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Early Retiree Reinsurance Program and UMC Plans

Introduction

The recently enacted health care reform acts establish a temporary Early Retiree Reinsurance Program (“Program”) to reimburse employment-based plans for health care costs of early retirees (pre-Medicare) and their dependents. The Department of Health and Human Services (HHS) will administer the Program. HHS has issued an interim final rule (“Rule”) in the *May 5, 2010 Federal Register* (45 CFR Part 149) (<http://edocket.access.gpo.gov/2010/pdf/2010-10658.pdf>), effective June 1, 2010, which relates to the Program’s administration.

Quick Action

Church annual conferences must act quickly if they wish to seek the reinsurance funds. The Program is effective on June 1, 2010, and reimbursements will be made on a *first-come, first-served basis*. Given the expectation that claims for reimbursements will substantially exceed the \$5 billion in funding allocated to the Program, speed is essential.

HealthFlex Plan Sponsors

The General Board intends to submit an application for the HealthFlex plan. HealthFlex plan sponsors will not need to submit their own applications.

Plan Sponsor Under the Program

HHS has defined “plan sponsor” in the Rule, with respect to multiple-employer plans, in the same manner as under the Medicare Part D Retiree Drug Subsidy (RDS). The plan sponsor is the “association, committee, joint board of trustees or similar group of representatives” that maintains the plan on behalf of participating employers. It appears that an annual conference board of pensions (or, in the case of HealthFlex, the General Board of Pension and Health Benefits) may apply for the Program.

Early Retiree

Early retirees under the Program generally are participants in an employer-sponsored health plan who are age 55 or older, are not active employees, and are not eligible for Medicare. The term includes the spouse and other dependents of the early retiree. Dependent under the Program is defined by the terms of the plan, not by the Tax Code.

Amount of Reimbursement

For each early retiree, a plan sponsor may receive reimbursement of 80% of the health benefit claims costs incurred and paid exceeding \$15,000, but not exceeding \$90,000, during the plan year. Health benefit costs are broadly defined and include “diagnosis, cure, mitigation, or prevention of physical or mental disease.” Costs may include amounts paid by the early retiree through co-payments, deductibles, etc. Costs must reflect any negotiated price concessions, rebates and discounts. For an insured plan, costs include actual claims paid, not premium amounts.

Plan Requirements

To qualify for the Program, the sponsor's plan must include three features:

- **Chronic condition management:** programs and procedures that generate or have the potential to generate cost savings with respect to participants who have chronic and high-cost conditions, such as diabetes or heart disease;
- **Disclosure agreement:** a written agreement with its plan or insurer to make required disclosures to HHS (including disclosures of health information protected by HIPAA); and
- **Fraud and abuse prevention:** policies and procedures to detect and reduce fraud and abuse.

Application Process

Before submitting claims, a plan sponsor must be certified by HHS by submitting an application. The Program application process will be based in large part on the RDS program. Among other things, the plan sponsor must include the projected reimbursement amounts for each of the first two plan years. (HHS may use these estimated reimbursement amounts to determine when the Program funds will be exhausted.) HHS will process applications in the order received; i.e., it is first-come, first-served. *Notably*, if an application does not satisfy all of the requirements, it will be rejected and the plan sponsor will need to submit a new application, which will be processed according to the date it was resubmitted, *i.e., the plan sponsor will be sent to the back of the queue*. Applicants also must explain to HHS how they expect to use any reimbursements received under the Program.

HHS has posted *draft* applications and additional guidance about the program on the website for the Office of Consumer Information and Insurance Oversight (OCIO) (<http://www.hhs.gov/ociio/regulations/index.html>).

Use of Reimbursements

The sponsor is required to use the reimbursements 1) to lower its health benefit premiums (for insured plans) or costs (for self-funded plans), 2) to lower costs directly for plan participants, or 3) any combination of 1 and 2. Reimbursements may not be used as general revenue for the plan sponsor, which the Rule interprets as requiring sponsors to maintain their level of plan contributions. For example, it would be appropriate for a plan sponsor to use the reimbursement to cover its share of premium increases from year to year.

2010 Transition Rule

The reinsurance amount is based solely on claims incurred on or after June 1, 2010. Costs incurred prior to June 1, 2010 are counted toward the \$15,000 initial cost threshold, but are not reimbursable and do not count against the \$90,000 limit.

Example: A plan has a plan year that began January 1, 2010, with an end date of December 31, 2010, and has an early retiree for whom it has spent \$20,000 in health benefit claims before June 1, 2010, and another \$30,000 in health benefit claims on the early retiree between June 1, 2010 and December 31, 2010. The plan sponsor, once certified, would receive credit for \$15,000 (toward the cost threshold) in claims incurred before June 1 and receive reimbursement of 80% of the \$30,000 (for the claims incurred after June 1, 2010)—or \$24,000.

Questions

If you have questions about the impact of health care reform, please send your inquiry to: healthcarereform@gbophb.org.

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