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Show Me the Money: HHS Issues Guidance On The New Early Retiree Reinsurance Program

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In an earlier client alert (***click here***),we reported that the Secretary of the Department of Health and Human Services (HHS) released an interim final rule with a 30-day public comment period that implements the Early Retiree Reinsurance Program established by the Affordable Care Act (the "Act").[1] The program provides $5 billion in financial assistance to employers to help them maintain health coverage for early retirees ages 55 to 64 and their spouses, surviving spouses, and dependents who are not yet eligible for Medicare.

The interim final rule is effective June 1, 2010. HHS has reported that it expects applications for the program to be available by the end of June. The program will end on January 1, 2014, when early retirees will be able to elect coverage under one of the health insurance exchanges, or when HHS has exhausted the $5 billion appropriated to the program, if earlier.

Because applications for reimbursements ***will be processed in the order received*** and funding for this program is limited, it is of paramount importance that plan sponsors be ready to act fast once applications are available in June.

ELIGIBILITY REQUIREMENTS

Employment Based-Plans

Only employment-based plans that provide health benefits to early retirees are eligible to participate in the reinsurance program.

Plans, either self-insured or fully-insured, sponsored by private employers, State and local governments, employee organizations, voluntary employees' beneficiary associations (VEBAs), churches, and multiemployer health funds are eligible for the program. Plans sponsored by the Federal government are excluded.

“Early retirees” include former employees age 55 to 64 who are not eligible for coverage under Medicare and their spouses, surviving spouses, and dependents (even if they are under the age of 65 and/or are eligible for Medicare).

Cost-savings or Potential Cost Savings for Chronic and High-Cost Conditions

The employment-based plan must include 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” who are likely to generate $15,000 in claims for a plan year. Examples provided by HHS include a diabetes management program; coverage of all or a large portion of the participant’s co-insurance or co-payments, and/or elimination or reduction of a plan’s deductible for treatment and visits related to cancer.

Because HHS believes Congress intended this program to be inclusive, it did not identify specific types of “chronic and high-cost conditions” that must be addressed by an employer-based plan. Nor does it require plan sponsors to implement new programs or procedures just to participate in this program or to target all chronic and high-cost conditions. Existing efforts may be sufficient.

Written Agreement with Insurer or Employment-Based Plan

Plan sponsors are required to have a written agreement with their health insurance issuer or employment-based plan, as applicable, requiring these entities to disclose information, data documents, and records on behalf of the plan sponsor to HHS in order for the sponsor to comply with the program, in part to accommodate the HIPAA privacy and security rules. Much of the data, such as claims, that HHS will need to support program reimbursements is going to be protected health information under the HIPAA privacy and security rules and may be in the hands of business associates (such as third party administrators) of the group health plans.

Disclosures to HHS under the program will not require specific authorization of individuals.

HHS Certification

Employment-based plans participating in the program must be certified by HHS. It is unclear in the interim final rule how employers will be certified. The rule states that applications can be denied based on funding availability so it is possible that HHS may stop certifying employment-based plans when certified plans' aggregate reimbursements are expected to reach the $5 billion funding limit.

APPLICATION PROCESS

Timing

The application process is similar to the application process for the Medicare Part D retiree drug subsidy (RDS). To participate in the program, plan sponsors must submit a complete application to HHS for each plan identifying the plan year cycle for which the sponsor is applying. However, unlike the RDS program, once a plan is certified and the application is approved, and the sponsor otherwise continues to meet the requirements of the program, the plan will continue to be certified and the application will continue to be approved. A sponsor need not thereafter file an application annually.

Applications for the program will be ***processed in the order received*.** Accordingly, HHS warns that it is imperative that applications be complete when initially filed. Incomplete applications will not be given an opportunity to cure defects. Instead, an incomplete application will be denied and a new application will need to be submitted. The new application will be processed based on the date the new application is received, which, depending on remaining funding in the program, may preclude reimbursement.

Applications may also be rejected based on the availability of funds. Plan sponsors will need to project their reimbursement amounts for the first two plan year cycles in their applications so that HHS can project the total reimbursement amounts and determine when it will stop accepting applications due to the program's funding limitations.

Content

Applications will include a plan sponsor agreement which will include, among other things: (1) an acknowledgment that the information in the application is being provided to obtain Federal funds, and that all subcontractors acknowledge that information provided in connection with a subcontract is used for purposes of Federal funds; (2) an attestation that policies and procedures are in place to detect and reduce fraud, waste and abuse; (3) a summary indicating how the applicant will use any reimbursement received under the program; (4) a projected amount of reimbursement for the first two plan year cycles with specific amounts for each cycle; and (5) a list of all benefit options under the employment-based plan that any early retiree for whom the sponsor receives program reimbursement may be claimed.

The application must be signed by an authorized representative of the plan sponsor.

HHS may reopen determinations of approved or denied applications for reimbursements: within 1 year of a determination for any reason; within 4 years of a determination, if information and data submitted by the sponsor is inaccurate, incomplete or incorrect; or at any time, in the event the sponsor committed a fraud or otherwise was untruthful.

Policies and Procedures to Detect and Reduce Fraud, Waste and Abuse

Plan sponsors will need to ensure and attest in the program's application that policies and procedures are in place to detect and reduce fraud, waste and abuse. Sponsors will also need to produce these policies and procedures and any documents or data to substantiate the implementation, and the effectiveness, of the procedures, upon request.

If it is found that a plan sponsor committed (or allowed to be committed) fraud, waste or abuse under its plan, HHS may recoup from the sponsor some or all of the reimbursements paid under the program, and/or may revoke a sponsor's certification to participate in the program. In addition, in such case, HHS may terminate or deny an application for reimbursement.

REIMBURSEMENT AMOUNTS

Reimbursement Formula

This program will reimburse the plan sponsor for 80% of the costs incurred and paid (even if paid in a later year) for health benefits under an employment-based plan (net of negotiated price concessions) between $15,000 and $90,000 (indexed for plan years on or after October 1, 2011) for each early retiree (and their spouse, surviving spouse and dependent), each plan year. Cost above and below the thresholds are subtracted from the reimbursement amount calculation.

“Health benefits” include medical, surgical, prescription drug, and mental health benefits, and excludes HIPAA-excepted benefits such as long-term care and stand-alone dental and vision plans. Reimbursement amounts are determined based on cumulative health benefits incurred in a given year and paid for a given early retiree, rather than reimbursements being made only for discrete health benefits items or services.

When calculating the employment-based plan cost of health benefits, some rules to consider:

- Deductibles, copayments, or coinsurance paid by early retirees (or their spouses, surviving spouses, or dependents) are *included*.
- If an early retiree or dependent changes benefit options (*e.g.*, HMO to PPO) in a year, all costs in those options must be aggregated for determining the threshold.
- For fully-insured plans, the cost means the amount paid by the insurer and early retirees for health care benefits net of negotiated price concessions, excluding the premiums paid by the sponsor and early retirees.

Transition Rule

Reimbursements are available for the first plan year that starts prior to June 1, 2010, provided that the plan year ends after that date. For claims incurred before June 1, 2010, the amount of such claims up to $15,000 counts toward the cost threshold and the cost limit. Claims incurred before June 1, 2010 that exceed $15,000 are not eligible for reimbursement and do not count toward the cost limit. The reimbursement amount to be paid is based solely on claims incurred on and after June 1, 2010, and that fall between the cost threshold and cost limit for the plan year.

Example: Assume that a plan has a plan year that began July 1, 2009 and ends June 30, 2010. Assume that this plan covers an early retiree for which it has spent $120,000 in health benefit claims before June 1, 2010, and it then spends another $30,000 in health benefit claims for the early retiree between June 1, 2010 and June 30, 2010. The sponsor would receive credit for $15,000 in claims incurred before June 1 and would be eligible to receive reimbursement of 80 percent of the $30,000 (for the claims incurred after June 1, 2010), or $24,000.

Use of Reimbursements

Sponsors must use reimbursements under the program to lower costs for the plan, which includes costs for the plan sponsor and plan participants. Sponsors may *not* use the reimbursements as "general revenue" for the sponsor.

HHS is encouraging plan sponsors to use the reimbursement amounts for either or both of the following: (1) to reduce the sponsor's health benefit premiums or health benefit costs, and (2) to reduce health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs, or any combination of these costs, for plan participants (including retirees, and their spouses and dependents, and *active* employees and their spouses and dependents).

HHS expects that sponsors will continue to provide at least the same level of contribution to support the applicable plan, as it did before this program. For example, for a sponsor that pays a premium to an insurer, if the premium increases, program funds may be used to pay the sponsor's share of the premium increase from year to year, which reduces the sponsor's premium costs. It is unclear at this time whether HHS will impose additional TARP-like restrictions on plan sponsors who accept funds under this program, although such restrictions have not yet been proposed and, presumably, would not apply in the absence of statutory authority.

Reimbursement Rules

Claims cannot be submitted for a given plan year until the application that is associated with the claim has been approved. With respect to a given early retiree, claims cannot be submitted until the early retiree's total paid costs for health benefits incurred for the plan year exceed the applicable cost threshold (*i.e.*, $15,000 for 2010). Once that threshold has been reached, claims can be submitted, but they must include all claims below the applicable cost threshold for the plan year in order to verify that the cost threshold has been met.

As noted above, claims must be submitted based on the amounts actually paid, including any amounts paid by the early retiree (evidence of such payment may include an actual payment receipt). Once the cumulative claims of an early retiree exceed $90,000 (as adjusted in future years) for a plan year, a sponsor should not submit claims above this claim limit for that early retiree because no reimbursement will be paid on these claims.

All claims submissions must include a list of early retirees for whom claims are being submitted. Claim submissions will be processed on a first-in, first-out basis until program funding is expended. Claims and the list of early retirees for fully-insured plans may be submitted directly to HHS by insurers.

Record Retention

Sponsors must maintain records relating to reimbursement of claims under the program for 6 years after the expiration of the plan year in which the costs were incurred, or longer if otherwise required by law.

Claim Appeals

Due to the limited funding and temporary nature of the program, HHS has established a one-step appeal process. A sponsor may appeal directly to HHS within 15 calendar days of receipt of the determination at issue. Sponsors should also note that the right to appeal will end when the $5 billion funding is exhausted.

CHANGE IN OWNERSHIP REQUIREMENTS

Similar to the requirements under the RDS program, sponsors must provide at least 60 days advance notice of any change of ownership of the sponsor to ensure that reimbursement under the program is being made only to legitimate entities, and only to such entities that are actually complying with the requirements of the program.

ACTION ITEMS

It is anticipated that applications for the program will be available by the end of June. Because applications will be processed in the order in which they are received and reimbursements will cease once funding is exhausted, sponsors need to be prepared to act quickly if they wish to receive reimbursement under the program. The benefits of applying for reimbursement will likely outweigh the costs and administrative burdens for large plan sponsors.

The following are some of the actions plan sponsors who wish to apply for reimbursements under the program will need to take:

- Identify programs that generate cost-savings for chronic and high-cost conditions between $15,000 and $90,000
- Maintain records of policies and procedures regarding chronic and high-cost conditions, and data to substantiate their effectiveness
- Adopt policies and procedures to detect and reduce fraud, waste and abuse
- Execute agreements with insurers or the employment-based plan requiring the plan to disclose information to HHS
- Designate an authorized representative to sign the application and to certify that the application is accurate and true
- Make projections for the first two plan year cycles
- Submit application and plan sponsor agreement (and accompanying data)
- Determine how to use reimbursement proceeds

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This client alert is meant to summarize and highlight the regulations regarding the Early Retiree Reinsurance Program established under health care reform. We will continue to update our clients on new developments in this rapidly changing area of the law. In the meantime, please feel free to contact your Proskauer attorney or any member of our Health Care Reform Task Force should you have questions regarding the Early Retiree Reinsurance Program or any other aspect of health care reform.

[1]“Affordable Care Act” means The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA).

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