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2d Session }

SENATE

{ REPORT
115-277 }

REPEAL INSURANCE PLANS OF THE
MULTI-STATE PROGRAM ACT OF 2017

R E P O R T

OF THE

COMMITTEE ON HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
WITH ADDITIONAL VIEWS

TO ACCOMPANY

S. 2221

TO REPEAL THE MULTI-STATE PLAN PROGRAM



JUNE 18, 2018.—Ordered to be printed

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| 115TH CONGRESS } 2d Session } | SENATE | { REPORT 115-277 |
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REPEAL INSURANCE PLANS OF THE MULTI-STATE
PROGRAM ACT OF 2017

JUNE 18, 2018.—Ordered to be printed

Mr. JOHNSON, from the Committee on Homeland Security and
Governmental Affairs, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany S. 2221]

[Including cost estimate of the Congressional Budget Office]

The Committee on Homeland Security and Governmental Affairs, to which was referred the bill (S. 2221) to repeal the multi-State plan program, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill, as amended, do pass.

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I. PURPOSE AND SUMMARY

S. 2221, the Repeal Insurance Plans of the Multi-State Program Act, or the RIP MSP Act, repeals the Multi-State Plan (MSP) Pro-

gram authorized under Section 1334 of the Patient Protection and Affordable Care Act (ACA). The MSP Program is not meeting statutory requirements under the ACA and eliminating this program will allow the Office of Personnel Management (OPM) to focus on mission-critical programs.

II. BACKGROUND AND THE NEED FOR LEGISLATION

On March 23, 2010, President Barack Obama signed the ACA into law.¹ The MSP Program mandated by the ACA was intended to increase competition and provide greater insurance choices for consumers.² To accomplish this task, Section 1334 authorized the Director of OPM to contract with health insurers to offer at least two multi-state plans on state exchanges for individual or group coverage, thereby competing against other plans offered through the exchanges.³ Section 1334 required issuers to be licensed in each state and subject to all the requirements of state law while complying with minimum standards established under chapter 89 of title 5, United States Code, as well as any other requirements as determined by the Director. OPM was granted a phase-in period for the multi-state plans with coverage of 60 percent of the states in the first year, 70 percent of states in the second year, 85 percent of states in the third year, and all states in each subsequent years.

Section 1334 was inserted into the ACA by former Senate Majority Leader Harry Reid during floor consideration after the legislation passed the Senate Finance Committee.⁴ Due to its late addition, there was little debate on the merits of creating the MSP program or whether it could meet the stated objective of offering increased competition and more choice.⁵ *Politico* reported on the rushed origins of the program, stating things happened so fast that there was little time for a robust, thoughtful conversation.⁶

News that some members of Congress were nearing an agreement to create the MSP Program became public in December 2009 when Majority Leader Reid announced that a health reform working group of ten senators had arrived at a “tentative consensus ‘that includes a public option.’”⁷ The working group Majority Leader Reid referenced explored several reform options before settling on the MSP Program. One proposal under discussion by the working group was a public option; however a public option in which the government acted directly as the issuer did not have enough support to pass through Congress.⁸ As a result, Senator Chuck Schu-

¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); see also *H.R. 3590—Patient Protection and Affordable Care Act*, Congress.gov, <https://www.congress.gov/bill/111th-congress/house-bill/3590/all-actions> (last updated Mar. 23, 2010).

² U.S. Off. of Pers. Mgmt., *A New Day for Federal Service: An Overview of the Multi-State Plan Program* (2014), <https://marketplace.cms.gov/technical-assistance-resources/multistate-plan-program.pdf>; see also Robert Moffit, *Will This Little-Known Obamacare Provision Lead to a Public Option?*, Daily Signal (Jan. 15, 2015), <http://dailysignal.com/2015/01/15/will-little-known-obamacare-provision-lead-public-option>.

³ Patient Protection and Affordable Care Act § 1334.

⁴ Moffit, *supra* note 2.

⁵ See Robert Moffit, Dan Blair & Linda Springer, *The Office of Personnel Management: A Power Player in America's Health Insurance Markets?*, Heritage Found. (Feb. 19, 2010), <https://www.heritage.org/health-care-reform/report/the-office-personnel-management-power-player-americas-health-insurance>.

⁶ Sarah Kliff, *No, The Public Option is Not Back From the Dead*, Wash. Post: Wonkblog (Oct. 30, 2012), https://www.washingtonpost.com/news/wonk/wp/2012/10/30/no-the-public-option-has-not-returned-from-the-dead/?utm_term=.f7fddd750b03.

⁷ Timothy Noah, *Medicare Buy-in, RIP*, Slate: Public Option Wiki (Dec. 14, 2009), http://www.slate.com/articles/news_and_politics/prescriptions/2009/12/public_option_wiki.html.

⁸ Kliff, *supra* note 6.

mer (D-N.Y.) worked with nine of his colleagues to come up with a backup plan to the public option.⁹ One alternative under consideration by the working group was the MSP Program through which OPM would work with private insurers to offer health insurance plans to compete with other plans available on state exchanges.¹⁰ Another alternative was allowing individuals over the age of 55 to enroll in Medicare.¹¹ It was reported that key senators withheld support for the second idea, leaving the MSP Program all that remained.¹² With a public option in which the government played the role of insurer off the table, the MSP Program was added to the ACA as the public option backup plan, described by some as a “sort of a catch-all for a lot of different ideas.”¹³

THE MSP PROGRAM IS FAILING TO INCREASE COMPETITION AND CHOICE

The MSP Program was created to increase both competition and choice in state health care exchanges.¹⁴ Section 1334 of the ACA requires the availability of two MSP plans in all 50 states by 2017.¹⁵ Additionally, the law requires OPM to contract with at least one non-profit provider, and to ensure that at least one MSP option does not provide abortion coverage.¹⁶ However, only one issuer association—the Blue Cross Blue Shield Association (BCBSA)—has ever participated in the MSP Program.¹⁷ BCBSA already had a significant market share in the states that previously participated in the MSP Program,¹⁸ and has approximately 70 percent of the market share in the one remaining state participating.¹⁹

In the 2014 plan year, OPM contracted with one group of issuers to offer more than 150 MSP options in 31 states, including the District of Columbia. The Obama Administration “told insurers to assume that each national plan would have 750,000 people enrolled in the first year.”²⁰ However, approximately 350,000 individuals enrolled in an MSP option in 2014. For plan year 2015, MSP coverage expanded to 36 states and 437,000 individuals.²¹ For plan year 2016, MSP covered approximately 375,000 individuals in 33 states, and in 2017 the MSP enrollment fell to 290,000 individuals

⁹*Id.*

¹⁰*Id.*

¹¹*Id.*

¹²*Id.*

¹³Rachana Pradhan & Paul Demko, *Another Piece of Obamacare Falls Short*, Politico (Sept. 7, 2016), <http://www.politico.com/story/2016/09/obamacare-falls-short-227854>.

¹⁴S. Rep. No. 111–89 (2009); see also Sabrina Corlette, *The Multi-State Plans Unveiled*, Geo. U. Ctr. On Health Ins. Reforms Blog (Sept. 30, 2013), <http://chirblog.org/multi-state-plans-unveiled/>.

¹⁵Patient Protection and Affordable Care Act § 1334.

¹⁶*Id.*

¹⁷Patient Protection and Affordable Care Act § 1334; see also U.S. Off. of Pers. Mgmt., *supra* note 2; U.S. Off. of Pers. Mgmt., *Multi-State Plan Program and the Health Insurance Marketplace: FAQs*, <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/consumer/?page=1#url=FAQs> (last visited Apr. 4, 2018).

¹⁸S. Rep. No. 111–89 (2009); see also Corlette, *supra* note 13.

¹⁹Christine Monahan, *Oh Where, Oh Where Are The Multi-State Plans?*, Geo. U. Ctr. On Health Ins. Reforms Blog (June 6, 2013), <http://chirblog.org/oh-where-oh-where-are-the-multi-state-plans/>; see also Sarah Goodell, *The Multi-State Plan Program (Updated)*, Health Affairs (May 29, 2014), <https://www.healthaffairs.org/doi/10.1377/hpb20140529.10243/full/>.

²⁰Robert Pear, *U.S. Plans to Unveil New Insurance Options*, N.Y. Times (Sept. 29, 2013), <https://www.nytimes.com/2013/09/30/us/politics/us-plans-to-unveil-new-insurance-options.html?mcubz=0>.

²¹Document productions from U.S. Off. of Pers. Mgmt. provided to S. Comm. on Homeland Sec. & Governmental Aff. (Oct. 6, 2017 and Feb. 13, 2018) (on file with S. Comm. on Homeland Sec. & Governmental Aff.).

in 22 states.²² By 2018, only one state—Arkansas—covering approximately 55,000 individuals was participating in the MSP Program.²³

Five years after its implementation in 2014, the MSP Program is both failing to fulfill program intent and to meet statutory requirements. In regard to the statutory requirement that all 50 states and the District of Columbia participate in the MSP Program, with only one state participating, the program has a state participation success rate of 1.9 percent.

A possible lack of issuer participation was a concern foreshadowed by the Congressional Budget Office (CBO). Shortly prior to passage of the ACA, CBO questioned the utility of the MSP Program and whether issuers would participate.²⁴ In a 2009 letter to Majority Leader Reid, CBO wrote:

[w]hether insurers would be interested in offering [MSP] plans is unclear, and establishing a nationwide plan comprising only nonprofit insurers might be particularly difficult. Even if such plans were arranged, the insurers offering them would probably have participated in the insurance exchanges anyway, so the inclusion of this provision did not have a significant effect on the estimates of federal costs or enrollment in the exchanges.²⁵

At the time, CBO also estimated that the creation of the MSP Program was “unlikely to have much effect on average insurance premiums because the existence of that public plan would not substantially change the average premiums that would be paid in the exchanges.”²⁶

In evaluating the merits of this legislation, CBO found that eliminating MSPs would not affect Federal subsidies for health insurance purchased through the marketplaces.²⁷ CBO also found that MSPs are not the lowest-cost or second-lowest cost silver plans in any rating areas where they are offered.²⁸ Because of this, CBO confirmed:

[d]ata from HHS on enrollment in and premiums for MSPs over a longer-period of time show that those plans serve a small and declining percentage of people who purchase coverage through the marketplaces. CBO and the staff of the Joint Committee on Taxation do not expect that eliminating such plans would affect the level of competition in or average premiums for marketplace coverage in future years.²⁹

²² *Id.*

²³ Majority Cmte. staff call with Arkansas State Insurance Department (Feb. 2, 2018).

²⁴ Letter from Douglas W. Elmendorf, Dir., Cong. Budget Off., to Harry Reid, Majority Leader, U.S. Senate (Dec. 19, 2009), http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/108xx/doc10868/12-19-reid_letter_managers_correction_noted.pdf.

²⁵ *Id.*

²⁶ *Id.*

²⁷ Cong. Budget Off., Congressional Budget Office Cost Estimate: S. 2221 Repeal Insurance Plans of the Multi-State Program Act of 2017 (2018), <https://www.cbo.gov/publication/53621>.

²⁸ *Id.*

²⁹ *Id.*

THE MSP PROGRAM DIVERTS OPM FROM MISSION-CRITICAL PROGRAMS THAT SERVE THE FEDERAL WORKFORCE AND ITS RETIREES

OPM supports passage of S. 2221, noting that “[r]epealing this statutory requirement would allow OPM to further strengthen its capacity to meet the important needs of our benefit programs serving the 2.7 million employees of the Federal workforce and over 2 million Federal workforce retirees.”³⁰

Since 1978, OPM’s core mission has been to serve the Federal workforce and its retirees.³¹ The creation of the MSP Program diverted OPM’s focus from this mission by requiring OPM to begin providing non-Federal services for the American public.³² From fiscal year (FY) 2011 to FY 2017, OPM spent \$54 million in “salaries and expenses” to administer the MSP Program.³³ This funding supported 42 full-time equivalents in FY 2017 alone.³⁴

These additional resources were requested for the MSP Program in the annual Congressional Budget Justification instead of being requested for mission-critical programs that serve the Federal workforce and its retirees. Diverting OPM resources away from its core mission is significant given that the agency is currently struggling to provide acceptable levels of service to Federal employees.³⁵ For instance, in FY 2017, OPM requested \$3.35 million less money to support processing of its backlog of Federal retirement claims.³⁶ At the same time, OPM expended \$10.3 million for MSP Program salaries and expenses alone.³⁷

S. 2221 will allow OPM to focus exclusively on mission-critical programs that benefit current members of the Federal workforce, tribes and tribal organizations and retirees.

Lastly, the volume of staff devoted to the program is disproportionate to the volume of people served. In 2018, 42 employees will serve no more than 55,000 participants in Arkansas.³⁸ The Federal Employee Health Benefits Program (FEHBP), by comparison, has 117 full-time employees but serves 8.2 million people.³⁹ Therefore, throughout most of the program’s existence, OPM has dedicated only 3.3 employees per 100,000 FEHBP enrollees while dedicating 14 employees per 100,000 MSP enrollees.

³⁰ E-mail from U.S. Off. of Pers. Mgmt. Staff to S. Comm. on Homeland Sec. & Governmental Aff. Majority Staff (on file with S. Comm. on Homeland Sec. & Governmental Aff.).

³¹ *Our Mission, Role & History*, U.S. Off. of Pers. Mgmt., <https://www.opm.gov/about-us/our-mission-role-history/> (last visited Apr. 4, 2018).

³² U.S. Off. of Pers. Mgmt., Congressional Budget Justification: Fiscal Year 2018 2 (2017), <https://www.opm.gov/about-us/budget-performance/budgets/congressional-budget-justification-fy2018.pdf>.

³³ Document production from U.S. Off. of Pers. Mgmt. provided to S. Comm. on Homeland Sec. & Governmental Aff. (Oct. 6, 2017) (on file with S. Comm. on Homeland Sec. & Governmental Aff.).

³⁴ *Id.*

³⁵ For example, as of Dec. 31, 2017, OPM had an inventory of 14,515 unprocessed retirement claims. See Michael O’Connell, *OPM Cuts Retirement Backlog to its Lowest Level in More Than a Year*, Fed. News Radio (Jan. 5, 2018), <https://federalnewsradio.com/retirement/2018/01/opm-cuts-retirement-backlog-to-its-lowest-level-in-more-than-a-year/>; see also U.S. Off. of Pers. Mgmt. Statistical Abstracts: Fiscal Year 2016 (2017).

³⁶ U.S. Off. of Pers. Mgmt., Congressional Budget Justification: Fiscal Year 2018 2 (2017), <https://www.opm.gov/about-us/budget-performance/budgets/congressional-budget-justification-fy2018.pdf>.

³⁷ Document production from U.S. Off. of Pers. Mgmt. provided to S. Comm. on Homeland Sec. & Governmental Aff. (Oct. 6, 2017) (on file with S. Comm. on Homeland Sec. & Governmental Aff.).

³⁸ Majority Cmte. staff call with Arkansas State Insurance Department (Feb. 2, 2018).

³⁹ See Kirstin B. Blom & Ada S. Cornell, Cong. Res. Serv., R43922, Federal Employees Health Benefits (FEHB) Program: An Overview (2016), <https://fas.org/sgp/crs/misc/R43922.pdf>.

In 2018, OPM has been working to right-size its workforce. However, prior to the reorganization, OPM requested in its FY 2018 congressional budget justification to support 72 full time employees—which would have been an increase over the 42 full time employees that served the program in FY 2014.⁴⁰ Following the reorganization that began on April 1, 2018, OPM is currently working to reduce the volume of Federal employees working on the MSP Program by redirecting staff from the MSP Program to mission-critical programs such as TRICARE and FEDVIP.

In addition to the MSP Program detracting from OPM’s mission-critical programs, the program continues to be a concern for the OPM Office of Inspector General (OIG). In December 2016, the OIG issued a Management Alert for the program due to a lack of participation on the part of states and providers, and confusion about the name incorrectly signaling coverage would cross state boundaries when MSP coverage does not.⁴¹ In FYs 2016 and 2017, the OIG also included the program in its list of top management challenges facing the agency.⁴² S. 2221 will allow OPM to focus exclusively on mission-critical programs.

III. LEGISLATIVE HISTORY

S. 2221, the RIP MSP Act, was introduced on December 12, 2017, by Chairman Ron Johnson (R-WI). The bill was referred to the Committee on Homeland Security and Governmental Affairs. On April 25, 2018, Senator Lamar Alexander was added as a cosponsor. On May 24, 2018, Senator James Risch joined as a cosponsor. On June 12, 2018, Senators Rand Paul, John McCain, and Steve Daines were added as cosponsors.

On June 8, 2018, the National Active and Retired Federal Employees Association (NARFE) expressed NARFE’s support for S. 2221 “in order to redirect staff and budgetary resources from the Multi-State Plan (MSP) Program to the Office of Personnel Management’s (OPM) core missions.”

The Committee considered S. 2221 at a February 14, 2018 business meeting. A substitute amendment offered by Chairman Johnson extended from October 1, 2018 to January 1, 2019 the date by which the MSP Program would end to align with the 2019 plan year. The substitute amendment also removed a rescission of unused funds, and a related Sense of Congress, to ensure Federal funds remain in OPM’s control for authorized functions. The substitute amendment was adopted by unanimous consent.

The Committee ordered S. 2221, as amended, reported favorably, by a roll call vote of 10 “yeas” to 3 “nays.” Senators voting in the affirmative were Senators Johnson, Portman, Paul, Lankford, Enzi, Hoeven, Daines, McCaskill, Heitkamp, and Jones. Senators voting

⁴⁰ U.S. Off. of Pers. Mgmt. briefing, majority staff (Nov. 20, 2017). *See also* Document production from U.S. Off. of Pers. Mgmt. provided to S. Comm. on Homeland Sec. & Governmental Aff. (Oct. 6, 2017) (on file with S. Comm. on Homeland Sec. & Governmental Aff.).

⁴¹ Memorandum from Norbert E. Vint, Deputy Inspector Gen., U.S. Off. of Pers. Mgmt., Off. of Inspector Gen., to Beth F. Cobert, Acting Dir., U.S. Off. of Pers. Mgmt. (Dec. 8, 2016), <https://www.opm.gov/our-inspector-general/reports/2016/management-alert-status-of-the-multi-state-plan-program-4a-hi-00-17-013.pdf>.

⁴² U.S. Off. of Pers. Mgmt. Off. of Inspector Gen., Top Management Challenges: Fiscal Year 2017 (2017), <https://www.opm.gov/our-inspector-general/special-reports-and-reviews/fy2017-top-management-challenges.pdf>; *see also* Memorandum from Norbert E. Vint, Deputy Inspector Gen., U.S. Off. of Pers. Mgmt., Off. of Inspector Gen. to Beth F. Cobert, Acting Dir., U.S. Off. of Pers. Mgmt. (Oct. 12, 2016), <https://www.opm.gov/our-inspector-general/special-reports-and-reviews/fy2016-management-challenges.pdf>.

in the negative were Senators Peters, Hassan, and Harris. For the record only, Senator McCain voted “yea” by proxy and Senator Carper voted “nay” by proxy.

IV. SECTION-BY-SECTION ANALYSIS OF THE BILL, AS REPORTED

Section 1. Short title

This section establishes the short title of the bill as the “Repeal Insurance Plans of the Multi-State Program Act” or the “RIP MSP Act.”

Section 2. Repeal of Multi-State Plan Program

This section repeals section 1134, the Multi-State Plan Program of the Patient Protection and Affordable Care Act (Public Law 111–148), effective January 1, 2019. It requires the OPM Director to brief the Committee on Homeland Security and Governmental Affairs in the Senate and the Committee on Oversight and Government Reform in the House of Representatives not later than 60 days after the legislation is enacted. The briefing must include information concerning how OPM and MSP issuers are notifying current enrollees that there will no longer be MSP options available; a description of how the OPM Director will work with the Secretary of Health and Human Services to ensure no MSP plans are made available; and a timeline detailing how OPM will close the information technology portal that MSP issuers utilize.

V. EVALUATION OF REGULATORY IMPACT

Pursuant to the requirements of paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee has considered the regulatory impact of this bill and determined that the bill will have no regulatory impact within the meaning of the rules. The Committee agrees with the Congressional Budget Office’s statement that the bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would impose no costs on state, local, or tribal governments.

VI. CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, February 27, 2018.

Hon. RON JOHNSON, *Chairman,*
Committee on Homeland Security and Governmental Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 2221, the Repeal Insurance Plans of the Multi-State Program Act of 2017.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Alice Burns.

Sincerely,

KEITH HALL,
Director.

Enclosure.

S. 2221—Repeal Insurance Plans of the Multi-State Program Act of 2017

S. 2221 would repeal Section 1334 of the Affordable Care Act (ACA), eliminating multi-state plans (MSPs) offered through marketplaces established by the ACA. Under current law, the Office of Personnel Management (OPM) contracts with private insurers to offer MSPs; those plans may operate in one or more states. The repeal would be effective January 1, 2019. Within 60 days of enactment, the bill also would require OPM to brief the Senate Committee on Homeland Security and Governmental Affairs and the House Committee on Oversight and Government Reform on OPM's efforts to wind-down the program.

OPM reports that in 2018 Arkansas Blue Cross and Blue Shield is the only insurer to offer MSPs and such plans are only available in Arkansas. Premium data from the Department of Health and Human Services (HHS) show that MSPs are not the lowest-cost or second-lowest cost silver plans in any rating areas where they are offered.¹ Because premiums for silver plans with the second-lowest-cost are the basis for calculating federal subsidies for health insurance purchased through the marketplaces, eliminating plans with premiums higher than those second-lowest cost plans would not affect subsidies.

Data from HHS on enrollment in and premiums for MSPs over a longer-period of time show that those plans serve a small and declining percentage of people who purchase coverage through the marketplaces. CBO and the staff of the Joint Committee on Taxation do not expect that eliminating such plans would affect the level of competition in or average premiums for marketplace coverage in future years. Thus, implementing S. 2221 would not have a significant effect on the federal budget.

The bill would not affect direct spending or revenues; therefore, pay-as-you-go procedures do not apply.

CBO estimates that enacting S. 2221 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

S. 2221 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

The CBO staff contact for this estimate is Alice Burns. The estimate was approved by Leo Lex, Deputy Assistant Director for Budget Analysis.

¹ Silver plans cover about 70 percent of the costs of covered benefits for people at most income levels.

VII. ADDITIONAL VIEWS

ADDITIONAL VIEWS OF SENATORS CLAIRE McCASKILL, HEIDI HEITKAMP, AND DOUG JONES

While the undersigned supported passage of S. 2221, the Repeal Insurance Plans of the Multi-State Program Act, during Committee consideration, our support was based on a recognition that the Office of Personnel Management (OPM) does not have the authorities needed to bring competition and choice into the health insurance marketplace, as is required by statute, and the Administration requests that the agency no longer be required to administer the program. We do not support the justification by the Majority that a lack of hearings, poor vetting of the policy proposal, and a misalignment of mission led to the failure of the Multi-State Plan program (MSPP). Further, we disagree that there was a diversion of resources from other insurance programs that lead to any unfulfilled mission-requirements based on administration of the MSPP. Lastly, the Senate Finance Committee and Senate Health, Education, Labor, and Pensions Committee have the legislative jurisdiction to stabilize the health insurance marketplace and fix the Affordable Care Act. They are better suited than the Senate Homeland Security and Governmental Affairs Committee to address the challenges of consumer choice, plan competition, high premium costs, and general market stabilization.

As the Congressional Budget Office (CBO) report for S. 2221 states, neither CBO nor the Joint Committee on Taxation “expect that eliminating such plans would affect the level of competition in or average premiums for marketplace coverage in future years.”¹

BACKGROUND

Section 1334 of the Affordable Care Act (ACA) created the MSPP.² This provision of the law required the Director of the Office of Personnel Management (OPM) to contract with health insurers to “foster competition among plans competing in the individual and small group health insurance markets.”³ S. 2221 would stop Section 1334 from having any force or effect of law effective October 1, 2018, but the bill would not repeal Section 1334, as is stated in its title.⁴

The process by which this provision was included in the bill is typical of the Senate floor amendment process. The provision was

¹ Congressional Budget Office, *S. 2221, Repeal Insurance Plans of the Multi-State Program Act of 2017 Cost Estimate* (Feb. 2018) (www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/s2221.pdf).

² Pub. L. No. 111–148 (2010).

³ Office of Personnel Management, Patient Protection and Affordable Care Act, *Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges*, 77 Fed. Reg. 72581 (Dec. 5, 2012) (proposed rule).

⁴ S. 2221, 115th Cong. (2017).

included as part of a Manager's Amendment filed by Senator Harry Reid on December 19, 2009, during floor consideration and debate of the ACA.⁵ The provision directing OPM to create the MSPP was devised by a bipartisan group of 10 Senators, and originally proposed by Senator Olympia Snowe (R-ME) as an alternative to the public option.⁶ The provision then became thought of as another way to interject competition and choice into the health insurance exchanges "modeled after the federal employee benefits program."⁷ Senators believed OPM could leverage its contract negotiations experience from running the Federal Employee Health Benefits Program (FEHBP) for 50 years to help drive competition and choice in marketplace Exchanges.⁸ In addition, the provision was thought to offer plans that would cross State lines and avoid individual State regulations, similar to the FEHBP National Plan options, which would help keep premiums low and increase plan choices.⁹

To imply that the failure of MSPP was related to the process by which it was included in the final bill is misleading and disingenuous. By that logic, any changes made to a bill after the Committee process, any amendment offered on the Floor of the Senate, or any bill passed without a hearing would raise similar concerns and should be repealed for lack of thorough vetting.

The FEHBP is a market-based employer-sponsored health insurance program that establishes its own rules and regulations for insurance issuers to participate in the program, and is not subject to State licensing and insurance requirements. OPM uses its preemption authority of State requirements to "deliver quality health care services to FEHBP Program members while controlling the costs of premium increases."¹⁰

In the debate around implementation of the MSPP, the paramount concern for consumer advocates and State health insurance commissioners was whether the authority in Section 1334 meant OPM could preempt State requirements and deem plans eligible to participate on the exchanges.¹¹ In response to these concerns and comments received during the regulatory process, the final rule published by OPM required issuers who chose to participate in the MSPP to comply with State law.¹²

When the health insurance marketplace exchanges were stood-up in 2013 for the 2014 plan year, OPM had contracted with one group of issuers, Blue Cross and Blue Shield, to offer more than

⁵ S. Amdt. 3276 to H.R. 3590 (December 19, 2009).

⁶ *Senators seek to put OPM in charge of health care public option*, Government Executive (Dec. 5, 2009) (www.govexec.com/federal-news/2009/12/senators-seek-to-put-opm-in-charge-of-health-care-public-option/30472/); *See also, OPM could get role running national health plan*, Government Executive (Dec. 6, 2009) (www.govexec.com/pay-benefits/2009/12/opm-could-get-role-running-national-health-plan/30473/).

⁷ *OPM could get role running national health plan*, Government Executive (Dec. 6, 2009) (www.govexec.com/pay-benefits/2009/12/opm-could-get-role-running-national-health-plan/30473/).

⁸ Sabrina Corlette, *Action on Multi-State Plans, But Still No Specifics*, CHIR (blog) (July 27, 2012) (www.chirblog.org/actiononmultistateplans/).

⁹ Sarah Goodell, *The Multi-State Plan Program (Updated) Health Policy Brief*, Health Affairs (May 29, 2014).

¹⁰ Office of Personnel Management, *Congressional Budget Justification Fiscal Year 2019* (Feb. 2018).

¹¹ Sabrina Corlette, *Action on Multi-State Plans, But Still No Specifics*, CHIR (blog) (July 27, 2012) (www.chirblog.org/actiononmultistateplans/); Letter from Consumer Representatives to Office of Personnel Management (Aug. 21, 2015); Comments from National Association of Insurance Commissioners to Office of Personnel Management's request for information regarding Multi-State Plan Nationwide Insurance Plans (Aug. 10, 2011).

¹² 45 CFR § 800.101.

150 plan options in 31 States and the District of Columbia. Approximately 350,000 individuals enrolled in a multi-State plan in 2014. Multi-State plan coverage expanded in 2015 to include 437,000 individuals in 36 States and the District of Columbia. In plan year 2016, the ability of OPM to attract more issuers and expand options to more States became a significant challenge, and only 375,000 individuals in 33 States and the District of Columbia enrolled in plans. This problem was exacerbated in 2017 where enrollment fell to 290,000 individuals in 22 States, and in plan year 2018, only 55,000 individuals in one State—Arkansas—are covered by the multi-State plans.¹³

OPM planned to expand insurance options in the MSPP to 44 States in 2016,¹⁴ and targeted a goal of more than 505,000 individuals to be covered by the multi-State plan options in 2017.¹⁵ However, these goals were never met as OPM struggled to attract new issuers, offer more plan options, and cover more individuals. As the OPM Office of the Inspector General (OIG) noted in a December 2016 Management Alert,

“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 . . . OPM’s National Healthcare Operations is doing the best that it can to retain and attract MSP issuers and state-level issuers 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.”¹⁶

OPM agreed with the OIG Management Alert and noted that it continues to struggle to attract insurers to participate in the MSPP. OPM stated in its fiscal year 2018 Congressional Budget Justification that,

“[T]he statute does not authorize the preemption of state law requirements governing health insurance. This lack of preemption capability is a significant difference between the [MSP] and the FEHBP. These statutory changes have been amplified by the volatility of the individual and small group health insurance markets, which has caused a number of issuers to cease offering products on the Health Insurance Exchanges.”

¹³ Office of Personnel Management, Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges, 80 Fed. Reg. 9649 (Mar. 26, 2015) (final rule).

¹⁴ Office of Personnel Management, *Congressional Budget Justification Fiscal Year 2016* (Feb. 2015).

¹⁵ Office of Personnel Management, *Congressional Budget Justification Fiscal Year 2017* (Feb. 2016).

¹⁶ Memorandum from Norbert Vint, Deputy Inspector General, to Beth Cobert, Acting Director, Management Alert—Status of the Multi-State Plan Program (Dec. 8, 2016).

RESOURCES

One concern raised during the consideration of the MSPP was the impact of the new requirement on the existing insurance benefit programs at the Office of Personnel Management. In particular, concerns were raised about the resource allocation and interplay between the new MSPP and the existing FEHBP. Section 1334 addressed this issue directly in subsection (g), which—

- prohibited OPM from allocating fewer financial or personnel resources to the administration of the FEHBP;
- required the MSPP to have a separate risk pool from the FEHBP;
- authorized creation of a separate program office for the MSPP;
- required the Director to separate resources in the program administration between the MSPP and FEHBP; and
- prohibited any requirement for FEHBP plans to participate in the MSPP.¹⁷

OPM stood up the MSPP using funds appropriated to the Department of Health and Human Services (HHS) for Affordable Care Act implementation.¹⁸ OPM used the \$5 million transferred from HHS between fiscal years 2011 and 2013 to carry-out the requirements of the ACA and establish the MSPP.¹⁹ Since the Program went into effect, OPM has allocated resources through its discretionary salaries and expenses appropriations, while the remainder of OPM's insurance program funding comes through appropriations limitations of Trust Fund transfers for administrative expenses.²⁰ It is misleading to suggest diversion of resources from other insurance programs lead to any unfulfilled mission-requirements.

In fiscal year 2018, OPM spent \$10.3 million to administer the MSPP.²¹ In the absence of the requirement for OPM to implement the MSPP, these discretionary funds could be used for other purposes such as information technology modernization or administration of other insurance programs. However, given that the funds are discretionary, elimination of the program could also mean that the salaries and expenses discretionary funding is reduced by a corresponding figure in future year appropriations. There is no guarantee that the repeal of the requirement for OPM to administer the MSPP will divert financial resources to other programs, and may

¹⁷ Pub. L. No. 111–148 (2010).

¹⁸ Document production from U.S. Off. of Pers. Mgmt. provided to S. Comm. on Homeland Sec. & Governmental Aff. (Oct. 6, 2017) (on file with S. Comm. on Homeland Sec. & Governmental Aff.).

¹⁹ Document production from U.S. Off. of Pers. Mgmt. provided to S. Comm. on Homeland Sec. & Governmental Aff. (Oct. 6, 2017) (on file with S. Comm. on Homeland Sec. & Governmental Aff.).

²⁰ Office of Personnel Management, *Congressional Budget Justification Fiscal Year 2013* (Feb. 2012); Office of Personnel Management, *Congressional Budget Justification Fiscal Year 2014* (Feb. 2013); Office of Personnel Management, *Congressional Budget Justification Fiscal Year 2015* (Feb. 2014); Office of Personnel Management, *Congressional Budget Justification Fiscal Year 2016* (Feb. 2015); Office of Personnel Management, *Congressional Budget Justification Fiscal Year 2017* (Feb. 2016); Office of Personnel Management, *Congressional Budget Justification Fiscal Year 2018* (Mar. 2017); and Office of Personnel Management, *Congressional Budget Justification Fiscal Year 2019* (Feb. 2018).

²¹ Document production from U.S. Off. of Pers. Mgmt. provided to S. Comm. on Homeland Sec. & Governmental Aff. (Oct. 6, 2017) (on file with S. Comm. on Homeland Sec. & Governmental Aff.).

require OPM to attrite personnel resources in the absence of funding for those personnel.

CONCLUSION

The goal of the MSPP was to inject competition and choice into the health insurance marketplace and as the CBO noted in 2009, this provision did not have a significant effect on budget estimates because OPM was not granted the kind of authority it needed to do so.²² OPM and the OPM Inspector General noted in various budget and management documents that the destabilization of the health insurance marketplace further led to the lack of efficacy in the MSPP.²³

In the absence of Congress and the Administration strengthening the Affordable Care Act, it is the view of the Minority that OPM should not be statutorily obligated to run this program. Furthermore, given ongoing efforts to destabilize the health insurance markets, it is the jurisdictions of the Senate Finance Committee and the Senate Health, Education, Labor, and Pensions Committee to address issues of healthcare market competition, choice, and stabilization not the Senate Homeland Security and Governmental Affairs Committee.

²² Letter from Douglas W. Elmendorf, Dir., Cong. Budget Off., to Harry Reid, Majority Leader, U.S. Senate (Dec. 19, 2009), [http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/108xx/doc10868/12-19-reid letter managers correction noted.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/108xx/doc10868/12-19-reid%20letter%20managers%20correction%20noted.pdf).

²³ Office of Personnel Management, Agency Financial Report Fiscal Year 2017 (Nov. 2017); Memorandum from Norbert Vint, Office of Personnel Management Deputy Inspector General, to Beth Cobert, Acting Director, Management Alert—Status of the Multi-State Plan Program (Dec. 8, 2016).

VIII. CHANGES IN EXISTING LAW MADE BY THE BILLS, AS REPORTED

Because S. 2221 would not repeal or amend any provision of current law, it would make no changes in existing law within the meaning of clauses (a) and (b) of paragraph 12 of rule XXVI of the Standing Rules of the Senate.

