

Employee Benefits & Executive Compensation ADVISORY

May 13, 2010

HHS Issues Interim Regulations on Early Retiree Health Insurance Program – Plan Sponsors Must Be Ready to Act Quickly to Take Advantage of the Program

On May 5, 2010, the Department of Health and Human Services (HHS) issued interim final regulations (“Interim Regulations”) for the early retiree reinsurance program (the “Program”) enacted as part of the Patient Protection and Affordable Care Act (PPACA). The Program is intended to help offset the costs of health claims for employers that provide health benefits for retirees ages 55 through 64 (“early retirees”) and will reimburse plan sponsors for a portion of the cost of benefits provided to early retirees and their spouses and dependents. PPACA expressly provides that reimbursements are not taxable income. PPACA directs the Secretary of HHS (the “Secretary”) to establish the Program within 90 days of enactment (June 21, 2010). The Interim Regulations are effective June 1, 2010. The Program is scheduled to run through January 1, 2014 or, if earlier, when the \$5 billion set aside for the program is exhausted. Plan sponsors must apply for the Program and be certified by HHS in order to participate. HHS has indicated that the application will be available by the end of June. Because the Program is limited by the amount of funds set aside and applications are reviewed on a first-come, first-served basis, there is a premium on submitting a *fully completed* application early. Applications will be denied if not complete, and will be considered a new application if additional information is needed. After a plan is certified, properly documented claims should also be submitted promptly.

This document contains a summary of key aspects of the program, followed by a more detailed description.

Comments on the Interim Regulations are due by June 4.

GENERAL OVERVIEW OF THE PROGRAM

In order to be eligible to receive reimbursements under the Program:

- The *plan sponsor* must apply to the Secretary;
- The Secretary must approve the application and certify that the plan sponsor and the plan sponsor’s *employment-based plans* meet the requirements for participation; and
- The certified plan sponsor must submit claims, with supporting documentation.

For each early retiree enrolled in a certified plan in a plan year, the plan sponsor is eligible to receive reimbursements equal to 80% of the costs for eligible health benefit claims incurred during the plan year that are between \$15,000 and \$90,000 (as indexed for medical inflation after October 1, 2011). Claims of the early retiree’s spouse, surviving spouse and dependents are taken into account in determining the amount of reimbursement.

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A plan sponsor may use the reimbursements from the Program to reduce the sponsor's health benefit premiums or costs and/or to reduce health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs for plan participants, including plan participants who are not early retirees.

It is expected that many employers who will seek to participate in the retiree reinsurance Program are already familiar with the Medicare retiree drug subsidy program ("RDS Program"). Therefore, many elements of the Program are defined in accordance with the RDS Program.

I. ELIGIBILITY TO PARTICIPATE IN THE PROGRAM

Eligible Plans

The Program is available to "employment-based plans" that provide health benefits for "early retirees." An employment-based plan is defined the same as under the RDS Program, except that plans of the federal government (and its agencies and instrumentalities) are excluded. Thus, employment-based plans include group health plans maintained by a private employer, state or local governments (and their agencies and instrumentalities), VEBA's, employee organizations, multiemployer plans, and church plans. Both insured and self-insured plans are eligible to participate, including self insured plans covering retirees only. The plan may qualify whether or not it covers active employees or retirees only.

Early Retiree

An "early retiree" is a plan participant who is age 55 or older, is not eligible for Medicare, and is not actively employed by any employer maintaining the plan, as determined by the plan sponsor in accordance with the rules of the plan. Notwithstanding this rule, an individual is presumed to be actively employed if he or she is considered under the Medicare Secondary Payer rules to be receiving coverage under the employment-based plan by virtue of their current employment status. Under the Interim Regulations, claims of COBRA-qualified beneficiaries and employees receiving disability benefits from the employer for more than six months would appear to qualify for reimbursement, because both of these categories of individuals are not considered to be in current employment status. Some have raised an issue as to whether this is intentional, particularly with respect to COBRA, as the employer is required to make COBRA coverage available, and the provision is intended as an encouragement to voluntarily offer retiree coverage. On the other hand, even in situations where the employer does not contribute toward the cost of COBRA coverage, the provision will serve the purpose of reducing costs to early retirees.

Enrolled spouses, surviving spouses, and dependents (as defined under the plan) are also included in the definition of early retiree and can be any age. Thus, reimbursements for such individuals qualify for reimbursement under the Program.

Plan Sponsor

Application for the Program must be made by the plan sponsor and reimbursements under the Program are paid to the plan sponsor. In general, the plan "sponsor" means: (i) the employer, in the case of a single employer plan; (ii) in the case of a plan maintained by an employee organization, the employee organization; (iii) in the case of a multiemployer plan, the board of trustees or other group of representatives of the parties maintaining the plan; and (iv) in the case of a plan maintained jointly by one employer and an employee organization, and for which the employer is the primary source of financing, the employer.

Plan and Plan Sponsor Requirements

To be eligible for the Program, the plan must include programs that have generated or have the potential to generate cost savings with respect to participants with “chronic and high-cost conditions” (see discussion below).

In addition, the plan sponsor must:

- maintain and make available to the Secretary such records and documentation as specified by the Secretary for six years, and must require its insurer or plan, as appropriate, to maintain and produce such records;
- have a written agreement with its insurer or plan regarding disclosure of information (including protected health information), data, documents and records to the Secretary;
- ensure that policies and procedures are in place to protect against fraud, waste and abuse, and timely comply with requests from the Secretary to produce the policies and procedures and any documents or data to substantiate the implementation of the policies and procedures and their effectiveness; and
- submit to the Secretary an application for participation in the Program within the time frame and in the manner specified by the Secretary.

Cost Savings with Respect to Chronic and High-Cost Conditions

A “chronic and high-cost condition” means a condition for which \$15,000 or more in health benefit claims are likely to be incurred during a plan year by any one participant. Thus, in order to be eligible for the Program, there must be programs and procedures in place that generate or have the potential to generate cost savings for plan participants with conditions that are likely to result in claims exceeding \$15,000 in a plan year for one participant. The preamble to the Interim Regulations provides that sponsors are not required to put new programs and procedures in place, nor are programs and procedures required to be in place for all conditions for which claims are likely to exceed \$15,000 in a plan year for a plan participant. Instead, plan sponsors are expected to take a reasonable approach when identifying conditions and selecting programs and procedures to lower the cost, as well as improve the quality of care. Upon audit, the sponsor must be able to demonstrate that the programs and procedures have generated or had the potential to generate cost savings, consistent with the representations the sponsor made in its program application.

Example: A plan sponsor determines that diabetes, if not managed properly, is likely to lead to claims in excess of \$15,000 for a plan year for one plan participant. An example of a program and procedure that generates cost savings for a participant with such a chronic condition would include implementation of a diabetes management program that includes aggressive monitoring and behavioral counseling to prevent complications and unnecessary hospitalization.

II. APPLICATION FOR PARTICIPATION IN THE PROGRAM

The sponsor must submit an application for the Program in accordance with the Interim Regulations. The information that must be included in the application is set forth below. In addition, the following are key aspects of the application process:

- **Importance of timely and complete application.** Applications will be processed in the order in which they are received. No more applications will be accepted once the Secretary determines that no further funds will be available. If an application is incomplete, it will be denied and the applicant must submit a new application, which will be processed based on when the new application is received. Therefore, it is important that applicants submit complete applications upon their first submission. The Interim Regulations specify that HHS will be providing assistance to plan sponsors to help ensure that applications are complete the first time. No details on how this assistance will be made available are provided.
- **One application per plan.** An application must be submitted for each plan of the sponsor.
- **Identification of plan year cycle.** The application must identify the plan year cycle for which the plan sponsor is applying (i.e., the starting and ending month and day; no year is required). In general, the plan year is the plan year designated in the plan document. If the plan document does not designate a plan year, if the plan year is not a 12-month plan year, or if there is no plan document, the plan year is (i) the deductible or limit year used under the plan; (ii) the policy year, if the plan does not impose deductibles or limits on a 12-month basis; (iii) the sponsor's taxable year if the plan does not impose deductibles or limits on a 12-month basis and either the plan is not insured or the insurance policy is not renewed on a 12-month basis; or (iv) the calendar year in any other case.
- **Signature of an authorized representative.** To verify the accuracy of the information contained in the application, the application must be signed by an authorized representative. The Interim Regulations define an authorized representative to mean an individual with legal authority to sign and bind a plan sponsor to the terms of a contract or agreement.
- **Annual application approval not required.** Once a plan is certified, the application approved, and the plan sponsor continues to satisfy the requirements of the statute, the plan and plan sponsor will continue to be certified and the application approved.

Application Requirements

The application for the Program must include the following:

- the applicant's TIN;
- the applicant's name and address;
- the applicant's contact information;
- an agreement between the plan sponsor and HHS (a "sponsor agreement") signed by an authorized representative that includes information set forth in the Interim Regulations (including an assurance that

the sponsor has a written agreement with the insurer or plan regarding disclosure and an attestation that policies are in place to detect fraud, waste and abuse) and such other information as the Secretary may require;

- a summary of how the sponsor will use reimbursements, including
 - how the sponsor will use the reimbursement to reduce plan participant or plan sponsor costs or a combination of both;
 - the sponsor’s plans to implement programs and procedures to generate savings for plan participants with chronic and high-cost conditions; and
 - how the sponsor will use the reimbursement to maintain its level of contribution to the plan;
- projected reimbursement amounts for the first two plan-year cycles;
- all benefit options under the plan that may be claimed by any early retiree for whom the applicant may receive program reimbursement; and
- any other information the Secretary requires.

The Interim Regulations contemplate that an application will be issued, which may include requirements for additional information.

III. CLAIMS SUBMISSION

Documentation

A plan must be certified before claims may be submitted. The Program will only accept claims that represent costs for health benefits for an early retiree that have already been incurred and paid. A “claim” includes documentation specifying the health benefit provided, the incurred date, the individual for whom the health benefit was provided, the date and the amount of payment minus any known negotiated price concessions and the plan and benefit option under which the health benefit was provided. Plan sponsors should only submit claims that are between \$15,000 (cost threshold) and \$90,000 (cost limit).¹ Claims that are below \$15,000 or above \$90,000 will not be reimbursed. Claims must be submitted based on the amounts actually paid, which may include amounts paid by the early retiree, if the sponsor provides prima facie evidence that the retiree paid such amount. Such evidence may include an actual payment receipt.

All claim submissions must include a list of early retirees for whom claims are being submitted. Both the documentation of actual cost of claims and the list of early retirees must be submitted in a form and manner to be specified by the Secretary. For an insured plan, the claims and the list of early retirees can be submitted directly to the Secretary by the insurer. Plan sponsors are responsible for ensuring that insurers submit the information required in a claim.

¹ For plan years beginning on or after October 1, 2011, the \$15,000 and \$90,000 figures will be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index.

In the case of a plan where the provider does not produce a claim in the normal course of business—for example, a staff-model HMO—the information required must be produced and provided to the Secretary. The plan sponsor must ensure that the insurer submits the required information, which must be reasonable in light of the specific market the insurer is serving.

A sponsor may appeal to the Secretary within 15 days of an adverse determination with respect to a claim. No appeal is available if the claim was denied due to lack of further funding under the Program.

Definition of Health Benefits Eligible for Reimbursement

Claims may be submitted for reimbursement of “health benefits,” which is defined as medical, surgical, hospital, prescription drug and such other benefits as determined by the Secretary, whether self-funded or provided through insurance or otherwise. Health benefits also include benefits for the diagnosis, cure, mitigation or prevention of physical or mental disease or condition with respect to any structure or function of the body. This is not intended as an exhaustive list of health benefits.

Health benefits do not include “excepted benefits” as defined under HIPAA. These benefits provide limited types of coverage. Thus, for example, the Program will not reimburse benefits under the following if provided under a separate policy: long-term care benefits, limited scope vision and dental, benefits for a specified disease, or hospital indemnity or other fixed indemnity benefits.

HIPAA Privacy

Certain information required to be disclosed for claims reimbursement would be considered protected health information (PHI) under the HIPAA privacy rules, but can be disclosed to HHS. Because this information belongs to the plan and not the employer, the Interim Regulations require the plan sponsor to have an agreement in place to directly disclose this information to HHS. This disclosure will be considered to qualify for the exception to the HIPAA privacy rules for disclosures required by law.

IV. REIMBURSEMENT AMOUNT

The Program provides reimbursement in an amount equal to 80% of the portion of the health benefit costs that exceed \$15,000 (cost threshold) but are below \$90,000 (cost limit), and that are paid by the employment-based plan, the insurer or an early retiree. Costs are considered paid by an early retiree if paid by that individual or another person on behalf of the early retiree, and the early retiree is not reimbursed through insurance or other third-party payment arrangement. Because enrolled spouses, former spouses and dependents are considered separate early retirees, the cost threshold and cost limit would appear to apply separately to each of these individuals.

In determining amounts eligible for reimbursements in the case of an insured plan, amounts the insurer pays and the amount the early retiree pays are taken into account. Thus, the sponsor’s premiums are irrelevant.

Rather than reimbursement being available only for discrete health benefit items or services whose reimbursement total falls between \$15,000 and \$90,000, the Program will reimburse cumulative health benefits incurred in a given plan year that fall between such amounts. In addition, all costs for health benefits paid by the plan or by the early retiree for all benefit options the early retiree is enrolled in will be combined for purposes of determining the amounts below the cost threshold and above the cost limit for any given early retiree.

Example: An early retiree is simultaneously enrolled in two different benefit options within one group health plan—Option 1 as a retiree and Option 2 as a spouse of a retiree. For purposes of determining when the early retiree satisfies the cost threshold, all claims incurred and paid for that early retiree under each benefit option will be aggregated.

In determining the amount of a claim under the Program, the employment-based plan must take into account any negotiated price concessions (i.e., discounts, direct or indirect subsidies, or rebates) obtained by the plan. The Interim Regulations define negotiated price concession as any direct or indirect remuneration that would serve to decrease the costs incurred under the health plan.

Transition Rule

The Interim Regulations provide a transition rule for claims in 2010. With respect to claims incurred before June 1, 2010, the amount of such claims up to \$15,000 count toward the cost threshold and cost limit. However, the amount of claims incurred before June 1, 2010, that exceed \$15,000 are not eligible for reimbursement.

Example: Joe is an early retiree who incurs \$20,000 in eligible health benefit expenses as of June 1, 2010, and \$30,000 after June 1, 2010. Under the transition rule, the \$20,000 of pre-June 1 expenses count toward the cost threshold. The sponsor may receive reimbursement of 80% of the \$30,000 incurred after June 1 (i.e., \$24,000).

V. USE OF REIMBURSEMENTS

The Interim Regulations take a fairly expansive view of how reimbursements may be used. Thus, reimbursements may be used to reduce sponsor costs or plan participant costs (e.g., deductibles and copayments). Although reimbursements are limited to claims for early retirees, reimbursements may be used to reduce costs for all plan participants, not just early retirees. Reimbursements may not be used as general revenue of the sponsor.

The Interim Regulations contemplate that plan sponsors will provide at least the same level of contribution to support the applicable plan as it did before the Program. Thus, for example, although reimbursements could be used to reduce increases in sponsor premiums, it is expected that reimbursements may not be used to pay current level premiums. HHS is expected to provide additional guidance with regard to how the Secretary will monitor the appropriate use of reimbursements.

*This advisory was written by **Ashley Gillihan, John R. Hickman, Carolyn E. Smith and Anne Tyler Hamby.***

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If you have any questions or would like additional information, please contact your Alston & Bird attorney or any one of the following:

Members of Alston & Bird's Employee Benefits & Executive Compensation Group

Robert A. Bauman
202.756.3366
bob.bauman@alston.com

James S. Hutchinson
212.210.9552
jamie.hutchinson@alston.com

Nancy B. Pridgen
404.881.7884
nancy.pridgen@alston.com

Saul Ben-Meyer
212.210.9545
saul.ben-meyer@alston.com

Lindsay Jackson
202.756.3002
lindsay.jackson@alston.com

Thomas G. Schendt
202.756.3330
thomas.schendt@alston.com

Philip C. Cook
404.881.7491
philip.cook@alston.com

David C. Kaleda
202.756.3329
david.kaleda@alston.com

John B. Shannon
404.881.7466
john.shannon@alston.com

Patrick C. DiCarlo
404.881.4512
pat.dicarlo@alston.com

Laurie Kirkwood
404.881.7832
laurie.kirkwood@alston.com

Maya D. Simmons
404.881.4601
maya.simmons@alston.com

Ashley Gillihan
404.881.7390
ashley.gillihan@alston.com

Johann Lee
202.756.5574
johann.lee@alston.com

Carolyn E. Smith
202.756.3566
carolyn.smith@alston.com

David R. Godofsky
202.756.3392
david.godofsky@alston.com

Blake Calvin MacKay
404.881.4982
blake.mackay@alston.com

Michael L. Stevens
404.881.7970
mike.stevens@alston.com

Anna Grant
404.881.7124
anna.grant@alston.com

Emily W. Mao
202.756.3374
emily.mao@alston.com

Laura G. Thatcher
404.881.7546
laura.thatcher@alston.com

Anne Tyler Hamby
404.881.4839
annetyler.hamby@alston.com

Sean K. McMahan
404.881.4250
sean.mcmahan@alston.com

Kerry T. Wenzel
404.881.4983
kerry.wenzel@alston.com

John R. Hickman
404.881.7885
john.hickman@alston.com

Michael G. Monnolly
404.881.7816
mike.monnolly@alston.com

Kyle R. Woods
404.881.7525
kyle.woods@alston.com

H. Douglas Hinson
404.881.7590
doug.hinson@alston.com

Craig R. Pett
404.881.7469
craig.pett@alston.com

ATLANTA

One Atlantic Center
1201 West Peachtree Street
Atlanta, GA 30309-3424
404.881.7000

CHARLOTTE

Bank of America Plaza
Suite 4000
101 South Tryon Street
Charlotte, NC 28280-4000
704.444.1000

DALLAS

Chase Tower
Suite 3601
2200 Ross Avenue
Dallas, TX 75201
214.922.3400

LOS ANGELES

333 South Hope Street
16th Floor
Los Angeles, CA 90071-3004
213.576.1000

NEW YORK

90 Park Avenue
New York, NY 10016-1387
212.210.9400

RESEARCH TRIANGLE

Suite 600
3201 Beechleaf Court
Raleigh, NC 27604-1062
919.862.2200

SILICON VALLEY

Two Palo Alto Square
Suite 400
3000 El Camino Real
Palo Alto, CA 94306-2112
650.838.2000

VENTURA COUNTY

Suite 215
2801 Townsgate Road
Westlake Village, CA 91361
805.497.9474

WASHINGTON, D.C.

The Atlantic Building
950 F Street, NW
Washington, DC 20004-1404
202.756.3300

www.alston.com

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