

CREATING MULTI-STATE QUALIFIED HEALTH PLANS IN HEALTH INSURANCE EXCHANGES: LESSONS FOR RURAL AND URBAN AMERICA FROM THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

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I. INTRODUCTION

The Affordable Care Act (“ACA”)¹ creates new state-level Health Insurance Exchanges (“HIEs”) to offer a one-stop shopping experience for those purchasing individual and small group health insurance.² The Exchanges will offer consumers the ability to go online and browse through health plan offerings and choose the plan that best meets their needs.³ Exchanges are intended to make plan comparisons easier, promote better competition and, hopefully, improve the price and quality of health insurance.⁴ Health Insurance Exchanges will also assure that plans meet

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). The two preceding laws will be hereinafter cited together as “ACA.”

2. ACA § 1311 (to be codified at 42 U.S.C. § 13031).

3. ACA § 1311(c)(5) (to be codified at 42 U.S.C. § 13031).

4. For more details on HIEs see Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them*, 5 ST. LOUIS

standards specified in the ACA and state law, allowing only plans certified by the Health Insurance Exchange to be sold through it.⁵

In addition to Exchange-certified health plans, the ACA provides that the Exchanges will also offer new Multi-State Qualified Health Plans ("MSQHPs"), private insurance plans available on a nationwide basis.⁶ The section of the ACA authorizing these new national MSQHPs appeared in the Senate version of the ACA as a private alternative to the hotly debated public option in the House version of the bill.⁷ It became law when the House agreed to pass the Senate version of the bill *carte blanche* to assure that some version of health reform would become law in 2010.

The ACA directs the United States Office of Personnel Management ("OPM") to negotiate with private insurers to offer at least two MSQHPs, one of which must be a not-for-profit.⁸ The ACA specifies that OPM is to implement the provisions for these new plans in a manner similar to that which it uses when contracting with carriers for plans offered through the Federal Employees Health Benefits Program ("FEHBP").⁹

The FEHBP provides Congressmen, federal employees, retirees, and their dependents with a choice of competing private health plans with different premium and benefit structures.¹⁰ The largest employer sponsored health insurance system in the country,¹¹ from a consumer's perspective the FEHBP is organized and structured in a manner similar to the new Health Insurance Exchanges: employees typically go online, browse through a variety of plans offered in their local area, and select among the competing

U. J. HEALTH L. & POL'Y 27 (2011) [hereinafter *Jost, Loopholes in the Affordable Care Act*] and Timothy Jost, *Implementing Health Reform: Health Insurance Exchanges*, HEALTH AFF. BLOG (July 12, 2011, 10:29 AM), <http://healthaffairs.org/blog/2011/07/12/implementing-health-reform-health-insurance-exchanges/> [hereinafter *Jost, Implementing Health Reform*].

5. ACA § 1331(d)(2) (stating exchanges may only offer "qualified health plans" a term defined by ACA § 1301).

6. ACA § 1334(a)(1) (to be codified at 42 U.S.C. § 18054).

7. Timothy Jost, *Revised Health Reform Bill Moves Forward in Senate*, HEALTH AFF. BLOG, (Dec. 19, 2009), at <http://healthaffairs.org/blog/2009/12/19/revised-health-reform-bill-moves-forward-in-senate> [hereinafter *Jost, Revised Health Reform Bill*]; see H.R. 3590, 111th Cong. § 1334 (as amended by the Senate, Dec. 24, 2009, 7:46 pm) (enacted); H.R. 4872, 111th Cong. (2010) (enacted).

8. ACA § 1334(a)(1), (3).

9. *Id.* § 1334(a)(4).

10. HINDA CHAIKIND & MARK NEWSOM, CONG. RESEARCH SERV., RS 21974, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: AVAILABLE INSURANCE OPTIONS 1-2 (2010); PAUL J. GRANEY, CONG. RESEARCH SERV., 94-615 EPW, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (1997).

11. CHAIKIND & NEWSOM, *supra* note 10, at 1.

choices.¹² The FEHBP, like the Health Insurance Exchange, offers both nationwide plans as well as locally offered plans.¹³

A better understanding of how FEHBP national and local plans are regulated in the FEHBP and how that impacts enrollees' choice of plans provides useful insights for those designing HIE local plan certification requirements and for OPM as it begins the process of creating contracting terms for MSQHPs. The National Association of Insurance Commissioners ("NAIC") recently expressed concern that offering MSQHPs in the Exchanges may have a disruptive effect on competition and plan choice in the state Exchanges.¹⁴ Learning more about how competition and choice work in the FEHBP and how the Health Insurance Exchanges and MSQHPs are both similar to and different from the FEHBP will help state and federal policy makers as they move forward.

We examined 2010 FEHBP enrollment data to see how local and national plans fared in terms of competition and enrollment.¹⁵ This article uses this enrollment data to analyze the potential role and impact MSQHPs are likely to have on plan choice and competition within the new Health Insurance Exchanges.

Part II describes the Federal Employee Health Benefit Program, OPM's role in negotiating both national and local plan offerings, and the legal requirements imposed on both national and local plans.¹⁶ Part III briefly explains how the new ACA Health Insurance Exchanges will operate and their role in certifying local plans eligible to be sold through the HIE.¹⁷ It also discusses the new nationwide MSQHPs and OPM's role in negotiating and regulating these new national plans.¹⁸

12. See, e.g., *2011 Plan Information for Missouri*, U.S. OFF. OF PERSONNEL MGMT., <http://www.opm.gov/insure/health/planinfo/2011/states/mo.asp#open> (last visited Dec. 2, 2011) [hereinafter 2011 Missouri Plans]. The six nationwide plans offered through FEHBP are fee-for-service plans open to any eligible federal employee. CHAIKIND & NEWSOM, *supra* note 10, at 2. The FEHBP also offers four other nationwide plans for employees of specific federal agencies. *Id.*

13. See CHAIKIND & NEWSOM, *supra* note 10, at 2.

14. Letter from Susan E. Voss, President, Nat'l Ass'n of Ins. Comm'rs ("NAIC"), Kevin M. McCarty, President-Elect, NAIC, James J. Donelon, Vice-President, NAIC, Adam Hamm, Secretary-Treasurer, NAIC, to Cheryl D. Allen, Contracting Officer, U.S. Office of Pers. Mgmt. (Aug. 10, 2011), available at http://www.naic.org/documents/committees_b_110810_naic_comments_msp_to_opm.pdf. In particular, the insurance commissioners are concerned that OPM has statutory authority under the ACA to contract with MSQHPs that do not meet state law requirements. *Id.*

15. See *infra* Part IV.

16. See *infra* Part II.

17. See *infra* Part III.

18. See *infra* Part III.

Part IV presents original data analyzing plan enrollment in FEHBP national and local plans. This data shows that FEHBP program enrollment is heavily concentrated in the national plans, and particularly in the national BlueCross/BlueShield plan. The data also show that federal employees are more likely to choose national plans over locally available plans because in many areas of the country—particularly in rural areas—the FEHBP offers few local HMO plans.¹⁹

Part V concludes that the new Health Insurance Exchanges are unlikely to generate the same kind of skewed competition between local plans and the new nationwide MSQHPs but that OPM should take care to avoid inadvertently creating a dominate set of nationwide MSQHPs that mimic BlueCross/BlueShield's role in the FEHBP and which could destabilize the competition that the Exchanges are intended to foster.²⁰ In the FEHBP, the small number of local plans and BlueCross/BlueShield's dominance are, to some extent, a function of the FEHBP authorizing statute which requires that local plans be licensed under state law as HMOs and which provides that OPM may negotiate for only one general nationwide plan, the plan offered by BlueCross/BlueShield. The ACA provides the new Health Insurance Exchanges with much more flexibility to contract with a variety of types of local health plans. However, it gives OPM the discretion to limit the number of national plans to two, an option that could result in two dominant national insurers emerging in the new Exchanges.

II. THE FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM: NATIONAL AND LOCAL PLANS

For decades, the Federal Employees Health Benefits Program has been touted as a model of competition and choice by both sides of the political aisle.²¹ Since its inception on July 1, 1960, the FEHBP has provided federal employees, members of Congress, federal retirees, and eligible family

19. See *infra* Part III.

20. See *infra* pp. xx-xx.

21. RANDALL R. BOVBJERG, ROBERT WOOD JOHNSON FOUND. & URBAN INST., LESSONS FOR HEALTH REFORM FROM THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY 1 (2009) available at <http://www.apha.org/NR/rdonlyres/6075D794-FEA5-4014-998A-68887EDCA09F/0/LessonsforHealthReformfromFEHBProgram.pdf>; see Alain C. Enthoven, *Consumer-Choice Health Plan (Second of Two Parts), Part 2: A National-Health-Insurance Proposal Based on Regulated Competition in the Private Sector*, 298 NEW ENG. J. MED. 709, 709, 720 (1978); see, e.g., Robert Moffit, *WebMemo No. 1515, State Based Health Reform: A Comparison of Health Insurance Exchanges and the Federal Employees Health Benefits Program*, THE HERITAGE FOUND. (June 20, 2007), <http://www.heritage.org/Research/Reports/2007/06/State-Based-Health-Reform-A-Comparison-of-Health-Insurance-Exchanges-and-the-Federal-Employees-Health-Benefits-Program>.

members with a choice of competitive private health plans.²² The program has performed well for enrollees, offering good benefits and a wide choice of plans at competitive premiums with low administrative costs.²³ Today, the FEHBP has nearly 8 million enrollees²⁴ and is the largest employer-sponsored health insurance program in the United States.²⁵

The FEHBP is administered by the Office of Personnel Management which is statutorily authorized to contract with private health insurance carriers to offer health plans and to promulgate regulations as necessary.²⁶ The OPM contracts annually with each carrier to offer a plan with a uniform benefit package and a uniform premium to all those who enroll in the plan.²⁷ While there is no standardized benefit package within the FEHBP programs, all programs are statutorily required to cover similar categories of services including hospital, surgical, in-hospital medical, ambulatory patient, supplemental, and obstetrical benefits.²⁸ Over the years, OPM has used its contracting authority to expand benefits and to control premium and out-of-pocket costs.²⁹

The FEHBP statute authorizes OPM to contract with two types of health plans, national fee-for-service plans ("PPOs") and local health maintenance

22. GRANNEY, *supra* note 10. It was Congress' intent to allow enrollees to exercise choice among various plan types and, by using their own judgment, select health plans that best meet their specific needs. H.R. REP. NO. 86-957 *passim* (1959). The ACA will move members of Congress from the FEHBP to the new Health Insurance Exchanges.

23. BOVBERG, *supra* note 21, at 1.

24. CHAIKIND & NEWSOM, *supra* note 10, at 1.

25. *Id.*

26. Established by the Federal Employees Health Benefits Act of 1959, Pub. L. No. 86-382, 73 Stat. 708, the FEHBP is codified at 5 U.S.C. §§ 8902-8914 (2006). Other statutorily authorized duties OPM maintains in administering the FEHBP include: receive and deposit premium withholdings and contributions, make final determinations of applicability of FEHB law to specific employees or groups, evaluate the operation and administration of FEHB law and plans offered, audit carriers' operations, and resolve disputed health insurance claims between the enrollee and carrier OPM functions. *Federal Employees Health Benefits Program Handbook*, U.S. OFF. OF PERSONNEL MGMT., <http://www.opm.gov/insure/health/reference/handbook/fehb01.asp> (last visited Jan. 9, 2012) [hereinafter FEHBP Handbook].

27. See FEHBA § 8902. All national PPOs and some local HMOs have their premiums set based upon the previous year's claims. Some HMOs premiums are set based upon their cost of serving other employer-sponsored group. See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-03-236, REPORT TO THE SUBCOMMITTEE ON INTERNATIONAL SECURITY, PROLIFERATION AND FEDERAL SERVICES, COMMITTEE ON GOVERNMENTAL AFFAIRS, U.S. SENATE: FEDERAL EMPLOYEES' HEALTH PLANS PREMIUM GROWTH AND OPM'S ROLE IN NEGOTIATING BENEFITS 18-20 (2002) [hereinafter GAO-03-236].

28. See FEHBA § 8904.

29. MARK MERLIS, KAISER FAMILY FOUND., NO. 6081, THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM: PROGRAM DESIGN, RECENT PERFORMANCE, AND IMPLICATIONS FOR MEDICARE REFORM 3, 10 (2003); see also CHAIKIND & NEWSOM, *supra* note 10, at 15-17.

organizations (“HMOs”).³⁰ In 2011 there were six national PPO plans and about 226 local HMO plans.³¹ National plans have uniform benefits and uniform premiums nationwide, while local HMOs have set premiums and benefits for the service area in which they are offered.³² Many national PPOs and almost half of local HMOs offer two levels of benefits, a high option and a standard option.³³ The high option plans provide lower cost-sharing or other enhanced benefits in return for a higher premium.³⁴ Some also offer a high deductible option with either a consumer driven health plan and/or health savings account.³⁵

The Office of Personnel Management contracting provisions broadly preempt state law requirements relating to covered benefits, premium rates and standards for provider networks.³⁶ National PPOs must be licensed to sell group health insurance in every state.³⁷ However, the PPO standard contract contains no PPO network adequacy standards and the PPO member handbooks warn employees that “non-PPO benefits are the standard benefits of this Plan.”³⁸

Local HMOs must be licensed under state law and serve a designated service area.³⁹ The Office of Personnel Management requires local HMOs to comply with state benefit mandates although it has statutory authority to override these state laws.⁴⁰ The Office of Personnel Management also reviews local HMO provider networks for evidence of “reasonable access to and choice of quality primary and specialty medical care throughout the service area.”⁴¹

30. FEHBA § 8902. The statute calls the PPOs government-wide service benefit plans and employee organization plans and the HMOs are denominated comprehensive medical plans. *Id.* § 8903. For various typologies of the types of plans, see GAO-03-236, *supra* note 27, at 4-8. For purposes of this discussion we categorize the plans as did BOVBERG, *supra* note 21, at 2.

31. For national offerings, see *2011 Missouri Plans*, *supra* note 12. In 2011, there were about 207 local plan choices. CHAIKIND & NEWSOM, *supra* note 10, at 2. The 2010 data set used for this research showed 207 local plans choices. Data on file with authors and Journal.

32. See FEHBP Handbook, *supra* note 26.

33. See, e.g., U.S. OFFICE PERS. MGMT., GOV'T EMP'S. HEALTH ASS'N, INC. BENEFIT PLAN 25 (2011) [hereinafter GEHA PLAN], available at <http://www.opm.gov/insure/health/planinfo/2011/brochures/71-006.pdf>.

34. *Id.*

35. *Id.* at 110.

36. FEHBA § 8902 (2006).

37. *Id.* § 8902(b).

38. GEHA PLAN, *supra* note 33, at 7.

39. See U.S. OFFICE PERS. MGMT., CARRIER APPLICATION 9-10, available at <http://www.opm.gov/insure/health/carriers/application.doc>.

40. CHAIKIND & NEWSOM, *supra* note 10, at 21.

41. *Id.* at 18.

National PPOs are designated in the statute as “fee-for-service” plans because they pay providers on a per-service basis rather than a flat fee per enrollee, a payment mechanism called capitation that is identified with HMO-style insurance.⁴² Over the years, OPM has used its contracting authority to encourage the national plans to use PPO panels as a cost control mechanism. Consequently, all the national plans are PPOs offering reduced cost-sharing when services are obtained through the plan’s PPO network of contracting providers.⁴³

For the national PPOs, the FEHBP statute provides for one national government-wide service benefit plan and other plans sponsored by employee organizations such as labor unions.⁴⁴ BlueCross/BlueShield has always offered the government-wide service benefit plan.⁴⁵ While OPM negotiates with the national BlueCross/BlueShield Association for a nationwide benefit package and premiums, it contracts with a variety of state-level insurance carriers for the government-wide plan, including both not-for-profit BlueCross/BlueShield state level affiliates and for-profit Anthem/Wellpoint which is licensed to use the BlueCross/BlueShield service mark for the government-wide plan.⁴⁶ The government-wide plan is required by statute to provide at least two levels of benefits, and BlueCross/BlueShield presently offers a Standard option PPO providing both in-network and out-of-network coverage⁴⁷ and a Basic option PPO that covers only in-network, non-emergency services.⁴⁸

Five employee organization PPOs are available to all federal employees and retirees: Mail Handlers Benefit Plan (“MHBP”); Government Employees Health Association, Inc. Benefit Plan (“GEHA”); National Association of

42. For a typology of insurance and managed care nomenclature, see BARRY R. FURROW ET AL., *HEALTH LAW* 643 (6th ed. 2008).

43. MERLIS, *supra* note 29, at 2; CHAIKIND & NEWSOM, *supra* note 10, at 5-6.

44. FEHBA § 8903(l) (2006); see also CHAIKIND & NEWSOM, *supra* note 10, at 5. The statute also authorizes a nationwide indemnity plan. FEHBP no longer offers a nationwide indemnity plan, reflecting the decreased interest in this type of health insurance. For many years, Aetna Life Insurance contracted with OPM to offer the national indemnity plan. However, as of 1990, Aetna withdrew its indemnity plan from the program “after its competitive position was damaged by adverse selection.” KARL POZER, NAT’L HEALTH POLICY FORUM, ISSUE BRIEF NO. 715, THE FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM: WHAT LESSONS CAN IT OFFER POLICYMAKERS? 2 (1998), available at http://www.nhpf.org/library/issue-briefs/IB715_FEHBP_3-12-98.pdf.

45. GRANEY, *supra* note 10, at 1-2; see also H.R. REP. NO. 86-957, *supra* note 22, at 22; CHAIKIND & NEWSOM, *supra* note 10, at 5.

46. See CHAIKIND & NEWSOM, *supra* note 10, at 4 n.13.

47. FEHBA § 8903(1); CHAIKIND & NEWSOM, *supra* note 10, at 5.

48. See U.S. OFFICE PERS. MGMT., BLUECROSS AND BLUESHIELD SERVICE BENEFIT PLAN 156-57 (2011) [hereinafter BCBS PLAN], available at <http://www.opm.gov/insure/health/planinfo/2011/brochures/71-005.pdf>.

Letter Carriers (“NALC”) Benefit Plan; Special Agents Mutual Benefit Association (“SAMBA”) Health Benefit Plan; and American Postal Workers Union (“APWU”) Health Plan.⁴⁹ Four plans are for employees of specific small federal agencies: the Rural Carrier Benefit Plan; Foreign Service Benefit Plan; Compass Rose Health Plan; and Panama Canal Area Benefit Plan.⁵⁰

The national employee organization PPOs are sponsored by not-for-profit employee groups, and OPM contracts with these not-for-profit corporations who serve as the insurance carriers offering these plans.⁵¹ However, the employee organizations contract with commercial insurance companies for a provider network.⁵² Thus, two of the nation’s largest commercial insurers play a substantial role in the employee PPO plans. Cigna provides the networks for four of the employee benefit plans, PPS, NALC, APWU and SAMBA, and Coventry is the network for the Mail Handlers Health Plan in every state except New Jersey and Ohio.⁵³

Local HMO offerings include both closed panel HMO plans that cover only in-network services as well as HMOs with a Point of Service option providing some reimbursement for out-of-network care.⁵⁴

In 2010, the FEHBP offered about 148 local HMO plans to its enrollees.⁵⁵ The FEHBP statute does not limit the number of local HMOs that may participate in the FEHBP, and OPM must contract with any qualified HMO that applies and meets its contracting standards.⁵⁶

Proponents of Health Insurance Exchanges have stressed both the similarities and differences between Exchanges and the FEHBP.⁵⁷ The next section explains briefly what the new Exchanges do and the role that OPM will play in negotiating plans to be offered through them.⁵⁸

III. AFFORDABLE CARE ACT, EXCHANGES & MULTI-STATE QUALIFIED HEALTH PLANS

The centerpieces of health reform under the Affordable Care Act are new Health Insurance Exchanges that are designed to provide one stop shopping for those who use the individual and small group insurance.⁵⁹ Exchanges are also intended to improve the transparency of prices and

49. 2011 Missouri Plans, *supra* note 12; see CHAIKIND & NEWSOM, *supra* note 10, at 5.

50. 2011 Missouri Plans, *supra* note 12.

51. See, e.g., GEHA PLAN, *supra* note 33, at 3, 8.

52. See, e.g., *id.* at 7.

53. See 2011 Missouri Plans, *supra* note 12.

54. See *id.*

55. Data available on file with authors and Journal.

56. FEHBA § 8902(l).

57. Moffit, *supra* note 21, at 1-6; BOVBERG, *supra* note 21, at 1-2.

58. See *infra* Part III.

59. Jost, *Implementing Health Reform*, *supra* note 4.

benefits in the health insurance market, regulate insurance products, and increase accessibility to private insurance coverage.⁶⁰

By January 1, 2014, each state must establish an American Health Benefit Exchange⁶¹ that is either a state governmental agency or nonprofit entity.⁶² States may establish one exchange for the individual market and a separate Small Business Options Program ("SHOP") for the small group market, or operate one exchange for both.⁶³ States also have the option to establish multiple exchanges to serve different geographic areas of the state or to offer multi-state Exchanges in cooperation with other states.⁶⁴ If a state opts not to establish an exchange, the Secretary of HHS has authority to create and operate an Exchange within that state.⁶⁵

Health Insurance Exchanges will provide an online web portal where individuals and small businesses will be able to see, compare and purchase private health insurance. They will also provide the place where low- to middle-income uninsured Americans, will apply for and obtain premium assistance tax credits and cost-sharing reductions.⁶⁶ Families earning between 133-400% of the federal poverty level (\$29,726 to \$89,400 for a family of three in 2011) will be eligible to purchase policies through the exchange using tax credits that will reduce the costs of premiums to a sliding scale of 2% to 9.5% depending on their income.⁶⁷ Only policies bought through an exchange will be eligible for tax credit support.⁶⁸

It is estimated that 24 million Americans will purchase health insurance through the new Exchanges including 19 million using premium tax credits.⁶⁹ It is also estimated that as many as 28 million people will move

60. Jon Kingsdale & John Bertko, *Insurance Exchanges Under Health Reform: Six Design Issues for the States*, 29 HEALTH AFF. 1158, 1158 (2010).

61. The ACA authorizes the establishment of the American Health Benefits Exchange for the individual market and the SHOP Exchange for the small group market. ACA § 1311(b) (to be codified at 42 U.S.C. § 18031). We will refer to both generically throughout this article as a "Health Insurance Exchange," or "Exchange."

62. *Id.* § 1311.

63. *Id.* § 1311(b)(2).

64. *Id.* § 1311. For a thorough discussion of the options states have in structuring these new exchanges, see Jost, *Loopholes in the Affordable Care Act*, *supra* note 4.

65. 42 U.S.C. § 180041(c).

66. *Id.*

67. See ACA § 1402(b)(2); *The 2011 HHS Poverty Guidelines: One Version of the [U.S.] Federal Poverty Measure*, U.S. DEP'T HEALTH & HUMAN SERVICES, available at <http://aspe.hhs.gov/poverty/11poverty.shtml> (last visited Oct. 24, 2011).

68. ACA § 1401(b)(2)(A).

69. Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives (Mar. 20, 2010) [hereinafter Elmendorf Letter], available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/Amendreconprop.pdf>; *infra* Figure 4.

annually between Health Insurance Exchange tax premium credit coverage and Medicaid.⁷⁰ As Sarah Rosenbaum and Benjamin Sommers note in their article in this symposium issue, a key issue in creating the new Exchanges will be designing mechanisms for transitioning enrollees between Exchange-sold policies and Medicaid so that those who move between the two types of insurance will not experience gaps in coverage or disruptions in provider relations.⁷¹ One solution being suggested is the offering of new insurance plans in both the Health Insurance Exchanges and Medicaid (sometimes called hybrid plans) so consumers could keep the same plan as they move between the two programs and thus be assured of continuity of care.⁷²

Only plans certified as qualified health plans ("QHP"), meeting minimum standards for quality and cost, shall be offered through the Exchange.⁷³ The ACA specifies that qualified health plans must meet standards for covered benefits, premiums, actuarial value, and out-of-pocket costs, although states may impose additional requirements.⁷⁴ The Secretary of HHS is to promulgate regulations to guide the Exchanges in setting standards for qualified health plans to meet for marketing, provider networks, quality improvement activities and accreditation.⁷⁵ The ACA specifically provides that Exchange-certified qualified health plans must provide a "sufficient choice of providers," and may not exclude an otherwise qualified health plan because it is a fee-for-service plan.⁷⁶

In addition to Exchange certified qualified health plans, the ACA also provides that every Health Insurance Exchange shall offer *at least two* "multi-state qualified health plans," to be negotiated by Office of Personnel Management.⁷⁷ MSQHP are to be offered nationwide,⁷⁸ and must meet the

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

71. Sara Rosenbaum & Benjamin Sommers, *Rethinking Medicaid in the New Normal*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 127 (2011).

72. *Id.* at 149–50.

73. ACA § 1311(d)(2)(B)(i) (to be codified at 42 U.S.C. § 18031).

74. See *id.* § 1311. For a detailed discussion of these provisions, see Sidney D. Watson, *Mending the Fabric of Small Town America: Health Reform & Rural Economics*, 113 W. VA. L. REV. 1, 22-29 (2010).

75. ACA § 1311(c).

76. See ACA § 1311(c), (e). Neither may an Exchange exclude an otherwise qualified health plan because of premium price controls nor on the basis that the plan provides treatments necessary to prevent patient deaths in circumstances the Exchange determines are inappropriate or too costly. *Id.* § 1311(e).

77. ACA § 1334 (to be codified at 42 U.S.C. § 18054).

78. See 42 U.S.C. § 18054(c)(1)(D). MSQHPs must be offered in all geographic regions and in all States that have adopted adjusted community rating prior to March 23, 2010. *Id.* ACA provides a four year phase in period to allow carriers who do not yet have the capability

ACA standards for qualified health plans including requirements for covered benefits, premiums and out-of-pocket costs, as well as any additional state law requirements for additional covered benefits.⁷⁹

The ACA directs OPM to contract for MSQHPs in a similar manner as to how it “implements the contracting provisions with respect to carriers under the Federal Employees health benefit program.”⁸⁰ MSQHPs are to be offered separately from the OPM administered FEHBP and are subject to separate risk pooling arrangements.⁸¹

The provision for national MSQHPs plans appeared in the Senate version of the ACA as an alternative to the hotly debated public health insurance option provided for by the House version of the bill.⁸² Instead of the House-envisioned government insurance program available nationally, the ACA authorizes OPM to use its contracting authority to offer new private MSQHPs on a national basis, similar to the manner in which it negotiates such contracts in the FEHBP.⁸³

The ACA section 1301(a)(2) provides that any MSQHP under contract with OPM shall be considered to be a qualified health plan and “deemed to be certified by an Exchange.”⁸⁴ MSQHPs do not have to apply for separate certification in each Health Insurance Exchange.⁸⁵ Instead, OPM will certify, through its MSQHP contracting process, that MSQHPs meet the ACA’s standards for a qualified health plan.⁸⁶

Health insurers wishing to offer MSQHPs must be licensed in each state and subject to all requirements of state law not inconsistent with ACA’s standards for MSQHPs. They must also comply with minimum standards prescribed for FEHBP health plan carriers,⁸⁷ and meet other requirements as determined by the Director of OPM.⁸⁸

to market a plan nationwide to begin offering a MSQHP as it builds. To be eligible to participate as a MSQHP such issuers must offer a plan in at least 60% of states in the first year of an issuer’s participation in an exchange, 70% of states in the second year, 85% of states in the third year, and all states by the fourth year. 42 U.S.C. § 18054(e)

79. ACA § 1334(c).

80. *Id.* § 1334(a)(4).

81. *Id.* § 1334(g).

82. Jost, *Revised Health Reform Bill*, *supra* note 7.

83. See ACA § 1334.

84. *Id.* § 1334(d); see Lynn Shapiro Snyder et al., *Health Reform: OPM RFI Regarding Multi-State/National Insurance Plans*, EPSTEIN BECKER GREEN (June 28, 2011), <http://www.ebg.com/showclientalert.aspx?Show=14556>.

85. See ACA § 1334(d) (to be codified at 42 U.S.C. § 18054).

86. *Id.* § 1334 (to be codified at 42 U.S.C. § 18054).

87. *Id.* § 1334(b). See also FEHBA § 8902(e) (2006) and 48 C.F.R. § 1609.7001 (2010) for a listing of these minimum standard requirements.

88. ACA § 1334(b)(4).

Health insurance issuers eligible to offer MSQHPs are a health insurer or group of insurers "affiliated either by common ownership and control or by the common use of a nationally licensed service mark."⁸⁹ Thus, BlueCross/BlueShield is eligible to offer a MSQHP because it is a group of insurers who use the nationally licensed BlueCross/BlueShield trademark. The FEHBP employee organization would qualify because they operate nationally under common ownership and control. Four of the five largest commercial health insurance companies would qualify because of their common ownership and nationwide scope: Aetna, Cigna, Coventry and United HealthCare.⁹⁰

It is less clear which insurance issuers qualify to offer the "at least one" not-for-profit MSQHP.⁹¹ The issue will likely be resolved by how OPM interprets whether the "not-for-profit entity," with which OPM is directed to contract must be the national entity with which it negotiates for a nationwide MSQHP or the state entities licensed to offer insurance in each state. For example, BlueCross/BlueShield local affiliates in fourteen states are the for-profit company Anthem/Wellpoint.⁹²

The ACA has propelled the OPM into a new role as the agency responsible for recruiting, negotiating and developing the contracting requirements for at least two MSQHPs to be offered through every Health Insurance Exchange and throughout the country. As in the FEHBP, these national plans will compete with locally offered plans. Since the FEHBP already offers both national and local plans, understanding how competition and plan choices have worked in the FEHBP is helpful in thinking about how policy makers should approach the local versus national plan design in the new Exchanges.

89. *Id.* § 1334(a)(1).

90. See generally *Aetna Facts*, AETNA, <http://www.aetna.com/about-aetna-insurance/aetna-corporate-profile/facts.html> (last visited Dec. 3, 2011); *About Us*, UNITEDHEALTHCARE, <https://studentcenter.uhcsr.com/AboutUs.aspx> (last visited Dec. 3, 2011); *Group Health Plans*, COVENTRY HEALTH CARE, <http://coventryhealthcare.com/health-care-solutions/group-health-plans/index.htm> (last visited Dec. 3, 2011); *Facts About Cigna*, CIGNA, <http://www.cigna.com/aboutus/cigna-fact-sheet> (last visited Dec. 3, 2011).

91. ACA § 1334(a)(3) (to be codified at 42 U.S.C. § 18054). The statute also specified that at least one MSQHP cannot offer coverage for abortion services. ACA § 1303(a)(1)(D)(i)(II) (to be codified at 42 U.S.C. § 18023).

92. See *Company History*, WELLPOINT, <http://www.wellpoint.com/AboutWellPoint/CompanyHistory/index.htm> (last visited Dec. 3, 2011). The fourteen states are California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. *Id.*; see also *Health Plans*, ANTHEM BLUECROSS BLUESHIELD, <http://www.anthem.com/health-insurance/plans-and-benefits/health-insurance-plan#> (last visited Dec. 3, 2011).

IV. DATA FROM THE FEHBP

An analysis of enrollment in FEHBPs, comparing enrollment in national and local plans, provides interesting insights into the role that the MSQHP offerings may have on competition within the ACA's health insurance exchanges. The FEHBP offers enrollees a choice of six national PPO plans available to all, four national plans available to employees of specific small federal agencies, as well as local HMO plans.⁹³ Similarly, the ACA's Health Insurance Exchanges will offer individuals and small groups the choice of at least two MSQHPs that will be offered nationwide as well as plans offered on a local basis.⁹⁴

To calculate how many employees and their dependents are enrolled in the various FEHBP programs, we obtained 2010 FEHBP program enrollment data from the Office of Personnel Management pursuant to a Freedom of Information Act request. The OPM data indicated the number of employees who enrolled in each plan by county, and whether the employee chose individual or family coverage.⁹⁵ Using data from each FEHBP program on the average size of covered families in each plan, we calculated total enrollment for each FEHBP program, by county and nationally.⁹⁶ Although the OPM provided data on both present employees and retirees,⁹⁷ the data presented here is for employees only, because they more closely match the under age 65 working population that will be eligible for plans offered through the Health Insurance Exchanges.

93. See *2011 Missouri Plans*, *supra* note 12. Because the six nationwide plans available to all employees offer multiple options for coverage, some plans appear two or three times in the list of available options. *Id.*; see CHAIKIND & NEWSOM, *supra* note 10, at 2 (describing six national plans).

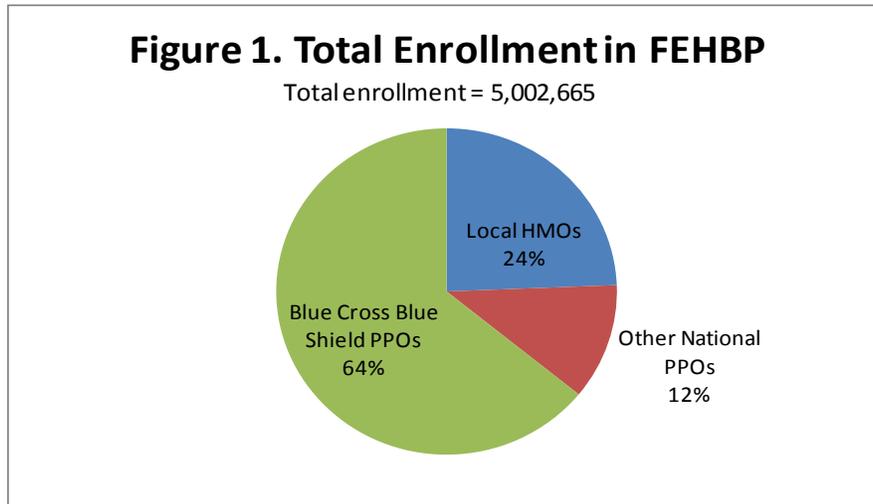
94. ACA § 1334 (to be codified at 42 U.S.C. § 18054).

95. On file with authors and Journal.

96. See TIMOTHY MCBRIDE ET AL., HEALTH INSURANCE EXCHANGES: WHAT LESSONS CAN BE LEARNED FROM THE FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM? 5-6 (providing a detailed description of the data sets and methods) (on file with authors and Journal).

97. FEHBP and OPM refer to retired federal workers as "annuitants." For purposes of this article we use the more familiar term retirees.

In 2010, just over 5 million employees and their dependents were enrolled in FEHBP programs.⁹⁸ Plan enrollment was heavily concentrated in the national PPO plans with 76% enrolled in these plans and 24% enrolled in local HMO plans (see Figure 1).⁹⁹ Moreover, enrollment was particularly concentrated in the BlueCross/BlueShield plans with 64% of covered persons enrolled in BlueCross/BlueShield plans (see Figure 1).¹⁰⁰

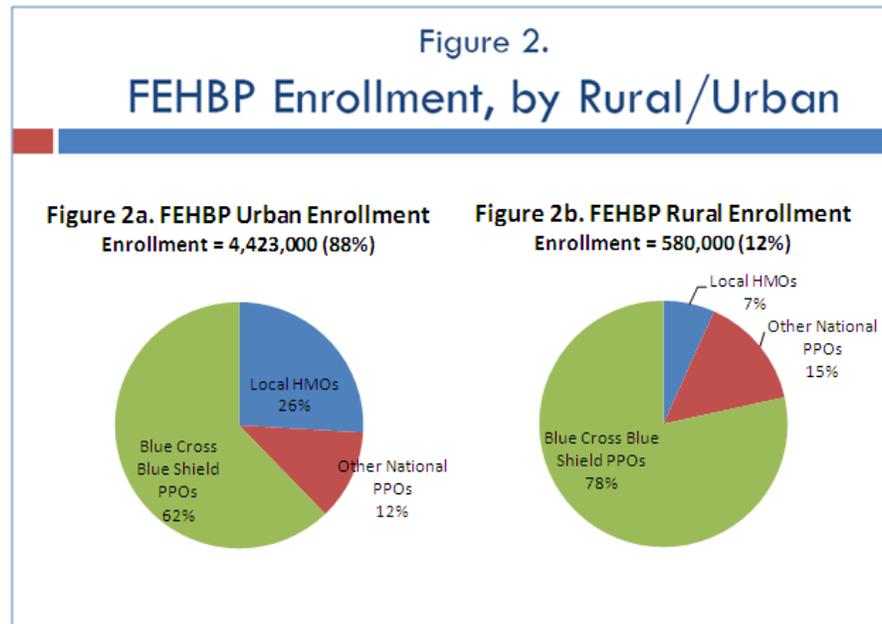


98. See *infra* Figure 1.

99. See *infra* Figure 1.

100. See *infra* Figure 1.

The reliance on national PPO plans and BlueCross/BlueShield in particular was striking in rural areas where 93% were enrolled in a national plan and 78% in a BlueCross/BlueShield plan (Figure 2).¹⁰¹ Only 7% of rural employees and their dependents enrolled in local HMO plans.¹⁰² In contrast, in urban areas 26% enrolled in local HMOs, 74% enrolled in national PPOs with 62% in BlueCross/BlueShield.¹⁰³



The lack of local plan enrollment in rural areas lead us to wonder if plan enrollment might be driven by plan choice or lack thereof. To determine if plan choice might be impacting plan enrollment, we next examined how many local HMO plans were offered in each county nationwide. While OPM contracted with approximately 148 local plans in 2010, we found that in almost two-thirds (61.2%) of the counties across the country federal

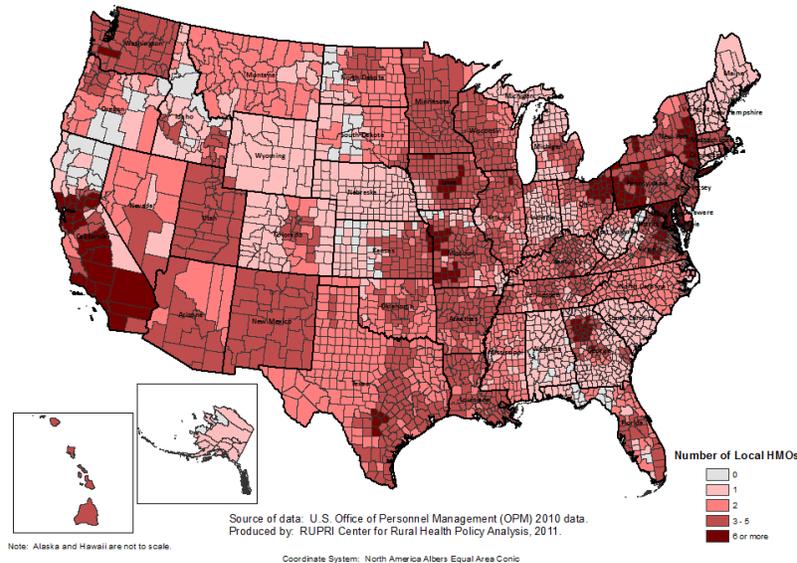
101. To identify rural and urban counties, the data were coded with the United States Census Bureau regions by state, using Economic Research Service (“ERS”) measures of type of county using the Urban Influence Code. UIC codes do not match correctly in all counties, and in these situations the individual records were evaluated and resolved by hand. Data from U.S. territories (American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands) and some from the state of Alaska were excluded from the analysis, because they do not use county designations. These restrictions reduce the size of the entire dataset, including both employees and retirees, to 7.66 million enrollees.

102. See *infra* Figure 2.

103. See *infra* Figure 2.

employees had access to only two or fewer local plans.¹⁰⁴ In over a quarter of the counties (28.3%) employees had a choice of only one or no local plan,¹⁰⁵ and in over three-quarters of the counties (78.2%) three or fewer local plans were offered.¹⁰⁶ Figure 3 provides a map of plan choice across the nation.¹⁰⁷ The Appendix provides tables with detailed figures.¹⁰⁸

Figure 3. Federal Employees Health Benefits Program (FEHBP): Availability of Local HMOs in the U.S. by County, 2010



104. Of 3,141 counties nationwide, in 1,922 employees have none to two local plans offered. Data on file with authors and the Journal. For purposes of this analysis we counted all options offered by a plan as one plan. Thus a plan that offered both a high and low option was counted as one plan. Similarly high deductible plans that offered both consumer directed and health savings account options were counted as one plan. This methodology is consistent with that used by Congressional Research Service and others. See *2011 Missouri Plans*, *supra* note 12.

105. *Id.* In counties where only one local HMO plan is offered, it is a high deductible plan with either a consumer driven option or a health savings account/health reimbursement account. See AETNA HEALTH, AETNA HEALTH FUND PLAN BROCHURE: AN INDIVIDUAL PRACTICE PLAN WITH A CONSUMER DRIVEN HEALTH PLAN OPTION AND A HIGH DEDUCTIBLE HEALTH PLAN OPTION (2011), available at <http://www.opm.gov/insure/health/planinfo/2011/brochures/73-828.pdf>. The Consumer Directed Option has a \$1,000 deductible for individual coverage and \$2,000 for family coverage. The High Deductible with Health Savings Account or Health Reimbursement Arrangement has a \$1,500 deductible for individual coverage and \$3,000 for in network coverage and \$2,500 and \$5,000 for out of network care. As required by the Affordable Care Act preventive services are covered with no deductible. *Id.* at 8.

106. *Id.*

107. See *infra* Figure 3.

108. See *infra* Appendix.

The county-level mapping of FEHBP local program offerings is striking because it shows the clustering of more local HMO offerings in and near urban centers. Mindful of this and that rural FEHBP enrollees are significantly less likely to enroll in local HMOs, we next sorted the data to determine if there was a significant difference in the number of rural counties with no or only a handful of local HMO offerings. The rural/urban differential is dramatic: almost three-quarters of rural counties (71.2%) had two or fewer local plans while only slightly more than 40% of urban counties (42.3%) had two or fewer local plans available.¹⁰⁹ At the other end of the spectrum, almost 25% of urban counties (22.9%) had five or more local HMOs offering FEHBP programs, while only 5.3% of rural counties had this many local options available. Figure 4, below, provides the break down of plan offerings by rural and urban counties. The Appendix has two tables with more detailed information by county.¹¹⁰

Figure 4. Number of FEHBP choices available to enrollees, by county, Rural and Urban Counties			
Number of local plan choices in county	Percentage of counties		
	Urban	Rural	ALL
None	0.4%	3.8%	2.6%
1	16.5%	30.6%	25.7%
2	25.4%	36.8%	32.9%
3	20.4%	15.2%	17.0%
4	14.4%	8.2%	10.4%
5	9.4%	3.2%	5.3%
6 or more	13.5%	2.1%	6.1%
TOTAL	100.0%	100.0%	100.0%

We conclude, based on this data, that FEHBP program enrollment in national PPOs versus local HMOs is in large part driven by the choice of plans available. To a large extent, FEHBP participants choose national PPO plans over local HMOs plans because relatively few local HMOs plans are

109. See *infra* Figure 4.

110. See *infra* Figure 4.

offered.¹¹¹ The small number of local HMO plans in rural areas explains both why only 7% of rural FEHBP enrollees are in local plans and why rural FEHBP enrollees are significantly less likely to enroll in local plans than are urban employees.

However, the lack of local HMOs does not explain why both rural and urban federal employees opt for the BlueCross/BlueShield national plans over other national options. The next section offers three possible explanations for BlueCross/BlueShield's dominance in the FEHBP as well as some lessons for those who wish to encourage greater competition in the new Health Insurance Exchanges.

V. POLICY IMPLICATIONS FOR THE ACA, EXCHANGES AND MSQHPs

Analysis of FEHBP program offerings and enrollments offers important lessons for both the Exchanges that will be certifying local plans to be offered through the Exchanges and to the OPM which has new authority to negotiate for MSQHPs to be offered through every Exchange. While there are important statutory and practical differences between the new Health Insurance Exchanges and the FEHBP, experience in the FEHBP will help policymakers as they plan for the new Exchange offerings.

This analysis of FEHBP program data shows that in almost two-thirds of counties across the country federal employees have limited choice of local plans.¹¹² In rural counties, the percentage jumps to almost three-quarters.¹¹³ The analysis also shows that plan availability is a primary driver of plan enrollment, particularly in rural areas, explaining to a great extent why 93% of rural enrollees are in a national plan compared to 73% in urban areas.¹¹⁴

The fact that the FEHBP limits local plans to HMO model plans has almost certainly contributed to the dearth of local options in the FEHBP.¹¹⁵ Creating HMO networks in rural areas has been a longstanding challenge

111. See GAO-03-236, *supra* note 27, at 8 (showing that in 2002 there were only 170 HMOs which led to HMO enrollees accounting for only 30% of FEHBP enrollees).

112. TIMOTHY MCBRIDE ET AL., RUPRI CTR. FOR RURAL HEALTH POLICY ANALYSIS, RURAL POLICY BRIEF PB2003-5, AN ANALYSIS OF AVAILABILITY OF MEDICARE+CHOICE, COMMERCIAL HMO, AND FEHBP PLANS IN RURAL AREAS: IMPLICATIONS FOR MEDICARE REFORM 7 (2003) (reporting that only 45% of counties had more than six plans); see also BOVBJERG, *supra* note 21, at 2-3 (stating over two-thirds of enrollees selected PPO plans, which are national plans).

113. See MCBRIDE ET AL., *supra* note 112, at 7 (reporting that 70% of rural counties had nine or fewer plans).

114. Bradley M. Gray & Thomas M. Selden, *Adverse Selection and the Capped Premium Subsidy in the Federal Employees Health Benefits*, 69 J. RISK & INS. 209, 219 n.20 (2002).

115. See MERLIS, *supra* note 29, at 2, 14 (stating all HMOs are only available to employees residing in specific service areas and only rated for a limited area, as opposed to PPO plans, which are rated nationally).

not only in the FEHBP but also for Medicare Advantage, Medicaid managed care and other commercial insurers.¹¹⁶ There are a number of reasons why HMOs are less prevalent in rural areas. In some areas there are too few providers to meet state HMO network adequacy requirements. In other areas, the few providers who are available are not willing to contract with HMOs for reduced payment rates.¹¹⁷

A similar problem is unlikely to arise in the new Health Insurance Exchanges because the ACA does not require that Exchange-certified qualified health plans be HMOs. The ACA not only gives Exchanges flexibility to certify non-HMOs as qualified health plans to participate in the Exchanges, it prohibits Exchanges from excluding fee-for-service plans, like PPOs, as a local plan option.¹¹⁸ The statutory directive specifying that PPOs as well as HMOs are eligible to be certified as local Exchange certified plans should address the problems that have arisen in the FEHBP, and elsewhere, in trying to create HMO networks in areas with few providers.

However, if the Exchanges default to certifying only local PPOs and fail to encourage development of HMO options, the result will likely be significantly higher out-of-pocket costs for those who rely on Exchange plans. One of the limitations of the data analysis presented here is that it does not address the cost impact on federal employees who must rely on PPOs because of the lack of HMO options. HMOs tend to be less costly for consumers in terms of out-of-pocket expenses, costing 18% less than PPOs and 25% less in those indemnity plans offering the same coverage.¹¹⁹ In a 2003 analysis of comparative out-of-pocket costs for a single FEHBP enrollee comparing local HMOs and national PPO plans, HMO out-of-pocket costs ranged from \$150-\$270 while PPO costs BlueCross/BlueShield Standard Option ranged from a low of \$230 for the to \$670.¹²⁰ Higher out-of-pocket costs for Exchange plans will not only pose a problem for the low-to-moderate income consumers who are estimated to be the bulk of those who will use the Exchanges to purchase insurance, but it will also have an impact on the federal budget which will

116. See MCBRIDE ET AL., *supra* note 112, at 2, 4 (showing the difficulty of establishing all three types of plans in rural areas); see Jon Gabel et al., *Generosity and Adjusted Premiums in Job-Based Insurance*, 25 HEALTH AFF. 832, 832 (2006) (noting the lack of HMO plans for rural employer sponsored insurance).

117. See MERLIS, *supra* note 29, at 12, 15-16 (stating HMOs are often not available in rural areas and providers in isolated areas may not be willing to grant discounts).

118. ACA § 1311 (e) (to be codified at 42 U.S.C. § 18031).

119. See also MERLIS, *supra* note 29, at 4 (“HMOs generally expose enrollees to lower out-of-pocket costs than the PPOs, in exchange for more restricted access to providers”).

120. *Id.*

fund part of the out-of-pocket costs for those eligible for tax credit subsidies.¹²¹

The sheer size of the Exchanges will likely mean that more local plans will be interested in selling qualified health plans through the Health Insurance Exchanges than are interested in competing in the FEHBP. While the FEHBP is the largest employer-sponsored insurance group in the country, with about 8 million enrollees, estimates are that the Health Insurance Exchanges will cover about three times as many people, perhaps more than 24 million people.¹²² This new Health Insurance Exchange marketplace for insurance may be too large for private insurers to ignore.¹²³ It also creates an important opportunity for the new Exchanges to help spur the development of new insurance products, including HMOs that provide consumers with better coverage and lower out-of-pocket costs and premiums.

The data highlighting BlueCross/BlueShield's dominant role in the FEHBP also offers a cautionary lesson for OPM as it develops the rules for MSQHP offerings; determines the types of plans, PPOs or HMOs, that will be offered; calculates how many MSQHPs will be available; and determines which entities will be eligible—and selected—to offer the new not-for-profit option. The ACA provides that OPM must offer at least two MSQHPs, one of which must be "entered into with a not-for-profit entity," but gives OPM discretion to offer more plans.¹²⁴ The ACA provides no guidance on the types of networks that MSQHPs should have.

In the FEHBP, with six national plans to choose from, 64% of employees and their dependents picked BlueCross/BlueShield with only 12% choosing

121. See TIMOTHY D. MCBRIDE, RURAL POLICY RESEARCH INSTITUTE (RUPRI), *IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ON COVERED PERSONS AS AMENDED 2 (2009)* [hereinafter *IMPACT ON COVERED PERSONS*] (stating 36.1% of previously uninsured persons will obtain insurance through HIE with subsidies or tax credits).

122. See MERLIS, *supra* note 29, at 1 (stating FEHBP covers more than 8.5 million people); Elmendorf Letter, *supra* note 69, at Table 2 (estimating 24 million people covered under exchanges by 2018). About 14 million newly insured will switch from the present individual and small group markets to plans offered through the Exchanges. See JONATHAN GRUBER, CTR. FOR AM. PROGRESS, *HEALTH CARE REFORM IS A "THREE-LEGGED STOOL": THE COSTS OF PARTIALLY REPEALING THE AFFORDABLE CARE ACT 1 (2010)* (estimating that 26.8 million people will be covered by 2019).

123. See *IMPACT ON COVERED PERSONS*, *supra* note 121, at 2 (showing that HIE enrollment numbers will approximate 45.4%). The population typically served by the FEHB program is comprised of federal workers and retirees who have higher incomes and are more educated than the population that will get insurance via the Exchange. This population is more likely to be previously uninsured, have lower incomes and a lower education. However, if premium rates are adequate there is no reason to believe that insurers will not market to this group, just as Medicaid Managed Care plans have developed to market to even poorer Americans.

124. ACA § 1334 (to be codified at 42 U.S.C. § 18054).

another national plan.¹²⁵ In rural areas, almost 80% of enrollees (78%) picked BlueCross/BlueShield.¹²⁶ Enrollment data does not tell us why BlueCross/BlueShield has achieved such dominance, but over the last ten years it has become increasingly dominant as enrollees have shifted from local HMOs to BlueCross/BlueShield.¹²⁷ Certainly, its sheer size has given it economies of scale that have allowed it to offer competitive premiums, benefits and somewhat lower out-of-pocket costs when compared with the other national plans.¹²⁸ However, other factors have also helped BlueCross/BlueShield grow, factors that the OPM should consider as it begins negotiating for MSQHPs.

One factor in BlueCross/BlueShield's dominance over other national FEHBP programs across both rural and urban counties may be because it is the only "name-brand" insurer that offers a national PPO in the FEHBP. Although all employees are eligible to enroll in the four employee-sponsored plans open to all workers, these plans may simply not have the name recognition to attract employees who do not self-identify with the group. In others words, an employee of U.S. Department of Health and Human Services or the Internal Revenue Service may simply not spend the time to learn much about a plan called National Association of Letters Carriers or Special Agents Mutual Benefit Association. Our data supports this conclusion because the employee organization plan with the most generic name, Government Employees Health Association, has the second largest enrollment after BlueCross/BlueShield, enrolling about 5% of FEHBP employees and their dependents.¹²⁹

To the extent that enrollment in the FEHBP BlueCross/BlueShield program is driven by name brand recognition, limiting national MSQHPs to only two plans during the Exchange start-up process may give these plans a similar national visibility and name recognition that will give them the

125. Authors' original data on file with Journal.

126. Authors' original data on file with Journal.

127. See MERLIS, *supra* note 29, at 13. In 2001, BlueCross/BlueShield had a 45% market share, compared with 31% for HMOS and 23% for the employee specific organization. *Id.*; see also GAO-03-236, *supra* note 27, at 7-8. In 2002, BlueCross/BlueShield had about one-half of enrollees and local HMOs had 30%. GAO-03-236, *supra* note 27, at 7-8. In 2001, BlueCross/BlueShield had 60% of rural employee and retiree enrollees. Keith Mueller, et al., *The Federal Employees Health Benefits Program: A Model for Competition in Rural America?*, 21 J. RURAL HEALTH 105, at 108 (2002).

128. See MERLIS, *supra* note 29, at 4, 6 (showing BCBS standard out-of-pocket costs lower for benefits among the Washington D.C. FEHBP PPO plans in 2003 and OPM has granted approval for BCBS to draw on its reserves if its costs exceed its premium revenue).

129. Of course this does not explain why employees might not investigate the employee organization plan with the most generic name, Government Employees Health Association (GEHA).

competitive edge to become dominant nationally. The FEHBP program handbooks identify two other commercial insurers, Cigna and Coventry who already have national networks of providers in place and who are likely in a position to bid to become MSQHPs¹³⁰ Both have high national visibility and name recognition.¹³¹ As OPM begins the MSQHP negotiating process it needs to consider whether contracting with one or more of these large commercial insurers without other national MSQHPs will likely encourage even further consolidation in insurance markets which have become increasingly concentrated in recent years.¹³²

The lack of enrollment in the employer sponsored organizations also raises some interesting questions about the types of not-for-profit MSQHPs that are likely to respond to public interest in a new nonprofit national plan and be competitive in the new Health Insurance Exchange.¹³³ While BlueCross/BlueShield is the dominant FEHBP program and has strong name recognition, it is not offered at the state level by not-for-profit entities.¹³⁴ In the FEHBP, OPM contracts at the carrier level, which means that although it negotiates a plan with the national BlueCross/BlueShield not-for-profit organization, it contracts with the various state licensed entities that operate under the BlueCross/BlueShield service mark. In fourteen states these are the for-profit publicly traded corporation, Anthem/Wellpoint.¹³⁵ It may be unpopular with both the public and Congressional leaders for OPM to designate a for-profit entity like Anthem/Wellpoint as the nonprofit MSQHP Exchange offering.

An important fact in BlueCross/BlueShield's success in the FEHBP may be that the other national PPO Plans do not have sufficient network

130. See, e.g., CIGNA HEALTH CARE OF CAL., INC., A HEALTH MAINTENANCE ORGANIZATION (2012); COVENTRY HEALTH CARE OF KAN., INC., A HEALTH MAINTENANCE ORGANIZATION (HIGH STANDARD OPTION), AND A HIGH DEDUCTIBLE HEALTH PLAN (2012).

131. *The Top 25 Health Insurance Companies*, U.S. NEWS & WORLD REP., <http://health.usnews.com/health-plans/national-insurance-companies> (ranking Coventry and Cigna, as #7 and #11, respectively, on the list of Top U.S. Health Insurance Companies).

132. See, AM. MED. ASS'N, COMPETITION IN HEALTH: A COMPREHENSIVE STUDY OF U.S. MARKETS, 2008 UPDATE 5 (2008). Ninety-four percent of statewide commercial health insurance markets are deemed to be highly concentrated using U.S. Department of Justice guidelines. *Id.*

133. See GEHA PLAN, *supra* note 33, at 8 (which is incorporated as a general not-for-profit corporation).

134. Compare BCBS PLAN, *supra* note 48 (which is a national not-for-profit plan), and BLUE PREFERRED PLUS POS (2012) (which under the for-profit company Anthem).

135. James Robinson, *The Curious Conversion of Empire BlueCross*, HEALTH AFF., July/Aug. 2003, at 100, 112 (stating Anthem is one of the investor owned multi-state Blue plans).

providers to offer participants a meaningful choice of network providers.¹³⁶ PPOs, like HMOs, achieve savings by negotiating discounted rates with providers.¹³⁷ In rural areas, where they are few providers, they may have little incentive to grant these discounts and join networks, whether they are HMOs or PPOs.¹³⁸ An analysis done in 2003 of FEHBP national program networks available in Lebanon, Kansas, found that BlueCross/BlueShield had network primary care physicians within a twenty minute commute and GEHA had in network providers within a twenty-six minute commute, but the other national PPO plans required enrollees to drive over an hour to reach an in-network primary care physician.¹³⁹ “BlueCross/BlueShield had fifty in-network primary care physicians within a fifty mile drive, while five of the six national PPO Plans then available had only one primary care physician within a fifty mile radius.”¹⁴⁰ One likely explanation of BlueCross/BlueShield’s dominant position in the FEHBP, particularly in rural areas is that it is the only PPO that has a sufficiently large network to protect consumers from the high costs of out-of-network care.

In the FEHBP, OPM imposes no network standards on national PPO networks, other than that they be accredited.¹⁴¹ While the ACA does not mention network standards for MSQHPs, it does provide that OPM is authorized to contract for “such other terms and conditions of coverage as are in the interest of enrollees of such plans.”¹⁴² Given data on FEHBP program enrollment, anecdotal information about sparse networks and the financial toll that out-of-network care can impose on enrollment, OPM needs to consider imposing network adequacy standards on the new MSQHPs. OPM should consider requiring MSQHPs comply with Exchange-established network standards. While this would require the new nationwide MSQHPs to comply with different states’ laws, the ACA already requires that MSQHPs comply with state laws requiring benefits in addition to the ACA’s essential benefits package and state-level rating requirements that are more stringent than the ACA.¹⁴³ Data from the FEHBP shows that federal

136. See MERLIS, *supra* note 29, at 15 (stating those FEHBP members in less populated areas may only have access to national plan that may not have much provider choice).

137. *Id.* at 15-16.

138. *Id.* (discussing the lack of incentives for providers to accept discounted rates from PPO networks).

139. *Id.* at 13. BlueCross/BlueShield has fifty in-network primary care physicians within a fifty-mile driving distance, while five of the six national PPO Plans then available had only one primary care physician within a fifty-mile radius. *Id.*

140. *Id.*

141. See GEHA PLAN, *supra* note 33; see also NCQA, 2011 NAT’L COMM. FOR QUALITY ASSURANCE (NCQA) HEALTH PLAN ACCREDITATION REQUIREMENTS (2011).

142. ACA § 1334 (to be codified at 42 U.S.C. § 18054).

143. *Id.* § 1334(c)(1)(A).

employees appear reticent to sign up for nationwide plans with thin provider networks. Offering plans with thin networks undermines the theory upon which the new Health Insurance Exchanges are built which is to create a competitive market offering consumers quality health insurance.

VI. CONCLUSION

An appreciation of how FEHBP national PPO plans and local HMOs are regulated and how that affects enrollees choice of plans provides useful insights for those who will be designing the new Health Information Exchanges and for OPM as it begins the process of creating contract terms for the new MSQHPs. The ACA provides the new Health Insurance Exchanges with flexibility to contract with a variety of types of local health plans which should help them generate more locally-based health insurance options for those who use the Exchanges. However, the ACA also gives the Office of Personnel Management discretion to limit the number of national plans to two, an option that OPM needs to ensure does not result in one or two national health insurers coming to dominate the new Exchanges.

APPENDIX

Appendix Table 1. Number of FEHB program choices available to enrollees, by county								
Number of state-specific plan choices in county*	Number of counties	Mean percent enrolled in national plans**	Distribution of counties by percent enrolled in national plans					
			Less than 50%	50-59.9%	60-69.9%	70-79.9%	80-89.9%	90-100%
None	82	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
1	808§	98.8%	0.0%	0.1%	0.0%	0.3%	0.0%	99.6%
2	1032	97.4%	0.3%	0.5%	0.5%	0.4%	3.5%	94.8%
3	534	85.6%	5.7%	3.1%	6.3%	7.0%	12.5%	65.4%
4	326	82.0%	10.6%	1.4%	8.2%	14.9%	22.9%	41.9%
5	168	75.2%	11.2%	8.6%	16.2%	9.9%	34.9%	19.4%
6+	191	59.8%	23.9%	27.0%	26.7%	15.3%	4.1%	2.9%

SOURCE: Analysis of FEHBP enrollment files, obtained from Office of Personnel Management (OPM).

* Standard and High options offered by a single firm are counted as one plan.

**National plans include certain nationally available plans open to specific groups.

§ This number includes 692 counties whose only choice is Aetna's high-deductible plan, which in many counties has no enrollment.