

NDPERS BOARD MEETING

Agenda

Bismarck Location:
ND Association of Counties
1661 Capitol Way
Fargo Location:
BCBS, 4510 13th Ave SW

August 22, 2013

Time: 8:30 AM

I. MINUTES

- A. July 25, 2013

II. GROUP INSURANCE

- A. Unum Long Term Care Plan Rate Adjustment – Sparb & Kathy (Information)
- B. Long Term Care Insurance – Sparb (Board Action)
- C. Medicare Part D Rates – Sparb (Board Action)
- D. Affordable Care Act Implementation – Sparb (Information)
- E. HIPAA Compliance Changes – Deb (Board Action)
- F. Interim Study–Health Premiums – Sparb (Information)
- G. 2012 Active Health Care Report – Bryan (Information)

III. RETIREMENT

- A. Defined Contribution Plan Research – Sparb (Board Action)
- B. Defined Contribution Plan Implementation – Deb (Board Action)
- C. Defined Contribution Plan Document – Deb (Board Action)
- D. HP Indexing – Kathy (Board Action)
- E. Interim Study - Retirement – Sparb (Information)

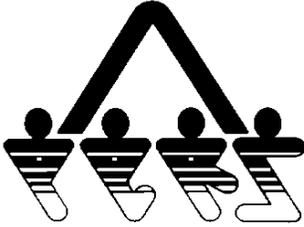
IV. FLEX COMP

- A. Flex Comp Survey Research – Sparb (Board Action)

V. MISCELLANEOUS

- A. Board Committee Assignments – (Board Action)
- B. Administrative Rules – Deb (Board Action)

Any individual requiring an auxiliary aid or service must contact the NDPERS ADA Coordinator at 328-3900, at least 5 business days before the scheduled meeting.



North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 • Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 • EMAIL: NDPERS-info@nd.gov • www.nd.gov/ndpers

Memorandum

TO: PERS Board
FROM: Sparb
DATE: August 14, 2013
SUBJECT: Unum Long Term Care Increase

Attached is a letter from Unum concerning a rate increase for our LTC plan. On page 2 they offer the options the plan has relating to the increase:

1. Make no changes to the plan and implement the rate increase as scheduled.
2. Consider plan changes such as funding arrangement, plan design, eligibility, etc
3. Terminate the group plan and offer participants the option to continue their coverage on a direct bill basis.

PERS presently has 60 members that participate in our LTC program. Staff would recommend that we move forward with the rate increase (option #1). If a member disagrees, they have the option to drop the coverage.

Board Action Requested:

To approve moving forward based on option #1 above.



RECEIVED

2211 Congress Street
Portland, ME 04122
207 575 2211
www.unum.com

AUG 06 2013

ND PERS

August 1, 2013

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
PO Box 1657
Bismarck, ND 58502-1657

RE: Policyholder Name: NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
Group Long Term Care 00510487-001

Dear Plan Administrator:

After careful consideration, we have determined that it is necessary to increase your policy's pricing by approximately 15%. Our intent to increase premiums has been acknowledged and approved by the State Insurance Department of North Dakota. This new pricing will better reflect overall claims rates and other factors related to the pricing of long term care coverage, and will be more consistent with the pricing of policies currently sold in the marketplace today.

The increase will take effect on **January 1, 2014**, your plan anniversary date, and will be applied to the premiums for all current and future participants in your plan. Participants who are currently receiving long term care benefits and are on waiver of premium will not receive this increase until premium payments resume.

Please be assured that your group policy is not being singled out, and this is not a reflection of the claims experience specific to your policy, if any. Instead, the premium increase will affect a broad group of our customers with similar policies.

Package materials

Enclosed is a rate change notification package, which includes additional information that will assist you with the administration and communication of this pricing change. This package includes:

- **Plan administrator's guide** that outlines timing, instructions and options
- **Frequently Asked Questions** for plan administrators
- **Sample communication materials** for plan participants

Unique informational website

We have developed an informational website ("info site") for plan administrators and participants who would like to view information about the new rates and their plan options, as well as access enrollment materials and other disclosure forms. The info site includes an interactive cost calculator that compares the new rates to the previous rates. This calculator will allow participants to compare their existing cost to their new cost, as well as provide cost illustrations for potential plan changes, if desired.

You can access a demo version of this info site by going to **<http://unuminfo.com/test/NDPERS>**.

The site will go live for plan participants approximately 60 days prior to the effective date of the rate increase. The live info site address will be **<http://unuminfo.com/NDPERS>**.

000000 000071 01192



Group policyholder options

Detailed guidance regarding your options is provided in your plan administrator's guide. Generally, you have three options to consider regarding the group plan:

1. **Make no changes** to the plan and implement the rate increase as scheduled;
2. **Consider plan changes*** such as funding arrangement, plan design, eligibility, etc.;
3. **Terminate the group plan** and offer participants the option to continue their coverage on a direct bill basis.

**Any plan change request must be reviewed and approved by our Underwriting Department.*

Immediate action required by the group policyholder

If you intend to make a plan change, eligibility change or elect to terminate the group policy as a result of this rate increase, then **it is important that your intent is communicated to Unum within 30 days from the date on this rate change notification letter**. Since the new pricing is effective on the group policy's upcoming plan anniversary date, it is important that any request to change or terminate the group policy is processed and enrollment materials are updated in a timely manner to align with the implementation timeline and participant communications for this pricing change.

Participant options

Participants in the plan will be offered three options that they should consider when notified of the pricing increase:

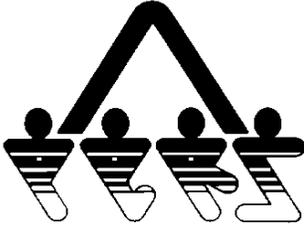
1. **Take no action:** Keep their exact coverage without any changes. The new premium will take effect on the group plan anniversary date. If we do not hear from the participant, then we will assume the higher premium amount has been accepted.
2. **Decrease coverage:** Request a decrease in coverage to keep premiums at, or close to, their current level. Any reduction in coverage must be within the plan options offered in the group policy.
3. **Elect the Contingent Non-forfeiture Benefit:** The participant can stop paying premiums and maintain a benefit that is equal to the premiums paid on the policy to date (inclusive of any premium paid by the employer). To preserve this benefit, the participant must choose the Contingent Non-forfeiture Benefit option within 120 days from the date the premium increase will take effect. If the participant would like to stop paying premiums and retain a maximum benefit equal to the premiums paid to us, they may do so by completing and returning the form provided in their communication packet. If elected, the Contingent Non Forfeiture will be effective as of the rate increase effective date.

Important: If the participant does not elect the Contingent Non-forfeiture Benefit option within the 120 day eligibility period and then later terminates the coverage, then the participant will no longer have the right, under this offer, to a benefit equal to the premiums paid.

We recognize the impact of increasing pricing for your group policy and do not take this action lightly. It is important, however, that our policies remain priced at an appropriate level to meet our future claims obligations. If you have any questions regarding the implementation of this rate increase, please contact your broker, Unum sales representative, or our Customer Service Center at 1.800.227.4165.

Sincerely,

Unum Long Term Care Operations



**North Dakota
Public Employees Retirement System**
400 East Broadway, Suite 505 • Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
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FAX: (701) 328-3920 • EMAIL: NDPERS-info@nd.gov • www.nd.gov/ndpers

Memorandum

TO: PERS Board
FROM: Sparb
DATE: August 14, 2013
SUBJECT: Long Term Care Insurance

Since 2012 we have looked into the long term care (LTC) program and our option to go out to bid. The present product that we offer is Unum. It is not a partnership eligible product and its design is old. Since we selected this product many years ago, numerous improvements have been added to LTC plans including the partnership program. Our product is not eligible for that program.

Study Process To Date

1. *April of 2012* – In April of 2012 we started our process to go out to bid. To get background on the LTC market we contacted Schmidt Insurance to give a presentation. They attended the meeting and their presentation is Attachment #1. We learned the following:
 - a) 70% of people who reach age 65 will require long term care services.
 - b) Average length of majority of LTC claims is 3.8 years.
 - c) The average cost of assisted living services is \$38,220, for in-home care is \$43,472 and for nursing home is \$72,190.
 - d) One out of 10 people who apply for LTC insurance ages 50-59 are declined, from ages 60-69 the decline rate doubles and decline rate for 70+ is 45%. Worksite LTC can provide expanded underwriting options.
 - e) North Dakota provides an annual tax credit of \$250 per person for someone who purchases a partnership qualified product and \$500 per couple.

At that meeting we also reviewed the attached relating to our existing carrier.



News from Unum regarding our long term care business
Feb. 7, 2012

Dear valued sales partner:

After a careful and comprehensive review, we have decided to end sales of new group long term care contracts. Although we recognize there is a market need for products to help individuals pay for long term care expenses, current economic, pricing and risk factors make it impossible for us to meet our financial and risk management objectives.

Unfortunately, we are not the only insurer to reach this conclusion as many others have now exited the long term care market given the combination of historically low interest rates and the uncertainty of risk and pricing trends.

The decision to end new group long term care sales is in the best interest of all of our policyholders, as it allows us to sharpen our focus on the markets and products that provide the greatest long-term opportunity for our company and are more compatible with our financial and risk management objectives.

This decision will not impact the high quality of service we provide to current policyholders and claimants. Additionally, we will continue to accept new enrollees on existing contracts.

Below are additional details about the changes that will affect you:

- As of Feb. 7, 2012, no additional group long term care quotes will be issued.
- Quotes issued prior to Feb. 7, 2012, are valid for 90 days from the date they were issued.
- Quotes will be considered sold if an application is signed prior to the 90-day window closing.
- Unum will honor all cases that have been sold and are in the enrollment process.
- New enrollees can be added to all inforce cases, according to the eligibility provisions in their contracts.

Additional information is [available here](#). If you have any additional questions, please contact your Unum service or sales representative or local manager. In addition, general questions can be directed to our Customer Support area at 800-227-4165, Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

2. December of 2012 – with the above background we had our consultant go to work on a RFP for LTC. In December of 2012 we received the draft RFP for our review and it is Attachment #2. We also noted the following from our consultant relating to our RFP:

I've delayed sending this pending responses to a Request for Information conducted by another state client. That client has been with Prudential and currently covers over 10,000 participants in its group long term care plan. In response to the RFI, no company indicated that it will be willing to submit a proposal if the state issues an RFP. We can go ahead with your solicitation; however it is unlikely that any company will respond.

Given the above and some questions on the RFP, it was decided to not distribute it and to schedule a meeting with GRS to discuss.

3. March of 2013 – in March the Board had a conference call with Bill Hickman with GRS. The following is from our minutes relating to that discussion:

Ms. Allen reported that Mr. Hickman with Gabriel Roeder Smith was attending via conference call to present information regarding long term care insurance products and the RFP they recently prepared

for PERS. Mr. Hickman reported that nationwide there are only a few companies in the market that offer group long term care insurance products. The policy presently offered by PERS is not a group product since there was not sufficient interest generated to meet the minimum participation requirement and it is not partnership qualified. An observation is that any product offered by PERS can be purchased by members as effectively directly from the market.

The Board discussed this and concluded that Schmidt Insurance Agency be invited to present additional information on long term care insurance for further consideration before the decision is made to do a request for proposal for our members. Chairman Strinden indicated that this will be put on a future agenda for further review and discussion.

4. June of 2013 - At his meeting Gene Schmidt of SIA presented information to the Board. Their firm specializes in Long Term Care products nationally and they have been active in this area for many years. In inviting him, I did share with him one of the issues we had been struggling with:

As I mentioned we are having a difficult time determining what value we can bring to our members by offering a PERS sponsored LTC plan. That is a group plan, if available, seems to be more expensive for a majority of our members compared to what they can buy on their own in the marketplace. If that is the case it may be better for our members to purchase the product through the existing distribution system than us. Your perspective will be very helpful so thanks again for coming to our meeting.

Attachment #3 is copy of his presentation. Some of the things we learned from his presentation were:

- a) Gender pricing has entered the market and underwriting requirements have been enhanced.
- b) Relating to gender pricing:
 - a. Females incurred 67% of claims and 69% of benefit dollars
 - b. Home Care incidence rates for females is more than double that for males
 - c. Mortality for males averages 33% greater than for females
- c) The cost of care is increasing:
 - a. The national average monthly rate for a semi-private nursing home is up 4.5% to \$76,285*
 - b. The national average monthly rate for an assisted living facility is up 5% to \$40,200*
 - c. The national average daily rate for adult day care is up 4.5% to \$69 *
 - d. \$750,000 projected average cost of three years of care in 30 years**
- d) Underwriting requirements have been substantially increased for individual policies however for group policies they can be significantly less. He shared the following to demonstrate the difference:

- i.* Reduce the underwriting requirement making the plan more accessible
 - ii.* Help with the overall pricing
- e. For every \$10 in premium support per month by the state, it would cost about \$150,000 per month or about \$3.6 million per biennium (assumes 15,000 state employees). Assuming the average classified salary is \$42,000 per year each \$10 is about .28% of salary. A \$40 premium support would be about 1.14% of payroll. Note: these numbers assume 100% participation.

Options For Going Forward

1. Move forward with the RFP from GRS. However, based upon the information received we will likely not get any group plan offers.
2. Accept the offer from Schmidt Insurance Agency and provide them census information on our plan and get a quote from one of their affiliated LTC firms. As part of this we would need to also supply them information on proposed employer premium participation. This information could be shared with the PERS Benefits Committee to get their recommendation for you about adding such a benefit. After review of this information and any recommendation from the Benefits Committee, consideration could be given to preparing a proposed bill to be submitted to the Legislative Employee Benefits Committee early next year.
3. The above information, not including the information in #2 above could be referred to the PERS Benefits Committee which will be meeting this fall. The Committee could discuss the information you have received thus far and share with you their thoughts. After hearing from them you could either move forward with the offer from Schmidt Insurance Agency or you could decide if you want to submit a proposed bill or not based upon the information received thus far and any information from the Benefits Committee.
4. You could decide not go forward with an RFP based upon the following:
 - a. That it would not be feasible to request funding for a LTC premium benefit based upon the costs and the needs for funding in the other core benefits
 - b. That without an employer premium payment, PERS cannot add any value to the member in terms of underwriting or premiums that they could not get directly from a local agent.

As alternative to offering a product, we could develop an approach where we facilitate the flow of information on the importance of this product, how to purchase it in the marketplace, the significance of having a “partnership product” and the effect of age on pricing. We could add this to our PREP seminars and our new seminar that will be rolled out next year oriented to younger members about the importance of planning for retirement. In addition, we could do a web video and put it on our web site.

Board Action Requested

Provide guidance on how to proceed with the LTC effort.



National Leaders in Long Term Care Insurance

Birth of an Industry



- 1977
 - Nursing Home Only Policies
 - \$50 per day in NH benefits
 - \$18,258 per year x 3 years
 - **\$54,750** total pay out
 - *And the cost?*
 - **\$234** per year

Defying the rules of insurance



- Insurers who entered this new market:
 - Had no real data to draw from
 - Of course, insurance is all about *understanding* risk
 - They defied the basic rules of insurance simply because they saw the need
 - The LTCi market was born out of passion
 - a passion for providing the financial means to make comfort-based healthcare decisions at end of life

Establishing the rules



- Because there was no data:
 - The decision was made to have the policies follow Medicare's example
 - Medicare required a 3-day hospital stay
 - So policies required a 3-day hospital prior to entering a Nursing Home in order to receive benefits
 - But Medicare's requirements quickly became limitations

Healthcare was evolving rapidly



- As the elderly population in the US grew:
 - Their political power and influence grew
 - They demanded more options
 - And the home healthcare industry was born
 - It took time to create a network of providers
 - It took even more time to get services to rural areas

NH Policies because LTCi



- The Insurance Industry had to keep up:
 - Benefits were expanded
 - Prices went up
 - Most people wanted to buy “lifetime coverage”
 - Example: \$70-\$100 *per day* in benefits *for life*
 - What do you have to charge to pay someone *for life*?
 - In the beginning, very little – too little – especially since longevity in the US was rising dramatically

Then came Assisted Living



Policies adapted again



- A typical policy today covers Assisted Living/Home & Community Care, and Nursing Home
 - Pays 3-5 years in benefits
 - Has an elimination period (deductible)
 - And features an appropriate inflation rider so it's Partnership-qualified
 - ***Dollar for Dollar Asset Protection***

The Need has never been greater



70% of people who reach age 65 will require Long Term Care services at some point in their lives.¹



¹ Source: U.S. Department of Health and Human Services National Clearinghouse for Long Term Care Information website, May 2010

Policies adapted again



41%

of people receiving
long term care

are between the ages 18-64

The Need has never been greater



Average length of
majority of long
term care claims

3.8
*years*²

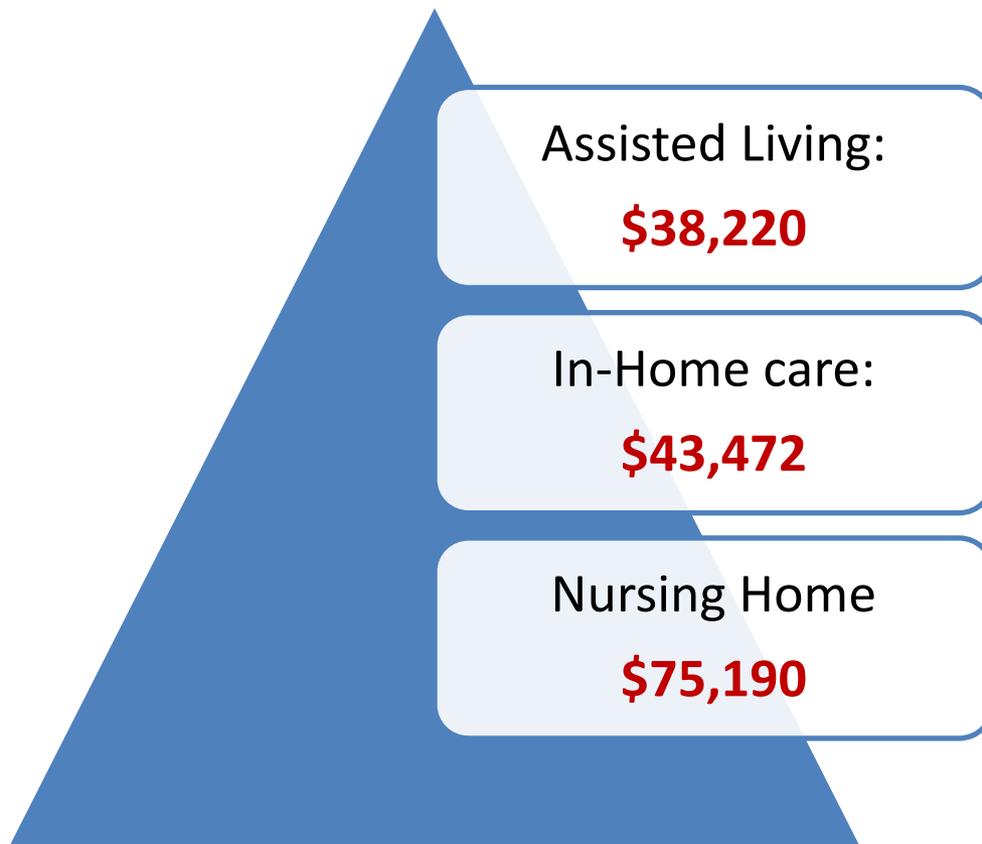
Average life
expectancy after
Alzheimer's diagnosis
after age 70

4-7
*years*³

² 1. Source: Genworth Financial Claims Data, December 2009

³ 2. Source: National Institute on Aging, National Institute of Health, 2/09

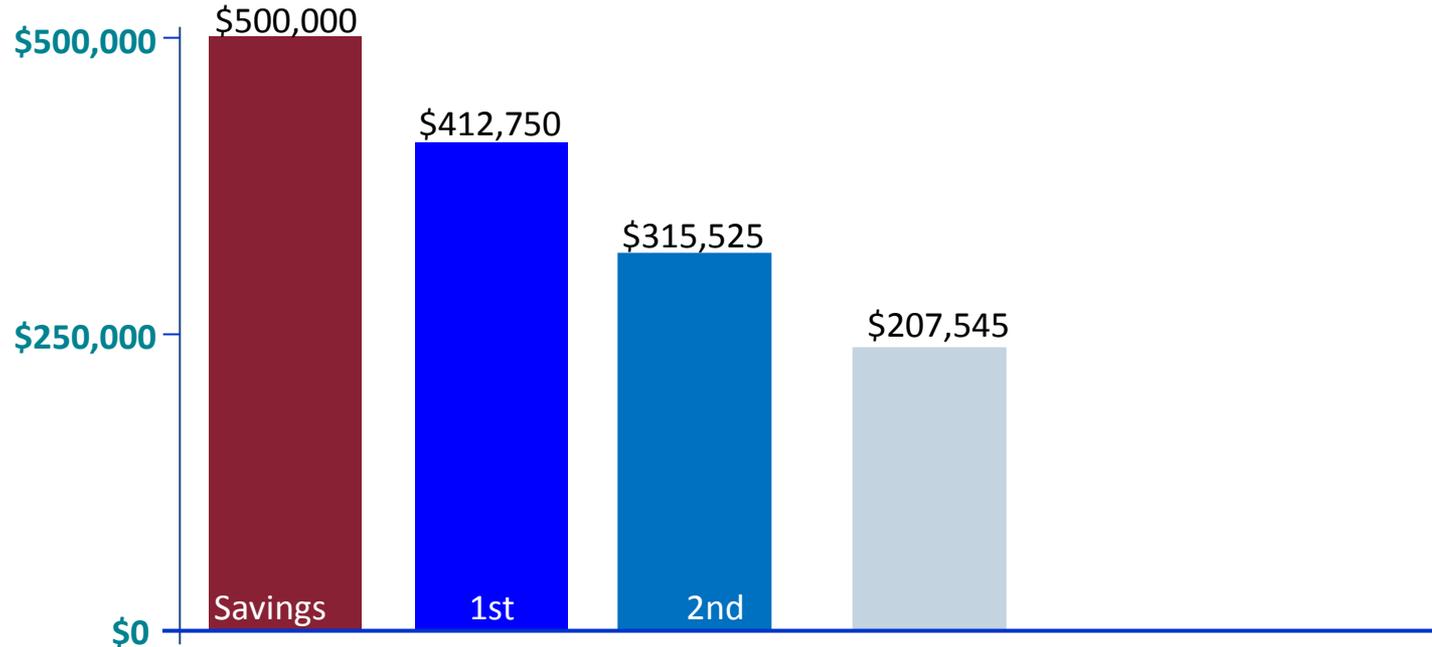
For one year in the United States:



The Personal Impact



- The potential impact of LTC expenses on a **\$500,000** portfolio (with spouse expenses during a 3-year stay)



FOR ILLUSTRATIVE PURPOSES ONLY. Assumptions: \$500,000 savings earning 5% net of expenses, Long Term Care costs \$69,400 per year in Private Room in a nursing home according to the 2005 Genworth Financial Cost of Care Survey conducted by CareScout, an independent research company, 05/05, with 5% simple inflation increase annually, spouse requires \$42,850 annual withdrawal w/a 5% simple inflation increase each year. All earnings and withdrawals occur at the beginning of each year. Does not take into account any other additions or subtractions that may occur with this account. Genworth Financial LTCi 101: The Basics

Medicaid Budgets are strained



*Without an LTCi policy,
too many people
are spending down their assets
and qualifying for Medicaid*

The Health Qualification Problem



*A study by the
American Association for Long-Term Care Insurance reveals:*

- a) One out of 10 people who apply for LTCi ages 50-59 are declined
- b) Ages 60-69 the decline rate almost doubles
- c) The declination rate for 70+ is 45%

Worksite LTCi can provide expanded underwriting options

The Business Impact



- Too many of our Employees are Caregivers
 - ***Caregiving is the act of providing unpaid assistance and support***
 - Paying Mom's bills, mowing the grass, and shoveling snow
 - Picking up groceries & meds
 - Organizing & attending Doctor's appointments
 - Help getting to bed and getting up
 - Phone calls all times of the day & night
 - Constant, unrelenting worry

Impact on Business



- **More than 6 in 10** caregivers surveyed reported direct **negative** consequences to their careers
 - **44%:** Had to work fewer hours
 - **48%:** Lost a job, changed shifts
and/or missed career opportunities
 - **38%:** Incurred repeated absences from work

Plus...



Working Caregivers use
8% more health care benefits
due to conditions such
as stress, anxiety, and depression

And the cost to companies?
\$13 Billion annually

Putting it all together



- A comprehensive well-received LTCi offering in your employee benefits package may:
 - **Significantly reduce premium rates**
 - **Make it easier for more people to qualify for coverage**
 - **Reduce strain on our Medicaid budget**
 - **Help you Recruit, Reward, & Retain**

The ND Advantage



An annual tax credit:

\$250 per person

\$500 per couple

Building Your RFP



Carriers will:

- A. Require a census that includes date of birth, occupations, gender, and salaries
- B. Produce materials and emails to employees
- C. Create PERS website for online enrollment
- D. Conduct open enrollment period and will want onsite meetings of not less than 45 minutes
- E. Not look favorably on firemen, policemen, etc.
- F. Be tough negotiators on underwriting eligibility and premium



North Dakota Public Employees Retirement System

North Dakota Public Employees Retirement
System (NDPERS)
Voluntary Long Term Care
Request for Proposal

RFP # XXXXXXXXXXXXXXXXX

Issue Date: XXXXX

Cover Letter

DRAFT

NDPERS
Proposal Form

DRAFT

Intent to Respond

DRAFT

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Section I: General Information

Background

The North Dakota Public Employees Retirement System (NDPERS) is issuing this Request for Proposal (RFP) for Long Term Care Insurance for NDPERS employees, retirees and their spouses. The term “NDPERS” refers to The North Dakota Public Employees Retirement System. NDPERS provides a **participant pay-all** group long term care (LTC) plan to all eligible state and university employees and their dependents. It is possible that participation will be extended in the future to certain political subdivisions eligible to participate in NDPERS. By NDPERS policy, the plan must be competitively bid every 6 years. The LTC plan is currently offered through UNUM. The offeror who is awarded the Contract pursuant to this RFP will be required to provide benefit coverage with an effective date of coverage beginning **DATE**, and begin the necessary implementation immediately upon contract award

NDPERS’s mission is to *design, communicate and efficiently administer a viable employee benefits program within a framework of prudent risk-taking, applicable state and federal laws, and professional and ethical standards so as to provide an employee benefit package that is among the best available from public and private employers in the upper Midwest*. NDPERS currently provides a range of employee benefit plans to approximately 20,695 contributing members and 7,835 retirees and beneficiaries currently receiving benefits. NDPERS is seeking an insurer to provide an equitable, affordable program of insurance for long term care services that proactively addresses the ever-changing and varied needs of its employees. The State of North Dakota has a tax credit up to \$250 for individuals paying premiums on a qualified LTC product. NPERS is seeking an insurer that will provide a LTC product that when combined with the tax credit will be very attractive to our youngest employees.

NDPERS covers substantially all employees of the State of North Dakota, its agencies and various participating political subdivisions. It also covers Supreme and District Court Judges, the National Guard Security Officers and Firefighters, Peace Officers and Correctional Officers employed by political subdivisions.

The current plan design is included and should be duplicated as closely as possible. The current plan has the choice of a 3 or 5 year benefit period. Creative plan designs, which offer lower premium costs yet are sensitive to the demographics of the employee group, are encouraged.

Performance Requirements and Specifications

The successful carrier will provide all services as specified in the RFP and proposal including but not limited to the following:

The successful carrier will be responsible for all enrollment functions associated with plan enrollment. All enrollment applications will be sent directly to the successful carrier who will process the applications. This includes review of the applications, determination of medical evidence of insurability, as required, and all premium calculations.

Enrollment and premium remittance will be accomplished on a decentralized basis. The carrier will be required to receive and process eligibility and premium remittance for active employees in conjunction with **26** different payroll systems. Retirees are on a direct bill premium basis. It is anticipated (but not guaranteed) that the format and process will be able to be largely standardized.

It will be expected that carriers will prepare multiple billings (currently 26 separate monthly billings) and that NO retroactive adjustments will be made for terminated employees.

Premiums will be eligible for salary reduction.

Premiums are to be 100% employee paid.

Unless quotations are Guaranteed Issue (GI), no minimum participation requirements will be allowed.

Eligible employees and retirees are defined as follows:

Permanent employees who are employed by a governmental unit, as that term is defined in Section 54-52-01. "Eligible employee" includes members of the legislative assembly, judges of the supreme court, paid members of the state or political subdivision boards, commissions or associations, elective state officers, as defined by Subsection 2 of Section 54-06-01, and permanent disabled employees who are receiving compensation from the North Dakota workers' compensation fund. As used in this Subsection, "permanent employee" means one whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employees at least seventeen and one-half hours per weeks and at least five months each year.

Retirees will be eligible for benefits on the following basis:

A retiree who has accepted a retirement allowance from the public employees retirement system, highway patrolmen's retirement system, the Teachers' Insurance and Annuity Association-College Retirement Equities Fund (TIAA-CREF) for service credit earned while employed by North Dakota institutions of higher education, the retirement system established under Chapter 27-17, or the teachers' fund for retirement will be allowed to elect to participate in the group upon initial offering of the program.

North Dakota insurance law provides that "any carrier underwriting any portion of the state's group insurance plan is exempt from paying premium taxes...on that portion of its business representing premiums collected for the group insurance plan". Thus, your responses should not reflect any amounts for premium taxes.

Retirees are allowed to continue coverage under certain specific situations. Please refer to retiree eligibility covered in the Summary Plan Description (SPD).

Attached in Exhibit A is a model contract. Unless you state otherwise it will be assumed that you agree to fully comply with the terms of the contract.

The carrier awarded the NDPERS voluntary LTC contract must be able to administer all current eligibility and coverage continuation provisions. Please refer to the above and applicable pages in the current SPD (Exhibit B), as well as state contract provisions included in Section V: Exhibits.

Additionally, please note the NDPERS will NOT accept any costs billed to NDPERS including costs for program implementation, enrollment, and/or administration either initially or on an on-going basis.

This RFP is being sent both directly to carriers and to agents/brokers.

Timetable

Below is the preliminary timetable for receiving bids, bid analysis, selection, and implementation of the program:

<u>Milestone</u>	<u>DATE</u>
Proposals due	XX/XX/XX
Evaluate Bids	XX/XX/XX
Final Selection Analysis	XX/XX/XX
Notify Successful Carrier	XX/XX/XX
Begin Implementation Meetings and activities	XX/XX/XX
Finalization of communication materials	XX/XX/XX
Effective Date of Coverage	XX/XX/XX

The dates above are subject to change at NDPERS' request.

General Proposal Requirements

Bidders shall agree to the general requirements noted below. The term "NDPERS" refers to The North Dakota Public Employees Retirement System.

1. Award or Rejection: All qualified proposals will be evaluated and the award will be made to the bidding offeror whose proposal is deemed to be in the best interest of NDPERS. NDPERS reserves the right to reject any or all proposals.
2. Decline to offer: Any bidder who receives a copy of the specifications but declines to make an offer is requested to send a written "Decline to Offer" to XXXX.
3. Costs for Proposal Preparation: Any costs incurred by the bidders in preparing or submitting proposals are the bidders' sole responsibility.
4. Oral Explanations: NDPERS will not be bound by oral explanations or instructions given at any time during the bidding process or after the award of the contract.
5. Reference to Other Data: Only information that is received in response to the specifications will be evaluated; reference to information previously submitted or explained will not be considered unless specifically authorized.
6. Time for Acceptance: The bidder agrees to be bound by its proposal for a period of at least 120 days, during which time the NDPERS and/or Gabriel, Roeder, Smith and Company, as NDPERS' benefits consultant, may require clarification or correction of the proposal for the purpose of

evaluation. Amendments or clarifications shall not affect the remainder of the proposal, but only the portion so amended or clarified.

7. **Exceptions:** Any exceptions to terms, conditions or other requirements in any part of these specifications must be clearly pointed out in the appropriate section of the proposal, otherwise it will be considered that all items offered are in compliance with the specifications as set forth in the RFP. The successful bidder will be responsible for compliance. Any exceptions will be part of the evaluation process and may constitute grounds for rejection of the proposal.
8. **Bidder’s Representative:** The proposal must be signed by a legal representative of the bidding firm, who is authorized to bind the firm to a contract in the event of the award.

Plan Design Summary

NDPERS current plan is summarized as follows:

The Plan Choices				
Facility Benefit Duration	3 years or 5 years			
Facility Monthly Benefit Amount	\$3,000			
Plans	Plan 1	Plan 2	Plan 3	Plan 4
Assisted Living Facility	60%	60%	60%	60%
Lifetime Maximum – 3 Years	\$108,000	\$108,000	\$108,000	\$108,000
5 Years	\$180,000	\$180,000	\$180,000	\$180,000
Professional Home Care	50%	50%	50%	50%
Total Home Care – Option	N/A	50%	N/A	50%
Inflation Protection* – Option	N/A	N/A	Simple Capped	Simple Capped

**If the individual selects inflation option, and he or she terminates the inflation option at a future date, the individual can purchase the inflated coverage amount at his or her original age*

A second level offers paid-up non-forfeiture across all four plan options.

Benefit Eligibility

Individuals will be deemed eligible for the plan if they are:

- An active employee who works 20 hours per week for 20 or more weeks and his/her spouse of the Sponsoring Organization
- A retired employee/spouse of the Sponsoring Organization

Claim holders are deemed eligible if they are assessed as suffering a covered loss of functional capacity or cognitive impairment. The claimant must be under the regular care of a doctor according to the condition. A monthly benefit will become payable on the day after the elimination period is completed.

Loss of Functional Capacity: loss of 2 or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness or because of advanced age.

Cognitive Impairment: deterioration or loss in intellectual capacity resulting from Alzheimer’s disease or similar forms of irreversible dementia.

Elimination Period: there is an Elimination Period of 90 consecutive days that must be satisfied once in the life of the plan.

Activities of Daily Living: consist of bathing, dressing, toileting, transferring, continence and eating.

NOTE: Activities of Daily Living that the claimant cannot perform without standby assistance on the date the individual becomes insured will not be considered when determining the extent of loss.

Proposal Instructions

Responses to this proposal shall be submitted electronically as a Microsoft Word document, excepting those areas where alternative methods of submission are specified. In addition to the electronic copy, it is necessary that one sealed copy of your proposal be received in the NDPERS office by XXXXXX. The address for the NDPERS office is listed below:

XXXXXXXXXX

North Dakota Public Employees Retirement System
400 East Broadway, Suite 505
Bismarck, ND 58502-1657

If your organization chooses not to offer a proposal, please submit a letter to our office indicating this is your intention. Questions regarding this RFP may only be submitted in writing to XXXX on or prior to XXXXX

Section II: Offeror Information

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Please provide the following general information about your company and proposed contact with NDPERS.

I. GENERAL INFORMATION	
Offeror's Legal Name	
Address	
City	
State	
Zip	
Website Address	
Year Operations Began	
Corporate Tax Status	Click to Select One
Federal Employer ID Number	
Ownership/Controlling Interest	

Please identify both the primary contact, who can answer questions related to this RFP, and the account manager, who will have overall responsibility for planning, implementing, supervising and performing account services if the Offeror is awarded this contract.

II. CONTACT INFORMATION	
Primary Contact	
Name	
Title	
Address	
City	
State	
Zip	
Telephone Number	
Cell Phone Number	
Fax Number	
E-mail Address	
Account Manager	
Name	
Title	
Address	
City	
State	
Zip	
Telephone Number	
Cell Phone Number	
Fax Number	
E-mail Address	

Please provide three references (preferably public sector), including one terminated/former reference, to whom your company has provided LTC coverage within the past 5 years.

III. REFERENCES	
First Reference-Current	
Company	
Contract Status	Click to Select One
Contact Person	
Title	
City, State	
Telephone Number	
Fax Number	
E-mail Address	
Second Reference-Current	
Company	
Contract Status	Click to Select One
Contact Person	
Title	
City, State	
Telephone Number	
Fax Number	
E-mail Address	
Third Reference-Terminated/Former	
Company	
Contract Status	Click to Select One
If "terminated or former" please state reason for termination	
Contact Person	
Title	
City, State	
Telephone Number	
Fax Number	
E-mail Address	

Section III: Proposal Questionnaire

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Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.

Instructions: Please provide a response to each of the following questions. If a drop-down list is available, please select a response from that list. If a response attachment is required, the attachment can be provided in either Microsoft Word or Excel (preferred) or Adobe pdf format unless specified otherwise.

Question		Response
I. ORGANIZATION INFORMATION		
Q-1	a) Describe the Offeror's experience in providing Long Term Care Insurance.	
	b) Please describe your experience with North Dakota based clients.	
Q-2	Please provide a brief history of the organization, its growth on a national level, and its ownership structure.	
Q-3	a) How many years has the Offeror administered Long Term Care Insurance?	
	b) How many years has the Offeror administered Long Term Care Insurance to North Dakota based clients?	
Q-4	a) Please state the name(s) of the LTC insurance product(s) you are proposing to NDPERS.	
	b) Is/Are the product(s) approved under the North Dakota Long-Term Care Partnership Program?	Click to Select One
Q-5	a) Will your organization be involved in any acquisitions or mergers within the next 12 months?	Click to Select One
	If yes, please describe.	
	b) Has your organization been involved in any recent acquisitions or mergers?	
	♦ Within the last year?	Click to Select One
	♦ 1-2 years ago?	Click to Select One
	♦ 2-5 years ago?	Click to Select One
	♦ None in the last five years	Click to Select One
If yes, please describe.		
Q-6	Because the policy will be issued in the state of North Dakota, the insurance policy must be in full accord with the laws of that jurisdiction. It will be the responsibility of the underwriting carrier to include all provisions	Click to Select One

Question		Response
	required by the laws of the jurisdiction in which the contract is issued. Are you currently able to fulfill this requirement?	
Q-7	Confirm that your organization has the following insurance coverage:	
	a) Worker's Compensation	Please submit a copy of your certificate(s) of insurance indicating coverage. Label as " Response Attachment Q-7a: Certificate of Insurance ".
	b) Errors & Omissions	Please submit a copy of your certificate(s) of insurance indicating coverage. Label as " Response Attachment Q-7b: Certificate of Insurance ".
	c) Commercial General Liability	Please submit a copy of your certificate(s) of insurance indicating coverage. Label as " Response Attachment Q-7c: Certificate of Insurance ".
Q-8	Please attach a copy of the company's two most recent annual reports.	Please submit a copy of your two most recent annual reports. Label as " Response Attachment Q-8: Annual Reports ".
Q-9	a) Please provide a copy of the last two (2) year end audited financial statements or best available equivalent report and an analysis of those financial statements/reports (independently audited preferred).	Please submit a copy of your two most recent audited financial statements. Label as " Response Attachment Q-9a: Audited Financial Reports ".
	b) Abbreviated profit and loss statements and abbreviated balance sheets for the last two (2) years.	and Please submit abbreviated profit and loss statements and abbreviated balance sheets for the last two (2) years. Label as " Response Attachment Q-9b: Profit and loss statements and abbreviated balance sheets ".
Q-10	Provide a copy of your most recent financial ratings and complete the following table.	Please submit a copy of your two most recent financial ratings. Label as " Response Attachment Q-10: Financial Ratings ".
	A.M. Best	
	◆ Current Financial Rating	
	◆ Date of Rating	
	◆ Prior Financial Rating	
	◆ Date of rating	
	Standard & Poor's	
	◆ Current Financial Rating	
	◆ Date of Rating	
	◆ Prior Financial Rating	
	◆ Date of rating	
	Fitch	
	◆ Current Financial Rating	
	◆ Date of Rating	
	◆ Prior Financial Rating	

Question		Response
	♦ Date of rating	
Weiss		
	♦ Current Financial Rating	
	♦ Date of Rating	
	♦ Prior Financial Rating	
	♦ Date of rating	
Moody's		
	♦ Current Financial Rating	
	♦ Date of Rating	
	♦ Prior Financial Rating	
	♦ Date of rating	
Q-11	Describe any litigation and/or government action taken, proposed or pending against your company or any entities of your company during the most recent five (5) years. This information shall include notice whether the Offeror's organization has had its registration and/or certification suspended or revoked in any jurisdiction within the last 5 years, along with an explanation.	
Q-12	In the event of contract termination, describe the process by which persons who are insured may continue coverage.	
Q-13	What key features distinguishes your LTC insurance product from your competitors and what do you perceive as your competitive advantages?	
Q-14	Provide the following enrollment history metrics as of January 1st of each year.	
2010		
	Number of covered lives:	
	Number of employer clients:	
	Number of statewide public entity clients:	
2011		
	Number of covered lives:	
	Number of employer clients:	
	Number of statewide public entity clients:	
2012		

Question		Response
	Number of covered lives:	
	Number of employer clients:	
	Number of statewide public entity clients:	
II. CLAIMS PROCESSING		
Q-15	a) What is the location (city/state) of the claims processing center the Offeror will be utilizing for the NDPERS Plan? (Please note that this location cannot be offshore.)	
	b) What is the annual claims volume for this location?	
	c) How many years has this location been in operation?	
	d) What is the turnover rate of claims processors for this location?	
Q-16	a) Please identify any secondary claims processing location(s).	
	b) Describe how these additional location(s) will support the primary location.	
Q-17	Describe the claims processing unit (organization, staffing and services) that would handle the NDPERS account.	
Q-18	Please provide the following statistics for each calendar year.	
	2010	
	Number of appeals	
	Average number of days between initial receipt and final resolution	
	2011	
	Number of appeals	
	Average number of days between initial receipt and final resolution	
	2012 (January through October)	
	Number of appeals	
Average number of days between initial receipt and final resolution		
Q-19	Do you expect to make major changes to the service organization (e.g. moving to a different location, merging units, etc)?	Click to Select One

Question		Response
	If yes, please describe the changes and the expected timing.	
Q-20	Describe the internal auditing protocols for your claims processing area.	
III. CUSTOMER SERVICE AND ACCOUNT MANAGEMENT		
Q-21	a) What is the location (city/state) of the customer service call center the Offeror will be utilizing for the NDPERS Plan? (Please note that this location cannot be offshore.)	
	b) Would a dedicated toll-free customer service line be available to NDPERS?	Click to Select One
	c) How many years has this location been in operation?	
	d) What is the turnover rate of CSRs for this location?	
Q-22	a) Please identify any secondary customer service call center location(s).	
	b) Describe how these additional location(s) will support the primary location.	
Q-23	Describe the customer service unit (organization, staffing and services) that would handle the NDPERS account.	
Q-24	Briefly describe the training program in general as well as the specific training that each associate receives to prepare to manage the NDPERS benefit. Include length of time it takes to go from training to CSR.	
Q-25	What are the hours of operation for the customer service department?	
Q-26	How do you track and monitor phone service on an account-specific basis?	
Q-27	a) Is there an available opt-out to a live representative at any time during an automated voice response?	Click to Select One
	b) Does the automated voice response system provide the estimated wait time until the live operator will pick up the call?	Click to Select One
Q-28	Provide your phone service standard versus actual results for 2010, 2011 and January through October 2012 for the primary customer service center proposed for this contract.	

Question		Response
Average speed to answer		
	Phone service standard	
	2010 Actual	
	2011 Actual	
	2012 Actual (January – October)	
Call abandonment rate		
	Phone service standard	
	2010 Actual	
	2011 Actual	
	2012 Actual (January – October)	
Percent of calls resolved on the first contact		
	Phone service standard	
	2010 Actual	
	2011 Actual	
	2012 Actual (January – October)	
Q-29	Provide an outline of your proposed communication plan. Please provide samples of communication materials (including any electronic media) to be distributed by the Contractor to all eligible participants informing them of the opportunity to purchase Long Term Care insurance including, but not limited to, education about the need for LTC insurance, the coverages available, and procedure for enrolling.	Label as "Response Attachment Q-29: Proposed Communication Plan and Sample Communication Materials" .
Q-30	Please provide copies of your application forms and any health statements that would be required for each participant.	Label as "Response Attachment Q-30: Application Forms and Health Statements" .
Q-31	How does your customer service system support and provide access to individuals with disabilities and individuals with limited English speaking abilities?	
Q-32	Do you expect to make major changes to the service organization (e.g. moving to a different location, merging units, etc)? If yes, please describe the changes and the expected timing.	Click to Select One
Q-33	Will plan members have access to a State dedicated website, which contains the following:	

Question		Response
	a) Access to Member Services;	Click to Select One
	b) Access to plan benefit information;	Click to Select One
	c) Access to self-help information;	Click to Select One
	d) Plan inquiries;	Click to Select One
	e) Other (please specify)	
Q-34	Please describe current services available to Plan Sponsors on your website.	
Q-35	Please describe current services available to Plan participants on your website.	
Q-36	How do you maintain a secure environment for communicating through your website? Please describe.	
Q-37	Do you expect to make major changes to the products being offered by your organization?	Click to Select One
	If yes, please describe the changes and the expected timing.	
Q-38	Provide your standard turnaround time in Business Days to Process an Application for Insurance	
	Guaranteed Issue Application	
	Inside State of North Dakota	
	Outside State of North Dakota	
	Underwritten Application	
	Inside State of North Dakota	
	Outside State of North Dakota	
Q-39	NDPERS may require modification or creation of new reports. Please provide samples of your standard reports.	Label as " Response Attachment Q-39: Standard Reports ".
Q-40	a) Provide a copy of the latest customer satisfaction survey your organization has conducted, including results.	Label as " Response Attachment Q-40: Customer Satisfaction Survey ".
	b) How was the survey instrument developed?	
	c) Do you use an independent outside vendor to conduct the survey? If so, who?	
	d) How are recipients to the survey selected?	
Q-41	Describe the organization and structure of the account services team that will support NDPERS. Include how this structure is particularly responsive to NDPERS' needs	

Question		Response
Q-42	Please provide the following information for the Proposed Account Manager identified in Section II, Offeror Information.	
	a) Where will the account manager be located?	
	b) What percentage of this person's time will be dedicated to the NDPERS account?	
	c) Please provide an organizational chart identifying the names, functions and reporting relationships of key personnel directly responsible for account support services to NDPERS.	Label as " Response Attachment Q-42c: Account Management Team Organizational Chart ".
IV. QUALITY IMPROVEMENT MANAGEMENT		
Q-43	Please indicate whether your organization's Quality Improvement (QI) work plan, or schedule of activities, includes the following:	
	a) Objectives, scope, and planned projects or activities for the year.	Click to Select One
	b) Planned monitoring of previously identified issues, including tracking of issues over time.	Click to Select One
	c) Planned evaluation of the QI program.	Click to Select One
V. PLAN PROVISIONS AND COVERAGE		
Q-44	Do you provide coverage at no additional charge for services in addition to the following: coverage for licensed skilled, intermediate or custodial nursing homes; home health and adult day care services; in-patient and at-home hospice care; assisted living facilities; personal care nursing, habilitation and rehabilitation; social services, case management and other assistive technology; and respite care services?	Click to Select One
	If yes, please list and describe the additional services covered.	
Q-45	Regarding all classes of eligible participants, is there an age limit for those applying for coverage?	
Q-46	What are the underwriting requirements for each classification of participant?	
Q-47	Is "Short-form" underwriting available for eligible participants requiring underwriting?	Click to Select One
Q-48	Under what conditions will you accept	

Question		Response
	participants from NDPERS' current plan?	
Q-49	Explain how your coverage works for those participants who are working or residing outside of the United States.	
Q-50	a) Do you allow family members to continue coverage if the employee terminates coverage or employment?	Click to Select One
	b) Will family members continue to pay current rates?	Click to Select One
Q-51	Describe your lifetime maximum formula with examples. Provide an example of how the lifetime benefit is calculated when the policy includes an inflation protector. If the maximum lifetime benefit does not apply to all covered services, which services are limited?	
Q-52	Describe your elimination period in detail. How are the days counted? Do they have to be consecutive? What documentation is required? Are days of service/expense required? What documentation will the participant receive?	
Q-53	a) If your plan includes a pre-existing condition exclusion/limitation, provide details on how pre-existing conditions are treated in the policy, including information regarding satisfaction of the elimination period as it relates to the pre-existing condition.	
	b) Can pre-existing conditions be covered at any time if the claim begins during the pre-existing period?	Click to Select One
	c) How is the beginning of the claim determined for purposes of the pre-existing condition clause?	
Q-54	Describe your plan's non-forfeiture provision.	
Q-55	Describe your plan's compound automatic inflation option benefit. Include in your description how this benefit works while a participant is in claim status.	
Q-56	Does your plan include a periodic inflation benefit?	Click to Select One
	If so, please describe, including underwriting requirements.	

Question		Response
Q-57	Does your plan include coverage for services provided by a continuing care or life-care retirement community?	Click to Select One
Q-58	Does your plan include a premium "grace period" for direct billed participants?	Click to Select One
	If so, please describe in detail.	
Q-59	Does your plan include an appeals process if benefits are denied?	Click to Select One
	If so, please describe in detail.	
Q-60	Does your plan include a Restoration of Benefits provision?	Click to Select One
	If so, please describe in detail.	
Q-61	Does your plan include a Return of Premium upon death benefit?	Click to Select One
	If so, please describe in detail.	
Q-62	Does your plan include a Transition of Care benefit?	Click to Select One
	If so, please describe in detail.	
Q-63	Does your plan include an Alternate Plan of Care benefit?	Click to Select One
	If so, please describe in detail.	
Q-64	Does your plan include an Information and Referral Services benefit?	Click to Select One
	If so, please describe in detail.	
Q-65	Does your plan include a Waiver of Premium provision?	Click to Select One
	If so, please provide details on how your waiver of premium provision is administered.	
Q-66	Please describe your plan's portability feature.	
Q-67	a) Describe all policy exclusions in detail.	
	b) Are there policy exclusions for employees who may become disabled due to countries in civil conflict, war or through acts of terrorism?	
Q-68	Is your plan guaranteed renewable?	Click to Select One
Q-69	a) What are the criteria for determining benefit eligibility? Please address functional and cognitive impairment separately.	
	b) What information is required by the	

Question		Response
	<p>attending physician, and what assessments are required by your organization, and at whose expense?</p> <p>c) What is the particular skill level required to complete the assessment (e.g., geriatrician)?</p>	
Q-70	Describe the process used to determine ability or inability to perform each ADL.	
Q-71	a) What criteria are used to measure the need for supervision and monitoring of people with cognitive and other mental impairments?	
	b) How do you measure the service needs of people with cognitive and other impairments?	
Q-72	a) Does your plan provide coverage for informal caregivers, e.g., family members?	Click to Select One
	b) Please explain how the use of informal caregivers may be covered.	
Q-73	When benefits are approved, how often is re-certification required?	
Q-74	What is your acceptance rate for underwritten applications?	
Q-75	Describe your appeals process including time frames for rejected applicants.	
Q-76	Describe your process for making up missed payroll deductions.	
Q-77	a) Describe the process for transferring an insured from the payroll deducted group plan to a direct-billed plan.	
	b) Are there any circumstances in which a participant would not be able to retain coverage on an individual basis?	Click to Select One
	If so, please describe.	
Q-78	a) Describe the process of how an insured applies for benefits.	
	b) Are physical exams or interviews normally required?	Click to Select One
	c) If so, who conducts the exam or interviews, and at whose expense?	
	d) Is there a maximum time period claimants are allowed to submit a claim from the date of occurrence?	Click to Select One

Question		Response
	e) If so, what is the time period?	
Q-79	Please provide copies of all required forms the insured, physician and/or facility needs to complete to file a claim.	Label as " Response Attachment Q-79: Plan Forms ".
Q-80	What is the average turnaround time for the approval of a claim?	
Q-81	a) Are benefit payments made directly to the insured/patient, or can they be assigned to a family member or provider?	
	b) What circumstances would allow benefit payments to be made to a family member?	
Q-82	a) Do you offer case management?	Click to Select One
	If so, please describe.	
	b) Is it voluntary or mandatory?	Click to Select One
	c) Does your organization or another entity provide the case management services?	
	d) What are the qualifications of your case managers?	
	e) What training do they undergo?	
Q-83	Under what conditions may a participant increase or decrease their daily or monthly benefit levels?	
Q-84	Under what conditions can a participant add a nonforfeiture benefit after coverage is in effect?	
Q-85	Under what conditions may a participant increase or decrease their lifetime maximum duration?	
Q-86	What performance standards do you currently monitor?	
Q-87	a) Describe your process for handling complaints and requests for customer service.	
	b) How quickly do you respond to complaints and to requests from participants?	
VI. HIPAA COMPLIANCE		
Q-88	Is the organization compliant with all applicable HIPAA administrative simplification rules?	Click to Select One
Q-89	a) What practices and policies have you implemented to ensure the confidentiality	

Question		Response
	of all confidential information, including protected health information as defined by the HIPAA privacy rule, member information, or other sensitive information of NDPERS and its plan participants?	
	b) How often do you update your HIPAA policies and procedures?	
Q-90	Please identify and describe all breaches of HIPAA privacy and security provisions within the last 18 months.	Label as "Response Attachment Q-90: HIPAA Privacy and Security Breaches" .
VIII. ELIGIBILITY		
Q-91	Please describe the eligibility system that will be used to keep track of NDPERS' eligibility files, including:	
	a) System "trade name"	
	b) System organization	
	c) Date eligibility system was put in place	
	d) Number of system upgrades since inception	
	e) Annual budget and planned system improvements for the hardware and software used in providing the services.	
IX. IMPLEMENTATION PROGRAM / COMMUNICATION		
Q-92	Please discuss your procedures and processes for handling the following during the transition period:	
	a) Transition of care	
	b) Employee communications regarding change in administrators	
Q-93	Implementation Plan	
	a) Name of the person with overall responsibility for planning, supervising and implementing the program for NDPERS.	
	b) Title	
	c) What other duties, if any, will this person have during implementation? Please include the number and size of other accounts for which this person will be responsible during the same time period.	
	d) What percentage of this person's time will be devoted to the NDPERS account during	

	Question	Response
	<p>the implementation process?</p> <p>e) Please provide an organizational chart identifying the names, area of expertise, functions, and reporting relationships of key people directly responsible for implementing the NDPERS account. In addition, resumes of these individuals should be included.</p> <p>f) Provide a detailed implementation plan that clearly demonstrates the Offeror's ability to meet NDPERS' requirements to have a fully functioning program in place and operable on XXX. This implementation plan should include a list of specific implementation tasks/transition protocols, primary party responsible for each step and a time-table for initiation and completion of such tasks, beginning with the contract award and continuing through the effective date of operation. The implementation plan should be specific about requirements for information transfer as well as any services or assistance required during implementation.</p>	<p>Label as "Response Attachment Q-93e: Implementation Team Organizational Chart".</p> <p>Label as "Response Attachment Q-93f: Implementation Plan".</p>
Q-94	Will representatives of your organization meet with participants and/or NDPERS staff to explain how the program works?	Click to Select One
Q-95	<p>Do you anticipate any major transition issues during implementation?</p> <p>If yes, please describe.</p>	Click to Select One

Section IV: Premium Quotation Forms

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Complete the tables on the following pages with premium rates that will be offered to the NDPERS participants. Please quote based on the following:

The Plan Choices – A Group				
Plans	Plan 1A	Plan 2A	Plan 3A	Plan 4A
Facility Benefit Duration	3 Years or 5 Years			
Facility Monthly Benefit Amount	\$3,000	\$3,000	\$3,000	\$3,000
Assisted Living Facility	60%	60%	60%	60%
Lifetime Maximum – 3 Years	\$108,000	\$108,000	\$108,000	\$108,000
5 Years	\$180,000	\$180,000	\$180,000	\$180,000
Professional Home Care	50%	50%	50%	50%
Total Home Care – Option	N/A	50%	N/A	50%
Inflation Protection* – Option	N/A	N/A	Simple Capped	Simple Capped

**If the individual selects inflation option, and he or she terminates the inflation option at a future date, the individual can purchase the inflated coverage amount at his or her original age*

The Plan Choices – B Group				
Plans	Plan 1B	Plan 2B	Plan 3B	Plan 4B
Facility Benefit Duration	3 Years or 5 Years			
Facility Monthly Benefit Amount	\$3,000	\$3,000	\$3,000	\$3,000
Assisted Living Facility	60%	60%	60%	60%
Lifetime Maximum – 3 Years	\$108,000	\$108,000	\$108,000	\$108,000
5 Years	\$180,000	\$180,000	\$180,000	\$180,000
Non-Forfeiture	Paid Up	Paid Up	Paid Up	Paid Up
Professional Home Care	50%	50%	50%	50%
Total Home Care – Option	N/A	50%	N/A	50%
Inflation Protection* – Option	N/A	N/A	Simple Capped	Simple Capped

Elimination Period: 90 days for all plans
Medical Underwriting: Yes
Pre-Existing Condition Provision: Yes
Alternative Plan Design: Alternative plan designs can be proposed. Specify in detail how benefits and contract provisions differ from existing plans.

Waiver of Premium:

Yes; included in all plans. (May exclude for respite care benefits only.)

Table A:

3 Year Benefit Period

Age	Plan 1A	Plan 2A	Plan 3A	Plan 4A
30	\$	\$	\$	\$
35	\$	\$	\$	\$
40	\$	\$	\$	\$
45	\$	\$	\$	\$
50	\$	\$	\$	\$
55	\$	\$	\$	\$
60	\$	\$	\$	\$
65	\$	\$	\$	\$
70	\$	\$	\$	\$
75	\$	\$	\$	\$
80	\$	\$	\$	\$

Table B:

3 Year Benefit Period

Age	Plan 1B	Plan 2B	Plan 3B	Plan 4B
30	\$	\$	\$	\$
35	\$	\$	\$	\$
40	\$	\$	\$	\$
45	\$	\$	\$	\$
50	\$	\$	\$	\$
55	\$	\$	\$	\$
60	\$	\$	\$	\$
65	\$	\$	\$	\$
70	\$	\$	\$	\$
75	\$	\$	\$	\$
80	\$	\$	\$	\$

Table C:

5 Year Benefit Period

Age	Plan 1A	Plan 2A	Plan 3A	Plan 4A
30	\$	\$	\$	\$
35	\$	\$	\$	\$
40	\$	\$	\$	\$
45	\$	\$	\$	\$
50	\$	\$	\$	\$
55	\$	\$	\$	\$
60	\$	\$	\$	\$
65	\$	\$	\$	\$
70	\$	\$	\$	\$

75	\$	\$	\$	\$
80	\$	\$	\$	\$

Table D:

5 Year Benefit Period

Age	Plan 1B	Plan 2B	Plan 3B	Plan 4B
30	\$	\$	\$	\$
35	\$	\$	\$	\$
40	\$	\$	\$	\$
45	\$	\$	\$	\$
50	\$	\$	\$	\$
55	\$	\$	\$	\$
60	\$	\$	\$	\$
65	\$	\$	\$	\$
70	\$	\$	\$	\$
75	\$	\$	\$	\$
80	\$	\$	\$	\$

The offeror may choose to propose alternative plan designs. Alternative plan designs should be based upon 3 and 5 year benefit periods, but other design elements can be proposed. Please complete the below Alternative Plan Choice(s) table below, using the “other benefit” space if there are additional elements you wish to offer. Please use Table E to price your alternative plan(s) for a 3 year benefit period; please use Table F to price your alternative plan(s) for a 5 year benefit period:

Proposed-Alternative Plan Option(s)		
Facility Benefit Duration	3 years or 5 years	
Facility Monthly Benefit Amount		
Plans	Plan 1	Plan 2
Assisted Living Facility		
Lifetime Maximum – 3 Years 5 Years		
Professional Home Care		
Total Home Care – Option		
Inflation Protection* – Option		
Other Benefit:		
Other Benefit:		

Table E:

3 Year Benefit Period

Age	Alternative Plan 1	Alternative Plan 2
30	\$	\$
35	\$	\$
40	\$	\$
45	\$	\$
50	\$	\$
55	\$	\$
60	\$	\$
65	\$	\$
70	\$	\$
75	\$	\$
80	\$	\$

Table F:

5 Year Benefit Period

Age	Alternative Plan 1	Alternative Plan 2
30	\$	\$
35	\$	\$
40	\$	\$
45	\$	\$
50	\$	\$
55	\$	\$
60	\$	\$
65	\$	\$
70	\$	\$
75	\$	\$
80	\$	\$

Section V: Exhibits

DRAFT

DRAFT

Exhibit B – Current Summary Plan Description

Double-Click below to open full Plan Description as a PDF

DRAFT



Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
(207) 575-2211

**LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE**
For the Employees of

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
(the Sponsoring Organization)

Group Master Summary of Benefits Form Number 510487

NOTICE TO BUYER: This plan may not cover all costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all plan limitations.

Caution: If you must complete an Application for Long Term Care Insurance which includes evidence of insurability, the issuance of a long term care insurance certificate will be based on your responses to the questions in your application. A copy of your Application for Long Term Care Insurance was retained by you when you applied. If your answers are incorrect or untrue, Unum has the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Unum at this address: Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

1. The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction of **Maine** and to the extent applicable by the Employee Retirement Income Security Act of 1974.

The Summary of Benefits is a part of the Select Group Insurance Trust situated in Maine. Fleet Bank of Maine is the Trustee.

2. **PURPOSE OF OUTLINE OF COVERAGE**

This outline of coverage provides a very brief description of the important features of the plan. You should compare this outline of coverage to outlines of coverage for other plans available to you. This is not an insurance contract, but only a summary of coverage.

Only the Summary of Benefits contains governing contractual provisions. This means that the Summary of Benefits sets forth in detail the rights and obligations of both you and us (Unum Life Insurance Company of America). Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR CERTIFICATE CAREFULLY!**

B.OOC (11/01)

Exhibit C – Employee Census

Suggest census information including age be included for 1. Current enrollees and 2. All eligibles

DRAFT

Changes in the LTCi Market

and how it affects you

Gene G Schmidt, CEO

The SIA Companies



Gene G Schmidt

CEO, The SIA Companies

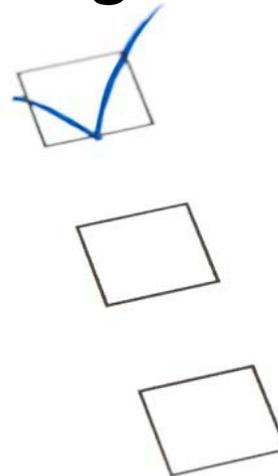


- Licensed since 1976
- Personally writing LTCi since 1976
- Started Schmidt Insurance: 1979
- Founded SIA in 1986
- SIA serves **14,000+** insurance professionals nationwide
- Nationally recognized expert on LTCi
who regularly contributes to the design of new benefits
for the industry's top companies

Today's Topics

- Gender Pricing Entering the Market**
 - **Claims on Women vs. Men**

- Updated Underwriting Requirements**
 - **Why the change in underwriting**



Topic #1

Gender Pricing Entering the Market

- Claims on Women vs. Men



Utilization is up

➤ Claims utilization continues to increase

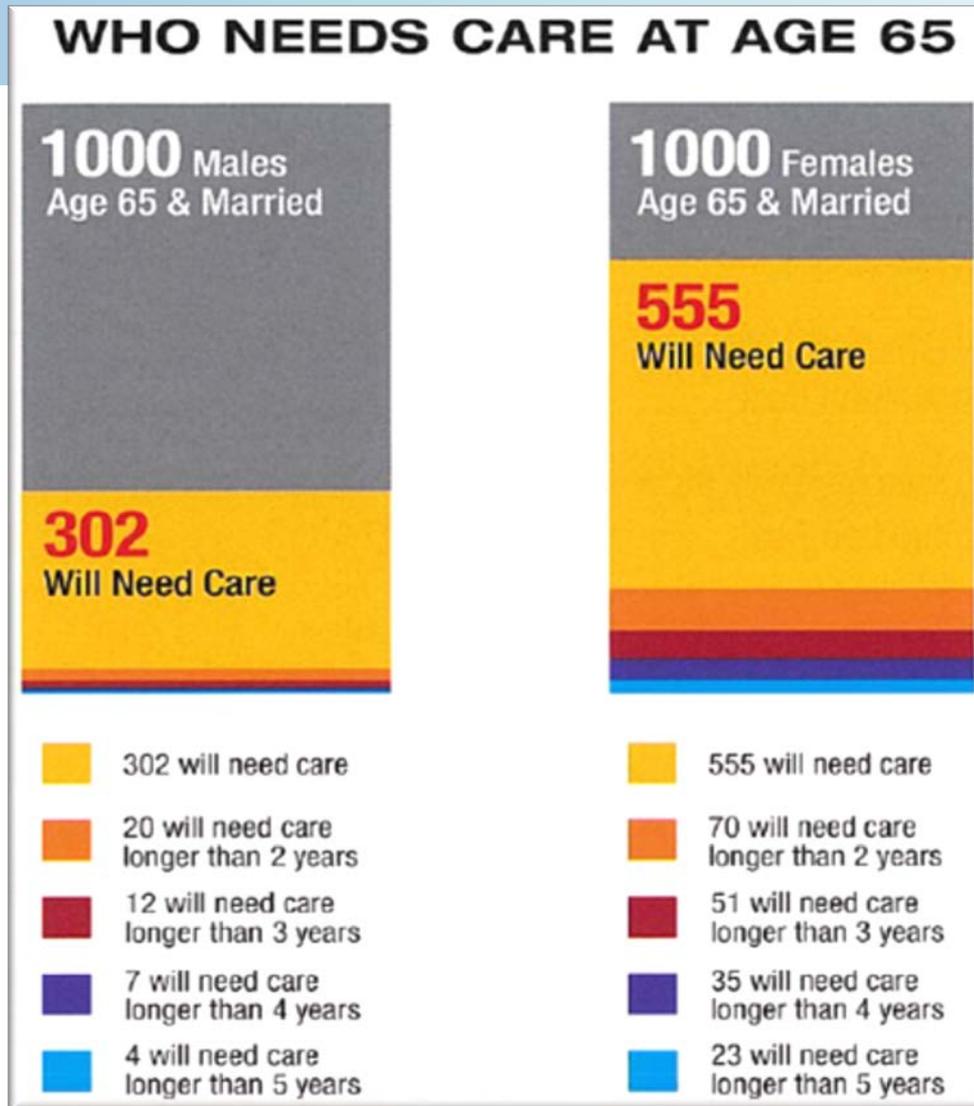
A 2012 survey* indicates that claims payments increased by 13% over apples to apples 2011 payments

- Total claims paid in 2012 increased 18% over 2010 paid claims
- In force premiums increased only 7% in 2012

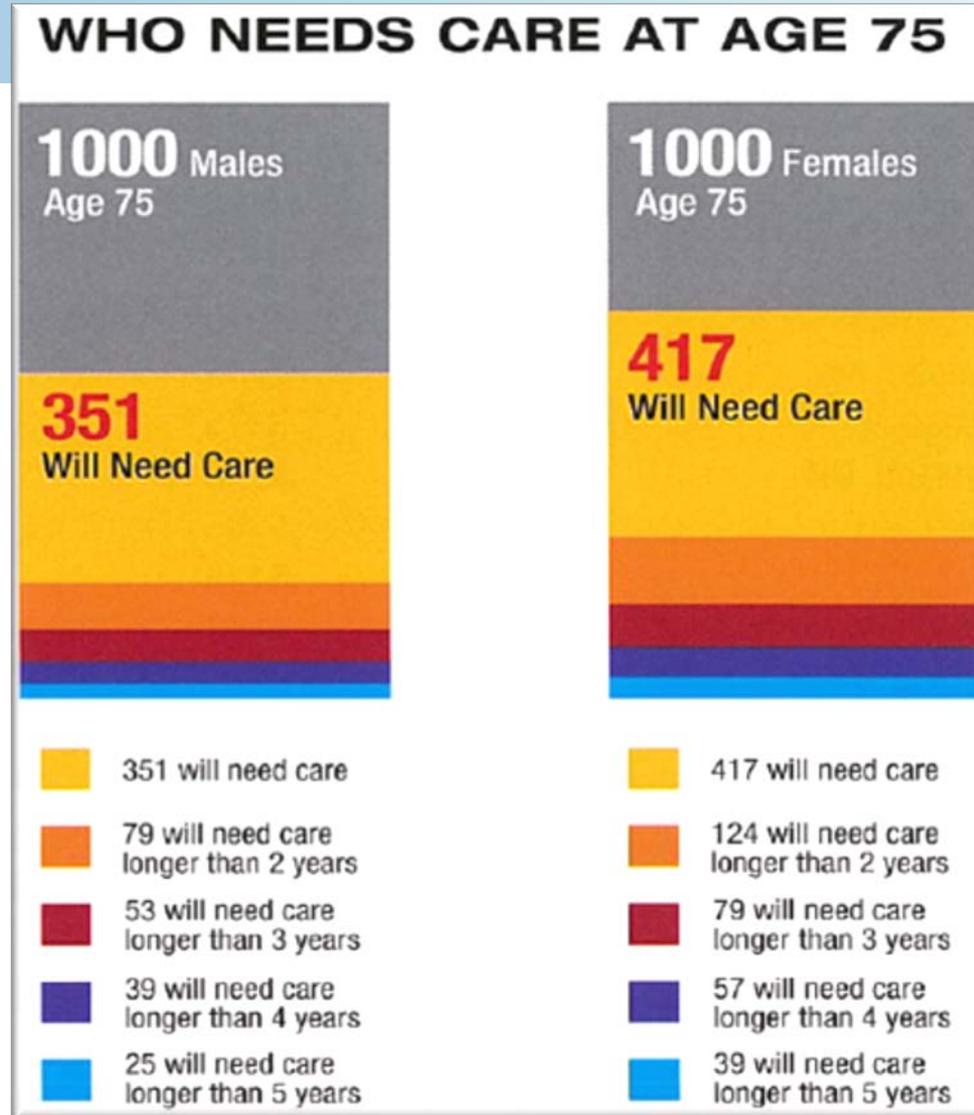


* LTC Insurance Survey, Brokers World, PO Box 11310, Overland Park, KS 66207-1010.

Who's on Claim



Who's on Claim



Who's has the most claims

New Claims Opened By Attained Age (2011)

	Men	Women	Total
Under 50	0.1 %	0.2 %	0.3 %
50 - 59	0.8 %	0.9 %	1.7 %
60 - 69	3.5 %	4.9 %	8.4 %
70 - 79	8.6 %	15.5 %	24.1 %
80 and over	22.0 %	43.5 %	65.5 %

*Source: American Association for Long Term Care Insurance, 2012 LTCi Sourcebook

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Longer & Larger Claims

- Females incurred 67% of claims and 69% of benefit dollars
- Home Care incidence rates for females is more than double that for males
- Mortality for males averages 33% greater than for females



*Source: American Association for Long Term Care Insurance, 2012 LTCi Sourcebook

Cost of Care Increasing

- The national average monthly rate for a semi-private nursing home is up 4.5% to \$76,285*
- The national average monthly rate for an assisted living facility is up 5% to \$40,200*
- The national average daily rate for adult day care is up 4.5% to \$69 *
- \$750,000 projected average cost of three years of care in 30 years**

*Source: American Association for Long Term Care Insurance, 2012 LTCi Sourcebook

**Based on John Hancock's Cost of Care Survey, conducted by LifePlans, Inc 2011 and an assumed rate of inflation of 4.1% based on the average annual increase in the Consumer Price index for All-Urban Consumers (CPI-U), obtained from the Bureau of Labor Statistics of the U. S. Department of Labor, for the 50-year period ending 12/31/10.

Current Environment

Utilization:

- Greater for Females
- 35% of new claims paid for Home care

**Cost of Care
Continues to
Increase!**

Lapse Rates

- Continue to decrease

Industry Response

Introduce Gender Specific rates
with new product design for Individual market

John Hancock's Product

Custom Care III featuring **Benefit Builder** in all Compact states

- Women's premiums *(on average)* increased by 24%¹
 - Men's premiums *(on average)* decreased by 21%¹
 - Married male/female couple's premiums *(on average)* increased about 1.5%¹
- The changes vary by issue age, benefit period and inflation option.*



1. LTC Newslink John Hancock's explanatory flier March 29, 2013.

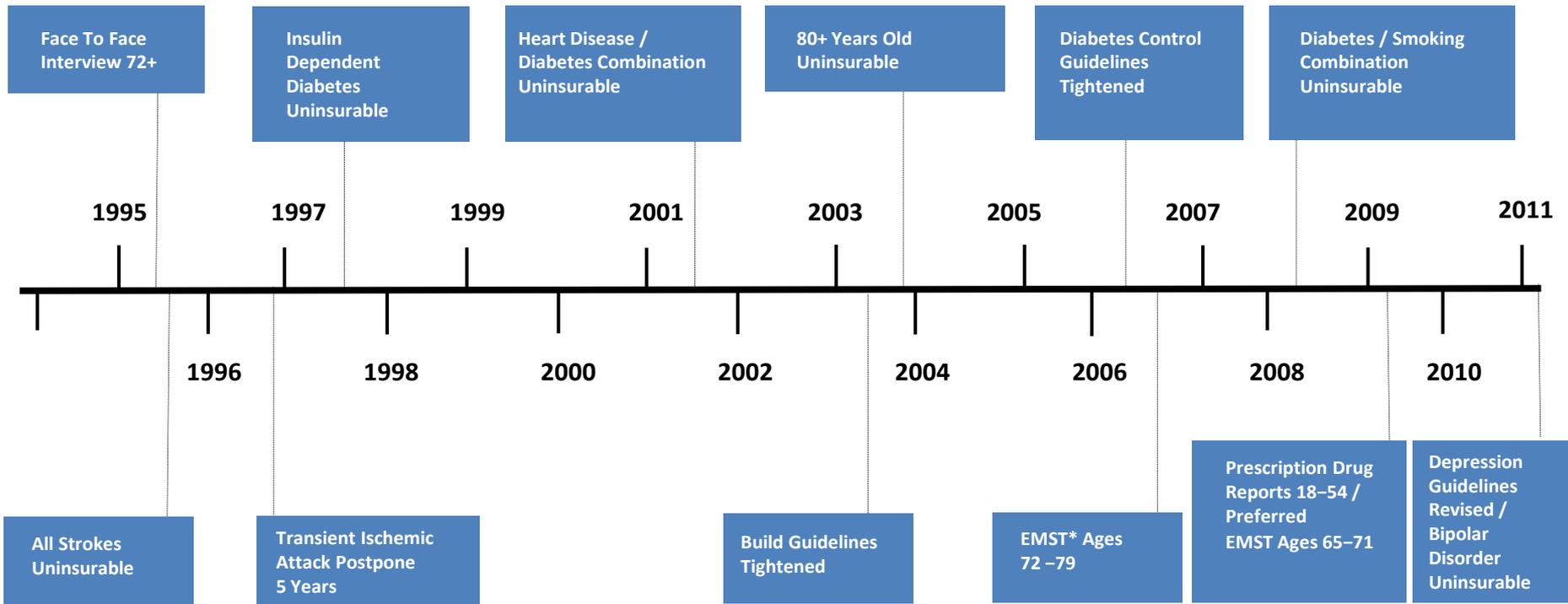
Topic #2

Updated Underwriting Requirements

- Why the change in underwriting



The Evolution



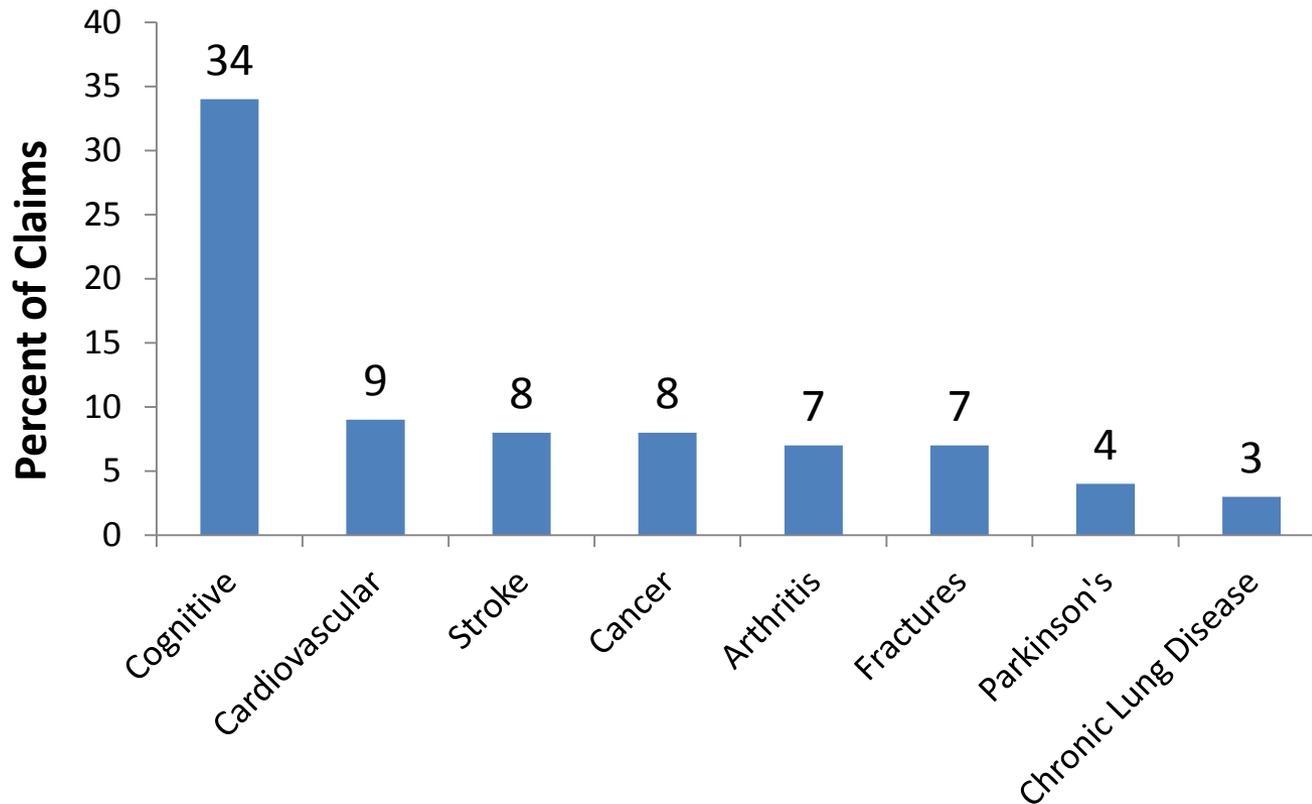
* EMST = Enhanced Mental Skills Test – Cognitive Screening Tool

*Source: Genworth The Next Generation Long Term Care Underwriting 154625

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The Risk

Claims Distribution by Cause



Stroke and All Other Cardiovascular Disorders Account for 17% of All Genworth LTC Claims

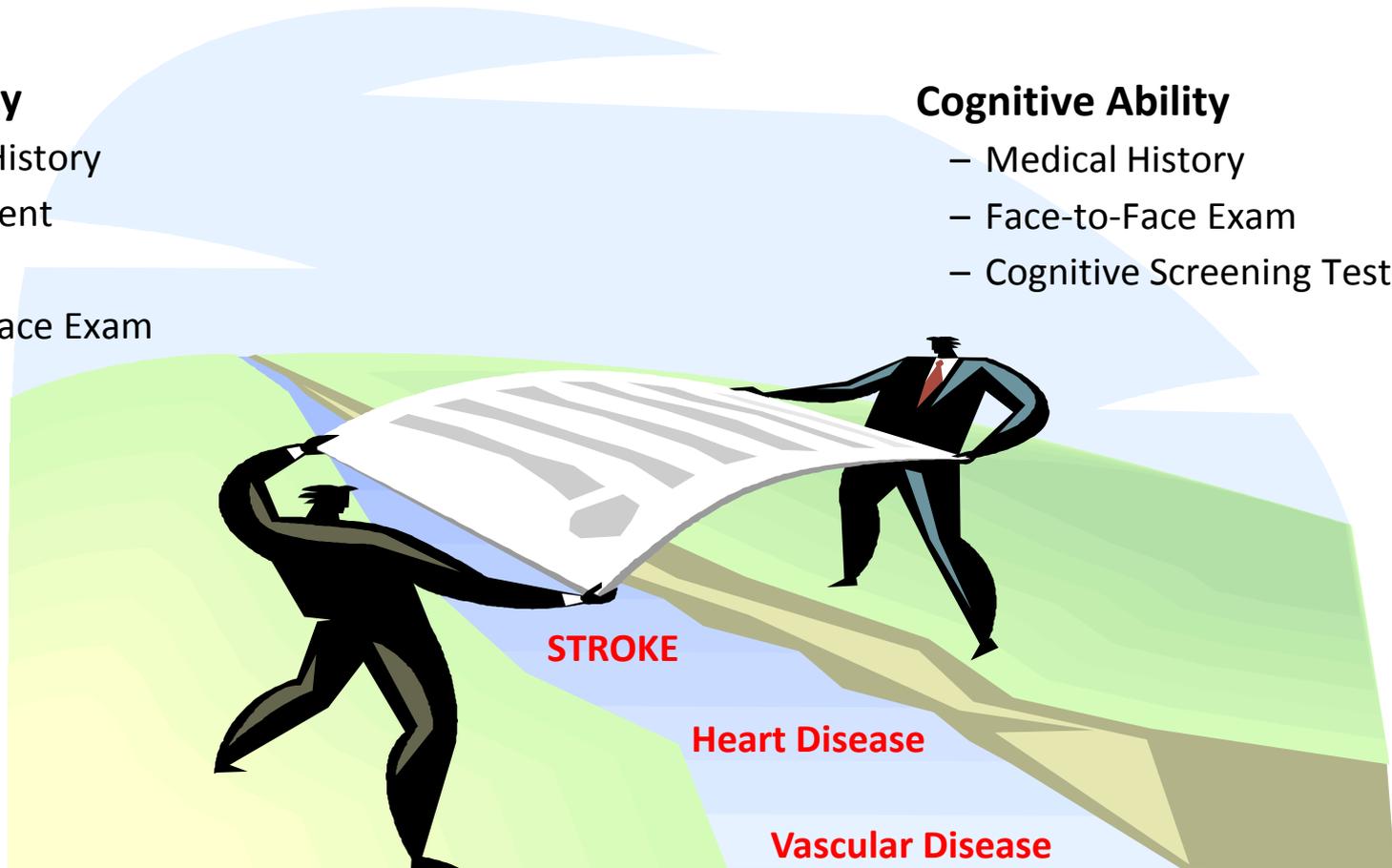
The Underwriting Gap

Functionality

- Medical History
- Employment
- Activities
- Face-to-Face Exam

Cognitive Ability

- Medical History
- Face-to-Face Exam
- Cognitive Screening Test



*Source: Genworth The Next Generation Long Term Care Underwriting 154625

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Assessment of Cardiovascular Risk

Risk Factors

- General Cardiovascular Disease
 - Age, Gender, Diabetes, Smoking, Blood Pressure, Cholesterol, HDL, Build
- Coronary Artery Disease
 - Age, Gender, LDL (Cholesterol), HDL, Blood Pressure, Diabetes, Smoking
- Stroke
 - Age, Gender, Blood Pressure, Diabetes, Smoking, History Cardiovascular Disease, Atrial Fibrillation, Heart Enlargement
- Dementia
 - Alzheimer's Disease
 - Age and Possibly Blood Pressure, Cholesterol, Diabetes, Build, Brain Injury
 - Vascular Dementia
 - Similar to general cardiovascular disease

New Application - Components

- **Part I**

- Personal Profile
- Insurability Profile
 - SSDI Past 3 Years
 - Assistive Devices/ADLs
 - Use of LTC Services
 - Uninsurable Conditions
- Client Profile
 - Tobacco Use
 - Employment
 - Volunteer, Hobbies, Driving
- Other Coverage/Replacement
- Protection Unintentional Lapse
- Declarations (Authorization)
- Conditional Insurance Agreement
- Signatures
- Agent Information

- **Part II (Paramed Exam)**

- Medical Questions
- IADLs
- Alcohol/Drug Use
- Family History
- Examiner's Report
 - Build
- Blood/Urine Samples
- Functional/Cognitive Assessment
 - Living Arrangements
 - ADLs/IADLs
 - Mobility Assessment
 - Cognitive Assessment (EMST*)

*EMST = Enhanced Mental Skills Test. Proprietary to LifePlans, Inc

Blood and Urine Testing

- Blood

- Glucose (Diabetes)
- Fructosamine (Diabetes)
- BUN (Kidney)
- Creatinine (Kidney)
- Alkaline Phosphatase (Liver/Bone)
- Total Bilirubin (Liver)
- AST (SGOT) (Liver)
- ALT (SGPT) (Liver)
- GGT (Liver)
- Total Protein (Blood Disorders)
- Albumin (Liver/Nutrition)
- Globulin (Blood Disorders)
- Triglycerides (CV Risk)
- Cholesterol (CV Risk)
- HDL (CV Risk)
- LDL (CV Risk)
- Hemoglobin A1C (Diabetes)
- HIV Screening
- Hepatitis B/C Screens (If Liver Tests Abnormal)

- Urine

- Glucose (Diabetes)
- pH
- Leukocyte Esterase (Urinary Tract Infection)
- Blood (Kidney Disorders)
- Protein (Kidney Disorders)
- Creatinine
- Cotinine (Nicotine Metabolite)
- Cocaine

Requirements Grid

Underwriting Requirements: Privileged Choice Flex 2 and My Future, My Plan 3	
18-59	RX, Paramed/Lab, MIB
60-75*	APS, Paramed/Lab, Functional/Cognitive Assessment, MIB

*60+: If no physician visit in past 2 years, RX

Benefits

Better, sharper risk classification – *Preferred Best, Preferred, Select, Standard*

Improved matching of risk to pricing

Expansion of allowable build

Detection of undiagnosed diabetes, kidney and liver disease

Stabilization of morbidity

Potential reduction in medical record ordering

Potential cross-selling opportunities



*Source: Genworth The Next Generation Long Term Care Underwriting 154625

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Underwriting Questions

MODIFIED GUARANTEE ISSUE – Answer Questions in SECTION A only.

SIMPLIFIED ISSUE- Answer Questions in SECTIONS A & B.

FULL UNDERWRITING - Answer Questions in SECTIONS A, B & C.

A

1. During the last 6 MONTHS, have you been continuously and actively at work for your current employer for a minimum of 30 hours per week (away from home), except for vacation? Yes No
2. During the last 6 MONTHS, have you missed more than five consecutive days of work due to accidents, injury, sickness or any physical or cognitive impairment? Yes No
3. During the last 12 MONTHS, have you ever required assistance or supervision of any kind to perform any everyday activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring, or toileting? Yes No

If any question 4 – 9 is answered Yes, You are not eligible for coverage.

B

4. Have you EVER had, or been diagnosed, treated or had symptoms of any of the following conditions? Yes No
 If Yes, please check the applicable condition(s):

<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Dementia or Senility	<input type="checkbox"/> Osteoporosis with fractures
<input type="checkbox"/> Amputation due to disease	<input type="checkbox"/> Mobility Deficit	<input type="checkbox"/> Paraplegia or Quadriplegia
<input type="checkbox"/> Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Arthritis with narcotic pain medication	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Cerebrovascular Accident* (Stroke, CVA, TIA)	<input type="checkbox"/> Myasthenia Gravis	<input type="checkbox"/> Polymyositis
	<input type="checkbox"/> Organic Brain Syndrome	<input type="checkbox"/> Scleroderma
	<input type="checkbox"/> Huntington's Chorea	<input type="checkbox"/> Memory loss requiring medical consultation

*If applicant has had a single Cerebrovascular Accident more than 2 years ago, complete Section C.

5. Have you ever been diagnosed by a medical practitioner as having AIDS (Acquired Immune Deficiency Syndrome) or tested positive for HIV? Yes No
6. During the last 3 YEARS, have you used over 60 units of insulin per day to treat Diabetes, or have you been diagnosed or treated for Diabetes WITH COMPLICATIONS (Neuropathy, Retinopathy, Heart Disease, Stroke), Chronic Hepatitis or Cirrhosis, alcohol abuse, drug or prescription drug addiction, or Transient Global Amnesia? Yes No
7. During the last 12 MONTHS, have you used a catheter, dialysis, oxygen equipment, a quad or three-pronged cane, respirator, walker, wheelchair, crutches, motorized scooter or chair lift?... Yes No
8. During the last 12 MONTHS, have you been confined to a nursing home, assisted living facility, attended an adult day care facility, or required home health care? Yes No
9. Do you have a direct family history (parents or siblings) of Huntington's Chorea or Polycystic Kidney Disease? Yes No

10. Are you currently taking or been prescribed any prescription drugs or medications? Yes No
 If Yes, please list all: _____

PRIMARY PHYSICIAN'S NAME	TELEPHONE NUMBER	HMO/PPO ID# (if known)
ADDRESS		DATE LAST CONSULTED
REASON LAST SEEN		

C

If any question 11 – 14 is answered Yes, You are not eligible for coverage. For questions 15-17, if Yes, circle any applicable diagnosis or condition(s) and give details in question # 18.

11. Have you EVER had, been diagnosed with, treated for, or had symptoms of:

a) COPD (Emphysema) with oxygen use, or steroid medications?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Multiple Strokes (CVA's), or Metastatic or Multi-site Cancer?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. In the last 24 MONTHS, have you had a Single Stroke (CVA or TIA)? Yes No
13. In the last 12 MONTHS, have you had Cardiomyopathy? Yes No
14. Within the last 3 MONTHS, have you had a Heart Attack (MI) or Chest Pain; uncontrolled Blood Pressure; Hip or Back Surgery; or Cancer? Yes No
15. In the last 5 YEARS, have you been diagnosed with, received treatment for, or had symptoms of:

a) Chronic Lymphocytic Leukemia, Diabetes, Cancer or Macular Degeneration?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Arthritis, Osteoporosis, Rheumatoid Arthritis, Fibromyalgia, Fractures, Joint Replacement or used a straight cane?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Heart Attack, Chest Pain, Heart Disease, Congestive Heart Failure (CHF), High Blood Pressure, Heart Murmur, Cardiomyopathy or Peripheral Vascular Disease?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Stroke, Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), Aneurysm, irregular heartbeat, Carotid Artery Stenosis, or Heart Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Mental or cognitive disorder including memory loss, confusion, disorientation, mental retardation, depression; or Epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Emphysema?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Dizziness, fainting, blurred vision, convulsions, paralysis, falls, loss of balance or strength?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Any condition requiring treatment, surgery, home care or hospitalization, but not mentioned above (NOT including routine Colds, Flu, etc.) or unplanned weight loss of 15 lbs or more?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. In the last 12 MONTHS, has any medical treatment, follow-up, diagnostic testing, or surgery been recommended, but not yet completed? If Yes, give details: _____

17. Do you have a handicap sticker, handicap placard, or handicap license plate? Yes No

18. Give details for all Yes answers. FOR EVERY MEDICATION THERE SHOULD BE A CONDITION AND FOR MOST CONDITIONS THERE SHOULD BE A MEDICATION OR TREATMENT.

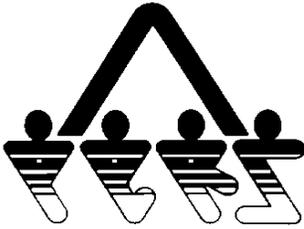
Question #	Nature of Condition/Medication	Date Last Treated/ Medication Taken	Name of Physician Seen/ Physician's Address





National Leaders in Long Term Care Insurance





**North Dakota
Public Employees Retirement System**
400 East Broadway, Suite 505 • Box 1657
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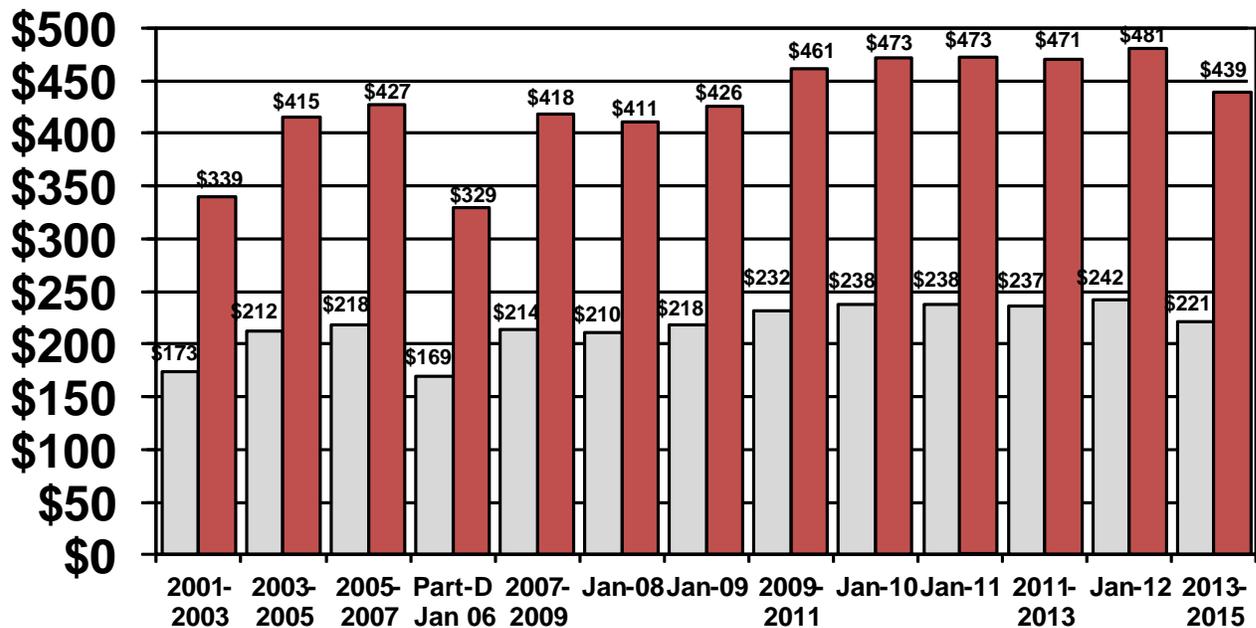
FAX: (701) 328-3920 • EMAIL: NDPERS-info@nd.gov • www.nd.gov/ndpers

Memorandum

TO: PERS Board
FROM: Sparb
DATE: August 15, 2012
SUBJECT: Medicare Part D Rates

Attachment #1 is the proposed renewal for the Medicare prescription drug plan (PDP) for 2014. The proposed rate is a .3% increase or 20 cents per month per member.

The following is our Medicare rate history:



□ Single ■ Family

As you will note, we have been able to keep these rates fairly stable over the last several years. If the proposed rate for the PDP is approved, the single plan premium will go 20 cents a month and the family plan premium will go up 40 cents a per month.

Attachment #2 is a letter from Deloitte relating to their review of the renewal. As you will note, they indicate we should request other information for the 2015 renewal; however, at this point they indicate *“Overall we find the renewal rate calculation reasonable and appropriate.”*

Board Action Requested

To approve the attached PDP rates for 2013.

North Dakota Public Employees Retirement System
2014 Renewal for Group Prescription Drug Plan

Enrollment on 6/30/2013	2013		2014		Rate Change
	Monthly Premium	Annual Income	Monthly Premium	Annual Income	
7,790	\$57.20	\$5,347,056	\$57.40	\$5,365,752	0.3%

Notes for 2014 Renewal:

- The Centers for Medicare and Medicaid Services (CMS) reported on July 30, 2013 the national average monthly bid amount for standard Part D individual coverage of \$75.88 and the Part D base beneficiary premium for 2014 (average individual premium) of \$32.42.

Further information on this topic can be found at the CMS website:

<http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2014.pdf>

- The NDPERS Group Prescription Drug Plan (GPDP) has been rated for 2014 based on prior claim experience from 2012.
- Effective January 1, 2013, the manufacturer discount program will apply to employer group Part D plans. This reduction in premium is included in the 2014 renewal calculation.

North Dakota Public Employees Retirement System
2014 Renewal for Group Prescription Drug Plan

1. Allowed Claims Amounts (Incurred 1-1-12 thru 12-31-12)	16,088,493
2. Incurred Allowed Claims for base period	16,088,493
3. Member Months Exposed (1-1-12 thru 12-31-12)	89,421
4. Adjusted Experience Period Allowed Claims PMPM [(2) / (3)]	179.92
5. Trend [24 months @ 2.0% annual]	1.040
6. Rating Period Allowed Claims PMPM [(4) x (5)]	187.19
7a. Rating Period Member Cost Share PMPM [(6) x 0.2815]	52.69
7b. Manufacturer Discount Program Paid PMPM [(6) x 0.098]	18.34
7. Total of Member Cost Share and Manufacturer Discount PMPM [(7a) + (7b)]	71.04
8. Rating Period Plan Paid PMPM [(6) - (7)]	116.15
9. Estimated 2014 Rx Drug Rebate PMPM	23.89
10. 2014 Plan Payments PMPM [(8) - (9)]	92.26
11. 2014 Anticipated Loss Ratio	87.5%
12. 2014 Gross Premium to BCBSND [(10) / (11)]	105.44
13. CMS Payments to BCBSND	48.08
14. Calculated Member Premium [(12) - (13)]	57.36
15. Rounded to Nearest \$0.10	57.40

North Dakota Public Employees Retirement System
 2014 Renewal for Group Prescription Drug Plan
 Data Request

2012 and 2013Q1 Rebates for NDPERS

Q1-2012	\$382,602
Q2-2012	\$401,878
Q3-2012	\$423,435
Q4-2012	\$457,060
Q1-2013	\$410,505
Total	\$2,075,479

2012 and 2014 projected risk scores for NDPERS

2012 Risk Score	0.8320
2014 Projected Risk Score	0.7597

January 2012 - December 2012 Costs for NDPERS

Month	Total Cost	Member Cost	Plan Cost
Jan-12	\$1,373,491	\$413,629	\$959,863
Feb-12	\$1,273,212	\$376,554	\$896,658
Mar-12	\$1,359,218	\$393,351	\$965,868
Apr-12	\$1,389,972	\$377,724	\$1,012,248
May-12	\$1,430,638	\$368,428	\$1,062,209
Jun-12	\$1,213,535	\$307,474	\$906,061
Jul-12	\$1,347,605	\$316,552	\$1,031,053
Aug-12	\$1,325,089	\$315,622	\$1,009,468
Sep-12	\$1,213,678	\$277,533	\$936,145
Oct-12	\$1,476,629	\$318,826	\$1,157,804
Nov-12	\$1,319,766	\$283,436	\$1,036,331
Dec-12	\$1,365,659	\$282,342	\$1,083,317
Total	\$16,088,493	\$4,031,470	\$12,057,023

Memo

Date: August 14, 2013
To: PERS Board
From: Pat Pechacek and Sean Chin
Subject: 2014 PDP Renewal

PERS staff asked that Deloitte Consulting LLP, review the Blue Cross Blue Shield of North Dakota (BCBSND) 2014 PDP renewal calculation for reasonableness and appropriateness.

On July 30, 2013, the Centers for Medicare and Medicaid Services (CMS) released the national average monthly bid amount for Standard Part D and the Base Beneficiary Premium for 2014. BCBSND receives payments from CMS based on these bidding averages. CMS payments to BCBSND account for a large percentage of the overall needed premium and factor into the overall renewal.

The national average monthly bid amount for Part D coverage decreased to \$75.88 (\$79.64 in 2013), and the Part D base beneficiary premium increased to \$32.42 (\$31.17 in 2013).

Deloitte Consulting LLP reviewed the following factors in the renewal:

- Experience Allowed and Paid Claim amounts
- Annual trend assumption (2.0%)
- Estimated drug rebate amounts (\$23.89 PMPM)
- Anticipated Loss Ratios (87.5%)
- CMS Payment estimates (\$48.08 PMPM)

Overall the monthly premium rates for 2014 will be increasing 0.3% from \$57.20 to \$57.40.

For the 2015 renewal, we recommend that PERS request that BCBSND provide the following supporting information:



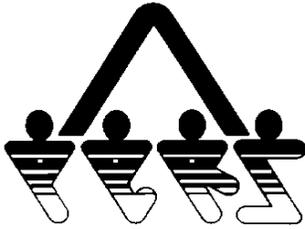
Official Professional Services Sponsor

To: PERS Board
Subject: 2014 PDP Renewal
Date: August 14, 2013
Page 2

- Detail breakdown of the CMS Payments to BCBSND (Reinsurance, Low Income Subsidy Cost Sharing (LICS), Coverage Gap Discount, Monthly Capitated Payments)

Overall we find the renewal rate calculation reasonable and appropriate. However, in future years it would be helpful to have the additional detail on CMS Payments in order to more precisely analyze the renewal calculations.

cc: Josh Johnson



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: August 14, 2013
SUBJECT: ACA Implementation

At the last meeting we discussed the Affordable Care Act and the action by the President to not enforce the Shared Responsibility provisions relating to employers until 2015 instead of starting in January of 2014. We discussed how this related to House Bill 1059 which was passed this last session so the North Dakota PERS health plan would comply with these provisions starting in January of 2014. We decided that as a result of the action of the Obama administration and House Bill 1059, we needed to request consideration of the Legislative Employee Benefits Committee on delaying the effective date for House Bill 1059.

Since the last PERS Board meeting I have met with the OMB about the issue and I will be having a meeting with the Chair of the Employee Benefits Committee after the date of this memo but before our next meeting. I will be able to give you an update at the Board meeting.

The next meeting of the Legislative Employee Benefits Committee has been scheduled for August 29th.



**North Dakota
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Memorandum

TO: PERS Board
FROM: Deb
DATE: August 14, 2013
SUBJECT: HIPAA Compliance Update

As you are aware, for several years the NDPERS plan has operated under the federally mandated Health Insurance Portability and Accountability Act (HIPAA). HIPAA became law in 1996 but has had several modifications since then. The most recent changes before you have come about as a result of some recently released privacy and security regulations that will require implementation for the most part by September 23, 2013.

Staff began working on revising existing materials and ensuring required materials were created last March. We initially met with Pam Crawford, our HIPAA resource, in the Attorney General's office and met periodically to work through the materials and have Pam review them to ensure we were compliant. In mid-May, Jan Murtha became our resource for HIPAA, retaining Pam Crawford as her resource.

At the Board meeting we will hand out the following materials that has either been revised or created over this process so you will have an opportunity to review over the next month before we need to take action on it at the September meeting.

- a. Revised Privacy Notice
- b. Revised Business Associate's Agreement
- c. Revised Policy & Procedure for Privacy of PHI for Deceased Participants
- d. Breach Analysis Protocol & Notice of Breach
- e. Revised Security Standards
- f. Revised Privacy Standards
- g. Request for Restrictions by Participant Policy
- h. Request for Access by Participant

At the September Board meeting, we will ask you to approve these materials so they can be finalized. However, since the Board meeting is scheduled for September 19th and the implementation date is September 23rd, it will be important to approve/finalize the materials at the September Board meeting. Therefore, if you find you have questions, comments or suggestions that may require altering the materials, please let staff know immediately instead of waiting until the September Board meeting. This will allow staff to make the changes in time to provide the full Board with some extra time to consider the proposed changes.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: August 14, 2013
SUBJECT: Interim Study – Health Insurance

The Government Finance Committee met on July 30, 2013. This committee is responsible for the following study.

SECTION 39. LEGISLATIVE MANAGEMENT STUDY - STATE EMPLOYEE HEALTH INSURANCE PREMIUMS. The legislative management shall consider studying, during the 2013-14 interim, the feasibility and desirability of establishing a maximum state contribution to the cost of state employee health insurance premiums. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fourth legislative assembly.

Attached please find the committee memorandum prepared by Legislative Council relating to the study. After discussion, the committee adopted the following study plan:

1. Receive information from the Legislative Council regarding historical costs for state employee health insurance premiums and estimated future premium costs.
2. Receive information from the Legislative Council regarding expected employee out-of-pocket costs paid through deductibles, coinsurance, copays, and pharmaceutical costs based on the current state employee health insurance plan.
3. Receive information from the Legislative Council on the state's available high-deductible health plan, including an explanation of plan components and the number of participants in the plan.
4. Receive and review information from the Legislative Council staff regarding state contributions for state employee health insurance premiums in other states, private employer health insurance premium contributions for private sector employees, and associated employee out-of-pocket costs.
5. Receive information from PERS on the process used for determining health insurance premiums each biennium.
6. Receive testimony from interested persons regarding the study.
7. Develop recommendations and any bill drafts necessary to implement the recommendations.
8. Prepare a final report for submission to the Legislative Management.

STUDY OF STATE CONTRIBUTIONS TO STATE EMPLOYEE HEALTH INSURANCE PREMIUMS - BACKGROUND MEMORANDUM

STUDY RESPONSIBILITIES

Section 39 of House Bill No. 1015 (attached as an [appendix](#)) provides for a study of the state contribution to the cost of state employee health insurance premiums, including the feasibility and desirability of establishing a maximum state contribution. The responsibility for this study was assigned to the Government Finance Committee by the Legislative Management.

BACKGROUND INFORMATION

North Dakota Century Code Chapter 54-52.1 provides group medical insurance is available to any employee who meets the eligibility requirements of being a permanent employee of the state. To be eligible, an employee must be at least 18 years of age, occupy a regularly funded position, work a minimum of 20 hours per week, and work at least 20 weeks each year. Temporary employees who work a minimum of 20 hours per week and 20 weeks per year may purchase health insurance at their own expense or the employing agency may pay the premium.

The 1963 Legislative Assembly enacted Chapter 52-12 which authorized state agencies, either individually or jointly with other agencies, to enter a group hospitalization and medical care plan and group life insurance plan for each agency's employees. The agencies were required to pay \$5 per month for each participating employee's insurance premium. An employee could elect to participate in either a single or family plan. The 1971 Legislative Assembly repealed Chapter 52-12 and enacted Chapter 54-52.1 establishing the uniform group insurance program. The program was placed under the authority of the Public Employees Retirement Board. The board was required to solicit bids and contract for the provision of insurance benefits coverage with an insurance carrier determined by the board.

From 1971 to 1983, Blue Cross Blue Shield of North Dakota provided and administered the health insurance benefits plan for public employees. In 1983 the Retirement Board was authorized by Section 54-52.1-04.2 to establish a plan of self-insurance for providing health benefits coverage under an administrative services-only contract or a third-party administrator contract if the board determined during any biennium that a self-insured plan is less costly than the lowest bid submitted by an insurance carrier. The board exercised the option to implement a self-insurance health benefits plan and administered the program in that manner from July 1, 1983, through June 30, 1989.

Rising health care costs in the state were the primary reason for the cashflow difficulties experienced in the health benefits plan. In the 1985-87 biennium, the Legislative Assembly appropriated funds for a 20 percent premium increase, and claims costs increased 42 percent.

Although the Retirement Board began its administration of the self-insured health benefits plan on July 1, 1983, with reserves of \$2,143,880, claim expenditures and other expenses of the program exceeded premium income and other revenue in 1984. By June 1987 the fund balance, as indicated in audited financial statements of the plan, was a negative \$4,759,963 with estimated outstanding claims payable of \$4,600,000.

In 1987 the Retirement Board incorporated various cost-containment components into the health benefits plan which included:

1. Implementation of a program of concurrent review of inpatient hospitalizations designed to eliminate unnecessary treatment or prolonged hospital stays and to allow consideration of less expensive appropriate treatment for long-term medical care.
2. Implementation of a program of mandatory second surgical opinions for certain elective surgeries. (This program did not generate anticipated results and after a one-year trial period was discontinued.)
3. Expansion of contract deductibles to include all inpatient, outpatient, and physician services.
4. Increase in the coinsurance base from the first \$2,000 in charges to the first \$4,000 in charges.
5. Implementation of a preferred pharmacy program.
6. Establishment of a separate premium rate for retirees, based on retiree claims experience.
7. Introduction of a \$25 copayment for each hospital emergency room visit.
8. Adjustment of the Medicare coordination of benefits formula applied to retiree members of the plan.

Due to the introduction of these cost-containment initiatives and the availability to public employees of a number of attractive health maintenance organization plans, approximately 3,350 membership contracts constituting 23 percent of the total contracts of the health benefits plan were lost during the 1987 open enrollment period, resulting in a decrease of approximately \$563,000 per month in premium income.

The decision by the Medcenter One HMO, a health maintenance organization that had the largest Public Employees Retirement System (PERS) eligible enrollment, to discontinue its participation agreement with PERS as of July 1, 1988, and substantial increases in premiums charged by other health maintenance organizations resulted in a substantial number of public employees choosing the PERS health benefits plan during the 1988 open enrollment period.

In January 1989 the Retirement Board voted to end the state-funded health insurance program and buy the coverage from Blue Cross Blue Shield of North Dakota. Officials of PERS predicted the state would end the 1987-89 biennium with a \$3.5 million deficit and would need to increase premium rates by 65 percent in 1989-91. The Blue Cross Blue Shield bid of about \$35 million to fund state employees' health insurance for the 1989-91 biennium included provisions that the company would absorb about \$5 million in unpaid claims when it took over in July 1989.

Senate Bill No. 2026 (1989) appropriated \$1.2 million from the fund for unemployment compensation claims to PERS for the state group health program for the period beginning January 1, 1989, and ending June 30, 1991.

Until 1993 the health insurance program charged premiums based on each employee's election of a single or family plan. Beginning in the 1993-95 biennium, the Retirement Board began to charge a combination rate that is a blended rate per employee whether a single or family plan is chosen. The blended rate enables agencies to budget the same premium rate for all employees; therefore, an agency's budget is not adversely affected if an employee electing to receive single health insurance coverage quits and is replaced by an employee electing to receive family coverage. The schedule below shows the premiums charged since the program began in 1963.

Biennium	Single Plan	Percentage Change	Family Plan	Percentage Change	Combination Rate	Percentage Change
1963-65	\$5.00		\$21.00			
1965-67	\$8.55	71.0%	\$21.50	2.4%		
1967-69	\$10.75	25.7%	\$25.00	16.3%		
1969-71	\$14.45	34.4%	\$34.90	39.6%		
1971-73	\$15.95	10.4%	\$41.90	20.1%		
1973-75	\$14.46	(9.3%)	\$41.90	0.0%		
1975-77	\$19.50	34.9%	\$59.95	43.1%		
1977-79	\$25.50	30.8%	\$67.42	12.5%		
1979-81	\$34.84	36.6%	\$87.40	29.6%		
1981-83	\$42.68	22.5%	\$107.07	22.5%		
1983-85	\$50.28	17.8%	\$140.28	31.0%		
1985-87	\$60.00	19.3%	\$168.00	19.8%		
1987-89	\$68.28	13.8%	\$191.28	13.9%		
1989-91	\$99.82	46.2%	\$280.39	46.6%		
1991-93	\$108.00	8.2%	\$304.00	8.4%		
1993-95					\$254.00	
1995-97					\$265.00	4.3%
1997-99					\$301.00	13.6%
1999-2001					\$349.72	16.2%
2001-03					\$409.09	17.0%
2003-05					\$488.70	19.5%
2005-07					\$553.95	13.4%
2007-09					\$658.08	18.8%
2009-11					\$825.66	25.5%
2011-13					\$886.62	7.4%
2013-15					\$981.69	10.7%

From 1963 through 1969, the state contributed \$5 per month toward the cost of health insurance for state employees. State employees paid any additional amount for single or family coverage. During the 1969-71 biennium, the state contributed \$7.50 per month. For the period 1973 through 1979, the state paid the cost of a single health insurance plan. Employees choosing a family plan paid any additional cost. Since 1979 the state has paid the full cost of either a single or family plan for eligible state employees.

The schedule below provides information on health insurance premiums and the cost of health insurance increases since the 1997-99 biennium.

State Employee Health Insurance Increases (Excluding Higher Education)						
Biennium	Monthly Premium	Increase From Previous Biennium	Percentage Increase	General Fund	Special Funds	Total
1997-99	\$301	\$36	13.6%	\$7,026,674	\$3,619,802	\$10,646,476
1999-2001	\$350	\$49	16.2%	\$6,989,537	\$3,858,174	\$10,847,711
2001-03	\$409	\$59	17.0%	\$11,182,551	\$6,001,252	\$17,183,803
2003-05	\$489	\$80	19.5%	\$8,027,122	\$8,258,216	\$16,285,338
2005-07	\$554	\$65	13.4%	\$5,335,798	\$7,903,870	\$13,239,668
2007-09	\$658	\$104	18.8%	\$9,115,817	\$12,346,031	\$21,461,848
2009-11	\$826	\$168	25.5%	\$15,889,790	\$20,215,824	\$36,105,614
2011-13	\$887	\$61	7.4%	\$7,179,809	\$5,995,847	\$13,175,656
2013-15	\$982	\$95	10.7%	\$11,127,312	\$9,700,989	\$20,828,301

High-Deductible Health Plan

Section 54-52.1-18, as enacted by the 2011 Legislative Assembly, requires the Public Employees Retirement Board to develop and implement a high-deductible health plan with a savings account as an alternative to the regular health insurance plan. The section requires the difference between the cost of single and family health plan for state employees to be deposited in a health savings account for the benefit of the participating employee. The high-deductible health plan has higher annual deductibles and larger out-of-pocket costs which are partially offset by the employer contribution to the health savings account. The health savings account is not subject to federal income tax at the time of deposit and funds may be carried over and used in subsequent years.

As of April 2013, there were 15,262 state contracts for the regular health insurance benefit, and 122 employees were enrolled in the high-deductible health plan.

STUDY PLAN

The following is a proposed study plan for the committee's consideration in its study of the state contributions for state employee health insurance premiums:

1. Receive information from the Legislative Council regarding historical costs for state employee health insurance premiums and estimated future premium costs.
2. Receive information from the Legislative Council regarding expected employee out-of-pocket costs paid through deductibles, coinsurance, copays, and pharmaceutical costs based on the current state employee health insurance plan.
3. Receive information from the Legislative Council on the state's available high-deductible health plan, including an explanation of plan components and the number of participants in the plan.
4. Receive and review information from the Legislative Council staff regarding state contributions for state employee health insurance premiums in other states, private employer health insurance premium contributions for private sector employees, and associated employee out-of-pocket costs.
5. Receive information from PERS on the process used for determining health insurance premiums each biennium.
6. Receive testimony from interested persons regarding the study.
7. Develop recommendations and any bill drafts necessary to implement the recommendations.
8. Prepare a final report for submission to the Legislative Management.

ATTACH:1



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Memorandum

TO: PERS Board
FROM: Bryan Reinhardt
DATE: August 15, 2013
SUBJECT: 2012 Active Health Care Report

Attached is the 2012 NDPERS Active health care report. Costs and trends are increasing slightly. A similar agency-specific report is developed for all 43 large groups on the health plan (over 100 employees).

If you have any questions, I will be available at the NDPERS Board Meeting.

NDPERS Health Care Analysis



2012

North Dakota Public Employees Retirement System

For January - December 2012, there were 20,530 active NDPERS employees. This is about 73% of the NDPERS contracts. The average age of these employees was 46 years. There were 32,642 dependents of NDPERS employees on the NDPERS health plan.

HOSPITAL

NDPERS health plan members had 71,405 hospital claims from January to December 2012. These claims had \$169,261,918.35 in total charges. The NDPERS health plan paid \$89,638,274.58 toward these charges.

HOSPITAL UTILIZATION
ADMISSION: 01/2012 - 12/2012

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,fffffffffffffffff...fffff...fff...fffffffff...fffffffffffff...fffffffffffff†
,          ,CLAIMS, % , DAYS , CHARGES , PAID ,
‡fffffffffffffffff^fffff^fff^fffffffff^fffffffffffff^fffffffffffff%
,CLAIM TYPE:      ,      ,      ,      ,      ,      ,
,IP=Inpatient     ,      ,      ,      ,      ,      ,
,OP=Outpatient    ,      ,      ,      ,      ,      ,
‡fffffffffffffffff%
,IP NEWBORN       , 694, 1, 2918, $7,774,728, $5,146,296,
‡fffffffffffffffff^fffff^fff^fffffffff^fffffffffffff^fffffffffffff%
,IP MEDICAL       , 1050, 1, 4133, $17,336,358, $12,171,414,
‡fffffffffffffffff^fffff^fff^fffffffff^fffffffffffff^fffffffffffff%
,IP MATERNITY     , 768, 1, 1778, $5,243,744, $2,828,659,
‡fffffffffffffffff^fffff^fff^fffffffff^fffffffffffff^fffffffffffff%
,IP SURGICAL      , 1284, 2, 4358, $43,735,355, $27,109,818,
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,IP PSYCH         , 228, 0, 1884, $2,304,704, $1,475,711,
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,IP CHEM DEP      , 49, 0, 191, $354,098, $237,838,
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,OP MATERNITY     , 2382, 3, 0, $1,174,729, $525,449,
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,OP SURGICAL      , 8247, 12, 0, $36,002,208, $16,155,505,
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,OP PSYCH         , 936, 1, 0, $1,563,559, $816,408,
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,OP CHEM DEP      , 524, 1, 0, $1,231,285, $849,587,
‡fffffffffffffffff^fffff^fff^fffffffff^fffffffffffff^fffffffffffff%
,OP MEDICAL       , 54893, 77, 0, $49,624,590, $21,350,541,
‡fffffffffffffffff^fffff^fff^fffffffff^fffffffffffff^fffffffffffff%
,SNF & SWING BED, 91, 0, 1261, $853,771, $573,761,
‡fffffffffffffffff^fffff^fff^fffffffff^fffffffffffff^fffffffffffff%
,HOME HEALTH AG , 108, 0, 0, $93,355, $74,598,
‡fffffffffffffffff^fffff^fff^fffffffff^fffffffffffff^fffffffffffff%
,HOSPICE          , 151, 0, 0, $1,969,435, $322,689,
‡fffffffffffffffff^fffff^fff^fffffffff^fffffffffffff^fffffffffffff%
,TOTAL            , 71405,100, 16523,$169,261,918, $89,638,275,
‡fffffffffffffffff<fffff<fff<fffffffff<fffffffffffff<fffffffffffff‡

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PHYSICIAN/CLINIC

NDPERS health plan members had 989,066 physician/clinic services from January to December 2012. These services had \$156,153,692.68 in total charges. The NDPERS health plan paid \$77,359,406.01 toward these charges.

PHYSICIAN/CLINIC UTILIZATION
SERVICE DATE: 01/2012 - 12/2012

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,fffffffffffffffff...fffff...fff...fffffffff...fffffffffffff...fffffffffffff†
,          ,SERVICES , % , CHARGES , PAID ,

```

,TYPE OF SERVICE	,	,	,	,	,
,SURGERY-IP	,	3498,	0,	\$6,548,231,	\$3,453,301,
,SURGERY-OP	,	9386,	1,	\$9,136,729,	\$3,705,654,
,SURGERY-OFFICE	,	21061,	2,	\$8,430,637,	\$3,043,640,
,ANESTHESIA	,	12230,	1,	\$7,869,476,	\$3,540,427,
,MATERNITY	,	8261,	1,	\$4,650,353,	\$2,302,144,
,ANCILLARY ROOMS	,	2464,	0,	\$4,637,623,	\$2,314,763,
,IP VISITS	,	14024,	1,	\$3,456,734,	\$2,347,198,
,OP / ER VISITS	,	15435,	2,	\$3,195,665,	\$1,570,262,
,OFFICE CALLS	,	170971,	17,	\$27,274,924,	\$16,786,969,
,OPTICAL	,	13331,	1,	\$1,483,203,	\$648,038,
,CHEM/PSYCH	,	39064,	4,	\$6,589,266,	\$3,823,650,
,THERAPIES	,	157358,	16,	\$17,004,858,	\$8,824,224,
,EKG/EEG	,	23572,	2,	\$4,410,831,	\$1,677,636,
,DIAGNOSTIC LAB	,	204602,	21,	\$15,224,169,	\$5,464,137,
,DIAGNOSTIC X-RAY	,	80989,	8,	\$12,570,300,	\$5,501,114,
,RX/INJECTIBLES	,	122825,	12,	\$11,511,528,	\$5,431,501,
,SPECIAL SERVICES	,	65691,	7,	\$7,985,954,	\$4,748,882,
,SUPPLIES	,	6632,	1,	\$684,168,	\$324,930,
,HME	,	17672,	2,	\$3,489,044,	\$1,850,935,
,TOTAL	,	989066,	100,	\$156,153,693,	\$77,359,406,

PRESCRIPTION DRUGS

NDPERS health plan members had 417,546 pharmacy claims from January to December 2012. These claims had \$59,381,701.96 in total charges. The NDPERS health plan paid \$24,013,242.70 toward these charges.

PRESCRIPTION DRUG UTILIZATION FILL DATE: 01/2012 - 12/2012

, CLAIMS	,	%	,	CHARGES	,	PAID	,
,NON-GENERIC	,	95320,	23,	\$34,180,167,	\$18,427,126,		
,GENERIC	,	322226,	77,	\$25,201,535,	\$5,586,116,		
,TOTAL	,	417546,	100,	\$59,381,702,	\$24,013,243,		

Generic drug use is at 77%, higher than the 74% reported in 2011, 71% reported in 2010, 68% reported in 2009, 65% reported in 2008, 60% reported in 2007, 56% reported in 2006, 52% reported in 2005, 48% reported in 2004, 44% reported in 2003, 41% reported in 2002, 40% in 2001 and 2000, 41% reported in 1999, 43% reported in 1998 and 44% 1997.

PERCENTAGES

EMPLOYEES, SPOUSES, & CHILDREN
BY MEMBERSHIP & CLAIM TYPE
01/2012 - 12/2012

	MEMBERSHIP	CLAIMS	SERVICES	CLAIMS	
	Sum	%	Sum	%	Sum
HOSPITAL	20477	39	17850	25	267038
PHYSICIAN					27
PHARMACY					80531
MEMBERSHIP					19
CLAIMS					
SERVICES					
CLAIMS					
CHILDREN	20477	39	17850	25	267038
EMPLOYEE	20530	39	32561	46	439413
SPOUSE	12165	23	20994	29	282615
TOTAL	53171	100	71405	100	989066

SUMMARY

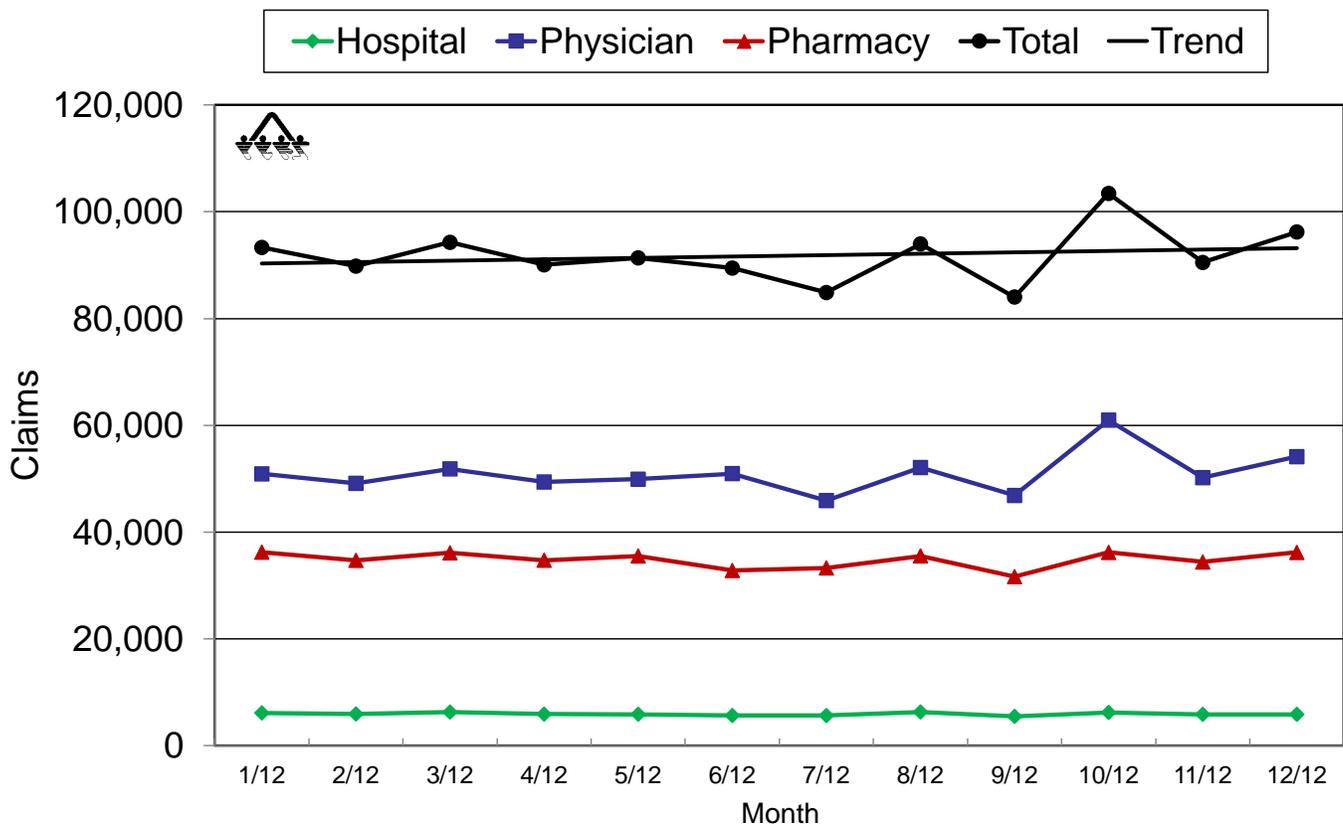
Diagnostic x-ray and lab services make up 29% of the professional services for 1/2012 - 12/2012 (30% in 2011, 29% in 2010, 32% in 2009, 31% in 2008 & 2007, 32% in 2006 & 2005, 33% in 2004, 32% in 2003 & 2002, 31% in 2001 & 2000). Employees made up 39% of the active membership, but were responsible for 44 - 51 percent of the claims / services in 2012. This is similar to the 2007-2011 percentages.

The following graph shows that the number of active claims per month increased slightly throughout 2012.

The second graph shows that per capita charges increased 4.2% and per capita costs increased about 3.2% from 2011 to 2012. The average charge per active member per month was \$124 in 1994, \$134 in 1995, \$143 in 1996, \$155 in 1997, \$171 in 1998, \$189 in 1999, \$207 in 2000, \$224 in 2001, \$256 in 2002, \$300 in 2003, \$318 in 2004, \$363 in 2005, \$396 in 2006, \$437 in 2007, \$484 in 2008, \$503 in 2009, \$531 in 2010, \$579 in 2011, and \$603 in 2012. The average amount paid by the NDPERS health plan per capita was \$84 in 1994, \$92 in 1995, \$96 in 1996, \$100 in 1997, \$110 in 1998, \$114 in 1999, \$117 in 2000, \$122 in 2001, \$134 in 2002, \$153 in 2003, \$163 in 2004, \$185 in 2005, \$206 in 2006, \$226 in 2007, \$249 in 2008, \$253 in 2009, \$267 in 2010, \$290 in 2011, and \$299 in 2012.

The last page shows that 2011-2012 overall per capita costs increased for the NDPERS health plan.

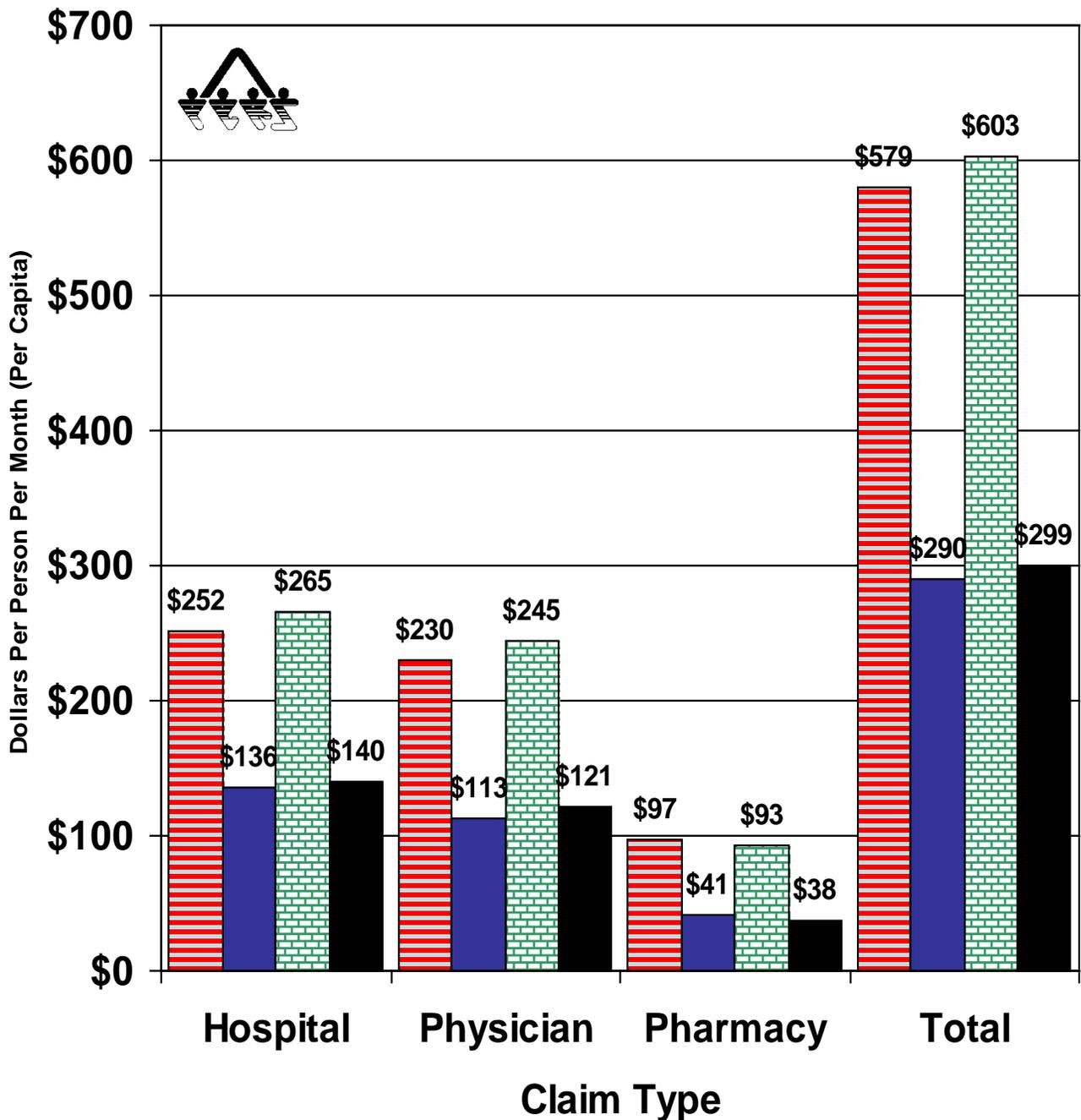
North Dakota Public Employees Retirement System Active Health Insurance Claims Jan-Dec 2012



NDPERS Health Plan

Active Contracts 2011-2012

2011 Charge 2011 Paid 2012 Charge 2012 Paid



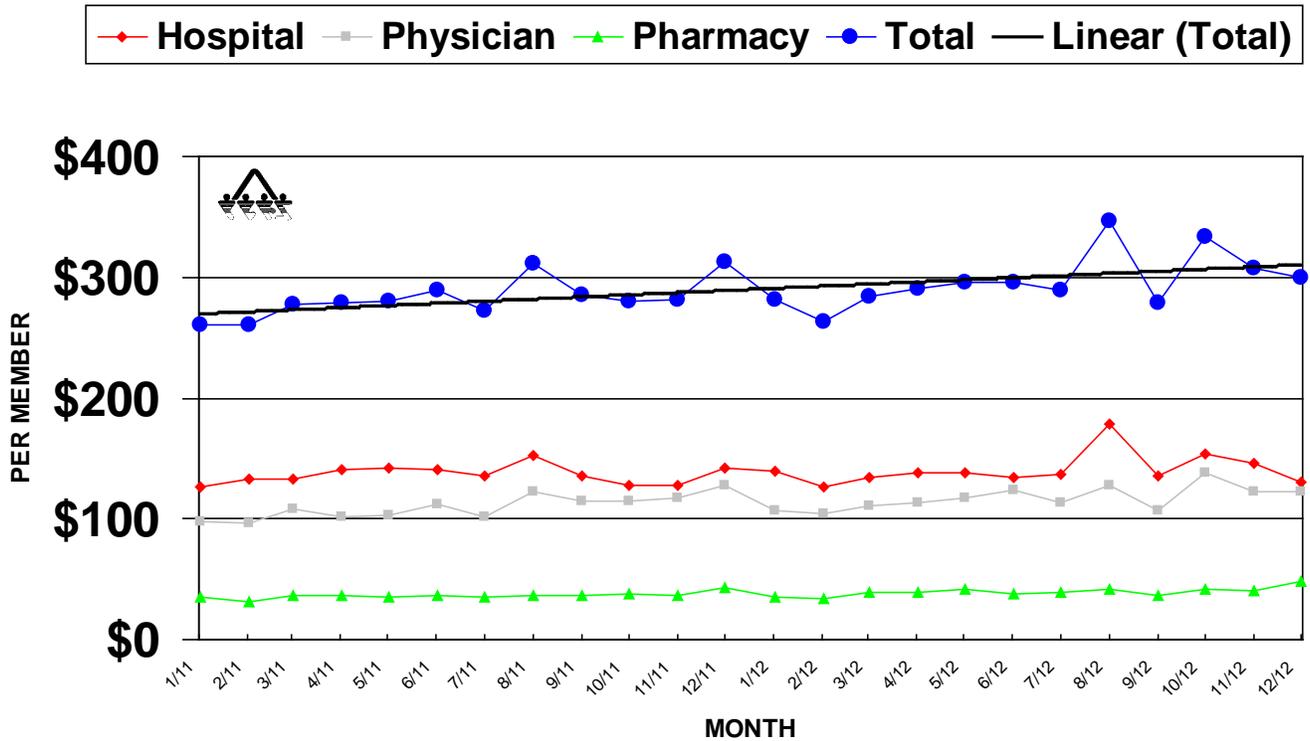
TOTAL NDPERS HEALTH PLAN

The graph below is for the total NDPERS health plan. It shows the average amount the NDPERS health plan paid per member per month (per capita). The graph depicts the latest two years of NDPERS data.

The active employees are at the \$400 per capita level. Their dependents cost the plan around \$275 per person per month. The retired membership's per capita costs are around \$250 per former employee and \$175 per dependent. As the graph below shows, overall, the NDPERS health plan is slightly over \$300 per person per month in medical claims. This is slightly higher than the 2011 report when costs were just under \$300. Costs were \$275 in the 2010 report, \$250 in the 2009 report, \$245 in the 2008 report, \$225 in the 2007 report, \$205 in the 2006 report, \$200 in the 2005 report, \$175 in the 2004 report, \$160 in the 2003 report and \$140 in the 2002 report. In addition to this, the NDPERS health plan currently paid \$39.82 per month per active contract in administration costs.

NDPERS HEALTH INSURANCE PLAN

TOTAL MEMBERSHIP





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Memorandum

TO: PERS Board
FROM: Sparb
DATE: August 14, 2013
SUBJECT: Defined Contribution Plan Research

Background

During the last few years several events have happened with the DC plan. First, we changed vendors from Fidelity to TIAA-CREF in November of 2012. Second, this last legislative session during the hearing on House Bill 1452 in the Senate about 25-30 members of the DC plan attended the hearing and requested an amendment to the bill to allow them an option to come back to the Hybrid/DB plan. Third, we had Segal do a study of the DC plan to assess the adequacy of the benefit offered at the existing contribution level and other levels.

As a result of the above, we decided this last spring to do several efforts. First, do a survey of our DC plan member concerning their satisfaction with the plan, TIAA-CREF and PERS. Second, we asked Segal to update there study of the DC plan with more current information. Specifically, since the markets had improved and our members account balances as a result, we wanted to know how this improved the adequacy of the benefit offered by the plan.

In this memo we will analyze the survey results with the Segal study where applicable.

SURVEY RESULTS

We sent out 270 surveys to the DC members (one to each active member) and we received 85 responses. This was about a 31% response rate. The average age of the respondents was 48.6 years. The average years of service they had was 17.2 years and 82% were married. Almost 65% of the respondents had a salary greater that \$4,000 per month.

Attachment #1 is the survey we sent with the results shown to you at the last meeting and updated to include additional analysis.

One of the additions in the attached is “comments” we received from members on the survey. For those comments received, we have assigned them to questions relating to the subject of the comment.

General Observations Relating to the Defined Contribution Plan (Questions 3, 4, 5, 14, 16, 17, 18, 19, 21, & 22)

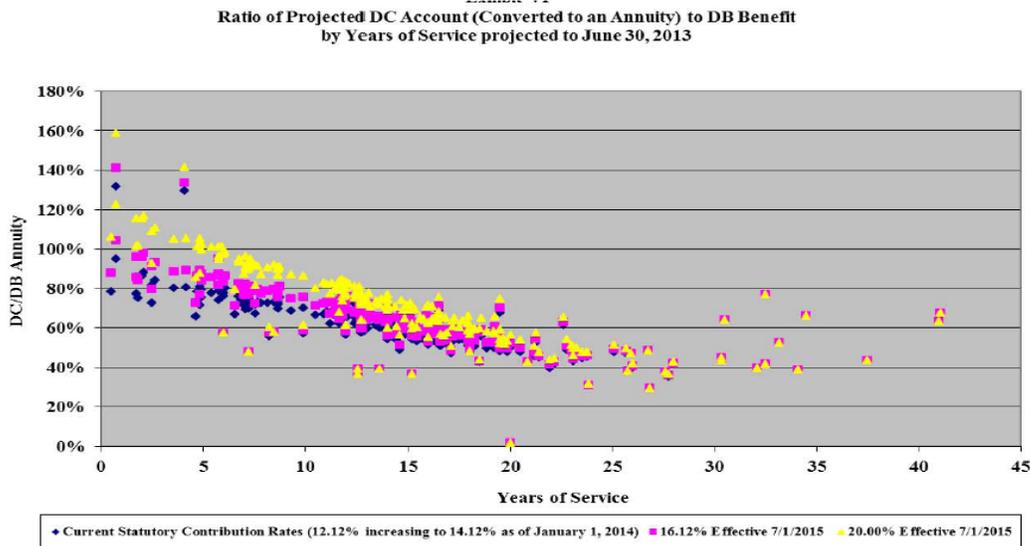
1. High levels of dissatisfaction exist with this plan (Questions 3, 4, 14, 17)
 1. Sixty-five to seventy six percent of the members feel they made the wrong decision in joining the plan depending how the question is asked (questions 4 & 14).
 2. Of all the comments we received, most of the comments related to the selection of the plan (37 comments out of about 56 comments related to the selection process).
 3. If given the opportunity to make a new election, 80% would rejoin the PERS DB/Hybrid plan.
2. The most common comment concerning the process is that individuals feel they did not have enough education concerning the selection process. However, it should be noted that all members did receive detailed information sent to their home address about the selection. Also, PERS would not accept an election until after a member had the opportunity to review this information (initially we did get election forms immediately from members upon starting employment which we did not accept until the detailed information was sent to their home address). This information compared the DB/Hybrid plan to the DC plan, provided information on the investments and an individual estimate. Members were also advised that they could contact PERS or the provider if they had questions. The form was also clear that this was an “irrevocable” election and if we did not get an answer, that they would stay in the DB/Hybrid plan. The second most common comment in this section was that some of the members felt pressured by their employer to join the DC plan.
3. Over half (59%) find the process of selecting their investments confusing. While more information is needed on this, we note that last TIAA-CREF reported that the Dc plan returns on average were 13.47% (ending June 30). This compares with the estimated DB/Hybrid plan returns of 13.43%. On average, the DC plan seems to be doing about the same as the DB/Hybrid plan for the year.
4. Over two-thirds of the members (71%) feel the PERS DB/Hybrid Plan is better than the DC plan.
5. Approximately three quarters of the DC plan members feel they will not have enough money to retire (questions 3 & 18). Segal has done a study to examine this issue by comparing the projected DC retirement benefit to the Db/Hybrid plan. As the following shows a majority of the members will get less than they would have had if

they stayed in the DB/Hybrid plan which provides a career employee (25 years of service) a benefit of 50% of their final average salary at current contribution levels (14.12%). It also shows that even if contributions increase, a majority will still be below that threshold.

Ratio of Projected DC to DB Benefits	Future Contribution Rate		
	Current Plan 14.12% effective January 1, 2014	Increase to 16.12% effective July 1, 2015	Increase to 20.00% effective July 1, 2015
Less than 50%	49	41	32
50% - 75%	149	131	106
75% - 100%	27	52	69
100% and Over	<u>2</u>	<u>3</u>	<u>20</u>
Total	227	227	227

Concerning the above, the Segal report stated: *Overall, this analysis shows that the majority of the current DC Plan members are projected to receive significantly less retirement income under the DC Plan than projected under the DB Plan. In particular, the ratio of DC Plan to DB Plan benefits declines somewhat as age increases, and declines dramatically as length of service increases. The DC Plan benefits are projected to be higher with an increase in the contribution rate but are still less than 100% of the DB Plan benefits for most participants. Under existing contribution levels, the only way that DC Plan benefits would consistently reach the level of DB Plan benefits would be to earn long term investment returns above the assumed 8%.*

The above situation is worse when you sort the DC members by the number of years in the system. The following shows that those with greater years of service (older employees) will be affected more than those employees with less years of service (younger employees) those with more years of service will be getting 60% less than if they stayed in the DB plan, whereas those with less years of service may be closer to the DB/Hybrid plan benefits especially if contributions are increased to 20%.



6. Most members believe that the contribution level to the DB plan is sufficient (questions 21 & 22). However, Segal has estimated that in order for a new DC plan member to get a benefit equal to the DB/Hybrid plan, they would need a total contribution of approximately 20% instead of the existing 14.12%. Higher contributions are the primary method to resolve the concern about the adequacy of the benefit without adding risk by investing more aggressively. The Segal estimate already assumes that a member will be an 8% return during their working career and 6% in retirement.

General Observations Relating to TIAA-CREF (Questions 1,2,6,8 – 13):

1. We do not have a high satisfaction level with TIAA-CREF. Looking at question 8 where it asks if the DC members are satisfied with change, 25% strongly disagree and only 8% sternly agree. Overall, 53% agree with change, but of that 24% only slightly agree. The satisfaction level with change is not high and we have a large group that has strong negative views of the change. If we look at question number 13, 50% of the respondents would not recommend TIAA-CREF, whereas 45% would.
2. Many members are not satisfied with the advisor services offered by TIAA-CREF (Questions 9, 11). One of the reasons why PERS selected TIAA-CREF was that they offered us significantly more on-site counseling than any other vendor including our existing vendor at this time. The Board viewed this as a strength of the TIAA-CREF offer in the proposal as compared to the others, however, our members now view this as a weakness.
3. Our members are not fully satisfied with the investment options offered by TIAA-CREF (questions 1 & 12).

General Observations Relating to PERS (Question 15):

1. Approximately 60% were satisfied with the services provided PERS and about 37% were not.
2. The one comment directly relating to PERS related to the website (they felt it was “horrible”) and the individual felt it needed updating.

Proposed Plan of Action

1. Refer the DC plan challenges to the Benefits Committee to seek their thoughts. Once that has been received, the issue should be again reviewed by the Board to determine if legislation should be submitted to provide members a new election opportunity and/or if contributions should be increased to provide members a better benefit at retirement.

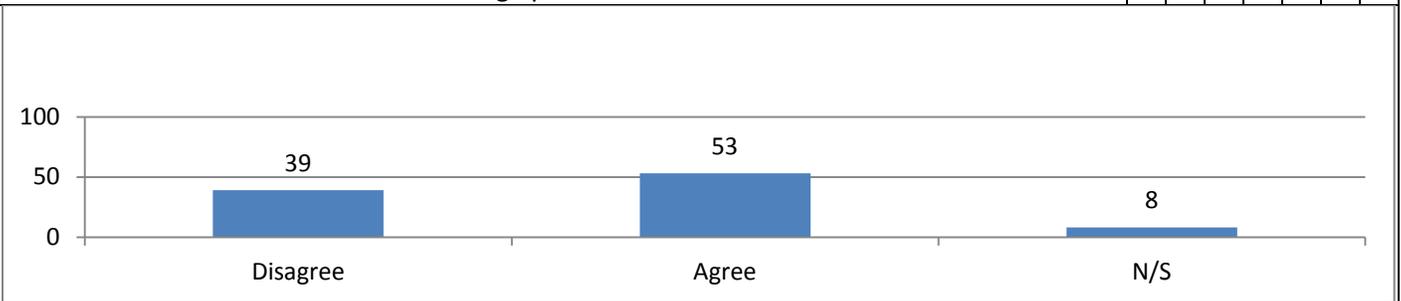
2. Have staff report to the Board at the October or November meeting on the election/enrollment process for the DC plan including all information that is sent to the members and the election form.
3. Concerning TIAA-CREF:
 - a. To help assess if the response was influenced by the strong negative feelings concerning the DC plan, PERS should send the same questions to Deferred Comp Companion Plan members to determine if their response is similar or different.
 - b. Once the above is complete, the information should be shared with TIAA-CREF for them to develop an action plan to respond to the members' concerns. Once completed, they should share their plan with the PERS Board.
 - c. Let TIAA-CREF know that prior to the next renewal, the Board will be doing another survey and the results will be a consideration in approving another 2 year extension.
4. Concerning the investment options concerns (questions 1, 9, 12 & 16) refer these questions to the Investment Committee to review and report back to the Board with an action plan.

NDPERS Defined Contribution 401(a) Plan Survey – 85 Responses (31%)

1. Are you satisfied with the investment funds available?	48% Yes 48% No
2. Are you satisfied with the availability of plan information?	45% Yes 51% No
3. Are you confident that you are on the right track for retirement?	29% Yes 68% No
4. Do you feel that you made the right decision to move to the Defined Contribution 401(a) plan from the Defined Benefit Pension Plan?	13% Yes 65% No 22% Unknown
5. If given the option, would you elect to drop the D.C. plan and rejoin the Defined Benefit Plan?	80% Yes 13% No
6. Have you ever met with a TIAA-CREF investment advisor?	39% Yes 61% No
7. Do you use an investment advisor or financial planner (other than TIAA-CREF) to help you with your investment decisions?	59% Yes 39% No

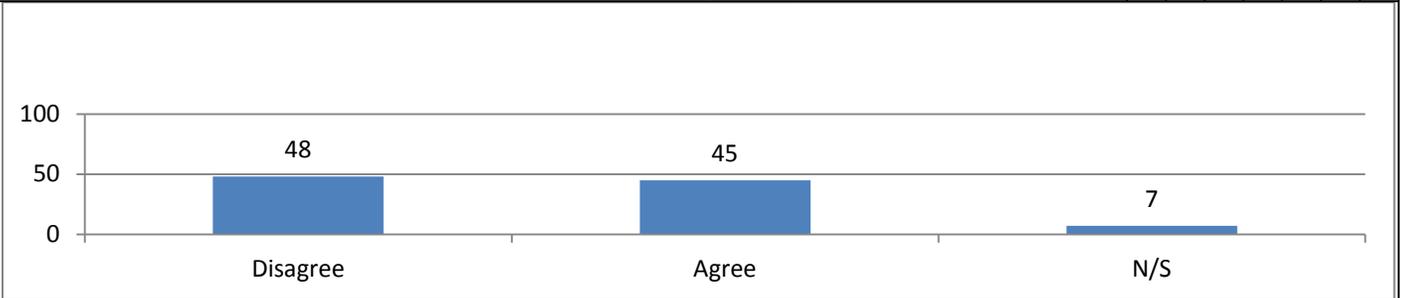
TIAA-CREF Questions

Answer %	Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	N/S
	8. I am satisfied with the decision to change providers to TIAA-CREF.	24	9	6	22	25	6



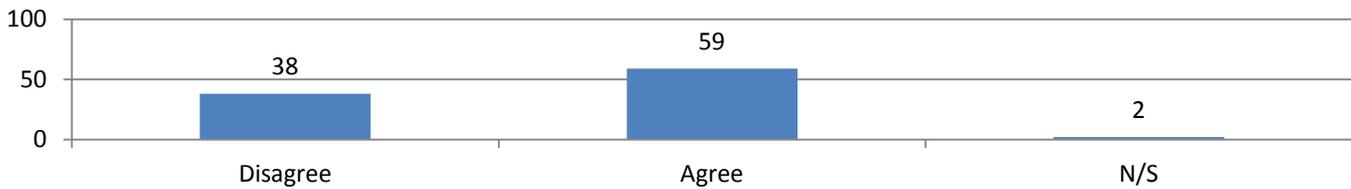
The transfer from TIAA-CREF from Fidelity was performed in an unprofessional manner. I wish you would return to Fidelity!
 PERS going to CREF was a mistake. Fidelity was much better.
 TIAA-CREF may be cheaper for the State, but not for the former employee!!

9. I am satisfied with the investment education and advice given by TIAA-CREF.	24	15	9	18	26	1	7
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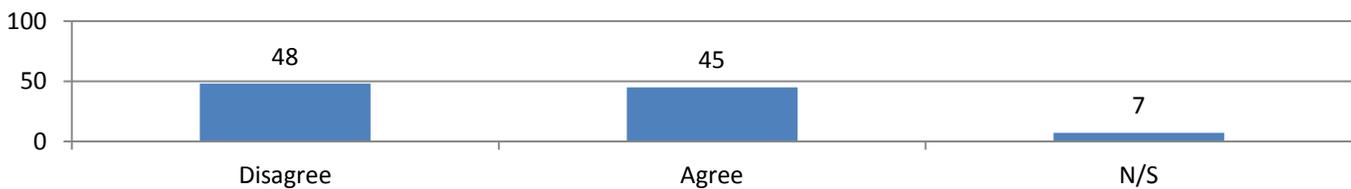
Advisors provided by TIAA-CREF are a joke. They don't give advice – they asked me what I should invest in – aren't they the experts??
 I am retired and used to work as a stockbroker. I am totally not impressed with TIAA-CREF. Their advice & investment choices are very limited and their fees are more than I was paying before.

10. I am satisfied with the web services and quarterly statements provided by TIAA-CREF. 21 8 9 21 33 5 2



I'd like to see my statement what I've put in and the return since the inception of my plan. Back all 11 yrs. Total Contributions Total Returns

11. I am satisfied with the availability of counselors and advisors from TIAA-CREF. 25 9 14 22 19 4 7



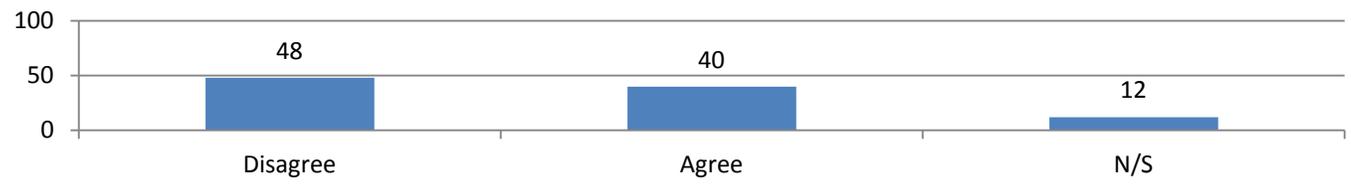
I scheduled an appt with TIAA-CREF advisor and they didn't show. I had to reschedule and he didn't know anything about my plan.

Talked to TIAA-CREF advisor on phone. Attempted to meet, but appt difficult.

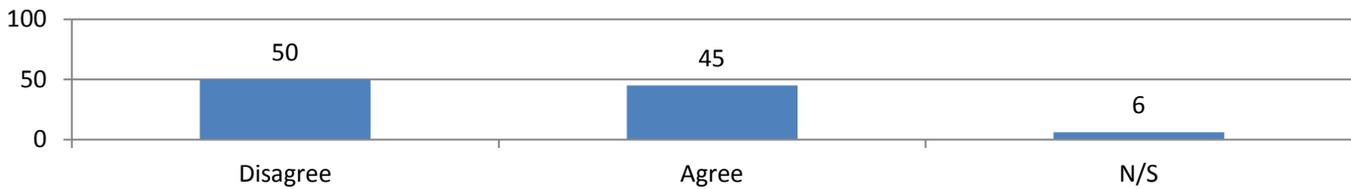
Tried to set up meeting with representative – full – received email same day – appointments were full.

Next to impossible to schedule a face to face session. I did not have this problem before.

12. I am satisfied with the brokerage window for investing in other mutual funds. 25 8 15 25 14 1 12



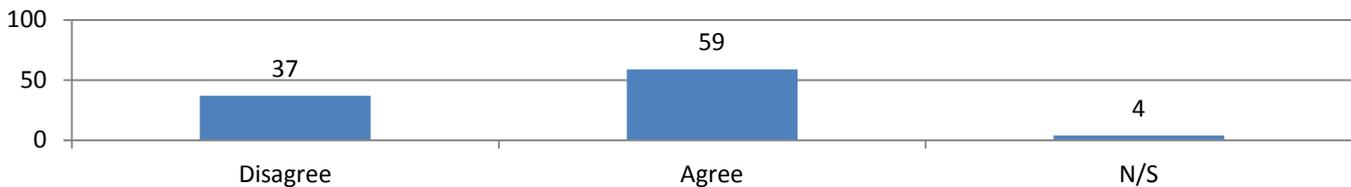
13. I would recommend TIAA-CREF to other employees. 24 18 8 24 19 2 6



TIAA has been very good in meetings.

NDPERS Questions

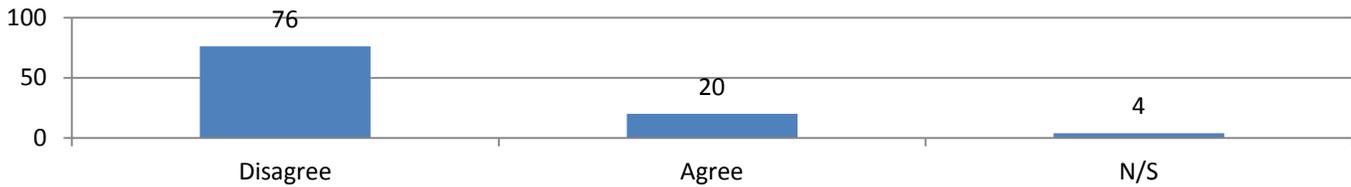
15. I am satisfied with the service provided by the NDPERS office. 16 10 11 31 23 5 4



The PERS website is horrible. Please work with someone to update it.

DC Questions

14. I feel I made the right decision selecting the DC 401(a) plan over the Defined Benefit plan. 54 9 13 7 8 5 4



I was not told that I was giving up my pension at the time I signed up for the DC plan – it was not explained! I feel cheated!

I was not informed of the differences between the Defined Contribution & Defined Benefits plan. Very disappointed. Do not feel we should be “stuck” in the Defined Contribution plan.

The D/C plan decision was the worst decision in my life & my biggest regret. I have no idea if I will ever be able to afford to retire with the D/C plan. I want the option to come back into the D/B plan.

I ask that you give individuals the opportunity to get back in the defined benefit plan, I was not aware that the Rule of 85 was lost & the disability benefit. When the choice was presented to me, it was presented in the form it was just a different company who to invest in, everything else remained the same. I would never have made this decision had I been better informed. I believe I was very ill advised, not only by my administration, PERS, and the info provided, I was never given a true comparison of the two plans. I ask for 1 time opportunity to get back in the Defined Benefit plan so I have a chance to retire.

I was misinformed about the defined contribution 401(a) plan when offered. They made me feel rushed and confused and pressured that the defined contribution 401a plan was a better deal & offer. They should have never offered this plan. They never mentioned the Rule of 85 being take away along with the disability plan. I pray that one day I will be able to retire, but under the DC plan, that will never happen. If given the opportunity to rejoin the defined benefit plan, I would do it in a heart beat. Thank you for your time.

Those put back in classified service by state referendum should be allowed to opt back in to defined benefit.

I believe I was misinformed and beguiled into selecting the DC plan.

There should have been more resources available at the time of election of plans. The agency's human resource manager was not helpful and I felt pressured into the decision.

We understand PERS was adamantly against the DC plan, but that was hidden from us. I am reviewing options of legal action against the State of ND for this. We were used by our executive director Pat Traynor so he could take his \$ and run to the private sector. He used his political influence to get the law passed. Plus notarized signatures were done after the fact – not legally binding. Our HR manager at WSI gave specific instructions to WSI employees that if under 10 years of service, you need to change. This was inappropriate guidance, border line dereliction of her HR responsibilities. HR managers do not give financial and retirement direction. Plus we were not provided information on how the switch would change our health credit.

The pros & cons of this plan was not explained thoroughly. We can't take advantage of PEP. For those that entered this plan within 5 years of intro. Should be allowed to go back to benefit plan. When I started this was introduced – Big Sales Pitch – and I was naive. If I knew what I know now, I would not have made the election. Even recent NDPERS reps have told us so. NDPERS needs to allow us back in the benefit plan. We were all misinformed & misled.

State employees have lost money due to the change. Thanks!

I did not move when I started I was told that the old plan was going to end so I just went with the DC plan.

To whom it may concern: After 14yrs of employment with the state and I have always been on the defined cont. I have around 38,000 for my retirement I have always had my money in medium funds (with Fidelity also) I could never retire with that amount of monies & I would need some type of help to make ends meet. I am smart enough to make other plans & I do not consider this a perk at all for working with the state my tax account remakes every year what a bad plan this is & my financial planner tell me not to even count on those monies. And now once again part of my raise goes back to a fund that I don't participate in??? Why should I give my raise away to someone else??? I would love to take my money and give it to my own planner & just start all over. 14yr = 38 thousand I would have better off putting it under my bed.

I ask you give me 1 opportunity to get back in so I can have a chance to retire with the state DBP. As a state employee I assumed I had a retirement plan. But now do not. I did not know I was losing the Rule of 85. Disability benefits. I really want to get back into the DBP so I have a chance to retire before I'm 70 or 80. I thought the plans were the same, with only a different company to pick. I also thought when the initiated measure passed, we would be able to get back in. We are now classified, at best when this choice was given we were not. Our agency also told us we would. We were not given clear and concise info to make a sound decision. The choice should not even have been given.

I think people who were advised it would be in their best interest to change plans be given the option to change back. There are a lot of loyal state employees upset.

I switched to the DC plan because I became a non-classified employee & at the recommendation/advice of my

employer. Now, through a vote of the people I am again a classified employee, but do not have an option to return to the DB plan, like other classified employees. This isn't right. If I'm a classified employee I should be given this benefit. It would be different if I voluntarily switched/changed positions from non-classified to classified. The change wasn't my choice, but a force situation.

I am currently not employed with the State of ND. If I returned and had the option I would choose the DB plan.

When I started I was told there are 2 retirement plans. The state and 401k. You should go with the 401k. I was never told the difference between the 2 and I have only known 401k before so thus I signed up for that one. I would strongly recommend more education on the two if both are going to be offered.

I feel I was not informed when I switched to the 401(a) plan. I was not told that I was not getting the rule of 85 and that I would not receive a pension! We were told to do this plan because the Defined Benefit would not be available in a few years. We were very misinformed and I feel that they did not had I would NOT HAVE SWITCHED!

Please allow us to go back to Defined Benefit.

I was really misinformed about the two retirement plans when I started. I enjoy my job with the state but the plan I'm in has me very concerned for the future. If provided with the opportunity to switch, I would be very grateful!!
Thanks!

I felt pressure to switch from defined benefit to DC. They made me feel there was no downside. I am beginning to question my decision.

I retired in 2012 and have returned to part-time work in 2013, medical costs and Ins premiums continue to rise.

I feel that I was not fully informed when given the option of moving from DB to DC. I was not aware that I was giving up the rule of 85 retirement option.

I was not given all of the information/facts when I opted out of Defined Benefit – Biggest mistake of my life! Please Help Us! Please let us be given the choice to opt back in to Defined Benefit!

I would have to take a look at the numbers, but I'm leaning toward defined benefit pension plan. The 401(a) Too unstable, I have been saving & investing over the years (13) and it's not panning out. I'm looking for financial stability in my retirement years. Thank you for sending out the survey.

There was no financial advisor to offer advice during the change from DB to DC. There was tremendous pressure to make the change. The PERS Board then raised multiplier, which would have made a difference in the decision process. With upcoming job loss there will be no way to retire.

At the time it looked good but then things changed over the years such as the multiplier used to determine your retirement. Looking back it was the worst mistake of my life.

Help me Fire Fighter at airport. I put all this time in and get nothing.

ND employee losing position due to A/C loss. Close to retirement, and no retirement funds avail.

We weren't informed in regards to the outcome if we would move over to defined contribution plan. I felt pressured to make this move. We were only given a very short time to make a decision. We were not given time to advise this with another financial planner. This was very unfair, we were totally misinformed & never given the whole picture on how this would effect us. We should not be penalized for this as we were not given and told the full truth.

It is a bad retirement plan. I was told at the time was a no brainer to get in. Bad information!

WSI employees were so misinformed when we were given this option yrs ago. Why should my retirement hinge on having trusted management to lead us correctly – and they didn't.

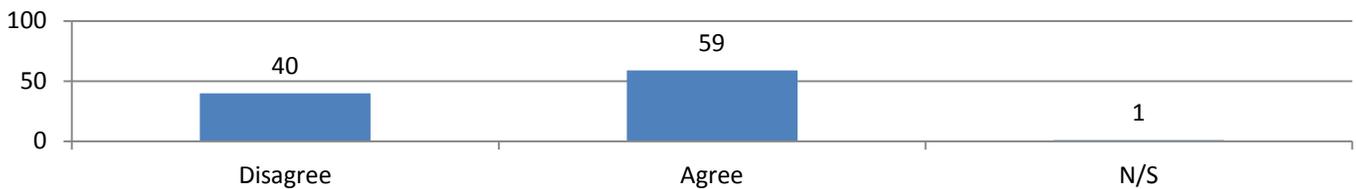
Was not given thorough and accurate information back in 1999 when had to decide whether to stay in DB plan or change to DC plan. Was mislead & misinformed. Also under DC plan are supposed to be able to invest in any funds buy only offered certain funds to choose from.

If given the opportunity, I would buy into the defined benefit plan.

The human resource dept at the time I elected this plan offered limited understanding/explanation of differences. At the very least PERS should explain the two plans in person and why a long term employee may benefit from defined benefit where as a short term employee would be better off in defined contribution.

I need more education on defined contribution versus defined benefit plans to answer these questions.

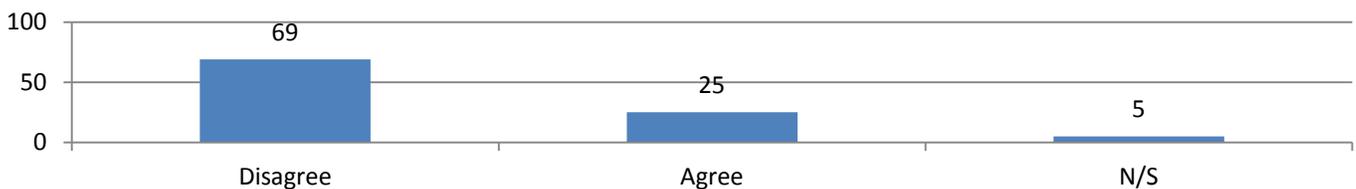
16. I find selecting my own investments and asset allocation confusing. 12 14 14 13 22 24 1



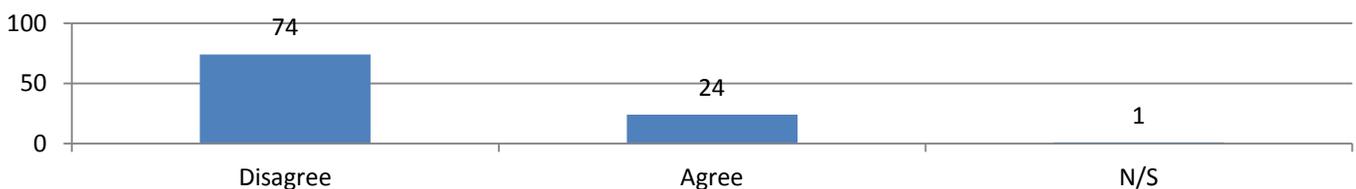
I don't like the qtrly fees being charged

For myself, I would recommend increase investment options – I am outperforming the TIAA-CREF options.

17. I would recommend the PERS Defined Contribution 401(a) plan to other employees? 47 15 7 15 9 1 5

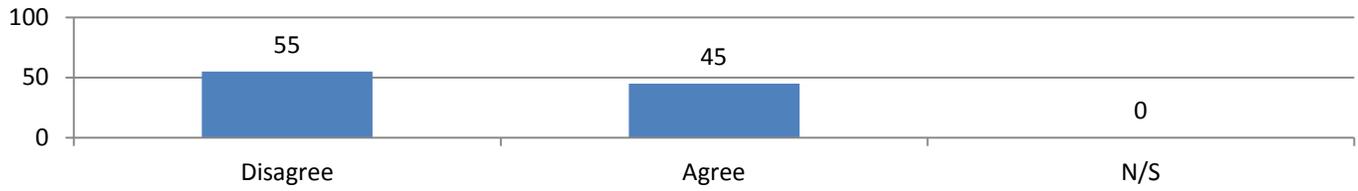


18. I am confident I will have enough money to retire. 47 13 14 6 16 2 1

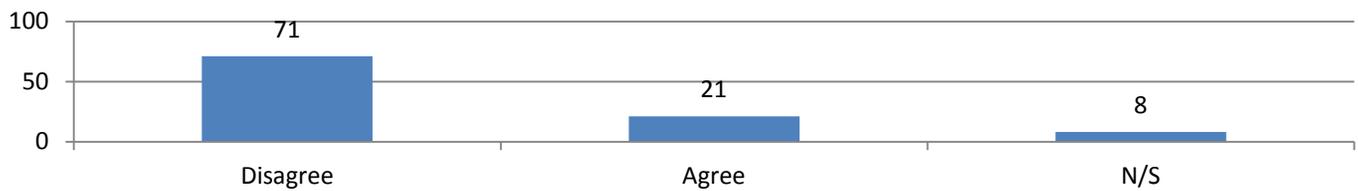


Given the volatility of the market, I am not confident I will have sufficient funds in my plan to retire.

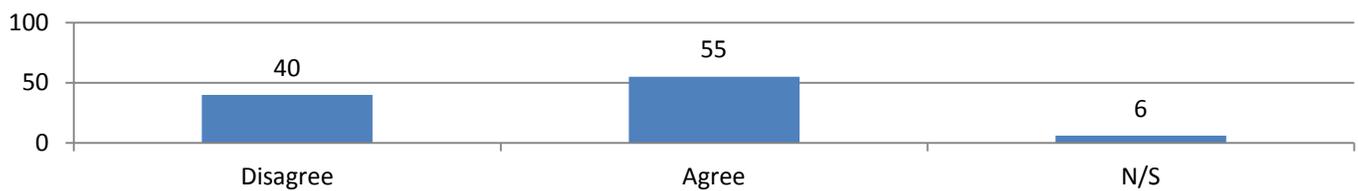
19. I am confident my retirement savings will grow over time. 28 18 9 19 24 2 0



20. The PERS Defined Contribution 401(a) plan is better than the Defined Benefit pension plan. 52 7 12 15 1 5 8

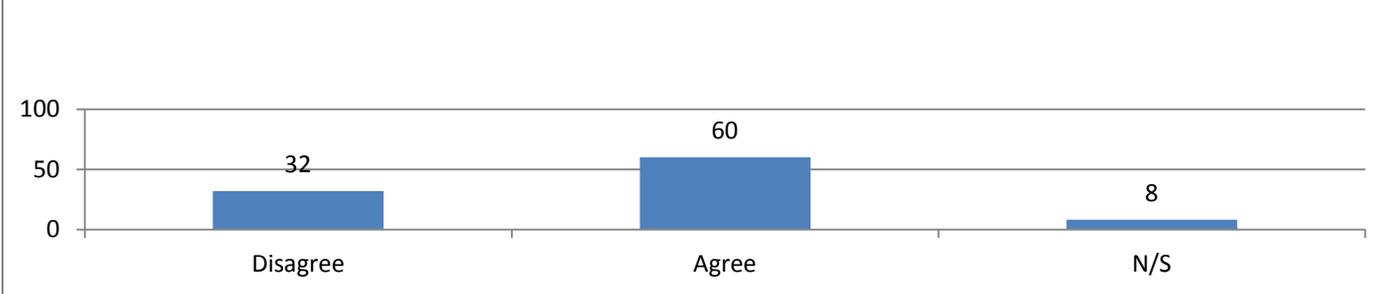


21. The employer contributions to my retirement plan are adequate. 13 12 15 24 24 7 6



Should have the option as an employee to contribute more.

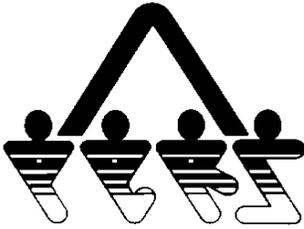
22. The employee contributions to my retirement plan are adequate. 12 7 13 27 25 8 8



According to state laws, I strongly believe it is illegal for the state to deduct any contributions from my paycheck!

Demographics:

23. Years of Service with the state	24. Age at last birthday	25. Marital Status
11% <10, 23% 10-14, 23% 15-19, 29% 20+, 4% N/S 17.2 Years average	11% <40, 45% 40-49, 33% 50-59, 9% 60+, 2% N/S 48.6 Years average	14% Single 82% Married 3% N/S
26. Please circle your current monthly salary range? 6% <\$2,000 20% \$2,000-\$3,999 35% \$4,000-\$5,999 29% \$6,000+ 9% N/S		



**North Dakota
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Memorandum

TO: PERS Board

FROM: Deb

DATE: August 14, 2014

SUBJECT: Defined Contribution Plan Implementation

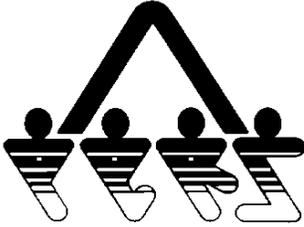
Attached is the defined contribution (DC) implementation task/timeline chart. We continue to meet weekly on the tasks identified and are making good progress towards our deadline of October 1st.

Per our last meeting, the pertinent DC rules that were identified have been relocated to the DC Plan document. Jan is working with the Legislative Council to suspend these rules, a process that is outside of the usual rulemaking activity.

Staff also met with TIAA-CREF on August 1 and were able to explain the requirements of House Bill 1452 implementation and explore areas where they could provide support. Specifically, they are providing assistance in updating and printing materials for individuals eligible for the election between the two plans, updating comparison software, and streamlining the process for transfers. They have also offered to help with anything else we think they could help with. Presently, we are in the process of updating their existing materials.

Information has been provided in the newsletter and in the PERSonnel News and our partners in Peoplesoft have been informed of the upcoming changes as well. PERSlink changes are also underway.

Although there are many issues still in process, it appears we are on course for the implementation date. Please let me know if you have any questions or concerns.



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Memorandum

TO: PERS Board

FROM: Deb

DATE: August 14, 2013

SUBJECT: Defined Contribution Plan Document

As indicated at the last Board meeting, enclosed is the Defined Contribution Plan Document containing both Segal's and staff's input. The changes have been underlined for your convenience. Also, the rules that will be suspended for the interim period provided by House Bill 1452 have been incorporated into this plan document, to ensure consistency of administration throughout this timeframe. During the course of working with Melanie Walker on this project, it was recommended that we add some additional safe harbor language to the plan document for purposes of IRC 415 limits. She recommends this, as it is likely that the IRS would require such language in the Plan document if we were to submit the plan for a determination letter. To provide you with more background, I have also included a letter from Melanie explaining the choices between the different safe harbor options we would have. Staff is comfortable with her recommendation, but she will be available that day by telephone for questions if you have any. The last step in the process will be to submit the document to our attorney, Jan, for a final review. Should Jan find any issues, staff will bring the document back to you in September.

Subject to your approval, staff will adopt the proposed changes and submit for Jan's review. After the Plan document is finalized, it will be posted to the NDPERS website on or around October 1 of this year.

Staff will be available at the Board meeting, but feel free to submit questions before the meeting if you have them. Thank you.

Board Action Requested

Approve the attached Defined Contribution Plan Document, subject to legal review.

MEMORANDUM

To: Deb Knudsen
Sparb Collins
Kathy Allen

From: Melanie Walker, JD

Date: August 2, 2013

Re: North Dakota PERS – Defined Contribution Retirement Plan

At your request, we are providing a memorandum that describes the three safe harbor definitions of compensation for purposes of contribution limitations under Internal Revenue Code (IRC) section 415. In our prior memorandum dated July 15, 2013, we recommended that the above referenced Defined Contribution Plan be amended to include a definition of compensation for purposes of IRC 415 limits. This is because it is likely that the IRS would require such language in the Plan document before issuing a favorable determination letter to the Plan.

Below is a brief description of each of the three safe harbor definitions of compensation for IRC 415 purposes that are set forth in Treas. Reg. section 1.415(c)-2. We recommend that you select the safe harbor definition that is the closest to the Plan's definition of compensation for purposes of making contributions to the Plan. This would enable the Plan to easily compare actual contributions to the Plan for each member (as a dollar amount and percentage of pay) to the IRC 415 limits to ensure these limits are not exceeded.

1. The first safe harbor definition of compensation is set forth in Treas. Reg. section 1.415(c)-2(d)(2). This definition merely references the general definition of compensation set forth in section 1.415(c)-2(b) and (c). Subsection (b) indicates that compensation is wages, salary and fees for professional services and provides a list of other types of payments that are includible in compensation for this purpose, such as commissions, bonuses, tips, fringe benefits, and allowable expense reimbursements. Subsection (c) provides a list of types of payments that are NOT includible in compensation for this purpose, such as employer contributions to a deferred compensation plan and certain types of stock options.

2. The second safe harbor, set forth in Treas. Reg. section 1.415(c)-2(d)(3), indicates that compensation is wages as defined in IRC section 3401(a), which is the IRC section that determines wages for purposes of FICA and FUTA taxes, and closely tracks the definition of wages for federal income tax withholding amounts reported on Form W-2. This is the most common safe harbor definition of compensation used by public sector retirement plans. For that

reason, I have included this definition of compensation in the draft changes to the Defined Contribution Retirement Plan document.

3. The third safe harbor, set forth in Treas. Reg. section 1.415(c)-2(d)(4), indicates that compensation is the same definition as set forth in the second safe harbor (paragraph (d)(3) of the Regulations) plus payments to an employee by an employer that are required to be reported under IRC sections 6041, 6051 and 6052. These IRC sections deal with income from sources such as direct sales receipts and wages paid as group term life insurance. It may be advisable to check with your payroll department to determine if these types of income are commonly paid to your employees. This safe harbor definition would be appropriate only if your employers report these types of payments to a significant number of employees or to several highly paid employees, which are the ones most likely to exceed IRC 415 limits.

We hope this discussion is helpful. Please let us know if you have any questions about this issue. As always, the information contained in this memorandum is provided within our role as your benefits consultant and is not intended to provide tax or legal advice.

cc: Brad Ramirez

**NORTH DAKOTA DEFINED CONTRIBUTION
RETIREMENT PLAN**

Plan Document

Amended and Restated Effective ~~July~~ October 1, 2013

ADOPTION RESOLUTION

Resolved, that effective ~~July-October 1, 2007~~²⁰¹³, the State of North Dakota has adopted the attached amended and restated Defined Contribution Retirement Plan. The Plan is a profit sharing plan that is intended to satisfy the requirements of Sections 401 and 501 of the Internal Revenue Code of 1986, as amended, and its associated regulations.

Signature

Date

Executive Director
Title

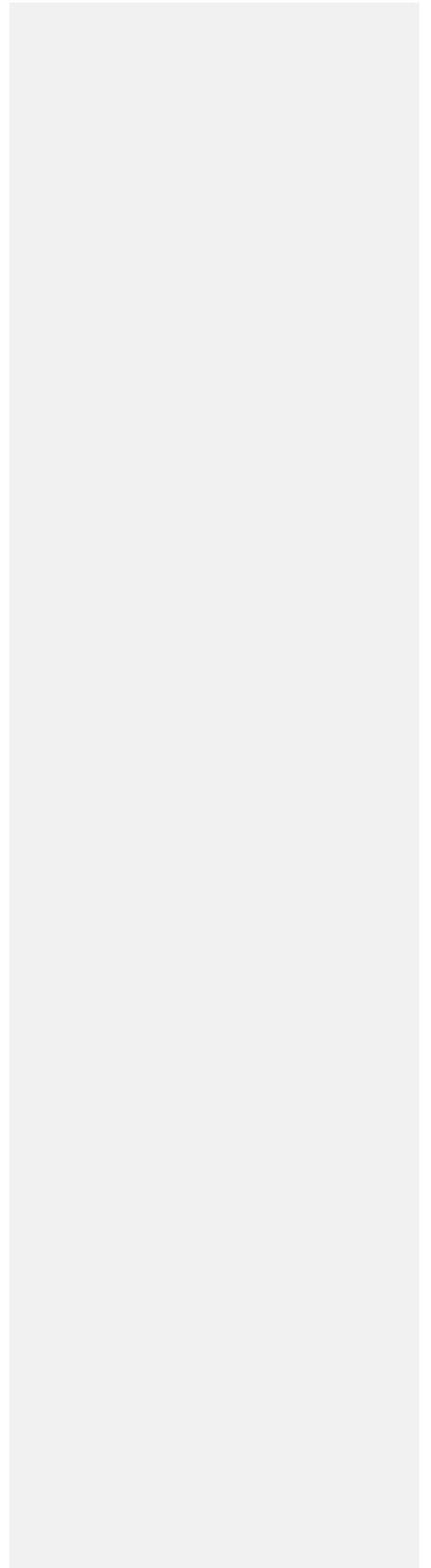


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ARTICLE 1.

DEFINITIONS

The following words and phrases shall, when used in this Plan, have the following meanings unless the context clearly indicates otherwise.

- 1.1 "Account balance" means the total contributions made by the employee, vested employer contributions, any transferred amounts under Section 3.4 and any investment gains or losses.
- 1.2 "Administrator" means any entity or individual designated by the Board to provide contractual administrative services to the Plan.
- 1.3 "Beneficiary" means any person designated by a participating member to receive a benefit provided by this Plan after the death of the member.
- 1.4 "Board" means the public employees retirement system board.
- 1.5 "Code" means the federal Internal Revenue Code of 1986, as amended from time to time, and as interpreted by applicable regulations and rulings.
- 1.6 "Deferred member" means a vested member of the public employees retirement system who has not elected to receive a refund and is eligible to receive deferred vested retirement benefits under the system.
- 1.7 "Effective date" means January 1, 2000.
- 1.8 "Eligible employee" means a permanent state employee who ~~is eighteen years or more of age and who is in a position not classified by the central personnel division. "Eligible employee" does not include an employee of the judicial branch or an employee of the board of higher education and state institutions under the jurisdiction of the board. elects to participate in the retirement plan provided in NDCC 54-52.6. "Eligible employee" does not include an employee who is eligible for the Highway Patrol Retirement System under NDCC 39-03.1, an employee who is eligible for the Teachers Fund For Retirement under NDCC 15-39.1 or an employee who is eligible for the alternate retirement program available under NDCC 15-10-17.4.~~
- 1.9 "Employee" means any person employed by a governmental unit, whose compensation is paid out of the governmental unit's funds, or funds controlled or administered by the governmental unit, or paid by the federal government through any of its executive or administrative officials.

1.10 "Employer" means the State of North Dakota.

1.11 "New Member" is an eligible employee who meets any one of the following : 1) is newly hired, with no previous service credit in any retirement system under NDCC 54-52, 2) has previous service credit under one of the retirement systems under chapter 54-52 but has been off the payroll of all covered employers for a minimum of 31 days. 3)a current employee presently covered under a defined benefit retirement plan under NDCC 54-52, who is newly elected or appointed as an official in state government, or 4) who is transferring from public employment with an employer not previously eligible for the defined contribution plan.

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1.12 "Participating member" or "participant" means an eligible employee who elects to participate in the North Dakota Defined Contribution Retirement Plan. For purposes of investment and payment of benefits under the Plan, the terms "participating member" or "participant" also includes individuals who have separated from employment with the Employer and beneficiaries, but who have retained benefit rights under the Plan.

~~1.42~~13 "Permanent employee" means a governmental unit employee whose services are not limited in duration and who is filling an approved and regularly funded position and is employed twenty hours or more per week and at least five months each year.

~~1.43~~14 "Plan" means the North Dakota Defined Contribution Retirement Plan, as stated herein, and as amended from time to time. This Plan shall be a profit sharing plan.

~~1.44~~15 "Plan Year" means a twelve consecutive month period beginning any July 1 and ending the following June 30, with a short initial Plan Year beginning January 1, 2000 and ending June 30, 2000.

~~4.45~~ 1.16 "Profit Sharing Contribution" means a discretionary contribution to the Plan made by the Employer. Profit Sharing Contributions under this Plan shall be made in accordance with Section 3.2, subsection b. and without regard to whether the Employer earns any profits.

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~~1.46~~17 "Public employees retirement system" or "system" means the defined benefit retirement plans established under North Dakota Century Code Chapter 54-52.

~~1.47~~18 "Required Beginning Date" means April 1 of the calendar year following the later of the calendar year in which the member retires or reaches age seventy and one-half.

- | ~~1.4819~~ "Service" means periods of active employment with the employer, determined in the same fashion as service and prior service under North Dakota Century Code §§ 54-52-11 and 54-52-17.
- | ~~1.4920~~ "Trust Fund" means the assets of the Plan held in trust by the trustee.
- | ~~1.2021~~ "Trustee" means the public employees retirement system board, which shall serve as the Board of Trustees for this Plan.
- | ~~1.2422~~ "Wages" and "salaries" means earnings in eligible employment under this Plan reported as salary on a federal income tax withholding statement plus any salary reduction or salary deferral amounts under Code Sections 125, 401(k), 403(b), 414(h) or 457. "Salary" does not include fringe benefits such as payments for unused sick leave, personal leave, vacation leave paid in a lump sum, overtime, housing allowances, transportation expenses, early retirement, incentive pay, severance pay, medical insurance, workers' compensation benefits, disability insurance premiums or benefits, or salary received by a member in lieu of previously employer-provided fringe benefits under an agreement between the member and participating employer. Bonuses may be considered as salary under this Section if reported and annualized pursuant to rules adopted by the Board.

Notwithstanding any other provision of the law, the amount of wages or salary used to determine the retirement benefits of a participating member in this Plan must not exceed the amount of compensation permitted to be taken into account under Code Section 401(a)(17).

ARTICLE 2.

PARTICIPATION

2.1 **Eligibility.** ~~Every eligible~~ An employee is eligible for membership under this Plan at the later of the first day of employment or the effective date of this Plan. Such eligibility, however, shall terminate at any time employment with the employer is terminated.

2.2 **Election to participate.** In order to participate in this Plan, an employee may make an election to participate in the defined contribution retirement plan established under NDCC 54-52.6 at any time during the first six months after the date of employment. If the board, in its sole discretion, determines that the employee was not adequately notified of the employee's option to participate in the defined contribution retirement plan, the board may provide the employee a reasonable time within which to make that election, which may extend beyond the original six-month decision window." If the employee making the election is married at the time of the election, the election is not effective unless it is signed by the individual's spouse. However, the board may waive this requirement if the spouse's signature cannot be obtained because of extenuating circumstances. member must make a valid election pursuant to Chapter 54-52.6 of the North Dakota Century Code and the rules and policies of the Board.

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2.3 **Participation in other plans.** A participating member may not participate in any other public sector retirement benefits plan for simultaneous services rendered to the same public sector employer. However, this Section does not prohibit a participant from participating in a retirement plan established by this state or other public sector employer under the Code.

ARTICLE 3.

CONTRIBUTIONS

- 3.1 **Mandatory employee contributions.** Each participating member shall contribute monthly ~~four~~six percent of the monthly salary or wage paid to such participant, ~~and effective 1/1/2014, seven percent.~~ ~~and~~ This

assessment must be deducted and retained out of such salary in equal monthly installments commencing with the first month of participation in this Plan.

3.2 **Employer contributions.**

- a. Each employer shall contribute an amount equal to ~~four-six~~ and twelve-hundredths percent of the monthly salary or wage of a participating member and effective 1/1/2014, seven and twelve-hundredths percent. If the employee's contribution is paid by the employer under Section 3.3, the employer shall contribute, in addition, an amount equal to the required employee contributions. The employer shall pay such contribution monthly into the participating member's account from funds appropriated for payroll and salary or any other funds available for such purposes. If the employer fails to pay the contributions monthly, it is subject to a civil penalty of fifty dollars and, as interest, one percent of the amount due for each month of delay or fraction thereof after the payment became due.
- b. Each employer, at its sole discretion, may elect to make a profit sharing contribution to the Plan. The profit sharing contribution shall be allocated among all or any part of the participating members of the Plan for such plan year in proportion to the salary or wage of the participating member. For purposes of this Section 3.2, subsection b. only, participating members include only those individuals who are eligible employees on the date the profit sharing contribution is declared by the employer. Each participating member's share of the profit sharing contribution will be allocated to his or her account balance. Profit sharing contributions shall be subject to the rules regarding vesting of employer contributions as set forth in Section 4.2.

- ### 3.3 **Employer pick up of employee contributions.**
- Each employer, at its option, may pay the employee contributions required by Section 3.1, in accordance with Code Section 414(h), for all compensation earned after December 31, 1999. The amount paid must be paid by the employer in lieu of contributions by the employee. Employee contributions paid by the employer must be treated as employer contributions in determining tax treatment under state tax law and the federal Code. Such contributions may not be included as gross income of the employee in determining tax treatment until they are distributed or made available. The employer shall pay these employee contributions by effecting an equal cash reduction in the gross salary of the employee or by an offset against future salary increases. ~~The option chosen may not be revoked for the remainder of the biennium. Thereafter, the option choice must be forwarded to the Board in~~

writing by June fifteenth of each odd-numbered year. An employer exercising this option shall report it's choice to the board in writing.

3.4 **Transfer of contributions.**

a. For an individual who elects to terminate membership in the public employees retirement system and become a participating member in this Plan, the Board shall transfer a lump sum amount from the retirement fund to the participating member's account under this Plan. However, if the individual terminates employment prior to receiving the lump sum transfer under this Section, the election made under Section 2.2 is ineffective and the member remains a member of the public employees retirement system and retains all rights and benefits under that plan.

b. The Board shall calculate the amount to be transferred for employees electing to transfer in accordance with North Dakota Century Code Section 54-52.6-0302, as follows: The actual employer contribution made, less vested employer contributions made pursuant to section 54-52-11.1, plus compound interest at the rate of one-half of one percent less than the actuarial interest assumption at the time of the election, plus the employee account balance.

c. Pursuant to an affirmative election to join the defined contribution retirement plan, all funds under 54-52 will be transferred to the defined contribution plan.

For purposes of this Section 3.4 b., the term "actuarial present value of the individual's accumulated benefit obligation" means the present value of the individual's accrued benefit based on an interest rate of 8%, the 1983 Group Annuity Mortality Table weighted 71% male and 29% female, and any relevant market value adjustment and other procedures adopted and consistently applied to all participating members by the Board.

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3.5 **Employee after-tax contributions.** This Plan does not allow voluntary after-tax employee contributions, except as may be attributable to transferred contributions under Section 3.4.

3.6 **Rollover contributions from other eligible plans.**

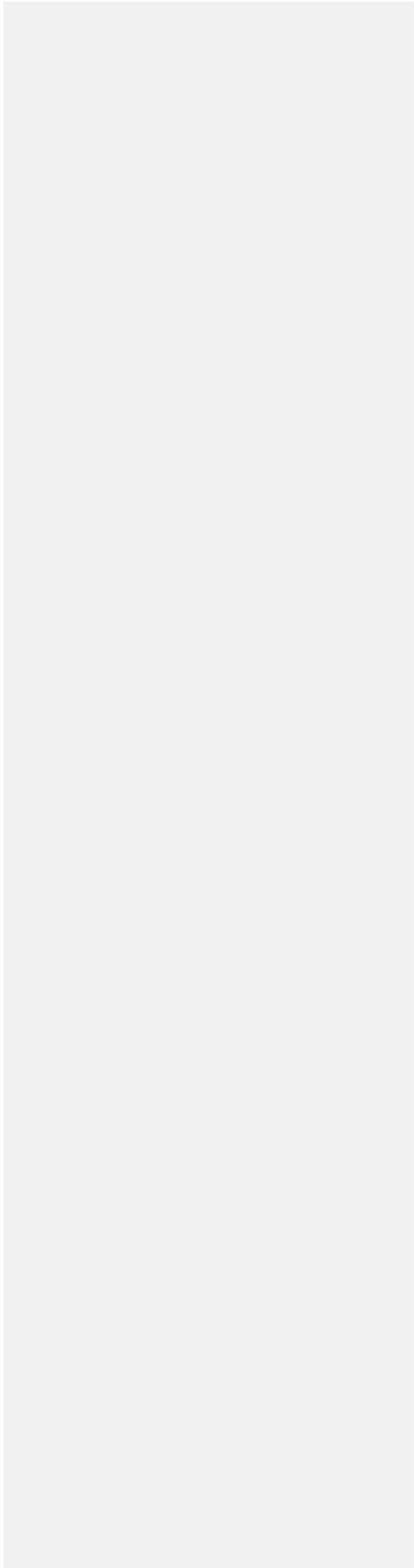
a. Subject to limitations and conditions adopted by the Board and in accordance with North Dakota Century Code Section 54-52.6-09.1, a Participant may make and the Plan will accept a direct rollover or regular rollover of an Eligible Rollover Distribution from an Eligible Retirement Plan as such terms are defined in §7.7- Code Sections 402(c)(4) and

402(c)(8)(B), respectively, and as permitted by §Section 408(d)(3) of the Code.

- b. Upon receipt of a rollover contribution, the Board shall credit the amount of any rollover contribution to the contributing Participant's Account in the Plan and shall invest such amount in accordance with the provisions of this Plan.
- c. The Participant shall establish to the satisfaction of the Board that the amount tendered as a rollover contribution represents a qualified distribution of the Participant from an Eligible Retirement Plan maintained by the former employer(s) of the Participant. The Board shall have the authority to determine whether or not a contribution proposed by a Participant constitutes a rollover contribution eligible for rollover treatment in accordance with this Section 3.6 and Code Section 402. In making such determination, the Board may require reasonable proof of demonstration by the Participant of the eligibility of the proposed contribution for rollover treatment.
- d. The Board shall maintain the rollover contributions for each Participant in a separate rollover account that will consist solely of the rollover contributions made by the Participant, plus any adjustments for investment gains or losses.
- e. The rollover contribution account under this Section shall be fully vested at all times, and shall be administered and distributed according to the same terms and conditions of this Plan applicable to other Participant accounts; provided, however, that it may distributed at any time without the occurrence of a distribution event under Section 6.1.

3.7 **Military service leave.** Notwithstanding any other provision of this Plan, a participating member returning from qualified military service protected under the Uniformed Services Employment and Reemployment Rights Act (Chapter 43 of Title 38, United States Code) shall be provided all participation, contribution, vesting and benefit rights required under that Act and Section 414(u) of the Code, as described in North Dakota Century Code Section 54-52.6-09.4. Effective for deaths occurring on or after January 1, 2007, if a participating member dies while performing qualified military service (as defined in Code Section 414(u)(5)), this Plan shall provide vesting service and any other benefits required in accordance with Code Section 401(a)(37), but the provisions of Code Section 414(u)(9) shall not apply to this Plan.

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ARTICLE 4.

VESTING

- 4.1 **Vesting of employee contributions.** A participating member is immediately one hundred percent vested in that member's contributions made to that member's account under Section 3.1 or paid by the employer under Section 3.3.
- 4.2 **Vesting of employer contributions.** A participating member vests in the employer contributions made on the member's behalf according to the following schedule:
- a. Upon completion of two years of service, fifty percent.
 - b. Upon completion of three years of service, seventy-five percent.
 - c. Upon completion of four years of service, one hundred percent.
 - d. Upon attainment of age 65 while an employee, one hundred percent.

A participating member who was a member or deferred member of the public employees retirement system and who makes an election to participate in this Plan must be credited with years of service accrued under the public employees retirement system on the effective date of participation in this Plan for the purpose of meeting vesting requirements under this Section. Any forfeiture as a result of a participating member to vest in the employer contributions must be used to defray administrative expenses.

- 4.3 **Reemployment.** If a participating member terminates employment, is paid a distribution from his account, and then becomes reemployed as an eligible employee, years of service completed before termination will not be counted for vesting. Otherwise, for purposes of vesting under the Plan, this Plan does not apply any break in service rule.

ARTICLE 5.

ACCOUNT VALUATION

- 5.1 **Separate accounts.** A separate bookkeeping account shall be established and maintained under this Plan for each participating member to which shall be credited, at times prescribed by the Board, all employee contributions and all employer contributions.
- 5.2 **Credits and debits.** Each participating member's account shall be credited or debited from time to time, under rules established by the Board, to reflect investment earnings and administrative expenses.
- 5.3 **Limited rights to assets.** The fact that separate accounts are established for each participating member shall not give any employee or others any right, title or interest in the Fund or its assets, or in any account except at the time and upon the terms and conditions provided in this Plan.

ARTICLE 6.
DISTRIBUTIONS

- 6.1 **Distribution eligibility.** A participating member's vested account balance is distributable upon the occurrence of one of the following events:
- a. The participating member has terminated employment with the employer. Termination of employment means a severance of employment by not being on the payroll of the employer for a minimum of one month. An approved leave of absence does not constitute termination of employment.
 - b. The participating member has become totally and permanently disabled according to medical evidence called for under the rules of the Board.
 - c. The participating member dies.
 - d. The participating member has reached the Required Beginning Date. In no event shall the distribution of a member's account

balance commence later than the Required Beginning Date, whether or not they apply for benefits.

ARTICLE 7.

FORM OF DISTRIBUTION

- 7.1 **Distribution election.** A participating member or his beneficiary who is eligible to receive benefits under Article 6 shall receive benefits upon proper application in a manner approved by the Board as to the date benefit distributions under the Plan will begin. This election must be made

consistent with the other distribution requirements of Section 6.1 and this Article 7.

- 7.2 **Payable benefits.** Benefits under this Article 7 shall be measured by participating member's vested account balance on the date or dates the benefits are payable under this Plan and shall be payable in lump sum or in periodic payments as specified by the member and as authorized by the Plan. However, members must take distribution at least annually to maintain eligibility for other NDPERS benefits in equal monthly, quarterly, semiannual or annual installments over a period of one or more years.

- 7.3 **Distribution over life expectancy.** A participating member's form of distribution election under Section 7.2 must be expected to result in the distribution of the member's entire interest in this Plan within a period not exceeding the life of the member or the lives of the member and the member's beneficiary, or over a period not extending beyond the life expectancy of the participating member or the life expectancy of the member and the member's designated beneficiary.

When a participating member dies after distribution of benefits has begun, the remaining portion of the member's interest shall be distributed at least as rapidly as under the method of distribution prior to the participating member's death.

When a participating member dies before distribution of benefits has begun, the entire interest of the member shall be distributed within five years of the member's death. The five year payment rule does not apply to any portion of the member's interest which is payable to a designated beneficiary over the life or life expectancy of the beneficiary and which begins within one year after the date of the participating member's death. The five year payment rule does not apply to any portion of the participating member's interest which is payable to a surviving spouse over the life or life expectancy of the spouse and which begins no later than the date the member would have reached age seventy and one-half.

- 7.4 **Additional distribution requirements.** In the case of distributions beginning before the death of a participating member, any amounts not distributed before the member's death shall be distributed at times specified by the Secretary of the Treasury which are not later than the time determined under Code Section 401(a)(9)(G), relating to incidental death benefits and at least as rapidly as under the method being used on the date of the participating member's death.

The Plan shall comply with the minimum distribution rules under Section 401(a)(9) of the Code and the Treasury Regulations issued under that provision to the extent applicable to governmental plans. Accordingly,

benefits must be distributed or begin to be distributed no later than a participating member's required beginning date (as defined in Section 1.17), and the required minimum distribution rules override any inconsistent provision of this Plan.

In addition, amounts that would have been 2009 required minimum distributions in the absence of Code Section 401(a)(9)(h), as added by the Worker, Retiree and Employer Recovery Act of 2008, including amounts that would have been first required minimum distributions payable in 2010, were paid as scheduled for 2009. Recipients of such required minimum distributions were given the opportunity to elect to stop receiving the 2009 required minimum distributions described in the preceding sentence, and a direct rollover was only offered for such distributions that would have been eligible rollover distributions without regard to Code Section 401(a)(9)(H).

7.5 **Small benefit cashouts.** Notwithstanding any other provision of the Plan to the contrary, the Board shall automatically distribute the benefits of a participating member in a lump sum as soon as administratively feasible after the member becomes eligible for a distribution in accordance with Section 6.1 if the total amount of the participating member's vested account balance and any amounts held in a rollover contribution account established under Section 3.6 is less than or equal to \$1,000. A participating member may waive the lump sum cashout if the member submits a written statement to the Board, within sixty days after termination of employment, requesting that the member's account balance remain in the Trust Fund.

7.6 **Death benefit payments.** In the event of the participating member's death prior to receiving payment in full of his benefits under this Plan, the Board shall pay the account balance of the participating member, ~~as of the date the Plan receives an application for benefits from the member's designated beneficiary, directly to the member's designated beneficiary, to the member's designated beneficiary.~~ If the deceased participant designated an alternate beneficiary with the surviving spouse's written consent, the board shall distribute the accumulated balance to the named beneficiary. If the deceased participant named more than one primary beneficiary with the surviving spouse's written consent, the board shall pay the accumulated account balance to the named primary beneficiaries in the percentages designated by the deceased participant or, if the deceased participant had not designated a percentage for the beneficiaries, in equal percentages. If one or more of the primary beneficiaries has predeceased the deceased participant, the board shall pay the predeceased beneficiary's share to the remaining primary beneficiaries. If any beneficiary survives the deceased participant, yet dies before distribution of the beneficiary's share, the beneficiary must be

treated as if the beneficiary predeceased the deceased participant. If there is no remaining primary beneficiary, the board shall pay the accumulated account balance of that deceased participant to the contingent beneficiaries in the same manner. If there is no remaining designated beneficiary, the board shall pay the accumulated account balance of that deceased participant to the deceased participant's estate.

If the surviving spouse is the beneficiary, the surviving spouse may select from a form payment as provided in NDCC Section 54-52.6-13(3). If the surviving spouse is not the sole beneficiary, the beneficiary may only choose a lump sum distribution of the accumulated balance.

7.7 Direct rollovers. A Distributee may elect, at the time and in the manner prescribed by the Board, to have any portion of an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan specified by the Distributee in a Direct Rollover, except that a Distributee may not elect a Direct Rollover of a distribution or series of distributions of less than \$200 in a single calendar year. For purposes of applying this Section 7.7, the following definitions shall apply:

- a. **Eligible Rollover Distribution.** An Eligible Rollover Distribution is any distribution of all or any portion of the balance of a participating member's account to the credit of the Distributee, including any after-tax employee contributions that are not includible in gross income except that an Eligible Rollover Distribution does not include:
 1. Any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the Distributee or the joint lives (or joint life expectancies) of the Distributee and his designated beneficiary, or for a specified period of ten (10) years or more;
 2. Any distribution to the extent such distribution is required under Code Section 401(a)(9);
 3. The portion of any distribution that is not includable in a Distributee's gross income (determined without regard to the exclusion for net unrealized unappreciation with respect to Employer securities); or
 4. Any corrective distribution of excess contributions and any corrective distribution of excess aggregate contributions and income allowable to such corrective distributions.

An Eligible Rollover Distribution also includes any portion of a distribution that consists of after-tax employee contributions that are not includible in gross income. However, such portion may be transferred only to an individual retirement account or annuity described in Code section 408(a) or (b), or to a qualified defined contribution plan described in Code section 401(a) or 403(a) that agrees to separately account for the after-tax employee contribution amounts so transferred.

- b. **Eligible Retirement Plan.** An Eligible Retirement Plan is an individual retirement account described in Code Section 408(a), an annuity plan described in Code Section 408 (b), an annuity plan described in Code Section 403(a), an eligible deferred compensation plan described in Code section 457(e)((1)(A), an annuity contract described in Code section 403(b) or a qualified trust described in Code Section 401(a) that accepts the Distributee's Eligible Rollover Distribution. In the case of an Eligible Rollover Distribution to a designated beneficiary other than a spouse or former spouse, an Eligible Retirement Plan is only a individual retirement account described in Code Section 408(a) or an annuity plan described in Code Section 408(b) that is treated as an inherited IRA in accordance with the provisions of Code Section 402(c)(11).
- c. **Distributee.** A Distributee includes an employee or former employee. In addition, the employee's or former employee's designated beneficiary or the employee's or former employee's spouse or former spouse, with regard to the interest of the spouse or former spouse, are Distributees.
- d. **Direct Rollover.** A Direct Rollover is a payment by the Plan to the Eligible Retirement Plan specified by the Distributee.

7.8 Benefits payable to alternate payee under qualified domestic relations order.

- a. The Board shall pay retirement benefits in accordance with the applicable requirements of any qualified domestic relations order. The Board shall review a domestic relations order submitted to it to determine if the domestic relations order is qualified under this Section 7.8 and under rules established by the Board for determining the qualified status of domestic relations orders and administering distributions under the qualified orders. Upon determination that a domestic relations order is qualified, the Board shall notify the participating member and the named alternate payee of its receipt of the qualified domestic relations order.

- b. A “qualified domestic relations order” for purposes of this Section 7.8 means any judgment, decree or order, including approval of a property settlement, which relates to a provision of child support, spousal support or marital property rights to a spouse, former spouse, child or other dependent of a participating member, is made pursuant to a North Dakota domestic relations law, and which creates or recognizes the existence of an alternate payee’s right to, or assigns to an alternate payee the right to, receive all or a part of the benefits payable to the participating member. A qualified domestic relations order may not require the Board to provide any type of benefit, or any option, not otherwise provided under this Plan, or to provide increased benefits as determined on the basis of actuarial value. However, payment of benefits to the alternate payee under a qualified domestic relations order shall be made as soon as administratively feasible after the order is determined to be qualified, notwithstanding that the participating member has not terminated eligible employment. A qualified domestic relations order must be in a form as may be required by the Board.

7.9 **BenefitContribution limitations.** ~~Contributions with respect to a member of this Plan may not exceed the maximum annual amounts specified under Code Section 415 for governmental plans. The Plan shall comply with the contribution limitation rules under Section 415 of the Code, including the defined contribution limitations under Section 415(c)(1)(A) and (B) of the Code and the Treasury Regulations thereunder, as such apply to governmental plans, which are incorporated herein by reference.~~

- a. ~~In accordance with the defined contribution limitations under Section 415(c) of the Code, annual additions (as defined in Section 415(c)(2) of the Code) under this Plan may not exceed the limitations set forth in Code Section 415(c)(1)(A) and (B), as adjusted under Section 415(d) of the Code, effective January first of each year following a regular legislative session. The annual addition to a participating member’s account for any calendar year shall not exceed the lesser of:~~

- 1. ~~\$40,000, as adjusted for increases in the cost of living under Code section 415(d); or~~
- 2. ~~100% of the compensation or wages paid or made available to the participating member in such year.~~

- b. ~~If a participating member’s aggregate annual additions exceed the defined contribution limitations under Section 415(c) of the Code, the member’s annual additions to this Plan must be reduced to the~~

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~~extent necessary to comply with Section 415(c) of the Code and the Treasury Regulations thereunder. The “annual addition” shall mean the sum allocated to a participating member’s account for any year of contributions or forfeitures, if any, pursuant to this Plan and allocated to the member’s benefit pursuant to all other defined contribution plans maintained by the employer for the calendar year, including employee contributions.~~

~~The annual addition shall not include the allocation of investment income to a participating member’s account balance pursuant to Section 5.2.~~

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- c. “Compensation” for purposes of this Section 7.9 shall mean compensation as defined ~~in Treasury Regulations section 1.415(c)-2(d)(3), which includes wages within the meaning of Code Section 3401(a), plus amounts that would be included in wages but for an election under Sections 125(a), 132(f)(4), 402(e)(3), 402(h)(1)(B), 402(k) or 457(b) of the Code; provided, however, that any rules that limit the remuneration included in wages based on the nature or location of the employment or services performed are disregarded for purposes of this definition.~~ ~~under Code Section 415(e)(3), including salary reduction amounts under Code Sections 125, 132(f)(4), 402(g) or 457.~~

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~~In order to be taken into account for a limitation year, compensation must be actually paid or made available to a participating member within the limitation year. For this purpose, compensation is treated as paid on a date if it is actually paid on that date or would have been paid on that date but for an election under Sections 125, 132(f)(4), 401(k), 403(b), 408(k), 408(p)(2)(A)(i), or 457(b) of the Code. In order to be taken into account for a limitation year, compensation must be paid or treated as paid to a participating member prior to a severance from employment.~~

- d. ~~If a participating member’s annual additions exceed the limits set forth in this Section 7.9 for a limitation year, such excess allocations shall be corrected in accordance with the applicable provisions of the Employee Plans Compliance Resolution System (EPCRS) issued by the Internal Revenue Service (currently Revenue Procedure 2013-12). The Board shall reallocate the excess of a participating member’s annual addition over the limits stated above to the accounts of the participating members in the Plan who have not exceeded the limits stated above. If the reallocation causes the limits stated above to be exceeded with respect to each participant for the calendar year, then these amounts shall be held unallocated in a suspense account and reallocated to participants’ accounts in~~

~~the next (or succeeding, if necessary) calendar year before the allocation of employer or employee contributions.~~

~~If the Plan terminates before the allocation of such excess, the excess shall revert to the employer, to the extent that it may not be allocated to any participant's account.~~

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ARTICLE 8.

ESTABLISHMENT AND ADMINISTRATION OF THE TRUST

- 8.1 **Establishment of trust.** There is hereby established a Trust Fund to be known as the North Dakota Defined Contribution Retirement Fund. This Trust Fund is intended to be a tax-exempt trust under Code Sections 401 and 501. The assets of this Plan, and all income attributable to such assets, are held in trust by the Board for the exclusive benefit of participating members and their beneficiaries.
- 8.2 **Acceptance of trust.** The Board consents to act as Trustee for this Trust Fund.
- 8.3 **Administration.** The Board shall supervise the operation of the Plan, maintain records and supply information to participating members and others. In administering this Plan, the Board shall have any applicable rights, powers and duties granted to it by law for the administration of the public employees retirement system.
- 8.4 **Specific powers and duties.** The Board shall:
- a. Exercise exclusive authority to invest and manage assets of the Plan. However, the Board shall permit each participating member to direct the investment of the individual's employer and employee contributions and earnings to one or more investment options within available categories of investment as established by the Board.
 - b. Establish and adopt a statement of investment objectives and policies setting forth the manner and parameters of the investment of the assets of the Plan. The statement of investment objectives and policies shall be established in a manner consistent with the purposes of the Plan. The Board shall monitor the performance of the investments of the Plan to ensure such remain consistent with the investment policy established by the Board.
 - c. Provide information to employees who are eligible to elect to become participating members in this Plan. The information must include at a minimum the employee's current account balance, the

assumption of investment risk under a defined contribution retirement plan, administrative and investment costs, coordination of benefits information, and a comparison of projected retirement benefits under the public employees retirement system and this Plan. Notwithstanding any other provision of law, the Board is not liable for any election or investment decision made by an employee based upon information provided to an employee under this Plan.

- d. Establish an administrative budget sufficient to perform the duties under the Plan and to draw upon authorized sources to fund the budget.
- e. Pay Plan benefits and related taxes from the assets of the Plan.
- f. Obtain by employment or contract all the services necessary or appropriate to administer the Plan, including actuarial, auditing, custodial, investment, legal and record keeping services.
- g. Procure and dispose of the goods and property of the Plan necessary for its proper administration.
- h. Have full power and authority to adopt rules and regulations for the administration of the Plan and to interpret, alter, amend or revoke any rules and regulations so adopted.

8.5 **Expenses.** The expenses incurred by the Board in the proper administration of the Plan shall be paid from sources made available under applicable state law, including the Trust Fund.

8.6 **Accounting.** For accounting purposes, the Board will maintain a summary of the account balances of each participating member whose benefits have not begun to be distributed. This accounting summary will reflect from time to time the total deferred liability of the Plan as well as the account balance for each participating member in the Plan.

8.7 **Compliance authority.** The Board may administratively alter the terms of the Plan as it determines to be necessary or appropriate to maintain the status of the Plan as a qualified defined contribution retirement plan under the Code.

8.8 **Delegation of responsibilities.** The Board may delegate the duties and authorities established under the Plan in a manner consistent with its fiduciary responsibilities as established under this Article 8.

8.9 **Fiduciary responsibilities.** The Board, the Administrator, and any agent or designee thereof with discretionary authority for the Plan, are fiduciaries under the Plan as to the discharge of their duties under the Plan and shall act as to their duties:

- a. Solely in the interest of the Plan's participating members and their beneficiaries;
- b. For the exclusive purpose of providing benefits to participating members and their beneficiaries and paying reasonable expenses of administering the Plan;
- c. With the care, skill, prudence and diligence under the circumstances then prevailing that a person acting a like capacity and familiar with such matters would use in the conduct of an activity of like character and purpose;
- d. Incurring only costs that are appropriate and reasonable; and
- e. In accordance with good faith interpretation of the law governing the Plan.

ARTICLE 9.

RIGHT OF APPEAL AND DETERMINATION OF DISPUTES

- 9.1 **Claim to benefits.** No participating member, beneficiary or other person shall have any right or claim to benefits under this Plan, or any right or claim to payment from the Trust Fund, other than as specified herein and under all applicable sections of North Dakota Century Code Chapter 54-52. Any dispute as to eligibility, type, amount or duration of benefits or any right or claim to payment from the Trust Fund shall be resolved pursuant to the terms of the Plan, under appeal procedures adopted by the Board.

ARTICLE 10.

AMENDMENT AND TERMINATION

- 10.1 **Right to amend plan.** The Board has the right to amend the Plan, in whole or in part, at any time and from time to time. However, no amendment shall, with respect to any participating member, reduce such benefits provided hereunder as are derived from vested contributions credited to the participating member before the effective date of any such amendment.
- 10.2 **Exclusive benefit.** Except as permitted specifically by law, it shall be impossible by operation of this Plan, by termination or amendment or by the happening of any contingency, for any part of the principle or income of the Trust Fund or any fund contributed thereto to be used for, or diverted to, purposes other than the exclusive benefit of participating members or their beneficiaries.
- 10.3 **Severability.** If any provision of the Plan or any step in the administration of the Plan is held to be illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan, unless such illegality or invalidity prevents accomplishment of the purposes and objectives of the Plan. In the event of any such holding, the Board will immediately amend the Plan to remedy the defect.
- 10.4 **Nonforfeitable benefits upon termination.** In the event of a termination of the Plan, the rights of each participating member to all benefits accrued to date of such termination, which is the vested account balance of each participating member, shall be one hundred percent nonforfeitable and fully vested in each participating member.

ARTICLE 11.
GENERAL PROVISIONS

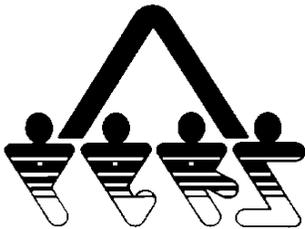
- 11.1 **Plan not employment contract.** The adoption of or participation in this Plan may not be deemed to give an employee the right to be retained in the employ of an employer or to interfere with the right of the employer to discharge any employee at any time.
- 11.2 **Alienation of benefits prohibited.** Neither the participating member nor his designated beneficiary, or any other designee, has any right to commute, sell, assign, transfer or otherwise convey the right to receive any payments or assets under this Plan. Such payments or assets are non-assignable and non-transferable. The participating member's rights under the Plan are not subject to the rights of creditors of the participating member, any beneficiary, the Board or the employer and shall be exempt from execution, attachment, prior assignment or any other judicial relief or order for the benefit of creditors or other third persons. This Section shall not apply to a qualified domestic relations order, as defined in Section 7.8.

- 11.3 **Beneficiary designation.** A participant or former participant in the Plan may nominate one or more individuals as a beneficiary by filing written notice of nomination with the Board. If the participating member or former member is married at the time of the nomination and the participant's spouse is not the beneficiary for one hundred percent of his account balance, the nomination is not effective unless it is signed by the participant's spouse. However, the Board may waive this requirement if the spouse's signature cannot be obtained because of extenuating circumstances.
- 11.4 **Overpayments.** The Board has the right of setoff to recover overpayments made under this Plan and to satisfy any claims arising from embezzlement or fraud committed by a participating member, deferred member, beneficiary or other person who has a claim to a distribution or any other benefit from this Plan.
- 11.5 **Plan qualification.** If the Board receives notice from the Internal Revenue Service that this Plan is not qualified for tax purposes under the Code, then the portion that will cause the disqualification does not apply.
- 11.6 **Construction.** The laws of the state of North Dakota, as amended from time to time, shall govern the construction and application of this Plan. Words used in the masculine gender shall include the feminine and words in the singular shall include the plural, as appropriate. The headings and subheadings of this Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

11.7 **Reemployment.** Any former participating member of the defined contribution retirement plan who returns to public employment following a previous termination or retirement and is eligible to participate in a retirement plan, must resume participation in the defined contribution retirement plan.

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**North Dakota
Public Employees Retirement System**
400 East Broadway, Suite 505 • Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
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1-800-803-7377

FAX: (701) 328-3920 • EMAIL: NDPERS@state.nd.us • discovernd.com/NDPERS

Memorandum

TO: NDPERS Board

FROM: Kathy & Sparb

DATE: August 12, 2013

SUBJECT: Final Average Salary Indexing for Highway Patrol

North Dakota Century Code 39-03.1-11(5) provides:

"...The final average salary used for calculating a deferred vested retirement benefit must be increased annually from the later of the date of termination of employment or July 1, 1991, until the date the contributor begins to receive retirement benefits from the fund, at a rate as determined by the board not to exceed a rate that would be approximately equal to annual salary increases provided state employees pursuant to action by the legislative assembly."

As provided in statute, it is necessary for the NDPERS Board to set a rate to be used in establishing the index factor for deferred members of the highway patrol. It has been PERS policy to solicit input and a recommendation from the Highway Patrol leadership.

The legislative assembly increased each agencies budget by an average of 4% for the first year of the 2013-14 biennium. The North Dakota Highway Patrol leadership is recommending that deferred members in its system have their final average salary indexed by 3%. Currently there are 18 members in the system in a deferred status.

The current assumption for indexing of deferred members is 5%. Therefore, an increase of 3% will result in an actuarial gain to the plan as confirmed by our consultant, The Segal Company.

For your information, listed below are the legislative increases granted, as well as the increase percentages set for indexing purposes by the Board since 1993 when the factor was first established.

	Legislative Increase %	Board Approved Index %
1993	3.00	3.57
1994	2.00	3.00
1995	2.00	2.00
1996	2.00+ 1.00 discretionary	2.00
1997	Average 3.00	3.00
1998	Average 3.00	1.80
1999	2.00 (min \$35)	1.26
2000	2.00 (min \$35)	2.00
2001	3.00 (min \$35)	1.81
2002	3.00 (min \$35)	1.73
2003	None authorized	-0-
2004	None authorized	-0-
2005	4.00	4.00
2006	4.00	4.00
2007	4.00	4.00
2008	4.00	4.00
2009	5.00	5.00
2010	5.00	5.00
2011	3.00	2.00
2012	3.00	2.00

As illustrated above, the Board has generally approved an indexing percentage, as recommended by the Highway Patrol leadership, that is the same or slightly lower than the salary increases granted to state employees.

Board Action Requested:

Accept or reject the Highway Patrol's recommendation.



North Dakota Highway Patrol



Colonel James J. Prochniak, Superintendent
State Capitol, 600 E Boulevard Ave. Dept. 504
Bismarck, ND 58505-0240
Telephone: 701-328-2455

Jack Dalrymple
Governor
State of North Dakota

RECEIVED

AUG 09 2013

ND PERS

August 8, 2013

Ms. Kathy Allen
North Dakota Public Employees Retirement System
P.O. Box 1657
Bismarck, ND 58502-1657

Dear Kathy:

We recommend the members of the North Dakota Highway Patrol Retirement System who participate in the Deferred Vested Benefit provision have their final average salary indexed by 3 percent July 1, 2013 and 3 percent July 1, 2014.

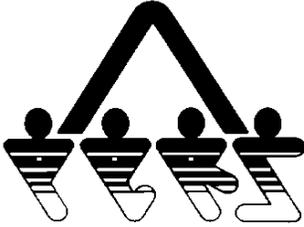
Effective July 1, 2013, the legislative increases provided to employees were 3 to 5 percent based on performance. Agencies were given the average of 4 percent to provide increases to employees. Effective January 1, 2014, current employees in the Highway Patrol Retirement System will be contributing an additional 1 percent to the retirement fund in an attempt to keep the system adequately funded. The average of 4 percent less the 1 percent employee contribution will be 3 percent. The salary schedules for state classified employees was increased 3 percent on July 1, 2013.

For the July 1, 2014 time period, legislators approved a 2 – 4 percent increase. Agencies were given 3 percent of the average for their budgets. They did not approve an additional contribution increase to the retirement system in January 2015. Salary schedules for state classified employees will be increased another 3 percent effective July 1, 2014.

Sincerely,

LORI R. MALAFA
Captain, NDHP
Administrative Services Commander

Irm/blc



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: August 14, 2013
SUBJECT: Interim Study – Retirement

The Government Finance Committee met on July 30, 2013. This committee is responsible for the following study.

SECTION 16. LEGISLATIVE MANAGEMENT STUDY - NORTH DAKOTA RETIREMENT PLANS.

During the 2013-14 interim, the legislative management shall consider studying the feasibility and desirability of existing and possible state retirement plans. The study must include an analysis of both a defined benefit plan and a defined contribution plan with considerations and possible consequences for transitioning to a state defined contribution plan. The study may not be conducted by the employee benefits programs committee. The legislative management shall report its findings and recommendations, together with any legislation needed to implement the recommendations, to the sixty-fourth legislative assembly.

Attached please find the committee memorandum prepared by Legislative Council relating to the study. After discussion, the committee adopted the following study plan:

1. Receive information from the Legislative Council regarding the current state employee retirement plans, including the number of participants enrolled in each plan, recent changes to retirement contributions, and estimated fund balances.
2. Receive information from the Legislative Council regarding the use of defined benefit and defined contribution plans in other states, including recent changes to the plans.
3. Receive and review information from the Legislative Council regarding options to transition to a defined contribution plan for all newly hired state employees, including estimated costs, benefits, or other effects.
4. Receive testimony from interested persons regarding the study.
5. Develop recommendations and any bill drafts necessary to implement the recommendations.
6. Prepare a final report for submission to the Legislative Management.

STUDY OF STATE CONTRIBUTIONS TO STATE EMPLOYEE HEALTH INSURANCE PREMIUMS - BACKGROUND MEMORANDUM

STUDY RESPONSIBILITIES

Section 39 of House Bill No. 1015 (attached as an [appendix](#)) provides for a study of the state contribution to the cost of state employee health insurance premiums, including the feasibility and desirability of establishing a maximum state contribution. The responsibility for this study was assigned to the Government Finance Committee by the Legislative Management.

BACKGROUND INFORMATION

North Dakota Century Code Chapter 54-52.1 provides group medical insurance is available to any employee who meets the eligibility requirements of being a permanent employee of the state. To be eligible, an employee must be at least 18 years of age, occupy a regularly funded position, work a minimum of 20 hours per week, and work at least 20 weeks each year. Temporary employees who work a minimum of 20 hours per week and 20 weeks per year may purchase health insurance at their own expense or the employing agency may pay the premium.

The 1963 Legislative Assembly enacted Chapter 52-12 which authorized state agencies, either individually or jointly with other agencies, to enter a group hospitalization and medical care plan and group life insurance plan for each agency's employees. The agencies were required to pay \$5 per month for each participating employee's insurance premium. An employee could elect to participate in either a single or family plan. The 1971 Legislative Assembly repealed Chapter 52-12 and enacted Chapter 54-52.1 establishing the uniform group insurance program. The program was placed under the authority of the Public Employees Retirement Board. The board was required to solicit bids and contract for the provision of insurance benefits coverage with an insurance carrier determined by the board.

From 1971 to 1983, Blue Cross Blue Shield of North Dakota provided and administered the health insurance benefits plan for public employees. In 1983 the Retirement Board was authorized by Section 54-52.1-04.2 to establish a plan of self-insurance for providing health benefits coverage under an administrative services-only contract or a third-party administrator contract if the board determined during any biennium that a self-insured plan is less costly than the lowest bid submitted by an insurance carrier. The board exercised the option to implement a self-insurance health benefits plan and administered the program in that manner from July 1, 1983, through June 30, 1989.

Rising health care costs in the state were the primary reason for the cashflow difficulties experienced in the health benefits plan. In the 1985-87 biennium, the Legislative Assembly appropriated funds for a 20 percent premium increase, and claims costs increased 42 percent.

Although the Retirement Board began its administration of the self-insured health benefits plan on July 1, 1983, with reserves of \$2,143,880, claim expenditures and other expenses of the program exceeded premium income and other revenue in 1984. By June 1987 the fund balance, as indicated in audited financial statements of the plan, was a negative \$4,759,963 with estimated outstanding claims payable of \$4,600,000.

In 1987 the Retirement Board incorporated various cost-containment components into the health benefits plan which included:

1. Implementation of a program of concurrent review of inpatient hospitalizations designed to eliminate unnecessary treatment or prolonged hospital stays and to allow consideration of less expensive appropriate treatment for long-term medical care.
2. Implementation of a program of mandatory second surgical opinions for certain elective surgeries. (This program did not generate anticipated results and after a one-year trial period was discontinued.)
3. Expansion of contract deductibles to include all inpatient, outpatient, and physician services.
4. Increase in the coinsurance base from the first \$2,000 in charges to the first \$4,000 in charges.
5. Implementation of a preferred pharmacy program.
6. Establishment of a separate premium rate for retirees, based on retiree claims experience.
7. Introduction of a \$25 copayment for each hospital emergency room visit.
8. Adjustment of the Medicare coordination of benefits formula applied to retiree members of the plan.

Due to the introduction of these cost-containment initiatives and the availability to public employees of a number of attractive health maintenance organization plans, approximately 3,350 membership contracts constituting 23 percent of the total contracts of the health benefits plan were lost during the 1987 open enrollment period, resulting in a decrease of approximately \$563,000 per month in premium income.

The decision by the Medcenter One HMO, a health maintenance organization that had the largest Public Employees Retirement System (PERS) eligible enrollment, to discontinue its participation agreement with PERS as of July 1, 1988, and substantial increases in premiums charged by other health maintenance organizations resulted in a substantial number of public employees choosing the PERS health benefits plan during the 1988 open enrollment period.

In January 1989 the Retirement Board voted to end the state-funded health insurance program and buy the coverage from Blue Cross Blue Shield of North Dakota. Officials of PERS predicted the state would end the 1987-89 biennium with a \$3.5 million deficit and would need to increase premium rates by 65 percent in 1989-91. The Blue Cross Blue Shield bid of about \$35 million to fund state employees' health insurance for the 1989-91 biennium included provisions that the company would absorb about \$5 million in unpaid claims when it took over in July 1989.

Senate Bill No. 2026 (1989) appropriated \$1.2 million from the fund for unemployment compensation claims to PERS for the state group health program for the period beginning January 1, 1989, and ending June 30, 1991.

Until 1993 the health insurance program charged premiums based on each employee's election of a single or family plan. Beginning in the 1993-95 biennium, the Retirement Board began to charge a combination rate that is a blended rate per employee whether a single or family plan is chosen. The blended rate enables agencies to budget the same premium rate for all employees; therefore, an agency's budget is not adversely affected if an employee electing to receive single health insurance coverage quits and is replaced by an employee electing to receive family coverage. The schedule below shows the premiums charged since the program began in 1963.

Biennium	Single Plan	Percentage Change	Family Plan	Percentage Change	Combination Rate	Percentage Change
1963-65	\$5.00		\$21.00			
1965-67	\$8.55	71.0%	\$21.50	2.4%		
1967-69	\$10.75	25.7%	\$25.00	16.3%		
1969-71	\$14.45	34.4%	\$34.90	39.6%		
1971-73	\$15.95	10.4%	\$41.90	20.1%		
1973-75	\$14.46	(9.3%)	\$41.90	0.0%		
1975-77	\$19.50	34.9%	\$59.95	43.1%		
1977-79	\$25.50	30.8%	\$67.42	12.5%		
1979-81	\$34.84	36.6%	\$87.40	29.6%		
1981-83	\$42.68	22.5%	\$107.07	22.5%		
1983-85	\$50.28	17.8%	\$140.28	31.0%		
1985-87	\$60.00	19.3%	\$168.00	19.8%		
1987-89	\$68.28	13.8%	\$191.28	13.9%		
1989-91	\$99.82	46.2%	\$280.39	46.6%		
1991-93	\$108.00	8.2%	\$304.00	8.4%		
1993-95					\$254.00	
1995-97					\$265.00	4.3%
1997-99					\$301.00	13.6%
1999-2001					\$349.72	16.2%
2001-03					\$409.09	17.0%
2003-05					\$488.70	19.5%
2005-07					\$553.95	13.4%
2007-09					\$658.08	18.8%
2009-11					\$825.66	25.5%
2011-13					\$886.62	7.4%
2013-15					\$981.69	10.7%

From 1963 through 1969, the state contributed \$5 per month toward the cost of health insurance for state employees. State employees paid any additional amount for single or family coverage. During the 1969-71 biennium, the state contributed \$7.50 per month. For the period 1973 through 1979, the state paid the cost of a single health insurance plan. Employees choosing a family plan paid any additional cost. Since 1979 the state has paid the full cost of either a single or family plan for eligible state employees.

The schedule below provides information on health insurance premiums and the cost of health insurance increases since the 1997-99 biennium.

State Employee Health Insurance Increases (Excluding Higher Education)						
Biennium	Monthly Premium	Increase From Previous Biennium	Percentage Increase	General Fund	Special Funds	Total
1997-99	\$301	\$36	13.6%	\$7,026,674	\$3,619,802	\$10,646,476
1999-2001	\$350	\$49	16.2%	\$6,989,537	\$3,858,174	\$10,847,711
2001-03	\$409	\$59	17.0%	\$11,182,551	\$6,001,252	\$17,183,803
2003-05	\$489	\$80	19.5%	\$8,027,122	\$8,258,216	\$16,285,338
2005-07	\$554	\$65	13.4%	\$5,335,798	\$7,903,870	\$13,239,668
2007-09	\$658	\$104	18.8%	\$9,115,817	\$12,346,031	\$21,461,848
2009-11	\$826	\$168	25.5%	\$15,889,790	\$20,215,824	\$36,105,614
2011-13	\$887	\$61	7.4%	\$7,179,809	\$5,995,847	\$13,175,656
2013-15	\$982	\$95	10.7%	\$11,127,312	\$9,700,989	\$20,828,301

High-Deductible Health Plan

Section 54-52.1-18, as enacted by the 2011 Legislative Assembly, requires the Public Employees Retirement Board to develop and implement a high-deductible health plan with a savings account as an alternative to the regular health insurance plan. The section requires the difference between the cost of single and family health plan for state employees to be deposited in a health savings account for the benefit of the participating employee. The high-deductible health plan has higher annual deductibles and larger out-of-pocket costs which are partially offset by the employer contribution to the health savings account. The health savings account is not subject to federal income tax at the time of deposit and funds may be carried over and used in subsequent years.

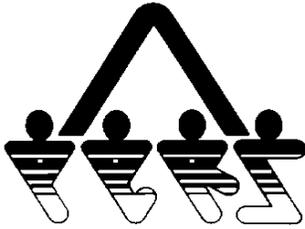
As of April 2013, there were 15,262 state contracts for the regular health insurance benefit, and 122 employees were enrolled in the high-deductible health plan.

STUDY PLAN

The following is a proposed study plan for the committee's consideration in its study of the state contributions for state employee health insurance premiums:

1. Receive information from the Legislative Council regarding historical costs for state employee health insurance premiums and estimated future premium costs.
2. Receive information from the Legislative Council regarding expected employee out-of-pocket costs paid through deductibles, coinsurance, copays, and pharmaceutical costs based on the current state employee health insurance plan.
3. Receive information from the Legislative Council on the state's available high-deductible health plan, including an explanation of plan components and the number of participants in the plan.
4. Receive and review information from the Legislative Council staff regarding state contributions for state employee health insurance premiums in other states, private employer health insurance premium contributions for private sector employees, and associated employee out-of-pocket costs.
5. Receive information from PERS on the process used for determining health insurance premiums each biennium.
6. Receive testimony from interested persons regarding the study.
7. Develop recommendations and any bill drafts necessary to implement the recommendations.
8. Prepare a final report for submission to the Legislative Management.

ATTACH:1



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Public Employees Retirement System**
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Memorandum

TO: PERS Board
FROM: Sparb
DATE: August 14, 2013
SUBJECT: Flex Survey

Background

During the last several years we reviewed our flex comp program and noted an opportunity to potentially increase our services to our members with the goal of increasing their satisfaction with the program and making it easier for them to participate by adding additional options including the debit card, on-line claims submission, mobile applications and auto-adjudication. We also noted during our considerations that the total number of dollars deferred was decreasing as a result of the change in the federal law which reduced the maximum medical spending account election from \$6,000 to \$2,500. This meant that if we were to keep the total elections near the same as before the federal change, we needed to increase the number of smaller accounts participating in the program. As a result of antidotal information, we believed the reason the number of smaller dollar amount elections to participate was not higher was due to the paperwork involved in the existing claims payment process administered by PERS. As a result of this review, we decided to move forward with adding these additional services to increase the options for our members to use the program and to make it easier for them. As a result of this decision, we needed to outsource the claims payment function.

We bid out the service last year and had a very competitive process with about 10 vendors offering their services. The successful vendor was ADP. They began offering services to our members beginning January 1. Their contract ends December 31, 2014. From a staff perspective they have been a good firm to work with.

Recently we conducted a survey of our members to help us assess how we are doing in meeting our original goal of increasing member satisfaction and making it easier to use this program.

Survey Results

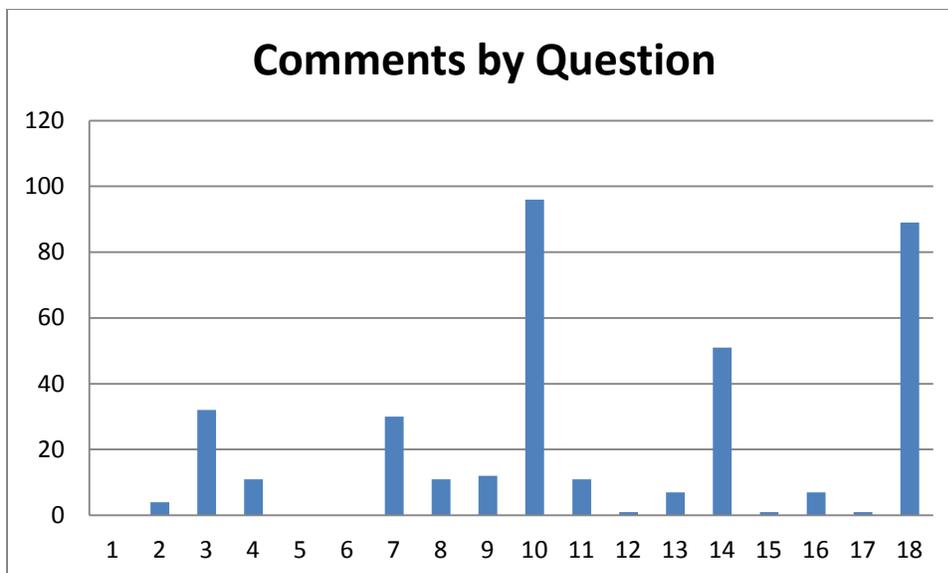
Attached are the flex comp survey results. The first page is what we shared with you at the last meeting. Added for this meeting is the comments we received on the survey. You will note that we have assigned the comments to the questions that they related to most closely.

We sent out approximately 2,700 surveys and received back 843 responses (approximately a 31% response rate). You will note the average age of the respondents is 50 years of age and they have about 17.8 years of service in the system. About 78% of them put over \$1,000 in their flex account. In addition:

1. 93% are in the medical account & 16% in dependent care account.
2. 89% are satisfied with the enrollment process.
3. 85% are satisfied with the information they received (please note on the attached we have 32 comments relating to the question most relate to providing better information about the new system, 3 comments relate to the PERS website being difficult to use).
4. 10% have not used the ADP claims processing yet. (We had 11 comments relating to this question).
5. 96% have been in the program in previous years (before ADP).
6. 90% said they will participate again next year.

Overall, the answers to the general question (1-6) are good. The members seem happy with the enrollment process and they plan to continue participation.

However, as we move to the responses on question 7-18 it becomes more difficult to assess. If we look at the total number of comments we received relating to the different questions, we find:



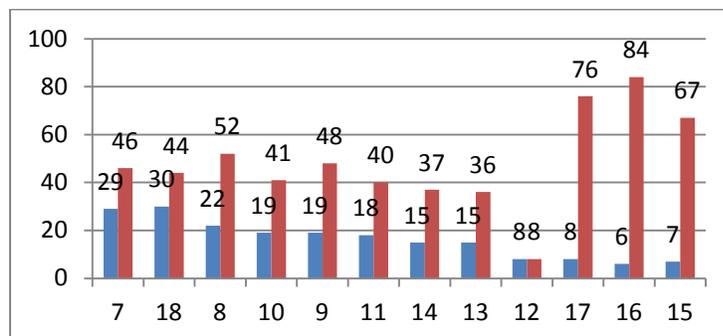
In addition, we find the following by doing an intensity analysis on the questions and sorting them by:

1. Ranking those who strongly were dissatisfied first.
2. Ranking second those who “disagreed” with being satisfied second.
3. Rank those who are very satisfied third.
4. Last ranking those are satisfied as fourth.

	Strongly Disagree	Disagree	Slightly disagree	Lightly agree	Agree	Strongly Agree	N/A
7. I am satisfied with the decision to change to ADP for Flexcomp claims processing.	17	12	9	11	30	16	5
18. I preferred the claims processing method before ADP.	14	16	9	8	11	33	9
8. I am satisfied with the claim submission options available from ADP.	13	9	9	12	33	19	6
10. I am satisfied with the Debit Card option available from ADP.	13	6	5	9	19	22	27
9. I am satisfied with the online Web Services available from ADP.	12	7	8	11	29	19	14
11. I am satisfied with the online claims submission option available from ADP.	11	7	7	10	24	16	25
14. I am satisfied with the customer service provided by ADP	10	5	6	10	21	16	32
13. I am satisfied with the Automatic Claim Reimbursement option available from ADP.	9	6	6	8	20	16	37
12. I am satisfied with the Mobile App option available from ADP.	6	2	2	3	5	3	79
17. I would recommend the NDPERS Flexcomp plan to other employees.	5	3	2	8	33	43	5
16. I plan to enroll in the Flexcomp plan next year.	5	1	1	4	29	55	5
15. I am satisfied with the Flexcomp service provided by the NDPERS office.	4	3	4	10	37	30	12

Concerning the above, the following observations can be a made:

1. If we look at the questions (7, 8, 9, 11 & 14) that have a high dissatisfaction or a high number of comments (8, 9, 10, 11 & 14) they all have satisfaction levels higher than the dissatisfaction levels (note the “slightly” responses are not tabulated in this count since we are only measuring those responses with a higher intensity). Question 18 is reversed where “Agree” is negative for ADP.



The labels across the bottom are the “question numbers”, the shorter line is the percentage that were very dissatisfied or dissatisfied and the taller line is those that were very satisfied or satisfied.

2. We received the most comments on question 10 which is “*I am satisfied with the Debit Card option available from ADP*”. You will note in reviewing the comments there is a lot of confusion on using the card. However, in the intensity analysis it ranked #4 with 19% indicating they are strongly dissatisfied or dissatisfied compared to 41% who are satisfied or strongly satisfied.
3. The second most comments were on question 18 which is “*I preferred the claims processing method before ADP*”. Of these responses, 17 were positive to ADP and approximately 56 said they liked it more when PERS processed the claims. The other comments were general. The most common reasons for people preferring it when PERS processed the claims was a feeling that it was not as confusing and the time it took to get the reimbursement was faster. It seems that most of the underlying frustration is the same as in number 1 above, that is confusion about how the new options work. In the intensity analysis it ranked #2 with 30% indicating they strongly disagree or disagree compared to 44% who agreed or strongly agreed.
4. Question 14 had the next most comments (51) and that question was “I am satisfied with the customer service provided by ADP”. Many of these comments range from general frustration to specific concerns with customer service. In the intensity analysis it ranked #7 with 15% indicating they were strongly disagreed or disagreed compared to 37% who agreed or strongly agreed.
5. Question #12 has a low intensity rating either favorable or negatively. Instead this question has a high number of responses that were “N/S” (79%). This question related to the “mobile app” which seems to indicate a high number of individuals are unaware of this option. As you may recall when we discussed the ADP proposal we had hoped offering this option would make the program more accessible/attractive to younger members with small balances to participate.
6. Question #13 (automatic claims reimbursement) also has a high number of individuals that answered “N/S” (37%) which also indicates a lower level of understanding of this option.
7. As we look at question numbers 15, 16 and 17, they all have high positive responses. These questions concern participating in the program next year or recommending the program. The last question relates to PERS.
8. Question 18 shows that overall 52% (33% strongly preferred PERS) preferred the claims processing method of PERS compared to 39% (14% strongly like ADP) that prefer the new method.

Conclusion and Suggested Plan of Action

Overall, the survey seems to show that the positive responses exceeded the negative responses concerning our change in the flex program (except for question 18). However, the comments and the level of negative responses clearly indicate that we have work to do to improve the understanding of the new options, customer service and general acceptance of the new service if we are to reach our goal of making this program more broadly used. Therefore, I would recommend the following three actions by the Board:

1. To direct staff to review in detail the findings of the survey with ADP and request that they bring back to the Board no later than October a plan of action for addressing the survey responses and in particular:
 - a. The need to change member's perception as shown in question 18.
 - b. The comments and high level of dissatisfaction with the debit card
 - c. The concerns with the customer service.
 - d. The confusion between the debit card and the automatic claim reimbursement.
 - e. The low level of understanding of the mobile application.
 - f. How they plan to decrease the intensity of responses relating to "dissatisfaction".
2. That we let ADP know that we plan to do another survey next year and the progress made from this year to next will be a consideration of the Board in extending the ADP contract past the end of the 2014.
3. That you request the PERS staff to come back with a plan of action to address those concerns raised about our website and the feeling that if a member calls our office that we are merely transferring them to ADP. PERS staff should report back to the Board no later than October as well.

Board Action requested

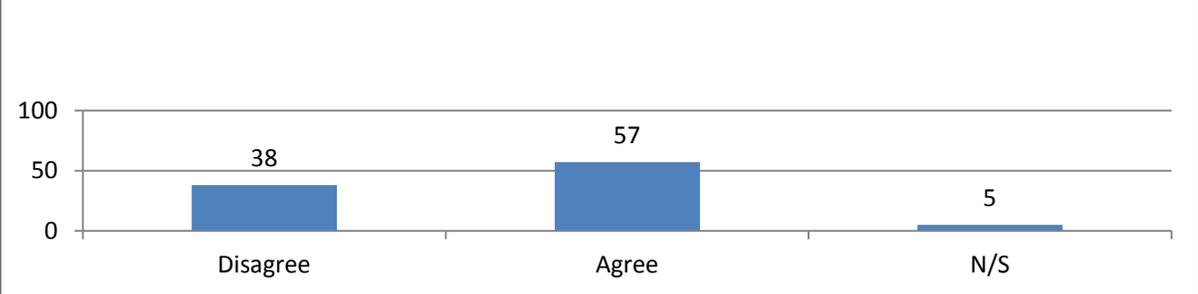
To adopt of plan of action in response to the survey.

NDPERS 2013 Flexcomp Plan Survey – 843 Responses (31%)

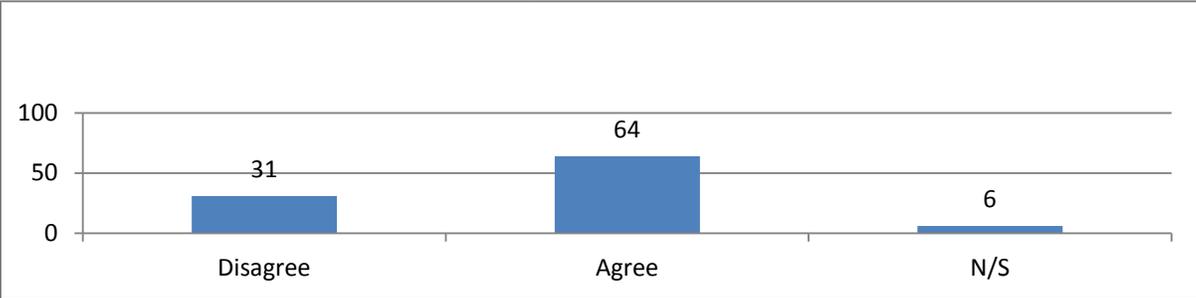
<p>1. Which Flexcomp program(s) do you participate in?</p>	<p>93% Medical 16% Dependent 38% Pre-Tax</p>
<p>2. Are you satisfied with the NDPERS Flexcomp enrollment process?</p> <p>Make open enrollment through MSS user friendly. Should be a summary type screen to check pretax for dental, vision, opt, Ded, rather than going into each plan. It's very confusing to members.</p> <p>\$900.00 medical flex comp for year before taxes, \$525.00 now taken out for deferred compensation each month. Also state retirement plan flex supply life and dental plan.</p> <p>Original enrollment was confusing and you couldn't get a printed confirmation of what you were doing. The switch over was confusing and ADP wasn't up to speed soon enough. Don't like the limits placed on amounts for medical this year.</p> <p>I have not used the new system yet. I find the annual enrollment process confusing at times.</p>	<p>89% Yes 9% No</p>
<p>3. Are you satisfied with the availability of Flexcomp plan information?</p> <p>Figure out a way to increase the amount we can contribute to the medical flex comp account.</p> <p>NDPERS website is one of the most cumbersome to navigate through. S/B completely scrapped and start fresh.</p> <p>NDPERS doesn't answer any of my questions just refers me to ADP. Not very good customer service.</p> <p>I am not familiar with any of the ADP options as I have not filed any claims this year and have never received any information regarding any changes in options or procedures.</p> <p>I would like to see the limit raised higher than \$2,600.00.</p> <p>The NDPERS website is atrocious! It takes forever to find the information one is looking for. In addition to the flexcomp. I am enrolled in the PEP where I contribute \$500. a month. I honestly still do not understand the PEP. I just know it is a place to save money. When I call NDPERS they have a difficult time explaining it. Anyway, maybe retool your website and make it easier for people to navigate, gain knowledge about your offerings and save your staff some time answering questions.</p> <p>I would like to be able to do both the high deductible health insurance and flexcomp. Maybe there are legal issues making that impossible? The debit card thing works so much better.</p> <p>NDPERS needed to do a better job of explaining the new service prior to taking effect. All I got was an email saying it was happening. There was no education on how to use the service. I learned it on my own. Wish there was an email option submit form.</p> <p>The transition to ADP was a bit rocky. Little information was sent out or was sent too early to be applicable. We received little from ADP and what was received didn't answer the questions. ADP was not prepared for transition. But now they have gotten it together. I'm ok with things now.</p> <p>Put a video role playing "how to" visual. It would be last years.</p> <p>More information about ADP would have been nice.</p> <p>Also dislike the reduction in amount that can be deferred but understand this is not NDPERS that did it.</p> <p>More information should be available and distributed to employees from PERS regarding the switch to using ADP prior to us receiving the debit cards.</p> <p>Some years more than \$2400.00 option would be nice!</p> <p>The flexcomp plan is not as good as it use to be. I understand this is due to federal regulations but it takes a lot of choice to consume any inflated costs.</p> <p>I was denied medical claims and lost over \$800.00 last year!</p>	<p>85% Yes 13% No</p>

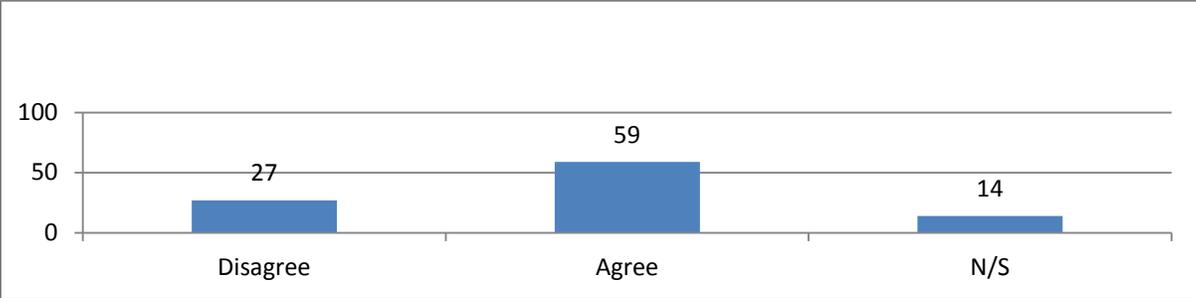
<p>I know IRS rules require prescriptions for over the counter medications but before ADP PERS would reimburse without having a pharmacist fill the rx (I could buy it at Target for instance). ADP won't allow this and I should have been told this information before I did my enrollment this year.</p>	
<p>Like the new service. Just wish we would get information when OTC drugs are added or removed from the list. I submitted an OTC drug and was denied because it now has to be filled out by the pharmacy. Would have been nice to know before hand.</p>	
<p>Did not like the max restriction on flex comp was such a big drop.</p>	
<p>I was appalled when the amount of pre tax was reduced. We have extensive medical expenses and would certainly set aside more money if possible.</p>	
<p>Whoever printed your envelopes should know how to spell Bismarck-hope you didn't pay for them.</p>	
<p>I would like more information on the automatic claim and debit card process.</p>	
<p>Not happy about the reduction to the amount we are able to flex for medical but the process with ADP has been smooth so far.</p>	
<p>Information sent out with choice of card or the old way was confusing. I don't know which I am enrolled under. More information prior to sending the card would have been helpful.</p>	
<p>First time I signed up. Haven't used it but the information on how to use it is very inadequate so far.</p>	
<p>For us it was more difficult than necessary to get complete, timely information for enrollment (on website) or other written sources. PERS services has been good at the office.</p>	
<p>Please do this survey next year at this time. Once the ADP process has been used for a whole year.</p>	
<p>Now that I am using the ADP system it is fine. However the start up process could have been much better. I work at WCHSC and feel the preparation for the transition was horrible. I know of several employees that shredded the ADP card when it came in the mail due to thinking it was just another pre-approved credit card. It would have been extremely helpful to have 20-30 minutes training before the change to be made aware of simple questions like which email to use, company name as well as if there was a number that could be used other than one's social security number (which their wasn't). It's frustrating to go to business office staff that should know the program but be told by them when you ask for training or questions "What questions do you have ". I don't use it. So I don't know! I was told this specifically by Heather Kitzan. It is also ridiculous during open enrollment when you ask a person in the business office, Dean Weigum, questions and are told "Just fill it out and turn it in, if it's wrong they'll send it back". Unbelievable! I sure hope other agencies within DHS were better prepared. All I can say is our business office needs a lot of improvement and am sure I am not the only one that feels this way. Once again a little training would have gone a long way and minimized a lot of confusion!</p>	
<p>NDPERS should promote me to the 457 option and explain how it works.</p>	
<p>There has been communication on this but I haven't been able to stay abreast with this change. I don't know how to use the new service. Why weren't there meetings and why weren't the departments more fully engaged. I work long and hard and should be able to access information at work during the day instead of being referred to the website.</p>	
<p>Should have an inservice training available when switching any benefits so employees can attend and ask questions if they want.</p>	
<p>It is very hard to estimate what your medical expenses will be for a year. My son needs knee surgery due to an accident. You cannot pre plan that. It would be nice to pull money out after the expense if needed.</p>	

<p>4. Have you used the ADP claims processing yet?</p> <p>Too early to tell on ADP, haven't gone on line to really see activity.</p> <p>I have not used ADP. I am choosing to not use it. I do not mind that it gets deposited right into my account.</p> <p>Initial information for ADP was confusing and I haven't gone back or even tried to use it. It would have been nice to have some onsite training/QA sessions.</p> <p>I did not notice/keep the card last fall and have not submitted a claim yet, so I can not answer these questions.</p> <p>I have not used ADP yet.</p> <p>I have never used ADP system and don't know anything about it. Not sure if I can ever file the old way.</p> <p>I still need to call for information to understand more about how the program works using the ADP card.</p> <p>I have not used the ADP. I do not have a debit card for ADP.</p> <p>Still getting familiar with new system. Please survey us again in the future! Thanks!</p> <p>I have not enrolled in ADP. I prefer to get the money back the original way.</p> <p>Haven't submitted claims yet under ADP.</p>	<p>89% Yes 10% No</p>
<p>5. Have you participated in the Flexcomp program before this year?</p>	<p>96% Yes 4% No</p>
<p>6. Do you plan to participate in the Flexcomp plan next year?</p>	<p>90% Yes 7% No</p>

<p>Please mark the box with how much you agree/disagree with the following statements. Use "N/A" if you have not used the service or don't know.</p>	Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	N/A								
<p>7. I am satisfied with the decision to change to ADP for Flexcomp claims processing.</p>  <table border="1"> <caption>Survey Results for Statement 7</caption> <thead> <tr> <th>Response</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Disagree</td> <td>38</td> </tr> <tr> <td>Agree</td> <td>57</td> </tr> <tr> <td>N/S</td> <td>5</td> </tr> </tbody> </table>	Response	Count	Disagree	38	Agree	57	N/S	5	17	12	9	11	30	16	5
Response	Count														
Disagree	38														
Agree	57														
N/S	5														
<p>Who's stupid idea was it to out source flex comp? The system thru NDPERS worked. Dump ADP and go back to NDPERS providing claim service.</p>															
<p>I was so very satisfied with the processing method before ADP. I find the ADP process takes me much longer to do. Why did we have to change?</p>															
<p>ADP was difficult to learn and is very cumbersome to use. It is not worth the trouble. Dump ADP and I will likely use flex comp again.</p>															
<p>Why switch to ADP? I don't recall hearing a reason for that.</p>															
<p>Just something new to get use to . Not crazy about the "outsourcing".</p>															

<p>I don't like sharing personal information with 3rd parties outside the state government system. It's bad enough Obama reading my emails and listening in on my phone calls. Go back to processing reimbursements in house.</p>									
<p>Good move NDPERS in another cost saving measure. Undoubtedly downsized in the number of personnel due to considerably less work load-saving the state/people money correct?</p>									
<p>Like it!</p>									
<p>I don't appreciate a 3rd party vendor for this service. I don't understand why a change in services was made. The information provided by ADP has been untimely and confusing. ADP website is difficult to navigate and find information. Please change this services and bring back to NDPERS!</p>									
<p>Change is always hard, the ADP process is easier now.</p>									
<p>Perhaps change is difficult. Liked as before changed to ADP! Don't like paying postage to submit claims.</p>									
<p>Smooth and easy transition.</p>									
<p>Letter stating change to ADP not very clear. Looked like junk mail.</p>									
<p>I am opposed to the change to ADP because I do not support outsourcing work that could be done by a state employee for a state sponsored employee program.</p>									
<p>Maybe it's the change that I don't like. It should get better as it goes.</p>									
<p>It would be good to keep the service in state. NDPERS website is not always easy to navigate to find what you are looking for.</p>									
<p>Maybe it's the transition but it was very confusing first time through. Didn't appreciate hearing to use my social security number as identifier online.</p>									
<p>Why didn't the employee's get a choice in who the provider was? Who gave ADP permission to access our medical records? We didn't! Ever hear of HIPPA?</p>									
<p>Don't understand why NDPERS recently spent a lot of money on a non user friendly computer program (one of the worst I've ever seen) and now is paying an outside -not ND company to do NDPERS work.</p>									
<p>At first the sign up was a nightmare. I hope the new people do not have that difficult of a process.</p>									
<p>Our agency has told us for copays at clinic, can't process at pharmacy -we will need to verify everyday. Also told could not use at pharmacy till April. Other state agency told could use for all non insurance covered bills at once. The requests for verification not timely, coming two months later. Not timely reporting of how much left in account. I do not want another agency contracted from god know where to have access to my personal and medical information. Why did you lower the amount we could put in flexcomp?</p>									
<p>ADP is a clunky system. It is not user friendly. There needs to be a connection between ADP and BCBS so when a card is used it is clear that payment was made. This system requires a lot of cross checking. ADP's statements are difficult to read and make sense of. Poor notification system of denied claims. Not user friendly system. I love the fact that we can have an online system just not sure if ADP is the right one.</p>									
<p>When you have to pay (I assume) another company to do what PERS has always done I would like to know how much it has saved the state and how many employees you reduced your staff down to by having us and an out of state company do the work.</p>									
<p>The change to ADP was unwelcome and is more cumbersome to employees. Although see how it saves NDPERS time. The card is ok but the employee is then responsible for keeping records-another burden.</p>									

<p>I prefer the service stay the same. Why am I sending information to Kentucky? Keep the form the same, don't keep changing it.</p> <p>Poor decision to change. If it was a cost savings- how many FTE were removed this last session.</p> <p>Get rid of ADP and keep local where you can actually talk to a person. The debit card is a good idea but you should be able to use it on a charge for the whole family and not just one employee.</p> <p>The previous claims processing was excellent and proved how well government process can function. The new process just adds more user name and passwords to forget and has no provision to notify you of the states of the claims. I don't understand the reason for the change. It certainly has not reduced paperwork.</p> <p>ADP is slow getting organized with NDPERS at the beginning. But changes are always slow.</p> <p>If I have problems with ADP is has to be handled in their state and not ND, seems wrong. Plaza Drug wasn't told the change with debit card and their machine still does not accept the card, according to the staff.</p> <p>Concerned with costs - is this a better deal?</p>															
<p>Please mark the box with how much you agree/disagree with the following statements. Use "N/A" if you have not used the service or don't know.</p>															
<p>8. I am satisfied with the claim submission options available from ADP.</p>  <table border="1"> <caption>Survey Results for Statement 8</caption> <thead> <tr> <th>Response</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Disagree</td> <td>31</td> </tr> <tr> <td>Agree</td> <td>64</td> </tr> <tr> <td>N/S</td> <td>6</td> </tr> </tbody> </table>	Response	Count	Disagree	31	Agree	64	N/S	6	13	9	9	12	33	19	6
Response	Count														
Disagree	31														
Agree	64														
N/S	6														
<p>It is 100% better than paper forms. Only complaint would be it seems slow to process but its fair trade off for convenience.</p> <p>Processing claims through ADP has been confusing for me. It has not been clear to me exactly what paperwork they are requesting. Card swipe services dates don't match statement dates (date of service) EOB totals don't match card swipe totals requesting receipts for. If the explanation is confusing, it is equally confusing to me to submit paperwork requested by ADP.</p> <p>Most of the problems I have encountered have been caused by not being familiar with the new procedures and paperwork.</p> <p>I didn't activate the card just did the direct deposit.</p> <p>A lot of older generation don't use computer, young people think everyone uses them. Very confusing. Still like it, that they let you do it my mail.</p> <p>I don't use a lot of services through ADP.</p> <p>Used it only once, mailed in claim. Did not have time to study the online submission; seemed more time consuming maybe try it next time.</p>															

<p>Somehow they pick up the payments on medicine and I think copays too. It confuses my book keeping. I would like to submit all expenses and may hold back some. I like to choose which bills I submit,.</p>																
<p>The ADP program is very hard to follow and get around. I get frustrated with it. I don't like that you have to wait and have a form sent to you before sending in for reimbursements.</p>																
<p>Unsure about how to submit claims.</p>																
<p>The submission process with ADP is more cumbersome, the directions are minimal so for a first timer user more time consuming, and payment is slow compared to previously with NDPERS.</p>																
<p>Please mark the box with how much you agree/disagree with the following statements. Use "N/A" if you have not used the service or don't know.</p>																
<p>9. I am satisfied with the online Web Services available from ADP.</p>  <table border="1"> <caption>Survey Results for Statement 9</caption> <thead> <tr> <th>Response</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Disagree</td> <td>27</td> </tr> <tr> <td>Agree</td> <td>59</td> </tr> <tr> <td>N/S</td> <td>14</td> </tr> </tbody> </table>	Response	Count	Disagree	27	Agree	59	N/S	14	12	7	8	11	29	19	14	
Response	Count															
Disagree	27															
Agree	59															
N/S	14															
<p>Every time I sign in I have to say I forgot my password and type my password in. Same one I didn't forget it-site error. Very frustrating.</p>																
<p>Had a hard time finding claim forms on the computer.</p>																
<p>I can't log on to ADP website! I've recorded username, password but always denied access. I do know how my mother's maiden name is spelled!</p>																
<p>Navigating the website to respond to a notification regarding a "questionable" claim was more difficult than it needed be. I attempted to go to the website to download the form, it didn't allow me. So I phoned customer service and was given a link. It was that link I found difficult to locate where to upload the scanned form.</p>																
<p>The website worked fine, once I figured it out. Very good to get the payment.</p>																
<p>Your website and forms could be more user friendly.</p>																
<p>I had trouble logging in.</p>																
<p>My only complaint with ADP is not user friendly nature of the website for submitting claims. Things to reevaluate:: limited number of attendants, required to select type of service, after stating a new claim with attachments the steps are not clear.</p>																
<p>Attempt to look at my deductions online but password did not work asked for help two weeks ago, still no response to my email!</p>																
<p>The website is not intuitive and proof of payment is a real hassle. Dates are changed, it's hard to find the dates covered under previous reimbursement requests and it's a real pain to find processed checks on my bank site, find the format and place to save them and upload them. I've seem to have found every mishap in my online efforts. Staff is helpful though!</p>																

I worry about over spending when using ADP. I don't know for sure how much is left in account every time I hand over the card to a healthcare provider. Also sometimes claims goes over smoothly other times a delay with more paperwork is needed. I worry how that will be handled. Website is a little confusing. It is faster but I guess I don't fully trust it yet.										
Once reaching the Flexcomp benefit, it should take no more than 3 clicks or less to find what you need. The web site takes you round & round and takes too long to find what is needed. The forms cannot be found "searching" for by number.										

Please mark the box with how much you agree/disagree with the following statements. Use "N/A" if you have not used the service or don't know.	Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	N/A								
10. I am satisfied with the Debit Card option available from ADP.	13	6	5	9	19	22	27								
<table border="1"> <caption>Survey Results for Statement 10</caption> <thead> <tr> <th>Response</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Disagree</td> <td>24</td> </tr> <tr> <td>Agree</td> <td>50</td> </tr> <tr> <td>N/S</td> <td>27</td> </tr> </tbody> </table>	Response	Count	Disagree	24	Agree	50	N/S	27							
Response	Count														
Disagree	24														
Agree	50														
N/S	27														
Have had to document almost every transaction processed with the debit card. I like having the instant payment, but the follow-up has been a real pain. Can't ADP get documents from Blue Cross to support my expenditures?															
Increase the limit from \$2500 to at least \$5000. Debit card works great, but doesn't show up on the PeopleSoft website as being used. Will check online service.															
I don't understand the debit card option. More information on that piece would've been helpful.															
My frustration with ADP is that every purchase I have made was at my pharmacy for prescriptions. I've had to "verify" every purchase -even for \$5.00. So, it is a little inconvenient. Debit cards great idea, however in the past years I had two children with orthodontics. I loved that I would pay for my entire portion on my credit card and get \$2500. worth of points, submit my claim and pay my bill ASAP. It was a little point per for me. This system wont let me do that, so I am grateful I was able to to that when I could.															
I've heard from others that the online submission of claims is not easy and the claims get lost after submitting them. I don't care for the ADP card because I like to submit all of my claims at the end of the year. I'm sure some people prefer the card. It's a good to have options.															
The debit card is supposed to prevent sending in receipts but I still had to submit receipts and EOBS for copay.															
Like the debit card, very handy.															
I enjoy the debit card option. I am surprised that you haven't figured out how to use survey monkey, this is a terrible waste of dollars.															

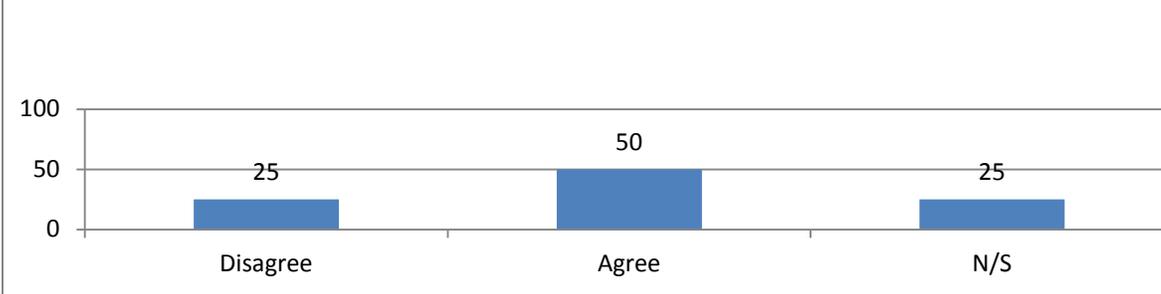
<p>I signed up for the debit card but had to send in my receipts on every bill because the charges could not be electronically verified. This ended up being more than if I would have sent in the receipts in the first place. Will not do a debit card again! The paper also said they would send me an email verification but I never got any emails.</p>									
<p>Use the debit card by a health care provider should be adequate rather than also requiring uploading receipts or bills.</p>									
<p>I do not plan on using the ADP card next year. Twice now we have had to scramble to get receipts to fax to ADP or suffer the consequences. Their verification process is very lacking and their customer service wasn't what I would prefer. It is better for me to stay with the previous procedures and deal with PERS folks The benefit of the ADP card was defeated by their request for receipts, (which I already did before) long after the medical charges and customer services that really wasn't that helpful. I was always happy to deal with PERS folks in Bismarck.</p>									
<p>Using the debit card to pay for medical services was great. And once I realized that I needed to supply ADP with additional documentation for claims not ran through my insurance they stopped sending me emails.</p>									
<p>I really like that ADP credit card process. Makes it so much easier to pay for bills.</p>									
<p>It's really a pain when one uses the debit card to pay for their medical expense and then two weeks later get a request from ADP for an itemized bill. What's the point of using the debit card if we still need an itemized bill to send in? Not very convenient. I might as well not use the debit card.</p>									
<p>Debit card option is too confusing. That's why I didn't bother with it.</p>									
<p>It has been very easy to use my ADP card to pay my part of RX drugs and office visits.</p>									
<p>It was all very confusing at the beginning and I still find their online information somewhat confusing, however the more we work with it the better it has gotten. I really like the debit card, however I tend to have less of a grasp on what I have for a balance. But learning more about the website has helped.</p>									
<p>They (ADP) question almost every card swipe. All dental appointments were questioned. Yet they did not question my Sam's Club swipe (which was for glasses). Please go back to the old processing.</p>									
<p>I do like the credit card system. But I'm not familiar with their online claims submission and I don't plan to use it.</p>									
<p>I didn't know a mobile app. option existed. The debit card is very nice option. I use that almost exclusively.</p>									
<p>The claims validation requests constantly are very frustrating. I thought it would be so easy using the debit card.</p>									
<p>Love the debit card option.</p>									
<p>I like the debit card it reduces waiting time for payment.</p>									
<p>I do not like having to use a debit card for claims. I really do not like having to save all receipts and having to send in originals upon request. I really do not like to have another online account to deal with. The previous system worked very well in my opinion.</p>									
<p>We did not know we needed to submit receipts when paying with debit card. Now card is shut off. Who can find old receipts? They should have contacted us right away-use another method-not email.</p>									
<p>I would not recommend any NDPERS plan with usage of ADP card. The claim submission to verify card swipes has been a BIG headache and more work. I have submitted a verification three times on one swipe and still trying to get it approved. It is an outpatient finger surgery fracture repair at a local hospital. Some card swipes have not been informed back to individual to let us know it went through. Communication is poor.</p>									

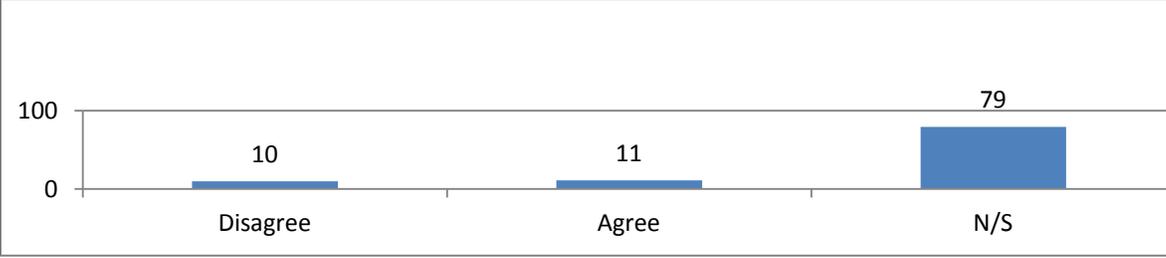
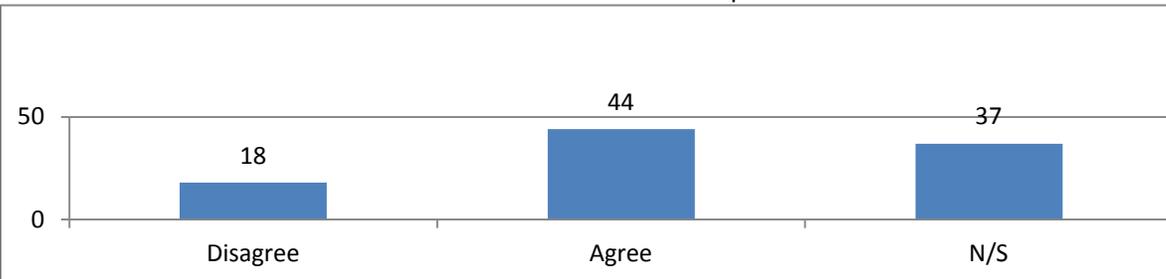
The ADP cards have been so easy to use! Love the new system!										
Would it be possible to have two cards for married couples?										
The debit card is awesome-it is so easy and no waiting to be reimbursed is the best feature.										
The debit card option could be great but when you have to get a detailed receipt and send it in anyway, I don't see the benefit of the card. And when you use the online functions it doesn't tell you how to validate a claim. I had to contact them two times before I get a response on how to validate a claim online. This change has potential but I am jut not sure this is the best vendor.										
ADP was kind of hard to get use to. ADP claims seems to take less time to reimburse than NDPERS did. I really like the email notifications. The debit card option is great, but keeping track of reimbursement documentation is a pain. We have stopped using the debit card for anything other than prescriptions.										
A debit card swipe was used at Dr. office, received a receipt for transaction. But received a letter from ADP that swipe was not accepted, then I had to send I all receipts from doctors visit and prove legitimate office visit or ADP card would be terminated. Not a nice process. Otherwise ok.										
I would stay away from the ADP debit card.										
Didn't like the additional need to for your social security number. Didn't like the card.										
Because lack of information on the change, when I received my payment card via mail it appeared to good to be true so I shredded it. An advanced warning would have been nice.										
In our agency we weren't told that a ADP debit card would be coming in the mail. Having no knowledge of it- I destroyed the card.										
The debit card sounded like a good idea. But when you use it a few months later ADP sends you a form to verify purchase, then you go back to pharmacy or eye doctor and get verification. Then mail paperwork in. Good idea give a card, done deal. Does not work that way. Happened to use four different places.										
Using the card was nice, but still having to submit documents made it seem like an extra step that was unnecessary. Just submitting documents and getting reimbursed directly to my account in one step would be my preference in the future.										
Too complicated if you use your credit card you can use the other form. Don't know what insurance will cover if use card at the time of service so what good is it.										
Love the ADP debit card. It works great.										
I was very excited that a debit card option was now available. We used my wife's flexcomp debit card in the past and it made things very simple. However what we have found through ADP is that way too often when using the card we still are asked for verification. So essentially have to mail invoice in anyway which we never had to do with my wife's.										
Disappointed that medical flex program limited to approximately \$2600. this year. Disappointed in number of times additional information is required to be mailed in on debt card medical expenses.										
Very disappointing that you need to send receipts in anyways. Because of verification, then they send email to accounts that aren't even opened yet and get no response so the card is shut off.										
I love the debit card option. It's great and easy.										
I don't use the debit card option and it takes longer to get the check compared to previously.										
Debit card option confusing.										
I don't think NDPERS office provided enough information on the process for using the debit card. I read all the information provided and watched a video online, and there were still things that I was sure about until I actually used the card.										

<p>I like the fact that I do not have to pay for the service up front, then ask for reimbursement. However, if there is something I dislike about ADP service is the letter sent requesting additional information for claim validation. Seems redundant to have to provide a copy of the EOB for pharmacy or doctor services. But why do they have to say they will shut off the card if adequate documentation is not received by the deadline.</p>									
<p>The card swipe validation process from ADP is nothing short of a royal pain in the ass! I'm not convinced of using flex next year because of this issue.</p>									
<p>My pharmacy, Arrowhead Plaza Drug is not yet enrolled in the debit card option. I have told them I will switch pharmacies if they don't start the program.</p>									
<p>The system needs to be better at automatically verifying uses on the card. I had multiple uses at the same dentist and some transactions would be automatically verified, while other required additional work on my end which defeat the point of having the card.</p>									
<p>I paid a clinic bill over the phone. Now they will cut off my card if I can't find the bill. Don't like this company at all!</p>									
<p>The biggest problem is just one debit card. So card doesn't end up with person seeking medical care and providers want instant paying so it gets more complicated than it needs to be make claims.</p>									
<p>I use the debit card. What I don't like is they send a validation request on June 24 telling you the information needs to be sent in by June 4 or your card will be closed on July 4. Why is the request coming to me 20 days after it was due? The request should be sent before it is due not 20 days after is it due.</p>									
<p>What I didn't like was after using the debit card for medical purposes is having to send in the EOB forms to validate expenses. Double the work!</p>									
<p>I've used the debit card option once and it didn't go well. It is not convenient to use. After the office visit, I went back into the office to use the card after the billing and I recently received a notification that the card swipe didn't work. This is suppose to make it easier, not harder. I think I'll go back to paper submission.</p>									
<p>I do not like the debit card route but when asked for my receipts and proof of expenditures it was so long after the date.</p>									
<p>I have not activated or utilized the debit card. I really dislike debit cards and hate to use them. It is sad that this switch was made without the participants input. I thought this was a voluntary thing but through discussion with co-workers I question this. The individuals I've spoke with have had nothing positive to say about the debit card method and it's usage.</p>									
<p>The debit card is a pain it's still necessary half of the time to send in documentation. If you are making a payment at a clinic, you shouldn't have to submit the documentation that it's a medical expense. The bill date and payment date at the clinic will never match the date of service as we need to wait until insurance clears before we make a payment.</p>									
<p>The only reason I did sign up for flex comp is because of the ease of access with ADP. Online services, debit card easy to submit expenses.</p>									
<p>The debit card is very convenient but submitting receipt documentation after the fact off sets that convenience. The request for documentation seems inconsistent and requires finding receipts later rather than simply submitting with the original claim.</p>									
<p>I love having the debit card, but was really disappointed they couldn't get my EOB from BCBS. Having constantly uploading eobs to their site was a pain. I have used discovery benefits through my spouse's employer and thought they were better.</p>									

<p>I am not sure why you would want to use the debit card when you still have to submit the eob or bill to ADP anyway. I feel like there are more steps to submitting to ADP than sending things to PERS. There are times when you call PERS and they can't answer your questions. I have had my dependent care rejected and there is nothing wrong with what was sent in. They just didn't read the statement correctly. Not impressed with ADP.</p>									
<p>Love the debit card.</p>									
<p>I like having the debit card option to pay my bills, it makes it much easier to pay the larger bills that I can't afford to wait for reimbursement for. The company does need to do a better job with customer service, replying to emails and making explanations. I am willing to give it a try again next year before making any changes. I hope they can improve their customer service.</p>									
<p>Have had to submit receipts for all claims after using the debit card. Faxed the receipts, didn't receive confirmation email in return for several submittals. Poor customer service on toll free phone number, couldn't transfer, etc.</p>									
<p>Love using the card. Have problems understanding information on ADP website. Used card, had to submit follow up documentation, never heard back whether accepted. Does not show online whether accepted. Been a few months.</p>									
<p>The new card is hard to get use to . You have to always carry it with you or your spouse does. Two cards would be nice per family.</p>									
<p>I began the process to activate and enroll to use the debit card. The process was not at all user friendly, was unable to ever get registered for the mail in for reimbursement. The process worked but I didn't care for the form layout.</p>									
<p>Don't like having to fax everything when I use my card to pay a clinic bill.</p>									
<p>Please continue the debit card service provided through ADP.</p>									
<p>I find the flexcomp medical reimbursement with ADP to be very cumbersome. Using the debit card option was worthless as they questioned every claim asking for more detailed receipts. Ex. Used at the dentist office and it wouldn't be processed until receipts were provided. I thought that was the point of using the debit card? For an online claim with ADP, when you have different medical providers listed on the eob statement from BCBS you have to enter each one separately and then attach the same eob statement to multiple claims. Why can't you submit one claim request with multiple medical providers listed to tie into each eob statement. I found some of the online claim process confusing. Why are there so many choices to describe a medical claim? General medical, medical copay, etc. It seemed far too detailed. Also the question of "covered by insurance" Y/N is confusing. If we are submitting a claim from an eob it is because the expense was not covered by insurance. But if we have an eob, we have insurance. So how are we supposed to answer the questions. I did not like having to use my social security number over the internet to create an account wit ADP. PERS really dropped the ball on that one. It was good that you changed that but it created a lot of heartburn for a lot of employees who didn't wait for that issue to be resolved. Despite the SSN misstep I had more faith and trust when the PERS office handled the flexcomp claims.</p>									
<p>ADP is a terrible provider for this service. It all sounds so slick- use a card and you are good to go. Then the confusing emails and lots to follow on the website. It took 6 weeks to get my first claim processed. Flexcomp is a great program for employers. It's too bad it had to dissolve into this nightmare.</p>									
<p>Love the debit card option.</p>									

Never know where I stand with this process. Have submitted paperwork three times and still get letters asking for submit paperwork that I had already submitted. They say they will close the account if they don't receive the paperwork. They tell me payments are denied but are out of pocket expenses. Don't know if I dare use the card for remaining balance.									
I really like the debit card option, however, if there is a problem with a change the process to correct it is frustrating and at this point I'm not sure I'll use it again. Due to the process but it could be really good.									

Please mark the box with how much you agree/disagree with the following statements. Use "N/A" if you have not used the service or don't know.		Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	N/A								
11. I am satisfied with the online claims submission option available from ADP.	11	7	7	10	24	16	25									
 <table border="1" data-bbox="97 724 1258 1018"> <caption>Survey Results for Statement 11</caption> <thead> <tr> <th>Response</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Disagree</td> <td>25</td> </tr> <tr> <td>Agree</td> <td>50</td> </tr> <tr> <td>N/S</td> <td>25</td> </tr> </tbody> </table>	Response	Percentage	Disagree	25	Agree	50	N/S	25								
Response	Percentage															
Disagree	25															
Agree	50															
N/S	25															
I have used the online source 2 to 3 times this year and find it easy to use. I was satisfied with how quickly my claims were processed. Change is good!																
The online claims system is not intuitive- it could use some streamlining. Reimbursement is very fast																
I have had 3 claims denied due to ineligible documentation. I scanned the documents in, attached them to my claim and submitted them. Then I had to fax these same documents again to get them paid. It takes at least 4 times as long to submit claims and when they're paid it can take much longer than PERS ever did.																
Every single dental, optical and medical transaction fails to get validated so we have to find a scanner for every single receipt. It is like they purposefully dispute the claim to avoid paying. What would we be getting from a dental office that isn't dental service???																
The online claim process is less convenient than before. Quite difficult if you try to process more than one claim at a time. Not very user friendly.																
Wish the amount you contribute wouldn't have been reduced. Extremely pleased with how easy, fast and efficient the online ADP reimbursement has been. Awesome!																
Every time I have to submit a claim-I have to enter the same information every time along with a receipt. Which in return is tedious and allows for more errors. This system isn't friendly and if an error occurs it's like pulling teeth out to get your money back. Not happy with ADP.																
The online option is easy to use and nice to check progress of flex.																

<p>The entire submission process for dependent care is awful. The first time I submitted my paperwork it was processed. The 2nd and 3rd time I submitted the same paperwork (different time frame) it was denied. I talked to two ADP employees who couldn't tell me why it was denied. The third employee told me to submit via fax. I submitted the same paperwork via fax and it was processed quickly and correctly. Needless to say, I have abandoned the online process.</p>																	
<p>Be able to scan the receipts and attach to an email.</p>																	
<p>When submitting online they make you submit each receipt repeatedly. It is stupid and time consuming. They have lines for more than on receipt but it will not go through that way.</p>																	
<p>Please mark the box with how much you agree/disagree with the following statements. Use "N/A" if you have not used the service or don't know.</p>		Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	N/A									
<p>12. I am satisfied with the Mobile App option available from ADP.</p>	6	2	2	3	5	3	79										
 <table border="1"> <caption>Data for Statement 12</caption> <thead> <tr> <th>Response</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Disagree</td> <td>10</td> </tr> <tr> <td>Agree</td> <td>11</td> </tr> <tr> <td>N/S</td> <td>79</td> </tr> </tbody> </table>	Response	Count	Disagree	10	Agree	11	N/S	79									
Response	Count																
Disagree	10																
Agree	11																
N/S	79																
<p>Didn't know there was a mobile app.</p>																	
<p>Please mark the box with how much you agree/disagree with the following statements. Use "N/A" if you have not used the service or don't know.</p>		Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	N/A									
<p>13. I am satisfied with the Automatic Claim Reimbursement option available from ADP.</p>	9	6	3	8	20	16	37										
 <table border="1"> <caption>Data for Statement 13</caption> <thead> <tr> <th>Response</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Disagree</td> <td>18</td> </tr> <tr> <td>Agree</td> <td>44</td> </tr> <tr> <td>N/S</td> <td>37</td> </tr> </tbody> </table>	Response	Count	Disagree	18	Agree	44	N/S	37									
Response	Count																
Disagree	18																
Agree	44																
N/S	37																

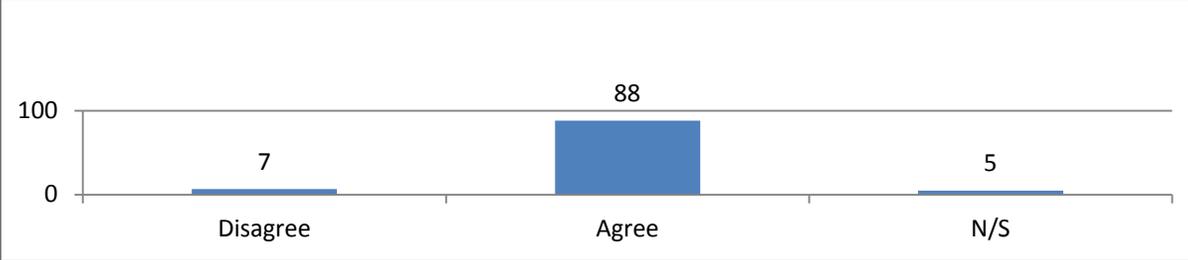
Love the automated processing.																		
1. \$2000.00 is not enough for some people. 2. The auto claim option did not work at any of the places I tried to use it. Use again next year-only if they have fixed the bugs! The people I talked to were great at explaining things but couldn't always fix it.																		
I selected the automatic claim reimbursement option. I have double payments on some claims and have old claims that I have not received reimbursement for. I have called on both with no results. I will not choose the automatic claim reimbursement option next year.																		
I had contacted customer service at the beginning of the year after I'd faxed over authorization for Blue Cross to auto submit claims. For some reason they indicated an indicator wasn't flagged so I elected to just fax them manually. I'm not sure if they ever got the problem fixed between ADP and Blue Cross Blue Shield.																		
Sent form (faxed) to have eob sent to ADP for reimbursements-this has not happened not sure why.																		
I feel ADP's automatic clearing of BCBS eobs is cumbersome to set up and is a low priority for ADP to implement. I signed up for automatic clearing on (and after a fair amount of hassle since I activated the debit card) but it still appears that none of my eobs from BCBS are being processed. ADP got an incorrect email address of mine early on which further complicated things. The old system was a hassle, but at least I knew my claims were being received. With ADP I'm not sure.																		
I sent in authorization for automatic claim reimbursement as soon as I learned of it and have still (months later) heard nothing from ADP.																		
Please mark the box with how much you agree/disagree with the following statements. Use "N/A" if you have not used the service or don't know.																		
		Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	N/A										
14. I am satisfied with the customer service provided by ADP.	10	5	6	10	21	16	32											
<table border="1"> <caption>Survey Results for Statement 14</caption> <thead> <tr> <th>Response</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Disagree</td> <td>21</td> </tr> <tr> <td>Agree</td> <td>47</td> </tr> <tr> <td>N/S</td> <td>32</td> </tr> </tbody> </table>	Response	Count	Disagree	21	Agree	47	N/S	32										
Response	Count																	
Disagree	21																	
Agree	47																	
N/S	32																	
If a member ok's a spouse to talk to them, that should be put into file to apply till revoked, not just for one phone call. Validation of card swipes is ridiculous. They didn't get one EOB I faxed over, suspended card. Wife faxed in immediately the next day, took two weeks for them to reinstate the card, completely unacceptable. Waiting average when you call in 10-15 minutes, unacceptable. Why do they need verification of card swipes when places of businesses are Hollevoit Orthodontics, Eyes on Parkway, Arlin Brend DDS ect., its ridiculous.																		
I had a lot of trouble with my claims using the ADP card. They even denied a dental bill because they said it did not qualify. They do not respond in a timely manner to e-mails and when you call sometimes you wait on hold as long as 45 minutes. With that being said I do love getting payments for things immediately and NOT having to wait for reimbursements. NDPERS customer service is GREAT! ADP customer service lack sensitivity.																		

<p>I have received emails to boot all of my claims from Mid Dakota Clinic, St. Alexius Hospital and Sanford Health stating my claims could not be validated when using the debit card option. I had to scan in my receipts and manually validate my claims. They would not manually validate my claim from my chiropractor, so I scanned in a receipt. They still would not accept it. So I had my chiropractor print out an itemized statement and they still would not validate it. Finally I send ADP a check for the amount of my chiropractor bill because I was tired of messing with it. It was only for \$26.00 and it was a waste of my time to be bothering my chiropractor with getting a receipt that ADP would validate and accept.</p>								
<p>ADP withholds all claims under \$25.00. Even after that amount is met, any claims under \$25.00 haven't been released back to me until they reach \$25.00. Even in the same year, so not happy with that process of having to wait.</p>								
<p>ADP sucks!</p>								
<p>I have submitted three separate large claims to ADP. Each of them have been unpaid due to various issues, which weren't true. One they actually read or changed a date to 2012 (I submitted 2013), they did I didn't have the right insurance benefit statement. It was exactly correct. The other time they made a mistake on one of the amount of payment. I have had to call every time to protest their decisions because they were wrong. Then I got immediate action. They admitted their mistakes. They have such incompetent people working there. You can tell I am not happy with their services.</p>								
<p>Every claim I filed was a hassle with ADP. Customer service was not much help and I didn't know how to resolve problem. ADP held my claim in "pending" because they said they didn't have all the information. Never let me know they were waiting for information. Turned out that they had all the information. Very disappointing, company all around. Takes much longer to get reimbursed. I am considering not even signing up for flex comp next year because it is a big hassle with no clear help or instructions. Please go back to previous way.</p>								
<p>ADP questioned two card swipes for Sanford Health. What the hell do they I was paying for - shoes? It was obviously a medication expense but they made a hassle to comply with their rules.</p>								
<p>Customer services through ADP is not good at all.</p>								
<p>ADP customer service is real good. It took awhile to get use to the process but I understand it now.</p>								
<p>I have to submit receipts a number of times, they question when you make a final payment for services that the insurance did not cover. The insurance is to lazy to get the explanation of benefits to ADP in a timely manner which makes the matter worse. If you call ADP it takes forever to get through and they are not helpful. You can't scan and send the receipts via email because they won't accept them that way. I have mailed this with a tracking number from the post office. Unfortunately, the post office is lazy and doesn't track the envelope on delivery of the mail. I tried to fax the document to the fax number ADP gave me and it came back undeliverable. We need to fix things that need fixing. There was nothing wrong with how it was done before ADP. We should not have fixed something that was not broken. If you want to fix something, fix the parking lot at the capitol, so we do not have to fall and get hurt. That does need fixing.</p>								
<p>It would be nice when ADP declines a claim or partially declines, they would send you an email. Right now, you only find out when your payment in to your bank account is less than your claim amount.</p>								
<p>The new program is very good. Customer service was excellent. I was satisfied with the previous program also.</p>								
<p>Employees at PERS have not always been friendly in the past in the flex comp program. The ADP customer service is far friendlier.</p>								

<p>Why do we have to send EOBS for chiropractor care but other doctors-clinics are ok, it is a hassle.</p>									
<p>The ADP did not take provider claim information as correct submission of claim. I have to send a second time for claim to be completed.</p>									
<p>Would be beneficial to receive an email from ADP when there are claims pending because documentation is due. Didn't know there was a mobile app. Have not had to contact either.</p>									
<p>Still nothing on "pending" reimbursement from ADP-been over 3 months!</p>									
<p>ADP asked for verification of the medical expenses. The documents I faxed the first time weren't adequate, although they had everything required (provider name, etc.). They suspended my card. It took my faxing the same documents two more times before the issue was resolved. It has been very frustrating.</p>									
<p>I'm not happy with the ADP flexcomp. I have to submit a receipt and proof of services for everything. You never hear back from them on status of the before mentioned. Next year I'll do the regular flexcomp plan.</p>									
<p>Everything is more complicated. Customer service terrible, do not return mail. Customer service representatives tell you anything just to get you off the phone. Card swipes typically require you to send in verification anyways, what's the point of having the card. High maintenance requires frequent visits to the website. They communicate terrible please go switch back.</p>									
<p>Our one experience, thought that if medical provider accepted ADP card for payment we wouldn't have to submit EOBS. As it turned out, after we used the ADP card, we received a letter "turn in your EOBS" or we'll cancel the card. They then did accept the EOBS we sent in.</p>									
<p>I am frustrated with ADP program!!! When I initially received my card I threw it away because I thought it was junk mail. It wasn't until I received an office email at work later about the program. When I realized my mistake. When I called to get a new card, the customer service person at ADP seemed irritated with me because I asked for a new card. They treated me like I was stupid for throwing it away. Of the three claims I have made, two of them have not processed properly. Now I have to go through a bunch of hoops to get them to accept them. So this morning I will have to spend a bunch of time figuring out their website and figuring out how to reapply. Not how I would choose to spend my vacation time. I don't even want to work with these people again.</p>									
<p>ADP seems to be an ok option. Customer service was poor when I called on a question. More specific training/explanation on using debit card. What bills need additional information to substantiate would have been helpful. Once I get it down, it will probably work well.</p>									
<p>Submitted daycare bill via fax. Flexcomp did not receive just denied the claim but did not tell why. It took two months to get \$620.00 from them. If it told the computer why the claim was denied it would have not taken an hour on the phone. They were not helpful until I got rude and told them I was going to complain to the state. Our office does not have a scanner so I have so I have to fax or mail the forms to them and there is no way to know if they get the fax. Speaking to a co-worker I don't think their fax is always working or someone is shredding the forms as they come in. Credit card does not work because my spouse can't use a credit card with my name on it and daycare does not take credit cards.</p>									
<p>I am unable to access direct deposit for medical. Flexcomp ADP customer service was unable to give directions clearly. It is a confusing process! Information is conflicting and unclear.</p>									
<p>I have spent four hours with ADP on the phone trying to get them to understand the EOB on my dental plan, they can not figure it out!</p>									
<p>Didn't like ADP services it was (is) all very confusing and the representative that I worked with on the phone was not very nice or helpful.</p>									

Please mark the box with how much you agree/disagree with the following statements.
Use "N/A" if you have not used the service or don't know.

16. I plan to enroll in the Flexcomp plan next year.



I really dislike the ADP flexcomp plan and if it continues I will not participate in flexcomp this next year. It was much easier with the claims processing method prior to ADP.

Very unhappy with ADP. Because of this I will not enroll again. Too time consuming dealing with claim processing. Takes forever to get issues resolved!! Not worth the trouble anymore.

ADP has been nothing but a nightmare. I have flexed since program started but will not continue if use ADP.

I will not sign up again if ADP is being used.

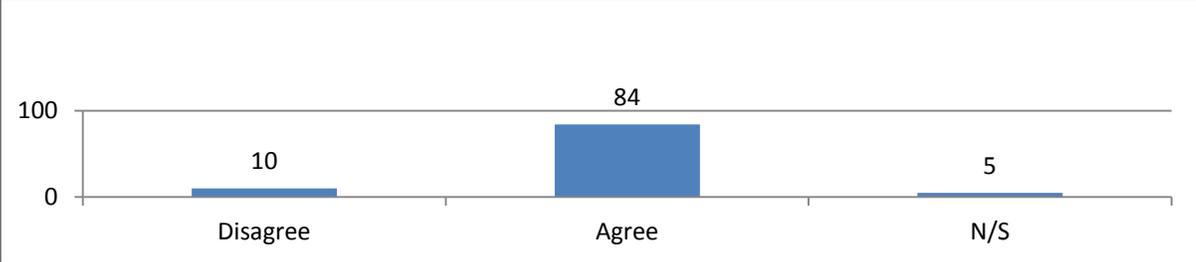
Process was cumbersome. Much easier before when administered by PERS. I will not enroll again if ADP is used.

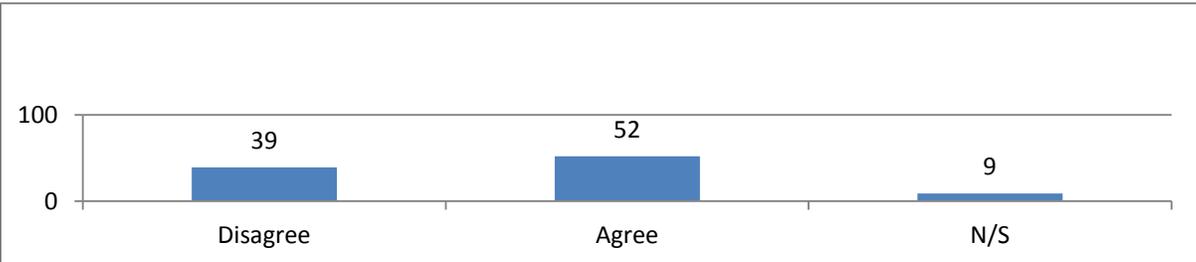
Only issue was I lost \$400.00 of my flex money in 2012. Appointment for eye exam was cancelled due to weather, busy work schedule on day rescheduled. Person was rude on phone-no approval for services done a few days ago after deadline. Hard to predict how much will be needed not sure if I will participate in future.

Even though I don't like the process, flexing is still a wise financial move. ADP is not so bad that I would quit using flex. I always recommend to co-worker that they take advantage of flex-ADP or not.

Strongly disagree
Disagree
Slightly Disagree
Slightly Agree
Agree
Strongly Agree
N/A

5 1 1 4 29 55 5

<p>Please mark the box with how much you agree/disagree with the following statements. Use "N/A" if you have not used the service or don't know.</p>	Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	N/A								
<p>17. I would recommend the NDPERS Flexcomp plan to other employees.</p>  <table border="1"> <caption>Survey Results for Statement 17</caption> <thead> <tr> <th>Response</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Disagree</td> <td>10</td> </tr> <tr> <td>Agree</td> <td>84</td> </tr> <tr> <td>N/S</td> <td>5</td> </tr> </tbody> </table>	Response	Count	Disagree	10	Agree	84	N/S	5	5	3	2	8	33	43	5
Response	Count														
Disagree	10														
Agree	84														
N/S	5														
<p>Wonderful benefit! It took numerous faxes to ADP to collect last years money. I started in January and finally got my money April 14. I also had to use my social security number because the form wouldn't take my employee ID. My question is - who has access to those faxes and will my id be stolen. I definitely will not recommend new employees to sign up for flex comp. Also my credit score dropped because they issued a debit card that I have not ordered and will not use. ADP is not getting my business!</p>															

<p>Please mark the box with how much you agree/disagree with the following statements. Use "N/A" if you have not used the service or don't know.</p>	Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	N/A								
<p>18. I preferred the claims processing method before ADP.</p>  <table border="1"> <caption>Survey Results for Statement 18</caption> <thead> <tr> <th>Response</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Disagree</td> <td>39</td> </tr> <tr> <td>Agree</td> <td>52</td> </tr> <tr> <td>N/S</td> <td>9</td> </tr> </tbody> </table>	Response	Count	Disagree	39	Agree	52	N/S	9	14	16	9	8	11	33	9
Response	Count														
Disagree	39														
Agree	52														
N/S	9														
<p>Far prefer current company. ADP is very convenient and easy to use. I think overall ADP is a good system, I still have few questions on how everything works with the program but generally I have been satisfied. I really like the fact that they send an email confirming that they received the reimbursement and notification of deposit. That is an absolutely fabulous system. I liked the old way because I used it as a savings account. I got all the money at once for something special.</p>															

<p>Why have the card if you still have to submit the claims. That is what I disagree with. I liked the NDPERS better.</p>									
<p>I did not like the lower max contribution. We always ran out before the end of the year when I contributed double the new max. The ADP online claims submission is very cumbersome. Debit card option is ok except they still asked for pharmacy receipts 90% of the time. I may as well use paper claims if I have to provide verification all the time. Customer service was not very helpful. Overall I was dissatisfied with ADP. I much preferred when NDPERS took care of everything.</p>									
<p>Would like statements of account (amount used/amount available for us) mailed out quarterly- as done in past years. I am having difficulty in tracking the amount I have remaining for use in my account.</p>									
<p>I had the medical debit card and after paying bills, got a letter from ADP saying they made "every effort" to make sure it was proper medical spending (all claims Sanford Health claims). I had to copy and send bills with EOBs in again. They couldn't have made any effort. The tedious process for dependent care is way worse as well. Finding the forms online is more difficult than previously, filling forms/paperwork is more difficult and it takes much longer to get the money. I miss the old PERS plans.</p>									
<p>ADP is doing a great job. So quick and efficient. I was weary at first but now I like it much better than before.</p>									
<p>I fax my forms in as I do not have a scanner. It takes longer for me to receive my reimbursement. Also my initial claim was denied. I had to call in and find out why my claim was refused. I had to redo the entire claim and then it took even longer to receive my money.</p>									
<p>I prefer the old claims processing method. I have a small balance on the ADP card it won't let me use it. It always says denied.</p>									
<p>I can not navigate the system. I have yet to get the link to come up so I can file a claim or get a card. I loved the old system it was easy and convenient.</p>									
<p>Dependent care reimbursement was much easier with previous system. Medical claims are easier with ADP. I love being able to simply pay with the debit card, rather than having to mail and wait for reimbursement, which is hard on a family budget.</p>									
<p>I dislike that there is a \$25.00 minimum before they process a payment. I have a payment on a claim for \$8.97 that is stalled until it reaches the \$25.00 threshold.</p>									
<p>The flexcomp claims submission/processing service via ADP is not user friendly! Go back to NDPERS processing.</p>									
<p>I really like having the debit card option. ADP way better than the old way.</p>									
<p>So far my experience with ADP has been somewhat of a nightmare. My first claim included 4 invoices. I uploaded them and attached them using my home computer and scanner. The claim was denied because they said there was no attachment. I called ADP and mailed a hard copy of the attachments using the document number that had been given to me. At that point, they paid one of the invoices. I called again and they said they couldn't read one of the invoices and didn't know what the others were for. I then submitted a hard copy claim with another document number that had been given to me on the phone. They denied that claim because the claim was not properly signed. I had printed the form from my home computer, but it printed in landscape instead of portrait and the certification statement didn't show. When I printed it again in portrait, the certification statement still didn't show. This may be due to a wrong version of acrobat. The form didn't seem correct so I did print it again at work before I submitted it. This time two invoices were paid. The other one was denied two codes. One was that it wasn't legible and one that it didn't have the applicable dates. This was for my husband's EOB. I knew that the copy was faint but it could be read with a little effort. After contacting Blue Cross and Blue Shield, we got another copy. I then called ADP. The gentleman that I talked to</p>									

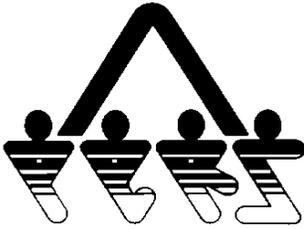
I do not like the new ADP program. It is so complicated I have yet to be able to figure it out to file a reimbursement claim and the prior system was so much easier to use. I have visited with co-workers and they have been unable to figure out the new system. I hope we go back to the way it was before.										
Two words: IT SUCKS!										
Take too long for ADP reimbursement when mailing claim.										
Give people the option of using the former flexcomp method.										
NDPERS should use their own card system for processing medical claims.										
I like the old system. You can call ADP and not talk to the same person twice. Very poor service!!										
I have only used the new system once. For approximately \$900.00 and there was no problem. I did however wait two weeks and finally called just to check the status. I recall the old program was faster.										
I still have to pay bills after getting medical run through insurance and then still have to scan and send in eobs. Previously I just sent in eobs. Now I have to match up bills to eobs and it's more paperwork and sometimes more confusing. It would be easy if you have 1 large bill only.										
This was the worst experience I have ever encountered with a claims processing plan. To say I am dissatisfied doesn't begin and address what I feel about this plan. Please select something different or revert it to the former plan.										
Would prefer to have flexcomp claims processed by NDPERS.										
Keep the ADP program!!										
I am very pleased with ADP. They are very fast. Submitting claims is very easy. Thank you.										
I hate the new program										
This was a hard transition for me but once I got use to typing in my information on the online forms and printing them out, it was actually much easier than using the old way.										
Change is hard, it took a bit of getting use to it. I miss the automatic deposit. I'll survive.										
Great service, like any changes takes time to get use to. But once you do would hate to go back. Thanks.										
ADP was a horrible choice. Every claim was denied and a latter was sent telling me to provide original receipts and eob. I provided the documents only to have some denied again. Only after a call to customer service and my explanation of disappointment in them did they take care of the bills. The card swipes were from a clinic; no need for a misunderstanding for about five visits.										
Very dissatisfied with the new program. VERY!										
I participated in 2011 then didn't think I needed to fill out paper work to continue. I really missed the flex comp deduction before tax on my income tax especially since I do not have enough medical to itemize the claims. Love the new system so easy and no waiting for money.										
Very overly complicated. Confusing, I feel I need an accounting background to complete this. Liked being able to copy receipts and just send them in. Please go back to old system. Thanks.										
Sometimes there is more of a delay with dependent care reimbursements than with the previous flex plan arrangements. Overall I really like ADP!										
Some things are smooth and simpler, but the increased verifying of submission process have added complications rather than simplified. The feedback about errors is confusing and hard to overcome with scanning some things, mailing others, etc.										
ADP is horrible. The debit card is a joke if we have to submit receipts anyway. The method used in prior years was far superior to ADP.										

Haven't used it much but so far so good.									
I have had nothing but problems with ADP since the switch. I have uploaded copies of receipts multiple time and still months later they say the deductions are non allowable or receipts are not enough. When I send a request for more information on what is needed they take over a month to reply and threaten to cancel my account. I prefer the old method of submission, a lot less stressful than these constant threats of taking my money with no reason.									
It is way too complicated. I need more communication from/by email. NDPERS did a better job.									
ADP is cumbersome - and difficult to use compared to NDPERS.									

19. Years of Service with the state	20. Age at last birthday	21. Marital Status
25% <10, 15% 10-14, 17% 15-19, 42% 20+, 1% N/S 17.8 Years average	16% <40, 23% 40-49, 40% 50-59, 17% 60+, 4% N/S 50.0 Years average	17% Single 81% Married 2% N/S
22. Did you defer/contribute more than \$1,000 to your Flexcomp account? 78% Yes 20%No 2% N/S		

Additional Comments?

THANK YOU!
Please return this survey in the postage-paid envelope by: July 15, 2013



North Dakota
Public Employees Retirement System
400 East Broadway, Suite 505 • Box 1657
Bismarck, North Dakota 58502-1657

Sparb Collins
Executive Director
(701) 328-3900
1-800-803-7377

FAX: (701) 328-3920 • EMAIL: NDPERS-info@nd.gov • www.nd.gov/ndpers

Memorandum

TO: PERS Board
FROM: Sparb
DATE: August 14, 2013
SUBJECT: Board Standing Committee Assignments

As of June 2013 the PERS Board had several standing committees comprised of the following Board members:

- Investment Committee: Mr. Sandal, Mr. Sage, Mr. Erdmann and Mr. Trenbeath (alternate)
- Audit Committee: Chairman Strinden and Ms. Smith
- Benefits Committee: Ms. Ehrhardt, Ms. Smith, and Mr. Trenbeath
- Election Committee: Ms. Smith, Mr. Sage, and Mr. Sandal

With Levi's departure from the Board, we currently have a vacancy on the Investment Committee and with Kim's election to the Board we need to consider the committee membership.

Concerning the Investment Board, state statute requires three members be appointed by PERS as specified below.

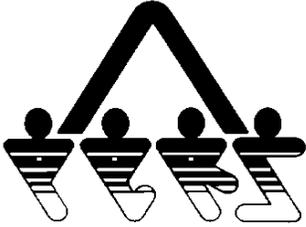
The North Dakota state investment board consists of the governor, the state treasurer, the commissioner of university and school lands, the director of workforce safety and insurance, the insurance commissioner, three members of the teachers' fund for retirement board or the board's designees who need not be members of the fund as selected by that board, two of the elected members of the public employees retirement system board as selected by that board, and one member of the public employees retirement system board as selected by that board. The director of workforce safety and insurance may appoint a designee, subject to approval by the workforce safety and insurance board of directors, to attend the meetings, participate, and vote when the director is unable to attend. The teachers' fund for retirement board may appoint an alternate designee with full voting privileges to attend meetings of the state investment board when a selected member is unable to attend. The public employees retirement system board may appoint an alternate designee with full voting privileges from the public employees retirement system board to attend meetings of the state investment board when a selected member is unable to attend. The members of the state investment board, except elected and appointed officials and the director of workforce safety and insurance or the director's designee, are entitled to receive as compensation one hundred forty-eight dollars per day and necessary mileage and travel expenses as provided in sections 44-08-04 and 54-06-09 for attending meetings of the state investment board.

At the last meeting the Board decided to reappoint Howard and Mike to the Investment Committee. The Board decided to defer action on our third member to see if Mr. Trenbeath, our alternate member, would be willing to serve as our permanent member. I did talk with Tom and he indicated he would will be willing to serve if the Board so elects. With this appointment, the Board would need to:

1. Appoint a member as the Alternate Member to the Investment Committee and the State Investment Board.
2. Confirm the other appointments:
 - a. Audit Committee: Chairman Strinden and Ms. Smith
 - b. Benefits Committee: Ms. Ehrhardt, Ms. Smith, and Ms. Wassim
 - c. Election Committee: Ms. Smith, Mr. Sage, and Mr. Sandal

Board Action Requested

Appoint members to the PERS standing committees.



**North Dakota
Public Employees Retirement System**
400 East Broadway, Suite 505 • Box 1657
Bismarck, North Dakota 58502-1657

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Executive Director
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Memorandum

TO: PERS Board

FROM: Deb

DATE: August 14, 2013

SUBJECT: Draft Administrative Rules

Attached are the proposed administrative rules developed by staff for your review, excluding the previously discussed rules for the Defined Contribution Plan. The proposed rules are in response to legislation or are to update Board policy or clarify existing language. Also included for your convenience is a draft summary of the proposed changes. Staff will still need to conduct a Small Entity Regulatory Analysis and Jan Murtha, is examining whether NDPERS needs to complete a Regulatory Analysis, Takings Assessment or a Small Entity Economic Impact Statement. The results of these analyses will be provided at the next Board meeting.

As in the past, we are providing these rules to you at this time for your review and consideration. They will be brought back at the September meeting for your final approval along with the above referenced analyses. A draft of the notice of our intent to promulgate rules will also be provided at next month's meeting.

Please contact me if you have questions or concerns. Also, please let us know if there are other areas that you feel we should be developing or updating rules so they can be included for your consideration in September. Staff will also be available at the Board meeting to address any questions.

Draft Summary of Proposed Rules

71-02-01-01(27) Definitions. Provides clarification for when a refund may be applied for .

71-01-02-04. Election notification. Administrative change to delete reference to deferred vested members for election notification purposes.

71-01-02-13. Election voting. New section adds option for electronic ballots.

71-02-04-01. Retirement benefits – Application Makes provision for if a birth certificate is not available for purposes of applying for retirement benefits.

71-02-04-04.1. Benefit modifications. Removes reference to repealed retirement benefit option.

71-02-04-09. Dual membership - Receipt of retirement benefits while contributing to the teachers' fund for retirement, the highway patrolmen's retirement system, or the teachers' insurance and annuity association of America - college retirement equities fund. Provides additional detail for process already in use.

71-02-10-02. Qualified domestic relations orders procedures. Provides processing guidelines for NDPERS relating to when a refund is being requested and a QDRO is pending.

71-03-03-08. Continuation of life insurance after retirement. Clarifies that supplemental life for retirees can continue until 65.

71-03-04-02. Information to employee Removes reference to paper forms.

71-03-05-10. Determining amount of premium overpayments and underpayments. Establishes a time period for determining amount of premium over or under payments.

71-03-07-07. Minimum requirements for political subdivisions. Language added pursuant to law change under NDCC 54-52.1-03.1 related to the Affordable Care Act.

71-04-03-01. Enrollment. Removes reference to paper forms.

71-04-04-07. Separation from service. Reflects current practice of providing termination information upon request for 457 purposes.

71-04-05-02. Payroll deductions. Removes reference to paper forms.

71-05-05-01. Normal and early retirement benefits - Application. Makes provision for if a birth certificate is not available for purposes of applying for retirement benefits.

71-07-01-01. Plan document. Revises schedule for reviewing the plan document from annual to as needed due to changes in federal law.

CHAPTER 71-01-02 ELECTION RULES

Section

71-01-02-01	Election Committee
71-01-02-02	Eligible Voters
71-01-02-03	Candidate Eligibility
71-01-02-04	Election Notification
71-01-02-05	Petition Format
71-01-02-06	Procedure for Completing and Filing Petitions
71-01-02-07	Election Ballots
71-01-02-08	Election
71-01-02-09	Canvassing Rules
71-01-02-10	Notification of Election Results
71-01-02-11	Special Elections
71-01-02-12	Penalties
<u>71-01-02-13</u>	<u>Election Voting</u>

Section 71-01-02-04 is amended as follows:

71-01-02-04. Election notification.

1. The director of the North Dakota public employees retirement system shall ensure that notification of an active member vacancy and the election is given to all employees through publication of a notice in the North Dakota public employees retirement system newsletter and any other method of communication as deemed appropriate by the director at least three weeks in advance of a filing date for nomination petitions. The director shall ensure that notification of the vacancy of a retiree member and the election is given to all persons who have accepted a retirement allowance ~~or who are eligible to receive deferred vested retirement benefits~~ through publication of a notice in the North Dakota public employees retirement system newsletter and any other method of communication as deemed appropriate by the director at least three weeks in advance of a filing date for nomination petitions.
2. The notice must include a statement of voter and candidate eligibility, the candidate nomination requirements, the date of election, and where to obtain the nomination petitions for filing.

History: Effective April 1, 1992; amended effective July 1, 2000; April 1, 2008; _____, 2013.

General Authority: NDCC 54-52-04

Law Implemented: NDCC 54-52-03

Section 71-01-02-13 is created as follows:

71-01-02-13. Election voting. In lieu of sections 71-01-02-07 and 71-01-02-08, the retirement board may allow for a process by which electronic ballots are submitted to elect an active or retiree candidate to the board.

History: Effective _____, 2013

General Authority: NDCC 54-52-04

Law Implemented: NDCC 54-52-03

Subsection 27 of Section 71-02-01-01 is amended as follows:

27. "Termination of employment" for the purposes of determination for eligibility for benefit payments means a severance of employment by not being on the payroll of a covered employer for a minimum of one month. Approved leave of absence or if reemployed by any covered employer prior to receiving a lump sum distribution of the member's account balance does not constitute termination of employment.

History: Amended effective September 1, 1982; November 1, 1990; September 1, 1991; January 1, 1992; September 1, 1992; June 1, 1993; July 1, 1994; June 1, 1996; July 1, 2000; April 1, 2002; May 1, 2004; July 1, 2006; July 1, 2010; _____, 2013.

General Authority: NDCC 54-52-04

Law Implemented: NDCC 54-52

Section 71-02-04-01 is amended as follows:

71-02-04-01. Retirement benefits - Application. Except as provided in section 71-02-04-02 for retirement options, applications for retirement, surviving spouse, and disability benefits must be filed at the public employees retirement system office at least thirty days before the retirement date or before the commencement of benefits. A member shall file a photocopy of the member's birth certificate, and if a benefit election is an optional benefit under subsection 1 or 2 of section 71-02-04-04, the member must provide a photocopy of the spouse's birth certificate and marriage certificate with the office. A surviving spouse shall file a photocopy of the surviving spouse's birth certificate, deceased spouse's birth certificate and certified copy of the death certificate, and marriage certificate if a benefit election is under subdivision b of subsection 6 of North Dakota Century Code section ~~54-54-17~~54-52-17. If a birth certificate is not available, a member or surviving spouse may submit other documentation based on policy and procedure adopted by the board.

History: Amended effective November 1, 1990; July 1, 1994; May 1, 2004; _____, 2013.

General Authority: NDCC 54-52-04, 54-52-17

Law Implemented: NDCC 54-52-17

Section 71-02-04-04.1 is amended as follows:

71-02-04-04.1. Benefit modifications. A member may elect as provided in section 71-02-04-02 to receive one of the following benefit modifications:

1. ~~**Level social security option.** A member who retires prior to receiving social security benefits may elect the level social security option. Under this option, the member's monthly benefit is adjusted so the combined benefits received from the fund and social security remain level before, and after, the date social security benefits begin. The adjusted benefit payable from the fund must be determined on an actuarial equivalent based on an age no earlier than sixty-two and no later than full retirement age as specified by the social security administration as chosen in writing by the member. A member shall submit an estimated benefit from social security that was computed no more than six months before commencement of retirement benefits. A member may only select this option if the member has selected to receive a single life/normal retirement option.~~
2. **Partial lump sum option.** The partial lump sum option will only be available to members who retire on or after reaching normal retirement date. This option is an irrevocable election and made at initial application for retirement. The payment is equal to twelve monthly payments determined under the single life annuity option. The member is permitted to choose one of the optional forms of payment as defined in section 71-02-04-04 for ongoing benefits. The ongoing benefits will be actuarially reduced to reflect the partial lump sum payment.
32. **Deferred normal retirement option.** The deferred normal retirement option will only be available to members who retire after reaching normal retirement date. This option is an irrevocable election and made at initial application for retirement. The payment is in lieu of a lump sum equal to the amount of missed payments, without interest, retroactive to the member's normal retirement date. The member is permitted to choose one of the optional forms of payment as defined in section 71-02-04-04. The ongoing benefits will be actuarially increased to reflect the lump sum.
43. **Graduated benefit option.** The graduated benefit option will only be available to members who retire after reaching normal retirement date. This option is an irrevocable election and made at initial application for

retirement. The member is permitted to choose one of the optional forms of payment for ongoing benefits as defined in section 71-02-04-04. The ongoing benefits will be actuarially reduced to reflect the election of the graduated benefit option.

History: Effective July 1, 2010; amended effective _____, 2013.

General Authority: NDCC 54-52-04, 54-52-17

Law Implemented: NDCC 54-52-17

Section 71-02-04-09 is amended as follows:

71-02-04-09. Dual membership - Receipt of retirement benefits while contributing to the teachers' fund for retirement, the highway patrolmen's retirement system, or the teachers' insurance and annuity association of America - college retirement equities fund. Dual members must select one of the following options:

1. Begin receiving retirement benefits from one plan prior to ceasing employment covered by the alternate plan, subject to termination of employment or termination of participation.
2. Begin receiving retirement benefits from one plan and begin work in a job covered by the alternate plan. If this option is chosen, benefits will be calculated based on the method provided in subsection 2 of North Dakota Century Code section 54-52-17.2.
3. Continue as a dual member and begin receiving retirement benefits from both plans after ceasing employment.

History: Effective June 1, 1996; amended effective May 1, 2004; _____, 2013.

General Authority: NDCC 54-52-04, 54-52-17, 54-52-17.2

Law Implemented: NDCC 54-52-17, 54-52-17.2

Section 71-02-10-02 is amended as follows:

71-02-10-02. Qualified domestic relations orders procedures.

1. Upon receipt of a proposed domestic relations order, the public employees retirement system shall send an initial notice to each person named therein, including the member and the alternate payee named in the order, together with an explanation of the procedures followed by the fund.
2. If a member who is not in pay status at the time the proposed domestic relations order, or notice of intent to submit a proposed domestic relations

order, was received from the member, the member's legal representative or an individual authorized to receive confidential information under subsection 8 of North Dakota Century Code section 54-52-26, makes application for a lump sum distribution due to termination of employment, the application for lump sum distribution will be held until such time as the proposed domestic relations order is determined to be qualified and a certified copy of such order is received at the North Dakota public employees retirement system office or until the end of the eighteen-month review period, or until the North Dakota public employees retirement system office receives notice that a proposed domestic relations order will not be submitted, whichever occurs first.

3. Upon receipt of a domestic relations order, the public employees retirement system shall review the domestic relations order to determine if it is a qualified order as established by the model language format specified by the board.
4. The domestic relations order shall be considered a qualified order when the executive director notifies the parties the order is approved and a certified copy of the court order has been submitted to the office.
5. If the order becomes qualified, the executive director shall:
 - a. Send notice to all persons named in the order and any representatives designated in writing by such person that a determination has been made that the order is a qualified domestic relations order.
 - b. Comply with the terms of the order.
6. If the order is determined not to be a qualified domestic relations order or a determination cannot be made as to whether the order is qualified or not qualified within eighteen months of receipt of such order, the public employees retirement system shall send written notification of termination of review to all parties at least forty-five days prior to the end of the eighteen-month review period. At the end of the eighteen-month review period, the proposed order is deemed to be withdrawn and of no legal effect.
 - a. If a member who was not in pay status at the time the proposed domestic relations order was received made application for a lump sum distribution due to termination of employment, the application for lump sum distribution will be processed at the end of the eighteen-month review period.

- b. If determined after the expiration of the eighteen-month period the order is a qualified domestic relations order, the qualified domestic relations order must be applied prospectively only.

History: Effective November 1, 1990; amended effective July 1, 1994; July 1, 2006; April 1, 2012; _____, 2013.

General Authority: NDCC 54-52-04

Law Implemented: NDCC 54-52-17.6

Section 71-03-03-08 is amended as follows:

71-03-03-08. Continuation of life insurance after retirement. An employee who is enrolled in the group life insurance program may continue the basic and supplemental life insurance coverage upon retirement or disability if the employee is entitled to a retirement allowance from an eligible retirement system by making application and remitting timely payments to the board. Supplemental life insurance coverage can only be continued until age 65.

History: Effective October 1, 1986; amended effective June 1, 1996; May 1, 2004; _____, 2013.

General Authority: NDCC 54-52.1-08

Law Implemented: NDCC 54-52.1-03

Section 71-03-04-02 is amended as follows:

71-03-04-02. Information to employee. Each agency shall inform its employees of their right to group insurance and the process necessary to enroll. ~~The agency shall provide each eligible employee such forms as necessary to enroll in the group insurance program.~~

History: Effective October 1, 1986; amended effective November 1, 1990; _____, 2013.

General Authority: NDCC 54-52.1-08

Law Implemented: NDCC 54-52.1-03

Section 71-03-05-10 is amended as follows:

71-03-05-10. Determining amount of premium overpayments and underpayments.

1. The amount of the health premium overpayment or underpayment will be determined by calculating the difference between the premium that was paid and the premium that should have been paid, retroactively to the

month the change in premium should have occurred, or July of the earliest contract period still open, whichever is more recent.

2. The amount of the life premium overpayment or underpayment will be determined by calculating the difference between the premium that was paid and the premium that should have been paid, retroactively to the month the change in premium should have occurred, or the first day of the first month of the earliest contract period still open, whichever is more recent.
3. The amount of the dental premium overpayment or underpayment will be determined by calculating the difference between the premium that was paid and the premium that should have been paid, retroactively to the month the change in premium should have occurred, or the first day of the first month of the earliest contract period still open, whichever is more recent.
4. The amount of the vision premium overpayment or underpayment will be determined by calculating the difference between the premium that was paid and the premium that should have been paid, retroactively to the month the change in premium should have occurred, or the first day of the first month of the earliest contract period still open, whichever is more recent.

History: Effective April 1, 2002; amended effective April 1, 2008; _____, 2013.

General Authority: NDCC 54-52.1-08

Law Implemented: NDCC 54-52.1-08

Section 71-03-07-07 is amended as follows:

71-03-07-07. Minimum requirements for political subdivisions. An enrolled political subdivision must extend the benefits of the group insurance program to its eligible employees and paid members of its board, commission, or association subject to minimum requirements established by the retirement board and a minimum period of participation of sixty months. If the political subdivision withdraws from participation before completing sixty months of participation, unless federal or state laws or rules are modified or interpreted in a way that makes participation by the political subdivision in the uniform group insurance program no longer allowable or appropriate, the political subdivision must make payment to the retirement board equal to the expenses incurred on behalf of that political subdivision's employees which exceed the income received by the retirement board on behalf of that political subdivision's employees during the time of participation. For purposes of this section:

1. "Expenses incurred" means:

- a. Claims incurred by the political subdivision during the enrolled period and paid during or within three months after the enrolled period and includes capitated payments to providers;
 - b. Reasonable administrative expenses as incurred by the public employees retirement system and the claims administrator as set forth in the master contract; and
 - c. The cost of any premium buy-down provided.
2. "Income received" means all premiums paid by the political subdivision to the retirement board.

Full payment is due within three months after receipt of notice from the executive director, unless an alternative payment schedule has been approved by the retirement board. A late payment charge must be assessed on all money due on an account at a rate of one and three-fourths percent per month.

History: Effective June 1, 1996; amended effective _____, 2013.

General Authority: NDCC 54-52-04, 54-52.1-03.1

Law Implemented: NDCC 54-52.1-02, 54-52.1-03, 54-52.1-03.1

Section 71-04-03-01 is amended as follows:

71-04-03-01. Enrollment. Public employees may enroll in the deferred compensation plan by completing a participant agreement and submitting the agreement to the retirement board. ~~The employee must also complete the necessary forms required by the provider and submit them to the retirement board for signature by the plan administrator.~~

History: Effective April 1, 1989; amended effective _____, 2013.

General Authority: NDCC 28-32-02, 54-52.2-03.2

Law Implemented: NDCC 54-52.2-03

Section 71-04-04-07 is amended as follows:

71-04-04-07. Separation from service. The board shall notify the participant, provider company, and provider representative of the employee's separation from service and eligibility for payment of benefits upon request.

History: Effective April 1, 1989; amended effective July 1, 1994; May 1, 2004; July 1, 2010; _____, 2013.

General Authority: NDCC 28-32-02, 54-52.2-03.2

Law Implemented: NDCC 54-52.2-03, 54-52.2-03.2

Section 71-04-05-02 is amended as follows:

71-04-05-02. Payroll deductions. The employer shall authorize employee payroll deductions only after receiving a ~~completed and signed participant agreement~~ notification from the public employees retirement system. The participant agreement ~~must be signed by a designated representative of the retirement board and~~ indicate the date the payroll deduction is to start, the provider, and the contribution amount. Payroll deductions must be remitted to the retirement board within ten days after each payroll period. Along with each payment, the employer must provide the retirement board with a listing of deferred compensation deductions for all employees participating in the deferred compensation plan using the deferred compensation transmittal of deduction form or the approved electronic format.

History: Effective April 1, 1989; amended effective July 1, 2006; _____, 2013.

General Authority: NDCC 28-32-02, 54-52-03.2

Law Implemented: NDCC 54-52.2-02

Section 71-05-05-01 is amended as follows:

71-05-05-01. Normal and early retirement benefits - Application. Except as provided in section 71-05-05-02 for retirement options, applications for retirement, surviving spouse, and disability benefits must be filed at the public employees retirement system at least thirty days before normal or early retirement date or before the commencement of benefits. A member shall file a photocopy of the member's birth certificate and, if the member is married, a photocopy of the member's spouse's birth certificate and marriage certificate. A surviving spouse shall file a photocopy of the surviving spouse's birth certificate, deceased member's birth certificate, and marriage certificate for a benefit election under subsection 6 of North Dakota Century Code section 39-03.1-11. If a birth certificate is not available, a member or surviving spouse may submit other documentation based on policy and procedure adopted by the board.

History: Effective October 1, 1991; amended effective May 1, 2004; _____, 2013.

General Authority: NDCC 39-03.1-06

Law Implemented: NDCC 39-03.1-11

Section 71-07-01-01 is amended as follows:

71-07-01-01. Plan document. The board must prepare a plan document for the pretax benefits program. The plan document must meet applicable requirements of the Internal Revenue Code. The board must annually review ~~the~~ any plan document updates prior to the beginning of each new plan year if necessary due to changes in federal law.

Modifications must be made to reflect changes in the program and to maintain a qualifiable program pursuant to the Internal Revenue Code.

History: Effective April 1, 1992; amended effective _____, 2013.

General Authority: NDCC 54-52-04, 54-52.3-02

Law Implemented: NDCC 54-52.3-02