§ 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' 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 administrating 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.