

§ 417.153 Offer of HMO alternative.

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

(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.

[59 FR 49839, Sept. 30, 1994, as amended at 61 FR 27287, May 31, 1996]

§ 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 that—

(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.

[59 FR 49840, Sept. 30, 1994, as amended at 61 FR 27288, May 31, 1996]

§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 bene-

fits 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.

[59 FR 49841, Sept. 30, 1994]

§417.157 Contributions for the HMO alternative.

(a) *General principles—(1) Non-discrimination.* The employer contribution to an HMO must be in an amount that does not discriminate financially against an employee who enrolls in an HMO. A contribution does not discriminate financially if the method of determining the contribution is reasonable and is designed to ensure that employees have a fair choice among health benefits plan alternatives.

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

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

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

(ii) The employer contribution reflects the composition of the HMO's enrollment in terms of enrollee attributes that can reasonably be used to