State of Alaska
ALASKA RETIREMENT MANAGEMENT BOARD
ACTUARIAL COMMITTEE MEETING

Club Room II – Captain Cook Hotel
939 W. 5th Avenue
Anchorage, Alaska

June 23, 2016

ATTENDANCE

Committee Present: Kristin Erchinger, *chair*
Tom Brice
Commissioner Sheldon Fisher
Gayle Harbo
Rob Johnson
Bob Williams

Committee Absent: --

Department of Revenue Staff Present:
Gary Bader (chief investment officer)
Pamela Leary (Treasury Division director)
Judy Hall (board liaison officer)

Department of Administration Staff Present:
John Boucher (deputy commissioner)
Kevin Worley (chief financial officer, Department of Retirement & Benefits)

Others Present:
David Kershner (Buck Consultants, actuary)
Larry Langer (Buck Consultants, actuary)
Melissa Bissett (Buck Consultants, actuary)
Leslie Thompson (Gabriel Roeder Smith, review actuary)

I. CALL TO ORDER

CHAIR ERCHINGER called the meeting to order at 11:45 a.m.

II. ROLL CALL

All six committee members were present to form a quorum.

III. PUBLIC MEETING NOTICE

MS. HALL confirmed that public meeting notice had been met.

IV. APPROVAL OF AGENDA

MS. HARBO moved to approve the agenda. MR. BRICE seconded. The motion passed unanimously.

V. PUBLIC/MEMBER PARTICIPATION, COMMUNICATIONS AND APPEARANCES

No one at the meeting site in Anchorage or listening by telephone indicated they wanted to speak before the committee. MS. HALL said she had received no communications for the committee.

VI. APPROVAL OF MINUTES – April 20, 2016

MR. BRICE moved to approve the minutes of the April 20, 2016 meeting. MS. HARBO seconded. The minutes were approved as presented.

CHAIR ERCHINGER said the purpose of this meeting was largely to talk about the updated audit findings list and to act upon accepting the fiscal year 2015 valuations and audit reports.

VII. ACTUARIAL REVIEW/AUDIT FINDINGS LIST UPDATE/CERTIFICATION AND ACCEPTANCE OF FY2015 VALUATIONS AND AUDIT REPORTS

A. Introduction

CHAIR ERCHINGER said the purpose of this meeting was largely to talk about the updated audit findings list and to act upon accepting the fiscal year 2015 valuations and audit reports.

B. Gabriel Roeder Smith Review

1. FY2015 Judicial Retirement System and National Guard Naval Militia Retirement System Roll-Forward Valuations

LESLIE THOMPSON of Gabriel Roeder Smith & Company (GRS) reported that her firm reviewed the roll-forward letter that Buck prepared on the Judicial Retirement System and the National Guard Naval Militia Retirement System (NGNMRS) roll-forward valuations. GRS was able to match all the numbers, so there are no findings.

2. Update: Defined Benefit and Defined Contribution Systems Valuations Previously Reviewed

No report or discussion.

C. Actuarial Audit Findings List – Review of All Accomplished Tasks

MS. THOMPSON indicated that the list was items that came from the PERS and TRS retirement valuations, as well as the defined contribution plan valuation. *[The audit findings spreadsheet is included in the GRS Actuarial Review Report, dated May 5, 2016, that was included in the meeting packet and is on file at the ARMB office.]* She said the first item on the list, "retiree healthcare elections," is really a broader issue: Buck has to use proxy data

for those people who are still in pay status. She had talked at the last meeting about how that needs to be disclosed in the final valuation report. Buck agreed to that; however, their disclosure is on page 80 as a little footnote. She has written a memo to the Board explaining why this is much more of a serious topic (*copy of the memo was in the meeting packet*). She has highlighted the proxy data issue so strongly because she believes the disclosure is not yet in compliance with actuarial standard ASOP #23 on data quality. In this case, the source of the data is the pension data. An actuary must disclosure what they have done to the data to make it useable. For example, if someone on the pension side is married, the assumption is that they are electing family coverage. There are other assumptions that Buck has made to make the data useable. This actuarial standard of practice does not say that using proxy data is wrong: they have recognized that there are times when data is not available or it is too mystical to use. But the actuary has to disclose it, and they have to disclose if they think there is a permanent bias in it based on what they had to do to the data in order to make it useable. She said Buck's footnote on page 80 of the valuation report is sufficiently vague that she would not know what to do to the data to make it useable. Her opinion is that it does not meet standards, and so she requested that more disclosure be added to the report.

The above covered both items #1 and #2 on the Actuarial Audit Findings list. #2 was persistent gains in retiree medical assumptions for PERS and TRS.

Chief investment officer GARY BADER asked what form a disclosure would take, in addition to a footnote.

MS. THOMPSON suggested that perhaps in the assumption section Buck could make a statement that "for purposes of this OPEB valuation, the source of the data was the pension data." GRS's opinion is that the data either has, or does not have, bias in its applicability to this valuation. Users should be cautious in using these numbers, or not cautious.

MR. JOHNSON stated that review of the medical care issues at the last board meeting resulted in a caveat letter that the Board adopted, recognizing that it was based on proxies, and the proxies were being used because of unavailable information due to a new third party administrator coming on board, etc. He asked if that caveat letter from the Board could serve as an additional highlight to the problem.

MS. THOMPSON replied that the Board's letter is serving as a highlight, but it does not meet actuarial standards. The actuary must have the disclosure in their report, signed under their name, in order to meet the standard.

MR. JOHNSON inquired as to GRS's recommendation for what the ARMB could do with respect to GRS's commentary on the use of pension data and assumptions regarding election as proxy for retiree healthcare election data.

MS. THOMPSON said it is to request that Buck Consultants put this more front and center in the PERS and TRS valuation reports. If she were a board member, she would want

something in the executive summary that says that "the retiree medical is based upon proxy data, for further information please see this section of the report."

COMMISSIONER FISHER said it seemed that this item should not rise to the level of this meeting until GRS and Buck have gone back and forth and reached an impasse.

CHAIR ERCHINGER stated that, because the committee at the last meeting felt strongly enough about the potential impact of the proxy data feeding into the $800 million gain on retiree healthcare, she felt it warranted the committee weighing in, and ultimately the Board, as to whether or not things need to be changed. She added that she appreciated GRS's letter with their recommendation to strengthen the disclosure language.

COMMISSIONER FISHER said he agreed it was an important issue and the committee should get a report on it. But whether Buck's disclosure in the valuation reports is adequate or not is something he felt the two actuaries should work on together. His recommendation was that only if there was an impasse would it need to elevate to the committee.

MS. HARBO wondered if Buck had a problem with it, because she thought the committee wanted to see it included in the executive summary.

LARRY LANGER of Buck Consultants said he agreed that it would be nice to have a process for the actuary and review actuary to have conversations in between. When Buck submits a valuation report around June 1, and then there is a need for commentary, there is not a lot of time to circulate views back and forth. Perhaps this is something that could occur a month before the board meeting. He expected that many of the issues could be worked out without going to "actuarial thunderdome."

CHAIR ERCHINGER remarked that it is a constrained time frame. If the committee is going to be asked to approve Buck's valuation reports, it needs to have sufficient time to make comments and make adjustments. If GRS recommends something that they feel super strongly about – and clearly they do or they would not have taken the time to write a letter about this one particular item – she did not know why it would not have been addressed before it came before the committee in final form to adopt now. It is prudent for the committee to act upon it, now that it is on the agenda for consideration and approval.

MR. LANGER said that Buck put into the valuation reports what they thought would satisfy the disclosure requirement. Clearly, it is GRS's opinion that that is not the case. Having a back-and-forth earlier would eliminate that type of situation.

MS. HARBO commented that it was not just GRS's opinion: it was the opinion of the actuarial standards that the disclosure has to be in the reports. To her, it was déjà vu about an actuary that the retirement systems had in 2003 that underestimated healthcare liabilities, and which has affected the employer contribution rates from that day forward. That is why in 2005 the legislature gave the newly created pension investment board a second actuary to check up on the primary actuary. It is the ARMB's duty to listen to what the second actuary

says. She heard Ms. Thompson say that Buck's disclosure in the valuation reports does not rise to actuarial standards, and she personally would like to see the disclosure in the executive summary.

MR. JOHNSON said he agreed with the commissioner, in terms of where this conversation could have ideally taken place. However, the problem is that the committee is at the point of having to approve or not accept the FY2015 valuations reports.

CHAIR ERCHINGER stated that the committee has to recommend at tomorrow's board meeting to have the proxy data disclosure changed or not, unless Buck agreed that the disclosure should be more strongly worded or more centrally placed.

MR. LANGER said that Buck was fine that additional wording would be helpful for the Board, as the review actuary had stated. Given the time frame, this would require Buck to update the valuation reports to put some language in a different spot, in order to have updated reports for the full Board to adopt tomorrow. He added that later in this meeting Buck would be talking about how to approach things, and he advised hashing over this item again later on.

The Chair prompted Ms. Thompson to continue reviewing the updated schedule of actuarial audit findings and resolutions.

MS. THOMPSON stated that she brought up the large gain on the mortality assumption for PERS at the April meeting (item #3 on the schedule). She has not received an answer that explains why mortality rates that are normally about 2% a year had a gain in FY2014 that was 10-fold compared to the prior year. She said Mr. Kershner had said at the April meeting that it depends upon who died, etc., which she totally agrees with. But the gain is of such a magnitude that she was concerned about that number. So that item is still open.

On Item #4, post-retirement benefit adjustments for survivors in PERS and TRS, MS. THOMPSON said that is still open because of a system limitation. She said another issue that she forgot to add is that GRS found a small error on PRPA with timing on the year of a death benefit. Buck had said they had fixed it, but when GRS reviewed the test lives it had not been fixed yet.

MR. KERSHNER indicated that Buck had reflected that correction in the final valuation. MS. THOMPSON said that left just the original item #4 open.

MS. THOMPSON stated that Items #5 (the methodology change in payroll) and #6 (clarification re ARC) were basically getting clarity around the new method of using rate pay versus valuation pay. She mentioned that to define the rate payroll as "the payroll used to develop the rate" is unfair: it should actually be stipulated in the definition what is being done to the permanent part-timers and about annualizing mid-year hires, so people can see the difference between the two. That is still open.

Item #7 (clarification of "Other") was fixed, breaking out Other for the big plans. But in the defined contribution plan (DCR), Buck included a footnote that explains what some of the sources are but did not break out the numbers. GRS recommended that next year Buck break out Other in the DCR as well.

MS. THOMPSON said she thought Item #8 (deferred disability commencement) was still open pending a discussion between Buck and Alaska staff on how to value this particular benefit.

MR. KERSHNER indicated he thought this was an item that GRS identified in one of the test lives, and Buck changed the valuation coding between the preliminary valuation and the final valuation. MS. THOMPSON said she did not think that it was this item, so she would leave Item #8 as possibly open.

MS. THOMPSON stated that Item #9 is still open, regarding getting clarity around references to fiscal years, plan years, and valuation years.

Item #10 is an open item for continued monitoring because of the issues related to getting data from the National Guard Naval Militia system.

Item #11 is regarding a formal plan for the PERS and TRS DCR plans. That documentation is in progress.

MS. THOMPSON mentioned the GRS findings from reviewing Buck's experience analysis. The first was the persistent losses on pensions for PERS and TRS, which is an item that is on hold until the next experience study. Regarding the large rehire loss in TRS, she said that at the April meeting Buck had said they agreed there probably needs to be an explicit rehire assumption. GRS recommends looking at that with the next experience study.

Chief financial officer KEVIN WORLEY reported that he met with the National Guard yesterday to discuss the process of capturing data properly. They also discussed the ramifications of the additional 225 members that the National Guard found to have eligible service in 2014. He said the Division of Retirement and Benefits would be looking at the data this year before sending it to Buck, to get a better feel for what they are forwarding.

Referring to GRS's finding on the large rehire loss in TRS, MS. HARBO stated that she questioned the number of 52 teacher rehires that Buck reported retrieving by taking a second look at teacher data after school started in the fall. She thought there should be many more rehires because Anchorage, Fairbanks and Mat-Su Valley would probably account for at least 300 teachers who get pink slips in the spring. Some get hired back and some not. Also of note is that under the TRS defined contribution plan (DCR) there was something like 263 teachers who had been let go in the spring.

MS. THOMPSON told Ms. Harbo that she was not alone in that surprise, including Buck. That is why GRS recommended moving to an explicit rehire assumption.

MS. HARBO reiterated that the rehired teachers are mostly going to be in the DCR population, because those are the last-hired, first-fired teachers.

MR. LANGER said he thought Buck was anticipating a fix for the large rehire loss in TRS for the upcoming valuation and not waiting until the next experience analysis. Buck might look at the impact of the rehires over the past handful of years and use that information to load the results, and not load it based on the actual data, because 52 rehires seems low.

MR. KERSHNER added that Buck has looked at this, and the average load on the TRS accrued liability over the last five years is .17%. If they compare what that load would have been versus the loss that was incorporated in the last valuation, the difference was around $600,000. So it was not a significant amount, but Buck can apply a load like that in the FY2016 valuation.

Responding to Ms. Thompson, MR. KERSHNER said the .17% average load was the figure for TRS, but Buck could do a similar analysis for the four large plans.

MR. JOHNSON returned to the earlier data disclosure discussion. He asked if it was possible for Buck and GRS representatives to talk and try to come up with some acceptable language that everyone agreed upon that could be presented to the Board tomorrow.

MR. LANGER said he preferred to do that so that Buck could present an updated report with language of that nature in it at tomorrow's board meeting.

CHAIR ERCHINGER reminded him that later in this meeting the committee had to vote on what to recommend to the full Board tomorrow. She added that the committee might not need to know exactly what the language is going to be as much as trusting that the two actuaries will work together to come up with language they can both agree upon.

MR. WILLIAMS commented that while the two actuaries reaching agreement on items weeks in advance was not realistic, he thought that having a conversation even the day before to clarify some things would make the process a bit smoother. Regarding Buck's use of pension data as proxy for healthcare election data, he asked if things were on track to completely move away from proxy data. Then the report about data from the National Guard and other places made him wonder how confident everyone is in the data the State is getting. He asked what ways the data can be improved so that everyone is confident in that data. He said he liked real data so much better than proxy data, but if the data being collected is incomplete, that is an issue too. He would like to see a probability of how confident people are in the current data, and that there is movement away from using proxy data, and what the timeline would be for that.

MR. LANGER replied that there has been some good progress on the proxy data elements to date. Buck's intent is to have an update at the September board meeting and absolutely

implement what they have for the June 30, 2016 valuation. He asked Buck's healthcare actuary, Melissa Bissett to comment on that.

MS. BISSETT explained that Buck has already gathered a 7/1/15 file from Aetna on the eligibility. They are in the process of matching the data with the people in the valuation census so they can append what the level of coverage is, as opposed to the current practice of relying on the pension form and marital status. Buck expects that will be complete in time for the September board meeting so they have an estimate of what any impact might be, and to have it set up for doing the 2016 valuation.

Deputy commissioner JOHN BOUCHER stated that one area of data in the retiree system that can tend to get stale is the dependent data. The Department of Administration is issuing an RFP (request for proposal) to verify the dependents of retirees in the coming year. This will improve the data quality.

CHAIR ERCHINGER called a lunch break about 12:15 p.m. The meeting reconvened at 1:30 p.m.

D. Buck Consultants Review

1. FY2015 Judicial Retirement System and National Guard Naval Militia Retirement System Roll-Forward Valuations

MR. KERSHNER directed attention to slide 31 of the Buck slide presentation, to the section titled "Final Actuarial Valuation Results for JRS and NGNMRS." *[The Buck presentation material is on file at the ARMB office.]* He stated that this was a roll-forward valuation for the two retirement systems. Because these plans are relatively small, there is no need to collect new data and run a full valuation every year. In the odd-number years, a roll-forward valuation is done, where the liabilities from the most recent valuation – in this case, the 2014 valuation – are projected based on simple actuarial principles. Buck collects real asset information as of 6/30/15, so they are not rolling forward the assets.

For JRS, he pointed out that the funded ratio went from 71.9% to 75.6%. That is mostly due to a gain on the assets, which is because Buck is using the five-year smoothed value on the assets. The market return on the assets in FY2015 was about 3%. But because of smoothing, the return on the actuarial value was 10.8%. The employer contribution as a percentage of payroll went from 76.49% to 74.21%, again, mostly because of the amortization of the unfunded liability based on the favorable return on the actuarial value of assets.

CHAIR ERCHINGER drew attention to the funded ratio of the JRS healthcare piece (146%) versus the pension piece (69%). She asked if it would be typical for Buck to recommend in the next valuation to reduce the recommended allocation to healthcare because the healthcare side is so overfunded, or to transfer assets into pension to raise

the funded ratio of pensions. She wondered if the actuary was even concerned about that.

MR. KERSHNER responded that there could be statutory restrictions on being able to transfer from one fund to another. There could also be some taxation issues for individuals. Even though the healthcare piece is well-funded, he thought the ARMB would still want to at least fund the normal cost (the benefits that are accruing for the upcoming year) because that is the real benefits that are being earned. When Buck sets the FY2018 contribution rates, the amortization of the unfunded liability for the healthcare will be zero. If the ARMB does not fund the normal cost, and assets do not do so well in a year and the funded status is not as great, then the plan is falling behind on the benefits that are accruing.

CHAIR ERCHINGER asked, if the legislative language did not have any prohibition against transferring money between pools, if that was something that would typically be done.

MR. KERSHNER said the taxation issue is at the participant level on the contributions that are being made by the individuals for pension versus healthcare. The tax issues at the individual level are why there are often healthcare funds separately funded without employee contributions.

MR. BOUCHER asked if the Chair wanted the department to research this.

CHAIR ERCHINGER said she was interested in it if someone had the knowledge at hand, but did not want the department to spend a lot of time on it.

Moving on to the NGNMRS FY2015 valuation results, MR. KERSHNER stated that it, too, was a roll-forward of the liabilities but using actual assets in the calculation. The market return was about 1% in 2015, and the return on actuarial value was 7%, which is exactly what the long-term earnings assumption is. There was not as much of a difference in the amortization piece because the return on the actuarial value of assets is driving the unfunded liability. The funded ratio stayed constant. The dollar amount of contribution went up slightly, partly because the expense load was higher.

CHAIR ERCHINGER commented that over the past few years staff has talked about the NGNMRS having the least amount of reliable data. She remained concerned that the plan is not really capturing all the people who are entitled to benefits, maybe because they are not being contributed properly or reported properly. If an entity was not reporting or paying contributions for an employee, and that person put in a claim for retirement benefits, she assumed they would have a valid claim. She asked if Buck had any concern about Alaska not adequately capturing people who are entitled to benefits, based on the lack of good data in this plan. If that is the case, and there is concern, she wondered if actuaries account for that by using an explicit assumption to increase the required contribution rates by some margin to capture that possibility.

MR. KERSHNER admitted that because Buck did not do a NGNMRS valuation this year and so did not collect data, he was not familiar with the data issues, other than hearing a couple of comments at earlier meetings. He understood that the Division of Retirement and Benefits (DRB) was working to resolve the data issues, which would hopefully be reflected in the upcoming FY2016 valuation. If the ARMB felt there were missing participants who would ultimately have a benefit claim, Buck could consider some sort of load. The problem is that it would be difficult to determine what an appropriate load should be because it would be a guess.

CHAIR ERCHINGER asked if DRB had encountered a claim for NGNMRS benefits where there has been no record of contributions or some other question about the claimant's eligibility.

MR. BOUCHER replied that there have been more such instances related to PERS employers than the National Guard. His understanding is that if a person does not have paid service, they do not get credit for the service.

CHAIR ERCHINGER said she asked the question because she recently had a conversation with one of the major government insurance plans that asked about this specific problem – who would have the liability for covering those types of claims. It sounds like the State thinks that it is actually on the employer and not on the plan or the State.

COMMISSIONER FISHER stated that they have talked about it, but he did not think they had a firm opinion on the State's position.

MR. BOUCHER said the department is starting some broader conversations, not only with National Guard, but with employers that are concerned about the potential for that liability.

CHAIR ERCHINGER stated that she serves on an insurance board for government employer insurance. They are having a conversation about fiduciary liability for employers. She brought it up today because if it is possible for employers to buy insurance against that type of liability, which would make the system whole if there was a claim but also not put undue burden on the employers, it might be an interesting consideration. She was wondering if DRB had any evidence of claims being made for service time, and the employer had not paid into the plan for the employee. It sounded, however, like that is not an ARMB problem or a system problem because the State just considers that someone is entitled to benefits when the State has received the contributions and the reports of employment. That made sense to her.

2. Update: Defined Benefit and Defined Contribution Systems Valuations Previously Presented

MR. KERSHNER drew attention to page 3 of the Buck slides, a summary chart of the final versus preliminary FY2015 valuation results for the PERS and TRS defined benefit plans and the PERS and TRS defined contribution plans. The final valuation results reflected the changes that came from GRS's comments. There was very little change in the final results because the revisions that were incorporated moved the needle very little.

MR. KERSHNER noted that except for slide 3 and slide 31, the other pages in the valuation reports were basically the same as the committee reviewed at its April meeting but with the updated numbers. Slide 24 showed the FY18 contribution rates.

CHAIR ERCHINGER drew attention to slide 26, the 30-year projection of funded status for PERS. She said it would be a good exercise to start talking about the ARMB having a funding plan, or at least finding out what other retirement systems do. Her focus was on disaster scenarios for the state, if things get really bad, and doing some planning up front to consider options. She mentioned the workshop in 2013 with various stakeholders that resulted in the recommendation that the governor consider a one-time contribution into the retirement trusts. Another brainstorming session might come up with ways that the cities and state could participate together and come up with fallback scenarios to deal with a downturn in the economy or the future inability to make contributions. One thing would be to talk with the actuaries about what funding plans they have seen from other states that have tried to be creative.

3. Health Gain/Loss Analysis

MR. LANGER stated that the FY2015 valuation results showed significant increases in the funded status of the plans, especially the healthcare portion. Some of that was due to the extra state appropriation. For PERS, the healthcare funded status of the plan increased from 87% in the prior year to 99% – a very large increase. The TRS healthcare funded status rose from 77% to 100%. The primary driver of the increase in the funded status was the retiree medical claims experience. Claims are coming in a lot lower than was anticipated in past valuations. So the Actuarial Committee requested that Buck do a deeper dive on that gain.

MR. LANGER reviewed a chart of factors that contributed to the medical claims experience gain for the PERS and TRS plans from the June 30, 2014 valuation to the 2015 valuation. These factors together resulted in a June 30, 2015 liability amount that was less than Buck had anticipated. He went on to describe each contributing factor in detail:

- An exhibit of the weighted claim cost rate at average age for the June 30, 2014 valuation showed how Buck developed the per capita claim cost. Buck takes an average of the claim amounts over the past four years. They take membership counts and average them over the past four years. They apply a factor to increase the four fiscal years up the current year. So Buck expected the FY2011 per person claim

amounts to increase by a full 33%. (It is a common convention within the actuarial world that increases will be 7%, 8%, 9% a year). Based on the calculation of what Buck thought the increases would be in the future, it suggests that the claims should have been much higher than they are seeing right now. Next in the process is to reduce the claims a bit to reflect the expected savings from the new third party administrator, Aetna. Finally, Buck weights the average claims in each year, giving more weighting to the more recent information and less weighting to older information. All that resulted in a FY2015 weighted claim cost rate of $8,342. The FY2015 amount is then increased by a trend amount to get to $8,944 for the FY2016 weighted claim cost rate. That cost amount forms the basis for going into the valuation.

- Completion factors – Buck does not have all the claims information when they do the valuation report in any given fiscal year because claims take time to process. Actuaries use a completion factor, based upon past experience, to reflect that they believe more claims will be coming. In the past, Buck anticipated that about 81% of the total claims were reflected in the data. Looking at it once the dust had settled for FY2014, the number had crept up to 85%. The current TPA seems to be settling medical claims a bit faster than the previous administrator. The result was the estimated weighted FY2016 average claim cost decreased from $8,944 to $8,822, for a reduction of about 1.4%. So the completion factor in the calculation was responsible for about 10% of the total gain amount on healthcare.
- Updated experience base period – Buck drops off the FY2011 claims experience and adds on what they expect to be the FY2015 claims experience. Every year when they update the valuation, they pick up a different set of claims for four years. For the FY2015 valuation, they picked up fiscal years 2015, 2014, 2013, and 2012. There are some higher per-person claims in fiscal years 2011, 2012 and 2013, and those are falling off, and Buck is trying to reflect what is more recent. Just the process of dropping totally those relatively higher amounts from FY2011 and partially from FY2012, plus adding on what Buck expects to have happen in FY2015, the weighted average claim for FY2016 reduced from $8,822 to $8,665. Even if claims increased as much as Buck thought they would, they still would have seen a decrease in the average claim rate used in the valuation of about 1.8%. That 1.8% corresponds to about 12% of the total gain amount on healthcare.

MR. BADER said he anticipated that a new TPA would provide more hospitals and providers that were in-network, which presumably would save the plans money. He asked if that impact on the cost of benefits to the plans could be measured. He said people simply are trying to understand why the numbers have changed in the magnitude that they have.

MS. BISSETT replied that the explanation was in line 6 of Buck's calculation of the weighted claim cost rate – "manual adjustment for TPA savings." Buck received information from Aetna during the RFP process that they expected the change in network to result in more and better discounts. Based on the information at that time, it moved Buck's estimate for adjusting for TPA savings.

MS. THOMPSON remarked that so far in this presentation she was seeing that Buck's model was predicting the claim amount conservatively. So it was more in the prediction method and not about people being treated in-network or any other reason around the claims.

MR. LANGER said that when compared to experience, the model predictions were conservative. But if one looked at the type of trend rates that are used, it is fairly consistent and comparable with other valuations prepared by other firms. During this period of time it looks like Buck overshot, but there could be other periods of time when Buck has undershot as well. It is hard to predict when that overshooting or undershooting would occur.

MR. BOUCHER explained that the State structured its last RFP to try to capture savings in the healthcare plans and bring in a more robust network. The year-on-year trends of 9%-10% were a concern, particularly when looking at the long-term for healthcare. Looking back at 2014, for instance, Buck had very recent experience that indicated, even with some savings, that they should have a relatively conservative trend going forward. Since the Aetna contract was implemented January 1, 2014, the savings have been greater than anticipated. The previous TPA's network discounts were generally in the neighborhood of 20%-25%. Aetna's network discounts have been consistently measured at 36%-37% (the discount off billed charges). At the same time, healthcare is continuing to ratchet up. The State, through its management of this, has been able to change the direction. Whether that is sustainable is another question because there are significant challenges.

MS. BISSETT stated that historically a new TPA results in a nice drop in claims costs at the beginning of the contract. As time goes on, the trends increase because the providers increase their rates. The TPA is still getting the discounts, but it is a discount off higher costs. So the value of having a new TPA starts to erode a bit over time. That is why she does not bring the trends way down, because she has seen a pattern with the prior TPA that a drop in claims costs is followed by costs going back up. Even at this point, Buck has only 18 months of claims data from Aetna, so it is still early in the cycle of the contract. Buck would have to have another meeting with Aetna to determine if the TPA is administering other things differently than the prior TPA did. Buck has to use what they expected from the TPA's proposal at the time, but results are different. Buck has to attribute most of that to experience based on the utilization itself and perhaps the providers that are being used.

MR. WILLIAMS commented that one change over the past 20 years in TRS is that the people with health benefits at 20 years' service have already retired. Also, half the TRS membership is now defined contribution plan, and they will not automatically be retiring at 20 or 25 years. They may be in and out of the system and may work much longer.

MS. BISSETT said that Buck will have to wait until they see the experience.

MR. BOUCHER pointed out that this particular analysis was only looking at the defined benefit plan population. However, he agreed with Mr. Williams that generally people are having to wait until later to take advantage of the healthcare benefits. Therefore, that period of pre-65 people using retiree health benefits is generally shorter, when they are the most expensive to the plan. There are fewer Tier I's, and the Tiers II and III are the larger portion of the retiree population that would represent future liabilities. In addition, the average demographic of the defined benefit group is moving over age 65, when a significant share of the healthcare cost is shifted to Medicare.

MR. LANGER continued with his presentation on the health gain/loss analysis.

- Pharmacy rebates – In the course of developing the FY2015 valuations, Buck learned that Aetna was not reflecting the pharmacy rebate amounts directly in the claims for FY2014 and FY2015 but was reporting them in a different area. Buck reflected the pharmacy rebates in the total claims amounts for the FY2015 valuations and updated the FY2014 claims amounts to also take into account the rebates. As a result, the weighted claim cost rate for FY2016 dropped from $8,665, after the updated experience base period, to $8,463. That reduction is about 2.3%, which contributed about 16% to the overall gain in healthcare gain/loss analysis.
- Updated FY2014 and FY2015 reported claims were used to develop the FY2016 weighted claim cost rate, which reduced it down to $8,034. That is about a 5% reduction, which corresponds to about 36% of the overall gain in healthcare.
- Experience period weighting created a small adjustment. Buck is becoming more comfortable with Aetna and the claims they are providing, so they are shifting more of the weighting to fiscal year 2015. The change reflected a bit more of the recent experience, but the impact on the results was hardly anything because the claims in those two years, once adjusted for trend, were somewhat similar.
- Aging adjustments – Buck uses an average claims amount, but the reality is that they know the claims amount is higher for people younger than 65 because they are not yet eligible for Medicare. The other truth is that as people age they have higher claims. Those things are not reflected in an average claims amount, but Buck makes use of aging adjustments. The valuation software converts the average claim amount to a claims amount for each age. The aging adjustment represents about 25% of the overall gain.

MR. LANGER posed the question of whether the medical claims experience gain was going to continue. He looked at the average claims over each of the past four years and pointed out that the older amounts will drop out of the calculation with each passing year. Looking at fiscal years 2014 and 2015, what Buck would have projected for the FY2016 average claims amount is sort of close, instead of the large decreases seen over the last couple of years. There are a couple more years where conservative numbers will be replaced by real experience. So there could be claims experience as expected and Buck would still come back and say that the liabilities are down a little bit as they drop

off the claim amounts from prior years that would suggest higher liabilities. He said not to be surprised if liabilities come in a little bit lower again as some of the higher amounts from previous years are shed.

MS. THOMPSON remarked that the scary thought is if it was possible to reverse and have a year with a billion-dollar loss.

MS. BISSETT said the wheels would really have to fall off the bus for that to happen. Even if the experience of 2014 and 2015 ended up coming in closer to the $9,000 average claim amount of the previous years, it would swing, but she did not think it would be to the extent of the $800 million. She would expect a 3%-4% swing the other way.

MR. LANGER pointed out that Buck is anticipating health care increases of about 7%-8% on average, so it would have to exceed that. They are continuing to anticipate increases that are consistent with what there was before: it is just that they have lowered the current year's expectation for clients. However, it could reverse. There are a lot of things contributing beyond just claims experience this past year, so to reverse it would take a lot of events going in the opposite direction of what they have seen in the past year.

MR. JOHNSON mentioned Buck's presentation at the last board meeting about reduced costs to the retirement systems of $1.2 billion. The Board had expressed some concern about the reality of that. He assumed that since that time the FY2014 and FY2015 reported medical claims was new data that refined the outcome and was distinct from the so-called proxy data that the Board criticized the first time around.

MR. LANGER said those were two separate issues. He said Ms. Bissett earlier gave an update that Buck has collected new data and is looking to incorporate it, and there will be an update at the September meeting. The proxy data underlies this. Buck believes there is consistency from year to year on the proxy data, whether it is providing for consistently higher liabilities or consistently lower liabilities. Buck thinks the proxy data may be resulting in the liabilities being a little bit higher or close to the same, but that is their educated guess based upon the information they have at the moment. The information before the committee today speaks just to the impact of medical claims on the liabilities. Buck just took the $1.2 billion amount from the reports to have a deeper discussion about what it could be attributed to.

CHAIR ERCHINGER stated a key take-away is that Buck has shown today that there are some tangible data-driven explanations for the medical claims experience that do not have anything to do with proxy data. So it may well be that proxy data in place of actual claims may have no impact, and everything is explained by what Buck just showed. However, it is possible there could be additional impacts, but Buck will not know that until they have a few years of actual different data to look at.

MR. LANGER said Buck will be able to ascertain that in a year, as they compare the liabilities with the proxy data in the next valuation, keep everything the same, and then replace a better data set.

MR. KERSHNER explained that the proxy data is the underlying census data that the average claims costs are applied to. For example, the proxy data tells Buck that there is a retiree on the pension side who has a survivor benefit and is listed as married. Buck's assumption is that healthcare is covering the participant and the spouse. The real data that Buck is going to get will tell them whether that person should be counted as having a spouse and/or children.

Regarding the materiality of the proxy data versus actual data, MR. BOUCHER remarked that what Buck just presented was what goes into calculating the average claims cost per covered life, which is multiplied by all the covered lives and then into the future. That is a basic piece of the calculation, whereas the proxy data is talking about potentially the number of dependents that they multiply that number by, which is a subset of the overall. The focus has to be on what the average healthcare cost is per an individual. The demographics will always move and shift. The overarching discussion needs to focus on the average claims cost calculation.

MR. WILLIAMS referred to the aging factors in Buck's valuation process that accounted for about 26% of the gain in healthcare. He asked how granular the information was, and if the medical claims cost data was available by age group, for example.

MS. BISSETT replied that she had tried to get that sort of information for the last experience study but the timing did not work out. When she applies the aging factor, it does not get down to that granular level. Buck would have to be careful about credibility because there has to be enough claimants and medical claims in each age cell to feel comfortable with the outcome. It is something that would have to be considered for the next experience study, and Buck would have to collect the data from Aetna.

MR. WILLIAMS said that having that data for multiple years would allow the committee to see quite a bit deeper.

MR. BOUCHER interjected that the Division of Retirement and Benefits has that data and looks at it regularly, but it is in broader swathes.

CHAIR ERCHINGER said she appreciated the deeper look on the healthcare gain/loss process. She hoped it had provided a higher level of comfort to the committee on where the retirement plans are, with regard to the medical claims experience, and where they are headed.

The Chair called a short break to permit time for the two actuaries to get together and propose some language about the proxy data disclosure. She said that if they could reach

agreement, it would allow the committee to consider and act upon something tangible to present to the Board tomorrow.

E. Action Items:

1. Committee Recommendation for Board Acceptance of GRS Certification for FY15 PERS/TRS, DC Plan Valuations; NGNMRS and JRS Roll-Forward Reports

[An Action Memo, dated June 23, 2016, giving the background and staff recommendation, was included in the meeting packet and is on file at the ARMB office.]

CHAIR ERCHINGER read into the record that Buck Consultants, the board's actuary, had completed: (1) a valuation of the Public Employees' Retirement System (PERS) as of June 30, 2015, (2) a valuation of the Teachers' Retirement System (TRS) as of June 30, 2015, (3) a valuation of the Defined Contribution Retirement Plan as of June 30, 2015, (4) a roll-forward valuation of the Judicial Retirement System (JRS) as of June 30, 2015, and (5) a roll-forward valuation of the National Guard Naval Militia System (NGNMRS) as of June 30, 2015.

Gabriel Roeder Smith & Company (GRS), the board's review actuary, had reviewed the work products prepared by Buck Consultants and provided several documents describing the reviews, along with their findings and recommendations.

MS. HARBO moved that the Actuarial Committee recommend that the Alaska Retirement Management Board accept the review and certification of actuarial reports by Gabriel Roeder Smith & Company. MR. JOHNSON seconded. The motion passed unanimously.

2. Committee Recommendation for Board Acceptance of Buck Valuations for FY15 PERS/TRS, DC Plan Valuations; NGNMRS and JRS Roll-Forward Reports
   [An Action Memo, dated June 23, 2016, giving the background and staff recommendation, was included in the meeting packet and is on file at the ARMB office.]

CHAIR ERCHINGER summarized the memo. She noted that, because the committee was being asked to approve the valuation reports, the committee hoped that the actuaries would agree upon the change in language specifically about the use of proxy data for the healthcare elections that participants choose for coverage. She asked the actuaries what they had come up with.

MR. LANGER read into the record the proposed change that would appear at the end of paragraph 3 of the valuation executive summary: "Valuation census data used for the retiree medical valuations utilized available retiree medical information, and certain pension data fields have been used to clarify the retiree medical data provided. Details regarding this information can be found in Section 6.2(d)."

MR. LANGER said the information to be attached in Section 6.2(d) talks to the source of the retiree data. The actuary's statement would read:

- "The Division of Retirement and Benefits provided pension valuation census data. This pension census data included retiree medical enrollment information that indicated the system, an indication regarding eligibility for system-paid benefits.
- The following adjustments or assumptions were made to the pension retiree data for its use in the retiree medical valuation. Where there is an indication of non-system-paid benefits, we reference the coverage level indicated. Where there is an indication of non-system-paid health benefits, we reflected the covered level – e.g., single vs. couple – indicated on the pension data in valuing retiree medical plan.
- Where system-paid health benefits coverage is indicated, the premium dollar amount indicated on the data is a composite rate that does not specify the number of people enrolled. Buck understands that retiree medical coverage eligibility is in place while a pension benefit is payable. For individuals who are receiving a pension benefit, Buck references the pension benefit payment form, single life annuity, joint survivor, etc., along with marital status, to determine the number of people to value for medical purposes.
- Where there is a single life annuity indicated, and the marital status is single, Buck values one member for health coverage. Where there is a single life annuity indicated and the marital status, we value two members until the retiree dies. Upon the retiree's death, medical coverage for the spouse is assumed to cease and that spouse is no longer valued. Where there is a joint survivor annuity, we assume a member and spouse are covered and, upon the retiree's death, health coverage is assumed to continue to the surviving spouse. For individuals included in the pension data expecting a future pension, we value the health benefits starting at the same point that the pension benefit is assumed to start. Future retirees' level of coverage is estimated according to valuation assumptions regarding spousal coverage."

MR. LANGER said that was the adjustments or assumptions piece. He then read into the record Item 3: "Any limitations on the use of valuation results due to uncertainty about various aspects of the data: pension data is used to estimate healthcare coverage. The liabilities and resultant figures regarding funded status and proposed employer contribution rates may be different if we had data that could directly determine the level of coverage for each retiree."

Item 4: "Any unresolved concerns that the actuary has about the data, such as the actuary is still waiting to receive the actual retiree medical plan data: we have not completed the reconciliation of retiree medical enrollment data to the OPEB valuation census data. Based on information provided, it appears that our valuations assume that a greater number of individuals are enrolled in a retiree medical coverage than are indicated in the enrollment statistics provided by the carrier. This is because our data assumptions for use of pension data is a proxy for individual retiree medical coverage conservatively includes in the valuation any potential dependent. The carrier enrollment information with lower enrollment figures is conservatively used to develop per capita costs, resulting in higher per capita costs than if we had used counts from the proxy data.

The existence nature or potential magnitude of any uncertainty or bias: until we can complete the comparison between the retiree medical enrollment and the proxy data, we cannot specify the magnitude. There is a potential for bias and we believe there is conservatism in our methodology, that is, it is possible there are more people included in the valuation than are enrolled in the retiree medical plan."

MR. LANGER said that was a summary of Buck's comments that would be added to all four valuation reports.

CHAIR ERCHINGER ascertained from Ms. Thompson that she agreed to those additions to the valuations. She thanked the actuaries for their work and said it goes a long way toward addressing the committee's concerns and makes it part of the record. She then read the recommendation into the record, as follows, and asked for a motion.

"The Actuarial Committee recommends that the Alaska Retirement Management Board accept the actuarial valuation reports prepared by Buck Consultants for the Public Employees', Teachers', Public Employees' Defined Contribution (for Occupational Death and Disability and Retiree Medical Benefits), Teachers' Defined Contribution (for Occupational Death and Disability and Retiree Medical Benefits), and the roll-forward valuation reports for the Judicial and National Guard and Naval Militia retirement systems as of June 30, 2015, as amended by mutual agreement of Buck Consultants and GRS."

MS. HARBO moved the motion, and MR. BRICE seconded.

MR. JOHNSON offered a friendly amendment that the clause at the end of the motion say subject to such cover letters as the ARMB may determine appropriate. He said he was referring specifically to so-called caveat letter that the Board voted into place at the last meeting. The concerns of the Board might well be the same, notwithstanding the clarifications that have been offered by Buck today.

MS. HARBO and MR. BRICE accepted the friendly amendment.

CHAIR ERCHINGER said she thought that including the cover letter had been voted on at the last meeting.

The Chair asked for a voice vote, and the vote was unanimous in favor.

3. Committee Recommendation for Board Acceptance of Audit Findings Report and Resolution of Findings

CHAIR ERCHINGER read into the record the following proposed motion:

The Actuarial Committee recommends that the Alaska Retirement Management Board accept the resolutions and findings as indicated on the Audit Findings Lists dated June 23, 2016.

MS. HARBO moved the motion. MR. BRICE seconded. The motion carried unanimously on a voice vote.

VIII. A. FY2016 Pre-Valuation Discussion

1. Actuarial principles and underlying assumptions; reporting protocols and any proposed new assumptions

CHAIR ERCHINGER inquired if Buck Consultants anticipated any recommended new assumptions.

MR. LANGER stated that Buck would continue on with the proxy data information. At the moment, the only other principles or assumptions they anticipate changing in the upcoming year is the rehire liability.

MR. KERSHNER added that it seemed that until Buck can gather more information the best approach would be to take the average of the last five years of rehire gains or losses to be the load as a percentage of liabilities.

MS. THOMPSON agreed with that.

Regarding reporting protocols, CHAIR ERCHINGER said that language was originally anticipated to distinguish how the actuaries report to this committee versus reporting out to the full board, with the idea to try and limit the time of the full board in presentations, because all but two of the board members participate in the committee meetings. She asked people to bear that in mind in not repeating to the board, in every case, a full presentation that was made to this committee, to make better use of people's time.

2. Clarification of medical claims data collection

CHAIR ERCHINGER noted that this topic was discussed earlier in the meeting, and she expected there would be further information on that.

MR. JOHNSON stated that there was discussion at the last Board meeting about a possible meeting amongst Buck, GRS, Aetna, and this committee about looking at how the medical data is assembled and presented and so on. Today's discussion may have made that moot, but he wondered if there was any further thought about such a meeting.

MS. BISSETT said Buck had thought about asking Aetna to provide more detailed information, beyond what was talked about here today, to help people understand truly the impact of discounts versus utilization versus how Aetna is administering the claims. Perhaps Aetna is adhering to protocols that the prior administrator did not adhere to, that sort of thing. That type of information would be in that last 5% piece, if the committee wanted to pursue that.

CHAIR ERCHINGER mentioned questions that came up at the previous meeting about

whether Aetna is processing claims differently than the prior TPA, and if they were denying a lot of claims and then allowing them. There are accusations out there that Aetna is maybe not processing claims correctly or the same, or they are delaying them. She asked committee members if they thought such a discussion would be helpful or necessary now or in the future.

MR. JOHNSON said he thought Buck representatives had said they were working with more data on that. Education and information does not hurt. Maybe an alternative to convening a meeting on this would be for one or more representatives of this committee to attend the quarterly healthcare meetings where Aetna participates. That is an existing scheduled forum that people might appropriately go to.

MR. BOUCHER informed the committee that former trustee Sam Trivette sort of served that role, in terms of regular attendance at the healthcare meetings between the TPA and the State. He thought that was a valuable source of information for the committee and board, and the committee might want to formalize that relationship if there was interest. Buck does not generally attend the quarterly healthcare meetings. As a secondary source, he could always provide the committee with the materials that are discussed at those meetings – but it is a lot of material.

CHAIR ERCHINGER commented that as long as Aetna is giving Buck the information that they need, perhaps the committee does not need to have a meeting with Aetna in the near future. She thought attending the quarterly healthcare meetings would be more direct and participatory. Any committee member interested in doing that should follow up with Ms. Hall to see if procedurally it is appropriate to appoint somebody or not, or if someone could just attend on their own.

MS. HARBO asked if the State had statistics on the number of medical claims appeals, how they are resolved, and how many go beyond the first levels to the body that settles appeals.

MR. BOUCHER reported that in calendar 2015, out of over a million claims, there were roughly 1,200 appeals that went to the first level. Of those, roughly 900 were upheld. Of those 150 or so appeals that continued on to level two, there were 62 that escalated all the way to the Office of Administrative Hearings. In terms of the potential materiality of unsettled claims, based upon the information that he has, he cannot see that it would be so large that it would even be significant in terms of the delay [unintelligible].

MS. HARBO said that a single sheet with those numbers would be helpful to be able to answer questions from the plan members.

MR. BOUCHER stated that he was happy to provide that.

MR. WILLIAMS asked if materials from the quarterly healthcare meetings could be forwarded to Judy Hall so she could send them out to committee members.

MR. BOUCHER indicated that he could do that.

3. Outstanding audit issues

CHAIR ERCHINGER indicated that the committee discussed the audit findings in depth. She asked if there were further comments, and there were none.

4. Integrity of actuarial reporting process and controls; significant changes to applicable actuarial principles; any items required to be communicated by independent actuaries

CHAIR ERCHINGER asked Buck representatives if there was anything that rose to the level of significant actuarial principles. They indicated not. Committee members had no concerns to voice.

CHAIR ERCHINGER said she thought it was great to have a dialogue with the primary actuary and the review actuary sitting at the table. It is a great opportunity to have robust, open communication, and it addresses a lot of questions. She appreciated the actuaries being so open and positive to that interaction, despite it maybe not being easy for them at times.

MS. THOMPSON mentioned that item 29 (roll-forward letter for judges and national guard) on the timeline for valuations will be different for next year because that will be a full valuation and not a roll-forward. GRS will need the information for a full valuation sooner, if possible. She added that the timeline worked very well for GRS this year.

MS. HALL pointed out that the timeline presented did not mirror the proposed 2017 ARMB meeting calendar. Assuming the Board approves the 2017 meeting calendar, which would determine this committee's meeting dates, she could coordinate between the actuaries and then update the timeline based on last year's structure.

MS. THOMPSON suggested, based on Commissioner Fisher's comments earlier, adding item 31.5 where GRS and Buck discuss the resolutions that emerge in the April meeting and have them resolved before the June meeting.

MR. LANGER proposed before February's committee meeting, because there is always something they are bouncing around. A month before the board meeting, just in case Buck finds something that needs to be polished, and that would give them two weeks to refine it and get it all together.

Others agreed that was a good idea.

CHAIR ERCHINGER thanked staff of the Department of Administration for doing a great job of getting information quicker, which has really helped everybody to stick to the timeline. Given all the other changes the Division of Retirement and Benefits has had to go through in the last year, she found that quite remarkable.

5. Review actuary issues
There was nothing to add.

B. Review and Approval of Valuation and Audit Timeline
MS. HARBO moved to approve the Valuation and Audit Timeline. Second by MR. WILLIAMS. On a voice vote, the motion passed unanimously.

IX. Review 2016-2017 Actuarial Committee Schedule
MS. HALL noted that the location of the September meeting was changed to Anchorage. Also, the 2017 meeting schedule would be official once the Board approves it tomorrow.

X. Other Matters to Properly Come Before the Committee – None.

XI. Public/Member Comments
There were no comments.

XII. Adjournment
The meeting adjourned at 4:05 p.m., on a motion made by Ms. Harbo and seconded by Mr. Brice.

Note: An outside contractor prepared the summary minutes from staff's recording of the meeting. For in-depth discussion and presentation details, please refer to the recording, staff reports, and written presentation materials on file at the ARMB office.

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