§ 800.103 Authority to contract with issuers.

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

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

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

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

§ 800.104 Phased expansion.

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

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

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

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

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

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

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

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

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

§ 800.105 Benefits.

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

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

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

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

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

(2) An issuer applying to participate in the MSPP must select one of the two benefits package options described in paragraph (b)(1) of this section in its application.
(3) An issuer must comply with any State standards relating to substitution of benchmark benefits or standard benefit designs.

(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 (c)(4) of this section.

(2) Any EHB-benchmark plan selected by OPM under paragraph (c)(1) of this section 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 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 and devices category pursuant to 45 CFR 156.110(f). In the case of any State that chooses not to define this category, if any OPM-selected EHB-benchmark plan lacks coverage of habilitative services and devices, OPM may determine what habilitative service and devices are to be included in that EHB-benchmark plan.

(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.

(d) OPM approval. An MSPP issuer’s benefits package, including its prescription drug list, must be submitted for approval 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 and HHS, including 45 CFR 156.115, 156.122, 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, advance payments of 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) Advance payments of premium tax credits and cost-sharing reductions. For each MSP it offers, an MSPP issuer must ensure that an eligible individual receives the benefit of advance payments of premium tax credits under section 36B of the Internal Revenue Code 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