

Health Care Reform

Bulletin

Early Retiree Reinsurance Program (ERRP) — HHS Issues New Guidance That Employers Should Evaluate Before Filing the ERRP Application

July 1, 2010

On June 29, 2010, the federal government posted online:

- The final ERRP application
- Instructions for completing the application
- Dos and don'ts for applicants
- FAQs containing *important new information affecting employer applications*

In addition, HHS posted an “important update” on June 30 reporting that a new version of the official application had been posted that corrected small bugs in the original final version, and clarifying how applicants are to send their applications.

All of these materials are available on the website of the Department of Health and Human Services Office of Consumer Information and Insurance Oversight (<http://www.hhs.gov/ociio/regulations/>). The application and instructions remain substantially unchanged from an earlier draft version; however, HHS used the FAQ format to provide new details of the ERRP programs and to confirm some earlier information. Because the FAQs contain information that, if not heeded, could lead to an application being rejected or returned to an employer for correction, anyone working on an ERRP application should carefully review these FAQs before filing the application.

Background

Under the health reform law enacted March 23, 2010, the federal government is authorized to reimburse certain medical costs covered under employer group health plans for retirees aged 55 through 64 (Public Law 111-148, Section 1102).

Reimbursements will be available for 80% of individuals' medical claim costs for health benefits between \$15,000 and \$90,000 for as long as the law's \$5 billion appropriation lasts. Employer plan sponsors with approved ERRP applications will be able to submit claims for medical care going back to June 1, 2010.

New or Revised Information on ERRP Will Affect Many Employers

The new FAQs include confirmation from HHS that while ERRP applications will be processed in the order they are received, that order will *not* determine the order in which ERRP funds are distributed. According to HHS, all qualified applications will be approved and ERRP payments made only when plans with approved applications submit their claims, not in the order that applications were submitted or approved. Once an employer's application is approved, it can submit claims for early retiree costs. Those claims will be processed in the order they are received.

This clarification is significant because the \$5 billion in available funds is expected to be depleted rapidly; however, it is apparently not the sequence in which ERRP applications are submitted that will determine the order of fund distribution, but rather the sequence in which approved plans submit claims for reimbursement that will establish priority in payment. HHS has the authority to stop accepting applications only if the \$5 billion in federal funding proves to be insufficient as reimbursements are being paid out. A plan can't submit a claim until its application is accepted, but the claim submission process has not yet been finalized. According to HHS, the critical step in receiving reimbursement is actually the submission of the request for claim reimbursement.

The following points highlight some of the information that is revealed or confirmed by the new FAQs.

Definitions

Early retiree — HHS will generally defer to a plan's existing written rules to determine whether someone is an active employee or an early retiree (e.g., a disabled individual). In the absence of such plan rules, HHS will default to the Medicare Secondary Payer standards for determining those who are in "current employment status."

Early retiree under non-employer-sponsored plan — When the plan sponsor is not an employer (e.g., is a union or association), the individual must not be an active employee of an employer contributing to the plan.

Number of plans — A sponsor may consider multiple health benefit arrangements as one "employment-based plan" unless (1) it is clear from the instruments governing an arrangement or arrangements to provide health benefits that the benefits are being provided under separate plans, and (2) the arrangement or arrangements are operated pursuant to such instruments as separate plans. However, a multiemployer plan and a non-multiemployer plan are always separate plans.

In borrowing these principles on identifying plans from the IRS's COBRA rules (which were also used under the Medicare Part D RDS program), HHS goes beyond the May 5 ERRP regulations to provide employers with a greater degree of flexibility in identifying "plans." Under these standards, an employer could have more of fewer plans than the number of Form 5500s that it files, depending on the employer's documents and its operational facts and circumstances. Since the "plan" is the context for applying ERRP funds to lower the future costs of participants or the sponsor, this may be a significant clarification for some employers.

Number of benefit options — In the application, sponsors must identify each benefit option within a plan for which it might request program reimbursement, by name and by creating a Unique Benefit Option Identifier (UBOI). According to HHS, the sponsor should identify a UBOI for each different health insurance issuer, TPA or vendor through which health benefits are provided or administered.

HHS' position on UBOIs is illustrated by the following example in the FAQ:

...within a single employment-based plan...a sponsor offers a self-funded major medical arrangement administered by Third-Party Administrator A, as well as separate insured major medical coverage arrangements through Insurer B and Insurer C. Insurer C offers both a “low” and a “high” option of major medical coverage. The self-funded arrangement and Insurer B offer prescription drug benefits through Prescription Benefit Manager D, while Insurer C offers prescription drug benefits through Prescription Benefit Manager E. The sponsor should assign names, and identifiers, to the arrangements provided by Third-Party Administrator A, Insurer B, Insurer C, Prescription Benefit Manager D, and Prescription Benefit Manager E. (The sponsor should assign only one name, and only one identifier, to the arrangement provided by Insurer C, notwithstanding the fact that Insurer C offers both a low and a high coverage option). The sponsor should list those names, and the identifiers, as the benefit option names and benefit option identifiers, respectively, in the application.

Thus the number of UBOIs appears to be equal to the number of vendors. This vendor-based approach may puzzle some sponsors; however, it is the approach that HHS has requested in its FAQ.

Applications

Expected timing of use of funds — HHS says that an employer planning to use ERRP proceeds only to reduce the sponsor's increased costs, but concerned that increased costs in a year might be insufficient to consume the funds, should disclose in the application that any remaining funds will be applied to offset the sponsor's increased costs for the following plan year (or alternatively to use the proceeds to reduce the participants' costs in the current or future plan year).

Chronic and high-cost conditions — HHS confirms that a plan's programs and procedures for chronic and high-cost conditions must be in place at the time the sponsor submits the application. Moreover, HHS states that “it would be helpful” for an applicant to explain how it determined which conditions to address (i.e., how it was determined that the chronic and high-cost condition has generated, or is likely to generate, \$15,000 in claims in a plan year), how the program and procedures will generate cost savings with respect to plan participants with these conditions, a description of the programs and procedures, and who benefits from the cost savings (i.e., the plan sponsor and/or plan participants). While HHS only expects a summary, the application must describe how any assertions would be supported in the event of an audit.

Delivering the application — Completed applications should be submitted via the U.S. Postal Service to:

HHS ERRP Application Center
4700 Corridor Place, Suite D
Beltsville, MD 20705

While an HHS statement on June 29 indicated that use of the U.S. Postal Service is “preferred” and confirmed that courier delivery would be acceptable, the June 30 “important update” clearly communicates HHS’ desire that applicants use the U.S. Postal Service.

Territories — Sponsors located in U.S. territories and territorial governments are not eligible to participate in ERRP (e.g., American Samoa, Federated States of Micronesia, Guam, Midway Islands, Puerto Rico and the U.S. Virgin Islands).

Claim Submission and Reimbursement

Submitting claims — HHS will announce instructions detailing the manner and timing for submitting this information in the near future. Plan sponsors will then be able to submit claim data and reimbursement requests. Sponsors will need to monitor the OCIO webpage at HHS for this and other program information.

Use of Reimbursements

Permitted uses — Sponsors must use ERRP proceeds (1) to reduce the sponsor’s health benefit premiums or health benefit costs, (2) to reduce plan participants’ health benefit premium contributions, copayments, deductibles, coinsurance or other out-of-pocket costs, or any combination of these costs, or (3) any combination of (1) and (2). The sponsor cannot use ERRP proceeds as general revenue. To ensure that ERRP proceeds are not *de facto* used as general revenue, sponsors must maintain their level of financial effort in supporting the applicable plan or plans. To the extent a sponsor decides to use the reimbursement for its own purposes, it can do so only to offset *increases* in its health benefit premiums or health benefit costs. The sponsor must explain in the program application how it will maintain its level of effort for the plan.

May not target participants within a plan to benefit — If a sponsor uses some or all of the ERRP proceeds to reduce plan participants’ health benefit premium contributions, copayments, deductibles, coinsurance or other out-of-pocket costs, it must do so *for all plan participants*, and not just for early retirees. For this purpose, “plan participant” means anyone enrolled in an applicable plan, including an early retiree, a retiree, a retiree’s spouse and dependent, an active employee, and an active employee’s spouse and dependent.

Administrative costs and ERRP expenses — Plan sponsors may not use ERRP funds to pay increased administrative costs generally related to the administration of the plan nor use the funds to pay for expenses that are created by participation in the ERRP program.

Holding proceeds in reserves — The sponsor of a self-insured plan could place ERRP proceeds funds into a *separate account* provided that, when audited by HHS, it could show how and when the

reimbursement was used as required under the program. HHS' view is that it could be difficult to make such a showing if the program reimbursement is placed into an ongoing pool of funds.

Reporting Data Inaccuracies

When and how to report — Sponsors must disclose the amount of post-point-of-sale negotiated price concessions that were received but not accounted for in their claim data and report other data inaccuracies; however, HHS has not yet set the manner and timing of making those disclosures. Sponsors will need to monitor the OCIO webpage at HHS for this and other program information.

Fraud, Waste and Abuse

Vendors — The requirement that a plan sponsor attest that it has fraud, waste and abuse policies and procedures in place can be satisfied if the vendors contracted by the sponsor to pay plan claims and/or to submit ERRP claims have their own fraud, waste and abuse procedures in place. Those policies and procedures must be able to effectively detect and reduce fraud, waste and abuse related to the ERRP program, although they need not specifically reference or be specifically designed for the ERRP program.

Maintenance of Effort (MOE)

Employer MOE — Plan sponsors need not maintain the same level of employer support as they did before applying for ERRP funds if they will use ERRP proceeds exclusively to reduce or offset increases in plan *participants'* health benefit premium contributions, copayments, deductibles and coinsurance.

Baseline — To show maintenance of effort, the baseline year for an employer is generally the plan-year cycle that ended immediately before the ERRP application was submitted. However, in cases where governmental or private-sector employers may be cutting health care budgets, HHS says it will look to a baseline that was the sponsor's finalized budget, provided it was finalized before June 1, 2010. The sponsor must be able to show upon audit that the budget was finalized prior to June 1, 2010.

Same dollar amount — HHS interprets its ERRP regulations to require that the sponsor show that it is contributing the same specific dollar amount as it paid during the baseline year, not the same percentage of plan cost.

Aggregate MOE — A sponsor must demonstrate that it meets the ERRP maintenance of effort requirement in the aggregate, for all plan participants, but not necessarily for each participant. For a multiemployer plan, HHS will look to the amount spent from the trust on health benefits or health premiums compared to the baseline year.

Contributions to an irrevocable health trust — According to HHS, if an employer-sponsor's payments into a fund or trust are irrevocable and can be used only for health benefits, it will look to those contributions in the baseline year compared to the applicable year to determine MOE compliance (i.e., as if such contributions were insurance premiums).

Employers using a VEBA trust will need to review carefully whether the facts and circumstances of their situation will satisfy these HHS requirements (e.g., are non-health benefits also payable from the trust).

Next Steps

Plan sponsors now have the final forms necessary to file an ERRP application. The new ERRP FAQs issued on June 29 provide additional clarity, and some new regulatory interpretations, that could affect the preparation and content of ERRP applications. The knowledge that one's application filing date does not dictate the ability to obtain ERRP proceeds provides employers with a brief but reasonable opportunity to consider how this new information should affect their ERRP filing strategy, for example, on the number of plans and the number of benefit options, and the description of programs for high-cost and chronic conditions, among other issues. Prior to filing their application, sponsors should review earlier decisions that may have been made regarding definition of a "plan" and intended use of funds, as the FAQs provided clarification on these issues that may differ from earlier interpretations and potentially have far-reaching impact for plan sponsors on how the ERRP funds will be requested, tracked and used.

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