Health Care Reform Advisory: HHS Issues "Early Retiree Reinsurance Program" Guidance

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By Thomas M. Greene

The Patient Protection and Affordable Care Act of 2010 together with the Healthcare and Education Reconciliation Act of 2010 (collectively, the "Act") established the Early Retiree Reinsurance Program (the "Program") for the purposes of subsidizing retiree medical benefits by reimbursing participating plan sponsors for the costs of providing group health plan coverage to early retirees. "Early retirees" consist of former employees age 55 and older who are not yet eligible for Medicare and who are not active employees of an employer maintaining or currently contributing to a plan, or of an employer that has made substantial contributions to fund a plan. The Program not only covers medical claims for early retirees, but also their eligible spouses, surviving spouses and dependents. Pursuant to the mandate of the Act, the Secretary of Health and Human Services (HHS) issued a regulation on the Program as of May 5, 2010. The Program is effective June 1, 2010 and terminates on January 1, 2014. If you provide applicable retiree medical coverage or advise entities that do, this Advisory contains important information for you.

Note: Applications will be processed in the order in which they are received and funding for the Program is capped at $5 billion in total, so timing is critical with respect to every application for reimbursement.

Reimbursements

The Program reimburses eligible plan sponsors for 80% of the "medical claims" actually paid by the plan, per retiree, between $15,000 and $90,000 each plan year. Such amount will be indexed based on the Medical Care Component of the Consumer Price Index. Since the Program begins in the middle of the year, it provides for a transition rule under which claims incurred before June 1, 2010 count towards the $15,000 minimum, but are not eligible for reimbursement and do not count towards the $90,000 cap on reimbursement.

Eligible "medical claims" include medical, surgical, hospital, and prescription drug benefit claims, and such amounts for the "diagnosis, cure, mitigation, or prevention of physical or mental disease or condition with respect to any structure or function of the body." However, any benefits exempt from the requirements of the Health Insurance and Accountability Act are not eligible for reimbursement. Amounts requested for reimbursement must take into account any "negotiated price reductions" enjoyed by the plan, but can also include employee out-of-pocket costs such as deductibles and co-payments.

Program reimbursements must be used to reduce plan costs and not to increase the sponsor's bottom line. For example, a plan sponsor cannot simply pocket the reimbursements because it

has already paid out costs through the plan. Accordingly, reimbursements must be used to reduce premiums, co-payments, deductibles, co-insurance or other out-of-pocket costs. Notably, the regulation specifically notes that reimbursements may be used to reduce or offset future premium increases.

Program Eligibility

A plan must meet the following requirements to be eligible for the Program:

- Must be an employment-based group health plan (individual agreements are not eligible)
- Must submit a proper application for reimbursement that has been "certified" by HHS
- Must have programs in place to generate cost savings with respect to chronic and high-cost conditions (conditions which will cost more than $15,000 in a plan year for one participant)
- Must make available all pertinent claims data and records requested by HHS (records must be maintained for at least six years following the close of the relevant plan year)
- Must have a written agreement with insurer or plan to disclose to HHS any information necessary to comply with the Program
- Must maintain suitable anti-fraud, waste and abuse policies and procedures.

Application Process

The Program establishes a detailed application process and requires each plan to submit a separate application, but allows one application to submitted for multiple plan years. Notably, an "authorized representative" of each applicant must certify the accuracy of the information contained on the application "to the best of the authorized representative's knowledge and belief," and there is an affirmative duty to update "data inaccuracies" after an application has been submitted. The Program also establishes an appeals process for adverse determinations, and the Secretary reserves the right to reopen and revise a reimbursement determination and claw back improperly reimbursed amounts.

Change in Control

Plan sponsors requesting reimbursement must inform HHS at least 60 days in advance of any pending change in control. A change in control includes a change in partners, a sale of substantially all the assets of the plan sponsor, or a merger resulting in a new "corporate body."

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For further information regarding this or any issue related to Health Care Reform, please contact one of the professionals listed below or the Mintz Levin attorney who ordinarily handles your legal affairs.

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