United Actuarial Services, Inc.
Actuaries and Consultants

2010-33

May 5, 2010

CLIENT BULLETIN

HHS Releases Regulation On Early Retiree Reinsurance Program

On May 5, 2010, the Department of Health and Human Services (HHS) published in the Federal Register (75 FR 24450) an interim final rule on the Early Retiree Reinsurance Program established under the health care reform laws. It appears that the two laws are being referred to collectively as "The Affordable Care Act" and we adopt that terminology. The regulation as published in the Federal Register is available by "*clicking here*" or at *http://edocket.access.gpo.gov/2010/pdf/2010-10658.pdf.* A copy of just the regulation is available *by* "*clicking here.*"

For more on the health care reform laws see *Client Bulletins 2010-26, 2010-28, 2010-30* and *Benefit News Briefs 2010-32*.

HHS also released a revised Fact Sheet on the Early Retiree Reinsurance Program which notes **that the Early Retiree Reinsurance Program will begin on June 1, 2010**, in advance of the June 21 start date required by the Affordable Care Act.

The details of the program are contained in the regulation, which is effective June 1, 2010 and discussed below. The Fact Sheet mentioned above is available by "*clicking here*" or at *http://www.whitehouse.gov/the-press-office/fact-sheet-early-retiree-reinsurance-program.* The Fact Sheet also clarifies the regulation by noting:

- Employers who are accepted into the program will receive reinsurance reimbursement for medical claims for retirees age 55 and older who are not eligible for Medicare, and their spouses, surviving spouses and dependents.

- Health benefits that qualify for relief include medical, surgical, hospital, prescription drug, and other benefits that may be specified by the Secretary of HHS, as well as coverage for mental health services.

- The amount of this reimbursement to the employer plan is up to 80% of claims costs for health benefits between $15,000 and $90,000. Claims

Prepared by Mike Ewing, J.D.
Director of Research
United Actuarial Services, Inc.
(317) 580-8659 • Fax (317) 580-8651
email: mewing@unitedactuarial.com
© United Actuarial Services, Inc. 2010

incurred between the start of the plan year (often January 1) and June 1st are credited towards the $15,000 threshold for reimbursement. However, only medical expenses incurred after June 1, 2010 are eligible for reimbursement under this program.

For example: If **an individual** incurs costs of $30,000 between the start of the plan year and June 1, and $40,000 after that date. The amount which may be reimbursed is $40,000 – the costs above the $15,000 threshold that occur after June 1.

If a plan incurs $90,000 or more in expenses before June 1, it is treated as having met the $15,000 threshold and is eligible for reimbursement for costs incurred after June 1.

- **These limits apply and claims are filed for *individual's costs*. Firms cannot add two or more individuals together to attain the threshold.**

- Both self-funded and insured plans can apply, including plans sponsored by private entities, state and local governments, nonprofits, religious entities, unions and other employers.

A Look at the Regulations

We will take a quick look at the regulation. We expect additional operational clarification as the application process is rolled out. The following discussion is drawn from the *Preamble* to the regulation.

To give one a bird's eye view, we would note the regulation has 8 subsections. We will discuss highlights of several sections, skipping most of Subparts F-H.

Subpart A – *General Provisions*
Subpart B – *Requirements for Eligible Employment-based Plans*
Subpart C – *Reinsurance Amounts*
Subpart D – *Use of Reimbursements*
Subpart E – *Reimbursement Methods*
Subpart F – *Appeals*
Subpart G – *Disclosure of Inaccurate Data*
Subpart H – *Change of Ownership Requirements*

As a refresher, the *Preamble* notes the interim final rule implements the Early Retiree Reinsurance Program, which was established by Section 1102 of the Patient Protection and Affordable Care Act (the Affordable Care Act). Congress appropriated funding of $5 billion for the temporary program which must be established by June 21, 2010 and ends no later than January 1, 2014. The program provides reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents for certain claims between $15,000 and $90,000.

Definitions

We will look at a few of the important definitions contained in Subpart A. The *Preamble* notes the statute requires employment-based plans to have programs and procedures in place to generate cost savings <u>for participants</u> *with "chronic and high-cost conditions."*

"chronic and high-cost conditions"

The regulation defines the term *''chronic and high cost condition''* to mean a condition for which $15,000 or more in health benefit claims are likely to be incurred during a plan year **<u>by any one participant</u>**. The *Preamble* explains that Plan Sponsors participating in this program are likely to be sponsors that will recognize which conditions are likely to result in $15,000 in claims in a plan year **<u>for one participant</u>**.

While HHS expected that employment-based plans will have programs and procedures in place that have generated or have the potential to generate savings for participants with these *"chronic and high cost conditions''*, HHS does not expect plans to have programs and procedures in place for <u>all</u> conditions for which claims are likely to exceed $15,000 in a plan year for <u>a plan participant</u>. The regulations do NOT require that plans have programs and procedures in place to address <u>all</u> chronic and high-cost conditions. HHS expects Plan Sponsors to take a reasonable approach when identifying such conditions and selecting programs and procedures to lower the cost of such care, and improve the quality of care for such conditions.

"claim or medical claim"

The regulation defines *''claim''* or *''medical claim"* in order to lay out in more detail what is required on the claim to be reimbursed under this program, and to note that the terms *''claim''* or *''medical claim''* include medical, surgical, hospital, prescription drug and other types of claims as determined by the Secretary.

"health benefits"

The regulation defines *''health benefits''* as such benefits including 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.

"early retirees"

The regulation defines *''early retirees''* as individuals who are age 55 and older but are not eligible for coverage under Medicare, and who are not active employees of an employer maintaining, or currently contributing to, the employment-based plan or of any employer that has made substantial contributions to fund such plan. The regulation clarifies that spouses, surviving spouses and dependents are also included in the definition of "early retiree", consistent with the statute. This definition allows reimbursement for the health benefit costs of eligible spouses, surviving spouses and dependents of such retirees, even if they are under the age of 55, and/or are eligible for Medicare.

Other definitions are discussed in the regulations and plan professionals involved in the program should review such definitions closely.

The Application

Once the application process is more defined and in place, we will have a better idea of the process. It is supposed to be like the Part D drug subsidy process. Until then, as part of the discussion of definitions, the *Preamble* notes that statute requires the Plan Sponsor to submit ''*an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require*.'' In order to implement this provision, a Plan Sponsor must:

- submit one application per plan, and
- identify the plan year cycle for which the sponsor is applying (that is, starting month and day, and ending month and day; no year is required).

One application must be filed for each plan. Filing a different application for each plan will aid HHS in tracking the plan as this program progresses to ensure proper reimbursement and compliance with program requirements. In order to verify the accuracy of the information contained in the application, the application will have to be signed by an authorized representative of the applicant and the authorized representative will have to certify that the information contained in the application is true and accurate to the best of the authorized representative's knowledge and belief, among other certifications.

An application for a given plan does NOT have to be submitted each year. To require a separate application for a plan each year would only complicate the process and would place unneeded burden on applicants and HHS. The application will request the plan year cycles (that is, the start month and day and the end month and day; no year required). Once a plan is certified, the application approved, and the Plan Sponsor continues to meet the requirements of the statute, the Plan Sponsor will continue to be certified and the application approved.

The application must include:

- the applicant's Tax Identification Number (TIN),
- the applicant's name address and contact information,
- a summary of how it will use the reimbursement to meet the requirements of the program, including how it will use the reimbursement to reduce plan participant or sponsor costs, or any combination of these costs, and its plans to implement programs and procedures to generate savings for plan participants with chronic and high cost conditions, and
- a projection of the reimbursement amounts for the first two plan-year cycles.

The application will also require applicants to identify all benefit options under the employment-based plan that any early retiree, for whom the applicant may receive program reimbursement, may be claimed on and requires Plan Sponsors to attest that there are fraud, waste and abuse policies and procedures in place. The application may request other information as determined to be relevant.

HHS expects that Plan Sponsors will use the reimbursement to pay for increases in, the Plan Sponsor's contribution *increases*, or *increases* in other health benefit costs (or to *reduce* plan participants' costs). Therefore, the Plan Sponsor's summary of how it will use the program's reimbursement must also explain how the reimbursement will be applied to maintain the Plan Sponsor's level of effort in contributing to support the applicable plan. For example, the *Preamble* notes HHS encourages Plan Sponsors to use their reimbursement under the program for both of the following purposes: (1) to *reduce increases* in the Plan 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.

HHS expects that Plan Sponsors will continue to provide at least the same level of contribution to support the plan, as it did before this program.

While the Plan Sponsor may only receive Early Retiree Reinsurance Program funds for claims of early retirees or their spouses, surviving spouses or dependents, the reimbursements may be used to lower health benefit costs for **all** participants in the plan, including retirees, and their spouses and dependents, and active employees and their spouses and dependents.

HHS does NOT expect an explanation of every detail of the program and procedures and use of program funds but enough detail to give HHS an idea of how the plan will meet these requirements. HHS understands that these submissions may vary because applicants' situations with respect to their plans may vary widely. For example, reimbursements received in the first year may be applied to the second year of participation because many plans will have already been negotiated, agreed to, and implemented upon the effective date of this regulation. Other sponsors may have more flexibility to use these reimbursements immediately to lower costs.

As is required in the RDS program, as a condition of participation, the Plan Sponsor will be required to sign a Plan Sponsor agreement, which will include certain assurances made by the Plan Sponsor. Included in this agreement will be a provision stating that reimbursement is based on information and data submitted by the sponsor and if the information and data are found to be inaccurate, incomplete or otherwise incorrect, the Secretary may reopen and revise a reimbursement determination, including recouping reimbursement from the sponsor. The sponsor will be required to specifically agree to comply with the terms and conditions for participation in the program, and acknowledge that information in the application is being provided for the purpose of obtaining federal funds.

Calculation Of The Reimbursement Amount

The regulation refers to the $15,000 lower limit and the $90,000 ceiling as the ''cost threshold'' and ''cost limit'', respectively, and indicates that reimbursement under the program is calculated by first determining the costs for health benefits net of negotiated price concessions, within the applicable plan year for each early retiree, and then subtracting amounts below the cost threshold and above the cost limit within the applicable plan year for each early retiree.

The *Preamble* clarifies that for purposes of determining the amounts below the cost threshold and above the cost limit for any given early retiree, all costs for health benefits paid by the plan or by the early retiree for all benefit options the early retiree is enrolled in with respect to a given certified employment-based plan for a given plan year, will be combined. The *Preamble* further clarifies that the total claims for the individual do not have to be between $15,000 and $90,000 to be reimbursed but that reimbursement is limited to claims falling in that range.

Accordingly, HHS will allow Plan Sponsors to apply for plan years that start before June 1, 2010, provided they end after that date (for example, calendar year 2010 plans). Plan Sponsors can also apply for plan years that start after June 1, 2010.

The *Preamble* explains how claims incurred during such a plan year, but before June 1, 2010, would be dealt with under the program. For claims incurred before June 1, 2010, the amount of such claims up to $15,000 count toward the cost threshold and the cost limit. The amount of claims incurred before June 1, 2010 that exceed $15,000 are not eligible for reimbursement and do not count toward the cost limit. The reinsurance amount is based solely on claims incurred on and after June 1, 2010 that fall between the cost threshold/cost limit for the plan year.

As an example: a plan with a plan year running from July 1, 2009 to June 30, 2010 has an early retiree for which it has spent $120,000 in health benefit claims before June 1, 2010. The plan then spends another $30,000 in health benefit claims on the early retiree between June 1, 2010 and June 30, 2010. The Plan Sponsor would receive credit for $15,000 in claims incurred before June 1 and receive reimbursement of 80% of the $30,000 of the claims incurred after June 1, 2010.

Appeals

Due to the limited funding and temporary nature of the program, HHS has established a one-step appeal process. A Plan Sponsor may appeal directly to the Secretary within 15 calendar days of receipt of the determination at issue. The request for appeal must specify the findings or issues with which the sponsor disagrees and the reasons for the disagreements. The request for appeal may include supporting documentary evidence the sponsor wishes considered.

For the Future

We will report when more information and/or the application is available for this program. In the Interim, Plan Sponsors may wish to identify qualifying claims.

BONUS:

The House Office of the Legislative Counsel (HOLC) has prepared an integrated version of the health care reform laws. It is not an official document of the House of Representatives or its committees but may be useful when wading through the labyrinth of the laws and is available by *"clicking here."*

* * *

LEGAL DISCLAIMER: Information contained in this publication is not legal advice, and should not be construed as legal advice. If you need legal advice upon which you can rely, you should seek a legal opinion from your attorney.