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## 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 Benefits 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 Plan (MSP) options 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 MSP Program and standards for an enrollee in an MSP option to appeal denials of payment or services by an MSP issuer.

### § 800.20 Definitions.

For purposes of this part:

*Actuarial value (AV)* has the meaning given that term in 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 that 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 that term in 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 MSP options 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 *FEHB Program* 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 that 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 health maintenance organization contract offered by a health insurance issuer. Health insur-

ance 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 a health maintenance organization) 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.

*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 option* or *MSP option* means a discrete pairing of a package of benefits with particular cost sharing (which does not include premium rates or premium rate quotes) that is offered pursuant to a contract with OPM pursuant to section 1334 of the Affordable Care Act and meets the requirements of 45 CFR part 800.

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

*Multi-State Plan Program issuer* or *MSP 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.

*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 that term in 45 CFR 156.20.

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

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

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

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

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

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

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

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

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

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

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

*State-level issuer* means a health insurance issuer designated by the Multi-State Plan (MSP) issuer to offer an MSP option or MSP options. The State-level issuer may offer health insurance coverage through an MSP option in all or part of one or more States.

### Subpart B—Multi-State Plan Program Issuer Requirements

#### § 800.101 General requirements.

An MSP 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 of this part;

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

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

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

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

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

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

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### § 800.102 Compliance with Federal law.

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

(b) *Affordable Care Act.* As a condition of participation in the MSP Program, an MSP issuer must comply with applicable provisions of title I of the Affordable Care Act. Compliance shall be determined by the Director.

### § 800.103 Authority to contract with issuers.

(a) *General.* OPM may enter into contracts with health insurance issuers to offer at least two MSP options 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 MSP options, 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 MSP options may be with a group of issuers as defined in § 800.20 of this part.

(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, etc.

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

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

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

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

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

(b) *Partial coverage within a State.* (1) OPM may enter into a contract with an MSP issuer even if the MSP issuer's MSP options for a State cover fewer than all the service areas specified for that State pursuant to § 800.110 of this part.

(2) If an issuer offers both an MSP option and QHP on the same Exchange, an MSP issuer must offer MSP coverage in a service area or areas that is equal to the greater of:

(i) The QHP service area defined by the issuer or,

(ii) The service area specified for that State pursuant to § 800.110 of this part covered by the issuer's QHP.

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

(2) An MSP issuer must comply with State standards governing participation in a State-based SHOP, consistent with § 800.114. For these State-based SHOP standards, OPM retains discretion to allow an MSP 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 MSP 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) *Package of benefits.* (1) An MSP issuer must offer a package of benefits that includes the essential health benefits (EHB) described in section 1302 of the Affordable Care Act for each MSP option within a State.

(2) The package of benefits 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 and any applicable standards set by HHS.

(b) *Package of benefits options.* (1) An MSP issuer must offer at least one uniform package of benefits in each State 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 MSP Program may select either or both of the package of benefits options described in paragraph (b)(1) of this section in its application. In each State, the issuer may choose one EHB-benchmark for each product it offers.

(3) An MSP 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 (FEHB) Program 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 (5) of this section.

(2) Any EHB-benchmark plan selected by OPM under paragraph (c)(1) 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) In all States where an MSP issuer uses the OPM-selected EHB-benchmark plan, the MSP issuer may manage formularies around the needs of anticipated or actual users, subject to approval by OPM.

(4) An MSP issuer must follow the definition of habilitative services and devices as follows:

(i) An MSP issuer must follow the Federal definitions where HHS specifically defines habilitative services and devices if the State does not define the term, if the State defines the term in a conflicting way, or if the State definition is less stringent than the Federal definition.

(ii) An MSP issuer must follow State definitions where the State specifically defines the habilitative services and devices category pursuant to 45 CFR 156.110(f) and the State definition is not in conflict with the Federal definition or goes above the standards set in the Federal definition.

(iii) In the case of any State that does not define this category and absent a clearly applicable Federal definition, if any OPM-selected EHB-benchmark plan lacks coverage of habilitative services and devices, OPM may determine what habilitative services and devices are to be included in that EHB-benchmark plan.

(5) 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 MSP issuer's package of benefits, including its formulary, must be submitted for approval by OPM, which will review a package of benefits proposed by an MSP 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 any applicable standards set forth by 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 defray the cost of such additional benefits by making payments either to the enrollee or to the MSP issuer on behalf of the enrollee.

**§ 800.106 Cost-sharing limits, advance payments of premium tax credits, and cost-sharing reductions.**

(a) *Cost-sharing limits.* For each MSP option it offers, an MSP issuer must ensure that the cost-sharing provisions of the MSP option comply with section 1302(c) of the Affordable Care Act, as

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well as any applicable standards set by OPM or HHS.

(b) *Advance payments of premium tax credits and cost-sharing reductions.* For each MSP option it offers, an MSP 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 MSP 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 MSP issuer must offer at least one MSP option at the silver level of coverage and at least one MSP option at the gold level of coverage on each Exchange in which the issuer is certified to offer an MSP option pursuant to a contract with OPM.

(b) *Bronze or platinum metal levels of coverage permitted.* Pursuant to a contract with OPM, an MSP issuer may offer one or more MSP options 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 MSP issuer must offer a child-only MSP option 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 MSP 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 MSP 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.* Beginning in plan year 2015, OPM may require an MSP issuer to pay an assessment or user fee as a condition of participating in the MSP Program.

(b) *Determination of amount.* The amount of the assessment or user fee charged by OPM for a plan year is the

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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 MSP options and MSP issuers for that plan year. The amount of the assessment or user fee charged by OPM will be offset against the assessment or user fee amount required by any State-based Exchange or federally-facilitated Exchange such that the total of all assessments and user fees paid by the MSP issuer for the year for the MSP option shall be no greater than nor less than the amount of the assessment or user fee paid by QHP issuers in that State-based Exchange or federally-facilitated Exchange for that year.

(c) *Process for collecting MSP assessment or user fees.* OPM may require an MSP issuer to make payment of the MSP Program assessment or user fee amount directly to OPM, or may establish other mechanisms for the collection process.

### § 800.109 Network adequacy.

(a) *General requirement.* An MSP issuer must ensure that the provider network of each of its MSP options, 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 MSP issuer must make its provider directory for an MSP option 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 MSP 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 MSP issuer must offer an MSP option 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 MSP issuer must obtain OPM's approval for its proposed service areas. Pursuant to § 800.104 of this part, OPM may enter into a contract with an MSP issuer even if the MSP issuer's MSP options for a State cover fewer than all the service areas specified for that State. MSP options will follow the same standards for service areas for QHPs pursuant to 45 CFR 155.1055.

**§ 800.111 Accreditation requirement.**

(a) *General requirement.* An MSP issuer must be or become accredited consistent with the requirements for QHP issuers specified in section 1311 of the Affordable Care Act and 45 CFR 156.275(a)(1).

(b) *Release of survey.* An MSP issuer must authorize the accrediting entity that accredits the MSP 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 MSP 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 MSP 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 MSP Program. OPM will also specify the form, manner, processes, and frequency for the reporting of data and information. The Director may require that MSP issuers submit claims payment and enrollment data to facilitate OPM's oversight and administration of

the MSP Program in a manner similar to the FEHB Program.

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

(1) *Accuracy.* An MSP issuer is responsible for the accuracy of its benefit plan material or information.

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

(i) Truthful, not misleading, and without material omissions; and

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

(3) *Uniform explanation of coverage documents and standardized definitions.* An MSP issuer must comply with the provisions of section 2715 of the PHS Act and regulations issued to implement that section.

(4) *OPM review and approval of benefit plan material or information.* OPM may request an MSP issuer to submit to

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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 MSP issuer complies with Federal and State laws, and the standards prescribed by OPM with respect to benefit plan material or information.

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

(i) OPM has certified the MSP option as eligible to be offered on the Exchange; and

(ii) OPM monitors the MSP option for compliance with all applicable law.

### § 800.114 Compliance with applicable State law.

(a) *Compliance with State law.* An MSP issuer must, with respect to each of its MSP options, generally comply with State law pursuant to section 1334(b)(2) of the Affordable Care Act. However, the MSP options and MSP issuers are not subject to 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; or

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

(b) *Determination of inconsistency.* After consultation with the State and HHS, OPM reserves the right to determine, in its judgment, as effectuated through an MSP Program 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.

### § 800.115 Level playing field.

An MSP issuer must, with respect to each of its MSP options, meet the following requirements in order to ensure a level playing field, subject to §800.114:

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

(b) *Rating.* In proposing premiums for OPM approval, use only the rating fac-

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tors 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 option;

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

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

(j) *Prompt payment.* Comply with 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 of this part;

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

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45 CFR part 164 and applicable State law; and

(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 option or MSP issuer of a State law, the State may request that OPM reconsider a determination that an MSP option or MSP issuer is not subject to such State law.

(b) *Required demonstration.* A State making a request under paragraph (a) of this section 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, email 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 a response under paragraph (c)(2) of this section, 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 MSP issuer, on a State by State basis, the premiums for each MSP option offered by that issuer in that State. Such negotiations may include negotiations about the cost-sharing provisions of an MSP option.

(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 MSP Program. That guidance will follow State rating standards generally applicable in a State, to the greatest extent practicable.

(d) *Calculation of actuarial value.* An MSP 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 MSP issuer must participate in the rate review process established by OPM to negotiate rates for MSP options. 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 MSP options, an MSP 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, HHS will defer to OPM's judgment regarding the MSP options'

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proposed rate increase. If a State withholds approval of an MSP option and OPM determines, in its discretion, that the State's action would prevent OPM from administering the MSP Program, OPM retains authority to make the final decision to approve rates for participation in the MSP Program, notwithstanding the absence of State approval.

(g) *Single risk pool.* An MSP issuer must consider all enrollees in an MSP option to be in the same risk pool as all enrollees in all other health plans in the individual market or the 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 that section.

### § 800.202 Rating factors.

(a) *Permissible rating factors.* In proposing premiums for each MSP option, an MSP 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 of the PHS Act must be applied by an MSP 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 MSP issuer must use the ratio established by the State in which the MSP option is offered, if it is less than 3:1.

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

(2) *Age curves.* An MSP issuer must use the age curves established under HHS regulations implementing section 2701(a) of the PHS Act, or age curves established by a State pursuant to HHS regulations.

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

(e) *Tobacco rating.* An MSP issuer must apply tobacco use as a rating fac-

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tor in accordance with any applicable Federal or State laws and regulations implementing section 2701(a) of the PHS Act.

(f) *Wellness programs.* An MSP issuer must comply with any applicable Federal or State laws and regulations implementing section 2705 of the PHS Act.

### § 800.203 Medical loss ratio.

(a) *Required medical loss ratio.* An MSP 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 MSP issuer fails to attain an MLR set forth in paragraph (a) of this section, OPM may take any appropriate action, including but not limited to intermediate sanctions, such as suspension of marketing, decertifying an MSP option in one or more States, or terminating an MSP issuer's contract pursuant to § 800.404 of this part.

### § 800.204 Reinsurance, risk corridors, and risk adjustment.

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

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

(c) *Risk adjustment program.* An MSP issuer must comply with section 1343 of the Affordable Care Act, 45 CFR part 153, and any applicable Federal or State regulations under section 1343 that set 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 41 U.S.C. 6101(b)–(d), or any other statute requiring competitive bidding, OPM may consider annual applications from health insurance issuers, including groups of health insurance issuers as defined in § 800.20, to participate in the MSP Program. If OPM determines that it is not beneficial for the MSP Program to consider new issuer applications for an upcoming year, OPM will issue a notice to that effect. Each existing MSP issuer may complete a renewal application annually.

(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 MSP Program.

(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 MSP Program.

(c) *Declination of application.* If, after reviewing an application to participate in the MSP Program, 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 MSP Program is committed to OPM's discretion.

(e) *Impact on future applications.* OPM's declination of an application to participate in the MSP Program will

not preclude the applicant from submitting an application for a subsequent year to participate in the MSP Program.

#### § 800.303 MSP Program contracting.

(a) *Participation in MSP Program.* To become an MSP issuer, the applicant and the Director or the Director's designee must sign a contract that meets the requirements of this part.

(b) *Standard contract.* OPM will establish a standard contract for the MSP Program.

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

(d) *Package of benefits.* OPM must approve the applicant's package of benefits for its MSP option.

(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 MSP Program contract will specify MSP options that OPM has certified, the specific package(s) of benefits authorized to be offered on each Exchange, and the premiums to be charged for each package of benefits on each Exchange.

(2) An MSP issuer may not offer an MSP option on an Exchange unless its MSP Program contract with OPM includes a certification authorizing the MSP issuer to offer the MSP option 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 MSP Program 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 option provides coverage for health benefits. A plan year may be a calendar year or otherwise.

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### § 800.305 Contract renewal process.

(a) *Renewal.* To continue participating in the MSP Program, an MSP 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 MSP issuer continues to meet the requirements of this part.

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

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

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

(2) The MSP issuer has engaged in conduct described in § 800.404(a) of this part; or

(3) OPM determines that the MSP 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 MSP issuer has complied with paragraph (a) of this section and OPM and the MSP issuer fail to agree on premiums and benefits for an MSP option 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 of this part, or OPM may in its discretion withdraw the certification of that MSP option on the Exchange or Exchanges for that plan year. In addition, if OPM and the MSP issuer fail to agree on benefits and premiums for an MSP option 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 MSP Program contract will be renewed and the existing premiums and benefits for that MSP option on that Exchange or Exchanges will remain in effect for the subsequent plan year.

### § 800.306 Nonrenewal.

(a) *Nonrenewal.* Nonrenewal may pertain to the MSP issuer or the State-

level issuer. The circumstances under which nonrenewal may occur are:

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

(2) *Nonrenewal of participation.* As used in this subpart and subpart E of this part, “nonrenewal of participation” means a decision by OPM, an MSP issuer, or a State-level issuer not to renew a State-level issuer’s participation in a MSP Program contract.

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

(c) *MSP issuer responsibilities.* The MSP issuer’s written notice of nonrenewal must be made in accordance with its MSP Program contract with OPM. The MSP issuer also must comply with any requirements regarding the termination of a plan that are applicable to a QHP offered on an Exchange on which the MSP option was offered, including a requirement to provide advance written notice of termination to enrollees. MSP issuers shall provide written notice to enrollees in accordance with § 800.404(d).

## Subpart E—Compliance

### § 800.401 Contract performance.

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

(b) *Specific requirements for issuers.* In addition to the requirements described in paragraph (a) of this section, each MSP issuer must:

(1) Have, in the judgment of OPM, the financial resources to carry out its obligations under the MSP Program;

(2) Keep such reasonable financial and statistical records, and furnish to OPM such reasonable financial and statistical reports with respect to the MSP option or the MSP issuer, as may be requested by OPM;

(3) 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 that pertain, directly or indirectly, to the MSP option at such reasonable times and places as may be designated by OPM or the U.S. Government Accountability Office;

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

(5) Perform the MSP Program contract in accordance with prudent business practices, as described in paragraph (c) of this section; and

(6) Not perform the MSP Program contract in accordance with poor business practices, as described in paragraph (d) of this section.

(c) *Prudent business practices.* OPM will consider an MSP issuer's specific circumstances and facts in using its discretion to determine compliance with paragraph (b)(5) of this section. 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 MSP Program 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 MSP Program contract, which includes segregating and pricing MSP option 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 MSP Program 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 is accurately and fairly disclosed in all reports required by OPM.

(d) *Poor business practices.* OPM will consider an MSP issuer's specific circumstances and facts in using its discretion to determine compliance with paragraph (b)(6) of this section. 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 ensure that the MSP issuer 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 MSP Program. 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.

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(e) *Performance escrow account.* OPM may require MSP 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 MSP Program contracts conform to the contract's quality requirements.

(b) *Internal controls.* OPM may periodically evaluate the contractor's system of internal controls under the quality assurance program required by the contract and will acknowledge in writing if the system is inconsistent 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 MSP Program contracts and will inform MSP 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) MSP issuers must comply with the performance standards issued pursuant to this section.

### § 800.403 Fraud and abuse.

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

(c) *Submission of information.* An MSP issuer must provide to OPM such information or assistance as may be necessary for the agency to carry out the duties and responsibilities, including those of the Office of Inspector General as specified in sections 4 and 6 of the Inspector General Act of 1978 (5 U.S.C.

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App.). An MSP 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 MSP issuer:

(1) Failure by the MSP issuer to meet the requirements set forth in § 800.401(a) and (b);

(2) An MSP issuer's sustained failure to perform the MSP Program 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, including pursuant to its authority under §§ 800.102 and 800.114.

(b) *Compliance actions.* (1) OPM may impose a compliance action against an MSP issuer at any time during the contract term if it determines that the MSP 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 areas;

(v) Withdrawal of the certification of the MSP option or options offered on one or more Exchanges;

(vi) Nonrenewal of participation

(vii) Nonrenewal of contract; and

(viii) Withdrawal of approval or termination of the MSP Program contract.

(c) *Notice of compliance action.* (1) OPM must notify an MSP 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 (viii), such notice must include a statement that the

MSP issuer is entitled to request a reconsideration of OPM's determination to impose a compliance action pursuant to § 800.405.

(3) Upon imposition of a compliance action listed in paragraphs (b)(2)(iv) through (vii) of this section, OPM must notify the State Insurance Commissioner(s) and Exchange officials in the State or States in which the compliance action is effective.

(d) *Notice to enrollees.* If the contract is terminated, if OPM withdraws certification of an MSP option, or if a State-level issuer's participation in the MSP Program contract is not renewed, as described in §§ 800.306 and 800.404(b)(2), or in any situation in which an MSP option is no longer available to enrollees, the MSP issuer must comply with any State or Exchange requirements regarding discontinuing a particular type of coverage that are applicable to a QHP offered on the Exchange on which the MSP option was offered, including a requirement to provide advance written notice before the coverage will be discontinued. If a State or Exchange does not have requirements about advance notice to enrollees, the MSP issuer must inform current MSP enrollees in writing of the discontinuance of the MSP option no later than 90 days prior to discontinuing the MSP option, 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 MSP Program contract prior to the end of its contract term. The term includes OPM's withdrawal of approval of an MSP Program contract.

**§ 800.405 Reconsideration of compliance actions.**

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

- (1) Withdrawal of the certification of the MSP option or options offered on one or more Exchanges;
- (2) Nonrenewal of participation
- (3) Nonrenewal of contract; or
- (4) Termination of the MSP Program contract.

(b) *Request for reconsideration and/or hearing.* (1) An MSP 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 MSP issuer's receipt of the notice of compliance action. The MSP issuer may request that OPM's reconsideration allow a representative of the MSP issuer to appear personally before OPM.

(4) A request under this section must include a detailed statement of the reasons that the MSP 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 MSP issuer with a copy of any additional information it obtains and provide an opportunity for the MSP issuer to respond (including by submitting 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 MSP issuer, in writing, of OPM's final decision on the MSP 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

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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 of Denials of Claims for Payment or Service

#### § 800.501 General requirements.

(a) *Definitions.* For purposes of this subpart:

(1) *Adverse benefit determination* has the meaning given that term in 45 CFR 147.136(a)(2)(i).

(2) *Claim* means a request for:

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

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

(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 MSP issuer internal claims and appeals.

(a) *Processes.* MSP issuers must comply with the internal claims and appeals processes applicable to group health plans and health insurance issuers under 45 CFR 147.136(b).

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

#### § 800.503 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 in 45 CFR 147.136(d).

(b) *Notice.* Notices to MSP enrollees regarding external review under paragraph (a) of this section must comply

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with 45 CFR 147.136(e), and are subject to review and approval by OPM.

(c) *Issuer obligation.* An MSP 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.

#### § 800.504 Judicial review.

(a) OPM's written decision under the external review process established under § 800.503(a) of this part will constitute final agency action that is subject to review under the Administrative Procedure Act in the appropriate U.S. district court. A decision made by an independent review organization under the process established under § 800.503(a) is not within OPM's discretion and therefore is not final agency action.

(b) Judicial review under paragraph (a) of this section is limited to the record that was before OPM when OPM 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 of this part, OPM will ensure that at least one of the MSP issuers on each Exchange in each State offers at least one MSP option that does not provide coverage of services described in section 1303(b)(1)(B)(i) of the Affordable Care Act.

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

(c) *Notice to Enrollees—(1) Notice of exclusion.* The MSP issuer must provide notice to consumers prior to enrollment that non-excepted abortion services are not a covered benefit in the

form, manner, and timeline prescribed by OPM.

(2) *Notice of coverage.* If an MSP issuer chooses to offer an MSP option that covers non-excepted abortion services, in addition to an MSP option that does not cover non-excepted abortion services, the MSP issuer must provide notice to consumers prior to enrollment that non-excepted abortion services are a covered benefit. An MSP issuer must provide notice in a manner consistent with 45 CFR 147.200(a)(3), to meet the requirements of 45 CFR 156.280(f). OPM may provide guidance on the form, manner, and timeline for this notice.

(3) *OPM review and approval of notices.* OPM may require an MSP issuer to submit to OPM such notices. OPM reserves the right to review and approve these consumer notices to ensure that an MSP issuer complies with Federal and State laws, and the standards prescribed by OPM with respect to § 800.602.

**§ 800.603 Disclosure of information.**

(a) *Disclosure to certain entities.* OPM may provide information relating to the activities of MSP issuers or State-level issuers to a State Insurance Commissioner or Director of a State-based Exchange.

(b) *Conditions of when to disclose.* OPM shall only make a disclosure described in this section to the extent that such disclosure is:

(1) Necessary or appropriate to permit OPM's Director, a State Insurance Commissioner, or Director of a State-based Exchange to administer and enforce laws applicable to an MSP issuer or State-level issuer over which it has jurisdiction, or

(2) Otherwise in the best interests of enrollees or potential enrollees in MSP options.

(c) *Confidentiality of information.* OPM will take appropriate steps to cause the recipient of this information to preserve the information as confidential.

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