§ 1.603 [Amended]

5. In § 1.603, paragraphs (a) and (b) are removed; the paragraph designation (c) and its heading are removed; paragraphs (c)(1) and (c)(2) are redesignated as paragraphs (a) and (b), respectively; and newly redesignated paragraphs (a)(i), (a)(ii), (a)(iii), and (a)(iv) are redesignated as paragraphs (a)(1), (a)(2), (a)(3) and (a)(4), respectively.

6. Section 1.620 is revised to read as follows:

§ 1.620 Eligibility for burial.

Section 2402 of title 38, United States Code, bestows eligibility for burial in any open cemetery in the National Cemetery System. The following rules in paragraphs (a) through (c) of this section state conditions in addition to those imposed by statute. To be eligible for burial in a national cemetery:

(a) A United States citizen who served in an allied armed force, as provided in 38 U.S.C. 2402(4), must have been a citizen of the United States at the time of entry on such service and at the time of his or her death.

(b) A minor child of an eligible person, as provided in 38 U.S.C. 2402(5), must have been at the time of his or her death under 21 years old or under 23 years old if pursuing a course of instruction at an approved educational institution.

(c) An unmarried adult child of an eligible person, as provided in 38 U.S.C. 2402(5), must have been physically or mentally disabled and incapable of self support.

(Authority: 38 U.S.C. 2402)

§ 1.630 [Amended]

7. In § 1.630, paragraph (b) is amended by removing the second and third sentences.

[FR Doc. 96–13477 Filed 5–30–96; 8:45 am]

BILLING CODE 8320–01–P

38 CFR Part 1

RIN 2900–AI09

Gender Policy for VA Publications and Other Communications

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends regulations of the Department of Veterans Affairs (VA) by removing § 1.13 of 38 CFR. This section provided that VA publications and other communications must avoid using language refering only to the masculine gender when the feminine gender also was intended to be included. This guidance was intended to avoid any incorrect appearance of seeming to preclude benefits for female veterans, dependents, or beneficiaries. Although, VA is fully committed to the gender-neutral concepts that were set forth in § 1.13, the material from § 1.13 is removed since the mandate from that section is being accomplished through internal issuances.

EFFECTIVE DATE: May 31, 1996.

FOR FURTHER INFORMATION CONTACT: Kenneth Hoffman, Director, Information Resources Management, Policy and Standards Service (045A3), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8129.

SUPPLEMENTARY INFORMATION: This final rule consists of nonsubstantive changes and, therefore, is not subject to the notice and comment and effective date provisions of 5 U.S.C. 553.

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (RFA), 5. U.S.C. 601–602. This final rule would not cause a significant effect on any entities since it does not contain any substantive provisions. Therefore, pursuant to 5 U.S.C. 605(b), this amendment is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

There are no Catalog of Federal Domestic Assistance program numbers for this regulation.

List of Subjects in 38 CFR Part 1

Administrative practice and procedure, Claims, Freedom of information, Government contracts, Government employees, Government property, Reporting and recordkeeping requirements.

Approved: May 13, 1996.

Jesse Brown,

Secretary of Veterans Affairs.

For the reasons set forth in the preamble, 38 CFR part 1 is amended as set forth below:

PART 1—GENERAL PROVISIONS

1. The authority citation for part 1 continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

§ 1.131 [Removed]

2. The undesignated centerheading preceding § 1.13 and § 1.13 are removed.

[FR Doc. 96–13478 Filed 5–30–96; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 417

[OMC–004–F]

RIN 0938–AE64

Health Maintenance Organizations: Employer Contribution to HMOs

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This rule amends § 417.157 of the HCFA regulations, which pertains to employer contributions to health maintenance organizations (HMOs) that are included among the alternatives in health benefits plans that an employer offers to its employees.

These amendments are necessary to conform that section to changes made in section 1310(c) of the Public Health Service Act by section 7(a)(2) of the HMO Amendments of 1988.

The intent is to ensure that employees who choose the HMO alternative are not financially disadvantaged.

DATES: Effective Date: These regulations are effective on July 1, 1996.

FOR FURTHER INFORMATION, CONTACT: Marty Abeln, (410) 786–1032.

SUPPLEMENTARY INFORMATION:

I. Background

Under section 1310 of the Public Health Service (PHS) Act, the following rules apply:

- Certain public and private employers that offer health benefits plans to their employees must include the option of enrollment in qualified health maintenance organizations (HMOs) if such HMOs request inclusion and their requests meet specified conditions as to content and timing (this is known as the ''employer mandate'' provision);
- The procedures for offering the HMO option must take into account the rules of collective bargaining; and
- No employer is required to contribute more for health benefits than would be required by any prevailing collective bargaining agreement or any other legally enforceable contract between the employer and the employees for health benefits.

These provisions are implemented by subpart E of part 417 of the HCFA rules. Section 417.157 of those rules provides that—

- The employer or designee must include the HMO option in the offering on terms no less favorable, with respect

to the employer's monetary contribution or designee's cost than the terms on which the other alternatives are included; and

• An employer's contribution must be equal, in dollar amount, to the largest contribution made by that employer, on behalf of a particular employee, to a non-HMO alternative included in the plan offering.

II. Statutory Amendment

Under amendments made to section 1310 of the Public Health Service Act by section 7 of Public Law 100–517—

• If an employer offers a health benefits plan to its employees and includes an HMO as required by the mandate provisions discussed above, any employer contribution under the plan must ''not financially discriminate'' against an employee who enrolls in the HMO;

• The employer's contribution does not discriminate if the ''method of determining the contribution on behalf of all employees is reasonable and is designed to assure employees a fair choice among health benefits plans''.

• The ''employer mandate'' provision expires on October 24, 1995, and employers that voluntarily include HMOs after that date must meet the nondiscrimination standard for their contributions.

The legislative history of this provision makes clear that, while the Congress agreed that our current ''dollar for dollar'' test was consistent with previous law, the Congress now intends to give employers greater flexibility.

The committee reports accompanying Public Law 100–517 provided examples of some methods of contribution that would meet the legislative requirement. (See, for example, the report of the Senate Committee on Labor and Human Resource, Sen. Rep. No 304, 100th Cong., 2nd Sess., 9–11 (1988).) We incorporated those examples in the proposed rule at § 417.157(a)(4). We indicated that, if an employer followed one of those methods, we would not consider the contributions to be financially discriminatory.

Method 1: The employer may contribute to the HMO the same amount it contributes to the non-HMO alternative. For example, an employer that contributes $80 per month on behalf of each employee who joins an indemnity plan and pays the same amount on behalf of each employee who joins the HMO would not be discriminating.

Method 2: An employer's contributions may vary for different classes of enrollees established on the basis of attributes, such as age, sex, or family status, that are reasonable predictors of utilization, experience, costs, or risk. For each enrollee in a given class, the employer would contribute an equal dollar amount, regardless of the plan that an employee chooses. To illustrate, one such class might be single males under the age of 30. If the employer's cost for the class of single males under age 30 in an indemnity or self-insurance plan is $60, and the employer's contribution for HMO enrollment for each employee in that particular class were $60, there would be no discrimination. The employer would follow this methodology for each of the other classes. By calculating the contribution for HMO enrollment for each class in this way, the employer would determine its total payment on behalf of all employees enrolling in the HMO.

Method 3: If the employer's policy is that all employees contribute to their health benefits plan, an employer may require employees to make a reasonable minimum contribution to an HMO. We would consider an employee contribution that did not exceed 50 percent of the employee contribution to the principal non-HMO alternative to be reasonable in such a situation. To illustrate, assume that the HMO's premium is $80, the alternative plan's premium is $100, and the employer contributes $80 on behalf of each employee who participates in the alternative plan. In such a case, employees who join the HMO would have no out-of-pocket costs while employees who remain with the alternative plan would contribute $20. If the employer had a policy requiring a minimum employee contribution for health benefits, we would consider it reasonable for the employer to require employees who enroll in the lower cost plan, in this example the HMO, to pay an amount not in excess of $10, which is 50 percent of the employee contribution to the non-HMO alternative.

Method 4: An employer's contribution may be the same percentage of the premium of each alternative the employer offers. For example, if the employer pays 90 percent of the premium of each non-HMO alternative offered, we would find no discrimination if the employer pays 90 percent of the HMO premium.

Method 5: Employers and HMOs may negotiate contribution arrangements that are mutually acceptable. In negotiating those arrangements with a Federally qualified HMO, an employer may not insist on terms that would cause the HMO to violate any of the requirements for being a qualified HMO, as set forth in subparts B and C of part 417 of the HCFA rules. Any negotiated arrangements must meet the basic criteria for nondiscrimination against employees who enroll in HMOs.

Although the major thrust of the statutory amendment is to provide greater flexibility to the employer while ensuring fair choice for employees, two of the committee reports (discussed below in the response to comment #6) specify that HMOs are also protected from ''discriminatory and unfair contribution practices''.

III. Proposed Rule

On July 5, 1991, at 56 FR 30723, we published a proposed rule that would amend § 417.157 to implement the statutory change discussed above, primarily by incorporating the examples.

Also included were proposed minor amendments to those portions of § 417.107 that pertained to quality assurance and to certification of institutional providers, and the removal of an outdated requirement. No comments were received on this part of the NPRM. While this final rule was under development, the document identified as OCC–015–FC (published on July 15, 1993 at 58 FR 38062) made the proposed changes. It removed obsolete paragraph (f), redesignated paragraph (h) as paragraph (a) of § 417.106, and redesignated paragraph (i) as paragraph (h) of § 417.124.

IV. Discussion of Comments on the Proposed Rule

We received seven letters of comment; three from HMOs, two from industry associations, and one each from a law firm and a consultant. Their comments and our responses to them are discussed under several subject areas.

A. ''Contribution by Class'' Method

This is the second of the five examples listed in the proposed rule. Under this method, employers may contribute different amounts for different classes of employees classes based on factors such as age, sex, and family status.

1. *Comment:* One commenter noted that this appeared to allow differential employer contributions for male and female employees which would presumably result in different out-of-pocket costs for male and female employees. The commenter thought this would be illegal discrimination as it would violate title VII of the 1964 Civil Rights Act. In addition, the commenter questioned whether an age-based classification would violate HCFA regulations that require that employees

and spouses over age 65 be provided health coverage on the same terms as coverage for younger employees.

1. *Response:* This comment has brought to our attention that ''Method 2'', which was taken directly from the legislative history, is misleading. First, the example assumes that the employer would have differential costs by age and sex in its contributions towards *indemnity* plans, which would be reflected in its payment to HMOs. However, we understand that health insurers that contract with *employer groups* do not vary rates between men and women, or according to age, but rather develop composite rates similar to the HMO community rates, i.e.,distinguishing only between individuals and families. This, as a practical matter, makes the example in ''Method 2'' inaccurate. We are revising the regulation text accordingly.

However, we note that gender-based distinctions under an employee benefit plan *would* likely violate title VII of the Civil Rights Act of 1964, as interpreted by the Supreme Court. That statute is under the jurisdiction of the Equal Employment Opportunity Commission (EEOC), and beyond the scope of this regulation. Any questions as to whether a particular fact situation would or would not violate title VII should be directed to the EEOC.

We also note that the HCFA regulations cited by the commenter do not impose a general prohibition against age-based distinctions, but apply only to distinctions based on attainment of age 65. This implements explicit statutory language.

2. *Comment:* Two commenters were concerned that some employers may wish to use prior year data on attributes that may not be reasonable predictors of utilization, experience, costs, or risk. In order to prevent confusion on this issue, one commenter proposed adding the word ''demographic'' to the example, to read:

> An employer's contributions may reflect the demographic composition of enrollees according to attributes such as age, sex and family status* * *

2. *Response:* We do not believe that the Congress intended to limit to ''demographic factors'' the ''attributes'' employers may use in determining their contribution amount. The supporting committee reports suggest a broader concern: that employers be able to determine their contribution using a method that reflects the HMO's actual costs, so that the employers realize cost savings if their employees use fewer or less costly services. We believe that the critical language is the requirement that the attributes must be such as can reasonably be expected to predict utilization, experience, costs, and risks. Age, sex, and family status are given only as examples. In summary, if an employer can establish that a nondemographic attribute can reasonably be considered a predictor of those factors, it is acceptable. On the other hand, if an HMO can show that a particular health status factor cannot reasonably be considered to be a predictor, it is not acceptable. We do not believe it is necessary or appropriate for the regulations to elaborate further on the standard.

3. *Comment:* One commenter had additional questions about the application of nondemographic factors. He expressed concern about the validity and potential for abuse of employers' revising their HMO contribution amount on the basis of studies of health costs incurred by persons who switched from the employer's self-insured plan to an HMO, or on national data showing that HMOs receive favorable selection.

The commenter requested that HCFA provide more information about how prior use data may appropriately be used to predict future health care costs and thus be a legitimate factor in developing employer contributions by class. The commenter concluded by proposing that HCFA—

a. Establish guidelines as to the circumstances under which employers may make contribution decisions using data on prior utilization of employees who switch to an HMO, and require justification for such use;

b. Require employers to obtain prior HCFA approval for any method not allowed under the guidelines; and

c. Specify the minimum number of employees for whom data must be obtained, for the data to be considered statistically valid.

3. *Response:* As previously discussed, under the contribution by class method, any employee attribute used in an employer's contribution methodology must be one that can reasonably be expected to predict the health care utilization, experience, costs, or risk of those employees who are enrolling in the HMO. Health status attributes such as previous health care utilization and costs are generally accepted as predictors of future health care costs and are acceptable for employers to use in determining their contribution to an HMO.

The legislation requires that the employer's method for calculating the contribution be ''reasonable'' and ensure employees a ''fair choice'' among the plans offered. We believe that in order to meet the standard of being reasonable and ensuring employees a fair choice, the method of determining the employer's contribution must reflect a reasonable estimate of the cost of providing health care services for the actual enrollees of a particular HMO.

We also believe that the intent of the legislation is to provide employers with flexibility in determining their contribution methodology, as long as it meets the ''reasonable'' and ''fair choice'' standards. Therefore, we will not specify a minimum number of employees to be used in the calculations. Although we do not require prior approval, we do require the employer to make available to HCFA, upon request, information on how it calculates its contribution. If the HMO or the employees believe that the contribution does not meet the ''reasonable'' and ''fair choice'' standards, they may request that HCFA review the methodology.

4. *Comment:* Two commenters requested that HCFA provide guidance on possible exceptions to the principle that the ''contribution by class'' method should reflect the actual enrollment of each HMO.

The first commenter noted that it is not unusual for an employer to offer one or more indemnity plans and several HMOs to achieve HMO coverage over a broad enough area or for other reasons. In such cases, the commenter noted, it would be desirable for the employer to establish a single HMO contribution rate, even though the different HMOs may in fact charge different rates. To avoid compelling the employer to find a separate contribution for each HMO, the final regulations should treat the HMO contribution as acceptable if it meets the required standard with respect to any of the HMOs or with respect to the average of the HMO charges.

The second commenter was concerned that an employer might take the demographic data from all the HMOs it offered and come up with a single ''composite'' contribution amount for all of them. This commenter believed that a single ''composite'' contribution should not be allowed because the employer had not developed it on the basis of the expected demographic characteristics of the mandating HMO. The commenter noted that if the employer combines the demographic data of the mandating HMO with the data of another HMO or other health benefits plans it offers its employees, the employer would not be making an equal dollar contribution for each employee in a particular class.

4. *Response:* The basic rule is that the methodology must be reasonable and

must offer employees a fair choice among health benefit plans. As noted above, we take the position that it must reflect the actual attributes of each HMO's enrollment. It seems unlikely, for example, that an employer with employees in widely dispersed geographic areas, or in rural as well as urban areas could establish a ''composite'' contribution that would meet the standard. However, if an employer can show that in its particular situation, a composite amount would meet the standard, it could be acceptable. For example, all of the HMOs might be shown to serve the same general geographic area and attract the same type of enrollee. Absent such a showing, it would not be sufficient to meet the standard for a single HMO without considering the others.

We note that the second commenter objected to a composite contribution amount on the grounds that the employer would not be making an equal dollar contribution for all members of a particular class. Although the ''contribution by class'' method requires equal dollar amounts within each class, there could be other similar approaches that do not use equal dollar amounts but still meet the standard of reasonableness and fair choice.

B. Minimum Employee Contribution Method

5. *Comment:* One commenter suggested that example (iii), which states that the employer may require employees to contribute to the HMO an amount that does not exceed 50 percent of the employee contribution to the principal non-HMO alternative, include two additional limitations:

a. The minimum contribution requirement can be invoked only if an employee would otherwise have to pay little or nothing for the HMO plan.

b. The employee contribution may not exceed $20 per month.

5. *Response:* We agree with the commenter that the ''minimum employee contribution'' approach can be used only if the HMO coverage would otherwise be available at nominal or no cost. This is specifically stated in the legislative history and was implicit in the proposed rule. We are making it explicit in the final rule. However, we will not establish a $20 maximum because the Congress, in stating that it would be reasonable to set the limit for the required contribution at 50 percent of the contribution to the non-HMO alternative, established that amount as the maximum.

C. Miscellaneous Aspects

6. *Comment:* One commenter was concerned that the intent of the Congress that contribution arrangements not discriminate against the HMO is not evident in the regulation. The committee report language is essential to an understanding of the legislative intent. There should be a statement in the final regulation or preamble to the effect that it is not the intent of the law to allow practices that would be unfair or discriminatory to the HMO, and that such practices will not be permitted.

The commenter also suggested that the purpose of the HMO provisions and the examples set forth in the committee reports could provide a basis for HCFA to establish strict criteria for evaluating any method that results in the employer's paying less on behalf of an employee who enrolls in an HMO than on behalf of an employee who enrolls in a non-HMO alternative. The commenter urged that exceptions be narrowly construed and allowed only for compelling reasons. Otherwise, the underlying purpose for enactment of section 1310 of the PHS Act would be circumvented. The commenter recommended that we adopt the following factors as the basis for determining whether an employer contribution is reasonable and offers a fair choice:

- The method proposed by the employer must be consistent with the purposes of encouraging the effective and efficient delivery of health care services and reducing health care costs.
- Financial discrimination against employees who enroll in an HMO must be minimal and only to the extent necessary to accomplish the purposes.

Another commenter asked if a contribution method in which the employer contributed the difference between the employee contribution and the health plans' premiums resulting in employees having an equal expense whether they choose an HMO or a more expensive indemnity plan, would be prohibited by these proposed rules. The commenter stated that such a practice *clearly* discriminates in favor of the more expensive plan (typically a non-HMO plan) and thus unfairly discriminates against employees and the HMO.

6. *Response:* With respect to the first comment, section 1310(c) of the PHS Act does not mention discrimination against the HMO. The employer contribution is acceptable if it ''is reasonable and is designed to assure employees a fair choice among health benefits plans''. The legislative history cited by the commenter states that the new standard ''enhances employers' flexibility in determining their contributions to HMOs while protecting employees and HMOs from discriminatory and unfair contribution practices.'' (Sen. Rep. No. 100–304, H.R. Rep. No. 100–417) However, the fact that the statute does not contain the reference to the HMO indicates that this statement supports, at most, a balance of the interests of the three parties, with primary weight given to the employer and employee interests.

With respect to the suggestion that the HMO contribution cannot be less than the non-HMO contribution, unless it is shown to ''encourage effective and efficient delivery of health care'', we note that the legislative history clearly states that a dollar-for-dollar match is no longer required. Moreover, two of the examples provided in the legislative history *assume* that there will be an unequal contribution, and that it will be to the HMO's disadvantage. First, an employer can require employees to pay for their HMO coverage *even if the methodology would otherwise result in no cost to the employees.*

Similarly, the employer is permitted to contribute *equal percentages* of the cost for the HMO and non-HMO options. Under this method, an employer can contribute far more, in terms of dollars, for the non-HMO option than for the HMO option. For example, if the HMO costs $100 per month, and the indemnity plan costs $300, and the employer pays 90 percent of the cost, it will pay $90 for an employee who chooses an HMO, and $270 for an employee who chooses the indemnity plan. (For the employee, the difference between the two options is only $20.)

Therefore, we see no justification for imposing a stricter standard simply because the employer pays less for the HMO than the non-HMO option. In addition, the commenter's proposed ''efficiency and cost effectiveness'' standard is neither required by the statutory amendment nor, arguably, supported by its legislative history. The latter states only that section 1310 was designed to give employees an opportunity to choose an HMO alternative. It does not mention efficiency and cost effectiveness.

Finally, with respect to determinations that result in equal employee contributions for all alternatives, we believe that this approach is clearly one way to provide a ''fair choice'' to employees. Under this approach, employees can choose the health plan that best serves their needs. The commenter's primary concern seems to be that this approach is unfair

to employees if they cannot ''share in the savings'' of choosing an HMO. We note, first, that ''fairness'' is a subjective standard. As long as an approach can reasonably be viewed as fair, it satisfies the standard. That judgment is not invalidated simply because there may be a basis for characterizing it as unfair.

We note further that the legislative history makes clear that the amendment was, to a large extent, prompted by a concern that the HMOs were engaging in ''shadow pricing''. Under shadow pricing, the HMOs would charge the same premium as more expensive non-HMO alternatives instead of passing the savings along to either the employer *or* the employee. Therefore, the argument that equal employee contributions are unfair because employees cannot ''share in the savings'' (from choosing a lower cost HMO) is not compelling.

7. *Comment:* One commenter noted that § 417.157(a)(2) lists five contribution methods as acceptable, but there are no examples of unacceptable methods. Several commenters asked for more guidance to assist them in determining what would be acceptable.

Another commenter strongly suggested that the proposed rules be amended to provide examples of types of arrangements that would be considered to be discriminatory, and therefore prohibited, by these regulations.

7. *Response:* The employer contribution requirements provide employers enhanced flexibility in determining their contributions to HMOs and other health benefits plans they offer. The limits on that flexibility are established by the statutory language which requires that the method of determining the contribution be reasonable and not discriminate financially against employees who choose to join an HMO. In part, this new flexibility is recognition that HMOs need less regulatory protection because in recent years they have become more accepted by both employers and employees and are generally better able to compete with other health benefits plans.

As previously stated, if the HMO or the employees believe that the employer's contribution does not meet the ''reasonable'' and ''fair choice'' standards, they may request that HCFA review the methodology. Generally, HCFA will not undertake a review if the employer has followed one of the examples given in the regulation.

If the employer uses a methodology other than one of those examples, HCFA generally will not review unless the methodology results in significantly higher costs for employees who select the HMO alternative. If it undertakes review, HCFA will consider whether the employer's methodology is based on factors that are reasonable and are applied fairly. For example, if the HMO has a more comprehensive benefits package than the principle indemnity plan, that could be a reasonable factor justifying a higher cost for employees who enroll in the HMO.

We will not attempt to define all possible reasonable explanations that would justify a larger contribution from HMO enrollees. We note however, that the rationale must apply to the actual employees of the particular HMOs.

8. *Comment:* One of the commenters, while agreeing that employers can now make unequal contributions, stated that the right to make unequal contributions should require substantial justification, be narrowly construed, and allowed only for compelling reasons.

8. *Response:* We believe such stringent requirements are not in keeping with the flexibility the Congress intended employers to have. As noted below under Changes in the Regulations, the final rule requires the employer to make available to HCFA, upon request, a description of the methodology it used to determine its contributions, and related data on the eligible employee population. HCFA may request the data on its own initiative or because an HMO or employee requests HCFA to review the methodology.

A contribution methodology that results in different contributions to different plans in order to ensure that employees have the same out-of-pocket costs, no matter which plan they choose, is consistent with the standards and would, therefore, be acceptable.

9. *Comment:* One commenter suggested that any method that does not fall into one of the first four examples provided in the regulation should be required to fall into the fifth example—the method must be mutually acceptable to both the employer and the HMO.

9. *Response:* The five examples of acceptable contribution methods listed under § 417.157(a)(2) are not meant to be exclusive. We note that the intent of the legislation is to allow employers increased flexibility in determining their contribution payment amounts. Accordingly, we will not restrict feasible contribution methodologies beyond the requirements already described.

10. *Comment:* One commenter noted that the last of the five examples under § 417.157(a)(2) allows for employers and HMOs to negotiate contribution arrangements that are mutually acceptable. The commenter goes on to ask if such mutually-agreed-upon arrangements must also meet the statutory standards of the proposed employer contribution regulation.

10. *Response:* Contribution levels that are mutually agreed upon by the employer and the HMO must also meet the standards established by this regulation.

V. Changes in the Regulations

A. Changes Required by the Expiration of the ''Employer Mandate'' Provisions Effective October 24, 1995

In § 417.151, we have revised paragraphs (a) and (e) to make clear that, effective October 24, 1995, inclusion of the HMO alternative in an employer's health benefits plan became optional.

We have removed §§ 417.152 and 417.154 because they would no longer be applicable.

In § 417.153, we have revised paragraph (a) to make paragraphs (b) and (c) applicable when an employing entity voluntarily includes one or more HMOs in its health plan offerings.

We have revised § 417.159 to make clear that inclusion of HMOs is at the employing entity's option.

B. Changes to Implement Statutory Amendments That Were Effective Upon Enactment.

In § 417.157, we have—

- Revised paragraphs (a)(1) and (a)(2) to eliminate the ''equal contribution'' requirement and to incorporate the criteria specified in the statute;
- Revised paragraph (a)(3) to remove the requirement for increased contribution to the HMO and to give examples of contributions that would be considered nondiscriminatory;
- Added a paragraph (a)(4) ''Adjustment of employer contribution'' to make clear that what appeared in the proposed rule as a third ''method'' is rather a general rule applicable, under specified circumstances, to a contribution determined by any acceptable method. Adjustment is permitted only when HMO enrollees would, otherwise, have to pay little or nothing at all because the HMO premium is lower than the premiums of other plans offered. The payment by the enrollee could not exceed 50 percent of the payment for the principal non-HMO alternative, that is, the alternative that covers the largest number of the employer's employees.
- Removed paragraphs (f) and (g) as inconsistent with the revised policy; and
- In response to certain comments, revised the content of paragraph (h) and redesignated it under new paragraphs (f) and (g).

VI. Regulatory Impact Statement

Consistent with the Regulatory Flexibility Act (RFA) and section 1102(b) of the Social Security Act, we prepare a regulatory flexibility analysis for each rule, unless the Secretary certifies that the particular rule will not have a significant economic impact on a substantial number of small entities, or a significant impact on the operations of a substantial number of small rural hospitals.

The RFA defines ''small entity'' as a small business, a nonprofit enterprise, or a governmental jurisdiction (such as a county, city, or township) with a population of less than 50,000. We also consider all HMOs to be small entities. For purposes of section 1102(b) of the Act, we define ''small rural hospital'' as a hospital that has fewer than 50 beds and is located anywhere but in a metropolitan statistical area.

For reasons noted below, we believe that any economic impact of the statutory provisions on which this rule is based will be small and transitory.

Effective as of October 24, 1995, inclusion of HMOs in employer health plan offerings became voluntary.

Employers that do include HMOs are no longer held to the previous ''dollar for dollar'' rule. An employer could, for example, base its contribution to an HMO on a reasonable estimate of what it will cost to provide care for its employees, and thus share in the savings resulting from efficient delivery of health care by the HMO.

However, the employer's contribution must meet new standards, that is, it must be an amount that is ''reasonable'' and that ensures employees a ''fair choice'' among health plan alternatives offered. This balanced approach means that, while employers benefit from greater flexibility, employees—and the HMOs they are free to join, are protected against discrimination.

We have not prepared a regulatory flexibility analysis because we have determined, and the Secretary certifies, that these rules will not have a significant economic impact on a substantial number of small entities or a significant impact on the operation of a substantial number of small rural hospitals.

In accordance with Executive Order 12866, this rule was reviewed by the Office of Management and Budget.

VII. Collection of Information Requirements

This rule contains new information collections that are subject to review by the Office of Management (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 through 3511). The title and description of the information collection and the description of respondents are shown below with an estimate of the annual reporting and recordkeeping burden.

§ 417.157(f): *Retention and availability of data,* is revised to specify that each employing entity or designee must retain the plan data for three years and make it available to HCFA upon request. The data must be that used to compute the level of contribution for each of the plans offered to employees, a description of the methodology for computing the level of contribution, and any related data about the employees who are eligible to enroll in a plan.

§ 417.157(g): *HCFA review of data,* is revised to make clear that HCFA may request and review the data specified in paragraph (f) of this section on its own initiative or in response to requests from HMOs or employees. The purpose of HCFA's review is to determine whether the methodology and the level of contribution comply with the requirements of this subpart. HMOs and employees that request HCFA to review the plan data must set forth reasonable grounds for making the request.

The respondents affected by section 417.157, paragraphs (f) and (g) are public and private employers and employees.

The burden under paragraphs (f) and (g) of section 417.157 is estimated at 8 to 10 hours per employer for compiling the data, usually once a year, and making it available to HCFA when requested.

The agency has submitted a copy of this rule to OMB for its review of these information collections. When OMB approves these provisions, we will publish a notice in the Federal Register to that effect.

We invite comments regarding this burden estimate or any other aspect of these collections of information, including any of the following:

- Whether the information collection is necessary and useful for carrying out the proper functions of the agency;
- the accuracy of the estimated burden;
- ways to enhance the quality, clarity, and usefulness of the information to be collected; and,
- recommendations for using automated collection techniques or other forms of information technology to minimize the information collection burden.

Please send any comments to HCFA, OFHR, MPAS, C2–26–17, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

List of Subjects in 42 CFR Part 417

Administrative practice and procedure, Grant programs-health, Health care, Health facilities, Health insurance, Health maintenance organizations (HMO), Loan programs-health, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 417 is amended as set forth below:

1. The authority citation for part 417 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh); secs. 1301, 1306, and 1310 of the Public Health Services Act (42 U.S.C. 300e, 300e–5, and 300e–9); and 31 U.S.C. 9701.

2. § 417.151 is amended to revise paragraphs (a) and (e) to read as follows:

§ 417.151 Applicability.

(a) *Basic rule.* Effective October 24, 1995 [1], this subpart applies to any employing entity that offers a health benefits plan to its employees, meets the conditions specified in paragraphs (b) through (e) of this section, and elects to include one or more qualified HMOs in the health plan alternatives it offers its employees.

* * * * *

(e) *Employees in HMO's service area.* At least 25 of the employing entity's employees reside within the HMO's service area.

§ 417.152 [Removed]

3. Section 417.152 is removed.

4. Section 417.153 is amended to revise the heading and paragraph (a) to read as follows:

§ 417.153 Offer of HMO alternative.

(a) *Basic rule.* An employing entity that is subject to this subpart and that elects to include one or more qualified HMOs must offer the HMO alternative in accordance with this section.

* * * * *

§ 417.154 [Removed]

5. Section 417.154 is removed.

6. Section 417.157 is revised to read as follows:

§ 417.157 Contributions for the HMO alternative.

(a) *General principles*—(1) *Nondiscrimination.* The employer contribution to an HMO must be in an amount that does not discriminate financially against an employee who

[1] Before October 24, 1995, an employing entity that met the conditions specified in § 417.151 was required to include one or more qualified HMOs, if it received from at least one qualified HMO a written request for inclusion and that request met the timing, content, and procedural requirements specified in § 417.152.

enrolls in an HMO. A contribution does not discriminate financially if the method of determining the contribution is reasonable and is designed to ensure that employees have a fair choice among health benefits plan alternatives.

(2) *Effect of agreements or contracts.* The employing entity or designee is not required to pay more for health benefits as a result of offering the HMO alternative than it would otherwise be required to pay under a collective bargaining agreement or contract that provides for health benefits and is in effect at the time the HMO alternative is included.

(3) *Examples of acceptable employer contributions.* The following are methods that are considered nondiscriminatory:

(i) The employer contribution to the HMO is the same, per employee, as the contribution to non-HMO alternatives.

(ii) The employer contribution reflects the composition of the HMO's enrollment in terms of enrollee attributes that can reasonably be used to predict utilization, experience, costs, or risk. For each enrollee in a given class established on the basis of those attributes, the employer contributes an equal amount, regardless of the health benefits plan chosen by the employee.

(iii) The employer contribution is a fixed percentage of the premium for each of the alternatives offered.

(iv) The employer contribution is determined under a mutually acceptable arrangement negotiated by the HMO and the employer. In negotiating the arrangement, the employer may not insist on terms that would cause the HMO to violate any of the requirements of this part.

(4) *Adjustment of employer contribution.* An employer contribution determined by an acceptable method may in some cases be adjusted if it would result in a nominal payment or no payment at all by HMO enrollees (because the HMO premium is lower than the premiums for the other alternatives offered). If, for example the employer has a policy of requiring all employees to contribute to their health benefits plan, the employer may require HMO enrollees who would otherwise pay little or nothing at all, to make a payment that does not exceed 50 percent of the employee contribution to the principal non-HMO alternative. The principal non-HMO alternative is the one that covers the largest number of enrollees from the particular employer.

(b) *Administrative expenses.* (1) In determining the amount of its contribution to the HMO, the employing entity or designee may not consider administrative expenses incurred in connection with offering any alternative in the health benefits plan.

(2) However, if the employing entity or designee has special requirements for other than standard solicitation brochures and enrollment literature, it must, in the case of the HMO alternative, determine and distribute any administrative costs attributable to those requirements in a manner consistent with its method of determining and distributing those costs for the non-HMO alternatives.

(c) *Exclusion for contribution for certain benefits.* In determining the amount of the employing entity's contribution or the designee's cost for the HMO alternative, the employing entity or designee may exclude those portions of the contribution allocable to benefits (such as life insurance or insurance for supplemental health benefits)—

(1) For which eligible employees and their eligible dependents are covered notwithstanding selection of the HMO alternative; and

(2) That are not offered on a prepayment basis by the HMO to the employing entity's employees.

(d) *Contributions determined by agreements or contracts or by law.* If the specific amount of the employing entity's contribution for health benefits is fixed by an agreement or contract, or by law, that amount constitutes the employing entity's obligation for contribution toward the HMO premiums.

(e) *Allocation of portion of a contribution determined by an agreement.* In some cases, the employing entity's contribution for health benefits is determined by an agreement that also provides for benefits other than health benefits. In that case, the employing entity must determine, or instruct its designee to determine, what portion of its contribution is applicable to health benefits.

(f) *Retention and availability of data.* Each employing entity or designee must retain the following data for three years and make it available to HCFA upon request:

(1) The data used to compute the level of contribution for each of the plans offered to employees.

(2) Related data about the employees who are eligible to enroll in a plan.

(3) A description of the methodology for computation.

(g) *HCFA review of data.* (1) HCFA may request and review the data specified in paragraph (f) of this section on its own initiative or in response to requests from HMOs or employees.

(2) The purpose of HCFA's review is to determine whether the methodology and the level of contribution comply with the requirements of this subpart.

(3) HMOs and employees that request HCFA to review must set forth reasonable grounds for making the request.

7. In § 417.155(d)(2) introductory text, ''which'' is removed and ''that'' is added in its place.

8. In § 417.159, ''The obligation'' is revised to read ''The decision'', and ''HMO option'' is revised to read ''HMO alternative''.

9. In the heading of § 417.164, ''qualifiers'' is removed and ''qualification'' is added in its place.

10. In § 417.166(a)(1), ''change'' is removed and ''changed'' is added in its place.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: August 14, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: December 5, 1995.

Donna E. Shalala,

Secretary.

[FR Doc. 96–13629 Filed 5–30–96; 8:45 am]

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DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

49 CFR Part 571

[Docket No. 96–050; Notice 1]

RIN 2127–AG31

Federal Motor Vehicle Safety Standards; Air Brake Systems

AGENCY: National Highway Traffic Safety Administration (NHTSA), DOT.

ACTION: Final rule; technical amendment.

SUMMARY: This document revises Standard No. 121, *Air brake systems* to remove obsolete provisions and to update and reorganize the standard. This revision substantially clarifies and simplifies this safety standard without changing any of its substantive requirements.

EFFECTIVE DATE: This rule is effective March 1, 1997.

FOR FURTHER INFORMATION CONTACT: Mr. Richard Carter, Office of Vehicle Safety Standards, NPS–11, National Highway Traffic Safety Administration, 400 Seventh Street, SW., Washington, DC