

ERRP

Early Retiree Reinsurance Program Application



U.S. Department of Health and Human Services

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1087. The time required to complete this information collection for this application is estimated to average 35 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HHS Form # CMS-10321



Please note that if any information in this Application changes or if the sponsor discovers that any information is incorrect, the sponsor is required to promptly report the change or inaccuracy.

Send, using the U.S. Postal Service, a hardcopy of the signed original ERRP Application (i.e. not a photocopy) and Attachments (if any) to:

HHS ERRP Application Center
4700 Corridor Place
Suite D
Beltsville, MD 20705



An asterisk (*) identifies a required field.

PART I: Plan Sponsor and Key Personnel Information	
1) *Organization's Name (Must correspond with the information associated with the Federal Employer Tax Identification Number (EIN): <u>State of Alaska Retirement and Benefits Plans</u>	
2) *Type of Organization (Check the one category that best describes your organization): <input checked="" type="checkbox"/> Government <input type="checkbox"/> Union <input type="checkbox"/> Religious <input type="checkbox"/> Commercial <input type="checkbox"/> Non-profit	
3) *Organization's Employer Identification Number (EIN): _____	
4) *Organization's Telephone Number: <u>907 - 465 - 4460</u> ext. _____	
5) Organization's FAX Number: <u>907 - 465 - 3086</u> ext. _____	
6) *Organization's Address (must be the address associated with the EIN provided above): * Street Line 1: <u>PO Box 110203</u> Street Line 2: _____ *City: <u>Juneau</u> *State: <u>Alaska</u> *Zip Code: <u>99811-0203</u>	
7) Organization's Website Address: <u>www.alaska.gov/drb</u>	
B. Authorized Representative Information	
1) *First Name: <u>Annette</u> Middle Initial: <u>E</u> *Last Name: <u>Kreutzer</u>	
2) *Job Title: <u>Commissioner</u>	
3) Date of Birth: Do not respond to this item now. To comply with the Application Instructions, you must provide this at a later date if and when the application is approved.	
4) Social Security Number: Do not respond to this item now. To comply with the Application Instructions, you must provide this at a later date if and when the application is approved.	
5) *Email Address: <u>annette.kreutzer@alaska.gov</u>	
6) *Telephone Number: <u>907 - 465 - 5671</u> ext. _____	
7) FAX Number: <u>907 - 465 - 2135</u> ext. _____	
8) *Employer Name: <u>State of Alaska</u>	



9) * Authorized Representative Business Address:

* Street Line 1: PO Box 110200

Street Line 2: _____

*City: Juneau*State: Alaska*Zip Code: 99811-0200**C. Account Manager Information**1) *First Name: Patrick Middle Initial: J*Last Name: Shier2) *Job Title: Division Director

3) Date of Birth: Do not respond to this item now. To comply with the Application Instructions, you must provide this at a later date if and when the application is approved.

4) Social Security Number: Do not respond to this item now. To comply with the Application Instructions, you must provide this at a later date if and when the application is approved.

5) *Email Address: pat.shier@alaska.gov6) *Telephone Number: 907 - 465 - 4817 ext. _____7) FAX Number: 907 - 465 - 3655 ext. _____8) *Employer Name: State of Alaska

9) *Account Manager Business Address:

* Street Line 1: PO Box 110203

Street Line 2: _____

*City: Juneau*State: Alaska*Zip Code: 99811-0203

PART II: Plan Information	
A. Plan Information	
1) *Plan Name: <u>State of Alaska Retirement and Benefits Plans</u>	
2) *Plan Year Cycle: Start Month/Day: <u>1</u> / <u>1</u> End Month/Day: <u>12</u> / <u>31</u>	
B. Benefit Option(s) Provided Under This Plan (If the plan has more than one benefit option for which you intend to seek program reimbursement, please include the information below for each benefit option, on a separate copy of the Attachment below.)	
1a) *Benefit Option Name: <u>AlaskaCare Retiree Health Plan</u>	
1b) *Unique Benefit Option Identifier: <u>AlaskaCare Retiree Health Plan</u>	
1c) *Benefit Option Type: Self-Funded <input checked="" type="checkbox"/> Insured <input type="checkbox"/> Both <input type="checkbox"/>	
1d) *Benefit Administrator Company Name: <u>Wells Fargo Insurance Services</u>	



C. *Programs and Procedures for Chronic and High-Cost Conditions

A sponsor cannot participate in the Early Retiree Reinsurance Program unless, as of the date of its application for the program is submitted, its employment-based plan has in place programs and procedures that have generated or have the potential to generate cost savings with respect to plan participants with chronic and high cost conditions. The program regulations define "chronic and high cost condition" as a condition for which \$15,000 or more in health benefit claims are likely to be incurred during a plan year by one plan participant. Please identify the chronic and high cost conditions for which the employment-based plan has such programs and procedures in place, and summarize those programs and procedures, including how it was determined that the identified conditions satisfy the \$15,000 threshold. If necessary to provide a complete response, the sponsor may submit additional pages as an attachment to the application. Please reference such attachment in this space.

See Attachment A



Alaska Retirement and Benefits Plans Application
Early Retiree Reimbursement Program

ATTACHMENT A (For Application Part II, C.)

The following is a description of the practices and procedures currently in place for the AlaskaCare Retiree Health Plan – the single benefit option for all retirees receiving benefits through the multi-employer, employment based State of Alaska Retirement and Benefits Plans. Because the Retiree Plan offers intervention on behalf of members as early as possible (precertification events, customer service representative inquiries and data mining, for example), savings opportunities and opportunities for higher quality outcomes are materially increased, compared to other methods where intervention offers are triggered solely by claim amount thresholds.

Case Management Process for
Patients with Chronic and High Cost Conditions

Wells Fargo Insurance Services employs a comprehensive case management program to promote optimum patient outcomes and reduce overall plan healthcare expenditures. The program employs registered nurses (RNs) who provide case management services to patients with chronic and high cost conditions.

In their role as case managers, WFIS nurses perform a variety of functions including, coordinating healthcare services from the patient's healthcare providers, providing education on healthcare best practices to patients and their families, and connecting patients with available "Centers of Excellence" and community resources.

The case manager works collaboratively with the patient, family, physician and interdisciplinary medical management team to coordinate care and services along the healthcare continuum by facilitating informed decision making and empowerment for long term self-management and independence. Each patient is managed individually by identifying their needs and developing a care plan to meet those needs. Continuous reevaluation of the plan along the way ensures that the patient's needs and goals are being met and that changes in patient condition or circumstance are adequately addressed and attended to.

How does this practice generate savings?

Members facing treatments associated with the listed diseases benefit in lower costs as WFIS directs members to network providers whenever appropriate, in the form of lower co-pay amounts, and protection from provider balance billing. Members also benefit from focused attention from the WFIS medical management team, in the form of no-cost access to advice about alternative treatments, best practices and "Centers of Excellence", leading to better

outcomes. Better outcomes include improved health and avoidance of unnecessary procedures and/or tests.

The plan realizes savings through discounted network charges and improved protocol compliance leading to better outcomes, as defined, above.

Patients with chronic and high cost conditions are identified and referred to case management in a variety of ways, including: reviewing precertification information, reviewing patient claim information, patient discussions with customer service representatives, and by utilizing predicative modeling software that mines data and trends within the overall plan claim experience data. WFIS records and reports to the Plan instances of case management. In the event of an audit, data exists to positively identify retiree claim eligibility based on age and retiree status, and to arrive at the proper dollar amounts considered for reimbursement. Case management dollar savings can be quantified through actuarial calculation based on the number of cases in management for a given disease, the case spend and industry benchmarks for similar disease cases.

The types of conditions/situations/procedures referred to case management include:

Inpatient stays longer than two weeks

Accidents with multiple injuries

Ascites

Amyotrophic lateral sclerosis

Aplastic Anemia

Automated implantable cardioverter-defibrillator

Brain hemorrhage

Burns

Cancer/Chemotherapy

Cardiomyopathy

Chemical dependency

Child Abuse/Neglect

Chronic inflammatory demyelinating polyneuropathy

Crainiotomy

Chrohn's disease

CVA/Stroke, brain hemorrhage

Cystic Fibrosis

Dialysis

Endocarditis

End stage renal disease

Factor infusions

Immunodeficiencies

Gaucher's disease

Guillian-Barre

Head injury, traumatic brain injury (TBI)

Hemophilla

HIV/AIDS

High risk pregnancy

Hodgkins and non-hodgkins lymphoma

Intracrainial bleed

Kaposi's sarcoma

Leukemia

Liver failure

Lou Gehrig's disease

Lymphoma

Multiple Sclerosis

Myasthenia gravis

Pacemakers/Defibrillators

Preterm infant

Preterm labor
Pulmonary hypertension
Renal failure
Respiratory failure
Sarcoma
Sarcoidosis
Sickle cell crisis or disease
Spinal cord injury

Spinal surgeries
Subarachnoid hemorrhage
Thrombocytopenia
Thrombotic thrombocytopenic
purpura
Transplants – organs and bone
marrow
Valve replacements

Wells Fargo Insurance Services is just completing the first year of a three year contract for AlaskaCare, with two one-year extensions possible. The AlaskaCare Plan requires contractors to provide similar services at each request for proposals, so this kind of service will survive any future change in Third Party Administrator.

D. *Estimated Amount of Early Retiree Reinsurance Program Reimbursements

Please estimate the projected amount of proceeds you expect to receive under the Early Retiree Reinsurance Program for the plan identified in this application, for each of the first two plan year cycles identified in this application. If you wish, you may provide a range of expected program proceeds that includes: (1) a low-end estimate of expected program proceeds, (2) an estimate that represents your most likely amount of program proceeds, and (3) a high-end estimate of expected program proceeds. For purposes of this estimate only, please assume for each of those plan year cycles that there will be sufficient program funds to cover all claims submitted by the Plan Sponsor that comply with program requirements. If necessary to provide a complete response, the sponsor may submit additional pages as an attachment to the application. Please reference such attachment in this space.

Estimated program proceeds: Low-end (1) \$87 million. Most Likely (2) \$89 million. High-end (3) \$93 million. These estimates are for the balance of the 2010 plan cycle beginning June 1, 2010 through December 31, 2010, plus the full calendar year 2011 plan cycle.



E. *Intended Use of Early Retiree Reinsurance Program Reimbursements

- 1) Please summarize how your organization will use the reimbursement under the Early Retiree Reinsurance Program to reduce health benefit or health benefit premium costs for the sponsor of the employment-based plan (i.e., to offset increases in such costs); or reduce, or offset increases in, premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs (or combination of these) for plan participants; or reduce a combination of any of these costs (whether offsetting increases in sponsor costs or reducing, or offsetting increases in, plan participants' costs). If necessary to provide a complete response, the sponsor may submit additional pages as an attachment to the application. Please reference such attachment in this space.

See Attachment B



E. *Intended Use of Early Retiree Reinsurance Program Reimbursements (continued)

2) If a sponsor decides to apply the reimbursement for its own use, it may only use the reimbursement to offset increases in its health benefit premium costs, if an insured plan, or its health benefit costs, if it is self-funded. If any amount of the reimbursement is used to offset increases in health benefit premium or health benefit costs of your organization (as opposed to offsetting increases to, or reducing, plan participants' costs), please summarize how program funds, as a result of being used by your organization for such purposes, will relieve your organization of using its own funds to subsidize such increases, thereby allowing your organization to instead use its own funds to maintain its level of financial contribution to the employment-based plan. (In other words, please explain how your organization will continue to maintain the level of support for this plan, and if it applies the reimbursement for its own use, will use the program reimbursement to pay for increases in health benefit premium costs or health benefit costs, as applicable). If necessary to provide a complete response, the sponsor may submit additional pages as an attachment to the application. Please reference such attachment in this space.

See Attachment B.



Alaska Retirement and Benefits Plans Application
Early Retiree Reimbursement Program

ATTACHMENT B (for Application Part II, E.)

1. Reimbursement program proceeds will be deposited in the multi-employer, employment based retiree health care trust known as the State of Alaska Retiree Health Care Trust as recognized by section 115 of the Internal Revenue Code in order to reduce health benefit plan costs borne by member employers. Contributions to the Trust are used solely for the payments of benefits, expenses and other charges properly allocated to the AlaskaCare Retiree Health Plan.
2. The Retiree Health Care Trust is in an underfunded condition estimated at over \$4 billion, in spite of pre-funding the liability for retiree health since inception of the AlaskaCare Retiree Health Plan. Member employers and the State have and will continue with their current level of effort to contribute hundreds of millions of dollars on an annual basis toward paying down the unfunded liability according to established plan valuations calculated by Buck Consultants on an annual basis. The contributions are based on actuarial analysis, and the resulting rates, as adopted by the Alaska Retirement Management Board. Retiree health benefit costs for retirees under age 65 were over \$223 million in 2008, and over \$250 million in 2009, and are expected to continue to increase year over year (Buck Consultants Public Employees Retirement System Annual Valuation 2009). Program reimbursements will help member employers by slightly mitigating future health benefit cost rates assessed on employers.

PART III: Banking Information for Electronic Funds Transfer

- 1) *Bank Name: State Street Bank and Trust

- 2) *Bank Address:
 - * Street Line 1: Lafayette Corporate Center
 - Street Line 2: 2 Avenue de Lafayette
 - *City: Boston
 - *State: Massachusetts
 - *Zip Code: 02111

- 3) *Account Number: _____

- 4) *Name of Organization Associated with Account: State of Alaska - General Investment Fund AY01

- 5) *Account type: (Checking or Savings Account) Checking

- 6) *Bank Routing Number: _____

- 7) *Bank Contact Name:
 - *First Name: _____ Middle Initial: _____
 - *Last Name: _____

- 8) *Email address: _____

- 9) *Telephone Number: ____-____-____ ext. _____



PART IV. Plan Sponsor Agreement

1. **Compliance:** In order to receive program reimbursement(s), Plan Sponsor agrees to comply with all of the terms and conditions of Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 C.F.R. Part 149 and in other guidance issued by the Secretary of the U.S. Department of Health & Human Services (the Secretary), including, but not limited to, the conditions for submission of data for obtaining reimbursement and the record retention requirements.
2. **Reimbursement-Related and Other Representations Made by Designees:** Plan Sponsor may be given the opportunity to identify one or more Designees (i.e., individuals the Sponsor will authorize to perform certain functions on behalf of the Sponsor related to the Early Retiree Reinsurance Program, such as individual(s) who will be involved in making program reimbursement requests). Plan Sponsor certifies that all individuals that will be identified as Designees will have first been given authority by the Plan Sponsor to perform those respective functions on behalf of the Plan Sponsor. Plan Sponsor understands that it is bound by any representations such individuals make with respect to the Sponsor's involvement in the Early Retiree Reinsurance Program, including but not limited to the Sponsor's reimbursement under, the program.
3. **Written Agreement:** Plan Sponsor certifies that, prior to submitting a Reimbursement Request, it has executed a written agreement with its health insurance issuer or employment-based plan regarding disclosure of information, data, documents, and records to HHS, and the issuer or plan agrees to disclose to HHS, on behalf of the Plan Sponsor, at a time and in a manner specified by the HHS Secretary in guidance, the information, data, documents, and records necessary for the Plan Sponsor to comply with the requirements of the Early Retiree Reinsurance Program, as specified in 45 C.F.R. 149.35.
4. **Use of Records:** Plan Sponsor understands and agrees that the Secretary may use data and information collected under the Early Retiree Reinsurance Program only for the purposes of, and to the extent necessary in, carrying out Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 C.F.R. Part 149 including, but not limited to, determining reimbursements and reimbursement-related oversight and program integrity activities, or as otherwise allowed by law. Nothing in this section limits the U.S. Department of Health & Human Services' Office of the Inspector General's authority to fulfill the Inspector General's responsibilities in accordance with applicable Federal law.
5. **Obtaining Federal Funds:** Plan Sponsor acknowledges that the information furnished in its Plan Sponsor application is being provided to obtain Federal funds. Plan Sponsor certifies that it requires all subcontractors, including plan administrators, to acknowledge that information provided in connection with a subcontract is used for purposes of obtaining Federal funds. Plan Sponsor acknowledges that reimbursement of program funds is conditioned on the submission of accurate information. Plan Sponsor agrees that it will not knowingly present or cause to be presented a false or fraudulent claim. Plan Sponsor acknowledges that any excess reimbursement made to the Plan Sponsor under the Early Retiree Reinsurance Program, or any debt that arises from such excess reimbursement, may be recovered by the Secretary. Plan Sponsor will promptly update any changes to the information submitted in its Plan Sponsor application. If Plan Sponsor becomes aware that information in this application is not (or is no longer) true, accurate and



	complete, Plan Sponsor agrees to notify the Secretary promptly of this fact.
6.	Data Security: Plan Sponsor agrees to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged under this Plan Sponsor application. Plan Sponsor recognizes that the use and disclosure of protected health information (PHI) is governed by the Health Insurance Portability and Accountability Act (HIPAA) and accompanying regulations. Plan Sponsor certifies that its employment-based plan(s) has established and implemented appropriate safeguards in compliance with 45 C.F.R. Parts 160 and 164 (HIPAA administrative simplification, privacy and security rule) in order to prevent unauthorized use or disclosure of such information. Sponsor also agrees that if it participates in the administration of the plan(s), then it has also established and implemented appropriate safeguards in regard to PHI. Any and all Plan Sponsor personnel interacting with PHI shall be advised of: (1) the confidential nature of the information; (2) safeguards required to protect the information; and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.
7.	Depository Information: Plan Sponsor hereby authorizes the Secretary to initiate reimbursement, credit entries and other adjustments, including offsets and requests for reimbursement, in accordance with the provisions of Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 C.F.R Part 149 and applicable provisions of 45 C.F.R. Part 30, to the account at the financial institution (hereinafter the "Depository") indicated under the Electronic Funds Transfer (EFT) section of the Plan Sponsor application. Plan Sponsor agrees to immediately pay back any excess reimbursement or debt upon notification from the Secretary of the excess reimbursement or debt. Plan Sponsor agrees to promptly update any changes in its Depository information.
8.	Policies and Procedures to Detect Fraud, Waste and Abuse. The Plan Sponsor attests that, as of the date this Application is submitted, has in place policies and procedures to detect and reduce fraud, waste, and abuse related to the Early Retiree Reinsurance Program. The Plan Sponsor will produce the policies and procedures, and necessary information, records and data, upon request by the Secretary, to substantiate existence of the policies and procedures and their effectiveness, as specified in 45 C.F.R. Part 149.
9.	Change of Ownership: The Plan Sponsor shall provide written notice to the Secretary at least 60 days prior to a change in ownership, as defined in 45 C.F.R, 149.700. When a change of ownership results in a transfer of the liability for health benefits costs, this Plan Sponsor Agreement is automatically assigned to the new owner, who shall be subject to the terms and conditions of this Plan Sponsor Agreement.
	<p>Signature of Plan Sponsor Authorized Representative</p> <p>I, the undersigned Authorized Representative of Plan Sponsor, declare that I have legal authority to sign and bind the Plan Sponsor to the terms of this Plan Sponsor Agreement, and I have or will provide evidence of such authority. I declare that I have examined this Plan Sponsor Application and Plan Sponsor Agreement. My signature legally and financially binds the Plan Sponsor to the statutes, regulations, and other guidance applicable to the Early Retiree Reinsurance Program including, but not limited to Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 C.F.R. Part 149 and applicable provisions of 45 C.F.R. Part 30 and all other applicable statutes and regulations. I certify that the information contained in this Plan Sponsor Application and Plan Sponsor Agreement is true, accurate and complete to the best of my knowledge and belief, and I authorize the Secretary to verify this information. I understand that, because program</p>



reimbursement will be made from Federal funds, any false statements, documents, or concealment of a material fact is subject to prosecution under applicable Federal and/or State law.

*Signature:

Janeth Keizer



Attachment: Additional Benefit Options

(Complete this form for each unique benefit option not already specified above in Part II.B)

1a) *Benefit Option Name: no other benefit options

1b) *Unique Benefit Option Identifier: _____

1c) *Benefit Option Type: Self-Funded Insured Both

1d) *Benefit Administrator Company Name: _____

