HHS Issues Interim Final Rule on Early Retiree Reinsurance Program
Employer Summary and Next Steps

The information below was provided for The Local Choice (TLC) by Aon Consulting. It is intended for employers with early retirees covered by a group health plan who may be interested in the reinsurance program. Other information sources are listed at the end of this document.

The Department of Health and Human Services (HHS) has issued an interim final rule implementing the temporary Early Retirement Reinsurance Program (Program) established by the Patient Protection and Affordable Care Act (PPACA) as part of the Health Care Reform Law. The Program, which has an overall funding limit of $5 billion, will start on June 1, 2010, and will expire on January 1, 2014, or when the Program's $5 billion in funding is exhausted, whichever comes first. The Program provides reimbursement to participating sponsors of employment-based plans for a portion of the costs of providing health coverage to early retirees age 55 and older who are not eligible for Medicare, and their eligible spouses, surviving spouses, and dependents. The Program will apply to claims incurred on or after June 1, 2010 in plan years ending after that date that fall between the cost threshold and the cost limit for the plan year.

The interim final rule sets out the framework of the Program, including the types of sponsors and plans covered, the application and certification process for participation in the Program, and the reimbursement process. Even though the guidance is in the form of an interim final rule, there is a 30-day comment period that ends on June 4, 2010.

Highlights of the Program

- Sponsors must apply to, and their employment-based plan must be certified by, HHS before a reimbursement claim is submitted.
- Applications will be reviewed on a first-come/first-serve basis. Incomplete applications will be rejected and the applicant will be required to refile. *[Note: This is a critical feature of the Program. HHS will use the first 2 plan-year cycle reimbursement projections that have to be included in the application in determining if and when to stop accepting applications due to the overall funding limitations. Once applications become available there will likely be a very short window of time to submit applications.]*
- A separate application must be submitted for each employment-based plan; however, the application can cover more than one plan year.
- As part of the application process, the sponsor must describe its programs and procedures that have or may generate cost-savings with respect to plan participants with chronic and high-cost conditions, and its policies and procedures to protect against fraud, waste, and abuse under the Program.
- The employer must agree to extensive disclosure requirements regarding information, data, documents, and records (including protected health information (PHI)), and to execute a sponsor agreement with HHS or its designee that includes certain assurances made by the sponsor (similar to the agreement currently required under the Retiree Drug Subsidy Program). The sponsor must also have a disclosure agreement with its health insurer or employment-based plan.
- Reimbursements under the Program must be used to reduce the sponsor's health benefit premiums or cost, and/or reduce health benefit premiums, copayments, deductibles, coinsurance or other out-of-pocket costs of plan participants (not limited to early

retirees). However, sponsors are expected to provide at least the same level of contributions to support the plan as before the Program.

- Applicants must project their reimbursement amounts for the first 2 plan-year cycles. *[Note: This will likely require some actuarial analysis that will need to be prepared in advance of the application process.]*
- The Program will reimburse 80% of the aggregate claims incurred by each early retiree during the plan year that are actually paid by the plan, the insurer, or early retiree, that exceed a $15,000 cost threshold, and that are less than a $90,000 cost limit. There is only one cost threshold and one cost limit per plan year for each early retiree. *[Note: It is presently unclear whether each covered dependent of a retiree has a separate threshold and cost limit, or whether a retiree and all his dependents are aggregated for Program purposes.]*
- Claims will only be reimbursed until the Program funding runs out. *[Note: This is another critical element of the Program, and requires that claims for reimbursement be submitted as soon as possible.]*
- Aggregate paid claims for an early retiree for a plan year must exceed $15,000 before the claim can be submitted for reimbursement.
- For a plan year beginning before June 1, 2010 and ending after that date, claims incurred on or after June 1, 2010 can be reimbursed under the Program, and claims up to $15,000 incurred prior to that date will be applied to the $15,000 cost threshold and $90,000 cost limit.
- The term "early retiree" includes not only the former employee, but also his or her enrolled spouse, surviving spouse, and dependents.
- Any appeal of a rejected application or reimbursement claim must be filed in writing with HHS within 15 calendar days after the sponsor receives an adverse reimbursement determination *[Note: sponsors cannot appeal an adverse reimbursement determination based on the unavailability of funds.]*.
- The sponsor is required to maintain records supporting the application and claims incurred during a plan year for 6 years after the end of the plan year in which the costs were incurred, or longer if otherwise required by law.
- The sponsor has a continuing obligation to update any inaccurate data provided in connection with a claim, and HHS can reopen a reimbursement determination within varying periods of time, depending on the reason.
- If a sponsor undergoes an ownership change, HHS must be notified at least 60 days in advance of the change.

Eligible Employer-Based Plans

Sponsors. The Program applies to sponsors and their employment-based plans. A sponsor is generally the employer in the case of a single employer plan or an employee organization (e.g., a union) in the case of a plan maintained by an employee organization. In the case of a plan maintained jointly by one employer and an employee organization and for which the employer is the primary source of funding, the sponsor is the employer.

Plans. An employment-based plan is a group health plan that provides health benefits to early retirees, but excludes Federal governmental plans. For this purpose, health benefits include medical, surgical, hospital, prescription drug, and other benefits that may be specified by HHS, whether self-funded, fully insured, or otherwise. Such benefits include benefits for the diagnosis, cure, mitigation, or prevention of physical or mental disease or condition with respect to any

structure or function of the body. Health benefits do not include excepted benefits under HIPAA, such as long-term care and limited scope dental and visions benefits.

Early Retiree. An early retiree is a plan participant age 55 and older who is enrolled for health benefits in a certified employment-based plan, who is not eligible for Medicare benefits, and who is not an active employee of an employer maintaining or currently contributing to the plan or an employer that has made substantial contributions to the plan. The participant's enrolled spouse, surviving spouse, and dependents (based on the rules of the plan; these individuals need not be tax dependents) are also considered to be early retirees, although it is not clear under the regulation whether they are each treated as separate early retirees, or if the family unit is treated as one early retiree for Program reimbursement purposes.

The Reimbursement Process
Employment-Based Plans -Approval by HHS

Certification. In order to participate in the Program, a sponsor's employment-based plan must be certified (approved) by HHS, and 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 (conditions for which $15,000 or more in health claims are likely to be incurred during a plan year by one plan participant). However, there is no need to have a program that addresses all conditions likely to result in claims of $15,000, or to implement new-cost-savings programs. To secure certification of its employment-based plan, a sponsor must:

- Make available information, data, documents, and records (including PHI) to HHS;
- Have a written agreement with its health insurance issuer (for fully-insured coverages) or employment-based plan (for self-insured coverages) regarding disclosure of information, data, documents, and records to HHS, and the health insurance issuer or employment-based plan must disclose such information to HHS, on behalf of the sponsor, at a time and in a manner specified by HHS for approval;
- Ensure that policies and procedures to protect against fraud, waste, and abuse under the Program are in place, and comply timely with any request from HHS to produce such policies and procedures and substantiate their implementation and effectiveness; and
- Submit an application to HHS.

Applications. Applications will be processed on a first-come/first-serve basis, and must comply with the requirements described below at the time submitted or they will be rejected. An application must be submitted once for each employment-based plan to be covered by the Program. The application must be signed by an authorized representative of the applicant and must include:

- Applicant-specific information, such as tax identification number, name and address, contact name, telephone number, and email address;
- The plan year start and end dates (but not the year);
- A summary of how the applicant will use any reimbursement received under the Program – i.e., how the reimbursement will be used to reduce premium contributions, co-payments, deductibles, coinsurance, or other out-of-pocket costs for plan participants (not limited to early retirees), to reduce health benefit or premium costs for the sponsor, or to reduce any combination of these costs (but not for general revenues);
- An explanation of how the reimbursement will be applied to maintain the sponsor's level of effort in contributing to support the plan;
- Projected amount of reimbursement to be received under the Program for the first 2 plan year cycles, with specific amounts for each cycle;

- List of all benefit options that may cover any early retiree under the employment-based plan for whom the sponsor may claim reimbursement;
- Plan sponsor agreement (see below) signed by an authorized representative; and
- Other information that HHS may require.

Sponsor Agreement. The plan sponsor agreement is between the sponsor and HHS. The agreement is to be submitted as part of the application and must include the following provisions: (1) assurance of a written agreement between the sponsor and health insurance issuer or employment-based plan, regarding the sponsor's disclosure obligations to HHS, (2) acknowledgment that 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 such purpose, (3) attestation of the anti-fraud, waste, and abuse policies in place, and (4) other terms and conditions required by HHS.

HHS' Reimbursement Process

Certification Required. A reimbursement request can only be made after the sponsor and employment-based plan have been certified by HHS.

Amount of Reimbursement. The reimbursement amount is 80% of the costs for health benefits (net of negotiated price concessions) for claims incurred during the plan year attributable to health benefit costs between the cost threshold ($15,000) and up to the cost limit ($90,000) for each early retiree enrolled in the certified plan in a plan year. Reimbursable costs include health benefit costs (not premiums) paid by the employment-based plan, the insurer (if an insured plan), and by the early retiree. Both the cost threshold and cost limit will be adjusted for inflation for plan years beginning on or after October 1, 2011.

Incurring a Claim. A claim is incurred only when the sponsor, health insurance issuer, employment-based plan, plan participant, or a combination of these or similar stakeholders, becomes responsible for payment of the claim.

Application of Threshold/Limit. All health benefit costs paid by the employment-based plan or health insurer, or by or on behalf of the early retiree for all benefit options the early retiree is enrolled in under the certified plan for a plan year, are combined in applying the threshold/limit. For each early retiree, there is only one cost threshold and one cost limit per plan year regardless of the number of benefit options available under the plan.

Timing of Incurred Claims/Special Transition Rule. The reimbursement amount is based only on claims incurred on or after June 1, 2010. However, under a special transition rule, for plan years beginning before and ending after June 1, 2010, up to $15,000 of claims incurred before June 1, 2010, count toward the cost threshold and cost limit. Claims incurred before June 1, 2010 that are in excess of $15,000 are disregarded in applying the cost threshold and cost limit.

Claims Submission for Reimbursement. HHS has not yet issued a model claims form; however, the regulations provide that the claims submission must include a list of early retirees for whom claims are submitted, and documentation of the actual costs of the items and services for the submitted claims. Only claims that have been incurred and paid may be submitted for reimbursement. Claims may only be submitted after the cost threshold has been reached, and then must include claims both above and below the cost threshold. Claims should not be submitted for early retirees that total more than the applicable cost limit for the year.

Maintenance of Records. All documentation, data, and other information required in the application and claims process must be maintained by the sponsor (or its subcontractor) for 6 years after the end of the plan year in which the costs were incurred, or longer if otherwise required by law. The sponsor must require its health insurance issuer or employment-based plan to maintain and produce upon request these required records.

Appeals Process. A complete or partial denial of a reimbursement request must be appealed in writing within 15 calendar days after receipt of the HHS determination. However, if a claim is rejected due to the exhaustion of Program funding, the claim rejection is not appealable. The decision of HHS on appeal is final and binding.

Update Inaccurate Data. The sponsor is required to disclose any data inaccuracies upon which a reimbursement determination is made, including inaccurate claims data and negotiated price concessions. HHS can reopen and may revise a reimbursement determination at its own behest or upon request of the sponsor within 1 year after the determination for any reason, within 4 years for good cause, and at any time for fraud or similar fault.

Use of Reimbursement Proceeds

Maintenance of Effort. A key part of the application process is determining how the reimbursement proceeds will be used. HHS indicates that sponsors should provide at least the same level of contribution to support the plan as they did before the Program (and, as indicated above, the application must include an explanation of how the reimbursement will be applied to maintain the sponsor's level of effort in contributing to support the plan). Consequently, reimbursements can be used to offset premium and cost increases for the sponsor and/or to reduce the premiums, co-payments, deductibles, coinsurance, or out-of-pocket costs for plan participants (not limited to early retirees). However, a sponsor may not use reimbursements to reduce its current contribution level. *[Note: From an employer prospective, the maintenance of effort obligation should be carefully considered, and the implications to future postretirement health plan modifications or future collective bargaining fully evaluated before committing to current contribution levels.]*

ERISA Implications. It is unclear, in the case of a health plan that is subject to ERISA, whether any portion of a reimbursement (e.g., where early retirees contribute to the plan) would be treated as a plan asset and required to be used solely for the benefit of plan participants.

Change of Sponsor Ownership

A change in the ownership of a sponsor (including the removal, addition, or substitution of a partner in a partnership) triggers a notice requirement if the sponsor has a sponsor agreement in effect. The sponsor must notify HHS of a potential ownership change at least 60 days before the anticipated effective date of the change. Failure to notify HHS in advance of the effective date of the change may result in HHS recovering funds paid under the Program. If the ownership change results in a transfer of liability for health benefits to a new owner, such change automatically assigns an existing sponsor agreement to the new owner.

Noncompliance

If there is any failure to comply with Program requirements, or there is fraud, waste, abuse, or similar fault, HHS can recoup or withhold funds, terminate or deny an application, or take any combination of these actions. Other Federal laws or consequences may also apply

Recommended Next Steps

Employers with health plans that cover early retirees need to move very quickly to evaluate their claims experience and determine whether it makes sense to apply for certification under the Program. A single early retiree with aggregate claims exceeding $90,000 in a plan year would generate a $60,000 reimbursement. Due to the temporary nature of the Program, limited funding available, and the detailed application process this decision should be made as quickly as possible. Employers should keep in mind, however, that due to Program funding limits, there is no guarantee that their application will be approved or that their anticipated reimbursements will be realized.

Once the decision is made to participate in the Program, the employer should:

- Policies and Procedures. Ensure it has programs and procedures in place to generate cost savings with respect to chronic and high-cost conditions, and to address fraud, waste, and abuse in the Program.
- Disclosure Agreement. Draft and have the appropriate agreement in place to require disclosure of required information to HHS. Because PHI disclosure triggers HIPAA concerns, business associate agreements may need to be reviewed to ensure that they address this disclosure obligation.
- Sponsor Agreement. Execute a sponsor agreement with HHS.
- Use of Reimbursements. Determine the manner in which it will use reimbursements to reduce plan costs.
- Submit an application to HHS – Time is of the Essence. Application forms should be available from HHS in early June 2010.
- Track Costs. Put procedures in place to (1) track benefit costs incurred by and for early retirees, (2) document costs paid by the early retirees, and (3) file for reimbursement when cost thresholds are exceeded.
- Record Maintenance. Ensure that it maintains the appropriate records to satisfy the records maintenance requirements.
- Tax and Accounting. Determine the appropriate tax and accounting treatment for Program reimbursements. PPACA provides that reimbursements are not included in the gross income of the sponsor; however, it is less clear whether sponsors that are taxable entities can currently deduct health plan costs that are or will be submitted to HHS for reimbursement.

If you have questions regarding the Early Retiree Reinsurance Program:

- Complete information on ERRP is available from HHS at http://www.hhs.gov/ociio/regulations/index.html ,
- For additional information on the application process, please see the Aon Alert: Health care Reform: Early Retiree Reinsurance Program Application included in this package,
- For advice on the application process, you may need to consult with a benefits advisor, actuary or consultant,
- For general questions, please contact Walter E.Norman, TLC Program Manager at (804) 786-6460 or via email at walter.norman@dhrm.virginia.gov, or
- For claims submission data, please contact Jim Rogers at Aon Consulting at (804) 320-8438 or via email at james.rogers@aon.com.