# Early Retiree Reinsurance Program: 'First Come-First Served!'

5/19/2010

*Sue O. Conway*

Once applications become available, post-retirement health plan sponsors will need to scramble to submit them to the Department of Health and Human Services ("**HHS**") if they want to participate in the temporary early retiree reinsurance program. Funds for the program are limited and applications will be processed in the order received subject to a cut-off when funds run out. Included within the new Health Care Reform law, the reinsurance program is intended to incentivize employers with retiree health plans to continue to cover early retirees who are not yet eligible for Medicare until state insurance exchanges are in place in 2014.

**Background of the Program**

The reinsurance program provides $5 billion to reimburse health plans (including plans sponsored by private employers, state and local governments, employee organizations such as unions, and multiemployer plans) for part of the cost of benefits for early retirees and their eligible spouses, surviving spouses and dependents. An early retiree is an individual who is:

(i) age 55 or older;
(ii) not eligible for Medicare; and
(iii) not an active employee of the employer maintaining (or contributing to) the health plan.

The program will reimburse 80% of the cost of health claims between $15,000 and $90,000 paid during the plan year for an eligible individual. A plan sponsor does not have to wait until the end of the plan year but can begin submitting reimbursement claims as soon as an individual's cumulative claims for the plan year exceed $15,000 and can continue until they reach the $90,000 ceiling (dollar limits are subject to medical CPI adjustment annually). To be eligible for reimbursement, the claims must be incurred and paid during the same plan year.

According to interim final regulations issued by HHS on May 5, reimbursed costs include cost-sharing amounts paid by the retirees and their dependents, such as deductibles, co-payments and co-insurance (if documentation of the payment is provided), but reimbursements must be net of negotiated price concessions such as rebates, discounts, coupons and the like. Insurance premiums for insured plans are not eligible for reimbursement; actual claims data must be provided. Only expenses incurred after the effective date of the program are eligible to be reimbursed; however, an individual's expenses incurred during the plan year but before the June effective date can be used to satisfy the $15,000 threshold for reimbursement to kick in.

**Use of Reimbursement Funds**

Reimbursements are not taxable to the plan sponsor but must be used to "lower costs for the plan," not as general revenue for the plan sponsor. The regulations say this means that the sponsor must use the proceeds to:

- Reduce health benefit costs or health benefit premium costs for the plan sponsor;
- Reduce premium contributions, co-payments, deductibles, coinsurance or other out-of-pocket costs for plan participants; or
- Any combination of the above.

The application to HHS must indicate how the plan sponsor will use reimbursement proceeds to accomplish the above and to "maintain its level of contribution to the plan." One example of an appropriate use of reimbursements is to pay the employer's share of an increase in the premiums for an insured plan. Unfortunately the regulation writers gave no other specific examples, including any for self-insured plans, other than to state that additional information on how HHS will monitor the appropriate use of reimbursements will be disseminated as it is developed. Presumably reimbursements can be used to cover plan cost increases, but it is not clear how this would work during the initial year of the program.

Interestingly, the plan sponsor can use the reimbursement funds to lower the benefit costs for all participants in a plan, including active employees and their dependents, not just the early retirees.

**Requirements for Sponsors to Participate**

Eligibility to participate is not automatic. The plan sponsor must submit an application to HHS and the plan must be certified as meeting all program requirements. Specifically, the plan must include "programs and procedures that have generated or have the potential to generate cost-savings with respect to plan participants with chronic and high-cost conditions" (defined as conditions likely to generate $15,000 or more in annual claims by one participant during a plan year). Recent guidance indicates that the cost savings requirement for chronic and high-cost conditions will be reasonably interpreted, that plans may already have such cost savings programs in place (for example, a diabetes management program that includes aggressive monitoring and behavioral counseling to prevent complications and unnecessary hospitalization, or a cancer program that covers all or a large portion of a participant's coinsurance or copayments and/or eliminates or reduces the deductible for treatment and visits related to the condition). The plan does not necessarily need to put new cost-savings programs in place nor have programs in place for *all* conditions likely to exceed $15,000 in claims, but sponsors are expected to take a reasonable approach in identifying conditions and selecting programs to lower the cost and improve the quality of care for such conditions.

In addition, the sponsor must maintain for 6 years and make available to HHS on request for audit purposes certain records, information, data and documents regarding its participation in the program,

must have a written agreement with its insurance company or with the plan (if self-insured) to disclose information to HHS to assure compliance with the program, and must have policies and procedures to protect against fraud, waste and abuse under the reimbursement program. If requested by HHS, it must produce those policies, procedures and any related documents.

**Applications are First-Come, First-Served**

It is expected that the HHS applications for the program will be available on or before June 1, 2010. A list of the information that will be required for the application is attached. A separate application must be submitted for each separate health plan and the applicant must estimate the reimbursement amounts anticipated for each of the first two years of the program.

The new regulations contemplate that the program will be open for business by June 1, 2010--earlier than expected. The program ends on January 1, 2014 or when the money runs out, if sooner. Most expect the money to run out well before 2014. The regulations are clear that HHS expects more requests for reimbursement than it has funds available to pay and that applications will be processed in the order received. If an application is incomplete or does not meet all requirements of the program, it will be rejected and the corrected application will be relegated to the back of the line. Reimbursement claims will be processed on a first-in, first-out basis until program funding is exhausted. Moreover, HHS may stop accepting applications or stop processing claims based on the availability of the $5 billion. The regulations provide an appeals process if applications or reimbursements are denied, but because funds are limited, a successful appeal could result in no payment if the funds are gone.

Sponsors who plan to apply for retiree funding should be ready to jump when the application forms become available. They should review and, if necessary, beef up their existing disease management and other programs for chronic and high cost conditions and their policies and procedures for protecting against fraud, waste and abuse. Employers that rely on their health insurers or claims administrators for these programs and policies should verify that they are in place and will be made available as required for the application. Potential applicants should also contact their insurers or claims administrators to determine whether other information required for the application and program participation is available, including individual claims information, projections on how much reimbursement will be requested for each of the first two years and documentation on how much participants pay towards their claims.

**Early Retirement Reinsurance Program**
**Application Requirements**

1. The plan sponsor's name, address, tax identification number and contact information (e-mail and telephone number).
2. An agreement signed by an authorized representative of the plan sponsor that includes:

- An assurance that the plan sponsor has a written agreement with its health insurance issuer or the plan regarding disclosure of the information required to participate in the program;
- An acknowledgement that the information in the application is being provided to obtain federal funds;
- An attestation that policies and procedures are in place to detect and reduce fraud, waste, and abuse under the program, and to timely comply with requests from HHS to produce information about such policies and procedures and their effectiveness; and
- Other terms as required by the Secretary of HHS.

3. A summary of how the plan sponsor will use reimbursements to meet the program's requirements, including:
    - How reimbursements will be used to reduce plan participant or plan sponsor costs;
    - Programs and procedures to generate cost savings with respect to the plan participants with chronic and high-cost conditions; and
    - How the reimbursements will be used to maintain the plan sponsor's level of contribution to the plan.
4. The projected amount of reimbursement to be received from the program for the first two plan year cycles, with specific amounts for each of the two cycles.
5. A list of all benefit options under the plan that early retirees for whom the plan sponsor receives reimbursement may be claimed.
6. Any other information the Secretary of HHS requires.