

# NDPERS BOARD MEETING

## Agenda

**Bismarck Location:**  
ND Association of Counties  
1661 Capitol Way  
**Fargo Location:**  
Sanford Health Plan  
1749 38<sup>th</sup> Street South

**December 17, 2015**

**Time: 8:30 AM**

### **I. MINUTES**

- A. November 19, 2015

### **II. RETIREMENT**

- A. Asset Liability Study Vendor Interviews (15 minutes each)– Sparb (Board Action)  
\* (Executive Session)
  - Callan \*
  - SEI \*
- B. IRS Cycle E Filing – Kathy/Jan (Board Action)
- C. RFP Update – Sparb (Information)
- D. Defined Benefit to Defined Contribution Plan Information – Sparb (Information)
- E. Defined Contribution to Defined Benefit Plan Update – MaryJo (Information)

### **III. GROUP INSURANCE**

- A. Medicare Part D Contract – Sparb/Rebecca/Jan (Board Action)
- B. Wellness Incentive Redemption – Rebecca (Board Action)
- C. Implementation Update – Sharon and Rebecca (Information)
- D. RFP Update – Sparb (Information)
- E. PPO Update - Sparb (Information)
- F. Infertility Benefit – Sparb/Kathy (Board Action)
- G. BCBS Update – Sparb/Jan (Board Action)
- H. Member Rebate Program Update - Kathy (Board Action)

### **IV. DEFERRED COMPENSATION**

- A. 3<sup>rd</sup> Quarter Investment Report – Bryan (Board Action)

### **V. MISCELLANEOUS**

- A. Administrative Rules – Sparb (Board Action)
- B. PERSLink – Sharon (Board Action)
- C. Annual Enrollment Update – Kathy (Information)

### **VI. MEMBER RETIREMENT ELIGIBILITY – Mary Jo \*\*Executive Session**

\*Executive Session pursuant to N.D.C.C. §§ 44-04-17.1(2) and (5), 44-04-18.4(6), and 44-04-19.2(1) and (6) to hear and discuss oral presentations regarding bids or proposals received by a public entity in response to a request for proposals and to sequester all competitors in a competitive selection or hiring process from that portion of a public meeting wherein presentations are heard or interviews are conducted. (Motion is necessary)

\*\*Executive Session to discuss confidential member information pursuant to NDCC 44-04-19.2(1), 54-52-26

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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.



**North Dakota  
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**Sparb Collins**  
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# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** December 9, 2015  
**SUBJECT:** Retirement Plan Services RFP Update

Our retirement plan services RFP is moving forward on the following timeline:

Timeline for RFP:

November 1, 2015	RFP for consultant services issued
December 1, 2015	Questions to RFP due
December 18, 2015	Responses to questions posted
January 15, 2016	Proposals due at NDPERS office no later than 5:00 p.m. Central Standard Time
May 1, 2016	PERS Board award date

The RFP was sent to the firms in Attachment #1. In addition, the notice in Attachment #2 appeared in newspapers. The list of questions concerning the RFP is included in Attachment #3 and we are developing answers that will be posted by December 18.

## Consultant Listing

Updated 11-2015

AON Hewitt	Mark D. Meyer	7650 W. Courtney Campbell Causeway, Suite 1000 Tampa, FL 33608 (813) 636-3533 (507) 381-6121(mobile) <a href="mailto:mark.meyer.2@aonhewitt.com">mark.meyer.2@aonhewitt.com</a>
Buck Consultants	Dave Slishinsky Principal and Consulting Actuary	1200 Seventeenth St., Suite 1200 Denver, CO 80202 (720) 359-7773 (720) 359-7701 FAX E-mail: <a href="mailto:david.slishinsky@buckconsultants.com">david.slishinsky@buckconsultants.com</a> Web: <a href="http://www.buckconsultants.com">www.buckconsultants.com</a>
Cammack Retirement Group	Alison Kellner Marketing Analyst	2 Rector Street/23 <sup>rd</sup> Floor New York, NY 10006 (646) 839-8202 (212) 267-3832 FAX <a href="mailto:akellner@cammackretirement.com">akellner@cammackretirement.com</a>
Cheiron, Inc.	Jed B. Torres	1750 Tysons Boulevard, Suite 1100 McLean, VA 22102 <a href="mailto:jtorres@cheiron.us">jtorres@cheiron.us</a> Web: <a href="http://www.cheiron.us">www.cheiron.us</a> (703) 893-1456 X 1024 (701) 893-2006 FAX
Cavanaugh Macdonald Consulting LLC	Thomas J. Cavanaugh, F.S.A. CEO	3550 Busbee Pkwy., Suite 250 Kennesaw, GA 30144 (678) 388-1708 (678) 388-1730 FAX <a href="mailto:tomc@cavmacconsulting.com">tomc@cavmacconsulting.com</a> <a href="mailto:johng@cavmacconsulting.com">johng@cavmacconsulting.com</a>
Deloitte Consulting, LLP	Patrick L. Pechacek, Director	50 South Sixth St., Suite 2800 Minneapolis, MN 55402-1538 (612) 397-4033 (612) 692-4033 FAX Cell: 612-270-3848 E-mail: <a href="mailto:ppechacek@deloitte.com">ppechacek@deloitte.com</a> <a href="mailto:mdeleon@deloitte.com">mdeleon@deloitte.com</a> Web: <a href="http://www.deloitte.com">www.deloitte.com</a>
Ennis, Knupp + Associates, Inc.	Harmony Watling Communications Manager	10 South Riverside Plaza, Suite 1600 Chicago, IL 60606 (312) 715-1700 (312) 715-1952 FAX E-mail: <a href="mailto:h.watling@ennisknupp.com">h.watling@ennisknupp.com</a> Web: <a href="http://www.ennisknupp.com">www.ennisknupp.com</a>
Gabriel, Roeder, Smith & Company	Leslie Thompson	7900 East Union Avenue, Suite 650 Denver, Colorado 80237-2746 (720) 274-7271 (720)560-8988 (mobile) E-mail: <a href="mailto:leslie.thompson@gabrielroeder.com">leslie.thompson@gabrielroeder.com</a> Web: <a href="http://www.grsnet.com">www.grsnet.com</a>

Gallagher Benefit Services, Inc.	Doug Anderson Area Senior Vice President	Retirement Plan Consulting/Actuarial Arthur J. Gallagher & Co. 3600 American Blvd W., Suite 500 Bloomington, MN 55431 (952) 356-3848 (866) 743-5313 (FAX) (612) 270-6125 (mobile) <a href="mailto:Doug_Anderson@ajg.com">Doug_Anderson@ajg.com</a> Web: <a href="http://www.ajg.com">www.ajg.com</a>
The Hay Group	Kimberly A. Fox, CEBS	The Wanamaker Building 100 Penn Square East Philadelphia, PA 19107 (215) 861-2522 (215) 861-2106 fax E-mail: <a href="mailto:Kimberly.Fox@haygroup.com">Kimberly.Fox@haygroup.com</a> Web: <a href="http://www.haygroup.com">www.haygroup.com</a>
Mercer	Norma Pocsatko	525 Vine Street, Suite 1600 Cincinnati, OH 45202 (513) 632-2600 Fax: (513) 632-2650 E-mail: <a href="mailto:norma.j.pocsatko@marsh.com">norma.j.pocsatko@marsh.com</a> Web: <a href="http://www.mercer.com">www.mercer.com</a>
Milliman, Inc.	Daniel Wade Consulting Actuary	Daniel Wade, FSA, EA, MAAA Consulting Actuary Milliman 1301 Fifth Avenue, Suite 3800 Seattle, WA 98101-2605 <a href="mailto:daniel.wade@milliman.com">daniel.wade@milliman.com</a>  Web: <a href="http://www.milliman.com">www.milliman.com</a>
Nyhart/ABG of Indiana	Leanne Willett	8415 Allison Pointe Boulevard, Suite 300 Indianapolis, IN 46250  (317) 845-3513 / 800-428-7106 (317) 845-3655 FAX <a href="mailto:leanne.willett@nyhart.com">leanne.willett@nyhart.com</a>  Web: <a href="http://www.nyhart.com">www.nyhart.com</a>
Raymond T. Clarke and Associates	Raymond T. Clarke	50 Fishing Brook Road Westbrook, CT 06498 Telephone: (203) 379-8345 E-mail: <a href="mailto:raymondclarke@yahoo.com">raymondclarke@yahoo.com</a>  Web: <a href="http://www.clarkraymond.com">www.clarkraymond.com</a>
Segal Consulting	Brad Ramirez, FSA, MAAA, EA Vice President and Consulting Actuary	Segal Consulting Brad Ramirez, FSA, MAAA, FCA, EA 5990 Greenwood Plaza Blvd., Suite 118 Greenwood Village, CO 80111-4708

		(303) 714-9952 (303) 223-9234 FAX (303) 875-2757 (mobile) Email: <a href="mailto:bramirez@segalco.com">bramirez@segalco.com</a> Web: <a href="http://www.segalco.com">www.segalco.com</a>
Towers Perrin	Shane Bartling Principal	525 Market Street , Suite 2900 San Francisco, CA 94105 (415) 836-1088 (415) 836-1350 FAX E-mail: <a href="mailto:shane.bartling@towersperrin.com">shane.bartling@towersperrin.com</a> Web: <a href="http://www.towersperrin.com">www.towersperrin.com</a>
Van Iwaarden Associates		840 Lumber Exchange Building Ten S 5 <sup>th</sup> Street Minneapolis, MN 55402-1010 (612) 596-5960 Mark: (507) 726-6269 (612) 596-5999 FAX  Web: <a href="http://www.vaniwaarden.com">www.vaniwaarden.com</a>
Middaugh & Associates	Jason Middaugh	1019 5th Avenue South P.O. Box 2543 Fargo, ND 58108 Phone: (701) 235-7023 Fax: (701) 280-9607 Email: <a href="mailto:jmiddaugh@cfsbd.com">jmiddaugh@cfsbd.com</a> Web: <a href="http://www.damiddaugh.com">www.damiddaugh.com</a>

# **PUBLIC NOTICE**

## **REQUEST FOR PROPOSAL Actuarial and Consulting Services Retirement Plan Services**

The North Dakota Public Employees Retirement System is seeking proposals for actuarial and consulting assistance in its retirement programs.

This website will contain the RFP and other important information. Bidders should check these electronic pages regularly.

<http://www.nd.gov/ndpers/providers-consultants/consultants/rfp-index.html>

Questions concerning the RFP shall be directed, in writing, to Cheryl Stockert and Bryan Reinhardt, or by email at [cstocker@nd.gov](mailto:cstocker@nd.gov) or [breinhar@nd.gov](mailto:breinhar@nd.gov) by 5:00 p.m. CST on December 1, 2015. Responses will be posted on the NDPERS website under "Request for Proposals" by December 18, 2015.

Proposals must be submitted no later than 5:00 PM (CST) on January 15, 2016 as indicated in the RFP.

# North Dakota Public Employees Retirement System

## Request for Proposal for Retirement Plan

### Question and Answers

1. What were the fixed fees for 2014 and 2015 for (a) Retirement and (b) Retiree Health Insurance Credit services?

ANSWER:

2. What special and/or out of scope services has NDPERS been billed for in the last two years, in addition to the fixed fees? How many hours billed for these services?

ANSWER:

3. For the following consulting areas, how many hours were billed and what rate was billed for 2014 and 2015?
  1. Retirement and Retiree Health General Consulting
  2. Legislative Work
  3. Defined Contribution/Deferred Compensation Consulting
  4. Flex Comp Consulting

ANSWER:

4. Please provide or post a copy of the letter dated September 16, 2014 (Exhibit A) that modified the contract.

ANSWER:

5. Please provide a copy of the NDPERS pension funding policy.

ANSWER:

6. What will be the effective date of the changes in actuarial factors and how was that date selected?

ANSWER:

7. Has NDPERS ever sued or threatened to sue its actuarial services vendor or any other of its vendors? If yes, please provide the dates and circumstances of such suits.

ANSWER:

8. Is it possible to submit a proposal on only the Deferred Compensation and Defined Contribution Plan services?

ANSWER:

9. Will the current actuary be participating in this RFP?

ANSWER:

10. What have been the annual fees for the last three years for the services listed in Sections 2A, 2B, 2C, and 2D of the RFP? What have been the total fees for the last three years including any special projects?

ANSWER:

11. The CAFR indicates that PERS is a multiple employer cost-sharing plan. How many employers participate in PERS?

ANSWER:

12. In addition to the plan reporting required by GASB 67 and the collective information needed for GASB 68, is the actuary expected to maintain all of the GASB 68 schedules for each employer (e.g., proportionate share of NPL, proportionate share of deferred inflows and outflows, proportionate share of pension expense, changes in proportionate share, difference between proportionate share of contributions and actual contributions, and contributions between the measurement date and employer's fiscal year end)? For each component unit of each employer? If so, how many component units are reported separately in the financial statements for each employer?

ANSWER:

13. Will the plan auditor be used to audit all the schedules for each employer or will the actuary need to work with each employer's auditor? If so, how many different auditors would the actuary need to work with?

ANSWER:

14. Are the GASB 67/68 results based on current year valuations or on a roll-forward from the prior valuations?

ANSWER:

15. Can we receive the 6/30/2014 and 6/30/2015 GASB 67/68 reports?

ANSWER:

16. Have the 2015 valuation reports been completed? If so, can we receive copies?

ANSWER:

17. Is the proposed valuation time line the same as has been in place for previous years? If not, why is it being changed?

ANSWER:

18. Would it be possible to submit a proposal for actuarial and consulting services relating to the PERS Defined Benefit Retirement Plans and the PERS Retiree Health Insurance Credit Program but not the PERS Section 457 Deferred Compensation Plan, PERS Defined Contribution Plan or PERS Section 125 Flex Program?

ANSWER:

19. Why are proposals for actuarial services being requested at this time?

ANSWER:

20. When was the last time the actuarial services were put out for bid?

ANSWER:

21. Who is the current actuary and how long have they been providing actuarial services to NDPERS?

ANSWER:

22. Are there any service concerns with the current actuary?

ANSWER:

23. Is the current actuary permitted to bid?

ANSWER:

24. In what format; e.g., Excel, Access or other, is member data submitted to the actuary?

ANSWER:

25. Can you please provide the annual actuarial fees paid to the actuary for each of the last three years for services comparable to those included in the RFP?

ANSWER:

26. Can you please provide the hourly rates being charged by your current actuary?

ANSWER:

27. Can you please provide a copy of the full Assumption/Experience Study Report dated May 21, 2015?

ANSWER:

28. Your RFP instructs us to deliver materials to a PO Box. Can the RFP response be delivered to a mailing address (for Federal Express), and if so, what is the mailing address?

ANSWER:

29. What are the fees that have been paid to the current actuary/consultant over the previous contract period based per category presented on page 25 (i.e.) Retirement, retiree health insurance credit, update of actuarial reduction factors, and GASB 67/68?

ANSWER:

30. Over the previous contract period, what were the total number of hours and flat fee paid by NDPERS for general consulting and legislative work, as listed on page 26 of the RFP?

ANSWER:

31. Please provide actuarial valuation reports for each system, as well as the RHIC program.

ANSWER:

32. Can NDPERS agree to a limitation of liability for its service providers?

ANSWER:

33. Can NDPERS agree to alternative dispute resolution (non-jury trial)?

ANSWER:

34. We note that there are several employee groups included in the valuation. Will all of the data be collected from a single source within ND PERS or will we need to collect data from various sources?

ANSWER:

35. The fee portion is discussed on page 25 of the RFP. On that page, it discusses travel reimbursements. Does the board anticipate that the fixed fee portion of the bid already contain and anticipate a certain number of meetings per year (beyond the presentation of the valuation report)?

ANSWER:

36. On the Legislative services, how often are the legislative sessions and what has been the number of projects for each of the past two sessions?

ANSWER:



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# Memorandum

**TO:** PERS Board

**FROM:** Sparb

**DATE:** December 9, 2015

**SUBJECT:** Defined Benefit to Defined Contribution Plan Articles

Attached is information relating to states (Alaska, Michigan and West Virginia) that changed from the defined benefit to the defined contribution plan and what they experienced.

Attachment #1 is a case study done by the National Institute for Retirement Security. They utilized existing state information such as the CAFR to develop their information.

Attachment #2 is a case study from the IFEBP. They used interviews with representatives from each state to develop their findings. The two reports both look at the same states but utilize different methodologies which together provide a broad insight into the experience of each state.



## PUBLIC PENSION RESOURCE GUIDE

# Case Studies of State Pension Plans that Switched to Defined Contribution Plans

The “Public Pension Resource Guide” provides readers with facts and data on the important role that public pensions play in the economy—for employees and retirees, public employers, and taxpayers alike.

A misperception persists among some that defined contribution (DC) plans “save money” when compared with traditional pensions. However, several states that switched to DC plans have experienced a much different reality over time. Indeed, a recent NIRS analysis of the economic efficiencies of defined benefit (DB) plans reconfirmed that pensions deliver the same amount of lifetime income for about half of the cost of providing the lifetime income from a typical DC plan.

“Case Studies of State Pension Plans that Switched to Defined Contribution Plans” presents summaries of past changes in three state retirement systems that made the switch to a DC plan from a traditional DB pension. Case studies cover the following states: West Virginia, Michigan, and Alaska. Rather than save states money, these DB to DC switch exacerbated funding problems and drove up pension debt.

Overall, certain trends appear common to all three states, such as:

- Changing from a DB plan to a DC plan did not help an existing underfunding problem, and, in fact, increased pension plan costs.
- Workers under the DC plan face increased levels of retirement insecurity.
- The best way to address a pension underfunding problem is to implement a responsible funding policy of making the full annual required contribution each year and to evaluate and adjust assumptions as well as funding over time.

Each analysis examines the key issues and the impact of the plan change over time. Specific areas include: the impact on the overall demographics of the system membership; changes in the cost of providing benefits under the plan; the percent of the actuarial required contribution made by the state and other public employers each year from 2003–2013; the effect on the retirement security of workers impacted by the change; and the impact on the overall funding level of the plan over time. To the extent possible, the case studies also examine subsequent action taken by policymakers to address the results of the plan changes.



## PUBLIC PENSION RESOURCE GUIDE

# Look Before You Leap: West Virginia Reopens DB Plan Within 15 Years of Closing; Commits to Improve Funding After DC Plan Benefits Prove Inadequate

Recently, there has been a misperception that defined contribution (DC) plans such as 401k plans “save money” as compared with traditional defined benefit (DB) plans. In light of this misperception, and in the wake of the financial crisis of 2008-2009 that caused underfunding in many public pension plans, many public employers have faced pressures to move from DB plans to DC accounts.

However, changing from DB to DC does not solve the underlying funding problem a state may be experiencing. One interesting case study that experienced this is that of the West Virginia Teachers Retirement System (TRS).

TRS, a traditional DB plan, was historically underfunded, due to lack of contributions from the state. While teachers had always made their contributions (6% of their pay out of every paycheck), the state and many county school boards failed to make their full contributions for many years. In fact, for some years from 1979 onward, the state and many school boards failed to match even employee contributions to the fund. To address the problem, in 1991, the state closed the TRS and moved newly hired teachers into a DC plan. Teachers in the DB plan were given a one-time choice to move to the DC plan as well.

The state later found, however, that this “funding solution” had overlooked some important considerations. Specifically, new members, by definition, do not start with any unfunded obligation. At the same time, unfunded obligations for existing members are not reduced when new members instead go into a DC plan. As a result, the loss of new members makes it more difficult to finance the unfunded obligations of the DB plan.

In other words, with the plan closed, TRS demographics shifted quickly. By 2005, TRS paid pension benefits to nearly 27,000 retired teachers, while less than 18,000 active teachers still contributed to the fund. The plan’s funding level stood at just 25%.

Meanwhile, the DC plan was fairing poorly as well. The members who had opted to transfer from the DB to the DC plan in 1991 found it hard to retire after the 2000–2002 bear market reduced the values of teachers’ accounts. While the state contributed 7.5% of salary to members’ DC accounts—supplemented by a mandatory 4.5% employee contribution—account balances were too low to provide an adequate retirement income. As of April 30, 2005, the average account balance was just \$41,478, and only 105 of the 1,767 teachers over age 60 had balances

over \$100,000. This was largely due to the fact that DC member accounts had achieved much lower investment returns than TRS. Between 2001 and 2010, for example, the average West Virginia DB return was 1.6% higher than the average DC return.

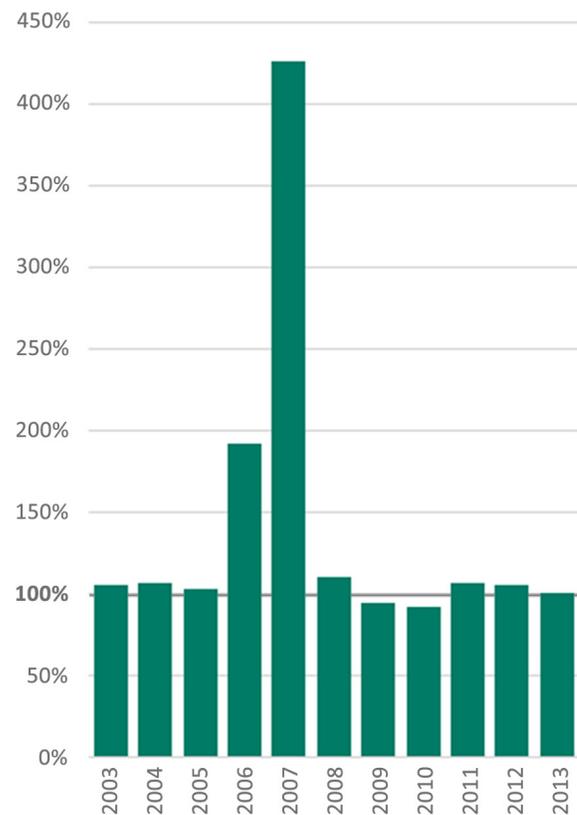
By 2003, the state began reexamining the switch. After studying the issue extensively, it found that the “normal cost” for TRS (the cost of benefits accrued in a single year) was roughly half of the required employer contribution to the DC plan. In other words, providing equivalent benefits would be far less expensive under the DB structure than in the DC plan. As a result, the state decided that, starting in 2005, all new hires would go back into the DB plan.

At the same time, the state became much more disciplined in funding the plan in order to make up for those years when the plan was deliberately underfunded. Extra contributions of \$290.1 million and \$313.8 million were made in 2006 and 2007, respectively. In addition, West Virginia completed a tobacco bond securitization in 2007 and deposited \$807.5 million of those proceeds into TRS as a special appropriation. All these amounts were in addition to the regular required contributions.

After TRS was reopened to new hires, in June 2008, the state allowed teachers who had been hired into the DC plan to choose whether they wanted to remain in that plan, or switch over to TRS. A full 78.6% of teachers (nearly 15,000 members) chose to switch, including 76% of teachers under 40 years old.

Surprisingly, the switch, which was expected to cost the state up to \$78 million before the elections were made, was now expected to save the state about \$22 million, because more young DC members than expected transferred. Specifically, 50% of those over age 70 transferred; 69% of those age 65 to 69 transferred; 81% of those age 45 to 64 transferred; and 76% of members under age 40 transferred.

**Table 1. Percentage of ARC Made to West Virginia Teachers, 2003-2013**



Ultimately, West Virginia projected \$1.2 billion in savings in the first 30 years by moving new entrants from the DC to the DB plan.

Today, the West Virginia TRS pension plan continues to improve. As of July 1, 2013, the plan’s funded level stood at 58%. That means that in the eight years since reopening the TRS pension, the state narrowed its historically sizeable funding gap by more than half. In addition, its recommended contribution has stabilized dramatically; in fact, in 2013, the recommended contribution was less than it was in 2010. The plan is expected to reach full funding by 2034.

Other states have watched and learned from the West Virginia experience, which showed that ultimately, moving from a DB plan to a DC plan can have dire consequence for employees,

employers, and taxpayers—even when a large unfunded liability exists. Indeed, all states have made significant changes to their retirement plans in the wake of the financial crisis. As states and municipalities have considered switching from the DB pension to a DC plan, those that have conducted a cost analysis have found that the move would save little to no money in the long term, and could actually substantially increase retirement plan costs in the near term. Not surprisingly, virtually no state that has conducted such a study has made the switch. Only one state (Oklahoma) ultimately opted in favor of moving to DC, but it did so as part of an overhaul of the total compensation package, without conducting a separate cost study for the switch.

#### Sources

- Boivie, I., and B. Almeida. 2008. *Look Before You Leap: The Unintended Consequences of Pension Freezes*. Washington, DC: NIRS.
- Boivie, I., and C. Weller. 2012. "The fiscal crisis, public pensions, and implications for labor and employment relations." In: Mitchell, D., ed. *Impact of the Great Recession on Public Sector Employment*. Ithaca, NY: Cornell University Press.
- Levitz, J. 2008. "When 401(k) investing goes bad: Teachers in West Virginia offer a valuable lesson for what not to do." *The Wall Street Journal*. August 4.
- Mathis, N. 1989. "W. Virginia pension fund going broke, union says." *Education Week*. September 28.
- Olleman, M. and I. Boivie. 2011. *Decisions, Decisions: Retirement Plan Choices for Public Employees and Employers*. Washington, DC: NIRS.
- Rhee, R. 2013, *On the Right Track? Public Pension Reforms in the Wake of the Financial Crisis*. National Institute on Retirement Security, Washington, DC.
- West Virginia Consolidated Public Retirement Board. Comprehensive Annual Financial Report, Fiscal Years Ending June 30, 2013, and June 30, 2012.
- West Virginia Consolidated Public Retirement Board. Audited Financial Statements, Years Ended June 30, 2005 and 2004.
- West Virginia Consolidated Public Retirement Board. Audited Financial Statements, Years Ended June 30, 2004 and 2003.



## PUBLIC PENSION RESOURCE GUIDE

# Look Before You Leap to DC: Michigan's Switch Increases Pension Costs, Reduces Retirement Security

Recently, there has been a misperception that switching from a traditional defined benefit (DB) pension plan to a defined contribution (DC) plan such as 401k plan will save taxpayer money and solve pension debt problems. In light of this misperception, and in the wake of the financial crisis of 2008-2009 that caused underfunding in many public pension plans, many public employers have faced pressures to move from DB plans to DC accounts.

However, changing from DB to DC does not decrease retirement plan costs, can drive up pension debt, and will almost certainly increase retirement insecurity. One interesting case study is that of the Michigan State Employees' Retirement System (MSERS).

In 1997, MSERS, a traditional DB pension plan, was closed to new hires, who were placed in a DC plan. Current employees were given a one-time choice to opt into the DC as well. In the DC plan, the state provides an automatic contribution of 4% of each employee's pay, with an additional match of 100% up to 3% of pay that the employee contributes.

At the time, the normal cost of the DB plan (the cost of benefits accrued in a single year) was approximately 9.1% of pay. So, it seemed as though the state would be "saving money"

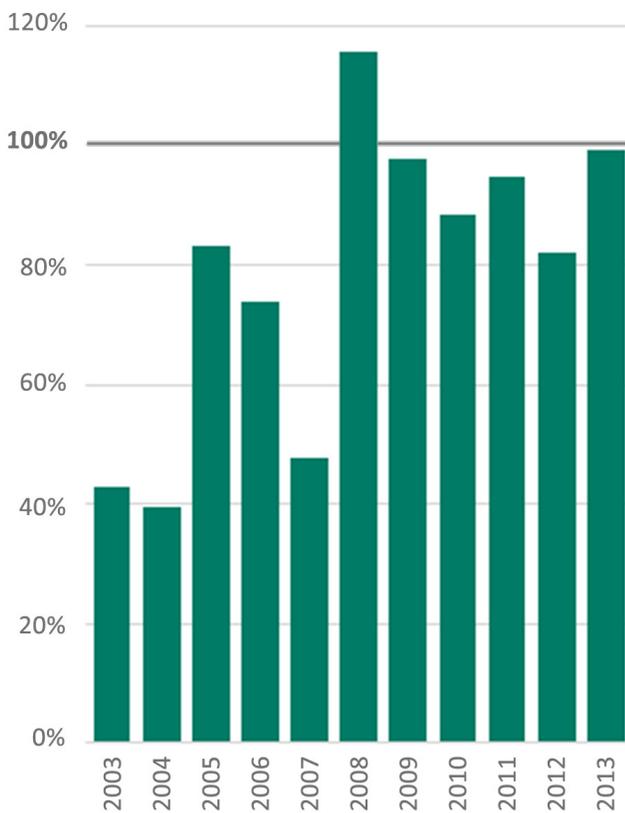
because the employer contribution to the DC plan would be capped at 7%, but any cost savings found by Michigan in the DC plan was produced by providing a lower income benefit in the DC plan.

Generally speaking, when a DB plan is frozen, plan costs will increase. This is because the plan's demographics tend to change rapidly. First, the active population will continue to age, and will amass a higher average liability as their wages grow. At the same time, the number of active members will steadily fall, as individuals retire, meaning an ever-smaller payroll base over which to spread payments on any unfunded liability.

When MSERS closed in 1997, the plan was actually overfunded; it had 109% of assets on hand to cover all liabilities. But by 2012—15 years after freezing new hires out—the plan had become severely underfunded, with an unfunded level of just 60.3%. In other words, while the plan had excess assets on hand of some \$734 million in 1997, by 2012, the plan amassed a significant unfunded liability of \$6.2 billion. Of course, between 1997 and 2012, other factors had come into play as well—two large financial market downturns, for example, as well as several years in which the state contributed less than its required payment.

More recently, however, the state has been making larger payments to MSERS, and financial markets have rebounded since the last downturn. Yet the state's unfunded liability continues to grow. As demographics continue to worsen, the burden increases. In 1997, the annual required contribution was about \$230 million, or \$4,140 per active member. By 2013, the required contribution had grown to \$611 million, or nearly \$37,100 per active employee.

**Table 1. Percentage of ARC Made to Michigan SERS, 2003-2013**



In just the one year from 2012 to 2013, the required payment on the unfunded liability grew by \$71.6 million to nearly \$567 million, despite an impressive 12.5% investment return in that year.

Meanwhile, in 2013, about two-thirds of current workers (33,000) were in the DC plan, and their retirement prospects seem dim. According to a 2011 report, the average balance was about \$50,000

in that year; for those close to retirement (age 60 or older), it was \$123,000. At current annuity rates, that balance would provide a benefit of about \$8,200 per year. Meanwhile, the average DB benefit for people currently retiring is over \$20,000 per year.

Even in a “best case” DC scenario—in which employees contribute enough of their own pay to receive the maximum employer contribution—a simple benefit projection shows that the DB benefit is worth much more. For example, an employee at a starting wage of \$40,000 per year, assuming 2% wage increases and 6% net investment returns each year, would accumulate a nest egg of approximately \$288,000 after 25 years of service; this can currently purchase an annuity of about \$1,600 per month. By contrast, an employee in the DB plan would see a monthly benefit of about \$2,050. Thus, the DB benefit is worth about 22% more, but actually costs less: The normal cost of the DB plan is roughly 8% of pay, while total contributions to the DC plan in this example are 10% of pay (7% employer and 3% employee).

This perhaps should not be surprising, as research shows that DB pensions are much more cost-efficient than DC plans, because they are able to achieve economies of scale by pooling employees. Specifically, they save money due to longevity risk pooling, maintaining a more balanced portfolio over a longer time, and achieving higher investment returns due to professional management and lower fees. NIRS has found that for a given level of retirement income, a typical DC plan costs 91% more than a typical DB plan.

Other states have watched and learned from the Michigan experience, which shows that ultimately, moving from a DB plan to a DC plan can have dire consequence for employees, employers, and taxpayers. The move can increase an unfunded liability, while simultaneously decimating the retirement prospects for workers. Indeed, all states have made significant changes to their retirement

plans in the wake of the financial crisis. As states and municipalities have considered switching from the DB pension to a DC plan, those that have conducted a cost analysis have found that the move would save little to no money in the long term, and could actually substantially increase retirement plan costs in the near term. Not surprisingly, virtually no state that has conducted such a study has made the switch. Only one state (Oklahoma) ultimately opted in favor of moving to DC, but it did so as part of an overhaul of the total compensation package, without conducting a separate cost study for the switch.

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PUBLIC PENSION RESOURCE GUIDE

## Look Before You Leap to DC: Alaska Compounds Its Unfunded Pension Liability

*“Going to a defined contribution system didn't solve the problem”*

In 2005, Alaska adopted a mandatory 401K-style defined contribution (DC) retirement program for all state employees hired after July 1, 2006 as a way to address its unfunded liabilities for retiree benefits. At the time, the state was facing a combined \$5.7 billion unfunded liability for its Public Employees Retirement System (PERS), Teachers Retirement System (TRS) and retiree medical plan. However, far from solving the pension funding problems, the switch to DC only exacerbated them. In 2006, underfunding increased by 20 percent; eventually, it more than doubled, as the combined unfunded liability reached \$12.4 billion in 2013.

### Alaska's Public Pensions in 2005

To examine the current state of public pensions in Alaska, it's important to look back at how the state amassed a \$5.7 billion debt in 2005. A 2014 article in the *Alaska Dispatch* faults funding decisions for the two defined benefit (DB) pensions by the Alaska legislatures and governors, together with sizeable stock market declines and devastating actuarial errors.

Mercer Inc., the state's actuary, made bad actuarial projections and attempted to hide them. A review by the state found that the firm

did not recommend the appropriate contribution increases needed to keep the plans on a sound financial basis. This error, according to officials, amounted to some \$2.5 billion of the unfunded liability. Subsequently, the Alaska Department of Law sued Mercer, and won an unprecedented \$500 million settlement—even as Mercer claimed that accurate information would not have changed the state's action to underfund its pension liabilities.

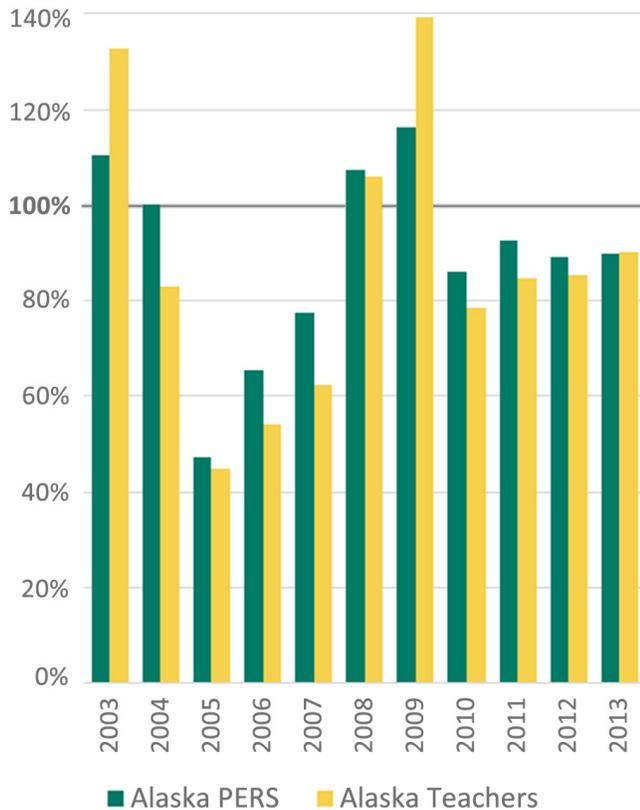
Governor Frank Murkowski used the \$5.7 billion funding shortfall to push the dramatic change from a DB pension to DC accounts, and he signed a bill (SB14) that made the switch into law after a special legislative session in 2005. Speaking at the press conference on the bill, the governor claimed that moving new employees into a DC plan “will stop the ‘so-called’ bleeding, so we can slow down the state's increasing liability.”

### SB 141 Did Not Address the Underfunding of PERS and TRS

Unfortunately, as many experts understand, the change did nothing to reduce the pension funding shortfalls. Instead, Alaska continued the same underfunding practice of paying less than the full cost. The state and public employees

contributed just 47% of the annual required contribution (ARC) to PERS and 45% of the ARC to TRS in 2005. As a result, the total unfunded liability reached \$6.9 billion in 2006.

**Table 1. Percentage of ARC Made to Alaska PERS and Teachers, 2003-2013**



In fact, Alaska failed to make the full ARC payments to both of the state’s DB pensions not only in 2005, but in six of the eight years from 2006 through 2013. This fairly consistent underfunding further increased the prior service costs for PERS and TRS in these years. Specifically, PERS past service cost as a percent of payroll was 12.4% in 2006, and grew to 24.2% in 2014 as the unpaid required contributions we added to outstanding liabilities each year they were not made. For TRS, its prior service cost as a percent of payroll rose from 24.6% in 2006 to 43.5% in 2014.

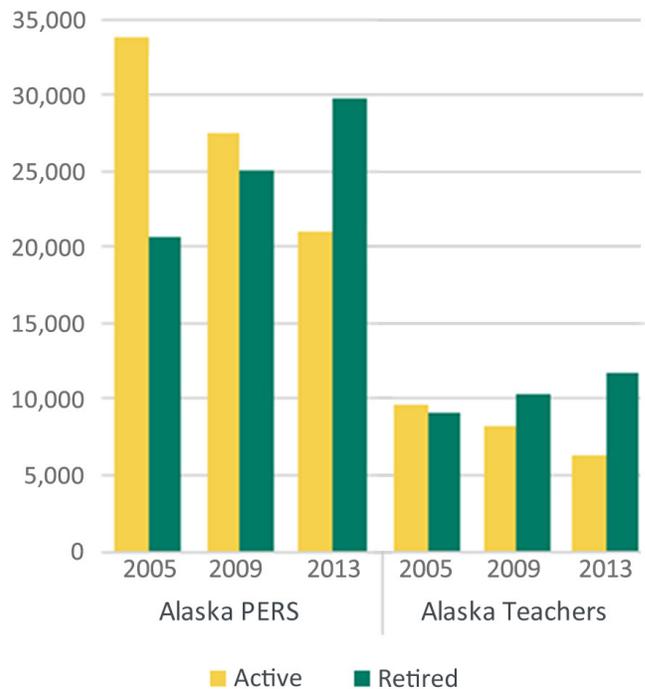
In all, the PERS and TRS total unfunded liabilities increased to \$7.8 billion and \$4.6 billion,

respectively, by 2013—for a total of some \$12.4 billion. In other words, the unfunded pension liability more than doubled since making the DC switch in 2005.

Meanwhile, with all new employees now covered by the DC plan, the demographics of the pensions changed quickly, which can worsen an underfunding problem. The loss of new employees’ contributions and corresponding employer contributions makes it more difficult to finance the pensions’ unfunded obligations. An issue paper published by gubernatorial candidate Sarah Palin in 2006 acknowledged that “employee contributions were the only constant source that continued coming into the system.”

In 2005, PERS made payments to nearly 21,000 retired employees and beneficiaries, and collected contributions from 33,730 active employees. In 2013, the plan was paying benefits to nearly 30,000 retired employees and beneficiaries, but collected contributions from less than 21,000 active members.

**Table 2. Alaska Retirement System Membership Status**



TRS also took a negative demographic turn. In 2005, TRS made payments to about 9,000 retired teachers and beneficiaries and collected contributions from nearly 9,700 teachers. By 2013, TRS had 11,705 retired teachers and beneficiaries but just 6,352 active teachers. Since July 2006, roughly 17,500 new public employees hired by Alaska began contributing to the DC plan. New members of a DB pension, by definition, do not start with any unfunded obligation for benefits. So, if Alaska kept open the DB pensions instead, these new employees would have resulted in the DB pensions getting a net funding contribution from a stable or growing group of employees rather than an ever smaller payroll base over which to spread the payments to meet the unfunded liabilities.

As early as 2007, legislation was introduced to reopen the DB pensions to new employees, in order to restore the demographic balance and to ensure retirement security with a predictable lifetime benefit for public sector workers. While these pension bills have received hearings and some votes in the legislature, they have not passed. New employees covered by the DC plan have planning and advice tools to help individuals estimate benefits, but the state has not published an analysis to assess how adequate such benefits will be when these employees retire.

Meanwhile, as the demographics of the pensions got worse, the underfunding increased. In 2005, PERS was 65.7% funded, as compared to 60.8% in 2013. The funding for TRS dropped from 60.9% in 2005 to 51.9% in 2013.

## Calls for Cash Infusions

Like most public pension plans, the largest potential source of revenue to PERS and TRS is investment earnings. Specifically, between 2006 and 2013—even after adjusting for the stock market losses in 2008-2009—investment income added over \$3 billion to PERS plan assets on a net basis. Had the needed, full ARC payments been

made since 2005, the state could have taken better advantage of the growth in financial markets since 2009.

However, this did not occur, and by 2013, the unfunded liability had grown to \$12.4 billion. Considering the impact of closing the pension to new employees, Representative Mike Hawker (Anchorage) commented in 2014 that “I very much was concerned when we closed our retirement systems and went to a defined contribution that by closing those systems we were going to find ourselves in the position we are in today, which was ultimately having to step in with a significant financial bailout.”

Reaching dire straits by 2014, Governor Sean Parnell proposed that Alaska add \$2 billion to its \$1 billion regular payment to reduce the underfunding. Eventually, the state made \$3 billion in contributions to PERS and TRS, per HB 385. After much legislative posturing, wrangling, and rewriting, the bill was rushed through in the final days of the legislative session. HB 385 also included a longer amortization period of 30 years, and shifted more of the pension cost to municipalities. This longer amortization allows for lower payments each year, but adds \$2.5 billion more to the funding cost over time—in the same way that the total cost of a 30-year mortgage is higher than that of a 15-year mortgage, due to compound interest on the outstanding unfunded balance.

## Key Takeaways from the Alaska Experience

Alaska presents a real-world example that switching to a DC plan does nothing to reduce DB plan costs, and can actually increase them. Losing a significant percent of employees to the DC plan reduced the one steady source of pension funding in Alaska. The false promise of the DC switch may have led policymakers to continue to underfund the pension plans, which only worsened the problem. As a result, the state’s unfunded liabilities

doubled in less than ten years.

Ultimately, Alaska saw increased pension costs for PERS and TRS after it switched to a DC plan for new hires.

Indeed, all states have made significant changes to their retirement plans in the wake of the financial crisis. Perhaps, it is based on the Alaska experience that as states and municipalities have considered switching from the DB pension to a DC plan, those that have conducted a cost analysis have found that the move would save little to no money in the long term, and could actually substantially increase retirement plan costs in the near term. Not surprisingly, virtually no state that has conducted such a study has made the switch. Only one state (Oklahoma) ultimately opted in favor of moving to DC, but it did so as part of an overhaul of the total compensation package, without conducting a separate cost study for the switch. Indeed, in the same year that Alaska decided to switch to a DC plan West Virginia was making a very different choice to “unscramble the egg,” reopening their traditional DB pensions to new employees, after having closed the plan many years ago.

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# Memorandum

**TO:** NDPERS Board

**FROM:** MaryJo

**DATE:** December 9, 2015

**SUBJECT:** DC to DB Implementation

With the implementation of the Defined Contribution (DC) plan special election period, NDPERS continues to receive phone calls from eligible participants regarding election process details and retirement plan comparisons. Of the 225 eligible participants, there are 54 members that have made an election and 171 members still remaining to make an election.

Since a number of members have indicated through counseling sessions they plan to delay making an election until the final month of the election period, NDPERS has decided to delay the reminder notification letter to eligible participants scheduled for December 10, 2015 until January 5, 2016. This will allow more time for additional December elections to be received at NDPERS and hopefully avoid election paperwork from getting lost with other holiday mail to participants.

As election forms are received, NDPERS notifies the member that the election has been received. The employer is also notified of the DC to DB transfer election for each individual election. Of the 5 employers within political subdivisions, 3 employers have been able to include the additional 2% assessment into payroll. There are 2 remaining employers within political subdivisions that have been notified of the election process and possibility of the 2% assessment being applied, depending on the member's election. Employers within the state system have been notified as each individual makes a DC to DB election and PeopleSoft instructions have been provided, when applicable, for setup of this 2% assessment in payroll.

NDPERS staff decided to wait until after supplemental payroll occurs on the 10<sup>th</sup> of each month before processing any member elections to transfer to the DB plan. This will avoid transfers from occurring too soon with TIAA-CREF before payroll adjustment contributions are posted. There are 40 elections that were made in the month of November and 40 of these elections were to transfer from the DC plan to the DB plan. Each of these 40 elections to transfer to the DB plan will occur in December 2015 after all November contributions have been confirmed. Employers are e-mailed verifying that each employee is still actively employed and paperwork is completed and sent to TIAA-CREF accordingly to initiate the transfer of funds.

Of the eligible DC participants, there are 4 members with rollovers and 1 member within a brokerage window account. These members have been notified funds must be moved prior to initiating any transfer into the DB plan, if elected. Qualified rollover funds into the DC plan must be liquidated prior to the transfer occurring and brokerage account funds must be moved into the TIAA-CREF cash reserve account prior to the transfer occurring.

The DC to DB election timeline is as follows:

Description of Task	Estimated Date	Date Completed
<b>Mail</b> notification letter for election window	Jun-15	9-Jun
Review with Jan	Aug-15	12-Aug
Determine data requirements /TIAA-CREF	20-Aug	20-Aug
Clarify legal requirements – eligibility of specific DC member	28-Aug	28-Aug
TIAA-CREF paperwork required for transfer	2-Sep	2-Sep
Draft Introductory Letter	10-Sep	2-Sep
Testing for system generated estimates / annual statements	Sep	7-Oct
Revised Plan Highlights DB/DC Comparison	N/A	
TIAA-CREF rollover / paperwork details	6-Oct	6-Oct
Finalize Introductory Letter	N/A	N/A
Board Action : specific DC member eligibility	24-Sep	24-Sep
Timeline presented to Board	24-Sep	24-Sep
<b>Mail</b> Introductory letter outlining timeline and election window	N/A	N/A
Train staff on benefit estimates / SB 2015 provisions	9-Oct	9-Oct
Finalize Benefit Specific Letter and Election Form for DC to DB transfer	9-Oct	7-Oct
Schedule On-site visits with TIAA-CREF	6-Oct	6-Oct
Confirm joint process with TIAA-CREF	6-Oct	6-Oct
Update PERSLink	Nov - Jan	Ongoing
Update PeopleSoft	Nov - Jan	Ongoing
<b>Mail</b> Member specific Calculated Benefit letter outlining transfer process, plan comparisons	9-Oct	14-Oct
Respond to Benefit Estimates	Oct - Jan	Ongoing
Confirm mail room/date stamp procedures	12-Oct	12-Oct
Establish Administrative Process	9-Oct	20-Oct
Informational Meeting with TIAA-CREF	3-Nov	3-Nov
Authorized Agent Training / Newsletter Article	Nov-Feb	Nov-Feb
Record webinar	1-Nov	1-Nov
Post all information to website	1-Nov	1-Nov
Develop Employee Valid/Invalid Election Letters	1-Nov	1-Nov
Develop Tracking Spreadsheet	1-Nov	1-Nov

<b>Description of Task</b>	<b>Estimated Date</b>	<b>Date Completed</b>
Identify & train specific staff processing DC election forms/paperwork	1-Nov	1-Nov
Informational Meeting with TIAA-CREF	13-Nov	13-Nov
Develop Employer Letters regarding 2%	13-Nov	13-Nov
On-site Consultations with TIAA-CREF	Nov 9-20	Nov 9-20
Finalize reminder letter	17-Dec	
<b>Mail</b> Reminder Letter	5-Jan	
Employee notification - election received	Nov - Jan	Nov - Jan
Employer notifications - DB election (2%)	Nov - Jan	Nov - Jan
Employer verification of employment status	Nov - Jan	Nov - Jan
Employee notification - transfer is final	Nov - Jan	Nov - Jan
3 Month Enrollment Window	Nov - Jan	Nov - Jan
Deadline for DC to DB Election Window	Jan 31 (Sunday)	
Process final account transfers for April contributions	Feb	



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# Memorandum

**TO:** PERS Board  
**FROM:** Sparb, Rebecca and Jan  
**DATE:** December 10, 2015  
**SUBJECT:** Medicare Part D Contract

Attached please find the most recent version of the Medicare Part D contract. Jan will be at the meeting and will provide you an update. This version is the most current version and is based upon the issues identified in the last draft; however, the parties have come to agreement regarding additional provisions not reflected in this draft. We hope to provide you with another draft prior to the meeting with these changes. You will note the following:

- Section 2.1: Language proposed by NDPERS regarding the process to be used if a change in the law affects the plan has been accepted.
- Sections 2.6 & 2.8: the parties have come to agreement regarding the timeframes for notification of disenrollment.
- Section 3.13: the parties have agreed to remove language regarding NDPERS responsibility for unpaid copayment amounts by members for prescriptions filed through the Mail Service Pharmacy.
- Section 4.4: this section is still under review, however, ESI has been provided the statutory authority references for audits by NDPERS and the State Auditor.
- Section 5.1(d): this section will be deleted.
- Section 9.6: Choice of law will be North Dakota.
- Section 9.15: the last sentence was proposed by NDPERS and has been accepted.

Concerning the ND Pharmacist suggestions we are pursuing those on a separate track. We are seeking comments from ESI and Deloitte on those suggestions and will bring them to the Board meeting.

At the last meeting there was also discussion on the type of Part D contract arrangement we have had and was the basis for our RFP. The following is some information from a Milliman Newsletter on the type of arrangements

distinct from the subsidy)

FIGURE 1		
RDS	800-SERIES EGWP	DIRECT-CONTRACT EGWP
Self-Insured	Fully Insured	Self-Insured, but with catastrophic coverage through federal government
Flexible plan design	Plan design subject to design of third-party Insurer	Flexible plan design
Subsidy received after end of year	Subsidy implicit in premiums charged by third-party Insurer	CMS Payment received monthly
Limit on retiree contributions	More flexibility in setting retiree contributions	Limit on retiree contributions
Cannot reflect in GASB 45 liability	Reflected in GASB 45 liability	Reflected in GASB 45 liability

The arrangement we use is the middle arrangement in which the plan is fully insured with the risk and CMS relationship shifted to the vendor. Our liability is limited to our premium. Consequently, we are not exposed to any loss the plan may incur. We also do not share in any gain incurred by the plan (we do with our modified fully insured plan on the medical side). As a result our contracting is substantially different.

When the program was developed back in 2005 our Retiree Committee and the Board reviewed the options. At that time we decided to go with the fully insured arrangement (PDP). The following is the motions from that meeting:

**Medicare Rx**

Mr. Collins reviewed the activity of the Medicare Rx retiree working group. He indicated the retiree group had reviewed many options but decided to focus on two. The first was to apply for the federal subsidy and the second was to enroll all the members in the BCBS Medicare prescription drug plan. The committee asked Segal to develop information relating to the subsidy and Blue Cross Blue Shield (BCBS) to develop some cost information relating to a prescription drug plan (PDP) with NDPERS duplicating the present coverage. The financial information supplied to the committee indicated that if NDPERS applied for the financial subsidy it could be eligible for about 1 million annually to subsidize premiums. However, if NDPERS participated in the prescription drug plan (PDP) its members could be eligible for 3 million in premium reductions.

After reviewing the above information, the retiree committee suggested to go the PDP route for 2006 and 2007. They also recommended NDPERS try and match its present plan as much as possible.

**MR LEINGANG MOVED TO PROCEED WITH THE PDP ROUTE. MS. SMITH SECONDED THE MOTION.**

At the last meeting we discussed PERS getting more involved with the drug pricing, rebates, etc. for this program. This means changes our contracting relationship to one of the self insured arrangements. If the Board would like to review this before the next contract we can put it on future agenda's for your consideration.

DRAFT

**MEDICARE PART D  
EMPLOYER/UNION-ONLY SPONSORED GROUP WAIVER PLAN  
PRESCRIPTION DRUG SERVICES AGREEMENT**

THIS MEDICARE PART D EMPLOYER-ONLY SPONSORED GROUP WAIVER PLAN PRESCRIPTION DRUG SERVICES AGREEMENT ("Agreement"), made as of the date of execution as set forth on the signature page (the "Execution Date"), is entered into by and between Medco Containment Life Insurance Company, a Pennsylvania corporation ("MCLIC") (an affiliate of Express Scripts, Inc.) and NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM, on its own behalf and on behalf of the Client Group Health Plan (as defined below) ("Client").

**RECITALS**

A. MCLIC has received approval from the Centers for Medicare and Medicaid Services ("CMS") to serve as a Prescription Drug Plan Sponsor (a "PDP Sponsor") and to provide prescription drug coverage that meets the requirements of, and pursuant to, the Voluntary Prescription Drug Benefit Program set forth in Part D of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 42 U.S.C. §1395w-101 through 42 U.S.C. §1395w-152 (the "Act") and all applicable and related rules and regulations promulgated, issued or adopted by CMS or other governmental agencies with jurisdiction over enforcement of the Act, including, but not limited to, 42 C.F.R. §423.1 through 42 C.F.R. §423.910 (with the exception of Subparts Q, R, and S), and the terms of any PDP Sponsor contract between CMS and MCLIC (collectively, the "Medicare Drug Rules"); and

B. Pursuant to the waivers granted by CMS under 42 U.S.C. §1395w-132(b), MCLIC offers employer/union-only sponsored group waiver plans ("EGWPs") to employers/unions that wish to provide prescription drug benefits to their Part D Eligible Retirees (as defined below) in accordance with the Medicare Drug Rules; and

C. Client desires to contract with MCLIC to offer a prescription drug benefit to Client's Part D Eligible Retirees pursuant to an EGWP (the "EGWP Benefit") (as further defined below) as part of Client's group welfare benefit plan (the "Client Group Health Plan"); and

E. Provided that the EGWP Benefit meets the actuarial equivalence standards of the Medicare Drug Rules, as more fully described below, MCLIC desires to offer the EGWP Benefit to Client's Part D Eligible Retirees in accordance with the Medicare Drug Rules and pursuant to the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the mutual representations, warranties and covenants herein contained, and pursuant to the terms and subject to the conditions set forth below, MCLIC and Client hereby agree as follows:

**TERMS AND CONDITIONS**

**ARTICLE I - DEFINITIONS**

Terms not otherwise defined in this Agreement shall have the meanings ascribed to them as set forth below, or as defined in the Medicare Drug Rules.

"Affiliate" means, with respect to MCLIC, individually or collectively, any other individual, corporation, partnership, limited liability company, trust, joint venture or other enterprise or entity directly or indirectly controlling (including without limitation all directors and executive officers of such entity), controlled by or under direct or indirect common control of or with MCLIC.

"Ancillary Supplies, Equipment, and Services" or "ASES" means ancillary supplies, equipment, and services provided or coordinated by ESI Specialty Pharmacy in connection with ESI Specialty Pharmacy's dispensing of Specialty Products. ASES may include all or some of the following: telephonic and/or in-person training, nursing/clinical services, in-home infusion and related support, patient monitoring, medication pumps, tubing, syringes, gauze pads, sharps containers, lancets, test strips, other supplies, and durable medical equipment. The aforementioned list is illustrative only (not exhaustive) and may include other supplies, equipment, and services

DRAFT

based on the patient's needs, prescriber instructions, payer requirements, and/or the Specialty Product manufacturer's requirements.

"Commercial Agreement" means that certain Pharmacy Benefit Management Agreement, dated January 1, 2014, by and between Express Scripts, Inc. ("ESI") and Sanford Health Plan and Sanford Health Plan of Minnesota (collectively "Sanford"), as amended from time to time (the "Commercial Agreement"). Client contracts with Sanford to receive pharmacy benefit services for its non-EGWP members.

"Copayment" or "Copay" means that portion of the charge for each Covered Drug dispensed to an EGWP Enrollee that is the responsibility of such EGWP Enrollee (e.g., copayment, coinsurance, cost sharing, and/or deductibles under initial coverage limits and up to annual out-of-pocket thresholds) as provided under the EGWP Benefit and shown on Exhibit A.

"Coverage Gap" means the stage of the benefit between the initial coverage limit and the catastrophic coverage threshold, as described in the Medicare Part D prescription drug program administered by the United States federal government.

"Coverage Gap Discount" means the manufacturer discounts available to eligible Medicare beneficiaries receiving applicable, covered Medicare Part D drugs, while in the Coverage Gap.

"Coverage Gap Discount Program" means the Medicare program that makes manufacturer discounts available to eligible Medicare beneficiaries receiving applicable, covered Medicare Part D drugs, while in the Coverage Gap.

"Covered Drug(s)" means those prescription drugs, supplies, Specialty Products and other items that are covered under the EGWP Benefit, or treated as covered pursuant to a coverage determination or appeal.

"EGWP Benefit" means the prescription drug benefit to be administered by MCLIC under this Agreement, as defined in the Recitals above and as further described in the Client Group Health Plan document, its summary plan description, and its summary of benefits, the latter of which is attached hereto as Exhibit A, as may be amended from time to time in accordance with the terms of this Agreement.

"EGWP Enrollee" means each Part D Eligible Retiree who is enrolled in the EGWP Benefit in accordance with the terms of this Agreement.

"EGWP Enrollee Submitted Claim" means (a) a claim submitted by an EGWP Enrollee for Covered Drugs dispensed by a pharmacy other than a Participating Pharmacy, or (b) a claim for Covered Drugs filled at a Participating Pharmacy for which the EGWP Enrollee paid the entire cost of the Covered Drug.

"Enrollment File" means the list(s) submitted by Client to MCLIC, in accordance with Article II, indicating the Part D Eligible Retirees that Client has submitted for enrollment in the EGWP Benefit, as verified by MCLIC through CMS eligibility files.

"ESI Specialty Pharmacy" means CuraScript, Inc., Accredo Health Group, Inc., Express Scripts Specialty Distribution Services, Inc., or another pharmacy or home health agency wholly-owned or operated by MCLIC or one or more of its affiliates that primarily dispenses Specialty Products or provides services related thereto; provided, however, that when the Mail Service Pharmacy dispenses a Specialty Product, it shall be considered an ESI Specialty Pharmacy hereunder.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder.

"Ineligible Enrollee" means an EGWP Enrollee who Client or MCLIC determines will no longer be eligible to participate as an EGWP Enrollee in the EGWP Benefit, in accordance with the EGWP Benefit's eligibility requirements and/or the Medicare Drug Rules.

"Late Enrollment Penalty" or "LEP" means the financial penalty incurred under the Medicare Drug Rules by Medicare Part D beneficiaries who have had a continued gap in creditable coverage of sixty-three (63) days or more after the end of the beneficiary's initial election period, adjusted from time to time by CMS.

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“Mail Service Pharmacy” means a duly licensed pharmacy wholly owned or operated by MCLIC or one or more of its Affiliates, other than ESI Specialty Pharmacy, where prescriptions are filled and delivered to EGWP Enrollees via mail or other delivery service.

“Manufacturer Administrative Fees” means those administrative fees of up to 3.5% of the AWP of certain Covered Drugs paid by pharmaceutical manufacturers to, or otherwise retained by, MCLIC or its Affiliate pursuant to a contract between MCLIC or its Affiliate and the manufacturer and directly in connection with MCLIC or its Affiliate administering, invoicing, allocating and collecting the Rebates for the EGWP Benefit under the Medicare Rebate Program.

“Medicare Formulary” means the list of prescription drugs and supplies developed, implemented and maintained in accordance with the Medicare Drug Rules for the EGWP Benefit.

“Medicare Rebate Program” means MCLIC’s or its Affiliate’s manufacturer rebate program under which MCLIC or its Affiliate contracts with pharmaceutical manufacturers for Rebates payable on selected Covered Drugs that are reimbursed, in whole or in part, through Medicare Part D, as such program may change from time to time.

“Part D” or “Medicare Part D” means the Voluntary Prescription Drug Benefit Program set forth in Part D of the Act.

“Part D Eligible Retiree” means an individual who is (a) eligible for Part D in accordance with the Medicare Drug Rules, (b) not enrolled in a Part D plan (other than the EGWP Benefit), and (c) eligible to participate in Client’s Current Benefit.

“Participating Pharmacy” means any licensed retail pharmacy, including retail, long-term care, home infusion, I/T/U pharmacies, with which MCLIC or one or more of its Affiliates has executed an agreement to provide Covered Drugs to EGWP Enrollees. These shall not include any mail order or specialty pharmacy affiliated with any such Participating Pharmacy.

“Pharmacy” or “Pharmacies” refers from time to time to any or all Participating Pharmacies, Mail Service Pharmacy, or ESI Specialty Pharmacy as the context of the provision dictates.

“Prescription Drug Claim” means an EGWP Enrollee Submitted Claim or claim for payment of a Covered Drug submitted to MCLIC by a Pharmacy.

“Prescription Drug Plan” or “PDP” shall have the meaning set forth in the Medicare Drug Rules.

“PHI” means protected health information as defined under HIPAA.

“Rebates” means retrospective formulary rebates that are paid to MCLIC or its Affiliate, pursuant to the terms of a formulary rebate contract negotiated independently by MCLIC or its Affiliate and directly attributable to the utilization of certain Covered Drugs by EGWP Enrollees under the EGWP Benefit. For sake of clarity, Rebates do not include, for example, Manufacturer Administrative Fees, product discounts or fees related to the procurement of prescription drug inventories by or on behalf of MCLIC or its Affiliates owned and operated specialty or mail order pharmacies; as more fully described in [Exhibit D](#); fees received by MCLIC from manufacturers for care management or other services provided in connection with the dispensing of Specialty Products; or other fee-for-service arrangements whereby pharmaceutical manufacturers generally report the fees paid to MCLIC, its Affiliates or wholly-owned subsidiaries for services rendered as “bona fide service fees” pursuant to federal laws and regulations, including, but not limited to the Medicaid “Best Price” rule (collectively, “Other Pharma Revenue”). Such laws and regulations, as well as MCLIC’s contracts with pharmaceutical manufacturers, generally prohibit MCLIC from sharing any such “bona fide service fees” earned by MCLIC, whether wholly or in part, with any MCLIC client.

“Specialty Product List” means the standard list of Specialty Products and their reimbursement rates applicable to Client and available to EGWP Enrollees as part of the EGWP Benefit provided to Client with this Agreement and as updated from time to time. MCLIC or its Affiliate will provide additional and/or updated Specialty Product Lists any time upon request from Client.

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“Specialty Products” means those injectable and non-injectable drugs on the Specialty Product List. Specialty Products typically have one or more of several key characteristics, including: frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; intensive patient training and compliance assistance to facilitate therapeutic goals; limited or exclusive product availability and distribution; specialized product handling and/or administration requirements and/or cost in excess of \$500 for a 30 day supply. Specialty Products elected for coverage shall be considered “Covered Drugs” as defined in the Agreement.

“True Out-of-Pocket Costs” or “TrOOP” means costs incurred by an EGWP Enrollee or by another person on behalf of an EGWP Enrollee, such as a deductible or other cost-sharing amount, with respect to Covered Drugs, as further defined in the Medicare Drug Rules.

“UM Company” means MCMC, LLC or other independent third party utilization management company contracted by MCLIC, subject to and as further described herein.

**ARTICLE II – PLAN STATUS UNDER APPLICABLE LAWS; ENROLLMENT AND DISENROLLMENT IN THE EGWP BENEFIT**

2.1 Medicare Part D. Client and MCLIC acknowledge and agree as follows:

(a) Under the Medicare Drug Rules, the EGWP Benefit will be deemed to be an EGWP administered by MCLIC and each EGWP Enrollee will be deemed to be a Part D enrollee of MCLIC who is covered by the EGWP Benefit.

(b) The design of and administration of the EGWP Benefit is subject to the applicable requirements of the Medicare Drug Rules. Client shall cooperate with MCLIC and, upon MCLIC’s request, do, execute, acknowledge, deliver, and provide such further acts, reports, information, and instruments as may be reasonably required or appropriate to administer the EGWP Benefit in compliance with the Medicare Drug Rules, applicable state insurance laws and other applicable laws. MCLIC shall provide reasonable guidance to Client regarding the requirements of the performance necessary for Client to meet its obligation under this section.

(c) In the event any Federal or State authority imposes any changes to plan design, plan benefits or other mandate affecting the Plan that results in the number of Client’s Part D Eligible Retirees being materially reduced or eliminated for any reason, MCLIC and Client shall reasonably cooperate to anticipate material increased expenses or other material effects and negotiate in good faith to incorporate consequent program pricing terms. In the event the parties are unable to reach agreement, either party may terminate this Agreement pursuant to 7.1 hereof. MCLIC reserves the right to adjust the program pricing terms hereunder to reflect the reduction or elimination of the number of Part D Eligible Retirees, with a 90-day notice, or when mandates imposed by State or Federal legislative action or NDCERS mandate become effective.

2.2 HIPAA.

(a) Each of Client, the Client Group Health Plan and MCLIC agrees to take reasonable and necessary actions to safeguard the privacy and security of information that identifies a particular EGWP Enrollee in accordance with state and federal privacy and security requirements, including HIPAA and the confidentiality and security provisions stated in 42 C.F.R. §423.136. Without limiting the generality of the foregoing, the parties acknowledge that, for the purposes of HIPAA compliance, each of MCLIC and the Client Group Health Plan is a Covered Entity, and that, with respect to the EGWP Benefit, MCLIC and the Client Group Health Plan shall be deemed to be an Organized Health Care Arrangement. MCLIC and the Client Group Health Plan may transmit and receive PHI as necessary for the operation of the EGWP Benefit. In addition, MCLIC may transmit PHI to the Client Group Health Plan for payment purposes and any other purpose permitted by HIPAA. Client hereby represents and warrants that: (i) the Client Group Health Plan’s documents have been amended to meet the specification requirements set forth at 45 C.F.R. §164.504(f); (ii) Client will use and disclose PHI solely in accordance with these provisions; and (iii) accordingly, MCLIC, at the direction of the Client Group Health Plan, may disclose PHI to Client consistent with the terms of this Section 2.2. The parties shall take reasonable steps to ensure that all uses and disclosures of PHI by MCLIC, the Client Group Health Plan and Client only include information that is minimally necessary to accomplish the purpose(s) of the use or disclosure. Capitalized terms used in this Section 2.2 and not otherwise defined in this Agreement shall have the meaning set forth in HIPAA. Notwithstanding the foregoing, the

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parties acknowledge that in providing services to EGWP Enrollees, ESI Specialty Pharmacy and the Mail Service Pharmacy are acting as separate health care provider covered entities under HIPAA and not as business associates to the Plan covered by the Business Associate Agreement. In providing services, ESI Specialty Pharmacy and the Mail Services Pharmacy shall abide by all HIPAA requirements applicable to covered entities and shall safeguard, use and disclose EGWP Enrollee PHI accordingly.

2.3 Group Enrollment. Subject to each individual's right to opt out, as described below, Client shall enroll Part D Eligible Retirees in the EGWP Benefit through a group enrollment process, as further described in and permitted under the Medicare Drug Rules. Client agrees that it will comply with all applicable requirements for group enrollment in EGWPs as set forth in the Medicare Drug Rules and related CMS guidance, and as described and required by MCLIC's policies and procedures. Client's performance under this Section 2.3 shall be a condition precedent to MCLIC's performance under this Agreement. MCLIC shall provide reasonable guidance to Client regarding the requirements of the performance necessary for Client to meet its obligation under this section.

2.4 Enrollment File. No later than thirty (30) days prior to the Effective Date (unless otherwise agreed to by the parties) and the first day of each EGWP Benefit enrollment period thereafter, so long as this Agreement is in effect, Client, or its authorized representative, shall provide an Enrollment File to MCLIC via on-line or other communication medium reasonably requested by MCLIC that lists those Part D Eligible Retirees for whom Client intends to make application for enrollment in the EGWP Benefit (i.e., those Part D Eligible Retirees who have not opted out of the group enrollment process) for that contract year. Client shall communicate all new enrollments, requested retroactive enrollments of Part D Eligible Retirees, and disenrollments from the EGWP Benefit via the communication medium reasonably requested by MCLIC. MCLIC agrees to process retroactive enrollment requests pursuant to the requirements of the Medicare Drug Rules. Client acknowledges and agrees that the requested effective date for any such retroactive enrollment may not be prior to the date that the enrollment request was completed by the individual, and that the effective date of enrollment may be adjusted by no greater than ninety (90) days. Client represents and warrants that the Enrollment File provided to MCLIC pursuant to this Section 2.4, and all retroactive additions thereto, shall only include those individuals eligible for enrollment under the Client Group Health Plan, and which have elected to participate in the EGWP Benefit. Client's performance under this Section 2.4 shall be a condition precedent to MCLIC's performance under this Agreement.

2.5 Implementation.

(a) MCLIC's Responsibilities. MCLIC shall implement the Enrollment File following confirmation of the eligibility of the Part D Eligible Retirees listed on the Enrollment File with CMS eligibility files. A Part D Eligible Retiree will not be enrolled in the EGWP Benefit unless such individual is listed on both the Enrollment File submitted by Client and the CMS eligibility files. MCLIC will seek from CMS verification of eligibility for all Part D Eligible Retirees whose names are listed in the Enrollment File. If an individual is listed on the Enrollment File provided by Client, but is not eligible for participation according to CMS eligibility files, then MCLIC shall notify Client in a timely manner regarding such individual's ineligibility. MCLIC will work with Client to determine if such individual has been rejected due to an administrative or clerical error (e.g., data field standards errors, rejections related to information input by MCLIC related to the EGWP Benefit into the CMS system, etc.), or an error requiring individual retiree contact, and if so in either case, MCLIC will take appropriate action and attempt to correct such error and resubmit the individual through the CMS system. Client acknowledges and agrees that MCLIC may update in the Enrollment File any and all information concerning Part D Eligible Retirees upon receipt of corrected information from CMS, and MCLIC may use such corrected information to obtain a Part D Eligible Retiree's enrollment in the EGWP Benefit. For all Part D Eligible Retirees that have been included by Client in the Enrollment File, but who are ultimately determined to be ineligible for participation in the EGWP Benefit, MCLIC or its Affiliate shall notify the individual of his or her ineligibility in the EGWP Benefit and take all other action as required by applicable law. MCLIC shall communicate to Client any changes to a Part D Eligible Retiree's information in the Enrollment File based upon updates or corrections received from CMS.

(b) Incomplete Enrollment File Information. Client acknowledges that its submission to MCLIC of an inaccurate or incomplete Enrollment File (e.g., missing date of birth, last name, first name, etc.) or otherwise of incomplete information with respect to any individual Part D Eligible Retiree, may result in a rejection of the Part D Eligible Retiree's enrollment in the EGWP Benefit. MCLIC will provide Client with regular reports providing the details of all such incomplete information needed to enroll Part D Eligible Retirees. Upon Client's request, MCLIC will perform research and may initiate contact and communication with all such Part D Eligible Retirees to obtain all missing information needed to complete enrollment of the Part D Eligible Retirees in the EGWP Benefit. Client

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acknowledges and agrees that MCLIC may contact Client's Part D Eligible Retirees to obtain the information required hereunder, and that MCLIC will update the Enrollment File on Client's behalf to reflect additional information needed to complete enrollment of the Part D Eligible Retirees in the EGWP Benefit. MCLIC shall provide to Client all such updated information through the regular reports provided hereunder. After obtaining all information needed to complete enrollment of the Part D Eligible Retirees in the EGWP Benefit, MCLIC shall complete such enrollment including verification with CMS; provided, however, that if MCLIC, using reasonable efforts, is not able to obtain all missing information from a Part D Eligible Retiree within twenty-one (21) days after receiving Client's initial request for enrollment of the Part D Eligible Retiree in the EGWP Benefit, then Client's request shall be deemed cancelled and MCLIC or its Affiliate shall notify the individual of his or her non-enrollment in the EGWP Benefit and shall take all other action as required by applicable law.

(c) Effective Date of Application for Enrollment into EGWP Benefit. Notwithstanding any provision of this Agreement to the contrary, the effective date of the application for any Part D Eligible Retiree who MCLIC seeks to enroll in the EGWP Benefit hereunder shall be the date on which the application for enrollment is entered by MCLIC into its enrollment system, subject however to any adjustments that MCLIC may make for retroactive enrollments as necessary to enroll the Part D Eligible Retiree in the EGWP Benefit.

(d) Client's Responsibilities. The parties agree that Sanford will be providing certain services on behalf of Client with respect to Client's obligations under this Agreement. Client shall bind Sanford for obligations Sanford performs on its behalf, and references in the Agreement to "Client" in performing a function shall be construed to include Sanford to the extent applicable. Further, Client shall require Sanford to comply with all applicable laws and the Medicare Drug Rules. The services provided by Sanford on behalf of client include, but may not be limited to the following:

- Help coordination of communication pieces between ESI and Client;
- Assisting Client with renewals or other contract negotiations with ESI;
- Helping to provide technical advice to Client on pharmacy issues;
- Assist Client/ESI with EGWP Enrollee appeals and general complaints;
- Assist Client/ESI with problem resolution;
- Assist EGWP Enrollees with appeals on formulary, network & other issues;
- Assist Client/ESI with general EGWP Enrollee inquiries related to their prescription drug plan.

2.6 Individual Disenrollment. If Client or MCLIC determines that an EGWP Enrollee will be an Ineligible Enrollee, in accordance with the EGWP Benefit's eligibility requirements and/or the Medicare Drug Rules, then the following procedures shall be implemented as applicable:

(a) Upon Client's determination, Client shall notify MCLIC no earlier than sixty (60) days prior to the effective date of such Ineligible Enrollee's ineligibility, in a manner and format agreed upon by the parties;

(b) MCLIC shall send a letter / notification to the Ineligible Enrollee alerting the Ineligible Enrollee that he or she is no longer eligible to participate in the EGWP Benefit;

(c) Client shall provide all information to MCLIC that is required for MCLIC to submit a complete disenrollment request transaction to CMS, as set forth in the Medicare Drug Rules; and

(d) MCLIC shall submit the disenrollment request transaction to CMS in accordance with the Medicare Drug Rules.

2.7 Group Disenrollment. If, upon the expiration of the then current term of this Agreement, or as otherwise provided in Section 8.2, Client plans to disenroll its EGWP Enrollees from the EGWP Benefit using a group disenrollment process, then Client shall implement the following procedures:

(a) Notification to EGWP Enrollees. Client shall provide at least twenty-one (21) days (or such other minimum days' notice as required by the Medicare Drug Rules) prior written notice to each EGWP Enrollee that Client plans to disenroll him or her from the EGWP Benefit and shall include with such written notification an explanation as to how the EGWP Enrollee may contact CMS for information on other Medicare Part D options that might be available to the EGWP Enrollee; and

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(b) Information to MCLIC. Client shall provide all the information to MCLIC that is required for MCLIC to submit a complete disenrollment request transaction to CMS, as set forth in the Medicare Drug Rules.

2.8 Voluntary Disenrollment. If an EGWP Enrollee makes a voluntary request to be disenrolled from the EGWP Benefit (the "Voluntary Disenrollee") to Client, then Client shall notify MCLIC no earlier than sixty (60) days prior to the effective date of such Voluntary Disenrollee's disenrollment, in a manner and format agreed upon by the parties. If Client does not timely notify MCLIC of such Voluntary Disenrollee's disenrollment in the EGWP Benefit, then MCLIC shall submit a retroactive disenrollment request to CMS. Client acknowledges this. If the Voluntary Disenrollee makes his or her request directly to MCLIC, then MCLIC shall direct the Voluntary Disenrollee to initiate the disenrollment with the Client.

2.9 Responsibility for Claims After Loss of Eligibility or Disenrollment. Client represents and warrants that all information that Client, or its authorized representative, provides to MCLIC in the Enrollment File will be complete and correct. Except for Prescription Drug Claims that are paid due to MCLIC's negligence, Client shall be responsible for reimbursing MCLIC pursuant to Section 5.1 for all Prescription Drug Claims processed by MCLIC (a) with respect to an Ineligible Enrollee, as determined by Client, during any period in which the Enrollment File indicated that such Ineligible Enrollee was eligible and (b) with respect to a Voluntary Disenrollee, in the event Client did not provide timely notice to MCLIC of such disenrollment as set forth in this Article II.

2.10 General Support Services. In addition to any other Client obligation under this Article II or elsewhere in this Agreement, Client shall be responsible for providing general support services to EGWP Enrollees throughout the enrollment process, including, but not limited to, EGWP Enrollee education concerning the EGWP Benefit, communicating information concerning premiums, providing information concerning alternative benefit options offered by Client, if any, and answering on-going inquiries related to the payment of the applicable EGWP Enrollee premium.

2.11 Effect On / Effect Of Commercial Agreement. Except as expressly provided in this Agreement, the parties acknowledge that MCLIC shall have no obligations under the Commercial Agreement with respect to the Client Group Health Plan, and that Client shall be solely responsible for determining the eligibility of members covered by the prescription drug benefit administered pursuant to the Commercial Agreement (the "Commercial Benefit"). Upon a member's enrollment as an EGWP Enrollee in the EGWP Benefit, such EGWP Enrollee's eligibility as a member in the Commercial Benefit shall immediately terminate. An EGWP Enrollee may not have dual coverage under the EGWP Benefit and the Commercial Benefit; and therefore, after any EGWP Enrollee's enrollment in the EGWP Benefit, all Prescription Drug Claims and member submitted claims submitted to ESI under the Commercial Agreement shall be treated as Prescription Drug Claims under this Agreement and shall be processed by MCLIC in accordance with the EGWP Benefit. Any Prescription Drug Claim or member submitted claim processed under the Commercial Agreement and the Commercial Benefit after the date of an EGWP Enrollee's enrollment in the EGWP Benefit shall be reversed and shall be re-processed under the EGWP Benefit. Client acknowledges that termination of a member's coverage under the Commercial Benefit prior to such member's enrollment as an EGWP Enrollee in the EGWP Benefit may result in a loss of prescription drug benefit coverage for such member; provided, however, notwithstanding the foregoing, the parties acknowledge and agree that a member's prescription drug benefit coverage under the Commercial Benefit shall be solely determined by Client and not by MCLIC or any of its Affiliates, including without limitation ESI.

### ARTICLE III – PRESCRIPTION DRUG SERVICES

3.1 Exclusivity. Client acknowledges and agrees that, in the event Client offers its Part D Eligible Retirees more than one Part D benefit option, the eligibility determinations, enrollment and disenrollment and other administration of such Part D options will require extensive coordination with the administration of the EGWP Benefit. For these reasons, Client agrees that Client shall use MCLIC as Client's exclusive provider of all Medicare Part D services for its Part D Eligible Retirees during the term of this Agreement unless otherwise requested by Client and agreed to by MCLIC in writing. Notwithstanding the foregoing, the parties agree that Retiree Health Insurance Credit benefits received by Part D Eligible Retirees does not violate or implicate this section. The terms and conditions of Client's and MCLIC's arrangements for Part D options other than the EGWP Benefit shall be set forth in separate agreements.

3.2 Prescription Drug Services. In exchange for Client's payment to MCLIC of the amounts set forth in Section 5.2, MCLIC will offer the EGWP Benefit to EGWP Enrollees in accordance with the terms and conditions of this

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Agreement. In its capacity as a PDP Sponsor with respect to the EGWP Benefit, MCLIC will be responsible for pharmacy network contracting; Mail Service Pharmacy and Specialty Products services; Prescription Drug Claim processing; Formulary and Rebate administration; Medication Therapy Management; and related services (collectively, "Prescription Drug Services"), as further described in this Agreement. All Prescription Drug Services shall be provided by MCLIC in accordance with the Medicare Drug Rules and the terms of the EGWP Benefit. Client acknowledges and agrees that MCLIC may provide Prescription Drug Services under this Agreement through one or more of its Affiliates. MCLIC represents and warrants that it will have written agreements with each Affiliate that will perform services on behalf of MCLIC in connection with the EGWP Benefit that meet the requirements the Medicare Drug Rules for subcontractors of PDP Sponsors.

3.3 Compliance with Medicare Drug Rules and State Insurance Laws. Under the Medicare Drug Rules, MCLIC is required to maintain licensure under applicable state insurance laws or to obtain appropriate waivers from CMS of such requirements. Notwithstanding any provision to the contrary in this Agreement, MCLIC shall not be obligated to take any action or omit to take any action with respect to the EGWP Benefit that is not in compliance with the Medicare Drug Rules, applicable state insurance laws or other applicable laws.

3.4 The EGWP Benefit. The EGWP Benefit will satisfy all actuarial equivalence standards set forth in the Medicare Drug Rules. Client hereby agrees to cooperate with MCLIC to perform the necessary actuarial equivalence calculations to determine whether the EGWP Benefit meets the foregoing actuarial equivalence standards prior to the Effective Date. If MCLIC determines that the EGWP Benefit does not meet the actuarial equivalence standards, then Client shall cooperate with MCLIC to make necessary adjustments to the EGWP Benefit design to meet the actuarial equivalence standards.

3.5 Changes to the EGWP Benefit. Client shall have the right to request changes to the terms of the EGWP Benefit from time to time by providing written notice to MCLIC. MCLIC shall implement any such requested changes in its sole discretion. Any such changes shall be subject to the following requirements: (a) all changes to the EGWP Benefit must be consistent with the Medicare Drug Rules; (b) the EGWP Benefit, after implementation of such changes, must continue to meet the actuarial equivalence standards referenced in Section 3.4 above; (c) EGWP Benefit changes may be implemented only at times and in the manner permitted by the Medicare Drug Rules; and (d) any requested change that would increase MCLIC's costs of administering the EGWP Benefit without an equivalent increase in the PMPM Fees (as defined in Section 5.2 below) paid to MCLIC from Client shall not be implemented unless and until Client and MCLIC agree in writing upon a corresponding adjustment to the PMPM Fees.

3.6 EGWP Enrollee Communications. All standard EGWP Enrollee communications concerning the EGWP Benefit (i.e., summary plan description, evidence of coverage, etc.) shall be mutually developed by MCLIC and the Client pursuant to the Medicare Drug Rules, including the CMS Marketing Guidelines contained therein. MCLIC shall be responsible, with assistance from Client, in completing EGWP Enrollee communications and distributing them to EGWP Enrollees as appropriate. Pursuant to the Medicare Drug Rules, Client acknowledges and agrees that MCLIC must provide all such EGWP Enrollee communications, whether created and/or distributed by MCLIC or Client, to CMS for review. If CMS notifies MCLIC that any such EGWP Enrollee communication is deficient, Client agrees to assist MCLIC to make necessary revisions to such EGWP Enrollee communication to correct such deficiency.

3.7 Network Access and Service Area Requirements. At least thirty (30) days prior to the Effective Date, Client shall provide MCLIC de-identified aggregate information concerning where: (A) all Part D Eligible Retirees reside; and (B) all of Client's employees reside, as necessary for MCLIC to determine whether MCLIC's network of Participating Pharmacies is sufficient to meet the needs of such individuals. Client represents and warrants that all such information shall be accurate and complete. Client's performance under this Section 3.7 shall be a condition precedent to MCLIC's performance under this Agreement. If MCLIC determines that its network of Participating Pharmacies is not sufficient to meet the needs of individuals eligible to participate in the EGWP Benefit, then MCLIC shall use its best efforts to address such deficiencies. If MCLIC is not able to satisfactorily address such deficiencies prior to the Effective Date, then MCLIC shall provide written notice to Client prior to the Effective Date and this Agreement shall automatically terminate.

3.8 Pharmacy Network. Subject to the terms of Section 3.7 above, MCLIC shall develop and maintain a Participating Pharmacy network that, at a minimum, is sufficient to meet the needs of the EGWP Enrollees, as provided in the CMS waiver guidance concerning network access under Medicare Drug Rules.

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(a) Pharmacy Credentialing. MCLIC agrees to comply with all applicable Medicare Drug Rules regarding credentialing requirements. MCLIC shall require Participating Pharmacies, MCLIC Mail Service Pharmacy and ESI Specialty Pharmacy to meet MCLIC's and the Medicare Drug Rules' credentialing requirements, including but not limited to licensure, insurance and provider agreement requirements.

(b) Independent Contractors. Neither MCLIC nor its Affiliate directs or exercises any control over the professional judgment exercised by any pharmacist in dispensing prescriptions or otherwise providing pharmaceutical related services at a Participating Pharmacy. Participating Pharmacies are independent contractors of MCLIC or its Affiliate, and neither MCLIC nor its Affiliate shall have any liability to Client, any EGWP Enrollee or any other person or entity for any act or omission of any Participating Pharmacy or its agents or employees.

(c) Pharmacy Help Desk. MCLIC will provide 24-hour a day, 7-days a week toll-free telephone support and Internet web site to assist Participating Pharmacies with EGWP Enrollee eligibility verification and questions regarding reimbursement, and Covered Drug benefits under the EGWP Benefit.

3.9 Audits of Participating Pharmacies; Fraud and Abuse. MCLIC shall periodically audit Participating Pharmacies to determine compliance with their agreements with MCLIC or its Affiliate and in order to meet the anti-fraud provisions of the Medicare Drug Rules applicable to PDPs. MCLIC also shall perform fraud and abuse reviews of EGWP Enrollees and physicians as required under the Medicare Drug Rules for PDPs.

3.10 Claims Processing. Subject to Sections 3.10(a)-(h), MCLIC will be responsible for all claims processing services for Covered Drugs dispensed to EGWP Enrollees by a Pharmacy consistent with the applicable standard transaction rules required under HIPAA and the Medicare Drug Rules. MCLIC also shall process EGWP Enrollee Submitted Claims.

(a) COB.

(i) MCLIC will coordinate benefits with state pharmaceutical assistance programs and entities providing other prescription drug coverage consistent with the Medicare Drug Rules. If Client, in accordance with the Medicare Drug Rules, elects to provide non-Medicare EGWP supplemental coverage for EGWP Enrollees through other health insurance separately issued by a carrier with which MCLIC or its Affiliate has contracted (the "EGWP Supplemental Policy"), then MCLIC will perform the following additional coordination of benefits: Coordination of benefits for Medicare Part D applicable drugs throughout the EGWP Benefit and the EGWP Supplemental Policy; single transaction for members at POS utilizing Medicare Part D eligibility and a single ID card; utilize EGWP Enrollee eligibility established under Medicare Part D plan; comprehensive EGWP Enrollee communications package for the EGWP Supplemental Policy; all CMS required reporting; claims reporting detailing primary and secondary payments; and financial reporting detailing application of Coverage Gap Discount Program.

(ii) The premium collected by MCLIC or its Affiliate for the EGWP Supplemental Policy, which is an amount set forth as a separate line item on Client's invoice, is included in the PMPM Fees paid to MCLIC pursuant to this Agreement. PMPM Fees collected by MCLIC pursuant to this Agreement will first be applied to all non-EGWP Supplemental Policy PMPM Fees owed to MCLIC before applying any remaining amounts to the EGWP Supplemental Policy premium amounts owned. As a result, default in payment of PMPM Fees by Client, in whole or in part, may result in a default under the EGWP Supplemental Policy for failure to pay premium amounts thereunder. In addition to the principal ESI revenue sources disclosed in Exhibit B (Financial Disclosure), in connection with the EGWP Supplemental Policy issued to Client in connection with this Agreement, MCLIC or its Affiliate is paid an original commission in an amount equal to one percent (1%) of the gross premium collected by MCLIC or its Affiliate for the EGWP Supplemental Policy.

(iii) If MCLIC and/or the carrier with which MCLIC or its Affiliate has contracted to provide the EGWP Supplemental Policy at any time does not receive authority to issue such EGWP Supplemental Policy, or has such authority revoked, then this Agreement is subject to immediate termination by MCLIC upon written notice to Client.

(b) Utilization Management. Consistent with the terms of the EGWP Benefit, MCLIC will establish a reasonable and appropriate drug management program that includes incentives to reduce costs when medically

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appropriate; maintains policies and systems to assist in preventing over-utilization and under-utilization of prescribed medications, according to guidelines specified by CMS and in accordance with the Medicare Drug Rules.

(c) Quality Assurance. Consistent with the terms of the EGWP Benefit, MCLIC will establish quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use in accordance with the Medicare Drug Rules.

(d) TrOOP. Consistent with the terms of the EGWP Benefit, MCLIC will establish and maintain a system to record EGWP Enrollees' TrOOP balances, and shall communicate TrOOP balances to EGWP Enrollees upon request.

(e) Coverage Determinations and Appeals. The parties acknowledge and agree that MCLIC is required under the Medicare Drug Rules to maintain oversight of coverage determinations under the EGWP Benefit, including prior authorizations and EGWP Enrollee Submitted Claims determinations, and to maintain an appeals process for EGWP Enrollees. Client acknowledges and agrees that ESI may perform such services through the UM Company. MCLIC or the UM Company, as applicable, will be responsible for conducting the appeal in a manner consistent with the requirements of the Medicare Drug Rules and shall ensure that the contract with the UM Company complies with the applicable delegation requirements of the Medicare Drug Rules, including without limitation 42 C.F.R. §423.505. ESI represents to Client that UM Company has contractually agreed that: (A) UM Company will conduct appeals in accordance with the the Medicare Drug Rules and the EGWP Benefit, (B) Client is a third party beneficiary of UM Company's agreement with MCLIC or its Affiliate (a copy of which is available upon request) and the remedies set forth therein, and (C) UM Company will indemnify Client for third party claims caused by the UM Company's negligence or willful misconduct in providing the appeal services.

(g) EOBs. MCLIC will furnish EGWP Enrollees, in a manner specified by CMS, a written explanation of benefits ("EOB") when prescription drug benefits are provided under qualified prescription drug coverage consistent with the requirements of the Medicare Drug Rules.

(h) EGWP Enrollee Services. MCLIC will provide 24-hours a day, 7-days a week toll-free telephone, IVR and Internet support to assist Client and EGWP Enrollees with EGWP Enrollee eligibility, benefits and TrOOP verification, location of Participating Pharmacies and other related EGWP Enrollee concerns.

3.11 Formulary and Medication Management.

(a) P&T Committee and Medicare Formulary. MCLIC or its Affiliate will maintain a pharmacy and therapeutics committee ("P&T Committee") in accordance with the Medicare Drug Rules, which will develop a Medicare Formulary for the EGWP Benefit consistent with the requirements of the Medicare Drug Rules. In accordance with the Medicare Drug Rules, all Covered Drugs on the Medicare Formulary shall be Part D drugs (within the meaning of the Medicare Drug Rules) or otherwise permitted to be covered by a PDP under the Medicare Drug Rules. Client acknowledges and agrees that the Medicare Formulary may not be modified by removing Covered Drugs, adding additional utilization management restrictions, making the cost-sharing status of a drug less beneficial or otherwise modified in a manner not consistent with the Medicare Drug Rules.

(b) Medication Therapy Management. Consistent with the terms of the EGWP Benefit, MCLIC or its Affiliate may implement a Medication Therapy Management program that is designed to ensure that Covered Drugs prescribed to targeted EGWP Enrollees are appropriately used to optimize therapeutic outcomes through improved medication use and reduce the risk of adverse events, including adverse drug interactions, in accordance with the Medicare Drug Rules.

3.12 Medicare Rebate Program.

(a) MCLIC or its Affiliate will negotiate with pharmaceutical manufacturers regarding the terms of the Medicare Rebate Program and will enter into agreements with such manufacturers for Rebates for certain Covered Drugs and Manufacturer Administrative Fees. MCLIC and its Affiliate retain all right, title and interest to any and all actual Rebates and Manufacturer Administrative Fees received from manufacturers. Client acknowledges and agrees that it shall not have a right to any Rebate and Manufacturer Administrative Fee payments received by MCLIC or its Affiliates.

(b) Client shall not negotiate or arrange with, or enter into an agreement with, a pharmaceutical manufacturer for rebates or similar discounts for any Covered Drugs dispensed to EGWP Enrollees for the term covered by this Agreement. A breach of the prior sentence shall be deemed to be a material breach of this Agreement.

(c) To the extent required under the Medicare Drug Rules, MCLIC shall disclose to Client the amount of all Rebates and Manufacturer Administrative Fees received from manufacturers or otherwise retained by MCLIC or its Affiliate with respect to the Rebate eligible EGWP Benefit utilization.

3.13 Mail Service Pharmacy. EGWP Enrollees may have prescriptions filled through the Mail Service Pharmacy. Subject to applicable law, MCLIC may communicate with EGWP Enrollees regarding benefit design, cost savings, availability and use of the Mail Service Pharmacy, as well as provide supporting services. MCLIC may suspend Mail Service Pharmacy services to an EGWP Enrollee who is in default of any Copayment amount due MCLIC. Client will be responsible for any unpaid EGWP Enrollee Copayment amounts if payment has not been received from the EGWP Enrollee within one hundred twenty (120) days following dispensing. Client will be billed following the one hundred twenty (120) day collection period, with payment due in accordance with the payment terms set forth in Article V of this Agreement.

Comment [DCH1]: Pending ESI internal discussions

3.14 Specialty Products

(a) Specialty Products and ASES. EGWP Enrollees may have prescriptions filled through ESI Specialty Pharmacy and Participating Pharmacies. Subject to applicable law, MCLIC and its affiliates may communicate with EGWP Enrollees and physicians to advise EGWP Enrollees filling Specialty Products at Participating Pharmacies of the availability of filling prescriptions through ESI Specialty Pharmacy.

(i) For Specialty Products filled through ESI Specialty Pharmacy only, EGWP Enrollees may receive the following services from ESI Specialty Pharmacy, depending on the particular therapy class or disease state: ASES; patient intake services; pharmacy dispensing services and/or social services (patient advocacy, hardship reimbursement support, and indigent and patient assistance programs).

(ii) Subject to Client's prior authorization requirements, if applicable, MCLIC or its affiliates will provide or coordinate ASES for EGWP Enrollees through ESI Specialty Pharmacy or through other specialty pharmacies or other independent third party providers of ASES when ASES is required. If MCLIC or its affiliates engages a third party provider of ASES, MCLIC or its affiliates shall contractually obligate such third party provider of ASES to comply with all applicable laws, including, without limitation, all applicable laws relating to professional licensure. Neither MCLIC nor its affiliates direct or exercise any control over any third party provider of ASES in administering Specialty Products or otherwise providing ASES.

(b) MCLIC shall notify Client no more frequently than monthly of new Specialty Products that are introduced to the market and added to the Specialty Product List on or after the Effective Date of this Agreement ("Notice").

3.15 Late Enrollment Penalty. Client agrees to and attests that it shall comply with the applicable CMS requirements of the LEP and shall comply with MCLIC's LEP policy, including participating with MCLIC in the following process:

(a) Client has an option to: (i) provide an initial global attestation to MCLIC to attest to a creditable coverage for all of its EGWP Enrollees; or (ii) periodically provide an attestation to MCLIC to attest to a creditable coverage for its EGWP Enrollees listed on the LEP report periodically provided to Client by MCLIC.

(b) If Client elects to periodically attest to MCLIC under Section 3.15(a)(ii) above, then:

(i) Client's response shall be delivered to MCLIC within five (5) business days from the receipt of LEP report from MCLIC;

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(ii) Client shall provide MCLIC with the file listing all EGWP Enrollees for whom Client was unable to attest; and

(iii) MCLIC shall also mail an attestation to each EGWP Enrollee that has gap in coverage as defined by CMS.

(c) Client has provided MCLIC with the attestation form and a file listing of all the EGWP Enrollees included in the attestation.

(d) MCLIC will collect responses to the attestations from Client or EGWP Enrollees and submits EGWP Enrollees information to CMS for processing and determination of applicable LEP.

(e) CMS calculates the LEP amount and transmits the LEP amount to MCLIC on the daily TRR file, which is communicated to Client. MCLIC shall invoice Client for payment of the LEP, which shall be due and owing by the Client to MCLIC. Per the Medicare Drug Rules, Client may elect to either pay for the LEP on behalf of the EGWP Enrollee, or seek reimbursement of the LEP amount from the EGWP Enrollee. This election must be made prior to the beginning of the plan year and must be applied consistently by Client for all EGWP Enrollees throughout the plan year.

**ARTICLE IV – PROGRAM OPERATIONS**

4.1 Program Reporting. MCLIC or its Affiliate shall make available to Client MCLIC's or its Affiliate's standard management information reporting applications. At the request of Client, MCLIC or its Affiliate may develop special reporting packages at MCLIC's or its Affiliate's standard hourly rate for such services.

4.2 Regulatory Reporting. MCLIC shall comply with the reporting requirements set forth in 42 C.F.R. §423.514, including reporting significant business transactions with parties in interest to CMS, notifying CMS of any loans or other financial arrangements that it makes with contractors, subcontractors, and related entities, and making such information available to EGWP Enrollees upon reasonable request.

4.3 Claims Data Retention. MCLIC and Client will maintain, for a period of the then current plan year plus an additional ten (10) years, the applicable books, contracts, medical records, patient care documentation, and other records relating to covered services under this Amendment. MCLIC may use and disclose both during and after the term of this Agreement the anonymized claims data (de-identified in accordance with HIPAA) including drug and related medical data collected by MCLIC or provided to MCLIC by Client for research; provider profiling; benchmarking, drug trend, and cost and other internal analyses and comparisons; clinical, safety and/or trend programs; ASES; or other MCLIC business purposes, in all cases subject to applicable law.

4.4 Government Audits. MCLIC and Client agree to allow the United States Department of Health and Human Services ("DHHS") and the Comptroller General or their designees, the right to audit, evaluate, inspect books, contracts, medical records, patient care documentation and other records relating to covered services under this Agreement, as are reasonably necessary to verify the nature and extent of the costs of the services provided to EGWP Enrollees under this Agreement, for a period of the then current plan year, plus an additional ten (10) years following termination or expiration of the Amendment for any reason, or until completion of any audit, whichever is later.

Comment [DCH2]: Pending ESI internal discussions

4.5 Liability Insurance. Each party shall maintain such policies of general liability, professional liability and other insurance of the types and in amounts customarily carried by their respective businesses. Proof of such insurance shall be available upon request. MCLIC agrees, at its sole expense, to maintain during the term of this Agreement or any renewal hereof, commercial general liability insurance, pharmacists professional liability insurance for the MCLIC Mail Service and ESI Specialty Pharmacies, and managed care liability with limits, excess of a self insured retention, in amounts of not less than \$5,000,000 per occurrence, and in the aggregate. MCLIC or its Affiliate does not maintain liability insurance on behalf of any Participating Pharmacy, but does contractually require such pharmacies to maintain a minimum amount of commercial liability insurance or, when deemed acceptable by MCLIC or its Affiliate, to have in place a self-insurance program.

**ARTICLE V – MONTHLY PREMIUMS; FEES; BILLING AND PAYMENT**

5.1 Monthly Premiums.

(a) Determination of Monthly Premium Amounts. Prior to the Effective Date and each EGWP Benefit enrollment period thereafter, MCLIC shall determine the amount of the monthly premium to be charged for each EGWP Enrollee for participation in the EGWP Benefit, which shall be determined based on the CMS Medicare Drug Rules and guidance for standard prescription drug coverage along with enhancements under the EGWP Benefit as compared to the standard prescription drug coverage as permitted.

(b) Collection of Monthly Premium Amounts. In accordance with the Medicare Drug Rules, MCLIC hereby delegates the premium collection function to Client and hereby directs Client, on behalf of MCLIC, to collect all monthly premium payments due from EGWP Enrollees for participation in the EGWP Benefit. In connection with MCLIC's delegation of the premium collection function to Client under this Section 5.1(b), Client hereby agrees as follows:

(i) That in no event, including, but not limited to, MCLIC's insolvency, or MCLIC's breach of this Agreement, will Client bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an EGWP Enrollee or persons acting on his or her behalf for payments that are the financial responsibility of MCLIC under this Agreement. The foregoing is not intended to prohibit Client from collecting premium amounts due by EGWP Enrollees for participation in the EGWP Benefit;

(ii) That DHHS, the Comptroller General, or their designees shall have the right to inspect, evaluate, and audit pertinent contracts, books, documents, papers and records of the Client involving Client's collection of premium amounts from EGWP Enrollees, and that DHHS', the Comptroller General's, or their designees' right to inspect, evaluate, and audit any such pertinent information will exist through ten (10) years from the date of termination or expiration of this Agreement, or from the date of completion of any audit, whichever is later;

(iii) That if MCLIC or CMS determines that Client is not performing the premium collection function in compliance with all applicable Medicare Drug Rules and Client is unable to cure such noncompliance within thirty (30) days following notice from MCLIC or CMS, then MCLIC may, at its sole discretion, either: (i) upon prior written notice to Client, revoke all or a portion of such delegated function as MCLIC deems necessary to effectuate MCLIC's ultimate responsibility to CMS for the performance of such delegated function under MCLIC's contract with CMS; or (ii) negotiate an alternative remedy in lieu of revocation of delegation, so long as such remedy conforms to the requirements of the Medicare Drug Rules. Nothing in this Section 5.1(b)(3), including, but not limited to, the thirty (30) day cure period, shall be construed in any way to limit MCLIC's right to suspend performance under Section 8.2 for non-payment; and

(iv) That Client shall not further delegate or subcontract the performance of the premium collection function to a third party without MCLIC's prior written consent, which consent will not be unreasonably withheld. If Client does further delegate or subcontract the performance of the premium collection function to a third party, then Client agrees that it shall: (i) amend its written agreement with such subcontractor or enter into a separate written agreement with such subcontractor that contains the terms, conditions, and provisions set forth in Schedule 5.1(a)(iv) attached hereto and incorporated herein by reference; and (ii) ensure that such subcontractor's performance of the premium collection function complies with the provisions set forth on Schedule 5.1(a)(iv).

(c) Determination of Monthly Premium Amounts (if any) to be Subsidized by Client. In determining the amount of the EGWP Enrollee's monthly premium for participation in the EGWP Benefit that Client will subsidize, Client shall make such determination subject to the following restrictions and any other restrictions that may be imposed by CMS:

(i) Client may subsidize different amounts for different classes of EGWP Enrollees provided such classes are reasonable and based on objective business criteria, such as years of service, business location, job category, and nature of compensation (e.g., salaried vs. hourly). Different classes cannot be based on eligibility for the Low Income Subsidy. Notwithstanding the foregoing, the parties agree that

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Retiree Health Insurance Credit benefits received by Part D Eligible Retirees does not violate or implicate this section;

(ii) Client may not vary the premium subsidy for individuals within a given class of EGWP Enrollees;

(iii) Client may not charge an EGWP Enrollee more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her supplemental prescription drug coverage, if any, and by signing this agreement, Client agrees to and attests that it shall abide by such provisions in accordance with the requirements set forth in 42 CFR 423.504 and 423.505;

(iv) Client shall directly refund to the EGWP Enrollee (or shall allow MCLIC to do so), within forty-five (45) days of original receipt from CMS of the Low Income Subsidy premium, the full premium subsidy amount up to the monthly beneficiary premium amount previously collected from the EGWP Enrollee; provided, however, that to the extent there are Low Income Subsidy premium amounts remaining after Client refunds the full monthly beneficiary premium amount to the EGWP Enrollee, then Client may apply that remaining portion of the Low Income Subsidy premium to the portion of the monthly premium paid by Client;

(v) If Client is not able to reduce the up-front monthly beneficiary premium as described in subsection (iv) above, Client shall directly refund to the EGWP Enrollee (or shall allow MCLIC to do so), within forty-five (45) days of original receipt from CMS of the Low Income Subsidy premium, the full premium subsidy amount up to the monthly beneficiary premium amount previously collected from the EGWP Enrollee;

(vi) If the Low Income Subsidy amount for which an EGWP Enrollee is eligible is less than the portion of the monthly beneficiary premium paid by the EGWP Enrollee, then Client must communicate to the EGWP Enrollee the financial consequences for the beneficiary of enrolling in the EGWP Benefit as compared to enrolling in another Medicare Part D plan with a monthly beneficiary premium equal to or below the Low Income Subsidy amount (MCLIC shall provide reasonable guidance to Client regarding the requirements of the performance necessary for Client to meet its obligation under this section); and

(vii) In the event of a change in an EGWP Enrollee's Low Income Subsidy status or an EGWP Enrollee otherwise becomes ineligible to receive the Low Income Subsidy after payment of the Low Income Subsidy premium amount to the EGWP Enrollee, and upon MCLIC's receipt of notification from CMS that such Low Income Subsidy premium amount will be recovered from MCLIC or withheld from future payments to MCLIC, then MCLIC in its sole discretion will invoice Client or set off from amounts otherwise owed from MCLIC to Client, and in either case Client shall reimburse MCLIC for, all amounts deemed by CMS to be ineligible Low Income Subsidy premium payments with respect to the EGWP Enrollee.

(d) Reporting and Auditing of Premium Amounts; Non-Payment by EGWP Enrollees. In the event of a CMS audit, Client shall provide a report to MCLIC, in a form and manner as agreed to by the parties, that includes all information concerning monthly premium amounts due by EGWP Enrollees for participation in the EGWP Benefit, including, without limitation, the monthly premium amount charged to each class of EGWP Enrollees, the amount that is being subsidized by the Client, and all premium amounts collected from EGWP Enrollees. Client represents and warrants that all information that it provides to MCLIC pursuant to this Section 5.1(d) shall be accurate and complete. Client further represents and warrants that it shall collect only those monthly premium amounts that are due from EGWP Enrollees, consistent with the information provided to MCLIC pursuant to this Section 5.1(d). Upon reasonable advance written notice, MCLIC or its Affiliate shall have access to Client's records in order to audit the monthly premium amounts collected from EGWP Enrollees for the purposes of fulfilling reporting requirements under the Medicare Drug Rules or applicable state insurance laws related to collection of such premium amounts or to otherwise assess compliance with the Medicare Drug Rules in connection with the collection of such premium amounts. Any audits performed by MCLIC or its Affiliate pursuant to this Section 5.1(d) will be at MCLIC's expense. Client acknowledges and agrees that neither MCLIC nor its Affiliate shall be responsible to Client for non-payment by any EGWP Enrollee of any monthly premium amount due by such EGWP Enrollee for participation in the EGWP Benefit. Client further acknowledges and agrees that in the event that either

**Comment [DCH3]:** While on a monthly basis this isn't applicable, in the event of a CMS audit we would need to obtain access to this information from the client.

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Client or MCLIC (through any audit) determines that Client has collected a greater premium amount from an EGWP Enrollee than is due, that Client shall promptly refund any such overpayment to the EGWP Enrollee.

5.2 Once a month, on or about the fifteenth (15<sup>th</sup>) of the month beginning on the Effective Date, Client shall be invoiced for an amount equal to the product of: (i) the then-current number of EGWP Enrollees; multiplied by (ii) a "per member per month" fee (i.e., member premium amount) determined by MCLIC on an annual basis, as may be adjusted by MCLIC pursuant to the terms of this Agreement. The monthly fee shall be referred to in this Agreement as the "PMPM Fees." During the Initial Term (as defined in Section 8.1 below) of this Agreement, the "per member per month" fee used to calculate the PMPM Fees shall be Eighty Two and 00/100 Dollars (\$82.00). Thereafter, MCLIC shall provide written notice to Client of any annual adjustment to the "per member per month" fee by the August 31st immediately prior to the commencement of any one (1) year renewal term hereunder. Any Administrative Service Fees incurred by Client during the previous month shall be invoiced to Client on or about the twentieth (20<sup>th</sup>) day of the month beginning on the Effective Date. "Administrative Service Fees" means the fees incurred by Client, if any, for MCLIC's or its Affiliate's performance of any agreed to administrative services.

5.3 CMS Reimbursement. MCLIC and its Affiliate retain all right, title and interest to any and all reimbursement received from CMS with respect to the EGWP Benefit and EGWP Enrollees, including the following: (1) advance direct subsidy monthly payments with respect to EGWP Enrollees, (2) reinsurance subsidy payments with respect to the EGWP Benefit, (3) low-income subsidy payments with respect to EGWP Enrollees, and (4) any other reimbursement payment by CMS to MCLIC for coverage provided to EGWP Enrollees under the EGWP Benefit for such period (each as further defined in the Medicare Drug Rules) (collectively, "CMS Reimbursement"). Client acknowledges and agrees that neither it nor its EGWP Enrollees shall have a right to any CMS Reimbursement payments received by MCLIC or its Affiliates during the collection period or moneys payable under this Section. Notwithstanding the foregoing, to the extent that MCLIC receives any low-income subsidy payments from CMS with respect to any EGWP Enrollee that qualifies for such payments, MCLIC will remit amounts equal to such payments to Client. In such case, Client shall apply such amounts received from MCLIC pursuant to Section 5.1(c)(iv) through (vi) above.

5.4 Payment. Client shall pay all Fees to MCLIC by wire or ACH transfer, debit or other electronic method within two (2) days from the date of Client's receipt of the MCLIC invoice.

5.5 Deposit. If, at any time: (i) Client has one (1) or more outstanding past due invoices; or (ii) MCLIC has reasonable grounds to believe that Client may become delinquent in payment of PMPM Fees to MCLIC based on Client's published financial data (examples include, but are not limited to, persistent negative cash flow, bankruptcy, and insolvency), then MCLIC may require that Client provide to MCLIC a deposit in an amount equal to one (1) month's billing, using the average of the last three (3) months of billing history as the basis for determining the one (1) month deposit amount or, if three (3) months billing history is not available, the most recent month of billing history as the basis. MCLIC shall retain the deposit until the earlier of: (i) termination of this Agreement (following any run-off period); or (ii) six (6) consecutive months of timely payments of all PMPM Fees following submission of the deposit, and may apply the deposit to delinquent PMPM Fees until return of the deposit.

5.6 Manufacturer Coverage Gap Discount. Pursuant to its CMS contract, MCLIC has agreed to administer for EGWP Enrollees at point-of-sale the Coverage Gap Discount authorized by section 1860D-14A of the Social Security Act. In connection with the Coverage Gap Discount, CMS will coordinate the collection of discount payments from manufacturers, and payment to MCLIC, through a CMS contractor (the "Coverage Gap Discount Payments"). MCLIC and its Affiliate retain all right, title and interest to any and all actual Coverage Gap Discount Payments received from CMS. Client acknowledges and agrees that neither it nor its EGWP Enrollees shall have a right to interest on, or the time value of, any Coverage Gap Discount Payments received by MCLIC or its Affiliates under this Section.

## ARTICLE VI - CONFIDENTIALITY

6.1 Access to Records and Confidential Information. Each party agrees that participation by EGWP Enrollees in programs administered by Client is confidential under North Dakota law. Each party agrees that confidential information of the other party, must be exchanged as necessary for MCLIC to provide the services described within this Agreement. MCLIC shall not use or disclose any information it receives from Client under this Agreement that Client has previously identified as confidential or exempt from mandatory public disclosure except as necessary to carry out the purposes of this Agreement or as authorized in advance by Client. Client shall not disclose any

information it receives from MCLIC that MCLIC has previously identified as confidential and that Client determines in its sole discretion is protected from mandatory public disclosure under a specific exception to the North Dakota public records law, N.D.C.C. ch. 44-04. The parties acknowledge that the following information may constitute confidential or exempt information of the other party under N.D.C.C. § 44-04-18.4, 44-04-18.5, 54-52.1-11, and 54-52.1-12, subject to final determination by Client: (a) with respect to MCLIC and its Affiliate: reporting and system applications, (web-based and other media), and system formats, databanks, clinical and formulary management operations and programs, fraud, waste and abuse tools and programs, manuals, and anonymized claims data (de-identified in accordance with HIPAA), ESI Specialty Pharmacy and Mail Service Pharmacy data, information concerning Rebates, prescription drug evaluation criteria, drug choice management, drug pricing information, and Participating Pharmacy agreements; and (b) with respect to Client: Participating Pharmacy Client and EGWP Enrollee identifiable health information and data, and Client information files. Neither party shall use the other's confidential or exempt information or disclose it to any third party, at any time during or after termination of this Agreement, except as specifically contemplated by this Agreement, upon prior written consent or as required by the Medicare Drug Rules or other applicable law. Upon termination of this Agreement, each party shall cease using the other's confidential or exempt information, and all such information shall be returned or destroyed upon the owner's direction, unless retention is otherwise required under applicable law. The duty of both parties to maintain the confidentiality of information under this section continues beyond the term of this Agreement. This section applies to confidential information that may be in the possession of subcontractors or agents of MCLIC.

6.2 Non-Access to MCLIC's or its Affiliate's Systems. Client will not, and will not permit any third party acting on Client's behalf to, access, attempt to access, test or audit MCLIC's or its Affiliate's systems or any other system or network connected to MCLIC's or its Affiliate's systems. Without limiting the foregoing, Client will not: (i) access or attempt to access any portion or feature of MCLIC's or its Affiliate's systems, by circumventing such systems' access control measures, either by hacking, password "mining" or any other means; or (ii) probe, scan, audit or test the vulnerability of such systems, nor breach the security or authentication measures of such systems.

## ARTICLE VII - COMPLIANCE WITH LAW AND FINANCIAL DISCLOSURE

7.1 Compliance with Law; Change in Law. MCLIC and Client hereby agree to perform their respective obligations under this Agreement in a manner that is consistent with and complies with the Medicare Drug Rules and with MCLIC's contractual obligations under its contract with CMS. In addition, each party shall be responsible for ensuring its compliance with all federal, state, and local laws and regulations applicable to its business, including maintaining any necessary licenses and permits. If the scope of MCLIC's duties under this Agreement is made materially more burdensome or expensive due to a change in federal, state or local laws or regulations or the interpretation thereof, including actions by CMS, the parties shall negotiate an appropriate modification of the services and/or an adjustment to the PMPM Fees paid to MCLIC. If the parties cannot agree on a modification or adjusted PMPM Fees, then either party may terminate this Agreement upon no less than thirty (30) days prior written notice to the other party. Further, Client by written notice to MCLIC, may terminate this Agreement at any time under the following conditions: 1) If funding from federal, state, or other sources is not obtained and continued at levels sufficient to allow for purchase of the services of supplies in the indicated quantities or term; 2) if federal or state laws or rules are modified or interpreted in a way that the services are no longer eligible or appropriate for purchase under this Agreement or are no longer eligible for the funding proposed for payments authorized by this Agreement; and 3) if any license, permit, or certificate required by law or rule, or by the terms of this Agreement, is for any reason denied, revoked, suspended, or not renewed and, as a result, would have a material impact on MCLIC's ability to perform services under this Agreement. Termination of this Agreement under this section is without prejudice to any obligations or liabilities of either party already accrued prior to termination.

7.2 Disclosure of Certain Financial Matters. Client acknowledges and agrees that MCLIC will contract with its Affiliate, ESI, to provide the pharmacy benefit management services contemplated by this Agreement on MCLIC's behalf. In addition to the administrative fees paid to MCLIC by Client, MCLIC and ESI's wholly-owned subsidiaries or Affiliates derive revenue in one or more of the ways as further described in the ESI Financial Disclosure to PBM Clients set forth in Exhibit D hereto ("Financial Disclosure"), as updated by ESI from time to time. Unlike the administrative fees, the revenues described in the Financial Disclosure are not direct or indirect compensation to MCLIC from Client for services rendered to Client or the Client Group Health Plan under this Agreement. In negotiating any of the fees and revenues described in the Financial Disclosure, ESI and ESI's wholly-owned subsidiaries and Affiliates act on their own behalf, and not for the benefit of or as agents for Client, EGWP Enrollees or the EGWP Benefit. Except for the Rebate amounts set forth in Exhibit B, if any, Client acknowledges and agrees that MCLIC and MCLIC's wholly-owned subsidiaries and Affiliates retain all interest, revenues, any or

all Rebates and Manufacturer Administrative Fees not payable to Client, and all Participating Pharmacy discounts, if any, in addition to any administrative and other fees paid by Client. Client acknowledges for itself and its EGWP Enrollees that, except as may be expressly provided herein, neither it nor any EGWP Enrollee has a right to receive, or possesses any beneficial interest in, any such discounts or payments.

#### ARTICLE VIII - TERM AND TERMINATION; DEFAULT AND REMEDIES

8.1 Term. The initial term of this Agreement (the "Initial Term") shall commence on the Execution Date, and coverage of EGWP Enrollees under the EGWP Benefit shall begin as of January 1, 2016 (the "Effective Date"). Unless earlier terminated as provided herein, the Initial Term shall continue until December 31, 2016. Thereafter, Client may renew this Agreement upon satisfactory completion of the Initial Term for successive one (1) year renewal terms with the same terms and conditions as set forth herein. MCLIC may decline to renew the Agreement for successive one (1) year terms by providing Client notice of its intent not to renew the Agreement in writing at least ninety (90) days prior to the expiration of the then current term.

MCLIC shall provide written notice to Client of any annual adjustment to the "per member per month" fee by the August fifteenth (15th) prior to the commencement of any one (1) year renewal term hereunder. Client shall provide notice of intent to renew this Agreement to MCLIC at least sixty (60) days prior to the expiration of the then current term, so long as Client does not have an annual open enrollment. Should Client change to an annual open enrollment, Client shall provide notice of intent to renew this Agreement to MCLIC at least ninety (90) days prior to the expiration of the then current term. Both parties acknowledge that nothing in this Agreement prevents Client from engaging in a competitive selection process and to accept a bid from another vendor through a competitive selection process for a subsequent contract term for the services provided hereunder. This Agreement may be terminated earlier during the Initial Term or any renewal terms pursuant to Section 8.2 below.

#### 8.2 Termination.

(a) Breach or Default. Either party may give the other written notice of a material, substantial and continuing breach of this Agreement. If the breaching party has not cured said breach within thirty (30) days from the date such notice was sent, this Agreement may be terminated at the option of the non-breaching party. If the amount of time commercially reasonable for the breach to be cured is longer than thirty (30) days, this Agreement may not be terminated by the non-breaching party pursuant to this provision until such commercially reasonable period of time has elapsed; provided, however, that in no event shall such period exceed sixty (60) days.

(b) Termination of MCLIC's Contract with CMS. If at any time throughout the term of this Agreement, CMS either does not renew its contract with MCLIC or terminates its contract with MCLIC such that MCLIC may no longer provide services as a PDP Sponsor under the Medicare Drug Rules, then this Agreement shall be automatically terminated conterminously with such CMS contract termination. MCLIC will provide Client one hundred and twenty (120) days' notice before MCLIC non-renews the CMS contract and thereby terminates this Agreement. MCLIC will provide Client as much notice as reasonably practical in the event of CMS's termination or non-renewal of the CMS contract. The notice will include the termination date for this Agreement.

(c) Non-Payment. To the extent permitted by the Medicare Drug Rules and other applicable laws, MCLIC and its Affiliate may terminate or suspend their performance hereunder and cease providing or authorizing provision of Covered Drugs to EGWP Enrollees upon forty-eight (48) hours written notice if Client fails to pay MCLIC or provide a deposit, if required, in accordance with the terms of this Agreement. MCLIC also may offset amounts overdue to MCLIC with amounts owed, if any, by MCLIC to Client. To the extent permitted by law, MCLIC may suspend Mail Service Pharmacy and/or ESI Specialty Pharmacy services to any EGWP Enrollee who is in default of payment of any Copayments or deductibles to the applicable Pharmacy.

(d) Insolvency; Regulatory Action. To the extent permitted by applicable law, MCLIC may terminate this Agreement, or suspend performance hereunder, upon the insolvency of Client, and Client may terminate this Agreement upon the insolvency of MCLIC. The "insolvency" of a party shall mean the filing of a petition commencing a voluntary or involuntary case (if such case is an involuntary case, then only if such case is not dismissed within sixty (60) days from the filing thereof) against such party under the United States Bankruptcy Code or applicable state law; a general assignment by such party for the benefit of creditors; the inability of such party to pay its debts as they become due; such party's seeking or consenting to, or acquiescence in, the

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appointment of any trustee, receiver or liquidation of it, or any material part of its property; or a proceeding under any state or federal agency declaration or imposition of receivership, composition, readjustment, liquidation, insolvency, dissolution, or like law or statute, which case or proceeding is not dismissed or vacated within sixty (60) days. Notwithstanding the preceding, in the event of Client's insolvency or other cessation of operations, MCLIC agrees to require Participating Pharmacies to continue to provide prescription drug services to EGWP Enrollees if required by the Medicare Drug Rules and all other applicable federal and state laws relating to insolvency or other cessation of operations or termination. Nothing herein shall be interpreted to require MCLIC or Pharmacies to provide services without being paid for Covered Drugs or Prescription Drug Services.

8.3 Remedies.

(a) Remedies Not Exclusive. A party's right to terminate this Agreement under Article VIII shall not be exclusive of any other remedies available to the terminating party under this Agreement or otherwise, at law or in equity.

(b) Force Majeure. Neither party shall be held responsible for delay or default caused by fire, riot, terrorism, extreme weather conditions, government acts or regulations, acts of God or war if the event is beyond the party's reasonable control and the affected party gives notice to the other party immediately upon occurrence of the event causing the delay or default or that is reasonably expected to cause a delay or default.

(c) Limitation of Liability. Client and MCLIC each agrees to assume its own liability for any and all claims of any nature including all, costs, expenses and attorneys' fees which may in any manner result from or arise out of this agreement.

8.4 Obligations Upon Termination. Client or its agent shall pay MCLIC in accordance with this Agreement for all PMPM Fees due hereunder on or before the later of: (i) the effective date of termination, or (ii) the final date that all EGWP Enrollees have been transitioned to a new Part D plan, as applicable (the "Termination Date"). The parties shall cooperate regarding the transition of Client and its EGWP Enrollees to a successor PDP Sponsor in accordance with all applicable Medicare Drug Rules and MCLIC will take all reasonable steps to mitigate any disruption in service to EGWP Enrollees. Specifically MCLIC agrees to provide to a successor PDP Sponsor information that includes a one year Claims History File. Notwithstanding the preceding, MCLIC may (a) delay payment of any amounts due Client, if any, to allow for any final adjustments to EGWP Enrollee enrollment information, or (b) request that Client pay a reasonable deposit in the event MCLIC is requested to process after the Termination Date claims incurred on or prior to such date.

Comment [DCH4]: Pending ESI internal discussions

8.5 Survival. The parties' rights and obligations under Section 3.8(b) and 3.10(e); Articles V and VI; and Sections 7.1, 8.3, 8.4, and 8.5 shall survive the termination of this Agreement for any reason.

**ARTICLE IX - MISCELLANEOUS**

9.1 Notice. Any notice or document required or permitted to be delivered pursuant to this Agreement must be in writing and shall be deemed to be effective upon mailing and must be either (a) deposited in the United States Mail, postage prepaid, certified or registered mail, return receipt requested, or (b) sent by recognized overnight delivery service, in either case properly addressed to the other party at the address set forth below, or at such other address as such party shall specify from time to time by written notice delivered in accordance herewith:

Medco Containment Life Insurance Company  
Attn: President  
One Express Way  
St. Louis, Missouri 63121  
with copy to: General Counsel  
Fax: 800-417-8163

North Dakota Public Employees Retirement System  
Attn: Sparb Collins  
400 East Broadway, Suite 505  
Bismarck, North Dakota 58502

9.2 Independent Parties. No provision of this Agreement is intended to create or shall be construed to create any relationship between MCLIC or its Affiliate and Client other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither party, nor any of their respective representatives, shall be construed to be the partner, agent, fiduciary, employee, or representative of the other and neither party shall have the right to make any representations concerning the duties, obligations or services of the other except as consistent with the express terms of this Agreement or as otherwise authorized in writing by the party about which such representation is asserted.

9.3 Assignment and Subcontracting. Client acknowledges and agrees that MCLIC may perform certain services hereunder (e.g., mail service pharmacy and specialty pharmacy services) through one or more MCLIC subsidiaries or Affiliates. MCLIC is responsible and liable for the performance of its subsidiaries and Affiliates in the course of their performance of any such service. To the extent that MCLIC subcontracts any PBM Service under this Agreement to a third party, MCLIC is responsible and liable for the performance of any such third party. In addition, MCLIC may contract with third parties to provide information technology support services and other ancillary services, which services are not PBM Services hereunder, but rather are services that support MCLIC's conduct of its business operations. This Agreement will be binding upon, and inure to the benefit of and be enforceable by, the respective successors and permitted assigns of the parties hereto.

9.4 Integration. This Agreement and all Exhibits hereto constitute the entire understanding of the parties hereto and supersede any prior oral or written communication between the parties with respect to MCLIC's plan offering to EGWP Enrollees as a PDP Sponsor of the EGWP Benefit under the Medicare Drug Rules. The parties hereby expressly agree that this Agreement and the Commercial Agreement are separate and independent agreements that stand on their own and that, unless otherwise specifically set forth in this Agreement, no term or condition in one such agreement shall have any connection to or bear any force or effect on the other agreement.

9.5 Amendments. No modification, alteration, or waiver of any term, covenant, or condition of this Agreement shall be valid unless in writing and signed by both parties or the agents of the parties who are authorized in writing.

9.6 Choice of Law. Unless governed by the Medicare Drug Rules or applicable state insurance laws, this Agreement shall be construed and governed in all respects according to the laws in the State of North Dakota, without regard to the rules of conflict of laws thereof.

9.7 Waiver. The failure of either party to insist upon the strict observation or performance of this Agreement or to exercise any right or remedy shall not be construed as a waiver of any subsequent breach of this Agreement or impair or waive any available right or remedy.

9.8 Taxes and Assessments. Any applicable sales, use, excise, or other similarly assessed and administered tax, surcharge, or fee imposed on items dispensed, or services provided hereunder or the EGWP Supplemental Policy, or the fees or revenues generated by the items dispensed or services provided hereunder or the EGWP Supplemental Policy, or any other amounts MCLIC or one or more of its subsidiaries or affiliates may incur or be required to pay arising from or relating to MCLIC's or its subsidiaries' or affiliates' performance of services as a pharmacy benefit manager, third-party administrator, or otherwise in any jurisdiction, will be the sole responsibility of Client or the EGWP Enrollee. If MCLIC is legally obligated to collect and remit, or to incur or pay, any such sales, use, excise, or other similarly assessed and administered tax, surcharge, or fee in a particular jurisdiction, such amount will be reflected on the applicable invoice or subsequently invoiced at such time as MCLIC becomes aware of such obligation or as such obligation becomes due. MCLIC reserves the right to charge a reasonable administrative fee for collection and remittance services provided on behalf of Client.

9.9 Severability. In the event that any provision of this Agreement is invalid or unenforceable, such invalid or unenforceable provision shall not invalidate or affect the other provisions of this Agreement which shall remain in effect and be construed as if such provision were not a part hereof; provided that if the invalidation or unenforceability of such provision shall, in the opinion of either party to the Agreement, have a material effect on such party's rights or obligations under this Agreement, then the Agreement may be terminated by such party upon thirty (30) days written notice by such party to the other party.

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9.10 Third Party Beneficiary Exclusion. This Agreement is not a third party beneficiary contract, nor shall this Agreement create any rights on behalf of EGWP Enrollees as against MCLIC. Client and MCLIC reserve the right to amend, cancel or terminate this Agreement without notice to, or consent of, any EGWP Enrollee.

9.11 Trademarks. Each party acknowledges each other party's sole and exclusive ownership of its respective trade names, commercial symbols, trademarks, and service marks, whether presently existing or later established (collectively "Marks"). No party shall use the other party's Marks in advertising or promotional materials or otherwise without the owner's prior written consent.

9.12 Debarment. MCLIC or its Affiliate shall not knowingly employ, or subcontract with, an individual or an entity that employs or contracts with an individual, who is excluded from participation in Medicare under section 1128 or 1128A of the Act or from participation in a Federal health care program for the provision of health care, utilization review, medical social work, or administrative services.

9.13 Signatures. Any documents required to implement the terms of this Agreement shall be signed by a representative of each party with legal authority to bind the entity.

9.14 Federal Funds. The parties acknowledge that information provided in connection with this Agreement is used for purposes of obtaining federal funds and, as such, the parties are subject to certain laws that are applicable to individuals and entities receiving federal funds.

9.15 Nondiscrimination and Compliance with Laws. MCLIC agrees to comply with all laws, rules, and policies, including those relating to nondiscrimination, accessibility and civil rights. MCLIC agrees to timely file all required reports, make required payroll deductions, and timely pay all taxes and premiums owed, including sales and use taxes and unemployment compensation and workers' compensation premiums. MCLIC shall have and keep current at all times during the term of this Contract all licenses and permits required by law.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the day and year below set forth.

MEDCO CONTAINMENT LIFE INSURANCE COMPANY

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

By: \_\_\_\_\_

By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Federal ID Number: \_\_\_\_\_

**EXHIBIT A**

**EGWP BENEFIT DESCRIPTION  
(Incorporated herein by reference)**

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**Plan Design Option: Current NDPERS Plan Design**

	Retail Pharmacy Network	Retail Maintenance Drug Program (MDP) Pharmacy	Express Scripts Home Delivery
<b>Day Supply</b>	Up to 31 day	Up to 90 day	Up to 90 day
<b>Member Co-Pay</b>	Generic: \$5 copay plus 15% coinsurance  Preferred Brand: \$15 copay plus 25% coinsurance  Non-Preferred Brand: \$25 copay plus 50% coinsurance  Specialty: \$15 copay plus 25% coinsurance	Generic: \$5 copay plus 15% coinsurance  Preferred Brand: \$15 copay plus 25% coinsurance  Non-Preferred Brand: \$25 copay plus 50% coinsurance  Specialty: \$15 copay plus 25% coinsurance	Generic: \$5 copay plus 15% coinsurance  Preferred Brand: \$15 copay plus 25% coinsurance  Non-Preferred Brand: \$25 copay plus 50% coinsurance  Specialty: \$15 copay plus 25% coinsurance
<b>Deductible</b>	No Deductible		
<b>Coverage Gap<sup>1</sup></b>	No Coverage Gap; Member Co-pays above apply.		
<b>Catastrophic Coverage</b>	Member cost share post TrOOP (\$4,850) is the greater of 5% or \$2.95 per generic or preferred multi-source drugs and the greater of 5% or \$7.40 per all other brands		
<b>Formulary</b>	Medicare Premier Access		
<b>Non Part D Drugs<sup>2</sup></b>	Mirror current coverage within CMS guidelines		
<b>Part B Drugs<sup>2</sup></b>	Not Covered		
<b>Generics Policy</b>	Voluntary		
<b>Utilization Management Program</b>	All Approved Standard Part D		
<b>Federal Poverty Limits</b>	Standard Federal Poverty Limit (FPL) guidelines apply		

Please note that most specialty medications can only dispensed up to a 31 day supply to Medicare members

	Effective Date	Expiration Date
	January 1st, 2016	December 31st, 2016
<b>EGWP Plan Premium (PMPM)</b>		\$69.26
<b>Enhanced Insurance Premium<sup>3</sup> (PMPM)</b>		\$12.74
<b>Total Premium<sup>4</sup> (PMPM)</b>		<b>\$82.00</b>

<sup>1</sup> Coverage Gap begins at the Initial Coverage Limit which is \$3,310 for CY 2016.

<sup>2</sup> Some states require coverage for certain Non Part D and Part B drugs. Express Scripts will comply with all state requirements on your behalf.

<sup>3</sup> This group Medicare Part D plan has additional benefits to enhance the Medicare Part D coverage, as required by the Centers for Medicare and Medicaid Services (CMS). Per CMS regulations, the benefit enhancements are considered other health benefits and require filing with and approval by the state department of insurance. Express Scripts Medicare will offer this product in conjunction with Companion/Niagara/Pan American.

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<sup>4</sup>The illustrated premium is subject to change in the event of CMS guidance and rate changes. Income Related Monthly Adjustment Amounts apply for high income beneficiaries. See page 2 for details.

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**Income Related Monthly Adjustment Amount (IRMAA)**

Effective January 1, 2011, individuals whose modified gross income (MAGI) exceeds certain thresholds will be required to pay an extra amount, referred to as an income related monthly adjustment amount, for their Medicare Part D coverage. In 2010, these amounts were \$85,000 for a beneficiary filing an individual income tax return or married and filing a separate return, and \$170,000 for a beneficiary filing a joint tax return. In accordance with the Affordable Care Act, these income threshold amounts will remain at the 2010 levels for calendar years 2011-2019. The Social Security Administration, not MCLIC, will determine which members are required to pay a Part D-IRMAA and will send the beneficiary a letter telling him or her what that extra amount will be and what information was used to make the determination. In general, the Part D-IRMAA will be paid through premium withholding from monthly Social Security benefit payments. For more information about Part D premiums based on income, visit [medicare.gov](http://medicare.gov) on the web or call 1-800-MEDICARE (1-800-633-4227). The Social Security Administration may also be contacted at 1-800-772-1213.

**Included Additional Services**

Claims Processing	
Electronic Claims Processing	No Additional Fee
Member Submitted Paper Claims Processing	No Additional Fee
Medicaid Subrogation Claims	No Additional Fee
Electronic Prescribing	No Additional Fee
Eligibility Administration	
Eligibility submission	No Additional Fee
Electronic/on-line submission (changes only)	No Additional Fee
Manual/hardcopy submission	No Additional Fee
Participating Pharmacies	
Pharmacy Audit	No Additional Fee
Pharmacy Help Desk	No Additional Fee
Pharmacy Network Management	No Additional Fee
Pharmacy Reimbursement	No Additional Fee
Network Development Upon Request	No Additional Fee
Mail Services	
My Rx Choices Medicare	No Additional Fee
Benefit Education (Includes Mail Promotion Program)	No Additional Fee
Prescription Delivery – standard	No Additional Fee
Standard PBM Reporting Services	
Ad-Hoc Desktop Parametric Reports	No Additional Fee
Billing Reports	No Additional Fee
Custom Ad-Hoc Reporting (up to 10 hours of programming time)	Included; additional programming may be billed at \$150 per hour
Load 12 Months Claims History for Clinical Programs and Reporting	No Additional Fee
Medicare Reporting Services	
Preparation of All Data Necessary to meet Medicare Part D Reporting Requirements	No Additional Fee
Provide Data to CMS in Required Format	No Additional Fee
TrOOP Facilitation	
CMS Designated Third Party Manages TrOOP ensuring Secondary Payments	No Additional Fee
Web Site	
Digital Certificates – Up to 5 certificates	No Additional Fee
Express-Scripts.com for Clients – access to Contact Directory, Sales and Benefit and Enrollment Support Marketing Information, and Benefit and Enrollment Support	No Additional Fee
Express-Scripts.com for Members – access to benefit, drug, health and wellness information; prescription ordering capability; and customer service	No Additional Fee

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Account and Member Service	
Call Center service for members	No Additional Fee
Fraud and Abuse Program – Pharmacy, Physician and Member Audit Program to Prevent Fraud, Waste and Abuse	No Additional Fee
Pharmacy Audit Only	No Additional Fee
Online member service application	No Additional Fee (up to 10 users)
Assigned account team, Training for online tools	No Additional Fee
Communication with physicians and/or members (Transition Letters, notifications, etc.)	No Additional Fee (Client Requested EOBs Extra)
Annual pharmacy benefit strategic planning with quarterly review	No Additional Fee
Postage (e.g., physician or member mailings)	No Additional Fee
CMS required Member Materials and New Enrollee Packets, which contain the following: 1 standard ID card and Enrollment Letter carrier, HIPAA Notice of Privacy, Abridged Formulary, Evidence of Coverage (Non-ERISA clients only), Quick Reference Guide and Checklist, and Home Delivery Form	No Additional Fee
Non-Standard Member Materials	Non Standard member materials priced upon request
Appeals and Grievances	
Appeals	No Additional Fee
Grievances	No Additional Fee
Prior Authorization services	
<b>Prior Authorization Services-Administrative</b>	
Manage plan benefits and drug costs by ensuring appropriate prescribing and use by members Non-clinical PA Lost/stolen overrides Vacation supplies	No Additional Fee
<b>Prior Authorization Services-Clinical</b>	
Prior Authorization, Step Therapy, Drug Quantity Level Limits Part B versus Part D coverage determinations Formulary exceptions Benefit level exceptions	No Additional Fee

**Optional Service (if elected by Client)**

Billing Services	Administrative Services Fee
Includes: <ul style="list-style-type: none"> <li>• Invoicing of EGWP Enrollees</li> <li>• Sending delinquency</li> <li>• Disenrollment for non-payment of premium</li> <li>• Processing of premium refunds</li> </ul>	\$0.80 Per EGWP Enrollee Per Month

MCLIC offers clinical programs focused on Safety Management and Care Management. Safety Management Programs are designed to provide an additional source of pharmaceutical information (a "safety net") for the most important drug and member specific pharmaceutical care issues. Care Management Programs offer disease-based programs focused on improving the health and well being of the patient, optimization of medication therapy, and compliance with prescribed therapy.

Safety and Care Management		
Program Name	Description	Fee
<b>Concurrent DUR</b>	Drug Utilization Review is a series of checks to insure that the drug being dispensed is appropriate; edits include dose checks, checks for drug interactions, duplicate Rx, step therapy, etc.	No Additional Fee

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<b>Medication Therapy Management Program (MTM)</b>	This CMS required clinical program is designed to improve the therapeutic outcomes associated with the use of medication for selected Medicare members.	No Additional Fee
<b>Emerging Therapeutic Interventions Program</b>	This CMS required notification is designed to alert members and healthcare professionals regarding significant safety-related drug recalls (FDA Removals) or market withdrawals (Manufacturer Removals) in a timely and efficient manner.	No Additional Fee
<b>Fraud, Waste and Abuse Program</b>	Express Scripts is strongly committed to the detection and prevention of Fraud, Waste and Abuse (FWA). This program includes the identification of potential problem pharmacies as well as prescribers and members with unusual or excessive utilization patterns. This program consists of two parts: the Network Pharmacy Audit Program and the Member and Physician Fraud Detection Program.	No Additional Fee
<b>Appeals</b>	Any of the procedures that deal with the review of adverse coverage determinations made by the Part D Plan Sponsor on the benefits a member believes he/she is entitled to receive, including the delay in providing or approving the drug coverage (when a delay would adversely affect the health of the member), or any amounts the member must pay for the drug coverage. These procedures include redeterminations by the Part D Plan Sponsor, reconsiderations by the independent review entity (IRE), ALJ hearings, MAC reviews, and judicial reviews. MCLIC contracts with an independent review agency to handle Re-determination appeals for the Express Scripts PDP. This vendor will perform redeterminations in compliance with CMS regulations for standard and expedited appeals.	No Additional Fee
<b>Grievance</b>	A 'grievance' is defined as a patient's expressed dissatisfaction with a specific event related to their Medicare Part D benefit that occurred within the last 60 calendar days or a complaint regarding the Part D sponsor's refusal to expedite a Coverage Determination or redetermination.	No Additional Fee

The following describes the CMS approved MCLIC Generics Policy.

<b>Generics Policy</b>	
Voluntary	No matter who requests Brand name, Physician or Member, no ancillary charge applies.

The following describes the MCLIC Standard Utilization Management Programs. These programs apply if the Design Option sections states "Standard Part D".

<b>Standard Utilization Management Programs</b>		
<b>Program</b>	<b>Description</b>	<b>Fee</b>
<b>Step Therapy</b>	CMS approved program that manages drug costs within specific therapy classes by ensuring that patients try a front-line or step one drug (usually generics) before a higher cost back-up or step two brand-name drug is covered. Within specific therapy classes, multiple drugs are available to treat the same condition. Step Therapy points a new patient to a front-line or step one, lower cost, clinically effective drug in each therapy group. Evidence-based clinical protocols are used to select front-line or step one drug. Members who fill a step therapy medication within the first 90 days of enrollment will be allowed to remain on that medication. Medicare Part D Step Therapy Drugs List stated below.	No Additional Fee
<b>Prior Authorization (PA)</b>	CMS approved program that manages plan benefits by ensuring appropriate prescribing and member usage. For MCLIC Standard list of drugs, client agrees to all updates/revisions as approved by CMS. B vs D require Prior Authorization, if determined to be a Part B drug, then the copay will process at the Part B co-pay (if covered); if determined to be a Part D drug then the co-pay will process at the applicable Part D co-pay. Members will be allowed one transition fill for a retail supply (up to 31 day supply) within the first 90 days of enrollment.	No Additional Fee
<b>Quantity Level Limit (QLL)</b>	CMS approved program that manages prescription costs by ensuring that the quantity of units supplied for each copayment are consistent with clinical dosing guidelines. The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care. MCLIC clinicians maintain a list of quantity limit drugs, which is based upon manufacturer-recommended guidelines and medical literature. Online edits help make sure optimal quantities of medication are dispensed per copayment and per days' supply.	No Additional Fee

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**SCHEDULE 5.1(a)(iv)**

If Client engages a subcontractor ("Subcontractor") to perform any of the functions that MCLIC has delegated to Client to perform under this Agreement, Client shall do so pursuant to a written agreement that includes the following terms, conditions, and provisions:

1. The agreement between Client and Subcontractor (the "Subcontract") must clearly identify the parties to the Subcontract.
2. The Subcontract must describe the functions that are being delegated to and performed by the Subcontractor.
3. The Subcontract must describe the manner in which Client will monitor the performance of the Subcontractor on an ongoing basis; specifically to monitor compliance with the Medicare Drug Rules.
4. The Subcontract must describe any reporting requirements that the Subcontractor has to Client.
5. The Subcontract must describe the payment that the Subcontractor will receive for performance under the Subcontract.
6. The Subcontractor must agree that the United States Department of Health and Human Services ("DHHS"), the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers and records (including medical records and documentation) of the Vendor involving transactions related to the Centers for Medicare and Medicaid Services' ("CMS") contract with MCLIC for a period of the then current plan year, plus an additional ten (10) years following the expiration or termination of the Subcontract or the date of any audit completion, whichever is later.
7. The Subcontractor must agree pursuant 42 CFR § 423.505(i)(3)(iv) to produce upon request by CMS, or its designees, any books, contracts, records, including medical records and documentation of the PDP Sponsor, relating to the Part D program, to either the PDP Sponsor to provide to CMS, or directly to CMS or its designees.
8. The Subcontractor must agree that in no event, including, but not limited to, nonpayment by Client, Client's insolvency, or breach of the Subcontract, will the Subcontractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a beneficiary of Client or persons acting on his or her behalf for services provided by the Subcontractor pursuant to the Subcontract.
9. The Subcontract must: (i) specify that the Subcontractor will perform all services under the Subcontract in a manner that is consistent with and that complies with MCLIC's contractual obligations under its contract with CMS; (ii) specify that the Subcontractor agrees to comply with all applicable federal laws, regulations, and CMS instructions; and (iii) provide for revocation of the Subcontractor's delegated activities and reporting responsibilities or specify other remedies in instances when CMS, Client, or MCLIC determine that the Subcontractor has not performed satisfactorily.
10. The Subcontract must require the Subcontractor to agree to comply with state and federal privacy and security requirements, including the confidentiality and security provisions stated in 42 CFR §423.136.
11. The Subcontract must include an acknowledgment by the parties that information provided in connection with the Subcontract is used for purposes of obtaining federal funds.

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12. If the Subcontract permits the Subcontractor to use a subcontractor to perform any of the services delegated to it under the Subcontract, the Subcontract must require that the Subcontractor include all of the above provisions in a written agreement with such subcontractor.
13. The Subcontract must be signed by a representative of the Subcontractor with legal authority to bind the Subcontractor.
14. The Subcontract must contain a representation by Client and the Subcontractor that they shall not knowingly employ, or subcontract with, an individual or an entity that employs or contracts with an individual, who is excluded from participation in Medicare under section 1128 or 1128A of the Act or from participation in a Federal health care program for the provision of health care, utilization review, medical social work, or administrative services.
15. The Subcontract must contain language clearly indicating that the first tier, downstream, or related entity has agreed to participate in the PDP Sponsor's Medicare Prescription Drug Benefit program. This requirement is not applicable for a network pharmacy if the existing contract would allow participation in this program.
16. The Subcontract must be for a term of at least the one-year contract period for which the PDP Sponsor's Medicare Part D Application is submitted. However, where the Subcontract is for services or products to be used in preparation for the next contract year's Part D operations (marketing, enrollment), the initial term of such Subcontract must include this period of performance (e.g., contracts for enrollment-related services must have a term beginning no later than November 15 extending through the full contract year ending on December 31 of the next year).
17. Insofar as the Subcontractor establishes the pharmacy network or select pharmacies to be included in the network, the Subcontractor must agree: i) pursuant 42 CFR § 423.505(i)(5) that the PDP Sponsor retains the right to approve, suspend, or terminate any arrangement with a pharmacy; ii) pursuant 42 CFR §423.505(i)(3)(vi) and consistent with 42 CFR § 423.520 to issue, mail, or otherwise transmit payment of all clean claim to such pharmacies (excluding long-term care and mail order) submitted by or on behalf of pharmacies within 14 days for electronic claims and within 30 days for claims submitted otherwise; iii) pursuant 42 CFR § 423.505(i)(3)(viii)(B) and 42 CFR § 423.505(i)(3)(viii)(A) that if a prescription drug pricing standard is used for reimbursement, Subcontractor will identify the source used by the PDP Sponsor for the prescription drug pricing standard of reimbursement and agree to a contractual provision that updates to such a standard occur not less frequently than once every 7 (seven) days beginning with an initial update on January 1 of each year, to accurately reflect the market price of acquiring the drug.

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**EXHIBIT B**

*As provided in the Agreement, MCLIC may provide services under this Agreement through one or more of its Affiliates, including Express Scripts, Inc. ("ESI"). The following financial disclosure statement relates to the rebate programs and other financial arrangements that may be used by Express Scripts, Inc. ("ESI") in connection with MCLIC's administration of the EGWP Benefit under this Agreement.*

**FINANCIAL DISCLOSURE TO ESI PBM CLIENTS**

This disclosure provides an overview of the principal revenue sources of Express Scripts, Inc. and Medco Health Solutions, Inc. (individually and collectively referred to herein as "ESI"), as well as ESI's affiliates. In addition to administrative and dispensing fees paid to ESI by our clients for pharmaceutical benefit management ("PBM") services, ESI and its affiliates derive revenue from other sources, including arrangements with pharmaceutical manufacturers, wholesale distributors, and retail pharmacies. Some of this revenue relates to utilization of prescription drugs by members of the clients receiving PBM services. ESI may pass through certain manufacturer payments to its clients or may retain those payments for itself, depending on the contract terms between ESI and the client.

**Network Pharmacies** – ESI contracts for its own account with retail pharmacies to dispense prescription drugs to client members. Rates paid by ESI to these pharmacies may differ among networks (e.g., Medicare, Worker's Comp, open and limited), and among pharmacies within a network, and by client arrangements. PBM agreements generally provide that a client pays ESI an ingredient cost, plus dispensing fee, for drug claims. If the rate paid by a client exceeds the rate contracted with a particular pharmacy, ESI will realize a positive margin on the applicable claim. The reverse also may be true, resulting in negative margin for ESI. ESI also enters into pass-through arrangements where the client pays ESI the actual ingredient cost and dispensing fee amount paid by ESI for the particular claim when the claim is adjudicated to the pharmacy. In addition, when ESI receives payment from a client before payment to a pharmacy, ESI retains the benefit of the use of the funds between these payments. ESI may maintain non-client specific aggregate guarantees with pharmacies and may realize positive margin. ESI may charge pharmacies standard transaction fees to access ESI's pharmacy claims systems and for other related administrative purposes.

**Brand/Generic Classifications** – Prescription drugs may be classified as either a "brand" or "generic;" however, the reference to a drug by its chemical name does not necessarily mean that the product is recognized as a generic for adjudication, pricing or copay purposes. For purposes of pharmacy reimbursement, ESI distinguishes brands and generics through a proprietary algorithm ("BGA") that uses certain published elements provided by First DataBank (FDB) including price indicators, Generic Indicator, Generic Manufacturer Indicator, Generic Name Drug Indicator, Innovator, Drug Class and ANDA. The BGA uses these data elements in a hierarchical process to categorize the products as brand or generic. The BGA also has processes to resolve discrepancies and prevent "flipping" between brand and generic status due to price fluctuations and marketplace availability changes. The elements listed above and sources are subject to change based on the availability of the specific fields. Updated summaries of the BGA are available upon request. Brand or generic classification for client reimbursement purposes is either based on the BGA or specific code indicators from Medi-Span or a combination of the two as reflected in the client's specific contract terms. Application of an alternative methodology based on specific client contract terms does not affect ESI's application of its BGA for ESI's other contracts.

**Maximum Allowable Cost ("MAC")/Maximum Reimbursement Amount ("MRA")** – As part of the administration of the PBM services, ESI maintains a MAC List of drug products identified as requiring pricing management due to the number of manufacturers, utilization and/or pricing volatility. The criteria for inclusion on the MAC List are based on whether the drug has readily available generic product(s), is generally equivalent to a brand drug, is cleared of any negative clinical implications, and has a cost basis that will allow for pricing below brand rates. ESI also maintains MRA price lists for drug products on the MAC List based on current price reference data provided by MediSpan or other nationally recognized pricing source, market pricing and availability information from generic manufacturers and on-line research of national wholesale drug company files, and client arrangements. Similar to the BGA, the elements listed above and sources are subject to change based on the availability of the specific fields. Updated summaries of the MAC methodology are available upon request.

**Manufacturer Formulary Rebates, Associated Administrative Fees, and PBM Service Fees** – ESI contracts for its own account to obtain formulary rebates attributable to the utilization of certain brand drugs and supplies (and possibly certain authorized generics marketed under a brand manufacturer's new drug application). Formulary rebate amounts received vary based on client specific utilization, the volume of utilization as well as formulary position applicable to the drug or supplies, and adherence to various formulary management controls, benefit design requirements, claims volume, and other similar factors, and in certain instances also may vary based on the product's market-share. ESI often pays an amount equal to all or a portion of the formulary rebates it receives to a client based

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on the client's PBM agreement terms. ESI retains the financial benefit of the use of any funds held until payment of formulary rebate amounts is made to the client. ESI or its affiliates may maintain non-client specific aggregate guarantees and may realize positive margin. In addition, ESI provides administrative services to contracted manufacturers, which include, for example, maintenance and operation of systems and other infrastructure necessary for invoicing and processing rebates, pharmacy discount programs, access to drug utilization data, as allowed by law, for purposes of verifying and evaluating applicable payments, and for other purposes related to the manufacturer's products. ESI receives administrative fees from the participating manufacturers for these services. These administrative fees are calculated based on the price of the drug or supplies along with the volume of utilization and do not exceed the greater of (i) 4.58% of the average wholesale price, or (ii) 5.5% of the wholesale acquisition cost of the products. In its capacity as a PBM company, ESI also may receive other compensation from manufacturers for the performance of various services, including, for example, formulary compliance initiatives, clinical services, therapy management services, education services, medical benefit management services, and the sale of non-patient identifiable claim information. This compensation is not part of the formulary rebates or associated administrative fees.

Copies of ESI's standard formularies may be reviewed at [www.express-scripts.com/wps/portal/](http://www.express-scripts.com/wps/portal/). In addition to formulary considerations, other plan design elements are described in ESI's Plan Design Review Guide, which may be reviewed at [www.express-scripts.com/wps/portal/](http://www.express-scripts.com/wps/portal/).

**ESI Subsidiary Pharmacies** – ESI has several licensed pharmacy subsidiaries, including our specialty pharmacies. These entities may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. These subsidiary pharmacies contract for these arrangements on their own account in support of their various pharmacy operations. Many of these subsidiary arrangements relate to services provided outside of PBM arrangements, and may be entered into irrespective of whether the particular drug is on one of ESI's national formularies. Discounts and fee-for-service payments received by ESI's subsidiary pharmacies are not part of the PBM formulary rebates or associated administrative fees paid to ESI in connection with ESI's PBM formulary rebate programs. However, certain purchase discounts received by ESI's subsidiary pharmacies, whether directly or through ESI, may be considered for formulary purposes if the value of such purchase discounts is used by ESI to supplement the discount on the ingredient cost of the drug to the client based on the client's PBM agreement terms. From time to time, ESI and its affiliates also may pursue and maintain for its own account other supply chain sourcing relationships not described below as beneficial to maximize ESI's drug purchasing capabilities and efficiencies, and ESI or affiliates may realize an overall positive margin with regard to these initiatives.

The following provides additional information regarding examples of ESI subsidiary discount arrangements and fee-for-service arrangements with pharmaceutical manufacturers, and wholesale distributors:

**ESI Subsidiary Pharmacy Discount Arrangements** – ESI subsidiary pharmacies purchase prescription drug inventories, either from manufacturers or wholesalers, for dispensing to patients. Often, purchase discounts off the acquisition cost of these products are made available by manufacturers and wholesalers in the form of either up-front discounts or retrospective discounts. These purchase discounts, obtained through separate purchase contracts, are not formulary rebates paid in connection with our PBM formulary rebate programs. Drug purchase discounts are based on a pharmacy's inventory needs and, at times, the performance of related patient care services and other performance requirements. When a subsidiary pharmacy dispenses a product from its inventory, the purchase price paid for the dispensed product, including applicable dispensing fees, may be greater or less than that pharmacy's acquisition cost for the product net of purchase discounts. In general, our pharmacies realize an overall positive margin between the net acquisition cost and the amounts paid for the dispensed drugs.

**ESI Subsidiary Fee-For-Service Arrangements** – One or more of ESI's subsidiaries, including, but not limited to, its subsidiary pharmacies also may receive fee-for-service payments from manufacturers or wholesalers in conjunction with various programs or services, including, for example, patient assistance programs for indigent patients, dispensing prescription medications to patients enrolled in clinical trials, various therapy adherence and fertility programs, administering FDA compliance requirements related to the drug, product reimbursement support services, and various other clinical or pharmacy programs or services. As a condition to having access to certain products, and sometimes related to certain therapy adherence criteria or FDA requirements, a pharmaceutical manufacturer may require a pharmacy to report selected information to the manufacturer regarding the pharmacy's service levels and other dispensing-related data with respect to patients who receive that manufacturer's product. A portion of the discounts or other fee-for-service payments made available to our pharmacies may represent compensation for such reporting.

**Other Manufacturer Arrangements** – ESI also maintains other lines of business that may involve discount and service fee relationships with pharmaceutical manufacturers and wholesale distributors. Examples of these businesses include a wholesale distribution business, group purchasing organizations (and related group purchasing organization fees), a medical benefit management company, and United BioSource Corporation

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("UBC"). Compensation derived through these business arrangements is not considered for PBM formulary placement, and is in addition to other amounts described herein. Of particular note, UBC partners with life sciences and pharmaceutical companies to develop, commercialize, and support safe, effective use and access to pharmaceutical products. UBC maintains a team of research scientists, biomedical experts, research operations professionals, technologists and clinicians who work with clients to conduct and support clinical trials, create, and validate and administer pre and post product safety and risk management programs. UBC also works on behalf of pharmaceutical manufacturers to provide product and disease state education programs, reimbursement assistance, and other support services to the public at large. These service fees are not part of the formulary rebates or associated administrative fees.

Third Party Data Sales – Consistent with any client contract limitations, ESI or its affiliates may sell HIPAA compliant information maintained in their capacity as a PBM, pharmacy, or otherwise to data aggregators, manufacturers, or other third parties on a fee-for-service basis or as a condition of discount eligibility. All such activities are conducted in compliance with applicable patient and pharmacy privacy laws and client contract restrictions.

December 1, 2014

**THIS EXHIBIT REPRESENTS ESI'S FINANCIAL POLICIES. ESI MAY PERIODICALLY UPDATE THIS EXHIBIT AND THE FINANCIAL DISCLOSURES CONTAINED HEREIN TO REFLECT CHANGES IN ITS BUSINESS PROCESSES; THE CURRENT FINANCIAL DISCLOSURE IS AVAILABLE UPON REQUEST AND ACCESSIBLE ON EXPRESS-SCRIPTS.COM AT WWW.EXPRESS-SCRIPTS.COM/WPS/PORTAL/.**



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# Memorandum

**TO:** PERS Board  
**FROM:** Rebecca  
**DATE:** December 10, 2015  
**SUBJECT:** \$250 Wellness Incentive Benefits for 2015

As discussed with the Board at the October meeting, NDPERS staff became aware in September that some members had received more than the \$250 wellness incentive in 2015 due to the carrier change. This occurred for several reasons, including the timing of the file transfers between BCBS and Sanford Health Plan, the date that the redemption center for bWell went live and that the point allocation on bWell facilitated members being able to accrue points on the site more rapidly than they could on the BCBS HealthyBlue System.

The redemption center became live on August 1, but the July file showing dollars paid by BCBS that was loaded by Sanford prior to this date did not have details on all members who had redeemed with BCBS. A second file was sent by BCBS and was received by Sanford on August 19. This file contained additional detail about members who had redeemed points with BCBS. Sanford did not load this file into their system until September 22.

Staff requested Sanford review their records to determine the amount of the overpaid benefits. The overpayments have been broken into 3 categories:

- 1) Members that received amounts in excess of the \$250 through BCBS. NDPERS staff has discussed this with BCBS and they have indicated that this does occur, typically at year-end due to the delay in the fitness center reimbursement and that they have absorbed this additional expense when it occurred.
- 2) Members that received their \$250 limit with BCBS but also received additional funds from Sanford Health Plan prior to SHP knowing the amount paid by BCBS. The total amount paid in excess by SHP is \$37,950.49.
- 3) Members that had redeemed less than the \$250 total with BCBS, and also redeemed points with Sanford Health Plan which resulted in a payment above the \$250 limit. The total amount paid in excess by SHP for this group is \$35,322.21.

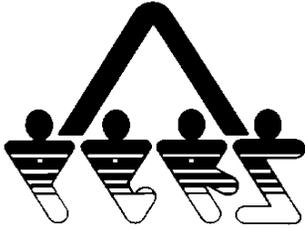
The total amount received by members in excess of what they should have received is \$73,272.70. Staff is seeking the board's input on how they would like to handle this occurrence. The options identified are:

- 1) Sanford can apply the amounts paid in excess to a member's 2016 bWell online portal account. Therefore, a participant would only be able to redeem the difference between \$250 for 2016 and the amounts over paid in 2015. This may result in some members not having any incentive to participate in the wellness program for 2016. However, for individuals that have terminated employment, there would be no way to recover the excess payment.
- 2) The board could opt to reimburse Sanford for the excess amount in recognition that this was a situation specific to the carrier change. This would then allow participants to have the full incentive available to them for 2016.

PERS and Sanford will be meeting next week to continue our review of this topic and if we identify any other options, we will bring them to the board meeting for your consideration.

**Board Action Requested:**

Determine how to handle the \$250 Wellness Benefit overages for 2015.



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# Memorandum

**TO:** PERS Board  
**FROM:** Sharon & Rebecca  
**DATE:** December 10, 2015  
**SUBJECT:** Health Plan Implementation Update

Staff continues to work with the Sanford Health Plan (SHP) team. Below is an update in each of the areas we have teams working.

**a. Operations**

- i. Operational items continue to be reviewed and addressed as they arise. We previously reported situations where members who transferred employment were experiencing problems with their coverage being set up correctly. We continue to look into these situations when we become aware of them. We have also implemented a new procedure to notify SHP enrollment staff of transfers to help facilitate the process. In the event a member incurs out of pocket expenses due to coverage not being set up correctly, the medical claims will be automatically reprocessed once the enrollment is corrected. However, the member will be responsible for filing a manual claim to receive reimbursement for prescription drug expenses.
- ii. We continue to work with SHP on the monthly files for claims data. SHP is working with ESI to get additional prescription drug claims data that NDPERS uses.
- iii. A team of NDPERS and SHP staff continue to meet monthly to discuss business processes and operational issues.
- iv. NDPERS and SHP staff recently determined a process to verify eligibility of grandchildren to be on a subscriber's policy. A new form has been developed that a subscriber will need to complete to certify that the adult child (parent of grandchild) is chiefly dependent upon the subscriber and therefore, the grandchild can be covered. NDPERS will be sending the verification form, requesting completion, to all subscribers who have added or applied to add a grandchild to their

policy since July 1 to certify that they meet the established criteria. Staff is reviewing application forms and plan materials to specify that the verification will be required. SHP will be reviewing the Certificate of Insurance to address an amendment to clarify the grandchild eligibility language.

- b. Dual Coverage & Coordination of Benefits** – We have heard from some members that have dual coverage that they have had issues with the coordination of their benefits between their two plans.
  - i. Medical – members that are covered on another SHP plan (other than NDPERS) and also on NDPERS have expressed frustration that SHP doesn't have a more automated process in place since they are two "SHP" plans. This is something that was seamless under BCBS when two BCBS plans existed for a subscriber.
  - ii. Pharmacy – issues were raised by members when trying to have prescriptions filled. Staff will be meeting with Sanford on this issue in the near future.
  
- c. Data Sharing**
  - i. NDPERS and SHP staff has discussed the SHP data system as it relates to the sharing of information between their overall Master Patient Index (MPI) and the sub-system that the Health Plan operates on. Staff met with Sanford on November 19<sup>th</sup> at the NDPERS office. Several questions were raised. Sanford is presently working on responses and once available, staff will share with the board.
  
- d. Marketing/Communication** – The FAQs are being reviewed related to the Part D transition (Retiree FAQs) and dual membership processing.
  
- e. Wellness**
  - i. The redemption center overages will be discussed under a separate memo.
  - ii. NDPERS and SHP Staff have been reviewing the point structure for bWell and also the health risk assessment completion date for 2016 so that communications can be provided to members.
  - iii. SHP has been exploring other online wellness platform and plans to implement a new platform in the second quarter of 2016. NDPERS staff requested a demo of the new platform, which is planned to occur prior to the board meeting.
  
- f. Tobacco Cessation Program** – Recent discussions have occurred between staff from NDPERS, SHP and the Dept of Health regarding the program given the amount of grant dollars used is lower than previous years. Attached is information from the Dept of Health that details this reduction. Staff determined additional opportunities to promote the program using the existing wellness program channels that include reminders in the monthly wellness newsletter sent to employees, coordinator webinar reminders and occasional

TCP specific email blasts. However, we do recognize that the nature of this type of program is that after a number of years, the participation will decline as those more apt to utilize the services would have taken advantage of them already.

In addition to doing general marketing to the broad eligible population, Sanford offered that they can have their health coaches begin specific outreach to enrollees in the program. The wellness coaches help individuals find the motivation and tools to meet their physical and emotional health goals. These goals may include losing weight, eating healthier, quitting smoking, having greater career satisfaction or reducing stress. A wellness coach helps individuals make better general choices that fit their lifestyle. Participation in the wellness coaching service would be voluntary and would not be a requirement of the plan. If the board is comfortable with Sanford moving forward with coaching for current TCP enrollees, it would become available to current enrollees on February 1.

Sanford will also be exploring how additional NDPERS tobacco users may be identified using claims data so that they can be offered the wellness coaching service and be notified, if eligible, about the Tobacco Cessation Program. This is not something that has been done previously and would be coupled with other health coaching on areas such as diabetes and pre-hypertension. We have asked staff from the Dept of Health to attend the meeting to be available to provide their thoughts on this type of outreach and also overall views on the program. We would also like input from the Board to determine if this type of outreach is something the Board would like to have done.

- g. **Preferred Provider Organizations** – Sparb sent letters on December 1 to 260 providers that were PPO providers with BCBS who have not yet signed a PPO agreement with SHP. Further information on this is being shared with the board under a different agenda item.

- h. **Pharmacy and Care Management**

- i. Kathy will be providing an update on the Infertility Benefits under a separate board memo.
- ii. Sanford has recommended a script for their UM team to use when a member or provider calls to Pre-authorize a service outside of North Dakota when services are available within the State. The script they would like to use is:

*“Do you know the member/patient will have lower “out of pocket expenses” if the services are provided in North Dakota, i.e. Essentia, Altru, Trinity, St Alexis and Sanford can provide these services? The care can be provided closer to home and it may be a better option for the patient.”*

Is the board comfortable with this script being used?

- i. **Medicare Part D – The transition of the Part D product continues to be the main focus of the NDPERS implementation team.** The team continues to participate in weekly calls with SHP and Express Scripts. Below is an update on this transition:
  - i. **Contract with ESI** – NDPERS staff and legal counsel have continued to work with ESI on the contract. Further details on the contract will be provided under a separate memo.
  - ii. **Fully Insured Rx Application** – Staff and legal counsel continue to work with ESI on the Memorandum of Understanding so that this application can be signed.
  - iii. **Files have been requested from CVS** – Staff continues to work with ESI and BCBS on the requested 4 data files that ESI has requested.
  - iv. **Eligibility Files** – The second eligibility file was sent to ESI on November 30. The results continue to be good with very few enrollments requiring additional follow-up.
  - v. **PERSLink Modifications** –Work continues on modifying the PERSLink system to better address the billing requirements for this product (i.e. late enrollment penalty, different effective dates than health plan). These changes will be implemented in December for the January billing cycle.
  - vi. **ESI Call Center** – The ESI call center is fully operational now as our eligibility files have been uploaded to the ESI system. NDPERS has received some member feedback about the assistance they've received from the call center representatives. When a member raises a complaint to NDPERS, we are able to capture the details of the call and forward them to our ESI contact that can then trace the call and review it to determine if misinformation was provided or if the call could have been better handled. So far, the volume of the complaints given the size of the population has been minimal. NDPERS staff is also tracking these issues to ensure they are resolved.
  - vii. **Member communications**
    - NDPERS was required by CMS and the existing contract with MedicareBlue Rx to send a notice to all participants at least 21 days prior to the termination of the plan with MedicareBlue Rx. These notices were prepared and sent on December 7 & 8. The board was provided a copy of this notice via email prior to its distribution.
    - ESI will be sending participants a Welcome Packet later in December that will include their benefits overview, formulary list and member ID card.
    - Enrollment and Disenrollment forms have been finalized and are available for use on the website.
  - viii. **NDPERS Website & Forms**
    - A review of the NDPERS website will be conducted during December to ensure that MedicareBlue Rx information is removed as of January 1 and that ESI information is available January 1.

- Enrollment and Disenrollment forms have been finalized and are available for use on the website.
- ix. **Pharmacy communications** – Staff have requested that notifications be sent to pharmacies in North Dakota and surrounding areas regarding the upcoming vendor change. ESI and SHP are working on this notification. It is anticipated that the notice will be provided by mid-December.

Staff continues to work with BCBS to facilitate the exit of the BCBS system. Below is an update on this transition:

- a. BCBS continues to provide deductible and co-insurance accumulator files to SHP bi-weekly. This is being evaluated each month to determine the appropriate frequency of files going forward.
- b. Transition of the PDP – terminating the plan through MedicareBlue Rx
  - o BCBS is helping to facilitate delivery of the transition files requested by ESI.
  - o Process for closing out and payment of the final billing is being clarified.
- c. Sparb has discussed the retention of our data at BCBS with BCBS and also with Deloitte to determine industry standards and if there should be concerns with retention. This issue has been forwarded to the board for direction on how to proceed.

Weekly meetings continue to be held with the internal NDPERS transition team to address issues that are specific to NDPERS and do not require involvement from BCBS or SHP. Internal transition issues for NDPERS continue to be identified and tracked and addressed by this team.

In addition, staff continues to hold bi-weekly status meetings with the Sanford implementation team. Representatives from Sanford will be at the meeting to provide an operational update and answer any questions you may have.

We will be at the Board meeting if you have any further questions or concerns.

	Amount Awarded	July	August	September	Ocotber	November	December	January	February	March	April	May	June	Accumulative	Funds Remaining
BCBSND/Noridian - Employee Cessation Services 2012-2013	100,000	2,095.41	2,080.12	2,058.38	3,885.61	2,573.00	3,788.63	3,124.37	2,815.23	3,489.44	2,920.91	3,021.45	2,767.72	34,620.27	
BCBSND/Noridian- Employee Cessation (G13.025) 2013-2014	80,000	720.8	3,350.63	2,160.77	2,086.58	825.88	987.1	2,863.35	3,017.43	2,725.05	2,766.86	3,308.72	3,258.51	28,071.68	
BCBSND/Noridian- Employee Cessation (G13.025) <b>2014-1015</b>	51,928.32	703.36	741.2	2,720.97	2,573.26	1,272.92	3,372.44	2,637.64	3,546.27	9,582.61	3,462.98	3,001.36	1,597.05	35,212.06	16,716.26
Sanford Health Plan (G15.052) 2015-2016	35,000		438.99	1720.23	1,029.83									3,189.05	31,810.95



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# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** December 9, 2015  
**SUBJECT:** Health RFP Update

Our health plan RFP is moving forward on the following timeline:

Timeline for RFP:

November 1, 2015 RFP issued

November 19, 2015 Questions to RFP Due

November 27, 2015 Responses to questions posted

December 11, 2015 Proposals due at NDPERS office no later than 5:00 p.m. Central Standard Time

The RFP was sent to the firms in Attachment #1. In addition, the notice in Attachment #2 appeared in newspapers. The list of questions and answers concerning the RFP is included in Attachment #3. We will report the number of proposals received at the Board meeting.

## Consultant Listing

Updated 10-2015

AON Consulting	Justin Kindy	4100 E Mississippi Ave., Suite 1600 Denver, CO 80246 (303) 782-3397 Cell: (720) 935-0542 Email: <a href="mailto:Justin.Kindy@aonhewitt.com">Justin.Kindy@aonhewitt.com</a> Web: <a href="http://www.aon.com">www.aon.com</a>
Buck Consultants	Dave Slishinsky Principal and Consulting Actuary	1200 Seventeenth St., Suite 1200 Denver, CO 80202 (720) 359-7773 (720) 359-7701 FAX E-mail: <a href="mailto:david.slishinsky@buckconsultants.com">david.slishinsky@buckconsultants.com</a> Web: <a href="http://www.buckconsultants.com">www.buckconsultants.com</a>
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Deloitte Consulting, LLP	Patrick L. Pechacek, Director	50 South Sixth St., Suite 2800 Minneapolis, MN 55402-1538 (612) 397-4033 (612) 692-4033 FAX Cell: 612-270-3848 E-mail: <a href="mailto:ppechacek@deloitte.com">ppechacek@deloitte.com</a> <a href="mailto:mdeleon@deloitte.com">mdeleon@deloitte.com</a> Web: <a href="http://www.deloitte.com">www.deloitte.com</a>
Ennis, Knupp + Associates, Inc.	Harmony Watling Communications Manager	10 South Riverside Plaza, Suite 1600 Chicago, IL 60606 (312) 715-1700 (312) 715-1952 FAX E-mail: <a href="mailto:h.watling@ennisknupp.com">h.watling@ennisknupp.com</a> Web: <a href="http://www.ennisknupp.com">www.ennisknupp.com</a>
Gabriel, Roeder, Smith & Company	Leslie Thompson	7900 East Union Avenue, Suite 650 Denver, Colorado 80237-2746 (720) 274-7271 (720)560-8988 (mobile) E-mail: <a href="mailto:leslie.thompson@gabrielroeder.com">leslie.thompson@gabrielroeder.com</a> Web: <a href="http://www.grsnet.com">www.grsnet.com</a>
Gallagher Benefit Services, Inc.	Doug Anderson Area Senior Vice President	Retirement Plan Consulting/Actuarial Arthur J. Gallagher & Co. 3600 American Blvd W., Suite 500 Bloomington, MN 55431 (952) 356-3848 (866) 743-5313 (FAX) (612) 270-6125 (mobile) <a href="mailto:Doug_Anderson@ajg.com">Doug_Anderson@ajg.com</a> Web: <a href="http://www.ajg.com">www.ajg.com</a>

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Mercer	Norma Pocsatko	525 Vine Street, Suite 1600 Cincinnati, OH 45202 (513) 632-2600 Fax: (513) 632-2650 E-mail: <a href="mailto:norma.j.pocsatko@marsh.com">norma.j.pocsatko@marsh.com</a> Web: <a href="http://www.mercer.com">www.mercer.com</a>
Milliman, Inc.	Daniel Wade Consulting Actuary	Daniel Wade, FSA, EA, MAAA Consulting Actuary Milliman 1301 Fifth Avenue, Suite 3800 Seattle, WA 98101-2605 <a href="mailto:daniel.wade@milliman.com">daniel.wade@milliman.com</a>  Web: <a href="http://www.milliman.com">www.milliman.com</a>
Nyhart/ABG of Indiana	Leanne Willett	8415 Allison Pointe Boulevard, Suite 300 Indianapolis, IN 46250  (317) 845-3513 / 800-428-7106 (317) 845-3655 FAX <a href="mailto:leanne.willett@nyhart.com">leanne.willett@nyhart.com</a>  Web: <a href="http://www.nyhart.com">www.nyhart.com</a>
Raymond T. Clarke and Associates	Raymond T. Clarke	50 Fishing Brook Road Westbrook, CT 06498 Telephone: (203) 379-8345 E-mail: <a href="mailto:raymondclarke@yahoo.com">raymondclarke@yahoo.com</a>  Web: <a href="http://www.clarkraymond.com">www.clarkraymond.com</a>
Segal Consulting	Brad Ramirez, FSA, MAAA, EA Vice President and Consulting Actuary	Segal Consulting Brad Ramirez, FSA, MAAA, FCA, EA 5990 Greenwood Plaza Blvd., Suite 118 Greenwood Village, CO 80111-4708 (303) 714-9952 (303) 223-9234 FAX (303) 875-2757 (mobile) Email: <a href="mailto:bramirez@segalco.com">bramirez@segalco.com</a> Web: <a href="http://www.segalco.com">www.segalco.com</a>
Towers Perrin	Shane Bartling Principal	525 Market Street , Suite 2900 San Francisco, CA 94105 (415) 836-1088 (415) 836-1350 FAX E-mail: <a href="mailto:shane.bartling@towersperrin.com">shane.bartling@towersperrin.com</a> Web: <a href="http://www.towersperrin.com">www.towersperrin.com</a>

Van Iwaarden Associates	Mark D. Meyer, MD, FSA Consulting Actuary	840 Lumber Exchange Building Ten S 5 <sup>th</sup> Street Minneapolis, MN 55402-1010 (612) 596-5960 Mark: (507) 726-6269 (612) 596-5999 FAX <a href="mailto:markm@vaniwaarden.com">markm@vaniwaarden.com</a>  Web: <a href="http://www.vaniwaarden.com">www.vaniwaarden.com</a>
Middaugh & Associates	Jason Middaugh	1019 5th Avenue South P.O. Box 2543 Fargo, ND 58108 Phone: (701) 235-7023 Fax: (701) 280-9607 Email: <a href="mailto:jmiddaugh@cfsbd.com">jmiddaugh@cfsbd.com</a> Web: <a href="http://www.damiddaugh.com">www.damiddaugh.com</a>

# **PUBLIC NOTICE**

## **REQUEST FOR PROPOSAL Actuarial and Consulting Services Uniform Group Insurance**

The North Dakota Public Employees Retirement System is seeking proposals for general consulting services, bid solicitation and evaluation for the health programs, and premium calculation for 2017-2019 for its uniform group insurance programs.

This website will contain the RFP and other important information. Bidders should check these electronic pages regularly.

<http://www.nd.gov/ndpers/providers-consultants/consultants/rfp-index.html>

Questions concerning the RFP shall be directed, in writing, to Cheryl Stockert and Bryan Reinhardt, or by email at [cstocker@nd.gov](mailto:cstocker@nd.gov) or [breinhar@nd.gov](mailto:breinhar@nd.gov) by 5:00 p.m. CST on November 19, 2015. Responses will be posted on the NDPERS website under "Request for Proposals" by November 27, 2015.

Proposals must be submitted no later than 5:00 PM (CST) on December 11, 2015 as indicated in the RFP.

**North Dakota Public Employees Retirement System**  
**Request for Proposal for Uniform Group Insurance**

**Question and Answers**

1. My question is specifically with regards to Employee Wellness Programs for NDPERS. Will NDPERS accept submissions for Employee Wellness Consulting and Services thru this RFP, specifically as a carve-out or dual award?

ANSWER: No

2. You list the health insurance bid process as beginning in September of 2016. What is the expectation as to the date at which best & final proposals would need to be received by?

ANSWER: The BAFO will be done in December/January.

3. What elements constitute health insurance for purposes of the bid; i.e. medical, prescription, stop loss, dental, vision, wellness, other?

ANSWER: Medical, Prescription, Stop Loss, Wellness, and Administration.

4. You list the Medicare D RFP process as occurring in August/September. Do you consider this to be the timeline from issuance of the RFP to selection for award, or can additional time be built into either the front or back end of the process?

ANSWER: Yes, but we would consider starting earlier.

5. With regard to the health premium estimate, what element constitute health premiums for this purpose; i.e. medical, prescription, dental, vision, wellness, other?

ANSWER: Medical, Prescription, Wellness, and Administration equivalent of fully insured.

6. If wellness is part of the RFP task, is it bundled with the carriers, unbundled, or both?

ANSWER: Bundled for both fully and self insured.

7. The consulting contract appears to be awarded on January 1, 2016. The benefit plan for premium analysis appears to be available starting July 1 with the analysis due August 1. Is it possible to get the proposed plan of benefits by June 1 in order to allow two months for the analysis and reporting. In the alternative can we perform our projection based on the current plan design in advance of July 1 and only modify that projection based on the new plan design changes during the month of July (i.e. no update of claims experience after the initial baseline projection based on current benefits)?

ANSWER: Yes, it is possible to get the proposed plan design before June 1<sup>st</sup>, but we would want to get the June paid claims experience for projections.

8. Item G on page 16 of the RFP indicates the contract will be awarded by January 1, 2017. Should that be January 1, 2016?

ANSWER: Yes, but due to possible Board interviews award may be in the first quarter of 2016.

9. The cost proposal requires fixed fees for the Health Bid and Medicare Part D and utilizes the phrase "Preparation of the Bid", which could indicate the scope associated with this item is limited to the preparation and release of the RFP/bid. However the scope outlined in the RFP (pages 9-11) includes evaluation of proposals and assistance with contract development and implementation. Is the scope described in pages 9-11 relative to conducting the RFP process and analyzing responses to be covered by the Fixed Fee Hourly Rate, or to be included in the fees proposed in Fixed Fee 1 and Fixed Fee 2 in the cost proposal?

ANSWER: The intent of the bid is a fixed fee for preparation and release of bids and the premium projection. The Fee For Service basis is for the evaluation of proposals.

10. Please provide copies of the most recent reports from the consultant for the most recent Health Bid, Part D bid and Health Premium estimate.

ANSWER: Unlike the last NDPERS bid, the Part-D will be separate. This information is posted on the NDPERS Web Site.

11. How many hours were invoiced by the consultant(s) at the Fixed Fee Hourly Rate for 2014 and 2015 (to date)?

ANSWER: Deloitte Fixed Fee Rate:  
Hours by month @ \$292 rate:  
June 2014 – 4.00 Hours  
Sept – Oct 2014 – 207.25 Hours  
November – December 2014 – 291.50 Hours  
January – February 2015 – 141.00 Hours  
March – April 2015 – 67.00 Hours  
May – June 2015 – 11.25 Hours

12. Regarding this RFP for Health & Benefits actuarial and consulting Services, I request that you provide me with a copy of the currently in force contract(s) with brokers or consultants for the scope of services called for in the RFP, including current broker/consultant compensation.

ANSWER: See #11, there are no brokers. The contract is posted on the NDPERS Web Site.

13. What is the reason NDPERS is issuing an RFP for actuarial and consulting assistance? Specifically, is NDPERS meeting a requirement to solicit proposals or are there other issues that led to this RFP?

ANSWER: Generally, the NDPERS Board issues a Request for Proposal every six years with the option to renew every two years within that period subject to an acceptable agreement being reached between the contractor and the Board. This RFP is being issued at this time to comply with this policy.

14. What are the billing rates for the current actuary/consultant?

ANSWER: Actuary Rate:  
Director - \$495/Hr  
Senior Manager - \$450/Hr  
Manager - \$420/Hr  
Analyst/Consultant - \$250/Hr  
  
Combined Rate: \$292 / Hour

15. What are the total fees that have been paid to the current actuary/consultant over the previous contract period?

ANSWER:

2015: Fully Insured RFP - \$49,277  
Travel Expenses - \$22,779  
Self-Insured RFP - \$25,959  
Hourly Billing – Regular Rates - \$13,181  
Hourly Billing – Composite Rates - \$173,351

2014: Insurance Time Charges - \$21,866

16. Can NDPERS agree to a limitation of liability for its service providers?

ANSWER: State agencies such as NDPERS must comply with N.D.C.C. 32-12.2-15 which restricts agencies from agreeing to limitations on liability except for contracts related to the purchase or lease of, or services related to, software, communication, or electronic equipment and economic forecasting.

17. Can NDPERS agree to alternative dispute resolution (non-jury trial)?

ANSWER: NDPERS will not agree to waive a right to a jury trial in a contract.

18. How are bidders to propose contract modifications to the Agreement for Services (page 18 of the RFP) or the Business Associate Agreement (page 24 of the RFP)?

ANSWER: Bidders can send a markup or redline copy of the contract showing the proposed changes. A Word version of the contract is on the NDPERS Web Site.



**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

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

# Memorandum

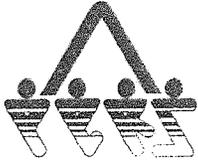
**TO:** PERS Board

**FROM:** Sparb

**DATE:** December 8, 2015

**SUBJECT:** Preferred Provider Organization (PPO) Update

Attached is the letter that was sent to those providers (list attached) that have declined participation as a PPO with the PERS plan or those providers with claim activity and no contract to participate.



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December 1, 2015

### Sample Letter Sent to PPO Declined Providers

Sanford Health Plan has informed us that you are declining participation in the North Dakota Public Employees Retirement System (NDPERS) Preferred Provider Organization (PPO) network. Our records show that you previously participated in the PPO network when administered by Blue Cross Blue Shield of North Dakota. The Sanford Health Plan administers the same NDPERS benefits as previously administered and I have been assured that the provider rates being offered are similar to those that have been offered and accepted by many of the providers in your market.

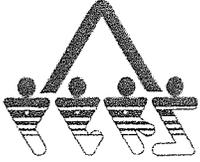
Sanford Health Plan has assembled a robust and extensive provider network, but your participation is important to us and I ask you to reconsider your decision to not participate in the NDPERS PPO network. Your participation in our network allows our members to use your services at a lower out of pocket expense. While this is beneficial to those of our members that already use your services, it is also helpful to our other members who have not used your services but would like to in the future.

Please feel free to contact me to discuss your non-participation status. Should you decide to continue your participation in the NDPERS PPO network, please contact Michelle Bucy, Director of Provider Contracting - Sanford Health Plan, at 701-417-6509.

Thank you for your consideration in this matter.

Sparb Collins, Executive Director  
North Dakota Public Employees Retirement System

- 
- |                                    |                                  |                                   |
|------------------------------------|----------------------------------|-----------------------------------|
| • FlexComp Program                 | • Retirement Programs            | • Retiree Health Insurance Credit |
| • Employee Health & Life Insurance | - Public Employees               | • Deferred Compensation Program   |
| • Dental                           | - Highway Patrol                 | • Long Term Care Program          |
| • Vision                           | - National Guard/Law Enforcement |                                   |
|                                    | - Judges                         |                                   |
|                                    | - Prior Service                  |                                   |
|                                    | - Job Service                    |                                   |



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December 1, 2015

Sample Letter Sent to  
PPO No Response Providers  
PPO Providers with Claim Activity

Sanford Health Plan has informed us that you have not signed a contract to participate in the North Dakota Public Employees Retirement System (NDPERS) Preferred Provider Organization (PPO) network. Our records show that you previously participated in the PPO network when administered by Blue Cross Blue Shield of North Dakota. The Sanford Health Plan administers the same NDPERS benefits as previously administered and I have been assured that the provider rates being offered are similar to those that have been offered and accepted by many of the providers in your market.

Sanford Health Plan has assembled a robust and extensive provider network, but your participation is important to us and I ask you to consider participation in the NDPERS PPO network. Your participation in our network allows our members to use your services at a lower out of pocket expense. While this is beneficial to those of our members that already use your services, it is also helpful to our other members who have not used your services but would like to in the future.

Please feel free to contact me to discuss your non-participation status. Should you decide to continue your participation in the NDPERS PPO network, please contact Michelle Bucy, Director of Provider Contracting - Sanford Health Plan, at 701-417-6509.

Thank you for your consideration in this matter.

Sparb Collins, Executive Director  
North Dakota Public Employees Retirement System



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# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** December 9, 2015  
**SUBJECT:** Infertility Benefit

At the last meeting the Board decided to move forward with developing a method of addressing the infertility deductible issue. The following motion was adopted:

**MR. SANDAL MOVED THAT PERS MAINTAIN THE PLAN DESIGN AND ALLOW MEMBERS THE OPPORTUNITY TO APPEAL THEIR SPECIFIC CASE RELATING TO THE DEDUCTIBLE TO THE BOARD SUBJECT TO A PLAN BEING DEVELOPED AND DETERMINED TO BE LEGALLY ACCEPTABLE. THE MOTION WAS SECONDED BY SENATOR DEVER.**

Based upon the above action, staff reviewed this with Sanford. Attached is their response and proposed approach for implementing the above action. I have referred this to Jan to review to determine its consistency with existing PERS statute. She will report her conclusions to you at the Board meeting. If this approach is acceptable to the Board and is legally acceptable, staff will work with Sanford and Jan to develop an amendment to the agreement.

Sanford Health Plan  
PO Box 91110  
Sioux Falls, SD 57109-1110  
(605) 328-6868  
(877) 305-5463  
sanfordhealthplan.com



December 4, 2015

Sparb Collins  
North Dakota Public Employees Retirement System  
400 E Broadway Ave Suite 505  
PO Box 1657  
Bismarck, ND 58502-1657

RE: Letter to PERS Board – Infertility Benefits

Dear Sparb:

This letter is to summarize the decision made by the NDPERS Board regarding the infertility benefits for the NDPERS medical insurance plan.

The current NDPERS infertility benefit includes a \$500 deductible with a \$20,000 lifetime benefit. During the insurance carrier change from Blue Cross Blue Shield of ND to Sanford Health Plan on July 1, 2015, the infertility benefit started over with a new \$500 deductible and a new \$20,000 lifetime benefit. On November 19<sup>th</sup>, 2015, the NDPERS Board voted to allow a member to appeal to the board if they incurred expenses toward their \$500 deductible prior to July 1, 2015. If the request was granted by the NDPERS Board, the amount that had applied to their \$500 deductible prior to July 1, 2015 would be credited to their current \$500 infertility deductible and reimbursed to the member by Sanford Health Plan.

It was also decided that NDPERS and Sanford Health Plan would annually verify the total number of infertility dollars credited to each member, and as a whole to the insurance plan. At the end of the benefit plan year, Sanford Health Plan will provide the NDPERS board the total “appealed” dollars reimbursed to members for the infertility credit. NDPERS will then reimburse Sanford Health Plan for that dollar amount.

Respectfully,

Sanford Health Plan



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# Memorandum

**TO:** PERS Board  
**FROM:** Sparb  
**DATE:** December 10, 2015  
**SUBJECT:** BCBS Update

In this memo staff is seeking your guidance on how you want us to proceed relating to the PERS data that BCBS retains. Our HIPPA agreement with them states:

d. Effect of Termination.

1. Except as provided in paragraph (2) of this subsection, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI and ePHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI or ePHI.
2. In the event that Business Associate determines that returning or destroying the PHI or ePHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this Agreement to that PHI and ePHI and limit further uses and disclosures of any such PHI and ePHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains that PHI or ePHI.

In discussions with BCBS they indicated they would need to retain the data for several reasons:

1. For doing the final accounting for the 2013-15 biennium. Under our last contract with BCBS we have a close out period of two years for final closing based upon the final accounting. At the last meeting I reported to you the final accounting for the 2011-13

that was completed that biennium's arrangement with BCBS. This would be the similar process followed for the closing of the 2013-15 contract.

2. To handle issues with claims that arise.

To get a perspective on reasonable approaches to this issue we asked Deloitte and Ice Miller for their observations. Their responses are attached.

Based upon the consultant observations, it seems reasonable for BCBS to retain the data for some period, possibly up to 6 or 7 years. It would also seem reasonable for us to enter into an understanding with them as to how long that would be, what happens to the data at the end of that period and how this process would be coordinated between the parties.

Staff is seeking your advice on how you want to proceed.

December 9, 2015

WRITER'S DIRECT NUMBER: (317) 236-5891  
DIRECT FAX: (317) 592-4755  
EMAIL: Christopher.Sears@icemiller.com

**Via Electronic Mail**

**Privileged & Confidential**

Ms. Janilyn Murtha  
Assistant Attorney General  
State of North Dakota  
Office of Attorney General  
State Capital  
600 E. Boulevard Ave., Dept. 125  
Bismarck, ND 58505

***RE: Health Plan Carrier Transition and Protected Health Information***

Dear Jan:

***This letter is given to you in confidence and with the attorney-client privilege. We have not delivered or mailed any copies of this letter to anyone else, other than those individuals noted in this letter. You should disclose the contents of this letter only to those officers or directors who need to know the contents in order to make informed decisions on the matters discussed herein.***

**Background**

This letter is in response to your e-mail of December 2 and also follows up on the call between you, Sparb Collins, and me on December 7. We understand that in 2015 the NDPERS Board voted to award the health insurance carrier bid for the fully-insured uniform group health plan to Sanford Health. Prior to that award Blue Cross/Blue Shield of North Dakota ("BCBS") had been the health insurance carrier for the NDPERS plan for over three decades. Consistent with the terms of the Business Associate Agreement between BCBS and NDPERS ("BAA"), NDPERS requested that BCBS return all protected health information ("PHI") or, if it was unable to do so, to explain the reasons making the return infeasible. BCBS responded in part that it would need to retain the data in order to respond to members about past coverage.

We further understand that NDPERS finds the basis for the response reasonable and under the provisions of the BAA, BCBS would have to continue to maintain the confidentiality of the information. Nevertheless, NDPERS wants to ensure that it is meeting its responsibilities to ensure the appropriate return and confidentiality of this data.

From a statutory standpoint, NDPERS owns the PHI and data related to the group health plan and is obligated to keep it confidential. NDCC 54-52.1-11 and 54-52.1-12 provide statutory

authority regarding the confidentiality and ownership of the data which highlights NDPERS's responsibility in ensuring the data is shared and maintained appropriately. Those statutes read:

**54-52.1-11. Confidentiality of employee records.** Information pertaining to an eligible employee's group medical records for claims, employee premium payments made, salary reduction amounts taken, history of any available insurance coverage purchased, and amounts and types of insurance applied for under the supplemental life insurance coverage under this chapter is confidential and is not a public record. The information and records may be disclosed, under rules adopted by the board, only to:

1. A person to whom the eligible employee has given written authorization to have the information disclosed.
2. A person legally representing the eligible employee, upon proper proof of representation, and unless the eligible employee specifically withholds authorization.
3. A person authorized by a court order.
4. A person or entity to which the board is required to disclose information pursuant to federal or state statutes or regulations.
5. Any person or entity if the purpose of the disclosure is for treatment, payment, or health care operations

**54-52.1-12. Ownership and confidentiality of the uniform group health insurance medical records of employees, retirees, and dependents.** The medical records and related data of the employees, retirees, and dependents, obtained as the result of enrollment in the uniform group insurance program, are the property of the public employees retirement system. The records and data are confidential and are not public records. However, the board may allow administrators of administrative services only contracts or third-party administrators contracts access to the records and data where it is required in the performance of the administrator's duties pursuant to the contract. No administrator may be held liable for furnishing to the board information with respect to any patient, or any physician, hospital, or other health care provider.

You have asked us our perspective regarding industry standards and protocols consistent with the Health Insurance Portability and Accountability Act ("HIPPA") for retention of PHI following a change of carriers.

### **Discussion**

In our experience, a plan sponsor of an insured group health plan generally retains no rights to PHI associated with the group health plan upon the termination of a relationship with an

insurance carrier. That PHI generally remains the property of the insurance carrier. The plan sponsor often makes arrangements with the prior carrier to receive claims information (commonly known as "summary health information" or "aggregate information") so that the plan sponsor can shop the coverage to other carriers; however, this information is usually de-identified. Indeed, the HIPAA privacy regulations exempt a plan sponsor from most privacy obligations under the regulations when the sponsor insures its health plan. In that case, the regulations require the insurer to comply with the privacy regulations because it is the insurer that actually maintains – and usually "owns" – the PHI. *See* 45 C.F.R. § 164.530(k).

NDPERS's relationship with BC/BS with respect to the PHI is made unique by virtue of NDCC 54-52.1-11 and 54-52.1-12 ("Records Statute") which vests ownership in data related to NDPERS's health plans in NDPERS. As we discussed, the Records Statute imposes a duty on NDPERS as owner of the records to ensure that they remain private and secure. We understand that NDPERS has, therefore, entered into a BAA with BC/BS asserting this ownership and ensuring that BC/BS maintains the privacy and security of the records. Also consistent with its privacy and security duties, NDPERS wishes to ensure that the records remain private and secure now that the relationship with BC/BS is terminating and wants to understand how long it should allow BC/BS to retain the records.

BC/BS certainly has legitimate interests in maintaining the records – at least for some amount of time – and it would be reasonable for NDPERS to accommodate BC/BS's reasonable interests in maintaining the records. The exercise is determining the amount of time that is reasonable given NDPERS's desire to mitigate its potential liability under the Records Statute. While we recommend that NDPERS engage in additional discussions with BC/BS to concretely determine the reasons for which BC/BS needs to maintain the data, we suspect that among those reasons are:

- Adjudication of run-out claims after NDPERS has moved to the new carrier;
- To do internal quality assurance on claims that have been adjudicated;
- To defend itself in the event that a member continues to appeal an adjudicated claim or otherwise makes legal claims against BC/BS;
- To have documentation of its actions and practices in the event that it becomes subject to an audit or investigation by the North Dakota Insurance Department or other agencies that might regulate aspects of BC/BS's business; or
- To make claims to excess insurers that might reinsure large claims for BC/BS.

We presume that BC/BS will have other reasons that it needs to maintain the records for some period into the future.

BC/BS's reasons for maintaining the records will be the critical factor in NDPERS's decision about how long it should allow the records to be maintained. Various legal periods could be used as measuring sticks:

- The statute of limitations for individuals to make legal claims against BC/BS for improper or bad faith adjudication of claims might be used. In North Dakota, the statute of limitations for common actions that might be brought against an insurer is six years.
- Although the NDPERS group health plan is not subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), we note that Section 413 of ERISA has a six-year statute of limitations with respect to claims for breach of fiduciary duty. Furthermore, Section 107 of ERISA has a six-year document retention requirement for all records pertaining to agency filings or to participant or beneficiary disclosures. We do note, however, that Section 209 of ERISA contains an open-ended document retention requirement for all records required to determine the benefits due under an employee benefit plan. Under that standard, records must be maintained for as long as they may be relevant to a determination of benefits entitlement. However, if an individual is no longer entitled to a health benefit after the passage of a statute of limitations, then the statute of limitations may still be the controlling standard.
- The HIPAA privacy regulations require that documentation related to compliance with the HIPAA privacy regulations be maintained for at least six years from the date of the creation of the documentation.
- Reference could be made to the ability of a governmental agency (such as the North Dakota Insurance Department) to audit BC/BS for regulatory or licensure matters. For example, in the ERISA context, the U.S. Internal Revenue Service and Department of Labor will generally not audit more than the most recent three prior years.

We would strongly suggest that NDPERS consult with BC/BS and require BC/BS to provide each reason that requires it to maintain the records after the termination of the relationship with NDPERS. NDPERS should also require BC/BS to indicate the time it believes it must continue to maintain the records based on those stated reasons. NDPERS should also ask whether BC/BS has a document retention policy that already defines when records such as these would be destroyed. Indeed, given the lengthy relationship with NDPERS, BC/BS may have already destroyed information related to NDPERS's health plans over the years. NDPERS may very well find BC/BS's document retention policy adequate for purposes of determining how long BC/BS should be able to maintain the records in the future. This should be a collaborative process to ensure that members' health information is maintained for no longer than necessary and that, while it is maintained, the privacy and security of the records are observed. BC/BS should be reminded that this is not the typical situation given the Records Statute applicable to NDPERS's data cited above.

When consensus is reached with regard to the future maintenance of the records, we would recommend that an amendment be crafted to the BAA that reaffirms BC/BS responsibilities to maintain the privacy and security of the records and to notify NDPERS of any

Ms. Janilyn Murtha  
December 9, 2015  
Page 5

breaches of privacy or security. The amendment should also clearly set forth the agreed upon period during which the records may be maintained by BC/BS and that the records will either be destroyed or returned to NDPERS at the end of the maintenance period.

We hope that this letter provides some perspective on how to approach the records issues as NDPERS transitions out of its relationship with BC/BS. We would be happy to discuss these matters with you at your convenience.

Very truly yours,

ICE MILLER LLP

A handwritten signature in black ink, appearing to read "Christopher S. Sears". The signature is written in a cursive style with a long horizontal flourish at the end.

Christopher S. Sears

cc: Mr. Sparb Collins

## Memo

**Date:** December 7, 2015  
**To:** Sparb Collins  
**From:** Robert Davis, Josh Johnson and Pat Pechacek  
**Subject:** CARRIER RETENTION OF HEALTH CARE DATA

Deloitte was asked to comment on the standard industry practices and potential legal implications around the retention and handling of health care data by the prior NDPERS medical carrier Blue Cross Blue Shield of North Dakota (BCBS).

The following summarizes our findings and thoughts in this regard.

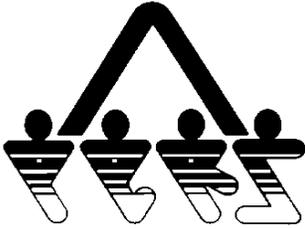
Insurance carriers typically own all data under fully insured arrangements and therefore have control over how it is handled (governed by federal privacy regulations like HIPAA). The fact that North Dakota law states that the data is owned by NDPERS regardless of the insurance contract type makes this a relatively unique situation.

### LEGAL CONSIDERATIONS

There does not appear to be any question that, under North Dakota law, NDPERS owns the data at issue. However, because BCBS is a covered entity and much/all of the data likely is protected health information (PHI) for HIPAA purposes, there are significant limitations on BCBS's ability to give the data back to NDPERS. As a result, BCBS will need to continue to hold the data.

ERISA plans generally must maintain plan data for a minimum of six years. Other federal and state recordkeeping laws may require a longer period for data retention. At a minimum, other plans – both ERISA and non-ERISA plans – appear to maintain health plan data for a period of at least 7 years. Even though the NDPERS plan is not an ERISA plan, it is possible these other federal and state recordkeeping requirements could apply. Thus, the best practice may be to retain the data for at least 7 years. BCBS should already have procedures in place for doing this.

Once the data has been maintained for the appropriate time period, the typical practice is for it to be destroyed. Because NDPERS owns the data, it should be able to direct BCBS to destroy it if BCBS does not automatically do so. Again, to the extent the data includes PHI, it must be destroyed in a manner consistent with HIPAA's privacy standards.



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# Memorandum

**TO:** NDPERS Board

**FROM:** Kathy Allen

**DATE:** December 8, 2015

**SUBJECT:** Member Rebate Program Update

At the August meeting, the Board was provided information regarding the status of re-establishing the Member Rebate Program with Sanford Health Plan. Options for this implementation were provided for the Board's consideration. In lieu of taking action at that time, the Board requested additional information regarding the responsibilities and payment obligations of BCBS under the program. At the September meeting, legal counsel indicated that based on language in the Administrative Services Agreement between BCBS and PERS and the Certificate of Insurance, BCBS did have discretion with regard to administration of the program. Based on this information the Board took action to have Sanford Health Plan re-establish the Member Rebate Program effective July 1, 2016. The motion further directed that inactive accounts not be set up and that the account balance refunded to PERS by BCBS be transferred to the reserve account.

Following the Board's action, we requested that Sanford Health Plan provide us with its proposal with regard to implementing and administering the plan. Following is the response:

## **NDPERS Member Rebate Account Plan Options History**

BCBSND passed a portion of their pharmacy rebates directly to NDPERS members. The rebated portion is based on a percentage of the out-of-pocket expenses, less the member copay. BCBSND established a Member Rebate Account (MRA) for each member and calculated the rebate amount 12-15 months after the purchase and transferred the dollars into the individual's account.

Prior to 2006, members received rebate checks in the mail. In 2006, the members were able to use their accumulated rebate dollars toward new prescription purchases. The account was automatically reduced from their account to pay for new drugs. Members had to call BCBSND to get their account balance, there was no online service. The MRA was updated quarterly. However, claims were on a real-time basis. Only certain brand-name drugs on the BCBSND formulary were eligible for a rebate. On January 1, 2015, BCBSND terminated the MRA program for NDPERS.

## **Current State**

In the RFP, Sanford Health Plan proposed a deviation from the BCBSND MRA process. Sanford Health Plan proposes the following two options for MRA configuration.

1. Via a Debit Card. Sanford Health Plan will establish the Member Rebate Program using Evolution1 Software.
  - Members will be issued a debit card to pay for prescription drugs at the point of sale.
  - This is not an HRA account, no substantiation is needed.
  - Members will have an online Member Rebate Program account where they can view their rebate balances.
  - The account will have an unending plan year, so balances transfer from year to year.
2. Via a quarterly check. Sanford Health Plan will issue a quarterly check to the member in the rebate amount owed to them.

## **Staff Recommendation**

Staff recommends that members be reimbursed by quarterly check with a set minimum amount. If the minimum isn't met during any quarter, the amount would be carried forward and distributed at such time as the minimum is met in a future quarter.

## **Decision Points:**

1. Does PERS want to discontinue the program? If so, discuss creating reserve account for PERS use to buy down future increases.
2. Does PERS want a portion of the rebate dollars to go to the members and a portion to go to NDPERS (i.e. 50% is allocated to Members and 50% is allocated to an NDPERS reserve fund)?
3. Does PERS want rebate dollars distributed based on member utilization of brand name drugs? This may create an unintentional "reward" for using more expensive brand name drugs. However, it also helps mitigate the cost of more expensive brand name drugs. SHP would do quarterly distribution of funds.
4. Does PERS want rebate dollars to be distributed equally to all members, regardless of drug utilization? For example, if rebate is \$1M and there are 30,000 subscribers, each subscriber would get a rebate in the amount of \$33.00. SHP would do quarterly distribution of funds.
5. The MRA is in the NDPERS contract. If the Board chooses to discontinue the program, or change how the rebate dollars are used, then we may need to amend the contract.

Representatives of SHP will be available to respond to any questions.

## **Board Action Requested**

- Action on staff recommendation.
- Provide SHP with guidance on how the Board wishes to proceed with implementation and administration of the Member Rebate Program based on decision points listed above.



# Memo

To: NDPERS Board  
From: Bryan T. Reinhardt  
Date: 12/10/2015  
Re: 457 Companion Plan & 401(a) Plan 3rd Quarter 2015 Report

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Here is the 3rd quarter 2015 investment report for the 401(a) & 457 Companion Plan. The reports are available separately on the NDPERS web site. The NDPERS Investment Subcommittee reviewed the 3rd quarter reports.

Assets in the 401(a) plan decreased to \$33.4 million as of September 30, 2015. The number of participants is at 324 (255 active), up slightly from when the plan started. The largest funds are the TIAA-CREF Lifecycle funds with 67% of assets.

Assets in the 457 Companion Plan decreased to \$69.9 million as of September 30, 2015. The number of participants is increasing and is now at 6,033 (4,462 active). The largest funds are the TIAA-CREF Lifecycle funds with 74% of assets.

## Benchmarks:

Fund returns for the quarter were mostly negative (except the Money Market, Stable Value and Real Estate Funds). Core fund performance was mixed when compared to their benchmarks and peer funds. Note that index funds are expected to slightly underperform their benchmarks because of fund administration fees.

## Fund / Investment News:

The NDPERS Investment Subcommittee reviewed an investment update from RIO, and started work on reviewing the investment policies for the plans. The committee reviewed the 3rd quarter plan and investment overview with TIAA-CREF. It was recommended by the committee that we consider including this report in the Board materials. The Subcommittee marked the PIMCO Real Return Fund (PARRX), PIMCO Total Return Fund (PTRAX), Templeton Global Bond (TGBAX), T.Rowe Price Equity Income Fund (PRFDX), Wells Fargo Growth Admin Fund (SGRXX), RidgeWorth Mid Cap Fund (SMVTX), ASTON/Fairpointe Mid Cap Fund (ABMIX), and Vanguard Total Intl Fund (VGTSX) as underperforming for the quarter. The Investment Subcommittee reviewed the investment lineup with TIAA-CREF and recommends adding the Vanguard Total Bond Fund (VBTKX) to the core lineup.

## **Board Action Requested:**

Add the Vanguard Total Bond Fund (VBTKX) to the core lineup for the 401(a) and 457 Companion plans.

NDPERS  
Quarterly Investment Report  
3rd Quarter  
7/1/2015 – 9/30/2015



North Dakota Public Employees Retirement System  
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## NDPERS 401(a) Defined Contribution Plan & 457 Companion Plan - TIAA-CREF

<b>INITIAL OFFERING:</b>			
	Hartford Dividend & Growth T.Rowe Price Equity Income	Vanguard 500 Index Signal Vanguard Dividend Growth	Franklin Growth Adv Wells Fargo Adv Growth Adm
			<b>LARGE</b>
	RidgeWorth Mid Cap Value Equity I	ASTON/Fairpointe Mid Cap I Columbia Mid Cap Index A	Prudential Jennison Mid Cap Growth Z
			<b>MEDIUM</b>
	Allianz NFJ Small Cap Value	DFA US Small Cap	Brown Capital Mgmt Small Co Inv
			<b>SMALL</b>
	<b>VALUE</b>	<b>BLEND</b>	<b>GROWTH</b>
<b>BALANCED FUND:</b>	T.Rowe Price Capital Appreciation		
<b>INCOME FUNDS:</b>	Wells Fargo Stable Value Fund J	Vanguard Prime Money Market	
<b>BOND FUNDS:</b>	PIMCO Total Return Bond Fund	Prudential High Yield Z	
	PIMCO Real Return Admin Bond Fund	Templeton Global Bond	
<b>REAL ESTATE:</b>	Cohen & Steers Realty Shares		
<b>INTERNATIONAL FUNDS:</b>	Mutual Global Discovery Z	Vanguard Total Intl Stock Index	Oppenheimer Developing Markets Y
<b>LIFESTYLE FUNDS:</b>	TIAA-CREF Lifecycle Ret Income	TIAA-CREF Lifecycle 2025	TIAA-CREF Lifecycle 2045
	TIAA-CREF Lifecycle 2010	TIAA-CREF Lifecycle 2030	TIAA-CREF Lifecycle 2050
	TIAA-CREF Lifecycle 2015	TIAA-CREF Lifecycle 2035	TIAA-CREF Lifecycle 2055
	TIAA-CREF Lifecycle 2020	TIAA-CREF Lifecycle 2040	TIAA-CREF Lifecycle 2060
<b>FUND STYLE CHANGES:</b>			
			<b>LARGE</b>
	ASTON/Fairpointe Mid Cap I		
			<b>MEDIUM</b>
			<b>SMALL</b>
	<b>VALUE</b>	<b>BLEND</b>	<b>GROWTH</b>
<b>OTHER FUNDS:</b>			
<b>CURRENT LINEUP:</b>			
	Hartford Dividend & Growth T.Rowe Price Equity Income	Vanguard 500 Index Signal Vanguard Dividend Growth	Franklin Growth Adv Wells Fargo Adv Growth Adm
			<b>LARGE</b>
	ASTON/Fairpointe Mid Cap I RidgeWorth Mid Cap Value Equity	Columbia Mid Cap Index A	Prudential Jennison Mid Cap Growth Z
			<b>MEDIUM</b>
	Allianz NFJ Small Cap Value	DFA US Small Cap	Brown Capital Mgmt Small Co Inv
			<b>SMALL</b>
	<b>VALUE</b>	<b>BLEND</b>	<b>GROWTH</b>
<b>BALANCED FUND:</b>	T.Rowe Price Capital Appreciation		
<b>INCOME FUNDS:</b>	Wells Fargo Stable Value Fund J	Vanguard Prime Money Market	
<b>BOND FUNDS:</b>	PIMCO Total Return Bond Fund	Prudential High Yield Z	
	PIMCO Real Return Admin Bond Fund	Templeton Global Bond	
<b>REAL ESTATE:</b>	Cohen & Steers Realty Shares		
<b>INTERNATIONAL FUNDS:</b>	Mutual Global Discovery Z	Vanguard Total Intl Stock Index	Oppenheimer Developing Markets Y
<b>LIFESTYLE FUNDS:</b>	TIAA-CREF Lifecycle Ret Income	TIAA-CREF Lifecycle 2025	TIAA-CREF Lifecycle 2045
	TIAA-CREF Lifecycle 2010	TIAA-CREF Lifecycle 2030	TIAA-CREF Lifecycle 2050
	TIAA-CREF Lifecycle 2015	TIAA-CREF Lifecycle 2035	TIAA-CREF Lifecycle 2055
	TIAA-CREF Lifecycle 2020	TIAA-CREF Lifecycle 2040	TIAA-CREF Lifecycle 2060

## NDPERS Investment Benchmarks - 3rd Quarter 2015

	<u>Quarter</u>	<u>Y-T-D</u>	<u>1-Year</u>	<u>3-Year</u>	<u>5-Year</u>
<u>Stable Value / Money Market Fund</u>					
<b>Vanguard Prime Money Market - VMMXX</b>	0.01%	0.02%	0.02%	0.02%	0.03%
<b>Wells Fargo Stable Return Fund J - WFSJ#</b>	0.22%	0.61%	0.81%	0.83%	1.11%
3 Month T-Bill Index	0.01%	0.02%	0.02%	0.04%	0.06%
<u>Fixed Income Fund</u>					
<b>PIMCO Real Return Admin - PARRX</b>	-1.87%	-2.13%	-2.90%	-2.58%	1.92%
<b>PIMCO Total Return Bond Fund - PTRAX &lt;ON WATCH&gt;</b>	-0.15%	0.06%	1.32%	1.11%	2.98%
Barclays Aggregate Bond Index	1.23%	1.13%	2.94%	1.71%	3.10%
Taxable Bond Fund Universe	1.35%	1.43%	N/A	1.90%	3.26%
<b>Prudential High Yield Z - PHYZX</b>	-3.35%	-0.79%	-1.30%	4.06%	6.32%
ML High Yield Bond Fund Index	-4.90%	-2.53%	-3.57%	3.47%	5.94%
High Yield Bond Fund Universe	N/A	N/A	N/A	N/A	N/A
<b>Templeton Global Bond Adv - TGBAX</b>	-6.11%	-6.15%	-7.69%	0.54%	2.41%
Citi World Govt Bond Index	1.71%	-2.38%	-3.57%	3.47%	5.94%
World Bond Fund Universe	N/A	N/A	N/A	N/A	N/A
<u>Real Estate Fund</u>					
<b>Cohen &amp; Steers Realty Shares - CSRSX</b>	2.59%	-2.64%	11.65%	10.06%	11.69%
FTSE NAREIT All Equity REITs Index	2.00%	-3.79%	9.88%	9.59%	12.00%
Real Estate Fund Universe	0.30%	-4.96%	N/A	8.15%	11.14%
<u>Balanced Fund</u>					
<b>T.Rowe Price Capital Appreciation - PACLX</b>	-2.83%	0.62%	5.40%	11.82%	11.95%
60% Large Cap Value Univ & 40% Taxable Bond Universe	-3.83%	-4.08%	N/A	6.09%	7.56%
60% Russell 1000 Value & 40% Agg Bond Index	-4.54%	-4.92%	-1.48%	7.64%	8.61%
<u>Large Cap Equities - Value</u>					
<b>Hartford Dividend &amp; Growth - HDGTX</b>	-7.02%	-7.04%	-3.14%	11.35%	11.59%
<b>T.Rowe Price Equity Income - PRFDX &lt;On Watch&gt;</b>	-10.24%	-11.67%	-9.01%	7.88%	9.73%
Russell 1000 Value Index	-8.39%	-8.96%	-4.42%	11.59%	12.29%
Large Cap Value Fund Universe	-7.28%	-7.75%	N/A	8.88%	10.43%
<u>Large Cap Equities - Blend</u>					
<b>Vanguard 500 Index Signal - VIFSX</b>	-6.45%	-5.30%	-0.64%	12.36%	13.30%
<b>Vanguard Dividend Growth Fund - VDIGX</b>	-3.26%	-3.94%	1.34%	12.07%	13.02%
S&P 500 Index	-6.44%	-5.29%	-0.61%	12.40%	13.34%
Large Cap Blend Fund Universe	-6.36%	-5.13%	N/A	12.07%	13.34%
<u>Large Cap Equities - Growth</u>					
<b>Wells Fargo Adv Growth Adm - SGRKX &lt;ON WATCH&gt;</b>	-8.43%	-3.51%	1.08%	9.30%	13.95%
Russell 3000 Growth Index	-5.93%	-1.86%	3.21%	13.54%	14.38%
<b>Franklin Growth Adv - FCGAX</b>	-5.95%	-2.89%	3.20%	13.69%	12.72%
Russell 1000 Growth Index	-5.29%	-1.54%	3.17%	13.61%	14.47%
Large Cap Growth Fund Universe	-5.24%	0.09%	N/A	13.84%	15.29%
<u>Mid Cap Equities - Value</u>					
<b>RidgeWorth Mid Cap Value Equity I - SMVTX</b>	-10.41%	-11.32%	-7.03%	11.04%	10.88%
Russell Mid Cap Value	-8.04%	-7.66%	-2.07%	13.69%	13.15%
Mid Cap Value Fund Universe	-6.88%	-6.54%	N/A	15.63%	13.48%
<u>Mid Cap Equities - Blend</u>					
<b>Columbia Mid Cap Index A - NTIAX</b>	-8.57%	-4.92%	0.96%	12.61%	12.45%
S&P Mid Cap 400	-8.50%	-4.66%	1.40%	13.12%	12.93%
<b>ASTON/Fairpointe Mid Cap I - ABMIX</b>	-14.59%	-14.53%	-10.72%	11.90%	10.95%
Wilshire 4500 Index	-9.78%	-5.58%	0.77%	13.29%	12.98%
Mid Cap Blend Fund Universe	-8.05%	-5.08%	N/A	14.43%	13.78%
<u>Mid Cap Equities - Growth</u>					
<b>Prudential Jennison Mid Cap Growth Z - PEGZX</b>	-9.59%	-5.05%	1.18%	10.05%	11.94%
Russell Mid Cap Growth	-7.99%	-4.15%	1.45%	13.98%	13.58%
Mid Cap Growth Fund Universe	-8.81%	-3.10%	N/A	12.98%	13.02%
<b>Fund Returns in RED do not meet both benchmarks. Fund Returns in BLACK meet both benchmarks.</b>					

## NDPERS Investment Benchmarks - 3rd Quarter 2015

	<u>Quarter</u>	<u>Y-T-D</u>	<u>1-Year</u>	<u>3-Year</u>	<u>5-Year</u>
<b>Small Cap Equities - Value</b>					
<b>Allianz NFJ Small Cap Value - PVADX</b>	<b>-9.51%</b>	<b>-8.84%</b>	<b>-7.42%</b>	<b>7.87%</b>	<b>9.11%</b>
Russell 2000 Value Index	-10.73%	-10.06%	-1.60%	9.18%	10.17%
Small Value Fund Universe	-9.92%	-11.11%	N/A	11.32%	11.91%
<b>Small Cap Equities - Blend</b>					
<b>DFA US Small Cap - DFSTX</b>	<b>-9.80%</b>	<b>-5.84%</b>	<b>2.41%</b>	<b>12.99%</b>	<b>13.44%</b>
Russell 2000 Index	-11.92%	-7.73%	1.25%	11.02%	11.73%
Small Blend Fund Universe	-10.94%	-7.74%	N/A	11.70%	12.29%
<b>Small Cap Equities - Growth</b>					
<b>Brown Capital Mgmt Small Co Inv - BCSIX</b>	<b>-6.84%</b>	<b>-0.42%</b>	<b>8.48%</b>	<b>15.83%</b>	<b>15.67%</b>
Russell 2000 Growth Index	-13.06%	-5.47%	4.04%	12.85%	13.26%
Small Growth Fund Universe	-11.38%	-4.30%	N/A	11.66%	13.00%
<b>International Equity Funds</b>					
<b>Mutual Global Discovery Z - MDISX</b>	<b>-9.48%</b>	<b>-6.93%</b>	<b>-5.99%</b>	<b>8.07%</b>	<b>7.49%</b>
<b>Vanguard Total Intl Stock Index Inv - VGTSX</b>	<b>-11.61%</b>	<b>-6.81%</b>	<b>-10.72%</b>	<b>3.13%</b>	<b>N/A</b>
MSCI EAFE	-9.79%	-4.28%	-7.54%	6.20%	4.39%
International Stock Fund Universe	N/A	N/A	N/A	N/A	N/A
<b>Oppenheimer Developing Markets Y - ODVYX</b>	<b>-17.28%</b>	<b>-17.68%</b>	<b>-23.19%</b>	<b>-3.69%</b>	<b>-1.47%</b>
MSCI Emerging Markets Index	-17.90%	-15.47%	-19.28%	-5.27%	-3.58%
Diversified Emerging Mkts Universe	N/A	N/A	N/A	N/A	N/A
<b>Asset Allocation Funds:</b>					
<b>TIAA-CREF Lifecycle Ret Income - TLIRX</b>	<b>-3.64%</b>	<b>-1.65%</b>	<b>-0.36%</b>	<b>4.48%</b>	<b>5.85%</b>
Income Benchmark	-2.80%	-1.65%	0.04%	5.08%	5.76%
<b>TIAA-CREF Lifecycle 2010 - TCLEX</b>	<b>-4.03%</b>	<b>-1.87%</b>	<b>-0.43%</b>	<b>5.21%</b>	<b>6.47%</b>
2010 Benchmark	-3.45%	-2.09%	-0.32%	5.76%	6.39%
<b>TIAA-CREF Lifecycle 2015 - TCLIX</b>	<b>-4.53%</b>	<b>-2.07%</b>	<b>-0.54%</b>	<b>5.80%</b>	<b>6.97%</b>
2015 Benchmark	-4.04%	-2.49%	-0.67%	6.35%	6.92%
<b>TIAA-CREF Lifecycle 2020 - TCLTX</b>	<b>-5.24%</b>	<b>-2.50%</b>	<b>-0.84%</b>	<b>6.56%</b>	<b>7.57%</b>
2020 Benchmark	-4.83%	-3.02%	-1.16%	7.11%	7.59%
<b>TIAA-CREF Lifecycle 2025 - TCLFX</b>	<b>-5.93%</b>	<b>-2.94%</b>	<b>-1.15%</b>	<b>7.30%</b>	<b>8.13%</b>
2025 Benchmark	-5.60%	-3.55%	-1.64%	7.86%	8.27%
<b>TIAA-CREF Lifecycle 2030 - TCLNX</b>	<b>-6.75%</b>	<b>-3.46%</b>	<b>-1.59%</b>	<b>7.94%</b>	<b>8.63%</b>
2030 Benchmark	-6.00%	-3.86%	-1.73%	8.50%	8.75%
<b>TIAA-CREF Lifecycle 2035 - TCLRX</b>	<b>-7.48%</b>	<b>-3.92%</b>	<b>-1.97%</b>	<b>8.56%</b>	<b>9.09%</b>
2035 Benchmark	-6.75%	-4.38%	-2.21%	9.20%	9.34%
<b>TIAA-CREF Lifecycle 2040 - TCLOX</b>	<b>-8.22%</b>	<b>-4.36%</b>	<b>-2.40%</b>	<b>8.82%</b>	<b>9.27%</b>
2040 Benchmark	-7.19%	-4.68%	-2.49%	9.62%	9.68%
<b>TIAA-CREF Lifecycle 2045 - TFRX</b>	<b>-8.23%</b>	<b>-4.38%</b>	<b>-2.46%</b>	<b>8.81%</b>	<b>9.21%</b>
2045 Benchmark	-7.20%	-4.69%	-2.50%	9.62%	9.68%
<b>TIAA-CREF Lifecycle 2050 - TLFrx</b>	<b>-8.24%</b>	<b>-4.39%</b>	<b>-2.49%</b>	<b>8.77%</b>	<b>9.23%</b>
2050 Benchmark	-7.20%	-4.68%	-2.51%	9.61%	9.68%
<b>TIAA-CREF Lifecycle 2055 - TTRLX</b>	<b>-8.23%</b>	<b>-4.41%</b>	<b>-2.42%</b>	<b>8.79%</b>	<b>N/A</b>
2055 Benchmark	-7.20%	-4.68%	-2.51%	9.61%	9.68%
<b>TIAA-CREF Lifecycle 2060 - TTRLX</b>	<b>-8.25%</b>	<b>-4.35%</b>	<b>-2.40%</b>	<b>N/A</b>	<b>N/A</b>
2060 Benchmark	-7.20%	-4.68%	-2.51%	9.61%	9.68%
Income Benchmark is comprised of 27.5% Wilshire 5000, 12.5% MSCI EAFE, 47.4% Ag Bond, 2.5% ML HY Bond, 10.1% 3 Month T-Bill					
2010 Benchmark is comprised of 32.6% Wilshire 5000, 14.5% MSCI EAFE, 42.8% Ag Bond, 2.8% ML HY Bond, 7.3% 3 Month T-Bill					
2015 Benchmark is comprised of 36.9% Wilshire 5000, 16.4% MSCI EAFE, 38.1% Ag Bond, 3.4% ML HY Bond, 5.2% 3 Month T-Bill					
2020 Benchmark is comprised of 42.5% Wilshire 5000, 18.8% MSCI EAFE, 31.1% Ag Bond, 4.4% ML HY Bond, 3.2% 3 Month T-Bill					
2025 Benchmark is comprised of 48.1% Wilshire 5000, 21.1% MSCI EAFE, 24.2% Ag Bond, 5.4% ML HY Bond, 1.2% 3 Month T-Bill					
2030 Benchmark is comprised of 53.8% Wilshire 5000, 23.4% MSCI EAFE, 22.8% Ag Bond					
2035 Benchmark is comprised of 59.4% Wilshire 5000, 25.8% MSCI EAFE, 14.8% Ag Bond					
2040 Benchmark is comprised of 62.7% Wilshire 5000, 27.2% MSCI EAFE, 10.1% Ag Bond					
2045 Benchmark is comprised of 62.7% Wilshire 5000, 27.3% MSCI EAFE, 10.0% Ag Bond					
2050 Benchmark is comprised of 62.6% Wilshire 5000, 27.4% MSCI EAFE, 10.0% Ag Bond					
2055&2060 Benchmark is comprised of 62.6% Wilshire 5000, 27.4% MSCI EAFE, 10.0% Ag Bond					
Wilshire 5000 Index	-7.42%	-5.79%	-1.18%	12.37%	13.04%
MSCI EAFE	-9.79%	-4.28%	-7.54%	6.20%	4.39%
Barclays Aggregate Bond Index	1.23%	1.13%	2.94%	1.71%	3.10%
ML High Yield Bond Fund Index	-4.90%	-2.53%	-3.57%	3.47%	5.94%
3 Month T-Bill Index	0.01%	0.02%	0.02%	0.04%	0.06%
<b>Fund Returns in RED do not meet both benchmarks. Fund Returns in BLACK meet both benchmarks.</b>					

## DC 401(a) Plan

401(a)	Assets	Pct
TIAA-CREF Lifecycle 2030 Fund Retirement	\$5,170,331	15.5%
TIAA-CREF Lifecycle 2025 Fund Retirement	\$4,792,317	14.3%
TIAA-CREF Lifecycle 2035 Fund Retirement	\$4,446,394	13.3%
TIAA-CREF Lifecycle 2020 Fund Retirement	\$3,520,606	10.5%
TIAA-CREF Lifecycle 2040 Fund Retirement	\$1,334,390	4.0%
TIAA-CREF Lifecycle 2015 Fund Retirement	\$1,266,143	3.8%
Wells Fargo Stable Return Fund - J	\$1,141,068	3.4%
TIAA-CREF Lifecycle 2010 Fund Retirement	\$1,125,593	3.4%
Vanguard Total International Stock Index Fund Admiral	\$883,217	2.6%
Vanguard 500 Index Fund Admiral	\$863,500	2.6%
Wells Fargo Advantage Growth Fund Administrator	\$726,550	2.2%
Vanguard Prime Money Market Fund Investor	\$709,210	2.1%
PIMCO Total Return Fund Admin	\$665,634	2.0%
Franklin Growth Fund Advisor	\$567,299	1.7%
Cohen & Steers Realty Shares	\$494,276	1.5%
Self Directed Brokerage Account	\$486,380	1.5%
T. Rowe Price Equity Income Fund	\$468,934	1.4%
AllianzGI NFJ Small Cap Value Fund Administrative	\$467,537	1.4%
T. Rowe Price Capital Appreciation Fund Advisor	\$435,383	1.3%
ASTON/Fairpointe Mid Cap Fund I	\$415,124	1.2%
Vanguard Dividend Growth Fund Investor	\$341,839	1.0%
TIAA-CREF Lifecycle 2045 Fund Retirement	\$339,936	1.0%
Hartford Dividend and Growth Fund R5	\$289,459	0.9%
Columbia Mid Cap Index Fund A	\$274,092	0.8%
Oppenheimer Developing Markets Fund Y	\$273,647	0.8%
RidgeWorth Mid Cap Value Equity Fund I	\$262,089	0.8%
Franklin Mutual Global Discovery Fund Z	\$250,531	0.7%
Prudential Jennison Mid-Cap Growth Fund Z	\$215,401	0.6%
TIAA-CREF Lifecycle Retirement Income Fund Retirement	\$209,787	0.6%
Templeton Global Bond Fund Advisor	\$188,342	0.6%
Prudential High Yield Fund Z	\$186,437	0.6%
Brown Capital Management Small Company Fund Institutional	\$177,678	0.5%
PIMCO Real Return Fund Administrative	\$170,903	0.5%
TIAA-CREF Lifecycle 2050 Fund Retirement	\$152,477	0.5%
TIAA-CREF Lifecycle 2055 Fund Retirement	\$72,006	0.2%
DFA U.S. Small Cap Portfolio Institutional	\$50,528	0.2%
TIAA-CREF Lifecycle 2060 Fund Retirement	\$0	0.0%
TIAA-CREF Money Market Fund Retirement	\$0	0.0%
<b>Total</b>	<b>\$33,435,037</b>	<b>100.0%</b>

## 457 Companion Plan

457(b)	Assets	Pct
TIAA-CREF Lifecycle 2020 Fund Retirement	\$11,384,720	16.3%
TIAA-CREF Lifecycle 2025 Fund Retirement	\$11,103,717	15.9%
TIAA-CREF Lifecycle 2015 Fund Retirement	\$7,314,719	10.5%
TIAA-CREF Lifecycle 2030 Fund Retirement	\$7,126,498	10.2%
TIAA-CREF Lifecycle 2035 Fund Retirement	\$4,517,543	6.5%
TIAA-CREF Lifecycle 2040 Fund Retirement	\$3,444,017	4.9%
TIAA-CREF Lifecycle 2045 Fund Retirement	\$2,710,572	3.9%
Vanguard 500 Index Fund Admiral	\$2,397,751	3.4%
TIAA-CREF Lifecycle 2010 Fund Retirement	\$1,899,773	2.7%
TIAA-CREF Lifecycle 2050 Fund Retirement	\$1,613,989	2.3%
Vanguard Total International Stock Index Fund Admiral	\$1,479,985	2.1%
PIMCO Total Return Fund Admin	\$1,418,838	2.0%
AllianzGI NFJ Small Cap Value Fund Administrative	\$1,306,674	1.9%
Wells Fargo Stable Return Fund - J	\$1,260,552	1.8%
Vanguard Dividend Growth Fund Investor	\$975,007	1.4%
Columbia Mid Cap Index Fund A	\$958,421	1.4%
Franklin Growth Fund Advisor	\$849,160	1.2%
T. Rowe Price Equity Income Fund	\$802,752	1.1%
Wells Fargo Advantage Growth Fund Administrator	\$744,136	1.1%
Vanguard Prime Money Market Fund Investor	\$681,901	1.0%
T. Rowe Price Capital Appreciation Fund Advisor	\$627,569	0.9%
Cohen & Steers Realty Shares	\$615,540	0.9%
Templeton Global Bond Fund Advisor	\$589,116	0.8%
ASTON/Fairpointe Mid Cap Fund I	\$452,989	0.6%
Oppenheimer Developing Markets Fund Y	\$402,342	0.6%
Hartford Dividend and Growth Fund R5	\$401,583	0.6%
TIAA-CREF Lifecycle Retirement Income Fund Retirement	\$349,839	0.5%
Prudential High Yield Fund Z	\$334,363	0.5%
Prudential Jennison Mid-Cap Growth Fund Z	\$322,245	0.5%
PIMCO Real Return Fund Administrative	\$299,165	0.4%
Self Directed Brokerage Account	\$297,893	0.4%
Franklin Mutual Global Discovery Fund Z	\$284,862	0.4%
RidgeWorth Mid Cap Value Equity Fund I	\$282,307	0.4%
Brown Capital Management Small Company Fund Institutional	\$255,046	0.4%
TIAA-CREF Lifecycle 2055 Fund Retirement	\$218,763	0.3%
DFA U.S. Small Cap Portfolio Institutional	\$139,084	0.2%
TIAA-CREF Lifecycle 2060 Fund Retirement	\$25	0.0%
TIAA-CREF Money Market Fund Retirement	\$0	0.0%
<b>Total</b>	<b>\$69,863,454</b>	<b>100.0%</b>

# Vanguard Total Bond Market Index Fund

Admiral Class (VBTLX)

As of 09/30/15

## Portfolio Strategies

The investment seeks the performance of a broad, market-weighted bond index. The fund employs an indexing investment approach designed to track the performance of the Barclays U.S. Aggregate Float Adjusted Index. This Index represents a wide spectrum of public, investment-grade, taxable, fixed income securities in the United States—including government, corporate, and international dollar-denominated bonds, as well as mortgage-backed and asset-backed securities—all with maturities of more than 1 year. All of the fund's investments will be selected through the sampling process, and at least 80% of the fund's assets will be invested in bonds held in the index.

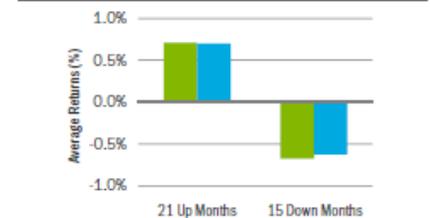
Performance							
Fund Name	Total Return		Average Annual Total Return				
	QTD	YTD	1 Yr	3 Yr	5 Yr	10 Yr	SI
Vanguard Total Bond Market Index Fund	1.18%	1.01%	2.75%	1.58%	2.98%	4.60%	4.49%
Barclays U.S. Aggregate Float Adjusted Index	1.19%	1.06%	2.83%	1.67%	3.09%	-	-
Barclays U.S. Aggregate Bond Index	1.23%	1.13%	2.94%	1.71%	3.10%	4.64%	4.65%
Morningstar Peer Group: Intermediate-Term Bond							
Median Quartile	0.52%	0.51%	1.75%	1.56%	3.23%	4.48%	-
Percentile Rank	-	-	13	48	60	42	-
Number of Funds in Peer Group	-	-	1,048	945	831	589	Overall: 945
Morningstar Rating	-	-	-	★★★	★★★	★★★	★★★

Calendar Year Performance										
	2005 – 2014									
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Vanguard Total Bond Market Index Fund	2.49%	4.36%	7.02%	5.15%	6.04%	6.54%	7.69%	4.15%	-2.15%	5.89%
Barclays U.S. Aggregate Float Adjusted Index						6.58%	7.92%	4.32%	-1.97%	5.85%

Portfolio Characteristics		
	As of 06/30/15	
	Fund	Benchmark
Duration (Option Adjusted)	5.70 yrs	5.63 yrs
Average Maturity	7.90 yrs	-
# Holdings	16,890	-

Descriptive Information	
Ticker	VBTLX
CUSIP	921937603
Share Class	Admiral Class
Portfolio Inception Date	12/11/1986
Fund Inception Date - Share Class	11/12/2001
Net Expense Ratio	0.07%
Revenue Share	0.00%
Portfolio Net Assets (As of 08/31/15)	\$152.20 billion
Turnover (As of 12/31/14)	72.0%
Manager Name	Joshua Barrtckman
Manager Tenure	2.60 years

## Up Down Market Chart 10/01/12 – 09/30/15



# Vanguard Total Bond Market Index Fund

Admiral Class (VBTLX)

As of 09/30/15

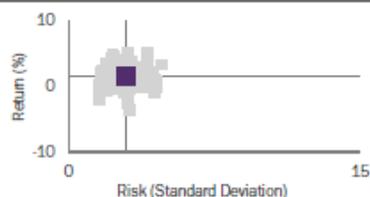
## Style Map 10/01/12 – 09/30/15



## Top 10 Holdings As of 08/31/15

Security	Yield	Weight
Govt Natl Mtg Asso	3.5% 09/15/43	0.81%
FNMA		0.65%
US Treasury Note	2.125% 05/15/25	0.55%
US Treasury Note	3.625% 08/15/19	0.52%
US Treasury Note	4.75% 08/15/17	0.49%
US Treasury Note	2.5% 05/15/24	0.44%
US Treasury Note	1.75% 05/15/23	0.43%
US Treasury Note	3.5% 05/15/20	0.43%
US Treasury Note	0.265% 03/15/18	0.41%
US Treasury Note	3.375% 11/15/19	0.41%
<b>Total</b>		<b>5.14%</b>

## Peer Group Scattergram As of 09/30/15



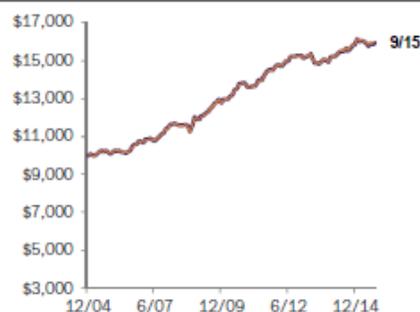
	Return	Standard Deviation
Vanguard Total Bond Market Index Fund	1.58%	3.00
Barclays U.S. Aggregate Bond Index	1.71%	2.90
– Median	1.56%	2.96

## Historical Statistics 10/01/12 – 09/30/15

	Return	Standard Deviation	Sharpe Ratio	Alpha	Beta	R <sup>2</sup>	Tracking Error	IR
Vanguard Total Bond Market Index Fund	1.58%	3.00	0.52	-0.18	1.03	0.99	0.30	-0.44
Barclays U.S. Aggregate Bond Index	1.71%	2.90	0.58	-	-	-	-	-
Peer Group Median	1.56%	2.96	0.53	-0.08	0.97	0.91	0.98	-0.18

Risk Statistics are calculated using a category benchmark and may not be the same as the benchmark index shown.

## Growth of \$10,000 12/31/04 – 09/30/15



Vanguard Total Bond Market Index Fund	\$15,962
Barclays U.S. Aggregate Bond Index	\$16,021

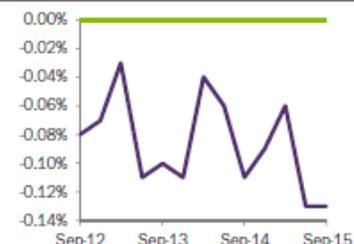
The total returns are not adjusted to reflect sales charges, the effects of taxation or redemption fees, but are adjusted to reflect actual ongoing expenses, and assume reinvestment of dividends and capital gains, net of all recurring costs.

## Sector Allocation As of 08/31/15

Sector	Fund
Government	40.59%
Corporate Bond	24.56%
Mortgage Backed	20.51%
Government Related	5.61%
Cash And Equivalents	5.31%
Commercial Mortgage Backed	1.44%
Municipal Taxable	0.72%
Asset Backed	0.71%
Non-Agency Residential Mortgage Backed	0.47%
Convertibles	0.08%
Preferred	0.01%

The Sector Allocation data is provided by Morningstar and includes the following approach for Cash & Equivalents. This Sector includes cash in the bank, certificates of deposit, currency, and money market holdings. Cash can also be any fixed-income securities that mature in less than 12 months. This Sector also includes commercial paper and any repurchase agreements held by the fund. In addition, the sector allocation may not reflect some liabilities present in the fund for the period reflected, which may partially offset the cash & equivalents listed.

## 3 yr Rolling Under/Over Performance 09/30/12 – 09/30/15



Vanguard Total Bond Market Index Fund	
Barclays U.S. Aggregate Bond Index	

## Maturity Allocation As of 08/31/15

0 - 1 Year	0.00%
1 - 3 Years	24.10%
3 - 5 Years	16.34%
5 - 7 Years	11.39%
7 - 10 Years	11.25%
10+ Years	36.92%

## Current Asset Allocation As of 08/31/15

U.S. Fixed Income	85.34%
International Fixed Income	9.34%
Short Term Investments	5.31%
Preferred	0.01%

## Credit Quality As of 06/30/15

AAA	69.31%
AA	3.90%
A	12.77%
BBB	14.02%
BB	0.00%
B	0.00%
Below B	0.00%
Not Rated	0.00%



**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

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

# Memorandum

**TO:** PERS Board  
**FROM:** Sparb Collins  
**DATE:** December 8, 2015  
**SUBJECT:** Administrative Rules

A hearing soliciting comments for the proposed amendments, additions and deletions to administrative rules was held on Tuesday, November 10, 2015 at 11:00 a.m. in the Conference Room at the NDPERS office at 400 East Broadway Avenue, Bismarck. There were no members of the public in attendance. The minutes from the hearing are attached as well as the proposed rules, summary of rules, formal notice and small entity regulatory analysis and impact statement. The comment period was held open until 5:00 p.m. on November 20, 2015. Also attached are staff's written comments on a suggested revision to the rules.

There has been no request for a regulatory analysis or a takings assessment received and the proposed rules are not anticipated to have a cost impact on the regulated community. However, staff has reviewed and discussed the questions provided by the Attorney General's Office regarding small entity impact analysis as well as economic impact. There were no significant findings to report or fiscal impact anticipated. NDPERS was the sponsor of the legislation associated with the rule changes and email notification was sent to the Chairman of the Senate Government and Veterans Affairs Committee as well as the Senate Appropriations Committee.

Staff is requesting the Board's approval to submit the enclosed rules to the Attorney General's Office for review. Subject to obtaining the Attorney General's approval, staff will then submit the rules to Legislative Council for final promulgation.

Also, attached for your information, is a letter to the Chairman of the Administrative Rules Committee, requesting repeal of specific sections of the retiree health insurance rules where the change in the law made these rules obsolete. The next meeting is scheduled for March 14, 2016.

**Board Action Requested:** Approve proposed rules and authorize staff to submit required materials to Attorney General's office and Legislative Council.

**Public Hearing Minutes**  
**North Dakota Administrative Code**  
**November 10, 2015**  
**NDPERS Conference Room**  
**400 East Broadway, Suite 505, Bismarck, ND**  
**11:00 A.M.**

Staff Present: Ms. Cheryl Stockert

Others Present: None

Ms. Cheryl Stockert acted as the hearing officer for this public hearing.

The hearing was opened at 11:00 a.m. on November 10, 2015 in the conference room of the Public Employees Retirement System at 400 East Broadway Avenue, Suite 505, Bismarck, North Dakota.

It was explained that the public hearing was called for the purpose of allowing all interested individuals an opportunity to submit information concerning proposed additions and amendments to the following sections of the North Dakota Administrative Code as read into the record:

- a. 71-01-01-01(2) relating to Board membership;
- b. 71-01-03-04 relating to information sharing provisions;
- c. 71-02-01-01 relating to definitions as recommended by our actuary to keep the plan tax code compliant;
- d. 71-02-02-01 relating to the option to automatically enroll an eligible employee when retirement contributions are received and employee has not filed the membership application;
- e. 71-02-04-07 relating to changing the early retirement adjustment as a result of National Guard members being merged with the state law enforcement plan;
- f. 71-02-04-09.1(3) relating to no longer requiring certified documents;
- g. 71-02-05-06 relating to correcting the reference to NDCC and removing the limit on reimbursement of cost of medical examinations to the member;
- h. 71-02-05-07 relating to optional benefits as a result of National Guard members being merged with the state law enforcement plan;
- i. 71-02-06-07 relating to the employer contribution as a result of National Guard members being merged with the state law enforcement plan;
- j. 71-02-06-12 (new section) relating to payment options for the recovery of missed employee retirement contributions;
- k. 71-03-03-01 relating to the clarification of enrollment eligibility in the uniform group insurance program;
- l. 71-03-03-02 relating to elimination of the provision of a six month waiting period for preexisting conditions;

- m. 71-03-03-05 relating to closing the pre-Medicare plan for retirees after 7-1-2015;
- n. 71-03-05-07 relating to clarification of who may be reimbursed for an overpayment of premiums;
- o. 71-03-05-08 relating to the clarification of retroactive cancellation of coverage for nonpayment of premiums it not automatic;
- p. 71-04-01-01(7) relating to the revision of the definition of participant agreement to reflect that enrollments are now completed on line using Member Self Service
- q. 71-04-03-01, 71-04-03-03, 71-04-04-05, 71-04-04-07, 71-04-04-08, 71-04-05-02, 71-04-05-06 all relating to the fact that enrollments are now completed on line using Member Self Service;
- r. 71-04-03-07 relating to clarification of the circumstances under which a distribution of assets may occur;
- s. 71-05-01-01 relating to recommendation by our actuary to keep the plan tax code compliant;
- t. 71-06-01-02 relating to calculation of retiree health insurance credit as a result of National Guard members being merged with the state law enforcement plan;
- u. 71-06-01-03 and 71-06-01-07 relating to changes as a result of the portability provisions of the RHIC program;
- v. 71-08-07-03 relating to providing for payment options for the recovery of missed employee retirement contributions.

It was explained that information gathered at this hearing will be transmitted to the NDPERS Board for its deliberation and final decision. A registration sheet was placed on the end of the table. The hearing was recorded.

PERS staff presented comments regarding suggested revision to 71-02-05-06, Determination of disability – Procedures. The reference to the \$400 limit was in both subsections 3 and 6. Staff submitted written comments indicating that they missed removing the second reference in subsection 6 to the \$400 limit and suggested it be removed to maintain consistency within this rule.

Since there were no attendees present, the recorder was turned off until 12:00 noon when it was turned back on for the closing comments.

Ms. Stockert indicated that all of the information gathered at this hearing or comments received thereafter through November 20, 2015 will be provided to the NDPERS Board for its consideration. The hearing was closed at 12:00 noon.

## **PERS Staff Comments Regarding Suggested Revision to 71-02-05-06**

Please include the following at the public hearing for administrative rules.

### **Revision to 71-02-05-06. Determination of disability - Procedures.**

**First reference to \$400 limit requested for removal was stated initially as a proposed change.**

#### 3. Medical Examination

c. If determined to be eligible for disability benefits, the member must be reimbursed ~~up to four hundred dollars~~ for the cost of medical examinations specifically requested by the medical adviser and the executive director.

**Second reference to \$400 limit in 71-02-05-06 was missed initially for removal as a proposed change.**

#### 6. Redetermination and recertification.

c. The medical consultant may require the disabled annuitant to be reexamined by a doctor. The submission of medical reports by the annuitant, and the review of those reports by the board's medical consultant, may satisfy the reexamination requirement. Upon recertification, the disabled annuitant must be reimbursed ~~up to four hundred dollars~~ for the cost of the required reexamination if deemed necessary by the medical consultant and the executive director.

**Please update second reference to \$400 limit in 71-02-05-06 for removal to maintain consistency within this rule.**

Thank you,

*MaryJo Steffes*

Benefit Programs Administrator  
North Dakota Public Employees Retirement System

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

**71-01-01-01. Organization of public employees retirement board.**

1. **History.** The 1965 legislative assembly created the public employees retirement system by legislation codified as North Dakota Century Code chapter 54-52. The starting date of the program was July 1, 1966. The board acts as the administrating body to manage the public employees retirement system, the judges retirement system, the highway patrol retirement system, the national guard security officers and firefighters system, the uniform group insurance program, the deferred compensation plan, the prefunded retiree health program, and a pretax benefit program for public employees.
2. **Board membership.** The board consists of ~~seven~~nine members. ~~One~~Two are members of the legislative assembly appointed by the chairman of legislative management; one member, the chairman, is appointed by the governor; one member is appointed by the attorney general from the attorney general's staff; one member is the state health officer or state health officer's designee; three members are elected by the active membership of the system; and one member is elected by the retired public employees.
3. **Executive director.** The executive director is appointed by the board and is responsible for the administration of the day-to-day activities of the retirement systems, the prefunded retiree health program, the uniform group insurance program, the deferred compensation program, and the pretax benefit program for public employees.
4. **Inquiries.** Inquiries regarding the board may be addressed to:

Executive Director  
Box 1657  
Bismarck, North Dakota 58502

**History:** Amended effective November 1, 1981; November 1, 1985; April 1, 1988; September 1, 1989; January 1, 1992; May 1, 2004, \_\_\_\_\_.

**General Authority:** NDCC 28-32-02.1, 54-52-04

**Law Implemented:** NDCC 28-32-02.1, 54-52-03

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

**71-01-03-04. Treatment, payment, or operations.** The board of the public employees retirement system has determined that:

1. Information related to enrollment, participation, benefits, or contributions may be shared with participating employers or public employees retirement system contractors for purposes of maintaining a member's participation and benefits in the public employees retirement system programs. Such sharing of information is limited to that information that is necessary to assure that a member's participation and benefits are properly handled. All such information remains confidential whether in the possession of the public employees retirement system, its participating employers, or its contractors.
2. Information relating to eligibility for retirement benefits may be shared with the social security administration and such other organizations to ensure that the member is still alive and continues to be eligible.
3. Information necessary for the administration and operation of the program may be shared with the public employees retirement system attorney and consultants. To the extent such information is shared it remains confidential.
4. Information relating to the death benefits and beneficiary designations of a deceased member may be shared with an ex-spouse if listed as a beneficiary on a designation of beneficiary form, or any other person listed as a beneficiary on a designation of beneficiary form, subsequent to the death of the member, but in advance of a final determination regarding the applicable designated beneficiaries, only to the extent necessary to accurately identify the appropriate designated beneficiaries.

All other requests for information under this section must first be submitted to the executive director and then reviewed by the public employees retirement system board.

**History:** Effective May 1, 2004, amended effective \_\_\_\_\_.

**General Authority:** NDCC 54-52-04

**Law Implemented:** NDCC 54-52-26

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

**71-02-01-01. Definitions.** As used in North Dakota Century Code chapter 54-52 and this article:

1. "Accumulated contributions" means the total of all of the following:

- a. The employee account fund balance accumulated under the prior plan as of June 30, 1977.
  - b. The vested portion of the employee's "vesting fund" accumulated under the prior plan as of June 30, 1977.
  - c. The member's mandatory contributions made after July 1, 1977.
  - d. The member's vested employer contributions made after January 1, 2000, pursuant to North Dakota Century Code section 54-52-11.1.
  - e. The interest on the sums determined under subdivisions a, b, c, and d, compounded annually at the rate of five percent from July 1, 1977, to June 30, 1981, six percent from July 1, 1981, through June 30, 1986, and one-half of one percent less than the actuarial interest assumption from July 1, 1986, to the member's termination of employment or retirement.
  - f. The sum of any employee purchase or repurchase payments.
2. "Actuarial equivalent" means a benefit calculated to be of equal value to the benefit otherwise payable when computed on the basis of assumptions and methods adopted for this purpose by the board in a way which precludes employer discretion pursuant to Internal Revenue Code section 401(a)(25). Such assumptions and methods adopted by the board, and any table of adjustment factors established in accordance with the assumptions and methods, shall be incorporated herein by reference.
  3. "Alternative retirement system" means the teachers' fund for retirement, the highway patrolmen's retirement system, and the teachers' insurance and annuity association of America.
  4. "Beneficiary" means any person in receipt of a benefit provided by this plan or any person designated by a participating member to receive benefits.
  5. "Bonus" means cash compensation for services performed in addition to base salary excluding commission and shift differentials. Bonus does not include lump sum payments of sick leave provided under North Dakota Century Code section 54-06-14 or lump sum payments of annual leave or vacation pay.
  6. "Claim" means the right to receive a monthly retirement allowance, the receiving of a retirement allowance, or the receiving of a disability benefit.

7. "Continuously employed" means any period of employment uninterrupted by voluntary or involuntary termination or discharge. A member who has taken a leave of absence approved by the member's employer, not to exceed a year unless approved by the executive director, and returns to employment shall be regarded as continuously employed for the period.
8. "Contribution" means the payment into the fund as a percentage of the salary of a member.
9. "Correctional officer" means a person who has completed a correctional officer course approved or certified by the North Dakota department of corrections and rehabilitation and is employed by a correctional facility as defined in North Dakota Century Code chapter 12-44.1.
10. "County judge" means a judge who was elected pursuant to North Dakota Century Code section 27-07.1-01 or an individual holding the position of county judge, county justice, or judge of county court prior to the general election in 1982, who meets all the eligibility requirements established under North Dakota Century Code chapter 54-52.
11. "Interruption of employment" is when an individual is inducted (enlists or is ordered or called to active duty into the armed forces of the United States) and leaves an employment position with a state agency or political subdivision, other than a temporary position. The individual must have left employment to enter active duty and must make application in accordance with the Uniformed Services Employment and Reemployment Rights Act.
12. "Leave of absence" means the period of time up to one year for which an individual may be absent from covered employment without being terminated. At the executive director's discretion, the leave of absence may be extended not to exceed two years, or indefinitely if the leave of absence is due to interruption of employment.
13. "Medical consultant" means a person or committee appointed by the board of the North Dakota public employees retirement system to evaluate medical information submitted in relation to disability applications, recertifications, and rehabilitation programs or other such duties as assigned by the board.
14. "Normal retirement age", except for members of the national guard and law enforcement, means age sixty-five unless otherwise provided. For members of the national guard and law enforcement, normal retirement age means age fifty-five, unless otherwise provided.
15. "Office" means the administrative office of the public employees retirement system.

16. "Participating employer" means an employer who contributes to the North Dakota public employees retirement system. For confidentiality purposes, "participating employer" means the person or group of persons with the ultimate authority over personnel decisions within the agency or political subdivision with which the member is employed or the person's or group's official designee.
17. "Pay status" means a member is receiving a retirement allowance from the fund.
18. "Permanent and total disability" for members of the main retirement system and the national guard/law enforcement retirement plan means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months. For members of the judge's retirement plan, "permanent and total disability" is determined pursuant to subdivision e of subsection 3 of section 54-52-17 of the North Dakota Century Code.
19. "Plan administrator" means the executive director of the North Dakota public employees retirement system or such other person or committee as may be appointed by the board of the North Dakota public employees retirement system from time to time.
20. "Plan year" means the twelve consecutive months commencing July first of the calendar year and ending June thirtieth of the subsequent calendar year.
21. "Prior plan" means the state employees' retirement system which existed from July 1, 1966, to June 30, 1977.
22. "Regularly funded" means a legislatively authorized full-time equivalent (FTE) position for state agencies. For all governmental units other than state agencies, regularly funded means a similar designation by the unit's governing board which is created through the regular budgeting process and receives traditional employee benefits such as sick leave and annual leave.
23. "Retiree" means an individual receiving a monthly retirement allowance pursuant to chapter 54-52.
24. "Retirement allowance" means a reoccurring, periodic benefit from an eligible employer-sponsored retirement plan as approved by the board.

25. "Service credit" means increments of time to be used in the calculation of retirement benefits. Service credit may be earned as stated in section 71-02-03-01 or may be purchased or repurchased according to section 71-02-03-02.1.
26. "Substantial gainful activity" is to be based upon the totality of the circumstances including consideration of an individual's training, education, and experience; an individual's potential for earning at least seventy percent of the individual's predisability earnings; and other items deemed significant on a case-by-case basis. Eligibility is based on an individual's employability and not actual employment status.
27. "Termination of employment" for the purposes of determination for eligibility for benefit payments means a severance of employment by not being on the payroll of a covered employer for a minimum of one month. Approved leave of absence or if reemployed by any covered employer prior to receiving a lump sum distribution of the member's account balance does not constitute termination of employment.
28. "Termination of participation" means termination of eligibility to participate in the retirement plan.

**History:** Amended effective September 1, 1982; November 1, 1990; September 1, 1991; January 1, 1992; September 1, 1992; June 1, 1993; July 1, 1994; June 1, 1996; July 1, 2000; April 1, 2002; May 1, 2004; July 1, 2006; July 1, 2010; April 1, 2014,

**General Authority:** NDCC 54-52-04

**Law Implemented:** NDCC 54-52

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

**71-02-02-01. Membership - General rule.** ~~Each~~When an eligible employee shall ~~become~~becomes a member of the public employees retirement system ~~upon filing a membership form with the office, and the beginning of contributions to the fund.~~ In addition, the following requirements apply:

1. A temporary employee must submit a completed participation agreement within six months of the date of hire as a temporary employee or within six months of a change in status from a permanent to temporary position. If no application is made and filed with the office, an irrevocable waiver of participation will occur for as long as the employee is in temporary status.
2. Contributions for temporary employees must be submitted no later than the sixth working day of the month for the previous month's salary.

3. Delinquent payments of over thirty days, for reasons other than leave of absence or seasonal employment, will result in termination of eligibility to participate as a temporary member.
4. Upon taking a refund, future participation as a temporary member is waived.
5. A member may not participate as both a permanent and a temporary member. Permanent employment has precedence.
6. Elected officials of participating counties and elected state officials, at their individual option, must enroll or waive participation in writing within six months of taking office or beginning a new term. If no application is made and filed with the office, an irrevocable waiver of participation will occur until the official makes application within six months from the start of a new term.

**History:** Amended effective September 1, 1982; November 1, 1990; September 1, 1992; June 1, 1996; July 1, 1998; May 1, 2004; July 1, 2006, \_\_\_\_\_.

**General Authority:** NDCC 54-52-04

**Law Implemented:** NDCC ~~54-52-01(3)~~54-52-01, 54-52-02.9, 54-52-05

Section 71-02-04-07 is amended as follows:

**71-02-04-07. Amount of early retirement benefit.**

1. Except for ~~members of the~~a national guard security officer or firefighter or a peace officer or correctional officer employed by the bureau of criminal investigation or by a political subdivision, the early retirement benefit ~~for members first enrolled prior to December 31, 2015,~~ shall be an amount actuarially reduced from the single life retirement benefit by one-half of one percent for each month (six percent per year) that the member is younger than the age at which the member would be at the member's normal retirement date on the date of the member's early retirement benefit effective date.
2. For ~~members of the~~a national guard security officer or firefighter or a peace officer or correctional officer employed by the bureau of criminal investigation or by a political subdivision, the early retirement benefit must be an amount actuarially reduced from the single life retirement benefit by one-half of one percent for each month (six percent per year) that the member is younger than age fifty-five on the date of the member's early retirement benefit effective date.

**History:** Amended effective September 1, 1982; June 1, 1996; April 1, 2002; May 1, 2004; July 1, 2006; July 1, 2010, \_\_\_\_\_.

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

**Law Implemented:** NDCC 54-52-17

Section 71-02-04-09.1 is amended as follows:

**71-02-04-09.1. Dual membership limitations.** The following limitations apply when a member elects an option under subsection 1 of section 71-02-04-09.

1. Eligible service credit may be used for vesting purposes and determining when the dual member may begin drawing normal retirement benefits. A member may begin drawing retirement benefits from one fund and use the same years, and any additional years, for reaching retirement from the alternate fund if the service credit is earned at different times.
2. If a dual member elects to receive retirement benefits as provided in subsection 1 of section 71-02-04-09, the final average salary, service credit, and member's age used to calculate the benefit that is applicable at the time retirement benefits begin may not be adjusted after the benefit effective date.
3. The salary used in calculating the retirement benefit must be ~~certified~~provided in writing by the alternate retirement system. Months not employed are excluded for the purpose of computing the final average salary. If a dual member works less than thirty-six months at retirement, the final average salary is the average salary for total months of employment.

**History:** Effective June 1, 1996; amended effective May 1, 2004; April 1, 2012, \_\_\_\_\_.

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

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

Section 71-02-05-06 is amended as follows:

**71-02-05-06. Determination of disability - Procedures.**

1. **Application.**
  - a. If the member is unable or unwilling to file a public employees retirement system application for disability retirement, the member's legal representative may file the member's disability application.

- b. For the main system and the national guard and law enforcement system, the application must explain the cause of the disability, the limitations caused by the disability, the treatment being followed, and the effect of the disability on the individual's ability to be engaged in any gainful occupation for which the person is, or could become, reasonably fitted by education, training, or experience. For the judges' retirement plan, the application must explain the cause of the disability, the limitations caused by the disability, the treatment being followed, and the effect of the disability on the individual's ability to mentally or physically fulfill the duties and responsibilities of being a judge. A judge who is determined to be disabled pursuant to subdivision a of subsection 3 of North Dakota Century Code section 27-23-03 shall file an application documenting this determination and the effective date of the disability.
- c. The application must be filed with the public employees retirement system and may not be filed earlier than one hundred twenty days before the expected termination date.

2. **Medical consultant.**

- a. The board may retain a medical consultant to evaluate and make recommendations on disability retirement applications.
- b. The medical consultant shall review all medical information provided by the applicant.
- c. The medical consultant is responsible to determine eligibility for disability benefits for applicants not approved for social security disability benefits or for judges not approved pursuant to subsection 3 of North Dakota Century Code section 27-23-03 and shall advise the executive director of the decision in writing. Applicants who become eligible for disability benefits under the Social Security Act and who meet the requirements of subdivision e<sub>h</sub> of subsection 3 of North Dakota Century Code section 54-52-17 are eligible for benefits under subdivision e of subsection 4 of North Dakota Century Code section 54-52-17 without submitting further medical information to the medical adviser, but are subject to recertification requirements specified in this chapter. The social security disability award must provide proof that the member's disability was determined during the member's period of eligible employment. In determining eligibility for judges not approved pursuant to the above, the medical director shall work with a review committee composed of one supreme court judge and a district court judge to review the proposed application. In order for the application to be

approved, it must have the concurrence of the medical director and at least one judge. The executive director shall appoint two judges to serve on the review committee.

**3. Medical examination.**

- a. The applicant for disability retirement shall provide the medical examination reports as requested by the medical consultant.
- b. The member is liable for any costs incurred by the member in undergoing medical examinations and completing and submitting the necessary medical examination reports, medical reports, and hospital reports necessary for initial determination of eligibility for benefits.
- c.        If determined to be eligible for disability benefits, the member must be reimbursed ~~up to four hundred dollars~~ for the cost of medical examinations specifically requested by the medical adviser and the executive director.

**4. Appeal.**

- a. If the applicant has terminated employment, the public employees retirement system shall notify the applicant in writing of the decision. If the applicant is determined not to be eligible for disability benefits, the public employees retirement system shall advise the applicant of the appeal procedure. If the applicant is determined eligible for disability benefits, benefits must be paid pursuant to subsection 5.
- b. If the applicant has not terminated employment, the applicant must be provided with a preliminary notification of the decision in writing. The preliminary notification remains in effect for a period not to exceed two hundred seventy days. If an applicant does not terminate employment within two hundred seventy days of the date of termination provided on the disability application, the application must be considered to be vacated but the applicant may reapply as provided in subsection 1.
- c. The applicant may appeal an adverse determination to the board by providing a written notice of appeal within thirty days of the date that the public employees retirement system mailed the decision.
- d. The board shall consider all appeals at regularly scheduled board meetings. The applicant must be notified of the time and date of the meeting and may attend and be represented by legal counsel. The

executive director shall provide to the board for its consideration a case history brief that includes membership history, medical examination summary, and the plan administrator's conclusions and recommendations. The board shall make the determination for eligibility at the meeting unless additional evidence or information is needed. The discussion concerning disability applications must be confidential and closed to the general public.

- e. If the initial board decision is adverse to the applicant after exhausting the administrative procedure under subdivisions a and b, the applicant may file a request for a formal hearing to be conducted under North Dakota Century Code chapter 28-32. The request for a formal hearing must be filed within thirty days after notice of the initial decision has been mailed or delivered. If an appeal is not filed within the thirty-day period, the initial decision of the board is final. If a request for a formal hearing is timely filed, notice of the hearing must be served at least thirty days prior to the date set for the hearing. The board shall request appointment of an administrative law judge from the office of administrative hearings to conduct the hearing and make recommended findings of fact, conclusions of law, and order. The board shall either accept the administrative law judge's recommended findings of fact, conclusions of law, and order or adopt its own findings of fact, conclusions of law, and order. The applicant may under North Dakota Century Code section 28-32-15 appeal the final decision resulting from this procedure to the district court.

- 5. **Payment of annuity.** If awarded, the disability annuity is payable on, or retroactive to, the first day of the month following the member's termination from covered employment minus any early retirement benefits that have been paid.

- 6. **Redetermination and recertification.**

- a. A disabled annuitant's eligibility must be recertified eighteen months after the date the first check is issued and thereafter as specified by the medical consultant. The executive director may waive the necessity for a recertification, based on the recommendation of the medical consultant.
- b. The public employees retirement system will send a recertification form and request for a statement of annual earnings by certified mail with return receipt to the disabled annuitant to be completed and sent back to the office. If completed recertification has not been received by the recertification date set in the recertification request, benefits will be suspended effective the first of the month following

that date. Benefits will be reinstated the first of the month following recertification by the medical consultant. The regular accrued disability benefits will commence with a lump sum equal to the amount of missed payments, without interest, retroactive to the first day of the month benefits were suspended, unless otherwise approved by the North Dakota public employees retirement system board.

- c. The medical consultant may require the disabled annuitant to be reexamined by a doctor. The submission of medical reports by the annuitant, and the review of those reports by the board's medical consultant, may satisfy the reexamination requirement. Upon recertification, the disabled annuitant must be reimbursed ~~up to four hundred dollars~~ for the cost of the required reexamination if deemed necessary by the medical consultant and the executive director.
- d. The medical consultant will make the recertification decision. The executive director may require additional recertifications, if the facts warrant this action. The decision may be appealed to the board within ninety days of receiving the written recertification decision.
- e. Benefit payments must be suspended immediately upon notice received from the medical consultant that the annuitant does not meet recertification requirements. The executive director shall notify the annuitant of the suspension of benefits by certified mail and shall reinstate benefits back to date of suspension if the annuitant is subsequently found to meet recertification requirements.
- f. If it is determined that the disability annuitant was not eligible for benefits during any time period when benefits were provided, the executive director may do all things necessary to recover the erroneously paid benefits.

**History:** Effective January 1, 1992; amended effective July 1, 1994; June 1, 1996; April 1, 2002; May 1, 2004; July 1, 2006, \_\_\_\_\_.

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

**Law Implemented:** NDCC 54-52-17, 54-52-26

Section 71-02-05-07 is amended as follows:

**71-02-05-07. Optional benefits.** For the main system and national guard-~~or~~/ law enforcement retirement plans, an individual deemed eligible for a disability benefit may elect, as provided in this section, to receive one of the following optional benefits in lieu of the regular disability benefit.

1. **One hundred percent joint and survivor benefit.** A member shall receive an actuarially reduced disability retirement benefit as long as the member remains eligible for benefits under subdivision e of subsection 3 of North Dakota Century Code section 54-52-17 and after the member's death the same amount will be continued to the member's surviving spouse during the spouse's lifetime. The designated beneficiary is limited to the member's spouse. Payments of benefits to a member's surviving spouse must be made on the first day of each month commencing on the first day of the month following the member's death, provided the beneficiary is still living and has supplied a marriage certificate and the member's death certificate. Benefits terminate in the month in which the death of the beneficiary occurs. In the event the designated beneficiary predeceases the member or, in the event of divorce, the option must be canceled and the member's benefit must be returned to the single life amount. Payment of the single life amount must commence on the first day of the month following the spouse's death providing written notification of death and a death certificate has been submitted or, in the event of divorce, a photocopy of the divorce decree.
  
2. **Fifty percent joint and survivor benefit.** A member shall receive an actuarially reduced disability retirement benefit as long as the member remains eligible for benefits under subdivision e of subsection 3 of North Dakota Century Code section 54-52-17 and after the member's death one-half the rate of the reduced benefit will be continued to the member's surviving spouse during the spouse's lifetime. The designated beneficiary is limited to the member's spouse. Payments of benefits to a member's surviving spouse must be made on the first day of each month commencing on the first day of the month following the member's death, providing the beneficiary has supplied a marriage certificate and death certificate and is still living. Benefits terminate in the month in which the death of the beneficiary occurs. In the event the designated beneficiary predeceases the member or, in the event of divorce, the option must be canceled and the member's benefit must be returned to the single life amount. Payment of the single life amount must commence on the first day of the month following the spouse's death providing written notification of death and a death certificate has been submitted or, in the event of divorce, a photocopy of the divorce decree.
  
3. **Twenty-year or ten-year certain option.** A member may elect an option which is the actuarial equivalent of the member's normal, early, or deferred vested retirement pension payable for life with a twenty-year or ten-year certain feature, as designated by the member.

**History:** Effective January 1, 1992; amended effective July 1, 1994; May 1, 2004; July 1, 2006; April 1, 2008; April 1, 2012, \_\_\_\_\_.

**General Authority:** NDCC 54-52-04  
**Law Implemented:** NDCC 54-52-17, 54-52-06.4

Section 71-02-06-07 is amended as follows:

**71-02-06-07. Employer contribution - National guard/law enforcement.**

As part of its annual actuarial evaluation, the board shall determine the amount required to support the level of benefits for national guard/law enforcement specified in North Dakota Century Code section 54-52-17. The board shall set the employer's contribution rate on a biennial basis, but may adjust that rate if it is actuarially necessary to maintain appropriate funding levels.

**History:** Effective July 1, 1994; amended effective May 1, 2004, \_\_\_\_\_.

**General Authority:** NDCC 54-52-04

**Law Implemented:** NDCC ~~54-52-06~~.254-52-06.4

Section 71-02-06-12 is created as follows:

**71-02-06-12. Employee paid contributions- Repayment options.** If the office determines that any required employee paid contributions have not been made, the cost of any required employee paid contributions may be paid in a lump sum or in installments in a manner consistent with installment payments permitted under section 71-02-03-02.2.

**History:** Effective \_\_\_\_\_.

**General Authority:** NDCC 54-52-04

**Law Implemented:** NDCC 39-03.1-09, 54-52-02.9, 54-52-05, 54-52-06.1, 54-52-06.3, 54-52-06.4

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

**71-03-03-01. Enrollment.** An eligible employee is entitled to coverage the first of the month following the month of employment, or the month following meeting eligibility criteria, if the employee submits an application for coverage within the first thirty-one days of employment or eligibility for one of the following special enrollment periods:

1. Loss of coverage under any other health, dental, vision, or prescription drug insurance plan.
2. Marriage. An employee who previously waived coverage must enroll for coverage at the time the employee's spouse is enrolled.
3. Addition of a dependent as a result of birth, adoption, placement for adoption, receiving legal guardianship, or receiving a court order to

provide health coverage. An employee who previously waived coverage must enroll for coverage at the same time that the employee's eligible dependent is enrolled.

**History:** Effective October 1, 1986; amended effective July 1, 1994; June 1, 1996; July 1, 1998; July 1, 2010; April 1, 2012, \_\_\_\_\_.

**General Authority:** NDCC 54-52.1-08

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

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

**71-03-03-02. Late enrollment.** An eligible employee failing to submit an application for coverage within the first thirty-one days of employment or eligibility for a special enrollment period may enroll during the annual open enrollment ~~and may be subject to a six-month waiting period for preexisting conditions.~~ Upon a showing of good cause, the executive director may waive the thirty-one day application requirement.

**History:** Effective October 1, 1986; amended effective June 1, 1996; July 1, 1998; May 1, 2004, \_\_\_\_\_.

**General Authority:** NDCC 54-52.1-08

**Law Implemented:** NDCC 54-52.1-03, 42 USC 300gg-3

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

**71-03-03-05. Special enrollment for certain qualifying events.** An eligible employee, retiree, or surviving spouse who elects to take a periodic distribution from the defined contribution retirement plan or a monthly retirement benefit from the North Dakota public employees retirement system, North Dakota highway patrolmen's retirement system, the retirement system established by job service North Dakota, the teachers' fund for retirement, or teachers' insurance and annuity association of America - college retirement equities fund, or retirees who have accepted a retirement allowance from a participating political subdivision's retirement plan and provide verification of distribution are eligible for coverage with the health, dental, vision, or prescription drug insurance program.

1. The employee, retiree, or surviving spouse must submit application for coverage within thirty-one days from one of the following qualifying events:
  - a. The month in which the eligible employee or retiree turns age sixty-five or becomes eligible for medicare.
  - b. The month in which the eligible employee's or retiree's spouse turns age sixty-five or becomes eligible for medicare.

- c. The month in which the eligible employee terminates employment.
  - d. The month in which the eligible retiree or surviving spouse receives the first monthly retirement benefit from one of the eligible retirement systems outlined above.
  - e. The month in which an eligible employee or retiree who is covered through a spouse's plan becomes ineligible for the spouse's plan due to divorce, death, loss of employment, reduction in hours or other events which may cause loss of coverage as determined by the board.
  - f. The month in which the eligible employee or retiree is no longer eligible for employer-sponsored insurance, including coverage provided under the Consolidated Omnibus Budget Reconciliation Act.
2. Coverage will become effective on the first day of the month following the month in which the qualifying event occurred. If an application is not submitted within thirty-one days of a qualifying event, the eligible individual must be considered to have waived coverage and may not be enrolled unless the individual meets the criteria of another qualifying event. Upon a showing of good cause, the executive director may waive the thirty-one day application requirement.
  3. Other individuals eligible for the health, dental, vision, or prescription drug insurance plan include a surviving spouse who is not receiving a qualified monthly retirement benefit from one of the eligible retirement systems outlined above, but who was a covered dependent on the eligible retiree's health, dental, vision, or prescription drug insurance plan at the time of the eligible retiree's death, if there is no lapse in coverage.
  4. Individuals not eligible for the health, dental, vision, or prescription drug insurance plan include:
    - a. A former employee who received a refund of the employee's retirement account, including individuals in the defined contribution plan who take a cash withdrawal of the employee's account, roll their account into another qualified plan, or use the moneys in their account to purchase an annuity.
    - b. A nonspouse beneficiary (eligible for Consolidated Omnibus Budget Reconciliation Act).
    - c. A deferred retiree or surviving spouse between the time in which the retiree or surviving spouse's eligibility for the Consolidated

Omnibus Budget Reconciliation Act (if eligible) ends and the month in which the eligible retiree or surviving spouse receives the first monthly retirement benefit from one of the eligible retirement systems.

- d. A formerly deferred retiree who received a refund of the retiree's retirement account.
- e. A surviving spouse of a nonvested employee eligible for the Consolidated Omnibus Budget Reconciliation Act.
- f. A surviving spouse of a former employee who received a refund of the employee's retirement account.
- g. A former participating member of the defined contribution retirement program who would not qualify for one of the retirement dates set forth in subsection 3 of North Dakota Century Code section 54-52-17 if that employee was a member of the defined benefit retirement plan, unless eligible under the Consolidated Omnibus Budget Reconciliation Act, and then only for the required duration of eligibility under the Act.
- h. For the purposes of the medical and prescription drug plan, employees who first retire after July 1, 2015, and are not eligible for medicare upon their retirement and completion of any period of eligibility under the Consolidated Omnibus Budget Reconciliation Act, until such time as they or their spouse become eligible for medicare.

**History:** Effective October 1, 1986; amended effective November 1, 1990; July 1, 1994; June 1, 1996; July 1, 1998; July 1, 2000; May 1, 2004; April 1, 2012,

**General Authority:** NDCC 54-52.1-08

**Law Implemented:** NDCC 54-52.1-02, 54-52.1-03, 54-52.1-03.1; Pub. L. 99-272; 100 Stat. 222; 26 USC 162 et seq.

Section 71-03-05-07 is amended as follows:

**71-03-05-07. Erroneous payment of premiums - Overpayments.**

- 1. An "overpayment" means a payment of money to the public employees retirement system for group insurance premiums that exceeds the premiums due for the level of coverage that should have been in effect.

2. If an overpayment occurs, the amount of the overpayment must be paid to the insured in a lump sum within thirty days of the discovery of the error. The payment may be made to any person insured under the policy.

**History:** Effective April 1, 2002, amended effective \_\_\_\_\_.

**General Authority:** NDCC 54-52.1-08

**Law Implemented:** NDCC 54-52.1-08

Section 71-03-05-08 is amended as follows:

**71-03-05-08. Erroneous payment of premiums - Underpayments.**

1. An "underpayment" means a payment of money to the public employees retirement system for group insurance premiums that is less than the premiums due for the level of coverage that should have been in effect. Underpayment of premium is solely an error in the amount of premium billed to the individual.
2. An individual who underpays premiums is liable to pay those premiums upon receiving a request for repayment and an explanation of the amount due from the executive director. All underpayments must be collected using the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like gains. If the cost of recovering the underpayment is estimated to exceed the amount of the underpayment, the underpayment is considered to be unrecoverable.
3. If an underpayment is discovered in the first month it occurs, the individual must pay the amount due in a lump sum within thirty days of the discovery of the error.
4. If an underpayment is not discovered within the first month it occurs, the following will apply:
  - a. If not the result of any wrongdoing, negligence, misrepresentation, or omission by the individual, then the individual must make arrangements within sixty days of receiving written notification to either pay by lump sum or installments. The installment payment schedule is subject to approval by the executive director with the minimum repayment amount no less than fifty dollars a month. If repayment arrangements are not in place within sixty days of the date of the written request for repayment, the executive director shall authorize payment to be made in three equal installments,

using the same payment method the individual has authorized for paying current monthly premiums.

- b. If underpayment is the result, in whole or in part, of the wrongdoing, negligence, misrepresentation, or omission of the individual, underpayments must be made in full within sixty days of written notification.
5. If an underpayment occurs and the individual no longer participates in the group insurance, any premium amounts due are immediately payable.
6. If the individual dies prior to paying in full, then the public employees retirement system must make application to the estate of the deceased to recover the remaining balance.
7. If the individual refuses to repay the underpayment, or the underpayment is not paid in full, coverage ~~will~~may be canceled retroactive to the first day of the month following the month for which full premium payment was received. ~~The public employees retirement system will provide written notice advising the individual that payment in full must be received within thirty days of the written notification to reinstate coverage retroactively to the date that coverage was canceled.~~

**History:** Effective April 1, 2002; amended effective April 1, 2008; July 1, 2010,

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**General Authority:** NDCC 54-52.1-08

**Law Implemented:** NDCC 54-52.1-08

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

**71-04-01-01. Definitions.** The terms used throughout this title have the same meaning as in North Dakota Century Code section 54-52.2-04, except:

1. "Beneficiary" means an individual designated by the participant to receive benefits under the plan in the event the participant dies.
2. "Compensation" means the total annual remuneration for employment or contracted services received by the participant from the employer.
3. "Deferred compensation" means the amount of compensation not yet earned which the participant and the employer shall mutually agree shall be deferred from current monthly salary in accordance with the provisions of the plan.

4. "Eligible state deferred compensation plan" means a plan established and maintained by this state that complies with the Internal Revenue Code (IRC) 457(b).
5. "Employer" means the state of North Dakota or any of its political subdivisions, institutions, departments, or agencies.
6. "Participant" is any employee of a participating employer who executes a participant agreement.
7. "Participant agreement" means a ~~written~~ an agreement between the employer and a participant setting forth certain provisions and elections relative to the plan, incorporating the terms of the plan and establishing the participant's deferral and participation in the plan.
8. "Provider" means any insurance company, federally insured financial institutions, Bank of North Dakota, or registered dealer under North Dakota Century Code chapter 10-04 authorized by the retirement board to provide investment vehicles to employees.
9. "Retirement" means separation from service with the employer on a date coincidental with the normal, postponed, early, or disability retirement dates as described in North Dakota Century Code chapter 54-52-17.3.
10. "Retirement board" or "board" means the seven persons described in North Dakota Century Code chapter 54-52-03.
11. "Separation from service" means that term as defined under Internal Revenue Code section 402(d)(4)(A)(3i) and includes termination of employment with the employer by reason of death, disability, retirement, resignation, or discharge.
12. "State" means the state of North Dakota, or any department, institution, or separate agency thereof acting as an employer of the participant.
13. "Unforeseeable emergency" means a severe financial hardship to the participant resulting from a sudden and unexpected illness or accident of the participant, the participant's spouse or dependent of the participant, loss of the participant's property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the participant.

**History:** Effective April 1, 1989; amended effective July 1, 1994; April 1, 2002; May 1, 2004; July 1, 2010, \_\_\_\_\_.

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

**Law Implemented:** NDCC 54-52.2-03, 54-52.2-03.2, 54-52.2-04

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

**71-04-03-01. Enrollment.** Public employees may enroll in the deferred compensation plan by completing and submitting a participant agreement ~~and submitting the agreement~~ to the retirement board office.

**History:** Effective April 1, 1989; amended effective April 1, 2014, \_\_\_\_\_.

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

**Law Implemented:** NDCC 54-52.2-03

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

**71-04-03-03. Change in monthly deferral.** A participant may change the amount of deferral at any time, as long as a participant agreement is completed and ~~filed with~~ submitted to the retirement board office as set forth in section ~~71-04-03-02~~ 71-04-03-01.

**History:** Effective April 1, 1989, amended effective \_\_\_\_\_.

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

**Law Implemented:** NDCC 54-52.2-03; IRC 457(b)(4)

Section 71-04-03-07 is amended as follows:

**71-04-03-07. Distribution of assets.** Distribution of assets may be made only upon separation from service as defined in section 71-04-01-01, or in accordance with section 71-04-03-05 or 71-04-08-01, or as a direct trustee-to-trustee plan transfer to a tax-qualified governmental defined benefit plan (as defined in Internal Revenue Code section 414(d)) for the purchase of permissive service credit (as defined in Internal Revenue Code section 415(n)(3(A)) or a repayment to which Internal Revenue Code section 415 does not apply by reason of section 415(k)(3), regardless of whether or not the participant has had a severance from employment, at a time and in a manner prescribed by the board, as set forth in the 457 deferred compensation plan document, and in a manner consistent with section 457(e)(17) of the Internal Revenue Code.

**History:** Effective May 1, 2004, amended effective \_\_\_\_\_.

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

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

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

**71-04-04-05. Payroll deduction authorization.** The ~~board~~office shall ~~deliver~~make available to the payroll division of each employer ~~a copy of direction to begin, modify or discontinue deductions pursuant to the signed~~completed participant agreement as the payroll division's authorization to begin deductions.

**History:** Effective April 1, 1989; amended effective July 1, 2010, \_\_\_\_\_.

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

**Law Implemented:** NDCC 54-52.2-02, 54-52.2-03

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

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

**History:** Effective April 1, 1989; amended effective July 1, 1994; May 1, 2004; July 1, 2010, \_\_\_\_\_.

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

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

Section 71-04-04-08 is amended as follows:

**71-04-04-08. Authorization.** The executive director or the executive director's designee is authorized to sign all provider agreements, employer agreements, ~~payroll deduction authorizations,~~ or benefit applications that meet the requirements under article 71-04 and under North Dakota Century Code chapter 54-52.2.

**History:** Effective July 1, 1994; amended effective May 1, 2004, \_\_\_\_\_.

**General Authority:** NDCC 54-52.2-03.2

**Law Implemented:** NDCC 54-52.2-01, 54-52.2-02, 54-52.2-03, 54-52.2-03.2

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

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

**History:** Effective April 1, 1989; amended effective July 1, 2006; April 1, 2014,

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

**Law Implemented:** NDCC 54-52.2-02

Section 71-04-05-06 is amended as follows:

**71-04-05-06. Separation from service notice.** The employer shall notify the retirement board office within thirty days of an employee's separation from service. The retirement board shall office may then notify the former employee's provider of the employee separation from service and eligibility for payment options under the plan.

**History:** Effective April 1, 1989; amended effective July 1, 1994; May 1, 2004,

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

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

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

**71-05-01-01. Definitions.** As used in North Dakota Century Code chapter 39-03.1:

1. "Actuarial equivalent" means a benefit calculated to be of equal value to the benefit otherwise payable when computed on the basis of assumptions and methods adopted for this purpose by the board in a way which precludes employer discretion pursuant to Internal Revenue Code section 401(a)(25). Such assumptions and methods adopted by the board, and any table of adjustment factors established in accordance with the assumptions and methods, shall be incorporated herein by reference.
2. "Covered employment" means employment with the North Dakota highway patrol.
- 2.3. "Medical examination" means an examination conducted by a doctor licensed to practice in North Dakota that includes a diagnosis of the disability, the treatment being provided for the disability, the prognosis and classification of the disability, and a statement indicating how the disability prevents the individual from performing the duties of a highway patrolman.
- 3.4. "Normal retirement age" means age fifty-five except as otherwise provided.
- 4.5. "Office" means the administrative office of the public employees retirement system.

- 5.6. "Permanent and total disability" means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months.
- 6.7. "Plan administrator" means the executive director of the North Dakota public employees retirement system.
- 7.8. "Substantial gainful activity" is to be based upon the totality of the circumstances, including consideration of an individual's training, education, and experience; an individual's potential for earning at least seventy percent of the individual's predisability earnings; and other items deemed significant on a case-by-case basis. Eligibility is based on an individual's employability and not actual employment status.

**History:** Effective November 1, 1990; amended effective October 1, 1991; June 1, 1992; July 1, 2006, \_\_\_\_\_.

**General Authority:** NDCC 39-03.1-06

**Law Implemented:** NDCC ~~39-03.1-07~~39-03.1

Section 71-06-01-02 is amended as follows:

**71-06-01-02. Calculation of retiree health insurance credit.** Retiree health insurance credit will be calculated on actual years and months of service, identical to retirement benefits under North Dakota Century Code chapter 54-52.

1. Retiree health insurance credit will be subject to reduction factors in the event of early retirement. For annuitants of the public employees retirement system defined benefit plan and North Dakota public employees retirement system judges, and for members of the defined contribution retirement plan, excluding national guard/law enforcement and highway patrol retirees, who take a periodic distribution:

Age at Retirement	Reduction Factor	Age at Retirement	Reduction Factor
64 to 65	3%	59 to 60	33%
63 to 64	9%	58 to 59	39%
62 to 63	15%	57 to 58	45%
61 to 62	21%	56 to 57	51%
60 to 61	27%	55 to 56	57%

For annuitants of the job service retirement program: This includes those who retired under a discontinued service annuity but does not include those who retired at a normal or optional date.

Age at Retirement	Reduction Factor	Age at Retirement	Reduction Factor	Age at Retirement	Reduction Factor
64 to 65	3%	59 to 60	33%	54 to 55	63%
63 to 64	9%	58 to 59	39%	53 to 54	69%
62 to 63	15%	57 to 58	45%	52 to 53	75%
61 to 62	21%	56 to 57	51%	51 to 52	81%
60 to 61	27%	55 to 56	57%	50 to 51	87%

For annuitants of the highway patrol fund and national guard ~~security police and firefighters~~/law enforcement retirees and national guard ~~security police and firefighters~~/law enforcement retirees who transferred to the defined contribution retirement plan:

Age at Retirement	Reduction Factor
54 to 55	3%
53 to 54	9%
52 to 53	15%
51 to 52	21%
50 to 51	27%

2. Disabled annuitants receiving benefits under subdivision g of subsection 3 of North Dakota Century Code section 54-52-17, subdivision d of subsection 3 of North Dakota Century Code section 39-03.1-11, North Dakota Century Code section 52-11-01, or section 71-02-05-05 will be eligible for full retiree health insurance credit benefits. No age reduction factor will be applied.
3. A surviving spouse eligible to receive benefits under paragraph 2 of subdivision a and paragraphs 2 and 3 of subdivision b of subsection 6 of North Dakota Century Code section 54-52-17, subdivisions b and c of subsection 6 of North Dakota Century Code section 39-03.1-11, or North Dakota Century Code section 52-11-01 will receive retiree health insurance credit based on the deceased member's years of service without any age reduction applied.
4. A surviving spouse receiving benefits under the provisions of subdivision b or d of subsection 9 of North Dakota Century Code section 54-52-17; subdivisions a, b, and c of subsection 5 of North Dakota Century Code section 27-17-01; subsection 9 of North Dakota Century Code section 39-03.1-11; or North Dakota Century Code section 52-11-01 will receive retiree health insurance credit for the duration benefits are paid, based upon the original annuitant's retirement age.

**History:** Effective April 1, 1992; amended effective June 1, 1996; July 1, 2000; July 1, 2010, \_\_\_\_\_.

**General Authority:** NDCC 54-52.1-03.2(b)  
**Law Implemented:** NDCC 54-52.1-03.3

Section 71-06-01-03 is amended as follows:

**71-06-01-03. For retirees receiving more than one benefit entitled to retiree health insurance credit.**

1. If a retiree is receiving more than one benefit from the public employees retirement system, or other participating system; one as a surviving spouse, and the other based upon the retiree's own service credit, the retiree health insurance credit for each benefit will be combined with an effective date based on eligibility in accordance with North Dakota Century Code section 54-52.1-03.3.
2. ~~If a retiree is receiving a public employees retirement system retirement benefit as a surviving spouse and is also an active contributor to either the public employees retirement system, the highway patrol retirement system, the judges retirement system, or the job service retirement program, the individual will not be eligible for retiree health insurance credit until one of the following events occurs:~~
  - a. ~~The active contributor terminates employment, at which time the active contributor may receive the retiree health insurance credit as any other surviving spouse.~~
  - b. ~~The active contributor retires and begins receiving a benefit through an eligible retirement system.~~
3. If the retiree was employed by a political subdivision which does not participate in the public employees retirement system health plan, and is drawing a retirement benefit or a surviving spouse benefit, the individual may receive the retiree health insurance credit as any other retiree based upon a retiree premium.
- 4.3. If a husband and wife are both receiving a benefit from a retirement system that provides the retiree health insurance credit, the retiree health insurance credit will be applied as follows:
  - a. ~~If each retiree takes a single health insurance plan under the uniform group health insurance program, each~~Each will have their respective retiree health insurance credit ~~applied to~~reimbursed for their respective premiums.

- b. If only one retiree takes a family health plan under the uniform group health insurance program, they may make application with the public employees retirement system to combine retiree health insurance credits.

Retirees are responsible for making application with the public employees retirement system to combine and discontinue combining retiree health insurance credits.

- 5.4. Retirees with service credit in more than one of the participating retirement systems will have their respective retiree health insurance credit for each benefit combined with an effective date based on eligibility in accordance with North Dakota Century Code section 54-52.1-03.1. Surviving spouses receiving multiple benefits from retirement systems that provide the retiree health insurance credit will have their respective retiree health insurance credit for each benefit combined with an effective date based on eligibility in accordance with North Dakota Century Code section 54-52.1-03.3.

**History:** Effective April 1, 1992; amended effective June 1, 1996; July 1, 1998; April 1, 2008; April 1, 2012, \_\_\_\_\_.

**General Authority:** NDCC 54-52.1-03.2(b)

**Law Implemented:** NDCC 54-52.1-03.3

Section 71-06-01-07 is amended as follows:

**71-06-01-07. Optional benefits.** A married member may elect to receive one of the following optional retiree health credit benefits in lieu of the retiree health insurance credit option provided in ~~section 71-06-01-04~~this chapter:

1. **Fifty percent joint and survivor benefit.** A member shall receive an actuarially reduced retiree health insurance credit during the member's lifetime and after the member's death one-half the rate of the reduced benefit will be continued to the member's surviving spouse during the spouse's lifetime. The designated beneficiary is limited to the member's spouse. Benefits shall terminate in the month in which the death of the beneficiary occurs. If the member's spouse predeceases the member or, in the event of divorce, the member's benefit must be returned to the standard option amount. The standard option amount must commence on the first day of the month following the spouse's death if a death certificate has been submitted or, in the event of divorce, a photocopy of the divorce decree.
2. **One hundred percent joint and survivor benefit.** A member shall receive an actuarially reduced retiree health insurance credit during the member's lifetime and after the member's death the same amount will be

continued to the member's surviving spouse during the spouse's lifetime. The designated beneficiary is limited to the member's spouse. Benefits shall terminate in the month in which the death of the beneficiary occurs. If the member's spouse predeceases the member or, in the event of divorce, the member's benefit must be returned to the standard option amount. The standard option amount shall commence on the first day of the month following the spouse's death providing written notification of the death and a death certificate has been submitted or, in the event of divorce, a photocopy of the divorce decree.

**History:** Effective July 1, 1998; amended effective April 1, 2008, \_\_\_\_\_.

**General Authority:** NDCC 54-52.1-03.2(b)

**Law Implemented:** NDCC 54-52.1-03.3

Section 71-08-07-03 is created as follows:

**71-08-07-03. Employee paid contributions- Repayment Options.** If the office determines that any required employee paid contributions have not been made, the cost of any required employee paid contributions may be paid in a lump sum or in installments in a manner consistent with installment payments permitted under section 71-02-03-02.2.

**History:** Effective \_\_\_\_\_.

**General Authority:** NDCC 54-52-04, 54-52.6-04

**Law Implemented:** NDCC 54-52.6-09

## NOTICE OF INTENT TO ADOPT AND AMEND ADMINISTRATIVE RULES

Take notice that the North Dakota Public Employees Retirement System will hold a public hearing to address proposed new rules and amendments to Title 71 of the North Dakota Administrative Code. The proposed rulemaking implements House Bill 1062, Senate Bill 2015, Senate Bill 2022 and Senate Bill 2102, enacted during the most recent legislative session concerning administration of the benefit plans administered by the North Dakota Public Employees Retirement System (NDPERS). The hearing will be held at 11:00 a.m. on Tuesday, November 10, 2015, in the NDPERS Conference Room at 400 E Broadway, Suite 505, Bismarck, North Dakota. The hearing will continue until 12:00 p.m. or until no further testimony is offered, whichever occurs last. The proposed rules may be viewed online at <http://www.nd.gov/ndpers/news/abbreviated-notice.html> or at the NDPERS office at the following location:

North Dakota Public Employees Retirement System  
400 E Broadway, Suite 505  
P.O. Box 1657  
Bismarck, ND 58502

Written or oral comments on the proposed rules submitted to the above address or below referenced telephone number and received by November 20, 2015 will be fully considered. The proposed rule changes are not expected to have an impact on the regulated community in excess of \$50,000. A copy of the proposed rules and/or regulatory analysis may also be obtained by accessing them on the PERS website at <http://www.nd.gov/ndpers/news/abbreviated-notice.html> or by writing to the above address, or by calling the North Dakota Public Employees Retirement System at 701-328-3900. If you plan to attend the public hearing and will need special accommodations or assistance relating to a disability, please contact the Public Employees Retirement System at the above address or telephone number at least three business days prior to the public hearing. Specific sections affected and explanations for proposed revisions are summarized below.

<b>Section</b>	<b>Description</b>	<b>Reason</b>
<b>71-01-01-01(2). Board membership</b>	Updates rule to reflect change in Board membership.	Legislative, to comply with SB 2022.
<b>71-01-03-04, Treatment, payment or operations</b>	Update information sharing provisions.	Administrative revision
<b>71-02-01-01. Definitions</b>	As recommended by our actuary to keep the plan tax code compliant.	To maintain tax qualified status of plan and comply with the Federal Internal Revenue Code
<b>71-02-02-01, Membership - General rule.</b>	Provides NDPERS the option to automatically enroll an eligible employee when retirement contributions are received and employee has not filed the membership application.	Administrative revision

<b>Section</b>	<b>Description</b>	<b>Reason</b>
<b>71-02-04-07. Amount of early retirement benefit.</b>	National Guard members are being merged with the State Law Enforcement Plan and the early retirement adjustment is being changed.	Legislative, to comply with provisions of SB 2102 and SB 2015.
<b>71-02-04-09.1(3). Dual membership limitations</b>	Certified documents are no longer required.	Administrative revision
<b>71-02-05-06. Determination of disability</b>	Correct reference to NDCC and remove limit on reimbursement of cost of medical examinations to member.	Administrative revision
<b>71-02-05-07. Optional benefits</b>	National Guard members are being merged with the State Law Enforcement Plan.	Legislative, to comply with provisions of SB 2102.
<b>71-02-06-07. Employer contribution – National guard/law enforcement</b>	National Guard members are being merged with the State Law Enforcement Plan.	Legislative, to comply with provisions of SB 2102.
<b>71-02-06-12 (new)</b>	Add new section to provide payment options for the recovery of missed employee retirement contributions.	Administrative revision
<b>71-03-03-01. Enrollment</b>	Clarifies enrollment eligibility in the uniform group insurance program.	Administrative revision
<b>71-03-03-02. Late enrollment</b>	Eliminate the provision of a six month waiting period for preexisting conditions.	Compliance with federal law, the Patient Protection and Affordable Care Act.
<b>71-03-03-05. Special enrollment for certain qualifying events</b>	Reflects closing of the pre-Medicare plan for retirees after 7/1/2015.	Administrative revision to reflect closing of plan under HB 1058 (2013 session).
<b>71-03-05-07 Erroneous payment of premiums - Overpayments.</b>	Clarifies who may be reimbursed for an overpayment of premiums.	Administrative revision
<b>71-03-05-08 Erroneous payment of premiums - Underpayments.</b>	Clarifies that retroactive cancellation of coverage for non-payment of premiums is not automatic.	Administrative revision
<b>71-04-01-01(7). Definitions.</b>	Revises definition of participant agreement to reflect that enrollments are now completed on line using Member Self Service.	Administrative revision

<b>Section</b>	<b>Description</b>	<b>Reason</b>
<b>71-04-03-01. Enrollment</b>	Revised to reflect that Enrollments are now completed on line using Member Self Service.	Administrative revision
<b>71-04-03-03. Change in monthly deferral.</b>	Revised to reflect that Enrollments are now completed on line using Member Self Service.	Administrative revision
<b>71-04-03-07. Distribution of assets.</b>	Clarifies the circumstances under which a distribution of assets may occur.	Administrative clarification related to transactions permitted under the Federal Internal Revenue Code
<b>71-04-04-05. Payroll deduction authorization.</b>	Reflects that Enrollments are now completed on line using Member Self Service.	Administrative revision
<b>71-04-04-07. Separation from service.</b>	Reflects that Enrollments are now completed on line using Member Self Service.	Administrative revision
<b>71-04-04-08. Authorization</b>	Reflects that Enrollments are now completed on line using Member Self Service.	Administrative revision
<b>71-04-05-02. Payroll deductions</b>	Reflects that Enrollments are now completed on line using Member Self Service.	Administrative revision
<b>71-04-05-06. Separation from service notice.</b>	Reflects that Enrollments are now completed on line using Member Self Service.	Administrative revision
<b>71-05-01-01. Definitions</b>	As recommended by our actuary to keep the plan tax code compliant.	To maintain tax qualified status of plan and comply with the Federal Internal Revenue Code
<b>71-06-01-02. Calculation of retiree health insurance credit.</b>	Amend rules to reflect National Guard members are being merged with the State Law Enforcement Plan.	Legislative, to comply with provisions of SB 2102.
<b>71-06-01-03. For retirees receiving more than one benefit entitled to retiree health insurance credit.</b>	Amend rules to reflect RHIC portability provisions.	Reflects portability of RHIC credit per HB 1058 from 2013 legislative session

<b>Section</b>	<b>Description</b>	<b>Reason</b>
<b>71-06-01-07. Optional benefits.</b>	Amend rules to reflect RHIC portability provisions.	Reflects portability of RHIC credit per HB 1058 from 2013 legislative session
<b>71-08-07-03. Employee paid contributions – Repayment options.</b>	Add new section to provide payment options for the recovery of missed employee retirement contributions.	Administrative revision

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**From:** Murtha, Janilyn K.  
**Sent:** Wednesday, September 16, 2015 9:06 PM  
**To:** Humann, Kim N.; Collins, J. Sparb  
**Cc:** Stockert, Cheryl L.; Allen, Kathy M.  
**Subject:** regulatory analysis, takings assessment, or small entity economic impact statement

Please accept this email as confirmation that based upon our discussion, my review of the administrative rule changes proposed by NDPERS staff, and applicable North Dakota law, it is my opinion that NDPERS need not complete a regulatory analysis, takings assessment, or small entity economic impact statement in connection with the promulgation of the proposed rules.

Specifically, NDPERS is not required to complete a regulatory analysis under NDCC § 28-32-08 at this time with regards to the proposed rules because none of these proposed rules are expected to have an economic impact on the regulated community in excess of \$50,000. Further, NDPERS is not required to complete a takings assessment under NDCC § 28-32-09 with regards to the proposed rules because none of these proposed rules would limit the use of private real property. Finally, NDPERS is not required to complete a small entity economic impact statement under NDCC § 28-32-08.1 with regards to the proposed rules because none of these proposed rules would have an adverse economic impact on small entities.

Please let me know if you have any further questions or if I may be of further assistance in this matter.

Janilyn K. Murtha

Assistant Attorney General  
State of North Dakota  
Office of Attorney General  
State Capital  
600 E. Boulevard Ave, Dept. 125  
Bismarck, ND 58505



Wayne Stenehjem  
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November 20, 2015

The Honorable Bill Devlin  
Chairman, Administrative Rules Committee  
Legislative Council  
600 E Boulevard Ave  
Bismarck, ND 58505

RE: Request to Repeal Rules

Dear Representative Devlin:

I am writing to you on behalf of the North Dakota Public Employees Retirement System ("NDPERS") regarding a request to repeal administrative rules due to a change in the law making the rules obsolete or not in compliance with the law pursuant to N.D.C.C. § 28-32-18.1. Specifically, NDPERS requests the Administrative Rules Committee repeal the following three administrative rules relating to the Retiree Health Insurance Credit (RHIC): N.D.A.C. §§ 71-06-01-01, 71-06-01-06, and 71-06-01-06.1. These rules refer to payment or collection of the RHIC in coordination with a member's participation in the NDPERS uniform group insurance program.

During the 2013 legislative session various statutory amendments were made in House Bill 1058 which allowed the RHIC to become portable, in that it could be used by a member as credit under any health insurance program as opposed to just the health insurance program administered by NDPERS. House Bill 1058 had a contingent effective date, delaying implementation until July 1, 2015. Upon review of the relevant administrative code provisions, NDPERS determined that these three rules were obsolete or not consistent with law because the rules restricted application of the RHIC to insurance premiums under the uniform group insurance program administered by NDPERS. These rules are set forth below for your convenience with emphasis added to the terminology relating to the application of the credit to the NDPERS health insurance premium.

**71-06-01-01. Eligibility for retiree health insurance credit applied to premiums for annuitants and surviving spouses under the North Dakota public employees retirement system, the North Dakota highway patrolmen's retirement system, the retired judges under North Dakota Century Code chapter 27-17, annuitants of the job**

**service retirement program, and former participating members of the defined contribution retirement plan receiving periodic distributions.** All receiving members of the public employees retirement system, highway patrolmen's retirement system, judges retirement system, retired judges under North Dakota Century Code chapter 27-17, and annuitants of the job service retirement program will be eligible for retiree health credit applied to premiums that satisfy the enrollment requirements of section 71-03-03-05, with the exception of those receiving members who are receiving their benefit based on prior service credits rather than the defined benefits program. Vested members deferring benefits will not be eligible until payment of benefits commences. A former participating member of the defined contribution retirement plan is similarly eligible for retiree health credit applied to premiums that satisfy the enrollment requirements of section 71-03-03-05, if the former participating member would qualify for one of the retirement dates set forth in subsection 3 of North Dakota Century Code section 54-52-17 if that former participating member was a member of the defined benefit retirement plan.

**71-06-01-06. Erroneous crediting of the retiree health insurance credit.** If an error occurs in granting retiree health insurance credit, the error shall be corrected the first of the month following discovery of the error in accordance with sections 71-02-04-10 and 71-02-04-11, except any underpayment of the retiree health insurance credit under this chapter must be returned to the uniform group insurance program where it will be treated as an overpayment of premium and paid in a lump sum within sixty days of the discovery of the error.

**71-06-01-06.1. Retroactive payment of the retiree health insurance credit.** Retroactive payments will be as reflected in chapters 71-02-04 and 71-02-05.

Retroactive payments will be made to the date the member was eligible for the disability benefits, in coordination with the first month the member was responsible for payment of the public employees retirement system group health insurance.

The date of eligibility for the retiree health insurance credit will be determined:

1. For a deceased, active member's surviving spouse, when the application for retirement benefits is received.

The Honorable Bill Devlin  
November 20, 2015  
Page 3

2. For a deceased retiree's surviving spouse, eligibility for the retiree health insurance credit is applied the first of the month following the member's date of death.

NDPERS therefore respectfully requests the Administrative Rules Committee consider repealing these rules pursuant to N.D.C.C. § 28-32-18.1 at its regularly scheduled meeting on December 7, 2015. Once this agenda item is confirmed, NDPERS will proceed to provide notice to the regulated community of the time and place of the meeting. Please let me know if you have any questions or if you would like NDPERS to submit additional information relating to this request. Thank you in advance for your assistance in this matter.

Sincerely,



Janylyn K. Murtha  
Assistant Attorney General

cc: Vonette J. Richter, Assistant Code Revisor  
J. Sparb Collings, Executive Director, NDPERS



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**Public Employees Retirement System**  
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# Memorandum

**TO:** NDPERS Board  
**FROM:** Sharon Schiermeister  
**DATE:** December 10, 2015  
**SUBJECT:** PERSLink Mobile App

At the last two Board meetings, we reviewed a proposal from Sagitec for implementing a mobile app that would be able to tie in with the PERSLink system. The mobile app has not yet been made available to any of their customers. They are looking to partner with a client to be an early adapter in this deployment and offering discount pricing in acknowledgment that there will be some unexpected challenges that will need to be worked through together.

The Board expressed interest in the proposal and directed staff to gather more information on pricing options. Attached is an updated proposal from Sagitec. The best and final offer reflects a reduced fee of \$80,000 to implement a mobile app that would include all the core functionality, as well as the optional features for benefit estimates and annual enrollment. The annual licensing fee would be \$30,000. We did negotiate the addition of this payment being contingent on usage with 50% paid up front, 25% paid when user registration hits 2,500 members and 25% paid when user registration hits 3,500.

The Board also directed staff to conduct a survey of our membership to see if there was interest in a mobile app. We sent a survey to our participating employers and received approximately 110 responses. The results are attached and show that there does appear to be interest.

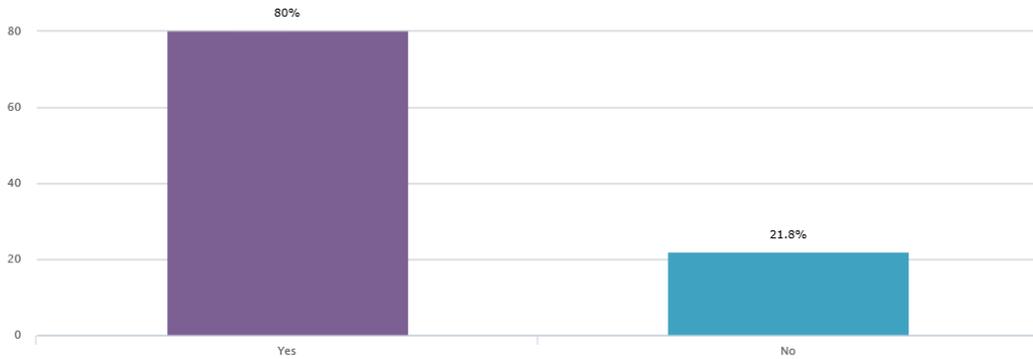
**Board Action Requested:**

Determine whether to proceed with a mobile app implementation

This report was last run on Dec 9, 2015 at 8:45 AM

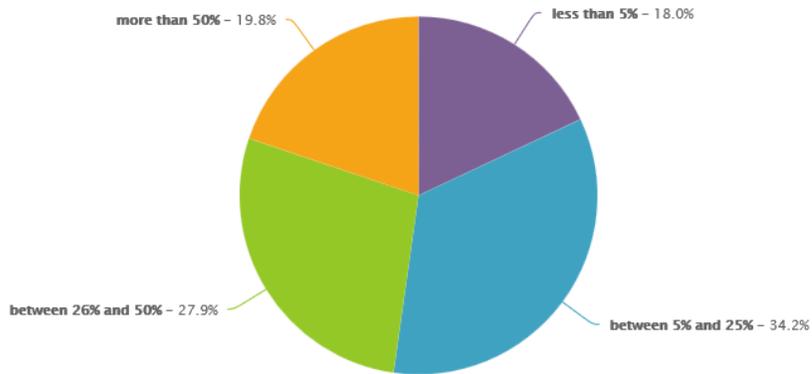
Run Report

1. Do you think your employees would use a mobile app to access their NDPERS benefit information?



Value	Percent	Count	Statistics
Yes	80.0%	88	Total Responses 110
No	21.8%	24	
<b>Total</b>		<b>110</b>	

2. How many of your employees do you think would use the mobile app?



Value	Percent	Count	Statistics
less than 5%	18.0%	20	Total Responses 111
between 5% and 25%	34.2%	38	
between 26% and 50%	27.9%	31	
more than 50%	19.8%	22	

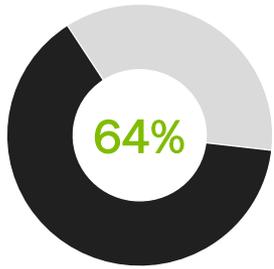
# MOBIAS PENSION

Mobile Application for NDPERS Members



**Best and Final Offer**  
**December 8, 2015**

# Integrating Mobile into your Modernization Initiatives



## OF AMERICANS OWN A SMART PHONE

10% of them have no internet access at home.



## APP USAGE ALONE SURPASSED TRAFFIC BY PCs USAGE

reported by CNN Money 2014.



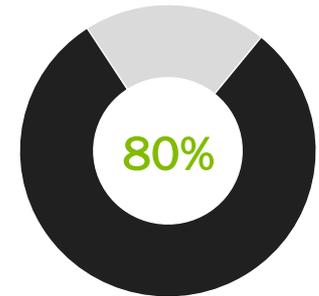
## OF ALL THE 65 AND OLDER REPORT USING SOCIAL MEDIA

compared with just 2% in 2005.

Mobile has evolved from an add-on to equal status with desktops.

Mobile as a driver is fundamentally reshaping operating models, business models and marketplaces.

An upward trend across all demographics and age group to access services through mobile application.



## ACTIVE MEMBERS BOTH OWN AND USE A SMARTPHONE

Sagitec estimates based on industry data and demographics.

# Why go Mobile?

**NEW MEMBER SELF-SERVICE  
CHANNEL**  
mobile (24x7x365)

**BRAND ENHANCEMENT**  
innovative and responsive

**OPERATIONAL  
EFFICIENCY**  
fewer calls

**PROACTIVE  
COMMUNICATION -**  
member engagement

**IMPROVES PERSLINK ROI**  
deployment speed and effort

**MEASURABLE**  
mobile usage analytics

**BACK-OFFICE EFFICIENCIES**  
fewer service requests

**LOWERS TOTAL COST OF  
OWNERSHIP**  
PERSLink reuse, support and  
maintenance

# A Bold Step Forward - Introducing MOBIAS ...

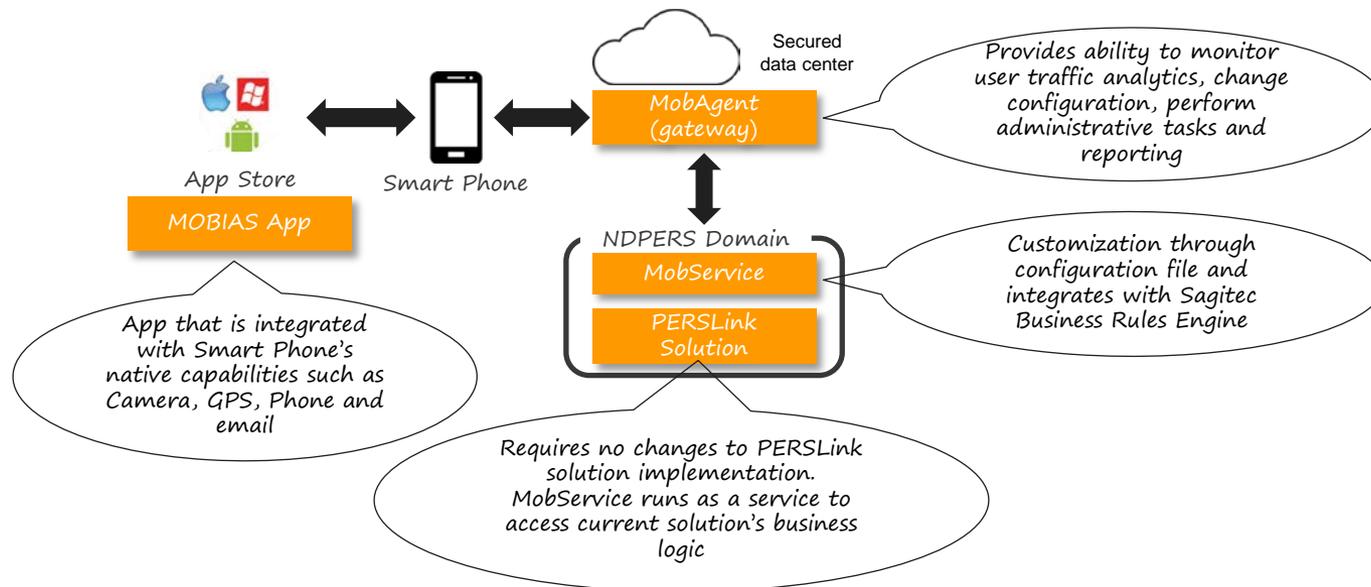
MOBIAS offers the opportunity to fundamentally rethink how an agency engages with and delivers services to their members (active or retirees).

- MOBIAS exploits the functionality of your existing PERSLink solution so you can quickly deliver self-service mobile technologies to your members.
- MOBIAS reuses the data and logic from PERSLink, lowering your time and effort to deploy a mobile app and thereby lowering the TCO for PERSLink.
- MOBIAS improves your ROI on PERSLink by reducing the need to design, develop and test your mobile app.
- MOBIAS provides core features out of the box; simply connect and go.

Active Member	Retiree	Capabilities
View Account Balance	View Benefit Summary	Core
View / Edit Address	View / Edit Address	Optional
View Insurance Coverage	View Insurance Coverage	Common
Perform Open Enrollment (Vision/Dental/Health)	View Payment History	
Perform Open Enrollment (Life)	View / Edit EFT	
Perform Benefit Calculation/Estimates	View / Edit Tax Withholding	
Perform Service Purchase Estimates		
View / Edit Profile (Name, Email)		
Device Native Integration (phone, email, map, camera)		
Contact Details, Basic Feedback		
App Notification (Messages)		
Security		

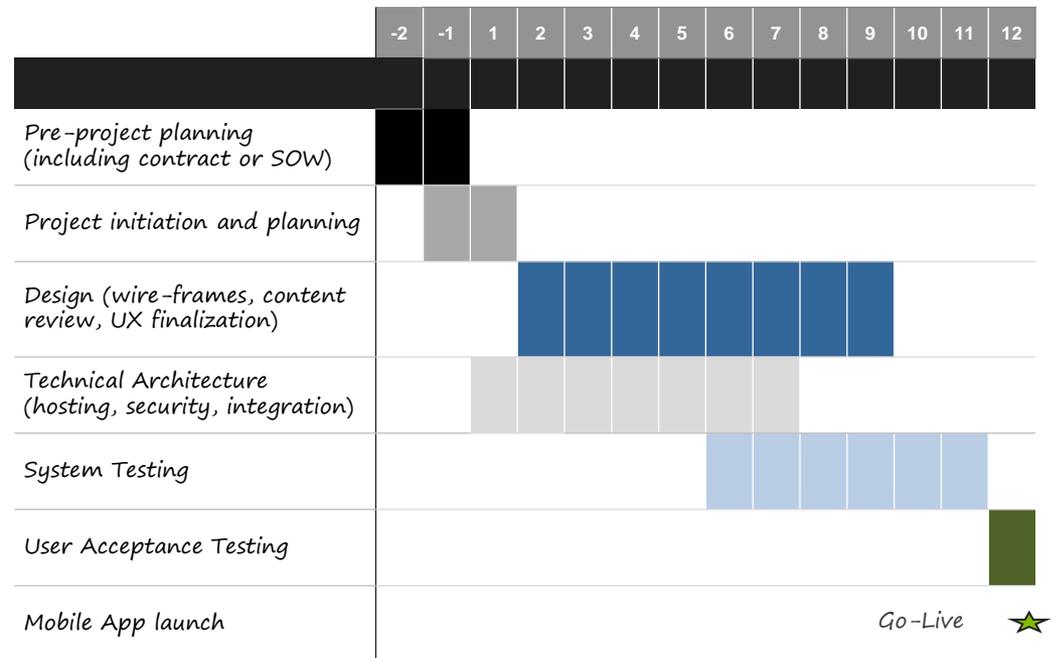
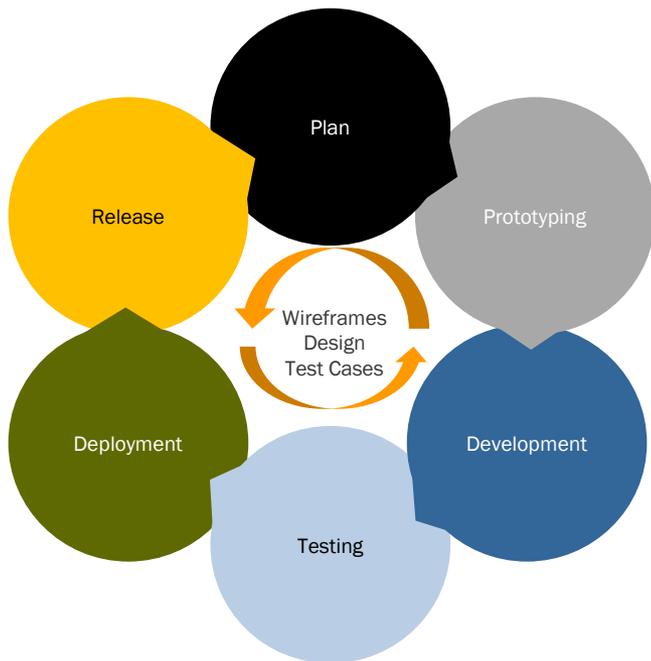
# MOBIAS Solution Architecture

- MobService and MobAgent are services built using Neospin™ and Sagitec Analyst Studio (rules engine) as web API end points.
- Server-side customization happens using an XML file.
- User Interface customization happens by modifying templates or web components.
- Additional processing of rules outside of PERSLink will happen within Sagitec Analyst Studio (rules engine).



# NDPERS Implementation Approach and Timeline

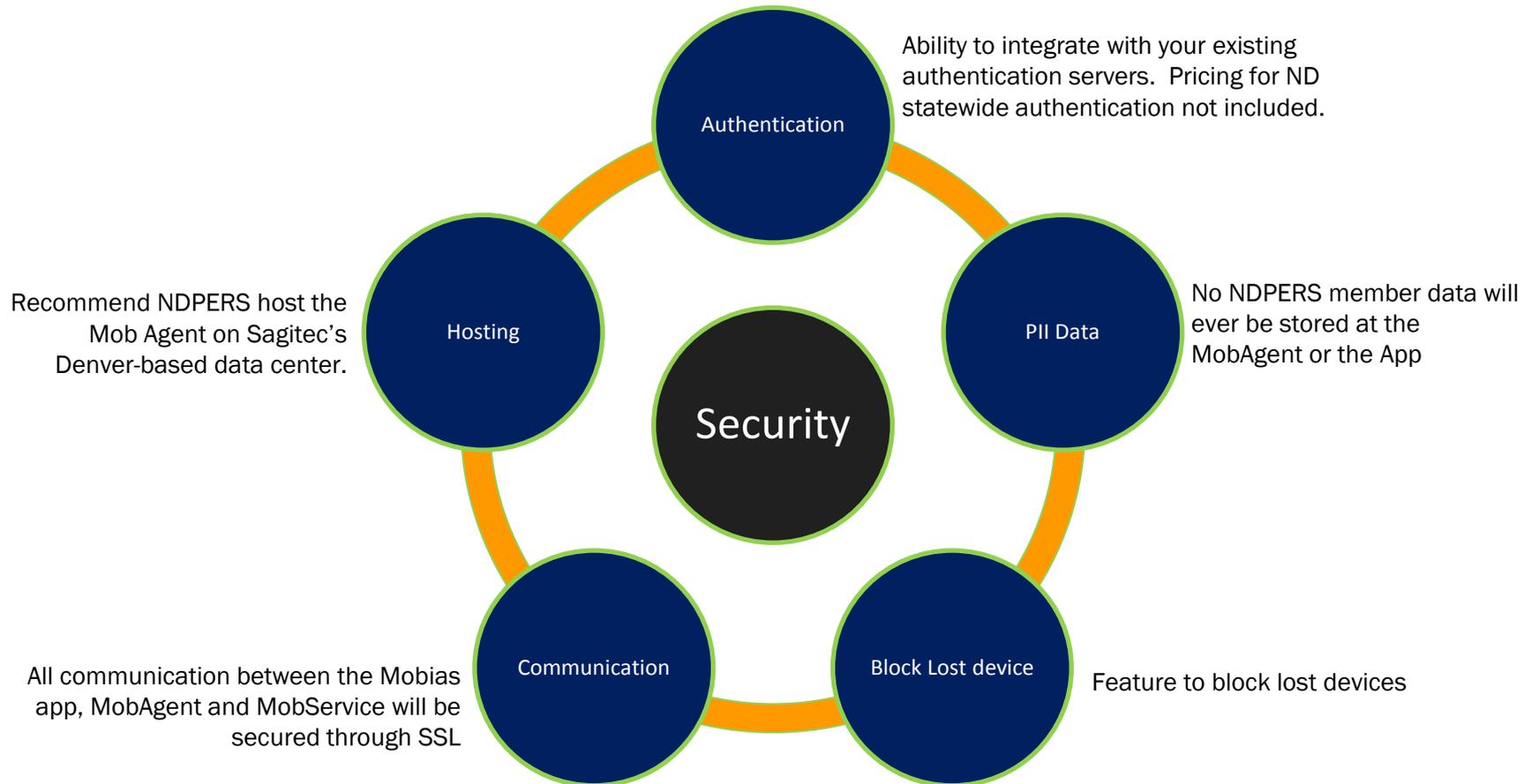
An 12 week user-centric and agile approach to deliver the core capabilities plus options (see page 4) with minimum involvement from your team/SME's.



12 week one-time implementation timeline to deliver core capabilities plus four optional components shown on page 4. Three months of warranty support is also included, following the go-live date.

# Security & Hosting Considerations

Security is a top concern. We take all reasonable measures to safeguard NDPERS member data.



# Early Adopter Pricing

Sagitec is seeking to partner with an early adopter and invest in a MOBIAS product launch. We are offering NDPERS early adopter deep pricing discounts to help us refine our implementation processes and technical architecture.

Cost Category	Description
Implementation	<ul style="list-style-type: none"><li>Covers a one-time cost to configure the core/optional capabilities and to integrate MOBIAS with PERSLink solution.</li><li>Making necessary one time customization on the MOBIAS App and MOBIAS Service Configuration.</li></ul>
Licensing (annual)	<ul style="list-style-type: none"><li>Grants non-perpetual rights to the use of the MOBIAS app, MOBIAS Agent, MOBIAS Admin and MOBIAS Service.</li><li>Access to the most up-to-date version of the MOBIAS app, MOBIAS Agent and MOBIAS Admin and MOBIAS Service.</li><li>Through MOBIAS Admin:<ul style="list-style-type: none"><li>Ability to make configuration changes to core and optional functionality.</li><li>Ability to monitor at user and access analytics.</li><li>Ability to perform administrative tasks relating to users and functionality.</li></ul></li><li>Sagitec assisting in making necessary deployments of the core and optional functionality.</li></ul>
Hosting (annual)	<p>Covers the recurring cost of:</p> <ul style="list-style-type: none"><li>Provisioning required hardware.</li><li>Software configurations at data center.</li><li>Data Center Maintenance.</li></ul>
Support	<p>Covers any ongoing maintenance and support to keep the MOBIAS stack in sync with PERSLink solution or Member Self Service. New MOBIAS modules or significant UI/UX design is not included in support.</p> <ul style="list-style-type: none"><li>Minimum 2 year agreement required. After 2 years, annual license fees will be the lesser of (a) new model, or (b) current fees with annual escalations. Annual license fees will increase by 3% per year.</li><li>Sagitec will implement a single-tenant solution. NDPERS agrees to keep MOBIAS Pension 'ever green' by implementing all releases when they are made available by Sagitec.</li><li>Annual licensing includes fees related to Apple, Android and Windows store fees and SSL certificate (not to exceed \$400).</li><li>ND Statewide authentication services not included in pricing.</li></ul>

# Early Adopter Pricing for NDPERS

## SINGLE TENANT

- NDPERS members can search app store for 'NDPERS' and download the MOBIAAS app.
- MobAgent and MobMonitor will be hosted at a ND State facility and the MobService will be hosted within NDPERS domain.
- Once a member selects 'NDPERS' as their provider, the user experience will change to NDPERS -branded user experience.

IMPLEMENTATION (ONE TIME)	Weeks	Fees	Discount	Total	Fees	Discount	Total	Savings
CORE CAPABILITIES*	8	\$165,000	100%	\$0	\$165,000	100%	\$0	\$0
OPTIONAL CAPABILITIES (4)+	12	\$270,000	50%	\$135,000	\$80,000	0%	\$80,000	\$75,000
<b>TOTAL (ONE TIME)</b>	<b>20</b>	<b>\$435,000</b>		<b>\$135,000</b>	<b>\$245,000</b>		<b>\$80,000</b>	<b>\$75,000</b>

LICENSING & HOSTING (ANNUAL)	Fees	Discount	Total	Fees	Discount	Total	Savings
LICENSING CORE CAPABILITIES	\$78,000	61.5%	\$30,000	\$78,000	61.5%	\$30,000	\$0
LICENSING (4 OPTIONAL CAPABILITIES)	\$8,000	0%	\$8,000	\$8,000	100%	\$0	\$8,000
HOSTING	\$5,750	0%	\$5,750	\$0	\$0	\$0	\$5,750
<b>TOTAL (ANNUAL)</b>	<b>\$91,750</b>		<b>\$43,750</b>	<b>\$86,000</b>		<b>\$30,000</b>	<b>\$13,750</b>

- See page for list of core and optional capabilities included in price. We assume the functionality will be limited to that which is available on the current PERSLink MWP. Onsite presence will be limited to the greatest extent possible.
- Pricing for each option was reduced to \$20,000.. Billing for licensing will be 50% paid up front, 25% when registration hits 2,500 members, and 25% when registration his 3,500 members.
- **This offer is good until December 31, 2015.** After that, discount associated with core capabilities will be revised.

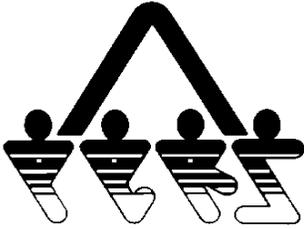
# Implementation staffing assumptions (based on 8 weeks)

Sagitec Team		Hours
Program Leadership	Engagement Leader	20
	Program Manager	40
Business Architecture	Application & Process Architect	320
	Offshore Application & Process Tester	240
	Offshore Application & Process Tester	240
Technology	Offshore Development Lead	320
	Offshore Developer	320
	Offshore Developer	320
	Offshore Developer	320
<b>Total</b>		<b>2,140</b>
Client Team		Hours
Program Leadership	Program Director	20
Business Team	Pension Solution SME	80
Technical Team	Technical SME	40
<b>Total</b>		<b>140</b>

# MOBIAS Hardware Requirements

NDPERS will need to provision for the below hardware/software to run the MOBIAS stack.

Server #	Purpose	Inside KPERs DMZ zone?	Configuration
1	Routes the request to MobAgent	No	This is public facing Server. It could either done using existing public facing server or DMZ zone itself routing the request
2	Runs the MobService.	Yes	<ul style="list-style-type: none"> <li>- VM Server</li> <li>- Windows Server 2012 (64 bit)</li> <li>- 16 Gb RAM</li> <li>- Quad processor</li> <li>- SQL Server 2012 or above</li> <li>- .NET framework 4.5</li> <li>- IIS 8.0 or higher</li> <li>- Enable MSMQ features</li> <li>- Windows Power Shell</li> <li>- C Drive 40 GB free space</li> <li>- D Drive 40 GB free space</li> <li>- Local Admin Access</li> <li>- C - Drive with OS and software D - Drive for the LOB software</li> </ul>



**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](mailto:NDPERS-info@nd.gov) • [www.nd.gov/ndpers](http://www.nd.gov/ndpers)

# Memorandum

**TO:** NDPERS Board  
**FROM:** Kathy  
**DATE:** December 10, 2015  
**SUBJECT:** Annual Enrollment Update

Annual enrollment was conducted from October 19<sup>th</sup> through November 6<sup>th</sup>. Since 2013 we have promoted the PERSLink Member Self Service (MSS) to employees for making their annual enrollment elections. Following are the statistics on the elections that were made through MSS during annual enrollment.

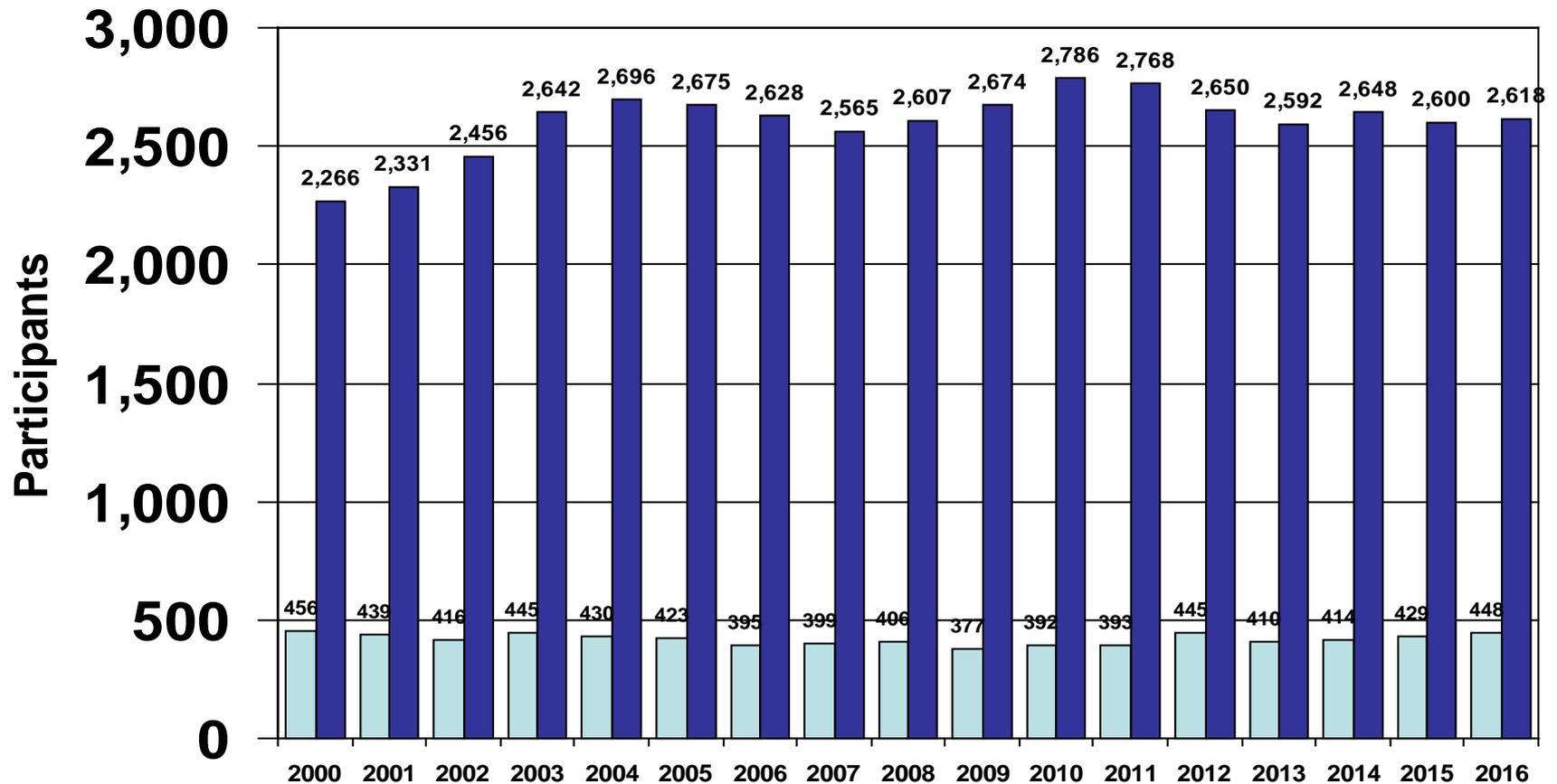
<b>Plan</b>	<b>Total Annual Enrollment Elections</b>	<b>Enrollments through MSS</b>	<b>% MSS</b>
Dental	2,825	2,758	98%
Vision	3,420	3,369	99%
Health	597	447	75%
Life	905	781	86%
FlexComp	3,489	3,146	90%

Included for your information are graphs tracking the participation in the flexcomp program since the year 2000. The participation for 2016 is up slightly from 2015 for both the medical spending and dependent care accounts. The annual dollars deferred and the average monthly deferrals have also increased.

We are available to answer any questions.

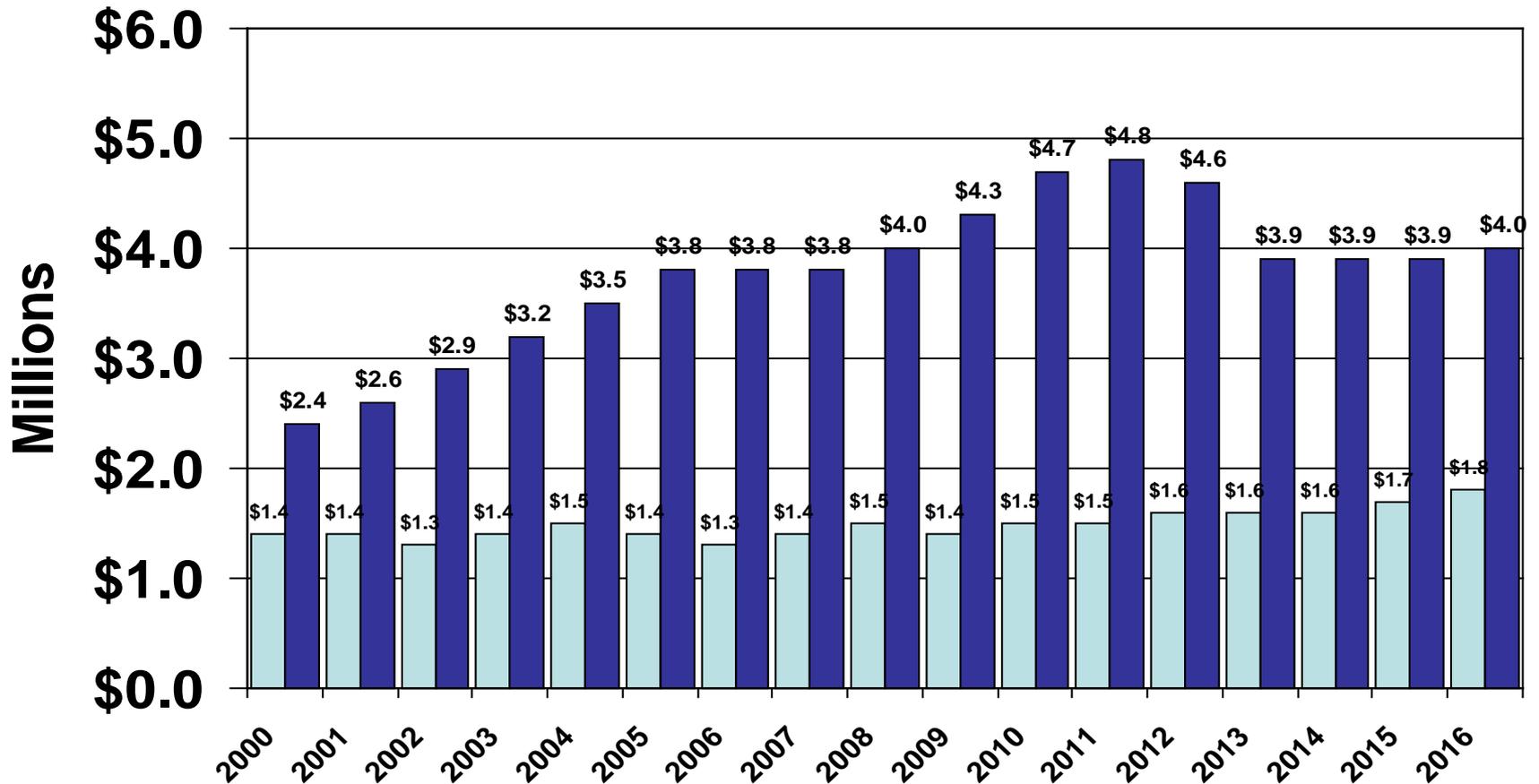
# NDPERS Flexcomp Participation

Dependent Care Medical Spending



# NDPERS Flexcomp Participation

Dependent Care Medical Spending



# NDPERS Flexcomp Participation

Dependent Care Medical Spending

