



EARLY RETIREE REINSURANCE PROGRAM UNVEILED

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On May 4, 2010, the United States Department of Health & Human Services (“HHS”) issued interim final rules implementing the Early Retiree Reinsurance Program. The Program provides subsidies to employers who provide health insurance to early retirees that can be used to lower health insurance costs for the employer and plan participants. There are limited funds available under the Program and funds are available on a first come first serve basis. The Program starts June 1, 2010. Employers who provide health insurance to early retirees, their spouses and dependents should prepare to apply for participation in the Program on June 1. Below is a summary of the Program.

1. **What Is the “Early Retiree Reinsurance Program”?** Starting June 1, 2010, participating plan sponsors of employment based health plans that cover early retirees can receive funds directly from the federal government if an early retiree or his/her spouse or dependent has claims during the plan year that exceed \$15,000. The Program is temporary and funds are limited.

2. **What Plans Qualify for the Program?** The plan must be an “employment-based plan” that: (i) provides “health benefits;” (ii) covers “early retirees;” and (iii) has a program in place to generate cost savings for participants with chronic and high cost conditions.

3. **What Plans are “Employment Based”?** A plan is employment-based if it’s a group benefits plan maintained by:

- Private employers;
- State or local governments;
- Employee organizations;
- VEBA’s; or
- Multiemployer Plans

The plan can be fully-insured or self-insured.

4. **What Plans Provide “Health Benefits”?** The plan provides “health benefits” if it provides medical, surgical, hospital, prescription drug and such other benefits as may be determined by HHS. Long term care benefits and certain limited scope benefits do not qualify as “health benefits.”

5. **Who is an Early Retiree?** An early retiree is a former employee who is (i) between the ages of 55 and 64, (ii) is not eligible for Medicare, and (iii) is not an active employee of the employer who sponsors the plan or an employer who makes substantial contributions to the plan. Early retirees also include an early retiree’s spouse, surviving spouse, and dependents.

6. **What Qualifies as a Program Designed to Generated Cost Savings for Chronic or High Cost Conditions?** For a plan to be eligible for the reinsurance benefits, it must have a program or procedures in place to generate cost savings for chronic or high cost conditions. A chronic or high cost condition is 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 participant. Plans do not have to have programs in place to target all types of chronic or high cost conditions. Plans will qualify even if they only have a program that targets certain chronic or high cost conditions. For example, a plan with a diabetes management program would likely satisfy this requirement. Fully-insured plans should discuss this issue with their insurance carrier to determine what types of cost-savings programs the carrier has in place for chronic or high cost conditions.

7. **What Benefits Does the Program Provide?** If your plan meets the conditions under items 3-6 above, it is eligible for benefits under the Program. The Program provides reinsurance to sponsors of early retiree benefits for high cost claims equal to 80% of the amount of the claim between \$15,000 and \$90,000. For example, if an early retiree has claims equaling \$100,000 during one plan year, the plan sponsor could receive 80% of \$75,000 (\$90,000 - \$15,000) or \$60,000. The “claim” must exceed \$15,000 and the benefit is available for claims in excess of \$15,000 but subject to a cap of \$90,000.

8. **How is the Amount of the Claim Determined?** The rules clarify many outstanding issues relating to which claims qualify for the reinsurance, specifically:

All claims of the individual for the plan year are aggregated to determine whether the \$15,000 threshold is satisfied. In determining whether a claim exceeds \$15,000, all claims for the early retiree (or his/her spouse or dependent) that are incurred during the plan year will be aggregated. This means that not one particular claim needs to exceed \$15,000 in order for the plan sponsor to receive the reinsurance benefit. Rather, the individual’s claims for the entire plan year must exceed \$15,000. For example, an early retiree is hospitalized and a claim submitted to the insurance carrier for \$14,000 associated with the hospitalization. Over the next several months, the early retiree receives follow-up care resulting in additional claims totaling \$10,000. At the end of the plan year, the

insurance carrier has paid total claims of \$24,000 for the early retiree's care. The plan sponsor is eligible for reinsurance for the plan year totaling 80% of \$10,000.

While all claims during the plan year are aggregated, individual family members' claims are not aggregated. For example, an early retiree and his/her spouse each have claims totaling \$10,000 during the plan year. Together, their claims exceed \$15,000; however, the plan sponsor receives no reinsurance because not one individual's claims exceeded \$15,000 during the plan year.

The claims are net of any discounts or rebates received by the plan. If the plan has negotiated discounted rates with providers, the amount of the claim is the amount actually paid by the plan, not the providers' charges. Additionally, if the plan receives any post-payment rebates or discounts, such as prescription drug rebates or subrogation amounts, these rebates will offset the amount of the claims.

The claim must be "incurred" meaning it has been paid by the insurance carrier or plan.

Cost-sharing and deductible amounts paid by the individual can be included in determining the amount of the claim. However, if you are counting the cost-sharing and deductible amounts, they must have been paid and you must have evidence that the individual has paid them before they will be counted toward the claim.

9. **How are Claims Incurred Before June 1, 2010 Treated.** Unless your plan year begins June 1, 2010, the plan has already incurred claims that may be eligible for the reinsurance. The interim rules make it clear that while claims incurred prior to June 1, 2010 may be counted toward meeting the \$15,000 threshold, no amounts paid prior to June 1, 2010 by the plan will be eligible for the 80% benefit.

For example, if the plan paid a claim for an early retiree on April 1, 2010 totaling \$20,000, the plan will not receive a benefit on the \$5,000 that exceeds \$15,000. However, if that same individual receives additional care on June 5, 2010 totaling \$2,000, the \$2,000 will be eligible for the 80% reinsurance because the \$15,000 threshold has been satisfied for this individual for the plan year.

10. **Who Receives the Benefits Paid By the Program?** The 80% reinsurance is paid to the plan sponsor. For a traditional, single employer plan, this is typically the employer. This is the case even if the plan is fully-insured.

11. **Are There Restrictions on How the Plan Sponsor May Use the Reinsurance Benefits Received from the Program?** Yes. The reinsurance benefits can only be used to lower costs for the plan. Under the interim rules this means the plan sponsor uses the reinsurance amounts received to (i) reduce the sponsor's health insurance premiums or costs, and (ii) to reduce the plan participants' contributions, co-payments,

deductibles, coinsurance or other out of pocket costs. HHS expects that a plan sponsor receiving reinsurance benefits will continue to provide at least the same level of contributions to support the applicable plan that it contributed prior to receiving the benefits. For example, a plan sponsor who receives reinsurance benefits experiences a premium increase in 2011. In 2010, the plan sponsor contributed 80% of the premium. While the plan sponsor can utilize the reinsurance benefits to reduce its own costs, it should continue to contribute at least 80% of the premium costs.

If you do not have a separate retiree plan, the reinsurance benefits can be utilized to lower the costs of all plan participants, not just early retirees and their spouses/dependents.

12. **How Do I Sign Up For the Program?** Plan sponsors must first apply for the Program and be approved by HHS. This is an initial step to qualify for the Program and should be done immediately, even before any claims subject to the reinsurance are incurred. HHS will begin taking applications on June 1, 2010. Plan sponsors should apply for the Program immediately on June 1, 2010 because HHS has indicated it may stop taking applications depending on the number of plan sponsors that apply given that there are limited funds available. Applications will be processed and approved on a first come first serve basis. Incomplete applications will be rejected and the applicant will need to reapply. Applications are submitted once for each plan. Plan sponsors do not need to submit an application for each plan year.

13. **What Information Must Be Provided In the Initial Application?** The plan sponsor must establish in the application that it meets the requirements for the Program. The application requires the plan sponsor to provide its Tax ID number, name, address, contact information, a summary of how it will use the reinsurance benefits to meet the requirements of the Program including how it will use the reimbursement to reduce plan participant or sponsor costs, and the programs and procedures the plan sponsor has in place to generate savings for plan participants with chronic and high cost conditions. The application will also ask you to project the total amount of reinsurance benefits the sponsor expects to receive for the first two plan years so that HHS can assess when to stop accepting applications. This is merely an approximation and we suggest sponsors utilize information from prior plan years. Fully-insured plans should request this information from their insurance carrier prior to June 1, 2010.

14. **After I've Filed an Application, How Do I Seek Reimbursement for Claims?** Once your initial application has been approved by HHS, you can begin filing claims. The claims must meet the \$15,000 threshold and must have been paid before you can submit them for reimbursement. When submitting reimbursement for the claim, the sponsor must provide information on all of the individual's claims, even those below the \$15,000 threshold so HHS can establish that the threshold has been satisfied. Once the cumulative amount of claims for an individual exceeds \$90,000, the sponsor should stop submitting claims for the individual. All claim submissions must be accompanied by the

list of early retirees for whom the claims are being submitted. Insurance carriers may submit the claims (and should submit them) for fully-insured plans. If the individual's cost-sharing amounts (deductible/co-pays) are included in the claim submitted, evidence that the cost-sharing amounts have actually been paid must be included with the claim submission. Claims will be processed and paid by HHS until the \$5 billion in funding is exhausted or until December 31, 2013.

15. **How Does the Program Work If I'm Fully-Insured?** If you are fully-insured and you do not typically receive identifiable health information, your insurance carrier will need to submit claims on your behalf. While the employer who sponsors the plan can submit the initial application, claims for reimbursement should be submitted by the insurance carrier. If claims for reimbursement are submitted by the employer, the employer will then become immediately subject to the HIPAA privacy and security regulations.

16. **If I Receive Benefits Under the Program Am I Subject to Any Additional Requirements?** If you qualify to receive benefits under the Program you must maintain documentation that substantiates the benefits received for a minimum of 6 years from the end of the plan year in which the benefits were received. Fully-insured plans will want to maintain de-identified information from their carrier as well as requiring their carrier to keep the detailed records for this length of time. It is also important to note that plan sponsors who misrepresent information submitted to HHS under the Program may be subject to penalties for fraud.

We expect to continue to receive guidance from HHS between now and June 1, 2010. Additionally, we are unaware of any guidance from the insurance industry on how carriers intend to implement the program and whether they will assist fully-insured groups with the claims submission process. Plan sponsors of fully-insured plans are encouraged to discuss the program with their carriers in the very near future so administrative details can be worked out prior to June 1, 2010.