(7) From subsections (e)(4) (G) and (H) because this system is exempt from the individual-access provisions of subsection (d) pursuant to subsections (j) and (k) of the Privacy Act.

(8) From subsection (e)(4)(I) because the categories of sources of records in this system have been published in the **Federal Register** in broad generic terms in the belief that this is all that subsection (e)(4)(I) of the Act requires. In the event, however, that this subsection should be interpreted to require more detail as to the identity of sources of the records in these systems, exemption from this provision is necessary in order to protect the confidentiality of the sources of criminal and other law-enforcement information. Such exemption is further necessary to protect the privacy and physical safety of witnesses and informants.

(9) From subsection (e)(8) because the individual-notice requirements of subsection (e)(8) could present a serious impediment to law enforcement through interference with the Office of Independent Counsel's ability to issue subpoenas and the disclosure of its investigative techniques and procedures.

(10) From subsection (f) because this system is exempt from the individual-access provisions of subsection (d) pursuant to subsections (j) and (k) of the Privacy Act. Furthermore, such notice to an individual would be detrimental to the successful conduct and/or completion of an investigation or prosecution pending or future.

(11) From subsection (g) because this system is exempt from the individual-access and amendment provisions of subsection (d) and the provisions of subsection (f) pursuant to subsections (j) and (k) of the Privacy Act.

(c) The following system of records is exempt from 5 U.S.C. 552a(c) (3) and (4), (d), (e) (1), (2) and (3), (e)(4), (G), (H) and (I); (e) (5) and (8); (f) and (g):

(1) Freedom of Information Act/ Privacy Act Files (OIC/002). These exemptions apply to the extent that information in this system is subject to exemption pursuant ot 5 U.S.C. 552a(j)(2), (k)(1), (k)(2,) and (k)(5).

(d) Because this system contains Office of Independent Counsel criminal law-enforcement investigatory records, exemptions from the particular subsections are justified for the following reasons:

(1) From subsection (c)(3) because the release of the disclosure accounting would permit the subject(s) of criminal investigations under investigation or in litigation to obtain valuable information concerning the nature of that investigation, matter or case and present a serious impediment to law-enforcement activities.

(2) From subsection (c)(4) because an exemption is being claimed for subsection (d) of the Act, rendering this subsection inapplicable to the extent that this system of records is exempted from subsection (d).

(3) From subsection (d) because access to the records contained in this system would inform the subject of criminal investigation or case of the existence of such, and provide the subject with information that might enable him to avoid detection, apprehension or legal obligations, and present a serious impediment to law enforcement and other civil remedies. Amendment of the records would interfere with ongoing criminal law-enforement proceedings and impose an impossible administrative burden.

(4) From subsection (e)(1) because in the courses of criminal investigations, matters or cases, the Office of Independent Counsel often obtains information concerning the violation of laws other than those relating to an active case, matter, or investigation. In the interests of effective law enforcement and criminal litigation, it is necessary that the Office of Independent Counsel retain this information since it can aid in establishing patterns of activity and provide valuable leads for future cases that may be brought within the Office of Independent Counsel.

(5) From subsection (e)(2) because collecting information to the greatest extent possible from the subject individual of a criminal investigation or prosecution would present a serious impediment to law enforcement. In such circumstances, the subject of the investigation would be placed on notice of the existence of the investigation and would therefore be able to avoid detection, apprehension, or legal obligations and duties.

(6) From subsection (e)(3) because providing individuals supplying information with a form stating the requirements of subsection (e)(3) would constitute a serious impediment to law enforcement. In those circumstances, it could compromise the existence of a confidential investigation, reveal the identity of confidential sources of information, and endanger the life and physical safety of confidential informants.

(7) From subsection (e)(4) (G), (H) and (I) because this system of records is exempt from the individual-access and amendment provisions of subsection (d) and the rules provisions of subsection (f).

(8) From subsection (e)(5) because, in the collection of information for law-enforcement purposes, it is impossible to determine in advance what information is accurate, relevant, timely, and complete. With the passage of time, seemingly irrelevant or untimely information may acquire new significance as further investigation brings new details to light and the accuracy of such information can only be determined in a court of law. The restrictions of subsection (e)(5) would inhibit the ability of trained investigators and intelligence analysts to exercise their judgment in reporting on investigations and impede the development of intelligence necessary for effective law enforcement.

(9) From subsection (e)(8) because the individual-notice requirements of subsection (e)(8) could present a serious impediment to law enforcement, i.e., this could interfere with the Office of Independent Counsel's ability to issue subpoenas and could reveal investigative techniques and procedures.

(10) From subsection (f) because this system has been exempted from the individual-access and amendment provisions of subsection (d).

(11) From subsection (g) because the records in this system are generally compiled for law-enforcement purposes and are exempt from the individual-access and amendment provisions of subsections (d) and (f), this rendering subsection (g) inapplicable.

[FR Doc. 87-29069 Filed 12-17-87; 8:45 am]
BILLING CODE 2210-01-M

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Part 1952

[Docket No. T-022]

South Carolina State Plan; Final Approval Determination

AGENCY: Occupational Safety and Health Administration (OSHA), Labor.

ACTION: Final State Plan Approval.

SUMMARY: This document amends Subpart C of 29 CFR Part 1952 to reflect the Assistant Secretary's decision granting final approval to the South Carolina State plan. As a result of this affirmative determination under section 18(e) of the Occupational Safety and Health Act of 1970, Federal OSHA standards and enforcement authority no longer apply to occupational safety and health issues covered by the South Carolina plan, and authority for Federal concurrent jurisdiction is relinquished.

Federal enforcement jurisdiction is retained over private sector maritime and employment on military bases. Federal jurisdiction remains in effect with respect to Federal Government employers and employees.

EFFECTIVE DATE: December 15, 1987.

FOR FURTHER INFORMATION CONTACT: James Foster, Director, Office of Information and Consumer Affairs, Occupational Safety and Health Administration, U.S. Department of Labor, Room N–3637, 200 Constitution Avenue, NW., Washington, DC 20210. Telephone (202) 523–8148.

SUPPLEMENTARY INFORMATION:

Introduction

Section 18 of the Occupational Safety and Health Act of 1970 (the "Act") provides that States which desire to assume responsibility for the development and enforcement of occupational safety and health standards may do so by submitting, and obtaining Federal approval of, a State plan. Procedures for State plan submission and approval are set forth in regulations at 29 CFR Part 1902. If the Assistant Secretary, applying the criteria set forth in section 18(c) of the Act and 29 CFR Parts 1902.3 and 1902.4, finds that the plan provides or will provide for State standards and enforcement which are "at least as effective" as Federal standards and enforcement, initial approval is granted.

A State may commence operations under its plan after this determination is made, but the Assistant Secretary retains discretionary Federal enforcement authority during the initial approval period as provided by section 18(e) of the Act. A State plan may receive initial approval even though, upon submission, it does not fully meet the criteria set forth in 29 CFR 1902.3 and 1902.4 if it includes satisfactory assurances by the State that it will take the necessary "developmental steps" to meet the criteria within a 3-year period. 29 CFR 1902.2(b). The Assistant Secretary publishes a notice of "certification of completion of developmental steps" when all of a State's developmental commitments have been satisfactorily met. 29 CFR 1902.34.

When a State plan that has been granted initial approval is developed sufficiently to warrant a suspension of concurrent Federal enforcement activity, it becomes eligible to enter into an "operational status agreement" with OSHA. 29 CFR 1954.3(f). A State must have enacted its enabling legislation, promulgated State standards, achieved an adequate level of qualified personnel, and established a system for review of contested enforcement actions. Under these voluntary agreements, concurrent Federal enforcement will not be initiated with regard to Federal occupational safety and health standards in those issues covered by the State plan, where the State program is providing an acceptable level of protection.

Following the initial approval of a complete plan, or the certification of a developmental plan, the Assistant Secretary must monitor and evaluate actual operations under the plan for a period of at least one year to determine, on the basis of actual operations under the plan, whether the criteria set forth in section 18(c) of the Act and 29 CFR 1902.3, 1902.4 and 1902.37 are being applied. An affirmative determination under section 18(e) of the Act (usually referred to as "final approval" of the State plan) results in the relinquishment of authority for Federal concurrent jurisdiction in the State with respect to occupational safety and health issues covered by the plan. 29 U.S.C. 667(e). To enable OSHA to evaluate State performance in relation to the foregoing criteria, State participation in OSHA's computerized Integrated Management Information System is required.

An additional requirement for final approval consideration is that a State must meet the compliance staffing levels, or benchmarks, for safety and health compliance officers established by OSHA for that State. This requirement stems from a 1978 Court Order by the U.S. District Court for the District of Columbia (*AFL–CIO* v. *Marshall*, C.A. No. 74–406), pursuant to a U.S. Court of Appeals decision, that directed the Assistant Secretary to calculate for each State plan state the number of enforcement personnel needed to assure a "fully effective" enforcement program.

History of the South Carolina Plan and Its Compliance Staffing Benchmarks

South Carolina Plan

On May 8, 1972, South Carolina submitted an occupational safety and health plan in accordance with section 18(b) of the Act and 29 CFR Part 1902, Subpart C. On May 24, 1972, a notice was published in the **Federal Register** (37 FR 10535) concerning submission of the plan, announcing that initial Federal approval was at issue and offering interested persons an opportunity to submit data, views and arguments concerning the plan. Because of the wide interest anticipated in the first State plan proposals, notice was also given that an informal public hearing on the plan would be held on July 10, 1972, in Columbia, South Carolina.

In response to comments on South Carolina's initial submission notice and testimony received at the informal hearing, the State submitted modifications to the plan on September 13, 1972. Notice of receipt of the modifications and an invitation for public comments on the plan as modified, as well as an opportunity to request an informal hearing, was published in the **Federal Register** on September 28, 1972 (37 FR 20289). Comments on the amended plan were received from the American Federation of Labor-Congress of Industrial Organizations (AFL–CIO). In response to these comments as well as OSHA's review of the plan modifications, South Carolina made additional changes in its plan. Since there were no objections which were outstanding on the plan, as amended, no further public hearing was held.

On December 6, 1972, the Assistant Secretary published a notice granting initial approval of the South Carolina plan as a developmental plan under section 18(b) of the Act (37 FR 25932). The plan provides for a program patterned in most respects after that of the Federal Occupational Safety and Health Administration.

The South Carolina State plan covers all occupational safety and health issues except private sector maritime employment, and employment on military bases. The South Carolina Department of Labor is designated as having responsibility for administering the plan throughout the State. The day-to-day administration of the plan is directed by the South Carolina Division of Occupational Safety and Health.

The plan provides for the initial adoption by South Carolina of all Federal occupational safety and health standards, contained in 29 CFR Parts 1910, 1926, and 1928, and for the adoption of future Federal standards after public hearings. The plan requires employers to furnish employment and a place of employment which is free from recognized hazards that are causing or are likely to cause death or serious physical harm, and to comply with all occupational safety and health standards promulgated by the agency. Employees are likewise required to comply with all standards and regulations applicable to their conduct. The plan contains provisions similar to Federal procedures governing emergency temporary standards; imminent danger proceedings; coverage under the general duty clause; variances; safeguards to protect trade

secrets; protection of employees against discrimination for exercising their rights under the plan; and employer and employee rights to participate in inspection and review proceedings. Appeals of citations, penalties and abatement periods are heard by the South Carolina Occupational Health and Safety Review Board. Decisions of the Review Board may be appealed to the Court of Common Pleas.

The notice of initial approval noted a few distinctions between the Federal and South Carolina Programs. The State plan does not cover safety and health in private sector maritime employment or employment on military bases.

The Assistant Secretary's initial approval of the South Carolina developmental plan, a general description of the plan, a schedule of required developmental steps and a provision for discretionary concurrent Federal enforcement during the period of initial approval were codified in the Code of Federal Regulations (29 CFR Part 1952, Subpart C; 37 FR 25932 (December 6, 1972)).

In accordance with the State's developmental schedule, all major structural components of the plan were put in place and appropriate documentation submitted for OSHA approval during the three-year period ending December 31, 1975. These "developmental steps" included: amendments to the South Carolina Occupational Safety and Health Act; promulgation of State occupational safety and health standards and program regulations; and establishment of a public employee program. In completing these developmental steps, the State developed and submitted for Federal approval all components of its enforcement program including, among other things, legislative amendments, management information system, merit staffing system, regulations for inspections, citations and proposed penalties, recordkeeping and reporting regulations, and a safety and health poster for private and public employees.

These submissions were carefully reviewed by OSHA; after opportunity for public comment and modification of State submissions, where appropriate, the major plan elements were approved by the Assistant Secretary as meeting the criteria of section 18 of the Act and 29 CFR 1902.3 and 1902.4. The South Carolina subpart of 29 CFR Part 1952 was amended to reflect each of these approval determinations (see 29 CFR 1952.94).

On May 9, 1975, OSHA entered into an operational status agreement with the State of South Carolina. A **Federal Register** notice was published on June 26, 1975 (40 FR 27024), announcing the signing of the agreement. (The agreement was subsequently amended, 49 FR 30173, July 27, 1984.) Under the terms of that agreement, OSHA voluntarily suspended the application of concurrent Federal enforcement authority with regard to Federal occupational safety and health standards in all issues covered by the South Carolina plan.

On August 3, 1976, in accordance with procedures at 29 CFR 1902.34 and 1902.35, the Assistant Secretary certified that South Carolina had satisfactorily completed all developmental steps (41 FR 32424). In certifying the plan, the Assistant Secretary found the structural features of the program—the statue, standards, regulations, and written procedures for administering the plan—to be at least as effective as corresponding Federal provisions. Certification does not entail findings or conclusions by OSHA concerning adequacy of actual plan performance. As has already been noted, OSHA regulations provide that certification initiates a period of evaluation and monitoring of State activity to determine, in accordance with section 18(e) of the Act, whether the statutory and regulatory criteria for State plans are being applied in actual operations under the plan and whether final approval should be granted.

On January 31, 1978 OSHA published notice in the **Federal Register** (43 FR 4073) requesting public comment on a petition requesting withdrawal of OSHA approval of the South Carolina plan. The petition was submitted by the President of the Carolina Brown Lung Association. A second petition was subsequently filed by the national American Federation of Labor-Congress of Industrial Organizations (AFL–CIO). On April 21, 1978 notice was published in the **Federal Register** (43 FR 17003) requesting public comments on the AFL–CIO petition to withdraw approval of the South Carolina State Plan and providing an additional time period for public comment on the Carolina Brown Lung Association petition, which was requested by the South Carolina General Assembly's Textile Studies Subcommittee. Both petitions alleged specific performance deficiencies in enforcement of the cotton dust standard and prosecution of contested cotton dust cases and in such other areas as hazard recognition, review procedures, inspection scheduling, health referrals, and response to major Federal Program changes. In addition, the Carolina Brown Lung Association petition alleged deficiencies in employee training and education, and the AFL–CIO petition alleged legislative and regulatory deficiencies.

OSHA's investigation of all allegations contained in the petitions revealed that charges of legislative and regulatory deficiencies were unfounded. Although the South Carolina Act does not mirror the Federal Act, the South Carolina Plan, along with its implementing regulations, provide coverage and employee rights comparable to that of the Federal Act. In addition, OSHA's investigation revealed that where performance deficiencies existed, they had been corrected or considerable improvement had been demonstrated by South Carolina, especially since the filing of the petitions. Based on the findings of OSHA's investigation, a **Federal Register** notice (44 FR 13013) was published on March 9, 1979, which denied both petitions to withdraw approval of the South Carolina State Plan.

South Carolina Benchmarks

In 1978, the Assistant Secretary was directed by the U.S. District Court for the District of Columbia (*AFL–CIO* v. *Marshall*, C.A. No. 74–406), pursuant to a U.S. Court of Appeals decision, to calculate for each State plan State the number of enforcement personnel (compliance staffing benchmarks) needed to assure a "fully effective" enforcement program. In 1980, OSHA submitted a Report to the Court containing the benchmarks and requiring South Carolina to allocate 39 safety compliance officers and 60 industrial hygienists to conduct inspections under the plan.

In September 1984 the South Carolina State designee in conjunction with OSHA completed a review of the components and requirements of the 1980 compliance staffing benchmarks established for South Carolina. Pursuant to an initiative begun in August 1983 by the State plan designees as a group with OSHA, and in accord with the formulas and general principles established by that group for individual State revision of the benchmarks, South Carolina reassessed the staffing necessary for a "fully effective" occupational safety and health program in the State. This reassessment resulted in a proposal to OSHA contained in comprehensive documents of revised staffing benchmarks of 17 safety and 12 health compliance officers. After the opportunity for public comment and service on the AFL–CIO, the Assistant Secretary approved these revised staffing requirements on January 17, 1986 (51 FR 2481).

History of the Present Proceedings

Procedures for final approval of State plans are set forth at 29 CFR Part 1902, Subpart D. On September 25, 1987, OSHA published notice (52 FR 36048) of the eligibility of the South Carolina State plan for determination under section 18(e) of the Act as to whether final approval of the plan should be granted. The determination of eligibility was based on monitoring of State operations for at least one year following certification, State participation in the Federal-State Integrated Management Information System, and staffing which meets the revised State staffing benchmarks.

The September 25 **Federal Register** notice set forth a general description of the South Carolina plan and summarized the results of Federal OSHA monitoring of State operations during the period from December 1, 1985 through January 31, 1987. In addition to the information set forth in the notice itself, OSHA submitted, as part of the record in this rulemaking proceeding, extensive and detailed exhibits documenting the plan, including copies of the State legislation, administrative regulations and procedural manuals under which South Carolina operates its plan, and copies of all previous **Federal Register** notices regarding the plan.

A copy of the December 1985–January 1987 Evaluation Report of the South Carolina plan ("18(e) Evaluation Report"), which was extensively summarized in the September 25 proposal and which provided the principal factual basis for the proposed 18(e) determination, was included in the record. Copies of all OSHA evaluation reports on the plan since its certification as having completed all developmental steps were made part of the record.

To assist and encourage public participation in the 18(e) determination, copies of the complete record were maintained in the OSHA Docket Office in Washington, DC, in the OSHA Region IV Office in Atlanta, Georgia, and the South Carolina Department of Labor in Columbia. Summaries of the September 25 proposal, with an invitation for public comments were published in South Carolina on October 2, 1987.

The September 25 proposal invited interested persons to submit, by October 30 written comments and views regarding the South Carolina plan, and whether final approval should be granted.

An opportunity to request an informal public hearing also was provided. One hundred and twenty-seven (127) comments were received in response to this notice. No requests for an informal hearing were received.

Summary and Evaluation of Comments Received

During this proposed rulemaking OSHA has encouraged interested members of the public to provide information and views regarding operations under the South Carolina plan, to supplement the information already gathered during OSHA monitoring and evaluation of plan administration.

In response to the September 25 **Federal Register** notice, OSHA received comments from 109 private employers, 12 State and local government entities, 1 consulting firm (2 comments), 2 safety associations, 1 attorney on behalf of one of the above-referenced safety associations, and 1 university.

All of the one-hundred and twenty-seven (127) comments expressed support for final approval on the grounds of State competence, responsiveness, and specific knowledge of local conditions. Several of these comments indicated that the State has established an outstanding safety and health program without adversarial relations with local industries, and that a climate of working together has gone far to stop costly accidents and to protect workers in South Carolina. Comments further express preference for State enforcement rather than Federal, because State inspectors are better able to deal with State-specific concerns. The comments also praise the State's effectiveness in reducing workplace injuries and illnesses, and praise the competency of South Carolina officials.

One initial comment (which was later updated) received from the consulting firm found fault with the State's response to asbestos hazards. The updated letter recommended final approval of the plan and indicated that the previous comments were only constructive suggestions for improvement of the South Carolina program.

Edgar L. McGowan, Commissioner of the South Carolina Department of Labor, responded to the initial comment made by the consulting firm regarding South Carolina's performance in the area of protection of workers and the public in asbestos removal. The response indicated that during fiscal years 1985, 1986 and 1987 (ending June 30) the State inspected 68 asbestos removal sites. The response also indicated that the State cooperates closely with the Department of Health and Environmental Control (DHEC), which has the responsibility of training removers, receiving notification of contracts, and inspecting the sites to assure public protection.

Findings and Conclusions

As required by 29 CFR 1902.41, in considering the granting of final approval to a State plan, OSHA has carefully and thoroughly reviewed all information available to it on the actual operation of the South Carolina State plan. This information has included all previous evaluation findings since certification of completion of the State plan's developmental steps, especially data for the period of December 1, 1985 through January 31, 1987 and information presented in written submissions. Findings and conclusions in each of the areas of performance are as follows:

(1) *Standards.* Section 18(c)(2) of the Act requires State plans to provide for occupational safety and health standards which are at least as effective as Federal standards. Such standards where not identical to the Federal must be promulgated through a procedure allowing for consideration of all pertinent factual information and participation of all interested persons (29 CFR 1902.4(b)(2)(iii); must, where dealing with toxic materials or harmful physical agents, assure employee protection throughout his or her working life (29 CFR 1902.4(b)(2)(i)); must provide for furnishing employees appropriate information regarding hazards in the workplace through labels, posting, medical examinations, etc. (29 CFR 1902.4(b)(2)(vi)); must require suitable protective equipment, technological control, monitoring, etc. (29 CFR 1902.4(b)(2)([(vii)); and where applicable to a product must be required by compelling local conditions and not pose an undue burden on interstate commerce (29 CFR 1902.3(c)(2)).

As documented in the approved South Carolina State plan and OSHA's evaluation findings made a part of the record in this 18(e) determination proceeding, and as discussed in the September 25 notice, the South Carolina plan provides for the adoption of standards and amendments thereto which are in most cases identical to Federal standards. The State's law and regulations, previously approved by OSHA and made a part of the record in this proceeding include provisions addressing all of the structural requirements for State standards set out in 29 CFR Part 1902.

In order to qualify for final State plan approval, a State program must be found to have adhered to its approved procedures (29 CFR 1902.37(b)(2)); to have timely adopted identical or at least

as effective standards, including emergency temporary standards and standards amendments (29 CFR 1902.37(b)(3)); to have interpreted its standards in a manner consistent with Federal interpretations and thus to demonstrate that in actual operation State standards are at least as effective as the Federal (29 CFR 1902.37(b)(4)); and to correct any deficiencies resulting from administrative or judicial challenge of State standards (29 CFR 1902.37(b)(5)).

As noted in the "18(e) Evaluation Report" and summarized in the September 25, 1987 **Federal Register** notice, South Carolina has generally adopted standards in a timely manner which are identical to Federal standards.

When a State adopts Federal standards, the State's interpretation and application of such standards must ensure consistency with Federal interpretation and application. South Carolina has generally adopted standards interpretations, which are at least as effective as the Federal. OSHA's monitoring has found that the State's application of its standards is comparable to Federal standards application. No challenges to standards have occurred in South Carolina.

Therefore, in accordance with section 18(c)(2) of the Act and the pertinent provisions of 29 CFR 1902.3, 1902.4 and 1902.37, OSHA finds the South Carolina program in actual operation to provide for standards adoption, correction when found deficient, interpretation and application, in a manner at least as effective as the Federal program.

(2) *Variances.* A State plan is expected to have the authority and procedures for the granting of variances comparable to those in the Federal program (29 CFR 1902.4(b)(2)(iv)). The South Carolina State plan contains such provisions in both law and regulations which have been previously approved by OSHA. In order to qualify for final State plan approval permanent variances granted must assure employment equally as safe and healthful as would be provided by compliance with the standard (29 CFR 1902.37(b)(6)); temporary variances granted must assure compliance as early as possible and provide appropriate interim employee protection (29 CFR 1902.37(b)(7)). As noted in the 18(e) Evaluation Report and the September 25 notice, four permanent variances were granted during the reporting period.

Action on these requests was in accordance with the State's procedures and the granted variances provided protection equivalent to that provided under the standard. No temporary variances were requested during the evaluation period.

Accordingly, OSHA finds that the South Carolina program effectively grants variances from its occupational safety and health standards.

(3) *Enforcement.* Section 18(c)(2) of the Act and 29 CFR 1902.3(d)(1) require a State program to provide a program for enforcement of State standards which is and will continue to be at least as effective in providing safe and healthful employment and places of employment as the Federal program. The State must require employer and employee compliance with all applicable standards, rules and orders (29 CFR 1902.3(d)(2)) and must have the legal authority for standards enforcement including compulsory process (29 CFR 1902.4(c)(2)).

The South Carolina Occupational Safety and Health Act and implementing regulations previously approved by OSHA, establish employer and employee compliance responsibility and contain legal authority for standards enforcement in terms substantially identical to those in the Federal Act. In order to be qualified for final approval, the State must have adhered to all approved procedures adopted to ensure an at least as effective compliance program (29 CFR 1902.37(b)(2)). The "18(e) Evaluation Report" data show no lack of adherence to such procedures.

(a) *Inspections.* A plan must provide for inspection of covered workplaces, including in response to complaints, where there are reasonable grounds to believe a hazard exists (29 CFR 1902.4(c)(2)(i)). As noted in the September 25, 1987 **Federal Register** notice South Carolina recently adopted a procedure similar to OSHA's for handling non-formal complaints by a letter to the employer. Data contained in the 18(e) Evaluation Report indicate the State responded to 34.6% of safety complaints and 20.2% of health complaints with an inspection. Complaints responded to by letter was comparable to OSHA. (Evaluation Report, pages 41 and 42).

In order to qualify for final approval, the State program, as implemented, must allocate sufficient resources toward high-hazard workplaces while providing adequate attention to other covered workplaces (29 CFR 1902.37(b)(8)). Data contained in the 18(e) Evaluation Report indicate that 100% of both, State programmed safety and programmed health inspections were conducted in high-hazard industries. (Evaluation report, page 38).

(b) *Employee notice and participation in inspections.* In conducting inspections the State plan must provide an opportunity for employees and their representatives to point out possible violations through such means as employee accompaniment or interviews with employees (29 CFR 1902.4(c)(2)(ii)). The State's procedures require compliance officers to provide this opportunity. During the evaluation period, 95.4% of initial inspections included either employee representatives on the walkaround or interviews with employees. OSHA has concluded that employee representation is properly provided in State inspections. (Evaluation Report, pages 47 and 48).

In addition, the State plan must provide that employees be informed of their protections and obligations under the Act by such means as the posting of notices, (29 CFR 1902.4(c)(2)(iv)) and provide that employees have access to information on their exposure to regulated agents and access to records of the monitoring of their exposure to such agents (29 CFR 1902.4(c)(vi)).

To inform employees and employers of their protections and obligations, South Carolina requires that a poster, which was previously approved by OSHA (41 FR 9547) be displayed in all covered workplaces. Requirements for the posting of the poster and other notices such as citations, contests, hearings and variance applications, are set forth in the previously approved State law and regulations which are substantially identical to Federal requirements. Information on employee exposure to regulated agents and access to medical and monitoring records is provided through State standards, including the Access to Employee Exposure and Medical Records standard and the Hazard Communication standard. Both of these standards were amended to make the definition of the "Designated Representative" identical to OSHA's. Federal OSHA's evaluation concluded that the State's performance is satisfactory.

(c) *Nondiscrimination.* A State is expected to provide appropriate protection to employees against discharge or discrimination for exercising their rights under the State's program including provision for employer sanctions and employee confidentiality (29 CFR 1902.4(c)(2)(v)). The South Carolina Act and regulations provide for discrimination protection equivalent to that provided by Federal OSHA. The State investigated 21 discrimination complaints during the evaluation period. Of the investigated complaints, (5) 23.8% were found to have merit and (4) 80.0% of the meritorious cases were settled or litigated. One case

is still pending. This compared very favorably with Federal experience. (Evaluation Report pp. 64–65.)

(d) *Restraint of imminent danger; protection of trade secrets.* A State plan is required to provide for the prompt restraint of imminent danger situations, (29 CFR 1902.4(c)(2)(vii) and to provide adequate safeguards for the protection of trade secrets (29 CFR 1902.4(c)(2)(viii)). The State has provisions concerning imminent danger and protection of trade secrets in its law, regulations and field operations manual which are similar to the Federal. The 18(e) Evaluation Report indicates that there were no imminent danger situations identified. (Evaluation Report, p. 53.) There were no Complaints About State Program Administration (CASPA's) filed concerning the protection of trade secrets during the reporting period. (Evaluation Report, p. 71.)

(e) *Right of entry; advance notice.* A State program is expected to have authority for right of entry to inspect and compulsory process to enforce such right equivalent to the Federal program (section 18(c)(3) of the Act and 29 CFR 1902.3(e)). Likewise, a State is expected to prohibit advance notice of inspection, allowing exception thereto no broader than the Federal program (29 CFR 1902.3(f)). The South Carolina Occupational Safety and Health Act authorizes the Commissioner to enter and inspect all covered workplaces in terms substantially identical to those in the Federal Act. In addition, South Carolina law allows the Commissioner to apply for a warrant from the State courts to permit entry into such establishments that have refused entry for the purpose of inspection or investigation. The South Carolina law likewise prohibits advance notice, and implementing procedures for exceptions to this prohibition are substantially identical to the Federal.

In order to be found qualified for final approval, a State is expected to take action to enforce its right of entry when denied (29 CFR 1902.37(b)(9)) and to adhere to its advance notice procedures. South Carolina had 15 denials of entry during this evaluation period, was successful in obtaining warrants for 11 of them, and gained entry voluntarily for the other 4. The 18(e) Evaluation Report indicates that 17 instances of advance notice procedures were used and in all cases the State's use of its procedures were proper.

(f) *Citations, penalties, and abatement.* A State plan is expected to have authority and procedures for promptly notifying employers and employees of violations identified during inspections, for the proposal of effective first-instance sanctions against employers found in violation of standards and for prompt employer notification of such penalties (29 CFR 1902.4(c)(2) (x) and (xi)). The South Carolina plan through its law, regulations and field operations manual, which have all been previously approved by OSHA, has established a system similar to the Federal for prompt issuance of citations to employers delineating violations and establishing reasonable abatement periods requiring posting of such citations for employee information and proposing penalties.

In order to be qualified for final approval, the State, in actual operation, must be found to conduct competent inspections in accordance with approved procedures and to obtain adequate information to support resulting citations (29 CFR 1902.37(b)(10)), to issue citations, proposed penalties and failure-to-abate notifications in a timely manner (29 CFR 1902.37(b)(11)), to proposed penalties for first instance violations that are at least as effective as those under the Federal program (29 CFR 1902.37(b)(12)), and to ensure abatement of hazards including issuance of failure-to-abate notices and appropriate penalties (29 CFR 1902.37(b)(13)).

Procedures for the South Carolina Occupational Safety and Health Compliance Program are set out in the South Carolina Field Operations Manual, which is patterned after the Federal manual, and thus the State follows inspection procedures, including documentation procedures, which are similar to the Federal. The evaluation report notes overall adherence by South Carolina to these procedures. South Carolina cites an average of 3.0 violations per programmed safety inspection with citations and 2.3 violations per programmed health inspection with citations; and 20.5% of safety and 21.2% of health violations cited as serious by the State was comparable to Federal performance during the evaluation period. (Evaluation Report, p. 51.)

South Carolina's lapse time from last day of inspection to issuance of citation averaged 12.8 days for safety and 11.3 days for health, both of which compare favorably with Federal performance during the period. (Evaluation Report, p. 68).

South Carolina's procedures for calculation of penalties are similar to Federal OSHA. However, there are some differences between the two programs, for example, the minimum penalty that can be proposed, number of penalty levels, multi-instance penalty, etc. The evaluation report indicates that the average proposed penalties for serious violations were $292 for safety and $400 for health. (Evaluation Report, pp. 56–58).

South Carolina conducts a lower percent of follow-up inspections to assure abatement of cited violations (1.8% of not-in-compliance inspections) than does Federal OSHA. In the past the State required a follow-up inspection on all cited violations except other-than-serious. However, the State reduced the number of follow-up inspections because over the past two years the State issued only one or two failure-to-abate notices. State abatement periods averaged 8.2 days for serious safety and 17.6 days for serious health violations. (Evaluation Report, pp. 54–55.)

(g) *Contested cases.* In order to be considered for initial approval and certification, a State plan must have authority and procedures for employer contest of citations, penalties and abatement requirements at full administrative or judicial hearings. Employees must also have the right to contest abatement periods and the opportunity to participate as parties in all proceedings resulting from an employer's contest (29 CFR 1902.4(c)(2)(xii)). South Carolina's procedures for employer contest of citations, penalties and abatement requirements and for ensuring employees rights are contained in the law, regulations and field operations manual made a part of the record in this proceeding and are similar to the Federal procedures which the exception of the expanded employee right to contest terms and conditions of citations as well as abatement dates. Appeals of citations, penalties and abatement periods are heard by the South Carolina's Occupational Health and Safety Review Board and may be further appealed to the Court of Common Pleas.

During the evaluation period, 6.9% of safety inspections with citation, and 12.2% of health inspections with citation, resulted in contests. This level is higher than the precentage of contests federally. The report indicates that the higher rate of contested cases is attributed to fewer settlements reached at the pre-contest level and concludes that the State's performance in this area is as effective as Federal OSHA. (Evaluation Report, pp. 60 and 63.)

To qualify for final approval, the State must seek review of any adverse adjudications and take action to correct any enforcement program deficiencies resulting from adverse administrative or judicial determinations (29 CFR 1902.37(b)(14)). The State had no

adverse decisions which would require review or corrective action. Accordingly, OSHA finds that the South Carolina plan effectively reviews contested cases.

(h) *Enforcement conclusion.* In summary, the Assistant Secretary finds that enforcement operations provided under the South Carolina plan are competently planned and conducted, and are overall at least as effective as Federal OSHA enforcement.

(4) *Public employee program.* Section 18(c)(6) of the Act requires that a State which has an approved plan must maintain an effective and comprehensive occupational safety and health program applicable to all employees of public agencies of the State and its political subdivisions, which program must be as effective as the standards contained in an approved plan. 29 CFR 1902.3(j) requires that a State's program for public employees be as effective as the State's program for private employees covered by the plan.

South Carolina's plan provides a program in the public sector which is very similar to that in the private sector, except that no penalties are proposed for other-than-serious violations. Additionally, employers in the public sector may be given a two-thirds credit on proposed penalties for serious violations if they certify that the funds saved will be utilized to correct the violations, provide safety and health training to employees, or improve other elements of their safety and health programs.

During the evaluation period, South Carolina conducted 70 public sector inspections, citing 122 violations of which 17.2% were classified as serious. The proportion of inspections dedicated to the public sector (3% of total inspections during the evaluation period) was appropriate to the needs of public employees. (Evaluation Report, pp. 23 and 26.)

Injury and illness rates for State and local government employment are lower than in the private sector (1985: all case rate—5.8; lost workday case rate—2.7.). The State and local government lost workday case rate did not change from 2.7 in 1984, while the private sector rate had a slight increase from 2.7 to 2.8.

Because South Carolina's performance in the public sector compares very favorably to that in the private sector, OSHA concludes that the South Carolina program meets the criterion in 29 CFR 1902.3(j).

(5) *Staffing and resources.* Section 18(c)(4) of the Act requires State plans to provide the qualified personnel necessary for the enforcement of standards. In accordance with 29 CFR 1902.37(b)(1), one factor which OSHA must consider in evaluating a plan for final approval is whether the State has a sufficient number of adequately trained and competent personnel to discharge its responsibilities under the plan.

The South Carolina plan provides for 17 safety compliance officers and 12 industrial hygienists as set forth in the South Carolina FY 1987 grant. This staffing level meets the approved, revised, fully effective benchmarks for South Carolina for safety and health staffing, as discussed elsewhere in this notice.

The State provides a comprehensive training program for new compliance personnel and refresher and specialized training for experienced staff, which includes attendance at the OSHA Training Institute and in-house and field training exercises.

As noted in the **Federal Register** notice announcing certification of the completion of developmental steps for South Carolina (41 FR 32424) all personnel under the plan meet civil service requirements under the State merit system, which was found to be in substantial conformity with the Standards for a Merit System of Personnel Administration by the U.S. Office of Personnel Management.

Because South Carolina has allocated sufficient enforcement staff to meet the revised benchmarks for that State, and personnel are trained and competent, the requirements for final approval set forth in 29 CFR 1902.37(b)(1), and in the 1978 Court Order in *AFL–CIO* v. *Marshall, supra,* are being met by the South Carolina plan.

Section 18(c)(5) of the Act requires that the State devote adequate funds to administration and enforcement of its standards. The South Carolina plan was funded at $2,606,014 in FY 1987. (Fifty percent of the funds were provided by Federal OSHA and 50% were provided by the State.)

As noted in the 18(e) Evaluation Report, South Carolina's funding is judged sufficient in absolute terms; moreover, the State allocates its resources to the various aspects of the program in a manner similar to OSHA. On this basis, OSHA finds that South Carolina has provided sufficient funding for the various activities carried out under the plan.

(6) *Records and reports.* State plans must assure that employers in the State submit reports to the Secretary in the same manner as if the plan were not in effect (section 18(c)(7) of the Act and 29 CFR 1902.3(k)). The plan must also provide assurances that the designated agency will make such reports to the Secretary in such form and containing such information as he may from time to time require (section 18(c)(8) of the Act and 29 CFR 1902.3(1)).

South Carolina's employer recordkeeping requirements are equivalent to those of Federal OSHA, and the State participates in the BLS Annual Survey of Occupational Illnesses and Injuries. As noted elsewhere in this notice, the State participates and has assured its continuing participation with OSHA in the Integrated Management Information System as a means of providing reports on its activities to OSHA.

For the foregoing reasons, OSHA finds that South Carolina has met the requirements of sections 18(c) (7) and (8) of the Act on employer and State reports to the Secretary.

(7) *Voluntary compliance program.* A State plan is required to undertake programs to encourage voluntary compliance by employers by such means as conducting training and consultation with employers and employees (29 CFR 1902.4(c)(2)(xiii)).

South Carolina does not differentiate between employers and employees when conducting training sessions in the public sector. In the public sector, 5,754 public sector employers and employees participated in 128 training sessions.

For the private sector, 1,375 employers participated in 62 training sessions, while 13,254 employees participated in 598 training sessions.

South Carolina has established a Voluntary Protection Program (VPP) identical to the Federal program. The program recognizes exemplary safety and health programs as a means of expanding worker protection. Establishments which meet the program criteria will be removed from the general schedule inspection list for one year from the date of the establishment's approval. There is currently one establishment particiating on this program.

In the private sector, South Carolina provides on-site consultative services to employers under a cooperative agreement with OSHA made pursuant to section 7(c)(1) of the Act and 29 CFR Part 1908. On-site consultation for the public sector is provided under the South Carolina plan.

Accordingly, OSHA finds that South Carolina has established and is administering an effective voluntary compliance program.

(8) *Injury and illness statistics.* As a factor in its 18(e) determination, OSHA must consider the Bureau of Labor Statistics Annual Occupational Safety and Health Survey and other available Federal and State measurements of

program impact on worker safety and health (29 CFR 1902.37(b)(15)). The 1984 and 1985 Bureau of Labor Statistics injury and illness rates for South Carolina (private sector all case rate for 1984 was 6.9% and for 1985 was 7.1%; lost workday case rate for 1984 was 2.7 and for 1985 was 2.8%) were lower than rates in the States where Federal OSHA provides enforcement coverage. In 1985, the all case incidence rates and the lost workday case rates for the private sector, manufacturing and construction experienced a mix of increases and decreases in South Carolina, the rates of increase were within the acceptable range established under OSHA's State Plan Activities Measures and the absolute rates in each case for 1985 were lower than corresponding rates in Federal States. In addition, the percent change in lost workday cases for the State's five most hazardous industries were all within the acceptable range when compared to the change in rates under Federal jurisdiction.

OSHA finds that the trends in injury and illness statistics in South Carolina compared favorably with those in States with Federal enforcement.

Decision

OSHA has carefully reviewed the record developed during the above described proceedings, including all comments received thereon. The present **Federal Register** document sets forth the findings and conclusions resulting from this review.

In light of all the facts presented on the record, the Assistant Secretary has determined that the South Carolina State plan for occupational safety and health, which has been monitored for at least one year subsequent to certification, is in actual operation at least as effective as the Federal program and meets the statutory criteria for State plans in section 18(e) of the Act and implementing regulations at 29 CFR Part 1902. Therefore, the South Carolina State plan is hereby granted final approval under section 18(e) of the Act and implementing regulations at 29 CFR Part 1902, effective December 15, 1987.

Under this 18(e) determination, South Carolina will be expected to maintain a State program which will continue to be at least as effective as operations under the Federal program in providing employee safety and health at covered workplaces. This requirement includes submitting all required reports to the Assistant Secretary as well as submitting plan supplements documenting State-initiated program changes, changes required in response to adverse evaluation findings, and responses to mandatory Federal program changes. In addition, South Carolina must continue to allocate sufficient safety and health enforcement staff to meet the benchmarks for State staffing established by the Department of Labor, or any revision to those benchmarks.

Effect of Decision

The determination that the criteria set forth in section 18(c) of the Act and 29 CFR Part 1902 are being applied in actual operations under the South Carolina plan terminates OSHA authority for Federal enforcement of its standards in South Carolina, in accordance with section 18(e) of the Act, in those issues covered under the State plan. Section 18(e) provides that upon making this determination "the provisions of sections 5(a)(2), 8 (except for the purpose carrying out subsection (f) of this section), 9, 10, 13, and 17, shall not apply with respect to any occupational safety or health issues covered under the plan, but the Secretary may retain jurisdiction under the above provisions in any proceeding commenced under section 9 or 10 before the date of determination."

Accordingly, Federal authority to issue citations for violation of OSHA standards (sections 5(a)(2) and 9); to conduct inspections (except those necessary to conduct evaluations of the plan under section 18(f), and other inspections, investigations or proceedings necessary to carry out Federal responsibilities which are not specifically preempted by section (18)(e)) (section 8); to conduct enforcement proceedings in contested cases (section 10); to institute proceedings to correct imminent dangers (section 13); and to propose civil penalties or initiate criminal proceedings for violations of the Federal Act (section 17) is relinquished as of the effective date of this determination.

Federal authority under provisions of the Act not listed in section 18(e) is unaffected by this determination. Thus, for example, the Assistant Secretary retains his authority under section 11(c) of the Act with regard to complaints alleging discrimination against employees because of the exercise of any right afforded to the employee by the Act although such complaints may be initially referred to the State for investigation. Any proceeding initiated by OSHA under sections 9 and 10 of the Act prior to the date of this final determination would remain under Federal jurisdiction. The Assistant Secretary also retains his authority under section 6 of the Act to promulgate, modify or revoke occupational safety and health standards which address the working conditions of all employees, including those in States which have received an affirmative 18(e) determination. In the event that a State's 18(e) status is subsequently withdrawn and Federal authority reinstated, all Federal standards, including any standards promulgated or modified during the 18(e) period, would be Federally enforceable in the State.

In accordance with section 18(e), this determination relinquishes Federal OSHA authority only with regard to occupational safety and health issues covered by the South Carolina plan, and OSHA retains full authority over issues which are not subject to State enforcement under the plan. Thus, for example, Federal OSHA retains its authority to enforce all provisions of the Act, and all Federal standards, rules or orders which relate to safety or health in private sector maritime employment and employment on military bases. In addition Federal OSHA may subsequently initiate the exercise of jurisdiction over any issue (hazard, industry, geographical area, operation or facility) for which the State is unable to provide effective coverage for reasons not related to the required performance or structure of the State plan.

As provided by section 18(f) of the Act, the Assistant Secretary will continue to evaluate the manner in which the State is carrying out its plan. Section 18(f) and regulations at 29 CFR Part 1955 provide procedures for the withdrawal of Federal approval should the Assistant Secretary find that the State has subsequently failed to comply with any provision or assurance contained in the plan. Additionaly, the Assistant Secretary is required to initiate proceedings to revoke an 18(e) determination and reinstate concurrent Federal authority under procedures set forth in 29 CFR 1902.47, *et seq.*, if his evaluations show that the State has substantially failed to maintain a program which is at least as effective as operations under the Federal program, or if the State does not submit program change supplements to the Assistant Secretary as required by 29 CFR Part 1953.

Explanation of Changes to 29 CFR Part 1952

29 CFR Part 1952 contains, for each State having an approved plan, a subpart generally describing the plan and setting forth the Federal approval status of the plan. 29 CFR 1902.43(a)(3) requires that notices of affirmative 18(e) determinations be accompained by changes to Part 1952 reflecting the final approval decision. This notice makes

changes to Subpart C of Part 1952 to reflect the final approval of the South Carolina plan.

The table of contents for Part 1952, Subpart C, has been revised to reflect the following changes.

Section 1952.94, Final approval determinations, which formerly was reserved, has been completed to reflect the determination granting final approval of the plan. The section contains a more accurate description of the current scope of the plan than the one contained in the initial approval decision.

Section 1952.95, Level of Federal enforcement, has been changed to reflect the State's 18(e) stauts. This replaces the former description of the relationship of State and Federal enforcement under an Operational Status Agreement which was entered into on May 9, 1975 and amended May 23, 1984. Federal concurrent enforcement authority has been relinquished as part of the present 18(e) determination for South Carolina and the Operational Status Agreement is not longer in effect. Section 1952.95 describes the issues where Federal authority has been terminated and the issues where it has been retained in accordance with the discussion of the effects of the 18(e) determination set forth earlier in the present **Federal Register** notice.

Regulatory Flexibility Act

OSHA certifies pursuant to the Regulatory Act of 1980 (5 U.S.C. 601, *et seq.*) that this rulemaking will not have a significant economic impact on a substantial number of small entities. Final approval will not place small employers in South Carolina under any new or different requirements nor would any additional burden be placed upon the State government beyond the responsibilities already assumed as part of the approved plan. Certification to this effect was previously forwarded to the Chief Counsel for Advoacy, Small Business Administration.

List of Subjects in 29 CFR Part 1952

Intergovernmental relations, Law enforcement, Occupational safety and health.

(Sec. 18, 84 Stat. 1608 (29 U.S.C. 667); 29 CFR Part 1902 (Sec. 18, 84 Stat. 1608 (29 U.S.C. 667); 29 CFR Part 1902, Secretary of Labor's Order No. 9–83 (48 FR 35736))

Signed at Washington, DC, this 15th day of December 1987.

John A. Pendergrass,

Assistant Secretary.

PART 1952—[AMENDED]

Accordingly, Subpart C of 29 CFR Part 1952 is hereby amended as follows:

1. The authority citation for Part 1952 continues to read:

Authority: Secs. 8, 18, Occupational Safety and Health Act 1970 (29 U.S.C. 657, 667); Secretary of Labor's Order No. 12–71 (36 FR 8754), 8–76 (41 FR 25059), or 9–83 (48 FR 35736), as applicable.

2. Section 1952.94 is added and 1952.95 is revised to read as follows:

§ 1952.94 Final approval determination.

(a) In accordance with section 18(e) of the Act and procedures in 29 CFR Part 1902, and after determination that the State met the "fully effective" compliance staffing benchmarks as revised in 1984 in response to a Court Order in *AFL–CIO* v. *Marshall* (CA 74–406), and was satisfactorily providing reports to OSHA through participation in the Federal-State Integrated Management Information System, the Assistant Secretary evaluated actual operations under the South Carolina State plan for a period of at least one year following certification of completion of developmental steps (41 FR 32424). Based on the 18(e) Evaluation Report for the period of December 1, 1985 through January 31, 1987, and after opportunity for public comment, the Assistant Secretary determined that in operation the State of South Carolina's occupational safety and health program is at least as effective as the Federal program in providing safe and healthful employment and places of employment and meets the criteria for final State plan approval in section 18(e) of the Act and implementing regulations at 29 CFR Part 1902. Accordingly, the South Carolina plan was granted final approval and concurrent Federal enforcement authority was relinquished under section 18(e) of the Act effective December 15, 1987.

(b) The plan which has received final approval covers all activities of employers and places of employment in South Carolina except for private sector maritime, and military bases.

(c) South Carolina is required to maintain a State program which is at least as effective as operations under the Federal program; to submit plan supplements in accordance with 29 CFR Part 1953; to allocate sufficient safety and health enforcement staff to meet the benchmarks for State staffing established by the U.S. Department of Labor, or any revisions to those benchmarks; and, to furnish such reports in such form as the Assistant Secretary may from time to time require.

§ 1952.95 Level of Federal enforcement.

(a) As a result of the Assistant Secretary's determination granting final approval to the South Carolina plan under section 18(e) of the Act, effective December 15, 1987, occupational safety and health standards which have been promulgated under section 6 of the Act do not apply with respect to issues covered under the South Carolina plan. This determination also relinquishes concurrent Federal OSHA authority to issue citations for violations of such standards under sections 5(a)(2) and 9 of the Act; to conduct inspections and investigations under section 8 (except those necessary to conduct evaluation of the plan under section 18(f) and other inspections, investigations, or proceedings necessary to carry out Federal responsibilities not specifically preempted by section 18(e)); to conduct enforcement proceedings in contested cases under section 10; to institute proceedings to correct imminent dangers under section 13; and to propose civil penalties or initiate criminal proceedings for violations of the Federal Act under section 17. The Assistant Secretary retains jurisdiction under the above provisions in any proceeding commenced under sections 9 or 10 before the effective date of the 18(e) determination.

(b)(1) In accordance with section 18(e), final approval relinquishes Federal OSHA authority only with regard to occuaptional safety and health issues covered by the South Carolina plan. OSHA retains full authority over issues which are not subject to State enforcement under the plan. Thus, Federal OSHA retains its authority relative to safety and health in private sector maritime activities and will continue to enforce all provisions of the Act, rules or orders, and all Federal standards, current or future, specifically directed to maritime employment (29 CFR Part 1915, shipyard employment; Part 1917, marine terminals; Part 1918, longshoring; Part 1919, gear certification) as well as provisions of general industry standards (29 CFR Part 1910) appropriate to hazards found in these employments, and employment on military bases. Federal jurisdiction is also retained with respect to Federal government employers and employees.

(2) In addition, any hazard, industry, geographical area, operation or facility over which the State is unable to effectively exercise jurisdiction for reasons not related to the required performance or structure of the plan shall be deemed to be an issue not covered by plan which has received final approval, and shall be subject to Federal enforcement. Where enforcement jurisdiction is shared between Federal and State authorities for a particular area, project, or facility, in the interest of administrative practicability Federal jurisdiction may be assumed over the entire project or facility. In either of the two aforementioned circumstances, Federal enforcement may be exercised immediately upon agreement between Federal OSHA and the State designated agency.

(c) Federal authority under provisions of the Act not listed in section 18(e) is unaffected by final approval of the plan. Thus, for example, the Assistant Secretary retains his authority under section 11(c) of the Act with regard to complaints alleging discrimination against employees because of the exercise of any right afforded to the employee by the Act, although such complaints may be referred to the State for investigation. The Assistant Secretary also retains his authority under section 6 of the Act to promulgate, modify or revoke occupational safety and health standards which address the working conditions of all employees, including those in States which have received an affirmative 18(e) determination, although such standards may not be federally applied. In the event that the State's 18(e) status is subsequently withdrawn and Federal authority reinstated, all Federal standards, including any standards promulgated or modified during the 18(e) period, would be federally enforceable in that State.

(d) As required by section 18(f) of the Act, OSHA will continue to monitor the operations of the South Carolina State program to assure that the provisions of the State plan are substantially complied with and that the program remains at least as effective as the Federal program. Failure by the State to comply with its obligations may result in the revocation of the final determination under section 18(e), resumption of Federal enforcement, and/or proceedings for withdrawal of plan approval.

[FR Doc. 87-29078 Filed 12-17-87; 8:45 am]

BILLING CODE 4510-26-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 401, 405 and 408

[BERC-402-FC]

Medicare Program; Supplementary Medical Insurance Premiums

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

ACTION: Final rule with comment period.

SUMMARY: These rules amend the Medicare regulations that deal with supplementary medical insurance (SMI) premiums.

These changes are necessary to conform our rules to changes made in the Medicare laws since the rules were last published.

The purpose is to ensure that those who must apply our rules are not misled or confused by content that fails to reflect statutory changes and modified policy.

DATES: These regulations are effective January 19, 1988.

Consideration will be given to comments received or postmarked no later that March 17, 1988.

ADDRESS: Address comments in writing to: Administrator, Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-402-FC, P.O. Box 26676, Baltimore, Maryland 21207.

In commenting, please refer to file code BERC-402-FC. If you prefer, you may deliver your comments to Room 309-G, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, DC, or to Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Comments will be available for public inspection as they are received, beginning approximately three weeks from today, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC 20201, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (202-245-7890).

FOR FURTHER INFORMATION CONTACT: Denis Garrison, (301) 594-9435.

SUPPLEMENTARY INFORMATION:

I. Purpose and Scope

These amendments conform HCFA regulations on SMI premiums (Part 405, Subpart I) to statutory changes enacted since Subpart I was last published. Because most of Subpart I was last published in 1968, it also needed updating to reflect administrative and procedural changes. For example, group payments must now be sent to the HCFA Premium Collection Center, instead of to the SSA Payment Center. As part of our ongoing project to assign a separate part to each major aspect of the Medicare program, we redesignated the premium provisions under a new Part 408. When the existing rules contained confusing language or incorrect cross-references, we also revised to clarify and correct.

II. Background

The SMI program is the voluntary Medicare Part B program that pays all or part of the costs for physicians' services, outpatient services, home health services, services furnished by rural health clinics, ambulatory surgical centers, and comprehensive outpatient rehabilitation facilities, and certain other medical and health services not covered by hospital insurance (Medicare Part A).

The SMI program is available to individuals who are entitled to hospital insurance and to U.S. residents who have attained age 65 and are citizens or are aliens lawfully admitted for permanent residence who have resided in the United States for five consecutive years. This program requires enrollment and payment of monthly premiums.

III. Changes in the Law and the Rules

The principal statutory and policy changes and the conforming changes to the regulations are discussed below.

A. Effect of Late Enrollment and Reenrollment

1. Statutory provisions

Before enactment of section 945 of Pub. L. 96-499, an individual could not enroll more than twice, and there was an annual general enrollment period that lasted from January 1 to March 31 of each calendar year. Section 945 amended sections 1837, 1838, 1839 of the Act to remove the two-enrollment limitation and establish an unlimited general enrollment period that began when the individual's initial enrollment period ended. (The initial enrollment period is a 7-month period beginning 3 months before the month the individual first meets the eligibility requirements for Medicare and ending with the third month after that first month of eligibility).

Section 945 was effective April 1, 1981. Section 2151 of Pub. L. 97-35 further amended sections 1837-1839 of the Act to eliminate continuous open enrollment, (that is, to restore the annual 3-month enrollment period) effective October 1, 1981, but retained the

provision allowing an unlimited number of reenrollments. Since the law requires that the monthly premium be increased for individuals who enroll after expiration of their initial enrollment periods and for those who reenroll, the enrollment provisions of sections 945 and 2151 also affected the way the premium increase would be determined.

2. Conforming Changes

The effect of these changes in the law is reflected in §§ 408.24 through 408.26 of the regulations.

B. Determination and Promulgation of Premium Amounts

1. Statutory Provisions

Section 124 of Pub. L. 97–248, as amended by section 606 of Pub. L. 98–21 (the Social Security Amendments of 1983) amended section 1839(a) of the Act to change the method of determining premiums for 1984 and 1985:

- Beginning with 1984, the SMI premium must be calculated on the basis of 50 percent of the actuarial rate for the aged (roughly 25 percent of program costs).
- Beginning with 1983, the promulgation date is September instead of December and the new premium is effective in January rather than July (to correspond to the date for cost-of-living increases in social security benefits).

Section 2302 of Pub. L. 98–369 further amended section 1839 of the Act to require that the SMI premium continue to be based on 50 percent of the actuarial rate for two more years—1986 and 1987, and included a hold-harmless provision, applicable during these two years, to ensure that the increase in the standard monthly premium will not result in a decrease in social security cash benefits in certain circumstances. The hold-harmless provision was not applied in 1986 since there was no increase in the standard monthly premium for that year. Section 9313 of Pub. L. 99–272 extends the section 2302 provisions for one more year, through 1988.

Section 2338(a) of Pub. L. 98–369 provided that, in determining the premium for late enrollment in SMI, the months during which an employer group health plan was primary payer for individuals age 65 to 69 be excluded.

Section 9001(c) of Pub. L. 99–509 provided technical clarification of the hold-harmless provision noted above. That clarification affects the procedural instructions but does not require any change in the regulations.

Section 9201 (a) and (c) of Pub. L. 99–272 amended sections 1837 and 1862 of the Act to remove the age-70 upper limit so that the employer group health plan is primary to Medicare for individuals age 65 or older, as long as they are covered under the employer plan on the basis of current employment.

Section 9219(a) of that same law amended section 1839 of the Act to provide that, in determining the premium for late enrollment in SMI (or in hospital insurance for individuals who must pay premiums for that program), the months of coverage under an employer group health plan are to be excluded even if the employer has fewer than 20 employees and even if the individual is not entitled to, or eligible for, hospital insurance. (In neither of the two latter circumstances would the employer plan be primary to Medicare.) Since, as discussed above, the age 70 cap has been removed, these provisions apply to individuals age 65 or older.

Section 9319(c) of Pub. L. 99–509 provides that, for disabled Medicare beneficiaries, months of employer group health plan coverage be excluded in determining the premium for late enrollment. The disabled beneficiary must be covered under a large employer group health plan as an employee, employer, individual associated with the employer in a business relationship, or family member of any of the foregoing. This provision is effective for months of coverage under a large employer plan from January 1987 through December 1991, and affects premiums due for any month from January 1987 onward. (A "large" employer group health plan is a plan that covers employees of at least one employer that had 100 or more employees on the majority of business days during the preceding calendar year.)

2. Conforming Changes

The rules on special enrollment periods for the aged and disabled are set forth in a new § 405.216. The other amendments discussed above are reflected in §§ 405.216, 408.20 and 408.24 of the new Part 408.

C. Collection of Premiums That Exceed Social Security Cash Benefits

1. Statutory Provisions

Under previous law, there was a minimum Social Security primary insurance amount of $122. Section 2201 of Pub. L. 97–35 amended section 215 of the Act to eliminate that minimum for beneficiaries who first become eligible after October 1981, and for all other beneficiaries beginning March 1982. Section 2 of Pub. L. 97–123 restored the minimum benefits for all individuals who first became eligible before January 1, 1982 (and for some individuals who become eligible in 1982–1991).

This means that, for an individual who becomes eligible on or after January 1, 1982 and whose benefits are based on very low earnings, the monthly benefit may be less than the monthly SMI premium. The billing procedures used in this situation are the same procedures used in the past when other situations resulted in monthly benefits that were less than the amount of the premium. The monthly benefit serves to pay part of the premium and the insured individual is required to pay the difference through direct remittance.

2. Conforming Changes

The above described billing procedures are set forth in § 408.63 and conforming language appears in §§ 408.6, 408.8, and 408.43.

IV. Regulatory Impact Statement

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any regulations that are likely to meet criteria for a "major rule". A major rule is one that would result in:

(1) An annual effect on the economy of $100 million or more;

(2) A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or any geographical regions; or

(3) Significant adverse effects on competition, employment, investment, productivity, innovation or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In addition, consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), we prepare and publish a regulatory flexibility analysis for regulations unless the Secretary certifies that the regulations will not have a significant impact on a substantial number of small entities.

These regulations are technical and conforming changes necessary to implement certain statutory provisions. In themselves, they will have no effects requiring an analysis under E.O. 12291. Further, the Secretary certifies that these regulations will not have a significant economic impact on a substantial number of small entities. Therefore, neither a regulatory impact analysis nor a regulatory flexibility analysis has been prepared.

V. Paperwork Reduction Act

These regulations impose no additional reporting or recordkeeping provisions requiring OMB clearance.

VI. Waiver of Notice of Proposed Rulemaking

These amendments make no substantive changes other than those that are discussed in this preamble and are required to conform our rules to changes in the law, or to reflect current practice and procedures.

With respect to the law, they conform to other regulations that implement those changes, or if other regulations have not been issued, merely reflect the language of the law without further interpretation or elaboration. With respect to administrative practice and procedures, they include nothing that is not already set forth in general instructions issued by HCFA.

We therefore find that notice and opportunity for public comment before final rules is unnecessary. However, we recognize that the process of redesignating and clarifying the rules carries the risk of unintentional alteration. For that reason, we will consider comments received within 60 days after publication of these rules. Although we cannot acknowledge individual comments, if we revise these rules, we will discuss all timely comments in the preamble to the revised rules.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 408

Administrative practice and procedure, Health insurance, Medicare, Premiums.

Redesignation Table

42 CFR Part 405, Subpart I

Old section	New section
405.901	408.2
405.902(a)	Removed as unnecessary.
405.902 (a)(1) and (a)(2)	408.20(b).
405.902(b)	408.22.
405.902(b)(1)	408.24.
Examples	408.26.
405.902(c)	408.27.
405.903(a)	408.4(a).
405.903(b), first sentence.	408.100.
405.903(b), rest of the paragraph.	408.4(b).
405.904, uncoded introduction.	408.6(a)(1) and 408.8(c).
405.904(a)	408.42 and 408.43.
405.904(b)	408.44.
405.904(c)	408.42.
405.904(d)	408.6(c).
405.904(e)	408.6(b)(3) and 408.60(a).
405.906	408.4(c).
405.908, uncoded introduction.	408.60(a).
405.908(a)–(c)	408.60(d).
405.911(a), first & third sentences.	408.40(a).
405.911(a), second sentence.	408.40(c).
405.911(b)	408.40(b).
405.911(c)	Deleted as duplicative and unnecessary.
405.912(a), except second parenthetical statement.	408.46(a).
405.912(a), parenthetical statement.	408.3.
405.912(b)	408.46(b).
405.913(a), first sentence.	408.46(a)(2).
405.913(a), second sentence.	408.47(a)(1).
405.941(f), rest of paragraph.	408.88(a).
Example	408.88(b).
405.942 (revised per changed practice).	408.84(b).
405.946(a)	408.84(a).
405.946(a), last sentence, and (b).	Deleted as duplicative of 405.841(d).
405.947(a)	408.92.
405.947(b)	408.92(b)(2).
405.948(a)	408.86(a).
405.948(b)	408.86(b).
405.948(c)	408.86(c).
405.949	408.90.
405.956(a)	408.50(a).
405.956(a), Examples	408.50(c).
405.956(b) (revised to reflect simplified practice).	408.68(b).
405.957(a)	408.68(b).
405.957(b)	408.100(b).
405.958(a)	Deleted as inconsistent with 405.958(b).
405.958(b)	408.68(a).
405.959(a)	408.102(a).
405.959(b)(1)	408.102(b).
405.959(b)(2)	408.102(c).
405.959(c)	408.104.
405.960(a)	408.71.
405.960(b)	408.52.
405.962	408.110.
405.964	408.112.
405.941(f), rest of paragraph.	408.88(a).
Example	408.88(b).
405.942 (revised per changed practice).	408.84(b).
405.946(a)	408.84(a).
405.946(a), last sentence, and (b).	Deleted as duplicative of 405.841(d).
405.947(a)	408.92.
405.947(b)	408.92(b)(2).
405.948(a)	408.86(a).
405.948(b)	408.86(b).
405.948(c)	408.86(c).
405.979	408.90.
405.956(a)	408.50(a).
405.956(a), Examples	408.50(c).
405.956(b) (revised to reflect simplified practice).	408.68(b).
405.957(a)	408.68(b).
405.957(b)	408.100(b).
405.958(a)	Deleted as inconsistent with 405.958(b).
405.958(b)	408.68(a).
405.959(a)	408.102(a).
405.959(b)(1)	408.102(b).
405.959(b)(2)	408.102(c).
405.959(c)	408.104.
405.960(a)	408.71.
405.960(b)	408.52.
405.962	408.110.
405.964	408.112.

42 CFR Chapter IV is amended as set forth below:

A. Part 405, Subpart B is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart B—Supplementary Medical Insurance Benefits; Enrollment, Coverage, Exclusions, and Payment

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

Authority: Secs. 1102, 1836, 1837, 1838, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395a, 1395p, 1395q, and 1395hh).

2. A new § 405.216 is added and the table of contents is amended to reflect the addition.

§ 405.216 Special enrollment periods related to coverage under an employer group health plan.

(a) *General rules.* Special enrollment periods (SEPs) are 7-month periods available to individuals who meet the general requirements of this paragraph (a), and the special conditions set forth in paragraph (b) or (c) of this section, as appropriate.

(1) They are eligible to enroll in SMI on the basis of age or disability, but not on the basis of end-stage renal disease.

(2) When first eligible to enroll in SMI (4th month of their initial enrollment period),

(i) They were covered under an employer group health plan; or

(ii) They enrolled in SMI during their initial enrollment period.

(3) Except as provided in paragraph (a)(4) of this section, they maintained coverage under either an employer group health plan or SMI for all months after the initial enrollment period.

(4) *Exception:* If an individual failed to enroll during any SEP because employer group health plan coverage was restored before the end of that SEP, that failure to enroll in SMI is not considered a break in coverage that would preclude another SEP now or in the future.

(b) *Specific rules: Individual age 65 or over.* Individuals entitled on the basis of age must meet the following conditions:

(1) They have been covered, on the basis of current employment, under an employer group health plan as defined in section 162(i)(3) of the Internal Revenue Code of 1954; and

(2) They are no longer covered under such a plan on the basis of current employment.

(c) *Specific rules: Disabled individual.* Individuals entitled on the basis of disability (but not on the basis of end-stage renal disease), must meet the following conditions:

(1) They have been covered under a large employer group health plan that meets the definition in § 5000(b) of the Internal Revenue Code of 1954;

(2) They had this coverage as an employee, employer, individual associated with the employer in a business relationship, or as a family member of one of the foregoing; and

(3) They no longer have the coverage described in this paragraph (c).

(d) *Beginning of special enrollment period: Individual age 65 or over.* For an aged individual—

(1) Before May 1986, the SEP began with whichever of the following resulted in earlier SMI entitlement:

(i) The first day of the third month before the month in which the individual attained age 70, if employer group health plan coverage continued to age 70.

(ii) The first day of the first month in which the individual was no longer enrolled in an employer plan on the basis of current employment.

(2) In and after May 1986, the SEP begins on the first day of the first month in which the individual is no longer enrolled in an employer plan on the basis of current employment.

(e) *Beginning of special enrollment period: Disabled individual.* For a disabled individual under age 65, the SEP begins with the first day of the first month after December 1986 in which the individual is no longer covered under an employer plan as described in paragraph (c) of this section. Because the provisions applicable to disabled individuals expire on December 31, 1991, the last SEP available under those provisions will begin with January 1992.

(f) *Beginning of special enrollment period: Partial coverage month.* When employer plan coverage ends before the end of a month, the following rules apply—

(1) If the individual enrolls in SMI before the end of the partial coverage month, the SEP begins with that month.

(2) If the individual does not enroll in SMI before the end of the partial coverage month, the SEP begins with the following month.

(g) *Beginning of Entitlement*—(1) *Enrollment or reenrollment before May 1986.* (i) If an individual enrolled during the 3 months before attainment of age 70, entitlement began with the month of attainment of age 70; and

(ii) If an individual enrolled during the month of attainment of age 70, or during any of the 3 following months, entitlement began with the month after the month of enrollment.

(2) *Enrollment or reenrollment in and after May 1986.* (i) If an individual enrolls during the first month of nonenrollment in an employer group health plan, which is the first month of the SEP, entitlement begins with the first day of that month.

(ii) If an individual enrolls during the last 6 months of the SEP, entitlement begins with the month after the month of enrollment.

3. Subpart I, consisting of §§ 405.901 to 405.964, is redesignated and revised as a new Part 408.

B. The sections removed from Subpart I of Part 405 are redesignated as a new Part 408 and revised to read as follows:

PART 408—PREMIUMS FOR SUPPLEMENTARY MEDICAL INSURANCE

Subpart A—General Provisions

Sec.

Subpart B—Amount of Monthly Premium

Subpart C—Deduction from Monthly Benefits

Sec.

Subpart D—Direct Remittance; Individual Payment

Subpart E—Direct Remittance: Group Payment

Subpart F—Termination and Reinstatement of Coverage

Subpart G—Collection of Unpaid Premiums; Refund of Excess Premiums After the Death of the Enrollee

Authority: Secs. 1102, 1818, 1837–1840, 1843, 1871 and 1881(d) of the Social Security Act (42 U.S.C. 1302, 1395i–2, 1395p, 1395q, 1395r, 1395s, 1395v, 1395hh, and 1395rr(d)), and the Federal Claims Collection Act (31 U.S.C. 3711).

Subpart A—General Provisions

§ 408.1 Statutory basis.

(a) This part implements certain provisions of sections 1837 through 1840 and 1881(d) of the Social Security Act (the Act) and conforms to other

regulations that implement section 1843 of the Act. Section 1838(b) requires regulations to establish when an individual's coverage ends because of nonpayment of premiums. It also specifies that those regulations may provide a grace period for payment of overdue premiums without loss of coverage. Section 1839 sets forth the specific procedures for determining the amount of the monthly premium and section 1840 establishes the rules for payment of premiums. Section 1843 provides that a State may enter into a buy-in agreement to secure SMI coverage for certain individuals by enrolling them in the SMI program and paying the premiums on their behalf. Section 1881(d) provides entitlement to Medicare benefits related to the donation of a kidney without payment of premiums, deductibles, or coinsurance.

(b) The Federal Claims Collection Act (31 U.S.C. 3711), as implemented by 4 CFR Parts 101–105, provides the basic authority for recovery of debts owed the United States Government and specifies the conditions for the suspension or termination of collection action. Departmental regulations at 45 CFR Part 430, updated by a final rule published on January 5, 1987 (52 FR 260) set forth procedures for the exercise of the Department's authority to collect and dispose of debts and we intended to complement rules applicable to particular programs. HCFA rules are set forth at 42 CFR Part 401, Subpart F.

§ 408.2 Scope and purpose.

(a) This part sets forth the policies and procedures for determining the amount of monthly supplementary medical insurance (SMI) premiums, for the payment, collection, or refund of premiums, for termination of coverage because of nonpayment of premiums, and for reinstatement of coverage if certain conditions are met. It conforms to Subpart B of Part 405 of this chapter, which sets forth the requirements for State buy-in agreements. These policies are intended to protect enrollee coverage to the maximum degree compatible with maintaining the integrity of the SMI program.

(b) Policies that apply to premiums required from certain individuals in order to become entitled to Medicare Part A hospital insurance benefits, are set forth in Part 406 of this chapter.

§ 408.3 Definitions.

As used in this part, unless the context indicates otherwise—

Enrollee means an individual who is enrolled in the SMI program under Medicare Part B.

Taxable year means the 12-month period (calendar or fiscal year) for which the individual files his or her income tax return.

§ 408.4 Payment obligations.

(a) *Month for which payment is due.* (1) A payment is due for each month, beginning with the first month of SMI coverage and continuing through the month of death or, if earlier, the month in which coverage terminates.

(2) A premium is due for the month of death, if SMI coverage is still in effect, even though the individual dies on the first day of the month.

(b) *Overdue premiums.* (1) Overdue premiums constitute an obligation enforceable against the enrollee or the enrollee's state.

(2) Overdue premiums are collected—

(i) By deduction from social security or railroad retirement benefits or Federal civil service annuities;

(ii) Directly from the enrollee or the enrollee's estate; or

(iii) By offset against any SMI payments payable to the enrollee or the enrollee's estate.

(3) Interest is not charged on overdue premiums, except under a State buy-in agreement, as provided in § 408.6(c)(4).

(c) *Premiums not required for certain kidney donors.* (1) No premiums are required for SMI benefits related to the donation of a kidney if the donor is not an enrollee.

(2) A kidney donor who is an enrollee is not relieved of the obligation for premiums.

§ 408.6 Methods and priorities for payment.

(a) *Methods of payment.*—(1) *General rules.* Premiums are paid by one of the following four methods:

(i) Payment by a State under a buy-in agreement.

(ii) Deduction from monthly railroad retirement of social security cash benefits or Federal civil service annuities.

(iii) Direct remittance on an individual basis, by or on behalf of the enrollee.

(iv) Direct remittance on a group basis, by an employer, union, lodge or other organization, or by an entity of State or local government.

(2) *Special situations.* (1) If the monthly social security benefit or age 72 special benefit is less than the monthly premium, the benefit is withheld and the enrollee is required to pay the balance through direct remittance. (This situation may arise if the individual first becomes eligible for social security benefits after December 31, 1981, and is, therefore, not eligible for the fixed minimum, or receives age 72 special benefits that are reduced because the individual receives a Government pension.)

(ii) If the monthly railroad retirement benefit or civil service annuity payment is less than the premium, the monthly payment is not withheld and the enrollee is required to pay the total premium by direct remittance.

(b) *Priorities for payment.* (1) If an enrollee is enrolled under a State buy-in agreement—

(i) SMI premiums may not be deducted from monthly cash benefits or annuities; and

(ii) The enrollee may not be required to pay by direct remittance.

(2) If an enrollee is not covered under a State buy-in agreement, but is receiving a monthly benefit or an annuity specified in paragraph (a)(1)(ii) of this section—

(i) The premiums are deducted from that benefit or annuity; or

(ii) If the monthly benefit or payment is less than the monthly premium, the rules of paragraph (a)(2) of this section apply.

(3) If an enrollee is neither covered under a State buy-in agreement, nor receiving monthly benefits or annuity payments, the premiums must be paid totally by direct remittance.

(c) *Payment by a State under a buy-in agreement.* (1) A buy-in agreement is an agreement under which a State, through enrollment and payment of SMI premiums, secures SMI benefits for individuals who are eligible for that program and also eligible for certain other cash or medical benefits. (Policies on enrollment under State buy-in agreements are contained in Subpart B of Part 405 of this chapter.)

(2) The State pays the premiums for each month for which an individual is covered under the agreement.

(3) If an individual's coverage under a State buy-in agreement terminates, his coverage continues on an individual enrollment basis. The premiums are then deducted from benefits, as set forth in Subpart C of this part, or paid by direct remittance in accordance with Subpart D or Subpart E of this part.

(4) Policy on collection of premiums from buy-in States is set forth in a **Federal Register** notice published on September 30, 1985 at 50 FR 39784.

§ 408.8 Grace period and termination date.

(a) *Grace period.* (1) For all initial premium payments (monthly or quarterly), and subsequent monthly payments, the grace period ends with the last day of the third month after the billing month.

(2) For subsequent quarterly payments, the grace period ends with the last day of each 3-month period for which the enrollee is billed.

(3) For payments that are required because of suspension of monthly benefits, the grace period ends the last day of the fourth month after the end of the enrollee's taxable year.

(4) For payments required because the monthly benefit is less than the monthly premium, the grace period ends on April 30 of the year following the calendar year for which the premiums are due.

(b) *Extension of grace period: Last day is nonwork day.* If the last day of the grace period is a Saturday, Sunday, legal holiday, or a day that, by statute or executive order, is a nonwork day for Federal employees, the grace period is extended to the next succeeding work day.

(c) *Termination date.* The end of the grace period is the termination date for SMI coverage if overdue premiums have not been paid by that date in accordance with § 408.68.

(d) *Extension of grace period for good cause.* (1) HCFA may reinstate entitlement, without interruption of coverage, if the individual shows good cause for failure to pay within the initial grace period, and pays all overdue premiums within three calendar months after the termination date.

(2) Good cause will be found if the individual establishes, by a credible statement, that failure to pay premiums within the initial grace period was due to conditions over which he or she had no control, or which he or she could not reasonably have been expected to foresee.

§ 408.10 Claim for monthly benefits pending concurrently with request for SMI enrollment.

(a) If it is clear that an individual who applies for social security or railroad retirement benefits and for SMI will be entitled to monthly benefits, the application for monthly benefits is processed simultaneously with the request for SMI enrollment.

(1) If monthly benefits are paid, the SMI premiums are deducted from those benefits.

(2) If monthly benefits are suspended (for instance, because the individual's earnings exceed the maximum allowed by law), the enrollee is billed for direct remittance.

(b) If it is clear that an individual will be entitled to SMI, but there is substantial question as to eligibility for monthly benefits, the request for SMI enrollment is processed separately.

(1) When SMI enrollment is approved, the enrollee is billed for direct remittance.

(2) When the application for monthly benefits is adjudicated, the following rules apply:

(i) If monthly benefits are paid, the SMI premiums are deducted from those benefits, with appropriate adjustments for any premiums already paid by direct remittance.

(ii) If the application for monthly benefits is approved but the benefits are suspended, the grace period is as set forth in § 408.8(a)(3).

(iii) If the application for monthly benefits is denied, the grace period is as set forth in § 408.8(a)(1).

Subpart B—Amount of Monthly Premiums

§ 408.20 Standard monthly premium.

(a) *Basic provisions.* (1) The law established a monthly premium of $3 for the initial period of the program. It also set forth criteria and procedures for the Secretary to follow each December, beginning with December 1968, to determine and promulgate the standard monthly premium for the 12-month period beginning with July of the following year.

(2) The law was amended in 1983 to require that the Secretary promulgate the standard monthly premium in September of that year, and each year thereafter, to be effective for the 12 months beginning with the following January.

(3) The standard monthly premium applies to individuals who enroll during their initial enrollment periods. In other situations, that premium may be increased or decreased as specified in this subpart.

(b) *Criteria and procedures for the period from July 1976 through December 1983, and for periods after December 1988.* (1) For periods from July 1976 through December 1983, the Secretary determined and promulgated as the standard monthly premium (for disabled as well as aged enrollees) the lower of the following:

(i) The actuarial rate for the aged.

(ii) The monthly premium promulgated the previous December for the year beginning July 1, increased by a percentage that is the same as the latest cost-of-living increase in old age insurance benefits that occurred before the current promulgation. (Because of the change in the effective dates of the premium amount (under paragraph (a)(2) of this section), there was no increase in the standard monthly premium for the period July 1983 through December 1983.)

(2) For periods after December 1988, the Secretary will determine the standard monthly premium in the manner specified in paragraph (b)(1) of this section, but promulgate it in September, for the following calendar year.

(c) *Premiums for calendar years 1984 through 1988.* For calendar years 1984 through 1988, the standard monthly premium for all enrollees—

(1) Is equal to 50 percent of the actuarial rate for enrollees age 65 or over, that is, is calculated on the basis of 25 percent of program costs without regard to any cost-of-living increase in old age insurance benefits; and

(2) Is promulgated in the preceding September.

(d) *Special provisions for calendar years 1987 and 1988*—(1) *Limitation on increase of standard premium.* If there is no cost-of-living increase in old age insurance benefits or disability insurance benefits effective for December 1986, or December 1987, the standard monthly premium for the succeeding year is not increased.

(2) *Nonstandard premiums for certain cases.* (i) A nonstandard premium may be established in individual cases if the following conditions are met:

(A) The individual is entitled to old age or disability benefits for the months of November and December, and actually receives the coresponding benefit checks in December and January.

(B) There is a cost-of-living increase in old age or disability benefits but, wholly or partly because of an increase in the standard monthly premium, the beneficiary would receive a lower cash benefit in January than he or she received in December.[1] (To the extent that a benefit reduction is the result of any factor other than the premium increase, the nonstandard premium provision does not apply.)

(ii) The nonstandard premium is the greater of the following:

(A) The premium paid for December.

(B) The standard premium promulgated for January, reduced as necessary to compensate for the fact that the cost of living increase was less than the increase in the standard premium.

(iii) A nonstandard premium established under paragraph (d)(2)(ii) of this section continues in effect for the rest of the calendar year even if later

[1] Cost-of-living increases are effective in December, and premium increases are effective in January. However, since premiums for each month are collected in the preceding month, both increases affect the amount of the check for December, which is mailed in January.

there are retroactive adjustments in benefit payments. (The only thing that could affect the nonstandard premium is a determination that the individual had not established, or had lost, entitlement to monthly benefits for November or December.)

(iv) A nonstandard premium is subject to increase for late enrollment or reenrollment as required under other sections of this subpart. The increase is based on the amount of the standard premium and added to the nonstandard premium.

§ 408.22 Increased premiums for late enrollment and for reenrollment.

For an individual who enrolls after expiration of his or her initial enrollment period or reenrolls after termination of a coverage period, the standard monthly premium determined under § 408.20 is increased by ten percent for each full twelve months in the periods specified in §§ 408.24 and 408.25.

§ 408.24 Individuals who enrolled or reenrolled before April 1, 1981 or after September 30, 1981.

(a) *Enrollment.* For an individual who first enrolled before April 1, 1981 or after September 30, 1981, the period *includes* the number of months elapsed between the close of the individual's initial enrollment period and the close of the enrollment period in which he or she first enrolled, and *excludes* the following:

(1) The three months of January through March 1968, if the individual first enrolled before April 1968.

(2) Any months before January 1973 during which the individual was precluded from enrolling or reenrolling by the 3-year limitation on enrollment or reenrollment that was in effect before October 30, 1972.

(3) Any months in or before a period of coverage under a State buy-in agreement.

(4) For an individual under age 65, any month before his or her current continuous period of entitlement to hospital insurance.

(5) For an individual age 65 or older, any month before the month he or she attained age 65.

(6) For premiums due for months beginning with September 1984 and ending with May 1986, the following:

(i) Any months after December 1982 during which the individual was—

(A) Age 65 to 69;

(B) Entitled to hospital insurance (Medicare Part A); and

(C) Covered under an employer group health plan by reason of current employment in accordance with § 405.340 of this chapter.

(ii) Any months of SMI coverage for which the individual enrolled during a special enrollment period as provided in section 9319(c) of Pub. L. 99–509 and § 405.216 of this chapter.

(7) For premiums due for months beginning with June 1986, the following:

(i) Any months after December 1982 during which the individual was:

(A) Age 65 or over; and

(B) Covered, by reason of current employment, under an employer group health plan that meets the definition of § 162(i)(3) of the Internal Revenue Code of 1954.

(ii) Any months of SMI coverage for which the individual enrolled during a special enrollment period as provided in section 9319(c) of Pub. L. 99–509 and § 405.216 of this chapter.

(8) For premiums due for months beginning with January 1987, the following:

(i) Any months after December 1986 and before January 1992 during which the individual was:

(A) A disabled Medicare beneficiary under age 65;

(B) Not eligible for Medicare on the basis of end stage renal disease, under § 406.13 of this chapter; and

(C) Covered, as an employee, employer, individual associated in a business relationship with an employer, or family member of any of the foregoing, under an employer group health plan meeting the definition in § 5000(b) of the Internal Revenue Code of 1954.

(ii) Any months of SMI coverage for which the individual enrolled during a special enrollment period as provided in section 9319(c) of Pub. L. 99–509 and § 405.216 of this chapter.

(b) *Reenrollment.* For an individual who reenrolled before April 1, 1981 or after September 30, 1981, the period:

(1) *Includes* the following: (i) The number of months elapsed between the close of the individual's initial enrollment period and the close of the enrollment period in which he or she first enrolled; plus

(ii) The number of months elapsed between the individual's initial period of coverage and the close of the enrollment period in which he or she reenrolled; plus

(iii) The number of months elapsed between each subsequent period of coverage and the close of the enrollment period in which he or she reenrolled.

(2) *Excludes* the following:

(i) The periods specified in paragraphs (a)(1) through (a)(8) of this section; and

(ii) Any month before April 1981 during which the individual was precluded from reenrolling by the two-enrollment limitation in effect before that date.

§ 408.25 Individual who enrolled or reenrolled between April 1 and September 30, 1981.

(a) *Basic rules.* Except as specified in paragraph (b) of this section, the rules set forth in § 408.24 apply to an individual who enrolled or reenrolled between April 1 and September 30, 1981.

(b) *Exception.* For an individual who enrolled or reenrolled between April 1 and September 30, 1981, the months to be counted ran through the month in which he or she reenrolled. (During those 6 months, continuous open enrollment was in effect and there was no 3-month "general enrollment period".)

§ 408.26 Examples.

Example 1. Mr. J, who became age 65 and otherwise eligible for enrollment in November 1965, first enrolls in March 1968. The months to be included in determining the amount of the increase in Mr. J's premiums begin with June 1966 (the first month after the close of his initial enrollment period and extend through December 1967 (the period January through March of 1968 is excluded in determining the total months) for a total of 19 months. Since there is only one full 12-month period in 19 months, Mr. J's premiums will be 10 percent greater than if he had enrolled in his initial enrollment period.

Example 2. Mr. V, who enrolled in December 1965, voluntarily terminates his enrollment effective midnight December 31, 1967. He enrolls for a second time in January 1969. The months to be included in determining the amount of the increase in Mr. V's premiums are January 1968 through March 1969, a total of 15 months. Since this totals one full 12-month period. Mr. V's monthly premium, will be increased by 10 percent.

Example 3. Ms. N becomes age 65 in July 1965 and first enrolls in December 1967. She pays premiums increased by 10 percent above the regular rate, beginning July 1968, the first month of her SMI coverage. Ms. N fails to pay the premiums for the calendar quarter ending June 30, 1970, and her coverage is terminated on that date, the end of her grace period. Ms. N enrolls for a second time in January 1971. The months to be included in determining the amount of the increase in Ms. N's premiums are June 1966 through December 1967, a total of 19 months, and July 1970 through March 1971, a total of 9 months, for a grand total of 28 months. Since this totals two full 12-month periods, Ms. N's

monthly premium will be increased by 20 percent.

Example 4. Mr. X attained age 65 in August 1966 and enrolled during his initial enrollment period. His coverage was terminated effective June 30, 1968, for nonpayment of premiums. He reenrolls in March 1973. For purposes of computing any applicable premium increase, he will not be charged any months between March 1971 (the end of the last general enrollment period during which he was eligible to reenroll under the law in effect before October 30, 1972) and January 1973. Therefore, he will be charged 36 months (July 1968–March 1971 plus January 1973–March 1973) and his premiums for his second period of coverage will be increased 30 percent.

Example 5. Ms. C, who attained age 65 in August 1973, had two periods of supplementary medical insurance coverage, both of which were terminated because of nonpayment of premiums: August 1973 through April 1975 and July 1977 through August 1978. She reenrolls in July 1981. The months to be included in determining the amount of premium increase are May 1975 through March 1977 (23 months) and April 1981 through July 1981 (4 months) for a total of 27 months. The 31 months from September 1978 through March 1981 may not be counted because Ms. C was prevented from reenrolling by the two-enrollment limitation in effect before April 1, 1981. For Ms. C, the standard monthly premium would be increased by 20 percent.

§ 408.27 Rounding the monthly premium.

Any monthly premium that is not multiple of 10 cents is rounded to the nearest multiple of 10 cents, and any odd mulitple of 5 cents is rounded to the next higher multiple of 10 cents.

Subpart C—Deduction from Monthly Benefits

§ 408.40 Deduction from monthly benefits: Basic rules.

(a) *Deduction from monthly benefits.* (1) Enrollees who are receiving monthly benefits do not have the option of paying by direct remittance to avoid deduction.

(2) If the enrollee is entitled to more than one type of monthly benefit, the order of priority for deduction is as follow:

(i) Railraod retirement benefits.

(ii) Social security benefits.

(iii) Civil service annuities.

(b) *Deduction from initial or reinstated benefits.* When an enrollee receives a monthly benefit check after an initial award or after a period of suspension, that check is, if administratively feasible, reduced or increased to deduct unpaid premiums or refund premiums paid in advance by direct remittance.

(c) *Ongoing deductions.* The premium for each month is deducted from the cash benefit for the preceding month, e.g., the premium for March is deducted from the benefit for February, which is paid at the beginning of March.

§ 408.42 Deduction from railroad retirement benefits.

(a) *Responsibility for deductions.* If an enrollee is entitled to railroad retirement benefits, his or her SMI premiums are deducted from those benefits by the Railroad Retirement Board (RRB) even though he or she is also entitled to social security benefits or a civil service annuity, or both.

(b) *Action when benefits are suspended.* If the railroad retirement benefits are suspended, the RRB sends premium notices requesting direct remittance, to be made in accordance with the rules set forth in Subpart D of this part.

§ 408.43 Deduction from social security benefits.

SSA, acting as HCFA's agent, deducts the premiums from the monthly social security benefits if the enrollee is not entitled to railroad retirement benefits. (If the benefit is less than the monthly premium, the benefit is withheld and the enrollee is required to pay the balance through direct remittance.)

§ 408.44 Deduction from civil service annuities.

(a) *Responsibility for deductions.* If an enrollee is not entitled to railroad retirement benefits or social security benefits, and is receiving a civil service annuity, the premiums are deducted from that annuity by the Office of Personnel Management (OPM) on the basis of a notice from SSA indicating that the annuitant is entitled to SMI.

(b) *Deduction of spouse's premiums.* If the annuitant's spouse is also enrolled for SMI and is not entitled to a civil service annuity or to social security or railroad retirement benefits, and the annuitant gives written consent, OPM also deducts the spouse's premium from the annuitant's monthly check.

(c) *Withdrawal of annuitant's consent.* (1) If an annuitant wishes to withdraw consent for deduction of the spouse's premium, he or she must send written notice of withdrawal to OPM.

(2) The withdrawal notice is effective with the third month after the month in which it is received, or with the month specified in the notice, whichever is later.

§ 408.45 Deduction from age 72 special payments.

(a) *Deduction of premiums.* SMI premiums are deducted from age 72 special payments made under section 228 of the Act or the payments are withheld under procedures that correspond to the rules set forth in §§ 408.40 and 408.43.

(b) *Collection of premiums while age 72 special payments are suspended.* If the age 72 special payments are suspended, HCFA or its agent notifies the enrollee to pay premiums by direct remittance, in accordance with the rules set forth in § 408.60.

(c) *Grace period.* The grace period ends with the last day of the third month after the billing month.

(d) *Resumption of age 72 special payments.* (1) If age 72 special payments are resumed before the end of the grace period and all premium arrears can be deducted from those special payments, SMI coverage continues and the enrollee need not pay by direct remittance.

(2) Subsequent special payments are reduced by the amount of the premium for as long as the enrollee receives special payments.

§ 408.46 Effect of suspension of social security benefits.

(a) *Benefit payments to be resumed during the taxable year.* (1) If social security benefit payments are scheduled to be resumed during the enrollee's current taxable year, the enrollee is not billed.

(2) The enrollee may, if he or she wishes, pay the premiums during suspension of benefits.

(b) *Benefit payments not to be resumed during the enrollee's current taxable year.* (1) If social security benefits are suspended for a period that will not permit collection of all premiums due from monthly benefits payable in the enrollee's current taxable year, HCFA or its agents bill the enrollee and require direct remittance in accordance with Subpart D of this part.

(2) The first billing is for whatever premiums are necessary to place the enrollee in a quarterly cycle.

(3) Thereafter, the billing is on a quarterly basis. (Quarters for different enrollees are staggered throughout the year.)

(4) The enrollee has the option of paying premiums for more than one quarter at the same time.

§ 408.47 Overdue premiums for months in a closed taxable year.

(a) *Reasons for overdue premiums.* An enrollee may have overdue

premiums for a closed taxable year for either of the following reasons:

(1) The monthly social security benefits were suspended.

(2) The request for SMI enrollment was adjudicated with coverage retroactive to the enrollee's previous taxable year.

(b) *Payment of overdue premiums for a closed taxable year.* (1) If the premiums are overdue because of suspension of social security benefits—

(i) The enrollee is billed at the end of his or her taxable year; and

(ii) The grace period ends with the last day of the fourth month after the close of the enrollee's taxable year.

(2) If the premiums are overdue because SMI enrollment was adjudicated with retroactive coverage and cannot be collected from past due or current monthly benefits—

(i) The enrollee is billed immediately after adjudication; and

(ii) The grace period ends with the last day of the third month after the billing month.

(3) The bill indicates that, unless the arrears are paid by the last day of the grace period, coverage will end on that day.

(c) *Example.* Mr. H became entitled to supplementary medical insurance effective July 1980. He was entitled to monthly benefits, but reported work and earnings which precluded payment of those monthly benefits. Although billed, he paid no premium by direct remittance. Mr. H's taxable year ends May 31 because he reports his earnings for fiscal years ending on that date. Early in May 1981, Mr. H is notified of his unpaid premiums ($105.60) for the fiscal year ending May 31, 1981, and advised that those premiums are overdue and should be paid promptly. Without good cause, Mr. H fails to pay by September 30, 1981, despite the May notice advising him that the termination date is September 30. Mr. H's supplementary medical insurance coverage is terminated effective midnight September 30, 1981.

§ 408.50 When premiums are considered paid.

(a) *Actual deduction.* A premium is considered paid if it is actually deducted from a monthly benefit check. Therefore—

(1) The premium is "paid" even if SSA later finds that the benefit was paid in error; but

(2) A finding that a monthly benefit was erroneously withheld does not constitute payment of the premium for that month. Since there was no payment, there was no deduction. The enrollee is billed and continuance of coverage depends on payment of premiums before the end of the grace period or extended grace period.

(b) *Payment within the grace period.* Overdue premiums are considered paid within the grace period in the following situations:

(1) *Benefits are resumed during the grace period.* (i) Monthly cash benefit payments are payable for the last month of the initial grace period or for earlier months on the basis of a notice filed by the enrollee before the initial grace period ends; and

(ii) Those payments are sufficient to permit deduction of all overdue premiums.

(2) *Annual accounting report or other report submitted during the grace period shows a benefit is due.* (i) Before the end of the grace period, the enrollee submits a report clearly showing that monthly cash benefits, previously withheld, are payable for one or more months of a closed taxable year; and

(ii) Those benefits are sufficient to permit deduction of the full amount of the overdue premiums.

(3) Premium arrears are paid by direct remittance. The enrollee makes a direct remittance payment of all overdue premiums before the end of the grace period.

(c) *Examples.* (1) Mr. C, who became entitled to SMI in July 1978, was entitled to monthly social security benefits of $300. His premium rate was $8.20. He was paid $291.80 for each month from July to December 1978. In 1979, SSA determined that Mr. C's work and earnings in *1978* precluded any benefit payments for that year. Mr. C would not be found to owe any premiums for July through December 1978. He would, of course, have to refund the full $300 a month overpayment to SSA.

(2) (i) Ms. M also become entitled in July 1978. On the basis of Ms. M's report of work and earnings, her monthly benefits for July through December 1978 were withheld and SMI premiums could not be deducted. She was billed but made no premium payments during 1978. In January 1979, Ms. M is notified of the overdue premiums for her closed taxable year and of the fact that her SMI coverage will terminate April 30, 1979 unless the overdue premiums are paid by then. Ms. M's monthly benefits continue suspended and she fails to pay the premiums. Consequently, her SMI coverage is terminated as of April 30, 1979. In March 1980, Ms. M submits an annual report that she did not work in December 1978. A benefit for that month is paid subsequently.

(ii) If Ms. M had submitted the report of the benefit due before the end of the grace period (April 30, 1979), it would have permitted deduction of all her overdue premiums and continuation of SMI coverage. Because the report was not submitted before April 30, 1979, Ms. M's coverage cannot be reinstated.

§ 408.52 Change from direct remittance to deduction.

If a direct remittance enrollee becomes entitled to monthly benefits—

(a) The SMI premiums are deducted from those benefits; and

(b) The enrollee is notified of the deduction and of any adjustment of the initial benefit check that is required to collect overdue premiums or refund premiums paid in advance.

§ 408.53 Change from partial direct remittance to full deduction.

If a benefit that was less than the premium (and therefore required direct remittance of the difference) is increased to an amount equal to, or greater than, the premium—

(a) The full premium is paid from the benefit; and

(b) Any amounts the enrollee had paid toward premiums not yet due are refunded.

Subpart D—Direct Remittance: Individual Payment

§ 408.60 Direct remittance: Basic rules.

(a) Premiums not deducted from monthly benefits under Subpart C of this part or paid by a State buy-in agreement must be paid by direct remittance to HCFA or its agents, by or on behalf of the enrollee.

(b) Quarterly payment is preferred as more cost-effective, but monthly payment is accepted if the enrollee is unwilling or unable to make quarterly payments or is also paying hospital insurance premiums, which must be paid every month.

(c) HCFA, directly or through its agents, sends quarterly or monthly premium bills and includes an addressed return envelope with the bill.

(d) The individual must—

(1) Send a check or money order that is drawn payable to "HCFA Medicare Insurance" and show the enrollee's name and claim number as it appears on the Medicare card; and

(2) Return the bill with the check or money order in the preaddressed envelope.

§ 408.62 Initial and subsequent billings.

(a) *Monthly billing.* (1) The first premium bill is for the period from the first month of coverage (or the first month of change from deduction or State buy-in payment) through the end of the first month after the month of billing.

(2) Subsequent billings are for periods of one month.

(b) *Quarterly billing.* (1) The first premium bill is for the period from the first month of coverage (or of change from deduction or State buy-in payment) through the third month after the month of billing.

(2) Subsequent billings are for periods of three months.

§ 408.63 Billing procedures when monthly benefits are less than monthly premiums.

If monthly benefits are less than monthly premiums, the following procedures apply:

(a) *Notice of amount due.* At the beginning of SMI entitlement, and at the beginning of each succeeding calendar year, SSA—

(1) Notifies the enrollee of the amount of benefits payable for the rest of the year and the total premiums due for those same months; and

(2) Bills the enrollee for the difference.

(b) *Notice of amount overdue.* At the beginning of each succeeding calendar year, SSA—

(1) Notifies the enrollee of any amounts overdue for premiums for the preceding calendar year; and

(2) Indicates that if the amount still overdue on April 30 is equal to or greater than the premium for 3 months, SMI coverage will terminate on that date.

§ 408.65 Payment options.

(a) The enrollee is not asked to pay premiums at the time of enrollment but is instructed to pay them upon receipt of a premium bill from HCFA or its agents.

(b) However, if the enrollee wishes, he or she may pay from one to 12 months or from one to four quarters at the time of enrollment.

§ 408.68 When premiums are considered paid.

(a) *Payment by check.* The premium is considered paid if the check is paid by the bank the first or second time it is presented for payment.

(b) *Payment within the grace period.* (1) A premium is considered paid within the grace period if it is delivered personally, or mailed on or before the last day of that period.

(2) A premium payment is considered to have been mailed 7 days before it is received by HCFA.

§ 408.70 Change from quarterly to monthly payments.

If an enrollee requests change from quarterly to monthly payment—

(a) If the enrollee is paid up under the quarterly cycle, the first monthly bill is for one month.

(b) If the enrollee is not paid up under the quarter system, the first bill includes all premiums due.

§ 408.71 Change from deduction or State payment to direct remittance.

(a) *Basis for change.* An SMI enrollee is required to pay by direct remittance in any of the following circumstances:

(1) The enrollee's entitlement to social security or railroad retirement benefits ends for any reason other than death.

(2) The premiums can no longer be deducted from the civil service annuity of the enrollee or the enrollee's spouse.

(3) The enrollee no longer qualifies for coverage under a State buy-in agreement, and is not entitled to social security or railroad retirement monthly benefits.

(b) *Billing.* When any of the events specified in paragraph (a) of this section occurs (or as soon thereafter as possible), HCFA or its agents bill the enrollee for direct remittance, in accordance with this subpart.

Subpart E—Direct Remittance: Group Payment

§ 408.80 Basic rules.

(a) *Sources of group payment.* An employer, a lodge, union, or other organization may pay SMI premiums on behalf of one or more enrollees.

(b) *Informal arrangement.* Enrollees may turn over their premium notices to their employer, union, lodge, or other organization and that organization may send a single payment (with the premium notices attached so that the payments can readily be identified with the appropriate enrollees) to the HCFA Premium Collection Center. Prompt payment is essential since SMI coverage terminates if premiums are not paid by the end of the grace period.

(c) *Group billing arrangement.* HCFA may send a single notice for the premiums due from a group of enrollees if the following conditions are met:

(1) The group payer—

(i) Uses funds other than the enrollees' to pay all or a substantial part of the premiums; or

(ii) Deducts the premiums from periodic payments it makes to the enrollees in the group.

(2) The enrollee's rights are protected and enrollees are not required to pay the costs of having their premiums paid on a group basis.

§ 408.82 Conditions for group billing.

HCFA agrees to a group billing arrangement only if the following conditions are met:

(a) Conditions the group payer must meet. The group payer submits a written request for group billing—

(1) Showing that all or part of the payments are made from the payer's funds or from funds due the enrollees and in the payer's possession; and

(2) Agreeing not to charge the enrollees for the service of paying the premiums or for the administrative costs such as recordkeeping and postage.

(b) *Enrollees eligible for group payment.* (1) Group payment may be made only on behalf of individuals who are already enrolled and are being billed for direct remittance.

(2) Group payment may not be made for enrollees whose premiums are being deducted from monthly benefits in accordance with Subpart C of this part or being paid by the State under a buy-in agreement.

(c) *Protection of enrollee's rights.* The use of group billing must not jeopardize the enrollees' right—

(1) To confidentiality of personal information;

(2) To terminate enrollment;

(3) To resume individual payment of premiums if he or she wishes; and

(4) To receive notice of any action that affects the SMI benefits.

(d) *Authorization by the enrollee.* (1) To ensure maximum feasible protection of the rights specified in paragraph (c) of this section, each enrollee must give written authorization as specified in § 408.84(a)(2).

(2) A group payer that is not an entity of State or local government must submit all enrollee authorizations to HCFA.

(3) A group payer that is an entity of State or local government may retain the authorizations and certify to HCFA that it has on file an authorization for each enrollee included in the group.

(4) It is on the basis of the enrollee's authorization that HCFA sends the group payer information about each enrollee, as necessary to carry out the group payment function.

(e) *Size of group.* The number of enrollees must be at least 20, which is the minimum size sufficient to make group billing efficient. (Smaller groups may use the informal procedure described in § 408.80(b).)

§ 408.84 Billing and payment procedures.

(a) *Initial premium notice.* (1) HCFA or its agent always sends the initial premium notice to the enrollee.

(2) An enrollee who wishes to have the premiums paid on a group basis must give the notice to the group payer, along with written authorization for sending subsequent notices to the group payer and for release of the information required for the group payment process.

(b) *Monthly billings.* Group premiums are billed on a monthly basis. However, the group payer may pay up to 12 months in advance.

(c) Group payers must make their payments within 30 days after billing, to avoid infringing on the 90-day grace period during which the premiums may be paid by the enrollee if he or she is dropped from the group.

(d) *Effect of group payment.* Payment by a group payer is considered payment by the enrollee.

§ 408.86 Responsibilities under group billing arrangement.

(a) *Enrollee responsibilities.* (1) The enrollee is still responsible for premium payments; the group payer simply acts as his agent. If the agent fails to pay, or identifies the payment incorrectly, SSA notifies both the agent and the enrollee that the enrollee's account is delinquent. If an enrollee fails to take action on that notice, entitlement is terminated for nonpayment of premiums.

(2) The enrollee must promptly notify both SSA and the group payer of any change of address.

(b) *Group payer's responsibilities.* The group payer must—

(1) Make premium payments promptly upon receipt of notices;

(2) Promptly notify both HCFA and the enrollee when it drops an enrollee from the group;

(3) Make payments in a way that facilitates efficient and economical processing; and

(4) Maintain the confidentiality of the personal information obtained from HCFA for the group payment process.

(c) *HCFA responsibilities.* HCFA—

(1) Sends the bill to the group payer upon authorization from the enrollee;

(2) Notifies both the payer and the enrollee if the payer fails to make timely payments; and

(3) Refunds excess premiums in accordance with § 408.88.

§ 408.88 Refund of group payments.

(a) *Basis for refund.* Group payments are refunded only in the following circumstances:

(1) The premium was for a month after the month in which the enrollee's SMI coverage terminated or the enrollee died.

(2) The premium was for a month after the month in which the group payer gave notice (before the 26th day of that month) that the enrollee was no longer eligible for group payment and was being dropped from the group.

(b) *Example.* F is the wife of J who is a retiree of Corporation X. That corporation pays premiums on behalf of all of its retirees and their dependents. F obtains a divorce from J on October 20 and thus disqualifies herself for further premium payments by the corporation. The corporation gives notice on November 10 that a refund is due because F has been dropped from the list of persons for whom it has agreed to pay premiums. The premium paid for December would be refunded to the group payer.

(c) *To whom refund is made.* (1) HCFA ordinarily refunds to the group payer the premiums specified in paragraph (a) of this section.

(2) However, if HCFA has information that clearly shows those premiums were paid from the enrollee's funds, it sends the refund to the enrollee.

§ 408.90 Termination of group billing arrangement.

(a) A group billing arrangement may be terminated either by the group payer or by HCFA upon 30 days' notice.

(b) HCFA may terminate the arrangement if it finds that the group payer is not acting in the best interest of the enrollees or that, for any other reason, the arrangement has proved inconvenient for HCFA.

§ 408.92 Change from group payment to deduction or individual payment.

(a) *Enrollee excluded from group payment arrangement because of entitlement to monthly benefits.* (1) When an enrollee becomes entitled to monthly benefits from which premiums can be deducted as specified in Subpart C of this part. HCFA notifies the group payer to discontinue payment for that enrollee.

(2) In order to maintain confidentiality, HCFA does not explain to the group payer the reason for excluding the enrollee from the group payment arrangement.

(3) the enrollee's premiums are thereafter deducted from the monthly benefits, in accordance with Subpart C of this part.

(b) *Enrollee no longer eligible for the group.* (1) When an enrollee is no longer eligible to be included in the group (for instance because he or she is no longer employed by the group payer or has terminated union or lodge membership), the group payer must promptly notify HCFA and the enrollee.

(2) HCFA or its agents resume sending individual bills to the enrollee, for direct remittance subject to the grace period and termination dates specified in § 408.8.

Subpart F—Termination and Reinstatement of Coverage

§ 408.100 Termination of coverage for nonpayment of premiums.

(a) *Effective date of termination.* Termination is effective on the last day of the grace period. The determination is not made until 15 days after that day to allow for processing of remittances mailed late in the grace period, as provided in § 408.68.

(b) *Notice of termination.* (1) SSA sends the enrollee notice of termination between 15 and 30 days after the end of the grace period and includes information regarding the enrollee's right of appeal.

(2) HCFA notifies any intermediary or carrier that had previously been informed that the enrollee had met the SMI deductible for the year in which the termination is effective.

§ 408.102 Reconsideration of termination.

(a) *Basic rules.* Coverage may be reinstated without interruption of benefits if the following conditions are met:

(1) the enrollee appeals the termination by the end of the month following the month in which SSA sent the notice of termination.

(2) The enrollee alleges and it is found that the enrollee did not receive timely and adequate notice that the premiums were overdue.

(3) The enrollee pays, within 30 days after SSA's subsequent request for payment, all premiums due through the month in which he or she appealed the termination.

(b) *Basis for reinstating coverage.* coverage may be reinstated if the evidence establishes one of the following:

(1) The enrollee acted diligently to pay the premiums or to request relief upon receiving a premium notice very late in the grace period or shortly after its end, and the delayed notice was not the enrollee's fault. (For example, if the billing notice was misaddressed or lost in the mail, it would not be the enrollee's fault; if the enrollee had moved and not notified SSA of the new address, he or she would be responsible for the delay.)

(2) On the basis of information given by SSA, the enrollee could reasonably have believed that the premiums were being paid by deduction from benefits or by some other means. (An example would be a notice indicating that premiums would be paid by a State Medicaid agency or a group payer or would be deducted from the spouse's civil service annuity.)

(c) *No basis for reinstating coverage.* Coverage may not be reinstated if the enrollee—

(1) Received timely and adequate notice but failed to pay within the grace period, for example because of insufficient income or resources; or

(2) Appealed the termination more than one month after the month in which SSA sent the termination notice.

§ 408.104 Reinstatement procedures.

(a) *Request for payment.* If the conditions of § 408.102(a) (1) and (2) are met, SSA sends written notice requesting the enrollee to pay, within 30 days, all premiums due through the month in which the enrollee appealed the termination.

(b) *Reinstatement of coverage.* If SSA receives the requested payment within 30 days, it sets aside the termination and reinstates the enrollee's coverage without interruption.

Subpart G—Collection of Unpaid Premiums; Refund of Excess Premiums After the Death of the Enrollee

§ 408.110 Collection of unpaid premiums.

(a) *Basis and scope.*—(1) *Basis.* Under the Federal Claims Collection Act of 1966 (31 U.S.C. 3711), HCFA is required to collect any debts due it but is authorized to suspend or terminate collection action on debts of less than $20,000 when certain conditions are met. (See 4 CFR, Parts 101–105 for general rules implementing the Federal Claims Collection Act.) As indicated in § 408.4, unpaid premiums are debts owed the Federal Government by the enrollee or the enrollee's estate.

(2) *Scope.* This section sets forth the methods of collection used by HCFA and the circumstances under which HCFA terminates or renews collection action. The regulations in this section apply to hospital insurance premiums as well as SMI premiums.

(b) *Collection of unpaid premiums.* Generally, HCFA will attempt to collect unpaid premiums by one of the following methods:

(1) By billing enrollees who pay the premiums directly to HCFA or to a designated agent in accordance with § 408.60.

(2) By deduction from any benefits payable to the enrollee or the estate of a deceased enrollee under Title II or XVIII of the Social Security Act, the Railroad Retirement Act or any act administered by the Office of Personnel Management in accordance with § 408.4(b) and Subpart C of this part (Deduction from Monthly Benefits); or

(3) By billing the estate of a deceased enrollee.

(c) *Termination of collection action.* HCFA terminates collection action on unpaid premiums under either of the following circumstances, if the cost of collection exceeds the amount of overdue premiums:

(1) The individual is not entitled to benefits under the Acts listed in paragraph (b)(2) of this section, is not currently enrolled for SMI or premium hospital insurance, and demonstrates, to HCFA's satisfaction, that he or she is unable to pay the debt within a reasonable time.

(2) The individual has been dead more than 27 months (the maximum time allowed for claiming SMI benefits), and the legal representative of his or her estate demonstrates, to HCFA's satisfaction, that the estate is unable to pay the debt within a reasonable time.

(d) *Renewal of collection efforts.* HCFA renews collection efforts in either of the following circumstances, if the cost of collection does not exceed the amount of the overdue premiums:

(1) The individual enrolls again for premium hospital insurance or SMI. (Payment of overdue premiums is not a prerequisite for reenrollment.)

(2) The individual becomes entitled or reentitled to social security or railroad retirement benefits or a Federal civil service annuity.

§ 408.112 Refund of excess premiums after the enrollee dies.

If HCFA has received premiums for months after the enrollee's death, HCFA refunds those premiums as follows:

(a) To the person or persons who paid the premiums or, if the premiums were paid by the enrollee, to the representative of the enrollee's estate, if any.

(b) If refund cannot be made under paragraph (a) of this section, HCFA refunds the premiums to the enrollee's survivors in the following order of priority:

(1) The surviving spouse, if he or she was either living in the same household with the deceased at the time of death, or was, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the decreased beneficiary;

(2) The child or children who were, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one child, in equal parts to each child);

(3) The parent or parents who were, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one parent, in equal parts to each parent);

(4) The surviving spouse who was not living in the same household with the deceased at the time of death and was not, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased beneficiary;

(5) The child or children who were not entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one child, in equal parts to each child);

(6) The parent or parents who were not entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one parent, in equal parts to each parent).

If none of the listed relatives survives, no refund can be made.

C. Technical amendments.

§ 401.601 [Amended]

1. In § 401.601(d)(2)(iv), reference to "§ 405.962" is changed to "§ 408.110".

§ 405.212 [Amended]

2. In § 405.212(e), "(see § 405.902)" is changed to "under Subpart B of Part 408 of this chapter,".

§ 405.223 [Amended]

3. In § 405.223(b), "Subpart I of this part." is changed to "Part 408 of this chapter.".

§ 405.226 [Amended]

4. In § 405.226, the phrase "Subpart I of this part," is changed to "Part 408 of this chapter,".

§ 405.705 [Amended]

5. In § 405.705(d), "405.962" is changed to "408.110".

(Catalog of Federal Domestic Assistance Program No. 13.774 Medicare—Supplementary Medical Insurance)

Dated: July 6, 1987.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: October 22, 1987.

Otis R. Bowen,

Secretary.

[FR Doc. 87–29062 Filed 12–17–87; 8:45 am]

BILLING CODE 4120–01–M