NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

Board Meeting Agenda

Location: WSI Board Room, 1600 East Century Avenue, Bismarck ND
By phone: 701.328.0950 Conference ID: 501 960 686
Date: **Tuesday, August 20, 2024**
Time: 8:30 A.M. Click here to join the meeting

I. MINUTES
A. July 9, 2024

II. CONFLICT OF INTEREST DISCLOSURE CONSIDERATION

III. PRESENTATIONS
A. Health Plan Executive Summary Quarter 1 2024

IV. DEFINED CONTRIBUTION PLAN IMPLEMENTATION
A. House Bill 1040 Implementation Update – Rebecca (Information)

V. DEFERRED COMPENSATION / DEFINED CONTRIBUTION
A. 401(a) Defined Contribution Plan Document – Rebecca (Board Action)

VI. GROUP INSURANCE / FLEXCOMP
A. Dental Contract – Katheryne (Board Action)
B. FlexComp Contract – Katheryne (Board Action)
C. FlexComp Voluntary Insurance Products – Rebecca (Board Action)
D. Medicare Part D Premium Renewal or RFP – Rebecca (Board Action)
E. Insulin/Diabetic Supplies Report and Recommendation – Rebecca (Board Action)
F. Sanford Health Plan Member Survey Results – Rebecca (Information)
G. Health Insurance Plan Renewal:
   1) Sanford Health Plan Renewal Presentation
   2) Closed Discussion ***EXECUTIVE SESSION** – Rebecca
   3) Open Discussion – Rebecca (Board Action)

VII. LEGISLATION / ADMINISTRATIVE RULES
A. Proposed Administrative Rules – Rebecca (Information)

VIII. OPERATIONS / ADMINISTRATIVE
A. Budget Status – Derrick (Information)
B. Contracts Under $10,000 – Rebecca (Information)
C. Next Meeting Date: Tuesday, September 10, 2024

*Executive Session pursuant to N.D.C.C. §44-04-19.1(9) and §44-04-19.2) to discuss negotiating strategy or provide negotiating instructions to its attorney or other negotiator.

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: August 20, 2024

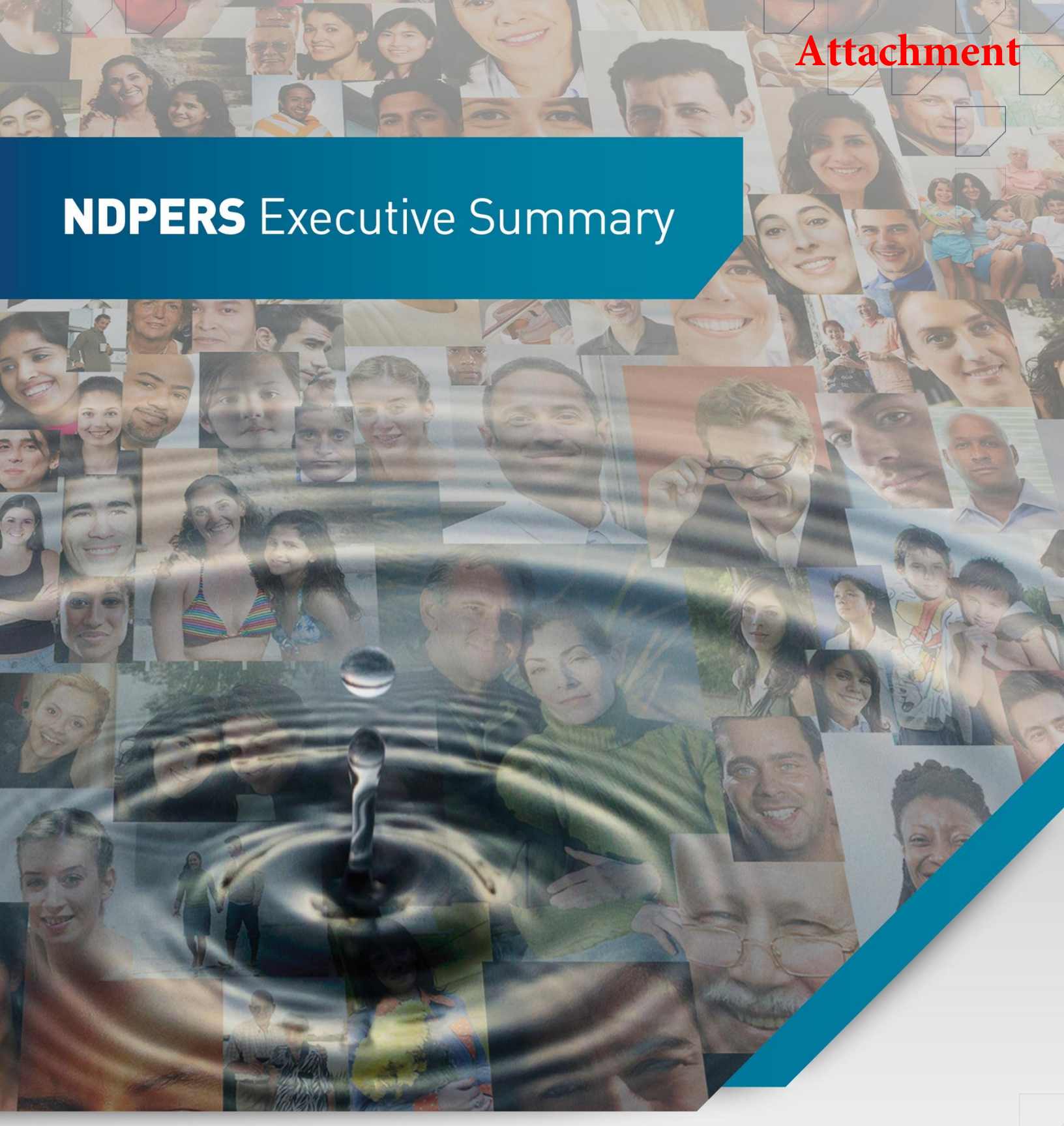
SUBJECT: Sanford Health Plan Executive Summary 2024 Quarter 1

Sanford Health Plan (SHP) will be at the meeting to review the attached Executive Summary 2024 Quarter 1 and answer any questions you may have. Representatives from Humana are also available to discuss any questions related to the Medicare Part D Plan information, labeled as NDPERS EGWP, found on page 17 of the summary.

This item is informational and does not require any action by the Board.

Attachment

NDPERS Executive Summary



Quarter 1 | 2024

Presented August 2024

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM | SANFORD HEALTH PLAN

CONTENTS

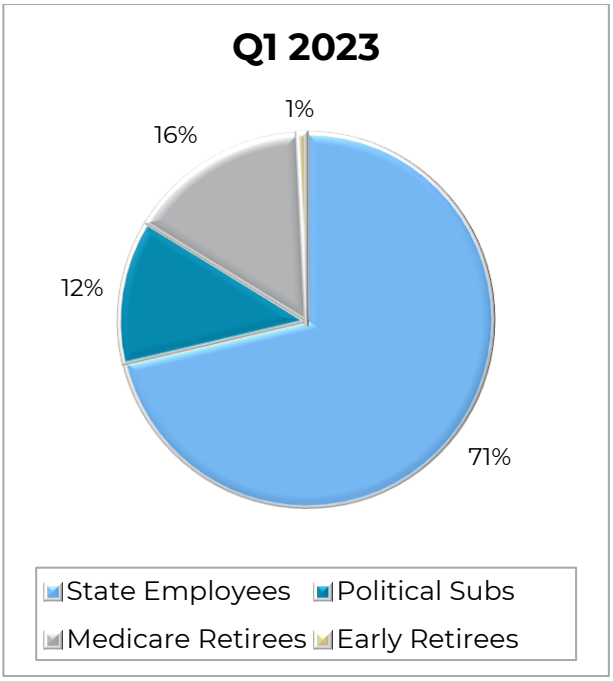
SECTION 1: MEMBERSHIP

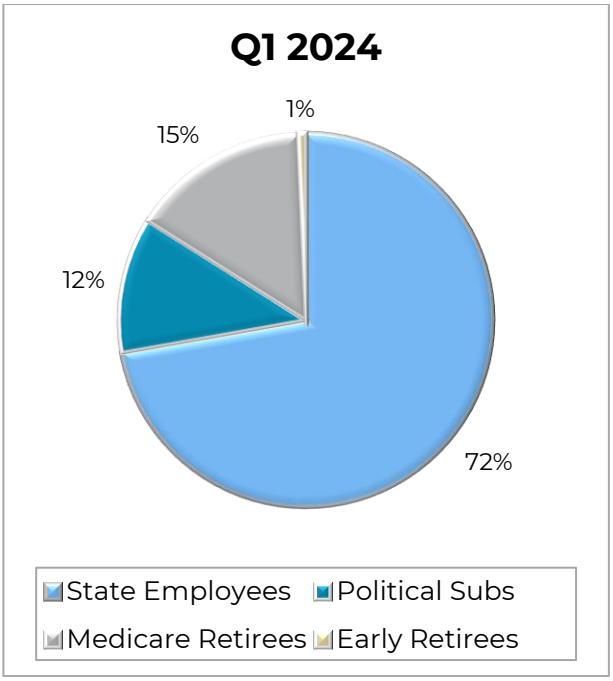
ANNUAL MEMBERSHIP SUMMARY

Exhibit 1.1

MEASURE	Q1 2023	Q1 2024	PERCENT CHANGE
State Employees	41,698	42,328	1.5%
Political Subs	7,286	6,907	-5.2%
Medicare Retirees	9,063	9,002	-0.7%
Early Retirees	421	380	-9.7%
TOTAL	**58,468**	**58,617**	**0.36%**

Exhibit 1.2





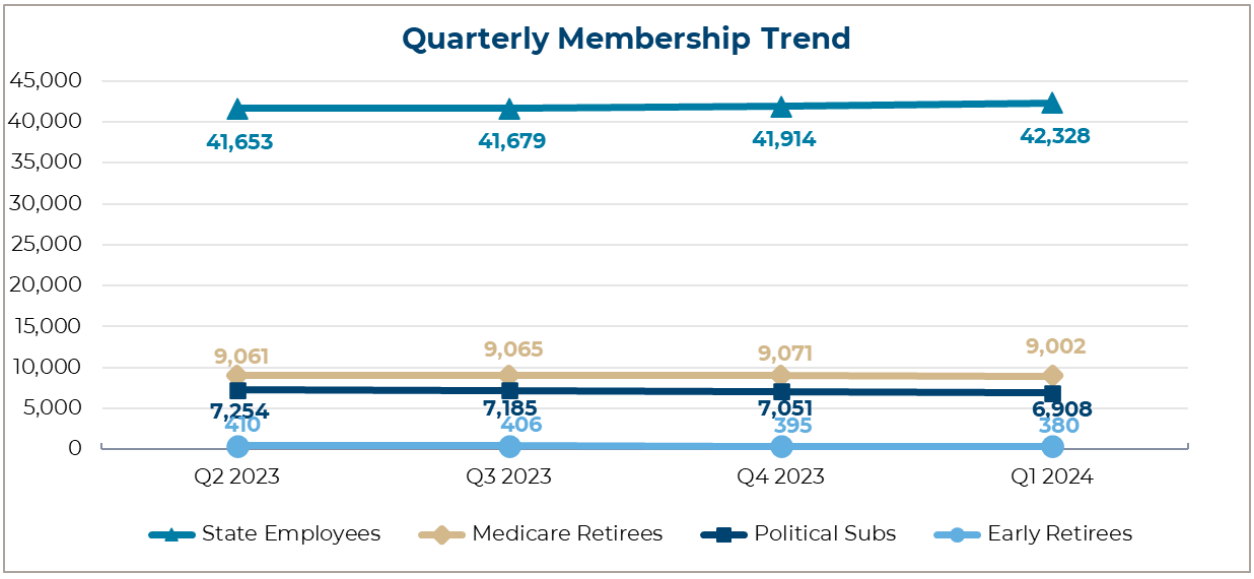
MEMBERSHIP TREND

Exhibit 1.3

MEASURE	Q1 2023	Q1 2024	% CHANGE	BENCHMARK	% VARIANCE
Average Employees	18,647	18,449	-1.1%		
Average Members	49,719	49,363	-0.7%		
Average Contract Size	2.67	2.68	0.3%		
Average Age	33.7	33.6	-0.4%		
% Female	51.0%	50.9%	-0.2%	50.9%	0.0%
HCCs (% of Members)	0.3%	0.3%	17.7%	0.3%	18.2%

*Includes State Employees, Early Retirees & Political Subs.

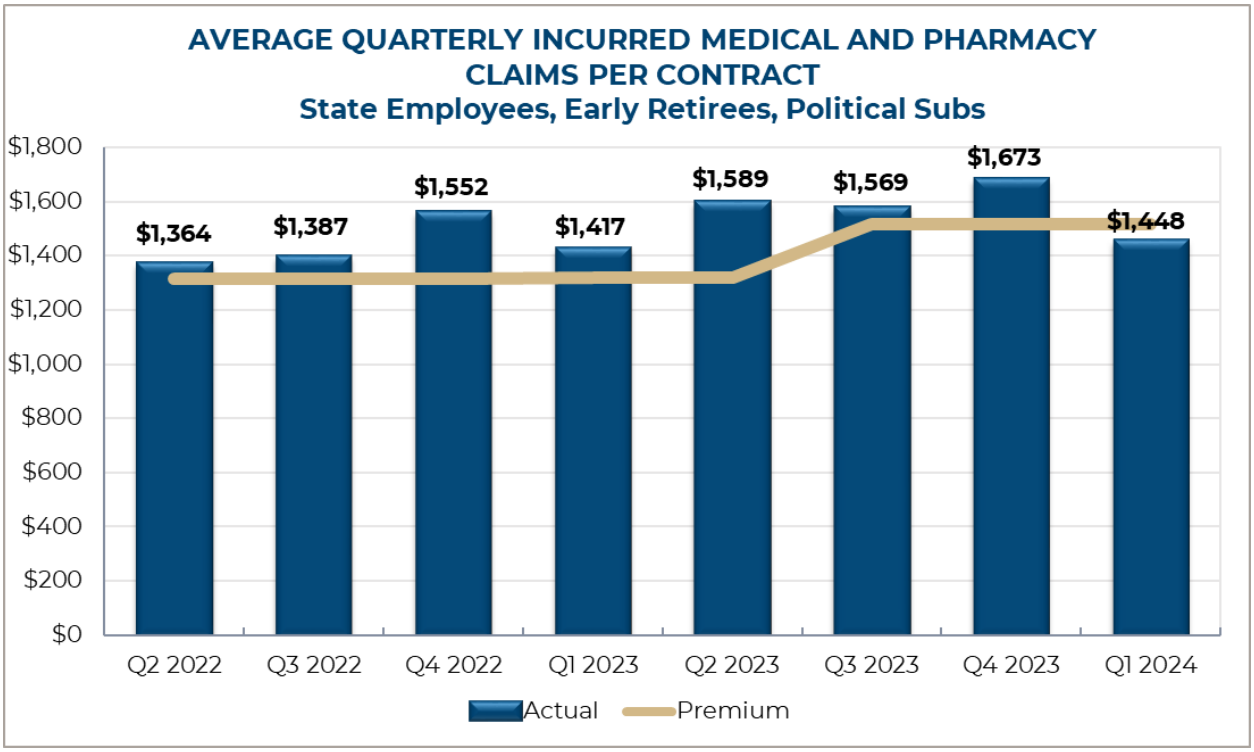
Exhibit 1.4



SECTION 2: CLAIMS ANALYSIS

PAID CLAIMS PER CONTRACT PER MONTH

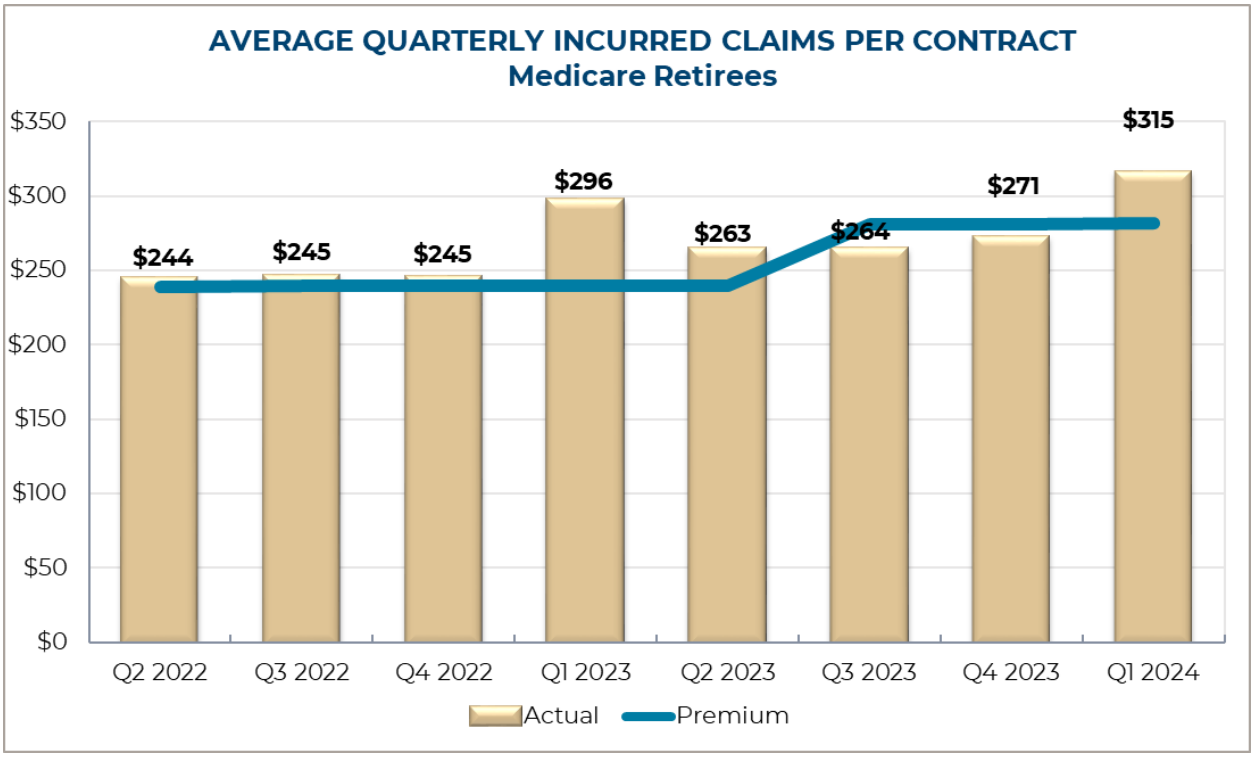
Exhibit 2.1



*Incurred between April 1, 2023 and March 31, 2024 with paid date as of June 30, 2024. Final Adjusted Claims.
*NDPERS Active contracts have approximately 2.68 members per contract.
*Includes medical claims and prescriptions without IBNR.
*Additional medical claims may be received.

PAID CLAIMS PER CONTRACT PER MONTH

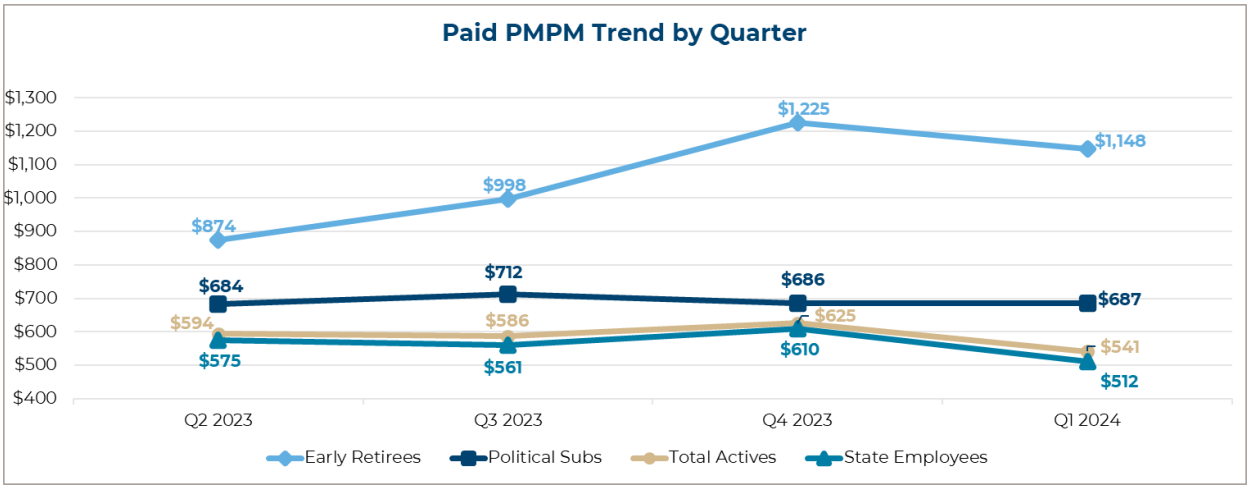
Exhibit 2.2



*Incurred between April 1, 2023 and March 31, 2024 with paid date as of June 30, 2024. Final Adjusted Claims.
*Includes medical claims only excludes prescription drug coverage (Medicare Part D).
*Additional medical claims may be received.
*Medicare Retirees contracts have approximately 1.37 members per contract.

PAID PER MEMBER PER MONTH (PMPM) TREND BY QUARTER

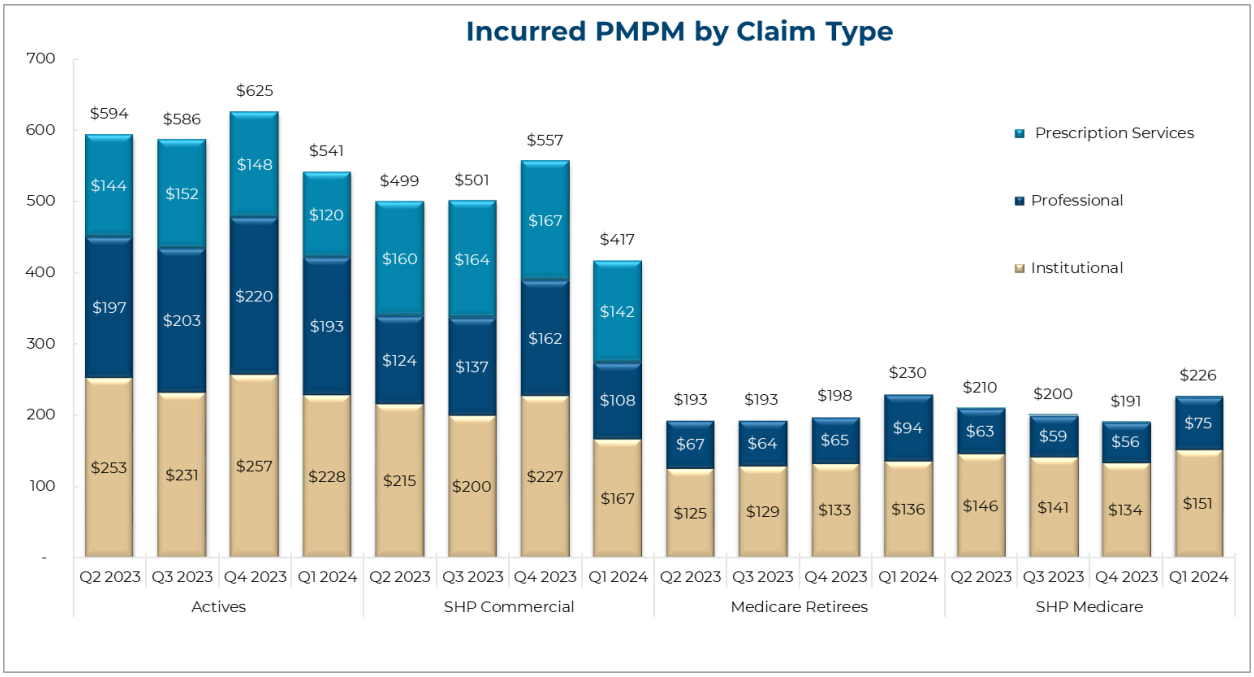
Exhibit 2.3



*Incurred between April 1, 2023 and March 31, 2024 with paid date as of June 30, 2024. Final Adjusted Claims.
*Total Actives = State Employees + Early Retirees + Political Subs
*Medical claims and Prescription services without IBNR.
*Additional medical claims may be received.

INCURRED PMPM BY CLAIM TYPE

Exhibit 2.4



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*Medical claims and prescription services without IBNR.
*Additional medical claims may be received.

SECTION 3: UTILIZATION

MEDICAL COST DRIVERS: ACTIVES

Exhibit 3.1

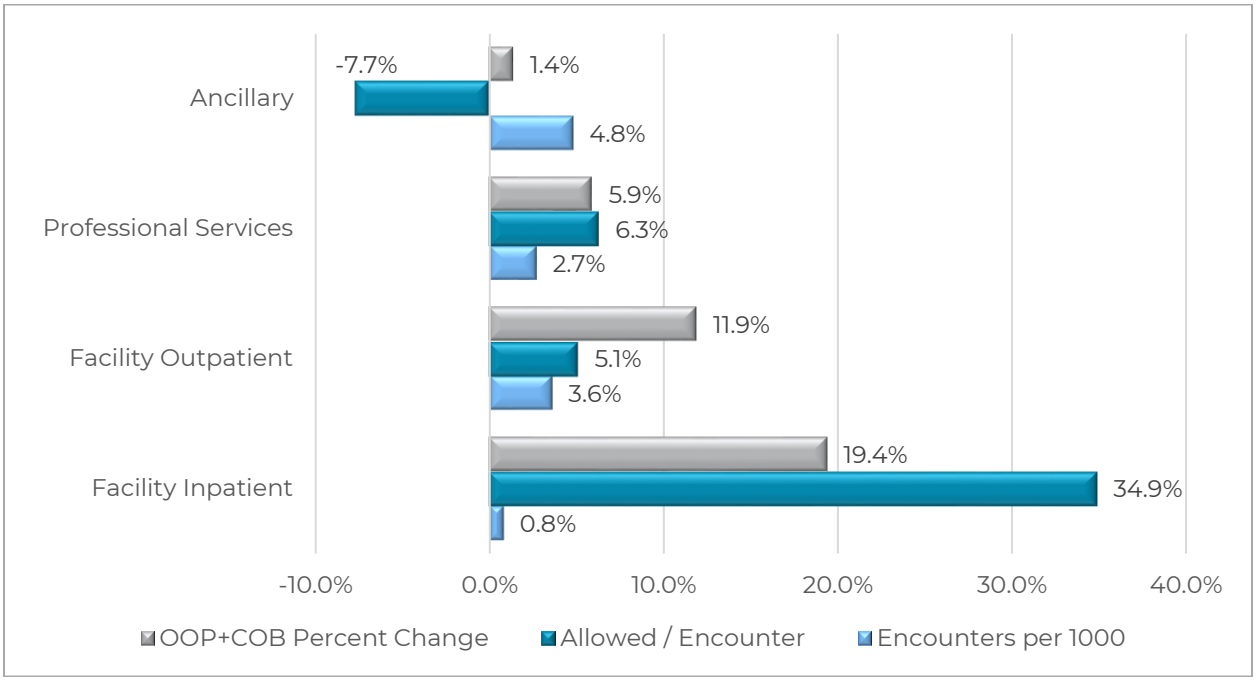


Exhibit 3.2

MEASURE	FACILITY INPATIENT	FACILITY OUTPATIENT	PROFESSIONAL SERVICES	ANCILLARY
Encounters per 1000 Prior Period	50	2,491	12,842	1,655
Encounters per 1000 Current Period	50	2,580	13,187	1,734
% Change	0.8%	3.6%	2.7%	4.8%
Amount Allowed per Encounter Prior Period	$21,698	$595	$174	$400
Amount Allowed per Encounter Current Period	$29,277	$625	$185	$369
% Change	34.9%	5.1%	6.3%	-7.7%
OOP+COB PMPM Prior Period	$0.29	$15.56	$36.42	$3.09
OOP+COB PMPM Current Period	$0.35	$17.41	$38.58	$3.13
% Change	19.4%	11.9%	5.9%	1.4%

*Prior Period: April 2022- March 2023. Current period: April 2023- March 2024. Paid through June 30, 2024.

SECTION 4: HIGH DOLLAR CASES: ACTIVES

Exhibit 4.1

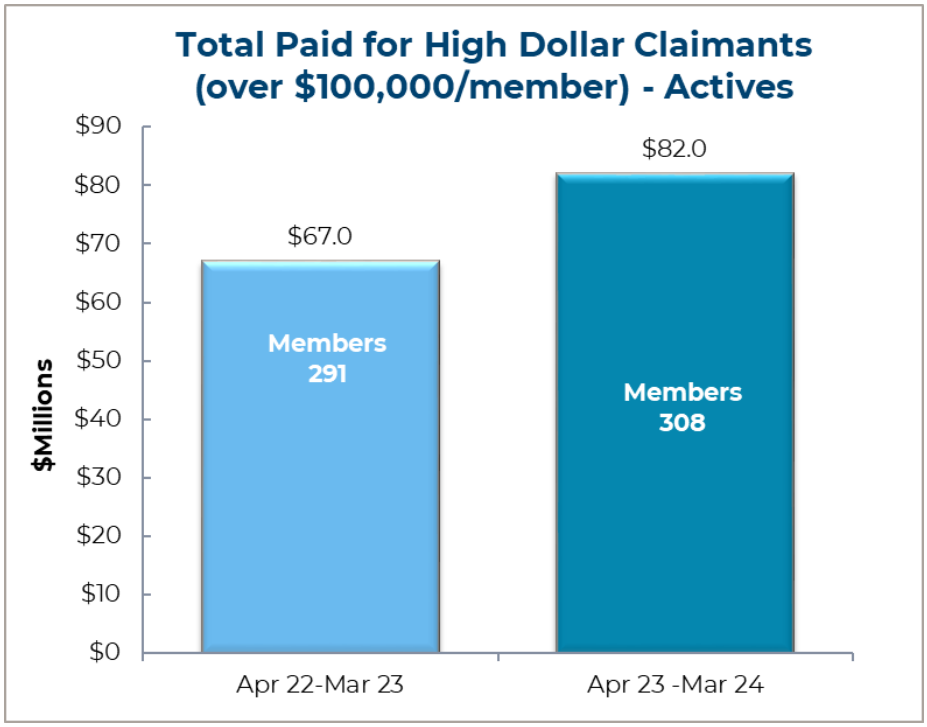
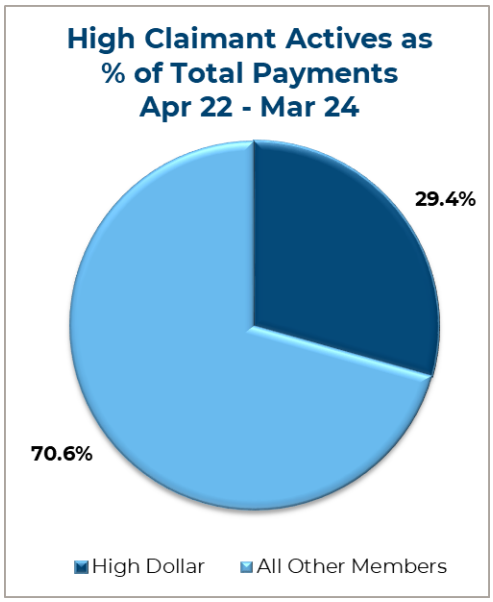


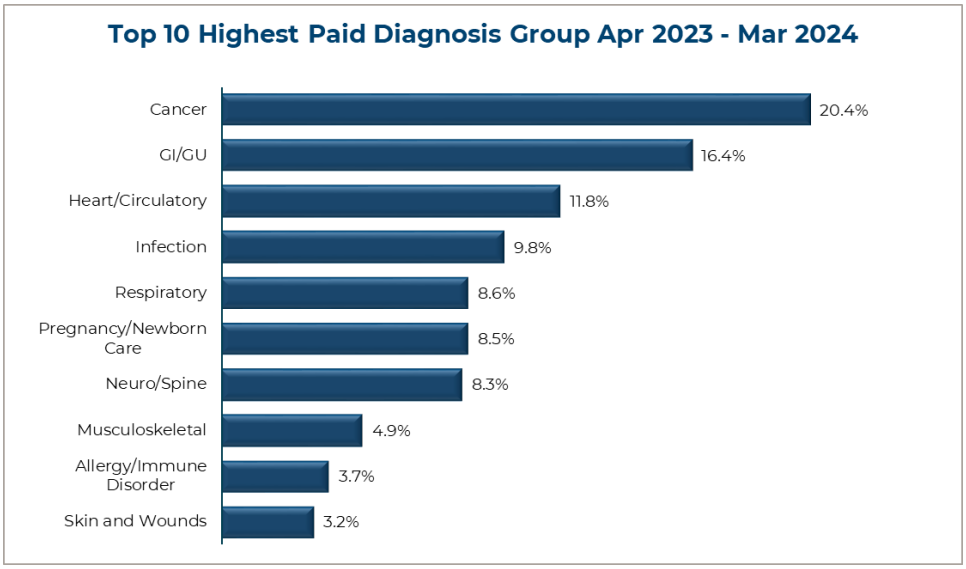
Exhibit 4.2



ACTIVE MEMBERS	
Avg. Paid/ Claimant	$266,182
% of Total Payments	29.4%

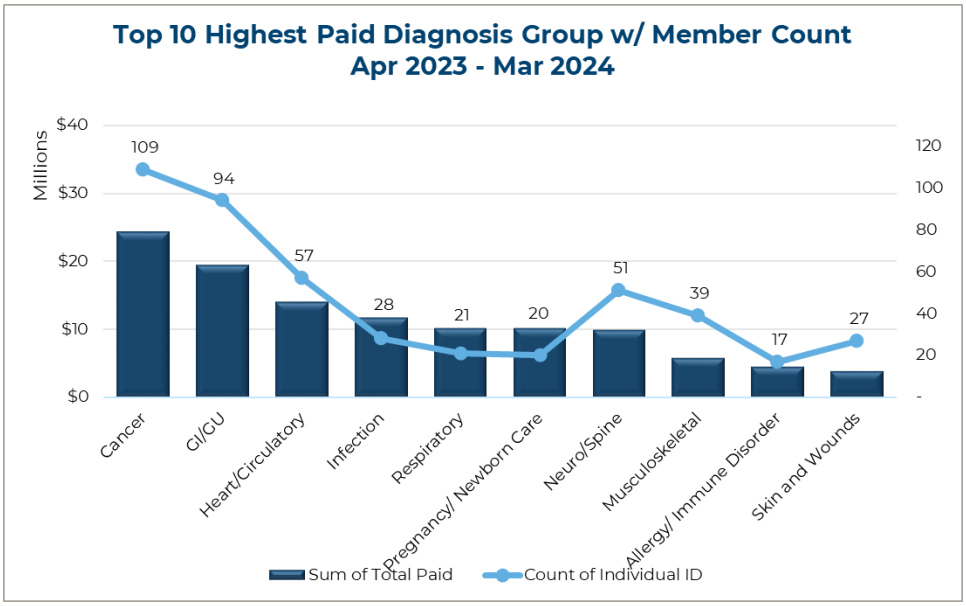
*Medical claims only without IBNR.
*Additional medical claims may be received.

Exhibit 4.3



*The remaining 4.4% represent 5 diagnosis groups.
*High dollar cases consist of combined medical claims and prescriptions with a total of $100K or greater.
*Includes Medical claims and Prescription services without IBNR.
*Additional medical claims may be received.

Exhibit 4.4



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*Includes Medical claims and Prescription services without IBNR.
*Additional medical claims may be received.

SECTION 5: PHARMACY

Exhibit 5.1

SUMMARY OF YOUR PLAN

NDPERS – Apr 23 – Mar 24
Apr 22- Mar 22 vs. Apr 23- Mar 24

PLAN PAID PMPM

- NDPERS Apr 23 – Mar 24's PMPM is trending at 9.4% versus previous period
- Inflammatory Conditions, Diabetes, and Oncology disease states accounted for 64.9% of overall plan paid and increased $8.22 PMPM in total plan paid. The benchmark increased $14.96 PMPM in these categories

YOUR OUTCOMES

- Strategic Solutions have resulted in a total of $47.77 PMPM plan savings
- Strategic Solutions have resulted in a total of $335,378 total healthcare (medical + pharmacy) savings

Exhibit 5.2

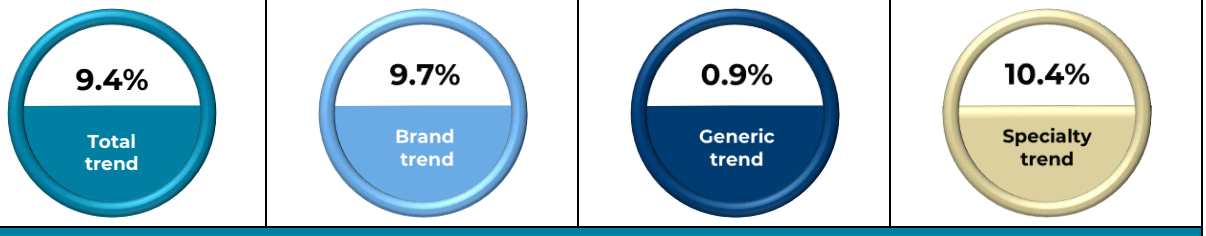
PLAN PERFORMANCE – PLAN PAID

NDPERS – Apr 23 – Mar 24
Apr 22- Mar 22 vs. Apr 23- Mar 24

TOTAL PLAN PAID PMPM: $141.06

TREND

- Plan paid PMPM has decreased 9.4% over the previous period driven primarily by drug mix in traditional and utilization for specialty.
- Specialty represents 1.3% of claims.



PLAN PAID PMPM

Current period PMPM of $141.06 equates to $83.6M in pharmacy spend. 62.3% of the spend is attributed to specialty medications.

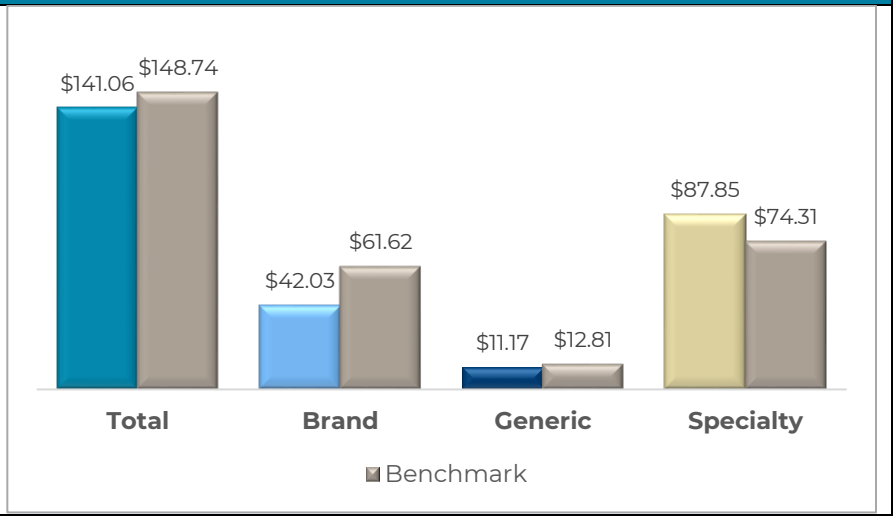


Exhibit 5.3

KEY STATISTICS

NDPERS – Apr 23 – Mar 24
Apr 22- Mar 22 vs. Apr 23- Mar 24

PLAN PAID PMPM: $141.06

The key metrics here help highlight the changes NDPERS Apr 23 – Mar 24 has experienced period over period.

- Eligibility has decreased by -338.
- Number of utilizers has decreased by -150.

TOTAL RXS	TOTAL PLAN PAID	UTILIZERS
CURRENT 449,991	**CURRENT** $83,573,512	**CURRENT** 38,859
PREVIOUS 446,424	**PREVIOUS** $76,927,595	**PREVIOUS** 39,009
PREVIOUS CHANGE 0.8%	**PREVIOUS CHANGE** 8.6%	**PREVIOUS CHANGE** -0.4%

KEY STATISTICS	NDPERS			COMMERCIAL BENCHMARK	
	CURRENT	PREVIOUS	% CHANGE	CURRENT	% CHANGE
Average Age	33.3	33.4	-0.4%	35.9	0.2%
Plan Paid PMPM	$141.06	$128.96	9.4%	$148.74	17.8%
Plan Paid Per Rx	$185.72	$172.32	7.8%	$180.91	15.6%
Rx PMPM	0.760	0.748	1.5%	0.822	1.9%
Average Days Supply	45.2	45.1	0.1%	39.8	2.2%
Days Supply PMPM	34.3	33.8	1.6%	32.7	4.2%
Member Paid Share	11.5%	12.4%	-7.0%	10.2%	-9.0%
Member Paid per Rx	$24.19	$24.39	-0.8%	$20.62	4.0%
Brand Dispensing Rate	13.1%	13.6%	-3.7%	13.7%	
Generic Dispensing Rate (GDR)	86.9%	86.4%	0.7%	86.3%	1.4%
GDR- Without Vaccines	88.2%	87.9%	0.3%	88.2%	0.4%
Home Delivery Rate	0.6%	0.6%	9.1%	6.2%	6.9%
Retail 90 Rate	32.5%	32.5%	0.0%	19.3%	2.9%
% of Specialty Plan Paid	62.3%	61.7%	0.9%	50.0%	0.5%

Exhibit 5.4

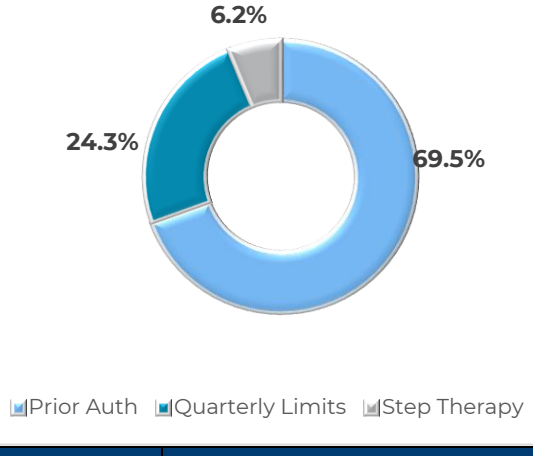
UM OUTCOMES

NDPERS – Apr 23 – Mar 24
Apr 22- Mar 22 vs. Apr 23- Mar 24

UTILIZATION MANAGEMENT SAVINGS: $21.14 PMPM

Your Program Savings: $12.5 M

Ensuring patients meet appropriate clinical criteria when initiating medication therapy not only helps to ensure that the patient is being treated safely according to guidelines, but also drives significant savings for both NDPERS and their members. Between Apr 23 - Mar 24 NDPERS realized over $12.5M in savings. Based on a study by OptumRx, leveraging UM strategies that drive members to appropriate and often lower cost medications for treatment can save a member up to $620 annually in out-of-pocket copayments.

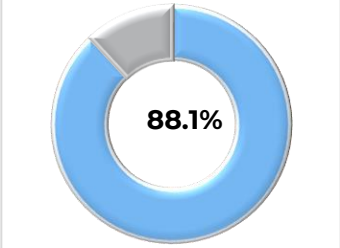


PRIOR AUTHORIZATION	TOTAL PLAN PAID	UTILIZERS
PMPM SAVINGS $14.69	**PMPM SAVINGS** $5.15	**PMPM SAVINGS** $1.31
# OF MEMBERS IMPACTED 1,956	**# OF MEMBERS IMPACTED** 1,741	**# OF MEMBERS IMPACTED** 691
# OF INTERVENTIONS 2,222	**# OF INTERVENTIONS** 1,892	**# OF INTERVENTIONS** 809

Exhibit 5.5

TOP 5 THERAPY CLASSES

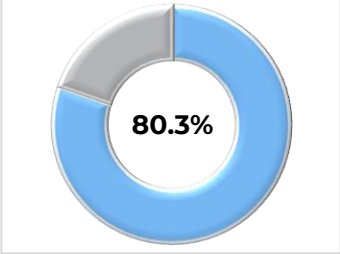
PRIOR AUTHORIZATION



Prior authorization savings from top 5 therapeutic class interventions

GPI-4 Description	Number of Cases	Plan Paid Savings
GLP-1 Receptor Agonists	1,198	$4,201,259
Chronic Inflammatory Disease	284	$2,810,243
Hereditary Angioedema	2	$266,344
Migraine Products	112	$238,399
Narcolepsy	5	$153,875

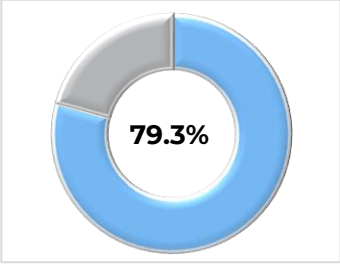
QUANTITY LIMITS



Quality limits savings from top 5 therapeutic class interventions

GPI-4 Description	Number of Cases	Plan Paid Savings
Chronic Inflammatory Disease	52	$1,082,506
GLP-1 Receptor Agonists	90	$585,103
Migraine Products	901	$478,545
Oncology	1	$173,073
Multiple Sclerosis	3	$129,895

STEP THERAPY



Step therapy savings from top 5 therapeutic class interventions

GPI-4 Description	Number of Cases	Plan Paid Savings
Atypical Antipsychotics	89	$254,144
Diabetes Monitoring and Testing Supplies	396	$147,196
Migraine Products	56	$123,681
Urinary Antispasmodics & OAB Drugs	32	$50,191
Antidepressants	39	$39,761

NDPERS EGWP: HUMANA

Exhibit 5.6

DESCRIPTION	Q1 2023	Q1 2024	CHANGE
Avg. Members per Month	9,058	9,005	-0.6%
Average Member Age	76.7	77.0	0.4%
Members Utilizing Benefit	8,225	8,249	0.3%
% Members Utilizing Benefit	90.8%	91.6%	0.9%
Total Rx (30 day adjusted)	118,532	119,601	0.9%
Total Rx PMPM (30 day adjusted)	4.36	4.43	1.6%
Generic Fill Rate	90.5%	89.7%	-0.9%
Maintenance 90 Day Utilization	79.1%	79.8%	0.8%
Retail – Maintenance 90 Day Utilization	77.4%	77.9%	0.6%
Home Delivery – Maintenance 90 Day Utilization	1.8%	1.9%	3.9%
Total Specialty Rx	266	308	15.8%
Specialty % of Plan Paid	27.1%	34.2%	26.2%

SECTION 6: WELLNESS CONTINUUM

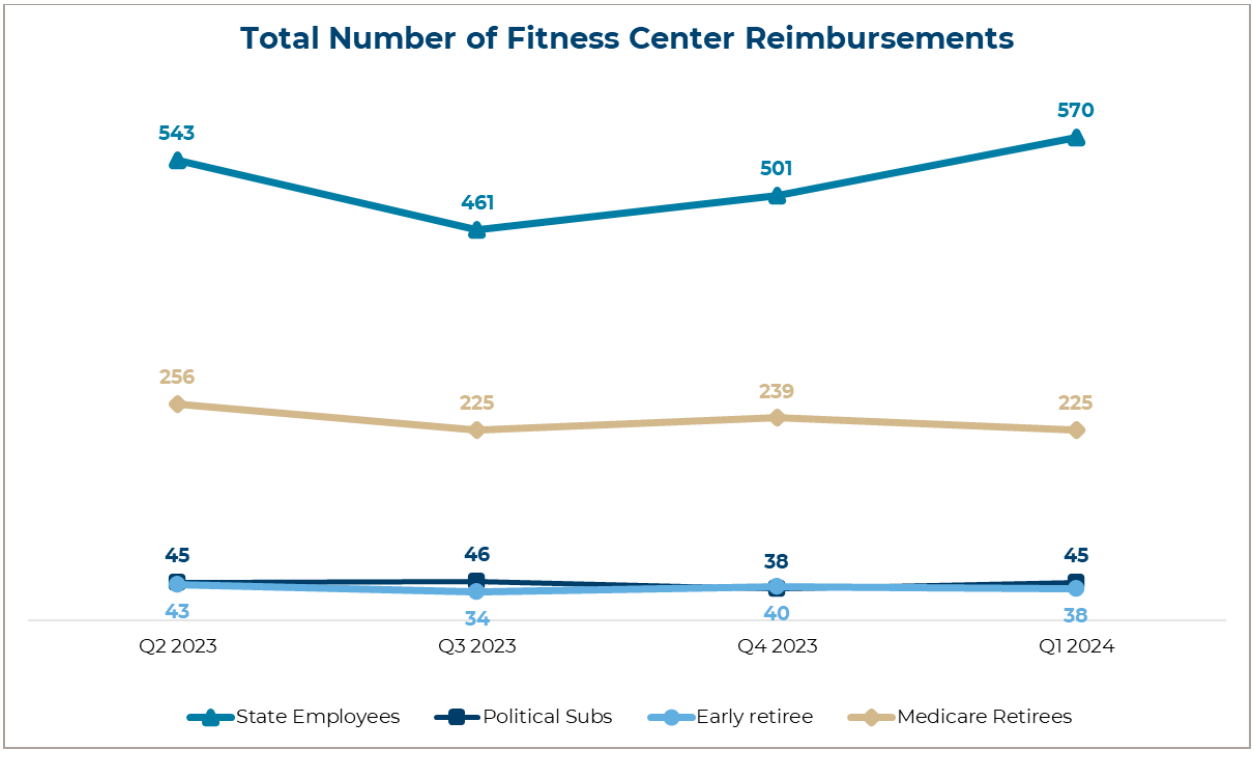
An integrated approach to health management

+Wellness is a family of services that identifies and delivers personalized, whole-person care to members based upon where they are on the wellness continuum. It helps ensure appropriate intervention, diagnoses and treatment plans while navigating members to appropriate resources and high-value specialty care when needed.

DAKOTA WELLNESS PROGRAM

FITNESS CENTER REIMBURSEMENT

Exhibit 6.1



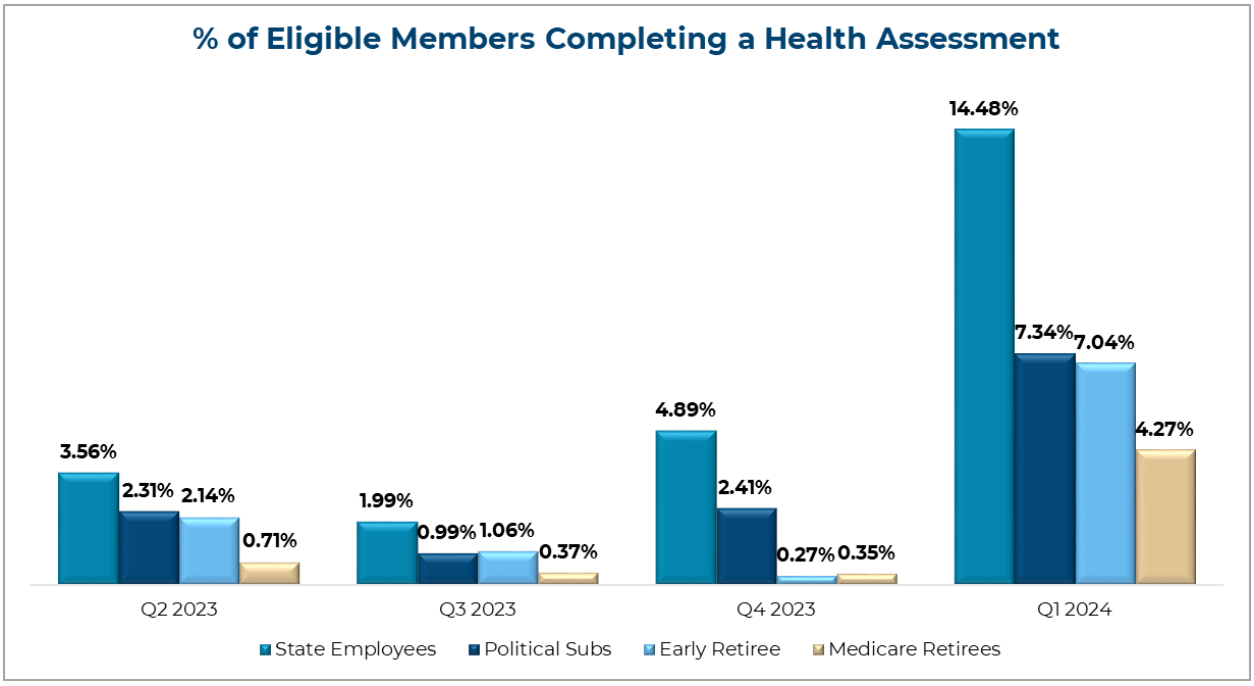
*Percentages are based on numbers per quarter and are not accumulated.

WELLNESS CONTINUUM

Well-being Resources | Preventive Care | Managing A Population | Care Management | Disease Management

HEALTH ASSESSMENT

Exhibit 6.2

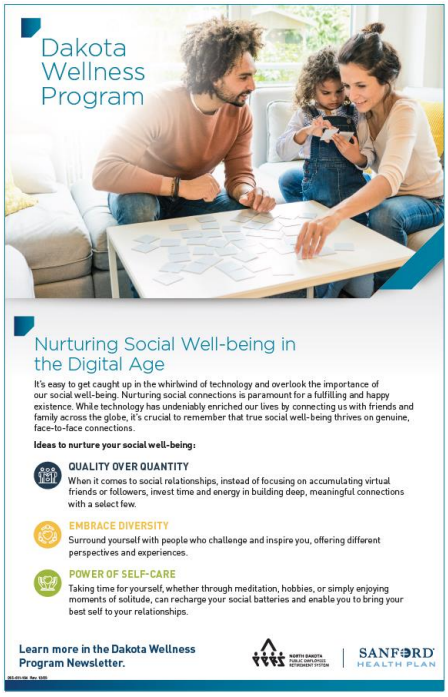


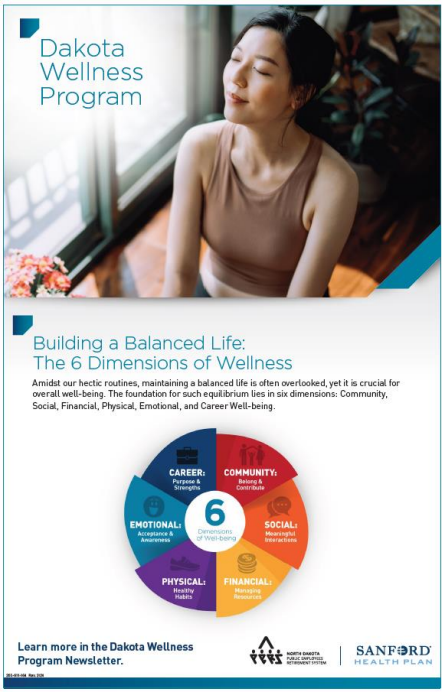
*Percentages are based on numbers per quarter and are not accumulated.

MONTHLY WELLNESS THEMES

Exhibit 6.3

Monthly themes keep the wellness program fresh throughout the year and keeps members engaged in their individual wellness pursuit. Newsletter, e-blasts and worksite posters are used to introduce themes.





Q1 QUARTERLY WELLNESS CHALLENGE

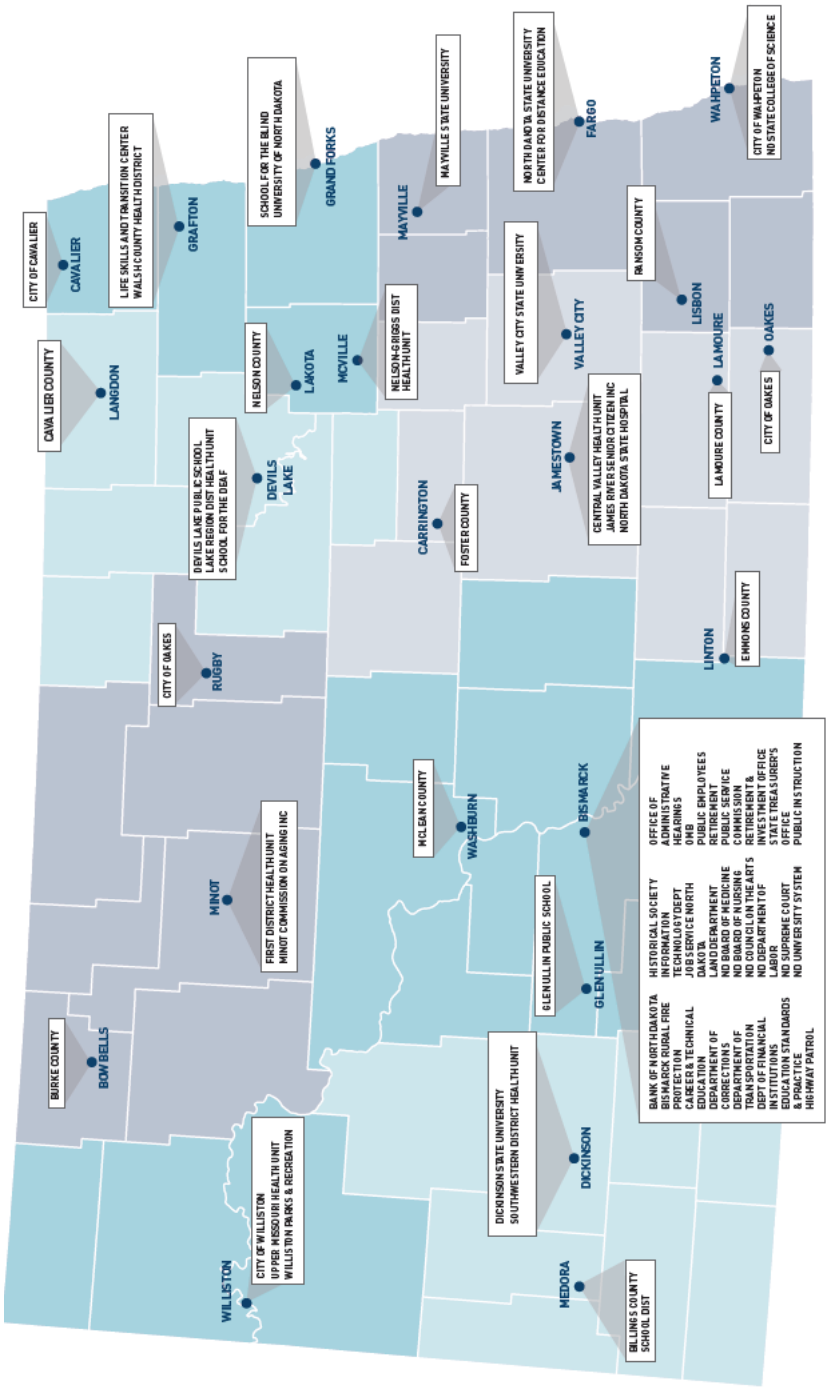
THRIVE FOR FIVE

- The Five to Thrive Nutrition Challenge encourages people to eat 5 or more servings of fruit and vegetables each day for better health.
- During the challenge, participants must track and record fruit and vegetable consumption for at least 21 out of 28 days. They are eligible to earn rewards if they consume 5 or more servings per day for at least 14 days.
- To help drive participation and engagement, Sanford Health Plan made promotion challenges easy with ready-to-go communications materials in a variety of formats, including postcards, tent cards, monitor ads, posters, promotional copy, emails and banner ads.
- The series of engagement emails included: Registration, Registration Reminder, Challenge Begins, four E-card Tips to send during each week of the challenge, and Challenge is Complete.
- Nutrition tips and advice on how to eat a healthier, more balanced diet were included in tent cards, postcards and emails.

- **Participation**:
    - **Members Enrolled**: 1,912
    - **Total Visits**: 48,400 visits
    - **Average Visits per Member**: 25

EVENT ATTENDANCE BY AGENCY

The Sanford Health Plan NDPERS wellness team continues to engage members across the state, despite pandemic-related in-person restrictions. Wellness educators support agency wellness coordinators and provide worksite education and activities in a virtual format. This map shows where participants are from.



WEBINARS/ PRESENTATIONS/ EVENTS:

Dakota Wellness Program Overview
Q1 Wellness Challenge: Thrive for Five
Promoting Health Behaviors with Positivity
Five Star Sleep
Body Mechanics and Posture
Nutrition and Hydration
Exercise without Perfection

TOTAL MEMBER ATTENDANCE THIS QUARTER:
3,668

TOTAL NUMBER OF AGENCIES VISITED (UNDUPLICATED)
81

Preventive Screening Rates

Exhibit 6.4

MEASURE	GOAL by 6/30/24	OUTCOME DATE	CURRENT
FOCUS AREAS			
Breast cancer screening rates	80%	March 31, 2024	79.6%
Cervical cancer screening rates	85%	March 31, 2024	78.9%
Colorectal cancer screening rates	60%	March 31, 2024	66.2%

POPULATION HEALTH TARGETED COHORTS

Exhibit 6.5

HEALTH COACHING

PROGRAM OVERVIEW

- Designed to help members reach their health and wellness goals and improve well-being in areas that matter to them.
- Members can participate in health coaching no matter where they are along the wellness continuum.
- Health coaching can help members prevent, delay or manage chronic conditions.

Member Reach:

- 103 members participated in health coaching
- Health coaches work with members to create a personalized wellness program, focusing on what they can do to feel and be their best.
- Topics members might discuss with their coach include:
  - Exercise & nutrition
  - Weight management
  - Stress resiliency
  - Tobacco cessation
  - Sleep hygiene
  - And more
- Coaches can help members create personal goals and provide the motivation, information and encouragement needed to achieve those goals.
- Members may find that coaching helps them reduce stress, manage stress better when it happens, lower blood pressure and cholesterol, prevent or keep diabetes under control, lose weight, and simply feel better overall.
- A health coach is not a substitute for a doctor or other health care professional. Coaches do not provide clinical information, diagnoses, or medication education but they can help members follow through on their doctor's recommendations.
- Confidential conversations with a health coach occur via phone or secure messaging platform.
- Members have access to health coaching at no charge.

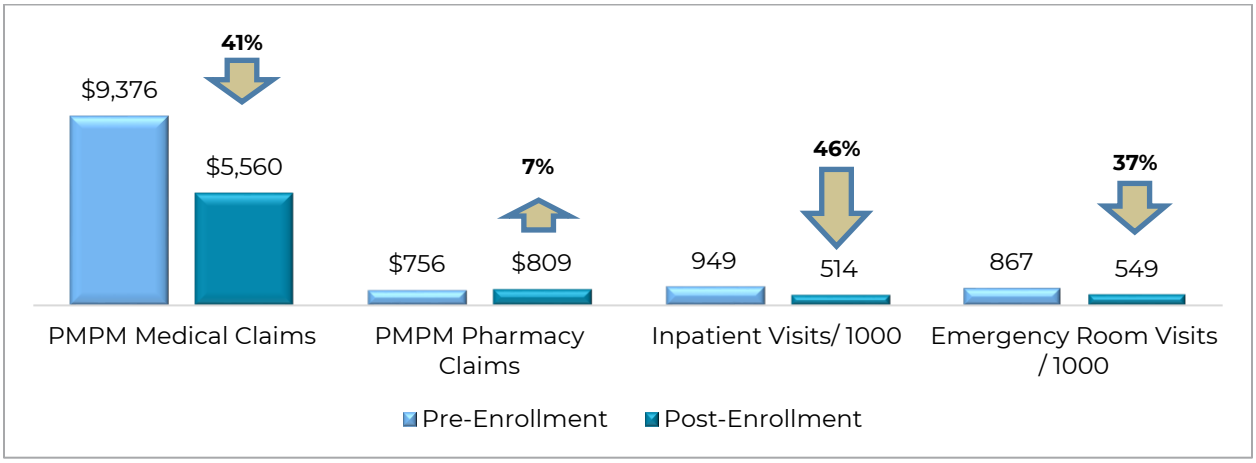
WELLNESS CONTINUUM

Well-being Resources | Preventive Care | Managing A Population | **Care Management** | Disease Management

CARE MANAGEMENT ENGAGEMENT

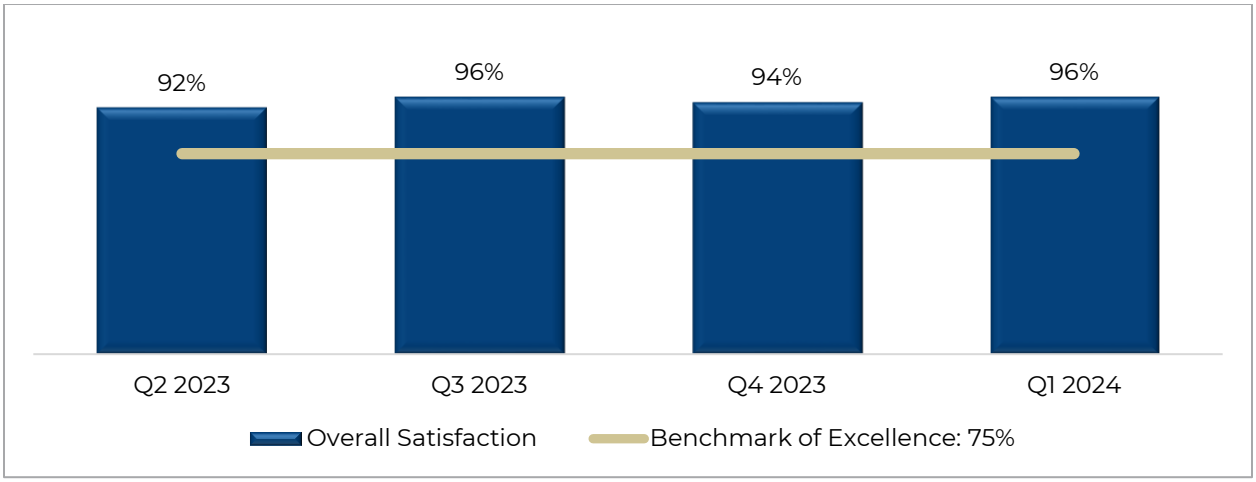
Exhibit 6.6

CARE MANAGEMENT PERFORMANCE METRICS April 1, 2023 – March 31, 2024				
OFFERED	**RESPONDED**		**ENGAGED**	
2,776	**1,406**	**50.65%**	**446**	**31.72%**



SURVEY SCORE

Exhibit 6.7



SECTION 7: PERFORMANCE GUARANTEES

Exhibit 7.1

MEASURE	GOAL	MEASUREMENT PERIOD	Q3 2023 REPORTING PERIOD	CURRENT
WELLNESS				
Health risk assessment completion	18%	7/1/23 – 6/30/25	7/1/23 – 3/31/24	13.85%
Worksite interventions agency participation	75%	7/1/23 – 6/30/25	7/1/23 – 3/31/24	60%
Fitness reimbursement participation	5%	1/1/23 – 12/31/23	1/1/24 – 3/31/24	2.23%
Wellness redemption center payments	$850,000	1/1/23 – 12/31/23	1/1/24 – 3/31/24	$133,417
Wellness redemption center rate	9%	1/1/23 – 12/31/23	1/1/24 – 3/31/24	1.86%
HEALTH OUTCOMES				
Healthy Pregnancy Program	+3%	7/1/23 – 6/30/24	7/1/23 – 3/31/24	41.8%
Diabetes Prevention Program	5%	1/1/23 – 12/31/23	1/1/24 – 3/31/24	7.4%
Breast cancer screening rates	80%	7/1/23 – 6/30/25	7/1/23 – 3/31/24	79.6%
Cervical cancer screening rates	85%	7/1/23 – 6/30/25	7/1/23 – 3/31/24	78.9%
Colorectal cancer screening rates	60%	7/1/23 – 6/30/25	7/1/23 – 3/31/24	66.2%
PROVIDER NETWORK / CONTRACTING				
PPO network participation rate	Hospital, MDs & DOs: 92%	7/1/23 – 6/30/25	7/1/23 – 3/31/24	100% Hospital 97% MD/DO
Provider network minimum discount	30%	7/1/23 – 6/30/25	1/1/23 - 3/31/24	44.19%
CUSTOMER SERVICE & CLAIMS				
Claims financial accuracy	99%	7/1/23 – 6/30/24	7/1/23 – 3/31/24	99.08%
Claims payment accuracy	98%	7/1/23 – 6/30/24	7/1/23 – 3/31/24	97.20%
Claim timeliness	99%	7/1/23 – 6/30/24	7/1/23 – 3/31/24	96.93%
Claims procedural accuracy	95%	7/1/23 – 6/30/24	7/1/23 – 3/31/24	96.93%
Average speed of answer	30 seconds	7/1/23 – 6/30/24	7/1/23 – 3/31/24	31 seconds
Call abandoned rate	5% or less	7/1/23 – 6/30/24	7/1/23 – 3/31/24	0.85%
First call resolution	95%	7/1/23 – 6/30/24	7/1/23 – 3/31/24	98.32%
Written inquiry response time	95%	7/1/23 – 6/30/24	7/1/23 – 3/31/24	99.26%
PHARMACY & FINANCIAL				
Prescription drug turnaround times	98%	7/1/23 – 6/30/25	7/1/23 – 3/31/24	100%
Network Pharmacy Access	<5%	7/1/23 – 6/30/24	7/1/23 – 3/31/24	<5%
About the Patient program payment	5 days	7/1/23 – 6/30/24	7/1/23 – 3/31/24	100%
Interest Rate determined by PERS/SHP	Quarterly	7/1/23 – 6/30/25	7/1/23 – 3/31/24	100%

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: August 20, 2024

SUBJECT: House Bill 1040 Implementation Update

The following activities have occurred for House Bill 1040 implementation since our last Board discussion:

- Weekly meetings are being conducted with both the Enrollment and Accounting Divisions to test the modifications made to our business system relating to HB 1040. On a weekly basis, updates are being submitted to Sagitec, our business system vendor, for additional modifications that need to be made based on user acceptance testing.
- Have discussions with Sagitec as vendor has questions.
- Followed up with legal counsel (both Ice Miller and Dean) on clarifications requested of the Board at July meeting related to the 401(a) Defined Contribution Plan Document. This item is a separate agenda item for the Board's approval of the Plan Document. Once approved, staff will begin working with Ice Miller on requesting the IRS Letter of Determination.
- Continued review of 457 Deferred Compensation Plan Document and 457 Companion Plan Document, including input from legal counsel (both Ice Miller and Dean) on suggested changes to ensure state and federal law compliance. Once final, the document will be brought to the Board for approval.
- Finalized internal staff training presentation regarding plan provisions. The presentation will be provided to staff at an August 22 all staff meeting. The presentation is also being recorded and broken into shorter videos to be used as education for members and employers also.
- Presented a transition update at the County Auditor and Treasurer Conference on July 11.

- Met with Human Resources Management Services (HRMS) to discuss timeline for updates they need for their resources used to promote and recruit for positions within the State of ND.
- Programmatic updates and testing continued within the State's Central Payroll reporting platform (PeopleSoft). Testing was successfully completed for the new DC plan matching provisions, 457 plan matching provisions, spillover, and the actuarially determined employer contribution (ADEC).
- Assigned a project lead for the 3-month state employee special election window to transfer from the defined benefit plan to the defined contribution plan.
- Received our first updated file for retirement reporting from one of our political subdivision employers.

Attachment 1 and Attachment 2 are included as an overview of work efforts and timelines identified.

Attachment 1

House Bill 1040 Administrative Implementation

	2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
HB 1040 Administrative Implementation													
Marketing intern recruitment		★											
1% employer contribution increase launched		★											
Inventory the PERSLink correspondence updates				★									
Targeted communications to subs in main but not public safety					★								
Targeted communications to subs in main but not deferred comp					★								
Recordkeeper transition							★						★
PERSLink correspondence updates							★				★		
PERSLink correspondence testing							★				★		
Form updates							★				★		
Plan document updates											★		
Plan handbook updates											★		
Special election window education for eligible employees												★	
Administrative rule making promulgation													★
Employer training													★
Website updates													★
Revise new hire, transfer, termination guides													★
Staff training													★
Biweekly internal administrative implementation meetings													★
Communication team biweekly meetings													★
Education on new plan provision to members						★			★			★	★
Education on new plan provision to employers				★			★			★			★

KEY

★ Deadline

Task Completed

Work Effort

Deadline Missed

House Bill 1040 Programming Implementation Timeline

	2023	Jul	Aug	Sep	Oct	Nov	Dec	2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
HB 1040 Programming Implementation																				
Funding for development effective		★																		
HB 1040 section-by-section analysis to determine system enhancements			★																	
Meet with GRS to discuss the incentive, and get programming parameters			★																	
NDPERS updates file layout documentation for employers													★							
NDPERS develops sample file layouts for employers													★							
Biweekly meetings to discuss section-by-section coding																		★		
NDPERS user acceptance testing of enhancements																		★		
State PeopleSoft development																			★	
Higher Ed PeopleSoft development																			★	
Political sub development																			★	
Employer file testing																				★

KEY

★Deadline

Task Completed

Work Effort

Deadline Missed

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Public Employees Retirement System
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Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: August 20, 2024

SUBJECT: 401(a) Defined Contribution Plan Document Revised Effective January 1, 2025

At the July meeting, the Board reviewed the updated 401(a) Defined Contribution Plan Document that staff and legal counsel have been working on as part of the House Bill 1040 implementation. The provisions of this bill need to be incorporated into the Plan Document with an effective date of January 1, 2025.

The Board had a few questions that they asked staff and legal to review to determine if additional clarifications were needed. Staff along with legal counsel from both the Attorney General's Office and Ice Miller reviewed the list and are providing the attached as the updated version, with changes and comments tracked related to these items.

At this time, we are seeking approval of the updated 401(a) Plan Document and request that it be approved with a January 1, 2025 effective date. Once approved, staff will begin working with Ice Miller to request an IRS Letter of Determination for the Plan per the Board's action at the June meeting.

Board Action Requested:

Approve the updated 401(a) Defined Contribution Plan Document effective January 1, 2025.

Attachment

NORTH DAKOTA DEFINED CONTRIBUTION RETIREMENT PLAN

Plan Document

Amended and Restated Effective January 1, 2025

ADOPTION RESOLUTION

Resolved, that effective January 1, 2025, the State of North Dakota has adopted the attached amended and restated Defined Contribution Retirement Plan. The Plan is a profit sharing plan that is intended to satisfy the requirements of Sections 401 and 501 of the Internal Revenue Code of 1986, as amended, and its associated regulations.

	Executive Director	
Signature	Title	Date Signed

TABLE OF CONTENTS

Commented [FRD1]: Added to address question raised related to 3.2(b).

ARTICLE 1.

DEFINITIONS

The following words and phrases shall, when used in this Plan, have the following meanings unless the context clearly indicates otherwise.

1.1 "Account Balance" means the total contributions made by the Employee, vested Employer contributions, any transferred amounts under Section 3.4 and any investment gains or losses.

1.2 "Administrator" means any entity or individual designated by the Board to provide contractual administrative services to the Plan.

1.3 "Beneficiary" means any person designated by a Participating Member to receive a benefit provided by this Plan after the death of the Participant.

1.4 "Board" means the Public Employees Retirement System Board.

1.5 "Code" means the federal Internal Revenue Code of 1986, as amended from time to time, and as interpreted by applicable regulations and rulings.

1.6 "Deferred Member" means a vested member of the Public Employees Retirement System who has not elected to receive a refund and is eligible to receive deferred vested retirement benefits under the System.

1.7 "Effective Date" means January 1, 2000.

1.8 "2025 Electing Employee" means a permanent State Employee who on December 31, 2024 is a Participating Member of the Public Employees Retirement System Main System Plan under 54-52 with no more than five years of Service who opted to terminate participation in the defined benefit plan and transfer to this Plan during the special election opportunity provided in NDCC 54-52.6-02.2. The election opportunity is a three-month election period, from January 1, 2025, through March 31, 2025 to elect to transfer to this Plan.

1.9 "Eligible Employee" for Employees who become Participating Members after December 31, 2024, has the same meaning as provided under section 54 - 52 - 02.15. It also shall include Temporary Employees who make the election under section 54-52-02.9(4) and elected or appointed State officials under section 54-52-02.5(2). For Employees who elected to join this Plan under this chapter before January 1, 2025, the term includes a permanent State Employee, except an Employee of the judicial branch or an Employee of the board of higher education and State institutions under the jurisdiction of the board of higher education, who is at least eighteen years of age and

Commented [FRD2]: Statutory definition and therefore, should remain as is.

who is in a position not classified by the North Dakota human resource management services. This term also includes 2025 Electing Employees under NDCC 54-52.6-02.2.

1.10 "Employee" means an individual employed by a Governmental Unit, whose compensation is paid out of the Governmental Unit's funds, or funds controlled or administered by the Governmental Unit, or paid by the federal government through any of its executive or administrative officials.

1.11 "Employer" means a Governmental Unit.

1.12 "Governmental Unit" means the State of North Dakota or a participating political subdivision of the State.

Commented [FRD3]: Statutory definition and therefore, should remain as is.

1.13 "Participating Member" or "Participant" means an Eligible Employee who through payment into the Plan has established a claim against the Plan. For purposes of investment and payment of benefits under the Plan, the terms "Participating Member" or "Participant" also includes individuals who have separated from employment with the Employer and Beneficiaries, but who have retained benefit rights under the Plan.

1.14 "Permanent Employee" means an Employee whose Services are not limited in duration and who is filling an approved and regularly funded position and is employed twenty hours or more per week and at least five months each year.

1.15 "Plan" means the North Dakota Defined Contribution Retirement Plan, as stated herein, and as amended from time to time. This Plan shall be a profit sharing plan.

1.16 "Plan Year" means a twelve consecutive month period beginning any July 1 and ending the following June 30, with a short initial Plan Year beginning January 1, 2000 and ending June 30, 2000.

1.17 "Profit Sharing Contribution" means a discretionary contribution to the Plan made by the Employer. Profit Sharing Contributions under this Plan shall be made in accordance with Section 3.2, subsection e. and without regard to whether the Employer earns any profits.

1.18 "Public Employees Retirement System" or "System" means the defined benefit retirement plans established under North Dakota Century Code Chapter 54-52.

1.19 "Required Beginning Date" means April 1 of the calendar year following the later of the calendar year in which the Participant retires or reaches the required minimum distribution age under Code Section 401(a)(9).

1.20 “Service” means periods of active employment with the Employer, determined in the same fashion as service and prior service under North Dakota Century Code § 54-52-01.

1.21 "State" means the State of North Dakota.

1.22 “Temporary Employee” means an Employee who is not eligible to participate as a Permanent Employee, who is at least eighteen years old and who is not actively contributing to another Employer-sponsored retirement fund, and, if employed by a school district, occupies a noncertified teacher’s position.

1.23 “Trust Fund” means the assets of the Plan held in trust by the Trustee.

1.24 “Trustee” means the Public Employees Retirement System Board, which shall serve as the Board of Trustees for this Plan.

1.25 “Wages” and “Salaries” means earnings in eligible employment under this Plan reported as salary on a federal income tax withholding statement plus any salary reduction or salary deferral amounts under Code Sections 125, 401(k), 403(b), 414(h) or 457. “Salary” does not include fringe benefits such as payments for unused sick leave, personal leave, vacation leave paid in a lump sum, overtime, housing allowances, transportation expenses, early retirement, incentive pay, severance pay, medical insurance, workers’ compensation benefits, disability insurance premiums or benefits, or salary received by a Participant in lieu of previously Employer-provided fringe benefits under an agreement between the Participant and participating Employer. Bonuses may be considered as Salary under this section pursuant to rules adopted by the Board.

Notwithstanding any other provision of the law, the amount of Wages or Salary used to determine the retirement benefits of a Participating Member in this Plan must not exceed the amount of compensation permitted to be taken into account under Code Section 401(a)(17).

ARTICLE 2.

PARTICIPATION

2.1 **Eligibility.** An Employee is eligible for membership under this Plan at the later of the first day of employment or the Effective Date of this Plan. Such eligibility, however, shall terminate at any time employment with the Employer is terminated.

2.2 **Election to participate.** Prior to January 1, 2025, in order to participate in this Plan, an Eligible Employee may make an election to participate in this Plan established under NDCC 54-52.6 at any time during the first six months after the date of employment. If the Board, in its sole discretion, determines that the Employee was not adequately notified of the Employee's option to participate in the Plan, the Board may provide the Employee a reasonable time within which to make that election, which may extend beyond the original six-month decision window." If the Employee making the election is married at the time of the election, the election is not effective unless it is signed by the individual's spouse. However, the Board may waive this requirement if the spouse's signature cannot be obtained because of extenuating circumstances.

An additional election opportunity is provided under NDCC 54-52.6-02.2 to 2025 Electing Employees.

Effective January 1, 2025 and after, participation in this Plan is mandatory for any new Eligible Employee.

2.3 **Participation in other plans.** A Permanent Employee may not participate in any other public sector retirement benefits plan for simultaneous Services rendered to the same Employer. However, this Section does not prohibit a Participant from participating in a retirement plan established by this State or other public sector Employer under the Code.

ARTICLE 3.

CONTRIBUTIONS TO THE PLAN

Commented [FRD4]: Added to address question related to 3.2(b).

3.1 **Mandatory Employee contributions.** For Participating Members enrolled prior to January 1, 2025 and Eligible Employees under NDCC 54-52.6-02.2 who elected to transfer to this Plan between January 1, 2025 and March 31, 2025, each Participating Member shall contribute monthly seven percent of the monthly Salary or Wage paid to such Participant. This assessment must be deducted and retained out of such Salary in equal monthly installments commencing with the first month of participation in this Plan. As of January 1, 2025, any newly Participating Members on or after this date shall contribute four percent of the monthly Salary or Wage paid to such Participant. In addition, this newly Participating Member can irrevocably elect within the first thirty days of employment to contribute up to an additional three percent Employee contribution. All additional contributions shall be in whole percentages.

Commented [FRD5]: Added same language as found in draft administrative rules.

3.2 **Employer contributions.**

a. For Participating Members enrolled in the Plan before December 31, 2019 or for those 2025 Electing Employees, each Employer shall contribute an amount equal to seven and twelve-hundredths percent of the monthly Salary or Wage of a Participating Member.

b. For Participating Members enrolled after December 31, 2019 and before January 1, 2025 or for those electing Employees who exercised their option under NDCC 54-52.6-02.2 to transfer to this Plan during their special window, the Employer shall make an additional one and fourteen-hundredths percent Employer contribution.

c. For Participating Members who were first enrolled after December 31, 2024, the Employer shall contribute an amount equal to five and twenty-six hundredths as an Employer contribution. If the Employee elects to contribute up to an additional three percent Employee contribution under 3.1, then the Employer shall make a matching Employer contribution up to three percent.

d. If the Employee's contribution is paid by the Employer under Section 3.3, the Employer shall contribute, in addition, an amount equal to the required Employee contributions. The Employer shall pay such contribution monthly into the Participating Member's account from funds appropriated for payroll and Salary or any other funds available for such purposes. If the Employer fails to pay the contributions

monthly, it is subject to a civil penalty of fifty dollars and, as interest, one percent of the amount due for each month of delay or fraction thereof after the payment became due.

e. Each Employer, at its sole discretion, may elect to make a Profit Sharing Contribution to the Plan. The Profit Sharing Contribution shall be allocated among all or any part of the Participating Members of the Plan for such Plan Year in proportion to the Salary or Wage of the Participating Member. For purposes of this Section 3.2, subsection b. only, Participating Members include only those individuals who are Eligible Employees on the date the Profit Sharing Contribution is declared by the Employer. Each Participating Member's share of the Profit Sharing Contribution will be allocated to his or her Account Balance. Profit Sharing Contributions shall be subject to the rules regarding vesting of Employer contributions as set forth in Section 4.2.

f. For 2025 Electing Employees, they shall be eligible for an additional annual Employer contribution of three thousand three hundred and thirty-three dollars for up to three years, beginning January 2026 and extending no further than January 2028, as long as the Employee remains under the employment of the State of North Dakota.

g. Notwithstanding any other requirements under this Section 3.2, Temporary Employees shall not be eligible to receive Employer contributions.

h In addition to the Employer contribution under section 54-52.6-09, a State Employer shall contribute to the defined benefit retirement plan under chapter 54-52, an amount equal to the contribution rate calculated under section 54-52-06 less the amount of the required Employer contribution under sections 54-52.2-09 and 54-52.6-09. If a State Employer uses federal funds to pay any or all of an Employee's Wages, the Employer shall use State funds to pay this additional contribution.

3.3 **Employer pick up of Employee contributions.** Each Employer, at its option, may pay the Employee contributions required by Section 3.1, in accordance with Code Section 414(h), for all compensation earned after December 31, 1999. The amount paid must be paid by the Employer in lieu of contributions by the Employee. Employee contributions paid by the Employer must be treated as Employer contributions in determining tax treatment under State tax law and the federal Code. Such contributions may not be included as gross income of the Employee in determining tax treatment until they are distributed or made available. The Employer shall pay these Employee contributions by effecting an equal cash reduction in

the gross Salary of the Employee or by an offset against future Salary increases. The option chosen may not be revoked for the remainder of the biennium. Thereafter, the option choice must be forwarded to the Board in writing by June fifteenth of each odd-numbered year.

3.4 **Transfer of contributions.**

a. For Participating Members prior to January 1, 2025, electing to terminate membership in the Public Employees Retirement System and to become a Participating Member in this Plan, the Board shall transfer a lump sum amount from the retirement fund to the Participating Member's account under this Plan. However, if the individual terminates employment prior to receiving the lump sum transfer under this Section, the election made under Section 2.2 is ineffective and the Participant remains a Participant of the Public Employees Retirement System and retains all rights and benefits under that plan.

Commented [FRD6]: See definition 1.18, which defines this term. No change needed.

b. For Participating Members prior to January 1, 2025, the Board shall calculate the amount to be transferred for Employees electing to transfer in accordance with North Dakota Century Code Section 54-52.6-02 as follows: The actual Employer contribution made, less vested Employer contributions made pursuant to section 54-52-11.1, plus compound interest at the rate of one-half of one percent less than the actuarial interest assumption at the time of the election, plus the Employee Account Balance.

c. For 2025 Electing Employees, the Board shall transfer a lump sum amount from the Public Employees Retirement System fund to the Participant's account in this Plan. However, if the Eligible Employee terminates employment before receiving the lump sum transfer, the election is made ineffective and the Participant shall remain in the Public Employees Retirement System under NDCC 54-52. The Board shall calculate the lump sum amount to be transferred based on the actuarial present value of the Eligible Employee's accumulated benefit obligation under the Public Employees Retirement System based on the assumption the Eligible Employee will retire under the earlier applicable normal retirement age, plus interest from January 1, 2025, to the date of transfer, at the rate of one-half of one percent less than the actuarial interest assumption at the time of the election.

3.5 **Rollover contributions from other eligible plans**.

a. Subject to limitations and conditions adopted by the Board and in accordance with North Dakota Century Code Section 54-52.6-09.1, a Participant may make and the Plan will accept a direct rollover or regular rollover of an Eligible Rollover Distribution from an Eligible Retirement Plan as such terms are defined in Code Sections 402(c)(4) and 402(c)(8)(B), respectively, and as permitted by Section 408(d)(3) of the Code.

b. Upon receipt of a rollover contribution, the Board shall credit the amount of any rollover contribution to the contributing Participant's Account in the Plan and shall invest such amount in accordance with the provisions of this Plan.

c. The Participant shall establish to the satisfaction of the Board that the amount tendered as a rollover contribution represents a qualified distribution of the Participant from an Eligible Retirement Plan maintained by the former employer(s) of the Participant. The Board shall have the authority to determine whether or not a contribution proposed by a Participant constitutes a rollover contribution eligible for rollover treatment in accordance with this Section 3.6 and Code Section 402. In making such determination, the Board may require reasonable proof of demonstration by the Participant of the eligibility of the proposed contribution for rollover treatment.

d. The Board shall maintain the rollover contributions for each Participant in a separate rollover account that will consist solely of the rollover contributions made by the Participant, plus any adjustments for investment gains or losses.

e. The rollover contribution account under this Section shall be fully vested at all times, and shall be administered and distributed according to the same terms and conditions of this Plan applicable to other Participant accounts; provided, however, that it may distributed at any time without the occurrence of a distribution event under Section 6.1.

3.6 **Military service leave.** Notwithstanding any other provision of this Plan, a Participating Member returning from qualified military service protected under the Uniformed Services Employment and Reemployment Rights Act (Chapter 43 of Title 38, United States Code) shall be provided all participation, contribution, vesting and benefit rights required under that Act and Section 414(u) of the Code, as described in North Dakota Century Code Section 54-52.6-09.4. Effective for deaths occurring on or after January 1, 2007, if a Participating Member dies while performing qualified military service (as defined in Code Section 414(u)(5)), this Plan shall provide vesting service and any other benefits required in accordance with

Code Section 401(a)(37), but the provisions of Code Section 414(u)(9) shall not apply to this Plan.

ARTICLE 4.

VESTING

4.1 **Vesting of Employee contributions.** A Participating Member is immediately one hundred percent vested in that Participant's contributions made to that Participant's account under Section 3.1 or paid by the Employer under Section 3.3.

4.2 **Vesting of Employer contributions.** A Participating Member vests in the Employer contributions made on the Participant's behalf according to the following schedule:

a. Upon completion of two years of Service, fifty percent.

b. Upon completion of three years of Service, seventy-five percent.

c. Upon completion of four years of Service, one hundred percent.

d. Upon attainment of age 65 while an Employee, one hundred percent.

A Participating Member who was a Participant or Deferred Member of the Public Employees Retirement System and who makes an election to participate in this Plan must be credited with years of Service accrued under the Public Employees Retirement System on the effective date of participation in this Plan for the purpose of meeting vesting requirements under this Section. Any forfeiture as a result of a Participating Member to vest in the Employer contributions must be used to defray administrative expenses.

4.3 **Reemployment.** If a Participating Member terminates employment, is paid a lump sum distribution from their account, and then becomes reemployed as an Eligible Employee, any years of Service completed before termination will not be counted for vesting. If a Participant does not take a distribution of their account, then for purposes of vesting under the Plan, upon reemployment, the Participating Member's years of Service completed before termination will count for vesting.

ARTICLE 5.

ACCOUNT VALUATION

5.1 **Separate accounts.** A separate bookkeeping account shall be established and maintained under this Plan for each Participating Member to which shall be credited, at times prescribed by the Board, all Employee contributions and all Employer contributions.

5.2 **Credits and debits**. Each Participating Member's account shall be credited or debited from time to time, under rules established by the Board, to reflect investment earnings and administrative expenses.

5.3 **Limited rights to assets.** The fact that separate accounts are established for each Participating Member shall not give any Employee or others any right, title or interest in the Plan or its assets, or in any account except at the time and upon the terms and conditions provided in this Plan.

ARTICLE 6.

DISTRIBUTIONS

6.1 **Distribution eligibility.** A Participating Member's vested Account Balance is distributable upon the occurrence of one of the following events:

a. The Participating Member has terminated employment with the Employer. Termination of employment means a severance of employment by not being on the payroll of the Employer for a minimum of one month. An approved leave of absence does not constitute termination of employment.

b. The Participating Member has become totally and permanently disabled according to medical evidence called for under the rules of the Board.

c. The Participating Member dies.

d. The Participating Member has reached the Required Beginning Date and has terminated employment. In no event shall the distribution of a Participant's Account Balance commence later than the Required Beginning Date, whether or not they apply for benefits.

ARTICLE 7.

FORM OF DISTRIBUTION

7.1 **Distribution election.** A Participating Member or his or her Beneficiary who is eligible to receive benefits under Article 6 shall receive benefits upon proper application in a manner approved by the Board as to the date benefit distributions under the Plan will begin. This election must be made consistent with the other distribution requirements of Section 6.1 and this Article 7.

7.2 **Payable benefits.** Benefits under this Article 7 shall be measured by Participating Member's vested Account Balance on the date or dates the benefits are payable under this Plan and shall be payable in lump sum or in equal monthly, quarterly, semiannual or annual installments over a period of one or more years, including annuities provided through an annuity provider selected pursuant to North Dakota Century Code Section 54-52.6-05.1.

7.3 **Distribution over life expectancy and deaths prior to January 1, 2022.** A Participating Member's form of distribution election under Section 7.2 must be expected to result in the distribution of the Participant's entire interest in this Plan within a period not exceeding the life of the Participant or the lives of the Participant and the Participant's Beneficiary, or over a period not extending beyond the life expectancy of the Participating Member or the life expectancy of the Participant and the Participant's designated Beneficiary.

For deaths prior to January 1, 2022, when a Participating Member dies after distribution of benefits has begun, the remaining portion of the Participant's interest shall be distributed at least as rapidly as under the method of distribution prior to the Participating Member's death.

For deaths prior to January 1, 2022, when a Participating Member dies before distribution of benefits has begun, the entire interest of the Participant shall be distributed within five years of the Participant's death. The five year payment rule does not apply to any portion of the Participant's interest which is payable to a designated Beneficiary over the life or life expectancy of the Beneficiary and which begins within one year after the date of the Participating Member's death. The five year payment rule does not apply to any portion of the Participating Member's interest which is payable to a surviving spouse over the life or life expectancy of the spouse and which begins no later than the date the Participant would have reached age seventy and one-half.

7.4 **Additional distribution requirements.** In the case of distributions beginning before the death of a Participating Member, any amounts not distributed before the Participant's death shall be distributed at times specified by the Secretary of the Treasury which are not later than the time determined under Code Section 401(a)(9)(G), relating to incidental death benefits and at least as rapidly as under the method being used on the date of the Participating Member's death.

The Plan shall comply with the minimum distribution rules under Section 401(a)(9) of the Code and the Treasury Regulations issued under that provision to the extent applicable to governmental plans. Accordingly, benefits must be distributed or begin to be distributed no later than a Participating Member's Required Beginning Date and the required minimum distribution rules override any inconsistent provision of this Plan.

In addition, amounts that would have been 2009 required minimum distributions in the absence of Code Section 401(a)(9)(h), as added by the Worker, Retiree and Employer Recovery Act of 2008, including amounts that would have been first required minimum distributions payable in 2010, were paid as scheduled for 2009. Recipients of such required minimum distributions were given the opportunity to elect to stop receiving the 2009 required minimum distributions described in the preceding sentence, and a direct rollover was only offered for such distributions that would have been eligible rollover distributions without regard to Code Section 401(a)(9)(H).

Notwithstanding any other provisions of this Plan, a recipient who would have been required to receive required minimum distributions in 2020 (or paid in 2021 for the 2020 calendar year for a recipient with a Required Beginning Date of April 1, 2021) but for the enactment of section 401(a)(9)(I) of the Code (2020 RMD), and who would have satisfied that requirement by receiving distributions that are (1) equal to the 2020 RMDs, or (2) one or more payments (that include the 2020 RMDs) in a series of substantially equal periodic payments made at least annually and expected to last for the life (or life expectancy) of the Participant, the joint lives (or joint life expectancies) of the Participant and the Participant's designated Beneficiary, or for a period of at least 10 years (Extended 2020 RMDs), will receive those 2020 distributions unless the recipient elects not to receive such distribution. Notwithstanding the preceding sentence, recipient will be given an opportunity to make an election as to whether or not to receive such 2020 RMD distributions.

7.5 **Small benefit cashouts.** Notwithstanding any other provision of the Plan to the contrary, the Board shall automatically distribute the benefits of a Participating Member in a lump sum as soon as administratively feasible after the Participant becomes eligible for a distribution in accordance with

Section 6.1 if the total amount of the Participating Member's vested Account Balance and any amounts held in a rollover contribution account established under Section 3.6 is less than or equal to $1,000. A Participating Member may waive the lump sum cashout if the Participant submits a written statement to the Board, within sixty days after termination of employment, requesting that the Participant's Account Balance remain in the Trust Fund.

7.6 **Death benefit payments.** In the event of the Participating Member's death prior to receiving payment in full of his benefits under this Plan, the Board shall pay the Account Balance of the Participating Member, to the Participant's designated Beneficiary. If the deceased Participant designated an alternate Beneficiary with the surviving spouse's written consent, the Board shall distribute the accumulated balance to the named Beneficiary. If the deceased Participant named more than one primary Beneficiary with the surviving spouse's written consent, the Board shall pay the accumulated Account Balance to the named primary Beneficiaries in the percentages designated by the deceased Participant or, if the deceased Participant had not designated a percentage for the Beneficiaries, in equal percentages. If one or more of the primary Beneficiaries has predeceased the deceased Participant, the Board shall pay the predeceased Beneficiary's share to the remaining primary Beneficiaries. If any Beneficiary survives the deceased Participant, yet dies before distribution of the Beneficiary's share, the Beneficiary must be treated as if the Beneficiary predeceased the deceased Participant. If there is no remaining primary Beneficiary, the Board shall pay the accumulated Account Balance of that deceased Participant to the contingent Beneficiaries in the same manner. If there is no remaining designated Beneficiary, the Board shall pay the accumulated Account Balance of that deceased Participant to the deceased Participant's estate.

If the surviving spouse is the Beneficiary, the surviving spouse may select from a form payment as provided in NDCC Section 54-52.6-13(3). If the surviving spouse is not the sole Beneficiary, the Beneficiary may only choose a lump sum distribution of the accumulated balance.

7.7 **Direct rollovers.** A Distributee may elect, at the time and in the manner prescribed by the Board, to have any portion of an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan specified by the Distributee in a Direct Rollover, except that a Distributee may not elect a Direct Rollover of a distribution or series of distributions of less than $200 in a single calendar year. For purposes of applying this Section 7.7, the following definitions shall apply:

a. **Eligible Rollover Distribution.** An Eligible Rollover Distribution is any distribution of all or any portion of the balance of a Participating

Member's account to the credit of the Distributee, including any after-tax Employee contributions that are not includible in gross income except that an Eligible Rollover Distribution does not include:

1. Any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the Distributee or the joint lives (or joint life expectancies) of the Distributee and his designated Beneficiary, or for a specified period of ten (10) years or more;

2. Any distribution to the extent such distribution is required under Code Section 401(a)(9);

3. The portion of any distribution that is not includable in a Distributee's gross income (determined without regard to the exclusion for net unrealized unappreciation with respect to Employer securities); or

4. Any corrective distribution of excess contributions and any corrective distribution of excess aggregate contributions and income allowable to such corrective distributions.

An Eligible Rollover Distribution also includes any portion of a distribution that consists of after-tax Employee contributions that are not includible in gross income. However, such portion may be transferred only to an individual retirement account or annuity described in Code section 408(a) or (b), or to a qualified defined contribution plan described in Code section 401(a) or 403(a) that agrees to separately account for the after-tax Employee contribution amounts so transferred.

b. **Eligible Retirement Plan.** An Eligible Retirement Plan is an individual retirement account described in Code Section 408(a), an annuity plan described in Code Section 408(b), an annuity plan described in Code Section 403(a), a qualified trust described in section 401(a) of the Code that accepts the Distributee's Eligible Rollover Distribution or an annuity contract described in Code Section 403(b), an eligible plan under Code Section 457(b) which is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state and which agrees to separately account for amounts transferred into such plan from this Plan, and, effective January 1, 2008, a Roth IRA described in section 408A of the Code, and effective December 18, 2015, a SIMPLE IRA as described in Code Section 408(p), provided that the rollover contribution is made after the two-year period

beginning on the date the Distributee first participated in any qualified salary reduction arrangement maintained by the Distributee's employer under Code Section 408(p)(2), as described in Code Section 72(t)(6). The definition of Eligible Retirement Plan shall also apply in the case of a distribution to a surviving spouse, or to a spouse or former spouse who is the Alternate Payee under a qualified domestic relations order, as defined in Code Section 414(p). The definition of an Eligible Retirement Plan for a nonspouse designated Beneficiary of a deceased Participant means an individual retirement annuity account established for the purpose of receiving a distribution from this Plan and treated as an inherited individual retirement account or annuity (within the meaning of Code Section 408(d)(3)(C)).

c. **Distributee.** A Distributee includes an Employee or former Employee. In addition, the Employee's or former Employee's designated Beneficiary or the Employee's or former Employee's spouse or former spouse, with regard to the interest of the spouse or former spouse, are Distributees.

d. **Direct Rollover.** A Direct Rollover is a payment by the Plan to the Eligible Retirement Plan specified by the Distributee.

7.8 **Benefits payable to alternate payee under qualified domestic relations order.**

a. The Board shall pay retirement benefits in accordance with the applicable requirements of any qualified domestic relations order. The Board shall review a domestic relations order submitted to it to determine if the domestic relations order is qualified under this Section 7.8 and under rules established by the Board for determining the qualified status of domestic relations orders and administering distributions under the qualified orders. Upon determination that a domestic relations order is qualified, the Board shall notify the Participating Member and the named alternate payee of its receipt of the qualified domestic relations order.

b. A "qualified domestic relations order" for purposes of this Section 7.8 means any judgment, decree or order, including approval of a property settlement, which relates to a provision of child support, spousal support or marital property rights to a spouse, former spouse, child or other dependent of a Participating Member, is made pursuant to a North Dakota domestic relations law, and which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a part of the benefits payable to the Participating Member. A qualified

domestic relations order may not require the Board to provide any type of benefit, or any option, not otherwise provided under this Plan, or to provide increased benefits as determined on the basis of actuarial value. However, payment of benefits to the alternate payee under a qualified domestic relations order shall be made as soon as administratively feasible after the order is determined to be qualified, notwithstanding that the Participating Member has not terminated eligible employment. A qualified domestic relations order must be in a form as may be required by the Board.

7.9 **Contribution limitations.** The Plan shall comply with the contribution limitation rules under Section 415 of the Code, including the defined contribution limitations under Section 415(c)(1)(A) and (B) of the Code and the Treasury Regulations thereunder, as such apply to governmental plans, which are incorporated herein by reference.

a. In accordance with the defined contribution limitations under Section 415(c) of the Code, annual additions (as defined in Section 415(c)(2) of the Code) under this Plan may not exceed the limitations set forth in Code Section 415(c)(1)(A) and (B), as adjusted under Section 415(d) of the Code, effective January first of each year following a regular legislative session.

If a Participating Member's aggregate annual additions exceed the defined contribution limitations under Section 415(c) of the Code, the Participant's annual additions to this Plan must be reduced to the extent necessary to comply with Section 415(c) of the Code and the Treasury Regulations thereunder.

b. "Compensation" for purposes of this Section 7.9 shall mean compensation as defined in Treasury Regulations section 1.415(c)-2(d)(3), which includes wages within the meaning of Code Section 3401(a), plus amounts that would be included in wages but for an election under Sections 125(a), 132(f)(4), 402(e)(3), 402(h)(1)(B), 402(k) or 457(b) of the Code; provided, however, that any rules that limit the remuneration included in wages based on the nature or location of the employment or services performed are disregarded for purposes of this definition. In order to be taken into account for a limitation year, compensation must be actually paid or made available to a Participating Member within the limitation year. For this purpose, compensation is treated as paid on a date if it is actually paid on that date or would have been paid on that date but for an election under Sections 125, 132(f)(4), 401(k), 403(b), 408(k), 408(p)(2)(A)(i), or 457(b) of the Code. In order to be taken into account for a limitation year, compensation must be paid or treated

as paid to a Participating Member prior to a severance from employment.

c. If a Participating Member's annual additions exceed the limits set forth in this Section 7.9 for a limitation year, such excess allocations shall be corrected in accordance with the applicable provisions of the Employee Plans Compliance Resolution System (EPCRS) issued by the Internal Revenue Service (currently Revenue Procedure 2021-30).

7.10 **Deaths After December 31, 2021.** Notwithstanding any contrary provisions, effective for Participant deaths after December 31, 2021, the following distribution provisions in this section 7.10 shall take effect; provided, however, that such provisions shall be subject to any regulations or other guidance issued under the SECURE Act.

a. **Death with a Designated Beneficiary.** If the Participant dies before the distribution of his or her entire account (regardless of whether any distributions had begun before the Participant's death) and the Participant has a designated Beneficiary:

1. The entire account shall be distributed to the designated Beneficiary by December 31 of the calendar year containing the tenth anniversary of the Participant's death.

2. Notwithstanding the paragraph above, if the designated Beneficiary is surviving spouse, then the surviving spouse may elect for the Participant's account(s) to be distributed (i) by December 31 of the calendar year containing the tenth (10th) anniversary of the Participant's death, or (ii) the later of December 31 of the calendar year immediately following the calendar year in which the Participant died or December 31 of the calendar year in which the Participant would have attained age seventy-two (72) (or age 70 ½ with respect to a Participant who was born before July 1, 1949), or other applicable age under Code Section 401(a)(9).

3. For calendar years beginning after December 31, 2023, if the designated Beneficiary is the Participant's surviving spouse, the surviving spouse may elect to be treated as if he or she were the Participant, pursuant to Code Section 401(a)(9)(B)(iv).

b. **Death without a Designated Beneficiary.** If the Participant dies before distributions of his or her account begins and the Participant has no designated Beneficiary, the Participant's account under the Plan shall be distributed by December 31 of the calendar year

containing the fifth (5th) anniversary of the Participant's death. If the Participant dies after distribution of his or her account begins and the Participant has no designated Beneficiary, any remaining portion of the account shall continue to be distributed at least as rapidly as under the method of distribution in effect at the time of the Participant's death.

ARTICLE 8.

ESTABLISHMENT AND ADMINISTRATION OF THE TRUST

8.1 **Establishment of trust.** There is hereby established a Trust Fund to be known as the North Dakota Defined Contribution Retirement Fund. This Trust Fund is intended to be a tax-exempt trust under Code Sections 401 and 501. The assets of this Plan, and all income attributable to such assets, are held in trust by the Board for the exclusive benefit of Participating Members and their Beneficiaries.

8.2 **Acceptance of trust.** The Board consents to act as Trustee for this Trust Fund.

8.3 **Administration.** The Board shall supervise the operation of the Plan, maintain records and supply information to Participating Members and others. In administering this Plan, the Board shall have any applicable rights, powers and duties granted to it by law for the administration of the Public Employees Retirement System.

8.4 **Specific powers and duties.** The Board shall:

a. Exercise exclusive authority to invest and manage assets of the Plan. However, the Board shall permit each Participating Member to direct the investment of the individual's Employer and Employee contributions and earnings to one or more investment options within available categories of investment as established by the Board.

b. Establish and adopt a statement of investment objectives and policies setting forth the manner and parameters of the investment of the assets of the Plan. The statement of investment objectives and policies shall be established in a manner consistent with the purposes of the Plan. The Board shall monitor the performance of the investments of the Plan to ensure such remain consistent with the investment policy established by the Board.

c. Provide information to Employees who are eligible to elect to become Participating Members in this Plan. The information must include at a minimum the Employee's current Account Balance, the assumption of investment risk under a defined contribution retirement plan, administrative and investment costs, coordination of benefits information, and a comparison of projected retirement benefits under the Public Employees Retirement System and this Plan. Notwithstanding any other provision of law, the Board is not liable for any election or investment decision made by an Employee based upon information provided to an Employee under this Plan.

d. Establish an administrative budget sufficient to perform the duties under the Plan and to draw upon authorized sources to fund the budget.

e. Pay Plan benefits and related taxes from the assets of the Plan.

f. Obtain by employment or contract all the services necessary or appropriate to administer the Plan, including actuarial, auditing, custodial, investment, legal and record keeping services.

g. Procure and dispose of the goods and property of the Plan necessary for its proper administration.

h. Have full power and authority to adopt rules and regulations for the administration of the Plan and to interpret, alter, amend or revoke any rules and regulations so adopted.

8.5 **Expenses.** The expenses incurred by the Board in the proper administration of the Plan shall be paid from sources made available under applicable state law, including the Trust Fund.

8.6 **Accounting.** For accounting purposes, the Board will maintain a summary of the Account Balances of each Participating Member whose benefits have not begun to be distributed. This accounting summary will reflect from time to time the total deferred liability of the Plan as well as the Account Balance for each Participating Member in the Plan.

8.7 **Compliance authority.** The Board may administratively alter the terms of the Plan as it determines to be necessary or appropriate to maintain the status of the Plan as a qualified defined contribution retirement plan under the Code.

8.8 **Delegation of responsibilities.** The Board may delegate the duties and authorities established under the Plan in a manner consistent with its fiduciary responsibilities as established under this Article 8.

8.9 **Fiduciary responsibilities.** The Board, the Administrator, and any agent or designee thereof with discretionary authority for the Plan, are fiduciaries under the Plan as to the discharge of their duties under the Plan and shall act as to their duties:

a. Solely in the interest of the Plan's Participating Members and their Beneficiaries;

b. For the exclusive purpose of providing benefits to Participating Members and their Beneficiaries and paying reasonable expenses of administering the Plan;

c. With the care, skill, prudence and diligence under the circumstances then prevailing that a person acting a like capacity and familiar with such matters would use in the conduct of an activity of like character and purpose;

d. Incurring only costs that are appropriate and reasonable; and

e. In accordance with good faith interpretation of the law governing the Plan.

ARTICLE 9.

RIGHT OF APPEAL AND DETERMINATION OF DISPUTES

9.1 **Claim to benefits.** No Participating Member, Beneficiary or other person shall have any right or claim to benefits under this Plan, or any right or claim to payment from the Trust Fund, other than as specified herein and under all applicable sections of North Dakota Century Code Chapter 54-52. Any dispute as to eligibility, type, amount or duration of benefits or any right or claim to payment from the Trust Fund shall be resolved pursuant to the terms of the Plan, under appeal procedures adopted by the Board.

ARTICLE 10.

AMENDMENT AND TERMINATION

10.1 **Right to amend Plan.** The Board has the right to amend the Plan, in whole or in part, at any time and from time to time. However, no amendment shall, with respect to any Participating Member, reduce such benefits provided hereunder as are derived from vested contributions credited to the Participating Member before the effective date of any such amendment.

10.2 **Exclusive benefit.** Except as permitted specifically by law, it shall be impossible by operation of this Plan, by termination or amendment or by the happening of any contingency, for any part of the principle or income of the Trust Fund or any fund contributed thereto to be used for, or diverted to, purposes other than the exclusive benefit of Participating Members or their Beneficiaries.

10.3 **Severability.** If any provision of the Plan or any step in the administration of the Plan is held to be illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan, unless such illegality or invalidity prevents accomplishment of the purposes and objectives of the Plan. In the event of any such holding, the Board will immediately amend the Plan to remedy the defect.

10.4 **Nonforfeitable benefits upon termination.** In the event of a termination of the Plan, the rights of each Participating Member to all benefits accrued to date of such termination, which is the vested Account Balance of each Participating Member, shall be one hundred percent nonforfeitable and fully vested in each Participating Member.

ARTICLE 11.

GENERAL PROVISIONS

11.1 **Plan not employment contract.** The adoption of or participation in this Plan may not be deemed to give an Employee the right to be retained in the employ of an Employer or to interfere with the right of the Employer to discharge any Employee at any time.

11.2 **Alienation of benefits prohibited.** Neither the Participating Member nor his designated Beneficiary, or any other designee, has any right to commute, sell, assign, transfer or otherwise convey the right to receive any payments or assets under this Plan. Such payments or assets are non-assignable and non-transferable. The Participating Member's rights under the Plan are not subject to the rights of creditors of the Participating Member, any Beneficiary, the Board or the Employer and shall be exempt from execution, attachment, prior assignment or any other judicial relief or order for the benefit of creditors or other third persons. This Section shall not apply to a qualified domestic relations order, as defined in Section 7.8.

11.3 **Beneficiary designation.** A Participant or former Participant in the Plan may nominate one or more individuals as a Beneficiary by filing written notice of nomination with the Board. If the Participating Member or former Participant is married at the time of the nomination and the Participant's spouse is not the Beneficiary for one hundred percent of his or her Account Balance, the nomination is not effective unless it is signed by the Participant's spouse. However, the Board may waive this requirement if the spouse's signature cannot be obtained because of extenuating circumstances.

11.4 **Overpayments.** The Board has the right of setoff to recover overpayments made under this Plan and to satisfy any claims arising from embezzlement or fraud committed by a Participating Member, Deferred Member, Beneficiary or other person who has a claim to a distribution or any other benefit from this Plan.

11.5 **Plan qualification.** If the Board receives notice from the Internal Revenue Service that this Plan is not qualified for tax purposes under the Code, then the portion that will cause the disqualification does not apply.

11.6 **Construction**. The laws of the State of North Dakota, as amended from time to time, shall govern the construction and application of this Plan. Words used in the masculine gender shall include the feminine and words in the singular shall include the plural, as appropriate. The headings and

subheadings of this Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

11.7 **Reemployment.** Any former Participating Member of this Plan who returns to public employment following a previous termination or retirement and is eligible to participate in a retirement plan, must resume participation in this Plan.

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North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Katheryne Korom

DATE: August 20, 2024

SUBJECT: Group Voluntary Dental PPO Benefits Contract

At the July Board meeting, the Board awarded the Group Voluntary Dental PPO Benefits contract to Delta Dental. The attached contract was drafted by NDPERS legal staff and approved by representatives from Delta Dental.

Board Action Requested: Approve the contract and Board Chairman's signature for the Group Voluntary Dental PPO Benefits with Delta Dental of Minnesota (Delta Dental) for the January 1, 2025, through December 31, 2026, contract period.

Attachment

Appendix A – Agreements

AGREEMENT FOR SERVICES BETWEEN DELTA DENTAL OF MINNESOTA AND NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

1. PARTIES

The parties to this contract (Contract) are the state of North Dakota, acting through its ***North Dakota Public Employees Retirement System*** (STATE), and ***Delta Dental of Minnesota*** having its principal place of business at 500 Washington Ave, Suite 2060, Minneapolis, MN 55415 (CONTRACTOR);

2. SCOPE OF WORK

CONTRACTOR agrees to provide the service(s) as specified in the 2024 bid document and VENDOR proposal (attached hereto and incorporated by reference Exhibit A).

3. COMPENSATION – PAYMENTS

a. Contractual Amount

NDPERS will pay for the services provided by CONTRACTOR under this contract pursuant to Exhibit A.

The Contractual Amount is firm for the duration of this Contract and constitutes the entire compensation due CONTRACTOR for performance of its obligations under this Contract regardless of the difficulty, materials or equipment required, including fees, licenses, overhead, profit and all other direct and indirect costs incurred by CONTRACTOR, except as provided by an amendment to this Contract.

b. Payment

1) Payment made in accordance with this Compensation section shall constitute payment in full for the services and work performed and the deliverables and work(s) provided under this Contract and CONTRACTOR shall not receive any additional compensation hereunder.

2) STATE will pay for the services provided by CONTRACTOR under this contract an amount not to exceed $42.24/Employee; $81.50/Employee & Spouse; $94.62/Employee & Child(ren); $134.74/Family per month.

3) Payments under this Contract shall be submitted with respect to the first month on or before the Contract Date in accordance with the Term of Contract section of this Contract and thereafter on the first day of each succeeding calendar month for the duration of the Term of Contract and any renewals or extensions thereof.

4) Payment of an invoice by STATE will not prejudice STATE's right to object to

or question that or any other invoice or matter in relation thereto. CONTRACTOR's invoice will be subject to reduction for amounts included in any invoice or payment made which are determined by STATE, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute allowable costs. At STATE's sole discretion, all payments shall be subject to reduction for amounts equal to prior overpayments to CONTRACTOR.

5) For any amounts that are or will become due and payable to STATE by CONTRACTOR, STATE reserves the right to deduct the amount owed from payments that are or will become due and payable to CONTRACTOR under this Contract.

c. Travel

CONTRACTOR acknowledges travel costs are covered by the Contractual Amount and shall not invoice STATE for travel costs.

d. Prepayment

STATE will not make any advance payments before performance or delivery by CONTRACTOR under this Contract.

e. Payment of Taxes by STATE

STATE is not responsible for and will not pay local, state, or federal taxes. STATE sales tax exemption number is E-2001. STATE will furnish certificates of exemption upon request by the CONTRACTOR.

f. Taxpayer ID

CONTRACTOR'S federal employer ID number is: 41-0952670.

4. TERM OF CONTRACT

This Contract term (Term or Initial Term) begins on ***January 1, 2025*** and ends on ***December 31, 2026***.

a. No Automatic Renewal

This Contract will not automatically renew.

b. Renewal Option

STATE may renew this Contract upon satisfactory completion of the Initial Term. STATE reserves

the right to execute up to ***2*** options to renew this Contract under the same terms and conditions for a period of ***24*** months each (Renewal Term).

c. Extension Option

The STATE at the discretion of the NDPERS' Board may extend the contract for up to two additional two-year periods. The premium and benefits structure of these extensions will be subject to negotiations prior to renewal. STATE has the right to discontinue the program if the legislature discontinues the program or for any other reason.

d. Renegotiation Option

If, during the initial Term, any renewal, or extension, STATE determines a realignment of the Term is needed (e.g., to align with STATE'S fiscal biennium), the parties may mutually agree, in writing, to a new Term with a termination date not to exceed the total available length of Contract including its initial Term, renewals, and extensions.

5. TIME IS OF THE ESSENCE

CONTRACTOR hereby acknowledges that time is of the essence for performance under this Contract unless otherwise agreed to in writing by the Parties.

6. TERMINATION

a. Termination by Mutual Agreement

This Contract may be terminated by mutual consent of both Parties executed in writing.

b. Early Termination in the Public Interest

STATE is entering this Contract for the purpose of carrying out the public policy of the State of North Dakota, as determined by its Governor, Legislative Assembly, Agencies and Courts. If this Contract ceases to further the public policy of the State of North Dakota, STATE, in its sole discretion, by written notice to CONTRACTOR, may terminate this Contract in whole or in part.

c. Termination for Lack of Funding or Authority

STATE by written notice to CONTRACTOR, may terminate the whole or any part of this Contract under any of the following conditions:

1) If funding from federal, state, or other sources is not obtained or continued at levels sufficient to allow for purchase of the services or goods in the indicated quantities or term.

2) If federal or state laws or rules are modified or interpreted in a way that the services or goods are no longer allowable or appropriate for purchase under this Contract or are no longer eligible for the funding proposed for payments authorized by this Contract.

3) If any license, permit, or certificate required by law or rule, or by the terms of this Contract, is for any reason denied, revoked, suspended, or not renewed.

Termination of this Contract under this subsection is without prejudice to any obligations or liabilities of either Party already accrued prior to termination.

d. Termination for Cause.

STATE may terminate this Contract effective upon delivery of written notice to CONTRACTOR, or any later date stated in the notice:

1) If CONTRACTOR fails to provide services or goods required by this Contract within the time specified or any extension agreed to in writing by STATE; **or**

2) If CONTRACTOR fails to perform any of the other provisions of this Contract, or so fails to pursue the work as to endanger performance of this Contract in accordance with its terms.

The rights and remedies of STATE provided in this subsection are not exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

7. FORCE MAJEURE

Neither Party shall be held responsible for delay or default caused by fire, riot, terrorism, pandemic (excluding COVID-19), acts of God, or war if the event was not foreseeable through the exercise of reasonable diligence by the affected Party, the event is beyond the Party's reasonable control, and the affected Party gives notice to the other Party promptly upon occurrence of the event causing the delay or default or that is reasonably expected to cause a delay or default. If CONTRACTOR is the affected Party and does not resume performance within fifteen (15) days or another period agreed between the Parties, then STATE may seek all available remedies, up to and including termination of this Contract pursuant to its Termination Section, and STATE shall be entitled to a pro-rata refund of any amounts paid for which the full value has not been realized, including amounts paid toward software subscriptions, maintenance, or licenses.

8. INDEMNIFICATION

CONTRACTOR agrees to defend, indemnify, and hold harmless the state of North Dakota, its agencies, officers and employees (State), from and against claims based on the vicarious liability of the State or its agents, but not against claims based on the State's contributory negligence, comparative and/or contributory negligence or fault, sole negligence, or intentional misconduct. This obligation to defend, indemnify, and hold harmless does not extend to professional liability claims arising from professional errors and omissions. The legal defense provided by CONTRACTOR to the State under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for the State is necessary. Any attorney appointed to represent the State must first qualify as and be appointed by the North Dakota Attorney General as a Special Assistant Attorney General as required under N.D.C.C. § 54-12-08. CONTRACTOR also agrees to defend, indemnify, and hold the State harmless for all costs, expenses and attorneys' fees incurred if the State prevails in an action against CONTRACTOR in establishing and litigating the indemnification coverage provided herein. This

obligation shall continue after the termination of this Agreement.

9. INSURANCE

Contractor shall secure and keep in force during the term of this agreement and Contractor shall require all subcontractors, prior to commencement of an agreement between Contractor and the subcontractor, to secure and keep in force during the term of this agreement, from insurance companies, government self-insurance pools or government self-retention funds, authorized to do business in North Dakota, the following insurance coverages:

1) Commercial general liability, including premises or operations, contractual, and products or completed operations coverages (if applicable), with minimum liability limits of $2,000,000 per occurrence.
2) Automobile liability, including Owned (if any), Hired, and Non-Owned automobiles, with minimum liability limits of $500,000 per person and $2,000,000 per occurrence.
3) Workers compensation coverage meeting all statutory requirements. The policy shall provide coverage for all states of operation that apply to the performance of this contract.
4) Employer's liability or "stop gap" insurance of not less than $2,000,000 as an endorsement on the workers compensation or commercial general liability insurance.
5) Professional errors and omissions with minimum limits of $1,000,000 per claim and in the aggregate, Contractor shall continuously maintain such coverage during the contract period and for three years thereafter. In the event of a change or cancellation of coverage, Contractor shall purchase an extended reporting period to meet the time periods required in this section.

The insurance coverages listed above must meet the following additional requirements:

1) Any deductible or self-insured retention amount or other similar obligation under the policies shall be the sole responsibility of the Contractor. The amount of any deductible or self-retention is subject to approval by the State.
2) This insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe form and must be placed with insurers rated "A-" or better by A.M. Best Company, Inc., provided any excess policy follows form for coverage. Less than an "A-" rating must be approved by the State. The policies shall be in form and terms approved by the State.
3) The duty to defend, indemnify, and hold harmless the State under this agreement shall not be limited by the insurance required in this agreement.
4) The state of North Dakota and its agencies, officers, and employees (State) shall be endorsed on the commercial general liability policy, including any excess policies (to the extent applicable), as additional insured. The State shall have all the benefits, rights and coverages of an additional insured under these policies that shall not be limited to the minimum limits of insurance required by this agreement or by the contractual indemnity obligations of the Contractor.
5) A "Waiver of Subrogation" waiving any right to recovery the insurance company may have against the State.
6) The Contractor shall furnish a certificate of insurance to the undersigned State representative prior to commencement of this agreement. All endorsements shall be provided as soon as practicable.

7) Failure to provide insurance as required in this agreement is a material breach of contract entitling the State to terminate this agreement immediately.
8) Contractor shall provide at least 30 day notice of any cancellation or material change to the policies or endorsements. Contractor shall provide on an ongoing basis, current certificates of insurance during the term of the contract. A renewal certificate will be provided 10 days prior to coverage expiration.

10. WORKS FOR HIRE

CONTRACTOR acknowledges that all work(s) under this Contract is "work(s) for hire" within the meaning of the United States Copyright Act (Title 17 United States Code) and hereby assigns to STATE all rights and interests CONTRACTOR may have in the work(s) it prepares under this Contract, including any right to derivative use of the work(s). All software and related materials developed by CONTRACTOR in performance of this Contract for STATE shall be the sole property of STATE, and CONTRACTOR hereby assigns and transfers all its right, title, and interest therein to STATE. CONTRACTOR shall execute all necessary documents to enable STATE to protect STATE's intellectual property rights under this section.

11. WORK PRODUCT

All work product, equipment or materials created for STATE or purchased by STATE under this Contract belong to STATE and must be immediately delivered to STATE at STATE's request upon termination of this Contract.

12. NOTICE

All notices or other communications required under this Contract must be given by registered or certified mail and are complete on the date postmarked when addressed to the Parties at the following addresses:

STATE	CONTRACTOR
Name: Mike Seminary	Name: Delta Dental of Minnesota
Title: Board Chairman	Title: General Counsel
Address: 1600 East Century Ave, Suite 2 PO Box 1657	Address: 500 Washington Ave, Suite 2060
City, State, Zip: Bismarck, ND 58502-1657	City, State, Zip: Minneapolis, MN 55415

Notice provided under this provision does not meet the notice requirements for monetary claims against the State found at N.D.C.C. § 32-12.2-04.

13. CONFIDENTIALITY

CONTRACTOR shall not use or disclose any information it receives from STATE under this Contract that STATE has previously identified as confidential or exempt from mandatory public disclosure except as necessary to carry out the purposes of this Contract or as authorized in advance by STATE. STATE shall not disclose any information it receives from CONTRACTOR that CONTRACTOR has previously identified as confidential and that STATE determines in its sole discretion is protected from mandatory public disclosure under a specific exception to the North

Dakota public records law, N.D.C.C. ch. 44-04. The duty of STATE and CONTRACTOR to maintain confidentiality of information under this section continues beyond the Term of this Contract.

14. COMPLIANCE WITH PUBLIC RECORDS LAWS

Under the North Dakota public records law and subject to the Confidentiality clause of this Contract, certain records may be open to the public upon request.

Public records may include: (a) records STATE receives from CONTRACTOR under this Contract, (b) records obtained by either Party under this Contract, and (c) records generated by either Party under this Contract.

CONTRACTOR agrees to contact STATE immediately upon receiving a request for information under the public records law and to comply with STATE's instructions on how to respond to such request.

15. INDEPENDENT ENTITY

CONTRACTOR is an independent entity under this Contract and is not a STATE employee for any purpose, including the application of the Social Security Act, the Fair Labor Standards Act, the Federal Insurance Contribution Act, the North Dakota Unemployment Compensation Law and the North Dakota Workforce Safety and Insurance Act. CONTRACTOR retains sole and absolute discretion in the manner and means of carrying out CONTRACTOR's activities and responsibilities under this Contract, except to the extent specified in this Contract.

16. ASSIGNMENT AND SUBCONTRACTS

CONTRACTOR may not assign or otherwise transfer or delegate any right or duty without STATE's express written consent, provided, however, that CONTRACTOR may assign its rights and obligations hereunder in the event of a change of control or sale of all or substantially all of its assets related to this Contract, whether by merger, reorganization, operation of law, or otherwise. Should Assignee be a business or entity with whom STATE is prohibited from conducting business, STATE shall have the right to terminate in accordance with the Termination for Cause section of this Contract.

CONTRACTOR may enter subcontracts provided that any subcontract acknowledges the binding nature of this Contract and incorporates this Contract, including any attachments. CONTRACTOR is solely responsible for the performance of any subcontractor with whom CONTRACTOR contracts. CONTRACTOR does not have authority to contract for or incur obligations on behalf of STATE.

17. SPOLIATION – PRESERVATION OF EVIDENCE

CONTRACTOR shall promptly notify STATE of all potential claims that arise or result from this Contract. CONTRACTOR shall also take all reasonable steps to preserve all physical evidence and information that may be relevant to the circumstances surrounding a potential claim, while maintaining public safety, and grants to STATE the opportunity to review and inspect such evidence, including the scene of an accident.

18. MERGER AND MODIFICATION, CONFLICT IN DOCUMENTS

This Contract, including the following documents, constitutes the entire agreement between the Parties. There are no understandings, agreements, or representations, oral or written, not specified within this Contract. This Contract may not be modified, supplemented, or amended, in any manner, except by written agreement signed by both Parties.

Notwithstanding anything herein to the contrary, in the event of any inconsistency or conflict among the documents making up this Contract, the documents must control in this order of precedence:

a. The terms of this Contract, including any BAA and/or MOU (if applicable), as may be amended;
b. STATE's Request for Proposal ("RFP") number 192.02-01-24,
c. CONTRACTOR's proposal in response to RFP number 192.02-01-24.
d. All automated end-user agreements (e.g., click-through, shrink-wrap, or browse-wrap) are specifically excluded and null and void. Clicking shall not represent acknowledgement or agreement to any terms or conditions contained in those agreements.

19. SEVERABILITY

If any term of this Contract is declared to be illegal or unenforceable by a court having competent jurisdiction, the validity of the remaining terms is unaffected and, if possible, the rights and obligations of the Parties are to be construed and enforced as if this Contract did not contain that term.

20. APPLICABLE LAW AND VENUE

This Contract is governed by and construed in accordance with the laws of the State of North Dakota. Any action to enforce this Contract must be adjudicated exclusively in the state District Court of Burleigh County, North Dakota. Each Party consents to the exclusive jurisdiction of such court and waives any claim of lack of jurisdiction or *forum non conveniens*.

21. ALTERNATIVE DISPUTE RESOLUTION – JURY TRIAL

By entering this Contract, STATE does not agree to binding arbitration, mediation, or any other form of mandatory Alternative Dispute Resolution. The Parties may enforce the rights and remedies in judicial proceedings. STATE does not waive any right to a jury trial.

22. ATTORNEY FEES

In the event a lawsuit is instituted by STATE to obtain performance due under this Contract, and STATE is the prevailing Party, CONTRACTOR shall, except when prohibited by N.D.C.C. § 28-26-04, pay STATE's reasonable attorney fees and costs in connection with the lawsuit.

23. NONDISCRIMINATION AND COMPLIANCE WITH LAWS

CONTRACTOR agrees to comply with all applicable federal and state laws, rules, and policies, including those relating to nondiscrimination, accessibility and civil rights. (*See* N.D.C.C. Title 34 – Labor and Employment, specifically N.D.C.C. ch. 34-06.1 Equal Pay for Men and Women.)

CONTRACTOR agrees to timely file all required reports, make required payroll deductions, and timely pay all taxes and premiums owed, including sales and use taxes, unemployment compensation and workers' compensation premiums.

CONTRACTOR shall have and keep current all licenses and permits required by law during the Term of this Contract all licenses and permits required by law.

CONTRACTOR's failure to comply with this section may be deemed a material breach by CONTRACTOR entitling STATE to terminate in accordance with the Termination for Cause section of this Contract.

CONTRATOR is prohibited from boycotting Israel for the duration of this Contract. (See N.D.C.C § 54-44.4-15.) CONTRACTOR represents that it does not and will not engage in a boycotting Israel during the term of this Contract. If STATE receives evidence that CONTRACTOR boycotts Israel, STATE shall determine whether the company boycotts Israel. The foregoing does not apply to contracts with a total value of less than $100,000 or if CONTRACTOR has fewer than ten full-time employees.

24. STATE AUDIT

Pursuant to N.D.C.C. § 54-10-19, all records, regardless of physical form, and the accounting practices and procedures of CONTRACTOR relevant to this Contract are subject to examination by the North Dakota State Auditor, the Auditor's designee, or Federal auditors, if required. CONTRACTOR shall maintain these records for at least three (3) years following completion of this Contract and be able to provide them upon reasonable notice. STATE, State Auditor, or Auditor's designee shall provide reasonable notice to CONTRACTOR prior to conducting examination.

25. COUNTERPARTS

This Contract may be executed in multiple, identical counterparts, each of which is to be deemed an original, and all of which taken together shall constitute one and the same contract.

26. EFFECTIVENESS OF CONTRACT

This Contract is not effective until fully executed by both Parties. If no start date is specified in the Term of Contract, the most recent date of the signatures of the Parties shall be deemed the Effective Date.

CONTRACTOR	**STATE OF NORTH DAKOTA**
Delta Dental of Minnesota	Acting through its **NDPERS**
BY: DocuSigned by: Nadia Martyn	BY:
Nadia Martyn	Mike Seminary
General Counsel & Assistant Secretary	NDPERS Board Chairman

Date: 8/1/2024	Date:

Business Associate Agreement

This Business Associate Agreement, which is an addendum to the underlying contract, is entered into by and between, the North Dakota Public Employees Retirement System ("NDPERS") and Delta Dental of Minnesota, **500 Washington Ave S, Suite 2060, Minneapolis, MN 55415.**

1. Definitions

   a. Terms used, but not otherwise defined, in this Agreement have the same meaning as those terms in the HIPAA Privacy Rule, 45 C.F.R. Part 160 and Part 164, Subparts A and E, and the HIPAA Security rule, 45 C.F.R., pt. 164, subpart C.
   b. Business Associate. "Business Associate" means the **Delta Dental of Minnesota**.
   c. Covered Entity. "Covered Entity" means the **North Dakota Public Employees Retirement System Health Plans**.
   d. PHI and ePHI. "PHI" means Protected Health Information; "ePHI" means Electronic Protected Health Information.

2. Obligations of Business Associate

The Business Associate agrees:

a. To use or disclose PHI and ePHI only as permitted or required by this Agreement or as Required by Law.
b. To use appropriate safeguards and security measures to prevent use or disclosure of the PHI and ePHI other than as provided for by this Agreement, and to comply with all security requirements of the HIPAA Security rule.
c. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains or transmits on behalf of the Covered Entity as required by the HIPAA Security rule.
d. To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI or ePHI by Business Associate in violation of the requirements of this Agreement.
e. To report to Covered Entity (1) any use or disclosure of the PHI not provided for by this Agreement, and (2) any "security incident" as defined in 45 C.F.R. § 164.304 involving ePHI, of which it becomes aware without unreasonable delay and in any case within thirty (30) days from the date after discovery and provide the Covered Entity with a written notification that complies with 45 C.F.R. § 164.410 which shall include the following information:
   i. to the extent possible, the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired or disclosed during the breach;
   ii. a brief description of what happened;
   iii. the date of discovery of the breach and date of the breach;

iv. the nature of the Protected Health Information that was involved;
v. identity of any person who received the non-permitted Protected Health Information;
vi. any steps individuals should take to protect themselves from potential harm resulting from the breach;
vii. a brief description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and
viii. any other available information that the Covered Entity is required to include in notification to an individual under 45 C.F.R. § 164.404(c) at the time of the notification to the State required by this subsection or promptly thereafter as information becomes available.

f. With respect to any use or disclosure of Unsecured Protected Health Information not permitted by the Privacy Rule that is caused by the Business Associate's failure to comply with one or more of its obligations under this Agreement, the Business Associate agrees to pay its reasonable share of cost-based fees associated with activities the Covered Entity must undertake to meet its notification obligations under the HIPAA Rules and any other security breach notification laws;
g. Ensure that any agent or subcontractor that creates, receives, maintains, or transmits electronic PHI on behalf of the Business Associate agree to comply with the same restrictions and conditions that apply through this Agreement to the Business Associate.
h. To make available to the Secretary of Health and Human Services the Business Associate's internal practices, books, and records, including policies and procedures relating to the use and disclosure of PHI and ePHI received from, or created or received by Business Associate on behalf of Covered Entity, for the purpose of determining the Covered Entity's compliance with the HIPAA Privacy Rule, subject to any applicable legal privileges.
i. To document the disclosure of PHI related to any disclosure of PHI as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
j. To provide to Covered Entity within 15 days of a written notice from Covered Entity, information necessary to permit the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
k. To provide, within 10 days of receiving a written request, information necessary for the Covered Entity to respond to an Individual's request for access to PHI about himself or herself, in the event that PHI in the Business Associate's possession constitutes a Designated Record Set.
l. Make amendments(s) to PHI in a designated record set as directed or agreed by the Covered Entity pursuant to 45 C.F.R. § 164.526 or take other measures as necessary to satisfy the covered entity's obligations under that section of law.

3. Permitted Uses and Disclosures by Business Associate

3.1. General Use and Disclosure Provisions

Except as otherwise limited in this Agreement, Business Associate may Use or

Disclose PHI and ePHI to perform functions, activities, or services for, or on behalf of, Covered Entity, specifically, insurance membership data to conduct RFP vendor searches – provided that such use or disclosure would not violate the Privacy Rule or the Security Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

3.2. Specific Use and Disclosure Provisions

Except as otherwise limited in this Agreement, Business Associate may use PHI and ePHI:

a. For the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
b. To provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B), but Business Associate may not disclose the PHI or ePHI of the Covered Entity to any other client of the Business Associate without the written authorization of the covered entity Covered Entity.
c. To report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §§ 164.304 and 164.502(j)(1).

4. Obligations of Covered Entity

4.1. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

Covered Entity shall notify Business Associate of:

a. Any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that any such limitation may affect Business Associate's use or disclosure of PHI.
b. Any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that any such changes may affect Business Associate's use or disclosure of PHI.
c. Any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that any such restriction may affect Business Associate’s use or disclosure of PHI.

4.2. Additional Obligations of Covered Entity

Covered Entity agrees that it:

a. Has included, and will include, in the Covered Entity’s Notice of Privacy Practices required by the Privacy Rule that the Covered Entity may disclose PHI for Health Care Operations purposes.
b. Has obtained, and will obtain, from Individuals any consents, authorizations and other permissions necessary or required by laws applicable to the Covered Entity

for Business Associate and the Covered Entity to fulfill their obligations under the Underlying Agreement and this Agreement.

c. Will promptly notify Business Associate in writing of any restrictions on the Use and Disclosure of PHI about Individuals that the Covered Entity has agreed to that may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Agreement.
d. Will promptly notify Business Associate in writing of any change in, or revocation of, permission by an Individual to Use or Disclose PHI, if the change or revocation may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Agreement.

4.3. Permissible Requests by Covered Entity

Covered Entity may not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule or the Security Rule if done by Covered Entity, except that the Business Associate may use or disclose PHI and ePHI for management and administrative activities of Business Associate.

5. Term and Termination

a. Term. The Term of this Agreement shall be effective as of 07/01/2023, and shall terminate when all of the PHI and ePHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI and ePHI, protections are extended to any such information, in accordance with the termination provisions in this Section.
b. Automatic Termination. This Agreement will automatically terminate upon the termination or expiration of the Underlying Agreement.
c. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
    1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the Underlying Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
    2. Immediately terminate this Agreement and the Underlying Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
    3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.
d. Effect of Termination
    1. Except as provided in paragraph (2) of this subsection, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI and ePHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI or ePHI.
    2. In the event that Business Associate determines that returning or

destroying the PHI or ePHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon explicit written agreement of Covered Entity that return or destruction of PHI or ePHI is not feasible, Business Associate shall extend the protections of this Agreement to that PHI and ePHI and limit further uses and disclosures of any such PHI and ePHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains that PHI or ePHI.

6. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the HIPAA Privacy or Security Rule means the section as in effect or as amended.
b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule, the Security Rule, and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
c. Survival. The respective rights and obligations of Business Associate under Section 5.c, related to "Effect of Termination," of this Agreement shall survive the termination of this Agreement.
d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy and Security Rules.
e. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything this Agreement confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
f. Applicable Law and Venue. This Business Associate Agreement is governed by and construed in accordance with the laws of the State of North Dakota. Any action commenced to enforce this Contract must be brought in the District Court of Burleigh County, North Dakota.
g. Business Associate agrees to comply with all the requirements imposed on a business associate under Title XIII of the American Recovery and Reinvestment Act of 2009, the Health Information Technology for Economic and Clinical Health (HI-TECH) Act, and, at the request of NDPERS, to agree to any reasonable modification of this agreement required to conform the agreement to any Model Business Associate Agreement published by the Department of Health and Human Services.

7. Entire Agreement

This Agreement contains all of the agreements and understandings between the parties with respect to the subject matter of this Agreement. No agreement or other understanding in any way modifying the terms of this Agreement will be binding unless made in writing as a modification or amendment to this Agreement and executed by both parties.

IN WITNESS OF THIS, **NDPERS** [CE] and **Delta Dental of Minnesota** [BA] agree to and intend to be legally bound by all terms and conditions set

forth above and hereby execute this Agreement as of the effective date set forth above.

For Covered Entity:	For Business Associate:
	DocuSigned by: Nadia Martyn 1E648CC7D83043E...
Mike Seminary, Board Chairman ND Public Employees Retirement System	Signature
	Nadia Martyn Printed Name
	General Counsel & Assistant Secretary Title
	8/1/2024
Date	Date

MEMORANDUM OF UNDERSTANDING BETWEEN THE NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM AND VENDOR RELATING TO MAINTAINING CONFIDENTIAL INFORMATION

This Memorandum of Understanding is between the State of North Dakota acting through its North Dakota Public Employees Retirement System (NDPERS) and VENDOR relating to maintenance and destruction of NDPERS Confidential Information held by VENDOR and its subsidiaries.

WHEREAS, NDPERS has previously entered into contracts with VENDOR to provide services related to administration of the NDPERS RFP (Contracts).

WHEREAS, the services provided by VENDOR under these Contracts required the exchange of information between the parties that is confidential under North Dakota Century Code §§ 54-52-26 and 54-52.1-11, 54-52.1-12 (Confidential Information).

WHEREAS, the parties acknowledge that these Contracts, including the Business Associate Agreements between the parties, required VENDOR to return or destroy Confidential Information subsequent to the termination of the applicable Contract, or if return or destruction of this information was infeasible to maintain its confidentiality.

WHEREAS, these Contracts have terminated and VENDOR has asserted and NDPERS agrees that member service, applicable audit, record keeping, and other required functions make the return or destruction of all Confidential Information infeasible at this time.

WHEREAS, VENDOR has provided and NDPERS has reviewed the VENDOR records retention policy (Policy) applicable to the Confidential Information and VENDOR has affirmed that it will maintain the confidentiality of NDPERS information pursuant to this Policy until such time as the information is destroyed in a manner designated by this Policy.

NOW THEREFORE, in consideration of the foregoing premises and in furtherance of the aforementioned contractual obligations, the parties agree as follows:

1. VENDOR shall continue to maintain the confidentiality of Confidential Information which it still possesses, in accordance with its Policy in a manner that is at least as secure and diligent as was done during the term of the applicable Contract, until such time as the Confidential Information is destroyed or returned.
2. Upon the request of NDPERS, VENDOR shall confirm the destruction of Confidential Information under its Policy.
3. Upon the request of NDPERS, VENDOR shall provide NDPERS a copy of any change to the Policy provided NDPERS on DATE.
4. NDPERS agrees these actions are consistent with VENDOR obligations under these Contracts.
5. This Memorandum of Understanding will terminate upon notice to

NDPERS by VENDOR that all Confidential Information has either been returned to NDPERS or destroyed, or earlier, upon thirty (30) days' notice by NDPERS to VENDOR if NDPERS determines that the Policy has been modified in a manner that is inconsistent with state or federal law.

6. This Memorandum of Understanding shall be governed by, and construed in accordance with, the laws of the State of North Dakota.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

BY: _____

Board Chairman

Date: _____

VENDOR

BY: DocuSigned by: Nadia Martyn 1E040CC7D83043E...

Its: General Counsel & Assistant Secretary

Date: 8/1/2024

Attach Contractor Records Retention Policy

Delta Dental of Minnesota
Serving North Dakota

Attachment 2

North Dakota Public Employees Retirement System (NDPERS) #537482

Effective: 1/1/2025 – 12/31/2030

Performance Item	Guarantee	Dollar amount of total at risk*	Methodology	Frequency*
Claim Turnaround Time - Number of days between receipt of claim and adjudication.	90% in 14 calendar days 99% in 30 calendar days	$2,500	Based on NDPERS specific measurements taken from cycle time reports from claims system. Excludes holidays and assumes clean claims.	Annual
Claim Financial Accuracy - Percent of claim dollars paid (or denied) in accordance with plan design.	99% of dollars paid accurately	$2,500	Based on aggregate audit results. Calculated as the total dollars paid accurately for audited claims (absolute value of positive and negative errors) divided by the total dollars paid.	Annual
Claim Incidence Accuracy - Percent of claims paid (or denied) in accordance with plan design.	98% of claims processed accurately	$2,500	Based on aggregate audit results. Calculated as the number of audited claims paid accurately divided by the total number of audited claims.	Annual
Phone Average Speed of Answer - Average number of seconds for Customer Service to answer phone.	25 seconds average speed of answer	$1,200	Based on aggregate audit results taken from phone system reports. For subscribers only (does not include providers). Does not include time in IVR.	Annual
Phone Abandonment Rate - Percent of callers who hang up prior to the call being answered by a Customer Service Representative.	3.0% or less	$1,200	Based on aggregate audit results taken from phone system reports. For subscribers only (does not include providers). Excludes subscribers who hang up in 10 seconds or less.	Annual
Employee Satisfaction - Percent of subscribers satisfied with our overall quality of service.	85% satisfied or better	$1,200	Based on annual Delta Dental corporate survey. 85% of the respondents indicate they are satisfied with overall quality of service.	Annual
Provider Network – Percent of participating providers terminating from the dental network.	10.0% or less	$5,000	Based on annual network analysis for Delta Dental Premier General Practice “GPs” dentists (no specialists) located in North Dakota only and does not include involuntary terminations (i.e. dental license suspensions, dental Board actions, criminal charges and/or convictions, dental fraud etc) or provider terminations outside of Delta Dental’s control (i.e. retirement, death, move out of state, etc.)	Annual
	Total	$16,100		

Richard DeMarco, SVP Chief Operating Officer Date

NDPERS Representative Name and Title Date

* The established annual amount at risk is not to exceed $16,100. The guarantee will be measured and reported to NDPERS quarterly with the frequency of payout based on the annual calendar year results. The annual reporting and amount at risk should be paid-out within 90 days following the end of the calendar year.

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Katheryne Korom

DATE: August 20, 2024

SUBJECT: Administrative and Recordkeeping Services for Section 125 FlexComp Plan (FlexComp) Contract

At the July Board meeting, the Board awarded the contract for the Administrative and Recordkeeping Services for Section 125 FlexComp Plan (FlexComp) to ASIFlex. The attached contract was drafted by NDPERS legal staff and approved by representatives from ASIFlex.

Board Action Requested: Approve the contract and Executive Director's signature for the FlexComp Plan with ASIFlex for the January 1, 2025, through December 31, 2026, contract period.

Attachment

Attachment

AGREEMENT FOR SERVICES BETWEEN Application Software, Inc. dba ASIFlex AND NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

1. PARTIES

The parties to this contract (Contract) are the state of North Dakota, acting through its ***North Dakota Public Employees Retirement System*** (STATE), and ***Application Software, Inc. a Missouri Corporation doing business as ASIFlex*** having its principal place of business at ***201 W. Broadway, Suite 4C, Columbia, MO 65203*** (CONTRACTOR);

2. SCOPE OF WORK

CONTRACTOR agrees to provide the service(s) as specified in the 2024 bid document and VENDOR proposal (attached hereto and incorporated by reference Exhibit A).

3. COMPENSATION – PAYMENTS

a. Contractual Amount

NDPERS will pay for the services provided by CONTRACTOR under this contract pursuant to Exhibit A.

The Contractual Amount is firm for the duration of this Contract and constitutes the entire compensation due CONTRACTOR for performance of its obligations under this Contract regardless of the difficulty, materials or equipment required, including fees, licenses, overhead, profit and all other direct and indirect costs incurred by CONTRACTOR, except as provided by an amendment to this Contract.

b. Payment

1) Payment made in accordance with this Compensation section shall constitute payment in full for the services and work performed and the deliverables and work(s) provided under this Contract and CONTRACTOR shall not receive any additional compensation hereunder.

2) STATE shall make payment under this Contract within forty-five (45) calendar days after receipt of a correct invoice.

3) Payment of an invoice by STATE will not prejudice STATE's right to object to or question that or any other invoice or matter in relation thereto. CONTRACTOR's invoice will be subject to reduction for amounts included in any invoice or payment made which are determined by STATE, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute allowable costs. At STATE's sole discretion, all payments shall be subject to

reduction for amounts equal to prior overpayments to CONTRACTOR.

4) For any amounts that are or will become due and payable to STATE by CONTRACTOR, STATE reserves the right to deduct the amount owed from payments that are or will become due and payable to CONTRACTOR under this Contract.

c. Travel

CONTRACTOR acknowledges travel costs are covered by the Contractual Amount and shall not invoice STATE for travel costs.

d. Prepayment

STATE will not make any advance payments before performance or delivery by CONTRACTOR under this Contract.

e. Payment of Taxes by STATE

STATE is not responsible for and will not pay local, state, or federal taxes. STATE sales tax exemption number is E-2001. STATE will furnish certificates of exemption upon request by the CONTRACTOR.

f. Taxpayer ID

CONTRACTOR'S federal employer ID number is: ***43-1303571***

4. TERM OF CONTRACT

This Contract term (Term or Initial Term) begins on ***January 1, 2025,*** and ends on ***December 31, 2026***.

a. No Automatic Renewal

This Contract will not automatically renew.

b. Renewal Option

STATE may renew this Contract upon satisfactory completion of the Initial Term. STATE reserves the right to execute up to ***2*** options to renew this Contract under the same terms and conditions for a period of ***24*** months each (Renewal Term).

c. Extension Option

STATE reserves the right to extend this Contract for an additional period, not to exceed 24 months, beyond the current termination date of this Contract.

d. Renegotiation Option

If, during the initial Term, any renewal, or extension, STATE determines a realignment of the Term is needed (e.g. to align with STATE'S fiscal biennium), the parties may mutually agree, in writing, to a new Term with a termination date not to exceed the total available length of Contract including its initial Term, renewals, and extensions.

5. TIME IS OF THE ESSENCE

CONTRACTOR hereby acknowledges that time is of the essence for performance under this Contract unless otherwise agreed to in writing by the Parties.

6. TERMINATION

a. Termination by Mutual Agreement

This Contract may be terminated by mutual consent of both Parties executed in writing.

b. Early Termination in the Public Interest

STATE is entering this Contract for the purpose of carrying out the public policy of the State of North Dakota, as determined by its Governor, Legislative Assembly, Agencies and Courts. If this Contract ceases to further the public policy of the State of North Dakota, STATE, in its sole discretion, by written notice to CONTRACTOR, may terminate this Contract in whole or in part.

c. Termination for Lack of Funding or Authority

STATE by written notice to CONTRACTOR, may terminate the whole or any part of this Contract under any of the following conditions:

1) If funding from federal, state, or other sources is not obtained or continued at levels sufficient to allow for purchase of the services or goods in the indicated quantities or term.

2) If federal or state laws or rules are modified or interpreted in a way that the services or goods are no longer allowable or appropriate for purchase under this Contract or are no longer eligible for the funding proposed for payments authorized by this Contract.

3) If any license, permit, or certificate required by law or rule, or by the terms of this Contract, is for any reason denied, revoked, suspended, or not renewed.

Termination of this Contract under this subsection is without prejudice to any obligations or liabilities of either Party already accrued prior to termination.

d. Termination for Cause.

STATE may terminate this Contract effective upon delivery of written notice to CONTRACTOR, or any later date stated in the notice:

1) If CONTRACTOR fails to provide services or goods required by this Contract within the time specified or any extension agreed to in writing by STATE; **or**

2) If CONTRACTOR fails to perform any of the other provisions of this Contract, or so fails to pursue the work as to endanger performance of this Contract in accordance with its terms.

The rights and remedies of STATE provided in this subsection are not exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

7. FORCE MAJEURE

Neither Party shall be held responsible for delay or default caused by fire, riot, terrorism, pandemic (excluding COVID-19), acts of God, or war if the event was not foreseeable through the exercise of reasonable diligence by the affected Party, the event is beyond the Party's reasonable control, and the affected Party gives notice to the other Party promptly upon occurrence of the event causing the delay or default or that is reasonably expected to cause a delay or default. If CONTRACTOR is the affected Party and does not resume performance within fifteen (15) days or another period agreed between the Parties, then STATE may seek all available remedies, up to and including termination of this Contract pursuant to its Termination Section, and STATE shall be entitled to a pro-rata refund of any amounts paid for which the full value has not been realized, including amounts paid toward software subscriptions, maintenance, or licenses.

8. INDEMNIFICATION

CONTRACTOR agrees to defend, indemnify, and hold harmless the state of North Dakota, its agencies, officers and employees (State), from and against claims based on the vicarious liability of the State or its agents, but not against claims based on the State's contributory negligence, comparative and/or contributory negligence or fault, sole negligence, or intentional misconduct. This obligation to defend, indemnify, and hold harmless does not extend to professional liability claims arising from professional errors and omissions. The legal defense provided by CONTRACTOR to the State under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for the State is necessary. Any attorney appointed to represent the State must first qualify as and be appointed by the North Dakota Attorney General as a Special Assistant Attorney General as required under N.D.C.C. § 54-12-08. CONTRACTOR also agrees to defend, indemnify, and hold the State harmless for all costs, expenses and attorneys' fees incurred if the State prevails in an action against CONTRACTOR in establishing and litigating the indemnification coverage provided herein. This obligation shall continue after the termination of this Agreement.

9. INSURANCE

Contractor shall secure and keep in force during the term of this agreement and Contractor shall require all subcontractors, prior to commencement of an agreement between Contractor and the subcontractor, to secure and keep in force during the term of this agreement, from insurance companies, government self-insurance pools or government self-retention funds, authorized to do business in North Dakota, the following insurance coverages:

1) Commercial general liability, including premises or operations, contractual, and products or completed operations coverages (if applicable), with minimum liability limits of $2,000,000 per occurrence.
2) Automobile liability, including Owned (if any), Hired, and Non-Owned automobiles, with minimum liability limits of $500,000 per person and $2,000,000 per occurrence.
3) Workers compensation coverage meeting all statutory requirements. The policy shall provide coverage for all states of operation that apply to the performance of this contract.
4) Employer's liability or "stop gap" insurance of not less than $2,000,000 as an endorsement on the workers compensation or commercial general liability insurance.
5) Professional errors and omissions with minimum limits of $1,000,000 per claim and in the aggregate, Contractor shall continuously maintain such coverage during the contract period and for three years thereafter. In the event of a change or cancellation of coverage, Contractor shall purchase an extended reporting period to meet the time periods required in this section.

The insurance coverages listed above must meet the following additional requirements:

1) Any deductible or self-insured retention amount or other similar obligation under the policies shall be the sole responsibility of the Contractor. The amount of any deductible or self-retention is subject to approval by the State.
2) This insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe form and must be placed with insurers rated "A-" or better by A.M. Best Company, Inc., provided any excess policy follows form for coverage. Less than an "A-" rating must be approved by the State. The policies shall be in form and terms approved by the State.
3) The duty to defend, indemnify, and hold harmless the State under this agreement shall not be limited by the insurance required in this agreement.
4) The state of North Dakota and its agencies, officers, and employees (State) shall be endorsed on the commercial general liability policy, including any excess policies (to the extent applicable), as additional insured. The State shall have all the benefits, rights and coverages of an additional insured under these policies that shall not be limited to the minimum limits of insurance required by this agreement or by the contractual indemnity obligations of the Contractor.
5) A "Waiver of Subrogation" waiving any right to recovery the insurance company may have against the State.
6) The Contractor shall furnish a certificate of insurance to the undersigned State representative prior to commencement of this agreement. All endorsements shall be provided as soon as practicable.
7) Failure to provide insurance as required in this agreement is a material breach of

contract entitling the State to terminate this agreement immediately.

8) Contractor shall provide at least 30 day notice of any cancellation or material change to the policies or endorsements. Contractor shall provide on an ongoing basis, current certificates of insurance during the term of the contract. A renewal certificate will be provided 10 days prior to coverage expiration.

10. WORKS FOR HIRE

CONTRACTOR acknowledges that all work(s) under this Contract is "work(s) for hire" within the meaning of the United States Copyright Act (Title 17 United States Code) and hereby assigns to STATE all rights and interests CONTRACTOR may have in the work(s) it prepares under this Contract, including any right to derivative use of the work(s). All software and related materials developed by CONTRACTOR in performance of this Contract for STATE shall be the sole property of STATE, and CONTRACTOR hereby assigns and transfers all its right, title, and interest therein to STATE. CONTRACTOR shall execute all necessary documents to enable STATE to protect STATE's intellectual property rights under this section.

11. WORK PRODUCT

All work product, equipment or materials created for STATE or purchased by STATE under this Contract belong to STATE and must be immediately delivered to STATE at STATE's request upon termination of this Contract.

12. NOTICE

All notices or other communications required under this Contract must be given by registered or certified mail and are complete on the date postmarked when addressed to the Parties at the following addresses:

STATE	**CONTRACTOR**
Name: Rebecca Fricke	Name **Dennis Jones**
Title: Executive Director	Title **Chief Operating Officer**
Address: 1600 East Century Ave, Suite 2 PO Box 1657	Address **201 W. Broadway, Suite 4C**
City, State, Zip: Bismarck, ND 58502-1657	City, State, Zip Columbia, MO 65203

Notice provided under this provision does not meet the notice requirements for monetary claims against the State found at N.D.C.C. § 32-12.2-04.

13. CONFIDENTIALITY

CONTRACTOR shall not use or disclose any information it receives from STATE under this Contract that STATE has previously identified as confidential or exempt from mandatory public disclosure except as necessary to carry out the purposes of this Contract or as authorized in advance by STATE. STATE shall not disclose any information it receives from CONTRACTOR that CONTRACTOR has previously identified as confidential and that STATE determines in its sole discretion is protected from mandatory public disclosure under a specific exception to the North

Dakota public records law, N.D.C.C. ch. 44-04. The duty of STATE and CONTRACTOR to maintain confidentiality of information under this section continues beyond the Term of this Contract.

14. COMPLIANCE WITH PUBLIC RECORDS LAWS

Under the North Dakota public records law and subject to the Confidentiality clause of this Contract, certain records may be open to the public upon request.

Public records may include: (a) records STATE receives from CONTRACTOR under this Contract, (b) records obtained by either Party under this Contract, and (c) records generated by either Party under this Contract.

CONTRACTOR agrees to contact STATE immediately upon receiving a request for information under the public records law and to comply with STATE's instructions on how to respond to such request.

15. INDEPENDENT ENTITY

CONTRACTOR is an independent entity under this Contract and is not a STATE employee for any purpose, including the application of the Social Security Act, the Fair Labor Standards Act, the Federal Insurance Contribution Act, the North Dakota Unemployment Compensation Law and the North Dakota Workforce Safety and Insurance Act. CONTRACTOR retains sole and absolute discretion in the manner and means of carrying out CONTRACTOR's activities and responsibilities under this Contract, except to the extent specified in this Contract.

16. ASSIGNMENT AND SUBCONTRACTS

CONTRACTOR may not assign or otherwise transfer or delegate any right or duty without STATE's express written consent, provided, however, that CONTRACTOR may assign its rights and obligations hereunder in the event of a change of control or sale of all or substantially all of its assets related to this Contract, whether by merger, reorganization, operation of law, or otherwise. Should Assignee be a business or entity with whom STATE is prohibited from conducting business, STATE shall have the right to terminate in accordance with the Termination for Cause section of this Contract.

CONTRACTOR may enter subcontracts provided that any subcontract acknowledges the binding nature of this Contract and incorporates this Contract, including any attachments. CONTRACTOR is solely responsible for the performance of any subcontractor with whom CONTRACTOR contracts. CONTRACTOR does not have authority to contract for or incur obligations on behalf of STATE.

17. SPOLIATION – PRESERVATION OF EVIDENCE

CONTRACTOR shall promptly notify STATE of all potential claims that arise or result from this Contract. CONTRACTOR shall also take all reasonable steps to preserve all physical evidence and information that may be relevant to the circumstances surrounding a potential claim, while maintaining public safety, and grants to STATE the opportunity to review and inspect such evidence, including the scene of an accident.

18. MERGER AND MODIFICATION, CONFLICT IN DOCUMENTS

This Contract, including the following documents, constitutes the entire agreement between the Parties. There are no understandings, agreements, or representations, oral or written, not specified within this Contract. This Contract may not be modified, supplemented, or amended, in any manner, except by written agreement signed by both Parties.

Notwithstanding anything herein to the contrary, in the event of any inconsistency or conflict among the documents making up this Contract, the documents must control in this order of precedence:

a. The terms of this Contract, including any BAA and/or MOU (if applicable), as may be amended;

b. STATE's Request for Proposal ("RFP") number 192.03-04-24,

c. CONTRACTOR's proposal in response to RFP number 192.03-04-24.

d. All automated end-user agreements (e.g., click-through, shrink-wrap, or browse-wrap) are specifically excluded and null and void. Clicking shall not represent acknowledgement or agreement to any terms or conditions contained in those agreements.

19. SEVERABILITY

If any term of this Contract is declared to be illegal or unenforceable by a court having competent jurisdiction, the validity of the remaining terms is unaffected and, if possible, the rights and obligations of the Parties are to be construed and enforced as if this Contract did not contain that term.

20. APPLICABLE LAW AND VENUE

This Contract is governed by and construed in accordance with the laws of the State of North Dakota. Any action to enforce this Contract must be adjudicated exclusively in the state District Court of Burleigh County, North Dakota. Each Party consents to the exclusive jurisdiction of such court and waives any claim of lack of jurisdiction or *forum non conveniens*.

21. ALTERNATIVE DISPUTE RESOLUTION – JURY TRIAL

By entering this Contract, STATE does not agree to binding arbitration, mediation, or any other form of mandatory Alternative Dispute Resolution. The Parties may enforce the rights and remedies in judicial proceedings. STATE does not waive any right to a jury trial.

22. ATTORNEY FEES

In the event a lawsuit is instituted by STATE to obtain performance due under this Contract, and STATE is the prevailing Party, CONTRACTOR shall, except when prohibited by N.D.C.C. § 28-26-04, pay STATE's reasonable attorney fees and costs in connection with the lawsuit.

23. NONDISCRIMINATION AND COMPLIANCE WITH LAWS

CONTRACTOR agrees to comply with all applicable federal and state laws, rules, and policies, including those relating to nondiscrimination, accessibility and civil rights. (*See* N.D.C.C. Title 34 – Labor and Employment, specifically N.D.C.C. ch. 34-06.1 Equal Pay for Men and Women.)

CONTRACTOR agrees to timely file all required reports, make required payroll deductions, and timely pay all taxes and premiums owed, including sales and use taxes, unemployment compensation and workers' compensation premiums.

CONTRACTOR shall have and keep current all licenses and permits required by law during the Term of this Contract all licenses and permits required by law.

CONTRACTOR's failure to comply with this section may be deemed a material breach by CONTRACTOR entitling STATE to terminate in accordance with the Termination for Cause section of this Contract.

CONTRATOR is prohibited from boycotting Israel for the duration of this Contract. (See N.D.C.C § 54-44.4-15.) CONTRACTOR represents that it does not and will not engage in a boycotting Israel during the term of this Contract. If STATE receives evidence that CONTRACTOR boycotts Israel, STATE shall determine whether the company boycotts Israel. The foregoing does not apply to contracts with a total value of less than $100,000 or if CONTRACTOR has fewer than ten full-time employees.

24. STATE AUDIT

Pursuant to N.D.C.C. § 54-10-19, all records, regardless of physical form, and the accounting practices and procedures of CONTRACTOR relevant to this Contract are subject to examination by the North Dakota State Auditor, the Auditor's designee, or Federal auditors, if required. CONTRACTOR shall maintain these records for at least three (3) years following completion of this Contract and be able to provide them upon reasonable notice. STATE, State Auditor, or Auditor's designee shall provide reasonable notice to CONTRACTOR prior to conducting examination.

25. COUNTERPARTS

This Contract may be executed in multiple, identical counterparts, each of which is to be deemed an original, and all of which taken together shall constitute one and the same contract.

26. EFFECTIVENESS OF CONTRACT

This Contract is not effective until fully executed by both Parties. If no start date is specified in the Term of Contract, the most recent date of the signatures of the Parties shall be deemed the Effective Date.

CONTRACTOR	STATE OF NORTH DAKOTA
Application Software, Inc. dba ASIFlex	Acting through its **NDPERS**
BY:	BY:
Ashlee Sorber	Rebecca Fricke
Vice President & General Counsel	NDPERS Executive Director
Date: August 6, 2024	Date:

Business Associate Agreement

This Business Associate Agreement, which is an addendum to the underlying contract, is entered into by and between, the North Dakota Public Employees Retirement System ("NDPERS") and the Application Software, Inc., a Missouri corporation doing business as ASIFlex, located at 201 W. Broadway, #4-C, Columbia, Missouri 65203.

1. Definitions

a. Terms used, but not otherwise defined, in this Agreement have the same meaning as those terms in the HIPAA Privacy Rule, 45 C.F.R. Part 160 and Part 164, Subparts A and E, and the HIPAA Security rule, 45 C.F.R., pt. 164, subpart C.

b. Business Associate. "Business Associate" means the Application Software, Inc.

c. Covered Entity. "Covered Entity" means the **North Dakota Public Employees Retirement System Health Plans**.

d. PHI and ePHI. "PHI" means Protected Health Information; "ePHI" means Electronic Protected Health Information.

2. Obligations of Business Associate.

2.1. The Business Associate agrees:

a. To use or disclose PHI and ePHI only as permitted or required by this Agreement or as Required by Law.

b. To use appropriate safeguards and security measures to prevent use or disclosure of the PHI and ePHI other than as provided for by this Agreement, and to comply with all security requirements of the HIPAA Security rule.

c. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains or transmits on behalf of the Covered Entity as required by the HIPAA Security rule.

d. To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI or ePHI by Business Associate in violation of the requirements of this Agreement.

e. To report to Covered Entity (1) any use or disclosure of the PHI not provided for by this Agreement, and (2) any "security incident" as defined in 45 C.F.R. § 164.304 involving ePHI, of which it becomes aware without unreasonable delay and in any case within thirty (30) days from the date after discovery and provide the Covered Entity with a written notification that complies with 45 C.F.R. § 164.410 which shall include the following information:

i. to the extent possible, the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired or disclosed during the breach;

ii. a brief description of what happened;

iii. the date of discovery of the breach and date of the breach;
iv. the nature of the Protected Health Information that was involved;
v. identity of any person who received the non-permitted Protected Health Information;
vi. any steps individuals should take to protect themselves from potential harm resulting from the breach;
vii. a brief description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and
viii. any other available information that the Covered Entity is required to include in notification to an individual under 45 C.F.R. § 164.404(c) at the time of the notification to the State required by this subsection or promptly thereafter as information becomes available.

f. With respect to any use or disclosure of Unsecured Protected Health Information not permitted by the Privacy Rule that is caused by the Business Associate's failure to comply with one or more of its obligations under this Agreement, the Business Associate agrees to pay its reasonable share of cost-based fees associated with activities the Covered Entity must undertake to meet its notification obligations under the HIPAA Rules and any other security breach notification laws;
g. Ensure that any agent or subcontractor that creates, receives, maintains, or transmits electronic PHI on behalf of the Business Associate agree to comply with the same restrictions and conditions that apply through this Agreement to the Business Associate.
h. To make available to the Secretary of Health and Human Services the Business Associate's internal practices, books, and records, including policies and procedures relating to the use and disclosure of PHI and ePHI received from, or created or received by Business Associate on behalf of Covered Entity, for the purpose of determining the Covered Entity's compliance with the HIPAA Privacy Rule, subject to any applicable legal privileges.
i. To document the disclosure of PHI related to any disclosure of PHI as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
j. To provide to Covered Entity within 15 days of a written notice from Covered Entity, information necessary to permit the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
k. To provide, within 10 days of receiving a written request, information necessary for the Covered Entity to respond to an Individual's request for access to PHI about himself or herself, in the event that PHI in the Business Associate's possession constitutes a Designated Record Set.
l. Make amendments(s) to PHI in a designated record set as directed or agreed by the Covered Entity pursuant to 45 C.F.R. § 164.526 or take other measures as necessary to satisfy the covered entity's obligations under that section of law.

3. Permitted Uses and Disclosures by Business Associate

3.1. General Use and Disclosure Provisions

Except as otherwise limited in this Agreement, Business Associate may Use or Disclose PHI and ePHI to perform functions, activities, or services for, or on behalf of, Covered Entity, specifically, insurance membership data to conduct RFP vendor searches – provided that such use or disclosure would not violate the Privacy Rule or the Security Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

3.2. Specific Use and Disclosure Provisions

Except as otherwise limited in this Agreement, Business Associate may use PHI and ePHI:

a. For the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
b. To provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B), but Business Associate may not disclose the PHI or ePHI of the Covered Entity to any other client of the Business Associate without the written authorization of the covered entity Covered Entity.
c. To report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §§ 164.304 and 164.502(j)(1).

4. Obligations of Covered Entity

4.1. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

Covered Entity shall notify Business Associate of:

a. Any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that any such limitation may affect Business Associate's use or disclosure of PHI.
b. Any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that any such changes may affect Business Associate's use or disclosure of PHI.
c. Any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that any such restriction may affect Business Associate’s use or disclosure of PHI.

4.2. Additional Obligations of Covered Entity.

Covered Entity agrees that it:

a. Has included, and will include, in the Covered Entity’s Notice of Privacy Practices required by the Privacy Rule that the Covered Entity may disclose PHI

for Health Care Operations purposes.

b. Has obtained, and will obtain, from Individuals any consents, authorizations and other permissions necessary or required by laws applicable to the Covered Entity for Business Associate and the Covered Entity to fulfill their obligations under the Underlying Agreement and this Agreement.
c. Will promptly notify Business Associate in writing of any restrictions on the Use and Disclosure of PHI about Individuals that the Covered Entity has agreed to that may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Agreement.
d. Will promptly notify Business Associate in writing of any change in, or revocation of, permission by an Individual to Use or Disclose PHI, if the change or revocation may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Agreement.

4.3. Permissible Requests by Covered Entity

Covered Entity may not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule or the Security Rule if done by Covered Entity, except that the Business Associate may use or disclose PHI and ePHI for management and administrative activities of Business Associate.

5. Term and Termination

a. Term. The Term of this Agreement shall be effective as of 01/01/2025, and shall terminate when all of the PHI and ePHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI and ePHI, protections are extended to any such information, in accordance with the termination provisions in this Section.
b. Automatic Termination. This Agreement will automatically terminate upon the termination or expiration of the Underlying Agreement.
c. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
    1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the Underlying Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
    2. Immediately terminate this Agreement and the Underlying Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
    3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.
d. Effect of Termination.
    1. Except as provided in paragraph (2) of this subsection, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI and ePHI that is in the possession of subcontractors or

agents of Business Associate. Business Associate shall retain no copies of the PHI or ePHI.

2. In the event that Business Associate determines that returning or destroying the PHI or ePHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon explicit written agreement of Covered Entity that return or destruction of PHI or ePHI is not feasible, Business Associate shall extend the protections of this Agreement to that PHI and ePHI and limit further uses and disclosures of any such PHI and ePHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains that PHI or ePHI.

6. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the HIPAA Privacy or Security Rule means the section as in effect or as amended.
b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule, the Security Rule, and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
c. Survival. The respective rights and obligations of Business Associate under Section 5.c, related to "Effect of Termination," of this Agreement shall survive the termination of this Agreement.
d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy and Security Rules.
e. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything this Agreement confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
f. Applicable Law and Venue. This Business Associate Agreement is governed by and construed in accordance with the laws of the State of North Dakota. Any action commenced to enforce this Contract must be brought in the District Court of Burleigh County, North Dakota.
g. Business Associate agrees to comply with all the requirements imposed on a business associate under Title XIII of the American Recovery and Reinvestment Act of 2009, the Health Information Technology for Economic and Clinical Health (HI-TECH) Act, and, at the request of NDPERS, to agree to any reasonable modification of this agreement required to conform the agreement to any Model Business Associate Agreement published by the Department of Health and Human Services.

7. Entire Agreement

This Agreement contains all of the agreements and understandings between the parties with respect to the subject matter of this Agreement. No agreement or other understanding in any way modifying the terms of this Agreement will be binding unless made in writing as a modification or amendment to this Agreement and executed by both parties.

IN WITNESS OF THIS, **NDPERS** [CE] and **APPLICATION SOFTWARE, INC.** [BA] agree to and intend to be legally bound by all terms and conditions set forth above and hereby execute this Agreement as of the effective date set forth above.

For Covered Entity:	For Business Associate:
_____	_____
Executive Director Signature ND Public Employees Retirement System	Ashlee Sorber Vice President & General Counsel
_____	August 6, 2024
Date	Date

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: August 20, 2024

SUBJECT: **FlexComp Voluntary Insurance Products**

We have conducted our annual review of the vendors for the voluntary insurance products approved for pretax premiums under our Section 125 FlexComp Plan. We sent all current vendors a request to confirm the products they offer, provide a brief product description, and verify whether it is eligible to be a pretax product. Following is a list of the respondents:

AFLAC
Central United
Colonial Life
Total Dental Administrators (TDA)
USABLE

All of the vendors have responded and confirmed the ongoing eligibility of their products for pretax treatment under our FlexComp Plan. The attached outlines the vendor products available for payroll deduction, a brief description of the product, and certification by the vendor regarding which products are or are not eligible to be pre-taxed. No new products are being proposed by any of the participating companies.

Staff recommends that the vendors and their eligible products be approved for inclusion as pretax benefits under the FlexComp Plan for the 2025 plan year.

Board Action Requested

Approve the inclusion of the products eligible to be pre-taxed for the FlexComp Plan for the 2025 plan year.

Attachment

AFLAC Product Name	Company Representative – Lynn Brokaw 925 Basin Ave Ste 1 Bismarck, ND 58504 701-208-0617 E-Mail: lynn_brokaw@us.aflac.com Product Description	Pretax Eligibility
Cancer	Cancer indemnity policies providing benefits for diagnosis of skin cancer, internal cancer as well as annual screening benefits.	Yes
Hospital Confinement	Indemnity benefits whether hospitalized days or weeks.	Yes
Hospital Intensive Care	Provides coverage in the event of a sickness or injury and is admitted to the ICU unit.	Yes
Accident	Accident indemnity policies providing benefits for accident/injury.	Yes
Lump Sum Critical Illness	Pays a lump sum benefit for code red major critical illness event. (Heart attack, stroke, coma, paralysis, major organ transplant, end stage renal failure. Riders available for cancer, sudden cardiac death.)	Yes
Personal Sickness Indemnity	Indemnity policy for sickness related hospital confinement, major diagnostic exams, in & out-patient surgeries.	No
Specified Health Event	Critical care, recovery indemnity policies for major critical illness.	Yes
Disability	All disability policies that are specific replacement of income benefits.	No
Dental	Voluntary dental. No networks, no deductibles, no pre-certifications.	No
Vision Now	Vision indemnity policy providing vision insurance, vision correction benefits.	No
Life	All life policies.	No

Lynn A Brokaw — Signature

July 23, 2024 — Date

Central United Product Name	Company Representative – James M Kasper C/O Asset Management Group Inc. PO Box 9016 Fargo ND 58103--9016 701-232-6250 E-Mail: jmkasper@amg-nd.com Product Description	Pretax Eligibility
Cancer Insurance	Provides cash benefits to covered persons for treatment of cancer.	Yes

James M Kasper

Signature

7/12/2024

Date

Everything is Correct

Jim Kasper

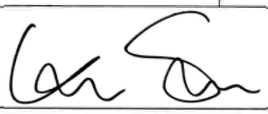
Colonial Life Product Name	Company Representative – John Guzman Famer's Union Insurance 4141 38th St S Ste C Fargo ND 58104 E-Mail: john.guzman@fumic.com Product Description	Pretax Eligibility
Accident	Composite rated, guaranteed renewable accident product with choice of plan levels and optional riders. It provides indemnity benefits for on and off the job accidents.	Yes
Cancer	Composite rated, guaranteed renewable specified disease product with choice of plan levels and optional riders. Provides benefits for expenses related to cancer.	Yes
Disability	Age banded, guaranteed renewable short-term disability income product.	No
Medical Bridge	Age banded, guaranteed renewable hospital confinement indemnity product. Choice of plans, levels. Includes confinement, rehab unit, surgical and diagnostic procedures.	Yes
Critical Illness	Specified disease product with a lump sum benefit upon diagnosis of a covered specified disease with a choice of plan options for reoccurrence, cancer, face amounts, and optional riders.	No
Life	All life insurance policies.	No

Signature

7/22/24

Date

Total Dental Administrators Product Name	Company Representative – Logan Stucki 2800 N 44th Street Ste 500 Phoenix AZ 85008 801-268-9740 Ext 306 E-Mail: lstucki@emihealth.com Product Description	Pretax Eligibility
Elite Choice	Fully insured dental program.	Yes



07.12.2024

Signature

Date

USABLE Product Name	Company Representative – Matthew Sullivan Azurance Group 4510 13 Ave S Fargo ND 58121 701-277-2319 E-Mail: Matthew.Sullivan@AzuranceGroup.net Product Description	Pretax Eligibility
Accident Elite	Employees can get help prevent financial hardship due to medical/travel expenses caused from an accident. Payments direct to employee.	Yes
Cancer Care Elite	Payments direct to employee for new and experimental treatment, travel, lodging, out of pocket medical costs, deductibles, co-pay amounts.	Yes
Hospital Confinement Plan	Payment direct to employee for costs related to intensive care, hospitalization, birth of a child, accidents.	Yes

Signature

7/12/2024

Date

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
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Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: August 20, 2024

SUBJECT: Medicare Part D Renewal and Request for Proposal (RFP)

At the May Board meeting, the Board was provided a preliminary renewal projection (Attachment 1) for the Medicare Part D Plan from Humana for the 2025 Plan Year. The current premium is $64.72 per member per month (PMPM). The premium projection supplied by Humana was an increase in premium to $77.38 PMPM. You may recall that the majority of the projected increase was due to the requirements of the Inflation Reduction Act (Attachment 2) and are provisions that all Medicare Part D plans must provide. Staff recommended and the Board approved deferring a decision on whether to bid the Medicare Part D Plan in order to consider the final renewal premium offered by Humana in August.

Humana has submitted its final renewal premium which is included as Attachment 3. The renewal premium for a similar plan design (Attachment 4), including the enhanced member benefits required under the Inflation Reduction Act for 2025, is $60.74 PMPM, which is a $3.98 PMPM **decrease**. Humana has indicated this decrease is due to the benchmarks that were released by the Center for Medicare and Medicaid Services (CMS) for 2025 and were favorable when applied to the NDPERS plan. Humana has also provided an updated list of Performance Guarantees (Attachment 5) for 2025.

Staff are satisfied with the services provided to our members by Humana, as well as, their responsiveness to staff when issues or questions arise. As reported at the April Board meeting, Humana met the Performance Guarantees requested of them by the Board for the 2023 Plan Year. Thus far for the 2024 Plan Year, Humana is on track to meet these guarantees.

A review of the renewal premium was requested of Deloitte Consulting. Deloitte Consulting has confirmed that the final renewal premium offered by Humana is reasonable based upon

expected trends and the 2025 CMS direct subsidy amounts that were released at the end of July.

If the Board opts not to renew with Humana, staff will need to issue a Request for Proposal (RFP) for the Medicare Part D Plan following the meeting. Attachment 6 is the current RFP that will be issued upon direction by the Board. The timeline for issuing this RFP is very tight as a vendor will need to be selected by October 1 in order for NDPERS to issue required notices and implement the possible vendor change.

As a reminder, the criteria that the Board needs to follow under NDCC 54-52.1-05 is:

54-52.1-05. Provisions of contract - Term of contract.

1. Each uniform group insurance contract entered by the board must be consistent with the provisions of this chapter, must be signed for the state of North Dakota by the chairman of the board, and must include the following:
   a. As many optional coverages as deemed feasible and advantageous by the board.
   b. A detailed statement of benefits offered, including maximum limitations and exclusions, and such other provisions as the board may deem necessary or desirable.
2. The initial term or the renewal term of a uniform group insurance contract through a contract for insurance, health maintenance organization, or self-insurance health plan for hospital benefits coverage, medical benefits coverage, or prescription drug benefits coverage may not exceed two years.
   a. The board may renew a contract subject to this subsection without soliciting a bid under section 54-52.1-04 if the board determines the carrier's performance under the existing contract meets the board's expectations, the proposed premium renewal amount does not exceed the board's expectations, and renewal best serves the interests of the state and the state's eligible employees.
   b. In making a determination under this subsection, the board shall:
      (1) Use the services of a consultant to concurrently and independently prepare a renewal estimate the board shall consider in determining the reasonableness of the proposed premium renewal amount.
      (2) Review the carrier's performance measures, including payment accuracy, claim processing time, member service center metrics, wellness or other special program participation levels, and any other measures the board determines relevant to making the determination and shall consider these measures in determining the board's satisfaction with the carrier's performance.
      (3) Consider any additional information the board determines relevant to making the determination.
   c. The board may determine the carrier's performance under the existing contract does not meet the board's expectations, the proposed premium renewal amount exceeds the board's expectations, or renewal does not best serve the interests of the state or the state's eligible employees and the board therefore may decide to solicit a bid under section 54-52.1-04.

Staff Recommendation

Staff would recommend renewing with Humana for the Medicare Part D Plan for the 2025 plan year. If renewed, approve the updated Performance Guarantees as provided by Humana and verified by staff.

Board Action Requested

Approve staff's recommendation to amend the current contract to continue with Humana as the Medicare Part D Plan vendor for the January 1, 2025 through December 31, 2025 contract period. If renewed, approve the updated Performance Guarantees provided by Humana for 2025.

If the Board does not wish to renew with Humana, staff request the Board's approval of the Medicare Part D Plan RFP so that we can seek another vendor.

Attachment 1

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: May 23, 2024

SUBJECT: Medicare Part D Plan 2025 Premium Projection

Per the terms of the contract with Humana for the Employer Group Waiver Plan (EGWP), referred to as the Medicare Part D product, we have received a preliminary projection for the 2025 premium.

Humana's preliminary projection for the 2025 premium is $77.38 per member, per month (PMPM). This is an increase of 19.56% over the current monthly premium of $64.72 per month. The information provided by Humana as part of their preliminary projection is provided in Attachment 1. Per Humana, the projection takes into account rating factors including; claims experience, Center for Medicare & Medicaid Services (CMS) reimbursements, pharmacy trends that include pipeline drugs, demographics, plan benefits, CMS mandates and regulatory changes. In addition, as discussed at the April meeting, there are significant changes being made to all Medicare Part D plans for the 2025 plan year due to the Inflation Reduction Act (IRA).

Humana has provided the following additional comments regarding this preliminary projection and will be available at the meeting to answer questions the Board may have:

- The IRA impact is $10.45 PMPM
    - Part D redesign under the IRA
        - The Part D benefit will be restructured to cap beneficiary out-of-pocket spending at $2,000 per plan year for covered Part D drugs. Beneficiaries will also have the option to "smooth" these costs across the plan year via the Medicare Prescription Payment Plan. (Noting that Humana will provide more details as information is available regarding the Medication Prescription Payment Plan for Maximum Out of Pocket, or MOOP, Smoothing).

    - Accumulation towards the $2,000 IRA MOOP is based on “incurred costs.” This is different than what the MOOP plans currently have which is based on the retiree’s out of pocket cost.
    - The current coverage gap will be eliminated.
    - A new shared liability is established in the catastrophic phase.
    - Plans will now be responsible for 60%, manufacturers for 20%, and the government for 20% brand and 40% generic.
    - Catastrophic phase: member cost share for Part D drugs is $0 (In 2024, cost sharing for Part D drugs was eliminated for beneficiaries in the catastrophic phase of coverage)
- Projected Primary Trend Increase Drivers
    - Eliquis & Ozempic utilization
    - IRA benefit enhancement
    - The plan is not responsible for Paxlovid in 2024 due to a government patient assistance program operated by Pfizer. Paxlovid is expected to return as a plan liability in 2025.
- Projected Member Cost Sharing is reducing due to enhanced benefits due to IRA (no coverage gap and mandatory $2000 MOOP)
- Projected CMS Federal Reinsurance is down as CMS’s liability reduces from 80% to 20% for brand and 40% for generic in 2025.
- Projected CMS Direct Subsidy is up significantly due to the increased National Average Bid driven by IRA.

Given we have a number of newer Board members, staff felt it would be helpful to share some recent history related to the Part D premiums. In 2021, the Board awarded the bid for the product and the plan was transitioned from Express Scripts Incorporated (ESI) to Humana for the 2022 plan year. The following table provides information on the premiums since that time:

Plan Year	Vendor	Premium PMPM	% Change
2021	ESI	$89.32	N/A
2022	Humana	$66.72	-25.3%
2023	Humana	$69.72	4.5%
2024	Humana	$64.72	-7.7%

Staff have asked Deloitte for analysis regarding the reasonableness of the preliminary projection and will have information at the meeting regarding their analysis for the Board’s consideration.

The normal process for renewal is that Humana will finalize the premium for the upcoming plan year after the Center for Medicaid and Medicare Services (CMS) releases the federal subsidy level for Part D plans. This occurs in late July each year. Humana then determines if they need to adjust premiums accordingly based on the subsidy amount and the experience of the plan. Per the terms of the contract, Humana must provide the final premium for the Board’s consideration by August 15 for consideration at the August Board meeting. Deloitte will again be utilized to analyze the reasonableness of the final premium.

At this time, staff would recommend that the Board defer a decision on whether to bid the Medicare Part D Plan in order to consider the final renewal premium offered by Humana in August. This recommendation is made due to:

- The overall ease of administration of the product for NDPERS processes
- The minimal disruption our members continue to experience with Humana
- The responsiveness of Humana when questions regarding NDPERS processes or members have been raised
- An understanding that a substantial amount ($10.45 of the $12.66 total) of the increase is due to the IRA and would likely be included in any vendor quote should the product be bid since any vendor bidding on the product would have to build in the same significant changes in the plan design.

Should the Board approve, staff will continue to review the information provided by Humana to confirm consistent plan design to the current plan year and will also work with Humana on 2025 Performance Guarantees. If staff have questions, we will work with Humana to have these resolved prior to the final decision by the Board in August.

If in August the final renewal premium exceeds the projected premium and is a rate that the Board does not wish to renew, then staff will have the final Medicare Part D RFP prepared for the August Board meeting so that it can be approved for immediate release.

If the Board does not agree to the staff recommendation, then staff provide Attachment 2 which is the Request for Proposal (RFP) for this product for the Board to approve so that the RFP can be released in June.

Board Action Requested:

Provide direction on whether to defer a bid for the Medicare Part D Plan until after Humana provides their final renewal premium in August 2024.

Attachment 2

Inflation Reduction Act: What you need to know

Overview:

As described below, the Inflation Reduction Act makes unprecedented changes to the Medicare Part D benefit between 2024 and 2026. Of greatest significance are the benefit changes taking effect on January 1, 2025, which include establishment of a $2,000 annual out-of-pocket cap on beneficiary spending on Part D covered drugs. These changes considerably increase the financial liability faced by Part D plan sponsors and employers offering Group Medicare plans. Both entities will face meaningful challenges over plan benefits and pricing in advance of CY 2025 with the potential for significant increases in plan-borne costs.

The Inflation Reduction Act affects 6 key areas:

- Inflationary Rebates for Parts B and D Drugs
- Vaccines
- Insulin
- Redesign of Part D Benefit
- Direct Negotiation
- Low-Income Subsidy (LIS) Program

I. Inflationary Rebates for Part B and D Drugs

- Beginning on 10/1/2022 for Part D and 1/1/2023 for Part B, the Act establishes an inflationary rebate requirement for drugs with price increases above inflation. For a current list of eligible Part B drugs click here.
- It also sets penalties remitted to the government for non-compliance.

II. Vaccines

- Starting January 1, 2023, Part D-covered adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including the shingles and Tetanus-Diphtheria-Whooping Cough vaccines, will be available with no deductible and no cost-sharing to people with Medicare prescription drug coverage.

III. Insulin

- Starting in 2023 the cost of covered insulin products shall be covered at $35 for a monthly supply.
- For 2026, cost-sharing in Part D shall be equal to the lesser of: 1) $35 or 2) 25% of the maximum fair price for a negotiated product or 3) 25% of the negotiated price.
- Also, a Part D deductible won't be applied to covered insulin products.

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Inflation Reduction Act: What you need to know

IV. Redesign of Part D Benefit

- Beginning in 2025, the Part D benefit will be restructured to cap beneficiary out-of-pocket spending at $2,000 per plan year for covered Part D drugs. Beneficiaries will also have the option to "smooth" these costs across the plan year via the Medicare Prescription Payment Plan.
- Accumulation towards the $2,000 IRA MOOP is based on "incurred costs." This is different than what the MOOP plans currently have which is based on the retiree's out of pocket cost.
- The current coverage gap will be eliminated.
- A new shared liability is established in the catastrophic phase.
    - Plans will now be responsible for 60%, manufacturers for 20%, and the government for 20% brand and 40% generic.
- In 2024, cost sharing for Part D drugs was eliminated for beneficiaries in the catastrophic phase of coverage (previously they paid 5%).

V. Direct Negotiation

- Starting in 2026, permits the Secretary of HHS to negotiate with manufacturers directly for brand-name drugs that lack price competition and for which 9 years has elapsed since the drug was first marketed for small molecule drugs and 13 years for biologicals.
- Insulin is no longer listed among the drugs required to be on the negotiation list.

VI. Low Income Subsidy (LIS) Program

- In 2024, the LIS program under Part D expanded so that beneficiaries who earn between 135% and 150% of the federal poverty level and meet statutory resource limit requirements will receive full LIS subsidies that were previously only available to beneficiaries earning less than 135% of the federal poverty level.
- These beneficiaries previously received partial LIS benefits, which subsidized some portion of the Part D premium and standard deductible, limited cost sharing to 15% coinsurance, and required modest co-payments for drugs above the catastrophic threshold.
- Those beneficiaries with full LIS benefits pay no premium or deductible and only modest co-payments for drugs until they reach the catastrophic threshold when cost sharing ends.

Humana®

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전 화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
یسراف(Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad ËNavajoЂ: W0dah7 b44sh bee hani'7 bee wolta'7g77 bich'9' h0d77lnih 47 bee t'11 jiik'eh saad bee 1k1'1n7da'1wo'd66 nik1'adoowo[.
ةيب رعلا(Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Attachment 3

Group Medicare Renewal - BAFO

August 15, 2024

Humana is pleased to deliver the 2025 Group Medicare Advantage Plan final renewal (BAFO) for North Dakota Public Employee Retirement system (NDPERS). Attached you will find the final 2025 rate, 2025 Performance Guarantee Agreement, and the pharmacy plan design for your review.

As far as the pharmacy component, the dollar limits have changed. These limits are set by CMS and are listed below for your reference.

As you review the final 2025 renewal, please let me know if you have any questions. If there are no questions, please provide the contract amendment for signature, and sign the included Performance Guarantee Agreement. We can then begin processing the renewal for 2025.

Thank you!

Stage	2024	2025
Deductible	$545	$590
Initial Coverage Limit (ICL)	$5,030	$2,000
Out-of-pocket threshold	$8,000	$2,000 (required by IRA)

Humana

Humana Medicare Group Plan – Premium Information

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM - PDP

BAFO

Date: 8/15/2024
Humana Medicare Group Plan
Plan Names: Custom PDP
Rx Formulary: Group Plus Formulary - 25800
Additional Medication Buy-Ups: Coughs and Colds, EDs Enhanced

Plan Year	Final Billed Premium (Per Member Per Month)
1/1/2025 - 12/31/2025	$60.74

PDP 037 161 Rx Benefit Overview

Prescription Drugs (Retail 30 day supply)	Custom PDP $5 copay plus 15% coinsurance/$15 copay plus 25% coinsurance/$25 copay plus 50% coinsurance/$25 copay plus 50% coinsurance from $0 to Catastrophic

See attached sheet for rating assumptions and stipulations. The benefits presented above are a high-level summary. Please consult the Plan Design Exhibit for a more detailed list of covered services, member cost shares, services subject to deductibles and any plan limitations.

Humana

HUMANA MEDICARE EMPLOYER PDP PLAN

2025 PDP for North Dakota Public Employees Retirement System (NDPERS) Plan 037 Option 161
Group Plus Formulary - PDG 50
With Package(s): 2 (Cough/Cold), 7 (Erectile Dysfunction)
Effective Date: 01/01/2025 - 12/31/2025

30 day Supplies

PDP Option Number	30 day Standard Retail from $0 to Catastrophic (1)				30 day Standard Retail from Catastrophic to Unlimited	MOOP (2)
	Tier 1*	Tier 2	Tier 3	Tier 4		
PDP 157	$5 copayment; 15% coinsurance of remaining cost share	$15 copayment; 25% coinsurance of remaining cost share	$25 copayment; 50% coinsurance of remaining cost share	$25 copayment; 50% coinsurance of remaining cost share	$0 copay	$2,000

PDP Option Number	30 day Standard Mail Order from $0 to Catastrophic (1)				30 day Standard Mail Order from Catastrophic to Unlimited	MOOP (2)
	Tier 1*	Tier 2	Tier 3	Tier 4		
PDP 157	$5 copayment; 15% coinsurance of remaining cost share	$15 copayment; 25% coinsurance of remaining cost share	$25 copayment; 50% coinsurance of remaining cost share	$25 copayment; 50% coinsurance of remaining cost share	$0 copay	$2,000

Note: Part D vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) for adults may be available at no cost.
Note: Plan covered insulin products will not exceed $35 for a one-month supply no matter what cost-sharing tier it's on.

*Tier 1: Generic or Preferred Generic - Generic or brand drugs that are available at the lowest cost share for this plan.
Tier 2: Preferred Brand - Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug.
Tier 3: Non-Preferred Drug - Generic or brand drugs that Humana offers at a higher cost than Tier 2 Preferred Brand drugs.
Tier 4: Specialty Tier - Some injectables and other higher-cost drugs.

90 day Supplies

PDP Option Number	90 day Standard Retail (3) from $0 to Catastrophic (1)				90 day Standard Retail (3) from Catastrophic to Unlimited	MOOP (2)
	Tier 1*	Tier 2	Tier 3	Tier 4		
PDP 157	$5 copayment; 15% coinsurance of remaining cost share	$15 copayment; 25% coinsurance of remaining cost share	$25 copayment; 50% coinsurance of remainnig cost share	N/A	$0 copay	$2,000

PDP Option Number	90 day Standard Mail Order (3) from $0 to Catastrophic (1)				90 day Standard Mail Order (3) from Catastrophic to Unlimited	MOOP (2)
	Tier 1*	Tier 2	Tier 3	Tier 4		
PDP 157	$5 copayment; 15% coinsurance of remaining cost share	$15 copayment; 25% coinsurance of remaining cost share	$25 copayment; 50% coinsurance of remaining cost share	N/A	$0 copay	$2,000

Note: Part D vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) for adults may be available at no cost.

Footnotes

1 Catastrophic: When a member's Maximum Out-of-Pocket (MOOP) cost reaches $2,000.
2 Plan MOOP (Maximum Out-of-Pocket): After a member's Plan Maximum Out-of-Pocket cost reaches $0 Humana pays 100%.
3 Retail and Mail Order: The benefit for a 90-day supply is limited to Rx formulary Tiers 1-2 and most drugs on Tier 3. Regardless of tier placement, Specialty drugs are limited to a 30-day supply.

Out of Network: Emergency Situations

When a member purchases a drug at an out-of-network pharmacy in an emergency situation:
a. the member will pay the same coinsurance as would have applied at a network pharmacy, but at the out-of-network pharmacy price, and/or,
b. the member will pay the same copayment as would have applied at a network pharmacy, plus the difference between the out-of-network pharmacy price and the network pharmacy price.

Humana's Group Medicare Performance Guarantee Agreement

North Dakota Public Employees Retirement Systems

2025 Group Medicare Performance Standards for PDP Only

Effective January 1, 2025 through December 31, 2025

Minimum Annual Average Membership Requirement: None

PG#	Category	Target	Standard & Measurement Criteria	Amount at Risk
1	**Plan Performance Review**	Measurement methodology shall be measured from date of delivery of the plan performance review in calendar days	Within ten (10) calendar days following delivery of performance reviews to NDPERS, vendor shall develop and submit a corrective action plan (CAP) of issues identified for approval by NDPERS, and implement such plan within the time prescribed in the approved CAP.	**Semi- annually** **$1,000 per calendar day beyond the due date**
2.1	**Customer Satisfaction Surveys**	Vendor will provide annual survey results to confirm compliance with performance standard	Member satisfaction surveys will be designed by the vendor and approved by NDPERS. Vendor will invite a random sample of members to participate in the survey to collect a statistically significant number of completed surveys. Member satisfaction rate will meet 90% or higher using a 1-5 scale of Completely Satisfied, Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied. Final survey questions and methodology will be agreed upon by vendor and NDPERS.	**Annually** **$25,000 per year**
2.2	**Customer Satisfaction Surveys - Illustrative Only**	Illustrative Group Specific Results Only - see 2.1	Illustrative Group Specific Results Only - see 2.1	**Illustrative Group Specific Results Only - see 2.1**
3	**Team Meetings**	Compliance to be monitored and assessed by NDPERS	NDPERS requires monthly team meetings to address all planning / implementation, business, financial, clinical / formulary (including new drug review) and operational needs	**Monthly** **$5,000 for each meeting missed**
4	**NDPERS board meetings**	Compliance to be monitored and assessed by NDPERS	Vendor will participate in quarterly performance reviews to examine operational and financial performance	**Quarterly** **$5,000 for each quarter missed**
5	**Electronic Eligibility**	Vendor will provide quarterly reports to confirm compliance with performance standard	Eligibility files will be installed in an electronic medium, logged within eight (8) hours and status will be effective within vendor's system within eighteen (18) hours from date of receipt, seven (7) days per week.	**Quarterly** **$500 for each missed file deadline**
6	**Manual Eligibility**	Vendor will provide quarterly reports to confirm compliance with performance standard	Manual eligibility will be loaded within eight (8) hours upon receipt or notification and must be applied and active in the vendor's system within one (1) business day.	**Quarterly** **$500 for each missed file deadline**
7	**Error Reports**	Vendor will provide quarterly reports to confirm compliance with performance standard	An error report on all eligibility file updates will be produced within eighteen (18) hours from the update.	**Quarterly** **$500 for each missed file deadline**
8	**Data Files**	Will be available to NDPERS on request	Monthly data files (membership, medical, pharmacy) will be available by the 15th of the following month.	**Monthly** **$1,000 for each month not met**
9	**Claims Financial Accuracy**	Claims Financial Accuracy will be 99% or greater, each year of the biennium. Measured as the absolute value of financial errors divided by the total paid value of audited dollars paid based on quarterly internal audit of statistically valid sample.	Vendor will provide annual reports to confirm compliance with performance standard	**Annually** **$12,500 per year**
10	**Claims Payment Accuracy**	Vendor will provide annual reports to confirm compliance with performance standard	Claims Payment incidence Accuracy will be 98% or greater, each year of the biennium. Measured as the percent of Claims processed without financial payment error.	**Annually** **$12,500 per year**

Humana's Group Medicare Performance Guarantee Agreement

North Dakota Public Employees Retirement Systems

2025 Group Medicare Performance Standards for PDP Only

Effective January 1, 2025 through December 31, 2025

Minimum Annual Average Membership Requirement: None

PG#	Category	Target	Standard & Measurement Criteria	Amount at Risk
11	**Claims Processing Accuracy**	Claims Procedural Accuracy will be 95% or greater, each year of the biennium. Measured as the percent of Claims processed without non-financial error.	Vendor will provide annual reports to confirm compliance with performance standard	**Annually** **$12,500 per year**
12	**Claim Timeliness**	Clean claims processing within 14 calendar days will be 95% or greater, each year of the biennium. Measured from the date the claim is received to the date claim is processed	Vendor will provide annual reports to confirm compliance with performance standard	**Annually** **$12,500 per year**
13	**Average Speed to Answer (ASA)**	Vendor will provide semi-annual reports to confirm compliance with performance standard	Average Speed of Answer will be 30 seconds or less, each year of the biennium. Vendor will have an established measurement process that shall be reviewed with NDPERS	**Semi-annually** **$10,000 per year**
14	**Call Abandonment**	Vendor will provide annual reports to confirm compliance with performance standard	Call Abandonment rate will be 5% or less, each year of the biennium	**Annually** **$10,000 per year**
15 a	**Accuracy and Timelines/**	Vendor must evaluate a statistically valid sample of inquiries with reports provided.	a.) 95% percent of callers receive accurate information. Calls requiring additional research is excluded from the computation of this metric.	**15a, 15b, and 15c** **Annually** **$12,500 per year**
15 b	**First Call Resolution**	Vendor must evaluate a statistically valid sample of inquiries with reports provided.	b.) 95% percent of inquiries must be resolved during the initial call (excluding appeals, billing, errors and escalations).	**15a, 15b, and 15c** **Annually** **$12,500 per year**
15 c	**Written Inquiry Response Time**	Vendor must evaluate a statistically valid sample of inquiries with reports provided.	c.) ≥ 90% response to written inquiries within 30 calendar days	**15a, 15b, and 15c** **Annually** **$12,500 per year**
16	**Prescription drug turnaround time – clean prescriptions**	Vendor will provide quarterly reports to confirm compliance with performance standard	98% within two (2) business days if no intervention required	**Quarterly** **$1,000 for each point below standard-**
17	**Prescription drug mail dispensing accuracy**	Vendor will provide annual reports to confirm compliance with performance standard	99.9% Mail service dispensing accuracy rate. Fields measured include member name, drug strength, directions, quantity and prescriber name.	**Annually** **$12,500 per year**
18	**Prescription drug home delivery member notifications**	Vendor will provide annual reports to confirm compliance with performance standard	Vendor is required to notify a member when a mail service prescription is changed or there is any expected shipping delay and provide reporting details to NDPERS capturing all occurrences by member/DOS/Issue	**Annually** **$12,500 per year**

Humana's Group Medicare Performance Guarantee Agreement

North Dakota Public Employees Retirement Systems

2025 Group Medicare Performance Standards for PDP Only

Effective January 1, 2025 through December 31, 2025

Minimum Annual Average Membership Requirement: None

PG#	Category	Target	Standard & Measurement Criteria	Amount at Risk
19	**Prescription drug specialty pharmacy delivery**	Vendor will provide annual reports to confirm compliance with performance standard	98% of prescriptions will be delivered and received by patients on the specified date of delivery	**Annually** **$12,500 per year**
20	**Network Pharmacy Access**	Vendor will provide annual reports to confirm compliance with performance standard	Pharmacy network composition will not be reduced by more than 5% in North Dakota compared to the network submitted in the RFP	**Annually** **$12,500 per year**
21	**Data Systems Availability and Adjudication**	Book of business level	Guarantees an annual average 99% system availability of the point-of-sale adjudication system on a book of business basis. This standard excludes downtime attributed to regularly scheduled systems maintenance or systems downtime	**Annually** **$12,500 per year**

Humana agrees to meet the performance standards as outlined above in providing administrative services for North Dakota Public Employees Retirement Systems. This agreement is contingent upon Humana being the only Part D Prescription Drug option for Medicare eligible retirees. The agreement will be for the contract period beginning January 1, 2025. This Performance Guarantee offering is based on a PDP Only plan offering. Performance results will be reported quarterly based upon center results for the member and claims services categories, not client specific results (except where otherwise stated) within 60 days after the end of the reporting period. Results will be assessed based on the annual results with payment of any penalties due following the end of the plan year. Please note that the performance standards are influenced by key market indicators (including changes in rules and standards from CMS) which could impact our performance standard metrics.

During implementation if significant changes to the Client's Plan, or in the event a benefit change notification is not received from the Client on a timely basis, Humana will not be responsible for performance results or penalty amounts as described within this Agreement.

ACCEPTED AND AGREED:

By: _____ Date: _____

In order for this contract to be binding, signatures are required from the client. This signed exhibit must be returned to the Humana Account Executive prior to implementation and no later than 30 days post effective date.

Attachment 6

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

Request for Proposal

Fully Insured and Self-Insured Medicare Part D Employer Group Waiver Plan (EGWP) + Wrap

Release Date: August 21, 2024
Due Date: September 11, 2024
Effective Date: January 1, 2025

Contents

**Password to access protected files may be requested from the RFP Coordinator via email*

I. Proposed Timetable

The timeline is provided below for informational purposes. NDPERS reserves the right to change the dates. Every effort will be made to notify Vendors of changes to the proposed timeline. Proposed 2024 schedule:

Activity	Date/Time
RFP Published	August 21, 2024
Questions Due	August 28, 2024
Question Answers Posted	September 4, 2024
Proposals Due	September 11, 2024
NDPERS Staff Interviews	September 2024
NDPERS Board Presentations, if deemed necessary by the NDPERS Board	September 2024
Selection of Vendor	September 2024
Contract Effective Date	January 1, 2025

II. Delivery of Proposals

Instructions

All proposals should be submitted simply and economically providing a direct, concise delineation of the vendor's proposal and qualifications adhering to the proposal format guidelines outlined below.

- Proposals should be typed or printed on 8.5" x 11" paper.
- All proposals must include the transmittal letter/statement which includes the following:
    - An acknowledgment of receipt of the EGWP Drug Plan RFP specifications.
    - This letter must include the title and signature of a Duly Authorized Officer of the company.
- All proposals must include a table of contents and appropriate page number references.
- All pages of proposals must have consecutive page numbers.
- Responses to questions must include a restatement of the question (number and text) with the response immediately following.
- Appendices and other supplemental information provided with your proposal must be clearly identified.
- Cost proposal must be submitted in a **separate, sealed envelope, and clearly marked**, "Cost Proposal". Cost Proposal Exhibits will be all-inclusive.
- NDPERS will not be billed any additional amounts for services, including commissions or brokerage fees.
- North Dakota insurance law 54-52.1-10 (Exemption From State Premium Tax) provides that "All premiums, consideration for annuities, policy fees, and membership fees collected under this chapter are exempt from the tax payable pursuant to section 26.1-03-17". Thus, Offeror's responses should not reflect any amounts for premium taxes.
- Any and all deviations must be clearly noted and submitted as defined in this RFP. If you do not identify and explain deviations, your proposal will be deemed a certification that you will comply in every respect with the requirements and contractual language set forth in this RFP.

Proposal Format and Contact Information

From the date of issuance until the announcement of the finalist, Vendors should only contact the Deloitte RFP coordinators. All correspondence and questions must be submitted in writing via e-mail to Deloitte Consulting in accordance with the timeline set forth in this RFP. NDPERS personnel are not authorized to discuss this RFP with a vendor; doing so may result in disqualification. Vendors may continue to communicate with NDPERS staff regarding other relevant business matters.

Proposals should be submitted in two parts, with the cost proposal separate from the qualitative proposal (qualitative to NDPERS, complete proposals to Deloitte Consulting, see below). Late proposals will not be considered unless approved by the NDPERS Board. Proposals will be sent to two parties, as described below:

- Qualitative proposals should include:
    - Appendix A
    - Appendix B
    - Appendix D
    - Appendix E
    - Appendix F
    - Appendix G
    - Appendix H
    - Appendix I

- Cost proposal should include Appendix C and any other documentation supporting your bid financials and cost proposal deviations.

Vendors are required to submit one (1) unbound original and six (6) paper copies of the *qualitative proposals* along with one (1) electronic copy (USB flash drive) as well as one (1) electronic, editable, PDF redacted copy of the qualitative proposal on a separate flash drive (note that the electronic redacted copy may not be a picture) to:

Katheryne Korom
North Dakota PERS
1600 East Century Avenue, Suite 2
PO Box 1657
Bismarck, ND 58502

A full electronic copy of the *qualitative proposal*, *cost proposal*, and *deviations* must be emailed to Deloitte Consulting. All appendices provided in Microsoft Word or Excel with the RFP must be provided along with your proposal in Word or Excel.

PLEASE NOTE: Cost proposals should only be submitted to Deloitte Consulting. Cost proposals should follow the Confidential/Proprietary Information instructions in Appendix H. Any provisions of the Vendor's proposal that are desired to be confidential must be identified specifically on each page of the proposal and included in the table provided in Appendix H.

Ford Edgerton
Deloitte Consulting
fedgerton@deloitte.com

&

Karno Sarkar
Deloitte Consulting
karsarkar@deloitte.com

III. Objective of RFP

North Dakota Public Employees Retirement System – Strategic Objectives

The North Dakota Public Employees Retirement System (NDPERS) covers approximately 60,000 lives including 9,100 members that participate in the Medicare Part D EGWP+Wrap plan. NDPERS has retained Deloitte Consulting LLP ("Deloitte Consulting") to assist with the RFP process. NDPERS is issuing this RFP with the intention of finding a PBM partner that:

- Provides exceptional service, from both a member's and NDPERS' experience
- Adheres to Centers for Medicare & Medicaid Services (CMS) regulations for the administration of EGWP products
- Manages pharmacy costs for members and NDPERS
- Champions transparency (and other innovations) in contracting
- Brings innovation to the PBM services provided by NDPERS
- Seamlessly integrates with NDPERS medical plans and analytical partners
- Complies with North Dakota Century Code 54-52.1 and other applicable state laws

Partnership Considerations

Our goal is to select a partner that will provide the highest quality service at the most competitive price while offering industry-leading compliance controls, data security protection, and financial disclosures.

- Administration of CMS required operations, subsidies, compliance, and reporting
- Competitive fully-insured or self-insured pricing
- Pharmacy claims processing and plan administration
- Network Management
- Formulary Management
- Customer Service excellence
- Clinical programs development and administration that focus on specialty drugs and chronic conditions
- Reporting and data analytics capabilities
- Administration of late enrollment penalties (LEP) and low-income premium subsidies (LIPS)

This request for proposal is intended to provide NDPERS with the necessary information to assess your capabilities and strategic fit. To the extent that you see opportunities to add value that we have not explicitly identified in the RFP, please provide additional information.

We thank you for your engagement in the process and look forward to reviewing your thoughtful responses to our request for proposal.

Special Self-Insurance Requirements for a Self-Insured Plan

The North Dakota Insurance Commissioner has oversight of PERS and its vendors under a self-insured arrangement:

26.1-36.6-03. Self-insurance health plans - Requirements.

The following policy provisions apply to a self-insurance health plan or to the administrative services only or third-party administrator, and are subject to the jurisdiction of the commissioner: 26.1-36-03, 26.1-36-03.1, 26.1-36-05, 26.1-36-10, 26.1-36-12, 26.1-36-12.4, 26.1-36-12.6, 26.1-36-13, 26.1-36-14, 26.1-36-17, 26.1-36-18, 26.1-36-19, 26.1-36-23, 26.1-36-29, 26.1-36-37.1, 26.1-36-38, 26.1-36-39, 26.1-36-41, 26.1-36-44, and 26.1-36-46

All self-insured arrangements must comply with the above and other applicable direction from the North Dakota Insurance Commissioner.

Pharmacy Benefit Manager (PBM) Requirement

North Dakota Century Code chapter 54-52.1 includes specific provisions for pharmacy benefits disclosures. Proposals are expected to comply with the law.

If you are unable to comply with the provisions described in North Dakota Century Code chapter 54-52.1 or other applicable state laws, you may still submit a proposal that specifies which provisions you are unable to comply with, why you are unable to comply, additional costs associated with compliance, and a recommended approach to meeting the intent of the law.

North Dakota statutes provide a preference for proposals with PBM efforts that meet the following requirements:

54-52.1-04.15. Health insurance benefits coverage – Prescription drug coverage - Transparency - Audits - Confidentiality.

1. *If the prescription drug coverage component of a health insurance benefits coverage contract received in response to a request for bids under section 54-52.1-04 utilizes the services of a pharmacy benefits manager, either contracted directly with a pharmacy benefits manager or indirectly through the health insurer, in addition to the factors set forth under section 54-52.1-04 the board shall consider and give preference to an insurer's contract that:*
    a. *Provides the board or the board's auditor with a copy of the insurer's current contract with the pharmacy benefits management company which controls the prescriptions drug coverage offered as part of the health insurance benefits coverage, and if the*

contract is revised or a new contract is entered, requires the insurer to provide the board with the revision or new contract within thirty days of the change.

   b. *Provides the board with monthly claims data and information on all programs being implemented or modified, including prior authorization, step therapy, mandatory use of generic drugs, or quantity limits.*
   c. *Describes the extent to which the board may customize the benefit plan design, including copayments, coinsurance, deductibles, and out-of-pocket limits; the drugs that are covered; the formulary; and the member programs implemented.*
   d. *Describes the audit rights of the board.*

2. *The board may conduct annual audits to the extent permitted under the contract terms agreed to under subsection 1. The audits must include:*
   a. *A review of a complete set of electronic prescription coverage claims data reflecting all submitted claims, including information fields identified by the board.*
   b. *A review of a list of all programs that have been implemented or modified during the audit period under subsection 1, and in connection with each program the auditor shall report on the cost, the cost savings or avoidance, member disruption, the process for and number of overrides or approvals and disapprovals, and clinical outcomes.*
   c. *Recommendations for proposed changes to the prescription drug benefit programs to decrease costs and improve plan beneficiaries' health care treatment. 3. Information provided to the board under the contract provisions required under this section are confidential; however, the board may disclose the information to retained experts and the information retains its confidential status in the possession of these experts. 4. The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefits manager; a pharmaceutical manufacturer representative; or any retail, mail, or specialty drug pharmacy representative or vendor.*
3. *Information provided to the board under the contract provisions required under this section are confidential; however, the board may disclose the information to retained experts and the information retains its confidential status in the possession of these experts.*
4. *The board may retain an auditor of the board's choice which is not a competitor of the pharmacy benefits manager; a pharmaceutical manufacturer representative; or any retail, mail, or specialty drug pharmacy representative or vendor.*

Model Contract

NDPERS has provided in Appendix E a model contract, NDPERS proposes to use this contract as a starting point for discussions with bidders. Please review the attached and redline this contract with any changes you would propose as part of the terms of your proposal. Include the marked-up contract with your proposal submission. Firms offering this contract may be eligible for the preference provided in this section. Firms that substantially alter this contract or offer a new contract will not be eligible for this preference.

Contract Term and Renewals

The term of this contract is one year, January 1 through December 31, 2025. The NDPERS Board intends that the successful bidder will have the opportunity to renew this contract five (5) additional times. The NDPERS Board will consider the following when determining whether to renew for subsequent plan years:

1. Satisfactory renewal price
2. Whether vendor performance has met the Board's expectations, and
3. Any other information the Board chooses to consider

The above are outlined in more detail NDCC 54-52.1-05. The renewal process will begin at the end of April when the PBM partner will submit an estimated renewal to the Board. The NDPERS Board may determine at this point to go out to bid or to defer a decision until August when the carrier will submit a formal renewal proposal and the NDPERS Board will decide to renew or go to bid.

IV. Overview of the NDPERS Program

NDPERS

The North Dakota Public Employees Retirement System is responsible for the administration of the State's retirement, health, life, dental, vision, deferred compensation, flex comp, retiree health insurance credit, and EAP programs.

Pursuant to 54-52-03, https://www.ndlegis.gov/cencode/t54c52.pdf, NDPERS is managed by a Board of trustees.

NDPERS is a separate agency created under North Dakota state statute and, while subject to state budgetary controls and procedures as are all state agencies, is not a state agency subject to direct executive control.

PROGRAMS

To review the benefit programs administered by NDPERS visit the NDPERS website at:

https://www.ndpers.nd.gov/

Current EGWP Benefit

The following table provides a summary of the current (2024) NDPERS EGWP benefit, including cost-sharing information. This plan provides coverage across all stages of an individual's benefit. Please be advised that NDPERS will update the Initial Coverage Limit, Out-of-Pocket Threshold, and Catastrophic Coverage Benefit consistent with the CMS Standard Benefit in 2025.

Deductible

Pharmacy (Part D) deductible	This plan does not have a deductible.

Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$5,030**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Tier	Standard Retail Pharmacy	Standard Mail Order
30-day supply		
1 (Generic or Preferred Generic)	**$5** copay and you pay **15%** of the remaining cost share	**$5** copay and you pay **15%** of the remaining cost share
2 (Preferred Brand)	**$15** copay and you pay **25%** of the remaining cost share	**$15** copay and you pay **25%** of the remaining cost share
3 (Non-Preferred Drug)	**$25** copay and you pay **50%** of the remaining cost share	**$25** copay and you pay **50%** of the remaining cost share
4 (Specialty Tier)	**$25** copay and you pay **50%** of the remaining cost share	**$25** copay and you pay **50%** of the remaining cost share
90-day supply		
1 (Generic or Preferred Generic)	**$5** copay and you pay **15%** of the remaining cost share	**$5** copay and you pay **15%** of the remaining cost share
2 (Preferred Brand)	**$15** copay and you pay **25%** of the remaining cost share	**$15** copay and you pay **25%** of the remaining cost share
3 (Non-Preferred Drug)	**$25** copay and you pay **50%** of the remaining cost share	**$25** copay and you pay **50%** of the remaining cost share
4 (Specialty Tier)	N/A	N/A

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary. To view the most complete and current Drug Guide information online, visit **www.humana.com/SearchResources**, locate Prescription Drug section, select **www.humana.com/MedicareDrugList** link; under Printable drug lists, click Printable Drug lists, select future plan year, select Group Medicare under Plan Type and search for GRP**49**.

Coverage Gap
Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$5,030**. After you enter the coverage gap, you pay a portion of the plan's cost for covered brand name drugs and covered generic drugs until your costs total **$8,000**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Tier	Standard Retail Pharmacy	Standard Mail Order
30-day supply		
1 (Generic or Preferred Generic)	**$5** copay and you pay **15%** of the cost of the remaining cost share	**$5** copay and you pay **15%** of the cost of the remaining cost share
2 (Preferred Brand)	**$15** copay and you pay **25%** of the cost of the remaining cost share	**$15** copay and you pay **25%** of the cost of the remaining cost share
3 (Non-Preferred Drug)	**$25** copay and you pay **25%** of the cost of the remaining cost share	**$25** copay and you pay **25%** of the cost of the remaining cost share
4 (Specialty Tier)	**$25** copay and you pay **25%** of the cost of the remaining cost share	**$25** copay and you pay **25%** of the cost of the remaining cost share

Tier	Standard Retail Pharmacy	Standard Mail Order
90-day supply		
1 (Generic or Preferred Generic)	**$5** copay and you pay **15%** of the cost of the remaining cost share	**$5** copay and you pay **15%** of the cost of the remaining cost share
2 (Preferred Brand)	**$15** copay and you pay **25%** of the cost of the remaining cost share	**$15** copayand you pay **25%** of the cost of the remaining cost share
3 (Non-Preferred Drug)	**$25** copay and you pay **25%** of the cost of the remaining cost share	**$25** copay and you pay **25%** of the cost of the remaining cost share
4 (Specialty Tier)	N/A	N/A
Catastrophic Coverage		
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$8,000**, you have a **$0** copayment.		

For complete details on the plan, please review the Benefits Overview at https://www.ndpers.nd.gov/retired-members/insurance-plans-retired-members/health-insurance-plans-retired-members/medicare

Services

Refer to Appendix F for details about current services the current EGWP provider is administering.

Eligibility

Retirees or surviving spouses who are age 65 or entitled to Medicare and are receiving a retirement benefit from the Public Employees Retirement System, the Highway Patrolmen's Retirement System, the Teachers' Insurance and Annuity Association of America (TIAA), the Job Service Retirement System, the Judges' Retirement System, the Teachers' Fund for Retirement (TFFR), or from a participating political subdivision are eligible to receive benefits. The NDPERS supplemental medical plan and prescription drug plan (EGWP) are currently bundled products.

Thus, a retiree electing to enroll with NDPERS must participate in both the NDPERS supplemental plan (Dakota Retiree Plan) and the NDPERS EGWP plan. NDPERS expects that this requirement will continue; however, if your proposed quote would change based on an "unbundled" benefit (or if the proposal would change based on higher or lower enrollment), please describe how your proposal would change in your Appendix C submission.

If the retiree elects to enroll, their Medicare eligible spouse is also eligible to enroll for coverage within the same timeframe, as long as the retiree provides coverage for the spouse on their medical supplemental plan. NDPERS does not conduct an annual open enrollment for Medicare eligible individuals.

Applications for coverage must be submitted within 31 days of Medicare entitlement or an NDPERS-approved qualifying event. The retiree and/or spouse must have both Medicare A & B in order to be eligible for coverage. The NDPERS qualifying events are:

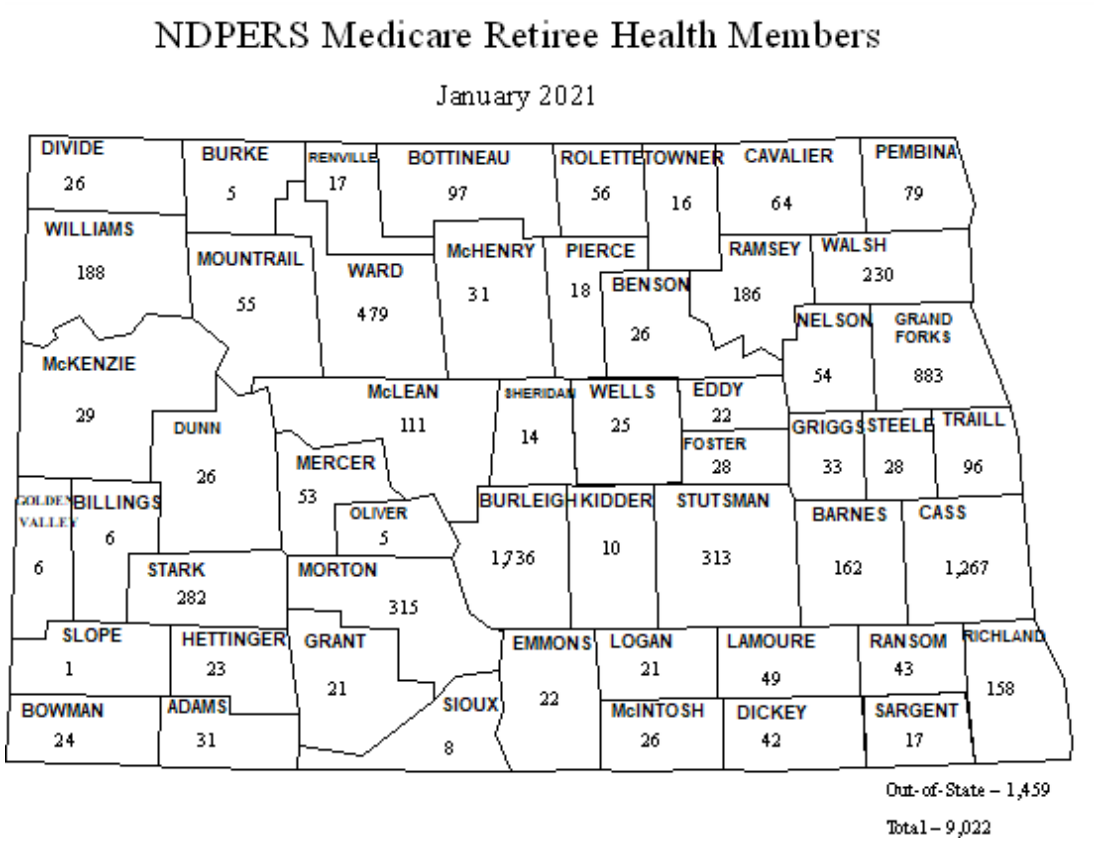
- Date of retirement, defined as either:
  - The last day of active employment if member does not defer his/her retirement benefit or take a lump-sum refund of his/her retirement account, or
  - Date of first retirement check if member deferred his/her retirement benefit.
- Member's 65th birthday or eligibility for Medicare;
- Member's spouse or eligible dependent's 65th birthday or eligibility for Medicare;
- The loss of coverage in a health plan sponsored or provided by member's employer or member's spouse's employer, if covered through spouse's employer group plan. This includes loss of coverage due to the death of, or divorce from, a spouse as well as completion of COBRA continuation coverage.
- Marriage
- Birth, adoption, or appointment of children for legal guardianship.

If a member or surviving spouse does not enroll within 31 days of any one of the above qualifying events or does not meet one of the above qualifying events, he/she will have forfeited his/her rights to enroll in the Plan.

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan

Administrator and is subject to CMS requirements. NDPERS has the ultimate decision-making authority regarding eligibility to receive benefits.

Geographic Distribution of the Population



V. Confidentiality

All materials submitted in response to this RFP will become property of NDPERS and, upon receipt by NDPERS, are subject to the North Dakota open records law. If the bidder submits information in response to this RFP that it believes to be confidential financial, commercial, proprietary, or trade secret information, the bidder must:

a. Clearly mark in the body of the proposal each provision that respondent believes to be confidential. Merely marking the entire page as confidential is not sufficient, and will not be recognized as an assertion of confidential information.

b. Complete the table provided in Appendix H, using the format provided, identifying the specific information that the responder asserts is confidential, the page and section number(s), and the reason the responder believes the information is confidential, including a specific citation to the North Dakota Public Records Law. Only confidential or propriety information on this table will be considered confidential by NDPERS. All other information not on this table will be considered an open record by NDPERS.

c. Offeror must submit a redacted copy of the proposal on a USB flash drive labeled "REDACTED" that accurately and completely redacts the information noted on the table in Appendix H.

d. Attest whether the information sought to be protected has ever been previously publicly disclosed.

e. Indicate the response has been reviewed by the responder's legal counsel and is so attested.

Responder is put on notice that, except for the information that is determined by NDPERS to be confidential or otherwise exempt from the North Dakota public records law, NDPERS must disclose to the public upon request any records it receives from Responder. If NDPERS receives a request for information that Responder has requested be kept confidential, NDPERS will review the information submitted by Responder and may also contact Responder for additional input regarding the nature of those records. However, NDPERS will be solely responsible for making the ultimate determination of whether the materials submitted are open or exempt. All information that has not been clearly identified by Responder as being confidential pursuant to this section and which NDPERS has not determined constitutes confidential or exempt information under the North Dakota public records law will be disclosed as an open record. NDPERS will not consider the bid cost information submitted by the Responder to be confidential under any circumstances.

Appendix A: Response Template

1. Face Sheet

Name of Proposer's Firm:	
Federal Tax I.D. Number:	
Principal Place of Business:	
Address:	
City:	
State and Zip:	
Contact Person:	
Title:	
Telephone:	
Fax:	
E-mail address:	

2. Minimum Requirements. Indicate in the table that you will meet these requirements. If you are not able to meet these requirements, your proposal may be dismissed from consideration.

#	Minimum Requirements	Response (Will Meet / Will Not Meet)
1	Bidder must be able to provide required coverages and services by January 1, 2025.	
2	Bidder must have all applicable licenses required by North Dakota or agree to obtain necessary licensure prior to the effective dates of coverage.	
3	Bidders must maintain compliance with all CMS requirements applicable to the Medicare Part D Prescription Drug Plan and EGWP+Wrap benefit.	
4	Bidder must support NDPERS with all legislative reporting requirements as a result of the Consolidated Appropriations Act (CAA) and any future transparency requirements.	
5	Proposals should match the existing plan design and member cost share.	
6	Premium and Administrative Fee Rates: Preliminary estimates for Medicare Part D EGWP+Wrap premiums (fully-insured proposals), administrative fees (self-insured proposals), CMS subsidies, and funding estimates (both fully-insured and self-insured) must be submitted to NDPERS no later than April 30 of the year preceding the contract renewal date	
7	Final renewals must be submitted to NDPERS no later than August 15 of the year preceding the contract renewal date	

#	Minimum Requirements	Response (Will Meet / Will Not Meet)
8	Bidders agree to comply with all provisions of the Health Insurance Portability Act of 1996 including, but not limited to providing certificates of creditable coverage. Bidders must also be in compliance with all HIPAA Privacy and HIPAA EDI requirements and be able to conduct all applicable employer/plan sponsor and provider transactions consistent with those requirements. Bidders will be expected to meet HIPAA security requirements when applicable to NDPERS. Bidders will also be expected to be in compliance with all ACA requirements.	
9	Bidder must be able to take current 834 electronic enrollment file (containing member eligibility) at no cost.	
10	Bidders agree, should they be selected, they will proactively manage the transition of coverage from the current carrier including the costs of managing the transition.	
11	Bidder must meet all requirements in the North Dakota Century Code including 54-52; 54-52.1 and all requirements in the North Dakota Administrative Code and other applicable State Laws. Bidder must also comply with all applicable statutes of the North Dakota Insurance Commissioner.	
12	Bidder must provide subject matter experts and other appropriate personnel to attend board meetings, legislative hearings, etc. as needed.	
13	Bidder must report insights and trends of plan back to NPDERS annually in form of an annual review meeting.	
14	Bidders have completed the requested information in Appendix H if they have asserted that any information is proprietary.	

3. Affidavit of Non-collusion

I swear (or affirm) under the penalty of perjury:

1. That I am the Responder (if the Responder is an individual), a partner in the company (if the Responder is a partnership), or an officer or employee of the responding corporation having authority to sign on its behalf (if the Responder is a corporation);

2. That the attached proposal submitted in response to the Medicare Part D EGWP+Wrap Request for Proposals has been arrived at by the Responder independently and has been submitted without collusion with and without any agreement, understanding or planned common course of action with, any other Responder of materials, supplies, equipment, or services described in the Request for Proposal, designed to limit fair and open competition;

3. That the contents of the proposal have not been communicated by the Responder or its employees or agents to any person not an employee or agent of the Responder and will not be communicated to any such persons prior to the official opening of the proposals; and

4. That I am fully informed regarding the accuracy of the statements made in this affidavit.

Responder's Firm Name: _____

Authorized Signature: _____

Date: _____

Subscribed and sworn to me this _____ day of _____

Notary Public: _____

My commission expires: _____

4. Conflicts of interest list
Bidders must provide a list of all entities with which it has relationships that create, or appear to create, a conflict of interest with the work that is contemplated in this request for proposals. The list should indicate the name of the entity, the relationship, and a discussion of the conflict.

5. Compliance with Federal and State Laws Form

NDPERS — Federal and State Law Compliance Certification

1. The company shown below is or will be in compliance with Federal and State laws and does not knowingly violate North Dakota or United States Laws. The company shown below will obtain this certification from all subcontractors who will participate in the performance of this contract; and

I certify that the company shown below is in compliance with items 1 above and that I am authorized to sign on its behalf.

Name of Company: _____Date: _____

Authorized Signature: _____Telephone Number: _____

Printed Name: _____Title: _____

6. Location of Service Disclosure and Certification

STATE OF NORTH DAKOTA

LOCATION OF SERVICE DISCLOSURE AND CERTIFICATION

LOCATION OF SERVICE DISCLOSURE

Check all that apply:

- ❑ The services to be performed under the anticipated contract as specified in our proposal will be performed ENTIRELY within the State of North Dakota.
- ❑ The services to be performed under the anticipated contract as specified in our proposal entail work ENTIRELY within another state within the United States.
- ❑ The services to be performed under the anticipated contract as specified in our proposal will be performed in part within North Dakota and in part within another state within the United States.
- ❑ The services to be performed under the anticipated contract as specified in our proposal DO involve work outside the United States. Below (or attached) is a description of

(1) the identity of the company (identify if subcontractor) performing services outside the United States;

(2) the location where services under the contract will be performed; and

(3) the percentage of work (in dollars) as compared to the whole that will be conducted in each identified foreign location.

CERTIFICATION

By signing this statement, I certify that the information provided above is accurate and that the location where services have been indicated to be performed will not change during the course of the contract without prior, written approval from the State of North Dakota.

Name of Company: _____

Authorized Signature:_____

Printed Name: _____

Title: _____

Date:_____ Telephone Number:_____

Appendix B Medicare Part D EGWP+Wrap Questionnaire

To be considered and accepted, your organization must provide answers to the questions presented in this section. Each question must be answered specifically and in detail. An electronic copy of this questionnaire has been provided to facilitate your response. If you choose not to respond directly in this document and instead will submit a formatted response document, you must include both the question and the answer in your proposal response and the question order must be maintained.

Question responses should not include references to prior questions. Bidders may include additional information that you consider relevant or useful to NDPERS. If you elect to provide additional information on services in response to a question, please specifically indicate that it is not included in the covered services offered in your proposal.

If this proposal results in your company being awarded a contract and if, in the preparation of that contract, there are inconsistencies between what was proposed and accepted versus the contract language that has been generated and executed, any such discrepancy will be resolved in favor of the language contained in the proposal or correspondence relating to your proposal. Bidders are reminded that **any and all deviations must be clearly identified and described in the RFP and the deviations worksheet provided in Appendix I.**

The questionnaire is broken down into the following categories:

1. Organizational Information
2. EGWP Operations
3. Clinical Management
4. Pharmacy Network
5. Account Management
6. Member Services
7. Implementation

1. Organizational Information

1.1 Please provide the legal name of the company that will be providing the pharmacy benefit management services in this contract.

1.2 Provide a brief description of your organization, including the length of time you have been in business, corporate structure, services provided, number of employees, and location of headquarters.

1.3 Please provide your year-end Part D membership for 2022 and 2023. Please provide your membership for "Group" and "Individual" separately. Please explain significant changes to membership.

1.4 How many prescription drug plan clients (plan sponsors) do you provide EGWP services to?

1.5 How many prescription drug plan clients (plan sponsors) that you provide EGWP services to are via an MAPD plan and how many are stand-alone PDPs?

1.6 How many EGWP clients do you serve with 9,000 or more Part D members?

1.7 Do you provide EGWP services to any State clients? If so, please name them.

1.8 How many government/public sector clients engage you to provide EGWP services?

1.9 Please provide the number of fully-insured and self-insured EGWP clients.

1.10 What percentage of your self-insured EGWP clients have "pass-through" financial contracts and how many have "spread/traditional" contracts?

1.11 Are the EGWP services proposed in this contract owned or subcontracted? If subcontracted, please identify the subcontractor, how long you have subcontracted services, and the expiration date of the current agreement.

1.12 If you are proposing a fully-insured EGWP option, please name the risk-bearing entity responsible for the EGWP.

1.13 In addition to EGWP services, please identify any other services that are currently outsourced or subcontracted and the name of the vendor/partner.

1.14 Describe any acquisitions, mergers, or partnerships your organization has entered into in the last three (3) years or is planning to enter into during the term of this agreement.

1.15 Describe any intent to either move exclusively into Medicare or terminate your Medicare business within the next 2 years.

1.16 You must be able to substantiate your financial stability. Provide a copy of your audited financial statement or other financial information. Include, at a minimum, a Balance Sheet and a Profit and Loss Statement, together with the name and address of the bank(s) with which you conduct business and the public accounting firm(s) that audit your financial statements. Other sufficient information may include a written statement from a financial institution confirming the creditworthiness and financial stability of the organization.

1.17 Please provide the most recent ratings from the following agencies, if applicable.

Rating Organization	**Rating**	**Date of Last Accreditation / Rating**
A.M. Best		
Standard & Poor's		
Moody's		

1.18 Please describe the accreditations you maintain (URAC, JCAHO, NCQA).

1.19 Please provide information regarding your latest internal controls and security audit, including a SOC 1, Type II and/or SOC 2, Type II report resulting from your most recent Statement on Standards for Attestation Engagements No. 22 (SSAE 23) audit.

1.20 Describe your privacy protection and data security standards as they relate to HIPAA and HITECH.

1.21 How do you maintain data security across your various worksites? How do you manage access and data security for employees that work offsite/virtually?

1.22 Describe your organization's usage of Generative AI and the controls in place when using this technology.

1.23 Do you maintain controls so that no single employee can use, change, or access protected data without authorization?

1.24 Describe certifications and other external audits. Describe the test criteria used

to ensure the standards are met. Have you completed external ethical hacking tests, etc.?

1.25 Have you had any security breaches involving electronically protected health information or personal financial information? If so, what was the scope of the breach? Were disclosures made to affected individuals? What changes in operations, if any, were implemented after the breach? Describe your capabilities to support the management of PHI data.

1.26 Do you have insurance to cover a breach or loss?

1.27 Are any of the services you are proposing to provide to NDPERS contracted outside the United States? If so, please describe any business services performed outside the United States and the financial impact, if any, of requiring those services to be provided within the United States.

1.28 Are there any major system enhancements or conversions planned or being considered within the next 24 months (specifically of interest are adjudication platform migrations or other services that may impact member or provider service or CMS adherence)?

1.29 Describe your business continuity and disaster recovery plans. Please be sure to address data security and file backup, claims processing, customer service centers, mail service, and specialty fulfillment operations.

1.30 The NDPERS Part D plan product is "bundled" with its medical supplement plan. The board may consider unbundling the product and offering the Part D plan and the supplement independently. Please discuss your perspective on this including but not limited to:

- 1.30.1 Do you think this would increase the possibility of adverse selection in the future?
- 1.30.2 If fully insured, would it affect your underwriting for future premium renewals?
- 1.30.3 Do you have any direct experience with clients that have addressed this issue, and, if so, what was the outcome of those discussions?

1.31 Provide the following information on a maximum of three (3) of your EGWP clients for whom you provide services similar to those proposed in this proposal. References of similar size and scope to NDPERS are preferred. Also provide the following for two former governmental clients similar to NDPERS or larger, if possible.

1.31.1 Name of employer sponsoring plan and location

1.31.2 Type of services provided to plan sponsor

1.31.3 Plan inception date

1.31.4 Length of time as a client

1.31.5 Number of contracts and members participating in the plan

1.31.6 Contact information (name, title, phone number, email address)

1.32 Include a description of your organization's short-term strategic initiatives and your long-term strategic business plan as it relates to retiree pharmacy benefits.

1.33 Describe how your organization differentiates itself from your competitors.

1.34 What makes your organization the best partner for NDPERS retirees? Do you have strategic advantages in North Dakota that make you a better choice for NDPERS than others?

2. EGWP Operations

2.1 What was the CMS star rating for your PDP for 2020, 2021, 2022, 2023, and 2024?

2.2 Have you been sanctioned by CMS in the past 5 years? If yes, please explain.

2.3 Please describe the Part D enrollment process under your PDP.

2.4 How do you manage missing or incorrect information during enrollment? Do you provide a process by which a member can correct missing or incorrect information in an expedited way? Is there a time limit for corrections?

2.5 If a member's information does not match CMS records and you contact the member for updated information, please discuss if there is a process to share the updated information back to NDPERS for correction in the NDPERS system.

2.6 Please describe your Part D disenrollment process for both voluntary and involuntary disenrollments. What is the timing for enrollments/disenrollments to go into effect?

2.7 Can NDPERS choose not to effectuate the optional involuntary disenrollments (e.g., failed to pay a premium on a timely basis, disruptive behavior, etc.)?

2.8 Please confirm that you will manage member communications related to terminations required by CMS

2.9 Please confirm that you will manage all CMS required pre-enrollment, post-enrollment, and renewal member communications.

2.10 Please confirm that Evidence of Coverage (EOC) and the Annual Notice of Change (ANOC) will be available to members prior to open enrollment.

2.11 Describe your handling of members who are eligible for the low-income premium subsidy available under Medicare Part D, specifically:

2.11.1 How are the members identified, and how are they informed of their enhanced benefits?

2.11.2 Please describe if the low-income premium subsidies will be paid directly to members.

2.11.3 Will you process low-income premium subsidy refunds to members, and low-income cost-sharing refund requests at no additional cost?

2.12 Describe your recommended billing and premium payment cycle.

2.13 Describe your handling of members who are subject to the late enrollment penalty under Medicare Part D, specifically:

2.13.1 How are the members identified, and how are they informed of their penalty?

2.13.2 Please describe how the late enrollment penalty will be invoiced/collected directly from members.

2.13.3 Will you process the collections at no additional cost?

2.13.4 Outline your process for delinquent payments of the late enrollment penalty. Please describe your process for notifying the plan sponsor of members who are delinquent.

2.13.5 How do you administer any reconsideration requests for members who are subject to the late enrollment penalty?

2.14 Please describe your ability to support NDPERS related to Income-Related Adjustment Amount (IRMAA) tracking and notifications (e.g., terminations, reinstatements)

2.15 Please describe how you work with CMS related to member risk scores.

2.15.1 Describe the data reported to CMS.

2.15.2 How do you track member risk scores?

2.15.3 Do you reconcile member risk scores with CMS?

2.16 Describe your straddle claim process.

2.17 Describe your process and adherence to Prescription Drug Event (PDE) requirements with CMS.

2.18 What was your book-of-business PDE error rate in 2022 and 2023?

2.19 Describe your procedures to detect and prevent Fraud, Waste and Abuse (FWA) and ensure claims are paid accurately. Please outline such procedures and how you implement and monitor FWA in the plan operation.

2.20 Please confirm that you will manage all CMS required reporting requirements related to FWA compliance.

2.21 Please confirm that you will manage all CMS required reporting requirements related to medication therapy management (MTM).

2.22 Please confirm that you will manage all initial internal and external appeals compliant with CMS requirements.

2.23 Please confirm you will manage all grievances compliant with CMS requirements.

2.24 Please describe your process of reporting rebates consistent with CMS requirements.

2.25 Describe audit rights for EGWP plans. What types of audits will NDPERS be entitled to perform (e.g., financial guarantees, plan design, PDE reconciliation, subsidy payments, etc.)?

2.26 How is CMS compliance monitored on an ongoing basis? Please describe your remediation process associated with areas of non-compliance.

2.27 Describe the support that you give clients during CMS audits.

3. Clinical Management

3.1 Describe your ability to provide and maintain a CMS compliant formulary program for NDPERS.

3.2 What is the name of the formulary proposed for NDPERS?

3.3 Does the tier structure of your proposed formulary align with the current tier

structure of the NDPERS plan? If not, please describe.

3.4 Please provide a copy of your proposed Formulary including NDC, drug name, and formulary tier in Excel format.

3.5 How frequently is your proposed formulary updated?

3.6 Does NDPERS have the ability to customize their formulary within the CMS limits?

3.7 Does the proposed formulary require compliance with formulary utilization management controls (prior authorization and/or step therapy and/or quantity limits) or are all formulary and clinical utilization management programs an "add-on" after the formulary is selected?

3.8 Does your formulary include all generics in the lowest cost tier and all brands in the preferred or non-preferred tiers or does your proposed formulary tier brand and generic products according to different criteria?

3.9 Please confirm you will provide a copy of the MAC list, including NDC and drug prices upon request.

3.10 If desired, could you grandfather existing members for a select period of time (1-3 fills, 1 year, indefinitely)?

3.11 How are Part B drugs treated on your proposed formulary?

3.12 How do you manage claims with overlapping coverage between Part D and Part B?

3.13 Is Part B claims management included in your proposal?

3.14 How are lifestyle drugs treated on your proposed formulary? Does NDPERS have the flexibility to include or exclude this category of drugs?

3.15 Does your EGWP formulary account for AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults? If so, please explain if drugs are excluded or if there are other clinical controls.

3.16 Please provide a list of your clinical programs, with a short description of each, and the associated cost for each program available to EGWP plans. This may be provided as a separate exhibit or included in this questionnaire. At a minimum, please include your Medication Therapy Management (MTM) program, prior authorization, step therapy, quantity limits, drug utilization review, opioid

management, diabetes management, compound management, and any distinct specialty drug management programs.

3.17 How do you target and enroll members in your MTM program?

3.18 Do you use any automated technology or predictive analytics to target members for MTM programs?

3.19 Please describe the outcomes reporting available for the MTM program.

3.20 Describe your quality assurance measures for your prior authorization process. What reports and tools do you provide for clients to assess if state/federal/NCQA quality measures (e.g., timeliness, overturn rates, accreditation) are met?

3.21 Explain your process around instances when your prior authorization team cannot immediately contact the provider (i.e., how often do you attempt to contact the provider, what methods do you use to contact the provider, what do you do when you get no response).

3.22 Please describe how members are notified of denials and the expiration of prior authorizations. How does the appeals process for prior authorization denials work?

3.23 Please discuss your strategies/programs related to the following:

3.23.1 High-Risk Medications in the Elderly

3.23.2 Statin Use in Persons with Diabetes

3.23.3 Medication Adherence for Diabetes Agents

3.23.4 Medication Adherence for Hypertension

3.23.5 Medication Adherence for Hypercholesterolemia

3.24 Please discuss how you measure adherence; do you track medication possession ratio (MPR) and/or proportion of days covered (PDC)? Are there other factors you evaluate for certain therapeutic classes?

3.25 Do you align your performance measurement with national quality measures (e.g., HEDIS)?

3.26 Describe your clinical programs for managing high-cost, high-risk populations including but not limited to Cystic Fibrosis, Cholesterol, Diabetes, Growth Deficiency, Hemophilia, Hepatitis, HIV, Inflammatory conditions (e.g., Rheumatoid arthritis), Medical reconciliation post-discharge, Multiple Scleroses, Oncology, Pulmonary Conditions

3.27 Do you have a vaccine administration program? If so, please describe the specifics of the program including if there are fixed prices for vaccine administration.

3.28 Please describe your approach to specialty pharmacy. Focus on the aspects that differentiate your services in the market.

3.29 Are members contacted before each specialty fill? If so, is the outbound call made by a representative or an automated call?

3.30 What is the average length of time spent with a member prior to the first fill of their specialty medication?

3.31 Please describe any specialty patient assistance programs that are offered. Describe how you can maximize the value of these programs for the member and the plan.

3.32 If you are bidding on self-insured business, do you have any stop loss measures to protect specifically against specialty drug costs?

4. Pharmacy Network

4.1 What is the name of your proposed pharmacy network?

4.2 How many retail pharmacies are in your EGWP network nationally?

4.3 How many retail pharmacies are in your EGWP network in North Dakota?

4.4 How often is your pharmacy network vetted for quality? Which quality metrics are used in the vetting process?

4.5 Does your proposed pharmacy network have sufficient pharmacy participation across North Dakota to service the NDPERS membership considering there are no national chains in the State?

4.6 Please confirm your network offering meets CMS requirements, including convenient access to long-term care (LTC) pharmacies, adequate access to home infusion pharmacies, and convenient access to I/T/U pharmacies for American Indian enrollees.

4.7 Please confirm you are compliant with CMS requirements to offer standard LTC pharmacy network contracts to any pharmacy willing to participate in the LTC network so long as the pharmacy is capable of meeting the performance and service criteria defined by CMS.

4.8 If necessary, please describe any modifications to your network in North Dakota that will need to be made to meet requirements.

4.9 Describe your 90-day retail network in North Dakota (i.e., number and percent of pharmacies that participate in 90-day fills in the State).

4.10 Is the mail service pharmacy owned or subcontracted?

4.11 Where are the centers located that will service NDPERS?

4.12 What are the operating hours of the mail centers?

4.13 What is protocol if the mail center does not have a drug in stock? Do you have a program at the mail facility to align and bundle shipment for members with more than one prescription?

4.14 Does your mail service pharmacy perform any interventions that are not performed in retail or are the interventions the same?

4.15 Confirm you offer expedited delivery of mail order prescriptions and who is responsible for paying for the expedited service (the plan or the member).

4.16 Please provide the name of your primary expedited shipping vendor.

4.17 How many specialty pharmacies do you operate?

4.18 Are the specialty pharmacies owned or subcontracted?

4.19 Where are the specialty pharmacies located? Which specialty pharmacy would primarily service the NDPERS account?

4.20 North Dakota law restricts prescriptions from being required to be filled at a specialty pharmacy and must be permitted by plans to be filled at retail pharmacies within the State. Please confirm your proposal will be in compliance.

4.21 Please confirm your proposal includes an “open” specialty pharmacy network. If your proposed EGWP network is not an “open” specialty network, please describe how your specialty network does not limit access to Part D in such a manner that it contravenes convenient access protections.

4.22 Please confirm that specialty products shipped in error, damaged in shipment, lost in transit, left by courier without confirmation of receipt, and rendered unusable by NDPERS to due negligence or error in the delivery process will not be the financial responsibility of NDPERS. How are these types of shipment errors reported to NDPERS?

4.23 What percentage of Limited Distribution Drugs commercially available do you have access to?

4.24 What is the process for procuring any limited distribution drugs that you currently do not have access to?

4.25 Do you have infusion services? Can you arrange for nurses or other assistance on behalf of the member?

4.26 Please provide a copy of your proposed specialty drug list including national drug code (NDC), drug name, and formulary tier in Excel format. Please include on the specialty drug list, or provide as a separate list, indicators for limited distribution drugs and include a separate indicator if you are an authorized distributor for that product.

5. Account Management

5.1 Provide an overview of how the NDPERS relationship will be managed, both strategically and on a day-to-day basis. Include an organizational chart. Please provide the names, titles, locations, telephone numbers, and email addresses of the representatives listed below. For the account service individuals listed, provide brief biographical information, such as years of service with your company, experience as it relates to this proposal, and the number of clients for which they perform similar services:

- 5.1.1 The individual representing your company during the proposal process;
- 5.1.2 The individuals on your proposed implementation team;
- 5.1.3 The individual assigned to overall contract management;
- 5.1.4 The individual or team members responsible for day-to-day account management and service;
- 5.1.5 The individual or team members responsible for Part D compliance;
- 5.1.6 The individual or team members responsible for clinical oversight;
- 5.1.7 Executive sponsor assigned to NDPERS (as applicable)

5.2 Will you agree to let NDPERS switch account team members if NDPERS is dissatisfied with service or fit?

5.3 If desired, can NDPERS update and maintain eligibility and check employee claim status online? Are there charges for access to and use of these tools?

5.4 Confirm your ability to accept a weekly enrollment file from NDPERS. Please see Exhibit 6 for a sample of the file layout.

5.5 Do you have any restrictions to the eligibility file layouts that you can support?

5.6 What is the timeframe that the file will be processed and loaded?

5.7 What happens if a record on file is rejected via the load process? What is the process to reconcile a file load? How quickly is the report/reconciliation regarding the file load returned to the Plan?

5.8 Please describe how you handle manual eligibility updates and the turn-around/timing of such updates.

5.9 Please provide samples of standard utilization management reports that can be accessed by NDPERS via your portal.

5.10 Please describe the frequency of the reporting and the flexibility NDPERS will have in determining when they receive reports.

5.11 Please confirm that you will provide a monthly prescription drug file feed, at no cost, to an NDPERS specified vendor to integrate with medical claims and laboratory data.

5.12 If requested, please confirm you will provide complete pharmacy claims data to other authorized third parties at no cost.

5.13 Please provide a sample of a quarterly/semi-annual review.

5.14 Please provide a sample of your rebate reconciliation report.

5.15 Please confirm that you will support NDPERS in the development of machine-readable files and RxDC reporting pursuant to Transparency in Coverage regulations. Provide a sample of both report formats.

6. Member Services

6.1 Where are the primary and secondary customer service centers located that would provide services to the NDPERS membership?

6.2 Describe your use of Interactive Voice Response (IVR).

6.3 Will you have a dedicated phone number for NDPERS?

6.4 Is your pharmacy call center available to members 24/7/365?

6.5 What is the protocol for reaching a customer service representative?

6.6 What is the average wait time to speak with a live person? Please provide a response for peak and non-peak hours.

6.7 How are the telephone calls serviced/routed for after-hours customer service calls (after normal business hours)?

6.8 Can a pharmacist be reached 24/7/365?

6.9 Is it a standard procedure to provide direct contact to NDPERS for referring member issues for resolution?

6.10 How would your call center assist requests for members or potential members who are comparing the NDPERS EGWP and need specific information on drug coverage prior to the new plan year starting or being enrolled in the plan?

6.11 Are multi-lingual services available? If so, which languages?

6.12 Please explain if training is provided to customer service representatives to accommodate individuals who have age-related deficiencies in perception and sensory limitations.

6.13 Does your customer service inquiry system allow representatives to record comments so other customer service representatives can view previous notes to assist members?

6.14 What is your first call resolution rate in the pharmacy call center?

6.15 How do you monitor customer service representatives for compliance and behavior? Do you record 100% of the calls?

6.16 Can a designated NDPERS representative listen to call recordings and receive call transcripts if requested?

6.17 Please describe the process associated with members who want to file a complaint about the behavior of a customer service representative. Please include how the complaint is made, resolved, and reported to NDPERS.

6.18 Do you provide single sign-on access to a link to third parties?

6.19 Please describe your member website and member portal that the NDPERS EGWP members would have access to.

6.19.1 Can your website provide NDPERS-specific plan information?

6.19.2 Does your website offer a pharmacy locator? Does the site offer information on retail stores that are open 24 hours/day?

6.19.3 Can members see their prescription drug claim history on the website?

6.19.4 Describe the web-enabled pricing comparison tools available to your members. Will the pricing tool account for NDPERS plan design?

6.19.5 Does your web-enabled pricing comparison tool provide pricing detail by pharmacy?

6.20 Do you have a smart phone mobile application or a mobile-optimized website?

6.21 Does your mobile app and/or mobile enabled website include the following:

6.21.1 Formulary information

6.21.2 Network pharmacy lookup

6.21.3 Plan design information

6.21.4 Member ID card

6.21.5 Claims history

6.21.6 Family claims history

6.21.7 Drug price lookup by pharmacy

6.22 Are ID cards the sole means of determining member eligibility? If not, please describe.

6.23 Describe your Coordination of Benefits (COB) process for secondary claims processing/payment.

6.24 Please provide a sample member welcome packet.

7. Implementation

7.1 Please confirm you can provide a CMS-compliant transition for NDPERS given the expected contract start date of January 1, 2025.

7.2 Please provide a Gantt chart of the implementation process to ensure a January 1, 2025 start date. Please outline in detail the specific activities and tasks necessary to implement the NDPERS program, as well as indicate any CMS requirements of a carrier transition. Be specific with regard to the following:

7.2.1 Amount of total time needed to effectively implement the program, including benefit testing, etc.

7.2.2 Activities/tasks and corresponding timing

7.2.3 Responsible parties and amount of time dedicated to implementation,

broken out by vendor, current vendor, and NDPERS staff

7.2.4 Any transition activities required with incumbent carriers, including data transfers, and providing members adequate notice regarding current care or treatment plans at least 60 days prior to a change

7.2.5 Length of time implementation team lead and members will be available to NDPERS

7.2.6 Provide the data layouts that your organization would need for the various inputs during installation.

7.3 What files would you require from the legacy EGWP provider in order to transition the plan to your organization? If you are provided with prior pharmacy claims history, will you load open prior authorization files, specialty pharmacy claims histories, open mail order refills, and accumulator files to avoid member disruption? If yes, explain the recommended process to follow and data specifications for transfer of data.

7.4 Please describe how you will transition members that will be subject to formulary disruption (e.g., non-preferred/not covered drugs, prior authorization, step therapy, quantity limits).

7.5 Please confirm the customer service call center can be set up to go live on or before November 1, 2024, to be able to take calls and answer questions from NDPERS members related to benefits, formulary changes, enrollment, etc.

7.6 How much lead time is necessary for you to guarantee that ID cards will be received by members prior to the plan year effective date of January 1, 2025?

7.7 What is your member communication plan that you use for accounts? Provide a sample of similar communications used when transitioning an EGWP client from another carrier.

7.8 Can you provide training to NDPERS staff on EGWP administration and compliance?

7.9 Please confirm that you are in compliance with all relevant provisions of the Inflation Reduction Act for 2023, 2024, and 2025 including:

7.9.1 Prescription Drug Inflation Rebates (effective 2023)

7.9.2 Beneficiary cost sharing for a monthly supply of insulin capped at $35 (effective 2023)

7.9.3 Part D vaccines have a $0 copay (effective 2023)

7.9.4 Part D beneficiary premium growth capped at 6% annually (effective 2024)

7.9.5 Low-Income Subsidy extended to enrollees up to 150% of Federal Poverty Level (FPL) (effective 2024)

7.9.6 No beneficiary cost sharing in Catastrophic Phase. Liability shifted to plan (effective 2024)

7.9.7 Out-of-pocket spending capped at $2,000 (effective 2025)

7.9.8 Replacement of the coverage gap discount program with the Manufacturer Discount Program (effective 2025)

Appendix C

North Dakota Public Employees Retirement System

Request for Proposals

Medicare Part D EGWP+Wrap

Please complete the tabs applicable to your cost proposal(s). The exhibits must be submitted in the prescribed format. Bidders may provide supplemental information but may not deviate from utilizing the provided Excel worksheets.

Fully-Insured Cost Proposals must complete the following exhibits:

1. Fully-Insured EGWP Premium
3. Specialty Drug List
5. Pricing Questionnaire

Self-Insured Cost Proposals must complete the following exhibits:

2. Self-Insured EGWP Pricing
3. Specialty Drug List
4. Self-Insured EGWP Cost Estimate
5. Pricing Questionnaire

North **Dakota** Public Employees Retirement System

Request for Proposals

Medicare Part D EGWP+Wrap

Fully-Insured Proposal

YOUR COMPANY NAME: _____

Premium estimate to be based on current enrollment and plan design

Product should be CMS-endorsed, insured PDP product with fully-insured wrap-around coverage that covers any gaps between what is covered by the PDP product and the existing plan benefits available to qualifying members

Bidders are required to populate the undeiwriting template below illustrating rate development.

Line	Premium Component	Response	Comments
1	Estimated Incurred Allowed Claims		
2	Member Months		
3	Experience Period Allowed Claims PMPM[(1) / (2))		
4	Trend (Drug Cost & Utilization)		
5	Benefit Adjustment Factor (Plan design, clinical mgmt, etc.)•		
6	Rating Period Allowed Claims PMPM[(3)x (4)X(5))		
7	Member Cost Share PMPM		
8	Manufacturer Discount PMPM		
9	CMS Federal Reinsurance Payment		
10	Rating Period Plan Paid PMPM[(6)- a)- (8)- (9))		
11	Rebate PMPM		
12	Plan Payments PMPM[(10)- (11))		
13	Administration		
14	Fees and Taxes		
15	Risk Charges		
16	Profit		
17	Gross Premium [(12) + (13) + (14) + (15) + (16))		
18	CMS Direct Subsidy (Risk Adjusted)		
19	Calculated Member Premium [(17)- (18)]		

• Clearly explain what is incorporated into any adjustment factor (if applicable)

List all clinical management programs assumed to be included (e.g. step therapy, prior authorization, etc.)

Comments/Assumptions/Caveats

List all pricing assumptions associated with changes to the IRA in 2025

North Dakota Public Ernployee,s Retirement System

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Medicare Part D EGWP'+Wrap

Self-lInsured Proposal

YOUR COMPANY NAME: _____

Self-insured EGVP

I. Guaranteed Ingredient Discounts	2025	Renewal 1	Renewal2	Renewal3	Renewal 4	Renewal 5
30 Dal Retail						
Brand fA'wP- 1/.1						
Generic fMAC & Non MAC - XI						
90 □a• Retail						
Brand fA'wP - XI						
Generic fMAC & Non MAC - 1/.1						
Mail Order						
Brand fA'wP- 1/.1						
Generic fMAC & Non MAC - XI						
Soecialt• fRetail fl Maill						
G dO IIEff D						

II. Guaranteed Dispensing Fees (Per Paid Script)	2025	Renewal 1	Renewal2	Renewal3	Renewal 4	Renewal 5
30 Da Retail						
Brand						
Generic						
90 Da Retail						
Brand						
Generic						
Mail Order						
Brand						
Generic						
Specialty (Retail & Mail)						
Guaranteed Overall Effective Discount						

III. Administrative Fees	2025	Renewal 1	Renewal 2	Renewal 3	Renewal 4	Renewal 5
EGVP Administration Fee (PMPM)						

IV. Guaranteed Minimum Manufacturer Derived Revenue	2025	Renewal 1	Renewal 2	Renewal 3	Renewal 4	Renewal 5
30 Day Retail						
Per Brand Script						
Estimated Annual Manufacturer Revenue Earned (Total)						
90 Day Retail						
Per Brand Script						
Estimated Annual Manufacturer Revenue Earned (Total)						
Mail Order						
Per Brand Script						
Estimated Annual Manufacturer Revenue Earned (Total)						
Specialty (Retail & Mail)						
Per Brand Script						
Estimated Annual Manufacturer Revenue Earned (Total)						

V. Other Fees	2025	Renewal 1	Renewal 2	Renewal 3	Renewal 4	Renewal 5
Enrollment M-In-lgement (including eligibility submissions. initial enrollment. age-in members)						
All required reporting to CMS						
Medicare required member communications						
Coordination of benefits between Part D and the 'wra lan						
CMS required Medication Therapy Management						
File feed tr-Insmission to 3rd p-lrty (consult-Int. d-lt-3 W-lrehouse. wellness or disease man-3gement. -3ccumul-3tors. stop loss) (per feed per transmission basis)						
Prior cl-lim history, prior -3uthori2ation. speci-llty claims histories. open moil order refills. accumulator file intake fees (to accept from incumbent during implementation)						
Electronic prescribing (per claim basis)						
Administrative Prior Authorization (per PA basis)						
Clinical Prior Authorization (per PA basis)						
Custom Reporting Programming (per hour basis)						
Other (please list)						
VI. Add-On solutions						
List out all potential clinical solutions a ailable to NDPERS along with their fees and a description of the ro r-lm						

North Dakota Public Employees Retirement System
Request for Proposals
Medicare Part D EGWP+Wrap
Fully-Insured & Self-Insured Proposals

YOUR COMPANY NAME: _____

Please provide your proposed specialty druglist with pricing and LOO indicators

NDC	Drug Name	Indication / Therapeutic Class	GPI	Limited Distribution Drug (Yes/ No)	If limited Distribution Drug, are you an authorized distributor	Specialty Network Compliant with CMS Requirements: Minimum Guaranteed Discount	Specialty Network Compliant with CMS Requirements: Maximum Guaranteed Dispensing Fee

Self-Insured Proposal

YOUR COMPANY NAME: _____

Plan cost estimate for 2025

Please assume the parameters setforth in the RFP (your network, your financial proposal, your proposed formulary, your clinical programs)
Include, as appropriate, drug interchanges aswell as utilization changes based on formularyor utilization management controls

2025				Dispensing Fees
30 DavRetail				
Brand				
Generic				
Total	0	$ -	$ -	$ -
90 DavRetail				
Brand				
Generic				
Total	0	$ -	$ -	$ -
Mail				
Brand				
Generic				
Total	0	$ -	$ -	$ -
Soecialtv				
Total	0	$ -	$ -	$ -
Limited Distribution Druas				
Total	0	$ -	$ -	$ -
Excluded Claims				
Total	0	$ -	$ -	$ -
Total	0	$ -	$ -	$ -

$ -	I$ -	I$ -

"Includes Direct Subsidy, Coverage Gap Discount Payments, Federal Reinsurance

Fully-Insured & Self-Insured Proposals

YOUR COMPANY **NAME:**

#	Question	Required Response (Confirmed / Not Confirmed)	Details / Explanation
1	Please confirm your proposal is based on the plan design included with this RFP and the proposal parameters.		
2	Please confirm your proposal does not require anyplan design changes to qualifyfor the terms in your offer (e.g., specific differential between preferrred and non-preferred brands to qualify for rebates).		
3	Please confirm your self-insured proposal pricing is based on a 1-year contract with 5 renewal options.		
4	Please confirm you will use Medi-Span as the sole source of AWP (excepting a change in the industrythat would require a change).		
5	Please confirm Usual and Customary (U&C) will be defined as: the retail price at a retail pharmacy on the date the drug is dispensed based on the NDC-11 dispensed.		
6	Please confirm that Average Wholesale Price (AWP) will be defined as Medi-Span's unit price for the 11-digit national drug code (NOC) of the product dispensed on the date-of-seivice for the quantity dispensed.		
7	Please confirm "Generic Drug• will be defined according to Medi-Span classification (Medi-Span Multisource Code field is a ·Y" indicator).		
8	Please confirm "Brand Drug• will be defined according to Medi-Span classification (Medi-Span Multisource Code field is a "M', "N', or ' O ' indicator).		
9	Please confirm that once a drug product is defined as "Generic" or "Braner at adjudication, it will remain classified as such for purposes of all financial measurements including AWP discounts, manufacturer revenue reporting and payment, management reporting and guarantee reconciliation.		
10	Please confirm that rebates will be defined as all revenue received from pharmaceutical manufacturers, whether from the manufacturer directly, rebate aggregator, or other third party and will include all monies received as a result of the formulary utilization which includes but is not limited to rebates, manufacturer administration fees, inflation or price protection payments, and pro rata share of monies received for seivices provided to manufacturers that depends on the inclusion of NDPERS' claim utilization or data.		

11	Please confirm postage increases will not be passed on to NDPERS.		
12	Please confirm you have indicated on the specialty drug list which drugs have exclusive or Limited Distribution classification.		
13	Please confirm you have included limited distribution drugs in the specialty drug guarantees OR have provided separate discount and rebate guarantees for exclusive or limited distribution drugs.		
14	Please confirm 100% of revenue earned from manufacturers will be passed through to NDPERS, which includes but is not limited to rebates, manufacturer administration fees, inflation or price protection payments, and pro rata share of monies received for seivices provided to manufacturers that depends on the inclusion of NDPERS's claim utilization or data.		
15	Please confirm that all revenue resulting from price protection/ inflation protection contracts will be included in the 100% pass-through requested for NDPERS?		
16	Please confirm that manufacturer revenue collected as a result of utilization from biosimilars or limited distribution drugs will be paid to NDPERS.		
17	Please confirm that your rebate guarantees are not conditioned on utilization of Hepatitis C products.		
18	Please confirm that your rebate guarantees accountfor Known patent expirations and the proposed guarantees will not be modified on the basis of patent expirations that can be reasonably Known at the time of this proposal.		
19	Please confirm that OTC exclusions (to the extent applicable) are not applicable to insulin or diabetic supplies (such as test strips) for purposes of rebate guarantees.		
20	Please confirm that if changes are made to the safe harbor provision governing rebates is eliminated, or if other regulatory changes are implemented that impact the payment of manufacturer revenue to the plan sponsor, the contract resulting from this RFP maybe re-opened.		
21	Please confirm thatfor purposes of discount and rebate guarantees, all HIV medications will be included as •specialty."		
22	Please confirm thatfor purposes of discount and rebate guarantees, all transplant medications will be included as ·soecialtv."		
23	Please confirm that rebate guarantees are not subject to aggregate day supplyminimums and will be reconciled according to distribution channel.		
24	Please confirm rebate guarantees will not include anyfunds collected through patient assistance programs.		
25	Please describe anyrequirements, terms, exclusions, or other caveats related to your rebate guarantee.		

26	What percentage of all generics are included on your MAC list?		
27	Please confirm generic discount guarantees are inclusive of MAC and Non-MAC discounts.		
28	Please confirm that the MAC listfor mail order will be equivalent or lower price than the MAC listfor retail claims.		
29	Please confirm that dispensing fees are assessed on paid claims only and not reversed or rejected claims.		
30	Please confirm member cost share will always be the lowest of the U&C, MAC, AWP discount, or member cost share.		
31	Please confirm that any coupons used bymembers will be excluded from ingredient cost calculation.		
32	Please confirm guarantees will include ·zero Balance Due· (100% member paid) claims at the ingredient cost prior to application of the member cost share and shall not be counted as AWP-100%.		
33	Please confirm that guarantees will exclude all claims that adjudicate at U&C.		
34	Please confirm there is no dispensing fee assessedfor U&C **claims.**		
35	In your extended supplyretail networks (90-daynetwork) are there different pricing provisions based on pharmacy (e.g. a subset of the pharmacies in the 90-daynetwork receive ·mail equivalent" pricing)? Please describe any differences that would be applicable to your pricing proposal.		
36	Please confirm that discount guarantees are not subject to aggregate day supplyminimums and will be reconciled according to distribution channel.		
37	Please confirm your proposal includes either a specialty drug list with drug level discounts or an overall effective specialty discount guarantee.		
38	How will newlyintroduced specialty drugs be included in the specialty drug discount guarantee? **Will**new specialtyproducts automatically default to a minimum discount in the therapeutic class?		
39	Please describe how a claim with a DAW codes (0 through 9) are reconciled in your Brand/Generic discount guarantees.		
40	Please confirm the proposed discounts, dispensing fees, and rebates are guaranteed by distinct component within the retail, mail, and specialty distribution channels such that a guarantee surplus in one guarantee component is not offset by a shortfall in another guarantee component.		
41	Please confirm that any shortfall determined during guarantee reconciliation will be paid to NDPERS on a dollar-for-dollar basis with no maximum limit of liability.		

42	Describe your reconciliation process and timing (in terms of reconciling a manufacturer revenue guarantee against actual payments)		
43	Please confirm that pricing guarantee reconciliation will take place within 90 days of the close of the contract year (including discounts, dispensing fees, admin fees (as applicable), as well as a preliminary analysis of manufacturer revenue paid compared to guarantees with a full reconciliation of manufacturer revenue after all manufacturer revenue has been collected and remitted from the manufacturers (no later than 270 days after the end of the contract year)).		
44	Do you collect point-of-sale (POS) price concessions from pharmacies or payincentives to pharmacies connected to pelformance criteria? If so, please describe the pelformance measures tied to payments.		
45	Do you collect retroactive DIR fees or assess copay clawbacks from pharmacies in your network? If so, please describe the situations where these fees or clawbacks are assessed.		
46	If you collect Direct or Indirect Revenue (DIR)from pharmacies in the network, is that DIR passed through to NDPERS in a self-insured contract?		

Appendix D

North Dakota Public Employees Retirement System
Request for Proposals
Medicare Part D EGWP+Wrap

Please complete each of the tabs in this workbook. The exhibits must be submitted in the prescribed format. Bidders may provide supplemental information but may not deviate from utilizing the provided Excel worksheets.

The Network & Formulary Match consists of the following components and related exhibits:

1. EGWP Network Match
2. EGWP Network Access
3. EGWP Formulary Match

North Dakota Public Employees Retirement System
Request for Proposals
Medicare Part D EGWP+Wrap

YOUR COMPANY NAME: _____

Using the pharmacy ID number, please insert the pharmacy name and answer if the pharmacy is in your proposed broad national network (Y) or if it is out of network (N)

Unique ID #	Pharmacy NABP	Pharmacy NPI	Pharmacy Name	Pharmacy City	Pharmacy State	Pharmacy Zip	In Network (Y/N)	Notes (Closed, Not Found, etc.)

North Dakota Public Employees Retirement System
Request for Proposals
Medicare Part D EGWP+Wrap

YOUR COMPANY NAME: _____

Please provide the GeoAccess summaries in the table below as well as back-up detail (back-up detail in electronic submission only, no hard copies) for employees who fall both within and outside the access standards. Your match should include all valid zip codes in each of the counties in North Dakota that your network serves and in which participants reside.

Please summarize the results of your analysis in the table below.

Retail Pharmacy Access	Participating Retail Pharmacy Network Standard	NDPERS Members Categorized as "Urban", "Suburban", "Rural"		NDPERS Members that Meet the Convenient Access Standard		NDPERS Members that Do Not Meet the Convenient Access Standard	
		Number of Members (#)	Percent of Members (%)	Number of Members (#)	Percent of Members (%)	Number of Members (#)	Percent of Members (%)
Urban	90% of members within 2 miles	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Suburban	90% of members within 5 miles	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Rural	70% of members within 15 miles	0	#DIV/0!	0	#DIV/0!	0	#DIV/0!
Total		**0**	**#DIV/0!**	**0**	**#DIV/0!**	**0**	**#DIV/0!**

North Dakota Public Employees Retirement System
Request for Proposals
Medicare Part D EGWP+Wrap

YOUR COMPANY **NAME:** _____

Indicate the tier on your proposed open formulary for each NOC.
You must include a "Key" or your responses will not be considered (e.g. 1 = Tier 1 (Generic), 2 = Tier 2 (Preferred Brand), 3 = Tier 3 (Non-Preferred Brand), 4 = Not Covered)

Unique ID #	NOC	Drug Product Label Name	Tier on Proposed Formulary as most recent update	Comments

Appendix E
PRESCRIPTION BENEFIT MANAGEMENT SERVICES AGREEMENT

THIS PRESCRIPTION BENEFIT MANAGEMENT SERVICES AGREEMENT (hereinafter referred to as the "Agreement") is entered into this _____ day of _____ 20__, between _____ (hereinafter referred to as "PBM"), with principal offices at _____ , and the State of North Dakota acting through its Public Employees Retirement System(NDPERS) ("the Plan Sponsor"), and North Dakota Public Employees Retirement System (NDPERS) ("the Plan Administrator"), with principal offices at 1600 East Century Avenue, Suite 2, Bismarck, North Dakota 58502-1657 (hereinafter referred to as "NDPERS"). [PBM to complete all "blanks" in paragraph, other than date]

WHEREAS, NDPERS wants to offer cost-effective prescription benefit services and cost-effective dispensing of prescription drugs and other covered products to its eligible employees and their eligible beneficiaries and dependents; and

WHEREAS, PBM has contracted with retail [mail order and specialty] pharmacies [and operates its own mail order and specialty drug pharmacy subsidiaries] for the purpose of providing prescription benefit services to its clients, including NDPERS; [PBM to select correct text and delete incorrect text, here, and in all other similar provisions in contract where orange font provides alternatives] and

WHEREAS, NDPERS desires to engage PBM to perform pharmacy benefit management services relating to (i) prescription claims processing; (ii) eligibility verification; (iii) negotiation and execution of contracts with retail [mail and specialty] pharmacies [and operation of its own mail order and specialty drug pharmacy subsidiaries]; (iv) negotiation and execution of contracts with pharmaceutical manufacturers, wholesalers, distributors, and other third parties to obtain favorable Financial Benefits for its clients, including NDPERS [or negotiation and execution of a contract with a third-party rebate aggregator to obtain favorable Financial Benefits for its clients, including NDPERS]; (v) creation of cost-effective and safe formularies for its clients, including NDPERS; (vi) management and administration of other prescription drug programs to benefit its clients, including NDPERS; and (vii) performance of other pharmaceutical benefit management services identified herein; and

WHEREAS, PBM agrees to perform all such services on a fully transparent basis in accordance with the terms of this Agreement, enabling NDPERS (and its agents) to have complete and full access to all information necessary to determine and verify that PBM has met all terms of this Agreement, and satisfied all Pass-Through Pricing requirements set forth herein; and

WHEREAS, PBM and NDPERS agree to satisfy all terms set forth in this Agreement subject to the terms and conditions hereof:

NOW THEREFORE, in consideration of the mutual promises and agreements contained herein, PBM and NDPERS hereby agree as follows:

ARTICLE 1 - DEFINITIONS

Additional Fee(s) – The term "Additional Fee(s)" shall have the meaning set forth in Section 4.3 of the Agreement.

Administrative Fee(s) - The term "Administrative Fee(s)" shall have the meaning set forth in Section 4.2 of the Agreement.

ANOC (Annual Notice of Change) – The term "ANOC" shall mean the Annual Notice of Change that is required by CMS and will be provided by PBM to the then-current Members enrolled in a Medicare Part D Plan through NDPERS. The ANOC will be timely provided, as required by federal regulations and guidelines, and will provide the Member with all required change notifications that will be made in benefits and costs, including without limitation, cost shares, if any. The ANOC will also include a new, and if necessary, revised EOC, LIS Rider, Formulary and Wrap Certificate of Coverage, if any, for the new Medicare Part D Contract Year.

Audit(s) - The term "Audit(s)" shall mean (1) NDPERS' assessment of PBM's satisfaction of all terms under this Agreement; and (2) PBM's verification that all third parties referenced in this Agreement (including but not limited to Participating Pharmacies, the Mail Order Pharmacy, the Specialty Drug Pharmacy and Pharmaceutical Manufacturers) have satisfied their obligations under this Agreement.

Average Annual Guarantee(s) - The term "Average Annual Guarantee(s)" shall have the meaning set forth in Exhibit A of the Agreement.

Average Wholesale Price or AWP - The term "Average Wholesale Price" or "AWP" shall mean the average wholesale price of a prescription drug or medication dispensed, on the date the prescription or medication is dispensed, as set forth in the most recent edition of the Medi-Span pricing guide or supplement as of that date. The applicable AWP for all prescriptions dispensed at retail pharmacies, the Mail Order Pharmacy and the Specialty Drug Pharmacy shall be based on (i) the Unit AWP using the NDC from which the medication was dispensed (not the package size of the prescription dispensed); and (ii) the actual manufacturer's AWP (repackager AWPs shall not be substituted for manufacturer AWPs); and (iii) the actual Unit prescribed (and an alternative Unit measure shall not be substituted, such as capsules for tablets, or tablets for capsules.). PBM shall not process any repackagers' AWPs in connection with any Claims.

In the event there is a change in the marketplace in connection with AWP reporting or any methodology impacting pricing and/or guarantees (including but not limited to a change in Medi-Span's information fields related to brand drug and generic drug classification), the Parties will be obligated to meet and agree upon changes in the pricing terms and guarantees contained in the Agreement so as to enable PBM and NDPERS to maintain the same financial relationship and obligations as set forth in the Agreement. PBM may not make any changes in pricing terms or guarantees in the Agreement unless NDPERS agrees to such changes in writing, and the changes are memorialized as a written amendment to the Agreement.

Benefit Change Form or BCF - The term "Benefit Change Form" or "BCF" shall mean the agreed upon form to make modifications to NDPERS' Benefit Plan Design. NDPERS' Benefit Change Form must be executed by NDPERS. PBM and NDPERS will each maintain a file of all Benefit Change Forms, but PBM will provide NDPERS with said BCFs upon request for Audits.

Benefit Effective Date or **Medicare Part D Benefit Effective Date** – The term "Benefit Effective Date" or Medicare Part D Benefit Effective Date shall mean January 1, 2025, which is the date when NDPERS will begin receiving services for its Medicare Part D Members from PBM's Medicare Part D Insurance Company.

Benefit Plan Design(s) or Plan Design(s) - The term "Benefit Plan Design(s)" or "Plan Design(s)" shall mean all matters described in Exhibit D to the Agreement and/or in a Benefit Specification Form or Benefit Change Form.

Benefit Specification Form or **BSF -** The term "Benefit Specification Form" or "BSF" shall mean the form that is completed by NDPERS that specifies the terms and provisions of NDPERS' Benefit Plan Design(s) and the configuration of system edits, including but not limited to which prescription and OTC medications are covered by NDPERS (and/or are not covered); Copayments and Coinsurance requirements; the Medicare Part D Formulary selected; the Benefit Plan Design tier structure; any limitations on coverage such as deductibles; and any Programs selected for any Plan, together with the relevant protocols and services that must be rendered in connection with each Program.

Each Benefit Specification Form must be executed by PBM and NDPERS. PBM and NDPERS will each retain a copy of all Benefit Specification Forms, but PBM will provide NDPERS with said Forms upon request for Audits.

Biosimilar – The term "Biosimilar" shall mean a type of biological product that is licensed by the FDA because it is similar to an already FDA approved biological product, the reference product, and has been shown to have the same clinical outcomes as the reference product. Biosimilar products will be included as Specialty Drug(s) in this Agreement.

Bona Fide Service Fees – Bona fide service fees means fees paid by a manufacturer to an entity, that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement, and that are not passed on in whole or in part to a client or customer of an entity, whether or not the entity takes title to the drug. The fee includes, but is not limited to, distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative service agreements and patient care programs (such as medication compliance programs and patient education programs).

Brand Drug(s) - The term "Brand Drug(s)" shall mean the following: The Multisource Code field in Medi-Span contains a "M" (co-branded product), "O" (originator brand) (except where the Claim is submitted with a DAW Code of "3","5" or "6", in which case it shall be considered a Generic Drug), or a "N" (single source brand). The Parties agree that when a drug is identified as a Brand Drug, it shall be considered a Brand Drug for all purposes by PBM, including but not limited to adjudicating the Claim, reimbursing the relevant pharmacy, invoicing NDPERS, determining the Copayment or Coinsurance to be paid by the Member, calculating the satisfaction of Average Annual Guarantees as further described in Exhibit A of the Agreement, calculating the satisfaction of Financial Benefit Guarantees as further described in Exhibit A of the Agreement, and calculating the satisfaction of generic fill rates (if any).

Claim(s) - The term "Claim(s)" shall mean all claims transmitted or sent to PBM by any pharmacies or by Members as a result of dispensing Covered Items to Members, including reversed and rejected Claims.

Claim Adjudication System – The term "Claims Adjudication System" means PBM's claims processing system.

Claim Processor Fee(s) or Click Fee(s) - The term "Claim Processor Fee(s)" or "Click Fee(s)" shall mean a payment made by retail pharmacies to PBM, or a fee withheld by PBM from retail pharmacy reimbursement when PBM processes an aggregated payment to a retail pharmacy. Claim Processor Fees shall be considered Financial Benefits or DIR and shall not be factored into Average Annual Guarantees for either Ingredient Costs or Dispensing Fees.

CMS (Centers for Medicare & Medicaid Services) – The term "CMS" references the federal agency within the United States Department of Health and Human Services that is responsible, among other matters, for administering various Medicare Plans.

Compound Drug(s) - The term "Compound Drug(s)" shall mean a drug that needs to be made by a pharmacist because it is not commercially available in the required form and strength. A Compound Drug must consist of two or more solid, semi-solid or liquid ingredients, at least one of which is a Covered Item. PBM is obligated to provide Pass-Through Pricing for every Compound Drug. PBM's invoiced Ingredient

Cost to NDPERS for each Compound Drug shall be the same as PBM's reimbursed Ingredient Cost to the retail pharmacy (and both shall be net of any Copayments, Coinsurance, and deductible, and if relevant, any LICS or Medicare Part D coverage gap rebate) PBM may also invoice NDPERS for the precise professional or compounding fee that PBM has paid to the dispensing pharmacy, if any. However, PBM shall not be allowed to make any profit spread on any Compound Drugs and shall pass through to NDPERS the exact Ingredient Cost and professional or compounding fee that PBM pays the dispensing pharmacy. Compound Drugs are excluded from the calculation of all Average Annual Guarantees, Minimum Guaranteed Discounts, the Default Discount Guarantee, Maximum Guaranteed Prices, and Financial Benefit Guarantees.

In submitting a Benefit Specification Form or a Benefit Change Form, NDPERS may state that if any pharmacy transmits a Claim for a Compound Drug where the total Ingredient Cost is above a dollar amount specified in the Form (e.g., $100), PBM will be required to (a) conduct a Prior Authorization evaluation to evaluate and verify that the cost of the Compound Drug is appropriate, and/or (b) block the dispensing of the Compound Drug.

Contract Year – The term "Contract Year" shall mean for NDPERS the period from January 1st to December 31st in any year.

Cost Share – The term "Cost Share" shall mean the amount of money that a Member must pay to the pharmacy to obtain a Covered Item in accordance with the terms of the Benefit Plan Design of NDPERS.

Copayment(s) or Coinsurance - The term "Copayment(s)" or "Coinsurance" shall mean those amounts collected from Members by the relevant pharmacy pursuant to NDPERS' Benefit Plan Design as specified in its Benefit Specification Form, and if relevant, as amended in a Benefit Change Form. "Copayment" shall mean any flat amount that a Member is required to pay. "Coinsurance" shall mean any percentage amount that a Member is required to pay.

Covered Item(s) - The term "Covered Item(s)" shall mean the covered drugs, supplies and small durable medical equipment ("DME") items listed in NDPERS' Benefit Plan Design, as specified in its Benefit Specification Form, and if relevant, as amended in a Benefit Change Form. PBM understands and agrees that it shall not be entitled to invoice or collect reimbursement from NDPERS for any Covered Item that is not included in, or that is excluded from, NDPERS' list of Covered Items.

Default Discount Guarantee - The term "Default Discount Guarantee" shall mean the automatic discount that must be provided by PBM on any and all new-to-market Specialty Drugs, as further described in Exhibit A of this Agreement.

Direct and Indirect Remuneration or DIR - The term "Direct and Indirect Remuneration" or "DIR" is defined to mean any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person) that serve to decrease the costs incurred by NDPERS (whether directly or indirectly) for Medicare Part D Covered Items, including without limitation: discounts, chargebacks, rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, legal judgment amounts, settlement amounts from lawsuits or other legal action, and other price concessions or similar benefits. DIR shall always have the same definition as the definition identified by CMS.

Dispensed Claim(s) - The term "Dispensed Claim(s)" shall mean each Claim that is actually dispensed to a Member. With respect to any Claim, if the Claim is not dispensed, but is instead denied, rejected or reversed, the Claim shall not constitute a Dispensed Claim. If the Claim is adjusted in any way, the original Claim and the adjusted Claim(s) shall together constitute only one Dispensed Claim. If a Claim is partially filled, and subsequently the remainder of the Claim is filled, the fills will together constitute only one Dispensed Claim. PBM may only invoice NDPERS for Dispensed Claims, may not invoice NDPERS for denied, rejected or reversed Claims, and may invoice only once for adjusted or partially filled Claims.

Dispensing Fee(s) - The term “Dispensing Fee(s)” shall mean the per prescription dispensing fee paid by the PBM to the dispensing pharmacy. Dispensing Fees shall only be invoiced to NDPERS for Dispensed Claims and shall be based on Pass-Through Pricing for retail pharmacy and Mail Order Pharmacy dispensed drugs, with said Pass-Through Pricing satisfying the Average Annual Guarantees for Dispensing Fees identified in Exhibit A of the Agreement. Dispensing Fees for Specialty Drugs dispensed from the Specialty Drug Pharmacy shall be based on the stated Dispensing Fee identified in Exhibit A of the Agreement. For every Dispensed Claim that PBM reimburses to the retail pharmacy based on U&C, PBM shall allocate the entire U&C charge to the Ingredient Cost and shall not allocate any of the U&C charge to the Dispensing Fee.

Effective Date - The term “Effective Date” shall mean the date upon which this Agreement becomes effective, namely the date upon which it has been executed by all Parties.

EGWP Plan – The term “EGWP Plan” shall mean an Employer Group Waiver Plan under Medicare Part D that is provided by PBM’s Medicare Part D Insurance Company via a Medicare Employer Group Policy (“EGWP Policy”), for a fully-insured plan, or a Medicare Employer Group Agreement (ASO) for a self-insured EGWP plan.

Eligibility Change(s) - The term “Eligibility Change(s)” shall mean a change in Member eligibility as reported to PBM by NDPERS whether in paper or electronic format.

Eligibility File – The term “Eligibility File” shall mean the file created by NDPERS and transmitted to PBM listing the names and other pertinent information necessary for PBM to enroll Members, terminate enrollment, or to make changes to existing Member records.

EOC (Evidence of Coverage and Disclosure Information) – The “EOC” is a document based on the CMS provided standardized model, supplied by PBM, approved by NDPERS, and thereafter issued by PBM to enrolled EGWP or EGWP + Wrap Members. The EOC discloses and sets forth the prescription drug benefits and terms and conditions of coverage to which NDPERS’ Members are entitled.

Exhibit(s) - The term “Exhibit(s)” shall mean an Exhibit to the Agreement, and all written amendments to any such Exhibits. Any Agreement Exhibit must be mutually agreed upon in writing by PBM and NDPERS.

Extended AWP - The term “Extended AWP” shall mean the product of the Unit AWP for a Dispensed Claim multiplied by the quantity of Units dispensed by the pharmacy for that Dispensed Claim.

Financial Benefits - The term “Financial Benefits” shall mean NDPERS’ Pro Rata Share (as Pro Rata Share is defined herein) of all financial benefits received by PBM (as PBM is defined herein) from all Pharmaceutical Manufacturers (as Pharmaceutical Manufacturers is defined herein), including without limitation NDPERS’ Pro Rata Share of all: rebates, discounts, administrative or other fees, chargebacks, grants, all other monies of any kind whatsoever paid by Pharmaceutical Manufacturers, all discounts or credits or reimbursements of any kind provided by Pharmaceutical Manufacturers, all financial benefits paid by Pharmaceutical Manufacturers to PBM for Covered Items dispensed on NDPERS’ behalf from retail pharmacies, the Mail Order Pharmacy, and the Specialty Drug Pharmacies, and all goods (or in kind services) provided by Pharmaceutical Manufacturers.

Financial Benefit Guarantee(s) - The term “Financial Benefit Guarantee(s)” shall mean the minimum amount that PBM has guaranteed will be passed through as Financial Benefits to NDPERS, as further described in Exhibit A of the Agreement.

Financial Guarantee(s) – The term “Financial Guarantee(s)” shall mean every financial guarantee in the Agreement (as opposed to Performance Guarantee identified in Exhibit C), including without limitation: every Average Annual Guarantee, every Specialty Drug Minimum Guaranteed Discount, the Specialty Drug Default Discount Guarantee and every Financial Benefit Guarantee.

Formulary - The terms “Formulary” shall have the meaning set forth in Article 5 of the Agreement.

Generic Drug(s) – The term "Generic Drug(s)" shall mean the following: The Multisource Code field in Medi-Span contains a "Y" (generic). Claims submitted with a Multisource Code field in Medi-Span containing the value of "O" and also submitted with a DAW Code of "3","5", or "6" shall also be consider a Generic Drug. PBM agrees that when a drug is identified as a Generic Drug, it shall be considered a Generic Drug for all purposes, including but not limited to adjudicating the Claim, reimbursing the relevant pharmacy, invoicing NDPERS, determining the Copayment or Coinsurance to be paid by the Member, calculating the satisfaction of Average Annual Guarantees as further described in Exhibit A of the Agreement, calculating the satisfaction of Financial Benefit Guarantees as further described in Exhibit A of the Agreement, and calculating the satisfaction of generic fill rates (if any).

Identification Card(s) or ID Card(s) - The term "Identification Card(s)" or "ID Card(s)" shall mean the printed plastic identification cards, and digital identification cards accessible online or via a mobile application, that contain specific information about the prescription drug benefits to which Members are entitled.

Ingredient Cost(s) - The term "Ingredient Cost(s)" shall mean the amount charged for each Dispensed Claim – prior to the deduction of any Copayment or Coinsurance or deductible (if any) – not including Dispensing Fees or any sales or use taxes – and without factoring in any Financial Benefits. For every Dispensed Claim that PBM reimburses to a retail pharmacy based on U&C (as defined herein), PBM shall allocate the entire U&C charge to the Ingredient Cost, and shall not allocate any of the U&C charge to the Dispensing Fee.

Limited Distribution Drug – The term "Limited Distribution Drug" shall mean Specialty Drug(s) that Pharmaceutical Manufacturer(s) distribute through a limited number of pharmacies and wholesalers selected by the Pharmaceutical Manufacturer(s).

Mail Order Pharmacy - The term "Mail Order Pharmacy" shall mean _____, [PBM to fill in the name of the pharmacy] which shall be the mail order pharmacy that PBM uses to service NDPERS.

MAC - The term "MAC" shall mean the maximum allowable cost of a Brand Drug or Generic Drug, as established by PBM for certain drugs in connection with reimbursing Participating Pharmacies. PBM's inclusion (or exclusion) of a drug on its MAC list(s) shall not in any way impact any of PBM's obligations in the Agreement, including without limitation its Pass-Through Pricing obligations, Average Annual Guarantees for Brand Drugs and Generic Drugs, since all such Guarantees and obligations are to be applied as specified in the Agreement.

Manufacturer Discount Program – The term 'Manufacturer Discount Program' is a term for the replacement program for the Coverage Gap Discount Program that will be sunset in 2025. It is a program intended to lower consumer costs by providing discounts directly to them from manufacturers rather than through a PBM.

Medicare Part D Formulary - The term "Medicare Part D Formulary" shall mean the list of CMS approved drugs and other items covered under an EGWP Plan.

Medicare Part D Insurance Company – The term "Medicare Part D Insurance Company" or "_____" [PBM to identify actual name of its Med D insurance company provider] shall mean PBM's affiliated insurance entity that will provide self-insured or fully-insured Medicare Part D EGWP coverage to NDPERS. Although the Medicare Part D Insurance Company will be providing said EGWP coverage, when requested, and the Medicare Part D Insurance Company will be contractually responsible for all such EGWP coverage, for simplicity of reference the term "PBM" has also been used throughout this Agreement to reference services that will be provided by, and obligations that must be satisfied by, the Medicare Part D Insurance Company for Medicare Part D matters.

Member(s) – The term "Member(s)" shall be defined as any retired Member eligible for and receiving Medicare Part D services. More specifically, a Member shall be defined as: a Medicare-eligible individual who has been enrolled in an EGWP by NDPERS and accepted for membership by CMS. The following individuals are NOT eligible to be a Member in an EGWP (or supplemental Wrap):

(i) Non-Medicare Eligible spouses and dependents of Eligible Individuals; or
(ii) Current employees of NDPERS Employer Group (i.e., active employees) or their eligible spouses and dependents, even if eligible for Medicare Part D.

To be a Member, i.e., a Medicare-eligible individual in an EGWP (and Wrap), the individual must also be eligible for Medicare Part A and/or Medicare Part B and must have a place of permanent residence inside the fifty United States or Washington, D.C. or any territories where PBM is authorized to do business. Individuals who are incarcerated and identified as such by CMS, or by NDPERS, cannot be Members and are not eligible for an EGWP (or Wrap), and may be retroactively disenrolled if PBM receives confirmation that the date incarceration began was prior to the Member's Benefit Effective Date.

Each individual who satisfies all of above standards shall, for purposes of an EGWP or Wrap Plan, be defined as an "Eligible Individual" and a "Member," regardless of whether that individual is a spouse or dependent of another Medicare eligible retiree.

Member List(s) - The term "Member List(s)" shall mean the initial Eligibility File provided by NDPERS for Medicare-eligible Members enrolling in NDPERS' EGWP, if any, and supplemental Wrap, if any.

Minimum Guaranteed Discount(s) - The term "Minimum Guaranteed Discount(s)" shall mean the minimum discount that PBM has guaranteed will be provided for each Specialty Drug when it is dispensed from the Specialty Drug Pharmacy, as further described in Exhibit A of the Agreement.

NCPDP - The term "NCPDP" shall mean National Council for Prescription Drug Programs.

New Eligibility Implementation Date(s) - The term "New Eligibility Implementation Date(s)" shall mean the date on which PBM services for new eligible Members are to begin, or end. PBM shall be obligated as of the New Eligibility Implementation Date to begin providing Covered Items for NDPERS' new Members, and, upon ineligibility of NDPERS' Members, to no longer provide Covered Items.

Over-the-Counter Drug(s) or OTC Drug(s) - The term "Over-the-Counter Drug(s)" or "OTC Drug(s)" shall mean a drug covered under NDPERS' Benefit Plan that is not required by law to be dispensed pursuant to a prescription and which is generally recognized as safe and effective because it meets each of the conditions contained in 21 C.F.R. Part 330 and each of the conditions contained in any applicable monograph.

Participating Pharmacy(ies) and **Pharmacy Network -** The term "Participating Pharmacy(ies)" shall mean those retail pharmacies that have contracted with PBM to create a "Pharmacy Network," together with the specified Mail Order Pharmacy and Specialty Drug Pharmacy. In the event that NDPERS limits in a Benefit Specification Form or Benefit Change Form the retail pharmacies that can dispense Covered Items to NDPERS' Members, the Participating Pharmacies and Pharmacy Network for NDPERS will be only those pharmacies allowed by NDPERS.

Party(ies) - The term "Party" shall refer either to NDPERS or PBM. The term "Parties" shall refer to both NDPERS and PBM.

Pass-Through Pricing - The term "Pass-Through Pricing" shall mean PBM's agreement that it shall not derive any profits whatsoever from the difference between amounts invoiced to NDPERS by PBM and amounts incurred by PBM for any Covered Item dispensed from any retail pharmacy, mail order pharmacy or specialty drug pharmacy (including the Mail Order Pharmacy and Specialty Drug Pharmacy). For purposes of clarification: For each pharmacy, PBM agrees to invoice for every Dispensed Claim - both for the Ingredient Cost and for the Dispensing Fee - the actual cost incurred by PBM. Said agreement includes

those Covered Items included within Average Annual Guarantees, and those Covered Items excluded from Average Annual Guarantees. Pass-Through Pricing shall also mean PBM's agreement to invoice for every Coordination of Benefit Claim based on PBM's exact amount paid for the Covered Item. Pass-Through Pricing shall also mean PBM's agreement that it shall invoice NDPERS for every vaccine, LTC dispensed, and home infusion therapy Covered Item based on PBM's exact amount reimbursed for that Covered Item. Pass-Through Pricing shall also mean that PBM shall invoice NDPERS for every Compound Drug based on PBM's exact reimbursement to the retail pharmacy for the Compound Drug, including PBM's exact reimbursement for the compounding fee.

For any EGWP Plan, Pass-Through Pricing shall mean (i) PBM's agreement that if NDPERS selects a self-insured EGWP Plan PBM shall pass through NDPERS' Pro Rata Share of all DIR, and if NDPERS selects a fully-insured EGWP Plan PBM shall pass through to CMS the legally required DIR allocable to that EGWP Plan; (ii) PBM shall properly allocate and retain only Bona Fide Service Fees; and (iii) PBM shall file accurate DIR and Bona Fide Service Fee reports with CMS. For any Wrap Plan, Pass-Through Pricing shall mean that to the extent that PBM receives any Financial Benefits, PBM agrees to pass through to NDPERS its Pro Rata Share of all such Financial Benefits.

Pass-Through Pricing shall also mean that PBM's only profits shall be those that may be embedded in (i) Administrative Fees; and (ii) Additional Fees.

Pharmacy Network – See Definition of "Participating Pharmacies."

PBM - The term "PBM" shall mean _____ *[PBM to identify its name]*, and all subsidiaries and affiliates providing PBM Services to NDPERS.

PBM Services - The term "PBM Services" shall mean claims processing, eligibility verification, all contracting and management and administration of contracts with Participating Pharmacies and/or Pharmaceutical Manufacturers, Formulary and clinical support, and all other services described in or performed by PBM as a result of the Agreement.

PBM/Participating Pharmacy Contract(s) - The term "PBM/Participating Pharmacy Contract(s)" shall mean all contracts, amendments or addendums thereto, letter agreements, or other written or oral agreements in any form, setting forth any terms between PBM and any retail, mail order pharmacy or specialty drug pharmacy, whether independent, or owned by or affiliated with PBM.

PBM/Pharmaceutical Manufacturer Contract(s) - The term "PBM/Pharmaceutical Manufacturer Contract(s)" shall mean all contracts, amendments or addendums thereto, letter agreements, or other agreements, providing that any Financial Benefits shall be paid or provided by any Pharmaceutical Manufacturer to PBM. PBM/Pharmaceutical Manufacturer Contracts shall include, but not be limited to, all: rebate agreements, administrative fee agreements, inflation protection payments, indication and/or outcomes based pricing arrangements, other fee agreements, service agreements, health or disease management agreements, data sales agreements, discount agreements, prompt payment agreements, bulk purchase agreements, pricing sheets/term sheets/or discount sheets providing pricing terms, etc.

Pharmaceutical Manufacturer(s) - The term "Pharmaceutical Manufacturer(s)" shall mean any pharmaceutical manufacturer or company, any drug wholesaler or distributor, or any other third party, that provides Financial Benefits.

Plan(s) – NDPERS may provide prescription coverage to one Plan or several different Plans. NDPERS shall have the right to add or eliminate a Plan or Plans during the period when this Agreement is in effect.

Prescriber – The term "Prescriber" means a licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Dentistry (D.D.S.), or other licensed health practitioner with independent prescribing authority in the state in which the dispensing pharmacy is located.

Program(s) - The term "Program(s)" shall mean any pharmacy benefit management program that NDPERS chooses to implement, in writing, via this Agreement, a Benefit Specification Form and/or Benefit Change Form, based on specified written protocols provided to the PBM.

Pro Rata Share - The term "Pro Rata Share" shall mean the proportion of total Financial Benefits that PBM collects from third parties that PBM is required to pass through to NDPERS, as further described in Exhibit A of the Agreement.

Protected Health Information or PHI – The term "Protected Health Information" or "PHI" shall mean individually identifiable health information, including summary and statistical information, collected from or on behalf of a Member that is transmitted by or maintained in electronic media, or transmitted or maintained in any other form or medium and that:

1. is created by or received from a Prescriber, health care employer, or health care clearinghouse;
2. relates to a Member's past, present or future physical or mental health or condition;
3. relates to the provision of health care to a Member;
4. relates to the past, present, or future payment for health care to or on behalf of a Member; or
5. identifies a Member or could reasonably be used to identify a Member.

Specialty Drug(s) - The term "Specialty Drug(s)" shall mean each drug identified on Exhibit B of the Agreement. The term "Specialty Drug" shall also include any new-to-market specialty drug that NDPERS allows to be dispensed. NDPERS shall have the right to select which Specialty Drugs on Exhibit B shall (or shall not) be dispensed to its Members. NDPERS shall also have the right to determine whether (i) to allow a new-to-market specialty drug to be dispensed automatically from the Specialty Drug Pharmacy at the Default Discount Rate prior to the specialty drug being added to Exhibit B; or (ii) to prohibit and block the dispensing of a new-to-market specialty drug until it has been added to Exhibit B, or NDPERS has specified in writing that it wants the drug added.

Specialty Drug Pharmacy - The term "Specialty Drug Pharmacy" shall mean _____ , *[Each PBM to fill in the name of its proposed Specialty Drug Pharmacy]* which shall be the only specialty drug pharmacy that PBM uses to service NDPERS.

State – The "State" means the State of North Dakota.

Successful Security Incidents - The term "Successful Security Incidents" shall mean security incidents that result in unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations.

Supplemental Formulary – The term "Supplemental Formulary" shall mean the Covered Items that NDPERS is providing to its Members as supplemental benefits (i.e., as Bonus Drugs and a Wrap), as specified in its Supplemental Benefit Plan.

U&C or Usual and Customary - The term "U&C" or "Usual and Customary" shall mean the walk-in price charged by a retail pharmacy to customers who are without prescription drug coverage. NDPERS shall never be charged for more than the U&C for a transaction. For every Dispensed Claim that PBM reimburses to the retail pharmacy based on U&C, PBM shall allocate the entire U&C charge to the Ingredient Cost and shall not allocate any of the U&C charge to the Dispensing Fee. PBM represents and warrants that each of its contracts with retail pharmacies requires each retail pharmacy to include as its transmitted U&C price to the PBM any and all U&C discounted prices that the pharmacy provides to non-insured customers.

Unit(s) - The term "Unit(s)" shall mean the unit of measure dispensed, such as tablet, capsule, ml of liquid, gm of cream, or other unit measure.

Unit AWP - The term "Unit AWP" shall mean the Unit of measure price, as defined by the NCPDP, with the Unit of measure being per tablet, or per capsule, or per ml of liquid, or per gm of cream, or per other Unit, dispensed.

Unsuccessful Security Incidents – The term "Unsuccessful Security Incidents" shall mean security incidents that do not result in unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations.

Wrap Plan – The term "Wrap Plan" shall mean the self-insured supplemental benefit plan that NDPERS may arrange for Medicare-eligible Members by executing a Coordination of Benefits Agreement.

ARTICLE 2 – GENERAL DUTIES TO BE PERFORMED BY NDPERS

2.1 NDPERS' Duty to Provide Member List. At least forty-five (45) days before NDPERS' Benefit Effective Date, NDPERS shall provide to PBM electronic files reflecting all Members as of that date (the "Member List"). NDPERS shall be solely and exclusively responsible for ensuring the accuracy of its Member List.

2.2 NDPERS' Duty to Provide Eligibility Changes in the Member List. NDPERS shall be solely and exclusively responsible for creating and providing Eligibility Files to PBM to update its Member List to reflect all additions and terminations ("Eligibility Changes"). For all eligible Members, NDPERS has determined that it wishes to update its Member List: once a week.

NDPERS' additions or deletions to a previously existing Eligibility File will be input and made operable by PBM within at least one (1) business day.

2.3 Information Required on Initial Member List, and For Eligibility Changes. NDPERS' Member List and Eligibility Changes shall contain the following minimum "information fields," each of which shall be incorporated into PBM's information system, and each of which shall be available to NDPERS via PBM's internet portal:

a. Each Member's identification number and social security number when available
b. Each Member's full name (last, first, and middle initial)
c. Each Member's date of birth
d. Each Member's address
e. The date the Member became eligible for coverage (Member's Effective Date)
f. The date the Member's eligibility for coverage under the Benefit Plan is terminated
g. The Benefit Plan Design identification number
h. Each Member's gender
i. Each Member's Person Code(s)
j. Each Member's Relationship Code(s)
k. A coordination of benefits Code or Indicator (as primary or secondary) for each Member
l. A Medicare Part D identifier (if relevant)
m. An active/retiree identifier (if relevant)

This data shall be provided to PBM in the industry standard, HIPAA-mandated 834 file format. PBM also agrees to provide additional "information fields" as required in writing by NDPERS.

NDPERS shall be responsible for the resolution of any errors identified by PBM in any error report that PBM transmits to NDPERS. Any Claims processed due to incorrect eligibility information transmitted by NDPERS to PBM will be the responsibility of NDPERS.

2.4 Benefit Plan Design Information and Changes. NDPERS' Benefit Plan Design(s) shall be provided to PBM and attached as Exhibit D hereto. NDPERS shall have the right to implement any Benefit Plan Design(s) of its choosing. NDPERS must provide its initial Benefit Plan Design(s) to PBM in writing at least sixty (60) days before NDPERS' Benefit Effective Date.

After NDPERS' Benefit Effective Date, NDPERS must provide all Benefit Plan Design changes to PBM at least forty-five (45) days prior to the date when such changes shall be made effective. PBM shall be obligated to input and perform a test run on any benefit changes identified by NDPERS as

requiring said test run prior to the date of required implementation, notifying NDPERS in writing of the results of its test run, and making all Benefit Plan Design changes operative within thirty (30) days of having received NDPERS' Benefit Plan Design changes. NDPERS and PBM may mutually agree, in writing, on different time frames for the implementation of Benefit Plan Design changes.

The specifics of how NDPERS directs PBM to configure the processing of benefits shall be provided to PBM using PBM's Benefit Specification Form (BSF), and any changes to the configuration using PBM's Benefit Change Form (BCF). PBM shall rely on the terms and provisions provided by NDPERS in the written and executed Benefit Specification Form and written and executed Benefit Change Forms. The most recent executed Benefit Specification Form or Benefit Change Form shall supersede any prior dated executed form to the extent the content of any prior form has been altered.

2.5 Cooperation. NDPERS and PBM shall promptly provide to each other all information that is reasonably requested and that is reasonably necessary for each to complete its obligations hereunder, and for NDPERS to provide the PBM Services it decides to provide.

2.6 Good Faith Negotiation Obligation. PBM and NDPERS agree that all conferences, meetings and negotiations will take place in good faith by balancing (i) PBM's obligation to provide low-cost pricing to NDPERS, with (ii) PBM's right not to expose itself to financial liability by promising to provide Covered Items and services on terms that PBM cannot satisfy.

Should PBM believe any NDPERS changes in a Formulary or Program require that any financial guarantee(s) be adjusted, PBM shall have the obligation to (i) provide evidence of the need for the change, and (ii) demonstrate through the evidence the extent of the adjustment that is needed as a result of the change, and the Parties thereafter shall negotiate in good faith and make any adjustment that PBM has demonstrated is needed. Similarly, if unforeseeable marketplace events or changes in government laws or regulations require an adjustment in any financial guarantee(s), PBM shall have the same obligations, and the Parties thereafter shall in good faith make any adjustment that PBM has demonstrated is needed. NDPERS may also request adjustments in financial guarantees and ask for documents or data related to its request. In connection with any change in any financial guarantee requested by either Party, PBM agrees that given that PBM retains most information related to the need for, or appropriateness of, any change, PBM shall be obligated to share the requisite information with NDPERS.

In connection with all of the above-described changes, each Party shall be required to consider in good faith the other Party's request, including all supporting PBM evidence that PBM must provide. NDPERS shall also be entitled to consult with outside experts to evaluate: the need for changes, PBM's supporting evidence, and other mitigating circumstances.

If the Parties cannot mutually agree on a requested adjustment within thirty (30) days of either Party's request for an adjustment then NDPERS may terminate this Agreement pursuant to the termination procedures set forth in Article 8.

ARTICLE 3 – GENERAL DUTIES TO BE PERFORMED BY PBM

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

PBM is prohibited from boycotting Israel for the duration of this Contract. (See N.D.C.C § 54-44.4-15.) PBM represents that it does not and will not engage in a boycotting Israel during the term of this Contract. If STATE receives evidence that PBM boycotts Israel, STATE shall determine whether the company boycotts Israel. The foregoing does not apply to contracts with a total value of less than $100,000 or if PBM has fewer than ten full-time employees.

3.2 Standards of Performance. PBM shall perform its obligations under this Agreement with care, skill, prudence, and diligence, and in accordance with the standards of conduct applicable to a fiduciary. PBM shall also disclose to NDPERS any activity, policy, or practice of which PBM is aware that presents a conflict of interest with the performance of its obligations hereunder. PBM represents and agrees that NDPERS is relying on PBM's expertise to ensure all PBM Services are rendered in accordance with applicable statutes and regulations.

3.3 Disaster Recovery Program. PBM shall establish and maintain a disaster recovery program consistent with industry practice and provide a copy of its disaster recovery program policies and procedures, if requested, to any party executing this Agreement and/or any government entity.

3.4 Provision of Basic Documents. PBM shall provide its latest SAS 70 report and any publicly available information on an annual basis, upon reasonable request by any party executing this Agreement and/or any government entity.

3.5 Indemnification. PBM agrees to defend, indemnify, and hold harmless the state of North Dakota, its agencies, officers and employees (State), from and against claims based on the vicarious liability of the State or its agents, but not against claims based on the State's contributory negligence, comparative and/or contributory negligence or fault, sole negligence, or intentional misconduct. The legal defense provided by PBM to the State under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for the State is necessary. Any attorney appointed to represent the State must first qualify as and be appointed by the North Dakota Attorney General as a Special Assistant Attorney General as required under N.D.C.C. § 54-12-08. PBM also agrees to reimburse the State for all costs, expenses and attorneys' fees incurred if the State prevails in an action against PBM in establishing and litigating the indemnification coverage provided herein. This obligation shall continue after the termination of this agreement.

3.6 Insurance. PBM shall secure and keep in force during the term of this Agreement, from insurance companies, government self-insurance pools or government self-retention funds, authorized to do business in North Dakota, the following insurance coverage:

a. Commercial general liability, including premises or operations, contractual, and products or completed operations coverages (if applicable), with minimum liability limits of $2,000,000 per occurrence.

b. Automobile liability, including Owned (if any), Hired, and Non-Owned automobiles, with minimum liability limits of $500,000 per person and $2,000,000 per occurrence.

c. Workers compensation coverage meeting all statutory requirements. The policy shall provide coverage for all states of operation that apply to the performance of this contract.

d. Employer's liability or "stop gap" insurance of not less than $2,000,000 as an endorsement on the workers compensation or commercial general liability insurance.

e. Professional errors and omissions with minimum limits of $1,000,000 per claim and in the aggregate, PBM shall continuously maintain such coverage during the contact period and for three years thereafter. In the event of a change or cancellation of coverage, PBM shall purchase an extended reporting period to meet the time periods required in this section.

The insurance coverages listed above must meet the following additional requirements:

a. Any deductible or self-insured retention amount or other similar obligation under the policies shall be the sole responsibility of PBM.

b. This insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe form and must be placed with insurers rated "A-" or better by A.M. Best Company, Inc., provided any excess policy follows form for coverage. Less than an "A-" rating must be approved by the State. The policies shall be in form and terms approved by the State.

c. The duty to defend, indemnify, and hold harmless the State under this agreement shall not be limited by the insurance required in this agreement.

d. The state of North Dakota and its agencies, officers, and employees (State) shall be endorsed on the commercial general liability policy on a primary and noncontributory basis, including any excess policies (to the extent applicable), as additional insured. The State shall have all the benefits, rights and coverages of an additional insured under these policies that shall not be limited to the minimum limits of insurance required by this agreement or by the contractual indemnity obligations of PBM.

e. A "Waiver of Subrogation" waiving any right to recovery the insurance company may have against the State.

f. PBM shall furnish a certificate of insurance to the undersigned State representative prior to commencement of this agreement. All endorsements shall be provided as soon as practicable.

g. Failure to provide insurance as required in this agreement is a material breach of contract entitling the State to terminate this agreement immediately.

h. PBM shall provide at least 30 day notice of any cancellation or material change to the policies or endorsements. PBM shall provide on an ongoing basis, current certificates of insurance during the term of the contract. A renewal certificate will be provided 10 days prior to coverage expiration. An updated, current certificate of insurance shall be provided in the event of any change to a policy.

3.7 PBM Provision of Services to NDPERS.

a. General Terms. PBM shall provide to NDPERS the Prescription Benefit Services detailed in this Agreement. All such services shall be provided at the agreed upon Administrative Fees and Additional Fees specified in this Agreement.

b. Pass-Through Pricing, Subject to Guarantees. PBM represents and agrees that all PBM Services will be performed using Pass-Through Pricing for every Covered Item dispensed, which Pass-Through Pricing shall be subject to all of the financial guarantees referenced in this Agreement, including (i) the Average Annual Guarantees (ii) Minimum Guaranteed Discounts and Default Discount Guarantees for Specialty Drugs, and (iii) rebate guarantees (referenced as Financial Benefit Guarantees).

c. Claims Processing, Retail Pharmacy Contracting, and Other Basic Services. PBM shall be solely responsible for all PBM Services detailed in this Agreement including the following:

1. Adjudicating all Claims accurately, including by correcting all pharmacy errors, including but not limited to pharmacy quantity errors
2. Contracting with and administering a national and local retail Pharmacy Network
3. Providing for the coordination of benefits
4. Being solely responsible for the timely accepting, inputting, and processing of all Eligibility Files that are transmitted in the appropriate format; Also, reporting back to NDPERS any errors or omissions in any Eligibility File that prevent timely inputting by the PBM
5. Accurately inputting the beginning and ending date of eligibility for each Member ("New Eligibility Implementation Date"), as provided by NDPERS
6. Timely processing all new eligibility information provided by NDPERS as further described in this Agreement
7. Providing the standard and customized reports
8. Providing additional ad hoc reports (if requested by NDPERS, at the Additional Fees identified if IT Programming time is required)
9. Performing concurrent and retrospective DUR
10. Performing all identified rebate/Financial Benefit activities
11. Providing EOBs (if requested by NDPERS)
12. Providing specified Website services for NDPERS and all Members
13. Providing E-Prescribing (as requested by NDPERS)
14. Operating a Customer Call Service Center with a toll-free number, 24/7/365 other than when the Center is unavailable for routine maintenance, for NDPERS, Members, Prescribers and Participating Pharmacies
15. Providing a service team that includes at minimum: an executive sponsor, an account manager, and a clinical account manager
16. Providing a complete set of Claims data to NDPERS with each Invoice Statement
17. As requested, conferring and/or meeting monthly, quarterly, semi-annually and annually with NDPERS to enable NDPERS to monitor, update and improve the Prescription Drug Services provided to NDPERS, and to enable PBM to educate NDPERS about new developments so as to assist NDPERS in making core choices, including about its Benefit Plan Design.

d. Retail, Mail Order Pharmacy and Specialty Drug Pharmacy. PBM represents and agrees that PBM currently includes __ retail pharmacies in its national Pharmacy Network. PBM also represents that having reviewed NDPERS' Claims data, PBM currently includes __ retail pharmacies in PBM's Pharmacy Network in NDPERS' region (defined as the State of North Dakota), and PBM binds itself to maintain ___ retail pharmacies in said Network throughout the duration of this Agreement. *[PBM to fill in all "blanks" above and below]*

PBM agrees to use _____ as the Mail Order Pharmacy for NDPERS, as further described in the definition of Mail Order Pharmacy. PBM also agrees to use _____ as the Specialty Drug Pharmacy for NDPERS, as further described in the definition of Specialty Drug Pharmacy.

e. Programs. Subject to Medicare Part D requirements for the EGWP Program, if NDPERS selects any Program for implementation, PBM will implement said Program based on the protocols agreed to by NDPERS in writing. In connection with any and every Program that PBM implements, the following general terms shall control:

1. Program Protocols and Program Changes. NDPERS may determine which Programs it wants to implement and identify specific protocols for each Program. All such protocols will be memorialized in writing.

2. Changes in Programs or Program Protocols. During the term of this Agreement, NDPERS may request Program or Program protocol changes on no more than a quarterly basis. PBM agrees to confer with NDPERS concerning all such requests, to provide whatever information is necessary to evaluate each request, and to make suggestions concerning Programs and Program protocols within thirty (30) days of NDPERS' initial request. All agreed upon Program and Program protocol changes will be implemented by PBM within no more than thirty (30) days, unless the Parties mutually agree on a greater delay.

3. PBM Suggestions for Program Changes. If at any time PBM believes NDPERS should expand or eliminate or alter any Program or Program protocol, PBM may inform NDPERS of all recommended changes to the Program or Program protocol. PBM will thereafter evaluate and discuss said recommendations with NDPERS. However, PBM may not implement any PBM recommendation unless NDPERS has approved the changes in writing.

4. Adherence to Protocols. PBM shall be obligated to implement each Program as specified by NDPERS' standard written requirements as set forth in NDPERS' Benefit Specification Form or Benefit Change Form. If all information necessary for PBM to implement a Program is not provided to PBM, PBM shall notify NDPERS of a need for additional written protocols and obtain said protocols from NDPERS in writing. PBM shall not implement its own protocols for any Program, unless PBM has obtained written approval from NDPERS to do so.

5. Program Implementation and Program Changes. The Parties agree that on or before thirty (30) days prior to NDPERS' Benefit Effective Date, NDPERS may choose which Programs to implement, and in connection with which Covered Items. The Parties also agree that at any time during the period when a Program is in effect, NDPERS may terminate any Program, in whole or in part, on thirty (30) calendar days' notice. The Parties also agree that NDPERS' Program choices will be memorialized in NDPERS' Benefit Specification Form and/or Benefit Change Forms.

6. PBM's Obligation to Provide Requested Information. At any time during the term of this Agreement, at NDPERS' request (but no more often than quarterly), in connection with any implemented Program, PBM shall provide information to NDPERS concerning the relative "net costs" of specified drugs, factoring in the Financial Benefits to be passed through on those drugs, to enable NDPERS to assess the savings that might be realized from including (or not including) certain specified drugs in a Program. If requested, PBM will also provide a disruption analysis to NDPERS to enable NDPERS to assess the disruption to Members if certain specified drugs are added to or deleted from a Program. If requested, PBM shall also provide a financial analysis to NDPERS to enable it to assess the savings that might result if certain specified drugs are added to or deleted from a Program.

7. Potential Program Impact on Guarantees. Should NDPERS choose to implement a Program or make changes to the protocols related to a Program, and PBM believe that any of the above could impact any guarantees stated in this Agreement, the Parties agree that changes may be made in the impacted guarantees, but only based on the procedures set forth in Section 2.6 of this Agreement.

8. Timing of Compensation Payment. In the event that NDPERS (or its auditor) determines that PBM has improperly implemented any Program, and its improper implementation results in a financial loss to NDPERS, and PBM is obligated to

compensate NDPERS as more fully described in Exhibit D, PBM's payment shall be made within thirty (30) days of the Parties' resolution of the issue.

3.8 General Responsibilities In Connection With Medicare Part D Plans. PBM's Medicare Part D Insurance Company will be contractually responsible for satisfying all matters related to NDPERS EGWP Plan. NDPERS acknowledges that this Agreement summarizes the services offered by PBM's Medicare Part D Insurance Company and that the provision of EGWP services will be governed by the agreements entered into between NDPERS and said Medicare Part D Insurance Company. The Parties represent and agree that PBM will be contractually responsible for coordinating all matters related to NDPERS supplemental Wrap Plan.

a. Initial Enrollment. NDPERS will provide a Member List to PBM containing all eligible Members.

b. Member Eligibility. Each Member's Benefit Effective Date will always fall on the first day of a month. The Parties agree that CMS regulations require that new enrollment information received by a Plan Sponsor on or before the last calendar day of the month must be processed with an effective date of the first day of the following month. For purposes of ensuring that a Member's enrollment is processed and materials are sent in advance of the Member's Benefit Effective Date (including the Member's ID Card), PBM recommends that enrollment information be submitted by NDPERS by the fifteenth (15th) of the month prior to the desired Member Benefit Effective Date. If PBM receives enrollment information after the fifteenth (15th) of the month, but before the end of the month, while enrollment will still be effective on the first day of the following month, PBM will not be obligated to ensure that the newly enrolled Member receives enrollment materials before enrollment begins, but rather will be required to provide such materials within fifteen (15) business days of its receipt of enrollment notification.

c. Involuntary Disenrollment of Individual Members by NDPERS. In the event a Plan Beneficiary no longer meets NDPERS' eligibility requirements. PBM shall assist NDPERS in dis-enrolling the Member in conformance with Medicare Laws and Regulations. In the event NDPERS manages the disenrollment, NDPERS shall notify PBM in writing or electronically of the date upon which the disenrollment is requested to be effective. NDPERS must notify PBM by the twenty fifth (25th) day of the month in order for disenrollment to be effective as of the last day of that month. If PBM does not receive a disenrollment request by the twenty fifth (25th) of the month, disenrollment may not be effective until the last day of the month that follows. The disenrollment process of individual Members must include notification to each Member as follows:

i. Every Member who is to be disenrolled must be notified; and
ii. The notice must be provided not less than twenty-one (21) calendar days prior to the effective date of the Member's disenrollment; and
iii. The information provided must include an explanation on how to contact Medicare for information on other Part D options that might be available to the Member.

d. Voluntary Disenrollment by Member. Members may only dis-enroll from NDPERS' Medicare Part D Plan during an AEP (Annual Enrollment Period) or SEP (Special Enrollment Period). Members may voluntarily dis-enroll in any of the following three (3) ways:
i. Enrolling in another plan (during a valid enrollment period);
ii. Providing written notice to PBM or NDPERS;
iii. Calling 1 800 MEDICARE.

e. Disenrollment Due to Member's Death or Loss of Medicare Eligibility. Pursuant to Medicare Laws and Regulations, CMS will dis-enroll a Member upon his/her death or due to loss of Medicare eligibility, and CMS will provide notification that the Member has died or lost eligibility. Upon receipt of notice of a Member's death or loss of eligibility from CMS, PBM will notify the NDPERS via a monthly enrollment/disenrollment transmitted report. Disenrollment will take place as of the date of death.

f. NDPERS' Group Disenrollment. Pursuant to Medicare Laws and Regulations, NDPERS may disenroll an entire group of Members from coverage through a group disenrollment process. The group disenrollment process must comply with CMS requirements.

g. PBM's Monthly Enrollment Reporting Obligation. PBM shall provide to NDPERS a monthly report to capture enrollment, which shall include but not be limited to: new enrollment, new disenrollment, CMS' rejections of enrollment and the reasons for those rejections, retroactive enrollment and disenrollment, and causes for disenrollment (including voluntary, involuntary, and disenrollment due to death/loss of eligibility).

h. LIP and LIC Subsidies. PBM will reimburse Members eligible for LIP and/or LIC Subsidies in accordance with the processes set forth in the applicable fully-insured EGWP Policy or self-insured EGWP Agreement.

i. DIR. PBM agrees to invoice for, and to attempt to collect, all DIR from all third parties, and to pass through to each self-insured Medicare Part D EGWP Plan its Pro Rata Share of all collected DIR. PBM further agrees to retain for its own account only Bona Fide Service Fees, as said Fees are defined by CMS and as is required by law. PBM also agrees to timely and accurately file all reports related to DIR (and Bona Fide Service Fees) to CMS on NDPERS' behalf, and in connection with self-insured EGWPs to provide all such reports (without redacting any NDPERS-related information) to NDPERS, if requested. If PBM contracts with and relies on a third party in connection with any DIR-related matters, PBM agrees that it will be fully liable for the above-described matters, and PBM further agrees that it will contractually bind the third party to comply with the above-described matters.

j. Monitoring and Pass-Through Of CMS and Other Revenues. PBM agrees to: (i) collect from CMS in connection with each NDPERS EGWP Plan all CMS and third party monies (including, without limitation, all CMS direct subsidies, LIPs, LICs, and Catastrophic Coverage reinsurance, and all Manufacturer Discounts and DIR); and (ii) monitor and analyze the accuracy of the amounts paid and received. PBM also agrees to timely and fully pass-through to NDPERS all such revenues as are required to be passed through no later than one month after receiving such revenues, except for LIPs which shall be passed through to those Members entitled to receive them within forty (45) days after receiving said revenues.

k. PBM's Obligation to Provide All Relevant Data and Reports. PBM agrees to provide on a monthly basis to NDPERS the following data/reports for EGWP Plans (redacted for NDPERS-related information only): PDE, MMR and MOR data/reports. Upon request, PBM also agrees to provide to NDPERS all other data/reports that NDPERS (or its advisors) reasonably believes to be necessary to monitor and evaluate NDPERs EGWP Plan.

l. PBM's Obligation To Periodically Review and Provide Analytical Cost Analyses. PBM agrees to provide to NDPERS a cost analysis (as described below) for each Medicare Part D Contract Year of coverage, containing cost information broken down on a monthly basis, for each of the following line items of information:

    i. Revenue
        1. NDPERS' Drug or Premium Payments
        2. CMS Direct Subsidy
        3. Total Revenue
    ii. Claims
        1. Allowed Claims
        2. Member Copay
        3. NDPERS Plan Liability (or underlying fully-insured Premium costs)

    iii. Claim Offsets

1. DIR
2. Coverage Gap Manufacturer Discounts
3. Catastrophic CMS Reinsurance
4. LIPs
5. LICs

iv. Net Claims Costs (or underlying fully-insured Premium net costs

v. Administrative Fees (for self-insured EGWP)

vi. Profit Margin

vii. Plan Beneficiaries (per month)

m. NDPERs may request that each of the above line items will be provided (i) based on the total dollar cost; and/or (ii) based on the PMPM cost.

n. NDPERS may also request that cost information be subdivided between (i) the Covered Items provided under the EGWP Plan that was covered by CMS under Medicare Part D; and (ii) the Bonus Drugs covered by NDPERS under its supplemental WRAP Plan.

o. The Parties understand and agree that NDPERS may rely on the cost analysis to:

i. understand NDPERS' costs;

ii. to make modifications to its Medicare Part D Plan;

iii. to determine a reasonable Premium for a fully-insured EGWP for the following Medicare Part D Contract Year and/or

iv. to audit PBM's compliance with its pass-through obligations and all other terms of this Agreement and the agreements executed in connection with its Medicare Part D Plan. Accordingly, PBM represents and agrees that it will provide accurate cost analysis information, and all projections will be provided in good faith.

3.9 Implementation Services. PBM shall provide the following implementation services for NDPERS, without limitation:

a. As soon as is feasible for PBM and NDPERS, PBM and NDPERS shall meet or confer to finalize an agreed-upon transition plan and implementation schedule.

b. Perform all tasks necessary to upload eligibility data, and timely "test" the upload as required by the agreed-upon implementation schedule.

c. Perform all tasks necessary to upload NDPERS' Benefit Plan Design, and timely "test" the upload as required by the agreed-upon implementation schedule.

d. Review PBM's Formulary, Medicare Part D Formulary, and Supplemental Formulary.

e. Review with NDPERS its proposed Programs; assist NDPERS in determining to what extent it wishes to implement its existing Programs or add new Programs; memorialize in writing all protocols for all Programs; and timely "test" the Program upload as stated in the agreed-upon implementation schedule.

f. Develop comprehensive reporting capability on Prior Authorization activities to include the following:

1. Turn-around-time
2. Number of total approvals
3. Number of total denials
4. Number of requests pended to NDPERS
5. Number of requests cancelled by PBM
6. Number of Prior Authorization requests by drug, drug class, or therapeutic category

g. Perform all tasks necessary to provide on-line access for Members.

h. Prepare to provide quarterly EOB Statements, automatically, to Members in a form to be reviewed by NDPERS.

i. Perform all tasks necessary to enable NDPERS to generate reports using its on-line access, with access to all Claim data elements.

j. Perform all tasks necessary to generate any customized reports identified in this Agreement.

k. Prepare and finalize the on-line and mobile access to be used by NDPERS, as well as the on-line and mobile Formularies that Members can access and ensure that all matters on the website accurately reflect all matters relevant to NDPERS.

l. Provide training for PBM's online portal usage to NDPERS.

m. Provide Member ID cards for approval by NDPERS, and timely print and distribute all ID cards, as required by the agreed-upon implementation schedule.

n. Train and ready a sufficient number of Customer Call Service Center representatives to ensure they are knowledgeable about all matters related to NDPERS, as required by the agreed-upon implementation schedule.

o. Load detailed Member Claim history in all instances where data is available from the incumbent vendor, including without limitation, Member history related to: Step Therapy, Prior Authorization, quantity limits, and drug utilization review.

p. Ensure that all Members then undergoing drug treatment for any therapeutic condition be transitioned without disruption in drug therapy or Program involvement, provided the data identified in subparagraph "o" has been made available to PBM.

3.10 NDPERS' Access to and Use of PBM's Computer Systems through an online portal. NDPERS will have access to PBM's computer systems via an online portal, in accordance with PBM's policies and procedures to maintain the confidentiality of such systems, for the following purposes: (a) adding, updating, or terminating eligibility; (b) generating overrides, as further detailed in this Agreement or as agreed upon by the Parties; (c) generating Standard Reports, as further detailed in this Agreement or as agreed upon by the Parties. The on-site "screen" information provided by PBM to NDPERS shall be identical to the "screen" information and access available to PBM and shall include at least the following: an eligibility screen, Prior Authorization screen, claims view screen, pricing screens and such other screens that are needed and identified by NDPERS. PBM shall provide assistance and training to NDPERS concerning use of its on-line access as needed. NDPERS acknowledges that PBM's computer systems are proprietary and agrees to maintain the systems in complete confidentiality and to access said systems with appropriate security in place.

3.11 Claims Data

a. PBM agrees that it is obligated to transmit to NDPERS a complete electronic Claims file, in the then-current NCPDP standard claims billing format monthly or upon request. All Claims shall be included on the file. Claims data shall be produced in one of the following formats: Access, fixed-length flat file or delimited flat file. Any data submitted in flat file format must either have a data layout attached, or the first line of the file must contain field names. File formats must remain constant from submission to submission, unless additional fields need to be added.

b. PBM shall provide at least the following information fields on the electronic Claims file. In providing such claims data, where "Brand Drug" and "Generic Drug" definitions are relevant, PBM will use the definitions contained in the Agreement.

1. Claim Number
2. Patient Date of Birth (DOB)
3. Patient Gender
4. Service Provider Qualifier
5. Service Provider Number Prescriber Identifier Qualifier
6. Prescriber Identifier
7. DAW
8. Fill #
9. Dispensing Status
10. Drug Coverage Status Code (Partial or Completion or blank)
11. Catastrophic Coverage Code - Attachment Point met on this event, Above Attachment Point, or attachment point not met
12. GDCB – Gross Drug Cost Below OOP Threshold
13. GDCA – Gross Drug Cost Above OOP Threshold
14. TrOOP Amt – True Out of Pocket Amount
15. Other TrOOP Amt - Other payments by TrOOP eligible payers
16. LIC Status – Low Income
17. LIC Amt – Low Income Cost Sharing Subsidy Amount
18. CPP – Covered Plan Paid
19. NPP – Non Covered Plan Paid
20. Received Date of Original Claim
21. Claim Adjudication Began Timestamp/Date
22. Brand/Generic Code (based on the definitions contained in this Agreement)
23. Beginning Benefit Phase
24. Ending Benefit Phase
25. Reported Gap Discount
26. Tier
27. Mail/retail/specialty indicator
28. Unique claims identifier
29. Unique claims identifier cross-reference (for reversals)
30. Claim status
31. Client subaccounts (carrier, group)
32. Date submitted
33. Date filled
34. Cycle Date
35. Rx#
36. Refill #
37. Compound Code
38. Member Submitted Identifier
39. NDC#
40. Drug Description
41. Metric Decimal Quantity

42. Days' Supply
43. DAW Code
44. Pharmacy Number (NABP or NPI)
45. Pharmacy Name
46. Unit AWP Used
47. Usual and Customary
48. Pharmacy Ingredient Cost
49. Pharmacy Dispensing Fee
50. Pharmacy Sales Tax
51. Pharmacy Patient Pay
52. Pharmacy Amount Due
53. Pharmacy Basis of Adjudication
54. Client Basis of Adjudication
55. Client Ingredient Cost Paid
56. Client Dispensing Fee Paid
57. Client Sales tax
58. Client Patient Pay
59. Client Amount Due
60. COB Indicator
61. COB Amount
62. PA#

3.12 Standard Reports.

a. General Terms. PBM shall provide the standard reports identified through PBM's online portal. The Parties agree that the specific layout for these reports will be mutually agreed to during implementation. PBM agrees to provide to NDPERS any standard reports that it provides to other clients and that NDPERS may view as useful or necessary to monitor its prescription drug benefit. All standard reports will be provided at no extra Additional Fee.

b. Ability of NDPERS to Obtain and Prepare Reports Via Online Portal. PBM represents and agrees that its online portal will enable NDPERS to have access to self-service reporting software and all Claim data fields. Said access will enable NDPERS to analyze Claims data in a [near] real-time environment, with Claims data available for analysis _____ *[PBM to state when Claims data becomes available, e.g.: immediately after Claim has been adjudicated, the day following any Claims processing by PBM, etc.]* In addition to the standard reports, PBM represents and agrees that the above-referenced access will enable NDPERS to generate reports concerning numerous matters without consultation with PBM, including but not limited to the following:

1. **Enrollment, Termination and Disenrollment Report**: A report sortable by Member, Plan, etc.

2. **Prior Authorization Report:** A report related to Prior Authorizations, sortable by Prior Authorizations, or by Covered Item, or by Member

3. **Utilization Report:** A report related to the utilization of Covered Items, sortable by Covered Item, therapeutic class, cost, Member

4. **Member Claims Report:** A report related to Member Claims history, sortable by Covered Item, prescriber, pharmacy, and therapeutic class

c. Timing of Online Portal Access to Standard Reports. PBM agrees that standard reports shall be available on the online portal based on the specified time frame (monthly, quarterly, or annually), and also capable of being run on demand by NDPERS at any time thereafter for an alternative time period. In the event NDPERS requests that standard reports be posted to

a secure FTP website, said reports will be provided no later than ten (10) business days after the end of each month for monthly reports and fifteen (15) business days after the close of the identified period for quarterly or annual reports.

d. Ad Hoc Reports. At NDPERS' request, PBM will assist NDPERS with generating ad hoc reports within seven (7) days of a request. All such reports will be provided at no cost, unless IT programming time is required, in which case the reports will be considered Customized Reports.

3.13 Customized Reports: PBM shall prepare and deliver to NDPERS Customized Reports. Certain of these Customized Reports may require PBM to provide IT Programming Time, which will result in the IT Programming Fee identified in Exhibit A of this Agreement.

3.14 Eligibility Changes and Benefit Plan Changes.

a. Eligibility Changes. PBM shall load and make operable all Eligibility Changes electronically submitted by NDPERS in appropriate format no later than one (1) business day from receipt of such data. Eligibility information will be loaded in the order received. In the event PBM receives electronic Eligibility Changes that it cannot process for any reason, PBM will be responsible for notifying NDPERS within one (1) business day that the information that was transmitted cannot be processed. PBM shall also identify with specificity the deficiency in the eligibility information that prevents processing.

b. Benefit Plan Changes. PBM shall electronically load all Benefit Plan Changes submitted by NDPERS into PBM's systems no later than ten (10) business days after receiving said information, unless a different time period is mutually agreed upon in writing by the Parties. The electronic loading of all Benefit Plan Changes shall enable NDPERS to view the changes on-line through the portal. In the event PBM receives electronic submitted Benefit Plan changes that it cannot process for any reason, PBM will be responsible for notifying within twenty-four (24) hours of PBM's receipt of the data that the Benefit Plan information transmitted cannot be processed. PBM shall also identify with specificity the deficiency in the Benefit Plan information that prevents processing.

3.15 Standardized Edits. PBM shall be responsible for maintaining standardized "edits" to enable the necessary dispensing of Covered Items on behalf of NDPERS.

a. Standardized "edits" shall include the following: Vacation overrides, lost/stolen/spilled overrides, emergency overrides, and school supply and facility overrides, in accordance with NDPERS' directions.

3.16 Clinical Services. The following Clinical services will be provided by PBM:

a. Concurrent and Retrospective Drug Utilization Reviews. PBM shall provide concurrent and retrospective drug utilization evaluation on all Claims based on an agreed-upon PBM/NDPERS policy.

b. Evaluation of Recalls. For prescription and non-lot-specific OTC Drugs, where the FDA or manufacturer has issued a drug recall, PBM shall perform and complete an evaluation to communicate a "hard edit" recommendation to NDPERS within five (5) business days of a recall. If NDPERS elects to accept the "hard edit" recommendation, PBM shall implement such edit within seventy-two (72) hours of NDPERS' decision. Additionally, PBM shall draft Member and prescriber communication regarding the specific recall, and upon approval and authorization by NDPERS, PBM will coordinate the mailing of the communication to the affected Members and/or their prescribing physicians and other qualified prescribing professionals.

3.17 Medi-Span Data. PBM agrees to rely on current (updated weekly by PBM), electronic data provided by Medi-Span to calculate all pricing related to this Agreement, including without limitation, all: invoices to NDPERS, reimbursements to Participating Pharmacies and non-network pharmacies, and the calculation of PBM's satisfaction of all Financial Guarantees in this Agreement. PBM further agrees that all such calculations shall be based on Medi-Span data (that has been timely loaded weekly into the system by PBM) as of the date each prescription is dispensed to Members. For all Covered Items (whether retail pharmacy, Mail Order Pharmacy or Specialty Drug Pharmacy dispensed Covered Items), the dispensing date shall be the date the pharmacy filled the prescription for the Member (the fill date), not the date the transaction is submitted to the PBM (the adjudication or submittal date).

3.18 Regular Conferences and Meetings between the Parties. PBM shall confer and/or meet with NDPERS on a monthly, quarterly, semi-annually, or annual basis, as requested by NDPERS.

3.19 Customer Service Center for Pharmacies, Providers and Members. PBM shall be responsible for responding to inquiries from Participating Pharmacies, providers and Members through a PBM toll-free phone line that will be accessible 24/7/365, except for scheduled maintenance. The Customer Service Center shall meet the following standards:

a. The Customer Service Center shall be responsible for answering questions on the following services, as applicable, without limitation: Member eligibility, Benefit Plan guidelines, deductibles, Copayments/Coinsurance, outstanding Copayments/Coinsurance that may be owed, maximum benefit status, instructions on completing a direct member reimbursement claim form, status of direct member reimbursement claims, Claims processing, Claims submission, Claims payment, benefit coverage, and all Programs.

b. PBM shall make interpretation services available free of charge in Spanish. PBM shall maintain the availability of services, such as TTY services or comparable services for the deaf or hard of hearing.

3.20 Survey. PBM shall work with NDPERS to develop an Annual Customer Satisfaction Survey that shall be transmitted by PBM to a sample of NDPERS Members. PBM agrees that, if requested by NDPERS, PBM will tally the responses of the Survey and report the results to NDPERS.

3.21 Performance Guarantees. PBM shall provide PBM Services in accordance with the Performance Guarantees stated in Exhibit C of this Agreement.

ARTICLE 4 – PBM's INVOICE REQUIREMENTS AND NDPERS' PAYMENT OBLIGATIONS

4.1 Invoice Statements. The Parties agree that PBM's invoicing procedures for (a) the costs of Covered Items, and (b) Administrative Fees and Additional Fees, in connection with Members are set forth in this Article 4.

All Invoice Statements shall be transmitted to NDPERS within three (3) days of the period specified below. PBM will submit invoices to NDPERS at the following address: PO Box 1657, Bismarck, North Dakota 58502-1657.

a. **PBM's Invoicing Procedure For The Cost of Covered Items For NDPERS' Retiree Medicare Part D Self-Insured EGWP Plan.** PBM shall provide a monthly Invoice Statement, accurately reflecting the costs for all Covered Items (Ingredient Costs and Dispensing Fees) that were dispensed by PBM to NDPERS' Members.

b. **PBM's Invoicing Procedure for Its Administrative Fees and Additional Fees.** PBM shall provide a monthly invoice to NDPERS for the Administrative Fees as well as for all Additional Fees owed for services performed during the previous month.

c. **NDPERS' Obligation In Connection with All Payments.** NDPERS shall pay each PBM Invoice Statement no later than thirty (30) business days from receipt of said Invoice Statement (inclusive of the day of invoicing) via wire transfer to PBM. Invoice Statements shall be deemed received by NDPERS upon the earliest delivery of the invoice by electronic copy or mail.

d. **PBM's Obligation to Provide Specified Summary Information with Each Invoice Statement.** Each Invoice Statement shall contain the following line item summary information, to the extent applicable for that Statement:

1. The amount owed for the costs of Covered Items during the period
2. The Administrative Fees
3. The Additional Fees
4. The total amounts owed, adding items 1) through 3) above.

e. **PBM's Obligation to Pass through Financial Benefits and DIR.** PBM agrees to pass through Financial Benefits and DIR disclose such pass-through on Invoice Statements, at least quarterly. PBM will provide NDPERS with a report within thirty (30) days after the end of each calendar quarter that will indicate the DIR that PBM's Medicare Part D insurance company expects to receive for the previous quarter for NDPERS self-insured EGWP Plan Claims identified on Invoice Statements during that previous quarter. In addition, based on the actual DIR collected by PBM's Medicare Part D insurance company by the end of each month, PBM will provide a credit to NDPERS during the following month, and identify said credit on the Invoice Statement of that following month.

f. PBM will separately invoice for the LICs amounts that are paid by PBM to pharmacies and that PBM anticipates collecting from CMS. PBM shall also separately invoice other monies that PBM's Medicare Part D Insurance Company anticipates collecting from CMS and that PBM's Medicare Part D Insurance Company is required to pass through to NDPERS based on its monthly processed Prescription Drug Event records (e.g., CMS direct subsidy payments, CMS catastrophic reinsurance and coverage gap manufacturer discounts). PBM agrees to provide a final true-up of all monies paid by CMS, which NDPERS will be entitled to audit.

4.2 Administrative Fees.

a. Amounts Owed. Commencing on NDPERS' Benefit Effective Date, NDPERS shall pay PBM an Administrative Fee as described in Exhibit A of this Agreement.

b. Calculation of Number of "Members" for Each Month's Payment. For purposes of determining the number of NDPERS' Members, the Parties agree that they will rely on the number of eligible Members for NDPERS as of the Monday following the fifteenth (15th) day of each month.

c. NDPERS' Annual Right to Renegotiate Administrative Fees. As long as this Agreement remains in effect, NDPERS shall have the right, at least annually, to renegotiate PBM's Administrative Fees. Should NDPERS choose to exercise said right, NDPERS' newly negotiated Administrative Fees shall be at least as favorable as the Administrative Fees stated above, unless forces outside the control of PBM preclude PBM from providing such Administrative Fees. Should PBM claim that its Administrative Fees must be increased, PBM shall have the obligation to demonstrate the need for the increase. The newly negotiated Administrative Fees shall be memorialized in writing by the Parties as an amendment to this Agreement.

4.3 Additional Fees.

a. Amount of Additional Fees. Commencing at the end of the first month after NDPERS' Benefit Effective Date, and to be paid at the end of each month thereafter, NDPERS shall pay to PBM any Additional Fees incurred during the previous month as described in Exhibit A.

b. Limit on Additional Fees. PBM represents and agrees that the Additional Fees listed in Exhibit A constitute the only Additional Fees that PBM shall seek during the initial two years of this Agreement. PBM further represents and agrees that PBM's agreed-upon Administrative Fees and profits constitute sufficient compensation to PBM for its administrative overhead and profits during this period, and no further Additional Fees shall be requested.

4.4 NDPERS' Payment Obligations in Connection with Disputed Amounts. The Parties agree that NDPERS shall be entitled to review Claims data and question any invoiced amounts – or Financial Benefit credits provided – in any Invoice Statement.

4.5 Failure to Question Invoices Does Not Constitute Waiver. Notwithstanding the provisions of Section 4.4, NDPERS shall not be obligated to raise any questions concerning any Invoice Statement, and NDPERS shall not waive its future right to do so, should NDPERS fail to transmit questions to PBM after receipt of an Invoice Statement.

ARTICLE 5 – FORMULARY OBLIGATIONS AND RIGHTS

5.1 Selection of Formulary. NDPERS may use PBM's standard formulary or customize its own formulary subject to Medicare Part D requirements. NDPERS understands and agrees that if NDPERS chooses to use PBM's standard formulary, NDPERS may not change said formulary. However, if NDPERS customizes its formulary, NDPERS shall have sole discretion how to do so, subject to PBM's right to request and obtain changes to Financial Guarantees.

If NDPERS wishes to consider customization of its Formulary for its Members, or implements a customized Formulary, PBM agrees to provide the following information to NDPERS: (a) the safety and efficacy of any identified Covered Items; (b) the net drug cost of any identified Covered Items, factoring in potential Financial Benefits that might be passed through; and (c) a disruption analysis for NDPERS to assess the likely impact of using PBM's standard formulary or customizing PBM's standard formulary, or implementing changes to its customized Formulary.

5.2 Change in Formulary. Unless otherwise agreed between PBM and NDPERS, NDPERS shall have the right each Contract Year to alter its selection of its Formulary. If NDPERS creates its own customized Formulary, NDPERS may alter its customized Formulary monthly. PBM agrees to provide requested information to NDPERS to enable NDPERS to change its customized Formulary, as requested by NDPERS.

ARTICLE 6 – AUDIT OBLIGATIONS AND RIGHTS

6.1 Audits shall be conducted pursuant to NDCC 54-52.1-04.15 and NDCC 54-52.1-04.16

6.2 Audits on Behalf of NDPERS. NDPERS and PBM agree that NDPERS shall have the right to conduct audits via its own internal auditor or a third-party auditor.

a. NDPERS will be entitled to conduct an audit to ascertain whether PBM has complied with the terms of this Agreement, including those provisions concerning:

1. Set -Up Audit. NDPERS will be entitled to conduct a Set-Up Audit for purposes of verifying that NDPERS' Benefit Plan Designs were properly input as of each date by PBM. NDPERS (or its auditor) may conduct a set-up Audit to verify, among other matters, that its Benefit Plan Design, and every Program and Program protocol, has been accurately loaded into PBM's computer systems. In the event subsequent changes by PBM are necessary to NDPERS' Benefit Plan Design or Program set-up, NDPERS (or its auditor) will be entitled to conduct an additional set-up Audit on reasonable notice after PBM makes requested necessary changes. Notwithstanding NDPERS' right to conduct a set-up Audit, should PBM later be discovered to have improperly input NDPERS' Benefit Plan Design or Programs, PBM shall be liable for any costs resulting from PBM's error, as further described in this Agreement.

2. Pass-Through Pricing Audit. If requested to conduct a Pass-Through Pricing Audit, NDPERS (or its auditor) shall be permitted to make a selection of retail pharmacy, Mail Order Pharmacy and Specialty Pharmacy Dispensed Claim transactions, as determined in NDPERS' discretion. In the event that any discrepancies are found, NDPERS (or its auditor) shall work with PBM to develop a plan to extend the selection. In the event that the parties are not able to agree on such a process, or the parties agree to such an extension and additional discrepancies are found, the parties agree that NDPERS (and its auditor) shall have the right to extrapolate from the results of the initial sample or the extended sample to determine the estimated total error and the amount owed to NDPERS as a result of the findings .

   In connection with NDPERS' Pass-Through Pricing Audit of Mail-Order Dispensed Claims – and NDPERS' Pass-Through Pricing Audit of Specialty Drug Pharmacy Dispensed Claims: The Parties agree that the Parties will calculate and determine whether PBM satisfied its Pass-Through Pricing requirements by measuring the Mail Order Pharmacy's and Specialty Drug Pharmacy's contractual agreements with the PBM and comparing costs to PBM's invoiced costs for each Dispensed Claim from the relevant Pharmacy.

3. Financial Benefits Audit. As requested for an Audit(s) related to Pass-Through Pricing and Guarantee requirements for Financial Benefits PBM shall provide information to NDPERS (or its auditor) sufficient to allow NDPERS to assess whether PBM (i) has passed through the appropriate Pro Rata Share of Financial Benefits to NDPERS; (ii) has satisfied its Financial Benefit Guarantee obligations; (iii) has performed PBM's Annual Reconciliations of all of the above matters accurately. Upon request, PBM shall break out each of the components of Financial Benefits by the type of Financial Benefit (e.g., Pharmaceutical Manufacturer rebates, health management fees, data sales fees, etc.) and by the manufacturer. PBM shall transmit all such electronic and other data to NDPERS, or to NDPERS' auditor, as directed by NDPERS. NDPERS' auditor may also request for review – and PBM shall be obligated to provide – copies of (i) PBM/Pharmaceutical Manufacturer Contracts, and/or (ii) PBM's invoices to

Pharmaceutical Manufacturers, and/or (iii) Pharmaceutical Manufacturers' payments or credits or discounts (or other Financial Benefits) made to PBM, including remittance statements. All such documents shall be produced by PBM solely at PBM's offices. NDPERS (or its auditor) may make notes of the contents of all referenced documents, however, neither NDPERS nor its auditor will be permitted to make a copy of any such documents.

4. Eligibility Audit. NDPERS (or its auditor) will be entitled to conduct an Audit of PBM's enrollment, eligibility and invoicing for eligible Members. PBM will produce its roster of all Members, together with identifying pertinent information about the demographics, including but not limited to, Member number, date of enrollment, and date of disenrollment, if any. In the event of any discrepancies between PBM's enrollment data and NDPERS', PBM will produce relevant Claims data for those Members for whom there is a discrepancy, as permitted under HIPAA. The Parties agree that NDPERS has executed the necessary attestation indicating its compliance with HIPAA thereby enabling NDPERS or its auditor to conduct an Audit of PBM's enrollment, eligibility and invoicing, subject to HIPAA privacy requirements for providing minimum necessary data.

5. Low Income Subsidies (LIPs and LICs). NDPERS will be entitled to audit (i) Member LIS status, and (ii) PBM's provision of accurate LIPs and LICs payments to Members to verify PBM is passing through to NDPERS (or Member) all appropriate monies, as required under this Agreement and under Medicare Laws and Regulations. PBM will produce its roster of all Members, including LIS indicator for all LIS Members, and its Claims data, with all fields necessary to enable NDPERS (or its auditor)) to conduct the above Audit.

6. TrOOP Calculations. NDPERS will be entitled to audit PBM's TrOOP calculations. PBM will produce its Claims data, with all fields necessary to enable NDPERS (or its auditor) to conduct said Audit.

7. Audit of Additional Medicare Part D and EGWP Plan Terms. NDPERS will be entitled to audit PBM's compliance with all other Medicare Part D requirements, including those related to EGWP Plans, such as PBM's provision to each self-insured Medicare Part D plan of the accurate amount of (i) CMS direct subsidies; (ii) Manufacturers' Coverage Gap discounts; (iii) CMS' Catastrophic Coverage reinsurance; and (iv) Manufacturers' payment of rebates/DIR to PBM, and PBM's receipt of Bona Fide Service Fees. PBM will provide PDE, MMR and MOR files/data, as requested, to enable the above Audit.

8. Fraud, Waste and Abuse Program. NDPERS will be entitled to audit PBM's Fraud, Waste and Abuse Program. PBM will produce its audit report to enable NDPERS to verify that PBM has an adequate Fraud, Waste and Abuse program of prevention, detection and correction.

9. Performance Guarantee Audit: NDPERS may conduct Audits of a Performance Guarantee(s). If it appears necessary for NDPERS to audit several Performance Guarantees, NDPERS will work with PBM to combine its Performance Guarantee Audits. Performance Guarantee Audits may be performed at any time within the contract period

b. NDPERS may determine which of the above areas to audit at the end of each Contract Year, or thereafter, but may decide to delay auditing certain areas in its own discretion until several months or years have passed. When any area is audited for any Contract Year, NDPERS may not re-audit that particular area for that Contract Year in a subsequent audit.

6.3 General Terms Related To Who May Audit, and How Audits Will Be Conducted. The following individuals and/or entities may conduct Audits related to this Agreement, based on the following general guidelines:

a. NDPERS shall have the right to use its own auditor or select any audit firm, as long as NDPERS' auditor shall not be an individual or entity that is: a competitor of PBM, a Pharmaceutical Manufacturer representative, or any retail, mail, or specialty drug pharmacy representative or vendor.

b. All Audits conducted by NDPERS (or any auditors retained by NDPERS) shall be made during normal business hours. All Audits shall be conducted without undue interference to the audited Party's business activity, and in accordance with reasonable audit practices.

c. NDPERS (or its auditors) shall be entitled to commence an Audit within thirty (30) days after NDPERS has provided written notice to PBM of its intention to conduct an Audit. PBM shall be obligated to provide all electronic data identified in Article 6 to NDPERS (or its auditor) within thirty (30) days of PBM's receipt of said notice. PBM shall be obligated to provide – or make available at its offices – as specified herein, all other documents and data identified in Article 6 no later than forty-five (45) days after PBM's receipt of said notice.

d. With respect to all data and documents produced by PBM to NDPERS or to its agents or auditors, PBM's production shall be made without redacting or altering any information from the data and documents produced. When electronic data is produced by PBM, all fields created or maintained or used by PBM shall be produced, and none shall be withheld, redacted or deleted. In addition, appropriate manuals and/or guides identifying the meaning of each field shall be produced.

e. As requested for an Audit, PBM shall provide to NDPERS (or its auditor) an electronic data file reflecting all Claims transactions for NDPERS for the specified Audit period. Said electronic file shall include (i) PBM's invoiced costs for NDPERS for each item dispensed from a retail pharmacy and the Mail Order Pharmacy and the Specialty Drug Pharmacy, and (ii) PBM's reimbursement costs to each pharmacy for each such item. Claims data shall be produced in one of the following formats: Access, fixed-length flat file or delimited flat file. Any data submitted in flat file format must either have a data layout attached, or the first line of the file must contain field names. File formats must remain constant from submission to submission, unless additional fields need to be added. PBM shall transmit all such electronic data to NDPERS or to its auditor, or to both, as directed by NDPERS.

f. In the event any questions are raised, or any additional requests for information or documents or data are requested, by NDPERS (or its auditor) during any Audit, PBM shall be obligated to respond to all such questions, and produce all additional information, documents and/or data within seven (7) business days of receipt of such questions or requests. If PBM cannot respond in said time period, PBM shall provide a written statement as to when PBM will respond, but in any event, PBM's response must be no later than twenty (20) days after receiving NDPERS' (or its auditor's) written request.

g. In the event that an Audit concludes that PBM has violated its obligations or the terms of this Agreement, and PBM disputes said Audit findings, PBM must set forth the basis for its dispute, with all supporting documentation, within thirty (30) days of PBM's receipt of the disputed Audit findings. PBM shall provide sufficient documentation to permit adequate review of the disputed issues and shall have the burden of demonstrating that NDPERS' (or its auditor's) conclusions are incorrect. To the extent PBM fails to provide documentation substantiating any part of its position, or fails to meet its burden of proof, PBM shall waive its right to further dispute that matter. After receiving PBM's documentation, NDPERS (or its auditor) shall review said documentation and advise PBM whether NDPERS has changed its Audit findings or conclusions. If the Parties do not resolve a dispute over Audit findings

within sixty (60) days of PBM's receipt of the disputed Audit findings, NDPERS may terminate the Agreement as set forth in the Agreement.

h. In the event that PBM disputes NDPERS' (or its auditor's) Audit findings, and PBM's basis for dispute is that NDPERS required or authorized certain activity, procedures, mechanisms or calculations to occur that are the subject of the dispute, PBM shall have the burden of providing written documentary evidence demonstrating its allegations. If PBM is unable to provide such evidence, PBM shall waive its right to assert such allegations.

6.4 PBM's Agreement to Pay Interest on Amounts Owed As A Result Of An Accurate Audit Finding

a. PBM acknowledges that should NDPERS (or its auditor) determine in an Audit that PBM has failed to satisfy certain obligations in this Agreement, PBM's subsequent payment to NDPERS will not make NDPERS whole, given the time lag between PBM's violation of terms in this Agreement, and its payment to NDPERS.

b. PBM agrees that should NDPERS (and its auditor) accurately conclude in an Audit that PBM has failed to satisfy any of the contract provisions included in Exhibit A, PBM will be required to pay interest on all amounts that are found due and owing, from the date that PBM's failure occurred (as more fully described below), until the date that PBM reimburses NDPERS for the damages caused. Interest shall be calculated at three percent (3%) per annum over the 10 Year Treasury Rate as of January 1st of the year that the Audit leading to the reimbursement concluded.

c. Timely Payment of Amounts Owed. Should NDPERS (or its auditor) accurately conclude that PBM has failed to meet any of the terms identified in this Agreement, PBM shall be obligated to reimburse NDPERS for the appropriate amount of interest within thirty (30) days after the Parties have resolved any dispute. After NDPERS (or the auditor) provides PBM with Audit findings, should PBM dispute any finding, the Parties will first attempt to resolve the dispute through discussion with the business managers of the respective Parties. If the business managers cannot successfully resolve the dispute, then NDPERS may terminate the Agreement under the terms of the Agreement.

ARTICLE 7 - CONFIDENTIALITY

7.1 Confidentiality of Information. PBM and NDPERS shall maintain the confidentiality of all Claims data and eligibility information to the full extent required by applicable law, including without limitation the provisions of the Health Insurance Portability and Accountability Act of 1996 (hereinafter, "HIPAA"), and may not use or disclose the information in any way prohibited by this Agreement or the law.

7.2 Treatment of Confidential Information NDPERS and PBM agree that all participation by NDPERS Members and their dependents in programs administered by NDPERS is confidential under North Dakota law. PBM may request and NDPERS shall provide directly to PBM upon such request, confidential information necessary for PBM to provide the services described in Article 3. PBM shall keep confidential all NDPERS information obtained in the course of delivering services. Failure of PBM to maintain the confidentiality of such information may be considered a material breach of the Agreement and may constitute the basis for additional civil and criminal penalties under North Dakota law. PBM shall not disclose any individual employee or dependent information without the prior written consent of the employee or family member. PBM has exclusive control over the direction and guidance of the persons rendering services under this Agreement.

PBM understands that, except for disclosures prohibited in this Agreement, NDPERS must disclose to the public upon request any records it receives from PBM. PBM further understands that any records that are obtained or generated by PBM under this contract, except for records that are confidential under this Agreement, may, under certain circumstances, be open to the public upon request under the North Dakota open records law. PBM agrees to contact NDPERS immediately upon receiving a request for information under the open records law and to comply with NDPERS' instructions on how to respond to the request.

7.3 Protected Health Information. NDPERS and PBM will have access to Protected Health Information (PHI) (as defined by HIPAA). Each party agrees, for itself and all of its officers, directors, management, employees, and any third parties it employs or with which it consults, that PHI shall not be used for any impermissible purpose, including, without limitation, the use of PHI for disciplinary or discriminatory purposes, and any user names and passwords assigned to designated individuals shall not be shared with non-designated individuals. Each Party, for itself and all of the above-identified agents, authorizes the other Party to use and share PHI as necessary to carry out its obligations in this Agreement, subject to each Party's obligation to fulfill all confidentiality requirements of HIPAA and all other applicable law.

7.4 HIPAA Compliance. NDPERS and PBM will comply with HIPAA and all applicable regulations published pursuant to HIPAA, as of the effective enforcement date of each standard. In addition, without limiting any other provision of this Agreement:

a. All services provided by PBM under this Agreement will be provided in such a manner as to enable every other Party to remain at all times in compliance with all HIPAA regulations applicable to the other Party to the extent that the other Party's compliance depends upon the manner in which such services are performed by PBM; and

b. All software, application programs and other products licensed or supplied by PBM under this Agreement will contain such characteristics and functionality (including as applicable, but not limited to, the ability to accept and securely transmit data using the standard HIPAA transaction sets) as necessary to ensure that each Party's use of such software, application programs and other products and associate documentation from PBM, when utilized by any Party in the manner directed by PBM, will fully comply with the HIPAA regulations.

7.5 Ownership of Information. All Claims data and other data arising from implementation of this Agreement shall solely be the property of NDPERS pursuant to N.D.C.C. § 54-52.1-12. PBM shall not be allowed to sell such data in any form, to any third party. Upon termination of this Agreement,

for any reason, PBM shall return or destroy all confidential information received from NDPERS, or created or received by PBM on behalf of NDPERS. This provision applies to confidential information that may be in the possession of subcontractors or agents of PBM. PBM shall retain no copies of the confidential information. In the event that PBM asserts that returning or destroying the confidential information is not feasible, PBM shall provide to NDPERS notification of the conditions that make return or destruction infeasible. Upon explicit written agreement of NDPERS that return or destruction of confidential information is not feasible, PBM shall extend the protections of this Agreement to that confidential information and limit further uses and disclosures of any such confidential information to those purposes that make the return or destruction infeasible, for so long as PBM maintains the confidential information.

ARTICLE 8 – TERM AND TERMINATION

8.1 Term of this Agreement. This Agreement shall become effective as of the execution of the Agreement by PBM and NDPERS. This Agreement shall remain in effect for a term of one Contract Year from the Benefit Effective Date of January 1, 2025, unless terminated by the Parties as described herein. NDPERS may terminate this Agreement, with or without cause, with written notice at least ninety (90) days prior to the termination date.

8.2 Termination of this Agreement due to NDPERS' Non-Payment. In the event NDPERS fails to timely pay PBM the full amounts owed as set forth in Article 4, PBM may issue a written Notification of Non-Payment informing NDPERS that (i) it is in material breach of the terms of this Agreement; and (ii) NDPERS will have thirty (30) days to cure its breach. Should NDPERS fail to comply with the above requirement, PBM shall be entitled to cease all PBM Services thirty (30) days after NDPERS receives PBM's Notification of Non-Payment. During the above-referenced period when NDPERS is in breach of its obligations to pay non-disputed amounts, PBM agrees to continue to provide PBM Services to NDPERS and its Members. However, PBM may set off any amounts owed for Financial Benefit Guarantees or to compensate PBM during that period for those undisputed amounts that have not been paid. In the event that NDPERS makes payment on or before the referenced thirty (30) day period, to be entitled to continue to receive PBM Services NDPERS must make payment for all amounts owed, less any amounts that PBM has previously set off. In the event that NDPERS fails to make full payment of all amounts owed as of the end of the thirty (30) day period, PBM shall be allowed to cut off all PBM Services to NDPERS, and PBM shall provide NDPERS with a Notice identifying the full amounts owed, less any amounts that PBM has previously set off. PBM shall also be entitled to continue to collect and retain all Financial Benefits until PBM has collected the amounts still owed, after which any additional Financial Benefits that PBM collects that represent NDPERS' Pro Rata Share of Financial Benefits must be passed through by PBM to NDPERS.

8.3 Termination by Mutual Agreement or with Notice. This Contract may be terminated at any time by mutual consent of both parties executed in writing, or by either party with ninety (90) days' notice.

8.4 Termination for Lack of Funding or Authority. NDPERS by written notice to PBM, may terminate the whole or any part of this Contract under any of the following conditions: 1) If funding from federal, state, or other sources is not obtained and continued at levels sufficient to allow for purchase of the services or supplies in the indicated quantities or term. 2) If federal or state laws or rules are modified or interpreted in a way that the services are no longer allowable or appropriate for purchase under this Contract or are no longer eligible for the funding proposed for payments authorized by this Contract. 3) If any license, permit, or certificate required by law or rule, or by the terms of this Contract, is for any reason denied, revoked, suspended, or not renewed. Termination of this Contract under this subsection is without prejudice to any obligations or liabilities of either party already accrued prior to termination.

8.5 Effect of Termination. Termination shall have no effect upon the rights and obligations of the Parties arising out of any transactions occurring prior to the effective date of such termination. Upon termination: (i) all further obligations of the Parties under this Agreement shall terminate as of the termination date (except as provided in this Agreement); (ii) all Confidential Information provided by any Party (except for Confidential Information required by any law, or by a contractual relationship to be retained by a Party) shall be immediately returned to a requesting Party, or the Party from whom information is requested shall certify to the requesting Party that all requested materials have been destroyed; (iii) no Party shall be relieved of any obligation or liability arising from any prior breach by such Party of any provision of this Agreement; and (iv) the Parties shall, in all events, remain bound by and continue to be subject to the provisions set forth in this Agreement, to the extent necessary to satisfy this Agreement's terms.

8.6 PBM's Agreements Concerning Documents, Data and Information, Should This Agreement Be Terminated. PBM hereby agrees to provide, without delay, but in any event no later than thirty days

prior to the expiration of the Agreement between NDPERS and PBM, and at no cost, in electronic or other standard PBM formats requested by NDPERS, all reasonably requested documents, data and information that are necessary to enable transition of the services being performed hereunder to any replacement PBM selected by NDPERS. PBM acknowledges that time is of the essence for providing the necessary documents, data and information described herein to effectuate a transition to any replacement PBM. At a minimum, such information shall **include:** (i) All Member enrollment information, including demographic information; (ii) Electronic claims prescription records from NDPERS' Benefit Effective Date(s) onwards; (iii) Hard copy claim transaction records as requested by NDPERS; and (iv) Information on Prior Authorization and Step Therapy and any other "accumulator benefit," for example, Member deductibles and maximum benefit amounts and refill information, all in electronic format.

ARTICLE 9 – RIGHT TO IMPLEMENT PLAN MANAGEMENT PROGRAMS

9.1 NDPERS' Right to Develop Programs, and PBM's Obligation to Assist NDPERS in the Development of Programs. Notwithstanding PBM's right to serve as NDPERS' prescription benefit provider, PBM acknowledges that NDPERS may implement new programs to improve drug coverage benefits, improve the health of Members, and/or reduce costs, provided said programs are in accordance with any CMS, federal or state statutes and/or regulations or rules

Should NDPERS request PBM's assistance with any of the matters identified in the above two paragraphs, PBM agrees to provide said assistance.

The Parties acknowledge that any of the above-described initiatives by NDPERS may impact PBM's ability to satisfy guarantees contained in this Agreement. Accordingly, NDPERS shall discuss all such initiatives with PBM prior to their implementation, and PBM shall thereafter provide a formal written notification to NDPERS of the extent to which any such initiative might impact guarantees in this Agreement. PBM represents and agrees that its notification will reflect the actual impact of NDPERS' initiatives on PBM's ability to satisfy any identified guarantees. Should an adjustment to a guarantee be necessitated due to NDPERS' initiative, PBM shall bear the burden of demonstrating the need for, and amount of, said adjustment.

ARTICLE 10 – MISCELLANEOUS ADDITIONAL PROVISIONS

10.1 Choice of Law and Venue. This agreement shall be construed, interpreted, and governed according to the laws of the State of North Dakota without regard to its conflict of laws and rules. Any action commenced to enforce this Contract must be brought in the District Court of Burleigh County, North Dakota.

10.2 Attorneys Fees. In the event a lawsuit is initiated by NDPERS to obtain performance due under this contract, and NDPERS is the prevailing party, PBM shall, except when prohibited by N.D.C.C. § 28-26-04, pay NDPERS's reasonable attorney fees and costs in connection with the lawsuit.

10.3 Use of the Name and all Symbols, Trademarks, and Service Marks. Each Party reserves the right to control the use of each of its own names and all symbols, trademarks, and service marks presently existing or subsequently established. Each Party further agrees that it will not use any other Party's name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without the other Party's prior written consent and will cease any and all usage immediately upon another Party's request or upon termination of this Agreement.

10.4 Force Majeure. A Party's performance obligations under this Agreement shall be suspended to the extent that all or part of this Agreement cannot be performed due to causes that are outside the control of the Party. Without limiting the generality of the foregoing, such causes include acts of God, acts of a public enemy, acts of any person engaged in a subversive or terrorist activity or sabotage, wars, fires, floods, earthquakes, explosions, strikes, slow-downs, freight embargoes, and comparable causes. The foregoing shall not be considered to be a waiver of any continuing obligations under this Agreement, and as soon as said conditions abate sufficiently to allow the resumption of operations, the Party affected thereby shall fulfill its obligations as set forth under this Agreement.

10.5 Consent to Amend. This Agreement may be amended at any time during the term of this Agreement, but only by mutual written consent of duly authorized representatives of each or the signatory Parties required to amend this Agreement.

10.6 Severability. In the event that any provision of any executed Agreement shall be determined to be invalid, unlawful, void, or unenforceable to any extent, the remainder of said Agreement, and the application of such provision other than those as to which it is determined to be invalid, unlawful, void or unenforceable, shall not be impaired or otherwise affected and shall continue to be valid and enforceable to the fullest extent permitted by law.

10.7 Successors and Assigns. No rights or benefits under this Agreement are assignable by any Party to any third party unless approved, in writing, by the other Parties executing this Agreement. Any assignment by any Party without the express prior written consent of all other executing Parties shall be void and shall not relieve the assigning Party of any of its obligations or liabilities arising from the attached Agreement. Notwithstanding the foregoing, PBM may assign any functions to be performed under this Agreement to its respective wholly-owned subsidiaries, provided all other provisions in the attached Agreement are honored.

PBM may not assign or otherwise transfer or delegate any right or duty without the express written consent of NDPERS. However, PBM may enter into subcontracts provided that any subcontract acknowledges the binding nature of this Agreement and incorporates this Agreement, including any attachments. PBM is solely responsible for the performance of any subcontractor. PBM does not have authority to contract for or incur obligations on behalf of NDPERS.

10.8 Prior Agreements Invalid. As of the execution date of this Agreement, this Agreement replaces and supersedes all other prior Agreements between the parties executing this Agreement, as well as any other prior written or oral understandings, negotiations, discussions, or arrangements between those parties, related to matters covered by this Agreement or the documents incorporated herein.

10.9 Entire Agreement. PBM agrees to provide the service(s) as specified in the 2024 RFP and proposal (attached hereto and incorporated by reference Exhibit A). The provisions of this Agreement, including all the Exhibits attached hereto, shall bind and inure to the benefit of the identified Parties executing this Agreement, and to their heirs, legal representatives, permitted successors and permitted assignees. Notwithstanding anything herein to the contrary, in the event of any inconsistency or conflict among the documents making up this Agreement, the documents must control in this order of precedence:

a. The terms of this Agreement.
b. Bidder's written responses provided as part of the Request for Proposal;
c. Bidder's Proposal for 2025

10.10 Counterparts. This Agreement may be executed in one or more counterparts, all of which shall be considered one and the same Agreement and shall become effective when one or more counterparts have been signed by each of the necessary Parties and delivered to the other necessary signing Parties, it being understood that each Party need not sign the same counterpart. The failure to deliver the original signature copy and/or the non-receipt of the original signature copy shall have no effect upon the binding and enforceable nature of this Agreement.

10.11 Representations. Each Party signing this Agreement represents and warrants that he or she (i) has read this Agreement and fully understands and agrees to the content herein; (ii) has entered into this Agreement voluntarily; (iii) has not transferred or assigned or otherwise conveyed in any manner or form any of the rights, obligations or claims which are the subject matter of this Agreement; and (iv) has the full power and authority to execute this Agreement. This Agreement is not binding unless executed by all signatories identified in this Agreement.

Signature Page

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be duly executed under seal effective as of the date set forth in the opening paragraph of this Agreement.

PBM: _____

By: Date:

Name and Title:_____

North Dakota Public Employees Retirement System (Plan Sponsor):

_____

By: Date:

Name and Title:_____

EXHIBIT A

PRESCRIPTION DRUG PRICING AND GUARANTEES

1. PBM's General Representations and Agreements. PBM agrees to provide to NDPERS, in full compliance with CMS and North Dakota law which contains certain restrictions related to pharmacies: (a) a Retail Pharmacy Network, and the ability for Members to process paper claims from retail pharmacies that may not be part of its Retail Pharmacy Network; (b) ongoing dispensing from its Mail Order Pharmacy; (c) ongoing dispensing from its Specialty Drug Pharmacy; (d) ongoing negotiations by PBM with its Retail Pharmacy Network and with Pharmaceutical Manufacturers to attempt to improve its pricing continuously; (e) Pass-Through Pricing for every Covered Item from each of the above pharmacies; and (f) PBM's agreement that to the extent it negotiates multiple contracts with the same pharmacy with different pricing, PBM will provide its "best pricing available" for NDPERS as its Pass-Through Pricing to NDPERS. The Parties agree that said "best pricing available" shall mean PBM will pass through to NDPERS the terms most favorable for (and least expensive to) NDPERS, unless PBM's multiple contracts or alternative financial terms were negotiated by PBM for purposes of providing terms to PBM clients that use limited pharmacy networks or have particular business terms acceptable to a pharmacy for one-off pricing, or that are "dissimilar" to NDPERS, such as Workers Compensation providers, 340(b) providers, a Staff Model Pharmacy, a long term care pharmacy provider or the pricing is for Medicaid or Dual Eligible clients.

2. In connection with any Medicare Part D Plan, PBM agrees to comply, and to contractually require all Related Entities and Downstream Entities (as those terms are defined by CMS) to comply, with all CMS Requirements, which require that PBM (and all Related Entities and Downstream Entities)

    i. pass through in connection with each self-insured EGWP Plan one hundred percent (100%) of all DIR, and

    ii. retain only those financial benefits that satisfy CMS Requirements concerning Bona Fide Service Fees,

    iii. properly allocate DIR as set forth in CMS requirements; and

    iv. properly report to CMS concerning all of the above. In connection with any fully-insured EGWP Plan, PBM agrees to adhere to the same standards as described above and to accurately account for all DIR and Bona Fide Service Fees to CMS.

3. Compliance with North Dakota Century Code. PBM agrees to comply with all provisions of North Dakota Century Code Chapter 54-52.1-04.

4. Average Annual Guarantees**:**

I. Average Annual AWP Discounts – Minimum Guarantees	**1/1/2025**
30 Day Retail	
Brand (AWP - __%)	
Generic (MAC & Non MAC - __%)	
90 Day Retail	
Brand (AWP - __%)	
Generic (MAC & Non MAC - __%)	
Mail Order	
Brand (AWP - __%)	
Generic (MAC & Non MAC - __%)	

Specialty	
Guaranteed Overall Effective Discount	
Limited Distribution Drugs	
Guaranteed Overall Effective Discount	
II. Average Annual Dispensing Fees – Maximum Guarantees	**1/1/2025**
30 Day Retail	
Brand	
Generic	
90 Day Retail	
Brand	
Generic	
Mail Order	
Brand	
Generic	
Specialty	
Brand	
Generic	
Limited Distribution Drugs	
Brand	
Generic	
III. Fixed Monthly Administrative Fees	**1/1/2025**
EGWP Administrative Fee *(insert basis here e.g. PEPM, PMPM, Per Rx)*	
IV. Financial Benefits – Minimum Per Brand Claim Guarantees	**1/1/2025**
Per Brand Prescription - 30 Day Retail	
Per Brand Prescription - 90 Day Retail	
Per Brand Prescription - Mail	
Per Brand Prescription - Specialty Excluding Limited Distribution Drugs	
Per Brand Prescription - Specialty Limited Distribution Drugs	
V. Other Fees	**1/1/2025**
Intake and load claim history files, prior authorization files, open mail order refill files, accumulator files during implementation	
Ongoing file feed transmission to 3rd party (consultant, data warehouse, wellness and/or disease management, accumulators, stop loss)	
Paper Claim Processing (per claim basis)	
Electronic prescribing (per claim basis)	
Administrative Prior Authorization (per authorization basis)	
Clinical Prior Authorization (per authorization basis)	
Nursing Charges (per visit (if applicable))	
Online Reporting Platform Access (per user basis)	
Custom Reporting Programming (per hour basis)	
Replacement of ID Card	
Other *(insert rows and list additional fees)*	

VI. Optional Clinical Programs	1/1/2025
(insert program name)	

5. The Measurement and Calculation of the Satisfaction of All Average Annual Guarantees**.** In measuring and calculating whether PBM satisfied every Average Annual Guarantee, all of the following parameters shall be used:

    a. In calculating each Average Annual Guarantee for Ingredient Costs: PBM shall categorize "Brand Drugs" and "Generic Drugs" based on the definitions contained in this Agreement, and shall include all Dispensed Claims for Covered Items, including, if they are Covered Items, all insulin supplies, all test strips and insulin products, but excluding all (i) coded and uncoded Compound Drugs; (ii) drugs dispensed at the Specialty Drug Pharmacy; (iii) Claims that are from LTC pharmacies or government owned or operated pharmacies (e.g. Veterans Administration); (iv) Claims paid at government required amounts (e.g. Medicaid); (v) 340B Claims; (vi) vaccines; and (vii) Claims processed and paid through another insurer as a result of the coordination of benefits. PBM shall include all of the Dispensed Claims described as being "included" in this paragraph, regardless of whether PBM reimbursed a pharmacy using an AWP discount price, a MAC price or a non-MAC price or U&C; In instances where PBM used U&C to reimburse the retail pharmacy, PBM will allocate its entire cost to the Ingredient Cost, as described in the Definition for Ingredient Cost.

    b. In calculating each Average Annual Guarantee for Dispensing Fees: PBM shall categorize "Brand Drugs" and "Generic Drugs" based on the definitions contained in this Agreement, and shall include all Dispensed Claims for Covered Items, including, if they are Covered Items, all insulin supplies, all test strips and insulin products, but excluding all (i) coded and uncoded Compound Drugs; (ii) drugs dispensed at the Specialty Drug Pharmacy; (iii) Claims from LTC pharmacies or government owned or operated pharmacies (e.g. Veterans Administration); (iv) Claims paid at government required amounts (e.g. Medicaid); (v) 340B Claims; (vi) vaccines; and (vii) Claims paid through another insurer as a result of the coordination of benefits. PBM shall include all Dispensed Claims described as being "included" in this paragraph, regardless of whether PBM reimbursed a pharmacy using an AWP discount price, a MAC price or a non-MAC price or U&C; In instances where PBM used U&C to reimburse the retail pharmacy, PBM will be entitled to credit itself with a $0 Dispensing Fee, as described in the Definition for Dispensing Fee.

    c. Treatment of Financial Benefits: In calculating each Average Annual Guarantee, PBM shall also not include any Financial Benefits.

    d. Exclusion of Program Savings: In calculating each Average Annual Guarantee, PBM shall also not include any savings brought about by any Program implemented by and for NDPERS. The AWP discount for the Brand Drug dispensed shall be factored into the applicable Brand Drug Average Annual Guarantee, and PBM shall not also include NDPERS' savings resulting from the differential between the cost of the Generic Drug and Brand Drug. Similarly, in connection with Programs such as a Prior Authorization and Step Therapy, the invoiced cost to NDPERS of the drug dispensed shall be the only figure used to determine PBM's satisfaction of Average Annual Guarantees, and any savings resulting from the Program shall not also be factored into calculating satisfaction of Average Annual Guarantees.

e. PBM's Payment for Failure to Satisfy Any Average Annual Guarantee. In addition to the parameters set forth herein, the Parties agree that the following methods shall be used by PBM, NDPERS and/or NDPERS' auditor to determine whether PBM has satisfied each of the Average Annual Guarantees for NDPERS:

1. For each of the Ingredient Cost Guarantees (one (1) brand, and two (2) generic, in each of three (3) drug categories – retail, Retail 90 and mail): The total sum of the Extended AWPs shall be calculated for all Dispensed Claims based on the parameters set forth herein and shall be called "Total AWPs." The total Ingredient Costs invoiced to NDPERS for the same Dispensed Claims shall be calculated and shall be called "Total Invoiced Costs." The following formula shall thereafter be applied:

   1 – (Total Invoiced Costs/Total AWPs) = Actual Average Annual Rate

   If the Actual Average Annual Rate is less than the Guaranteed Average Rate stated for any Guarantee, than the overcharge that the PBM must reimburse to NDPERS shall be:

   (Guaranteed Average Rate - Actual Average Annual Rate) x (Total AWPs)

2. For each of the Dispensing Fee Guarantees (retail brand, retail generic, Retail 90 brand, Retail 90 generic, mail brand, and mail generic): The total number of Dispensed Claims shall be calculated based on the parameters set forth herein, and the total Dispensing Fees associated with those Dispensed Claims shall be calculated, and the latter shall be divided by the former to determine the actual average Dispensing Fee for that Guarantee.

   If the actual Average Annual Dispensing Fee is greater than the Guaranteed Average Dispensing Fee stated, than the overcharge that PBM must reimburse to NDPERS shall be:

   (Actual Average Annual Dispensing Fee - Guaranteed Average Dispensing Fee) x (total numbers of Dispensed Claims)

f. Non-Offsetting Guarantees. Should PBM be found by NDPERS (or NDPERS' auditor) to have failed to satisfy any of the Average Annual Guarantees (or any renegotiations of said Guarantees), PBM shall pay NDPERS the amounts reflected by the formulas stated in this Exhibit. PBM shall not be allowed to offset any failure to satisfy any Financial Guarantee against PBM's excess satisfaction of any Financial Guarantee. In the event that PBM fails to satisfy any Average Annual Guarantee, PBM shall be fully liable for its failure to satisfy that Guarantee, regardless of PBM's success in exceeding any other Financial Guarantee in this Agreement.

6. PBM's Agreement to Provide Annual Reconciliations. PBM agrees to provide to NDPERS (and its auditors) Annual Reconciliations of PBM's Actual Average Rates as compared to its Guaranteed Average Rates. Should PBM's Actual Average Rates be weaker than its Guaranteed Average Rates, PBM further agrees to pay the difference to NDPERS at the time of its Annual Reconciliation.

7. On or about the beginning of the tenth (10th) month of each Medicare Part D Contract Year - beginning in the second year after the Effective Date of this Agreement and continuing until the year after termination of this Agreement, PBM agrees to perform an Annual Reconciliation calculating the difference between (i) the Financial Benefits or DIR that were passed through up until that date for the previous relevant Contract Year in connection with Invoice Statements, and the (ii) actual Financial Benefits or DIR collected by PBM from Pharmaceutical Manufacturers and due and owing to NDPERS as NDPERS' Pro Rata Share of Financial Benefits or DIR for the previous relevant Contract Year. Should the amounts passed through in item (i) above be less than the amounts calculated in item (ii)

above, PBM shall pay NDPERS the difference, at the time PBM transmits its Annual Pass-Through Reconciliation. Should the amounts passed through in item (i) above be more than the total amounts calculated in item (ii) above, NDPERS will not owe PBM the differential, but said amount shall be used as an offset against PBM's pass-through obligations in the future. Notwithstanding PBM's obligation to provide Annual Pass-Through Reconciliations, NDPERS shall have the right to conduct its own Audit to determine whether PBM has satisfied its Financial Benefit and DIR Pass-Through obligations under this Agreement.

8. Specialty Drugs.

   a. Management and Administration. Subject to the requirements of any regulatory authority, PBM is required to (i) ensure that Specialty Drugs are dispensed using the pricing and guarantees described in this Agreement; (ii) apply any agreed upon protocols established by PBM and NDPERS including but not limited to protocols concerning quantity limits and refill/renewal practices.

   b. Specialty Drug Minimum Guaranteed Discounts for Specialty Drugs Dispensed from the Specialty Drug Pharmacy. The Parties agree that the Minimum Guaranteed Discounts identified on Exhibit B shall constitute "Minimum Guaranteed Discounts" for each Specialty Drug, when it is dispensed from the Specialty Drug Pharmacy. For every Claim, PBM agrees to invoice for each Specialty Drug that is on Exhibit B and that is dispensed from the Specialty Drug Pharmacy using Pass-Through Pricing, with such Pass-Through Pricing being as favorable as, or more favorable than, the Minimum Guaranteed Discounts identified on Exhibit B. *[Each PBM Contestant must provide a Specialty Drug Pricing Schedule and thus identify its drug-by-drug Minimum Guaranteed Discount for each Specialty Drug when said Specialty Drug is dispensed from the Specialty Pharmacy.]*

   c. Default Discount Guarantee for New-to-Market Specialty Drugs Dispensed from the Specialty Drug Pharmacy. PBM agrees to provide a Default Discount Guarantee of AWP-___% for all new-to-market Specialty Drugs dispensed from the Specialty Drug Pharmacy. [*Each PBM to fill in blank with proposed Default Discount Guarantee]*

   d. Protocol for Dispensing New-to-Market Specialty Drugs. In connection with dispensing new-to-market Specialty Drugs (that are not yet listed on Exhibit B), NDPERS has decided that: NDPERS will allow PBM to dispense new-to-market Specialty Drugs from retail pharmacies or the Specialty Drug Pharmacy without the NDPERS' prior approval. For all such dispensed drugs, PBM will be obligated to invoice using Pass-Through Pricing whether the Drugs are dispensed from retail Pharmacies or the Specialty Drug Pharmacy. If the new-to-market Specialty Drug is dispensed from the Specialty Drug Pharmacy, PBM will also be obligated to ensure said pricing is at least as favorable as the Default Discount Guarantee.

   e. PBM's Payment for Failure to Satisfy Any Specialty Drug Minimum Guaranteed Discount, or Default Discount Guarantee. The Parties agree that the following method shall be used by PBM, NDPERS or NDPERS' auditor to determine whether PBM has satisfied each of the Specialty Drug Minimum Guaranteed Discounts stated on Exhibit B, or when applicable, PBM's Default Discount Guarantee: For each Specialty Drug dispensed from the Specialty Drug Pharmacy each Dispensed Claim shall be re-priced according to the Minimum Guaranteed Discounts identified on Exhibit B (or an amendment thereto) or if the Specialty Drug was dispensed from the Specialty Drug Pharmacy but was a new-to-market Specialty Drug not yet listed on Exhibit B with an agreed upon Minimum Guaranteed Discount, based on application of the Default Discount Guarantee. Should the amount calculated be less than the amount invoiced to NDPERS, PBM shall pay the difference to NDPERS.

   f. PBM shall not be allowed to offset its failure to satisfy any Specialty Drug Minimum Guaranteed Discount or Default Discount Guarantee against PBM's excess satisfaction of any other

Specialty Drug Minimum Guaranteed Discount or the Default Discount Guarantee (or any other Financial Guarantee in this Agreement).

9. PBM's Pass-Through of Financial Benefits. PBM agrees to pass-through 100% of NDPERS' Pro Rata Share of all Financial Benefits that PBM receives from all third parties. PBM agrees to pay its Financial Benefit Guarantees at the end of each quarter, beginning at the end of the second quarter after NDPERS' Benefit Effective Date and continuing until after NDPERS' termination date when all Financial Benefits are paid according to this contract.

    a. PBM's Agreement To Pass Through - and Report - To NDPERS Its Pro Rata Share of Financial Benefits. PBM agrees to pass through to NDPERS 100% of NDPERS' Pro Rata Share of all Financial Benefits that PBM receives from all Pharmaceutical Manufacturers, and as are reflected in all PBM/Pharmaceutical Manufacturer Contracts.

    b. Definition of Pro Rata Share of Financial Benefits. NDPERS' Pro Rata Share of Financial Benefits shall be defined to include, but not be limited to, the following:

        1. In connection with any PBM/Pharmaceutical Manufacturer Contract that calls for the payment of a flat amount per prescription (or per Dispensed Claim), PBM shall pass through to NDPERS that amount times the number of prescriptions (or Dispensed Claims) dispensed to NDPERS' Members.

        2. In connection with any PBM/Pharmaceutical Manufacturer Contract that calls for the payment of a percentage amount (of the total AWP, or total WAC, or total ASP, etc.) dispensed, PBM shall pass through to NDPERS the percentage amount times the total AWP, or total WAC, or total ASP (or other identified amount) dispensed to NDPERS' Members.

        3. In connection with any PBM/Pharmaceutical Manufacturer Contract that calls for the payment of tiered additional payments based on any factor (such as the added market share, or added number of prescriptions dispensed, etc.), PBM shall multiply the total amount paid as a tiered additional payment, by the "Percentage of PBM's Aggregate Book Of Business" that NDPERS represents (as described below in subparagraph v).

        4. In connection with any PBM/Pharmaceutical Manufacturer Contract that calls for a flat payment of money related – or unrelated - to any drugs dispensed (e.g., the payment by a Pharmaceutical Manufacturer of a health management fee, or data sales fee, or educational grant, etc.), PBM shall calculate NDPERS' Pro Rata Share of said payment by multiplying the amount of the payment, by the "Percentage of PBM's Aggregate Book Of Business" that NDPERS represents (as described below in subparagraph v).

        5. The "Percentage of PBM's Aggregate Book Of Business" that NDPERS represents shall be measured by the total amount paid to Participating Pharmacies (Ingredient Costs plus Dispensing Fees) by PBM on behalf of NDPERS, divided by the total amount paid to Participating Pharmacies (Ingredient Costs plus Dispensing Fees) by PBM on behalf of all PBM's clients including NDPERS. The time frame for the calculations identified herein shall be the same time frame used by the Pharmaceutical Manufacturer to pay the PBM.

    c. PBM's Obligation To Pass Through To NDPERS Its Pro Rata Share of All Financial Benefits. In connection with any Financial Benefits that may be collected by PBM from Pharmaceutical Manufacturers, PBM agrees that it is obligated to pass through to NDPERS the appropriate amount of Rebates, including if said Rebates are collected after any Annual Reconciliation or after the termination of this Agreement.

    d. The Parties agree that in calculating PBM's satisfaction of any Financial Benefit Guarantees, the Parties will determine what constitutes a Brand Drug based on the Definitions in this

Agreement, and the Parties will not include: member submitted paper Claims, or Claims submitted to and paid by another provider based on coordination of benefits programs, or Compound Drugs or VA Claims or 340b Claims. However, the Parties will include: OTC Claims and insulin and test strips. The Parties further agree that in calculating PBM's satisfaction of any Financial Benefit Guarantees, the Parties will not include any Dispensed Claims representing drugs dispensed in connection with government programs that receive rebates, discounts or other forms of price reduction and that therefore preclude PBM from payment of Financial Benefits to NDPERS.

e. Annual Reconciliation of Financial Benefit Guarantees and NDPERS' Right to Audit All Such Guarantees. Within 90 days after the end of each Contract Year, PBM agrees to perform – and transmit to NDPERS – an annual Reconciliation calculating the difference between the amount of payments that were owed during the previous Contract Year based on the Financial Benefit Guarantees stated in this Agreement, and the total amount that was actually passed through during the previous Contract Year. Should the total amounts passed through in connection with Invoice Statements be less than the guaranteed amounts, PBM will pay NDPERS the differential at the time that the Reconciliation is transmitted. Should the total amounts passed through in connection with Invoice Statements be more than the guaranteed amounts, no exchange of funds will take place as a result of this Annual Guarantee Reconciliation, since the guaranteed amounts are in fact guaranteed.

EXHIBIT B

LIST OF SPECIALTY DRUGS,
AND MINIMUM GUARANTEED DISCOUNTS FOR SPECIALTY DRUGS

The Parties agree that the drugs identified on this Exhibit shall be categorized as Specialty Drugs during the term of the Agreement. The Parties also agree that the drugs identified on this Exhibit can be modified by mutual, written agreement of the Parties on a quarterly basis, as described in Exhibit A of the Agreement.

The Parties further agree that the discounts specified below shall constitute Specialty Drug Minimum Guaranteed Discounts, as described in Exhibit A of the Agreement. The specified Minimum Guaranteed Discounts are exclusive of any Financial Benefits that are passed through by PBM to NDPERS, exclusive of Dispensing Fees or sales taxes or use taxes, but inclusive of any Copayment or Coinsurance to be paid by the Member.

The Parties also agree that assuming that a Specialty Drug identified on this Exhibit is a Covered Item for NDPERS, and allowed by NDPERS to be dispensed from the Specialty Drug Pharmacy, when said Specialty Drug is dispensed by PBM's Specialty Drug Pharmacy PBM shall invoice NDPERS for each such Specialty Drug using Pass-Through Pricing, with said invoiced cost being no more than the cost resulting from application of the Specialty Drug Minimum Guaranteed Discount identified below (or in mutually agreed upon written amendments hereto), less the appropriate Copayment or Coinsurance. In referencing drugs "dispensed from PBM's Specialty Drug Pharmacy" in this paragraph, the Parties agree that said reference includes certain Specialty Drugs that may be dispensed from an alternative specialty drug pharmacy if said pharmacy is the exclusive provider of said drugs.

The Parties also agree that in the event the PBM receives a prescription for a new-to-market Specialty Drug that has not yet been added to this Exhibit, PBM will adhere to NDPERS' protocols, by delaying the dispensing of said new-to-market Specialty Drug until such time as NDPERS has granted approval in writing for the Specialty Drug to be dispensed, at which time PBM will dispense and invoice for the Drug using the agreed-upon Minimum Guaranteed Discount.

If a Specialty Drug with a different NDC or J Code, but the same "Label Name" as identified below is a Dispensed Claim, and the Specialty Drug is dispensed by PBM's Specialty Drug Pharmacy, PBM guarantees that NDPERS shall be invoiced using the above-described protocols, but relying on the AWP discount identified below for that Specialty Drug with that Label Name.

Specialty Drug List to be attached here. *List must include NDC, Label Name, and Minimum Guaranteed Discount. The PBM's Specialty Drug Spreadsheet will represent a binding contractual commitment, and will be included and incorporated into this contract prior to NDPERS' execution of the contract.*

PBM acknowledges its understanding that NDPERS values outstanding and timely performance and services to NDPERS and to all Members. Accordingly, PBM provides the following Performance Guarantees *[Appendix G – Performance Guarantees to be inserted below]*

[Plan Design to be inserted here by NDPERS]

Business Associate Agreement

This Business Associate Agreement, which is an addendum to the underlying contract, is entered into by and between, the North Dakota Public Employees Retirement System ("NDPERS") and *[PBM to identify its name].*

1. Definitions

   a. Terms used, but not otherwise defined, in this Agreement have the same meaning as those terms in the HIPAA Privacy Rule, 45 C.F.R. Part 160 and Part 164, Subparts A and E, and the HIPAA Security rule, 45 C.F.R., pt. 164, subpart C.
   b. Business Associate. "Business Associate" means *[PBM to identify its name]*
   c. Covered Entity. "Covered Entity" means the **North Dakota Public Employees Retirement System Health Plans**.
   d. PHI and ePHI. "PHI" means Protected Health Information; "ePHI" means Electronic Protected Health Information.

2. Obligations of Business Associate.

2.1. The Business Associate agrees:

   a. To use or disclose PHI and ePHI only as permitted or required by this Agreement or as Required by Law.
   b. To use appropriate safeguards and security measures to prevent use or disclosure of the PHI and ePHI other than as provided for by this Agreement, and to comply with all security requirements of the HIPAA Security rule.
   c. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains or transmits on behalf of the Covered Entity as required by the HIPAA Security rule.
   d. To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI or ePHI by Business Associate in violation of the requirements of this Agreement.
   e. To report to Covered Entity (1) any use or disclosure of the PHI not provided for by this Agreement, and (2) any "security incident" as defined in 45 C.F.R. § 164.304 involving ePHI, of which it becomes aware without unreasonable delay and in any case within thirty (30) days from the date after discovery and provide the Covered Entity with a written notification that complies with 45 C.F.R. § 164.410 which shall include the following information:
      i. to the extent possible, the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired or disclosed during the breach;
      ii. a brief description of what happened;
      iii. the date of discovery of the breach and date of the breach;
      iv. the nature of the Protected Health Information that was involved;
      v. identity of any person who received the non-permitted Protected Health Information;
      vi. any steps individuals should take to protect themselves from potential harm resulting from the breach;
      vii. a brief description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and
      viii. any other available information that the Covered Entity is required to include in notification to an individual under 45 C.F.R. § 164.404(c) at the time of the notification to the State required by this subsection or promptly thereafter as information becomes available.

f. With respect to any use or disclosure of Unsecured Protected Health Information not permitted by the Privacy Rule that is caused by the Business Associate's failure to comply with one or more of its obligations under this Agreement, the Business Associate agrees to pay its reasonable share of cost-based fees associated with activities the Covered Entity must undertake to meet its notification obligations under the HIPAA Rules and any other security breach notification laws;
g. Ensure that any agent or subcontractor that creates, receives, maintains, or transmits electronic PHI on behalf of the Business Associate agree to comply with the same restrictions and conditions that apply through this Agreement to the Business Associate.
h. To make available to the Secretary of Health and Human Services the Business Associate's internal practices, books, and records, including policies and procedures relating to the use and disclosure of PHI and ePHI received from, or created or received by Business Associate on behalf of Covered Entity, for the purpose of determining the Covered Entity's compliance with the HIPAA Privacy Rule, subject to any applicable legal privileges.
i. To document the disclosure of PHI related to any disclosure of PHI as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
j. To provide to Covered Entity within 15 days of a written notice from Covered Entity, information necessary to permit the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
k. To provide, within 10 days of receiving a written request, information necessary for the Covered Entity to respond to an Individual's request for access to PHI about himself or herself, in the event that PHI in the Business Associate's possession constitutes a Designated Record Set.
l. Make amendments(s) to PHI in a designated record set as directed or agreed by the Covered Entity pursuant to 45 C.F.R. § 164.526 or take other measures as necessary to satisfy the covered entity's obligations under that section of law.
m. To participate in The Third Party Risk Management (TPRM) program in order to identify and reduce risks associated with third party security breaches and protect North Dakota state citizen data, unless Business Associate is able to provide FedRAMP, StateRAMP, or HiTrust certifications. Business Associate will be reassessed at least every one to two years based on the risk associated with their service or the data they handle.

3. Permitted Uses and Disclosures by Business Associate

3.1. General Use and Disclosure Provisions

Except as otherwise limited in this Agreement, Business Associate may Use or Disclose PHI and ePHI to perform functions, activities, or services for, or on behalf of, Covered Entity, specifically, Pharmacy Benefit Management Services – provided that such use or disclosure would not violate the Privacy Rule or the Security Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

3.2. Specific Use and Disclosure Provisions

Except as otherwise limited in this Agreement, Business Associate may use PHI and ePHI:

a. For the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
b. To provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B), but Business Associate may not disclose the PHI or ePHI of the Covered Entity to any other client of the Business Associate without the written authorization of the covered entity Covered Entity.

c. To report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §§ 164.304 and 164.502(j)(1).

4. Obligations of Covered Entity

4.1. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

Covered Entity shall notify Business Associate of:

a. Any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that any such limitation may affect Business Associate's use or disclosure of PHI.
b. Any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that any such changes may affect Business Associate's use or disclosure of PHI.
c. Any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that any such restriction may affect Business Associate's use or disclosure of PHI.

4.2. Additional Obligations of Covered Entity. Covered Entity agrees that it:

a. Has included, and will include, in the Covered Entity's Notice of Privacy Practices required by the Privacy Rule that the Covered Entity may disclose PHI for Health Care Operations purposes.

b. Has obtained, and will obtain, from Individuals any consents, authorizations and other permissions necessary or required by laws applicable to the Covered Entity for Business Associate and the Covered Entity to fulfill their obligations under the Underlying Agreement and this Agreement.

c. Will promptly notify Business Associate in writing of any restrictions on the Use and Disclosure of PHI about Individuals that the Covered Entity has agreed to that may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Agreement.

d. Will promptly notify Business Associate in writing of any change in, or revocation of, permission by an Individual to Use or Disclose PHI, if the change or revocation may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Agreement.

4.2. Permissible Requests by Covered Entity
Covered Entity may not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule or the Security Rule if done by Covered Entity, except that the Business Associate may use or disclose PHI and ePHI for management and administrative activities of Business Associate.

5. Term and Termination

a. Term. The Term of this Agreement shall be effective as of January 1, 2025, and shall terminate when all of the PHI and ePHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI and ePHI, protections are extended to any such information, in accordance with the termination provisions in this Section.
b. Automatic Termination. This Agreement will automatically terminate upon the termination or expiration of the Underlying Agreement.

c. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
    1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the Underlying Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;
    2. Immediately terminate this Agreement and the Underlying Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
    3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

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

6. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the HIPAA Privacy or Security Rule means the section as in effect or as amended.
b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule, the Security Rule, and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
c. Survival. The respective rights and obligations of Business Associate under Section 5.c, related to “Effect of Termination,” of this Agreement shall survive the termination of this Agreement.
d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy and Security Rules.
e. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything this Agreement confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
f. Applicable Law and Venue. This Business Associate Agreement is governed by and construed in accordance with the laws of the State of North Dakota. Any action commenced to enforce this Contract must be brought in the District Court of Burleigh County, North Dakota.
g. Business Associate agrees to comply with all the requirements imposed on a business associate under Title XIII of the American Recovery and Reinvestment Act of 2009, the Health Information Technology for Economic and Clinical Health (HI-TECH) Act, and, at the request of NDPERS, to agree to any reasonable modification of this agreement required to conform the agreement to any Model Business Associate Agreement published by the Department of Health and Human Services.

7. Entire Agreement

This Agreement contains all of the agreements and understandings between the parties with respect to the subject matter of this Agreement. No agreement or other understanding in any way modifying the

terms of this Agreement will be binding unless made in writing as a modification or amendment to this Agreement and executed by both parties.

IN WITNESS OF THIS, **NDPERS** [CE] and *[PBM to identify its name]* [BA] agree to and intend to be legally bound by all terms and conditions set forth above and hereby execute this Agreement as of the effective date set forth above.

For Covered Entity:	For Business Associate:
_____	_____
Board Chair ND Public Employees Retirement System	Signature
	_____
	Printed Name
	_____
	Title
_____	_____
Date	Date

Appendix F – This section identifies NDPERS' EGWP plan requirements. Please indicate if you can match these benefits/services and if so with what resources and if not what specifically you would not be able to provide.

Current Contract Benefits	Discuss and Identify comparable service offerings.
<u>PDP Plan</u> • Maintain a Medicare Part D Prescription Drug Plan with EGWP+Wrap, compliant with CMS requirements and will incorporate all required updates for 2025	

<u>Pharmacy Benefit Manager Programs</u>
• Perform the following services:
  • Perform claims adjudication
  • Maintain retail pharmacy network (compliant with CMS requirements).
  • Maintain specialty pharmacy program
  • Maintain mail-order pharmacy program
  • Administer clinical programs (compliant with CMS requirements)
  • Maintain Formulary (compliant with CMS requirements)
  • Drug utilization reviews
  • Retrospective DUR
  • Concurrent DUR
  • Prospective DUR
  • Provide Medication Therapy Management Program (compliant with CMS requirements)
  • Administer Coordination of Benefits	

Current Contract Benefits	Discuss and Identify comparable service offerings.
• Allow NDPERS to conduct periodic performance audits	
<u>Enrollment Services</u> • Provide enrollment specialists to be available 24 hours a day 7 days a week to answer questions from members wishing to enroll in a plan or get further information on their enrollment • Provide weekly member enrollment/disenrollment report that includes: - Out-of-country address - Not entitled to Medicare A or B - Disenroll due to incarceration - Member denied due to no response - Cancel enrollment/disenrollment - Deaths - HICN discrepancies - Enrollment in another PDP • Complete enrollment verification of entries by NDPERS staff and sent through NDPERS electronic file • Notify NDPERS if there are problems with processing the electronic file • Conduct ongoing communication with NPERS including on problems with processing electronic files • Rush enrollments with immediate updates • Provide ongoing administrative enrollment process support such as: - Send notice to members who report address changes	

Current Contract Benefits	Discuss and Identify comparable service offerings.
- Generate and mail ID cards - Mail benefit books • Administer late enrollment penalties (LEP) and low-income subsidies (LIS) directly to members on behalf of NDPERS • Provide ongoing reporting of members approved for the low-income subsidy and the effective date • Provide ongoing reporting of members with late enrollment penalties (LEP) including listing of delinquent participants • Notifications and tracking of Income-related monthly adjustment amount (IRMAA) • Notify PERS of Annual Adjustment to Part D rates based on the Federal subsidy and the Low-Income Subsidy (LIS) • Designate a point of contact for questions on enrollments/discrepancies	
<u>Plan Communication Services</u> • Help Desk: Provide toll-free access to Participating Pharmacies to obtain assistance with eligibility, claims processing, DUR, and other troubleshooting • Provide communications to members including: - All CMS required notices - Benefit Overview - Formulary List - Formulary updates or changes - Previous coverage attestation notice to members - IRMAA required notices	

Current Contract Benefits	Discuss and Identify comparable service offerings.
Member Services • Provide a toll-free telephone number for members, and individuals interested in enrolling, to speak to a licensed pharmacist or other appropriate representative • Provide a toll-free telephone number for Members 24 hours a day, 7 days a week, answering questions regarding eligibility, claims, prior authorization status, drug coverage, enrollment status, and other PBM related services • Manage member appeals • Administer communication and educational materials to Members about plan details • Set up and maintain a member portal to allow users to look up drugs, pharmacies, and formularies, and mail order and claim information • Provide reporting on customer service metrics including online and telephonic call types and volume	

Billing
• Carrier provides monthly billing to NDPERS to include:
  • Detailed listing of each participant (in Excel format)
  • LEP detail
  • PERS assigned member ID
  • Retro billing amount and coverage period
• Carrier provides monthly LIS report and corresponding rebate to NDPERS	

Current Contract Benefits	Discuss and Identify comparable service offerings.
• Designate point of contact for questions on billing	
<u>Information Technologies</u> • Maintain secure data protection protocols • Maintain a secure file transfer system • Facilitate NDPERS specific enrollment file • Update and maintain NDPERS specific benefit matrix and claims processing logic • Provide access for NDPERS staff to online plan sponsor portal	
<u>Legislative and Legal Services</u> • Actively monitor State and Federal legislation for changes affecting NDPERS, with corresponding analysis of potential impact of legislation on the plan (costs, design requirements, etc.) • Adhere to CMS compliance requirement related to Medicare Part D and EGWP+Wrap benefits • Perform internal audit functions • Monitor prescriber and provider trends to maintain compliance with CMS standards • Update NDPERS on pharmacy class action lawsuits or settlements that may be applicable to the NDPERS benefit	
<u>Account Management Staff</u> • Designate individuals for each of the following positions:	

Current Contract Benefits	Discuss and Identify comparable service offerings.
• NDPERS Implementation Manager • NDPERS Enrollment Specialists • NDPERS Account Executive with EGWP expertise • NDPERS Account Manager (day-to-day) • NDPERS Clinical Account Manager • NDPERS Executive Sponsor • Provide access to all subject matter experts and other appropriate personnel and make them available for attending board meetings, legislative, hearings, etc., as needed • Attend NDPERS Board meetings upon request (remotely or onsite) • Attend Monthly team meetings to pinpoint any pain points, discuss future plan design and other ongoing items.	
<u>Reporting</u> • Provide an Annual Review Report • Provide monthly data files through secure file transfer system • As requested by NDPERS, perform ad-hoc reporting including cost, utilization, and risk analysis • Provide reporting on member utilization across all phases of the Part D Standard Benefit to identify the benefits provided by the PDP and the benefits provided by the EGWP+Wrap • Report and disclose all Direct and Indirect Remuneration (DIR) including manufacturer rebate payments, CMS subsidies, and any other price concessions • Reconcile and report on all Performance Guarantees at least annually	

Current Contract Benefits	Discuss and Identify comparable service offerings.
<u>Actuarial Services</u> • Complete actuarial services to determine the performance of the plan annually • Communicate prescription drug cost and utilization trends used for analysis, estimates, and underwriting • If requested by NDPERS, provide plan design options with impacts to cost (either self-insured claims or fully-insured premium) • Conduct actuarial services to determine improvements to plan design or program savings • For a fully-insured EGWP, provide a preliminary renewal premium projection for a potential renewal (typically provided by the end of April for the upcoming year). Premium projection must include the underwriting elements used to establish the premium (claims, plan design adjustments, risk adjustments, other adjustments (as necessary), trend factors, rebate estimates, subsidy estimates, administration fees, etc.) • For a fully-insured EGWP, provide a final premium calculation for the renewal no later than August 15 prior to the upcoming plan year. Premium projection must include the underwriting elements used to establish the premium (claims, plan design adjustments, risk adjustments, other adjustments (as necessary), trend factors, rebate estimates, subsidy estimates, administration fees, etc.) • Other services as requested	

Appendix G – Performance Standards and Guarantees

This section identifies the NDPERS performance standards and guarantees requested. Please confirm compliance with each guarantee. Some performance guarantees may not be applicable based on the services proposed. If the performance guarantee is not applicable, please note "N/A".

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
1.	**Implementation Team**	Vendor will provide NDPERS with an implementation team no later than 14 days after award of contract to be responsible for accurate installation of all administrative, clinical, and financial parameters	14 days after award of contract by NDPERS board	$1,000 per day from day 15 forward for which a team has not been appointed		
2.	**Project Plan**	Vendor will provide an implementation project plan no later than 20 days after contract award to be responsible for accurate installation of all administrative, clinical, and financial parameters	20 days after award of contract by NDPERS board	$1,000 per day from day 20 forward for which a team has not been appointed.		

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
3.	**Customer service call center will "go-live" on or before December 1, 2024**	Vendor's customer service call center will be fully-operational to respond to member inquiries prior to the effective date to assist members with questions related to the new service and transition	Compliance to be monitored and assessed by NDPERS	$1,000 for each calendar day after December 1, 2024		
4.	**All services will "go-live" and be fully-operational on January 1, 2025**	All services will be fully operational and the implementation plan complete on or before January 1, 2025	Compliance to be monitored and assessed by NDPERS	$25,000 if not operational on January 1, 2025, and $1,000 for each calendar day after January 1, 2025		
5.	**Systems Training for NDPERS Staff**	Vendor will provide training on the utilization of systems and reporting tools sixty (60) days prior to implementation	Compliance to be monitored and assessed by NDPERS	$1,000 for each day less than 60 days prior to implementation		

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
6.	**Plan Performance Review**	Within ten (10) calendar days following delivery of performance reviews to NDPERS, vendor shall develop and submit a corrective action plan (CAP) of issues identified for approval by NDPERS, and implement such plan within the time prescribed in the approved CAP.	Measurement methodology shall be measured from date of delivery of the plan performance review in calendar days	***Semi- annually*** $1,000 per calendar day beyond the due date		
7.	**Identification Cards**	For the initial implementation, accurate identification cards will be mailed	At least ten (10) days before the effective date	$5,000 for each day less than 10 days before the effective date		

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
8.	**Customer Satisfaction Surveys**	Member satisfaction surveys will be designed by the vendor and approved by NDPERS. Vendor will invite a random sample of members to participate in the survey to collect a statistically significant number of completed surveys. Member satisfaction rate will meet 90% or higher using a 1-5 scale of Completely Satisfied, Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied. Final survey questions and methodology will be agreed upon by vendor and NDPERS.	Vendor will provide annual survey results to confirm compliance with performance standard	***Annually*** $25,000 per year		

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
9.	**Team Meetings**	NDPERS requires monthly team meetings to address all planning / implementation, business, financial, clinical / formulary (including new drug review) and operational needs	Compliance to be monitored and assessed by NDPERS	***Monthly*** $5,000 for each meeting missed		
10.	**NDPERS board meetings**	Vendor will participate in quarterly performance reviews to examine operational and financial performance	Compliance to be monitored and assessed by NDPERS	***Quarterly*** $5,000 for each quarter missed		
11.	**Electronic Eligibility**	Eligibility files will be installed in an electronic medium, logged within eight (8) hours and status will be effective within vendor's system within eighteen (18) hours from	Vendor will provide quarterly reports to confirm compliance with performance standard	***Quarterly*** $500 for each missed file deadline		

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
		date of receipt, seven (7) days per week.				
12.	**Manual Eligibility**	Manual eligibility will be loaded within eight (8) hours upon receipt or notification and must be applied and active in the vendor's system within one (1) business day.	Vendor will provide quarterly reports to confirm compliance with performance standard	***Quarterly*** $500 for each missed file deadline		
13.	**Error Reports**	An error report on all eligibility file updates will be produced within eighteen (18) hours from the update.	Vendor will provide quarterly reports to confirm compliance with performance standard	***Quarterly*** $500 for each missed file deadline		
14.	**Data Files**	Monthly data files (membership, medical, pharmacy) will be available by the 15th of the following month.	Will be available to NDPERS on request	***Monthly*** $1,000 for each month not met		

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
15.	**Claims Financial Accuracy**	Claims Financial Accuracy will be 99% or greater, each year of the biennium. Measured as the absolute value of financial errors divided by the total paid value of audited dollars paid based on quarterly internal audit of statistically valid sample.	Vendor will provide annual reports to confirm compliance with performance standard	***Annually*** $12,500 per year		
16.	**Claims Payment Accuracy**	Claims Payment incidence Accuracy will be 98% or greater, each year of the biennium. Measured as the percent of Claims processed without financial payment error.	Vendor will provide annual reports to confirm compliance with performance standard	***Annually*** $12,500 per year		

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
17.	**Claims Processing Accuracy**	Claims Procedural Accuracy will be 95% or greater, each year of the biennium. Measured as the percent of Claims processed without non-financial error.	Vendor will provide annual reports to confirm compliance with performance standard	***Annually*** $12,500 per year		
18.	**Claim Timeliness**	Clean claims processing within 14 calendar days will be 95% or greater, each year of the biennium. Measured from the date the claim is received to the date claim is processed	Vendor will provide annual reports to confirm compliance with performance standard	***Annually*** $12,500 per year		
19.	**Average Speed of Answer**	Average Speed of Answer will be 30 seconds or less, each year of the biennium. Vendor will have an established measurement process that shall be reviewed with NDPERS	Vendor will provide semi-annual reports to confirm compliance with performance standard	***Semi-annually*** $10,000 per year		

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
20.	**Call Abandonment**	Call Abandonment rate will be 5% or less, each year of the biennium	Vendor will provide annual reports to confirm compliance with performance standard	***Annually*** $10,000 per year		
21.	**Accuracy and Timelines/First Call Resolution Written Inquiry Response Time**	a.) 95% percent of callers receive accurate information. Calls requiring additional research is excluded from the computation of this metric. b.) 95% percent of inquiries must be resolved during the initial call (excluding appeals, billing, errors and escalations).	Vendor must evaluate a statistically valid sample of inquiries with reports provided.	***Annually*** $12,500 per year		
22.	**Overpayment Recovery**	One hundred percent (100%) of all confirmed overpayments identified shall be recovered and returned to the	Vendor will provide annual reports to confirm compliance with	***Annually*** $12,500 per year		

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
		Department within ninety Calendar Days. Measured as the number (count) of overpayments identified by monthly Overpaid Claims Report and paid to the State (not an offset of Claims) within ninety (90) Calendar Days.	performance standard			
23.	**Prescription drug turnaround time – clean prescriptions**	98% within two (2) business days if no intervention required	Vendor will provide quarterly reports to confirm compliance with performance standard	***Quarterly*** $1,000 for each point below standard-		
24.	**Prescription drug mail dispensing accuracy**	99.9% Mail service dispensing accuracy rate. Fields measured include member name, drug strength, directions, quantity, and prescriber name.	Vendor will provide annual reports to confirm compliance with performance standard	***Annually*** $12,500 per year		

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
25.	**Prescription drug home delivery member notifications**	Vendor is required to notify a member when a mail service prescription is changed or there is any expected shipping delay and provide reporting details to NDPERS capturing all occurrences by member/DOS/Issue	Vendor will provide annual reports to confirm compliance with performance standard	***Annually*** $12,500 per year		
26.	**Prescription drug specialty pharmacy delivery**	98% of prescription will be delivered and received by patients on the specified date of delivery	Vendor will provide annual reports to confirm compliance with performance standard	***Annually*** $12,500 per year		
27.	**Network Pharmacy Access**	Pharmacy network composition will not be reduced by more than 5% in North Dakota compared to the network submitted in the RFP	Vendor will provide annual reports to confirm compliance with performance standard	***Annually*** $12,500 per year		

#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Semi-annually, Annually) & dollars at risk	Bidder Response: (Agree, Does Not Agree, N/A)	Requested Modification
28.	**Data Systems Availability and Adjudication**	Guarantees an annual average 99% system availability of the point-of-sale adjudication system on a book-of-business basis. This standard excludes downtime attributed to regularly scheduled systems maintenance or systems downtime	Book of business level	***Annually*** $12,500 per year		

Appendix H
Confidential/Proprietary Information
Request for Redaction Chart

The Responder submitting a proposal to the attached RFP is required to complete the following. Any provisions of the company's proposal that are desired to be confidential must be identified specifically on each page of the proposal and in a table format as provided below. Information not identified in the table will be considered an open record by NDPERS, regardless of whether the information is marked confidential in the body of the proposal.

In response to the Request for Proposals entitled _____ (please check one):

___ Offeror asserts that the information noted in the table below constitutes proprietary, trade secret, commercial, or financial information as defined by North Dakota Century Code section 44-04-18.4, and desires that the information noted in the table below not be disclosed if requested pursuant to the North Dakota Open Records law. **Offeror has submitted a redacted copy of the proposal on a USB flash drive labeled "REDACTED" that accurately and completely redacts the information noted in the table below.**

___ Offeror makes NO assertion that any information in its Proposal, in whole or in part, should be protected from disclosure under the North Dakota Open Records law.

Technical Proposal:				
Specific wording that Responder desires to protect	Page Number, Section Number	Specific reason Responder believes the language should not be disclosed	North Dakota Century Code provision that allows NDPERS to withhold the information if requested	Has this information ever been publicly disclosed? (Yes/No)
Insert rows above as necessary				
Cost Proposal:				
Specific wording that Responder desires to protect	Page Number, Section Number	Specific reason Responder believes the language should not be disclosed	North Dakota Century Code provision that allows NDPERS to withhold the information if requested	Has this information ever been publicly disclosed? (Yes/No)
Insert rows above as necessary				

The above information has been reviewed by Responder's legal counsel and is attested to by _____ (insert name of Responder representative who is authorized to contractually bind Responder), on this _____ day of _____, 2024.

_____ (Signature) _____(Vendor)

Appendix I – Proposed Deviations

Please complete the following worksheet for all deviations and exceptions to the RFP requirements. Suggested alternatives or solutions must be included. Vendors should add additional pages as needed. This document should not include deviations to the sample contract included as Appendix E. A red-lined version of Appendix E should be submitted separately.

NDPERS RFP ALL OTHER DEVIATIONS AND EXCEPTIONS	
Specific Deviation	**Proposed Alternative/Solution**

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca Fricke

DATE: August 20, 2024

SUBJECT: Insulin/Diabetic Supplies Report and Recommendation

At the July meeting, the Board discussed SB 2140 that was passed last Session and requires a monthly cap of $25/month for insulin and diabetic supplies within the NDPERS health insurance active plans and became effective July 1, 2023. Section 4 of SB 2140 is shown below and requires that the NDPERS Board submit a bill in the upcoming Session that would roll this coverage out to the commercial market in North Dakota. Draft bill # 118 (Attachment 1) is the bill that the Board approved for submission by the April 1, 2024 Employee Benefits Programs Committee's deadline.

In addition to the bill submission, Section 4 of SB 2140 requires the Board to "append a report to the bill regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued."

> SECTION 4. PUBLIC EMPLOYEES RETIREMENT SYSTEM - INSULIN DRUG AND SUPPLIES BENEFITS - REPORT. Pursuant to section 54-03-28, the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for this Act and to extend the coverage of insulin drug and supplies benefits to all group and individual health insurance policies. The public employees retirement system shall append a report to the bill regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs, information on the utilization and costs relating to the coverage, and a recommendation regarding whether the coverage should be continued.

Sanford Health Plan (SHP) has provided Attachment 2 to provide reporting on the utilization and cost impact of the bill related to insulin coverage. Included in the analysis are details comparing utilization and cost for the year prior to and year following the July 1, 2023 bill effective date. Attachment 2 has several items for the board's review:

1) Tab 1 provides a Dashboard (overview)
2) Tab 2 gives the Average Member Cost Share and Average Paid by SHP
3) Tab 3 shows utilization and adherence information
4) Tab 4 provides the NDPERS Type 1 Diabetes Membership details
5) Tab 5 gives details specific to types of insulin being filled

Attachment 3 provides information specific to the impact related to diabetic supplies as required by the bill. SHP has indicated that the majority of the supplies cost less than $25/month so there was minimal impact after the cap was implemented.

Attachment 4 provides details comparing the per member per month medical expenses for members with type 1 diabetes before and after the insulin cap was implemented. Of note is that there still could be pending claims to be processed so this information is as of the date provided.

Attachment 5 is a brief prepared by SHP regarding what other states have experienced that have implemented caps. SHP does not have any other lines of business with a cap on insulin to provide information about their experience.

Attachment 6 is an additional brief provided by SHP regarding changes that have occurred in the amount that the drug manufacturers are charging for insulin. SHP found during their research that even though NDPERS members were paying a lower portion of the charge for insulin at the pharmacy, SHP's total reimbursement was lower after the cap was implemented. Starting January 1, 2024, two pharmaceutical companies (Eli Lilly & Novo Nordisk), reduced their prices on insulin which resulted in lower reimbursements by SHP.

Deloitte provided input through their analysis (Attachment 7) of Draft Bill # 118, which was prepared following the Employee Benefits Programs Committee taking jurisdiction of the bill at their April meeting. In addition, Deloitte has provided Attachment 8, which is a memo regarding their market analysis related to SB 2140.

Sanford Health Plan has provided two additional attachments based upon questions from Deloitte. Attachment 9 expands the information provided in Attachment 2, Tab 4 to include both Type 1 and Type 2 diabetes details. Attachment 10 provides additional information related to insulin and insulin supplies broken out by days of service (1-30, 31-60, and 61+).

Representatives from both Sanford Health Plan and Deloitte will be at the meeting and available to discuss the information provided in the various attachments.

In order to meet the requirements of Section 4 of SB 2140, the Board will need to provide direction to staff:

1) regarding what information they would like to include in the report regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs
2) what information on the utilization and costs relating to the coverage should be included in the report
3) regarding a recommendation whether the coverage should be continued.

Once this is determined, staff would then need to provide the Board's report and recommendation to the Employee Benefits Programs Committee at their September 12 meeting, or their meeting tentatively scheduled for November 6.

Board Action Requested:

Provide direction to staff regarding:

1) Information to be included in the report regarding the effect of the insulin drug and supplies benefits requirement on the system's health insurance programs
2) Information to be included in the report related to utilization and costs
3) Recommendation regarding whether the coverage should be continued

Attachment 1

Sixty-ninth
Legislative Assembly
of North Dakota

BILL NO.

Introduced by

(North Dakota Public Employees Retirement System)

A BILL for an Act to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to individual and group health insurance coverage of insulin drugs and supplies; and to amend and reenact section 54-52.1-04.18 of the North Dakota Century Code, relating to health insurance benefits coverage of insulin drugs and supplies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations.

1. As used in this section:

   a. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:

      (1) Rapid-acting insulin;

      (2) Short-acting insulin;

      (3) Intermediate-acting insulin;

      (4) Long-acting insulin;

      (5) Premixed insulin product;

      (6) Premixed insulin/GLP-1 RA product; and

      (7) Concentrated human regular insulin.

   b. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical

emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:

(1) Blood glucose meters;

(2) Blood glucose test strips;

(3) Lancing devices and lancets;

(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;

(5) Glucagon, in injectable and nasal forms;

(6) Insulin pen needles; and

(7) Insulin syringes.

c. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a prescription.

2. An insurance company, nonprofit health service corporation, or health maintenance organization may not deliver, issue, execute, or renew any health insurance policy, health service contract, or evidence of coverage on an individual, group, blanket, franchise, or association basis unless the policy, contract, or evidence of coverage provides benefits for insulin drug and medical supplies for insulin dosing and administration which complies with this section.

3. The health benefit plan must limit out-of-pocket costs for a thirty-day supply of:

a. Covered insulin drugs, which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.

b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.

4. The health benefit plan may not allow a pharmacy benefits manager or the pharmacy or distributor to charge, require the pharmacy or distributor to collect, or require a covered individual to make a payment for a covered insulin drug or medical supplies

for insulin dosing and administration in an amount exceeding the out-of-pocket limits under subsection 3.

5. The health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount under subsection 3.

6. Subsection 3 does not require the health benefit plan to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. This section does not limit whether the health benefit plan classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.

7. If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has met the minimum deductible under section 26 U.S.C. 223.

8. This section does not apply to the Medicare part D prescription drug coverage plan.

SECTION 2. AMENDMENT. Section 54-52.1-04.18 of the North Dakota Century Code is amended and reenacted as follows:

54-52.1-04.18. Health insurance benefits coverage - Insulin drug and supply out-of-pocket limitations. ~~(Expired effective July 31, 2025)~~

~~1. As used in this section:~~

~~a. "Insulin drug" means a prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:~~

~~(1) Rapid-acting insulin;~~

~~(2) Short-acting insulin;~~

~~(3) Intermediate-acting insulin;~~

~~(4) Long-acting insulin;~~

~~(5) Premixed insulin product;~~

~~(6) Premixed insulin/GLP-1 RA product; and~~

~~(7) Concentrated human regular insulin.~~

~~b. "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:~~

~~(1) Blood glucose meters;~~

~~(2) Blood glucose test strips;~~

~~(3) Lancing devices and lancets;~~

~~(4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips;~~

~~(5) Glucagon, in injectable and nasal forms;~~

~~(6) Insulin pen needles; and~~

~~(7) Insulin syringes.~~

~~c. "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a covered individual's prescriptions.~~

~~2.~~ The board shall provide health insurance benefits coverage that provides for insulin drug and medical supplies for insulin dosing and administration ~~which complies with this section~~as provided under section 1 of this Act.

~~3. The coverage must limit out-of-pocket costs for a thirty-day supply of:~~

~~a. Covered insulin drugs which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs.~~

~~b. Covered medical supplies for insulin dosing and administration, the total of which may not exceed twenty-five dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.~~

4. ~~The coverage may not allow a pharmacy benefits manager or the pharmacy or distributor to charge, require the pharmacy or distributor to collect, or require a covered individual to make a payment for a covered insulin drug or medical supplies for insulin dosing and administration in an amount that exceeds the out-of-pocket limits set forth under subsection 3.~~

5. ~~The coverage may not impose a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for prescribed insulin or medical supplies for insulin dosing and administration to exceed the amount set forth under subsection 3.~~

6. ~~Subsection 3 does not require the coverage to implement a particular cost-sharing structure and does not prevent the limitation of out-of-pocket costs to less than the amount specified under subsection 3. Subsection 3 does not limit out-of-pocket costs on an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor. This section does not limit whether coverage classifies an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor as a drug or as a medical device or supply.~~

7. ~~If application of subsection 3 would result in the ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of subsection 3 do not apply with respect to the deductible of the health benefit plan until after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.~~

8. ~~This section does not apply to the Medicare part D prescription drug coverage plan.~~

Attachment 2 Tab 1

Rx Type	Members with Pharmacy Claims for Insulin Before Insulin cap	Members with Pharmacy Claims for Insulin After Insulin cap	Change in Members	Pharmacy Claims Before Insulin cap	Pharmacy Claims After Insulin cap	Change in Claims	SHP Paid Amount Before Insulin cap	SHP Paid Amount After Insulin cap	Change in SHP Paid Amount**	Cost Share Amount Before Insulin cap	Cost Share Amount After Insulin cap	Change in Cost Share Amounts
1-INSULIN	824	831	7	5,483	5,442	-41	$3,885,235	$3,112,208	($773,026)	$644,584	$250,617	($393,967)
Total	**824**	**831**	**7**	**5,483**	**5,442**	**-41**	**$3,885,235**	**$3,112,208**	**($773,026)**	**$644,584**	**$250,617**	**($393,967)**

Days of Supply (DOS) Group	Pharmacy Claims Before Insulin cap	Pharmacy Claims After Insulin cap	Change in Claims	% Change in claims	SHP Paid Amount Before Insulin cap	SHP Paid Amount After Insulin cap	Change in SHP Paid Amount	Cost Share Amount Before Insulin cap	Average Member Cost Share Before Insulin cap	Cost Share Amount After Insulin cap	Average Member Cost Share after Insulin cap*	Change in Cost Share Amount
01-30 DOS	2,009	1,952	-57	-3%	$1,184,018	$942,932	($241,086)	$186,043	$93	$47,573	$24	($138,469)
31-60 DOS	2,119	2,071	-48	-2%	$1,512,316	$1,151,299	($361,017)	$248,465	$117	$99,934	$48	($148,531)
61+ DOS	1,355	1,419	64	5%	$1,188,900	$1,017,976	($170,924)	$210,077	$155	$103,110	$73	($106,967)
Total	**5,483**	**5,442**	**-41**	**-1%**	**$3,885,235**	**$3,112,208**	**($773,026)**	**$644,584**	**$118**	**$250,617**	**$46**	**($393,967)**

Before time period: July 1, 2022-June 30, 2023
After time period: July 1, 2023-June 30, 2024

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.
**Jan 1, 2024 Insulin manufacturers, Novo Nordisk & Eli Lilly, reduced prices on their insulin and diabetic supplies in response to public & political pressure.

Attachment 2 Tab 2

DATE FILLED MONTH		2022-07	2022-08	2022-09	2022-10	2022-11	2022-12	2023-01	2023-02	2023-03	2023-04	2023-05	2023-06	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	2024-01	2024-02	2024-03	2024-04	2024-05	2024-06	**Total**
Rx Type	Days of Supply (DOS) Group	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share*	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	Average Member Cost Share	**Average Member Cost Share**
1-INSULIN	**Total**	**$96**	**$86**	**$76**	**$78**	**$72**	**$69**	**$222**	**$208**	**$182**	**$153**	**$117**	**$100**	**$45**	**$46**	**$48**	**$47**	**$48**	**$48**	**$46**	**$48**	**$48**	**$47**	**$47**	**$36**	**$82**
	01-30 DOS	$71	$64	$63	$54	$61	$59	$187	$170	$142	$114	$90	$68	$24	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$19	**$59**
	31-60 DOS	$94	$81	$76	$74	$69	$75	$241	$202	$174	$147	$116	$101	$48	$49	$49	$50	$49	$49	$50	$50	$50	$50	$50	$35	**$83**
	61+ DOS	$150	$127	$94	$120	$94	$73	$240	$304	$248	$220	$170	$143	$72	$74	$75	$73	$75	$74	$74	$74	$74	$74	$74	$58	**$113**

	Days of Supply (DOS) Group	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP**	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	Average Paid by SHP	**Average Paid by SHP**
Rx Type																										
1-INSULIN	**Total**	**$747**	**$724**	**$804**	**$766**	**$743**	**$855**	**$531**	**$583**	**$612**	**$670**	**$686**	**$701**	**$793**	**$760**	**$792**	**$805**	**$789**	**$852**	**$336**	**$341**	**$340**	**$321**	**$317**	**$372**	**$640**
	01-30 DOS	$585	$622	$639	$627	$625	$667	$463	$477	$566	$571	$597	$595	$665	$653	$635	$662	$688	$683	$301	$274	$301	$324	$272	$329	**$537**
	31-60 DOS	$764	$735	$739	$797	$774	$798	$579	$643	$587	$696	$680	$727	$761	$779	$770	$797	$753	$757	$308	$379	$281	$306	$325	$366	**$636**
	61+ DOS	$1,027	$864	$1,100	$931	$860	$1,147	$552	$695	$712	$776	$850	$804	$1,030	$913	$1,026	$1,007	$982	$1,174	$435	$373	$463	$339	$368	$433	**$796**

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.

**Jan 1, 2024 Insulin manufacturers, Novo Nordisk & Eli Lilly, reduced prices on their insulin and diabetic supplies in response to public & political pressure.

Attachment 2 Tab 3

DATE FILLED MONTH				
Rx Type	Days of Supply (DOS) Group	**Total claims before Insulin cap**	**Total claims after to Insulin cap**	**Change in insulin claim count before & after Insulin cap**
1-INSULIN	**Total**	**5,483**	**5,442**	**-1%**
	01-30 DOS	2,009	1,952	-3%
	31-60 DOS	2,119	2,071	-2%
	61+ DOS	1,355	1,419	5%

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.

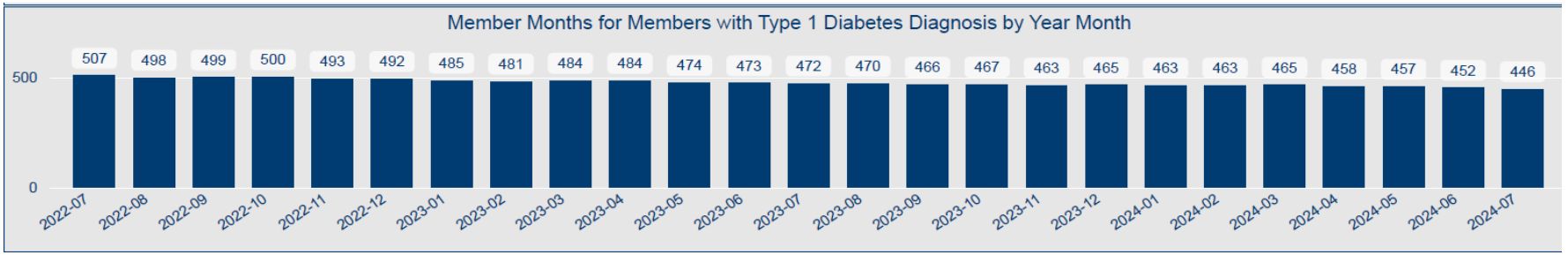
PDC Adherence	**Before Insulin Cap**	**After Insulin Cap**	**Difference**
<80%	30.70%	28.10%	-2.6%
>=80%	69.30%	71.90%	2.6%

*The proportion of days covered (PDC) is used to estimate medication adherence.

*PDC **>=80%** is considered adhering to their medication while **<80%** is considered not adhering.

*PDC calculation= (number of days covered) / (total days in time period) x 100

Attachment 2 Tab 4



NDPERS Type 1 Diabetic membership:

July 1, 2022-June 30, 2023 averaged 489 members

July 1, 2023- June 30, 2024 averaged 462 members (*5.5% fewer*)

UNKNOWN: NDPERS Type 2 diabetic members that filled insulin prescriptions

Attachment 2 Tab 5

Rx Type	DrugDESC	Members with Pharmacy Claims Before Insulin cap	Members with Pharmacy Claims After Insulin cap	Members with Pharmacy Claims Change	Pharmacy Claims Before Insulin cap	Pharmacy Claims After Insulin cap	Pharmacy Claim Change	SHP Paid Amount Before Insulin cap	SHP Paid Amount After Insulin cap	SHP PAID Amount Change	CoPay Amount Before Insulin cap	CoPay Amount After Insulin cap	CoPay Amount Change
1-INSULIN	**Total**	**1,964**	**2,119**	**155**	**5,483**	**5,442**	**-41**	**$3,885,235**	**$3,112,208**	**($773,026)**	**$644,584**	**$250,617**	**($393,967)**
	BASAGLAR INJ	33	37	4	101	110	9	$16,322	$43,121	$26,799	$21,183	$5,375	($15,808)
	FIASP INJ	22	24	2	61	77	16	$52,788	$81,603	$28,815	$9,421	$3,675	($5,746)
	FIASP FLEX INJ TOUCH	38	49	11	111	140	29	$75,241	$118,407	$43,166	$12,902	$6,225	($6,677)
	FIASP PENFIL INJ U	3	4	1	7	10	3	$3,458	$6,359	$2,900	$815	$400	($415)
	GLARGIN YFGN INJ		1	1	0	1	1	$0	$0	$0	$0	$65	$65
	HUMALOG INJ		2	2	0	5	5	$0	$1,850	$1,850	$0	$175	$175
	HUMALOG KWIK INJ	10	12	2	38	36	-2	$35,372	$80,651	$45,280	$36,722	$1,325	($35,397)
	HUMULIN R INJ U	6	3	-3	38	20	-18	$63,982	$41,713	($22,269)	$3,910	$500	($3,410)
	INS DEGL FLX INJ	20	89	69	34	189	155	$8,636	$44,875	$36,239	$2,461	$9,420	$6,959
	INSULIN ASPA INJ	3	6	3	17	15	-2	$268	$2,998	$2,730	$799	$675	($124)
	INSULIN ASPA INJ FLEXPEN	1		-1	4	0	-4	$0	$0	$0	$20	$0	($20)
	INSULIN GLAR INJ	1		-1	3	0	-3	$0	$0	$0	$135	$0	($135)
	INSULIN LISP INJ	1	2	1	2	4	2	$397	$284	($113)	$517	$300	($217)
	LANTUS INJ	34	23	-11	90	56	-34	$66,678	$34,877	($31,801)	$11,530	$2,750	($8,780)
	LANTUS SOLOS INJ	378	434	56	1,049	1,049	0	$478,802	$293,187	($185,615)	$102,402	$52,002	($50,400)
	LEVEMIR INJ	4	4	0	7	10	3	$2,677	$2,992	$315	$832	$475	($357)
	LEVEMIR INJ FLEXPEN	67	102	35	128	303	175	$63,578	$133,887	$70,309	$13,324	$13,200	($125)
	LEVEMIR INJ FLEXTOUC	96	1	-95	244	1	-243	$126,186	$423	($125,763)	$21,516	$0	($21,516)
	NOVOLIN INJ	2	1	-1	9	5	-4	$2,110	$1,415	($695)	$622	$250	($372)
	NOVOLIN N INJ	8	6	-2	10	7	-3	$2,297	$1,614	($683)	$1,047	$400	($647)
	NOVOLIN N INJ U	4	4	0	8	8	0	$3,061	$2,692	($369)	$1,420	$575	($845)
	NOVOLIN R INJ		1	1	0	1	1	$0	$159	$159	$0	$75	$75
	NOVOLIN R INJ U	2	2	0	7	15	8	$472	$2,655	$2,183	$448	$520	$72
	NOVOLIN70/3	2	2	0	5	2	-3	$1,136	$455	($681)	$376	$150	($226)
	NOVOLOG INJ	328	308	-20	964	1,028	64	$892,455	$687,960	($204,495)	$140,138	$47,469	($92,669)
	NOVOLOG INJ FLEX REL	3	5	2	7	7	0	$251	$365	$114	$379	$450	$71
	NOVOLOG INJ FLEXPEN	447	472	25	1,271	1,220	-51	$1,047,029	$661,121	($385,908)	$133,060	$52,116	($80,944)
	NOVOLOG INJ PENFILL	20	24	4	82	86	4	$55,231	$52,643	($2,587)	$10,270	$3,400	($6,870)
	NOVOLOG INJ RELION	1	1	0	2	4	2	$701	$1,449	$748	$334	$300	($34)
	NOVOLOG MIX INJ FLEXPEN	8	13	5	31	29	-2	$27,803	$18,253	($9,550)	$3,329	$1,325	($2,004)
	SEMGLEE INJ	1	1	0	1	1	0	$3	$25	$22	$33	$25	($8)
	SOLIQUA INJ	16	9	-7	55	32	-23	$45,750	$25,435	($20,315)	$6,885	$1,225	($5,660)
	TOUJEO MAX INJ	35	80	45	88	101	13	$79,673	$98,734	$19,061	$7,845	$4,300	($3,545)
	TOUJEO SOLO INJ	100	178	78	262	258	-4	$155,772	$168,335	$12,563	$21,206	$11,325	($9,881)
	TRESIBA INJ	1	2	1	4	5	1	$3,361	$5,358	$1,997	$461	$375	($86)
	TRESIBA FLEX INJ	265	215	-50	729	596	-133	$559,716	$482,282	($77,434)	$76,016	$29,450	($46,566)
	XULTOPHY INJ	4	2	-2	14	11	-3	$14,030	$14,031	$2	$2,228	$325	($1,903)

Attachment 3

Rx Type	Days of Supply (DOS) Group	Pharmacy Claims Before Insulin Supply cap	Pharmacy Claims After Insulin Supply cap	Pharmacy Claim Change	% change in claims	SHP Paid Amount Before Insulin Supply cap	SHP Paid Amount After Insulin Supply cap	SHP PAID Amount Change**	Member Cost Share Amount Before Insulin Supply cap	Average Member Cost Share before Insulin Supply cap	Member Cost Share Amount After Insulin Supply cap*	Average Member Cost Share after Insulin Supply cap	Member Cost Share Amount Change
2-BLOOD GLUCOSE METERS	**Total**	143	103	-40	**-28%**	$2,436	$1,692	($744)	$634	**$4**	$463	**$4**	($171)
3-BLOOD GLUCOSE TEST STRIPS	**Total**	1,729	1,226	-503	**-29%**	$156,322	$116,411	($39,911)	$33,349	**$19**	$24,804	**$20**	($8,545)
4-LANCETS AND LANCET DEVICES	**Total**	637	492	-145	**-23%**	$5,490	$4,160	($1,330)	$1,301	**$2**	$1,153	**$2**	($149)
5-KETONE TESTING	**Total**	29	8	-21	**-72%**	$19,921	$4,360	($15,561)	$449	**$15**	$15	**$2**	($435)
6-GLUCAGON	**Total**	80	78	-2	**-3%**	$27,475	$34,864	$7,389	$6,623	**$83**	$1,367	**$18**	($5,257)
7-SYRINGE/PEN NEEDLE	**Total**	1,638	1,391	-247	**-15%**	$112,768	$96,948	($15,820)	$7,502	**$5**	$8,786	**$6**	$1,284
Grand Total		4,256	3,298	(958)	**-23%**	$324,411	$258,435	($65,976)	$49,860	**$12**	$36,587	**$11**	($13,273)

Before time period: July 1, 2022-June 30, 2023
After time period: July 1, 2023-June 30, 2024

*July 1, 2023 SHP implemented a $25 cap on 30 day supply of Insulin. Prior to July 1, 2023 benefits were based on 35 day supply without a cap.
**Jan 1, 2024 Insulin manufacturers, Novo Nordisk & Eli Lilly, reduced prices on their insulin and diabetic supplies in response to public & political pressure.

NOTEWORTHY COMMENTS:

Continuous Glucose Monitors and Insulin Pumps may replace the need for some of these supplies.
252 NDPERS members enrolled in Livongo Diabetes program bewteen July 1, 2023- June 30, 2024. Livongo provides Blood Glucose Monitors & test strips to the participants.
Blood Glucose Meters, Test Strips & Lancets can be used by any diabetic including those not using insulin.

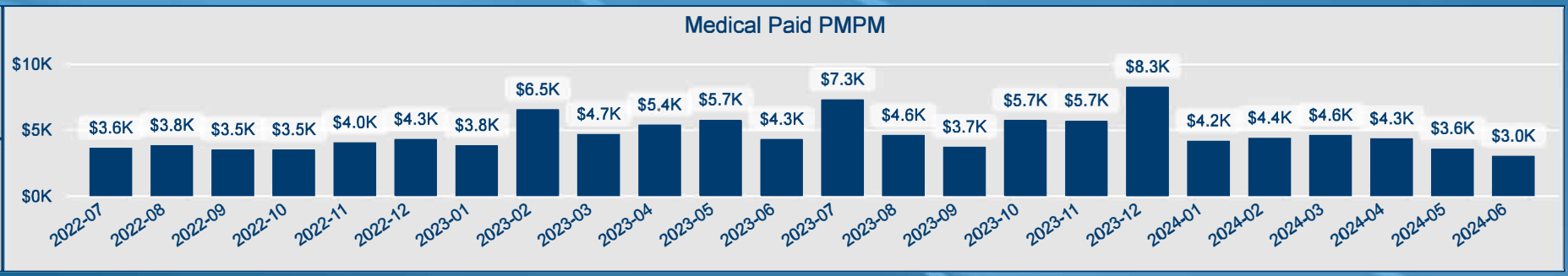
Attachment 4

NDPERS - Medical Utilization for Members with Type 1 Diabetes Diagnosis Only and Insulin and Diabetes Supplies Claims - All LOB's

SANFORD

Medical PMPM Before $4,428

Medical PMPM After $4,932



ER Visits/1000 Before 877.1

ER Visits/1000 After 915.4

IP Admits/1000 Before 747.5

IP Admits/1000 After 592.4

Last Data Refresh: 07-24-2024 01:02 PM CT

Notice: This report and any exported data is for internal use only and should not be sent outside of Sanford.

INSULIN & DIABETIC SUPPLY BRIEF

SANFORD HEALTH PLAN

PROGRAM BACKGROUND

Attachment 5

In the landscape of healthcare affordability, few issues resonate as profoundly as the accessibility of insulin and diabetic supplies, especially within the United States. The soaring prices of these life-sustaining medications have sparked national outcry, prompting legislative actions in several states aimed at implementing price caps. As diabetes prevalence continues to rise, individuals facing this chronic condition grapple not only with its daily management but also with the financial burden imposed by escalating medication costs. Understanding the varied approaches and efficacy of state-level price caps is essential in assessing the impact on patients, healthcare systems, and the broader socio-economic landscape.

CURRENT LANDSCAPE OVERVIEW

In a recent discussion, it was highlighted that diabetics nationwide are set to benefit from reduced out-of-pocket costs for insulin, thanks to efforts by pharmaceutical companies. Sanofi has joined Eli Lilly and Novo Nordisk in capping insulin co-pays at $35. This move follows pressure from President Biden, lawmakers, and activists to lower drug prices.

Laura Barron-Lopez, White House correspondent, emphasized the significance of these measures. She noted that while Medicare beneficiaries automatically benefit from the $35 co-pay cap, those with private insurance or without insurance must navigate more complex processes to access the reduced costs. Advocates like Shaina Kasper of TIInternational suggest that a federal mandate is needed to ensure consistency in cost reductions.

Beyond insulin, other healthcare reforms are underway. For Medicare recipients, drug costs will be capped annually, starting at $3,300 in 2024 and decreasing to $2,000 by 2025. Additionally, Medicare now has the authority to negotiate drug prices, potentially saving billions over the next decade.

Despite these changes, there's a notable gap in public awareness. Many Americans are unaware of these reforms, complicating efforts to credit President Biden politically for these achievements. Analysts suggest that effective communication will be crucial for the administration to highlight these reforms ahead of the upcoming elections[1].

A gathering of families and advocates convened with Governor Doug Burgum at the North Dakota Capitol to commemorate a recent law that limits the cost of insulin for state employees' health insurance beneficiaries. Under this law, those covered by the state employee health plan now pay no more than $25 per month for insulin. Additionally, the law extends this monthly price cap to medical supplies needed to administer insulin.

Danelle Johnson, who supported the legislation during her testimony in 2023, expressed mixed feelings about its scope. Originally proposed to benefit all North Dakotans, the law was amended by lawmakers to apply solely to individuals under the Public Employees Retirement System's health insurance. Johnson acknowledged the legislation as a significant advancement but expressed a desire for broader accessibility to the price caps. She emphasized the importance of incremental progress over a stalemate in legislative action.

Insulin, critical for diabetes management, can cost hundreds of dollars per vial. A 2023 report by the Health Care Cost Institute indicated that average monthly insulin costs in the U.S. rose from $271 in 2012 to about $499 in 2021. The exorbitant prices often lead diabetes patients to ration their insulin or even skip

[1] https://www.pbs.org/newshour/show/new-law-caps-insulin-prices-for-some-with-diabetes-but-cost-remains-high-for-millions

treatment, risking severe health complications. In 2022, approximately 100,000 Americans died from diabetes, a figure similar to the number of deaths from drug overdoses reported by the CDC.

State Senator Tim Mathern, the bill's primary sponsor, highlighted the dire consequences of unaffordable medication, stressing the need for reform. Angela and Nina Kritzberger, also advocates for insulin affordability, were present at the ceremony. Both families recounted instances where insufficient access to insulin necessitated emergency medical interventions. Looking ahead, Mathern noted efforts to garner support for broader reforms in the upcoming legislative session. The law, effective since August 1, 2023, will remain in force until July 31, 2025, with an estimated cost of $900,000 over the 2023-2025 budget cycle. Although signed over a year ago, logistical issues delayed the official signing ceremony, according to Mathern. Additionally, the federal government implemented a $35 monthly insulin price cap for Medicaid patients through the Inflation Reduction Act signed by President Joe Biden in 2022[2].

Healthcare executives faced intense scrutiny from lawmakers on Capitol Hill during a House Energy and Commerce Committee hearing focused on insulin prices. Representative Jan Schakowsky of Illinois directly challenged panelists, expressing disbelief over their actions and warning of consequences. Amid the hearings, a social media suggestion resurfaced: patients should opt for Walmart's affordable insulin. Over the past decade, the cost of popular insulin brands has tripled, leading many Americans with Type 1 or Type 2 diabetes to ration their doses or skip treatments entirely.

Walmart provides Novo Nordisk's Novolin ReliOn Insulin for less than $25 per vial without a prescription. However, healthcare professionals caution that this "human" insulin, introduced in the 1980s, lacks the refined capabilities of newer analogs in preventing severe blood sugar fluctuations. Critics argue that relying on Walmart's insulin overlooks the complexities of diabetes management and the risks associated with unsupervised treatment. Advocates emphasize that while this option may suit some patients, it's far from a comprehensive solution to the ongoing insulin affordability crisis. The blame for rising insulin prices has been volleyed between drug manufacturers and pharmacy benefit managers. While executives defend financial assistance programs, lawmakers assert that unchecked price hikes by pharmaceutical companies are at the heart of the issue. Unlike many other countries, the U.S. allows drug companies considerable freedom in setting prices, resulting in disproportionately high insulin costs despite the country representing a minority share of the global insulin market. Recent efforts, such as Cigna and Express Scripts capping insulin costs at $25 per month, are viewed as temporary fixes by critics like Elizabeth Pfiester of TIInternational. She insists that true resolution requires systemic changes to reduce insulin's list prices permanently.

As the debate intensifies, healthcare professionals and advocates continue to call for legislative intervention to protect diabetic patients from the financial and health risks posed by exorbitant insulin costs[3],[4]

State Copay Caps[5]

- Alabama: $100 cap for 30-day supply
- Colorado: $100 collective cap for 30-day supply
- Connecticut: $25 cap for 30-day supply of insulin or other diabetes medications, $100 cap for 30-days' worth of devices and supplies
- Delaware: $100 collective cap for 30-day supply, $0 for insulin pumps, and collective $35 cap per month for other specified diabetes equipment and supplies
- District of Columbia: $30 cap for a 30-day supply of insulin and $100 cap for a 30-day supply of covered diabetes devices

[2] https://northdakotamonitor.com/2024/05/28/patient-advocates-plan-to-continue-pushing-for-insulin-price-cap/
[3] https://www.vox.com/science-and-health/2019/4/10/18302238/insulin-walmart-relion)
[4] https://www.novonordisk-us.com/patient-help/access-and-affordability.html
[5] https://diabetes.org/tools-resources/affordable-insulin/state-insulin-copay-caps

- Illinois: $100 collective cap for 30-day supply
- Kentucky: $30 cap for 30-day supply
- Louisiana: $75 cap for 30-day supply
- Maine: $35 cap for 30-day supply
- Maryland: $30 cap for 30-day supply
- Minnesota: State-required manufacturer assistance program has a $35 cap for one per year emergency 30-day supply, $50 cap for 90-day supply
- Montana: $35 for 30-day supply
- Nebraska: $35 cap for 30-day supply
- New Hampshire: $30 cap for 30-day supply
- New Jersey: $30 cap for 30-day supply
- New Mexico: $25 cap for 30-day supply
- New York: $100 cap for 30-day supply
- North Dakota: $25 cap for a 30-day supply*
- Oklahoma: $30 cap for 30-day supply, $90 cap for 90-day supply
- Oregon: $75 cap for a 30-day supply, $225 cap for a 90-day supply
- Rhode Island: $40 cap for a 30-day supply
- Texas: $25 cap for a 30-day supply
- Utah: $30 cap for 30-day supply
- Vermont: $100 collective cap for 30-day supply
- Virginia: $50 cap for 30-day supply
- Washington: $35 cap for 30-day supply
- West Virginia: $35 collective cap for 30-day supply; $100 collective cap on a 30-day supply of specified diabetes equipment and supplies.

The State of Utah conducted a study and published their findings regarding Insulin costs. Insulin costs have become a major issue for diabetes patients in the U.S. In response, Utah passed House Bill 207, capping insulin copayments at $30 per month, effective January 1, 2021.

This study evaluated changes in basal insulin adherence, out-of-pocket expenses, health plan costs, overall insulin expenditures, and hemoglobin A1c (A1c) levels before and after the policy's implementation. Conducting a retrospective analysis using data from a Utah health plan between October 2019 and September 2021, the study included commercially insured members who filled insulin prescriptions in both pre- and post-policy periods. Insulin adherence was assessed using the proportion of days covered (PDC), and statistical tests compared health and economic outcomes. Out of 24,150 individuals, 244 patients were analyzed. Results showed a **58.5% reduction** in median monthly out-of-pocket costs for insulin (from $65 to $27), while health plan costs increased by **22%** (from $346 to $444). Total monthly insulin costs remained unchanged. Among 74 patients analyzed for PDC, no significant change was observed (P = 0.43). Similarly, A1c levels did not significantly improve (mean A1c rose from 8.2% to 8.6%). The $30 copayment cap reduced patient out-of-pocket costs but led to higher costs for health plans without improving adherence or A1c levels. Further research over longer periods and with larger populations is necessary to assess long-term impacts.

The Utah study highlights that capping insulin copayments effectively reduced patient costs but shifted financial burdens to health plans. While adherence and health outcomes remained unchanged, further investigation is essential to determine if this policy yields long-term benefits for diabetes management[6].

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10839465/

MANUFACTURER'S INSULIN CHARGE CHANGE

SANFORD HEALTH PLAN

Attachment 6

PROGRAM BACKGROUND

Since 2023, insulin manufacturers have reduced prices on their insulin and diabetic supplies in response to mounting public pressure and advocacy efforts highlighting the exorbitant costs faced by diabetic patients. These reductions come amidst growing awareness of the essential nature of insulin for millions of individuals worldwide, many of whom have struggled with affordability and access issues for years. Additionally, regulatory scrutiny and legislative initiatives have pushed manufacturers to reassess their pricing strategies, aiming to make these life-saving medications more accessible and affordable. These changes mark a significant step towards addressing healthcare inequities and ensuring that essential treatments are within reach for those who need them most.

CURRENT LANDSCAPE OVERVIEW

Eli Lilly and Company has taken significant steps to enhance insulin affordability with recent initiatives. Starting May 1, 2023, Lilly will reduce the list price of Insulin Lispro Injection to $25 per vial, making it the most affordable mealtime insulin available. Humalog® and Humulin® will see a 70% price cut from Q4 2023, and RezvoglarTM, a biosimilar basal insulin, will be priced at $92 per five-pack of KwikPens®, a 78% discount compared to Lantus®. Lilly has also capped out-of-pocket costs at $35 per month for commercial insurance users immediately and offers uninsured individuals Lilly insulin for $35 monthly through the Lilly Insulin Value Program. These measures aim to address healthcare system gaps hindering affordable insulin access, with CEO David A. Ricks stressing the need for broader collaboration for comprehensive diabetes care. Lilly's efforts build on prior initiatives such as low-list-price insulins since 2019 and participation in the Medicare Part D Senior Savings Model, reducing average out-of-pocket costs for Lilly insulins to $21.80 over five years. Future plans include a national awareness campaign to promote these solutions and advocate systemic insulin accessibility improvements, alongside ongoing innovation in diabetes care.[1]

Novo Nordisk will significantly lower US list prices for insulin products by up to 75% effective January 1, 2024, following Eli Lilly's lead in reducing insulin prices by 70% and capping out-of-pocket costs at $35 monthly. President Joe Biden commended Eli Lilly's initiative, urging other insulin makers to follow. Novo Nordisk's price cuts cover NovoLog and Levemir, aiming to ease financial burdens for uninsured and high-deductible patients, with Medicare seniors benefiting from an Inflation Reduction Act cap. Advocacy groups like TIInternational applaud these steps while noting ongoing insulin affordability challenges relative to production costs. Novo Nordisk reaffirms commitment to insulin affordability through support programs, contrasting with Sanofi, which has yet to announce price cuts, focusing instead on existing assistance for uninsured and privately insured individuals. The US insulin price gap compared to other countries remains a concern, reflecting broader American healthcare drug pricing and access challenges[2].

Over the past two decades, insulin list prices by pharmaceutical manufacturers have risen annually, posing affordability challenges for insured patients facing soaring out-of-pocket costs. Simultaneously, insurers and pharmacy benefit managers (PBMs) negotiated increasing rebates and confidential discounts, significantly lowering net prices despite gross sales doubling for leading insulin products from 2012 to 2019.

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[1] https://investor.lilly.com/news-releases/news-release-details/lilly-cuts-insulin-prices-70-and-caps-patient-insulin-out-pocket#:~:text=Today%2C%20Lilly%20is%20reducing%20the,Humalog%C2%AE%20vial%20in%201999.

[2] https://www.nbcnews.com/health/health-news/novo-nordisk-lower-list-price-insulin-rcna74836

Eli Lilly, Novo Nordisk, and Sanofi responded with substantial list price cuts of 65% to 80% in March 2023, driven by impending 2024 Medicaid rebate changes under the American Rescue Act. The gross-to-net price bubble persists for many brand-name drugs, reflecting opaque pricing and rebate structures. Future policy efforts, such as Medicare price negotiation and enhanced transparency, are crucial for equitable patient access to vital medications amid systemic pharmaceutical market challenges[3].

In 2024, Sanofi and other insulin manufacturers are implementing transformative initiatives to significantly reduce insulin costs for millions of Americans with diabetes. Sanofi has introduced price caps and savings programs, ensuring many patients pay no more than $35 monthly for insulin, responding to public outcry and legislative changes. The Inflation Reduction Act capped Medicare enrollees' out-of-pocket expenses, alleviating financial burdens and addressing insulin rationing risks. These actions aim to enhance affordability and equity in healthcare, signaling collaborative efforts among policymakers, patient advocates, and industry leaders to improve insulin accessibility and support a sustainable healthcare system[4].

CONCLUDING

In conclusion, the landscape of insulin pricing in the United States is undergoing significant shifts as major manufacturers like Eli Lilly and Novo Nordisk respond to longstanding affordability challenges. These companies have taken proactive steps to reduce list prices by substantial margins, with Eli Lilly cutting prices by up to 70% and Novo Nordisk following suit with reductions of up to 75% effective January 2024. These efforts, applauded by President Joe Biden and advocacy groups like T1International, aim to alleviate financial burdens on patients, particularly the uninsured and those with high deductibles. The implementation of caps on out-of-pocket costs under the Inflation Reduction Act further supports affordability for Medicare enrollees.

Despite these positive developments, disparities persist in insulin pricing between the U.S. and other countries, reflecting broader complexities in drug pricing and access within the American healthcare system. The ongoing challenge of insulin affordability underscores the need for continued policy reforms, including enhanced transparency in pricing practices and potential Medicare negotiations on drug prices. These reforms could further address the gross-to-net price discrepancies observed not only in insulin but also in other essential medications.

Looking forward, the commitment of pharmaceutical companies to affordability initiatives, alongside advocacy efforts and legislative changes, offers hope for more equitable access to insulin and other critical medications. As industry leaders navigate these reforms, the focus remains on ensuring that patients can affordably access the medications they need to manage chronic conditions effectively. This collaborative approach between stakeholders sets a precedent for addressing broader healthcare affordability issues and advancing towards a more inclusive and sustainable healthcare system in the United States.

[3] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806020
[4] https://www.cnn.com/2024/01/01/politics/insulin-price-cap/index.html

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000

www.deloitte.com

Attachment 7

Memo

Date: June 7, 2024

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **FINANCIAL REVIEW OF PROPOSED BILL 25.0118.01000**

Deloitte Consulting LLP (Deloitte [i]) was engaged to review the proposed legislation and the potential financial impact to the Uniform Group Insurance Program (Program) administered by the North Dakota Public Employees Retirement System (NDPERS), as well as other considerations that may contribute to the evaluation of the legislation.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

OVERVIEW OF PROPOSED BILL

The Bill would create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to public employee insulin drug and supplies benefits. The legislation does the following:

- defines "insulin drug", "medical supplies for insulin dosing and administration", and "pharmacy or distributer"
- restricts insurers and plan sponsors from offering any health insurance coverage unless the coverage meets the cost-sharing and covered service requirements listed in the Bill
- provides a $25 member cost-share limit per thirty-day supply of insulin drugs and medical supplies for insulin dosing and administration regardless of the quantity or type of insulin drug
- restricts pharmacy benefit managers from collecting payment in excess of the cost-sharing requirements covered in the Bill
- restricts health plans from imposing a cost-sharing structure like a deductible or coinsurance that would require a member to pay more than the cost-share limit to receive insulin services

- allows for plans to impose cost-sharing limits that are lower than the $25 member cost-share limit included in the Bill
- stipulates that high-deductible health plans that qualify for health savings accounts are exempt from this cost-share limit until a member reaches their minimum deductible

ESTIMATED FINANCIAL IMPACT

Based on the analysis, it is anticipated the proposed legislation will have a financial impact on the Uniform Group Insurance Program. It is estimated the financial impact of the proposed legislation on the Uniform Group Insurance Program is approximately $1,000,000 in the 2025-2027 biennium ending 6/30/2027.

The Uniform Group Insurance Program requires members to pay a copayment and coinsurance for insulin. Depending on the cost of the insulin prescribed and/or the cost of the supplies purchased, the member cost-share can exceed the proposed $25 limit. Therefore, it is expected that imposing this limit will shift costs from members to the Uniform Group Insurance Program.

Using 12 months of NDPERS claims data from September 2021 through August 2022, Sanford Health Plan estimated that a $25 per month limit on member cost share would have shifted $445,000 from the member to the Uniform Group Insurance Program in that period. Assuming prescription drug trend of 9.4% per year, the cost in the 2025-2027 biennium is estimated to be approximately $1,000,000 (or 0.12% increase to the estimated Program total claims costs). The estimate does not assume changes to drug mix or formulary changes that could impact member out-of-pocket payments (pharmacy benefit managers typically update their formularies at least twice per year).

OTHER CONSIDERATIONS

By limiting or capping the out-of-pocket cost to members for specific services, a smaller amount of those related costs will accumulate towards a member's deductible. As a result, members may have to pay for other services out-of-pocket until they reach their deductible, which may negate a component of the estimated 0.12% increase to the estimated Program total claims costs. Therefore, the $1,000,000 estimated increase in cost can be treated as a conservative estimate, assuming no other change in utilization.

Clinical outcomes associated with lowering member out-of-pocket costs on insulin drugs and medical supplies for insulin dosing and administration may have a favorable impact on the Uniform Group Insurance Program, but such effects are difficult to quantify. If insulin and supplies are more affordable, member adherence may increase and result in fewer adverse health effects that result in expenditures to the Program, such as increased doctor and emergency department visits and prolonged hospitalization.

Deloitte Consulting LLP
50 South Sixth Street
Suite 2800
Minneapolis, MN 55402
USA

Tel: 612 397 4000

www.deloitte.com

Attachment 8

Memo

Date: August 2, 2024

To: Rebecca Fricke - Executive Director, North Dakota Public Employees Retirement System

Representative Austen Schauer - Chair, Legislative Employee Benefits Programs Committee, North Dakota State Government

From: Tim Egan, Dan Plante, Ford Edgerton, and Karno Sarkar - Deloitte Consulting LLP

Subject: **MARKET ANALYSIS RELATED TO BILL 23.0532.03000**

In the 2023 legislative session, the North Dakota legislature passed SB 2140 which, among other items, requires the NDPERS Board to evaluate and report on the feasibility of extending the $25/month cap on insulin and diabetic supplies from a pilot to the commercial market statewide. Deloitte Consulting LLP (Deloitte [i]) was commissioned to analyze similar initiatives in other states and industries to assess their impact on adherence among diabetic populations and other relevant outcomes to inform the legislative review.

The information included in the review relies on data provided by NDPERS, as well as publicly available data and industry studies. From the data provided by NDPERS, some of these data sources were developed by NDPERS, while others were prepared or created by third parties and delivered to NDPERS.

As part of the review, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues.

OVERVIEW OF BILL

The amended bill would create and enact a new section to chapter 54-52.1 of the North Dakota Century Code, relating to public employee insulin drug and supplies benefits. The legislation does the following:

- Defines "insulin drug" and "medical supplies for insulin dosing and administration"
- Directs the Board to provide health insurance benefits coverage that complies with the defined cost-share provisions
- Provides a $25 member cost-share limit per thirty-day supply of insulin drugs and medical supplies for insulin dosing and administration
- Clarifies that cost-sharing is not limited for insulin pumps, electronic insulin-administering smart pens, or continuous glucose monitors
- Declares the application of this legislation to be June 30, 2023, to June 30, 2025
- Requires that the public employees retirement system shall prepare and submit for introduction a bill to the sixty-ninth legislative assembly to repeal the expiration date for

this Act and to extend the coverage of insulin drug and supplies benefits to all group and individual health insurance policies, and;

- Directs the public employees retirement system to provide a report on the effect of the insulin drug and supplies requirements on the system's health insurance programs, including utilization and cost, and a recommendation on continuing the coverage

CONSIDERATIONS AND RELATED LEGISLATION

Currently, 24 other states plus the District of Columbia have set caps on insulin cost-sharing for state-regulated commercial health plans, as reported by the American Diabetes Foundation. The caps vary significantly across the states:

- Alabama: $100 cost-share cap for a 30-day supply
- Colorado: $100 collective cost-share cap for any 30-day supply regardless of dosage
- Connecticut: $25 cost-share cap for 30-day supply of insulin or any other diabetic medication; $100 cap for 30-day supply of devices and supplies
- Delaware: $100 collective cost-share cap for 30-day supply, $0 for insulin pumps, and collective $35 cost-share monthly cap for other diabetic specific equipment and supplies
- District of Columbia: $30 cost-share cap for 30-day supply of insulin; $100 cost-share cap for 30-day supply of diabetic devices
- Illinois: $35 collective cost-share cap for 30-day supply (effective 7/1/2025)
    - Current provision through 6/30/2025 is a $100 collective cost-share cap for a 30-day supply
- Kentucky: $30 cost-share cap for 30-day supply
- Louisiana: $75 cost-share cap for 30-day supply
- Maine: $35 cost-share cap for 30-day supply
- Maryland: $30 cost-share cap for 30-day supply
- Minnesota: $25 cost-share monthly cap for diabetes medications; $50 cost-share monthly cap for supplies; State-required manufacturer assistance program has a $35 cost-share cap for one per year emergency 30-day supply, $50 cost-share cap for 90-day supply
- Montana: $35 cost-share cap for 30-day supply
- Nebraska: $35 cost-share cap for 30-day supply
- New Hampshire: $30 cost-share cap for 30-day supply
- New Jersey: $35 cost-share cap for 30-day supply
- New Mexico: $25 cost-share cap for 30-day supply

- New York: $0 cost for 30-day supply of insulin (effective 1/1/2025)
    - Current provision is a $100 cost-share cap for a 30-day supply
- Oklahoma: $30 cost-share cap for 30-day supply; $90 cost-share cap for 90-day supply
- Oregon: $35 cost-share cap for 30-day supply; $105 cost-share cap for 90-day supply (effective 1/1/2025)
    - Current provision is a $85 cost-share cap for 30-day supply
- Rhode Island: $40 cost-share cap for 30-day supply
- Texas: $25 cost-share cap for 30-day supply
- Utah: $30 cost-share cap for 30-day supply
- Vermont: $100 collective cost-share cap for 30-day supply
- Virginia: $50 cost-share cap for 30-day supply
- Washington: $35 cost-share cap for 30-day supply
- West Virginia: $35 cost-share cap for 30-day supply of insulin; $100 cost-share cap for 30-day supply of diabetic devices

Effective July 1, 2023, the federal government, under the Inflation Reduction Act, has introduced a $35 copay cap for Medicare retirees purchasing insulin. According to the Department of Health and Human Services, this measure is estimated to save retirees over $500 annually.

Additionally, the Inflation Reduction Act includes a provision that expands the coverage of insulin under High Deductible Health Plans (HDHPs). This legislation formalizes IRS Notice 2019-45, which permits certain preventive care for chronic conditions, such as insulin, to be covered without requiring members to meet a deductible first.

Colorado was the first state to implement an insulin cost-share cap in May 2019 with HB19-1216. The initial legislation faced challenges due to ambiguities over applicable insulin types and coverage for multiple prescriptions. These issues led to confusion and potentially higher costs for patients requiring multiple types of insulin[1].

In response, Colorado passed an amendment effective January 1, 2022 with HB21-1307, clarifying that the $100 cap covers all prescribed insulin medications combined per 30-day supply. The amendment also introduced an insulin affordability program for uninsured individuals, offering a 12-month supply at $50 per month and an emergency supply at $35.

The implementation of insulin cost-share caps across various states and at the federal level represents a step towards reducing the financial burden on individuals with diabetes. However, ongoing evaluation is necessary to address potential unintended consequences and ensure the sustainability of these measures. Due to the infancy of a majority of these bills and implementation of the cost-share caps in other states, states are still analyzing the impact of the cost-share caps on members' out-of-pocket costs as well as the impact to premiums.

While these caps reduce out-of-pocket costs for insulin and increase costs for plan sponsors, they do not decrease the overall cost of the drug. However, the lower cost of insulin for members can

potentially lead to better adherence to their medication regimen. Improved adherence can result in lower healthcare costs overall, as members are more likely to avoid costly inpatient care due to better management of their condition.

It remains uncertain whether the potential cost savings from improved drug adherence will offset other rising costs. Over the past decade, insulin prices have tripled, raising concerns that cost-share caps might shift expenses to other areas, such as insurance premiums.

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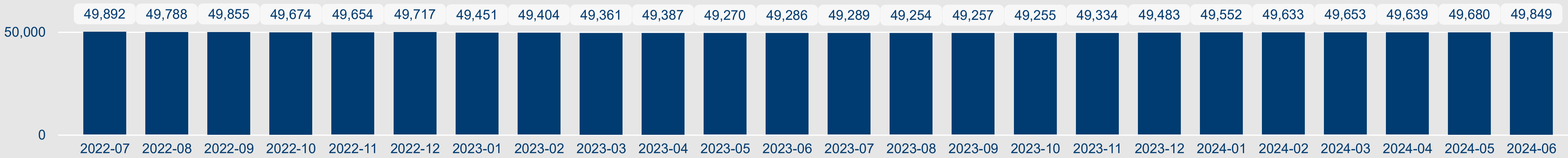
[1] Endocrine Today. (2013). "How Colorado's insulin cap law evolved" Retrieved from https://www.healio.com/news/endocrinology/20230510/how-colorados-insulin-cap-law-evolved#:~:text=In%20May%202019%2C%20Colorado%20became,of%20insulin%20for%20Colorado%20residents.

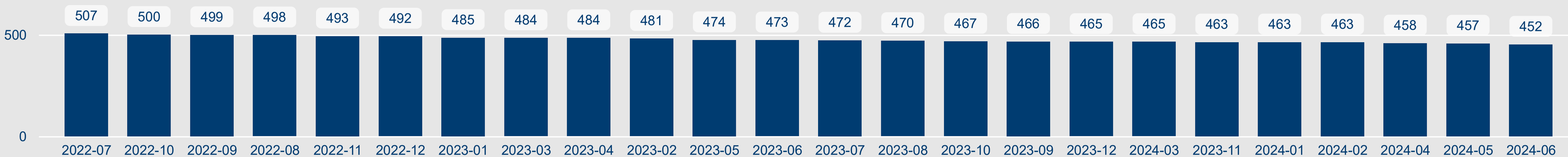
NDPERS COI Insulin & Diabetes Supplies Impact Analysis

Attachment 9

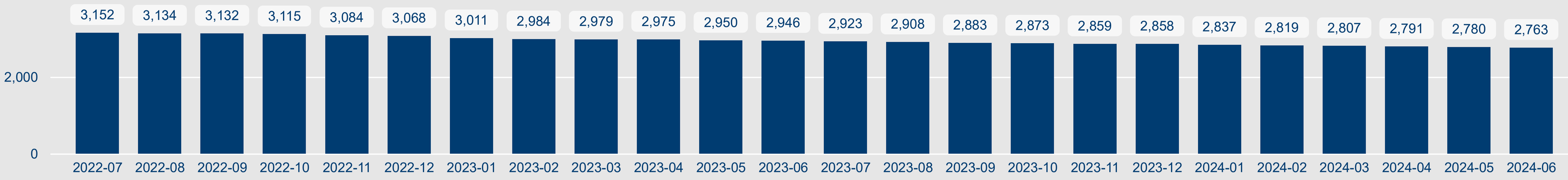
Total Members Months by Year Month



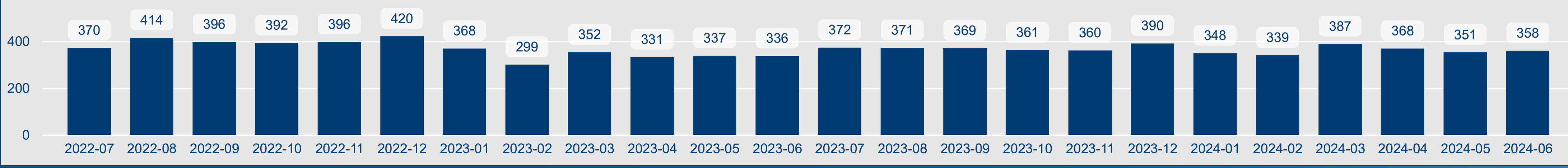
Member Months for Members with Type 1 Diabetes Diagnosis



Member Months for Members with Type 2 Diabetes Diagnosis



Distinct Count of Patient ID's with Insulin Rx Claims by Month Filled



Last Data Refresh: 08-15-2024 02:40 PM CT

Rx Type	Days of Supply Group	DrugDESC	Members with Pharmacy Claims Before Imsulin cap	Members with Pharmacy Claims After Insulin cap	Members with Pharmacy Claims Change	Pharmacy Claims Before Insulin cap	Pharmacy Claims After Insulin cap	Pharmacy Claim Change	SHP Paid Amount Before Insulin cap	SHP Paid Amount After Insulin cap	SHP PAID Amount Change	CoPay Amount Before Insulin cap	CoPay Amount After Insulin cap	CoPay Amount Change
1-INSULIN	**Total**		**1,964**	**2,119**	**155**	**5,483**	**5,441**	**-42**	**$3,885,235**	**$3,112,092**	**($773,142)**	**$644,584**	**$250,592**	**($393,992)**
	01-30 DOS	**Total**	**541**	**562**	**21**	**2,009**	**1,951**	**-58**	**$1,184,018**	**$942,817**	**($241,202)**	**$186,043**	**$47,548**	**($138,494)**
		BASAGLAR INJ	10	8	-2	39	36	-3	$5,546	$10,553	$5,007	$6,716	$900	($5,816)
		FIASP INJ	9	5	-4	27	27	0	$15,318	$22,286	$6,968	$2,816	$675	($2,141)
		FIASP FLEX INJ TOUCH	18	18	0	69	59	-10	$39,827	$44,458	$4,631	$7,243	$1,475	($5,768)
		FIASP PENFIL INJ U	3	2	-1	7	7	0	$3,458	$4,093	$635	$815	$175	($640)
		HUMALOG INJ		1	1	0	4	4	$0	$40	$40	$0	$100	$100
		HUMALOG KWIK INJ	7	7	0	26	22	-4	$20,946	$41,683	$20,737	$21,726	$550	($21,176)
		HUMULIN R INJ U	3	3	0	34	20	-14	$58,502	$41,713	($16,788)	$3,398	$500	($2,898)
		INS DEGL FLX INJ	7	17	10	11	62	51	$3,293	$16,459	$13,166	$918	$1,525	$607
		INSULIN ASPA INJ	1	1	0	14	9	-5	$177	$181	$4	$558	$225	($333)
		INSULIN ASPA INJ FLEXPEN	1		-1	4	0	-4	$0	$0	$0	$20	$0	($20)
		LANTUS INJ	15	7	-8	32	9	-23	$17,758	$4,939	($12,819)	$3,281	$225	($3,056)
		LANTUS SOLOS INJ	75	88	13	305	278	-27	$118,902	$64,772	($54,130)	$18,698	$6,528	($12,170)
		LEVEMIR INJ		2	2	0	5	5	$0	$814	$814	$0	$125	$125
		LEVEMIR INJ FLEXPEN	20	34	14	49	129	80	$25,106	$52,427	$27,321	$3,638	$3,225	($413)
		LEVEMIR INJ FLEXTOUC	28		-28	115	0	-115	$51,216	$0	($51,216)	$7,490	$0	($7,490)
		NOVOLIN INJ	1		-1	8	0	-8	$1,740	$0	($1,740)	$449	$0	($449)
		NOVOLIN N INJ	1	1	0	2	1	-1	$549	$231	($318)	$233	$25	($208)
		NOVOLIN R INJ U		1	1	0	7	7	$0	$2,429	$2,429	$0	$150	$150
		NOVOLOG INJ	99	92	-7	367	396	29	$250,980	$200,688	($50,292)	$38,789	$9,795	($28,994)
		NOVOLOG INJ FLEX REL		1	1	0	1	1	$0	$59	$59	$0	$25	$25
		NOVOLOG INJ FLEXPEN	148	154	6	507	510	3	$336,948	$226,716	($110,233)	$42,781	$12,400	($30,381)
		NOVOLOG INJ PENFILL	8	10	2	46	47	1	$17,126	$15,460	($1,666)	$3,846	$1,175	($2,671)
		NOVOLOG MIX INJ FLEXPEN	1	5	4	3	8	5	$1,507	$2,468	$960	$82	$200	$118
		SEMGLEE INJ	1	1	0	1	1	0	$3	$25	$22	$33	$25	($8)
		SOLIQUA INJ	5	3	-2	28	16	-12	$20,590	$13,112	($7,478)	$2,102	$400	($1,702)
		TOUJEO MAX INJ	10	19	9	41	35	-6	$30,760	$26,925	($3,835)	$2,976	$825	($2,151)
		TOUJEO SOLO INJ	28	41	13	117	101	-16	$34,894	$34,795	($99)	$6,277	$2,350	($3,927)
		TRESIBA FLEX INJ	39	40	1	144	151	7	$114,978	$102,587	($12,390)	$9,024	$3,700	($5,324)
		XULTOPHY INJ	3	1	-2	13	10	-3	$13,893	$12,902	($991)	$2,133	$250	($1,883)
	31-60 DOS	**Total**	**679**	**739**	**60**	**2,119**	**2,071**	**-48**	**$1,512,316**	**$1,151,299**	**($361,017)**	**$248,465**	**$99,934**	**($148,531)**
		BASAGLAR INJ	15	14	-1	40	43	3	$5,476	$16,806	$11,330	$7,847	$2,150	($5,697)
		FIASP INJ	5	8	3	14	28	14	$10,165	$20,837	$10,672	$1,750	$1,350	($400)
		FIASP FLEX INJ TOUCH	7	18	11	20	53	33	$10,292	$35,885	$25,593	$1,718	$2,650	$932
		HUMALOG KWIK INJ	3	3	0	12	11	-1	$14,426	$25,271	$10,845	$14,996	$550	($14,446)
		HUMULIN R INJ U	2		-2	3	0	-3	$5,480	$0	($5,480)	$497	$0	($497)
		INS DEGL FLX INJ	7	21	14	15	47	32	$2,246	$8,229	$5,983	$1,046	$2,150	$1,104
		INSULIN ASPA INJ	1		-1	2	0	-2	$61	$0	($61)	$151	$0	($151)
		LANTUS INJ	10	11	1	42	36	-6	$29,238	$19,564	($9,673)	$4,560	$1,700	($2,860)
		LANTUS SOLOS INJ	122	144	22	403	420	17	$175,193	$112,512	($62,681)	$40,430	$20,080	($20,351)
		LEVEMIR INJ	2	1	-1	3	1	-2	$581	$231	($349)	$294	$50	($244)
		LEVEMIR INJ FLEXPEN	22	32	10	50	112	62	$23,960	$47,669	$23,709	$5,630	$5,475	($155)
		LEVEMIR INJ FLEXTOUC	27		-27	70	0	-70	$40,557	$0	($40,557)	$7,250	$0	($7,250)
		NOVOLIN INJ	1	1	0	1	5	4	$371	$1,415	$1,045	$174	$250	$76
		NOVOLIN N INJ	3		-3	3	0	-3	$877	$0	($877)	$417	$0	($417)
		NOVOLIN N INJ U	1	1	0	1	1	0	$63	$4	($59)	$71	$50	($21)
		NOVOLIN R INJ U	2	1	-1	7	8	1	$472	$227	($245)	$448	$370	($78)
		NOVOLOG INJ	105	91	-14	361	352	-9	$309,214	$207,740	($101,474)	$45,031	$17,310	($27,721)
		NOVOLOG INJ FLEX REL	1		-1	5	0	-5	$196	$0	($196)	$261	$0	($261)
		NOVOLOG INJ FLEXPEN	165	176	11	517	467	-50	$474,597	$259,790	($214,807)	$56,701	$22,250	($34,451)
		NOVOLOG INJ PENFILL	6	7	1	27	28	1	$25,521	$24,062	($1,459)	$4,509	$1,400	($3,109)
		NOVOLOG MIX INJ FLEXPEN	4	6	2	21	18	-3	$18,290	$12,888	($5,403)	$2,321	$900	($1,421)
		SOLIQUA INJ	6	5	-1	19	15	-4	$11,877	$11,602	($274)	$3,496	$750	($2,746)
		TOUJEO MAX INJ	13	32	19	30	44	14	$36,768	$51,357	$14,588	$2,938	$1,900	($1,038)
		TOUJEO SOLO INJ	40	75	35	90	104	14	$78,357	$84,480	$6,122	$8,103	$5,150	($2,953)
		TRESIBA FLEX INJ	109	92	-17	363	278	-85	$238,037	$210,730	($27,307)	$37,827	$13,450	($24,377)
	61+ DOS	**Total**	**744**	**818**	**74**	**1,355**	**1,419**	**64**	**$1,188,900**	**$1,017,976**	**($170,924)**	**$210,077**	**$103,110**	**($106,967)**
		BASAGLAR INJ	8	15	7	22	31	9	$5,300	$15,762	$10,462	$6,620	$2,325	($4,295)
		FIASP INJ	8	11	3	20	22	2	$27,305	$38,480	$11,175	$4,855	$1,650	($3,205)
		FIASP FLEX INJ TOUCH	13	13	0	22	28	6	$25,122	$38,064	$12,942	$3,941	$2,100	($1,841)
		FIASP PENFIL INJ U		2	2	0	3	3	$0	$2,265	$2,265	$0	$225	$225
		GLARGIN YFGN INJ		1	1	0	1	1	$0	$0	$0	$0	$65	$65
		HUMALOG INJ		1	1	0	1	1	$0	$1,810	$1,810	$0	$75	$75
		HUMALOG KWIK INJ		2	2	0	3	3	$0	$13,697	$13,697	$0	$225	$225
		HUMULIN R INJ U	1		-1	1	0	-1	$0	$0	$0	$15	$0	($15)
		INS DEGL FLX INJ	6	51	45	8	80	72	$3,096	$20,187	$17,090	$497	$5,745	$5,248
		INSULIN ASPA INJ	1	5	4	1	6	5	$30	$2,817	$2,787	$90	$450	$360
		INSULIN GLAR INJ	1		-1	3	0	-3	$0	$0	$0	$135	$0	($135)
		INSULIN LISP INJ	1	2	1	2	4	2	$397	$284	($113)	$517	$300	($217)
		LANTUS INJ	9	5	-4	16	11	-5	$19,683	$10,374	($9,309)	$3,688	$825	($2,863)
		LANTUS SOLOS INJ	181	202	21	341	351	10	$184,707	$115,903	($68,804)	$43,274	$25,395	($17,879)
		LEVEMIR INJ	2	1	-1	4	4	0	$2,096	$1,946	($150)	$539	$300	($239)
		LEVEMIR INJ FLEXPEN	25	36	11	29	62	33	$14,512	$33,791	$19,279	$4,057	$4,500	$443
		LEVEMIR INJ FLEXTOUC	41	1	-40	59	1	-58	$34,413	$423	($33,989)	$6,776	$0	($6,776)
		NOVOLIN N INJ	4	5	1	5	6	1	$871	$1,383	$512	$397	$375	($22)
		NOVOLIN N INJ U	3	3	0	7	7	0	$2,998	$2,688	($310)	$1,349	$525	($824)
		NOVOLIN R INJ		1	1	0	1	1	$0	$159	$159	$0	$75	$75
		NOVOLIN70/3	2	2	0	5	2	-3	$1,136	$455	($681)	$376	$150	($226)
		NOVOLOG INJ	124	125	1	236	280	44	$332,261	$279,531	($52,730)	$56,318	$20,364	($35,954)
		NOVOLOG INJ FLEX REL	2	4	2	2	6	4	$55	$306	$252	$118	$425	$307
		NOVOLOG INJ FLEXPEN	134	142	8	247	242	-5	$235,484	$174,500	($60,984)	$33,578	$17,441	($16,137)
		NOVOLOG INJ PENFILL	6	7	1	9	11	2	$12,584	$13,122	$538	$1,915	$825	($1,090)
		NOVOLOG INJ RELION	1	1	0	2	4	2	$701	$1,449	$748	$334	$300	($34)
		NOVOLOG MIX INJ FLEXPEN	3	2	-1	7	3	-4	$8,005	$2,897	($5,108)	$926	$225	($701)
		SOLIQUA INJ	5	1	-4	8	1	-7	$13,283	$720	($12,562)	$1,287	$75	($1,212)
		TOUJEO MAX INJ	12	29	17	17	22	5	$12,145	$20,452	$8,307	$1,930	$1,575	($355)
		TOUJEO SOLO INJ	32	62	30	55	53	-2	$42,520	$49,060	$6,539	$6,827	$3,825	($3,002)
		TRESIBA INJ	1	2	1	4	5	1	$3,361	$5,358	$1,997	$461	$375	($86)
		TRESIBA FLEX INJ	117	83	-34	222	167	-55	$206,700	$168,964	($37,736)	$29,165	$12,300	($16,865)
		XULTOPHY INJ	1	1	0	1	1	0	$136	$1,129	$993	$95	$75	($20)

Rx Type	Days of Supply Group	DrugDESC	Pharmacy Claims Before Insulin Supply cap	Pharmacy Claims After Insulin Supply cap	Pharmacy Claim Change	SHP Paid Amount Before Insulin Supply cap	SHP Paid Amount After Insulin Supply cap	SHP PAID Amount Change	CoPay Amount Before Insulin Supply cap	CoPay Amount After Insulin Supply cap	CoPay Amount Change
2-BLOOD GLUCOSE METERS	**Total**		**143**	**103**	**-40**	**$2,436**	**$1,692**	**($744)**	**$634**	**$463**	**($171)**
	01-30 DOS	**Total**	**136**	**96**	**-40**	**$2,331**	**$1,608**	**($723)**	**$599**	**$414**	**($185)**
	61+ DOS	**Total**	**7**	**7**	**0**	**$106**	**$84**	**($21)**	**$35**	**$49**	**$14**
3-BLOOD GLUCOSE TEST STRIPS	**Total**		**1,729**	**1,226**	**-503**	**$156,322**	**$116,411**	**($39,911)**	**$33,349**	**$24,804**	**($8,545)**
	01-30 DOS	**Total**	**520**	**374**	**-146**	**$36,163**	**$26,476**	**($9,687)**	**$7,975**	**$5,745**	**($2,230)**
	31-60 DOS	**Total**	**699**	**496**	**-203**	**$56,048**	**$40,930**	**($15,118)**	**$12,886**	**$9,739**	**($3,146)**
	61+ DOS	**Total**	**510**	**356**	**-154**	**$64,110**	**$49,005**	**($15,106)**	**$12,488**	**$9,319**	**($3,169)**
4-LANCETS AND LANCET DEVICES	**Total**		**637**	**492**	**-145**	**$5,490**	**$4,160**	**($1,330)**	**$1,301**	**$1,153**	**($149)**
	01-30 DOS	**Total**	**199**	**160**	**-39**	**$1,541**	**$1,225**	**($315)**	**$376**	**$329**	**($47)**
	31-60 DOS	**Total**	**189**	**125**	**-64**	**$1,541**	**$1,046**	**($495)**	**$386**	**$300**	**($87)**
	61+ DOS	**Total**	**249**	**207**	**-42**	**$2,409**	**$1,888**	**($520)**	**$540**	**$524**	**($15)**
5-KETONE TESTING	**Total**		**29**	**8**	**-21**	**$19,921**	**$4,360**	**($15,561)**	**$449**	**$15**	**($435)**
	01-30 DOS	**Total**	**29**	**7**	**-22**	**$19,921**	**$4,352**	**($15,569)**	**$449**	**$12**	**($437)**
	31-60 DOS	**Total**	**0**	**1**	**1**	**$0**	**$8**	**$8**	**$0**	**$3**	**$3**
6-GLUCAGON	**Total**		**80**	**78**	**-2**	**$27,475**	**$34,864**	**$7,389**	**$6,623**	**$1,367**	**($5,257)**
	01-30 DOS	**Total**	**80**	**78**	**-2**	**$27,475**	**$34,864**	**$7,389**	**$6,623**	**$1,367**	**($5,257)**
7-SYRINGE/PEN NEEDLE	**Total**		**1,638**	**1,391**	**-247**	**$112,768**	**$96,948**	**($15,820)**	**$7,502**	**$8,786**	**$1,284**
	01-30 DOS	**Total**	**544**	**462**	**-82**	**$26,042**	**$24,335**	**($1,707)**	**$1,827**	**$2,548**	**$720**
	31-60 DOS	**Total**	**322**	**293**	**-29**	**$25,803**	**$21,453**	**($4,351)**	**$1,593**	**$1,980**	**$388**
	61+ DOS	**Total**	**772**	**636**	**-136**	**$60,922**	**$51,160**	**($9,763)**	**$4,082**	**$4,258**	**$176**

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: August 20, 2024

SUBJECT: Sanford Health Plan 2024 Member Survey

Representatives from Sanford Health Plan (SHP) will be at the meeting to present the results of the SHP 2024 Member Survey (Attachment 1). The full report is provided as informational in Attachment 2.

JULY 2024 | Sanford Health Market Research

Attachment 1

2024 NDPERS MEMBER EXPERIENCE SURVEY

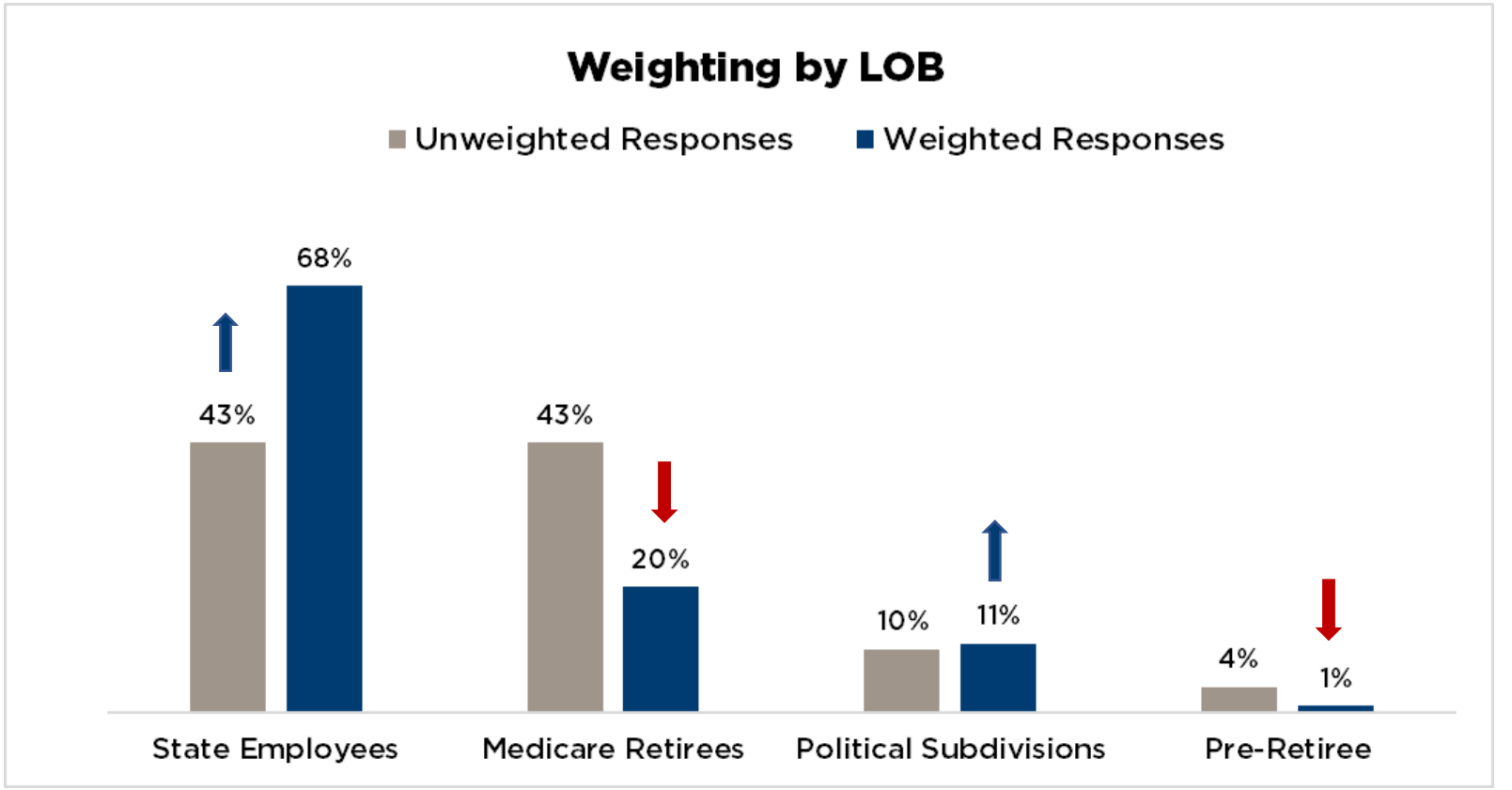
Prepared by Shawn Tronier
Sanford Health Market Research

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

METHODOLOGY

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

WEIGHTING



N =1,100

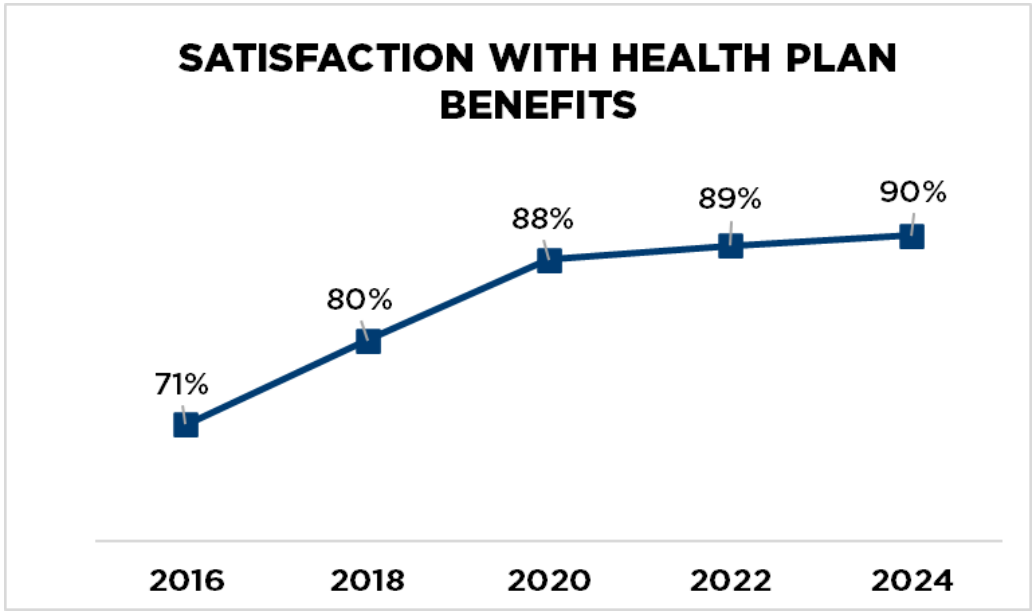
EXECUTIVE SUMMARY

MEMBER EXPERIENCE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SATISFACTION WITH BENEFITS

Q. How satisfied are you with your NDPERS Health Plan Benefits?

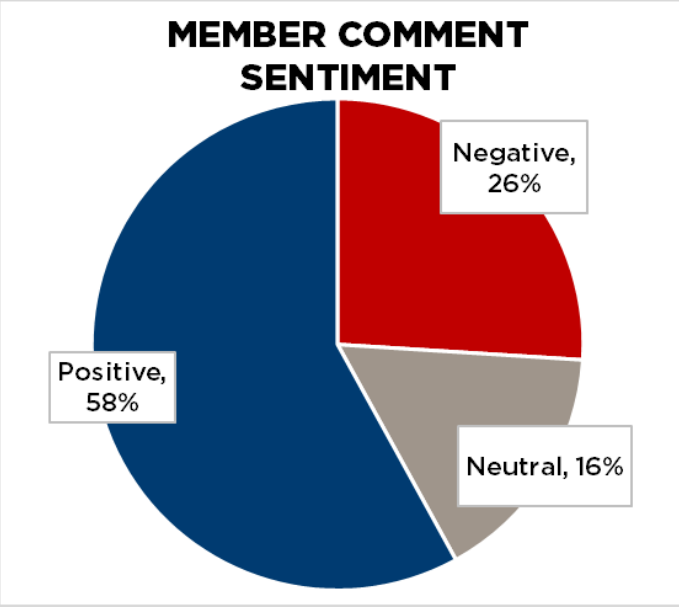


	Satisfaction with Health Plan Benefits	
	2024	% Change from 2022
State Employees	85%	⬆ 3%
Medicare Retirees	96%	⬆ 1%
Political Subdivisions	88%	⬇ 2%
Pre-Retiree	91%	⬇ 5%

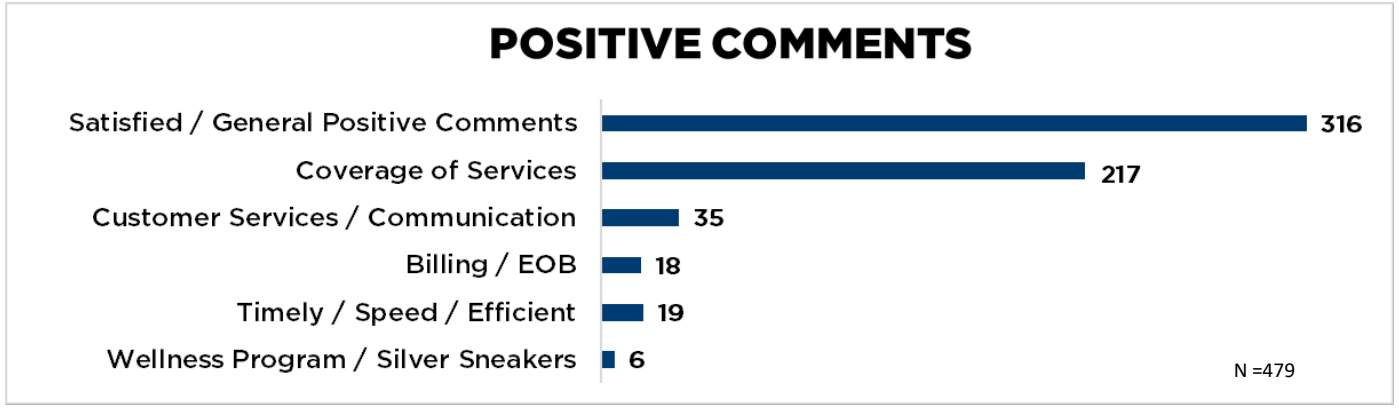
N =1,088

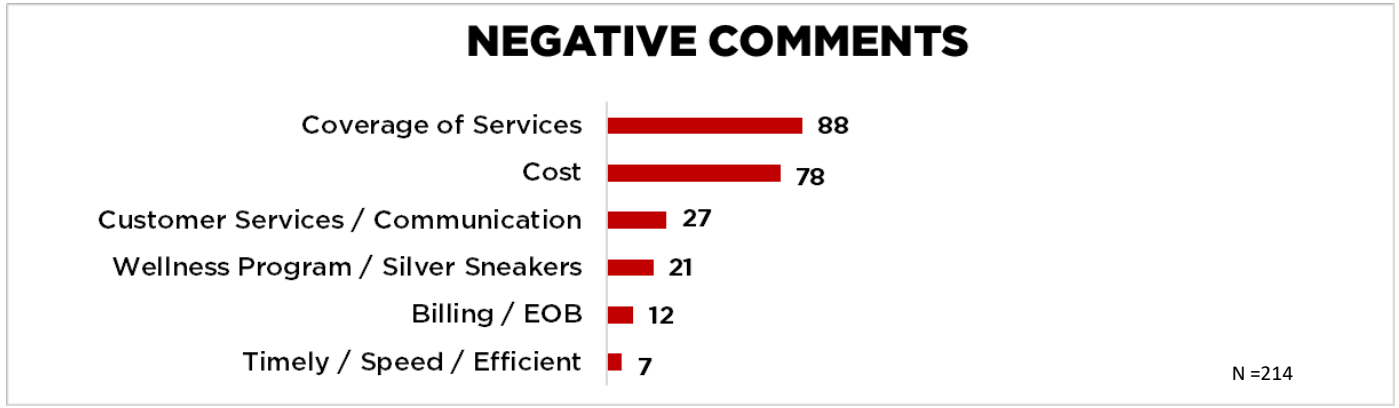
POSITIVE AND NEGATIVE COMMENTS

Q. Why did you give NDPERS Dakota Plan Health Benefits that rating?



N =826





AI SUMMARY OF COMMENTS

Q. Why did you give NDPERS Dakota Plan Health Benefits that rating?

ChatGPT 4o

A Summary of Comments by Artificial Intelligence

The majority of respondents are generally satisfied with their NDPERS health plan. The most frequently mentioned positive aspects include comprehensive coverage of services, affordability, and efficient customer service. Wellness programs and fitness reimbursements were also highly valued. Overall, the feedback indicates strong approval of the plan's benefits and services, with high satisfaction levels among the majority of participants.

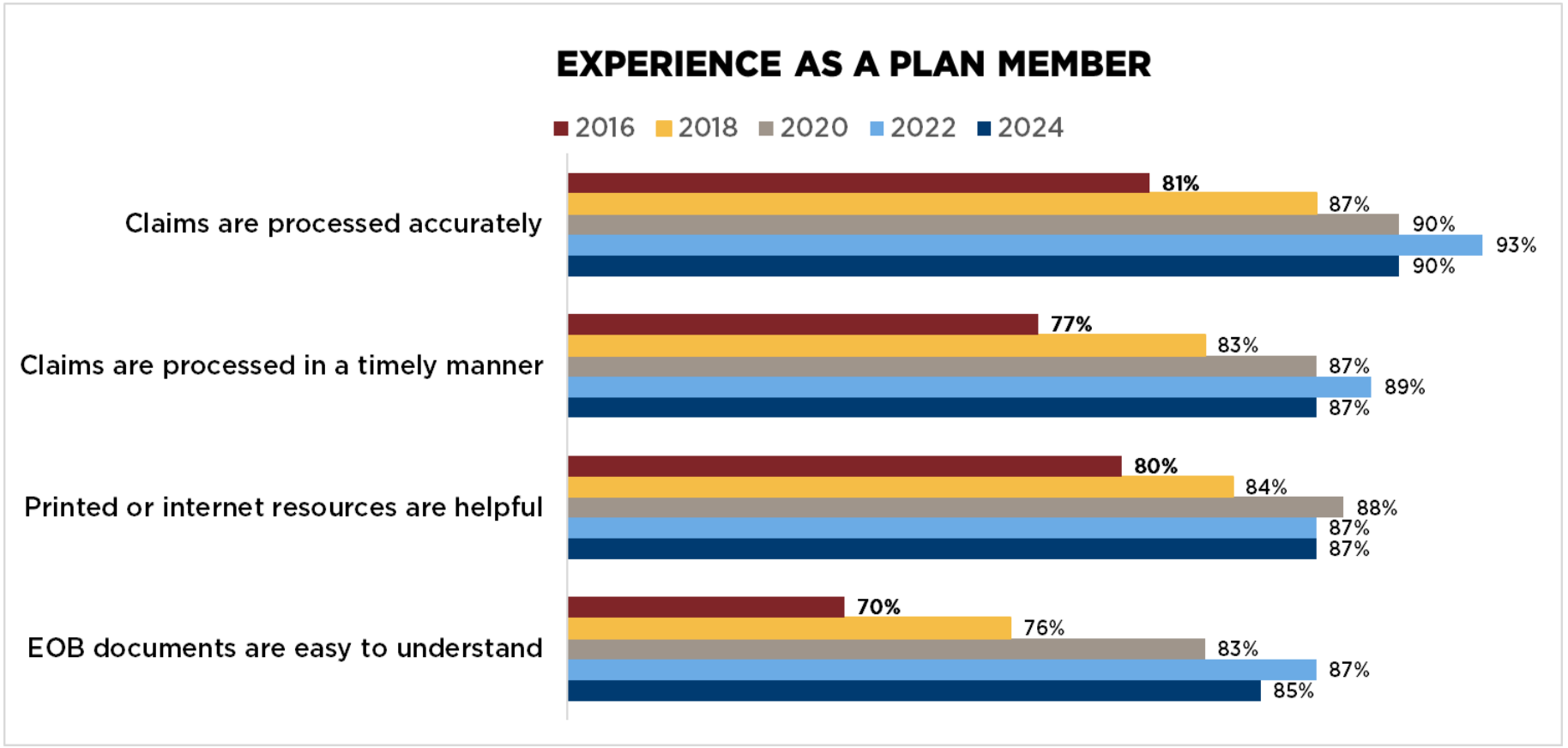
Microsoft Excel Worksheet

Improvement Priorities

To further enhance member satisfaction, address top concerns related to coverage of services, cost transparency and out-of-pocket expenses. Members also mentioned wellness services, billing, customer service and communications as areas of improvement. Focusing on these areas will help address the few areas of concern raised by respondents and strengthen the overall member experience.

MEMBER EXPERIENCE

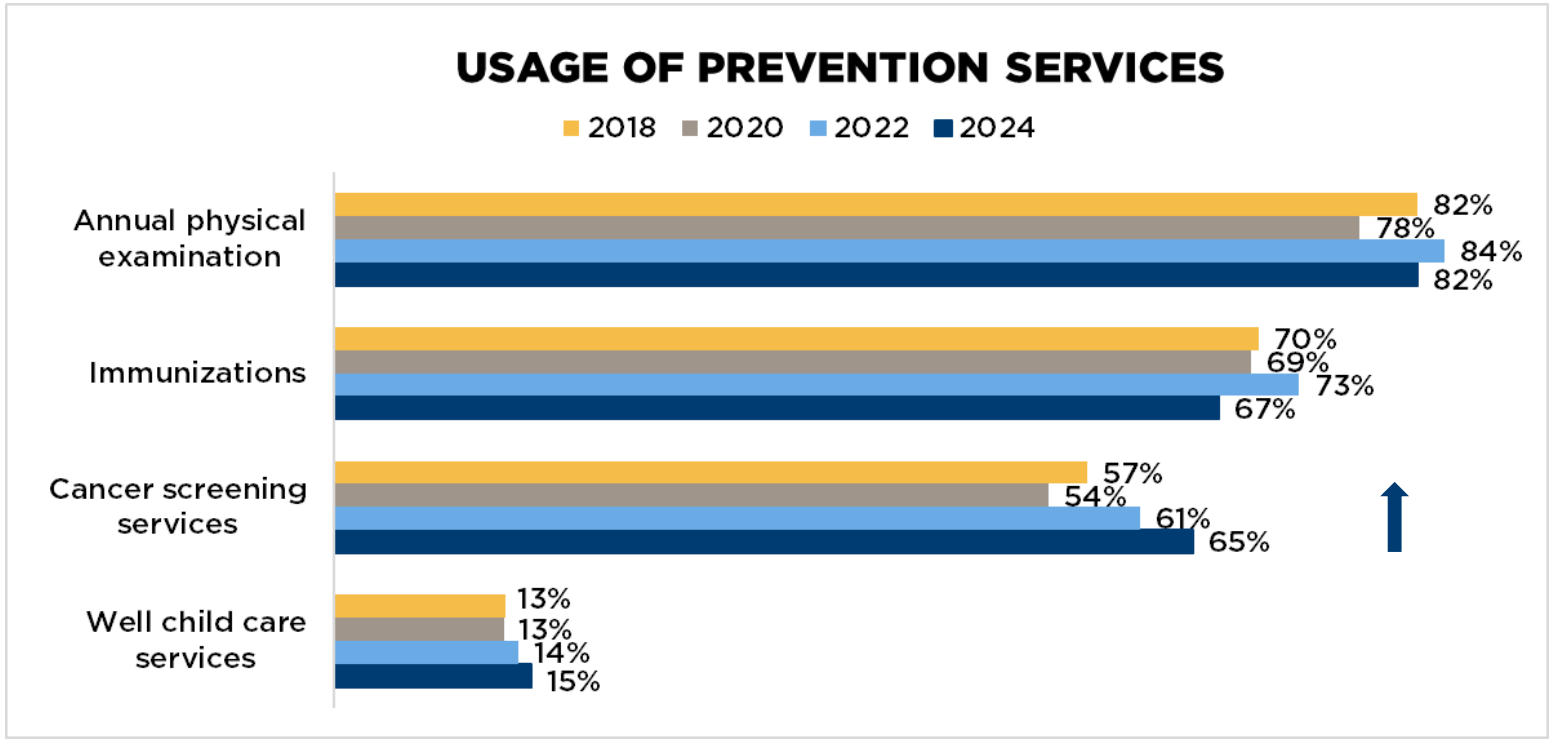
Q. Please tell us more about your experience as a plan member?



N =1,047

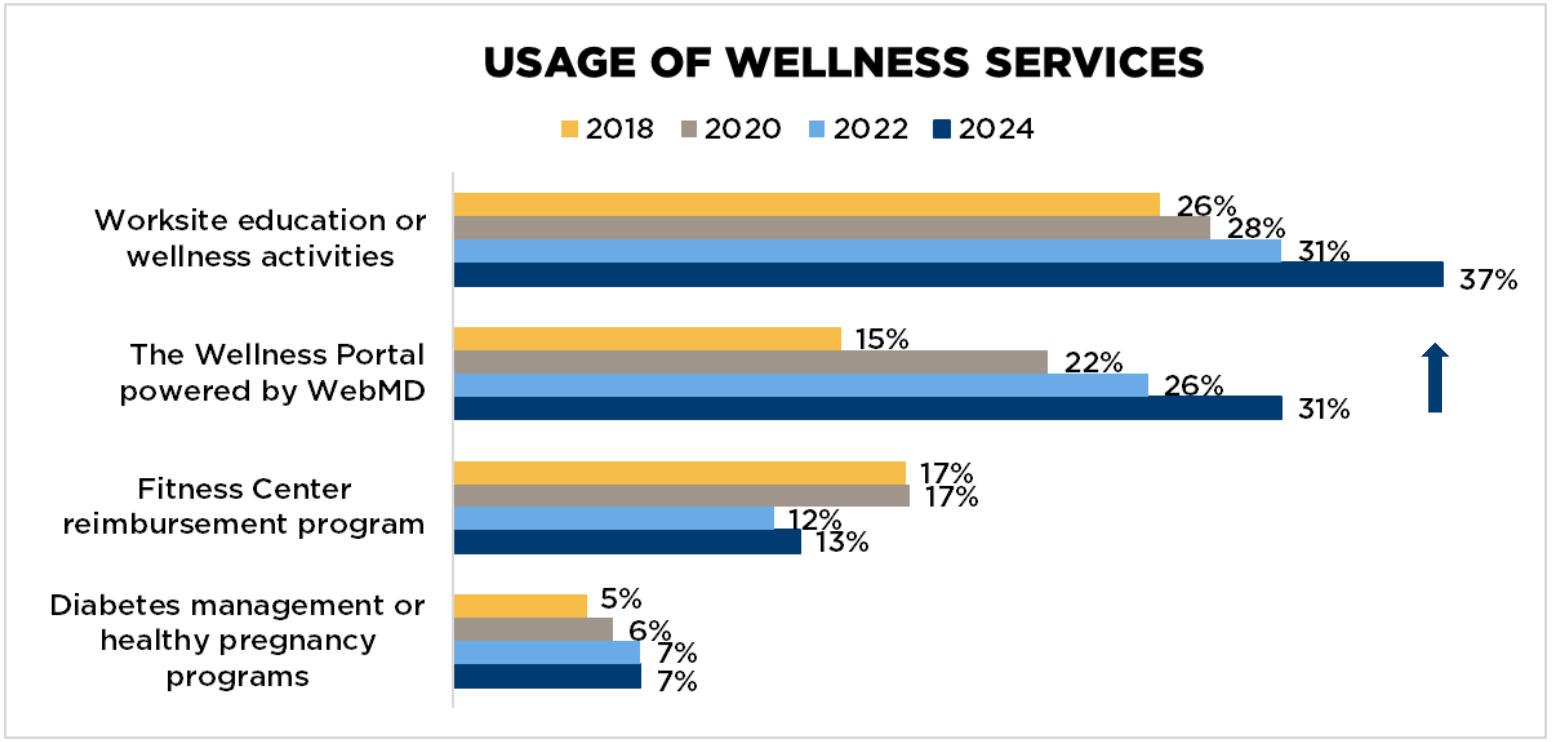
USAGE - PREVENTION SERVICES

Q. Which health prevention services do you use?



USAGE - WELLNESS SERVICES

Q. Which wellness program benefits do you use?

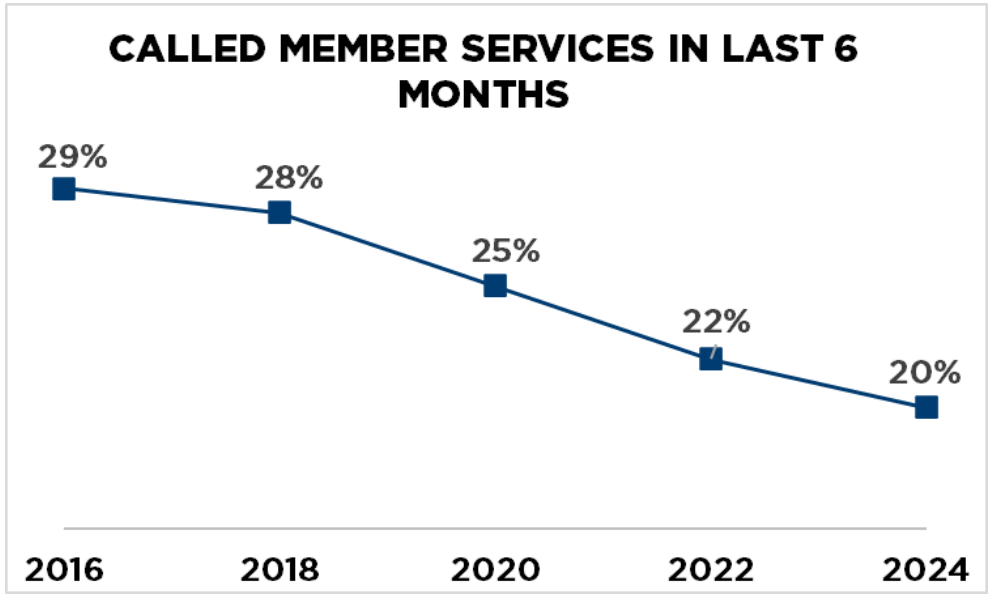


MEMBER SERVICE CENTER

NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

USAGE OF MEMBER SERVICE CENTER

Q. Have you called the Sanford Health Plan member services center within the last 6 months?

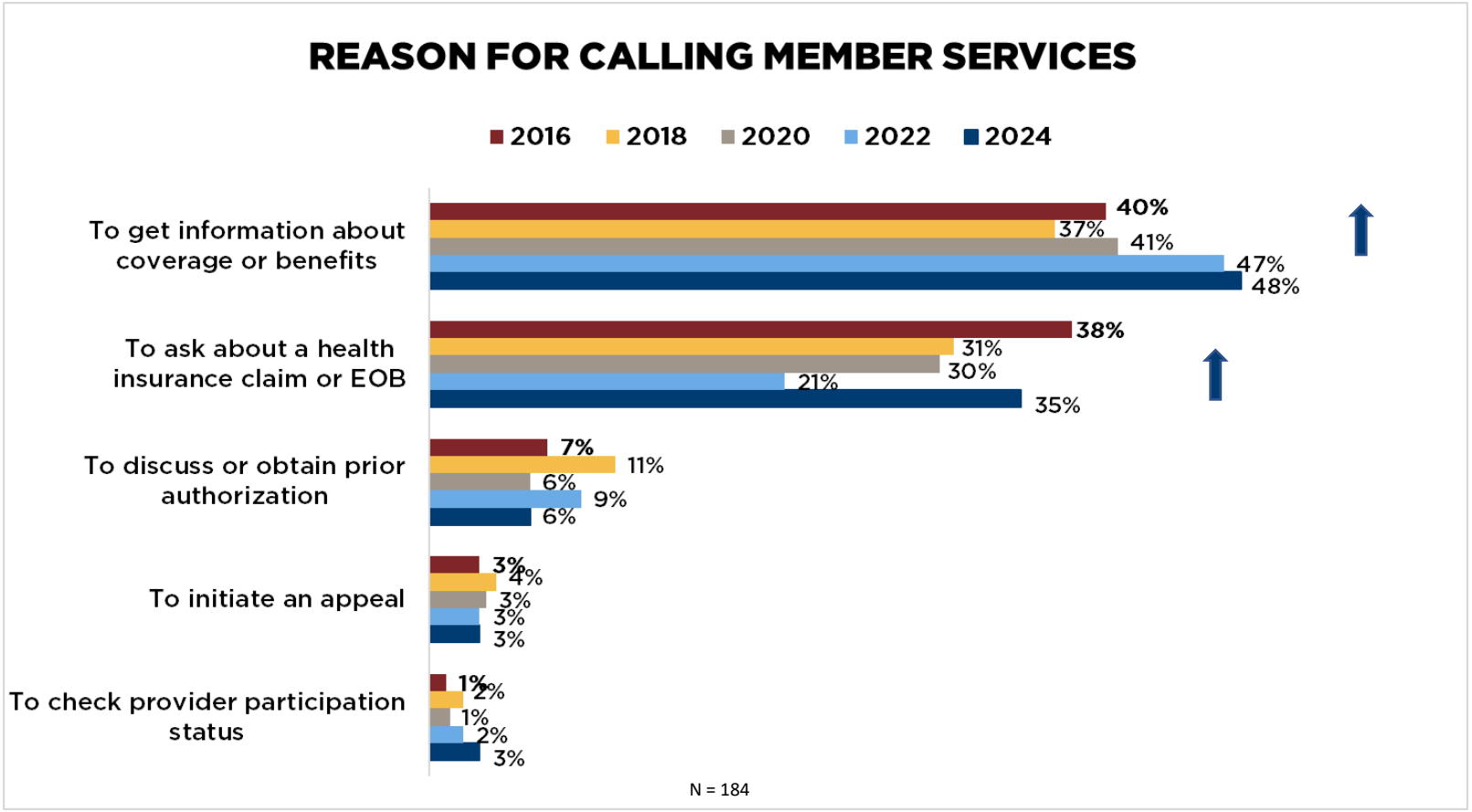


	Called Member Services in Last 6 Months	
	2024	% Change from 2022
State Employees	22%	↓ 6%
Medicare Retirees	12%	↓ 1%
Political Subdivisions	16%	↑ 1%
Pre-Retiree	30%	↑ 12%

N =1,076

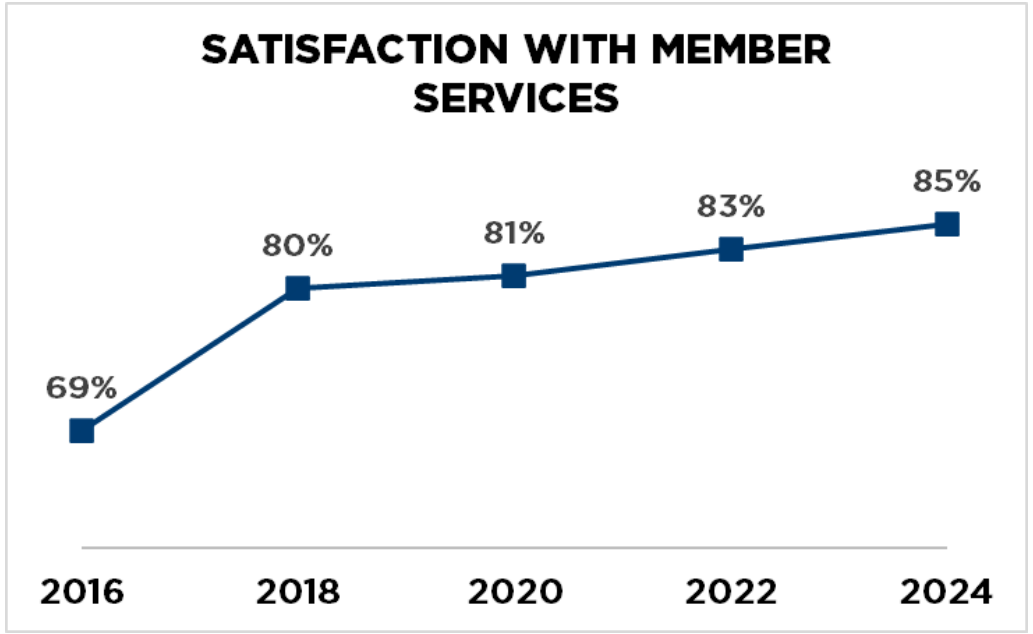
REASON FOR CALLING SERVICE CENTER

Q. Why did you call the member service center?



SATISFACTION WITH MEMBER SERVICES

Q. How satisfied were you with the service when you called the member services center?



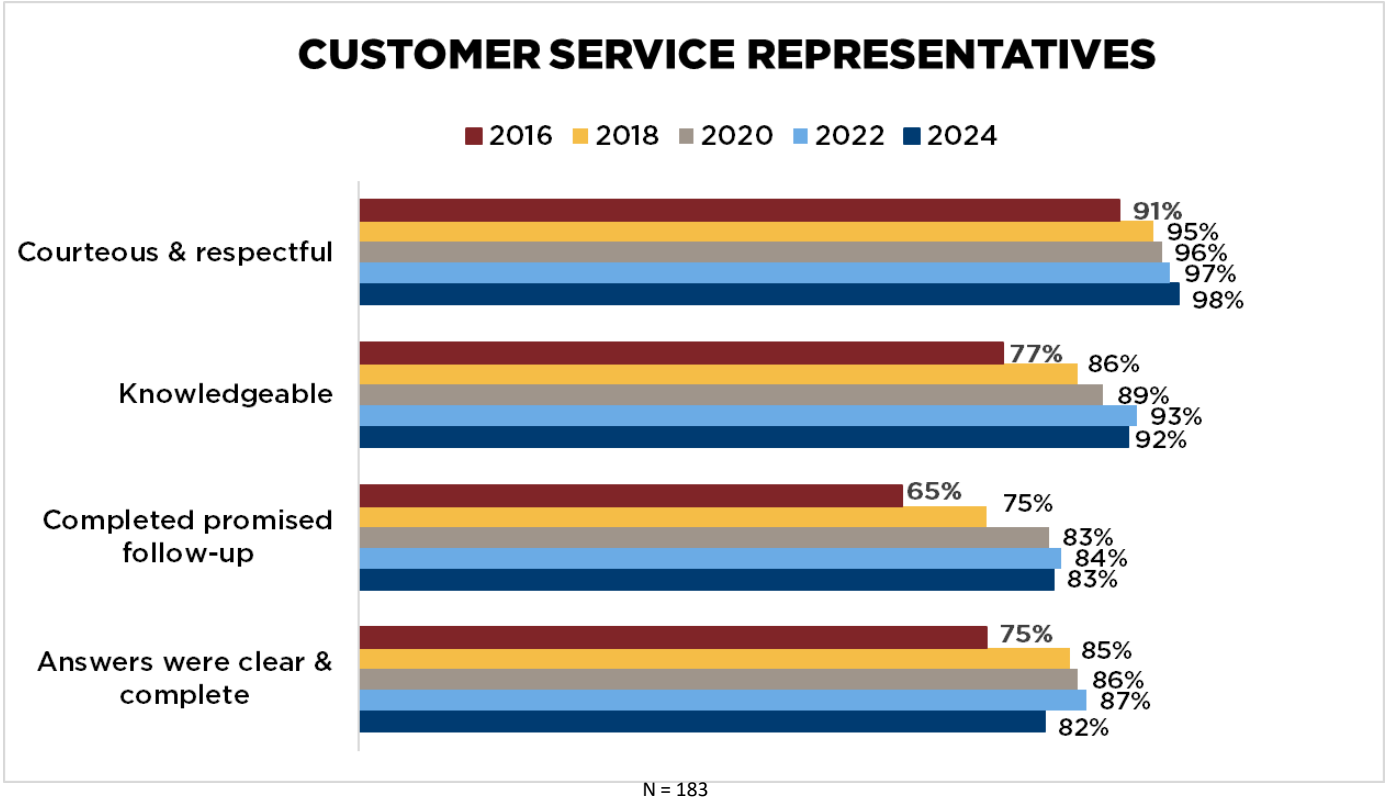
	Satisfaction with Member Services Center	
	2024	% Change from 2022
State Employees	83%	↑ 3%
Medicare Retirees	91%	↓ 3%
Political Subdivisions	94%	↑ 4%
Pre-Retiree	n/a*	n/a*

*Statistically invalid number

N =186

CUSTOMER SERVICE REPRESENTATIVES

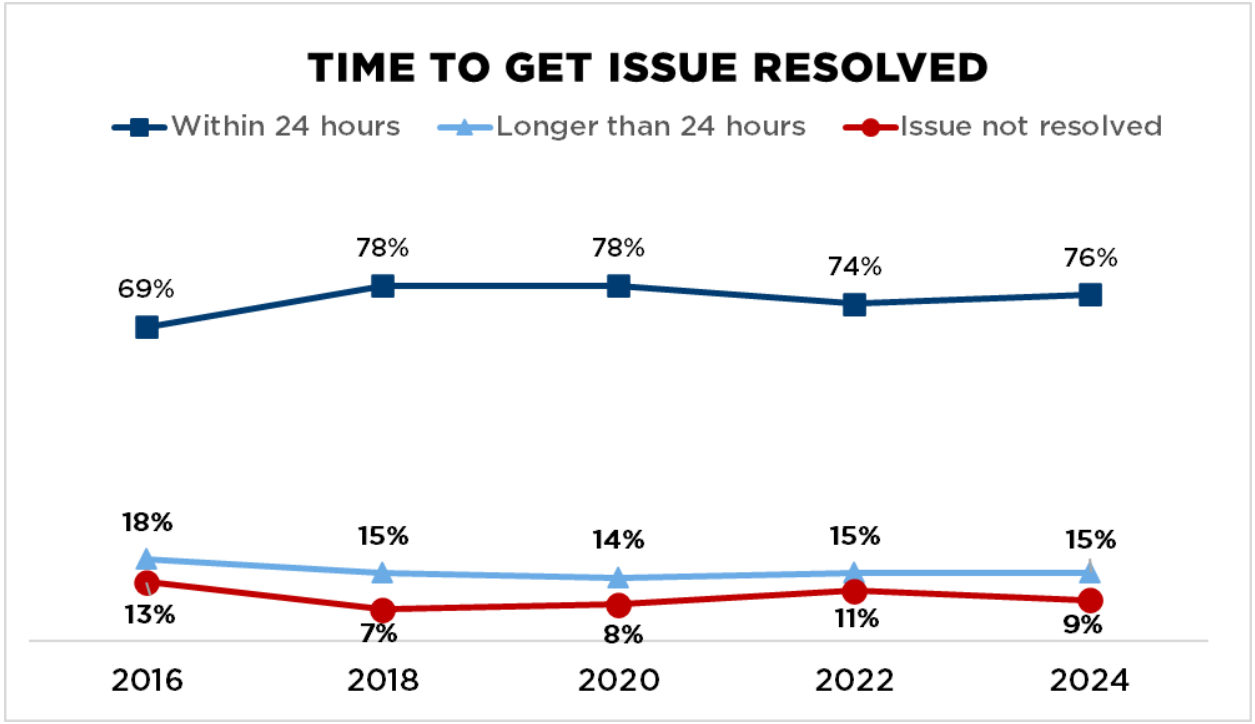
Q. Please share your feedback about the representative you talked with



N = 183

TIME TO GET ISSUE RESOLVED

Q. How long did it take the representative to provide the information or help you needed?



N = 185

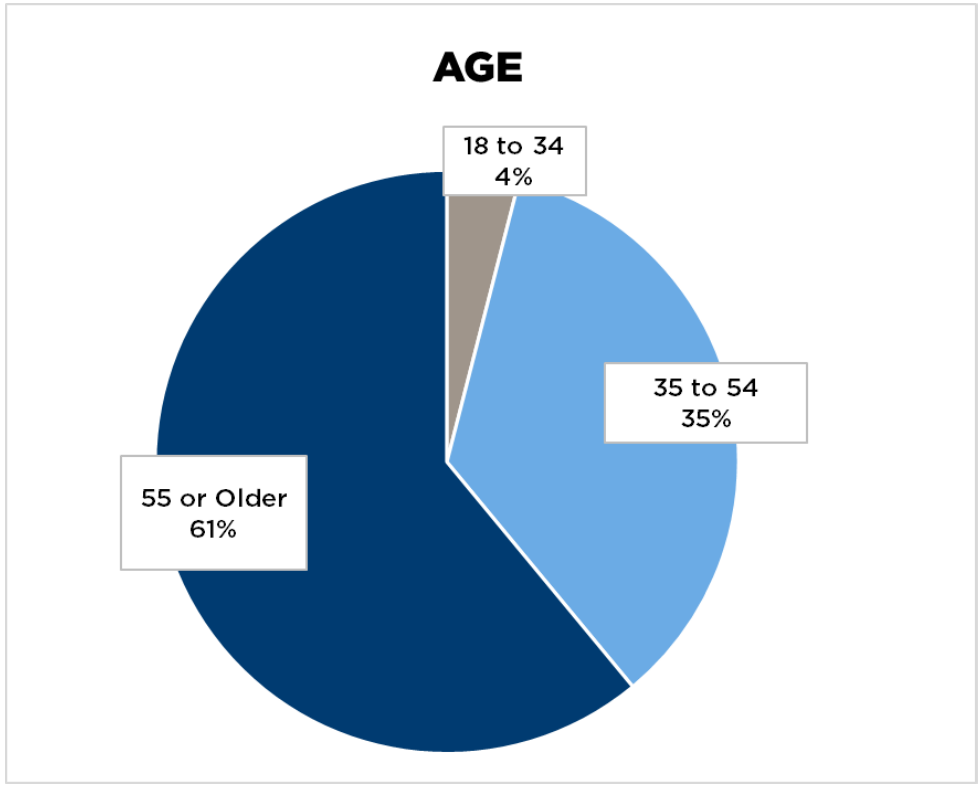
EXECUTIVE SUMMARY

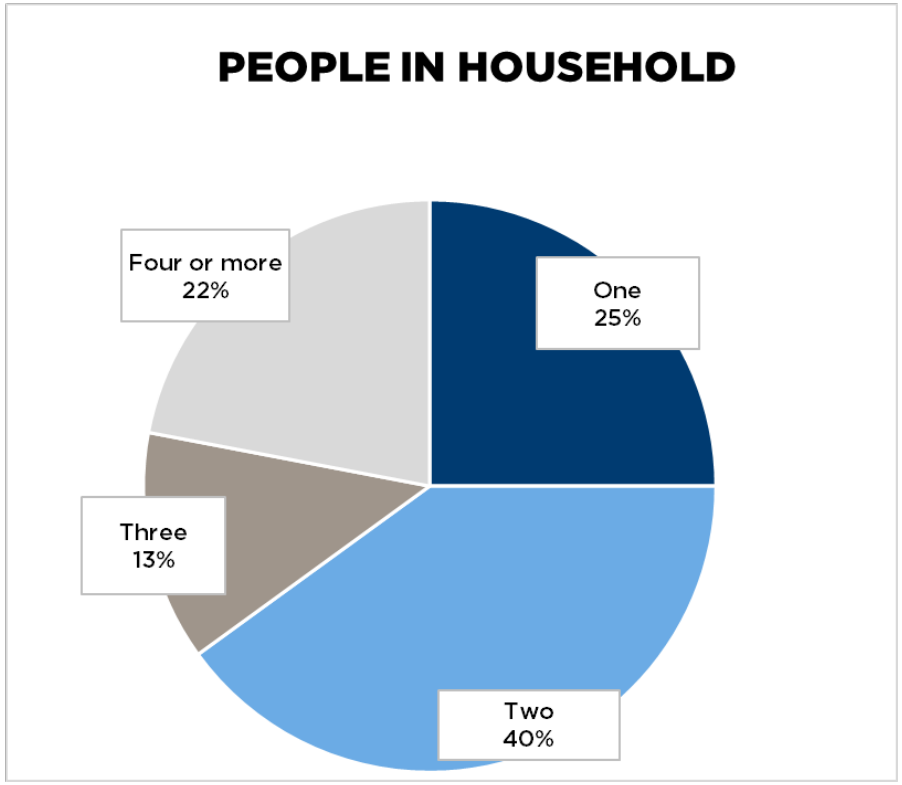
RESPONDENT DEMOGRAPHIC

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

AGE & HOUSEHOLD

Q. How old are you?
Q. How many people in your household?





N =1,020

Attachment 2

2024 NDPERS MEMBER EXPERIENCE SURVEY

Executive Summary and Full Report

July 2024

Jointly Commissioned by the North Dakota Public Employees Retirement System & Sanford Health Plan

Prepared by: Sanford Health Market Research

SANFORD HEALTH PLAN

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EXECUTIVE SUMMARY: NDPERS MEMBER EXPERIENCE

Eight years following a change in their health plan service providers, NDPERS members are highly satisfied with their Dakota Health Plan Benefits and with the customer service provided by Sanford Health Plan. This executive summary details topline results, presents key insights from analysis, provides survey methodology notes and presents a summary of open-ended comments.

ABOUT THE RESULTS

- ***Survey Response***: A random, representative sample of 7,500 NDPERS members was invited to participate. Results are based on **1,100** returned Surveys
- ***Margin of Error***: The full sample has a margin of error of **± 2.9%**, and the sub-sample of Member Services Call Center callers (n=188) has a margin of error ± 7.1%. Both samples are reported at the 95% confidence level.
- ***Time Frame***: Responses were gathered from April 1st to May 31st, 2024.

TOPLINE RESULTS: GENERAL MEMBERSHIP SURVEY

Member satisfaction with their NDPERS benefits is high and continues to improve. Almost all lines of business saw increases in satisfaction and all metrics we measured have had significant improvements since 2016.

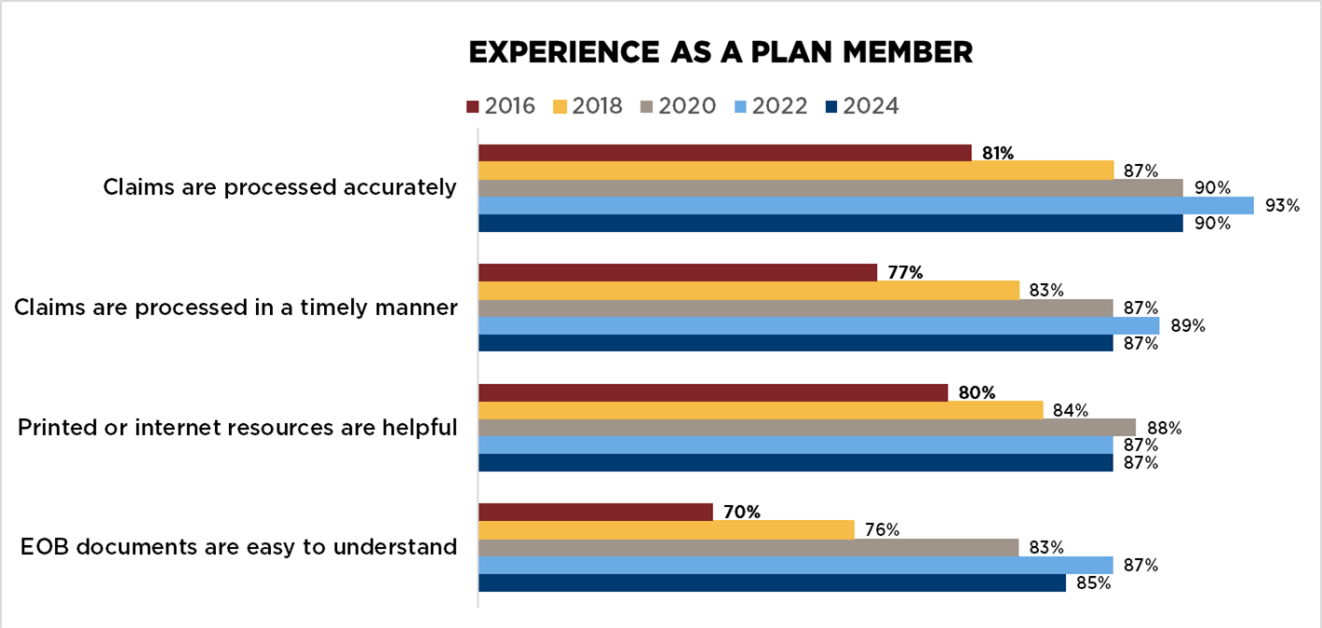
- 90% are satisfied with their NDPERS Dakota Health Plan Benefits (a 1-point increase from 2022).
- 90% agree that health insurance claims are processed accurately (a 3-point decrease from 2022).
- 87% agree that claims are processed in a timely manner (a 2-point decrease from 2022).
- 87% agree that printed materials or internet resources are helpful (no change from 2022).
- 85% agree that EOBs are easy to understand (a 2-point decrease from 2022).

TOPLINE RESULTS: MEMBER SERVICES CALL CENTER

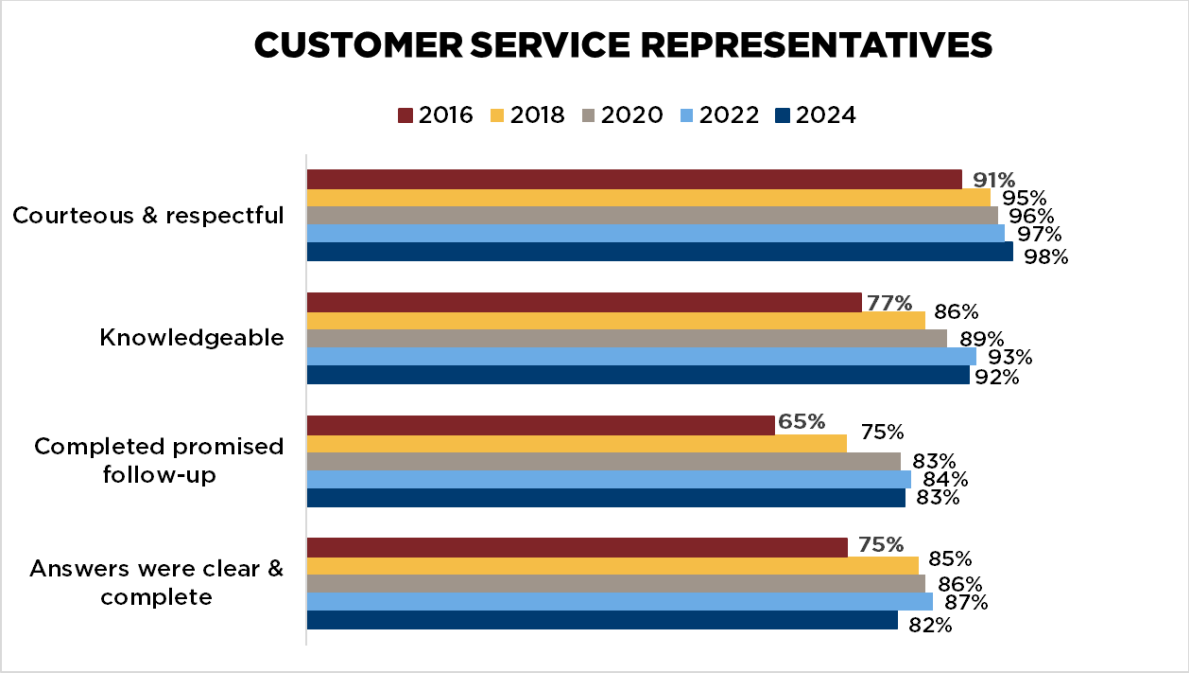
Significant progress continues to be made. Member Services satisfaction improved significantly between 2016 and 2018 but has only improved slightly since then. Customer Service Representatives continue to have improvement in scores related to the service they provide.

- 20% of members report calling Member Services in the past six months (a 2-point decrease from 2022).
- 85% of callers are satisfied with the service they received when they called Member Services (a 2-point increase from 2022).
- 98% agreed that the service representative was courteous and respectful (a 1-point increase from 2022).
- 92% agreed that the service representative was knowledgeable (a 1-point decrease from 2022).
- 83% agreed that the service representative completed any promised follow-up (a 1-point decrease from 2020).
- 82% agreed that questions were answered clearly and completely (a 5-point decrease from 2020).
- 48% called the call center to get information about coverage or benefits, and 35% called to ask a question about a health insurance claim or explanation of benefits (EOB).

TOPLINE RESULTS: GENERAL MEMBERSHIP SURVEY



TOPLINE RESULTS: MEMBER SERVICES CALL CENTER



ANALYSIS: KEY INSIGHTS

MEMBER SATISFACTION CONTINUES TO IMPROVE

- 90% of members are satisfied with their benefits…up 19 points in last 8 years
  - Positive comments outweigh negative comments by more than a 2-1 margin
- Overall, member satisfaction with benefits is increasing except for pre-retirees (down 5 points)
- Member experience has improved significantly in the last 8 years but has decreased slightly since 2022
- Worksite wellness activities and wellness portal usage continues to rise
- Percentage of members calling the service center continues to decrease except for pre-retirees (up 12 points)
- Overall, satisfaction with customer service representatives continues to improve

OPPORTUNITIES FOR IMPROVEMENT

Evaluate Wellness Programming for Medicare Retiree Population

The most requested wellness benefit improvement is the inclusion of a Silver Sneakers program. The second most requested improvement is to increase the dollar amount for fitness center reimbursements and simplify the process. This accounted for almost 10% of the negative comments about benefits. Sanford will review the wellness strategy for the Medicare retiree program to ensure they have programming that fits their needs.

Continue to Provide the Best Coverage of Services at an Affordable Price

The two topics of "coverage of services" and "cost" accounted for almost 80% of the negative comments we received from NDPERS members. These two related factors are the most important drivers of member satisfaction for a health plan. Members expect the best coverage possible at an affordable price.

Improve Member Service & Enhance Informational Resources

Member satisfaction with their benefits increased significantly between 2018 and 2020 and has leveled off since then but continues trending up, at 90%. In addition, member satisfaction with member service center is also high and continues to increase, up 16 percentage points in the last eight years. The data reveals the top reasons members call the service center is to get information about coverage or benefits and to ask about health insurance claim and EOB. However, we continue to see a positive downward trend in members needing to call the member service center. Enhancing member self-service informational resources has the potential to increase member satisfaction and lower service center volumes.

Billing & EOBs are Still a Source of Dissatisfaction

Although significant improvements have been made, the understandability of EOBs are rated low comparably to other member experiences at 85%. Additionally, the topic of "Billing / EOBs" accounted for almost 6% of the negative comments received. Members expect a Billing / EOB process that is timely, accurate and easy to understand.

METHODOLOGY: FIELDING THE SURVEY AND PREPARING RESULTS

Sanford Health Market Insights conducts consumer and market research for Sanford Health's various service divisions and partners. Survey goals, methodology and questions for this effort were developed in cooperation with Sanford Health Plan and NDPERS leadership.

FIELDING THE SURVEY: SURVEY SAMPLING AND DISTRIBUTION

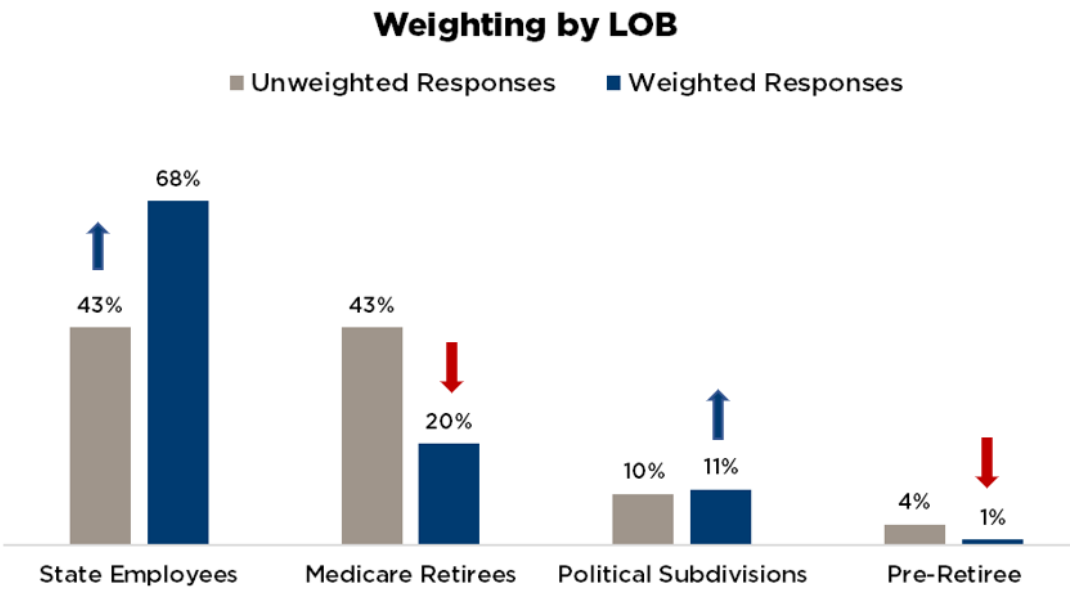
To generate accurate, credible and actionable results, the survey effort focused on asking the right questions to the right people.

- ***Survey Sample***: Using policy holder lists provided by Sanford Health Plan, 7,500 members were randomly selected to participate in the survey. Invitations were sent in proportion to how NDPERS members receive benefits - 66% of surveys were sent to state employees, 17% to Medicare retirees, 15% to members of political subdivisions and 2% to pre-retirees.
- ***Survey Distribution***: Surveys were sent via postal mail, and members had the option of returning a paper survey or completing the survey online by visiting www.surveyndpers.com. 81% of the respondents mailed in their survey and 19% took the survey online.
- ***Unique Survey IDs***: To track survey participation, eliminate the possibility of double-participation and allow for data entry validation, each survey was assigned a unique survey ID number.
- ***Survey Collection***: Surveys were received by Sanford Health Market Insights between April 1st to May 31st, 2024. Paper surveys were returned via pre-paid envelopes, and completing the survey online required a survey password and survey ID.
- ***Survey Questions***: The 2024 NDPERS questionnaire was identical to previous waves to preserve trends.

PREPARING RESULTS: ANALYZING AND REPORTING RESULTS

Due to the nature of the survey effort, preparing survey results involved establishing consistent analysis and reporting methods over multiple waves.

- ***Weighting by Line of Business***: To account for uneven response rates, overall totals were weighted to ensure the results accurately reflect the membership base. For example, Medicare Retirees accounted for 46% of survey responses but only represent 20% of NDPERS members. The graph below depicts how the results were weighted either up or down based on response rate and line of business.



- ***Net Effect of Weighting***: Because Medicare Retires are typically highly satisfied with their benefits and their scores are weighted down, the net effect of weighting lowers all satisfaction scores. For example, the raw results show that 92% of members are satisfied with their NDPERS benefits. When we weight the results, that number is lowered to 90%.
- ***Calculating Percentage Totals***: Two different scales were used in question responses.
  - ✓ ***Satisfied/Not Satisfied Totals:*** Satisfaction questions asked members to use a 1 to 10 scale, with 10 representing "Extremely Satisfied." Answers values from 1 to 5 are reported as "Not Satisfied" and answers from 6 to 10 are reported as "Satisfied."
  - ✓ ***Agree/Disagree Totals:*** Agreement questions asked members to use a 1 to 4 scale, with 4 representing "Strongly Agree." Answer values of 1 and 2 are reported as "Disagree" and values 3 and 4 are reported as "Agree."
- ***Number of Responses Per Question:*** Not all survey questions were answered by all survey responders. Responses for each question may vary based on whether the question was skipped or had an "N/A" option.

OPEN-ENDED COMMENTS: METHODOLOGY

The survey included one open-ended question asking NDPERS members to explain their overall satisfaction with NDPERS Dakota Health Plan Benefits.

- ***Statement Groupings and Sentiment***: Statements were separated into 7 categories and assigned either a positive, negative or neutral sentiment.
- ***Statement Examples***: The chart below shows the 7 categories and provides examples of statements for each category.
- ***AI Summary:*** All member comments are analyzed by ChatGPT4.0 to provide an overall summary of member comments.

	SAMPLE COMMENTS BY CATEGORY
Category	**Sample Statements**
Coverage of Services	"Coverage for reproductive healthcare is abysmal"
Satisfied / General Positive Comments	"Excellent plan and have paid very well since my cancer diagnosis"
Cost	"Out of pocket cost keeps getting higher"
Customer Services / Communication	"It's easy to talk to someone when we call; low wait time, knowledgeable personnel"
Wellness Program / Fitness Reimbursement / Silver Sneakers	"I really appreciate the health screening/prevention programs. I use the fitness center reimbursement program monthly"
Billing / EOB	"I'm satisfied with our plan, but find the billing confusing"
Timely / Speed / Efficient	"Efficient, seldom requires action on my part"

GENERAL MEMBER SURVEY

Detailed Topline Survey Results

This section provides a detailed breakdown of key general membership survey questions, including member satisfaction with NDPERS Dakota Health Plan benefits and perception of core health plan customer services.

RESULTS OVERVIEW: SURVEY PARTICIPATION

This section details who responded to the general membership portion of the 2020 NDPERS/Sanford Health Plan Member Survey.

	GENERAL MEMBERSHIP SURVEY PARTICIPATION				
	All Policy Holders	Surveys Sent		Survey Responses	
	%	%	n	%	n
State Employees	67.7%	65.3%	4,900	43.3%	476
Medicare Retirees	20.1%	17.3%	1,300	43.2%	475
Political Subdivisions	11.4%	14.7%	1,100	9.5%	104
Pre-Retiree	.8%	2.6%	200	4.1%	45
Total Members		7,500		1,100	
Total Possible		44,833		7,500	
% of Total Possible		**16.7%**		**14.7%**	

NOTES

- A total of 1,100 individuals returned a survey, delivering a response rate of 14.7%.
- A simple random sample of NDPERS was designed to provide a representative cross sample of NDPERS members - based online of business.
- Overall policy holder distribution by line of business was derived from a Sanford Health Plan cleaned and deduplicated member list.
- To account for the over-participation of Medicare Retirees, final results are presented by line-of-business, and, when applicable, results are weighted to accurately reflect the actual membership.
- The 1,100 responses have a +/-2.9% margin of error.
- Given the variance in responses across questions, margins of error fluctuate and are not reported for each question.

GENERAL MEMBERSHIP SURVEY QUESTIONS

SURVEY QUESTION (#4)

How satisfied are you with your NDPERS Dakota Plan Health Benefits?

Use the 10-point scale below to tell us your opinion; 1 is "Not At All Satisfied" and 10 is "Extremely Satisfied." Place a (✓) beneath one number.

Not at All Satisfied									Extremely Satisfied
1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	SATISFACTION WITH HEALTH PLAN BENEFITS			
	Responses	Distribution		Average
	n	Satisfied %	Not Satisfied % (n)	out of 10
State Employees	472	85%	15%	7.7
Medicare Retirees	468	96%	4%	9.0
Political Subdivisions	103	88%	12%	7.8
Pre-Retiree	45	91%	9%	8.4
Weighted Totals		**90%**	**10%**	**8.3/10**

NOTES

- For purposes of this analysis, values 1 to 5 were considered "Not Satisfied" and values 6 to 10 were considered "Satisfied."

SURVEY QUESTION (#6)

Printed materials or internet resources help you understand how your health plan works.
Consider any information about your benefits provided by Sanford Health Plan, which may include written materials or information available on Sanford Health Plan's website. Place a (✓) below one of the options below. If you have not read any printed materials or internet resources, please choose the "N/A" option.

Strongly Disagree			Strongly Agree	N/A
1	2	3	4	
☐	☐	☐	☐	☐

	PRINTED MATERIALS OR INTERNET RESOURCES ARE HELPFUL			
	Responses	Distribution		Average
		Agree %	Disagree %	
State Employees	394	85%	15%	3.1
Medicare Retirees	315	95%	5%	3.4
Political Subdivisions	83	88%	12%	3.3
Pre-Retiree	33	88%	12%	3.2
Weighted Totals		**87%**	**13%**	**3.3/4**

NOTES

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. User the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

SURVEY QUESTION (#7)

Explanation of Benefits (EOB) documents are easy to understand.

Place a (✓) below <u>one</u> of the options below. If you have not received an explanation of benefits, please choose the "NA" option.

Strongly Disagree			Strongly Agree	N/A
1	2	3	4	
☐	☐	☐	☐	☐

	EOBs ARE EASY TO UNDERSTAND			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	462	83%	17%	3.2
Medicare Retirees	412	93%	7%	3.5
Political Subdivisions	98	84%	16%	3.2
Pre-Retiree	43	94%	6%	3.4
Weighted Totals		**85%**	**15%**	**3.3/4**

NOTES

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. User the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

SURVEY QUESTION (#8)

Health insurance claims are processed in a timely manner.

Place a (✓) below <u>one</u> of the options below. If you have not received any services that generated a health insurance claim, please choose the "N/A" option.

Strongly Disagree			Strongly Agree	N/A
1	2	3	4	
☐	☐	☐	☐	☐

	CLAIMS ARE PROCESSED IN A TIMELY MANNER			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	470	84%	16%	3.2
Medicare Retirees	448	96%	4%	3.7
Political Subdivisions	97	84%	16%	3.3
Pre-Retiree	42	90%	10%	3.5
Weighted Totals		**85%**	**15%**	**3.4/4**

NOTES

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. User the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

SURVEY QUESTION (#9)

Health insurance claims are processed accurately.

Place a (✓) below <u>one</u> of the options below. If you have not received any services that generated a health insurance claim, please choose the "N/A" option.

Strongly Disagree			Strongly Agree	N/A
1	2	3	4	
☐	☐	☐	☐	☐

	CLAIMS ARE PROCESSED ACCURATELY			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	465	87%	13%	3.3
Medicare Retirees	445	98%	2%	3.7
Political Subdivisions	96	91%	9%	3.4
Pre-Retiree	41	92%	8%	3.6
Weighted Totals		**93%**	**7%**	**3.5/4**

NOTES

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. User the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

MEMBER SERVICES CALL CENTER

Detailed Topline Survey Results

This section provides a detailed breakdown of questions asked in the member services call center portion of the survey.

RESULTS OVERVIEW: MEMBER SERVICES SURVEY PARTICIPATION

This section details who responded to Member Services call center portion of the 2018 NDPERS/Sanford Health Plan Member Survey.

SURVEY QUESTION (#16)

Have you called the Sanford Health Plan Member services center in the past 6 months?
Place a (✓) next to one of the options below.

- ▫ No ➔ *(You are finished with the survey. Please do not complete the remaining questions).*
- ▫ Yes ➔ *(Please continue to Question 17).*

	MEMBER SERVICES CALL CENTER SURVEY PARTICIPATION	
	Survey Responses (Yes to Q16)	
	%	n
State Employees	22%	104
Medicare Retirees	12%	54
Political Subdivisions	16%	17
Pre-Retiree	30%	13
Total Callers	188	
Total Possible	*1076*	
% of Total Possible	20%	

NOTES

- A total of 188 individuals - or 20% of all survey responders - reported calling members services in the past six months, a result that closely tracks with actual call volumes.
- 188 responses produce a +/-7.1 % margin of error. Given the variance in responses across questions, margins of error fluctuate and are not reported for each question.
- To account for variance in participation, results are weighted by line-of-business to accurately reflect the actual membership.
- Overall policy holder distribution by line of business was derived from a Sanford Health Plan deduplicated member list.

MEMBER SERVICES CENTER SURVEY QUESTIONS

SURVEY QUESTION (#17)

How satisfied were you with the service you received when you called member services?

Use the 10-point scale below to tell us your opinion; 1 is "Not At All Satisfied" and 10 is "Extremely Satisfied." Place a (✓) beneath one number.

Not at All Satisfied									Extremely Satisfied
1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	SATISFACTION WITH MEMBER SERVICES CALL CENTER SERVICE			
	Responses	Distribution		Average
	n	Satisfied %	Not Satisfied % (n)	out of 10
State Employees	103	83%	17%	7.5
Medicare Retirees	53	91%	9%	8.7
Political Subdivisions	17	94%	6%	8.0
Pre-Retiree	13	92%	8%	8.6
Weighted Totals		**85%**	**15%**	**8.0/10**

NOTES

- For purposes of this analysis, values 1 to 5 were considered "Not Satisfied" and values 6 to 10 were considered "Satisfied."

SURVEY QUESTION (#18)

Why did you call the member services call center?

Place a (✓) next to one of the options below.

- ▫ To get information about coverage or benefits
- ▫ To ask a question about a health insurance claim or explanation of benefits (EOB)
- ▫ To discuss or obtain prior authorization
- ▫ To check provider participation status
- ▫ To initiate an appeal
- ▫ Other - Please specify _____

	REASON FOR CALLING MEMBER SERVICES					
	Benefits Info	Claim or EOB	Prior Auth	Provider Status	Appeal Claim	Other
State Employees	48%	35%	6%	3%	3%	4%
Medicare Retirees	48%	33%	8%	6%	0%	6%
Political Subdivisions	53%	35%	6%	0%	0 %	6%
Pre-Retiree	69%	15%	8%	0%	0%	8%
Weighted %	**49%**	**35%**	**6%**	**3%**	**3%**	**4%**

SURVEY QUESTION (#19)

How long did it take the representative to provide the information or help you needed?

Place a (✓) next to <u>one</u> of the options below.

- The issue was addressed during the initial call
- Less than 24 hours
- Less than 1 week
- 1 to 2 weeks
- 3 or more weeks
- The issue was not resolved

	LENGTH OF TIME TO PROBLEM RESOLUTION					
	Right Away	Less than 24 hours	Less than 1 week	1 to 2 Weeks	3+ Weeks	Not Resolved
State Employees	61%	12%	8%	5%	3%	12%
Medicare Retirees	73%	12%	10%	2%	2%	2%
Political Subdivisions	76%	12%	0%	6%	6%	0%
Pre-Retiree	92%	8%	0%	0%	0%	0%
Weighted %	**64%**	**12%**	**7%**	**5%**	**3%**	**9%**

SURVEY QUESTION (#20)

How long did you have to wait before you were able to talk a to customer service representative?

Place a (✓) next to <u>one</u> of the options below.

- ▫ The call was answered immediately by a representative
- ▫ Less than 1 minute
- ▫ 1 to 2 minutes
- ▫ Longer than 2 minutes
- ▫ I hung up before talking to a customer service representative.
- ▫ Don't Know / Don't Remember

	WAIT TIME BEFORE TALKING TO A REPRESENTATIVE					
	Right Away	Less than 1 minute	1 to 2 Minutes	2+ Minutes	Hung Up	Don't Know
State Employees	14%	18%	31%	21%	0%	17%
Medicare Retirees	25%	17%	35%	12%	0%	12%
Political Subdivisions	18%	35%	35%	12%	0%	0%
Pre-Retiree	23%	31%	38%	8%	0%	0%
Weighted %	**16%**	**19%**	**32%**	**18%**	**0%**	**14%**

SURVEY QUESTION (#21)

The customer service representative treated you with courtesy and respect.

Place a (✓) below <u>one</u> of the options below.

Strongly Disagree			Strongly Agree
1	2	3	4
☐	☐	☐	☐

	REPRESENTATIVE TREATED YOU WITH COURTESY AND RESPECT			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	100	98%	2%	3.8
Medicare Retirees	53	99%	1%	3.9
Political Subdivisions	17	100%	0%	3.9
Pre-Retiree	13	100%	0%	3.8
Weighted Totals		**98%**	**2%**	**3.8/4**

NOTES

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. User the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

SURVEY QUESTION (#22)

The customer service representative was knowledgeable.

Place a (✓) below <u>one</u> of the options below.

Strongly Disagree			Strongly Agree
1	2	3	4
☐	☐	☐	☐

	REPRESENTATIVE WAS KNOWLEDGEABLE			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	100	89%	11%	3.5
Medicare Retirees	53	96%	4%	3.7
Political Subdivisions	17	100%	0%	3.8
Pre-Retiree	13	92%	8%	3.6
Weighted Totals		**92%**	**8%**	**3.6/4**

NOTES

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. User the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

SURVEY QUESTION (#23)

The customer service representative answered my questions clearly and completely.

Place a (✓) below one of the options below.

Strongly Disagree			Strongly Agree
1	2	3	4
☐	☐	☐	☐

	REPRESENTATIVE ANSWERS WERE CLEAR AND COMPLETE			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	100	79%	21%	3.4
Medicare Retirees	53	92%	8%	3.7
Political Subdivisions	17	94%	6%	3.6
Pre-Retiree	13	92%	8%	3.7
Weighted Totals		**82%**	**18%**	**3.5/4**

NOTES

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. User the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

SURVEY QUESTION (#24)

The customer service representative completed any follow-up that was promised.

Place a (✓) below <u>one</u> of the options below. If your call did not require follow-up, please choose the "N/A" option.

Strongly Disagree			Strongly Agree	N/A
1	2	3	4	
☐	☐	☐	☐	☐

	REPRESENTATIVE COMPLETED PROMISED FOLLOW-UP			
	Responses	Distribution		Average
	n	Agree %	Disagree %	out of 4
State Employees	52	80%	20%	3.3
Medicare Retirees	21	95%	5%	3.8
Political Subdivisions	6	100%	0%	3.8
Pre-Retiree	4	100%	0%	3.8
Weighted Totals		**83%**	**17%**	**3.5/4**

NOTES

- For purposes of this analysis, values 1 and 2 were considered "Disagree" and values 3 and 4 were considered "Agree."
- This question was 1 of 4 questions that came after the following survey instructions: "For the next 4 questions, read each statement and rate your experience. User the 4-point scale to tell us your opinion; 1 is 'Strongly Disagree' and 4 is 'Strongly Agree.' If the statement doesn't apply to you, choose the N/A option."

OPEN-ENDED RESPONSES

QUALITATIVE SUMMARY

This section provides an overview of qualitative methodology and a summary of open-ended responses to the 1 open-ended question asked to NDPERS members.

SUMMARY: MEMBER OPEN-ENDED COMMENTS

SURVEY QUESTION (#5)

Why did you give your NDPERS Dakota Plan Health Benefits that rating?

In the previous question, you rated your satisfaction with NDPERS Dakota Plan Health Benefits. Use the space below to briefly explain your satisfaction with your NDPERS Dakota Health Plan benefits.

	OPEN-ENDED COMMENT SUMMARY			
Category	**Number of Statements**	**Percent of Respondents**	**% Positive**	**% Negative**
Satisfied / General Positive Comments	316	38%	100%	0%
Coverage of Services	305	37%	71%	29%
Cost	78	9%	0%	100%
Customer Services / Communication	62	8%	56%	44%
Billing / EOB	30	4%	60%	40%
Wellness Programs / Silver Sneakers	27	3%	22%	78%
Timely / Speed / Efficient	26	3%	73%	27%
Total	**826**			

NOTES

- Each statement was coded and categorized into 7 categories.
- Additionally, each statement was analyzed and coded as either having a positive or negative tone.

RESPONDENT CHARACTERISTICS

Detailed Topline Survey Results

This section provides detailed breakdowns of demographic questions and other questions that describe the individuals who participated in the survey. Results in this section are weighted to line of business expected ratios.

SURVEY QUESTION (#1)

When was the last time you received health services that led to a health insurance claim?

Consider any service that impacts your individual or family deductible or coinsurance. Examples include services provided by physicians, hospitals, laboratories or pharmacies. Place a (✓) next to one of the options below.

- Within the last 30 days
- 1 to 2 months ago
- 3 to 4 months ago
- 5 to 6 months ago
- More than 6 months ago
- N/A - Neither I nor my family have used any services that led to a health insurance claim

	LAST TIME USED HEALTH SERVICES					
	<30 Days	1-2 Mo.	3-4 Mo	5-6 Mo	6+ Mo	N/A
State Employees	63%	19%	8%	5%	4%	1%
Medicare Retirees	59%	19%	10%	4%	6%	2%
Political Subdivisions	42%	26%	12%	7%	11%	3%
Pre-Retiree	49%	40%	2%	2%	4%	2%
Weighted %	59%	20%	9%	5%	5%	1%

Totals (n=1,076)

	USED HEALTH SERVICES IN THE PAST 6 MONTHS			
	Used Within Last 6 Months		Not Used Within Last 6 Months	
	n	%	n	%
State Employees	451	95%	25	5%
Medicare Retirees	434	92%	38	8%
Political Subdivisions	90	87%	14	13%
Pre-Retiree	42	93%	3	7%
Weighted%		**93%**		**7%**

Totals (n=1,076)

SURVEY QUESTION (#2)

Which health prevention or health screening services do you use?

Place a (✓) next to every prevention or screening service used by you or any member of your family.

- ▫ Annual physical examination
- ▫ Immunizations, such as flu shots
- ▫ Well Child Care services
- ▫ Cancer screening services, such as breast cancer or colon cancer screenings.
- ▫ Other (please specify) _____
- ▫ N/A - Neither I nor my family use prevention or screening services

	USE OF PREVENTATIVE HEALTH SERVICES					
	Annual Physical	Flu Shots & Immun.	Cancer Screening	Well Child Care	Other	N/A
State Employees	82%	67%	67%	22%	15%	2%
Medicare Retirees	87%	74%	59%	0%	18%	2%
Political Subdivisions	74%	52%	59%	4%	14%	5%
Pre-Retiree	82%	73%	82%	0%	20%	2%
Weighted%	**82%**	**67%**	**65%**	**15%**	**16%**	**2%**

Totals (n=1,097)

SURVEY QUESTION (#3)

Which NDPERS Dakota Wellness Program benefits do you use?

Place a (✓) next to every NDPERS Dakota Wellness Program benefit used by you or any member of your family.

- ▫ Worksite education or wellness activities (newsletters, book clubs, wellness challenges)
- ▫ Fitness Center Reimbursement Program
- ▫ Tobacco Cessation, Diabetes Management or Healthy Pregnancy programs
- ▫ The Staywell online wellness portal
- ▫ Other (please specify) _____
- ▫ N/A - Neither I nor my family use NDPERS Dakota Wellness Program benefits

	USE OF WELLNESS SERVICES					
	Don't Use Wellness Benefits	Worksite Wellness	Wellness Portal Powered by WebMD	Fitness Center Reimbursement	Diabetes Management or Pregnancy Programs	Other
State Employees	38%	45%	38%	14%	6%	1%
Medicare Retirees	66%	10%	11%	13%	7%	2%
Political Subdivisions	49%	40%	23%	7%	8%	0%
Pre-Retiree	64%	11%	20%	7%	9%	2%
Weighted%	**45%**	**37%**	**31%**	**13%**	**7%**	**1%**

Totals (n=1,052)

SURVEY QUESTION (#13)

Which health insurance plan do you have?

Place a (✓) next to one of the options below.

- NDPERS PPO/Basic Plan
- NDPERS High Deductible Health Plan (HDHP)
- NDPERS Dakota Retiree Plan (Medicare)
- Don't Know / Unsure

	TYPE OF HEALTH PLAN		
	PPO Basic	HDHP	Retiree Plan
State Employees	91%	4%	0%
Medicare Retirees	3%	0%	89%
Political Subdivisions	90%	0%	1%
Pre-Retiree	58%	0%	38%
Weighted %	**73%**	**3%**	**19%**

Totals (n=936)

SURVEY QUESTION (#14)

How many people in your household are covered by your NDPERS Dakota Plan Health Benefits?

Place a (✓) next to one of the options below.

- 1
- 2
- 3
- 4 or more

	NUMBER IN HOUSEHOLD COVERED BY BENEFITS			
	1	2	3	4 or More
State Employees	14%	37%	16%	32%
Medicare Retirees	53%	46%	0%	0%
Political Subdivisions	40%	42%	13%	5%
Pre-Retiree	16%	84%	0%	0%
Weighted %	**25%**	**40%**	**13%**	**22%**

Totals (n=1,085)

SURVEY QUESTION (#15)

How old are you?

Place a (✓) next to one of the options below.

- ▫ Under 25 years old
- ▫ 25 to 34 years old
- ▫ 35 to 44 years old
- ▫ 45 to 54 years old
- ▫ 55 to 64 years old
- ▫ 65 years or older

	AGE DISTRIBUTION					
	<25	25-34	35-44	45-54	55-64	65+
State Employees	1%	4%	18%	28%	39%	9%
Medicare Retirees	1%	0%	0%	0%	0%	99%
Political Subdivisions	0%	2%	14%	20%	54%	12%
Pre-Retiree	0%	0%	0%	19%	86%	14%
Weighted %	**1%**	**3%**	**14%**	**21%**	**33%**	**27%**

Totals (n=1,089)

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: August 20, 2024

SUBJECT: Health Insurance Renewal

The memo I provided at the February meeting (attached) provides the statutory requirements regarding the health insurance renewal process. To summarize:

1) The Board must have its consultant independently prepare a renewal estimate for the Board to use in determining the reasonableness of the proposed premium;
2) The Board must review the carrier's relevant performance measures and use them to determine the Board's satisfaction with the carrier's performance;
3) The Board must consider other relevant information, including:
   a. The economy to be effected.
   b. The ease of administration.
   c. The adequacy of the coverages.
   d. The financial position of the carrier, with special emphasis on the solvency of the carrier.
   e. The reputation of the carrier and any other information available tending to show past experience with the carrier in matters of claim settlement, underwriting, and services.

Deloitte has prepared a renewal estimate, which we will review with the Board in closed session after the Sanford Health Plan (SHP) presentation. SHP has presented its member survey results, and during this agenda topic will make its renewal presentation incorporating additional considerations for the Board and the proposed renewal premium.

As we have in the past, we have obtained Sanford Health's assurance that it financially backs Sanford Health Plan and its provision of health insurance to NDPERS' participants. We have also reached out to the Insurance Department for any information they have regarding SHP's performance and financial position, and they report that they have no solvency concerns with SHP.

Next month we will bring the renewal topic back for a final review of any additional information the Board needs. The Board will make a decision in September on whether to renew with SHP or issue an RFP for the health plan.

Board Action Requested: Provide staff with guidance (in closed session) regarding negotiation strategy with SHP for a possible renewal.

North Dakota
Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Interim Executive Director
(701) 328-3900
1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Attachment 1

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: February 13, 2024

SUBJECT: Health Insurance Renewal

As you will recall, our health plan contract with Sanford Health Plan (SHP) runs for two years (biennium), with two additional possible two-year renewals. The current contract, the second two years of the possible six years, runs through June of 2025. Because an RFP in the event we do not renew takes so much time, we need to begin the process to determine if the Board would like to renew with SHP for another two years.

The timeframe for this process is as follows:

- July/August – obtain renewal estimate from Deloitte
- August – receive and consider the proposed renewal and other required information
- September – determine whether to renew or issue an RFP

If the Board decides to issue an RFP, the timeframe for that is as follows:

- September – issue RFP
- November/December – receive RFPs
- February – award the plan for the 2023-2025 biennium

To expedite the RFP process in the event the Board goes that direction, staff are in the process of reviewing and updating the previous RFP, and will bring the final product to the Board for its approval should the Board opt to issue the RFP.

The statutory requirements for renewal are found in NDCC section 54-52.1-05(2):

2. The initial term or the renewal term of a uniform group insurance contract through a contract for insurance, health maintenance organization, or self-insurance health plan for hospital benefits coverage, medical benefits coverage, or prescription drug benefits coverage may not exceed two years.
   a. The board may renew a contract subject to this subsection without soliciting a bid under section 54-52.1-04 if the board determines the carrier's performance under the existing contract meets the board's expectations, the proposed premium renewal amount does not exceed the board's expectations, and renewal best serves the interests of the state and the state's eligible employees.
   b. In making a determination under this subsection, the board shall:
      (1) Use the services of a consultant to concurrently and independently prepare a renewal estimate the board shall consider in determining the reasonableness of the proposed premium renewal amount.
      (2) Review the carrier's performance measures, including payment accuracy, claim processing time, member service center metrics, wellness or other special program participation levels, and any other measures the board determines relevant to making the determination and shall consider these measures in determining the board's satisfaction with the carrier's performance.
      (3) Consider any additional information the board determines relevant to making the determination.
   c. The board may determine the carrier's performance under the existing contract does not meet the board's expectations, the proposed premium renewal amount exceeds the board's expectations, or renewal does not best serve the interests of the state or the state's eligible employees and the board therefore may decide to solicit a bid under section 54-52.1-04.

The proposed premium renewal amount has historically been the sticking point in the renewal process.

As we have in the past, we will have Deloitte prepare a renewal estimate for the Board’s use in the negotiation process, as required by subsection 2(b)(1). SHP will also perform its usual customer survey, which satisfies some of the requirements in subsection 2(b)(2).

Also to assist with some of the requirements in 2(b)(2), Shawna Piatz goes to SHP every year to perform an audit of SHP claims processing, which typically goes very well. Current practice is for the findings of the audit and NDPERS management responses to be shared with the Audit Committee, as well as, the full Board. The results for the 2023 audit will be shared prior to the renewal discussions.

The “additional information” the Board has typically reviewed to comply with subsection 2(b)(3) includes the information required by NDCC section 54-52.1-04(1) for an RFP:

a. The economy to be effected.
b. The ease of administration.
c. The adequacy of the coverages.
d. The financial position of the carrier, with special emphasis on the solvency of the carrier.
e. The reputation of the carrier and any other information available tending to show past experience with the carrier in matters of claim settlement, underwriting, and services.

Little has changed since the 2020 RFP process regarding subsections 1(a), 1(b) and 1(c). As such, we may not need additional information on these. SHP’s performance measures and the customer survey should satisfy subsection 1(e). To satisfy subsection 1(d), the financial position of the carrier, in the past we have requested a letter from the President of Sanford Health, the overarching legal entity, confirming the financial stability of Sanford Health and its willingness to financially support SHP if needed. We will also reach out to the Insurance Department to see what information they have.

We have typically asked for the following additional information from SHP, and staff would recommend it for this renewal, as well:

- the effect on the rates of losing our Grandfathered status
- a schedule from Sanford Health Plan of the effect of plan design changes (deductibles, co-insurance, etc.)
- the cost of coverage changes (ACA benefits, coverage for birth control without cost sharing, additional wellness incentives such as smoking deterrents and re-starting the tobacco cessation program, etc.)
- information on the PERS special programs including wellness, About the Patient, and the Healthy Pregnancy Program

Staff are seeking consensus from the Board regarding if they wish to follow the same process for the renewal. Also, are there additional items other than those identified by staff that the Board would like provided as part of the renewal for the Board’s consideration?

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Public Employees Retirement System
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Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
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1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: August 20, 2024

SUBJECT: Proposed Administrative Rules Update

NDPERS has received initial comments on the review of our proposed administrative rules by the Attorney General's Office. The comments include clarifying questions and suggestions on some of the proposed rules. Staff are reviewing these comments and working closely with the Assistant Attorney General assigned to perform the review.

In addition, I will be appearing before the Administrative Rules Committee at their September 4th meeting to discuss questions about the proposed rules.

Staff will provide a final version of the rules at a future meeting. Staff anticipates being able to send the proposed rules to Legislative Council by the October 31 deadline.

This item is informational and doesn't require any action of the Board.

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Public Employees Retirement System
1600 East Century Avenue, Suite 2 ● PO Box 1657
Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
(701) 328-3900
1-800-803-7377

Fax: (701) 328-3920 Email ndpers-info@nd.gov Website https://ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Derrick Hohbein

DATE: August 20, 2024

SUBJECT: Budget Status

Twice a year staff provides the Board with an update on the status of the current budget and answers any questions or concerns the Board may have. The expenses for the biennium through June 30, 2024, as well as our total appropriation, are summarized in the table below:

	2023-2025 Appropriation	Expenditures to Date	Remaining Appropriation	% Remaining
Salaries & Wages	9,068,789	4,381,411	4,687,378	52%
Operating	2,542,712	1,180,593	1,362,119	54%
Contingency	250,000	-	250,000	100%
DB Closure	372,027	82,106	289,921	78%
Total	12,233,528	5,644,110	6,589,418	54%

We did receive $4,500 in both funding and appropriation authority for the internship program. There is $161,673 of salary appropriation available through the Vacant FTE pool that we can access in March 2025, if needed.

The biennium ends June 30, 2025.

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

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Bismarck, North Dakota 58502-1657

Rebecca Fricke
Executive Director
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1-800-803-7377

Fax (701) 328-3920 Email ndpers-info@nd.gov Website www.ndpers.nd.gov

Memorandum

TO: NDPERS Board

FROM: Rebecca

DATE: August 20, 2024

SUBJECT: Contracts under $10,000

Attached is a document that shows the contracts under $10,000 that have been signed since the last update. Please let me know if you have any questions on any of these contracts.

This topic is informational only.

Attachment 1

All Contracts Signed During 2024:

Vendor	Amount	Notes
CliftonLarsonAllen	$ -	GASB 68 & 75 Representation Lettess
TIAA	$ -	Termination notice due to recordkeeper award
BND	$ 909.00	Staff Years of Service Awards (Gift Cards)
City of Berthold	$ -	Joined Life Insurance Plan 3/1/2024
Mandaree Public Schools	$ -	Joined Deferred Compensation Plan 3/1/2024
Interoffice	$ 1,179.44	Office Chair
Emmons County	$ -	Joined Public Safety Plan 4/1/2024
City of Leeds	$ -	Joined Defined Benefit Plan 4/1/2024
City of Leeds	$ -	Joined Deferred Compensation Plan 4/1/2024
City of Emerado	$ -	Joined Public Safety Plan 2/1/2024
City of Riverdale	$ -	Joined Defined Benefit Plan 4/1/2024
City of Riverdale	$ -	Joined Deferred Compensatoin Plan 4/1/2024
Fireside	$ 3,079.80	5 year total lease on multi-function printer
Advanced Business Methods	$ 5,713.20	5 year total lease on document scanner
Eddy County	$ -	Joined Life Insurance Plan 5/1/2024
Galliard Fund Agreements	$ -	Lowering the share class in the Galliard investments in the 401(a) & 457 Plans
Larimore Public School	$ -	Joined Deferred Compensation Plan 1/1/2025
TIAA Deconversion Guide	$ -	Strategy guide with TIAA for deconvertig to Empower
TIAA Letter of Direction	$ -	Direction to pay out RMDs & scheduled installments early with TIAA prior to blackout
Empower Letter of Instruction	$ -	Letter of instruction on brokerage account in 457 and 401(a) plans
Empower Brokerage Application	$ -	Application on brokerage account in 457 and 401(a) plans
TIAA Custodial Agreement Terminations	$ -	Termination of Custodial Agreements with TIAA for both the 457 and 401(a) Plans
TIAA Record Keeper Amendment	$ -	Authorization for TIAA to pull recordkeeper fees through June 2024
Beulah Public School # 27	$ -	Joined Deferred Compensation Plan 7/1/2024
TIAA Brokerage Re-Registration Letter	$ -	Authorizes the transfer of brokerage acocunts on both the 457 and 401(a) Plans
Empower Brokerage Transfer Request Form	$ -	Authorizes the transfer of brokerage acocunts on both the 457 and 401(a) Plans
Empower Plan Asset Transfer & Investment Direction	$ -	Directs the investments of brokerage acocunts on both the 457 and 401(a) Plans
Inter Office	$ 824.76	Rising legs for standing desk
Advanced Business Methods	$ 3,930.00	5 year total lease on multi-function printer
Steele County	$ -	Joined Public Safety Plan 7/1/2024
City of Grand Forks	$ -	Joined Deferred Compensation Plan 9/1/2024
Fargo Public Schools	$ -	Joined Deferred Compensation Plan 1/1/2025

Contracts Signed Since Last Reported:

Vendor	Amount	Notes
Garrison Public Schools	$ -	Joined Deferred Compensation Plan 7/1/2024
Empower	$ -	Staff setup on plan sponsor website
Oliver Mercer Special Education	$ -	Joined Deferred Compensation Plan 7/1/2024
Central Cass School District	$ -	Joined Deferred Compensation Plan 7/1/2024
Grand Forks Public Library	$ -	Joined Deferred Compensation Plan 9/1/2024
Tri-County Water District	$ -	Joined Defined Benefit Plan and Deferred Compensation Plan 8/1/2024
Inter-office	$ 1,206.66	Office Chair
Northern Cass School District	$ -	Joined Deferred Compensation Plan 1/1/2025
Empower	$ -	401(a) NDPERS Admin Fee Agreement
Oakes Public School District	$ -	Joined Deferred Compensation Plan 1/1/2025