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LEGAL ALERT

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Preparing for the Early Retiree Reinsurance Program: A Checklist

The Department of Health and Human Services (HHS) has issued an interim final rule implementing the Early Retiree Reinsurance Program established under the Patient Protection and Affordable Care Act (PPACA) that permits sponsors of retiree medical plans to obtain government reimbursements for certain early retirees' benefits. This regulation, which provides for a 30-day comment period ending June 4, 2010, amends title 45 of the Code of Federal Regulations (CFR) Subtitle A, Subchapter B, by adding a new part 149 that describes the requirements for participation in the Program, the methods for reimbursement, procedures for appeals, and certain plan sponsor notice requirements prior to a change in ownership. The White House has also issued a fact sheet regarding the Program.

While the Program provides an opportunity to reduce certain retiree medical costs, the application, submission, and reporting requirements will involve a considerable amount of administrative effort and programming. In addition, the amount available for the Program is expected to be far less than the amounts eligible for reimbursement since plans maintained by state and local governments will be eligible, as well as private employer plans and multiemployer plans. Thus, prior to the June 1, 2010, effective date and the opening of the application process later in June, plan sponsors should weigh the potential benefits associated with participation in the Program against the administrative obligations of the application and submission process.

Background

Section 1102(a)(1) of PPACA establishes a temporary program providing for reimbursement for certain costs paid under employment-based plans covering early retirees. Under the Program, the Secretary of HHS (the Secretary) is directed to reimburse plans for 80% of qualified claims of not less than $15,000 and not more than $90,000 (as indexed beginning as early as 2011) for early retirees who are at least 55 but are not yet eligible for Medicare. The Secretary is required to implement the $5 billion Program no later than June 21, 2010; the Program is slated to end by the earlier of January 1, 2014, or when the appropriated funds are expended.

Understanding that employers are anxious to take advantage of the Program, HHS plans to make the Program effective as of June 1, 2010 – a full three weeks ahead of schedule. The process for receiving reimbursements will begin with an application submitted by the plan sponsor or employer[1] on behalf of the plan. The application process will be similar to the process for requesting reimbursements under the Medicare Part D Subsidy Program. Once the application is approved, the plan sponsor will receive a certification from HHS that will allow the sponsor to begin submitting claims for reimbursement. The HHS regulations set forth many of the requirements for applications and reimbursements but do not include the application form or include all the details of the reimbursement process. The application itself and instructions for seeking reimbursement are expected to be available by mid to late June.

[1] Reimbursement is requested and received by the employer, as opposed to the plan sponsor, only in the case of a plan maintained jointly by an employer and an employee organization for which the employer is the primary source of financing.

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Application Requirements for the Program

To participate in the Program, a plan must:

- ☐ Be certified by HHS prior to submitting any claims.
- ☐ Include programs and procedures that have generated, or have the potential to generate, cost savings for chronic and high-cost conditions.

In addition, a plan sponsor must:

- ☐ Be prepared to make information, data, documents, and records available to HHS as specified in the regulations.
- ☐ Have a written agreement with the insurer or the plan regarding the disclosure of information, data, documents, and records necessary to comply with the Program, and the insurer or the plan must agree to disclose that information in compliance with the regulations.
- ☐ Ensure that it has implemented policies and procedures to protect against fraud, waste, and abuse under the Program, and comply with any request from HHS to produce these policies.
- ☐ Submit an application to HHS as described below, and have the application approved by HHS prior to requesting any reimbursement.
    - o The application must be signed and certified by an authorized representative of the plan sponsor. The authorized representative must be someone with the authority to bind the plan sponsor (not the plan) to a contract or agreement.
    - o Applications will be processed in the order in which they are received. Given the first-in, first-out nature of the approval process and the limited availability of funds for the Program, plan sponsors must be prepared to submit complete applications as quickly as possible. Incomplete or inaccurate applications will be denied, and the plan sponsor will need to submit a new application. There will be no opportunity to cure defects in the original application. However, the preamble to the regulations indicates that HHS will be willing to discuss the application requirements with plan sponsors to assist them in submitting complete and accurate applications.
    - o The plan sponsor must submit a separate application for each plan, but need not submit a new application each year. The application must identify the plan year start and end date cycle (for example, 1/1-12/31) for which the plan sponsor is applying.
    - o The application must include the plan sponsor's tax identification number, name and address, contact information, and a plan sponsor agreement stipulating to the disclosure of applicable information and documents to HHS. The plan sponsor agreement must also include: (1) a certification that the plan sponsor acknowledges that the application is being used to procure federal funds (and that subcontractors acknowledge the same); (2) an attestation regarding the plan sponsor's policies and procedures to detect and reduce fraud, waste, and abuse; and (3) an agreement to produce both these procedures and information to substantiate the existence of the policies and their effectiveness to HHS.
- ☐ The plan sponsor's application must include a summary regarding the plan sponsor's intended use of the reimbursement to reduce participant and/or sponsor costs. The plan sponsor also must describe how the sponsor will use the reimbursement to maintain its level of contribution to the plan. (The preamble to the rule implies that this "maintenance of effort" with respect to employer contributions is required to continue participation in the Program.) In addition, the summary must include a description of the programs in place to generate cost savings for plan participants with chronic and high-cost conditions.

- The regulations define the term "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 any one participant in the plan based on past claims experience.
- Sponsors need not develop cost-saving programs for every such condition, but should take a reasonable approach toward identifying such conditions and selecting appropriate programs. The regulations use as an example a diabetes management program that includes aggressive monitoring and behavior counseling to prevent complications and unnecessary hospitalizations. Any existing programs targeting high-cost or chronic conditions may meet this criterion; the plan is not required to implement new programs.
- On audit, the sponsor must be able to demonstrate that the programs have generated cost savings or at a minimum have the potential to generate cost savings.
- Note that staffers at the Equal Employment Opportunity Commission (EEOC) have indicated they have concerns whether certain disease management programs comply with the Americans with Disabilities Act, but the EEOC has taken no formal position on this issue as of now.

☐ The application must project the amount of reimbursements to be received under the Program for each of the first two plan cycles. Note that this will require the sponsor to begin an immediate review of past-years' claims; plan sponsors should attempt to be as accurate as possible, because it is unclear how this projection will affect the level of reimbursement made available to the plan sponsor. There has been some speculation that HHS may use these projections by early applicants as a basis to cut off approval of later applicants.

☐ The application must include a list of all benefit options under the plan for which early retirees are eligible. A benefit option is defined as a particular benefit design, category of benefits, or cost-sharing arrangement offered under the plan.

☐ The application must include any other information required by the Secretary.

As noted above, the actual application will be available in mid to late June, and we understand that it will be similar to the application for the retiree drug subsidy under Medicare Part D.

Funding Limitations

HHS will deny or stop accepting applications, and may deny reimbursements, based on the actual or projected availability of program funding. The decision by HHS is final and not appealable.

Amount of Reimbursement

Under the rule, a plan sponsor may receive a reimbursement of up to 80% of the costs for medical claims between $15,000 and $90,000 during the plan year (for plan years that start before October 1, 2011)[2] that are paid by the plan and the early retiree on behalf of the retiree (in the form of deductibles, copayments, etc.). Claims include medical, surgical, hospital, and prescription drug claims. Costs that are reimbursed to the retiree, or a person or entity paying costs on behalf of the retiree, are not eligible for reimbursement under the Program. In addition, any price concessions negotiated by the plan or the insurer are not reimbursable. Plan sponsors may be required to disclose the amount of any post-point-of-sale price

[2] These amounts are adjusted for plan years that start on or after October 1, 2011, based on the percentage increase of the Medical Care Component of the CPI-Urban, rounded to the nearest multiple of $1,000.

concessions received but not accounted for in claims that have been already submitted. For insured plans, reimbursable costs include costs the insurer and the early retiree pay; the amount of premiums the plan sponsor pays, and the amount of the retiree's premium contribution, are irrelevant for purposes of calculating the reimbursement under the Program.

An "early retiree" is anyone who is 55 or older but is not eligible for Medicare, and is not receiving coverage from the employer due to current employment status pursuant to the Medicare Secondary Payer rules. Claims made by the retiree's spouse, surviving spouse, or dependents[3] (collectively with the early retiree, the "plan participants") are also eligible for reimbursement. Each retiree has one cost threshold ($15,000) and one cost limit ($90,000) per plan year, regardless of the number of benefit options in which the retiree is enrolled.

The guidance provides specific rules for "transition" claims – claims incurred before June 1, 2010, but after the beginning of the current plan year. These claims are not reimbursable under the Program, but may be counted toward the $15,000 cost threshold. Plan sponsors will need to examine claims incurred between the first day of the plan year and June 1, 2010, to determine which retirees may have reached the threshold. Only claims incurred on or after June 1, 2010, are actually reimbursable, and then only to the extent that the claims fall between $15,000 and $90,000 for the plan year.

Use of Reimbursements

Prior to the release of the regulations, it was unclear whether plan sponsors could use Program reimbursements for any purpose other than to reduce participant costs. However, the rule makes clear that a plan sponsor may use the proceeds to: (1) reduce the plan sponsor's health benefit premiums or health benefit costs; (2) reduce the health benefit premium payments, copayments, deductibles, coinsurance, or other out-of-pocket costs (or any combination thereof) for participants; or (3) for any combination of (1) or (2). While the rule clarifies that the plan sponsor retains a considerable amount of flexibility as to the use of reimbursements, sponsors should keep in mind that the application process requires that the plan sponsor certify its intended use of the proceeds in the application. This will require some forethought and a considerable amount of planning even prior to submitting an application to participate in the Program.

Reimbursement Methods

After submitting an application and having the application approved by the Secretary, the plan sponsor may begin submitting claims for reimbursement for that plan year. The time and manner for the actual submission of claims are not specified in the guidance – however, it is expected that detailed instructions will be released in mid to late June. Submitted claims must:

- ☐ Actually be incurred and paid during the plan year. Pending claims are not eligible for reimbursement until either the plan or the insurer has paid the claim.
- ☐ Include claims that fall below the $15,000 threshold, even though these claims are not reimbursable.

[3] "Dependent" is defined in the same manner as this term is defined under the applicable plan, regardless of whether the person constitutes a dependent under Internal Revenue Code section 152 or state tax statutes.

- ☐ Only be submitted after total costs for health benefits paid for the early retiree for that plan year have reached or exceeded $15,000. Also, once submitted claims for the early retiree have reached the $90,000 threshold, the plan sponsor may not submit additional claims for that retiree.
- ☐ Consist of a list of early retirees for whom claims are being submitted, and documentation of actual costs of the items and services for claims being submitted, in a form and manner to be prescribed by the Secretary.
- ☐ Include prima facie evidence that the retiree paid his or her portion of the claim (for instance, a receipt) if the submission includes claims paid by the retiree.

For insured plans, this information may be submitted directly by the insurer. However, self-insured plan sponsors must presumably collect this information in the format required by the regulations and other guidance, and must submit it to HHS. This process will require considerable cooperation between the self-insured plan's claims administrator and the plan sponsor, and will require a deft navigation of the plan's HIPAA privacy policies. The rule recognizes that much of the requested claims information will be protected health information (PHI) not readily accessible by the plan sponsor, but contemplates that the data will be subject to disclosure by HIPAA Business Associates under HIPPA's "as required by law" disclosure requirement. The regulations do not authorize the disclosure of PHI to plan sponsors. Self-insured plan sponsors should begin discussions with their counsel and with claims administrators in order to design adequate compliance procedures. Finally, plan sponsors will be required, and must require the plan or the insurer, to maintain reimbursement records for six years after the expiration of the plan year for which the reimbursement is submitted, or longer if otherwise required by law.

Appeals

A plan sponsor may appeal an adverse reimbursement determination by HHS unless the denial by HHS is based on the unavailability of funds. Appeals must be submitted within 15 calendar days of the receipt of the denial, and must specify the finding or issues with which the plan sponsor disagrees along with any supporting documentary evidence. The statute does not provide a time limit for the response by HHS to a request for appeal. HHS decisions on appeal are final and binding.

Mandatory Disclosure of Data Inaccuracies

The regulations provide that, if a plan sponsor determines that certain claims data used to request a reimbursement is inaccurate, the plan sponsor must disclose the inaccuracies to HHS in a manner and at a time to be determined under future guidance. HHS has the authority to reopen and revise a reimbursement determination for any reason within one year of the reimbursement determination, for "good cause" (not to include a change in law or guidance) within four years of the determination, or at any time in instances of fraud or similar fault.

Notice of Change in Ownership Requirements

Finally, the regulations require that, in the event of any corporate transaction involving the plan sponsor (other than a pure stock sale or a merger in which the plan sponsor is the surviving entity), a participating plan sponsor must notify HHS at least 60 days before the anticipated effective date of the transaction. In addition, if there is a change in ownership of the plan sponsor in which liability for health benefits transfers, the existing sponsor agreement is automatically assigned to the new owners, and the new owner becomes subject to all applicable statutes and regulations and to the terms of the plan sponsor's

original Program agreement with HHS. The rule gives HHS the authority to recover any funds paid to the plan sponsor under the Program if the plan sponsor fails to notify HHS of the transaction.
Given the temporary nature of the Program, and the inherent uncertainty regarding most corporate transactions, the notice, mandatory assignment, and "claw back" requirements may be significant for employers, particularly those anticipating asset-based transactions. A plan sponsor who chooses to participate in the Program will need to take immediate steps to coordinate with the employer's corporate function regarding this aspect of the rule.

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