

Multistate Health Plans: Agents for Competition or Consolidation?

Robert Emmet Moffit and Neil R. Meredith

January 2015

MERCATUS WORKING PAPER



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Robert Emmet Moffit and Neil R. Meredith. "Multistate Health Plans: Agents for Competition or Consolidation?" Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, January 2015. <http://mercatus.org/publication/health-insurance-multi-state-plan-program-competition>.

Abstract

We discuss and evaluate the Multi-State Plan (MSP) Program, a provision of the Affordable Care Act which has not been the subject of much debate as yet. The MSP Program provides the Office of Personnel Management with new authority to negotiate and implement multistate insurance plans on all health insurance exchanges within the United States. We raise the concern that the MSP Program may lead to further consolidation of the health insurance industry despite the program's stated goal of increasing competition by means of health insurance exchanges. The MSP Program arguably gives a competitive advantage to large insurers, which already dominate health insurance markets. We also contend that the MSP Program's failure to produce increased competition may motivate a new effort for a public health insurance option.

JEL codes: I13, D43, I18

Keywords: Affordable Care Act, OPM, Multi-State Plan Program, health insurance exchanges, Federal Employees Health Benefits Program, health insurance regulation, health insurance competition, health insurance market concentration, public option, market concentration, market structure

Author Affiliation and Contact Information

Robert Emmet Moffit
Senior Fellow
Center for Health Policy Studies
Heritage Foundation
214 Massachusetts Ave. NE
Washington, DC 20002
202-608-6210
Bob.Moffit@heritage.org

Neil R. Meredith
Assistant Professor of Economics
College of Business
West Texas A&M University
2501 4th Ave.
WTAMU Box 60187
Canyon, TX 79016
806-651-2493
nmeredith@wtamu.edu

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Multistate Health Plans: Agents for Competition or Consolidation?

Robert Emmet Moffit and Neil R. Meredith

The United States Office of Personnel Management (OPM), which is the federal agency that enforces civil service laws, rules, and regulations, is playing a new role in America's health insurance markets. Beginning in 2014, the Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA), requires OPM to contract with at least two national health plans to offer coverage to millions of Americans—individuals and small businesses—in the newly created health insurance exchanges throughout the nation. By law, at least one of those plans must be a nonprofit health plan, and one must not cover abortion.¹ This new type of plan is called a multistate plan (MSP). By law, MSP options must become available for US citizens in all 50 states and the District of Columbia by the end of 2017.

As with the ACA's other qualified health plans, enrollment in an MSP can be secured through either state-facilitated or federally facilitated exchanges. OPM has claimed that the MSP options are generally not more expensive than are other plans that compete in the federal and state health insurance exchanges, and the premiums for those plans also vary according to the level of standardized coverage they provide, whether they are relatively low-cost bronze plans or more expensive silver or gold plans.²

Qualified individuals, the uninsured, and those who do not have access to federally approved employer-sponsored coverage and whose annual incomes range from 100 to 400 percent of the federal poverty level (FPL) would be eligible for premium subsidies to offset the

¹ The Patient Protection and Affordable Care Act of 2010, Pub. L. no. 111-148, § 1334(a)(3) (2010).

² US Office of Personnel Management, the Multi-State Program, "Frequently Asked Questions—Insurance—Multi-State Plan Programs," last accessed December 15, 2014, <http://www.opm.gov/FAQS/topic/insure/index.aspx?cid=d45b11e4-e5a7-4012-a529-60a748e45502>; hereafter cited as "OPM Insurance FAQs."

premium costs of enrolling in these plans just as they are for all other plans on state and federal health insurance exchanges. For 2014, Obama administration officials initially estimated that each national plan would enroll 750,000 persons at the end of the 2014 “open enrollment” period.³ As of April 1, 2014, a total of 280,000 persons selected an MSP option nationwide.⁴ Plan selection on a website does not automatically translate, of course, into insurance coverage. The Congressional Budget Office (CBO) reports that the true number of those with insurance through the exchanges will not be known until the data collection for 2014 is complete.⁵

As for insurer participation, thus far OPM has entered into a contract with just one carrier: the Blue Cross and Blue Shield Association. For 2014, the association offers 154 MSP options on the exchanges in 30 states and the District of Columbia. The number available to any individual varies state by state.

Alaska offers 36 such options, followed by Pennsylvania with 12 and Maryland with 8. In 15 states, just two plans are available.⁶ For 2015, OPM’s goal is to expand the program to five more states and to add at least one new issuer that would offer MSP options with “meaningful differences” from other health plan options on the exchanges.⁷

³ Robert Pear, “US Set to Sponsor Health Insurance,” *New York Times*, October 27, 2012, http://www.nytimes.com/2012/10/28/health/us-to-sponsor-health-insurance-plans-nationwide.html?_r=0.

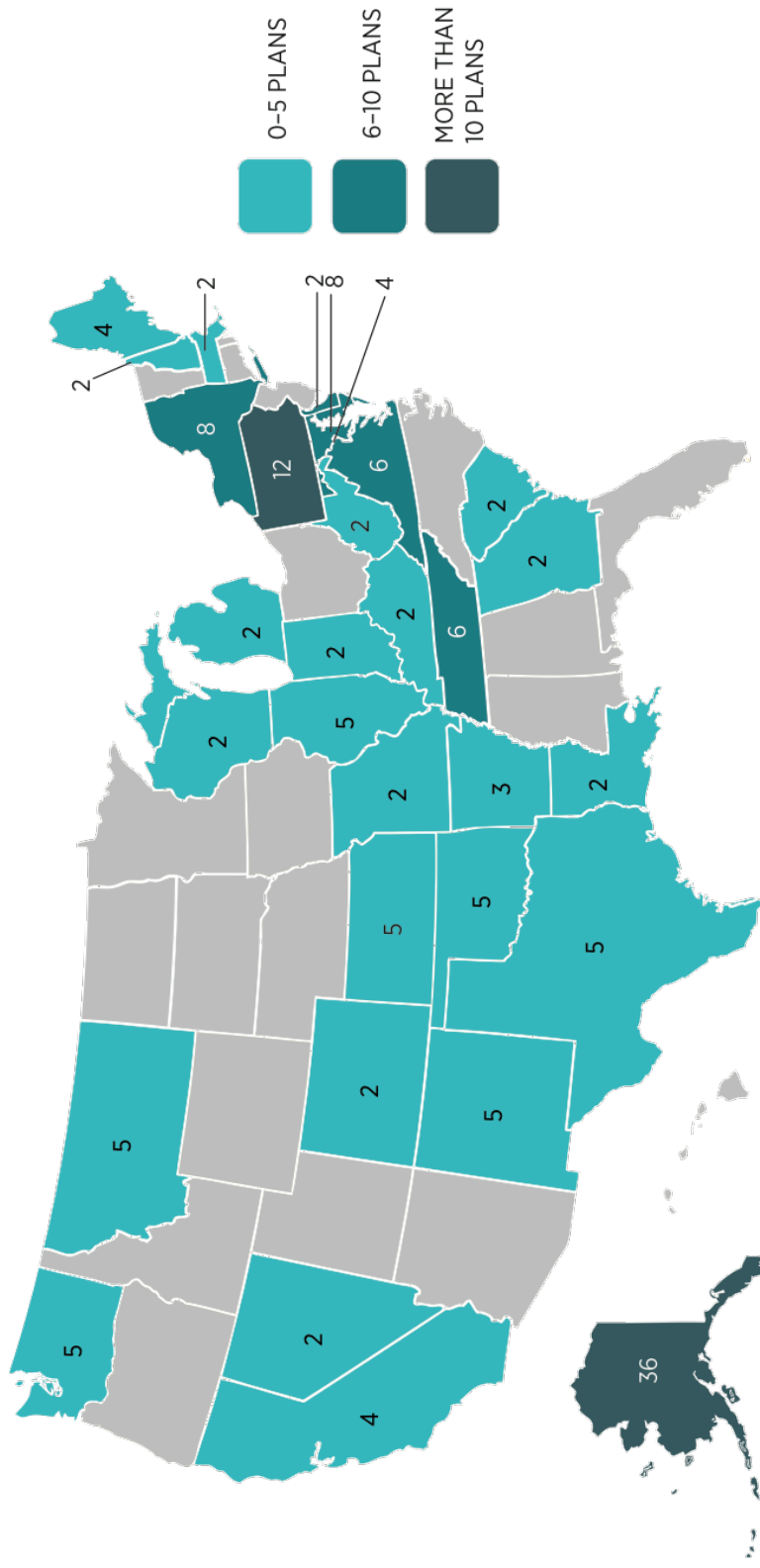
⁴ Sarah Goodell, “The Multi-State Plan Program (Updated),” *Health Affairs*, Health Policy Briefs, May 29, 2014, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=116.

⁵ Congressional Budget Office, “Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014” (April 2014): 6, http://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf.

⁶ US Office of Personnel Management, “Multi-State Plan Program and the Health Insurance Marketplace,” OPM Multistate Plan Program Fact Sheet (2014), available at <http://www.opm.gov/healthcare-insurance/multi-state-plan-program/opm-multi-state-plan-program-fact-sheet/>; hereafter cited as “OPM Fact Sheet.”

⁷ US Office of Personnel Management, “Multi-State Plan Program Issuer Letter,” no. 2014-002, February 4, 2014, http://www.opm.gov/media/4518099/2014-002_multi-state_plan_program_call_letter.pdf.

STATES WITH MULTISTATE PLAN COVERAGE



Source: US Office of Personnel Management, "Multi-State Plan Program and the Health Insurance Marketplace," accessed November 5, 2014, <http://www.opm.gov/healthcare-insurance/multi-state-plan-program/consumer>.

Agents for Competition?

According to OPM, the need for increased competition motivated the creation of MSP options.⁸ Some analysts also assert that MSPs are an effort to increase competition.⁹ The law's advocates have likewise argued that the goal of expanded competition would satisfy the Senate's original objective of a public option, a government-backed plan competing directly with private health insurance in the health insurance exchanges.¹⁰

OPM's official rationale for its management of the program is rooted in its institutional experience, spanning more than five decades, in administering the Federal Employees Health Benefits Program (FEHBP): "OPM contracts with health insurance companies to offer a wide variety of FEHBP coverage options throughout the country. In the Multi-State Plan Program, consumers benefit from OPM experience with contract negotiation and oversight of insurers."¹¹

The relationship between OPM and large health insurers, forged by the ACA, is designed to deliver on the promises of the law, including expanded competition. The failure of that collaboration in the MSP Program could very well set the stage for a second major debate on a "robust" public option. The federal government exercises formidable regulatory control over health plans, and nonprofit insurance required by the MSP Program could evolve into the equivalent of a public option.

⁸ OPM Fact Sheet.

⁹ Timothy Jost, "Implementing Health Reform: The ACA's Multi-State Plan Program," *Health Affairs Blog*, December 3, 2012, <http://healthaffairs.org/blog/2012/12/03/implementing-health-reform-the-acas-multi-state-plan-program/>.

¹⁰ "The nationwide plans are meant to increase competition in the state health insurance markets, as these two options will be available in every state. In smaller states where a single insurer is dominant, this might mean competition and price pressure where it wouldn't otherwise exist—a role that the public option was meant to play." Sarah Kliff, "No, the Public Option Is Not Back from the Dead," *Wonkblog, Washington Post*, October 30, 2012, <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/10/30/no-the-public-option-has-not-returned-from-the-dead/>.

¹¹ OPM Insurance FAQs.

The purpose of this paper is to provide an overview of the MSP option and what it may mean for health insurance markets. The next section discusses what the law states. The paper then analyzes the new regulatory regime created, reviews the possible effect on health insurance markets, and examines the new role of OPM in national health policy. The last section concludes the paper.

What the Law Says

OPM is solely responsible for administering the MSP Program. Specifically, the director of OPM, pursuant to section 1334(a), must contract with at least two health insurers to offer “multi-State qualified health plans through each Exchange in each State.”¹² According to the plain language of the statute, OPM did not meet its obligation to contract with two insurers in 2014.¹³

MSPs are “qualified health plans” that must meet statutory standards, such as (a) provision of the 10 categories of essential health benefits, (b) coverage of preventive services, (c) age rating and pre-existing condition restrictions, (d) guaranteed issue and renewability requirements, and other requirements outlined in Title I of the ACA.¹⁴ Moreover, to ensure a level playing field, the ACA requires that all private and multistate plans must be subject to the same federal and state laws governing specific insurance practices: (a) guaranteed renewal and rating, (b) pre-existing conditions and nondiscrimination, (c) quality improvement and

¹² Affordable Care Act, § 1334(a) (2010).

¹³ OPM contracted only with the Blue Cross and Blue Shield Association. Some analysts insist, nonetheless, that OPM did, in fact, meet its legal obligation in the spirit, if not in the letter, of the law. Observes Timothy Jost, “Because the [Blue Cross and Blue Shield Association] is offering at least two plans in each of the states, the requirements of the law are met even though the OPM has a contract with only one issuer. The OPM did not publicly state how many applicants applied to the [MSP Program].” Sarah Goodell, “The Multi-State Plan Program (Updated),” *Health Affairs*, Health Policy Briefs, May 29, 2014, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=116.

¹⁴ Bernadette Fernandez and Annie L. Mach, “Private Health Plans under the ACA: In Brief,” Congressional Research Service (September 19, 2013): 8–9, <https://www.fas.org/sgp/crs/misc/R43233.pdf>.

reporting, (d) oversight to prevent fraud and abuse, and (e) solvency and financial requirements.¹⁵

The FEHBP Format

In contracting with selected insurers, the OPM director “shall” implement the MSP Program “in a manner similar to the manner in which the Director implements the contracting provisions” with carriers to administer the FEHBP.¹⁶ That stipulation establishes a critical legal requirement. According to chapter 89 of Title 5 of the US Code, the director of OPM essentially acts as the government’s employer. In this capacity and subject to the provisions of chapter 89, the director exercises wide discretion in negotiating the rates and benefits for health plans in the FEHBP, developing and enforcing related regulations, and imposing contractual conditions for the participation of the plans. Historically, few legal limitations have restricted the director’s authority in FEHBP contract negotiations, which are confidential and largely insulated from direct congressional interference. In litigation with federal employee organizations and unions about rates and benefits, the federal courts have routinely upheld the director’s broad discretion in those areas.¹⁷

Insurers are eligible to contract with OPM to offer an MSP in the exchanges if the insurers agree to meet the conditions for a qualified health plan (i.e., the essential health benefits

¹⁵ Affordable Care Act, § 1324 (2010).

¹⁶ Id. at § 1334(a)(4).

¹⁷ In upholding OPM’s broad contracting authority in 1983, then appellate court judge Ruth Bader Ginsburg wrote, “Courts reviewing a contract negotiation must be mindful of the considerable leeway an agency has in that setting to balance and accommodate competing interests. The agency’s judgment must be respected if consistent with the governing law and not unreasonable.” John and Joan Doe et al. v. Donald J. Devine, Director, Office of Personnel Management et al., United States Court of Appeals for the District of Columbia 703 F.2d 1319, 227 US App. D.C. (1983), <https://casetext.com/#!/case/doe-v-devine>. See also John and Joan Doe et al. as well as Richard Roe et al. v. Donald J. Devine, Director, Office of Personnel Management et al., and Blue Cross Association and Blue Shield Association and Aetna Life Insurance Company, US District Court, District of Columbia, 545 F.Supp. 576 (1982), <http://law.justia.com/cases/federal/district-courts/FSupp/545/576/1431887>.

categories, the standardized levels of coverage (bronze, silver, or gold), and the rating requirements).¹⁸ Insurers also must (a) be licensed in the states where they make their offerings, (b) comply with the preventive services requirements of the Public Health Service Act, (c) meet minimum standards for carriers that offer coverage through the FEHBP, and (d) meet other such requirements that the director of OPM may deem appropriate.¹⁹

Beginning in 2014, members of Congress and selected staff members are no longer eligible for enrollment in the FEHBP and must instead get health coverage through the ACA's health insurance exchange system.²⁰ OPM requires those individuals to get their coverage through the DC Health Link Small Business Market in Washington, DC, a Small Business Health Options Program exchange that includes multistate health plans. OPM, which administers both the MSP and the FEHBP, emphasizes that MSP coverage is not the same health insurance as that offered to federal employees.²¹ Although members of Congress and their staffs are not eligible for the ACA's insurance subsidies, OPM ruled that they may receive the same level of insurance subsidies that they previously enjoyed as enrollees in the FEHBP.²² Unlike the ACA subsidies, the FEHBP subsidies—which can cover up to 75 percent of the premium cost of a health plan—are available to persons (such as members of Congress) whose annual incomes exceed 400 percent of the federal poverty level.

¹⁸ Affordable Care Act, § 1334(c)(1) (2010).

¹⁹ *Id.* at § 1334(b).

²⁰ *Id.* at § 1312.

²¹ OPM Insurance FAQs.

²² Federal Employees Health Benefits Program: Members of Congress and Congressional Staff, 78 Fed. Reg. 60653 (October 2, 2013), <http://www.gpo.gov/fdsys/pkg/FR-2013-10-02/pdf/2013-23565.pdf>.

Health Benefits

With the mandatory offering of the statutorily prescribed essential health benefits, OPM staff members originally contemplated a single uniform national benefits package. The secretary of the Department of Health and Human Services (HHS), however, ruled that each state would set its own benchmarks for the benefit package and would be in tandem with additional state-mandated benefits to be financed by state taxpayers. This rule has added another layer of administrative complexity to the MSP Program.²³

Just as with FEHBP plans, the director of OPM can exclude MSPs that do not comply with terms and conditions of law or regulation. OPM's regulatory enforcement includes the application of HHS insurance regulations to multistate plans, such as the requirement that plans offer essential benefits and adhere to rules concerning cost-sharing, rating nondiscrimination, and preexisting conditions. OPM also administers and regulates the external review to settle coverage disputes and issues rules governing plan coverage areas and contract compliance. The ACA states that the director may also withdraw a contract with a multistate plan after a notice and a hearing.²⁴ The Center for Medicare and Medicaid Service reaffirmed, through regulations issued in 2012, that OPM—not the states—will determine whether or not MSPs meet federal standards for qualified health plans in the health insurance exchanges.²⁵

²³ “Allowing each state some discretion in defining the essential health benefit may complicate how MSPs could then offer a uniform benefit in every state, as required by law. Specifically, the law requires that ‘the plan offers a benefits package that is uniform in each state and consists of the essential health benefits. . . .’ Some read that language to mean plans must be uniform only in each single state; others note that the language does not say uniform ‘within’ each state and therefore believe that the law’s intent is to promote a single uniform benefit.” Trish Riley and Janet Hyatt Thorpe, “Multi-State Plans under the Affordable Care Act,” George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy (2013), 5. http://www.healthreformgps.org/wp-content/uploads/dhpPublication_A80A0AAA-5056-9D20-3D25B59C65680B79.pdf.

²⁴ Affordable Care Act, § 1334(a)(7) (2010).

²⁵ Riley and Thorpe, “Multi-State Plans under the Affordable Care Act,” 3.

In carrying out OPM's responsibilities, the director has the power to negotiate four specific items with prospective multistate insurers.²⁶ Those items include the medical-loss ratio of the plans, the health plans' profit margin, the premiums to be charged, and the plans' provider network adequacy. All of those issues greatly affect health insurance plans' premium cost and, hence, affordability. The statutory language does not require the director to consult or obtain concurrence with the secretary of the HHS about such items, although the law does not preclude such consultation or concurrence.

OPM is legally required to negotiate premiums for MSP plans in the same way that it negotiates premiums for FEHBP plans. The agency sends out an annual call letter asking issuers for proposals, including premium rate filings and benefit offerings, and then it negotiates premiums state by state with each multistate plan, as the law provides. The premiums vary for different levels of coverage, and plans are categorized by and named for metallic values. Although OPM encourages plans to abide by state premium rate reviews (the reviews required by the Affordable Care Act), OPM reserves the final authority to approve MSP premium rates.²⁷

The language of the ACA also includes a catch-all provision: the director can negotiate such terms and conditions that he or she deems necessary for the benefit of enrollees²⁸—a formidable grant of regulatory authority.²⁹

²⁶ Affordable Care Act, § 1334(a)(4) (2010).

²⁷ Patient Protection and Affordable Care Act: Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges, 78 Fed. Reg. 15576 (March 11, 2013), <http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04954.pdf>.

²⁸ Affordable Care Act, § 1334(a)(4)(D) (2010).

²⁹ Hon. Linda Springer et al., "The Office of Personnel Management: A Power Player in America's Health Insurance Markets?" Heritage Foundation Lecture, no. 1145, February 19, 2010, p. 6, <http://www.heritage.org/research/lecture/the-office-of-personnel-management-a-power-player-in-americas-health-insurance-markets>.

OPM and the States

OPM thus functions as both an insurance negotiator and an insurance regulator. As an insurance negotiator, OPM independently exercises its aforementioned contracting authority over MSP premiums, profits, and medical-loss ratios, and the adequacy of plan provider networks. As an insurance regulator, OPM sets and enforces minimum standards for the MSP Program's participating health plans, but it also enforces the HHS rules for health insurance plans as required by the ACA.

Insurers participating in the MSP Program are subject to yet another level of regulation. MSPs are required to comply with state licensure and other state health insurance requirements, such as financial or solvency requirements that are not inconsistent with the ACA.³⁰ At the same time, OPM is responsible for operational oversight of MSPs.³¹ Moreover, OPM may impose additional requirements on MSPs beyond those required by state law. According to its own stated interpretation of its statutory authority, the agency can even override state law in the process: "As a general rule, Multi-State Plan (MSP) insurers have to comply with applicable State laws. The Affordable Care Act reserves *the possibility that certain exceptions to State law may become necessary* for appropriate OPM oversight of the program."³² In short, OPM can determine exceptions to the general rule of compliance with state law. MSPs must adhere to state law except in cases in which OPM's oversight of MSPs necessitates overriding state law. Essentially, MSP issuers seem to be subject to less regulation through OPM, which may provide a competitive advantage to issuers that are able to meet all the requirements of the MSP Program.

³⁰ Affordable Care Act, Pub. L. 111-148, § 1334(b)(2) (2010).

³¹ Riley and Thorpe, "Multi-State Plans under the Affordable Care Act," 2.

³² OPM Insurance FAQs. Emphasis added.

The MSPs, as noted, can compete only in the health insurance exchanges. The statutory language, however, provides that those plans are to be automatically certified for participation in the state-based health insurance exchanges.³³ This language means that the MSPs would *not* be subject to the same state certification or qualification processes established under section 1311 of the ACA for other qualified health plans.

Trish Riley and Jane Hyatt Thorpe, researchers at George Washington University, note that Centers for Medicare and Medicaid Services further clarified and broadened those plan exemptions in its 2012 regulations: “In addition to exemption from state certification procedures for qualified health plans (QHPs), MSPs are exempt from Exchange processes for receiving and considering rate increase justifications and for Exchange processes for receiving annual rate and benefit information.”³⁴ By law and regulation, then, MSPs directly and immediately qualify for exchange participation, subject only to OPM’s broad contracting authority and its oversight.³⁵

MSPs must also meet the specific statutory standards for geographic coverage. The director of OPM can enter into a contract with an insurer to offer a multistate plan if the insurer offers the plan in at least 60 percent of all the states in the first year, 70 percent in the second

³³ Affordable Care Act, Pub. L. 111-148, § 1334(d) (2010). As George Washington University researchers Trish Riley and Jane Hyatt Thorpe note, “For states in competitive markets that are building exchanges designed to negotiate for price and quality, the requirement to deem MSPs eligible to offer products in the exchange conflicts with those state goals. The law requires plans to be licensed in the state and to comply with state laws not inconsistent with MSP provisions, but that does not assure that all plans will meet the standards established in a value purchasing exchange.” Riley and Thorpe, “Multi-State Plans under the Affordable Care Act,” 13.

³⁴ Riley and Thorpe, “Multi-State Plans under the Affordable Care Act,” 3.

³⁵ During final consideration of the ACA in the House of Representatives, Rep. Edolphus Towns (D-NY) clarified § 1334(a)(4) concerning OPM’s role in the administration of the MSP:

The intent of this provision is that OPM oversee multi-State health plans in the same manner in which oversight is provided under the FEHB program for the purposes of uniformity of health insurance plans. OPM should exercise this authority, as it does in the FEHBP, to ensure that multi-State plans offer uniform benefits, negotiate premiums with multi-State plans, and require these plans to set aside a certain amount of reserve funds. Moreover, it is imperative that OPM issue rules and guidelines as necessary to effectively and efficiently administer the multi-State plans, including for uniform adjudication procedures for disputes involving the multi-State plans.

Cong. Rec. H1906 (March 21, 2010) (statement of Rep. Towns (D-NY)), <https://beta.congress.gov/congressional-record/2010/03/21/house-section>.

year, and 85 percent in the third year.³⁶ In the fourth year, the insurer must offer coverage in 100 percent of the states and in the District of Columbia, and national coverage must continue in every subsequent year. For 2014, with 30 states covered, OPM has met the statutory requirement.

MSP Program and FEHBP

The statute provides for a clear separation of the MSP Program and FEHBP within OPM. Additionally, premiums paid for MSP coverage are not to be considered federal funds “for any purposes.”³⁷ Moreover, health plans participating in the FEHBP will not be required to participate in the MSP Program. The OPM director “shall” establish an MSP advisory board to make recommendations for administering the program, and a “significant percentage” of its membership must comprise MSP enrollees or their representatives.³⁸ To carry out all of those MSP functions, the statute “authorizes to be appropriated, such sums as may be necessary.”³⁹

The Creation of a New Regulatory Regime

The MSP Program increases government involvement in health insurance markets that are already heavily regulated. OPM thus joins the multitude of government agencies and programs involved in the administration of the ACA. The MSP Program also gives OPM the power to provide access to health insurance exchanges for all 50 states and the District of Columbia and, in this function, may serve as a fast track for MSP insurers.

The regulations favor large insurers by constructing barriers to entry to state health insurance exchanges that make gaining access to state insurance markets relatively easier for

³⁶ Affordable Care Act, § 1334(e) (2010).

³⁷ Id. at § 1334(g)(5).

³⁸ Id. at § 1334(h).

³⁹ Id. at § 1334(i).

large insurers. For example, geographic requirements for insurers providing an MSP dictate that a given MSP must be available in all states and the District of Columbia within four years of the plan's initiation. Large insurance groups and companies are more likely than small insurance companies to already participate as insurers in all states and the District of Columbia. Smaller insurers face quite a challenge in building such a presence within four years so that they may offer an MSP. Large insurers offering an MSP, therefore, have an advantage when it comes to entering state health insurance exchanges.

Purely for-profit insurers also are at a disadvantage for participating in MSPs. MSP regulations state that two MSPs must be offered on each health insurance exchange and that one of the issuers of an MSP must be nonprofit. As a result, competition that could arise between for-profit insurers through MSPs is effectively banned until a nonprofit issuer brings an MSP to fruition. Essentially, entry into health insurance exchanges nationwide is made relatively harder for for-profit insurers, so large nonprofit insurers stand to benefit.

The Effect on Health Insurance Markets

The relevant geographic market for health insurance is the metropolitan statistical area because provider networks in health insurance plans tend to be local.⁴⁰ Research indicates that relevant metropolitan statistical area markets are concentrated throughout the United States.⁴¹ In fact, US health insurance markets are aptly characterized by the rule of three, which means that

⁴⁰ See William G. Kopit, "At the Intersection of Health, Health Care, and Policy," *Health Affairs* 23, no. 6 (2004): 29–31; James C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs* 23, no. 6 (2004): 11–24.

⁴¹ See Leemore S. Dafny, "Are Health Insurance Markets Competitive?," *American Economic Review* 100, no. 4 (2010): 1399–431; Laurie J. Bates, James I. Hilliard, and Rexford E. Santerre, "Do Health Insurers Possess Market Power?," *Southern Economic Journal* 78, no. 4 (2012): 1289–304.

approximately three insurers usually control a vast share of the health insurance market in any given metropolitan statistical area.⁴²

Current studies indicate that market power is present and exercised within the health insurance industry, which raises concerns that prices higher than those indicative of a highly competitive market are occurring within the health insurance industry.⁴³ The American Hospital Association and the American Medical Association also report such concerns.⁴⁴ To address the problem of market power, the Affordable Care Act was designed to increase competition in health insurance markets. Recent evidence suggests that individuals enrolling in federally facilitated health insurance exchanges have a range of health plan choices, which are available from 2 to 11 issuers.⁴⁵ As it is functioning, however, the MSP Program seems to be at odds with the goal of increased competition.

As previously stated, large insurers are likely to currently have a nationwide presence, whereas smaller carriers are less likely to be able to build the presence necessary to carry out an MSP on all exchanges within four years. As a consequence, those requirements may further concentrate the insurance industry and enhance market power for large insurers. Early evidence

⁴² Jagdish Sheth and Rajendra Sisodia, *The Rule of Three: Surviving and Thriving in Competitive Markets* (New York: Free Press, 2010).

⁴³ Leemore S. Dafny, “Are Health Insurance Markets Competitive?,” *American Economic Review* 100, no. 4 (2010): 1399–431; Laurie J. Bates, James I. Hilliard, and Rexford E. Santerre, “Do Health Insurers Possess Market Power?,” *Southern Economic Journal* 78, no. 4 (2012): 1289–304; Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, “Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry,” (NBER Working Paper no. 15434, National Bureau of Economic Research, Cambridge, MA, 2009); Leemore S. Dafny, Jonathan Gruber, and Christopher Ody, “More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces” (NBER Working Paper no. 20140, National Bureau of Economic Research, Cambridge MA, 2014).

⁴⁴ “The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform,” American Hospital Association (2009), accessed July 2, 2014, <http://www.aha.org/content/00-10/09-05-11-antitrust-rep.pdf>; American Medical Association, *Competition in Health Insurance: A Comprehensive Study of US Markets, 2013 Update* (Chicago: American Medical Association, 2013).

⁴⁵ Amy Burke, Arpit Misra, and Steven Sheingold, “Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014” (ASPE Research Brief, Department of Health and Human Services, June 2014).

suggests that large insurers may already be exercising market power, as they have submitted proposals to increase premiums for health insurance exchange policies in 10 states in 2015, whereas smaller insurers plan to hold steady or attempt to cut their rates.⁴⁶

Future analysis to evaluate the effect of the MSP Program should consider the following for each metropolitan statistical area market for health insurance: (a) the percentage of exchange enrollees choosing an MSP, (b) changes in the Herfindahl-Hirschman Index (HHI), and (c) changes in the four-firm concentration ratio.⁴⁷ A recent annual report on the health insurance industry by the American Medical Association (AMA) provides information on HHIs for 386 metropolitan areas, the 50 US states, and the District of Columbia.⁴⁸ For 2014, if the percentage of exchange enrollees in MSPs is high or if the four-firm concentration ratio or HHIs are statistically higher in value or unchanged from 2013, those results may indicate that the health insurance industry remains concentrated. In essence, increased competition expected from the ACA may not materialize, and the MSP Program may decrease rather than enhance competition.

OPM: A New Role in National Health Policy

The administration, as noted, states that OPM is authorized by Congress to administer the MSP Program because of OPM's decades-long experience in administering the FEHBP. Although that is true, the FEHBP and the MSP Program are two dissimilar types of programs, serve unique constituencies, and have different purposes.

⁴⁶ Louise J. Radnofsky. "Large Health Plans Set to Raise Rates," *Wall Street Journal*, June 19, 2014.

⁴⁷ The Herfindahl-Hirschman Index (HHI) is an index ranging from 0 to 10,000, where 0 indicates no concentration in a market and 10,000 implies that a market is perfectly concentrated and controlled by one firm. The index is computed by finding the sum of the squares of market shares for all firms in a market. The four-firm concentration ratio is computed by finding the sum of the market shares for the four largest firms in a market. The closer the ratio is to 100 percent, the more concentrated the market. For more details on the HHI and four-firm concentration ratio, see R. Glenn Hubbard and Anthony Patrick O'Brien, *Economics*, 5th ed. (Boston: Pearson Higher Ed, 2015).

⁴⁸ American Medical Association, *Competition in Health Insurance: A Comprehensive Study of US Markets, 2013 Update* (Chicago: American Medical Association, 2013).

OPM's role in administration of the MSP Program is inherently different from its function in running the FEHBP. In the FEHBP, OPM acts as an employer and negotiates rates and benefits with all insurers *as an employer*. OPM also contracts with private insurers nationally and in the states to provide health benefits to federal and postal employees and enforces a common set of consumer protection rules for all competing private health plans within the FEHBP market.

In the MSP Program, OPM acts *as an agent of the federal government* in its interaction with all other health plans and potentially millions of Americans as consumers nationwide. OPM contracts with a select group of health plans to compete directly with all other private health insurance plans. The intent of the MSP Program is to boost the enrollment of private citizens and small businesses in those select health plans; national insurers' plans compete with all other plans in every state of the nation. In other words, the federal government, by virtue of its selective contracting authority, becomes a competitor in the new insurance market.⁴⁹

That institutional change also broadens and deepens OPM's relationship, in reporting and oversight, with Congress. Because OPM is an agency focused exclusively on civil service matters, oversight of OPM has historically been narrowly confined to certain congressional committees: the House Committee on Oversight and Government Reform, the Senate Homeland Security and Governmental Affairs Committee, and the House and Senate subcommittees responsible for the Treasury Department and Postal Service Appropriations. Powerful committees with oversight over national health policy include the House Ways and Means Committee; the House Energy and Commerce Committee; the Senate Finance Committee; and

⁴⁹ Kay Coles James, "OPM Should Be Running the Civil Service, Not Undercutting Private Health Insurance," *Critical Condition, National Review Online*, December 23, 2009, <http://www.nationalreview.com/critical-condition/47705/opm-should-be-running-civil-service-not-undercutting-private-health-insuran>.

the Senate Health, Education, Labor and Pensions Committee. Because of the vast scope of federal authority over health care financing and delivery under the ACA, OPM's activities will also come under the purview of the major congressional committees with jurisdiction over federal health policy.

The director of OPM reports to the president and executes the policy agenda of the administration, as does the secretary of the HHS. Although the secretary of HHS exercises oversight and regulatory authority over the health insurance exchanges, state officials retain some residual authority over health insurance, including licensure and the fiscal solvency requirement. Because OPM also exercises oversight and independent regulatory authority over its selectively contracted health insurance plans, areas of federal–state conflict are bound to arise. Inasmuch as OPM is to be a major player in the health insurance exchanges, the potential also exists for institutional friction with HHS.⁵⁰ Naturally, such interagency conflicts or disagreements—whether about items such as premiums, benefits, or the level of competition within the exchanges—will be resolved by the president of the United States. In that sense, the ACA provides the White House, as an institution, with the capacity to influence the course of developments in state health insurance markets.

Notwithstanding the significant differences in statutory scope and regulatory authority of the two programs, one obvious area where OPM's dual roles in administering the FEHBP and the MSP Program are certain to overlap is in the implementation of the administration's health policy initiatives.

⁵⁰ During final debate in the US House of Representatives, Rep. Edolphus Towns (D-NY) observed, “There are overlapping responsibilities between HHS and OPM with regard to the multi-State plans offered on State Exchanges. The legislation envisions that the Secretary of HHS will coordinate and consult with the Director of OPM on any policy decisions that would affect the administration of multi-State plans. This joint effort is essential to ensuring the proper operation of the multi-State program as envisioned by Section 1334.” 156 Cong. Rec. H1907 (daily ed. March 21, 2010) (statement of Rep. Towns).

Agents of Consolidation?

American health insurance markets, heavily penetrated by the Blue Cross and Blue Shield Association, among others, are already highly concentrated. Given OPM's new institutional responsibilities to contract with selected health plans, it remains to be seen how the MSP Program will evolve over time. It could further market consolidation.

By law, OPM has independent authority to negotiate premium rates for MSPs. OPM can bind itself to state premium rules, but it is not statutorily required to do so. As noted, OPM also has independent authority to negotiate and thus establish a medical loss ratio for multistate plans. OPM could stake out an aggressive position and set an independent medical loss ratio standard different from that of the states,⁵¹ or it could refrain from doing so, as it has done thus far.

As noted, OPM could also negotiate with plans and set their profit margins, but it has refrained from doing that as well; however, that too could change. As for handling the financial losses from adverse selection or related shortfalls, the multistate plans—like other health plans in the exchanges—will rely on the reinsurance, risk adjustment, and risk corridors established under the ACA. In this respect, the MSP plans are currently under the HHS rules governing the administration of these programs, just like other health plans. Time will tell how this process will work.

Among health insurers and state regulators, the initial concern was that OPM would use its formidable regulatory power to create an unlevel playing field in the competition between

⁵¹ “While it is unlikely that OPM will hold MSPs to different medical loss ratios, they will likely vary in terms of premium rates and network adequacy standards based on the multi-state nature of the MSPs. While this could make the MSPs highly competitive, it could also be disruptive to the underlying state-based exchange market driving [qualified health plans] out of the market if they can’t compete with the more favorable terms provided to MSPs that allow them to offer lower premiums or a broader network.” Riley and Thorpe, “Multi-State Plans under the Affordable Care Act,” 11.

multistate plans and other plans.⁵² The ACA includes language to guarantee a level playing field, specifying 13 categories that all plans must meet on the same basis. Some analysts, however, note concerns that multistate plans may not be subject to state laws and regulations, which may provide a competitive advantage for multistate plans over other insurance plans on exchanges.⁵³ Whether such a process, administered by OPM itself, will be fair and impartial in adjudicating competing claims between OPM and state regulators remains to be seen.

A Public Option or Public Utility?

A central question is the future role of such plans in relation to other health plans in the nation's health insurance markets. Using its formidable new contracting and regulatory powers, OPM could transform the Multi-State Plan Program into the lost "public option" originally envisioned by the ACA's congressional champions. Such an option, according to its advocates, holds the promise of enrolling millions of Americans because it would reduce costs by paying doctors and other medical professionals at rates tied to Medicare. Congressional champions of a robust public option have also argued that it would significantly cut administrative costs.

As proposed in the "Tri-Committee" proposal, the initial 2009 House version of the legislation, the HHS secretary would have administered such a government health plan.⁵⁴ The

⁵² A number of organizations responded to OPM's formal "request for information" on the administration of the MSP Program issued in June 2011. Among these was the prominent and influential National Association of Insurance Commissioners. "Notably, the National Association of Insurance Commissioners (NAIC) submitted lengthy comments critical of the plan, largely based on the potential to provide large insurers with [a significant, anticompetitive market share; with opposition to deeming; and with concerns] about appropriate safeguarding of consumer protection and state regulatory roles. NAIC also raised concerns about an uneven playing field, the potential for adverse selection, and the impact on rates if the MSPs are held to different rules, as well as the potential to diminish a state's value purchasing efforts by deeming plans in an Exchange. NAIC cautioned OPM not to engage the nonprofits currently offering FEHBP coverage as they meet different solvency standards than commercial carriers are held to by the states." *Ibid.*, 5.

⁵³ Goodell, "Multi-State Plan Program," 4.

⁵⁴ The original House version of the health reform legislation, unveiled on June 9, 2009, was titled the "Tri-Committee Health Reform Draft Proposal," prepared by the House Committees on Ways and Means, Energy and

MSP Program is arguably a consolation prize for congressional champions of the public option.⁵⁵

As a practical matter, a clear distinction between a private health plan and a public option is rapidly becoming inconsequential. The ACA has already blurred that distinction in a variety of ways, leaving private health insurance little room for independent business operations outside federal law and regulation.

Under the terms of the statute, federal authorities define acceptable benefits and acceptable levels of insurance coverage; impose uniform insurance and rating restrictions, as well as standardized medical loss ratios for individual and group coverage; and establish allowable cost sharing, deductibles, and coverage limits. Also, plans generally are subject to a federal–state review of premium increases, a process by which health plans must submit written justification for premiums that are determined to be “unreasonable” or must face exclusion from competition in the health insurance exchanges. Whether this premium review and restriction will apply to the multistate plans also remains to be seen.

Beyond the specific statutory requirements, federal authorities can and do impose detailed regulatory requirements on health plans, whereas state exchange officials also must impose requirements on health plans under federal law, must impose additional benefit mandates on plans, and must enforce traditional state licensure and solvency requirements.

Commerce, and Education and Labor. It contained a public option (see <http://waysandmeans.house.gov/media/pdf/111/tri.pdf>). According to Title II, Subtitle B, Section 221, the secretary of HHS would have been required to establish a “public health insurance option.” Section 223 stipulates that the secretary would have been required to establish payment rates for medical services on the basis of Medicare payment rates under Parts A and B. See also Robert E. Moffit, “Statement on the Tri-Committee Draft Proposal for Health Care Reform,” testimony before the Committee on Education and Labor, US House of Representatives, June 23, 2009, <http://www.heritage.org/research/testimony/statement-on-the-tri-committee-draft-proposal-for-health-care-reform>.

⁵⁵ John Reichard, “Blues MultiState Exchange Plans: Next Best Thing to Public Option?,” *Washington Health Policy Week in Review*, October 7, 2013, <http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2013/oct/october-7-2013/blues-multi-state-exchange-plans>. See also Sarah Kliff, “No, the Public Option Is Not Back from the Dead,” *Wonkblog, Washington Post*, October 30, 2012, <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/10/30/no-the-public-option-has-not-returned-from-the-dead>; Stuart M. Butler, “Risking Big Changes with Small Reforms,” *New England Journal of Medicine* 362 (February 25, 2010): 673–75, <http://www.nejm.org/doi/full/10.1056/NEJMp1001054>.

Sara Rosenbaum, a professor of law at George Washington University, has perhaps best summarized the new status of health insurance: “The law fundamentally transforms health insurance from a product designed to preserve profitability in the face of rampant adverse selection to a regulated industry whose long-term strength and stability are essential to the public interest and that, in its restructured form, will therefore take on certain characteristics of a public utility.”⁵⁶

Conclusion

The MSP Program is supposed to provide a robust level of competition in state health insurance exchanges; however, whether competition will be enhanced is arguably doubtful. For instance, during the 2009 Senate debate about the “Manager’s Amendment” offered by Senator Harry Reid (D-NV), the CBO expressed skepticism that the program would foster the kind of robust competition that would generate significant health care savings or even enrollment: “Whether insurers would be interested in offering such plans is unclear, and establishing a nationwide plan comprising only nonprofit insurers might be particularly difficult. Even if such plans were arranged, the insurers offering them would probably have participated in the insurance exchanges anyway, so the inclusion of this provision did not have a significant effect on the estimates of federal costs or enrollment in the exchanges.”⁵⁷

On the basis of what the law says and what it does, large insurers apparently may have their market dominance further solidified. Barriers to entry, such as having a presence in all 51 health insurance exchanges within four years of the launch of a plan, may effectively discourage

⁵⁶ Sara Rosenbaum, “A ‘Broader Regulatory Scheme’—The Constitutionality of Health Reform,” *New England Journal of Medicine* 363, no. 20 (2010): 1881–83, <http://www.nejm.org/doi/full/10.1056/NEJMp1010850>.

⁵⁷ Douglas Elmendorf, director, Congressional Budget Office, to Hon. Harry Reid, Majority Leader, United States Senate, December 19, 2009, p. 9.

competition from small competitors. Market power may increase, and prices for premiums may rise if competition does not materialize.

The law also expands government involvement in health insurance markets through the Office of Personnel Management. OPM has been given new power to act as an agent of the federal government in implementing MSPs with insurers for potentially millions of American consumers. OPM also may override the authority of state regulations in its charge of administering the MSP Program.

The possibility that a public option could emerge as additional competition has not come to fruition. By the end of 2014, only one large nonprofit insurer had participated in the MSP Program. If all the MSP Program accomplishes is increased concentration in health insurance markets, then arguments for a public option through the MSP Program may arise as a means for combating the lack of competition in health insurance markets.

Large health insurance plans, such as the Blue Cross and Blue Shield plans, effectively are collaborating with government officials in carrying out federal health policy. If the MSP Program should fail to generate competition, the original form of the public option—based on a *nonprofit* health plan—could indeed become a viable alternative for those who favor it.

One such advocate is Jacob Hacker, professor of political science at Yale University. He has strongly urged the Obama administration to get “tough” with health insurers to carry out the goals of the law. He adds,

In the process, reformers should revive the public option. A simple, Medicare-like public plan could build on the provisions of the law that create at least one national nonprofit plan. Regardless of the near-term political prospects, the public option is a clear and simple goal that links concerns about health security, the affordability of coverage, and the nation’s larger fiscal challenge. It is popular. It will save serious money. And it can function as a sword of Damocles: If insurers fail to live up to the obligations of the law

and tackle rising costs, they will face the only form of accountability that really matters in the private market—losing customers.⁵⁸

In essence, the MSP Program is likely to fail in achieving its aim of increased competition and may deliver the unintended consequence of consolidation. The law could be anticompetitive rather than competitive. Increased competition in health insurance may remain elusive.

⁵⁸ Jacob Hacker, “Health Reform 2.0,” *American Prospect*, July 29, 2010, 5, <http://prospect.org/article/health-reform-20-0>.