§ 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 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 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.