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OPM'S Multi-State Plan Program: Time to Say Goodbye

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KEY TAKEAWAYS

It is long past time for Congress to repeal a section of Obamacare that allows for a multistate insurance plan program as a substitute for a public option.

This multistate plan program has not been able to meet its own requirements let alone the broader goals of lowering health plan prices and offering more choices.

Congress should resist pushing a government plan to compete against private health plans and instead secure a level playing field for real choice and competition.

Congress should repeal Section 1334 of the Affordable Care Act (ACA), which maintains the Multi-State Plan (MSP) program, a special set of health plans deployed by the United States Office of Personnel Management (OPM) to compete against other private plans in the ACA health insurance exchanges nationwide. To accomplish that goal, Senator Ron Johnson (R–WI) and 15 other Senators have cosponsored S. 2519, the Repeal Insurance Plans of the Multi-State Program Act (RIP MSP Act).[1]

When the House of Representatives passed its version of the ACA in 2009, the House bill included a "public option," a new government plan to compete against private health plans in the nation's health insurance exchanges. Because the House provision was unable to secure majority Senate support on final passage, Senate Democrats created the MSP program

as a substitute or backup for a public option.[2] Based on the MSP's requirement for nonprofit coverage, Jacob Hacker, professor of political science at Yale University, argues that "[a] simple Medicare-like plan could build on the provision of the law that creates at least one nonprofit plan."[3]

Even though the new OPM-administered health plans were given certain statutory advantages, the MSP program has not been able to meet its own statutory requirements, let alone the policy goals and objectives of the Obama Administration or its progressive congressional allies. In 2019, therefore, OPM suspended further operation of the MSP program and endorsed its repeal because the program was draining staff time and agency resources from one of OPM's core missions: providing health and retirement benefits to millions of federal workers, retirees, and their families.

Despite certain statutory advantages over competitors, the MSP program was a monumental failure. It was unable to compete on a level playing field with other private plans. Nor did it offer consumers benefit or service options that were superior in any way to those offered by other private health plans in the ACA's insurance exchanges.

The MSP's Statutory Requirements

Since January 1, 2014, the Office of Personnel Management, the agency that runs the federal civil service, has been legally obligated to contract with at least two national health plans to offer multistate health plans to Americans in the ACA's health insurance exchanges. By law, at least one of these plans must be a nonprofit health plan, and one must *not* cover abortion.[4] The law requires the Director of OPM to contract with these selected "health insurance insurers...to offer at least 2 multi-State qualified health plans through each Exchange in each State."[5] The statute also requires that these plans be available to *all* eligible persons in the ACA exchanges in all 50 states and the District of Columbia by 2017.

The OPM multistate plans must meet the ACA's minimum benefits, rating, and coverage rules as well as state licensure and other state health insurance requirements that are "not inconsistent" with the ACA. In contracting with these selected insurers, the Director of OPM is authorized to replicate the contractual authority that he or she currently exercises in administering the Federal Employee Health Benefits Program (FEHBP), the health program that serves federal workers and retirees nationwide.[6]

Certain Advantages. In its administration of the multistate health plans, OPM can legally confer on these plans certain advantages in market competition over all other ACA exchange plans.[7] For example, OPM can

separately negotiate their medical loss ratios: the amount of revenues that must be allocated for benefit payments and the amount of revenues that may be retained for administrative and related costs. OPM can also negotiate their profit margins to the advantage of these plans if it sees fit to do so and has final authority over the premiums they can offer in the health insurance exchanges in the states.[8]

Beyond these specified items, the Director's discretionary authority is also extremely broad. Under Section 1334, the Director shall take into consideration "such other terms and conditions of coverage as are in the interests of enrollees in such plans."[9]

Though the ACA's language provides for a "level playing field" for competition among all health plans,[10] the multistate plans enjoy certain other advantages. For example, Subsection (d) of Section 1334 provides that the federal government can automatically certify the multistate plans for participation in the state-based health insurance exchanges. This means that these plans would not be subject to the separate certification or qualification processes that are required for other private health plans competing in the exchanges.

In short, the multistate plans are automatically "qualified" health plans. In contrast to other plans, their qualification for competition is preordained in statute.

Furthermore, while all other plans must meet state licensure and other requirements such as financial or solvency requirements, the OPM Director alone can contract with a multistate plan, regardless of the state financial and solvency requirements, if the insurer offers the plan in at least 60 percent of all the states in the first year of operation, 70 percent in the second year, and 85 percent in the third year.[11]

Big insurance carriers have their affiliated health plans deployed in state health insurance markets around the nation. With such a large preexisting market penetration, the goal of offering the required health coverage in all 50 states and the District of Columbia within the statutory requirement of four years would be much easier for large insurers than it would for small or mid-size companies. With an already extensive market penetration, a large insurer can deploy a multistate plan product and secure market share in a larger number of states more rapidly than is possible for a small insurance company.

Thus, the ACA statutory language governing the MSP program directly benefits large, nonprofit health insurance companies. This is not and cannot be a prescription for enhanced competition within the nation's health insurance markets.[12]

Independent analysts were initially skeptical about whether these new federally sponsored health plans would enhance consumer choice and competition in the nation's health insurance markets. During the 2009 debate on the ACA, the Congressional Budget Office (CBO) commented that:

> 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.[13]

Timothy Jost, professor of law at Washington and Lee University and a supporter of the ACA, similarly observed that "[a]s there are already Blue Cross and Blue Shield plans available in many of the exchanges, it is unclear how much competition the multi-state plan will add to some markets."[14]

Decline and Fall of the MSP

The MSP program has failed to meet its statutory requirements and the stated goals of "enhanced competition" in the nation's individual markets. Two principal reasons for this failure are declining health plan participation and declining enrollment.

Declining Health Plan Participation. From its inception, the MSP program failed to attract sufficient carrier participation. In 2014, the first year of the program, only one insurer—not the statutorily required two—was approved to participate in the program: the Blue Cross Blue Shield Association. Like other large corporate insurers, the Blues had numerous plans operating in various states throughout the nation. In 2014, the Blues offered 150 MSP options on the exchanges in 30 states and the District of Columbia.[15] In 2015, 36 states had such multistate plans; in 2016, participation dropped to 33 states; and in 2017, when all 50 states were required by law to have multistate plans, only 22 states had MSP participation.[16]

Acknowledging the gravity of the situation, OPM indicated that the program might not succeed unless it was armed with a mandate to compel insurer participation.[17] In 2018, OPM reported that only one state had an MSP option: the State of Arkansas.[18] In 2019, participation collapsed.

Declining Enrollment. In the ACA's federally regulated individual exchange market, individuals and families could enroll in an MSP either through state-organized health insurance exchanges or in the federally

organized exchanges. They could do so through *healthcare.gov*, the website that serves the "federally facilitated" exchanges.

Obama Administration officials believed the MSP program would be a vehicle for a robust growth in the ACA's overall enrollment. In 2014, they estimated that two insurers would participate, as the law provides, and that each national plan would enroll 750,000 persons.[19] In fact, total MSP enrollment that year was only slightly more than 370,000; in 2015, enrollment climbed to approximately 450,000.[20] In 2016, however, it dropped to 440,000, or just 4 percent of the nation's entire exchange enrollment.[21] By 2018, MSP enrollment, then confined to Arkansas, had declined to "no more than 55,000 participants."[22]

On April 29, 2019, OPM informed Congress that it would suspend MSP operations because it could no longer "achieve the statutory goals and objectives of the Program."[23] Shortly thereafter, on June 15, 2020, OPM endorsed repeal of the program, claiming that "[r]epealing this statutory requirement would allow OPM to further strengthen its capacity to important needs of our benefit programs serving the 2.7 million members of the Federal workforce and over 2 million Federal workforce retirees."[24]

After more than seven years on the statute books, in other words, the MSP program is no longer operational.

Anatomy of a Public Policy Failure

The MSP's dramatic failure provides at least four lessons for Washington's policymakers to consider in the next phase of the national debate on health care.

First, Obama Administration officials and their congressional allies made the mistake of assuming that OPM's success with the FEHBP for the federal civil service could somehow be replicated in administering a component of the ACA. In its administration of the FEHBP, OPM acts as an umpire, enforcing the same rules for all health plans in national and state market competition; it does not have a player or set of players in the game. In designing this substitute for the Senate's rejected public option, Congress assigned OPM a vastly different role for a very different program: sponsoring a class of special health insurance plans, legally gifted with certain advantages, to compete directly against all other private health insurance in the individual markets in every state in the nation. OPM had never previously embarked on anything even vaguely resembling such a mission.

In the FEHBP—the largest group health insurance program in the world—hundreds of private health plans contract with OPM as an employer to

provide benefits for federal employees and retirees, and federal employees and retirees can pick and choose among competing plans with the employer's defined contribution toward the premium cost of their coverage. With more than 50 years of experience in administering the FEHBP under a light and flexible legal regime, OPM has had an enviable record of success. It is a record of robust health plan participation, a wide variety of benefit and plan options, superior cost control, and a high degree of patient satisfaction.[25]

Second, the MSP program did not fail because these special ACA plans were either handicapped or denied special advantages. The truth is exactly the opposite. Unlike all other ACA plans, OPM's insurance contractors were automatically eligible to compete in the federal or state-based exchanges. On behalf of the multistate plans, OPM was granted independent statutory authority to negotiate their medical loss ratios, their profit margins, and their premiums. Moreover, as noted, OPM was given the power to take any actions that it determined to be in the "interests of enrollees in such plans"—an extremely broad grant of administrative power to ensure the program's success.

Third, the MSP program did not attract consumers. In a real market, there is real choice and real competition; decisions are bottom up from consumers, not top down from government officials. The ACA exchanges (officially dubbed "marketplaces") do not resemble anything remotely close to the ideal model of functioning free markets: dynamic playing fields of intense competition characterized by innovation in benefit design and competitive cost control.

The ACA exchanges are heavily regulated with highly prescriptive benefit offerings and diminished health plan participation. The result: reduced consumer choice and market competition combined with breathtaking premium and out-of-pocket cost increases. In the ACA "marketplaces," the multistate plans did not offer consumers anything that was substantively different from what they could secure just as easily from other health plans on the exchanges. Nor did these plans offer consumers lower costs for ACA benefits.[26]

Finally, the MSP program would not have been more successful unless Congress rigged the markets more forcefully to guarantee unfair competition. This would have required heavier regulation or more coercive legislation, such as giving OPM the power to mandate insurer participation in the program; giving the multistate plans even greater statutory advantages against competing plans; providing additional taxpayer subsidies for multistate plans or enrollees; or perhaps arming OPM with greater regulatory power such as the power to impose artificially lower provider rates

or price-controlled premiums, to compel provider participation, or some combination of these coercive measures.

The problem is that such policies directly contradict the principle of a level playing field, which is essential to the functioning of a normal market. Without such a level playing field, there can be no enhanced competition in the nation's health insurance markets.

Looking Ahead: Promoting Real Choice and True Competition

Federal health policy should no longer be a progressive social engineering project. In the next phase of the health care debate, Congress should refrain from rigging the market or tilting the competitive playing field in favor of a federally sponsored insurer or any select group of insurers. Repealing the failed MSP program would be a good first step in this direction.

Instead, while maintaining reasonable consumer protections, Congress should establish a level playing field for personal choice and genuine market competition among plans and providers, thereby enabling Americans to secure better value for their health care dollars. To this end, Congress should embrace the policies outlined in the Health Care Choices proposal.[27] These policies would:

- Significantly lower Americans' health insurance costs, particularly those of middle-class consumers struggling with high premiums and out-of-pocket costs;
- Slash the excessive federal regulation that contributes to high health care costs;
- Target existing financial assistance to the poor and the sick; and
- Enable Americans, including those currently enrolled in Medicaid, to enroll in the health insurance plans of their choice.

Meanwhile, it is past time to close the books on yet another failed federal health program.

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Endnotes

1. S. 2519, RIP MSP Act, 117th Cong., introduced July 28, 2021, https://www.congress.gov/bill/117th-congress/senate-bill/2519/text (accessed October 1, 2021). The 15 cosponsors as of October 1, 2021, included Senators Roger Wicker (R–Miss); Hyde-Smith (R–MS); Patrick Toomey (R–PA); Mike Lee (R–Utah); Cynthia Lummis (R–WY); John Barrasso (R–WY); Mike Braun (R–IN); Kevin Cramer (R–ND); James Lankford (R–OK); Jim Inhofe (R–OK); Marsha Blackburn (R–TN); Rand Paul (R-Ky.); Tim Scott (R–SC); Mike Rounds (R–SD); and Joni Ernst (R–IA).
2. For details on the legislative history of the MSP program, see Robert Emmet Moffit and Neil R. Meredith, "Multistate Health Plans: Agents for Competition or Consolidation?" Mercatus Center at George Mason University *Working Paper*, January 2015, https://www.mercatus.org/system/files/Moffit-Multistate-Health-Plans.pdf (accessed October 1, 2021). See also Report No. 116-86, *Repeal Insurance Programs of the Multi-State Program Act*, Report to Accompany S. 1378 to Repeal the Multi-State Plan Program, Committee on Homeland Security and Governmental Affairs, U.S. Senate, 116th Cong., 1st Sess., September 10, 2019, https://www.congress.gov/congressional-report/116th-congress/senate-report/86/1?overview=closed (accessed October 1, 2021).
3. See Jacob S. Hacker "Health Reform 2.0," *The American Prospect*, July 29, 2010, https://prospect.org/special-report/health-reform-2.0/ (accessed October 1, 2021).
4. H.R. 3590, Patient Protection and Affordable Care Act, Public Law 111-148, 111th Cong., March 23, 2010, Section 1334, https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf (accessed October 1, 2021). Cited hereafter as Affordable Care Act or ACA.
5. Ibid., Section 1334. Section 1334 includes all of the provisions governing the multistate health plans.
6. Ibid., Section 1334(a)(4). In contract negotiation over the rates and benefits with health insurers participating in the FEHBP, the Director of OPM has very broad authority, and in litigation, the federal courts have routinely upheld the Director's very broad administrative discretion in these areas.
7. Under the ACA, the MSP plans are categorized as "qualified health plans" that are permitted to participate in the state and federal health insurance exchanges. Statutorily, all such plans must meet "essential benefit" requirements, coverage of preventive services, age rating and pre-existing condition rules, and guaranteed issue and renewability requirements. However, while all other qualified plans must abide by the specific statutory medical loss ratio requirements, MSP plans' medical loss ratio and profit margins, premiums to be charged, and provider network adequacy are set independently by OPM. Similarly, all other qualified plans must abide by state premium rate reviews, but OPM has final authority over the MSP plans' premium rates; qualified health plans must meet state certification procedures for participation in the exchanges, but MSP plans are automatically entitled to participate, subject only to OPM's determination; and states can impose benefit mandates above those required by the ACA, but MSP plans' benefit requirements are subject to the OPM Director's authority. For a detailed discussion of the ACA's separate statutory and regulatory standards governing MSP plans and all other ACA plans, see Moffit and Meredith, "Multistate Health Plans: Agents for Competition or Consolidation?" pp. 12–16.
8. Affordable Care Act, Section 1334(a)(4)(C). OPM has final authority over these plan premiums.
9. Affordable Care Act, Section 1334(a)(4)(D).
10. Affordable Care Act, Section 1324(a): "Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under Section 1332, a community health insurance option under section 1323, or a nationwide qualified health plan under section 1333(b), is not subject to such law." The 13 federal or state laws outlined in subsection (b) include laws relating to guaranteed renewal, rating, preexisting conditions, non-discrimination, quality improvement and reporting, fraud and abuse, solvency and financial requirements, market conduct, prompt payment, appeals and grievances, privacy and confidentiality, licensure, and benefit plan material or information. A potential for federal–state conflict is inherent in the provision because of the primacy of OPM in administering the program. To address this problem, in 2014, under its regulatory authority, OPM created a "dispute resolution process" to resolve conflicts between itself and the states. See John O'Brien, Director of Healthcare and Insurance, U.S. Office of Personnel Management, "Multistate "Multi-State Plan Program Dispute Resolution Process for States," *Multi-State Plan Program Administration Letter* No. 2014-003, March 14, 2014, https://www.opm.gov/media/4609387/2014-003.pdf (accessed October 1, 2021).
11. Affordable Care Act, Section 1334(e).
12. "The reason is that only a handful of insurance companies are currently in [a] position to participate. The issuers participating in the Multi-State Plan Program must be licensed in each state and have sufficient provider networks and financial reserves and an adequate information technology structure in place to meet enrollees' needs nationwide. Many plans that will fulfill those obligations are likely to be dominant players in state markets already." Sarah Goodell, "The Multi-State Plan Program," *Health Affairs* and Robert Wood Johnson Foundation *Health Policy Brief*, March 26, 2013, p. 3, https://www.healthaffairs.org/do/10.1377/hpb20130326.43447/full/healthpolicybrief_88.pdf (accessed October 1, 2021).
13. Letter from Douglas Elmendorf, Director, Congressional Budget Office, to Honorable Harry Reid, Majority Leader, United States Senate, concerning the spending and revenue estimates of the Patient Protection and Affordable Care Act, December 19, 2009, p. 9, https://www.cbo.gov/sites/default/files/12-19-reid_letter_managers_correction_noted.pdf (accessed October 1, 2021).
14. Timothy Jost, "Implementing Health Reform: Congressional Coverage, Multi-State Plan Program, and ACA Litigation with a Twist," Health Affairs Blog, October 1, 2013, https://www.healthaffairs.org/do/10.1377/hblog20131001.034663/full/ (accessed October 1, 2021).
15. U.S. Office of Personnel Management, Healthcare & Insurance, National Healthcare Operations, "An Overview of the Multi-State Plan Program," p. 7, https://marketplace.cms.gov/technical-assistance-resources/multistate-plan-program.pdf (accessed October 1, 2021). Curiously, OPM subsequently contracted with the so-called CO-OP plans, which were financed with generous federal loans, to bolster insurer participation—another ACA failed insurance scheme.

16. Senate Report No. 116-86, *Repeal Insurance Programs of the Multi-State Program Act*, pp. 3–4.
17. "It remains the goal of the MSP program to provide nationwide availability of MSP options by an issuer or group of issuers. However, the experience of the first three years of the program has demonstrated that providing nationwide coverage for any issuer or group of issuers is difficult to achieve. Moreover, the statute does not give the Director of OPM authority to compel any issuer to provide nationwide coverage or to participate in the MSP Program." John O'Brien, Director, Healthcare and Insurance, U.S. Office of Personnel Management, "Multi-State Plan Program Annual Letter for Plan Year 2017, *Multi-State Plan Program Issuer Letter* No. 2016-001, January 13, 2016, p. 2, https://www.opm.gov/media/5206258/multi-state-plan-program-plan-year-2017-annual-letter-.pdf (accessed October 1, 2021).
18. U.S. Office of Personnel Management, Healthcare & Insurance, "Multi-State Plan Program and the Health Insurance Marketplace: Overview," https://www.opm.gov/healthcare-insurance/multi-state-plan-program/consumer/ (accessed October 2, 2021).
19. Robert Pear, "U.S. Set to Sponsor Health Insurance," *The New York Times*, October 27, 2012, http://www.nytimes.com/2012/10/28/health/us-to-sponsor-health-insurance-plans-nationwide.html (accessed October 2, 2021).
20. U.S. Office of Personnel Management, Healthcare & Insurance, National Health Care Operations, "An Overview of the Multi-State Plan Program," pp. 7 and 9.
21. Rachana Pradhan and Paul Demko, "Another Piece of Obamacare Falls Short," *Politico*, September 7, 2016, https://www.politico.com/story/2016/09/obamacare-falls-short-227854 (accessed October 1, 2021).
22. Senate Report No. 116-86, *Repeal Insurance Programs of the Multi-State Program Act*, p. 5.
23. Ibid., p. 4.
24. Ibid., pp. 4–5.
25. There is a rich professional literature on the historical experience and success of the FEHBP. See, for example, Walton J. Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington: AEI Press, 2009); Frank B. McArdle, "Opening up the Federal Employees Health Benefits Program," *Health Affairs*, Vol. 14, No 2 (Summer 1995), pp. 40–50, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.14.2.40 (accessed October 1, 2021); Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, Volume 14, No. 4 (Winter 1995), pp. 47–61, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.14.4.47 (accessed October 1, 2021); and Allen Dobson, Rob Mechanic, and Kellie Mitra, *Comparison of Premium Trends for Federal Employees Health Benefits Program to Private Sector Premium Trends and Other Market Indicators* (Fairfax, VA: Lewin-ICF, 1992).
26. In fact, they were never counted among the lowest-cost or even the second-lowest-cost plans in any of the nation's health insurance exchanges. Senate Report No. 116-86, *Repeal Insurance Programs of the Multi-State Program Act*, pp. 4 and 8.
27. Health Policy Consensus Group, *Health Care Choices 20/20: A Vision for the Future*, November 18, 2020, https://galen.org/assets/HEALTH-CARE-CHOICES-2020_A-Vision-for-the-Future_FINAL-002-1.pdf (accessed October 1, 2021).