

WILL COMPETITION ARISE FOR MULTI- STATE HEALTH PLANS?

Recent regulations are unlikely to make the MSP program a platform for more robust health insurance competition.

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As part of the 2010 Patient Protection and Affordable Care Act (ACA), Congress and President Obama passed into law the Multi-State Plan (MSP) program. Beginning in 2014, the program requires the U.S. Office of Personnel Management (OPM)—the agency that administers civil service laws, rules, regulations, and the Federal Employees Health Benefits Program (FEHBP)—to contract with two or more national insurance carriers to offer coverage on health insurance exchanges. The program mandates that at least one carrier must be nonprofit. Coverage through an MSP program issuer must also be obtainable on exchanges in the District of Columbia and all 50 states within four years.

MSPs must fulfill certain statutory requirements, including

- provision of the 10 categories of essential health benefits
- coverage of preventive services
- age rating and pre-existing condition restrictions
- guaranteed issue and renewability

State and federal laws for particular insurance practices also apply, such as

- guaranteed renewal and rating
- coverage of pre-existing conditions and nondiscrimination
- quality improvement and reporting
- oversight to prevent fraud and abuse
- solvency and financial requirements

Similar to other ACA-qualified plans, MSP enrollment can occur through federally facilitated or state-facilitated exchanges. Contingent on family size and income, enrollees are also eligible for subsidies, as in other ACA plans.

Presently, the OPM has more than 200 MSP options available through two issuers on 36 exchanges. Despite Obama administration officials' projections of enrolling 750,000 people in MSPs by the end of 2014, recent estimates show that just 371,000 people are participating in an MSP plan. Average annual premiums for participants stand at \$4,200, according to OPM estimates.

The legislative history surrounding the creation of the MSP program is, to put it mildly, sparse. Some analysts who worked closely with developing the legislation noted that the program was not rigorously discussed.

The OPM reports that MSP options were developed to increase competition. Moreover, some advocates for the MSP program have argued that the pursuit of increased competition would meet the U.S. Senate's goal of a "public option," where the government would support a plan that competes with private insurance in health exchanges. Additionally, the OPM attributes the congressional authorization for its administration of the MSP program to its more than 50 years of experience running the FEHBP. Failure of the MSP program may lead to renewed calls for a public option. With the federal government's considerable involvement in health care and the requirement of nonprofit insurance in the MSP program, a public option may slowly come to fruition.

This article describes what the law says and does through the MSP program, the possible effect on health insurance markets, recent regulatory changes to the MSP program, and possible effects of the changes. Through our exposition we aim to shed

light on a program within the ACA that, contrary to its intended purpose, could damage competition. We also explore the possible effect of recent regulatory changes that may contribute to more or less competition in health insurance markets.

WHAT THE LAW SAYS AND DOES

The MSP program is created under Section 1334 of the ACA. It requires the OPM director to exercise the agency's contractual authority with the MSPs in the same way that it contracts with health plans in the FEHBP.

While the MSPs must comply with the laws and rules governing all other "qualified health plans" in the health insurance exchanges as promulgated and enforced by the U.S. Department of Health and Human Services, the OPM is authorized under Section 1334 (a)(4) to negotiate four specific items with the MSP plans: their medical loss ratios, profit margins, premiums, and provider networks. Moreover, in conducting negotiations with the plans, the OPM director shall take into consideration "such other terms and conditions of coverage as are in the interests of the

enrollees in such plans," according to Section 1334 (a)(4)(D). This is, of course, a formidable grant of broad administrative authority.

Under the law, the MSPs are automatically "qualified" plans by statute, and the OPM alone determines their eligibility for participation in the health insurance exchanges. Notwithstanding requirements that the plans meet state licensure and other requirements (such as financial or solvency requirements for health insurance), the OPM—as the agency asserts on the basis of its own regulatory authority—can override state laws and rules if it deems such an override in the interest of the MSP program. So, conceivably, the MSPs would not necessarily be subject to the same certification or qualification processes that are outlined for other "qualified health plans" participating in the health insurance exchanges.

Under Section 1334 (e), the MSPs enjoy another advantage. The issuer, contracting with the OPM, can only offer a plan in the exchanges if the issuer offers the plan in at least 60 percent of all the states in the plan's first year; 70 percent in the second year, and 85 percent in the third year. By the fourth year, an MSP issuer would be legally required to offer coverage in every exchange in the



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nation. MSP participation is thus confined to those issuers with a capacity to expand rapidly their geographic range of coverage.

POSSIBLE EFFECT ON HEALTH INSURANCE MARKETS

Evidence suggests that metropolitan statistical area health insurance markets (which constitute the relevant geographic market because provider networks are usually local) throughout the country are concentrated. In fact, in many markets, evidence shows that a substantial share of the market is dominated by a few health insurance issuers. Market power also is exercised and may lead to prices in excess of those in a more competitive market. While the ACA was put together with the idea of improving competition, the MSP program may make fruition harder.

The requirement that a given MSP must be available on all 51 exchanges in the United States within four years may damage competition. While larger insurers are more likely to already possess a national presence, smaller insurers are not as likely to be able to form the infrastructure necessary to establish an MSP with all 51 exchanges in that short time span. In essence, the four-year requirement serves as a barrier to entry that may increase concentration in the health insurance industry and deliver more market power to larger insurers. Some early evidence from this past June suggests that larger insurers are already using market power by intending to raise health insurance exchange premiums while smaller insurers propose decreasing rates or keeping them steady.

The MSP program also creates a barrier to entry by requiring that at least two MSP options must be available on all 51 exchanges, with at least one option originating from a nonprofit issuer. The requirement basically does not permit for-profit issuers to take part in the MSP program until a nonprofit makes an MSP option available. As a result, it is relatively more difficult for for-profit issuers to participate in the MSP program and provide additional competition.

While it is early, the future presents the opportunity to investigate the effect of the MSP program. If data are available, the program should be measured in each metropolitan statistical area market to determine

- the percentage of exchange participants who select an MSP
- alterations to the four-firm concentration ratio
- alterations to the Herfindahl-Hirschmann Index (HHI) that measures overall market concentration

Should the HHI and four-firm concentration ratios rise or remain stable in 2014 compared to 2013, or if the percentage of exchange participants choosing an MSP is high, it may imply a lack of competition from new health insurance exchanges and that the MSP program has not lived up to its hope of expanding competition.

OPM'S REGULATORY CHANGES

In light of challenges and potential pitfalls of the MSP program,

the OPM recently issued regulatory changes to the law. Some of the changes include but are not limited to:

- forming an MSP Program Advisory Board composed of a significant number of representatives of enrollees or enrollees themselves to provide feedback on the program
- altering the requirement that an MSP must present a plan to provide coverage statewide. The OPM believes increased flexibility is warranted to help determine the appropriate coverage area for an MSP issuer.
- making the process of benefit package selection more fluid
- providing flexibility for participation in the small business health options program

The OPM also claims that a regulatory impact analysis (RIA) of its proposed changes is not needed because an economic effect of \$100 million per year will likely not materialize from the alterations. It only permitted a 30-day public comment period for the regulatory changes.

Analysis/ The OPM's changes have the underlying goals of clarifying its approach to fulfilling its obligations in administering the MSP program and increasing competition. The OPM also indicates its objectives are to

- help consumers with the advent of additional competition
- deliver at least two choices of excellent health insurance plans
- create a framework where MSP issuers and non-MSP issuers operate in a fair and competitive environment for all 51 health insurance exchanges

The OPM hopes that its experience overseeing the FEHBP will help it to successfully run the MSP program.

As long as the MSP program exists, the OPM should consider taking all measures to promote additional competition. First, the OPM should reevaluate the rule that MSP providers need to make coverage available on all 51 health exchanges within four years. As noted, the current requirements dictate that an MSP must be available in 60 percent of states in its first year, increasing annually until it reaches 100 percent in its fourth year. The OPM may contact possible MSP issuers to ask if altering the four-year rule would increase participation in the program. Using the responses it obtains, the OPM may recommend to the president and Congress that changing the four-year rule may increase competition.

Congressional and public debate on the MSP program can best be characterized as deficient. The program appears to have been passed into law without a careful congressional evaluation of either its substance or its effects. Given that the program is still relatively new, there is considerable room for comments on its delivery and execution. For instance, concerning the proposed MSP Program Advisory Board, the OPM should carry out its formation of the board with a robust representation of ordinary

consumers rather than representatives of narrow special interests or political factions. Those consumers would be more likely to make recommendations to increase MSP quality and competition.

The OPM also intends to begin charging a user fee to MSP issuers in 2015 that amounts to 0.2 percent or less of MSP premiums. Currently, with 371,000 enrollees paying an average of \$4,200 per person in annual premiums, user fees should be a little over \$3 million. Reducing user fees temporarily for new issuers may help attract additional competition to the MSP program. The OPM should consider this economic incentive to help bolster competition.

As already noted, the OPM director is permitted to negotiate with MSP issuers on four specific items: premiums charged, profit margin, medical-loss ratio, and provider network adequacy. Each of those items can significantly affect premiums for a health insurance plan. In essence, the OPM director should deal flexibly with potential MSP issuers to increase competition—and, of course, refrain from favoritism.

The OPM may also wish to reevaluate the relatively short period of time it allowed for public comment on its recent regulatory changes. With a short period of 30 days, thorough analytics are hard to complete, making it difficult to fully explore the possible implications of the OPM's intended actions. A comment period of 90 days may have better served the interests of the public and the OPM.

Another issue is the OPM's dismissal of the need for a RIA. Under Executive Order 12866, a RIA must be completed if the OPM's proposed regulatory changes induce an economic effect of \$100 million or more per year. This would render the rule a "major rule" under current law and thus subject to a legislative veto under the Congressional Review Act. According to figures provided by the OPM, 371,000 persons are enrolled in an MSP and pay average monthly premiums of \$4,200 annually. Provided premiums remain constant, if regulatory alterations result in an additional 23,810 (i.e., a 6.4 percent increase), then a \$100 million effect would result. The Office of Information and Regulatory Affairs indicates that a RIA should yield useful information on the costs and benefits—qualitative and quantitative—of the program, the reasoning for regulations, and an exploration of a variety of regulatory approaches.

CONCLUSION

MSPs, administered by the OPM, are authorized to compete directly against all other health plans in all 51 health insurance exchanges. Under law and regulation, they are administered directly by the federal government for the ostensible purpose of fostering increased competition. But also under law and regulation, they are granted certain statutory advantages. For example, they report to the OPM, which can independently set criteria for their premiums, profits, provider networks, and medical-loss ratios. They can secure exemptions from state laws and rules governing health insurance if the OPM simply determines that a suspension

of, or exemption from, such state requirements is in the best interest of the MSP program. Finally, the pool of MSP competitors is artificially and automatically reduced because of the statutory requirement that confines participation to issuers who can readily achieve rapid coverage expansion over the next four years. Only large insurers can meet that requirement. No other "qualified health plans" enjoy such statutory or regulatory privileges.

The OPM's already formidable contractual authority over the terms and conditions of health plan participation in the FEHBP is transported into the MSP program. With the statutory and regulatory advantages available to MSP issuers, the OPM's administration could easily become the means for an even narrower health plan consolidation rather than robust competition in the health insurance markets. Not only could the OPM administer the MSP program to advance the president's particular health policies, but it could also lay the ground work for the public option initially championed by the Obama administration and its allies in Congress.

The OPM's recent regulatory changes to the MSP program also warrant a more thorough assessment. The changes that the OPM has made would be improved by a full RIA, a longer phase-in time requirement, a substantial number of seats allocated to consumers on the MSP Program Advisory Board, and an expansion of the amount of time devoted to public comments on the OPM's changes. Any alterations that could improve competition through the MSP program should be sought as long as the program exists.

Currently, data on the MSP program are sparse and do not reveal much about the program. For the future, any information that could provide greater insight into the effects of actions the OPM seeks should be made available to the public as the MSP program matures.

To date, it appears that the MSP program has not increased competition, its ostensible goal. But it can consolidate the health insurance markets and evolve, over time, into a novel, if unanticipated, version of the public option. R

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