

**ALERT:
HEALTH CARE REFORM BILL**

May 2010 – Vol. 3, No. 7

www.willis.com**IT'S A START:
GUIDANCE ON THE EARLY
RETIREE REINSURANCE PROGRAM**

Interim final regulations issued on May 5, 2010 describe the operation of the early retiree reinsurance program called for in the recently enacted health care reform law. Although the regulations do not provide the anxiously anticipated procedure for application, they do address other requirements such as the conditions to be met in order to qualify for the new subsidy.

BACKGROUND

The Patient Protection and Affordable Care Act (signed into law on March 23, 2010) directed the Department of Health and Human Services (HHS) to establish an early retiree reinsurance program (ERRP) providing reimbursement to participating employment-based plans for certain retiree health benefits coverage. The ERRP will reimburse 80% of the costs of all the claims paid by or for a plan participant that are between \$15,000 and \$90,000 for the plan year. Employers are understandably anxious to apply for ERRP reimbursement.

The purpose of the ERRP is to encourage sponsors to maintain retiree health programs, especially for early retirees not yet eligible for Medicare, until the state-based health insurance exchange programs become operational in 2014. It's expected that, by then, there will be a marketplace for pre-Medicare eligible early retirees to obtain affordable insurance without the fear of medical underwriting and pre-existing condition exclusions. Temporary in nature, the program is anticipated to be in place by June 1, 2010 and expire no later than January 1, 2014. As the program has a limited funding of \$5 billion dollars, it may end sooner than 2014 if the allocated funds are depleted. Thus, it is dubbed a "first-come-first-served" program and, as such, employers should be prepared to step up to the plate as soon as applications are available.

WHO CAN PARTICIPATE?

The regulations specify that the entity that is eligible to obtain reimbursement from the ERRP is the "sponsor" of a certified employment-based plan. A "sponsor" is an entity that establishes or maintains a group health plan, whether fully or self-insured. While federal governmental plans are excepted from the program, church, state or local governmental plans are included. In addition, VEBAs, committees or boards of individuals appointed to administer a plan, employee organizations, multi-employer plans, and private employers are all eligible for reimbursement under the program. Ultimately, sponsor means the employer for most plans.

Sponsors may receive reimbursements for claims of any early retiree, meaning someone who is age 55 or older, ineligible for Medicare and not an active employee of the employer sponsoring the plan in which the individual participates. The term early retiree also includes the covered spouse, surviving spouse, and dependents of an early retiree, regardless of their

age. Whether an individual is an active employee or a dependent is determined solely by the sponsor in accordance with the terms of the plan.

REQUIREMENTS TO PARTICIPATE

Only sponsors of eligible employment-based plans can receive reimbursements under the program. A group health plan is an eligible employment-based plan if it provides benefits to early retirees, is certified by HHS and provides documentation of the actual cost of medical claims involved.

There are additional requirements in order to participate in the program which are also a part of the application process (more about the application process later in the *Alert*). As mentioned the sponsor must be certified, which means that the sponsor and its plans have met all of the requirements to be outlined and approved by the Secretary. Certification is part and parcel of the application process.

The first condition for participation – providing benefits to early retirees – is straightforward. The plan need not provide benefits exclusively to early retirees (it can include active employees and older retirees). The HHS certification requirement is met by submitting an application that HHS approves (more about the application process later in the *Alert*). To successfully complete the application process, the sponsor must meet some additional requirements.

For one, the plan sponsor must implement programs and procedures that generate, or have the potential to generate, cost savings for participants with chronic and high-cost conditions (those for which claims of \$15,000 or more are likely to be incurred during a plan year by one plan participant). Also, the term “implement” should not be interpreted to necessarily mean new programs, they can be procedures that the plan currently has in place which have demonstrated the ability to generate cost savings. The preamble to the

regulations clarifies that it is not expected that a plan have programs/procedures in place for *all conditions*, which likely could exceed \$15,000 in a plan year, but a reasonable approach should be used when identifying such conditions and selecting programs and procedures.

Example of Cost-Savings Program: The plan sponsor determined that diabetes, if not properly managed, could lead to claims in excess of \$15,000 in a plan year for one plan participant. Therefore, the sponsor implemented a program that included aggressive monitoring and behavioral counseling for preventing diabetic complications and possible hospitalization.

In addition to having cost-savings programs, the plan sponsor must put in place a written arrangement allowing disclosures of plan participants’ protected health information (PHI) to HHS. This is because certain claim information must be submitted in order to apply for reimbursement under the program. That information is PHI under HIPAA. Since PHI belongs to the plan, and not the plan sponsor, it may be unlawful for this information to be shared with the sponsor. Thus, there is the requirement that a written agreement exist between the sponsor and the group health plan or health insurance issuer allowing disclosures to be made to HHS as required. It is assumed for fully insured plans that health insurance issuers would draft an agreement for plan sponsors to sign, whereas, for self-insured plans, a modification to the plan sponsor certification required under the HIPAA privacy rules when a plan sponsor obtains PHI from the plan may be sufficient.

Next, the plan sponsor must have policies and procedures in place to detect and reduce fraud, waste and abuse. Although these policies can be maintained by the sponsor, the insurer or the group health plan, the sponsor must attest to their existence, produce them upon request by HHS, and substantiate their implementation.

The plan sponsor must also have a plan for use of any reimbursements received. Sponsors must use the reimbursement to lower costs for the plan or its participants. Sponsors are encouraged to use the reimbursements to reduce not only their costs but costs of plan participants as well by lowering participant costs such as premium contributions, co-payments, deductibles, coinsurance, out-of-pocket costs or any combination of these expenses. Although reimbursements can only be made for claims of a defined early retiree, those funds may be used to lower benefits costs for all plan participants, meaning early retirees, spouses, surviving spouses, dependents and active employees if covered under the plan. The regulations reaffirm the law’s prohibition of using the reimbursements as part of the sponsor’s general assets.

APPLYING FOR PARTICIPATION

Although anxiously anticipated by sponsors, the regulations do not provide, nor has HHS yet issued, application forms. However, the regulations state with specificity what must be submitted in the application. First, only one application, identifying the “plan year cycle” (starting January 1 and ending December 31, for example) per plan is needed. It is strongly recommended that if a sponsor has more than one plan, an application for each plan be completed. An authorized representative (i.e., an individual with legal authority to contractually bind the sponsor) must sign the application and certify its truthfulness and accuracy.

Since applications will be processed in the order they are received, and incomplete applications will be rejected and subject to re-application, a sponsor seeking certification should take extra care in preparing its application. This warning should be especially heeded because HHS has the *ability to deny even application to the program* based on projected or actual availability of the \$5 billion appropriated funding. So the sponsor should ensure it has all of its required policies and procedures, attestation, acknowledgment, summaries and benefit information along with ensuring that all of the “I”s are dotted and “T”s crossed so as to avoid rejection of the application.

In the application process, the regulations refer to the sponsor as an applicant to clarify that, until the application has been certified, there are no privileges of a certified sponsor such as the ability to submit reimbursement requests. Now, as to the actual application, specific information that will be required of applicants includes:

- Applicant’s Tax Identification Number
- Applicant’s name and address
- Contact name, telephone number and email address
- Plan sponsor agreement signed by an authorized representative, which includes:
 - An assurance of a plan sponsor’s written agreement with its health insurance issuer or employment-based plan regarding disclosure of information to HHS and their agreement to disclose, on behalf of the sponsor, information, data, documents, and records to HHS at a time and in a manner necessary for program compliance
 - Acknowledgement that information in the application is being provided to obtain federal funds and that subcontractors have acknowledged that information provided in connection with a subcontract is provided for obtaining federal funds
 - Attestation that policies to detect and reduce fraud, waste and abuse are in place and that any necessary substantiation as to their existence and effectiveness will be produced
 - Summaries of (1) reimbursement use meeting the program requirements, including how sponsor and plan participant costs will be reduced using the reimbursements, how the sponsor will maintain its level of contribution to the plan and programs, and (2) procedures set in place by the sponsor that have generated or have the potential to generate cost savings for chronic and high cost conditions of plan participants
- Projected amount of reimbursements for the first two plan years with specific amounts for each year
- List of all benefits options under the employment-based plan in which any early retiree for whom the sponsor receives program reimbursement may participate
- Any other information the Secretary requires

REIMBURSEMENTS

WHAT IS A CLAIM?

Only costs that are actually incurred (meaning the sponsor becomes responsible for the payment of the claim) and paid (either by the plan, insurer or early retiree) are reimbursable. Thus, reimbursable costs will include deductibles, copayments, or coinsurance, (but not premiums) as long as they can be substantiated by the sponsor and have not otherwise been reimbursed by insurance or some other third-party arrangement. Thus, any expenses that may have been reimbursed through a spouse's or dependent's health FSA would not be reimbursable under the program.

Costs are to be calculated net of any negotiated price concessions, such as discounts, rebates or coupons. If a price concession is not known or not realized until the end of the plan year, and a claim has been reimbursed by HHS, then the plan sponsor will have to notify HHS of the concessions for adjustments to the reimbursement according to procedures to be defined in future guidance. This means HHS may have to be reimbursed or credits would have to be applied to future reimbursement claims.

HOW MUCH CAN BE CLAIMED AND WHEN?

The ERRP provides for reimbursement of 80% of the cumulative costs of health benefits for each early retiree (including claims of the spouse, surviving spouse and dependent) that are between \$15,000 (cost threshold) and \$90,000 (cost limit) in a plan year (these amounts will be indexed for plan years starting on or after October 1, 2011). As noted in the White House's Fact Sheet on the ERRP: "These limits apply and claims are filed for individual's costs. Firms cannot add two or more individuals together to attain the threshold."

For purposes of ERRP, the plan year is the plan's designated plan year, the deductible or limit year used by the plan, the policy year, the sponsor's taxable year, or the calendar year, in that order. Health benefits that are eligible for reimbursement are "medical, surgical, hospital, prescription drug and other such claims as determined by the Secretary." The regulations also clarify that claims for 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 are eligible. Although this is not an exhaustive list of types of reimbursable benefits, it does exclude claims for HIPAA "excepted benefits" which include limited scope dental and vision benefits, as well as long-term care benefits.

The program is intended to be effective as of June 1, 2010. It is important to understand that reimbursement is based only on claims incurred on and after June 1, 2010 that fall between the

cost threshold (\$15,000) and the cost limit (\$90,000). In order that no plan is treated unfairly, the interim final rule provides a transition provision for 2010 plan years that begin before June 1, 2010, such as a calendar plan year. Claims that are incurred before June 1, 2010, up to \$15,000 per early retiree, count toward the \$15,000 cost threshold and the \$90,000 cost limit. At the same time, any amount of claims incurred prior to June 1, 2010 that *exceed* \$15,000 are not eligible for reimbursement and *do not count toward* the cost limit.

EXAMPLE 1 HCR Plan is an early retiree plan with a plan year that starts on April 1 and ends on March 31. HCR paid claims incurred for Retiree A between April 1, 2010 and May 31, 2010 in the amount of \$22,000 (net discounted concessions). HCR then pays \$30,000 for Retiree A claims from June 1, 2010 through November 30, 2010. HCR receives a credit for \$15,000 of A's claims incurred before June 1, 2010 towards the cost threshold for Retiree A for the plan year. *The remaining \$7,000 does not count toward the \$90,000 cost limit.* HCR can then receive reimbursement of 80% of \$30,000 (or \$24,000) of Retiree A's claims from June 1, through November 30, 2010. Retiree A can incur claims up to another \$45,000 through March 31, 2011 for which HCR could seek 80% reimbursement. (\$90,000-\$15,000 [incurred before June 1, 2010] - \$30,000 [incurred from June 1, 2010 through November 30, 2010] = \$45,000)

EXAMPLE 2 Same Company and plan year as Example 1. HCR paid claims incurred for Retiree B between April 1, 2010 and May 31, 2010 in the amount of \$10,000 (net discounted concessions). HCR then pays \$100,000 for Retiree B claims from June 1, 2010 through February 28, 2011. HCR receives credit for \$10,000 of B's claims incurred before June 1, 2010 towards the cost threshold for Retiree B for the plan year. The first \$5,000 in claims incurred on or after June 1 counts toward meeting the \$15,000 claims threshold for Retiree B. HCR receives reimbursement of 80% of \$75,000 (or \$60,000) of Retiree B's remaining claims from June 1 through February 28, 2011. HCR cannot receive reimbursement for Retiree B's claims paid which exceed \$90,000.

HOW ARE CLAIMS SUBMITTED?

Just as application forms have not yet been issued by HHS, neither have claim submission forms been provided. However, the regulations do provide some information on how the process will work. *First and foremost, claims cannot be submitted for reimbursement until the sponsor's program has been approved by HHS.* Next, although claims may not be submitted until the \$15,000 cost threshold is met for an early retiree, when claims are first submitted, the submission will have to include the claims below the \$15,000 cost threshold for the plan year so the sponsor can show that the cost threshold has been met.

All claim submissions must include a list of early retirees, which includes the documentation of actual claim costs, including the health benefit provided, the provider or supplier, the incurred date, the individual for whom the benefit was provided, date and amount of payment (net any negotiated price concessions), the employment-based plan and benefit option under which the health benefit was provided. Sponsors can receive credit for the out-of-pocket costs paid by early retirees only with evidence of payment, such as an actual receipt for payment. Since obtaining such evidence from an early retiree may be difficult, the sponsor may decide to seek, and can only be reimbursed, for the portion of any claims actually paid by the sponsor. The regulations are clear that an insurer can submit claims on behalf of a plan directly to HHS.

APPEALS

Unless appealed in writing within 15 days of receipt, an adverse reimbursement determination is final and binding. An exception exists for an adverse determination based on unavailability of funds, which cannot be appealed. An appeal must specify the issues with which the sponsor disagrees and reason for the disagreement. The

sponsor is permitted to include any supporting documentary evidence it wishes the Secretary to consider. A decision on the appeal is final and binding.

MISCELLANEOUS OBLIGATIONS

Upon request, a plan sponsor must provide documentation, data, information and records related to the ERRP for six years after the end of the plan year in which the claims were incurred, or longer if otherwise required by law.

Failure to comply with the ERRP rules, or a finding of fraud, waste or abuse, can result in the recoupment or withholding of funds, termination or denial of application for program participation, or a combination of these actions. This would be in addition to any other penalties applicable under federal law.

A plan sponsor has the responsibility to report any data inaccuracies under which a reimbursement was made, including inaccurate claim data or negotiated price concessions. At the time this *Alert* was written, the manner and time for this reporting was yet to be provided.

Any sponsor who has an effective sponsor agreement and who is considering or negotiating a change in ownership, must notify HHS at least 60 days in advance of the change. A change in ownership can occur in several ways: removal, addition or substitution of a partner (unless the partners agree otherwise as permitted by state law), an asset sale transferring all or substantially all of the sponsor's assets to another party, or merger of the sponsor's corporation into another corporation or consolidation of the sponsor's organization with one or more corporations, resulting in a new corporation. A transfer of stock or merger of another corporation into the sponsor's corporation with the sponsor surviving generally does not constitute a change of ownership. When a change in ownership results in the transfer of liability for health benefits, an existing sponsor agreement, and all its terms and conditions, is automatically assigned to the new owner.

CONCLUSION

As with most of the health care reform law, although some answers have been provided through this interim final regulation, issues still remain to be addressed. The application is not yet available, the claim process is not finalized, and employers still want to know when they can start to submit claims. The regulatory authorities have begun to provide guidance and as soon as any additional information on the ERRP is available, Willis will communicate it to you.

EMPLOYER ACTION PLAN: GETTING READY FOR EARLY RETIREE REINSURANCE PROGRAM (ERRP)

- Consider whether applying for the ERRP makes sense for the plan (may not make sense for small employers).
 - Fully insured clients should inquire whether the insurance company will handle the application process and submission of claims for reimbursement under the ERRP.
 - Self-insured clients should inquire what assistance the TPA or stop-loss carrier will provide in preparing the application in submitting claims for reimbursement under the ERRP.
- Be prepared to act reasonably quickly when the application form is issued.
- Identify all benefits providing for medical care under the plan and determine whether any coordination between benefit administrators is required (PBM, EAP, HRA).
- Start to compile claim information for early retirees (including spouses, surviving spouses and dependents) for the 2010 plan year. Note: claims must be cumulated for individuals separately.
 - Determine as a plan sponsor whether you will only seek reimbursements for claims for which the plan has paid, thus eliminating the need to seek documentation from plan participants of proof of expenses paid. This would mean deductible, co-pays and coinsurance could not be included as part of the cost of a claim.
- Review the plan design for benefits that cover chronic or high-cost conditions, remember to take into consideration mental and substance use disorders.
 - Obtain and review programs and procedures that generate or have the potential to generate cost savings for chronic and high-cost conditions.
 - Consider disease management and possibly wellness programs.
 - Implement if none are currently in place.
- Have in place the written agreement allowing disclosures of plan participants' Protected Health Information.
 - Fully insured clients should inquire of insurance issuers whether this document has been drafted and is ready for execution.
 - Self-insured clients will need to modify their certifications required under the HIPAA privacy rules.
 - Business Associate Agreements with any vendors as subcontractors will need to be amended to reflect (or acknowledgement otherwise obtained) that information may be obtained from them in order to collect federal funds.
- Obtain or implement policies/procedures to detect and reduce fraud, waste and abuse.
- Have in place or implement the sponsor's plan for reimbursements to lower costs for the plan and/or participants and how the sponsor will maintain its level of contribution to the plan and programs.
- Prepare estimated reimbursements, *with specific amounts*, for the first two plan years.
- Ensure all of the following information is current and correct: Sponsor's name, address, and Tax Identification Number, beginning and ending dates of plan year, list of all benefit options under the plan for which reimbursements may be claimed, and authorized representative.
- Determine the format in which information required to be included as part of a claim will be provided. The following must be included:
 - Provider or supplier
 - Incurred date
 - Individual for whom the health benefit was provided
 - Date and amount of payment (net any known negotiated price concessions)
 - If proof of payment will not be provided by plan participants remember not to include those costs or show them separately as not being paid by the plan
 - Plan and benefit option under which the benefit was provided

KEY CONTACTS

US BENEFITS OFFICE LOCATIONS

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