

# ERRP

## Early Retiree Reinsurance Program Application



### U.S. Department of Health and Human Services

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1087. The time required to complete this information collection for this application is estimated to average 35 hours, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HHS Form # CMS-10321

Please note that if any information in this Application changes or if the sponsor discovers that any information is incorrect, the sponsor is required to promptly report the change or inaccuracy.

An asterisk (\*) identifies a required field.

<b>PART I: Plan Sponsor and Key Personnel Information</b>	
<b>A. Plan Sponsor Information</b>	
1) *Organization's Name (Must correspond with the information associated with the Federal Employer Tax Identification Number (EIN): _____	
2) *Type of Organization (Check the one category that best describes your organization): <input type="checkbox"/> Government <input type="checkbox"/> Union <input type="checkbox"/> Religious <input type="checkbox"/> Commercial <input type="checkbox"/> Non-profit	
3) *Organization's Employer Identification Number (EIN): _____	
4) *Organization's Telephone Number: ____ ext. _____	
5) Organization's FAX Number _____	
6) *Organization's Address (must be the address associated with the EIN provided above): * Street Line 1: _____ Street Line 2: _____ *City: _____ *State/US Territory: _____ *Zip Code: _____	
7) Organization's Website Address: _____	
<b>B. Authorized Representative Information</b>	
1) *First Name: _____ Middle Initial (optional): ____ *Last Name: _____	
2) *Job Title: _____	
3) *Date of Birth(Month/Day/Year): _____	
4) *Social Security Number: _____	
5) *Email Address: _____	
6) *Telephone Number: _____ ext _____	
7) FAX Number: _____	

8) \*Employer Name: \_\_\_\_\_

9) \* Authorized Representative Business Address:

\* Street Line 1: \_\_\_\_\_

Street Line 2: \_\_\_\_\_

\*City: \_\_\_\_\_

\*State/US Territory: \_\_\_\_\_

\*Zip Code: \_\_\_\_\_

**C. Account Manager Information**

1) \*First Name: \_\_\_\_\_ Middle Initial (optional): \_\_\_\_ \*Last Name: \_\_\_\_\_

2) \*Job Title: \_\_\_\_\_

3) \*Date of Birth(Month/Day/Year): \_\_\_\_\_

4) \*Social Security Number: \_\_\_\_\_

5) \*Email Address: \_\_\_\_\_

6) \*Telephone Number: \_\_\_\_\_ ext \_\_\_\_\_

7) FAX Number: \_\_\_\_\_

8) \*Employer Name: \_\_\_\_\_

9) \*Account Manager Business Address:

\* Street Line 1: \_\_\_\_\_

Street Line 2: \_\_\_\_\_

\*City: \_\_\_\_\_

\*State/US Territory: \_\_\_\_\_

\*Zip Code: \_\_\_\_\_

<b>PART II: Plan Information</b>
<b>A. Plan Information</b>
1) *Plan Name:
2) *Plan Year Cycle: Start Month/Day: _____ End Month/Day: _____
<b>B. Benefit Option(s) Provided Under This Plan (If the plan has more than one benefit option for which you intend to seek program reimbursement, please include the information below for each benefit option, on a separate copy of the Attachment below.</b>
1a) *Benefit Option Name: _____
1b) *Unique Benefit Option Identifier: _____
1c) *Benefit Option Type: Self-Funded _____ Insured _____ Both _____
1d) *Benefit Administrator Company Name: _____
<b>C. *Programs and Procedures for Chronic and High-Cost Conditions</b>
<p>A sponsor cannot participate in the Early Retiree Reinsurance Program unless, as of the date of its application for the program is submitted, its employment-based plan has in place 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. The program regulations define “chronic and high cost condition” as a condition for which \$15,000 or more in health benefit claims are likely to be incurred during a plan year by one plan participant. Please identify the chronic and high cost conditions for which the employment-based plan has such programs and procedures in place, and summarize those programs and procedures, including how it was determined that the identified conditions satisfy the \$15,000 threshold. If necessary to provide a complete response, the sponsor may submit additional pages as an attachment to the application. Please reference such attachment in this space.</p>
<b>D. *Estimated Amount of Early Retiree Reinsurance Program Reimbursements</b>
<p>Please estimate the projected amount of proceeds you expect to receive under the Early Retiree Reinsurance Program for the plan identified in this application, for each of the first two plan year cycles identified in this application. If you wish, you may provide a range of expected program proceeds that includes: (1) a low-end estimate of expected program proceeds, (2) an estimate that represents your most likely amount of program proceeds, and (3) a high-end estimate of expected program proceeds. For purposes of this estimate only, please assume for each of those plan year cycles that there will be sufficient program funds to cover all claims submitted by the Plan Sponsor that comply with program requirements. If necessary to provide a complete response, the sponsor may submit additional pages as</p>

an attachment to the application. Please reference such attachment in this space.

**E. \*Intended Use of Early Retiree Reinsurance Program Reimbursements**

- 1) Please summarize how your organization will use the reimbursement under the Early Retiree Reinsurance Program to reduce health benefit or health benefit premium costs for the sponsor of the employment-based plan (i.e., to offset increases in such costs); or reduce premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs (or combination of these) for plan participants; or reduce a combination of any of these costs (whether offsetting increases in sponsor costs or offsetting or reducing plan participants' costs). If necessary to provide a complete response, the sponsor may submit additional pages as an attachment to the application. Please reference such attachment in this space.
  
- 2) If a sponsor decides to apply the reimbursement for its own use, it may only use the reimbursement to offset increases in its health benefit premium costs, if an insured plan, or its health benefit costs, if it is self-funded. If any amount of the reimbursement is used to offset increases in health benefit premium or health benefit costs of your organization (as opposed to offsetting increases to, or reducing, plan participants' costs), please summarize how program funds, as a result of being used by your organization for such purposes, will relieve your organization of using its own funds to subsidize such increases, thereby allowing your organization to instead use its own funds to maintain its level of financial contribution to the employment-based plan. (In other words, please explain how your organization will continue to maintain the level of support for this plan, and if it applies the reimbursement for its own use, will use the program reimbursement to pay for increases in health benefit premium costs or health benefit costs, as applicable). If necessary to provide a complete response, the sponsor may submit additional pages as an attachment to the application. Please reference such attachment in this space.

**PART III: Banking Information for Electronic Funds Transfer**

1) \*Bank Name: \_\_\_\_\_

2) \*Bank Address:

\*Street Line 1: \_\_\_\_\_

Street Line 2: \_\_\_\_\_

\*City: \_\_\_\_\_

\*State/US Territory: \_\_\_\_\_

\*Zip Code: \_\_\_\_\_

3) \*Account Number: \_\_\_\_\_

4) \*Name of Organization Associated with Account: \_\_\_\_\_

5) \*Account type: (Checking or Savings Account) \_\_\_\_\_

6) \*Bank Routing Number: \_\_\_\_\_

7) \*Bank Contact First Name: \_\_\_\_\_ Middle Initial (optional): \_\_\_\_ \*Last Name: \_\_\_\_\_

8) \*Email address: \_\_\_\_\_

9) \*Telephone Number: \_\_\_\_\_

<b>PART IV. Plan Sponsor Agreement</b>	
1.	<b>Compliance:</b> In order to receive program reimbursement(s), Plan Sponsor agrees to comply with all of the terms and conditions of Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 C.F.R. Part 149 and in other guidance issued by the Secretary of the U.S. Department of Health & Human Services (the Secretary), including, but not limited to, the conditions for submission of data for obtaining reimbursement and the record retention requirements.
2.	<b>Reimbursement-Related and Other Representations Made by Designees:</b> Plan Sponsor may be given the opportunity to identify one or more Designees (i.e., individuals the Sponsor will authorize to perform certain functions on behalf of the Sponsor related to the Early Retiree Reinsurance Program, such as individual(s) who will be involved in making program reimbursement requests). Plan Sponsor certifies that all individuals that will be identified as Designees will have first been given authority by the Plan Sponsor to perform those respective functions on behalf of the Plan Sponsor. Plan Sponsor understands that it is bound by any representations such individuals make with respect to the Sponsor's involvement in the Early Retiree Reinsurance Program, including but not limited to the Sponsor's reimbursement under, the program.
3.	<b>Written Agreement:</b> Plan Sponsor certifies that, prior to submitting a Reimbursement Request, it has executed a written agreement with its health insurance issuer or employment-based plan regarding disclosure of information, data, documents, and records to HHS, and the issuer or plan agrees to disclose to HHS, on behalf of the Plan Sponsor, at a time and in a manner specified by the HHS Secretary in guidance, the information, data, documents, and records necessary for the Plan Sponsor to comply with the requirements of the Early Retiree Reinsurance Program, as specified in 45 C.F.R. 149.35.
4.	<b>Use of Records:</b> Plan Sponsor understands and agrees that the Secretary may use data and information collected under the Early Retiree Reinsurance Program only for the purposes of, and to the extent necessary in, carrying out Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 C.F.R. Part 149 including, but not limited to, determining reimbursements and reimbursement-related oversight and program integrity activities, or as otherwise allowed by law. Nothing in this section limits the U.S. Department of Health & Human Services' Office of the Inspector General's authority to fulfill the Inspector General's responsibilities in accordance with applicable Federal law.
5.	<b>Obtaining Federal Funds:</b> Plan Sponsor acknowledges that the information furnished in its Plan Sponsor application is being provided to obtain Federal funds. Plan Sponsor certifies that it requires all subcontractors, including plan administrators, to acknowledge that information provided in connection with a subcontract is used for purposes of obtaining Federal funds. Plan Sponsor acknowledges that reimbursement of program funds is conditioned on the submission of accurate information. Plan Sponsor agrees that it will not knowingly present or cause to be presented a false or fraudulent claim. Plan Sponsor acknowledges that any excess reimbursement made to the Plan Sponsor under the Early Retiree Reinsurance Program, or any debt that arises from such excess reimbursement, may be recovered by the Secretary. Plan Sponsor will promptly update any changes to the information submitted in its Plan Sponsor application. If Plan Sponsor becomes aware that information in this application is not (or is no longer) true, accurate and

	complete, Plan Sponsor agrees to notify the Secretary promptly of this fact.
6.	<p><b>Data Security:</b> Plan Sponsor agrees to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged under this Plan Sponsor application. Plan Sponsor recognizes that the use and disclosure of protected health information (PHI) is governed by the Health Insurance Portability and Accountability Act (HIPAA) and accompanying regulations. Plan Sponsor certifies that its employment-based plan(s) has established and implemented appropriate safeguards in compliance with 45 C.F.R. Parts 160 and 164 (HIPAA administrative simplification, privacy and security rule) in order to prevent unauthorized use or disclosure of such information. Sponsor also agrees that if it participates in the administration of the plan(s), then it has also established and implemented appropriate safeguards in regard to PHI. Any and all Plan Sponsor personnel interacting with PHI shall be advised of: (1) the confidential nature of the information; (2) safeguards required to protect the information; and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.</p>
7.	<p><b>Depository Information:</b> Plan Sponsor hereby authorizes the Secretary to initiate reimbursement, credit entries and other adjustments, including offsets and requests for reimbursement, in accordance with the provisions of Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 C.F.R Part 149 and applicable provisions of 45 C.F.R. Part 30, to the account at the financial institution (hereinafter the "Depository") indicated under the Electronic Funds Transfer (EFT) section of the Plan Sponsor application. Plan Sponsor agrees to immediately pay back any excess reimbursement or debt upon notification from the Secretary of the excess reimbursement or debt. Plan Sponsor agrees to promptly update any changes in its Depository information.</p>
8.	<p><b>Policies and Procedures to Detect Fraud, Waste and Abuse.</b> The Plan Sponsor attests that, as of the date this Application is submitted, has in place policies and procedures to detect and reduce fraud, waste, and abuse related to the Early Retiree Reinsurance Program. The Plan 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, as specified in 45 C.F.R. Part 149.</p>
9.	<p><b>Change of Ownership:</b> The Plan Sponsor shall provide written notice to the Secretary at least 60 days prior to a change in ownership, as defined in 45 C.F.R, 149.700. When a change of ownership results in a transfer of the liability for health benefits costs, this Plan Sponsor Agreement is automatically assigned to the new owner, who shall be subject to the terms and conditions of this Plan Sponsor Agreement.</p>
	<p><b>Signature of Plan Sponsor Authorized Representative</b></p> <p>I, the undersigned Authorized Representative of Plan Sponsor, declare that I have legal authority to sign and bind the Plan Sponsor to the terms of this Plan Sponsor Agreement, and I have or will provide evidence of such authority. I declare that I have examined this Plan Sponsor Application and Plan Sponsor Agreement. My signature legally and financially binds the Plan Sponsor to the statutes, regulations, and other guidance applicable to the Early Retiree Reinsurance Program including, but not limited to Section 1102 of the Patient Protection Act (P.L. 111-148) and 45 C.F.R. Part 149 and applicable provisions of 45 C.F.R. Part 30 and all other applicable statutes and</p>

	<p>regulations. I certify that the information contained in this Plan Sponsor Application and Plan Sponsor Agreement is true, accurate and complete to the best of my knowledge and belief, and I authorize the Secretary to verify this information. I understand that, because program reimbursement will be made from Federal funds, any false statements, documents, or concealment of a material fact is subject to prosecution under applicable Federal and/or State law.</p> <p>Signature</p>
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**Attachment: Additional Benefit Options**

**(Complete this form for each unique benefit option)**

1a) \*Benefit Option Name: \_\_\_\_\_

1b) \*Unique Benefit Option Identifier: \_\_\_\_\_

1c) \*Benefit Option Type: Self-Funded \_\_\_\_\_ Insured \_\_\_\_\_ Both \_\_\_\_\_

1d) \*Benefit Administrator Company Name: \_\_\_\_\_