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Act, Public Law 111–148, as amended by the Health Care and Education Reconciliation Act, Public Law 111–152 (the Affordable Care Act or the Act), by an employee otherwise covered by 5 U.S.C. 8901(1)(B) and (C) from being considered a ''health benefit plan under this chapter'' for purposes of 5 U.S.C. 8905(b) and 5 U.S.C. 8906.

[33 FR 12510, Sept. 4, 1968, as amended at 43 FR 52460, Nov. 13, 1978; 47 FR 14871, Apr. 6, 1982; 49 FR 48905, Dec. 17, 1984; 52 FR 10217, Mar. 31, 1987; 54 FR 52336, Dec. 21, 1989; 55 FR 9108, Mar. 12, 1990; 55 FR 22891, June 5, 1990; 69 FR 31721, June 7, 2004; 75 FR 76616, Dec. 9, 2010; 78 FR 60656, Oct. 2, 2013; 80 FR 55734, Sept. 17, 2015; 83 FR 18401, Apr. 27, 2018]

§ 890.202 Minimum standards for health benefits carriers.

The minimum standards for health benefits carriers for the FEHB Program shall be those contained in 48 CFR subpart 1609.70.

[57 FR 14324, Apr. 20, 1992]

§ 890.203 Application for approval of, and proposal of amendments to, health benefit plans.

(a) *New plan applications.* (1) The Director of OPM shall consider applications to participate in the FEHB Program from comprehensive medical plans (CMP's) at his or her discretion. CMP's are automatically invited to submit applications annually to participate in the FEHB Program unless otherwise notified by OPM. If the Director should determine that it is not beneficial to the enrollees and the Program to consider applications for a specific contract year, OPM will publish a notice with a 60 day comment period in the FEDERAL REGISTER no less than 7 months prior to the date applications would be due for the specific contract year for which applications will not be accepted.

(2) When applications are considered, CMP's should apply for approval by writing to the Office of Personnel Management, Washington, DC 20415. Application letters must be accompanied by any descriptive material, financial data, or other documentation required by OPM. Plans must submit the letter and attachments in the OPM-specified format by January 31, or another date specified by OPM, of the year preceding the contract year for which applications are being accepted. Plans must submit evidence demonstrating they meet all requirements for approval by March 31 of the year preceding the contract year for which applications are being accepted. Plans that miss either deadline cannot be considered for participation in the next contract year. All newly approved plans must submit benefit and rate proposals to OPM by May 31 of the year preceding the contract year for which applications are being accepted in order to be considered for participation in that contract year. OPM may make counter-proposals at any time.

(3) OPM may approve such comprehensive medical plans as, in the judgment of OPM, may be in the best interest of enrollees in the Program. In addition to specific requirements set forth in 5 U.S.C. chapter 89, in chapter 1 and other relevant portions of title 48 of the Code of Federal Regulations, and in other sections of this part, to be approved, an applicant plan must actually be delivering medical care at the time of application; must be in compliance with applicable State licensing and operating requirements; must not be a Federal, State, local, or territorial governmental entity; and must not be debarred, suspended, or ineligible to participate in Government contracting or subcontracting for any reason, including fraudulent health care practices in other Federal health care programs.

(4) Applications must identify those individuals who have the legal authority and responsibility to enter into and guarantee contracts. The applications will be reviewed for evidence of substantial compliance with the following standards:

(i) *Health plan management:* Stable management with experience pertinent to the prepaid health care provider industry; sufficient operating experience to enable OPM to realistically evaluate the plan's past and expected future performance;

(ii) *Marketing:* A rate of enrollment that ensures equalization of income and expenses within projected timeframes and sufficient subscriber income to operate within budget thereafter; enrollment dispersed among

groups such that there is not a concentration of enrollment with one or a few groups so that the loss of one or more contracts by the carrier would not jeopardize its financial viability; 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 specialty 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]