

NDPERS BOARD MEETING

Agenda

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

February 16, 2012

Time: 8:30 AM

I. MINUTES

- A. December 28, 2011
- B. January 11, 2012

II. PERS AUDIT – Brady Martz (Information)

III. GROUP INSURANCE

- A. BCBS Update – (Information)
- B. Wellness Program Update – BCBS (Information)
- C. Tobacco Cessation Program Update – BCBS (Information)
- D. Trend Analysis – BCBS (Information)
- E. Dependent Coverage Update – Sparb (Board Action)
- F. Heart of America HMO – Kathy (Board Action)
- G. Medicare Secondary Payer Recovery – Kathy (Information)
- H. Affordable Care Act (ACA) Compliance – Deloitte (Board Action)
- I. Health Insurance Bid – Sparb (Board Action)

IV. RETIREMENT

- A. Segal Renewal – Sparb (Board Action)
- B. Federal Regulatory Update – Sparb (Board Action)

V. MISCELLANEOUS

- A. Legislation/PERS Benefits Committee Update – Sparb (Board Action)
- B. Personnel Policies – Kathy (Board Action)
- C. Quarterly Consultant Fees – (Information)
- D. Election Committee – Kathy (Board Action)
- E. Administrative Rules Update – Deb (Information)
- F. 2011 Comprehensive Annual Financial Report – Sharon (Information)
- G. SIB Agenda

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.

Memorandum

TO: NDPERS Board

FROM: Jamie

DATE: January 30, 2012

SUBJECT: 2011 Audit Report Presentation

Included is the 2011 audit report for the PERS agency. John Mongeon from Brady Martz & Associates will be at the Board meeting to review the report with you and answer any questions you may have. This report will be reviewed by the Audit Committee at its February meeting.



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

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

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

Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 9, 2012
SUBJECT: BCBS Update

Attached, for your information, is a letter from Paul von Ebers providing a BCBS update.

BlueCross BlueShield of North Dakota

*An independent licensee of the
Blue Cross & Blue Shield Association*



4510 13th Avenue South
Fargo, North Dakota 58121

PAUL VON EBERS
President and
Chief Executive Officer

(701) 282-1327
FAX (701) 282-1866
paul.vonebers@bcbsnd.com

January 10, 2012

Mr. Sparb Collins
Executive Director
North Dakota Public Employee Retirement System
400 East Broadway, Suite 505
P.O. Box 1657
Bismarck, ND 58502-1657

Dear Mr. Collins:

On behalf of Blue Cross Blue Shield of North Dakota (BCBSND), I want to thank North Dakota Public Employees Retirement System (NDPERS) for its continued membership. We want to ensure that our products and services align with your commitment to provide sustainable health care to your members, and we appreciate your willingness to continue to communicate your concerns and suggestions with us. Below, are updates regarding BCBSND initiatives that will have a positive impact on NDPERS, and the benefits of a continued and collaborative partnership between our two great organizations.

First, we want to address your members' frustrations with the poor performance of our wellness portal, MyHealthCenter. BCBSND apologizes for the time it has taken to transition to a new online provider. We will launch a new wellness site for NDPERS members in February 2012 that will provide increased functionality and usability. As a result, we believe the new site will make it easier and more efficient for more NDPERS members to engage in healthy lifestyle choices.

In tandem with our wellness site is our MediQHome program which provides a tool for patients to manage chronic conditions together with their primary care doctors. BCBSND has data that shows MediQHome has already improved patient engagement and decreased health care costs. In fact, 52 percent of NDPERS members (excluding retirees) living in North Dakota are enrolled in MediQHome. Fifteen hospital and doctor groups were added in 2011. Overall, 74 percent of BCBSND participating providers are part of the MediQHome initiative and we expect that number to increase in 2012. The program has received national attention, with several Blues plans adopting the platform. BCBSND would be pleased to have our Chief Medical Officer, Dr. David Hanekom, present early findings of the program to you that show positive tangible results.

In addition to member engagement, BCBSND converted North Dakota pharmacies to the Prime Select Network in 2011 and generic drug pricing improvements were also made with estimated annual savings of more than \$2,400,000. NDPERS has a high generic dispensing rate of nearly 75 percent and we will continue to promote generic prescription use so members receive the best possible pricing on prescriptions.

BCBSND and Prime Therapeutics continue to work on numerous initiatives to reduce the overall pharmacy cost trend. A future Prime software infrastructure will allow for the integration of medical and pharmacy data that will allow medical providers to identify gaps in care based on diagnosis and prescription histories. The software will also allow for prescription adherence programs to improve medication adherence for depression, chronic respiratory conditions, and other chronic conditions.

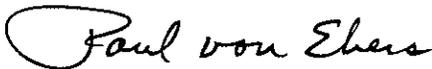
BCBSND and Prime are committed to full transparency on pharmacy pricing methodologies and outcomes. Again, we would be pleased to present more information to you on all our pharmacy strategies that will contribute to sustainable health care for NDPERS members.

An advantage BCBSND has in reversing the health care cost trend is our Total Cost of Care Contract relationships with large provider systems in the state. As discussed at the June 2011 board meeting, we plan to establish even more relationships and have already received several letters of intent. We expect to have new Total Cost of Care Contract relationships in place in 2012. BCBSND continues to maintain strong long-term participation relationships with all hospitals and 99 percent of health care professionals in North Dakota. The financial arrangements in these relationships support the NDPERS Basic and PPO products with discounts that contribute to cost stability.

Through our Large Group Management team, which includes Kevin Schoenborn, manager of consulting services, and Onalee Sellheim, NDPERS service representative, we will continue to develop assessments of the NDPERS plan, provide insight and recommendations on medical and pharmacy utilization and benefits, and plan strategy and outreach opportunities. BCBSND will, again, provide feedback on suggestions and observations for the RFP development to support your efforts in collecting meaningful data for comparing vendors. BCBSND would encourage, and would consider funding the cost of performing a provider claims re-pricing strategy by an external vendor. BCBSND and its large group management team are committed to working with NDPERS and your members to ensure you get the best value and service in the years to come. BCBSND would also be pleased to discuss and provide feedback on the impact of health care reform on product design in the next biennium.

BCBSND is committed to the important relationship we share with you and we appreciate your partnership. I am always available to discuss your suggestions and concerns, and attend meetings where I can provide information or answer questions. Thank you for your continued business.

Best regards,

A handwritten signature in cursive script that reads "Paul von Ebers". The signature is written in dark ink and is positioned above the typed name and title.

Paul von Ebers
President and CEO
Blue Cross Blue Shield of North Dakota



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Memorandum

TO: PERS Board

FROM: Sparb

DATE: February 7, 2012

SUBJECT: Wellness Program Update

Staff from BCBS will be available at the February meeting to review the attached wellness program information with the Board and to answer any questions you may have.



Memorandum

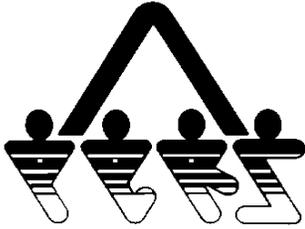
TO: Sparb Collins, NDPERS

FROM: Kevin Schoenborn, BCBSND

DATE: February 8, 2012

SUBJECT: Introduction to the new online wellness tool, HealthyBlue

Tara Roberts, BCBSND/NDPERS Wellness Specialist, will be at the February 16th Board meeting to introduce HealthyBlue, the new online wellness tool. Tara will be providing information on the communication strategy associated with the launch of HealthyBlue to the NDPERS members as well as providing an introductory demonstration of the site. HealthyBlue will be replacing MyHealthCenter as the online wellness tool made available to NDPERS.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 7, 2012
SUBJECT: Tobacco Cessation Program

Staff from BCBS will be available at the February meeting to review the attached tobacco cessation information with the Board and to answer any questions you may have.

NDPERS Tobacco Cessation: Program Outcomes

2005-2011 Outcomes of the NDPERS Tobacco Cessation Program

*Division of Medical
Management*

*Jami Berger
Director Quality
Management*

*Wendy Blair
Health Care Data
Analyst*

*December 2011
Last Updated: 1/23/2012*

Purpose

The NDPERS Smoking Cessation Program was designed to help State employees and their families to stop using tobacco. Members who participate in the program receive reimbursement for medical office visits and medication to facilitate their smoking cessation. If successful, the program could result in a reduction of members who use tobacco, which could result in significant health care cost savings. The current report examines four biennia of the program:

1. July 1, 2005 through June 30, 2007 (1st Biennium)
2. July 1, 2007 through June 30, 2009 (2nd Biennium)
3. July 1, 2009 through June 30, 2011 (3rd Biennium)
4. July 1, 2011 through December 31, 2011 (six months of 4th Biennium)

Results presented herein examine members, start dates, and expenditures among NDPERS members.

Methodology

Data were submitted to Noridian Benefit Plan Administrators (NBPA). NBPA collected enrollment information and administered ID cards. Each ID card issued represents a new start date. Enrollment information and subsequent claims information for counseling, physician visits and medication were stored in the Noridian Mutual Insurance Company's (NMIC) data warehouse. Management Information Services (MIS) gathered the data and submitted it to Health Informatics (HI) for further analysis. Data were obtained from July 1, 2005 through December 31, 2011.

Findings

- I. Demographics : Throughout the four biennia, there have been a total of 1,041 unique NDPERS members that have participated in a tobacco cessation program (1,441 program start dates). It was found that 41.1% of the participants were male, and the average age of all participants was 46.1 years old (at time of program start).

Table 1 demonstrates the number of unique members that started a tobacco cessation program within each of the biennium periods, the number of start dates by those members and demographics within each biennium period.

Table 1. Demographics

Biennium	# Mems	# Start Dates	% Male	Avg Age
July 1, 2005 to June 30, 2007	239	243	45.2%	47.1
July 1, 2007 to June 30, 2009	448	516	48.2%	45.3
July 1, 2009 to June 30, 2011	319	417	50.8%	45.7
July 1, 2011 to December 31, 2011	73	73	41.1%	46.1
Total			46.3%	46.1

Findings (continued)

Table 2 (below) examines the total expenditures incurred by biennium for the members that used the available services, and was obtained through the Finance Department at BCBSND. Total costs of the program for all biennia thus far were \$333,296.

Members in this analysis included only those who incurred expenses. In the 4th biennium, there were 147 members who registered for a tobacco cessation program but did not incur any expenses.

Table 2. Biennium Program Expenditures *

Biennium	# Mems	Total Dollars Paid	Average Dollars per Member
(07/01/05 - 06/30/07)	245	\$106,558	\$435
(07/01/07 - 06/30/09)	314	\$130,689	\$416
(07/01/09 - 6/30/11)	207	\$82,171	\$397
(07/01/11 - 12/31/11)	48	\$13,878	\$289
Total	814	\$333,296	\$409

* Expense data were received from the Finance Department at BCBSND and includes administrative costs and claims.

II. Expenditures: Table 3 (below) examines the benefit type expenditures incurred by biennium.

Table 3. Biennium Claim Expenditures

Biennium	Benefit Description	Services	Total Paid	Avg Paid
2005-2007	CONSULTATION	226	\$22,129.00	\$113.48
	INELIGIBLE	3	\$0.00	\$0.00
	O.T.C. DRUGS	209	\$8,769.01	\$72.47
	OFFICE VISIT	58	\$4,433.24	\$80.60
	PPO PHARMACY	646	\$48,812.24	\$120.23
	Total		\$84,143.49	
2007-2009	BUPROPION	1	\$0.00	\$0.00
	CHANTIX	272	\$27,734.07	\$119.03
	CONSULTATION	160	\$15,127.00	\$123.99
	NICOTINE GUM	35	\$1,781.42	\$65.98
	NICOTINE INHALER	1	\$217.47	\$217.47
	NICOTINE LOZENGE	26	\$1,211.43	\$80.76
	NICOTINE PATCH	25	\$1,187.09	\$62.48
	O.T.C. DRUGS	81	\$3,497.66	\$59.28
	OFFICE VISIT	47	\$3,734.87	\$81.19
PPO PHARMACY	438	\$46,263.15	\$129.23	
	Total		\$100,754.16	
2009-2011	BUPROPION	19	\$455.00	\$23.95
	CHANTIX	338	\$46,201.00	\$137.50
	CONSULTATION	3	\$373.00	\$124.33
	NICOTINE GUM	207	\$10,614.00	\$52.03
	NICOTINE LOZENGE	48	\$2,323.00	\$48.40
	NICOTINE PATCH	84	\$3,598.00	\$42.83
	OFFICE VISIT	54	\$3,259.00	\$69.34
	Total		\$66,823.00	
2011-2013	BUPROPION	3	\$42.00	\$14.00
	CHANTIX	45	\$6,973.00	\$162.16
	NICOTINE GUM	55	\$3,503.00	\$63.69
	NICOTINE LOZENGE	14	\$737.00	\$52.64
	NICOTINE PATCH	24	\$835.00	\$34.79
	OFFICE VISIT	5	\$526.00	\$105.20
	Total		\$12,616.00	

It should be noted that the category *PPO Pharmacy* was used in the 2005-2007 biennium. However, starting in July 2008, the category was no longer summarized, with services and total paid allocated to the appropriate type of medication. Therefore, the 2007-2009 biennium contains both the *PPO Pharmacy* category, as well as the different types of medications. The current biennium only reports by type of medication.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 7, 2012
SUBJECT: Financial/Trend Analysis

Staff from BCBS will be available at the February meeting to review the attached financial/trend analysis with the Board and to answer any questions you may have. As you are aware trend is what our premiums are based upon. A annual trend of 7% could translate into a biennial premium increase of 14%. As you will note on the attached our trend has been increasing since our last renewal which is not good news since our renewal projections will be done this summer. The attached shows a trend of about 9% for the last month shown. The following table shows what the effect could be on premiums at various levels.

Active State Renewal Rate

PERS 2011- 2013 Allocation and 2013-2015Projection	NDPERS 2013-2015 Planning Projections			
	7% Trend	8% Trend	9% Trend	10% Trend
7-2009 rate	\$658.08	\$658.08	\$658.08	\$658.08
9-2011 rate	\$825.66	\$825.66	\$825.66	\$825.66
1-2013 rate	\$886.62	\$886.62	\$886.62	\$886.62
1-2013 % increase	7.4%	7.4%	7.4%	7.4%
ected 2013-2015 BCBS rate	\$1015.09	\$1034.15	\$1053.39	\$1072.81
3-2015 \$ increase	\$128.47	\$147.53	\$166.77	\$186.19
3-2015 % increase	14.5%	16.6%	18.8%	21.0%
al State additional funds *	\$35,458,000	\$40,718,000	\$46,029,000	\$51,388,000
al additional general funds **	\$21,275,000	\$24,431,000	\$27,617,000	\$30,833,000

* - For biennium assuming 11,500 State FTE's

** - Assumed to be 60% of total funds

BCBS will be at the meeting to review the attached and answer questions.

Financial/Trend Analysis

NDPERS Quarterly Trend Analysis

Paid through December 31, 2012

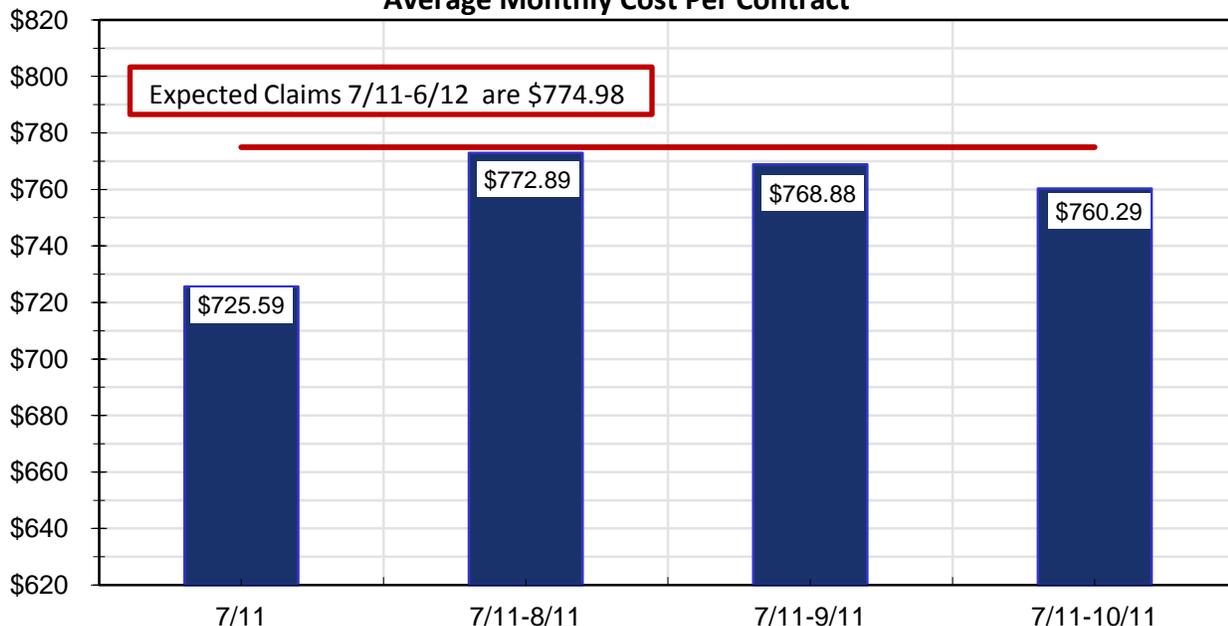
Twelve Month Moving Average				
Incurred Month	Est Incurred Claim/Contract		Annual Trend	
	Actives	Med Retirees	Actives	Med Retirees
12/09	649.13	156.02	1.0%	6.8%
1/10	649.62	161.37	2.0%	12.4%
2/10	654.15	163.47	3.1%	12.5%
3/10	661.15	164.27	4.2%	10.6%
4/10	660.09	164.52	3.5%	10.3%
5/10	656.07	165.54	2.2%	11.0%
6/10	663.09	165.98	2.9%	10.2%
7/10	667.63	166.56	3.6%	10.8%
8/10	673.09	166.31	4.7%	8.6%
9/10	672.56	165.90	4.1%	7.3%
10/10	675.15	166.70	4.9%	8.1%
11/10	678.07	168.40	4.5%	8.8%
12/10	680.83	167.47	4.9%	7.3%
1/11	687.44	171.32	5.8%	6.2%
2/11	691.53	171.17	5.7%	4.7%
3/11	693.50	170.71	4.9%	3.9%
4/11	700.14	170.85	6.1%	3.8%
5/11	710.60	170.40	8.3%	2.9%
6/11	714.51	171.44	7.8%	3.3%
7/11	715.28	170.98	7.1%	2.7%
8/11	726.14	170.44	7.9%	2.5%
9/11	735.75	169.14	9.4%	2.0%
10/11	737.37	167.01	9.2%	0.2%

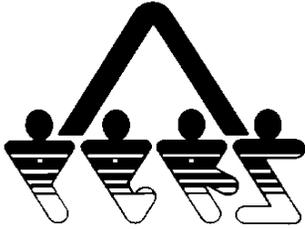
•The 9.4% twelve month rolling trend for NDPERS Actives through September 2011 is greater than the Blue Cross Blue Shield overall trend of 4.0%.

• The table below shows that current experience is below the claim level that is built into the pricing.

NDPERS - Actives

Average Monthly Cost Per Contract





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Memorandum

TO: PERS Board
FROM: Sparb and Kathy
DATE: February 8, 2012
SUBJECT: Dependents

Attachment #1 is a memo we reviewed in December concerning the eligibility of dependents. Attachment #2 is the updated wording for our plan document which is effective February 1; this will be mailed to our members.

With this change it is possible that some dependents have been dropped from coverage based upon the old definition. Based upon current provision they can come on the plan during the next open enrollment which would be effective January, 2013. However, given the evolving change in the definition over the last several months, BCBS has indicated they would allow a special open enrollment opportunity should PERS so elect which would allow those eligible dependents to enroll on the plan before the next open enrollment.

Board Action Requested

To determine if PERS should offer a special enrollment opportunity to dependents this spring.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: December 12, 2011
SUBJECT: Health Reform

The following is a recent guidance bulletin issued by the Insurance Commissioner relating to Dependent Coverage:



North Dakota
Insurance Department
Adam W. Hamm, Commissioner

BULLETIN 2011-3

TO: All Health Insurers
FROM: Adam Hamm, Commissioner
DATE: December 6, 2011
SUBJECT: Dependent Coverage to Age 26 Under State Law and Federal Law

Under the federal law known as the Patient Protection and Affordable Care Act (PPACA), health plans that provide dependent coverage must extend coverage to adult children up to age 26.

Insurers are reminded, however, that PPACA does not supersede North Dakota insurance law, N.D.C.C. § 26.1-36-22, which requires most health insurance policies to provide coverage to certain adult children up to 26 years of age regardless of whether the adult child has employer-sponsored coverage. State law also requires coverage of dependents of dependents and of certain adult children of any age who are disabled. Insurers must be aware that a young adult may not qualify for dependent coverage under the federal law, but could qualify under the more generous state law.

If you have questions regarding this bulletin, please contact Cydra Sauter at the North Dakota Insurance Department at (701) 328-2440.

AH/njb

We will updating our procedures based upon the above.

Group Benefit Plan Amendment

This is an amendment made to your health benefit plan effective on your Group's anniversary date. Please read this amendment carefully and keep it with your Certificate of Insurance for future reference. All other provisions remain as set forth in your Certificate of Insurance.

Under Section 8, DEFINITIONS:

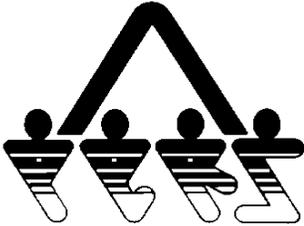
The Eligible Dependent definition:

- B. The Subscriber's or the Subscriber's living, covered spouse's children under the age of 26 years who are not eligible to enroll in an employer sponsored health plan other than a group health plan of a parent. Children are considered under age 26 until the end of the month in which the child becomes 26 years of age. The term child or children includes:

is amended as follows:

- B. The Subscriber's or the Subscriber's living, covered spouse's children under the age of 26 years. Children are considered under age 26 until the end of the month in which the child becomes 26 years of age. The term child or children includes:

If you have any questions regarding this amendment, please contact Member Services at the address or telephone number on the back of your Identification Card.



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Memorandum

TO: NDPERS Board

FROM: Kathy

DATE: February 9, 2012

SUBJECT: Heart of America Health Plan

Attached is the request from Heart of America Health Plan in Rugby to continue to offer its health plan to state and participating political subdivision employees in its Rugby service area. The term of this renewal is from July 1, 2012 through June 30, 2013. The new rates are included in the materials provided by Heart of America. The premiums for all coverage levels of coverage and plan options for the upcoming contract period have increased by approximately 10% over the current year. All other required information is attached and appears to be in order. The State Insurance Department has indicated that it has not received any complaints or appeals on Heart of America over the past year.

The following outlines the current number of contracts for those employers in the Rugby service area:

Rolette County	3
Game & Fish	1
Pierce County	8
City of Rugby	1

Since we last reported, Pierce County increased from 2 to 8 contracts and the City of Rugby is a new addition.

BOARD ACTION REQUESTED

Accept or reject the Heart of America request to continue to offer its health plan to PERS membership in the Rugby service area.



810 S. Main, Rugby, ND 58368
(701) 776-5848 or 800-525-5661
www.hoahp.com
email: hoahp@gondtc.com

January 12, 2012

RECEIVED

JAN 17 2012

ND PERS

Sparb Collins
North Dakota Public Employees Retirement System
Box 1657
Bismarck, ND 58502

RE: Request to offer Heart of America Health Plan membership
To qualified North Dakota Public Employees

Dear Mr. Collins,

The Heart of America Health Plan is requesting its continued participation in the North Dakota Public Employees Retirement System. We are asking for the continued participation for eligible employees living in the Rugby market area. We are also enclosing the following information in compliance with Article 71-03-02 of the NDCC 54-52-1.

1. Copy of Certificate of Authority issued by the ND Commissioner of Insurance
2. Copy from the Secretary of Health and Human Services that Heart of America Health Plan is a federally qualified HMO.
3. Rate sheets for 2012.
4. Financial statements for Heart of America Health Plan.
5. Benefit grids for Rugby market area plans (High, Low & Share Option).
6. Provider directory for the Rugby market area.

In addition, Heart of America Health Plan agrees to hold open enrollment coinciding with the dates the board holds open enrollment for the program.

As in the past, we are submitting this information to assure our continued participation with NDPERS as a health carrier for our Rugby market area. Please consider this at your next meeting and let us know if any further information is needed. Thank you for your consideration of our request.

Sincerely,

A handwritten signature in cursive script that reads "Mary Ann Jaeger".

Mary Ann Jaeger
Marketing Representative

Enc.

Cc: Kathy Allen

STATE OF NORTH DAKOTA
Department of Insurance



RECEIVED
AUG 5 2004
~~HMC~~
RECEIVED
JAN 17 2012
ND PERS

Certificate of Authority

This Is To Certify that pursuant to the Insurance Code of the State of North Dakota, Heart of America Health Plan, organized under the laws of North Dakota, subject to its Articles of Incorporation or other fundamental organizational documents is hereby authorized to transact within the State of North Dakota, subject to provisions of this certificate, the following lines of insurance:

Accident & Health

as such lines are now or may hereafter be defined in Title 26.1, the insurance laws of the State of North Dakota.

This certificate is expressly conditioned upon the holder hereof now and hereafter being in full compliance with all of the applicable laws and lawful requirements made under authority of the laws of the State of North Dakota as long as such laws or requirements are in effect and applicable, and as such laws and requirements now are, or may hereafter, be changed or amended.

This certificate is at all times the property of the State of North Dakota and shall continue in force as long as the Insurer is entitled thereto under the laws of the State of North Dakota and until suspended or revoked or otherwise terminated, at which time the Insurer shall promptly deliver this Certificate to the Insurance Commissioner of the State of North Dakota.

In Witness Whereof, I have hereunto set my hand at the City of Bismarck on August 1, 2004.

JIM POOLMAN



COMMISSIONER OF INSURANCE

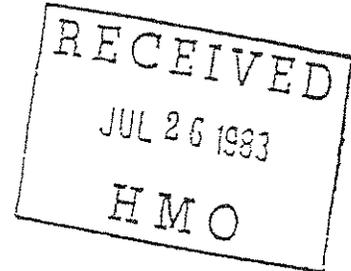
Bureau of Health Maintenance Organizations
and Resources Development

RECEIVED
Health Resources and
Services Administration
JAN 17 2012
Rockville MD 20857

ND PERS

July 22, 1983

Mr. Kenneth L. Ulmer
Executive Director
Heart of America Health Maintenance
Organization
Human Service Center
Rugby, North Dakota 58368



Dear Mr. Ulmer:

We are pleased to inform you that Heart of America Health Maintenance Organization meets the requirements of an operational group model qualified health maintenance organization in accordance with Title XIII of the Public Health Service Act and 42 CFR 110.603. This finding is based on a review of the qualification application, other submissions to the Department and on-site inspections. The service area shown in the enclosure has been approved.

Qualification will be effective on the date of the signature on the enclosed assurance document by which the HMO agrees to continue to abide by the requirements of the Act and applicable regulations. To assist us in verifying continued compliance with the requirements of the Act, Heart of America Health Maintenance Organization must comply with the National Data Reporting Requirements for a Type A HMO. These reporting requirements will be sent to you by the Division of Compliance upon receipt of your assurances.

Please sign, notarize, and return the assurances to the Division of Qualification, Room 9-21 Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857 within 30 days of the date of this letter. If the assurances are not returned by this date, we will assume that Heart of America Health Maintenance Organization is declining designation as a federally qualified health maintenance organization.

My best wishes for success in your HMO endeavors.

Sincerely

A handwritten signature in cursive script that reads "Frank Seubold".

Frank H. Seubold, Ph.D.
Acting Associate Director for
Health Maintenance Organizations

Enclosures

cc: Chairman of the Board

HEART OF AMERICA HEALTH PLAN RATES - 2012**RUGBY PLAN***Group***CONTRACT****PLAN TYPE**

	<u>HIGH OPTION</u>	<u>LOW OPTION</u>	<u>SHARE OPTION</u>
SINGLE	\$489.60	\$448.80	\$365.50
SINGLE PLUS DEPENDENT	\$840.60	\$773.60	\$630.40
FAMILY	\$1,148.30	\$1,064.70	\$868.30

EXCELLENT COVERAGE AND LESS CONFUSION!

~ GREAT CLINIC COVERAGE

~ EXCELLENT MATERNITY COV. (YOU PAY VIRTUALLY NOTHING - HIGH OPTION)

~ NO HOSPITAL DEDUCTIBLE (HIGH OPTION)

~ LESS OUT/POCKET COST (HIGH AND LOW OPTION)

~ COMPREHENSIVE COVERAGE, INCLUDING PREVENTIVE HEALTH SERVICES, REFERRAL SERVICES AND OUT-OF-AREA EMERGENCIES

HAHP'S BALANCE SHEET

As of 10-31-11

ASSETS	Current YTD	Previous YTD
General Checking	\$218,045	\$193,187
Money Market Accounts	\$230,046	\$118,948
Kodiak Oil & Gas	\$0	\$0
Ferrelgas Stock	\$48,659	\$39,900
Central Harvest States Stock	\$40,810	\$39,159
Investors Real Estate Trust (IRET)	\$194,981	\$183,788
Bonds	\$0	\$119,525
CD's	\$1,013,762	\$1,186,160
Accrued Interest on Investments	\$21,858	\$30,413
Premium Income	\$7,569	\$8,038
A/R Reinsurance	\$18,823	\$175,029
A/R CMS Settlements	\$0	\$0
A/R Operations	\$0	\$0
Prepaid Insurance	\$0	\$0
Furniture, Equipment & Leasehold	\$4,446	\$6,271
TOTAL ASSETS	\$1,798,999	\$2,100,418
LIABILITIES		
Unearned Premium		
Rugby Non-Medicare	\$51,245	\$42,484
Minot Non-Medicare	\$4,338	\$2,565
Rugby Medicare	\$36,093	\$36,468
CMS Contribution	\$0	\$0
A/P Administrative Bills	\$0	\$0
A/P Premium Tax	\$10,380	(\$3,681)
A/P Payroll Taxes	\$635	\$560
Accrued Vacation	\$13,140	\$12,378
IRA's Payable	\$0	\$0
Claims Adjustment Payable	\$29,264	\$21,112
Reported But Unpaid Claims	\$164,764	\$201,739
Incurred But Not Reported	\$274,386	\$321,642
TOTAL LIABILITIES	\$584,245	\$635,267
Surplus Notes	\$320,000	\$320,000
Accumulated Surplus Funds	\$894,754	\$1,145,151
TOTAL SURPLUS	\$1,214,754	\$1,465,151
TOTAL LIABILITIES & SURPLUS	\$1,798,999	\$2,100,418

HAHP Income Statement

As of 10-31-11

REVENUE	Current Month	Current YTD	Previous YTD
Rugby Non-Medicare Premium	\$271,475	\$2,688,700	\$2,615,137
Minot Non-Medicare Premium	\$14,554	\$150,707	\$152,314
Medicare Premium	\$102,321	\$1,016,041	\$1,037,917
Rugby Reinsurance	\$22,300	\$328,999	\$214,177
Minot Reinsurance	\$0	\$0	\$19,220
Interest	\$2,055	\$33,593	\$37,550
CMS Settlement Reimbursement	\$0	\$33,708	\$22,085
TOTAL REVENUE	\$412,705	\$4,251,748	\$4,098,400
EXPENSES			
Rugby			
Capitation Payments	\$91,484	\$841,514	\$857,582
In-Area Services	\$30,813	\$415,449	\$414,820
Referral Services	\$221,053	\$2,891,417	\$2,643,418
Out-Of-Area Services	\$1,217	\$89,755	\$84,250
Other Medical Services	\$5,411	\$25,594	\$77,912
Minot			
In-Area Services	\$86,675	\$455,311	\$390,056
Out-Of-Area Services	\$1,739	\$2,627	\$772
Other Medical Services	\$151	\$3,163	\$896
Discounts from Providers	(\$85,092)	(\$898,266)	(\$859,053)
Reinsurance	\$26,132	\$219,802	\$199,642
Premium Tax	\$5,482	\$55,256	\$54,331
Plan Administration	\$24,186	\$300,445	\$289,495
TOTAL EXPENSES	\$409,251	\$4,402,067	\$4,154,121
SURPLUS (DEFICIT)	\$3,454	(\$150,319)	(\$55,721)
Unrealized Gain/Loss w/ Investments	\$0	\$0	\$0
Realized Gain/Loss w/ Investments	\$0	\$0	\$1,140
NET SURPLUS / DEFICIT	\$3,454	(\$150,319)	(\$54,581)

Heart of America Health Plan

"High Option Plan"

RECEIVED
JAN 17 2012

NO PERS

NO Annual Deductibles!!	COPAYMENT	HAHP	EXCEPTIONS/LIMITATIONS
DESCRIPTION OF BENEFITS	AMOUNT YOU PAY	BENEFIT AMOUNT	
Preventive Health Services			No maximum benefit allowance.
Routine childhood and adult immunizations.	\$0	100%	
Routine physicals, Gynecological exams, Prostate and Breast exams, Mammograms, Pap smears, PSA's and other preventive health services.*	\$0	100%	
Physician Services			
Hospital visits, including inpatient and skilled nursing facility visits.	\$0	100%	
Office visits and/or house calls authorized by PCP.	\$15	100%	
Specialist consultation and treatment when authorized by PCP.	\$25	100%	
Diagnostic / Therapeutic Services			
X-Rays, CT scans, MRI's, EKG's, Laboratory Tests, Chemotherapy, Radiation, & other medically necessary services.	\$0	100%	
Inpatient Hospital Services			
Semi-private room, Physician services, General nursing services, Surgery and facilities, Intensive care, & other medically nec. services.	\$0	100%	
Outpatient Hospital Services at Primary Care Hospital	\$0	100%	
Maternity Services			
Prenatal care.	\$15	100%	\$15 copay on first visit. Then 100% covered.
Hospital services, Birthing/delivery, & Newborn nursery.	\$0	100%	
Well-baby care.	\$0	100%	
Emergency Services			
Emergency room, Physician/Nursing services, & Ambulance services.	\$30	100%	In or Out of Area Emergencies.
Mental Health Services			
Inpatient &/or Partial hospitalization.	\$0	100%	Inpatient Max: 45 days per calendar year. Outpatient: 100% hours 1-5; hours 6-30 80% Up to 120 days per member per calendar year
Outpatient		100%/80%	
Residential Treatment	\$0	100%	
Alcohol and Substance Abuse Services			
Inpatient &/or Partial hospitalization.	\$0	100%	Inpatient Max: 60 days per calendar year. Outpatient: 100% visits 1-5; visits 6-20 80%
Outpatient.		100%/80%	
Referral Services			
Authorized referral to a specialty physician or facility on the HAHP preferred physician referral list.	\$25	100%	With prior authorization by PCP and HAHP
Authorized referral to a specialty physician or facility NOT on the HAHP preferred physician referral list when services can NOT be provided by participating providers.	\$25	100%	
Authorized referral to a specialty physician or facility NOT on the HAHP preferred physician referral list when services CAN be provided by participating providers.	\$25	80%	
Chiropractic Care	\$10	100%	With prior approval by PCP and HAHP
Physical, Speech, and Occupational Therapy	\$10		Short-term therapy is 1st two consecutive months. Long-term therapy is one PT and one OT visit/month following short term.
Durable Medical Equipment Orthopaedic and Prosthetic Devices.			80% coverage on items exceeding \$25. Coinsurance max. payable by the member is \$500/contract/year. Maximum benefit is \$3,500 member/year.
Skilled Nursing Facility Medical care and treatment including room and board, when prescribed by PCP and in participating provider facility.			100% coverage when authorized by primary care physician. (Up to 60 days per calendar year)
TMJ (Temporomandibular joint disorder) CMJ (Craniomandibular joint disorder)			Lifetime maximum of \$10,000 surgical, \$2,500 non-surgical/member.
Home Health Nursing Care			100% coverage when authorized by primary care physician.
Hospice Services			Covered in accordance with Medicare Guidelines.
This sheet describes the essential features of the HAHP plan in general terms and is not intended to be a full description.			
* Copayment, coinsurance and deductible cost-sharing is waived for certain preventive services.			

Heart of America Health Plan

"Low Option Plan"

RECEIVED
JAN 17 2012

IND PERS

NO Annual Deductibles!!	COPAYMENT	HAHP	EXCEPTIONS/LIMITATIONS
DESCRIPTION OF BENEFITS	AMOUNT YOU PAY	BENEFIT AMOUNT	
Preventive Health Services Routine childhood and adult immunizations. Routine physicals, Gynecological exams, Prostate and Breast exams, Mammograms, Pap smears, PSA's and other preventive health services.*	\$0 \$0	100% 100%	No maximum benefit allowance.
Physician Services Hospital visits, including inpatient and skilled nursing facility visits. Office visits and/or house calls authorized by PCP. Specialist consultation and treatment when authorized by PCP.	\$0 \$15 \$25	100% 100% 100%	
Diagnostic / Therapeutic Services at Primary Care Hosp. X-Rays, CT scans, MRI's, EKG's, Lab tests, Chemotherapy, Radiation, & other medically necessary services.	\$0	100%	20% Coinsurance will be applied to readings & interpretations for these services billed by an outside facility.
Inpatient Hospital Services Semi-private room, Physician services, General nursing services, Surgery and facilities, Intensive care, & other medically nec. services.	\$250 (1st/4th Day)	100%	\$1,000 copay maximum per contract per calendar year
Outpatient Hospital Services at Primary Care Hospital	\$0	100%	
Maternity Services Prenatal care. Hospital services, Birthing/delivery, & Newborn nursery. Well-baby care.	\$15 \$250 (1st/4th day) \$0	100% 100% 100%	\$15 copay on first visit. Then 100% covered. \$1,000 copay max per calendar year
Emergency Services Emergency room, Physician/Nursing services, & Ambulance services.	\$30	100%	In or Out of Area Emergencies.
Mental Health Services Inpatient &/or Partial hospitalization. Outpatient. Residential Treatment	\$250 (1st/4th day) \$250 (1st/4th day)	100% 100%/80% 100%	Inpatient Max: 45 days per calendar year. Outpatient: 100% hours 1-5; hours 6-30 80% Up to 120 days per member per calendar year
Alcohol and Substance Abuse Services Inpatient &/or Partial hospitalization. Outpatient.	\$250	100% 100%/80%	Inpatient Max: 60 days per calendar year. Outpatient: 100% visits 1-5; visits 6-20 80%
Referral Services Authorized referral to a specialty physician or facility on the HAHP preferred physician referral list. Authorized referral to a specialty physician or facility NOT on the HAHP preferred physician referral list when services can NOT be provided by participating providers. Authorized referral to a specialty physician or facility NOT on the HAHP preferred physician referral list when services CAN be provided by participating providers.	\$25 \$25 \$25	80% 80% 80%	\$500 coinsurance max. per calendar year \$500 coinsurance max. per calendar year With prior authorization by PCP and HAHP. \$3,000 coinsurance max. per calendar year
Chiropractic Care	\$10	80%	With prior approval by PCP and HAHP.
Physical, Speech, and Occupational Therapy	\$10		Short-term therapy is 1st two consecutive months. Long-term therapy is one PT and one OT visit/month following short term
Durable Medical Equipment Orthopaedic and Prosthetic Devices.			80% coverage on items exceeding \$25. Coinsurance max. payable by the member is \$500/contract/year. Maximum benefit is \$3,500/member/year.
Skilled Nursing Facility Medical care and treatment including room and board, when prescribed by PCP and in participating provider facility.			100% coverage when authorized by primary care physician. (Up to 60 days per calendar year)
CMJ (Cranio-mandibular joint disorder) TMJ (Temporomandibular joint disorder)			Lifetime maximum of \$10,000 surgical, \$2,500 non-surgical/member.
Home Health Nursing Care			100% coverage when authorized by primary care physician.
Hospice Services			Covered in accordance with Medicare Guidelines.

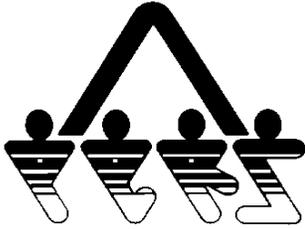
This sheet describes the essential features of the HAHP plan in general terms and is not intended to be a full description.

* Copayment, coinsurance and deductible cost-sharing is waived for certain preventive services.

Heart of America Health Plan "Share Option Plan" FIVE

JAN 17 201

Deductibles= SNG-\$500 SPD-\$750 FAM-\$1000 Coinsurance Max/Yr= SNG-\$1000 SPD-\$1500 FAM-\$2000	COPAYMENT AMOUNT YOU PAY	BENEFIT AFTER DEDUCT.	EXCEPTIONS/LIMITATIONS
DESCRIPTION OF BENEFITS			
Preventive Health Services (By Primary Care Physician) Routine childhood and adult immunizations. Routine physicals, Gynecological exams, Prostate and Breast exams, Mammograms, Pap smears, PSA's and other preventive health services.*	\$0 \$0	100% 100%	No maximum benefit allowance. Deductible Waived
Physician Services (By Primary Care Physician) Hospital visits, including inpatient and skilled nursing facility visits. Office visits and/or house calls authorized by PCP.	\$0 \$15	100% 100%	Deductible Waived
Diagnostic Services X-Rays, CT scans, MRI's, EKG's, Lab Tests and other medically necessary services provided at Primary Care hospital or other facility.	\$0	80%	
Chemotherapy & Radiation Therapy Services provided at Primary Care Clinic Services provided at Primary Care Hosp.or contracted Referral Facility	\$0 \$0	100% 80%	Deductible Waived Deductible Applies
Inpatient Hospital Services Semi-private room, Physician services, General nursing services, Surgery and facilities, Intensive care, & other medically nec. services.	\$0	80%	
Outpatient Hospital Services at Primary Care Hospital or Referral Facility	\$0	80%	
Maternity Services Prenatal care (at Primary Care Clinic) Hospital services, Birthing/delivery, & Newborn nursery. Well-baby care (at Primary Care Clinic)	\$15 \$0 \$0	100% 80% 100%	\$15 copay on first visit. Then 100% covered. Deductible applies Deductible waived
Emergency Services Emergency room, Physician/Nursing services.	\$30	80%	In or Out of Area Emergencies.
Ambulance Services	\$0	80%	When medically necessary
Mental Health Services Inpatient &/or Partial hospitalization. Outpatient. Residential Treatment	\$0 \$0 \$0	80% 80% 80%	Inpatient Max: 45 days per calendar year. 100% hours 1-5; (hours 6-30 80% after deductible) Up to 120 days per member per calendar year
Alcohol and Substance Abuse Services Inpatient &/or Partial hospitalization. Outpatient.	\$0 \$0	80% 80%	Inpatient Max: 60 days per calendar year. 100% visits 1-5;(visits 6-20; 80% after deduct.)
Referral Services Authorized referral to a specialty physician or facility on the HAHP preferred physician referral list. Authorized referral to a specialty physician or facility NOT on the HAHP preferred physician referral list when services can NOT be provided by participating providers. Authorized referral to a specialty physician or facility NOT on the HAHP preferred physician referral list when services CAN be provided by participating providers.	\$25 \$25 \$25	80% 80% 60%	With prior authorization by PCP and HAHP With prior authorization by PCP and HAHP With prior authorization by PCP and HAHP
Chiropractic Care	\$10	80%	With prior approval by PCP and HAHP
Physical, Speech, and Occupational Therapy Outpatient	\$10	80%	Short-term therapy: 1st two consecutive months Long-term therapy: one PT/ one OT visit/month
Durable Medical Equipment Orthopaedic and Prosthetic Devices.	\$0	80%	\$2,000 Maximum Benefit per member/year.
Skilled Nursing Facility Medical care and treatment including room and board, when prescribed by PCP and in participating provider facility.	\$0	80%	When authorized by primary care physician. (up to 60 days per calendar year)
TMJ/CMJ (Temporomandibular/Craniomandibular joint disorder)	\$0	80%	Lifetime max. of \$10,000 surg./\$2,500 non-surg.
Home Health Nursing Care	\$0	80%	when authorized by primary care physician.
Hospice Services	\$0	80%	Covered in accordance with Medicare Guidelines.
This sheet describes the essential features of the HAHP plan in general terms and is not intended to be a full description.			
* Copayment, coinsurance and deductible cost-sharing is waived for certain preventive services.			



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

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

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

Memorandum

TO: PERS Board

FROM: Sparb

DATE: February 6, 2012

SUBJECT: Medicare Secondary Payer Recovery Contractor

The Medicare Secondary Payer Recovery Contractor (MSPRC) protects the Medicare trust fund by recovering payments Medicare made when another entity had primary payment responsibility. The MSPRC accomplishes these goals under the authority of the Medicare Secondary Payer (MSP) Act. The MSPRC identifies and recovers Medicare payments that should have been paid by another entity as the primary payer either under a Group Health Plan (GHP) or as part of a Non-Group Health Plan (NGHP) claim. The MSPRC does not pursue supplier, physician, or other provider recovery.

PERS staff and BCBS have struggled with this program over the years and it has caused some of our participating employees worry as well. At this meeting we wanted to brief the board on this program so staff from BCBS will be at the Board meeting to review the MSPRC.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 9, 2012
SUBJECT: ACA Compliance

Attached is a memo from Deloitte concerning the "Shared Responsibility" provision of the Affordable Care Act (ACA) which is effective January 2014. As you will note in reviewing the attached the affordable care act establishing a definition of "full time employee" and then sets forth specific requirements for employers. You will also note in the attached that our definition of "Permanent employee" which is our equivalent to "full time" is not the same. Finally you will note in the attached that while the law sets forth certain requirements much is yet to be clarified in rules which are expected to be released in draft form sometime this year. Pat Pechacek from Deloitte will be at our meeting to further review with you the attached and answer your questions.

Given the above the challenge we face is that the effective date of the above after the beginning of the next biennium so if we are to legislatively address this question it must be during the 2013 session. We know we must have our proposed legislation submitted next month so given that we know what the law requires but we do not know what the rules say the question is how do we go forward? Staff would recommend that we submit at this time a proposed bill to change the definitions in our statute to match those in the law and in so submitting acknowledge that we are awaiting the proposed rules and would expect at that time to be proposing changes based upon the additional recommendations.

Board Action Requested

Authorize staff to move forward based upon the above recommendation.

Memo

Date: February 6, 2012
To: Sparb Collins, NDPERS
From: Robert Davis
Subject: Shared Responsibility Rules

Following is a preliminary assessment of the State of North Dakota's potential exposure to Shared Responsibility payments under the Affordable Care Act ("ACA"). It is based on the current eligibility and premium contribution requirements under the PERS group health plan, as summarized below, and on the relevant provisions of the ACA and related guidance issued as of February 6, 2012.

The Shared Responsibility rules discussed below are effective for months beginning after December 31, 2013. These rules apply to "applicable large employers,"¹ and not to group health plans. As a result, the effective date should not vary according to plan or policy year.

Current Eligibility Rules and Premium Contributions

The following two classes of employees are eligible to participate in the PERS group health plan:

1. "Eligible Employees" include –
 - a. "permanent employees," defined as employees "whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1, 2003, is employed at least twenty hours per week and at least twenty weeks each year of employment", and
 - b. Members of the legislative assembly, judges of the supreme court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, certain elective state officers, and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund.

¹ The ACA defines "applicable large employer" for a calendar year as any "employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year."



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Member of Deloitte Touche Tohmatsu Limited

To: Sparb Collins, NDPERS
Subject: Shared Responsibility Rules
Date: February 6, 2012
Page 2

2. “Temporary Employees” who satisfy the following criteria –
 - a. If employed before August 1, 2007, by completing the necessary enrollment forms and qualifying under the medical underwriting requirements, or
 - b. If employed on or after August 1, 2007, if employed at least 20 hours per week and at least 20 weeks per year.

Eligible Employees do not pay any portion of the premium for PERS group health plan coverage. Temporary Employees generally pay the entire premium for PERS group health plan coverage.

Affordable Care Act Shared Responsibility Rules

The Affordable Care Act’s Shared Responsibility rules, effective beginning on January 1, 2014, will impose potential penalties on “applicable large employers” that –

1. fail to offer “minimum essential coverage”² to “full-time employees” and their dependents (“No Coverage”), or
2. offer “minimum essential coverage” to full-time employees and their dependents, but the coverage does not meet certain minimum value and affordability thresholds (“Inadequate Coverage”).

For purposes of the Shared Responsibility rules, a “full-time employee” for any month is anyone who is employed on average at least 30 hours of service per week during that month. The Shared Responsibility penalty for No Coverage will be \$2,000 per “full-time employee” per year. This penalty will be imposed in these circumstances only if at least one full-time employee purchases coverage in a State Health Insurance Exchange and qualifies for a Premium Tax Credit or Cost-Sharing Reduction. A full-time employee who is not offered minimum essential coverage by his or her employer will qualify for a Premium Tax Credit or Cost-Sharing Reduction if his or her household income is at least 100%, but not more than 400%, of the federal poverty level.

The Shared Responsibility penalty for Inadequate Coverage will be \$3,000 per year for each full-time employee who –

1. Opts-out of the State’s coverage;
2. Purchases coverage in a State Health Insurance Exchange; and
3. Qualifies for a Premium Tax Credit or Cost-Sharing Reduction.

² The PERS group health plan will qualify as “minimum essential coverage” assuming it is a “governmental plan” under Public Health Service Act § 2791(d)(8) and assuming its coverage is not limited to “excepted benefits.”

To: Sparb Collins, NDPERS
Subject: Shared Responsibility Rules
Date: February 6, 2012
Page 3

A full-time employee who is offered minimum essential coverage by the State will qualify for a Premium Tax Credit or Cost-Sharing Reduction only if –

1. The State's coverage:
 - a. Does not meet a 60% minimum value threshold, or
 - b. Is unaffordable to the employee, meaning the employee's required contribution for self-only coverage exceeds 9.5% of his or her household income; AND
2. The employee's household income is at least 100%, but does not exceed 400%, of the federal poverty level.

Potential Exposure to Shared Responsibility Penalties Based on Eligibility Requirements

There are gaps in the eligibility rules for the PERS group health plan that may expose the State to potential Shared Responsibility penalties. Specifically, Permanent Employees employed less than 5 months per year (or less than 20 weeks per year, if first employed after August 1, 2003) and Temporary Employees employed on or after August 1, 2007 who are employed fewer than 20 weeks per year are not eligible for coverage. However, if any of these employees work an average of 30 hours per week during a month they technically will be treated as full-time employees for that month for purposes of the Shared Responsibility rules. As a result, these individuals may expose the State to Shared Responsibility penalties.

Options for addressing this potential problem include –

- Eliminating the 20 week (or 5 month) per year threshold for Permanent and Temporary Employees to be eligible for coverage;
- Eliminating the 20 week (or 5 month) per year threshold only for Permanent and Temporary Employees working at least 30 hours per week;
- Prohibiting Permanent and Temporary Employees who work fewer than 20 weeks per year from working 30 or more hours per week; or
- Eliminating the distinction between Permanent and Temporary Employees for eligibility purposes and making all employees who are full-time employees as defined in the ACA Act eligible for coverage.

Additional options might become available when the IRS issues guidance on the Shared Responsibility rules. For example, IRS Notice 2011-36 stated Treasury was considering “alternatives to a month-by-month determination of full-time employee status for purposes of calculating an applicable large employer's potential” Shared Responsibility penalty.³

³ Future guidance also should clarify how the Shared Responsibility rules will apply to employers that offer minimum essential coverage to most, but not all, full-time employees.

To: Sparb Collins, NDPERS
Subject: Shared Responsibility Rules
Date: February 6, 2012
Page 4

Potential Exposure to Shared Responsibility Penalties Based on Premium Contributions

The State also may be exposed to potential Shared Responsibility penalties with respect to Temporary Employees who are eligible for coverage if their premium contributions will exceed 9.5% of their household incomes. This almost certainly will be the case for at least some Temporary Employees because they pay the full premium cost.

In order to avoid this second potential problem, the State would need to subsidize the premiums for Temporary Employees who are full-time employees (as defined by the ACA) at least to the extent necessary to ensure their required contributions do not exceed 9.5% of their household incomes.

Alternative Solution

In addition to the possible solutions outlined above, another alternative the State may consider would be setting up a plan for all Permanent and Temporary Employees who are full-time employees (as defined by the ACA) that just meets the 60% minimum value threshold. By making all such employees eligible for this plan and providing an adequate premium subsidy the State could avoid both problems. The total cost of this plan would likely be less than the current PERS group health plan because it provides less comprehensive benefits.

cc: Pat Pechacek



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 9, 2012
SUBJECT: Health Bid

Attached is a memo from Deloitte concerning the upcoming bid for the group health plan. Pat Pechacek will be at the next meeting to review the attached and answer your questions.

The primary question we need to address is how to move forward with the health plan. It is scheduled to go to bid this year for the period starting July 2013. It has been our past practice to issue bids for both fully insured and self insured for a six year period. Last biennium we elected to issue the bid for two years and for fully insured for the following reasons:

1. At that time it was understood that changing carriers would have resulted in a plan losing its "Grandfathered" status under the health reform bill.
2. Due to the evolving nature of the health care market place because of health care reform, it was felt it would be difficult for PERS to fully consider a self insured product since we would not be able to clearly understand the extent of the financial and actuarial risks to the plan. More specifically, health care reform and its implications could cause a plan to face new risks that could not be fully understood or quantified that would limit our ability to fully understand the implications of self insurance. In addition, given the time, effort and resources required to submit and review a bid, it

was felt it would not be fair to vendors to ask for a bid that we could not fully consider given the above.

3. We also noted some NDCC statutory provisions that also limited our ability to fully consider self insurance.

As a result of the above three considerations, it was decided that PERS would go to bid for two years and on a fully insured basis only. It was hoped that during the subsequent two years we would be able to get a better understanding of the implications of health care reform and we could seek statutory changes to North Dakota Law.

Since our decision, we have learned two things:

1. Federal rules have clarified that changing carriers will not result in a plan losing its "Grandfathered" status.
2. We were able to amend state statute to allow us the opportunity to more fully consider the self insurance option and to allow us to bid the Rx plan separately.

The attached memo from Deloitte discusses the current health care market place and how it could affect our consideration of a self insured plan at this time and our ability to contract for a six year period.

Board Action Requested

1. Determine if PERS should issue a bid for 2 years or 6 years
2. Determine if PERS should issue a bid for fully insured and self insured with Rx or fully insured only.

Staff Recommendation:

Staff would recommend we issue a bid for two years for a fully insured plan only. The reason for this is two-fold:

1. As noted in the attached, it would be difficult for us to consider entering into an arrangement for more than two years at this time. Health care reform and its potential implications make the health care marketplace very uncertain at this time. Consequently, it is difficult for us to make a commitment to move forward along a

specific path for a period beyond two years. Once some of the uncertainty in the healthcare marketplace with the resolution of the provisions of the healthcare reform bill then we should move forward with a longer contracting once again.

2. If we are not going to bid for more than two years and given the uncertainty in the health care market place noted in the attached, it is very difficult for us to fully consider a self insured proposal at this time. Since we cannot give a self insured proposal full consideration, for us to put out a bid at this time requesting firms to take the time, effort and expense to submit a proposal that we ultimately don't fully consider, would be unfair to them and could hurt our creditability in the market resulting in less interest in our business when we are prepared to give a self insured proposal full consideration.

In 2012 NDPERS will begin soliciting bids on its health plan for the period beginning in July 2013. Some of the key issues to be decided include whether to pursue a standard 6-year bid instead of another 2-year bid, as well as whether to seek bids on a self-insured plan. Factors affecting these decisions will include a number of variables relating to the Federal Affordable Care Act (“ACA”). As summarized below, these variables include whether the ACA will survive current legal and political challenges and, if it does, the compliance burdens associated with the ACA’s primary requirements that become effective in 2014 and the impact on the NDPERS plan’s demographics when those requirements are fully implemented.

Will the ACA be changed, invalidated, or repealed before it is fully implemented?

Pending Supreme Court Ruling: The U.S. Supreme Court has agreed to hear a series of legal challenges to the ACA. Oral arguments have been scheduled for March 26-29, 2012; a decision may be issued before the Court’s current term ends in June of 2012. The Supreme Court may reject all challenges to the ACA, or decide the challenges are not ripe for consideration. Some other possible outcomes include the Supreme Court invalidating just the ACA’s individual mandate, or invalidating the ACA in its entirety.

Political Volatility: The November 2012 elections will determine control of the Executive and Legislative Branches of the Federal government during the period when most of the ACA’s key provisions are scheduled to take effect. The ACA almost certainly will be an issue during this election cycle, regardless of how the Supreme Court rules. But the combination of the Supreme Court’s ruling and election results will lay the groundwork for possible legislative and regulatory developments during the 113th Congress. The possibilities range from full repeal of the ACA to implementation according to the current schedule without significant changes. Some of the potential scenarios are summarized in the following table.

		2012 Election Results			
		<i>Obama wins re-election and Democrats retain Senate; Republicans retain House</i>	<i>Obama wins re-election; Republicans retain House and take control of Senate</i>	<i>Republicans win White House, retain House and take control of Senate</i>	<i>Republicans win White House; Democrats retain Senate and/or take control of House</i>
Supreme Court Ruling	<i>Supreme Court upholds ACA or decides challenges not “ripe”</i>	Repeal or significant legislative changes highly unlikely; implementation probably continues without interruption	Repeal or significant legislative changes unlikely; implementation probably continues with minimal interruption.	Repeal or significant legislative changes very possible.	Repeal unlikely but significant legislative changes possible; changes to implementing regulations very possible.
	<i>Supreme Court invalidates individual mandate but leaves rest of ACA intact</i>	Repeal of remainder of ACA highly unlikely; uncertain outlook for possibility of compromise on replacing individual mandate.	Repeal of remainder of ACA highly unlikely; compromise on replacing individual mandate less likely.	Repeal of or significant legislative changes to remainder of ACA very likely.	Repeal of remainder of ACA unlikely; uncertain outlook for possibility of compromise on replacing individual mandate.

	Supreme Court invalidates entire ACA	New health reform effort likely during 113 th Congress, but House likely to block any proposals by President Obama and/or Senate Democrats.	New health reform effort unlikely during the 113 th Congress.	New health reform effort unlikely during the 113 th Congress.	New health reform effort will likely be driven by Congressional Democrats; uncertain outlook for possibility of compromise with Republican President.
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Potential impact on Board's decision to --	
<ul style="list-style-type: none"> <i>Pursue a 2-year bid vs. a 6-year bid:</i> 	<i>Much of the uncertainty surrounding the ACA's fate should be resolved during the next 2 years, but until that time it might be difficult to negotiate beyond the 2-year horizon.</i>
<ul style="list-style-type: none"> <i>Pursue a fully-insured plan vs. a mix of fully-insured and self-insured:</i> 	<i>The significant uncertainty surrounding the future Federal legal framework for group health plans is a relevant consideration when deciding whether to assume the risks of self-insurance.</i>

If implemented as enacted, what are the compliance-related considerations?

Grandfather Status: NDPERS maintains a grandfathered health plan and a non-grandfathered health plan. The grandfathered health plan does not have to comply with certain of ACA's group health plan mandates, including the one relating to mandatory coverage of certain preventive care services without any cost-sharing. The cost of maintaining grandfathered status is limited flexibility to make certain plan design changes, such as increasing deductibles or copays by more than specified thresholds.

Compliance Burden: A second round of group health plan mandates is currently scheduled to take effect in 2014. These include a total bans on preexisting condition exclusions, annual dollar limits on essential health benefits, and waiting periods of more than 90 days.

Potential impact on Board's decision to --	
<ul style="list-style-type: none"> <i>Pursue a 2-year bid vs. a 6-year bid:</i> 	<i>Either a 2-year or 6-year bid will need to take into consideration the group health plan mandates taking effect in 2014.</i>
<ul style="list-style-type: none"> <i>Pursue a fully-insured plan vs. a mix of fully-insured and self-insured:</i> 	<i>The switch from a fully-insured plan to a mixed fully-insured/self-insured arrangement would not necessarily cause a loss of grandfathered health plan status. The burden of ensuring compliance with new group health plan mandates becoming effective in 2014 generally will fall to the insurer in the case of a fully-</i>

	<i>insured plan, and on the plan sponsor/plan administrator in the case of a self-insured plan.</i>
--	---

If implemented as enacted, what are the potential implications for plan demographics?

At least three aspects of the ACA will affect the number of active employees, spouses, and dependents participating in the NDPERS plans: (1) the Individual Mandate, which will impose financial penalties on individuals who do not carry minimum essential coverage; (2) the Shared Responsibility rules, which will impose financial penalties on employers that fail to offer minimum essential coverage to all “full-time employees” (generally, anyone working at least 30 hours per week) and their spouses and dependents; and (3) the availability of Health Insurance Exchanges, which will provide a group market alternative to the individual market for those who do not receive coverage through an employer or qualify for government-provided coverage. Until these three aspects of the ACA become effective in 2014 it is difficult to predict how they will impact the number of participants in the NDPERS plans. However, a significant decrease is possible if the political subdivisions find it is cheaper to pay the Shared Responsibility penalty and allow their employees to obtain coverage in an Exchange than providing coverage through NDPERS. But an increase in the number of participants is also possible if the political subdivisions continue providing coverage through NDPERS and change their eligibility standards to reflect the 30-hour per week definition of full-time employees. In either event, the individual mandate may result in enrollment by a higher percentage of eligible employees.

<i>Potential impact on Board’s decision to --</i>	
<ul style="list-style-type: none"><i>Pursue a 2-year bid vs. a 6-year bid:</i>	<i>Uncertainty about the impact of these provisions on the plan’s demographics might make it difficult to negotiate beyond the 2-year horizon.</i>
<ul style="list-style-type: none"><i>Pursue a fully-insured plan vs. a mix of fully-insured and self-insured:</i>	<i>Introducing self-insurance means the plan sponsor is assuming some of the risks associated with any changes to participant demographics resulting from the implementation of these provisions.</i>



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 9, 2012
SUBJECT: Segal Renewal

Attached please find the proposed renewal for Segal. While we had requested a two year renewal quote, they offered that plus an additional one year. For your reference, the following is the renewal quote for last time (we accepted the one year renewal based upon the two year offer).

Fixed Fee Rates	Existing One Year Fee	Proposed One Year Fee	Proposed Two Year Fee	
	7/1/10-6/30/11	7/1/11-6/30/12	7/1/11 - 6/30/12	7/1/12 - 6/30/13
Actuarial Valuation and Consulting Services				
-Plans: General, Judges, Law Enforcement with prior service, Law Enforcement without prior service, National Guard et.al.	\$59,500	\$75,000	\$65,600	\$75,000
- Retiree Health Insurance Credit Fund	\$11,000	\$16,000	\$12,100	\$16,000
- Job Service North Dakota	\$16,000	\$24,000	\$17,600	\$24,000
Total Fixed Fee Matters	\$86,500	\$115,000	\$95,300	\$115,000

Also the following is the information related to the last bid by TFFR:

	<u>Valuation Fixed Fee</u>	<u>Hourly Rate</u>
Cheiron	35,000	\$250 hour
Segal	38,000	\$265 hour
Cav Mac	40,000	\$280 hour
GRS	39,000	\$288 hour

Board Action Requested:

To accept or reject the Segal renewal and if accepted at what level (one, two or three years)



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February 8, 2012

Mr. Sparb Collins
Executive Director
North Dakota Public Employees' Retirement System
400 East Broadway, Suite 505
Bismarck, ND 58502

Re: Proposed Contract Extension

Dear Sparb:

The current consulting services contract extension expires June 30, 2012. Based upon your request, we are proposing a two-year extension of the current contract. The proposed fee increases are necessary to continue to provide quality consulting and are supported by the actual level of effort expended for NDPERS.

Segal values our over 20-year relationship with the System and has made every effort to provide increases that support the ever increasing level of diligence and care required for all public employee retirement systems. Our knowledge of the System's plans and provisions enhances assessing the impact of proposed changes and identifying future challenges. We will continue to work closely with the Board and staff through increased communications utilizing team calls to assure concurrence on and the outcome of core services and special projects.

The following tables set forth the proposed fees for consideration.

Benefits, Compensation and HR Consulting ATLANTA BOSTON CALGARY CHICAGO CLEVELAND DENVER HARTFORD HOUSTON LOS ANGELES
MINNEAPOLIS MONTREAL NEW ORLEANS NEW YORK PHILADELPHIA PHOENIX PRINCETON RALEIGH SAN FRANCISCO TORONTO WASHINGTON, DC



Multinational Group of Actuaries and Consultants BRUSSELS DUBLIN GENEVA HAMBURG JOHANNESBURG LONDON MELBOURNE NEW YORK
PARIS STOCKHOLM TOKYO TORONTO UTRECHT

Fixed Fee Rates	Existing Fee 7/1/11-6/30/12	Proposed Fee Year One 7/1/12-6/30/13	Proposed Fee Year Two 7/1/13-6/30/14
Actuarial Valuation and Consulting Services			
<i>-Plans: General, Judges, Law Enforcement with prior service, Law Enforcement without prior service, Highway Patrol, National Guard et.al.</i>	\$65,600	\$68,200	\$71,000
<i>- Retiree Health Insurance Credit Fund</i>	\$12,100	\$12,600	\$13,100
<i>- Job Service North Dakota</i>	\$17,600	\$18,300	\$19,000
Total Fixed Fee Matters	\$95,300	\$99,100	\$103,100

Time Charge Rates			
QDRO, Compliance Consulting, General Consulting and Special Projects	Time Charges per schedule	Time Charges per schedule	Time Charges per schedule
Flexible Compensation	Time Charges per schedule	Time Charges per schedule	Time Charges per schedule
Legislative Analysis	Time Charges per schedule	Time Charges per schedule	Time Charges per schedule
401(a) Defined Contribution Plans	Time Charges per schedule	Time Charges per schedule	Time Charges per schedule
457 Plan	Time Charges per schedule	Time Charges per schedule	Time Charges per schedule

The overall fixed fee covers the valuations listed above and two onsite meetings, one with the Board and one before the Legislative Committee. Other special projects or consulting will be charged on an hourly rate basis as listed below with prior approval from the System.

Hourly Rates	Existing Fee 7/1/11-6/30/12	Proposed Fee Year One 7/1/12-6/30/13	Proposed Fee Year Two 7/1/13 - 6/30/14
Consulting Actuary	\$380	\$395	\$410
Reviewing Actuary	\$410	\$425	\$440
Senior Actuarial Analyst	\$350	\$365	\$380
Actuarial Analyst	\$235	\$245	\$255
Compliance Consultant	\$360	\$375	\$390
Compliance Analyst	\$235	\$245	\$255

Instead of the consultant-based rates above, if the Board wishes, for all special projects or consulting outside the fixed fee may instead be charged at blended rate, held constant for two years, shown below.

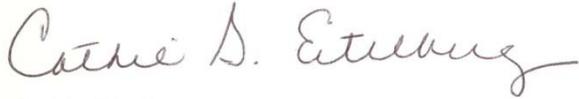
Hourly Rates	Existing Fee 7/1/11-6/30/12	Proposed Fee Year One 7/1/12-6/30/13	Proposed Fee Year Two 7/1/13 - 6/30/14
Blended Rate	N/A	\$350	\$350

Please note that any charges associated with the internal transition of work between the San Francisco and Los Angeles offices will not be charged to the System.

Mr. Sparb Collins
North Dakota Public Employees' Retirement System
February 8, 2012
Page 4

We respectfully submit this proposal for an extension. Please do not hesitate to call if I can answer any questions.

Sincerely,



Cathie Eitelberg
Senior Vice President
National Director, Public Sector Market

Sparb Collins
Executive Director
North Dakota Public Employees' Retirement System

Date

cc: John Coyle
Brad Ramirez
Tammy Dixon
Steve Ohanian

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Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 9, 2012
SUBJECT: Federal Regulatory Update

Attachment #1 is a memo from Melanie Walker at Segal providing an update on proposed regulations presently being considered at the national level. The one immediate concern relates to the Normal Retirement Age definition. As you will note in the attached, the IRS has issued proposed rules that would be effective for plan years starting after January 1, 2013 that would not allow a normal age based solely on years of service. However, you can have an unreduced retirement based upon the "Rule". The IRS has extended the compliance deadline on this twice and it is rumored that it will be extended again.

Further information on this issue is included in Attachment #2 which is a briefing memo from NCTR.

Given the above, the question is should we propose legislation to bring our plan in compliance with the proposed rule in March or wait to see if this extended again?

Melanie will be available via conference call to review this with you and answer questions.

Board Action Requested

To determine if we should submit proposed legislation relating to the IRS rules concerning "normal retirement age" or wait until a final determination is made.



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MEMORANDUM

To: Sparb Collins
From: Melanie Walker, JD
Date: February 7, 2012
Re: North Dakota PERS – status of federal regulations affecting governmental retirement plans

Per our telephone conversation last week, this memorandum provides an update of the status of two important federal regulations from the IRS, including a brief description of the potential impact such regulations may have on defined benefit plans of the PERS.

Normal Retirement Age Definition

In 2007, the IRS issued final regulations regarding permissible normal retirement age definitions for qualified pension plans (See Treasury Regulations section 1.401(a)-1(b)). Since then, the IRS has twice extended the deadline for governmental plans to comply with these regulations. Currently, governmental plans must comply with the normal retirement age regulations as of the first plan year beginning on or after January 1, 2013 (See IRS Notice 2009-86). The extensions were provided to give the IRS additional time to address comments on the application of the regulations to governmental plans.

These regulations do not permit a normal retirement age based solely on years of service or a combination of years and service where the age may be below 55 (or below age 50 for public safety employees). For example, neither the Hybrid Plan's Rule of 85 normal retirement age definition nor the Highway Patrol's Rule of 80 normal retirement age definition would comply with the regulations. Such restrictions on normal retirement age under the regulations are problematic for many governmental plans, especially in jurisdictions where state law does not permit reduction of benefits provided under a retirement plan in order to comply with federal laws and regulations. For this reason, it is possible that the normal retirement age rules for governmental plans may be modified, either by legislative or regulatory action, before the compliance deadline. In any case, governmental plans have an extended deadline for amending their plan documents to comply with IRS rules, which is generally the last day of the legislative session that begins after the effective date of the required amendment. For North Dakota, that would be the legislative session beginning in January 2013.

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Definition of Governmental Plan

In November 2011, the IRS issued a discussion draft of proposed regulations on the definition of a governmental plan under Internal Revenue Code section 414(d). The draft was released to provide interested parties the opportunity to comment on the proposed language before it is even issued as a regulation. In the last few days, the IRS has extended the deadline for written comments on the discussion draft until June 18, 2012, with public hearings on the matter to take place in July 2012. It is anticipated that after the comment period and public hearings, the IRS will release proposed regulations on the definition of a governmental plan, with a transition period before the regulations become final.

Under Code section 414(d), the basic definition of a governmental plan is one “established and maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing.” The draft language provides a proposed definition for each element under this Code section. In addition, the IRS requests input from interested parties on a de minimis rule which would permit a small number of non-governmental employees to participate in a governmental plan.

The draft language of the proposed regulations defines “State” as any State of the United States or the District of Columbia. The draft defines “political subdivision of a State” generally as a regional, territorial or local authority, such as a county or municipality, that is created or recognized by State statute to exercise sovereign authority where the governing officers either are appointed by State officials or publicly elected.

Under the North Dakota Century Code, only employees of the State of North Dakota or of a participating political subdivision may participate in defined benefit plans of the PERS. The statute does not permit participation by agencies or instrumentalities. To the extent only State employees and employees of political subdivisions participate in PERS, the IRS regulations, when finalized, should have no impact on the defined benefit plans.

Please let us know if you have any questions regarding the federal regulations described herein. As always, the information contained in this memorandum is provided within our role as your benefits consultant and is not intended to provide tax or legal advice.

Final Normal Retirement Age Regs for Governmental Plan In Limbo

It has been almost four years since the Internal Revenue Service (IRS) first asked the question whether normal retirement age under a public plan may be based, in whole or in part, on years of service. The issue was raised in connection with so-called "Normal Retirement Age" regulations that were released in final form in 2007, but whose application to governmental plans has been repeatedly delayed. Progress has been slow in resolving the matter, despite repeated meetings between governmental plan organizations, including NCTR, and the Treasury Department. Now, however, hundreds of determination letter requests are reportedly being held up by uncertainty regarding pending guidance in this area, and pressure is growing to provide a final ruling. Some believe that another extension may be in order, while others think that the matter may ultimately need to be dealt with legislatively.

Background

The so-called Normal Retirement Age (NRA) regulations that the IRS issued in May of 2007 in final form actually deal with the ability of individuals (both public sector and private sector) to receive "in-service" distributions. Generally speaking, the Internal Revenue Code (IRC) permits pension distributions only after a participant terminates employment, or reaches "normal retirement age." The 2007 regulations, which currently apply to the private sector only, now additionally permit a pension plan to pay benefits to an employee who has not terminated if the employee has attained age 62 – a provision which was contained in the "Distributions During Working Retirement" language of the Pension Protection Act of 2006 (PPA).

With regard to what qualifies as "normal retirement age," the regulations require that the normal retirement age under a plan be an age that is "not earlier than the earliest age that is reasonably representative of the typical retirement age for the industry in which the covered workforce is employed."

Several safe harbors are provided. For example, a normal retirement age of at least age 62 is deemed to meet this new "typical retirement age" standard; for plans with normal retirement ages between ages 55 and 62, there will be a presumption that they are acceptable based on a "good faith determination of the typical retirement age for the industry in which the covered workforce is employed that is made by the employer." (However, private sector employers have indicated this presumption is being interpreted as still requiring proof regarding the typical retirement age for the industry of the covered workforce.) For a normal retirement age that is lower than age 55, there is a presumption that it does not meet the new standard "absent facts and circumstances that demonstrate otherwise." (For plans where substantially all of the participants in the plan are qualified public safety employees, a normal retirement age of age 50 or later is deemed to meet the new standard.)

In 2007, the IRS also issued Notice 2007-69, underscoring that the new regulations do not provide a safe harbor with respect to a retirement age that is conditioned (directly or indirectly) on the completion of a stated number of years of service. The IRS also requested comments from sponsors of governmental plans on whether "normal retirement age" under such a plan may be based on years of service.

Governmental Plan Issues

There are several problems with the final regulations, whose application to governmental plans has been extended several times and which are now set to apply to public plans in the first plan year beginning on or after January 1, 2013.

1. All governmental pension plans would be required to specifically define a normal retirement age as an actual age. However, many governmental plans define normal retirement age or normal

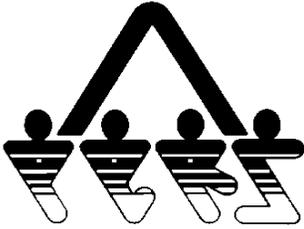
retirement date as the time or times when participants qualify for unreduced retirement benefits under the plan, which is set forth in State and/or local statutes and may not state a specific age.

2. Many governmental plans define normal retirement age or normal retirement date often based wholly or partly on years of service. Furthermore, under many governmental pension plans, a participant can reach normal retirement age by satisfying one of several age and service combinations. Sponsors of such plans would find it very difficult to select a single age to be the plan's normal retirement age. Selecting an age that is higher than the lowest age would likely impair the constitutionally protected rights of the participants to any benefit conditioned on normal retirement. Selecting an age that is lower than the highest age could impact the actuarial cost of the plan.
3. Governmental pension plans often provide multiple benefit structures and cover multiple employee groups. The use of the term "plan" under the Final Regulations makes it unclear whether such governmental plans will be required to engage in the enormous undertaking of going through state and local governing bodies to unnecessarily fracture governmental pension systems into several smaller "plans" in order to have multiple normal retirement ages or take advantage of the safe harbor relief provided under the final regulations. It is also unclear how "the typical retirement age for the industry in which the covered workforce is employed" would be applied in the diverse public sector setting.

Accordingly, NCTR and NASRA have proposed that governmental plans should not be required to define normal retirement age. For those, however, that do define a normal retirement age or date, such normal retirement age or date should be permitted to be based on age, service, or a combination of age and service. Finally, whether or not normal retirement age or date is specifically defined for a governmental plan, in-service distributions should be permitted when made on or after the earlier of age 62 or the date on which the participant is permitted to receive unreduced benefits under the plan.

Current Status

There have been several meetings with the Treasury Department over the last three years to discuss these regulations and the serious problems they would present for governmental plans. However, there has been little progress to date.



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Memorandum

TO: PERS Board
FROM: Sparb
DATE: February 9, 2012
SUBJECT: Legislation/PERS Benefits Committee

In March we must finalize our proposed legislation. We have discussed possible considerations at our last meeting and Attachment #1 includes the thoughts of the PERS Benefits Committee for your consideration. Attachment #2 is a memo from Segal reviewing several considerations that were discussed at the January meeting and reviewed by the PERS Benefits Committee. Attachment #3 includes suggestions from the PERS staff relating to various administrative changes including our biennial update for the IRS. Staff is seeking your direction on the attached so we can prepare legislative bill drafts for your consideration and approval at the next meeting.

PERS Benefits Committee

The PERS Benefits Committee basically felt that the primary consideration PERS should bring forward next session was the recovery plan. While the committee felt that some of the other ideas discussed had merit, they felt that we should not pursue them at this time since they were not as important as the recovery and could be a distraction for consideration of the recovery plan.

PERS Administrative Suggestions

In reviewing the attached, please note the discussion on items #2 and #3. In particular the discussion relating to dropping the level social security option.

BOARD ACTION REQUESTED

To determine what items should be included in proposed legislation for next session.

STAFF RECOMMENDATION

To accept the recommendation of the PERS Benefits Committee and:

1. Submit a single bill for the remaining years of the recovery plan with a 1% employer contribution increase and a 1% employee contribution increase effective January of 2014 and January of 2015 (1/2% for Law Enforcement Plans). Also, we would review the level of these increases when we have the information for 2012.
2. To accept staff recommendations for a separate bill dealing with administrative changes.

PERS BENEFITS COMMITTEE CONSIDERATIONS, DISCUSSIONS AND RECOMMENDATIONS

Considerations	Discussion	Consider	Do not Consider
<i>RETIREMENT</i>	<i>RETIREMENT</i>		
Submit original recovery plan	The committee felt it was prudent to stay the course on the recovery plan as proposed and communicated to the members and our employers	X	
Reduce request from original recovery plan based upon 21% return	That at this time it may be too early to adjust the recovery plan based upon a single year of earnings. PERS should wait until after this years returns are determined and the new actuarial report before making any adjustment to the recovery plan	X	
Reduce New member benefits	Due to the minimal effect this will have on helping the plan and the outcome of the considerations of this issue last time it should not be considered at this time.		X
Transfer contribution from Retiree Health	These contributions are dedicated to the RHIC program and should stay with that plan so its funded status can continue to improve as it has over that past years.		X
Reduce Multiplier for all members prospectively	Due to the legal complications and the outcome of the considerations of this issue last time it should not be considered at this time.		X
Transfer Money from Health Plan	It was noted that these funds will be needed for that program and should not be transferred. Further it was discussed that such a transfer could present problems with the federal rules		X
Submit more than one bill – like last time (based upon different funding methods – employer only, employee only or both)	Before last session three bills were submitted to the Legislative Employees Benefits Committee and they studied the three options and gave the employer only and employee only methods unfavorable recommendation. To repeat this process would be duplicative and at this point PERS should follow the		X

Considerations	Discussion	Consider	Do not Consider
	direction of the shared approach as approved previously and therefore submit one bill only (with the shared approach)		
Service Purchase method	The committee felt no legislative change should be done in this area however they indicated the board may want to review the administrative methodology (also see discussion in Segal memo, page 1)		X
Enhance PEP based upon new contribution	Segal indicated there would be a cost to enhancing this and therefore the committee felt it should not be pursued at this time. However it was suggested that this should be considered when the plan is in a better funded position (also see discussion in Segal memo, page 3)		X
Limit cost of sick leave conversion	Since there would be a cost to this, as indicated by Segal, it was felt this should not be pursued at this time (also see discussion in Segal memo, page 4)		X
Change Interest methodology (employee contributions)	Segal noted that this could save funds at this time if the rate was lowered. However the committee felt it should not be considered at this time. Specifically it was felt that if we lowered the rate at this time based upon market conditions it would mean that in the future we would need to increase the rate based upon market considerations. Consequently any savings would be short term and potentially offset by costs in the long term. Therefore it was felt that maintaining the existing fixed rate was the best approach (also see discussion in Segal memo, page 2)		X
Defined Contribution	Defined Contribution		
Continue to increase contributions	The committee felt that DC members should continue to be treated the same as DB members for contributions	X	
Do something extra for older members	The committee did not recommend any changes in this area		X

Considerations	Discussion	Consider	Do not Consider
<i>Retiree Health Plan</i>	<i>Retiree Health Plan</i>		
Allow the RHIC credit to be used for the dental, vision and LTC programs in addition to the health plan	Segal indicated there would be a cost of .18% to this change. As a result the committee felt it should not be pursued at this time and the additional funds should continue to be used to reduce the unfunded liability (also see discussion in Segal memo, page 4)		X



THE SEGAL COMPANY
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February 2, 2012

Mr. Sparb Collins
North Dakota Public Employees
Retirement System
400 East Broadway, Suite 505
Bismarck, ND 58502

RE: NDPERS - Plan Change Analysis

Dear Sparb,

Currently, the actuarial cost of the plan exceeds the statutory contribution that is being made to the plan. This gap can be reduced by greater statutory contributions, changes in plan design that reduce benefits, or both. In a recent phone conversation, we discussed potential plan design changes that might help close this gap, as well as some other minor changes that would increase plan costs. Specifically, you asked us to study the following six changes to the NDPERS Hybrid Plan:

1. Changing the Service Purchase feature to eliminate purchases of eligibility service.
2. Lowering the interest crediting rate on employee contributions
3. Updating the PEP contributions to reflect new contribution rates under SB 2108
4. Freezing the sick leave conversion rate
5. Offering the retiree health credit to participants in any medical plan
6. Offering the retiree health credit to participants in any North Dakota plan, including dental and vision

We'll cover each of these below, with items 5 and 6 combined.

Service Purchases

The plan currently allows participants to purchase service credits in order to increase plan benefits. Additional service is added for both benefit service (service that increases the benefit) and eligibility service (service that determines eligibility for the benefits). For example, a 62 year old participant with 20 years of service who purchased three years of service would receive an additional three years of benefit in his or her calculated retirement benefit and also would immediately become eligible for the unreduced Rule of 85 benefit.

The amount of benefit purchased is converted to a payment made by the member using age-based factors. These factors were designed so that the purchase of service credits will cover the



cost of the additional benefit purchased. However, the purchase factors do not reflect the cost of additional eligibility service that allows participants to receive benefits earlier than they would have had the service credits not been purchased.

Segal was asked to comment on the proposal that service purchases would continue to affect benefit service but no longer affect eligibility service.

To the extent that participants currently receive benefits earlier than they would have without the purchase of service, an actuarial loss is experienced by the plan. This loss is reflected in the unfunded actuarial accrued liability of the plan, increasing the employer actuarial contribution. If the provisions were changed so that service purchases no longer increased eligibility service, the result would be a lower unfunded actuarial accrued liability and lower employer actuarial contributions. It is difficult to estimate the effect of this change without a detailed review of the service purchase factors and utilization of the program.

Employee Contributions

Employee contributions to the plan are credited with interest at a rate defined by statute to be 0.5% less than the actuarial valuation's assumed rate of return on assets. Based upon the current assumption of 8%, the interest crediting rate is 7.5%. We were asked to assess two methods of reducing the interest crediting rate. One would tie the rate to an index and the other would be fixed.

If the rate was tied to an index (such as the CPI or LIBOR rate), a long-term assumption for this index would be made for subsequent actuarial valuations. An assumed rate less than the current rate of 7.5% would result in lower projected liabilities. However, to the extent that the actual indexed crediting rate differed from the assumed rate, actuarial gains or losses would occur.

If the current rate definition was changed to be a lower fixed rate, the employer actuarial contribution would decrease. For example, lowering the interest crediting rate to 4.0% would result in an employer cost savings of 0.31% of covered payroll for PERS Main members as illustrated below. Since this rate would be fixed by statute, we would not need an assumption for the valuation and no actuarial gains and losses would occur.

PERS Main System Employer Contribution Rate	7.50% Crediting Rate (Current Plan)	4.00% Crediting Rate (Proposed)	Savings
Normal Cost*	5.31%	5.00%	0.31%
20-Year UAL Payment	6.05%	6.05%	0.00%
Actuarial Recommended Contribution	11.36%	11.05%	0.31%

* The amount shown is net of member contributions and includes administrative expenses.

PEP Contributions

SB 2108 increased employer contribution rates for PERS members. For Main System participants, the employer contribution rate increased to 5% on January 1, 2012 and will increase to 6% on January 1, 2013. However, the employer contributions affected by the Portability Enhancement Provision (PEP) remain capped at 4% under current law. If the PEP cap increased along with the corresponding increases in employer contributions, an increase in plan costs would result.

Enhanced employer contributions under the PEP are subject to a graded vesting schedule. If the maximum contributions affected by the PEP were increased to reflect the increase in employer contributions, this vesting schedule would change. We have evaluated the change in cost using the following vesting schedule:

Service Credit	PEP Contribution (Current Plan)	PEP Contribution (Proposed)
0 – 12 months	1%	1.5%
13 – 24 months	2%	3.0%
25 – 36 months	3%	4.5%
37 or more months	4%	6.0%

If this change was implemented along with the contribution increase effective January 1, 2012, the additional vesting of employer contributions would increase the annual employer actuarial contribution for PERS Main members by 0.14% of covered payroll as shown below. Please note that we did not change the assumed participation in the PEP program in this estimate. It is possible that participation rates could change as a result of the higher PEP matching percentages.

PERS Main System Employer Contribution Rate	PEP Contribution (Current Plan)	PEP Contribution (Proposed)	Increase
Normal Cost*	5.31%	5.48%	0.17%
20-Year UAL Payment	6.05%	6.02%	(0.03%)
Actuarial Recommended Contribution	11.36%	11.50%	0.14%

*The amount shown is net of member contributions and includes administrative expenses.

Sick Leave Conversions

At retirement, members are allowed to convert unused sick leave pay into benefits under the PERS and the Retiree Health Insurance Credit Fund (RHICF) in a similar manner as service purchases. Instead of using actuarially determined factors for this conversion, members contribute the combined statutory rate of 11.26% of covered payroll (10.12% for the retirement plan and 1.14% for the RHICF) on the amount of service converted. These rates change automatically whenever the statutory contribution rates change.

We were asked to consider the effect of freezing the conversion rate at 11.26% of covered payroll, rather than reflecting the increases in contributions scheduled to occur on January 1, 2013. If these amounts are frozen, it would result in less contributions in the form of sick leave conversions than if the amounts were not frozen.

We have not performed a detailed analysis of sick leave conversions. Nonetheless, it seems that conversions under the current method would result in actuarial losses because the conversions are made at retirement when there is less time for the contributions to accumulate with interest. If the contribution rates were frozen, those losses would increase, as would the unfunded actuarial accrued liability and recommended actuarial contributions.

Retiree Health Insurance Credit Fund

Benefits under the Retiree Health Insurance Credit Fund are offered to PERS members who participate in the NDPERS Group Health Plan. In order to estimate the expected costs of the RHICF, we make certain participation assumptions in the actuarial valuation based upon NDPERS members' years of service at retirement and employment group.

If participation in the RHICF were extended to participants of any other NDPERS plan (including the Dental or Vision plans), it is expected that participation in the plan would increase. It is difficult to predict the precise effect that this would have upon participation without a detailed analysis of the experience of each of the plans. As an estimate, we increased the current participation assumptions to a minimum of 80% for all ages. The resulting change in annual employer actuarial contribution (as a percent of covered payroll) is shown below.

If benefits under the RHICF were extended to participants of any health plan (not just the NDPERS Group Health Plan), it is expected that the vast majority of participants would elect to receive the benefit. If 100% of NDPERS retirement plan members elected to receive RHICF benefits, the increase in annual employer actuarial contribution (as a percent of covered payroll) to the RHICF is as follows.

RHICF Employer Contribution Rate	Current Plan and Assumptions	Any NDPERS Insurance plan (80%)	Any Insurance Plan (100%)
Normal Cost*	0.40%	0.43%	0.50%
19-Year UAL Payment	0.48%	0.49%	0.56%
Actuarial Recommended Contribution	0.88%	0.92%	1.06%
Increase in Contribution	n/a	0.04%	0.18%

*The amount shown is net of member contributions and includes administrative expenses.

These calculations were performed under the supervision of Tammy Dixon, FSA, MAAA, EA. Unless otherwise specified above, the data and assumptions used are the same as those used in the July 1, 2011 Actuarial Valuations.

We look forward to reviewing these results with you. Please let us know if you have any questions.

Sincerely yours,

Brad Ramirez, FSA, MAAA, FCA, EA
 Consulting Actuary

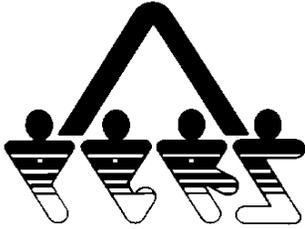
/cz

cc: Tammy Dixon

Attachment #3 – Administrative changes

	<i>NDCC Section Changed</i>	<i>Proposed Change</i>	<i>Reason for Proposed Change</i>
1	54-52-17.(3)	<p>c. Normal retirement date for a peace officer or correctional officer employed by a political subdivision is:</p> <p>(1) The first day of the month next following the month in which the peace officer or correctional officer attains the age of fifty-five years and has completed at least three consecutive <u>eligible</u> years of employment as a peace officer or correctional officer immediately preceding retirement; or.....</p>	<p>Last session we had made this change to other parts of the statute however missed it here so we need to update this to conform with the other changes</p>
2	54-52-17.(9)	<p>9. The board shall adopt rules providing for the receipt of retirement benefits in the following optional forms:</p> <p>a. Single life.</p> <p>b. An actuarially equivalent joint and survivor option, with fifty percent or one hundred percent options.</p> <p>c. An actuarially equivalent level social security option, which is available only to members who retire prior to attaining the age at which they may begin to receive unreduced social security benefits.</p> <p>d. Actuarially equivalent life with ten-year or twenty-year certain options.</p> <p>e. An actuarially equivalent partial lump sum distribution option with a twelve-month maximum lump sum distribution.</p>	<p>We are proposing to eliminate the level social security option for several reasons:</p> <ol style="list-style-type: none"> 1. Social Security no longer will provide the benefit estimate that we relied upon to do the adjustment 2. Less than 5% of the members that retiree select this option 3. Even though we council members carefully on this benefit they are still surprised when their benefit is reduced in the future – so this option remains confusing 4. The addition of the 20 year term certain option provides another alternative for members
3	54-52.1-18	<p>High-deductible health plan alternative with health savings account option.</p> <p>The board shall develop and implement a high-deductible health plan with a health savings account as an alternative to the plan under section 54-52.1-06. The high-deductible health plan alternative must be made available to state employees by January 1, 2012, and may be offered, at the discretion of the board, to political subdivisions after June 30, 2013. Health savings account fees must be paid by the employer. The difference between the cost of the single and family premium for eligible state employees under section 54-52.1-06 and the premium for those employees electing to participate under the high-deductible health plan under this section must be deposited in a health savings account for the benefit of</p>	<p>As originally adopted this statue allows us to offer the HDHP/HSA to political subdivisions. We are not proposing to change our ability to offer the HDHP to political subdivision but we are proposing to delete the HSA option for political subs. Our experience with the state implementation indicates to us that it would be more efficient if the political subdivision would contract directly with an HSA vendor for this service instead of having to do it through PERS.</p>

	<i>NDCC Section Changed</i>	<i>Proposed Change</i>	<i>Reason for Proposed Change</i>
		<p>each participating employee. For political subdivision employees, the board shall deposit into a health savings account for the benefit of the participating political subdivision employee, an amount equal to the difference between the primary plan premium as established by the board and the premium for the high-deductible health plan under this section. Each new employee of a participating employer under this section must be provided the opportunity to elect the high-deductible health plan. At least once each biennium, the board shall have an open enrollment period allowing existing employees of a participating employer under this section to change their coverage.</p>	
4	54-52-28	<p>The board shall administer the plan in compliance with the following sections of the Internal Revenue Code in effect on August 1, 2011<u>2013</u>, as it applies for governmental plans.....</p>	<p>Each session we submit this to update the reference to the IRS code</p>



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Memorandum

TO: NDPERS Board
FROM: Kathy
DATE: February 8, 2012
SUBJECT: Personnel Policy Manual

As a result of changes approved by the legislature and incorporated into Article 4-07 of the administrative rules for the Human Resource Management Division, NDPERS has updated its Policy Manual accordingly. Following is a summary of the changes:

- Chapter 3.5: Clarifies probationary periods for employee promoted within an agency.
- Chapter 9.3: Increases the amount of sick leave hours that may be used for the care of family members and allows supervisor discretion to approve additional hours subject to limits. Modified outdated language to conform to OMB manual.
- Chapter 13.1: Clarifies definition of family member for the purposes of funeral leave and allows the supervisor to approve leave even if the absence interferes with operations of the agency.
- Chapter 13.2: Allows leave to participate as an honor guard as part of an official funeral.

Included for your information are the above sections with the changes noted.

Board Action Requested

To approve the proposed changes.

3.5 Probationary Period - The purpose of the probationary period is to evaluate whether you can meet the performance requirements of your position. At the time of initial hiring, all regular employees will serve a probationary period of no less than six months. This period may be extended up to an additional six-month period contingent on the outcome of your performance evaluation. Non-probationary classified employees are not required to serve a probationary period upon promotion within an agency.

9.3 Sick leave may be used for the following occurrences:

1. Recuperation from illness or injury.
2. Appointments for treatment of medically related ~~or dental~~ conditions.
3. To tend to the needs of your eligible family members who are ill or to assist them in obtaining services related to their health or well being.
 - a. Sick leave used for these purposes may not exceed 40 eighty (80) hours per calendar year.
 - b. Upon the approval of the agency appointing authority or your supervisor, you may, per calendar year, take up to an additional ten percent (10%) of your accrued sick leave to care for your child, spouse, or parent with a serious health condition. The supervisor may require you to provide written verification of the serious health condition by a health care provider.
4. ~~Medical leave required due to pregnancy.~~
5. ~~4.~~ To participate in the Employee Assistance Program.

13.1 "Funeral Leave" means an approved absence from work, with pay, of up to twenty-four (24) working hours, provided to an employee to attend or make arrangements for a funeral, as a result of a death in the employee's family, or in the family of an employee's spouse. Absence due to a death in your or your spouse's immediate family will be excused and paid up to a maximum of twenty-four working hours (3 days) to attend to family matters. Immediate Family means is defined as husband, wife, son, daughter, father, mother, stepparents, brother, sister, brother-in-law, sister-in-law, grandparents, grandchildren, stepchildren, foster parents, foster children, daughter-in-law and son-in-law. Funeral- This leave will not be considered sick or annual leave. Your supervisor may approve a request for funeral leave even if the absence might interfere with the normal operations of the agency. To attend Time off for other funerals not covered under the 'funeral leave' definition, you may request the use of annual leave. These requests will be considered on an individual basis and subject to approval by your supervisor. For the death of a relative or friend not referenced by the funeral leave rule,

13.2 "Honor guard leave" means the approved absence from work, with pay, for up to twenty-four (24) working hours per calendar year for an employee to participate in an honor guard for a funeral service of a veteran. Honor guard means an individual with an essential ceremonial role performing as part of the official funeral service of a veteran, is a member

of the flagbearers, a member of the flag-folding team, a member of the firing party, the bugler, or the honor guard captain. This will not be considered sick or annual leave. Your supervisor may approve a request for honor guard leave even if the absence might interfere with the normal operations of the agency.

MEMORANDUM

TO: NDPERs Board
FROM: Jim Smrcka
DATE: January 20, 2012
SUBJECT: **Consultant Fees**

Attached is a report showing the consulting, investment and administrative fees paid during the quarter ended December 31, 2011.

Attachment

**North Dakota Public Employees Retirement System
Consulting/Investment/Administrative Fees
For the Quarter ended December 31, 2011**

Program/Project	Fee Type	Oct-11	Nov-11	Dec-11	Fees Paid During The Quarter	Fees Paid Year-To-Date
Actuary/Consulting Fees:						
LR Wechster, LTD	IT Project	Fixed Fee			-	6,750
Sagitec Solutions LLC	PERSLINK Project		24,981		24,981	1,059,406
Sagitec Solutions LLC	Enhancements	Actual			-	83,556
UND	Diabetes management	consulting			-	2,570
Brady Martz	Bank Reconciliations	Contract			-	3,431
Deloitte consulting			31,131		31,131	39,413
CALLAN ASSOCIATES				53,000	53,000	55,508
Gabriel Roeder Smith & Company					-	10,320
Segal Advisors	RFP and consulting			49,878	49,878	64,878
Mid Dakota Clinic	Retirement Disability	Time charges	1,150	1,800	2,950	7,600
The Segal Company	Retirement (DB)	Fixed Fee	16,400		16,400	62,513
The Segal Company	Ret Health Credit	Fixed Fee	3,025		3,025	11,550
The Segal Company	FlexComp	Fixed Fee			-	9,300
The Segal Company	Job Service	Fixed Fee	4,400		4,400	16,800
The Segal Company	QDRO/Compliance	Time charges	6,783	9,833	16,615	65,740
The Segal Company	Legislation	Time charges	2,410	9,730	12,140	134,363
The Segal Company	Group Ins	Time charges	3,060		3,780	6,840
The Segal Company	Def comp	time charges	2,880	1,260	1,530	5,670
The Segal Company	FLEX COMP	time charges		7,560	7,560	10,908
			\$ 71,238	\$ 43,531	\$ 119,820	\$ 234,590
						\$ 1,663,999
Audit Fees:						
Brady Martz	Annual audit	Fixed Fee		10,000	-	10,000
						57,820
Legal Fees:						
ND Attorney General	Administrative	Time charges	780	989	850	2,618
Calloun Law Group	Administrative	Time charges	\$ -	\$ -	\$ -	-
						25,678
						-
Investment Fees:						
SIB - Investment Fees	Retirement (DB)	% Allocation	50,993	298,584	952,931	1,302,508
SIB - Investment Fees	Ret Health Credit	% Allocation	489	449	591	1,529
SIB - Investment Fees	Insurance	% Allocation	155	44	58	257
SIB - Administrative Fees	Retirement (DB)	% Allocation	25,242	19,386	19,860	64,488
					\$	1,368,782
						\$7,432,447
Administrative Fee:						
Blue Cross Blue Shield	Health Plan	Fixed fee	\$ 1,014,875	\$ 1,014,221	\$	2,029,095
						10,684,636

* fees not yet available



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Memorandum

TO: NDPERS Board

FROM: Kathy

DATE: February 3, 2012

SUBJECT: Board Election

The term of board member Mike Sandal will expire on June 30, 2012. Pursuant to Section 71-01-02-01 of the election rules, the Retirement Board must appoint a committee of three from its membership, one of whom must be designated as chair, to oversee the election process.

The following is the 2012 election schedule developed in compliance with the rules:

May 4, 2012 – Deadline to file nomination petitions

May 29, 2012 – Ballots sent to membership

June 15, 2012 – Deadline to return ballots

June 18, 2012 – Ballot canvassing

June 21, 2012 – Present election results to Board membership

June 22, 2012 – Notify candidates of election results

BOARD ACTION REQUESTED:

Appoint a committee of three from the Board and designate one as committee chair.



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Memorandum

TO: PERS Board
FROM: Deb Knudsen
DATE: February 9, 2012
SUBJECT: Administrative Rules Update

As directed by the NDPERS Board in December, staff submitted the proposed rules to the Attorney General's office for review and has received their opinion that the rules are in compliance with N.D.C.C. Ch. 28-32 and are approved as to their legality. As approved by the Board and the Attorney General, they were submitted to the Legislative Council on January 25, 2012. The proposed rules will now be considered by the Administrative Rules Committee and subject to that body's approval, will become effective on April first.

Please let me know if you have any further questions or concerns.



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Memorandum

TO: NDPERS Board

FROM: Sharon Schiermeister

DATE: February 2, 2012

SUBJECT: 2011 COMPREHENSIVE ANNUAL FINANCIAL REPORT

The 2011 comprehensive annual financial report has been completed. Here is the link to our website if you wish to review the report.

<http://www.nd.gov/ndpers/forms-and-publications/index.html>

An email notice was sent to each participating employer notifying them that the annual report is available on the NDPERS website. The report was submitted to the Government Finance Officers Association with an application for the GFOA Certificate of Excellence in Financial Reporting.

Please let me know if you have any questions on the report.

Enclosure