



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: 397 687 977#
Date: Tuesday, April 14, 2026
Time: 8:30 A.M. [Join the meeting now](#)

I. MINUTES

- A. March 10, 2026

II. CONFLICT OF INTEREST DISCLOSURE CONSIDERATION

III. BOARD ELECTION

- A. Board Election Results – Representative Stemen (Board Action)

IV. PRESENTATIONS

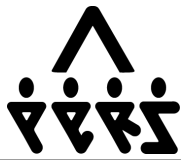
- A. 2025 About the Patient Diabetes Management Annual Report – Jesse Rue (Information)

V. GROUP INSURANCE / FLEXCOMP

- A. Health Insurance Plan Request for Proposal (RFP) – Rebecca & Deloitte Consulting (Board Action)
- B. 2025 Medicare Part D Plan Performance Guarantees Report – Lindsay (Information)
- C. Sanford Health Plan Second-Pass Claim Editing Process – Lindsay (Information)

IX. OPERATIONS / ADMINISTRATIVE

- A. Executive Director Performance Review – Shawna (Information)
- B. Audit Committee Vacant Position – Shawna (Board Action)
- C. Contracts Under \$15,000 – Rebecca (Information)
- D. Next Meeting Date: Tuesday, May 12, 2026



North Dakota
Public Employees Retirement System
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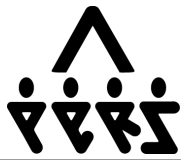
Board Election Results

TO: NDPERS Board

FROM: Greg Stemen, Election Subcommittee Chair

DATE: April 14, 2026

The Election Subcommittee will meet on April 8, 2026 to canvass the electronic election ballots. The results will be announced during the April 14 Board Meeting.



2025 About the Patient Diabetes Management Program Annual Report

TO: NDPERS Board

FROM: Rebecca Fricke

DATE: April 14, 2026

Jesse Rue from the ND Pharmacists Association will be attending the meeting to provide their 2025 Annual Report (Attachment 1) of the NDPERS About The Patient Diabetes Management Program.

The program that we partner with ND pharmacists in offering to our members is pursuant to NDCC sections 54-52.1-16 and 54-52.1-17:

54-52.1-16. Uniform group insurance program - Collaborative drug therapy program - Continuing appropriation.

1. The board may establish a collaborative drug therapy program available to individuals in the medical and hospital benefits coverage group. The purpose of the collaborative drug therapy program is to improve the health of individuals in identified health populations and to manage health care expenditures.
2. Under the program, the board may involve physicians, pharmacists, and other health professionals to coordinate health care for individuals in identified health populations in order to improve health outcomes and reduce spending on care for the identified health problem. Under the program, pharmacists and other health professionals may be reimbursed for providing face-to-face collaborative drug therapy services to covered individuals in the identified health population. To encourage enrollment in the plan, the board may provide incentives to covered individuals in the identified health population which may include waived or reduced copayment for related treatment drugs and supplies.
3. The board may request the assistance of the North Dakota pharmacists association or a specified delegate to implement a formalized disease management program with the approval of the prescriptive practices committee established in section 43-15-31.4, which must serve to standardize chronic disease care and improve patient outcomes. This program must facilitate enrollment procedures, provide standards of care, enable consistent documentation of clinical and economic outcomes, and structure an outcomes reporting system.
4. The board may seek and accept private contributions, gifts, and grants-in-aid from the federal government, private industry, and other sources for a collaborative drug therapy program for identified health populations. Any funds

that may become available through contributions, gifts, grants-in-aid, or other sources to the board for a collaborative drug therapy program are appropriated to the board on a continuing basis.

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

1. The board shall establish a collaborative drug therapy program that is to be available to individuals in the medical and hospital benefits coverage group. The purpose of the collaborative drug therapy program is to improve the health of individuals with diabetes and to manage health care expenditures.

2. The board shall involve physicians, pharmacists, and certified diabetes educators to coordinate health care for covered individuals with diabetes in order to improve health outcomes and reduce spending on diabetes care. Under the program, pharmacists and certified diabetes educators may be reimbursed for providing face-to-face collaborative drug therapy services to covered individuals with diabetes. To encourage enrollment in the plan, the board shall provide incentives to covered individuals who have diabetes which may include waived or reduced copayment for diabetes treatment drugs and supplies.

3. The North Dakota pharmacists association or a specified delegate shall implement a formalized diabetes management program with the approval of the prescriptive practices committee established in section 43-15-31.4, which must serve to standardize diabetes care and improve patient outcomes. This program must facilitate enrollment procedures, provide standards of diabetes care, enable consistent documentation of clinical and economic outcomes, and structure an outcomes reporting system.

4. The board shall fund the program from any available funds in the uniform group insurance program and if necessary the fund may add up to a two dollar per month charge on the policy premium for medical and hospital benefits coverage. A state agency shall pay any additional premium from the agency's existing appropriation.

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

ANNUAL REPORT FOR NDPERS

About the Patient Collaborative Diabetes Drug ← Therapy Program

In **the lineup** for today

Here are the topics presented today: ←

1. Program Design

2. Key Health Indicators

3. Medication Related Problems

4. Member Engagement

5. Member Satisfaction

6. Budget Status Update

Program Design



At its heart, this is a program to optimize treatment plans and adherence for chronic illnesses

CALENDAR DIVIDED INTO THREE BLOCKS



Calendar divided into three segments



Visit made within each segment



When visit is made, copay reimbursement awarded for segment



Without a visit, reimbursement isn't awarded

When a visit occurs during a block, the reimbursement is awarded for certain diabetes, hypertension and cholesterol meds as well as certain testing supplies.

FRESH ASSETS MAINTAIN VIBRANCY.



Program assets are continually refreshed to provide members with appealing and impactful educational materials, better standardizing their experiences.

Key



Health Indicators

Insight into program impact in 2025 for members with diabetes and hypertension

Some Background

A few words on measures, prevalence, and personal impact to members. Hypertension and diabetes impact health and quality of life in profound ways.

DIABETES

- 01** Quality Measures often require HbA1c <9%. Good control often considered HbA1c <7% depending upon variables.
- 02** Over 9% of people in North Dakota have diabetes.
- 03** Persons with diabetes experience health expenditures >2x those without and risk of early death increases by 60%.

HYPERTENSION

- 01** Quality Measures often report Hypertension control <140/90, whereas ACC/AHA defines it as <130/80. We use the more stringent <130/80 in our report.
- 02** Over 30% of North Dakota adults have hypertension.
- 03** About 7 of 10 people having their first heart attack have high blood pressure and 8 out of 10 having first stroke.

Adapted from Health Issues for the State of ND, Biennial Reports 2021,2023, & 2025 University of North Dakota

A1c data **for** Diabetes

Program care initiatives have helped members improve their Hemoglobin A1c measurement, which is critical for long term success.

AVERAGE A1C IMPROVEMENT

Members improving their A1c for this program year did so by an average of 0.6 points.

0.6 point
A1c reduction

Pressure data for Hypertension

Program care initiatives helped members improve their blood pressure, which is critical in avoiding complications such as heart attack and stroke.

UNCONTROLLED ACHIEVING CONTROL

We evaluated patients experiencing uncontrolled blood pressure in 2025 and tracked progress. Of those, 60% found control later in the year with blood pressure reading <130/80.

60% controlled
by end of year

Medication ←

Related Problems

Key to the program is resolving Medication Related Problems to avoid Adverse Drug Events

Adverse Drug Events remain a **persistent national problem.** ←

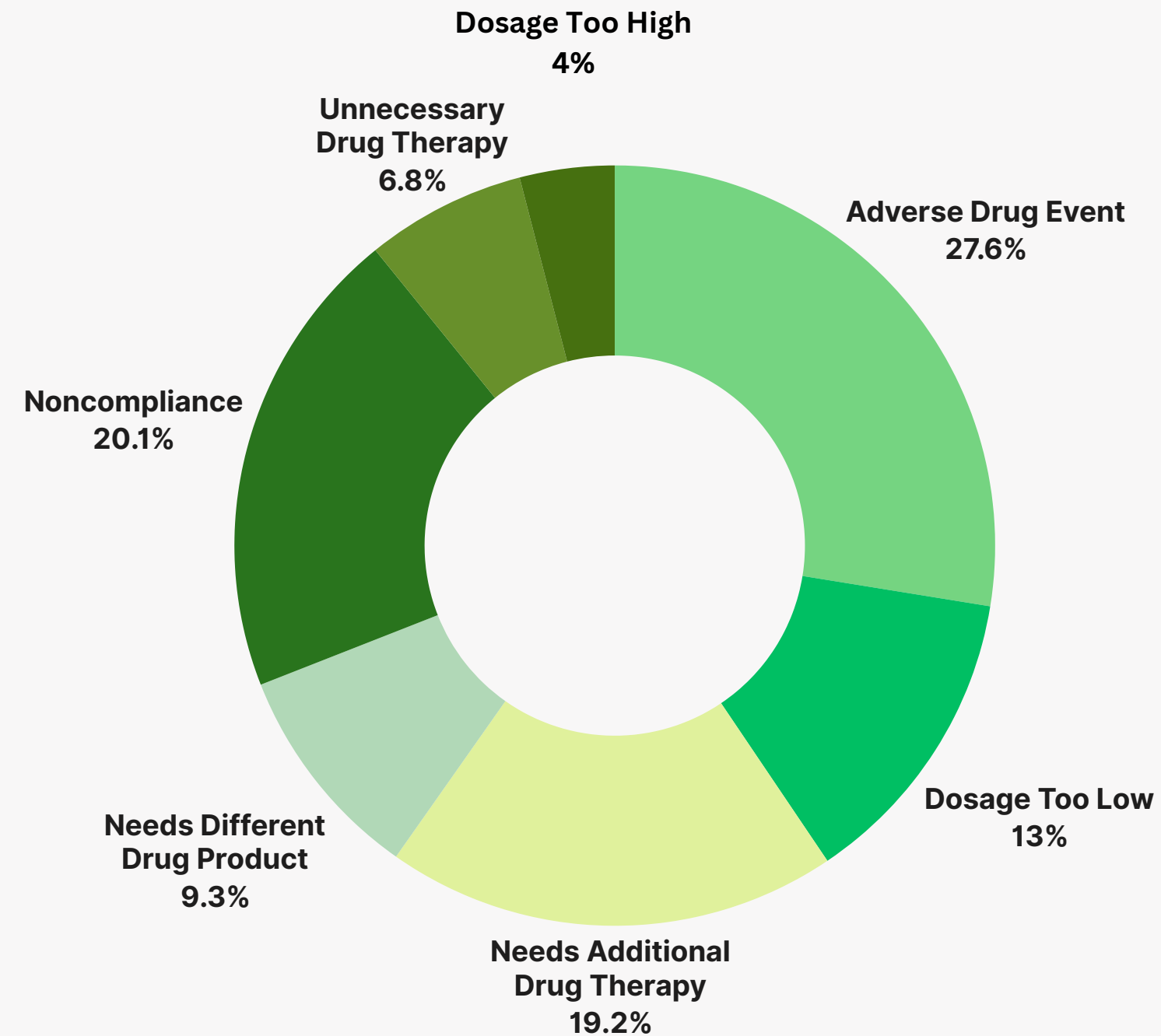
An ADE is an event resulting in harm from a medication. Identifying Drug Therapy Problems are a way for pharmacists to resolve issues **before they turn into a serious ADE.**

Intervening to mitigate or prevent these problems is an area where the pharmacist is addressing issues that remain unresolved elsewhere and is a unique contribution to care.

Pharmacists in this program are making over two interventions per member on average.

Problems Identified

Identifies >2 problems per member on average



From the Federal Office of Disease Prevention and Health Promotion:

“Each year, ADEs in outpatient settings account for:

- Over 3.5 million physician office visits
- An estimated 1 million ER visits
- Approximately 125,000 hospital admissions

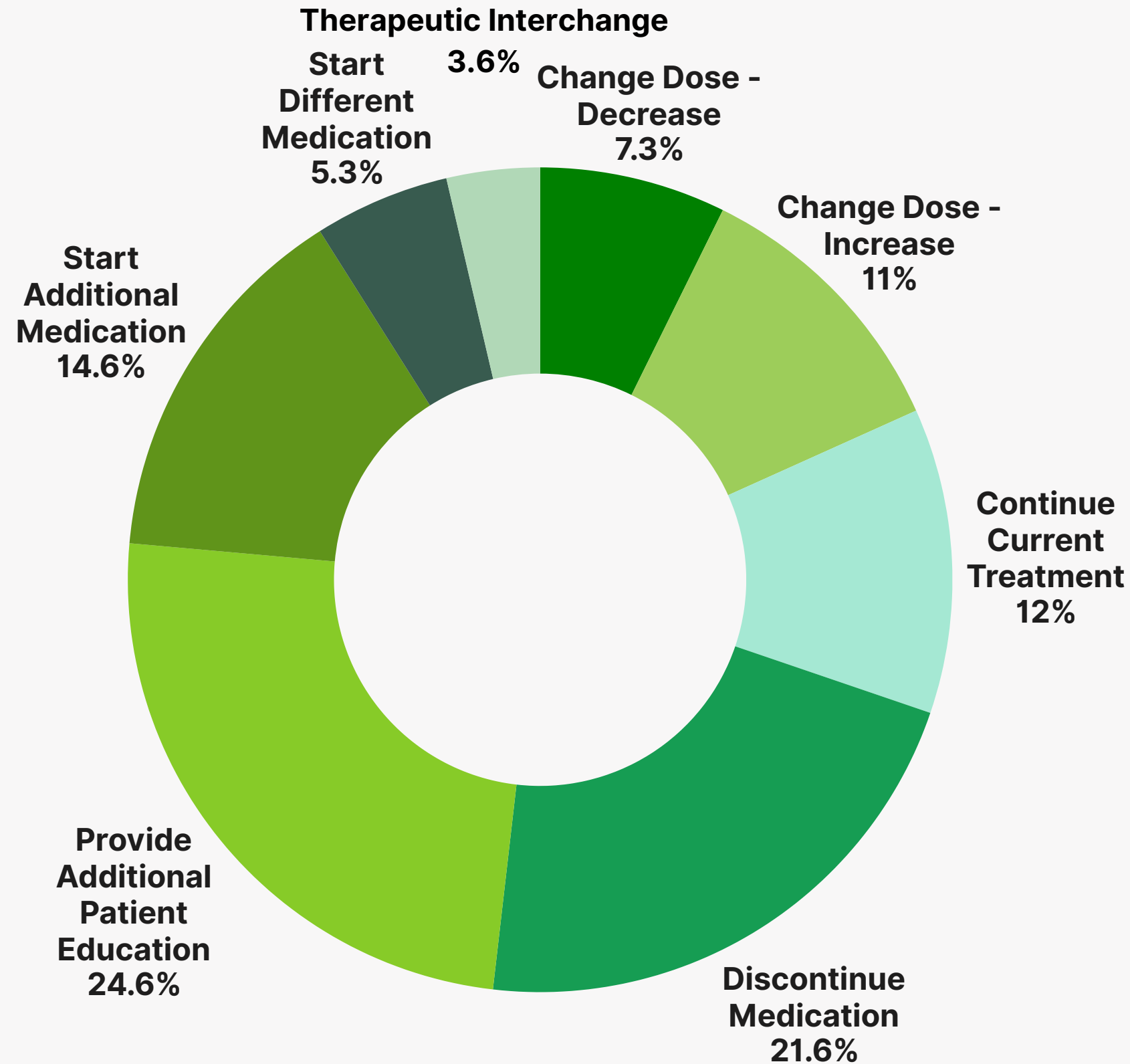
THE GOOD NEWS IS THAT LARGE MAJORITY OF ADE'S ARE PREVENTABLE. REDUCING ADES IS EXPECTED TO RESULT IN SAFER AND HIGHER QUALITY HEALTH CARE SERVICES, REDUCED HEALTH CARE COSTS, MORE INFORMED AND ENGAGED CONSUMERS, AND IMPROVED HEALTH OUTCOMES.”

[HTTPS://HEALTH.GOV/HCQ/ADE.ASP](https://health.gov/hcq/ade.asp)

Problem Resolution

IMPROVEMENTS TO OVERALL CARE RESULTED FROM INTERVENTIONS DESCRIBED ABOVE AND IMPROVED SELF-MANAGEMENT EDUCATION THROUGH THE PROGRAM VISITS.

THIS IS THE FOUNDATION OF THE PROGRAM'S DESIGN.



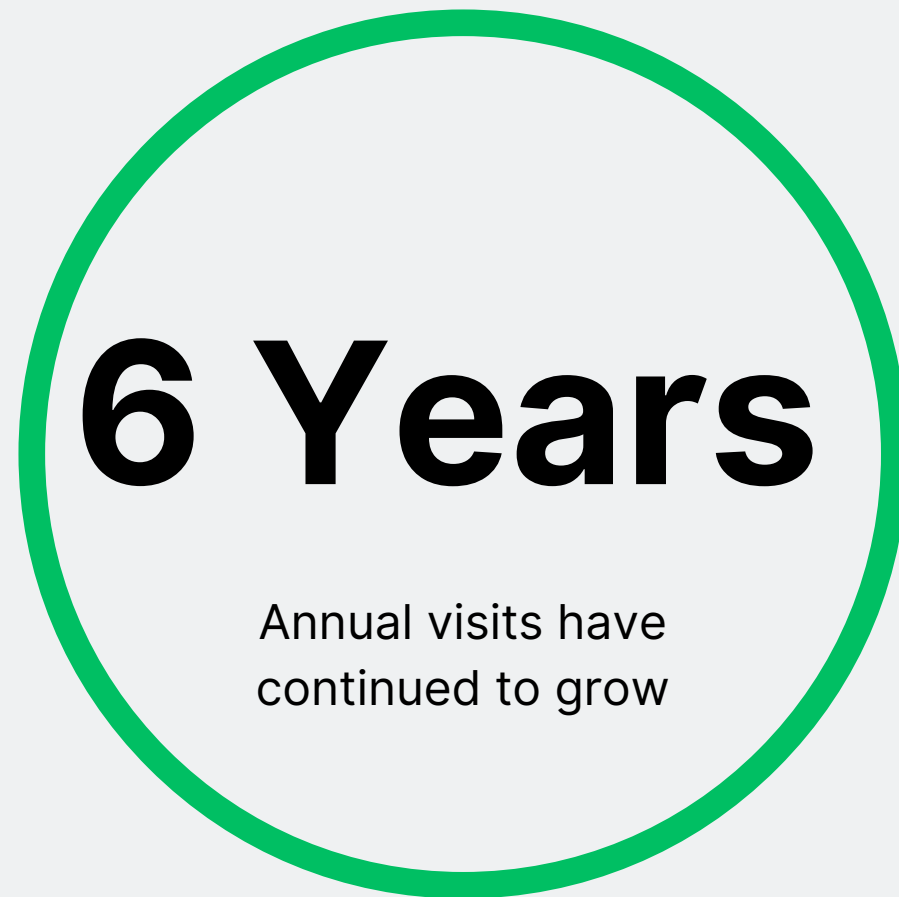
Member ←

Engagement

Chronic disease care improves when members are able to engage conveniently and often

Member Engagement

We were successful in achieving another year of engagement growth in 2025. We remained encouraged by the resiliency of members, NDPERS leadership and staff, and providers in this program as stakeholders maintained commitment to improving member health.



2020

COVID impact begins in March. Visits increase 5% for the year.

2021

COVID continues to ravage healthcare. Visits increase 27% for the year.

2022

COVID remains but lessens deeper into the calendar. Visits increase 4% for the year.

2023

Member visit growth remains a durable narrative. Visits increase 12% for the year.

2024

Member visits increased 3% for the year.

2025

With an increase of 10%, we achieved another consecutive year of growth.

Member ← Satisfaction

Satisfaction with care received remains a strength of the program year over year

Member Satisfaction

Remained Strong in 2025

Member satisfaction remains consistently strong and stable year to year, indicating belief that the providers have member's best interests in mind and are effective in improving health overall.



The provider's interest in your health = **4.87**



How well the provider helps you manage your medications = **4.85**

**1 = Strongly Disagree to
5 = Strongly Agree**



The provider's efforts to improve your health or stay healthy = **4.85**



The program services overall = **4.84**

Budget ←

Status Update

A snapshot of spend in 2025 compared with budgeted amounts

Budget **status snapshot**



CATEGORY	ANNUAL BUDGET	ACTUAL SPEND
PATIENT COPAY INCENTIVE	\$111,500	\$113,470
PROVIDER VISITS	\$66,000	\$92,640
ADMIN FEE	\$10,000	\$10,000
MARKETING	\$2,500	\$2,500
TOTAL	\$190,000	\$218,610

This year the program is tracking higher than budgeted.

The table displays one year of budgeted expenses and demonstrates that the program is currently exceeding the target for budget goals during the biennium.

The 10% increase in patient visits year over year is impacting this trend significantly. Patient incentives and provider fees have been increasing as volume has increased.

Gratitude

We appreciate the opportunity to deliver this report and are grateful to be part of your continued efforts to create healthier members and communities across North Dakota.

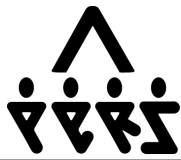
Thank You



Contact

Jesse Rue, PharmD, BCBS
Clinical Coordinator
About the Patient Programs

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jrue@aboutthepatient.net
701-258-4968



Health Insurance Plan Request for Proposal (RFP)

TO: NDPERS Board

FROM: Rebecca Fricke & Deloitte Consulting

DATE: April 14, 2026

Representatives from Deloitte Consulting will be providing an overview of the Request for Proposal (RFP) including an overview of the Health RFP documents, evaluation criteria, scoring, plan education, discussion on alternate plan designs to request and the timeline. The RFP document, a majority of the Appendices (including questionnaire documents) and Exhibits were provided to Board members prior to the meeting as one PDF document via the FTP secure email site.

Requested Scope

The scope of the RFP includes seven (7) options to respond:

1. Fully-insured medical and pharmacy proposal
2. Self-insured medical and pharmacy proposal
3. Fully-insured medical proposal only
4. Self-insured medical proposal only
5. Fully-insured pharmacy proposal only
6. Self-insured pharmacy proposal only
7. Stop loss insurance for all Self-insured options

Selection Criteria

N.D.C.C. § 54-52.1-04(1) provides the following guidance:

In determining which bid, if any, will best serve the interests of eligible employees and the state, the board shall give adequate consideration to the following factors:

- 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.

In order to consider a self-insured bid, the following is required of the Board: “The board may not establish a self-insurance health plan unless the board determines the self-insurance health plan best serves the interests of the state and the state’s eligible employees.” N.D.C.C. § 54-52.1-04.2(2).

In the evaluation of the previous health insurance plan proposals, and when considering a self-insured bid vs a fully insured bid, staff and the Board considered several sub-criteria under each of the five criteria provided by N.D.C.C. § 54-52.1-04(1). Those sub-criteria were:

- a. The economy to be effected.
 1. Overall Pricing – this includes all costs of the insurance product, including administrative fees, reinsurance or stop-loss insurance, and any federal fees. The additional personnel/office costs of administering a self-insured plan would seem to fall within this sub-criteria. Premium costs, including any additional amount that would be necessary to add to a self-insurance premium to establish adequate reserves, are also included.
 2. The effect on North Dakota – would choosing one of the bids add to or detract from North Dakota’s economy and job base?
 3. Value proposition of different insurance arrangements – analysis of modified fully insured vs self-insured options
 4. The effect on North Dakota’s economy and job base
- b. The ease of administration.
 1. Infrastructure – does the provider have the necessary office space, technology and claims payment system, and personnel system to most beneficially serve our needs?
 2. Staffing – does the provider have adequate personnel to most beneficially serve our needs? How does the bid affect ongoing staffing within NDPERS?
 3. Transition – what would a transition from one carrier to another require of NDPERS?
 - i. PERS call center
 - ii. Member communication materials
 - iii. PERS staff time
 - iv. Informational meetings with both members and employers
 4. Goals and objectives – does the bidder have the same objectives as NDPERS and the State of North Dakota?
- c. The adequacy of the coverages.
 1. Plan benefits comparison – do the proposed benefits match our current menu of benefits?
 2. Proposal deviations from our standard contract
 3. Disruption analysis – would a transition overly disrupt our members by affecting their choice of physician or pharmacist?
- d. The financial position of the carrier, with special emphasis on the solvency of the carrier.
 1. Ratings agency ratings
 2. Financial stability

- 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.
 - 1. References
 - 2. Information from the Insurance Department
 - 3. Member satisfaction information
 - 4. Performance standards proposed

Alternative Plan Designs

As part of their presentation, Deloitte will be sharing the alternative plan designs being requested. Based upon the January Board discussion, it will include alternative plan design options for the High Deductible Health Plan.

Timeline

At this time, we are still on track for a June 1 release date. However, as the Board reviews the RFP documents, should there be any additional items to be considered or questions, please let us know as soon as possible.

In order to meet the expected release date, we will be asking the Board for final approval to release the RFP at the May Board meeting.

Board Action Requested

- 1) Approval of the Requested Scope as outlined above.
- 2) Approval of the Selection Criteria as outlined above. Are there any additional criteria or sub-criteria the Board would like added to the analysis of the responses?
- 3) Is the Board comfortable with the alternative plan design options being requested as outlined by Deloitte Consulting or are there other or additional options to request?

A semi-transparent white rectangular box containing the text "NDPERS 2026 Health Insurance RFP April 14, 2026" in a green, sans-serif font. The background of the slide is a scenic landscape of rolling hills and a winding river.

Agenda

- 1 Health RFP Documents
- 2 Evaluation Criteria
- 3 Grandfathered (GF) PPO/Basic Plan
- 4 High Deductible Health Plan (HDHP)
- 5 Next Steps
- 6 Appendix

Health RFP Documents: Overview



Category	Document Names
RFP Overview Documents	<ul style="list-style-type: none"> 2026 Health RFP Wrap Document Appendix B – Response Template
Fully-Insured Questionnaire and Financial Documents	<ul style="list-style-type: none"> Appendix C1 – Fully-Insured Questionnaire Appendix D1 – Fully-Insured Cost Proposal
Self-Insured Questionnaire and Financial Documents	<ul style="list-style-type: none"> Appendix C2 – Self-Insured Medical Questionnaire Appendix C3 – Self-Insured Prescription Drug Questionnaire Appendix D2 – Self-Insured Medical Cost Proposal Appendix D2 Supplement – Medical Discount Tool Appendix D3 – Self-Insured Pharmacy Cost Proposal Appendix D4 – Stop Loss Cost Proposal
Other Financial Documents	<ul style="list-style-type: none"> Appendix D5 – Cost Proposal for Plan Design Changes Appendix E1 – Medical Network Access Appendix E2 – Prescription Drug Network & Formulary Match
Contract, Compliance, and Deviations	<ul style="list-style-type: none"> Appendix A1 – Model Fully-Insured Contract Appendix A2 – Model Self-Insured Prescription Drug Contract Appendix A3 – Model Self-Insured Medical Contract Appendix F – Response Deviations Appendix H – Performance Guarantees Appendix I – Suggested Changes Appendix J – Confidential Information
Other	<ul style="list-style-type: none"> Appendix G1 – Medical & Prescription Drug Contract Benefits Appendix G2 – Services to be performed Rx Data

- ❑ Vendors may offer various types of proposals based on combinations of risk-sharing and service offerings.
- ❑ The type of bid will help determine which appendices a vendor will complete.

	Fully-Insured	Self-Insured
Medical Only	<u>FI Medical Only</u> A1, B, C1, C2, D1, D5, E1, F, G, H, I, J	<u>SI Medical Only</u> A3, B, C2, D2, D4, D5, E1, F, G, H, I, J
Rx Only	<u>FI Rx Carve-Out</u> A1, B, C1, D1, E2, F, G, H, I, J	<u>SI Rx Carve-Out</u> A2, B, C3, D3, E2, F, G, H, I, J
Medical & Rx	<u>FI Bundled*</u> A1, B, C1, D1, D5, E1, E2, F, G, H, I, J	<u>SI Bundled*</u> A2, A3, B, C2, C3, D2, D3, D4, D5, E1, E2, F, G, H, I, J

***Bundled:** Medical and PBM plans are managed by the same vendor as an integrated solution. | **Unbundled:** Vendor offers a standalone medical and/or PBM plan.

Health RFP Documents: Wrap Document

Document Sample

I. 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, N.D.C.C., <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.

Dakota Plan

NDPERS contracts with the Incumbent Vendor to provide fully-insured health care coverage with a risk sharing agreement. The plans provided pursuant to this fully funded arrangement are:

- PPO/Basic – Grandfathered plan
[PPO/Basic Grandfathered Certificate of Insurance](#)
[PPO/Basic Grandfathered Certificate of Insurance - Amendment](#)
- PPO/Basic – Non-grandfathered plan
[PPO/Basic Non-Grandfathered Certificate of Insurance](#)
[PPO/Basic Non-Grandfathered Certificate of Insurance - Amendment](#)
- HDHP/HSA Plan – Non-grandfathered plan
[HDHP Certificate of Insurance](#)
[HDHP Certificate of Insurance - Amendment](#)
- Dakota Retiree Plan
[Dakota Retiree Plan \(Medicare\) Certificate of Insurance](#)

Document Description

The main purpose of the Wrap Document is to outline the RFP process and provide a summary of the NDPERS benefit offering to potential vendors.

The document contains the following sections:

- Background information on NDPERS and its benefits program
- RFP objectives and vendor responsibilities
- Proposal content
- Evaluation criteria
- Submission instructions
- Timeline
- Relevant contact information

Health RFP Documents: Questionnaires

Document Sample

Sample Questions:

- Provide a brief description of your organization, including your company's history, organizational structure, services provided, location of headquarters, and length of time you have been in business. Describe any significant historical or future organizational developments (acquisitions, mergers, change in subcontracted vendors, etc.)
- What is your account team turnover rate (%)?
- Confirm that you will communicate legislative changes related to the operations of the plan in a timely manner, and describe the support staff and process. Provide examples of materials you have used in the past to educate your clients on legislative changes/updates.
- Describe your privacy protection and data security standards (e.g., HIPAA, PHI). Describe certifications and other external audits. Describe the test criteria used to ensure the standards are met. Can you supply the results? Have you completed external ethical hacking tests?
- What is your organization doing to identify and reduce health outcome disparities by race, ethnicity, or other social determinants of health?

Document Description

There are two questionnaires that address **Medical coverage**:

Appendix C1: Fully-Insured Questionnaire

- Contains medical and Rx questions for fully-insured bids

Appendix C2: Self-Insured Medical Questionnaire

- Contains medical questions for self-insured bids

The questionnaire gives vendors a chance to describe the qualitative aspects of their offering, including organizational information, account team information, reporting practices, member services, plan and claims administration, data and technology, and product innovation.

Health RFP Documents: Questionnaires (cont.)

Document Sample

Sample Questions:

- Based on the plan design currently in place, drug utilization, and demographics, what are three specific recommendations to reduce cost and/or improve the health of NDPERS members (without changing plan design elements like copays)?
- What tools and programs do you utilize to shift percent of membership toward formulary and preferred/generic drugs? Specify how this works with regards to biosimilars.
- How do you notify/advise clients of new drugs in the pipeline and potential budget impact as well as benefit design implications?
- Is a pharmacist available to members 24/7/365?
- Does your retail network contracting recognize some of the unique challenges of largely rural state? If so, how?
- Under a pass-through contract, will you agree to a full pass-through for all manufacturer revenue derived by NDPERS specific utilization, with full audit rights to manufacturer contracts, rebate payments, and administrative fees?

Document Description

There are two questionnaires that address **Pharmacy coverage**:

Appendix C1: Fully-Insured Questionnaire

- Contains medical and Rx questions for fully-insured bids.

Appendix C3: Self-Insured Prescription Drug Questionnaire

- Contains Rx questions for self-insured bids

The questionnaire gives vendors an opportunity to describe the qualitative aspects of their pharmacy program and service model, including company and PBM capabilities, implementation and account management, clinical programs (e.g., formulary strategy, utilization management, specialty pharmacy), member and provider support, pharmacy network and access, benefit administration and adjudication operations, reporting and analytics, data/technology and integrations, and innovation. The questionnaire is intended to capture how the vendor will operate and deliver outcomes.

Health RFP Documents: Performance Guarantees



Document Sample							Document Description
#	Performance Guarantee	Requirement	Measurement	Performance guarantee reporting period (Monthly, Quarterly, Annual) & dollars at risk	Vendor Response: (Agree, Does Not Agree, N/A)	Requested Modification	
1	Implementation Team	Vendor will provide NDPERS with an implementation team to be responsible for accurate installation of all administrative, clinical, and financial parameters no later than 14 days after award of contract	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			<p>The main purpose of performance guarantees is to set clear, measurable service standards for medical and pharmacy vendor administration and outline financial consequences if the vendor fails to meet those standards.</p> <p>The performance guarantees measure administrative performance in several areas, including:</p> <ul style="list-style-type: none"> • Account Management • Claims Processing • ID Card Delivery • Customer Satisfaction • Reporting • Condition Management Programs
2	Project Plan	Vendor will provide an implementation project plan to be responsible for accurate installation of all administrative, clinical, and financial parameters no later than 20 days after contract award	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			
3	Identification Cards	For the initial implementation, accurate identification cards will be mailed	At least 10 days before the effective date	\$5,000 for each day less than 10 days before the effective date			

Health RFP Documents: Financial Exhibits



Document Sample

<h1 style="font-size: 48px; margin: 0;">01</h1> <p style="color: white; font-weight: bold;">Fully-Insured Cost Proposal (bundled or unbundled)</p>	<p style="font-size: 18px; margin: 0;">This exhibit asks carriers to provide their premium rates and add-ons for the NDPERS health plans</p>
<h1 style="font-size: 48px; margin: 0;">02</h1> <p style="color: white; font-weight: bold;">Self-Insured Medical Proposal</p>	<p style="font-size: 18px; margin: 0;">This exhibit asks medical vendors to provide all financial components of their standalone medical proposal</p>
<h1 style="font-size: 48px; margin: 0;">03</h1> <p style="color: white; font-weight: bold;">Medical Supplement</p>	<p style="font-size: 18px; margin: 0;">This exhibit asks vendors to provide their discount for their proposed network</p>
<h1 style="font-size: 48px; margin: 0;">04</h1> <p style="font-weight: bold;">Self-Insured Rx Proposal</p>	<p style="font-size: 18px; margin: 0;">This exhibit asks PBMs to provide all financial components of their standalone Rx proposal</p>
<h1 style="font-size: 48px; margin: 0;">05</h1> <p style="color: white; font-weight: bold;">Stop Loss Proposal</p>	<p style="font-size: 18px; margin: 0;">This exhibit asks vendors to provide reinsurance quotes if NDPERS moves to self-insured</p>

Dakota Plan		Status	Coverage Level	Billed Rate	Paid to Carrier	Enrollment
State Program						
Grandfathered Plan**						
July 1, 2025 - June 30, 2027	Active COBRA*/Part- Time/Temporary/LOA	Flat Rate per Contract		\$1,906.18	\$1,903.38	13,888
		Single		\$935.78	\$914.66	177
		Family		\$2,256.74	\$2,209.70	55
High Deductible Health Plan**						
July 1, 2025 - June 30, 2027	Active COBRA*/Part- Time/Temporary/LOA	Flat Rate per Contract		\$1,906.18	\$1,662.88	1,457
		Single		\$807.96	\$789.32	3
		Family		\$1,947.50	\$1,906.54	4
Political Subdivision Enrolled Prior to July 1, 2025						
Grandfathered Plan**						
July 1, 2025 - June 30, 2027	Active/COBRA*	Single		\$980.26	\$977.46	1,330
		Family		\$2,369.58	\$2,366.78	1,429
Non-Grandfathered Plan**						
July 1, 2025 - June 30, 2027	Active/COBRA*	Single		\$986.06	\$983.26	32
		Family		\$2,383.68	\$2,380.88	49
Political Subdivision Enrolled On or After July 1, 2025						
NonGrandfathered Plan**						
July 1, 2025 - June 30, 2026	Active/COBRA*	Single		\$960.50	\$957.70	0
		Family		\$2,321.78	\$2,318.98	0
July 1, 2026 - June 30, 2027	Active/COBRA*	Single		\$1,011.62	\$1,008.82	0
		Family		\$2,445.58	\$2,442.78	0
Non-Medicare Retirees						
Grandfathered Plan**						
July 1, 2025 - June 30, 2027	Non-Medicare Retirees	Single		\$1,376.20	\$1,373.40	243
		Family		\$2,752.40	\$2,749.60	24
		Family 3+		\$3,440.50	\$3,437.70	3
Total						18,694
				7/1/2027 - 6/30/2028	7/1/2028 - 6/30/2029	
Service Fees				Fee (Must be Quoted on a Per Employee Per Month (PEPM) Basis)	Fee (Must be Quoted on a Per Employee Per Month (PEPM) Basis)	
Base Operations Fees						
Base Plan Administration Fee.						
Must include:						
<ul style="list-style-type: none"> > Claims Processing > Network Access > HIPAA Administration > Customer Service > Account Management > Eligibility Management > Standard Banking Management > Standard Employee Communications > ID Card Production > Standard Reporting Packages > Assistance with Summary Plan Description (SPD) / Summary of Benefits and Coverage (SBC) / Summary of Material Modifications (SMM) > Performance Guarantee Tracking and Reconciliation 						
Claim Fiduciary Liability Fee (full)						
Value Based Contract (VBC) or Accountable Care Organization (ACO) Payment Fees						
Claims File Feed Fees (receiving or transmitting claims files with a third party)						
Other Base Operational Fees (please insert rows, if applicable)						

Evaluation Criteria: Status Quo (Same as 2020)



Evaluation Criteria	
A. The Economy to be Effected	A1. Overall Pricing
	A2. Multi-year guarantee premium/fees
	A3. Value proposition of different insurance arrangements
	A4. The effect on North Dakota's economy and job base
B. The Ease of Administration	B1. Infrastructure
	B2. Staffing
	B3. Transition
	B4. Goals and Objectives
C. The Adequacy of the Coverages	C1. Plan Benefits Comparison
	C2. Proposal Deviations from standard Contract
	C3. Disruption Analysis
D. The financial position of the carrier, with special emphasis on the solvency of the carrier.	D1. Ratings Agency Ratings
	D2. Financial Stability
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.	E1. References
	E2. Information from the Insurance Dept
	E3. Member Satisfaction Information
	E4. Performance standards Proposed

The table reflects the status quo evaluation criteria and sub-criteria utilized in the 2020 RFP process.

- A, B, C, D, and E come directly from N.D.C.C. 54-52.1-04:
 - In determining which bid, if any, will best serve the interests of eligible employees and the state, the board shall give adequate consideration to the following factors...*
- Criteria are the same for medical and pharmacy

Evaluation Criteria: Scale

Proposals will be scored on a 0-4 scale.

Scoring Criteria	
4	Exceeds PERS Requirements
	Responses clearly demonstrates capabilities that will exceed PERS requirements, without modification, and bring superior expertise, innovation, and value for PERS. The response illustrates significant experience conducting work of similar scope, scale, and complexity.
3	Fully Meets PERS Requirements
	Responses demonstrate capabilities to fully-meet PERS requirements, without modification, and clearly define how the proposed services will be a good fit for PERS. The responses are comprehensive and demonstrates sufficient expertise to successfully administer the PERS uniform group insurance program.
2	Partially Meets PERS Requirements
	Responses meet most PERS requirements but include some apparent limitations. Responses introduce questions about capabilities or potential challenges that merit additional review. Experience, expertise, and fit are not immediately apparent.
1	Does Not Meet PERS Requirements
	Responses do not meet PERS requirements or demonstrate a lack of understanding of requirements. Capabilities, team, experience, implementation plan, are insufficient to meet PERS needs.
0	Failure to Respond
	Responses do not appropriately address the questions asked. Exhibits are missing or incomplete. Bidder is unresponsive.

NDPERS Health Insurance Plans

- ❑ NDPERS manages the healthcare plans for state employees, retirees, and employees of political subdivisions. These employee groups are covered under four health plans by NDPERS:
 - PPO/Basic Grandfathered: ~ 17,100 employees
 - PPO/Basic Non-Grandfathered: ~ 100 employees
 - High Deductible Health Plan: ~ 1,500 employees
 - Medicare Retiree Plan: ~ 6,600 retirees
- ❑ State Actives are eligible for:
 - PPO/Basic Grandfathered
 - High Deductible Health Plan
- ❑ Political Subgroup Actives are eligible for:
 - PPO/Basic Grandfathered
 - PPO/Basic Non-Grandfathered (Only Mercer County)
- ❑ All Medicare eligible retirees are eligible for the Medicare Retiree Plan

GF PPO/Basic Plan: Grandfathering

- ❑ The Patient Protection and Affordable Care Act (PPACA), enacted in 2010, created the concept of a “grandfathered health plan” and “non-grandfathered health plan”.
 - Grandfathered health plans are plans enacted before 2010 with various plan components that are exempt from PPACA compliance
 - Grandfathered plans can make some changes over time but may lose grandfathered status if they make specific, “significant” plan design changes
- ❑ These plan design changes include:
 - Any increase in coinsurance
 - Any increase in copayments exceeding the greater of \$5 or 15% plus medical inflation measured from the date of ACA passage
 - Any increase in the deductible or out-of-pocket max by more than 15% plus medical inflation measured from the date of ACA passage
 - Any decrease in the employer contribution towards health plan premium of more than 5%
 - Any elimination or substantial reduction in benefits for specific medical conditions
 - Adding any annual limits to benefits where none existed before or tightening an existing benefit limit
- ❑ Moving to non-Grandfathered would require the plan to
 - Cover preventive services (as defined by ACA) at 100%. This includes certain drugs, immunizations, and contraceptive coverage
 - Have out-of-pockets (OOP) costs for covered services apply to the OOP max

GF PPO/Basic Plan: Plan Summary

- GF PPO/Basic plan accounts for about 92% of membership for eligible active employees

NDPERS Grandfathered Plan (PY25-26: PPO, Basic)		
Network:	PPO	Basic
Deductible	\$500/\$1500	\$500/\$1500
OOP Max	\$1,500/\$3,500 (\$1,200 formulary Rx OOPM)	\$2,000/\$4,500 (\$1,200 formulary Rx OOPM)
Medical Provisions		
Primary Care Visit	\$30 Copay	\$35 Copay
Specialist Office Visit	\$30 Copay	\$35 Copay
Inpatient	20% Coinsurance	25% Coinsurance
Outpatient	20% Coinsurance	25% Coinsurance
ER	20% Coinsurance	25% Coinsurance
Pharmacy Provisions		
Generic Formulary Drugs	\$7.50 Copay + 12% Coinsurance	\$7.50 Copay + 12% Coinsurance
Brand Name Formulary Drugs	\$15 Copay + 12% Coinsurance	\$15 Copay + 12% Coinsurance
Non-Formulary Drugs	\$30 Copay + 50% Coinsurance	\$30 Copay + 50% Coinsurance

GF PPO/Basic Plan: Midwest PPO Benchmarking



	NDPERS GF Plan	Iowa PPO	Indiana PPO	Wisconsin PPO	Michigan PPO	Missouri Median PPO	Ohio PPO	South Dakota PPO	Illinois Median PPO	Midwest Median PPO *
Payment Levels										
Deductible	\$500/\$1,500	\$250/\$500	\$1,000/\$2,000	\$250/\$500	\$400/\$800	\$1,125/\$2,250	\$400/\$800	\$2,000/\$4,000	\$0/\$0	\$400/\$800
OOP Max	\$1,500/\$3,500	\$1,000/\$2,000	\$2,500/\$5,000	\$1,250/\$2,500	\$2,000/\$4,000	\$3,000/\$6,000	\$2,500/\$5,000	\$4,500/\$9,000	\$3,000/\$6,000	\$2,500/\$5,000
Medical Provisions										
Primary Care Provider	\$30	\$15	10%	\$15	\$20	20%	\$30	\$50	\$30	\$25
Specialist Office Visit	\$30	\$30	10%	\$25	\$20	20%	\$35	\$100	\$40	\$32.50
Inpatient	20%	10%	10%	10%	10%	20%	20%	30%	\$475	10%
Outpatient	20%	10%	10%	10%	10%	20%	20%	30%	\$350	10%
ER	\$60 Copay + 20%	\$100	10%	\$75 Copay + 10%	\$200	\$250 Copay + 20%	\$150 Copay + 20%	\$250 Copay + 30%	\$275	\$175 Copay + 10%
Pharmacy Provisions										
Generic	\$7.50 Copay + 12% Coinsurance	\$10	\$10	\$5	\$10	\$15	\$10	\$25	\$20	\$10
Formulary	\$15 Copay + 12% Coinsurance	\$25	\$30	20% (max \$50)	\$30	\$50	\$40	\$65	\$35	\$37.50
Non-Formulary	\$30 Copay + 50% Coinsurance	\$50	\$50	40% (max \$150)	\$60	\$120	\$75	\$150	\$60	\$67.50

Observations:

- The deductible, OOPM, and cost-sharing for the PPO/Basic plan are near the middle of what other Midwest states are offering.
- The PPO plans offered by Midwest states have non-grandfathered status, whereas NDPERS is the only plan that maintains grandfathered status.

* Median is determined as the median of the plans listed in the table, not including NDPERS.

GF PPO/Basic Plan: Plan Considerations



- Within the RFP (Appendix D5), vendors are requested to propose plan design modifications that can generate cost savings while preserving Grandfathered Status. Additionally, vendors are asked to provide pricing for alternative plan designs that would transition the PPO/Basic plan to a non-Grandfathered* status.

Plan Design Provisions	Existing PPO/Basic Grandfathered		Option 1 Non-Grandfathered		Option 2 Non-Grandfathered		Option 3 Non-Grandfathered	
	PPO	Basic	PPO	Basic	PPO	Basic	PPO	Basic
Single Deductible	\$500	\$500	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Family Deductible	\$1,500	\$1,500	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000	\$3,000
Single Coinsurance	80%	75%	80%	75%	80%	75%	80%	75% \$4,500
Family Coinsurance	80%	75%	80%	75%	80%	75%	80% \$8,000	75% \$9,000
Single Maximum Out of Pocket	\$1,500	\$2,000	\$2,750	\$3,250	\$3,750	\$4,250	\$5,000	\$5,500
Family Maximum Out of Pocket	\$3,500	\$4,500	\$6,500	\$7,500	\$8,500	\$9,500	\$11,000	\$12,000
Office Visit Copayment	\$30	\$35	\$30	\$35	\$30	\$35	\$30	\$35
Emergency Room Copayment	\$60/20%	\$60/20%	\$60	\$60	\$60	\$60	\$60	\$60
Preventive Care	\$30 Copay	\$35 Copay	100%	100%	100%	100%	100%	100%
Formulary Generic	\$7.50/88%	\$7.50/88%	\$10	\$10	\$10	\$10	\$10	\$10
Formulary Brand	\$25/75%	\$25/75%	\$25/75%	\$25/75%	\$25/75%	\$25/75%	\$25/75%	\$25/75%
Non-Formulary Drugs	\$30/50%	\$30/50%	\$30/50%	\$30/50%	\$30/50%	\$30/50%	\$30/50%	\$30/50%
Pharmacy Coinsurance Max	\$1,200	\$1,200	Part of Medical	Part of Medical	Part of Medical	Part of Medical	Part of Medical	Part of Medical

* The Majority of political subgroups are small employers under the ACA and therefore are not eligible for the NDPERS Non-Grandfathered PPO/Basic Plan. Therefore, NDPERS must maintain the Grandfathered plan for this population, or they would be removed from NDPERS group insurance all together. Thus, the alternatives pricing would only apply to State actives.

HDHP: Background

- ❑ At the January Board Meeting, Board Members expressed:
 - Interest in increasing High-Deductible Health Plan (HDHP) enrollment as a vehicle to help NDPERS employees.
 - Desire to solicit vendors on how changes to the HDHP plan design would impact pricing in the proposal.
- ❑ Based on Board feedback from January, the following are being included in the presentation today:
 - HDHP overview, legislative history and landscape, and NDPERS-specific data.
 - Potential HDHP plan change considerations to increase enrollment.

HDHP: Key Provisions

- ❑ Due to higher cost sharing, in theory, HDHPs should encourage policyholders to practice *consumerism*, or in other words, be more vigilant in their healthcare spending choices:
 - Higher deductible and OOP-Max levels drive members to seek the most efficient means for accessing healthcare.
 - Members should be discouraged from unnecessary utilization of the plan (e.g., overuse of urgent care facilities, etc.) and instead utilize services like telemedicine and PCP visits.

Note, however, there is a risk that members may not obtain medically necessary care due to the higher costs.

- ❑ No first-dollar coverage for prescription drugs except preventive drugs:
 - Unlike PPO plans, which usually have copays and first dollar coverage for drugs, HDHPs usually have members fulfill their deductible obligations before covering any costs.
 - Rx deductibles are generally combined with the medical deductible, though for some plans, there may be a separate deductible.

HDHP: Legislative History

Early Stages

HSAs introduced in the Medicare Modernization Act and made available to anyone purchasing a qualifying HDHP beginning January 1, 2004

Tax Relief and Health Care Act of 2006 makes HSAs more attractive by raising the contribution limit from the annual deductible to the IRS annual maximum

2003 - 2006

2010-2011

ACA Changes

The penalty for non-qualifying HSA withdrawals is increased from 10% to 20%

Prohibits use of HSA funds for non-prescribed over-the-counter medications

2019-2020

COVID-Era Changes

IRS expands preventive care services that HSA participants can purchase before reaching their deductible

HSA eligibility for OTC medicines without a prescription is restored in the CARES Act

Pre-deductible telehealth coverage is allowed until 2024

2025-Onward

Recent Developments

One Big Beautiful Bill Act introduces HSA-Compatibility for ACA Bronze and Catastrophic Plans

The bill also permanently extends telehealth pre-deductible eligibility

Discussion in DC around direct payment to HSAs in lieu of ACA subsidies

HDHP: Plan Summary

- The following details the PPO/Basic plan compared with IRS requirements

	NDPERS HDHP (PY25-26: PPO, Basic)	
Network:	PPO	Basic
Deductible	\$2,000 / \$4,000	\$2,000 / \$4,000
OOP Max	\$3,500 / \$7,000	\$4,000 / \$8,000
Account Seed	\$1,435 / \$3,472	\$1,435 / \$3,472
Medical Provisions		
Primary Care Visit	20%	25%
Specialist Office Visit	20%	25%
Inpatient	20%	25%
Outpatient	20%	25%
ER	20%	20%
Pharmacy Provisions		
Generic Formulary Drugs	20%	20%
Formulary Drugs	20%	20%
Non-Formulary Drugs	50%	50%

Minimum deductible: \$1,700 / \$3,400

Maximum Out-of-pocket: \$8,500 / \$17,500

Regulatory limit of account funding: \$4,400 / \$8,750

Deductibles apply before plan pays except for preventive care / preventive prescriptions

IRS Requirements

GF PPO/Basic Plan vs HDHP: Plan Comparison

- The following details the PPO/Basic plan compared with the HDHP. For more details on how the two plan designs compare, visit <https://www.ndpers.nd.gov/sites/www/files/documents/members-additional-information/all-health/shp-plan-comparison.pdf>

NDPERS Grandfathered Plan (PY25-26: PPO, Basic)			NDPERS HDHP (PY25-26: PPO, Basic)		
Network:	PPO	Basic	Network:	PPO	Basic
Deductible	\$500/\$1500	\$500/\$1500	Deductible	\$2,000 / \$4,000	\$2,000 / \$4,000
OOP Max	\$1,500/\$3,500 (\$1200 formulary Rx OOPM)	\$2,000/\$4,500 (\$1,200 formulary Rx OOPM)	OOP Max	\$3,500 / \$7,000	\$4,000 / \$8,000
Medical Provisions			Medical Provisions		
Primary Care Visit	\$30 Copay	\$35 Copay	Primary Care Visit	20%	25%
Specialist Office Visit	\$30 Copay	\$35 Copay	Specialist Office Visit	20%	25%
Inpatient	20% Coinsurance	25% Coinsurance	Inpatient	20%	25%
Outpatient	20% Coinsurance	25% Coinsurance	Outpatient	20%	25%
ER	20% Coinsurance	25% Coinsurance	ER	20%	20%
Pharmacy Provisions			Pharmacy Provisions		
Generic Formulary Drugs	\$7.50 Copay + 12% Coinsurance	\$7.50 Copay + 12% Coinsurance	Generic Formulary Drugs	20%	20%
Brand Name Formulary Drugs	\$15 Copay + 12% Coinsurance	\$15 Copay + 12% Coinsurance	Formulary Drugs	20%	20%
Non-Formulary Drugs	\$30 Copay + 50% Coinsurance	\$30 Copay + 50% Coinsurance	Non-Formulary Drugs	50%	50%

GF vs HDHP Differentiators

Lower Deductibles and OOPMs; separate Rx OOPM

Copays for office visits rather than coinsurance

Copays for drugs rather than coinsurance

HDHP: Midwest HDHP Benchmarking



	NDPERS PPO HDHP	Indiana Median HDHP	Minnesota PEIP HDHP	Michigan HDHP	Missouri HDHP	Ohio HDHP	South Dakota Median HDHP	Nebraska HDHP	KS Median HDHP	Illinois HDHP	Midwest Median HDHP*
Payment Levels											
Deductible	\$2,000/\$4,000	\$2,500/\$5,000	\$2,000/\$3,625	\$1,700/\$3,400	\$1,800/\$3,600	\$2,000/\$4,000	\$4,625/\$9,250	\$3,300/\$5,200	\$2,750/\$5,500	\$1,650/\$3,300	\$2,000/\$4,000
OOP Max	\$3,500/\$7,000	\$4,250/\$8,500	\$3,250/\$6,500	\$4,000/\$8,000	\$5,400/\$10,800	\$3,500/\$7,000	\$6,125/\$12,250	\$4,300/\$8,200	\$5,575/\$11,150	\$3,000/\$6,000	\$4,250/\$8,200
Account Seed	\$1,435/\$3,472	\$956/\$1913	N/A	\$800/\$1600	\$500/\$1,000	\$1,000/\$2,000	\$500/\$1,000	N/A	\$750/\$1,563	\$550/\$1,100	\$750/\$1562.50
Medical Provisions											
Primary Care Provider	20%	10%	\$50	20%	20%	20%	12.5%	20%	22.5%	10%	20%
Specialist Office Visit	20%	10%	\$50	20%	20%	20%	12.5%	20%	22.5%	10%	20%
Inpatient	20%	10%	\$525	20%	20%	20%	12.5%	20%	22.5%	10%	20%
Outpatient	20%	10%	\$325	20%	20%	20%	12.5%	20%	22.5%	10%	20%
ER	20%	10%	\$275	20%	20%	20%	12.5%	20%	22.5%	10%	20%
Pharmacy Provisions											
Generic	20%	\$10	\$30	\$10	10% up to \$50	20%	12.5%	20%	20%	10%	16.25%
Formulary	20%	20% Min \$30 Max \$50	\$50	\$30	20% up to \$100	20%	12.5%	20%	35%	10%	20%
Non-Formulary	50%	40% Min \$50 Max \$70	\$75	\$60	40% up to \$200	20%	18.75%	20%	60%	10%	38.75%
Mail Order	Same as Retail	2 x Retail	2 x Retail	2 x Retail	2.5 x Retail	Same as Retail	Same as Retail	Same as Retail	Same as Retail	Same as Retail	Same as Retail

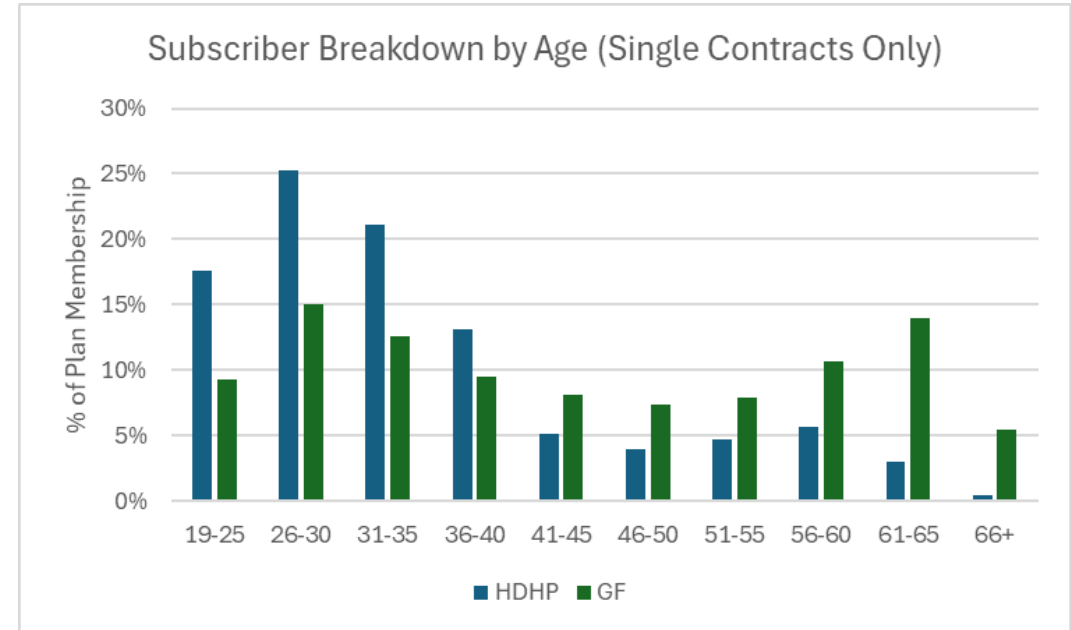
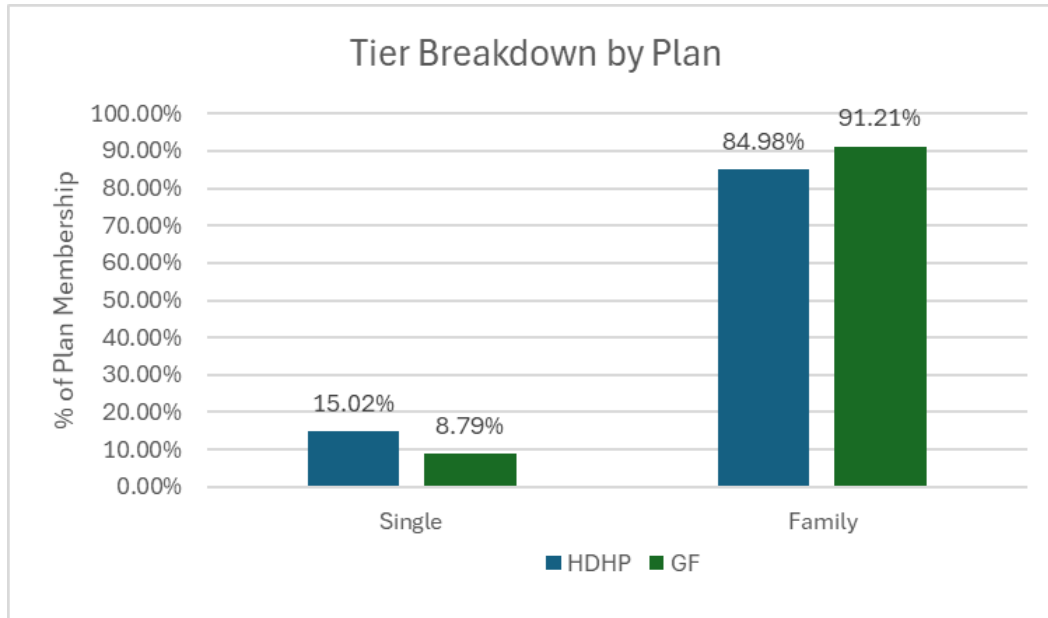
Observations:

- The deductible, OOPM, and coinsurance for the HDHP plan are near the middle of what other Midwest states are offering.
- NDPERS offers more seed dollars to fund the HSA accounts compared to other Midwest states.

* Median HDHP is calculated based on plans shown in the table. Median seed ignores plans where seed is unknown.

HDHP: NDPERS Demographics

- State Active Population (Enrollment)

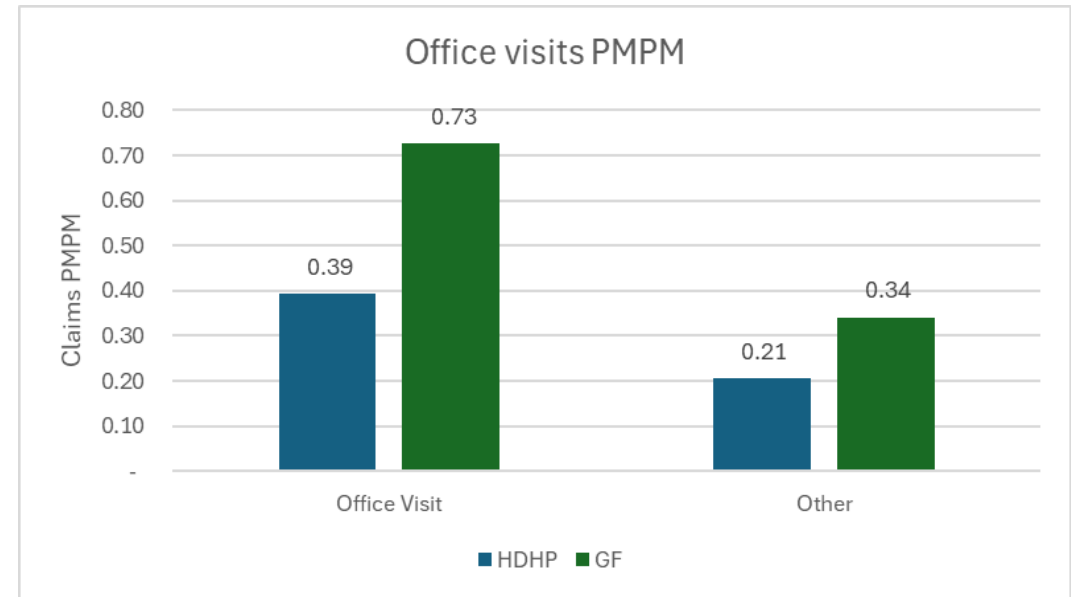
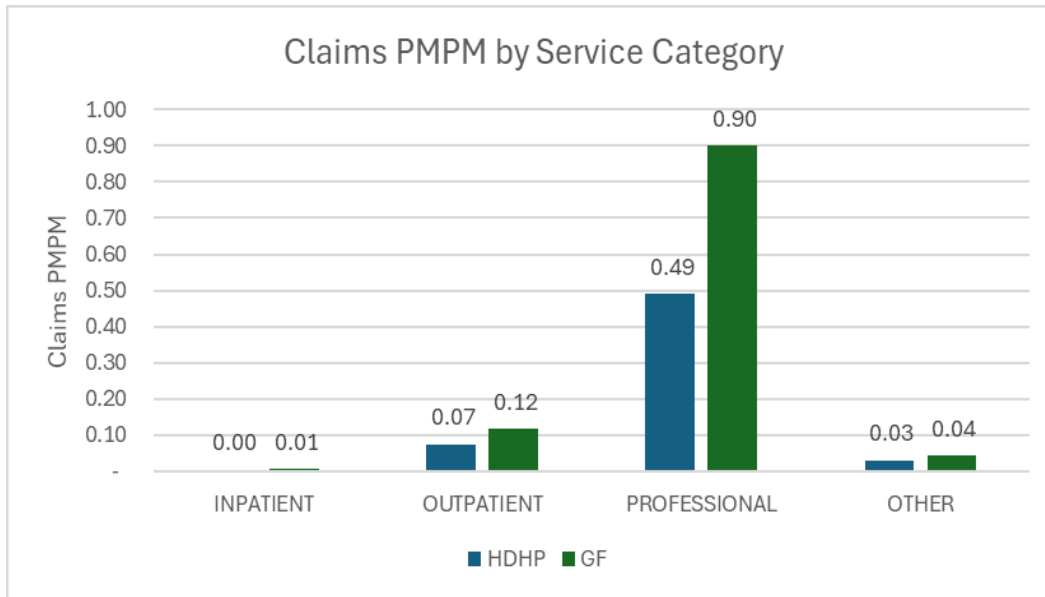


Observations:

- More employees that only cover themselves utilize the HDHP plan benefits, whereas the Grandfathered plan covers more dependents.
- The age distribution of subscribers in the HDHP plan skews much younger than that of the GF plan.

HDHP: NDPERS Demographics

- State Active Population (Utilization)

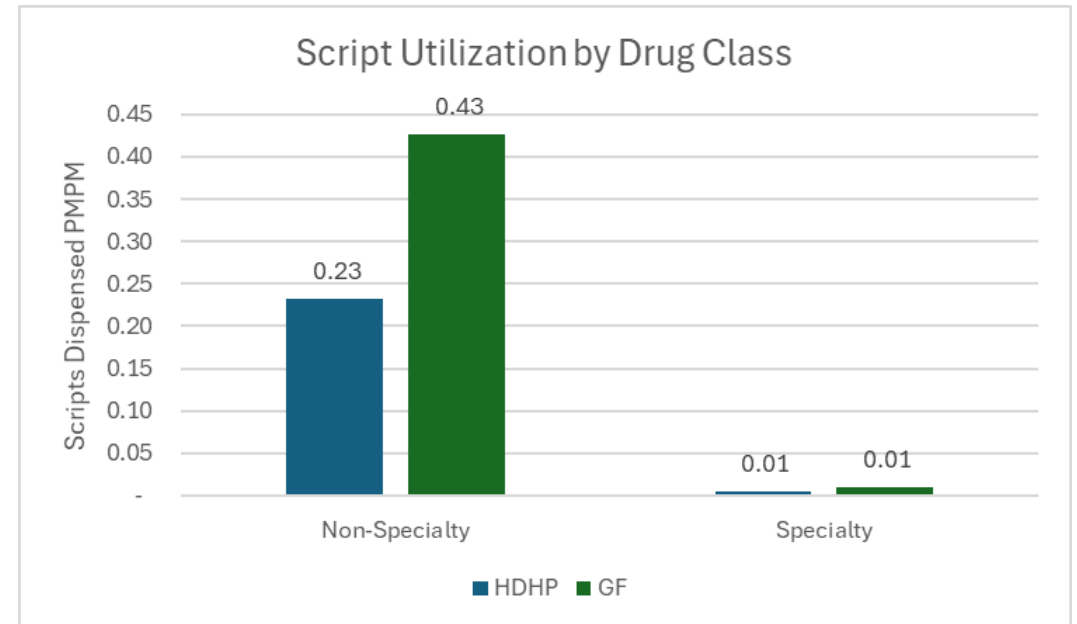
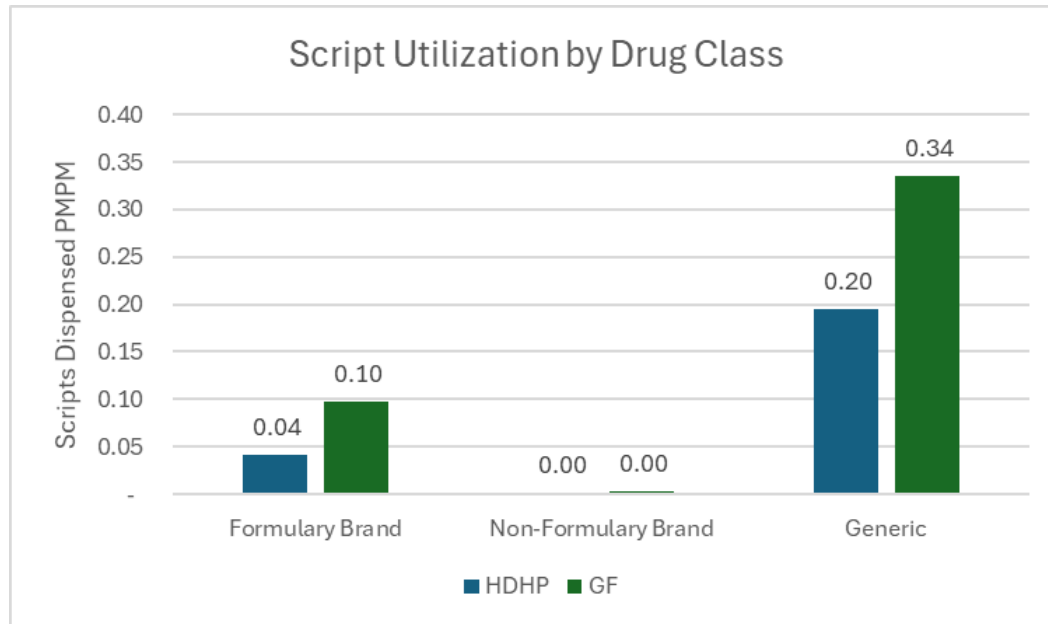


Observations:

- Generally, the grandfathered plan members utilize more services than those in the HDHP plan.
- There is a significant increase in office visit utilization for those enrolled in the grandfathered plan.

HDHP: NDPERS Demographics

- State Active Population (Pharmacy Utilization)



Observations:

- GF plan members utilize the prescription drug benefit more than those on the HDHP plan.
 - Note: the GF plan pharmacy benefit has first dollar coverage, while the HDHP plan does not.

HDHP: Plan Considerations

- To increase the attractiveness of the HDHP plan to members who are older and utilize more services and drugs, the RFP requests that vendors provide pricing impacts for the following changes:
 - Lower deductible to \$1,700/\$3,400
 - Lower deductible to \$1,700/\$3,400 and lower the out-of-pocket max to \$3,200/\$6,400 for the PPO and \$3,700/\$7,400 for the Basic
 - Keep the deductible and OOP max the same; **decrease** member coinsurance after the deductible to **10%**

Next Steps

The following steps in the Health RFP process are on the horizon:

- Finalize RFP Documents incorporating feedback from the April Board meeting.
- Request approval for RFP issuance at the May Board meeting.
- Prepare for RFP issuance on June 1, 2026.
- Finalize list of vendors to notify of RFP issuance.

APPENDIX

Health RFP: Timeline

Health RFP

Board meetings



Activity	Description	Tentative Timing
RFP Preparation	Update RFP Documents/Exhibits	November 2025 – January 2026
January Board Meeting	Board Meeting – RFP Overview	January 13, 2026
Present RFP to NDPERS Staff	Present Updated RFP to NDPERS Staff	February – March 2026
Update RFP	Incorporate NDPERS Staff Feedback	March – April 2026
April Board Meeting	Board Meeting – Draft RFP Review	April 14, 2026
Update RFP	Incorporate NDPERS Staff / Board Feedback	April – May 2026
May Board Meeting	Board Meeting – Final RFP Approval	May 12, 2026
RFP Release	Release RFP to Vendors	June 1, 2026
Vendor Q&A Meeting	Meet with Vendors to Clarify RFP	June 2026
Vendor Questions Due	Receive RFP Questions from Vendors	June 2026
Respond to Vendor Questions	Respond to RFP Questions from Vendors	June 2026
Proposals Due	Receive Proposals from Vendors	July 2026
RFP Analysis	Analyze Proposals from Vendors	July – August 2026
August Board Meeting	Board Meeting – Present Preliminary Results	August 18, 2026
Finalist Meetings	Interview Vendor Finalists	September 2026
1 st October Board Meeting	Board Meeting – Provide Update	October 13, 2026
2 nd October Board Meeting	Board Meeting – Present Final Results	October 27, 2026
Vendor Selection	Select Vendor	October 2026
Begin Implementation	Vendor Implementation Commences	December 2026
Effective Date	New Biennium Commences	July 1, 2027



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2025 Medicare Part D Plan Performance Guarantees Report

TO: NDPERS Board

FROM: Lindsay Schaf

DATE: April 14, 2026

Julie Bodenski of Humana will be attending the meeting to review the results (Attachment 1) of the 2025 performance guarantees related to the Medicare Part D plan. The full list of performance guarantees and the results of each measurement can be found on Attachment 2.

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



Memorandum

To: Board of Trustees - NDPERS
From: Julie Bodenski, Humana
Date: March 4, 2026
Re: 2025 Performance Guarantee Results

The 2025 Performance Guarantee results for the Humana Part D Prescription Drug Plan were delivered to NDPERS on March 1, 2026, summarizing that Humana met twenty (20) of the twenty-one (21) Performance Guarantees.

Service level Performance Guarantees:

- **Service level miss: PG #16 - Prescription drug turnaround time – clean prescriptions**
 - o Service level/measurement criteria: 98% within two (2) business days if no intervention required
 - o Q4 Humana results: 96.54% (Annual result of 95.70%)
 - o Amount at risk: \$1,000 for each point below the standard, assessed and paid quarterly
 - o Penalty for Q4 miss: \$1,000

PG #16 Details:

Orders are prioritized based on "need by date" to ensure patients who are at risk of running low on medications or patients with new prescriptions receive timely delivery. This may result in some refills—particularly for patients who have accumulated extra medication—to process slightly slower and miss the 2-day clean turnaround time.

Humana reported on PG#16 going back to 2024 plan year results and communicated this change in prioritizing prescriptions with no intervention (i.e. clean orders) at the April 2025 Board meeting.

Historical background details (April 2025 Board meeting):

- Clean orders are almost always a refill, and often an auto-refill. That means the members typically have several weeks, or more, of their medication on-hand when processing and shipping their orders.
- Prioritizing these clean orders above new prescriptions to meet both the 2-day clean and 5 day all turnaround metrics leads to scenarios where pharmacies will ship medications more quickly for patients with weeks of medication on hand, than for patients who are starting a new therapy or changing their therapy and have a more urgent need to receive the new medication.
- Humana recognized an opportunity to prioritize our work better and developed a proprietary algorithm to assist our pharmacy with prioritizing orders.
- We can determine when a member is receiving a new therapy, a change in therapy, or they are running low on an existing medication and prioritize those orders more highly than member's who have adequate stock on hand. We do this by calculating a "need by date". This ensures members are less likely to go without critical medications, and to get new medications into their hands more quickly so that they can start them right away.



- This new approach leads to more orders missing the 2-day clean metric, but a better overall experience for all members utilizing CenterWell Pharmacy for 90-day mail order.
- We are now able to focus more energy on member's who are at risk of running out of medication or need to start a new medication, than for members with weeks of medication on-hand.
- We believe the tradeoff will have a positive impact on our member's health; while not fully sacrificing the great service we provide on refills.
- **Most refill orders for members who have adequate on-hand quantities will still ship in 3 days or less.**
- Due to this change in focus, we may see some months where we have misses with this metric in the future

Thank you,

A handwritten signature in black ink, appearing to read "Julie Bodenski". The signature is fluid and cursive, written over a light blue horizontal line.

Julie Bodenski
Group Medicare Senior Account Executive – Humana

Enclosures: 2025 Performance Guarantee Results

CC: Stephanie Heller, Director Account Management
Mia Ajekwu Bassaragh/Mark Powell, Clinical Pharmacy Lead

Humana's Group Medicare Performance Guarantee Quarterly Report Card

North Dakota Public Employees Retirement Systems



2025 Group Medicare Performance Standards for PDP Only
 4th Quarter Report Card
 Contract Period 1/1/2025 - 12/31/2025

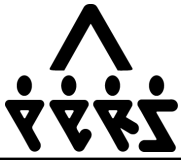
PG#	Category	Target	Humana's Recommended Standard & Measurement Criteria	Amount at Risk	4th Qtr 2025 Result	4th Qtr 2025 Target Met	2025 Annual Average	4th Qtr 2025 Penalty	2025 Annual Target Met	2025 Annual Penalty
1	Plan Performance Review	Measurement methodology shall be measured from date of delivery 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	Met	Reported Quarterly (as applicable), Assessed Annually	Met	Reported Quarterly (as applicable), Assessed Annually	Yes	\$0.00
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	94.07%	Reported Quarter 4 Only, Assessed Annually	94.07%	Reported Quarter 4 Only, Assessed Annually	Yes	\$0.00
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	90.00%	Reported Quarter 4 Only, Assessed Annually	90.00%	Reported Quarter 4 Only, Assessed Annually	Illustrative Only	Illustrative Only
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	Met	Reported Quarterly, Assessed Annually	Met	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	Met	Reported Quarterly, Assessed Annually	Met	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	Met	Reported Quarterly, Assessed Annually	Met	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	Met	Reported Quarterly, Assessed Annually	Met	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	Met	Reported Quarterly, Assessed Annually	Met	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	Met	Reported Quarterly, Assessed Annually	Met	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	100.00%	Reported Quarterly, Assessed Annually	99.99%	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	100.00%	Reported Quarterly, Assessed Annually	99.99%	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	100.00%	Reported Quarterly, Assessed Annually	99.99%	Reported Quarterly, Assessed Annually	Yes	\$0.00

North Dakota Public Employees Retirement Systems



2025 Group Medicare Performance Standards for PDP Only
 4th Quarter Report Card
 Contract Period 1/1/2025 - 12/31/2025

PG#	Category	Target	Humana's Recommended Standard & Measurement Criteria	Amount at Risk	4th Qtr 2025 Result	4th Qtr 2025 Target Met	2025 Annual Average	4th Qtr 2025 Penalty	2025 Annual Target Met	2025 Annual Penalty
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	100.00%	Reported Quarterly, Assessed Annually	100.00%	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	19.14 seconds	Reported Quarterly, Assessed Annually	10.81 seconds	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	1.19%	Reported Quarterly, Assessed Annually	0.61%	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	97.50%	Reported Quarterly, Assessed Annually	99.13%	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	97.48%	Reported Quarterly, Assessed Annually	96.90%	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	100.00%	Reported Quarterly, Assessed Annually	99.62%	Reported Quarterly, Assessed Annually	Yes	\$0.00
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-	96.54%	No	95.70%	\$1,000.00	Reported Quarterly, Assessed Quarterly	Reported Quarterly, Assessed Quarterly
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	99.93%	Reported in Quarter 4 Only, Assessed Annually	99.93%	Reported in Quarter 4 Only, Assessed Annually	Yes	\$0.00
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	Met	Reported Quarterly, Assessed Annually	Met	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	98.00%	Reported in Quarter 4 Only, Assessed Annually	98.00%	Reported in Quarter 4 Only, Assessed Annually	Yes	\$0.00
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	Met	Reported Quarterly, Assessed Annually	Met	Reported Quarterly, Assessed Annually	Yes	\$0.00
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	100.00%	Reported Quarterly, Assessed Annually	99.97%	Reported Quarterly, Assessed Annually	Yes	\$0.00



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Sanford Health Plan Second-Pass Claim Editing Process

TO: NDPERS Board

FROM: Lindsay Schaf

DATE: April 14, 2026

Sanford Health Plan (SHP), in partnership with Zelis, implemented a second-pass claim editing process effective November 1, 2025 to enhance claims accuracy in alignment with current reimbursement policies and established coding guidelines. A detailed memo from SHP regarding this change is included as Attachment 1. Representatives from SHP will be available to answer any questions you may have regarding the second-pass claim editing process.

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

Memo

To: Rebecca Fricke

From: Kim Haug

Date: 4/14/2026

Re: Second-pass Claim Editing

Sanford Health Plan (SHP) implemented a second-pass claim editing process on November 1, 2025, to enhance claims accuracy and strengthen payment integrity. SHP partnered with Zelis to introduce this additional review, ensuring alignment with current reimbursement policies and established coding guidelines, including CPT, HCPCS Level II, and ICD-9/10.

This second-pass review supports more consistent identification of incorrect, inappropriate, or duplicative services and payments. SHP notified contracted providers of these enhancements prior to implementation in accordance with contract provisions.

The service fee is 15% of the savings generated through the additional editing and is reported as an expense on the monthly Interest Calculation Report.



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Executive Director Performance Review

TO: NDPERS Board

FROM: Shawna Piatz

DATE: April 14, 2026

The Executive Director Performance Review and Compensation Subcommittee will meet soon to begin discussions on the 2025 performance review and compensation recommendations. As part of this process, Board members will be asked to complete a Performance Review template and return it to the Chief Audit Officer, Shawna Piatz, by Thursday, April 23rd. The template will be distributed via email following this meeting and will contain Rebecca's self-evaluation scores, as well as the scores provided by the Chief Audit Officer. The compiled results will be reviewed by the Subcommittee and a final recommendation will be presented at the May Board meeting.



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Audit Committee Vacant Position

TO: NDPERS Board

FROM: Shawna Piatz

DATE: April 14, 2026

The Audit Committee is a five member subcommittee. Per the [Audit Committee Charter Policy](#), "the Committee will consist of two to five members with the majority of the members selected from the Board of Trustees, and one may be selected from outside the agency. The Board will appoint Committee members and the Committee chair. The Board should attempt to appoint Committee members who are knowledgeable and experienced in financial matters, including the review of financial statements."

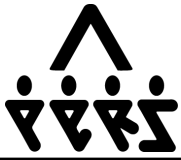
The external member has recently submitted her resignation leaving an open position. The current members are:

- Tyler Erickson (Chair)
- Adam Miller
- Bryan Klipfel
- Senator Dever
- Vacant

The Board will need to determine their wishes to fill the vacant position and if they do wish to fill it, if they wish to fill it with an external member or a member of the Board.

Board Action Requested

Determine if a new member should be appointed to fill the Audit Committee vacancy. Further determine if that position should be filled with a Board member or an external member.



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Contracts Under \$15,000

TO: NDPERS Board

FROM: Rebecca Fricke

DATE: April 14, 2026

Attached is a document that shows the contracts under \$15,000 that have been signed since the last update. Please let me know if you have any questions on any of these contracts.

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

Contracts Under \$15,000

All Contracts Signed During 2026:

Vendor	Amount	Notes
UHY LLP	\$	- GASB Management Representation Letters
Trall County	\$	- Expanded Public Safety Plan effective 3/1/2026

Contracts Signed Since Last Reported:

Vendor	Amount	Notes
United Printing	\$	689.15 Member Brochures ADA Compliance Remediation Work Order Not to Exceed
NDIT	\$	- \$20,000