

feasible projections of future enrollment and employer distribution, as well as the potential enrollment area for marketing purposes;

(iii) *Health care delivery system*: A health care delivery system providing reasonable access to and choice of quality primary and specialty medical care throughout the service area; specifically, in the individual practice setting, contractual arrangements for the services of a significant number of primary care and speciality physicians in the service area; and in the group practice setting, compliance with 5 U.S.C. 8903(4)(A) preferably demonstrated by full-time providers specializing in internal medicine, family practice, pediatrics, and obstetrics/gynecology; and

(iv) *Financial condition*: Establishment of firm budget projections and demonstrated success in meeting or exceeding those projections on a regular basis; evidence of the ability to sustain operation in the future and to meet obligations under the contract OPM might enter into with the plan; clearly specified committed funding to see the plan to an expected break-even point including a sufficient amount for unexpected contingencies; adequate current and projected funding, such as estimated premium income or commitment from a financially sound and acceptable parent organization or a mature stable entity outside the plan; insolvency protection, such as stop-loss reinsurance services and agreements with all plan providers that they will hold members harmless if, for any reason, the plan is unable to pay its providers.

(5) A comprehensive medical plan that has been certified either as a qualified Health Maintenance Organization (HMO) or as a qualified Competitive Medical Plan by the Department of Health and Human Services (HHS) at the time of application to OPM, and whose qualification status is not under investigation by HHS, will need to submit only an abbreviated application to OPM. The extent of the data and documentation to be submitted by a plan so qualified by HHS, as well as by a non-qualified plan, for a particular review cycle may be obtained by writing directly to the Office of Insurance Programs, Retirement and

Insurance Service, Office of Personnel Management, Washington, DC 20415.

(b) *Participating plans*. Changes in rates and benefits for approved health benefits plans shall be considered at the discretion of the Director of OPM. If the Director of OPM determines that it is beneficial to enrollees and the Federal Employees Health Benefits Program to invite health plan benefit and/or rate changes for a given contract period, a "call letter" shall be issued to the carrier approximately 9 months prior to the expiration of the current contract period. Any proposal for change shall be in writing, specifically describe the change proposed, and be signed by an authorized official of the carrier. OPM will review any requested proposal for change and will notify the carrier of its decision to accept or reject the change. OPM may make a counter proposal or at any time propose changes on its own motion. Benefits changes and rate proposals, when requested by OPM, shall be submitted not less than 7 months before the expiration of the then current contract period, unless the Director of OPM determines that a later date is acceptable. The negotiation period shall begin approximately 7 months before the expiration of the current contract period, and OPM shall seek to complete all benefit and rate negotiations no later than 4 months preceding the contract period to which they will apply. If OPM and the carrier do not reach agreement by this date, either party may give written notice of nonrenewal in accordance with § 890.205 of this part.

[37 FR 20668, Oct. 3, 1972, as amended at 41 FR 40090, Sept. 17, 1976; 43 FR 52461, Nov. 13, 1978; 48 FR 16232, Apr. 15, 1983; 50 FR 8315, Feb. 28, 1985; 52 FR 23934, June 26, 1987; 54 FR 52337, Dec. 21, 1989; 55 FR 22891, June 5, 1990; 57 FR 19374, May 6, 1992; 59 FR 62284, Dec. 5, 1994; 60 FR 62988, Dec. 8, 1995]

§ 890.204 Withdrawal of approval of health benefits plans or carriers.

(a) The Director may withdraw approval of a health benefits plan or carrier if the standards at § 890.201 of this part and 48 CFR subpart 1609.70 are not met. Such action carries with it the right to a hearing as provided in paragraph (a)(2) of this section.

(1) Before withdrawing approval, the Director or his or her representative shall notify the carrier of the plan, by certified mail, that OPM intends to withdraw approval of the health benefits plan and/or carrier. The notice shall set forth the reasons why approval is to be withdrawn. The carrier is entitled to reply in writing within 15 calendar days after its receipt of the notice, stating the reasons why approval should not be withdrawn.

(2) On receipt of the reply, or in the absence of a timely reply, the Director or representative shall set a date, time, and place for a hearing. The carrier shall be notified by certified mail at least 15 calendar days in advance of the hearing. The hearing officer shall be the Director, or a representative designated by the Director, who shall not otherwise have been a party to the initial administrative decision to issue a letter of intent to withdraw the plan's or carrier's approval. The hearing officer shall conduct the hearing unless it is waived in writing by the carrier. The carrier is entitled to appear by representative and present oral or documentary evidence, including rebuttal evidence, in opposition to the proposed action.

(i) A transcribed record shall be kept of the hearing and shall be the exclusive record of the proceeding.

(ii) After the hearing is held, or after OPM's receipt of the carrier's written waiver of the hearing, the Director shall make a decision on the record, taking into consideration any recommendation submitted by the hearing officer, and send it to the carrier by certified mail. A decision of the Director shall be considered a final decision for the purposes of this section. The Director, or his or her representative, may set a future effective date for withdrawal of approval.

(3) The Director, or his or her representative, may give written notice of non-renewal of the contract of a carrier whose plan does not meet the minimum enrollee requirement in § 890.201(a)(11). However, the Director may defer withdrawing approval of a plan not meeting the requirement in § 890.201(a)(11) of this part when, in the judgment of OPM, the carrier shows good cause. The Director or representa-

tive may authorize a plan with fewer than 300 employees or annuitants to remain in the FEHB Program when he or she determines, in his or her discretion, that it is in the best interest of the Program (e.g., when the plan is the only plan available to enrollees in a rural area).

(b) During a current contract term, the Director, in his or her discretion, may reinstate approval of a plan or carrier under this section on a finding that the reasons for withdrawing approval no longer exist.

[55 FR 9109, Mar. 12, 1990, as amended at 57 FR 14324, Apr. 20, 1992]

§ 890.205 Nonrenewal of contracts of health benefits plans.

(a) Either OPM or the carrier may terminate a contract by giving a written notice of nonrenewal which includes an indication of the reason for the intended action.

(b) Where termination by notice of intent not to renew is made by OPM, the carrier contesting that notice may request that OPM review the proposed decision. Such review shall be conducted by the Director or a representative designated by the Director, who shall not otherwise have been a party to the initial decision to issue a notice of intent not to renew. A request for such review, which may include a request that a representative of the carrier appear personally before OPM, shall be in writing. That request must be received within 10 calendar days of the carrier's receipt of the notice of intent not to renew. Such request shall include a detailed statement as to why the carrier disagrees with OPM's notice of nonrenewal and shall be accompanied by appropriate supporting documentation. Where a carrier has requested review under this section, the final decision by OPM not to renew a health benefits contract shall be communicated to the carrier in writing not more than 30 days after OPM's receipt of the carrier's request for review, unless a later date is mutually agreed upon.

(c) In the absence of a timely request for review as set forth in paragraph (b) of this section, OPM's notice of intent