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Employee Benefits Briefing

Retiree Reinsurance Regulations Issued: Program Effective June 1, 2010

On May 4th, the Department of Health and Human Services (HHS) issued interim final regulations relating to the retiree reinsurance program (the "Program") that was contained in the Patient Protection and Affordable Care Act (the "Act").

Although employers cannot apply for certification by HHS until the application form is issued (anticipated in late June), employers should be preparing the necessary information now in order to be able to move quickly when the application is available.

Background

The Program will be the first major piece of the Act to become effective and is designed to provide $5 billion in reimbursements for retiree medical claims between June 2010 and the end of 2013 (or until all funds are expended, if earlier). It applies to employer plans covering retirees who are between the ages of 55 and 64, and their eligible dependents. The Program generally provides for reimbursements of 80% of the costs incurred for eligible claims each plan year between $15,000 and $90,000. The statute requires plan sponsors that participate in the Program to implement cost containment programs for participants with chronic and high-cost conditions, and otherwise requires plan sponsors to file for reimbursement in accordance with the requirements of HHS. The statute also requires plan sponsors that receive reimbursements to use the proceeds to reduce health care premiums and/or reduce costs to participants.

Regulations

The regulations detail the following requirements of the Program:

- Who is an eligible early retiree and who is an eligible dependent?
- What are eligible expenses?
- How is the $15,000 threshold and $90,000 maximum applied?
- What programs and policies must a plan sponsor have in place to generate cost savings for participants with chronic and high-cost conditions?
- What other programs or policies must the plan sponsor have in place?
- How are reimbursements to be used by the plan sponsor?
- What is the application process?
- When can claims be submitted, and how will they be processed?

The remainder of this Briefing describes these questions and provides suggested next steps.

Eligible Early Retirees and Dependents

An eligible retiree is a former employee who is not receiving medical coverage by reason of current employment status.

The term "early retiree" includes the retiree's eligible spouse, surviving spouse and dependents of the retiree, even if they are under age 55 and/or

are eligible for Medicare. In other words, the term "early retiree" refers to both the individual retiree and his/her covered family members regardless of the ages of the covered family members.

Eligible Expenses

Expenses eligible for reimbursement are those incurred by the early retiree on and after June 1, 2010.

Reimbursements are based on plan year health care expenses incurred by early retirees. Expenses that are eligible for reimbursement are expenses for the diagnosis, cure, mitigation, or prevention of physical or mental disease or condition with respect to any structure or function of the body. These are the type of expenses typically associated with a major medical plan.

Expenses for items that typically are not part of a major medical plan are not reimbursable. For example, expenses for long-term care benefits are not reimbursable. Similarly, expenses under stand-alone dental and vision plans are also not reimbursable.

For purposes of the Program, a medical claim is incurred when the plan sponsor, health insurance issuer, group health plan or plan participant become responsible for payment of the claim. This appears to be when the services are performed.

Application of the $15,000 Threshold and $90,000 Maximum

Expenses incurred by the early retiree during the plan year before June 1, 2010 count toward satisfying the $15,000 threshold, but are not eligible for reimbursement. For example, if the plan year is a calendar year, expenses incurred between January 1, 2010 and May 31, 2010 will count toward satisfying the $15,000 threshold, but only expenses incurred between June 1, 2010 and December 31, 2010 are eligible to be reimbursed.

Similarly, if the plan year is a July 1 fiscal year, expenses incurred from July 1, 2009 through May 31, 2010 count toward satisfying the $15,000 threshold, but only the expenses incurred between June 1, 2010 and June 30, 2010 are eligible to be reimbursed for the plan year ending on June 30, 2010. Expenses incurred on and after July 1, 2010 will be eligible to be reimbursed during the plan year ending on June 30, 2011 if the new $15,000 threshold for that plan year is satisfied.

Because expenses incurred by eligible retirees and their eligible dependents are aggregated under the Program, there is only one $15,000 reimbursement threshold and one $90,000 claim cap per early retiree per plan year. Thus, if an eligible retiree and his/her spouse each incur $50,000 in eligible expenses during a plan year, those two amounts are added together, so the maximum that can be reimbursed for that retiree is $60,000 (i.e., [$90,000 - $15,000] x .8 = $60,000).

Expenses that are eligible for reimbursement are health care costs *actually paid* by the plan and the early retiree. For insured plans, the amount of premium the sponsor pays (and the amount of premium contribution the early retiree pays) is irrelevant for purposes of calculating reimbursement under the program. Rather, the determination is based on the costs the insurer and the early retiree pay for health benefits (net of negotiated price concessions the insurer receives for health benefits).

Cost-Savings Programs

A plan sponsor must, as a prerequisite for participating in the Program, implement programs and procedures that have generated or have the potential to generate cost savings for participants with chronic and high-cost conditions. In this regard, chronic and high-cost conditions are those that are expected to generate $15,000 or more in claims each year for a participant. The key concept here is that cost savings must inure to the benefit of the participants, and only indirectly to the plan sponsor through lower hospitalization charges and other major expenses.

The regulations contain two examples of such procedures. The first example relates to a plan sponsor implementing programs to reduce the costs to the participant of chronic diabetes by

implementing a diabetes management program that includes aggressive monitoring and behavioral counseling to prevent complications and unnecessary hospitalization.

The second example relates to programs that try to reduce the costs to participants associated with cancer treatments by paying all or a large portion of the participant's coinsurance or copayments and/or eliminating or reducing the plan's deductible for treatment and visits related to cancer.

Although the regulations do not contain other specific examples, they note that the examples are not exclusive. Plan sponsors may choose other chronic and high-cost conditions to address. The regulations state that a plan sponsor must take a reasonable approach to identifying which conditions it addresses. Also, these programs and procedures do not need to be newly implemented (existing programs can satisfy this requirement). Upon audit, the employer must be able to demonstrate that its programs and procedures have generated or had the potential to generate cost savings to participants.

Other Procedures and Policies

A plan sponsor must also have in place policies and procedures to detect fraud, waste and abuse, and must be able to provide HHS with data to substantiate the effectiveness of these policies and procedures.

In addition, the plan sponsor must have a written agreement with the plan (for self-insured plans) or with the health insurer (for insured plans) requiring the plan or health insurance issuer to disclose information on behalf of the plan sponsor to HHS in connection with the Program.

Use of Reimbursements

The regulations do not dictate exactly how plan sponsors are to use reimbursements. Rather, plan sponsors are encouraged to use their reimbursement under the Program for both of the following purposes: (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.

The preferred approach appears to be to lower costs for participants. The reimbursements may be used to lower health benefit costs for all participants in the plan, including retirees, and their spouses and dependents, as well as active employees and their spouses and dependents.

HHS expects that plan sponsors will continue to provide at least the same level of contribution to support the applicable plan as it did before the Program. For example, if a plan is insured, the plan sponsor may use the reimbursements to pay any increase in premiums from year to year (which will reduce the sponsor's future premium costs). However, it does not appear that reimbursements can be used directly to reduce current year premiums for the plan sponsor (or reduce future premiums below current levels). Similarly, it does not appear that employers with self-funded plans may use reimbursements to offset current expenses that would otherwise be borne by the employer. Again, it appears that if reimbursements are to be used to reduce plan sponsor expenses, they may only be used to reduce future increases in benefits.

Application Requirements

The plan sponsor is the entity that must apply for and receive reimbursements under the Program. This is similar to the reimbursement procedure under the Medicare Part D subsidy. A plan sponsor must submit an application for each plan for which it will seek reimbursement. The following items must be contained in the application:

- Plan sponsor's tax identification number; plan sponsor's name and address; and contact name, telephone number and e-mail address.
- Plan sponsor agreement. Plan sponsors must sign an agreement with HHS making certain assurances to the government and acknowledging that the information in the application is being provided to HHS for

purposes of obtaining federal funds. This agreement is intended to be similar to plan sponsor agreements executed with HHS relating to Medicare Part D subsidies. *A copy of the plan sponsor agreement is not yet available.*

- Summary of how the applicant will use the reimbursement received under the Program to meet the requirements of the Program, including a summary of how the plan sponsor will use the reimbursement to reduce plan participant or sponsor costs, or any combination of these costs, and a summary of how the reimbursement will be applied to maintain the sponsor's level of effort in contributing to support the applicable plan.
- Summary of the plan sponsor's plans to implement programs and procedures to generate savings for plan participants (existing programs and procedures may also be described).
- Projected amount of reimbursement to be received over each year of the two-plan-year cycle.
- List of all plan options under which early retirees (and their eligible dependents) may claim benefits. A benefit option is defined as a particular benefit design, category of benefits, or cost-sharing arrangement offered within a plan.
- The application must be signed by an "authorized representative" of the plan sponsor. The plan sponsor must specify an authorized representative who has legal authority to sign and bind a sponsor to the terms of a contract or agreement. This is similar to the "authorized representative" concept under the Medicare Part D subsidy program.

Submission of Claims

When a claim is filed, it must include all claims below the applicable cost threshold for the plan year in order to verify that the cost threshold has been met. Once the cumulative claims of an early retiree for a plan year exceed $90,000, a sponsor should not submit claims above this claims limit.

Other Issues

Change in Ownership: A plan sponsor must provide HHS with advance notice of any change of ownership of the sponsor. This notice requirement is similar to the notice requirement relating to the Medicare Part D subsidy. The notice must be provided at least 60 days in advance of the change in ownership. Failure to notify HHS at least 60 days before the anticipated effective date of the change may result in HHS recovering funds paid under the Program. If the change in ownership results in a transfer of the liability for health benefit costs, the existing sponsor agreement is automatically assigned to the new owner.

Record Retention: Plan sponsors must maintain records for at least 6 years after the expiration of the plan year in which the costs were incurred, or longer if otherwise required by law.

Next Steps

HHS has stated that the application will be available by the end of June. Because applications will be reviewed on a first-in, first-processed basis, it will be important to file the application shortly after the application becomes effective. In the interim, plan sponsors who are interested in participating in the Program should review their current procedures in order to smooth the application process.

- Review plan provisions to identify current programs and procedures that have or are expected to reduce costs to participants with chronic and high-cost conditions. Consider expanding the programs along the lines described in the regulations.
- Review existing agreements and policies regarding fraud, waste and abuse, and if necessary, make such policies and procedures more explicit.
- Prepare an agreement between the plan sponsor and the plan or the insurance company regarding disclosure of documents to HHS.

- Review recent claims history to provide HHS with an estimate of expected reimbursement claims for each plan year during the first two-plan-year cycle.
- Identify an "authorized representative" to execute the application and enter into the plan sponsor agreement with HHS. This may be the same person who completes the Medicare Part D subsidy application if the plan sponsor participates in that program.

If you have any questions regarding this retiree reinsurance program, please contact **Philip L. Mowery** (312-609-7642), **Paul F. Russell** (312-609-7740), **Jessica L. Winski** (312-609-7678) or any other employee benefits attorney with whom you have worked.

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