

an equal amount, regardless of the health benefits plan chosen by the employee.

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

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

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

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

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

(c) *Exclusion for contribution for certain benefits.* In determining the amount of the employing entity's contribution or the designee's cost for the HMO alternative, the employing entity or designee may exclude those portions of the contribution allocable to bene-

fits (such as life insurance or insurance for supplemental health benefits)—

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

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

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

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

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

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

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

(3) A description of the methodology for computation.

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

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

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

[61 FR 27287, May 31, 1996]

§ 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.

[59 FR 49841, Sept. 30, 1994]

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

The decision of an employing entity subject to this subpart to include the HMO alternative 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.

[59 FR 49841, Sept. 30, 1994, as amended at 61 FR 27288, May 31, 1996]

Subpart F—Continued Regulation of Federally Qualified Health Maintenance Organizations

SOURCE: 43 FR 32255, July 25, 1978, unless otherwise noted. Redesignated at 52 FR 36746, Sept. 30, 1987.

§ 417.160 Applicability.

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

[59 FR 49841, Sept. 30, 1994]

§ 417.161 Compliance with assurances.

Any entity subject to this subpart must comply with the assurances that it provided to CMS, unless compliance is waived under § 417.166.

[58 FR 38071, July 15, 1993]

§ 417.162 Reporting requirements.

Entities subject to this subpart must submit:

(a) The reports that may be required by CMS under § 417.126, and

(b) Any additional reports CMS may reasonably require.

[58 FR 38071, July 15, 1993]

§ 417.163 Enforcement procedures.

(a) *Complaints.* Any person, group, association, corporation, or other entity may file with CMS 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) CMS may initiate investigations when, based on a report, a complaint, or any other information, CMS 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 CMS 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) CMS 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 CMS considers appropriate in seeking this information.

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

(ii) CMS publishes in the FEDERAL REGISTER a notice of each determination of non-compliance.

(2) *Notice of determination: Corrective action.* (i) CMS 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 CMS 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 CMS, or within any longer period that CMS determines