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Employers With Early Retiree Health Coverage Should Prepare Now for Reimbursement

May 19, 2010

On May 5, 2010, the federal Department of Health and Human Services (“DHHS”) published an interim final rule providing guidance on the requirements for employers seeking federal reimbursement for health insurance costs attributable to early retirees and their covered dependents. Under the Patient Protection and Affordable Care Act (“PPACA”) which became effective on March 23, 2010, Congress set aside \$5 billion to fund a program to provide reimbursements for the cost of health coverage for early retirees aged 55 and above, but not eligible for Medicare, under employer-sponsored group health plans.

Employers providing early retiree health coverage should begin preparing now for the application process if they want to pursue reimbursement. The DHHS is anticipated to publish its application forms by June 1, 2010.

Health plan sponsors (usually, an employer) may seek reimbursement for 80% of the costs of health benefit claims incurred by an early retiree or his/her covered dependents which are between \$15,000 but not more than \$90,000 during a plan year. “Claims” include the costs of medical, surgical, hospital, prescription drug, and similar health benefits (but not including long-term care benefits). Because the effective date of the program is June 1, 2010, only health benefit costs incurred after June 1, 2010 are eligible for reimbursement, but plan sponsors may count health care costs incurred prior to June 1, 2010 towards the \$15,000 claim threshold if those costs were incurred within the current plan year. (See below for explanation).

Plan sponsors must submit an application for plan certification to the DHHS, once the application forms are published. Both insured and self-insured group health plans are eligible to participate. It is important to note that according to the DHHS, employers will not be reimbursed based on premiums paid by the employer or plan participant, but reimbursement instead will be based on the **actual medical costs** incurred by the health plan. For example, if an early retiree has a surgical operation which causes the plan to incur \$50,000 in medical costs, the employer may submit a request for reimbursement for 80% of that amount (i.e. \$40,000).

Once the plan sponsor’s application is approved, the plan sponsor can begin submitting requests for reimbursement. The DHHS interim rules make clear that it is crucial that plan sponsors submit correct applications as soon as possible. No reimbursement requests will be considered by DHHS until after a plan sponsor’s application has been approved, and reimbursement will be on a first-come, first-served basis. The Department anticipates that the \$5 billion dollars in funding will run out quickly.

However, as discussed below, the PPACA limits employers in their use of reimbursement funds. Employers cannot use the reimbursement funds to lower their contribution levels (although they can use the funds to pay for future increases). As a result, some employers may decide it is not worth pursuing reimbursement.

Application Requirements

Plan sponsors will be required to submit applications to DHHS. If an application is found to be deficient, the plan sponsor will have to submit a new application, and plans will be approved in the order in which



they are received. Therefore, it is important that the applications be complete and correct. Note that plan applications must be approved prior to the submission of any reimbursement request.

All applicants will have to show proof of a “Plan Sponsor Agreement.” The Plan Sponsor Agreement must contain the following elements:

1. Insurer Disclosure Agreement: As part of the program, DHHS must obtain health benefit claims information from plan sponsors, which may include information considered to be “protected health information” under HIPAA. However, under HIPAA, plan sponsors should not be in receipt of protected health information from plan participants. Accordingly, to comply with HIPAA, the employer must have an agreement with its insurer which obligates the insurer to provide health benefit claims information directly to DHHS.

Note that because self-insured plans generally have access to protected health information, and are considered “covered entities” under HIPAA, employers with self-insured plans obviously are not required to have an insurer disclosure agreement.

2. Attestations regarding purpose of application and anti-fraud measures: Plan Sponsor Agreements must include (1) a written attestation that the information is being provided by the employer to obtain federal funding; and (2) an attestation that the group health plan has policies and procedures in place to detect and reduce fraud, waste, and abuse. Note that most insurers already have policies or procedures to reduce waste and fraud, and employers may rely on such pre-existing programs. However, in the rare event that your insurer does not have such a program or policy in place, you will be required to develop a program before applying. DHHS estimates that it will take the average employer about 20 hours to develop and implement such a program.
3. Projected Reimbursements for 2 Year Cycle: Employers will be required to project their reimbursement amounts for the first 2 plan year cycles, to aid DHHS in anticipating when funds will run out. The regulations do not specify any particular method of calculating reimbursement projections.
4. Limitations on Use of Reimbursements: Section 1102 of the PPACA provides that “amounts paid to a participating employment-based plan under this subsection shall be used to lower costs for the plan.” More specifically, reimbursement amounts may not be treated as general revenues. The statute allows reimbursement amounts to be used (1) to reduce premium costs for the group health plan; (2) to lower the deductibles, copays, or other out-of-pocket costs of plan participants; or (3) any combination of the two. However, the DHHS guidance has imposed an additional requirement not found in the PPACA. According to DHHS, employers will be required to maintain their current “level of effort” or “level of contribution” to support the group health plan which includes early retirees and their dependents. The DHHS guidance indicates that employers may apply the reimbursement funds to premium increases, but reimbursements should not be used to reduce the employer’s current overall level of funding for the group health plan on a dollar-for-dollar basis. In the application, employers will be required to describe how they plan to use reimbursement funds according to the foregoing limitations.
5. Programs To Reduce Costs for Chronic and High-Cost Conditions: As part of the early retiree reinsurance program, the PPACA requires eligible early retiree plans to have programs and procedures to generate cost saving for participants with “chronic and high-cost” conditions. The DHHS defines such conditions as ones which are likely to generate \$15,000 or more in medical costs during a plan year for an individual participant. They could include, for example, cancer or conditions requiring expensive surgery.



The interim guidance notes that employers are not required to have cost-saving plans and programs in place for all conditions which are likely to be chronic and high-cost, but states that employers should take a “reasonable approach.” Employers are not required to create new programs if their health plans already have existing programs which qualify as tending to reduce costs (to either the employer or to plan participants) for chronic or high-cost conditions.

The program examples given in the guidance are: (1) a diabetes management program that includes aggressive monitoring and behavioral counseling to prevent complications; and (2) a procedure through which the plan covers all or a large portion of the participant’s coinsurance, or eliminates deductibles. The employer need not prove that the program has actually reduced costs for chronic and high-cost conditions, only that it is reasonably likely to do so.

6. List of Plan Benefit Options: Employers will be required to list the benefit options available under the early retiree group health plans for which reimbursement may be sought.

Reimbursement Procedure and Requirements

Claim between \$15,000 and \$90,000 for a plan participant: The reimbursement is available only for medical costs incurred by early retirees and their covered dependents under the employer’s group health plan. An employer can seek reimbursement of up to 80% of the costs of claims incurred for an individual plan participant for a plan year that is between \$15,000 and up to \$90,000. Note that the \$15,000 threshold must be met for a single plan participant, so employers cannot aggregate claims of the early retiree and his/her covered dependents.

The health benefit claims incurred must be net of any negotiated price concessions. However, in determining the amount of claims, the employer may also count amounts paid by the plan participant under the plan, such as copays, deductibles, and co-insurance, to the extent that the employer can document payment (through receipts, for example).

Timing of Claim Amounts: The \$15,000 threshold and \$90,000 upper limit is for a plan year. However, a special rule applies to requests for reimbursement in a plan year that spans June 1, 2010, which is the effective start date of the PPACA reimbursement program.

The DHHS guidance notes that only claims incurred by early retirees (or their covered dependents) on or after June 1, 2010 are eligible for reimbursement. To enable early retiree health plans to take immediate advantage of the reimbursement program, however, if a plan year spans June 1, 2010, expenses incurred prior to June 1, 2010 (but are within the same plan year) up to \$15,000 count towards the cost threshold of \$15,000.

In addition, to ensure that reimbursement may be sought for participants who have already incurred substantial costs in the plan year, amounts incurred above \$15,000 in the plan year prior to June 1, 2010 will not be counted towards the upper limit of \$90,000.

For example, a plan beginning July 1, 2009 and ending June 30, 2009 has an early retiree for which it incurred \$120,000 in medical claims between July 1, 2009 and May 31, 2010. The plan then incurs another \$30,000 in claims for the retiree between June 1, 2010 and June 30, 2010. For purposes of meeting the \$15,000 threshold, the plan sponsor can credit \$15,000 (out of the \$120,000) incurred prior to June 1, 2010. The plan sponsor can then apply for and obtain reimbursement for 80% of the \$30,000 in costs it incurred after June 1, 2010 (even though for the plan year, it has already incurred more than \$90,000 in claims for the participant).



Documentation of Claims: DHHS will require documentation of claim amounts using forms to be developed in the future by DHHS. For insured group health plans, much of the documentation will probably come directly from the insurer. Therefore, it is important to have in place an agreement with the insurer which requires the insurer to disclose claims information directly to DHHS, to avoid HIPAA privacy violations. According to DHHS, covered entities may disclose private health information pursuant to such an agreement without obtaining authorization from individuals, pursuant to the “required by law” exception under HIPAA, 45 CFR 164.512(a).

It appears that employers may begin submitting claims for reimbursement for a participant once the \$15,000 threshold for the plan year is reached. Employers may submit multiple claims as soon as they are “incurred,” meaning once the insurer, employer, or participant becomes responsible for payment. Even though claims under \$15,000 are not reimbursable, employers will be required to submit documentation showing that the \$15,000 threshold was reached.

Calculation of Reimbursement: According to the DHHS guidance, reimbursement will be based on 80% of the costs of medical “claims” incurred by the group health plan, the employer, or the participant between \$15,000 and up to \$90,000 – and not on the premium amounts paid by the employer or participant. Note that no reimbursement is available for the first \$15,000 of claims incurred in a plan year, or for claim amounts exceeding \$90,000 in a plan year.

For example, assume a plan year begins on June 1, 2010, and ends on May 31, 2011. The plan incurs \$15,000 in medical costs for Participant X as of August 1, 2010. On October 1, 2010 the plan incurs another \$10,000 in medical costs for Participant X. On October 2, 2010, the plan sponsor submits a reimbursement request for 80% of the \$10,000 in medical costs (i.e. \$8,000 in reimbursement) above the \$15,000 threshold.

Note that the plan sponsor must also submit documentation of the \$15,000 it incurred for Participant X between June 1, 2010 and August 1, 2010, even though the \$15,000 threshold will not be reimbursed. If the plan incurs another \$10,000 in medical costs on December 1, 2010, it may submit another reimbursement request for \$8,000. However, once total medical costs for the participant during the plan year reach \$90,000, no reimbursement may be had for amounts above \$90,000. Accordingly, the maximum reimbursement amount per early retiree per plan year is $\$90,000 - \$15,000 \times .80 = \$60,000$.

Steps to Take Now:

1. Consult with your insurer and determine what procedures or programs are in place to reduce costs for chronic and high cost conditions. If no such procedures or programs are currently in place, begin developing such programs.
2. Consult with your insurer and determine what policies and procedures are in place in your group health plan to reduce fraud, abuse, and waste.
3. Consult with your insurer and draft a HIPAA compliant agreement obligating the insurer to provide documentation regarding individual participant benefit costs for early retirees and covered dependents in the form and manner required by DHHS to support a claim for reimbursement under PPACA Section 1102. See sample below.
4. Consult with your insurer and analyze medical cost data for early retirees and their covered dependents so that you can provide a reasonable projection of projected reimbursement amounts for a two year plan period cycle. The DHHS guidance does not specify how the projections are to be formulated, and there is no requirement that your projection be accurate. Ostensibly, you could review early retiree benefit costs over the most recent, 2, 3, 4, or 5 year period, and then



predict the early retiree benefit costs (including anticipated price increase adjustments) for the next 2 plan year cycle.

5. Determine how you will use the reimbursements in a manner that does not simply reduce your current overall costs for group health coverage for the plan covering early retirees. It is clearly appropriate to use the reimbursements to pay for premium increases, as well as to partially or fully refund co-pays, deductibles, or other out-of-pocket costs of plan participants. Note also that the reimbursement may be used towards the premiums or out-of-pocket costs of all participants in the group health plan, if the plan includes participants other than early retirees. However, the DHHS guidance appears to prohibit employers from using the reimbursements to simply lower their own current premium contribution costs. It is likely that employers could hold reimbursement funds in reserve to be used to cover any future premium increases.



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SAMPLE

Agreement for Disclosure of Information and Documents to DHHS

In accordance with the Patient Protection and Affordable Care Act (“PPACA”) and the Health Insurance Portability and Accountability Act (“HIPAA”), the undersigned Plan Sponsor _____, and Insurer _____, agree as follows:

1. Section 1102 of the PPACA allows a Plan Sponsor of a group health plan to seek reimbursement from the federal government for a portion of the health benefit costs incurred by a group health plan for early retirees and their covered dependents.
2. In order to support an application made by the Plan Sponsor to the federal Department of Health and Human Services (“DHHS”) for reimbursement of early retiree health benefit costs under Section 1102, the Insurer agrees to provide documentation and information regarding the costs of items and services for early retirees and their covered dependents, and such other information relating to the group health plan or health benefit costs for early retirees and their covered dependents as may be required by DHHS.
3. The information and documentation described above shall be provided by the Covered Entity directly to DHHS (and not to the Plan Sponsor) at a time and in a manner specified by DHHS. If DHHS does not directly notify the Insurer of its requirements regarding the time and manner of disclosure, the Plan Sponsor shall notify the Insurer of any applicable DHHS requirements.
4. It is understood that the documentation and information supporting a Plan Sponsor’s request for reimbursement may contain private health information of a plan participant who is an early retiree or a covered dependent of an early retiree. It is also understood that pursuant to guidance issued by DHHS (see 75 Fed. Reg. 24455, 5/10/2010), such disclosure complies with the “required by law” exception to the HIPAA privacy rule at 45 CFR 164.512(a).

Dated: _____

XYZ Company

ABC Insurance

By:

By: