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Multistate Health Plans: Agents for Competition or Consolidation?

Robert E. Moffit, PhD[1] and Neil R. Meredith, PhD[2]

Abstract

We discuss and evaluate the Multi-State Plan (MSP) Program, a provision of the Affordable Care Act that 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.

Keywords

Affordable Care Act, Multi-State Plan Program, health insurance, regulation, market structure

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. As of January 2014, the Patient Protection and Affordable Care Act (ACA) requires OPM to contract with at least 2 national health plans to offer coverage in health insurance exchanges throughout the nation. By law, at least one of those plans must be a nonprofit health plan.[1] This new type of plan is called a Multi-State 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.

Enrollment in an MSP can be secured through either state-facilitated or federally facilitated 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.[2] In fact, OPM contracted with only 1 national, nonprofit carrier, the Blue Cross and Blue Shield Association. As of November 2014, an estimated 371 000 people were enrolled in a MSP option nationwide.[3] As for insurer participation for 2015, thus far OPM has entered into a contract with just the Blue Cross and Blue Shield Association and the Consumer Operated and Oriented Plans (CO-OPs), the nonprofit plans established, with federal loans, under the Patient Protection and ACA. Altogether, for 2015, there are 212 MSP options on the exchanges in 35 states and the District of Columbia. The number available to any individual varies state by state.

Agents for Competition?

According to OPM, the need for increased competition motivated the creation of MSP options. (Although OPM and the ACA do not define the term *competition*, this article considers it to be the rivalrous act of 2 or more parties to independently obtain the business of a third party.)[4] Some analysts also assert that MSPs are an effort to increase competition.[5] 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.[6]

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 initiate 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. The

[1]Heritage Foundation, Washington, DC, USA
[2]West Texas A&M University, Canyon, USA

Corresponding Author:
Neil R. Meredith, West Texas A&M University, 2501 4th Ave., WTAMU Box 60187, Canyon, TX 79016, USA.
Email: nmeredith@wtamu.edu

purpose of this commentary is to provide an overview of the MSP option and what it may mean for health insurance markets.

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 2 health insurers to offer "multi-state qualified health plans through each Exchange in each State."[1] According to the plain language of the statute, OPM did not meet its obligation to contract with 2 insurers in 2014. (OPM contracted only with the Blue Cross and Blue Shield Association in 2014.)

MSPs are "qualified health plans" that must meet statutory standards, such as (1) provision of the 10 categories of essential health benefits, (2) coverage of preventive services, (3) age rating and preexisting condition restrictions, and (4) guaranteed issue and renewability requirements, and other requirements outlined in Title I of the ACA.[7] Moreover, to ensure a level playing field, the ACA requires that all private and MSPs must be subject to the same federal and state laws governing specific insurance practices: (1) guaranteed renewal and rating, (2) preexisting conditions and nondiscrimination, (3) quality improvement and reporting, (4) oversight to prevent fraud and abuse, and (5) solvency and financial requirements.[1]

The Federal Employee Health Benefits Program (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.[1] That stipulation establishes a critical legal requirement. According to chapter 89 of Title 5 of the US Code, the director of OPM acts as the government's employer. 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.[8,9]

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.[1] Insurers also must (1) be licensed in the states where they make their offerings, (2) comply with the preventive services requirements of the Public Health Service Act, (3) meet minimum standards for carriers that offer coverage through the FEHBP, and (4) meet other such requirements that the director of OPM may deem appropriate.[1]

Health Benefits

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 the US Department of Health & Human Services (HHS) insurance regulations to MSPs, 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 an MSP after a notice and a hearing.[1]

In carrying out OPM's responsibilities, the director has the power to negotiate 4 specific items with prospective multistate insurers.[1] 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.

The OPM is legally required to negotiate premiums for MSP plans in the same way that it negotiates premiums for FEHBP plans. Although OPM encourages plans to abide by state premium rate reviews (the reviews required by the ACA), OPM reserves the final authority to approve MSP premium rates.[10] 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 enrollees[1]—a formidable grant of regulatory authority.[11]

OPM and the States

Insurers participating in the MSP Program are also 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.[1] At the same time, OPM is responsible for operational oversight of MSPs.[12] 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.[13] MSPs must adhere to state law except in cases where 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.

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.[1] 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.

MSPs are also not subject to the same procedural requirements applying to other exchange plans such as receiving annual rate and benefit information, qualified health plans' state certification, and reception and evaluation of rate increase justifications.[12] By law and regulation, MSPs directly and immediately qualify for exchange participation, subject only to OPM's broad contracting authority and its oversight. (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.)[14]

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 an MSP if the insurer offers the plan in at least 60% of all the states in the first year, 70% in the second year, and 85% in the third year.[1] In the fourth year, the insurer must offer coverage in 100% of the states and in the District of Columbia, and national coverage must continue in every subsequent year.

The Creation of a New Regulatory Regime

The MSP Program increases government involvement in health insurance markets that are already heavily regulated. 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 relatively easier for 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 4 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 a considerable challenge in building such a presence within 4 years so that they may offer an MSP.

Purely for-profit insurers also are at a disadvantage for participating in MSPs. MSP regulations state that 2 MSPs must be offered on each health insurance exchange and that 1 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.[15,16] Research indicates that relevant metropolitan statistical area markets are concentrated throughout the United States.[17,18] Current studies also 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.[17-19]

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 4 years. As a consequence, those requirements may further concentrate the insurance industry and continue to enhance market power of large insurers. Future analyses to evaluate the effect of the MSP Program should consider the following for each metropolitan statistical area market for health insurance: (1) the percentage of exchange enrollees choosing an MSP, (2) changes in the Herfindahl-Hirschman Index (HHI), and (3) changes in the 4-firm concentration ratio. (The 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 4-firm concentration ratio is computed by finding the sum of the market shares for the 4 largest firms in a market. The closer the ratio is to 100%, the more concentrated the market.) For 2014, if the percentage of exchange enrollees in MSPs is high or if the 4-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.

OPM: A New Role in National Health Policy

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 effect, the federal government, by virtue of its selective contracting authority, becomes a competitor in the new insurance market.[20]

Notwithstanding the significant differences in statutory scope and regulatory authority of the 2 programs, 1 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.

Agents of Consolidation?

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. 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 establish a medical loss ratio for MSPs. OPM could stake out an aggressive position and set an independent medical loss ratio standard different from that of the states, or it could refrain from doing so, as it has done thus far.[12]

As noted, OPM could also negotiate with plans and set their profit margins, but it has refrained from doing that as well; however, that could change. As for handling the financial losses from adverse selection or related shortfalls, the MSPs—like other health plans in the exchanges—will rely on the reinsurance, risk adjustment, and risk corridors established under the ACA.

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 MSPs and other plans.[12] 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 MSPs may not be subject to state laws and regulations, which may provide a competitive advantage for MSPs over other insurance plans on exchanges.[21]

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 MSP 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.

The MSP Program is arguably a consolation prize for congressional champions of the public option.[22,23] 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.

Beyond 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. 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.[24]

Regulatory changes. Because the MSP Program is facing difficulties and potential complications, OPM put forth possible regulatory changes for public comment in November 2014 and enacted a final regulatory rule in February 2015. Some of the more significant changes include the following[3,25]:

1. Assembling an MSP Program Advisory Board with a considerable portion of the board consisting of MSP enrollees or representatives of MSP enrollees to make suggestions for improvement of the MSP Program.
2. Changing the initial mandate requiring MSP issuers to formulate a proposal for delivering coverage statewide. While reaffirming the goal of statewide coverage, OPM is not requiring it from issuers to participate in the program.

Changes in the MSP Program are motivated by the underlying goals of increasing competition, ensuring a level playing field, and improving the program's performance. Although it is conceivable that changes could induce growth in enrollees, OPM anticipates no economically significant impact from their regulatory changes.[3] It appears doubtful that robust competition will arise from the changes proposed.

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. During the 2009 Senate debate on the national health legislation, the Congressional Budget Office 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.[26]

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 4 years of the launch of a plan, may effectively discourage 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 OPM. 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 1 large nonprofit insurer, the Blues, had participated in the MSP Program. More recently, the Office of the Inspector General of the HHS found that most of the nation's 23 CO-OPs had not met their initial enrollment and profitability projections; indeed 21 of 23 CO-OPs incurred net losses at the end of 2014.[27] 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.

In essence, the MSP Program may deliver the unintended consequence of further consolidation. The law could be anticompetitive rather than competitive. Increased competition in health insurance may remain elusive.

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