Summary of the HHS Early Retiree Reinsurance Program Under the Patient Protection and Affordable Care Act of 2010

This is a summary of the Early Retiree Reinsurance Program (the "Program") that was included in the Patient Protection and Affordable Care Act of 2010. This Program may be of interest to sponsors of early retiree health plans.

In the Health Care Reform legislation, Congress appropriated a one-time $5 billion for this Program which will be in effect from June 1, 2010 to the earlier of December 31, 2013 or when the appropriated funds are exhausted. The Program will be administered by the Secretary of Health and Human Services ("HHS") and will reimburse the sponsors of employment-based plans for eighty percent (80%) of the cost of health benefits for each participant that is between $15,000 and $90,000 in a plan year the Program is in effect. A "plan participant" for this purpose may be an early retiree who is age 55 or older but is not eligible for Medicare, his or her enrolled spouse, surviving spouse or dependent. Each covered individual is a separate plan participant for the purpose of claims and reimbursements under the Program. The early retiree and any other plan participant must not be an active employee of the plan sponsor.

Health claims include medical, surgical, hospital, prescription drugs or other claims, as determined by the Secretary of HHS. The HHS interim final rule defines "health benefits" to include "benefits for any physical or mental disease affecting any structure or function of the body" and to exclude "excepted benefits," as defined in HIPAA (such as dental and vision benefits). The preamble to the HHS interim final rule indicates that this is not an exhaustive list of appropriate health benefits under the Program.

An employment-based plan is defined to include plans maintained by private employers, state or local governments, employee organizations, voluntary employee beneficiary associations and multi-employer plans. The plan may be insured or self-insured. Reimbursements under the Program cannot be used as general revenue of the plan sponsor. Reimbursements under the Program will not be includable in the plan sponsor's income for Federal tax purposes (according to a White House Fact Sheet).

In order to qualify for the Program, the plan must have: (i) programs and procedures in place that have generated or have the potential to generate cost savings for participants with chronic and high cost conditions (such as a diabetes management program or lower deductibles for cancer patients); (ii) a written agreement with a health insurance issuer or third party administrator to make protected health information available to HHS; and (iii) policies and procedures in place to protect against fraud, waste and abuse under the Program.

The application to participate in the Program must be submitted to HHS and include:

(i) A summary of how applicants will use any reimbursements the plan sponsor receives under the Program;

(ii) An explanation of how the plan sponsor will use reimbursements to reduce participant premium contributions, co-payments, deductibles, co-insurance and other out-of-pocket costs;

(iii) A description of the procedures and programs that are in place with respect to chronic and high cost conditions and whether they have generated or have the potential to generate cost savings;

(iv) An explanation of how the plan sponsor will maintain its level of contributions to the plan;

(v) A plan sponsor agreement with HHS (which is in the HHS form application) that includes provisions relating to:

- Disclosing information;
- Acknowledging that information is being provided to obtain Federal funds, which includes an acknowledgement that subcontractors are aware that the information they provide is for the purpose of obtaining Federal funds;
- Attesting to fraud, waste, and abuse procedures; and
- Agreeing to comply with all applicable Program requirements.

(vi) The projected amounts to be received under the Program for the first two plan year cycles with specific amounts for each cycle.

Applications will be processed in the order in which they are received and, if denied, will be returned and must be resubmitted. This "first come first served/one strike (or mistake) and you are out" procedure is perceived by many to be unfair and unreasonable. Alternative application timing and processing procedures have been suggested by employer advocacy organizations, including the American Benefits Council. HHS has indicated that the final application form will be available sometime in June. Perhaps revised "fair and reasonable procedures" will be provided at the same time or within a reasonable period of time before the application submission deadline.

Because of the limited amount of appropriated funds for this Program, HHS will stop accepting application requests when no more plans can be accepted by the Program, based on projected reimbursement requests of applicants that have been accepted by HHS. This decision is not appealable.

If a plan sponsor wants to explore whether to participate in the HHS Early Retiree Reinsurance Program, we suggest the following action plan in coordination with the insurer or third party administrator of the plan:

1) Project the claims of the retiree health plan that may be reimbursed for each of the first two plan year cycles.

2) Determine how the client's health plan could use reimbursements under the Program to reduce participant contributions, co-payments, deductibles, coinsurance and other out-of-pocket costs;

3) Determine whether the plan sponsor has procedures and programs in place that have generated (or have the potential to generate) cost savings with respect to chronic and high cost conditions, or if such procedures and programs need to be adopted to qualify for this early retiree subsidy;

4) Determine whether the plan sponsor and/or its TPA or insurer has policies and procedures in place to protect against fraud, waste or abuse under the Program or if such policies and procedures will need to be created and be "in place" before the application is submitted;

5) Project whether any reimbursements under the Program can be applied to reduce estimated plan sponsor cost increases (with the plan sponsor maintaining its level of employer contributions to the plan);

6) Determine whether the TPA or insurer can provide the claims submission services required under the Program and, if so, the additional cost for such additional services;

7) Decide whether the plan sponsor's participation in the Program is feasible and cost efficient; and

8) If an application to participate in the Program is submitted, enter into an agreement with the TPA or insurer that includes a provision authorizing the TPA or insurer to provide protected health information to HHS in connection with the claims for reimbursements they will send to HHS.

There will be a lot of early retiree plans in line for part of this $5 billion subsidy program. If an eligible plan sponsor is interested in applying, they will need to be in line early and satisfy all the requirements in the application, including, but not limited to, procedures and policies relating to cost savings for chronic health conditions and to protect against fraud, waste and abuse under the Program.

Dated: June 15, 2010