



Multi-State Plans Under the Affordable Care Act¹

Trish Riley
Jane Hyatt Thorpe²

Abstract

New state health insurance exchanges that are developing under The Patient Protection and Affordable Care Act (ACA) will offer consumers a choice of private health plans known as qualified health plans (QHPs). Under the law, in every state, two of those must be multi-state plans or MSPs. These plans will be administered by the federal Office of Personnel Management (OPM). The MSPs must meet the same requirements as other QHPs. As with other QHPs, people enrolled in the plans will be eligible for premium tax credits and cost sharing assistance if their income is less than 400 percent of poverty or \$92,200 for a family of four. OPM, which also administers the Federal Employee Health Benefits Plan, must administer MSPs separately and must contract with both a non-profit insurer and one that does not provide abortion coverage. OPM will negotiate premiums, set rates, establish medical loss ratios and profit margins as well as certify and de-certify plans and make sure they have adequate networks of providers. OPM is expected to release its proposed rule on the MSPs this spring. This paper, based on interviews with federal and state policy makers and others, examines key implementation issues.

Overview

In 2014, The Patient Protection and Affordable Care Act (ACA) will provide near universal health insurance coverage through a substantial expansion in Medicaid, premium tax credits that will cap premium contributions as a share of income for people purchasing private plans through new state insurance exchanges, and new insurance market rules that will prevent health insurers from denying coverage or charging higher premiums to people with preexisting health conditions. With some exceptions, all individuals will be required to obtain insurance coverage through employers, public programs, the individual market, or the health insurance exchanges for the individual and small group markets.

A primary goal of the law is to increase consumer choice by stimulating market competition among health plans to offer more affordable, value-based options through the new insurance exchanges. The state health insurance exchanges are designed to provide consumers choices among pre-approved health plans that meet certain federal standards ranging from the provision

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² Trish Riley is a Distinguished Visiting Fellow and Lecturer in State Health Policy and Jane Hyatt Thorpe, J.D. is an Associate Research Professor in the Department of Health Policy, School of Public Health and Health Services at George Washington University. The authors wish to thank Resa Cascio, J.D. for her research and contributions to this paper.

of specific benefits to anti-discriminatory requirements for pre-existing health conditions.³ Only plans that meet these standards – the qualified health plans or QHPs – will be allowed to participate in the exchanges. To further foster competition, the ACA also requires two QHPs participating in each exchange to be multi-state plans or MSPs. Unlike other QHPs participating in state-based exchanges that will be regulated at the state level, the MSPs will be licensed by the states but regulated by the federal Office of Personnel Management (OPM), the same agency that is today responsible for the Federal Employees Health Benefit Plan (FEHBP).

What are the multi-state plans?

The ACA charges the Director of OPM to establish two MSPs and offer them through state exchanges – one plan must be offered by a non-profit organization and one plan must not provide abortion coverage. MSPs must meet the same federal requirements as other QHPs, including offering certain essential health benefits and setting premiums that do not discriminate based on pre-existing health conditions and other factors such as race and gender, as well as any additional state requirements (e.g., provision of additional essential health benefits at state option and cost). Individuals enrolled in an MSP are eligible for premium tax credits and cost sharing assistance just like the credits and assistance available through a QHP that is only offered in one state. However, unlike other QHPs, MSPs must offer uniform essential health benefits in every state in which they operate and be available in all geographic regions and in all states that adopted a community-based rating system for setting premiums prior to the passage of the ACA (e.g., rating systems that take into account the health of the entire population and not certain subgroups). As discussed further below, OPM will be responsible for contracting with and oversight of the MSPs rather than the states.

The MSPs will be phased in nationally and available in 60% of states in year one, 70% in year two, 85% of states by year 3 and all states in subsequent years. The MSPs must be separate from the FEHBP, with a separate risk pool. That is, the revenues from MSPs and the claims against those revenues to pay for care for MSP enrollees must be kept separate and distinct from the costs of FEHBP. The OPM Director may not take resources away from FEHBP, but may create separate offices to administer the MSPs. Health insurance companies or carriers participating in FEHBP cannot be required to participate in a MSP.⁴

OPM has a long track record in administering health plans. The FEHBP offers federal employees and retirees and their dependents coverage through over 200 plans. They include plans that are nationally available, local Health Maintenance Organizations (HMOs), and various high deductible and consumer driven plans across the country. OPM has been able to negotiate lower premium growth than other large employer purchasers.⁵

³ QHPs must be certified, comply with rules and regulations related to marketing, applications and notice, transparency, enrollment and termination and must offer at a minimum one silver and one gold plan. Patient Protection and Affordable Care Act § 1334, 42 U.S.C. § 18054 (2011).

⁴ §1334(g).

⁵ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-141, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: PREMIUM GROWTH HAS RECENTLY SLOWED, AND VARIES AMONG PARTICIPATING PLANS (2006).

Who has oversight for MSPs in the exchanges?

The OPM Director will contract with health insurance companies to offer MSP individual coverage and group coverage for small employers in exchanges for a one-year maximum term. This is different from the arrangements for other QHPs, which will contract directly with states. The MSP contracts will be automatically renewable for additional one-year terms. This approach is modeled on how OPM administers nationally available FEHBP plans.

MSPs must be licensed in each state and meet other state requirements similar to the intrastate QHPs, but it is the OPM Director that has general oversight of the MSPs. OPM will negotiate premiums, set profit margins, medical loss ratios, and other coverage terms with insurers and can prohibit them from offering plans that do not meet these terms. This is important because these are functions that states will carry out for other QHPs. OPM may go beyond state regulations to establish more rigorous review than states and to more actively pursue value-based purchasing or payment reform strategies, for example.

In addition, CMS has recently released rules⁶ governing state exchanges which further clarify that OPM will determine if MSPs meet all QHP standards and will certify, recertify, and decertify MSPs.⁷ OPM also will determine rates, transparency reporting, accreditation timelines and network adequacy standards for MSPs. In addition to exemption from state certification procedures for QHPs, MSPs are exempt from Exchange processes for receiving and considering rate increase justifications and for Exchange processes for receiving annual rate and benefit information.

Further, an MSP must meet specific requirements set by OPM and meet relevant state requirements. For example, consumers are protected if an MSP experiences difficulties. MSPs that are discontinued must credit contingency reserves to the contingency reserves of continuing plans for the contract term following termination. OPM has established regulations in the event that a plan discontinues prior to receipt of contingency fees owed due to discontinuance of a different plan.

Upon OPM approval, MSPs will be “deemed” eligible to participate in every state’s exchange – that is, a state exchange cannot deny consumers’ access to the two MSPs. This raises concern in some states as it will prevent states that may be pursuing value-based purchasing and selective contracting from eliminating MSPs that are not subject to state oversight as an option through their exchanges.

⁶ Department of Health and Human Services, CMS-9989-F: The Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (Mar. 12, 2012), http://www.ofr.gov/OFRUpload/OFRData/2012-06125_PL.pdf.

⁷ An insurer must receive notice and a hearing before the Director can revoke an approved contract. *Id.*

A level playing field

While providing for specific responsibilities to rest with the federal rather than state government, the ACA does require MSPs and other QHPS to operate on a “level playing field.”⁸ If the MSPs (or the Consumer Operated and Oriented Plan (Co-OP) also established by the ACA) are exempted from thirteen specific provisions in federal or state law, then private health insurers offering QHPs are also exempted. This assures that the MSPs meet the same minimum standards as all other QHPs.

Some fear that in order to negotiate lower rates for MSPs, the OPM could hold MSPs to lower standards than the state which would pre-empt state regulation for all plans. That is, if MSPs are held to lower standards, the level playing field language says that the OPM standards will effectively become the market standards in that state. The level playing field language then, gives assurances to states that OPM will comply with the following minimum standards or risk disruption in market oversight. Those standards include:

- guaranteed renewal
- rating
- pre-existing 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

Nothing in the law prohibits MSPs from going beyond state minimum requirements. For example, OPM may wish to hold the MSPs to higher quality standards than other QHPs.

How can MSPs provide a uniform benefit in each state?

The federal government recently issued a bulletin that provides some state discretion in defining essential health benefits. Specifically, the bulletin requires that all plans sold through the exchanges and in the individual and small group markets must offer the ten essential health benefits defined in the law. States can choose a benchmark plan from among four choices. Those choices include 1) one of three largest plans sold in the small group 2) one of three largest plans in the state employee health plan 3) one of the three largest plans offered by the federal

⁸ § 1324.

employee health benefits plan or 4) the largest HMO in the commercial market.⁹ Allowing each state some discretion in defining the essential health benefit may complicate how MSPs could then offer a uniform benefit in every state, as required by law. Specifically, the law requires that “the plan offers a benefits package that is uniform in each state and consists of the essential health benefits....” Some read that language to mean plans must be uniform only in each, single state; others note that the language does not say uniform “within” each state and therefore believe that the law’s intent is to promote a single uniform benefit.

OPM seeks stakeholder guidance on implementation of the MSPs

OPM has reached out to stakeholders for guidance on how to best implement the MSPs. While the ACA calls upon the OPM Director to create an Advisory Board to provide recommendations about the MSPs, the composition of that Board must be enrollees of the plans or their representatives so the group cannot yet be convened. However, on June 16, 2011, OPM issued a Request for Information (RFI) to gather information on key implementation issues. In the RFI, OPM envisions establishing MSPs in much the way it operates the FEHBP, with annual negotiations of rates under a national contract. OPM anticipates having contracts in place with MSPs by October 2013.

The RFI was directed to health insurers and solicited feedback in five broad categories: background and interest; network and quality measures; enrollment and marketing; operations; and pricing and reserves. Responses were due August 2011 but that deadline was extended. OPM has responded to some questions raised through the RFI process but has not made responses public.

Although the RFI was directed to health plans, other organizations responded and have made their comments public. Notably, the National Association of Insurance Commissioners (NAIC) submitted lengthy comments critical of the plan, largely based on the potential to provide large insurers with significant, anti-competitive market share, opposition to deeming and concerns about appropriate safeguarding of consumer protection and state regulatory roles. NAIC also raised concerns about an uneven playing field, the potential for adverse selection and the impact on rates if MSPs are held to different rules as well as the potential to diminish a state’s value purchasing efforts by deeming plans in an Exchange. NAIC cautioned OPM not to engage the non-profits currently offering FEHBP coverage as they meet different solvency standards than commercial carriers are held to by the states.¹⁰

The American Medical Association also made public comments to OPM, echoing some of the concerns of NAIC regarding the level playing field and the need for consumer protection,

⁹ December 16, 2011, the HHS Center for Consumer Information and Insurance Oversight (CCIIO) released an Essential Health Benefits Bulletin with comments due by January 31, 2012.

¹⁰ Letter from National Association of Insurance Commissioners to Cheryl Allen, United States Office of Personnel Management (Aug. 10, 2011), http://www.naic.org/documents/committees_b_110810_naic_comments_msp_to_opm.pdf.

network adequacy and prompt payment protections.¹¹ The AMA called upon OPM to hold MSPs to standards, articulated in the AMA Health Insurer Code of Conduct Principles, that are higher than the baseline included in the ACA.

OPM is currently reviewing comments and deliberating questions about the MSPs in anticipation of rulemaking in the spring of 2012.

Potential Opportunities and Challenges for MSPs

As OPM moves through the rulemaking process and toward implementation of MSPs, there are a number of opportunities and challenges that OPM and stakeholders will need to consider.

Potential Opportunities

Will MSPs provide more competition and consumer choice?

The availability of two MSPs in every exchange by 2017 can significantly increase plan choices for consumers in the exchanges. For the many states with consolidated markets, MSPs could be uniquely positioned to expand competition. However, the potential for new covered lives through the individual mandate and premium and cost sharing tax credits may not be enough to increase competition in markets that are highly concentrated and have long been unattractive for insurers.

The median market share of the largest insurer in the individual market was 54% (and 51% in the small group market) in 2010.¹⁰ In eleven states the largest insurer has over 73% of market share in the individual market and in ten states one insurer holds 67% or more of the market share in the small group.

In short, in seventeen states one insurer holds at least 67% of market share in either the individual or small group markets or both. These states are disproportionately small and rural and include: Louisiana, Mississippi, Alabama, Tennessee, South Carolina, Maryland, Rhode Island, Montana, South and North Dakota, Arkansas, Kentucky, North Carolina, Virginia, New Jersey, Iowa, and Vermont. For these states, the availability of an MSP may be the only assurance of increased competition. But, to meet that goal of increased competition, who would that MSP be? The GAO recently surveyed states regarding the small group market. Fourteen of the seventeen states reported above responded to the survey; in thirteen, a Blue Cross Blue Shield plan was the single largest carrier and, on average, held about 60% of the market share.¹²

Blue Cross Blue Shield plans are significant players in the individual and small group markets and many are non-profit. If they are selected as the non-profit MSP, the result could be further

¹¹ Letter from James Madara, M.D., CEO, American Medical Association to Cheryl Allen, United States Office of Personnel Management (Sep. 6, 2011); KAISER FAMILY FOUNDATION, HOW COMPETITIVE ARE INSURANCE MARKETS?, (2011) <http://www.kff.org/healthreform/upload/8242.pdf>.

¹² U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-09-363R, PRIVATE HEALTH INSURANCE: 2008 SURVEY RESULTS ON NUMBER AND MARKET SHARE OF CARRIERS IN THE SMALL GROUP HEALTH INSURANCE MARKET (2008).

market consolidation, rather than increased competition. Generally, Blues plans operate within their own geographic service areas. This suggests that, in those states where a for-profit Blues plan holds significant market share, a non-profit plan other than a Blues plan would be required to assure an MSP that could bring added competition.

As OPM contemplates how best to phase in the MSPs, it might consider including these states with highly concentrated markets in the first wave of implementation.

How will MSPs and federally facilitated exchanges operate?

Only fifteen states have enacted legislation or are operating under a Governor's executive order to create an exchange, either for the individual market or the SHOP exchange for small business. While states are making progress, it seems likely that the federal government will be deeply engaged in federally facilitated exchanges in 2013-14. There may be additional opportunities for the federal government to coordinate the offer of MSPs with their own exchange development. For example, in those states that do not enact legislation to establish exchanges by 2013, it is possible that they likewise may not enact the insurance reforms required in the ACA. Although states have been actively engaged in enacting the early insurance reforms, such as elimination of lifetime benefits and mandating coverage of young adults on parents' plans,¹³ some states may be unable or unwilling to enact guaranteed issue and community rating requirements in time for ACA implementation. Those provisions will need to be in effect by late 2013 in order to begin marketing under the ACA. In that instance, responsibility to assure marketplaces are in compliance with the law will fall to federal officials. That regulatory role, coupled with a federally facilitated exchange, may provide opportunities for the federal government to include MSPs in those marketplaces and to make them market leaders

Can MSPs be a high value option?

OPM will negotiate nationally and can, through its premium setting and other authorities, negotiate for high value plans. The language that assures MSPs operate on a level playing field and meet the same general rules that other plans meet does not preclude an MSP from going beyond those minimums. For example, they may elect to hold MSPs to higher quality standards. Because the federal government will establish network adequacy standards for MSPs, there may be opportunities for selective contracting with providers who meet higher quality standards. MSPs with the same benefits, operating through one contract from OPM and the reporting and oversight it provides, could be a model engaging in national marketing, quality and consumer information efforts. The plans offered as MSPs could become national benchmarks of quality performance.

The National Committee on Quality Assurance (NCQA) issued a "Value Agenda for Health Plans" in its 2011 annual report. It identifies five broad categories for plans to follow to achieve

¹³ KATIE KEITH, KEVIN LUCIA & SABRINA CORLETTE, THE COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: STATES ACT ON EARLY MARKET REFORMS (2012)
http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Mar/1586_Keith_state_action_early_market_reforms_v2.pdf.

high value. Those include fostering delivery system reform; designing benefits and reimbursement strategies that improve health and reduce ineffective care; collecting and publically reporting performance data; and establishing provider networks that use value metrics and support centers of excellence and activating patients, including in health promotion and end of life care. OPM could negotiate with plans and use its authorities to establish rates and define network adequacy, for example, to select plans as MSPs that best demonstrate a value agenda at an affordable price.

Can MSPs offer greater portability-coverage that travels with enrollees?

Americans are a mobile society and might value a plan that moves with them. Families may include students or spouses who live and work in different states and may now be required to participate in different health plans. Young adults may be more inclined to purchase coverage that was designed to meet their needs and pocketbook.

An MSP could offer continuity of coverage and assure a family that all its members could be covered in one plan, regardless of their state of residence. The ACA requires the creation of catastrophic plans for young adults, exempt from the essential health benefit definition that may vary by state. As such, a young adult product could be a starting point for MSPs.

Could federal agencies work creatively to expand Medicaid and exchange collaboration?

Significant numbers of exchange enrollees will experience income fluctuations that will cause them to churn between Medicaid and subsidy eligibility through the exchanges. Low-income Americans often have fragile and erratic connections to the workplace and see their incomes vary significantly throughout the year. Based on historical data, within six months, more than a third of all adults (age 19-60) with family incomes below 200% of the federal poverty level might be expected to experience income fluctuations that might change their eligibility from Medicaid (for families with incomes under 133% of poverty) to subsidized private coverage through the insurance exchanges or the reverse.¹⁴ The potential for these enrollees to fall through the cracks, lose needed coverage or be required to change provider networks as their coverage changes will create further administrative challenges for both Medicaid and the private plans in the exchange. If a health plan, either directly or in collaboration with others, agrees to participate in a state's Medicaid program, enrollment can be seamless and continuity of coverage and care assured, should a state choose to contract with that plan. A member who loses Medicaid or who loses tax subsidies because of Medicaid eligibility could stay in the same plan with the same providers; a back office function could assure the proper allocation of costs between Medicaid and private coverage, given that two distinct payers will need to be coordinated.

The ACA's provision, that those newly eligible for Medicaid may be offered a plan more like a commercial product than most Medicaid benefits, provides additional opportunity for health plans, including MSPs. But each state Medicaid program will have unique attributes and the

¹⁴ Benjamin Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Health Insurance Exchanges*, 30 HEALTH AFF. 228 (2011).

churning between the tax credits and Medicaid will not be limited to those newly eligible. That raises issues about how best to coordinate the two programs through the MSPs.

Of course the challenges of incentivizing any plans, including the MSPs, to enroll Medicaid members are significant. Different payers, payment rates, provider networks and benefit packages as well as the possibility of a new Basic Health Plan that will cover those above Medicaid eligibility but below 200% of the federal poverty level, need to be considered. But the MSPs may create a unique opportunity to address the problem of churning between Medicaid and subsidies, either directly or through subcontracts with more established Medicaid managed care plans. And the sister federal agencies of OPM, the Centers for Medicare & Medicaid Services (CMS) and Center for Consumer Information and Insurance Oversight (CCIIO) may be able to collaborate to facilitate innovation over time.

OPM, working with CMS, CCIIO and the states, could establish incentives for MSPs to operate in both the subsidy and Medicaid markets. The OPM RFI suggests such an interest and asks for related information and possible partnerships with community health plans and Medicaid plans.

Is there an opportunity to expand health insurance options?

OPM could encourage the formation of new health plans or collaborations between carriers and community health plans or Medicaid managed care plans. Could the Consumer Operated and Oriented Plans (Co-Ops),¹⁵ established under the ACA, organize to become an MSP? The ACA includes specific provisions¹⁶ that would allow plans operating within states to form regional or national affiliations to become MSPs; however Co-Ops are only now beginning to form and may not be ready to organize together as an MSP consistent with the law's timetable.

Can MSPs help transition Members of Congress and their staffs to ACA coverage?

The law requires Members of the Congress and Congressional staff to receive health coverage through health plans that are created by the ACA or offered through a newly authorized state or federal based exchange.¹⁷ Their health coverage is currently provided through the FEHBP administered by OPM. However, the law does not identify an administering entity or implementing authority responsible for making this transition.

The conversion of Members of Congress and their staffs from FEHBP to an Exchange raises a number of issues such as whether and how the Federal government will pay premiums, which Congressional staff are included in the new health plan provisions, and whether the FEHBP plan will be considered a "grandfathered plan"- that is one that is able to continue to offer coverage

¹⁵ACA §1332 establishes a program to facilitate the creation of not-for-profit consumer operated health plans for offer in state Exchanges and permits CMS to award loans to eligible start-ups.

¹⁶ Patient Protection and Affordable Care Act § 1334(a)(1), 42 U.S.C. § 18054(a)(1) (stating "health issuers may include a group affiliated either by common ownership and control or by the common use of a nationally licensed service mark.").

¹⁷ § 1312(d)(3)(D).

without complying with all provisions of the ACA.^{18,19} Resolving these issues will require considerable engagement of OPM staff.

The MSPs may provide a logical vehicle for this transition. While the ACA is clear that OPM must maintain discrete staffing and risk pools for FEHBP and the MSPs, it would seem reasonable to coordinate the conversion from FEHBP through the new MSP office. Because OPM will administer the MSPs, they seem a logical vehicle for providing the mandated coverage of staff and Members of Congress and coordinating the financial participation of the Federal government toward the cost of coverage.

Challenges for MSPs

Why would health plans seek to become MSPs?

New opportunities exist under the ACA for health plans to expand markets to people who will become newly insured under the law's insurance expansions. The question is will insurance carriers want to become MSPs, when they can simply participate directly in the exchanges? OPM may attract national firms to become MSPs by providing national marketing assistance; assuring one contract rather than state by state negotiations; experimenting with different pooling and risk arrangements and otherwise streamlining administrative procedures and costs.

Will MSPs create adverse selection?

The law gives significant authority to OPM to set rates, determine network adequacy and otherwise certify and regulate MSPs differently than the state. While the plans will need to comply with the level playing field rules and comply with state licensure rules, it is possible for OPM to meet that benchmark and still design a unique product in the market.

MSPs will need to attract providers and, in many markets, those provider networks are highly consolidated. It is unclear what incentives providers will have to negotiate rates with MSPs. OPM holds the authority to establish network adequacy standards. If OPM cannot secure competitive rates from providers, they may be able to establish payment reform strategies or define network adequacy standards to achieve more competitive rates, assuring a smaller number of providers receive a larger market share.

If an MSP is a high value plan – offering better services than other QHPs in the exchange- it could attract a disproportionate enrollment of unhealthy people who require more care; if the plan is able to underprice the competition, it could attract a disproportionately healthy

¹⁸ JENNIFER STAMAN, EDWARD LIU, ERIKA LUNDER, & KENNETH THOMAS RESEARCH SERV., M-042910, QUESTIONS REGARDING EMPLOYER RESPONSIBILITY REQUIREMENTS AND SECTION 1312(D)(3)(D) OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010).

¹⁹ JENNIFER A. STAMAN & TODD B. TATELMAN, RESEARCH SERV., M-040210-A ANALYSIS OF § 1312(D)(3)(D) OF PUB. L. NO. 111-148, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND ITS POTENTIAL IMPACT ON MEMBERS OF CONGRESS AND CONGRESSIONAL STAFF (2010).

population. That market segmentation could result in a disproportionate enrollment of healthy people in the MSP and a cost increase in other plans. Alternatively, if the MSP provided richer benefits than others in the market, the MSP could effectively become a high risk pool, attracting the sickest and those most in need of richer benefits. Finally, if the MSP were a young adult only plan, the state's risk pool would be negatively impacted by the loss of young, healthy lives.

However, the ACA requires provisions to mitigate risk selection, including a permanent mechanism of risk adjustment and two temporary measures, risk corridors and reinsurance, designed to avoid the scenarios described above. Risk adjustment requires payment adjustments relative to the risk of a plan's covered lives. Risk corridors protect against inaccurate cost estimates in the first three years and funding for reinsurance protects against very high-cost enrollees. With the exception of funding for reinsurance, the cost of these provisions is generally born by insurers. States, however, seek assurances that MSPs will participate in these programs and in their costs.

Because the OPM will develop medical loss ratios and negotiate premium rates and standards for network adequacy, MSPs will be held to different standards that could affect state markets. How MSPs will affect broader markets remains an important concern, particularly for the states. While it is unlikely that OPM will hold MSPs to different medical loss ratios, they will likely vary in terms of premium rates and network adequacy standards based on the multi-state nature of the MSPs. While this could make the MSPs highly competitive, it also could be disruptive to the underlying state-based exchange market driving QHPs out of the market if they can't compete with the more favorable terms provided to MSPs that allow them to offer lower premiums or a broader network.

Do MSPs limit opportunities for states to establish exchanges that are active purchasers of health care and conflict with state oversight responsibilities?

The ACA allows states to establish state specific standards for QHPs that exceed federal minimums in areas such as benefit design, number of available plans in the exchange, and contracting periods. It also requires MSPs to be licensed and subject to requirements in state law. Even if an MSP complies with state laws, exchanges may wish to selectively contract among available plans. For states that wish to selectively contract for health plans in the exchange, this provision that automatically qualifies MSPs to participate in an exchange makes it impossible to exclude an MSP that does not meet higher state purchasing standards. This could minimize the effectiveness of value-based purchasing in exchanges.

The creation of MSPs challenges established state insurance regulation and consumer protection, although it is modeled after existing nationwide plans in the FEHBP. Those plans, for example, are exempt from state mandates and state premium taxes. The NAIC, noted earlier, has raised significant concerns about the potential conflict between MSPs and state regulatory responsibilities. The ACA explicitly requires the OPM Director to negotiate with each MSP the medical loss ratio, premiums and profit margin and such other terms and conditions as are in the interest of enrollees, while states retain authority for an array of regulations including licensing and solvency.

It remains unclear how MSPs will be treated regarding risk sharing, risk corridors and reinsurance, and who pays. Given there is a possibility that MSPs might disrupt markets and create adverse selection, that potential could be ameliorated by the ACA's provision to protect against selection bias through these risk arrangements. States make clear that markets are local, risk must be born locally and MSPs must be regulated locally and comply with all state laws, as articulated in the "level playing field" language. Additionally, states need assurances regarding how MSPs will participate in the exchanges and that they will pay whatever fees may be assessed on health plans to maintain the exchanges.

Does the insurance industry have adequate capacity to launch MSPs?

While several major carriers are licensed in each state today, any new offering requires state action and companies would need to build capacity and provider networks where they may be licensed but not active. And those companies may be offering products only in the large group, and have long been reluctant to expand their offerings into the individual and small group markets. Still, a company that is already operating and licensed in the large group in a state has provider networks which could make it easier to enter the individual and small group markets and meet network adequacy standards.

The requirements to comply with multiple and potentially conflicting state insurance, OPM, and exchange rules are disincentives for plan engagement. The industry, like the states, is already grappling with the myriad of ACA requirements implementation and consideration of an MSP may not be a high priority for many of them. The requirement to be operational in 60% of states by 2013 is daunting. Some companies may be interested in a truly national plan, with a national medical loss ratio that operates more like the FEHBP, exempt from much state regulation.

Discussion

The law requires OPM to enter into contracts with health insurance issuers to offer "at least 2 multi-state qualified health plans through each exchange in each state"²⁰ and requires those plans to offer a benefits package that is uniform in each state. On its face, this suggests the availability of fully portable health plans nationwide. One plan must be a non-profit entity; another must not offer coverage for abortion services. The law spells out clear authorities for OPM to negotiate many of the conditions of coverage even while requiring the plans to be licensed and comply with laws in each state. It authorizes OPM to contract with issuers or with a group of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark. Finally, the law phases in nationwide coverage, requiring plans to operate in at least 60 percent of states in the first year.

Such a plan could provide added value in states that are not ready to implement exchanges by 2014. It appears today that many states will be unable to have fully operational exchanges that meet federal timelines. Those states may not yet have enacted the insurance reforms in the individual and small group markets required by the law. In those instances, the federal

²⁰ § 1334(a)(1).

government will enforce the insurance requirements directly and establish federally facilitated exchanges. An MSP in that scenario might serve as a bridge to state readiness.

Importantly, the ACA does not use the term “national plan” but instead consistently refers to “multistate plans.” The ACA already includes controversial provisions to allow states to enter into compacts²¹ that allow health plans to be sold in more than one state subject only to the laws of the state where it was issued. Even here, however, the law requires the issuer to be licensed in each state and to meet each state’s unfair trade practices and consumer protection laws. The compacts must be enacted by state legislatures and approved by the Secretary. Unlike the MSPs, compacts cannot be implemented until 2016. And, unlike the compacts, the MSP is administered by OPM and one plan must be a non-profit.

OPM has a long track record in performing exchange-like activities – selecting and contracting with multiple plans, negotiating rates and informing consumers about their choices. As such, the OPM may be uniquely qualified to develop new and discrete MSPs that are value based and could be market leaders in cost and quality. But many issues must be resolved including attracting plans to the MSP market; the impact of MSPs on state markets and state insurance regulation and on the capacity of exchanges to administer and compare plan offerings that are accountable to different entities and different rules.

OPM will need to address whether and how an MSP provides added value, particularly to attract insurers, and determine how to phase in MSPs to assure they are available to 60% of states in 2014 and to all states by 2017. State marketplaces are heterogeneous. In some states, the marketplace is robust; in others there is little or no competition. Generally, states will fall into several broad categories:

1. States on target to develop exchanges by 2013:
 - A. With competitive markets who are designing exchanges to be active and selective purchasers
 - B. With competitive markets who are designing open exchanges
 - C. With consolidated markets and little competition
2. States not on target to fully implement exchanges by 2103.

For states in competitive markets that are building exchanges designed to negotiate for price and quality, the requirement to deem MSPs eligible to offer products in the exchange conflicts with those state goals. The law requires plans to be licensed in the state and to comply with state laws not inconsistent with the MSP provisions, but that does not assure that all plans will meet the standards established in a value purchasing exchange.

It is unclear how many states will establish exchanges that wish to be value purchasers and selectively contract with plans. To avoid conflicting with those that do, OPM, either directly or

²¹ § 1332(a) (1)-(4).

through statutory change, could articulate a standard that defines a competitive market and exempt those states from MSP requirements. Or, a state that has a competitive market could be deemed in compliance with the law and exempt from the requirement to offer an MSP.

However, in most states, the individual market and often the market for small business, is highly consolidated. The MSP could focus on those states where competition is limited and where the MSP might offer competition and choice. At least some states may find themselves developing exchanges but unable to attract insurers to offer adequate options within them, even with an individual mandate and the availability of subsidies. If that proves to be the case, the MSP could provide an important option. It may be in these states, and states where a federally facilitated exchange will be required in 2014, that MSPs should first be offered.

The MSPs provide consumers with more choice and present the opportunity to create high value plans. While concerns about the impact of MSPs on state markets have been well articulated by NAIC and others, MSPs may also help create markets that drive all insurers to develop competitive plans.

Looking forward

MSPs are a requirement of the ACA and OPM will soon issue proposed rules governing them. However, there is opportunity and time for states, insurers, advocates and other interested parties to contemplate whether and how MSPs could advance the goals of affordable, quality health care.