plan maintained jointly by one employer and an employee organization and for which the employer is the primary source of financing, the term means the employer.

Sponsor agreement means an agreement between the sponsor and the United States Department of Health & Human Services, or its designee, which is made to comply with the provisions of this part.

Subpart B—Requirements for Eligible Employment-Based Plans

§ 149.30 General requirements.

A sponsor is eligible to participate in the program if it meets the requirements of section 1102 of the Patient Protection and Affordable Care Act, this part, and guidance developed by the Secretary.

§ 149.35 Requirements to participate.

(a) A sponsor's employment-based plan must—

(1) Be certified by the Secretary.

(2) Include programs and procedures that have generated or have the potential to generate cost-savings with respect to plan participants with chronic and high-cost conditions.

(b) A sponsor must—

(1) Make available information, data, documents, and records as specified in § 149.350.

(2) Have a written agreement with its health insurance issuer (as defined in 45 CFR 160.103) or employment-based plan (as applicable) regarding disclosure of information, data, documents, and records, to the Secretary, and the health insurance issuer or employment-based plan must disclose to the Secretary, on behalf of the sponsor, at a time and in a manner specified by the Secretary in guidance, the information, data, documents and records necessary for the sponsor to comply with the program, this part, and program guidance.

(3) Ensure that policies and procedures to protect against fraud, waste and abuse under this program are in place, and must comply timely with requests from the Secretary to produce the policies and procedures and any documents or data to substantiate the implementation of the policies and procedures and their effectiveness.

(4) Submit an application to the Secretary in the manner, and at the time, required by the Secretary as specified in § 149.40.

§ 149.40 Application.

(a) The applicant must submit an application to participate in this program to the Secretary, which is signed by an authorized representative of the applicant who certifies that the information contained in the application is true and accurate to the best of the authorized representative's knowledge and belief.

(b) Applications will be processed in the order in which they are received.

(c) An application that fails to meet all the requirements of this part will be denied and the applicant must submit another application if it wishes to participate in the program. The new application will be processed based on when the new submission is received.

(d) An applicant need not submit a separate application for each plan year but must identify in its application the plan year start and end date cycle (starting month and day, and ending month and day) for which it is applying.

(e) An applicant must submit an application for each plan for which it will submit a reimbursement request.

(f) In connection with each application the applicant must submit the following:

(1) Applicant's Tax Identification Number.

(2) Applicant's name and address.

(3) Contact name, telephone number and email address.

(4) Plan sponsor agreement signed by an authorized representative, which includes—

(i) An assurance that the sponsor has a written agreement with its health insurance issuer (as defined in 45 CFR 160.103) or employment-based plan, as applicable, regarding disclosure of information to the Secretary, and the health insurance issuer or employment-based plan must disclose to the Secretary, on behalf of the sponsor, at a time and in a manner specified by the Secretary in guidance, information, data, documents, and records necessary

for the sponsor to comply with the requirements of the program.

(ii) An acknowledgment that the information in the application is being provided to obtain Federal funds, and that all subcontractors acknowledge that information provided in connection with a subcontract is used for purposes of obtaining Federal funds.

(iii) An attestation that policies and procedures are in place to detect and reduce fraud, waste, and abuse, and that the sponsor will produce the policies and procedures, and necessary information, records and data, upon request by the Secretary, to substantiate existence of the policies and procedures and their effectiveness.

(iv) Other terms and conditions required by the Secretary.

(5) A summary indicating how the applicant will use any reimbursement received under the program to meet the requirements of the program, including:

(i) How the reimbursement will be used to reduce premium contributions, co-payments, deductibles, coinsurance, or other out-of-pocket costs for plan participants, to reduce health benefit or health benefit premium costs for the sponsor, or to reduce any combination of these costs;

(ii) What procedures or programs the sponsor has in place that have generated or have the potential to generate cost savings with respect to plan participants with chronic and high-cost conditions; and

(iii) How the sponsor will use the reimbursement to maintain its level of contribution to the applicable plan.

(6) 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.

(7) A list of all benefit options under the employment-based plan that any early retiree for whom the sponsor receives program reimbursement may be claimed.

(8) Any other information the Secretary requires.

(g) An application must be approved, and the plan and the sponsor certified, by the Secretary before a sponsor may request reimbursement under the program.

(h) The Secretary may reopen a determination under which an application had been approved or denied:

(1) Within 1 year of the determination for any reason;

(2) Within 4 years of the determination if the evidence that was considered in making the determination shows on its face that an error was made; or

(3) At any time in instances of fraud or similar fault.

§ 149.41 Consequences of Non-Compliance, Fraud, or Similar Fault.

Upon failure to comply with the requirements of this part, or if fraud, waste, and abuse, or similar fault are found, the Secretary may recoup or withhold funds, terminate or deny a sponsor's application, or take a combination of these actions.

§ 149.45 Funding limitation.

(a) Based on the projected or actual availability of program funding, the Secretary may deny applications that otherwise meet the requirements of this part, and if an application is approved, may deny all or part of a sponsor's reimbursement request.

(b) The Secretary's decision to stop accepting applications or satisfying reimbursement requests based on the availability of funding is final and binding, and is not appealable.

Subpart C—Reinsurance Amounts

§ 149.100 Amount of reimbursement.

(a) For each early retiree enrolled in a certified plan in a plan year, the sponsor receives reimbursement in the amount of 80 percent of the costs for health benefits (net of negotiated price concessions for health benefits) for claims incurred during the plan year that are attributed to health benefits costs between the cost threshold and cost limit, and that are paid by the employment-based plan or by the insurer (if an insured plan), and by the early retiree.

(b) Costs are considered paid by an early retiree, if paid by that individual or another person on behalf of the early retiree, and the early retiree (or

person paying on behalf of the early retiree) is not reimbursed through insurance or otherwise, or other third party payment arrangement.

(c) Reimbursement is calculated by first determining the costs for health benefits net of negotiated price concessions, within the applicable plan year for each early retiree, and then subtracting amounts below the cost threshold and above the cost limit within the applicable plan year for each such individual.

(d) For purposes of determining amounts below the cost threshold and above the cost limit for any given early retiree, all costs for health benefits paid by the employment-based plan (or by the insurer, if applicable), or by or on behalf of, an early retiree, for all benefit options the early retiree is enrolled in with respect to a given certified employment-based plan for a given plan year, will be combined. For each early retiree enrolled in an employment-based plan, there is only one cost threshold and one cost limit per plan year regardless of the number of benefit options the early retiree is enrolled in during that plan year.

§ 149.105 Transition provision.

For a certified plan that has a plan year that begins before June 1, 2010 and ends on any date thereafter, the reinsurance amount for the plan year must be determined as follows:

(a) With respect to claims incurred before June 1, 2010, the amount of such claims up to $15,000 count toward the cost threshold and the cost limit. The amount of claims incurred before June 1, 2010 that exceed $15,000 are not eligible for reimbursement and do not count toward the cost limit.

(b) The reinsurance amount to be paid is based only on claims incurred on and after June 1, 2010, that fall between the cost threshold and cost limit for the plan year.

§ 149.110 Negotiated price concessions.

(a) The amount of negotiated price concessions that will be taken into account in determining the reinsurance amount will reflect negotiated price concessions that have already been subtracted from the amount the employment-based plan or insurer paid for the cost of health benefits and the amount of post-point-of-sale negotiated price concessions received.

(b) At a time specified by the Secretary, sponsors are required to disclose the amount of post-point-of-sale price concessions that were received but not accounted for in their submitted claims.

§ 149.115 Cost threshold and cost limit.

The following cost threshold and cost limits apply individually, to each early retiree as defined in § 149.2:

(a) The cost threshold is equal to $15,000 for plan years that start on any date before October 1, 2011.

(b) The cost limit is equal to $90,000 for plan years that start on any date before October 1, 2011.

(c) The cost threshold and cost limit specified in paragraphs (a) and (b) of this section, for plan years that start on or after October 1, 2011, will be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of $1,000) for the year involved.

Subpart D—Use of Reimbursements

§ 149.200 Use of reimbursements.

(a) A sponsor must use the proceeds under this program:

(1) To reduce the sponsor's health benefit premiums or health benefit costs,

(2) To reduce health benefit premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs, or any combination of these costs, for plan participants, or

(3) To reduce any combination of the costs in (a)(1) and (a)(2) of this section.

(b) Proceeds under this program must not be used as general revenue for the sponsor.

Subpart E—Reimbursement Methods

§ 149.300 General reimbursement rules.

Reimbursement under this program is conditioned on provision of accurate