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Health Policy Brief

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The Multi-State Plan Program. To boost competition in new insurance exchanges, the federal government will select and oversee at least two nationwide plans.

WHAT'S THE ISSUE?

One of the key mechanisms for expanding health insurance coverage under the Affordable Care Act is the creation of new insurance exchanges—marketplaces where people can compare and purchase qualified private health plans based on benefits, quality, and price. Although one goal is to stimulate competition among private health plans, in most states the insurance markets for individuals and small businesses are highly concentrated. For example, in 30 states a single insurance company accounts for more than half the enrollees in the individual market, and in most states one or two insurers dominate the small-group market.

To spur competition among plans, the Affordable Care Act also created the Multi-State Plan Program. The Office of Personnel Management (OPM), which administers health insurance programs for federal employees and members of Congress, will certify and oversee health insurance issuers to offer at least two plans in every state exchange.

This policy brief explores the background of the Multi-State Plan Program, the challenges facing OPM in administering it, and the issues associated with offering health insurance plans in multiple states.

WHAT'S THE BACKGROUND?

States have several options for organizing and operating their exchanges, also known as "health insurance marketplaces." A state can establish and operate its own exchange, work with other states to establish regional exchanges, or run an exchange in partnership with the federal government. If a state does not establish its own exchange, the Department of Health and Human Services will operate a "federally facilitated exchange" for the state (the option that most states have chosen to date). As of March 2013, 17 states and the District of Columbia have elected to operate their own exchanges; 7 states will operate partnership exchanges; and 26 states will let the federal government operate their exchanges for them.

Regardless of which entity runs an insurance exchange, there will be two types in each state—one for individuals and their families and one for the employees of small businesses, with the possibility that some states may combine their individual and small-group exchanges. (See previous Health Policy Briefs for additional background on insurance market reforms, published April 30, 2010; on the Small Business Health Options Program (SHOP) exchanges, published February 9, 2012; on federally facilitated exchanges, published January 31, 2013; and on CO-OP insurance plans, published February 28, 2013.)

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PROGRAM SPECIFICS: As mentioned, the Multi-State Plan Program was included in the Affordable Care Act to increase competition among the health plans offered through the exchanges. Under the law, the program will be administered by OPM, drawing on that agency's more than 50 years of experience in administering the Federal Employees Health Benefits (FEHB) program. An estimated 8 million federal workers and their dependents, federal retirees, and members of Congress and their staffs obtain health coverage through FEHB, making it the nation's largest employer-sponsored health insurance program. OPM has been recognized for its ability to negotiate relatively low rates with insurance carriers, keep administrative costs low, and offer government employees a wide range of health plans and coverage options.

OPM must certify at least two issuers to be able to sell coverage in the exchanges in time for open enrollment on October 1, 2013. By law, at least one issuer must be nonprofit, and one must not offer coverage for abortion services, so that people who have religious or other objections to abortion will not have their premium dollars subsidize the procedure.

The multistate issuers must offer plans in at least 60 percent of states on January 1, 2014, expanding to every state and the District of Columbia within four years. Until then, the insurance companies can determine which states they will offer coverage in, as long as they do so in a nondiscriminatory manner. The companies may initially offer plans in only parts of a state and expand to the rest of the state later on. Companies may also offer plans only in the individual markets and expand into the SHOP exchange markets over time.

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Also under the law, insurers participating in the multistate program must offer at least two plans through each exchange—one at the "silver" level of coverage and one at the "gold" level. These terms refer to the average percentage of medical costs a plan is required to cover. Silver plans on average will cover 70 percent of an enrollee's medical costs, and gold plans will cover 80 percent.

OVERSIGHT: Historically, insurance regulation has been a state responsibility, but for multistate plans OPM will play a greater regulatory role. In addition to oversight at the federal level, the insurance companies must also be licensed by each state in which they offer a multistate plan. They will also be subject to all pertinent state laws and regulations, so long as these rules do not conflict with the federal government's multistate plan requirements. OPM officials say that they will have a review and appeals process in place to deal with any unforeseen conflicts between federal and state requirements.

As it does with FEHB plans, OPM will negotiate premiums with participating multistate plan issuers, monitor their performance, and oversee plan compliance with legal requirements and contractual terms. Multistate plans that meet OPM's requirements will automatically be certified to operate in all the exchanges and will not need to be separately certified by individual states.

On March 1, 2013, OPM published a final regulation laying out additional requirements for the multistate plans and delineating specific areas of federal and state responsibility, as follows:

- **Appeals.** Multistate plan issuers will be subject to state laws regarding appeals procedures involving disputes over such issues as whether a particular aspect of care is deemed medically necessary and therefore to be covered by insurance. However, OPM will conduct a separate review when disputes involve issues of contract coverage, such as whether a benefit is covered under the plan. This approach is intended to make sure that disputes involving OPM-administered contracts are resolved in a uniform fashion across states.

- **Rate Review.** Nearly every state requires insurance companies to file their proposed rates for review by state regulators, who examine whether the rates are both affordable and sufficient to cover expected medical claims. Although state regulators may also review proposed rates of multistate plans, OPM will retain final authority, noting that the review process is essential for negotiating rates, which is OPM's responsibility.

- **Benefit Plan Materials And Information.** OPM intends to review all information that explains or describes the insurance products offered by the multistate plans. This intention does not preclude states from also requiring multistate plans to file this information for review by state insurance departments. OPM intends to work with states to resolve any discrepancies that may arise between federal and state reviews.

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Specific categories of exemption
The law specifies that if a multistate plan were exempted from federal or state laws in any of 13 specific categories, such as with respect to solvency and financial requirements, then other health plans would not be subject to those requirements, either.

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ESSENTIAL HEALTH BENEFITS: The Affordable Care Act requires qualified health plans in the individual and small-group markets to cover 10 categories of so-called essential health benefits, including hospitalization and emergency care, maternity and newborn care, ambulatory care, prescription drugs, and mental health and substance abuse. The health care law allows each state to choose from a set of plans to serve as the benchmark in their state. (See the Health Policy Brief published April 25, 2012, for more information on essential health benefits.)

With respect to the essential health benefits, OPM gives multistate plans some flexibility. Multistate plan issuers can offer essential health benefits equal either to a state's benchmark plan or to one of the three largest FEHB plans. However, OPM requires that whatever option the issuer chooses, it must be consistent across states. That is, an issuer cannot offer a state benchmark plan in one state and a FEHB benchmark plan in another. In taking this approach, OPM disagreed with some state insurance commissioners and consumer advocates, who had argued that multistate plan issuers should be required to offer the same essential health benefits package as other plans in a state to allow consumers to compare across health plans, reduce confusion, and ensure a level playing field.

SEAL OF APPROVAL: Multistate plans approved by OPM will be permitted to market themselves as being certified by a federal agency. Many states have laws prohibiting plans from advertising that they are endorsed by a government agency. In comments responding to earlier proposed federal regulations, the National Association of Insurance Commissioners expressed concern that multistate plans would gain a competitive advantage by claiming they were "government approved" or "government certified." OPM acknowledged this concern but said that the plans would, in fact, be OPM certified, and therefore state law could not prohibit them from using that designation.

WHAT ARE THE CONCERNS?

A core issue is whether the Multi-State Plan Program will genuinely increase competition among health plans. In addition, tensions over the Multi-State Plan Program have also arisen in several areas between the federal government and states and their respective regulatory roles.

COMPETITION: As noted above, although one of the goals of the Multi-State Plan Program was to increase competition, it is possible that the program could have the opposite effect and increase dominant players' share of an already concentrated market. The reason is that only a handful of insurance companies are currently in 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.

Many companies that are positioned to be able to participate in the Multi-State Plan Program already participate in FEHB. For example, Blue Cross Blue Shield (BCBS) is the dominant carrier offering preferred provider organization plans through FEHB. Nearly 65 percent of FEHB participants are enrolled in BCBS or one of its affiliates. In addition, BCBS is also the dominant carrier in the individual market in most states. If BCBS is chosen for the Multi-State Plan Program, it could lead to further market concentration, not increased competition. On the other hand, the Government Employees Health Association, commonly known as GEHA, may be positioning itself to participate in the Multi-State Plan Program. GEHA does not have a strong presence in states' individual and small-group markets, although it does participate in FEHB.

CONFLICTING AIMS: A conflict may emerge between federal officials' desire to carry out the law and have at least two multistate plans available through all exchanges and states' desire to drive the plans in the exchanges toward particular goals. For example, at least a handful of states are exploring so-called active purchasing strategies. In other words, instead of allowing all plans that meet certification requirements to participate in the exchange, a state regulatory authority operating as an active purchaser might select only those plans that submit the lowest bids or meet other standards, such as for customer service, benefit design, or quality.

The Multi-State Plan Program may interfere with such strategies, however. Under the Affordable Care Act, states must allow multistate plans to participate in their exchanges and cannot weed them out through active purchaser selection strategies.

REGULATORY CONFLICTS: Lawmakers drafting the Affordable Care Act included language requiring multistate plan issuers to operate on a "level playing field" with other plans in the exchanges. For example, the law specifies that if a multistate plan were exempted from federal or state laws in any of 13 specific categories, such as with respect to solvency and financial requirements, then other health plans would not be subject to those requirements, either. This provision was intended to ensure that multistate plans are neither competitively advantaged nor disadvantaged compared to other private health plans in the exchange.

But because OPM is the primary regulator of multistate plans, some state insurance commissioners and consumer advocates have expressed concerns that multistate plans might still not be subject to important state oversight and consumer protection laws and regulations beyond the 13 categories cited in the law. This, in turn, could give multistate plans an unfair competitive advantage over other insurance plans offered through the exchanges. OPM is providing a dispute resolution process if a state wants to challenge OPM's ruling that a state law is not applicable to a multistate plan issuer.

SERVICE AREAS AND PHASED-IN COVERAGE: As mentioned above, multistate plans must offer a plan in at least 60 percent of the states on January 1, 2014, and then expand to all states incrementally over four years. OPM has also determined that multistate plans will be able initially to offer coverage in only parts of a state and to expand coverage statewide over time. However, many stakeholders have objected to allowing multistate plans to have only partial coverage within a state, arguing that the plans could gain an unfair economic advantage by avoiding high-cost areas.

Acknowledging concerns for "cherry-picking," OPM says that it will review and approve expansion plans to ensure that they are not discriminatory—that is, they have not been designed to exclude high-cost or medically underserved populations. Nevertheless, depending on how the expansion is implemented, rural parts of many states—the areas suffering the most from a lack of competition—may not see the benefits of increased competition for years.

Similarly, OPM will allow multistate plans to phase in coverage in the small-group market through the SHOP exchanges. The small-group insurance market is nearly as concentrated as the individual market in most states; therefore, allowing plans to phase in small-business coverage will not quickly improve that situation.

There is also uncertainty as to how many insurers will participate in the multistate plan program. OPM has said that it is optimistic that there will be at least two issuers; however, as of the date of publication of this brief, none have made a definitive commitment.

WHAT'S NEXT?

OPM is now moving forward on implementation of the program. A final application form for issuers was published earlier this year and applications are due March 29, 2013. At that time, it will become clear how much interest there is from health plan issuers in participating in the Multi-State Plan Program. ■

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