

NDPERS BOARD MEETING

Agenda

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

April 21, 2011

Time: 8:30 AM

I. MINUTES

- A. March 24, 2011
- B. April 7, 2011

II. DEFINED CONTRIBUTION/DEFERRED COMPENSATION

- A. Defined Contribution/457 RFP – Segal (Board Action)
Executive Session *

III. GROUP INSURANCE

- A. Group Life AD&D Interviews
- B. BCBS Optional Settlement Proposal – Sparb (Board Action)
- C. Performance Guarantees – Sparb (Board Action)
- D. Diabetes Management Program – Sparb (Board Action)

IV. RETIREMENT

- A. IRS Determination Letter – Deb (Information)

V. MISCELLANEOUS

- A. PERS Budget – Sparb (Information)
- B. Legislative Update- Sparb (Information)
- C. Executive Director Evaluation – Sparb (Board Action)
- D. SIB Agenda
- E. Appeal Case Number 20, Health Insurance – (Board Action)
Executive Session ** – Kathy

*Executive Session is held pursuant to NDCC 44-04-19.1(9)
for purposes of negotiating strategy.

**Executive Session is held pursuant to NDCC 44-04-19.2(1) for purposes of
confidentiality of member information.

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



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

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

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

Memorandum

TO: PERS Board
FROM: Sparb
DATE: April 12, 2011
SUBJECT: 401(a)/457 Plan RFP

Attached please find a review of the 401(a)/457 proposals prepared by Segal. The Board may want to consider going into Executive Session pursuant to NDCC 44-04-19.1(9) to discuss negotiating strategy relating to this RFP.

Bob Liberto will be at the April meeting to review this with you and answer questions. Our goal will be to narrow the list to 2-4 vendors to invite to our May meeting for interviews.



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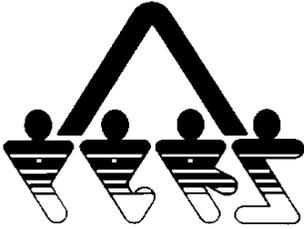
Sparb Collins
Executive Director
(701) 328-3900
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FAX: (701) 328-3920 • EMAIL: NDPERS-info@nd.gov • www.nd.gov/ndpers

Memorandum

TO: PERS Board
FROM: Sparb
DATE: April 12, 2011
SUBJECT: Group Life Insurance Proposals/Interviews

Attached is a memo from Gabriel Roeder Smith explaining an error in the calculation of the overall premium cost for one of the carriers we included in our final three. As you will note, once corrected, this carrier fell from an overall ranking on price from #1 to #4. The #3 and #4 carriers, after the recalculation, have a total premium cost that is very close but about 5% more than the #1 and #2 carrier. As a result of this new premium spread due to the calculation correction and the new ranking, staff asked GRS to invite the top 2 carriers to the interview at the Board meeting instead of going to 4 carriers or replacing the selected carrier (who went from #1 to #4) with the new #3 carrier. If you decide at the meeting after interviewing the #1 and #2 carriers that we need to interview additional carriers, we can have a special meeting the following week and invite the #3 and #4 carriers.



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

Memorandum

TO: PERS Board
FROM: Sparb
DATE: April 14, 2011
SUBJECT: BCBS Optional Settlement Proposal

Risk Sharing Options

In the BCBS proposal that we received this last fall they offered us two risk sharing options. The first is extending our current arrangement and the second is an alternative that we can select in lieu of the existing arrangement. These are:

Current Settlement:

If a gain, BCBS keeps 50% of first \$3M.
If a loss, BCBS loses 50% of first \$6 M and 100% of rest.

Optional Settlement:

If a gain, BCBS keeps nothing.
If a loss, BCBS loses nothing for first \$3 M and 50% of next \$4 M and 100% of rest.

Basically, the above optional settlement process allows us to get 100% of any gain instead of sharing the first \$3 million 50/50 and in return instead of having a maximum loss liability of \$3 million it increases to \$5 million. Therefore, on the upside we could make \$1.5 million more; however, on the downside we could lose \$2 million more.

Please note the contract this time is for two years compared to our previous six year arrangements.

At a recent meeting BCBS reviewed with us the two options and shared with us the following illustration of how it would work at different gain/loss levels:

Profit/(Loss)	Current Settlement		Optional Settlement	
	BCBS	NDPERS	BCBS	NDPERS
\$5,000,000	\$1,500,000	\$3,500,000	\$0	\$5,000,000
\$3,000,000	\$1,500,000	\$1,500,000	\$0	\$3,000,000
\$2,000,000	\$1,000,000	\$1,000,000	\$0	\$2,000,000
\$1,000,000	\$500,000	\$500,000	\$0	\$1,000,000
\$0	\$0	\$0	\$0	\$0
(\$1,000,000)	(\$500,000)	(\$500,000)	\$0	(\$1,000,000)
(\$2,000,000)	(\$1,000,000)	(\$1,000,000)	\$0	(\$2,000,000)
(\$3,000,000)	(\$1,500,000)	(\$1,500,000)	\$0	(\$3,000,000)
(\$5,000,000)	(\$2,500,000)	(\$2,500,000)	(\$1,000,000)	(\$4,000,000)
(\$7,000,000)	(\$4,000,000)	(\$3,000,000)	(\$2,000,000)	(\$5,000,000)
(\$10,000,000)	(\$7,000,000)	(\$3,000,000)	(\$5,000,000)	(\$5,000,000)

Staff identified the following advantages/disadvantages of the two approaches:

Option #1

Advantages	Disadvantages
Maintains the status quo – all parties are familiar with the arrangement (state, legislature, participating employers, etc)	May incent BCBS to rate the plan premiums higher to insure a gain sharing
Easy to explain	Limits PERS upside gain since we share part with BCBS
Limits our total out of pocket expense	
Provides a reward to BCBS for lower claims expense	

Option #2

Advantages	Disadvantages
Allows PERS to get 100% of any gain	May allow BCBS to rate the plan less conservatively since the first \$3 million in losses would be paid by PERS and 50% of the next 4 million would be paid by PERS
If trends stay low or go lower we would get back more	Not as easy to explain
For the last 11 biennium's (including this one) the PERS plan has had a gain 8 biennium's and a loss 3 biennium's. Consequently if the past is an indicator of the future this option may be more advantageous	Changes the status quo and we will need to educate our constituents
	Puts more PERS funds at risk in case of a loss
	Given our low trends it is unlikely they will fall further and possible more likely they would go up which could result in losses for which we would have a higher financial risk.

Attached is a memo from Deloitte reviewing the options.

Board Action Requested:

Determine which option PERS should use for the 2011-2013 biennium



Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA
Tel: +1 612 397 4000
Fax: +1 612 397 4450
www.deloitte.com

April 12, 2011

Mr. Sparb Collins
Executive Director
NDPERS
400 East Broadway, Suite 505
Box 1214
Bismarck, ND 58502

Subject: BCBSND Risk Share Options

Dear Sparb:

In the RFP for Medical and Prescription Drug Coverage, Blue Cross Blue Shield of North Dakota (BCBSND) proposed two separate risk share arrangements. You had asked Deloitte to summarize and document our thoughts regarding the two arrangements.

As has been done in the past, BCBSND performs an accounting and financial settlement following 12 and 24 months of the contract. The July 1, 2009 – June 30, 2011 contract term included the risk share arrangement as outlined as Option 1. For the new contract term, July 1, 2011 – June 30, 2013, BCBSND proposed the existing option as well as an Option 2 which provides NDPERS to retain more of the positive gains while taking on slightly more risk for negative balances.

Option 1 (same as current contract)

If final accounting shows a positive balance (claims and fees do not exceed premiums), BCBSND retains the lesser of 50% of this amount or \$1.5 million. The remainder stays with NDPERS.

If final accounting shows a negative balance (claims and fees do exceed premiums), BCBSND takes on the risk. However, BCBSND is refunded the lesser of 50% of this amount or \$3.0 million.

Option 2 (new option)

If final accounting shows a positive balance (claims and fees do not exceed premiums), NDPERS retains all gains.

If final accounting shows a negative balance (claims and fees do exceed premiums), BCBSND takes on the risk. However, NDPERS will be liable for 100% up to \$3.0 million and 50% of the next \$4.0 million or a maximum liability of \$5.0 million.

Basically, Option 1 would be the preferred Option if you anticipate a negative balance, and Option 2 would be preferred if you anticipate a positive balance.

In August 2010, Deloitte performed an independent evaluation of the original BCBSND proposal and found the rates reasonable but slightly overrated. A summary is shown below:

NDPERS	
Development of Projected Deficit/Surplus	
For Biennium July 1, 2011 through June 30, 2013	

Total 2011-2013 BCBSND Premium:	\$ 438,482,059
Estimated 2009-2011 Surplus:	\$33 to 37,000,000

	Trend Assumption			Final Costs	
	Active Medical	Active Rx	Retiree Medical	Needed Premium	Deficit/Surplus
Optimistic Estimate	2%	2%	2%	\$ 389,044,269	\$ 49,437,790
	4%	4%	4%	\$ 407,141,362	\$ 31,340,697
Best Estimate	6%	6%	6%	\$ 425,768,096	\$ 12,713,963
	8%	8%	8%	\$ 444,929,541	\$ (6,447,482)
Conservative Estimate	10%	10%	10%	\$ 464,630,718	\$ (26,148,658)

At that time our best estimate resulted in a 2011-2013 positive balance or surplus of \$12.7 million. The most recent BCBSND accounting through February 2011 shows an estimated 2009-2011 gain of \$37.2 million. The most recent experience does not cause us to change our prior estimates and supports our belief that the 2011-2013 premiums will likely result in a positive balance.

With the continued good experience we believe that Option 2 would be the preferred option at this time. However if claims experience were to deteriorate, Option 2 may result in NDPERS taking on liability of up to \$5.0 million (current Option 1 capped at \$3.0 million).

An additional consideration is that the risk arrangement only pertains to a two-year contract period since the bids were accepted on that basis. So this arrangement won't be carried forward into multiple contract years as has been done previously.

I hope that this summary provides the high level overview and analysis that you were requesting. If you have questions please do not hesitate to contact Pete or me.

Sincerely,



Patrick Pechacek, CEBS
Director



Peter Roverud
Senior Manager



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Executive Director
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Memorandum

TO: PERS Board
FROM: Sparb
DATE: April 14, 2011
SUBJECT: Performance Guarantees

Recently BCBS reviewed with you the proposed performance guarantees that were a part of the proposal we accepted for the 2011-13 biennium. Staff has worked with BCBS to refine the attached and it is submitted for your approval.

Board Action Requested

Approve the attached performance guarantees.

Staff Recommendation

Approve the attached.

2011 NDPERS Performance Standards and Guarantees

Cost Management:

Metric	Definition	Biannual Value of Forfeiture
<p>By December 31, 2012, increase the number of NDPERS members completing a Well Being Assessment (WBA) by 10% over the 2011 completion rate.</p>	<p>Measure the percentage of NDPERS members completing the Well Being Assessment for the time period of 1/1/2012 – 12/31/2012 divided by the 2011 completion rate.</p>	<p>\$15,000</p>
<p>By December 31, 2012, NDPERS will have a 5% point increase in the NDPERS group aggregate WBA wellness score.</p>	<p>Measure the NDPERS group aggregate WBA wellness score at 12/31/2011 and again on 12/31/2012.</p>	<p>\$10,000</p>
<p>2012 MyHealthCenter NDPERS group aggregate incentives paid for MyHealthCenter redemptions will increase by 10% over 2011 NDPERS rate.</p>	<p>Measure the incentives paid to NDPERS members for the MyHealthCenter tool for the time period of 1/1/2011 – 12/31/2011 vs. 1/1/2012 – 12/31/2012.</p>	<p>\$7,500</p>
<p>2012 annual percentage average of NDPERS members receiving the Health Club Credit will increase by 10% over 2011 NDPERS rate.</p>	<p>Measure the annual average percentage number of NDPERS members receiving the Health Club Credit Program incentive for the time period of 1/1/2011 – 12/31/2011 vs. 1/1/2012 – 12/31/2012.</p>	<p>\$7,500</p>

Health Outcomes:

Metric	Definition	Biannual Value of Forfeiture
By June 30, 2013, 80% of the NDPERS population will be enrolled in a medical home.	Measure the percentage of in state NDPERS members identified in the MediQHome program as of 6/30/2013.	\$15,000
HEDIS-like measures breast cancer screening rates will be at least 80%	Calculate screenings using HEDIS results/methodology for 2012 refreshing results with screening data contained within MediQHome to determine compliance as of 6/30/2013.	\$15,000
HEDIS-like measures cervical cancer screening rates will be at least 85%	Calculate screenings using HEDIS results/methodology for 2012 refreshing results with screening data contained within MediQHome to determine compliance as of 6/30/2013.	\$15,000
HEDIS-like measures colorectal cancer screening rates will be at least 60%	Calculate screenings using HEDIS results/methodology for 2012 refreshing results with screening data contained within MediQHome to determine compliance as of 6/30/2013.	\$15,000

Provider Network Management:

Metric	Definition	Biannual Value of Forfeiture
BCBSND will maintain an NDPERS PPO network consisting of 90% or more of the in-state hospitals, MDs and DOs that participate in the Company's Par Network.	This standard will be measured by comparing the number of hospitals (including short term acute, free standing psychiatric and long term acute), MDs, and DOs in the BCBSND participating network to those same provider types in the NDPERS PPO network. This measurement will be completed at the end of the biennium contract.	\$25,000

Operational Performance:

All operational performance audits will be conducted according to guidelines defined in the Blue Cross Blue Shield Association's Member Touchpoint Measure (MTM) quality assurance program.

At the end of each year within the biennium (6/30/2012 and 6/30/2013), the annual operational performance of each metric will be calculated and if the operational performance goal is not met the annual value of the forfeiture amount will be paid to NDPERS.

Metric	Definition	Performance Goal	Annual Value of Forfeiture	Biannual Value of Forfeiture
Claims Financial Accuracy	Measures the percentage of paid dollars processed accurately: Total paid dollars minus absolute value of over and underpayments divided by total paid dollars.	99%	\$12,500	\$25,000
Claims Payment Incidence Accuracy *	Measures the percentage of claims processed without a payment error: Total number of claims (pays and no pays) that were processed without a payment error divided by total number of claims processed.	97%	\$12,500	\$25,000
Claim Timeliness	Measures the percentage of all claims processed within 30 number of calendar days. Excludes BlueCard.	99%	\$12,500	\$25,000
Average Speed of Answer	Measures the average speed of answer of all member calls in seconds.	30 or less	\$12,500	\$25,000
Call Abandonment Rate	Measures the percentage of callers who disconnect before being connected to a live customer service representative.	5% or less	\$12,500	\$25,000

* Claims Payment Incidence Accuracy is not reported to the Blue Cross Blue Shield Association as part of the MTM program; however, the Claims Payment Incidence Accuracy calculation uses information collected in the Claims Financial Accuracy audit.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: April 12, 2011
SUBJECT: Diabetes Program

Section 54-52.1-17 of the North Dakota Century states:

54-52.1-17. Uniform group insurance program - Collaborative drug therapy program - Funding.

1. The board shall establish a collaborative drug therapy program that is to be available to individuals in the medical and hospital benefits coverage group. The purpose of the collaborative drug therapy program is to improve the health of individuals with diabetes and to manage health care expenditures.
2. The board shall involve physicians, pharmacists, and certified diabetes educators to coordinate health care for covered individuals with diabetes in order to improve health outcomes and reduce spending on diabetes care. Under the program, pharmacists and certified diabetes educators may be reimbursed for providing face-to-face collaborative drug therapy services to covered individuals with diabetes. To encourage enrollment in the plan, the board shall provide incentives to covered individuals who have diabetes which may include waived or reduced copayment for diabetes treatment drugs and supplies.
3. The North Dakota pharmacists association or a specified delegate shall implement a formalized diabetes management program with the approval of the prescriptive practices committee established in section 43-15-31.4, which must serve to standardize diabetes care and improve patient outcomes. This program must facilitate enrollment procedures, provide standards of diabetes care, enable consistent documentation of clinical and economic outcomes, and structure an outcomes reporting system.
4. The board shall fund the program from any available funds in the uniform group insurance program and if necessary the fund may add up to a two dollar per month charge on the policy premium for medical and hospital benefits coverage. A state agency shall pay any additional premium from the agency's existing appropriation.

Pursuant to the above, we established the PERS diabetes disease management program modeled on the Asheville program with North Dakota pharmacists. We also commissioned a study of the program by the Center for Health Promotion and Prevention. That study was reviewed with the Board at a meeting earlier this year. Attachment #1 is the Executive Summary of the study. We also heard from Jayme Steig the clinical coordinator for the program, Attachment #2 is his presentation.

The question before us is: should continue the program for the 2011-2013 biennium? The following is the estimate for continuation:

- Next biennium estimates (July 2011-June 2013)
 - Visits - \$38,400
 - Incentives - \$29,000
 - Admin Fee - \$10,000
 - Total - \$77,400

Staff Recommendation

Staff would recommend that we continue the program for the 2011-13 biennium. However, we should closely monitor the implementation of the MediQHome program during the biennium to assess its implications on further renewals of this program beyond 2013.

Board Action Requested

To approve continuing this program for the 2011-13 biennium.

EXECUTIVE SUMMARY

The North Dakota Diabetes Management Program (DMP) was implemented in July 2008 to provide community pharmacy-based diabetes management services for NDPERS members and their dependents diagnosed with diabetes. DMP participants could receive up to six free educational care visits with a DMP provider during an initial 12-month period and an additional two visits during a subsequent 13-24 month period. All enrolled participants were eligible to receive waived co-payments for their diabetes and certain other medications and co-insurance on diabetic testing supplies. NDPERS contracted with researchers at the Center for Health Promotion and Prevention Research (CHPPR) at the University of North Dakota School of Medicine and Health Sciences (UNDSMHS) to provide an independent costs evaluation of the DMP.

Methodology:

- Approximately 2800 individuals were eligible for the DMP. As of June 30, 2010, 346 people had enrolled in the DMP and completed at least one care visit. Services were provided in over 70 North Dakota pharmacies involving over 125 individual providers. Only 12.5% of eligible NDPERS members (including eligible family members) elected to self-enroll in the DMP, suggesting that the sample was biased and is not representative of the DMP-eligible NDPERS population.
- Several differences were noted between eligible persons enrolled in the DMP and those that did not enroll in the DMP (controls). The DMP group, compared to controls, had higher proportions of participants who were women ($p=.07$), older ($p=.10$), and who had Type I diabetes ($p<.001$). Of greatest concern was that baseline total, provider/clinic, and pharmacy costs were significantly higher in the DMP group compared to controls ($p<.01$).
- To reduce potential bias attributable to the imbalance between the DMP and control groups at baseline, a matching technique called propensity score matching was used to select control participants having similar characteristics to the DMP participants including type of diabetes, gender, age, and baseline health claims costs. The final sample for analysis compared 302 DMP participants with 302 propensity score matched controls. All analyses controlled for the effects of gender, age, diabetes type. Statistical analyses used Generalized Estimating Equations (GEE) with the non-linear gamma distribution.

Key Findings:

- *Primary Findings: Changes in Health Care Claims Costs.* The primary result of the evaluation was that the DMP and control groups did not statistically differ in their total, clinic, pharmacy, or hospital costs changes from baseline to post-DMP when controlling for participants' ages, genders, and diabetes type. This means that the changes observed during the evaluation period in per-person, per-month (PPPM) claims costs between the DMP (\$30 PPPM decrease) and control groups (\$94 PPPM increase) were not large enough, given the great variation in health care expenditures across people, to confidently conclude that

the DPM would be a cost-effective approach if used with all NPERS enrollees with diabetes.

- Exploratory analyses examined the effects of DMP on costs changes separately for participants with Type I and Type II diabetes as well as other subgroups including: (a) the 10% of the sample with the highest baseline costs; (b) the 20% of the sample with highest baseline costs; and (c) only those participants who completed six or more DMP sessions. All results were similar with no significant DMP treatment effects for any of the costs components.
- *Secondary Findings: Glycemic Control and Cost Changes in DMP Participants.* DMP participants' baseline A1c levels of 7.28% significantly decreased to 6.97% at post-DMP. Although 7.3% of DMP participants reduced their baseline A1c levels by 1% or more, 15.9% had increases of 1% or more from baseline. At baseline, 51.9% of DMP participants had A1c levels below the clinically relevant level of 7.0%, and at post-DMP, 57.1% had A1c levels below 7.0%. The difference between these two proportions (-5.2%) was not significant ($Z=-1.589$, $p=.1122$). Moreover, because there was no control group for comparing changes in A1c from pre- to post-DMP, the observed changes cannot be attributed to DMP effects.

Conclusions and Future Considerations:

- Due to the high variability of the data, the costs savings found for the DMP group relative to the control group were not statistically significant, indicating that the current findings could not be reliably replicated. Inspection of the confidence intervals around the estimates of costs changes shows that the true difference in costs lies between a range of DMP participants saving \$404 PPPM more than non-participants to DMP participants costing \$147 PPPM more than onparticipants.
- Results were promising that DMP participants' significantly reduced their baseline A1c levels by 0.31%. If these reductions can be maintained over the long-term, this should result in improvements in health and quality of life.



NDPERS Diabetes
Management Program

Next Steps

Jayne Steig, PharmD, RPh
Frontier Pharmacy Services, Inc
Clinical Coordinator Provider

1-877-364-3932

jsteig@froniterRx.com

Program Overview

- Diabetes care services are provided by a network of pharmacists and other providers who have completed an accredited diabetes certification program
- Providers “coach” eligible participants on how to self-manage their diabetes
- Modeled after “Asheville Project”
 - Some variations

Program Overview Continued...

- Providers complete an assessment, develop a care plan and provide follow-up services and referrals
- Clinical, humanistic, and economic measures are recorded for analysis
 - Refer to Sept 2010 presentation for more information
- Initially 6 visits over 12 month period
 - 7th and 8th visits added for 24 month program
- Over 70 provider sites in North Dakota
 - Over 125 individual providers



Program Promotion

- Program launch
 - Mailings to all eligible members with follow up postcards 1 month later
- PERS website – link to program website
- Wellness newsletters
- Annual Wellness Forum presentation
 - Did not occur in 2010
- Monthly mailing to newly identified eligible members

Patient Participation

- 3,078 eligible members in Jan 2011 according to eligibility file
 - Approximately 30-40 letters mailed by NDPERS each month to newly identified eligible members
- 352 members have completed at least 1 visit
 - 11.5% enrollment
 - Asheville – 67% enrollment

Patient Incentives

- Patients receive financial incentives for participating
 - Copay on formulary diabetic medications, ACE inhibitors, and ARBs (\$5 generic, \$20 brand)
 - Coinsurance on diabetic testing supplies
 - Issued quarterly
 - 2010 costs/quarter
 - \$20,799 total (\$83.85/member)
 - \$4,444 supplies (\$17.92/member)
 - \$16,355 medications (\$65.93/member)
 - Range - \$5 to \$330 quarterly

Program Costs

- Next biennium estimates (July 2011-June 2013)
 - Visits - \$38,400
 - Incentives - \$29,000
 - Admin Fee - \$10,000
 - Total - \$77,400
- Based off of current program structure (enrollment rates and incentives)

UND Analysis

- Independent analysis provided results similar to that of similar studies
- Statistically significant clinical outcomes
 - Participants health improved
- Economic analysis showed positive trends, but were not statistically significant
 - Due to large standard deviation in costs and small sample size
 - Occurs this way in many studies of this type
 - Including Asheville Project

UND Analysis – Points of Interest

- Selection Bias – to be expected
 - Those with higher costs enrolled
 - Incentive structure played a role
 - More Type I vs Type II
 - UND Discussion – select those closer to “average”
 - Those with diabetes less than 5 years had greater reductions in A1C than those with diabetes longer

UND Analysis – Points of Interest

- Health care costs
 - PPPM cost savings of \$124 comparing participants vs control (\$1488 annually)
 - \$71.14 when program costs included
 - Not significant due to large variation
 - Savings occurred mainly in hospital costs
 - Pharmacy costs increased at a similar rate in participants vs control
 - Pharmacy costs increase significantly in other studies, including Asheville

UND Analysis – Points of Interest

- Health care costs

- Note – diabetes related costs were not broken out from non-diabetes related costs
 - Done in many studies
 - Could have helped answer some questions related to costs, etc
 - Could have reduced some of the variability
 - ie, did an asthma attack or some accident result in added hospital costs in one group vs the other, etc

UND Analysis – Points of Interest

○ Discussion

- Authors mention use of blood pressure as a valuable indicator for health and cost improvement
- This data, along with other secondary outcomes, was available, but not analyzed
- Data is included in following slides

Systolic

- 282 have multiple values
 - 1st visit avg = 132
 - Most recent avg = 130
 - Std dev 16.5, 15.4
- 47.5% did not initially meet goal
 - 32% of those now meet goal
 - 1st value avg = 146
 - Most recent avg = 138
 - Std dev 11.35, 15.03

Diastolic

- 279 have multiple values
 - 1st visit avg = 78
 - Most recent avg = 77
 - Std dev 9.93, 9.09
- 41% did not initially meet goal
 - 47% of those now meet goal
 - 1st value avg = 84.88
 - Most recent avg = 80.3
 - Std dev 10.13, 9.22

UND Analysis

- Summary

- Focused on economic analysis
- Shows positive trends, but due to lack of statistical significance, cannot extrapolate to entire NDPERS diabetic population
- Identifies potential areas for improvement
 - Selection bias
 - Increased participation

How do we compare?

Outcome	About the Patient	Asheville	10 City Challenge
Hemoglobin A1C (base/~ 1 yr)	7.25/6.98 N=249	7.7/6.7 N=81	7.5/7.1 N=554
LDL	95/93 N=172	115/108.5 N=70	97.5/94.1 N=528
HDL	45/44 N=181	46/47.5 N=72	Not reported
SBP	132/130 N=282	Not reported	132.5/130.1 N=551
DBP	78/77 N=279	Not reported	80.8/77.6 N=550
Annual healthcare spending reduction	\$853.68/patient*	\$1079/patient**	\$1200-1872/patient***
Patient Satisfaction	90+%	90+%	90+%

* - \$1488 if program costs & incentives are excluded

** - did not include program costs & incentives

*** - savings from "projected" costs



How do we compare?

- Notes on comparison chart
 - NDPERS participants, on average, were healthier than Asheville and 10 City Challenge patients upon enrollment
 - Easier to go from A1C of 8 to 7 than 7 to 6
 - Yet, clinical outcome endpoints were still similar
 - Each study used different methods to calculate economic outcomes
 - Asheville did not include program costs
 - Each study showed positive, but not statistically significant, trends in controlling health care costs

Keep in mind....

- Wellness programs have difficulty showing immediate returns
 - Long term benefits – reducing complications
 - No definitive long term studies

Moving forward – next steps

- Use UND Study and clinical data to improve program
- Goals
 - Increase enrollment
 - Decrease selection bias
 - Maintain positive clinical outcomes
 - Further demonstrate cost savings

Moving forward – Increase Enrollment

- Allow About the Patient program do promote the program and send out enrollment information
 - Similar to other pharmacy based programs
 - Asheville, Medicare Part D MTM
 - Provide pharmacy claim information with eligibility file – allows for local contact
 - Removes administrative burden from NDPERS staff

Moving forward – Decrease Selection Bias

- Perform a mailed, paper survey on a “focus group” of past participants
 - Select variety of patients based on age, time with diabetes, baseline levels
 - Look for motivators for participation
 - Use results to make modifications to program visit design and structure

Moving forward – Decrease Selection Bias

- Review incentive structure
 - Large reason for selection bias
 - Those with largest costs had greatest motivation to participate
 - Use focus group results
 - Possible solution – change incentive to a per visit payment
 - Give everyone the same incentive for participating
 - May increase participation of those newly diagnosed that do not yet have large costs
 - UND Study identified this group as the most benefited
 - Example - \$80 per visit
 - Currently \$83.85/member/quarter
 - Similar to other wellness incentives
 - Health risk assessments, health clubs
 - Decreases administrative burden

Moving forward

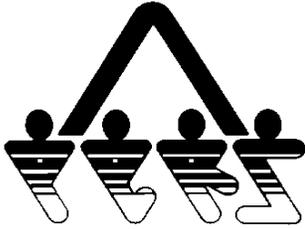
- Maintain positive outcomes
 - About the Patient responsibility
 - Maintain competent provider network
 - Keep up to date on diabetes treatment developments
- Further Demonstrate Cost Savings
 - NDPERS decision
 - Assess long term cost effects of program
 - Do participants stay healthy after participation?
 - Assess effects of program changes on cost

Summary

- Program has had successes and challenges
- Challenges
 - Low enrollment rate
 - Selection bias
- Successes
 - Clinical outcomes
 - Broad network
 - Patient satisfaction
- Unknown
 - Economic outcomes
- Successes outweigh challenges
 - Use lessons learned to improve program

Thank you

- Questions/Discussion



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

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

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

Memorandum

TO: PERS Board

FROM: Deb & Sparb

DATE: April 13, 2011

SUBJECT: IRS Determination on NDPERS Hybrid Retirement Plan

Recently staff received notice from the IRS providing us with a favorable determination on the NDPERS Hybrid Plan which was submitted back in January 2009. I visited with Melanie Walker of the Segal Company to put this into perspective before reporting to you. She indicated that basically, the IRS is telling us that they have reviewed our plan as of the dates indicated and have made a favorable determination based upon our existing statutes at the time. The letter also indicates that if we wish to keep the determination current, we will have to submit a new application no later than January 2014 to maintain our status while they review it again. Melanie also indicated that since we are not subject to ERISA, we are not required to re-submit. I asked her about what other systems are doing and although she indicated that in the past it was not common for governmental plans to file for a determination letter on a regular basis, it appears to her that it will be a more common practice in the future due to increased IRS scrutiny of such plans.

In addition to the Hybrid Plan, we also submitted the Highway Patrol Retirement Plan at the same time. Although we have received some inquiries on this plan, including a request that our statutes be amended, we have not received any further correspondence since August of 2010. The statutes have been amended and we hope to receive positive results on that plan's review soon. Please let me know if there is any additional information you would like me to provide.

INTERNAL REVENUE SERVICE
P. O. BOX 2508
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

RECEIVED

Date: APR 04 2011

Employer Identification Number:
45-0309764

APR 07 2011

DLN:
509031005

ND PERS

STATE OF NORTH DAKOTA
400 E BROADWAY SUITE 505
BISMARCK, ND 58502

Person to Contact:
MADAN DUA

ID# 50130

Contact Telephone Number:
(202) 283-9603

Plan Name:
NORTH DAKOTA PUBLIC EMPLOYEES
RETIREMENT SYSTEM HYBRID PLAN

Plan Number: 002

Dear Applicant:

We have made a favorable determination on the plan identified above based on the information you have supplied. Please keep this letter, the application forms submitted to request this letter and all correspondence with the Internal Revenue Service regarding your application for a determination letter in your permanent records. You must retain this information to preserve your reliance on this letter.

Continued qualification of the plan under its present form will depend on its effect in operation. See section 1.401-1(b)(3) of the Income Tax Regulations. We will review the status of the plan in operation periodically.

The enclosed Publication 794 explains the significance and the scope of this favorable determination letter based on the determination requests selected on your application forms. Publication 794 describes the information that must be retained to have reliance on this favorable determination letter. The publication also provides examples of the effect of a plan's operation on its qualified status and discusses the reporting requirements for qualified plans. Please read Publication 794.

This letter relates only to the status of your plan under the Internal Revenue Code. It is not a determination regarding the effect of other federal or local statutes.

This determination letter gives no reliance for any qualification change that becomes effective, any guidance published, or any statutes enacted, after the issuance of the Cumulative List (unless the item has been identified in the Cumulative List) for the cycle under which this application was submitted.

This letter may not be relied on after the end of the plan's first five-year remedial amendment cycle that ends more than 12 months after the application was received. This letter expires on January 31, 2014. This letter considered the 2007 Cumulative List of Changes in Plan Qualification Requirements.

Based on the information you have supplied, you are a participating

Letter 2002 (DO/CG)

RECEIVED

APR 07 2011

ND PERS

STATE OF NORTH DAKOTA

employer in a multiple employer plan under section 413(c) of the Code.

This determination letter is based solely on your assertion that the plan is entitled to be treated as a Governmental plan under section 414(d) of the Internal Revenue Code.

This determination letter is applicable to the plan and related documents submitted in conjunction with your application filed during the remedial amendment cycle ending 2009.

We have sent a copy of this letter to your representative as indicated in the Form 2848 Power of Attorney or appointee as indicated by the Form 8821 Tax Information Authorization.

If you have questions concerning this matter, please contact the person whose name and telephone number are shown above.

Sincerely,



Andrew E. Zuckerman
Director, EP Rulings & Agreements

Enclosures:
Publication 794

RECEIVED

APR 07 2011



Department
of the
Treasury
Internal
Revenue
Service

Publication 794
(Rev. October 2010)
Catalog Number 20630M

Favorable Determination Letter

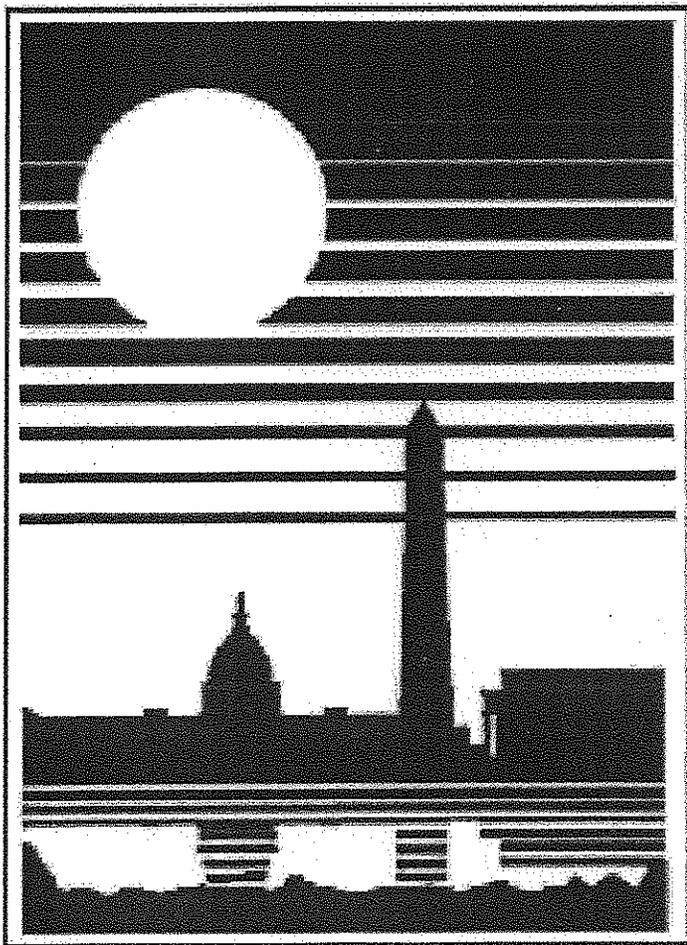
Introduction

This publication explains the significance of your favorable determination letter, points out some features that may affect the qualified status of your employee retirement plan and nullify your determination letter without specific notice from us, and provides general information on the reporting requirements for your plan.

Significance of a Favorable Determination Letter

An employee retirement plan qualified under Internal Revenue Code (IRC) section 401(a) (qualified plan) is entitled to favorable tax treatment. For example, contributions made in accordance with the plan document are generally currently deductible. However, participants will not include these contributions in income until the time they receive a distribution from the plan, at which time special income averaging rates for lump sum distributions may serve to reduce the tax liability. In some cases, taxation may be further deferred by rollover to another qualified plan or individual retirement arrangement. (See Publication 575, Pension and Annuity Income, for further details.) Finally, plan earnings may accumulate tax free. Employee retirement plans that fail to satisfy the requirements under IRC section 401(a) are not entitled to favorable tax treatment. Therefore, many employers desire advance assurance that the terms of their plans satisfy the qualification requirements.

The Internal Revenue Service provides such advance assurance through the determination letter program. A favorable determination letter indicates that, in the opinion of the IRS, the terms of the plan conform to the requirements of IRC section 401(a). A favorable determination letter expresses the IRS's opinion regarding the form of the plan document. However, to be a qualified plan under IRC section 401(a) entitled to favorable tax treatment, a plan must satisfy, in both form and operation, the requirements of IRC section 401(a), including nondiscrimination and coverage requirements. A favorable determination letter may also provide assurance, on the basis of information and demonstrations provided in your application, that the plan satisfies certain of these nondiscrimination and coverage requirements in form or operation. See the following topic, Limitations and Scope of a Favorable Determination Letter, for more details.



Limitations and Scope of a Favorable Determination Letter

A favorable determination letter is limited in scope. A determination letter generally applies to qualification requirements regarding the form of the plan. A determination letter may also apply to certain operational (non-form) requirements.

Generally, a favorable determination letter does not consider, and may not be relied on with regard to:

- certain requirements under IRC section 401(a)(4), including the requirement that the plan be nondiscriminatory in the amounts of contributions or benefits for highly compensated and nonhighly compensated employees;
- the coverage requirements under IRC sections 410(b) and 401(a)(26); and
- the definition of compensation under IRC section 414(s).

In addition, a favorable determination letter may not be relied on for any qualification changes that become effective, any guidance published, or any statutes enacted, after the issuance of the applicable Cumulative List of Changes in Plan Qualification Requirements (Cumulative List) unless the item has been identified in that Cumulative List for the cycle under which the application was submitted. See section 4 of Revenue Procedure (Rev. Proc.) 2007-44, 2007-28 I.R.B. 54.

However, if you requested one or more of the optional nondiscrimination and coverage determinations offered on the determination letter application forms (Form 5300, Form 5307, Schedule Q), your favorable determination letter considers, and may be relied on, with regard to the specific determination(s) you requested, provided you satisfy the following requirement: you must retain copies of the application forms, any required demonstrations, and all correspondence with the IRS Revenue Service related to the application for a favorable determination letter. **A favorable determination letter cannot be relied on with regard to any optional determination request unless all of the required information is retained.**

In addition, the following apply generally to all determination letters:

- If you maintain two or more retirement plans, some of which were either not submitted to the IRS for determination or not disclosed on each application, certain limitations and requirements will not have been considered on an aggregate basis. Therefore, you may not rely on the determination letter regarding the plans when considered as a total package.
- A determination letter for a defined benefit plan may be relied on regarding the requirements of IRC section 401(a)(26) if the application requested a determination regarding section 410(b).
- A determination letter does not consider the special requirements relating to: (a) affiliated service groups, (b) leased employees, or (c) plan assets or liabilities involved in a merger, consolidation, spin-off or transfer of assets with another plan unless the letter includes a statement that the requirements of IRC section 414(m) (affiliated service groups), or 414(n) (leased employees) has been considered.
- No determination letter may be relied on with respect to the effective availability of benefits, rights, or features under the plan. (See section 1.401(a)(4)-4(c) of the Income Tax Regulations.) Reliance on whether benefits, rights, or features are currently available to a non-discriminatory group of employees is provided to the extent requested in the application.
- A determination letter does not consider whether actuarial assumptions are reasonable for funding or deduction purposes or whether a specific contribution is deductible.
- A determination letter does not consider, and may not be relied on with respect to, certain other matters described in section 5 of Rev. Proc. 2009-6, 2009-1 I.R.B. 189 (i.e., whether a plan amendment is part of a pattern of amendments that significantly discriminates in favor of highly compensated employees; the use of the substantiation guidelines contained in Rev. Proc. 93-42, 1993-31 I.R.B. 32; and certain qualified separate lines of

business requirements of IRC section 414(r)).

- The determination letter applies only to the employer and its participants on whose behalf the determination letter was issued.
- A determination letter does not express an opinion whether disability benefits or medical care benefits are acceptable as accident or health plan benefits deductible under IRC section 105 or 106.
- A determination letter does not express an opinion on whether the plan is a governmental plan defined in IRC section 414(d).
- A determination letter does not express an opinion on whether contributions made to a plan treated as a governmental plan defined in IRC section 414(d) constitute employer contributions under IRC section 414(h)(2), nor on whether a governmental excess benefit arrangement satisfies the requirements of IRC section 415(m).

You should become familiar with the terms of the determination letter. Please call the contact person listed on the determination letter if you do not understand any terms in your determination letter.

Retention of information. Whether a plan meets the qualification requirements is determined from the information in the written plan document, the application form and the supporting information submitted by the employer. **Therefore, you must retain copies of any demonstrations or other information submitted with your application. Such demonstrations determine the extent of reliance provided by your determination letter. Failure to retain such information may limit the scope of reliance on issues for which demonstrations were provided.**

Other conditions for reliance. We have not verified the information submitted with your application. The determination letter will not provide reliance if:

- (1) there has been a misstatement or omission of material facts, (for example, the application indicated that the plan was a governmental plan and it was not a governmental plan);
- (2) the facts subsequently developed are materially different than the facts on

which the determination was made; or

(3) there is a change in applicable law.

Law changes affecting the plan. A determination issued to an adopting employer of an individually designed plan will be based on the most recent Cumulative List published prior to the one year period starting February 1st and ending January 31st in which the determination letter application was filed. The Cumulative List is a list published annually by the IRS that identifies on a year-by-year basis all changes in the qualification requirements resulting from statute changes, regulations, or other guidance published in the Internal Revenue Bulletin that are required to be taken into account in the written plan document. See sections 4, 13, and 14 of Rev. Proc. 2007-44 for further details. Generally, a determination letter issued to an adopting employer of a pre-approved plan (i.e., Master & Prototype (M&P) plan or volume submitter (VS) plan) will be based on the Cumulative List used by the IRS in reviewing the pre-approved plan. However, see section 19 of Rev. Proc. 2007-44 for exceptions to this rule. For terminating plans, a determination letter is based on the law in effect at the time of the plan's proposed date termination. See Section 8 of Rev. Proc. 2007-44.

Amendments to the plan. A favorable determination letter issued to an individually designed plan will provide reliance up to and including the expiration date identified on the determination letter. This reliance is conditioned upon the timely adoption of any necessary interim amendments as required by section 5.04 of Rev. Proc. 2007-44. A favorable determination letter issued to an adopting employer of a preapproved plan will provide reliance up to and including the last day of the six-year cycle following the six-year remedial amendment cycle in which the determination letter application was filed. The reliance is conditioned upon the timely adoption of any necessary interim amendments as required by section 5.04 of Rev. Proc. 2007-44. Also see Rev. Proc. 2005-16, 2005-10 I.R.B. 674 sections 5.01 and 15.05 and Announcement 2005-37, 2005-21 I.R.B. 1096.

Plan Must Qualify in Operation

Generally, a plan qualifies in operation if it continues to satisfy the coverage and nondiscrimination requirements and is maintained according to the terms on which the favorable determination letter was issued. Changes in facts and other basis on which the determination letter was issued may mean that the determination letter may no longer be relied upon.

Some examples of the effect of a plan's operation on a favorable determination are:

Not meeting nondiscrimination in amount requirement. If the determination letter application requested a determination that the plan satisfies the nondiscrimination in amount requirement of section 1.401(a)(4)-1(b)(2) of the regulations on the basis of a design-based safe harbor, the plan will generally continue to satisfy this requirement in operation if the plan is maintained according to its terms. If the determination letter application requested a determination that the plan satisfies the nondiscrimination in amount requirement on the basis of a nondesign-based safe harbor or a general test, and the plan subsequently fails to meet this requirement in operation, the favorable determination letter may no longer be relied upon with respect to this requirement.

Not meeting minimum coverage requirements. If the determination letter application includes a request for a determination regarding the ratio percentage test of IRC section 410(b) and the plan subsequently fails to satisfy the ratio percentage test in operation, the letter may no longer be relied upon with respect to the coverage requirements. Likewise, if the determination letter application requests a determination regarding the average benefit test, the letter may no longer be relied upon with respect to the coverage requirements once the plan fails to satisfy the average benefit test in operation.

Changes in testing methods. If the determination letter is based in part on a demonstration that a coverage or nondiscrimination requirement is satisfied, and, in the operation of the

plan, the method used to test that this requirement continues to be satisfied is changed (or is required to be changed because the facts have changed) from the method employed in the demonstration, the letter may no longer be relied upon with respect to this requirement.

Contributions or benefits in excess of the limitations under IRC section 415. A retirement plan may not provide retirement benefits or, in the case of a defined contribution plan, contributions and other additions, that exceed the limitations specified in IRC section 415. Your plan contains provisions designed to provide benefits within these limitations. Please become familiar with these limitations, for your plan will be disqualified if these limitations are exceeded.

Top-heavy minimums. If this plan primarily benefits employees who are key employees, it may be a top-heavy plan and must provide certain minimum benefits and vesting for non-key employees. If your plan provides the accelerated benefits and vesting only for years during which the plan is top-heavy, failure to identify such years and to provide the accelerated vesting and benefits will disqualify the plan.

Actual deferral percentage or contribution percentage tests. If this plan provides for cash or deferred arrangements, employer matching contributions, or employee contributions, the determination letter does not consider whether special discrimination tests described in IRC section 401(k)(3) or 401(m)(2) have been satisfied in operation. However, the letter considers whether the terms of the plan satisfy the section 401(k)(3) or 401(m)(2) requirements specified in IRC section 401(k)(3) or 401(m)(2).

Reporting Requirements

Most plan administrators or employers who maintain an employee benefit plan must file an annual return/report. The following is a general discussion of the forms to be used for this purpose. See the instructions to each form for specific information:

Form 5500-EZ Annual Return of One-Participant (Owners and their Spouses) Pension Benefit Plans - generally for a "one-participant" plan, which is a plan that covers only:

- (1) an individual, or an individual and his or her spouse who wholly own a business, whether incorporated or not; or
- (2) partner(s) in a partnership or the partner(s) and the partner's spouse.

If Form 5500-EZ cannot be used, the one-participant plan should use Form 5500, Annual Return/Report of Employee Benefit Plan.

See Instructions to Form 5500-EZ for specific rules.

Note: A "one-participant" plan that has no more than \$250,000 in assets at the end of the plan year is not required to file a return. However, Form 5500-EZ must be filed for any subsequent year in which plan assets exceed \$250,000. If two or more one-participant plans have more than \$250,000 in assets, a separate Form 5500-EZ must be filed for each plan.

Instead of filing the paper Form 5500-EZ, plan administrators or employers may choose to file electronically using Form 5500-SF. Detailed information for electronic filing is available in the 2009 Instructions for Form 5500-EZ or at www.efast.dol.gov.

A "Final" Form 5500-EZ must be filed if the plan is terminated.

Form 5500, Annual Return/Report of Employee Benefit Plan - for a pension benefit plan that is not eligible to file Form 5500-EZ.

Note. Keogh (H.R. 10) plans having over \$250,000 in assets are required to file an annual return even if the only participants are owner-employees. The term "owner-employee" includes a partner who owns more than 10% interest in either the capital or profits of the partnership. This applies to both defined contribution and defined benefit plans.

Form 5330 for prohibited transactions. Transactions between a plan and someone having a relationship to the plan (disqualified person) are prohibited, unless specifically exempted from this requirement. A few examples are loans, sales and exchanges of property, leasing of property, furnishing goods or services, and use of plan assets by the disqualified person. Disqualified persons who engage in a prohibited transaction for which there is no exception must file Form 5330 by the last day of the seventh month after the end of the tax year of the disqualified person.

Form 5330 for tax on nondeductible employer contributions to qualified plans - If contributions are made to this plan in excess of the amount deductible, a tax may be imposed upon the excess contribution. Form 5330 must be filed by the last day of the seventh month after the end of the employer's tax year.

Form 5330 for tax on excess contributions to cash or deferred arrangements or excess employee contributions or employer matching contributions - If a plan includes a cash or deferred arrangement (IRC section 401(k)) or provides for employee contributions or employer matching contributions (IRC section 401(m)), then excess contributions that would cause the plan to fail the actual deferral percentage or the actual contribution percentage test are subject to a tax unless the excess is eliminated within 2½ months after the end of the plan year. Form 5330 must be filed by the due date of the employer's tax return for the plan year in which the tax was incurred.

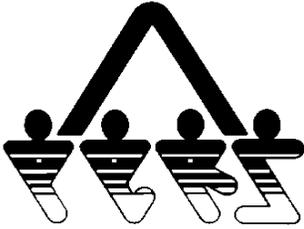
Form 5330 for tax on reversions of plan assets - Under IRC section 4980, a tax is payable on the amount of almost any employer reversion of plan assets. Form 5330 must be filed by the last day of the month following the month in which the reversion occurred.

Form 5310-A for certain transactions - Under IRC section 6058(b), an actuarial statement is required at least 30 days before a merger, consolidation, or transfer (including spin-off) of assets to another plan. This statement is required for all plans. However, penalties for non-filing will not apply to defined contribution plans for which:

- (1) The sum of the account balances in each plan equals the fair market value of all plan assets,
- (2) The assets of each plan are combined to form the assets of the plan as merged,
- (3) Immediately after a merger, the account balance of each participant is equal to the sum of the account balances of the participant immediately before the merger, and
- (4) The plans must not have an unamortized waiver or unallocated suspense account.

Penalties will also not apply if the assets transferred are less than three percent of the assets of the plan involved in the transfer (spinoff), and the transaction is not one of a series of two or more transfers (spinoff transactions) that are, in substance, one transaction.

The purpose of the above discussions is to illustrate some of the principal filing requirements that apply to pension plans. This is not an exclusive listing of all returns and schedules that must be filed.



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

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

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

Memorandum

TO: PERS Board
FROM: Sharon Schiermeister
DATE: April 8, 2011
SUBJECT: Budget Status

During this biennium, we have incurred additional costs relating to the work effort for the PERSLink project that impact our administrative budget. In addition, a staff member has made the decision to retire. We have taken a look at our actual expenditures to date and estimated the expenditures for the remainder of the biennium. Overall, we will have a favorable budget variance of approximately \$244,000. However, as the table below shows, our projected expenditures for the Salary & Wage line item exceed our appropriation authority for that line item by \$24,000.

Line Item	2009-11 Budget	Projected Expenditures	Variance
Salary & Wage	4,236,489	4,260,500	(24,011)
Operating Expenses	1,659,999	1,645,149	14,850
Contingency	250,000	0	250,000
Technology Project	4,734,726	4,734,726	0
Total	10,881,214	10,640,375	240,839

The reasons for the additional expenditures are:

1. Overtime pay for staff since going live with PERSLink
2. Pay out of annual leave for project team staff whose annual leave balance exceeds the carryover limit. Ability to take annual leave during 2010 was restricted for project team members.
3. Payout of accrued leave for staff member who is retiring
4. Fill vacancy that is resulting from staff member retiring, 1 month before employee retires

As part of our appropriation bill, the NDPERS Board is provided with the authority to make line item transfers from the Contingency line item. Staff is requesting that the Board approve a line item transfer of \$30,000 from the Contingency line item to the Salary and Wage line item, to cover the budget variance.

Board Action Requested

Approve or reject staff recommendation for a line item transfer of \$30,000 from the Contingency line item to the Salary and Wage line item.



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

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

Memorandum

TO: PERS Board
FROM: Sparb
DATE: April 12, 2011
SUBJECT: Legislative Update

The following is the legislative update on bills affecting NDPERS. I will review this with the Board at the meeting.

HB1228 - Failed
HB1258 - Failed
HB1364 - Signed by President of Senate
SB2022 - Signed by Speaker of House
SB2108 - Signed by Speaker of House
SB2109 - Signed by Speaker of House
SB2110 - Signed by Speaker of House
SB2302 - Conference Committee
SB2344 - Failed
SB2358 - Failed



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

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

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

Memorandum

TO: PERS Board

FROM: Sparb

DATE: April 14, 2011

SUBJECT: EXECUTIVE DIRECTOR EVALUATION

Attached is the form that is used yearly to evaluate the NDPERS Executive Director. Last year the Board discussed whether this evaluation form should be reviewed and/or revised.

If the Board would like to update the evaluation form, you may want to appoint a committee to make recommendations to the Board in May so the evaluation can be completed by June. Alternatively, if it is felt no changes need to be made at this time, the Board may want to appoint a committee to do the annual evaluation of the Executive Director and make a salary recommendation at the May or June meeting. Last year, Mr. Erdmann, Mr. Sage, and Chairman Strinden were on the committee.

Board Action Requested

To determine how to proceed with the evaluation process.