

Health Care Reform Update

Early Retiree Reinsurance Program

The Department of Health and Human Services (HHS) issued an interim final rule on May 5, 2010, setting forth the initial parameters of the Early Retiree Reinsurance Program (ERRP or “Program”).¹ The Early Retiree Reinsurance Program was established by Congress with the enactment of the Patient Protection and Affordable Care Act.² Congress funded the program with \$5 billion and intended that the program continue until December 31, 2013, or until funding runs out.

The Program, which begins June 1, 2010,³ provides reimbursement to participating sponsors for a portion of the cost of maintaining this health coverage for early retirees, and its purpose is to encourage employers to continue maintaining early retiree health coverage prior to the establishment of the exchanges in 2014. The Program is designed to work with the Retiree Drug Subsidy (RDS) program and HHS does expect that many of the employers in that program will also enroll in the ERRP.

DEFINITIONS

The final interim rule sets forth various definitions that largely track the meaning of the terms found in previous regulations under the Employee Retirement Income Security Act (ERISA) and under the RDS. Therefore, the terms used by HHS in this interim final rule generally mean the same as employee benefits practitioners and individuals in human resources management are used to them meaning.

An *employment-based plan*, for the purposes of the ERRP, is one maintained by private entities, state or local governments, employee organizations, voluntary employee beneficiary’s associations, a committee or board of individuals appointed to administer a group health plan, and also includes multiemployer plans.⁴ The plan may be fully insured or self-funded.

HHS specifies that the *sponsors* of the plans are the entities to which the ERRP is aimed and are the entities that will apply for and obtain reimbursement under the program. An *authorized representative* is an individual with legal authority to sign and bind a sponsor to the terms of a contract and whose signature is necessary to sign the plan sponsor agreement as part of the program application.

An *early retiree* is defined as an individual who is age 55 and older but is not eligible for coverage under Medicare and who is not an active employee of the employer maintaining or contributing to the employment-based plan. Spouses, surviving spouses and dependents are also included in the definition of early retiree so that reimbursement may be made under the ERRP for the claims of these additional covered individuals even if they are under the age of 55 and/or are eligible for Medicare.

¹ 75 FR 24450 (May 5, 2010).

² *Public Law No. 111-149*, enacted March 23, 2010.

³ The effective date of the regulations is June 1, 2010. The PPACA required HHS to establish a program by June 21, 2010, and to better align the program with some sponsors’ plan year start dates and to simplify accounting for sponsors and the Secretary, HHS decided to open the Program on June 1, 2010.

⁴ Federal government plans are specifically excluded from participation in the ERRP.

ENROLLMENT AND PARTICIPATION IN THE PROGRAM

Enrollment in the program is contingent on application to and certification by the Secretary of HHS. A separate application is required for each plan enrolling. All elements of the application must be satisfied prior to certification by the Secretary, which include but are not limited to:

- The plan must provide its tax identification number (TIN);
- The plan's application will include the applicant plan's name, address and contact information;
- The plan must specify the plan year cycle for which the sponsor is applying (annual application is not necessary or desired);
- The plan must provide a summary of how the sponsor will use the reimbursement to meet the requirements of the program, including how it will reduce costs and maintain its contributions to support the plan;
- The plan must have an established program and procedure(s) to generate cost savings for participants with chronic and high-cost conditions;
- The plan will be required to submit a specific projection of the expected reimbursement amounts for the first two plan-year cycles;
- The plan will identify all benefit options under the plan that may be included in the reimbursement claims;
- The plan must include a signed plan sponsor agreement agreeing to the parameters of claim submission, audit by the Secretary and other terms and conditions of the program, as the Secretary may specify; and
- The application must be signed and certified by an authorized representative.

Projection of Expected Reimbursement Amounts

The applications will be processed in the order in which they are received. If an application is incomplete, it will be sent back to the applicant and the applicant's new application will be processed based on the time that the new application is received by HHS. HHS does offer assistance; however, the interim final rule does not specify the form that this assistance will take. Because funding is limited, HHS has requested from each applicant a projection of expected reimbursement amounts with specific amounts for each of two years. These projections should better enable HHS to anticipate and communicate the end of the period in which it will take new applications, based on the funding limitation under the Program.

Cost Saving Programs and Procedures

In addition to the summary of the sponsor's program to implement cost reductions, maintain its support of its early retiree health plan, and generate cost savings for the chronic or high-cost conditions of its participants, the sponsor will be required, upon audit, to demonstrate that these policies and procedures have in fact generated cost savings or have otherwise operated consistently with the sponsor's representations made in its application. Also, the sponsor must be able to demonstrate how it has used the reimbursements it has obtained through the Program.

Chronic and High-Cost Conditions

HHS has not identified any specific chronic or high-cost conditions on which sponsors might focus their cost-saving efforts. Instead, HHS has left it up to the sponsor to identify the chronic and/or high-cost conditions affecting participants in the sponsor's plan, with "chronic" and/or "high-cost" meaning a condition for which claims totaling \$15,000 or more are likely to be incurred by the plan. The sponsor is not required to identify and put cost-saving measures in place for all chronic and high-cost conditions affecting their plan, however, they are to take a "reasonable approach" in identifying the conditions the

sponsor will address. Upon audit, the sponsor will be required to provide data substantiating the effectiveness of the sponsor's cost-savings program.

CLAIMS AND REIMBURSEMENTS

Amount of Reimbursement

Generally, the amount of reimbursement will be 80 percent of the submitted claims, which are to be net of any negotiated price concessions or other discounts.

The submitted claims may be aggregated per employee for all costs for health benefits paid by the plan or by the early retiree for all benefit options for which the early retiree is enrolled. The total of the claims submitted must be between \$15,000 and \$90,000 (again, net of negotiated price concessions or other arrangements, including post-point-of-sale price concessions). Claims for an early retiree for a plan year cannot be submitted until the total paid costs for health benefits for that early retiree incurred for that plan year exceed the cost threshold. It is possible that only one claims reimbursement submission per employee will be necessary given the aggregate nature of the cost threshold calculation.

The costs paid by the early retiree or other participant in the early retiree health plan may be included in the amounts submitted as paid by the employment-based plan. The claims must be incurred and paid during the plan year for which reimbursement is sought. The reimbursement claim to the Secretary must also contain documentation of actual costs of items and services.

The health benefits for which claim reimbursement submissions are allowed is defined under the interim final rule as meaning major medical benefits. The ERRP will not reimburse claims for "excepted benefits" as specified in the Health Insurance Portability and Accountability Act (HIPAA).⁵

Finally, the cost threshold of \$15,000 and the cost limit of \$90,000 will be adjusted annually for inflation based on the percentage increase in the Medical Care Component of the Consumer Price Index. The adjustments will take effect for plan years beginning on or after October 1, 2011.

Application of the Cost Threshold and Cost Limit Amounts for 2010 Claims (Transition Rule)

Plans with plan years beginning before June 1, 2010, may participate in the program as long as the plan year ends after June 1, 2010. Sponsors may also apply for plan years that start after June 1, 2010. Claims incurred before June 1, 2010, are not eligible for reimbursement. However, they may count toward the cost threshold. Claims incurred after June 1, 2010, count both toward the cost threshold and the cost limit. Sponsors should not submit claims over the \$15,000 threshold that were incurred before June 1, 2010, as they will not be reimbursed and will slow the reimbursement process.

Example

Facts: Plan year July 1, 2009-June 30, 2010. The plan has incurred and paid \$120,000 in plan year claims for one early retiree before June 1, 2010 and it incurs and pays an additional \$30,000 in health benefits between June 1, 2010 and June 30, 2010.

In this fact pattern, the sponsor would receive credit for \$15,000 toward the cost threshold, and receive reimbursement of 80% of \$30,000 (or \$24,000).

⁵ Excepted benefits, as described in HIPAA, include: long-term care benefits, AD&D benefits, disability income benefits, workers' compensation, and etc. Please see 45 CFR §148.220 for a full list of excepted benefits under the HIPAA Portability rules.

Reimbursement Determinations

The Secretary may reopen and revise a reimbursement determination in the following circumstances:

- Upon the Secretary's own motion;
- Upon the request of the plan sponsor within 1 year of the reimbursement determination for any reason;
- Within 4 years of the reimbursement determination for good cause; and
- At any time in instances of fraud or similar fault.

Treatment of Protected Health Information

Because the claims data requested by the Secretary will be protected health information (PHI), the sponsor must also have a written agreement with its health insurance issuer, business associates or third-party administrators regarding the disclosure of the information and data necessary for the sponsor to comply with the data disclosure requirements of the ERRP. Audits by the Secretary will also require access to PHI. The access is required by law, therefore covered entities will be able to comply without first obtaining specific disclosure authorization from the individuals whom it affects.⁶

APPEALS

A sponsor may appeal a decision directly to the Secretary within 15 days of receipt of an adverse claims determination. Denials of reimbursements based on the lack of funding cannot be appealed. In addition, a decision by HHS not to revise a reimbursement determination is final and binding and cannot be appealed.

FRAUD AND WASTE PREVENTION

The Secretary has outlined several ways that it intends will prevent fraud and waste in the ERRP.

- The sponsor is required have procedures and policies in place to protect against fraud and will be required to disclose those to the Secretary upon request;
- The Secretary will coordinate with the HHS Office of the Inspector General and the U.S. General Services Administration to ensure that applicants listed on the Exclusions List maintained by the HHS Inspector General⁷ will be allowed to enroll;
- The Secretary will verify the identities of the early retirees for whom claims are being submitted;
- The Secretary may verify the identities of the contacts at the sponsor and/or the health insurance issuer;
- The Secretary will examine claims before reimbursement; and
- The Secretary will perform an annual audit.

Penalties for fraud, waste, or abuse will include termination of the application, recoupment of reimbursements, and/or revocation of approval of the sponsor's participation in the Program.

⁶ See 45 CFR §164.512(a).

⁷ For more information on the Exclusions List and how it is used, please see <http://oig.hhs.gov/fraud/exclusions.asp>.

OTHER RULES

The interim final rules also provide records retention guidelines and guidance as to how a change of ownership will affect participating sponsors.

WHAT WE DO NOT KNOW

The ERRP will become effective on June 1, 2010. There are still several items for which we are awaiting guidance, including:

- The date on and the method by which the Secretary will begin to accept applications for enrollment;
- The date on and the method by which the Secretary will begin accepting reimbursement claims; and
- The form and manner of disclosures of negotiated price concessions, including those post-point-of-sale.

TEXT

For a copy of the regulations, visit: <http://frwebgate5.access.gpo.gov/cgi-bin/TEXTgate.cgi?WAISdocID=162126380878+0+1+0&WAIAction=retrieve>.



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