WebMemo
Published by The Heritage Foundation
No. 3101
January 18, 2011

Obamacare and the Hidden Public Option: Crowding Out Private Coverage

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Under the Patient Protection and Affordable Care Act (PPACA),[1] the federal government, through the Office of Personnel Management (OPM), is legally required to sponsor at least two national health insurance plans beginning in 2014.[2] These OPM-sponsored plans would automatically be eligible to compete against private health insurance offered in the new health insurance exchanges to be established in every state.[3]

Summary. Under Section 1334(a), the director of OPM, the agency that runs the federal civil service, is to contract with selected health insurers to offer "multi-State qualified health plans through each Exchange in each State."[4]

The OPM-sponsored plans must meet the minimum benefits package, the rating and coverage rules as specified elsewhere in Title I, and state licensure and other state health insurance requirements that are "not inconsistent" with PPACA. Otherwise, in contracting with these selected insurers, the director of OPM, with a few qualifications, is to replicate the contractual authority over the multi-state plans that he currently exercises in administering the Federal Employees Health Benefits Program (FEHBP) under chapter 89 of Title V of the U.S. Code. Under Section 1334(a)(4) of the new law, it is clear that the director "shall implement this subsection in a manner similar to the manner in which the Director implements the contracting provisions" with carriers in the FEHBP.[5]

Under Section 1334(a)(4), OPM is required to negotiate certain items with these selected plans: specifically, their medical loss ratio,[6] their profit margins, and the premiums they will offer in the health insurance exchanges in the states. In the conduct of these negotiations, the director of OPM is also authorized to consider "such other terms and conditions of coverage as are in the interests of the enrollees in such plans."[7]

For purposes of competition in the exchanges, Section 1334(d) provides that the government multi-state plans are "deemed" certified for participation in the health insurance exchanges. The OPM-sponsored health plans would thus *not* be subject to the same certification or qualification processes that are outlined for private health plans for competition in the health insurance exchanges established under Section 1311. OPM-sponsored plans are thus "qualified" plans, pre-ordained in statute and defined solely by OPM.

Under Section 1334(e), there is another crucial exception to the rules that apply to private health insurance plans: Notwithstanding requirements to meet state licensure and other obligations—such as financial or solvency requirements for health insurance—the director of OPM can enter into a contract with a multi-state plan if the insurer offers the plan in at least 60 percent of all the states in the first year, 70 percent in the second, and 85 percent in the third.

This paper, in its entirety, can be found at:
http://report.heritage.org/wm3101

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

This would obviously favor certain large insurance companies, assuming they enter into contract to deliver the OPM product, though it would not necessarily contribute to the Obama Administration's stated policy goal of securing lower costs.[8] Apparently, OPM-sponsored health plans, depending on their capacity to expand geographically, would be able to bypass state financial and solvency requirements.

Impact. The director of OPM has broad authority to contract with health plans competing for the business of federal employees and retirees in the FEHBP. Under PPACA, OPM's role is expanded to sponsor a new set of health plans that compete against all other private health plans. This is a very different role for OPM, the federal government's personnel agency. Section 1334 has certain undesirable consequences.

It Creates an Uneven Playing Field. Former OPM Director Kay Cole James notes that "OPM would not merely serve as the umpire overseeing competition among private health plans. It would also become a health-plan sponsor, fielding its own team of players to compete against the existing private plans in every state."[9]

OPM-sponsored plans would thus have an exclusive franchise: They would be perfectly poised to compete nationwide; they would be subject to OPM-negotiated determinations for medical loss ratios, profit margins, and premiums; they would have their own standards for state certification and solvency requirements. This clearly gives the OPM-sponsored plans special advantages.

It Creates the Foundation for a "Robust Public Option." In their authoritative taxonomy of PPACA, Kaiser Family Foundation analysts categorize the OPM-sponsored health plans as "the Public Option."[10] Original proponents of a "robust public option"—a government plan that would base provider payments on Medicare rates—viewed it as an ideal vehicle to undercut private health plans and

1. Congress cannot build sound market-based health care reform on the foundation of a flawed health care law. Therefore, the health care law must be repealed in its entirety.

   The House of Representatives has taken a major step towards full repeal of the Patient Protection and Affordable Care Act (PPACA—otherwise known as "Obamacare"). Until full repeal occurs, Congress must continue to focus on the core failures and consequences of PPACA and block its implementation to allow time to achieve repeal and lay the groundwork for a new market-based direction for health care reform.
2. Patient Protection and Affordable Care Act of 2010, Public Law 111–148, and Health Care and Education Reconciliation Act of 2010, Public Law 111–152.
3. Under the law, at least one plan must be nonprofit and at least one plan is not to cover abortion.
4. All of the provisions governing the OPM-sponsored plans are embodied in Section 1334.
5. Under current law, the director of OPM is authorized to negotiate rates and benefits for health plans, and in the conduct of those negotiations, there are very few limitations on the director's authority. In disputes with federal employee organizations and unions, federal courts have routinely upheld the director's discretion in these areas.
6. The medical loss ratio is the amount of revenues that must be allocated for payment for health benefits versus the amount retained for administrative and other costs.
7. Commenting on this provision, former OPM Director Donald J. Devine remarked, "That's open-ended. You can do anything." The Honorable Linda Springer *et al.*, "The Office of Personnel Management: A Power Player in America's Health Insurance Markets?" Heritage Foundation *Lecture* No. 1145, February 19, 2010, at *http://www.heritage.org/Research/Lecture/The-Office-of-Personnel-Management-A-Power-Player-in-Americas-Health-Insurance-Markets*.
8. According to the Congressional Budget Office, "Whether insurers would be interested in offering such 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." Douglas W. Elmendorf, Director, Congressional Budget Office, letter to Harry Reid, Majority Leader, U.S. Senate, December 19, 2009, p. 9.
9. Kay Cole James, "OPM Should Be Running the Civil Service, Not Undercutting Private Health Insurance," National Review Online, December 23, 2009, at *http://www.nationalreview.com/critical-condition/47705/opm-should-be-running-civil-service-not-undercutting-private-health-insuran* (January 13, 2011).
10. Henry J. Kaiser Family Foundation, "Summary of New Health Reform Law," *Focus on Health Reform*, June 18, 2010, p. 4.

ensure a rapid evolution toward a single-payer system. With the creation of this "OPM alternative," advocates of a "robust public option" have a second chance to crowd out private health insurance and secure their original policy goals.[11]

It Concentrates Power in the Executive Branch. Like the Secretary of HHS, the director of OPM reports directly to the President. As with the FEHBP today, the director carries out the President's health policy agenda.[12] Any actual or potential conflict between the director of OPM and the Secretary of HHS on issues relating to health benefits, premiums, or competition in the exchanges will be resolved by the White House. The President, in other words, will exercise enormous authority over the direction of health policy and the shape of state health insurance markets.

It Threatens Taxpayers with Unknown Liabilities. Section 1334 appropriates "such sums as may be necessary to carry out this section" for OPM. While such language is routinely understood to cover administrative costs incurred in establishing a government program, there is no spending prohibition if OPM runs a deficit. OPM may agree to premiums that allegedly cover the plans' projected costs, but they could still face shortfalls. A common characteristic of taxpayer-financed health programs is that they do not go out of business. With a set of large government-sponsored plans enrolling millions of Americans nationwide, taxpayers could very well find themselves subsidizing shortfalls of the OPM-sponsored plans—plans literally "too big to fail."

It Threatens the OPM's Traditional Role. Section 1334(g) specifies continued support for the administration of the FEHBP. Former OPM Director Linda Springer observes that "administering new plans in a health insurance exchange would require that [OPM personnel] devote at least some measure of their time to that new task. Whatever time they spend on the exchange program, they are not spending on the Federal Employees Health Benefits plan and their existing work today."[13]

A New Direction. Under Section 1334, OPM-sponsored plans would compete nationwide against private health insurance. In effect, Congress is creating a special set of plans, governed by special rules, in a closed national "market." Instead of fair competition with private health plans, Congress is sponsoring the equivalent of a national monopoly. That the OPM-sponsored plans are offered by private contractors (like Medicare contractors) is irrelevant. For consumers, it is hard to imagine anything worse than a government-sponsored "private" monopoly.

Instead of giving government-sponsored health plans such an exclusive franchise, Congress, using its authority under the Commerce Clause of the Constitution, should allow a variety of health plans, including individual membership association plans, to market their products and services anywhere in the United States, subject to basic federal rules governing the interstate sale of goods and services.[14] The competing plans should be subject to the anti-fraud and abuse and consumer protection rules of the states in which their policyholders reside.

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11. On the potential of OPM creating a powerful public option, see Stuart M. Butler, "Why the Health Reform Wars Have Only Just Begun," Heritage Foundation *Lecture* No. 1158, July 6, 2010, at *http://www.heritage.org/research/lecture/why-the-health-reform-wars-have-only-just-begun*.
12. Examples are numerous. During the Reagan Administration in the 1980s, the OPM director reduced health benefits to control rising costs while emphasizing co-payments and cost-sharing as routine FEHBP plan features. During the Clinton Administration in the 1990s, the FEHBP experienced a sharp increase in mandated health benefits. And during the second Bush Administration, the FEHBP became a marketplace for high-deductible health plans and health savings accounts.
13. Springer *et al.*, "The Office of Personnel Management."
14. Under the McCarran–Ferguson Act, regulation of the business of health insurance is subject to the laws of the states unless Congress provides otherwise. In the 111th Congress, Senator Jim DeMint (R–SC) and former Representative John Shadegg (R–AZ) sponsored the Health Choice Act, which would have allowed for such interstate competition. Shadegg also sponsored legislation that would have given individuals tax relief to buy health insurance, including health plans sponsored by individual membership associations.