GBS
Group Benefit Services

Compliance Alert

May 28, 2010

Group Benefit Services is pleased to announce the first of our Health Care Reform Compliance Alert series. Every other week or so you will receive a Compliance Alert that will concentrate on a specific Health Care Reform topic that could affect your group health plan. As information changes or more details are clarified by the government entities we will continue to keep you informed. This first Compliance Alert includes two Health Care Reform topics. We hope you find this information informative and helpful through this challenging time in our industry.

- ***Grandfathered Plans***
- ***Early Retiree Health Insurance Program***

Health Care Reform – What is a Grandfathered Plan?

The Patient Protection and Affordable Care Act (PPACA) and The Health Care and Education Reconciliation Act of 2010 (together known as the "Reform Legislation") will affect the design and administration of employer-sponsored group health plans.

This Compliance Alert is to define a Grandfathered Plan and will explain how the Reform Legislation impacts employer-sponsored group health plans that were in effect on March 23, 2010.

What is a Grandfathered Plan?

A 'grandfathered plan' is a plan where an individual was enrolled on March 23, 2010. A grandfathered plan can be a single employer plan or a multi-employer plan. The plan can also be an insured plan or a self-insured arrangement.

In the case of collectively bargained plans, a group health plan is a grandfathered health plan until the last of the collective bargaining agreements related to the coverage under the group health plan terminates.

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A few of the known facts regarding keeping the status of a grandfathered plan:

1. A grandfathered plan may enroll new employees and their families in the plan without losing the plan's grandfathered status. The grandfathered status also continues to apply to the coverage of an individual covered by the plan on the date of enactment regardless of whether the individual renews coverage or adds family members after the date of enactment. Some guidance is still needed on this topic.
2. Some amendments will be allowed to be made to the plan without losing the grandfathered status. Until further guidance is issued, plan sponsors should take care to consider amendments that would substantially alter the nature of a benefit or the coverage of the members.

Grandfathered plans must comply with the following provisions. More information will be coming in a later Compliance Alert.

1. Requirement that plans and insurers issue standardized summaries of benefits and coverage explanations.
2. Prohibition on lifetime limits.
3. Extension of dependent coverage to adult children.
4. Restriction on annual limits.
5. Prohibition on pre-existing condition exclusions.
6. Prohibition on excessive waiting periods.

Grandfathered plans are not required to comply with the following provisions.

1. Requirements regarding preventive health services.
2. Prohibition against discrimination in favor of highly compensated individuals.
3. Required reporting on quality features.
4. Requirement regarding internal appeals.
5. Prohibitions on restrictions regarding health care providers and other patient protections.
6. Prohibition against discrimination based on health status.
7. Prohibition against discrimination against health care providers.
8. Comprehensive health insurance requirement.
9. Coverage requirement for clinical trials.

As more clarification is provided regarding "grandfathered plans" and the requirements we will provide you with the detail.

Attached to this Compliance Alert is a Legal Alert from an Employee Benefits law firm detailing more information on Grandfathered Plans and the requirements.

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Health Care Reform – Early Retiree Health Insurance Program

The Department of Health and Human Services (HHS) has issued an interim final rule for the Early Retiree Health Insurance Program that was enacted as part of the Patient Protection and Affordable Care Act (PPACA).

This Program will provide an opportunity to help offset the costs of health claims for employers that provide health benefits for retirees age 55 through 64 and not eligible for coverage under Medicare. The Act has labeled these individuals 'early retirees'. The Program could reimburse plan sponsors for a portion of the cost of benefits provided to early retirees and their spouses and dependents.

The Program is to be established by HHS within 90 days of the enactment which is June 21, 2010.

The Program is to run through January 1, 2014 or earlier if the $5 billion set aside for the program is exhausted.

Although the Program provides an opportunity for the plan sponsor to reduce certain medical costs, a considerable amount of administrative effort will be involved. Plan Sponsors must apply for the Program and be approved (certified) by HHS in order to participate.

The Program has limited funds as explained above therefore the applications are reviewed on a first come, first served basis. *HHS has stated the application will be available by the end of June.*

General Overview of the Program

To be eligible to receive reimbursements under the Program:

- The plan sponsor must apply to the HHS;
- HHS must approve the application and certify that the plan sponsor and the plan sponsor's employment-based plans meet the requirements for participation;
- The plan sponsor must include programs and procedures that have generated or have the potential to generate cost savings for the plan participants with claims for chronic and high cost conditions.
- The certified plan sponsor must submit claims, with supporting documentation.

If the requirements are met, the plan sponsor is eligible to receive reimbursements equal to 80% of the costs of eligible health benefit claims incurred during the current plan year.

This Alert is an overview to provide you with information so you can determine whether or not you may be eligible to receive reimbursement under this new Program.

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Attached to this Compliance Alert is a detailed description of the Program as described by a law firm specializing in Employee Benefits.

If you have any questions regarding this information, please contact your Group Benefit Services Account Manager at 1.800.638.6085.

This communication is not intended to be legal advice and should not be construed as legal advice. If you have any legal questions or concerns about your plan, GBS recommends seeking counsel from an ERISA attorney.

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LEGAL ALERT

May 5, 2010

Health Care Reform: Understanding the Grandfather Rules

The coverage mandates and insurance reforms in Subtitles A and C of the Patient Protection and Affordable Care Act (PPACA) will require significant changes to employer-sponsored health plans. Several of the mandates become effective in 2010 or 2011, requiring immediate attention, while others become effective over the next several years. Also, though PPACA generally applies to all group health plans and health insurance coverage going forward, certain existing plans and coverage are exempted, or "grandfathered," from a number of the new requirements. The grandfather provision delays the time a new rule will apply to a grandfathered plan in some cases and in other cases seems to provide a complete exemption from the rules.

The grandfather provision, found in section 1251 of PPACA[1], is intended to provide plan sponsors and insurers with greater certainty regarding their current benefit arrangements. Grandfathered plans will be able to maintain many of their current coverage provisions and will require fewer changes to plan documents and administrative procedures in order to comply with the new law. However, with its caveats, ambiguities and exceptions, the grandfather provision has raised as many questions as it has answered, particularly for large employers with complex benefits arrangements.

This Alert addresses the ten most frequently asked questions regarding grandfather protection for large employer-sponsored group health plans. The Alert also includes a quick-reference chart with details on key provisions that are applicable to grandfathered plans, as well a final section summarizing the rules that grandfathered plans are able to avoid – at least for the time being.

Q-1: What is a grandfathered group health plan?

A-1: A grandfathered group health plan is a plan in which an individual was enrolled on March 23, 2010. A grandfathered plan can be a single employer plan, a multi-employer plan, or a multiple employer plan; it can also be an insured or a self-insured arrangement.

Q-2: My plan appears to be grandfathered. What does that mean?

A-2: Depending on the provision, grandfathered plans may benefit from either a delayed effective date for compliance with, or a total exception from, certain insurance market reforms and coverage mandates under Subtitles A and C of PPACA. However, it is important to note that grandfathering does not protect a plan from the reforms found in other parts of the statute, including, for example, the mandatory requirement to include the value of coverage on each employee's Form W-2 (effective January 1, 2011), the large-employer mandate to offer affordable coverage to full-time employees (effective January 1, 2014), the high-cost health plan excise tax (effective January 1, 2018) and the mandatory automatic enrollment requirement (effective once regulations are issued).

[1] As amended by section 10103 of PPACA and section 2301 of the Health Care and Education Affordability Reconciliation Act of 2010.

Q-3: Is grandfathering indefinite? In other words, for any rule that does not expressly include a delayed effective date, does the grandfather rule mean that we will never need to amend the plan for that provision?

A-3: While the grandfather provision does not include a general sunset date for non-collectively bargained grandfathered plans, it is unlikely that these plans will have a permanent exception from compliance with any of the insurance market reforms and coverage mandates in the statute that do not expressly include a delayed effective date. Given the flexibility of the language of the grandfather rule, the federal agencies invested with regulatory authority over the new law (specifically, the Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services) are likely to issue guidance that places certain parameters around grandfather protection.

Q-4: If I add new employees (or new enrollees) to my currently grandfathered plan, does the plan lose its grandfathered status?

A-4: No. Section 1251(c) of PPACA specifically provides that a grandfathered plan may enroll new employees and their families in the plan without losing the plan's grandfather status. In addition, the statute also states that grandfathering continues to apply to the coverage of an individual covered by the plan on the date of enactment regardless of whether the individual renews coverage or adds family members after the date of enactment. Although the statute does not specifically state that a plan may add other new enrollees (*i.e.*, current employees who have not previously enrolled in the plan), it is unlikely that enrollment of such employees in the ordinary course will cause the plan to lose its grandfathered status. Guidance is needed as to whether more significant changes in enrollment will cause a plan to lose grandfather status (*e.g.,* the enrollment of a large group of employees following a corporate acquisition).

Q-5: Can I amend my grandfathered plan without losing the grandfathered status?

A-5: Presumably some amendments are permitted, but the complete answer to this question is still unclear. Unlike the grandfather provisions of other legislation, section 1251 of PPACA does not expressly prohibit amendments to a grandfathered plan, nor does it contain a mandate requiring plan sponsors to maintain benefits at current levels in order to preserve grandfather status. Arguably, this means that plan sponsors may freely amend their grandfathered plans without jeopardizing the plan's grandfathered status. However, it is unlikely that such a liberal reading of the provision accurately reflects legislative intent. Until further guidance is issued, plan sponsors must consider amendments to grandfathered plans on a case-by-case basis to determine (1) whether the amendment substantively alters the nature of the plan's coverage in a manner that may jeopardize the plan's grandfathered status, and (2) the true cost impact of losing grandfather status.

Q-6: How does the grandfather rule apply to collectively bargained plans?

A-6: Section 1251(d) of PPACA provides that health insurance coverage maintained pursuant to one or more collective bargaining agreements that were ratified before March 23, 2010, is not subject to the insurance market reforms and coverage mandates in Subtitles A and C of PPACA until the date on which the last collective bargaining agreement relating to coverage terminates. The provision also states that any coverage amendments made pursuant to a collective bargaining agreement that amends the coverage to conform with Subtitles A or C will not cause the plan to lose its grandfathered status. However, the application of the rule to collectively bargained plans remains unclear in several respects. For instance, the statute does not clarify whether the termination of the collective bargaining agreement subjects the collectively bargained plan to <u>all</u>

provisions of Subtitles A and C, or whether "regular" grandfathering (as described above) will then apply. In addition, the language of the statute suggests that grandfathering may only apply to fully insured (not self-insured) collectively bargained plans. Finally, it is also unclear how the grandfather rule will apply to plans subject to "evergreen" bargaining agreements.

Q- 7: Are all of my medical plans that covered employees as of March 23, 2010, grandfathered?

A-7: Grandfathering applies to all group health plans that are welfare benefit plans under ERISA section 3(1) and all health insurance coverage to the extent that the plan or coverage provides medical care to employees and their dependents through insurance, reimbursement, or otherwise, even if coverage is offered through a medical service policy or an HMO offered by a health insurance issuer.

Q- 8: Will my grandfathered plan satisfy the minimum essential coverage requirement under Section 5000A and 4980H of PPACA?

A-8: PPACA creates a new section 5000A of the Internal Revenue Code (IRC), which mandates that individuals maintain "minimum essential coverage." PPACA also creates new IRC section 4980H, which mandates that large employers offer the minimum essential coverage to their full-time employees. Each of these provisions becomes effective January 1, 2014. To the extent that an individual is covered under, or an employer offers, a grandfathered plan (that otherwise meets the provisions of the PPACA, as amended) the individual and the employer will be treated as satisfying the respective mandates as of the effective date.

Q-9: When will I need to make amendments to the plan to comply with the market reform provisions that are applicable to grandfathered plans?

A-9: The effective date for each of the provisions applicable to grandfathered plans is outlined on the attached chart. Grandfathered plans should be amended to comply with these provisions before each applicable effective date. However, depending on individual circumstances, some employers that are in the process of drafting amendments for the 2011 plan year may consider making one set of amendments to comply with provisions that become effective as late as 2014. The last section of the chart lists provisions that it currently appears will never apply to grandfathered plans.

Q-10: Are the agencies planning to issue guidance on the grandfather provisions in PPACA in the near future?

A-10: While it is difficult to predict when any particular PPACA guidance will be issued, agency officials have informally indicated that clarifying the grandfather rules is an important issue that will likely receive priority as guidance is developed.

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If you have any questions about this Legal Alert, please feel free to contact the attorneys listed below or the Sutherland attorney with whom you regularly work.

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Required compliance provisions for grandfathered Group Health Plans[2]
Subtitle A and Subtitle C Provisions

Grandfathered plans must comply with the following provisions as of March 23, 2010:
Utilization of a uniform explanation of benefits - requires plans and insurers to issue standardized summaries of benefits and coverage explanations pursuant to standards established by the Secretary of HHS. *(Patient Protection and Affordable Care Act (PPACA) §§1001, 1562(e), 10103*; *Public Health Services Act* (*PHSA) §§2715, 2715A)*
Reporting loss ratios - requires fully insured plans and insurers to submit a report regarding non-claims expenses to the Secretary of HHS, and to provide annual rebates to enrollees if the ratio of costs to premium revenue exceeds 85%. *(PPACA §§1001, 1562(e), 10103; PHSA §2718)*

Grandfathered plans must comply with the following provisions for plan years beginning on or after September 23, 2010:
Prohibition on lifetime limits - prohibits plans and insurers from placing lifetime limits on the dollar value of certain essential benefits. *(PPACA §1001, 10101; Health Care and Education Affordability Reconciliation Act (Reconciliation Act) §2301; PHSA §2711)*
Prohibition on rescissions - prohibits plans and insurers from rescinding an enrollee's coverage (except in the case of fraud or misrepresentation), or cancelling coverage without prior notice. *(PPACA §1001, Reconciliation Act §2301, PHSA §2712)*
Extension of dependent coverage to adult children - requires plans and insurers that offer dependent coverage to children to extend such coverage to adult children up to age 26 (regardless of marital or student status). However, for plan years beginning prior to January 1, 2014, grandfathered group health plans are only required to extend coverage if an adult dependent is not eligible to enroll in an employer-sponsored health plan other than a grandfathered plan. After January 1, 2014, all plans must extend this coverage regardless of the child's ability to obtain other coverage. *(PPACA §1001, Reconciliation Act §2301, PHSA §2714)*
Restriction on annual limits - prohibits plans and insurers from placing annual limits on the dollar value of certain essential benefits for any participant or beneficiary. However, for plan years beginning prior to January 1, 2014, a grandfathered plan may establish a restricted annual limit on essential health benefits,[3] as defined by HHS in forthcoming guidance. *(PPACA §§1001, 10101, Reconciliation Act §2301, PHSA §2711)*
Prohibition on pre-existing condition exclusions - prohibits plans and insurers from imposing any preexisting condition exclusion on coverage. Generally effective for plan years beginning prior to January 1, 2014; however, for enrollees who are under age 19, the provision is effective for plan years beginning on or after September 23, 2010. *(PPACA §1201, Reconciliation Act §2301; PHSA §2704)*

Grandfathered plans must comply with the following provision for plan years beginning on or after January 1, 2014:
Prohibition on excessive waiting periods - prohibits plans and insurers from applying a waiting period that exceeds 90 days. *(PPACA § 1201, Reconciliation Act §2301, PHSA §2708)*

[2] The provisions described in this chart apply only to non-collectively bargained plans with 100 or more employees.

[3] Essential health benefits, as defined under section 1302(b) of PPACA, includes ambulatory patient services, emergency services, hospitalization coverage, maternity and newborn care coverage, mental health and substance abuse disorder services (including behavioral health treatment), prescription drug coverage, rehabilitative and habilitative services and devices, lab services, preventive and wellness services, chronic disease management, and pediatric services, including oral and dental care. It is unclear whether the Secretary will follow this definition.

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Provisions NOT applicable to grandfathered Group Health Plans (until further guidance is issued):

SUBTITLE A provisions (generally effective for non-grandfathered plans for plan years beginning on or after September 23, 2010)	**SUBTITLE C provisions (generally effective for non-grandfathered plans for plan years beginning on or after January 1, 2014)**
Requirements regarding preventive health services - requires plans and insurers to cover, with no cost-sharing requirements, certain types of preventive health care, including certain immunizations and cancer screenings. *(PPACA §1001, PHSA §2713)*	**Prohibition against discrimination based on health status -** prohibits plans from establishing eligibility rules based on certain health status factors; codifies wellness program rules and increases maximum reward amounts for wellness programs. *(PPACA §1201, PHSA §2705)*
Prohibition against discrimination in favor of highly compensated individuals - applies the nondiscrimination provisions of IRC section 105(h) to fully insured health plans, preventing such plans from discriminating in favor of highly compensated individuals (as defined in IRC section 105(h)(5)). *(PPACA §§1001, 10101; PHSA §2716)*	**Prohibition against discrimination against health care providers -** prohibits plans from discriminating against any health care provider acting within the scope of his or her provider's license with regard to benefits coverage or participation under the plan. *(PPACA §1201; PHSA §2706)*
Required reporting on quality features - requires group health plans and insurers to submit a report on certain quality of care structures to the Secretary of Health and Human Services (HHS) and enrollees. *(PPACA §1001, PHSA §2717)* (becomes effective in practice only after the Secretary of HHS issues guidance).	**Comprehensive health insurance requirement -** requires that plans limit cost-sharing and offer certain minimum coverage levels as set out in section 1302 of PPACA. *(PPACA §1201; PHSA §2706)*
Requirement regarding internal appeals - appears to extend certain ERISA protections regarding claims appeals to the individual insurance market. *(PPACA §§1001, 10101; PHSA §2719)*	**Coverage requirement for clinical trials** - prohibits group health plans and insurers from denying coverage for participation in a clinical trial. *(PPACA §10101, PHSA §2709)*
Prohibitions on restrictions regarding health care providers and other patient protections - prohibits plans and insurers from limiting the types of health care providers that may be designated as a primary care provider; requires plans that cover emergency services to do so without requiring prior authorization and prohibits limits on coverage or additional cost-sharing for emergency services provided by non-network providers; prohibits plans and insurers from requiring a referral in order for a female participant to obtain access to an obstetrician or gynecologist. *(PPACA §10101, PHSA §2719A)*	

Employee Benefits & Executive Compensation ADVISORY

May 13, 2010

HHS Issues Interim Regulations on Early Retiree Health Insurance Program – Plan Sponsors Must Be Ready to Act Quickly to Take Advantage of the Program

On May 5, 2010, the Department of Health and Human Services (HHS) issued interim final regulations ("Interim Regulations") for the early retiree reinsurance program (the "Program") enacted as part of the Patient Protection and Affordable Care Act (PPACA). The Program is intended to help offset the costs of health claims for employers that provide health benefits for retirees ages 55 through 64 ("early retirees") and will reimburse plan sponsors for a portion of the cost of benefits provided to early retirees and their spouses and dependents. PPACA expressly provides that reimbursements are not taxable income. PPACA directs the Secretary of HHS (the "Secretary") to establish the Program within 90 days of enactment (June 21, 2010). The Interim Regulations are effective June 1, 2010. The Program is scheduled to run through January 1, 2014 or, if earlier, when the $5 billion set aside for the program is exhausted. Plan sponsors must apply for the Program and be certified by HHS in order to participate. HHS has indicated that the application will be available by the end of June. Because the Program is limited by the amount of funds set aside and applications are reviewed on a first-come, first-served basis, there is a premium on submitting a *fully completed* application early. Applications will be denied if not complete, and will be considered a new application if additional information is needed. After a plan is certified, properly documented claims should also be submitted promptly.

This document contains a summary of key aspects of the program, followed by a more detailed description.

Comments on the Interim Regulations are due by June 4.

GENERAL OVERVIEW OF THE PROGRAM

In order to be eligible to receive reimbursements under the Program:

- The *plan sponsor* must apply to the Secretary;
- The Secretary must approve the application and certify that the plan sponsor and the plan sponsor's *employment-based plans* meet the requirements for participation; and
- The certified plan sponsor must submit claims, with supporting documentation.

For each early retiree enrolled in a certified plan in a plan year, the plan sponsor is eligible to receive reimbursements equal to 80% of the costs for eligible health benefit claims incurred during the plan year that are between $15,000 and $90,000 (as indexed for medical inflation after October 1, 2011). Claims of the early retiree's spouse, surviving spouse and dependents are taken into account in determining the amount of reimbursement.

A plan sponsor may use the reimbursements from the Program to reduce the sponsor's health benefit premiums or costs and/or to reduce health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs for plan participants, including plan participants who are not early retirees.

It is expected that many employers who will seek to participate in the retiree reinsurance Program are already familiar with the Medicare retiree drug subsidy program ("RDS Program"). Therefore, many elements of the Program are defined in accordance with the RDS Program.

I. ELIGIBILITY TO PARTICIPATE IN THE PROGRAM

Eligible Plans

The Program is available to "employment-based plans" that provide health benefits for "early retirees." An employment-based plan is defined the same as under the RDS Program, except that plans of the federal government (and its agencies and instrumentalities) are excluded. Thus, employment-based plans include group health plans maintained by a private employer, state or local governments (and their agencies and instrumentalities), VEBAs, employee organizations, multiemployer plans, and church plans. Both insured and self-insured plans are eligible to participate, including self insured plans covering retirees only. The plan may qualify whether or not it covers active employees or retirees only.

Early Retiree

An "early retiree" is a plan participant who is age 55 or older, is not eligible for Medicare, and is not actively employed by any employer maintaining the plan, as determined by the plan sponsor in accordance with the rules of the plan. Notwithstanding this rule, an individual is presumed to be actively employed if he or she is considered under the Medicare Secondary Payer rules to be receiving coverage under the employment-based plan by virtue of their current employment status. Under the Interim Regulations, claims of COBRA-qualified beneficiaries and employees receiving disability benefits from the employer for more than six months would appear to qualify for reimbursement, because both of these categories of individuals are not considered to be in current employment status. Some have raised an issue as to whether this is intentional, particularly with respect to COBRA, as the employer is required to make COBRA coverage available, and the provision is intended as an encouragement to voluntarily offer retiree coverage. On the other hand, even in situations where the employer does not contribute toward the cost of COBRA coverage, the provision will serve the purpose of reducing costs to early retirees.

Enrolled spouses, surviving spouses, and dependents (as defined under the plan) are also included in the definition of early retiree and can be any age. Thus, reimbursements for such individuals qualify for reimbursement under the Program.

Plan Sponsor

Application for the Program must be made by the plan sponsor and reimbursements under the Program are paid to the plan sponsor. In general, the plan "sponsor" means: (i) the employer, in the case of a single employer plan; (ii) in the case of a plan maintained by an employee organization, the employee organization; (iii) in the case of a multiemployer plan, the board of trustees or other group of representatives of the parties maintaining the plan; and (iv) in the case of a plan maintained jointly by one employer and an employee organization, and for which the employer is the primary source of financing, the employer.

Plan and Plan Sponsor Requirements

To be eligible for the Program, the plan must include programs that have generated or have the potential to generate cost savings with respect to participants with "chronic and high-cost conditions" (see discussion below).

In addition, the plan sponsor must:

- maintain and make available to the Secretary such records and documentation as specified by the Secretary for six years, and must require its insurer or plan, as appropriate, to maintain and produce such records;
- have a written agreement with its insurer or plan regarding disclosure of information (including protected health information), data, documents and records to the Secretary;
- ensure that policies and procedures are in place to protect against fraud, waste and abuse, and timely comply with requests from the Secretary to produce the policies and procedures and any documents or data to substantiate the implementation of the policies and procedures and their effectiveness; and
- submit to the Secretary an application for participation in the Program within the time frame and in the manner specified by the Secretary.

Cost Savings with Respect to Chronic and High-Cost Conditions

A "chronic and high-cost condition" means a condition for which $15,000 or more in health benefit claims are likely to be incurred during a plan year by any one participant. Thus, in order to be eligible for the Program, there must be programs and procedures in place that generate or have the potential to generate cost savings for plan participants with conditions that are likely to result in claims exceeding $15,000 in a plan year for one participant. The preamble to the Interim Regulations provides that sponsors are not required to put new programs and procedures in place, nor are programs and procedures required to be in place for all conditions for which claims are likely to exceed $15,000 in a plan year for a plan participant. Instead, plan sponsors are expected to take a reasonable approach when identifying conditions and selecting programs and procedures to lower the cost, as well as improve the quality of care. Upon audit, the sponsor must be able to demonstrate that the programs and procedures have generated or had the potential to generate cost savings, consistent with the representations the sponsor made in its program application.

Example: A plan sponsor determines that diabetes, if not managed properly, is likely to lead to claims in excess of $15,000 for a plan year for one plan participant. An example of a program and procedure that generates cost savings for a participant with such a chronic condition would include implementation of a diabetes management program that includes aggressive monitoring and behavioral counseling to prevent complications and unnecessary hospitalization.

II. APPLICATION FOR PARTICIPATION IN THE PROGRAM

The sponsor must submit an application for the Program in accordance with the Interim Regulations. The information that must be included in the application is set forth below. In addition, the following are key aspects of the application process:

- **Importance of timely and complete application.** Applications will be processed in the order in which they are received. No more applications will be accepted once the Secretary determines that no further funds will be available. If an application is incomplete, it will be denied and the applicant must submit a new application, which will be processed based on when the new application is received. Therefore, it is important that applicants submit complete applications upon their first submission. The Interim Regulations specify that HHS will be providing assistance to plan sponsors to help ensure that applications are complete the first time. No details on how this assistance will be made available are provided.
- **One application per plan.** An application must be submitted for each plan of the sponsor.
- **Identification of plan year cycle.** The application must identify the plan year cycle for which the plan sponsor is applying (i.e., the starting and ending month and day; no year is required). In general, the plan year is the plan year designated in the plan document. If the plan document does not designate a plan year, if the plan year is not a 12-month plan year, or if there is no plan document, the plan year is (i) the deductible or limit year used under the plan; (ii) the policy year, if the plan does not impose deductibles or limits on a 12-month basis; (iii) the sponsor's taxable year if the plan does not impose deductibles or limits on a 12-month basis and either the plan is not insured or the insurance policy is not renewed on a 12-month basis; or (iv) the calendar year in any other case.
- **Signature of an authorized representative.** To verify the accuracy of the information contained in the application, the application must be signed by an authorized representative. The Interim Regulations define an authorized representative to mean an individual with legal authority to sign and bind a plan sponsor to the terms of a contract or agreement.
- **Annual application approval not required.** Once a plan is certified, the application approved, and the plan sponsor continues to satisfy the requirements of the statute, the plan and plan sponsor will continue to be certified and the application approved.

Application Requirements

The application for the Program must include the following:

- the applicant's TIN;
- the applicant's name and address;
- the applicant's contact information;
- an agreement between the plan sponsor and HHS (a "sponsor agreement") signed by an authorized representative that includes information set forth in the Interim Regulations (including an assurance that

the sponsor has a written agreement with the insurer or plan regarding disclosure and an attestation that policies are in place to detect fraud, waste and abuse) and such other information as the Secretary may require;

- a summary of how the sponsor will use reimbursements, including
  - how the sponsor will use the reimbursement to reduce plan participant or plan sponsor costs or a combination of both;
  - the sponsor's plans to implement programs and procedures to generate savings for plan participants with chronic and high-cost conditions; and
  - how the sponsor will use the reimbursement to maintain its level of contribution to the plan;
- projected reimbursement amounts for the first two plan-year cycles;
- all benefit options under the plan that may be claimed by any early retiree for whom the applicant may receive program reimbursement; and
- any other information the Secretary requires.

The Interim Regulations contemplate that an application will be issued, which may include requirements for additional information.

III. CLAIMS SUBMISSION

Documentation

A plan must be certified before claims may be submitted. The Program will only accept claims that represent costs for health benefits for an early retiree that have already been incurred and paid. A "claim" includes documentation specifying the health benefit provided, the incurred date, the individual for whom the health benefit was provided, the date and the amount of payment minus any known negotiated price concessions and the plan and benefit option under which the health benefit was provided. Plan sponsors should only submit claims that are between $15,000 (cost threshold) and $90,000 (cost limit).[1] Claims that are below $15,000 or above $90,000 will not be reimbursed. Claims must be submitted based on the amounts actually paid, which may include amounts paid by the early retiree, if the sponsor provides prima facie evidence that the retiree paid such amount. Such evidence may include an actual payment receipt.

All claim submissions must include a list of early retirees for whom claims are being submitted. Both the documentation of actual cost of claims and the list of early retirees must be submitted in a form and manner to be specified by the Secretary. For an insured plan, the claims and the list of early retirees can be submitted directly to the Secretary by the insurer. Plan sponsors are responsible for ensuring that insurers submit the information required in a claim.

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[1] For plan years beginning on or after October 1, 2011, the $15,000 and $90,000 figures will be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index.

In the case of a plan where the provider does not produce a claim in the normal course of business—for example, a staff-model HMO—the information required must be produced and provided to the Secretary. The plan sponsor must ensure that the insurer submits the required information, which must be reasonable in light of the specific market the insurer is serving.

A sponsor may appeal to the Secretary within 15 days of an adverse determination with respect to a claim. No appeal is available if the claim was denied due to lack of further funding under the Program.

Definition of Health Benefits Eligible for Reimbursement

Claims may be submitted for reimbursement of "health benefits," which is defined as medical, surgical, hospital, prescription drug and such other benefits as determined by the Secretary, whether self-funded or provided through insurance or otherwise. Health benefits also include benefits for the diagnosis, cure, mitigation or prevention of physical or mental disease or condition with respect to any structure or function of the body. This is not intended as an exhaustive list of health benefits.

Health benefits do not include "excepted benefits" as defined under HIPAA. These benefits provide limited types of coverage. Thus, for example, the Program will not reimburse benefits under the following if provided under a separate policy: long-term care benefits, limited scope vision and dental, benefits for a specified disease, or hospital indemnity or other fixed indemnity benefits.

HIPAA Privacy

Certain information required to be disclosed for claims reimbursement would be considered protected health information (PHI) under the HIPAA privacy rules, but can be disclosed to HHS. Because this information belongs to the plan and not the employer, the Interim Regulations require the plan sponsor to have an agreement in place to directly disclose this information to HHS. This disclosure will be considered to qualify for the exception to the HIPAA privacy rules for disclosures required by law.

IV. REIMBURSEMENT AMOUNT

The Program provides reimbursement in an amount equal to 80% of the portion of the health benefit costs that exceed $15,000 (cost threshold) but are below $90,000 (cost limit), and that are paid by the employment-based plan, the insurer or an early retiree. Costs are considered paid by an early retiree if paid by that individual or another person on behalf of the early retiree, and the early retiree is not reimbursed through insurance or other third-party payment arrangement. Because enrolled spouses, former spouses and dependents are considered separate early retirees, the cost threshold and cost limit would appear to apply separately to each of these individuals.

In determining amounts eligible for reimbursements in the case of an insured plan, amounts the insurer pays and the amount the early retiree pays are taken into account. Thus, the sponsor's premiums are irrelevant.

Rather than reimbursement being available only for discrete health benefit items or services whose reimbursement total falls between $15,000 and $90,000, the Program will reimburse cumulative health benefits incurred in a given plan year that fall between such amounts. In addition, all costs for health benefits paid by the plan or by the early retiree for all benefit options the early retiree is enrolled in will be combined for purposes of determining the amounts below the cost threshold and above the cost limit for any given early retiree.

Example: An early retiree is simultaneously enrolled in two different benefit options within one group health plan—Option 1 as a retiree and Option 2 as a spouse of a retiree. For purposes of determining when the early retiree satisfies the cost threshold, all claims incurred and paid for that early retiree under each benefit option will be aggregated.

In determining the amount of a claim under the Program, the employment-based plan must take into account any negotiated price concessions (i.e., discounts, direct or indirect subsidies, or rebates) obtained by the plan. The Interim Regulations define negotiated price concession as any direct or indirect remuneration that would serve to decrease the costs incurred under the health plan.

Transition Rule

The Interim Regulations provide a transition rule for claims in 2010. With respect to claims incurred before June 1, 2010, the amount of such claims up to $15,000 count toward the cost threshold and cost limit. However, the amount of claims incurred before June 1, 2010, that exceed $15,000 are not eligible for reimbursement.

Example: Joe is an early retiree who incurs $20,000 in eligible health benefit expenses as of June 1, 2010, and $30,000 after June 1, 2010. Under the transition rule, the $20,000 of pre-June 1 expenses count toward the cost threshold. The sponsor may receive reimbursement of 80% of the $30,000 incurred after June 1 (i.e., $24,000).

V. USE OF REIMBURSEMENTS

The Interim Regulations take a fairly expansive view of how reimbursements may be used. Thus, reimbursements may be used to reduce sponsor costs or plan participant costs (e.g., deductibles and copayments). Although reimbursements are limited to claims for early retirees, reimbursements may be used to reduce costs for all plan participants, not just early retirees. Reimbursements may not be used as general revenue of the sponsor.

The Interim Regulations contemplate that plan sponsors will provide at least the same level of contribution to support the applicable plan as it did before the Program. Thus, for example, although reimbursements could be used to reduce increases in sponsor premiums, it is expected that reimbursements may not be used to pay current level premiums. HHS is expected to provide additional guidance with regard to how the Secretary will monitor the appropriate use of reimbursements.

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