Act, implemented by 21 CFR part 900, subpart B.

(iii) Must not employ for provision of the professional component of mammography services a physician or physicians for whom the facility has received written notification by FDA that the physician (or physicians) is (or are) in violation of the certification requirements set forth in section 354 of the PHS Act, as implemented by 21 CFR 900.12(a)(1)(i).

(b) *Conditions for coverage of diagnostic mammography services.* Medicare Part B pays for diagnostic mammography services if they meet the following conditions:

(1) They are ordered by a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

(2) They are furnished by a supplier of diagnostic mammography services that meets the certification requirements of section 354 of the PHS Act, as implemented by 21 CFR part 900, subpart B.

(c) *Conditions for coverage of screening mammography services.* Medicare Part B pays for screening mammography services if they are furnished by a supplier of screening mammography services that meets the certification requirements of section 354 of the PHS Act, as implemented by 21 CFR part 900, subpart B.

(d) *Limitations on coverage of screening mammography services.* The following limitations apply to coverage of screening mammography services:

(1) The service must be, at a minimum—

(i) A four-view exposure (that is, a cranio-caudal and a medial lateral oblique view of each breast); or

(ii) In the case of a postmastectomy patient, a two-view exposure (that is, a cranio-caudal and a medial lateral oblique view) of the remaining breast.

* * * * *

C. Part 411, subpart A is amended as set forth below:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

Subpart A—General Exclusions and Exclusion of Particular Services

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102, 1834, 1842(l), 1861, 1862, 1866, 1871, 1877, and 1879 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395u(l), 1395x, 1395y, 1395cc, 1395hh, 1395nn, and 1395pp).

2. In § 411.15, the introductory text for the section is republished, and paragraph (a)(1) is revised to read as follows:

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage.

(a) Routine physical checkups such as—

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptom, complaint, or injury, except for screening mammography (including a physician's interpretation of the results) that meets the conditions for coverage and limitations on coverage of screening mammography specified at § 410.34 of this chapter and the certification requirements of section 354 of the PHS Act, as implemented by 21 CFR part 900, subpart B.

* * * * *

D. Part 413, subpart F is amended as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

Subpart F—Specific Categories of Costs

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1122, 1814(b), 1815, 1833 (a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act as amended (42 U.S.C. 1302, 1320a–1, 1395f(b), 1395g, 1395l (a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

2. In § 413.123, paragraph (b) is revised to read as follows:

§ 413.123 Payment for screening mammography performed by hospitals on an outpatient basis.

* * * * *

(b) *Payment to hospitals for outpatient services.* Payment to hospitals for screening mammography services performed on an outpatient basis is determined in accordance with the technical component billing requirements in § 405.534(d) of this chapter.

PART 494—[REMOVED AND RESERVED]

E. Part 494 is removed and reserved.

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

Dated: August 3, 1994.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: September 8, 1994.

Donna E. Shalala,

Secretary.

[FR Doc. 94–24335 Filed 9–29–94; 8:45 am]

BILLING CODE 4120–01–P

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42 CFR Part 417

[OMC–009–FC]

RIN: 0938–AG92

Medicare Program; Qualified Health Maintenance Organizations: Technical Amendments

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

ACTION: Final rule with comment period.

SUMMARY: This rule clarifies and updates portions of the HCFA regulations that pertain to Federal qualification and continued regulation of health maintenance organizations (HMOs), inclusion of qualified HMOs in employee health benefits plans, and the administration of outstanding loans and loan guarantees that were awarded before October 1, 1986, under the Public Health Service Act (PHS Act). This rule is part of a special project to clarify and update all of 42 CFR part 417, which contains the regulations applicable to all entities that provide prepaid health care, that is, HMOs, CMPs (competitive medical plans) and HCPPs (health care prepayment plans).

These are technical and editorial changes that do not affect the substance of the regulations. They are intended to make it easier to find particular provisions, to provide overviews of the different program aspects, and to better ensure uniform understanding of the rules.

DATES: *Effective Date:* These regulations are effective on October 31, 1994.

Comment Date: We will consider all comments received at the appropriate address as provided below no later than 5 p.m. on November 29, 1994.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: OMC–9–FC, P.O. Box 26676, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (an original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or
Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, MD 21207.

Due to staff limitations, we cannot accept facsimile (FAX) transmission of comments. Comments will be available for public inspection as they are received, beginning approximately 3 weeks from date of publication in the **Federal Register**, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

FOR FURTHER INFORMATION CONTACT: Tracy Jensen, (202) 619–2158.

SUPPLEMENTARY INFORMATION:

A. Background

This rule revises subparts D, E, F, and V of part 417 of the HCFA rules as part of the special project noted in the **SUMMARY.**

The first two steps in the project to clarify and update part 417 were the publication of two final rules identified as OCC–22–F and OCC–15–FC. The first was published in the **Federal Register** on October 17, 1991, at 56 FR 51984; the second, on July 15, 1993, at 58 FR 38062.

The regulation identified as OCC–22–F—

- Removed most of the outdated content;
- Redesignated certain portions of part 417 to free section numbers needed so that new rules can be incorporated in logical order; and
- Designated the remaining text under subpart headings that identify the different program aspects so that it is easier to refer to those aspects and to find particular rules.

The second regulation, identified as OCC–15–F—

- Through nomenclature and definition changes, established certain terms to be used throughout part 417 with the aim of avoiding confusion, making clear that responsibility for the prepaid health care programs has been delegated to HCFA, and ensuring use of the most precise terms available.
- Established a separate subpart C with four sections to set forth the many requirements that apply to the organization and operation of HMOs, and that were previously compressed into a single section (§ 417.107).

As a result of the redesignations made by OCC–22–F and OCC–15–FC, §§ 417.107 through 417.119 are now available for new rules that are required because of statutory amendments that affect the furnishing of services by qualified HMOs or may be needed because of future changes in the statute.

B. Changes in the Regulations

In order to clarify and update subparts D, E, F, and V, this rule makes the following changes:

- Uses terminology established by OCC–15–FC or that reflects accepted usage in all HCFA regulations.
- Revises long unbroken columns of text to designate separate provisions and to provide headings that help the reader to get an overview and to find particular provisions.
- Uses the active voice and the present indicative (rather than the future tense) to describe what HCFA or its employees, agents, or contractors do, and uses the most precise terms available.

A specific goal is to complete the separation of the rules that pertain to assurances required of entities applying for Federal qualification from those that pertain to assurances given in applying for financial assistance (grants, loans, and loan guarantees) that was available under the PHS Act before October 1986. To achieve this goal, we have—

- Removed the portion of § 417.160 applicable to financial assistance that is no longer available; and
- Added a new § 417.940 in subpart V to reference § 417.163(g) as applicable to entities that have outstanding loans or loan guarantees, and that fail to comply with assurances they gave in applying for the loan or loan guarantee. (Section 417.163(g) provides that HCFA may bring civil action to enforce compliance with assurances.)

In addition, we have—

- Removed the definitions of the three types of "qualified" HMOs (§ 417.141) because definitions are not used for substantive content, and in this case simply constituted a partial duplication of the rules themselves;
- Incorporated paragraph (a) of § 417.143 into § 417.140 to set forth the scope of the whole subpart D; and
- Removed §§ 417.168 and 417.169 from subpart F because their content is being transferred to § 417.142(g) and (h).

Waiver of Proposed Rulemaking

With one exception, the changes made by this rule are technical and editorial in nature. Their aim is to simplify, clarify, and update subparts D, E, F, and V without substantive change.

We have removed from § 417.169 (now redesignated as § 417.142(h)), the words "for purposes of receiving assistance under this subpart." HCFA has consistently interpreted this language (which appears in section 1307(d) of the PHS Act) as applying to continued qualification of HMOs as well as to initial applications for assistance that was available under that Act before October 1986. This interpretation avoids what would be an unintended result: Now that the assistance is no longer available, HMOs that had qualified in connection with their requests for assistance would have to disenroll their Federal Employee Health Benefit Program (FEHBP) enrollees in order to retain qualification and to be able to take advantage of the requirement that employers include qualified HMOs in their employee health benefits plans. It was a mistake to include in § 417.169 the limiting language, which did not appear in the predecessor rule issued in 1974. We have deleted the language to achieve consistency between paragraphs (g) and (h) of § 417.142 and with HCFA's long-standing interpretation of the statute.

Given this justification, we find that there is good cause to waive proposed rule-making procedures as unnecessary. As previously indicated, however, we will consider timely comments from anyone who questions the deletion of the reference to "assistance" or believes that, in making the technical and editorial changes, we have altered the substance of the rules. Although we cannot respond to comments individually, if we revise these rules as a result of comments, we will discuss all timely comments in the preamble to the revised rules.

Paperwork Reduction Act

These regulations contain no new information collection requirements subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980.

Regulatory Impact Statement

Regulatory Flexibility Analysis

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

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

operation of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was not reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 417

Administrative practice and procedure, Health maintenance organizations (HMOs), Medicare.

42 CFR Part 417 is amended as set forth below.

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

A. The authority citation for part 417 is revised to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), Title XIII of the Public Health Service Act (42 U.S.C. 300e through 300e–17), and 31 U.S.C. 9701, unless otherwise noted.

B. Subpart D is amended as set forth below.

Subpart D—Application for Federal Qualification

1. Section 417.140 is revised to read as follows:

§ 417.140 Scope.

This subpart sets forth—

(a) The requirements for—

(1) Entities that seek qualification as HMOs under title XIII of the PHS Act; and

(2) HMOs that seek—

(i) qualification for their regional components; or

(ii) Expansion of their service areas;

(b) The procedures that HCFA follows to make determinations; and

(c) Other related provisions, including application fees.

§ 417.141 [Removed]

2. Section 417.141 is removed.

3. Section 417.142 is revised to read as follows:

§ 417.142 Requirements for qualification.

(a) *General rules.* (1) An entity seeking qualification as an HMO must meet the requirements and provide the assurances specified in paragraphs (b) through (f) of this section, as appropriate.

(2) HCFA determines whether the entity is an HMO on the basis of the entity's application and any additional information and investigation (including site visits) that HCFA may require.

(3) HCFA may determine that an entity is any of the following:

(i) An operational qualified HMO.

(ii) A preoperational qualified HMO.

(iii) A transitional qualified HMO.

(b) *Operational qualified HMO.* HCFA determines that an entity is an operational qualified HMO if—

(1) HCFA finds that the entity meets the requirements of subparts B and C of this part.

(2) The entity, within 30 days of HCFA's determination, provides written assurances, satisfactory to HCFA, that it—

(i) Provides and will provide basic health services (and any supplemental health services included in any contract) to its enrollees;

(ii) Provides and will provide these services in the manner prescribed in sections 1301(b) and 1301(c) of the PHS Act and subpart B of this part;

(iii) Is organized and operated and will continue to be organized and operated in the manner prescribed in section 1301(c) of the PHS Act and subpart C of this part;

(iv) Under arrangements that safeguard the confidentiality of patient information and records, will provide access to HCFA and the Comptroller General or any of their duly authorized representatives for the purpose of audit, examination or evaluation to any books, documents, papers, and records of the entity relating to its operation as an HMO, and to any facilities that it operates; and

(v) Will continue to comply with any other assurances that it has given to HCFA.

(c) *Preoperational qualified HMO.* (1) HCFA may determine that an entity is a preoperational qualified HMO if it provides, within 30 days of HCFA's determination, satisfactory assurances that it will become operational within 60 days following that determination and will, when it becomes operational, meet the requirements of subparts B and C of this part.

(2) Within 30 days after receiving notice that the entity has begun operation, HCFA determines whether it is an operational qualified HMO. In the absence of this determination, the entity is not an operational qualified HMO even though it becomes operational.

(d) *Transitional qualified HMO: General rules*—(1) *Basic requirements.* HCFA may determine that an entity is a transitional qualified HMO if the entity—

(i) Meets the requirements of paragraph (d)(2) through (d)(4) of this section; and

(ii) Provides the assurances specified in paragraphs (d)(5) through (d)(7) of this section within 30 days of HCFA's determination.

(2) *Organization and operation.* The entity is organized and operated in accordance with subpart C of this part, except that it need not—

(i) Assume full financial risk for the provision of basic health services as required by § 417.120(b); or

(ii) Comply with the limitations that are imposed on insurance by § 417.120(b)(1).

(3) *Range of services.* The entity is currently providing the following services on a prepaid basis:

(i) Physician services.

(ii) Outpatient services and inpatient hospital services. (The entity need not provide or pay for hospital inpatient or outpatient services that it can show are being provided directly, through insurance, or under arrangements, by other entities.)

(iii) Medically necessary emergency services.

(iv) Diagnostic laboratory services and diagnostic and therapeutic radiologic services.

These services must meet the requirement of § 417.101, but may be limited in time and cost without regard to the constraints imposed by § 417.101(a).

(4) *Payment for services*—(i) *General rule.* The entity pays for basic health services in accordance with § 417.104, except that it need not comply with the copayments limitations imposed by § 417.104(a)(4).

(ii) *Determination of payment rates.* In determining payment rates, the entity need not comply with the community rating requirements of §§ 417.104(b) and 417.105(b).

(5) *Contracts in effect on the date of HCFA's determination.* The entity gives assurances that it will meet the following conditions with respect to its group and individual contracts that are in effect on the date of HCFA's determination, and which are renewed or renegotiated during the period approved by HCFA under paragraph (d)(6) of this section:

(i) Continue to provide services in accordance with paragraph (d)(3) of this section.

(ii) Continue to be organized and operated and to pay for basic health services in accordance with paragraphs (d)(2) and (d)(4) of this section, respectively.

(6) *Time-phased plan.* The entity gives assurances as follows:

(i) It will implement a time-phased plan acceptable to HCFA that—

(A) May not extend for more than 3 years from the date of HCFA's determination; and

(B) Specifies definite steps for meeting, at the time of renewal of each

group or individual contract, all the requirements of subparts B and C of this part.

(ii) Upon completion of this time-phased plan, it will—

(A) Provide basic and supplemental services to all of its enrollees; and

(B) Be organized and operated, and provide services, in accordance with subparts B and C of this part.

(7) *Contracts entered into after the date of HCFA's determination.* The entity gives assurances that, with respect to any group or individual contract entered into after the date of HCFA's determination, it will—

(i) Be organized and operated in accordance with subpart C of this part; and

(ii) Provide basic health services and any supplemental health services included in the contract, in accordance with subpart B of this part.

(e) *Failure to sign assurances timely.* If HCFA determines that an entity meets the requirements for qualification and the entity fails to sign its assurances within 30 days following the date of the determination, HCFA gives the entity written notice that its application is considered withdrawn and that it is not a qualified HMO.

(f) *Qualification of regional components.* An HMO that has more than one regional component is considered qualified for those regional components for which assurances have been signed in accordance with this section.

(g) *Special rules: Enrollees entitled to Medicare or Medicaid.* For an HMO that accepts enrollees entitled to Medicare or Medicaid, the following rules apply:

(1) The requirements of titles XVIII and XIX of the Act, as appropriate, take precedence over conflicting requirements of sections 1301(b) and 1301(c) of the PHS Act.

(2) The HMO must, with respect to its enrollees entitled to Medicare or Medicaid, comply with the applicable requirement of title XVIII or XIX, including those that pertain to—

(i) Deductibles and coinsurance;

(ii) Enrollment mix and enrollment practices;

(iii) State plan rules on copayment options; and

(iv) Grievance procedures.

(3) An HMO that complies with paragraph (g)(2) of this section may obtain and retain Federal qualification if, for its other enrollees, the HMO meets the requirements of sections 1301(b) and 1301(c) of the PHS Act and implementing regulations in this subpart D and in subparts B and C of this part.

(h) *Special rules: Enrollees under the Federal employee health benefits program (FEHBP).* An HMO that accepts enrollees under the FEHBP (Chapter 89 of title 5 of the U.S.C.) may obtain and retain Federal qualification if, for its other enrollees, it complies with the requirements of section 1301(b) and 1301(c) of the PHS Act and implementing regulations in this subpart D and subparts B and C of this part.

4. Section 417.144 is revised to read as follows:

§ 417.144 Evaluation and determination procedures.

(a) *Basis for evaluation and determination.* (1) HCFA evaluates an application for Federal qualification on the basis of information contained in the application itself and any additional information that HCFA obtains through on-site visits, public hearings, and any other appropriate procedures.

(2) If the application is incomplete, HCFA notifies the entity and allows 60 days from the date of the notice for the entity to furnish the missing information.

(3) After evaluating all relevant information, HCFA determines whether the entity meets the applicable requirements of §§ 417.142 and 417.143.

(b) *Notice of determination.* HCFA notifies each entity that applies for qualification under this subpart of its determination and the basis for the determination. The determination may be granting of qualification, intent to deny, or denial.

(c) *Intent to deny.* (1) If HCFA finds that the entity does not appear to meet the requirements for qualification and appears to be able to meet those requirements within 60 days, HCFA gives the entity notice of intent to deny qualification and a summary of the basis for this preliminary finding.

(2) Within 60 days from the date of the notice, the entity may respond in writing to the issues or other matters that were the basis for HCFA's preliminary finding, and may revise its application to remedy any defects identified by HCFA.

(d) *Denial and reconsideration of denial.* (1) If HCFA denies an application for qualification under this subpart, HCFA gives the entity written notice of the denial and an opportunity to request reconsideration of that determination.

(2) A request for reconsideration must—

(i) Be submitted in writing, within 60 days following the date of the notice of denial;

(ii) Be addressed to the HCFA officer or employee who denied the application; and

(iii) Set forth the grounds upon which the entity requests reconsideration, specifying the material issues of fact and of law upon which the entity relies.

(3) HCFA bases its reconsideration upon the record compiled during the qualification review proceedings, materials submitted in support of the request for reconsideration, and other relevant materials available to HCFA.

(4) HCFA gives the entity written notice of the reconsidered determination and the basis for the determination.

(e) *Information on qualified HMOs—*(1) **Federal Register** *notices.* In quarterly **Federal Register** notices, HCFA gives the names, addresses, and service areas of newly qualified HMOs and describes the expanded service areas of other qualified HMOs.

(2) *Listings.* A cumulative list of qualified HMOs is available from the following office, which is open from 8:30 a.m. to 5 p.m., Monday through Friday: Office of Managed Care, Room 4360, Cohen Building, 400 Independence Avenue SW., Washington, DC 20201.

C. Subpart E is amended as set forth below.

Subpart E—Inclusion of Qualified Health Maintenance Organizations in Employee Health Benefits Plans

1. Section 417.150 is amended to revise the introductory text, add definitions of "agreement," "contract," and "qualified HMO," remove the definition of "health benefits," and revise the definitions of "bargaining representative," "collective bargaining agreement," "eligible employee," "employer," "health benefits plan," "public entity," and "to offer a health benefits plan" to read as follows:

§ 417.150 Definitions.

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

Agreement means a collective bargaining agreement.

Bargaining representative means an individual or entity designated or selected, under any applicable Federal, State, or local law, or public entity collective bargaining agreement, to represent employees in collective bargaining, or any other employee representative designated or selected under any law.

* * * * *

Collective bargaining agreement means an agreement entered into between an employing entity and the bargaining representative of its employees.

Contract means an employer-employee or public entity-employee contract, or a contract for health benefits.

Eligible employee means an employee who meets the employer's requirements for participation in the health benefits plan.

* * * * *

Employer has the meaning given that term in section 3(d) of the Fair Labor Standards Act of 1938, except that it—

(1) Includes non-appropriated fund instrumentalities of the United States Government; and

(2) Excludes the following:

(i) The governments of the United States, the District of Columbia and the territories and possessions of the United States, the 50 States and their political subdivisions, and any agencies or instrumentalities of any of the foregoing, including the United States Postal Service and Postal Rate Commission.

(ii) Any church, or convention or association of churches, and any organization operated, supervised, or controlled by a church, or convention or association of churches that meets the following conditions:

(A) Is an organization that is described in section 501(c)(3) of the Internal Revenue Code of 1954.

(B) Does not discriminate, in the employment, compensation, promotion or termination of employment of any personnel, or in the granting of staff and other privileges to physicians or other health personnel, on the grounds that the individuals obtain health care through HMOs, or participate in furnishing health care through HMOs.

Health benefits plan means any arrangement, to provide or pay for health services, that is offered to eligible employees, or to eligible employees and their eligible dependents, by or on behalf of an employing entity.

Public entity means the 50 states, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands and American Samoa and their political subdivisions, the District of Columbia, and any agency or instrumentality of the foregoing, and *political subdivisions* include counties, parishes, townships, cities, municipalities, towns, villages, and incorporated villages.

Qualified HMO means an HMO that has in effect a determination, made under subpart D of this part, that the HMO is an operational, preoperational, or transitional qualified HMO.

To offer a health benefits plan means to make participation in a health benefits plan available to eligible employees, or to eligible employees and their eligible dependents regardless of whether the employing entity makes a financial contribution to the plan on behalf of these employees, directly or indirectly, for example, through payments on any basis into a health and welfare trust fund.

2. Sections 417.151 through 417.156 are revised to read as follows:

§ 417.151 Applicability.

(a) *Basic rule.* This subpart applies to any employer or public entity that offers a health benefits plan to its employees and meets the conditions specified in paragraphs (b) through (e) of this section.

(b) *Number of employees.* During any calendar quarter of the preceding calendar year, the employer or public entity employed an average of not less than 25 employees.

(c) *Minimum wage.* During any calendar quarter of the preceding calendar year, the employer was required to pay the minimum wage specified in section 6 of the Fair Labor Standards Act of 1938, or would have been required to pay that wage but for section 13(a) of that Act.

(d) *Federal assistance under section 317 of the PHS Act.* The public entity has a pending application for, or is receiving, assistance under section 317 of the PHS Act.

(e) *Request for inclusion of qualified HMO.* The employer or public entity has received, from at least one qualified HMO, a request to be included in the health benefits plan offered to employees, and the following conditions are met:

(1) The request is in writing and meets the requirements of § 417.152.

(2) At least 25 of the employees of the employer or public entity reside within the HMO's service area.

§ 417.152 Request for inclusion of the HMO in a health benefits plan; employing entity's response.

(a) *Time limitations.* (1) Unless otherwise agreed to by the HMO and the employing entity or its designee, an HMO's request for inclusion in a health benefits plan must be received by the employing entity or designee—

(i) Not more than 365 nor less than 180 days before the expiration or renewal date of—

(A) A health benefits contract or employing entity-employee contract; or

(B) A collective bargaining agreement; or

(ii) In the case of a public entity, any longer period prescribed by State law.

(2) For purposes of this paragraph, the dates are considered to be as follows:

(i) For a collective bargaining agreement that is automatically renewable or without fixed term, the expiration or renewal date is the earliest anniversary date of the agreement.

(ii) For a collective bargaining agreement that is for a fixed term of more than 1 year and provides that its health benefits terms may be renegotiated during the term of the agreement, the expiration date is the date provided by the agreement for discussion of health benefits changes.

(b) *To whom the request must be addressed.* The HMO must direct its written request for inclusion to—

(1) The employer's managing official at the employer site being solicited or the employer's designee; or

(2) The public entity's chief executive officer or designee.

(c) *Required information.* The request must include the following:

(1) Evidence showing that the HMO has been determined to be a qualified HMO in accordance with section 1310(d) of the PHS Act and subpart D of this part.

(2) A description of the HMO's service area or proposed service area and the dates when the HMO will furnish basic and supplemental health services in the area.

(3) Indication of whether the HMO furnishes the basic health services that are the services of health professionals—

(i) Through health professionals who are—

(A) Members of the HMO's staff;

(B) Members of one or more medical groups;

(C) Members of one or more individual practice associations (IPAs); or

(D) Under direct contract with the HMO; or

(ii) Through any combination of the foregoing.

(4) If the HMO provides health services through IPAs, a listing of member physicians by name, specialty, and whether they are accepting new patients from the HMO enrollment. This listing must be current within 90 days of the date of the request for inclusion.

(5) If the HMO provides health services other than through IPAs, for each ambulatory care facility the facility's address, days and hours of operation, a statement whether it is accepting new patients from the HMO enrollment, and the names and specialties of the facility's providers of basic and supplemental health services. This information must be current within 90 days of the date of the request for inclusion.

(6) A list of the hospitals where HMO enrollees will be provided basic and supplemental health services.

(7) Identification of the type of HMO entity specifying, for example, whether for profit or nonprofit, public or private, sole proprietorship, partnership or stock corporation; the members of the HMO's policymaking body; and the principal managing officer of the HMO.

(8) A statement of the HMO's capacity to accept new enrollees and the likelihood of any future limitations on enrollment.

(9) The HMO's most recently audited annual financial statement.

(10) Proposed implementing agreements between the HMO and the employer, public entity, or designee for the HMO offering.

(11) Sample copies of solicitation brochures and enrollment literature that will be used in the offer of the HMO option to employees.

(12) The HMO's current rates, including copayments, for basic and uniformly included supplemental health services and the dates these rates became effective; or the HMO's estimated rates for these services.

(d) *Employing entity's response*—(1) *Timing.* An employing entity or its designee must respond in writing to an HMO's request for inclusion no later than 60 days after receipt of the request.

(2) *Basic statement.* The response must state whether the employing entity has 25 or more employees who reside within the HMO's service area.

(3) *Additional information: Public entities only.* A public entity's response must specify the health benefits, including limitations and exclusions, that are required under State law or regulations for employees of the public entity.

(4) *Additional information: All employing entities.* If the employing entity has 25 or more employees who reside within the HMO's service area, the response must include the following:

(i) Expiration or renewal dates of contracts that cover those employees.

(ii) The amount of the employing entity's current contribution and, if applicable, the employee's contribution, for health benefits, and the dates when those contribution levels became effective.

(iii) The expiration dates of any collective bargaining agreements covering those employees.

(e) *Effect of inadequate request.* If the request for inclusion does not meet the requirements of paragraphs (a) through (c) of this section, the following rules apply:

(1) The employing entity is not required to include the HMO option in its employees' health benefits plan under § 417.154 until the HMO makes its request in accordance with those paragraphs.

(2) The employing entity or its designee must, within 60 days after receipt of the request, notify the HMO in writing of the basis for its conclusion that the request does not meet the requirements of paragraphs (a) through (c) of this section.

(f) *New request for inclusion.* (1) If an employing entity includes the HMO option in a health benefits plan in accordance with a request meeting the requirements of paragraphs (a) through (c) of this section, the employing entity must offer the HMO option to all the eligible employees who reside in the HMO's service area during the entire health benefits year.

(2) However, if no employees enroll during the health benefits year, the HMO seeking inclusion in the health benefits plan for subsequent enrollment periods must submit a new request in accordance with paragraphs (a) through (c) of this section.

§ 417.153 Offer of HMO option to employees.[1]

(a) *Basic rule.* An employing entity subject to this subpart must, at the time it offers a health benefits plan to its eligible employees, include in the plan the option of enrollment in qualified HMOs in accordance with this section.

(b) *Employees to whom the HMO option must be offered.* Each employing entity must offer the option of enrollment in a qualified HMO to each eligible employee and his or her eligible dependents who reside in the HMO's service area.

(c) *Manner of offering the HMO option.* (1) For employees who are represented by a bargaining representative, the option of enrollment in a qualified HMO——

(i) Must first be presented to the bargaining representative; and

(ii) If the representative accepts the option, must then be offered to each represented employee.

(2) For employees not represented by a bargaining representative, the option must be offered directly to those employees.

§ 417.154 HMOs that must be included in a health benefits plan.

(a) *HMOs of different models*—(1) *Categories of HMO models.* The following categories describe the manner in which an HMO furnishes the basic health services that are provided by physicians.

(i) A "staff/group model HMO" provides more than one-half of those services through members of the HMO's staff or of a medical group or groups.

(ii) An "IPA/direct contract model HMO" provides those services through——

(A) An IPA or IPAs; or

(B) A combination of IPAs, medical groups, staff, and individual physicians and other health professionals under contract with the HMO.

(2) *Requirement.* If at least one HMO from each category described in paragraph (a)(1) of this section requests inclusion in a health benefits plan, the employing entity must include at least one HMO from each category.

(3) *Terms.* For purposes of this paragraph (a), "health professionals under contract" does not include health professionals who are members of any of the following:

(i) The HMO's staff.

(ii) Medical groups.

(iii) Entities that would be medical groups if they met the following requirements:

(A) For the group members individually, the coordinated practice of their profession represents more than 50 percent of their professional activity.

(B) For the group as a whole, the delivery of health services to HMO enrollees represents more than 35 percent of their professional activity.

(b) *Additional HMOs that must be included.* An employing entity that is subject to this subpart must offer its eligible employees the option of enrollment in additional qualified HMOs if the HMOs demonstrate that at least 25 of those eligible employees reside in the HMO's service areas and meet either of the following conditions:

(1) They do not reside in the service areas of other HMOs already included in the employing entity's health benefits plan.

(2) They cannot enroll in any other HMO included in the plan because those HMOs have closed their enrollment to additional eligible employees of the employing entity.

(c) *Optional inclusion of alternative HMOs.* An employing entity may include in its health benefits plan, instead of an HMO that made a timely request for inclusion, one or more other HMOs that may not have made a request within the established time limits but are willing to be included, if the following conditions are met:

(1) The alternative HMOs are of the same type (as described in paragraph (a) of this section) as the HMO that submitted the timely request.

(2) All of the eligible employees who reside in the service area of the HMO

[1] The statutory requirement for the employing entity to include the HMO option has a sunset date of October 24, 1995. Accordingly, the statutory requirement expires on that date unless Congress extends it.

that made the timely request reside in the service areas of the alternative HMOs.

§ 417.155 How the HMO option must be included in the health benefits plan.

(a) *HMO access to employees*—(1) *Purpose and timing.*

(i) *Purpose.* The employing entity must provide each HMO included in its health benefits plan fair and reasonable access to all employees specified in § 417.153(b), so that the HMO can explain its program in accordance with § 417.124(b).

(ii) *Timing.* The employing entity must provide access beginning at least 30 days before, and continuing during, the group enrollment period.

(2) *Nature of access.* (i) Access must include, at a minimum, opportunity to distribute educational literature, brochures, announcements of meetings, and other relevant printed materials that meet the requirements of § 417.124(b).

(ii) Access may not be more restrictive or less favorable than the access the employing entity provides to other offerors of options included in the health benefits plan, whether or not those offerors elect to avail themselves of that access.

(b) *Review of HMO offering materials.* (1) The HMO must give the employing entity or designee opportunity to review, revise, and approve HMO educational and offering materials before distribution.

(2) Revisions must be limited to correcting factual errors and misleading or ambiguous statements, unless—

(i) The HMO and the employing entity agree otherwise; or

(ii) Other revisions are required by law.

(3) The employing entity or designee must complete revision of the materials promptly so as not to delay or otherwise interfere with their use during the group enrollment period.

(c) *Group enrollment period; prohibition of restrictions; effective date of HMO coverage*—(1) *Prohibition of restrictions.* If an employing entity or designee includes the option of enrollment in a qualified HMO in the health benefits plan offered to its eligible employees, it must provide a group enrollment period before the effective date of HMO coverage. The employing entity may not impose waiting periods as a condition of enrollment in the HMO or of transfer from HMO to non-HMO coverage, or exclusions, or limitations based on health status.

(2) *Effective date of coverage.* Unless otherwise agreed to by the employing entity, or designee, and the HMO, coverage under the HMO contract for employees selecting the HMO option begins on the day the non-HMO contract expires or is renewed without lapse.

(3) *Coordination of benefits.* Nothing in this subpart precludes the uniform application of coordination of benefits agreements between the HMOs and the other carriers that are included in the health benefits plan.

(d) *Continued eligibility for "free-standing" health benefits*—(1) *Basic requirement.* At the request of a qualified HMO, the employing entity or its designee must provide that employees selecting the option of HMO membership will not, because of this selection, lose their eligibility for free-standing dental, optical, or prescription drug benefits for which they were previously eligible or would be eligible if selecting a non-HMO option and that are not included in the services provided by the HMO to its enrollees as part of the HMO prepaid benefit package.

(2) *"Free-standing" defined.* For purposes of this paragraph, the term "free-standing" refers to a benefit which—

(i) Is not integrated or incorporated into a basic health benefits package or major medical plan, and

(ii) Is—

(A) Offered by a carrier other than the one offering the basic health benefits package or major medical plan; or

(B) Subject to a premium separate from the premium for the basic health benefits package or major medical plan.

(3) *Examples of the employing entity's obligation with respect to the continued eligibility.* (i) The health benefits plan includes a free-standing dental benefit. The HMO does not offer any dental coverage as part of its health services provided to members on a prepaid basis. The employing entity must provide that employees who select the HMO option continue to be eligible for dental coverage. (If the dental coverage is not optional for employees selecting the non-HMO option, nothing in this regulation requires that the coverage be made optional for employees selecting the HMO option. Conversely, if this coverage is optional for employees selecting the non-HMO option, nothing in this regulation requires that the coverage be mandatory for employees selecting the non-HMO option.) -

(ii) The non-HMO option provides free-standing coverage for optical services (such as refraction and the provision of eyeglasses), and the HMO does not. The employing entity must provide that employees who select the HMO option continue to be eligible for optical coverage.

(iii) The non-HMO option includes dental coverage in its major medical package, with a common deductible applied to dental as well as non-dental benefits. The HMO provides no dental coverage as part of its pre-paid health services. Because the dental coverage is not free-standing, the employing entity is not required to provide that employees who select the HMO option continue to be eligible for dental coverage, but is free to do so.

(e) *Opportunity to select among coverage options: Requirement for affirmative written selection*—(1) *Opportunity other than during a group enrollment period.* The employing entity or designee must provide opportunity (in addition to the group enrollment period) for selection among coverage options, by eligible employees who meet any of the following conditions:

(i) Are new employees.

(ii) Have been transferred or have changed their place of residence, resulting in—

(A) Eligibility for enrollment in a qualified HMO for which they were not previously eligible by place of residence; or

(B) Residence outside the service area of a qualified HMO in which they were previously enrolled.

(iii) Are covered by any coverage option that ceases operation.

(2) *Prohibition of restrictions.* When the employees specified in paragraph (e)(1) of this section are eligible to participate in the health benefits plan, the employing entity or designee must make available, without waiting periods or exclusions based on health status as a condition, the opportunity to enroll in an HMO, or transfer from HMO coverage to non-HMO coverage.

(3) *Affirmative written selection.* The employing entity or designee must require that the eligible employee make an affirmative written selection in any of the following circumstances:

(i) Enrollment in a particular qualified HMO is offered for the first time.

(ii) The eligible employee elects to change from one option to another.

(iii) The eligible employee is one of those specified in paragraph (e)(1) of this section.

(f) *Determination of copayment levels and supplemental health services.* The selection of a copayment level and of supplemental health services to be contracted for must be made as follows:

(1) For employees represented by a collective bargaining representative, the selection of copayment levels and supplemental health services is subject to the collective bargaining process.

(2) For employees not represented by a bargaining representative, the selection of copayment levels and supplemental health services is subject to the same decisionmaking process used by the employing entity with respect to the non-HMO option in its health benefits plan.

(3) In all cases, the HMO has the right to include, with the basic benefits package it provides to its enrollees for a basic health services payment, on a non-negotiable basis, those supplemental health services that meet the following conditions:

(i) Are required to be offered under State law.

(ii) Are included uniformly by the HMO in its prepaid benefit package.

(iii) Are available to employees who select the non-HMO option but not available to those who select the HMO option.

§ 417.156 When the HMO must be offered to employees.

(a) *General rules.* (1) The employing entity or designee must offer eligible employees the option of enrollment in a qualified HMO at the earliest date permitted under the terms of existing agreements or contracts.

(2) If the HMO's request for inclusion in a health benefits plan is received at a time when existing contracts or agreements do not provide for inclusion, the employing entity must include the HMO option in the health benefits plan at the time that new agreements or contracts are offered or negotiated.

(b) *Specific requirements.* Unless mutually agreed otherwise, the following rules apply:

(1) *Collective bargaining agreement.* The employing entity or designee must raise the HMO's request during the collective bargaining process—

(i) When a new agreement is negotiated;

(ii) At the time prescribed, in an agreement with a fixed term of more than 1 year, for discussion of change in health benefits; or

(iii) In accordance with a specific process for review of HMO offers.

(2) *Contracts.* For employees not covered by a collective bargaining agreement, the employing entity or designee must include the HMO option in any health benefits plan offered to eligible employees when the existing contract is renewed or when a new health benefits contract or other arrangement is negotiated.

(i) If a contract has no fixed term or has a term in excess of 1 year, the contract must be treated as renewable on its earliest anniversary date.

(ii) If the employing entity or designee is self-insured, the budget year must be treated as the term of the existing contract.

(3) *Multiple arrangements.* In the case of a health benefits plan that includes multiple contracts or other arrangements with varying expiration or renewal dates, the employing entity must include the HMO option, in accordance with paragraphs (b)(1) and (b)(2) of this section,—

(i) At the time each contract or arrangement is renewed or reissued; or

(ii) The benefits provided under the contract or arrangement are offered to employees.

3. Sections 417.158 and 417.159 are revised to read as follows:

§ 417.158 Payroll deductions.

Each employing entity that provides payroll deductions as a means of paying employees' contributions for health benefits or provides a health benefits plan that does not require an employee contribution must, with the consent of an employee who selects the HMO option, arrange for the employee's contribution, if any, to be paid through payroll deductions.

§ 417.159 Relationship of section 1310 of the Public Health Service Act to the National Labor Relations Act and the Railway Labor Act.

The obligation of an employing entity subject to this subpart to include the HMO option in any health benefits plan offered to its eligible employees must be carried out consistently with the obligations imposed on that employing entity under the National Labor Relations Act, the Railway Labor Act, and other laws of similar effect.

D. Subpart F is amended as set forth below.

Subpart F—Continued Regulation of Federally Qualified Health Maintenance Organizations

1. The heading of subpart F is revised to read as set forth above.

2. Section 417.160 is revised to read as follows:

§ 417.160 Applicability.

This subpart applies to any entity that has been determined to be a qualified HMO under subpart D of this part.

3. Section 417.163 is revised to read as follows:

§ 417.163 Enforcement procedures.

(a) *Complaints.* Any person, group, association, corporation, or other entity may file with HCFA a written complaint with respect to an HMO's compliance with assurances it gave under subpart D of this part. A complaint must—

(1) State the grounds and underlying facts of the complaint;

(2) Give the names of all persons involved; and

(3) Assure that all appropriate grievance and appeals procedures established by the HMO and available to the complainant have been exhausted.

(b) *Investigations.* (1) HCFA may initiate investigations when, based on a report, a complaint, or any other information, HCFA has reason to believe that a Federally qualified HMO is not in compliance with any of the assurances it gave under subpart D of this part.

(2) When HCFA initiates an investigation, it gives the HMO written notice that includes a full statement of the pertinent facts and of the matters being investigated and indicates that the HMO may submit, within 30 days of the date of the notice, a written report concerning these matters.

(3) HCFA obtains any information it considers necessary to resolve issues related to the assurances, and may use site visits, public hearings, or any other procedures that HCFA considers appropriate in seeking this information.

(c) *Determination and notice by HCFA*—(1) *Determination.* (i) On the basis of the investigation, HCFA determines whether the HMO has failed to comply with any of the assurances it gave under subpart D of this part.

(ii) HCFA publishes in the **Federal Register** a notice of each determination of non-compliance.

(2) *Notice of determination: Corrective action.* (i) HCFA gives the HMO written notice of the determination.

(ii) The notice specifies the manner in which the HMO has not complied with its assurances and directs the HMO to initiate the corrective action that HCFA considers necessary to bring the HMO into compliance.

(iii) The HMO must initiate this corrective action within 30 days of the date of the notice from HCFA, or within any longer period that HCFA determines to be reasonable and specifies in the notice. The HMO must carry out the corrective action within the time period specified by HCFA in the notice.

(iv) The notice may provide the HMO an opportunity to submit, for HCFA's approval, proposed methods for achieving compliance.

(d) *Remedy: Revocation of qualification.* If HCFA determines that a qualified HMO has failed to initiate or to carry out corrective action in accordance with paragraph (c)(2) of this section—(1) HCFA revokes the HMO's qualification and notifies the HMO of this action.

(2) In the notice, HCFA provides the HMO with an opportunity for reconsideration of the revocation,

including, at the HMO's election, a fair hearing.

(3) The revocation of qualification is effective on the tenth calendar day after the day of the notice unless HCFA receives a request for reconsideration by that date.

(4) If after reconsideration HCFA again determines to revoke the HMO's qualification, this revocation is effective on the tenth calendar day after the date of the notice of reconsidered determination.

(5) HCFA publishes in the **Federal Register** each determination it makes under this paragraph (d).

(6) A revocation under this paragraph (d) has the effect described in § 417.164.

(e) *Notice by the HMO.* Within 15 days after the date HCFA issues a notice of revocation, the HMO must prepare a notice that explains, in readily understandable language, the reasons for the determination that it is not a qualified HMO, and send the notice to the following:

(1) The HMO's enrollees.

(2) Each employer or public entity that has offered enrollment in the HMO in accordance with subpart E of this part.

(3) Each lawfully recognized collective bargaining representative or other representative of the employees of the employer or public entity.

(f) *Reimbursement of enrollees for services improperly denied, or for charges improperly imposed.* (1) If HCFA determines, under paragraph (c)(1) of this section, that an HMO is out of compliance, HCFA may require the HMO to reimburse its enrollees for the following—

(i) Expenses for basic or supplemental health services that the enrollee obtained from other sources because the HMO failed to provide or arrange for them in accordance with its assurances.

(ii) Any amounts the HMO charged the enrollee that are inconsistent with its assurances. (Rules applicable to charges for all enrollees are set forth in §§ 417.104 and 417.105. The additional rules applicable to Medicare enrollees are in § 415.454.)

(2) This paragraph applies regardless of when the HMO failed to comply with the appropriate assurances.

(g) *Remedy: Civil suit*—(1) *Applicability.* This paragraph applies to any HMO or other entity to which a grant, loan, or loan guarantee was awarded, as set forth in subpart V of this part, on the basis of its assurances regarding the furnishing of basic and supplemental services or its operation and organization, as the case may be.

(2) *Basis for action.* If HCFA determines that the HMO or other entity has failed to initiate or refuses to carry out corrective action in accordance with paragraph (c)(2) of this section, HCFA may bring civil action in the U.S. district court for the district in which the HMO or other entity is located, to enforce compliance with the assurances it gave in applying for the grant, loan, or loan guarantee.

4. Section 417.164 is revised to read as follows:

§ 417.164 Effect of revocation of qualifiers on inclusion in employee's health benefit plans.

When an HMO's qualification is revoked under § 417.163(d), the following rules apply:

(a) The HMO may not seek inclusion in employees health benefits plans under subpart E of this part.

(b) Inclusion of the HMO in an employer's health benefits plan—

(1) Is disregarded in determining whether the employer is subject to the requirements of subpart E of this part; and

(2) Does not constitute compliance with subpart E of this part by the employer.

5. Section 417.166 is revised to read as follows:

§ 417.166 Waiver of assurances.

(a) *General rule.* HCFA may release an HMO from compliance with any assurances the HMO gives under subpart D of this part if—

(1) The qualification requirements are change by Federal law; or

(2) The HMO shows good cause, consistent with the purposes of title XIII of the PHS Act.

(b) *Basis for finding of good cause.* (1) Grounds upon which HCFA may find good cause include but are not limited to the following:

(i) The HMO has filed for reorganization under Federal bankruptcy provisions and the reorganization can only be approved with the waiver of the assurances.

(ii) State laws governing the entity have been changed after it signed the assurances so as to prohibit the HMO from being organized and operated in a manner consistent with the signed assurances.

(2) Changes in State laws do not constitute good cause to the extent that the changes are preempted by Federal law under section 1311 of the PHS Act.

(c) *Consequences of waiver.* If HCFA waives any assurances regarding compliance with section 1301 of the PHS Act, HCFA concurrently revokes the HMO's qualification unless the waiver is based on paragraph (a)(1) of this section.

§§ 417.168 and 417.169 [Removed]

6. Sections 417.168 and 417.169 are removed.

E. Subpart V is amended as set forth below:

Subpart V—Administration of Outstanding Loans and Loan Guarantees

1. Section 417.910 is revised to read as follows:

§ 417.910 Applicability.

The regulations in this subpart apply, as appropriate, to public and private entities that have loans or loan guarantees that—

(a) Were awarded to them before October 1986 under section 1304 or section 1305 of the PHS Act; and

(b) Are still outstanding.

2. Section 417.911 is amended to remove the definitions of any *12-month period, health system agency* (including *State health planning and development agency*), and *nonprofit.*

§§ 417.912 through 417.919, 417.921 through 417.926, 417.932, 417.933, 417.935, and 417.936 [Removed]

3. Sections 417.912 through 417.919, 417.921 through 417.926, 417.932, 417.933, 417.935, and 417.936 are removed.

4. Sections 417.934 and 417.937 are revised to read as follows:

§ 417.934 Reserve requirement.

(a) *Timing.* Unless the Secretary approved a longer period, an entity that received a loan or loan guarantee under section 1305 of the PHS Act was required to establish a restricted reserve account on the earlier of the following:

(1) When the HMO's revenues and costs of operation reached the break-even point.

(2) At the end of the 60-month period following the Secretary's endorsement of the loan or loan guarantee.

(b) *Purpose and amount of reserve.* The reserve had to be constituted so as to accumulate, no later than 12 years after endorsement of the loan or loan guarantee, an amount equal to 1 year's principal and interest.

§ 417.937 Loan and loan guarantee provisions.

(a) *Disbursement of loan proceeds.* The principal amount of any loan made or guaranteed by the Secretary under this subpart was disbursed to the entity in accordance with an agreement entered into between the parties to the loan and approved by the Secretary.

(b) *Length and maturity of loans.* The principal amount of each loan or loan guarantee, together with interest

thereon, is repayable over a period of 22 years, beginning on the date of endorsement of the loan, or loan guarantee by the Secretary. The Secretary could approve a shorter repayment period if he or she determined that a repayment period of less than 22 years is more appropriate to an entity's total financial plan.

(c) *Repayment.* The principal amount of each loan or loan guarantee, together with interest thereon is repayable in accordance with a repayment schedule that is agreed upon by the parties to the loan or loan guarantee and approved by the Secretary before or at the time of endorsement of the loan. Unless otherwise specifically authorized by the Secretary, each loan made or guaranteed by the Secretary is repayable in substantially level combined installments of principal and interest to be paid at intervals not less frequently than annually, sufficient in amount to amortize the loan through the final year of the life of the loan. Principal repayment during the first 60 months of operation could be deferred with payment of interest only during that period. The Secretary could set rates of interest for each disbursement at a rate comparable to the rate of interest prevailing on the date of disbursement for marketable obligations of the United States of comparable maturities, adjusted to provide for appropriate administrative charges.

5. A new § 417.940 is added, to read as follows:

§ 417.940 Civil action to enforce compliance with assurances.

The provisions of § 417.163(g) apply to entities that have outstanding loans or loan guarantees administered under this subpart.

F. Technical amendments.

1. In § 417.124, a new paragraph (e)(4) is added, to read as follows:

§ 417.124 Administration and management.

* * * * *

(e) *Conversion of enrollment.* * * *

(4) The HMO must offer the enrollment on the same terms and conditions that it makes available to other nongroup enrollees.

§ 417.150 [Amended]

2. In § 417.150, in the definitions of "carrier" and "designee", "membership" is revised to read "enrollment".

§ 417.400 [Amended]

3. In § 417.400, in paragraph (a), "as amended by section 114 of public law 97–248. Section 1876 of the Act," is removed and "which" is added in its place.

§ 417.436 [Amended]

4. In § 417.436, in paragraph (a)(11), "Advanced directives" is revised to read "Advance directives".

§ 417.460 [Amended]

5. In § 417.460, the heading of paragraph (a) is revised to read *"Disenrollment of Medicare beneficiaries."*

§ 417.801 [Amended]

6. In § 417.801, in paragraph (b)(2), ", a beneficiary," is removed, and "individual" is revised to read "enrollee" each time it appears.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773, Medicare Hospital Insurance Program; No. 93.774, Medicare Supplementary Medical Insurance Program)

Dated: June 23, 1994.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: September 7, 1994.

Donna E. Shalala,

Secretary.

[FR Doc. 94–23281 Filed 9–29–94; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Public Land Order 7088

[CO–930–4210–06; COC–43908]

Withdrawal of National Forest System Land for Breckenridge Ski Area; Colorado

AGENCY: Bureau of Land Management, Interior.

ACTION: Public Land Order.

SUMMARY: This order withdraws 280 acres of National Forest System land from mining for protection of recreational resources and facilities at the Breckenridge Ski Area. This withdrawal is an addition to the existing Breckenridge Ski Area. The land has been and remains open to such forms of disposition as may by law be made of National Forest System land and to mineral leasing.

EFFECTIVE DATE: September 30, 1994.

FOR FURTHER INFORMATION CONTACT: Doris E. Chelius, BLM Colorado State Office, 2850 Youngfield Street, Lakewood, Colorado 80215–7076, 303–239–3706.

By virtue of the authority vested in the Secretary of the Interior by Section 204 of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714 (1988), it is ordered as follows:

1. Subject to valid existing rights, the following described National Forest System land is hereby withdrawn from location and entry under the United States mining laws (30 U.S.C. Ch. 2 (1988)), for protection of facilities at the Breckenridge Ski Area:

Sixth Principal Meridian

Arapaho National Forest

T. 6 S., R. 78 W.,
Sec. 34, Nominal W½W½ (Protraction Diagram No. 9, accepted April 26, 1965).
T. 7 S., R. 78 W.,
Sec. 3, Nominal N½NW¼ and N½S½NW¼ (Protraction Diagram No. 45, accepted August 20, 1986).

The area described contains approximately 280 acres in Summit County.

2. The withdrawal made by this order does not alter the applicability of those public land laws governing the use of National Forest System land under lease, license, or permit, or governing the disposal of their mineral or vegetative resources other than under the mining laws.

3. This withdrawal will expire June 14, 2038, unless, as a result of a review conducted before the expiration date pursuant to Section 204(f) of the Federal Land and Policy and Management Act of 1976, 43 U.S.C. 1714(f) (1988), the Secretary determines that the withdrawal shall be extended.

Dated: September 26, 1994.

Bob Armstrong,

Assistant Secretary of the Interior.

[FR Doc. 94–24266 Filed 9–29–94; 8:45 am]

BILLING CODE 4310–JB–P

43 CFR Public Land Order 7089

[CO–930–4210–06; COC–54072]

Withdrawal of National Forest System Land for the Purgatory Ski Area; Colorado

AGENCY: Bureau of Land Management, Interior.

ACTION: Public Land Order.

SUMMARY: This order withdraws 2,360.78 acres of National Forest System land from mining for 50 years to protect recreational resources and facilities at the Purgatory Ski Area. The land has been and remains open to such forms of disposition as may by law be made of National Forest System land and to mineral leasing.

EFFECTIVE DATE: September 30, 1994.

FOR FURTHER INFORMATION CONTACT: Doris E. Chelius, BLM Colorado State

Office, 2850 Youngfield Street, Lakewood, Colorado 80215–7076, 303–239–3706.

By virtue of the authority vested in the Secretary of the Interior by Section 204 of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714 (1988), it is ordered as follows:

1. Subject to valid existing rights, the following described National Forest System land is hereby withdrawn from location and entry under the United States mining laws (30 U.S.C. Ch. 2 (1988)) for protection of the Purgatory Ski Area:

New Mexico Principal Meridian

San Juan National Forest

T. 39 N., R. 9 W.,
Sec. 22, lots 1 to 4, inclusive, S½NW¼ and S½;
Sec. 23, lots 1 through 16, inclusive;
Sec. 24, W½E½NE¼NW¼, W½E½NW¼, and W½NW¼;
Sec. 25, lot 10.

A parcel described by metes and bounds within sec. 24, beginning at corner No. 1, being the southwest corner of sec. 24, T. 39 N., R. 9 W., described as follows:

From Corner No. 1, by metes and bounds,
S. 89°25′ E., 661.98 ft.;
N. 1°03′05″ W., 65.84 ft.;
N. 89°24′28″ W., 661.86 ft.;
S. 1°00′37″ E., 65.84 ft. to corner No. 1, the place of beginning.

A parcel described by metes and bounds within secs. 21, 26, 27, and 28; Beginning at corner No. 1, being the ¼-corner of secs. 21 and 22, T. 39 N., R. 9 W., described as follows:

From Corner No. 1, by metes and bounds,
S. 88°50′23′ W., 2481.30 ft, on the E–W centerline of sec. 21;
S. 0°07′ W., 1,282.19 ft.;
S. 32°10′ E., 3,132.00 ft.;
S. 68°17′ E., 2,585.32 ft.;
N. 80°12′ E., 2,343.21 ft.;
S. 82°04′ E., 1,723.00 ft.,
S. 60°04′ E., 1,939.00 ft.;
S. 82°45′ E., 2,070.00 ft.,
N. 41°04′ E., 3,350.00 ft.,
N. 0°53′ W., 1,903.12 ft. to the northeast corner of sec. 26;
S. 84°27′ W., 5,782.26 ft. to the northwest corner of sec. 26;
S. 85°33′ W., 5,767.74 ft. to the northwest corner of sec. 27;
N. 0°05′ W., 2,583.90 ft. to corner No. 1, the point of beginning.

The area described contains approximately 2,360.78 acres in La Plata County.

2. The withdrawal made by this order does not alter the applicability of those public land laws governing the use of National Forest System land under lease, license, or permit, or governing the disposal of their mineral or vegetative resources other than under the mining laws.

3. This withdrawal will expire 50 years from the effective date of this order unless, as a result of a review conducted before the expiration date pursuant to Section 204(f) of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714(f) (1988), the Secretary determines that the withdrawal shall be extended.

Dated: September 26, 1994.

Bob Armstrong,

Assistant Secretary of the Interior.

[FR Doc. 94–24267 Filed 9–29–94; 8:45 am]

BILLING CODE 4310–JB–P

43 CFR Public Land Order 7090

[CO–932–4210–06; COC–39308]

Withdrawal of National Forest System Land for Keystone Ski Area; Colorado

AGENCY: Bureau of Land Management, Interior.

ACTION: Public Land Order.

SUMMARY: This order withdraws approximately 1,778 acres of National Forest System lands from mining for protection of recreational resources and facilities at the Keystone Ski Area. This withdrawal is an addition to the existing Keystone Ski Area. The lands have been and remain open to such forms of disposition as may by law be made of National Forest System lands and to mineral leasing.

EFFECTIVE DATE: September 30, 1994.

FOR FURTHER INFORMATION CONTACT: Doris E. Chelius, BLM Colorado State Office, 2850 Youngfield Street, Lakewood, Colorado 80215–7076, 303–239–3706.

By virtue of the authority vested in the Secretary of the Interior by Section 204 of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714 (1988), it is ordered as follows:

1. Subject to valid existing rights, the following described National Forest System lands are hereby withdrawn from location and entry under the United States mining laws (30 U.S.C. Ch. 2 (1988)), for protection of facilities at the Keystone Ski Area:

Sixth Principal Meridian

Arapaho National Forest

T. 5 S., R. 76 W.,
Sec. 19, lots 19, 22, 25, 26, and 58;
Sec. 20, lots 30, 31, and 46;
Sec. 29, W½E½SW¼, W½NW¼, and W½E½NW¼ exclusive of patented land;
Sec. 32, W½NE¼NW¼, SW¼NW¼, and W½SW¼.
T. 5 S., R. 77 W.,
Sec. 24, lot 13 and E½SW¼;
Sec. 25, SE¼NW¼, E½NE¼SW¼, and SW¼SE¼;
Sec. 36, NE¼NE¼, NE¼SE¼ and E½NW¼SE¼.
T. 6 S., R. 76 W.,
Sec. 5, S½ exclusive of patented land;
Sec. 6, lots 2, 7, and 10;
Sec. 7, SE¼SW¼ and SW¼SE¼;
Sec. 8, N½ and N½N½SW¼ exclusive of patented land.
T. 6 S., R. 77 W.,
Sec. 2, SE¼NE¼;
Sec. 12, SW¼NW¼, NE¼SW¼, and S½SE¼.

The areas described aggregate approximately 1,778.03 acres in Summit County.

2. The withdrawal made by this order does not alter the applicability of those public land laws governing the use of National Forest System lands under lease, license, or permit, or governing the disposal of their mineral or vegetative resources other than under the mining laws.

3. This withdrawal will expire October 15, 2036, unless, as a result of a review conducted before the expiration date pursuant to Section 204(f) of the Federal Land and Policy and Management Act of 1976, 43 U.S.C. 1714(f) (1988), the Secretary determines that the withdrawal shall be extended.

Dated: September 26, 1994.

Bob Armstrong,

Assistant Secretary of the Interior.

[FR Doc. 94–24268 Filed 9–29–94; 8:45 am]

BILLING CODE 4310–JB–P

DEPARTMENT OF TRANSPORTATION

Coast Guard

46 CFR Part 67

[CGD 94–008]

RIN 2115–AE83

Documentation of Vessels

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: The Coast Guard is amending its vessel documentation regulations. The amendments clarify the vessel documentation regulations by restating the citizenship requirements for trusts to reflect the Coast Guard's policy; by correcting an existing cross-reference error regarding mortgagee consent for exchange of Certificates of Documentation; by implementing statutory requirements concerning the endorsements on Certificates of Documentation for dredges and towing vessels; and by making other minor technical amendments.

EFFECTIVE DATE: October 31, 1994.

ADDRESSES: Unless otherwise indicated, documents referred to in this preamble are available for inspection or copying at the office of the Executive Secretary,