

Your guide to making HRA administration easier



4th quarter carryover

Medical plan – All Priority Health medical plans that have a deductible have a “4th Quarter Deductible Carryover” (the sole exception is the **PriorityHSA**). 4th Quarter Deductible Carryover is a function that automatically credits any deductible met in the last quarter of a 12-month health plan against the next plan year’s deductible. This helps employees satisfy their deductible sooner and move into coinsurance benefits. The credit amount tends to change throughout the year due to the nature of 4th quarter claims lag. As 4th Quarter deductible claims are processed, they are credited toward the next plan year’s deductible on a prospective basis.

HRA plan - The Health Reimbursement Arrangement is separate from the medical plan. There is no “4th Quarter Deductible Carryover” on the HRA.

When the HRA requires the employee to pay the first portion of the deductible:

- Credit only offsets the employee’s medical plan deductible.
- Credit does not directly offset the employee’s HRA deductible (otherwise known as the employee’s “pays first” obligation).

Exception: The Deductible Carryover credit can offset the employee’s HRA deductible only if the Carryover credit is greater than the employer’s HRA contribution.

Bottom line: In most situations, the employee will be responsible for the “pays first” portion before the HRA will pay. Only when the 4th Quarter Deductible Carryover is very large will there be any reduction of this “pays first” liability for the employee.

COBRA

An HRA is a group health plan and is subject to COBRA’s continuation requirements. HRAs are subject to the same qualified beneficiary rules, qualifying event rules, and COBRA time limitations as any other group health plan.

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When beneficiaries elect COBRA, they have access to their unspent HRA balance, plus they continue to receive the same new employer contributions to the HRA that active participants receive.

The employer, as the plan sponsor, is entitled to charge a premium for the HRA COBRA benefit *in addition to* the medical COBRA benefit. Note that Priority Health does not establish or collect this HRA COBRA premium. The employer must notify their COBRA administrator of this premium amount. The employer keeps the HRA COBRA premium to help them pay HRA claims (as the HRA is a self-funded plan).

The applicable premium must be determined using either (1) the “actuarial determination” method, or (2) the “past cost” method. In other words, it’s not as simple as taking the annual employer HRA contribution, dividing it by 12 and then increasing it by 2%. A plan sponsor is only permitted to charge a “reasonable estimate of the cost of providing coverage for such period for similarly situated beneficiaries.”

“Actuarial determination” requires the employer to make reasonable estimate of cost of providing HRA coverage for similarly-situated beneficiaries. The employer is not required to hire an actuary (but if premiums are challenged, may need to). One thing to note is that an employer cannot charge different COBRA HRA premiums to different beneficiaries – the premium must be the same. New HRAs must use actuarial method since they have no past cost for prior year.

Example: The employer estimates that 50% of HRA dollars are typically spent over the entire employee population. So, for a \$1,000 HRA contribution, the employer can charge an HRA COBRA premium of $\$1,000 \times 50\%$ divided by 12 months and increased by the permitted 2% administration load – which equals \$42.50. This would be in addition to the medical COBRA premium.

“Past cost” is calculated based upon past expenditures of the employees under the HRA.

HRA COBRA premiums must be calculated *prior* to each 12-month determination period.

Run-out

Claims run-out refers to the amount of time after the plan year ends during which we will continue to pay claims for that same plan year. This allows providers more time to submit bills to Priority Health for payment.

The HRA claims run-out period is 12 months (this follows the same rule governing fully funded health plans) meaning that the HRA will continue to pay on claims up to 12 months after the date of service. Note that the date of service must be a date in which the member was eligible for coverage.

Example: HRA plan year is 1/1/2009 – 12/31/2009. The member went to the doctor on 11/1/2009 but the provider didn't bill Priority Health until 2/1/2010. The HRA will still pay on this claim because the claim was received within 12 months of the date of service.

Reprocessing Claims

HRA Pay-out Error: HRAs are self-funded — all “HRA dollars” are contributed by the employer. If an HRA claim requires reprocessing causing the HRA to have overpaid, overpayment recovery occurs in the following manner:

1. The claim adjustment triggers an overpayment recovery letter requesting a refund from the provider.
2. Providers receive monthly overpayment statements which also initiates refunds.
3. Providers send refund checks to Priority Health directly.
 - If after 120 days the provider has not sent a refund check, the overpayment recovery is transferred to an external collections agency.
4. Once the refund check is received, Priority Health sends the employer a refund check and an overpayment statement (including the associated claim detail). Because the HRA is a self-funded plan, we cannot reimburse the employer until we receive the refund from the provider.

Please note that we request the entire HRA payment back from the provider and replace the entire HRA payment with the correct payment. Because of this, the employer may see a “duplicate” HRA payment to that provider for a participant's claim. There may be a lag between the corrective payment and overpayment recovery of the original payment.

The overpayment reimbursement is not included in the weekly funding registers, but is managed outside of the funding process.

Claim payment error

Priority Health uses a third party vendor, AIM Healthcare, to identify claims that were paid in error. Coordination of Benefits (COB) is the main reason why this might occur. If a claim is paid that should have been paid by another party (another insurance company), and AIM Healthcare discovers this error, they will recover the money from the provider. When remitting the payment to Priority Health, AIM keeps roughly 25% of the refund as a commission for their services. If this occurs on an HRA, Priority Health will only return the amount received (full refund minus AIM's commission) back to the employer. Again, this is because the HRA is

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self funded. This doesn't happen often and the best way to avoid it is to report COB situations as soon as possible.

While receiving only a portion of the refund may seem like a negative experience for the group, remember that without the services of AIM Healthcare the group wouldn't have received a refund of any kind.

Reporting

Reports are delivered electronically via Filemart, a secure transmission system. In order to receive reporting, employers are required to create an account at *priorityhealth.com*. Once created, we'll contact them to confirm. Weekly courtesy e-mails advise designated recipients of the reports that their funding reports are ready to be viewed. The **Weekly Funding Report** outlines the claims to be funded and the total amount of the funding draw. Employers can choose to receive reports that come:

1. With protected health information (PHI) — participant name, provider name and claims payment amount, or
2. Without PHI — provider name and claims payment amount only.

Employers can select which version they wish to receive when they initially enroll in the HRA and it can be changed any time.

The employer will also receive a **monthly HRA Employer Account Balance** report via Filemart. This report is available as both a PDF and an Excel spreadsheet. The employer may also receive the report showing balance information for the previous contract year. There is a three month overlap between the previous plan year and the current plan year where the employer will receive this report for both contract years.

The weekly funding report and the HRA employer account balance report may not always match due to claims reprocessing/overpayments. Overpayments are handled outside of the weekly funding report which means it won't show credits for overpayments. The HRA employer account balance report will show a credit for an overpayment because if HRA dollars were pulled from a member's HRA funds in error, Priority Health will automatically credit the HRA so it can be spent again by the member.

Other insurance and Coordination of Benefits (COB)

If a member has other medical insurance, the other insurance must pay before the HRA pays. The Priority Health medical plan is primary, the other carrier health plan is secondary and the HRA pays last.

How claims are processed:

Our claims system processes the incoming medical claim and if we have COB information, we pend the claim until we receive information from the other payer. We send the member an EOB stating that the HRA can't make payment because of other insurance and that the EOB from the other carrier is needed. When the member sends us that EOB, we reprocess the claim to pay remaining eligible member liability expenses from the HRA.

Employers have an option to change the HRA payment order for all members enrolled in the employer's HRA plan to: Priority Health medical plan as primary, the HRA as secondary and the other health plan last. This option is an exception to the standard and must be requested as such in writing. The plan document for the group will then reflect this non-standard HRA payment ordering.

The only exceptions to this are Medicare and Medicaid which always pay last.

HRA and coinsurance

We can set up HRAs to reimburse on the coinsurance portion of the medical plan whether this is in addition to deductible reimbursement or on its own. There are, however, some misconceptions that often surface related to the HRA plan design when both deductible and coinsurance expenses are reimbursed.

There is only one bucket for HRA dollars and it can only be turned "on" and "off" one time. Our HRA doesn't feature the thousands of set-up options like health plans. It has four rather simple options:

- What is the HRA allocation?
- Who pays first?
- What expenses are reimbursable?
- Can HRA dollars be carried into future years?

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Examples for a medical plan with a \$2,000 deductible and 80% coinsurance:

We can't do this:

Employee pays the first \$500 of the deductible, and the employer pays the remaining \$1,500 of the deductible; employee pays the first \$500 in coinsurance and employer pays out \$1,000 in coinsurance responsibility. There are too many steps in this set-up because the HRA is turned “on” and “off” two times.

We can do this:

Employee pays the first \$500 of the deductible and the employer designates \$2,500 in HRA dollars to be paid out in deductible and coinsurance expenses until the funds are exhausted. In this scenario the HRA is only turned “on” and “off” one time and captures both the deductible and coinsurance. Or, the employee pays the first \$500 of the deductible and the employer splits the rest of the deductible responsibility and coinsurance responsibility at 80/20% until the funds are exhausted.

Keep in mind that when the HRA reimburses on coinsurance, it will pay out on any claim that is a percentage, including: in/outpatient hospital claims, substance abuse, durable medical equipment, prosthetics and orthotics, etc. This means that the HRA could pay out on claims that don't apply toward the out-of-pocket maximum. Large groups (51+ eligible employees) can carve out services from HRA reimbursement. Remember, carving out a service means excluding it from HRA reimbursement altogether – whether the member owes deductible or coinsurance dollars for the service.

HRA and in-network vs. out-of-network reimbursement

HRAs are automatically set up to reimburse in-network/preferred and out-of-network/alternate claims on PPO and POS plan unless we're told otherwise. HRAs can be set up to pay in-network/preferred only.

When reimbursing on both in and out-of-network claims, our system doesn't separate HRA dollars between the two. Example: The employer can't pay out \$1,000 in HRA dollars for in-network claims and \$500 on out-of-network claims. The group would have to put a total of \$1,500 in the “bucket” and the money could be used for in or out-of-network claims.