**HHS Issues Important Interim Final Rule on Early Retiree Reinsurance Program**

May 2010

On May 4, 2010, the Department of Health and Human Services (HHS) released an interim final rule (with comment period) implementing the Early Retiree Reinsurance Program established by the Patient Protection and Affordable Care Act (Affordable Care Act). The Affordable Care Act appropriated $5 billion to provide reimbursement to participating employment-based plans for a portion of the cost of health care benefits for early retirees and their spouses, surviving spouses, and dependents. The regulations are effective June 1, 2010, and HHS expects the program to be established by this date. The program ends when all funds have been exhausted but in no case later than January 1, 2014.

HHS states that the reimbursement process will be similar to the process used for the Medicare Part D retiree drug subsidy (RDS). The interim final rule provides plan sponsors with answers to a number of important questions, including the following.

**Program Eligibility**
To be eligible for the reinsurance program, a plan must be employment-based and must provide health care benefits to early retirees. An employment-based plan includes both insured and self-insured group benefit plans providing health care benefits that are maintained by private employers, state or local governments, employee organizations, and voluntary employee beneficiary associations (VEBAs). The program excludes federal governmental plans.

**Chronic and High-Cost Conditions**
The employment-based plan must have programs and procedures in place that generate or have the potential to generate cost savings with respect to participants with chronic and high-cost conditions for which $15,000 or more in applicable claims are likely to be incurred during a plan year by one participant. Recognizing that chronic and high-cost conditions can vary significantly across geographic regions, age ranges, and other factors, the rule expects plan sponsors to focus cost-saving programs and procedures on conditions that affect enrollees in their plan or plans. Upon audit, a plan sponsor will need to substantiate programs and procedures and may need to provide data to substantiate the effectiveness of such programs.

**Written Agreements With Vendors**
HHS requires the plan sponsor to have a written agreement in place with its health insurance issuer or employment-based plan (as applicable) that requires the health insurance issuer or employment-based plan to disclose information on behalf of the sponsor to HHS. While a Health Insurance Portability and Accountability Act (HIPAA) Business Associate agreement is one critical component, the regulations indicate that additional agreements (similar to RDS) with a plan sponsor’s vendors may be required. For example, employers will want an agreement that contains an acknowledgement from the vendor that information in the application is being used to obtain federal funds.

**Application**
Like the RDS program, the early retiree reinsurance program requires one application per group health plan, but an application for a given plan only has to be submitted once instead of each year. It appears that
once an application is submitted by the authorized representative (an individual authorized to sign on behalf of the plan sponsor) and approved, the plan sponsor will continue to be eligible.

The application must include information such as (not exhaustive): 1) an acknowledgement that the information is being provided to obtain federal funds; 2) an attestation that policies and procedures are in place to detect and reduce fraud, waste, and abuse; and 3) a summary of how reimbursements will be used that generally explains how the reimbursement will be applied to maintain the sponsor’s level of effort in contributing to support the applicable plan. In addition, the summary should outline what procedures or programs the sponsor has in place that have generated or have the potential to generate cost savings with respect to plan participants with chronic and high-cost conditions.

**Timing**

Applications will be processed in the order in which they are received. It is critical that an application meet all the requirements because a denied application will need to be resubmitted. The new application will be processed based on when the new submission is received.

Because funding for the program is limited ($5 billion), HHS expects to have more requests for reimbursement than there are funds to pay the requests. Applicants will need to project their reimbursement amounts for the first two plan year cycles in the application so that HHS can project total reimbursement amounts. Claims will not be paid until an application is approved.

**Reimbursement for Claims**

In general, HHS will reimburse an amount equal to 80% of the portion of health benefit costs (net of negotiated price concessions) attributable to claims that exceed $15,000 (cost threshold) but are below $90,000 (cost limit) (indexed for plan years starting on or after October 1, 2011).

Reimbursement can be made under the program for the health benefit costs for early retirees. An early retiree generally means a plan participant who is age 55 and older, is enrolled in the employment-based plan, is not an active employee of the employer sponsoring such plan, and who is not eligible for Medicare. In addition, eligible spouses, surviving spouses, and dependents of such retirees are considered “early retirees” for purposes of reimbursement, even if they are under the age of 55 and/or are eligible for Medicare. Similar to the RDS program, a dependent does not have to be a dependent for federal or state tax purposes.

**Reimbursement Calculation**

Reimbursement is calculated by first determining the costs for health care benefits net of negotiated price concessions, within the applicable plan year for each early retiree, and then subtracting amounts below the cost threshold and above the cost limit within the applicable plan year for each such individual.

The reimbursement amount will be determined based on the cumulative health care benefits incurred in a given plan year and paid for a given early retiree, rather than reimbursement being made only for discrete health care benefit items or services. “Incurred” is defined as the point in time when the sponsor, health insurance issuer, group health plan, or plan participant, or a combination of these, become responsible for payment of the claim. The costs paid by the early retiree (or his or her spouse, surviving spouse, or dependent) in the form of deductibles, copayments, or coinsurance are included in the amounts paid by the participating early retiree plan.

Similar to the RDS program, all costs for health care benefits paid by the plan or by the early retiree for all benefit options the early retiree is enrolled in with respect to a given employment-based plan for a given plan year will be combined for purposes of the cost threshold and the cost limit. This will require employers to aggregate costs for early retirees who transfer between benefit options within a plan. It appears that spouses, surviving spouses, and dependents of early retirees will be treated independently from the early
retiree for purposes of the cost threshold and the cost limit, although it’s likely that additional guidance may be needed to completely confirm this interpretation.

**Transition Rule**
The rule provides a transition for plans with a plan year that begins before June 1, 2010 and ends on any date thereafter. For claims incurred before June 1, 2010, the amount of such claims up to $15,000 count toward the cost threshold and the cost limit. Claims incurred before June 1, 2010 that exceed $15,000 are not eligible for reimbursement and do not count toward the cost limit. The reinsurance amount to be paid is based only on claims incurred on and after June 1, 2010 that fall between the cost threshold and cost limit for the plan year.

**Example:** A plan has a plan year that began July 1, 2009, with an end date of June 30, 2010, with an early retiree for which it has spent $120,000 in health care benefit claims before June 1, 2010. The plan then spends another $30,000 in health care benefit claims on the early retiree between June 1, 2010 and June 30, 2010. The sponsor would receive credit for $15,000 in claims incurred before June 1 and receive reimbursement of 80% of the $30,000 (for the claims incurred after June 1, 2010), or $24,000.

HHS believes this is a reasonable approach because it provides as much relief as possible as soon as possible to sponsors, while giving meaning to the effective date of the program. A sponsor should therefore not submit claims above the $15,000 cost threshold that were incurred before June 1, 2010 for reimbursement, as submission of such claims is outside the scope of the regulation.

**Insured Plans**
The rule specifies that the reimbursement formula applies to both self-insured and fully insured plans. With respect to insured plans, costs for health care benefits means costs the insurer and the early retiree pay for health care benefits net of negotiated price concessions the insurer receives for health care benefits and excludes the premium paid by the sponsor and the early retiree.

**Negotiated Price Concessions**
With respect to negotiated price concessions, the rule recognizes that sponsors and insurers sometimes do not receive certain negotiated price concessions until after payment is made, and in many cases, after the plan year during which the claim is incurred and paid has ended, such as with prescription drug rebates. The rule notes future guidance will be provided regarding the disclosure of “post-point-of-sale” negotiated price concessions.

**Use of Reimbursements**
Reimbursements must be used to: 1) reduce the sponsor’s health care benefit premiums or health care benefit costs; 2) reduce health care benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs or any combination of these costs, for all “plan participants”; or 3) reduce any combination of costs in 1) and 2).

**Claim Submissions**
With respect to a given early retiree, claims cannot be submitted until the early retiree’s total paid costs for health care benefits incurred for the plan year exceed the cost threshold. As indicated earlier, claims must be submitted based on the amounts actually paid, which may include amounts paid by the early retiree. Once such amounts exceed $90,000 for a plan year, no additional claims can be submitted for that early retiree.

All claims submissions must include a list of early retirees for whom claims are being submitted. The documentation of actual costs must be submitted in a form and manner approved by HHS (to be issued). Claims submissions will be processed on a first-in, first-out basis. Clear evidence must accompany amounts
paid by the early retiree, the early retiree’s spouse, surviving spouse, or dependent, such as a receipt. If this evidence is not available, then only the employer’s costs can be reimbursed.

A reimbursement request made on behalf of a plan may be denied, in whole or in part, due to limitation of funds.

Other Considerations
- Records Retention. Records must be retained for six years after the expiration of the plan year in which costs were incurred, or longer if otherwise required by law;
- Appeals;
- Disclosure of Data Inaccuracies; and
- Change of Ownership.

More Information
The interim final rule will be published in the Federal Register on May 5. Comments are due 30 days after publication in the Federal Register.


A fact sheet on the early retiree reinsurance program is available at: http://www.whitehouse.gov/the-press-office/fact-sheet-early-retiree-reinsurance-program