Issue:

The Early Retiree Reinsurance Program

Citation:

Title I, Subtitle B, Section 1102 of the Patient Protection and Affordable Care Act.

Statutory Directive:

Requires the Department of Health and Human Services (HHS) to establish a temporary program within 90 days of enactment (June 1, 2010) for the purpose of providing reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees, individuals 55 and over, and their spouses, surviving spouses, and dependents. HHS will reimburse certain claims between $15,000 and $90,000. Beginning with plan years on or after October 1, 2011 those amounts will be indexed.

Program Duration:

June 1, 2010 through January 1, 2014.

Funding:

$5 billion in financial assistance to eligible employers

Definitions:

Definition in Statute
Employee-based Health Plan–a group benefit plan providing health benefits that is maintained by private employers, state or local governments, employee organizations, voluntary employees' beneficiary association, a committee or board of individuals appointed to administer such plans, or a multiemployer plan.

Definition in Rule
Sponsor* i**s a plan sponsor as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1002(16)(B), except that, in the case of a plan maintained jointly by one ***employer and an employee organization and or which the employer is the primary source of financing, the term means the employer.

The term "**plan sponsor**" means
(i) the employer in the case of an employee benefit plan established or maintained by a single employer,
(ii) the employee organization in the case of a plan established or maintained by an employee **o**rganization, or
(iii) in the case of a plan established or maintained by two or more employers or jointly by one or more **e**mployers and one or more employee organizations, the association, committee, joint board of trustees, **o**r, other similar group of representatives of the parties who establish or maintain the plan.

Interim Final Rule:

Released in the Federal Register May 5, 2010, and effective June 1, 2010, comments will be accepted until 5 p.m. EST June 4, 2010.

- **Requirements to Participate**:

1. Plans must have in place programs and procedures to generate cost-savings for participants with chronic and high-cost conditions. Plan sponsors must take a reasonable approach in identifying which conditions must be addressed. Chronic and high-cost conditions are defined as meaning a condition for which $15,000 or more in applicable claims are likely to be incurred during a plan year by one participant.
2. Plan sponsors must have an agreement in place with health insurance issuers requiring disclosure of information on behalf of the sponsor to HHS. Section 1102 (d) requires HHS to conduct audits of claims data to ensure plan compliance requiring disclosure of private health information (PHI). The disclosure of PHI within this context will not require specific authorization from individuals as the disclosure is pursuant to "the required law."
3. Section 1102 (d) also requires HHS to establish procedures to protect against fraud, waste, and abuse**. Sponsors must have policies and procedures in place to detect and reduce fraud, and attest that they are in place in the application**.

- **Application—a sponsor must submit the following**:

1. One application must be filed for each plan and will be processed in the order they are received.
2. A description of all benefit options under the employment-based plan.
3. Applicants must submit a complete application the first time to be considered. All incomplete applications will be denied.
4. Applicants must include a summary of how they will use the reimbursement to reduce costs and their plans to implement programs and procedures to generate savings for plan participants with chronic conditions.
5. **Maintenance of Effort Requirement**—participating sponsors must agree to maintain funding levels to support their applicable plan or plans. The statute requires that funds dispersed under this program not be used as general revenue. The sponsors' plan for use must include how the funding received will be applied to maintain their level of effort in supporting the plan.
6. Applicants must provide a projection of their reimbursement amounts for the first two plan-year cycles in their application.

- **Benefits Eligible for Reimbursement**

1. Benefits are defined as medical, surgical, hospital, prescription drug, and such other benefits as determined by the secretary,
2. The regulatory definition of "health benefits" clarifies that these benefits include benefits for diagnosis, cure, mitigation, or prevention of physical or mental disease or condition with respect to any structure or function of the body.
3. Health benefits do not include benefits specified at 45 CFR 146.145(c) (2) as follows:
   i. Coverage only for accident (including accidental death and dismemberment),
   ii. Disability income coverage,
   iii. Liability insurance, including general liability insurance and auto mobile liability insurance,
   iv. Coverage issued as a supplement to liability insurance,
   v. Workers compensation or similar coverage,
   vi. Automobile medical payment insurance,
   vii. Credit-only insurance (for example, mortgage insurance),
   viii. Coverage for on-site medical clinics,
   ix. Limited scope dental and vision or long-term care provided under a separate policy or contract,
   x. Benefits provided under a health flexible spending arrangement, or

xi. Benefits provided under coverage for only a specified disease, i.e. a cancer policy.

- **Consequences of Non-compliance, Fraud or Similar Fault**

1. Failure to comply with the requirements of this part, or if fraud, waste and abuse or similar faults are found, the secretary may recoup or withhold funds, terminate or deny an application.

- **Amount of Reimbursement**

1. Claims submitted will be reimbursed at **80 percent of the health benefit costs for claims between $15,000 and $90,000** while funding is available.
2. Negotiated price concessions must be reflected on claims submitted for program reimbursement.

- **Reimbursement Method**

1. Claims for an early retiree may not be submitted until they have reached the required threshold in any given plan year. When that the threshold has been reached all claims below the applicable cost must be submitted in order to verify the cost threshold has been met.
2. Once the early retiree has reach $90,000 for a plan year, claims submission should cease.
3. In the case of a plan year that begins prior to June 1, 2010 and ends after, the plan sponsor may count claims that occurred prior June 1, 2010, but within the current plan year, toward the required claims threshold of $15,000. However, claims occurring prior to the June 1 effective date will not be tallied toward the $90,000 claim limit. Claims occurring prior to the effective date of June 1, 2010 are not reimbursable.

- **Maintenance of Records**

1. Specified records must be maintained for six years after expiration of the associated plan year.

- **Appeals**

1. The rule establishes a one-step appeals process.
2. Sponsors may appeal within 15 days of receipt of a determination at issue.