

OFFICE OF PERSONNEL MANAGEMENT

45 CFR Part 800

RIN: 3206-AM47

Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges

AGENCY: U.S. Office of Personnel Management.

ACTION: Proposed rule.

SUMMARY: The U.S. Office of Personnel Management (OPM) is issuing a proposed rule to implement the Multi-State Plan Program (MSPP). OPM is establishing the MSPP pursuant to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. Through contracts with OPM, health insurance issuers will offer at least two multi-State plans (MSPs) on each of the Affordable Insurance Exchanges (Exchanges). Under the law, an MSPP issuer may phase in the States in which it offers coverage over four years, but it must offer MSPs on Exchanges in all States and the District of Columbia by the fourth year in which the MSPP issuer participates in the MSPP. OPM aims to administer the MSPP in a manner that is consistent with State insurance laws and that is informed by input from a broad array of stakeholders.

DATES: Comments are due on or before [INSERT DATE 30 DAYS AFTER PUBLICATION.]

ADDRESSES: You may submit comments, identified by Regulation Identifier Number (RIN) 3206-AM47 using any of the following methods:

Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

Mail, Hand Delivery or Courier: National Healthcare Operations, Healthcare and Insurance, U.S. Office of Personnel Management, 1900 E Street, NW, Room 2347, Washington, DC 20415.

FOR FURTHER INFORMATION CONTACT: Julia Elam by telephone at (202) 606-2128, by FAX at (202) 606-4430, or by email at mspp@opm.gov.

SUPPLEMENTARY INFORMATION: The U.S. Office of Personnel Management (OPM) is proposing this regulation to outline the Multi-State Plan Program (MSPP), a new program created pursuant to section 1334 of the Affordable Care Act to offer high-quality health insurance products on the Exchanges.

Abbreviations:

FEHBA Federal Employees Health Benefits Act (5 U.S.C 8901 et seq.)

FEHBP Federal Employees Health Benefits Program

HHS U.S. Department of Health and Human Services

HMO Health Maintenance Organization

MSP Multi-State Plan

MSPP	Multi-State Plan Program
NAIC	National Association of Insurance Commissioners
OPM	U.S. Office of Personnel Management
PHS Act	Public Health Service Act
QHP	Qualified Health Plan
SHOP	Small Business Health Options Program

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I. Background

Section 1334 of the Affordable Care Act creates the Multi-State Plan Program (MSPP) to foster competition among plans competing in the individual and small group health insurance markets

on the Affordable Insurance Exchanges (Exchanges) on the basis of price, quality, and benefit delivery. The Affordable Care Act directs the U.S. Office of Personnel Management (OPM) to contract with private health insurance issuers to offer at least two multi-State plans (MSPs) on each of the Exchanges in the 50 States and the District of Columbia. The law allows MSPP issuers to phase in coverage, but coverage must be offered on Exchanges in all States and the District of Columbia by the fourth year in which the MSPP issuer participates in the MSPP. The first open enrollment period for plans offered through Exchanges will begin on October 1, 2013, for coverage starting in January 2014.

A. Affordable Insurance Exchanges

The Affordable Care Act authorizes the establishment of Exchanges where individuals and small businesses with up to 100 employees can purchase qualified coverage. States have the option of defining a small group as one with up to 50 employees through 2016.¹ Beginning January 1, 2014, the Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges will enhance competition in the health insurance market, improve choice of affordable health insurance, and give individuals and small businesses purchasing power comparable to that of large businesses.

The U.S. Department of Health and Human Services (HHS) has issued a final regulation outlining standards to certify Exchanges and qualified health plans (QHPs) that will be offered on Exchanges.² If a State does not elect to operate an Exchange or is not certified (or

¹ For purposes of this regulation, OPM refers to Affordable Insurance Exchanges and SHOPs as “Exchanges” collectively.

² 45 CFR Parts 155 and 156.

conditionally approved) to operate one by January 1, 2013, HHS will operate the Exchange in that State.

The purpose of this proposed regulation is to outline the process by which OPM will establish the MSPP, pursuant to section 1334 of the Affordable Care Act, to offer high-quality, private health insurance products on the Exchanges, as well as to establish standards and requirements for MSPs and MSPP issuers. This proposed regulation recognizes that the MSPP is an important tool for implementing the Affordable Care Act by fostering competition in Exchanges on the basis of price, quality, and benefit delivery, while ensuring that MSPs operate on a level playing field with other issuers operating in the Exchanges.

B. Objectives of the Multi-State Plan Program (MSPP)

The MSP is a new product and will be one of several private health insurance options offered on the Exchanges beginning in 2014. In administering the MSPP, OPM is advancing several important objectives:

- To ensure a choice of at least two high-quality products to consumers participating on each Exchange;
- To promote competition in the health insurance marketplace to the benefit of all consumers;
- To offer plans from the same issuer to families or small businesses that may reside or operate in more than one State;

- To provide strong, effective contractual oversight of the issuers that choose to offer MSPs; and
- To work cooperatively with States and HHS to ensure a level playing field between QHPs and MSPs.

Across the country, consumers shopping for insurance in the individual and small group market often have limited options. In some States, the market is extremely concentrated. The MSPP will provide consumers in every Exchange with the additional choice of two high-quality health insurance plans thereby further promoting competition on the Exchanges. Moreover, like the health plans offered in the Federal Employees Health Benefits Program (FEHBP), consumers will benefit from OPM oversight and contract negotiation experience to ensure consumers get the greatest value for their premium dollars. Section 1334 of the Affordable Care Act directs OPM to enter into contracts with participating issuers, including negotiating premiums and benefits, as is done in the FEHBP. In addition, OPM will monitor MSP performance in the market, and oversee plan compliance with legal requirements and contractual terms.

Issuers participating in the MSPP will benefit from market efficiencies because they will contract with a single agency – OPM – which will enable them to participate in all Exchanges.

Specifically, section 1334(d) of the Affordable Care Act provides that health plans that meet OPM's requirements for MSPs are deemed certified to be offered on all Exchanges. In return for these administrative efficiencies, MSPP issuers will offer at least two plans (one at the silver level of coverage and one at the gold level of coverage) in each Exchange. The statute allows MSPP issuers to phase in their coverage in all States and the District of Columbia over four

years, though MSPP issuers must offer coverage in at least 31 States in the first year of their participation.

Pursuant to section 1334 of the Affordable Care Act, the Director of OPM will set the standards for the MSPP. OPM expects that these standards will be consistent with the standards set for QHPs and QHP issuers by HHS and the Exchanges, although in some unique and specific circumstances, as addressed in this proposed rule, the MSP standards may differ from QHP requirements. In implementing the MSPP, OPM will promote a level playing field on each Exchange, meaning that, to the extent any of the rules governing MSPs and MSPP issuers differ from those governing QHPs, they will be designed to afford the MSPs and MSPP issuers neither a competitive advantage nor a disadvantage with respect to other plans offered on the Exchange. OPM will administer the MSPP in a manner that is sensitive to the significant State and Federal interests affected by the MSPP and that is informed by input from a broad array of stakeholders. Accordingly, OPM appreciates the coordination and cooperation with the States and HHS in administration of the MSPP.

C. Review of OPM's Role in Contracting under the Federal Employees Health Benefits Program (FEHBP)

Section 1334(a)(4) directs OPM to implement the MSPP “in a manner similar to the manner in which the Director implements the contracting provisions with respect to carriers” under the FEHBP. OPM therefore intends to draw on its significant experience in contracting with and overseeing private issuers in administering FEHBP to develop and manage the MSPP.

The Federal Employees Health Benefits Act (FEHBA) was enacted in 1959 to provide health benefits to Federal employees, annuitants, and their dependents. OPM has more than 50 years of

experience working with private issuers in the large group market. Approximately eight million employees, annuitants, and their family members are currently covered under the FEHBP.

Enrollees can choose from among fee-for-service plans with preferred providers, local HMOs, consumer-driven health plans, or high-deductible health plan options. Among these options are six nationwide plans, each of which offers coverage in all 50 States and the District of Columbia. In 2011, 78.9 percent of Federal employees and annuitants chose to participate in the FEHBP nationwide plans, which offer portable coverage that continues when the enrollee or a covered family member moves to another State.³ OPM has been able to administer this robust health insurance program efficiently, keeping administrative costs low.

In managing contracts with carriers in FEHBP, OPM negotiates rates and benefits annually, oversees contract compliance, reviews plan brochures, handles enrollees' complaints, contracts with an external entity for recommendations during OPM's review of disputed claims, and monitors the financial stability of all participating carriers, including the maintenance of adequate reserves in a dedicated fund. Through this process, OPM has developed relationships with health insurance issuers and plans around the country, including local, community-based plans. In the FEHBP, OPM acts on behalf of employees and annuitants of the Federal government. OPM has significant responsibility to ensure that FEHBP health plans provide the best possible coverage at the lowest cost.⁴

³ U.S. Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations (March 2011). This percentage includes participation in the following nationwide plans: Blue Cross Blue Shield (BCBS), Government Employees Health Association, Inc. (GEHA), Mail Handlers, American Postal Workers Union (APWU), National Association of Letter Carriers (NALC), and Special Agents Mutual Benefit Association (SAMBA).

⁴ It should be noted that § 1334(g)(2) directs OPM to treat MSPs as a separate risk pool from the FEHBP, and the MSPP will not affect FEHBP costs.

OPM currently only negotiates contracts with carriers in the large group market. While OPM intends to create a process for negotiating with issuers participating in the MSPP that is guided by its experience in the FEHBP, this process will necessarily differ in certain respects from the FEHBP process to account for the differences between the large group market, where OPM currently operates, and the individual and small group markets, which will be served by the Exchanges.

D. Overview of the MSPP's Statutory Requirements

Section 1334 of the Affordable Care Act directs OPM to administer the MSPP. Specifically, section 1334(a)(1) of the Affordable Care Act requires OPM to “enter into contracts with health insurance issuers, (which may include a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark)...to offer at least 2 multi-State qualified health plans through each Exchange in each State.”⁵ OPM interprets section 1334(a)(1) as requiring OPM to contract with at least two issuers, which may be “groups of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark.”⁶

The Director is authorized to implement and administer the MSPP “in a manner similar to the manner in which the Director implements the contracting provisions with respect to carriers under the Federal Employees Health Benefit Program.”⁷ Further, OPM may enter into these contracts without regard to competitive bidding laws.⁸ Each MSPP contract must be for a term of

⁵ Affordable Care Act § 1334(a)(1).

⁶ Affordable Care Act § 1334(a)(1).

⁷ Affordable Care Act § 1334(a)(4).

⁸ Affordable Care Act § 1334(a)(1).

at least one year, but can be automatically renewable in the absence of a notice of termination from either the MSPP issuer or OPM.⁹

The statute grants to OPM the authority to certify MSPs.¹⁰ Any MSPs offered under a contract negotiated with OPM are then “deemed to be certified by an Exchange for purposes of section 1311(d)(4)(A)” of the Affordable Care Act and would not need to apply separately for certification on each individual Exchange,¹¹ as recognized in current regulations at 45 CFR 155.1010(b)(1). The Director is authorized to withdraw approval of an MSPP contract after notice and opportunity for a hearing.¹² The Director is also given the explicit statutory authority to negotiate with each MSP “(A) a medical loss ratio; (B) a profit margin; (C) the premiums to be charged; and (D) such other terms and conditions of coverage as are in the interests of enrollees in such plans.”¹³

The Affordable Care Act directs that an MSPP issuer be licensed in each State where it offers an MSP¹⁴ and be “subject to all requirements of State law not inconsistent with this section [1334], including the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act (PHS Act) or a requirement of this title [I of the Affordable Care Act].”¹⁵ The Affordable Care Act directs that issuers must comply with the minimum standards for carriers under section 8902(e) of title 5 of the United States Code to the extent that the standards do not conflict with provisions of title I of

⁹ Affordable Care Act § 1334(a)(2).

¹⁰ Affordable Care Act § 1334(d).

¹¹ Affordable Care Act § 1334(d).

¹² Affordable Care Act § 1334(a)(7).

¹³ Affordable Care Act § 1334(a)(4).

¹⁴ Affordable Care Act § 1334(b)(2).

¹⁵ Affordable Care Act § 1334(b)(2).

the Affordable Care Act.¹⁶ Congress also authorized OPM to establish additional standards for MSPs that OPM, in consultation with HHS, deems “appropriate.”¹⁷

The Affordable Care Act authorizes an MSPP issuer to phase-in the States in which the MSP is offered.¹⁸ In the first year the MSP is offered, it must be offered in at least 60 percent of the States (31 States).¹⁹ In the second year, it must be offered in at least 70 percent of the States (36 States).²⁰ In the third year, it must be offered in at least 85 percent of the States (44 States).²¹ In all subsequent years, the MSPP issuer must offer the MSP in all States and District of Columbia.²²

The statute gave the Director the authority to determine if the plan meets essential health benefits package requirements, meets qualified health plan requirements of title I of the Affordable Care Act, meets premiums rating requirements under part A of title XXVII of the PHS Act, and offers the plan in all geographic locations prescribed by the statute.²³ The statute specifies that an MSP must offer a uniform benefits package in each State that includes essential health benefits pursuant to section 1302 of the Affordable Care Act.²⁴ Under the statute, this does not prevent a State from requiring additional benefits²⁵ so long as it defrays the costs.²⁶ The MSPP issuer must offer the plan in all States after a phase-in, including those with adjusted community rating at the time of enactment of the Affordable Care Act.²⁷ At least one MSP must not provide coverage of

¹⁶ Affordable Care Act § 1334(b)(3).

¹⁷ Affordable Care Act § 1334(b)(4).

¹⁸ Affordable Care Act § 1334(e).

¹⁹ Affordable Care Act § 1334(e)(1).

²⁰ Affordable Care Act § 1334(e)(2).

²¹ Affordable Care Act § 1334(e)(3).

²² Affordable Care Act § 1334(e)(4).

²³ Affordable Care Act § 1334(c)(1).

²⁴ Affordable Care Act § 1334(c)(1)(A).

²⁵ Affordable Care Act § 1334(c)(2).

²⁶ Affordable Care Act § 1334(c)(4).

²⁷ Affordable Care Act § 1334(c)(1)(D).

services described in section 1303(b)(1)(B)(i) of the Affordable Care Act as applicable.²⁸ Finally, to the extent that they do not conflict with provisions in title I of the Affordable Care Act, requirements under chapter 89 of title 5 of the United States Code (the FEHBA) will apply to MSPs.

Though our experience with the FEHBP guides us in crafting the MSPP, the statute distinguishes the MSPP from FEHBP in important respects. Thus, the Affordable Care Act prohibits the Director from allocating fewer resources to administering the FEHBP in order to administer the MSPP and requires the Director to ensure that the two programs are kept separate.²⁹ Any premiums paid for coverage under the MSPP are not to be considered Federal funds.³⁰ Enrollees of each program must be treated as separate risk pools³¹ and FEHBP carriers are not required to participate in the MSPP.³²

We are also guided by the level playing field provision of the Affordable Care Act. Section 1324 of the Act specifies that if an MSP or Consumer Operated and Oriented Plan (CO-OP)³³ is not subject to any Federal or State law related to one of the 13 categories listed in section 1324(b), then neither shall any health insurance coverage offered by a private health insurance issuer be subject to such law.³⁴ The categories listed in section 1324(b) are: guaranteed renewal, rating, preexisting conditions, non-discrimination, quality improvement and reporting, fraud and abuse, solvency and financial requirements, market conduct, prompt payment, appeals and grievances, privacy and confidentiality, licensure, and benefit plan material or information. Beginning in

²⁸ See also Affordable Care Act § 1334(a)(6).

²⁹ Affordable Care Act § 1334(g)(5).

³⁰ Affordable Care Act § 1334(g)(5).

³¹ Affordable Care Act § 1334(g)(2).

³² Affordable Care Act § 1334(g)(6).

³³ Affordable Care Act § 1322.

³⁴ Affordable Care Act § 1324.

2014, the Affordable Care Act sets Federal standards for categories such as guaranteed renewal, preexisting conditions, and non-discrimination that will apply in all States.

E. Stakeholder Interaction

In order to assess the level of interest in participating in the MSPP, and to obtain feedback from stakeholders about the program, OPM issued a Request for Information (RFI) on June 16, 2011.³⁵ OPM received 19 responses representing the views of 39 groups and organizations. Responses came from health insurance issuers (including dental and vision insurance vendors), employer organizations, labor organizations, consumer groups, patient organizations, and provider associations. This proposed rule does not directly respond to each of the responses from the RFI. However, these responses informed the drafting of this proposed rule.

In addition to the RFI, OPM has held meetings and phone calls with numerous stakeholders to seek input and guidance before engaging in proposed rulemaking, including from the National Association of Insurance Commissioners (NAIC), States, tribal representatives through the tribal consultation process, consumer advocates, health insurance issuers, labor organizations, provider associations, and trade groups. OPM values the participation of a broad array of diverse stakeholders, and OPM encourages them to submit comments on this proposed rule.

II. Proposed Regulatory Approach

A. Overview of Regulatory Approach

OPM's approach to the development of this proposed regulation seeks to:

³⁵ The RFI is available at https://www.fbo.gov/index?s=opportunity&mode=form&id=677e422dd3f2bc983cb985eb73995b63&tab=core&_cvIEW=1.

- Create a program that will attract issuers to apply to offer a new product in each Exchange in 50 States and the District of Columbia.
- Balance State and Federal regulatory interests in a manner that will enable MSPP issuers to offer viable plans on Exchanges while maintaining a level playing field between issuers.

Ensure a level playing field such that neither MSPs nor plans offered by non-MSPP issuers are advantaged or disadvantaged on Exchange marketplaces.

OPM seeks comment on whether these proposed regulations satisfy these goals.

B. Governing Law

The Affordable Care Act generally requires that the MSPP be governed by all State and Federal laws that apply to QHPs. The Act, however, grants discretion to the Director to administer the MSPP in a manner that fulfills OPM's statutory responsibility to ensure that there are at least two issuers offering MSPs on each Exchange in every State and the District of Columbia. OPM recognizes that potential MSPP issuers seek administrative simplicity and some uniformity of standards in the MSPP. Accordingly, in unusual circumstances, it may be necessary for the Director to adopt standards or requirements for the MSPP that differ from standards and requirements applicable to QHPs under either State or Federal law. This proposed regulation, however, reflects the Director's intention for the MSPs and MSPP issuers to adhere to all State and Federal laws applicable to QHPs and QHP issuers, except to the extent any such laws are inconsistent with these regulations, OPM guidance, or OPM's contracts with MSPP issuers.

It is not possible at this time, however, to identify with specificity the laws that OPM deems to be inconsistent with these regulations, OPM guidance, or OPM's contracts with MSPP issuers. OPM will monitor future developments around the State specific requirements that will be in place in 2014 and beyond and identify inconsistencies as they arise.

OPM has addressed the evolving nature of the law and OPM's interest in providing meaningful guidance to the public regarding the standards and requirements that apply to the MSPP in four primary ways. First, OPM has identified the currently existing provisions of Federal law that govern QHPs and, thus, the MSPP. Second, OPM has asserted its intention to require MSPs and MSPP issuers to follow all State law requirements with respect to the 13 categories of laws set forth in section 1324(b) of the Affordable Care Act, the level playing field provision. Third, OPM has set forth the standards and requirements that will govern the MSPP, which it has established based on its research into currently existing State and Federal requirements. OPM believes that these standards and requirements are consistent with State legal requirements. Fourth, OPM has proposed establishing a dispute resolution process to be used after these regulations are published in final form to resolve future disputes about the applicability of State law requirements to the MSPP. OPM believes this approach affords it sufficient flexibility to administer the MSPP in 50 States and the District of Columbia without disrupting State markets. OPM requests public comment on whether these proposed standards and requirements will ensure a level playing field between MSPP issuers and QHP issuers, whether the standards and requirements OPM is proposing for the MSPP are consistent with applicable State and Federal requirements for QHPs, and whether the MSPs or MSPP issuers will be at a competitive advantage or disadvantage under this approach with respect to the QHPs offered on the Exchanges.

Level Playing Field

As discussed above, OPM is proposing to require compliance with State and Federal laws related to the 13 categories listed in section 1324(b) of the Affordable Care Act. There are, however, three categories of law among the 13 listed in section 1324(b) of the Affordable Care Act for which OPM would like specifically to solicit public comment: appeals, rating, and benefit plan material or information.

Appeals

OPM proposes to resolve external appeals pursuant to its own process, which will be similar to the disputed claims process used in the FEHBP. OPM interprets section 1334(a)(4) of the Affordable Care Act to require OPM to maintain authority over external review because Congress directed that OPM implement the MSPP in a manner similar to the manner in which it implements the contracting provisions of the FEHBP. In the FEHBP, OPM resolves all external appeals as a part of its contract administration responsibilities. OPM similarly believes that it is necessary to decide these appeals in the MSPP in order to ensure that the MSPP contract is administered equitably throughout all 51 jurisdictions and to provide enrollees an avenue of redress for all denied claims. This proposed approach would not trigger the level playing field provisions of section 1324 because MSPP issuers will still be subject to the same law as other issuers. The law governing external appeals for all issuers is found in section 2719 of the PHS Act and its implementing regulations at 45 CFR 147.136. The Departments of Health and Human Services, Labor, and the Treasury intend to propose amendments to those regulations to apply to the MSPP process the same standards that apply to State external review processes.

Rating

For purposes of compliance with section 1324(b)(2) of the Affordable Care Act, OPM has defined “rating” to require compliance with the rating factors permitted by section 2701 of the PHS Act. Thus, the proposed rule would require MSPP issuers, in proposing premiums for OPM approval, to use only the rating factors permitted by section 2701 of the PHS Act. It would also require MSPP issuers to comply with State laws relating to rating factors.

With regard to the MSPP, OPM does not consider “rating” to be the same as “rate review.” As directed by section 1334(a)(4) of the Affordable Care Act, the Director negotiates premiums, a medical loss ratio, a profit margin, and such other terms and conditions as are in the best interest of enrollees. With respect to rate review, OPM intends to conduct its own rate review process, and provide its rate review analysis to each State in which the MSP is operating. Each State also would have the opportunity to review the MSP rates under its own procedures. If a State disagrees with OPM’s determination to approve the MSP rates, OPM would work with the State to attempt to resolve the differences. We expect that few such disagreements will arise and, if they do, that we will be successful in resolving them in a manner that is acceptable both to OPM and the State. In the event that a State withholds approval of an MSP rate for reasons that OPM determines, in its discretion, to be arbitrary, capricious, or an abuse of discretion, the Act authorizes the Director to make the final decision to approve rates for participation in the MSPP notwithstanding the absence of State approval. We expect that the Director will rarely, if ever, have to exercise this authority to approve MSP rates over the objection of a State. . OPM welcomes comments on whether this is an appropriate approach and on the impact of this approach.

Benefit Plan Material or Information

MSPs will be subject to Federal and State laws with respect to benefit plan material or information, including requirements proposed in § 800.113. OPM has defined the term “benefit plan material or information” to include explanations or descriptions, whether printed or electronic, that describe a health insurance issuer’s products. The term does not include a policy or contract for health insurance coverage. While OPM intends to review and approve policy forms for health insurance coverage, OPM expects MSPP issuers to comply with related state law requirements for policy form review. OPM expects that that few disagreements will arise between OPM and a state regarding policy form review and, if they do, that we will be successful in resolving them in a manner that is acceptable both to OPM and the State at issue. As it does in the FEHBP, OPM will review and approve the policy or contract for health insurance coverage. In § 800.113, OPM has proposed reserving its authority to request benefit plan material or information (other than the policy document or information) for review by OPM in addition to any State review. In § 800.113, OPM also has proposed to allow an MSPP issuer to state that OPM has certified a plan and will oversee its administration. OPM solicits comments on whether it is appropriate to exclude policies and contracts from the definition of “benefit plan material or information.”

Process for disputes regarding State law

OPM is sensitive to the impact that its decisions with respect to the standards and requirements applicable to the MSPP could potentially have on State insurance markets. For this reason, with respect to the 13 categories listed in section 1324(b) of the Affordable Care Act, as stated above, OPM’s proposal is to require MSPP issuers to comply with all State laws in those categories, as defined in these regulations. There may be other State laws, however, that are not related to the 13 categories listed in section 1324(b) for which compliance would prevent OPM from

administering the MSPP. In those circumstances, the State law requirements may be inconsistent with these regulations, OPM guidance, or OPM's contracts with MSPP issuers. With respect to those non-1324(b) provisions, OPM is proposing a process for States to seek changes to the regulations, OPM guidance, or OPM's contracts with MSPP issuers in order to bring them into compliance with applicable State law.

The proposed process is intended to allow for a targeted analysis of particular State law provisions and its impact on OPM's ability to administer the MSPP. This process is particularly important given that many States are still developing their Exchange standards. OPM invites comments on this process, including its scope, the factors OPM should consider when determining whether State law is applicable or whether the relevant market has been or will be disrupted by the inapplicability of State law and whether the process will be an effective way to resolve any such disputes.

OPM also invites comments on whether it should include in this process States' having concerns about MSPP issuer compliance with State law requirements related to the 13 categories listed in section 1324(b) of the Affordable Care Act. As discussed above, OPM's intention is to ensure that MSPP issuers comply with all State law requirements concerning the 13 categories, and OPM appreciates comments on whether this proposed rule has met this intent. However, OPM recognizes that future issues could arise regarding whether MSPs and MSPP issuers are properly made subject to State and Federal laws related to the section 1324(b) categories. OPM is asking for comment on whether the dispute resolution process should also be available as another avenue for addressing any such concerns.

III. Provisions of the Proposed Regulation

A. General Provisions and Definitions (Subpart A, 800.10 and 800.20)

The purpose of this subpart is to define the basis and scope of part 800. In addition, this subpart sets forth definitions for terms that are used throughout this part.

1. Basis and scope (§ 800.10)

The primary authority for the establishment of the MSPP is section 1334 of the Affordable Care Act. In addition, section 1324 of the Affordable Care Act is the level playing field provision. It addresses MSP compliance with applicable Federal or State law in 13 categories. Other relevant statutory provisions of title I of the Affordable Care Act are enumerated in § 800.102. In addition, MSPP issuers and MSPs must comply with all provisions of part A of title XXVII of the PHS Act enumerated in § 800.102.

Section 800.10 proposes the scope of this proposed regulation, which is to establish standards for the following:

- (1) health insurance issuers wishing to contract with OPM to participate in the MSPP;
- (2) health insurance issuers to appeal a decision by OPM either to non-renew or terminate a health insurance issuer's contract to participate in the MSPP; and
- (3) enrollees in an MSP to appeal denials of payment or services by an MSPP issuer.

2. Definitions (§ 800.20)

Section 800.20 proposes definitions for terms that are used throughout part 800. In general, the definitions contained in § 800.20 come from three sources: title I of the Affordable Care Act and the final Exchange regulation at 45 CFR parts 155, 156, and 157; title XXVII of the PHS Act and the regulations at 45 CFR part 144; and the FEHBA at chapter 89 of title 5, United States Code and the regulations governing the FEHBP at 5 CFR part 890 and 48 CFR 1609.70. Some new definitions were created for the purpose of implementing the MSPP. The application of the terms defined in this section is limited to this proposed rule.

Several defined terms in this section are in common use and are defined as such. These include:

- FEHBP
- HHS
- HHS Secretary (“Secretary”)
- OPM
- OPM Director (“Director”)

Several terms are based on definitions in the Affordable Care Act or regulations issued to implement 45 CFR Parts 155, 156, and 157. These include:

- Cost sharing (defined in 45 CFR 155.20).
- Exchange (defined in 45 CFR 155.20).
- Level of coverage (defined as one of four standardized actuarial values, or AV, of plan coverage specified in section 1302(d)(1) of the Affordable Care Act).

- Plan year (defined in 45 CFR 155.20).
- QHP (defined in 45 CFR 155.20).
- SHOP (defined in 45 CFR 155.20).
- Small employer (defined in 45 CFR 155.20).
- State (defined in 45 CFR 155.20).

OPM proposes definitions for several terms based on three HHS proposed rules. First, HHS published a proposed essential health benefits (EHB) rule in the Federal Register on November 26, 2012 to provide standards related to EHB, actuarial value (AV), and accreditation. Second, HHS published a proposed rule in the Federal Register on November 26, 2012 to provide standards related to fair health insurance premiums, guaranteed availability, guaranteed renewability, risk pools, and rate review (the proposed health insurance market rules). Third, HHS will soon publish a proposed rule in the Federal Register to provide notice of standards relating to benefit and payment parameters for 2014, including standards related to advance payments of the premium tax credit and cost-sharing reductions (the proposed payment rule). OPM expects to follow the definitions promulgated by HHS. The proposed definitions include:

- Actuarial value (AV) (defined in proposed 45 CFR 156.20).
- EHB-benchmark plan (defined in proposed 45 CFR 156.20).
- Indian (defined in proposed 45 CFR 155.300(a)).

- Zero cost sharing plan variation (defined in proposed 45 CFR 156.400).
- Percentage of total allowed cost of benefits (defined in proposed 45 CFR 156.20).
- Plan variation (defined in proposed 45 CFR 156.400).
- Silver plan variation (defined in proposed 45 CFR 156.400).
- Standard plan (defined in proposed 45 CFR 156.400).

Several terms are given the same definition as previously released regulations pertaining to the PHS Act, the Affordable Care Act, and the FEHBA. These include:

- Health insurance coverage (defined in 45 CFR 144.103).
- Health insurance issuer, or issuer, means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act (ERISA)). This term does not include a group health plan as defined in 45 CFR 146.145(a).

Several terms below are given specific definitions for use in this regulation and should only be read to apply to this proposed rule. OPM proposes the following definitions to implement this regulation.

- Applicant means an issuer or group of issuers that submitted an application to OPM to be considered for participation in the MSPP.

- Benefit plan material or information means explanations or descriptions, whether printed or electronic, that describes a health insurance issuer's products. The term does not include a policy or contract for health insurance coverage.
- Group of issuers means (1) a group of health insurance issuers who are either affiliated by common ownership and control or by common use of a nationally licensed service mark, or (2) an affiliation of health insurance issuers and an entity who is not an issuer but who owns a nationally licensed service mark.
- Licensure means the authorization obtained from the appropriate State official or regulatory authority to offer health insurance coverage in the State.
- MSP means a private health plan that is offered under a contract with OPM pursuant to section 1334 of the Affordable Care Act and meets the requirements of this part.
- MSPP means the program administered by OPM pursuant to section 1334 of the Affordable Care Act.
- MSPP issuer means a health insurance issuer or group of issuers, as defined in this proposed rule, that has a contract with OPM to offer health plans pursuant to section 1334 of the Affordable Care Act and meets the requirements of this part.
- Nationally licensed service mark means a word, name, symbol, or device, or any combination thereof, that an issuer or group of issuers uses consistently nationwide to identify itself. Section 1334(a)(1) states that issuers applying for an MSPP contract may include a group of issuers affiliated either by common ownership and control or by the

common use of a nationally licensed service mark. Licensing of service marks can take place by private agreement between two or more issuers.

- Non-profit entity means: (1) an organization that is incorporated under State law as a non-profit entity and licensed under State law as a health insurance issuer, or (2) a group of health insurance issuers licensed under State law a substantial portion of which are incorporated under State law as non-profit entities. Pursuant to section 1334(a)(3), at least one MSPP contract is to be with a non-profit entity. OPM has interpreted this requirement with the goal of attracting a broad pool of potential issuers that will provide high-quality private health insurance coverage to consumers.
- 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.
- Rating means the process, including rating factors, numbers, formulas, methodologies, and actuarial assumptions, used to set premiums for a health plan.
- State insurance commissioner means the commissioner or other chief insurance regulatory official of a State.³⁶

³⁶ This definition is used in many of the models issued by the NAIC. See, for example, NAIC Unfair Trade Practices Model Act § 2.B. and accompanying Drafting Note (July 2008).

B. Multi-State Plan Issuer Requirements (Subpart B, 800.101 through 800.116)

The purpose of this subpart is to set forth standards for MSPP issuers in order to participate in the MSPP pursuant to section 1334(b) of the Affordable Care Act. The following proposed provisions of the regulation implement this statutory provision.

1. General requirements (§ 800.101)

This section proposes standards to implement section 1334(b) of the Affordable Care Act. It also proposes that an MSPP issuer must offer a choice of plans (i.e., at least one of each at the silver level of coverage and gold level of coverage) on the individual Exchange and in the SHOP, if the MSPP issuer chooses to participate in the SHOP. In addition, OPM proposes that the MSPP issuer will, pursuant to its contract with OPM, offer child-only coverage for each level of coverage that it makes available in each Exchange. An MSPP issuer must ensure that all MSPs it offers meet the requirements of this proposed rule.

Regarding eligibility and enrollment, OPM proposes that MSPP issuers meet the same requirements as those that apply to QHP issuers under the Exchange rules in 45 CFR parts 155 and 156. OPM seeks comment on any unique enrollment and eligibility issues that might affect MSPs.

2. Compliance with Federal law (§ 800.102)

The purpose of this section is to specify the laws with which MSPP issuers must comply as a condition of participation in the MSPP. Section 1334(b)(2) of the Affordable Care Act directs an MSPP issuer to be licensed in every State and be “subject to all requirements of State law not inconsistent with this section [1334], including the standards and requirements that a State

imposes that do not prevent the application of a requirement of part A of title XXVII of the PHS Act or a requirement of this title [I of the Affordable Care Act].” Section 1334(b)(3) further directs an MSPP issuer to comply “with the minimum standards prescribed for carriers offering health benefits plans under section 8902(e) of title 5, United States Code, to the extent that such standards do not conflict with a provision of this title [I of the Affordable Care Act].” In addition, section 1334(c)(1)(B) requires an MSP to meet all the requirements of title I of the Affordable Care Act with respect to a QHP, and section 1334(f) states that “the requirements under chapter 89 of title 5, United States Code, applicable to health benefits plans under such chapter shall apply to multi-State qualified health plans provided for under this section [1334] to the extent that such requirements do not conflict with a provision of this title.” OPM has performed a detailed analysis of title I of the Affordable Care Act and part A of title XXVII of the PHS Act. The list contained in the appendices of the proposed rule is intended to clarify for applicants and MSPP issuers the exact provisions of these laws that they must comply with in order to enter into an MSPP contract with OPM and maintain that contract.

This list is focused exclusively on title I of the Affordable Care Act and part A of title XXVII of the PHS Act. It is not intended to specify every legal requirement that applies to MSPP issuers and MSPs. In addition to the statutory provisions that are listed, MSPP issuers must comply with any applicable regulations implementing those provisions. For example, MSPP issuers must ensure guaranteed availability of coverage, and MSPP issuers offering MSPs in a State must accept every individual and employer in the State that applies for coverage, subject to certain exceptions, as outlined in § 147.104 of the HHS proposed health insurance market rules (including any modifications adopted in the final HHS rules). Additionally, MSPP issuers must ensure guaranteed renewability of coverage, and MSPP issuers offering MSPs in a State must

renew coverage at the option of the plan sponsor or individual, with certain exceptions, as outlined in § 147.106 of the HHS proposed health insurance market rules (including any modifications adopted in the final HHS rules). OPM will coordinate its approach with the final HHS health insurance market rules.

OPM notes that the preamble to the regulations implementing 45 CFR parts 155, 156, and 157 leaves to the discretion of each Exchange whether to require a QHP issuer to participate in both the SHOP and the individual market Exchanges.³⁷ Given that MSPP issuers are required to make MSPs available in 31 States in the first year and must build the capacity to be available in all States and the District of Columbia by the fourth year, OPM is proposing to allow MSPP issuers flexibility to phase in coverage to the SHOPS. Accordingly, MSPP issuers may offer coverage in the individual Exchange, and not the SHOP, throughout the duration of the phase-in period. MSPP issuers that initially choose to offer coverage only in the individual Exchange and not the SHOP must provide to OPM their plan to expand coverage to the SHOP in all States. In any event, OPM proposes that by the end of the phase-in period, MSPP issuers are required to offer coverage on the SHOP in addition to the individual Exchange. We solicit comments on this approach to SHOP participation, including on whether participation in SHOP should be required from the outset or, whether we should allow MSPP issuers to provide a plan that requires a period longer than the phase-in period to fully participate in the SHOP.

3. Authority to contract with issuers (§ 800.103)

In this section, OPM specifies that it may enter into an MSPP contract with a group of issuers affiliated either by common ownership and control or by the use of a nationally licensed service

³⁷ 77 Fed. Reg. at 18401 (March 27, 2012).

mark, or an affiliation of health insurance issuers and an entity that is not an issuer but that owns a nationally licensed service mark, as set forth in section 1334(a)(1) of the Affordable Care Act.

4. Phased expansion (§ 800.104)

This section implements provisions of section 1334(e) of the Affordable Care Act. OPM proposes to allow for contracting with an issuer that offers coverage in part of a State, but not necessarily the entire State. OPM proposes that, for each State in which the MSPP issuer offers partial coverage, the issuer's application for participation in the MSPP under § 800.301 and the MSPP issuer's information submitted to support renewal of the contract under § 800.305 must include 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. OPM requests comment on whether an MSPP issuer should be required to offer coverage statewide by the fourth year of participation in the MSPP, when coverage must be offered in each Exchange in 50 States and the District of Columbia. OPM will evaluate MSP issuers to ensure that the locations in which they propose to offer MSP coverage have been established without regard to racial, ethnic, language, health status-related factors listed in section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost, or medically-underserved populations. OPM also proposes to clarify that, during each year of the phase-in period, an issuer need only be licensed in the States where it is offering coverage during that year, and not in all States.

5. Benefits (§ 800.105)

The RFI did not ask specific questions about the health benefit packages that would be offered by MSPs.³⁸ However, some respondents mentioned benefits package design in addressing questions about the level of interest in the MSPP, enrollment and marketing, and operations. Some respondents preferred a uniform benefits package for MSPs. For instance, one respondent stated that consumers would benefit from having an MSP structured as a national plan offering uniform benefits across all States. Other respondents raised the concern that a uniform package would be inconsistent with or inadequate in comparison to State benefit mandates. Another respondent stated that if OPM requires MSPP issuers to provide benefits that are not required for QHP issuers, MSPs may attract higher risk individuals, making the MSP less competitive on an Exchange.

Section 1334(c)(1)(A) of the Affordable Care Act directs that an MSP offer a benefits package that is uniform in each State and consists of the essential health benefits described in section 1302 of the Affordable Care Act. OPM proposes to implement this provision through proposed § 800.105. OPM has developed its proposed benefits policy in coordination with HHS, which has already promulgated the EHB proposed rule. HHS proposes that EHB would be defined by a benchmark plan selected by each State, or in the absence of a State benchmark designation, a default benchmark. These proposed base-benchmark plans would be supplemented, if necessary, to ensure they meet EHB standards including coverage in each of the 10 coverage categories set forth in the statute.³⁹ HHS also proposed at 45 CFR 156.105 that MSPs must meet benchmark standards set by OPM.

³⁸ Responses to the RFI were due on September 9, 2011 to OPM, which was before HHS published its proposed rule on essential health benefits.

³⁹ The four benchmark plan types for EHB proposed by HHS for 2014 and 2015 are: (1) the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market; (2) any of the largest three State employee health benefit plans by enrollment; (3) any of the largest three national FEHBP plan

In § 800.105(a)(1), OPM proposes that an MSPP issuer must offer a uniform benefits package for each MSP. OPM proposes that the benefits for each MSP must be uniform within a State, but not necessarily uniform among States. In § 800.105(a)(2), OPM proposes that the benefits package noted in § 800.105(a)(1) must comply with section 1302 of the Affordable Care Act as well as any applicable standards set by OPM or HHS in regulations. Together, these two provisions clarify that MSPP issuers must comply with applicable HHS requirements and that OPM may issue additional guidance regarding any issues unique to MSPs.

In § 800.105(b)(1), OPM proposes allowing potential MSPP issuers to offer a benefits package, in all States, that is substantially equal to either (1) each State's EHB-benchmark plan in each State in which it operates; or (2) any EHB-benchmark plan selected by OPM. The second option offers administrative efficiencies for MSPP issuers, who face a number of challenges in being able to offer MSPs in all 50 States and the District of Columbia. We note, however, that issuers could potentially accomplish a similar consistency in their benefits offerings by adhering to State EHB benchmark plans and applying the EHB substitution rules proposed at 45 CFR 156.115. We request comment on these options, including on whether either option would discourage or encourage an issuer's participation in the MSPP and whether or not, given the proposed substitution rules, the allowance of the OPM benchmark option disrupts State level playing fields.

No matter which option an MSPP issuer chooses, it would need to apply that benefits package option uniformly to each of the States in which the MSPP issuer proposes to offer MSPs. That is, except as discussed below with respect to § 800.105(c)(5), our proposed approach does not

options by enrollment; or (4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State. See proposed 45 CFR 156.100.

permit an issuer to use a State benchmark plan in some of the States in which it is operating and an OPM-chosen benchmark plan in others.

In § 800.105(c)(1), OPM proposes selecting, as EHB-benchmark plans, the three largest FEHBP plan options by enrollment that are open to Federal employees, and annuitants, which have been identified by HHS pursuant to section 1302(b) of the Affordable Care Act. On July 3, 2012, HHS identified the largest three FEHBP plan options, as of March 31, 2012, to be the following: Blue Cross Blue Shield (BCBS) Standard Option, BCBS Basic Option, and Government Employees Health Association (GEHA) Standard Option.⁴⁰ An MSPP issuer that selects one of these benchmarks must have a uniform benefits package in all States in which it operates an MSP.

Upon initial comparative research, it appears that the proposed OPM-selected EHB-benchmark plans are largely similar in scope of benefits covered as those benchmark-eligible plans in the small group markets.⁴¹ This research also indicates that the proposed OPM-selected EHB-benchmark plans, like other benchmark-eligible plans, may lack coverage for pediatric oral services, pediatric vision services, and habilitative services and devices. Moreover, the EHB-benchmark may also lack State-required benefits. Accordingly, OPM is proposing standards for supplementing the proposed OPM-selected EHB-benchmark plans in proposed §§ 800.105(c)(2)-(4).

⁴⁰ Centers for Medicare and Medicaid Services, Essential Health Benefits: List of the Largest Three Small Group Products by State, available at <http://cciio.cms.gov/resources/files/largest-smgroup-products-7-2-2012.pdf>.PDF (July 3, 2012).

⁴¹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, ASPE Research Brief, Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans, available at <http://aspe.hhs.gov/health/reports/2011/MarketComparison/rb.pdf> (December 2011).

In § 800.105(c)(2), OPM proposes that any OPM-selected EHB-benchmark plan lacking coverage of pediatric oral services or pediatric vision services must be supplemented by the addition of the entire category of benefits from the largest Federal Employee Dental and Vision Insurance Program (FEDVIP) dental or vision plan option, respectively, pursuant to 45 CFR 156.110(b) and section 1302(b) of the Affordable Care Act. On July 3, 2012, HHS identified the largest FEDVIP dental and vision plan options, as of March 31, 2012, to be, respectively, the following: MetLife Federal Dental Plan High Option and FEP BlueVision High Option.

In § 800.105(c)(4), an MSPP issuer must follow State definitions where the State chooses to specifically define the habilitative services category pursuant to proposed 45 CFR 156.110(f). In the case in which a State chooses not to define this category, OPM proposes that if any OPM-selected EHB-benchmark plan lacks coverage of habilitative services and devices, then OPM may determine what habilitative services and devices are to be included in that EHB-benchmark plan.

In § 800.105(c)(5), OPM proposes that, for at least years 2014 and 2015, OPM's EHB-benchmark plans would also include, for each State, any State-required benefits enacted by December 31, 2011 that are included in a State's EHB-benchmark plan or specific to the market in which the MSP offers coverage. Accordingly, these State-required benefits would be treated as part of the EHB. However, consistent with proposed 45 CFR 155.170, OPM is proposing that State-required benefits enacted after December 31, 2011 would be in addition to the EHB. Under section 1334(c)(4) of the Affordable Care Act, a State must assume the cost of such additional benefits over the EHB by making payments either to the enrollee or on behalf of the enrollee to the MSPP issuer, if applicable. An MSPP issuer must calculate and report the costs of additional State-required benefits pursuant to 45 CFR 155.170.

OPM is proposing that if an MSPP issuer chooses to use an EHB-benchmark plan selected by OPM in all States, the MSPP issuer would need to use a State-selected benchmark only in States that do not allow substitution for services at all within the benchmark benefits. MSPs using an OPM benchmark in States that require all plans to offer the same set of benefits would be different from all of the other plans offered on the market, potentially causing adverse selection. OPM seeks comment on this proposal.

In § 800.105(d), OPM proposes that an MSPP issuer's benefits package, including its prescription drug list, must be submitted to and approved by OPM, which would determine whether a benefits package proposed by a MSPP issuer is substantially equal to an EHB-benchmark plan, in accordance with the guidelines set forth by HHS in the proposed EHB rule. In determining whether an MSPP issuer's benefits package should be approved, OPM proposes to follow the HHS approach set forth at proposed 45 CFR 156.115, 156.120, and 156.125 (subject to any changes adopted in the final HHS rule). Proposed 45 CFR 156.115(b) allows issuers to make benefit substitutions within each EHB category, and directs issuers to submit evidence of actuarial equivalence of substituted benefits to a State. OPM requests comments on whether MSPP issuers should submit evidence of actuarial equivalence of substituted benefits to the OPM in addition to, or in lieu of, their submission to a State.

In reviewing an MSPP issuer's proposed benefit design, OPM plans to review an MSPP issuer's benefits package for discriminatory benefit design pursuant to section 1302(b)(4) of the Affordable Care Act and proposed 45 CFR 156.110(d), 156.110(e), and 156.125. OPM will work closely with States and HHS to identify and investigate any potentially discriminatory benefit design in MSPs.

OPM solicits comments on the provision of pediatric dental services by MSPs in order to meet the requirements of section 1302(b)(1)(J) of the Affordable Care Act. Under one possible approach, an MSP would have to cover pediatric dental services in conjunction with other benefits in its benefits package. OPM solicits comments on how stand-alone dental plans offered on the Exchanges should affect this requirement, if at all. OPM solicits comments on this approach, including their advantages, disadvantages, and whether there is legal justification for each approach, and invites comment on other possible approaches.

OPM anticipates that its policy on EHB benchmark standards for the MSPP will evolve as HHS develops the final EHB rule. OPM solicits comments on the provisions of proposed § 800.105, including provisions relating to the two EHB benchmark options and limited scope dental plans.⁴²

6. Cost-sharing limits, premium tax credits, and cost-sharing reductions (§ 800.106)

In § 800.106(a), OPM proposes that for each MSP it offers, an MSPP issuer must ensure that the cost-sharing provisions of the MSP comply with section 1302(c) of the Affordable Care Act as well as any applicable standards set by OPM or HHS in regulations. This provision clarifies that MSPP issuers must comply with any applicable HHS requirements and that OPM may issue additional guidance regarding issues unique to MSPs. See HHS proposed standards at 45 CFR 156.170. OPM solicits comments on additional standards, if any, that it should adopt to address unique issues faced by MSPs.

⁴² In a pending advanced notice of proposed rulemaking regarding Certain Preventive Services under the Affordable Care Act (77 Fed. Reg. 16,501 (Mar, 21, 2012)), one of several proposals for comments was that one or more issuers offering an MSP could be incentivized or required to provide contraceptive coverage to participants and beneficiaries covered under certain religious organizations' self-insured plans as part of an accommodation of those organizations' religious objections to providing such coverage. Should the proposed and final rule regarding Certain Preventive Services affect the MSPP, this final rule may include that policy as well.

In § 800.106(b), OPM proposes that for each MSP it offers, an MSPP issuer must make available to an eligible individual the premium tax credits under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402 of the Affordable Care Act. An MSPP issuer must also comply with any standards set by OPM or HHS in regulations concerning the administration of these subsidies. This provision would implement section 1334(c)(3)(B) of the Affordable Care Act, which specifies that individuals enrolled in an MSP are eligible for the premium tax credits and cost-sharing reductions just as they would be if purchasing any other insurance product on the Exchange. This provision also clarifies that MSPP issuers must comply with applicable statutory and HHS requirements, and that OPM may issue additional guidance regarding any unique issues faced by MSPs. See HHS proposed standards at 45 CFR part 156, subpart E. OPM solicits comments on what additional guidance, if any, it should adopt to address unique issues faced by MSPs.

7. Levels of coverage (§ 800.107)

In § 800.107(a), OPM proposes that an MSPP issuer, like QHPs participating in Exchanges, must offer at least one plan at the silver level of coverage and one plan at the gold level of coverage in each Exchange in which the issuer is certified to offer an MSP pursuant to a contract with OPM. OPM also clarifies that it will use its discretion about whether an MSPP issuer may offer products in addition to the required gold and silver products.

In § 800.107(c), OPM proposes that for each level of coverage, an MSPP issuer must offer a child-only plan at the same level of coverage, as any health insurance coverage offered to individuals who, as of the beginning of the plan year, have not attained the age of 21. An MSPP issuer could satisfy this standard by offering the same product to consumers seeking child-only

coverage that it offers to consumers seeking coverage solely for adults or for families including both adults and children, as long as the child-only coverage is priced in accordance with the applicable rating rules.

OPM recognizes that HHS has requested comments in its proposed EHB rule and draft notice of benefit and payment parameters for 2014 on the definition of levels of coverage and plan variations. The proposed HHS regulations direct QHP issuers to offer silver plan variations for the purpose of implementing the reduction or elimination of cost sharing for eligible enrollees in a QHP pursuant to section 1402 of the Affordable Care Act, see proposed 45 CFR part 156.

OPM proposes in § 800.107(d) that MSPP issuers shall comply with applicable HHS requirements to offer such plan variations. In addition, OPM proposes in § 800.107(e) that MSP plan variations will be submitted to OPM for review and approval. OPM will coordinate its approach on this issue with the final HHS notice of benefit and payment parameters for 2014. OPM will exercise this discretion to promote the best interests of enrollees and potential enrollees in the MSPP and to assure adequate administrative oversight of each MSP and MSPP issuer.

8. Assessments and user fees (§ 800.108)

In this section, OPM proposes to reserve its authority to assess a user fee on MSPP issuers to cover the agency's costs of performing its functions under the Affordable Care Act for a plan year. The purpose of assessments and user fees would be to cover the administrative costs of performing the contracting and certification of MSPs and of operating the program, functions typically conducted through an Exchange for QHPs. OPM seeks comments on the use of assessments and user fees to fund the MSPP.

9. Network adequacy (§ 800.109)

Consistent with the Affordable Care Act's goal of providing more competition in the health insurance markets and expanding coverage of the uninsured, OPM asked RFI respondents to indicate which areas of the country are difficult to serve and how the respondent would handle hard-to-serve areas. OPM also asked for recommendations with respect to standards for network access. Respondents identified rural areas as difficult to serve, and one respondent noted that every State has areas that are difficult to serve. Some respondents were able to identify a means of reaching hard-to-serve areas, and some stated that they had been able to overcome these difficulties. In addition, some respondents indicated a willingness to collaborate with other organizations to increase capacity to provide coverage. Some respondents suggested having a uniform network adequacy standard across all States for MSPs, some wanted to preserve State network adequacy laws, and others suggested using the rule applicable to QHPs on a specific Exchange.

With respect to network adequacy, OPM's proposed standard mirrors the HHS standard set forth in 45 CFR 156.230 and is intended to ensure that an MSP's services are available to all enrollees.⁴³ Consistent with the Exchange final rule's alignment with the NAIC Model Act, OPM proposes to require an MSPP issuer to: (1) maintain a sufficient provider network in the number and types of providers to assure that all services will be accessible without reasonable delay for enrollees; (2) offer a provider network that is consistent with network adequacy provisions set out in section 2702(c) of the PHS Act; and (3) offer a provider network that includes essential community providers in compliance with 45 CFR 156.235. OPM intends for

⁴³ This HHS standard is based on the NAIC Managed Care Plan Network Adequacy Model Act (74-1) and establishes a baseline for measuring network adequacy.

an MSPP issuer to make its provider directory available to the Exchange for online publication and to potential enrollees in hard copy, upon request. OPM is aware that certain States have more specific rules on network adequacy and will consult with States to set more specific criteria with respect to network adequacy for the MSPP in future guidance. OPM requests comments on its approach to network adequacy, including issues concerning network adequacy as a condition of State licensure and any issues for MSPs with respect to State-specific network adequacy requirements.

10. Service area (§ 800.110)

With respect to service areas, OPM proposes that MSPP issuers adhere to the service areas defined by Exchanges, but does not necessarily require that an MSP be offered in all defined service areas. OPM proposes that, for each State in which the MSPP issuer does not offer coverage in all service areas, the MSPP issuer's application for participation in the MSPP under § 800.301 and the MSPP issuer's information submitted to support renewal of the contract under § 800.305 must include 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. OPM seeks comment on whether MSPP issuers should be required to offer MSPs in all service areas by the fourth year of participation in the MSPP, when coverage must be offered in each Exchange in all the States and the District of Columbia. OPM has also heard concerns about MSPP issuers' ability to cover an entire Exchange service area during the four year phase-in period and is considering permitting an exception if an MSPP issuer can only offer an MSP in a portion of a service area during the phase-in as long as the selection of the service areas is not discriminatory. In States where the Exchange permits issuers to define their service areas, OPM proposes to require that it approve an MSPP issuer's service areas and will ensure

MSPs meet QHP requirement in 45 CFR 155.1055(b).⁴⁴ OPM also plans to review any requests for coverage of partial county service areas and coordinate with HHS in order to align service areas with those of QHPs to prevent gaming of service areas. OPM believes that allowing MSPP issuers time to develop the capacity to offer coverage throughout a service area will enhance competition in the MSPP. OPM invites comments on this approach.

11. Accreditation requirement (§ 800.111)

With respect to accreditation, OPM proposes that MSPP issuers be or become accredited consistent with the requirements for QHP issuers specified in section 1311 of the Affordable Care Act, in 45 CFR 156.275(a), and in applicable State law. OPM proposes that MSPP issuers be or become accredited by an accrediting entity recognized by HHS pursuant to 45 CFR 156.275(c).

Consistent with 45 CFR 155.1045, which gives OPM discretion to establish a timeline for accreditation for MSPP issuers not already accredited, OPM proposes to require that an MSPP issuer that is not accredited as of the date that it enters into a contract with OPM become accredited within the timeframe established by OPM. A potential MSPP issuer may need additional time to obtain accreditation on the basis of the local performance of its MSPs in multiple States.

⁴⁴ 45 CFR 155.1055(b) establishes that QHP service areas be established in a non-discriminatory manner and states that: “such service areas meet the following minimum criteria: (a) The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers. (b) The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.”

OPM also proposes that the MSPP issuer authorize the accrediting entity to release to OPM and to Exchanges a copy of the MSPP issuer's most recent accreditation survey, along with any survey-related information that OPM or an Exchange may require, such as corrective action plans and summaries of findings. The release of survey information is intended to strengthen OPM's oversight of MSPs and MSPP issuers and is the same as standards for QHP issuers set forth in 45 CFR 156.275. OPM requests comments on its proposed accreditation requirements.

12. Reporting requirements (§ 800.112)

OPM also proposes to use the FEHBP approach as a model for reporting requirements, and OPM requests comment on this approach. Examples of reporting that is currently required for the FEHBP and that may be required for the MSPP include financial reports, premium payment information, enrollment reporting, and quality assurance information.⁴⁵ OPM will determine the data and information that MSPP issuers report and the frequency and process for submitting such reports. Reporting of certain types of information is critical for OPM to implement and administer the MSPP. To oversee MSPP contracts, OPM will need to collect certain information to ensure the integrity of the MSPP, to protect enrollees, to prevent fraud and abuse, to monitor quality and quality improvement, and for other purposes. The agency will develop and issue guidance on this subject for MSPP issuers and potential issuers.

The proposed regulation specifies that OPM may collect such data and information as are permitted or required by the Affordable Care Act to be collected from an MSPP issuer.

Additionally, the Affordable Care Act at section 3101 (a)(2)(E), requires that "any reporting requirement imposed for purposes of measuring quality under any ongoing or federally

⁴⁵ OPM's Routine Reports and Submissions required for FEHB carriers is available at <http://www.opm.gov/carrier/reports/index.asp>.

conducted or supported health care or public health program, activity, or survey includes requirements for the collection of data on individuals receiving health care items or services under such programs activities by race, ethnicity, sex, primary language, and disability status.”

Therefore, OPM intends to collect this data by these categories.

OPM will also collect such other data and information as it determines necessary for the oversight and administration of the MSPP. OPM requests comments on the types of information it proposes to collect and mechanisms that can reduce unnecessary duplication of data disclosure to OPM, HHS, States, and the Exchanges.

With respect to quality reporting, under FEHBP, OPM requires all health plans to report their performance through Healthcare Effectiveness Data and Information Set (HEDIS) metrics and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, independent of the source of plan accreditation. This allows for comparison between plans in a consistent manner. OPM expects to take a similar approach to performance measurement in MSPs to facilitate oversight. OPM requests comments on the unique aspects of accreditation and reporting for MSPs as compared with accreditation of QHPs.

13. Benefit plan material or information (§ 800.113)

OPM has defined the term “benefit plan material or information” narrowly to include explanations or descriptions, whether printed or electronic, that describe a health insurance issuer’s products. The term does not include a policy or contract for health insurance coverage.

OPM proposes that MSPP issuers comply with Federal and State laws related to benefit plan material or information. OPM also proposes that an MSPP issuer must comply with OPM

guidance specifying OPM standards, process, and timeline for approval of benefit plan material or information.

Similar to QHPs, OPM proposes that all MSP enrollee notices must meet minimum access standards for individuals with limited English proficiency and for individuals with disabilities as described in 45 CFR 155.205(c). As stated in the final Exchange rule, HHS intends to issue further guidance on minimum standards to address language access and coordinate HHS accessibility standards with insurance affordability programs, and across HHS programs, as appropriate. OPM expects MSPP issuers to adhere to these minimum access standards once HHS publishes this guidance. OPM may also establish additional standards for MSPP applications and notices.

OPM proposes that an MSPP issuer is responsible for the accuracy of its benefit plan material or information. Benefit plan material or information must also be in plain language, be truthful, not be misleading, and contain no material omissions. QHPs must comply with the provisions of section 2715 of the PHS Act and its implementing regulations at 45 CFR 147.200 on uniform explanation of coverage documents and standardized definitions, and OPM also will require MSPs to comply with the statute and regulations. Additionally, OPM expects that MSPP issuers will meet any requirements that allow standardized benefit information to be displayed on HHS or Exchange web portals.

Unlike the policy or contract for health insurance coverage, which OPM will review and approve, OPM proposes to review and approve only certain benefit plan material or information as defined in § 800.20 of the proposed regulation. OPM may not necessarily review all benefit plan material or information. It may request from MSPP issuers those materials that it wishes to

review and approve. OPM's review will focus on the MSPP issuer's compliance with the standards promulgated by OPM with respect to benefit plan material or information. OPM will work with States concerning this review of benefit plan material or information and may work with States to define the respective roles through Memoranda of Understanding (MOU).

In paragraph (g) of § 800.113, OPM proposes to allow an MSPP issuer to state that OPM has certified a plan as an MSP and will oversee its administration. OPM is aware that many States have adopted laws or regulations prohibiting issuers from using advertisements that “may lead the public to believe that the advertised coverages are somehow provided by or endorsed by [a] governmental agenc[y].”⁴⁶ However, because OPM will have certified an MSPP issuer and an MSP as meeting certain standards, potential issuers may wish to include this fact in materials they distribute to the public subject to review by OPM. OPM does not view this as a violation of State law anti-endorsement provisions, because it is a recitation of the fact that the issuer is providing coverage pursuant to a contract with OPM.

14. Compliance with State law (§ 800.114)

In § 800.114, OPM proposes that MSPP issuers generally must comply with State law in accordance with section 1334(b)(2) of the Affordable Care Act. However, the Affordable Care Act provides that MSPs and MSPP issuers need not comply with State laws that:

- (1) are inconsistent with section 1334 of the Affordable Care Act or regulations issued to implement that section;
- (2) prevent the application of a requirement of part A of title XXVII of the PHS Act; or

⁴⁶ These State law prohibitions derive from the NAIC's Advertisements of Accident and Sickness Insurance Model Regulation § 13.C. (Apr. 1999).

(3) prevent the application of a requirement of title I of the Affordable Care Act.

Accordingly, OPM reserves the right to determine in its judgment, as effectuated through an MSPP contract, these regulations, or OPM guidance, whether particular State laws fall into these categories.

15. Level playing field (§ 800.115)

In § 800.115, OPM proposes to maintain a level playing field by requiring MSPs and MSPP issuers to comply with the State and Federal laws relating to the 13 categories listed in section 1324(b) of the Affordable Care Act.

16. Process for dispute resolution (§ 800.116)

In § 800.116, OPM proposes a process for resolving disputes about the applicability to the MSPs and MSPP issuers of State laws not related to the categories set forth in section 1324(b) of the Affordable Care Act. Under this process, a State may request that OPM reconsider a standard applicable to MSPs or MSPP issuers that is consistent with that State's laws for QHPs or QHP issuers. As discussed above (see discussion on proposed § 800.114), the State must demonstrate that the law is not inconsistent with section 1334 or regulations issued to implement that section; does not prevent the application of part A of title XXVII of the PHS Act; and does not prevent the application of a requirement of the sections of title I of the Affordable Care Act specified in § 800.101 of this proposed regulation. In making these determinations, OPM proposes to examine several factors, including whether the law at issue:

- (1) imposes on MSPP issuers or MSPs any requirement that differs from those applicable to QHP issuers or QHPs offered in one or more Exchanges in that State;

- (2) creates responsibilities, administrative burdens, or costs for an MSPP issuer that significantly deter or impede the MSPP issuer from offering a viable product in one or more Exchanges;
- (3) creates responsibilities, administrative burdens, or costs for OPM that significantly deter or impede OPM's effective implementation of the MSPP; or
- (4) prevents an MSPP issuer from offering an MSP in one or more Exchanges in a State.

OPM solicits comments on whether to have such a process, its scope, the factors OPM should consider when determining whether State law is applicable or whether the relevant market has been or will be disrupted by the inapplicability of State law, and whether the process will be an effective way to resolve any such disputes. OPM further invites comments on whether the process should also be available for States to raise disputes concerning laws related to the 13 categories listed in section 1324(b) of the Affordable Care Act.

17. Other issues

Adjusted community rating:

Section 1334(c)(1)(D) of the Affordable Care Act requires that MSPP issuers offer the MSP in all geographic regions and in all States that have adopted adjusted community rating before March 23, 2010, the enactment date of the Affordable Care Act. The statute does not require that these adjusted community rating States be included in the first year of the phase -in process described in section 1334(e) of the Affordable Care Act and in § 800.104 of this proposed regulation for several reasons. First, in 2014 all health insurance issuers in the individual and small group market, both inside and outside the Exchange, must comply with section 2701 of the

PHS Act and will therefore use adjusted community rating based only on age, tobacco use, geographic area, and family composition. The States described in section 1334(c)(1)(D) will therefore not be unique. Second, OPM interprets the phase-in provision of subsection (e) of section 1334 to permit a phase-in of compliance with (c)(1)(D) of section 1334. OPM's rationale is that an MSPP issuer has four years to offer MSPs in each Exchange in all States and the District of Columbia, and section 1334(e) contains no requirements about the particular States an MSPP issuer must cover in any of the phase-in years. Potential issuers will need flexibility to choose their initial States and the order in which they phase in other States. For this reason, OPM proposes not to identify any specific States that an MSPP issuer must cover in the initial years of the MSPP.

Financial requirements:

OPM anticipates MSPP issuers will meet State financial requirements including participation in State guaranty funds and meeting State reserving requirements. OPM may seek to execute an MOU between a State and OPM specifying how OPM will be notified and the circumstances that would trigger a payment from such fund with respect to an MSPP issuer or MSP. OPM invites comments on the participation of MSPP issuers in State guaranty funds. OPM also seeks comment on how it may further ensure the financial stability of MSPs across State lines.

C. Premiums, Rating Factors, Medical Loss Ratios, and Risk Adjustment (Subpart C, 800.201 through 800.204)

Section 1334(a)(4) on "Administration" directs that OPM implement the MSPP "in a manner similar to the manner" in which OPM implements the contracting provisions with respect to carriers under the FEHBP, including negotiating with each MSPP issuer: (1) a medical loss ratio

(MLR); (2) a profit margin; (3) the premiums to be charged; and (4) such other terms and conditions of coverage as are in the interests of enrollees in such plans. The following proposed provisions of the regulation implement this section.

1. General requirements (§ 800.201)

As it does with FEHBP carriers, OPM proposes in § 800.201(a) and (b) to negotiate annually with an MSPP issuer the premiums for each MSP offered by that issuer, and these premiums will remain in effect for the 12-month plan year. OPM has authority to negotiate “premiums to be charged,” including the authority to review an MSPP issuer’s rating practices. “Rating” means the process, including rating factors, numbers, formulas, methodologies, and actuarial assumptions, used to set premiums for a health plan. In addition to rating factors, HHS or the States may set other requirements for premium increases in the individual and small group markets. In reviewing an MSPP issuer’s proposed rate information, OPM plans to review an MSPP issuer’s rate proposal and cost-sharing arrangements for discriminatory benefit design, and will work closely with States to identify and investigate any potentially discriminatory benefit design in MSPs.

In FEHBP, OPM issues rating guidance to FEHBP carriers via a carrier letter. This guidance provides carriers information needed to construct their rating structures for FEHBP and instructions for submitting rates for negotiation with OPM. Similarly, OPM proposes to issue guidance addressing methods for the development of rates for the MSPP. In addition, this guidance will provide instructions for submitting rating structures as part of OPM’s process for negotiating premiums with each MSPP issuer.

OPM intends that each MSP set its premiums on a State-by-State basis. Unlike the FEHBP, there will not be any MSPs that are offered at one premium nationwide. Therefore, OPM intends to follow State rating laws as much as practicable so as not to distort local markets. This will also be necessary in order for MSPP issuers to participate in the temporary reinsurance program established pursuant to section 1341 of the Affordable Care Act and 45 CFR part 153, the risk corridor program established pursuant to section 1342 of the Affordable Care Act and 45 CFR part 153, and the risk adjustment program established pursuant to section 1343 of the Affordable Care Act and 45 CFR part 153.

OPM recognizes that HHS has requested comments on calculation of AV in its proposed EHB rule; see proposed 45 CFR 156.135. The proposed HHS regulation states an issuer would use the AV calculator developed by HHS to determine the plan's level of coverage as proposed, subject to exceptions in section 156.135(b). OPM proposes in section 800.201(d) that MSPP issuers shall calculate AV in the same manner as QHP issuers. OPM intends to review MSPP issuer compliance with these AV provisions. OPM will coordinate its approach with the final HHS EHB rule on this issue.

In approving rates for MSPs, OPM intends to follow State rating standards with respect to rating factors generally applicable in a State. OPM will comply with section 2701 of the PHS Act and any applicable regulations under that section that sets forth basic requirements in terms of rating factors and their application. Under section 2701, States have flexibility in applying narrower ratios for age and tobacco use and may require issuers to use pure community rating. Section 1334(a)(4) gives OPM the explicit authority to negotiate premiums, profit margins, and an MLR. Recognizing that some States have a prior approval process for rates and the authority to reject rates, OPM intends to work closely with each State in approving a rate for the MSPs in that State

and will consult with that State about patterns in its markets and about other rates that an MSPP issuer might be proposing in that State for non-MSPs. However, the final decision regarding rates for MSPs rests with OPM, as required by the statute. OPM proposes that MSPP issuers follow State rating standards, and OPM's process will meet the standards with respect to review and disclosure requirements for an "effective rate review program" as set out in 45 CFR 154.⁴⁷

As described above, and set out in the proposed § 800.201(e) and (f), with respect to rate review, OPM intends to conduct its own rate review process, but intends to share its rate review analysis with each State in which an MSP is operating. MSPP issuers are subject to a State's rate review process including a State's Effective Rate Review Program established by HHS pursuant to section 2794 of the PHS Act and 45 CFR 154. OPM proposes that for States with Effective Rate Review Programs under section 2794, the MSPP issuer would comply with the State standards. In addition, OPM proposes that in States where HHS is reviewing rates, HHS would take the judgment of OPM for MSP rates. Furthermore, MSPP issuers must comply with the reporting and disclosure requirements for all rate justifications to HHS, States, and Exchanges, such as the requirements set forth in 42 CFR 156.210(c).

Each State would have the opportunity to review the MSP rates under its own procedures and processes. If a State disagrees with OPM's determination to approve the MSP rates, OPM would work with the State to attempt to resolve the differences. OPM expects that few such disagreements will arise and, if they do, that we will be successful in resolving them in a manner that is acceptable both to OPM and the State at issue. In the event that a State withholds approval of an MSP rate for reasons that OPM determines, in its discretion, to be arbitrary,

⁴⁷ Rate Increase Disclosure and Review, 45 CFR 154 (May 23, 2012), available at http://cciio.cms.gov/resources/files/rate_increase_final_rule.pdf

capricious, or an abuse of discretion, the Act authorizes the Director to make the final decision to approve rates for participation in the MSPP notwithstanding the absence of State approval. We expect that the Director will rarely, if ever, have to exercise this authority to approve MSP rates over the objection of a State. OPM welcomes comments on whether this is an appropriate approach and on the impact of this approach.

After OPM and the MSPP issuer complete the rate negotiation process, and OPM approves the rates, an MSPP issuer would file rates with the Exchange, when necessary to post MSP premium and rate information to the Exchange portal, and with the State, when necessary to meet licensure requirements.

Section 1312(c)(1) and (2) of the Affordable Care Act provide that a health insurance issuer consider all enrollees in all non-grandfathered health plans in the individual market to be members of a single risk pool and all enrollees in non-grandfathered health plans in the small group market to be members of a single risk pool within a State. With proposed § 800.201(g), OPM clarifies that an MSPP issuer must consider MSP enrollees to be members of the same risk pool as all other enrollees of the issuer in non-grandfathered health plans in the individual and small group markets, respectively. OPM intends for the MSPP issuer to be subject to any Federal or State regulations that implement or enforce section 1312(c), such as proposed 45 CFR 156.80. In addition, section 1312(c)(3) permits a State to merge the individual and small group markets within the State. Under § 800.201(g), a State election to merge its individual and small group markets, as well as any Federal or State regulations promulgated to implement section 1312, would apply to an MSPP issuer.

2. Rating factors (§ 800.202)

Section 2701 of the PHS Act, as amended by the Affordable Care Act, requires issuers in the individual and small group market to rate based only on permitted rating factors: family composition, geographic area, age, and tobacco use within limits. Section 1334(c)(1)(C) of the Affordable Care Act explicitly limits MSPP issuers to only these factors as well. OPM proposes in § 800.202(a) that MSPP issuers shall comply with requirements setting standards for fair health insurance premiums appearing in HHS regulations. MSPP issuers must follow standards set for rating areas in a State established under any HHS or State regulations implementing section 2701 of the PHS Act.

In approving rates for MSPs, OPM intends to follow State rating standards with respect to rating factors, including the application of tobacco use. OPM will also coordinate its approach with the final HHS health insurance market rules.

3. Medical loss ratio (§ 800.203)

OPM expects MSPP issuers to attain the MLR required under section 2718 of the PHS Act and regulations promulgated by HHS. Section 1334(a)(4) of the Affordable Care Act authorizes OPM to set an MLR for each MSP, similar to FEHBP. OPM reserves the authority to impose a different, MSP-specific MLR threshold (i.e., an MLR threshold based only on an MSPP issuer's MSP population in each State) if that would be in the best interests of enrollees. Proposed § 800.203 articulates this discretion. It is not OPM's intention to apply a national aggregate MLR. OPM requests comments on its proposal to set an MSP-specific MLR and the methodology that MSPP issuers should use to calculate an MSP-specific MLR.

The proposed rule gives OPM the discretion to take appropriate action if an MSPP issuer fails to attain any required MLR. Such appropriate actions may include intermediate sanctions, such as

suspension of marketing. In the case of widespread, repeated failures, more severe sanctions may include decertifying an MSP in one or more States or terminating an MSPP issuer's contract pursuant to § 800.404. OPM will coordinate all actions concerning MLR with HHS to ensure that there is not duplicative reporting by issuers or duplicative compliance activity.

In addition to the explicit authority for OPM to set an MLR, section 1334(a)(4) also provides OPM with the authority to set a profit margin. OPM has not proposed a standard for profit margin. OPM seeks comment on whether OPM should set such a standard, and the impact that such a standard would have on the Exchanges and any existing state requirements concerning profit margin.

4. Reinsurance, risk corridors, and risk adjustment (§ 800.204)

OPM proposes that an MSPP issuer participates in the transitional reinsurance program for the individual market established pursuant to section 1341 of the Affordable Care Act and 45 CFR part 153 and comply with requirements issued by HHS or the State, if the State is operating an Exchange, to implement the program. For example, if a State were to impose additional reinsurance assessments on issuers, MSPs would be subject to such assessments in order to maintain a level playing field. OPM also proposes that an MSPP issuer participates in the temporary risk corridors program established pursuant to section 1342 of the Affordable Care Act and 45 CFR part 153 and comply with requirements issued by HHS to implement the program. Additionally, OPM proposes that an MSPP issuer participates in the risk adjustment program established pursuant to section 1343 of the Affordable Care Act and 45 CFR part 153 and comply with requirements on issued by HHS or the State, if the State is operating an

Exchange, to implement the program. Participation by MSPP issuers in these programs will ensure that all issuers have the same fiscal responsibilities and protections.

D. Application and Contracting Procedures (Subpart D, 800.301 through 800.306)

This subpart describes the process by which issuers can apply to participate in the MSPP.

1. Application process (§ 800.301)

Section 1334(a) authorizes OPM to implement the MSPP without regard to section 5 of title 41, United States Code, or other statutes requiring competitive bidding. Therefore, OPM has structured the process as an application process rather than a request for proposals, which affords the agency discretion to contract with as many issuers as meet the requirements of section 1334. The MSPP contract application must be in such form, contain such information, and be submitted in such manner as OPM may prescribe. This process is modeled on the approach OPM uses under the FEHBP.

2. Review of applications (§ 800.302)

OPM will review applications to determine whether the applicant meets the requirements of this part. OPM may request additional information from the applicant to make the determination. OPM may either accept an applicant to enter into MSPP contract negotiations or decline to enter negotiations with the applicant. In the latter case, OPM will inform the applicant in writing of the reason(s) for declining the application.

OPM reserves discretion about whether to enter into contract negotiations with an applicant. However, a decision by OPM to decline an application to participate in the MSPP does not

preclude the applicant from submitting an application to participate in the MSPP for a subsequent year.

3. MSPP contracting (§ 800.303)

An applicant does not become an MSPP issuer until it signs a contract with OPM to participate in the MSPP. OPM will establish a standard contract for the MSPP. OPM will approve benefit packages and negotiate premiums for an MSP for each plan year. OPM may also negotiate additional terms, conditions, and requirements that are in the interests of MSP enrollees or that OPM, in consultation with HHS, determines to be appropriate.

Each MSPP contract will specify the Exchanges in which the MSPP issuer is authorized to offer the MSP for a plan year, as well as the benefit packages and premiums to be charged. An MSPP issuer cannot offer an MSP on an Exchange unless its MSPP contract includes a certification authorizing the MSPP issuer to offer the MSP on that Exchange.

4. Term of the contract (§ 800.304)

The term of the contract will be for a period of at least 12 consecutive months defined as the plan year. “Plan year” is defined as a consecutive 12-month period during which the MSP provides coverage for health benefits and may be a calendar year or otherwise.

5. Contract renewal process (§ 800.305)

If an MSPP issuer is in compliance with the requirements of this rule and wishes to continue participating in the MSPP, OPM will conduct negotiations with such an issuer to renew its MSPP contract. The agency recognizes that section 1334(a)(2) creates an expectation of automatic

renewal. However, OPM intends to fulfill its statutory responsibility to ensure that all MSPP issuers and MSPs remain in compliance with all legal requirements. Therefore, an MSPP issuer wishing to continue in the MSPP for a subsequent year must provide to OPM, in the form, manner, and timeline prescribed by OPM, the information requested by OPM for determining whether the MSPP issuer continues to meet the requirements of the MSPP. OPM retains discretion to renew the MSPP contract for a subsequent plan year with an MSPP issuer who submits the information described above and continues to meet the requirements of applicable law and this rule. OPM may decline to renew the MSPP contract of an MSPP issuer if: (1) OPM and the MSPP issuer fail to agree on benefits and premiums for an MSP on one or more Exchanges for the subsequent plan year; (2) the MSPP issuer has engaged in conduct described in § 800.404(a); or (3) OPM determines that the MSPP issuer will be unable to comply with a material provision of section 1334 of the Affordable Care Act.

If OPM and the MSPP issuer fail to agree on benefits and premiums for an MSP on one or more Exchanges by the date set by OPM, that MSP would be offered on that Exchange or Exchanges in the subsequent plan year with the same premiums and benefits as in the current plan year, unless OPM or the MSPP issuer provides written notice of non-renewal, or OPM exercises its discretion to withdraw the certification of that MSP on one or more Exchanges. Based on its experience with the FEHBP, OPM anticipates that situations in which OPM and the MSPP issuer fail to agree on premiums and benefits will occur infrequently. If OPM chooses not to renew an MSPP issuer's MSPP contract, OPM must provide the MSPP issuer with notice and the opportunity for a hearing pursuant to § 800.405. It is OPM's intention to ensure that premium and benefit information for all MSPs are submitted to each Exchange in compliance with the timeline established by that Exchange.

6. Nonrenewal (§ 800.306)

For this subpart, OPM is defining “nonrenewal” to mean the decision by either OPM or an MSPP issuer to not renew an MSPP contract. Either OPM or an MSPP issuer may decline to renew a contract by giving a written notice of nonrenewal. The issuer’s notice must be given in accordance with its MSPP contract, and an issuer must comply with the rules of an Exchange with respect to termination of a QHP, including the requirement to provide advance notice in writing to enrollees. If an Exchange does not specify the timeframe for notifying enrollees, OPM will require notice no later than 90 days prior to termination, unless OPM determines that there is good cause for less than 90 days’ notice.

E. Compliance (Subpart E, 800.401 through 800.405)

This subpart describes how OPM will enforce compliance in the MSPP.

1. Contract performance (§ 800.401)

Pursuant to an MSPP contract with OPM, an MSPP issuer must meet the requirements of section 1334 and the requirements of this part. Each MSPP issuer will be required to:

- Have the financial resources, in the judgment of OPM, to carry out its obligations under the MSPP.
- Keep reasonable financial and statistical records, and furnish reports related to these records with respect to the MSP or the MSPP, as may be requested by OPM.
- Permit representatives of OPM (including the OPM Office of Inspector General), the U.S. Government Accountability Office, and any other applicable Federal government

auditing entities to audit and examine its records and accounts which pertain, directly or indirectly, to the MSP at such reasonable times and places as may be designated by OPM or the U.S. Government Accountability Office. Also, note that nothing in this proposed regulation changes or diminishes the authorities of HHS, including the authorities of the HHS Office of Inspector General.

- Submit to OPM a properly completed and signed novation or change-of-name agreement in a timely manner and in accordance with 48 CFR 42.12.
- Perform the MSPP contract in accordance with prudent business practices as described below.
- Not engage in poor business practices as described below.

Under the MSPP, OPM proposes prudent businesses practices to include, but not be limited to: (1) timely compliance with OPM instructions and directives; (2) legal and ethical business and health care practices; (3) compliance with the terms of the MSPP contract, regulations, statutes, and additional agency guidance; (4) timely and accurate adjudication of claims or rendering of medical services; (5) a system of accounting for costs incurred under the MSPP contract; (6) accurate accounting reports of administration costs relevant to the MSPP contract; (7) applying performance standards for assuring contract quality outlined in § 800.402; and (8) a system of internal controls related to the MSP and MSPP issuer.

Under the MSPP, OPM will consider the following types of activities, among others, as poor business practices: (1) using fraudulent or unethical business or health care practices or otherwise displaying a lack of business integrity or honesty; (2) repeatedly or knowingly

providing false or misleading information in the rate setting process for an MSP; (3) failing to comply with OPM instructions or directives; (4) having an accounting system that is incapable of separate accounting for costs incurred under the MSPP contract and/or lacks internal controls necessary to fulfill the terms of the MSPP contract; (5) failing to assure that the MSPP issuer properly pays or denies claims, or provides medical services which are inconsistent with standards of good medical practice; and (6) entering into contracts or employment agreements with providers, provider groups, or health care workers that include provisions or financial incentives that directly or indirectly create an inducement to limit or restrict communication about medically necessary services to any individual covered under the MSPP. Financial incentives are defined as bonuses, withholds, commissions, profit sharing or other similar adjustments to basic compensation (e.g., service fee, capitation, salary) which have the effect of limiting or reducing communication about appropriate medically necessary services.

OPM seeks to encourage MSPP issuers to meet or exceed performance standards. OPM proposes to establish performance escrow accounts for each MSPP issuer through a modest assessment on issuers. The funds from such accounts could be used to provide a rebate to enrollees in cases of inadequate performance or could be returned to plan as a reward for meeting performance standards. These accounts could also be used to hold funds paid in response to audit findings, not meeting performance standards under the contract, or other issues of noncompliance. OPM requests comment on the establishment of a performance escrow account. Specifically, OPM solicits comments on how best to collect, hold, and release these funds. OPM also requests comments on alternative methods of fulfilling OPM's goals of ensuring contract compliance and ensuring performance standards are met.

2. Contract quality assurance (§ 800.402)

This section describes general policies and procedures to ensure that services acquired under the MSPP contract conform to the contract's quality assurance requirements. Periodically, OPM will evaluate an MSPP issuer's system of internal controls as discussed in § 800.401. Upon the initial review, OPM will acknowledge in writing whether or not the system established and maintained by the MSPP issuer is consistent with the requirements set forth in the MSPP contract. In addition to reviewing an MSPP issuer's system of internal controls, OPM will issue specific performance standards for MSPP contracts. The OPM Office of the Inspector General will conduct periodic evaluations of the contractor's system of internal controls.

3. Fraud and abuse (§ 800.403)

Pursuant to the MSPP contract, an MSPP issuer is required to have a program to assess its vulnerability to fraud and abuse as well as to address such vulnerabilities. The fraud detection system of the MSPP issuer must be designed to detect and eliminate fraud and abuse by employees of the MSPP issuer and its subcontractors, by providers furnishing goods and services to MSP enrollees, and by MSP enrollees. An MSPP issuer must provide to OPM, upon request, such information or assistance as may be necessary for OPM to carry out any audit activities. OPM will determine the timeline, form, and manner in which the MSPP issuer must submit this information to OPM.

4. Compliance actions (§ 800.404)

OPM may impose compliance actions against an MSPP issuer for the following causes, as OPM may determine:

- Failure of the MSPP issuer to meet the requirements of the MSPP contract and § 800.401(a) and (b).
- Sustained failure of the MSPP issuer to perform the MSPP contract in accordance with prudent business practices.
- Evidence of poor business practices or demonstration of a pattern of poor business practices by the MSPP issuer.
- Violation of law or regulation by the MSPP issuer.

At any time during the contract term, OPM may impose a compliance action against an MSPP issuer if it determines that the MSPP issuer is not in compliance with applicable law, this part, or the terms of the MSPP contract. In this situation, OPM may take compliance actions against the MSPP issuer, including, but not limited to: (1) establishing and implementing a corrective action plan; (2) imposing intermediate sanctions; (3) imposing monetary penalties; (4) reducing the MSPP issuer's service area; (5) withdrawing certification for the MSPP issuer to offer an MSP on one or more Exchanges; (6) not renewing the MSPP contract; or (7) terminating the MSPP contract. If OPM initiates a compliance action, it will notify the MSPP issuer in writing of the compliance action. The notice will indicate the specific reason for the compliance action. If the compliance action is the withdrawal of the certification of the MSPP issuer to offer the MSP on one or more Exchanges, the nonrenewal of the MSPP contract, or the termination of the MSPP contract, the notice must also include a statement that the MSPP issuer is entitled to request a reconsideration of OPM's determination to impose the compliance action in accordance with § 800.405, including a hearing on the issuer's request.

If OPM does not renew or terminates an MSPP contract or withdraws certification of the MSPP issuer to offer an MSP on one or more Exchanges, the MSPP issuer must adhere to any requirements related to notification of termination of a QHP imposed by an Exchange. If an Exchange does not have requirements to notify enrollees of the termination of a QHP, then the MSPP issuer must provide current enrollees with a notice of the MSP's termination no later than 90 calendar days prior to termination.

For purposes of subpart E of 45 CFR 800, termination of a contract means OPM's withdrawal of approval of the contract.

5. Reconsideration of compliance actions (§ 800.405)

In the case of withdrawal of the certification of the MSPP issuer to offer the MSP on one or more Exchanges, nonrenewal of the MSPP contract, or termination of the MSPP contract, the MSPP issuer has the right to request a reconsideration of OPM's action in accordance with the process proposed in this regulation. OPM's reconsideration may be conducted by the Director or a representative designated by the Director who did not participate in the initial decision that is the subject of the request for review. OPM will notify the MSPP issuer in writing of the final decision and the specific reasons for that final decision. OPM's written decision will constitute final agency action that is subject to review under the Administrative Procedure Act in the appropriate U.S. district court. Such review is limited to the record that was before OPM when it made its decision.

F. Appeals by Enrollees for Denial of Claims for Payment or Service (Subpart F, 800.501 through 800.505)

The Affordable Care Act added a new section 2719 to the PHS Act. This section requires that all non-grandfathered group health plans and health insurance issuers provide for internal appeals and external review processes that meet specific consumer protection standards. Under regulations and guidance issued by HHS, along with the Departments of Labor and Treasury, health insurance issuers must meet specific standards with respect to internal appeals and external review processes. With respect to external review, States must have external review processes that meet specific minimum criteria. If a State external review process meets these criteria, an issuer in that State must comply with that external review process. In States with no external review process, or with a process that has not been determined to meet specific criteria, health insurance issuers must implement a separate “federal external review process.” In this subpart, OPM proposes that MSPP issuers have an internal appeals process consistent with the requirements of section 2719 of the PHS Act and its implementing regulations at 45 CFR 147.136(b). With respect to its internal appeals process, therefore, an MSP must meet the same standards as QHPs.

With respect to external review, OPM proposes that MSPP issuers would comply with OPM’s external review process, which will meet the standards for State external review processes established under section 2719 of the PHS Act and 45 CFR 147.136(c). OPM’s external review process for the MSPP will be similar to the disputed claims process administered under the FEHBP.

The disputed claims process serves two purposes: first, it provides an avenue of redress for enrollees whose claims have been denied, and second, it permits OPM to ensure the uniform and correct administration of FEHBP contracts. Similarly, proposed § 800.504(b) would protect enrollees by creating a process for review of adverse benefit determinations while simultaneously providing OPM with a necessary tool for contractual oversight. By reviewing these adverse benefit determinations, OPM would be able to ensure the uniform and equitable administration of the MSPP. OPM will issue further guidance explaining the details of its process for external review of adverse benefit determinations.

OPM considered an approach for external review that would expand the use of the Federal external review process that OPM administers in conjunction with HHS, which is currently used for external review of cases arising in States without effective processes, to be the exclusive method of external review for the MSPP. OPM also considered a hybrid approach to external review under which OPM would render a final decision in all cases, using the standards and timeframes of 45 CFR 147.136(d) for adverse benefit determinations based on medical judgment, and using a process similar to the FEHBP disputed claims process for adverse benefit determinations not based on medical judgment.

OPM proposes instead to build on its expertise concerning external review while adhering to external standards under section 2719 and its implementing regulations. MSP enrollees would benefit from access to an external review process that is consistent with the process that is available to enrollees in QHPs for adverse benefit determinations. OPM considers it necessary for the appropriate administration of MSPP contracts to perform external review of adverse benefit determinations

For all notices involving internal appeals and external review, cultural and linguistic appropriateness standards, as articulated in 45 CFR 147.136(e), would apply. Notices to MSP enrollees must adequately describe the enrollee's rights and obligations with respect to external review of adverse benefit determinations. OPM will review such notices to ensure appropriateness and accessibility.⁴⁸

OPM's decision about an adverse benefit determination will constitute final agency action that is subject to review under the Administrative Procedure Act in the appropriate U.S. district court.

OPM requests comments on this approach for MSPP appeals as well as the alternative approaches mentioned and feasible combinations of the different approaches. OPM also invites comments on the impact of the approaches in providing for a level playing field for all plans on the Exchanges, consumer choice and consistency of processes across different Exchanges.

G. Miscellaneous (Subpart G, 800.601 and 800.602)

Section 800.601 reserves to OPM the right to implement and supplement this regulation with operational guidelines.

Section 800.602(a) implements the requirement of section 1334(a)(6) of the Affordable Care Act that at least one MSP on each Exchange not provide coverage of services described in

⁴⁸ Note, nothing in this regulation should be construed as limiting an individual's rights under federal civil rights statutes, such as Section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964 (Title VI). For example, to ensure non-discrimination on the basis of national origin, entities covered by Title VI must take reasonable steps to ensure meaningful access by persons with limited English proficiency to their programs and activities. For more information, see "Guidance to federal Financial Assistance recipients regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons to better understand the obligations under Title VI," at <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>.

section 1303(b)(1)(B) of the Affordable Care Act. OPM proposes to implement this requirement across all Exchanges subject to the phase-in provision of § 800.104. In § 800.602(b), OPM proposes to apply the State opt out provisions in section 1303(a) of the Affordable Care Act to MSPs.

IV. Regulatory Impact Analysis

OPM has examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993) and Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011). Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year adjusted for inflation). Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule that may:

- (1) Have an annual effect on the economy of \$100 million or more in any one year or adversely affect in a material way a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal government or communities;
- (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency;

(3) Materially alter the budgetary impacts of entitlement grants, user fees, or loan programs, or the rights and obligations of recipients thereof; or

(4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in Executive Order 12866.

The economic impact of this rule may exceed the \$100 million threshold for at least one year; we therefore assess costs and benefits as required by the Executive Order.

This rule gives health insurance issuers the opportunity to contract with OPM to offer a product on the Affordable Insurance Exchanges, but does not require those issuers to outlay funds. In a 2009 analysis of legislation that ultimately became the Affordable Care Act, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimated the effects of the Affordable Care Act on nationwide insurance enrollment and on the federal budget.⁴⁹ CBO and JCT estimated that “from 2016 on, between 23 million and 25 million people will receive coverage through the [E]xchanges.”⁵⁰ We lack the information necessary to make assumptions about the potential enrollment penetration for MSPs on the Exchange but seek comment on the number of states where MSPs will participate and the influence of current market dynamics on enrollment in MSPs.

One primary benefit of health insurance coverage would be an increase in longevity or health for newly enrolled individuals. Improved access to health care services has been shown to lead to higher use of preventive services and health improvements, such as reduced hypertension,

⁴⁹ Letter to Senator Harry Reid, Majority Leader, from Douglas W. Elmendorf, Director of the Congressional Budget Office, December 19, 2009, p. 9.

⁵⁰ Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* (July 2012), p.13.

improved vision and better self-reported health status, as well as better clinical outcomes and lower mortality.^{51,52}

Additional benefits would be generated for newly enrolled individuals in the form of improved financial security. There is evidence that bankruptcy filings, for instance, decrease in response to increases in Medicaid eligibility.⁵³ Furthermore, a 2011 analysis by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that most of the uninsured were unable to afford a single hospitalization, because 90 percent of the uninsured reported having total financial assets below \$13,000.⁵⁴ A related benefit would be generated by increased access to non-employment-based health insurance, which can give individuals greater flexibility to separate from current employment in order to search for positions that better match their skills or interests.

Expansion of health insurance coverage leads to many benefits such as improved access to health care, and improved financial security for the newly insured. However, insurance coverage, which generally makes medical care more affordable, can lead to an inefficiency commonly called moral hazard. When people make economic decisions to purchase goods and services, but

⁵¹ Brook, Robert H., John E. Ware, William H. Rogers, Emmett B. Keeler, Allyson Ross Davies, Cathy D. Sherbourne, George A. Goldberg, Kathleen N. Lohr, Patricia Camp and Joseph P. Newhouse. *The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment*. Santa Monica, CA: RAND Corporation, 1984. Finkelstein, A. et al. "The Oregon Health Insurance Experiment: Evidence from the First Year." *NBER Working Paper* No. 17190, July 2011. Doyle, J.J. "Health Insurance, Treatment and Outcomes: Using Auto Accidents and Health Shocks." National Bureau of Economic Research. *NBER Working Paper* No. 11099, February 2005.

⁵² See the regulatory impact analysis developed by HHS for the Exchange Establishment final rule, available at <http://cciio.cms.gov> under "Regulations and Guidance", for a comprehensive overview of the empirical evidence on the benefits of enhanced availability of quality, affordable health insurance, which to great extent applies to the MSPP program and this proposed rule as well.

⁵³ Gross, T., Notowidigdo, M. "Health Insurance and the Consumer Bankruptcy Decision: Evidence from Medicaid Expansions." *Journal of Public Economics* 95(7-8): 2011.

⁵⁴ Assistant Secretary for Planning and Evaluation The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills: 2011. Washington DC: US Department of Health and Human Services.

do not bear the full cost of these goods and services, there can be a tendency to purchase more than the efficient amount of that service. Studies that estimated the effects of Medicare, however, found that the cost of this inefficiency is likely more than offset by the benefit of risk reduction.^{55,56}

Administrative costs of the rule would be generated both within OPM and by issuers deciding to offer MSPs. The costs that MSPP issuers may incur are the same as those of QHPs and, as stated in 45 CFR part 157, will include: accreditation, network adequacy standards, and quality improvement strategy reporting. The costs associated with MSP certification offset the costs that issuers would face were they to be certified by the State, or HHS on behalf of the State, to offer QHPs through the Exchange. .

Finally, some of the most notable effects of Exchanges in general, and MSPs in particular, may not be net social costs or benefits, but would instead be transfers between members of society. Potential examples include decreases in uncompensated care and changes in premiums that do not reflect shifts in society's resource use to or away from provision of medical services and insurance policies.

OPM lacks data to quantify most of these benefits, costs and transfers. Perhaps most notably, OPM cannot isolate the effects of MSPs from forecasts of the overall effects of the Affordable Care Act coverage provisions, and, therefore, requests comments on any aspects of this proposed rule's cost-benefit analysis.

⁵⁵ Finkelstein A, McKnight R: "What Did Medicare Do (And Was It Worth It)?" *Journal of Public Economics* 2008, 92 :1644-1669.

⁵⁶ Finkelstein, Amy, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," National Bureau of Economic Research. Working Paper No. 11619, Sept, 2005.

V. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35; see 5 CFR part 1320) requires that OMB approve all collections of information by a Federal agency from the public before they can be implemented. Respondents are not required to respond to any collection of information unless it displays a current valid OMB control number. OPM is proposing several collections from MSPP issuers or applicants seeking to become MSPP issuers, but we have determined that they are exempt from the requirements of the Paperwork Reduction Act. For example, we seek to collect information in connection with the MSPP application process and reporting requirements under § 800.112. We are also proposing requirements for issuers to authorize accrediting entities to send documentation to OPM under § 800.111. The proposal would also set up a process under § 800.116 for states to request that OPM reconsider a standard applicable to MSPs or MSPP issuers that does not comply with that State's laws for QHPs. Under § 800.503, MSPP issuers are directed to provide certain written notices, which are third-party disclosures under the Paperwork Reduction Act. These collections would generally be considered reporting requirements under the Paperwork Reduction Act. Moreover, based on responses to the RFI, subsequent conversations with both responding health insurance issuers and other health insurance issuers subsequent to the RFI, and other practical considerations, OPM expects fewer than ten responsible entities to respond to all of the collections noted above. For that reason alone, the collections are exempt from the Paperwork Reduction Act under 44 U.S.C. 3502(3)(A)(i). There may also be other reasons why these collections are exempt from these requirements. We seek comments on these assumptions.

VI. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA)⁵⁷ requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule would not have a significant economic impact on a substantial number of small entities. The RFA generally defines a “small entity” as -- (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a not-for-profit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of “small entity.”

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a proposed rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, small non-profit organizations, and small government jurisdictions. Small businesses are those with sizes below thresholds established by the SBA. With respect to health insurers, the SBA size standard is \$7.0 million in annual receipts.⁵⁸

OPM does not think that small businesses with annual receipts less than \$7.0 million would likely have sufficient economies of scale to become MSPP issuers or be part of a group of MSPP issuers. Similarly, while the Director must enter into an MSPP contract with at least one non-profit entity, OPM does not think that small non-profit organizations would likely have sufficient economies of scale to become MSPP issuers or be part of a group of MSPP issuers.

⁵⁷ 5 U.S.C. 601 *et seq.*

⁵⁸ According to the SBA size standards, entities with average annual receipts of \$7 million or less would be considered small entities for North American Industry Classification System (NAICS) Code 524114 (Direct Health and Medical Insurance Carriers) (for more information, see “Table of Size Standards Matched To North American Industry Classification System Codes,” effective March 26, 2012, U.S. Small Business Administration, available at <http://www.sba.gov>).

OPM does not think that this proposed rule would have a significant economic impact on a substantial number of small businesses with annual receipts less than \$7.0 million, because there are only a few health insurance issuers that could be considered small businesses. Moreover, while the Director must enter into an MSPP contract with at least one non-profit entity, OPM does not think that this proposed rule would have a significant economic impact on a substantial number of small non-profit organizations, because few health insurance issuers are small non-profit organizations.

OPM incorporates by reference previous analysis by HHS, which provides some insight into the number of health insurance issuers that could be small entities. Particularly, as discussed by HHS in the Medical Loss Ratio interim final rule (75 FR 74918), few, if any, issuers are small enough to fall below the size thresholds for small business established by the SBA. In that rule, HHS used a data set created from 2009 NAIC Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, HHS used total Accident and Health earned premiums as a proxy for annual receipts. HHS estimated that there are 28 small entities with less than \$7 million in accident and health earned premiums offering individual or group comprehensive major medical coverage. OPM concurs with this HHS analysis, and, thus, does not think that this proposed rule would have a significant economic impact on a substantial number of small entities.

Based on the foregoing, OPM is not preparing an analysis for the RFA because OPM has determined, and the Director certifies, that this proposed rule would not have a significant economic impact on a substantial number of small entities.

VII. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA)⁵⁹ requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a proposed rule (and subsequent final rule) that includes any Federal mandate that may result in expenditures in any one year by a State, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold is approximately \$139 million. UMRA does not address the total cost of a rule. Rather, it focuses on certain categories of costs, mainly those “Federal mandate” costs resulting from: (1) imposing enforceable duties on State, local, or Tribal governments, or on the private sector; or (2) increasing the stringency of conditions in, or decreasing the funding of, State, local, or tribal governments under entitlement programs.

This proposed rule does not place any Federal mandates on State, local, or Tribal governments, or on the private sector. This proposed rule would establish the MSPP, a voluntary federal program that provides health insurance issuers the opportunity to contact with OPM to offer MSPs on the Exchanges. Section 3 of UMRA excludes from the definition of “Federal mandate” duties that arise from participation in a voluntary Federal program. Accordingly, no analysis under UMRA is required.

VIII. Federalism

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have “substantial direct effects” on the States, the relationship

⁵⁹ Pub. L. 104-4.

between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

These proposed regulations have federalism implications, because they have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. In particular, under proposed § 800.114, OPM may deem a State law to be inconsistent with section 1334 of the Affordable Care Act, and, thus, inapplicable to an MSP or MSPP issuer. However, in OPM's view, the federalism implications of these proposed regulations are substantially mitigated because, OPM expects that the vast majority of States have laws that are consistent with section 1334 of the Affordable Care Act. Furthermore, proposed § 800.116 sets forth a process for dispute resolution if a State seeks to challenge OPM's determination that a State law is inapplicable to an MSP or MSPP issuer.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, OPM has engaged in efforts to consult with and work cooperatively with affected State and local officials, including attending meetings of the NAIC and consulting with State insurance officials on an individual basis. It is expected OPM will act in a similar fashion in enforcing the Affordable Care Act requirements. Throughout the process of developing these proposed regulations, OPM has attempted to balance the States' interests in regulating health insurance issuers, and the statutory requirement to provide two MSPs in all Exchanges in the 50

States and the District of Columbia. By doing so, it is OPM's view that it has complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signature affixed to this proposed regulation, OPM certifies that it has complied with the requirements of Executive Order 13132 for the attached regulations in a meaningful and timely manner.

List of Subjects in 45 CFR Part 800

Administrative practice and procedure, Health facilities, Health insurance, Health professions, reporting and recordkeeping requirements.

U.S. OFFICE OF PERSONNEL MANAGEMENT.

John Berry,

Director.

For the reasons stated in the preamble, the U.S. Office of Personnel Management proposes to add 45 CFR chapter VIII, consisting of part 800, to read as follows:

Title 45

CHAPTER VIII—OFFICE OF PERSONNEL MANAGEMENT

PART 800 – MULTI-STATE PLAN PROGRAM

Subpart A – General Provisions and Definitions

Sec.

800.10 Basis and scope.

800.20 Definitions.

Subpart B – Multi-State Plan Issuer Requirements

800.101 General requirements.

800.102 Compliance with Federal law.

800.103 Authority to contract with issuers.

800.104 Phased expansion.

800.105 Benefits.

800.106 Cost-sharing limits, premium tax credits, and cost-sharing reductions.

800.107 Levels of coverage.

800.108 Assessments and user fees.

800.109 Network adequacy.

800.110 Service area.

800.111 Accreditation requirement.

800.112 Reporting requirements.

800.113 Benefit plan material or information.

800.114 Compliance with applicable State law.

800.115 Level playing field.

800.116 Process for dispute resolution.

Subpart C – Premiums, Rating Factors, Medical Loss Ratios, and Risk Adjustment

800.201 General requirements.

800.202 Rating factors.

800.203 Medical loss ratio.

800.204 Reinsurance, risk corridors, and risk adjustment.

Subpart D – Application and Contracting Procedures

800.301 Application process.

800.302 Review of applications.

800.303 MSPP contracting.

800.304 Term of the contract.

800.305 Contract renewal process.

800.306 Nonrenewal.

Subpart E – Compliance

800.401 Contract performance.

800.402 Contract quality assurance.

800.403 Fraud and abuse.

800.404 Compliance actions.

800.405 Reconsideration of compliance actions.

Subpart F – Appeals by Enrollees for Denials of Claims for Payment or Service

800.501 General requirements.

800.502 MSPP issuer internal claims and appeals processes.

800.503 MSPP issuer internal claims and appeals timeframes and notice of determination.

800.504 External review.

800.505 Judicial review.

Subpart G – Miscellaneous

800.601 Reservation of authority.

800.602 Consumer choice with respect to certain services.

Appendix A to Part 800—Applicable Provisions of Part A of title XXVII of the PHS Act

Appendix B to Part 800—Applicable Provisions of the Affordable Care Act

Appendix C to Part 800—Applicable Provisions of the Internal Revenue Code

Authority: Section 1334 of the Patient Protection and Affordable Care Act, (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Subpart A – General Provisions and Definitions

§ 800.10 Basis and scope.

(a) Basis. This part is based on the following sections of title I of the Affordable Care Act:

- (1) 1001. Amendments to the Public Health Service Act.
- (2) 1302. Essential Health Benefit Requirements.
- (3) 1311. Affordable Choices of Health Benefit Plans.
- (4) 1324. Level Playing Field.
- (5) 1334. Multi-State Plans.
- (6) 1341. Transitional Reinsurance Program for Individual Market in Each State.
- (7) 1342. Establishment of Risk Corridors for Plans in Individual and Small Group Markets.
- (8) 1343. Risk Adjustment.

(b) Scope. This part establishes standards for health insurance issuers to contract with the United States Office of Personnel Management (OPM) to offer multi-State plans to provide health insurance coverage on Exchanges for each State. It also establishes standards for appeal of a decision by OPM affecting the issuer's participation in the Multi-State Plan Program (MSPP) and standards for an enrollee in a multi-State plan (MSP) to appeal denials of payment or services by an MSPP issuer.

§ 800.20 Definitions.

The following definitions apply to this part:

Actuarial value (AV) has the meaning given such term in proposed 45 CFR 156.20.

Affordable Care Act means the Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Applicant means an issuer or group of issuers that has submitted an application to OPM to be considered for participation in the Multi-State Plan Program.

Benefit plan material or information means explanations or descriptions, whether printed or electronic, that describe a health insurance issuer's products. The term does not include a policy or contract for health insurance coverage.

Cost sharing has the meaning given such term in 45 CFR 155.20.

Director means the Director of the United States Office of Personnel Management.

EHB-benchmark plan has the meaning given such term in proposed 45 CFR 156.20.

Exchange means a governmental agency or non-profit entity that meets the applicable requirements of 45 CFR part 155 and makes qualified health plans (QHPs) and MSPs available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange.

Federal Employees Health Benefits Program or FEHBP means the health benefits program administered by the United States Office of Personnel Management pursuant to chapter 89 of title 5, United States Code.

Group of issuers means:

(1) A group of health insurance issuers who are affiliated either by common ownership and control or by common use of a nationally licensed service mark (as defined in this section); or

(2) An affiliation of health insurance issuers and an entity that is not an issuer but that owns a nationally licensed service mark (as defined in this section).

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited duration insurance.

Health insurance issuer or Issuer means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act (ERISA)). This term does not include a group health plan as defined in 45 CFR 146.145(a).

HHS means the United States Department of Health and Human Services.

Indian has the meaning given to the term in proposed 45 CFR 155.300(a).

Indian plan variation has the meaning given such term in proposed 45 CFR 156.400.

Level of Coverage means one of four standardized actuarial values of plan coverage as defined by section 1302(d)(1) of the Affordable Care Act.

Licensure means the authorization obtained from the appropriate State official or regulatory authority to offer health insurance coverage in the State.

Multi-State Plan or MSP means a health plan that is offered under a contract with OPM pursuant to section 1334 of the Affordable Care Act and meets the requirements of this part.

Multi-State Plan Program Issuer or MSPP issuer means a health insurance issuer or group of issuers (as defined in this section) that has a contract with OPM to offer health plans pursuant to section 1334 of the Affordable Care Act and meets the requirements of this part.

Multi-State Plan Program or MSPP means the program administered by OPM pursuant to section 1334 of the Affordable Care Act.

Nationally licensed service mark means a word, name, symbol, or device, or any combination thereof, that an issuer or group of issuers uses consistently nationwide to identify itself.

Non-profit entity means:

(1) An organization that is incorporated under State law as a non-profit entity and licensed under State law as a health insurance issuer; or

(2) A group of health insurance issuers licensed under State law , a substantial portion of which are incorporated under State law as non-profit entities.

OPM means the United States Office of Personnel Management.

Percentage of total allowed cost of benefits has the meaning given such 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 such 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 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 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 such term in proposed 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.

Subpart B – Multi-State Plan 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 parts 155 subparts D, E, and H and 45 CFR 156.250, 156.260, 156.265, 156.270, 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 § 1334(b)(4) of the Affordable Care Act.

(i) Non-discrimination. In carrying out the requirements of this part, the MSPP issuer must:

(1) Comply with applicable non-discrimination statutes; and

(2) With respect to its MSP, not discriminate based on race, color, national origin disability, age, sex (including pregnancy and gender identity), or sexual orientation.

§ 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 the provisions of part A of title XXVII of the PHS Act, as determined by the Director, as listed in appendix A to this part.

(b) Affordable Care Act. As a condition of participation in the MSPP, an MSPP issuer must comply with the provisions of title I of the Affordable Care Act, as determined by the Director, as listed in appendix B to this part.

§ 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.

(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 (31 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 (36 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 (44 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's application for participation in the MSPP under section 800.301 and the MSPP issuer's information submitted to support renewal of the contract under section 800.305 must include 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) 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 noted 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.

(c) OPM selection of benchmark plans. (1) The OPM-selected EHB-benchmark plans are the three largest Federal Employees Health Benefits Program (FEHBP) plan options, as identified by HHS pursuant to section 1302(b) of the Affordable Care Act, and as supplemented pursuant to paragraphs (c)(2) through (4) of this section.

(2) Any EHB-benchmark plan selected by OPM under paragraph (c)(1) of this section lacking the coverage of pediatric oral services or pediatric vision services must be supplemented by the addition of the entire category of benefits from the largest Federal Employee Dental and Vision Insurance Program (FEDVIP) dental or vision plan options, respectively, pursuant to 45 CFR 156.110(b) and section 1302(b) of the Affordable Care Act.

(3) An MSPP issuer must follow State definitions where the State chooses to specifically define the habilitative services category pursuant to 45 CFR 156.110(f).

(4) Any EHB-benchmark plan selected by OPM under paragraph (c)(1) of this section must include, for each State, any State-required benefits enacted before December 31, 2011 that are included in the State's EHB-benchmark plan as described in paragraph (b)(1)(i) of this section, or specific to the market in which the plan is offered. In the case in which a State chooses not to define this category, OPM proposes that if any OPM-selected EHB-benchmark plan lacks coverage of habilitative services and devices, then OPM may determine what habilitative services and devices are to be included in that EHB-benchmark plan.

(d) OPM approval. An MSPP issuer's benefits package, including its prescription drug list, must be submitted to approved by OPM, which will review a benefits package proposed by an MSPP issuer and determine if it is substantially equal to an EHB-benchmark plan described in paragraph (b)(1) of this section pursuant to standards set forth by OPM or HHS including proposed 45 CFR 156.115, 156.120, and 156.125.

(e) State payments for additional State-required benefits. If a State requires that benefits in addition to the benchmark package be offered to MSP enrollees in that State, then pursuant to section 1334(c)(2) of the Affordable Care Act, the State must assume the cost of such additional benefits by making payments either to the enrollee or on behalf of the enrollee to the MSPP issuer.

§ 800.106 Cost-sharing limits, premium tax credits, and cost-sharing reductions.

(a) Cost-sharing limits. For each MSP it offers, an MSPP issuer must ensure that the cost-sharing provisions of the MSP comply with section 1302(c) of the Affordable Care Act as well as any applicable standards set by OPM or HHS.

(b) Premium tax credits and cost-sharing reductions. For each MSP it offers, an MSPP issuer must make available to an eligible individual the premium tax credits under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402 of the Affordable Care Act. An MSPP issuer must also comply with any applicable standards set by OPM or HHS.

§ 800.107 Levels of coverage.

(a) Silver and gold levels of coverage required. An MSPP issuer must offer at least one MSP at the silver level of coverage and at least one MSP at the gold level of coverage on each Exchange in which the issuer is certified to offer an MSP pursuant to a contract with OPM.

(b) Bronze or platinum metal levels of coverage permitted. Pursuant to a contract with OPM, an MSPP issuer may offer one or more MSPs at the bronze level of coverage or the platinum level of coverage, or both, on any Exchange or SHOP in any State.

(c) Child-only plans. For each level of coverage, the MSPP issuer must offer a child-only plan at the same level of coverage, as any health insurance coverage offered to individuals who, as of the beginning of the plan year, have not attained the age of 21.

(d) Plan variations for the reduction or elimination of cost sharing. An MSPP issuer must comply with section 1402 of the Affordable Care Act as well as any applicable standards set by OPM or HHS.

(e) OPM approval. An MSPP issuer must submit the levels of coverage plans and plan variations to OPM for review and approval by OPM.

§ 800.108 Assessments and user fees.

(a) Discretion to charge assessment and user fees. OPM may require an MSPP issuer to pay an assessment or user fee as a condition of participating in the MSPP.

(b) Determination of amount. The amount of the assessment or user fee charged by OPM for a plan year is the amount determined necessary by OPM to meet the costs of OPM's functions under the Affordable Care Act for a plan year, including but not limited to such functions as entering into contracts with, certifying, recertifying, decertifying, and overseeing MSPs and MSPP issuers for that plan year.

§ 800.109 Network adequacy.

(a) General requirement. An MSPP issuer must ensure that the provider network of each of its MSPs, as available to all enrollees, meets the following standards:

(1) Maintains a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay;

(2) Is consistent with the network adequacy provisions of section 2702 (c) of the Public Health Service Act; and

(3) Includes essential community providers in compliance with 45 CFR 156.235.

(b) Provider directory. An MSPP issuer must make its provider directory for an MSP available to the Exchange for publication online pursuant to guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, an MSPP issuer must identify providers that are not accepting new patients.

(c) OPM guidance. OPM will issue guidance containing the criteria and standards that it will use to determine the adequacy of a provider network.

§ 800.110 Service area.

An MSPP issuer must offer an MSP within one or more service areas in a State defined by each Exchange pursuant to 45 CFR 155.1055. If an Exchange permits issuers to define their service areas, an MSPP issuer must obtain OPM's approval for its proposed service areas. Pursuant to § 800.104, 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. For each State in which the MSPP issuer does not offer coverage in all service areas, the MSPP issuer's application for participation in the MSPP under section 800.301 and the MSPP issuer's information submitted to support renewal of the contract under section 800.305 must include 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 and will ensure MSPs meet QHP requirement in 45 CFR 155.1055(b).

§ 800.111 Accreditation requirement.

(a) General requirement. An MSPP issuer must be or become accredited consistent with the requirements for QHP issuers specified in section 1311 of the Affordable Care Act and in 45 CFR 156.275(a).

(b) Release of survey. An MSPP issuer must authorize the accrediting entity that accredits the MSPP issuer to release to OPM and to the Exchange a copy of its most recent

accreditation survey, together with any survey-related information that OPM or an Exchange may require, such as corrective action plans and summaries of findings.

(c) Timeframe for accreditation. An MSPP issuer that is not accredited as of the date that it enters into a contract with OPM must become accredited within the timeframe established by OPM as authorized by 45 CFR 155.1045.

§ 800.112 Reporting requirements.

(a) OPM specification of reporting requirements. OPM will specify the data and information that must be reported by an MSPP issuer, including data permitted or required by the Affordable Care Act and such other data as OPM may determine necessary for the oversight and administration of the MSPP. OPM will also specify the form, manner, processes, and frequency for the reporting of data and information. The Director of OPM may require that MSPP issuers submit claims payment and enrollment data to facilitate OPM's oversight and administration of the MSPP in a manner similar to the FEHBP.

(b) Quality and quality improvement standards. An MSPP issuer must comply with any standards required by OPM for reporting quality and quality improvement activities including, but not limited to, implementation of a quality improvement strategy, disclosure of quality measures to enrollees and prospective enrollees, reporting of pediatric quality measures, and implementation of rating and enrollee satisfaction surveys, which will be similar to standards under section 1311(c)(1)(E), (H), and (I), (c)(3), and (c)(4) of the Affordable Care Act.

§ 800.113 Benefit plan material or information.

(a) Compliance with Federal and State law. An MSPP issuer must comply with Federal and State laws relating to benefit plan material or information, including the provisions of this section and guidance issued by OPM specifying its standards, process, and timeline for approval of benefit plan material or information.

(b) General standards for MSP applications and notices. An MSPP issuer must provide all applications and notices to enrollees in accordance with the standards described in at 45 CFR 155.205(c). OPM may establish additional standards to meet the needs of MSP enrollees.

(c) Accuracy. An MSPP issuer is responsible for the accuracy of its benefit plan material or information.

(d) Truthful, not misleading, no material omissions, and plain language. All benefit plan material or information must be:

(1) Truthful, not misleading, and not contain material omissions; and

(2) Written in plain language, as defined in section 1311(e)(3)(B) of the Affordable Care Act.

(e) Uniform Explanation of Coverage Documents and Standardized Definitions. An MSPP issuer must comply with the provisions of section 2715 of the PHS Act and regulations issued to implement that section.

(f) OPM review and approval of benefit plan material or information. OPM may request an MSPP issuer submit to OPM benefit plan material or information, as defined in § 800.20.

OPM reserves the right to review and approve benefit plan material or information to ensure that an MSPP issuer complies with Federal and State laws, and the standards prescribed by OPM with respect to benefit plan material or information.

(g) Statement on certification by OPM. An MSPP issuer may include a statement in its benefit plan material or information that:

- (1) OPM has certified the MSP as eligible to be offered on the Exchange; and
- (2) OPM monitors the MSP for compliance with all applicable law.

§ 800.114 Compliance with applicable State law.

(a) Compliance with State law. An MSPP issuer must, with respect to each of its MSPs, generally comply with State law pursuant to section 1334(b)(2) of the Affordable Care Act.

However, the MSPs and MSPP issuers need not comply with State laws that:

- (1) Are inconsistent with section 1334 of the Affordable Care Act or this part;
- (2) Prevent the application of a requirement of part A of title XXVII of the PHS Act; and
- (3) Prevent the application of a requirement of title I of the Affordable Care Act.

(b) Determination of inconsistency. OPM reserves the right to determine, in its judgment, as effectuated through an MSPP contract, these regulations, or OPM guidance whether the standards set forth in paragraph (a) of this section are satisfied with respect to particular State laws. In making any such determinations, OPM will consider whether the State law at issue:

(1) Imposes on MSPP issuers or MSPs a requirement or requirements that differ from those applicable to QHP issuers and QHPs offered on one or more Exchanges in that State;

(2) Creates responsibilities, administrative burdens, or costs for an MSPP issuer that significantly deter or impede the MSPP issuer from offering a viable product on one or more Exchanges;

(3) Creates responsibilities, administrative burdens, or costs for OPM that significantly deter or impede OPM's effective implementation of the MSPP; or

(4) Prevents an MSPP issuer from offering an MSP on one or more Exchanges in that State.

§ 800.115 Level playing field.

An MSPP issuer must, with respect to each of its MSPs, meet the following requirements in order to ensure a level playing field:

(a) Guaranteed renewal. Guarantee that an enrollee can renew enrollment in an MSP in compliance with sections 2703 and 2742 of the PHS Act.

(b) Rating. In proposing premiums for OPM approval, use only the rating factors permitted under section 2701 of the PHS Act and State law.

(c) Preexisting conditions. Not impose any preexisting condition exclusion and comply with section 2704 of the PHS Act.

(d) Non-discrimination. Comply with section 2705 of the PHS Act.

(e) Quality improvement and reporting. Comply with all Federal and State quality improvement and reporting requirements. “Quality improvement and reporting” means quality improvement as defined in section 1311(h) of the Affordable Care Act and quality improvement plans or strategies required under State law, and quality reporting as defined in section 2717 of the PHS Act and section 1311(g) of the Affordable Care Act. Quality improvement also includes activities such as, but not limited to, implementation of a quality improvement strategy, disclosure of quality measures to enrollees and prospective enrollees, and reporting of pediatric quality measures, which will be similar to standards under section 1311(c)(1)(E), (H), and (I) of the Affordable Care Act.

(f) Fraud and abuse. Comply with all Federal and State fraud and abuse laws.

(g) Licensure. Be licensed in every State in which it offers an MSP.

(h) Solvency and financial requirements. Comply with the solvency standards set by each State in which it offers an MSP.

(i) Market conduct. Comply with the market conduct standards of each State in which it offers an MSP.

(j) Prompt payment. Adhere to applicable State law in negotiating the terms of payment in contracts with its providers and in making payments to claimants and providers.

(k) Appeals and grievances. Comply with Federal standards under section 2719 of the PHS Act for appeals and grievances relating to adverse benefit determinations, as described in subpart F.

(l) Privacy and confidentiality. Comply with all Federal and State privacy and security requirements and laws. Comply with any standards required by OPM in guidance or contract, which will be similar to the standards contained in 45 CFR part 162 and applicable State law.

(m) Benefit plan material or information. Comply with Federal and State law, including § 800.113 of this part.

§ 800.116 Process for dispute resolution.

(a) Determinations about applicability of State law under section 1334(b)(2) of the Affordable Care Act. In the event of a dispute about the applicability to an MSP or MSPP issuer of a State law not related to the 13 categories in section 1324(b) of the Affordable Care Act, the State may request that OPM reconsider a determination, made under section 800.114 that an MSP or MSPP issuer is not subject to such State law.

(b) Required demonstration. A State making a request under subparagraph (1) must demonstrate that the State law at issue:

(1) Is not inconsistent with section 1334 of the Affordable Care Act or this part;

(2) Does not prevent the application of a requirement of part A of title XXVII of the PHS Act; and

(3) Does not prevent the application of a requirement of title I of the Affordable Care Act.

(c) Request for review. The request must be in writing and include contact information, including the name, telephone number, e-mail address, and mailing address of the person or

persons whom OPM may contact regarding the request for review. The request must be in such form, contain such information, and be submitted in such manner and within such timeframe as OPM may prescribe.

(1) The requester may submit to OPM any relevant information to support its request.

(2) OPM may obtain additional information relevant to the request from any source as it may, in its judgment, deem necessary. OPM will provide the requester with a copy of any additional information it obtains and provide an opportunity for the requester to respond (including by submission of additional information or explanation).

(3) OPM will issue a written decision within 60 calendar days after receiving the written request, or after the due date for the response, whichever is later, unless a different timeframe is agreed upon.

(4) OPM's written decision will constitute final agency action that is subject to review under the Administrative Procedure Act in the appropriate U.S. district court. Such review is limited to the record that was before OPM when OPM made its decision.

Subpart C – Premiums, Rating Factors, Medical Loss Ratios, and Risk Adjustment

§ 800.201 General requirements.

(a) Premium negotiation. OPM will negotiate annually with an MSPP issuer, on a State by State basis, the premiums for each MSP offered by that issuer in that State. Such negotiations may include negotiations about the cost-sharing provisions of an MSP.

(b) Duration. Premiums will remain in effect for the plan year.

(c) Guidance on rate development. OPM will issue guidance addressing methods for the development of premiums for the MSPP. Such guidance will follow State rating standards generally applicable in a State to the greatest extent practicable.

(d) Calculation of actuarial value. An MSPP issuer must calculate actuarial value in the same manner as QHP issuers under section 1302(d) of the Affordable Care Act as well as any applicable standards set by OPM or HHS.

(e) OPM rate review process. An MSPP issuer must participate in the rate review process established by OPM to negotiate rates for MSPs. The rate review process established by OPM will be similar to the process established by HHS pursuant to section 2794 of the PHS Act and disclosure and review standards established under 45 CFR part 154.

(f) State Effective Rate Review. With respect to its MSPs, an MSPP issuer is subject to a State's rate review process including a State's Effective Rate Review program established by HHS pursuant to section 2794 of the PHS Act and 45 CFR part 154. In the event HHS is reviewing rates for a State pursuant to section 2794 of the PHS Act, then HHS will defer to OPM's judgment of the MSPs proposed rate increase.. In the event that a State withholds approval of an MSP rate for reasons that OPM determines, in its discretion, to be arbitrary, capricious, or an abuse of discretion, OPM retains authority to make the final decision to approve rates for participation in the MSPP notwithstanding the absence of State approval.

(g) Single risk pool. An MSPP issuer must consider all enrollees in an MSP to be in the same risk pool as all enrollees in all other health plans in the individual market or small group market, respectively, in compliance with section 1312(c) of the Affordable Care Act, 45 CFR 156.80, and any applicable Federal or State laws and regulations implementing section 1312(c).

§ 800.202 Rating factors.

(a) Permissible rating factors. In proposing premiums for each MSP, an MSPP issuer must use only the rating factors permitted under section 2701 of the PHS Act.

(b) Application of variations based on age or tobacco use. Rating variations permitted under section 2701(a) of the PHS Act must be applied by an MSPP issuer based on the portion of the premium attributable to each family member covered under the coverage in accordance with any applicable Federal or State laws and regulations implementing section 2701(a) of the PHS Act.

(c) Age rating. For age rating, an MSPP issuer must use the ratio established by the State in which the MSP is offered if it is less than 3:1.

(1) Age bands. An MSPP issuer must use the uniform age bands established under HHS regulations implementing section 2701(a) of the PHS Act.

(2) Age curves. An MSPP issuer must use the age curves established under HHS regulations implementing section 2701(a) of the PHS Act.

(d) Rating areas. An MSP must use the rating areas appropriate to the State in which the MSP is offered and established under HHS regulations implementing section 2701(a) of the PHS Act.

(e) Tobacco rating. An MSPP issuer must apply tobacco use as a rating factor in accordance with any applicable Federal or State laws and regulations implementing section 2701(a) of the PHS Act.

§ 800.203 Medical loss ratio.

(a) Required medical loss ratio. An MSPP issuer must attain:

(1) The medical loss ratio (MLR) required under section 2718 of the PHS Act and regulations promulgated by HHS; and

(2) Any MSP-specific MLR that OPM may set in the best interests of MSP enrollees or that is necessary to be consistent with a State's requirements with respect to MLR.

(b) Consequences of not attaining required medical loss ratio. If an MSPP issuer fails to attain an MLR set forth in paragraph (a), then OPM may take any appropriate action including, intermediate sanctions, such as suspension of marketing, but not limited to, decertifying a MSP in one or more States or terminating an MSPP issuer's contract pursuant to § 800.404.

§ 800.204 Reinsurance, risk corridors, and risk adjustment.

(a) Transitional reinsurance program. An MSPP issuer must comply with section 1341 of the Affordable Care Act, 45 CFR part 153, and any applicable Federal or State regulations under that section that sets forth requirements to implement the transitional reinsurance program for the individual market.

(b) Temporary risk corridors program. An MSPP issuer must comply with section 1342 of the Affordable Care Act, 45 CFR part 153, and any applicable Federal or State regulations under section 1342 that sets forth requirements to implement the risk corridor program.

(c) Risk adjustment program. An MSPP issuer must comply with participate in the risk adjustment program established pursuant to section 1343 of the Affordable Care Act, 45 CFR

part 153, and any applicable Federal or State regulations under section 1343 that sets forth requirements to implement the risk adjustment program.

Subpart D – Application and Contracting Procedures

§ 800.301 Application process.

(a) Acceptance of applications. Without regard to section 6101(b) through (d) of title 41, United States Code, or any other statute requiring competitive bidding, OPM may consider annually applications from health insurance issuers, including groups of health insurance issuers as defined in § 800.20, to participate in the MSPP. If OPM determines that it is not beneficial for the MSPP to consider new applications for an upcoming year, OPM will issue a notice to that effect.

(b) Form and manner of applications. An applicant must submit to OPM, in the form and manner, and in accordance with the timeline specified by OPM, the information requested by OPM for determining whether an applicant meets the requirements of this part.

§ 800.302 Review of applications.

(a) Determinations. OPM will determine if an applicant meets the requirements of this part. If OPM determines that an applicant meets the requirements of this part, OPM may accept the applicant to enter into contract negotiations with OPM to participate in the MSPP.

(b) Requests for additional information. OPM may request additional information from an applicant before making a decision about whether to enter into contract negotiations with that applicant to participate in the MSPP.

(c) Declination of application. If, after reviewing an application to participate in the MSPP, OPM declines to enter into contract negotiations with the applicant, OPM will inform the applicant in writing of the reasons for that decision.

(d) Discretion. The decision whether to enter into contract negotiations with a health insurance issuer who has applied to participate in the MSPP is committed to OPM's discretion.

(e) Impact on future applications. OPM's declination of an application to participate in the MSPP will not preclude the applicant from submitting an application for a subsequent year to participate in the MSPP.

§ 800.303 MSPP contracting.

(a) Participation in MSPP. To become an MSPP issuer, the applicant and the Director or his designee must sign a contract that meets the requirements of this part.

(b) Standard contract. OPM will establish a standard contract for the MSPP.

(c) Premiums. OPM and the applicant will negotiate the premiums for an MSP for each plan year in accordance with the provisions of subpart C.

(d) Benefit packages. OPM must approve the applicant's benefit packages for an MSP.

(e) Additional terms and conditions. OPM may elect to negotiate with an applicant such additional terms, conditions, and requirements that:

- (1) Are in the interests of MSP enrollees; or
- (2) OPM determines to be appropriate.

(f) Certification to offer health insurance coverage. (1) For each plan year, an MSPP contract will contain a certification that specifies the Exchanges in which the MSPP issuer is authorized to offer an MSP, as well as the specific benefit packages authorized to be offered on each Exchange and the premiums to be charged for each benefit package on each Exchange.

(2) An MSPP issuer cannot offer an MSP on an Exchange unless its MSPP contract with OPM includes a certification authorizing the MSPP issuer to offer the MSP on that Exchange in accordance with paragraph (f)(1) of this section.

§ 800.304 Term of the contract.

(a) Term of a contract. The term of the contract will be specified in the MSPP contract and must be for a period of at least the 12 consecutive months defined as the plan year.

(b) Plan year. The plan year is a consecutive 12 month period during which an MSP provides coverage for health benefits. A plan year may be a calendar year or otherwise.

§ 800.305 Contract renewal process.

(a) Renewal. To continue participating in the MSPP, an MSPP issuer must provide to OPM, in the form and manner, and in accordance with the timeline prescribed by OPM, the information requested by OPM for determining whether the MSPP issuer continues to meet the requirements of this part.

(b) OPM decision. Subject to paragraph (c) of this section, OPM will renew the MSPP contract of an MSPP issuer who timely submits the information described in paragraph (a) of this section.

(c) OPM discretion not to renew. OPM may decline to renew the contract of an MSPP issuer if:

(1) OPM and the MSPP issuer fail to agree on premiums and benefits for an MSP for the subsequent plan year;

(2) The MSPP issuer has engaged in conduct described in § 800.404(a); or

(3) OPM determines that the MSPP issuer will be unable to comply with a material provision of section 1334 of the Affordable Care Act or this part.

(d) Failure to agree on premiums and benefits. Except as otherwise provided in this part, if an MSPP issuer has complied with paragraph (a) of this section and OPM and the MSPP issuer fail to agree on premiums and benefits for an MSP on one or more Exchanges for the subsequent plan year by the date required by OPM, either party may provide notice of nonrenewal pursuant to § 800.306 or OPM may in its discretion withdraw the certification of that MSP on the Exchange or Exchanges for that plan year. In addition, if OPM and the MSPP issuer fail to agree on benefits and premiums for an MSP on one or more Exchanges by the date set by OPM and in the event of no action (no notice of nonrenewal or renewal) by either party, the MSPP contract will be renewed and the existing premiums and benefits for that MSP on that Exchange or Exchanges will remain in effect for the subsequent plan year.

§ 800.306 Nonrenewal.

(a) Definition of nonrenewal. As used in this subpart and subpart E of this part, “nonrenewal” means a decision by either OPM or an MSPP issuer not to renew an MSPP contract.

(b) Notice required. Either OPM or an MSPP issuer may decline to renew an MSPP contract by providing a written notice of nonrenewal to the other party.

(c) MSPP issuer responsibilities. The MSPP issuer's written notice of nonrenewal must be made in accordance with its MSPP contract with OPM. The MSPP issuer must also adhere to any requirements imposed by an Exchange with respect to the termination of a QHP, including the requirement to provide advance written notice of termination to enrollees. If an Exchange does not have requirements about advance written notice of termination to enrollees, the MSPP issuer must inform current MSP enrollees in writing of the MSP's termination no later than 90 days prior to termination, unless OPM determines that there is good cause for less than 90 days' notice.

Subpart E – Compliance

§ 800.401 Contract performance.

(a) General. An MSPP issuer must perform an MSPP contract with OPM in accordance with the requirements of section 1334 of the Affordable Care Act and the requirements of this part. The MSPP issuer must continue to meet such requirements while under an MSPP contract with OPM.

(b) Specific requirements for issuers. In addition to the requirements described in paragraph (a) of this section, the following requirements apply to each MSPP issuer:

(1) It must have, in the judgment of OPM, the financial resources to carry out its obligations under the MSPP;

(2) It must keep such reasonable financial and statistical records, and furnish to OPM such reasonable financial and statistical reports with respect to the MSP or the MSPP, as may be requested by OPM;

(3) It must permit representatives of OPM (including the OPM Office of Inspector General), the U.S. Government Accountability Office, and any other applicable Federal government auditing entities to audit and examine its records and accounts which pertain, directly or indirectly, to the MSP at such reasonable times and places as may be designated by OPM or the U.S. Government Accountability Office;

(4) It must timely submit to OPM a properly completed and signed novation or change-of-name agreement in accordance with 48 CFR part 42 subpart 42.12;

(5) It must perform the MSPP contract in accordance with prudent business practices, as described in paragraph (c) of this section; and

(6) It must not perform the MSPP contract in accordance with poor business practices, as described in paragraph (d) of this section.

(c) Prudent business practices. For purposes of paragraph (b)(5) of this section, prudent business practices include, but are not limited to, the following:

- (1) Timely compliance with OPM instructions and directives;
- (2) Legal and ethical business and health care practices;
- (3) Compliance with the terms of the MSPP contract, regulations, and statutes;
- (4) Timely and accurate adjudication of claims or rendering of medical services;

(5) Operating a system for accounting for costs incurred under the MSPP contract, which includes segregating and pricing MSP medical utilization and allocating indirect and administrative costs in a reasonable and equitable manner;

(6) Maintaining accurate accounting reports of costs incurred in the administration of the MSPP contract;

(7) Applying performance standards for assuring contract quality as outlined at § 800.402; and

(8) Establishing and maintaining a system of internal controls that provides reasonable assurance that:

(i) The provision and payments of benefits and other expenses comply with legal, regulatory, and contractual guidelines;

(ii) MSP funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and

(iii) Data are accurately and fairly disclosed in all reports required by OPM.

(d) Poor business practices. For purposes of paragraph (b)(6) of this section, poor business practices include, but are not limited to, the following:

(1) Using fraudulent or unethical business or health care practices or otherwise displaying a lack of business integrity or honesty;

(2) Repeatedly or knowingly providing false or misleading information in the rate setting process;

(3) Failing to comply with OPM instructions and directives;

(4) Having an accounting system that is incapable of separately accounting for costs incurred under the contract and/or that lacks the internal controls necessary to fulfill the terms of the contract;

(5) Failing to assure that the MSP properly pays or denies claims, or if applicable, provides medical services that are inconsistent with standards of good medical practice; and

(6) Entering into contracts or employment agreements with providers, provider groups, or health care workers that include provisions or financial incentives that directly or indirectly create an inducement to limit or restrict communication about medically necessary services to any individual covered under the MSPP. Financial incentives are defined as bonuses, withholds, commissions, profit sharing or other similar adjustments to basic compensation (e.g., service fee, capitation, salary) which have the effect of limiting or reducing communication about appropriate medically necessary services.

(e) Performance escrow account. OPM may require MSPP issuers to pay an assessment into an escrow account to ensure contract compliance and benefit MSP enrollees.

§ 800.402 Contract quality assurance.

(a) General. This section prescribes general policies and procedures to ensure that services acquired under MSPP contracts conform to the contract's quality requirements.

(b) Internal controls. OPM will periodically evaluate the contractor's system of internal controls under the quality assurance program required by the contract and will acknowledge in

writing whether or not the system is consistent with the requirements set forth in the contract. OPM's reviews do not diminish the contractor's obligation to implement and maintain an effective and efficient system to apply the internal controls.

(c) Performance standards. (1) OPM will issue specific performance standards for MSPP contracts and will inform MSPP issuers of the applicable performance standards prior to negotiations for the contract year. OPM may benchmark its standards against standards generally accepted in the insurance industry. OPM may authorize nationally recognized standards to be used to fulfill this requirement.

(2) MSPP issuers must comply with the performance standards issued under this section.

§ 800.403 Fraud and abuse.

(a) Program required. An MSPP issuer must conduct a program to assess its vulnerability to fraud and abuse as well as to address such vulnerabilities.

(b) Fraud detection system. An MSPP issuer must operate a system designed to detect and eliminate fraud and abuse by employees and subcontractors of the MSPP issuer, by providers furnishing goods or services to MSP enrollees, and by MSP enrollees.

(c) Submission of information. An MSPP issuer must provide to OPM (including its Office of Inspector General) such information or assistance as may be necessary for the agency to carry out the duties and responsibilities specified in sections 4 and 6 of the Inspector General Act of 1978 (5 U.S.C. App.). An MSPP issuer must provide any requested information in the form, manner, and timeline prescribed by OPM.

§ 800.404 Compliance actions.

(a) Causes for OPM compliance actions. The following constitute cause for OPM to impose a compliance action described in paragraph (b) of this section against an MSPP issuer:

(1) Failure by the MSPP issuer to meet the requirements described in § 800.401(a) and (b);

(2) An MSPP issuer's sustained failure to perform the MSPP contract in accordance with prudent business practices, as described in § 800.401(c);

(3) A pattern of poor conduct or evidence of poor business practices such as those described in § 800.401(d); or

(4) Such other violations of law or regulation as OPM may determine.

(b) Compliance actions. (1) OPM may impose a compliance action against an MSPP issuer at any time during the contract term if it determines that the MSPP issuer is not in compliance with applicable law, this part, or the terms of its contract with OPM.

(2) Compliance actions may include, but are not limited to:

- (i) Establishment and implementation of a corrective action plan;
- (ii) Imposition of intermediate sanctions such as suspension of marketing;
- (iii) Performance incentives;
- (iv) Reduction of service area or area(s);

(v) Withdrawal of the certification of the MSPP issuer to offer the MSP on one or more Exchanges;

(vi) Nonrenewal of the MSPP contract; and

(vii) Withdrawal of approval or termination of the MSPP contract.

(c) Notice of compliance action. (1) OPM must notify an MSPP issuer in writing of a compliance action under this section. Such notice must indicate the specific compliance action undertaken and the reason for the compliance action.

(2) For compliance actions listed in § 800.404(b)(2)(v) through (vii), such notice must include a statement that the MSPP issuer is entitled to request a reconsideration of OPM's determination to impose a compliance action pursuant to § 800.405.

(d) Notice to enrollees. If OPM terminates an MSPP issuer's MSPP contract with OPM, or OPM withdraws the MSPP issuer's certification to offer the MSP on an Exchange, the MSPP issuer must adhere to any requirements imposed by an Exchange in which the MSP was offered with respect to the termination of a QHP, including the requirement to provide advance written notice of termination to enrollees. If an Exchange does not have requirements about advance written notice of termination to enrollees, the MSPP issuer must inform current MSP enrollees in writing of the MSP's termination no later than 90 days prior to termination, unless OPM determines that there is good cause for less than 90 days' notice.

(e) Definition. As used in this subpart, "termination" means a decision by OPM to cancel an MSPP contract prior to the end of its contract term. The term includes OPM's withdrawal of approval of an MSPP contract.

§ 800.405 Reconsideration of compliance actions.

(a) Right to request reconsideration. An MSPP issuer may request that OPM reconsider a determination to impose one of the following compliance actions:

(1) Withdrawal of the certification of the MSPP issuer to offer the MSP on one or more Exchanges.

(2) Nonrenewal of the MSPP contract; or

(3) Termination of the MSPP contract;

(b) Request for reconsideration and/or hearing. (1) An MSPP issuer with a right to request reconsideration specified in paragraph (a) of this section may request a hearing in which OPM will reconsider its determination to impose a compliance action.

(2) A request under this section must be in writing and contain contact information, including the name, telephone number, email address, and mailing address of the person or persons whom OPM may contact regarding a request for a hearing with respect to the reconsideration. The request must be in such form, contain such information, and be submitted in such manner as OPM may prescribe.

(3) The request must be received by OPM within 15 calendar days after the date of the MSPP issuer's receipt of the notice of compliance action. The MSPP issuer may request that OPM's reconsideration allow a representative of the MSPP issuer to appear personally before OPM.

(4) A request under this section must include a detailed statement of the reasons that the MSPP issuer disagrees with OPM's imposition of the compliance action, and may include any additional information that will assist OPM in rendering a final decision under this section.

(5) OPM may obtain additional information relevant to the request from any source as it may, in its judgment, deem necessary. OPM will provide the MSPP issuer with a copy of any additional information it obtains and provide an opportunity for the MSPP issuer to respond (including by submission of additional information or explanation).

(6) OPM's reconsideration and hearing if requested may be conducted by the Director or a representative designated by the Director who did not participate in the initial decision that is the subject of the request for review.

(c) Notice of final decision. OPM will notify the MSPP issuer, in writing, of OPM's final decision on the MSPP issuer's request for reconsideration and the specific reasons for that final decision. OPM's written decision will constitute final agency action that is subject to review under the Administrative Procedure Act in the appropriate U.S. district court. Such review is limited to the record that was before OPM when it made its decision.

Subpart F – Appeals by Enrollees for Denials of Claims for Payment or Service

§ 800.501 General requirements.

(a) Definitions. For purposes of this subpart:

(1) Claim means a request for:

(i) Payment of a health-related bill; or

(ii) Provision of a health-related service or supply.

(2) Adverse benefit determination means an adverse benefit determination as defined in 45 CFR 147.136(a)(2)(i).

(b) Applicability. This subpart applies to enrollees and to other individuals or entities who are acting on behalf of an enrollee and who have the enrollee's specific written consent to pursue a remedy of an adverse benefit determination.

§ 800.502 MSPP issuer internal claims and appeals processes.

MSPP issuers are required to comply with the internal claims and appeals processes applicable to group health plans and health insurance issuers under 45 CFR 147.136(b).

§ 800.503 MSPP issuer internal claims and appeals timeframes and notice of determination.

An MSPP issuer must provide written notice to an enrollee of its determination on a claim brought under § 800.502 according to the timeframes and notification rules under 45 CFR 147.136(b) and (e), including the timeframes for urgent claims. If the MSPP issuer denies a claim (or a portion of the claim), the enrollee may appeal the adverse benefit determination to the MSPP issuer in accordance with 45 CFR 147.136(b).

§ 800.504 External review.

(a) External review by OPM. OPM will conduct external review of adverse benefit determinations using a process similar to OPM review of disputed claims under 5 CFR 890.105(e), subject to the standards and timeframes set forth at 45 CFR 147.136(c)(2).

(b) Notice. Notices to MSP enrollees regarding external review under paragraph (a) of this section must comply with 45 CFR 147.136(e), and are subject to review and approval by OPM.

(c) Issuer obligation. An MSPP issuer must pay a claim or provide a health-related service or supply pursuant to OPM's final decision or the final decision of an independent review organization without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

§ 800.505 Judicial review.

OPM's written decision under § 800.504(a) will constitute final agency action that is subject to review under the Administrative Procedure Act in the appropriate U.S. district court. Such review is limited to the record that was before OPM when it made its decision.

Subpart G – Miscellaneous

§ 800.601 Reservation of authority.

OPM reserves the right to implement and supplement these regulations with written operational guidelines.

§ 800.602 Consumer choice with respect to certain services.

(a) Assured availability of varied coverage. Consistent with § 800.104, OPM will ensure that at least one of the MSPP issuers on each Exchange in each State offers at least one MSP that does not provide coverage of services described in section 1303(b)(1)(B) of the Affordable Care Act.

(b) State opt-out. An MSP may not offer abortion coverage in any State where such coverage of abortion services is prohibited by State law.

Appendix A to Part 800—Applicable Provisions of Part A of title XXVII of the PHS Act

Section 2701: Fair Health Insurance Premiums

Section 2702: Guaranteed Availability of Coverage

Section 2703: Guaranteed Renewability of Coverage

Section 2704: Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status

Section 2705: Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status

Section 2706: Non-Discrimination in Health Care

Section 2707: Comprehensive Health Insurance Coverage

Section 2708: Prohibition on Excessive Waiting Periods

Section 2709: Coverage for Individuals Participating in Approved Clinical Trials.

Section 2709 [sic]: Disclosure of Information

Section 2711: No Lifetime or Annual Limits

Section 2712: Prohibition on Rescissions

Section 2713: Coverage of Preventive Health Services

Section 2714: Extension of Dependent Coverage

Section 2715: Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions

Section 2715A: Provision of Additional Information

Section 2717: Ensuring the Quality of Care

Section 2718: Bringing Down the Cost of Health Care Coverage

Section 2719: Appeals Process

Section 2719A: Patient Protections

Section 2725: Standards Relating to Benefits for Mothers and Newborns [in the Group Market]

Section 2726: Parity in Mental Health and Substance Use Disorder Benefits

Section 2727: Required Coverage for Reconstructive Surgery Following Mastectomies

Section 2728: Coverage of Dependent Students on Medically Necessary Leave of Absence

Section 2741: Guaranteed Availability of Individual Health Insurance Coverage to Certain Individuals with Prior Group Coverage

Section 2742: Guaranteed Renewability of Individual Health Insurance Coverage

Section 2743: Certification of Coverage

Section 2751: Standards Relating to Benefits for Mothers and Newborns [in the Individual Market]

Section 2752: Required Coverage for Reconstructive Surgery Following Mastectomies

Section 2753: Prohibition of Health Discrimination on the Basis of Genetic Information

Section 2753 [sic]: Coverage of Dependent Students on Medically Necessary Leave of Absence

Appendix B to Part 800—Applicable Provisions of the Affordable Care Act

Section 1302: Essential Health Benefits Requirements

Section 1303: Special Rules

Section 1304: Related Definitions

Section 1311: Affordable Choices of Health Benefit Plans

Section 1334: Multi-State Plans

Section 1341: Transitional Reinsurance Program for Individual Market in Each State

Section 1342: Establishment of Risk Corridors for Plans in Individual and Small Group Markets

Section 1343: Risk Adjustment

Section 1401: Refundable Premium Tax Credit Providing Premium Assistance for Coverage under a Qualified Health Plan

Section 1402: Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans

Section 1412(c): Payment of Premium Tax Credits and Cost-sharing Reductions

Section 1557: Nondiscrimination

Section 6005: Pharmacy Benefit Managers Transparency Requirements

Appendix C to Part 800—Applicable Provisions of the Internal Revenue Code

Section 36B: Internal Revenue Code of 1986

[FR Doc. 2012-29118 Filed 11/30/2012 at 11:15 am; Publication Date: 12/05/2012]