to Slide 3. He said there was a desire to keep cost sharing consistent from when retirees were in a pre-Medicare status to when they went to a Medicare status.

[9:25:06 AM](#)

REPRESENTATIVE GRUENBERG asked Ms. Lea to confirm how many years ago the change [from using the maintenance of benefits method to using the traditional method] took place.

[9:25:23 AM](#)

KATHY LEA, Retirement Manager, Division of Retirement & Benefits, Department of Administration, on behalf of the division, stated her belief that that change took place in approximately 2000. She explained the reason for the change is that the funds appeared well funded at the time and the retirees were notifying both the division and the boards that with increasing Medicare costs, they weren't getting anything for their Medicare premium.

[9:26:34 AM](#)

REPRESENTATIVE GRUENBERG asked, "If we went to this plan now, how would that negatively affect these people vis a vis back then when they still had their longevity bonus?"

[9:26:53 AM](#)

MS. LEA responded that some of the members were receiving a longevity bonus and have not since received it; therefore, returning back to [the maintenance of benefits method] would increase their out of pocket share up to the out of pocket limit.

[9:27:09 AM](#)

CHAIR SEATON asked if it is known what proportion of the retirees were or were not receiving a longevity bonus.

[9:27:52 AM](#)

MS. LEA replied that there are a portion of members who were receiving the longevity bonus, but the division is not aware of how many. She said it's still important to note that "there is

still the health reimbursement arrangement portion of the health plan that would be paying deductibles and premiums as well."

[9:28:18 AM](#)

CHAIR SEATON asked for those numbers to be given to the committee.

[9:29:03 AM](#)

MR. LAWSON continued on to Slide 12, which shows the normal cost rates for Alternative 2 as follows [original punctuation provided with some formatting changed]:

"Normal cost" rates for Alternative 2 are expected to be as follows:

	<u>Normal Cost Rates</u>	
	<u>TRS</u>	<u>PERS</u>
Medical normal cost rate	3.75%	3.5%
Defined contribution rate	13.5%	11.5%
HRA contribution rate	<u>1.5%</u>	<u>1.0%</u>
Gross normal cost rate	18.75%	16.0%
Member contribution rate	(10.0%)	(8.0%)
Employer normal cost rate	8.75%	8.0%

MR. LAWSON noted that, in comparison, [the medical normal cost rate] prior to program changes previously discussed, those costs were 9.07 percent and 8.68 percent. He said there is already, even with the health benefit portion there is significant savings to the system with this program.

[9:30:49 AM](#)

MS. MILLHORN clarified that those numbers - 9.07 percent and 8.68 percent - reflect the normal cost rate right now for PERS and TRS, respectively.

[9:33:19 AM](#)

MR. LAWSON indicated that Slide 13 is [the title page for] the next section regarding Health Reimbursement accounts (HRAs), and Slide 14 is [the first of four slides] overviewing HRAs, which read as follows [original punctuation provided with some formatting changed]:

Arrangement that:

- Is solely employer paid
- Reimburses employees for medical expenses
- Provides reimbursements up to a maximum dollar amount for a defined coverage period

Unused funds are carried forward to the next coverage period

Usually, but not required to be, associated with high-deductible health plans or consumer directed health plans

Includes aspects of FSAs

Also known as

- Health Reimbursement Arrangements
- Defined contribution health care plans

MR. LAWSON said it's important to note that [the HRAs] were something that was discussed later during the tier redesign process; therefore, it did not have the opportunity to be flushed out in detail and discussed in as much depth as some of the other components of the medical program. He offered further details.

[9:35:34 AM](#)

MR. LAWSON turned to Slide 15, the second of four slides covering the overview of HRAs, which read as follows [original punctuation provided with some formatting changed]:

Funding

- Employer only
- Employer sets own limits

Eligibility

- Current and former employees (including retired employees), spouses and dependents
- COBRA participants
- Dependent medical expenses on death of employee

MR. LAWSON, in response to a request from Chair Seaton, explained that [the Comprehensive Omnibus Budget Reform Act (COBRA)] allows for individuals to retain their health care coverage for 18-36 months for a fee. Employers can charge those individuals up to 102 percent of the current active medical cost.

[9:37:25 AM](#)

MR. LAWSON directed attention to slide 16, the third of four slides covering HRAs, which read as follows [original punctuation provided with some formatting changed]:

Benefits

- Reimbursements for medical expenses as defined in IRC section 213(d)
- No IRS limit on reimbursements
- Employee responsible for substantiating expenses
- Cannot use for over-the-counter drugs
- Cannot have any right to receive cash benefit

[In Slide 16, IRC stands for Internal Revenue code and IRS stands for Internal Revenue Service.]

[9:38:36 AM](#)

MR. LAWSON moved on to Slide 17, the fourth of four slides covering HRAs, which read as follows [original punctuation provided with some formatting changed]:

Plan design

- Plan sponsor dictates plan design
- Contribution amount
- Covered expenses
- Termination provisions

Tax Treatment

- Requirements for exclusion from employee/retiree income:
 - Employer funding only - no employee contributions
 - Only reimbursed for qualified medical expenses
- Subject to non-discrimination rules under IRS code section 105(h)

MR. LAWSON said he thinks the theme is flexibility.

CHAIR SEATON asked Mr. Lawson to explain to the committee the implications of the non-discrimination rule.

[9:39:28 AM](#)

MR. LAWSON responded that that's not his area of expertise. Notwithstanding that, he proffered that that would be the case where, for example, a high-salaried individual would not be permitted to receive a substantially larger contribution than a lower salaried individual.

CHAIR SEATON said he has discussed this issue with Ms. Millhorn and asked her to speak to it.

[9:41:08 AM](#)

MS. MILLHORN stated:

In my discussion with [Chair] Seaton, I needed to provide a little bit of background about the HRA and how the amounts were arrived at, because I think it is confusing if you were not there and worked through that process. And I'm not sure that the presentation material really lends itself to a clear understanding about the 1 percent portion. Because the 1 percent portion that is the cost to employer for HRA is really derived by looking at a system-wide average salary amount in order to make that computation, and that goes back to the nondiscriminatory language to ensure that an individual that is less compensated as compared to an individual who would have a higher level of compensation would - under an health reimbursement arrangement - receive the same level of benefit. So, the 1 percent portion - the cost to the employer - the projections were to look at a system-wide average of \$35,000 and make a computation of a system-wide average salary in order to determine what that benefit amount is for all members.

[9:42:06 AM](#)

MR. LAWSON added, "The other issue that we ran into by doing a percentage of an individual salary is that very closely linked that contribution amount to that account to the employee's personal salary." He explained that, for tax purposes, there can be no direct or indirect funding related to an employee's personal compensation."

[9:42:53 AM](#)

CHAIR SEATON offered an example for clarification.

[9:44:53 AM](#)

MS. MILLHORN concurred with Chair Seaton's example.

[9:45:10 AM](#)

MR. LAWSON said, "I think each year the intent was to determine an average salary for the system as a whole and ... to apply that 1 or 1.5 percent to that average salary, ... thereby becoming a fixed dollar amount."

[9:45:18 AM](#)

CHAIR SEATON explained that that fixed dollar amount will not be seen in "any of the materials" but "we need to remember that because it's going to affect different employees differently."

[9:45:31 AM](#)

MS. MILLHORN, in response to a question from Chair Seaton, said there are approximately 155 PERS employers.

[9:45:50 AM](#)

CHAIR SEATON observed that if the calculation was based on the average wages of the 155 PERS employers then there wouldn't be discrimination within that employer pool. Using system wide averages would get rid of the discrepancy between higher wage and lower wage employers. He asked if a system of averages would qualify under the new program and not fall under the nondiscriminatory provision in the IRS code.

[9:46:04 AM](#)

MS. MILLHORN said Mr. Lawson was asked to make a determination "if that would create a discrimination kind of issue for us." She said because the division manages the system as a whole, she would like to have that question answered definitively. She said it could be argued that by treating one employer within the whole system differently for benefit calculation purposes may cause a problem. She said there is merit to Chair Seaton's asking his question; however, she would like to hear response

from the experts "to get some confidence that it's not problematic."

9:47:56 AM

CHAIR SEATON clarified that \$500 dollars in the charts doesn't mean that "at one percent of their salary you were limited at \$500." Instead it means "\$500 is growth over time." He explained, "If the average salary gets up to \$60,000, it would still be limited to \$500 in the future. He said it's confusing to figure this out based on the limited data available. He asked Ms. Millhorn if what he said is a fair representation.

9:48:32 AM

MS. MILLHORN replied that she believes that's accurate. She said there's also additional information available. She described the presentation given today as a "broad brush." She suggested to Mr. Lawson that it would be beneficial if he would provide the committee members with projected benefit amounts that would be available to members who retired under the system under the HRA, because she said she thinks "this feature is a very key feature; it provides a very powerful vehicle for members to start thinking about health care costs for themselves"

MS. MILLHORN said she thinks everyone recognizes that health care costs are a national issue, "and this is one vehicle that is thought to be very powerful for the individual on a tax-deferred basis to plan for those expenditures in the future, and then to make some corresponding decisions about that." The current plan doesn't make an employee have to think about medical expenses, because they are simply provided. She added, "And by providing a vehicle that accumulates assets, it triggers you to be cognizant of those assets and make some key decisions based on that." She offered an example wherein a person would have the opportunity to choose whether it was more economical to have a surgical procedure done in Juneau, or in Anchorage. She continued:

This is that type of vehicle that looks at consumer-driven health care for the future. And it's asking members to share in those costs, recognizing that 40 percent of the accrued liabilities for our underfunded status is medical cost for PERS, 28 [percent] for TRS. This particular medical plan goes a long way toward

addressing medical costs in the future, and still provides a very solid benefit to the members.

[9:51:40 AM](#)

CHAIR SEATON stated that the primary purpose is to have a benefit that will attract and maintain employees. He said a huge portion of the unfunded liability comes from the current health care system and must be fixed. He described that his experience in private health care plans is: "doubling the deductible almost halves the premium." He suggested that it might be better to have a slightly higher deductible, even if the amount of the health care reimbursement has to increased. He speculated that having that higher deductible would save money over time because the base contribution into the premium amount would be less.

[9:53:05 AM](#)

MS. MILLHORN said that is an area in which Mr. Lawson specializes exclusively. Notwithstanding that, she offered:

In benchmarking with some of the other pension systems that were looked at, including two employers in the State of Alaska, it appears that that deductible kind of aligns itself when you compare across those various different benchmarks.

[9:53:47 AM](#)

CHAIR SEATON clarified that he is not meaning to say he wants to reduce a benefit, but he just wants to know if a lot of money could be saved in the system by having a higher deductible coupled with a higher contribution into the health care reimbursement account, which would offset that amount for individual employees.

[9:54:16 AM](#)

MR. LAWSON recollected that when [Mercer] went through its design-processing phase, it arrived at "the \$250." He noted that a few years ago that was the benchmark for cost sharing. He said there were deductible level proposals of \$500 and \$350, and during the process those levels were felt to be too high. He said the deductible "definitely can get you some mileage," but sometimes it needs to be increased "more than you might intuitively expect" in order to get substantial savings. He

mentioned the effect of catastrophic claims. He noted the other element of the deductible, particularly in the State of Alaska's case, is the inability to increase it in future years. He said many plan sponsors that Mercer has worked with will, every couple of years, increase the deductible by \$50-\$100 in order to keep pace with inflation. He explained, "When you have a constant deductible, but you have a growing health care cost, ... the value of that constant deductible tends to erode over time. And so, if we look back 10 years ago or 15 years ago, a \$200 or \$250 deductible would mean a lot more back then than it does today."

MR. LAWSON said one challenge is the "nondiminution of the benefits." He said that protected status of the benefits is probably the largest factor preventing the implementation of such a strategy where a cost share can be changed over time as costs change. When faced with that kind of restraint, he advised, the next best place to try to establish a cost sharing is by a percent of premium. By establishing a constant percent of premium contribution to save on costs, as costs continue to grow, so will the contributions. He said, "So, we kind of felt that it was better to focus on the contribution aspect of it, because that was a percentage of the cost and could grow with time."

[9:57:54 AM](#)

CHAIR SEATON said he would like Aetna or someone to supply the committee with a spreadsheet regarding that issue. He said, "We're building in a new tier on these, so we're not talking about diminishing past accrued benefits. So, is there any reason why we can't build in whatever that deductible is and have it change at a fixed 5 percent rate?"

[9:58:36 AM](#)

MR. LAWSON responded that he thinks that would be outstanding. He said that was explored a little bit, and he said he thinks the [PERS/TRS] Board's attorney was of the opinion that that was "dangerous" or "uncertain" territory, which could provide grounds for challenge based on past case history.

[9:59:03 AM](#)

CHAIR SEATON said, "Well, I ... guess I'm just having a problem figuring out how we can say that we're going to have [a] premium escalating at 5 percent and say that that's ... not going to be

subject to the same challenge as the deductible escalating at a maximum of 5 percent. I mean, it seems that we have the same exact thing. We're building a new tier; if everybody knows the benefit when they come in and the benefit is this escalating at 5 percent, ... there's no question of changing the deal, because they know the deal when they come in."

[HB 238 was heard and held.]

[10:00:11 AM](#)

CHAIR SEATON made committee announcements.

ADJOURNMENT

There being no further business before the committee, the House State Affairs Standing Committee meeting was adjourned at [10:01:44 AM](#).