



Client Alert

Health Care Reform Series 2010



Show Me the Money: HHS Issues Guidance On The New Early Retiree Reinsurance Program

May 10, 2010

In an earlier client alert, we reported that the Secretary of the Department of Health and Human Services (HHS) released an interim final rule with a 30-day public comment period that implements the Early Retiree Reinsurance Program established by the Affordable Care Act (the "Act").^[1] The program provides \$5 billion in financial assistance to employers to help them maintain health coverage for early retirees ages 55 to 64 and their spouses, surviving spouses, and dependents who are not yet eligible for Medicare.

The interim final rule is effective June 1, 2010. HHS has reported that it expects applications for the program to be available by the end of June. The program will end on January 1, 2014, when early retirees will be able to elect coverage under one of the health insurance exchanges, or when HHS has exhausted the \$5 billion appropriated to the program, if earlier.

Because applications for reimbursements **will be processed in the order received** and funding for this program is limited, it is of paramount importance that plan sponsors be ready to act fast once applications are available in June.

ELIGIBILITY REQUIREMENTS

Employment Based-Plans

Only employment-based plans that provide health benefits to early retirees are eligible to participate in the reinsurance program.

Plans, either self-insured or fully-insured, sponsored by private employers, State and local governments, employee organizations, voluntary employees' beneficiary associations (VEBAs), churches, and multiemployer health funds are eligible for the program. Plans sponsored by the Federal government are excluded.

"Early retirees" include former employees age 55 to 64 who are not eligible for coverage under Medicare and their spouses, surviving spouses, and dependents (even if they are under the age of 65 and/or are eligible for Medicare).

Cost-savings or Potential Cost Savings for Chronic and High-Cost Conditions

The employment-based plan must include programs and procedures that have generated or have the potential to generate cost-savings with respect to plan participants with "chronic and high-cost conditions" who are likely to generate \$15,000 in claims for a plan year. Examples provided by HHS include a diabetes management program; coverage of all or a large portion of the participant's co-insurance or co-payments, and/or elimination or reduction of a plan's deductible for treatment and visits related to cancer.

Because HHS believes Congress intended this program to be inclusive, it did not identify specific types of "chronic and high-cost conditions" that must be addressed by an employer-based plan. Nor does it require plan sponsors to implement new programs or procedures just to participate in this program or to target all chronic and high-cost conditions. Existing efforts may be sufficient.

Written Agreement with Insurer or Employment-Based Plan

Plan sponsors are required to have a written agreement with their health insurance issuer or employment-based plan, as applicable, requiring these entities to disclose information, data documents, and records on behalf of the plan sponsor to HHS in order for the sponsor to comply with

the program, in part to accommodate the HIPAA privacy and security rules. Much of the data, such as claims, that HHS will need to support program reimbursements is going to be protected health information under the HIPAA privacy and security rules and may be in the hands of business associates (such as third party administrators) of the group health plans.

Disclosures to HHS under the program will not require specific authorization of individuals.

HHS Certification

Employment-based plans participating in the program must be certified by HHS. It is unclear in the interim final rule how employers will be certified. The rule states that applications can be denied based on funding availability so it is possible that HHS may stop certifying employment-based plans when certified plans' aggregate reimbursements are expected to reach the \$5 billion funding limit.

APPLICATION PROCESS

Timing

The application process is similar to the application process for the Medicare Part D retiree drug subsidy (RDS). To participate in the program, plan sponsors must submit a complete application to HHS for each plan identifying the plan year cycle for which the sponsor is applying. However, unlike the RDS program, once a plan is certified and the application is approved, and the sponsor otherwise continues to meet the requirements of the program, the plan will continue to be certified and the application will continue to be approved. A sponsor need not thereafter file an application annually.

Applications for the program will be ***processed in the order received***. Accordingly, HHS warns that it is imperative that applications be complete when initially filed. Incomplete applications will not be given an opportunity to cure defects. Instead, an incomplete application will be denied and a new application will need to be submitted. The new application will be processed based on the date the new application is received, which, depending on remaining funding in the program, may preclude reimbursement.

Applications may also be rejected based on the availability of funds. Plan sponsors will need to project their reimbursement amounts for the first two plan year cycles in their applications so that HHS can project the total reimbursement amounts and determine when it will stop accepting applications due to the program's funding limitations.

Content

Applications will include a plan sponsor agreement which will include, among other things: (1) an acknowledgment that the information in the application is being provided to obtain Federal funds, and that all subcontractors acknowledge that information provided in connection with a subcontract is used for purposes of Federal funds; (2) an attestation that policies and procedures are in place to detect and reduce fraud, waste and abuse; (3) a summary indicating how the applicant will use any reimbursement received under the program; (4) a projected amount of reimbursement for the first two plan year cycles with specific amounts for each cycle; and (5) a list of all benefit options under the employment-based plan that any early retiree for whom the sponsor receives program reimbursement may be claimed.

The application must be signed by an authorized representative of the plan sponsor.

HHS may reopen determinations of approved or denied applications for reimbursements: within 1 year of a determination for any reason; within 4 years of a determination, if information and data submitted by the sponsor is inaccurate, incomplete or incorrect; or at any time, in the event the sponsor committed a fraud or otherwise was untruthful.

Policies and Procedures to Detect and Reduce Fraud, Waste and Abuse

Plan sponsors will need to ensure and attest in the program's application that policies and procedures are in place to detect and reduce fraud, waste and abuse. Sponsors will also need to produce these policies and procedures and any documents or data to substantiate the implementation, and the effectiveness, of the procedures, upon request.

If it is found that a plan sponsor committed (or allowed to be committed) fraud, waste or abuse under its plan, HHS may recoup from the sponsor some or all of the reimbursements paid under the program, and/or may revoke a sponsor's certification to participate in the program. In addition, in such case, HHS may terminate or deny an application for reimbursement.

REIMBURSEMENT AMOUNTS

Reimbursement Formula

This program will reimburse the plan sponsor for 80% of the costs incurred and paid (even if paid in a later year) for health benefits under an employment-based plan (net of negotiated price concessions) between \$15,000 and \$90,000 (indexed for plan years on or after October 1, 2011) for each early retiree (and their spouse, surviving spouse and dependent), each plan year. Cost above and below the thresholds are subtracted from the reimbursement amount calculation.

"Health benefits" include medical, surgical, prescription drug, and mental health benefits, and excludes HIPAA-excepted benefits such as long-term care and stand-alone dental and vision plans. Reimbursement amounts are determined based on cumulative health benefits incurred in a given year and paid for a given early retiree, rather than reimbursements being made only for discrete health benefits items or services.

When calculating the employment-based plan cost of health benefits, some rules to consider:

- § Deductibles, copayments, or coinsurance paid by early retirees (or their spouses, surviving spouses, or dependents) are *included*.
- § If an early retiree or dependent changes benefit options (*e.g.*, HMO to PPO) in a year, all costs in those options must be aggregated for determining the threshold.
- § For fully-insured plans, the cost means the amount paid by the insurer and early retirees for health care benefits net of negotiated price concessions, excluding the premiums paid by the sponsor and early retirees.

Transition Rule

Reimbursements are available for the first plan year that starts prior to June 1, 2010, provided that the plan year ends after that date. For claims incurred before June 1, 2010, the amount of such claims up to \$15,000 counts toward the cost threshold and the cost limit. Claims incurred before June 1, 2010 that exceed \$15,000 are not eligible for reimbursement and do not count toward the cost limit. The reimbursement amount to be paid is based solely on claims incurred on and after June 1, 2010, and that fall between the cost threshold and cost limit for the plan year.

Example: Assume that a plan has a plan year that began July 1, 2009 and ends June 30, 2010. Assume that this plan covers an early retiree for which it has spent \$120,000 in health benefit claims before June 1, 2010, and it then spends another \$30,000 in health benefit claims for the early retiree between June 1, 2010 and June 30, 2010. The sponsor would receive credit for \$15,000 in claims incurred before June 1 and would be eligible to receive reimbursement of 80 percent of the \$30,000 (for the claims incurred after June 1, 2010), or \$24,000.

Use of Reimbursements

Sponsors must use reimbursements under the program to lower costs for the plan, which includes costs for the plan sponsor and plan participants. Sponsors may *not* use the reimbursements as "general revenue" for the sponsor.

HHS is encouraging plan sponsors to use the reimbursement amounts for either or both of the following: (1) to reduce the sponsor's health benefit premiums or health benefit costs, and (2) to reduce health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs, or any combination of these costs, for plan participants (including retirees, and their spouses and dependents, and *active* employees and their spouses and dependents).

HHS expects that sponsors will continue to provide at least the same level of contribution to support the applicable plan, as it did before this 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. It is unclear at this time whether HHS will impose additional TARP-like restrictions on plan sponsors who accept funds under this program, although such restrictions have not yet been proposed and, presumably, would not apply in the absence of statutory authority.

Reimbursement Rules

Claims cannot be submitted for a given plan year until the application that is associated with the claim has been approved. With respect to a given early retiree, claims cannot be submitted until the early retiree's total paid costs for health benefits incurred for the plan year exceed the applicable cost threshold (*i.e.*, \$15,000 for 2010). Once that threshold has been reached, claims can be submitted, but they must include all claims below the applicable cost threshold for the plan year in order to verify that the cost threshold has been met.

As noted above, claims must be submitted based on the amounts actually paid, including any amounts paid by the early retiree (evidence of such payment may include an actual payment receipt). Once the cumulative claims of an early retiree exceed \$90,000 (as adjusted in future years) for a plan year, a sponsor should not submit claims above this claim limit for that early retiree because no reimbursement will be paid on these claims.

All claims submissions must include a list of early retirees for whom claims are being submitted. Claim submissions will be processed on a first-in, first-out basis until program funding is expended. Claims and the list of early retirees for fully-insured plans may be submitted directly to HHS by insurers.

Record Retention

Sponsors must maintain records relating to reimbursement of claims under the program for 6 years after the expiration of the plan year in which the costs were incurred, or longer if otherwise required by law.

Claim Appeals

Due to the limited funding and temporary nature of the program, HHS has established a one-step appeal process. A sponsor may appeal directly to HHS within 15 calendar days of receipt of the determination at issue. Sponsors should also note that the right to appeal will end when the \$5 billion funding is exhausted.

CHANGE IN OWNERSHIP REQUIREMENTS

Similar to the requirements under the RDS program, sponsors must provide at least 60 days advance notice of any change of ownership of the sponsor to ensure that reimbursement under the program is being made only to legitimate entities, and only to such entities that are actually complying with the requirements of the program.

ACTION ITEMS

It is anticipated that applications for the program will be available by the end of June. Because applications will be processed in the order in which they are received and reimbursements will cease once funding is exhausted, sponsors need to be prepared to act quickly if they wish to receive reimbursement under the program. The benefits of applying for reimbursement will likely outweigh the costs and administrative burdens for large plan sponsors.

The following are some of the actions plan sponsors who wish to apply for reimbursements under the program will need to take:

- § Identify programs that generate cost-savings for chronic and high-cost conditions between \$15,000 and \$90,000
- § Maintain records of policies and procedures regarding chronic and high-cost conditions, and data to substantiate their effectiveness
- § Adopt policies and procedures to detect and reduce fraud, waste and abuse
- § Execute agreements with insurers or the employment-based plan requiring the plan to disclose information to HHS
- § Designate an authorized representative to sign the application and to certify that the application is accurate and true
- § Make projections for the first two plan year cycles
- § Submit application and plan sponsor agreement (and accompanying data)
- § Determine how to use reimbursement proceeds

This client alert is meant to summarize and highlight the regulations regarding the Early Retiree Reinsurance Program established under health care reform. We will continue to update our clients on new developments in this rapidly changing area of the law.

Health Coverage For Children To Age 26: Interim Final Regulations

May 11, 2010

On May 10, 2010, the Departments of Labor and Health and Human Services published interim final regulations (the "Regulations") implementing the requirements regarding dependent coverage of children who have not attained age 26 for group health plans and health insurance issuers under the provisions of the Affordable Care Act (the "Act").^[1]

Background

The Act requires plans and issuers that provide dependent child coverage to make that coverage available for children until the attainment of age 26. There is no requirement for a group health plan or insurance issuer to provide coverage to dependent children; however, if a plan or issuer offers dependent child coverage, that coverage must be available until the attainment of age 26. This coverage mandate applies to all plans otherwise subject to the Act but not those that are excepted from coverage (such as HIPAA-excepted flexible spending accounts or HIPAA-excepted stand-alone dental or vision plans).

Understanding The Regulations

Effective Date Issues/Grandfathering

In general, the requirement to make available dependent coverage for children who have not attained age 26 is effective for plan years beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). However, there is a limited delayed effective date for certain grandfathered plans (*i.e.*, plans in existence on March 23, 2010), which may exclude an adult child who has not attained age 26 from coverage if the adult child is eligible to enroll in an eligible employer-sponsored health plan *other than* a group health plan of either parent. Thus, for example, in the case of an adult child who is eligible for coverage under the plans of the employers of both parents, neither plan may exclude the adult child from coverage based on the fact that the adult child is eligible to enroll in the plan of the other parent's employer.

Plans and issuers are allowed to adopt the coverage mandate rule earlier than otherwise required. In fact, the preamble to the Regulations clarifies that this early adoption should not adversely affect a plan's grandfathered status. Separate guidance is expected on the definition of grandfathering and what types of amendments, if any, will adversely affect grandfathering treatment.

Definition of Dependent

The Regulations clarify that plans and issuers may no longer condition coverage on whether a child under the age of 26 is a dependent under the Internal Revenue Code (the "Code") or student. Instead, the term "dependent" may only be defined in terms of the relationship between the child and the participant. Specifically, the following factors may not be used for defining "dependent" for purposes of eligibility or continued eligibility for children under age 26: (1) financial dependency; (2) residency; (3) student status; (4) employment; (5) eligibility for other coverage; or (6) any combination of these factors. Presumably, a plan could impose these types of requirements for covered children who are age 26 or older, subject to applicable state law for insured plans.

In light of this, employers should review the specific terms of their group health plans (as well as summary plan descriptions and open enrollment materials) for the following issues and amend them as necessary:

- § Review definitions and other applicable provisions to ensure that they do not reference only Code dependent children.
- § Review definitions and other applicable provisions to ensure that, where appropriate, the plan terms clearly distinguish between dependent children who have not attained age 26 and other non-Code dependents who may also be eligible for coverage, such as domestic partners or children of domestic partners.
- § Remove references to Michelle's Law, to the extent it no longer applies to the plan at issue.

Tax Treatment of Coverage

As described in more detail in our April 28, 2010 Client Alert entitled "Important IRS Guidance on Tax Treatment of Health Coverage for Children Under Age 27," [\[click here\]](#) employers are permitted to exclude from an employee's taxable income the value of any employer-provided health coverage for an employee's child for the period before the child turns age 26 and for the entire taxable year in which the child turns 26.

In this regard, however, there is some uncertainty about the extent to which the definition of “child” under the Regulations is the same as the definition of child under previously issued IRS guidance. For purposes of determining whether coverage for a child is tax free, the IRS clarified that a child is defined based on the Code list of parent-child relationships (without regard to any financial dependency or whether the parent can claim the child as a tax dependent). Under the Regulations, however, no specific definition is used. Instead, the rule appears to be based on the plan’s or issuer’s definition of dependent child. Therefore, it is possible that if a plan’s or issuer’s definition of child is broader than the Code’s definition, the coverage mandate may apply based on the specific coverage terms, even if that coverage is not tax-free coverage. Further clarification on this point is needed.

Premium Differences for Children Under Age 26

The Regulations clarify that separate premiums for covered children are not allowed if they are based solely on the age of a child. For example, a group health plan cannot charge one premium amount for children up to age 22 and another premium amount for children between ages 23 and 26. On the other hand, if a plan has a tiered premium structure for single coverage as opposed to single plus a certain number of dependents, the plan is allowed to charge the employee for the appropriate number of dependents as long as it is without regard to age.

Coverage Differences for Children Under Age 26

Under the Regulations, the coverage terms of a plan or policy for dependent children cannot vary based on the age of a child under age 26. Additionally, dependent child coverage may not be limited based on whether a child is married. Nevertheless, a plan is not required to cover the spouse or child of a child receiving dependent coverage.

Transitional Rule

When this mandate becomes applicable for a plan or issuer, children under age 26 may not be excluded, regardless of whether or when a child was enrolled in the plan or coverage. The Regulations therefore provide transitional relief for a child whose coverage ended or who was denied coverage because, under the terms of the plan or coverage, the availability of dependent coverage ended before the attainment of age 26.

The Regulations require plans and issuers to give these adult children a special opportunity to enroll (or re-enroll) as well as notice of that opportunity no later than the first day of the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). The enrollment opportunity must continue for at least 30 days, regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. A plan could provide this enrollment opportunity as part of its regular open enrollment period as well.

Importantly, even if the request for enrollment is made after the first day of the plan year, if the child is enrolled, coverage must begin not later than the first day of the first plan year beginning on or after September 23, 2010 (January 1, 2011 for calendar year plans). This could raise issues regarding premium refunds for children who were enrolled in COBRA coverage prior to enrolling in dependent coverage as permitted under the transitional rule. In subsequent years, dependent coverage may be elected for an eligible child in connection with normal enrollment opportunities under the plan or coverage.

The Regulations clarify that notice of this enrollment right may be provided to an employee on behalf of the employee’s child. Additionally, the notice may be included with other enrollment materials distributed to employees so long as the statement is prominent. Although the Regulations do not specify a means of delivery for this notice, presumably a notice sent by first class mail to the employee’s last known address should be sufficient.

Also, note that the mandate for covering dependent children up to age 26 would have to be extended to qualified beneficiaries under COBRA coverage as well. Therefore, if a former employee is on COBRA coverage, that former employee would have the same right to add an adult child up to age 26 as a similarly situated active employee.

Children who enroll in group health plan coverage pursuant to this transitional rule must be treated as HIPAA special enrollees. This means, among other things, that the child (1) must be offered all benefit packages available to, and (2) cannot be required to pay more for coverage than, similarly situated individuals who did not lose coverage by reason of cessation of dependent status. It also means that parents have the ability to enroll themselves in the plan in addition to the child.

State Law

Notably, state laws that impose stricter requirements on health insurance issuers than those imposed by the Act are not preempted. Therefore, employers offering insured group health plans in states such as New York, New Jersey, and Pennsylvania, which already require dependent coverage to continue beyond age 26, must continue to meet these state law insurance requirements.

Outstanding Issues

Although the Regulations clarify many important issues and are relatively straightforward, certain open issues remain:

- § It is clear that a child under age 26 who is receiving COBRA coverage under his or her parent's plan must be afforded an opportunity to enroll as a dependent of his or her parent under the Regulations' transitional rule. However, it is not clear whether a child under age 26 who is receiving COBRA coverage under his or her former employer's plan or spouse's employer's plan must be given the same enrollment opportunity under a grandfathered plan for pre-2014 years.
- § As indicated above, the Regulations do not include a definition of the term "child." Thus, for example, it is not clear whether a broad plan definition of child will apply to the coverage mandate even if it is broader than the definition of child for tax exclusion purposes.
- § Guidance regarding the effective date of the dependent coverage provisions for collectively-bargained plans has not been provided.

We will monitor these and all other issues related to health care reform and provide updates as guidance becomes available.

[1] "Affordable Care Act" means The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA). This is designed only to give general information on the developments actually covered. It is not intended to be a comprehensive summary of recent developments in the law, treat exhaustively the subjects covered, provide legal advice, or render a legal opinion.