UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

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Office of the
Inspector General

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MEMORANDUM FOR BETH F. COBERT
Acting Director

FROM: NORBERT E.VINT
Deputy Inspector General

SUBJECT: Management Alert – Status of the Multi-State Plan Program

Executive Summary

The U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG) is issuing this Management Alert to highlight and bring to your immediate attention the status of the Multi-State Plan (MSP) Program.

- The MSP Program is experiencing a reduction in the number of options offered by MSP Issuers. We expect this to continue until the market stabilizes.

- The MSP Program currently faces many challenges. Some of these challenges are specific to the program while others are related to the Patient Protection and Affordable Care Act (Affordable Care Act).

- OPM's National Healthcare Operations (NHO) is doing the best that it can to retain and attract MSP Issuers and state-level issuers[1] into the program. However, the program is voluntary and the Affordable Care Act does not provide OPM with flexibilities, such as allowing the MSP Program to establish requirements that are consistent across all states, that can be used to attract and incentivize participation in the program. Legislative changes would be required to allow for such flexibilities.

[1] An MSP Issuer is a health insurance issuer or group of issuers that has a contract with OPM to offer MSP coverage. A State-level issuer is an issuer that is designated by an MSP Issuer to offer MSP coverage in all or part of one or more States, e.g., XYZ of Maryland.

Background Information

The MSP Program was established by Section 1334 of the Affordable Care Act. Under the Affordable Care Act, OPM was directed to contract with private health insurers to offer MSP products in each state and the District of Columbia. MSP Issuer products may be phased-in over four years, with a requirement that MSP products be in at least 31 states in the first year; at least 36 states in the second year; at least 44 states in the third year; and all 50 states and the District of Columbia in the fourth year. OPM negotiates contracts with MSP Issuers, including rates and benefits, in consultation with states and marketplaces. In addition, OPM monitors the performance of MSP Issuers and oversees compliance with legal requirements and contractual terms. OPM's NHO has overall responsibility for program administration.

The OIG has been tasked with oversight of the MSP Program and Issuers that have contracted with OPM to provide MSP options. To date, we have issued five OIG audit reports covering MSP Issuer compliance with its contract with OPM.

Currently, OPM contracts with two MSP Issuers, the Blue Cross Blue Shield Association (Association) and an association of Health Insurance Cooperatives (Co-Ops). From these MSP Issuers, the MSP Program universe consists of approximately 36 state-level issuers (SLIs) covering 32 states and the District of Columbia.[2]

The ACA requires OPM to provide MSP options in all 50 states and the District of Columbia and allows a four year phase-in to meet this requirement. However, through year three of the program, there has been stagnation and even a reduction in the total number of MSP state-level issuers.

Listed below is the coverage data throughout the initial years of the MSP Program:

Participation Year	Contract Year	Issuer	SLI's	States & DC	Required States	Requirement Met
1	2014	Association	35	31	31	Yes
2	2015	Association	38	34	36	No
3	2016	Association	36	33	44	No
1	2015	Co-Op	11	11	31	No
2	2016	Co-Op	2	2	36	No

[2] Some states include multiple state-level issuers that cover different regions within the state.

Per conversations with NHO, contract year 2017 will see additional reductions in program participation as a result of several challenges that will begin to significantly impact health insurance carriers participating in the MSP Program and the marketplaces established by the Affordable Care Act as a whole.

Challenges to the Program

1. General Challenges

There are challenges that affect all health insurers participating in the marketplaces established by the Affordable Care Act and which are not specific to the MSP Program. The implementation of the Affordable Care Act created a period of uncertainty for health insurers in terms of pricing and risk. In 2014, when the Affordable Care Act marketplaces came on-line and began to allow consumers to enroll in health plans, health insurers utilized many assumptions to underwrite their premium rates for a population segment that had been uninsured for many years. Because this population segment had so many unknowns, including demand for health services as well as payment history, the market experienced significant pricing volatility from 2014 to 2016 as health insurers began to gain data and better understand the population they were insuring. The population has proven to be more expensive to insure than originally anticipated due to higher instances of chronic conditions and use of high cost procedures. This initially made it difficult for health insurers to price products accurately and has led to large price increases from year to year.

The Affordable Care Act originally had programs in place to alleviate issuer losses and stabilize premium rates. These programs are effectively known as the "3Rs," or risk adjustment, risk corridor, and reinsurance. However, through a variety of legislative and budgeting measures, these programs have not been fully funded and health insurers have taken on more risk and financial losses than what was originally anticipated. Because of these additional risks and financial losses, some health insurers are passing on the costs to the consumer or withdrawing from the Affordable Care Act marketplaces altogether. The Co-Ops have been drastically affected by the changes to the 3R programs as well as the unhealthier than expected population. The current Co-Ops created under the Affordable Care Act do not have the financial strength to withstand the amount of losses and volatility presented and have, consequently, ceased their participation in the MSP Program. In fact, many have ceased operations completely. However, it is our understanding that a new Co-Op will enter the MSP Program in calendar year 2017.

Another challenge that health insurers are facing is that enrollment in the marketplace options is not as high as originally forecasted. This population has also not included enough young, healthy people to offset the utilization of the unhealthier participants. Consequently, a smaller number of healthy participants have been priced at a level to cover the costs of a population with a higher than expected total claims experience.

2. MSP Program-Specific Challenges

The MSP Program offers some unique challenges to MSP Issuers, as well as to the NHO as it tries to attract more MSP Issuers and state-level issuers. The biggest challenge that NHO faces is providing encouraging reasons for health insurers to join the program. The intent of the program is, ultimately, for consumers to have access to at least two high quality health options through their respective marketplace. This is a great benefit for consumers, however, there is not a clear, encouraging reason for a health insurer to offer MSP options in addition to any Qualified Health Plans (QHPs) that they offer through a marketplace.

Some other MSP Program-specific challenges include, but are not limited to, the following:

- The MSP Program is totally voluntary and health insurers can choose to not participate. The regulations do not grant the Director of OPM any flexibilities to incentivize or encourage a health insurer to join the MSP Program.

- Unlike the Federal Employees Health Benefits Plan (FEHBP), MSP Issuers are not exempt from state law and must follow all applicable state regulations. This creates a challenging regulatory environment for an issuer and eliminates the possibility of a simple, uniform MSP product.

- MSP Issuers have to operate in a dual regulatory environment with a parallel application approval process. OPM is responsible for the MSP application approvals, and the Department of Health and Human Services or the applicable state is responsible for the QHP application approvals.

- OPM, through section 1324 of the Affordable Care Act that relates to the Level Playing Field provision, is restricted from asking for a federal or state regulatory exemption in 13 defined categories because any request submitted by OPM would have to apply to all private health insurers. The Level

Playing Field provision makes it practically impossible for an MSP Issuer to deviate from state requirements and offer a standardized benefit package across multiple states.

- MSP Issuers operate in a complex and potentially burdensome oversight environment. MSP Issuers are overseen by various agencies, including: the OPM/OIG, the Center for Consumer Information and Insurance Oversight (CCIIO), and other applicable state and federal oversight agencies, such as the Health and Human Services OIG and specific state Departments of Insurance. While the OPM/OIG has taken steps to coordinate with other agencies and reduce any duplicative audit work, constant oversight and audit requests could be resource-intensive for an MSP Issuer.

- As stated above, MSP Issuers are expected to provide coverage to all 50 states and the District of Columbia by the fourth year of participation. This provision may limit interest in the program due to the nationwide coverage requirement.

- There are situations where differentiations between the MSP options and QHP options are difficult to achieve. Some states require standardized benefit packages for any plan offered on their marketplace. Also, health insurers are moving to narrower provider networks, which hinders network differentiation between options.

- There is confusion surrounding the "multi-state plan" name as MSP options do not provide for out-of-state health coverage.

Steps NHO has Taken to Attract and Retain Issuers

While the MSP Program faces broad and unique challenges, NHO has taken many steps to try to expand the number of MSP Issuers in the program and the number of states with MSP options.

For instance, NHO has conducted outreach to the FEHBP carriers and other health care associations to attempt to attract health insurers to the MSP Program. Specifically, NHO has hosted an MSP Issuer day the past two years in order to explain the value of the program to potential MSP Issuers and also for potential and existing MSP Issuers to have in-person communication with the NHO team and other relevant parties. In addition, NHO conducts conference calls with Association plans and Co-Op state-level issuers that do not participate in the program to determine why they are not currently participating and to gauge future interest in program participation. Similarly, NHO performs outreach with Association state-level issuers that decide to discontinue participation in the MSP Program in order to gather valuable feedback

regarding their decision, some of which has been presented above in the "Challenges" section of this memorandum.

NHO also actively worked to recruit a well-established FEHBP carrier to join the MSP Program. NHO walked the carrier through the regulatory environment, marketplace requirements, and a potential partnership with another entity to offer MSP options. Although the carrier made a business decision not to join the program, NHO was proactive in its recruiting efforts.

In addition to its outreach and recruiting efforts, NHO has actively promoted the MSP Program. Specifically, NHO provided MSP Program welcome cards for participating MSP Issuers to provide to new enrollees. NHO also worked with CCIIO to disseminate information about the MSP Program and to ensure the information was accurate. Moreover, NHO instructs MSP Issuers to utilize "a Multi-State Plan" as the second part of the plan option name. OPM has registered "Multi-State Plan" as a service mark, and this may provide the MSP Issuers and consumers with a level of distinction.

Finally, NHO helps alleviate the potential burden of dual regulatory approval processes for MSPs and QHPs by coordinating the approval processes for the MSP options with all of the applicable marketplaces. MSP Issuers can also coordinate with NHO in order to work through issues and problems with the marketplaces and state regulators.

Recommendations

1. Continue to Pursue MSP Issuer and State Expansion

We recommend that NHO continue to pursue MSP Issuer and state-level issuer expansion to attempt to meet the regulatory requirement of coverage in all 50 states and the District of Colombia.

We understand that the MSP Program is voluntary and OPM does not currently have tools at its disposal to encourage health insurers or state-level issuers to join the program. In addition, the health care environment will continue to be in a state of volatility for the near future as the experience and utilization data related to the Affordable Care Act becomes more established. While these realities present challenges to NHO in terms of recruitment, NHO should continue to try to meet the ultimate goal of having two health plan options for every consumer nationwide. NHO is already taking constructive steps to do this by health insurer outreach, open communication, and working with MSP Issuers to address problems, and we recommend that NHO build on these efforts for potential future recruitment. NHO should continue to pursue various strategies, including legislative changes, that would encourage,

incentivize, and make program participation attractive to potential MSP Issuers and state-level issuers.

2. Communicate and Work With Successful State-Level Issuers

We recommend that NHO communicate and work with state-level issuers that have developed unique ways to differentiate their MSP options and be successful. These could then be shared with other state-level issuers to increase their chance at success.

During our initial years of auditing the program, we have interviewed many personnel at the various state-level issuers. As a result, we have found that some state-level issuers have used creative ways to attract membership into their MSP options.

For example, Blue Cross Blue Shield of Michigan (BCBSM) has included family dental coverage in its MSP options in order to attract enrollment. This benefit is not available in any other QHP that BCBSM offers.

Also, Arkansas Blue Cross Blue Shield (ARBCBS) has paired with the State of Arkansas to provide coverage through the state's private option. ARBCBS contracts with the state to use an MSP option for enrollment through the state's website for people below the poverty line. The enrollees get assigned to one of four options that the state offers in a sequential order, with one of the options being an ARBCBS MSP option.

We have found that these state-level issuers are using creative methods to attract membership into their MSP options, and we recommend that NHO analyze these methods to determine if any are applicable to other state-level issuers. We understand that each state-level issuer operates in a unique business environment and that a one size fits all approach is not possible. However, open discussion and the exchange of ideas may create an environment where a state-level issuer begins to think about other ways to differentiate the MSP options and potentially grow membership in the MSP Program.

3. Clarify "Multi-State Plan" for the Consumer

We recommend that NHO clarify the "Multi-State Plan" nomenclature for the names of MSP options.

There may be continued confusion for the consumer regarding marketplace plans labeled as "Multi-State" plans. The name, taken by itself, is misleading to the consumer as they may not fully understand the program's intent. Much of the uninsured population is gaining access to health insurance for the first time and health care literacy may be very low. Some consumers may not fully understand the benefit materials that are provided to them and think

the title of the Plan would allow for coverage in multiple states. We understand that NHO has worked on developing a service mark for the "Multi-State Plan" moniker, but we recommend that NHO clearly explain that the plan option does not cover out-of-state health services.

This Management Alert has been issued by the OIG to OPM officials for resolution of the recommendations contained herein. As part of this process, OPM may release the Management Alert to authorized representatives of the audited party. Further release outside of OPM requires the advance approval of the OIG. Under section 8M of the Inspector General Act, the OIG makes redacted versions of its reports available to the public on its webpage.

In accordance with Office of Management and Budget Circular A-50 and/or Public Law 103-355, all audit recommendations must be resolved (agreement reached on actions to be taken on reported recommendations; or, in the event of disagreement, determination by the agency follow-up official that the matter is resolved) within six months of the date of the report.

Since the OIG exercises oversight concerning the progress of corrective actions, we request that NHO provide us with a report describing the corrective action taken, and in instances where the corrective action differs from the recommendation, include the rationale for the resolution. If the corrective action has not been completed, we ask that the NHO provide us with a report on the staus every March and September thereafter until the corrective action has been completed.

Please provide a response, within 45 days of the date of this Management Alert, indicating whether you agree or disagree with the recommendations. If you are in agreement with the recommendations, please provide a corrective action plan that will resolve each issue.

Please contact me, on 606-1200, if you have any questions regarding this Management Alert, or someone from your office may wish to contact Michael R. Esser, Assistant Inspector General for Audits, on [redacted], or [redacted], Chief, Community-Rated Audits Group, on [redacted].

cc: Kiran A. Ahuja
Chief of Staff

Kathleen McGettigan
Chief Management Officer

John O'Brien
Senior Advisor

Alan Spielman
Director, Healthcare and Insurance

Elizabeth Hadley
Assistant Director for National Healthcare Operations

[redacted]
Program Manager, National Healthcare Operations

Jonathan Foley
Director, Planning and Policy Analysis

Mark W. Lambert
Associate Director, Merit System Audit and Compliance

Janet L. Barnes
Director, Internal Oversight and Compliance

Dennis D. Coleman
Chief Financial Officer