



# Health Care Reform Management Alert Series

Issue 2

## Early Retiree Reinsurance Program

This is the second issue in our health care reform series of alerts for employers on selected topics in health care reform. (Our general summary of health care reform and other issues in this series can be accessed by clicking [here](#).) This series of Health Care Reform Management Alerts is designed to provide a more in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

This issue of the series focuses on one of the provisions that requires the most immediate attention for many employers: the Early Retiree Reinsurance Program (the “Program”). If you provide medical coverage to retirees between ages 55 and 64 (or are thinking about offering it in conjunction with an early retirement or voluntary separation program), read on. Your plan may be eligible for a reimbursement from the government.

***Please note: Applying in a timely fashion under the Program will be important. This temporary Program is first come, first served and has limited funding (currently only \$5 billion). Once the funding is exhausted, the Program will end. It is expected that this Program will be very popular so plans interested in obtaining this reimbursement should act quickly.***

- ✓ Applies to grandfathered plans
- ✓ Applies to new health plans

## Creation of Early Retiree Reinsurance Program

The Patient Protection and Affordable Care Act (PPACA), as modified by the Health Care and Education Reconciliation Act of 2010 (HCERA) (collectively the “Act”), required the Secretary of Health and Human Services (HHS) to establish a temporary reinsurance program that reimburses employer plans for a portion of the cost of providing health coverage to early retirees (as well as their spouses, surviving spouses, and dependents who are eligible under the plan). Eligible health benefit costs incurred beginning on the date the Program is established are eligible for reimbursement. HHS issued interim final rules establishing this Program that were published in the Federal Register on May 5, 2010. Under these final rules, the Program is effective June 1, 2010.

## Expenses Reimbursed Under the Program

The Program will reimburse an eligible plan for 80 percent of the cost of an eligible claim that exceeds \$15,000 and is no greater than \$90,000. For purposes of determining if the \$15,000 threshold or \$90,000 maximum has been reached, all

amounts paid with respect to an eligible individual during the plan year are considered (i.e., they are not measured on a per-service or per-episode-of-care basis). Costs of benefits provided to early retirees, their spouses, surviving spouses or eligible dependents are all reimbursable under the Program.

Plan sponsors may consider claims incurred during the plan year before June 1, 2010, toward meeting the \$15,000 threshold, but only amounts incurred on or after June 1, 2010, that exceed \$15,000 are eligible for reimbursement. For example, Company X sponsors a self-insured medical plan for eligible early retirees. During the Plan's 2010 plan year, Retiree A incurred claims for \$15,000 in medical expenses before June 1, 2010, and \$75,000 in medical expenses for June 1, 2010, through December 31, 2010. As a result, the plan could potentially receive reimbursement for \$60,000 (80% X \$75,000).

The amount eligible for reimbursement is the amount actually paid by the plan or the insurer for eligible health benefits, taking into account any negotiated price reductions (e.g., prescription drug rebates). This amount can also include amounts paid by the individual for those benefits (such as co-payments, co-insurance and deductibles) but a plan must have evidence that the individual paid these amounts, which may raise administrative issues. Eligible health benefits include benefits for the diagnosis, cure, mitigation or prevention of physical or mental disease, but exclude HIPAA exempted benefits such as limited scope dental and vision plans.

## Plans That are Eligible for Reimbursement

A plan must satisfy all the requirements listed below to be eligible for the Program.

- It must be a group health plan that is either a single-employer plan sponsored by an employer (including state or local government) and/or employee organization, or is a multiemployer plan.
- It must cover retirees who are at least age 55 but not yet eligible for Medicare. A retiree cannot be an active employee of any employer contributing to the plan.
- It must provide health benefits (medical, surgical, hospital, prescription drug, and other benefits determined by HHS) to these early retirees through self-funding or insurance.
- It must have programs and procedures that have generated or have the potential to generate cost-savings with respect to participants with chronic and high-cost conditions (e.g., disease management programs). Chronic and high-cost conditions are those conditions for which \$15,000 or more in health benefit claims are likely to be incurred during a plan year by one participant. New programs are not necessarily required, so many plans may already satisfy this requirement. In the preamble to the guidance, HHS provides two examples of qualifying programs: (1) a diabetes management program that includes aggressive monitoring and behavioral counseling to prevent complications; and (2) a procedure through which the plan covers all or a large portion of the participant's coinsurance or eliminates deductibles for treatment and visits related to the high-cost condition of cancer.
- It must have policies and procedures in place to protect against, fraud, waste and abuse. Again, it is likely that most plans already have such notices and procedures in place.

## How To Apply for Reimbursement

### *Step 1: Apply to the Secretary to Have the Plan Certified*

The plan sponsor must apply to HHS for certification for each plan. This application is not yet available, but HHS has indicated it will be available by the end of June. According to the guidance, a completed application will include:

- The applicant's name, address, tax identification number, and contact information;
- The plan year start and end date;
- A plan sponsor agreement providing:
  - o the plan sponsor has a written agreement with the plan or the insurer regarding disclosure of information, data, documents and records the Secretary requests related to the Program;
  - o an acknowledgement that the information is being provided to obtain federal funds and all subcontractors acknowledge the same;
  - o an attestation that policies and procedures are in place to detect and reduce fraud, waste and abuse, and the sponsor will produce these policies and procedures upon request.

*Many of these items are similar to those included in the agreements necessary to receive the Medicare Part D subsidy.*

- A summary indicating how the applicant will use any reimbursement received under the Program (including a description of how the sponsor will use the reimbursements under the Program to maintain its level of contribution to the plan);
- A summary of the plan's procedures or programs that have generated or have the potential to generate cost savings with respect to plan participants with chronic and high-cost conditions;
- The amount of reimbursement projected to be received under the Program for the first two plan year cycles; and
- A list of all benefit options under the plan for which an early retiree is eligible and reimbursement may be claimed.

HHS will process applications in the order in which they are received. *Incomplete applications must be re-submitted and will be considered a new submission at the end of the line.*

## *Step 2: After the Plan is Certified, Submit a Reimbursement Request*

The reimbursement request must include:

- A list of all benefit options under the plan for which an early retiree is eligible and reimbursement may be claimed;
- Documentation of the health benefits provided including:
  - o the provider or supplier;
  - o the incurred date;
  - o the individual for whom the benefit was provided;
  - o the date and amount of payment (as adjusted for any negotiated price concessions); and
  - o the applicable plan and benefit option; and
- If the claim includes amounts paid by the early retiree paid (e.g., co-insurance, co-pay, deductible), evidence that the early retiree paid those amounts, such as a receipt. It may be difficult for the plan to provide such evidence. Plans are not, however, *required* to seek reimbursement for amounts paid by the early retirees, and may decide not to if obtaining this type of evidence would be too cumbersome in light of the potential size of additional reimbursement amounts related to the amounts paid by the early retiree.

A claim may not be submitted until the total paid for health benefits for the early retiree (or eligible spouse, surviving spouse or dependent) exceed the cost threshold (\$15,000) and no claims over the maximum amount (\$90,000) may be submitted. It appears, however, that within those dollar amounts, claims may be submitted as they are incurred. In other words, after the \$15,000 threshold is reached, each subsequent claim paid up to \$90,000 for the eligible individual could be submitted to HHS for processing. If HHS rejects a claim, the plan sponsor may appeal the decision in writing to the Secretary within 15 days of receipt of the rejection.

## **Reimbursements**

Any reimbursements received are not taxable income to the plan sponsor. There are, however, limits on how reimbursements can be used.

A plan that receives reimbursements under the Program must use them to lower costs for the plan, such as by reducing premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. The reimbursement cannot be used for the general revenue of the plan sponsor. In the preamble to the guidance, HHS has interpreted these provisions to require that a plan sponsor maintain its current level of effort in contributing to the plan and indicated the expectation of HHS that reimbursements will be used to pay for the increases in health benefit costs or to reduce plan participant costs.

## Employer Action Plan

- Determine whether your plan is eligible for reimbursement.
- Discuss with your vendors what relevant services they are willing to provide related to obtaining reimbursements (determining eligible reimbursement amounts, etc.) under this Program and the cost of these services.
- Decide how reimbursements would be applied to lower costs for your plan (such as by reducing premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants).
- Assess whether your plan should apply for reimbursement considering your plan's eligible claims, the potential reimbursement amount, your administrative resources and any costs associated with applying for reimbursement.
- Submit your application to certify the plan as soon as possible. HHS is expected to issue applications in June.
- If you are certified, decide how frequently you will submit eligible claims to improve your chances of receiving the limited reimbursement funds.

*For further details, or if you have any questions regarding the Early Retiree Reinsurance Program, contact your Seyfarth Shaw LLP attorney or any Employee Benefit attorney listed on the website at [www.seyfarth.com/employeebenefits](http://www.seyfarth.com/employeebenefits).*



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