

(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.

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§ 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.

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§ 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