11/01/2013

OVERVIEW: PERS/TRS AND MEDICAID

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Angela Kodell Remarks to SFC 11/1/13 9:00 am meeting -> received via email

Senate Finance Committee – November 1, 2013

Thank you for the opportunity to make a presentation today. We have heard a lot about whether or not the pension trust funds are "healthy" or whether or not they are in "fiscal stress". We have also talked a lot about affordability. What can the state afford and what are our options going forward? Do we really need to do anything at this time? The State of Alaska was upgraded by Fitch and Standard & Poor's over the last two years and we now share triple A ratings from all three nationally recognized rating services. One of the primary reasons cited by all three rating agencies was good or sound financial management. Good credit scores for any of us means we sometimes have to make hard decisions. The legislature and the governors over the years have taken necessary and – at times uncomfortable – steps towards keeping the state on sound financial footing. It is no secret that we have a volatile revenue source which has led us to be conservative in our budgeting practices. We believe in paying up front for those things we are required to provide - even going so far as to forward fund education. We honor our debts, pay them off early if we can and equally importantly we honor our contracts.

The unfunded pension liability or net pension liability is the gap between the assets we have to fund the benefits promised under contracts made years ago. In 2005 the legislature and the governor took the very hard step of closing the defined benefit program so that the state could take direct control of its contract obligations by no longer promising benefits it may not be able to deliver. The liability continued to grow over those years because the costs of benefits grew more than predicted and expected investment earnings failed to materialize.

It is true that under any level percent of pay or level dollar amortization, liabilities will be paid off. So why should we take any other actions than those already described? Because this state needs to have the financial flexibility in future years to continue to grow this state – whether it is investing in a hydroelectric project, rebuilding coal fired facilities or making a major investment in a gas line from the north slope. Right now we rely on the assets in the pension trust funds to generate enough cash to pay each year's benefits. We have designed an asset allocation with the goal of earning at least 8%. If those assets do not generate enough cash to pay all the benefits, we are required to sell assets to come up with the cash deficiency. The unfunded liability will grow because we are unable to achieve 8% and requests to the general fund will be even higher than today. There are very real and tangible benefits to the State for addressing this issue now – the most important one maintaining financial resources to fund future priorities.

At this time I would like to turn to Gary Bader and have him walk you through an analysis we have prepared which will demonstrate in more detail our concerns about our future flexibility.

Attachment 2 – Medicaid

Medicaid

Introduction

Medicaid is jointly funded by the federal government and by the individual states, with each state managing its own program. Participation in the Medicaid program is optional, but all states choosing to participate in the program must follow certain federal guidelines pertaining to eligibility and services to be provided. In order to modify how Medicaid is operated, an individual state is permitted to make a Medicaid state plan amendment (SPA). However, the Centers for Medicare and Medicaid Services (CMS) must review and approve the SPA for consistency with federal laws and regulations before the state is allowed to implement a Medicaid program modification.

Medicaid was established by Title XIX of the Social Security Act in 1965 to provide medical assistance to certain low-income needy individuals and families. Medicaid is basically intended to provide coverage for needy children, pregnant women, and aged, blind and disabled persons.

Alaska joined the Medicaid program in September 1972. New services and eligible groups have been added to the program since that time by the Legislature. The Medicaid program in Alaska is authorized under Alaska Statutes 47.07.010 - 47.07.900 and the Alaska Administrative Code, Title 7 Chapter 43 and Chapter 100.

Alaska Medicaid consists of the Office of Children's Services (OCS), the Division of Behavioral Health (DBH), the Division of Health Care Services (DHCS), the Division of Senior & Disabilities Services (DSDS), and the Division of Public Assistance (DPA). OCS covers behavioral rehabilitation services for children in state custody. DBH covers mental health clinics, substance abuse clinics, psychiatric physicians, residential psychiatric treatment centers, and inpatient psychiatric hospitals. Alaska Psychiatric Institute also falls under this division. DHCS covers inpatient and outpatient hospital services, physician services, pharmacy, transportation, dental, vision, laboratory and X-ray services, physical/occupational/speech therapy, chiropractic, medical equipment, home health, hospice, and state-only Medicaid benefits. Other activities include supporting direct services delivery including providing Medicare premium assistance for dual eligibles, recovering third-party liability payments, and making supplemental (disproportionate share, or DSH) payments to hospitals. Adult Dental covers preventative and restorative dental services for adults. SDS covers nursing home and personal care services, Home and Community based waiver programs for children with complex medical conditions (CCMC), individuals with intellectual and developmental disabilities (IDD), Alaskans living independently (ALI), and adults with physical and developmental disabilities (APDD). DPA is the organization that reviews and determines eligibility for all the Medicaid programs.

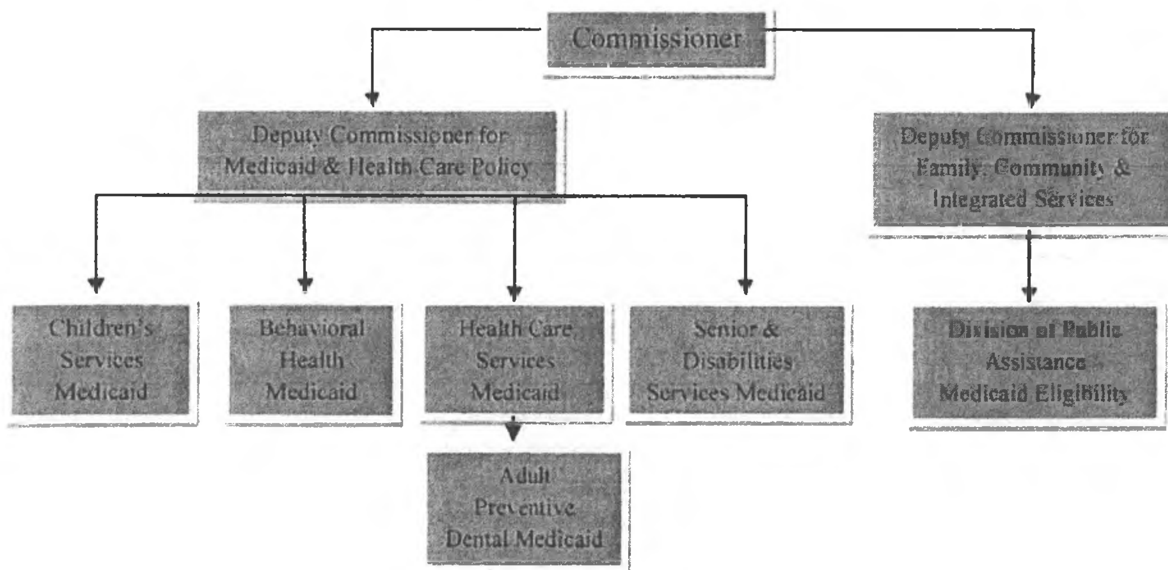
Medicaid

Medicaid Service Category Descriptions

Service Group	Service Category	Description
Behavioral Health	**Inpatient Psychiatric Hospital**	Inpatient psychiatric hospital services
Behavioral Health	**Outpatient Mental Health**	Outpatient mental health services, psychology services, and drug abuse centers
Behavioral Health	**Residential Psychiatric/Behavioral Rehabilitation Services**	Residential psychiatric treatment centers and behavioral rehabilitation services (BRS)
Long-term Care	**Home & Community Based Waiver**	Home and community based long-term care services offered through Medicaid Waivers including Alaska Pioneer Homes, assisted living homes, respite care, adult day care, chore services, residential and day habilitation, nutrition, and meals.
Long-term Care	**Home Health/Hospice**	Home health services, hospice care, nutrition services, and private duty nursing
Long-term Care	**Nursing Home**	Skilled nursing and intermediate care facilities including intermediate-care facilities for the mentally retarded; and temporary long-term care services
Long-term Care	**Personal Care**	Personal care attendant services including agency-based and consumer-directed programs
Primary Care	**Dental**	Dental services for children and adults
Primary Care	**Durable Medical Equipment/Supplies**	Durable medical equipment (DME), medical supplies, prosthetics, and orthotics
Primary Care	**Early & Periodic Screening, Diagnosis & Testing**	Early, periodic screening, diagnosis and treatment (EPSDT) including preventive health checkups, health screenings and immunizations
Primary Care	**Health Clinic**	Health clinic services including rural health clinics, federally-qualified health clinics and tribal health clinics
Primary Care	**Inpatient Hospital**	Inpatient hospital services
Primary Care	**Laboratory/X-Ray**	Laboratory, x-ray and diagnostic services
Primary Care	**Other Services**	Other services not classified elsewhere
Primary Care	**Outpatient Hospital**	Outpatient hospital services, outpatient surgery services, and end-stage renal disease services
Primary Care	**Pharmacy**	Prescription drugs
Primary Care	**Physician/Practitioner Services**	Physician, podiatrist, advanced nurse practitioner, and midwifery services
Primary Care	**Therapy/Rehabilitation**	Outpatient rehabilitation, physical therapy, occupational therapy, speech therapy, audiology, and chiropractic services
Primary Care	**Transportation**	Emergency and non-emergency medically necessary transportation and accommodation
Primary Care	**Vision**	Optometrist services and eyeglasses

Medicaid

Medicaid Organization Chart



Population

The population of Alaska has changed substantially in the years since statehood. In 1960, one year after Alaska became a state, the population was 226,167 and about one-fifth (44,237) of all Alaskans lived in Anchorage.[1] By the time Alaska started its Medicaid program in 1972, the population of the state had increased to 329,800, for an average annual growth of 3.2 percent.[2] Population continued to grow quickly through the 1970s and 1980s, partly influenced by the construction of the Trans-Alaska Pipeline from 1975 to 1977 and other jobs related to the oil industry.[3] By 1990, the State's population had risen to 550,043 and the population of Anchorage had grown to 226,338 residents, or just over two-fifths of the state population.[4]

Alaska's population growth has slowed in recent years. From 1990 to 2012, the population increased on average by 1.3 percent per year, reaching 732,298 in 2012. Of these residents, 298,842 lived in Anchorage (41 percent).

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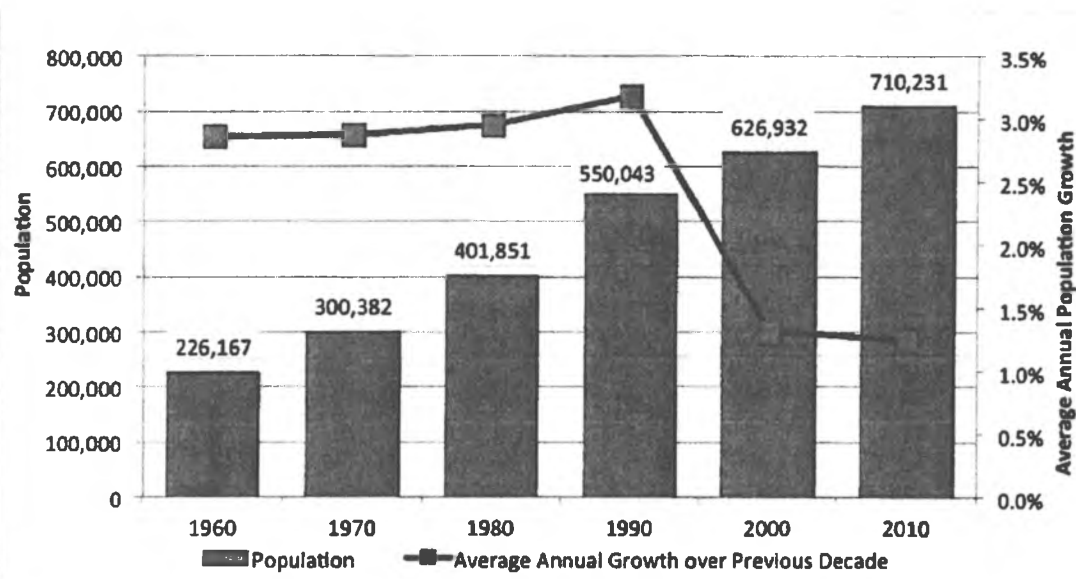
[1] http://www2.census.gov/prod2/decennial/documents/15611103.pdf

[2] See the Alaska Department of Labor and Workforce Development's report Alaska Population Overview 2009 Estimates, page 13, available at http://labor.alaska.gov/research/pop/estimates/pub/popover.pdf

[3] Population grew at an average annual rate of 2.9 percent over this period. For more information on the impact of the Trans-Alaska Pipeline see http://www.alyeska-pipe.com/pipelinefacts.html

[4] See http://www.census.gov/prod/cen1990/cph2/cph-2-3.pdf

Medicaid



Enrollment and Participation

Enrollment refers to the number of individuals who both meet the requirements and are registered to receive Medicaid services. Growth in enrollment is determined by two primary factors: (1) population growth and changes in the demographics of the population and (2) changes in eligibility requirements.

The growth in Medicaid enrollment for the entire population will slow over time however; the Medicaid program will experience substantial growth in the elderly (age 65 and older) population. The growth rate in enrollment for children (age 0-19) will be faster than that of working-age adults (age 20-64) for this forecast period.

The elderly population is projected to grow faster than other age groups

ALASKA'S PROJECTED POPULATION BY AGE GROUP FOR SELECTED YEARS, 2012—2022

Age Group	2012	2017	2022
Children (0-19)	210,758	224,857	238,216
Working Age Adults (20-64)	455,938	464,050	465,282
Elderly (65+)	62,950	87,744	115,319
Total Population	729,645	776,651	818,817

Source: MESA model, using data from the Alaska Department of Labor and Workforce Development.

Medicaid

Percent of participants that use their Medicaid benefits

Fiscal Year	Alaska Population	Medicaid Enrollment	Medicaid Beneficiaries	Percent of Population Enrolled in Medicaid	Percent of Enrollees Receiving Benefits
2000	626,931	110,219	96,033	18%	87%
2001	632,200	116,226	104,730	18%	90%
2002	640,643	121,582	109,571	19%	90%
2003	647,884	126,632	116,008	20%	92%
2004	657,483	129,528	118,466	20%	91%
2005	664,334	131,136	125,318	20%	96%
2006	671,202	131,996	122,978	20%	93%
2007	676,056	128,295	121,864	19%	95%
2008	681,977	125,138	117,472	18%	94%
2009	692,314	127,944	123,791	18%	97%
2010	710,231	135,086	126,127	19%	93%
2011	722,190	146,244	134,768	20%	92%
2012	732,183	150,998	138,755	21%	92%

The demographic characteristics of Medicaid enrollees have changed and will continue to do so in the future. The share of children as a percent of all participants enrolled in Medicaid increased in the late 1990s and continued to increase until 2004, when they accounted for 67% of enrollees. The proportion of enrollees who are children has since dropped to 63%. With a projected 1.76% annual growth rate, children's share of enrollment will remain largely unchanged.

The proportion of Medicaid enrollees who are working-age adults decreased from 35% of enrollment in 1997 to 27% of enrollment in 2002. Enrollment of working-age adults is projected to grow over the forecast period at 0.68% per year—slower than the projected rate for children and much slower than the projected rate for the elderly. The share of enrollees who are working-aged adults is projected to decrease.

With ever more people in the Baby Boom Generation reaching retirement age, the elderly will account for a larger share of Medicaid. Alaska Natives currently make up a little more than 36 percent of Medicaid enrollees, and the Native/Non-Native ratio of enrollees will remain stable through the forecast period.

Medicaid

Historical Enrollment by Demographic Group

Year	Non-Native	Native	Female	Male	Children	Working Age	Elderly	Total
1997	59,803	30,327	52,149	37,981	53,098	31,290	5,742	90,130
1998	58,154	30,572	50,967	37,759	52,103	30,754	5,869	88,726
1999	62,994	32,840	54,381	41,453	58,296	31,444	6,094	95,834
2000	72,898	37,368	61,889	48,377	71,649	32,133	6,484	110,266
2001	76,732	39,524	64,603	51,653	77,477	32,038	6,741	116,256
2002	80,588	41,021	67,201	54,408	81,677	32,943	6,989	121,609
2003	84,045	42,621	69,828	56,838	85,171	34,116	7,379	126,666
2004	84,943	44,611	71,305	58,249	87,027	34,946	7,581	129,554
2005	85,450	46,569	72,742	59,277	87,485	36,619	7,915	132,019
2006	85,269	47,695	73,215	59,749	87,232	37,433	8,299	132,964
2007	81,048	47,027	70,580	57,495	83,930	35,829	8,316	128,075
2008	78,813	46,325	68,745	56,393	81,694	35,126	8,318	125,138
2009	80,670	47,274	70,193	57,751	82,930	36,578	8,436	127,944
2010	85,733	49,353	74,014	61,072	86,502	39,849	8,735	135,086

The Medicaid program projects an increase in enrollment levels for each eligibility group, with the greatest growth tending to be in eligibility categories that have a larger share of the disabled and the elderly. These groups include Other Disabled, Long Term Care Non-Cash, and SSI/APA/LTC Cash,[5] which we project will experience average annual enrollment growth of 1.3 percent, 4.2 percent, and 2.9 percent, respectively. SSI/APA/LTC Cash is the eligibility group that we project will experience the greatest increase in enrollment between 2012 and 2022.

Enrollment in eligibility groups associated with the disabled and elderly will grow faster than other eligibility categories

MEDICAID ENROLLMENT FOR SELECTED ELIGIBILITY GROUPS

Eligibility group	2012	2017	2022
LTC Non-cash	2,596	3,227	4,049
Medicare	552	601	634
SSI/APA/LTC Cash	25,651	30,609	36,054
All Other Eligibility Categories	117,677	130,596	140,699

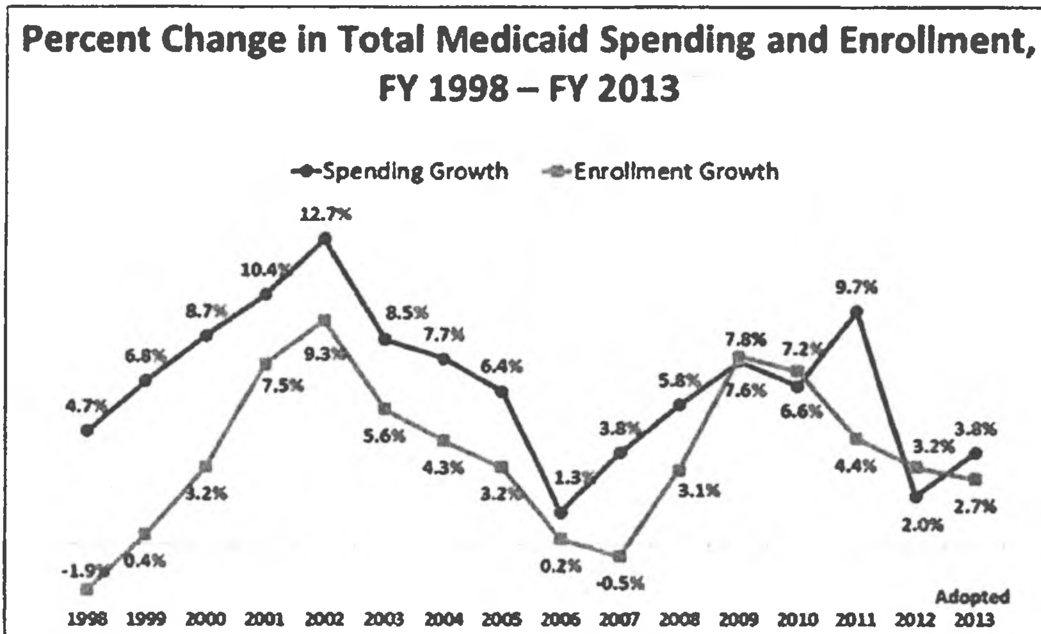
Source: Medicaid Budget Group, MESA Model

[5] SSI = Social Security income; APA = Adult Public Assistance; LTC Cash = long-term care cash assistance

Medicaid

Medicaid Spending

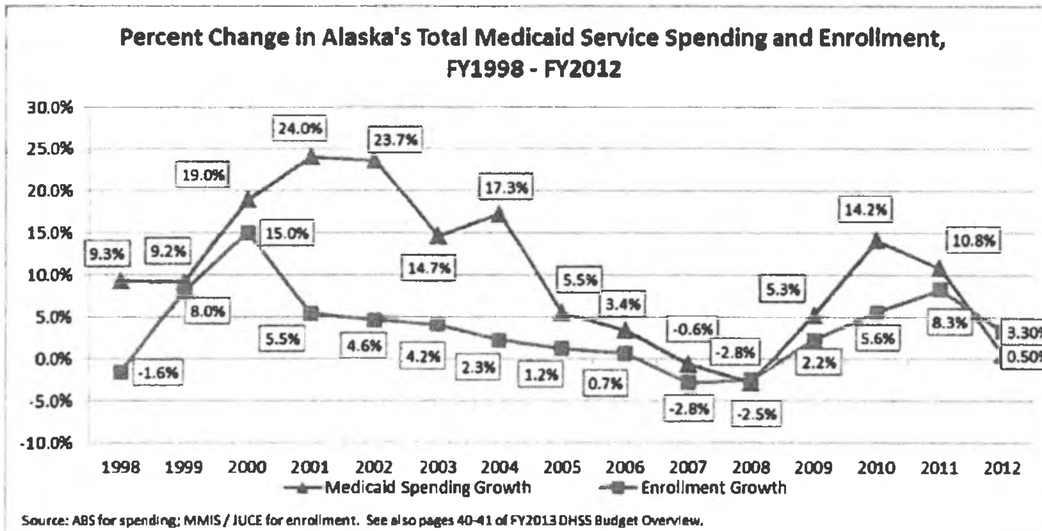
Medicaid enrollment and spending quite closely mirrors the effects of swings in the economy. This chart shows the spending growth and enrollment growth in the United States.



SOURCE: Enrollment Data for 1998-2009: *Medicaid Enrollment in 50 States,* KCMU. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2010 and FY 2011 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2010.

Medicaid

Alaska's Medicaid cost trends are little different than the Medicaid spending in the rest of the nation.



The following table shows the Medicaid spending by fund source from 1991 through 2012:

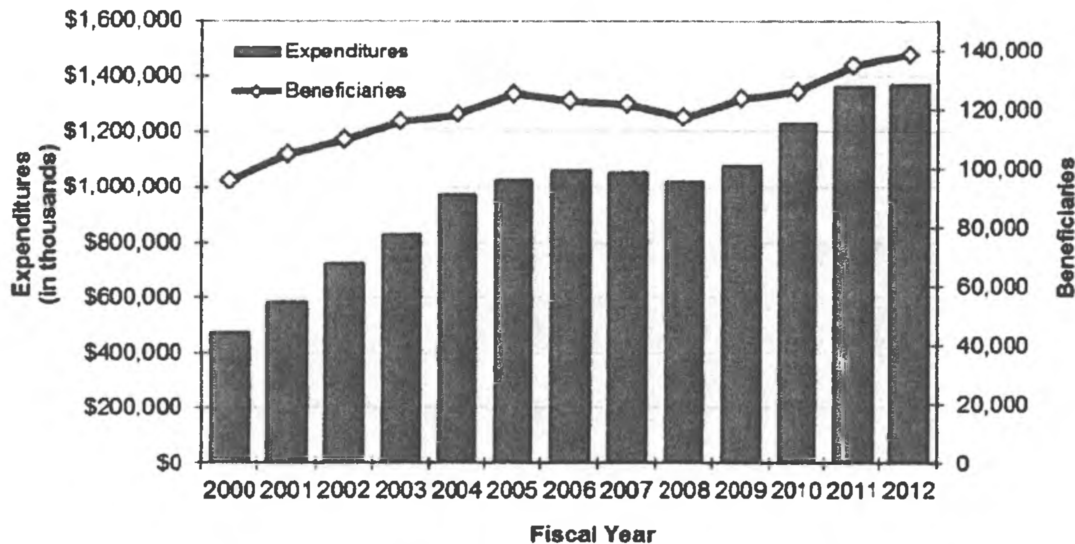
Fiscal Year	Unrestricted General Funds	Designated General Funds	Federal Funds	Other Funds	Total Funds
1991	$80,094		$91,990	$1,796	$173,880
1992	$93,582		$105,740	$934	$200,256
1993	$103,447		$119,602	$708	$223,757
1994	$123,553		$142,729	$1,401	$267,684
1995	$127,125		$149,589	$1,792	$278,506
1996	$138,013		$167,280	$3,105	$308,398
1997	$141,517		$183,355	$6,568	$331,440
1998	$125,542		$231,330	$5,476	$362,347
1999	$131,328	$195	$261,316	$2,851	$395,690
2000	$145,250	$265	$307,508	$17,686	$470,709
2001	$152,427	$364	$387,432	$43,671	$583,894
2002	$192,558	$364	$461,847	$38,911	$693,680

Medicaid

2003	$211,076	$1,427	$558,581	$57,034	$828,117
2004	$230,119	$4,512	$658,741	$78,119	$971,491
2005	$276,089	$1,533	$685,474	$61,822	$1,024,918
2006	$348,648	$1,500	$664,722	$45,007	$1,059,877
2007	$374,492	$52	$651,908	$26,924	$1,053,376
2008	$408,250	$1,558	$604,348	$9,632	$1,023,788
2009	$389,170	$74	$682,271	$6,774	$1,078,288
2010	$400,284	$87	$822,907	$6,982	$1,230,260
2011	$466,585	$192	$888,944	$4,527	$1,360,248
2012	$566,268	$195	$798,346	$4,825	$1,369,633

Medicaid

This graph shows the direct correlation to the number of enrolled participants to the amount of money spent on Medicaid services.



Source Expenditures are from AKSAS Beneficiaries are from MMIS-JUCE data

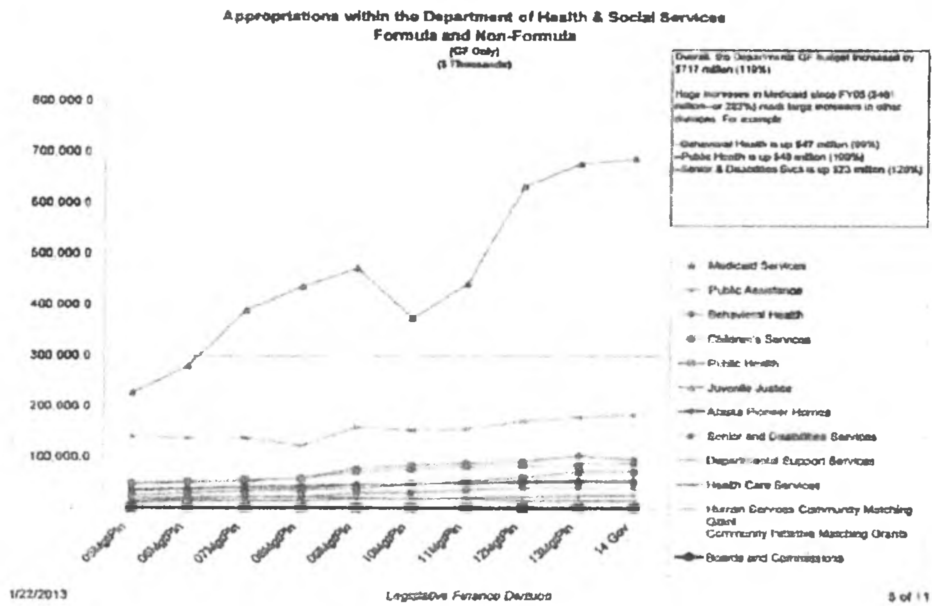
In 2007 and 2008 we had a decrease in the number of individuals enrolled in Medicaid, with the number of recipients who utilized services at 95% and 94% respectively. However, the most people utilizing services was in 2009 when expenditures jumped 5.05%. Enrollment began increasing again in 2010.

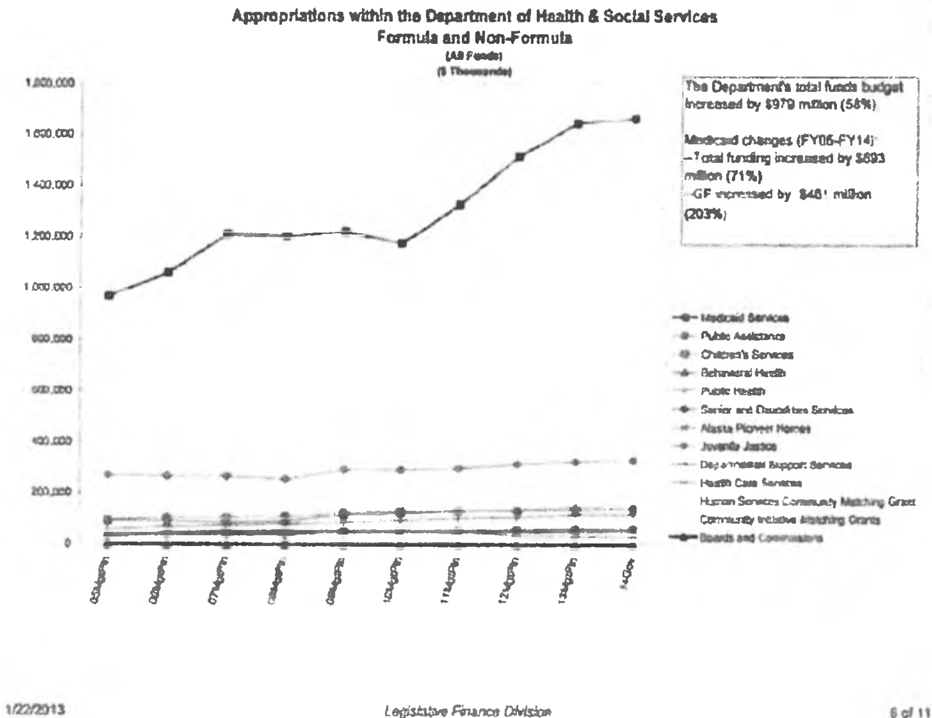
In 2012 we had the highest percent of the population enrolled in Medicaid with 92% utilizing services, but expenditures did not increase exponentially. Early reports for 2013 show an all time high percentage of recipients utilizing services.

We did have some successes in both Behavioral Health Medicaid and Health Care Services Medicaid where the amount spent per beneficiary decreased during 2012. Behavioral Health cost per beneficiary went from $12,041 to $11,613 (down 3.6%.) and Health Care Services' cost per beneficiary went from $5,428 to $5,315 (down 2.1%.) Following along with the population and enrollment indicators, Senior and Disability Services increased 2.7%. The spending in that component grew from $43,652 to $44,844 per beneficiary.

Medicaid

These charts from Legislative Finance show the spending in the Department by Division:





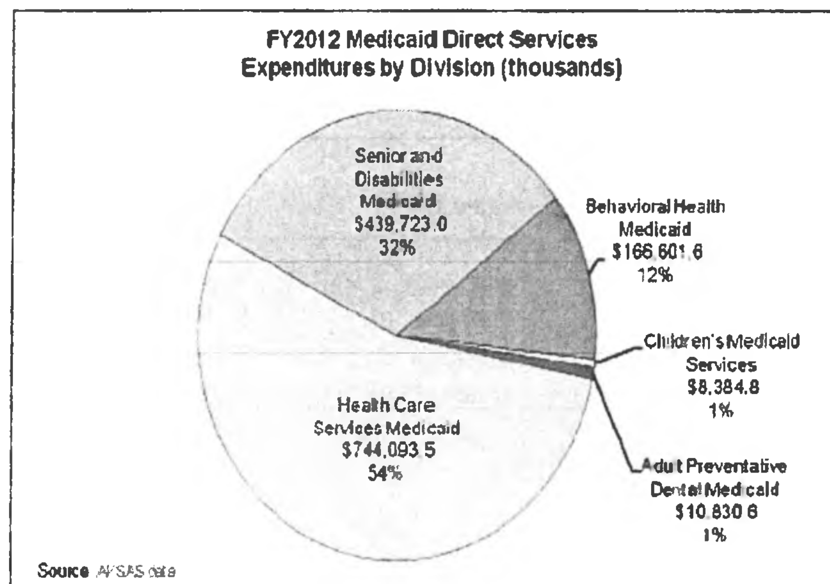
Medicaid

2012 Medicaid Spending:

Total Medicaid Direct Services	**$1,369,633.4**
Health Care Services Medicaid Services	**$744,093.5**
Hospital Services	**$298,932.0**
Physician Services	**$178,473.0**
Pharmacy Services	**$33,513.6**
Dental Services	**$52,169.5**
Transportation	**$64,443.8**
Other Medicaid Direct Services	**$54,184.9**
Non-MMIS Services	**$43,636.5**
Medicaid Financing	**$260.5**
Medicaid (State-only)	**$590.7**
Contracts (XEROX, Qualis, etc.)	**$17,888.9**
Adult Preventive Dental Medicaid	**$10,830.6**
Senior & Disability Services Medicaid	**$439,723.0**
Personal Care Services	**$117,672.7**
Nursing Homes	**$93,644.1**
Adults with Physical Disabilities Waiver	**$30,672.9**
Children with Complex Medical Conditions	**$12,386.9**
Intellectual & Developmental Disability Waiver	**$127,209.6**
Older Alaskan Waiver	**$57,836.3**
Other Services	**$300.5**
Behavioral Health Medicaid Services	**$166,601.6**
Residential Psychiatric Treatment Centers	**$36,330.8**
Inpatient Psychiatric Hospitals	**$19,495.5**
General Mental Health Services	**$106,748.0**
Psychiatric Residential Treatment Facility Waiver	**$2,475.4**
Medical Necessity Review Contract (Qualis)	**$1,551.9**
Children's Medicaid Services	**$8,384.8**
Behavioral Rehabilitation Services	**$5,184.4**
Behavioral Rehabilitation Services - BTKH	**$3,200.4**

Health Care Services had the largest share of the total budget at 54.33%. Senior and Disability Services was next with 32.11% and then Behavioral Health with 12.16%. The remaining 1.4% was split between Adult Preventive Dental and Children's Medicaid.

Medicaid



Long-term care is projected to be the fastest growing service category

MEDICAID SPENDING ON ***CLAIM PAYMENTS*** BY SERVICE GROUP FOR SELECTED YEARS (MILLIONS)

Service	2012	2017	2022	Annual Growth (2012-2022)
Behavioral Health	$162.41	$230.67	$325.23	7.2%
Long-Term Care	$432.66	$761.77	$1,282.49	11.5%
Primary Care	$789.27	$1,091.61	$1,430.65	6.1%
Total	$1,384.33	$2,084.04	$3,038.37	8.2%

Source: Medicaid Budget Group, MESA model.

Controlling Medicaid Spending in Alaska

There are four ways to control Medicaid spending. They are:

- Controlling Eligibility.
- Controlling covered services.
- Controlling what we pay for those services or products.
- Controlling how much or how often recipient access those services by controlling utilization.

Controlling Eligibility

Controlling cost through eligibility is difficult to do. We cannot eliminate or reduce eligibility categories from which we received funding from the American Recovery and Reinvestment Act (ARRA). The reality is that when we received enhanced funding under ARRA, a maintenance-of-

effort requirement was imposed on the states. This maintenance of effort has been extended until 2014 for adults and 2019 for children through the Affordable Care Act (ACA.)
Under the ACA, individuals are going to be required to have insurance coverage. If an individual does not already have insurance, they will be able to purchase it through a federally facilitated exchange using tax credits. In order to utilize these tax credits, the federal government had to change the eligibility standards for Medicaid to a tax-based system. Eligibility for Medicaid will now be done using a Modified Adjusted Gross Income (MAGI) method. What MAGI does is take away the income disregards that were previously allowed and it increases the amount of income that an individual or household can have with regard to eligibility determination. This increase in the poverty level is intended to make up for the disregards that have been taken away. This process standardizes the Medicaid eligibility methodology on a national level for the first time.

At this point in time, we are not able to control eligibility as it is dictated on a federal level. We had the same eligibility categories when we received ARRA funding that we do currently. We have not expanded Medicaid. The only way to do something different is through a special waiver program and that usually ends up expanding services.

Controlling Covered Services

Medicaid has mandatory and optional services:

Mandatory		Optional	
Inpatient Hospital	$176,983,680.00	MH rehab/Statilization	$33,838,750.88
Outpatient Hospital	$124,922,058.18	Diagnostic/screening Preventive	*
Physician Services	$178,710,292.37	Therapies (OP,PT,SLP)	$14,598,331.99
Nurse Midwives	*	Inpatient Psychiatry	$20,459,850.88
Lab and X-ray	$3,033,457.28	Drugs	$86,238,775.14
Advanced Nurse Practitioners	*	Intermediate Care Facility/Intellectual Disability	$977,887.54
EPSDT	$7,820,947.26	Personal Care	$126,703,236.75
Family Planning	$2,505,958.88	Dental	$50,911,789.01
Pregnancy-related services	*	Other Home Health	$378,347,848.17
Nursing Facility	$99,442,778.66	Other licensed practitioners	$7,570,164.84
Home Health	*	Transportation	$68,128,880.59
Medical/surgical dental	*	Targeted Case Management	$1,191,379.85
	$593,419,172.63		$788,966,895.64

** Additional analysis is needed to determine these costs*

Medicaid

Looking at a table like this seems to make it clear which services can be eliminated and those which cannot. One of the problems is that the elimination of an optional service results in a shifting of, or an increase in the cost to the mandatory services. For example, if you cut drugs (pharmacy) you will have more outpatient and emergency room visits as people may not be able to afford the therapies for chronic conditions. Another example is if you cut home and community based waivers, you end up with a population of approximately 2,500 people who have a demonstrated need for a nursing level of care, yet we only have 708 nursing home beds in the state. Keeping a beneficiary in his/her home costs about $40,000 per year while institutionalizing him/ her would cost over $100,000 per year. We use a balloon analogy to explain this cost shifting. If you poke the balloon on one side it bulges on the other.
We must fully analyze the effects of cutting any service: Will it shift costs to another category of service? Will it prevent other services from being utilized? Will someone or something else be able to fill the gap? These are a few examples that must be considered when making any changes, as well as the state's capacity to handle the workload caused by the change.
States are finding it hard to make changes because CMS will not approve changes if there is even a hint that there would be an impact to beneficiary access to necessary services. In May 2011, CMS issued a proposed rule stating that for any proposed change, they would require us to study access for each service category. We would have to study it for a year, then provide CMS with the data when we submit the proposed change. If we could not prove that there would not be reduced access, it is likely that the proposed change would not be approved.

Controlling what we pay providers to deliver those services or products

Controlling rates in Alaska is complex and more difficult than in other states. We constantly assess we are not impacting access in rural areas. This is one of our greatest challenges. If a reduction in reimbursement rates results in rural entities no longer being able to provide services to Medicaid recipients, then the cost shifts to transportation as beneficiaries will have to travel to a provider in a hub or urban area. This will likely increase costs in greater amounts than paying the providers a higher rate. We analyze the different providers and the rates they receive. Last year we cut the amount that was being paid to dialysis centers too much and ended up with clinics threatening to close their doors. In response, we increased the new rate to an amount that remained lower than the original reimbursement, but that was enough to ease the financial impact to the provider. We are moving all providers to a cost based rate structure or, if Medicare rates are available, to a Medicare adjusted rate.
Each provider community has their own advocacy group(s). These groups are very vocal and become actively involved in any regulation promulgation we offer. To help with changes going forward, Medicaid has partnered with several provider groups and contractors in an effort to find some kind of payment reform that will be acceptable to all.

Medicaid

Controlling Utilization

Utilization is the number and type of services a recipient is using. One way to control utilization is through the use of prior authorization of certain services. High cost Medical procedures such as radiological services are prior authorized, as are all home and community based waiver services. We contract with an entity who applies national standards to a particular procedure or category of service, especially in-patient hospital.

As well, each Medicaid division performs post-payment reviews, to review categories of service to analyze trends, look for new service types, etc. Our management information system also uses soft and hard claims processing edits to ensure that services are not inappropriately paid. For example, edits exists to ensure that we do not double pay for the same service on the same day for the same recipient. Edits prevent payment for a service that is inappropriate for a particular gender, or age of recipient. We incorporate new edits into the system frequently to maintain currency on healthcare changes and as service arrays.
This emphasis has been successful in reducing costs, and we are always analyzing for new opportunities. We continuously review other states' best practices and we employ the best of the best. We have learned about other states' methods for utilization control in pharmacy services, and areas like controls on accessing eyeglasses and durable medical equipment. We look closely at the order of billing for dental services including: How many surfaces are being billed? Has more than one service been billed for a single tooth repeatedly? We also have a surveillance utilization team that data mines and develops algorithms, looking for patterns to identify areas of potential improvement.

What we are doing to control costs now

Controlling costs in Medicaid is an on-going process. As you can see from the Medicaid Spending Section, we have turned the curve with processes that we have put in place. The following table contains initiatives that we have recently taken on to help control costs:

Div.	Initiative	Savings Method & Amount (Real, estimated, average, etc)	Barriers & Benefits
HCS	**Care Management/Case Management:** Begin case management of high utilizers of the Emergency Room and in-patient hospital stays.	**Method:** Cost Avoidance **Savings:** Est. $4.5 mil/yr	**Benefits:** Cost containment for high utilizers **Barriers:** Recipients are resistant to having case management. Takes away freedom of choice.
HCS	**Substitution to Generic Medication:** New regulations implemented in 2012 require use of generic medication whenever possible.	**Method:** Cost Avoidance **Savings:** Est. $7.5 mil/yr	**Benefits:** Results in decreased pharmacy costs **Barriers:** Recipients and some providers are resistant to generic medications.

Medicaid

HCS	**Psychiatric Medication Policy:** Putting limits on the amount of medication that can be prescribed without review.	**Method:** Cost Avoidance **Savings:** Est. $1.8 mil/yr	**Benefits:** Individuals are receiving a lower amount of psychiatric medication and are still having effective therapies. **Barriers:** Provider push back.
HCS	**Commercial Insurance Recoupment:** The new Medicaid Management Information System which goes online October 1, 2013 will reprice Medicare claims correctly to include the 2% fee reduction.	**Method:** Re-pricing/recoupment **Savings:** Est. $350k/yr	**Benefits:** Cost Savings **Barriers:**
HCS	**Imaging Prior Authorization:** Require prior authorization of high cost imaging.	**Method:** Cost Avoidance **Savings:** Unknown (began 3 months ago.)	**Benefits:** Lowering the number of high cost images that are prescribed **Barriers:** Pushback from providers that own their own imaging equipment.
HCS	**Pain Management Contract:** Began to review prescriptions for high utilizers of pain medications	**Method:** Cost Avoidance **Savings:** Unknown (began 7 months ago.)	**Benefits:** Lowering the number of prescriptions for pain medications. **Barriers:** Pushback from providers that overprescribe.
HCS	**Complete Affordable Care Act (ACA)-required enrollment and claims processing modifications to identify rendering providers on claims.** This will allow for improved editing and post-payment analysis for quality assurance/program integrity. It will allow the Medicaid program to identify the direct service providers and prohibit enrollment and service payment for any who have been sanctioned or, for other reasons, should not participate in the program.	**Method:** Post-payment recovery; cost-avoidance **Savings:** unknown	**Benefits:** The Alaska Medicaid program will be compliant with ACA rules. **Barriers:** The fiscal agent may challenge the additional enrollment work effort. Impacted divisions may challenge the need to enroll these rendering providers. Providers may object to the additional work effort to enroll their staff and accurately identify the renderer on claims.
HCS	**Complete ACA-required enrollment and claims processing modifications to identify referring/ordering/prescribing providers on claims.** This will allow for improved editing and post-payment analysis for quality assurance/program integrity. It will allow the Medicaid program to identify the direct service providers and prohibit enrollment and service payment for any who have been sanctioned or, for other reasons, should not participate in the program.	**Method:** Post-payment recovery; cost-avoidance **Savings:** unknown	**Benefits:** The Alaska Medicaid program will be compliant with ACA rules. **Barriers:** Providers will challenge the additional work effort to enroll their staff and accurately identify the referring/ordering/prescribing provider on claims. The fiscal agent may challenge the additional enrollment work effort.

Medicaid

HCS	**Complete the federal National Correct Coding Initiative (NCCI) mandate by including claims from Home and Community Based Agencies in NCCI editing.** Savings realized through application of NCCI edits to this provider type. Our current understanding of Enterprise MMIS NCCI editing is that these claims will automatically be included in the files sent to the NCCI editor.	**Method:** Cost-avoidance **Savings:** approx. $4 mil.	**Benefits:** Alaska Medicaid program will be fully compliant with the federal NCCI mandate. **Barriers:** HC providers may object to application of these edits to their claims.
HCS	**Health Care Services contracted Qualis Health during April 2013 to perform reviews and authorize medically necessary imaging (CT Scans, MRI, etc) requests.**	**Method:** Cost-containment **Savings:** First quarter savings was $92,019 with an annual estimated savings of $400k/yr.	**Barriers:** No barriers identified at this time. **Benefits:** The provider community has complied.
DBH	**Service Authorization Reviews.** Beginning in FY 13, DBH implemented a standardized clinical review process for all outpatient Behavioral Health Services requiring an authorization. Providers must submit clinical documentation to support the medical necessity and all requests are reviewed by behavioral health professional staff using the uniform clinical criteria.	**Method:** Cost-containment / Quality Improvement **Savings:** Behavioral Health cost per beneficiary went from $12,041 to $11,613 (down 3.6 %.) from FY11 to FY 12.	**Benefits:** Improved utilization control of services, insuring services are delivered based on documented need. **Barriers:** Providers have had to change operations. Increases demand on limited state staff resources.
DBH	**Integrated Site Reviews/Enhanced Technical Assistance/Program Integrity.** In FY 13, DBH implemented an integrated approach to review agencies approved as both grantees and Medicaid providers that are providing services as Community Behavioral Health Providers. The review is designed provide the agencies with a comprehensive report noting both areas of high quality and those in need of improvement. The division has increased its data mining efforts, reviews of clinical records for compliance and improved its collaborative efforts (with the Office of Program Integrity) to identify and recover overpayments	**Method:** Cost-containment/ Quality Improvement **Savings:** Too soon to determine.	**Benefits:** Improves Medicaid and grant oversight to maximize return on state funded programs. **Barriers:** Increases demand on limited state staff resources.

Medicaid

DBH	**Enhanced Quality Improvement.** The division has revised the focus of Residential Psychiatric Treatment Center (RPTC) site reviews to a focus on improving results. The site review tool and associated metrics have been updated to track agency performance both over time and across providers	**Method:** Cost-containment/ Quality Improvement **Savings:** Too soon to determine.	**Benefits:** The goals include reducing length of stay, reducing instances of restraint and seclusion, reducing cost per admission, improving patient satisfaction, improving quality of care, and reducing recidivism through use of high performing facilities. **Barriers:** Increases demand on limited state staff resources.
DBH	**Program/Regulation Changes.** Revision of program regulations to improve service delivery, simplify coverage rules and lower costs. Current efforts include: changes to Behavioral Rehabilitative Services implementing standardized assessment requirements and admission criteria; changes to Outpatient Behavioral Health Services clarifying coverage guidelines; and regulations governing the payment methodology for out-of-state inpatient psychiatric services.	**Method:** Cost-containment/ Quality Improvement **Savings:** Too soon to determine.	**Benefits:** Improved utilization control of services, insuring services are delivered based on documented need. **Barriers:** Providers have had to change operations. Increases demand on limited state staff resources.
DBH	**The Complex Behavior Collaborative (CBC).** The division continues to implement the CBC program focused on improving Alaska's services for high-risk Medicaid clients with complex needs and challenging behaviors who have strained the State's service delivery system.	**Method:** Cost-containment/ Quality Improvement **Savings:** Preliminary findings indicate that the utilization pattern of Medicaid services for clients completing this program is reduced by 64%.	**Benefits:** Populations served, are those that are seriously mentally ill (SMI), have an intellectual disabled (ID), developed Alzheimer's/dementia or related disease (ADRD), sustained a traumatic brain injury (TBI) and are at risk for out-of-state placement, moving to a higher level of care, frequently hospitalized or institutionalized and use multiple high-level resources. **Barriers:** Providers have had to change operations. Increases demand on limited state staff resources.
DSDS	**Consumer Assessment Tool/Electronic Consumer Assessment Tool.** In conjunction with regulation changes, DSDS implemented an improved, electronic assessment tool used for waivers and personal care services.	**Method:** Cost-containment **Savings:** Too soon to determine.	**Benefits:** Allows assessors and reviewers to work more efficiently and provides for more accurate, objective calculation of authorized service amounts.. **Barriers:** Lack of staff resources to serve as subject matter experts, recipient and advocates resistance to changes that result in decrease in eligibility or services.

Medicaid

DSDS	**Material Improvement Review**. DSDS has made substantial improvements to the Material Improvement Review process, which is used when individuals no longer meet the institutional eligibility criteria for waivers.	**Method:** Cost-containment **Savings:** Too soon to determine.	**Benefits:** By streamlining and standardizing the process, DSDS has able to reduce the amount of decisions overturned at fair hearing and enforce appropriate determinations. **Barriers:** Recipient and advocates resistance to changes that result in decrease in eligibility.
DSDS	**Medicaid Home and Community-Based Waivers Regulations.** DSDS recently implemented new waiver regulations with several changes designed to ensure efficient use of Medicaid funding and services. These changes include limited the use of day habilitation services for individuals living in group habilitation homes.	**Method:** Cost-containment **Savings:** Too soon to determine.	**Benefits:** avoid duplicative payment for services; moving to different payment rates for individual and group settings for adult daycare, day habilitation, and supported employment. **Barriers:** Providers may be reluctant to alter plans of care to reflect new requirements.

Medicaid

In addition to what we have already identified, we are committed to implementing the following initiatives in FY14:

Div.	Initiative	Savings Method & Amount (Real, estimated, average, etc)	Barriers & Benefits
HCS	**Commercial Insurance Recoupment:** Currently, we only recoup for Inpatient claims. We will expand this effort to include recouping for outpatient facility claims (claim type 3)..	**Method:** Recoupment **Savings:** Estimated $410k/yr	**Benefits:** Cost containment **Barriers:**
HCS	**Expand Claim Check editing to apply to Physical Therapy, Speech Therapy and Occupational Therapy claims.** Apply Claim Check rules to claims from these provider types.	**Method:** Cost-avoidance **Savings:** unknown	**Benefits:** The Alaska Medicaid program will realize savings from inappropriate coding. **Barriers:** This will cause claims that paid in the past not to be paid in the future. Providers will be upset.
HCS	**Using a cost-based rate system for Medicaid Waiver services and Personal Care Attendant Services.** The Department has been working since 2009 to transition from a budget-based rate calculation system to a more accurate cost-based system. Cost-based rates are set to go into effect starting January 1, 2014 for home and community based (HCB) waiver services and Personal Care Attendant (PCA) services.	**Method:** Cost-avoidance **Savings:** Budget impact is unknown at this time.	**Benefits:** To tie Medicaid payments to the actual costs of providing HCB waiver services and PCA services in the state. This will result in more uniform and accurate rates, which in turn, supports the efficient use of Medicaid dollars. **Barriers:**
HCS	**Disproportionate Share Hospital (DSH) Overpayment Recoupments.** The Department is nearly finished adopting regulations that will allow it to procedurally recoup any DSH overpayments made to hospitals.	**Method:** Recovery **Savings:** unknown	**Benefits:** The Department will be in compliance with federal law and ready to ensure that public funds are being spent correctly and efficiently. **Barriers:**
HCS	**Implement a Quality Assurance Section.** This section will be responsible to go through claims and find trends in billing practices, services, etc. .	**Method:** Recovery **Savings:** Unknown	**Benefits:** Be able to recover on erroneous payments, provide better provider education. **Barriers:** Capacity

Medicaid

HCS	**Improve monitoring and collecting provider negative balances. Some providers avoid repaying a negative balance by discontinuing service to Medicaid patients.** Providers that have not repaid a negative balance by the agreed upon date will be referred to Program Integrity for collection.	**Method:** Recovery **Savings:** Estimated $1 mil/yr	**Benefits:** Low impact to the provider and recipient community. **Barriers:** Capacity
HCS	**DJJ Medicaid.** Enroll providers providing services into a state only Medicaid program so that when appropriate we can claim any funds spent and get 65% federal match.	**Method:** Cost-avoidance **Savings:** Estimated $10k /yr	**Benefits:** The state will be paying Medicaid rates which are lower than the current billed charges. Children will have Medicaid coverage upon release. **Barriers:** Some of the current providers do not want to accept Medicaid.
HCS	**Indian Health Service Mid-level renderer billing issues.** Midlevel services are not to be billed in addition to outpatient facility service.	**Method:** Recovery **Savings:** Estimated $2,500,000	**Benefits:** **Barriers:** Pushback from provider - will take 1.5 years to finalize
HCS	**DME Higher Allowable Requests (using the current rates).** We are in the process of transitioning the Prior Authorization (PA) requests for higher allowable pricing from the initial PA request for medical necessity, or as a preemptive PA, to a PA with the claim adjustment.	**Method:** Cost-containment **Savings:** min.$1 mil/per yr.	**Benefits:** The number of higher allowable requests has increased over the past several years and it is imperative that if we are approving the payments we are at least using the provider's current acquisition cost and not an inflated estimate. **Barriers:** Some resistance from the fiscal agent and providers.
HCS	**Durable Medical Equipment (DME) Coverage and Payment Revisions. Coverage:** We are moving towards a capped rental model like Medicare switched to in 2006. The primary changes in the coverage section will be that creams, ointments, and lotions will be covered according to the pharmacy regulations and we would no longer pay for over the counter moisturizing creams. Diaper wipes and disposable washcloths will also be eliminated from coverage.	**Method:** Cost-containment/Cost-avoidance **Savings:** . It would be fair to expect at least $1-2 mil/yr in savings but additional savings are very likely	**Benefits:** **Barriers:**. The coverage and payment regulations have been drafted in order to bring the program into compliance and to keep Medicaid paying adequate and appropriate rates.

Medicaid

DBH	**Early Childhood Behavioral Health Services.** The department is working to revise the coverage guidelines and services provided to young children. The goal is to identify at-risk children early and provide them with low cost intervention services targeted to meet their specialized needs and prevent behaviors and treatment costs from escalating.	**Method:** Cost-containment/ Quality Improvement **Savings:** Anticipate cost reductions based on benefits gained from early intervention.	**Benefits:** Early identification and intervention results in lower costs and improved quality. **Barriers:** This requires major system changes for providers and the state (MMIS, regulations, training, supports)
DSDS	**Telehealth Assessment.** DSDS is implementing a pilot project to conduct waiver and personal assessments and reassessments by video conference.	**Method:** Cost-containment **Savings:** At the end of the first year, we can compare travel/accommodation costs with previous years.	**Benefits:** Reduced travel and staff expenditures, more timely assessments and reassessments. **Barriers:** Minimal barriers anticipated.
DSDS	**ADRC Pilot.** DSDS is about to implement a three year pilot for Aging and Disability Resource Centers (ADRC) to better guide individuals to the most appropriate services.	**Method:** Cost containment **Savings:** At the end of the first year, we can evaluate the reduction in assessment costs.	**Benefits:** More accurate screening, improved quality of referrals for services, reduced assessment costs. **Barriers:** Care coordinators and providers may resist altering traditional intake processes.

For FY 2015 and beyond we have already identified the following initiatives:

Div.	Initiative	Savings Method & Amount (Real, estimated, average, etc)	Barriers & Benefits
HCS	**Implement transportation broker to manage, monitor, review and validate individual travel requests.** Broker would be responsible to identify lowest cost provider available and combine more-than-one recipient travel to local provider whenever possible. Broker to confirm that travel benefit coincided with health care episode. Broker to confirm that travel benefit coincided with health care episode.	**Method:** Cost-containment **Savings:** Anticipated cost savings of $2.5 - 4 mil in the first 5 years of implementation	**Benefits:** Broker would be responsible to identify lowest cost provider available and combine more-than-one recipient travel to local provider whenever possible. **Barriers:** Transportation broker could be high impact to recipients and providers.

Medicaid

DBH	**Acuity and Rate Adjustment Methodology Project.** The division continues to work with the DHSS Office of Rate Review to incorporate acuity adjustment strategies into the rate setting process This will influence service delivery resulting in fewer more inappropriate services being delivered and lowering costs.	**Method:** Cost-containment/ Quality Improvement **Savings:** It is anticipated future analysis will indicate productive trends.	**Benefits:** . This will result in a standardized methodology for all treatment grantees to establish the acuity and severity of need for services that are aligned with actual costs of service delivery. **Barriers:** This is a significant systems change and will challenge current state staffing resources.
DSDS	**Automated Service Plan.** DSDS is developing an Automated Service Plan system to support DSDS program functions. This system will build upon the existing electronic case management system to allow DSDS to support many more business processes with automation and increase efficiency of operation in the face of growing program demand.	**Method:** Cost containment **Savings:** unknown	**Benefits:** Streamlined operational processes will improve quality of work and facilitate provider interaction with the Division. **Barriers:** Lack of staff resources to serve as subject matter experts.

Fraud

Medicaid Fraud is generally categorized as either Recipient or Provider Fraud. Two state agencies coordinate Medicaid ***Recipient*** fraud investigation:

1. The Department of Health and Social Services, Division of Public Assistance, Fraud Control Unit, and
2. The Department of Law, Office of Special Prosecutions and Appeals, Welfare Fraud Section

Medicaid ***Provider*** Fraud is investigated by the Alaska Medicaid Fraud Control Unit (MFCU) within the Department of Law. The DHSS and MFCU operate together under a Memorandum of Understanding which helps to provide for effective law and program enforcement, and increased efficiency to the state. The following points focus primarily on Provider fraud.

- In general, fraud occurs when a provider submits a claim for payment to Medicaid when the provider knows, or should know, they are not entitled to the payment. While health care fraud can take many forms, the most common involves billing for services not performed or billing for more expensive services than those actually provided. Medicaid patients may not suspect fraud, as they are seldom made aware of the procedures or dollar amounts billed to Medicaid. An unscrupulous provider can generate a fraudulent Medicaid payment simply by filing a false claim with an eligible recipient's identification number and a valid procedure code.

Medicaid

- Fraud referrals come from a variety of sources including providers, recipients, the DHSS fiscal agent (Xerox), DHSS program personnel, results from contracted audits and other sources. Both Xerox and the Medicaid Fraud Control Unit operate Fraud Hotlines.

- Xerox also routinely mails statements to Medicaid recipients in order to verify that the services billed by providers were indeed received by the beneficiary.

Once a complaint or fraud referral is made, essential information regarding the complaint is organized and reviewed. A Preliminary investigation is conducted by the Department to determine if a credible allegation of fraud exists. If a credible allegation of fraud exists, the case is referred to the MFCU for investigation. MFCU will accept and work the case, frequently gathering information from the DHSS in the process. If the case is referred back to the department, DHSS will pursue administrative remedies such as recovery of overpayments.

Erroneous billing by providers that is not fraudulent is the most common cause of loss and may account for the greatest financial loss to the Medicaid program. Program losses also result from innocent errors or lack of understanding.

Metrics

The relative success of any fraud control program is extremely difficult to measure. Metrics currently in use around the country, while meaningful have limitations and drawbacks as a measure of fraud control. Common Metrics include number of cases prosecuted, convictions, and amount of restitution ordered.

For FFY 2013, to date, the MFCU charged 53 cases. Thirteen cases have resulted in convictions from guilty pleas. The Alaska Medicaid Fraud Control Unit expects 63-68 cases prosecuted by the end of Federal Fiscal Year (FFY) 2013:

- Of the 53 cases, 13 Fraud resulted in convictions to date
- 29 cases were filed for criminal cases on July 9, 2013
- 11 cases are pending at this time
- Assault- 1 case (from above)
- Failure to Report Harm-2 cases (from above)

In addition to the metrics tracked specifically for fraud cases, other related metrics tracked by DHSS include: Number of audits conducted, Amount of overpayments identified, Overpayment recoveries The wide variety in state Medicaid programs size, structure and staffing contribute to the difficulty in making side by side comparisons of fraud control efforts. Due to Alaska's remoteness and relatively small size, we have not seen some of the most sophisticated fraud schemes that are present in our largest state.

Medicaid

Conclusion

We believe that our new Medicaid Management Information System (MMIS), which will go live on October 01, 2013, will provide us with many more ways to ensure compliance and provide us with the reports needed to track utilization and spending. In the past year we have been doing more outreach with our providers and will continue to do so in the future.

We know that there are more ways to find efficiencies and continue to explore for best practices. We have described the efforts that we have made this past year and those that are currently proposed. There are a lot of options for savings, from requiring prior authorization for all non-emergent medical appointments to ensuring that Medicaid is not duplicating something that another program such as Women, Infants, Children (WIC) program should. We will ensure a proper analysis of all changes to determine what the impact would be on our recipients, our providers, our contractors, and also to assess our own capacity to implement. This is an exciting time to be part of Medicaid and we look forward to working with you to ensure cost containment in our programs.

THE STATE of ALASKA

GOVERNOR SEAN PARNELL

Department of Health and Social Services

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August 13, 2013

Senator Pete Kelly
Co-Chair, Senate Finance Committee
State Capitol, Room 516
Juneau, Alaska 99801-1182

Dear Senator Kelly:

At long last, I am responding to your letter of May 31, 2013 requesting preliminary reports on Public Assistance and Medicaid programs' potential cost-savings. I thank you for the opportunity, as I believe we are at work aggressively and innovatively addressing the growth of entitlement programs in Alaska.

For the Division of Public Assistance in Attachment 1, we identify the programs that we manage as well as the number of individuals that we serve. We then detail the different programs and the funding sources for each. We close by detailing how we save approximately $5.8 million per year through efficiencies and fraud control activities. In addition, we have generated performance bonuses that have increased federal revenues by another $1.0M. Attachment 1a breaks down the number of recipients served by each program; the benefits issues; the criteria to participate in the programs, and applicable Federal and/or State regulations directing each program.

For Medicaid in Attachment 2, we provide an Introduction and explanation of the categories of service that individuals can receive. "Medicaid" is not housed in just one division in the State of Alaska, but rather crosses five divisions. Three divisions provide services (Behavioral Health, Health Care Services and Senior and Disability Services) and one division (Public Assistance) determines the eligibility for the programs. The report begins by showing the demographics of the population served as well as the spending by fund source, service category and the enrollment statistics over time. The report continues with details about optional and mandatory services; the four ways that we could control Medicaid spending in Alaska, and those options that may be feasible in our state. We have included specifics that show our current savings of approximately $21.2 million annually; how we intend to save an additional $16 million this year, and how in FY 2015 we already have plans to implement projects that will save an additional approximately $5 million per year, all of which offset the annual cost increases for publically paid healthcare in Alaska. These savings are not one-time savings; they build upon each other year after year and serve to offset additional costs related to enrollment, rate and utilization increases .

As you can see from these reports, we have and will continue to find cost savings in all of our program areas. We look forward to your continued interest and partnership with us to further contain costs in these programs.

Sincerely,

William J. Streur
Commissioner

A Discussion of Retirement Systems in Alaska

Senate Finance Committee
November 2013

David Teal, Director
Legislative Finance Division

Are Alaska's Public Employee Retirement Systems Healthy?

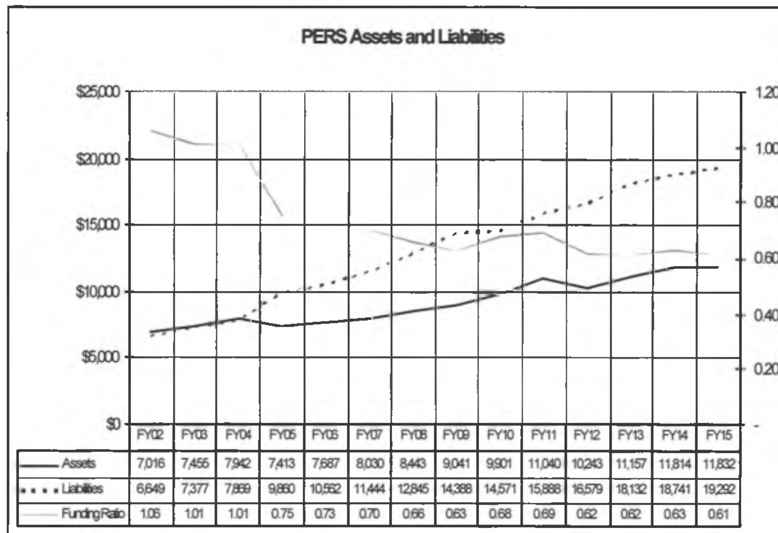
If not, what can be done about it?

System Health refers to the likelihood that promised benefits will be paid when due.

- **Defined Contribution (DC) Plans**
  - No promised benefit level
  - So no measure of health required
- **Defined Benefits (DB) Plans**
  - Promised benefits (pensions)
  - So it is it critical to track and maintain system health

Measuring the Health of a Retirement System

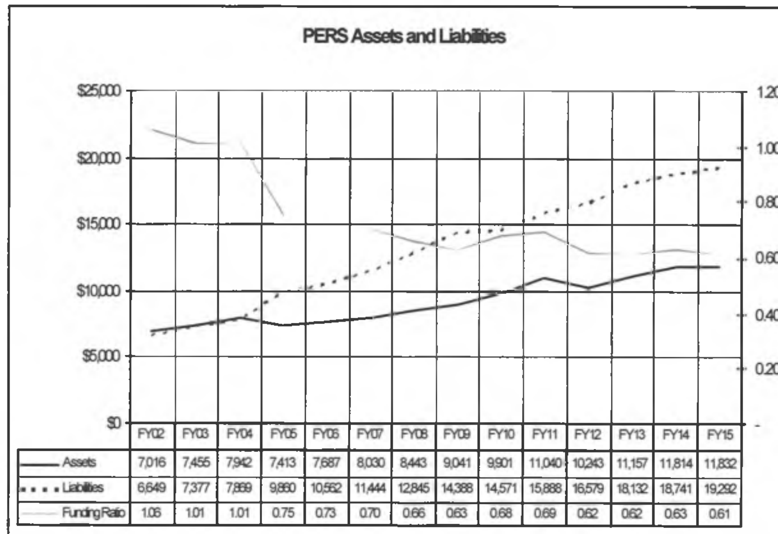
1. **Funding Ratio = Assets/Liabilities.**
2. **Unfunded Liability—just a dollar amount; not a relative measure.**
3. Are employers paying the actuarially required contribution (ARC)?
4. Are contributions causing financial stress?



	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
Assets	7,016	7,455	7,942	7,413	7,687	8,030	8,443	9,041	9,901	11,040	10,243	11,157	11,814	11,832
Liabilities	6,649	7,377	7,869	9,860	10,562	11,444	12,845	14,388	14,571	15,888	16,579	18,132	18,741	19,292
Funding Ratio	1.06	1.01	1.01	0.75	0.73	0.70	0.66	0.63	0.68	0.69	0.62	0.62	0.63	0.61

Unfunded Liability is the Consequence of Assumptions that Fail to Materialize

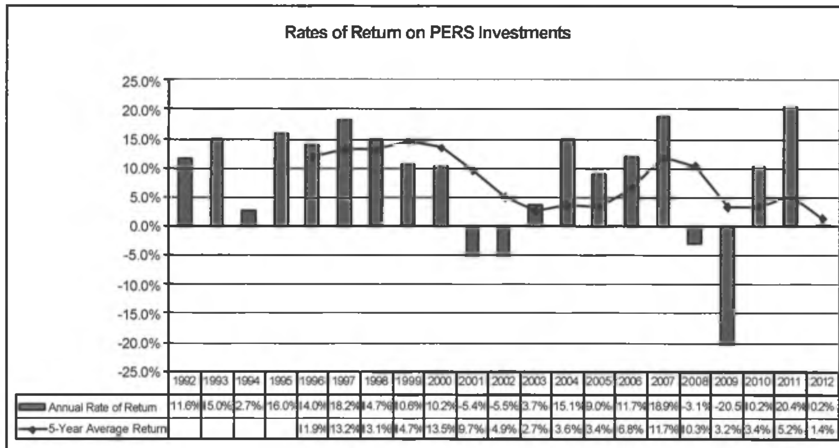
- **Benefits may exceed expectations.** (Liability increases)
- **Contributions or earnings may be less than anticipated.** (Assets fail to increase as expected)



	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15
Assets	7,016	7,455	7,942	7,413	7,687	8,030	8,443	9,041	9,901	11,040	10,243	11,157	11,814	11,832
Liabilities	6,649	7,377	7,869	9,860	10,562	11,444	12,845	14,388	14,571	15,888	16,579	18,132	18,741	19,292
Funding Ratio	1.06	1.01	1.01	0.75	0.73	0.70	0.66	0.63	0.68	0.69	0.62	0.62	0.63	0.61

How Volatility of Investment Returns Affects Unfunded Liability

		Assets	Liability	Unfunded Liability	Funding Ratio	Contribution Rate
Year 1 Start		$ 12,000	$ 12,000	$ -	100.0%	
Benefits Payments		$ (1,000)	$ (1,000)			
Net		$ 11,000	$ 11,000			
Accrued Liability			$ 1,350			
Earnings	8.0%	$ 920				
Contributions (set in advance)		$ 430				17.9%
Year 1 End		$ 12,350	$ 12,350	$ -	100.0%	
Year 2 Start		$ 12,350	$ 12,350	$ -	100.0%	
Benefits Payments		$ (1,000)	$ (1,000)			
Net		$ 11,350	$ 11,350			
Accrued Liability			$ 1,37[illegible]			
Earnings	8.0%	$ 948				
Normal Contributions		$ 430				17.9%
Past Service Contributions		$ -				0.0%
Year 2 End		$ 12,728	$ 12,728	$ -	100.0%	17.9%
Change in UL				$ -		



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Annual Rate of Return	11.6%	15.0%	2.7%	16.0%	14.0%	18.2%	14.7%	10.6%	10.2%	-5.4%	-5.5%	3.7%	15.1%	9.0%	11.7%	18.9%	-3.1%	-20.5	10.2%	20.4%	0.2%
5-Year Average Return					11.9%	13.2%	13.1%	14.7%	13.5%	9.7%	4.9%	2.7%	3.6%	3.4%	6.8%	11.7%	10.3%	3.2%	3.4%	5.2%	1.4%

Take-away Points Regarding Earnings

1. Earnings are volatile and unpredictable.
2. Small variations can be addressed by smoothing, amortization and good fortune.
3. When variations are small, unfunded liability is a soft liability that can be repaid with earnings (rather than contributions).
4. The road to recovery from large losses can be very long—so long that the system may appear to be broken.
5. The system is unlikely to stay broken in the long-run.
6. If you pay what you owe, the system will fix itself.
7. As time passes, assumptions are replaced with reality.

Measuring the Health of a Retirement System

1. Funding Ratio = Assets/Liabilities.
2. Unfunded Liability—just a dollar amount; not a relative measure.
3. **Are employers paying the actuarially required contribution (ARC)?**
4. Are contributions causing financial stress?

ARM Board Proposals

- Cash infusion of $1 billion to PERS and $1 billion to TRS.
- Adopt the level dollar amortization method in order to accelerate contributions.

Amortization Methods

- ***Level percent of pay*** amortization applies a constant contribution rate over the amortization period. Use of this method is near universal and is currently used in Alaska.

- ***Level dollar*** amortization splits unfunded liability into equal payments over the amortization period, much as for a standard home mortgage. Relative to the level percent method, payments to eliminate unfunded liability will be higher in the early years, and contribution rates required to generate level dollar payments will decline over time. Because the level dollar method has larger payments in the early years, it is sometimes referred to as "front loading."

The ARMB Proposals: Questions to Consider

1. Are the proposals necessary?
2. Does the path to full funding matter?
3. Are the proposals affordable?

Annual State Assistance Savings from $2 Billion Cash Injection (vs. Status Quo) (PERS Only)
(in $000)

Discount Rate: 0%

Years From Present	Year	Baseline State Assistance (Level Dollar and 8% Return)	Discount Multiplier	Discounted Baseline Assistance	State Assistance (Baseline plus $250 million in FY14-FY17)	Savings over Baseline Scenario	Cumulative Savings over Baseline Scenario
0	FY14	319,456	1.00	319,456	569,456	(250,000)	(250,000)
1	FY15	519,676	1.00	519,676	769,676	(250,000)	(500,000)
2	FY16	572,439	1.00	572,439	815,639	(243,200)	(743,200)
3	FY17	576,925	1.00	576,925	787,294	(210,369)	(953,569)
4	FY18	563,734	1.00	563,734	486,636	77,098	(876,471)
5	FY19	566,220	1.00	566,220	446,414	119,806	(756,665)
6	FY20	549,597	1.00	549,597	397,960	151,637	(605,028)
7	FY21	530,984	1.00	530,984	372,455	158,529	(446,499)
8	FY22	511,130	1.00	511,130	348,993	162,137	(284,362)
9	FY23	490,148	1.00	490,148	327,713	162,435	(121,927)
10	FY24	469,924	1.00	469,924	307,485	162,439	40,512
11	FY25	449,483	1.00	449,483	287,253	162,230	202,742
12	FY26	429,310	1.00	429,310	267,492	161,818	364,560
13	FY27	407,509	1.00	407,509	245,981	161,528	526,088
14	FY28	384,751	1.00	384,751	224,501	160,250	686,338
15	FY29	360,954	1.00	360,954	201,123	159,831	846,169
16	FY30	10,870	1.00	10,870	-	10,870	857,039
17	FY31	-	1.00	-	-	-	857,039
18	FY32	-	1.00	-	-	-	857,039

Measuring the Health of a Retirement System

1. Funding Ratio = Assets/Liabilities.
2. Unfunded Liability—just a dollar amount; not a relative measure.
3. Are employers paying the actuarially required contribution (ARC)?
4. **Are contributions causing financial stress?**

What Fiscal Stress???

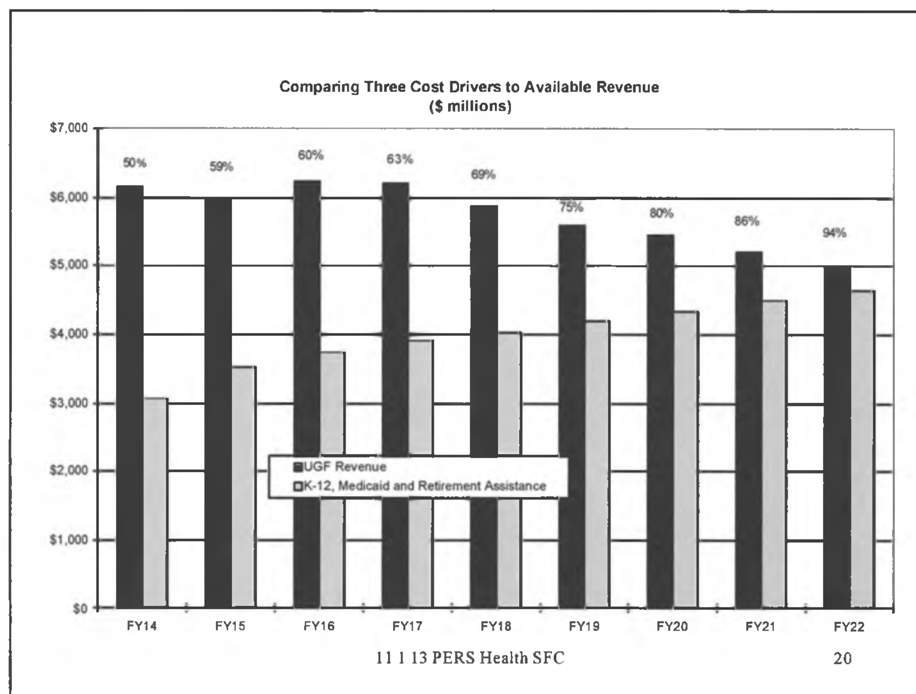
- The state may be paying too much into retirement plans, but it is better to choose to pay when we can afford it than be forced to pay when we cannot afford it.
- When budget surpluses turn into deficits, we can work to reduce state costs.
- Until then, state contributions reduce the magnitude of the future fiscal problem.

Books, Bonds and Budgets

- **Accountants**: Must report net pension liability on the balance sheet.
- **Rating Agencies**: Use a common set of assumptions to make system health comparable.
- **Legislators**: GASB no longer provides guidance.

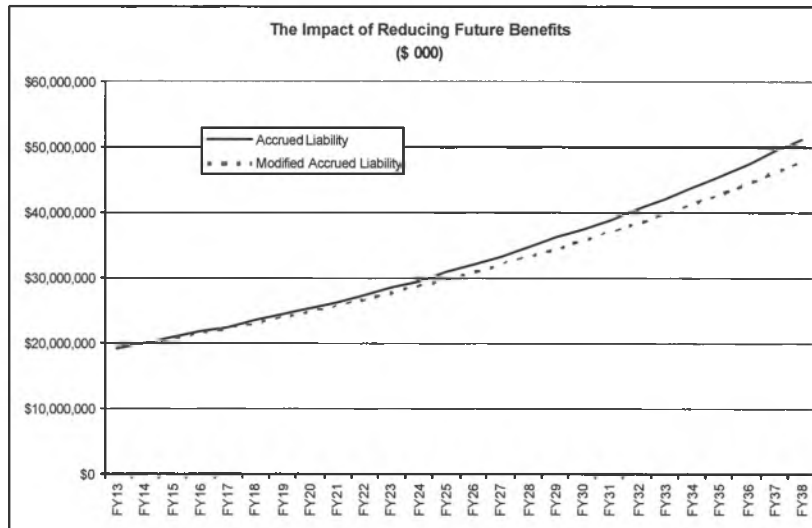
Advice from a National Pension Funding Task Force

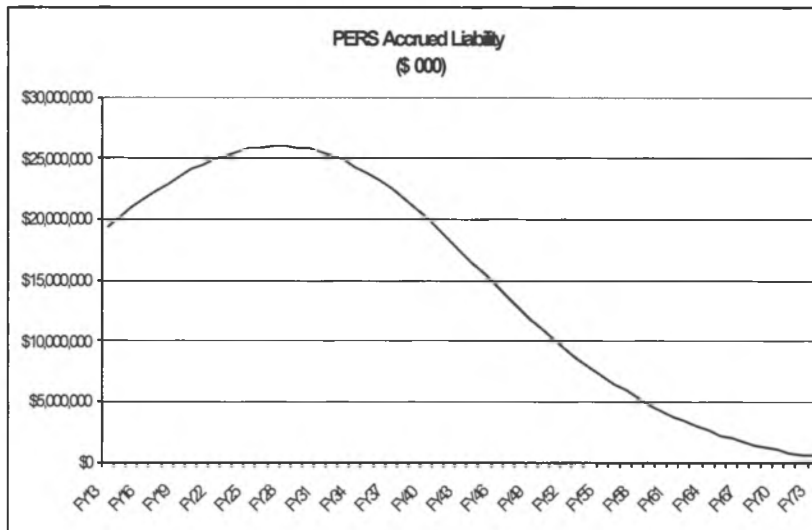
- **Put funding guidelines in statute.** Describe computation of the ARC (Annual Required Contribution). Show the plan to bring the system to full funding.
- The numeric approach offers sound guidance, but the funding ratio and other actuarial measures are not the most important measure of system health. **What really matters is what is affordable.**



What Other States Have Done to Improve Retirement System Health

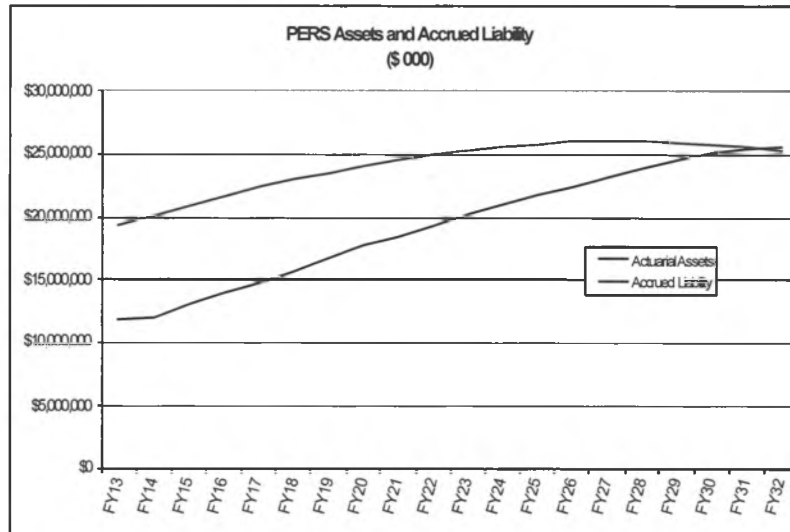
1. Increase Assets
   - Increase employee contributions
2. Reduce Benefits
   - Raise the retirement age
   - Increase service requirements
   - Reduce post-retirement adjustments
   - Adopt hybrid plans





A National Task Force Recommends that Pension Funding Policies:

1. Be based on actuarially determined contribution rates—and the calculation of rates should be in statute so the plan is clear to employees, retirees, administrators, boards, and legislators.
2. Collect a consistent percentage of payroll—use the Level Percent of Pay amortization method.
3. Be disciplined—to ensure that promised benefits can be paid (i.e., pay the ARC).
4. Maintain intergenerational equity (i.e., the cost of benefits should be paid by the generation of taxpayers that were served by the employees who earned those benefits).
5. Require clear reporting to show how and when plans will be fully funded and the progress toward that goal.

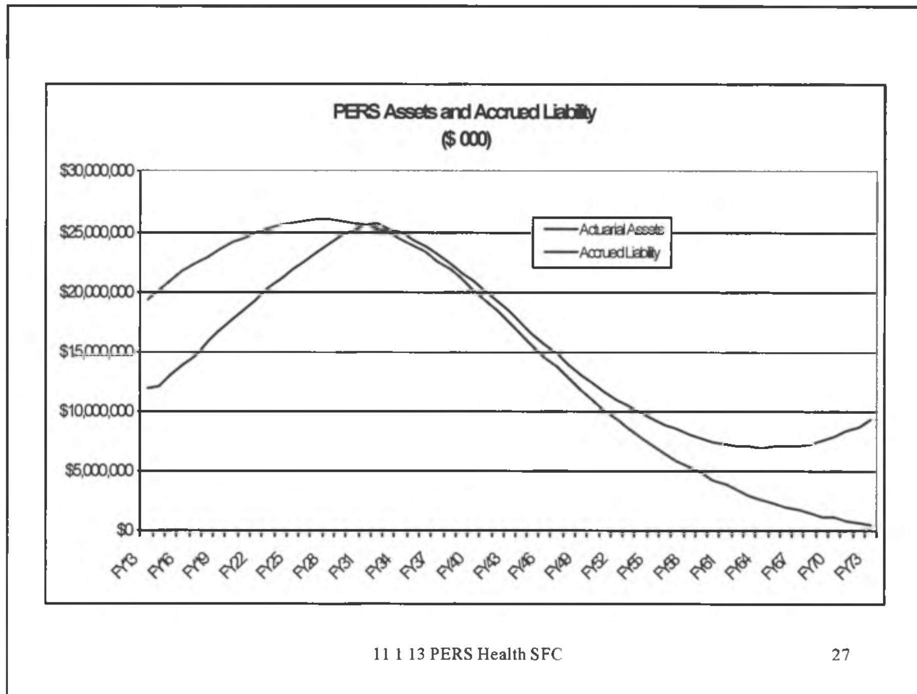


What is the Goal?

and

What Options Might Achieve It?

Goal: a healthy system—meaning a system with a plan to eliminate unfunded liability in a reasonable time at an affordable cost.



Recommendation: Reconsider an Approach like that in SB 187

- A cash infusion sufficient to maintain system health while capping employer contributions at 22%.
- No more state assistance—saving approximately $500 million annually for 15 years.

Public Employee Retirement System (PERS)
Teachers Retirement System (TRS)

FALL 2013 UPDATE

Deputy Commissioner Mike Barnhill

Department of Administration

PERS / TRS Basic Facts Organization

PERS / TRS Basic Facts Membership

MEMBERSHIP STATISTICS AS OF JUNE 30, 2013

	PERS					TRS				JRS	NG	SBS	DCP
	DB			DC		DB		DC					
	Tier I	Tier II	Tier III	Tier IV	TOTAL	Tier I	Tier II	Tier III	TOTAL				
Active Members	3,313	5,864	12,299	14,795	36,271	1,197	5,661	3,735	10,593	72	n/a	28,245	7,642
Terminated Members	2,417	5,274	11,337	6,495	25,523	542	2,615	1,276	4,433	4	n/a	13,415	2,568
Retirees & Beneficiaries	22,941	5,142	1,608	4	29,695	10,290	1,098	-	11,388	110	657	n/a	n/a
Managed Accounts	n/a	n/a	n/a	6,748	6,748	n/a	n/a	1,783	1,783	n/a	n/a	900	834
Retirements - 4th QTR FY13	259	164	109	n/a	532	22	16	n/a	38	-	42	n/a	n/a
Full Disbursements - 4th QTR FY13	38	26	117	350	531	7	24	39	70	0	n/a	639	154
Partial Disbursements - 4th QTR FY13	n/a	n/a	n/a	28	28	n/a	n/a	4	4	n/a	n/a	433	447

Source: Div. Retirement & Benefits

STATE OF ALASKA

PERS / TRS Basic Facts
Defined Benefits

Defined Benefit Pension: fixed benefit amount from date of retirement to death

Contributions + Investment Earnings = Benefits + Expenses

IF

All actuarial assumptions are accurate

Actuarial Assumptions:

Inflation, Investment Return, Mortality, Date of Retirement, Cost of Healthcare, Payroll Growth, Disability, Spouse Age, Dependent Children, COLA, Plan Expenses, Turnover

Inaccurate Projections Lead to Unfunded Liability

Employer Takes the Risk

STATE OF ALASKA

PERS / TRS Basic Facts
Contributions – Employee

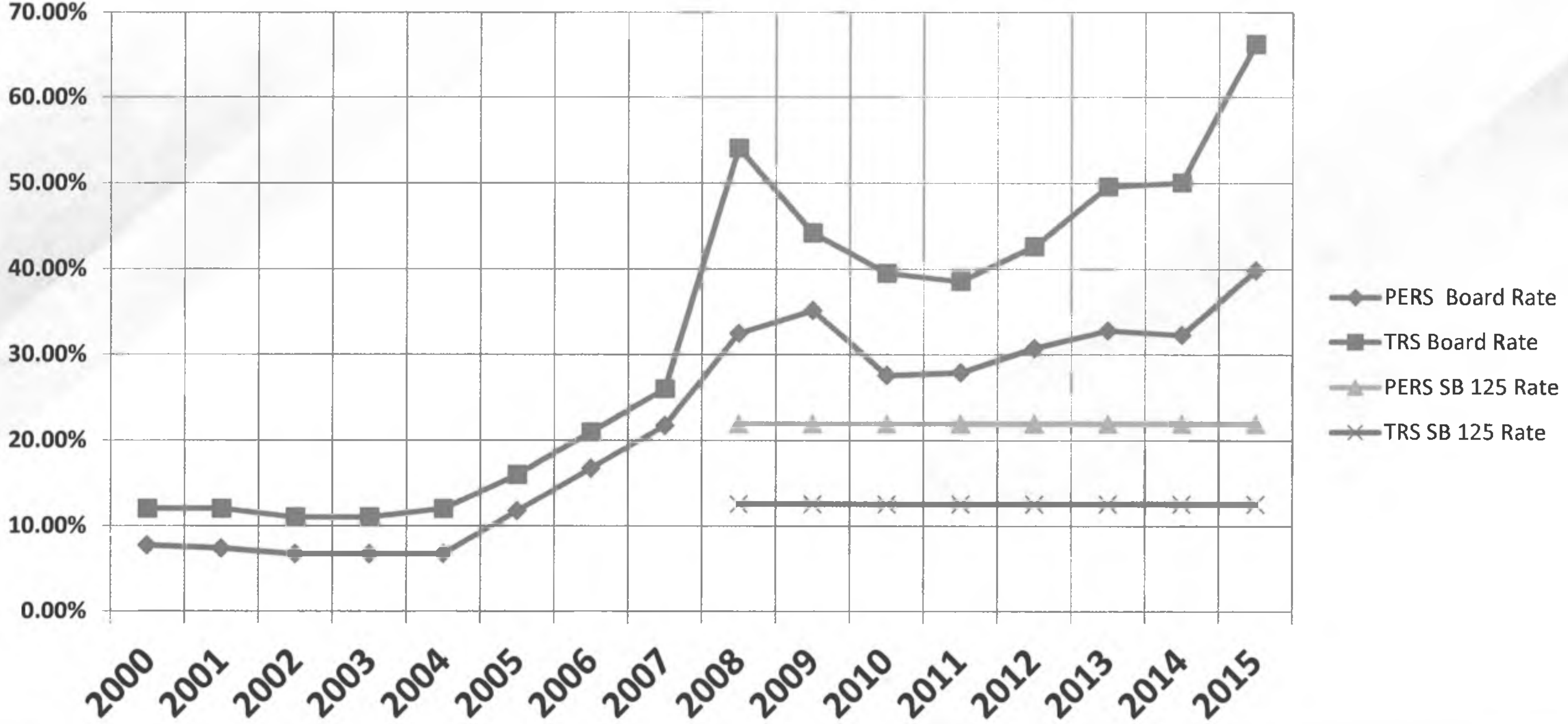
C + I = B + E

PERS Other Employee Contribution Rate:	6.75%
PERS Police / Fire Employee Contribution Rate:	7.5%
TRS Employee Contribution Rate:	8.65%

STATE OF ALASKA

PERS / TRS Basic Facts
Contributions – Employer

C + I = B + E



STATE OF ALASKA

PERS / TRS Basic Facts
Investment Returns

C + I = B + E

ARM Board Annualized Returns Through FY 2013			
Annualized Returns	PERS	TRS	Average
29 year	9.07%	9.43%	9.26%
25 Year	8.12%	8.13%	8.12%
20 year	7.27%	7.30%	7.29%
15 Year	5.43%	5.47%	5.45%
10 Year	6.94%	6.99%	6.97%
5 Year	3.92%	3.98%	3.95%
3 Year	11.05%	11.15%	11.10%
1 Year	12.50%	12.59%	12.55%

STATE OF ALASKA

PERS / TRS Basic Facts
Benefits

C + I = **B** + E

DB Benefit Amount:

Sum of Multipliers x Avg. High 3 (Tier 1-2) or Avg. High 5 (Tier 3)

PERS Multipliers: 2% first 10 yrs; 2.25% second 10 yrs; 2.5% thereafter

TRS Multipliers: 2% first 20 years; 2.5% thereafter

Example: 30 years PERS service:

(2%x10)+(2.25%x10)+(2.5%x10) x $85,000 =

67.5% x $85,000 = $57,375

Note: State of Alaska employees also participate in the supplemental annuity plan (SBS)

STATE OF ALASKA

PERS / TRS Basic Facts Benefits

Pay $140 billion in benefits payments over next 70 years
Current PERS/TRS account balance: $16.8 billion
Unfunded Liability: approx $11.9 billion

STATE OF ALASKA

PERS / TRS Basic Facts
Expenses

C + I = B + **E**

PERS FY 2012 Expenses

Investment	$23.3mm
Administrative	$14.9mm
	$38.2mm

TRS FY 2012 Expenses

Investment	$ 9.9mm
Administrative	$ 6.1mm
	$16.0mm

PERS / TRS
Events That Led to C + I ≠ B + E

2002 – Milliman actuarial audit; dotcom collapse

2003 – FY 2002 valuations released with revised assumptions. $4.1B unfunded liability

2005 – SB 141 enacted: DB plans closed; DC plans created; PERB/TRB/ASPIB sunset; ARM Board created

2007 – ARM Board files suit against Mercer for actuarial negligence; SB 123 enacted: PERS cost share

2008 – SB 125 enacted: employer contribution rates capped; state assistance begins; Great Recession begins

2009 – PERS / TRS investment loss: (20.5%)

2010 – Mercer litigation settled for $500mm (net $403mm); other states begin to cut DB benefits, change plans;

2012 – ARMB adopts level dollar amortization; $11.9B unfunded liability

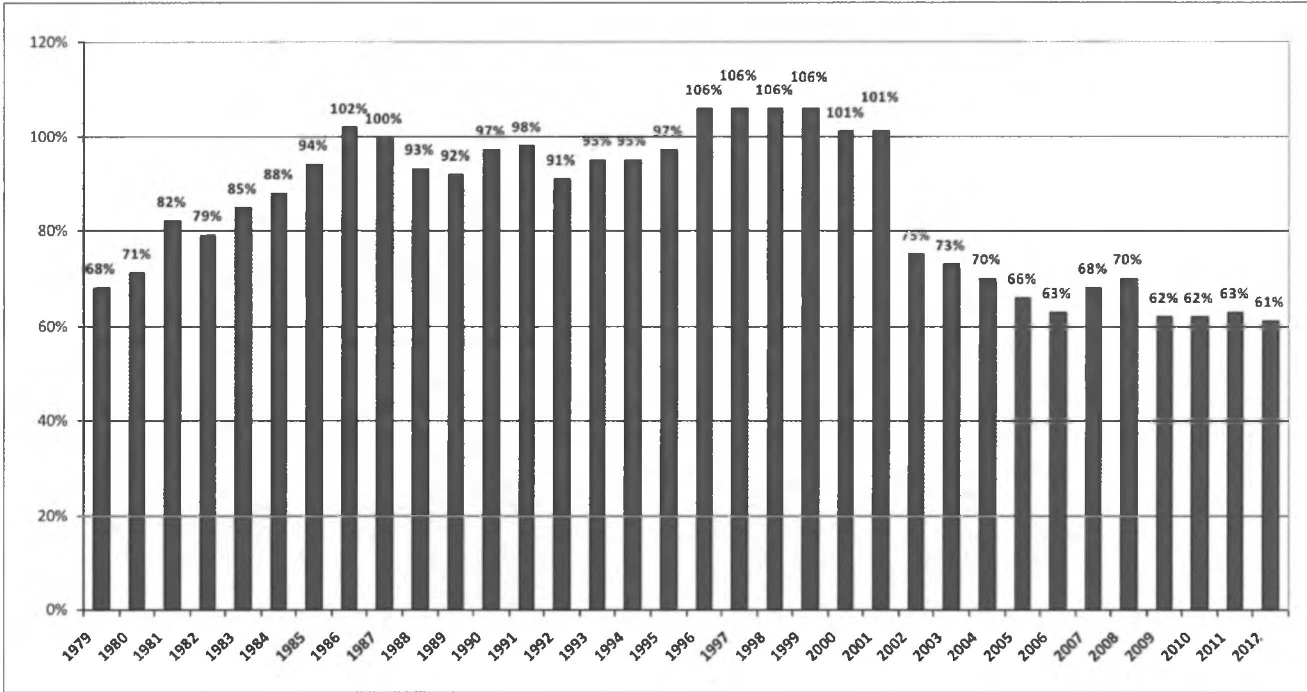
2013 – 12.5% investment gain; recession over?

STATE OF ALASKA

PERS / TRS
Funding Ratio History – PERS

(Based on Valuation Assets)

$$C + I \neq B + E$$



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State of Alaska
Public Employees' Retirement System
As of June 30, 2012

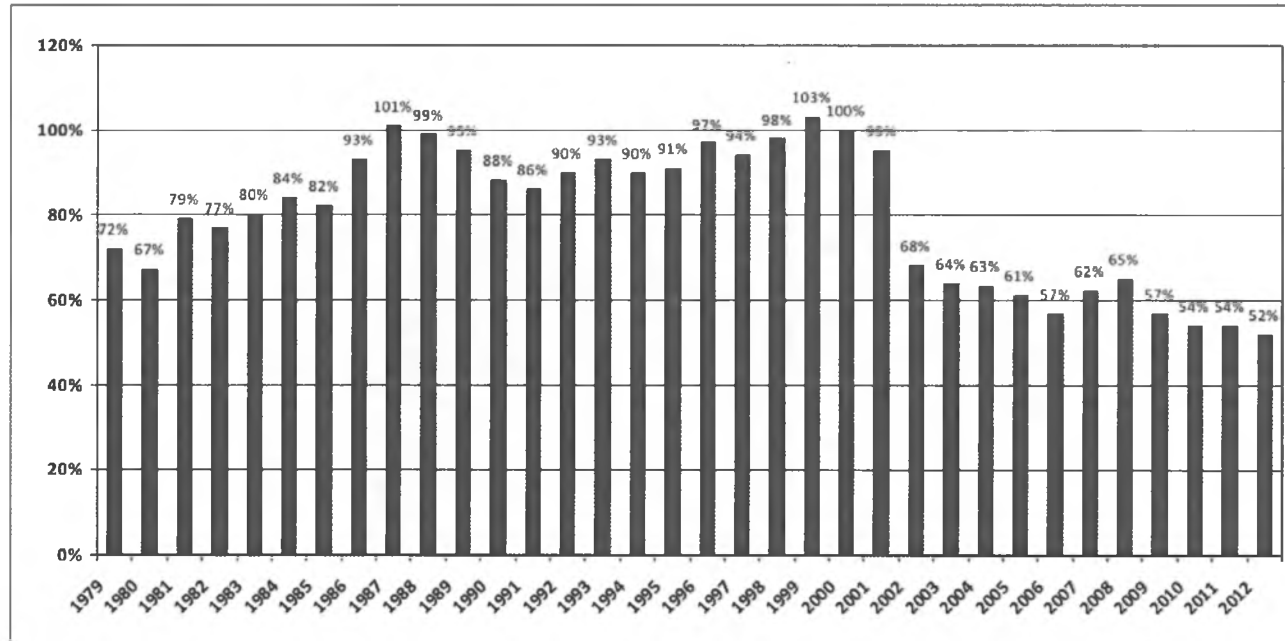
buckconsultants

STATE OF ALASKA

PERS / TRS
Funding Ratio History – TRS

(Based on Valuation Assets)

$$C + I \neq B + E$$



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State of Alaska
Teachers' Retirement System
As of June 30, 2012

STATE OF ALASKA

PERS / TRS Health Cost Trends

Time Period	Monthly Premium Per Retiree For Health Coverage	Annual Percentage Change	Average Compound Annual Increase Since FY78
2/1/77-1/31/78	$ 57.64	66%	- -
2/1/78-1/31/79	69.10	20%	20%
2/1/79-1/31/80	64.70	-6%	6%
2/1/80-1/31/81	96.34	49%	19%
2/1/81-1/31/82	96.34	0%	14%
2/1/82-1/31/83	115.61	20%	15%
2/1/83-1/31/84	156.07	35%	18%
2/1/84-1/31/85	191.85	23%	19%
2/1/85-1/31/86	168.25	-12%	14%
2/1/86-1/31/87	165.00	-2%	12%
2/1/87-1/31/88	140.25	-15%	9%
2/1/88-1/31/89	211.22	51%	13%
2/1/89-1/31/90	252.83	20%	13%
2/1/90-1/31/91	243.98	-4%	12%
2/1/91-1/31/92	243.98	0%	11%
2/1/92-1/31/93	226.90	-7%	10%
2/1/93-1/31/94	309.72	37%	11%
2/1/94-1/31/95	336.05	9%	11%
2/1/95-1/31/96	350.50	4%	11%
2/1/96-1/31/97	350.50	0%	10%
2/1/97-1/31/98	368.00	5%	10%
2/1/98-12/31/98	368.00	0%	9%
1/1/99-12/31/99	442.00	20%	10%
1/1/00-12/31/00	530.00	20%	10%
1/1/01-12/31/01	610.00	15%	10%
1/1/02-12/31/02	668.00	10%	10%
1/1/03-12/31/03	720.00	8%	10%
1/1/04-12/31/04	806.00	12%	10%
1/1/05-12/31/05	850.00	5%	10%
1/1/06-12/31/06	876.00	3%	10%
1/1/07-12/31/07	876.00	0%	10%
1/1/08-12/31/08	876.00	0%	9%
1/1/09-12/31/09	937.00	7%	9%
1/1/10-12/31/10	1,068.00	14%	9%
1/1/11-12/31/11	1,176.00	10%	9%
1/1/12-12/31/12	1,200.00	2%	9%
1/1/13-12/31/13	1,223.00	2%	9%

Source: Buck Consultants

STATE OF ALASKA

PERS / TRS Balance Sheet

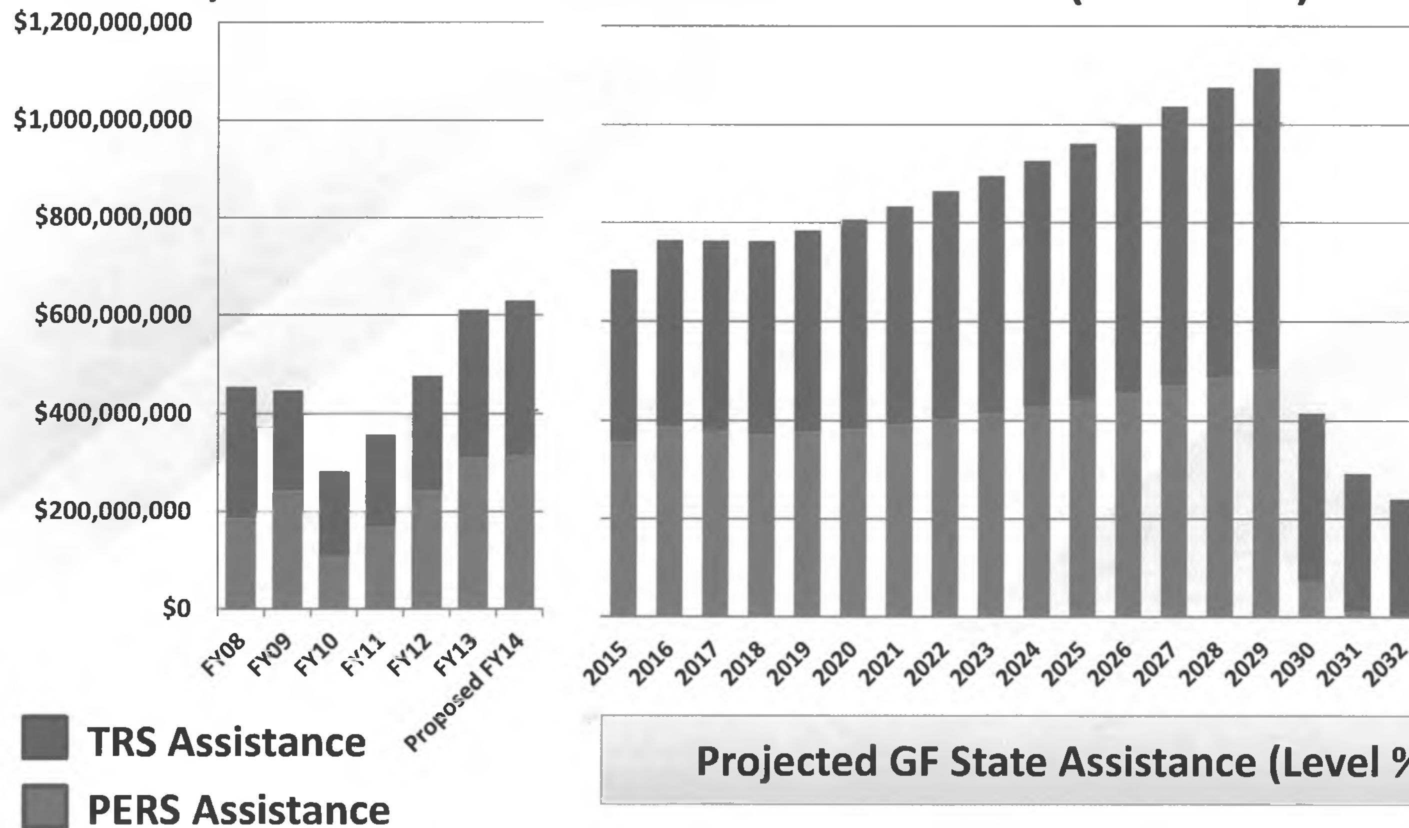
PERS DB:	
Assets (actuarial value, 6/30/12)	$11,832,030,000
Accrued Liabilities (6/30/12)	19,292,361,000
Unfunded Liability	($ 7,460,331,000)
Funding Ratio	61.3%
TRS DB:	
Assets (actuarial value, 6/30/12)	$4,869,154,000
Accrued Liabilities (6/30/12)	9,346,444,000
Unfunded Liability	($4,477,290,000)
Funding Ratio	52.1%
Total DB:	
Assets (actuarial value, 6/30/12)	$16,701,184,000
Accrued Liabilities (6/30/12)	28,638,805,000
Unfunded Liability	($11,937,621,000)
Funding Ratio	58.3%

Note: Treasury reports PERS/TRS DB assets of $19.04B as of September 30, 2013.

Source: Buck Consultants

PERS/TRS
Approaches to Unfunded Liability

PERS/TRS GF State Assistance (SB125)



STATE OF ALASKA

PERS/TRS
Approaches to Unfunded Liability

PERS/TRS GF State Assistance (SB125)

PERS/TRS
Approaches to Unfunded Liability

STATE OF ALASKA

Contributions
- Amortization Method (ARM Board)
- Amortization Term
- Reserve Account (SB 187)
- Cash Infusion (SB 187)
- Contribution Rates

Investment Return
- Asset Allocation

Benefits
(options limited by diminishment clause)
- Reduce Healthcare Costs
- Permit Plan Opt Outs
- COLA and Alive Audits

Expenses
- Optimize plan mgmt.

Retirement System Liquidity Analysis

Senate Finance Standing Committee

November 1, 2013

Angela Rodell
Acting Commissioner, Revenue

Gary Bader
Chief Investment Officer

Fund Liquidity Analysis

- Although there is a substantial unfunded liability in both the PERS and TRS, there are billions of dollars to pay benefits well into the future.
- Benefits payments will increase substantially in the next decade. Unless addressed, the combination of increased benefit payments and insufficient assets in the trusts will require investing in more liquid assets.
- Investing in more liquid assets will negatively impact the rate of return of fund assets, therefore, increasing the unfunded liability.

PERS Data Points

Fiscal Year Ending 2015

(Projection from Actuary)

Earnings Assumption	8%
Assets	$12,088,182
Liability	$20,109,112
Deficit	$8,020,930

PERS Data Points

Fiscal Year Ending 2015

Without State Assistance

Employer Contributions	$422,343
State Assistance	-0-
Employee Contributions	$120,633
Total Contributions	$542,976
Benefit Payments	$1,056,528
NET	<$513,552>

TRS Data Points

Fiscal Year Ending 2014

(Projection from Actuary)

Earnings Assumption	8%
Assets	$4,898,818
Liability	$9,651,582
Deficit	$4,752,764

TRS Data Points

Fiscal Year Ending 2014

Without State Assistance

Employer Contributions	$67,056
State Assistance	-0-
Employee Contributions	$54,446
Total Contributions	$121,502
Benefit Payments	$556,844
NET	<$435,342>

Growth of Benefits
PERS/TRS

Fiscal Year Ending	PERS/TRS Estimated Benefits (millions)
2013	$1,499,626
2014	$1,613,372
2015	$1,727,481
2016	$1,844,295
2017	$1,953,707
2018	$2,056,645
2019	$2,161,620
2020	$2,277,447
2021	$2,392,711
2022	$2,498,580

Annual Cash Yield DB Plans

	ASSETS	YIELD	ESTIMATED ANNUAL CASH FLOW
Fixed Income	2,688,804,465		64,812,459
Public Equity	9,745,978,092		243,996,390
Real Assets	3,100,326,188		80,799,903
Private Equity and Absolute Return	2,404,508,649		0
Total	17,939,617,394		389,608,751
Estimate Annual Cash Yield		2.17%	

Ten Year Returns by Asset Class

PERS

	Assets	
Private Equity	$1,610,699,722	13.35%
International Equity	$4,097,062,076	9.02%
Real Assets	$3,100,326,188	8.10%
Domestic Equity	$5,648,916,016	7.08%
Fixed Income	$2,688,804,465	4.55%
Absolute Return	$793,808,927	2.89%

ARMB Liquidity Projection

Fiscal Year End	Actuarial Assets (in thousands)	Net Contributions*	Cash Earned on Assets**	Difference
2014	$17,166,162	($285,301)	$372,506	$87,204
2015	$18,377,782	($66,974)	$398,798	$331,824
2016	$19,850,755	($112,289)	$430,761	$318,472
2017	$21,044,812	($217,551)	$456,672	$239,121
2018	$22,495,709	($343,161)	$488,157	$144,996
2019	$23,931,778	($447,932)	$519,320	$71,388
2020	$25,373,480	($589,426)	$550,605	($38,821)
2025	$32,094,630	($1,265,395)	$696,453	($568,942)
2030	$38,049,095	($2,352,697)	$825,665	($1,527,031)
2033	$38,596,450	($3,431,712)	$837,543	($2,594,169)

***Contributions minus benefits paid.**
****Assuming 2.17% Yield**

Alaska Retirement Management Board

Senate Finance Committee

November 1, 2013

Alaska Retirement Management Board

- Role of the Alaska Retirement Management Board
- ARMB Actions (and Limitations) to Address Unfunded Liability
- Funding Request
- Outcomes of Anchorage Stakeholder Workshop

Role of ARMB

Alaska Retirement Management Board (2005-present)

1. Manage/invest assets to meet liabilities & pension obligations of the systems, plan, program, and trusts.
2. Set employer contribution rates
3. Greater duty w/respect to pension liabilities & obligations
4. Recommend to budget-setting and appropriations arms of gov't, but cannot appropriate or submit a budget
5. Adopt investment policies for each of the Funds; approve investment options for DC plans after consulting with Plan Administrator

Role of ARMB, contd.

6. Approve investment objectives for DB Plans
7. Annual actuarial evaluation to determine assets, accrued liabilities, funding ratios and certify appropriate contribution rate for normal cost and liquidating past service liability
8. Annually report to Governor, legislature, employers valuation of trust fund assets and liabilities and other statistical data to understand system
9. Quarterly report of investment performance to Legislative Budget and Audit
10. Contract for services to execute boards powers and duties

ARMB Powers and Duties

- AS 37.10.071(a)(7): "In making investments under this section, the fiduciary of a state fund shall ... perform all acts, not prohibited by this section, whether or not expressly authorized, that the fiduciary considers necessary or proper in administering the assets;"
- 071(c): "In exercising investment, custodial, or depository powers or duties under this section, the fiduciary of a state fund shall apply the prudent investor rule and exercise the fiduciary duty in the sole financial best interest of the fund entrusted to the fiduciary. Among beneficiaries of the fund, the fiduciaries shall treat beneficiaries with impartiality."

Limited Ability to Impact Unfunded Liability

ARMB Responsibilities:

- Determine asset allocation and investment objectives
- Determine amortization methodology
- Set investment return assumption
- Set employer contribution rates
- Provide input on actuarial assumptions

Limited Ability to Impact Unfunded Liability

ARMB cannot:

- Appropriate funds
- Submit budgets
- Authorize issuance of POBs
- Authorize loans or funding into the retirement system

Where We Have Been

The Alaska Retirement Management Board has taken actions to address the pension systems' unfunded liability and other issues over the past seven years including:

- Supported cost-sharing multiple employer system for PERS
- Supported direct appropriations to PERS and TRS
- Supported pension obligation bonds (2007 and 2011)
- Reduced earnings assumption rate to 8% (2011)
- Adopted level-dollar amortization to fund costs sooner rather than later (2012; effective FY15)
- Stakeholder meeting
- Outreach to Legislature

Impact of Reduced Earnings Assumption

- Reduced earnings assumption 8.25% to 8.00%
- 3.12% inflation assumption = 4.88% real return
- Return is consistent with asset allocation
- Reduces funded ratio due to lower assumed future assets
- Increased ER rate by 1.53% PERS; 1.77% TRS (2012)

Investment Returns (PERS and TRS)*

PERS	TRS
2013 = 12.5%	2013 = 12.5%
2012 = 0.2%	2012 = 0.2%
2011 = 20.4%	2011 = 20.5%
2010 = 10.2%	2010 = 10.6%
2009 = (20.5%)	2009 = (21.0%)
2008 = (3.1%)	2008 = (3.0%)
2007 = 18.5%	2007 = 18.5%
2006 = 11.4%	2006 = 11.4%
2005 = 8.5%	2005 = 8.5%

*Fair Value

Source: State of Alaska PERS Actuarial Valuation Report @ 6/30/12 p. 38 and TRS p. 29.

Impact of change from Level % of Pay to Level Dollar Amortization

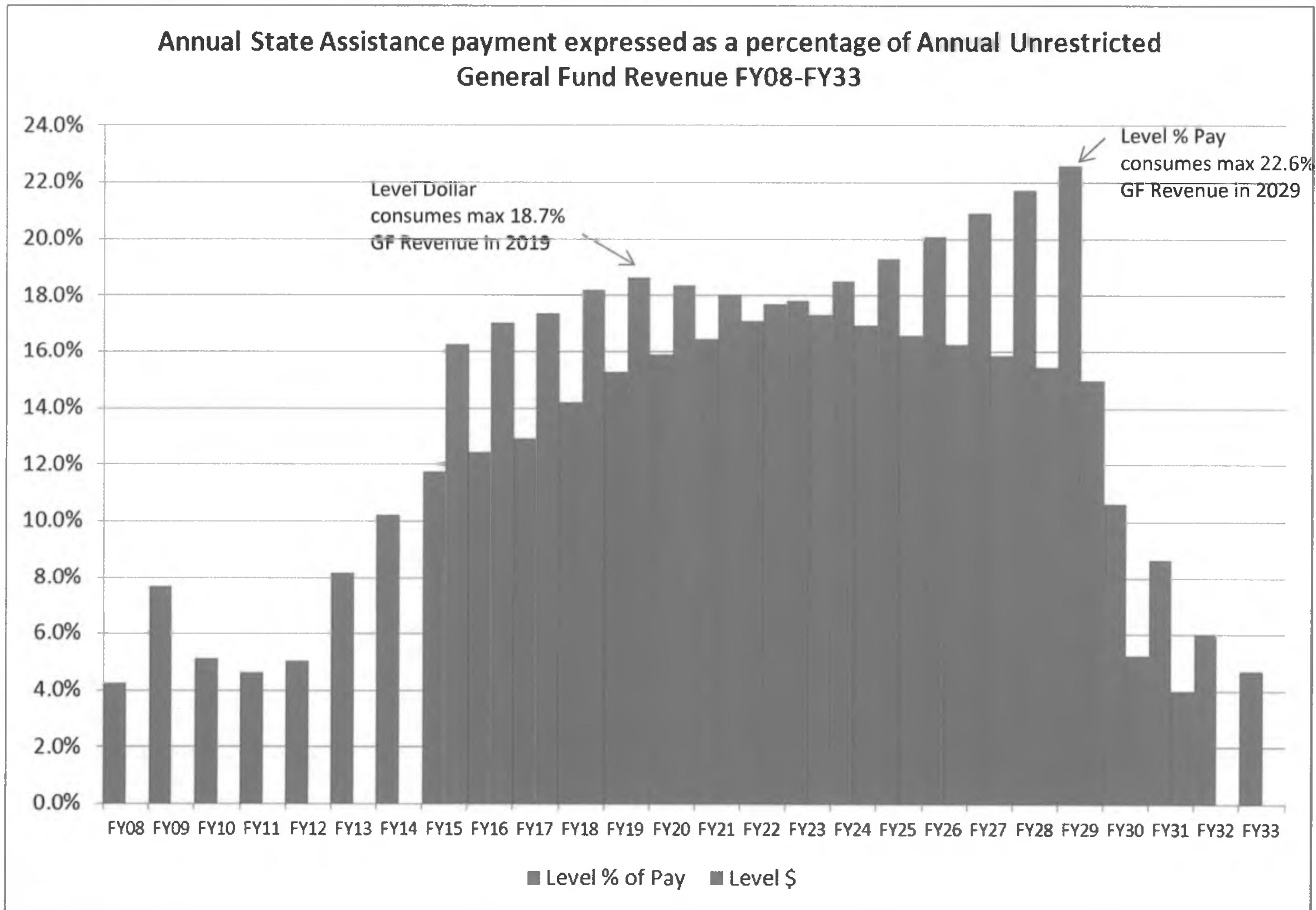
- Reduces overall contributions by nearly $2 Billion
- Reduces State Assistance by $1.26 Billion
- Reduces overall State payments by $1.64 Billion *
- Reduces Muni payments by $285 Million
- Level % of Pay delays contributions to future

* Includes State Assistance and State payments as an employer

Impact of change from Level % of Pay to Level Dollar Amortization

- Level Dollar results in higher contributions in early years, reduced contributions later
- Increased contribution rates for PERS by 7.21% of pay and for TRS by 13.07% of pay
- Since 2006, Level Dollar would have added $623 Million addtl to PERS; $351 Million addtl to TRS

Why change Level % of Pay to Level Dollar



Comparison Level % of Pay and Level Dollar

		Level Percent of Pay			Level Dollar		
	Total GF Unrestricted Revenue **	State Assistance % of Pay	Percent of GF Revenue	Cumulative State Assistance % of Pay	State Assistance Level $	Percent of GF Revenue	Cumulative State Assistance Level $ *
FY08	$ 10,728	$ 455.0	4.2%	$ 455			
FY09	$ 5,831	$ 447.9	7.7%	$ 903			
FY10	$ 5,513	$ 281.4	5.1%	$ 1,184			
FY11	$ 7,693	$ 356.7	4.6%	$ 1,541			
FY12	$ 9,485	$ 477.1	5.0%	$ 2,018			
FY13	$ 7,476	$ 610.1	8.2%	$ 2,628			
FY14	$ 6,163	$ 629.3	10.2%	$ 3,258			
FY15	$ 5,994	$ 703.2	11.7%	$ 3,961	$ 975.6	16.3%	$ 4,233
FY16	$ 6,232	$ 775.9	12.4%	$ 4,737	$ 1,062.4	17.0%	$ 5,296
FY17	$ 6,207	$ 804.1	13.0%	$ 5,541	$ 1,079.2	17.4%	$ 6,375
FY18	$ 5,865	$ 832.4	14.2%	$ 6,373	$ 1,067.4	18.2%	$ 7,442
FY19	$ 5,775	$ 881.6	15.3%	$ 7,255	$ 1,077.3	18.7%	$ 8,519
FY20	$ 5,775	$ 917.0	15.9%	$ 8,172	$ 1,060.6	18.4%	$ 9,580
FY21	$ 5,775	$ 952.0	16.5%	$ 9,124	$ 1,042.0	18.0%	$ 10,622
FY22	$ 5,775	$ 990.0	17.1%	$ 10,114	$ 1,022.0	17.7%	$ 11,644
FY23	$ 5,775	$ 1,029.0	17.8%	$ 11,143	$ 1,001.0	17.3%	$ 12,645
FY24	$ 5,775	$ 1,070.0	18.5%	$ 12,213	$ 980.0	17.0%	$ 13,625
FY25	$ 5,775	$ 1,114.0	19.3%	$ 13,327	$ 958.9	16.6%	$ 14,584
FY26	$ 5,775	$ 1,160.0	20.1%	$ 14,487	$ 938.3	16.2%	$ 15,522
FY27	$ 5,775	$ 1,207.0	20.9%	$ 15,694	$ 915.5	15.9%	$ 16,438
FY28	$ 5,775	$ 1,256.0	21.7%	$ 16,950	$ 891.5	15.4%	$ 17,329
FY29	$ 5,775	$ 1,304.0	22.6%	$ 18,254	$ 866.4	15.0%	$ 18,196
FY30	$ 5,775	$ 613.0	10.6%	$ 18,867	$ 302.7	5.2%	$ 18,498
FY31	$ 5,775	$ 500.0	8.7%	$ 19,367	$ 230.0	4.0%	$ 18,728
FY32	$ 5,775	$ 349.0	6.0%	$ 19,716	$ -	0.0%	$ 18,728
FY33	$ 5,775	$ 271.0	4.7%	$ 19,987	$ -	0.0%	$ 18,728

Level Dollar maxes out at 18.7% of GF Revenue

Level % of Pay Consumes up to 22.6% of GF Revenue

Projected Actuarial Results Revised

ARMB requested actuaries revise Table of Projected Actuarial Results purporting to show System overfunding (surplus) in excess of $3 Billion by 2072, as misleading.*

* See 2011 PERS Actuarial Valuation Report, p. 57.

Where We Have Been

The Alaska Retirement Management Board evaluated 40 potential scenarios in 2011.

Recommended:

- 25-year or 30-year amortization
- Lump-sum contributions with continued State assistance
- Change to level dollar amortization

Rejected:

- Lump-sum contributions with no further State assistance > 22%
- Cost-shifting from State to municipalities and vice-versa
- Requiring assets outside trust fund be used to set rates
- Extending amortization if significantly higher costs than status quo

Resolution 2013-02

At its February 2013 meeting ARMB passed Resolution 2013-02 requesting:

....that the Alaska Legislature, in addition to state assistance, appropriate in each of the next four sessions the sum of $500 million toward retirement of the unfunded liability of the Alaska Public Employees' Retirement System and Teachers' Retirement System.

*Resolution included in packet

Problem Definition

At $11.8 Billion as of June 30, 2012, the unfunded liability of the retirement systems creates growing pressures on the state budget as annual contributions exceed $1 Billion per year under the current amortization schedule

Problem Definition: Increasing State Contributions

Growth in Unfunded Liability

- At June 30, 2012
  - PERS - $7.4 billion
  - TRS - $4.4 billion
- 2005 - $6.9B in 2005 to $11.8B in 2012
- Grew $4.9B in 7 years ($700M / year)

Growth in State Contributions

- 2013 - $608M;
- 2015 = $975M;
- Thereafter > $1B for 8 years; 13 consecutive years > $900M

Status Quo

- FY12 State payroll makes up 61% of total PERS payroll, leading to state paying 81.7% of PERS U/L under SB125
- State pays significant portion of TRS employer contributions
- Employer contribution rate caps: 22% for PERS; 12.56% for TRS
- Retirement System fully funded in 2031 (18 years)

- PERS/TRS unfunded liability grew $889 Million last year as a result of insufficient assets upon which to earn interest
- It will take $27 Billion to pay off $12 Billion Liability
- Approx. 69% of benefits are funded through interest earnings; 23% employer contributions; 9% employee contributions
- When the system is underfunded employer contributions must fill the void.

Details of Funding Request

FY 2014-2017 appropriation cycle = $2B infusion

* $250 Million to PERS x 4 years
* $250 Million to TRS x 4 years

Current Actuarial Assumptions Remain in Place

* 8% Earnings Assumption
* Level Dollar Amortization

Details of Funding Request (continued)

Baseline State Assistance PERS and TRS Contributions (2013-2031)	State Assistance after FY14-17 Appropriations $250 Million Each to PERS/TRS
$16.7 Billion	$14.9 Billion

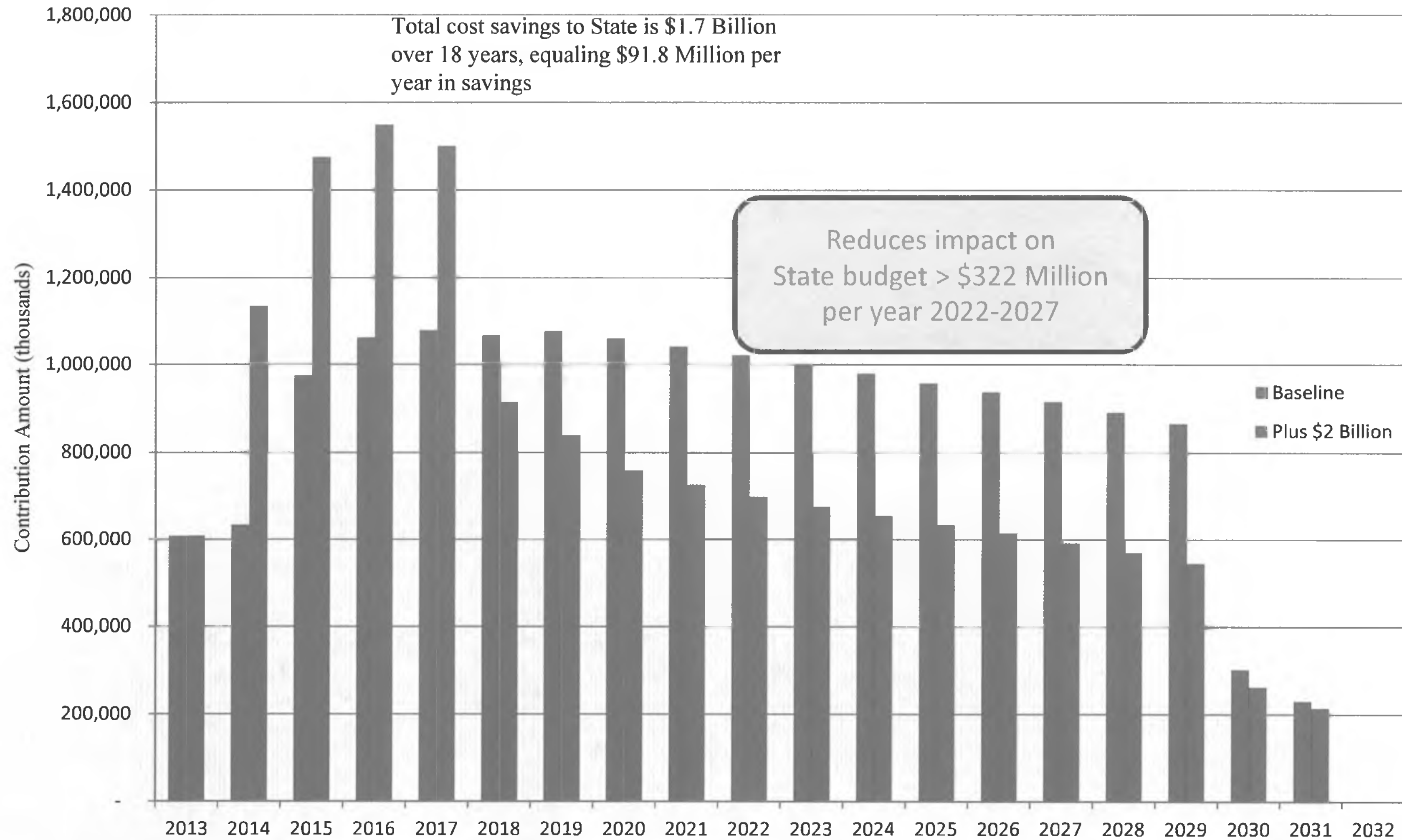
$1.7 Billion Savings in State of Alaska Assistance Contributions

[$91.8 Million Savings Each Year]

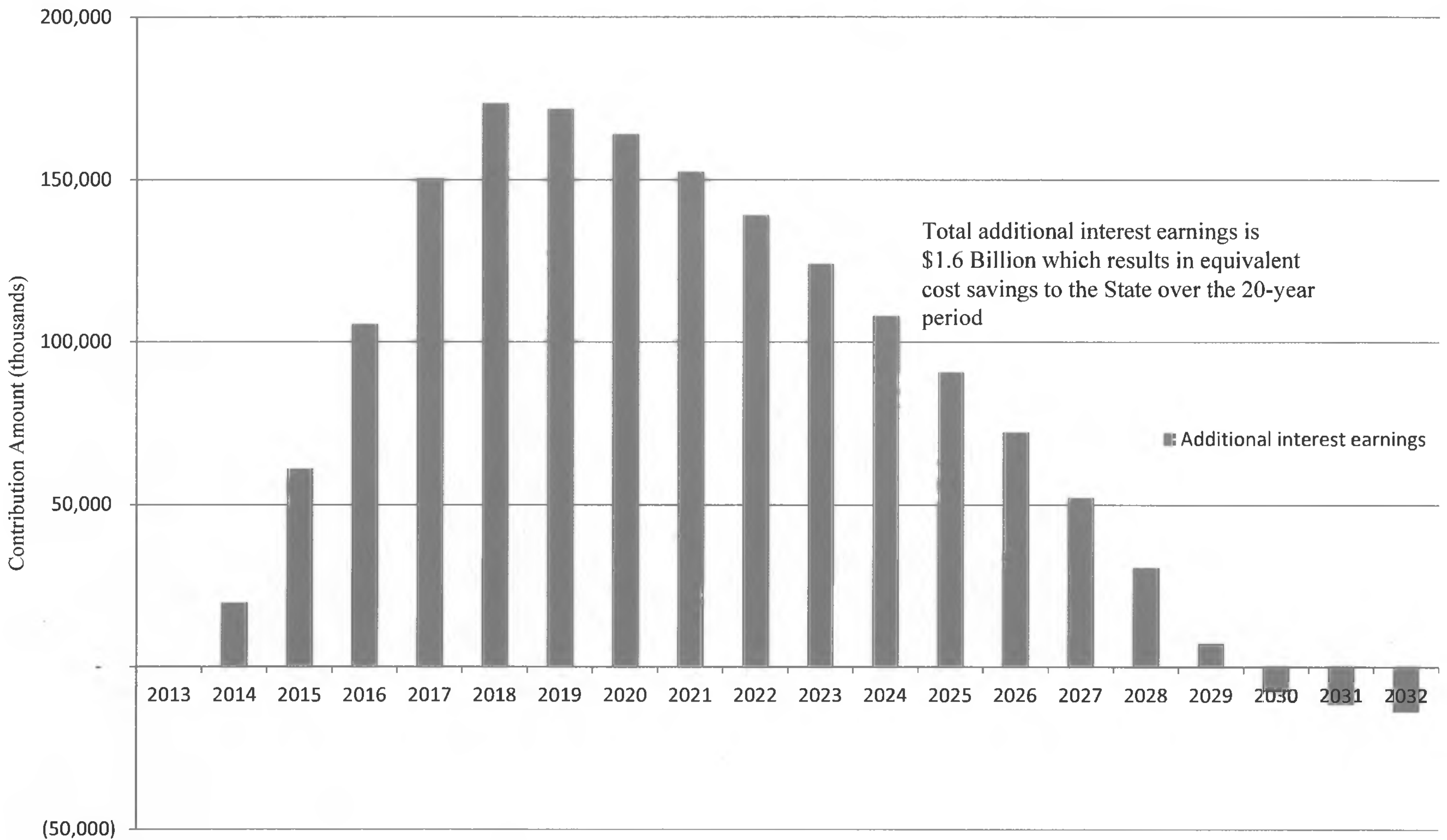
$33 Million Savings in Employer Contributions 2013-2031

[$1.65 Million Savings Each Year – Includes Savings to State as an Employer]

State Assistance: Baseline vs. $2B injection



Additional Fund Earnings with $2B Injection



Annual State Assistance Savings in thousands from $2B Injection* (vs. status quo)

	Baseline - Level Dollar and 8% return			Level Dollar and 8% return PLUS $250M to PERS and $250M to TRS each year FY14 - FY17			Annual Savings
	PERS	TRS	PERS + TRS	PERS	TRS	PERS + TRS	
2013	310,528	298,101	608,629	310,528	298,101	608,629	-
2014	319,456	315,053	634,509	569,456	565,053	1,134,509	(500,000)
2015	519,676	455,904	975,580	769,676	705,904	1,475,580	(500,000)
2016	572,439	489,935	1,062,374	815,639	733,165	1,548,804	(486,430)
2017	576,925	502,245	1,079,170	787,294	712,891	1,500,185	(421,015)
2018	563,734	503,650	1,067,384	486,636	426,968	913,604	153,780
2019	566,220	511,074	1,077,294	446,414	392,443	838,857	238,437
2020	549,597	510,979	1,060,576	397,960	360,845	758,805	301,771
2021	530,984	511,071	1,042,055	372,455	354,025	726,480	315,575
2022	511,130	510,919	1,022,049	348,993	350,213	699,206	322,843
2023	490,148	510,769	1,000,917	327,713	349,007	676,720	324,197
2024	469,924	510,255	980,179	307,485	347,931	655,416	324,763
2025	449,483	509,478	958,961	287,253	347,339	634,592	324,369
2026	429,310	508,993	938,303	267,492	347,179	614,671	323,632
2027	407,509	508,033	915,542	245,981	346,594	592,575	322,967
2028	384,751	506,783	891,534	224,501	345,865	570,366	321,168
2029	360,954	505,441	866,395	201,123	344,827	545,950	320,445
2030	10,870	291,874	302,744	-	262,474	262,474	40,270
2031	-	230,333	230,333	-	213,718	213,718	16,615
2032	-	-	-	-	-	-	-
	8,023,638	8,690,890	16,714,528	7,166,599	7,804,542	14,971,141	1,743,387
Savings:	857,039	886,348	1,743,387				

* $500M/year x 4 years

Funding Request (continued)

- For every $1 contributed today, the State saves an *additional* $1 in required future State assistance
- $500M added contribution for four years saves > $300M per year over ten years, at a time when oil production is declining and the State budget is strained
- Level Dollar reduces pressure on State budget when oil production is declining and State budget is even more strained
- Cash infusion allows investment earnings to replace employer contributions and state assistance

Where Do We Go From Here

The Alaska Retirement Management Board recognizes that funding for the retirement systems and the increasing amounts to pay down the unfunded liability compete with other needs for the residents of Alaska

Stakeholder Meeting Held

Purpose: *Provide a forum for stakeholders to discuss potential solutions to pay down the retirement systems' unfunded liability and mitigate the impact of increasing retirement system contributions on future state budgets.*

Attendees included: Legislators and/or staff; OMB, DOR, DOA; NEA, RPEA, APEA, Firefighters; AGFOA, AML, AASB

Primary Outcomes

- Borrow from ourselves
  - Mitigates risks of borrowing from capital markets
  - Provides guaranteed return to reserves
  - Prefer to borrow from CBR since SBR earnings are swept into GF
  - State's bond rating not adversely affected if we borrow from ourselves
  - Demonstrates that Alaska has a plan to address U/L
  - Leverages significant reserves without consuming them
- Direct appropriation
  - Prefer a single lump-sum rather than spread over multiple years
- Pension Obligation Bonds as a partial solution

Majority agreed on the need for substantial injection into system now.

Summary

- ARMB believes up-front cash infusion is critical to sustainability of retirement system
- Lack of infusion will exacerbate problems when liquidity of System becomes a concern in approx. 7 years
- Continued State Assistance payments are also a critical component of stable system
- Bottom line: Pay now or pay much more later

Thank You

The Alaska Retirement Management Board thanks the Alaska State Legislature for its commitment to fund the State's retirement system, and for its consistent annual contributions to the Systems.

Thank you also for the opportunity to present this information to you.

APPENDIX

Chronology of ARMB actions re: Unfunded Liability

- October 11, 2005 - First meeting of the Alaska Retirement Management Board (Board).
- April 10, 2006 - Board presented a report to the legislature which included the Board's preliminary assessment of the financial health of the retirement plans.
- February 9, 2007 - Board adopted Resolution 2007-04 in support of a cost-sharing multiple employer arrangement for the Public Employees' Retirement System (PERS).
- February 9, 2007 - Board adopted Resolution 2007-05 in support of appropriations to pay funds directly into the Teachers' Retirement System (TRS) defined benefit plan.
- April 27, 2007 - Board adopted Resolution 2007-17 in support of enabling public employers access to capital markets, with pension obligation bonds (POBs) being one such potential means of access.

Chronology, contd.

- February 11, 2011 - Board adopted Resolution 2011-01 relating to the experience analysis assumption changes for the PERS and TRS Defined Contribution System.
- May 2, 2007 - Board adopted resolution 2007-19 in support of SB 125, converting PERS to a cost-share plan and establishing a 22% contribution rate for employers.
- February 14, 2008 - Board adopted Resolution 2008-04 in support of the administration's request for an appropriation of $450 million to the TRS fund.
- November 18-19, 2010 - ARMB Working Group met; participants included trustees, staff from DOR and DOA, Buck Consultants, OMB, Senator Stedman, Representative Munoz, Legislative Finance and legislative staff.

Chronology, contd.

- December 3, 2010 - Board adopted Resolution 2010-31. The resolution reduced the earnings assumption, comprised of a real rate of return of 4.88% and an inflation rate of 3.12%, resulting in a Rate of Return expectation of 8%.
- September 21, 2011 - Governor Sean Parnell addressed the Board and provided suggested solutions. He asked the board to consider a number of options.
- December 2, 2011 - Board adopted Resolution 2011-23, recommending consideration of various funding scenarios prepared by Buck.
- January 11, 2012 - Trustees and staff appeared before the Senate leadership to "Provide Legislators a clear understanding of Resolution 2011-23."
- February 17, 2012 - Board adopted Resolution 2012-02 in opposition to legislation that required assets held outside the trust funds to be used in determining employer contribution rates.

Chronology, contd.

- June 21, 2012 - Board adopted Resolution 2012-19 setting forth the level dollar amortization method.
- September 19, 2012 - Board convened its first Legislative Committee meeting.
- March 15, 2013 – Letter transmitted to Senate President Charlie Huggins and Speaker Mike Chenault with a chronology of Board actions and resolution 2013-02 requesting additional appropriations to PERS and TRS.
- April 1, 2013 – Board Chair Gail Schubert testified before House Finance Committee in support of additional appropriations to PERS and TRS.
- August 8, 2013 – ARMB convenes stakeholder meeting to address Unfunded Liability.

ARMB Role

ARMB Statutes 2005 – AS 37.10.210-390

- Legislative intent: fiduciary responsibility investment and management of funds with attention to liabilities and obligations rest with ARMB
- Major differences between ASPIB and ARMB

ARMB Scope of Mandate:

- "Consistent with the standards of prudence, the [ARMB] board has the fiduciary obligation to manage and invest these assets in a manner that is sufficient to meet the liabilities and pension obligations of the systems, plan, program, and trusts."
- Duty to set employer contribution rates (previously PERS/TRS Boards)
- Greater fiduciary responsibility than ASPIB particularly re: unfunded status and liabilities and obligations of the funds
- ARMB can make recommendations to and advise budget-setting and appropriating arms of government, but cannot appropriate funds or submit a budget

ARMB Role

ARMB powers and duties:

- "AS 37.10.220(a)(2): "after reviewing recommendations from the Department of Revenue, adopt investment policies for each of the funds entrusted to the board."
- 220(a)(3): "determine the appropriate investment objectives for the defined benefit plans.."
- 220(a)(4): "assist in prescribing the policies for the proper operation of the systems and take other actions necessary to carry out the intent and purpose of the systems in accordance with AS 37.10.210 – 37.10.390."
- 220(a)(8): "coordinate with the retirement system administrator to have an annual actuarial evaluation...prepared to determine system assets, accrued liabilities, and funding ratios and to certify to the appropriate budgetary authority of each employer in the system (A) an appropriate contribution rate for normal costs; and (B) an appropriate contribution rate for liquidating any past service liability."

ARMB Role

ARMB powers and duties:

- 220(a)(13): "[annually]...report to the governor, the legislature, and the individual employers...on the financial condition of the systems in regard to (A) the valuation of trust fund assets and liabilities....and (G) other statistical data necessary for proper understanding of the financial status of the system."
- 220(a)(14): "Submit quarterly updates of the investment performance reports to the Legislative Budget and Audit Committee."
- 220(b)(3): "contract for other services necessary to execute the board's powers and duties."

Actuarial Oversight

- Primary actuary: Responsible for conducting annual actuarial valuation to determine assets, accrued liabilities, funding ratios; certify contribution rate for normal cost and rate for liquidating past service liability; experience analysis performed once every four years
- Review Actuary: Responsible for reviewing and certifying all actuarial assumptions contained in primary actuary valuation and experience analysis before presentation to Board; health cost assumptions reviewed annually
- Auditing Actuary: Responsible for conducting an independent audit of the state's actuary not less than once every four years

Role of Review Actuaries

- AS 37.10.220(a):
- 220(a)(8): Coordinate with the retirement system administrator to have an annual actuarial valuation of each retirement system prepared to determine system assets, accrued liabilities, and funding ratios and to certify to the appropriate budgetary authority of each employer in the system (A) an appropriate contribution rate for normal costs; and (B) an appropriate contribution rate for liquidating any past service liability
- 220(a)(9): Review actuarial assumptions prepared and certified by a member of the American Academy of Actuaries and conduct experience analyses of the retirement systems not less than once every four years, except for health cost assumptions, which shall be reviewed annually; the results of all actuarial assumptions prepared under this paragraph shall be reviewed and certified by a second member of the American Academy of Actuaries before presentation to the board;
- 220(a)(10): Contract for an independent audit of the state's actuary not less than once every four years;
- 220(a)(11): Contract for an independent audit of the state's performance consultant not less than once every four years;
- 220(a)(12): Obtain an external performance review to evaluate the investment policies of each fund entrusted to the board and report the results of the review to the appropriate fund fiduciary;

PERS: 2012 increase in Unfunded Liability

Public Employees' Retirement System

Changes in Unfunded Liability Since Last Year
($ in millions)

Development of Change in Unfunded Liability during FY12		
1. 2011 Unfunded Liability		$6,927
a. Interest on unfunded liability	$554	
b. Normal cost	289	
c. Employee contributions	(113)	
d. Employer contributions	(406)	
e. State relief under SB 125	(243)	
f. Medicare Part D subsidy	(32)	
g. Interest on b., c., d., e., and f.	(8)	
h. Expected change in unfunded liability during FY12		41
2. Expected 2012 Unfunded Liability		$6,968
a. Liability (gains)	$(540)	
b. Assets losses	805	
c. Change in healthcare assumptions	227	
d. Other changes in unfunded liability during FY12		492
3. Actual 2012 Unfunded Liability		$7,460

+ 533M

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PERS: 2012 change in Employer/State Contribution Rate

Public Employees' Retirement System

Peace Officer/Firefighter and Others Combined
Change in Total Employer/State Contribution Rate

Normal cost: 6.82%;
Past service cost: 33.03%
Total Rate: 39.85%

	Pension	Healthcare	Total
1. Last year's total Employer/State contribution rate	16.47%	15.84%	32.31%
2. Change due to:			
• Change in amortization method	4.89%	2.32%	7.21%
• New healthcare assumptions	N/A	0.75%	0.75%
• Effect of two-year delay in the contribution rate	0.25%	(0.04%)	0.21%
• Asset experience	2.40%	0.71%	3.11%
• Salary increases	0.23%	N/A	0.23%
• Demographic experience and other*	(1.00%)	(1.23%)	(2.23%)
• Claims costs	N/A	(1.74%)	(1.74%)
• Total change	6.77%	0.77%	7.54%
3. Total Employer/State contribution rate this year	23.24%	16.61%	39.85%

*Includes data and programming changes.

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TRS: 2012 increase in Unfunded Liability

Teachers' Retirement System

Changes in Unfunded Liability Since Last Year
($ in millions)

Development of Change in Unfunded Liability during FY12		
1. 2011 Unfunded Liability		$4,191
a. Interest on unfunded liability	$335	
b. Normal cost	98	
c. Employee contributions	(52)	
d. Employer contributions	(74)	
e. State relief under SB 125	(235)	
f. Medicare Part D subsidy	(13)	
g. Interest on b., c., d., e., and f.	(7)	
h. Expected change in unfunded liability during FY12		52
2. Expected 2012 Unfunded Liability		$4,243
a. Liability (gains)	$(192)	
b. Assets losses	359	
c. Change in healthcare assumptions	67	
d. Other changes in unfunded liability during FY12		234
3. Actual 2012 Unfunded Liability		$4,477

+ $286 M

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TRS: 2012 change in Employer/State Contribution Rate

Teachers' Retirement System

Change in Total Employer/State Contribution Rate

Normal cost: 6.40%;
Past service cost: 59.91%
Total Rate: 66.31%

	Pension	Healthcare	Total
1. Last year's total Employer/State contribution rate	31.40%	18.70%	50.10%
2. Change due to:			
• Change in amortization method	9.52%	3.55%	13.07%
• New healthcare assumptions	N/A	0.63%	0.63%
• Effect of two-year delay in the contribution rate	0.52%	0.19%	0.71%
• Asset experience	3.47%	0.71%	4.18%
• Salary increases	0.00%	N/A	0.00%
• Demographic experience and other*	(0.36%)	(0.29%)	(0.65%)
• Claims costs	N/A	(1.73%)	(1.73%)
• Total change	13.15%	3.06%	16.21%
3. Total Employer/State contribution rate this year	44.55%	21.76%	66.31%

*Includes data and programming changes.

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Unfunded Liability and Funded Ratio (PERS)

At June 30:

Valuation Date	Funded Ratio	Unfunded Liability (Billion)
2012	61.3%	$7.46
2011	63.0%	$6.93
2010	61.5%	$6.98
2009	61.8%	$6.34
2008	69.5%	$4.85
2007	68.0%	$4.67
2006	62.8%	$5.35
2005	65.7%	$4.40

Source: State of Alaska Public Employees Retirement System Actuarial Valuation Report as of June 30, 2012, p.32; Based on Valuation Assets.

Unfunded Liability and Funded Ratio (TRS)

At June 30:

Valuation Date	Funded Ratio	Unfunded Liability (Billion)
2012	52.1%	$4.48
2011	54.1%	$4.19
2010	53.6%	$4.11
2009	57.0%	$3.37
2008	64.8%	$2.68
2007	61.5%	$2.77
2006	57.3%	$3.08
2005	60.9%	$2.54

Source: State of Alaska Teacher Retirement System Actuarial Valuation Report as of June 30, 2012, p.23;
Based on Valuation Assets

Fairbanks Legislative Information Office

Date 11/1/13

Time 9:00 - 4:30

Meeting ID

Testimony: Yes ____ No

Listen Only ____

Committee Senate Finance

Subject PERS/TRS Liability / Medicaid overview

Full Name PLEASE PRINT	Organization Representing (if applicable)	Contact Information Phone / Cell / Email	Testify please check	Observe please check	Bill #
John Alcantra	NEA - Alaska				
Kristin Erchinger	ARMB		✓		
GARY BADER	DOR		✓		
Angela Rodell	DOR		✓		
→ Mike Barnhill	DOA		✓		
Katrine Wasserman	AML	katrine@akml.org			
→ Robert Grove (1)	RPEA	robertakgrove@gmail.com	✓		
Ashton Compton		ashton.compton@akleg.gov		✓	
Ron Johnson (2)	RPEA	rqjohnson@alaska.edu	✓		
Charles H Dallagher (3)	RPEA	cgallagher@alaska.net			