Health Care Reform Alert

Qualified Employers Should Prepare Now For the Retiree Reinsurance Program

The Patient Protection and Affordable Care Act, the recently enacted health care reform law *(see our Alert: www.jaeckle.com/EmployerHealthCareChallenges)*, establishes a federal subsidy for health plans that cover certain early retirees. Under the Early Retiree Reinsurance Program, a qualifying plan can receive a subsidy equal to 80% of its annual costs that are more than $15,000 but not more than $90,000 for a retiree. Only limited funds were allocated to the program and they will be disbursed on a "first come first served" basis until exhausted, at which point the program will end. The available funds are expected to be substantially less than the amounts eligible for reimbursement. Sponsors of plans that cover early retirees should therefore take immediate steps to determine whether their plans could qualify for the subsidy and, if they could, prepare to apply for program certification beginning next month.

The Early Retiree Reinsurance Program

Overview: In order to encourage employers who sponsor retiree health plans to continue providing such coverage, Congress included a reinsurance subsidy in the Patient Protection and Affordable Care Act. Under the Act, the early retiree reinsurance program was to established by the Secretary of Health and Human Services (HHS) no later than June 21, 2010. HHS issued an interim final rule on May 5, 2010[1] with regulations that answer many questions concerning the program. The regulations state that the program will be established effective as of June 1, 2010.

The program will reimburse eligible employment-based health plans for a portion of the costs of providing coverage to early retirees (age 55 and older and not Medicare-eligible) and such retirees' spouses, surviving spouses and dependents. Specifically, the program will reimburse such plans for 80 percent of annual costs for any one such person in excess of $15,000 but not greater than $90,000. Program funds are limited to $5 billion, and the program will terminate as soon as available funds are used up (or on January 1, 2014, if sooner).

Use of Subsidy Funds: Subsidy funds must be used to lower the sponsor's premium costs or plan costs, the plan participants' plan related costs (premiums, deductibles, co-pays, etc.) or any combination of these. Funds cannot be used by the sponsor as general revenues. The interim final rule strongly suggests that the sponsor of an insured plan could not use subsidy funds to reduce its share of the premium cost below the level it contributed before the subsidy program began. A sponsor could, however, use the subsidy to offset its share of a premium increase. The precise limits on sponsor use of subsidy funds are not yet clear.

Sponsor Requirements: In order to receive the reinsurance subsidy, a plan must:

- be an eligible "employment-based health plan" that meets certain specific requirements,
- submit an application to participate in the program and have such application approved and certified by HHS,

[1] The interim final rule provides for a 30 day comment period, which ends on June 4, 2010.

- submit claims for eligible costs incurred and paid during the applicable plan year, and
- be prepared to make supporting documents and records available for audit by HHS, and notify HHS of a change in ownership of the sponsor.

"Employment-Based Health Plans"

Eligible Health Plans: The reinsurance program is available to "employment-based health plans" that cover early retirees, including plans sponsored or contributed to by private for-profit and nonprofit employers, state and local governments and employee organizations. VEBAs and multiemployer plans can also qualify.

Chronic and High Cost Conditions: An eligible plan must have programs and procedures in place to generate cost savings for participants with chronic and high-cost conditions. The HHS regulations define "chronic and high-cost condition", somewhat mechanically, as any condition likely to result in $15,000 or more in annual claims by any one participant. The regulations do not require that an eligible plan have programs and procedures to address *all* such conditions, and such programs and procedures that do exist need only generate *or have the potential to generate* cost savings for affected participants.

> *Example:* A diabetes management program that includes monitoring and behavioral counseling to prevent complications and unnecessary hospitalization could qualify as a cost saving program aimed at chronic and high-cost conditions.

Fraud Prevention: An eligible plan must implement policies and procedures designed to prevent fraud, waste and abuse under the program, and document these policies if requested to do so by HHS.

HHS Application and Certification

Requirements of the Application: Before submitting claims or receiving subsidy funds, the sponsor of an eligible plan must apply to and be certified by HHS. The application must be signed and certified by an authorized representative of the sponsor. Only one application must be submitted for each plan; a plan does not have to be re-certified each year. HHS has stated that the application will be available in late June, and will be similar to the application used for the retiree drug subsidy.

Applications will be processed in the order in which they are received. Given the first come, first served mechanism for disbursing subsidy funds, sponsors should be prepared to submit complete applications as soon as possible. Incomplete or defective applications will be denied, and the sponsor will be required to submit a new application.

According to the HHS regulations, the application will be required to include:

- a summary of how the plan sponsor intends to use the subsidy to meet the requirements of the reinsurance program, including
  - how it will use the subsidy to reduce participant and/or sponsor costs (see "Use of Subsidy Funds", above),
  - the programs and procedures to generate savings for plan participants with chronic and high cost conditions (see "Chronic and High Cost Conditions", above), and

- an attestation by the sponsor that the plan has implemented policies and procedures to prevent fraud, waste and abuse under the program (see "Fraud Prevention", above),

- a list of all benefit options under the plan with respect to which a program subsidy may be claimed,

- a projection of the plan's reimbursement amounts for the first two plan year cycles,

- a certification by the sponsor that it has signed an agreement with the insurer (or with the plan itself, if a self-insured plan) requiring the insurer or plan to disclose pertinent information to HHS on behalf of the sponsor (see "Agreement With Insurer", below), and

- a "Plan Sponsor Agreement" with HHS under which the sponsor provides certain assurances to the Department, and which probably will be similar to the Plan Sponsor Agreement used under the retiree drug subsidy program (a copy of the drug subsidy agreement can be found here: http://rds.cms.hhs.gov/reference_materials/agreement_terms/plan_sponsor.htm).

Agreement with Insurer: In most cases, the sponsor of an insured health plan will need the insurer to provide much or most of the information needed to complete the HHS application, submit claims for reimbursement and respond to HHS inquiries. Much of this information will be "protected health information" for purposes of the HIPAA privacy rule. By requiring insurers to disclose such information to HHS, insurers can make the disclosures without running afoul of the privacy rule (because disclosures "required by law" do not violate the rule).

> Note: The sponsor itself may need protected health information from the insurer or plan in order to analyze and complete the subsidy application. This requirements raises important issues under the HIPAA privacy and security rules that must be addressed by the sponsor and insurer.

Reimbursable Costs

General: In general, costs eligible for the reinsurance subsidy are amounts expended by the plan during the plan year for health benefits provided to early retirees and their spouses, surviving spouses and dependents. For this purpose, amounts paid by the early retiree (or the retiree's spouse, surviving spouse or dependent) in the form of deductibles, co-payments or co-insurance are included as plan costs. For an insured plan, eligible costs are the health costs paid by the insurer (and the retirees) - *not* premiums paid by the employer.

Rules For Determining Eligible Costs: For these purposes:

- An eligible retiree is a participant who is age 55 or older, not eligible for Medicare, and not an active employee of an employer maintaining or contributing to the plan or of any employer that has made substantial contributions to the plan.

- "Health benefits" include medical, hospital, surgical and prescription drug benefits, whether paid on an insured or self-insured basis, and including benefits for the diagnosis, cure, mitigation, or prevention of any physical or mental disease or condition.

- A plan's reimbursable costs are computed by taking into account any negotiated price concessions (such as discounts, rebates and direct or indirect subsidies or remunerations) obtained by such plan with respect to such health benefits, including price concessions made after the initial sale.

The Reimbursement Subsidy: The reinsurance program will reimburse eligible plans for 80 percent of annual costs in excess of $15,000 (the cost threshold) but not greater than $90,000 (the cost limit) per retiree. Costs must be both incurred and paid during a plan year in order to be counted toward the cost threshold or reimbursed.

Transition Rule: As noted above, the reinsurance program will go into effect beginning June 1, 2010. For plan years that begin before and end after that date (calendar year 2010, for example), costs incurred during the current year but before June 1, 2010 count toward the cost threshold, but are not eligible for reimbursement. Only cost incurred on and after June 1, 2010 may be reimbursed.

> *Example:* A plan with a calendar plan year spends $20,000 on health benefits for an early retiree before June 1, 2010, and another $30,000 in benefits between June 1, 2010 and December 31, 2010. The sponsor would receive credit for $15,000 in claims incurred before June 1 for purposes of the cost threshold, and receive reimbursement of 80 percent of the $30,000 in costs incurred on and after June 1, 2010, or $24,000.

Supporting Documentation, Notification and Audit Requirements

A plan that participates in the reinsurance program must:

- maintain all pertinent records for at least six years after the end of the plan year in which reimbursed costs were incurred,
- correct any inaccuracies in data submitted to HHS (for example, as a result of a health care provider reversing an already submitted claim, or a post-point-of-sale price concession),
- notify HHS of a change in ownership of the sponsor, and
- submit to HHS audits to confirm compliance with all program requirements.

What Sponsors Should Do

A sponsor of a health plan that covers early retirees should immediately begin to analyze whether the plan has costs for which the reinsurance subsidy could be available. For insured plans, this will require working with the insurer, which may require a plan amendment and other actions in order to comply with the HIPAA privacy rule. If a sponsor determines that it could benefit from the subsidy, it should be prepared to submit an application as soon as HHS makes the application available, which is expected to occur next month (June 2010), and to submit claims for reimbursement as soon as the claim submission mechanism is up and running.

If you have any questions about the retiree reinsurance program or any other aspect of health care reform, please contact Robert W. Patterson at 716.843.3910 or rpatterson@jaeckle.com, or Michele O. Heffernan at 716.843.3850 or mheffernan@jaeckle.com.