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HHS Releases Interim Final Regulations on Temporary Early Retiree Reinsurance Program

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The Department of Health and Human Services (HHS) has released the first detailed guidance explaining the early retiree health benefit claim reinsurance program established under the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (the Healthcare Reform Law). The new interim final regulations outline the timing, requirements, transition rules, and claims submission processes necessary to obtain reinsurance for certain early retiree health benefit claims. However, a maintenance-of-effort requirement, the general structure of the program, and the "first-come, first-served" application and claims submission processes may make all but the largest employers, collectively bargained plans, and public plans think twice about choosing to participate.

Background

Section 1102 of the Healthcare Reform Law requires HHS to establish a temporary reinsurance program to provide reimbursement of certain eligible retiree medical expenses no later than June 21. The purpose of the program is to reinsure 80% of a plan's early retiree health benefit claims between $15,000 and $90,000 per year per retiree for retirees who are 55 or older but not yet entitled to Social Security (and their spouses and dependents). The program runs until the earlier of January 1, 2014 (when the Healthcare Reform Exchanges start up) or when the $5 billion in funding runs out. The program contains limitations on the permissible uses for the reinsurance amounts and treats the amounts as tax-free to the entity maintaining the early retiree health benefit plan.

Interim Final Regulations

The new interim final regulations contain detailed guidance outlining the full scope of the early retiree reinsurance program. Included in the regulations are the following significant details:

- **Application Timing**—While the program will begin June 1, HHS anticipates releasing the application for the program in the middle of June. Informal comments from the HHS Office of Consumer Information and Insurance Oversight (the OCIIO), which will administer the program, indicate that it has not yet decided whether the application will be electronic or in paper form. Further, it is anticipated that there will be some time allowed for applicants to examine and complete the application before the program will start accepting applications.

However, since the regulations state that applications will be handled on a first-come, first-served basis and that applications will be cut off when two-year claims projections (which are part of the application) show that the $5 billion will be consumed, applicants will have to submit complete and accurate applications as quickly as possible, or risk losing the opportunity to participate in the program. Interested applicants should monitor the OCIIO website (http://www.hhs.gov/ociio) so they will be ready to act when the OCIIO posts the application, future guidance, and expected FAQs.

- **Requirements**—The reinsurance program is open to employment-based plans (whether insured or self-insured) maintained by private employers, state or local governments, employee organizations, voluntary employees' beneficiary associations (VEBAs), nonprofit employers, religious entities, and multiemployer plans. In order to be certified by HHS to participate in the program, each separate plan must include the following information on an application signed by an authorized representative:

    - The applicant's TIN, name, address, contact information, and a signed sponsor agreement (which will contain, among other things, a statement that the application is being made "to obtain federal funds," thus triggering the application of the False Claims Act)
    - The plan year of the plan
    - All benefit options under the plan
    - Projected reimbursement amounts for the current and subsequent plan year
    - A summary of how the applicant will use the reinsurance funds (see "Maintenance of Effort" below)
    - A summary of procedures or programs that the applicant already has in place to generate cost savings for participants with chronic and high-cost conditions that exceed $15,000 during a plan year
    - An attestation that the plan sponsor already has policies in place to detect and reduce fraud, waste, and abuse
    - An indication that the plan sponsor has an agreement with its insurer or plan requiring disclosure of information on behalf of the plan sponsor to HHS

  It will be particularly important to submit a complete and accurate application, as any application that does not meet the requirements will be denied, placing the applicant at the end of the queue. Given the first-come, first-served nature of the application process, this may mean that the reinsurance program closes before the applicant is able to submit a revised application.

- **Maintenance of Effort**—The program establishes strict rules surrounding the permissible uses for the reinsurance amounts. These rules revolve around the linchpin of a maintenance-of-effort requirement, which mandates that participating sponsors continue their level of contributions to the plan. This requirement is to prevent sponsors from circumventing the statutory prohibition against using the funds for general revenue purposes. It is unclear how long the maintenance-of-effort requirement will last (or whether it will run all the way until 2014), which may prove troublesome for sponsors that want to reduce or terminate their retiree medical program in the near future.

  In addition, the funds can only be used by the sponsor to offset future premium increases or cost increases (for self-insured plans). This likely means that employers that have already hit a FAS

106 cap on retiree medical cost subsidies will not be able to use the funds for their premiums or costs. Alternately, the reinsurance funds can be used to reduce participant expenses such as premiums, co-payments, deductibles, co-insurance, or other out-of-pocket costs. Informal comments from OCIIO representatives indicate that the reinsurance amounts cannot be used for plan expenses. Interestingly, the regulations state that reinsurance amounts can be used to reduce costs not only for retirees (and their spouses and dependents) but also for active employees, spouses, or dependents covered by the same plan.

- **Transition Rules**—While the reinsurance program begins on June 1, special transition rules will count early retiree health benefit claims incurred and paid prior to June 1 against the $15,000 reinsurance threshold (even though such claims are never eligible for reinsurance). As such, many plans will find that claims incurred and paid on and after June 1 are immediately eligible for reinsurance.

- **Claims Submission**—Once an application is certified by HHS, there is a subsequent first-come, first-served process associated with submitting early retiree health benefit claims to the program. Each reimbursement request must contain a list of early retirees, documentation of actual costs for items and services that have already been paid, and prima facie evidence of early retiree payment (if the sponsor requests reimbursement for amounts paid by early retirees) of early retiree costs. Claims for the early retiree, their spouse, and any dependents are independently submitted and are not combined to meet the $15,000 threshold or for reinsurance purposes. Claims for medical, surgical, hospital, and prescription drugs and other services for the diagnosis, cure, mitigation, or prevention of physical or mental diseases are eligible for the reinsurance program.

The interim final regulations from HHS impose specific appeals processes, audit requirements, required disclosure of data inaccuracies, and a mandatory 60-day advance notification of change in ownership.

In all, the structure of the interim final regulations, the twin first-come, first-served processes for applications and claims submission, and the $5 billion funding limit will favor very large applicants, as these will have a far greater dollar volume of early retiree health benefit claims in the initial days of the reinsurance program. However, as HHS is soliciting comments on the interim final regulations for 30 days, it is possible that the interim final regulations could be revised to be more favorable to a larger number of potential applicants.

Morgan Lewis will continue to monitor developments as further guidance is released regarding the early retiree reinsurance program. If you have any questions or would like more information on any of the issues discussed in this LawFlash, please contact the author of this LawFlash, **Andy R. Anderson** (312.324.1177; aanderson@morganlewis.com), or any of the following key members of our cross-practice Healthcare Reform Law resource team:

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