A Timely Analysis of Legal Developments

ASAP®

In This Issue:

May 2010

On May 4, 2010, the Department of Health and Human Services (HHS) issued an Interim Final Rule establishing the temporary early retiree reinsurance program under the Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010.

HHS Issues Interim Rule for Early Retiree Reinsurance Program

By Susan K. Hoffman and Ilyse W. Schuman

On May 4, 2010, the Department of Health and Human Services (HHS) issued an Interim Final Rule establishing the temporary early retiree reinsurance program under the Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010. Under the PPACA, $5 billion was appropriated to reimburse the sponsors of employment-based retiree medical plans for the cost of coverage for any retiree age 55 to 65, in the amount of 80% of the costs for any eligible individual between $15,000 and $90,000 of expenses per plan year. The reimbursements must be applied to reduce future increases in employer costs, and/or out-of-pocket costs for the covered early retirees and cannot be used to reimburse the employer's contributions towards the costs of the plan. The PPACA called for the program to be in place by June 21, 2010, but the Interim Final Rule provides for the program to commence on June 1, 2010. The key features of the Rule are:

Eligible Plans

The early retiree medical plan must apply to the HHS and be "certified" before reimbursements can be made. The plan must be employment-based and a group plan, but can be sponsored by an employer, a trade association, jointly by an employer (or group of employers) and a union (or group of unions), or by a "VEBA" (a trust fund established by a union or employer or a combination of them, to provide health benefits to former employees). In addition, the plan must have certain cost-reduction programs in place to manage care and reduce costs for certain chronic conditions likely to result in expenses in excess of $15,000 per year, and must also have programs in place to reduce fraud, waste, and abuse. The Interim Final Rule does not specify the chronic and high-cost conditions to be addressed. However, sponsors must be able to demonstrate, upon audit, that its programs have generated or had the potential to generate cost savings. The plan can be either insured or self-funded. In addition, state and local government plans are eligible.

Eligible Retirees

The individuals whose expenses can be reimbursed must be former employees of the employer that established the plan or that made contributions to the plan. They must be age 55 or over, and not eligible for Medicare. Spouses, surviving spouses, and dependents of eligible retirees also are included in the program, even if they are under age 55 or eligible for Medicare.

Eligible Expenses

Generally, all medical expenses paid by the plan will be eligible for reimbursement, including prescription drugs, medical, surgical, and hospital benefits. But ancillary benefits such as dental and vision care and long-term care benefits will not be eligible.

The medical expenses must have been actually incurred and paid. Thus, if a plan only reimburses a negotiated amount, or if the plan receives a retroactive discount, the reimbursement will be based on the reduced, net cost to the plan (reimbursements or rebates expected to be received after the plan year must be disclosed). The expenses are measured by plan years, which will be the plan year specified in the plan document or, if not specified, the year used for measuring annual limits under the plan or, if none, the policy year or, if none, the sponsor's fiscal year or the calendar year. The first eligible plan year is the year in effect on June 1, 2010, (thus, a plan year beginning anytime between June 2, 2009, and June 1, 2010, is eligible for reimbursement). But the costs incurred before June 1, 2010 will count only in determining whether the $15,000 threshold has been reached. Only expenses incurred on or after June 1, 2010, are eligible for reimbursement. An expense is "incurred" at the point in time when the plan or participant becomes legally responsible for payment of the expense.

In determining whether (and to what extent) the costs for any eligible individual have exceeded $15,000, amounts paid out-of-pocket by the covered individual are *included*. Thus, if a plan has a deductible and co-insurance feature, such that the covered individual has paid $5,000 of a $21,000 medical expense, the sponsor can apply for reimbursement of $6,000, even though the plan itself has spent only $1,000 more than the $15,000 threshold. For insured plans, the cost includes out-of-pocket payments by the eligible individual plus payments to providers by the insurer, but does not include premium payments.

In its initial application, the plan sponsor must estimate the likely reimbursement amounts for the first two plan years it will participate in the program.

For plan years starting on or after October 1, 2011, the $15,000 cost threshold and $90,000 cost limit will be adjusted by the percentage increase in the Medical Care Component of the Consumer Price Index for urban consumers.

Application of Reimbursement Funds

The PPACA requires that the reimbursements received under the program be used to reduce premiums paid by the sponsor, or out-of-pocket costs for retirees in the health plan. In order to implement this requirement, the Interim Final Rule requires the applicant to specify how the reimbursement will be used to reduced costs, and also requires the applicant-sponsor to certify that it will not reduce its own expenditures towards the costs of the program while applying the reimbursement to benefit the participants in the plan (a "maintenance of effort" requirement). For example, reimbursements in one year may be used to keep retiree premiums steady (or reduced) in the next year, or may be used to keep the plan sponsor's premium costs steady in the next year (but cannot be used to reduce the sponsor's costs). The recipients of the cost reduction may include other retirees in the plan (*e.g.*, those under age 55 or who are Medicare eligible) as well as active employees if they are in the same plan as the retirees whose expenses are being reimbursed as well as spouses or dependents enrolled in the plan.

Technical Requirements

The Rule sets out various technical requirements for certified plans, in order to facilitate audits of the program. For example, a plan's

sponsor must have a HIPAA associate agreement in place with its plan administrator or insurer, such that protected health information can be provided to HHS upon request. A separate application must be filed for each plan and must specify the first year covered in the request for certification. But once a plan is certified, the certification covers each year in the program (which expires on January 1, 2014, or when the $5 billion has been exhausted). Upon certification, the plan sponsor will enter into a written agreement with HHS designed to facilitate the agency's monitoring and enforcement functions.

The claim submissions must include a list of each eligible individual and specify the claims incurred on behalf of that individual (including the individual's out-of-pocket costs) up to $90,000 (claims in excess of that amount are not to be submitted) for the plan year. The sponsor must include evidence that the out-of-pocket cost was actually paid (a receipt, for example). Claims will be paid on a first-in, first-out basis until funds are exhausted.

What an Employer Should Do Now

Employers with retiree medical plans that cover individuals age 55 to 65 should begin gathering data concerning eligible individuals whose medical expenses are likely to exceed $15,000 for the current plan year. In addition, the plan should be reviewed to ensure that the proper cost-containment and anti-fraud measures are in place, so that the plan can qualify for the reimbursement. The sponsor also should consider alternative approaches for application of the reimbursements to reduce costs, and select the approach most suitable for its circumstances. Because of the limited funding for the program, it may be advisable to apply for certification as soon as possible.

Susan K. Hoffman is a Shareholder in Littler Mendelson's Philadelphia office, and Ilyse W. Schuman is a Shareholder in Littler Mendelson's Washington, D.C. office. If you would like further information, please contact your Littler attorney at 1.888.Littler, info@littler.com, Ms. Hoffman at shoffman@littler.com, or Ms. Schuman at ischuman@littler.com.