MEMORANDUM

May 6, 2010

Re: Retiree Reinsurance Program Interim Final Regulation

The Patient Protection and Affordable Care Act ("PPACA") requires the Department of Health and Human Services ("HHS") to establish a temporary retiree reinsurance program through which plan sponsors may receive reimbursement for certain claims incurred by early retirees. PPACA § 1102. On May 5, 2010, HHS issued an interim final regulation ("Regulation") (with a comment period that ends June 4, 2010) providing guidance related to the retiree reinsurance program. 75 Fed. Reg. 24450. The program is expected to be established effective June 1, 2010, earlier than the June 21, 2010 statutory deadline.

The program will be available to reimburse 80% of claims between $15,000 and $90,000 of retirees age 55 and older who are not eligible for Medicare ("Early Retirees"), their spouses (or surviving spouses) and dependents. Funds for the program are capped at $5 billion, and the Regulation makes clear that the program will end once those funds are depleted. An application must be filed with HHS and a plan must be certified by HHS before a sponsor may submit claims for reimbursement. Applications will be approved in the order in which they are received, and incomplete or inaccurate applications will be rejected. HHS has also indicated that it may stop accepting applications once *projected* claims reach $5 billion. The Secretary of HHS issued a press release on May 4, 2010 stating that the application for the program will be available by the end of June, 2010.

Key details on the retiree reinsurance program are set forth below.

I. Eligible Plan Sponsors

The Regulation permits reimbursement to a "sponsor" of a certified "employment-based plan." A sponsor is defined in the preamble by reference to the Medicare Part D regulations for purposes of receiving the Retiree Drug Subsidy. 75 Fed. Reg. 24450, 24451. This includes sponsors of self-funded and insured group health plans, other than federal governmental plans. This means that private employers, state or local governments, VEBAs, committees or boards of individuals appointed to administer the plan, employee organizations, and multi-employer plans are all eligible for reimbursements under the program – assuming the plan is certified and meets all requirements.

Generally, plan sponsors are responsible for submitting the application to the program, ensuring that an agreement is in place that satisfies the HIPAA privacy rules with regard to the program, and recordkeeping.

A. Application Process

Applications will be approved in the order in which they are received, and incomplete or inaccurate applications will be rejected. After the application is submitted and approved, HHS will "certify" the plan, allowing the plan to submit data regarding claims once those claims are paid by the plan. The application itself will need to contain a projection concerning the amount of claims that would be reimbursed under the program for the first two plan years (but not actual claims data). Once HHS projects that the $5 billion appropriated is no longer available, further applications may not be accepted. Sponsors with more than one plan will need to file one application per plan. 45 C.F.R. § 149.40.

To increase the likelihood of receiving reimbursements, it will be critical for applicants to file applications correctly and as soon as possible. Any error in the application means that the application will be rejected and there may not be funds left when the application is re-submitted. Correction of an application will not be permitted -- the only way to correct is to submit a new application. The preamble to the Regulation, however, indicates that HHS will provide assistance to applicants to ensure the applications are completed properly. 75 Fed. Reg. 24450, 24455.

Among other things, the application must state how the reimbursements will be used to: (1) reduce premium contributions, co-payments, deductibles, co-insurance or other out-of-pocket costs for plan participants; (2) reduce health benefit costs or premium costs for the sponsor; or (3) reduce a combination of plan participant and sponsor costs. In addition to stating how the sponsor will use reimbursements, the application must also indicate how the sponsor will maintain its current level of contribution to the applicable plan. The application must also indicate the procedures or programs that are in place that have generated or have potential to generate cost savings with respect to plan participants with chronic and high cost conditions. 45 C.F.R. § 149.40.

B. HIPAA Privacy

As discussed below, plan sponsors must submit certain claims information in order to apply for reimbursement. This information would be considered protected health information ("PHI") under the HIPAA privacy rules, but can be disclosed to HHS. Since this information technically belongs to the plan itself (not the plan sponsor), the Regulation consistent with HIPAA requires the plan sponsor to have an agreement in place with the plan (either the insurer for an insured arrangement, or the employment-based plan for a self-funded arrangement) directing the plan to disclose this information to HHS. 45 C.F.R. § 149.35(b)(2). The preamble to the Regulation says that this type of disclosure would fall under the "required by law" exception in the HIPAA privacy rules. 75 Fed. Reg. 24450, 24454. This agreement likely could be a side agreement between the parties, or a modification to an existing agreement, such as the plan sponsor certification already required under the HIPAA privacy rules where a plan sponsor obtains PHI from the plan.

C. Recordkeeping

A sponsor must make available information, data, documents, and records related to the program for six years following the end of the plan year in which the claims were incurred, or longer if otherwise required by law. 45 C.F.R. § 149.350.

II. Eligible Employment-Based Plans

An eligible employment-based plan is a group health plan that provides benefits to Early Retirees (but can cover active employees as well) that is certified by HHS, and provides documentation of the actual cost of medical claims involved.

In order to be eligible for the program, an employment-based plan also must implement programs and procedures to generate cost-savings with respect to participants with "chronic and high-cost conditions." The preamble to the Regulation indicates that HHS will provide a lot of flexibility with respect to the chronic and high-cost condition requirement. Plans are expected to use a "reasonable approach" when identifying such conditions and selecting programs and procedures to lower the cost of care, as well as improve the quality of care, for such conditions. "Chronic and high-cost" is defined as 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. The plan need not adopt new procedures to satisfy this requirement, and need not have these procedures for all conditions. Also, "cost savings" is defined with reference to a participant -- for example, if a participant with a chronic and high cost condition receives more generous cost-sharing than other participants, the requirement seems to be satisfied. Preventive benefits/monitoring programs that will save the plan money (i.e., diabetes monitoring) should also satisfy this requirement. 75 Fed. Reg. 24450, 24452.

III. Key Claims Issues

A. Eligible Plan Participants

Plans may receive reimbursements for claims of Early Retirees, their spouses (or surviving spouses) and dependents under the program. Spouses and dependents can be any age.

Whether an individual is "retired" will be determined using standards under the Medicare Secondary Payer ("MSP") rules pertaining to coverage by reason of current employment status. In other words, if Medicare pays secondary for the retiree under the MSP rules (i.e., because the individual is covered under the plan as an active employee), the person is not considered to be an Early Retiree for whom the sponsor could receive reimbursements under this program. 49 C.F.R. § 149.2 (definition of Early retiree).

B. Reinsurance Amounts

A sponsor may receive reimbursement of 80% of the costs for health benefits (net of negotiated price concessions) for claims incurred by a particular participant during the plan year

that are between the cost threshold ($15,000) and the cost limit ($90,000) that are paid by the plan, an insurer and the Early Retiree. 45 C.F.R. § 149.100. For plans with plan years beginning before June 1, 2010, claims incurred prior to June 1, 2010 may be counted toward the $15,000 cost threshold and the $90,000 cost limit. Reimbursements, however, will be based only on claims that are incurred and paid after June 1, 2010. 45 C.F.R. § 149.105.

A "claim" is defined broadly to include all types of medical claims (including mental health and prescription drug claims) but does not include "excepted benefits" as defined in HIPAA (e.g., hospital indemnity) or long-term care benefits. 45 C.F.R. § 149.2 (definition of Claim).

The claims that may be reimbursed are calculated per Early Retiree (including claims of his or her spouse, surviving spouse and dependent) and are aggregated over the plan year. In other words, it is not necessary for an Early Retiree to incur one claim in excess of $15,000 as long as all claims incurred by that individual (and his or her spouse, surviving spouse and dependent) under all plans during the plan year period are in excess of $15,000. Claims may only be submitted for reimbursement after a claim is paid out by the plan. Cost sharing amounts paid by participants can be included as part of the claim, but there would need to be proof that payment had been made by the participant. If a plan does not have this proof, the claim can be submitted based on the amount that the plan expended. See 45 C.F.R. §§ 149.320 – 149.335.

Price concessions and discounts need to be subtracted from the claim amount. If a price concession or discount is given after the claims are submitted (e.g., prescription drug rebates), or if a claim is reversed, the plan sponsor will have an obligation to notify HHS. A periodic notification will be permitted for this purpose. HHS can also reopen and revise a reimbursement determination for any reason, within four years of the reimbursement determination for good cause, or at any time in instances of fraud. 45 C.F.R. § 149.110.

C. Insured Plans

For an insured plan, the preamble makes clear that the claim is calculated based upon what the insurer and participant pays for health benefits (net of negotiated price concessions) without regard to what the plan sponsor pays in premiums. Reimbursements, however, go to the plan sponsor. An insurer can submit claims on behalf of a plan directly to HHS. 75 Fed. Reg. 24450, 24457.

D. Use of Funds

A sponsor may use reimbursements to (1) reduce the sponsor's health benefit premiums or health benefit costs; (2) reduce health benefit premium contributions, copayments, deductibles, coinsurance or other out-of-pocket costs for plan participants, or (3) a combination of sponsor and participant costs. Proceeds under the program are not taxable and must not be used as general revenue for the sponsor. PPACA § 1102(c)(4) & (5). The Regulation makes clear that a plan sponsor who receives funds under the program may not reduce premiums/ contributions (must remain level each year). The plan sponsor can use the funds to reduce future

premiums (or other plan costs) for active employees in addition to Early Retirees. The preamble makes clear that, while a sponsor may receive reimbursement only for Early Retirees or their spouses, surviving spouses and dependents, funds received under the program can be used to lower health benefit costs for all participants in the plans, including active employees. 75 Fed. Reg. 24450, 24458.

A sponsor also must have policies and procedures in place to guard against fraud, waste and abuse. 45 C.F.R. § 149.35.

E. Appeal

If a plan sponsor disagrees with HHS' determination as to the amount of the reimbursement, an appeal may be made directly to HHS within fifteen days. No appeal may be made once the $5 billion is expended. 45 C.F.R. § 149.500.

HHS has invited public comment on all relevant issues. Comments must be received by June 4, 2010.

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We have been working with clients to address questions regarding PPACA. Please let us know if you have questions. You may contact your regular Groom contact or any of the Health and Welfare practice group attorneys listed below:

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