

## HEALTH CARE REFORM

June 11, 2010

### Q&A Questions:

### Questions and Answers Regarding the Early Retiree Reinsurance Program

The Early Retiree Reinsurance Program (the "Program") was established by Congress through the Patient Protection and Affordable Care Act (the "Affordable Care Act"). The Program is intended to be a temporary reinsurance program providing reimbursements to eligible employment-based group health plans which provide medical benefits to early retirees and their spouses, surviving spouses and dependents.

On May 5, 2010, the Office of the Secretary for the Department of Health and Human Services ("HHS") published guidance in the form of an Interim Final Rule implementing the Program. The following series of questions and answers based upon that guidance are intended to describe the program.

#### 1. When Does the Program Begin and End?

The Program is effective beginning **June 1, 2010**, and will end no later than the earlier of January 1, 2014, or the date when funding for the Program is exhausted. Currently, Congress has earmarked \$5 billion in funding for the Program.

#### 2. What Does the Program Do?

In general terms (more details follow below), the Program is intended to encourage plan sponsors to provide health benefits to early retirees by providing reimbursements for a portion of the cost of claims incurred by early retirees, or by one of their plan-covered dependents, once those claims are shown to have been paid. Specifically, the Program will reimburse a participating plan sponsor for 80% of the total cost of claims incurred under a plan by an early retiree (or by his/her plan-covered spouse or surviving spouse, or plan-covered dependents) to the extent the claims incurred by an individual exceed \$15,000 but do not exceed \$90,000 for a plan year, once those claims are shown to have been paid. (The \$15,000 cost threshold and the \$90,000 cost limit are indexed for inflation for plan years starting on or after October 1, 2011.) Plan sponsors must apply to participate in the Program and plan sponsors and their respective plan(s) must both be approved and certified by HHS in order to participate in the Program and be eligible for the reimbursements. Reimbursements may be used to reduce certain costs of the plan sponsor and/or plan participants.

#### 3. Who May Participate in the Program?

Plan sponsors who want to participate in the Program must submit an application to the Secretary of HHS (or her designee) on behalf of their respective plans to be approved to participate in the Program. A separate application for each plan will be required. HHS must approve the application and certify both the plan and the plan sponsor before reimbursements may be requested under the Program. A "plan

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sponsor,” for purposes of participation in the Program, means: (a) the employer, in the case of a single-employer plan or a plan maintained jointly by one employer and a union where the employer is the primary source of financing; (b) the union in the case of a plan maintained by a union; or (c) the committee, board of trustees or other similar group of representatives who maintain a plan to which more than one employer or employee organization contributes. Plans for which reimbursement may be sought must be employment-based plans, but may be insured or self-insured, and may be a private employer plan, a multiemployer or collectively-bargained plan, a voluntary employees’ beneficiary association (“VEBA”), a church plan, or a state or local government plan.

#### 4. What Requirements Must a Plan Meet in Order to Be Approved by HHS?

In order for a plan to be approved and certified by the Secretary of HHS through the application process (see Q&A-5 below for information regarding the application process), the plan and its plan sponsor first must be able to satisfy the following requirements:

- The plan must have in place programs and procedures that have generated (or have the potential to generate) cost savings with respect to plan participants with chronic or high-cost conditions. Chronic and high-cost conditions are conditions which are likely to lead to claims of more than \$15,000 per plan year for a participant. A plan is not required to have in place programs and procedures to address all chronic and high-cost conditions; however, a plan sponsor should take a reasonable approach to identifying which conditions the plan will address. Generally, a plan’s cost-savings programs and procedures should relate to conditions affecting enrollees in the plan. Plan sponsors are not required to put new programs and procedures in place in order to apply for the Program, but they may adopt new programs and procedures (in which case they should indicate that in their application).
- The plan sponsor must maintain certain information, data, documents, and records and provide that information to the Secretary of HHS upon request. The Secretary of HHS may request and use such information, data, documents, and records to administer and audit the Program. Generally, the plan sponsor should maintain all information, data, documents, and records required by the Program for a period of at least six years after the plan year to which the information, data, documents or records applied.
- The plan sponsor must have a written agreement in place with its insurer or self-funded plan requiring the insurer or plan to disclose certain information, data, documents, and records to the Secretary of HHS on behalf of the plan sponsor, in the time and manner specified by the Secretary. (Such written agreement would permit the insurer or plan to release protected health information (“PHI”) to the Secretary of HHS, pursuant to HIPAA’s Privacy Rule, in instances where the plan sponsor may not have such information, data, documents, and/or records itself.)
- The plan sponsor must attest that it has policies and procedures in place to protect against fraud, waste and abuse under the Program. Additionally, if requested by the Secretary of HHS, the plan sponsor must produce such policies and procedures, along with documents or data substantiating the implementation and effectiveness of the policies and procedures.

#### 5. What Information Will Be Required on the Application to Participate in the Program?

Each plan sponsor who is interested in participating in the Program must submit an application to HHS in order to participate in the Program. The application must be approved and both the plan and plan sponsor certified before the plan sponsor may request reimbursement under the Program. Additionally, the plan sponsor must submit a separate application for each plan for which reimbursements may be sought. As of the date these Q&As were posted, only a draft application had been released by HHS. The draft application, following the requirements set forth in the Interim Final Rule, requires that the following items be included among the information to be provided on an application:

- The applicant’s name, address, telephone and fax numbers, website address, type of organization, and tax identification number;
- The authorized representative’s and the account manager’s names, contact information and other identifying information for each;
- The plan year cycle for which the plan sponsor is applying (i.e., the month and day of the starting and ending dates of the plan year);
- A list of the benefit options under the plan in which any early retiree may participate and for which the plan sponsor may receive reimbursements under the Program;

- A description of the policies and procedures that the plan has in place (or will put in place) which are intended to generate cost savings for plan participants with respect to chronic and high-cost conditions;
- A projected amount of reimbursements to be received under the Program for the first two plan-year cycles;
- A summary description on how the applicant will use reimbursements received under the Program, including:
  - (i) how the reimbursement will be used to reduce certain expenses for plan participants, offset increases in costs for the plan sponsor, or both, and (ii) an explanation of how the plan sponsor will maintain at least the same level of support to the plan as it did before the plan sponsor began participating in the Program;
- A plan sponsor agreement, to be signed by an authorized representative of the plan, whereby the plan sponsor:
  - o agrees to comply with the applicable sections of the Affordable Care Act and other HHS guidance;
  - o certifies that the plan sponsor has a written agreement in place with the plan's health insurance issuer or with the plan regarding disclosure of data, documents and records for the purpose of reimbursements under the Program;
  - o acknowledges that information used in the application is provided for obtaining federal funds and that the plan sponsor will require subcontractors to acknowledge the same;
  - o agrees to establish and implement appropriate safeguards against unauthorized use and data in compliance with HIPAA with respect to data exchanged under the application;
  - o attests that policies and procedures are in place to detect and reduce fraud, waste and abuse; and
  - o makes other representations or provides authorizations as required by HHS; and
- Other information.

The Secretary of HHS may modify these requirements and/or may add additional items for plan sponsors to address in an application for the Program.

## 6. When Will Final Applications Be Made Available for the Program?

HHS is expected to make available final applications for the Program before the end of June. However, draft application forms already have been published and currently are available. Plan sponsors interested in participating in the Program should not wait until the final application is released to begin preparing the information needed for the application and are being encouraged to use the drafts as a guideline.

## 7. How Will HHS Process and Approve Applications?

HHS has indicated that it will process applications for participation in the Program in the order such completed applications are received. If an application does not contain all required information, the incomplete application will be rejected and the applicant must submit a new application in order to participate in the Program. The new application will be placed "at the end of the line" with other new applications. Thus, it is important that a plan sponsor submit a complete application upon its first submission. A separate application must be filed for each plan for which the plan sponsor desires to seek reimbursements under the Program. However, once an application to participate in the Program is approved, no further applications need to be filed on behalf of the plan in any subsequent year.

## 8. What Is the Amount of Reimbursements a Plan Sponsor May Receive Under the Program?

Assuming the plan and plan sponsor have been approved and certified, and as long as Program funds remain available, a plan sponsor may receive reimbursements under the Program in an amount equal to 80% of the cumulative costs of health benefits incurred during the plan year by an early retiree that are between \$15,000 (the "cost threshold") and \$90,000 (the "cost limit") so long as those costs are shown to have been paid. Note that the cost threshold and cost limit will be adjusted for plan years beginning after October 1, 2011, based upon increases in the medical care component of the Consumer Price Index for urban consumers.

Note that if an early retiree participates in more than one benefit plan option under the plan, then for purposes of reimbursements, the claims incurred by the early retiree under all plan options are aggregated for the year. Additionally, as noted above, to be reimbursed, the claims incurred by the early retiree must be shown to have been paid by the plan, the insurer, or by the early retiree (or on the early retiree's behalf by another individual, other than insurance or another third-party payment arrangement). Reimbursements are determined net of negotiated price concessions available under the plan.

A special transition rule applies for determining reimbursable claims in 2010 for plans with plan years beginning before the Program's effective date of June 1, 2010, and ending after June 1, 2010. Specifically, claims of up to \$15,000 that have been incurred before June 1, 2010, will count toward the cost threshold. However, claims above \$15,000 incurred before June 1, 2010, will not be eligible for reimbursement and do not count against an early retiree's cost limit. Only claims that are incurred and paid on or after June 1, 2010, that fall between the cost threshold and cost limit will be reimbursed. An example illustrating the special transition rule is as follows:

Employer A sponsors a group health plan which is operated on a calendar-year basis (January 1 – December 31). Employer A meets all of the requirements to participate in the Program. Employer A's application to participate in the Program has been approved, and Employer A and its group health plan have been certified by HHS. An early retiree who participates in Employer A's group health plan has incurred \$100,000 in health benefit claims (net of price concessions negotiated by the plan) under the plan during the time period beginning January 1, 2010, and ending before June 1, 2010. The early retiree then incurs another \$30,000 in health benefits claims under the plan during the 2010 plan year, after June 1, 2010. The claims were paid by the early retiree and the insured plan.

While none of the \$100,000 of the early retiree's health benefit claims incurred before June 1 will be reimbursed, \$15,000 of that amount will count toward the cost threshold, making the early retiree's claims of \$30,000 incurred under the plan after June 1, 2010 eligible for reimbursement. The \$100,000 in claims incurred by the early retiree prior to June 1 will not count against the reimbursable cost limit. Therefore, Employer A would be eligible to receive a reimbursement of 80% of the early retiree's claims incurred after June 1, 2010, (80% x \$30,000) or \$24,000.

## 9. Who Is an "Early Retiree" for Purposes of Claims Reimbursements Under the Program?

An early retiree is defined as a plan participant who is:

- age 55 or older;
- not yet eligible for Medicare; and
- not actively employed by any employer maintaining the plan.

Additionally, health benefits claims incurred by an early retiree's plan-covered spouse or surviving spouse (even if under age 55) or plan-covered dependent are eligible for reimbursements under the Program.

## 10. What Constitutes Health Benefits for Which Reimbursements May Be Obtained?

The term "health benefits" for purposes of the reimbursements available under the Program includes (but is not limited to): medical, surgical, hospital, and prescription drug benefits. The term "health benefits" also includes benefits for the diagnosis, cure, mitigation, or prevention of physical or mental diseases or conditions with respect to any structure or function of the body. Health benefits may be self-funded or provided through health insurance or otherwise.

Health benefits do not include "excepted benefits" (as defined under the regulations implementing HIPAA), or, in general terms, benefits that provide limited types of coverage under a separate policy. The following are some of the examples of benefits which are not reimbursable health benefits: long-term care benefits, limited scope vision and dental plans, benefits for a specified disease, hospital indemnity or other fixed indemnity plans, accidental death and dismemberment coverage, disability income coverage, liability insurance, supplemental liability insurance, workers' compensation or similar coverage, automobile medical payment insurance, credit-only insurance, or on-site medical clinics.

## 11. How Does a Plan Receive Reimbursements of Health Benefit Claims?

Once a plan sponsor and plan are approved and certified by HHS for participation in the Program, a submission of claims for reimbursement may be made to HHS. Claims generally are submitted by the plan sponsor, but may be submitted by the insurer (in the case of an insured plan) directly to HHS.

Claims for an early retiree may be submitted for reimbursement once the cost threshold for the plan year has been satisfied with respect to the particular early retiree, and the claims have been paid. All claims for an early retiree up to the cost limit (including claims below the cost threshold) must be submitted to HHS, in order to verify that the cost threshold has been met. However, cumulative claims for an early retiree which exceed the cost limit should not be submitted.

All claim submissions must be made in the form and manner specified by HHS, and must include a list of the early retirees for whom claims are being submitted, along with documentation of the actual cost of the items and services for which claims are being submitted. Additionally, the plan sponsor must provide evidence of payment for the claims (e.g., actual

payment receipt), including evidence of payments made by the early retiree. If evidence of the early retiree's payment cannot be provided or is not provided to HHS, then reimbursement for the portion of the claim paid by the early retiree would not be available.

The following information generally must be included in the claims:

- the health benefits provided;
- the provider or supplier;
- the incurred date;
- the individual to whom the health benefit was provided;
- the date and amount of payment (net of any known negotiated price concessions); and
- the employment-based plan and the benefit option under which the health benefit was provided.

HHS is expected to release more specific information regarding the form and manner for which claims are to be submitted to HHS. Reimbursements available under the Program will be based upon the availability of Program funds.

## 12. How May Plan Sponsors Use the Reimbursements They Receive?

In general terms, a plan sponsor may use the reimbursements to:

- offset increases in the sponsor's premiums;
- offset increases in the sponsor's other health benefit costs;
- reduce plan participant's costs (e.g., premiums, co-payments, deductibles, coinsurance, or other out-of-pocket costs); or
- a combination of the above.

Additionally, reimbursements received in one year may be applied for permissible purposes in subsequent years; for example, to defray a plan sponsor's increase in costs from one year to the next year. However, HHS has indicated that it expects that a plan sponsor will continue to maintain at least the same level of contributions that the plan sponsor had been making to the plan prior to participation in the Program. HHS has indicated that it will release additional information regarding the monitoring of appropriate uses of reimbursements under the Program, as HHS develops such monitoring tools. In no event may plan sponsors use reimbursements received under the Program as general revenue.

## 13. If a Plan Sponsor's Request for Reimbursement Is Denied, May a Plan Sponsor Submit an Appeal to HHS?

A plan sponsor who disagrees with HHS' determination as to the amount of reimbursement or the complete denial of a reimbursement request may file an appeal with the HHS within 15 calendar days of receiving the determination. However, no appeal may be made if the reimbursement claim is denied because the Program's funding has been exhausted. The appeal must specify the findings or reasons with which the plan sponsor disagrees and the plan sponsor's reasons for disagreeing with HHS' findings or reasons. The plan sponsor also may include documentation to support its appeal.

The Secretary of HHS will make a final and binding decision based upon information submitted with the appeal. A written decision will be issued by the Secretary of HHS upon request. However, regardless of the decision upon appeal, additional reimbursements will be made only if Program funds are available at the time the appeal is determined.

## 14. If Facts Change After a Request for a Reimbursement Has Been Approved, Must the Plan Sponsor Update HHS?

Under the Interim Final Rule, a plan sponsor has the obligation to disclose any data inaccuracies upon which a reimbursement determination is made, including inaccurate claims data and negotiated price concessions. Plan sponsors should take steps to provide accurate information upfront and disclose any inaccuracies when known. The Secretary of HHS has authority under the Interim Final Rule to reopen and revise a reimbursement determination, either upon a plan sponsor's request or on its own initiative.

## 15. What Happens if a Plan Sponsor Undergoes a Change in Ownership? What Effect Does the Change in Ownership Have Upon Its Participation in the Program?

If a plan sponsor is considering or negotiating a change in its ownership, the plan sponsor must notify the Secretary of HHS at least 60 days prior to the anticipated effective date, or risk a recovery of all funds paid under the Program to the plan sponsor.

For purposes of the Program, a “change in ownership” for a partnership generally includes the removal, addition, or substitution of a partner. A change in ownership in an asset sale context occurs when a transfer of all, or substantially all, of the assets of the sponsor are transferred to another party. In addition, for a corporation, a change in ownership generally means the merger of the plan sponsor’s corporation into another corporation or the consolidation of the plan sponsor with one or more other corporations, forming a new corporation. However, a stock sale or a merger with another corporation, where the plan sponsor survives does not normally constitute a change of ownership.

When a change of ownership occurs which results in a transfer of liability for early retiree health benefits, the existing sponsor agreement automatically transfers to the new owner. The new owner must comply with the sponsor agreement and with all applicable statutes, regulations, and guidance applicable to the Program.

## 16. What Record Retention Requirements Does the Program Impose Upon Plans?

The Interim Final Rule released by HHS states that the plan sponsor of a certified plan must maintain records for a period of six years after the end of the plan year in which the costs submitted for reimbursement were incurred (or longer, if required by law). The plan sponsor may be required to furnish such records to the Secretary of HHS upon request. If the records are kept by a third-party administrator or an insurer, the plan sponsor must require the administrator or insurer to maintain and produce the records to the Secretary upon request. The records that should be maintained include, at a minimum, all documentation and data pertaining to any claims reimbursement requests, in addition to all documentation and data relating to the application to participate in the Program. The Interim Final Rule provides HHS with the ability to issue additional guidance addressing recordkeeping requirements.

## 17. What Should a Plan Sponsor Do Now?

If a plan sponsor is interested in applying for the Early Retiree Reinsurance Program, the plan sponsor will want to be ready to submit an application to HHS as quickly as possible, once the final application is made available and the Program formally commences.

Prior to the formal applications becoming available, plan sponsors should (at a minimum):

- review their existing plans to see what programs may be in place to address and lower costs for chronic and high-cost conditions, and determine whether new programs must be adopted, and/or current programs modified.
- engage an actuary to review past-years' claims and develop projections on the amounts that may be reimbursed under the Program for the first two plan-year cycles.
- determine and review how the anticipated reimbursements will be used.
- update, as necessary, HIPAA privacy agreements and other data-sharing agreements with plan recordkeepers and insurers to allow the plan sponsor to fulfill its disclosure and record retention obligations under the Program.
- ascertain whether the insurer, the third-party administrator, or the plan sponsor itself have written policies and procedures in place to protect against fraud, waste and abuse and confirm that those policies and procedures are in effect for claims which could qualify for reimbursement under the Program. If not, such policies and procedures need to be prepared, formalized, implemented and put into effect.

## More Information

The Interim Final Rule implementing the Early Retiree Reinsurance Program provided a framework for the Program; however, the Rule also left many unanswered questions. The Health Care Reform attorneys at Baker Hostetler continue to monitor developments in this area. Please contact Terry Connerton (tconnerton@bakerlaw.com or 202.861.1613), Deborah Bracy (dbracy@bakerlaw.com or 216.861.7354) or any member of the Baker Hostetler Health Care Reform team with your Early Retiree Reinsurance Program questions.

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