

FL site were in error. Those coordinates appeared incorrectly as:

28°17'02"N., 82°46'21"W.; 28°17'02"N.,  
82°45'12"W.; 28°16'25"N.,  
82°45'00"W.; 28°16'42"N.,  
82°45'00"W.

The correct coordinates for the Pithlachascotee, FL site are as follows:

28°17'02"N., 82°46'21"W.; 28°17'02"N.,  
82°45'12"W.; 28°16'25"N.,  
82°45'00"W.; 28°16'42"N.,  
82°45'00"W.; 28°16'42"N.,  
82°46'21"W.

Withlacoochee, FL—28°59'08"N.,  
82°48'48"W.; 28°59'32"N., 82°47'40"W.;  
28°59'18"N., 82°47'32"W.; 28°58'54"N.,  
82°48'40"W.

Cedar Keys, FL—29°08'43"N.,  
83°07'53"W.; 29°08'43"N., 83°07'03"W.;  
29°08'33"N., 83°07'03"W.; 29°08'33"N.,  
83°07'03"W.

Cedar Keys, FL—

The coordinates printed in the Proposed Rule for the second Cedar Keys, FL site were in error. Those coordinates appeared incorrectly as:

29°04'08"N., 83°04'06"W.; 29°04'01"N.,  
83°03'54"W.; 29°03'28"N.,  
83°04'12"W.; 29°03'28"N.,  
83°04'24"W.

The correct coordinates for the second Cedar Keys, FL site are as follows:

29°04'08"N., 83°04'06"W.; 29°04'01"N.,  
83°03'54"W.; 29°03'28"N.,  
83°04'12"W.; 29°03'35"N.,  
83°04'24"W.

Horseshoe Cove, FL—29°25'58"N.,  
83°17'32"W.; 29°25'53"N., 83°17'22"W.;  
29°25'44"N., 83°17'28"W.; 29°25'49"N.,  
83°17'38"W.

Apart from the errors noted above in the Proposed Rule's listing of site coordinates, an error also appears in the current Code of Federal Regulations (CFR) in the listing for the site designated off Anclote, FL. The southeast corner of this site is shown in the CFR as 28°08'48"N., 83°50'54"W., whereas the correct coordinates for this point, as stated above, are 28°08'30"N., 83°50'54"W. To avoid any confusion which this discrepancy might cause, the rule amendment being finalized today cancels the Anclote, FL designation as both correctly and incorrectly described.

Action: The cancellation of these ten sites as EPA interim approved ocean dumping sites is being published as final rulemaking.

Regulatory Assessments: Under the Regulatory Flexibility Act, EPA is required to perform a Regulatory Flexibility Analysis for all rules which may have a significant impact on a substantial number of small entities. Under Executive Order 12291, EPA must judge whether a regulation is "major"

and therefore subject to the requirement of a Regulatory Impact Analysis.

EPA has determined that this rule will not have a significant impact on small entities. No small entities are using or, as far as EPA is aware, are planning to use these sites in the near future. Furthermore, the cancellation of these site designations will have no effect on the economy or cause any of the other effects which could result in its being qualified as a "major" action. Consequently, this rule does not necessitate the preparation of a Regulatory Flexibility Analysis or Regulatory Impact Analysis.

This rule does not contain any information collection requirements subject to Office of Management and Budget review under the Paperwork Reduction Act of 1980, 44 U.S.C. et seq.

#### List of Subjects in 40 CFR Part 228

Water pollution control.

Dated: February 13, 1987.

Approved by:

Jack E. Ravan,

Regional Administrator for Region IV.

#### PART 228—[AMENDED]

In consideration of the foreign, Subchapter H of Chapter I of Title 40 is amended as set forth below.

1. The authority citation for Part 228 continues to read as follows:

Authority: 33 U.S.C. sections 1412 and 1418.

#### § 228.12 [Amended]

Amend § 228.12(a)(3) is amended by removing from the list of dredged material sites the following ten ocean dumping sites:

St. Augustine Harbor, FL—29°55'04"N.,  
81°17'04"W.; 29°55'13"N., 81°16'11"N.;  
29°54'30"N., 81°15'58"W.; 29°54'19"N.,  
81°16'51"W.

St. Lucie Inlet, FL—27°09'58"N.,  
80°09'30"W.; 27°09'58"N., 80°08'42"W.;  
27°09'52"N., 80°08'42"W.; 27°09'52"N.,  
80°09'30"W.

Ponce de Leon Inlet, FL—29°04'46"N.,  
80°53'40"W.; 29°04'36"N., 80°53'40"W.;  
29°04'36"N., 80°54'26"W.; 29°04'40"N.,  
80°54'26"W.

Largo Sound, FL—25°06'06"N.,  
80°24'42"W.; 25°05'58"N., 80°24'05"W.;  
25°05'50"N., 80°24'10"W.; 25°05'58"N.,  
80°24'47"W.

Anclote, FL—28°09'00"N., 83°51'48"W.;  
28°09'00"N., 83°50'54"W.; 28°08'48"N.,  
83°50'54"W.; 28°08'30"N., 83°51'48"W.

Pithlachascotee, FL—28°17'02"N.,  
82°46'21"W.; 28°17'02"N., 82°45'12"W.;  
28°16'25"N., 82°45'00"W.; 28°16'42"N.,  
82°45'00"W.; 28°16'42"N., 82°46'21"W.

Withlacoochee, FL—28°59'08"N.,  
82°48'48"W.; 28°59'32"N., 82°47'40"W.;

28°59'18"N., 82°47'32"W.; 28°58'54"N.,  
82°48'40"W.

Cedar Keys, FL—29°08'43"N.,  
83°07'53"W.; 29°08'43"N., 83°07'03"W.;  
29°08'33"N., 83°07'03"W.; 29°08'33"N.,  
83°07'53"W.

Cedar Keys, FL—29°04'08"N.,  
83°04'06"W.; 29°04'01"N., 83°03'54"W.;  
29°03'28"N., 83°04'12"W.; 29°03'35"N.,  
83°04'24"W.

Horseshoe Cove, FL—29°25'58"N.,  
83°17'32"W.; 29°25'53"N., 83°17'22"W.;  
29°25'44"N., 83°17'28"W.; 29°25'49"N.,  
83°17'38"W.

[FR Doc. 87-3718 Filed 2-26-87; 8:45 am]

BILLING CODE 6550-50-M

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Health Care Financing Administration

#### 42 CFR Parts 431, 433, and 435

[BPO-052-F]

#### Medicaid Program; Identification of Third Party Liability Resources for Medical Assistance

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

ACTION: Final rule.

**SUMMARY:** This final rule revises regulations governing a Medicaid State agency's responsibility to take reasonable measures to determine the legal liability of third parties to pay for services under the plan. The final regulations require that the agency at a minimum: (1) Obtain certain health insurance information for Medicaid applicants or recipients during the initial application and redetermination processes; (2) conduct, or in some cases attempt to secure agreements to conduct, certain types of data exchanges with specific State and Federal agencies, or in some cases alternate sources, to identify legally liable third parties; (3) conduct diagnosis and trauma code edits to identify third party resources; and (4) follow other specified procedures regarding frequency of conducting the above activities, follow up, safeguarding information obtained and exchanged, and reporting and reimbursement requirements.

The objectives of these requirements are to improve State agency performance in the identification of third party resources and to assure the timely incorporation of this resource information into the third party claims payment processing system.

This regulation also makes minor technical revisions to the Income and

Eligibility Verification System final rule published in the *Federal Register* on February 28, 1986.

**EFFECTIVE DATE:** These regulations are effective May 28, 1987.

**FOR FURTHER INFORMATION CONTACT:** Al Czerski (301) 597-0463.

**SUPPLEMENTARY INFORMATION:**

**I. Background**

*A. General*

A "third party" is any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. Examples of liable third parties include commercial insurance companies, through employment-related or privately purchased health insurance or through casualty coverage resulting from an accidental injury; an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more Medicaid recipients; fraternal groups; unions; or State Workers' Compensation commissions. Other examples of a third party would include an absent parent or other entities providing medical support or services.

*B. Statute-General*

Section 1902(a)(25) of the Social Security Act (the Act), requires that State or local Medicaid agencies take all reasonable measures to ascertain the legal liability of third parties to pay for care and services furnished to Medicaid recipients. This section requires the agency to seek reimbursement from a third party to the extent that the party is legally liable for Medicaid covered services.

Section 1903(o) of the Act prohibits Federal matching of State Medicaid payments if a private insurer would have been liable to pay for the medical care, except that the insurance contract limits or excludes liability when the individual is eligible for Medicaid. Section 1903(d)(2) of the Act provides for consideration of the Federal share of any amounts already recovered by a State from a third party for medical assistance as an overpayment to the State, and for appropriate adjustment of the quarterly Medicaid payments made by the Federal government to the State.

*C. Deficit Reduction Act (DEFRA) of 1984*

The Deficit Reduction Act of 1984 (Pub. L. 98-369, July 18, 1984) made several changes to the statute that affect requirements related to third party liability.

Section 2367 of DEFRA added a new section 1902(a)(45) to the Act to provide, as a Medicaid State plan requirement, for mandatory assignment of rights to payments for medical support and other medical care owed to recipients in accordance with section 1912 of the Act. Section 2367 also amended section 1912 of the Act to require (rather than allow as an option) that the State Medicaid plan provide that (1) as a condition of eligibility for medical assistance, individuals assign to the State their rights to any medical support or other payments for medical care and that they cooperate with the State in establishing paternity and in obtaining third party payments; and (2) States enter into certain cooperative agreements for the enforcement of rights to and collection of third party benefits. These agreements may be with State child support enforcement (title IV-D) agencies, any other appropriate agency of a State, and appropriate courts and law enforcement officials. In addition, section 2651 of DEFRA added a new section 1137 to the Act. This section, in part, requires State agencies that administer the Unemployment Compensation program, the Food Stamp program, the Aid to Families with Dependent Children (AFDC) program (title IV-A), the adult assistance programs (Titles I, X, XIV, and XVI (AABD) of the Act) and the Medicaid program to have in effect an Income and Eligibility Verification System (IEVS) under which certain income and other relevant information would be exchanged and utilized among the above agencies for the purpose of verifying eligibility and benefit amounts under the programs administered by those agencies (section 1137(a)(2) of the Act). Section 2651 also provides that such information be targeted to uses most likely to identify and prevent erroneous eligibility determinations and incorrect payments. (Section 1137(a)(4)(C) of the Act).

We interpret the language of section 1137 of the Act to mean that State Medicaid agencies must use relevant information available under that section to the extent it is useful, as determined by the Secretary in the identification and pursuit of legally liable third party payers of medical expenses, since this affects the correct amount of payment made under Medicaid.

*D. Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985*

Section 9503 of COBRA, in part, amended section 1902(a)(25) of the Act by adding a new provision under section 1902(a)(25)(A)(i) to specify that the Medicaid State plan must provide for

the collection of sufficient information to enable the State to pursue claims against third parties, with such information being collected at the time of any application or redetermination process with regard to eligibility for medical assistance.

*E. Current Third Party Regulations*

Regulations containing third party liability requirements are located at 42 CFR Part 433, Subpart D. For purposes of the provisions set forth in this document, the relevant regulations sections to be considered are §§ 433.138 through 433.140. Section 433.138 requires the State agency to take reasonable measures to determine the legal liability of third parties to pay for services covered under the State's Medicaid State plan. Section 433.139 (as amended under final regulations published on November 12, 1985 (50 FR 46652)) sets forth provisions for payment of claims involving probable third party liability. Under § 433.140, one of the requirements for Federal financial participation in Medicaid payments is that the State agency has fulfilled the requirements of §§ 433.138 and 433.139.

In an effort to improve the administration of the Medicaid program and implement certain sections of DEFRA and COBRA with respect to third party liability, on May 28, 1986, we published in the *Federal Register* a proposed rule (51 FR 19227). The major provisions of that rule, the comments received, our responses, and the changes we made in response to those comments are discussed below.

**II. Provisions of the Proposed Rule**

The May 28 proposed rule provided that the State Medicaid agency take reasonable measures to determine the legal liability of third parties to pay for services under the plan, at a minimum, providing for the following:

*A. Obtaining Health Insurance Information: Initial Application and Redetermination Processes*

**1. Collection by the Social Security Administration (SSA)**

Under section 1634 of the Act, SSA is authorized to enter into agreements with interested State Medicaid agencies to determine Medicaid eligibility for individuals who receive Supplemental Security Income (SSI) benefits under title XVI. The proposed rule would require States to enter into an agreement with HCFA (or prior to February 1, 1985, have executed a modified section 1634 agreement with SSA that is still in effect) to—

a. Provide for collection, from the SSI applicant or recipient during the initial and each redetermination process of health insurance information in the form and manner specified by the Secretary; and

b. Transmit the information to the Medicaid agency.

## 2. Collection by State Agencies Other Than the Medicaid Agency

Under § 431.10(d) of current regulations, the State plan must provide for written agreements between the Medicaid agency and other State agencies that determine Medicaid eligibility; for example, the State agency administering the AFDC program. We proposed that the Medicaid agency must modify its agreement to provide for the collection, during the initial application and each redetermination process for eligibility, of health insurance information useful in identifying legally liable third party resources. This information would be forwarded to the Medicaid agency.

## 3. Collection by State Medicaid Agency

If the State Medicaid agency determines Medicaid eligibility, our proposal would require the agency itself to collect the health information described above during the initial application and each redetermination process.

## 4. Followup Procedures

With respect to the health insurance information obtained by agencies, we would require that within 30 days the Medicaid agency must followup on such information (if appropriate) in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency can process claims under the third party liability payment procedures. We would require the State to describe in their State plan the methods the agency would use to meet these requirements.

## B. Data Exchanges With State Wage Information Collection Agencies (SWICAs), the SSA Wage and Earnings Files and State Title IV-A Agencies.

### 1. General

We also proposed changes to § 433.138 of the regulations that would require use of information obtained from certain data exchanges which each State is now required to have under the final IEVS regulations published in the *Federal Register* February 28, 1986 (51 FR 7178). That final rule implements section 1137 of the Act, described earlier

in this document, by requiring Federally-funded State administered programs such as Medicaid, AFDC, food stamps, etc., to have in effect an Income and Eligibility Verification System (IEVS) under which certain wage and other relevant information must be exchanged and utilized among those program agencies for purposes of verifying eligibility and benefit amounts under those programs.

## 2. Social Security Numbers (SSNs) of Absent or Custodial Parents

The agency would be required to incorporate into the Medicaid eligibility case file the names and SSNs (to the extent available) of absent or custodial parents of recipients for the purpose of conducting data matches with SWICAs, the SSA wage and earnings files and the Workers' Compensation or Industrial Accident Commissions. As set forth in the IEVS final rule, a SWICA is the State agency administering the State unemployment compensation law, a separate agency administering a quarterly wage reporting system, or a State agency administering an acceptable alternative system. A SWICA that does not use reported wages for unemployment insurance benefit calculations or that is an alternative system approved by the Secretary of Labor is required (and other SWICAs are strongly encouraged) to maintain and exchange wage information that identifies the SSN, full name, wages earned, and an identifier of the employer (for example, name and address). The SSA wage and earnings files are nationwide files of wages, including those paid by Federal government, earnings from self-employment and pension benefits.

## 3. Data Exchanges With SWICAs and SSA Wage and Earnings Files

Under our proposal the agency would be required (for purposes of identifying third parties) as part of the SWICA and SSA wage and earnings files data exchange requirements, to use the information that identifies those Medicaid recipients that are employed and their employer(s), and the agency must also (assuming that it has obtained the names and SSNs of absent or custodial parents of Medicaid recipients) obtain information that identifies those absent or custodial parents of recipients that are employed and their employer(s), unless the agency can demonstrate to HCFA that it has an alternate source of information that can be obtained as timely and is as complete and useful for identifying third parties as SWICA and SSA information.

## 4. Data Exchanges with State Title IV-A (Aid to Families With Dependent Children) Agencies

The proposed rule provides that the Medicaid agency must, as required under the final IEVS regulations, request from the State title IV-A agency income information obtained from the title IV-A agency SWICAs and SSA wage and earnings files data exchanges to identify those Medicaid recipients that are employed and their employer(s).

## 5. Followup Procedures

With respect to the information obtained from the data exchanges with the SWICAs, the SSA wage and earnings files and title IV-A agencies, followup requirements would be the same as for obtaining health insurance information.

## 6. Frequency of Exchanges

The frequency of the Medicaid agency's data exchanges with regard to SWICAs and SSA wage and earnings files have already been set under the final IEVS regulations. The frequency of title IV-A agency data exchanges with SWICAs and SSA wage and earnings files under the IEVS regulations are located at 45 CFR 205.55(a)(1) and (a)(3). With regard to the Medicaid agency obtaining information from the State title IV-A agency, our proposal provides that the information be obtained from the title IV-A agency on a timely basis that is consistent with the intervals specified in § 205.55(a)(1) and (a)(3).

## C. Other Data Exchanges

We proposed to require that State Medicaid agencies attempt to secure agreements with the following two agencies (to the extent permitted by State law) to conduct data exchanges as discussed below.

### 1. State Worker's Compensation or Industrial Accident Commission Files

Assuming that an agreement can be reached, and such exchanges comply with applicable State and Federal law, data exchanges would entail matching identifying information (for example, name, SSN) for Medicaid recipients and (assuming names and SSNs have been obtained) absent or custodial parents of Medicaid recipients with Workers' Compensation or Industrial Accident files to identify those individuals with employment-related injuries or illnesses.

### 2. State Motor Vehicle Accident Report Files

Required data exchanges would involve matching identifying information for Medicaid recipients with State Motor

Vehicle Accident Report Files to identify those recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers or passengers in motor vehicles, or as bicyclists.

### 3. Securing Agreements

The proposed rule would require the Medicaid agency to attempt to secure agreements with the above two agencies. If unable to secure agreements, the agency would have to submit documentation to the regional office that demonstrates that the agency made a reasonable attempt to secure them. If HCFA determines that a reasonable attempt was made, the requirements concerning data exchanges with these two agencies would be deemed to be met.

### 4. Frequency of Exchange

If agreements have been secured, States would be required to conduct data exchanges with the above two agencies on a routine and timely basis. The State Medicaid agency would have the flexibility to develop a plan (as part of its State plan) defining the frequency of the exchanges.

### 5. Followup Procedures

a. *State Workers' Compensation or Industrial Accident Commission Files.* Followup requirements would be the same as for obtaining and acting on health insurance information. States would have flexibility in developing a plan for followup.

b. *State Motor Vehicle Accident Report Files.* With respect to the information obtained from the State Motor Vehicle Accident Report Files, our proposal provides that the agency develop and submit a plan (as part of its State plan) that describes its methods for following up on this information in order to identify legally liable third party resources so the agency can process claims under the third party liability payment procedures. Also, after followup, the agency would be required to incorporate that information into the eligibility case file and into its third party data base and third party recovery unit within timeframes specified in the State plan.

### D. Diagnosis and Trauma Code Edits

#### 1. General

We proposed to amend regulations to include a requirement regarding diagnosis and trauma code edits. State claims data that are generated periodically include a listing of claims paid, the amount of the claim and the diagnosis code under which the claim was submitted. These diagnosis codes

can be found in the International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD-9-CM). We proposed to require that State agencies take action to identify those paid claims that contain diagnosis or trauma codes 800-999, inclusive, and follow up on that information for purposes of identifying liable third parties.

### 2. Frequency of Trauma Edits and Followup

We would require agencies to conduct these edits on a routine and timely basis and develop and specify in the plan the frequency of the edits performed and the methods used to follow up. As part of the followup procedures, we also proposed that States periodically take action to identify those trauma codes which have yielded the highest third party collections. Based on these findings, future followup procedures would give higher priority to those codes likely to be the most productive. After followup, the agency must incorporate all information identifying legally liable third parties so the agency can process claims under the third party liability payment procedures into the eligibility case file and its third party data base and recovery unit within timeframes specified in the plan.

### E. Safeguarding of Information

#### 1. General Safeguards

Our proposal provided that the agency have criteria that govern the safeguarding of third party liability data received under the proposed rule and also provided that the agency must safeguard information obtained under this proposed rule in accordance with regulations at Part 431, Subpart F.

#### 2. Data Exchanges

The proposal provided that the State Medicaid agency have a written agreement before requesting information from, or releasing information to, other agencies to identify legally liable third party resources under the data exchange requirements of the proposed regulations. The written agreement requirements would parallel the requirements contained in the final IEVS regulations.

### F. Reimbursement and Reports

We proposed to provide for reimbursement to agencies for furnishing information and for reports with respect to certain activities.

#### 1. Reimbursement

We would require State Medicaid agencies to reimburse other agencies, upon request, for reasonable costs

incurred in furnishing information to the Medicaid agency. Also, in connection with reimbursement, we would require each State Medicaid agency to specify, when entering into an agreement with another agency to obtain data, how it would reimburse reasonable costs for those activities.

### 2. Reports

Finally, we would require State Medicaid agencies to provide such reports as the Secretary prescribes for purposes of determining compliance with requirements in § 433.138, and evaluating the effectiveness of the third party liability identification system.

## II. Public Comments

We received suggestions on the proposed rule from eight Medicaid State agencies and State technical advisory groups. The main comments and our responses to those comments are as follows:

### A. Followup

*Comment:* Several commenters objected to the 30 day timeframe for following up on information in order to identify liable third party resources, and for incorporating such information into the eligibility case file and third party data base. They contend this is not adequate time to verify and process the information. One commenter pointed out that the 30 day requirement is in conflict with System Performance Review (SPR) requirements. The SPR allows for 30 days after verification of third party data for the information to be placed into the third party data base. Two commenters requested clarification of the 30 day requirement. One of the commenters questioned whether the timeframe begins at intake and ends when the request for verification is made or whether it begins upon receipt of verified information and ends when the data is entered into the third party data base. Another commenter asked if the data from IV-A and the data matches must be followed up on within 30 days of receipt of third party data or entered into the eligibility file and the third party data base within 30 days or both.

*Response:* We are revising the followup timeframes from 30 to 60 days for followup on health insurance information obtained from applicants and recipients and workers' compensation data exchanges. The 60 day period encompasses the following required followup activities:

(1) Verification that third party resources exist, and (2) incorporation of identifying information into the

eligibility case file and into the State's third party data base and third party recovery unit. We believe the additional 30 days will provide State agencies with sufficient time to complete all activities necessary to verifying third party resources including those situations in which, for example, followup with several agencies would be necessary to verify information.

The followup procedures for identifying legally liable third party resources for the SWICA, SSA wage and earnings files, and title IV-A data exchanges were set forth in final IEVS regulations published February 28, 1986 (§ 435.952(d)). The followup timeframe for verifying information under these exchanges and entering information into the case file is 30 days. An exception applies when the agency does not receive requested verification within the timeframe. However, action on no more than twenty percent of the information items may be delayed beyond 30 days. Therefore, to be consistent with the requirements under the IEVS regulations, we are amending § 433.138(g)(i) of the proposed rule to allow the same exception criteria to the 30 day timeframe for followup that is contained in § 435.952(d).

We are making no changes in followup timeframes with respect to the State Motor Vehicle Accident Report File data exchanges and diagnosis and trauma code edits since the proposed rule does not include a 30 day followup requirement. States have flexibility in describing in their State plans the methods the agency will use for following up on potential third party resource information.

#### B. Obtaining Health Insurance Information-SSA

*Comment:* One commenter expressed concern about the proposed requirement that all section 1634 States must contract with the Social Security Administration (SSA) to collect and transmit health insurance information obtained from SSI clients at application and redetermination. Inasmuch as SSA will not verify the TPL information obtained at intake, the commenter objects to being required to pay for information that is not verified.

*Response:* The current agreement between SSA and HCFA does not require SSA to verify TPL information obtained during initial application and redetermination processes. This remains the responsibility of the State Medicaid Agency. However, the cost to States under the agreement between HCFA and SSA for the TPL data is based on the collection and transmission of TPL information to the State Medicaid

agency only. It would be much more costly to the States if SSA was required to verify the data.

#### C. Data Matches

##### 1. SSNs

*Comment:* One commenter pointed out that experience has indicated that data matches on recipients with unverified SSNs has resulted in mismatches and discrepancy problems. The commenter is concerned that performing matches using absent parents' SSNs will result in an even greater number of mismatches and discrepancies since these SSNs are not verified by the State Medicaid agency. The State would have to expend a great deal of time and money to research and disregard the data from such mismatches.

*Response:* We are aware that there could be mismatches based on the use of unverified SSNs of custodial parents or SSNs of absent parents furnished by recipients. However, as a result of changes made under section 2367 of DEFRA, applicants (usually custodial parents) are required to provide their SSNs as a condition of Medicaid eligibility. (Previously, SSNs were required as a condition of AFDC eligibility.) In addition, under the medical support regulations published by the Office of Child Support Enforcement (OCSE) on October 16, 1985, the IV-D agency is now required to provide the SSN of the absent parent to the Medicaid Agency (45 CFR 306.50(a)). With the advent of these new requirements we believe the number of mismatches will decrease. Also, based on the experience of States reporting in *A Guide to Successful State Agency Practices-TPL in the Medicaid Program*, the data matches using absent and custodial parents SSNs have proven to be cost effective.

##### 2. Accident Report Files

*Comment:* One commenter objected to the requirement that States conduct data exchanges with the State Motor Vehicle Accident Report Files. The commenter stated that since States do not require SSNs to be included on the accident reports, it would not be cost-effective to require States with a large Medicaid population to conduct a match manually by name. The commenter also pointed out that the same information could be obtained from the diagnosis and trauma code edits.

*Response:* We recognize that a manual match of Medicaid recipients by name with the State Motor Vehicle Accident Report Files is labor intensive.

However, experience indicates that due to the severity of motor vehicle accident related injuries, extended medical care is usually required which results in substantial Medicaid program expenditures. In addition, with respect to the last comment, Motor Vehicle Accident Report Files may provide more comprehensive information regarding the identity of the insurer of parties involved in the accident, witnesses, and responsible parties (information that the recipient cannot always provide).

In considering the suggestion of the commenter regarding cost effectiveness, if HCFA receives substantial complaints from State Medicaid agencies regarding the cost effectiveness of the State Workers' Compensation, Motor Vehicle Accident Report File data matches and diagnosis and trauma code edits we will reevaluate these requirements.

#### D. Diagnosis and Trauma Code Edits

*Comment:* Several commenters objected to following up on all claims that contain diagnosis or trauma codes 800-999. Certain codes (e.g., 994.6, motion sickness) are nonproductive for identifying third party resources.

They asked if States have flexibility to eliminate some diagnosis codes from the initial identification of claims process based on their experience. One commenter asked whether a State that can successfully followup on all trauma related claims is required to prioritize claims for followup.

*Response:* The specific diagnosis codes in the 800 to 999 series inclusive, contained in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) are codes that could denote a possible trauma related injury. The use of diagnosis code edits to identify third party resources has produced significant third party recoveries. We agree with the commenter, however, that the likelihood of code 994.6, Motion Sickness, being productive is remote. Therefore, we are amending regulations at § 433.138(e) to remove from the 800-999 series for edits the code 994.6. Also, as we discussed in our response to the previous comment, if we receive substantial complaints regarding diagnosis and trauma code edits, we will reevaluate the code requirements regarding this activity.

With respect to followup requirements, in our proposed rule we proposed to require that States periodically take action to identify those trauma codes which have yielded the highest third party collections and give higher priority to following up on those codes which are likely to be the most

productive. We believe the identification of the most productive codes, with revisions based on periodic analysis will ensure a more cost-effective program and, therefore, do not believe that a State should be permitted to avoid this prioritization process because it has the resources to fully follow up on all trauma related claims.

#### E. Eligibility File and Data Base

*Comment:* Two commenters objected to including information on resources belonging to someone other than the recipient in the eligibility case file and third party data base. They claim that in the case of an automobile accident, updating the files with the other party's policy information would result in claims being incorrectly edited.

*Response:* We believe that all identifying third party information should be included in the Medicaid eligibility case file since that file is intended to contain all pertinent information involving the recipient. With respect to entry of information into the third party data base, we would expect that once Medicaid has been reimbursed, the information should remain in the third party data base for a reasonable period in case there is a recurring need for additional medical care by the recipient. The information including the automobile accident data and the diagnosis and trauma code edits is not required to be placed in the third party data base on a permanent basis.

#### F. Definitions

##### 1. Custodial parent

*Comment:* One commenter contends that the reference to "custodial parent" used in § 433.138(c) of the proposed regulations is inappropriate unless the regulation means to identify parents having the legal status of custodial parent. They suggested use of the phrase "parent living with child and providing parental care and guidance."

*Response:* We believe the use of the term "custodial parent" is appropriate since "custodial parent" is used extensively in Medicaid regulations and other program regulations (for example, OCSE regulations). Any revision to this phrase (for example, making a distinction between a parent that has a legal status of a custodial parent and one that does not) may result in confusion and a conclusion that we are setting up a new category of parent.

##### 2. Eligibility Case File

*Comment:* Two commenters requested that we define "eligibility case file." They questioned whether it was an automated file or a hard copy file and

also whether it was the master eligibility file maintained by the Medicaid agency or the eligibility file of the certifying agency when it is separate from the Medicaid agency.

*Response:* The Medicaid eligibility file is the hard copy or automated eligibility case record containing the required current and past data necessary to establish eligibility and evaluate the efficiency and effectiveness of State eligibility, claims processing and third party liability operations. In some States it may be a county office hard copy file while in others it may be an automated record.

The Medicaid eligibility file is the file maintained by the certifying agency (if separate from the Medicaid agency). For example, the IV-A agency file would be the eligibility file in States where IV-A is responsible for the eligibility determination.

#### G. General

##### 1. Clarification

*Comment:* One commenter requested that the language contained in § 433.138(d)(1)(ii) be clarified. They contend that it is not clear whether we mean employed absent or custodial parents of recipients or whether we mean absent or custodial parents of employed recipients.

*Response:* We concur with the commenter and are revising § 433.138(d)(1)(ii) to read ". . . identifies employed absent or custodial parents of recipients and their employer(s)."

*Comment:* One commenter pointed out that in sections II.B.5 and II.C.5 of the preamble to the proposed rule, reference is made to section II.A.5 which is not included in the proposed regulations.

*Response:* The commenter is correct. The reference should have been II.A.4.

##### 2. Reasonable Measures

*Comment:* A commenter recommended States be given an opportunity to determine reasonable measures based on appropriate cost-effective needs.

*Response:* States have been provided with sufficient opportunity to determine and take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State plan. While some States have taken appropriate measures to do so, others have not. In its report to the Congress dated February 12, 1985, the General Accounting Office (GAO) indicates that States are not taking adequate measures to identify and collect from available third party resources. A Maximus study completed in 1981 concluded that between 1.0 and

2.5 percent of annual Medicaid expenditures could be eliminated through better use of third party information collection and utilization. The regulation is intended to assist States in improving the effectiveness of third party liability programs.

#### H. Confidentiality

*Comment:* One commenter was concerned that contacting the employer of an absent parent would violate the parent's rights to confidentiality (since the absent parent is not a member of the applying household). The commenter questioned whether the State has the right to contact an absent parent's employer.

*Response:* Under § 306.50 of the final OCSE regulations published on October 16, 1985, the State IV-D agency is now required to: gather medical support enforcement information, submit the information to the Medicaid agency for use in its third party liability activities, and to petition the court to include employment related group health insurance coverage for dependent children in new or modified court orders. The IV-D agency's authority for obtaining this information is vested under title IV-D of the Act and applies to all IV-D cases, including those which are not AFDC recipients. Included in the information obtained by the IV-D agency is the name and address of the absent parent's place of employment, whether the absent parent has a health insurance policy and, if so, the policy number. The IV-D agency is also required to take steps to enforce court or administrative orders and provide the information to the Medicaid agency when a support order requires that the absent parent obtain health insurance coverage for a dependent child. As a result of the OCSE regulation, the need for the Medicaid agency to contact an absent parent's employer should not be necessary in situations where the Medicaid case involves a family receiving IV-D services. However, since a recipient must assign all rights to available third party benefits Medicaid is authorized to make such contacts as necessary to establish the existence of available third party benefits.

*Comment:* One commenter requested that we clarify the phrase contained in the preamble to the proposed rule (section II.B.4.) regarding written agreements to make Medicaid eligibility determinations.

*Response:* When we made reference in the preamble under section II.B.4. to written agreements, we stated that these written agreements had been mentioned earlier in the preamble. We refer the

commenter to section II.A.2. of the preamble to the proposed rule, which discusses such agreements.

#### I. Reporting Requirements

**Comment:** One commenter objected to the requirement in proposed § 433.138(j) that State Medicaid agencies provide such reports as the Secretary prescribes for purposes of determining compliance with requirements in § 433.138. The commenter asserted that specific reporting requirements must be prescribed and that States be given opportunity to comment on such requirements.

**Response:** We have not included the specific reporting in the regulation since the requirements have not been determined at this time. The reporting requirements will involve the States furnishing necessary information required to evaluate the implementation and effectiveness of these regulations. When the reporting requirements have been determined we will solicit State comments through the State Medicaid Directors Third Party Liability Technical Advisory Group prior to the issuance of the Medicaid Manual instructions.

#### J. Implementation-Timeframes

**Comment:** Three commenters expressed concern that sufficient time be given for States to implement the proposed changes to the regulations. They believe it will take over a year for some States to negotiate necessary contracts, to redesign systems, and to establish and implement procedures. One of these commenters recommended being given one full year to implement certain provisions of COBRA and recommended that System Performance Review (SPR) penalties not be imposed for the first full year following implementation of the provisions.

**Response:** We believe that States were given sufficient notice of the implementation requirements for the data exchanges with SWICAs, the SSA Wage and Earnings file, and State Title IV-A agencies since those requirements were published in the IEVS Notice of Proposed Rulemaking on March 14, 1985 and the final rule on February 28, 1986. We considered the implementation time required by States in establishing the effective date for this regulation. With regard to implementation of COBRA, the requirements contained in the proposed rule include only one provision contained under section 9503 of COBRA. That provision amends section 1902(a)(25) of the Act by requiring that the State Plan must provide for the collection of sufficient information to enable States to pursue claims against third parties with the information being

collected at application or eligibility redetermination process.

With regard to the SPR penalty mentioned by the commenter, our proposed rule does not include that provision of the COBRA legislation. That provision will be contained in another HCFA proposed rule to be published shortly. We suggest the comment regarding the SPR penalties be submitted in connection with the proposed rule to be published in the Federal Register.

#### K. Paperwork Burden

**Comment:** Two commenters objected to additional paperwork requirements under these regulations, such as maintaining documentation for audit trails to verify timeliness and accuracy of data updates. These commenters believe that these requirements are unnecessary.

**Response:** The TPL information must be entered into the Medicaid file and the third party data base on a timely basis in order to provide the information necessary to determine if the requirements of § 433.138 and 433.139 are being met. State and Federal reviewers must have access to current and past third party liability data to evaluate the effectiveness of the eligibility, claims processing and third party liability operations.

#### III. Technical Revisions

On February 28, 1986, we published in the Federal Register a final rule, establishing the Income and Eligibility Verification System (the IEVS), that implements the legislative requirement that Medicaid State agencies exchange information with various agencies to verify income and eligibility of applicants and recipients (51 FR 7178). One section of that rule, 42 CFR 435.960, has proven to be ambiguous in content.

The purpose of § 435.960 is to implement the legislative requirement that State agencies use a standardized format, as prescribed by the Secretary, when releasing or requesting information. Exceptions to this general rule are the formats the Social Security Administration (SSA) and the Internal Revenue Service (IRS) use; State agencies must request data from SSA and IRS as those agencies require. Paragraph (a) of the section as written does not clearly state this policy, but instead appears to emphasize requests for information rather than formats. In addition, the paragraph cross-references only § 435.945(b) for the programs involved. Although § 435.945(b) discusses those agencies to which a Medicaid agency must furnish information, § 435.960 dictates the

agencies from which the Medicaid agency must request information; § 435.948(a) is the section that lists the agencies from which Medicaid State agencies must request information. Since the agencies must use the same format (except as noted) for requesting and furnishing information, we are revising paragraph (a) to emphasize the use of a standardized format for requesting and releasing data and to cross-refer to § 435.948(a) as well as § 435.945(b) to assure that all agencies are using the same format.

The current paragraph (b) is deleted. In view of the revision to paragraph (a) (which will be broken down into two paragraphs), paragraph (b) is redundant, except for its requirement that release and receipt of data be "timely". Since this requirement does not fit well in a section on standardized formats, and one cannot require an agency to receive information timely, we are moving the requirement to § 435.945(b) to require that "The agency must timely furnish to other agencies . . . information . . .".

#### IV. Changes to the Regulations

Based on the comments received, we are making the following changes to the proposed rule.

- We are clarifying the language contained in § 433.138(d)(1)(ii) to make clear that we are referring to employed absent or custodial parents, not employed recipients.

- We are amending § 433.138(d)(3) to make clear that the Medicaid agency is to request from the State title IV-A agency information that has not been previously reported. This should alleviate the collection of duplicate information which may result in unnecessary workload burden on both agencies.

- We are amending § 433.138(e) to delete from the required 800-999 series for edits, the code 994.6.

- To be consistent with the requirements in the IEVS regulations, § 433.138(g)(i) is amended to allow the same flexibility in the 30 day timeframe for followup that is contained in § 435.952(d).

- We are amending from 30 days to 60 days the timeframe for State Medicaid agencies to followup on health insurance information and on information obtained under the workers' compensation data exchanges.

- We have made minor technical changes to various sections of the regulations to correct typographical errors and to make minor clarifications.

## V. Impact Analyses

### A. Executive Order 12291

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any 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 geographic 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.

This regulation is likely to result in a significant reduction of Federal Medicaid program expenditures. Additionally, while there may be moderate increases in State administrative costs, such costs would be offset by larger savings to States due to more effective identification of liable third parties.

Implementation of this rule would result in program savings to the extent that liable third parties are identified and payments are made for services that would otherwise be paid for by the Medicaid program under existing TPL identification programs. It is difficult to estimate precisely the overall impact of this rule due to the flexible nature of many of the requirements, a lack of sufficient data on existing State TPL programs, and the overlapping nature of this regulation with other regulations that affect TPL collections.

We have, however, made a rough estimate of the impact based on a study prepared under contract with HCFA by Maximus, Inc. (Contract No. 500-79-0500) titled *Evaluation of the Cost-Effectiveness of the Collection of Third-Party Liability by State Medicaid Agencies*, completed in 1981. Based on the findings of that study, we concluded that between 1.0 and 2.5 percent of annual Federal Medicaid expenditures could be eliminated through better use of TPL information collection and related State agency procedures. We attempted to take into account the impact of related regulations discussed elsewhere in this preamble, and developed low and high approximations, reflecting 1.0 percent and 2.5 percent reductions respectively, of savings that could be achieved if all the TPL-related regulations were implemented. We then apportioned that estimate to each of the regulations under development. Below, we provide our best high and low approximations illustrating the range of

potential savings that would result from implementing the provisions of this rule.

FEDERAL SAVINGS PER FISCAL YEAR  
[Rounded to nearest \$25 million]

|           | 1987 | 1988 | 1989 | 1990 | 1991 |
|-----------|------|------|------|------|------|
| Low.....  | 25   | 75   | 125  | 125  | 150  |
| High..... | 75   | 200  | 300  | 325  | 350  |

In total, we estimate that implementation of this rule would result in Federal Medicaid savings of between 500 million and 1.275 billion during the next five-year period. Because potential annual savings would exceed the \$100 million threshold under E.O. 12291, this is considered a major rule and a regulatory impact analysis is necessary. While each requirement is discussed previously in this preamble, fulfilling some of the requirements of an impact analysis, we are highlighting below the areas that may produce the greatest impact.

The costs of implementation and operation of a revised TPL identification program will vary from State to State. We recognize that in some States the costs will be high. However, it is these States that we believe will benefit the most from the requirements. The States that already have effective TPL identification and collection procedures will not benefit as much. On the other hand, implementation costs for them will be relatively small.

The main factors that will affect the magnitude of savings achieved by implementation of these regulations are:

- The effectiveness of agencies in obtaining liability information at the time of application or redetermination.
- The intensity of followup actions taken by the State Medicaid agency to bring about actual payments from liable third parties.
- The degree of success in obtaining agreements with other agencies for exchanging relevant data.
- The relative usefulness and frequency of utilizing diagnosis codes related to trauma in identifying liable third parties.

This final rule should have no effect on Medicaid eligibility determinations. It is intended to provide assistance and incentives to States for the identification of alternative sources of payment for health services provided to Medicaid participants. It is further possible that by making Medicaid enrollees more aware of other health insurance coverage available to them, access to care may be enhanced.

### B. Regulatory Flexibility Act

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 regulation would not have a significant economic impact on a substantial number of small entities.

The primary impact of this rule would fall on State Medicaid agencies and on other, primarily private, insurers. For purposes of the RFA, States are not considered small entities. Further, we do not believe that increased payments on the part of other insurers or payers would represent a significant portion of their total payments. The Department generally uses 3 percent as a threshold in determining whether the impact is significant under the RFA. We estimate that private insurance companies, in calendar year 1984, paid out about \$111.8 billion in the form of benefits to enrollees. Thus, even the high estimate of \$325 million eventual additional annual payments by other payers is significantly less than the 3 percent criteria. Additionally, the increased payments by third parties would not be a result of revised payment policies. These would be payments for which the third parties are presently liable but ineffectively identified and billed. For these reasons, we have determined, and the Secretary certifies, that this regulation would not have a significant economic impact on a substantial number of small entities. Therefore, a final regulatory flexibility analysis is not required.

### VI. Information Collection Requirements

Sections 431.306, 433.138(b)-(h) and (j), 435.945(b), and 435.960(a) of this final rule contain information collection requirements. However, the information collection requirements contained in §§ 435.945(b) and 435.960(a) have been approved under OMB control number 0938-0467. As required by the Paperwork Reduction Act of 1980, we have submitted a copy of the final to the Office of Management and Budget (OMB) for its review of these information collection requirements. Other organizations and individuals desiring to submit comments on the information collection requirements should direct them to the agency official designated for this purpose whose name appears in this preamble, and to the Office of Information and Regulatory Affairs, OMB, New Executive Office Building, Room 3208, Washington, DC 20503, Attn: Allison Herron.

## VII. List of Subjects

## 42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Reporting and recordkeeping requirements.

## 42 CFR Part 433

Administrative practice and procedure, Claims, Grant programs-health, Medicaid, Reporting and recordkeeping requirements.

## 42 CFR Part 435

Aid to families with dependent children, Grant programs-health, Medicaid, Supplemental Security Income (SSI).

42 CFR Chapter IV, Subchapter C is amended as set forth below:

**CHAPTER IV—HEALTH CARE FINANCING  
ADMINISTRATION, DEPARTMENT OF  
HEALTH AND HUMAN SERVICES**

**SUBCHAPTER C—MEDICAL ASSISTANCE  
PROGRAMS**

**PART 431—STATE ORGANIZATION  
AND GENERAL ADMINISTRATION**

The authority citation for Part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act. (42 U.S.C. 1302), unless otherwise noted.

A. Part 431, Subpart F is amended as set forth below:

1. In § 431.305, the introductory text to paragraph (b) is republished and a new paragraph (b)(7) is added to read as follows:

**§ 431.305 Types of information to be safeguarded.**

(b) This information must include at least—

(7) Any information received in connection with the identification of legally liable third party resources under § 433.138 of this chapter.

2. In § 431.306, a new paragraph (h) is added to read as follows:

**§ 431.306 Release of information**

(h) Before requesting information from, or releasing information to, other agencies to identify legally liable third party resources under § 433.138(d) of this chapter, the agency must execute data exchanges agreements, as specified in § 433.138(h)(2) of this chapter.

**PART 433—STATE FISCAL  
ADMINISTRATION**

B. Part 433 is amended as set forth below:

1. The authority citation for Part 433 is revised to read as follows:

Authority: Secs. 1102, 1137, 1902(a)(4), 1902(a)(25), 1902(a)(45), 1903(a)(3), 1903(d)(2), 1903(d)(5), 1903(o), 1903(p), 1903(r), and 1912 of the Social Security Act; 42 U.S.C. 1302, 1320b-7, 1396a(a)(4), 1396a(a)(25), 1396a(a)(45), 1396b(a)(3), 1396b(d)(2), 1396b(d)(5), 1396b(o), 1396b(p), 1396b(r) and 1396k, unless otherwise noted.

2. In Part 433, Subpart D, § 433.138 is revised to read as follows:

**§ 433.138 Determining liability of third parties.**

(a) *Basic provisions.* The agency must take reasonable measures to determine the legal liability of third parties to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (j) of this section.

(b) *Obtaining health insurance information: Initial application and redetermination processes for Medicaid eligibility.* (1) If the Medicaid agency determines eligibility for Medicaid, it must, during the initial application and each redetermination process, obtain from the applicant or recipient such health insurance information as would be useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f). Health insurance information may include, but is not limited to, the name of the policy holder, his or her relationship to the applicant or recipient, the social security number (SSN) of the policy holder, and the name and address of insurance company and policy number.

(2) If Medicaid eligibility is determined by the Federal agency administering the supplemental security income program under title XVI in accordance with a written agreement under section 1634 of the Act, the Medicaid agency must take the following action. It must enter into an agreement with HCFA or must have, prior to February 1, 1985, executed a modified section 1634 agreement that is still in effect to provide for—

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of health insurance information in the form and manner specified by the Secretary; and

(ii) Transmittal of the information to the Medicaid agency.

(3) If Medicaid eligibility is determined by any other agency in accordance with a written agreement, the Medicaid agency must modify the agreement to provide for—

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of such health insurance information as would be useful in identifying legally liable third party resources so that the Medicaid agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f). Health insurance information may include, but is not limited to, those elements described in paragraph (b)(1) of this section; and

(ii) Transmittal of the information to the Medicaid agency.

(c) *Obtaining other information.* The agency must, for purposes of implementing the requirements in paragraph (d)(1)(ii) and (d)(4)(i) of this section, incorporate into the eligibility case file the names and SSNs of absent or custodial parents of Medicaid recipients to the extent such information is available.

(d) *Exchange of data.* To obtain and use information for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f), the agency must take the following actions:

(1) Except as specified in paragraph (d)(2) of this section, as part of the data exchange requirements under § 435.945 of this chapter, from the State wage information collection agency (SWICA) defined in § 435.4 of this chapter and from the SSA wage and earnings files data as specified in § 435.948(a)(2) of this chapter, the agency must—

(i) Use the information that identifies Medicaid recipients that are employed and their employer(s); and

(ii) Obtain and use, if their names and SSNs are available to the agency under paragraph (c) of this section, information that identifies employed absent or custodial parents of recipients and their employer(s).

(2) If the agency can demonstrate to HCFA that it has an alternate source of information that furnishes information as timely, complete and useful as the SWICA and SSA wage and earnings files in determining the legal liability of third parties, the requirements of paragraph (d)(1) of this section are deemed to be met.

(3) The agency must request, as required under § 435.948(a)(6)(i), from the State title IV-A agency, information not previously reported that identifies

those Medicaid recipients that are employed and their employer(s).

(4) Except as specified in paragraph (d)(5) of this section, the agency must attempt to secure agreements (to the extent permitted by State law) to provide for obtaining—

(i) From State Workers' Compensation or Industrial Accident Commission files, information that identifies Medicaid recipients and, (if their names and SSNs were available to the agency under paragraph (c) of this section) absent or custodial parents of Medicaid recipients with employment-related injuries or illnesses; and

(ii) From State Motor Vehicle accident report files, information that identifies those Medicaid recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.

(5) If unable to secure agreements as specified in paragraph (d)(4) of this section, the agency must submit documentation to the regional office that demonstrates the agency made a reasonable attempt to secure these agreements. If HCFA determines that a reasonable attempt was made, the requirements of paragraph (d)(4) of this section are deemed to be met.

(e) *Diagnosis and trauma code edits.* With the exception of code 994.6, the agency must take action to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 (ICDCM) International Classification of Disease, 9th Revision, Clinical Modification, Volume 1) inclusive, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f).

(f) *Data exchanges and trauma code edits: Frequency.* The agency must conduct the data exchange required in paragraph (d)(1) of this section in accordance with the intervals specified in § 435.948 of this chapter, the data exchanges required in paragraph (d)(3) of this section on a timely basis that is consistent with the intervals specified in 45 CFR 205.55 (a)(1) and (a)(3); and must conduct the data exchanges and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely basis. The State plan must specify the frequency of these activities.

(g) *Followup procedures for identifying legally liable third party resources.*—(1) *SWICA, SSA wage and earnings files, and title IV-A data exchanges.* With respect to information obtained under paragraphs (d)(1) through (d)(3) of this section—

(i) Except as specified in § 435.952(d)

of this chapter, within 30 days, the agency must followup (if appropriate) on such information in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(1)(i) of this section.

(2) *Health insurance information and workers' compensation data exchanges.* With respect to information obtained under paragraphs (b) and (d)(4)(i) of this section—

(i) Within 60 days, the agency must followup on such information (if appropriate) in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(2)(i) of this section.

(3) *State motor vehicle accident report file data exchanges.* With respect to information obtained under paragraph (d)(4)(ii) of this section—

(i) The State plan must describe the methods the agency uses for following up on such information in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify timeframes for incorporation of the information.

(4) *Diagnosis and trauma code edits.* With respect to the paid claims identified under paragraph (e) of this section—

(i) The State plan must describe the methods the agency uses to follow up on such claims in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f) (Methods must include a procedure for periodically identifying those trauma codes that yield the highest third party

collections and giving priority to following up on those codes.);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify the timeframes for incorporation of the information.

(h) *Obtaining other information and data exchanges: Safeguarding information.* (1) The agency must safeguard information obtained from and exchanged under this section with other agencies in accordance with the requirements set forth in Part 431, Subpart F of this chapter.

(2) Before requesting information from, or releasing information to other agencies to identify legally liable third party resources under paragraph (d) of this section the agency must execute data exchange agreements with those agencies. The agreements, at a minimum, must specify—

(i) The information to be exchanged;

(ii) The titles of all agency officials with the authority to request third party information;

(iii) The methods, including the formats to be used, and the timing for requesting and providing the information;

(iv) The safeguards limiting the use and disclosure of the information as required by Federal or State law or regulations; and

(v) The method the agency will use to reimburse reasonable costs of furnishing the information if payment is requested.

(i) *Reimbursement.* The agency must, upon request, reimburse an agency for the reasonable costs incurred in furnishing information under this section to the Medicaid agency.

(j) *Reports.* The agency must provide such reports with respect to the data exchanges and trauma code edits set forth in paragraphs (d)(1) through (d)(4) and paragraph (e) of this section, respectively, as the Secretary prescribes for the purpose of determining compliance under § 433.138 of the regulations and evaluating the effectiveness of the third party liability identification system.

## PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA AND THE NORTHERN MARIANA ISLANDS

C. Part 435 is amended as set forth below:

1. The authority citation for Part 435 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302)

2. In § 435.945, paragraph (b) is revised to read as follows:

**§ 435.945 General requirements.**

(b) The agency must furnish timely to other agencies in the State and in other States and to Federal programs income, eligibility and medical assistance payment information for verifying eligibility or benefit amounts for the programs listed in § 435.948(a)(6) of this subpart. In addition, the agency must furnish income and eligibility information to—

(1) The child support enforcement program under part D of title IV of the Act; and

(2) SSA for old age, survivors and disability benefits under title II and for SSI benefits under title XVI of the Act.

3. Section 435.960 is revised to read as follows:

**§ 435.960 Standardized formats for furnishing and obtaining information to verify income and eligibility.**

(a) The agency must maintain for all applicants and recipients within an agency file the SSN, surname and other data elements in a format that at a minimum allows the agency to furnish and to obtain eligibility and income information from the agencies or programs referenced in § 435.945(b) and § 435.948(a).

(b) The format to be used will be prescribed by—

(1) HCFA when the agency furnishes information to, or requests information from, any Federal or State agency, except SSA and the Internal Revenue Service as specified in paragraphs (b) (2) and (3), respectively;

(2) The Commissioner of Social Security when the agency requests information from SSA; and

(3) The Commissioner of Internal Revenue when the agency requests information from the Internal Revenue Service.

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program)

Dated: October 6, 1986.

William L. Roper,  
Administrator, Health Care Financing Administration.

Approved: January 29, 1987.

Otis R. Bowen,  
Secretary.

[FR Doc. 87-4005 Filed 2-26-87; 8:45 am]

BILLING CODE 4120-01-M

**FEDERAL EMERGENCY MANAGEMENT AGENCY**

**44 CFR Part 61**

**National Flood Insurance Program; Insurance Rates**

**AGENCY:** Federal Emergency Management Agency (FEMA).

**ACTION:** Final rule.

**SUMMARY:** This final rule increases the National Flood Insurance Program (NFIP) chargeable (subsidized) rates, which apply to all structures located in communities participating in the Emergency Program of the NFIP and to certain structures in communities in the Regular Program of the NFIP.

**EFFECTIVE DATE:** June 1, 1987.

**FOR FURTHER INFORMATION CONTACT:** Charles M. Plaxico, Federal Emergency Management Agency, Federal Insurance Administration, Room 429, 500 "C" Street, SW., Washington, DC 20472; telephone number (202) 646-3422.

**SUPPLEMENTARY INFORMATION:** On April 10, 1986, FEMA published for comment in the Federal Register (Vol. 51, Page 12348) a proposed rule to increase the National Flood Insurance Program (NFIP) chargeable (subsidized) rates. The proposed increase was intended to help the NFIP satisfy the premium requirements for the historical average loss year and to reduce the general taxpayer's burden with a more equitable sharing of the costs of flood losses between the general taxpayers and the insureds. In addition to rate increases, other measures, such as coverage changes, optional deductibles, rating system changes, and measures to reduce flood losses are part of the ongoing effort to achieve these goals.

The chargeable (subsidized) rates, for which an increase was proposed, are the rates applicable to structures located in communities participating in the Emergency Program of the NFIP and to certain structures in communities in the Regular Program. They are countrywide rates for two broad building type classifications which, when applied to the amount of insurance purchased and added to the expense constant, continue to produce a premium income somewhat less than necessary to cover the expense and loss payments incurred on the flood insurance policies issued on that basis. The funds needed to supplement the inadequate premium income are provided by the National Flood Insurance Fund. The subsidized rates are promulgated by the Federal Insurance Administrator for use under

the Emergency Program (added to the NFIP by the Congress in section 408 of the Housing and Urban Development Act of 1969) and for the use in the Regular Program on construction or substantial improvement started before December 31, 1974 (this additional grandfathering was added to the NFIP by Congress in Section 103 of the Flood Disaster Protection Act of 1973) or the effective date of the initial Flood Insurance Rate Map (FIRM), whichever is later.

FEMA proposed to increase the chargeable or subsidized rates as follows:

| Type of Structure                                                                                         | Rates per year per \$100 coverage on |          |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------|----------|
|                                                                                                           | Structure                            | Contents |
| (1) Residential.....                                                                                      | \$0.55                               | \$0.65   |
| (2) All other (including hotels and motels with normal occupancy of less than 6 months in duration) ..... | .65                                  | 1.30     |

For comparison, the current subsidized rates are as follows:

| Type of Structure                                                                                         | Rates per year per \$100 coverage on |          |
|-----------------------------------------------------------------------------------------------------------|--------------------------------------|----------|
|                                                                                                           | Structure                            | Contents |
| (1) Residential.....                                                                                      | \$0.45                               | \$0.55   |
| (2) All other (including hotels and motels with normal occupancy of less than 6 months in duration) ..... | .55                                  | 1.10     |

Subsequent to the publication of the proposed rule on April 10, 1986, the House Appropriations Committee in its Report (dated July 31, 1986) accompanying H.R. 5313 directed that NFIP premium rates not be increased "during the period beginning on the date of enactment of this bill and ending on September 30, 1987, by more than a prorated annual rate of 10 percent." Also, the Senate Appropriations Committee in its Report (dated September 25, 1986) accompanying H.R. 5313 stated that it was "in agreement with the House Appropriations Committee and both authorizing committees that premium rate changes for flood insurance during fiscal year 1987 may not be increased by more than 10 percent."

To comply with this Congressional limit, the increase in the chargeable or subsidized rates made by this final rule are not as great as proposed. This final rule increases the chargeable or subsidized rates to the following amounts:

| Type of structure                                                                                        | Rates per year per \$100 coverage on |          |
|----------------------------------------------------------------------------------------------------------|--------------------------------------|----------|
|                                                                                                          | Structure                            | Contents |
| (1) Residential.....                                                                                     | \$0.50                               | \$0.60   |
| (2) All other (including hotels and motels with normal occupancy of less than 6 months in duration)..... | .60                                  | 1.20     |

Of the 23 comments received on the proposed rule, one supported the proposed increase in chargeable premium rates, three urged a larger rate increase, and the remainder were critical of the rate increase. A number of the comments expressed the view that the NFIP rate revision program was inconsistent with the intent of Congress in establishing the NFIP, which they believed was to provide very long term subsidies until the building stock was replaced, with premiums being required to be affordable in the meantime. A number of the comments also were concerned about possible large reductions in the number of NFIP policies as a result of rate increases. Some of these comments also were concerned about the impact on disaster relief programs if there were large reductions in the number of NFIP policies. Two comments referred to the NFIP making a profit in Fiscal Year 1985. Comments also raised the possibility of higher rates resulting in communities dropping out of the NFIP, as well as the possibility of requests being made for the repeal of the mandatory purchase requirement. Several comments suggested that the administrative costs of the NFIP were high compared to private insurance companies and should be reduced. A number of comments suggested various measures to reduce flood damage as an alternative to rate increases. Among the measures suggested were technical assistance to local communities in developing sound flood plain management practices, a community rating system, encouraging retrofitting of existing buildings, correcting misrated policies by better monitoring and enforcement, expanding the policy base, and increasing the waiting period for coverage to become effective. Two environmental groups urged an even greater rate increase as a disincentive to development in flood prone areas. One of the environmental groups also urged FEMA to consider the cost of loss of wild-life habitat and recreational opportunities as a result of building in flood prone areas and contended that doing that would justify a larger rate increase.

FEMA has responded in the past to a number of these concerns and welcomes this opportunity to explain its rate

revision program. First, in explaining the self-supporting goal, it would be appropriate to provide the full statement of the goal as expressed in the Federal Insurance Administration's (FIA) planning documents:

Implement a self-supporting nationwide flood insurance program by 1988 which minimizes the general taxpayer burden through an equitable sharing of the costs of flood losses; fulfills the financial need in risk transfer for the average loss year and has mechanisms in place to develop reserves or otherwise meet the needs of catastrophic loss years; results in rates which are not excessive, inadequate, unfairly discriminatory or otherwise unreasonable; responds to competitive market conditions; improves the availability and reliability of flood insurance; and does not violate public policy. Study the feasibility of proposing legislative initiatives to permit a systematic phase out of program subsidies. In addition to rating and coverage changes, this goal will be achieved through appropriate support of and commitment to Write-Your-Own and loss reduction activities.

A key term in the statement of the goal is "average loss year," which in this case refers to the historical average loss year. Over the NFIP's history, the Program has not been subjected to the truly catastrophic flood event, with more than a billion dollars in flood insurance claims. Thus, the historical average is substantially less than could be expected over the long term when the influence of the extremely infrequent, truly catastrophic flood would result in a significant increase in the average year's losses.

Because the estimated amount of flood losses in any future one-year period is so uncertain, it can only be provided for by having available large loss reserves. Those reserves should be replenished by accumulating funds in low loss years to offset the drain on the reserves during heavy loss years. However, on an earned premium and incurred loss and expense basis, the NFIP has operated at a deficit since its inception. Thus, the general taxpayer has subsidized the beneficiaries of the Program through appropriations to repay borrowing authorized by statute from the U.S. Treasury to cover the losses and expenses exceeding premium income.

This has occurred even during a period where the average year's losses have been less than can be expected over the long term. Additionally, the deficit operation has prevented any accumulation of reserves.

The National Flood Insurance Act of 1968 (Section 1302(d)(2)) has the requirement of "distributing burdens equitably among those who will be protected by flood insurance and the

general public." FEMA has concluded that an equitable sharing of the burdens can be achieved through rating and coverage changes that will provide adequate premium income to meet losses and expenses of a "normal" year (the average year experienced to date as opposed to the average resulting from a time period including a truly catastrophe reserves during lower loss years). The realization of the 1988 goal will not eliminate the subsidy of the NFIP, but it will allow the NFIP to operate during lower loss years with an underwriting profit which can be used to pre-fund some of the reserves needed for high loss years.

The key elements of FEMA's plan for achieving the goal of a self-supporting Program for the historical average loss year by 1988 include:

1. Regularly scheduled review of experience and revision of rates and coverage. The NFIP is a relatively young insurance program dealing with a risk about which very little was known at the time of the Program's inception. Because initially the rate structure was necessarily based to a large degree on professional judgement, it is important, now that there is credible experience available, to translate that experience into action. Some coverage has proven to be very expensive to provide. Such was the case with finished basements where coverage is now provided for structural elements and items necessary to the habitability of the building such as washers, dryers, water heaters, furnaces, air conditioners, but not for items such as carpeting and wet bars. Experience has shown that it is very expensive to provide first dollar, all inclusive coverage and that flood insurance must be oriented more toward coverage that maintains a building's habitability and prevents the truly large loss that could be someone's personal financial disaster. Therefore, FEMA has introduced a program of optional increased deductibles.

2. Increased market penetration and broader spread of risk. One of the goals of the Write-Your-Own (WYO) Program, which has re-involved the insurance industry in the NFIP by providing for the issuance of the Standard Flood Insurance Policy by private sector insurers who enter into an arrangement with the Federal Insurance Administrator to do so, is to make use of the industry's existing marketing apparatus to increase the policy base and broaden the geographic spread of business. So far about 28% of WYO policies are new to the NFIP.

3. Loss reduction efforts and incentives for good flood plain management at the local level. In addition to both the technical assistance offered by FEMA and to the NFIP regulations covering the construction of new buildings so as to reduce the risk of flood damage, a guidance manual on retrofitting techniques to reduce damage to existing buildings was published in 1986. The rating of a local community's efforts in flood plain management is being explored for a possible system of community-wide rate adjustments

recognizing meaningful efforts to reduce losses.

In response to the view that the rating and coverage changes proposed by FEMA are moving the NFIP away from its purposes as stated in the National Flood Insurance Act of 1968, FEMA believes that, on the contrary, its actions legitimately further the purposes of the 1968 Act. The equitable distribution of burdens has already been discussed. An additional purpose is the encouragement of sound flood plain management measures to minimize exposure of property to flood losses. Inexpensive, highly subsidized flood insurance with broad indemnification provisions encourages owners of existing flood prone properties to increase their capital investment in those risky properties. Through the use of increased insurance rates and leaner coverage so that the property owner still bears some risk, this threat of expansion of flood risk can be managed and still protect these individuals from severe financial losses. To ignore economic leverage as a flood plain management tool, particularly with respect to existing construction, where Federal regulations have little effect, would be a mistake.

With respect to legislative intent and legislative authority for FEMA to raise chargeable rates and thereby reduce or eliminate the subsidy, the General Accounting Office (GAO) in its 1983 report, "National Flood Insurance Program-Major Changes Needed If It Is To Operate Without a Federal Subsidy," reviewed in depth the FEMA ratemaking procedures and the Federal Insurance Administrator's (the Administrator) goal to make the Program self-sustaining. The GAO concluded that "The act currently allows FEMA considerable freedom in establishing chargeable rates."

There was no finding that indicated that the FEMA goal to obtain a self-sustaining program violated either legislative intent or authority. The GAO report states: "In establishing the flood insurance program the Congress gave FEMA very general guidance on the level and duration of the subsidy in the program's chargeable rates. These rates have been set based on what FIA's Administrators believed people could afford. In setting these rates the Administrators sought to encourage wide participation. While not ignoring the desirability of wide participation, the current Administrator has emphasized making the program self-sustaining and actuarially sound by fiscal year 1988. To achieve this goal some as yet undetermined rate increases and/or coverage reductions will be necessary." In commenting on FEMA

ratemaking activities, the GAO encouraged FEMA to continue to give more credence to its recent loss experience, estimate and establish a catastrophe reserve, correct data and methodological weaknesses and avoid unnecessary complexity in the rating of risks. The GAO was informed of the Administrator's policy to reduce or suspend future rate increases and reevaluate the time frame for achieving a self-sustaining, actuarially sound program if rate increases were having a negative impact on the National Flood Insurance Program.

In response to the view that the administrative costs of the NFIP are too high in comparison with those of the private insurance industry and should be reduced, recognition must be given to the statutory requirements that the NFIP make extensive flood risk studies, flood loss reduction studies and implement flood plain management programs that go beyond the comparable risk studies and risk management programs currently needed by the private insurance for normal property insurance lines of business. The NFIP expenses for these activities are subsidized by the federal government and therefore, not included in the ratemaking procedures. The normal administrative expenses of the NFIP compare favorably with those of the private insurance industry. The latest two year average expense ratio of .34 is the same as the latest two year average expense ratio of the private insurance industry for property insurance. FEMA continues to explore means available to reduce all administrative costs.

Increasing the waiting period required for a policy to be in force before a disaster strikes as a way of reducing claims has been suggested in the past but the need to attain a proper balance between the waiting period, the NFIP objective to write more insurance policies, and previous public comment on this matter have led to the current five day waiting period. However, FEMA intends to review the experience to determine whether or not the five day waiting period is resulting in a costly adverse selection and will reevaluate the waiting period rule if warranted.

In response to the view that the rate revision be postponed until several NFIP enhancements recently implemented or proposed are studied to determine their effect on rates, FEMA believes that, in abiding by the limitation of 10%, it has taken into consideration the NFIP objectives and the expectation that the program enhancements may reduce losses.

Regarding the suggestion that the NFIP include the cost of the loss of wildlife habitat and recreational opportunities as a result of building in the flood plain in the evaluation of insurance rates, FEMA does not believe that these elements are on appropriate part of a consideration of the risk in the NFIP ratemaking process. Further, considering such elements would be inconsistent with standard industry principles of insurance ratemaking.

It has been mentioned already that the NFIP's legislation considers the equitable distribution of cost for flood insurance among policyholders and the general public. The 1968 Act additionally mentions "making flood insurance coverage available on reasonable terms and conditions" (Section 1302(a)). Also, the FEMA goal states that rates should be established "which are not excessive, inadequate, unfairly discriminatory or otherwise unreasonable." (In the case of chargeable (subsidized) rates, inadequacy is accepted.) The question remains as to what rates, terms and conditions are "reasonable". Some have equated "reasonable" with "affordable". Although reasonableness may include consideration of affordability, it is not equivalent to affordability and it must take into account other concerns. As stated before, FEMA has concluded that it is reasonable for flood insurance to be provided on terms and conditions such that losses and expenses in the historical average loss year, which is significantly less than the long-term average, can be adequately funded from premium income without the necessity of borrowing from the U.S. Treasury. Additionally, it is reasonable, even for a subsidized Program, to experience years where premium income exceeds losses and expenses so that reserves are accumulated for use in higher loss years.

The projected average annual premium for subsidized policies using the revised chargeable rates is \$267. This represents 80% of the premium needed to fund the normal loss year currently projected at 1987 cost levels.

The revised chargeable rates are considered by FEMA to be reasonable. During the study of the feasibility of a flood insurance program conducted at the direction of Congress, by the Department of Housing and Urban Development in 1966, projections were made of the realistic limit of flood insurance rates at which it would still be economically justified to continue using residentially developed land while paying those rates for flood insurance. It was estimated this limit would be around \$1.00 per \$100 of insurance

purchased to cover building and contents. The revised rates are well within this limit. Additionally, the 1966 feasibility study anticipated that only buildings within the 50-year flood plain would be subsidized. The revised chargeable rates represent a rate level that provides a subsidy to many buildings outside the 50-year flood plain and therefore actually represent a more generous subsidy.

Concerns have been raised regarding the effects of rating and coverage changes on the policyholder base and how losses to that base of the better risks will possibly worsen the chances for the Program to eventually be actuarially sound and will possibly increase disaster relief expenditures. FEMA established a monitoring system to evaluate whether or not rate increases were having a negative effect on the NFIP. FEMA and GAO jointly did an initial evaluation of the pre-1983 rate revision on the NFIP. This evaluation established that several factors other than rate increases were negatively affecting insurance policy sales, and that no community had left the Program because of the rate increase. Further, FEMA has seen no indication that the rate increases would cause policyholders to request a repeal of the mandatory purchase requirement. FEMA has continued to monitor the number of flood insurance policies in force on a monthly basis. This includes monthly statistical reports, monthly State and regional analyses by NFIP regional offices and monthly policy meetings with the Administrator. The monthly technical analyses show that current renewal rates for FY 1983, 1984, 1985 and 1986 generally exceed those of 1981 and 1982.

The following table of renewal percentage illustrates this point:

FY RENEWAL PERCENTAGE

| 1981 | 1982 | 1983 | 1984 | 1985 | 1986 |
|------|------|------|------|------|------|
| 78   | 80   | 84   | 80   | 82   | 81   |

The sale of new flood insurance policies appears to be influenced by several factors in addition to cost, namely mortgage activity, the local economy, insurance purchased as a result of post-flood disaster public awareness campaigns, and insurance purchased as a condition to obtain Federal disaster relief. The study that FEMA performed in conjunction with the GAO report referred to above showed that most of the fluctuations in the numbers of new policies could be attributed to housing market activity and flood disaster occurrences.

In spite of a relatively low frequency of major flood disasters since 1982, the insurance in force has shown some growth. The policies in force at the end of FY 1982, 1983, 1984 and 1985 were 1,866,801, 1,911,316, 1,865,076 and 1,904,052, respectively. The number of policies in force as of the end of FY 1986 is estimated to be 2,075,496. It is quite evident from the information that FEMA reviews that the past rate increases have had no negative impact on the NFIP. FEMA believes that the rate increases are consistent with the use of a premium subsidy to help existing property owners maintain their properties and temporarily save capital, as well as to help these individuals salvage some of their investment in the property, as suggested in the premium payment and risk compensation discussion in the 1966 feasibility study. Further, the rate increases are consistent with the legislative purpose in section 1302(d)(2) of the 1968 Act to "provide flexibility in the program so that such flood insurance may be based on workable methods of pooling risks, minimizing costs, and distributing burdens equitably among those who will be protected by flood insurance and the general public."

FEMA has determined, based upon an Environmental Assessment, that this proposed rule does not have a significant impact upon the quality of the human environment. A finding of no significant impact is included in the formal docket file and is available for public inspection and copying at the Rules Docket Clerk, Office of General Counsel, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472.

These regulations do not have a significant economic impact on a substantial number of small entities and have not undergone regulatory flexibility analysis.

The rule is not a "major rule" as defined in Executive Order 12291, dated February 17, 1981, and, hence, no regulatory analysis has been prepared.

FEMA has determined that the proposed rule does not contain a collection of information requirement as defined in section 3502 of the Paperwork Reduction Act.

#### List of Subjects in 44 CFR Part 61

Flood insurance.

Accordingly, Subchapter B of Chapter 1 of Title 44 is proposed to be amended as follows:

## PART 61—INSURANCE COVERAGE AND RATES

1. The authority citation for Part 61 continues to read as follows:

Authority: 42 U.S.C. 4001 et seq.; Reorganization Plan No. 3 of 1978; E.O. 12127.

2. Section 61.9 is revised to read as follows:

### § 61.9 Establishment of chargeable rates.

(a) Pursuant to section 1308 of the Act, chargeable rates per year per \$100 of flood insurance are established as follows for all areas designated by the Administrator under Part 64 of this subchapter for the offering of flood insurance.

#### RATES FOR NEW AND RENEWAL POLICIES

| Type of structure                                                                                         | Rates per year per \$100 coverage on— |          |
|-----------------------------------------------------------------------------------------------------------|---------------------------------------|----------|
|                                                                                                           | Structure                             | Contents |
| (1) Residential .....                                                                                     | \$0.50                                | \$0.60   |
| (2) All other (including hotels and motels with normal occupancy of less than 6 months in duration) ..... | .60                                   | 1.20     |

(b) The contents rate shall be based upon the use of the individual premises for which contents coverage is purchased.

Harold T. Duryee,  
Federal Insurance Administrator.  
[FR Doc. 87-4086 Filed 2-26-87; 8:45 am]  
BILLING CODE 6718-03-M

## 44 CFR Part 67

[Docket No. FEMA-6709]

### Final Flood Elevation Determination; Buchanan County, VA; Rescission

AGENCY: Federal Emergency Management Agency.

ACTION: Rescission of final rule.

**SUMMARY:** The Federal Emergency Management Agency published the final flood elevation determination for Buchanan County, Virginia. This notice will serve to rescind that publication. Following an engineering analysis and review, a new notice of final flood elevation determination will be made.

**EFFECTIVE DATE:** February 27, 1987.

**FOR FURTHER INFORMATION CONTACT:** John L. Matticks, Chief, Risk Studies Division, Federal Insurance Administration, Federal Emergency Management Agency, Washington, DC 20472, (202) 646-2767.

**SUPPLEMENTARY INFORMATION:** As a result of recent data developed by the

Army Corps of Engineers, Huntington District, the Federal Emergency Management Agency gives notice of rescission of the final flood elevation determination for Buchanan County, Virginia, published at 51 FR 37287 on October 21, 1986, in accordance with section 110 of the Flood Disaster Protection Act of 1973 (Pub. L. 93-234), 87 Stat. 980, which added section 1363 to the National Flood Insurance Act of 1968 (Title XIII of the Housing and Urban Development Act of 1968 (Pub. L. 90-448)), 42 U.S.C. 4001-4128, and 44 CFR Part 67.

Issued: February 18, 1987.

Harold T. Duryee,

Administrator, Federal Insurance Administration.

[FR Doc. 87-4085 Filed 2-26-87; 8:45 am]

BILLING CODE 6718-03-M

## FEDERAL COMMUNICATIONS COMMISSION

### 47 CFR Part 73

[MM Docket No. 86-92; RM-5226, 5315, and 5453]

#### Radio Broadcasting Services; Bar Harbor and Milbridge, ME

AGENCY: Federal Communications Commission.

ACTION: Final rule.

**SUMMARY:** This document allocates FM Channels 256B1 and 299B to Bar Harbor, Maine, and Channel 229B to Milbridge, Maine. Bar Harbor will receive its first and second service and Milbridge, its first service. This action is taken in response to petitions filed by Pierless Broadcasting Company (Ch. 256B1), Sound Innovations, Inc. (Ch. 299B) and a counterproposal filed by Gordon Kelley (229B at Milbridge). Canadian concurrence has been obtained for the allotment of the above channels. With this action this proceeding is terminated.

**DATES:** Effective April 6, 1987; the window period for filing applications will open on April 7, 1987, and close on May 6, 1987.

**FOR FURTHER INFORMATION CONTACT:** Kathleen Scheuerle, Mass Media Bureau, (202) 634-6530.

**SUPPLEMENTARY INFORMATION:** This is a summary of the Commission's Report and Order, MM Docket No. 86-92, adopted January 30, 1987 and released February 19, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street NW., Washington, DC. The complete text of

this decision may also be purchased from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street NW., Suite 140, Washington, DC 20037.

### List of Subjects in 47 CFR Part 73

Radio broadcasting.

### PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

#### § 73.202 [Amended]

2. In § 73.202(b), the Table of FM Allotments is amended, under Maine, by adding Channel 256B1 and Channel 299B to Bar Harbor, and by adding Channel 229B to Milbridge, Maine.

Federal Communications Commission.

Mark N. Lipp,

Chief, Allocations Branch, Mass Media Bureau.

[FR Doc. 87-4134 Filed 2-26-87; 8:45 am]

BILLING CODE 6712-01-M

### 47 CFR Part 73

[MM Docket No. 86-375; RM-5511]

#### Radio Broadcasting Services; Hyannis, MA

AGENCY: Federal Communications Commission.

ACTION: Final rule.

**SUMMARY:** This document allocates FM Channel 275A to Hyannis, Massachusetts, and modifies the permit of Station WPXC(FM), Channel 276A, to specify Channel 275A. This action is taken in response to a petition filed by Radio Hyannis, Inc. permittee of Channel 276A. The substitution of channels will provide a greater area in which the transmitter site can be located. Comments were filed by the petitioner. No other comments were received. With this action, this proceeding is terminated.

**EFFECTIVE DATE:** April 6, 1987.

**FOR FURTHER INFORMATION CONTACT:** Kathleen Scheuerle, (202) 634-6530, Mass Media Bureau.

**SUPPLEMENTARY INFORMATION:** This is a summary of the Commission's Report and Order, MM Docket No. 86-375, adopted December 24, 1986 and released February 19, 1987. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Dockets Branch (Room 230), 1919 M Street NW., Washington, DC. The complete text of this decision may also be purchased

from the Commission's copy contractors, International Transcription Service, (202) 857-3800, 2100 M Street NW., Suite 140, Washington, DC 20037.

### List of Subjects in 47 CFR Part 73

Radio broadcasting.

### PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303.

#### § 73.202 [Amended]

2. In § 73.202(b), the Table of FM Allotments is amended by revising the entry of Hyannis, Massachusetts, to delete Channel 276A and add Channel 275A.

Federal Communications Commission.

Mark N. Lipp,

Chief, Allocations Branch, Mass Media Bureau.

[FR Doc. 87-4135 Filed 2-26-87; 8:45 am]

BILLING CODE 6712-01-M

## GENERAL SERVICES ADMINISTRATION

### 48 CFR Part 503

[APD 2800.12 CHGE 39]

#### General Services Administration Acquisition Regulation; Procedures for Voiding and Rescinding Contracts

AGENCY: Office of Acquisition Policy, GSA.

ACTION: Final rule.

**SUMMARY:** The General Services Administration Acquisition Regulation (GSAR), Chapter 5, is amended to add Subpart 503.7 which implements Subpart 3.7 of the Federal Acquisition Regulation (FAR) by providing agency procedures for voiding and rescinding contracts. The intended effect is to improve the regulatory coverage and provide uniform procedures for contracting under the regulatory system.

**EFFECTIVE DATE:** February 9, 1987.

**FOR FURTHER INFORMATION CONTACT:** Mr. Edward Loeb, Office of GSA Acquisition Policy and Regulations, (VP) (202) 535-7791.

#### SUPPLEMENTARY INFORMATION:

##### Background

This rule was published in the *Federal Register* for public comment on October 28, 1986 (51 FR 39404). No public comments were received. Comments from various GSA offices have been