JONES DAY

MAY 2010

THE EARLY RETIREE REINSURANCE PROGRAM– U.S. EMPLOYERS TO LINE UP FOR $5 BILLION POOL OF FEDERAL FUNDS

The Patient Protection and Affordable Care Act creates the Early Retiree Reinsurance Program (the "Program"). On May 5, 2010, the Department of Health and Human Services ("HHS") published interim final regulations (the "ERRP Regulations") setting forth the requirements for the Program. The purpose of the new Program is to encourage employers to continue to offer health plan coverage to early retirees by providing reimbursements to the employers for a portion of the claims paid for the covered early retirees. Reimbursements under the Program are made to the employer as the plan sponsor.

FIRST COME, FIRST SERVED

Under the Program, $5 billion in federal funds is made available to reimburse employers that provide retiree health care coverage to early retirees. The reimbursements will be paid, on a first-come, first-served basis, to employers that apply for the federal funds. The earliest filers who:

- Satisfy the requirements for the Program under the ERRP Regulations, and
- Submit complete, correct applications

will maximize their chance to share in the available $5 billion fund.

Once the $5 billion is gone, additional claims will not be reimbursed. HHS has made it clear that they anticipate that applications for reimbursements *will* exceed $5 billion. The ERRP Regulations also provide that applicants for certification will not be allowed to cure defective applications; incomplete applications will be denied. Once an application has been denied, a plan sponsor will be required to submit a new application and move to the back of the queue. Accordingly, it is essential that employers act promptly to commence the certification process. Employers should take great care in fully and accurately completing their certification applications and

reimbursement claims in accordance with the ERRP Regulations and other applicable guidance.

REQUIREMENTS FOR PARTICIPATION

General. Before an employment-based health plan can participate in the Program, the plan must be "certified" by the Secretary of HHS (the "Secretary"). "Certification" means that the plan sponsor and the employment-based health plan have met the requirements to participate in the Program, and the Secretary has approved the plan sponsor's application to participate. The ERRP Regulations make clear that additional guidance regarding the Program will be forthcoming.

The Early Retiree Reinsurance Program is designed to operate consistently with the Retiree Drug Subsidy Program. The two programs have many similarities, and the use of common terms and concepts is intended to minimize confusion and encourage participation in the Program. When confronting difficult interpretive questions under the Program, it may be helpful to review similar language or provisions under the Retiree Drug Subsidy Program.

Employment-Based Health Plan. The Early Retiree Reinsurance Program is available to employment-based health plans. "Employment-based plans" are defined as group health plans that provide health benefits to early retirees (other than federal governmental plans). The term includes group health plans maintained by private employers, both insured and self-insured, that provide benefits to early retirees (including collectively bargained plans).

Programs or Procedures that Promote Cost Savings. In order to participate in the Program, an employment-based health plan must have in place programs or procedures that have generated or could generate cost savings for chronic and high-cost conditions. "Chronic and high-cost conditions" are defined as conditions for which $15,000 or more in health benefit claims are likely to be incurred during a plan year by any one plan participant. Such programs and procedures do not have to be newly created and need not address every chronic and high-cost condition.

Written Information Sharing Agreement between Sponsor and Plan. Sponsors must have a written agreement with the group health plan (or insurer, in the case of a fully insured plan) requiring the disclosure of information regarding compliance with the Program to the Secretary. The plan is permitted to disclose the information under the "required by law" rule that allows disclosure under HIPAA. Self-funded plans with legal access to the data can either provide this data to the Secretary themselves or have the plan administrator provide the data.

Policies and Procedures to Detect Fraud. In order to participate in the Program, an employment-based health plan must have policies and procedures to detect fraud, waste, and abuse (such policies and procedures do not have to be newly created). Details with respect to these policies and procedures must be provided to HHS upon request (*e.g.*, for purposes of an audit).

APPLICATION PROCEDURES

Applications for participation in the Program must be verified and certified by an authorized representative of the applicant. An "authorized representative" is an individual with legal authority to sign and bind the plan sponsor by signing the required documents. Applications will be processed in the order they are received. Incomplete applications will be denied, and a new application (with a new application date) will be necessary to join the Program.

One application is to be filed for each plan. For these purposes, benefit options under a plan (*e.g.*, different benefit options, category of benefits, or cost sharing arrangements) are not separate plans. The application will identify the plan-year cycle for the plan by noting the month and day on which the 12-month plan year begins. The application will also include the applicant's Taxpayer Identification Number, name, address, and contact information.

The application must include a summary of how reimbursements under the Program will be used to meet the Program requirements, including how the plan sponsor will use the reimbursements to reduce plan participant or sponsor health benefit costs, or any combination of those costs, and the plan sponsor's plans to implement programs and procedures to generate savings for plan participants with chronic and high-cost conditions. Reimbursed funds may not be used as

general revenue for the plan sponsor, and the application for certification must show how the sponsor will use the reimbursement amounts to maintain the same level of contribution to the applicable plan. The Secretary is to develop a mechanism to monitor the appropriate use of the reimbursements. Reimbursement amounts may be used for all plan participants, not just early retirees and their dependents.

The application must also provide a projection of the reimbursement amounts that the plan sponsor expects to receive under the Program for the first two plan-year cycles of participation in the Program. These projections will be used by the Secretary to determine when the Program will stop taking applications for participation. The application must also identify all benefit options under the employment-based plan under which an early retiree or his dependents could be covered.

As part of the application process, the applicant must include an attestation that the plan has fraud, waste, and abuse policies and procedures in place.

As a requirement for participation in the Program, the authorized representative of the plan sponsor will be required to sign a "plan sponsor agreement." Under the plan sponsor agreement, the authorized representative will have to specifically agree to comply with the terms and conditions of the Program and acknowledge that the information in the application is being provided for the purpose of obtaining federal funds.

When the application has been approved by the Secretary, the plan and the plan sponsor will be certified for participation in the Program. Claims cannot be submitted until the certification process has been completed.

REINSURANCE AMOUNTS

Early retirees under the Program are individuals who are not active employees, are age 55 or older, and are not eligible for coverage under Medicare, and also include the spouses, surviving spouses, and dependents of such individuals. Claims for spouses and dependents are permitted under the Program regardless of the age of the spouse or dependent.

A claim under the Program includes expenses for benefits paid for items or services, including medical benefits, surgical benefits, hospital benefits, prescription drug benefits, and other benefits for the diagnosis, treatment, cure, mitigation, or prevention of physical or mental disease or condition with respect to any structure or function of the body.

Upon receipt of a valid claim, the reimbursement amount is 80 percent of the portion of the health benefit costs (net of negotiated price concessions attributable to the claims) that exceed $15,000 but are below $90,000. The claim includes *all* cumulative health benefits incurred in a given plan year and paid for a given early retiree—not just discrete health benefit items or services. Costs paid by the early retiree may also be included (but *see* further discussion below). Reimbursement will be made only for claims that are incurred during the applicable plan year and paid. For this purpose, the term "incurred" means the point in time when the payer becomes responsible for the payment of the claim, not the time when the services or items are received.

The $15,000 limit is called the "cost threshold." The $90,000 limit is called the "cost limit." For determining amounts below the cost threshold (and above the cost limit), all costs for health benefits paid by the plan (or by the early retiree) for all benefits options in which the early retiree is enrolled are combined. The $15,000 and $90,000 numbers will be adjusted based on the increase in the medical care component of the consumer price index for plan years beginning on or after October 1, 2011.

Premiums are not part of the calculation of the costs because premiums are not costs of items and services.

TRANSITION

The Program is effective June 1, 2010. Plan sponsors, however, may apply for participation in the Program for plan years that begin prior to June 1, 2010, and end on any date thereafter. For this purpose, claims incurred prior to June 1, 2010, up to $15,000, count toward the cost threshold and the cost limit for the plan year. Claims incurred prior to June 1, 2010, that exceed $15,000, however, are not eligible for reimbursement and do not count toward the cost limit. Reimbursement is solely based on claims incurred on and after

June 1, 2010 that fall between the cost threshold and the cost limit for the plan year.

DOCUMENTATION OF MEDICAL CLAIMS

Once the cost threshold has been met for an early retiree for a plan year, claims can be submitted under the Program. Claims under the Program must show all claims paid below the cost threshold so that it is clear that the claim is eligible for reimbursement.

Claim submissions must include a list of early retirees for whom claims are being submitted. Submissions will be processed on a first-in, first-out basis.

For the plan sponsor to get credit for claim amounts paid by the early retiree, the plan sponsor must provide "prima facie evidence" with the claim submission that the early retiree paid his or her portion of the claim. Evidence may include an actual payment receipt. If a sponsor cannot provide prima facie evidence of payment, it may receive credit only for the portion of the claim paid by the sponsor.

NEGOTIATED PRICE CONCESSIONS

Negotiated price concessions must be reflected in the claims for reimbursement under the Program. If price concessions, such as prescription drug rebates, occur after a claim for reimbursement is paid, the plan sponsor must disclose the later negotiated price concession in the form and manner required by the Secretary.

PROGRAM TERMINATION

The Program will terminate on the earlier of (a) when $5 billion has been reimbursed to certified plan sponsors, or (b) on January 1, 2014.

IN CONCLUSION

This is one in a series of *Commentaries* Jones Day intends to provide to our clients and friends on health care reform laws. In the weeks ahead, we will be providing additional guidance on how the provisions of the new laws—and the developing regulatory framework assembly unfolding—affect employer-sponsored health plans and their sponsoring employers, both in the near future and over the longer term.

LAWYER CONTACTS

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