NDPERS BOARD MEETING
Agenda

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

January 20, 2011 **Time: 8:30 AM**

I. MINUTES
- A. December 21, 2010

II. GROUP INSURANCE
- A. Prime Therapeutics Response (PBM Audit) – (Information)
- B. UND Diabetes Study – Nancy Vogeltanz (Information)
- C. BCBS – Sparb (Information)
- D. Vision Enrollment Update – Kathy (Information)
- E. Heart of America Health Plan – Kathy (Board Action)

III. RETIREMENT
- A. Segal Contract – Sparb (Board Action)

IV. MISCELLANEOUS
- A. Executive Director Policies – Sparb (Information)
- B. Attorney General Update – Sparb (Information)
- C. Comprehensive Annual Financial Report – (Information)
- D. 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.

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: January 13, 2011

SUBJECT: Prime Therapeutics

Representatives of Prime Therapeutics will be at the next meeting to review with you their observations on the recent audit conducted by TRICAST. I have attached for your reference a copy of the summary audit report that was reviewed at the last meeting.

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Memorandum

TO: PERS Board

FROM: Sparb

DATE: January 13, 2011

SUBJECT: UND Study

Nancy Vogeltanz-Holms will be at the next Board meeting via conference call to review with the attached report on our diabetes program. At the next meeting we will invite the Pharmacy Association to provide you their perspective on the program and comments on the attached report. At the March meeting we will need to decide if the program should be continued into the 2011-2013 biennium.

Costs Analysis of the North Dakota Diabetes Management Program

Report to the North Dakota Public Employees Retirement System

Center for Health Promotion & Prevention Research
University of North Dakota School of Medicine & Health Sciences
Grand Forks, ND

Dr. Nancy Vogeltanz-Holm, Director
Dr. Jeffrey Holm, Senior Scientist

November 2010

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INTRODUCTION

This report summarizes a non-randomized controlled cost evaluation of the North Dakota Diabetes Management Program (DMP). Sponsored by the North Dakota Public Employees Retirement System (NDPERS), the DMP was implemented in July 2008 to provide community pharmacy-based diabetes management services for NDPERS members and their dependents diagnosed with diabetes. In brief, the DMP utilizes a network of certified diabetes educator pharmacists and "other providers" to "complete an assessment, develop a care plan, and provide follow-up services and referrals" for individuals who self-select into the DMP (J. Steig, DMP Clinical Coordinator, 2010).

NDPERS members and dependents who select to participate in the DMP may receive up to 6 free educational care visits with their DMP provider over a 12-month period and an additional two visits during the 13-24 month period. DMP participants also receive waived co-payments for their diabetes and certain other medications and co-insurance on diabetic testing supplies. As of June 30, 2010, DMP clinical coordinator J. Steig reported that 346 DMP participants have completed at least one care visit in over 70 North Dakota provider sites involving over 125 individual providers. For more information about the DMP, please refer to the implementing agency, the North Dakota Pharmacy Service Corporation (in collaboration with the North Dakota Pharmacists Association, the North Dakota Society of Health-System Pharmacists, and the North Dakota State University College of Pharmacy, Nursing, and Allied Sciences).

NDPERS contracted with researchers at the Center for Health Promotion and Prevention Research (CHPPR) at the University of North Dakota School of Medicine and Health Sciences (UNDSMHS) to provide an independent costs evaluation of the DMP. The primary task for CHPPR researchers was to analyze changes in total health claims costs from a baseline period (June 2007-2008) to 22 months after the DMP start date (July 2008-April 2010) for the DMP participants compared to a control group of NDPERS members and dependents who did not participate in the program. Costs of the DMP were added to health costs to determine the average return on investment for the DMP. All claims cost data used in the study originated from North Dakota Blue Cross and Blue Shield (BCBS), made available to the authors by NDPERS. DMP participant data was provided by J. Steig, Frontier Pharmacy Services, Inc., and made available to the authors by NDPERS.

Secondary analyses examined the effects of participant characteristics on changes in costs and glycemic control (hemoglobin A1c levels) for the DMP-only participants. Results of both primary and secondary analyses are interpreted in the context of the current literature on the cost-effectiveness of educational/self-management programs for persons with diabetes.

RESEARCH DESIGN AND METHODS

DMP Eligibility for NDPERS Members and Their Dependents

NDPERS non-retired members and their dependents were eligible for the DMP if they were diagnosed with Type 1 diabetes (T1D) or Type 2 diabetes (T2D), as determined by claims specialists at North Dakota BCBS. Further details of criteria used for diabetes diagnoses may be obtained from BCBS or the DMP Clinical Coordinator.

The number of NDPERS members and their dependents who were identified as eligible for the DMP varied across the study period. Steig (2010) reported 2,871 eligible persons in August 2008; NDPERS provided CHPPR researchers with claims costs data for an eligible sample of 2,707 persons in January 2010. An additional 27 persons were identified in June 2010, resulting in 2,734 persons who were eligible for the DMP and therefore considered for inclusion in the study sample.

DMP Participants and Non-Participant Controls

Prior to the start date, and continuing thereafter, NDPERS notified members and their dependents about the DMP through mailings and mass media promotions. All participants self-selected into the DMP. According to Steig (2010), 346 persons had enrolled into the DMP (had at least one care visit) as of June 30, 2010 (12.7% enrollment rate).

Phase I, non-matched study sample. Eligible persons who enrolled in the DMP (had at least one DMP care visit) before November 15, 2009 and had continuous health claims data for at least six months prior to, and six months after, their enrollment formed the DMP group in the first phase of the study analyses. The control group consisted of all eligible participants who did not enroll in the DMP and who had continuous health claims data for at least six months prior to, and six months after, the July 2008 DMP start date. Based on these criteria, the Phase I total study population included 302 DMP participants and 2,140 non-participant controls (N=2,442).

As expected, given the non-randomization of the study groups and the low (12.7%) enrollment rate into the DMP, the Phase I DMP and control groups were significantly unbalanced at baseline (see Table 1). The DMP group, compared to controls, had higher proportions of participants who were women (p=.07), older (p=.10), and who had T1D (p<.001). PPPM baseline costs for total, provider/clinic, and pharmacy sources were significantly higher in the DMP group compared to controls (p<.01), but not for hospital costs (p=.28).

Phase II, matched study sample. When baseline differences between treatment and control groups on variables known to influence the treatment outcome are substantial, as in this study, adjustment through regression techniques, e.g., use of difference scores or analysis of covariance, generally lead to biased estimates with the true effects

of treatment either under- or over-estimated (Basu, Polsky, & Manning, 2008; Jones, 2008). Under these circumstances, researchers generally consider the use of propensity score matching (PSM) as the most effective method for reducing conditional bias (e.g., Austin, 2009). Essentially, PSM estimates how the observed variables (e.g., baseline costs, diabetes type, etc.) affect the probability of treatment receipt (e.g., enrolling in the DMP), then derives a score based on this estimation and compares observed baseline characteristics between participants and non-participants conditional on this score (Rubin, 2006).

Therefore, to reduce potential bias from the imbalance between the DMP and control groups at baseline, we used baseline costs (provider/clinic, pharmacy, and hospital), diabetes type, gender, and age to conduct PSM to derive a 1:1 matched sample. Our procedure used logistic regression to derive scores and the nearest neighbor technique without replacement (with replacement trial was not as balanced). Balance from this initial PSM trial was improved by further segregating baseline costs predictors into diabetes-related costs and non-diabetes costs. The six cost predictors along with age, gender, and diabetes type resulted in a 1:1 matched sample that was significantly more balanced than the Phase I sample on all covariates (see Table 2 and Figures 1-7). All subsequent analyses testing the effects of DMP participation (hereafter called "treatment") on changes in costs from baseline were conducted comparing the 302 DMP participants and their 302 matched controls (*N*=604).

Description of Claims Costs Data

All analyses are based on BCBS-designated *paid* health claims costs from provider/clinic (hereafter called "clinic" costs), pharmacy, and hospital sources. All costs were adjusted to 2007 dollars to control for inflationary increases from the beginning of the 2007 baseline period (adjustment factors provided by NDPERS/BCBS). Baseline costs were totaled over the median 12-month period preceding the July 2008 DMP start date (July 2007-June 2008) and were averaged to derive the mean per person per month (PPPM) cost. Post-DMP start costs were totaled over the median 21-month period from the DMP start in July 2008 to the study closing date of April 2010 and were averaged to derive the mean PPPM cost. Although study participants were included with a minimum of six months of baseline and post-start date claims costs data, 91.2% of the sample had at least one year of continuous baseline and one year of continuous post-DMP cost data.

Table 1
Phase I Study Sample: Baseline Comparisons of Diabetes Management Program (DMP) Participants (n=302) and Non-Participant Controls (n=2,140)

	DMP	Controls	P value
Gender			
Women	51.7%	46.1%	
Men	48.3%	53.9%	*p*=.07
Age			
Mean	54.8	53.7	*p*<.07
SD	9.7	11.1	*p*<.001
Median	57	56	*p*=.39
Diabetes Type			
Type 1	27.8%	15%	
Type 2	72.2%	85%	*p<.001*
Total PPPM Costs			
Mean	$745	$511	*p*=.002
SD	$1248	$1201	*p*=.03
Median	$347	$205	*p*<.001
Clinic PPPM Costs			
Mean	$239	$165	*p*=.01
SD	$499	$331	*p*<.001
Median	$94	$65	*p*<.001
Pharmacy PPPM Costs			
Mean	$221	$119	*p*<.001
SD	$280	$169	*p*<.001
Median	$163	$69	*p*<.001
Hospital PPPM Costs			
Mean	$286	$227	*p*=.28
SD	$835	$895	*p*=.14
Median	$8	$4	*p*=.01

Notes. SD=standard deviation. PPPM=per person per month, adjusted to 2007 dollars. Differences in DMP and control group means were tested using *Independent Sample t-tests*, differences in medians were tested using the *Medians Test*, and differences in variances (*SD*) were tested using *Levine's Test for Equality of Variances*. The *Kolmogorov-Smirnov Test of Equality of Distributions* showed significant differences (*p*<.05) between DMP and control group distributions for total, clinic, pharmacy, and hospital costs.

Table 2.
Phase II Propensity Score Matched Sample: Baseline Comparisons of Diabetes Management Program (DMP) Participants (n=302) and Non-Participant Matched Controls (n=302)

	DMP	Controls	P value
Gender			
Women	51.7%	52.6%	
Men	48.3%	47.4%	*p*=.81
Age			
Mean	54.8	55.6	*p*=.33
SD	9.7	10.3	*p*=.08
Median	57	57	*p*=.17
Diabetes Type			
Type 1	27.8%	28.5%	
Type 2	72.2%	71.5%	*p=.86*
Total PPPM Costs			
Mean	$745	$681	*p*=.48
SD	$1248	$964	*p*=.40
Median	$347	$343	*p*=.87
Clinic PPPM Costs			
Mean	$239	$229	*p*=.77
SD	$499	$313	*p*=.36
Median	$94	$123	*p*=.03
Pharmacy PPPM Costs			
Mean	$221	$213	*p*=.75
SD	$280	$289	*p*=.51
Median	$163	$148	*p*=.42
Hospital PPPM Costs			
Mean	$286	$239	*p*=.44
SD	$835	$604	*p*=.11
Median	$8	$10	*p*=.87

Notes. SD=standard deviation. PPPM=per person per month, adjusted to 2007 dollars. Differences in DMP and control group means were tested using *Independent Sample t-tests*, differences in medians were tested using the *Medians Test*, and differences in variances (*SD*) were tested using *Levine's Test for Equality of Variances.* The *Kolmogorov-Smirnov Test of Equality of Distributions* showed no significant differences (*p*>.05) between DMP and control group distributions for total, clinic, pharmacy, and hospital costs.

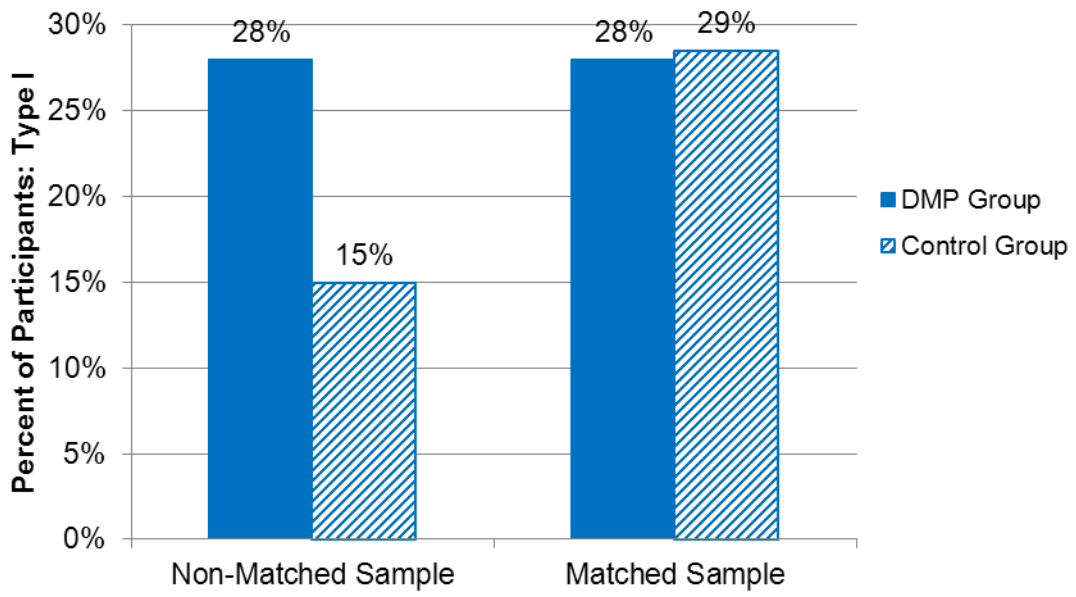

Figure 1. *Percent of Persons with Type 1 Diabetes in Groups for the Phase I Non-Matched (N=2, 442) and Phase II Matched Samples (N=604)*

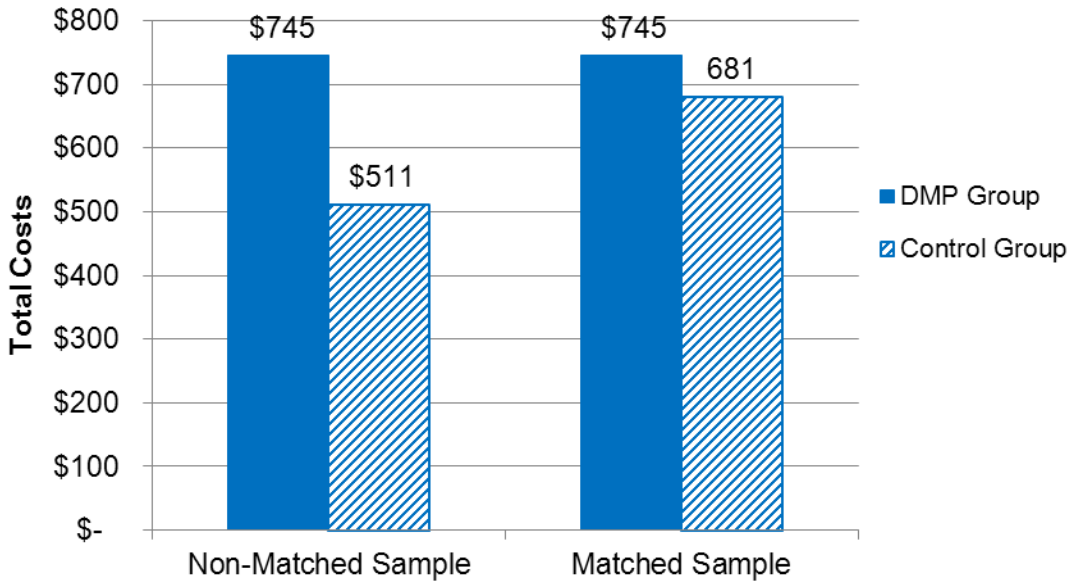

Figure 2. *Total Mean PPPM Baseline Costs in the Phase I Non-Matched (N=2,442) and Phase II Matched Samples (N=604)*

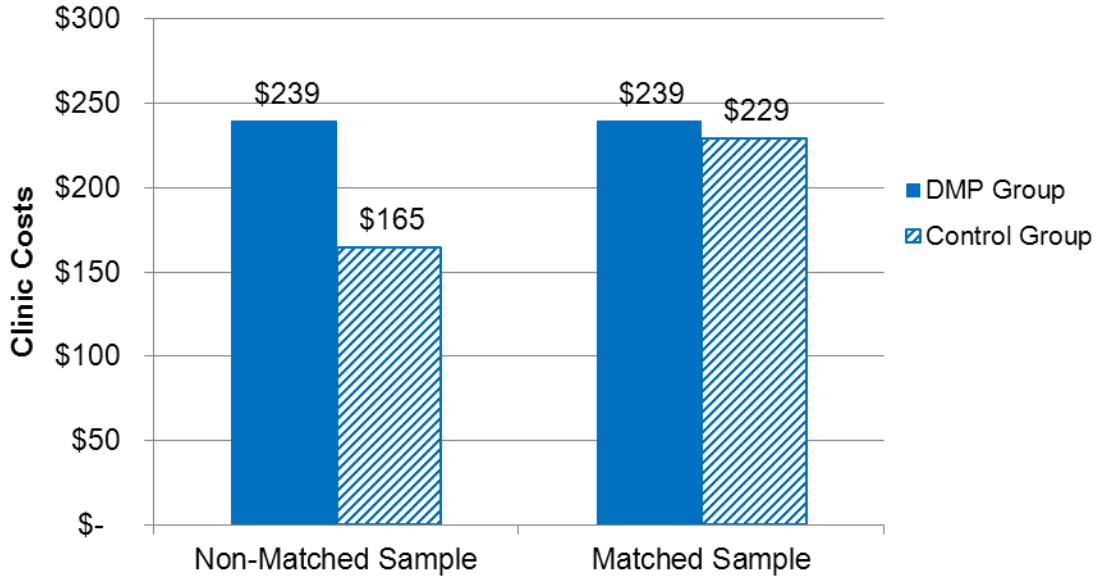

Figure 3. *Clinic Mean PPPM Baseline Costs in the Phase I Non-Matched (N=2,442) and Phase II Matched Samples (N=604)*

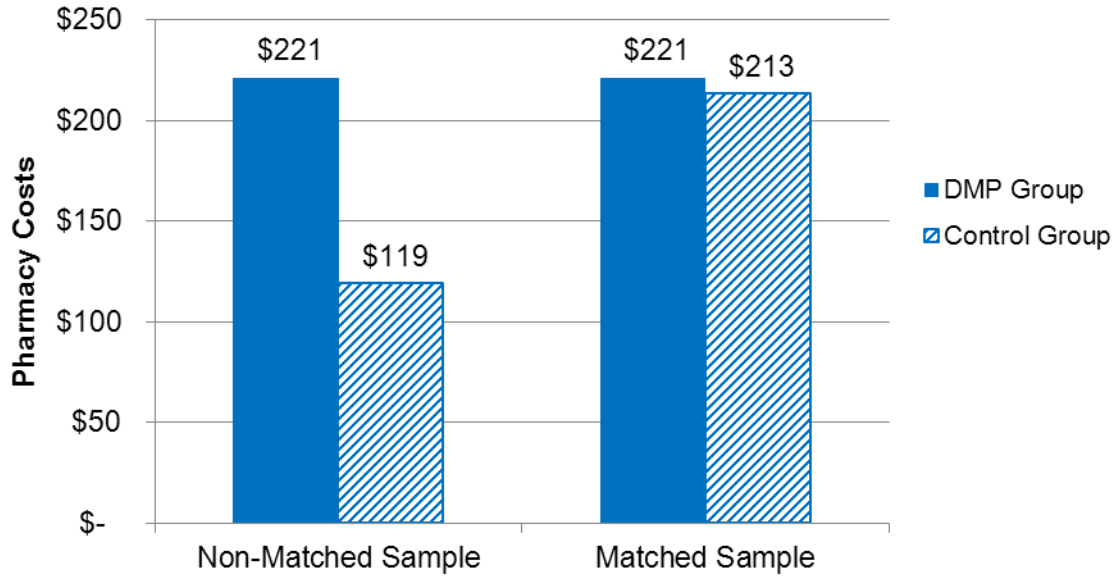

Figure 4. *Pharmacy Mean PPPM Baseline Costs in the Phase I Non-Matched (N=2,442) and Phase II Matched Samples (N=604)*

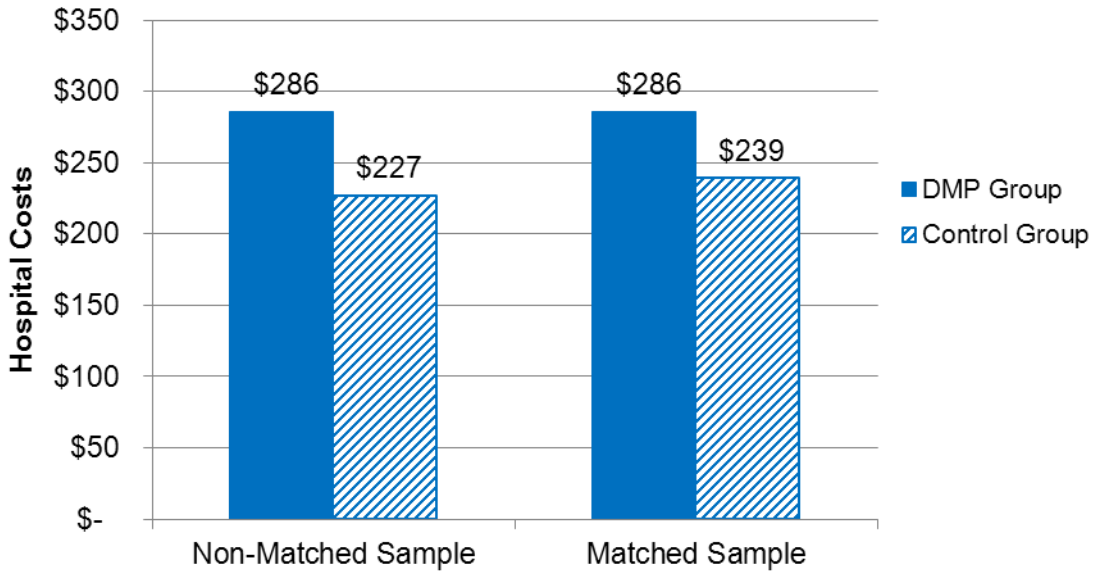

Figure 5. *Hospital Mean PPPM Baseline Costs in the Phase I Non-Matched (N=2,442) and Phase II Matched Samples (N=604)*

Statistical Design

Primary analyses: Effects of treatment from pre- to post-DMP on costs. Even though we effectively controlled for unequal baselines on several key predictors by matching, inferential statistical analyses were further complicated by the distribution of the cost data which was, as expected, non-normal (non-linear) and characterized as extremely right-skewed and with numerous zero values in the hospital costs data (39% of the sample). Because linear regression techniques assume normal distributions and are generally not appropriate for use in estimating health costs, we used a sensitivity analysis approach to determine which of two estimation procedures most often used with non-linear cost data would best model the data: log-transforming raw costs to achieve a normal distribution and then using Ordinary Least-Squares (OLS) Regression (with retransformation to actual dollars); or using a non-linear distribution with a log-link within the generalized linear model (GLM) approach. Although modeling cost data with a non-linear distribution appears to more consistently result in less biased estimates and has the advantage of not requiring retransformation, econometricians point out that log-transformed OLS models may be more precise with certain distributions even though bias may still be a concern (Buntin & Zaslavsky, 2004; Manning & Mullahy, 2001).

To account for (i.e., control) the correlation in repeated (pre-post) cost data, we used Generalized Estimating Equations (GEE). GEE has the further advantage of accommodating linear and non-linear data distributions. The non-linear gamma

distribution with a log-link best fit total, clinic, and pharmacy costs data; and we specified the unstructured covariance matrix to account for the within-subjects (pre-post) correlations. The hospital costs data with its numerous zeros was modeled with the non-linear Tweedie distribution with a log-link and an unstructured covariance matrix. The GEE analyses modeling linear distributions with identity-links used log-transformed total, clinic, pharmacy, and hospital costs and specified independent covariance matrices. All models tested the effects of DMP treatment, relative to the control group, on changes across time (baseline to post-DMP) in health claims costs or the *treatment by time interaction effect*. The effects of gender, age, and diabetes type were controlled in all models. Results were that both the linear log-transformed models and the non-linear models were very similar, with no differences between the two approaches on tests of significance for treatment effects. We therefore present the potentially less biased non-linear distribution models which also allow for direct reporting of the mean differences in costs without the need for retransforming logged values into actual dollars. All analyses used SPSS, version 18.0.

Secondary analyses: Effects of DMP variables on DMP participants' costs and clinical outcomes. Secondary GEE analyses within the DMP group (n=302), tested the effects of participant characteristics on changes from baseline to post-DMP in (a) health costs (total, clinic, pharmacy, hospital); and (b) A1c levels. The model testing changes in costs used the gamma distribution with a log-link and an unstructured covariance matrix. The model testing changes in A1c levels used the linear distribution with an identity-link and an unstructured covariance matrix. For participants with more than one post-DMP A1c value, we used the last reported level. Predictors used in the costs and A1c models were gender, age, diabetes type, number of DMP participants served by the provider site, number of months with diabetes, number of other medical conditions, and number of completed DMP sessions. Baseline A1c level was also used in the model predicting changes in costs.

We note here that our original analytic plan proposed using linear mixed models (LMM) for analyzing the secondary (DMP only) data. With LMM, we can not only control for the correlations inherent in repeated cost data as in the GEE procedure, but LMM also controls for the correlations that arise from clustered or nested data such as when DMP participants receive treatment from the same pharmacist/provider within the same provider site. The clinical data for the 302 DMP study participants indicated that 64 different provider sites were used with 56% of sites serving fewer than five participants and only six sites serving more than 10 participants (mean number served=4.72 per site, SD=3.53). Thus, we could not analyze the effects of sites/providers (clusters) on treatment, and so used the more flexible GEE approach for analyzing the secondary data. As described above, we include a provider site predictor in these models (i.e., number of participants served by the provider site), as one way to examine the influence of providers on participants' changes in costs and A1c levels.

RESULTS

Primary Analyses

Effects of DMP treatment. As shown in Table 3 (tests of significance) and Table 4 (adjusted mean estimates of costs changes), and as illustrated in Figures 6-9, the primary result of the study was that the DMP and control groups did not significantly differ in their total, clinic, pharmacy, or hospital costs changes from baseline to 22 months post-DMP start. Of most importance, the treatment X time interaction was not significant, indicating that the DMP did not significantly improve costs for participants relative to a group of matched non-participants. The non-significant mean differences, however, were in the hypothesized direction: total costs for the DMP group decreased from baseline by $30 PPPM (CI, -$158 to $99) and increased in the control group by $94 (CI, -$48 to $246). Most of the non-signficant change in total PPPM costs was related to a trend towards significance for changes in hospital PPPM costs: the DMP group hospital costs decreased $56 (CI, -$149 to $37) while control group hospital costs increased $57 (CI, -$40 to $154). Pharmacy costs signficantly increased from baseline for both the DMP and control groups, but at the same rate resulting in no group differences.

There were significant main effects for the control variables (gender, age, and diabetes type) on some of the costs components (see Table 3), indicating that, averaging across both baseline and post-DMP costs, women had significantly higher pharmacy costs than men; older compared to younger persons had higher total, clinic, and hospital costs; and T1D compared to T2D persons had higher costs in all costs categories.

Exploratory subgroup analyses (data not shown) examined the effects of the DMP separately for T1D person and for T2D persons. Although T1D persons who participated in the DMP did have significant total and hospital costs decreases from baseline relative to non-participants, this difference was due to DMP T1D persons having substantially higher baseline costs relative to controls. Once these differences were controlled, there were no group differences.

Various other exploratory analyses examined the effects of DMP on costs changes for (a) the 10% of the sample with the highest baseline costs; (b) the 20% of the sample with highest baseline costs; (c) only those participants who completed six or more DMP sessions; and (d) modeling the data with different distributional assumptions that might have improved the estimation procedures (repeated measures ANOVA, ANCOVA, OLS regression with and without log transformations). All results were similar with no significant DMP treatment effects for any of the costs components. Although power was limited in analyses with smaller sample sizes (10% of highest costs), inspection of means suggested similar levels of changes as a result of treatment.

Table 3.

Wald Chi-Square Tests of Significance from Generalized Estimating Equations (GEE): Effects of DMP Treatment (n=302) Compared to Controls (n=302) on Changes in Mean PPPM Costs from Baseline to Post-DMP

	Total Costs	Clinic Costs	Pharmacy Costs	Hospital Costs
Gender	$X^2(1)=.36$	$X^2(1)=2.52$	$X^2(1)=3.99^{\dagger}$	$X^2(1)=1.29$
Age	$X^2(1)=12.03^{*}$	$X^2(1)=5.92^{\dagger}$	$X^2(1)=.01$	$X^2(1)=14.38^{**}$
Diabetes Type	$X^2(1)=7.29^{*}$	$X^2(1)=5.41^{\dagger}$	$X^2(1)=5.66^{\dagger}$	$X^2(1)=3.95^{\dagger}$
Treatment	$X^2(1)=.01$	$X^2(1)=.08$	$X^2(1)=.57$	$X^2(1)=.11$
Time	$X^2(1)=.44$	$X^2(1)=.78$	$X^2(1)=10.95^{*}$	$X^2(1)=.01$
Treatment X Time	$X^2(1)=1.63$	$X^2(1)=.26$	$X^2(1)=.02$	$X^2(1)=2.89^{\dagger\dagger}$

Notes. PPPM=per person per month. Significant main effects indicate higher average baseline and post-DMP costs in the following directions: women higher than men; T1D higher than T2D; older higher than younger; time 2/post-DMP higher than time 1/baseline.

Treatment X time interaction ($p<.10$) indicates a trend toward lower hospital costs in the DMP treatment group compared to controls.

$^{**}p < .001$. $^{*}p < .01$. $^{\dagger}p < .05$. $^{\dagger\dagger}p < .10$

Table 4.
GEE Results: DMP and Control Group Mean PPPM Changes in Costs from Baseline to Post-DMP

	Baseline	Post-DMP	Difference‡	P Value[Φ]
Total PPPM Costs				
DMP Group	$776	$746	-$30	*p*=.193
	($630, $922)	($629, $864)	(-$158, $99)	
Control Group	$725	$819	$94	*p*=.652
	($609, $840)	($674, $963)	(-$48, $246)	
Clinic PPPM Costs				
DMP Group	$242	$249	$7	*p*=.772
	($189, $295)	($199, $299)	(-$43, $57)	
Control Group	$241	$270	$29	*p*=.795
	($202, $280)	($204, $335)	(-$35, $93)	
Pharmacy PPPM Costs				
DMP Group	$231	$248	$17	*p*=.005
	($198, $264)	($211, $285)	($5, $29)	
Control Group	$224	$242	$18	*p*=.048
	($191, $257)	($204, $280)	($0, $36)	
Hospital PPPM Costs				
DMP Group	$295	$239	-$56	*p*=.237
	($194, $395)	($176, $301)	(-$149, $37)	
Control Group	$252	$309	$57	*p*=.251
	($183, $321)	($229, $389)	(-$40, $154)	

Notes. PPPM=per person per month. Means are without parentheses, 95% confidence intervals are within parentheses. There were no significant differences between DMP and controls on all baseline costs or on all post-DMP costs.

‡ Negative dollar amounts indicate decreases in costs from baseline to post-DMP.

Φ Pairwise comparisons of estimated marginal means from the Generalized Estimating Equations models that controlled for gender, age, and diabetes type.

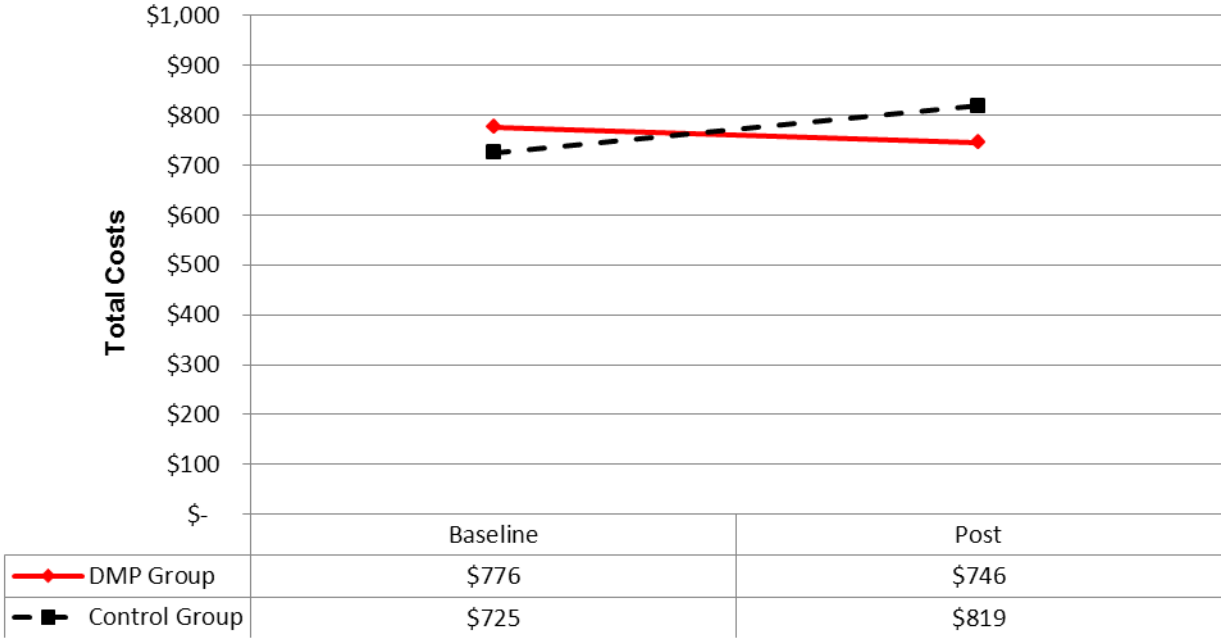

Figure 6. *DMP and Control Groups Total PPPM Changes in Costs from Baseline to Post-DMP*

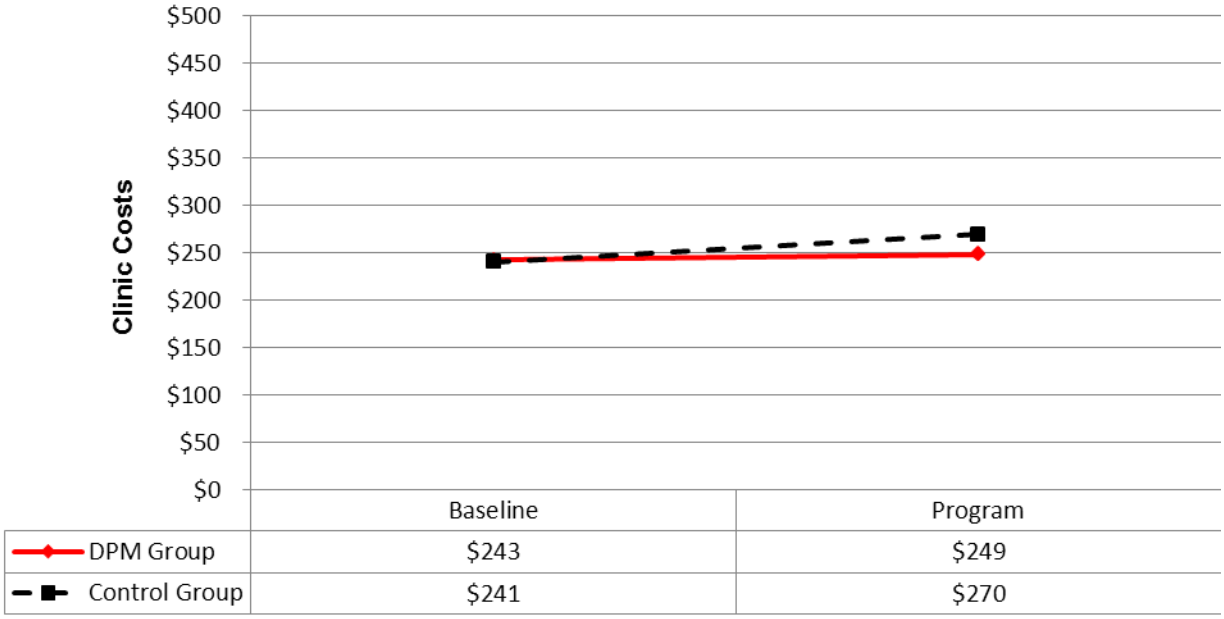

Figure 7. *DMP and Control Groups Clinic PPPM Changes in Costs from Baseline to Post-DMP*

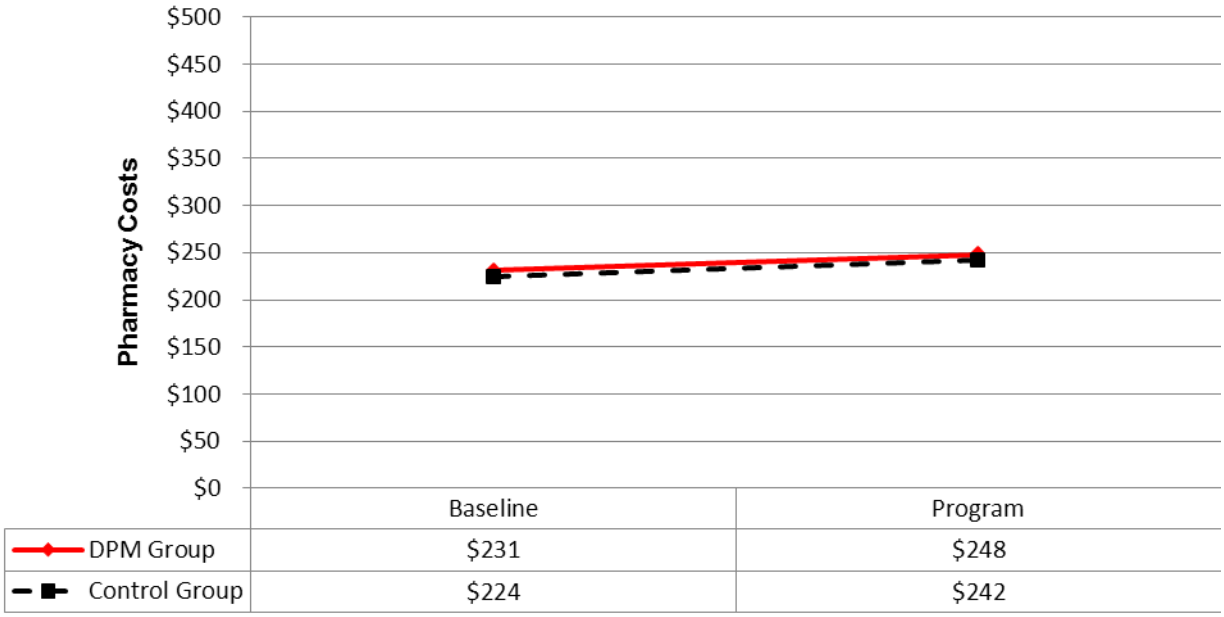

Figure 8. DMP and Control Groups Pharmacy PPPM Changes in Costs from Baseline to Post-DMP

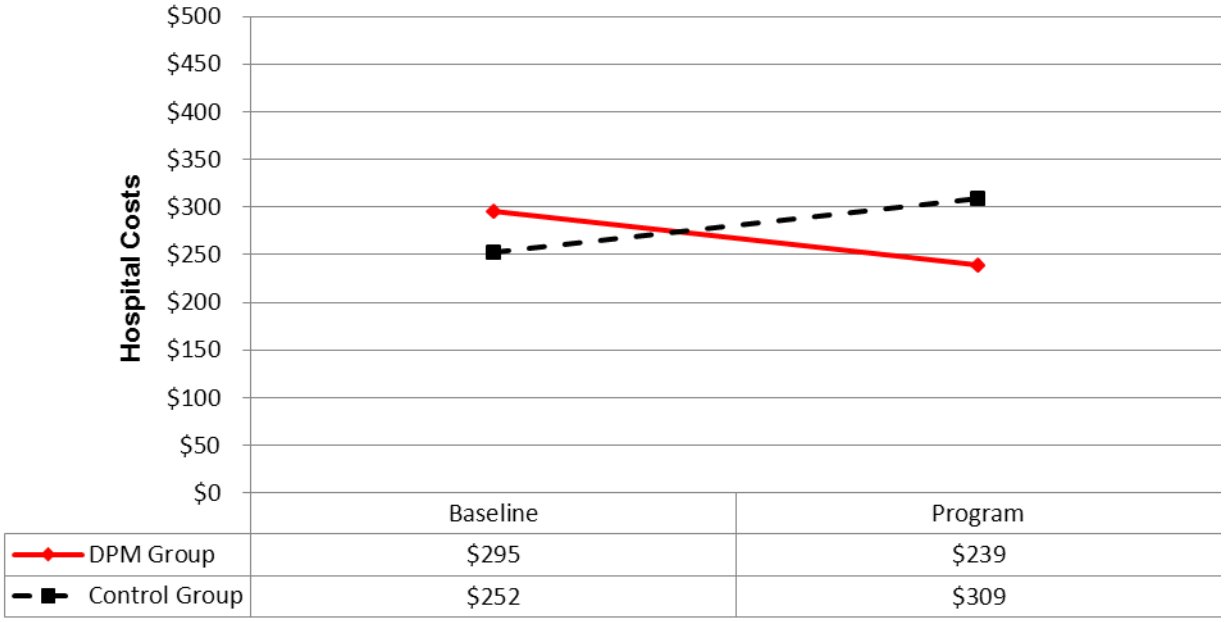

Figure 9. DMP and Control Groups Hospital PPPM Changes in Costs from Baseline to Post-DMP

Return on investment calculations. The DMP clinical coordinator estimated that the total DMP administrative and participant incentive costs for 346 persons as of June 30, 2010 were $373,405. However, our study analyzed 302 DMP participants with data ending no later than April 30, 2010. It may be that some of the DMP participants represented in this study did not receive incentives in the final quarter in which administrative costs were calculated, therefore we adjusted the incentive costs down from the January-June 2010 six month costs of $66,668 to a four month total of $44,445. This resulted in a total DMP cost of $351,182 for the July 2008-April 2010 22-month period or $52.86 per month per each of the 302 partcipants.

Adding the monthly per participant program costs to any estimated DMP cost savings found in the study to calculate a return-on-investment (ROI) is problematic because our analyses indicated costs changes were not signficantly different from baseline costs in either group, nor were differences between the groups signficant. This means that these estimated mean costs could not be replicated with any confidence for future DMPs. However, in the spirit of exploration, if we assume that the estimated mean differences were reliable and could be replicated, the analysis would be as follows:

Total health costs changes from baseline for control group = +$30 (increase) PPPM
Total health costs changes from baseline for DMP group = -$94 (decrease) PPPM
Total health costs *savings* for DMP participants = $124 PPPM

$124 PPPM health costs minus $52.86 monthly program costs = $71.14 PPPM health costs savings ($2.34 saved for every $1 spent for the DMP).

Thus, for the July 2009-April 2010 22 months period, 302 DMP participants reduced their health costs by an estimated $21,484 from the previous 12 month period, after subtracting program costs.

Results of the study indicate these savings could not necessarily be replicated at another time or for another sample of participants; therefore extrapolating from these figures to estimate savings in the total NDPERS population of persons with diabetes is not appropriate.

Secondary Analyses

As shown in Table 5, 90% of DMP participants reported having 3 or more other medical conditions with 49% reporting 6 or more other medical conditions. The majority of participants (77%) had diabetes for 2 or more years at baseline with 54% reporting having diabetes for five or more years. Almost one-half (48%) had baseline A1c levels of 7.0 or higher (mean baseline A1c of 7.2). The median number of sessions completed was six, with 76% of the participants completing five or more sessions. Sixty-seven percent of participants used provider/pharmacist sites that served five or more DMP participants during the 22 month study period. Table 6 shows dichotomized values for participant characteristics used in GEE analyses.

Table 5.
Baseline DMP and Clinical Characteristics of DMP Participants

	Number of DMP Participants	Percent	Mean (*SD*)
Provider Site, No. of Participants Served			
Provider site for 1-2 participants	30	10%	
Provider site for 3-4 participants	51	17%	
Provider site for 5-6 participants	56	19%	
Provider site for 7-8 participants	72	24%	
Provider site for 9-10 participants	18	6%	
Provider site for 11-12 participants	44	15%	
Provider site for 13-14 participants	13	4%	
Provider site for 15-16 participants	0	0%	
Provider site for 17-18 participants	18	6%	
Number of Completed DMP Sessions			5.47 (1.63)
1 session	6	2%	
2 sessions	20	7%	
3 sessions	16	5%	
4 sessions	31	10%	
5 sessions	37	12%	
6 sessions	101	33%	
7 sessions	86	29%	
8 sessions	5	2%	
Baseline A1c Levels			7.22 (1.30)
4.4% to 6.5%	59	25%	
6.5% to 6.9%	62	27%	
7.0% to 12.9%	112	48%	
Months with Diabetes			
< 12 months	22	9%	
12 to 23 months	34	14%	
24 to 59 months	55	23%	
60 to 119 months	56	23%	
120 or more months	75	31%	
Number of Other Medical Conditions			5.93 (3.09)
0 to 2 other conditions	36	12%	
3 to 5 other conditions	123	41%	
6 to 8 other conditions	80	27%	
9 to 10 other conditions	33	11%	
11 to 15 other conditions	30	11%	

All clinical data provided by J. Steig, DMP Clinical Coordinator.

Table 6.
Baseline DMP and Clinical Characteristics of DMP Participants, Dichotomized for GEE Analyses

	Number of DMP Participants	Percent
Provider Site, No. of Participants Served		
Provider site for 1-6 participants	137	45%
Provider site for 7-18 participants	165	55%
Number of Completed DMP Sessions		
1 to 5 sessions	110	36%
6 to 8 sessions	192	64%
Baseline A1c Levels		
4.4% to 6.9%	121	52%
7.0% to 12.9%	112	48%
Months with Diabetes		
< 60 months	111	46%
≥ 60 months	131	54%
Number of Other Medical Conditions		
0 to 5 other conditions	159	53%
6 to 15 other conditions	143	47%

Notes. Number of completed sessions was dichotomized at less than full treatment vs. full treatment plus boosters. Baseline A1c was dichotomized at a clinically relevant value for acceptable glycemic control (ADA, 2002). Provider site, number served, and number of other medical conditions were dichotomized at median values.

Effects of participants' characteristics on changes in costs. GEE analyses were used to test the effects of DMP participants' characteristics on changes in costs from baseline to post-DMP (see Table 7). Results were that participants with baseline ≥ 7.0% A1c levels had significantly increased pharmacy costs from baseline to post-DMP compared to participants with baseline < 7.0% A1c levels, controlling for all other variables in the model. Additionally, participants that used DMP provider sites that served < 7 participants had significantly higher total and clinic costs from baseline to post-DMP than participants using DMP provider sites that served ≥ 7 participants. However, supplemental analyses controlling for baseline differences, found that changes from baseline to post-DMP for both total and clinic costs were not significantly different between those participants using provider sites serving < 7 and those serving ≥ 7 participants (see Table 8).

Effects of participants' characteristics on changes in A1c levels. Table 9 shows results from GEE analyses testing the effects of DMP participants' characteristics on changes in A1c levels from baseline to post-DMP. Analyses included only participants with at least two A1c measures, using the last measure as the post-DMP value (n=233). There were significant main effects of age, months with diabetes, and time, indicating that overall A1c levels were higher in older persons, those with diabetes ≥ 60 months, and at baseline. As shown in Figure 10, the significant adjusted mean decrease in A1c levels from the baseline of 7.28% to post-DMP of 6.97% was 0.31%. There was also a significant time by number of months with diabetes interaction, indicating that participants with diabetes for < 60 months had significantly greater decreases in A1c levels from baseline compared to participants with diabetes for ≥ 60 months (see Table 10).

We calculated that 7.3% of DMP participants reduced their baseline A1c levels by 1% or more; however, 15.9% had increases of 1% or more from baseline. At baseline, 51.9% of DMP participants had A1c levels below the clinically relevant level of 7.0%, and at post-DMP, 57.1% had A1c levels below 7.0%. The difference between these two proportions (-5.2%) was not significant (Z=-1.589, p=.1122).

Table 7.

Wald Chi-Square Tests of Significance from Generalized Estimating Equations (GEE): Effects of Baseline DMP Participant Characteristics on DMP Participants' Changes in Mean PPPM Costs from Baseline to Post-DMP (n=302)

	Total Costs	Clinic Costs	Pharmacy Costs	Hospital Costs
Gender	$X^2(1)=.04$	$X^2(1)=4.85^{\dagger}$	$X^2(1)=5.94^{\dagger}$	$X^2(1)=.38$
Age	$X^2(1)=.01$	$X^2(1)=.36$	$X^2(1)=10.20^{*}$	$X^2(1)=2.44$
Diabetes Type	$X^2(1)=10.38^{*}$	$X^2(1)=7.89^{*}$	$X^2(1)=2.25$	$X^2(1)=8.87^{*}$
No. of Other Conditions	$X^2(1)=21.76^{**}$	$X^2(1)=19.23^{**}$	$X^2(1)=14.91^{**}$	$X^2(1)=6.96^{*}$
Months with Diabetes	$X^2(1)=.08$	$X^2(1)=.11$	$X^2(1)=1.44$	$X^2(1)=.38$
Baseline A1c Levels	$X^2(1)=5.24^{\dagger}$	$X^2(1)=2.28$	$X^2(1)=.16$	$X^2(1)=5.80^{\dagger}$
No. of DMP Sessions	$X^2(1)=.86$	$X^2(1)=1.33$	$X^2(1)=.98$	$X^2(1)=.92$
Provider Site, No. Served	$X^2(1)=2.59$	$X^2(1)=1.21$	$X^2(1)=.25$	$X^2(1)=6.68^{\dagger}$
Time	$X^2(1)=.64$	$X^2(1)=3.33^{\dagger\dagger}$	$X^2(1)=1.37$	$X^2(1)=.04$
Diabetes Type X Time	$X^2(1)=.21$	$X^2(1)=.45$	$X^2(1)=.17$	$X^2(1)=.21$
Other Conditions X Time	$X^2(1)=.40$	$X^2(1)=1.27$	$X^2(1)=.03$	$X^2(1)=.07$
Months of Diabetes X Time	$X^2(1)=.02$	$X^2(1)=.16$	$X^2(1)=2.21$	$X^2(1)=.01$
A1c Levels X Time	$X^2(1)=.01$	$X^2(1)=.09$	$X^2(1)=5.45^{\dagger}$	$X^2(1)=.40$
No. DMP Sessions X Time	$X^2(1)=.10$	$X^2(1)=.01$	$X^2(1)=.53$	$X^2(1)=.13$
Site, No. Served X Time	$X^2(1)=4.59^{\dagger}$	$X^2(1)=4.32^{\dagger}$	$X^2(1)=1.46$	$X^2(1)=2.42$

Notes. Significant main effects indicate higher average baseline and post-DMP costs in the following directions: women higher than men; older persons higher than younger; time 2/post-DMP costs higher than time 1/baseline; T1D higher than T2D; $\geq$6 other medical conditions higher than <6; $\geq$7.0 A1c level higher than <7.0; $\geq$7 participants served at site higher than <7.

Significant A1c X time interaction indicates that participants with A1c levels $\geq$ 7.0 had significant increases in pharmacy costs from baseline compared to participants with A1c < 7.0.

Significant provider site, number served X time interaction indicates that participants from sites that served < 7 participants had significant increases in total and clinic costs from baseline compared to participants from sites serving $\geq$ 7 participants.

** $p < .001$. * $p < .01$. $^{\dagger}p < .05$. $^{\dagger\dagger}p < .10$

Table 8.
GEE Results: Significant Effects of Number of Participants Served at Site and Baseline A1c on Changes in PPPM Total and Pharmacy Costs from Baseline to Post-DMP

	Baseline	Post-DMP	Difference‡	P Value[Φ]
Site, No. Participants Served				
Total Costs				
1 to 6	$568	$731	$163	*p*=.034
	($439, $696)	($562, $900)	(-$13, $314)	
7 to 18	$836*	$766	-$69	*p*=.547
	($575, $1096)	($511, $1021)	(-$295, $156)	
Site, No. Participants Served				
Clinic Costs				
1 to 6	$172	$246	$74	*p*=.017
	(128, $216)	($174, $319)	(-$13, $135)	
7 to 18	$244*	$250	$6	*p*=.852
	($165, $322)	($144, $355)	(-$57, $69)	
Baseline A1c Levels				
Pharmacy Costs				
4.4% to 6.9%	$214	$211	-$3	*p*=.822
	($163, $264)	($159, $264)	(-$24, $19)	
7.0% to 12.9%	$211	$237	$26	*p*=.031
	($165, $256)	($192, $283)	(-$2, $52)	

Notes. PPPM=per person per month. Means are without parentheses, 95% confidence intervals are within parentheses.

* Participants from sites serving ≥7 participants had significantly higher baseline total and clinic costs compared to those from sites serving <7. After controlling for this baseline difference, the finding of increased total and clinic costs for participants using sites serving fewer participants compared to larger numbers of participants was no longer significant.

‡ Negative dollar amounts indicate decreases in costs from baseline to post-DMP.

Φ Pairwise comparisons of estimated marginal means from the Generalized Estimating Equations models that controlled for several predictors (main effects and time X predictor interaction effects), see table 7.

Table 9.
Wald Chi-Square Tests of Significance from Generalized Estimating Equations (GEE): Effects of Baseline DMP Participant Characteristics on DMP Participants' Changes in Mean A1c Levels from Baseline to Post-DMP (n=233)

	A1c Levels
Gender	$X^2(1)=1.75$
Age	$X^2(1)=4.86^{\dagger}$
Diabetes Type	$X^2(1)=.54$
No. Other Conditions	$X^2(1)=1.33$
Months with Diabetes	$X^2(1)=8.27^{*}$
No. of DMP Sessions	$X^2(1)=.02$
Provider Site, No. Served	$X^2(1)=.78$
Time	$X^2(1)=12.33^{**}$
Diabetes Type X Time	$X^2(1)=.37$
Other Conditions X Time	$X^2(1)=.59$
Months of Diabetes X Time	$X^2(1)=4.29^{\dagger}$
No. DMP Sessions X Time	$X^2(1)=.58$
Site, No. Served X Time	$X^2(1)=.17$

Notes. Significant main effects indicate higher average baseline and post-DMP A1c levels in the following directions: older participants' levels higher than younger participants; time 1/baseline levels higher than time 2/post-DMP; ≥60 months with diabetes levels higher than <60 months.

Significant months of diabetes X time interaction indicates that DMP participants with diabetes for < 60 months had significant decreases in A1c levels from baseline compared to those with diabetes ≥ 60 months.

** $p < .001$. * $p < .01$. † $p < .05$.

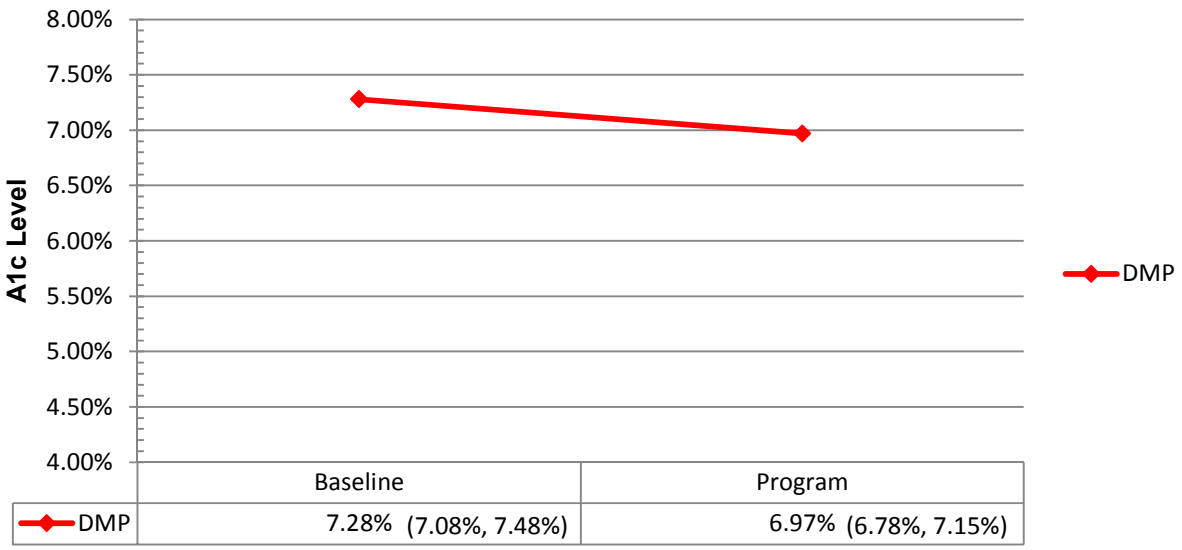

Figure 10. *Mean Change in A1c Levels from Baseline to Post-DMP for DMP Participants*
Notes. 95% confidence intervals are in parentheses. The model controlled for the effects of gender, age, diabetes type, and five DMP participation predictors.

Table 10.
GEE Results: Significant Effect of Number of Months with Diabetes on Changes in A1c Levels from Baseline to Post-DMP

	Baseline	Post-DMP	Difference‡	P Value$^{\Phi}$
Months with Diabetes A1c Levels				
< 60 months	7.15% (6.85%, 7.45%)	6.67% (6.43%, 6.90%)	-.48% (-.75%, .21%)	*p*=.001
≥ 60 months	7.41% (7.17%, 7.66%)	7.27%* (7.03%, 7.51%)	-.14% (-.34%, .05%)	*p*=.149

Notes. Means are without parentheses, 95% confidence intervals are within parentheses.

*Post-DMP A1c levels were significantly higher in those with diabetes ≥ 60 months compared to those with diabetes < 60 months.

‡ Negative values indicate a decrease in A1C level.

$^{\Phi}$ Pairwise comparisons of estimated marginal means from the Generalized Estimating Equations models that controlled for several predictors (main effects and time X predictor interaction effects, see table 9).

DISCUSSION AND CONCLUSIONS

The results of this study provide a controlled evaluation of the effects of a 22-month, pharmacy-based, diabetes management program (DMP) on changes in health claims costs. To our knowledge, this is the first study using a matched control group to evaluate a DMP based on the Asheville (North Carolina) project model. As in the Asheville model, the North Dakota DMP employed community pharmacists trained as diabetes educators to deliver free diabetes care sessions and provided incentives (waived copayments for medications and supplies) for participation. Unlike the Asheville model, the North Dakota DMP was not implemented through employer sites, but was promoted statewide through mailings and mass media to all NDPERS members and their dependents with diabetes. For further information about the North Dakota DMP and how it differed from the Asheville project, see Steig (2010).

The results of the analyses show that changes in costs from baseline to post-DMP did not differ for DMP participants and their matched controls. As discussed below, several factors influenced these results including selection bias, variability of individuals' health costs, and DMP treatment effectiveness relative to treatment as usual. We conclude our discussion by using results from the DMP participants-only analyses to explore the DMP's potential clinical and cost effectiveness value for future participants.

Selection Bias

The selection or enrollment rate into the DMP by eligible NDPERS members and dependents was very low—approximately 12.5% using estimates from Steig (2010) or about 350 persons enrolled from an eligible population of about 2800 persons. Selection *bias* occurs when individuals that share some characteristic are more likely to select treatment and therefore comparison with non-participants is unbalanced and leads to biased estimates of treatment effectiveness. Selection bias is increased when only a small percent of the population choose treatment, as was the case in the DMP. DMP participants and non-participants significantly varied at baseline on the primary analysis variable—health care costs. Compounding this problem was that DMP participants were more likely to have Type 1 diabetes—which also was related to having higher baseline costs and potentially leads to a differential response to treatment compared to persons with Type 2 diabetes.

Fortunately, through propensity score matching, we were able to derive a matched sample that was comparable to the DMP participants on all measured variables (baseline costs, diabetes type, gender, and age), thus reducing bias and confounding in the analytic models. It is possible that participants and non-participants might have shown significant differences on various unmeasured factors such as education, income, social support, and measures of health and functioning, and the match might have been improved if we could have included some of these factors as well as some of the clinical data that were obtained for DMP participants (e.g., A1c level and months with diabetes) but were not available for control participants. However, given that the

matched sample was comparable to the DMP participants on all measured variables and that we did not find any significant treatment effects/group differences, any concerns about the adequacy of the matching process are moot.

The Effects of High Variability in Non-Linear Health Costs Data

Our analytic strategy for detecting group differences in changes in costs used state of the art prediction modeling methods appropriate for health data which are typically skewed (non-normal) in their distributions. As expected, the median health costs were much lower than mean costs, reflecting the very high costs for a few individuals which distort mean estimates and necessitates using non-linear statistical techniques. Our analyses also used an analytic technique that controlled for the correlations inherent in outcome measures (costs) that are repeated over multiple time periods. Finally, we conducted sensitivity analyses (alternative models) to determine if our results held under different assumptions, e.g., within a linear distribution and for the Type 1 vs. Type 2 diabetes groups modeled separately. All alternative and exploratory examinations resulted in similar results; thus, we can be highly confident about our conclusions.

Although the findings do point in the hypothesized direction of the DMP participants decreasing costs relative to non-participants, the observed group differences are not at a level that could be replicated with another sample with confidence. However tempting it may be to say that the non-significant estimated savings of $124 per person per month (PPPM) in total costs for the DMP group compared to the control group is indeed meaningful, this is not a scientifically justified conclusion. To easily illustrate this, inspection of the confidence intervals around the estimates of costs show that the “true” difference between DMP participants and matched controls lies between the best case estimate of DMP participants saving $404 PPPM more than non-participants to the worst case in which DMP participants could actually cost $147 PPPM more than non-particIpants. Put another way, when large differences in group means are due to only a few individuals, as inherent in health cost data, this high variation makes it difficult to assert that the differences are not due to chance alone.

Factors Influencing Treatment Effectiveness on Costs and Clinical Outcomes

Treatment intensity. The next important question for discussion then is “why was treatment not effective in reducing costs?” Of course we cannot answer this question with certainty, but we offer a few possible explanations. DMP participants, relative to all eligible persons with diabetes, were older, had higher baseline costs, and had a higher percentage of persons with Type 1 diabetes. It seems likely that the incentives established to encourage participation in the DMP (co-payment waivers) were more attractive to those with higher costs and other complicating medical factors, and may have inadvertently led to this self-selection bias. To examine treatment effects it was necessary to equalize the groups by matching the DMP participants with controls who were similar in gender, age, type of diabetes, and baseline costs. Therefore, the resulting sample for analyses contained persons who clearly have had signficiant contact with health providers as demonstrated by their high provider/clinic, pharmacy,

and hospital costs. Although we don't know if DMP participants and controls were equal in their baseline clinical characteristics (e.g., number of other conditions, length of diabetes diagnosis, A1c levels), we can assume a relatively equal clinical profile given the equal costs profile. It may be that a brief (six to eight sessions) diabetes education intervention delivered at the participants' community pharmancy may not have been of sufficient intensity to (a) affect costs changes when costs are high and potentially related to many different health conditions; and/or (b) affect costs changes significantly more than a comparison group which are potentially receiving equally high levels of contact with and services from their usual medical providers. Perhaps if both participants and controls had been composed of more persons who were younger, healthier, and with lower baseline costs, i.e., were more like the general population of adults with diabetes, treatment may have had a more significant effect on participants' present and even future health costs relative to controls who may not be receiving regular medical care for their not yet complicated diabetes. This hypothesis is supported by the finding that DMP participants who had diabetes for less than five years showed greater decreases in A1c levels than those having diabetes for a longer time.

Treatment fidelity and adherence. Another influence on treatment is the degree to which providers reliably and effectively deliver the DMP treatment (fidelity). We did not have information for this analysis about the fidelity in which the treatment was delivered by pharmacists, how pharmacists altered their management for persons with Type 1 vs. Type 2 diabetes, or about participants' adherence to recommendations. However, our confidence in fidelity is increased because all pharmacists/providers received similar training and were certified as diabetes educators. If possible, DMP coordinators should further analyze the effects of DMP providers' on participants' costs.

Long-term complications and costs. Despite the importance of all the above considerations, the lack of treatment effects in diabetes management programs is often attributed to the fact that disease complications occur over time and the economic benefits of preventing such complications cannot adequately be assessed without study periods of at least five years. Although it is outside the scope of this report to fully review the literature on this issue related to the cost effectiveness of diabetes educational/self-management interventions, we briefly consider how our study results fit within the current knowledge base.

Previous studies of cost-effectiveness of diabetes interventions. There have been very few well-designed studies examining economic outcomes of educational/self-management interventions for diabetes. Recent reviews (Boren et al., 2009; Urbanski et al., 2008) suggest that self-management for Type 2 diabetes may be cost-effective, but most studies were short-term and did not include enough data to allow for critical review of outcomes. For example, the primary study of the Asheville project, on which the current DMP is based (Cranor et al., 2003a, 2003b), indicated that pharmacy-based diabetes education interventions decreased total costs from baseline in every year of the five-year study. However, methodological problems including lack of a control group, lack of adjustment for drop-outs, small sample size, biased estimation

procedures, and lack of effects in the multivariate logistic regressions limit confidence in the reported outcomes.

Although there are no well-designed, long-term studies examining the cost-effectiveness of diabetes self-mangement programs, one recent short-term study by Brownson et al. (2009) estimated lifetime benefits of their self-management program. The study involved results from the Robert Wood Johnson (RWJ) Diabetes Initiative in which adults with Type 2 diabetes received self-mangement interventions in primary care settings. Results were mean 0.5% decreases in A1c levels, 10% decreases in cholesterol, and $866 annual per person program costs. The simulation model used (CDC, 2002) assumed the improvements in health and costs would be maintained in the long-term and also estimated changes in quality-adjusted life years (QALYs). The diabetes self-management program was estimated to save approximately $3400 per person in lifetime treatment and complication costs, but the estimated per person lifetime costs of $15,000 for the program far exceeded savings. The authors concluded, however, that the estimated increase in QALYs justified the program's costs which were below standard benchmarks for many commonly adopted medical interventions.

This study showed that self-management interventions resulting in A1c reductions as small as 0.5%, maintained long-term, provide added QALYs. Unfortunately, results to date from high-quality studies using randomized controlled trials designs estimate that, at best, educational and behavioral interventions for adults with Type 2 diabetes have modest effects on lowering A1c: about 0.4% reductions (Gary et al., 2003).

DMP Participants' Clinical Data: Promising Outcomes and Future Considerations

DMP participants had a significant mean reduction in their A1c levels of 0.31%. This level of improvement, if maintained over several years, would likely result in lifetime improvements in health with potentially added QALYs. Although the annual cost of the DMP at $634 is lower than costs estimated by Brownson et al. (2008), it is still unlikely that the program would result in costs savings and we cannot confidently assume that the decreases would be maintained over several years. Moreover, without a control group for comparison, we cannot determine if the significant decrease in A1c was due to the DMP treatment. There is some evidence that glycemic control (A1c < 7.0%) improved in the general U. S. population from 1999-2000 to 2003-2004, suggesting improvements in public health messaging and/or medical care for persons with diabetes and pre-diabetes (Ford et al., 2008). It will be important to assess for the long-term maintenance of DMP participants' A1c decreases. Finally, we did not assess changes in DMP participants' blood pressure, which will be an important additional indicator of the DMP's potential for health and costs improvement. Unlike lifetime glycemic control estimates which improve health but do not save costs, there is good evidence that maintaining a lifetime healthy blood pressure results in both health improvements and costs savings in persons with Type 2 diabetes (CDC, 2002).

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

Sparb Collins
Executive Director
(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: January 13, 2011

SUBJECT: BCBS

BCBS will be at the next Board meeting to review with some of the remaining decisions that will need to be made concerning the bid and give you an update on the plan. With the background provided at this meeting, staff will prepare a final memo on the subject for your consideration and decision at the February or March 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@state.nd.us ● discovernd.com/NDPERS

Memorandum

TO: **NDPERS Board**

FROM: **Kathy**

DATE: **January 13, 2011**

SUBJECT: **Vision Enrollment**

In September last year, the Board awarded the voluntary vision insurance contract to Superior Vision. Open enrollment was conducted for active employees from October 18 through November 5, 2010. Active and retired employees enrolled in the plan through Ameritas were transferred by electronic file upload to Superior Vision. Following is a breakdown by coverage type of the total enrollment in the vision plan as of January 13, 2011, the date of our last file upload:

Coverage Level	**Number of Contracts**			
	Actives	**Retirees**	**COBRA**	
Employee	1,794	489	8	
Employee+Child(ren)	470	4	1	
Employee+Spouse	1,269	317	3	
Employee+Family	1,560	8	5	
Total	**5,093**	**818**	**17**	**= 5,928**

There is an increase of 1,541contracts for the group. Retirees were not eligible to participate in the open enrollment.

This represents an increase in participation of approximately 35% for the group.

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@state.nd.us ● discovernd.com/ndpers

Memorandum

TO: **NDPERS Board**

FROM: **Kathy**

DATE: **January 10, 2011**

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, 2011 through June 30, 2012. The new rates are included in the materials provided by Heart of America. The premiums for all coverage levels and plan options increased by approximately 8.5% over the previous 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 enrollment in the plan:

Last year the Board approved the plan for the Rugby service area.

<u>Rolette County Contracts</u>
2 Single

<u>Game & Fish</u>
1 SPD

<u>Pierce County Contracts</u>
1 Single
1 Family

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.

HEART OF AMERICA
Health Plan

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

RECEIVED
JAN 06 2011
ND PERS

December 31, 2010

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 2011.
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 you next meeting and let us know if any further information is needed. Thank you for your consideration of our request.

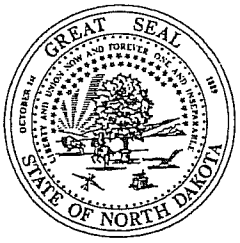
Sincerely,

Mary Ann Jaeger
Marketing Representative

Enc.
Cc: Kath Allen

STATE OF NORTH DAKOTA
Department of Insurance

RECEIVED
AUG 5 2004
HMO



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

Health Resources and
Services Administration
Rockville MD 20857

July 22, 1983

RECEIVED
JUL 26 1983
HMO

Mr. Kenneth L. Ulmer
Executive Director
Heart of America Health Maintanance
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

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 - 2011

RUGBY PLAN

Group

CONTRACT	PLAN TYPE		
	HIGH OPTION	LOW OPTION	SHARE OPTION
SINGLE	$445.20	$408.10	$332.30
SINGLE PLUS DEPENDENT	$764.70	$703.60	$573.30
FAMILY	$1,044.60	$968.50	$789.80

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 10-31-10

ASSETS	**Current YTD**	**Previous YTD**
General Checking	$193,187	$330,531
Money Market Accounts	$118,948	$179,488
Kodiak Oil & Gas	$0	$0
Ferrellgas Stock	$39,900	$0
Central Harvest States Stock	$39,159	$0
Investors Real Estate Trust (IRET)	$183,788	$200,860
Bonds	$119,525	$112,876
CD's	$1,186,160	$1,157,583
Accrued Interest on Investments	$30,413	$16,309
Premium Income	$8,038	$44,410
A/R Reinsurance	$175,029	$209,905
A/R CMS Settlements	$0	$0
A/R Operations	$0	$0
Prepaid Insurance	$0	$0
Furniture, Equipment & Leasehold	$6,271	$817
TOTAL ASSETS	**$2,100,418**	**$2,252,779**

LIABILITIES		
Unearned Premium		
Rugby Non-Medicare	$42,484	$44,661
Minot Non-Medicare	$2,565	$1,699
Rugby Medicare	$36,468	$38,056
CMS Contribution	$0	$46,690
A/P Administrative Bills	$0	$0
A/P Premium Tax	($3,681)	($3,980)
A/P Payroll Taxes	$560	$583
Accrued Vacation	$12,378	$13,035
IRA's Payable	$0	$0
Claims Adjustment Payable	$21,112	$17,866
Reported But Unpaid Claims	$201,739	$229,588
Incurred But Not Reported	$325,286	$290,904
TOTAL LIABILITIES	$638,911	$679,102
Surplus Notes	$320,000	$320,000
Accumulated Surplus Funds	$1,141,507	$1,253,677
TOTAL SURPLUS	**$1,461,507**	**$1,573,677**
TOTAL LIABILITIES & SURPLUS	**$2,100,418**	**$2,252,779**

HAHP Income Statement

As of 10-31-10

REVENUE	Current Month	Current YTD	Previous YTD
Rugby Non-Medicare Premium	$254,957	$2,615,137	$2,684,842
Minot Non-Medicare Premium	$16,468	$152,314	$133,491
Medicare Premium	$102,490	$1,037,917	$1,101,055
Rugby Reinsurance	$18,913	$214,177	$259,967
Minot Reinsurance	$0	$19,220	$140,359
Interest	$2,105	$37,550	$35,026
CMS Settlement Reimbursement	$0	$22,085	$36,391
TOTAL REVENUE	$394,933	$4,098,400	$4,391,131
EXPENSES			
Rugby			
Capitation Payments	$92,528	$857,582	$886,399
In-Area Services	$46,074	$413,720	$437,763
Referral Services	$230,358	$2,628,162	$2,429,613
Out-Of-Area Services	$19,308	$99,250	$140,765
Other Medical Services	$6,975	$77,912	$71,505
Minot			
In-Area Services	$13,908	$395,056	$498,998
Out-Of-Area Services	$16	$772	$59,541
Other Medical Services	$0	$896	$2,632
Discounts from Providers	($60,814)	($859,053)	($729,382)
Reinsurance	$20,409	$199,642	$244,328
Premium Tax	$5,274	$54,331	$55,350
Plan Administration	$28,900	$289,495	$308,006
TOTAL EXPENSES	$402,936	$4,157,765	$4,405,518
SURPLUS (DEFICIT)	**($8,003)**	**($59,365)**	**($14,387)**
Unrealized Gain/Loss w/ Investments	$0	$0	$0
Realized Gain/Loss w/ Investments	$0	$1,140	$0
NET SURPLUS / DEFICIT	**($8,003)**	**($58,225)**	**($14,387)**

Heart of America Health Plan "High Option Plan"

NO Annual Deductibles!! DESCRIPTION OF BENEFITS	COPAYMENT AMOUNT YOU PAY	HAHP BENEFIT AMOUNT	EXCEPTIONS/LIMITATIONS
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, Electrocardiograms, 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%/80%	Outpatient: 100% hours 1-5; hours 6-30 80%
Residential Treatment	$0	100%	Up to 120 days per member per calendar year
Alcohol and Substance Abuse Services			
Inpatient &/or Partial hospitalization.	$0	100%	Inpatient Max: 60 days per calendar year.
Outpatient.		100%/80%	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.	**$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%	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 be provided by participating providers.	**$25**	80%	With prior authorization by PCP and HAHP $3,000 coinsurance maximum per contract per calendar year.
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"

NO Annual Deductibles!! DESCRIPTION OF BENEFITS	COPAYMENT AMOUNT YOU PAY	HAHP BENEFIT AMOUNT	EXCEPTIONS/LIMITATIONS
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 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.	**$15**	100%	$15 copay on first visit. Then 100% covered.
Hospital services, Birthing/delivery, & Newborn nursery.	**$250 (1st/4th day)**	100%	$1,000 copay max per calender year
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.	**$250 (1st/4th day)**	100%	Inpatient Max: 45 days per calendar year.
Outpatient.		100%/80%	Outpatient: 100% hours 1-5; hours 6-30 80%
Residential Treatment	**$250 (1st/4th day)**	100%	Up to 120 days per member per calendar year
Alcohol and Substance Abuse Services			
Inpatient &/or Partial hospitalization.	**$250**	100%	Inpatient Max: 60 days per calendar year.
Outpatient.		100%/80%	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.	**$25**	80%	$500 coinsurance max. per calendar year
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**	80%	$500 coinsurance max. per calendar year
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%	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 (Craniomandibular 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"

Deductibles= SNG-$500 SPD-$750 FAM-$1000 Coinsurance Max/Yr= SNG-$1000 SPD-$1500 FAM-$2000 **DESCRIPTION OF BENEFITS**	**COPAYMENT AMOUNT YOU PAY**	**BENEFIT AFTER DEDUCT.**	**EXCEPTIONS/LIMITATIONS**
Preventive Health Services *(By Primary Care Physician)*			
Routine childhood and adult immunizations.	$0	100%	No maximum benefit allowance.
Routine physicals, Gynecological exams, Prostate and Breast exams, Mammograms, Pap smears, PSA's and other preventive health services.*	$0	100%	Deductible Waived
Physician Services *(By Primary Care Physician)*			
Hospital visits, including inpatient and skilled nursing facility visits.	$0	100%	Deductible Waived
Office visits and/or house calls authorized by PCP.	**$15**	100%	
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	$0	100%	Deductible Waived
Services provided at Primary Care Hosp.or contracted Referral Facility	$0	80%	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)*	**$15**	100%	$15 copay on first visit. Then 100% covered.
Hospital services, Birthing/delivery, & Newborn nursery.	$0	80%	Deductible applies
Well-baby care *(at Primary Care Clinic)*	$0	100%	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.	$0	80%	Inpatient Max: 45 days per calendar year.
Outpatient.	$0	80%	100% hours 1-5; (hours 6-30 80% after deductible)
Residential Treatment	$0	80%	Up to 120 days per member per calendar year
Alcohol and Substance Abuse Services			
Inpatient &/or Partial hospitalization.	$0	80%	Inpatient Max: 60 days per calendar year.
Outpatient.	$0	80%	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.	**$25**	80%	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**	80%	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 be provided by participating providers.	**$25**	60%	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: January 13, 2011

SUBJECT: Segal Contract

Attached is the Segal proposal for extending our contract for another year. As you will note, they also provided a two year renewal amount. This was not requested, but they offered since they felt they would be in a position to offer a better renewal proposal for a longer term. For your reference, I will have at the Board meeting what TFFR pays for its actuarial report.

If you are not comfortable with the renewal terms, our alternative would be to issue an RFP.

Board Action Requested

To approve or reject the contract extension terms.

SEGAL

THE SEGAL COMPANY
1920 N Street NW, Suite 400 Washington, DC 20036
T 202.833.6400 F 202.833.6490 www.segalco.com

DIRECT DIAL NUMBER
(202) 833-6437

E-MAIL ADDRESS
ceitelberg@segalco.com

January 10, 2011

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, 2011. Based upon your request, we are proposing a one-year extension of the current contract. We are also providing a two-year proposal that encourages more service continuity and is structured to provide greater transition to the value costing with a lower fee for the first year of the extension. The proposed fee increases are necessary to continue to provide quality consulting and are supported by the actual level of effort expended for NDPERS.

As you will remember we kept fees constant for the last one-year extension. In developing this proposal, we reviewed several past years of consulting experience to reach the fee structure below. With careful review of the effort and staff expertise dedicated to the NDPERS valuation work we verified that we have committed increased time and level of actuarial staff. In addition, we continue to enhance processes, quality review and actuarial expertise to mitigate and continue to manage litigation risk. As you are aware, several firms have exited the public sector or now require clients to agree to limits on liability, we have approached this issue through our ongoing focus on quality control and building trust with our clients. The fee increase represents approximately 60 percent of the additional production hours that have consistently been spent on the NDPERS valuations. The combination of more committed hours to produce the five main valuations and the other two under the fixed fee, consistence quality review and enhanced actuarial expertise dedicated to NDPERS result in the proposed alternative fee structures and hourly rates.

The following tables set forth the proposed fees:

Fixed Fee Rates	**Existing One Year Fee** 7/1/10-6/30/11	**Proposed One Year Fee** 7/1/11-6/30/12	**Proposed Two Year Fee**	
			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**

Time Charge Rates				
QDRO, Compliance Consulting, General Consulting and Special Projects	Time Charges per schedule	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	Time Charges per schedule
Legislative Analysis	Time Charges per schedule	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	Time Charges per schedule
457 Plan	Time Charges per schedule	Time Charges per schedule	Time Charges per schedule	Time Charges per schedule

Hourly 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 to 6/30/12**	**7/1/11 to 6/30/12**
Consulting Actuary	$365	$400	$380	$400
Reviewing Actuary	$395	$420	$410	$420
Senior Actuarial Analyst	$310	$370	$350	$370
Actuarial Analyst	$225	$240	$235	$250
Compliance Consulting	$345	$365	$360	$385
Compliance Analyst	$225	$240	$235	$250

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 above with prior approval from the System.

We have appreciated our long relationship with North Dakota PERS, and we respectfully submit this proposal for an extension. We encourage you to consider the two-year option for continuity and transitional value.

Please do not hesitate to call if I can answer any questions.

Sincerely,

Cathie Eitelberg
Senior Vice President
National Director, Public Sector Market

cc: John Coyle
Brad Ramirez
Dave Bergerson
Steve Ohanian

5115239v2/01640.001

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: January 13, 2011

SUBJECT: Policies

At the last meeting we discussed the policies of the Board relating to delegation of duties to the Executive Director. Attached for your information and review is that document. Supplementing this would be any delegation in the administrative rules.

NDPERS

Operating Guidelines

GENERAL

	Board	Executive Director
Rules	Must approve all rules	Proposes, drafts and implements
Benefit Structure	Must approve all program design features	Proposes and drafts changes; implements
Legislation	Must approve	Proposes; drafts and represents Board's position
Plan Documents	Must approve	Proposes; drafts and implements
Member Booklets, Newsletters, and Other Informational Material Sent to Members		Approves

FINANCE

	Board	Executive Director
Emergency Commission (i.e. line item transfers or transfers from contingency)	Approves	Proposes
Budget Preparation and Submittal to OMB	Approves	Proposes and represents agency before Legislature and OMB
Budgeted Expenses		Approves as long as expenses do not exceed the approved budget. Must report the status of the budget at each Board meeting. Director must assure the rate of expenditures for salaries and operating is consistent with Section 54-27-10 NDCC. Arrangements for office space must be reviewed by the Board before committing the Agency.
Consulting Service Contracts		
• **On Budget**		Approves (i.e. temp services, EAP, Printing, Etc.)
• **Off Budget**	Approves all contracts over $10,000	Approves if under $10,000; must report all contracts to the Board at the earliest opportunity
Contracts with Political Subs		
• **Retirement** • **Health** • **Life** • **Deferred Compensation**	Approves standard agreement	Approves as long as consistent with standard agreement

	Board	Executive Director
Uniform Group Insurance Contract	Approves and must be signed by Chairman (54-52.1-05 NDCC)	Recommends
PPO Contracts	Approves guidelines and standard agreement	Negotiates and approves if consistent with guidelines and the arrangement is equal to, or more stringent than, a standard agreement; must advise Board of status and terms.
Travel	Approves all out of state Board travel; the Chairman will review for approval any requests for Board travel that occurs prior to the reconvening of the full Board. Approves all staff travel outside the continental United States	Approves all staff travel (including the Executive Director's) within the continental United States and in-state Board travel

PERSONNEL

	Board	Executive Director
Personnel Policies	Approves	Recommends and implements
New FTE Positions	Approves	Recommends
Hiring	Responsible for Executive Director	Responsible for filling authorized FTE and temporary assistance pursuant to OMB guidelines and available funds.
Firing	Responsible for Executive Director	Approves
Overtime Authorization		Approves subject to available funds
Severance Pay	Approves, subject to Section 54-14-04.3 NDCC	
Leave of Absence	Approves for Executive Director	Approves for staff
Job Evaluations	Responsible for Executive Director	Approves staff evaluations; advises Board annually of increases
Reclassifications		Approves; must advise Board of any major changes
Salary Increases	Approves for Executive Director	Approves, subject to available funds and OMB guidelines
Promotions		Approves, subject to OMB Human Resources guidelines
Educational Reimbursement	Approves for Executive Director	Approves for staff

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: January 13, 2011

SUBJECT: Legal Assistance

Matt Sagsveen will be at the next meeting to give you an update on our legal assistance from the Attorney General's Office. Aaron Webb recently submitted his resignation since he accepted a job at the Department of Financial Institutions.

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Memorandum

TO: PERS Board

FROM: Sharon

DATE: January 13, 2011

SUBJECT: 2010 COMPREHENSIVE ANNUAL FINANCIAL REPORT

The 2010 comprehensive annual financial report has been completed. Here is the link to our website for you to review the report which over 120 pages in length.

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