

Environmental Protection proposal for nitrogen oxide reasonably available control technology (NO_x RACT) for the Pennsylvania Power—New Castle plant located in Lawrence County. At the request of Paul, Hastings, Janofsky & Walker LLP, attorneys representing Pennsylvania Power—New Castle plant, EPA is extending the comment period through November 18, 1997.

DATES: Comments must be received on or before November 18, 1997.

ADDRESSES: Comments may be mailed to David L. Arnold, Chief, Ozone/CO and Mobile Sources Section, Mailcode 3AT21, U.S. Environmental Protection Agency, Region III, 841 Chestnut Building, Philadelphia, Pennsylvania 19107.

FOR FURTHER INFORMATION CONTACT: Cynthia H. Stahl, U.S. EPA Region III, (215) 566-2180.

Dated: September 16, 1997.

W. Michael McCabe,

Regional Administrator, Region III.

[FR Doc. 97-25224 Filed 9-22-97; 8:45 am]

BILLING CODE 6560-50-P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[Region 2 Docket No. NY24-2-172a; FRL-5892-4]

Approval and Promulgation of Implementation Plans; Reasonably Available Control Technology for Oxides of Nitrogen for Specific Sources in the State of New York

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The EPA proposes to approve three (3) State Implementation Plan (SIP) revisions submitted by the State of New York related to development of reasonably available control technologies for oxides of nitrogen from various sources in the State. In the Final Rules section of this **Federal Register**, EPA is approving the State's SIP revisions, as a direct final rule without prior proposal because the Agency views this as a noncontroversial revision and anticipates no adverse comments. A detailed rationale for the approval is set forth in the direct final rule. If no adverse comments are received in response to that direct final rule no further activity is contemplated in relation to this proposed rule. If EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be

addressed in a subsequent final rule based on this proposed rule. The EPA will not institute a second comment period on this rulemaking. Any parties interested in commenting on this **Federal Register** should do so at this time.

DATES: Comments must be received on or before October 23, 1997.

ADDRESSES: All comments should be addressed to: Ronald Borsellino, Chief, Air Programs Branch, Environmental Protection Agency, Region 2 Office, 290 Broadway, New York, New York 10007-1866.

Copies of the State submittal are available at the following addresses for inspection during normal business hours:

Environmental Protection Agency, Region 2 Office, 290 Broadway, 25th Floor, New York, New York 10007-1866.

New York Department of Environmental Conservation, Division of Air Resources, 50 Wolf Road, Albany, New York 12233.

FOR FURTHER INFORMATION CONTACT: Ted Gardella or Rick Ruvo, Air Programs Branch, Environmental Protection Agency, 290 Broadway, 25th Floor, New York, New York 10007-1866, (212) 637-4249.

SUPPLEMENTARY INFORMATION: For additional information see the direct final rule which is published in the rules section of this **Federal Register**.

Dated: September 2, 1997.

William J. Muszynski,

Acting Regional Administrator.

[FR Doc. 97-25231 Filed 9-22-97; 8:45 am]

BILLING CODE 6560-50-F

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 86

[FRL-5897-5]

Control of Air Pollution From New Motor Vehicles and New Motor Vehicle Engines; Voluntary Standards for Light-Duty Vehicles; Extension of Comment Period

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule; extension of comment period.

SUMMARY: The U.S. Environmental Protection Agency is extending the comment period on the Supplemental Notice of Proposed Rulemaking (SNPRM) which takes comment on the few remaining issues necessary to finalize the regulations for the National

LEV program, and which appeared in the **Federal Register** on August 22, 1997 (62 FR 44754). The public comment period was to end on September 22, 1997. The purpose of this document is to extend the comment period an additional 7 days beyond that, to end on September 29, 1997. This extension of the comment period is provided to allow commenters additional time to respond to the SNPRM.

DATES: EPA will accept public comments on the Supplemental Notice of Proposed Rulemaking until September 29, 1997.

ADDRESSES: Written comments should be submitted (in duplicate if possible) to: the EPA, Air Docket, Room M-1500 (Mail Code 6102), Waterside Mall, Attn: Docket A-95-26, 401 M Street, SW., Washington, DC 20460. Materials relevant to this rulemaking are contained in Docket No. A-95-26. The docket is located at The Air Docket, 401 M Street, SW., Washington, DC 20460, and may be viewed in room M-1500 between 8:00 a.m. and 5:30 p.m., Monday through Friday. The telephone number is (202) 260-7548 and the facsimile number is (202) 260-4400. A reasonable fee may be charged by EPA for copying docket material.

FOR FURTHER INFORMATION CONTACT: Karl Simon, Office of Mobile Sources, U.S. Environmental Protection Agency, 401 M Street SW, Washington, DC 20460. Telephone (202) 260-3623; Fax (202) 260-6011; e-mail simon.karl@epamail.epa.gov.

Dated: September 17, 1997.

Richard D. Wilson,

Acting Assistant Administrator for Air and Radiation.

[FR Doc. 97-25233 Filed 9-22-97; 8:45 am]

BILLING CODE 6560-50-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Chapter IV

[OMC-029-N]

RIN 0938-AI25

Medicare Program; Solvency Standards for Provider-Sponsored Organizations; Intent To Form Negotiated Rulemaking Committee

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

ACTION: Intent to form negotiated rulemaking committee and notice of meetings.

SUMMARY: The Balanced Budget Act of 1997 requires the Secretary to establish a Negotiated Rulemaking Committee under the Federal Advisory Committee Act (FACA). The Committee's purpose will be to negotiate the solvency standards for provider-sponsored organizations under part C of the Medicare program. The Committee will consist of representatives of interests that are likely to be significantly affected by the solvency rule. The Committee will be assisted by a neutral facilitator.

We request public comment on whether—we have identified the key solvency issues to be negotiated by the Committee; We have identified the interests that will be affected by key issues listed below; The party we are proposing to serve as the neutral facilitator is acceptable. Additionally, comments are sought on several key definitions related to the negotiated rulemaking and the forthcoming rulemaking for Medicare+Choice organizations.

DATES: Comments will be considered if we receive them at the appropriate address provided below, no later than 5 p. m. on October 8, 1997. Comments on the definitions for the terms described in section VII of this notice will be accepted separately until October 20, 1997.

The first meeting will be held at 9:00 a.m. on October 20, 21, and 22, 1997.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: PSO NOTICE, P.O. Box 7517, Baltimore, MD 21244-0517.

If you prefer, you may deliver your written comments (1 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 C5-09-26, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code OMC-029-N. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in room 309-G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a. m. to 5 p. m. (Phone: (202) 690-7890).

The October meeting will be held at the Sheraton National Hotel, 900 South

Orme Street, Arlington, VA; (703) 521-1900.

FOR FURTHER INFORMATION CONTACT: Maureen Miller, (410) 786-1097, for general issues related to standards for provider-sponsored organizations. Philip Doerr, (410) 786-1059, for technical issues related to solvency standards. Judy Ballard, (202) 690-7419, or Celia Ford, (202) 690-8020, Conveners.

SUPPLEMENTARY INFORMATION:

I. Negotiated Rulemaking Process

The Negotiated Rulemaking Act (Pub. L. 101-648, 5 U.S.C. 561-570) establishes a framework for the conduct of negotiated rulemaking and encourages agencies to use negotiated rulemaking to enhance the informal rulemaking process. Under the Act, the head of an agency must consider whether—

- There is a need for a rule;
- There are a limited number of identifiable interests that will be significantly affected by the rule;
- There is a reasonable likelihood that a committee can be convened with a balanced representation of persons who—
 - Can adequately represent the interests identified; and
 - Are willing to negotiate in good faith to reach a consensus on the proposed rule;
 - There is a reasonable likelihood that a committee will reach a consensus on the proposed rule within a fixed period of time;
 - The negotiated rulemaking procedure will not unreasonably delay the notice of proposed rulemaking and the issuance of a final rule;
 - The agency has adequate resources and is willing to commit such resources, including technical assistance, to the Committee; and
 - The agency, to the maximum extent possible, consistent with the legal obligations of the agency, will use the consensus of the Committee with respect to the proposed rule as the basis for the rule proposed by the agency for notice and comment.

Negotiations are conducted by a Committee chartered under the Federal Advisory Committee Act (FACA) (5 U.S.C. App. 2). The Committee includes an agency representative and is assisted by a neutral facilitator. The goal of the Committee is to reach consensus on the language or issues involved in a rule. If consensus is reached, it is used as the basis of the agency's proposal. The process does not affect otherwise applicable procedural requirements of the FACA, the Administrative Procedure Act, and other statutes.

II. Subject and Scope of the Rule

A. Need for the Rule

The Balanced Budget Act of 1997, Pub. L. 105-33, establishes a new Medicare+Choice program under part C of title XVIII of the Social Security Act (the Act). Under this program, an eligible individual may elect to receive Medicare benefits through enrollment in a Medicare+Choice plan that has a contract with us, which may include a health plan offered by a provider-sponsored organization (PSO). We may contract only with organizations that we have certified as meeting program requirements.

A PSO is defined as a public or private entity—

- That is established or organized, and operated, by a health care provider, or group of affiliated health care providers;
- That provides a substantial proportion of the health care items and services directly through the provider or affiliated group of providers; and
- With respect to which the affiliated providers share, directly or indirectly, substantial financial risk for the provision of such items and services and have at least a majority financial interest in the entity (section 1855(d) of the Act).

Generally, a Medicare+Choice organization must be "organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a Medicare+Choice plan." (section 1855(a)(1) of the Act).

Section 1855(a)(2) of the Act provides, however, that the Secretary may waive the licensing requirement for a PSO that has filed a waiver application by November 1, 2002, if the Secretary determines that the State failed to complete action on a licensing application within 90 days, denied the licensing application based on discriminatory treatment, or denied the licensing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and—

- Such requirements are not the same as the solvency standards established by negotiated rulemaking as authorized under section 1856(a) of the Act; or
- The State conditioned approval on "documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, and standards applied by the Secretary" under section 1855(d)(2) of the Act

regarding the use of the term "substantial proportion."

A waiver is effective only with respect to that State, only for a nonrenewable 36-month period, supersedes any State licensing provision that would prohibit the organization from participating in a Medicare+Choice contract, and is conditioned upon the organization's compliance with State consumer protection and quality standards as provided for in section 1855(a)(2)(E) and (G) of the Act. PSOs that have a waiver application approved must meet program requirements including standards for financial solvency and capital adequacy of the organization.

B. Modified Negotiated Rulemaking Committee

Section 4001 of the BBA mandates an expedited and modified negotiated rulemaking process for establishing solvency standards for PSOs under a new Medicare Part C. The standards must be published as an interim final rule, subject to comment, by April 1, 1998. In order to meet this deadline, the BBA mandated that this notice be published within 45 days after enactment, shortened the notice's comment period to 15 days, and shortened the time period for appointment of Committee members as well as the facilitator. The Committee is required to report its proposed standards to the Secretary by March 1, 1998. Further, the Committee is required to report to the Secretary by January 1, 1998 regarding its progress and whether it is likely to achieve consensus. If the Committee reports that it has failed to make significant progress or that consensus is unlikely within the assigned time frame, the Committee will be terminated and publication of a rule will proceed using other rulemaking procedures.

C. Issues and Questions to be Resolved

The issues we anticipate include fundamental questions about solvency standards, definitions, threshold questions, overarching policy issues, and finally specific matters identified by the Congress for consideration. We invite public comment on these and on other issues, which are believed to be in the scope of the rule.

- What are solvency standards? What is the purpose of these standards? We expect the Committee to address the purpose and scope of solvency standards, particularly with regard to the operation of a fiscally sound organization and needed protections in the event of insolvency, including financial viability at application (that is, initial capitalization) and on an ongoing

basis, as well as liquidity and cash flow. These discussions may extend to alternative models for approaching solvency standards, such as focusing on the nature of the health products being offered and the actual risk being assumed, in addition to the nature, assets, or other resources of the entity providing the benefits.

- Should solvency standards for PSOs be equivalent or substantially similar to those for other risk-bearing organizations? We expect to discuss the concept, or goal, of a "level playing field" between PSOs (which may or may not be Medicare-only health plans) and other health plans that enroll members from the general population and, possibly, Medicaid recipients; the impact of the organizational structure and nature of PSOs, and the characteristics of their enrollment, on decreasing or increasing factors that affect the financial stability of risk-bearing health plans; and the patterns and trends in State solvency requirements that are relevant to Medicare-contracting PSOs.

- How should the solvency rule take into account the delivery system assets of the PSO and its ability to provide services directly to enrollees through affiliated providers? This is a key issue, and one which the BBA directs the Committee to consider. We expect discussion of various PSO assets, such as property, plant, equipment, or other non-fiscal assets; how to value these assets, giving consideration to market forces that may affect or cause fluctuation of value; the ability to increase services to meet increased demand, and the potential, if any, of higher efficiency of an integrated network; the relevancy of Medicare enrollment size and potential use of services in comparison to PSO assets and obligations; and financial reserves.

- How should the rule take into account alternative means of protecting against insolvency? There are a number of "tools" or mechanisms that are used, or have been proposed for use, to assure that a health plan remains fiscally sound and to protect enrollees in the event of insolvency. The statute lists the following alternative means as included in factors to be considered: reinsurance, unrestricted surplus, letters-of-credit, guarantees (third party guarantees), organizational insurance coverage (including stop-loss and insolvency insurance), partnerships with other licensed entities, and valuation attributable to the ability of the PSO to meet its service obligations through direct delivery of care (discussed previously). Other mechanisms, or factors, will be discussed including the

possibility of guarantee associations and state-held reserves where PSOs are state-licensed. The Committee will discuss the merits of these factors, their interrelatedness and will report to the Secretary on specific requirements for their use in a solvency standard.

- How should the rule take into account any standards established by the National Association of Insurance Commissioners (NAIC) for risk-based health care delivery organizations? This is the third area in which the BBA directs the Committee to work. The National Association of Insurance Commissioners invested significant time and resources to develop and improve State solvency standards for risk-bearing health care delivery organizations, specifically focusing on what is called "risk-based capital (RBC)." However, given that the RBC formula is in a transitional phase between development and implementation, its inclusion as part of the Medicare PSO solvency standards requires careful consideration. We believe the Committee should become knowledgeable about the RBC formula and its role relative to solvency standards. In addition, we believe the Committee should discuss the applicability of the current National Association of Insurance Commissioners' RBC formula to PSOs with Medicare-only enrollment as well as those with enrollments other than the Medicare population. We may ask the Committee to advise us on how to proceed toward utilizing a RBC formula, including further developmental work, and how to proceed with implementation given voluntary adoption by States and where PSOs may or may not be licensed by the State.

- What provisions are necessary to prevent enrollees from being held liable to any person or entity for the Medicare+Choice organization's debts in the event of the PSO's insolvency? There appears to be agreement that the provider contracts of Medicare+Choice organizations should include contractual language that prohibits providers from billing enrollees and requires continuation of care through the period for which premiums have been paid. We anticipate that the Committee may wish to discuss the period of time for which these contractual agreements are in effect, as well as difficulties in ensuring that providers continue to provide services, problems ensuring that insolvency insurance is in place, and the difficulties of getting affected patients appropriate coverage.

- What factors not specifically listed in the statute should be considered? We

believe the Committee should consider the need for more stringent solvency standards if the Secretary exercises the option to waive the minimum enrollment requirement and grants a waiver to the PSO. We believe the Committee should consider adopting certain requirements related to the fiscal soundness for health maintenance organizations, especially those requirements commonly considered good business practices, such as having insurance policies against losses stemming from fire, theft, and fraud. There may be other factors, such as actuarial opinions and cash reserves, that the Committee should consider. In addition, on the matter of cash reserves, we expect the Committee will discuss how to handle the cash reserve requirement with multi-State PSOs.

- What reporting requirements will we impose? The Committee will discuss the nature and frequency of reporting requirements. Currently, we require Medicare contracting health plans to report using the National Association of Insurance Commissioners' "Orange Blank," but some modification of this requirement may be necessary to account for the organizational nature of PSOs and differences between PSOs and other Medicare+Choice plans. We anticipate that such differences will have to be limited to ensure efficient use of State and Federal monitoring resources.

- How will definitions and policies that the Secretary will develop affect the negotiations? The statute contains definitions and terms to be defined by the Secretary that are relevant to the development of solvency standards. We anticipate that the Committee will need to have guidance on the definition of the terms "substantial proportion" (including potential variations in the definition of this term), "substantial financial risk," "affiliated health care providers," "providers," and "partnerships" as they relate to the financial stability of PSOs. We will provide preliminary definitions and use of these terms. However, because these definitions and policies will be part of a separate regulation to be published by June 1, 1998, the information provided to the Committee will not be final definitions at the time of negotiated rulemaking.

D. Issues and Questions Not Open to Negotiation

With regard to parameters outside the scope of this rule, we will not discuss or consider issues not directly related to PSO solvency standards. Thus, we will not discuss the PSO waiver process, the PSO application process, monitoring,

compliance actions, or matters that will be the subject of the June 1, 1998, interim final rule. Further, issues such as who can qualify as a PSO or those that are definitional (and thereby subject of the June 1, 1998 interim final rule) will be discussed only to the extent that solvency standards may be contingent on establishing some parameters.

III. Affected Interests and Potential Participants

In addition to our participation on the committee, the Convener has proposed and we agree to accept the following as negotiation participants, some of which are coalitions of two or more groups:

American Association of Health Plans
American Association of Homes and Services for the Aging/American Health Care Association/Home Health Services and Staffing Association/National Association for Home Care

American Association of Retired Persons

American Hospital Association
American Medical Association
American Medical Group Association
Blue Cross/Blue Shield Association
Catholic Health Association / Premier Consortium on Citizens with Disabilities
Federation of American Health Systems
National Association of Insurance Commissioners

National Independent Practice Association (IPA) Coalition/The IPA Association of America
National Rural Health Association

Individuals representing the proposed organizations and health industry sectors should have "real world" experience, be respected in their particular community, have the ability to engage in negotiations that lead to consensus, and be able to fully represent the views of the interests they represent. We reserve the right to refuse representatives that do not possess these characteristics. Given the limited time frame for the development of this rule, it is expected that the negotiations will be time consuming and intensive. Representatives must be prepared and committed to fully participating in the negotiations. The names of the Committee members will be announced before the first meeting and Committee members will be notified. We are establishing an Internet site on our Managed Care home page, which will carry this information as well as other meeting information. We invite public comment on this list of negotiation participants.

The intent in establishing the negotiating committee is that all interests are represented, not necessarily

all parties. We believe this proposed list of participants represents all interests associated with adoption of solvency standards for provider-sponsored organizations. In determining whether a party had a significant interest and was represented, we considered groups who have and will continue to actively represent the main provider groups who will form PSOs, groups that represent providers experienced in bearing risk and managed care, groups that represent entities similar in nature to PSOs, groups representing affiliated providers and the continuum of care, beneficiary groups, and state regulators. In addition, we sought to achieve balance between providers seeking to enter the Medicare market and those (including existing Medicare contractors) who advocate for strong solvency standards. We believe a complex balance has been achieved due to the diversity within the groups named or within the health systems that are their members. Lastly, while we are obligated to assure that all interests that are significantly affected are adequately represented, it is critical to the Committee's success that it be kept to a manageable size. Committee size is a consideration because of the short time frame in which the Committee must complete its task.

Groups or individuals who wish to apply for a seat on the Committee should respond to this notice, and provide detailed information as to how they would be affected by the solvency standards rule (rather than the new legislation generally) and why their interest could not be adequately represented by the proposed committee.

IV. Schedule for the Negotiations

The BBA requires that the Committee submit its final report to the Secretary by March 1, 1998. The BBA further directs that the activities of the Committee be terminated if the Committee does not report, no later than January 1, 1998, that it has made significant progress and is likely to reach consensus within the time line established by the statute. The first meeting is scheduled for October 20, 21, and 22, 1997, at a meeting facility in the Greater Washington, D.C. area beginning at 9:00 a.m. on the first day. The purpose of this meeting will be to discuss in detail how the negotiations will proceed and how the Committee will function. The Committee will agree to ground rules for committee operation, will determine how best to address the principal issues, and, if time permits, will begin hearing presentations and to address those issues.

A second meeting is scheduled for November 12, 13, and 14, 1997. We

expect that by this meeting the Committee can complete action on any procedural matters remaining from the organizational meeting and either begin or continue to address the issues. The third meeting is scheduled for December 3, 4, and 5, 1997 for continued discussion of the issues. Three subsequent meetings will be held in January and February of 1998. Times and locations of the meetings in the Greater Washington DC area will be published in the **Federal Register** and announced and placed on our Internet Managed Care Home Page.

V. Formation of the Negotiating Committee

A. Procedure for Establishing an Advisory Committee

As a general rule, an agency of the Federal government is required to comply with the requirements of FACA when it establishes or uses a group that includes non-Federal members as a source of advice. Under FACA, an advisory committee begins negotiations only after it is chartered. This process is underway.

B. Participants

The number of participants in the group is estimated to be 14 and should not exceed 16 participants. A number larger than this could make it difficult to conduct effective negotiations. One purpose of this notice is to help determine whether the proposed rule would significantly affect interests not adequately represented by the proposed participants. We do not believe that each potentially affected organization or individual must necessarily have its own representative. However, each interest must be adequately represented. Moreover, we must be satisfied that the group as a whole reflects a proper balance and mix of interests.

C. Requests for Representation

If, in response to this notice, an additional individual or representative of an interest requests membership or representation on the Committee, we will determine, in consultation with the convener, whether that individual or representative should be added to the Committee. We will make that decision based on whether the individual or interest—

- Would be significantly affected by the rule, and
- Is already adequately represented in the negotiating group.

D. Establishing the Committee

After reviewing any comments on this notice and any requests for

representation, we will take the final steps to form the committee unless the comments and other relevant considerations convince us that such action is inappropriate or our charter request is disapproved.

VI. Negotiation Procedures

If a committee is formed, the following procedures and guidelines will apply, unless they are modified as a result of comments received on this notice or during the negotiating process.

A. Facilitator

We will use a neutral facilitator. The facilitator will not be involved with the substantive development or enforcement of the regulation. The facilitator's role will be to—

- Chair negotiating sessions;
- Help the negotiation process run smoothly; and
- Help participants define and reach consensus.

We propose to use the Department's Appeals Board as the facilitator.

B. Good Faith Negotiations

Participants must be willing to negotiate in good faith and be authorized to do so. We believe this may best be accomplished by selection of senior officials as participants. We believe senior officials are best suited to represent the interests and viewpoints of their organizations. This applies to us as well, and we are designating Kathleen Buto, Deputy Director of our Center for Health Plans and Providers to represent us.

C. Administrative Support

We will supply logistical, administrative, and management support. If it is deemed necessary and appropriate, we will provide technical support to the committee in gathering and analyzing additional data or information.

D. Meetings

Meetings will be held in the Baltimore/Washington area (or in another location). We will announce committee meetings and agendas in the **Federal Register**. Unless announced otherwise, meetings are open to the public.

E. Committee Procedures

Under the general guidance and direction of the facilitator, and subject to any applicable legal requirements, the members will establish the detailed procedures for committee meetings that they consider most appropriate.

F. Defining Consensus

The goal of the negotiating process is consensus. Under the Negotiated Rulemaking Act, consensus generally means that each interest concurs in the result unless the term is defined otherwise by the Committee. We expect the participants to fashion their working definition of this term.

G. Failure of Advisory Committee To Reach Consensus

If the Committee is unable to reach consensus, we will proceed to develop an interim final rule. Parties to the negotiating may withdraw at that time. If this happens, we and the remaining Committee members will evaluate whether the Committee should continue.

H. Record of Meetings

In accordance with FACA's requirements, minutes of all committee meetings will be kept. The minutes will be placed in the public rulemaking record and Internet site on our Managed Care home page.

I. Other Information

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

VII. Special Solicitation of Public Comment

Given the abbreviated time lines and absence of proposed rulemaking (as directed by the BBA) for this negotiated rulemaking and the forthcoming rules for Medicare Part C, we are taking this opportunity to solicit views on the definitions and use of the terms (as directed by BBA): substantial proportion, substantial financial risk, affiliated provider, provider of health services, partnerships, organized and licensed under State law as a risk-bearing entity. Because this solicitation will assist us in developing policy and providing guidance to the Committee, comments should be submitted no later than October 20, 1997, to the following addresses: Health Care Financing Administration, ATTN: Ms. Maureen Miller, Room S3-21-17, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Final definitions of these terms will appear in the June 1, 1998 final rule.

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

Dated: September 16, 1997.

Nancy-Ann Min DeParle,

Deputy Administrator, Health Care Financing Administration.

Approved: September 18, 1997.

Donna E. Shalala,

Secretary.

[FR Doc. 97-25343 Filed 9-19-97; 2:27 pm]

BILLING CODE 4120-01-P

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

49 CFR Part 387

[FHWA Docket No. MC-97-11]

RIN 2125-AE06

Qualifications of Motor Carriers To Self-Insure Their Operations and Fees To Support the Approval and Compliance Process

AGENCY: Federal Highway Administration (FHWA).

ACTION: Advance notice of proposed rulemaking (ANPRM); request for comments.

SUMMARY: This action is being taken pursuant to the ICC Termination Act of 1995 (ICCTA), which, among other things, directs the Secretary of DOT to adopt regulations governing the standards to approve motor carriers as self-insurers. The FHWA proposes to examine the sufficiency of the existing requirements for self-insurance authorizations, as well as the need for additional fees for functions performed in addition to the processing of the initial application. More specifically, the FHWA is considering the need for fees to cover costs associated with processing multi-carrier applications and alterations to self-insurance authorizations, and for a monitoring fee to cover costs related to compliance responsibilities. The FHWA also requests public comment on the merits of continuing the self-insurance program and whether congressional action should be proposed to terminate the authorizations.

DATES: Comments must be received on or before November 24, 1997.

ADDRESSES: Submit written, signed comments to FHWA Docket No. MC-97-11, Room 4232, HCC-10, Office of the Chief Counsel, Federal Highway Administration, 400 Seventh Street, SW., Washington, DC 20590. All comments received will be available for examination at the above address from 8:30 a.m. to 3:30 p.m., e.t., Monday through Friday, except Federal holidays.

Those desiring notification of receipt of comments must include a self-addressed, stamped postcard.

FOR FURTHER INFORMATION CONTACT: John F. Grimm, Office of Motor Carriers, (202) 366-4039 or Stanley M. Braverman, Motor Carrier Law Division, Office of the Chief Counsel, (202) 358-7035; Federal Highway Administration, 400 Virginia Ave., SW, Suite 600, Washington, DC 20024. Office hours are from 7:45 a.m. to 4:15 p.m., e.t., Monday through Friday except Federal holidays.

SUPPLEMENTARY INFORMATION:

Background

The former Interstate Commerce Commission (ICC), in its earliest days of motor carrier regulation, considered applications of carriers seeking authority to self-insure their operations. The ICC took the position that self-insurance requirements should be stringent and that carriers availing themselves of that privilege should maintain adequate reserves to meet claims. *Motor Carrier Insurance Protection of the Public*, 1 M.C.C. 45, 58 (1936).

The ICC set no rules at that time governing the qualifications for self-insurers, but decided to consider for approval the application of any carrier that could establish its ability to satisfy, "its obligations for bodily-injury liability, property-damage liability, or cargo liability without affecting the stability or permanency of its business." *Id.* at 59. Motor carrier requests to self-insure which were approved by the ICC required the execution of insurance endorsements which obligated the insurance company to pay final judgments regardless of any policy defenses it may have against the insured. *Id.* at 53. The self-insurance was based upon deductible levels in the insurance policies which were authorized by the ICC. Despite the size of any deductible, the insurance company remained liable to the public for the entire amount of the policy. Although the ICC considered use of deductibles to be tantamount to self-insurance, the motor carrier would be fully insured since the insurance company remained liable for the entire amount of the policy. The self-insurance authorization posed no additional risk to the public because the insurance company would be required to pay a judgement, without regard to the deductible, if the carrier refused to pay.

In response to an insurance crisis in the motor carrier industry in the mid 1980's which increased the cost of insurance coverage to extraordinary levels and affected its availability, the

ICC began authorizing carriers with adequate financial resources to self-insure all, or part of, their required liability coverage backed by adequate security without the public protection provided by the traditional insurance company endorsement.¹ The ICC recognized that self-insurance plans do not necessarily afford the precise level of protection that customary insurance plans provide since insurance policies cover liability for every accident within the policy limits. Nevertheless, the ICC began issuing self-insurance authorizations subject to an extensive series of conditions designed to insure that the public would be protected from uncompensated losses. *See*, No. MC-128527, *May Trucking Company* (unpublished decision), served April 22, 1986. (*See* Appendix to this ANPRM.). Interim rules designed to establish minimum criteria that motor passenger and property carriers must meet to qualify as self-insurers were adopted by the ICC. Ex Parte No. MC-178, *Investigation into Motor Carrier Insurance Rates*, served April 12, 1986 (51 FR 15008, April 22, 1986). Final rules were adopted which included application guidelines covering the adequacy of the carrier's net worth, the existence of a sound self-insurance program, a "satisfactory" safety rating, and additional information the ICC might require. *Investigation into Motor Carrier Insurance Rates*, 3 I.C.C. 2d 377 (1987) (52 FR 3814, February 6, 1987).² The ICC expanded the list of methods carriers can use to demonstrate sound self-insurance programs to include irrevocable letters of credit and irrevocable trust funds. *Id.* at 388. In reviewing self-insurance applications, the ICC relied on its general powers to impose conditions on a case-by-case basis to insure that the public was adequately protected. *Id.* at 383. The requirement of an irrevocable trust fund or letter of credit in at least the amount of the self-insurance liability has been imposed in virtually all self-insurance authorizations.

The ICCTA, Pub. L. 104-88, 109 Stat. 803, provides that "[T]he Secretary of Transportation shall continue to enforce the rules and regulations of the Interstate Commerce Commission, as in effect on July 1, 1995, governing the qualifications for approval of a motor carrier as a self-insurer, until such time as the Secretary finds it in the public interest to revise such rules." Section

¹ The minimum financial responsibility requirements for for-hire carriers, formerly regulated by the ICC and now by the FHWA, are contained in 49 CFR Part 387.

² These rules are now codified at 49 CFR 387.309 [former 49 CFR 1043.5].