

# HHS Guidance on Early Retiree Reinsurance Program

Client Bulletin provided by Hub International



The Department of Health & Human Services (HHS) has issued guidance on the early retiree reinsurance program, part of the new health reform law. The program will reimburse participating plan sponsors a portion of the costs of providing health insurance to early retirees. A plan sponsor must be ready to apply for this program as soon as HHS releases the application form. The program is funded with \$5 billion; when funding is exhausted, the program will end. Plans must be certified as acceptable. Plan sponsor applications for the program must be submitted and approved *prior* to requesting reimbursements. Applications will be processed in the order in which received. Care and due diligence in completing the application are important; a complete and acceptable application should be filed the first time. Any incomplete application will be denied, with no opportunity to amend or fix application defects. That applicant must resubmit a new application and return to the back of the line, so to speak.

## **Early Retiree Expenses & Program Overview**

“Early retirees” are individuals age 55 or older who are not eligible for Medicare and who are not active employees of an employer maintaining or currently contributing to an employment-based health plan. (Medicare rules on “active employment status” will apply and may disallow reimbursement for persons on disability leave, for example.) The program will reimburse expenses of retirees’ spouses, dependents, and survivors regardless of their ages, eligibility for Medicare or other coverage, or dependent status for income tax purposes. The program will operate similarly to the current Retiree Drug Subsidy program.

Fully-insured and self-funded plans are eligible for these reimbursements. Support and assistance from an insurance carrier or plan administrator will be very important. “Employment-based plans” are entitled to the reimbursement, including plans sponsored by private employers, state or local governments, voluntary employees’ beneficiary associations (VEBAs), committees or boards appointed to administer such plans, or multiemployer plans (within the meaning of ERISA).

HHS will reimburse plans 80% of certain benefit claims (net of negotiated price concessions) between \$15,000 and \$90,000. The claims must have been incurred and paid. For a retiree with less than \$15,000 in claims, no reimbursement will be available. Once \$15,000 in claims has been incurred and paid, the plan sponsor may begin applying for reimbursement as to that person. The \$15,000 threshold and the \$90,000 limit apply only once per year to each retiree or family member. Consider, for example, when both spouses worked for the plan sponsor, and an individual has dual coverage as a result -- both as a retiree in his own right and as the spouse of a retiree. A person with such dual coverage must only reach \$15,000 in incurred and paid claims, not \$30,000. Premium amounts are irrelevant, do not count toward these amounts, and are not reimbursable -- only actual paid claims are eligible.

The reimbursable amount *may* include the amounts paid by the early retiree and persons covered with the early retiree, but the plan sponsor must provide receipts for amounts individuals actually paid, which will not be easy. The insurance carrier or third party administrator generally will not have proof of payment by the individual.

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## **Eligible Claims**

In addition to falling within the \$15,000 to \$90,000 range, a claim must be for medical, surgical, hospital, prescription drug, and other claims allowed by HHS. The expense must relate to the diagnosis, cure, mitigation, or prevention of physical or mental illness or condition with respect to any structure or function of the body. Health benefits do not include:

- Coverage only for accident (including accidental death and dismemberment)
- Disability income insurance
- Liability insurance, including general liability insurance and automobile liability insurance
- Coverage issued as a supplement to liability insurance
- Workers' compensation or similar coverage
- Automobile medical payment insurance
- Credit only insurance (such as mortgage insurance)
- Coverage for on-site medical clinics
- If provided in a separate policy, certificate or contract of insurance, or not otherwise an integral part of the group health plan:
  - Limited scope dental benefits
  - Limited scope vision benefits
  - Long-term care benefits
- Certain indemnity insurance, such as cancer-only policies

The claim must have been incurred and paid, and must be the actual amount the plan spent toward the claim. In other words, the claim amount is not billed charges, but rather the amount payable by the plan after taking into account any pre-care, and post-care, negotiated price concessions -- including discounts, reductions, coupons, goods in kind, and other adjustments. The plan is required to recalculate reimbursement requests to reflect later revisions to claims expenses, such as pharmacy / prescription drug rebates. Excess reimbursements must be returned to HHS.

## **Plan Sponsor Requirements**

**Fraud, Waste and Abuse Policies and Procedures** -- The plan must have written policies and procedures to detect fraud, waste, and abuse, and documents or data to substantiate their effectiveness. (Most health plans do not have such procedures in place; Hub International will assist our clients in this matter.) The plan sponsor, insurance carrier, or the plan may maintain these standards, but the plan sponsor must produce them upon request. HHS will check the "exclusions list" developed by the Office of the Inspector General and the U.S. General Services Administration before allowing an entity to participate or play a role in the program. (A plan sponsor should make certain it does not use a listed organization as a carrier or other vendor.) HHS may examine the identities of the individuals covered by the plan, as well as people associated with the plan, the plan sponsor, carrier or other entity, and will examine claims before reimbursement is made to (among other things) reduce fraud, waste, and abuse.

**Third Party Disclosure Agreement** -- There must be a written agreement between the plan sponsor and its health insurance issuer or the plan itself, requiring the issuer or plan to disclose information on behalf of the plan sponsor to the Secretary of HHS. While the regulations are not entirely clear on this point, the plan sponsor should have such an agreement with its third party administrator (TPA) if self-funded. The agreement will require

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and allow the plan to disclose HIPAA-protected information to the federal agency through the plan sponsor without the need to obtain individual authorizations. Hub International will assist its clients with obtaining these new agreements.

**Sponsor Agreement** -- A "Sponsor Agreement" must be executed by the plan sponsor, binding the plan sponsor to comply with the terms of the early retiree reinsurance program as expressed in regulations and other guidance from the agency regarding the program. A sample agreement will be available for review with legal counsel.

**Plan Certification & Cost Saving Policies and Procedures** -- Before HHS will certify a health plan, the plan must have policies and procedures in place with the *potential* to generate cost savings for participants with chronic and high-cost conditions. The policies and procedures need not actually *ensure* reduced costs. "Chronic and high-cost conditions" are those conditions for which \$15,000 or more in health benefit claims are likely to be incurred during a plan year for any one participant. Plan sponsors are permitted to determine which conditions fall into this category, so long as they take a "reasonable approach" when identifying these conditions and selecting programs to lower the cost of care and improve care quality. HHS will not require the plan sponsor to address *all* conditions possibly resulting in claims over the threshold amount. Hub International will assist our clients in identifying conditions and implementing any needed cost reduction efforts.

HHS suggests several plan designs that encourage proper management and treatment for these high-cost conditions. The regulations provide an example: Diabetes can be a chronic and high cost condition resulting in claims over the threshold amount, so a diabetes management program with aggressive monitoring and behavioral counseling may prevent complications and reduce hospitalizations. The regulations also note a plan may waive or reduce cost-sharing for cancer, another high-cost condition. (While this plan design reduces a person's out-of-pocket costs for an illness, this design does not reduce costs overall through prevention, and may be less popular among plan sponsors.) The new law does not supersede other federal laws, such as the Americans with Disabilities Act; plan sponsors must comply with those standards as well.

Upon audit, the plan sponsor must be able to demonstrate that its programs and procedures have generated, or had the potential to generate, cost savings, consistent with the representations the plan sponsor made in its program application.

**Application for Program Participation** -- The plan must submit an application for each plan, signed by its authorized representative certifying the information in the application is true and accurate to the best of his/her knowledge and belief. Before the plan sponsor can submit claims for reimbursement, the application must be approved by HHS. The application does not need to be re-filed each year. Once the plan is certified and the application is accepted, the plan sponsor may continue to request reimbursements, so long as its plan and operations continue to satisfy the program's standards.

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The application must:

- State the month and day the plan year begins and ends (for example, January 1 to December 31); no year is required.
- Provide the plan sponsor's Tax Identification Number (TIN), and the applicant's name and address, and contact information.
- Describe how the plan sponsor will use reimbursements from the program in accordance with program requirements, including how it will use reimbursements to reduce participant or plan sponsor costs, or any combination of these costs, and its programs and procedures to generate savings for participants with chronic and high cost conditions.
- State the plan sponsor will not treat reimbursements as part of its general assets.
- Express a commitment to maintain at least the same level of effort (in other words, the same level of contributions and financial support) when contributing to the retiree plan, and explain how the plan sponsor will use the reimbursement in a manner consistent with this requirement (such as to offset future increases *above* the *current* level of employer contributions toward the plan).
- Contain an attestation by the plan sponsor to having policies and procedures in place to minimize fraud, waste, and abuse.
- Project the amounts of reimbursements for the first two plan year cycles. (HHS will use these projections for its own funding projections and for determining when to stop accepting applications.) Hub International will assist in making such projections.
- Identify all benefit options in the plan under which an early retiree reimbursement may be claimed. (HHS will use this information to track where funds are being spent and to otherwise manage the program.)

**Notice of Change of Ownership** -- A plan sponsor must notify HHS at least 60 days in advance of any change in ownership. Failure to provide the 60-day notice may result in the agency requesting repayment of all amounts previously paid pursuant to the program.

A "change of ownership" occurs when there has been a transfer of all or substantially all of the assets of the plan sponsor to another party. A change of ownership occurs with a merger of the plan sponsor's corporation into another corporation, or the consolidation of the plan sponsor's organization with one or more other corporations, resulting in a new corporate body. A transfer of stock to, or a merger into, the plan sponsor's organization -- with the plan sponsor as the surviving entity -- is not a change in ownership. For a partnership, a change of ownership occurs with removal, addition, or substitution of a partner, unless the partners expressly agree otherwise as permitted by applicable state law (as commonly allowed).

When liability for health plan costs is transferred, the plan sponsor agreement is automatically assigned to the new owner by operation of law. The agency will expect that company to repay HHS any amounts that were improperly reimbursed. The remaining company cannot assert it refuses to abide by the terms of the agreement because it was not a party to the original agreement. That entity will be treated as if it signed the agreement itself. Due diligence in corporate transactions will require examination into these matters.

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## *Reimbursement Requests, First-Year Transition Rule, & Indexing*

The amount the plan sponsor may request is determined based on the “plan year,” which generally has the same meaning as in ERISA. Claims submissions will be processed on a first-in, first-out basis until program funding is spent. The program does *not* limit a plan to submitting claims once a year; given the program’s limited funding, submitting claims as incurred and documented is a wise approach.

A claim must show the health benefit provided, the provider or supplier, the patient, the date incurred, the date of payment, the amount of the payment (net any known negotiated price concessions), the plan name, and the benefit option under which the health benefit was provided. All claims submissions must list the early retirees (and covered family members) for whom claims are submitted. The carrier or TPA may submit the information directly to HHS. The method of submission has yet to be determined, but likely will be electronic, to facilitate processing and to allow cross-checks for whether an individual is also covered by Medicare.

Although not entirely clear, the regulations address claims documentation when a plan sponsor contracts with certain entities (such as staff model HMOs) employing their own providers and which do not ordinarily produce claims. The entity must create and submit the claim, in a manner reasonable in light of the specific market it is serving. These entities may or may not cooperate with such requests, given the extra effort needed to generate a claim and the fact the employer receives the reimbursement, not them.

Any after-the-fact adjustments need to be reported to HHS, and a portion of the reimbursement refunded to HHS, as applicable. An example is a drug rebate that is determined and credited after the end of the plan year.

A transition rule, designed for fairness to plan sponsors with plan years other than June 1, will grant plan sponsors some *recognition* for claims incurred prior to June 1, but not any *reimbursement*. In 2010, a plan can submit claims for reimbursement provided the claims are incurred *after* June 1, 2010 (the date the program is effective). A plan may have a plan year beginning prior to June 1. For claims incurred prior to June 1, the amount of those claims -- up to \$15,000 -- will be counted toward that same threshold amount figure. Claims exceeding \$15,000 which were incurred prior to June 1 are not reimbursable, but amounts after that date, and before the end of the plan year, will be.

*Example:* A plan with an early retiree benefit has a July 1 plan year. The federal program becomes available June 1, 2010. Assume an early retiree has incurred claims of \$120,000 prior to June 1. The plan then spends an additional \$30,000 in claims for that person between June 1, 2010 and June 30, 2010 (the end of that plan year). The plan sponsor would receive credit for \$15,000 in claims prior to June 1, and would receive reimbursement for 80% of the \$30,000 in claims for claims incurred after June 1, 2010, or \$24,000.

The \$15,000 and \$90,000 amounts will be indexed for plan years starting on or after October 1, 2011. Indexing is based on the Medicare Care Component of the Consumer Price Index for all urban consumers, rounded to the nearest multiple of \$1,000.

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## **Use of Reinsurance Reimbursements**

A plan sponsor must use the money received as a reimbursement to lower costs for the plan. HHS encourages a plan sponsor to reduce *both* the plan sponsor's costs as well as costs for plan participants, such as by reducing participants' cost-sharing amounts and premiums. The "participants" who may benefit from the reimbursement includes *active* employees, as well as *retirees*, and the covered spouses and dependents of each.

Reimbursements from the first year of participating in the program can be used to offset or reduce a plan sponsor's increased costs in the next and subsequent plan years. The plan sponsor should be careful to *never* reduce its own expenses below the amount of its expenses as of the date the program becomes effective in June 2010.

## **Record Keeping**

All items required as part of the application, claims submissions, supporting documentation, and additional data should be kept as plan records and provided upon request during an HHS review or formal audit. Records must be kept for a period similar to that required by ERISA -- for six years after the end of the plan year in which the claims costs were incurred, or for a longer period if required by law. The plan sponsor must require its insurance carrier, plan administrator, or the plan itself to maintain and produce these records upon request.

## **HHS Re-Determinations of Reimbursements**

HHS can reopen and revise a reimbursement determination at the option of either the Secretary of HHS or the plan sponsor within one year for any reason, within four years, for "good cause," or at any time for fraud or similar fault. "Good cause" means:

- New, material evidence exists that was not readily available at the time the reimbursement determination was made,
- A clerical error was made in computing the reimbursement determination, or
- The evidence considered at the time the decision was made clearly shows on its face an error was made.

Once funding for the reinsurance program is exhausted, the plan will not be entitled to any additional amounts, regardless of the outcome of an appeal. On the other hand, if HHS has reimbursed an improper amount, the agency should be able to recoup those amounts from the plan sponsor, despite the program ending due to no remaining funding.

## **Appeals**

A plan sponsor may appeal a determination by HHS using a simple, one-step appeals process. The plan sponsor must initiate an appeal within 15 days of an agency denial. If the plan sponsor cannot include all of information by the appeal deadline, it should state in the appeal it lacked sufficient time to perform a comprehensive analysis, and it will provide additional information to support the appeal, to be received by HHS by a stated date. No oral evidence or testimony is allowed. If the plan sponsor requests a written response, one will be provided; otherwise, the decision may be communicated as HHS selects. Once the funds for the program are exhausted, appeals will stop, as further action will not result in additional funds being paid. An HHS appeal decision is binding unless the plan sponsor can prove fraud or fault.