

§ 417.150

42 CFR Ch. IV (10-1-00 Edition)

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.

[59 FR 49837, Sept. 30, 1994]

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

SOURCE: 45 FR 72517, Oct. 31, 1980, unless otherwise noted. Redesignated at 52 FR 36746, Sept. 30, 1987.

**§ 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.

*Carrier* means a voluntary association, corporation, partnership, or other organization that is engaged in providing, paying for, or reimbursing all or part of the cost of health benefits under group insurance policies or contracts, medical or hospital service agreements, enrollment or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier.

*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.

*Designee* means any person or entity authorized to act on behalf of an employing entity or a group of employing entities to offer the option of enrollment in a qualified health maintenance organization to their eligible employees.

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

*Employee* means any individual employed by an employer or public entity on a full-time or part-time basis.

*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.

*Employing entity* means an employer or public entity.

*Employing entity-employee contract* means a legally enforceable agreement (other than a collective bargaining agreement) between an employing entity and its employees for the provision of, or payment for, health benefits for its employees, or for its employees and their eligible dependents.

*Group enrollment period* means the period of at least 10 working days each calendar year during which each eligible employee is given the opportunity to select among the alternatives included in a health benefits plan.

*Health benefits* means health benefits and services.

*Health benefits contract* means a contract or other agreement between an employing entity or a designee and a carrier for the provision of, or payment for, health benefits to eligible employees or to eligible employees and their eligible dependents.

*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.

[45 FR 72517, Oct. 31, 1980, as amended at 47 FR 19341, May 5, 1982. Redesignated at 52 FR 36746, Sept. 30, 1987, as amended at 58 FR 38077, July 15, 1993; 59 FR 49837, 49843, Sept. 30, 1994]

#### §417.151 Applicability.

(a) *Basic rule.* Effective October 24, 1995<sup>1</sup>, this subpart applies to any employing entity that offers a health benefits plan to its employees, meets the conditions specified in paragraphs (b) through (e) of this section, and elects to include one or more qualified HMOs in the health plan alternatives it offers its employees.

<sup>1</sup>Before October 24, 1995, an employing entity that met the conditions specified in §417.151 was required to include one or more qualified HMOs, if it received from at least one qualified HMO a written request for inclusion and that request met the timing, content, and procedural requirements specified in §417.152.