manatt

December 3, 2012

Office of Personnel Management Releases Proposed Rules to Govern Selection and Operation of Multi-State Plans Under the Affordable Care Act

On November 30 the U.S. Office of Personnel Management (OPM) released its proposed rules for the Multi-State Plan Program (MSPP) of the Affordable Care Act (ACA). The ACA directs OPM to select at least two multi-state plans (MSPs) to be offered in each exchange.

The ACA seeks to harness the OPM's track record in sponsoring Federal Employee Health Benefit Program (FEHBP) national plans to create more choices within state individual and small group insurance markets, especially where there are only a few, dominant participants. For example, in 17 states, one insurer has at least two-thirds of the market in either the individual or small group markets or both.[1]

The MSPP and its rules are important not only to those who might consider applying to offer an MSP, but also to those interested in exchange operations, those who may compete against MSPs in the exchange, those who may contract with MSP issuers to provide products and services, and to consumers who may enroll in these plans.

Executive Summary

The proposed rules, which will be published in the *Federal Register* on December 5, seek to strike a balance between ensuring that the MSPP meets the goal of creating MSP options within exchanges and the concern that these plans may have advantages over other exchange products. The rules, consistent with the ACA, would accomplish this balance by generally subjecting MSP issuers to the same requirements as other plans within exchanges and, more generally, the same rules as other insurance products within a state.

The areas in which this balance is most difficult are in establishing essential health benefits (EHBs) and in implementing the so-called "level playing field" provisions of the ACA that are designed to ensure that MSP issuers neither have an advantage nor disadvantage in the exchange competition because they are not subject to all the same rules as other products.

For EHBs, OPM proposes a complex path that would provide MSP issuers with the option of adopting state-by-state EHBs or modifying an OPM-sponsored FEHBP benchmark for use in all or nearly all states. This attempts to navigate the difficult path created by the Department of Health and Human Services' (HHS) adoption of a state-by-state approach to EHBs that is at odds with uniform national benefits in MSP offerings.

To provide a level playing field, OPM proposes generally to require MSP issuers to follow state and federal laws that are critical to defining the terms of competition within exchanges, although OPM proposes some variations in the areas of appeals, rating, and benefit plan material or information.

[1] "Multi-State Plans Under the Affordable Care Act," Trish Riley and Jane Hyatt Thorpe, George Washington University, accessed at http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_A80A0AAA-5056-9D20-3D25B59C65680B79.pdf.

In other areas, the proposed rules offer few surprises in honing closely to the MSPP requirements established in the ACA. OPM is charged with negotiating premiums, profit margins, medical loss ratios and "other terms and conditions of coverage as are in the interests of enrollees."

These broad powers mirror the powers that an exchange has, particularly in a state that has chosen to make the exchange a selective or active purchaser. In essence, OPM is put in the place of the exchange in selecting issuers to participate in the exchange and negotiating the terms of their participation, as reflected in the ACA provision deeming MSPs to be Qualified Health Plans (QHPs).

The situation is more complex when it comes to state laws regulating the terms of health insurance coverage and how the coverage is priced. OPM recognizes the tension between its powers and these state "rate and form review" laws, which generally apply to all products sold inside or outside the exchanges, and proposes that MSP issuers remain subject to state reviews, with a dispute resolution process when there are disagreements. OPM does leave itself some room, however, such as the right to implement its negotiated rate if it determines that the state is acting arbitrarily.

Comments on the proposed rules are due on January 4, 2013.

Key Provisions

Eligible MSP Issuers

Under the ACA, both for-profit insurers and nonprofits are eligible to apply to provide MSPs. Insurers must be licensed to provide insurance in any state in which they propose to offer an MSP. The ACA requires, and the proposed rules specify, that at least one MSP issuer must be a non-profit. OPM is proposing to define nonprofits to include "a group of health insurance issuers licensed under State law, a substantial portion of which are incorporated under State law as non-profit entities."[2] The ACA also provides that issuers applying for an MSPP contract may include a group of issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark.[3]

Plan Selection and Contracting

OPM proposes to model MSPP plan selection and contracting on its approach in the FEHBP. OPM will solicit applications, negotiate and sign contracts with selected issuers. The contract term will be one year, subject to renewal at the discretion of OPM and the issuer. Renewal would not be automatic but dependent on compliance and annual agreement on benefits, premiums, coverage areas, and other terms. Where a current MSP issuer and OPM cannot agree on premiums and benefits, OPM will allow the MSP issuer to continue to offer its plan in the next plan year on the previous terms. OPM intends to get premium and benefit information for MSPs to exchanges according to exchange timelines for providing such information.

Phase-In and Coverage Area

As provided for by the ACA, the MSP issuers do not initially need to provide coverage in all states. Instead, the ACA allows MSP issuers selected to begin offering MSPs in 2014 to phase in plans as long as they cover 60 percent of states (31) in 2014, 70 percent of states (36) in 2015, 85 percent of states (44) in 2016, and all states in 2017 and after.[4] Consistent with this, the proposed rules clarify that MSP issuers do not need to have insurance licenses in all 50 states from the start, just the ones in which they will initially offer MSPs.

In addition, OPM proposes that MSP issuers may, initially, cover only parts of a state (as coverage areas are defined by the state exchange) as long as they submit a plan for how they intend to expand coverage to the entire state over time. OPM also is considering allowing MSP issuers to offer coverage in only a part of an exchange service area as long as OPM determines that the choice of areas is not designed to

[2] Proposed rule at page 26 as accessed at http://www.ofr.gov/OFRUpload/OFRData/2012-29118_PI.pdf.
[3] Section 1334(a)(1).
[4] For issuers entering the MSPP after 2014, the four-year phase-in will begin the year they enter the program.

discriminate against certain people or to seek a favorable risk pool. OPM is seeking comment on whether coverage of an entire state should be required by the fourth year of MSPP participation, which is when MSP issuers must cover all 50 states and the District of Columbia.

Required Plan Offerings

OPM proposes that an MSP issuer must offer at least one plan at the Gold and Silver levels in the individual exchange market. The issuer may also apply to OPM to offer Bronze and Platinum plans. OPM is also proposing that issuers do not have to offer plans in the Small Business Health Option Programs (SHOP) exchange during the four-year phase-in period. If issuers choose to participate in the SHOP exchange, they must also offer one or more Gold and Silver plans and may offer Bronze and Platinum plans. If they do not initially participate in SHOP, OPM will require issuers to provide a plan for how they will expand coverage to the SHOP over time. Issuers will also have to offer a child-only plan for each metal level they offer in the exchange.

Essential Health Benefits

While the ACA requires that MSP issuers provide a uniform benefit package that includes all EHBs,[5] the approach that HHS has taken in allowing state-by-state variation in EHBs has led OPM to propose an EHB rule for MSPs that requires uniformity of benefit packages within a state but not necessarily among states.

OPM proposes to give MSP issuers two options. The MSP issuer may base the benefits it offers within a state on either:

- the EHB benchmark for the state, or
- an OPM-selected benchmark (one of the three largest FEHBP plans by enrollment: Blue Cross Blue Shield (BCBS) Standard Option, BCBS Basic Option, and Government Employees Health Association (GEHA) Standard Option.

If an MSP issuer selects the first option (state EHB benchmark), it may modify the benefits it offers consistent with HHS rules on making actuarially equivalent substitutions. If the issuer selects the second option (OPM-selected benchmark), then it must supplement the chosen OPM benchmark plan with specified vision and dental options.[6] It must also add habilitative services as either defined by the state or, where states have not defined them, by OPM.

In addition, an MSP must provide all state-mandated benefits enacted prior to December 31, 2011. These benefits will be considered part of the EHB package for MSPs, regardless of whether the MSP issuer chooses the option of a state EHB benchmark or OPM-selected benchmark (at least for 2014 and 2015). That is, even if an MSP issuer opts for an OPM-selected benchmark that does not contain a state-mandated benefit, that benefit will nonetheless be considered an EHB. Therefore, states will not be required to pay for these mandated benefits. As with other plans that are not MSPs, state-mandated benefits enacted after December 31, 2011, will require the state to pay the full additional cost of the MSP providing those benefits.

The proposed rules would require MSP issuers to submit their proposed benefits packages, including prescription drug lists, to OPM so that it can determine whether the benefits are "substantially equal" to the benchmark. As discussed below, states have a similar responsibility to review issuer filings to determine compliance with benefit mandates and other legal standards. OPM pledges cooperation with states in areas such as evaluating products for discriminatory benefit designs, but OPM does not clearly indicate what the consequences are if a disagreement over a benefit issue cannot be resolved.

Whichever EHB option the MSP chooses, it must follow that choice in all states in which it offers a plan

[5] Section 1334(c)(1)(A).
[6] The largest Federal Employee Dental and Vision Insurance Program (FEDVIP) dental and vision plan options (MetLife Federal Dental Plan High Option and FEP BlueVision High Option).

(i.e., an MSP can't choose to follow an OPM-selected benchmark in some states and the state benchmark in others). However, the proposed rules create an exception to this general requirement that mandates that MSPs use the first option (state EHB benchmark) in any state that does not "allow substitution for services at all within the benchmark benefits."[7] Some believe that this exception undermines the ACA intent that the MSPP provide a standard, national option.

The proposed rules caution that EHB provisions are subject to change as HHS finalizes its EHB rule.

Premiums, Rate Review, and Medical Loss Ratio

Consistent with its administration of the FEHBP and the requirements of the ACA, OPM will negotiate with MSP issuers on premiums, medical loss ratios (MLRs), allowable profits and other terms. OPM pledges to issue guidance to potential issuers to guide rate submission as they do with the FEHBP. Premiums will vary from state to state. OPM announced that there will be no national premium plans as exist in the FEHBP.

This means that OPM intends to do rate and form reviews that overlap with state reviews generally required before health insurance products, including those to be offered on the exchanges, can be sold to consumers. OPM seeks to walk a fine line in this area, protecting its prerogatives to do reviews but also proposing to work closely with states. In terms of reviewing MSP rates, while OPM will do reviews, it proposes to share such authority with states that also have rate review authority over exchange plans. If a state has HHS certification as an "Effective Rate Review Program," the proposed rules would require that the MSP comply with state standards. If a state does not have such a program and HHS is therefore conducting rate review for the state, OPM proposes to replace HHS and be solely responsible for rate review of the MSPs.

In cases where there is disagreement between OPM and an effective state program, OPM pledges to work with the state to try to resolve differences. In the preamble, OPM states its expectation that there will be few such disagreements. However, if there is an unresolved difference and the state denies rate approval for reasons that OPM determines are arbitrary, capricious, or an abuse of discretion, OPM will make the final decision.

In terms of reviewing the policy and contract terms for MSPs, the proposed rules provide that OPM will review these forms as it typically does for FEHBP plans. However, OPM recognizes that states will also conduct such reviews under their traditional function of form review. OPM pledges that it will resolve disagreements with states that may arise from states' concurrent review process, though it is unclear what the consequences are if a disagreement cannot be resolved.

On MLRs, OPM states that it intends generally to follow the rules that apply to all plans, but it reserves the right to establish different rules for MSPs as allowed by the ACA. The preamble discloses that OPM does not intend to apply its own national aggregate MLR. If an MSP violates the MLR rules, OPM will sanction plans, including through limits on marketing or termination of contracts.

At this time, OPM does not believe it will establish a set profit margin, but it is seeking comment on whether it should.

Risk Pooling

MSP enrollees will be considered to be in the same risk pool as all other non-grandfathered plans in individual and small group markets. This means that MSP business will be pooled with the rest of the issuer's business in the individual and small group markets, respectively, unless the state has merged the two markets, in which case the issuer would have one combined pool.

[7] Proposed rule at page 35 as accessed at http://www.ofr.gov/OFRUpload/OFRData/2012-29118_PI.pdf.

Level Playing Field

In order to ensure that MSPs compete fairly in exchanges and do not have any advantages over other exchange plans or disadvantages based on different rules, the ACA provides level playing field requirements. Under these requirements, if OPM exempts an MSP from any state or federal law related to one of 13 categories of plan rules, then all insurers (inside and outside exchanges) in the state are also exempt.[8] The categories are:

1. guaranteed renewal,
2. rating,
3. preexisting conditions,
4. nondiscrimination,
5. quality improvement and reporting,
6. fraud and abuse,
7. solvency and financial requirements,
8. market conduct,
9. prompt payment,
10. appeals and grievances,
11. privacy and confidentiality,
12. licensure, and
13. benefit plan material or information.

Despite the fact that OPM proposes some rules in these categories that differ from those that otherwise may be applicable within a state, OPM states its belief that these differences do not trigger the level playing field requirement to exempt all state insurers from any of the requirements in these categories. In the preamble, OPM writes that

> to the extent any of the rules governing MSPs and MSPP issuers differ from those governing QHPs, they will be designed to afford the MSPs and MSPP issuers neither a competitive advantage nor a disadvantage with respect to other plans offered on the Exchange.[9]

OPM promises to monitor implementation to evaluate whether any of its proposed categories of plan rules, advantage or disadvantage MSPs or non-MSPs in exchanges. OPM is also proposing a process for states to seek changes in the MSPP where a state believes that state-specific requirements, other than in any of the 13 categories, may conflict with the MSPP. Although this process would not include requirements in the 13 categories, OPM is seeking comment on whether it should.

The specific categories in which OPM believes that its rules differ from those in the states but do not create advantages or disadvantages for MSPs are appeals, rating, and benefit plan material or information. These differences are described below:

Appeals

For internal appeals, the proposed rules would require MSP issuers to meet the same standards as the ACA requires of all non-grandfathered health plans. For external appeals, however, OPM is proposing to use its own appeals process that is "similar to the disputed claims process administered under the FEHBP."[10]

This proposed external appeals process differs from the process required by the ACA of all plans, inside and outside an exchange. Generally, the ACA requires that plans comply with a state external review process that complies with the NAIC Model Act on external review. In states where the state process does not comply with the NAIC Model Act, HHS establishes a similar process. HHS has determined that most

[8] Section 1324(b).
[9] Proposed rule at page 8 as accessed at http://www.ofr.gov/OFRUpload/OFRData/2012-29118_PI.pdf.
[10] Proposed rule at page 64 as accessed at http://www.ofr.gov/OFRUpload/OFRData/2012-29118_PI.pdf.

states have external review processes that comply with the NAIC Model Act. In addition to being different from state and HHS external review, the OPM external reviews will be appealable in federal court under the federal Administrative Procedures Act. This is different from most external appeals in the individual market outside of MSPs, where there is no right to federal court review.

Although OPM believes that utilizing its own external appeals process based on FEHBP does not trigger level playing field issues, it is seeking comment. Some may disagree with OPM's conclusion and may believe that a different external appeals process may advantage an MSP.

Rating

Under the proposed rules, MSPs will be subject to same rating limitations as other plans in the state such as limits on varying premiums based on family composition, geographic area, age, and tobacco use. For example, if a state modifies its rating rules, as allowed by the ACA, to narrow the 3:1 maximum allowed age rating ratio or implement pure community rating, OPM will require MSPs to comply with such changes.

While OPM will do its own rate reviews, it does not believe this conflicts with the level playing field requirements, since such reviews will be based on each state's rating rules. As discussed above regarding rate reviews, the same rating rules are applied in state and OPM rate reviews. However, it is possible that OPM will receive comment on this issue.

Benefit Plan Material or Information

OPM proposes to review and approve plan materials, but does not believe this violates level playing field requirements since OPM also expects MSP issuers to comply with state review processes. As noted in the rate review section above, OPM also believes that any disagreements arising from joint review can be resolved to the satisfaction of both OPM and the state.

OPM also proposes to allow MSP issuers to advertise that they are OPM approved. This may conflict with state laws that prevent statements by issuers that they are endorsed by a government agency. Plans that are not MSPs may raise competitive issues with this and assert that the level playing field requirement should come into play.

Reporting Requirements

The proposed rules would require MSPs to make regular reports to OPM in a manner similar to FEHBP plans including financial reports, premium payment information, enrollment reporting, and quality assurance information. For quality reporting, OPM intends to use, as it does for FEHBP, Healthcare Effectiveness Data and Information Set (HEDIS) metrics and Consumer Assessment of Healthcare Providers and Systems (CAHPS).

User Fees

OPM has reserved making any decisions on user fees for MSP issuers. Therefore, we do not yet know what fees, if any, MSP issuers will pay to OPM and whether MSPs will be required to pay some or all of the fees to exchanges that are charged to other plans. This is an important potential issue for QHPs in exchanges that may want to ensure that MSP issuers pay fees so as not to have a competitive advantage over exchange plans that must pay fees.

Conclusion

MSPs have the potential to add competition to state exchanges, particularly in the third of states without significant competition today. In its proposed rules for the MSPP, OPM has attempted to navigate the tricky waters created by the ACA's sometimes inconsistent goals of MSPP national uniformity and the ACA's deference, in many cases, to state regulation of the health insurance market. Comments on the proposed rules and its implementation starting later in 2013 will reveal its success.

****

About Manatt, Phelps & Phillips, LLP
Manatt, Phelps & Phillips, LLP, is one of the nation's leading law firms, with offices strategically located in California (Los Angeles, Orange County, Palo Alto, San Francisco and Sacramento), New York (New York City and Albany) and Washington, D.C. The firm represents a sophisticated client base – including Fortune 500, middle-market and emerging companies – across a range of practice areas and industry sectors. For more information, visit **www.manatt.com**.

About Manatt Health Solutions
Manatt Health Solutions is a division of Manatt, Phelps & Phillips, LLP. Its interdisciplinary team provides strategic business advice, policy analysis, project implementation, and coalition-building and advocacy services to clients in the areas of health information technology, healthcare access and coverage, including development of new healthcare delivery system models. MHS professionals also provide counsel on financing, reimbursement, restructurings, and mergers and acquisitions to clients in the healthcare sector. For more information, visit **www.manatthealthsolutions.com**.