OPM means the United States Office of Personnel Management.

Percentage of total allowed cost of benefits has the meaning given that term in 45 CFR 156.20.

Plan year means a consecutive 12-month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise.

Prompt payment means a requirement imposed on a health insurance issuer to pay a provider or enrollee for a claimed benefit or service within a defined time period, including the penalty or consequence imposed on the issuer for failure to meet the requirement.

Qualified Health Plan or *QHP* means a health plan that has in effect a certification that it meets the standards described in subpart C of 45 CFR part 156 issued or recognized by each Exchange through which such plan is offered pursuant to the process described in subpart K of 45 CFR part 155.

Rating means the process, including rating factors, numbers, formulas, methodologies, and actuarial assumptions, used to set premiums for a health plan.

Secretary means the Secretary of the Department of Health and Human Services.

SHOP means a Small Business Health Options Program operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more qualified health plans (QHPs).

Silver plan variation has the meaning given that term in 45 CFR 156.400.

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define *small employer* by substituting ''50 employees'' for ''100 employees.''

Standard plan has the meaning given that term in 45 CFR 156.400.

State means each of the 50 States or the District of Columbia.

State Insurance Commissioner means the commissioner or other chief insurance regulatory official of a State.

[78 FR 15587, Mar. 11, 2013, 78 FR 18246, Mar. 26, 2013]

Subpart B—Multi-State Plan Program Issuer Requirements

§ 800.101 General requirements.

An MSPP issuer must:

(a) *Licensed*. Be licensed as a health insurance issuer in each State where it offers health insurance coverage;

(b) *Contract with OPM*. Have a contract with OPM pursuant to this part;

(c) *Required levels of coverage*. Offer levels of coverage as required by § 800.107;

(d) *Eligibility and enrollment*. MSPs and MSPP issuers must meet the same requirements for eligibility, enrollment, and termination of coverage as those that apply to QHPs and QHP issuers pursuant to 45 CFR part 155, subparts D, E, and H, and 45 CFR 156.250, 156.260, 156.265, 156.270, and 156.285;

(e) *Applicable to each MSP*. Ensure that each of its MSPs meets the requirements of this part;

(f) *Compliance*. Comply with all standards set forth in this part;

(g) *OPM direction and other legal requirements*. Timely comply with OPM instructions and directions and with other applicable law; and

(h) *Other requirements*. Meet such other requirements as determined appropriate by OPM, in consultation with HHS, pursuant to section 1334(b)(4) of the Affordable Care Act.

(i) *Non-discrimination*. MSPs and MSPP issuers must comply with applicable Federal and State non-discrimination laws, including the standards set forth in 45 CFR 156.125 and 156.200(e).

§ 800.102 Compliance with Federal law.

(a) *Public Health Service Act*. As a condition of participation in the MSPP, an MSPP issuer must comply with applicable provisions of part A of title XXVII of the PHS Act. Compliance shall be determined by the Director.

(b) *Affordable Care Act*. As a condition of participation in the MSPP, an MSPP

issuer must comply with applicable provisions of title I of the Affordable Care Act. Compliance shall be determined by the Director.

§ 800.103 Authority to contract with issuers.

(a) *General.* OPM may enter into contracts with health insurance issuers to offer at least two MSPs on Exchanges and SHOPs in each State, without regard to any statutes that would otherwise require competitive bidding.

(b) *Non-profit entity.* In entering into contracts with health insurance issuers to offer MSPs, OPM will enter into a contract with at least one non-profit entity as defined in § 800.20 of this part.

(c) *Group of issuers.* Any contract to offer an MSP may be with a group of issuers as defined in § 800.20.

(d) *Individual and group coverage.* The contracts will provide for individual health insurance coverage and for group health insurance coverage for small employers.

§ 800.104 Phased expansion.

(a) *Phase-in.* OPM may enter into a contract with a health insurance issuer to offer an MSP if the health insurance issuer agrees that:

(1) With respect to the first year for which the health insurance issuer offers an MSP, the health insurance issuer will offer the MSP in at least 60 percent of the States;

(2) With respect to the second such year, the health insurance issuer will offer the MSP in at least 70 percent of the States;

(3) With respect to the third such year, the health insurance issuer will offer the MSP in at least 85 percent of the States; and

(4) With respect to each subsequent year, the health insurance issuer will offer the MSP in all States.

(b) *Partial coverage within a State.* OPM may enter into a contract with an MSPP issuer even if the MSPP issuer's MSPs for a State cover fewer than all the service areas specified for that State pursuant to § 800.110. For each State in which the MSPP issuer offers partial coverage, the MSPP issuer must submit a plan for offering coverage throughout the State. OPM will monitor the MSPP issuer's progress in implementing the plan as part of its contract compliance activities under subpart E of this part.

(c) *Participation in SHOPs.* (1) An MSPP issuer's participation in the Federally-facilitated SHOP must be consistent with the requirements for QHP issuers specified in 45 CFR 156.200(g).

(2) An MSPP issuer must comply with State standards governing participation in State-based SHOPs, consistent with § 800.114. For these State-based SHOP standards, OPM retains discretion to allow an MSPP issuer to phase-in SHOP participation in States pursuant to section 1334(e) of the Affordable Care Act.

(d) *Licensed where offered.* OPM may enter into a contract with an MSPP issuer who is not licensed in every State, provided that the issuer is licensed in every State where it offers MSP coverage through any Exchanges in that State and demonstrates to OPM that it is making a good faith effort to become licensed in every State consistent with the timeframe in paragraph (a) of this section.

§ 800.105 Benefits.

(a) *Benefits package.* (1) An MSPP issuer must offer a uniform benefits package, including the essential health benefits (EHB) described in section 1302 of the Affordable Care Act, for each MSP within a State.

(2) The benefits package referred to in paragraph (a)(1) of this section must comply with section 1302 of the Affordable Care Act, as well as any applicable standards set by OPM or HHS.

(b) *Benefits package options.* (1) An MSPP issuer must offer a benefits package, in all States, that is substantially equal to:

(i) The EHB-benchmark plan in each State in which it operates; or

(ii) Any EHB-benchmark plan selected by OPM under paragraph (c) of this section.

(2) An issuer applying to participate in the MSPP must select one of the two benefits package options described in paragraph (b)(1) of this section in its application.