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HEALTH REFORM UPDATE Early Retiree Reinsurance Program (“ERRP”)

As part of the Health Reform package passed this year, a new program entitled the Early Retiree Reinsurance Program (“ERRP”) was instituted. This temporary program was developed to assist employers with the costs of health care coverage for early retirees age 55 and over, who are not eligible for Medicare and not active employees, and their eligible dependents regardless of age. The program has been allotted \$5 billion dollars in funding, and eligible claims will be reimbursed by the U.S. Department of Health and Human Services until the earlier of exhaustion of the funds or January 1, 2014.

Full details regarding how this program will be administered by DHHS are still forthcoming, but we do have some information that we would like to provide to you. The U.S. Department of Health and Human Services has published an initial application form with instructions, however has not yet indicated how or to whom the application is to be submitted for review and approval. The actual form and format of the request for reimbursement under the program is also still under development at this time.

***NOTE:** If you are interested in participating in the ERR program, please let your Account Manager know immediately. Funds for this program are limited and the date your application is submitted for consideration to the U.S. Department of Health and Human Services may materially affect the determination to approve or deny requests for claims reimbursement.*

Following are some answers to frequently asked questions:

- Q. What plans are eligible to apply for certification under this program?**
- A.** Any employment based group health plan (including union based plans) with more than two participants that provides benefits to early retirees, through insurance, reimbursement or otherwise is eligible to apply for certification. Self-funded group health plans are eligible to apply if they provide benefits for early retirees. Federal governmental plans are expressly excluded from eligibility under this program.
- Q. Who must apply for the certification under the program, and who can apply for reimbursements once approved for participation?**
- A.** The Plan Sponsor must be the primary applicant under this program, and is the only entity that is approved to receive any reimbursements under the program.
- Q. What benefits are considered reimbursable under the program?**
- A.** In general, the Plan Sponsor may apply for reimbursement for major medical type services incurred and paid for diagnosis, cure, mitigation or prevention (medical, hospital, surgery, RX) for eligible early retirees who are over age 55 who are not

active employees and not eligible for medicare, and/or their eligible dependents regardless of age. An active employee is defined as employed by “an employer maintaining, or currently contributing to, the employment based plan or of any employer that has made substantial contributions to fund such a plan”.

Q. How much will be reimbursed?

A. Reimbursements for eligible claims will be 80% of the actual claims incurred and paid between \$15,000 and \$90,000 for an eligible individual in a plan year. Accumulated claims for any one eligible individual must reach a threshold of \$15,000 before they will be eligible for reimbursement, and reimbursement will be capped at a maximum of \$90,000 in incurred and paid claims for any one eligible individual in a plan year.

Q. My Group Health plan year is a calendar year plan, but the ERR program does not begin until June 1, 2010. Will any of the claims incurred and paid for eligible retirees and/or their dependents prior to June 1, 2010 be eligible for reimbursement?

A. No. To be eligible for reimbursement under the program, the claim must be incurred and paid after June 1, 2010, however, claims incurred and paid for an individual prior to June 1, 2010 (but still within your plan’s current plan year) may be used to meet the \$15,000 threshold requirement.

Q. I understand the funds for this program are limited. Can my plan apply for reimbursement before the application process is completed?

A. No. The U.S. Department of Health and Human Services has determined that only Plans whose applications have been completed in their entirety, completely reviewed, and where both the Plan Sponsor and the Plan have been “certified” are eligible to request reimbursement under the program.

Q. Who completes the application form?

A. The Plan Sponsor must designate a single Authorized Representative (a senior level employee of the Plan or the Plan Sponsor who has authority to bind the Sponsor to the terms of a contract or agreement), and the Authorized Representative must sign the application form attesting that the information included is true and accurate. However, the Plan Sponsor must also designate an Account Manager to coordinate the actual completion of the application and to be the primary contact with DHHS during the application process. This Account Manager is not required to be an employee of the Plan Sponsor or of the Plan, and may be a consultant or other individual entrusted with this task. Both of these named individuals must provide their social security numbers on the application form for identity verification purposes.

Q. If my plan submits a completed application form meeting all the criteria requested in a timely manner, is it certain that the Plan and Plan Sponsor will be certified?

A. No. Even if an application form satisfies all of the criteria required, it may still be denied, depending on the availability of the limited ERRP funds. Incomplete application forms will be rejected immediately and a new application form required.

Q. Are there any health benefits that are not reimbursable under the program?

A. Yes. Limited scope benefits such as stand alone dental and vision plans, workers compensation, indemnity plans, FSA expenses, costs from on-site medical clinics, LTD, and automobile personal injury protection costs are some of the benefits specifically excluded from eligibility.

Q. My group health plan receives various negotiated discounts from providers, at point of sale, or by virtue of Medicare Like Rates. Can my Plan seek reimbursement for the billed charges and ignore the discounts?

A. No. Reimbursements under the program will only be provided for actual paid claims costs.

Q. My self funded plan has Stop Loss coverage to protect the Plan from high cost claims. Can the Plan request reimbursement under the ERR program and under Stop Loss?

A. Yes. Even though the name of the federal program is the Early Retiree Reinsurance Program, it is not related to Reinsurance or Stop Loss in reality. There is no prohibition in the rules and regulations governing the ERR program against a Plan Sponsor requesting reimbursement from their Stop Loss carrier for eligible claims. Any funds received from the ERR program can only be used to offset Plan cost increases, reduce the costs for plan participants or provide enhanced benefits that will or have the potential to reduce health care costs.

Q. If my plan receives a reimbursement from the ERR program, does this mean that we must reduce any claims that are otherwise eligible for Stop Loss coverage by the amount reimbursed before they are submitted to Stop Loss?

A. No. The Stop Loss claim can still be submitted in its entirety in the usual way for payment. The majority of self-funded group health plans under ERISA pay claims costs out of their general revenues. The ERR program expressly prohibits using any ERR reimbursements as general revenue, so reimbursements under the ERR program cannot be used to directly offset paid claims costs for a self-funded ERISA plan. Instead the program requires that the Plan Sponsor use all ERR reimbursements to either offset Plan cost increases, reduce the costs of plan participants, or provide enhanced benefits that will or have the potential to reduce health care costs.

Q. Can reimbursements under the program be considered general revenue?

A. No. All reimbursements must be used to pay or reduce Plan Participant premiums, co-pays, co-insurance, or other out of pocket costs or provide plan enhancements that will or have the potential to reduce health care costs. Plan Sponsors are required to maintain their current level of contribution to the cost of

coverage under their group health plan, but may use the reimbursements to offset any cost increases.

Q. How will the actual amount of reimbursement under the plan be calculated?

A. The actual costs of the eligible claims paid for an eligible Plan Participant will be determined, net of any negotiated savings or price concessions, within the applicable plan year for each early retiree, and then the amount below the cost threshold and above the cost limit will be subtracted. The determination is made for each early retiree or dependent for each applicable plan year. Note that reimbursements will be limited by funds available, so not all claims may be reimbursed.

Q. What are some of the criteria required for a Plan to be eligible to participate under this program?

- A.** The Plan must provide the following:
- Identification of the conditions they consider chronic and high cost (defined as those which are expected to generate \$15,000 or more in health benefit claims in a plan year for one plan participant in absence of any cost savings programs). The Plan Sponsor is expected to take a reasonable approach to identify these chronic and high cost conditions within their own participant population and is not expected to identify all conditions that may qualify.
 - A description of the programs and procedures the Plan has in place that have or have the potential to generate cost savings with respect to Plan Participants with the identified chronic and high cost conditions. The final rule anticipates that Plans will select programs and procedures that are expected to lower the cost of care, as well as improve the quality of care, for the identified conditions.
 - An estimate of the projected amount of proceeds the Plan expects to receive under the ERRP for each of the first two plan years identified in the application.
 - A statement of how the Plan will use the reimbursements to reduce health benefit costs or plan premium costs (i.e. reductions in retiree contributions, copayments, deductibles, coinsurance, or other out-of-pocket expenses). Proceeds from this program cannot be used as general revenue for the Plan Sponsor.
 - An attestation that the Plan has in place policies and procedures to detect fraud, waste and abuse, and will, upon request, provide evidence of the same, as well as data to substantiate the effectiveness of the policies and procedures.

All information provided in the application is subject to audit by the U.S. DHHS.

Q. One of the requirements for a Plan to obtain certification under the ERR program is that programs and procedures must be in place that have generated or have the potential to generate cost savings with respect to Plan participants with identified chronic and high cost conditions. How can my Plan meet this requirement?

A. Specific details relating to the process that DHHS will follow to review, approve and certify ERRP applications and the benchmarks that will be used to determine if application requirements, such as this one, have been met are not available at this time. Because of this, we cannot with certainty state what programs and procedures will meet this requirement. However, RGA offers an optional Disease Management (“DM”) service to our clients that we believe will satisfy this requirement. Under our DM program, chronic and high cost conditions are actively managed by our nurse case managers to ensure that the patient receives the highest level of care at the lowest cost. Our Nurses actively work with both the patient and the providers to achieve cost savings and increased quality of care. If your Plan has elected to purchase DM services from RGA, and you elect to have RGA assist you in the application process, we will provide you with the information needed to respond to this application requirement. However, please note that because so much is still unknown, RGA is unable to warrant or guarantee that our DM program and procedures will meet the ERRP requirement.

Q. The final rule governing this program requires a new written agreement be in place between the Plan Sponsor and the health insurer or claims administrator. What is required to be in this agreement?

A. The required written agreement will include provisions requiring that the Business Associate agree, on behalf of the Plan Sponsor and Plan, to disclose to the Secretary of DHHS any and all relevant records, information, data, claims information, PHI, documents and any other records necessary for the Plan Sponsor to comply with the program or as required to verify reimbursement requests made by the Plan Sponsor.

Q. How does the Plan apply for reimbursement, once certified?

A. The actual form and format of the application form for reimbursement has not yet been published by DHHS, but the final rule indicates that the following information will be required:

- A listing of all eligible early retirees.
- Documentation of the actual costs for items and services provided to eligible early retirees and their dependents.
- Prima Facie evidence that the early retiree and/or their dependent(s) paid their share of the costs.

Q. Are there any other requirements for a Plan to be eligible to participate in this program?

A. Yes, several. This summary is not intended to be an exhaustive analysis of the requirements of the program, but to provide you with the high level summary of the criteria. We have attached a copy of the DHHS application form and the accompanying instructions to this update for your review.

How can RGA assist you in this process? We can assist with the following:

- 1) Identification of early retirees and their dependents.
- 2) Identification of Chronic and High Cost conditions.
- 3) Information and documentation on RGA policies and procedures that have or have the potential to control costs and improve the quality of care for the identified Chronic and High Cost conditions.
- 4) Information and documentation on policies and procedures relating to detection and reduction of fraud, waste and abuse.
- 5) Assist the plan to estimate the expected reimbursement from the ERRP in the first two plan years for those with the identified Chronic and High Cost conditions.
- 6) Execute the new written agreement required by the ERR program with the Plan Sponsor.

If you would like RGA to assist you by providing the services listed above, there will be a one time fee of \$25 for each eligible retiree/dependent (minimum requirement of \$500.00) to cover our expenses and costs.

What does the Plan Sponsor need to do (actions that cannot be completed by RGA) in addition to the services listed above?

- 1) Designate the Authorized Representative and Account Manager for the program.
- 2) Prepare the written statement describing how the reimbursements received from the ERR program will be utilized by the Plan.
- 3) Execute the written agreement required by ERRP with RGA and any other Business Associates who will be required to provide data to DHHS on the Plan's behalf.
- 4) Complete the ERRP application form and submit it for consideration.

For additional information on this program, please go to the DHHS website on this topic, located at <http://www.hhs.gov/ociio/regulations/>.

As more information becomes available on this or other provisions of the Affordable Care Act, RGA will provide you additional updates. If you have any questions, please don't hesitate to contact any member of your RGA Account Team.

Disclaimer: The information contained herein is not intended to be legal advice, and while every effort has been made to ensure that the content of this legislative update is accurate, RGA makes no representations or warranties in relation to the information provided, and assumes no liability or responsibility for any acts or omissions based on this information. As always, we encourage you to consult with your own legal counsel prior to making any decisions regarding plan design or administration.