June 4, 2010

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: DHHS–9996–IFC
P.O. Box 8014
Baltimore, MD 21244–8014

Re: RIN 0991-AB64
Comments on Early Retiree Reinsurance Program Interim Final Rule

Dear Sirs & Madams:

I am writing on behalf of the American Benefits Council (the Council) to comment on the Early Retiree Reinsurance Program (ERRP) interim final rule (IFR) published in the Federal Register on May 5, 2010. 75 Fed. Reg. 24450 (2010).

The Council represents employers, primarily large ones, and other organizations that collectively sponsor or administer health and retirement benefits covering over 100 million Americans. Most large employers and many smaller employers make retiree health coverage available to their employees. A May 25, 2010, Hewitt Associates survey of large employers with retiree health programs found that 76% of them are planning to participate in ERRP. These findings are consistent with an informal Council survey indicating strong interest by its member plan sponsors in ERRP participation.

The Council commends the Department of Health & Human Services (HHS) for implementing ERRP as of June 1, 2010, well before the legislatively-established deadline, and for speedily issuing the IFR. Although the IFR addresses many employer concerns, it leaves a number of important questions unanswered. As or more important, HHS' first-come-first-served ERRP implementation approach raises serious fairness issues. We will address those fairness issues first, and then set forth important questions that the IFR leaves unanswered, but which HHS should immediately address.

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First-Come-First-Served

ERRP is a finite program. It will lapse when the $5 billion Congress appropriated for it has been spent or in 2014, whichever comes first. Plan sponsors who wait too long to participate in ERRP may lose the opportunity to fully participate.

To participate in ERRP, a plan sponsor must apply for plan certification and, thereafter, submit reimbursement claims. The IFR states that certification applications will be processed in the order received, and states that erroneous applications will be rejected and must be refiled. IFR Preamble at 75 Fed. Reg. 24455. The IFR strongly suggests that HHS intends to stop processing certification applications when it has approved enough to use up ERRP's $5 billion funding reimbursing 2010 and 2011 claims. *Id.* The IFR at least implies that claims will be processed as received. Hence, a plan sponsor that is tardy or errant in seeking certification may entirely lose the right to participate, and a plan sponsor that is less than vigilant in filing claims may not receive as much reimbursement as the most vigilant employers.

While the Council understands HHS' desire to implement ERRP speedily, we have significant concerns regarding the first-come-first-served provisions described in the preceding paragraph. If stringently implemented, they will generate an intense rush for limited funding, be unfair, and unnecessarily embroil HHS in the controversies that it will inevitably generate. A few modest changes would prevent these untoward outcomes. The Council recommends that HHS announce, by modifying the IFR, that:

1. **Certification applications will not be accepted for filing until the first calendar month at least 60 days after HHS issues the application form.** This would give plan sponsors at least 60 days to complete and file certification applications after HHS issues the form without undue haste. It would also provide HHS the opportunity to engage in further outreach with plan sponsors and service providers regarding the application process and related guidance. (The Council is not wedded to the time periods in this or the following points; rather, they are intended to be examples of reasonable time periods.)
2. **All applications that are filed during a calendar month will be treated as simultaneously filed.** This will further avoid undue rushes to file first.
3. **All simultaneously filed applications will be certified or denied certification at the same time.** Hence, no successful or unsuccessful applicant during a filing period would be favored over any other successful or unsuccessful applicant during the filing period.
4. **Erroneous or incomplete applications will not be rejected if the errors are minor and are timely corrected.** The IFR states the incomplete applications will be rejected. HHS presumably would also reject complete applications that contain unsatisfactory responses. In either case, the applicant would then have

to refile, but would have to do so at the very end of the line. This seems entirely appropriate for grossly inadequate applications, but much too harsh if the errors are minor and timely corrected. For example, such an application could be conditionally approved subject to correction of the error within 15 days after notice is given of the error.

5. **No reimbursement claims will be accepted until the beginning of the first calendar month that is at least 30 days after the first plans are certified.** This will permit plan sponsors to file their initial claims without undue haste after the first plans are certified.
6. **All reimbursement claims submitted in a calendar month will be treated as simultaneously filed.** Again, batch processing of claims submitted in a period will eliminate the incentive to be first to file.
7. **When approving claims for a calendar month, HHS will announce how much remains available for reimbursement under ERRP's $5 billion appropriation.** This will give plan sponsors information they need to know to file timely claims.
8. **In the calendar month in which the $5 billion is exhausted, approved claims will be paid pro rata. Thereafter, HHS will pay the balance of those claims pro rata out of any subsequent ERRP reimbursement recoupments.** This will treat all plan sponsors equally, and deal with later ERRP reimbursement recoupments.

Issues Needing Clarification

Although the IFR provides guidance on many employer concerns, a number of ERRP issues remain unclear. HHS should issue prompt guidance on the following points, e.g., by written announcement or IFR modification:

Certification Issues

1. If HHS does not adopt the recommendations set forth above, will it at least give reasonable advance notice of when the certification application will be available?
2. IFR Section 149.40(f)(7) requires certification applications to list all "benefit options." This requirement needs to be clarified. Does it merely require that the major benefit alternatives be listed, e.g., PPO and HMO options, or does it require a more detailed listing of plan terms? If the latter, would including a plan's benefit chart or grid in the application satisfy this requirement? Examples should be provided in the application or instructions so that plans sponsors know how much detail is required.
3. IFR Section 149.35(b)(3) and 149.40(f)(4)(iii) require a plan to have, and describe in its certification application, "policies and procedures for detecting and reducing fraud, waste, and abuse." Can such policies and procedures be limited to ERRP claims or must they apply to the plan as a whole?

4. Is a plan that just provides retiree coverage precluded from participating in ERRP if it is entirely funded by retiree contributions?

"Early Retiree" Issues

5. Is an inactive employee who is at least age 55 and not yet Medicare-eligible an "early retiree" if he or she is buying health coverage from a certified plan through COBRA?
6. Is an inactive employee who is at least age 55 and not yet Medicare-eligible an "early retiree" if he or she is buying health coverage from a certified plan that charges the individual what it considers to be the full cost of coverage?
7. Do an ex-employee "early retiree" and each of his or her covered spouse and dependents each constitute a separate "early retiree" under IFR Section 149.2 or do they collectively constitute a single "early retiree"? The Council interprets the IFR as making them each a separate early retiree, which means that each one's benefit costs are separately totaled up in determining whether the plan sponsor has a reimbursable claim, rather than requiring all of their costs being aggregated in a single claim.

Claim Issues

8. How much data must be submitted to prove up a claim?
9. Can it be submitted in summary format like the Medicare RDS, or must it be claim-level or member-level data?
10. IFR Section 149.335(b) states that "for a sponsor to receive reimbursement for the portion of a claim that an early retiree paid, the sponsor must submit prima facie evidence that the early enrollee paid his or her portion of the claim." What constitutes prima facie evidence and how is a plan sponsor to provide it? The Council recommends that plan sponsors be permitted to satisfy this requirement by obtaining attestations from early retirees that such amounts were paid.
11. Will the payment system be like the RDS program, under which plan sponsors can make periodic payment requests and then reconcile annually?

Use of Proceeds Issues

12. Reinsurance Program proceeds must be used by the Certified Plan's sponsor "[t]o reduce the sponsor's health benefit premiums or health benefit costs" or "[t]o reduce health benefit premium contributions, copayment, deductibles, coinsurance, or other out-of pocket costs, or any combination of these costs, for plan participants," but "not . . . as general revenue for the sponsor." IFR § 149.200. The IFR Preamble at 75 Fed. Reg. 24458 states that HHS expect[s] that sponsors will continue to provide the same level of contribution to support the

applicable plan, as it [sic] did before the program. For example, for a sponsor that pays a premium to an insurer, if the premium increases, program funds may be used to pay the sponsor's share of the premium increase from year to year, which reduces the sponsor's premium costs.

This example does not address self-insured plans. We interpret this to apply equally to self-insured plans, but confirmation would be helpful.

13. Is the maintenance of contribution "expectation" an absolute requirement? It would be extremely helpful for HHS to clarify that the expectation is **not** an absolute requirement. If it is not an absolute requirement, plan sponsors will know that they can be flexible in their approaches towards satisfying the maintenance of contribution expectation. Even more important, by recognizing that it is only an expectation, not a requirement, HHS will help minimize or entirely prevent potential disputes regarding how plan sponsors utilize or apply ERRP reimbursements. Finally, if a controversy over the use of ERRP reimbursements is ever to arise, it should arise and be addressed before ERRP reimbursements are first paid, rather than after plan sponsors have already disbursed or utilized them.
14. How long can ERRP proceeds be accumulated by the plan sponsor before it must start applying them to provide benefits or reduce costs, and how soon thereafter must they be utilized? Plan sponsors should be permitted to accumulate ERRP proceeds for at least two calendar years before starting to apply them to reduce costs for plan participants, and then have at least two calendar years to utilize them. This will permit their orderly and sensible utilization.
15. While ERRP proceeds are being held for future use, must interest be credited on them? For convenience reasons, the answer should be no.
16. If a plan covers more than just early retirees, must ERRP proceeds be used only with respect to early retiree coverage? The IFR Preamble at 75 Fed. Reg 24458 says that the proceeds may be used to lower costs for all "plan" participants, but disputes may arise as to the scope of the "plan." It would be helpful if HHS clarified that a plan sponsor's reasonable determination of who are plan participants will be respected.
17. Can ERRP proceeds be used to pay for the cost of ERRP participation, e.g., the cost of applying for certification and filing ERRP claims? HHS should state that this use is permissible.
18. Can ERRP proceeds be used to pay plan administrative expenses or the cost of stop loss coverage? Again, the answer should be yes.
19. Does the requirement that plan sponsors "maintain [their] current level of support" mean that they must continue to spend the same aggregate amount, the amount per participant, or the same percentage of overall cost, as they did pre ERRP?

20. Over what period is that maintenance obligation measured, e.g., is it per month per plan year, or over a reasonable period of plan years?
21. What is the base period for determining pre-ERRP contribution levels? 2009 seems the most logical.
22. How is cost stability to be determined? Is it determined on an aggregate basis or per capita basis, what stability measurement periods can be used, how are plan design changes factored into stability measurement (e.g., must stability be measured as if PPACA mandates had not been adopted), and must stability be measured just with respect to a the plan's Reinsurance Program-covered participants?
23. Can an employer reduce its costs (i.e., go beyond stability) by retaining Reinsurance Program proceeds?
24. The IFR Preamble states that "Section 1102(c)(4) . . . envisions a role for the Secretary [of HHS] in developing a mechanism to monitor the appropriate use of such reimbursements. Additional information about this mechanism will be disseminated as it is developed." HHS should clarify that any reasonable use of ERRP reimbursements will be respected, even if it deviates from the use set forth in the certification application.
25. HHS might undertake a significant amount of claim or proceed-usage auditing. The IFR Preamble at 12 says that it may do so up to four years after initial claim payment, or at any time in the event of fraud. If repayment were required after Reinsurance Program proceeds have been shared with plan participants, plan sponsors would have passed through illusory ERRP reimbursements. To avoid discouraging employers from participating, HHS should clarify that (a) it generally will not require repayment of amounts already passed through to plan participants, or (b) permit plan sponsors to defer such pass-throughs for at least five years after ERRP reimbursement.

Coordination with Department of Labor

26. Has HHS discussed ERRP's ERISA implications with the Department of Labor? If not, it should ask it to issue immediate guidance on the following issues.
27. Do ERISA plan fiduciaries have a fiduciary duty to participate in ERRP? The answer ought to be that participation is a settlor decision, not a fiduciary decision. Otherwise, HHS may be flooded by certification applications from fiduciaries seeking to avoid liability for not having sought to participate.
28. Are ERRP reimbursements "plan assets"? Must they be held in trust? In both cases, hopefully the answer will be no even as to reimbursements that are being held for future use to provide plan benefits or lessen participant costs. If reimbursements are plan assets, plan sponsors will be discouraged from participating in ERRP and the cost of doing so will be higher, especially if trusts must be established to hold ERRP reimbursements pending utilization.

Tax Consequences

29. PPACA Section 1102(c)(5) makes ERRP reimbursements tax-free. Has HHS confirmed with the IRS that an employer's health plan expenses will remain deductible even if reimbursed by ERRP? If reimbursed health plan expenses would not be deductible, PPACA Section 1102(c)(5) would be rendered moot.

Thank you for your consideration of our views on this important issue to employers and retirees.

Sincerely,

Kathryn Wilber
Senior Counsel, Health Policy