

Background

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The Public Health Plan Reincarnated: New—and Troubling—Powers for OPM

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Abstract: *The U.S. Senate’s much-discussed Christmas Eve vote on health care reform has not received the attention it deserves on certain crucial details concerning the replacement of the so-called public option with a new federal contracting authority. In fact, the Yuletide bill is nothing more than a reincarnation of the same old government-run health care that has become increasingly unpopular with the American public. There is one new aspect: This newest version provides the U.S. Office of Personnel Management with new and expanded powers. This Heritage Foundation analysis explains why that is dangerous.*

Despite media reports to the contrary, the “public plan” for government-run health care is alive and well and traveling through the legislative process under a false identity in the giant Senate health bill, the Patient Protection and Affordable Care Act (H.R. 3590). During the final stages of the Senate floor debate on this bill, Senate Majority Leader Harry Reid (D–NV) amended it with a 383-page “Manager’s Amendment” that removed the earlier provisions for a “public plan” and substituted new provisions that would expand the authority of the U.S. Office of Personnel Management (OPM), the agency that runs the federal civil service, to sponsor health plans. The Senate bill, with the Manager’s Amendment, passed the Senate on December 24, 2009. In effect, this Senate action is not the death of the public plan, but a reincarnation of it.

This reincarnation would give the Office of Personnel Management a new role: fielding a special team of

Talking Points

- The sponsors of the Christmas Eve Senate health bill have replaced a public plan administered by the Secretary of HHS with a set of health plans sponsored by the U.S. Office of Personnel Management. Like the public option, these plans would compete directly against private health plans.
- The OPM contracting authority is broad, and OPM appears to have independent regulatory authority over premium-setting, the establishment of medical loss ratios, and profit margins, which could enable OPM to tilt the “playing field” against private health plans.
- The Senate bill gives new authorities to OPM to become a major player in the health insurance markets—but is silent on the crucial issue of taxpayer liability.
- Given the new statutory and regulatory powers of OPM, it appears that the Senate bill creates another public plan; and that the federally sponsored health plans are “private” in name only.

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selected health insurance plans that would “compete” against private health plans in the government health insurance exchanges, potentially in every state in the country. Under Section 1334 of the amended Senate bill, OPM would be authorized to contract with at least two such “multi-state” health plans, and at least one of them must be “non-profit,” which means that the plan would meet the legal requirements for tax exemption.

Exclusive Franchise. The main reason these government-sponsored health plans would exist would be to compete directly against private health plans on a national basis. They would be the only health plans in America that would be permitted, under the Senate bill, to compete on a national or “multi-state” basis—they would enjoy an exclusive franchise. No other private health plans would enjoy that scope of competition. In that respect, at least, the new Senate bill makes no pretense to establishing anything resembling a level playing field for market competition between public and private health insurance options.

The fact that the government-sponsored health plans would be administered by private contractors, of course, does not in itself mean that they would operate like independent private health plans, or be any less of a “public option.” In Medicare, which is America’s quintessential single-payer system for senior and disabled citizens, the federal bureaucracy contracts with numerous private carriers for Medicare Parts A and B to provide benefits under terms and conditions set by law. The fact that Blue Cross or Anthem insurers are Medicare contractors does not in any sense mean that any Medicare product that they deliver is a “private option” or anything less than a “public plan.” Likewise, the fact that OPM, not the Centers for Medicare and Medicaid Services (CMS), would be authorized to make these contracts with private insurance carriers—for the specific purpose of competing against them—does not mean that the OPM option is a “private option.” It is another version of a “public plan” but the provision creating it has never been subject to a con-

gressional hearing or the normal processes of legislative deliberation.

As plainly conceded by the most ardent liberal “public option” champions in Congress, such as Representatives Barney Frank (D-MA) and Jan Schakowsky (D-IL), the ultimate objective of the “public option” is the erosion of private health insurance and its replacement by a single-payer health care system.

How OPM Administers the Federal Employees Health Benefits Program

Beyond its duties in enforcing civil service laws, rules and regulations, the Office of Personnel Management also administers the Federal Employees Health Benefits Program (FEHBP), the largest group insurance program in the world. The FEHBP is a consumer-driven system of private health insurance; plans compete both nationally and within state insurance markets, serving federal workers, retirees, and their families—altogether roughly 8 million people. It is both popular and successful.¹

An Employer Program. In administering the FEHBP, OPM enters into contracts with private health plans, and negotiates rates and benefits on behalf of federal employees and retirees. Under Section 8902 of Title V of the United States Code, OPM may enter into contracts with qualified carriers on an annual basis. By law, carriers must have reinsurance, provide a detailed statement of benefits subject to OPM’s approval, and comply with what OPM deems “reasonable minimum standards for benefits.” Rates, according to law, must “reasonably and equitably” reflect the costs of the benefits. As the federal employment agency, OPM enforces these contracts and applies rules generally applicable to employment-based insurance in the private sector, as well as enforces specific consumer-protection rules.

Structurally, the main difference between the FEHBP, as administered by OPM, and conventional employment-based health insurance is that the financing of coverage is effectively a defined contribution arrangement rather than a defined benefit system, and the availability of a wide range of health

1. For the best and most recent description of the functioning of the FEHBP, see Walton Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, D.C.: The AEI Press, 2009).

plan choices among competing health plans that is unknown in the private sector. In the FEHBP, the federal government—as an employer—makes a defined contribution to an employee’s health plan. This government contribution is determined yearly by a market-based formula, and it is capped each year at a certain dollar amount. In no case can the federal government contribute more than 75 percent to the premium cost of a given health plan. In effect, the heavy lifting on decisions about what kind of health plan, what combination of benefits, what premiums or co-payments are to be made, is largely left to federal employees and their families. The OPM sets the rules for the market competition among health plans; it competes for consumers’ dollars directly; and the federal government agencies (and OPM on behalf of federal retirees) make the contributions to the health plans that federal employees choose.

A Light Touch—So Far. Throughout most of its history, OPM has generally enjoyed a positive relationship with competing private-sector health plans, and has facilitated a broad range of personal choice and competition. In that respect, OPM’s management of the FEHBP is one of the best examples on record of a successful public-private partnership. As a matter of institutional culture, OPM has been light-handed in its administration of the program, allowing and promoting a great deal of private-sector flexibility and innovation. Health plan coverage is not in any sense rigidly standardized. Private health plans are allowed to offer a wide variety of health plans (ranging from HMOs to Health Savings Accounts) and benefit packages at a variety of premium prices, co-payments, and deductibles.

Enormous Authority in Reserve. While OPM and private plans have historically enjoyed a cordial and cooperative relationship, OPM’s power over the FEHBP is enormous. It has been held in reserve, but it can be summoned in a crisis or when the director of OPM believes it is necessary to exercise such power.

Chapter 89 of Title V of the U.S. Code sets the statutory framework for the program and its administration by OPM. But current law does not include language that restricts OPM in any way from imposing stricter standards on benefits, or from setting the rates for plans offered to federal employees. OPM can add or subtract benefits, or define how they are to be structured and delivered. The director of OPM has thus enormous residual authority, which can either advance or undermine choice and competition of the program and either broaden or restrict health benefit options.

The director’s plenary authority is deeply rooted in Title V, and confirmed repeatedly in federal courts. In 1981, in confronting a projected \$440 million shortfall in health care funding, President Ronald Reagan’s director of OPM ordered health plans to make a series of across-the-board benefit cuts to stay within the \$2.2 billion budget allocation for the program. OPM prescribed reductions in certain benefits, such as outpatient mental health benefits. These actions, though highly unpopular with federal employee organizations and Congress, were nevertheless upheld by the federal judiciary, which affirmed the director’s “broad discretionary authority” in negotiating contracts and “considerable latitude” in approving benefits.² The rates and benefits that prevail in the program are only those that the OPM director agrees to in contract negotiations with the private carriers. The director can just as easily disagree—and private health plans can either submit to his decisions or leave the program.

Advancing Policy. The director of OPM is directly accountable to the President, and will execute the Administration’s broad policy agenda, including health policy. The Clinton Administration, for instance, broke what the Congressional Research Service described as the “passive management” pattern of the FEHBP program,³ which emphasized give and take between the federal government and private plans in sensitive negotiations, and deference to private plans in the development

2. *National Federation of Federal Employees v. Donald J. Devine, Director, Office of Personnel Management et al., Appellants, and Group Health Association of American Intervener, American Federation of Government Employees, AFL-CIO, v. Donald J. Devine, Director, Office of Personnel Management, Appellant*, United States Court of Appeals, District of Columbia Circuit, Nos. 81–2184, 812187. Decided on December 21, 1981.

of combinations of benefits and rates in meeting consumer demand. According to the staff of the House Subcommittee on Civil Service, between 1990 and 1997, OPM imposed 27 specific mandated benefits on FEHBP plans. The representatives of Blue Cross/Blue Shield, which is the largest health plan in the program, told Congress that these mandates alone added approximately \$100 million to the cost of the Blues' plan. In 1994, the Clinton Administration ordered FEHBP plans to cover an expensive and experimental treatment using bone marrow transplants to fight breast cancer. Plans were required to offer the treatment within 24 hours or face exclusion from the program—even though the procedure was not widely tested and medical authorities generally favored restriction of the treatment to major academic medical centers. This was largely the result of congressional pressure, and thus a politically driven initiative.⁴

When government officials make health care decisions, these decisions are often political, not just economic or medical.

In carrying out the Administration's policy agenda, or in bowing to congressional pressure, OPM, under its broad authority to set benefits, can and will mandate benefits or procedures, irrespective of the objection of medical professionals to their clinical effectiveness or medical necessity. This is a key difference between public and private employers who offer health insurance. When government officials make health care decisions, these decisions are often political, not just economic or medical. This does not change merely because OPM, the agency making those decisions, has enjoyed a historic cordiality with the private sector.

How the Senate Expands OPM's Power—and Changes its Role

Under Section 1334, subsection (a) of the "Manager's Amendment" to the Christmas Eve Senate bill, OPM is given new authority to contract with private insurers to offer "multi-State qualified health plans through each Exchange in each State." These government-sponsored health plans would compete against private health plans. In making these contracts, OPM is authorized to negotiate several specific items with these plans: the medical loss ratio (the amount of revenues that must be allocated for payment for health benefits and the amount retained for administrative and other costs); their profit margins; and the premiums they will offer in the exchanges. In the conduct of these negotiations, the director shall take into consideration "such other terms and conditions of coverage as are in the interests of the enrollees in such plans."

This broad language would allow OPM, with a few qualifications, to replicate the kind of broad contractual authority over the multi-state plans that it currently has in the administration of the FEHBP. This is clear from the text. According to Section 1334 (a) (4), 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. This means that the director could set terms and conditions that could easily give its selected carriers an advantage in any competition with private sector competitors.

The language of the bill also provides that the government-sponsored multi-state plans must meet the minimum benefits package, the rating and coverage rules as specified elsewhere in the Senate health bill, as well as state licensure and other state health insurance requirements "not inconsistent" with the Senate bill. For purposes of the competition with other private plans, subsection (d) of Sec-

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3. See Congressional Research Service, *The Federal Employees Health Benefits Program: Possible Strategies for Reform*, A Report Prepared by the Congressional Research Service for the Committee on Post Office and Civil Service, United States House of Representatives (Washington, D.C.: Government Printing Office, 1989).
 4. For a description of this policy change, as well as the broader regulatory interventions of the Clinton Administration in running the FEHBP, see Robert E. Moffit, "How Washington Can Improve Health Care Coverage for Federal Workers and Their families," Heritage Foundation *Background* No. 1504, November 19, 2001, at <http://www.heritage.org/Research/HealthCare/bg1504.cfm>.

tion 1334 provides that the government multi-state plans are to be deemed certified for participation in the state-based health insurance exchanges. This means that the government-sponsored health plans would not be subject to the same qualification processes as other private plans; their status as a “qualified plan,” pre-ordained in statute, would be defined solely by OPM.

Under Subsection (e) of 1334, there is an important qualification: Notwithstanding the requirements to meet state licensure and other requirements, 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 year, and 85 percent in the third year. This would, of course, favor big insurers, assuming they would participate, but would offer no guarantee of cost control.⁵ It appears, in other words, from the plain text, that the government-sponsored health plans, depending on their geographical capacity to expand coverage rapidly, would by law be able to bypass state financial and solvency requirements. That being the case, OPM would presumably be able to devise its own regulatory standards for the health plans it sponsors, including solvency. The language of the bill provides neither statutory guidelines to do it nor prohibition against doing it; indeed, Section 1334 provides no guidance at all in this matter. This is a problem; for it could, once again, give the government-sponsored plans an unfair competitive advantage.

What happens if the multi-state plans run a deficit? The issues of financial rectitude or solvency, plus the pledge of a “level playing field” for competition between the government plan, or government-sponsored plans, and the private health plans

are critical for both taxpayers and the private-sector health plans that are expected to compete against the government plan. In the original version of the House health bill, for example, the congressional sponsors clearly specified that the financing of the public plan was to come solely from premiums and start-up appropriations, with the implication that the public plan would not be a candidate for regular infusions of taxpayers’ money or “bailouts.”⁶ In contrast, Section 1334 of the Senate bill provides no similar language.

Do taxpayers bear the insurance risk for the public plan?

Of course, regardless of the statutory language of the legislation, there is nothing to prevent Congress from bailing out any institution. But it is particularly liable to do so if the institution is one of its own creations, such as a public health plan, enrolling millions of Americans, or, by extension a government-sponsored health plan under a contract to compete against private health plans like that envisioned in Section 1334 of the amended Senate bill.

Another way of looking at potential taxpayer liability is whether or not taxpayers bear the insurance risk for the public plan. In OPM’s administration of the FEHBP, the private health plans that compete for the dollars of federal workers and retirees bear the risk, not the taxpayers. In the original version of the House health care bill, under Section 221 of Title I, the Secretary of HHS was authorized, like the director of OPM, to enter into contracts in order to administer the proposed public plan; this was very much like the private contracting that is integral to the administration of Medicare, for example. But

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5. 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.” Letter from Douglas Elmendorf, Director, Congressional Budget Office, to Hon. Harry Reid, Majority Leader, United States Senate, concerning the spending and revenue estimates of the Patient Protection and Affordable Care Act, December 19, 2009, p. 9.
 6. For a description of the provisions of the original House bill, see Robert E. Moffit, “Statement on the Tri-Committee Draft Proposal for Health Care Reform,” testimony before the Committee on Education and Labor, United States House of Representatives, June 23, 2009, at <http://www.heritage.org/research/healthcare/tst063009a.cfm>.

the original House language was very explicit on one key point: No contractual arrangements with these entities could “involve the transfer of insurance risk to such entity.”⁷ In other words, taxpayers would assume the insurance risk. On the topic of the assumption of insurance risk, Section 1334 of the Senate bill is silent.

This silence on the crucial topics of insolvency and insurance risk for the new government-sponsored health plans, plus the range of powers inherent in the director of OPM to set premiums and benefits, should be troubling to members of Congress who, correctly, are concerned that health care legislation could serve as a vehicle to undercut existing private health insurance plans, or tilt the insurance markets to the advantage of the federal government’s health plan or a plan sponsored by federal officials. Like the Secretary of Health and Human Services, the director of OPM reports to the President, and, in all cases, is charged with executing not only the law but also the policy agenda of the President. If OPM can set premiums or issue rules that give government-sponsored health insurance plans special advantages, it can accomplish the objectives of the more traditional variants of the public plan. In either case, the results would be the same: the erosion of private health care coverage for millions of Americans and federal government domination of the insurance markets.

Health Care Bureaucrat in Chief

Under Section 1334, government-sponsored multi-state health plans will compete in the state-based, but federally designed, health insurance exchanges nationwide. Under Section 1311 of the Senate bill, states are required to establish these exchanges, and the health plans that compete within them must also comply with new federal and state rules.

In both the House and Senate versions of the health care legislation, the Secretary of Health and Human Services will have authority over the con-

The President becomes the chief health care bureaucrat.

tent of health benefits packages. In the Senate bill, for example, this would include employer, individual, and self-insured health insurance plans.⁸ Based on previous experience with government health benefit-setting, the political dynamics of the process invariably result in increased health benefit levels, often through the addition of benefits or their expansion to more conditions or a mandate for lengthening the duration of medical treatments and procedures. This would invariably drive up the cost of coverage.

These cost increases are often countered by legislative or regulatory action to limit reimbursements to doctors, hospitals, or other medical professionals, or a tightening of the conditions under which medical treatments or procedures are to be reimbursed. This is the experience with Medicare and Medicaid. Another political option is to use government boards, councils, commissions, or panels to limit or tighten coverage or reimbursement rules for the expanded health benefits in order to cut or reduce costs. The reality, in any case, is a highly regulatory environment, where health plans will be increasingly standardized, with little variation and little innovation.

In a situation where the key decisions in health insurance are federal regulatory decisions, not market decisions, the opportunities for cooperation, conflict, or collusion between HHS and OPM are bountiful. With the federal government sponsoring its own health plans in competition against private plans, with the government plans subject to OPM contracting and regulatory authority, and with the federally designed exchanges serving as the arena for HHS-regulated private health plans, any disputes or issues of comparative advantage between the two agencies will be settled by the White House.

7. *Ibid.*

8. For a brief description of the insurance provisions in the Senate bill, see “An Analysis of the Senate Democrats’ Health Care Bill,” Heritage Foundation *Background* No. 2353, December 18, 2009, pp. 7–10, at <http://www.heritage.org/research/healthcare/bg2353.cfm>.

In such an arrangement, the President, by necessity, will have the ultimate authority in changing, shaping, or driving the direction of the American health insurance markets. The President becomes the chief health care bureaucrat.

In the Senate bill, there appears to be a unified statutory ground between OPM and HHS in setting minimum benefits and rating and coverage rules, but OPM appears to have its own authority in premium-setting, medical loss ratio standards, and determining profit levels for its multi-state health plans. It is unclear whether OPM can set its own solvency standards, or whether the multi-state plans will assume insurance risk or whether the taxpayers will be insulated from the costs of any shortfall incurred by these carriers, even though they are clearly serving a “public” purpose. The OPM-sponsored multi-state plans are clearly an extension of the federal government, and under certain statutorily defined conditions they would not be subject to the same qualifying processes as other plans selling insurance in the state-based exchanges.

Conclusion

The “Manager’s Amendment” to the Senate health bill, crafted by Senate Majority Leader Harry Reid, with a new role for OPM has been widely advertised as an “alternative” to the public option.

But a closer look at the Senate’s legislative language shows that OPM is given broad authority, and could use this authority on behalf of its sponsored health plans, giving these plans a comparative advantage in competition with other private insurance plans. In effect, the multi-state plans could function as a public option.

OPM-sponsored multi-state plans would not be able to make independent decisions about their premiums, profits, or their benefits packages—they would be government-run. In that respect, given the regulatory power of OPM, the effects on ordinary Americans’ health care would largely be the same as with a public option. While federal employees are rightly concerned that this new mission for OPM could compromise its traditional mission to run the federal civil service, all Americans should recognize the Senate alternative for what it is: a vehicle for an enormous concentration of government power over the financing and delivery of their health care.

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