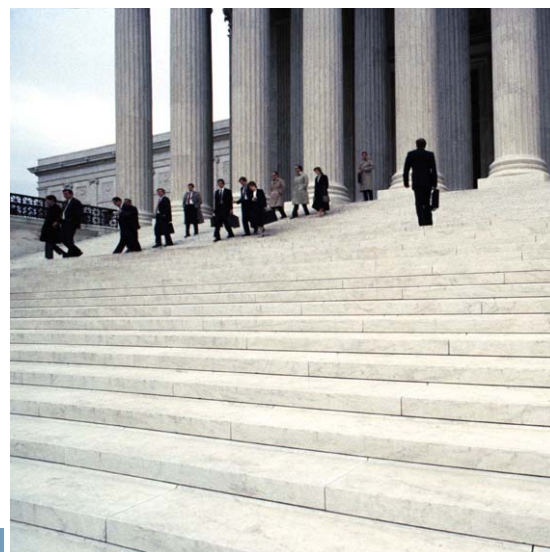


# Legislative Brief

## Health Care Reform: Interim Final Rule on Retiree Reinsurance Program



### **EXECUTIVE SUMMARY**

On May 5, 2010, the Department of Health and Human Services (HHS) published an interim final rule (Final Rule) implementing the Early Retiree Reinsurance Program (the Reinsurance Program) established by the Patient Protection and Affordable Care Act. HHS expects the program to be finalized by June 1, 2010, and applications to be available by the end of June 2010. There is limited funding for this program, so employers who are interested should act quickly.

This FAS-EBA, Inc. Legislative Brief describes the provisions of the interim final rule. Please read below for more information.

### **EXPLANATION OF THE INTERIM FINAL RULE**

#### **Background**

The Reinsurance Program was initially established by section 1102 of the Patient Protection and Affordable Care Act. The purpose of the program is to make health benefits more affordable to retiree plan participants and sponsors so that health benefits are accessible to more Americans. Congress appropriated funding of \$5 billion for the program. The Retiree Program is temporary – it must be implemented by June 21, 2010, and is set to end by January 1, 2014.

The program provides reimbursement to participating employer-based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents. Plans may be reimbursed for certain claims between \$15,000 and \$90,000 (these amounts are indexed for plan years starting on or after October 1, 2011).

#### **Participation Requirements**

The Reinsurance Program is available to sponsors of employment-based plans. The Final Rule defines an employment-based plan as a group health plan that provides health benefits to early retirees (excluding a federal government plan). In order to participate in the Reinsurance Program, the plan must:

- Be certified by HHS; and
- Include cost-saving programs and procedures with respect to plan participants with chronic and high-cost conditions (those for which \$15,000 or more in health benefit claims are likely to be incurred during a plan year by a single participant).

Plan sponsors must also:

- Make certain records available to HHS upon request;
- Have a written agreement with its health insurance issuer or employment-based plan (as applicable) regarding disclosure of information to HHS;
- Ensure that policies and procedures to protect against fraud, waste and abuse of the Reinsurance Program are in place and comply with any request from HHS to confirm their implementation and effectiveness; and
- Submit an application to HHS.

# Legislative Brief

## Health Care Reform: Interim Final Rule on Retiree Reinsurance Program

### Application Requirements

Applications to participate in the Reinsurance Program must be submitted to HHS and signed by an authorized representative of the applicant. A separate application must be submitted for each plan for which reimbursement is sought. Separate applications need not be submitted for each plan year, but the application must identify the plan year start and end date cycle. HHS plans to have the application process finalized in June 2010 and more information will be available at that time.

The following information must be submitted in connection with each application:

- The applicant's tax identification number, name and address, and contact name, telephone number and e-mail address.
- A signed plan sponsor agreement, including:
  - o An assurance that the sponsor has an agreement in place with its health insurance issuer or plan regarding disclosure of information to HHS;
  - o An acknowledgment that the information in the application is being provided to obtain federal funds; and
  - o An attestation that policies and procedures are in effect to detect and reduce fraud, abuse and waste and that the plan sponsor will provide them to HHS upon request.
- A summary indicating how the applicant will use any reimbursement received under the program, including:
  - o How the reimbursement will be used to reduce costs for plan participants and/or health benefit costs for the plan sponsor;
  - o What programs the plan sponsor has in place that have generated (or will generate) cost savings with respect to participants with chronic and high-cost conditions; and
  - o How the plan sponsor will use the reimbursement to maintain its level of contribution to the plan.
- The projected amount of reimbursement to be received under the program for the first two plan year cycles with specific amounts for each of the two cycles.
- A list of all benefits options under the plan for early retirees.
- Any other information required by HHS.

The Final Rule states that applications will be processed in the order in which they are received. If an application is not complete, it will be denied and the applicant must submit another application to participate in the program. The new application will be processed based on when it is received, not when the first application was received. Therefore employers should be sure that their applications are complete and timely.

### Reinsurance Amounts

The Final Rule provides additional information about the specific amount of reimbursement available. For each early retiree, the plan sponsor can be reimbursed for 80 percent of the costs for health benefits (net of negotiated price concessions) for claims that are:

- Attributed to health benefits costs between \$15,000 and \$90,000; and
- Are paid by the employment-based plan or health insurer and the early retiree.

# Legislative Brief

## Health Care Reform: Interim Final Rule on Retiree Reinsurance Program

Health benefits are medical, surgical, hospital, prescription drug and other services for the diagnosis, cure, mitigation, or prevention of physical or mental diseases or conditions, whether self-funded or insured. They do not include HIPAA “excepted benefits” such as disability income insurance, long-term care benefits, or stand-alone dental or vision plans and do not appear to include premiums for fully-insured plans.

Costs are considered paid by the early retiree if they are paid by the individual, or another person on his or her behalf, and are not reimbursed through insurance or other third party payment arrangement.

The Final Rule provides transition relief for plan years that begin before June 1, 2010. For those plans, the amount of claims incurred before June 1, 2010, up to \$15,000 counts toward the \$15,000 cost threshold and \$90,000 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 reimbursement amount to be paid is based only on claims incurred on and after June 1, 2010, that fall between \$15,000 and \$90,000.

### Use of Reimbursements

Plan sponsors may use the reimbursements received under the Reinsurance Program to either reduce the plan sponsor’s health benefit premiums or costs, or reduce health benefits costs for plan participants, or a combination of both. Reimbursements may not be used as general revenue for the plan sponsor.

### Claims for Reimbursement

In this section, the Final Rule spells out general rules for reimbursement. Specifically, reimbursement is conditioned on provision of accurate information by the plan sponsor. The information must be submitted in accordance with HHS guidance.

Also, a plan sponsor and its employment-based plan must be certified by HHS before a reimbursement request may be made. Claims may be submitted only after an application is approved and after the total paid costs for health benefits for the particular retiree exceed the \$15,000 cost threshold. However, the claims submitted must include claims below the cost threshold.

Claims include medical, surgical, hospital, prescription drug and other claims as determined by HHS. To be eligible for reimbursement, claims must include documentation indicating:

- The health benefit provided;
- The provider or supplier;
- The incurred date;
- The individual for whom the health benefit was provided;
- The date and amount of payment (net any known negotiated price concessions); and
- The employment-based plan and benefit option under which the health benefit was provided.

A submission of claims must include a list of early retirees for whom claims are being submitted and documentation of the actual costs of the items and services for claims being submitted. For insured plans, the claims and data required may be submitted directly by the insurer. Plan sponsors must also retain records related to claims submitted for six years after the end of the plan year in which the costs were incurred.

The Final Rule specifically states that reimbursement is conditioned on the availability of funds for the Reinsurance Program, and that any decision by HHS to deny a request due to funding limitations is final.

# Legislative Brief

## Health Care Reform: Interim Final Rule on Retiree Reinsurance Program

### Appeals

The Final Rule provides an appeal process for reimbursement requests that are partly or completely denied. However, a denial based on unavailability of funds may not be appealed.

To appeal a denial, the plan sponsor must submit the appeal in writing to HHS within 15 calendar days of receiving the denial. The appeal must specify the findings or issues with which the plan sponsor disagrees and the reasons for the disagreement. The plan sponsor may include supporting documentary evidence as part of the appeal. HHS will notify the plan sponsor in writing of its decision, which is final and binding.

In addition to the appeal process, the Final Rule states that HHS may reopen and revise a reimbursement determination at its own discretion or at the request of a plan sponsor. This can be done within one year of a reimbursement determination for any reason, within four years for good cause and at any time if fraud is involved.

### Notification Requirements

The Final Rule contains some requirements regarding notice and disclosure by plan sponsors. A plan sponsor must disclose any data inaccuracies upon which a reimbursement determination is made. HHS will issue additional guidance regarding this requirement. Also, any sponsor that has a sponsor agreement in effect under the Reinsurance Program and is considering or negotiating a change in ownership, such as an asset sale, must notify HHS at least 60 days before the anticipated effective date of the change. Failure to notify HHS of the change could result in recovery of funds paid by HHS.

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