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Early Retiree Reinsurance Customer Summary and FAQs
June 3, 2010

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Background:
The health care legislation enacted by Congress and signed into law by President Barack Obama on March 23, 2010, requires the Department of Health and Human Services (HHS) to establish an early retiree reinsurance program, which must be operational within 90 days after enactment and will precede the implementation of health insurance exchanges in 2014. Recently, HHS released interim final rules relating to the Early Retiree Reinsurance Program and called for a 30-day public comment.

In general, the program provides $5 billion in financial assistance to employers to offset a portion of the costs of providing health coverage for early retirees ages 55-64 who are not yet eligible for Medicare and their spouses, surviving spouses and dependents.

The interim final rule is effective on June 1, 2010. Applications for the program will be posted some time in June on the Office of Consumer Information and Insurance Oversight's website (http://www.hhs.gov/ociio/index.html) and are expected to be accepted and processed by HHS on a first-come, first-served basis. The program will end on January 1, 2014, or when the $5 billion Congress allocated through the legislation is exhausted.

High Level Program Requirements:
The key elements of the Early Retiree Reinsurance Program are:

- The program regulations are effective June 1, 2010.
- By law, the program will expire on January 1, 2014, or when the $5 billion Congress allocated through the legislation is exhausted.
- The program applies to fully insured and self-insured groups providing early retiree coverage.
- All groups (except federal governmental plans) are eligible, regardless of size.

Employer Requirements:
Groups qualified for the reimbursement are "employment-based plans" that:

- Provide health benefits to early retirees;
- Meet the definition of "group health plan" as defined by the regulation; and
- Are certified by HHS.

State and municipal plans, plans maintained pursuant to a collective bargaining agreement, church plans, and other ERISA-qualified plans are eligible.

The plan sponsor (employer) must file an application directly with the secretary of HHS.

Plans sponsored by the federal government are not eligible to participate.

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FREQUENTLY ASKED QUESTIONS:

Which employers are eligible for the early retiree reinsurance program?
Employment-based plans that provide health benefits to early retirees are eligible to participate in the program. For example:

- state and municipal plans
- plans maintained pursuant to a collective bargaining agreement
- church plans
- other ERISA-qualified plans

Employer groups must also meet the definition of "group health plan" (as defined by the regulation) and be certified by HHS.

Plans sponsored by the federal government are not eligible to participate.

What is the application process?
Eligible employers will apply directly to the U.S. Department of Health and Human Services. For details on the application process, please visit http://www.hhs.gov/ociio/regulations/index.html

Where does the employer get the application?
Employers will obtain the application from the U.S. Department of Health and Human Services. A copy of the application will be posted sometime in June on the Office of Consumer Information and Insurance Oversight's website: http://www.hhs.gov/ociio/index.html

When does a company have to file for the funds?
Once the U.S. Department of Health and Human Services releases the application (expected sometime in June), it is expected that HHS will then indicate the date on which it will begin accepting applications, and employers can then apply for the reimbursement program, receive certification from HHS and then submit to HHS the required claims reporting for qualified retiree plans. It is expected that applications will be processed on a first-come, first-served basis.

What are the application requirements?

- Must include each retiree benefit plan that will be considered under the program.
- Sponsor must have a written agreement with its employment-based plan or health insurance issuer to ensure any personal health information disclosure required to meet the program's specifications meets HIPAA guidelines.
- Must demonstrate that a qualifying plan has programs and procedures in place that generate (or have the potential to generate) savings for plan participants with chronic and high-cost conditions. (These conditions are not specified or limited.)
- Must demonstrate that it has policies and procedures in place to detect fraud, waste and abuse. (If the health insurance issuer maintains these policies and procedures, the sponsor will attest to this in the application.)
- Include the estimated reimbursement amounts for the first two plan-year cycles to assist HHS with projecting total reimbursement amounts under the program.
- Must sign a plan sponsor agreement, including a provision stating that reimbursement data submitted by the sponsor, if found to be inaccurate or incomplete, may be re-opened, revised and recouped by the HHS secretary.
- ***HHS estimates that it will take 35 hours for a plan sponsor or designee to complete one application package.***

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Whose claims are eligible for reimbursement?
Claims for early retirees ages 55-64 and their enrolled spouses, surviving spouses and dependents are eligible. Early retirees cannot be eligible for Medicare. Spouses, surviving spouses and dependents are eligible regardless of Medicare eligibility.

Are the provisions for the early retiree reinsurance program for anyone over the age of 55? What about early retirees under age 55?
Early retirees ages 55-64 and their enrolled spouses, surviving spouses and dependents are eligible. Early retirees cannot be eligible for Medicare. Spouses, surviving spouses and dependents are eligible regardless of Medicare eligibility

What are the claims reporting requirements?

- Claims eligible for reimbursement include medical, surgical, hospital, prescription drug and other types of claims as determined by the HHS secretary.
- Claims must be incurred and paid by the plan before the HHS secretary will direct reimbursement payment to a sponsor.
- For plan years starting before June 1, 2010, claims incurred before that date will be applied toward the $15,000 annual minimum threshold; however, only claims incurred and paid after June 1, 2010, are eligible for reimbursement.
- Requests for reimbursement must include
  - a list of early retirees for whom claims are being submitted
  - documentation of the actual costs of the items and services for each claim being submitted.
- If there is an enrollee cost-sharing component (for example, copayments, deductible amounts), those amounts may be included in the total claims cost, and the sponsor must provide prima facie evidence that the enrollee has paid his or her share of the cost.
- ***HHS estimates that it will take an average of 45 hours for a plan sponsor or designee to complete one claims submission and request for reimbursement.***

How much will be paid?
Reimbursement will be made for 80% of a retiree's (or spouse's or dependent's) cumulative claims between $15,000 and $90,000 in a given plan year. Through the legislation, Congress allocated a total of $5 billion in funding available through the program.

Is it a single claim in the $15,000 - $90,000 range or aggregated by specific member?
Reimbursement amounts are based on cumulative health benefits incurred and paid per qualified member, and may include the amounts paid by the early retiree (or spouse, surviving spouse or dependent), in a specific plan year.

How will we help clients apply for funds?
This process will largely follow the process developed for the Retiree Drug Subsidy Program. We will assist with appropriate reporting and information required for the Early Retiree Reinsurance Program application and claims submission process. Specifically:

- Data for use in projecting the estimated reimbursement amounts for the first two plan-year cycles in the application
- Ongoing data to submit claims eligible for reimbursement under the program
- Information about our programs to fulfill the requirement to demonstrate that a qualifying plan has programs in place to generate savings for participants with chronic and high-cost conditions,
- Information to demonstrate that policies and procedures are in place to detect fraud, waste and abuse, as they apply to our business responsibilities.

Can clients get data on applicable claims that qualify to determine if they will apply for the reimbursement?
We will provide data to help our clients apply for funds, including applicable reports for our clients to submit through the HHS application process. Account management has been trained on the report request process and timeline, and can assist interested clients.

What's the deadline for requesting the report?
We highly encourage clients who want to submit their applications to the U.S. Department of Health and Human Services in June to submit report requests as soon as possible. This will enable us to quickly turn around all requests and meet the needs of our customers and clients. We will process requests in the order in which they are received.

What is the time frame for the claims to be incurred? Is it based on date of service or date of payment?
The program will become effective on June 1, 2010, with reimbursements made for services provided and paid during the plan year. Claims incurred between the start of the plan year and June 1, 2010, are credited toward the $15,000 threshold for reimbursement. However, only medical expenses incurred after June 1, 2010, are eligible for reimbursement under this program.

For example: An early retiree incurs claims totaling $30,000 between the start of the plan year and June 1, 2010, and an additional $40,000 after that date. The amount that may be submitted for reimbursement is $40,000 – the costs above the $15,000 threshold that are incurred after June 1, 2010.

How much is available? If a group applies, is it guaranteed to get the funds?
Through the legislation, Congress allocated $5 billion in funding available through the program, and because of that finite amount, there is no guarantee a group will receive reimbursement.

How is the reimbursement from HHS handled? Are the funds used to pay the claims directly?
The U.S. Department of Health and Human Services will provide the reimbursement directly to the certified plan sponsor. Claims must be incurred by the plan before the HHS secretary will remit reimbursement to the plan sponsor.

Are there any requirements on how the reinsurance payments must be used by an employer?
Employers can use the reimbursements to reduce their own health care costs, provide premium relief to their workers and families, or a combination of both. Reimbursement from this program must not be used as general revenue for the employer.

What requirements are there for employers to have cost-savings programs and procedures in place for plan participants with chronic and high-cost conditions? Will employers have to make changes to their health plans to qualify?
To qualify for reimbursement, plans must have their applications approved, document claims incurred, and have in place programs and procedures that generate (or have the potential to generate) cost savings for plan participants with chronic and high-cost conditions. For employers whose plans include these types of programs and procedures, we will provide documentation about them for the employer to submit.