

# NDPERS BOARD MEETING

## Agenda

**Bismarck Location:**  
ND Association of Counties  
1661 Capitol Way  
**Fargo Location:**  
BCBS, 4510 13<sup>th</sup> Ave SW

**September 18, 2008**

**Time: 8:30 AM**

### **I. MINUTES**

- A. July 17, 2008
- B. August 26, 2008

### **II. RETIREMENT**

- A. Segal Presentation – (Information)

### **III. DEFERRED COMPENSATION**

- A. Workshops – Kathy (Information)
- B. Single Fund Initiative – Kathy (Information)

### **IV. MISCELLANEOUS**

- A. Board Election Petitions – Sparb (Information)
- B. Internal Audit Policy 101 – Audit Committee (Board Action)
- C. Audit Committee Minutes – (Information)
- D. SIB Agenda

### **V. GROUP INSURANCE**

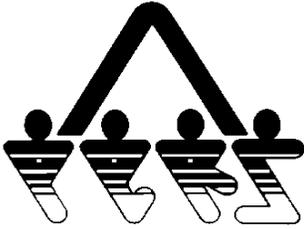
- A. BCBS
  - 1. Renewal Questions (Information)
  - 2. Plan Performance Overview & response (Information)
  - 3. Plan Design/Funding Priorities (Board Action)
  - 4. August Board Renewal Information (Information)
- B. Bid Document – RFP (Board Action)
- C. Medicare Part D Renewal – Sparb (Board Action)
- D. Industry, Business and Labor Pharmacy Study – Deb & Kathy (Information)
- E. Annual Flu Shot Clinic – Kathy (Information)

### **VI. EXECUTIVE SESSION**

- A. BCBS Renewal
- B. Appeal for Premium Underpayment– Sparb & Kathy (Board Action)

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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.



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# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** September 10, 2008  
**SUBJECT:** Segal Presentation

Cathie Eitelberg, Senior Vice-President and National Director for the Public Sector Market and Melanie Walker, JD and Vice President, will present at the next Board meeting via videoconference on national retirement issues. They will give you an update on developing legislation, the issue of financial economics and the recent position of the IRS on governmental plans.

The IRS has recently stated its intent to significantly increase audits of governmental pension plans. IRS officials have said they believe they have not dedicated the time and effort to the governmental plans area that its size and importance warrants, citing numerous press articles on plans in the governmental sector as the reason to increase enforcement (despite the fact that such press reports usually have nothing to do with federal tax code compliance nor would the select problems cited be benefited in any way by increased federal tax audits). Cathie and Melanie will review this and discuss its implication. Their prepared information will be sent to us on Friday, September 12, at which time we will forward onto Board members.

The financial economics issue is the ongoing discussion nationally about how to report public pension responsibilities. As discussed this would affect how we report our assets, our funding method and possibly our investment strategy. Cathie will review this in more detail and talk about how this could affect public sector plans. Also attached are two recent articles on this topic.

They will also address other issues and answer any questions you may have.

## **American Academy of Actuaries Public Interest Committee forum held Friday, September 4**

From [www.actuary.org](http://www.actuary.org):

The American Academy of Actuaries' Public Interest Committee held this public forum to hear views on the disclosure of market value of assets and liabilities for public pension plans.

The committee will use information obtained through this forum to determine whether a statement from the Academy's board of directors on the issue is in the public interest.

The AAA has posted oral and written statements submitted as part of this forum to its website, accessible here:

[http://www.actuary.org/events/2008/forum\\_statements.asp](http://www.actuary.org/events/2008/forum_statements.asp)

It is difficult to read the leanings, if any, most members of the committee already have on this issue, although one committee member nodded enthusiastically each time a point in favor of MVL disclosure was made, and asked more than one panelist, "What would be so bad about simply providing more information?" At one point, this committee member asked, "Is MVL disclosure like giving an infant a loaded gun?"

I am aware of two news reports submitted by reporters who were present at the forum; those reports are posted below. In my view, neither report fairly represented the reality of the event. Specifically, the Washington Post story includes references to bankruptcies or pending bankruptcies in Vallejo, California and Montgomery County, Alabama. These references are red herrings. These bankruptcies are not a result of pension plan funding problems and actuarial disclosures have little to nothing to do with these entities' fiscal problems.

Moreover, the Post story demonstrates a lack of understanding of the public pension funding condition and operating environment. It states:

Even with current accounting methods, state and local governments are increasingly struggling to keep up with the soaring cost of retirement promises, some pension analysts say. The number of public plans that are underfunded -- defined by the industry as not having enough money to meet 80 percent of future payouts -- soared to 40 percent in 2006, a five-fold increase from 2000

In fact, the cost of pension promises is not "soaring," for the community in general, although some pension plans do face increasing costs, and many entities face growing costs for retiree health care benefits. The Post story, in my view, misrepresents the overall condition and environment of public pensions, and nowhere acknowledges the argument, articulated by multiple forum panelists, that public pensions are fundamentally different than corporate pensions and that MVL is irrelevant to their operating environment.

The BNA reports that remarks by opponents of required MVL by public plans centered on the potential abandonment of pensions by the public sector that could result from such disclosure. In fact, comments from required MVL disclosure opponents centered on the inapplicability of this measure to the public pension operating and legal environment. *kb*

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## Washington Post Account of Actuarial Forum Revisions Considered for Valuations Of Public Pension Fund Payouts

David Cho Washington Post Friday, September 5, 2008; D02

The leading U.S. association of actuaries is considering a change to the way state and local officials value the cost of their pension promises, which could force governments to dramatically raise their contributions to their retirement plans.

The [American Academy of Actuaries](#) heard testimony yesterday on whether to revise accounting methods used by public pension funds that determine how much money they must invest now to meet their payments to workers in the future. Some economists said the current practices, which use optimistic assumptions that are not permitted in the private sector, allow public pensions to understate the cost of the future payouts.

The debate is being described by pension actuaries as a "family fight" within their close-knit community. But it has also sparked an uproar among pension fund managers and public officials around the country.

Several leading pension managers say the change could confuse governments and their constituents. And they accused the academy of being unduly influenced by big [Wall Street](#) firms, which stand to make money from offering services to pension funds if they change their accounting methods. William Bluhm, the academy's president, denied the charge.

Bluhm said an Academy board could issue new standards directing pension funds to modify their accounting methods, but municipalities could pass their own measures trumping the requirement. A second Academy board could make recommendations on the matter as soon as next month to the Governmental Accounting Standards Board, a federal body that sets voluntary standards that most public pension funds follow. GASB officials have been considering this issue since July.

Even with current accounting methods, state and local governments are increasingly struggling to keep up with the soaring cost of retirement promises, some pension analysts say. The number of public plans that are underfunded -- defined by the industry as not having enough money to meet 80 percent of future payouts -- soared to 40 percent in 2006, a five-fold increase from 2000, according to the [Government Accountability Office](#).

The trend has presented taxpayers with a bill that is eating up a vast portion of government budgets at the cost of other services. In [Montgomery County](#), pension and retiree health-care costs are already higher than the combined budgets for the departments of transportation and health and human services.

In May, the city of Vallejo, a suburb of San Francisco, became the largest city in California's history to declare bankruptcy after it was swamped by salary and pension costs. The city had agreed to pay rank-and-file police officers an average of \$122,000 before overtime while firefighters made an average of \$130,000. They also could retire at age 50, walking away with an annual pension equal to 90 percent of the pay in their final year.

Public pension funds generate money from worker contributions, government payments and the returns from investing that money. These funds pay an annual pension salary and health benefits

to retirees and often their spouses for as long as they live. As state and local entities, pension funds are not subject to federal oversight and have wide latitude in how they estimate the cost of their future obligations.

One of the most important assumptions they use in their calculations concerns the rate at which a fund makes money on its investments. The better these investments fare, the more flush the fund. If a government projects a high rate of return, there is less need to tap taxpayer money to finance a shortfall. Most assume their investments will earn 8 percent interest.

That is about twice the market-based rate that private firms are allowed to use under federal regulations. Economists and some actuaries say public pension funds should use these market rates, which they argue are more realistic gauges of long-term returns from risk-free investments such as 30-year Treasury bonds. The rate on the 30-year Treasury was a little higher than 4 percent yesterday.

Using such a risk-free market rate is a widely accepted practice that is "drilled into the head" of "every first-year MBA student," said David Wilcox, deputy director of the division of research and statistics at the [Federal Reserve](#), who testified before the Academy yesterday and who advocates the accounting change. "A market-based estimate provides the truest measure of the burden on taxpayers of providing the pension benefit in question."

Some Academy leaders say pension funds should disclose their future payouts using the two different interest rate assumptions. "I lean in the direction that if you give out information, that can't be a bad thing," said Bruce Schobel, an Academy board member.

But Christian Weller, a senior fellow at the [Center for American Progress](#), told the Academy panel that disclosing the two numbers would confuse workers. He said politicians who oppose government pensions might also try to exploit the difference in the numbers.

"I'm not sure why you should confuse things by even implying that you should be using a different system than the one you are using," added Nancy Kopp, Maryland's treasurer. "We are trying to be as straightforward and transparent as we can, and we also are trying to have a diversified portfolio to ensure we will be well funded so that taxpayers don't have to pay any more than they should."

Other pension managers noted that fund returns have historically averaged about 8 percent per year for the past two decades. And because they do not face the possibility of going out of business, unlike firms in the private sector, they should be allowed more leeway in their rate of return assumptions.

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## **BNA Account of Actuarial Forum Speakers Offer Opinions to Actuary Panel On Need for Market Value Liability Disclosure**

**BNA September 9, 2008**

During an impassioned debate Sept. 4 before a forum held by the Public Interest Committee of the American Academy of Actuaries, invited speakers argued whether or not the Academy should issue a formal statement supporting the disclosure of a calculation method that arguably better states a public pension plan's economic value.

Those supporting the disclosure of this calculation, known as market value liability (MVL), argued at the forum that the current method used by actuaries underestimates the true economic value of public plans to the detriment of future taxpayers. Those arguing against such disclosure warned that such a calculation would cause confusion and be misinterpreted by some and also would be intentionally misused by others with a political agenda that could ultimately endanger the use of defined benefit plans in the public sector.

Included among written comments to the committee was a petition signed by 175 pension actuaries agreeing that it was "not in the public interest for the Academy to advocate for disclosure of 'market value liability' measures by public pension plans."

### **Method Promoted by Financial Economists**

While actuaries traditionally determine a plan's funding target by projecting the future salary of plan participants and by applying a discount rate that accepts the fact that plans use risky investments such as equities and long-term bonds, some financial economists have argued that the plan's economic value is underestimated by using this method.

Consequently, these economists have urged actuaries to also disclose a calculated number that doesn't project the participants' future salaries and at the same time applies a "risk free rate of return," such as a rate of return offered by U.S. Treasury instruments.

The public interest committee invited the speakers to help it determine whether it was in the public interest for the Academy to issue a statement recommending that actuaries disclose the MVL. Such a statement could recommend that the MVL be disclosed either in a plan's financial report or in reports prepared by plan actuaries.

### **Statements in Support of Disclosure**

Michael Peskin, managing director of Morgan Stanley Investment Management, urged the Academy to issue a statement in support of MVL disclosure. He told the committee the failure to use an MVL calculation underestimates the cost of public pensions and transfers that cost to future taxpayers--"our kids."

In addition, he said use of the traditional "equity risk premium" calculation alone results in the public plan system giving more benefits to participants than they otherwise would receive and more benefits than taxpayers would want to pay. He said that while "we want to pay our public servants well, we don't want them to be overpaid."

In his written comments to the committee, Peskin said the "current methodology tends to significantly under-price pension promises (and has done so since the late 80's, early 90's.)" In addition, he wrote, "Many here today believe that what I am saying endangers the public defined benefit system. I see the choice as between an unsustainable [defined benefit plan] system versus an unsustainable [defined contribution plan] system and I am advocating a more disciplined approach that results in a sustainable public plan system."

Mark Ruloff, director of asset allocation with Watson Wyatt Investment Consulting, argued for MVL as a method for better disclosure of risks taken by plans. He told the committee that one problem with the traditional method used by actuaries is that it ignores the risk inherent in more aggressive investment strategies. He said MVL will help plans make better investment decisions by lowering investment risk.

Ruloff explained this further in his written comments: "The basic mathematics of the traditional approach may lead a plan sponsor to believe that lower funding with a more aggressive

investment strategy is expected to be as successful as a less aggressive one. Simply increasing the use of equities in the portfolio could immediately lead to plan sponsors thinking they have gone from an underfunded position to a fully funded position, or to a surplus position. However, if we take this argument to the extreme, like suggesting a 100 percent allocation to a single more aggressive asset class, you will hopefully start to have your doubts in this approach."

David Wilcox, deputy director with the Division of Research and Statistics at the Federal Reserve Board, also agreed that public plans should disclose a market-value based estimate of their liabilities because such an estimate "provides the truest measure of the burden on taxpayers of providing the pension benefit in question."

### **Opponents Cite Abandonment of Defined Benefit Plans**

Norman Jones, chief actuary, Gabriel Roeder, Smith & Co., told the committee that MVL could lead to the abandonment of public defined benefit plans. Disclosure of MVL could be "alarming" to public policymakers who are already feeling pressure to switch public employees to defined contribution plans, he said. Furthermore, Jones said there was no public need for such disclosure and that public plans strongly oppose the measure.

Ron Mulvihill, employee benefits specialist with the American Federation of State, County and Municipal Employees Union, told the committee that disclosure of MVL will add an additional level of complexity that can be "misconstrued or intentionally misused."

Karen Steffen, principal and consulting actuary, with Milliman Inc., agreed with Mulvihill. She asked how such disclosure was useful or relevant to the public? She said the "very term market liability bothers me," because there is no market for public plan liabilities. "No one will buy these assets," she said

Paul Angelo, senior vice president and actuary with the Segal Co., said the mere fact that most actuaries oppose such disclosure is reason enough that the Academy should not issue a statement supporting it.

Christian Weller, senior fellow, Center for American Progress, Washington, D.C., urged the committee not to "prepare a solution in search of a problem."

Robert North, chief actuary, New York City Office of the Actuary, said that although he has been disclosing MVL for a number of years, the problems warned by some of the measure's opponents have yet to materialize.

### **Committee to Mull Recommendation**

The committee was expected to meet the week of Sept. 8 to decide whether to issue a recommendation to the Academy, which is scheduled to meet in October. Alternatively, such disclosure may ultimately be required by either or both the Actuarial Standards Board and or the Governmental Accounting Standards Board.

It was also possible that the Academy could recommend that the MVL calculation be disclosed for private corporate-sponsored plans as well as for public plans.

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# Memorandum

**TO: NDPERS Board**

**FROM: Kathy**

**DATE: September 10, 2008**

**SUBJECT: Defined Contribution 401(a) & Deferred Compensation Companion Plan 457(b) Plans - Educational Workshops**

Fidelity will present a WebEx workshop on navigating its NetBenefits web site on September 29<sup>th</sup> and on October 2<sup>nd</sup> from 12:15 to 12:45 p.m. on both days. Also on September 29<sup>th</sup> there is a 7:00 p.m. presentation scheduled on asset allocation. Access for these sessions is from personal computers and phone and they are live interactive presentations. In addition, we have arranged for the following on-site visits in October:

October 15 – 2:00 pm to 5:00 pm  
October 16 – 8:00 am to 4:30 pm  
October 17 – 8:00 am to 11:30 pm

The above is for one-on-one consultations that will be conducted in the Lewis & Clark Room at the Capitol. Reservations must be made with Fidelity through its toll free call center number that will be provided on the announcement notices.



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# Memorandum

**TO:** NDPERS Board

**FROM:** Kathy & Sparb

**DATE:** September 10, 2008

**SUBJECT:** Defined Contribution 401(a) & Deferred Compensation Companion Plan 457(b) Plans - Single Fund Initiative

In August, Fidelity presented the Investment Subcommittee with a report outlining some strategic options and industry trends relative to management and administration of the above referenced plans. One of the items highlighted with regard to our plans was the number of single-investment option holders. Included for your information is a breakdown of this information by plan. It indicates that for the 401(a) defined contribution plan 56 participants or 6.9% are invested in only one fund. For the 457(b) Companion Plan 1,340 or 4.1% participate in only one investment fund.

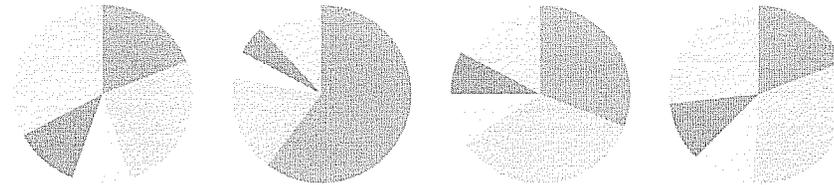
As part of its service, Fidelity suggested that we do a single fund campaign wherein all participants invested in one fund would receive a letter which discusses the advantages of diversification and provides information about the Freedom Funds as well as offers on-line and toll free services to assist participants with asset allocation decisions. A copy of the letter is included for your information.

We will be conducting this campaign in conjunction with National Save for Retirement Week which has been established as the week of October 19<sup>th</sup>. This is an annual initiative based on a resolution passed by Congress. It is for the purpose of furthering the goal of educating and urging employees, both public and private, to increase their savings for retirement.



# Single-Investment Option Holders

Information as of 6/30/2008



How many participants hold:	401a	457b	Industry peers*	Same-size peers*
1 Fund (Freedom Fund)	19.2%	60.3%	30.8%	19.1%
1 Fund (Non-Freedom Fund)	6.9%	4.1%	20.5%	17.1%
2 Funds	18.9%	13.5%	14.5%	14.8%
3 Funds	10.7%	5.0%	9.0%	11.4%
4 Funds	11.7%	5.3%	7.9%	10.9%
5 or more Funds	32.6%	11.8%	17.2%	26.7%
Average # of Funds Held	3.7 funds	2.1 funds	2.6 funds	3.4 funds

## Participants holding this fund

Funds held as a single investment	Asset class	401a	457b	Total
Fidelity <i>Puritan</i> ® Fund	Blended	1	27	28
Managed Income Portfolio	Stable Value	10	11	21
Fidelity Blue Chip Growth Fund	Domestic Equities	0	17	17
Spartan® U.S. Equity Index Fund	Domestic Equities	0	13	13
Fidelity Growth Company Fund	Domestic Equities	6	2	8
Fidelity Diversified International Fund	International/Global	1	6	7
Plus 8 other funds	-	2	15	17
Fidelity Freedom Funds	-	56	1,340	1,396

\*Please see "Important Legal Information" for important information regarding plan peer size and industry benchmarks.



Fidelity Confidential Information



September, 2008

Dear NDPERS Employee:

Our records show that your North Dakota Public Employees Retirement System Plan account is fully invested in only one investment option. Whether you are just getting started or you're nearing retirement, you may want to consider the benefits of diversifying your investments. Diversification means spreading your money among different investment options and having an asset allocation strategy—a mix of investment options that makes sense for your personal situation. Keep in mind though that neither diversification nor asset allocation ensures a profit or guarantees against loss.

Of course, any funds you choose should fit into your long-term investment strategy. Here are some resources to help you learn more about investing in your NDPERS 401(a) and 457(b) Plan.

Consider the **Fidelity Freedom Funds**.<sup>®</sup> Freedom funds offer a simple way to diversify your retirement account. The funds are designed for participants who want a simple yet diversified approach to investing. Simply choose the Freedom fund that corresponds to your current age. These funds are subject to the volatility of the financial markets in the United States and abroad, and may be subject to the additional risks associated with investing in high yield, small cap, and foreign securities. Please refer to the enclosed brochure for more information about the Freedom funds.

Try **Portfolio Review** from Fidelity. With Portfolio Review, Fidelity's streamlined investment planning tool, you get guidance to help you make decisions about all your investments, including your retirement plan portfolio. In as little as 10-15 minutes, Portfolio Review can help you answer questions such as:

- What is an appropriate asset allocation for me?
- How does my portfolio compare to this target asset allocation?
- What changes might I consider to help me achieve my target?

Try Portfolio Review from Fidelity today:

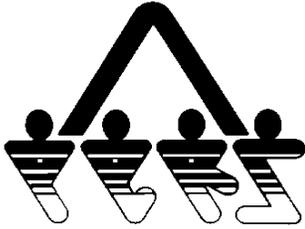
1. Log on to your Fidelity NetBenefits<sup>®</sup> account at [www.fidelity.com/atwork](http://www.fidelity.com/atwork)
2. Click on "Tools & Learning"
3. Select "Investing for the Future"

Still have questions? Call Fidelity toll free at **1-800-343-0860**, Monday–Friday 8 a.m. to midnight ET. Fidelity Retirement Services Specialists are available to help you take this important step and diversify your NDPERS 401(a) and 457(b) Plan.

***Before investing in any mutual fund, please carefully consider the investment objectives, risks, charges and expenses. For this and other information, call Fidelity at 1-800-343-0860 or visit [www.fidelity.com](http://www.fidelity.com) for a free prospectus. Read it carefully before you invest.***

Keep in mind, investing involves risk. The value of your investment will fluctuate over time and you may gain or lose money.

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# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** September 11, 2008  
**SUBJECT:** Board Elections Petition

Recently staff was asked by a member interested in running for a Board position if they could collect the required signatures before the announcement of the election in February. For example could they collect the signatures in October? Staff referred the issue to the election committee who reviewed the election rules of the Board. The committee sought the advice of legal counsel who concluded "I do not see anything in the rules that would prohibit this practice". Based upon this review, we are advising the member that they can collect signatures for an upcoming election before the formal announcement of the opening.



**NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM**  
**Internal Audit Division**  
**Office Memorandum**

TO: NDPERs Board

FROM: Jamie Kinsella

DATE: August 20, 2008

**SUBJECT: Internal Audit Policy 101**

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During the August Audit Committee meeting the committee reviewed revisions suggested by the Internal Auditor to Internal Audit Policy 101, Audit Committee Charter. Internal Audit proposed revising the policy to include compensation for all members of the audit committee for attendance at committee meetings, not just audit committee members who are board members.

We request that the NDPERs Board review this policy and provide their approval of this change. I have included for your reference the original policy, as well as the revised policy.

Those who attended the meeting are available to answer any questions you may have.

**Board Action Requested:** Approve the attached revised Policy #101.

INTERNAL AUDIT POLICY

PUBLIC EMPLOYEES RETIREMENT SYSTEM INTERNAL AUDIT POLICY	Policy No. 101
	Effective Date: 8/26/93
	Revised: <u>August 20, 2008</u>
Subject: Audit Committee Charter	Page 1 of 5

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**PURPOSE**

The audit committee is appointed by the board of directors of the agency to assist the board of directors in fulfilling its fiduciary oversight responsibilities for the (1) financial reporting process, (2) the system of risk management, (3) the system of internal controls, (4) the performance of the agency's internal audit process, (5) the external audit of the financial statements, (6) the engagements with other external audit firms, (7) the organization's processes for monitoring compliance with laws, regulations and the ethics policy, code of conduct and fraud policy, (8) the special investigations and whistleblower mechanism, and (9) the audit committee management and reporting responsibilities.

**STRUCTURE**

The audit committee will consist of two to five members with the majority of the members selected from the Board of Directors, and one may be selected from outside the organization. The Board or its nominating committee will appoint committee members and the committee chair. The Board should attempt to appoint committee members who are knowledgeable and experienced in financial matters, including the review of financial statements.

**MEETINGS**

The audit committee will meet as often as it determines is appropriate, but not less frequently than quarterly. All committee members are expected to attend each meeting, in person or via tele- or video-conference. The committee periodically will hold individual meetings with management, the internal auditor and the external auditor. The audit committee may invite any officer or employee of the agency, the external auditor, the agency's outside counsel, or others to attend meetings and provide pertinent information. Meeting agendas will be prepared by the Chief Audit Executive and provided in advance to members, along with appropriate briefing materials. Minutes will be kept by a member of the audit committee or a person designated by the audit committee. Members of the audit committee will be compensated for attendance at committee meetings in accordance with NDPERS' policy for compensation in effect at the time for Board members. Audit Committee members who are not PERS board members will be compensated at the same rate.

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**AUTHORITY**

The audit committee has authority to conduct or authorize examinations into any matters within its scope of responsibility for the following functions:

- 1) Financial Reporting,
- 2) System of Risk Management,
- 3) System of Internal Control,
- 4) Internal Audit,
- 5) External Audit of the Financial Statements,
- 6) Engagements with Other External Audit Firms,
- 7) Monitoring Compliance with Laws and Regulations and the Ethics Policy, Code of Conduct and Fraud Policy,
- 8) Special Investigations and Whistleblower Process, and
- 9) Audit Committee Management and Reporting Responsibilities

## INTERNAL AUDIT POLICY

PUBLIC EMPLOYEES RETIREMENT SYSTEM INTERNAL AUDIT POLICY	Policy No. 101
	Effective Date: 8/26/93
	Revised: <del>August 20, 2008</del>
Subject: Audit Committee Charter	Page 2 of 5

Deleted: 6/29/06

### RESPONSIBILITIES

The audit committee will carry out the following responsibilities:

#### 1) Financial Reporting:

- a. Obtain information and/or training to enhance the committee members' expertise in financial reporting standards and processes so that the committee may adequately oversee financial reporting.
- b. Review significant accounting and reporting issues, including complex or unusual transactions and highly judgmental areas, and recent professional and regulatory pronouncements, and understand their impact on the financial statements.
- c. Review with management, the external auditors, and the internal auditors the results of the audit, including any difficulties encountered.
- d. Review all significant adjustments proposed by the external financial statement auditor and by the internal auditor.
- e. Review all significant suggestions for improved financial reporting made by the external financial statement auditor and by the internal auditor.
- f. Review with the General Counsel the status of legal matters that may have an effect on the financial statements.
- g. Review the annual financial statements, and consider whether they are complete, consistent with information known to committee members, and reflect appropriate accounting principles.
- h. Review with management the external auditors all matters required to be communicated to the committee under generally accepted auditing *Standards*.
- i. Understand how management develops interim financial information, and the nature and extent of internal and external auditor involvement.
- j. Review the statement of management responsibility for and the assessment of the effectiveness of the internal control structure and procedures of the organization for financial reporting. Review the attestation on this management assertion by the financial statement auditor as part of the financial statement audit engagement.

#### 2) System of Risk Management

- a. Obtain information about, training in and an understanding of risk management in order to acquire the knowledge necessary to adequately oversee the risk management process.
- b. Periodically review that the organization has a comprehensive policy on risk management.
- c. Consider the effectiveness of the organization's risk management system, including risks of information technology systems.
- d. Consider the risks of business relationships with significant vendors and consultants.
- e. Reviews management's reports on management's self-assessment of risks and the mitigations of these risks.
- f. Understand the scope of internal auditor's and external auditor's review of risk management over financial reporting.
- g. Understand the scope of internal auditor's review of risk management over all other processes, and obtain reports on significant findings and recommendations, together with management's responses.
- h. Understand the scope of any other external auditor's or consultant's review of risk management.

- i. Hire outside experts and consultants in risk management as necessary subject to full board approval.

### 3) System of Internal Control

- a. Obtain information about, training in and an understanding of internal control in order to acquire the knowledge necessary to adequately oversee the internal control process.
- b. Ensure that the organization has a comprehensive policy on internal control and compliance.
- c. Review periodically the policy on ethics, code of conduct and fraud policy.
- d. Consider the effectiveness of the organization's internal control system, including information technology security and control.
- e. Consider any internal controls required because of business relationships with significant vendors and consultants.
- f. Understand the scope of internal auditor's and external auditor's review of internal control over financial reporting, and obtain reports on significant findings and recommendations, together with management's responses.
- g. Understand the scope of internal auditor's review of internal control over all other processes, and obtain reports on significant findings and recommendations, together with management's responses.
- h. Review the role of the internal auditor's involvement in the corporate governance process, including corporate governance documentation and training.
- i. Periodically review that contracts with external service providers contain appropriate record-keeping and audit language.

### 4) Internal Audit

- a. Obtain the information and training needed to enhance the committee members' understanding of the role of internal audits so that the committee may adequately oversee the internal audit function.
- b. Oversee the selection process for the Chief Audit Executive.
- c. Assure and maintain, through the organizational structure of the organization and by other means, the independence of the internal audit process.
- d. Review any difficulties encountered in the course of audit work, including any restrictions on the scope of activities or access to required information
- e. Review with management and the Chief Audit Executive the charter, objectives, plans, activities, staffing, budget, qualifications, and organizational structure of the internal audit function.
- f. Receive and review all internal audit reports and management letters.
- g. Review the responsiveness and timeliness of management's follow-up activities pertaining to any reported findings and recommendations.
- h. Receive periodic notices of advisory and consulting activities by internal auditors.
- i. Review and concur in the appointment, replacement, or dismissal of the Chief Audit Executive.
- j. Review the performance of the Chief Audit Executive periodically.
- k. Review the effectiveness of the internal audit function, including compliance with The Institute of Internal Auditors' *Standards for the Professional Practice of Internal Auditing*.
- l. On a regular basis, meet separately with the Chief Audit Executive to discuss any matters that the committee or internal audit believes should be discussed privately (subject to open meeting laws).
- m. Designate the Chief Audit Executive as the lead coordinator for handling all matters related to audits, examinations, investigations or inquiries of the State Auditor and other appropriate State or Federal agencies.

**5) External Audit of the Financial Statements**

- a. Obtain the information and training needed to enhance the committee members' understanding of the purpose of the financial statements audit and the role of external financial statement auditor so that the committee may adequately oversee the financial statement audit function.
- b. Review the external auditor's proposed audit scope and approach, including coordination of audit effort with internal audit.
- c. Review the performance of the external financial statement audit firm, and review the State Auditor's recommendation for the final approval on the request for proposal for, and the appointment, retention or discharge of the audit firm. Obtain input from the Chief Audit Executive, management and other parties as appropriate.
- d. Review the independence of the external financial statement audit firm by obtaining statements from the auditors on relationships between the audit firm and the organization, including any non-audit services, and discussing these relationships with the audit firm. Obtain from management a listing of all services provided by the external audit firm. Obtain information from the Chief Audit Executive and other sources as necessary.
- e. Review the audited financial statements, associated management letter, attestation on the effectiveness of the internal control structure and procedures for financial reporting, other required auditor communications, and all other auditor reports and communications relating to the financial statements.
- f. Review all other reports and communications made by the external financial statement auditor.
- g. Review the responsiveness and timeliness of management's follow-up activities pertaining to any reported findings and recommendations.
- h. On a regular basis, meet separately with the external financial statement audit firm to discuss any matters that the committee or auditors believe should be discussed privately (subject to open meeting laws).
- i. Provide guidelines and mechanisms so that no member of the audit committee or organization staff shall improperly influence the auditors or the firm engaged to perform audit services.
- j. Periodically review a report of all costs of and payments to the external financial statement auditor. The listing should separately disclose the costs of the financial statement audit, other attest projects, agreed-upon-procedures and any non-audit services provided.

**6) Engagements with Other External Audit Firms**

- a. Obtain the information and training needed to enhance the committee members' understanding of the role of the other external audit firm(s) so that the committee may adequately oversee their function(s).
- b. Confirm coordination of efficient and effective audit activities between the internal and external auditors.
- c. Review the performance of the other external audit firm(s),
- d. Review the scope all services to be performed by the other external auditor.
- e. Review the reports of the audits and/or agreed-upon-procedures.
- f. Provide a forum for follow up of findings from the audit reports or agreed-upon-procedures.
- g. Meet separately with the other external audit firm(s) on a regular basis to discuss any matters that the committee or staff of the audit firm(s) believes should be discussed
- h. Review a report of all costs of and payments to other external audit firm(s). The listing should separately disclose the costs of any audit, other attest projects, agreed-upon-procedures and any non-audit services provided.

**7) Monitoring Compliance**

- a. Review the effectiveness of the system for monitoring compliance with laws and regulations and the results of management's investigation and follow-up (including disciplinary action) of any instances of noncompliance.
- b. Review the findings of any examinations by regulatory agencies, and any auditor observations, including investigations of misconduct and fraud.
- c. Review the process for communicating to all affected parties the ethics policy, code of conduct and fraud policy to organization personnel, and for monitoring compliance therewith.
- d. Obtain regular updates from management and organization legal counsel regarding compliance matters.
- e. Monitor changes and proposed changes in laws, regulations and rules affecting the organization.

**8) Special Investigations and Whistleblower Process**

- a. Institute and oversee special investigations as needed.
- b. Provide an appropriate confidential mechanism for whistleblowers to provide information on potentially fraudulent financial reporting or breaches of internal control to the audit committee.

**9) Audit Committee Management and Reporting Responsibilities**

- a. Regularly report to the Board of Directors about all committee activities, issues, and related recommendations.
- b. Perform other activities related to this charter as requested by the Board of Directors, and report to the Board
- c. Provide an open avenue of communication between internal audit, the external financial statement auditors, other external auditors, management and the Board of Directors.
- d. Review any other reports that the organization issues that relates to audit committee responsibilities.
- e. Confirm annually that all responsibilities outlined in this charter have been carried out. Report annually to the Board, members, retirees and beneficiaries, describing the committee's composition, responsibilities and how they were discharged, and any other information required by rule, including approval of non-audit services.
- f. Review and assess the adequacy of the committee charter periodically, requesting Board approval for proposed changes, and ensure appropriate disclosure as may be required by law or regulation.

Submitted by: Jamie Kinsella

Approved by: NDPERS Board June 29, 2006

## INTERNAL AUDIT POLICY

PUBLIC EMPLOYEES RETIREMENT SYSTEM INTERNAL AUDIT POLICY	Policy No. 101
	Effective Date: 8/26/93
	Revised: 5/17/05
Subject: Audit Committee Charter	Page 1 of 5

### PURPOSE

The audit committee is appointed by the board of directors of the agency to assist the board of directors in fulfilling its fiduciary oversight responsibilities for the (1) financial reporting process, (2) the system of risk management, (3) the system of internal controls, (4) the performance of the agency's internal audit process, (5) the external audit of the financial statements, (6) the engagements with other external audit firms, (7) the organization's processes for monitoring compliance with laws, regulations and the ethics policy, code of conduct and fraud policy, (8) the special investigations and whistleblower mechanism, and (9) the audit committee management and reporting responsibilities.

### STRUCTURE

The audit committee will consist of at least two and no more than three members of the Board of Directors. The Board or its nominating committee will appoint committee members and the committee chair. The Board should attempt to appoint committee members who are knowledgeable and experienced in financial matters, including the review of financial statements.

### MEETINGS

The audit committee will meet as often as it determines is appropriate, but not less frequently than quarterly. All committee members are expected to attend each meeting, in person or via tele- or video-conference. The committee periodically will hold individual meetings with management, the internal auditor and the external auditor. The audit committee may invite any officer or employee of the agency, the external auditor, the agency's outside counsel, or others to attend meetings and provide pertinent information. Meeting agendas will be prepared by the Chief Audit Executive and provided in advance to members, along with appropriate briefing materials. Minutes will be kept by a member of the audit committee or a person designated by the audit committee.

### AUTHORITY

The audit committee has authority to conduct or authorize examinations into any matters within its scope of responsibility for the following functions:

- 1) Financial Reporting,
- 2) System of Risk Management,
- 3) System of Internal Control,
- 4) Internal Audit,
- 5) External Audit of the Financial Statements,
- 6) Engagements with Other External Audit Firms,
- 7) Monitoring Compliance with Laws and Regulations and the Ethics Policy, Code of Conduct and Fraud Policy,
- 8) Special Investigations and Whistleblower Process, and
- 9) Audit Committee Management and Reporting Responsibilities

## RESPONSIBILITIES

The audit committee will carry out the following responsibilities:

### 1) Financial Reporting:

- a. Obtain information and/or training to enhance the committee members' expertise in financial reporting standards and processes so that the committee may adequately oversee financial reporting.
- b. Review significant accounting and reporting issues, including complex or unusual transactions and highly judgmental areas, and recent professional and regulatory pronouncements, and understand their impact on the financial statements.
- c. Review with management, the external auditors, and the internal auditors the results of the audit, including any difficulties encountered.
- d. Review all significant adjustments proposed by the external financial statement auditor and by the internal auditor.
- e. Review all significant suggestions for improved financial reporting made by the external financial statement auditor and by the internal auditor.
- f. Review with the General Counsel the status of legal matters that may have an effect on the financial statements.
- g. Review the annual financial statements, and consider whether they are complete, consistent with information known to committee members, and reflect appropriate accounting principles.
- h. Review with management the external auditors all matters required to be communicated to the committee under generally accepted auditing *Standards*.
- i. Understand how management develops interim financial information, and the nature and extent of internal and external auditor involvement.
- j. Review the statement of management responsibility for and the assessment of the effectiveness of the internal control structure and procedures of the organization for financial reporting. Review the attestation on this management assertion by the financial statement auditor as part of the financial statement audit engagement.

### 2) System of Risk Management

- a. Obtain information about, training in and an understanding of risk management in order to acquire the knowledge necessary to adequately oversee the risk management process.
- b. Periodically review that the organization has a comprehensive policy on risk management.
- c. Consider the effectiveness of the organization's risk management system, including risks of information technology systems.
- d. Consider the risks of business relationships with significant vendors and consultants.
- e. Reviews management's reports on management's self-assessment of risks and the mitigations of these risks.
- f. Understand the scope of internal auditor's and external auditor's review of risk management over financial reporting.
- g. Understand the scope of internal auditor's review of risk management over all other processes, and obtain reports on significant findings and recommendations, together with management's responses.
- h. Understand the scope of any other external auditor's or consultant's review of risk management.
- i. Hire outside experts and consultants in risk management as necessary subject to full board approval.

### 3) System of Internal Control

- a. Obtain information about, training in and an understanding of internal control in order to acquire the knowledge necessary to adequately oversee the internal control process.
- b. Ensure that the organization has a comprehensive policy on internal control and compliance.

- c. Review periodically the policy on ethics, code of conduct and fraud policy.
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- h. Review the role of the internal auditor's involvement in the corporate governance process, including corporate governance documentation and training.
- i. Periodically review that contracts with external service providers contain appropriate record-keeping and audit language.

#### **4) Internal Audit**

- a. Obtain the information and training needed to enhance the committee members' understanding of the role of internal audits so that the committee may adequately oversee the internal audit function.
- b. Oversee the selection process for the Chief Audit Executive.
- c. Assure and maintain, through the organizational structure of the organization and by other means, the independence of the internal audit process.
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- h. Receive periodic notices of advisory and consulting activities by internal auditors.
- i. Review and concur in the appointment, replacement, or dismissal of the Chief Audit Executive.
- j. Review the performance of the Chief Audit Executive periodically.
- k. Review the effectiveness of the internal audit function, including compliance with The Institute of Internal Auditors' *Standards for the Professional Practice of Internal Auditing*.
- l. On a regular basis, meet separately with the Chief Audit Executive to discuss any matters that the committee or internal audit believes should be discussed privately (subject to open meeting laws).
- m. Designate the Chief Audit Executive as the lead coordinator for handling all matters related to audits, examinations, investigations or inquiries of the State Auditor and other appropriate State or Federal agencies.

#### **5) External Audit of the Financial Statements**

- a. Obtain the information and training needed to enhance the committee members' understanding of the purpose of the financial statements audit and the role of external financial statement auditor so that the committee may adequately oversee the financial statement audit function.
- b. Review the external auditor's proposed audit scope and approach, including coordination of audit effort with internal audit.
- c. Review the performance of the external financial statement audit firm, and review the State Auditor's recommendation for the final approval on the request for proposal for, and the appointment, retention or discharge of the audit firm. Obtain input from the Chief Audit Executive, management and other parties as appropriate.

- d. Review the independence of the external financial statement audit firm by obtaining statements from the auditors on relationships between the audit firm and the organization, including any non-audit services, and discussing these relationships with the audit firm. Obtain from management a listing of all services provided by the external audit firm. Obtain information from the Chief Audit Executive and other sources as necessary.
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- c. Review the performance of the other external audit firm(s),
- d. Review the scope all services to be performed by the other external auditor.
- e. Review the reports of the audits and/or agreed-upon-procedures.
- f. Provide a forum for follow up of findings from the audit reports or agreed-upon-procedures.
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- a. Review the effectiveness of the system for monitoring compliance with laws and regulations and the results of management's investigation and follow-up (including disciplinary action) of any instances of noncompliance.
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- c. Review the process for communicating to all affected parties the ethics policy, code of conduct and fraud policy to organization personnel, and for monitoring compliance therewith.
- d. Obtain regular updates from management and organization legal counsel regarding compliance matters.
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- a. Institute and oversee special investigations as needed.
- b. Provide an appropriate confidential mechanism for whistleblowers to provide information on potentially fraudulent financial reporting or breaches of internal control to the audit committee.

**9) Audit Committee Management and Reporting Responsibilities**

- a. Regularly report to the Board of Directors about all committee activities, issues, and related recommendations.
- b. Perform other activities related to this charter as requested by the Board of Directors, and report to the Board
- c. Provide an open avenue of communication between internal audit, the external financial statement auditors, other external auditors, management and the Board of Directors.
- d. Review any other reports that the organization issues that relates to audit committee responsibilities.
- e. Confirm annually that all responsibilities outlined in this charter have been carried out. Report annually to the Board, members, retirees and beneficiaries, describing the committee's composition, responsibilities and how they were discharged, and any other information required by rule, including approval of non-audit services.
- f. Review and assess the adequacy of the committee charter periodically, requesting Board approval for proposed changes, and ensure appropriate disclosure as may be required by law or regulation.

Submitted by: Jamie Kinsella

Approved by: NDPERS Audit Committee

Date: May 17, 2005

## MEMORANDUM

**TO:** Audit Committee  
Jon Strinden  
Ron Leingang

**FROM:** Jamie Kinsella, Internal Auditor

**DATE:** September 12, 2008

**SUBJECT:** **May 21, 2008 Audit Committee Meeting**

In Attendance:

Jon Strinden, via conference call  
Ron Leingang  
Rebecca Dorwart  
Jamie Kinsella  
Sparb Collins  
Leon Heick  
Kathy Allen  
Bryan Reinhardt  
Carole Kessel, ND Insurance Department  
Rebecca Ternes, ND Insurance Department

The meeting was called to order at 10:00 a.m.

**I. February 20, 2008 Audit Committee Minutes**

The audit committee minutes were examined and approved by the Audit Committee.

**II. Internal Audit Quarterly Report**

- A. Internal Audit Quarterly Report – The Internal Audit quarterly report listed all of the projects that are in active status as of April 30 2008. Ms. Kinsella reviewed with the audit committee a project staff is working on regarding final average salary. This has an impact on benefits and the retirement fund. Also, with the PERSLink project, salaries will need to be corrected before the data conversion is done.

Quarterly Audit Recommendation Status Report – As stated in the Audit Policy #103, the Internal Audit Division is to report quarterly to management and the audit committee the status of the audit recommendations of the external auditors, as well as any found by the internal auditor.

During the past year efforts have been made to ensure that management continues to work on these recommendations. As part of this process, staff reviews these recommendations and their progress at the quarterly Loss Control

Committee meetings. Ms. Kinsella reported that in the past quarter there were four recommendations completed, progress made on three, and no change for 8 of the recommendations. The audit committee expressed their appreciation to staff for making progress with the recommendations.

### III. Administrative

- A. Request for Quality Assurance Review – Included with the audit committee materials was the memo from the February 2008 meeting regarding the Quality Assurance Review. During the discussion the audit committee requested that staff inquire with the external auditor whether having a quality assurance review would have an impact on their reliance on the Internal Audit's work.

The response received from Mr. Pat Brown, Brandy Martz & Associates was: "If a Quality Assurance Review was performed, we would still need to perform the above procedures (selecting a sample of Internal Audit's sample and testing to determine level of reliance) to determine our reliance on the specific tests that were performed by the internal audit that were relevant to our audit."

Staff recommended audit committee action to:

1. Make final decision whether to have a Quality Assurance Review.
2. If we have a review, determine the method of Quality Assurance Review:
  - a. Full external review
  - b. Internal self-assessment with external validation.

The audit committee approved having a Quality Assurance Review done through an internal self-assessment with external validation. Ms. Kinsella indicated she will report back at the August meeting when this will be conducted.

- B. Audit Committee Meeting Date & Time – The August audit committee meeting is scheduled for August 20, 2008 at 10:30 am.
- C. Internal Audit Charter Review Matrix– Staff provided the audit committee with the results of the Audit Committee Charter Review matrix in November 2007 and the subsequent actions in February. There were two issues still outstanding as of the February meeting.

Item #10 discussed risk assessment policy. The second bullet stated that the audit committee will: "Periodically review that the organization has a comprehensive policy on risk management".

Ms. Kinsella met with Mr. Collins and Ms. Knudsen and indicated staff will be providing the audit committee with a quarterly report on the minutes of the loss control meetings and annually Ms. Knudsen will come to the audit committee to do a report on the activities of the loss control committee.

Item #13 discussed the audit committee's understanding of the purpose of the financial statements audit..." The ninth bullet stated the Audit Committee

“Provide guidelines and mechanisms so that no member of the Audit Committee or organization staff shall improperly influence the auditors or the firm engaged to perform audit services.

There is a statement in the contract between the State Auditor’s office and Brady Martz that addresses conflict of interest. In addition, Ms. Kinsella reviewed the Internal Audit policies and found one that discusses independence. The Internal Audit Division has not been in compliance with this policy. A review of the standards provided direction on how best to handle the independence issue. There is a planning memo as part of the audit workpapers that addresses several items as part of the planning process. It is the appropriate place to place this issue as another step for staff to review as part of the planning process for each audit. Ms. Kinsella conveyed a worksheet was included so the audit committee could see where staff will address independence for each audit done.

With the change to the planning workpaper to include the independence review, staff revised the Internal Audit Policy #104 which was included with the audit committee materials. Ms. Kinsella felt that the policy is best to be a general statement, whereby the planning memo is the conduit to ensure the independence issue is reviewed.

Staff recommended the following:

- 1) Approve the recommended changes to the Internal Audit Policy #104.
- 2) Approve bringing the revised Policy #104 before the Board of Directors for their approval at the next board meeting.

By general consensus the audit committee approved staff’s recommendation.

- D. Audit Committee Charter Revision – Included with the audit committee minutes was a draft of the Audit Committee Charter. Ms. Kinsella conveyed staff entered a change that is proposed for the audit committee’s consideration and approval. Discussion followed. Staff will change the wording to “in accordance with NDPERS policy for compensation in effect at that time” and bring to the August meeting for approval.
- E. Annual Performance Evaluation – The annual performance evaluation has been completed. The evaluation form was signed and returned on May 13, 2008.
- E. Confidential Meeting between Internal Audit and Audit Committee - The meeting between the audit committee and the internal audit division is scheduled to take place in February of each year. The meeting was conducted at the end of the meeting.

#### **IV. Miscellaneous**

- A. Pharmacy Benefits Manager (PBM) Project – Ms. Rebecca Ternes and Ms. Carole Kessel, ND Insurance Department, presented the process the ND Insurance Department uses to review pharmacy benefits rebates. BCBS had

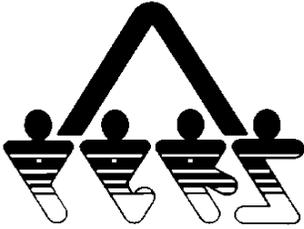
alerted PERS of the following:

“In the PBM law passed in 2005 (HB 1332), there is a provision that specifically gives the Insurance Department the authority to audit the insurance company to ensure that “the payment received by the pharmacy benefits manager which the covered entity (insurance company) received from the pharmacy benefits manager has been applied toward reducing the covered entity’s rates or has been distributed to covered individuals.” (NDCC 26.1-27.1-06 (1)) In addition, there is a requirement that each insurer must report annually all of these payments (rebate, etc.) to the insurance department.

In addition, a letter from BCBS was included in the audit committee materials. Mr. Collins, Mr. Reinhartdt, Ms. Allen and Mr. Heick participated in a conference call on May 5, 2008 relating to the PBM audit. The letter from BCBS summarizes the outcome of that meeting. Ms. Kinsella conveyed many of the issues have been resolved which means staff can move forward. Staff recommended the development of a request for proposal (RFP) and also proposed requesting if GBS could provide assistance in this effort. Discussion followed. Mr. Collins felt if an RFP was done staff could determine the cost of the audit versus the PBM rebates received and from there determine how to proceed. By general consensus, the audit committee recommended staff issue a request for request for proposal (RFP) from a third party vendor to conduct an audit on the pharmacy benefits manager.

- B. PERSLink Quarterly Report – Included with the audit committee minutes was the PERSLink quarterly status report. Mr. Collins informed the audit committee that ITD is looking for positive project messages and requested PERS staff to present the status of the PERSLink project. ITD felt that PERS has done a great job in managing and controlling our project with success and it continues to do so in the implementation phase. Staff will be presenting its report to the IT Committee on June 5.
- C. Report on Consultant Fees - According to the Audit Committee Charter, the audit committee should “Periodically review a report of all costs of and payments to the external financial statement auditor. The listing should separately disclose the costs of the financial statement audit, other attest projects, agreed-upon-procedures and any non-audit services provided.” Included with the audit committee materials was a copy of the report showing the consulting, investment and administrative fees paid during the quarter ended March 31, 2008.
- D. Publications – Included with the audit committee materials were publications and/or articles from the Institute of Internal Auditors.

The meeting adjourned at 11:20 a.m.



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**Sparb Collins**  
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# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** September 11, 2008  
**SUBJECT:** BCBS Renewal

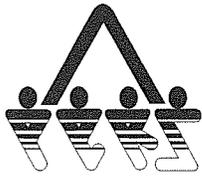
At this meeting will continue our discussion of the BCBS renewal. You will note the agenda and material is broken down into 4 sections.

Section 1 is a letter that was sent to BCBS with additional questions about the renewal since the last meeting.

Section 2 of the agenda (please note there is not Board material since BCBS will bring it directly to the meeting) is the presentation from BCBS on the plan performance and why plan costs have increased as dramatically as they have over the last several years. The second part of this conversation relates to their answers to questions posed in section 1.

Section 3 is a memo relating to the plan design/funding options that we developed and the cost as projected by BCBS. Also identified are some funding options. Since we will be forwarded these options on the Governor and Legislature we need to prioritize them for their consideration.

Section 4 is the Board material from the last meeting for your reference.



September 5, 2008

Kevin Schoenborn  
 Consulting Services Unit  
 BCBSND  
 4510 13<sup>th</sup> Avenue SW  
 Fargo, ND 58121

Thank you for your response to our previous letter. The following is some additional questions.

**Administrative Costs**

1. You state that our administrative charge is lower than others and you cite the OPM contract. However, you did not acknowledge the information in the August 13 letter indicating:
  - a. PERS administers the COBRA provisions and that is not a part of the responsibilities of BCBS.
  - b. PERS does all the billings to the employer groups, COBRA participants, and the 6,000 or so retirees which is not part of the BCBS responsibilities.
  - c. PERS is making a substantial investment in its business system during the next biennium which will increase the efficiency of our interfaces and further reduce the BCBS administrative burden.

Please discuss how this is adjusted in figuring your administrative costs. What would BCBS or its subsidiary charge for COBRA administration? What would you or your subsidiary charge a client to do billings only for a group our size? We would note that the OPM contract is \$33 and ours is \$29.90 with PERS investing the resources to administer and maintain the items listed above. Would you or your subsidiaries charge less than \$3.10 for the above services? Also, is the OPM rate a national rate?

2. BCBS changed its method for determining administrative costs from your last renewal to this one. In the last renewal you set it independently as 10% even though premiums were inflating at a much higher rate. This time you set it at a percentage of premiums. Why the change? We note that such a change works to your advantage in high inflation periods. What if in the next renewal rates went down 10%, would your administration expenses go down or would you change the methodology again?

3. We note that in your response you did not answer the following questions:
  - a. What are BCBS business goals relating to administrative/retention expenses with PERS? Specifically what is the level of administrative fees that BCBS is trying to reach for the PERS business?
  - b. What is the timeframe allocated to achieving this goal?
  - c. What were the specific considerations of BCBS in establishing this policy goal for PERS?
  
4. Is there any relationship between your 21% increase in administrative costs and your cost of doing business? You stated several times during your presentation that the BCBS Board endorsed a 21% increase in BCBS administrative costs for the next two years even though PERS has granted a 242% increase since 1999. What is their justification for such a dramatic increase or would it be more appropriate for PERS to refer that question to the Board for an answer?
  
5. You did not comment on our concern with your administrative fee methodology that rewards you with higher administration fees and profits when premium increases are high. Please discuss why you think this method provides a proper incentive for BCBS to control PERS health care costs.
  
6. Would PERS see any increase in services as a result of this increase?
  
7. It is our understanding from your response that the following is your rationale for the 20% administration increase for 2009-2011 biennium. Please indicate if this is correct or supplement it as you feel appropriate (please note the importance of this explanation since it will be compared with our consultants in the Board's review so please make sure it fully represents your reasoning):

### BCBS

- In developing administrative expense charges for its customers, BCBSND must both cover its internal cost structure and also distribute these costs equitably among the company's various accounts and lines of business.
- In 2007 the company's overall administrative expenses were 7.4% of overall net income, slightly below the company's average between 1998 and 2007 of 7.8%. It should be noted these expense levels, and their dollar per contract equivalents, are among the lowest in the industry. When recently ranked with 14 other Blue Cross and Blue Shield organizations in the western United States, the BCBSND expense level is second lowest as dollars PMPM and third lowest as percent of gross revenue.
- During the ten year period referenced above NDPERS accounted for 13.4% of the company's overall revenue. The administrative charges paid by NDPERS covered only 7.3% of BCBSND's administrative expenses in the same period.
- The NDPERS administrative expense charge of \$28.00 PCPM was developed as 4.00% of the average renewal premium. This is approximately the same level used by BCBSND in each of the last four renewals. This level is reflective of both the magnitude of the NDPERS account and its marginal contribution to BCBSND's cost structure. At 4.00% of premium, this charge is lower than that of any other account or product that BCBSND administers. If NDPERS reduces benefits for the 2009 through 2011 biennium, BCBSND will re-calculate the administrative charge as 4.00% of the resulting premium.
- For comparison, the federal government's Office of Personnel Management (OPM) contracts with the Blue Cross & Blue Shield Association to provide health insurance benefits to more than half of all federal employees enrolled in the Federal Employee Health Benefit Program (FEHBP). This insurance contract is approximately 100 times the size of the NDPERS program and was rated in 2007 with a 4.8% administrative expense loading, or approximately \$33 ppm. Note that this dollar amount will increase when rated in 2010, the midpoint of the NDPERS 2009-2011 biennium.
- In September 2006 the National Association of State Personnel Executives (NASPE) Healthcare Taskforce published a white paper entitled "State Government Employee Healthcare Benefits" which stated "Administrative costs...impact...about 5 to 8 percent of overall self-funded healthcare budgets". This report can be found at [www.naspe.net](http://www.naspe.net). The BCBSND charge of 4.00% is below this range.
- As a final and conclusive demonstration of the value provided by BCBSND to NDPERS, please see the attached exhibit "NDPERS Financial Experience: Five Biennial renewals Ending 6/30/09". Total NDPERS premium dollars retained by BCBSND over the 10 years ending 6/30/09, including underwriting gains and losses, and settlement payments, is expected to be 4.2% of gross premium.
- With a total retention equal to 4.2% of premium BCBSND has administered the NDPERS account with exceptional service, accepted the associated underwriting risk, and funded necessary contributions to surplus. We do not believe that any carrier or benefit administrator can compete with the corresponding 10 year average loss ratio of 95.8%, or the 94.8% loss ratio expected in the rating of the 2009-2011 biennium.

### Risk/Service Charge

1. Please discuss your philosophy about the risk charge. It seems in your discussions that BCBS feels this amount should be treated as profit or that claims should never be at a level that would utilize any of these dollars.
2. Please identify how much PERS has paid in risk charges since 1999 and has BCBS ever had to draw upon this balance? If so for what amount?
3. On average do we have better or worse performance than your other clients?

**2007-2009 Biennium and Trend**

1. You stated the 2007-2009 biennium will produce a loss. Please discuss this in more detail. As you are aware, our projections do not indicate a loss of anywhere near the magnitude you are suggesting.
2. What if the trend for the remainder of this biennium is 10% or 9% instead of the 11% you are projecting? What would be the state rate for 2009-2011 at these levels?
3. In February when you do the reprojection, are you planning to reduce your trend from 11% in the first couple of months and 10% for the last 24 months to lower levels if emerging experience justifies it? What would justify this change or any change?
4. It is our understanding from your response that the following is your rationale for the trend used for the remaining months of this biennium. Please indicate if this is correct or supplement it as you feel appropriate (please note the importance of this explanation since it will be compared with our consultants in the Board's review so please make sure it fully represents your reasoning):

BCBS
<ul style="list-style-type: none"><li>• The resulting 29.5% increase for active employees (13.8% annual increase over two years) is due to the inadequacy of current rates with respect to current claims experience.</li></ul>

Please provide additional narrative justification, the above is the only written justification we could find.

5. It is our understanding from your response that the following is your rationale for the trend used for 2009-2011 biennium. Please indicate if this is correct or supplement it as you feel appropriate (please note the importance of this explanation since it will be compared with our consultants in the Board's review so please make sure it fully represents your reasoning):

BCBS
<p>For non-Medicare claims experience an 11.0% trend is used for 2008, followed by 10.0% trend for 2009 through 2011. For Medicare retiree claims experience a 3.0% trend is used for 2008 through 2011.</p> <p>The above trend assumptions are developed in total rather than separately for prescription drug and medical claims experience. Contractual arrangements with providers are confidential. BCBSND does not evaluate various components of trend (cost, utilization, technology, generic utilization, etc) explicitly. Reporting of recent brand and generic prescription drug utilization is available upon request.</p>

**Contingency**

1. We note your explanation of the contingency margin; however, we remain confused. Why is this not new? What motivated the change? How was previous practice modified? Was anyone in the organization besides the actuarial department involved in making this decision to change?
2. Do you use this practice with other groups?
3. Do you submit your actuarial projections to any outside group for verification? If so, can we get a copy of that review?
4. It is our understanding from your response that the following is your rationale for the contingency. Please indicate if this is correct or supplement it as you feel appropriate (please note the importance of this explanation since it will be compared with our consultants in the Board's review so please make sure it fully represents your reasoning):

<b>BCBS</b>
<ul style="list-style-type: none"><li>• The 1.0% contingency margin used in the renewal rating of the 2009-2011 NDPERS biennium is an element of trend and cannot be viewed separately from the trend assumptions used in the rating. That is, in lieu of the 1.0% contingency margin BCBSND would have used more conservative trend assumptions in developing the renewal premiums.</li><li>• In aggregate, the contingency margin and the trend assumptions used in this renewal rating for active employees are equivalent to an overall rating trend of 10.7%. This aggregate trend assumption is neither unreasonable when compared to recent actual claims experience, nor is it outside the range of trend assumptions used in rating the previous four biennial renewals. <i>See attached exhibit "NDPERS Trend and Rate Increase History".</i></li><li>• The resulting 29.5% increase for active employees (13.8% annual increase over two years), while greater than recent rate increases is not the result of the contingency margin or excessive rating trends employed by BCBSND. Rather, the increase exceeds the level of trend (10.7% annual rating trend in aggregate) due to the inadequacy of current rates with respect to current claims experience.</li><li>• It is worth noting that BCBSND will re-rate the NDPERS contract in February 2009. If at that time the re-calculated premiums decrease as a result of lower than expected claims experience, NDPERS will receive the lower premiums. BCBSND cannot increase premiums as a result of the re-rate.</li></ul>

**Conversion Charge**

1. We note your explanation of the conversion charge but as noted it is excessive. Does PERS have the option of not having this coverage?

2. What is the cost to the PERS plan if we allowed members to stay on the plan after COBRA? PERS used to allow this and when we stopped the practice it was not considered by BCBS as a reduction in premium.
3. What do you charge a self funded plan for conversion?
4. We do not have a written response on the conversion question, please add to the following table:

BCBS
Please provide a written response

### Additional Questions

1. We made the following observations and conclusions in our August 13 letter:
  - a. The BCBS increase is not based upon workload.
  - b. BCBS administrative/retention expenses were stable from 1989-1999.
  - c. Since 1999 BCBS has aggressively increased administrative/retention expenses.
  - d. From 1999 to 2007 administrative/retention expenses have increased 242%.
  - e. As proposed, BCBS administrative/retention expenses would increase by 21.7% more for the 2009-2011 bienniums.
  - f. As proposed, the administrative expenses will increase from 1999 to 2009 by 295%.
  - g. Since 1989 BCBS will have made 17 million on the PERS business. How are these dollars used in BCBS?
  - h. Almost 50% of that profit has come since 2001 (the last 3 biennium's of the last 10).
  - i. Recent rating and other provisions have substantially increased the BCBS profit margin on the PERS business (1989 to 2001 compared 2001-2007).
  - j. Historically the existing rating method has more then adequately covered the risk on the PERS product.
  - k. The PERS business has contributed substantial profits to BCBS.
  - l. There has been very little risk to BCBS in providing this product.

In your August 25<sup>th</sup> letter we note you did not take exception to any of our observations or conclusions. Therefore, can we conclude that all of the above is accurate from your perspective as well?

2. In your letter you indicate that "BCBS has been extremely effective in controlling premium levels in North Dakota". Please discuss why you believe a 29% increase is effectively controlling costs (last biennium it was almost 20%). Does the BCBS Board feel this is effective as well?
3. You did not respond to the following question:

- a. What is the history over the above period for increases in provider reimbursement schedules?
- b. Also, please discuss how much of the proposed 29% increase is attributable to increases in the provider reimbursement schedule and what increases you are granting for each year of the upcoming biennium.

Please respond. It would be our observation that the proposed rates include a substantial increase for BCBS providers. Does the BCBS Board set this increase? Do they consider the effect this will have on their participating employers/members? What factors do they consider in making this decision? Do they hear directly from providers on this issue? If so why do they not consult their participating employers?

### **Self Insurance**

1. At the PERS Board meeting you stated that if the plan was self-funded it would save 1.5%. Please detail this savings. Would PERS not also save the gain sharing and the contingency?
2. Please discuss the individual stop loss coverage you provide. What are its provisions? What is the expected loss ratio?
3. Compare and contrast the administrative costs for self-funding under BCBS and the proposal you submitted.
4. Given the contingency fees and administrative costs, please discuss in detail why PERS should consider the fully insured option when our numbers show that BCBS at the proposed level has virtually no risk on this product.

We'd appreciate your response by Friday, September 12. If you have questions on the above, please feel free to give me a call.

  
Sparb Collins  
Executive Director



**North Dakota  
Public Employees Retirement System**  
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# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** September 11, 2008  
**SUBJECT:** Plan Design and Funding Options

## Background

In addition to reaching an agreement with BCBS on the renewal, we need to do two other tasks. First, we need to determine our funding policy, that is how do we allocate our reserve funds that we have as a result of gains from previous bienniums. Second, we need to review and prioritize the alternative plan designs. Please note that the numbers used in this memo at this point are estimates and will change as we move forward with the renewal and any adjustments that may come about from that process and as we refine our reserve estimate.

## Funding Priorities

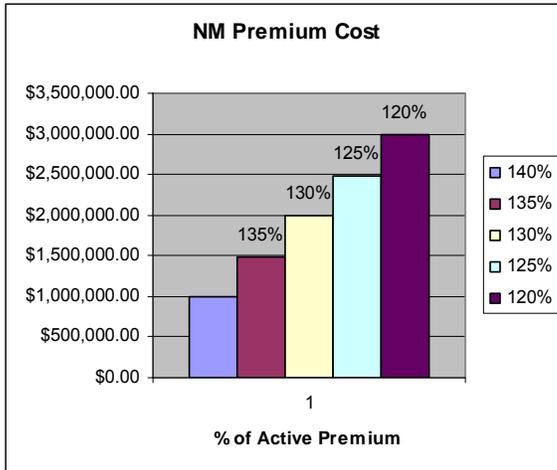
Our present reserve estimate (not counting future interest income) is that NDPERS has approximately \$5.6 million on deposit at BCBS (please note that about \$3 million of this is still at risk for the next 12 months) and another \$4.4 million at RIO for a total of approximately \$10.0 million. The PERSLink project is going to use approximately \$3 million of this and the diabetes project will take about \$400,000 this biennium and another \$800,000 the next for \$1.2 million. This will leave about \$5.5 million. In deciding our recommendation on how to use these funds, the following are the considerations:

1. The funds could be used to reduce the cost of all contracts for the next for next biennium which could produce a rate reduction of about \$9 per contract per month (\$5.5 million/25000 contracts/24 months).
2. The funds could be used to reduce the active and pre Medicare rates only since the retiree rates are not experiencing the same inflation pressure (active and preMedicare rates are going up 28% and Medicare retiree rates are going down 17%). This could reduce active rates by about \$12 per contract per month
3. The funds could be used for two purposes. First to pay the incremental cost of the PERS proposed legislation relating to preMedicare rates. The following is the summary of that bill:

**Bill Draft – LC 90113.01** – This bill proposes to change the PreMedicare calculation method to reduce the cost for these retirees and members (PERS, TFFR, TIAA-Creff, HP, Job Service and former legislators)

<b>Proposals</b>	<b>Section</b>
<p>1. State law presently sets the premedicare rate as:</p> <ul style="list-style-type: none"> <li>a. For single plans it is 150% of the state single rate</li> <li>b. For family plans of 2 it is 2 times the single rate (set in a)</li> <li>c. For family plans of 3 or more it is 2.5% times the single rate (set in a)</li> </ul> <p>The proposed change in this section would change the 150% to 125% thereby reducing the premedicare rates. This will increase the active rates and have an effect on the OPEB liability that will be determined in the actuarial review.</p>	Section 1
2. Provides an expiration for the bill as July 1, 2011.	Section 2

The cost of funding this bill is about 2.5 million for the 2009-2011 biennium (however to provide more of a contingency on this we may want to increase it from 125 to 130 or 135 in October when we consider the final on the bill). If this bill would pass the preMedicare rates would go up about 8%, if it does not they would go up about 28%. The following table shows how changing the percent would change the cost:



The second part of this option would be to use the remaining funds to reduce the active rates only. This could produce a reduction of about \$6.50 per contract per month.

**Recommendation**

Staff and the PERS Benefits Committee would recommend option #3.

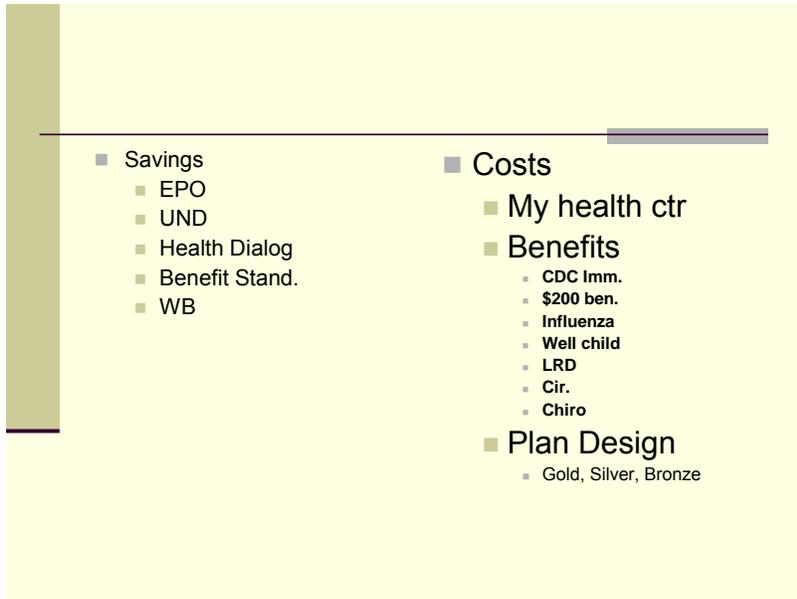
**Plan Design Priorities**

At the June PERS Board meeting we reviewed the suggestions of the PERS Benefits Committee relating to plan design options to be requested from BCBS as part of the renewal. The purpose of collecting this information is to show the Governor and Legislature the effect on premiums of changes in the plan design. The following is a summary of the plan design alternatives/option:

<b>Option A</b>	<b>Increase individual coinsurance by \$250 and family by \$500</b>
<b>Alternative 1</b>	<b>Increase individual deductibles by \$50 on EPO and \$100 on PPO and Basic plans. Increase family deductible by \$150 on EPO and \$300 on PPO and Basic Plans</b>
<b>Alternative 1.A</b>	<b>Both Alternative 1 and Option A</b>
<b>Alternative 2</b>	<b>Increase individual deductibles by \$300 on EPO and \$350 on PPO and Basic plans. Increase family deductible by \$900 on EPO and \$1050 on PPO and Basic Plans</b>
<b>Alternative 2.a</b>	<b>Both Alternative 2 and Option A</b>
<b>Alternative 3</b>	<b>HDHP with \$1250 individual deductible and \$2,500 family deductible</b>

Also the last page of this memo shows the plan design changes compared to this biennium and last.

We also reviewed at that meeting a proposed wellness plan design change which the board also agreed to ask BCBS to price in the renewal. That plan was a combination of changes and additions and included the following:



The PERS Benefits Committee met and reviewed the various plan designs and cost information and would offer the following suggestions for the priorities:

	Reduce Wellness	Existing Wellness	Existing Plan	Option A Wellness	Alt 1 Wellness	Alt 1-A Wellness	Reduced Plan	Alt 2 Wellness	Alt 2- A Wellness	HDHP
BCBS bid	\$ 846.64	\$846.64	\$846.64	\$839.00	\$837.88	\$830.64	846.64	\$810.56	\$803.70	\$749.10
Deductions										
Reserve	(\$6.50)	(\$6.50)	(\$6.50)	(\$6.50)	(\$6.50)	(\$6.50)	(6.50)	(\$6.50)	(\$6.50)	(\$6.50)
Sub total	\$840.14	\$840.14	\$840.14	\$832.50	\$831.38	\$824.14	\$840.14	\$804.06	\$797.20	\$742.60
	27.67%	27.67%	27.67%	26.50%	26.33%	25.23%	27.67%	22.18%	21.14%	12.84%
Wellness Package										
EPO	\$ (16.93)	\$0.00		\$ (16.93)	\$ (16.93)	\$ (16.93)	(16.93)	\$ (16.93)	\$ (16.93)	
Benefit Standard	\$ (3.40)	\$0.00		\$ (3.40)	\$ (3.40)	\$ (3.40)	(3.40)	\$ (3.40)	\$ (3.40)	
Wellness Benefit	\$8.78	\$8.78		\$8.78	\$8.78	\$8.78	0.00	\$8.78	\$8.78	
Incentives	\$6.00	\$6.00		\$6.00	\$6.00	\$6.00	0.00	\$6.00	\$6.00	
Subtotal	\$ (5.55)	\$14.78		\$ (5.55)	\$ (5.55)	\$ (5.55)	(20.33)	\$ (5.55)	\$ (5.55)	
Sub Total	\$834.59	\$854.92	\$840.14	\$826.95	\$825.83	\$818.59	\$819.81	\$798.51	\$791.65	\$742.60
	26.82%	29.91%	27.67%	25.66%	25.49%	24.39%	24.58%	21.34%	20.30%	12.84%
Priority	2	1	3	4	5	6	7	8	9	10

The existing plan is the same plan in place now. The existing with wellness is the existing plan with the EPO and maintaining the existing benefits but adding the wellness provisions. The reduced plan is the existing plan less the EPO and benefit reduction. The remaining are the alternatives/option identified above with the wellness package.

**Recommendation**

The benefits committee and staff would recommend that the above be the priorities for the plan designs and be the PERS position as this information is forwarded to the Governor and Legislature.

**Board Action Requested:**

To approve the funding priorities and plan design priorities.



**INTEROFFICE MEMORANDUM**

SUBJECT: NDPERS 2009-2011 RENEWAL PROPOSAL

DATE: AUGUST 1, 2008

TO: LARRY BROOKS  
KEVIN SCHOENBORN

CC: LINDA MERCK  
TAMI RODER  
TOM PAULSON  
ROB SCHEIRING

FROM: BRAD BARTLE

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Renewal rating for the 2009-2011 NDPERS biennium assuming current benefit structure is attached. The overall rate increase required for the new biennium is 25.8%. This is comprised of a 29.5% increase for active state employees, an approximate 17.5% rate decrease for Medicare retirees, and other rate adjustments for minor census categories.

A complete proposal with rating of alternate plan designs and benefit changes, information concerning additional design features including proposed wellness designs, and additional requested reporting will be prepared and forwarded to you in the coming week.

Narrative Information

1. What is the rating period? If more than 12 months of data is used, how much weighting is placed on the prior experience period versus the current period?  
[The experience period used in this rating is 5-1-07 through 4-30-08 with payments made through 6-30-08.](#)
2. What is the IBNR adjustment? How many days on average does it take BCBSND to pay claims? Is the IBNR adjustment based on the BCBS book of business, or NDPERS case specific data?  
[Claims in total are estimated to be 98.72% complete as paid through 6-30-08. IBNR adjustments are based on prior NDPERS claims experience.](#)
3. What is the pooling level/point? What was the basis for determining this point?  
[Not applicable.](#)
4. What is the pooling charge?  
[Not applicable.](#)
5. Where, if any, is capitation built into the rating model? Is it based on actual or forecast capitation?  
[Not applicable.](#)
6. Was any demographic adjustment made? How was it determined? What was the basis of the adjustment?

Not applicable.

7. What are the trend assumptions for Rx and Medical separately? Prospectively, what are your assumptions regarding contractual charges with providers? How much of the trend adjustment is due to contractual changes? Prospectively, what are your assumptions regarding changes in frequency of procedures? How much of the trend adjustment is due to technology changes? How has BCBS adjusted trend for drugs coming off brand and going generic? What is the current NDPERS generic utilization rate? What is your forecast NDPERS generic utilization rate (during the rating period)?

For non-Medicare claims experience an 11.0% trend is used for 2008, followed by 10.0% trend for 2009 through 2011. For Medicare retiree claims experience a 3.0% trend is used for 2008 through 2011.

The above trend assumptions are developed in total rather than separately for prescription drug and medical claims experience. Contractual arrangements with providers are confidential. BCBSND does not evaluate various components of trend (cost, utilization, technology, generic utilization, etc) explicitly. Reporting of recent brand and generic prescription drug utilization is available upon request.

8. What are your retention assumptions? Please break out between the following: Administration, Profit/Risk, Wellness/DM.

Administration: 4.0% of premium ~ \$28.00 per contract per month

Service Charge: 1.0% of premium ~ \$7.00 per contract per month

Conversion Privilege: 0.2% of premium ~ \$1.40 per contract per month

9. Are any other adjustments made to the rating model?

A contingency margin (1.0% of premium ~ \$7.00 per contract per month) is included in premiums. This amount will not be treated as retention during settlement, and will be included as premium revenue in the calculation of gains/losses for the biennium.

10. Will BCBS agree to re-review the proposed premium in February of 2009 and if the new projection is lower offer that rate for the 2009-2011 biennium? If the February re-projection is higher, agree to use the original estimate for 2009-2011? Please review and note the progress on those issues identified in the renewal letter for this biennium.

BCBSND agrees to re-rate the biennium in February of 2009 and offer any premium reduction to NDPERS. Premiums will not increase as a result of the re-rate.

# North Dakota Public Employees Retirement System

## 7-09/6-11 Renewal Results based on Current Plan Design

		April 2008 Contracts	7-07/6-09 Rates *	Biennium Income	7-09/6-11 Rates *	Biennium Income	Rate Increase
Actives	Single	3,307	\$653.83	\$51,893,179	\$846.64	\$67,196,124	29.5%
	Family	11,031	\$653.83	\$173,097,570	\$846.64	\$224,142,860	29.5%
Actives LOA, COBRA, Temp.	Single	293	\$314.05	\$2,208,400	\$408.22	\$2,870,603	30.0%
	Family	138	\$759.77	\$2,516,358	\$987.94	\$3,272,057	30.0%
Non-Medicare Retirees	Single	548	\$471.09	\$6,195,776	\$612.34	\$8,053,496	30.0%
	Family	226	\$942.17	\$5,110,330	\$1,224.66	\$6,642,556	30.0%
	Family 3+	6	\$1,177.73	\$169,593	\$1,530.84	\$220,441	30.0%
Political Subs.	Single	1,625	\$335.31	\$13,077,090	\$433.90	\$16,922,100	29.4%
	Family	1,881	\$813.33	\$36,716,970	\$1,053.66	\$47,566,427	29.5%
Pol. Subs. All in EPO	Single	378	\$312.05	\$2,830,918	\$403.72	\$3,662,548	29.4%
	Family	516	\$756.61	\$9,369,858	\$980.10	\$12,137,558	29.5%
Medicare Retirees	1 Medicare only	2,965	\$154.06	\$10,962,910	\$127.22	\$9,052,975	-17.4%
	2 Medicare only	1,424	\$298.18	\$10,190,600	\$245.78	\$8,399,777	-17.6%
	3 Medicare only	5	\$317.02	\$38,042	\$261.28	\$31,354	-17.6%
	4 Medicare only	0	\$194.66	\$0	\$160.62	\$0	-17.5%
	Part A 1 Medicare	1	\$424.32	\$10,184	\$349.54	\$8,389	-17.6%
	1 Medicare + others	328	\$561.74	\$4,422,017	\$462.58	\$3,641,430	-17.7%
	2 Medicare + others	7	\$439.38	\$73,816	\$361.92	\$60,803	-17.6%
	3 Medicare + others	1	\$317.02	\$7,608	\$261.28	\$6,271	-17.6%
		24,680		\$328,891,218		\$413,887,768	25.8%

\* Rates include \$2.80 NDPERS Fee but exclude Wellness Benefit Programs and Health Dialog.

Blue Cross Blue Shield of North Dakota reserves the right to adjust premiums if the NDPERS Uniform Group Insurance Program is changed, modified, varied, altered or amended for the contract period 7-1-09/6-30-11, or if the legislature adds any mandated benefits.

# North Dakota Public Employees Retirement System

## 2009-2011 Biennium

- 1. Health Dialog Rate for 2009-2011 Biennium:**  
\$4.18 per contract per month, spread over all Non-Medicare contracts. This reflects an annual inflation adjustment of approximately 5% based on current CPI.
- 2. MyHealth Center rate for 2009-2011 Biennium:**  
\$0.72 per contract per month, spread over all Non-Medicare contracts
- 3. Eliminating the EPO:**  
A 2% drop in income needed for Actives and Political Subdivisions. Revised premium rates and exhibit would be created.
- 4. Medicare Retiree Benefits: (Illustration Only)**  
A group retiree benefit mirroring Medicare Supplement Plan F would be rated at approximately \$150 per Medicare member per month for the 2009-2011 biennium. This rate reflects NDPERS Medicare experience and a benefit increase of 35%-40% over the current NDPERS Medicare carve-out benefit. This product may be considered a Medicare Supplement plan by the North Dakota Department of Insurance and require filing and approval of group product and rates.

If Medicare retiree benefits are offered by NDPERS independently of prescription drug coverage, and if members are allowed to distribute accumulated service credits toward the premium of each product independently, this will create the potential for adverse selection by members against both coverages. In particular, the current practice of offering Medicare medical coverage with community rated premiums may need to be changed to an age-rated premium design.

- 5. Changing Political Subdivisions to a 3-tier rate structure:**  
The 3-tier rate structure below is based on the current plan designs and uses standard employee plus dependent children definition and rate relativities for the single plus dependent (SPD) class. This rate structure assumes that all political subdivisions would change to 3-tier rates.

Current 2-tier structure (for comparison):

PPO/EPO Choice	single	\$431.10 pcpm
	family	1,050.86 pcpm
EPO Only	single	\$400.92 pcpm
	family	977.30 pcpm

3-Tier structure:

PPO/EPO Choice	single	\$418.86	pcpm
	SPD	737.16	pcpm
	family	1,089.02	pcpm
EPO Only	single	\$389.52	pcpm
	SPD	685.56	pcpm
	family	1,012.76	pcpm

**6. Rates changes for PERS benefit variances:**

Attached exhibit

**7. Rate exhibits for alternative benefit plans:**

Attached exhibits

**8. High Deductible Health Plan: (Illustration Only)**

Product Description: High Deductible Health Plan with \$1,250 CYD single and \$2,500 family (comprehensive) deductible; 80%/20% coinsurance with \$1,250 maximum per single and \$2,500 maximum per family; deductibles and coinsurance apply to all services including prescription drugs.

**“No Individual Choice Scenario”**

Election to participate in HDHP made at the employer level for all employees. No individual election by employees allowed. Election may not be changed for two years. Renewal rate for current PERS benefit design (net of \$2.80 PERS fee): \$843.84 composite pcpm (EPO & PPO). Rate for HDHP product as described above: \$749.10 composite pcpm. “Cost neutral” annual employer contribution to HSA (equal to premium differential): \$546.21 per single, \$1,327.25 per family.

**“Individual Choice Scenario”**

Election to participate in HDHP made by the individual. Election may not be changed for two years. Risk charge of 2.0% added to all premium rates (both PPO/EPO and HDHP). Renewal rate for current PERS benefit design (net of \$2.80 PERS fee): \$860.72 composite pcpm (EPO & PPO). Rate for HDHP product as described above: \$764.08 composite pcpm. “Cost neutral” annual employer contribution to HSA (equal to premium differential): \$557.13 per single, \$1,353.80 per family.

Note that HDHP as described and rated above may not qualify members for HSA according to IRS regulation regarding individual and family deductible levels. Adjustments to benefit design necessary for qualification will require corresponding adjustment to rates.

## NDPERS Variances for 7-09/6-11

Costs/savings are spread over all contracts and assume the 7-07 benefit design.

### The following items would be a benefit increase and produce a rate increase:

- 1.) cover routine circumcisions, subject to cost-share = **\$0.18 per contract per month cost increase**
- 2.) the proposed rewrite for preventive screening would change the "schedule" of preventive benefits to the first \$200 paid at 100% and then anything after that subject to cost-share = **\$5.84 per contract per month cost increase**. Items that have been previously priced separately such as preventive bone density scans, colonoscopies, sigmoidoscopies, etc. would be included in this benefit.
- 3.) \* cover HPV immunizations for ages 19-26, paid at 100% = **\$0.36 per contract per month cost increase**
- 4.) \* cover Zoster immunizations for ages 60+, paid at 100% = **\$0.30 per contract per month cost increase**
- 5.) \* cover Tetanus immunization for age 19+ (and others currently on the list of CDC recommendations) for age 19+, paid at 100% = **\$0.20 per contract per month cost increase**  
\* Note that adding coverage for Gardasil and Zostavax and Tetanus for ages 19+ will mean they have coverage for all currently recommended CDC immunizations, and that any future recommended immunizations can be added without a cost.
- 6.) when a Chiropractic Office Visit and Manipulation are billed on the same day by the same provider, change to apply only one copay instead of two = **\$0.24 per contract per month cost increase**
- 7.) allow one LRD visit per year for the treatment of obesity = **\$0.72 per contract per month increase**
- 8.) allow 7 Well Child Care visits through 12 months age = **\$0.12 per contract per month increase**
- 9.) pay influenza immunizations for ages 19+ at 100% = **\$0.10 per contract per month increase**

### The following items would be a benefit decrease and produce a rate savings:

- 1.) change office visits for well child care from coinsurance to copay then 100% = **\$1.02 per contract per month reduction** (this assumes the Medicare benefits would remain at current benefits)
- 2.) change PT, OT, ST services from deductible then coinsurance to copay then coinsurance = **\$1.06 per contract per month reduction** (this assumes the Medicare benefits would remain at current benefits) (copays assumed are \$20 PPO in-area, \$25 PPO basic plan, \$15 EPO in-network, \$25 EPO self-referral)
- 3.) Maintenance Drugs apply two copays per prescription order or refill for a 35-100 day supply = **\$1.32 per contract per month reduction**

# North Dakota Public Employees Retirement System

## 7-09/6-11 Renewal Results based on Current Plan Design

		April 2008 Contracts	7-07/6-09 Rates *	Biennium Income	7-09/6-11 Rates *	Biennium Income	Rate Increase
Actives	Single	3,307	\$653.83	\$51,893,179	\$846.64	\$67,196,124	29.5%
	Family	11,031	\$653.83	\$173,097,570	\$846.64	\$224,142,860	29.5%
Actives LOA, COBRA, Temp.	Single	293	\$314.05	\$2,208,400	\$408.22	\$2,870,603	30.0%
	Family	138	\$759.77	\$2,516,358	\$987.94	\$3,272,057	30.0%
Non-Medicare Retirees	Single	548	\$471.09	\$6,195,776	\$612.34	\$8,053,496	30.0%
	Family	226	\$942.17	\$5,110,330	\$1,224.66	\$6,642,556	30.0%
	Family 3+	6	\$1,177.73	\$169,593	\$1,530.84	\$220,441	30.0%
Political Subs.	Single	1,625	\$335.31	\$13,077,090	\$433.90	\$16,922,100	29.4%
	Family	1,881	\$813.33	\$36,716,970	\$1,053.66	\$47,566,427	29.5%
Pol. Subs. All in EPO	Single	378	\$312.05	\$2,830,918	\$403.72	\$3,662,548	29.4%
	Family	516	\$756.61	\$9,369,858	\$980.10	\$12,137,558	29.5%
Medicare Retirees	1 Medicare only	2,965	\$154.06	\$10,962,910	\$127.22	\$9,052,975	-17.4%
	2 Medicare only	1,424	\$298.18	\$10,190,600	\$245.78	\$8,399,777	-17.6%
	3 Medicare only	5	\$317.02	\$38,042	\$261.28	\$31,354	-17.6%
	4 Medicare only	0	\$194.66	\$0	\$160.62	\$0	-17.5%
	Part A 1 Medicare	1	\$424.32	\$10,184	\$349.54	\$8,389	-17.6%
	1 Medicare + others	328	\$561.74	\$4,422,017	\$462.58	\$3,641,430	-17.7%
	2 Medicare + others	7	\$439.38	\$73,816	\$361.92	\$60,803	-17.6%
	3 Medicare + others	1	\$317.02	\$7,608	\$261.28	\$6,271	-17.6%
		24,680		\$328,891,218		\$413,887,768	25.8%

\* Rates include \$2.80 NDPERS Fee but exclude Wellness Benefit Programs and Health Dialog.

Blue Cross Blue Shield of North Dakota reserves the right to adjust premiums if the NDPERS Uniform Group Insurance Program is changed, modified, varied, altered or amended for the contract period 7-1-09/6-30-11, or if the legislature adds any mandated benefits.

## North Dakota Public Employees Retirement System

**7-09/6-11 Renewal Results based on Current Plan Design with alternate coinsurance  
(PPO \$400 ded./\$1000 coins., EPO \$200 ded./\$750 coins., Basic \$400 ded./\$1500 coins.)  
(Medicare Retiree plan design does not change)**

		April 2008 Contracts	7-07/6-09 Rates *	Biennium Income	7-09/6-11 Rates *	Biennium Income	Rate Increase
Actives	Single	3,307	\$653.83	\$51,893,179	\$839.00	\$66,589,752	28.3%
	Family	11,031	\$653.83	\$173,097,570	\$839.00	\$222,120,216	28.3%
Actives LOA, COBRA, Temp.	Single	293	\$314.05	\$2,208,400	\$404.54	\$2,844,725	28.8%
	Family	138	\$759.77	\$2,516,358	\$979.02	\$3,242,514	28.9%
Non-Medicare Retirees	Single	548	\$471.09	\$6,195,776	\$606.82	\$7,980,897	28.8%
	Family	226	\$942.17	\$5,110,330	\$1,213.64	\$6,582,783	28.8%
	Family 3+	6	\$1,177.73	\$169,593	\$1,517.04	\$218,454	28.8%
Political Subs.	Single	1,625	\$335.31	\$13,077,090	\$430.04	\$16,771,560	28.3%
	Family	1,881	\$813.33	\$36,716,970	\$1,044.24	\$47,141,171	28.4%
Pol. Subs. All in EPO	Single	378	\$312.05	\$2,830,918	\$400.14	\$3,630,070	28.2%
	Family	516	\$756.61	\$9,369,858	\$971.34	\$12,029,075	28.4%
Medicare Retirees	1 Medicare only	2,965	\$154.06	\$10,962,910	\$127.22	\$9,052,975	-17.4%
	2 Medicare only	1,424	\$298.18	\$10,190,600	\$245.78	\$8,399,777	-17.6%
	3 Medicare only	5	\$317.02	\$38,042	\$261.28	\$31,354	-17.6%
	4 Medicare only	0	\$194.66	\$0	\$160.62	\$0	-17.5%
	Part A 1 Medicare	1	\$424.32	\$10,184	\$349.54	\$8,389	-17.6%
	1 Medicare + others	328	\$561.74	\$4,422,017	\$462.58	\$3,641,430	-17.7%
	2 Medicare + others	7	\$439.38	\$73,816	\$361.92	\$60,803	-17.6%
	3 Medicare + others	1	\$317.02	\$7,608	\$261.28	\$6,271	-17.6%
		24,680		\$328,891,218		\$410,352,215	24.8%

\* Rates include \$2.80 NDPERS Fee but exclude Wellness Benefit Programs and Health Dialog.

Blue Cross Blue Shield of North Dakota reserves the right to adjust premiums if the NDPERS Uniform Group Insurance Program is changed, modified, varied, altered or amended for the contract period 7-1-09/6-30-11, or if the legislature adds any mandated benefits.
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## North Dakota Public Employees Retirement System

**7-09/6-11 Renewal Results based on Alternate Plan Design 1  
(PPO \$500 ded./\$750 coins., EPO \$250 ded./\$500 coins., Basic \$500 ded./\$1250 coins.)  
(Medicare Retiree plan design does not change)**

		April 2008 Contracts	7-07/6-09 Rates *	Biennium Income	7-09/6-11 Rates *	Biennium Income	Rate Increase
Actives	Single	3,307	\$653.83	\$51,893,179	\$837.88	\$66,500,860	28.1%
	Family	11,031	\$653.83	\$173,097,570	\$837.88	\$221,823,703	28.1%
Actives LOA, COBRA, Temp.	Single	293	\$314.05	\$2,208,400	\$404.00	\$2,840,928	28.6%
	Family	138	\$759.77	\$2,516,358	\$977.72	\$3,238,209	28.7%
Non-Medicare Retirees	Single	548	\$471.09	\$6,195,776	\$606.00	\$7,970,112	28.6%
	Family	226	\$942.17	\$5,110,330	\$1,212.02	\$6,573,996	28.6%
	Family 3+	6	\$1,177.73	\$169,593	\$1,515.02	\$218,163	28.6%
Political Subs.	Single	1,625	\$335.31	\$13,077,090	\$428.48	\$16,710,720	27.8%
	Family	1,881	\$813.33	\$36,716,970	\$1,040.44	\$46,969,623	27.9%
Pol. Subs. All in EPO	Single	378	\$312.05	\$2,830,918	\$398.68	\$3,616,825	27.8%
	Family	516	\$756.61	\$9,369,858	\$967.80	\$11,985,235	27.9%
Medicare Retirees	1 Medicare only	2,965	\$154.06	\$10,962,910	\$127.22	\$9,052,975	-17.4%
	2 Medicare only	1,424	\$298.18	\$10,190,600	\$245.78	\$8,399,777	-17.6%
	3 Medicare only	5	\$317.02	\$38,042	\$261.28	\$31,354	-17.6%
	4 Medicare only	0	\$194.66	\$0	\$160.62	\$0	-17.5%
	Part A 1 Medicare	1	\$424.32	\$10,184	\$349.54	\$8,389	-17.6%
	1 Medicare + others	328	\$561.74	\$4,422,017	\$462.58	\$3,641,430	-17.7%
	2 Medicare + others	7	\$439.38	\$73,816	\$361.92	\$60,803	-17.6%
	3 Medicare + others	1	\$317.02	\$7,608	\$261.28	\$6,271	-17.6%
		24,680		\$328,891,218		\$409,649,372	24.6%

\* Rates include \$2.80 NDPERS Fee but exclude Wellness Benefit Programs and Health Dialog.

Blue Cross Blue Shield of North Dakota reserves the right to adjust premiums if the NDPERS Uniform Group Insurance Program is changed, modified, varied, altered or amended for the contract period 7-1-09/6-30-11, or if the legislature adds any mandated benefits.
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## North Dakota Public Employees Retirement System

**7-09/6-11 Renewal Results based on Alternate Plan Design 1.A.  
(PPO \$500 ded./\$1000 coins., EPO \$250 ded./\$750 coins., Basic \$500 ded./\$1500 coins.)  
(Medicare Retiree plan design does not change)**

		April 2008 Contracts	7-07/6-09 Rates *	Biennium Income	7-09/6-11 Rates *	Biennium Income	Rate Increase
Actives	Single	3,307	\$653.83	\$51,893,179	\$830.64	\$65,926,236	27.0%
	Family	11,031	\$653.83	\$173,097,570	\$830.64	\$219,906,956	27.0%
Actives LOA, COBRA, Temp.	Single	293	\$314.05	\$2,208,400	\$400.52	\$2,816,457	27.5%
	Family	138	\$759.77	\$2,516,358	\$969.28	\$3,210,255	27.6%
Non-Medicare Retirees	Single	548	\$471.09	\$6,195,776	\$600.78	\$7,901,459	27.5%
	Family	226	\$942.17	\$5,110,330	\$1,201.54	\$6,517,153	27.5%
	Family 3+	6	\$1,177.73	\$169,593	\$1,501.94	\$216,279	27.5%
Political Subs.	Single	1,625	\$335.31	\$13,077,090	\$424.78	\$16,566,420	26.7%
	Family	1,881	\$813.33	\$36,716,970	\$1,031.40	\$46,561,522	26.8%
Pol. Subs. All in EPO	Single	378	\$312.05	\$2,830,918	\$395.24	\$3,585,617	26.7%
	Family	516	\$756.61	\$9,369,858	\$959.40	\$11,881,210	26.8%
Medicare Retirees	1 Medicare only	2,965	\$154.06	\$10,962,910	\$127.22	\$9,052,975	-17.4%
	2 Medicare only	1,424	\$298.18	\$10,190,600	\$245.78	\$8,399,777	-17.6%
	3 Medicare only	5	\$317.02	\$38,042	\$261.28	\$31,354	-17.6%
	4 Medicare only	0	\$194.66	\$0	\$160.62	\$0	-17.5%
	Part A 1 Medicare	1	\$424.32	\$10,184	\$349.54	\$8,389	-17.6%
	1 Medicare + others	328	\$561.74	\$4,422,017	\$462.58	\$3,641,430	-17.7%
	2 Medicare + others	7	\$439.38	\$73,816	\$361.92	\$60,803	-17.6%
	3 Medicare + others	1	\$317.02	\$7,608	\$261.28	\$6,271	-17.6%
		24,680		\$328,891,218		\$406,290,561	23.5%

\* Rates include \$2.80 NDPERS Fee but exclude Wellness Benefit Programs and Health Dialog.

Blue Cross Blue Shield of North Dakota reserves the right to adjust premiums if the NDPERS Uniform Group Insurance Program is changed, modified, varied, altered or amended for the contract period 7-1-09/6-30-11, or if the legislature adds any mandated benefits.
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## North Dakota Public Employees Retirement System

**7-09/6-11 Renewal Results based on Alternate Plan Design 2  
(PPO \$750 ded./\$750 coins., EPO \$500 ded./\$500 coins., Basic \$750 ded./\$1250 coins.)  
(Medicare Retiree plan design does not change)**

		April 2008 Contracts	7-07/6-09 Rates *	Biennium Income	7-09/6-11 Rates *	Biennium Income	Rate Increase
Actives	Single	3,307	\$653.83	\$51,893,179	\$810.56	\$64,332,526	24.0%
	Family	11,031	\$653.83	\$173,097,570	\$810.56	\$214,590,897	24.0%
Actives LOA, COBRA, Temp.	Single	293	\$314.05	\$2,208,400	\$390.84	\$2,748,387	24.5%
	Family	138	\$759.77	\$2,516,358	\$945.86	\$3,132,688	24.5%
Non-Medicare Retirees	Single	548	\$471.09	\$6,195,776	\$586.26	\$7,710,492	24.4%
	Family	226	\$942.17	\$5,110,330	\$1,172.50	\$6,359,640	24.4%
	Family 3+	6	\$1,177.73	\$169,593	\$1,465.62	\$211,049	24.4%
Political Subs.	Single	1,625	\$335.31	\$13,077,090	\$415.98	\$16,223,220	24.1%
	Family	1,881	\$813.33	\$36,716,970	\$1,009.96	\$45,593,634	24.2%
Pol. Subs. All in EPO	Single	378	\$312.05	\$2,830,918	\$387.06	\$3,511,408	24.0%
	Family	516	\$756.61	\$9,369,858	\$939.46	\$11,634,273	24.2%
Medicare Retirees	1 Medicare only	2,965	\$154.06	\$10,962,910	\$127.22	\$9,052,975	-17.4%
	2 Medicare only	1,424	\$298.18	\$10,190,600	\$245.78	\$8,399,777	-17.6%
	3 Medicare only	5	\$317.02	\$38,042	\$261.28	\$31,354	-17.6%
	4 Medicare only	0	\$194.66	\$0	\$160.62	\$0	-17.5%
	Part A 1 Medicare	1	\$424.32	\$10,184	\$349.54	\$8,389	-17.6%
	1 Medicare + others	328	\$561.74	\$4,422,017	\$462.58	\$3,641,430	-17.7%
	2 Medicare + others	7	\$439.38	\$73,816	\$361.92	\$60,803	-17.6%
	3 Medicare + others	1	\$317.02	\$7,608	\$261.28	\$6,271	-17.6%
		24,680		\$328,891,218		\$397,249,212	20.8%

\* Rates include \$2.80 NDPERS Fee but exclude Wellness Benefit Programs and Health Dialog.

Blue Cross Blue Shield of North Dakota reserves the right to adjust premiums if the NDPERS Uniform Group Insurance Program is changed, modified, varied, altered or amended for the contract period 7-1-09/6-30-11, or if the legislature adds any mandated benefits.
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## North Dakota Public Employees Retirement System

**7-09/6-11 Renewal Results based on Alternate Plan Design 2.A.  
(PPO \$750 ded./\$1000 coins., EPO \$500 ded./\$750 coins., Basic \$750 ded./\$1500 coins.)  
(Medicare Retiree plan design does not change)**

		April 2008 Contracts	7-07/6-09 Rates *	Biennium Income	7-09/6-11 Rates *	Biennium Income	Rate Increase
Actives	Single	3,307	\$653.83	\$51,893,179	\$803.70	\$63,788,062	22.9%
	Family	11,031	\$653.83	\$173,097,570	\$803.70	\$212,774,753	22.9%
Actives LOA, COBRA, Temp.	Single	293	\$314.05	\$2,208,400	\$387.52	\$2,725,041	23.4%
	Family	138	\$759.77	\$2,516,358	\$937.84	\$3,106,126	23.4%
Non-Medicare Retirees	Single	548	\$471.09	\$6,195,776	\$581.28	\$7,644,995	23.4%
	Family	226	\$942.17	\$5,110,330	\$1,162.56	\$6,305,725	23.4%
	Family 3+	6	\$1,177.73	\$169,593	\$1,453.20	\$209,261	23.4%
Political Subs.	Single	1,625	\$335.31	\$13,077,090	\$412.50	\$16,087,500	23.0%
	Family	1,881	\$813.33	\$36,716,970	\$1,001.48	\$45,210,813	23.1%
Pol. Subs. All in EPO	Single	378	\$312.05	\$2,830,918	\$383.82	\$3,482,015	23.0%
	Family	516	\$756.61	\$9,369,858	\$931.58	\$11,536,687	23.1%
Medicare Retirees	1 Medicare only	2,965	\$154.06	\$10,962,910	\$127.22	\$9,052,975	-17.4%
	2 Medicare only	1,424	\$298.18	\$10,190,600	\$245.78	\$8,399,777	-17.6%
	3 Medicare only	5	\$317.02	\$38,042	\$261.28	\$31,354	-17.6%
	4 Medicare only	0	\$194.66	\$0	\$160.62	\$0	-17.5%
	Part A 1 Medicare	1	\$424.32	\$10,184	\$349.54	\$8,389	-17.6%
	1 Medicare + others	328	\$561.74	\$4,422,017	\$462.58	\$3,641,430	-17.7%
	2 Medicare + others	7	\$439.38	\$73,816	\$361.92	\$60,803	-17.6%
	3 Medicare + others	1	\$317.02	\$7,608	\$261.28	\$6,271	-17.6%
		24,680		\$328,891,218		\$394,071,975	19.8%

\* Rates include \$2.80 NDPERS Fee but exclude Wellness Benefit Programs and Health Dialog.

Blue Cross Blue Shield of North Dakota reserves the right to adjust premiums if the NDPERS Uniform Group Insurance Program is changed, modified, varied, altered or amended for the contract period 7-1-09/6-30-11, or if the legislature adds any mandated benefits.

## NDPERS (excluding Medicare Retirees) 7-09/6-11

### Illustrative Only

assumes no adverse selection

Current PPO/EPO/Basic benefits      **816.87** Target average premium per contract per month

		<u>average monthly premium</u>	<u>distribution of enrollment</u>
Gold	\$100 Deductible	837.76	10%
Silver	\$200 Deductible	824.86	20%
Bronze	\$300 Deductible	813.03	30%
Base PPO	\$400 Deductible	<u>802.27</u>	<u>40%</u>
	combined	813.56	100%
Gold	\$100 Deductible	837.76	25%
Silver	\$200 Deductible	824.86	25%
Bronze	\$300 Deductible	813.03	25%
new PPO	\$400 Deductible	<u>802.27</u>	<u>25%</u>
	combined	819.48	100%
Gold	\$100 Deductible	837.76	40%
Silver	\$200 Deductible	824.86	30%
Bronze	\$300 Deductible	813.03	20%
new PPO	\$400 Deductible	<u>802.27</u>	<u>10%</u>
	combined	825.39	100%

# GALLAGHER BENEFIT SERVICES, INC. ≈ ≈ Memo

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**To:** Sparb Collins  
Executive Director, NDPERS

**From:** Jerry Rueschhoff, ASA, MAAA  
Senior Client Consultant, GBS Denver Office

**Date:** July 29, 2008

**Re:** Medical and Prescription Drug Plan Renewal Projection  
2009-2011 Biennium

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## Introduction

NDPERS retained Gallagher Benefit Services, Inc. (GBS) to independently develop the projected rate renewal for its employee and retiree medical and prescription drug plans for the budget biennium beginning July 1, 2009. This memo and the attached documents will summarize our projections.

Once we receive the BCBSND renewal proposal we will provide our assessment of the proposal relative to our independent projections.

## Methodology

Enclosed with this memo are:

1. Development of Projected Medical and Rx Incurred Claims for Active and Non-Medicare Retirees for Plan Year July 1, 2009 through June 30, 2011
2. Development of Projected Medical Incurred Claims for Medicare Retirees for Plan Year July 1, 2009 through June 30, 2011.
3. Summary of Current Enrollment and Fully Insured Rates
4. Historical trend analysis for medical and Rx paid claims.

To develop our projections, we used the following methodology:

1. Develop Net Paid Claims for the period 7/1/07-6/30/08
2. Develop Estimated Incurred Claims by adding an Incurred But Not Reported (IBNR) adjustment
3. Using current enrollment, develop PMPM incurred claim costs
4. Multiply the results from step #3 above times our assumed trend factors for the duration of the biennium
5. Convert the PMPM costs to PEPM costs
6. Add in projected BCBSND retention costs

A key observation is that over the last couple of years, BCBSND medical costs for Medicare eligible retirees have been dropping substantially with a 16% drop in the per retiree per month costs in the last fiscal year alone. This does not meet with our expectations and should be investigated further.

Additionally, based on our recent conversation we are assuming that any Rx rebates retained by BCBSND are netted from the claims provided by NDPERS. Note that for a membership base the size of NDPERS, we would expect the vast majority (if not all) of the rebates to be directed to NDPERS and their members.

As indicated in the attached documents and based on the assumptions outlined above, our independent 2009-2011 biennium projections are as follows:

- **Active/early retiree medical and prescription drugs:** +23.9% from current "net" premium rates
- **Medicare retirees medical:** -22.3% from current "net" premium rates

We look forward to discussing our projections with NDPERS. As discussed, once we receive the renewal from BCBSND, we will provide our assessment of their proposal relative to these independent projections.

Regards,

cc: Bill Robinson, GBS Denver  
Shawn Adkins, GBS Denver

## **NDPERS**

### **Development of Projected Medical & Rx Incurred Claims and Retention For Plan Year July 1, 2009 through June 30, 2011**

1. Development of Projected Medical & Rx Incurred Claims and Retention
2. Summary of Current Enrollment and Fully Insured Rates
3. Historical Paid Claims Trend Analysis - Active and Non-Medicare Medical
4. Historical Paid Claims Trend Analysis - Active and Non-Medicare Rx
5. Historical Paid Claims Trend Analysis - Active and Non-Medicare Combined
6. Historical Paid Claims Trend Analysis - Medicare Eligible Retiree Medical

This analysis is for illustrative purposes only, and is not a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend, or alter the coverage provided by the actual insurance policies and contracts. Please see your policy or contact us for specific information or further details in this regard.

**NDPERS**  
**Development of Projected Medical & Rx Incurred Claims and Retention**  
**For Plan Year July 1, 2009 through June 30, 2011**

Biennium Rate Development (1)	Active & Non-Medicare Retiree			Medicare Retiree	Total NDPERS
	Medical	Rx	Total	Medical	
1. Current Subscribers (from June billing statement)	20,299	20,299	20,299	4,689	24,988
2. Current Membership	49,898	49,898	49,898	6,163	56,061
3. Total Paid Claims (7/1/2007 to 6/30/2008)	\$122,706,284	\$21,359,741	\$144,066,025	\$5,428,868	\$149,494,893
6. Incurred But Not Reported (IBNR) Adjustment	1.40%	0.00%	1.19%	1.50%	1.2%
7. Estimated Incurred Claims	\$124,424,172	\$21,359,741	\$145,783,913	\$5,510,301	\$151,294,214
6. Average Exposure Units (Membership)	49,738	49,738	49,738	6,123	55,861
7. Incurred Claims / Member / Month	\$208.46	\$35.79	\$244.25	\$75.00	\$225.70
8. Trend Factor (2)	24.0%	24.0%	24.0%	21.2%	23.9%
9. Trended Medical & Rx Paid Claims / Member / Month	\$258.58	\$44.39	\$302.97	\$90.91	\$279.66
10. Conversion to Per Employee Per Month			\$744.75	\$119.49	\$627.42
11. Claims Retention - BCBSND / Employee / Month (3)			\$31.72	\$31.72	\$31.72
<b>12. Needed Medical &amp; Rx Premium / Employee / Month</b>			<b>\$776.47</b>	<b>\$151.21</b>	<b>\$659.14</b>
<b>13. Current Net Premium / Employee / Month (4)</b>			<b>\$626.48</b>	<b>\$194.60</b>	<b>\$545.44</b>
<b>14. Percent Change</b>			<b>23.9%</b>	<b>-22.3%</b>	<b>20.8%</b>

(1) Rate Development assumes Rx rebates and interest credits on surplus and reserves will be used for potential rate buy-downs in the future.

(2) Annual Trend Factors	<b>9.00%</b>	<b>9.00%</b>	<b>9.00%</b>	<b>8.0%</b>	<b>8.95%</b>
Months of Trend	30.0	30.0	30.0	30.0	30.0

(3) Claims retention projected to increase 3% per year from current levels. Other administration costs not included in the premium projection are:

a) NDPERS Admin	\$2.80
b) Disease Management & Wellness	\$4.25

(4) Based upon June 2008 billing received from NDPERS, which represents the amount paid to BCBSND before NDPERS Administration or Wellness/DM charges. Excludes Medicare Part D premiums for Medicare subscribers.

**NDPERS**  
**Development of Projected Medical & Rx Incurred Claims and Retention**

Rate Category	NDPERS Contracts	BCBSND Net Rates (1)
<b>State Actives</b>		
Flat Rate	14,361	\$651.03
Temp., Part-Time, & COBRA		
Single	264	\$311.25
Family	121	\$756.97
<b>Political Subdivisions * Rate Structure A</b>		
PPO/EPO (w/ COBRA)		
Single	1,627	\$332.51
Family	1,852	\$810.53
EPO Basic (w/ COBRA)		
Single	382	\$309.25
Family	519	\$753.81
<b>Political Subdivisions * Rate Structure B</b>		
PPO/EPO (w/ COBRA)		
Single	10	\$317.31
Family	13	\$773.65
EPO Basic (w/ COBRA)		
Single	0	\$295.11
Family	0	\$719.51
<b>Non-Medicare Retirees</b>		
Single	584	\$468.29
Family	226	\$939.37
Family 3+	7	\$1,174.93
<b>Total for All</b>	<b>19,966</b>	<b>\$12,581,895</b>

**Summary**

(1) Active & Non-Medicare Retiree	20,299	\$12,716,951
(2) Medicare Retiree	4,689	\$1,260,766
(3) Medicare Part D Premium		\$348,269
<b>Total Premium (1+2-3)</b>	<b>24,988</b>	<b>\$13,629,448</b>

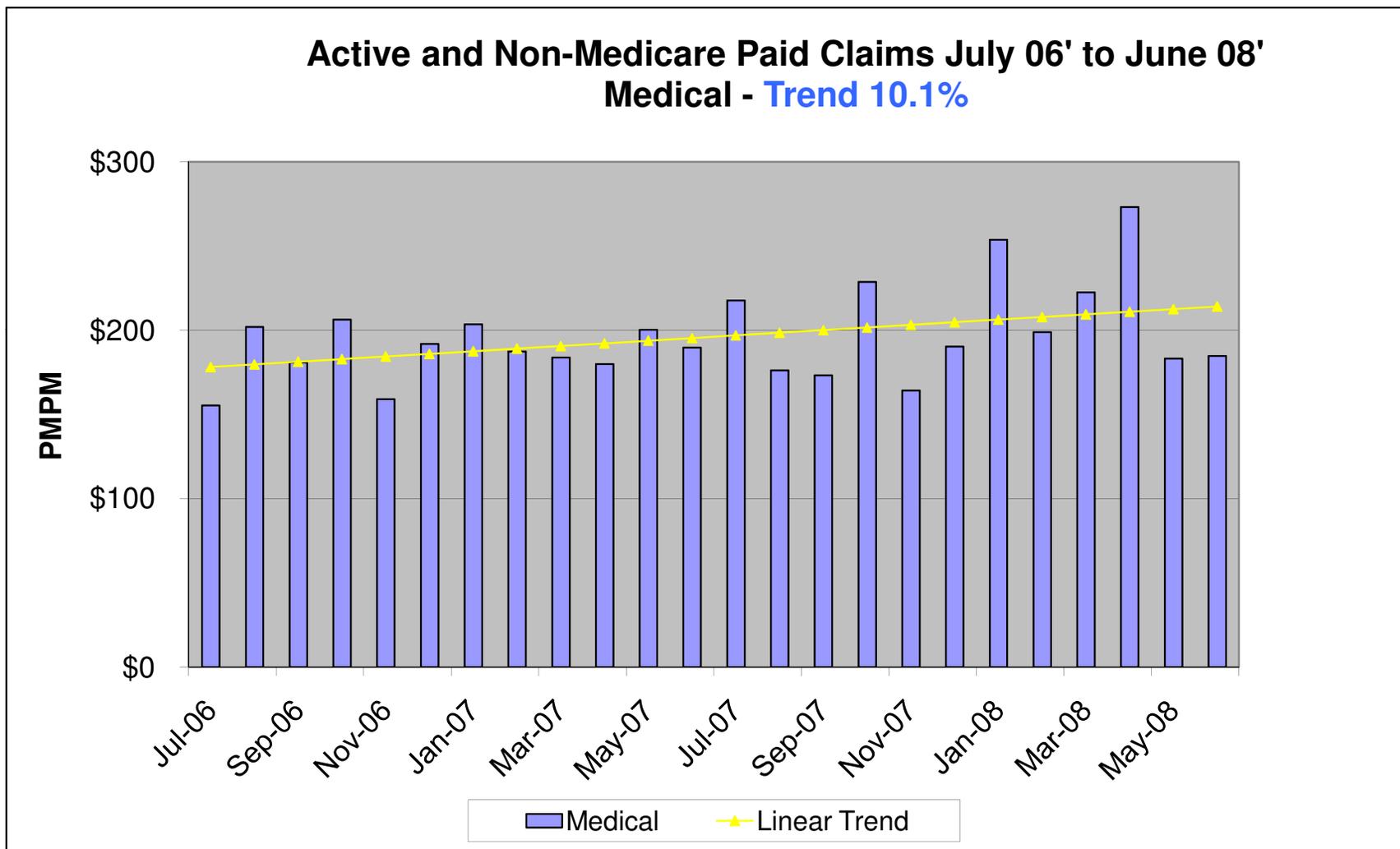
Rate Category	NDPERS Contracts	BCBSND Net Rates (1)
<b>Medicare Retirees * Rate Structure A</b>		
Medicare Part A Only		
Single	1	\$477.92
Medicare Part A & B		
Single	2,899	\$207.66
Family	1,424	\$408.18
<b>Medicare Retirees * Rate Structure B</b>		
Medicare Part A & B		
Single	24	\$200.68
Family	8	\$394.66
<b>Total</b>	<b>4,356</b>	<b>\$1,191,706</b>

Rate Category	NDPERS Contracts	BCBSND Net Rates (1)
<b>Over 1/Under 1 (Rate Structure A)</b>		
3 Medicare+Others	313	\$615.34
2 Medicare+Others	7	\$549.38
3 Medicare+Others	0	\$483.42
<b>Over 1/Under 1 (Rate Structure B)</b>		
1 Medicare+Others	13	\$589.88
<b>Assumed Rate Breakdown</b>		
	<b>Medicare</b>	<b>Non-Medicare</b>
1 Medicare+Others	\$207.66	\$407.68
2 Medicare+Others	\$207.66	\$341.72
3 Medicare+Others	\$207.66	\$275.76
One Medicare+Others (w/o buy-down)	\$200.68	\$389.20

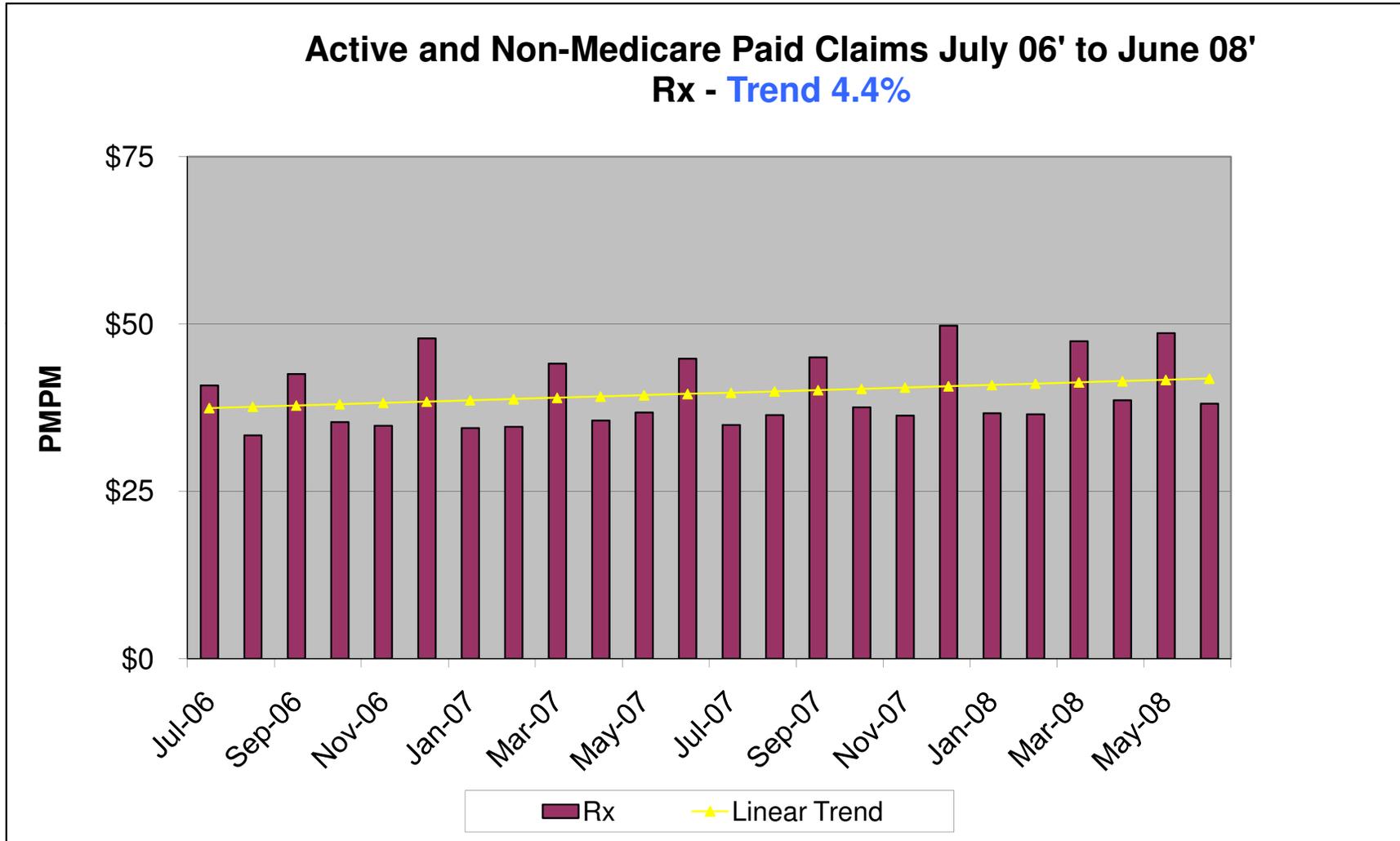
Total Medicare from Over 1/Under 1	333	\$69,060
Total Non-Medicare from Over 1/Under 1	333	\$135,055

(1) BCBSND Net Rates represent the per subscriber per month premium before NDPERS Administration and Wellness/DM charges.

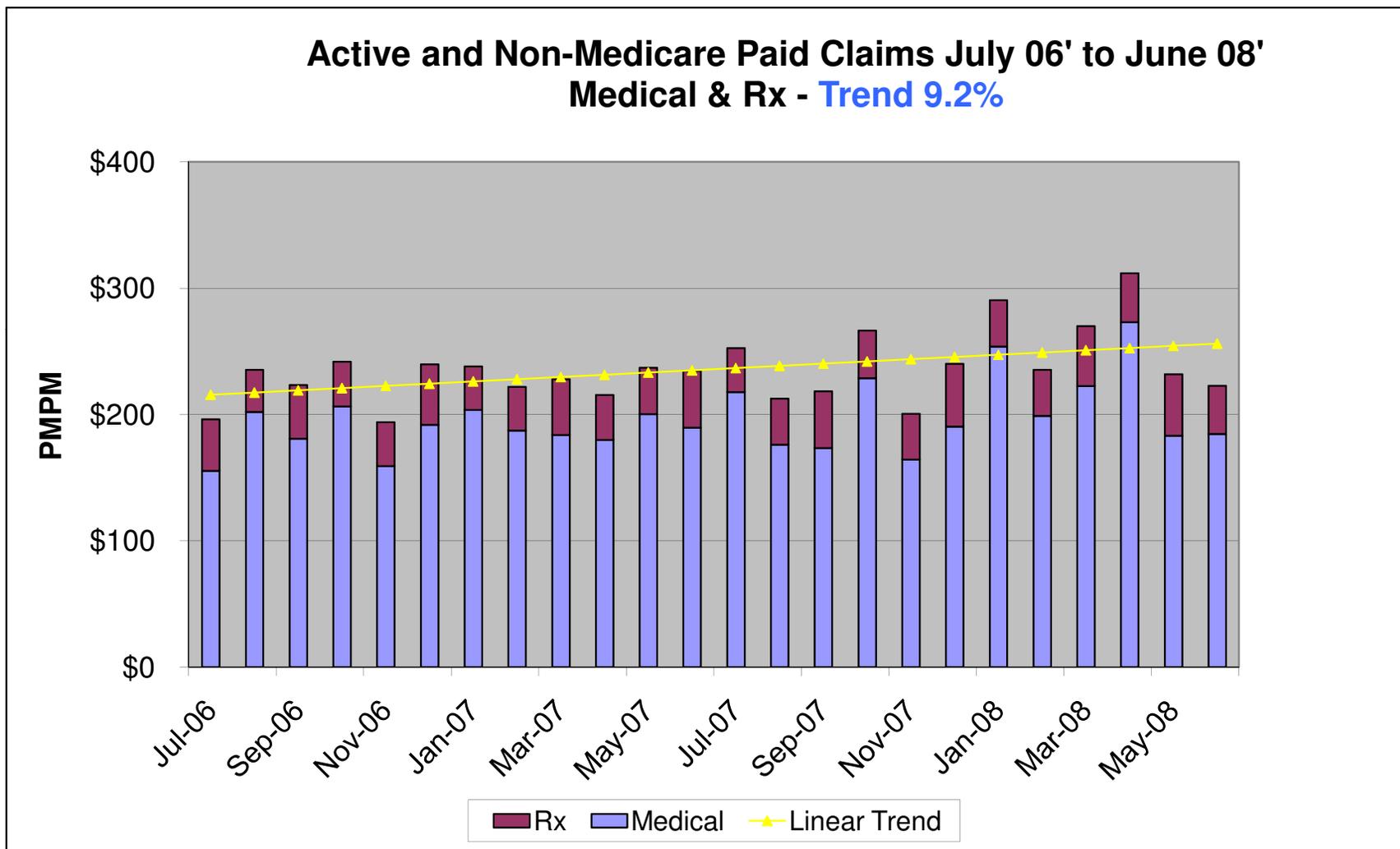
**NDPERS**  
**Historical Paid Claims Trend Analysis - Active and Non-Medicare Medical**



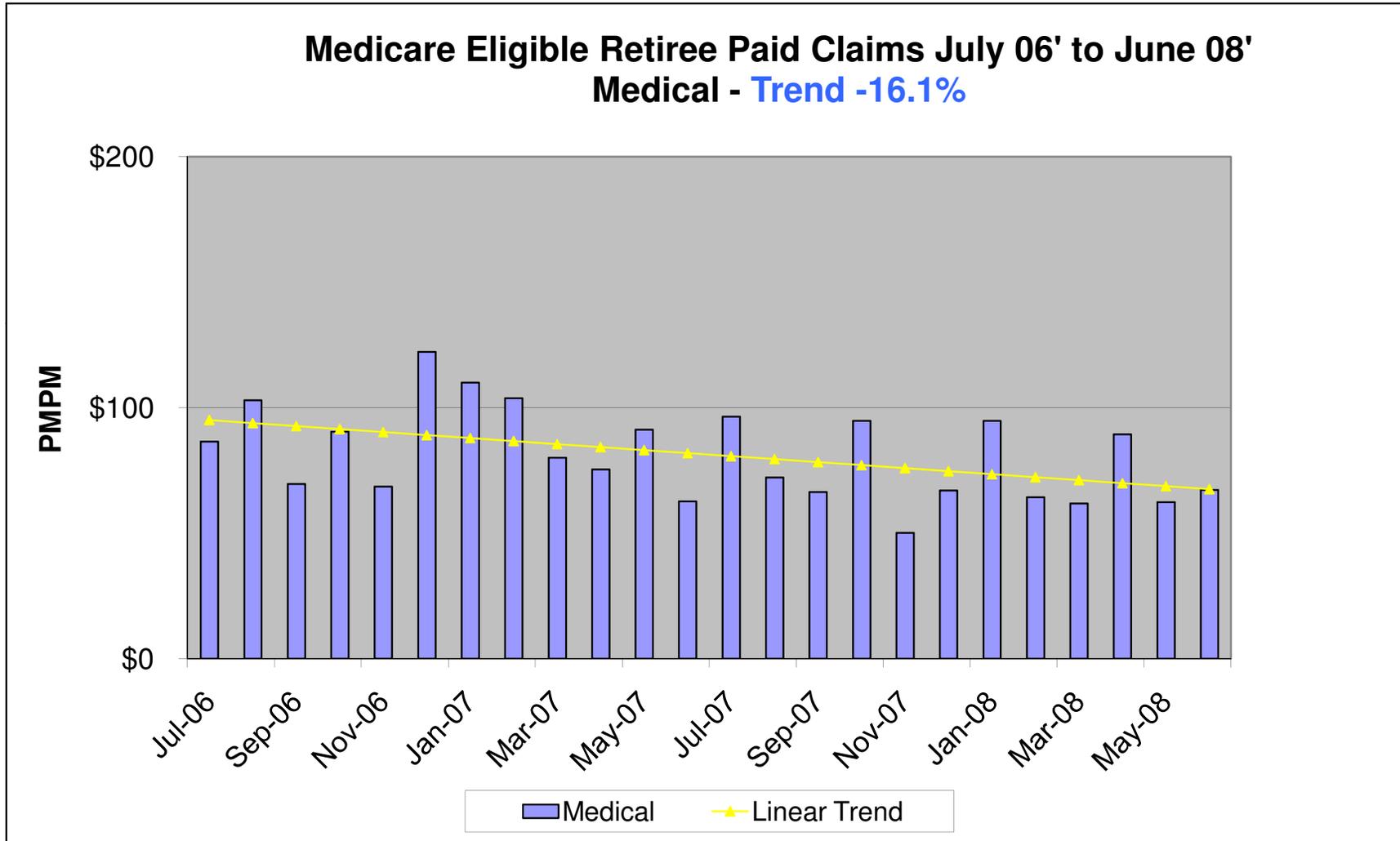
**NDPERS**  
**Historical Paid Claims Trend Analysis - Active and Non-Medicare Rx**



**NDPERS**  
**Historical Paid Claims Trend Analysis - Active and Non-Medicare Combined**



**NDPERS**  
**Historical Paid Claims Trend Analysis - Medicare Eligible Retiree Medical**



# GALLAGHER BENEFIT SERVICES, INC. ≈ ≈ Memo

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**To:** Sparb Collins  
Executive Director, NDPERS

**From:** Jerry Rueschhoff, ASA, MAAA  
Senior Client Consultant, GBS Denver Office

**Date:** August 6, 2008

**Re:** BCBSND Medical and Prescription Drug Plan Renewal Review  
2009-2011 Biennium

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## Introduction

NDPERS retained Gallagher Benefit Services, Inc. (GBS) to independently develop the projected rate renewal for their employee and retiree medical and prescription drug plans for the budget biennium beginning July 1, 2009 and provide a review of BCBSND's renewal as it compares to our projections. This memo provides our assessment of the BCBSND renewal proposal relative to the independent projections we provided on July 29, 2008.

## General Observations

BCBSND's initial renewal is about \$14.5 million (or about 3.6%) higher than our independent projection. The differential is almost entirely due to differences in assumed retention/contingency margin (\$4.2 million or 1.0%) and trend (\$10.3 million or 2.6%).

The following explains the differences in our assumptions.

## Retention/Administration

BCBSND's retention assumptions increased nearly 22% or about \$3.8 million from the current period to the projection period. This increase is significantly higher than what we have seen with other carriers. Additionally, the conversion charge of 0.2% of premium appears to be high and it may be advantageous for NDPERS to receive a charge from BCBSND that is on a per conversion basis.

Additionally, BCBSND has introduced an additional 1% contingency margin which will be included in the premium rates but not in the retention amounts used to calculate surpluses and deficits for the biennium. The following is the expected cost to NDPERS of the newly introduced contingency margin under various claims assumptions and assuming the current risk sharing arrangement which is 100% of deficits to BCBSND, 50/50 of first \$3 million in surpluses and 100% of surpluses to NDPERS in excess of \$3 million:

- No cost (other than loss of cash flow) if surpluses were greater than \$3 million,
- \$1.5 million cost if claims come in at expected
- \$4.1 million cost if claims come in at least 1% worse then expected.

The following table illustrates the proposed retention and contingency margin amounts assumed by BCBSND relative to the GBS projected amounts.

	7/1/07 thru 6/30/09	7/1/09 thru 6/30/11	% Increase	Increase in Millions <sup>4</sup>
Administration Expense	\$23.00	\$27.95	21.5%	\$2,932,151
Risk/Service Charge	5.76	6.99	21.3%	727,114
<u>Conversion Cost</u>	<u>1.14</u>	<u>1.40</u>	<u>22.6%</u>	<u>152,531</u>
Total Retention	\$29.90	\$36.34	21.5%	\$3,811,796
Contingency Margin (CM) <sup>1</sup>	<u>\$0.00</u>	<u>\$6.99</u>	n/a	<u>\$4,138,878</u>
Expected Cost of CM <sup>2</sup>	\$0.00	\$2.53	n/a	\$1,500,000
Total Expected Increase				\$5,311,796
Increase Assumed by GBS <sup>3</sup>				<u>\$1,078,561</u>
Differential				\$4,233,235
<sup>1</sup> According to BCBSND renewal this amount will not be treated as retention during settlement, and will be included in as premium revenue in the calculation of gains/losses for the biennium.				
<sup>2</sup> Assumes actual claims come in at expected and the surplus which is equal to the 1% contingency margin is shared 50/50 with NDPERS on the first \$3 million and 100% to NDPERS after \$3 million.				
<sup>3</sup> GBS assumed a 3% annual increase of the retention amounts in our projections and no contingency margin.				
<sup>4</sup> Based on BCBSND's reported headcount of 24,680.				

### Trend

For non-Medicare claims experience BCBSND has assumed a trend rate of 11% for 2008 and 100% for 2009 through 2011. This is significantly higher than the assumed trend rate used by GBS of 9% per year. For Medicare claims experience BCBSND assumed a 3% trend and GBS assumed an 8% trend per year. Overall, BCBSND's trend assumptions result in premium rates which are 2.6% or roughly \$10.3 million higher than the GBS projected premium rates.

### Proposed Re-Rate

The proposal by BCBSND to re-rate the biennium in February of 2009 and offer any premium reduction to NDPERS without the possibility of a rate increase is beneficial to NDPERS. The terms of how BCBSND will re-rate the group should be agreed to prior the re-rate. It should be noted that BCBSND's projections are likely conservative as a result of this proposal since the re-rate could only benefit NDPERS.

Please do not hesitate to call us with questions regarding our review and we look forward to discussing this further with NDPERS.

Regards,

cc: Bill Robinson, GBS Denver  
Shawn Adkins, GBS Denver



August 13, 2008

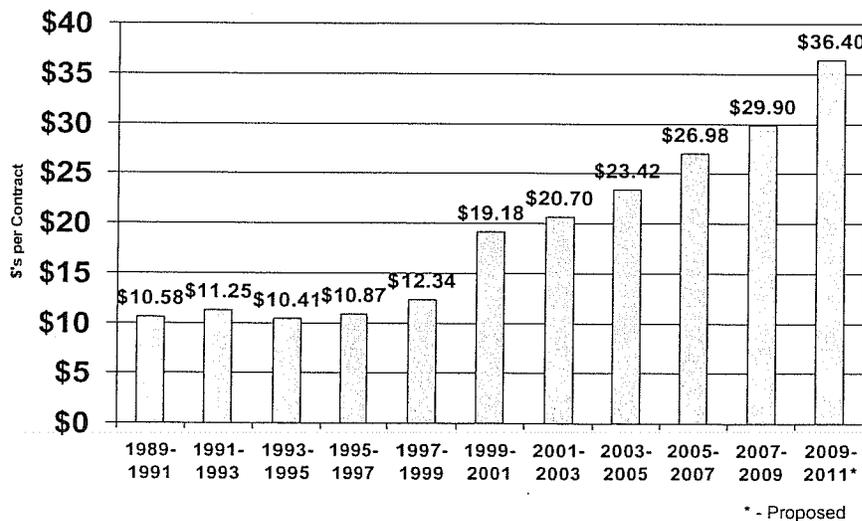
Larry Brooks  
 Kevin Schoenborn  
 Consulting Services Unit  
 BCBSND  
 4510 13<sup>th</sup> Avenue SW  
 Fargo, ND 58121

I am writing with some additional observations and questions in follow-up to our meeting.

**Administrative Expenses**

PERS notes the following history of administrative/retention charges:

**BCBS Administration  
 NDPERS Health Plan**



This table shows:

1. BCBS administrative/retention expenses were stable from 1989-1999.
2. Since 1999 BCBS has aggressively increased administrative/retention expenses.
3. From 1999 to 2007 administrative/retention expenses have increased 242%.
4. As proposed BCBS administrative/retention expenses would increase by 21.7% more for the 2009-2011 bienniums.

5. As proposed, the administrative expenses will increase from 1999 to 2009 by 295%.

PERS would note the following in relation to administrative expenses:

1. PERS has not requested any major new initiatives in terms of workload over the above period.
2. Staffing levels assigned to PERS by BCBS have not changed dramatically over any of the above periods.
3. PERS administers the COBRA provisions and that is not a part of the responsibilities of BCBS.
4. PERS does all the billings to the employer groups, COBRA participants, and the 6,000 or so retirees and that is not a part of the BCBS responsibilities.
5. PERS is making a substantial investment in its business system during the next biennium which will increase the efficiency of our interfaces and further reduce the BCBS administrative burden.
6. BCBS administrative expenses only as proposed are almost \$9 million dollars a year. We note the total budget for an agency such as WSI with almost 250 employees, a new building and other administrative burdens is just about \$17 million a year (not including a one time \$14 million biennial business system replacement). By comparison this would mean that BCBS is proposing a level of effort associated with the PERS business that is the equivalent of 52% of the full administration of the entire WSI effort.
7. HIPAA compliance was paid with earlier increases.

In recognition of the above, the following conclusions are drawn:

1. The BCBS increase is not based upon workload.
2. The level of effort being proposed is the equivalent of funding and supporting over 120 positions with associated expenses. The increase could be the equivalent of asking for 20 more positions to support the PERS effort.
3. BCBS does not have the same level of administrative responsibilities as it and other carriers have in more traditional relationships in terms of COBRA administration and billings.
4. The new PERS business system is going to dramatically increase the efficiency of the PERS/BCBS relationship and this is not being recognized by BCBS.
5. BCBS appears to be implementing a business decision relating to PERS administrative fees to reach some specific level.

Based upon the above, we would ask:

1. What are BCBS business goals relating to administrative/retention expenses with PERS? Specifically what is the level of administrative fees that BCBS is trying to reach for the PERS business?
2. What is the timeframe allocated to achieving this goal?
3. What were the specific considerations of BCBS in establishing this policy goal for PERS?

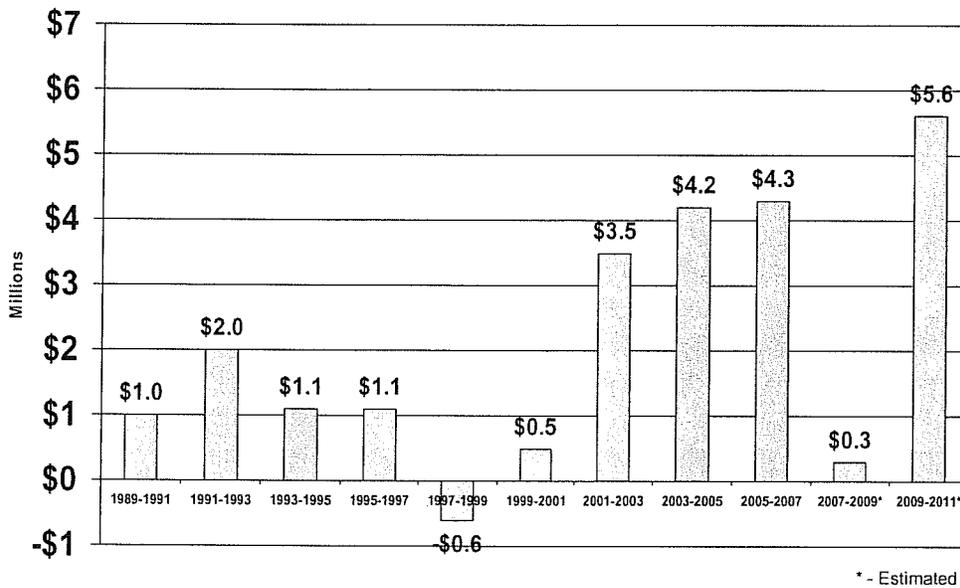
- 4. At what level in the BCBS organization was this policy established?
- 5. What is the % of PERS administrative expense income to BCBS of its total administrative expense income over the above period?

**Additional 1% Risk Charge**

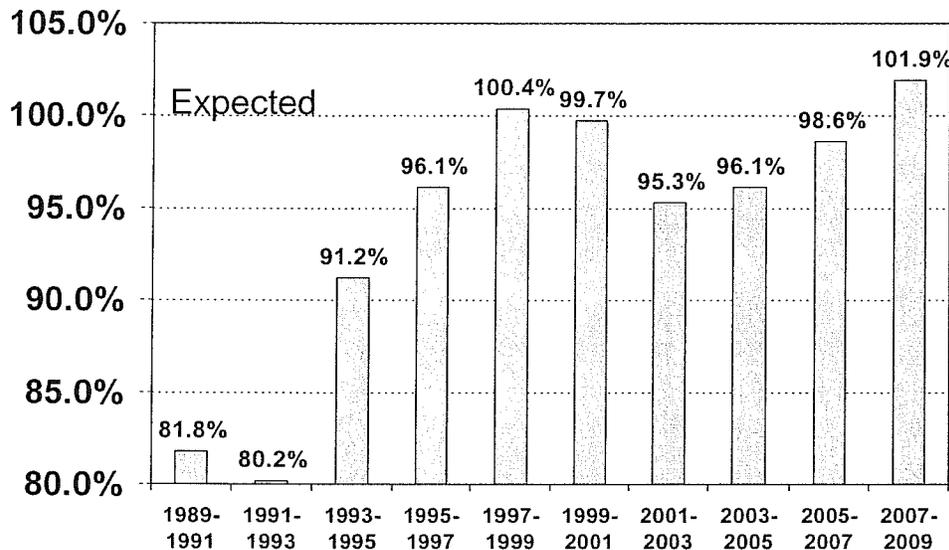
PERS would note the following related to BCBS risk with the PERS contract:

## BCBS Gain

Includes: Risk Charge, Gain Sharing, Interest, and Losses  
NDPERS Health Plan



## NDPERS Health Plan Expected VS Actual History



The above tables show:

1. Since 1989 BCBS will have made \$17 million on the PERS business.
2. Almost 50% of that profit has come since 2001 (the last 3 biennium's of the last 10).
3. Recent rating and other provisions have substantially increased the BCBS profit margin on the PERS business (1989 to 2001 compared 2001-2007).
4. Historically the existing rating method has more than adequately covered the risk on the PERS product.

Based upon the above the following observations and conclusions can be drawn:

1. The PERS business has contributed substantial profits to BCBS.
2. There has been very little risk to BCBS in providing this product.
3. The introduction of an additional 1% will significantly shift risk to PERS and would not appear justified relative to past gains for BCBS and the conservative trend assumptions.
4. The additional 1% in conjunction with the conservative trend assumptions will virtually guarantee that BCBS will get 5.6 million in profits for the 2009-2011 bienniums.

Based upon the above we would ask:

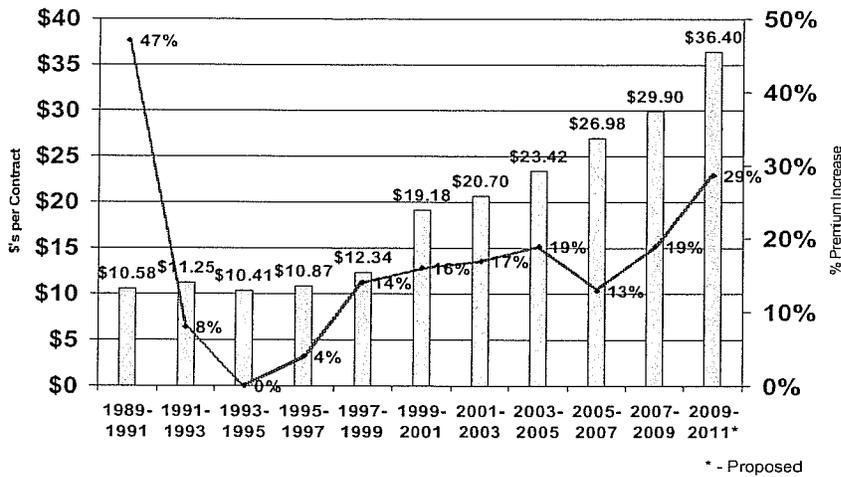
1. Is it the goal of BCBS to eliminate all risk relating to the product and at that level what advantage is it to PERS to have a fully insured product? Why wouldn't PERS self-insure at a funding level that is virtually no risk?

2. What level of profit is BCBS trying to guarantee relating to the PERS business?
3. If BCBS is going to have virtually no risk what will be its motivation to control costs.

**Relationship Between BCBS Administration/Retention, Gains (Profit) and Premiums**

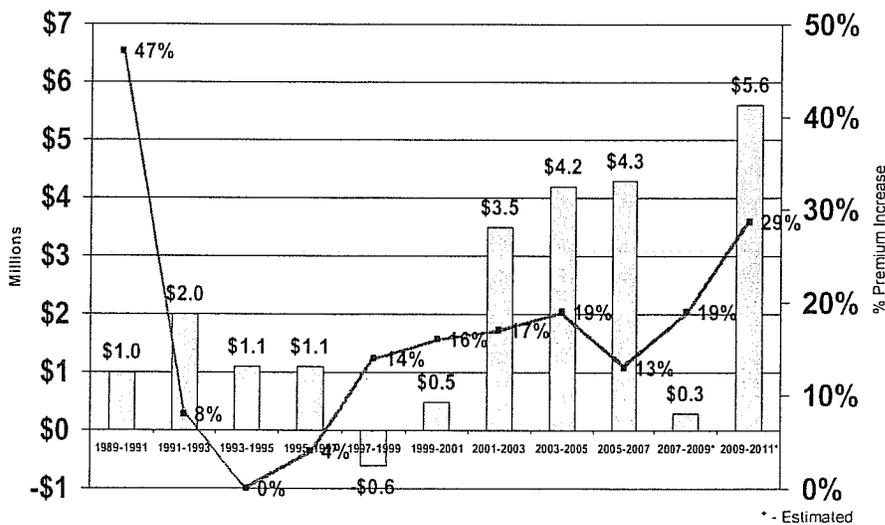
PERS has observed the following relationship between BCBS administrative/retention expenses, gains and premium increases:

**BCBS Administration  
 NDPERS Health Plan**



**BCBS Gain**

Includes: Risk Charge, Gain Sharing, Interest, and Losses  
 NDPERS Health Plan



The above tables show:

1. That health premiums have increased substantially as BCBS costs and gains have gone up (2001 to 2008 vs. 1991 to 1998).
2. That the increased investment by PERS in BCBS administrative/retention costs has not resulted in effective cost control of premium expenses by BCBS, in fact the reverse seems to have occurred (2001 to 2008 vs. 1991 to 1998).
3. BCBS gains or profits increase more dramatically with higher premium increases and in fact the present system seems to reward BCBS with larger gains for large increases in PERS premiums (2001 to 2008 vs. 1991 to 1998).
4. In addition the above increases the coverage or scope of benefits has diminished in the last several biennium's as a result of increased out of pocket costs that were incurred to reduce the increase in premiums.

The following observations/conclusions can be drawn from the above:

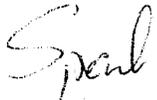
1. One of the primary responsibilities of BCBS is to deliver affordable insurance coverage and reasonable increases in premiums. BCBS has not provided this in recent bienniums.
2. BCBS, as the primary insurance company in North Dakota, is in a unique position to control costs.
3. It seems there is a negative relationship between PERS investments in BCBS administration/retention and premiums. Specifically the more PERS pays in administration/retention results in higher premiums by BCBS rather than lower premiums.
4. Additional investments by PERS in BCBS have yielded no positive ROI in terms of premiums and in fact it seems to be a negative ROI.
5. It appears that BCBS gains are larger with higher premium increases than lower increases which appear to be creating an incentive for BCBS not to control premium costs.
6. Based upon the above information BCBS is not as effective at controlling employer costs as it was previously.
7. BCBS does not deliver the value it used to in terms of administrative/retention costs, gains and control of health care premiums.
8. It appears that BCBS is passing along substantially higher increases in its rate schedule to health care providers than it did previously.

Based upon the above we would ask:

1. Why has BCBS effectiveness in restraining premiums increases diminished as the investment by PERS in its operations has increased?
2. Why should PERS continue to reward BCBS for performance that has resulted in large premium increases for our employers and members?
3. Specifically what will BCBS do differently in the future to reverse this situation? How does this relate to the proposed increase?

Larry Brooks  
Kevin Schoenborn  
Page 7

4. Why is BCBS requesting a 20% increase in light of its performance?
5. What is the history over the above period for increases in the provider reimbursement schedule?



Sparb Collins  
Executive Director

# GALLAGHER BENEFIT SERVICES, INC. ≈≈ Memo

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**To:** Sparb Collins  
Executive Director, NDPERS

**From:** Jerry Rueschhoff, ASA, MAAA  
Senior Client Consultant, GBS Denver Office

**Date:** August 11, 2008

**Re:** Observations and Follow-up Questions for BCBSND Regarding the Medical and Prescription Drug Plan Renewal (2009-2011 Biennium)

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## Introduction

NDPERS retained Gallagher Benefit Services, Inc. (GBS) to independently develop the projected rate renewal for their employee and retiree medical and prescription drug plans for the budget biennium beginning July 1, 2009 and provide a review of BCBSND's renewal as it compares to our projections. This memo provides suggested follow-up questions to ask of BCBSND based on our review and August 8th meeting with NDPERS and BCBSND.

## General Observations

BCBSND's initial renewal is about \$14.5 million (or about 3.6%) higher than our independent projection. The differential is almost entirely due to differences in assumed retention/contingency margin (\$4.2 million or 1.0%) and trend (\$10.3 million or 2.6%).

The following explains the differences in our assumptions and provides a formal request for justification from BCBSND regarding their assumptions.

## Retention/Administration

BCBSND's retention assumptions increased nearly 22% or about \$3.8 million from the current period to the projection period. This increase is significantly higher than what we have seen with other carriers. Additionally, the conversion charge of 0.2% of premium appears to be high relative to the actual number of conversions in recent years.

We ask that BCBSND provide formal explanation of their assumptions and/or reconsider their increase to retention. Additionally, we are requesting a reconciliation of the actual claims for the conversion block versus the actual premiums and corresponding subsidies (0.2% from NDPERS and 1.0% from the rest of BCBSND's book of business).

### Contingency Margin

Additionally, BCBSND has introduced an additional 1% contingency margin which will be included in the premium rates but not in the retention amounts used to calculate surpluses and deficits for the biennium. The following is the expected cost to NDPERS of the newly introduced contingency margin under various claims assumptions and assuming the current risk sharing arrangement which is 100% of deficits to BCBSND, 50/50 of first \$3 million in surpluses and 100% of surpluses to NDPERS in excess of \$3 million:

- No cost (other than loss of cash flow) if surpluses are greater than \$3 million,
- \$1.5 million cost if claims come in at expected
- \$4.1 million cost if claims come in at least 1% worse then expected.

Given the years of experience with BCBSND under the current arrangement, we do not believe there is a valid need for this additional contingency margin at this time. We ask that BCBSND provide formal justification for the introduction of this added margin and/or reconsider the introduction of it.

### Trend

For non-Medicare claims experience BCBSND has assumed a trend rate of 11% for 2008 (8 months) and 10% for 2009 through 2011 (24 months). This is significantly higher than the assumed trend rate used by GBS of 9% per year. For Medicare claims experience BCBSND assumed a 3% trend and GBS assumed an 8% trend per year. Overall, BCBSND's trend assumptions result in premium rates which are 2.6% or roughly \$10.3 million higher than the GBS projected premium rates.

We ask that BCBSND provide formal justification for the double digit active and non-Medicare trend rates and consider lowering these assumptions to be more in line with industry trends and effective utilization management techniques.

Requested Data

To complete our review, we request that BCBSND provide a monthly lag triangle and matching subscribers/contracts for the most recent four years of history for the following two populations:

- Actives and Non-Medicare Retirees
- Medicare Eligible Retirees

Additionally, we would like BCBSND's assumed benefit adjustment factors for any benefit changes that occurred within this four year time period.

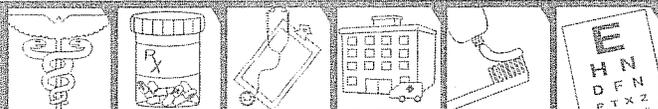
Sparb, please let us know if you have any questions regarding our review and/or the requested information of BCBSND.

Regards,

cc: Bill Robinson, GBS Denver  
Shawn Adkins, GBS Denver

# 2009 Segal Health Plan Cost Trend Survey

★ SEGAL



## Most Trend Rates Projected to Be Lower in 2009 than in 2008

The 2009 *Segal Health Plan Cost Trend Survey* — The Segal Company's twelfth annual survey of managed care organizations (MCOs), health insurers, pharmacy benefit managers (PBMs) and third party administrators (TPAs) — reflects continued declines in trend assumptions for most of the coverages surveyed. For the first time since the survey's inception, prescription drug trend assumptions are projected to hit single digits and drop below medical plan trends. The deceleration in projected prescription drug trends is expected to outpace the rate of decline in medical health plan cost trends.

### More Survey Highlights

Other notable findings from this year's survey include:

➤ Similar to findings for 2007 and 2008, all medical plan types are projected to see cost trends in 2009 that are higher than inflation: more than four percentage points higher than the consumer price index for all urban consumers (CPI-U), which was 5.6 percent as of July 2008, and higher than the annual increase in average weekly earnings, which was 2.8 percent as of July 2008.<sup>1</sup>

➤ Although overall projected prescription drug trend is decelerating, specialty drug<sup>2</sup> forecasts are still

almost double that of retail trend, and the utilization component of drug trend is higher for generic drugs than for brand drugs.

- Trend rates for hospital services are projected to be 10.9 percent in 2009, exceeding trends for physician services and prescription drug supplies.
- The variance in trend rates among all managed care medical plan types

continues to be marginal, ranging from 10.0 percent to 10.8 percent.

- Medicare Advantage HMOs are projected to have a 7.1 percent trend rate for 2009, a significant decline in expected increases from 2008.
- Projected medical plan trend rates for retirees age 65 and older are not only expected to be lower in 2009 but are also expected to be

## What Is Trend and How Does it Differ from Actual Cost Increases?

The *Segal Health Plan Cost Trend Survey* focuses on trend, which is the projected change in health plans' per-capita *claims cost* determined by insurance carriers, MCOs, PBMs and TPAs. Many factors influence trend:

- Price inflation,
- The leveraging effect of fixed deductibles and copayments,
- Cost-shifting,
- Utilization increases due to aging, promotion and improved diagnostic services,
- The availability and use of more expensive treatment and drug therapies, including biotech drugs.
- Government-mandated benefits and other legislative changes, and
- Technological changes and their effect on the intensity of care.

Although there is usually a high correlation between a trend rate and the actual cost increase assessed by a carrier, *trend and the net annual change in plan costs are not the same*. Changes in the costs to plan sponsors can be significantly different from projected claims cost trends, reflecting such diverse factors as plan design changes, employee contribution rate increases, group demographics, carrier retention, margins, stop-loss coverage and artificial rate relief from the effects of competitive bidding, all of which have an impact on actual claims experience.

The 2009 *Segal Health Plan Cost Trend Survey* reports projections obtained from a survey of major insurance carriers, MCOs — including preferred provider organizations (PPOs), point-of-service (POS) plans and health maintenance organizations (HMOs) — PBMs and TPAs conducted by Segal in the summer of 2008. Segal received 70 responses to the survey.<sup>3</sup> Survey participants were asked to provide the trend factors they will be applying to historical claims to predict expected claims for 2009.

<sup>3</sup> The following participants agreed to disclose their names: Aetna, Altius Health Plans, Arkansas Blue Cross and Blue Shield, Assurant Employee Benefits, BeneCare Dental Plans, Blue Cross & Blue Shield of Rhode Island, Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Minnesota, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Texas, Blue Cross of Northeastern Pennsylvania, Blue Shield of California, BlueCross BlueShield of Tennessee, CareFirst BlueCross BlueShield, Care-Plus Dental Plans, ConnecticutCare, Inc., Coventry Health Care of Georgia, Inc., CVS Caremark, Delta Dental Insurance Company, Delta Dental of Arizona, Delta Dental of California, Delta Dental of Colorado, Delta Dental of Illinois, Delta Dental of Massachusetts, Delta Dental of New Jersey, Delta Dental of Virginia, Delta Dental of Wisconsin, Employers Dental Services, Inc., Great-West Healthcare (now part of Cigna), Group Health Cooperative (Kaiser Foundation Health Plan, Inc.), Group Health Incorporated (GHI), Guardian Life Insurance, Health Alliance Medical Plans, Health Net of the Northeast, Inc., HealthTrans, Horizon BCBSNJ, Humana, Inc., Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of Hawaii, Kaiser Foundation Health Plan of Ohio, Kaiser Foundation Health Plan of the Northwest, Kaiser Permanente of the Mid-Atlantic States, Kaiser Permanente of Colorado, Kaiser Permanente of Northern California, Kaiser Permanente of Southern California, Lincoln Financial Group, Medco Health Solutions, Inc., Medica Health Plans, MedImpact Healthcare Systems, Inc., Nippon Life Insurance Co. of America, Northeast Delta Dental, Preferred Health Systems, Inc., Prescription Solutions, Principal Life Insurance Company, RxAmerica LLC, Security Health Plan of Wisconsin, Inc., SXC Health Solutions, Inc./informedRx, Trustmark Group Insurance, Union Health Service, Inc., United Concordia Companies, Inc., UnitedHealthcare and WellPoint NextRx.

<sup>1</sup> These statistics, both of which were released on August 14, 2008, were the most recent available at the time this survey report went to press.

<sup>2</sup> Specialty or biotech drugs, which require special handling, support and delivery, address a number of complicated conditions, including osteoporosis, arthritis, multiple sclerosis and cancer. This category contains genetically engineered, injectable therapies with costs greatly exceeding those of most traditional therapies.

measurably lower than the medical plan trend rates projected for active participants and early retirees.

- Combined PPO and POS plan projected trend rates show variation among regions. For example, in the Midwest, trends are projected to be 9.4 percent, whereas the forecasts for this medical coverage in the Northeast and West are 10.5 and 10.6 percent, respectively. The trend rate in the South is projected to be between these levels: 10.0 percent.

- For most dental plan types, trends for 2009 are forecast to rise slightly from 2008 levels. Fee-for-service (FFS)/indemnity dental plans are projected to have the highest trend increase at 6.9 percent in 2009.
- The average reported projected trend rate for scheduled vision plans remains almost unchanged from 2008 at 3.6 percent while the projected trend for reasonable and customary plans increased slightly to 4.9 percent.

Table 1 summarizes key findings.

**Trend Ranges**

Table 2 on page 3 shows trend *ranges* for medical PPO coverage and retail prescription drug carve-out coverage.

Over two-thirds of survey respondents, 71 percent, projected open-access PPO trend rates in the range of 10.0 to 14.9 percent for 2009. The concentration of respondents within this range is slightly lower than last year (76 percent). No respondent projected trend rates of 15 percent or higher for 2008 and 2009.

More than half of survey respondents (54 percent) reported 2009 projected prescription drug trends of less than 10 percent, up from 31 percent of respondents in the 2008 survey. In addition, all respondents reported projected prescription drug trend rates of less than 15 percent for 2009. This compares to 83 percent of respondents forecasting lower than 15 percent trend rates just two years ago.

**Trends for Active Participants & Retirees**

In addition to the key finding already noted, that projected medical plan trend rates for retirees age 65 and older are projected to be lower in 2009 than the projected medical plan trend rates for active participants and early retirees, notable findings about trends for both groups include the following:

- Projected retail *and* mail order prescription drug trends continue to be reduced significantly for both active participants and retirees.
- Projected retail prescription drug trend rates for retirees age 65 and over show a one-percentage-point drop to 9.1 percent for 2009. Medicare-eligible retiree prescription drugs trends for mail order networks are projected to decrease almost two percentage points, from 10.7 percent in 2008 to 9.3 percent in 2009.

**Table 1: Projected Medical, Prescription Drug, Dental & Vision Trends: 2008 & 2009**

	2008 Projected		2009 Projected	
	(without Rx)	(with Rx)*	(without Rx)	(with Rx)*
<b>Medical (Actives &amp; Retirees &lt; Age 65)</b>				
FFS/Indemnity Plans	12.5%	12.1%	<b>13.2%</b>	<b>12.5%</b>
High-Deductible Health Plans (HDHPs)**	10.9%	10.9%	<b>10.8%</b>	<b>10.6%</b>
Open-Access PPOs/POS Plans***	10.6%	10.6%	<b>10.6%</b>	<b>10.4%</b>
PPOs/POS Plans (with PCP gatekeepers)	10.5%	10.5%	<b>10.4%</b>	<b>10.3%</b>
HMOs	10.7%	10.7%	<b>10.0%</b>	<b>10.0%</b>
<b>Medical (Retirees Age 65+)</b>				
Medicare Advantage (MA)**** Private Fee-for-Service (PFFS) Plans		9.8%	<b>8.2%</b>	<b>8.5%</b>
MA HMOs	9.7%	9.2%	<b>7.1%</b>	<b>7.8%</b>
<b>Prescription Drug (Rx) Carve-Out (Actives &amp; Retirees &lt; Age 65)</b>				
Retail Network		10.7%		<b>9.8%</b>
Mail Order		10.6%		<b>9.4%</b>
<b>Rx Carve-Out (Retirees Age 65+)</b>				
Retail Network		10.1%		<b>9.1%</b>
Mail Order		10.7%		<b>9.3%</b>
<b>Dental</b>				
Scheduled Plans		4.3%		<b>4.6%</b>
FFS/Indemnity Plans		6.8%		<b>6.9%</b>
Dental Provider Organizations (DPOs)		5.8%		<b>5.9%</b>
Dental Maintenance Organizations (DMOs)		4.3%		<b>4.2%</b>
<b>Vision</b>				
Scheduled Plans		3.6%		<b>3.6%</b>
Reasonable & Customary (R&C) Plans		4.6%		<b>4.9%</b>

\* Trend projections were derived by proportionally blending medical plan trends and freestanding prescription drug trends.

\*\* HDHPs are defined as those where the deductible is at least the minimum health savings account (HSA) level required by the Internal Revenue Service (\$1,150 single, \$2,300 family in 2009).

\*\*\* Open-access PPOs and POS plans are those that do not require a primary care physician (PCP) gatekeeper referral for specialty services.

\*\*\*\* Medicare Advantage plans, part of the Medicare program, can be PFFS plans, HMOs, PPOs or special needs plans.

Segal Health Plan Cost Trend Survey

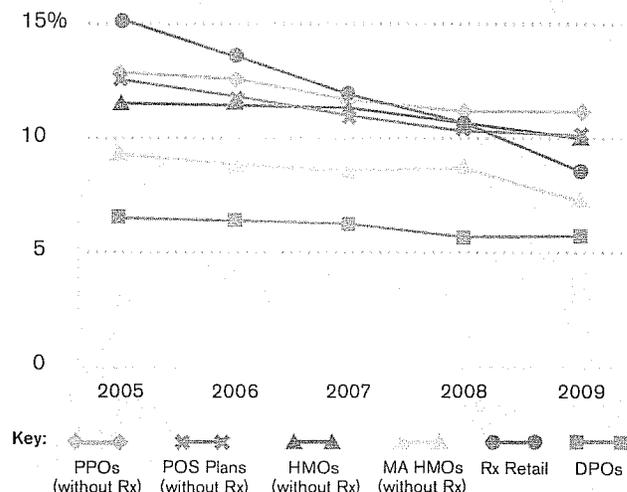
**Table 2: Projected Trend Ranges for PPOs & Retail Network Rx Carve-Out Coverage: 2005 – 2009**

	Percentages of Respondents*				
	2005 Survey	2006 Survey	2007 Survey	2008 Survey	2009 Survey
<b>PPOs (without Rx)</b>					
<10%	14%	16%	19%	24%	29%
10–14.9%	69%	78%	78%	76%	71%
15–19.9%	17%	3%	3%	0%	0%
≥20%	0%	3%	0%	0%	0%
Average	12.6%	12.4%	11.6%	10.6%	10.6%

<b>Retail Rx Carve-Out</b>					
<10%	10%	7%	30%	31%	54%
10–14.9%	37%	55%	53%	62%	46%
15–19.9%	37%	36%	16%	7%	0%
≥20%	17%	2%	0%	0%	0%
Average	15.2%	13.8%	11.9%	10.7%	9.8%

\* Some totals do not equal 100% due to rounding.

**Graph 1: Selected Projected Medical, Rx Carve-Out & Dental Trends: 2005 – 2009\***



\* All trends are illustrated for actives and retirees under age 65, except for the trend for MA HMOs. An expanded version of this graph, showing survey data for 10 years, is available on the following page of Segal's Web site: <http://www.segalco.com/publications/surveysandstudies/2009trendsurveysupplement.pdf>

- > The projected HMO trend rate of 10.0 percent for active participants and early retirees is almost three percentage points higher than the projected trend rate of 7.1 percent for Medicare Advantage HMOs for retirees age 65 and over.
- > For 2009, the trend rate for Medicare Advantage PFFS plans, the most recent newcomer to the Medicare Advantage marketplace, is projected to continue increasing at a rate somewhat faster than the projected trend for Medicare Advantage HMOs.

Graph 1 shows selected projected trends from the last five surveys. For most plan types, projected trend rates continue to decline.

**Trend Components**

The survey captured data about components of trend. As reported in 2008, price inflation for services and supplies continues to be the biggest element of overall medical plan trend. For 2009, price inflation is

driving medical trend at a rate of 6.1 percent for open-access PPO plans and 6.6 percent for HMO plans.

As shown in Table 3 at the bottom of the next column, the survey also examined 2009 medical trends by service type. For open-access PPO plans, price inflation is the largest component of hospital and prescription drug trend. Utilization is projected to have a more moderate effect on overall trend for 2009. Forecasts for price inflation component of trend for physician services have increased in 2009 to 4.3 percent, up from 4.0 percent in 2008. Price inflation for hospital admission is also projected to increase slightly over the 2008 level. Prescription drug price inflation trend is projected to decrease slightly to 6.3 percent.

Trends in utilization rates, another key component of trend, are projected to be lower than those reported in 2008. For hospital and physician services, the projected utilization trends are 2.5 percent and 4.3 percent, respectively,

in 2009. The largest slowdown in utilization trend is projected for prescription drugs, which is forecast to drop almost two percentage points in 2009 to 2.9 percent.

Graph 2 on page 4 summarizes trends broken down by brand and generic drug types. Utilization trend rates of both brand and generic drugs are projected to be lower in 2009 than in 2008. The finding noted earlier, that generic drug utilization trend is

**Table 3: Components of 2009 Projected Trends by Service Type**

Trend Component	Hospitals*	Physicians*	Rx
Price Inflation	7.9%	4.3%	6.3%
Utilization	2.5%	4.3%	2.9%
<b>Total Trend**</b>	<b>10.9%</b>	<b>8.9%</b>	<b>9.8%</b>

\* Hospital and physician trends are for open-access PPO plans.

\*\* The components do not add up to total because there are other components of trend not illustrated, reflecting such factors as impact of cost-shifting, technology changes and drug mix. Also, not all participants provided a breakdown of trend by component.

expected to outpace brand drug utilization trend, is consistent with the 2008 survey. This is the result of more generic alternatives in the marketplace due to patent expiration (e.g., availability of Zolpidem, a generic form of Ambien CR™) and plan design changes. Plan design to increase generic utilization includes coinsurance design, tiered benefits, and the use of a mandatory “dispensed-as-written” penalty.

Price inflation remains the largest component of brand drug trend at 6.8 percent, and representing 79 percent of total brand prescription drug trend. However, the price inflation component of brand drug trend has remained stable compared to the 2008 forecast of 6.9 percent.

Where most of the projected trend increase for brand drugs is driven by cost inflation, the projected trends for generic drugs are influenced more or less equally by price inflation (4.2 percent), utilization (5.1 percent) and drug mix (3.5 percent), as more blockbuster brand names come off patent and become available on a generic basis.

The 2009 trend rate for specialty drugs, a segment of brand drugs, is forecast to be 18.1 percent, down more than two percentage points from last year’s projection of 20.5 percent. Although this projected trend rate is decelerating, it should be noted that specialty drug forecasts are still almost double that of retail prescription drug trend. Specialty pharmaceuticals account for 13.1 percent of total trend and continue to drive brand drug mix increases. Furthermore, as existing specialty drugs continue to gain new approved indications, specialty drug utilization is expected to rise.

**Accuracy of Projections**

To assess the accuracy of projections, Segal compared the average 2007 trend forecasts by national and regional insurers, MCOs, PBMs and TPAs for group medical, prescription drug benefit and dental plans to the actual average trend rates experienced by the health plans covered by those organizations for the same 12-month period, as reported by the survey respondents. Comparing past projections to actual increases reveals

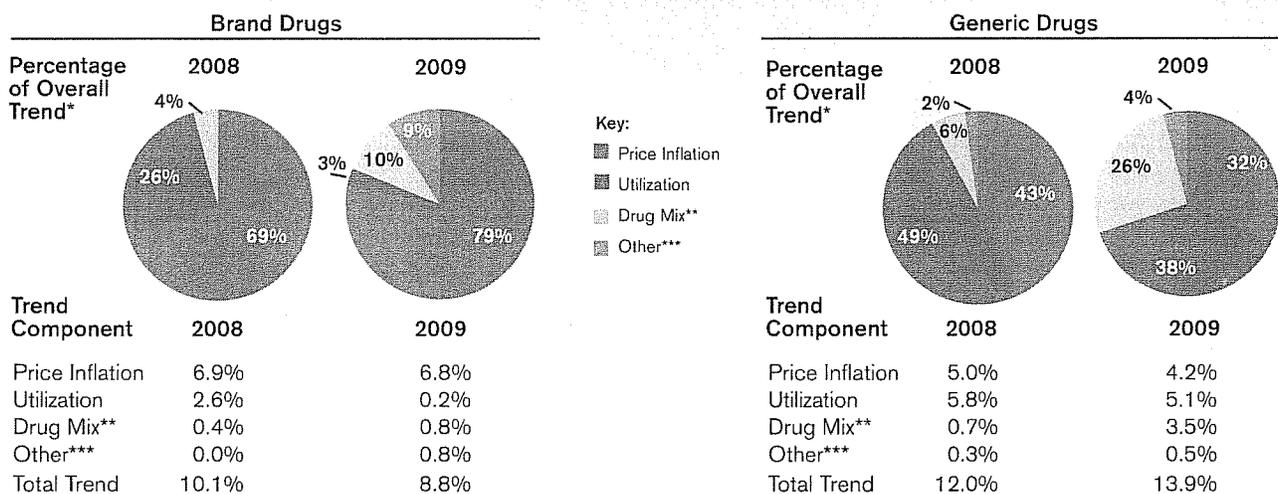
that insurers and PBMs tend to make conservative projections for cost increases and that their forecasts are generally higher than the actual experience observed for the period. This comparison is shown in Table 4 on page 5.

Graphs 3 and 4 on page 5 illustrate the variances between trend forecasts and actual observed trends experienced in 2003 through 2007 for PPOs and prescription drug plans, respectively. It should be noted that the accuracy of underwriter projections is subject to a natural lag in the underwriting cycle. In periods where costs are decelerating, forecasters will tend to overestimate trends. Similarly, when costs are accelerating, trend projections will sometimes be underestimated. Accuracy of trend assumptions is best measured by comparing projected trend to actual trend over multiple years.

The following are the most notable findings about the accuracy of trend projections:

- Actual prescription drug plan increases continue to be significantly

**Graph 2: Components of 2008 & 2009 Projected Rx Carve-Out Trend for Brand & Generic Drugs**

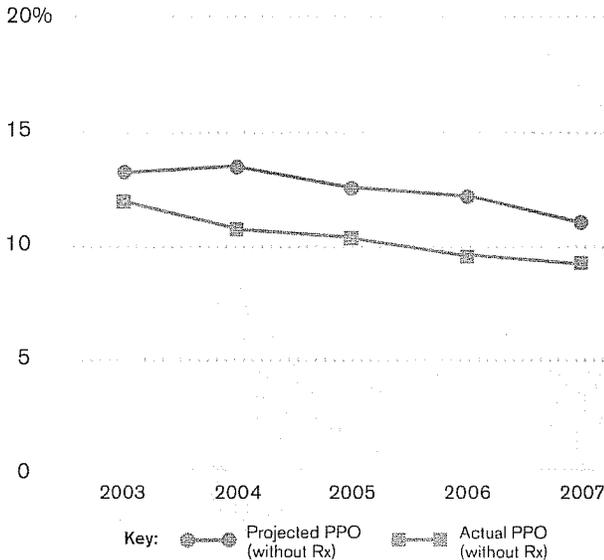


\* Total percentages of overall trend may not equal 100% due to rounding.

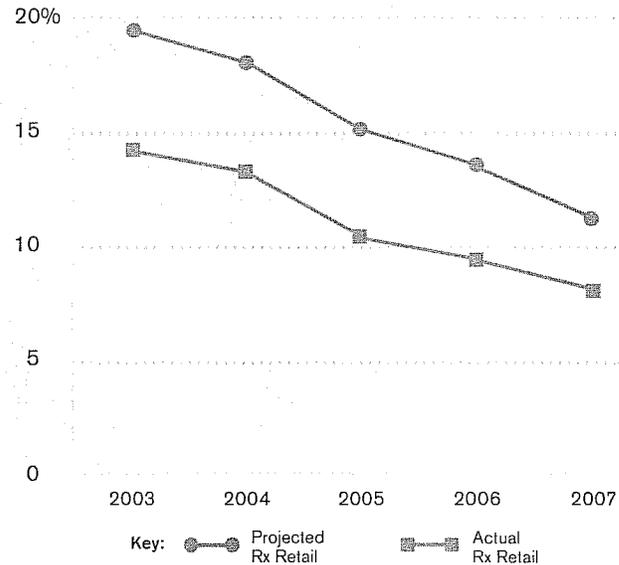
\*\* Drug mix reflects therapeutic mix, brand/generic mix and new drugs.

\*\*\* The Segal Health Plan Cost Trend Survey also measured “Other” as a component of prescription drug trend. Other includes items such as leveraging from cost-shifting and government-mandated benefits and other legislative changes.

**Graph 3: Comparison of Projected to Actual Trends for PPOs for Actives & Retirees under Age 65: 2003-2007**



**Graph 4: Comparison of Projected to Actual Trends for Retail Rx Carve-Out Coverage for Actives & Retirees under Age 65: 2003-2007**



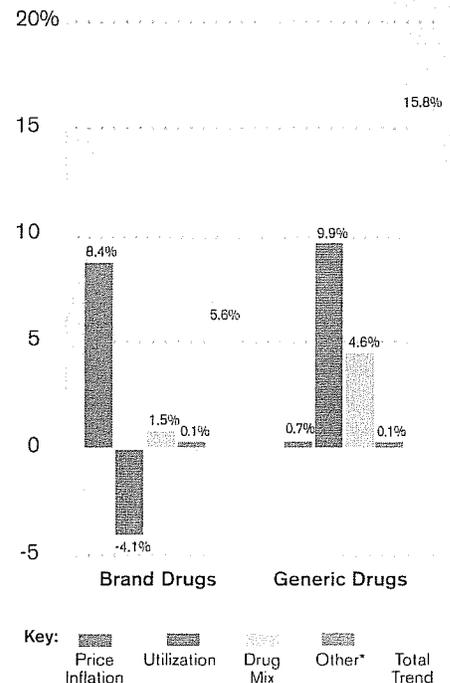
**Table 4: Comparison of 2007 Projected Trends to 2007 Actual Trends**

	Projected	Actual
<b>Medical (Actives &amp; Retirees &lt; Age 65) (without Rx)</b>		
FFS/Indemnity Plans	13.7%	12.8%
HDHPs	12.0%	9.5%
Open-Access PPOs/POS Plans	11.6%	8.9%
PPOs/POS Plans (with PCP gatekeeper)	11.0%	9.5%
HMOs	11.1%	9.8%
<b>Medical (Retirees Age 65+) (without Rx)</b>		
MA PFFS Plans	8.7%	8.9%
MA HMOs	8.6%	7.0%
<b>Rx Carve-Out (Actives &amp; Retirees &lt; Age 65)</b>		
Retail Network	11.9%	7.9%
Mail Order	11.5%	6.9%
<b>Rx Carve-Out (Retirees Age 65+)</b>		
Retail Network	12.0%	8.2%
Mail Order	11.1%	8.3%
<b>Dental</b>		
Scheduled Plans	5.0%	3.8%
Indemnity Plans	7.5%	6.0%
DPOs	6.2%	5.0%
DMOs	5.2%	4.1%
<b>Vision</b>		
Scheduled Plans	5.1%	1.9%
R&C Plans	5.5%	2.4%

lower than projected trend for the fifth consecutive year. As projected and actual trends have come down, so has the gap between the rates. For example, the difference between 2007 actual and projected retail prescription drug trend rates is four percentage points, whereas the difference between those same rates in 2003 was just over five percentage points.

- The actual 2007 Medicare PFFS trend of 8.9 percent was slightly *higher* than projected trend of 8.7 percent. This is the only coverage surveyed in which the 2007 actual trend rate was greater than the projected trend rate for the same year.
- For both fixed-scheduled and reasonable and customary vision plans, 2007 trend projections were more than double the actual 2007 trend rates.
- The actual generic utilization prescription drug trend rate increased almost three percentage points from 7.0 percent in 2006 to 9.9 percent in 2007. By contrast, the actual

**Graph 5: Components of 2007 Actual Rx Carve-Out Trend for Brand & Generic Drugs**



\* "Other" includes items such as leveraging from cost-shifting and government-mandated benefits and other legislative changes.

brand utilization trend rate decreased over two percentage points, from -1.7 percent in 2006 to -4.1 percent in 2007. This reflects a significant move from brand to generic during 2007. See Graph 5 on page 5.

**Commentary & Conclusion**

Projected medical and prescription drug plan cost trends continue to decline for most plan types for the sixth consecutive year. Projected retail prescription drug cost trend has fallen from a high of 19.7 percent in 2001 to 9.8 percent for 2009. However, health plan cost trends continue to remain above general inflation rates and continue to outpace increases in labor costs for both the public and private sectors.

Fortunately, a growing number of plan sponsors are experiencing actual trend rates that are less than projected and are reducing from previous year increases. For example, in 2007, approximately 37 percent of respondents had actual trends of 8.0 percent or less for open-access PPO plans, supporting the premise that aggressive cost management strategies can produce more tolerable trend rates.

**Utilizing Data Analytics to Target Cost Management Efforts**

Increasingly, plan sponsors are exploring total health management (THM) strategies as a vehicle for managing increasing medical and prescription drugs costs. By analyzing cost and utilization trends with precision, plan sponsors can target effective intervention to manage future health care expenses as part of their THM strategy. In addition, plan sponsors can redesign plan provisions to eliminate barriers to care and provide incentives to comply with recommended care for particular diseases.

Effective THM strategies include mining data to identify a plan's cost drivers and developing multi-year strategic plans for implementing

THM programs that target those cost drivers. Such an approach might consist of the following six steps:

- **Analytics** Using data analytics to begin the THM process is an important first step. Plan sponsors should collect claims data to develop a predictive model detailing the health risks of their plan participants. Medical and prescription drug claims data can be reviewed to perform a cost-savings opportunity/health-risk(s) analysis.
- **Planning** It is critical to establish the plan's guiding principles, key objectives, and how success will be measured in both the short and long term.
- **Design** Plan sponsors should also develop the key elements of the THM design while modernizing the current health plan policies and procedures to lower barriers to success. This includes the presence of financial or other incentives to change behavior.
- **Selection** This process allows plan sponsors to select service vendors to perform the key roles of data management, steering participants to high-quality providers, coordinating participant care and treatment, identifying high-risk participants and promoting good health and participant wellness. It also enables the development of performance standards and the key metrics for measuring program success.
- **Management** Managing each aspect of the THM process is a key element of a successful THM strategy. Plan sponsors should establish reporting requirements and set a schedule for regular monitoring of the results.
- **Outreach** A well-developed communication strategy for educating participants about the THM design elements is essential. This strategy should include determining the

media requirements to implement the key communication messages, rolling out the stakeholder education and communication campaign for each of the design elements of the plan, and initiating outreach to plan participants identified with high health risks and beginning effective support and delivery of medical care to these participants.

Utilizing the above THM strategies can reduce plan costs over time. Several best practices produced by such strategies yield improved health outcomes, which, in turn, produce savings. Embracing THM strategies will allow plan sponsors to continue to offer affordable, quality benefits while helping to improve the overall health of their plan participants and decrease costs.



*For assistance with health care cost management strategies, contact your Segal consultant or the nearest Segal office.*

THE SEGAL COMPANY	
Atlanta	678.306.3100
Boston	617.424.7300
Calgary	403.692.2264
Chicago	312.984.8500
Cleveland	216.687.4400
Denver	303.714.9900
Hartford	860.678.3000
Houston	713.664.4654
Los Angeles	818.956.6700
Minneapolis	952.857.2480
Montreal	614.989.3735
New Orleans	504.483.0744
New York	212.251.5000
Philadelphia	215.854.4017
Phoenix	602.381.4000
Princeton	609.520.2700
Raleigh	919.233.1226
San Francisco	415.263.8200
Toronto	416.969.3960
Washington	202.833.6400
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# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** September 11, 2008  
**SUBJECT:** Bid Document

Pursuant to the Board's direction at the last meeting, we have started work on the bid document with GBS. The following is the schedule that has been established for this work effort should we be required by BCBS to go to bid:

## NDPERS: MEDICAL MARKETING PROJECT PROPOSED TIMELINE

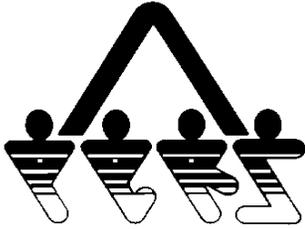
September 8, 2008

TASK	RESPONSIBILITY	BEGIN	END	COMMENTS
PROJECT TEAM MEETING	GBS	9/3/08	-	
DATA REQUESTS	GBS	9/8/08	9/8/08	TO CLIENT & BCBSND
DATA DUE TO GBS	PERS / BCBSND	9/9/08	9/29/08	
VENDOR LIST (DRAFT)	PERS	9/8/08	9/25/08	PERS TO SEND LIST OF LICENSED CARRIERS TO GBS
	GBS	9/8/08	9/25/08	GBS TO RESEARCH TPAs
RFP DRAFT	GBS	9/4/08	9/30/08	
ADVERTISEMENT DRAFT	GBS	9/4/08	9/30/08	9/30/08 GBS TO SEND AD DRAFT TO PERS
RFP DRAFT TO CLIENT	GBS	9/30/08	9/30/08	
CLIENT REVIEW & APPROVAL	CFU	9/30/08	10/7/08	
RFP FINALIZED	GBS	10/7/08	10/13/08	
ADVERTISEMENT TO NEWSPAPERS	PERS	TBD	TBD	
SEND INVITATION TO RFP	GBS	10/20/08	10/20/08	ITR TO VENDORS
RELEASE RFP (POST TO WEBSITE)	PERS	10/20/08	10/20/08	
INTENT TO BID	VENDORS	-	10/27/08	
DEADLINE FOR QUESTIONS	VENDORS	-	11/7/08	MUST BE IN WRITING
RESPONSES TO QUESTIONS	GBS	11/7/08	11/14/08	
PROPOSALS DUE	VENDORS	-	12/5/08	
RFP ANALYSIS	GBS	12/5/08	1/10/09	
DRAFT REPORT TO CLIENT	GBS	1/10/09	1/10/09	
PERS BOARD MEETING	PERS	1/15/09	1/15/09	SELECT FINALISTS
FINALIST INTERVIEWS	PERS/GBS	TBD	TBD	IF REQUIRED
BEST & FINAL OFFERS	VENDORS	TBD	TBD	IF REQUIRED
FINALIZE REPORT	GBS	2/12/09	2/12/09	
SELF-FUNDED CONTRACT AWARD	PERS	3/1/09	3/1/09	
FULLY INSURED CONTRACT AWARD	PERS	4/1/09	4/1/09	
COVERAGE EFFECTIVE DATE	CFU		7/1/09	

This schedule was developed in recognition of the NDCC requirement for all self funded bids to be received by January 1 and awarded no later than March 1. Therefore, to allow the Board adequate time for review, discussion, possible interviews and a decision, we decided that the review needed to be complete for your consideration at the January meeting. With the holidays and the time needed by GBS to review the submissions, this meant bids needed to be received by December 5. With the Thanksgiving holiday and the our desire to allow the bid to be in the marketplace for about six weeks, this meant we needed to release it in the first part of October. This, however, will mean that while we supply a copy of it to the Board at the October meeting, it will have already been released and any modifications the Board may want to make will have to be done by addendums.

Board Action Requested

Approve the above plan of action.



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# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** September 11, 2008  
**SUBJECT:** Medicare Part D Renewal

Attached please find the Medicare Part D PDP renewal. As you will note, the proposed 2009 premium changes to \$81.12 per month, an increase of 13.0% over the \$71.79 premium for 2008.

In summary, the premium change can be reconciled as follows:

2008 premium \$71.79

2009 premium:

experience, no change in fed. sub. 73.82 +2.8%  
expc + change in fed. subsidy 81.12 +13%

That is, if the expected federal subsidy did not change, the premium would have been \$73.82, a 2.8% increase.

Attached is the renewal information. GBS is reviewing it and will present its conclusions at the Board meeting

## North Dakota Public Employees Retirement System

2009 Renewal for Group Prescription Drug Plan  
Based on Current Plan Design

Enrollment on 6/30/2008	2008		2009		Rate Increase
	Monthly Premium	Annual Income	Monthly Premium	Annual Income	
6,201	71.79	\$5,342,037	81.12	\$6,036,479	13.0%

### Notes for 2009 Renewal:

- The Centers for Medicare and Medicaid Services (CMS) reported on August 14, 2008 the national average monthly bid amount for standard Part D individual coverage of \$84.33 and the Part D base beneficiary premium for 2008 (average individual premium) of \$30.36. These amounts are increases from those used in 2008, which were \$80.52 and \$27.93 respectively.

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

<http://www.cms.hhs.gov/medicareadvtspecratestats/Downloads/PartDandMAbenchmarks2009.pdf>

- Direct CMS subsidy payments, which account for more than half of expected claim costs for the NDPERS GPDP, are derived from bidding averages discussed above. For the 2009 NDPERS GPDP rating estimated total CMS payments are expected to **decrease by 12.4%** from that assumed in the 2008 GPDP rating.
- The NDPERS Group Prescription Drug Plan (GPDP) has been rated for 2009 based on prior claim experience from 2007 and the first half of 2008.

**North Dakota Public Employees Retirement System**  
2009 Renewal Rate Calculation for Group Prescription Drug Plan  
Based on 2008 Plan Design

1. Allowed Claims Amounts (Incurred 1-1-07 thru 6-30-08, paid thru 6-30-08)	18,213,002
2. Benefit Adjustment to Current Period [ (1) x 1.0000 ]	18,213,002
3. Completed Incurred Allowed Claims [ (2) / 0.9954 ]	18,297,169
4. Member Months Exposed	109,661
5. Adjusted Experience Period Allowed Claims PMPM [ (3) / (4) ]	166.85
6. Trend [ 21 months @ 9.0% annual ]	1.15750
7. Rating Period Allowed Claims PMPM [ (5) x (6) ]	193.13
8. Rating Period Plan Paid PMPM [ (7) x 0.661 ]	127.66
9. Rating Period Member Cost Share PMPM [ (7) - (8) ]	65.47
10. Estimated 2009 Rx Drug Rebate PMPM	14.75
11. 2009 Plan Payments PMPM [ (8) - (10) ]	112.91
12. 2009 Anticipated Loss Ratio	85%
13. 2009 Gross Premium to BCBSND [ (11) / (12) ]	132.84
14. CMS Payments to BCBSND	51.72
15. 2009 Member Premium [ (13) - (14) ]	81.12



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# Memorandum

**TO: NDPERS Board**

**FROM: Deb Knudsen & Kathy Allen**

**DATE: September 11, 2008**

**SUBJECT: Industry Business and Labor Committee**

On August 21, 2008, staff attended a meeting of the Industry, Business and Labor Committee at the Capital in the Roughrider Room. At that meeting, Legislative Council staff presented a background memorandum relating to the committee's study of regulation and licensing of pharmacists and pharmacies in North Dakota. A copy of that memorandum is attached for your information. The study highlighted the make-up of the Pharmacy Board and the requirement that a registered pharmacist be in charge of or effectively own every store or business that carries the words "drugs", "drugstore" or "pharmacy" in its name, excepting hospitals, which have been given dispensation to serve only patients in the hospital. The study also explained that state law requires any pharmacist licensed in the state of North Dakota to be a member of the North Dakota Pharmaceutical Association (NDPA) and licensing fees reflect dues for that mandatory membership. The council noted further that the ownership issue had been challenged twice in court but has so far been upheld. Additional background was given regarding policies in neighboring states, with the conclusion that North Dakota presently has a unique situation relating to corporate ownership of pharmacies in the state.

Comments were provided by various parties and proved to be numerous and extensive. Individuals listed on the enclosed agenda were present as were others. Specifically, comments centered around changing the required membership in the NDPA and funding for the NDPA as well as the ownership issue. Although written testimony was not provided in most cases, we did obtain a copy of a report that was submitted and presented to the committee by Professor David Flynn from UND. Dr. Flynn was hired to conduct the study by the North Dakotans for Affordable Healthcare represented by Mr. Dan Traynor and funded by WalMart and Walgreens. This group seeks to introduce competition into North Dakota's pharmacy market with its primary focus on removing restrictions on pharmacy ownership.

If you have any further questions, please let either of us know.

NORTH DAKOTA LEGISLATIVE COUNCIL

Tentative Agenda

**INDUSTRY, BUSINESS, AND LABOR COMMITTEE**

Thursday, August 21, 2008  
Roughrider Room, State Capitol  
Bismarck, North Dakota

- 8:30 a.m. Call to order  
Roll call  
Consideration of the minutes of July 9-10, 2008, meeting
- 8:35 a.m. Presentation by representatives of Verizon Wireless regarding the committee's study of wireless providers in the state
- 8:55 a.m. Presentation by the Legislative Council staff of a background memorandum relating to the committee's study of regulation and licensing of pharmacists and pharmacies
- 9:00 a.m. Comments by interested individuals regarding the structure of the State Board of Pharmacy and the relationship between the board and the North Dakota Pharmaceutical Association
- Mr. Howard Anderson, State Board of Pharmacy
  - Mr. Mike Schwab, North Dakota Pharmaceutical Association
  - Other interested persons
- 10:00 a.m. Break
- 10:15 a.m. Comments by interested persons regarding pharmacy ownership requirements
- Mr. Howard Anderson, State Board of Pharmacy
  - Mr. Mike Schwab, North Dakota Pharmaceutical Association
  - Representatives of the Health Policy Consortium
  - Mr. Larry Gauper
  - Mr. Adam Jaffe, Walgreens
  - Mr. Tom Simmer, MedCenter One
  - Representatives of the North Dakota Healthcare Association
  - Representative of North Dakotans for Affordable Healthcare
  - Other interested individuals
- 12:15 p.m. Luncheon recess
- 1:15 p.m. Comments by interested persons regarding the committee's review of Workforce Safety and Insurance
- 1:45 p.m. Presentation by representatives of Workforce Safety and Insurance regarding the committee's review of Workforce Safety and Insurance
- 2:15 p.m. Committee discussion regarding review by committee members of concerns expressed by injured workers
- 4:15 p.m. Committee discussion and staff directives
- 4:45 p.m. Adjourn

**Committee Members**

Representatives Rick Berg (Chairman), Bill Amerman, Tracy Boe, Donald L. Clark, Mark A. Dosch, Glen Froseth, Jim Kasper, Darrell D. Nottestad, Gary Sukut, Elwood Thorpe, Don Vigesaa, Steve Zaiser

Senators Arthur H. Behm, Nicholas P. Hacker, Robert M. Horne, Jerry Klein, Terry M. Wanzek

August 2008

## REGULATION AND LICENSING OF PHARMACISTS AND PHARMACIES - BACKGROUND INFORMATION

Section 2 of House Bill No. 1299 (2007) (attached as an appendix) provides for a study of:

1. The State Board of Pharmacy, the board's size, the manner of board membership appointment, and whether the board is representative of commercial and noncommercial pharmacists;
2. The state's demographics and the impact changing demographics in rural areas will have on the ability of small, locally owned pharmacies to remain economically viable and on the ability of rural residents to access low-cost pharmaceuticals and pharmacy and pharmacists' services;
3. The pharmacy ownership restrictions, the relevance of those restrictions in terms of marketplace competition, and the impact of those restrictions on the price and availability of pharmaceuticals and on pharmacy and pharmacists' services; and
4. The statutory interplay between the State Board of Pharmacy and the North Dakota Pharmaceutical Association and whether the regulatory function of the board conflicts with the advocacy function of the association.

### BACKGROUND

#### State Board of Pharmacy

North Dakota Century Code Chapter 43-15 governs the regulation of pharmacists and pharmacies. Section 43-15-03 provides for a State Board of Pharmacy consisting of five members appointed by the Governor upon the recommendation of the North Dakota Pharmaceutical Association. The individuals appointed to the board must be licensed pharmacists and must be members of the North Dakota Pharmaceutical Association. Section 43-15-04 provides that the term of office of members of the board is five years. Under Section 43-15-05, board members are entitled to a per diem of \$200 for attendance at board meetings.

Section 43-15-06 requires the board president to be a member of the board, but provides that the secretary and treasurer do not have to be members of the board. The board is required to hire a pharmacist as the full-time executive director.

Section 43-15-09 requires the board to meet at least two times, but not more than four times, each year for the examination of applicants. In addition, the board is authorized to meet as necessary for the performance of its duties.

Section 43-15-10 sets forth the duties of the board. Among its duties, the board is authorized to:

1. Place on probation, reprimand, or fine any pharmacy, pharmacist, or pharmacy intern or pharmacy technician; or refuse to issue or renew, or suspend, revoke, restrict, or cancel, the license, permit, or registration of any pharmacy, pharmacist, or pharmacy intern or pharmacy technician.
2. Adopt rules governing the cancellation or suspension of a license.
3. Examine and license pharmacists.
4. Adopt rules for the guidance of its members, officers, and employees, and to ensure the proper and orderly dispatch of its business.
5. Employ individuals to inspect pharmacies, investigate pharmacies, procure evidence in any proceeding pending before the board, or procure evidence in aid of any prosecution.
6. Employ counsel to advise the board or to prosecute or defend any action or proceeding commenced by or against the board or pending before it.
7. Grant permits and renewals for the establishment and operation of pharmacies.
8. For good cause, cancel, revoke, or suspend permits and renewals for the establishment and operation of pharmacies.
9. Adopt reasonable and nondiscriminatory rules with respect to granting, renewing, canceling, revoking, or suspending permits and renewals for establishing and operating pharmacies.
10. Adopt reasonable rules relating to the physical design of space occupied by a pharmacy to ensure appropriate control of and safeguards over the contents of the pharmacy.
11. Regulate and control the practice of pharmacy in North Dakota.
12. Adopt, amend, and repeal rules for the regulation of pharmacies and pharmacists providing radiopharmaceutical services.
13. Adopt, amend, and repeal rules for the proper administration and enforcement of Chapter 43-15, Chapter 19-02.1 as that chapter pertains to drugs, subject to approval of the director of the State Department of Health, and Chapter 19-03.1.
14. Investigate and gather evidence concerning alleged violations of the provisions of Chapter 43-15, Chapter 19-02.1 as it pertains to drugs, Chapters 19-03.1, 19-03.2, and 19-04, or of the rules of the board.
15. Adopt, amend, and repeal rules to register pharmacy technicians.
16. Require the self-reporting by an applicant or a licensee of any information the board determines may indicate possible deficiencies

in practice, performance, fitness, or qualifications.

17. Require information regarding an applicant's or licensee's fitness, qualifications, and previous professional record and performance from recognized data sources, licensing and disciplinary authorities of other jurisdictions, professional education and training institutions, liability insurers, health care institutions, and law enforcement agencies be reported to the board.

#### **North Dakota Pharmaceutical Association**

Section 43-15-13.2 provides that the North Dakota Pharmaceutical Association consists of every person:

1. Who has secured a current annual license to practice pharmacy in this state.
2. Who has paid an annual membership fee directly to the association as determined and permitted by the association and who does not hold a current license to practice pharmacy in this state.

Section 43-15-30 provides that licensure as a pharmacist by the board entitles the person so licensed to a one-year membership in the North Dakota Pharmaceutical Association.

Section 43-15-13.3 provides that the members of the association who have secured a current annual license to practice pharmacy in this state are entitled to all the rights and privileges of the association and may vote, serve as an officer or director of the association, and participate in all the meetings of the association. The members of the association who have not secured a current annual license to practice pharmacy are entitled to all the rights and privileges of the association, except that they may not vote at the meetings or serve as an officer or director of the association.

Section 43-15-13.4 mandates that the association is to receive 50 percent of the fees received by the board for license renewals. The section allows the association to use the funds for payment of expenses of the association including continuing pharmaceutical education, pharmacist discipline, the impaired pharmacist program, matters related to pharmacist registration standards, professional service standards, and general operating expenses.

#### **Pharmacist Licensing**

Section 43-15-15 requires that an applicant for a pharmacist license must be at least 18 years of age, be of good moral character, and be a graduate of a school or college of pharmacy recognized by the board as an approved school. Section 43-15-22 provides for licensing of pharmacists from other states or foreign countries without an examination if the qualifications from the other state or country are equivalent to those in this state.

Section 43-15-25 provides that a license is valid for one year and establishes a renewal fee not to exceed \$200. Before a renewal may be issued, a pharmacist

is required under Section 43-15-25.1 to complete an accredited program of continuing education. The continuing education requirements may not exceed 30 hours in each biennium.

#### **Pharmacy Operation**

Section 43-15-32 provides a registered pharmacist must be in charge of every store, dispensary, pharmacy, laboratory, or office, selling, dispensing, or compounding drugs, medicines, or chemicals, or compounding or dispensing prescriptions of medical practitioners in the state, and every business carried on under a name which contains the words "drugs," "drugstore," or "pharmacy," or which is described or referred to in such terms by advertisements, circulars, posters, signs, or otherwise.

Section 43-15-34 prohibits any person from opening, establishing, operating, or maintaining a pharmacy in the state without obtaining a permit from the board. Section 43-15-34.1 requires an out-of-state pharmacy that ships or delivers a dispensed prescription drug or legend drug into the state to hold a pharmacy permit issued by the board. The section also provides that the part of the pharmacy operation dispensing the prescription for a resident of this state abide by state law and rules of the board.

Section 43-15-35 sets forth the requirements to operate a pharmacy in the state. The section requires that the management of a pharmacy must be under the personal charge of a pharmacist licensed in this state. In addition, the section establishes pharmacy ownership requirements. Those requirements have been the subject of litigation twice since the adoption of the requirements in 1963.

The 1963 Legislative Assembly adopted legislation that provided that an applicant for a permit to operate a pharmacy must be a registered pharmacist or a partnership, each active member of which is a registered pharmacist, or a corporation or an association, the majority of stock of which is owned by registered pharmacists actively and regularly employed and responsible for the management, supervision, and operation of the pharmacy. The legislation included an exception for the holder of a permit on July 1, 1963, if otherwise qualified to conduct the pharmacy, for so long as the permit holder continues operations and renews the permit. The legislation also included an exception for hospital pharmacies furnishing service only to patients in the hospital.

The 1963 legislation, which was codified as Section 43-15-35, faced a constitutional challenge that was ultimately decided by the United States Supreme Court in 1973. In 1972 the State Board of Pharmacy denied a permit to Snyder's Drug Stores because the board determined the applicant "did not comply with the stock-ownership requirements of the statute, it appearing that all the common stock of Snyder's was owned by Red Owl Stores and it not being shown if any Red Owl shareholders were pharmacists registered and in good standing in North Dakota."

*North Dakota Pharmacy Bd. v. Snyder's Stores*, 414 U.S. 156 (1973). Although the North Dakota Supreme Court found the pharmacy ownership requirements to be unconstitutional, the United States Supreme Court overruled the decision upon which the North Dakota Supreme Court based its decision, reversed the decision, and remanded the case to the North Dakota Supreme Court. The North Dakota Supreme Court then upheld the constitutionality of the law.

The pharmacy ownership law was challenged again in the mid-1990s. In 1996 Medcenter One Hospital decided to expand its pharmacy at the hospital to make pharmacy sales to the general public. The State Board of Pharmacy, through its legal counsel, informed Medcenter One that the "exemption for community/retail pharmacies set forth in N.D.C.C. 43-15-35 would [not] be available to Medcenter One Hospital Pharmacy." The opinion of the board's legal counsel concluded that:

Before July 1, 1963, there were two type[s] of pharmacy permits for two types of pharmacy practice, one for hospitals serving only patients in that hospital and one for community/retail pharmacies. When N.D.C.C. 43-15-35 was amended effective July 1, 1963, the legislature recognized that distinction in permits and pharmacy practice and codified that distinction by providing that N.D.C.C. 43-15-35 does not apply to hospital pharmacies furnishing service only to patients in such hospital or to community/retail pharmacies holding a permit on July 1, 1963.

Because the Bismarck Hospital Pharmacy was the beneficiary of the hospital exemption since that was the type of pharmacy practice it was engaged in on July 1, 1963, the opinion concluded that "Medcenter One Pharmacy is not now (32 years later) entitled to an additional exemption for community/retail pharmacies, because it was not engaged in that type of practice on July 1, 1963."

Medcenter One Hospital sought and received a declaratory judgment from the district court which concluded that the unambiguous language of Section 43-15-35 did not differentiate between hospital and retail pharmacy permits and held that Medcenter One Hospital, as the continuous holder of a permit since before 1963, was exempt from the pharmacist ownership requirements. The North Dakota Supreme Court affirmed the decision in *Medcenter One v. State Bd. of Pharmacy*, 561 N.W.2d 634 (1997). The Supreme Court stated that Section 43-15-35 clearly and unambiguously describes two exemptions to the pharmacist ownership requirements. The first exemption is for pharmacies that held permits on July 1, 1963, and have not discontinued operations or failed to renew their permit. The court concluded the plain language of that exemption applies to all pharmacy permitholders on that date, not just retail or nonhospital pharmacies. The second exemption applies to hospital pharmacies furnishing service only to patients in the hospital. The court concluded if the

Legislative Assembly had intended the first exemption only to apply to retail or nonhospital pharmacies, it would have limited that exemption with appropriate language.

Section 43-15-35, as amended by the Legislative Assembly in 2007, retains the pharmacist ownership requirements. House Bill No. 1299 (2007) created an exception from the requirements for an applicant for a permit to operate a pharmacy which is a hospital if the pharmacy for which the hospital seeks a permit to operate is a retail pharmacy that is the sole provider of pharmacy services in the community and is a retail pharmacy that was in existence before the hospital took over operations. A hospital operating a pharmacy under that exception may operate the pharmacy at any location in the community. House Bill No. 1350 (2007) established an exception from the ownership requirements for an applicant for a permit to operate a pharmacy which is the owner of a postgraduate medical residency training program if the pharmacy is collocated with and is run in direct conjunction with the postgraduate medical residency training program.

## 2007 LEGISLATION

In addition to the two bills that created exceptions to the pharmacist ownership requirements, two other bills were considered by the Legislative Assembly which related to the State Board of Pharmacy and the North Dakota Pharmaceutical Association. House Bill No. 1148 (2007), which failed, would have repealed the statutory provisions relating to the North Dakota Pharmaceutical Association and would have removed the requirement that the members of the State Board of Pharmacy be appointed upon the recommendation of the association. The bill also would have prohibited the board from requiring that a pharmacist be a member of any association as a requirement for initial licensure or for license renewal and would have prohibited the board from using licensure fees to pay a pharmacist's membership dues to a professional association. Senate Bill No. 2387 (2007), which also failed, was identical to 2007 House Bill No. 1148.

## PHARMACIST REGULATION IN NEIGHBORING STATES

### South Dakota

The South Dakota Codified Laws provide for a State Board of Pharmacy consisting of four professional members and one laymember. The term of office of the members is three years.

South Dakota law provides that participation in the South Dakota Pharmacists Association by pharmacists is elective. The State Board of Pharmacy is authorized to pay to the South Dakota Pharmacists Association 80 percent of all fees the board receives for renewals of certificates as registration as a pharmacist. The association is required to use the funds for continuing education, matters related to registration standards for pharmacists, professional

service standards, and general operating expenses related to those activities. The association is also required to use funds received to pay any legislated assessment to support a diversion program for chemically impaired pharmacists.

Under South Dakota law, the State Board of Pharmacy may not issue a permit to conduct a pharmacy to any pharmacist applicant unless the applicant is owner, or part-owner, of the merchandise and fixtures of the place of business for which the pharmacy registration is applied; the application is made jointly with a registered pharmacist owner; or the nonpharmacist owner of the merchandise and fixtures of the place of business for which pharmacy registration is applied, has made an affidavit delegating complete responsibility for the pharmaceutical services in the place of business to the pharmacist applicant. The board also is authorized to issue to pharmacists in good standing a permit to conduct a part-time, limited, or conditional pharmacy in hospitals, nursing homes, or related facilities if the pharmacy services are limited to patients.

### **Montana**

The Montana Code Annotated provides for a Board of Pharmacy consisting of six members, three of whom must be licensed pharmacists, two of whom must be from the general public, and one of whom must be a registered pharmacy technician. The term of office of the members is five years. The members are appointed by the Governor with the consent of the Senate.

Montana law prohibits the Board of Pharmacy from issuing a license to a pharmacy unless the pharmacy is operated by a pharmacist registered by the board.

The Montana Pharmacy Association provides continuing education opportunities, advocacy, and pharmacy information. The association is a voluntary organization.

### **Minnesota**

The Minnesota State Board of Pharmacy consists of five pharmacists and two public members appointed by the Governor for a term of office of four years. The Minnesota Statutes provide that the Minnesota State Pharmaceutical Association and the Minnesota Society of Hospital Pharmacists jointly may recommend five names for each pharmacist to be appointed.

Under rules adopted by the Minnesota State Board of Pharmacy, a pharmacy must be licensed in at least one of the following categories of licensure: a community/retail pharmacy; a hospital pharmacy; a parenteral-enteral/home health care pharmacy; a long-term care pharmacy; a nuclear pharmacy; or a central service pharmacy.

The Minnesota State Pharmaceutical Association is a voluntary association that provides advocacy, professional development and education, communications, and products and services.

### **SUGGESTED STUDY APPROACH**

In conducting this study, the committee may choose to:

1. Receive information from the State Board of Pharmacy, the North Dakota Pharmaceutical Association, other pharmacy groups, hospital and other health care facility groups, and individual pharmacists regarding the structure of the board, access to pharmacy services, the restrictions on pharmacist ownership, and the relationship between the board and association.
2. Develop recommendations and draft legislation, if necessary to implement the recommendations, to address any concerns identified.

ATTACH:1

from the provisions of ~~subsection 5 subdivision e of subsection 1~~ as to the discontinued or lapsed permit. ~~The provisions of subsection 5 shall not apply to~~

- b. ~~A hospital pharmacies~~ pharmacy furnishing service only to patients in that hospital.
- c. The applicant for a permit to operate a pharmacy which is a hospital, if the pharmacy for which the hospital seeks a permit to operate is a retail pharmacy that is the sole provider of pharmacy services in the community and is a retail pharmacy that was in existence before the hospital took over operations. A hospital operating a pharmacy under this subdivision may operate the pharmacy at any location in the community.

## **SECTION 2. LEGISLATIVE COUNCIL STUDY - REGULATION AND LICENSING OF PHARMACISTS.**

1. The legislative council shall consider studying, during the 2007-08 interim, the regulation and licensing of pharmacists in this state. The study must include an examination of:
  - a. The state board of pharmacy, the board's size, the manner of board membership appointment, and whether the board is representative of commercial and noncommercial pharmacists;
  - b. The state's demographics and the impact changing demographics in rural areas will have on the ability of small, locally owned pharmacies to remain economically viable and on the ability of rural residents to access low-cost pharmaceuticals and pharmacy and pharmacists' services;
  - c. The pharmacy ownership restrictions, the relevance of those restrictions in terms of marketplace competition, and the impact of those restrictions on the price and availability of pharmaceuticals and on pharmacy and pharmacists' services; and
  - d. The statutory interplay between the state board of pharmacy and the North Dakota pharmaceutical association and whether the regulatory function of the board conflicts with the advocacy function of the association.
2. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-first legislative assembly.

# Economic Impact of the Removal Pharmacy of Ownership Restrictions in North Dakota\*

David T. Flynn, Ph.D.

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\* The analysis and opinions contained in this report are those of the author and do not necessarily reflect the opinions of the Bureau of Business & Economic Research, the College of Business & Public Administration, or the University of North Dakota

Rec'd from  
Dan Traynor of  
North Dakota for  
Dakota Health

### **Executive Summary**

This report employs economic impact analysis to study the effects of a proposed change in North Dakota's pharmacy ownership rules. The results indicate significant economic benefit to the state economy. The two scenarios created display this sizable benefit. The theoretical maximum scenario generates \$49.6 million in additional output through consumer spending and other factors. With the output increase there are also nearly 350 new jobs and \$1.85 million in additional tax revenues. A more conservative scenario indicates an output increase of \$11.8 million, a tax collection increase of \$437,000 and 82 new jobs. Competition benefits consumers and as a result benefits the overall economy in North Dakota.

## **Introduction**

North Dakotans for Affordable Healthcare (NDAH) seeks to introduce competition into North Dakota's pharmacy market. The removal of restrictions on pharmacy ownership is their preferred method of introducing competition. The current situation in North Dakota is that corporate ownership of pharmacies is not allowed, restricting access to corporations such as Wal-Mart, Target, Walgreens and regionally based corporations such as Hugo's (grocery store) and Pamida. In this report I provide insight into the issues of prescription drug prices on the national level and the income of pharmacists and pharmacy technicians in North Dakota relative to other states. In addition, I perform an economic impact analysis describing likely results to North Dakota's economy as a result of a change in pharmacy ownership laws. The study ends with conclusions based on the results of the impact analysis.

## **Prescription Drug Prices**

### *National Data*

The level of prices and inflation are a constant concern in the current US economy and much of the world. Price changes alter the available budget resources for consumers, and when unanticipated fluctuations in prices occur consumer spending plans may need to change drastically, particularly when changes are in the area of health care. Anecdotally, I have heard from many people about ever-rising drug prices and the adverse impacts on low income households, people living on fixed incomes, and many others on a frequent basis. In fact, there is another group that suffers as a result of price increases but we seldom hear about, those with good incomes but significant medical expenses. These households have typically made a choice to spend any amount necessary on medical care for family members and therefore sacrifice on other expenses, such as houses and consumer goods.<sup>1</sup>

The Bureau of Labor Statistics (BLS) tracks an index value for prescription drug prices as part of their medical care commodities series.<sup>2</sup> Using this index I calculate an annual percentage change from July of 2001 to July of 2008 and a total percentage change over this 7 year period. The percentage change in prescription drug prices over this time period is 24.6%, higher than the overall percentage change in the CPI. Table 1 below displays the one year percentage change in prescription drug prices and compares the rate to the increase in the overall CPI. Figure 1 provides a graphical perspective for the data in Table 1. Both Figure 1 and Table 1 show that the annual percentage changes in prescription drug prices are quite large until the 2006 to 2007 period, in fact they are above the overall increase in prices for the same period. While prices in general fell from 2006 to 2007 we see that drug prices fall by more and that they continue to stay below the general rate of inflation to the end of the analysis. The 2006 to 2007 calculation coincides with the introduction of Wal-Mart's \$4 drug plan.<sup>3</sup> The increase from 2007 to 2008 is at a lower rate than the general inflation currently rippling through the U.S. economy. The primary culprit for the current increase is higher fuel prices, and the uncertainty surrounding the permanency of this change. Fuel price increases are driving up prices for almost all goods where shipping is an important part of the final retail price, such as food.

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<sup>1</sup> There are no statistics developed to describe the impacts of drug prices on these groups so quantitative analysis is not possible. The author admits to considering his own household in this category.

<sup>2</sup> The data used come from BLS series CUSR0000SEMA and are seasonally adjusted. The data include all drugs dispensed by prescription and include purchases through mail. These are transaction prices between the pharmacy, the patient, and any third party payer.

<sup>3</sup> It should be noted that Target, Walgreen's and others followed suit soon after Wal-Mart's announcement and continue to do so.

Figure 1. Annual percentage change in prescription drug prices and overall CPI.

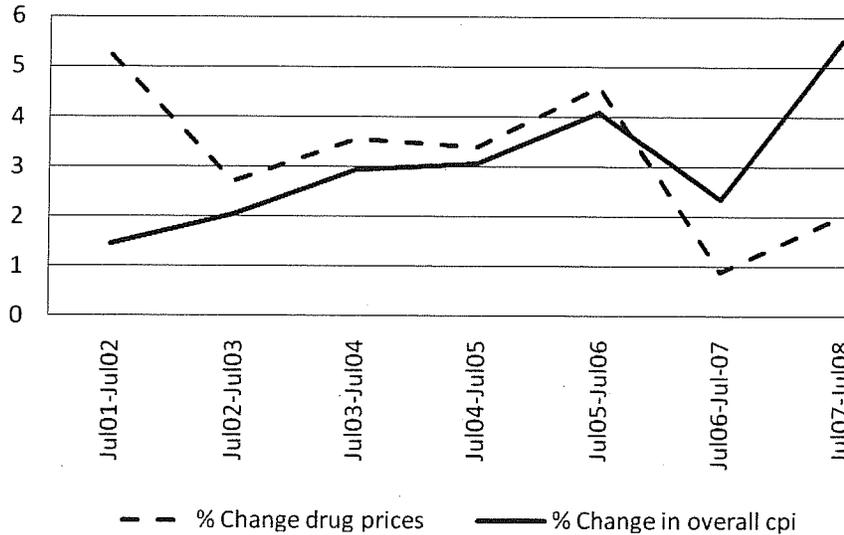


Table 1. Percentage change in prescription drug price index July to July for various years

Period	% change in drug prices	% change in overall cpi
<b>Jul01-Jul02</b>	5.2	1.5
<b>Jul02-Jul03</b>	2.7	2.1
<b>Jul03-Jul04</b>	3.6	2.9
<b>Jul04-Jul05</b>	3.4	3.1
<b>Jul05-Jul06</b>	4.6	4.1
<b>Jul06-Jul-07</b>	0.9	2.44
<b>Jul07-Jul08</b>	2.0	5.5

The precise share of the reduction in medical care commodity inflation attributable to Wal-Mart and other discount retailers offering pharmacy services requires further analysis with more detailed data, though the likelihood of the dramatic drop in price inflation for prescription drugs being a coincidence is small in my opinion. I also provide data for North Dakota and Minnesota White Drug's prices compared with Wal-Mart's in Table 2 below.<sup>4</sup> This clearly demonstrates that Wal-Mart's lower prescription drug prices contributed to the recent reduction in prescription drug price inflation nationwide.

<sup>4</sup> For Tables 2 and 3 data supplied by Wal-Mart for period 8/01/2007 through 7/31/2008.

*North Dakota, Minnesota Data*

To demonstrate regional consistency with the national data Table 2 provides a comparison of generic drug prices between Wal-Mart and White Drug's in North Dakota and Minnesota.<sup>5</sup> Wal-Mart's price is a significant improvement in many cases.<sup>6</sup>

Table 2. Comparison of Wal-Mart prices with North Dakota & Minnesota White Drug's, generic and brand name drugs, by volume.

QTY	DRUG	Dosage	Wal-Mart's Price	North Dakota White Drug's Price	Minnesota White Drug's Price
#30	HCTZ	25mg	4.00	11.89	9.99
#30	Lisinopril	20mg	4.00	13.89	13.89
#60	Tramadol	50mg	4.00	18.79	18.79
#60	Metformin	500mg	4.00	19.99	19.99
#30	Fluoxetine	20mg	4.00	15.19	15.19
#30	Fluoxetine	40mg	4.00	72.09	37.52
#60	Metoprolol	50mg	4.00	22.29	17.39
#30	Pravastatin	40mg	4.00	15.99	15.99
#30	Cyclobenzaprine	10mg	4.00	16.09	16.09
#20	SMZ/TMP DS		4.00	14.19	14.09
#20	Ciprofloxacin	500mg	4.00	33.49	12.99
#30	Plavix	75mg	147.84	162.79	162.79
#30	Singulair	10mg	130.68	127.19	127.19
#30	Nexium	40mg	171.72	189.09	159.99
#30	Lipitor	20mg	126.62	142.69	129.70
#30	Prevacid	30mg	165.46	186.89	157.01
#30	Lipitor	10mg	88.68	100.09	100.09

The average savings North Dakotans would receive from a Wal-Mart pharmacy would be significant, averaging \$16.92 per fill. The savings received by Minnesotans from Wal-Mart averages \$9.04. Annual savings for users of Lipitor or Prevacid would amount to more than \$130 and \$250 respectively. The data in Table 2 also indicate lower prices for Minnesotans from White Drugs. North Dakotans pay on average \$7.88 more for their prescriptions from the same pharmacy outlet, White Drugs. Clearly, there are savings to be had for consumers of prescription drugs with a change in the ownership rules for pharmacies.

### Impact Analysis

The significant savings levels represent an opportunity for North Dakota's economy to experience a further buffer against recessionary forces prevalent in other parts of the country. Consumer savings, Total results and the major sector results. Highlight impacts on pharmacy sector. Maximum theoretical amount, results from any changed sector as a result of more consumption. Highlight tax results too.

There are two scenarios developed for the impact analysis that incorporate the consumer sector, insurers, and pharmacies.<sup>7</sup> The first scenario, explained in a more complete fashion later, estimates the maximum

<sup>5</sup> This data also supplied by Wal-Mart for the period 8/1/2007 through 7/31/2008.

<sup>6</sup> Data provided by Wal-Mart based on survey from 8/16/2008 to 8/18/2008 from selected North Dakota White Drug's.

possible impact from a change in pharmacy ownership rules. The other scenario estimates the impact using percentages and ratios from Blue Cross/Blue Shield of North Dakota (BCBS) data. For each scenario I report the output and employment impacts for top sectors as well as for pharmacies if outside the top. I also report the tax impact resulting from the scenario.

*Scenario 1:* The task set forth in this scenario is estimating the maximum possible impact from a change in pharmacy ownership laws. The maximum impact relies on the data provided by BCBS. Table 3 displays estimated expenditures on prescription drugs by BCBS members by location and by type of pharmacy for out-state expenditures. This is the baseline data and our scenario creates changes in spending as a result from changes in the law.

Table 3. Cost breakdown for prescription drug expenditures.<sup>8</sup>

<b>Area &amp; Store</b>	<b>Total amount</b>	<b>Consumer share</b>	<b>BCBS share</b>
<b>In-state total cost</b>	\$152,212,555.69	\$60,885,022.28	\$91,327,533.42
<b>Out-state total cost<sup>9</sup></b>	\$50,944,515.85	\$20,377,806.34	\$30,566,709.51
<b>Wal-Mart total cost</b>	\$8,347,921.82	\$3,339,168.73	\$5,008,753.09
<b>Non-WM</b>	\$42,596,594.03	\$17,038,637.61	\$25,557,956.42

The first assumption is that the introduction of discount retailer pharmacies results in a reduction of prices such that all prescription drug prices are at the level of Wal-Mart. The second assumption is that all out-state prescription drug purchases are repatriated to North Dakota. We do not engage in any changes in consumer behavior here as there are no good estimates of these changes, particularly for groups such as those lacking health insurance.<sup>10</sup>

Table 4. Cost breakdown assuming all prescription drug expenditures are at Wal-Mart average costs.

<b>Area &amp; Store</b>	<b>Total amount</b>	<b>Consumer share</b>	<b>BCBS share</b>
<b>In-state total cost</b>	\$117,169,981.58	\$46,867,992.63	\$70,301,988.95
<b>Out-state total cost<sup>11</sup></b>	\$35,298,376.64	\$14,119,350.65	\$21,179,025.98
<b>Wal-Mart total cost</b>	\$8,347,921.82	\$3,339,168.73	\$5,008,753.09
<b>Non-WM</b>	\$26,950,454.82	\$10,780,181.93	\$16,170,272.89

The resulting savings to North Dakota consumers from the assumption of Wal-Mart average prices is \$14,017,029.65, while the savings to BCBS is \$21,025,544.47.<sup>12</sup> The consumer savings are distributed

<sup>7</sup> The one sector lacking from the analysis is the government sector through such programs as Medicare or Medicaid. At this time we do not have data providing an estimate of the change in program spending from lower prescription drug prices. We continue to seek this information and will update any and all analyses as soon as they are available.

<sup>8</sup> BCBS provided 2006 claims, a sample quarter breakdown expenditure type and average cost figures that allowed for the creation of Table 3.

<sup>9</sup> Out-state costs are broken down into Wal-Mart and non-Wal-Mart expenditures. The average cost sharing ratio was provided by BCBS as was the other pieces used to develop the data in this and other scenario tables.

<sup>10</sup> Certainly it seems logical to assume an increase in purchases of prescription drugs when the price falls, particularly for those with more limited resources and lacking health insurance. The problem is that there is no definitive estimate of the extent of this change at this time. The Census Bureau estimates there are 69,000 North Dakotans lacking health insurance, more than 10% of the state population.

<sup>11</sup> Out-state costs are broken down into Wal-Mart and non-Wal-Mart expenditures. The average cost sharing ratio was provided by BCBS as was the other pieces used to develop the data in this and other scenario tables.

across income categories according to the Census Bureau American Community Survey population breakdown according to income. Existing pharmacies in North Dakota will incur a retail markup loss under this scenario. A sizable portion of consumer prescription drug prices comes from manufacturing expense, research and development, as well as wholesale markup and transportation costs. The loss to pharmacies is equal to the retail markup on the combined consumer and BCBS amount, \$35,042,574.12. In addition, the lower cost availability of prescription drugs in North Dakota is assumed to attract back all prescriptions filled out of state, but at the average cost for Wal-Mart prescriptions, a total of \$35,298,376.64.<sup>13</sup>

Table 5. Output impacts from Scenario 1.

Sector	Impact Amounts			Total
	Direct	Indirect	Induced	
Insurance Carriers	\$21,152,790	\$1,068,180	\$97,045	\$22,318,010
Insurance agencies/brokerages	\$0	\$3,501,022	\$15,484	\$3,516,507
Hospitals	\$801,957	\$0	\$423,007	\$1,224,964
Offices of physicians/dentists	\$695,489	\$0	\$392,025	\$1,087,515
Food service & drinking places	\$533,919	\$63,960	\$341,964	\$939,843
Wholesale trade	\$349,849	\$110,761	\$250,900	\$711,510
Real estate	\$165,012	\$355,087	\$165,994	\$686,093
Depository Institutions	\$285,833	\$190,769	\$192,156	\$668,758
Securities, commodity contracts, investments	\$57,327	\$398,904	\$70,068	\$526,299
Power generation & supply	\$237,792	\$80,027	\$158,956	\$476,744
<i>Pharmacies</i>	\$164,154	\$4,788	\$51,154	\$220,096
<b>Grand Totals</b>	<b>\$35,106,064</b>	<b>\$8,430,843</b>	<b>\$6,066,517</b>	<b>\$49,603,424</b>
<b>Tax Totals</b>	<b>\$1,287,315</b>	<b>\$198,407</b>	<b>\$362,578</b>	<b>\$1,848,299</b>

The output impacts are quite large with a total economic impact of \$49.6 million. Insurance and medical services are among the sectors benefitting the most from such a change, though financial services and food service also benefit. There is also a benefit to the pharmacy sector as well with an increase in output of over \$200,000. There are important employment impacts as well.

<sup>12</sup> BCBS indicated that eventually all savings would pass on to members, but that would take time so we apply the initial BCBS savings to their business model.

<sup>13</sup> I emphasize that this is a theoretical maximum. It is obviously highly unlikely that all out of state prescriptions will be filled in North Dakota.

Table 6. Employment impacts from Scenario 1.

Sector	Impact Amounts			Total
	Direct	Indirect	Induced	
Insurance Carriers	102.1	5.2	0.5	107.7
Insurance agencies/brokerages	0.0	38.9	0.2	39.0
Food service & drinking places	12.5	1.5	8.0	22.0
Hospitals	7.7	0.0	4.0	11.7
Offices of physicians/dentists	6.5	0.0	3.7	10.2
Real estate	1.9	4.0	1.9	7.8
Food and beverage stores	4.7	0.2	2.7	7.6
Nursing and residential care facilities	4.7	0.0	2.5	7.2
General merchandise stores	4.3	0.2	2.5	7.1
Social assistance except daycare	4.2	0.0	2.4	6.6
<i>Pharmacies</i>	2.6	0.1	0.8	3.5
<b>Grand Totals</b>	201.2	80.2	66.8	348.2

Insurance and medical services of various types are among the chief beneficiaries from the change in law, though clearly the gains are spread around with restaurants, discount retailers, grocery stores and others sharing in the almost 350 jobs created under this scenario.

*Scenario 2:* Scenario 2 pulls back from the theoretical maximum and distributes in-state changes in a pattern similar to that found in the current out of state data. Roughly 25% of out of state prescription claims from BCBS were filled at Wal-Mart. The assumption for this scenario is that 25% of in state prescriptions will be filled at Wal-Mart type stores. In addition, the Wal-Mart portion of out of state fills is assumed to come into the state. Prescriptions filled at Wal-Mart use the Wal-Mart total cost and those from other in state pharmacies use the in state cost. The initial figures for this scenario are the same as we see in Table 3 from scenario 1. The adjusted figures based on this scenario are found in Table 7.

Table 7. Cost breakdown under scenario 2.

Area & Store	Total amount	Consumer share	BCBS share
<b>In-state total cost</b>	\$143,802,337.91	\$57,520,935.16	\$86,281,402.74
<b>In-state non Wal-Mart Pharmacies</b>	\$115,681,542.33	\$46,272,616.93	\$69,408,925.40
<b>In-state Wal-Mart pharmacies</b>	\$28,120,795.58	\$11,248,318.23	\$16,872,477.35
<b>Out of state Wal-Mart fills returning</b>	\$8,347,921.82	\$3,339,168.73	\$5,008,753.09

The total savings to the consumer sector as a result of this scenario are \$3,364,087.12 while BCBS looks to save \$5,046,130.67. The total negative for the pharmacy sector results in \$8,410,217.79, though this is offset by the former out of state Wal-Mart amount of \$8,347,921.82, implying a negative of only \$62,295.97.

Table 8. Output impacts from Scenario 2.

Sector	Impact Amounts			Total
	Direct	Indirect	Induced	
Insurance Carriers	\$5,076,669	\$256,318	\$23,096	\$5,356,083
Insurance agencies/brokerages	\$0	\$840,238	\$3,685	\$843,923
Hospitals	\$192,470	\$0	\$100,674	\$293,143
Offices of physicians/dentists	\$166,918	\$0	\$93,300	\$260,218
Food service & drinking places	\$128,141	\$15,193	\$81,386	\$224,719
Wholesale trade	\$83,964	\$26,417	\$59,713	\$170,094
Real estate	\$39,603	\$84,330	\$39,506	\$163,439
Depository Institutions	\$68,600	\$45,538	\$45,732	\$159,870
Securities, commodity contracts, investments	\$13,758	\$95,667	\$16,676	\$126,101
Power generation & supply	\$57,070	\$18,752	\$37,831	\$113,653
<i>Pharmacies</i>	\$1,986	\$1,124	\$12,174	\$15,285
<b>Grand Totals</b>	<b>\$8,387,978</b>	<b>\$2,014,829</b>	<b>\$1,443,801</b>	<b>\$11,846,608</b>
<i>Tax Totals</i>	\$303,642	\$47,262	\$86,292	\$437,196

Despite the more limited assumptions in scenario 2 than those found in scenario 1 there is still a positive output impact of nearly \$12 million. The pharmacy impact is smaller, though remains positive despite the negative net gain for pharmacy dollars. Clearly the pharmacy specific changes were outweighed by the BCBS effects and the changes in consumer income. The same positive impacts are evident in the employment impacts for scenario 2 as well.

Table 9. Employment impacts from Scenario 2.

Sector	Impact Amounts			Total
	Direct	Indirect	Induced	
Insurance Carriers	24.5	1.2	0.1	25.8
Insurance agencies/brokerages	0.0	9.3	0.0	9.4
Food service & drinking places	3.0	0.4	1.9	5.2
Hospitals	1.8	0.0	1.0	2.8
Offices of physicians/dentists	1.6	0.0	0.9	2.4
Real estate	0.4	1.0	0.4	1.8
Food and beverage stores	1.1	0.0	0.7	1.8
Nursing and residential care facilities	1.1	0.0	0.6	1.7
General merchandise stores	1.0	0.0	0.6	1.7
Social assistance except daycare	1.0	0.0	0.6	1.6
<i>Pharmacies</i>	0.0	0.0	0.2	0.2
<b>Grand Totals</b>	<b>47.7</b>	<b>19.2</b>	<b>15.9</b>	<b>82.7</b>

Output growth occurs in the same top sectors as from before. Despite the initial negative impact on the pharmacy sector in the end there is no loss of employment there.

### ***Impact Conclusions***

Scenario 2 shows that under realistic assumptions about changes occurring as a result of the amendment of the law governing pharmacy ownership a significant positive economic impact occurs for the state of North Dakota. The maximum benefits achievable, described in scenario 1, represent a large improvement but are less realistic than scenario 2. It is highly unlikely that all out of state spending returns to North Dakota. There will always be emergencies that require prescriptions to be filled outside the borders of North Dakota. In addition, the significant number of border communities makes it likely that BCBS covers residents of Minnesota that will fill prescriptions outside North Dakota at pharmacies nearer their residence.

However, there are reasons to believe the impacts would be larger than those estimated in scenario 2. The benefits to government, beyond increased tax revenues provided in the output impact tables, are not yet included. Specifically, we have not yet incorporated the cost savings to government from lower prescription drug prices. As mentioned before that information is not currently available and will be incorporated as soon as it is. Those cost savings should have an impact on spending for government. Government may transfer the funds to other priorities or return it to taxpayers, either situation creating a new chain of spending to add to the overall economic impact results.

The impacts on the pharmacy sector may in fact be larger too. There is little data regarding the change in spending behavior on prescription drugs after the reduction in price, particularly for those who lack health insurance. Common sense tells us purchases increase, but by how much is unclear. An often overlooked benefit of this would be the increased health of the population at large. The likely result is a healthier population that would be more productive, have fewer sick days, transfer disease less readily, all of which would result in a stronger state economy with a higher gross state product.

### **Relative Income of Pharmacists**

The economic impact analysis indicates no loss of pharmacy employment under the assumptions of the two scenarios. This is good news, particularly given the current labor market for pharmacists and pharmacy technicians. In particular, the current competitive nature of the market for pharmacists indicates problems for retaining them in North Dakota.

Table 10 displays regional figures for employment and annual wage of pharmacists for North Dakota and its bordering states. As can be seen, the wages North Dakota are lower than elsewhere.<sup>14</sup> The appendix contains a table with data for all 50 states and shows that North Dakota is in fact the lowest annual mean wage for the United States. This could be a symptom of an insufficient level of competition in the state. NDSU reports that slightly more than one-third of the pharmacists from their program stay to work in state.<sup>15</sup>

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<sup>14</sup> This and other information can be found from the Bureau of Labor Statistics website and the various surveys and databases they track.

<sup>15</sup> Available from NDSU College of Pharmacy, Nursing, and Allied Sciences website. (Accessed 8/20/2008).

Table 10. Regional employment of pharmacists, annual mean wage and difference with ND annual mean wage.

State	Employment	Annual mean wage	Difference from ND annual mean wage
Minnesota	4,990	\$105,440	\$21,730
Montana	1,020	\$87,260	\$3,550
North Dakota	810	\$83,710	----
South Dakota	1,040	\$88,650	\$4,940
Wyoming	480	\$91,320	\$7,610

North Dakota ranks 18<sup>th</sup> in the United States for pay for pharmacy technicians, a surprise given its poor performance for pharmacists.

Table 11. Regional employment of pharmacy technicians, annual mean wage and difference with ND annual mean wage.

State	Employment	Annual mean wage	Difference from ND annual mean wage
Minnesota	6,030	\$29,360	\$890
Montana	850	\$28,290	-\$180
North Dakota	450	\$28,470	----
South Dakota	910	\$26,320	-\$2,150
Wyoming	430	\$29,000	\$530

The positive output and employment impacts suggested by scenario 1 and 2 may help correct some of the problems indicated by the Bureau of Labor Statistics data.

### **Conclusion**

Competition benefits consumers. The more competitors exist to supply a product, the higher the supply of the product and, everything else equal, the lower the market price. North Dakota's prescription drug consumers currently face higher prices than those in other states due to a restriction on competition: the pharmacy ownership laws. Common sense and the preceding economic impact analysis indicate that a change in the law will not result in a loss of services to North Dakotans. It is also the case that increases in competition are typically followed by improvements in the quality of service. Allowing Wal-Mart, Target, Walgreen's, Hugo's, Pamida, and others to operate pharmacies raises the potential of increased quantity and quality of pharmacy service and lower prescription drug prices creating significant economic benefits to North Dakotans.

## Appendix

Table 12. United States Employment and Income for Pharmacists by State

State	Employment	Annual mean wage	State	Employment	Annual mean wage
Alabama	4440	101140	Montana	1020	87260
Alaska	360	109810	Nebraska	1980	89120
Arizona	4940	97570	Nevada	2240	99760
Arkansas	2580	94410	New Hampshire	1140	102170
California	23030	112020	New Jersey	7900	98200
Colorado	4080	98570	New Mexico	1510	95980
Connecticut	2820	101850	New York	15310	97270
Delaware	780	93360	North Carolina	7590	102480
District of Columbia	590	83870	North Dakota	810	83710
Florida	17690	98190	Ohio	11260	95750
Georgia	7530	98070	Oklahoma	3280	92210
Hawaii	1310	95000	Oregon	3100	99410
Idaho	1410	99870	Pennsylvania	11810	89650
Illinois	9250	96730	Puerto Rico	1850	58740
Indiana	5680	93400	Rhode Island	1150	95500
Iowa	2820	89150	South Carolina	3950	98540
Kansas	2480	94130	South Dakota	1040	88650
Kentucky	4000	103800	Tennessee	6130	105280
Louisiana	3820	90150	Texas	17660	103820
Maine	1190	108930	Utah	1840	100440
Maryland	4640	94460	Vermont	450	102100
Massachusetts	6780	88920	Virginia	5790	98570
Michigan	8640	97640	Washington	5250	97860
Minnesota	4990	105440	West Virginia	1890	100080
Mississippi	2250	95630	Wisconsin	5060	102910
Missouri	5360	98500	Wyoming	480	91320

Note: Annual wages have been calculated by multiplying the hourly mean wage by 2,080 hours.  
Available from the Bureau of Labor Statistics website, [www.bls.gov](http://www.bls.gov)

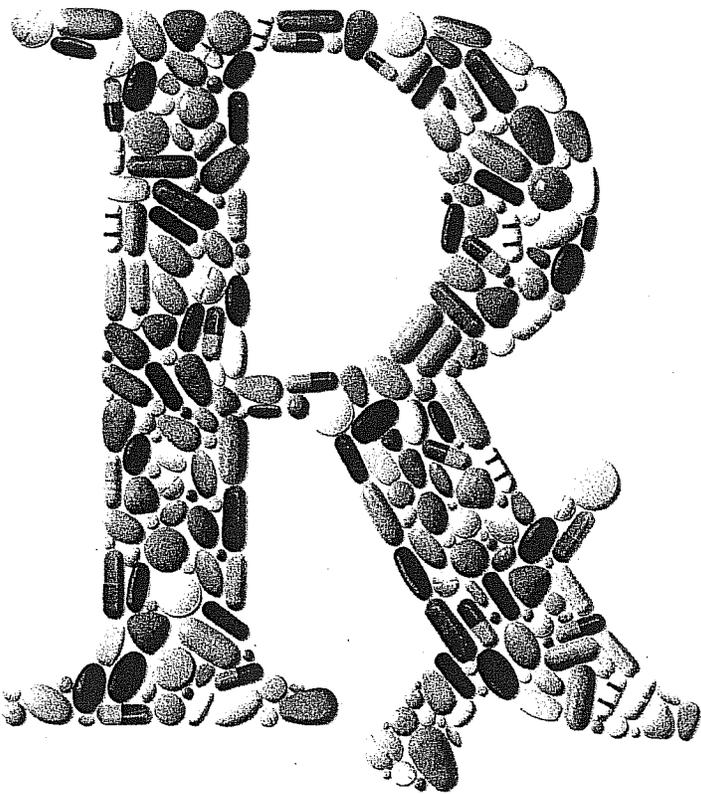
Table 13. United States Employment and Income for Pharmacists by State

Area name	Employment	Annual mean wage	Area name	Employment	Annual mean wage
Alabama	6080	23380	Montana	850	28290
Alaska	520	33970	Nebraska	2090	25880
Arizona	6440	28770	Nevada	2210	31390
Arkansas	2850	23770	New Hampshire	1180	26530
California	24540	35450	New Jersey	7410	27890
Colorado	3760	30580	New Mexico	1700	27480
Connecticut	3120	30860	New York	12790	28760
Delaware	1200	24830	North Carolina	9920	24700
Florida	21550	26940	North Dakota	450	28470
Georgia	9300	25530	Ohio	12450	24980
Hawaii	1060	33150	Oklahoma	4030	23970
Idaho	1430	27180	Oregon	3720	31770
Illinois	16000	26530	Pennsylvania	14740	25180
Indiana	7070	25990	Rhode Island	1140	30120
Iowa	3410	25080	South Carolina	5090	24480
Kansas	2530	25790	South Dakota	910	26320
Kentucky	6120	23700	Tennessee	8770	26620
Louisiana	4030	24830	Texas	25430	27750
Maine	1590	26010	Utah	2390	29460
Maryland	5050	28790	Vermont	440	26740
Massachusetts	5810	29480	Virginia	6920	26240
Michigan	10470	27550	Washington	5370	34700
Minnesota	6030	29360	West Virginia	2480	22720
Mississippi	2320	24080	Wisconsin	6540	27070
Missouri	9510	23810	Wyoming	430	29000

Note: Annual wages have been calculated by multiplying the hourly mean wage by 2,080 hours. Available from the Bureau of Labor Statistics website, [www.bls.gov](http://www.bls.gov)



## North Dakotans for Affordable Healthcare



Are your prescription  
drugs too expensive?

## Prescription drugs cost too much in North Dakota.

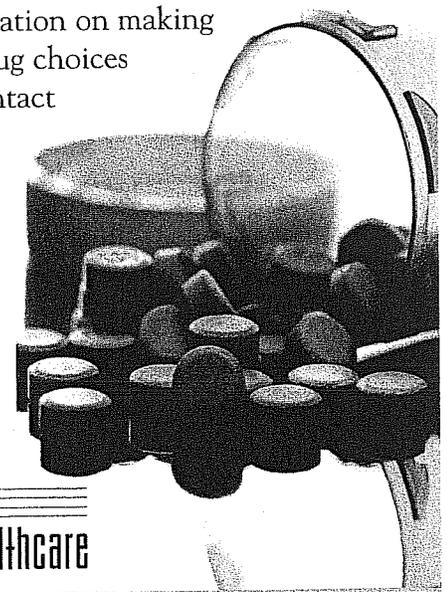
Part of the problem is a law from the 1960's that limits the type of stores that can sell prescription drugs — stifling competition between pharmacies and creating a government protected system that drives up drug costs and hurts North Dakotans.

North Dakota is the only state in the nation to have a law creating these government protected pharmacies.

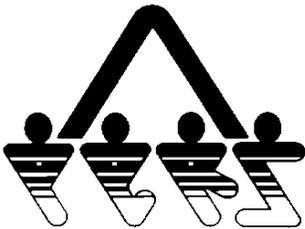
Changing this law will:

- Lower prices for many prescription drugs
- Provide more choice and convenience by increasing the number of locations you can purchase your prescriptions
- Keep more money in North Dakota since families will no longer need to leave the state to find better prices for their prescriptions
- Create more and better paying jobs for young North Dakotans

For more information on making your prescription drug choices more affordable, contact North Dakotans for Affordable Healthcare at (701) 252-1346 or visit our website at [www.NDRx.org](http://www.NDRx.org).



North Dakotans for  
Affordable Healthcare



**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@state.nd.us](mailto:ndpers@state.nd.us) • [discovernd.com/ndpers](http://discovernd.com/ndpers)

# Memorandum

**TO: NDPERS Board**

**FROM: Kathy**

**DATE: September 10, 2008**

**SUBJECT: Flu Shot Program**

We were notified and met with staff of the UND Center for Family Medicine in August to review its proposal for this year's Flu Shot Clinic for State Employees.

This year the cost for each immunization has been established at \$15.00. This is the same price charged last year. This year employees will receive a choice as to whether or not they would like to receive nasal-spray (FluMist®) versus an injection. The cost is the same for either of the two types of influenza vaccine.

The Centers for Disease Control & Prevention/Advisory Committee on Immunization Practices (CDC/ACIP) have indicated that "Administration of LAIV [FluMist®] is encouraged as soon as it is available and throughout the season". Therefore, this year, the Center will be a Flu Mist® "only" night on September 25<sup>th</sup> to kick-off the campaign. The vaccines will be administered at the Center for Family Medicine Offices from 4:00 p.m. to 6:00 p.m. according to the schedule below:

<b>Thursday</b>	<b>September 25<sup>th</sup> Flu Mist® <u>only</u> night</b>
Tuesday	October 21 <sup>st</sup> Persons age $\geq$ 50 yrs + ANY individuals considered @ High-Risk (A – K)
Wednesday	October 22 <sup>nd</sup> Persons age $\geq$ 50 yrs + ANY individuals considered @ High-Risk (L – Z)
Wednesday	October 29 <sup>th</sup> Families - Last Names beginning with (A – K)
Thursday	October 30 <sup>th</sup> Families - Last Names beginning with (L – Z)
Thursday	November 6 <sup>th</sup> OPEN to those members that remain to be immunized

Attached is the memo provided by UND to notify our active and retired members about the program along with a notice to educate the public on what the difference is between an injection (flu shot) and nasal-spray (FluMist®) vaccination. PERS will distribute this information to its agency contacts for dissemination to their employees. All information will also be posted on the PERS web site home page throughout the duration of the program.

## Annual Flu Vaccination Clinic 2008

The **UND Center for Family Medicine** will be offering a Flu Vaccination Clinic again this fall to N.D. State employees, retirees, and their eligible family members participating in the NDPERS health insurance plan. The cost for each immunization is **\$15.00** and is payable by cash or personal check (please make payable to UND Center for Family Medicine) at the door.

**No insurance claim(s) will be filed.** However, participants of the NDPERS FlexComp plan may use the Flu Shot Receipt to file a claim for reimbursement from their medical spending account. Receipts will only be available at the clinic and will not be reissued should you misplace your original copy or once the clinic has ended. This receipt can not be used to file for insurance benefits from your group health plan.

There are two types of influenza vaccine available this year: Live, attenuated influenza vaccine (FluMist®) and Inactivated influenza vaccine (Flu Shot). **Please advise nursing representatives if you wish to have members of your family receive the nasal-spray versus an injection.** There is a limited amount of flu-mist, so to ensure the mist is available plan to attend the flu-mist only night on Thursday, September 25<sup>th</sup>. Cost is the same for either of the two types of influenza vaccine.

Immunizations will be given at the **UND Center for Family Medicine**, 515 East Broadway Avenue, Bismarck, ND from **4:00 PM to 6:00 PM** according to the schedule below. For your convenience, please have each individual receiving the flu shot complete the [UND Center for Family Medicine release form](#). Free parking will be available in the Parkade ramp. Members will be required to show their NDPERS/BCBS insurance identification card. If possible, we are requesting your cooperation in assisting us to comply with the outlined scheduled.

The Centers for Disease Control & Prevention/Advisory Committee on Immunization Practices (CDC/ACIP) have indicated that “Administration of LAIV [FluMist®] is encouraged as soon as it is available and throughout the season”. Therefore, this year, we will be hosting our first Flu Mist® “only” night.

<b>Thursday</b>	<b>September 25<sup>th</sup> Flu Mist ® <u>only</u> night</b>
<i>Tuesday</i>	<i>October 21<sup>st</sup> Persons age ≥ 50 yrs + ANY individuals considered @ High-Risk (A – K)</i>
<i>Wednesday</i>	<i>October 22<sup>nd</sup> Persons age ≥ 50 yrs + ANY individuals considered @ High-Risk (L – Z)</i>
<i>Wednesday</i>	<i>October 29<sup>th</sup> Families - Last Names beginning with (A – K)</i>
<i>Thursday</i>	<i>October 30<sup>th</sup> Families - Last Names beginning with (L – Z)</i>
<i>Thursday</i>	<i>November 6<sup>th</sup> OPEN to those members that remain to be immunized</i>

***The number of immunizations allocated to our group is limited based on availability.***

Key Facts about Influenza (Flu) Vaccine issued by the Department of Health & Human Services, Centers for Disease Control & Prevention can be located on their web-site:

<http://www.cdc.gov/flu/protect/keyfacts.htm>

Priority groups for vaccination (as per the ACIP) Advisory Committee on Immunization Practices

**1.) People at high risk for complications from the flu, including:**

- Children aged 6 months until their 5<sup>th</sup> birthday,

- Pregnant women,
- People 50 years of age and older, and
- People of any age with certain chronic medical conditions;
- People who live in nursing homes and other long term care facilities.

**2.) People who live with or care for those at high risk for complications from flu, including:**

- Household contacts of persons at high risk for complications from the flu (see above),
- Household contacts and out of home caregivers of children less than 6 months of age (as these children are too young to be vaccinated), and
- Healthcare workers.

**The single best way to prevent the flu is to get a flu vaccine each fall!**

# INACTIVATED INFLUENZA VACCINE

## WHAT YOU NEED TO KNOW 2008-09

Many Vaccine Information Statements are available in Spanish and other languages. See [www.immunize.org/vis](http://www.immunize.org/vis).

### 1 Why get vaccinated?

**Influenza (“flu”) is a contagious disease.**

It is caused by the influenza virus, which can be spread by coughing, sneezing, or nasal secretions.

Other illnesses can have the same symptoms and are often mistaken for influenza. But only an illness caused by the influenza virus is really influenza.

Anyone can get influenza, but rates of infection are highest among children. For most people, it lasts only a few days.

It can cause:

- fever
- sore throat
- chills
- fatigue
- cough
- headache
- muscle aches

Some people get much sicker. Influenza can lead to pneumonia and can be dangerous for people with heart or breathing conditions. It can cause high fever, diarrhea and seizures in children. On average, 226,000 people are hospitalized every year because of influenza and 36,000 die – mostly elderly.

**Influenza vaccine can prevent influenza.**

### 2 Inactivated influenza vaccine

There are two types of influenza vaccine:

**1. Inactivated** (killed) vaccine, or the “flu shot” is given by injection into the muscle. **2. Live, attenuated** (weakened) influenza vaccine is sprayed into the nostrils. *This vaccine is described in a separate Vaccine Information Statement.*

Influenza viruses are always changing. Because of this, influenza vaccines are updated every year, and an annual vaccination is recommended.

Each year scientists try to match the viruses in the vaccine to those most likely to cause flu that year. When there is a close match the vaccine protects most people from serious influenza-related illness. But even when there is not a close match, the vaccine provides some protection. Influenza vaccine will *not* prevent “influenza-like” illnesses caused by other viruses.

It takes up to 2 weeks for protection to develop after the shot. Protection lasts up to a year.

Some inactivated influenza vaccine contains a preservative called thimerosal. Some people have suggested that thimerosal may be related to developmental problems in children. In 2004 the Institute of Medicine reviewed many studies looking into this theory and concluded that there is no evidence of such a relationship. Thimerosal-free influenza vaccine is available.

### 3 Who should get inactivated influenza vaccine?

*All children 6 months and older and all older adults:*

- **All children** from 6 months through 18 years of age.
- **Anyone 50 years of age or older.**

*Anyone who is at risk of complications from influenza, or more likely to require medical care:*

- Women who will be **pregnant** during influenza season.
- Anyone with **long-term health problems** with:
  - heart disease
  - kidney disease
  - liver disease
  - lung disease
  - metabolic disease, such as diabetes
  - asthma
  - anemia, and other blood disorders
- Anyone with a **weakened immune system** due to:
  - HIV/AIDS or other diseases affecting the immune system
  - long-term treatment with drugs such as steroids
  - cancer treatment with x-rays or drugs
- Anyone with certain **muscle or nerve disorders** (such as seizure disorders or cerebral palsy) that can lead to breathing or swallowing problems.
- Anyone 6 months through 18 years of age on **long-term aspirin treatment** (they could develop Reye Syndrome if they got influenza).
- **Residents of nursing homes and other chronic-care facilities.**

*Anyone who lives with or cares for people at high risk for influenza-related complications:*

- **Health care providers.**
- **Household contacts and caregivers of children** from birth up to 5 years of age.
- **Household contacts and caregivers of**
  - people 50 years and older, or
  - anyone with medical conditions that put them at higher risk for severe complications from influenza.

Health care providers may also recommend a yearly influenza vaccination for:

- People who provide **essential community services.**
- People living in **dormitories, correctional facilities, or under other crowded conditions**, to prevent outbreaks.
- People at high risk of influenza complications who **travel** to the Southern hemisphere between April and September, or to the tropics or in organized tourist groups at any time.

Influenza vaccine is also recommended for anyone who wants to **reduce the likelihood of becoming ill** with influenza or **spreading influenza to others.**

## 4

### When should I get influenza vaccine?

Plan to get influenza vaccine in October or November if you can. But getting vaccinated in December, or even later, will still be beneficial in most years. You can get the vaccine as soon as it is available, and for as long as illness is occurring in your community. Influenza can occur any time from November through May, but it most often peaks in January or February.

Most people need one dose of influenza vaccine each year.

**Children younger than 9 years of age getting influenza vaccine for the first time** – or who got influenza vaccine for the first time last season but got only one dose – should get 2 doses, at least 4 weeks apart, to be protected.

Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.

## 5

### Some people should talk with a doctor before getting influenza vaccine

Some people should not get inactivated influenza vaccine or should wait before getting it.

- Tell your doctor if you have any **severe** (life-threatening) allergies. Allergic reactions to influenza vaccine are rare.
  - Influenza vaccine virus is grown in eggs. People with a severe egg allergy should not get the vaccine.
  - A severe allergy to any vaccine component is also a reason to not get the vaccine.
  - If you have had a severe reaction after a previous dose of influenza vaccine, tell your doctor.
- Tell your doctor if you ever had Guillain-Barré Syndrome (a severe paralytic illness, also called GBS). You may be able to get the vaccine, but your doctor should help you make the decision.
- People who are moderately or severely ill should usually wait until they recover before getting flu vaccine. If you are ill, talk to your doctor or nurse about whether to reschedule the vaccination. People with a **mild illness** can usually get the vaccine.

## 6

### What are the risks from inactivated influenza vaccine?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.

Serious problems from influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so you cannot get influenza from the vaccine.

#### Mild problems:

- soreness, redness, or swelling where the shot was given
- fever
- aches

If these problems occur, they usually begin soon after the shot and last 1-2 days.

#### Severe problems:

- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.
- In 1976, a type of influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, flu vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current flu vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

## 7

### What if there is a severe reaction?

#### What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

#### What should I do?

- **Call** a doctor, or get the person to a doctor right away.
- **Tell** your doctor what happened, the date and time it happened, and when the vaccination was given.
- **Ask** your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

Or you can file this report through the VAERS web site at [www.vaers.hhs.gov](http://www.vaers.hhs.gov), or by calling 1-800-822-7967.

*VAERS does not provide medical advice.*

## 8

### The National Vaccine Injury Compensation Program

A federal program exists to help pay for the care of anyone who has a serious reaction to a vaccine.

For more information about the National Vaccine Injury Compensation Program, call 1-800-338-2382 or visit their website at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation).

## 9

### How can I learn more?

- Ask your immunization provider. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO)
  - Visit CDC's website at [www.cdc.gov/flu](http://www.cdc.gov/flu)



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