

## Patient Protection and Affordable Care Act Early Retiree Reinsurance Program

The health care reform legislation, the Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, contains a provision for a new temporary early retiree reinsurance program. This reinsurance program will reimburse a plan for 80% of the cost of claims between \$15,000 and \$90,000. Only employment-based plans that provide health benefits to pre-Medicare retirees are eligible to participate in the program. Both self-insured and fully-insured plans sponsored by private employers, State and local governments, employee organizations, voluntary employees' beneficiary associations (VEBAs), churches, and multiemployer health funds are eligible. By offering financial relief to plans providing this coverage, this program encourages employers to maintain retiree health benefits.

The program is set to begin June 1, 2010 – three weeks prior to the start date required under the legislation. The program's funding is limited to \$5 billion dollars and is set to expire no later than January 1, 2014. However, with this set amount of funding, the program is likely to run out of money before this date. Because the initial Department of Health and Human Services (HHS) program guidance creates a "first come, first served" process, **employers and plan sponsors offering retiree health coverage should take action now to be prepared to submit applications for the program as soon as a process for doing so is finalized.**

### Key Provisions

1. **Amount of reimbursement:** The program will reimburse 80% of the annual health benefit costs (less any negotiated price concessions) between \$15,000 and \$90,000 for each early retiree enrolled. These costs include payments by the plan and the early retiree (copays, deductibles). "Early retiree" includes an eligible early retiree's spouse, surviving spouse and dependents, including those under age 55 and/or eligible for Medicare. There is a transition provision this year for plan year costs incurred before June 1, 2010. Costs incurred before June 1 count toward reaching the \$15,000 threshold (and limit), however those costs exceeding the \$15,000 limit prior to June 1 are not eligible for reimbursement. Claims will be reimbursed on a first-come, first-served basis until the program's funding is exhausted. A reimbursement request can only be made after the sponsor and plan have been certified by HHS.
2. **Use of reimbursements:** A sponsor must use the funds received under this program to either reduce the sponsor's health benefit premiums/costs or to reduce the plan participants' premiums/costs. Under no circumstances may the funds be used as general revenue for the sponsor.

3. **Pre-requisites:** A plan sponsor must, as a condition for participating in the program, implement health plan design features that have generated or have the potential to generate cost savings for participants with chronic and high-cost conditions. In this regard, chronic and high-cost conditions are those that are expected to generate \$15,000 or more in claims each year for a participant. HHS has indicated they “expect sponsors to take a reasonable approach when identifying [chronic] conditions and selecting programs and procedures to lower the cost of care, as well as improve the quality of care, for such conditions.”
4. **Application:** In order for a plan to participate, they must be certified by the HHS Secretary. Certification is accomplished by submitting a completed application meeting all requirements. Applications are processed in the order they are received. Those failing to meet all the requirements will be denied, and any new application filed by the sponsor will be processed based on when the new submission is received. Yearly applications are not necessary - only one application per plan must be submitted. Included among the application requirements are:
  - a summary of how the plan sponsor will use any reimbursement to lower sponsor and/or retiree costs for the plan.
  - a summary of programs that have generated or could generate cost savings for plan participants with chronic and high-cost conditions.
  - the projected amount of reimbursement to be received under the program for the first two plan-year cycles.
  - verification that policies and procedures to protect against fraud, waste and abuse are in place.

**It should be noted that the Secretary may stop accepting (deny) applications based on the projected or actual availability of program funding. Therefore, it is critical for interested plan sponsors to submit a fully completed application as soon as possible to prevent being shut out of the program. HHS expects applications to be available in June.**

AFSCME urges all affiliates to immediately contact our members’ employers who offer coverage for pre-Medicare eligible retirees and urge them to participate in the program. Some plans may be required to immediately develop and implement chronic condition management features in their plan in order to be eligible for the program. HHS has indicated that they are available to provide technical assistance. If you need assistance, contact AFSCME’s Department of Research and Collective Bargaining Services.

For more information concerning the program, including a link to the regulations and the application, go to: [http://www.hhs.gov/ociio/regulations/index.html#early\\_retiree](http://www.hhs.gov/ociio/regulations/index.html#early_retiree) .