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S. Hrg. 114–193

REVIEW OF THE AFFORDABLE CARE ACT HEALTH INSURANCE CO–OP PROGRAM

HEARING

BEFORE THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

MARCH 10, 2016

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Printed for the use of the
Committee on Homeland Security and Governmental Affairs

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REVIEW OF THE AFFORDABLE CARE ACT HEALTH INSURANCE CO-OP PROGRAM

THURSDAY, MARCH 10, 2016

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:34 a.m., in room SD–342, Dirksen Senate Office Building, Hon. Rob Portman, Chairman of the Subcommittee, presiding.

Present: Senators Portman, Johnson, Lankford, Ayotte, and Sasse.

Staff present: Mel Beras, Chris Barkley, Bryan Berky, Samantha Brennan, David Brewer, Kyle Brosnan, Brian Callanan, Will Council, Margaret Daum, John Kashuba, Andrew Polesovsky, Matt Owen, Aylene Senger, Kelsey Stroud, and Satya Thallam.

OPENING STATEMENT OF SENATOR PORTMAN

Senator PORTMAN. Let us go ahead and get started. There is a vote at 11:30, and this may make it difficult for us to get through all the questions unless we get started now. I want to thank Senator Sasse for being here. I think at least four of our colleagues have indicated they are going to join us today, so we will be seeing Senators coming in and out during a busy day. But let us bring the hearing to order.

I want to begin by noting that Senator McCaskill will not be with us today. As some of you know, she is home in Missouri attending to some very important health issues. We wish her well. We know she will be back with us soon, I hope as soon as next week. And I will say I suggested to her that we postpone this hearing until she got back, and her answer was, no, that there is lots of work for our Subcommittee to do and we should allow the Senate's business to go on, which is the way she is. I appreciate her attitude. She will be submitting questions for the record, and I want to on behalf of the Subcommittee thank Senator McCaskill's staff for their hard work in preparing for this hearing.

We are here today to discuss the Administration's unfortunate adventure in the health care startup business. That is kind of how I look at this. The Affordable Care Act (ACA) created something called the Consumer Operated and Oriented Plan (CO–OP) Program. It was really a gesture to those who favored a public option and were not successful in advocating for that. Under the CO–OP Program, the Department of Health and Human Services

(HHS) awarded $2.4 billion of taxpayer money to 23 nonprofit health insurance CO–OPs. As of today, of those 23, 12 have failed. These 12 collectively received about $1.2 billion in taxpayer money that is almost certainly lost, and we can talk about that later in the Q&A. Their collapse, by the way, also caused 740,000 people in 14 States to lose their health insurance provider and have to scramble to find new coverage, most with little or no time.

Over the last 9 months, our Subcommittee has carefully investigated these failures. We wanted to know whether HHS, when it played the role of investor, made good or bad decisions with taxpayer money.

Unfortunately, what we found out is that a lot of bad decisions were made. In a Majority Staff Report released today[1], we detail those findings. This report is here, and you all should have it. We detail findings that HHS was aware of serious problems concerning the failed CO–OPs' enrollment strategies, pricing, financial forecasts, and management before the Department ever approved the initial loans. Once the CO–OPs got going in 2014, things went south in a hurry—both in terms of financial losses and enrollment figures that wildly deviated from the CO–OPs' own projections. The failed CO–OPs ultimately racked up $376 million in losses in 2014 and more than $1 billion in losses in 2015. But despite getting regular reports that the CO–OPs were hemorrhaging cash, HHS took essentially no corrective action for over a year.

Worse, the Department approved additional loan awards to three of the now failed CO–OPs. This happened in 2014. This was despite clear warnings that these CO–OPs did not have reliable plans for turning things around.

The Majority Staff Report explains these findings in great detail, and without objection, that report and its appendix are ordered to be made part of the record.

Senator PORTMAN. Let me give you a few highlights.

When HHS approved startup loans for the failed CO–OPs in 2012, it asked a reputable firm, Deloitte Consulting, to evaluate the CO–OPs' proposed loan applications and business plans. We have reviewed Deloitte's analysis as part of our investigation. Here is what we found.

You will probably hear from our witnesses that Deloitte gave the CO–OPs a "passing" score, but it was based on a grading scale set by HHS, and Deloitte warned HHS of very specific concerns with the failed CO–OPs that foreshadowed the problems we will talk about today, the problems that were to come.

They said, among other things, many of the failed CO–OPs could not identify their senior leadership team. Seven of the 12 had serious deficiencies in their enrollment strategy—which later turned out to be a chief reason for CO–OP failure. Many of them submitted budgets that were incomplete, unreasonable, not cost-effective, or that did not align with the CO–OPs' own financial projections.

Those financial projections were not so hot either. Deloitte warned that several CO–OPs relied on unreasonable projections about their own growth. As just one example, Deloitte noted that

[1] The Majority Staff report appears in the Appendix on page 77.

CoOportunity—the CO–OP for Iowa and Nebraska that I imagine Senator Sasse will be talking about a little later—had a target profit "much lower than the industry benchmark" of 4.8 percent. That was an understatement: CoOportunity's stated target profit margin was 0 percent.

Nevertheless, HHS approved all the loan applications to the failed CO–OPs, to the tune, again, of $1.2 billion.

After they entered the marketplace in 2014, the CO–OPs' financial health deteriorated rapidly. And HHS knew it. The Department regularly received key financial information from the CO–OPs, including monthly reports and audited quarterly financial statements. These reports showed that, starting almost immediately, the failed O–OPs experienced severe financial losses that exceeded even the worst-case scenarios outlined in their loan applications to HHS. Cumulatively, by the end of 2014, the failed CO–OPs exceeded their projected worst-case-scenario losses by at least $263.7 million—which is four times above the projection.

The CO–OPs' enrollment numbers were no less problematic. According to the 2014 monthly reports submitted to HHS, five of the failed CO–OPs dramatically underperformed enrollment projections, while five others overshot their projections by wide margins. Both errors can cause serious financial losses. And they did. Low enrollment means insufficient income to cover expenses, of course, but excessively high enrollment was an even greater threat to solvency because it multiplies losses rather than profits when those premiums are underpriced—as many of the CO–OPs' premiums were.

Despite having that information at its fingertips, HHS did not step in. The Department's loan agreements with the CO–OPs entitled it to invoke a number of accountability tools for borrowers who were missing the mark, but here HHS chose to take a pass. Inexplicably, for over a year, the agency took no corrective action, nor did it put any CO–OP on enhanced oversight. Five of the 12 failed CO–OPs were never subject to corrective oversight. Five of the 12 failed CO–OPs were never subject to corrective action by HHS, and HHS waited until September 2015 to put five others on corrective action or enhanced oversight. Two months later, all 12 CO–OPs had failed.

HHS also had the power to stop disbursing funds if a CO–OP's financial viability was in doubt. It never did to the bitter end. Instead, over the course of 2014 and 2015, HHS disbursed $848 million in Federal loan dollars to the failed CO–OPs, even as those entities lost more than $1.4 billion. That is about $1.65 in losses for every $1 that HHS gave them. Think about that.

More unbelievable, near the end of 2014, HHS approved additional solvency loans for three of the failed CO–OPs that were in danger of being shut down by State regulators for having insufficient capital—despite clear warning signs that those CO–OPs could not turn things around. Here again HHS asked Deloitte to complete an external review of the CO–OPs' application for additional solvency loans and their plans to improve their finances going forward. But according to Deloitte, HHS truncated its review of these applications. Deloitte did not evaluate, for example, "the likelihood that each CO–OP would achieve sustainable operations based on

the revised business plan"—which I would have thought was the whole point. But even the limited analysis that HHS allowed Deloitte to conduct pointed to clear warning signs that CoOportunity, the New York CO–OP, and the Kentucky CO–OP did not have a sound plan to regain their footing.

Nevertheless, these three CO–OPs alone received $355 million in additional solvency loans from the taxpayers. All have failed, by the way. The Kentucky CO–OP collapsed after suffering losses of over $50 million in 2014 and another $115 million in 2015. At the time of CoOportunity's closure, that company's operating losses exceeded $163 million. And most staggering of all, after HHS gave the New York CO–OP $90 million to prolong its financial life rather than allow it to scale down, that CO–OP went on to lose another $544 million in 2015.

The financial aftermath of all this is dire. The Subcommittee obtained the failed CO–OPs' most recent financial statements, and those statements show that none of the failed CO–OPs have repaid a single dollar—not a single dollar—principal or interest, of the $1.2 billion in Federal loans they received. In my view, it is unlikely they will pay any significant fraction back. The latest statements show that the failed CO–OPs' non-loan liabilities exceed $1.13 billion—which is 93 percent greater than their reported assets, including money they expect to receive. On top of that, they owe $1.2 billion to the Federal Government. As we said, we should not hold our breath on repayment.

The American taxpayer is not the only creditor that stands to suffer large losses due to the failure of the CO–OP Program. The latest balance sheets we obtained show the failed CO–OPs have more than $700 million in unpaid medical claims to doctors and hospitals. Unpaid medical claims. In some States, these losses will be absorbed by other insurance companies—which means by the policyholders of other insurance companies who have to pay increased premiums. This is going to go back to our constituents, again, to the taxpayer. In other States, doctors, hospitals, and individual patients stand to suffer large out-of-pocket losses due to the CO–OP failures, as our report details. We will talk about this more in relationship to the New York CO–OP.

These failed CO–OPs were a costly experiment gone wrong, and real people got hurt, including the more than 700,000 Americans who lost their health plans. Today I plan to ask HHS whether they accept any responsibility for the taxpayer waste, the disruption to consumers, and the losses to doctors and hospitals that the CO–OPs' failures have wrought.

At this point, I would like to ask my colleagues if they would like to make opening statements. All of you are welcome to do so. Senator Sasse arrived first, and, Senator Sasse, again, as I mentioned earlier, you have done a lot of work on the issue of CoOportunity and its effect on your constituents in Nebraska. And I appreciate your being involved in this issue, and I wonder if you have an opening statement.

OPENING STATEMENT OF SENATOR SASSE

Senator SASSE. Yes, thank you, Chairman Portman, for your leadership and for holding this important hearing today. I would also first like to acknowledge our colleague and Ranking Member, Senator McCaskill. We all wish her well and a speedy return to the Senate.

Today's hearing is about the families who lost their health care plans. It is about the taxpayers who were swindled. It is about the bureaucrats who mismanaged this program. And it is about the local governments who had to cut budgets from firefighters and schools to make up for Washington's failures. Everyone in this room—Republican and Democrat—has a duty to their constituents to get the whole story.

The Affordable Care Act's CO–OP Program created 23 not-for-profit health insurers using $2.4 billion in "loans" from the taxpayer.

Less than a year into operation, the financial condition of many of these CO–OPs was unstable at best. As today's report being released by the Committee shows, the Centers for Medicare and Medicaid Services (CMS') own private consultant, Deloitte, warned that this was the case. Despite this, CMS continued to disburse loans and then began awarding additional loans to these troubled CO–OPs. Since then, 12 of the 23 have gone out of business, representing a CO–OP failure rate of more than 50 percent.

Sadly, there were about 740,000 Americans covered by these 12 defunct insurance companies that were given $1.2 billion in so-called loans from the taxpayer. As we have suspected for some time, this Subcommittee's report concludes that these loans will never be repaid.

When these companies failed, they imposed varying degrees of disruption on their enrollees and the markets in which they operated.

Unfortunately, the mess caused by this program began in my State with the abrupt failure of CoOportunity Health. CoOportunity was headquartered in Iowa, but it operated in both Nebraska and Iowa. And the newly created insurer was given a total of $145 million of taxpayer-funded loans. Things seemed to be going well at first when CoOportunity announced they had signed up far, far more enrollees than they had anticipated.

However, despite ample funding and more than enough enrollees, on December 16, 2014, as people were signing up for their 2015 coverage, the Iowa Insurance Commissioner placed CoOportunity under a supervision order. One month later, in January of last year, the Iowa Insurance Commissioner said rehabilitation of CoOportunity would be impossible, and he sought a court order for liquidation. After just one year of operation, the new not-for-profit health insurer would collapse completely.

When CoOportunity failed, 120,000 enrollees, a majority of these being Nebraskans, had their coverage canceled and were forced to find new insurers. But the collateral damage from CoOportunity's failure does not end there for Nebraskans. CoOportunity, of course, owed millions of dollars, as Chairman Portman has mentioned, to doctors and hospitals for claims by its enrollees that will not be repaid.

To address the insurer collapse, the State of Nebraska has a guaranty fund that pays claims in the event of insurer collapse, such as CoOportunity's, and the guaranty fund is financed by assessments on other insurance companies selling similar plans in our State, prices that were at market rates, unlike what CoOportunity offered originally, and that is why they had far too many enrollees, because there was not competence to run this program.

To help pay for CoOportunity's unpaid claims, insurers in Nebraska were assessed fees totaling about $47 million last year alone. It should be noted that this sum was not even enough to cover CoOportunity's losses and that the guaranty fund had to take out a loan. As CoOportunity has no remaining assets, it is improbable that the guaranty fund will ever be repaid this $47 million. In other words, it will be assessed onto other insurers in the market.

These insurers had to pay CoOportunity's outstanding bills, and there is no reason to believe that CoOportunity will ever pay any of this money back. As a result, Nebraska tax revenues will be decreased by $47 million because these insurers are subsequently able over a 5-year period to reduce their tax liability to the State in the amount of their contributions to bail out CoOportunity.

This means that my State will have much less revenue to pay for priorities like education, roads, firefighters, and other local government issues. Thus, Nebraskans are going to have to pay for the CoOportunity failure again, first as individuals became uninsured and now as taxpayers have to bail out CoOportunity, on top of the $145 million that they as taxpayers made in Federal loans to CoOportunity.

As previously mentioned, 11 other CO–OPs have now failed, likely initiating variations of this same story across 11 more States. Moreover, depending on the viability of the 11 remaining CO–OPs, it could happen in more States in the years to come. Indeed, of the 11 CO–OPs that remain in operation, we know that as of February 25th, CMS had placed 8 of the 11 under corrective action plans. In addition, updated financial reports show that conditions here have gravely worsened for the four CO–OPs with data available for the fourth quarter of 2015.

Despite this mess, CMS has to date offered very little in terms of a substantive explanation for the problems. I have been questioning the Department since last May about all of this after only one failure. We now have 12 and potentially more on the horizon. I have sent four letters to your agency over the course of this period and have been working alongside Chairman Portman and the Ranking Member to request documents to unearth the cause of this debacle.

HHS owes all CoOportunity enrollees and all Federal taxpayers, and particularly taxpayers in my State, an answer. I look forward to this hearing, and I hope for some new and actual substantive answers from the witness panel today.

Thank you.

Senator PORTMAN. Thank you, Senator Sasse. Senator Ayotte.

Senator AYOTTE. I want to thank the Chairman for holding this important hearing. I do not have an opening Statement. Thank you.

Senator PORTMAN. Thank you. Senator Lankford

Senator LANKFORD. No opening Statement.

Senator PORTMAN. Thank you. Excellent. We will now call our first panel of witnesses for this morning's hearing.

Andy Slavitt is the Acting Administrator for the Centers for Medicare & Medicaid Services. Before becoming Acting Administrator, he served as Principal Deputy Administrator beginning in July 2014. Before joining CMS, he was group executive vice president for Optum, where he oversaw the delivery of clinical, technical, and operational solutions to health care clients and consumers, including the Department of Health and Human Services.

Kevin Counihan is the Marketplace Chief Executive Officer (CEO) and CMS Deputy Administrator. Before joining CMS, he served as CEO of Connecticut's health insurance exchange, AccessCT.

I appreciate both of you for being with us this morning, and we look forward to your testimony. It is the custom before this Subcommittee to swear in all witnesses, so at this time I would ask you to please stand and raise your right hand. Do you swear that the testimony you are about to give before this Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. SLAVITT. I do.

Mr. COUNIHAN. I do.

Senator PORTMAN. Thank you. Having heard in the affirmative, I appreciate your being here again, and your written testimony, you should know, will be printed in the record in its entirety, and we would ask you to try to limit your oral testimony to 5 minutes each.

Mr. Slavitt, we will hear from you first.

TESTIMONY OF ANDY SLAVITT,[1] ACTING ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES

Mr. SLAVITT. Thank you. Chairman Portman, thank you, and Members of the Subcommittee. And I also want to offer my best to Ranking Member McCaskill as well. And thank you for the invitation to participate in this hearing on the CO–OP health insurance companies.

I know you are all aware of the challenges that the CO–OPs have faced, 12 having closed their doors prior to the end of 2015. And I understand the questions that you have about how CMS provides oversight to CO–OPs, how CMS makes awards decisions, and CMS' level of accountability when a CO–OP closes.

As you know, the Affordable Care Act allocated over $2 billion to start the CO–OP Program, the idea to stimulate new local competition in an industry that has a history of being very difficult for small companies to enter, with some entering markets that had not seen a new competitor in decades.

[1] The prepared joint statement of Mr. Slavitt and Mr. Counihan appear in the Appendix on page 50.

Let me first clarify our oversight purview. Under law, the Federal Government is not granted authority reserved for the States; analyzing and actuarially certifying rates and surplus levels, and determining who is qualified to offer insurance during open enrollment. CMS' responsibility is to award and oversee funds and ultimately maximize the likelihood that taxpayer funds are returned.

CO–OPs were selected and 85 percent of the loans were made prior to the start of the first open enrollment in 2015. The remaining 15 percent of funds were awarded during 2014. Loans were made through an evaluation process and review and scoring from a third party, which resulted in 16 percent of applications being granted loans.

By the time I took this job in 2015, having come out of the private sector, all the loan funding had been obligated, and my principal focus was to ensure we had the best possible oversight practices. One of the first things I did was hire an independent actuarial consulting firm to do a risk assessment of all the companies afresh.

Now, from that, our approach was driven by three unique challenges in overseeing CO–OP loan programs:

First, the challenges CO–OPs have had should not be viewed as a CO–OP problem but as a small business startup problem in a very difficult industry. And I hazard to say that all of the small companies experienced similar challenges, CO–OP and non-CO–OP.

While we were making loans to companies with 30 to 50 employees, they are typically competing with companies with multiple thousands of people and worth tens of billions of dollars in capital. Having run a startup in the past myself, trial and error is part of creating success, and in this situation, with the limited capital available and competing against giants, the CO–OPs had very little room for error.

Second, as Mr. Counihan will elaborate on in a moment, across the marketplace, during 2014 there was actually very limited actual performance information available before plans filed rates for the 2015 year and for the CO–OP oversight team to evaluate the financial position of the CO–OPs. Unlike almost every other business, in insurance you get to make one pricing decision per year, and you live to see the outcome. This is why our decisions to shut down the CO–OPs were largely made prior to the third open enrollment period.

Finally, all of the loan funding had been granted. Our strongest remaining tool from oversight is to call the loan, which I can tell you we did not take lightly, as it had ramifications for disrupting consumers, as you know, and would certainly not have increased the collectability of the CO–OP loans.

In light of these three challenges, we set up an extremely active oversight process, which Mr. Counihan will cover in more detail. We created other oversight tools, new methods of gathering information, and focused decisions around key events like open enrollment. We were guided by the view, and are guided by the view, that the best way to maximize the opportunity for Federal loans to be repaid is if the CO–OP makes it through the startup stage when most failures occur and reaches a point of stability. Absent that, I

have expected our team to be sober in their assessments and make difficult judgments. And they have, making recommendations to withhold funds, to place CO–OPs on corrective action plans, and to work with States to shut down operations when that is what the analysis suggested.

Mr. Counihan represents by almost anyone's description as knowledgeable and capable an executive as there is in these matters, and he and his team have not hesitated to make tough-minded calls. I recognize that when any program does not fully succeed, it raises important questions for you. We, too, go through after-action review to see what we would do differently and could improve.

Ultimately, our goal at CMS is to make sure that the programs we are charged with are working as they should for American families. Today more than 90 percent of Americans have health coverage, and even in States where CO–OPs proved unsuccessful, in the first year the overall uninsured rate decreased by 20 percent and has continued to improve.

Challenges like the ones we are discussing today are part of every program, and we must always be ready to work with them transparently, with urgency, with accountability, and in the best interests of taxpayers and consumers.

So thank you, Mr. Chairman, for allowing me these few minutes, and, of course, we will be pleased to take your questions.

Senator PORTMAN. Thank you Mr. Slavitt. Mr. Counihan.

TESTIMONY OF KEVIN COUNIHAN,[1] MARKETPLACE CHIEF EXECUTIVE OFFICER AND DEPUTY ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES

Mr. COUNIHAN. Thank you. Chairman Portman and Members of the Subcommittee, thank you for the invitation to discuss the CO–OP Program with you.

The team at CMS has the charge to specifically oversee the Federal loans made to these startups with the goal of maximizing the return taxpayer funds, supporting the CO–OPs so that consumers have access to uninterrupted competitive insurance coverage, and providing information to State Departments of Insurance (DOIs) so they can make the best possible decisions about the future of the CO–OPs in their State.

Like Andy, I came to CMS from a long career in the private sector. I have had executive roles in insurance companies, and I have overseen four successful health insurance exchanges.

Leveraging our experience, we worked with the teams to build and improve the oversight operation for the CO–OP loans that includes tailored oversight protocols, a formal risk committee, and an enhanced monitoring process. These processes are robust, have built-in controls, including reviews from independent firms, and utilized the knowledge of top financial professionals and actuaries.

The lifeblood of any oversight process is, of course, data-driven decisionmaking. I will pick up on something Andy said. Our oversight team at CMS makes the best decisions they can based on the information available at the time.

[1] The prepared joint statement of Mr. Counihan and Mr. Slavitt appear in the Appendix on page 50.

I think it is important to explain more about the information available to the CO–OPs, the State Departments of Insurance and CMS. In insurance, you know your revenues relatively quickly. What you do not know for some time are your real claims costs because of the back-weighted nature of how care is consumed in the year and the lag time in how claims are submitted, processed, and paid.

Due to the lag in claims data, as we neared the end of 2014, meaningful and complete data from the first and second quarters of the year was all that was available. The first reliable financial information on the CO–OPs' 2014 performance from actual claims only became available in the middle of 2015. This was well after pricing decisions for plan year 2015 were made by the CO–OPs, well after funding decisions needed to be made by CMS, and well after certification and licensing decisions needed to be made by the State Departments of Insurance for 2015 open enrollment.

Even when information is not readily available, we aggressively gather and analyze the best information we can on program performance and early warning signs. We used each of the oversight tools at our disposal to support and correct the CO–OPs on issues identified. In 2015, we conducted 27 financial and operational reviews, 16 in-person visits, and had 43 communications, not to mention hundreds of phone calls with the CO–OPs. This work is done in close collaboration with the State Departments of Insurance who have the full authority over all insurers in their State.

As Andy said, we have several oversight tools short of calling a loan, including corrective action plans and using the leverage of cash disbursements when possible to push for performance improvement. Approximately one-third of the time, we have withheld some or all of a requested disbursement until the companies more clearly demonstrated the need or took some other action.

This tool had limitations as not funding a cash disbursement would cause a company to be out of State compliance, be unable to pay claims, and ultimately default on their loan. Even with the oversight and support provided by CMS and the Departments of Insurance, having operated insurance businesses, I can tell you that the outcomes of these companies are very much in their own hands, more so than either their regulators or lenders. For the existing CO–OPs, we are now reviewing their fourth quarter financials and the results of the most recent open enrollment period. Plan Year 2016 is a critical year for these CO–OPs. They must move from startup to stability and improve their financial capabilities, which are vital for their ability to predict, manage, and control costs.

For the CO–OPs that are in the wind-down process, we are working with the Department of Justice (DOJ) to use every tool at our disposal to maximize recovery of Federal funds owed, including recently at the request of DOJ putting a hold on tens of millions of funds as the process plays out.

CMS will continue to work closely with this Subcommittee, the CO–OPs, and the State Departments of Insurance to provide the best outcome for consumers and taxpayers. We appreciate the Subcommittee's interest, and I am happy to answer any of your questions.

Senator PORTMAN. Thank you, Mr. Counihan. We will have a number of questions, and I appreciate you both being here and your testimony.

I will say some of what you have just said confuses me, at least as to the period 2014 and 2015. You talk about not having adequate information, I think very limited information for HHS to review. You talk about a lag in data. HHS had monthly financial data to work with. You received the quarterly financial reports, Q1 by mid-May, Q2 by mid-August, so there was plenty of time to put the failed CO–OPs on a corrective action plan or to cut your losses before sending them into open enrollment in 2015. So I just do not think that is accurate.

It is interesting also when you say, Mr. Slavitt, our strongest tool is to call the loan. You have a lot of other tools, and Mr. Counihan actually has laid out some of those tools to deal with CO–OPs: corrective action plans, we talked about enhanced oversight plans, termination, of course. Ms. O'Brien, who is your CO–OP program director, told us these are all very valuable tools, and I know you are using them now more frequently, but our question is: How did this happen?

Throughout 2014, HHS did not use the tools at all with respect to these failed CO–OPs. In fact, 5 of those 12 CO–OPs we have talked about were never put on a corrective action or enhanced oversight plan despite the fact, again, that you were receiving these regular monthly and quarterly financial reports showing massive losses. By the second quarter of 2014, 6 of the 12 failed CO–OPs reported net income losses that exceeded the worst-case scenario in their own business plans. By the end of the year, 10 of the 12 had exceeded their projected worst-case-scenario losses for 2014 by at least 300 percent—$263 million.

So I just do not think it is accurate to say you did not have information and that there was a lag time that made it impossible to respond. It is just not accurate. The loan agreement says enhanced oversight plans should be used when a CO–OP "consistently underperforms relative to its business plan." That is in the agreement. How could consistent monthly losses exceeding the worst-case scenario by 300 percent not be considered underperformance? I guess I would ask you that, Mr. Slavitt.

Mr. SLAVITT. Sure. Thank you. And let me just start by saying these are very fair and appropriate questions, and they are questions that I have asked myself. To go back and look at 2014, obviously, a lot of this was before my time.

You may remember that in 2014 the exchanges got off to what I might charitably call a "slow start." Open enrollment had to be extended, and so membership did not start to come until late. And then, of course, the way health insurance works, people have deductibles, so claim filings do not start to happen for a while. And as Mr. Counihan described, you do not really get an accurate picture. And, look, I have been in this business a long time. You do not really get a good, accurate picture. Certainly in my view, the question I ask is: Did the people on the CO–OP team have enough information to effectively shut down a CO–OP or call a loan? Because if they did not continue to disburse a loan, they would, in effect, put the plan out of compliance, and then obviously the kind

of situation that we had in Nebraska and Iowa is not the kind of situation we wanted to be in.

And I will say, to be fair, as I look back about things we would have done differently, I will say that CoOportunity should never have been allowed to go into the 2015 year, either by the CO–OP or by ourselves. And I think that is a very fair criticism in looking back, and I think that is something that we would all say.

When I look at the other CO–OPs and I look at all the evaluations, notwithstanding that many of them were ahead of their business plan on membership, some were behind, I can tell you that the expression that once you have your first customer, your business plan goes out the window, it is very true. The team I think did the best job they could of evaluating the information they had. But 3 to 6 months into a CO–OP being off the ground as a startup, when I look at it—and, again, this is my opinion—and a reasonable person could reach a different judgment. But when I look at it, I look at the CO–OP team's work, and I find it very difficult to criticize them, with the exception of CoOportunity, for letting those CO–OPs move forward into the 2015 open enrollment year, reset their pricing, which was allotted to them and approved by the Departments of Insurance, who also thought they should move in, and to move forward and see what happened in 2015.

Obviously, looking back on judgments today, we have information we did not have then about how their claims developed, and I think that is why these are very fair questions.

I do not know, Kevin, if you want to add anything.

Mr. COUNIHAN. I guess what I would just add is, based on my experience, startup health insurance companies are very high risk. Over half of them fail. They take 3 to 5 years to stabilize and mature. It is seductive to look back and say look at what happened after a certain amount of period and say, you should have done something here and, if you look at open enrollment, for example, in that period and when it ended, it took us until October into November to actually have any credible experience, because in the first 3 months there is literally very modest utilization. And then it continues to get a little bit better in the fourth and fifth and sixth months, which is one of the reasons when issuers set their rates for 2015, they were setting their rates on manual rates, not based on experience. 2016 was the first year in which issuers actually had credible claims experience to set their rates from.

So, again, a lot of different factors. It is dynamic, and it is complicated.

Senator PORTMAN. Yes, look, I know you were not there, but I just think it is totally inappropriate for you all to say, as Mr. Slavitt just did, they did the best job they could with the information they had, and that somehow, this is just a problem with startups.

First of all, we are talking about taxpayer money, $1.2 billion certainly lost, 700,00-plus people losing their health care, and somehow you guys seem to be saying that is just fine.

In terms of startups, these CO–OPs failed at a much higher rate than the average startup. In fact, they did that despite the fact that they had something that no startup I have ever known has, which is millions of dollars in subsidized government loans. You

say you have been in business a while. Wouldn't you have loved to have those millions of dollars in subsidized loans? You say that they did not have information. Let us talk about that. By March 2014, two of the CO–OPs—this is 2014—CoOportunity and New York CO–OP, had already exceeded their high enrollment projections for the year. We talked about that as being one of the data points you are supposed to look at. They exceeded their scenario by more than 150 percent within the first month of enrollment. By the end of March 2014, New York CO–OP had more than doubled the high enrollment scenario in its feasibility study. There was plenty of information out there, and, again, you were not there. I am not blaming you personally, but for HHS not to take some responsibility or any accountability—were there any objective standards for deciding when underperformance would trigger an enhanced oversight plan?

Mr. SLAVITT. Yes.

Senator PORTMAN. And what were those?

Mr. COUNIHAN. Well, it depended. There was a series, Mr. Chairman, of what those could be. But one thing I would just like to note——

Senator PORTMAN. But what were the objective—because let me just tell you something so I am not surprising you. And, again, we gave you guys this report to look at, OK? And we are trying to be fair here. It is a thorough report. You gave us some comments. We took your comments. But here is what we heard from the person who is in charge of the CO–OP Program, the CO–OP director. She told the Subcommittee there was no standard, no objective standard. She said there still is not a standard, by the way. It is done on an ad hoc basis. That is information that we have. So to say that there is and was assurance objective standard for deciding when underperformance should trigger an enhanced oversight plan, that is not what we learned. So, as manager of this $2.4 billion portfolio, do you not think it would have been good to have some kind of a metric to decide when enhanced oversight was appropriate?

Mr. SLAVITT. So, thank you, and the thing that I would say is what I think the team does goes a level further than just having a standard rote plan. They really get into these businesses because they are at such an early and precarious stage. And as Kevin described, we sent our teams out into the field not just to evaluate but to provide technical assistance and the best advice that we can relative to how these CO–OPs perform.

I will tell you that even when we put a CO–OP on an enhance oversight plan, it is not a silver bullet because the reality is that CO–OPs themselves have to perform. They have to price right, they have to have a good enrollment strategy, they have to sell, they have to service. And the Departments of Insurance are watching them every step of the way to make sure that they are doing it right, and I think everybody watches with a set of nervousness because these are such early and precarious operations.

So it is absolutely at least—and I can speak more to the time since I have been here and since Kevin has been here, there has been very intense activity——

Senator PORTMAN. Let me just—not to interrupt, we are talking about 2014 into 2015.

Mr. SLAVITT. Yes.

Senator PORTMAN. And, I do not know what the level of losses needed to be. Certainly 300 percent was not enough. But you did not have standards in place that enabled you to react quickly enough to be able to save this hemorrhaging of taxpayer dollars and the dislocation to all those patients who lost their health care.

Senator Sasse, I will turn to you for questions. Sorry I am a little bit over my time. We will come back for another round, too.

Senator SASSE. Thank you, Chairman.

First of all, before I go to my questions, I just want to acknowledge something that Mr. Slavitt said a minute ago. I think you said that the CoOportunity failure should have been foreseen in 2014, should have never entered 2015. Is that correct?

Mr. SLAVITT. I think that is correct.

Senator SASSE. Well, thank you for that. That is a significant admission, so I appreciate your honesty on that.

More broadly, as far as distinguishing between different regulatory responsibilities at HHS and in State Departments of Insurance, I understood in your opening statement that you said many of these issues are failures of State Departments of Insurance, and I think you said that the primary responsibility of HHS was to maximize potential repayment of loans to the taxpayer. Is that correct?

Mr. SLAVITT. I would not use the word "failures," but I think you have the sense right of the delineation of responsibilities.

Senator SASSE. OK. So let us distinguish between CoOportunity, which you have acknowledged was a failure of oversight, should have never been able to go from 2014 to 2015, the next 11 that failed, and the 11 that remain. If one of your primary responsibilities is to maximize repayment to the fisc and to the American taxpayer, do you expect that there will be any repayment to taxpayers from CoOportunity?

Mr. SLAVITT. So I think it is too early to say, but let me walk you through how we are approaching this. I think that is the fairest way to answer your question.

Senator SASSE. The place is insolvent. They do not exist. You do not think they are actually going to pay any dollars back to the taxpayer, do you?

Mr. SLAVITT. Well, so there are three sources of funds that we look to, and the Department of Justice is in the lead on this, and I think they would be happy to answer your questions on these more specifically. And because I do want to maximize these recoveries, I do not want to say anything in this hearing publicly that is going to hurt my negotiating position or the position of the Department of Justice. But, briefly, three things that we look at:

First, after the CO–OP finishes paying claims, which for these 11 additional CO–OPs they are going to do roughly through the first 6 months of this year. Again, there is this lag effect. All the claims are still coming in.

Second, there are a series of receivables that we, as Mr. Counihan said in his opening statement, if you caught it, that we

have just put a hold on some funds that the CO–OPs have been expecting. That is a second source of funds.

The third——

Senator SASSE. What are those?

Mr. SLAVITT. They are receivables for things like the reinsurance payment, things like that.

Mr. COUNIHAN. Risk adjustments.

Mr. SLAVITT. And so that is the second source of funds.

And then the third source of funds is there are lawsuits and judgments both with contractors and vendors, and in many of these situations—and, again, I do not want to venture into someone else's fight. CO–OPs have felt poorly served by some of their vendors in terms of providing them enough financial information to see the full picture. That is also a potential source. So the DOJ, in looking at all three of those categories, is taking the lead and pursuing the Federal Government's interests. I think it will take some time to play this out in the case of all of these situations. Obviously, we do not expect 100 percent recovery or anything close to that. But we are expecting between those sources and the strategy that they pursue that there will be funds recovered for the taxpayers.

Senator SASSE. And if you had to guess, across the 12 failures, what percentage of their $1.2 billion do you think taxpayers will ultimately receive?

Mr. SLAVITT. I cannot guess. It would be irresponsible for me to guess. I also do not want to bias our opportunities here.

Senator SASSE. Would a fair bet on over-under between 100 bucks? I mean, they are not going to repay any of these moneys.

Mr. SLAVITT. I am not going to take that bait, because I want the Department of Justice, as they have asked me to do, to let them do their jobs.

Senator SASSE. To this point about what State Departments of Insurance, particularly in Iowa and Nebraska, should have done, if we can look at the exhibit book, page 35,[1] it reads that the cash on hand—or CoOportunity Health will ultimately be assumed to achieve a total enrollment of 66,101 by the end of year 2014, which is 55,000 more than original projections. That is pretty extraordinary.[2]

Mr. SLAVITT. I am sorry. Can you help me where——

Senator SASSE. On exhibit book, page 35——

Mr. SLAVITT. Am I looking at——

Senator SASSE [continuing]. The heading is——

Mr. SLAVITT. Is this what I am looking at?

Senator SASSE. Yes.

Mr. SLAVITT. OK. And where are the page——

Senator SASSE. Page 35 is essentially the CoOportunity additional solvency loan funding request report submitted to CMS in July 2014. The second page of that addendum, there is "Critical Assertions." Point 1 is about enrollment. There is an enrollment table there, and it says that CoOportunity—you do not have it?

Mr. SLAVITT. I am not seeing this.

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[1] The exhibit referenced appears in the Appendix on page 176.

[2] Additional excel exhibits are too large to be printed in the hearing record and are available on http://www.hsgac.senate.gov/subcommittees/investigations/hearings/review-of-the-affordable-care-act-health-insurance-co-op-program.

[Pause.]

Senator SASSE. So the overenrollment in CoOportunity is extraordinary, I mean, both of you having had private sector experience. I have not worked in the insurance space like you all have, but I have never heard of any startup business overperforming its projected volume of subscriber base by anything like this.

Mr. SLAVITT. Right.

Senator SASSE. I think you are going to say that this is primarily a Department of Insurance in Iowa and Nebraska problem, but I guess I have two lines of questioning there. One is: Were you talking to them? And if not, on what basis would you possibly have—your Department. I recognize that you were not there personally, but on what basis would your Department have possibly concluded that they were solvent and that their pricing was right? Because one more bit of context. Other insurers in the State and brokers in the State were talking widely across Nebraska that we have 93 counties, and we have two metropolitan regions, Omaha and Lincoln, and we have a whole bunch of cattle country. And pricing in rural places is complicated because you only have a couple of hospital systems. We have a Catholic health system, we have a University of Nebraska system, and you have a few small independent freestanding hospitals. And trying to project utilization and rates a year into the future is difficult, and so the insurers and the brokers in our State have a rough sense of how pricing should work, and everybody who knew anything knew that CoOportunity was pricing way too cheap. They did not know what they were doing. And yet you all gave them additional money.

So either you should have known that they were incompetent, or you are going to assert that the Departments of Insurance in Iowa and Nebraska should have known. And then I wonder if you were talking with them. On what basis would you make the decision to give them additional loans.

Mr. SLAVITT. I am not going to pass the buck. Looking at it, we both should have known, I think particularly relative to moving into 2015.

A couple things. As we have done our autopsy on that situation, we do think that they underpriced perhaps, and also that their benefit designs attracted disproportionately sicker populations. And when things go bad, they go bad fast.

So by no means do I want to point the finger at either Nebraska or Iowa State Department of Insurance. Kevin spent a ton of time talking to them, and so he can talk through a lot of—we were in constant contact, constant dialogue, because it is challenging. And when things start to go fast, they go fast in an awful hurry. So if someone beats their projections on revenue, some will look at that as a good thing. They will present that as, "Hey, look at how great I am doing. More people like our product." Others will look at it and say, "Well, gee, the reason you beat your projections is you underpriced your product." And because they do not have a chance to correct it until the next year, they have to live through the entire year with whatever price they set.

So the real decision point should have been what do we do about entering the next year, because that is the point in time when they should have known. Obviously, as you have pointed out and you

well know, the situation deteriorated pretty rapidly, and I think it became apparent to everybody involved and everybody looking at the data, both the departments and ourselves, that we should have taken action.

Senator SASSE. And, Mr. Counihan, I will go to you, and then I know that I have to yield back to the Chairman. But the 120,000 people who became uninsured in Nebraska and Iowa became uninsured with plans that they re-enrolled in in December 2014 and had knowledge basically that they were going to be uninsured by the end of January 2015. So as far as going bad fast, I will acknowledge that. And yet people who were uninsured for the 11 months of 2015, so obviously that is a complete regulatory travesty. But I think it begs questions not only about the decision to fund the additional loans, but what kinds of technical assistance was possibly——

Mr. SLAVITT. I think folks——

Senator SASSE [continuing]. Provided to these insurers.

Mr. SLAVITT. I am sorry to interrupt. I think folks got covered. About 40 percent of people in Nebraska opted for another plan. The other 60 percent were covered by the guaranty fund, and we can certainly talk about guaranty fund——

Mr. COUNIHAN. I do not think anybody lost coverage, Senator.

Mr. SLAVITT. There is a cost, certainly a cost to the State of the guaranty fund, typically borne by the insurers, and we can talk about the merits and the challenges of that. But our priority at the time was to set up a team to focus on each individual in Iowa and Nebraska and track their cases and make sure that people did get coverage. It was disruptive for them, so I am not going to excuse that. But we did track that.

Mr. COUNIHAN. Yes. And, you made some good insights about the market in Nebraska. Frankly, we depend on the Departments of Insurance to really have that same kind of insight, much more than we are going to have. The rates that you talked about are actuarially developed. They have to be presented to the actuary in the actuarial departments of each State Department Insurance. They are walked through; the assumptions are kicked. Those DOIs do a pretty good job of trying to understand what the rates ought to be, and we trust them. And as Andy said, we got intimately involved in that transition.

You look back and say, "Could we have done something differently?" In retrospect, you bet. But what we tried to do is acknowledge, move on, learn from it, and make sure that those patients in both States got coverage.

Senator SASSE. Thank you.

Senator PORTMAN. Thank you, Senator Sasse.

Let me just follow up on one of the questions you had, which is, will these Federal loans ever be repaid? And the answer was we are not going to talk about it, that the Department of Justice is working on it. The real answer, of course, is no. Our investigation shows that in the aggregate, the failed CO–OPs' non-loan—this is non-loan liabilities, that is, not even counting what they owe the Treasury, exceed $1.13 billion, which is 93 percent greater than the reported assets. So just in case you did not know that, if you get asked that question again, I think your answer is, "Where is it

going to come from?" I mean, we are talking about failed CO–OPs' non-loan liabilities, forgetting the $1.2 billion we talked about, exceed $1.13 billion, which is 93 percent greater than the reported assets. So I think it is a near certainty that you are going to have a complete loss here in addition to the dislocation that we talked about.

Let us talk for a second about another issue that was raised briefly but one that concerns me a lot, and I think continues to be a huge problem with the way in which this was handled back in 2014 and 2015, and that is the issue of unpaid medical claims. In certain States, as you know, there is a substantial amount of unpaid claims, and one example would be New York. Health Republic of New York currently has $157 million in assets according to the latest balance sheet. It also has $379.5 million in unpaid medical claims. So their unpaid medical claims are well in excess of their assets, a shortfall of about $221 million, even if all those assets were devoted just to pay the doctors and the hospitals and the clinics and the patients that relied on it for their insurance payments.

In other States, that shortfall might be covered your statewide guaranty funds, as was talked about today, including Nebraska, in which other insurance companies basically chip in to cover the losses, or sometimes it is an unfunded mandate on the States. But in New York, the CO–OPs' unpaid medical claims are not covered by a guaranty fund. So I guess, Mr. Counihan, my question to you is: What is going to happen to these claims? Doctors, hospitals, patients are likely to go unpaid, right?

Mr. COUNIHAN. I know the New York situation extremely well, Senator.

Senator PORTMAN. What is going to happen?

Mr. COUNIHAN. In all likelihood—I do not know the complete answer to that question yet. They are still going through a complicated wind-down process. So in all honesty, it is premature for me to say. But you are right in what you said, which is New York is a State that does not have a guaranty fund for health insurance. They have guaranty funds for many other insurance coverages. At present, they do not have one for health insurance.

Senator PORTMAN. The experts tell us that, if anything, the year-end claims numbers are likely to turn out even worse than they are now, that it is not going down, it is going up. And I just do not know how you can imagine that these claims are going to be paid when, again, you have a balance sheet that shows $379.5 million in unpaid medical claims, a shortfall over its assets of $222 million, even, again, if all those assets were just devoted to these unpaid medical claims.

Mr. SLAVITT. Yes, and I do not know that they are. I would like to——

Senator PORTMAN. You do not know that they are——

Mr. SLAVITT. I do not know that they are going to be paid. I would like, though, to talk a little bit about New York in this context. But I also have to say the numbers you quoted me about assets and liabilities, with due respect I need time to review this report. Some of our staff got to review it in camera yesterday, and I am not willing to accept that those are the accurate numbers until I have had a chance to review——

Senator PORTMAN. Well, Mr. Slavitt, with all due respect, you are a smart guy, why should we be having to give you numbers that are publicly available? Get the numbers yourself.

Mr. SLAVITT. I have—we have our numbers.

Senator PORTMAN. You should have already had these numbers. You are saying that you do not trust our numbers. Again, we showed you this report. We gave you the chance to respond to it. That is unusual, as you know. We made all the changes that you suggested. But you are saying you cannot trust our numbers. You should know these numbers. This is your job. Not to know what the assets and liabilities are of these companies. Let me give you some more numbers because they are accurate.

Our report points out that in three States with no guaranty fund coverage—in other words, no guaranty fund here—failed CO–OPs are reporting $500 million in unpaid claims and not nearly enough assets to cover them. And we are talking about New York, as I said, but also Kentucky, Louisiana. Imagine that. You sign up for health insurance in the Obamacare marketplace. You pay your premiums on time. You do everything right, and you play by the rules. And then your insurance company goes bust. And then what happens? The hospital can sue you for your unpaid bill, even though you have done everything right.

I mean, I just think it is amazing that you guys are not more concerned about this. Can you give all those patients assurance that is not going to happen, they are not going to get a bill and have to pay twice?

Mr. SLAVITT. We certainly are concerned about all these wind-downs, and these wind-downs are complicated processes both from the standpoint of the patients, who I think are the first priority, the physicians and hospitals who you discuss in the context of New York, and also the Federal Government interests. So, there are precedents through the course of history of health insurance companies winding down. There are processes that States run. States have jurisdiction over that process. We try to represent our own interests in that process, the Federal Government. But I will say we have—and you may criticize us for this, but we have released funds—in fact, we have released $30 million of funds last year under my authority to CO–OPs that were closing down so that they could pay claims for consumers. And you could argue that that was $30 million that could have been in the Federal Treasury, but we believed it was an obligation that——

Senator PORTMAN. Well, $30 million of taxpayer money. It is the same people. These are taxpayers who have found themselves losing their health insurance and now potentially facing claims from providers because their health insurance company that was a federally established, federally subsidized health care company went bust.

Mr. SLAVITT. Well, I can tell you——

Senator PORTMAN. There are some real human costs to this. Let me tell you what the New York CO–OP situation is, because you question our numbers or you have not looked at the numbers yourselves. This is how we got into that mess. It vastly overshot its enrollment targets while underpricing its premiums, leading to multi-

plying financial losses. And all this information was available to you guys.

In response, it considered scaling down its operations and reducing membership to a sustainable level, but HHS gave the CO–OP $90.7 million, so you are talking about giving them more money, which it used to scale up and add about 58,000 enrollees in 2015. OK? So you made it worse. The resulting losses led to a $544 million loss, sent those enrollees scrambling for new coverage, and, again, left doctors, hospitals, and patients with medical costs worth hundreds of millions of dollars. That is what happened. And so as you give out more taxpayer money, I hope you will look at that example of New York. And who did that help at the end of the day? It certainly did not help those individuals, those families who are now facing this prospect of having to pay twice and undergo the dislocation we talked about.

Mr. SLAVITT. I would like to try to respond, and in doing so, I want to make sure that in the course of saying I want to review your numbers, the more important point is not lost that if there are individual cases where individuals are in difficult situations and are not getting covered, we have a unit that is set up that looks at all these kinds of cases, and I want to know of any of these specific cases, because that will be a very high priority for us. So whether or not your numbers and our numbers match, that is less material to me than making sure that I communicate that if there are situations that you hear of in any of those States.

New York is an interesting situation, and Mr. Counihan will be able to talk about this because he spent days and days and days on end, did multiple trips to New York. We conducted separate special audits for New York. What is interesting about New York is when the original loan was made, as I look back on the Deloitte reports that were before my time, New York had scored over 90 percent, I think the highest if not one of the highest scores, and even when I hired an independent auditing firm when I took the job in February, New York was not identified as high-risk. And so there was a narrative or a belief, again, based upon the fact that claims had not come in yet from many independent sources, that New York was doing really well.

We saw some early warning signs, and Kevin and I ordered and independent audit and sent auditors up there in, I believe, the third quarter, and presented to the States and to the CO–OPs that they were going to see losses they had not yet expected. And I think what happened in New York, if I can get into the specific example, is their financial systems were not as accurate, and so the reports that they were sending us around the profitability of that large book of business was not accurate. And it was not until we did this independent audit—and you can correct me if I have gotten any of this in any way incorrect—that we realized that this was a situation that was going to come back and hurt them. And we spent a significant amount of time in the situation to try to prevent the damage that we are talking about right now. But, Kevin, you can add anything.

Mr. COUNIHAN. No, Andy. I think you said it well.

Senator PORTMAN. OK. Well, if there had been proper oversight back in 2014, we would have been able to address this issue, be-

cause they did overshoot substantially their enrollment targets. And, again, underpricing premiums, overshooting enrollment targets leads to this multiplying effect we talked about, and that is exactly what happened. And then we gave them more money, and it created even more problems. And that is the reality.

I want to give Senator Sasse the opportunity to ask a question. I will come back for one more round. Senator Sasse.

Senator SASSE. Thank you.

I would like to look at the report. I know that you said you have not had a chance to read all of it in detail, but I want to point to two pages that I think are fairly self-explanatory.

The main report that we are talking about today that was released, can we go to pages 56 and 57, "IV. Misconceptions Concerning the CO–OP Program." When I asked a few minutes ago if you really thought that any of these 12 failed CO–OPs were conceivably going to ever repay the taxpayer, you said that potentially their accounts receivable would become a source of some of the funding that might come back to the taxpayer. And I asked what that meant, and you said that the reinsurance program might be yielding funds for some of these failed CO–OPs.

If you would go with me to page 56 and 57, I would like—again, as the Chairman has said, these are publicly available numbers. I would like you to just walk me through what this table[1] means. I think what it means is that the CO–OPs had much healthier populations than the overall Obamacare or Affordable Care Act marketplace. And if that is true, this means that, on net, our CO–OPs paid in $116 million to the reinsurance program. They are not getting any money back. I mean, here and there you may have one. The Arizona example, Meritus Health Partners, I am not familiar with them. It says that they are going to receive $2 million of reinsurance payments. But, on net, these insurers, including CoOportunity in my State, if you look at CoOportunity on page 56, they, on net, paid in $6.4 million because they had healthier populations than the insurance marketplace as a whole, which I think, humbly, contradicts the entire line of answers you gave in our last exchange.

Mr. SLAVITT. Well, that would be bad if it did. I think the confusion—and these are complicated programs—is between risk adjustment, which you are referring to, and reinsurance.

Senator SASSE. OK, you are right. I should have used the term "risk adjustment." Let us go forward with that.

Mr. SLAVITT. So risk adjustment is one source, one potential source of receivable. So is reinsurance, and so is risk corridors, because no one really has a good feel for how much risk corridors are going to pay in the coming years, so those are reserved, separately.

So all three of those are potential sources of funds, and as I mentioned, we have just put a hold on tens of millions of dollars of receivables to CO–OPs that they have been expecting from those sources. So those funds are available.

Senator SASSE. OK, tens of millions. We are talking about $1.2 billion, though, so let us have our numerator and denominator right. I mean, how much are we talking about, $30 million?

[1] The table referenced by Senator Sasse appears in the Appendix on page 136.

Mr. SLAVITT. Correct—I do not have the exact figure, but I can get that to you.

Senator SASSE. What is that? That is 2 percent of the total we are talking about today. Let us say your tens of millions is $90 million. We are still at less than 5 percent of the real question here, right?

Mr. SLAVITT. From that particular hold, correct.

Senator SASSE. OK. Are there other sources?

Mr. SLAVITT. That hold does not represent the entirety of what the receivables would be. And, look, I know it would be helpful if I could give you an estimate, and I understand why you would want me to—why it would be helpful to give you an estimate. And I hope you understand why I am reluctant to start negotiating publicly some figure. And I also think it is irresponsible because I will be wrong almost no matter what number I say.

But to your general point, do I expect we are going to recover 95 percent or 100 percent of these loans? No, I do not.

Senator SASSE. But do you really expect we are going to recover 10 percent of these loans? You do not——

Mr. SLAVITT. I do not know. I do not know. I really do not.

Senator SASSE. What is the universe that could ever get us to 10 percent?

Mr. SLAVITT. I think I went through the categories. I do not know that I could be more specific. But I would be happy——

Senator SASSE. I know, but I do not want the categories. I want the taxpayers' money.

Mr. SLAVITT. I would be happy to followup, go through this report, which I have not had a chance to go through—I am sure there will be things in there that will be helpful to us; we do have our own sets of numbers—and sit down and try to see how much information we can provide you.

Senator SASSE. OK. Your distinction between risk adjustment and reinsurance and the risk corridors is important. Technically, obviously, that is true. But it is still based on the underlying premise that maybe the CO–OPs failed because they had a much sicker population. And I think what the risk insurance numbers on page 56 and 57 show us is that the CO–OP enrollees were actually healthier than the average population. So the broad ideas that these CO–OPs failed because they sort of accidentally attracted a much sicker population, I do not think we have any evidence that shows that to be the case.

Mr. SLAVITT. And I do not think I made that claim. If I did—certainly that would be a sweeping generalization that I would not make. And I also do not know that they had a healthier population because of the risk adjustment. I think the CO–OPs would tell you, many of the CO–OPs would tell you that they had a sicker population, but they were not able to get their numbers submitted for risk adjustment appropriately, and Kevin can walk through that, if you would like.

Senator SASSE. Sure, I would love to hear that.

Mr. COUNIHAN. OK. Well, essentially, Senator, the risk adjustment program is highly sensitive to claim coding and diagnostic codes. And if they are not done properly or thoroughly, that can have a real impact on the financials of that CO–OP and other risk

adjustment. And we clearly have a terrific example with one of those who has subsequently corrected that. Again, no heroes or villains. We are all learning, but that is very sensitive to that.

Mr. SLAVITT. But in a nutshell, their financial systems were behind at the time they made——

Senator SASSE. Understood. But I am not looking for villains. I am thinking we need to acknowledge the just utter incompetence of trying to essentially plan a program like this. So I am not asserting that anyone here is evilly motivated. But whether or not anybody is competent to oversee this program, I have not seen any evidence of that yet. So, humbly, I am not asserting villain. I am just saying that, the more you look at these numbers, the less plausible it is that anybody knew what they were doing when they looked at these CO–OPs when one of the sort of core answers for why this sub-segment of the larger Affordable Care Act population marketplace could have failed would have been because the CO–OPs attracted an unusually sick population. It does not seem like we have any evidence that suggests that, and it would appear, again, just based on the snapshot we have from the risk adjustment market, that a net pay-in of $116 million is not a net zero and it is not a net pay-out. I think your evidence would suggest these are healthier than average, which makes it even harder to understand how we would not have recognized that we were going to have a failure rate of more than 50 percent among the CO–OPs.

Thank you, Mr. Chairman.

Senator PORTMAN. Thank you, Senator Sasse.

We are in the third round here, Mr. Chairman, and I do not want to catch you unaware, but if you are interested in asking a question, I would like you to go before me since I know you have other hearings to attend.

Chairman JOHNSON. Go ahead.

Senator PORTMAN. All right. Well, let us followup on New York, because, Mr. Slavitt, you indicated that you all had spent a lot of time looking at that, and particularly you said that Mr. Counihan had spent time. You made a statement that said that you thought that your team, again, had done the best job they could with the information that they had. When HHS awarded additional solvency loans to these three failed CO–OPs we talked about—Kentucky, New York, and CoOportunity—when they were in danger of missing their capital requirements, you had to know they were in financial trouble and at risk of being shut down by State regulators. And yet you invested hundreds of millions of additional dollars in taxpayer dollars.

In your written testimony, you confirm what you said today. You say that in evaluating additional solvency loan applications, "CMS undertook a rigorous review process substantially similar to what was conducted for the initial round of loans." That is your testimony. Let us explore that for a minute. Let us take, again, New York as an example, because you both talked about that earlier, how you spent a lot of time on that.

Like all CO–OPs, its initial loan application involved third-party review of its business plan by Deloitte. We talked about the Deloitte review earlier, which included extensive discussion of the reasonableness of proposed budgets, finances, and business plans.

Let us turn to the first page, page 1 of the hearing exhibit package.[1] That is this package. On page 1, you see the analysis that Deloitte did of the New York CO–OP's application for an additional solvency loan. Right at the top, the first sentence reads, and I quote, "Deloitte will not provide an opinion regarding the reasonableness of the proposed changes to each CO–OP's business plan. Nor will Deloitte provide an opinion regarding the likelihood of each CO–OP achieving sustainable operations based upon the revised business plan."

So this notion that it was substantially similar to what was conducted in the initial round of loans is just not accurate. Deloitte did not provide the analysis. I am told, by the way, by some of your people that they said you guys did not give them enough time to do it because you wanted to get the money out the door. But Deloitte did not do that analysis.

In light of that, do you stand by your testimony that this review was rigorous and substantially similar to the review provided to initial loan applications which did include, again, this third-party analysis of whether the CO–OP'S business plans were reasonable?

Mr. SLAVITT. I do not, and I know I do not need to keep stipulating it was before my time, so—but I will say——

Senator PORTMAN. And I understand that, but in your testimony you are making the statements that are important for this hearing because we are talking about, again, this question of competence, as we said earlier, but also, accountability and what can we learn from this.

Mr. SLAVITT. Sure.

Senator PORTMAN. If you are saying everything was done right, we did the analysis just as we did with the initial loans, it is just not accurate.

Mr. SLAVITT. It is a fair question, absolutely. And I think the way I interpret Deloitte's statement here is that they are not ultimately accountable for these decisions. We are. And that is absolutely correct. The purpose behind hiring——

Senator PORTMAN. Well, wait. They are saying they did not provide an opinion. They are—period. Not that here is our opinion but you guys are ultimately accountable. They did provide opinions on the initial loans. We talked about that. We talked about it. You guys set up the standards. And I talked about the concerns that they raised in each of those where there should have been a red flag. But here they did not even do it. That is the point.

Mr. SLAVITT. I think the team, what they were doing, the risk committee, was getting multiple sets of eyes, and I think what the Deloitte team is saying is, Hey, you cannot count on what you are seeing from us to be what they are warranting, at least the way I read this, they are warranting that we should not count on their analysis in making this judgment. And I think that is——

Senator PORTMAN. They did not do an analysis. That is the point. So here is my question to you: Who did do the analysis? Who did do the analysis when additional taxpayer dollars were given to New York? Who did the analysis? We have asked you all this, by

[1] The page referenced by Senator Portman appears in the Appendix on page 142.

the way, for several months now, and we cannot get an answer. That is one reason I am asking you, because we do not know.

Mr. SLAVITT. I believe they did do the analysis. I believe they did not render an opinion.

Senator PORTMAN. Who is "they"?

Mr. SLAVITT. Deloitte.

Senator PORTMAN. No. Let me look at the document. This is page 1. Page 1 right here. This is from Deloitte: ". . . will not provide an opinion regarding the reasonableness of the proposed changes to each CO–OP's business plan. Nor will Deloitte provide an opinion regarding the likelihood of . . . sustainable operations based upon the revised business plan."

Mr. SLAVITT. Are you saying because they did not render an opinion they did not do an analysis?

Senator PORTMAN. Yes. Well, did they?

Mr. SLAVITT. Yes.

Senator PORTMAN. Why haven't you provided us that analysis?

Mr. SLAVITT. That is what it is. That is what this is. This is the analysis. They provided the analysis, and what they said is use this analysis, make your decision, but we are not providing an opinion.

Senator PORTMAN. Yes, and you are saying they did not provide opinions for the initial loans?

Mr. SLAVITT. No, I am not saying that. I am saying they——

Senator PORTMAN. Well, that is what your statement says. Your statement says you "undertook a rigorous review process substantially similar . . ." Do you think substantially similar means in one case there is an opinion, in another case there is not an opinion, and those are substantially similar? You did not give them enough time because you wanted to get the money out the door. That is what we are told. And so, I mean, look——

Mr. SLAVITT. I think I would find the work substantially similar enough that I would stand by that statement. Regardless of the fact that they said, hey, we are not willing to say that this is an opinion, I think the work is substantially similar. I understand you do not think that it is.

Senator PORTMAN. Yes, well, look, you probably had some internal experts analyze the question and, therefore, you felt like you did not need Deloitte to do it, which is probably what your more accurate answer would be. My view is you needed the third-party analysis and the third-party opinion.

Again, let us recap what happened in New York. Health Republic of New York applies for an additional solvency loan. It was projecting a loss of $62.8 million in 2014, $23 million in the next year, so we know the CO–OP's original business plan was not working. The original projections were wildly off the mark, as we talked about earlier. Its losses were 14 times greater. And yet you awarded the CO–OP an additional $90.7 million without having any third-party opinion as to whether its new business plan was reasonable or likely to work. And the consequence was that the CO–OP lost $77.5 million in 2014, $544 million—more than half a billion dollars—in 2015. And, again, we talked about the consequences of this, the human toll, which is families, individuals not just having to be dislocated, but now facing the possibility that these claims that have not been paid—doctors, hospitals,

clinics—could come back on them. So they paid once; they paid their premiums. They did everything they were told to do. And now they have this risk.

So I guess I would hope that you would say if you had to do it over again, you would actually ask for that third-party analysis that you—and opinion that you had in the initial loans that you say were substantially similar.

With that, let me turn to the Chairman of the Committee who has joined us and thank him for his help with regard to PSI generally, but specifically on this investigation. Senator Johnson.

Chairman JOHNSON. Thank you, Mr. Chairman, and I appreciate you calling this hearing. I apologize I could not be here earlier. I was at a Senate Foreign Relations business meeting, which had some important resolutions we had to be passing. So I missed a lot of the detailed testimony and questions and answers, and I really do not want to hop into where some other people have tread.

Let me kind of pull back and let us go to the obvious. Mr. Slavitt, your background is in the private sector, correct?

Mr. SLAVITT. That is correct, Senator.

Chairman JOHNSON. You came from Optima, which is a division of United Health?

Mr. SLAVITT. Optum, yes.

Chairman JOHNSON. What was the average profit margin of United Health after tax?

Mr. SLAVITT. Four, 5, 6 percent perhaps.

Chairman JOHNSON. Relatively low. I mean, on average, public corporations have pre-tax about 10 percent and after-tax about 5 percent, correct?

Mr. SLAVITT. Yes.

Chairman JOHNSON. Not a wildly profitable or outrageously profitable type of industry, correct.

Mr. SLAVITT. That is correct.

Chairman JOHNSON. From your standpoint—again, I know you are new to the position—wouldn't you have kind of real concerns as a private sector insurer under the old system that when the government set up a bunch of these CO–OPs, that they were going to subsidize them with these risk corridors and these reinsurance plans, weren't you a little concerned that maybe these CO–OPs might tend to try and gain market share by underpricing their premiums?

Mr. SLAVITT. So, you ask a really good, difficult question.

Chairman JOHNSON. So I would like just a basic, obvious answer to it. From the private sector, isn't that a real legitimate concern? And isn't that exactly what happened?

Mr. SLAVITT. Well, so these companies entered markets that had not had new competitors in many cases in decades. So, of course, I think you are correct, the companies would not like to see someone come in and offer more——

Chairman JOHNSON. It is not what the company—I am saying what was the natural result of what was going to happen with these government-run CO–OPs? Because they were going to come in, they were going to try and gain market share, they were going to underprice their product based on what their loss ratio would be, correct?

Mr. SLAVITT. Well——

Chairman JOHNSON. And isn't that exactly what happened? Isn't that exactly why the American taxpayers are on the hook for about $2.5 billion now in loans?

Mr. SLAVITT. So these were loans to local nonprofit companies who I do not think had as a goal—I would not imagine they had as a goal to price themselves out of business. I think they clearly in many cases——

Chairman JOHNSON. That is exactly what happened, though, correct?

Mr. SLAVITT. That is correct in many cases, yes.

Chairman JOHNSON. In the private sector, did you ever believe for a moment President Obama's insurance—that under Obamacare the cost of family health care would decline by $2,500 per year?

Did you ever think that was possible coming, again, from the insurance industry, where you know that the profit margin is about 5 percent? There is about $1 trillion of the $2.8 trillion that we spent annually in 2012 runs through insurance companies. The average after-tax profits of the top seven is about 4.4 percent. So, again, that is about $45 to $50 billion of profit out of a $2,800 billion a year market. Did you ever think for a minute that this government-run health care system would actually deliver health care costs $2,500 less per year per family?

Mr. SLAVITT. So the way I interpret that $2,500—and maybe I am not interpreting it correctly—is that that would be the reduction in health care cost trend under the Affordable Care Act, which——

Chairman JOHNSON. Do you think that is the way the American people heard that?

Mr. SLAVITT. I think that is how some people heard it.

Chairman JOHNSON. You think that is what the majority of Americans heard when they listened to President Obama and supporters of the bill promise that if you pass this wonderful bill, the average cost for insurance per family is going to decline by $2,500? Do you think people thought, well, that will just be—otherwise, it would go up higher by $2,500.

Mr. SLAVITT. When I look at the text of that statement, yes, that is how I interpret it, and also that 20 million new people have health insurance and we have an uninsured rate below 10 percent. I think all of those things—I do not think anybody could have perfectly predicted the outcome of a new law of this size and complexity. And I think there are certainly some very good things and certainly some bad things and some challenges, and we are talking about one of the biggest challenges——

Chairman JOHNSON. In your private sector experience, did you ever participate in high-risk pools in different States?

Mr. SLAVITT. I am aware of them, sure.

Chairman JOHNSON. OK. Another problem Mr. Obama made and other supporters of the bill made is that if you like your health care plan, you can keep it, period. Again, coming from the private sector, understanding how those high-risk pools—by the way, we had one in Wisconsin. About 22,000 people were getting coverage that they liked, that they could afford. Coming from the private

sector looking at the Obamacare law, you knew in the private sector those high-risk pools would be gone, correct? That people that were being insured under the high-risk pools would not have access to those health care plans, correct? Did you have any doubt that those things would survive? In other words, did you believe President Obama's repeated assurance and promise that if you like your health care plan, you can keep it, period? Did you ever for a minute believe that claim?

Mr. SLAVITT. Well, what I believe was that there would be guaranteed coverage in the marketplace so that everybody could get coverage. Whether or not——

Chairman JOHNSON. So, in other words, you did not believe President Obama's claim that if you like your health care plan you can keep it?

Mr. SLAVITT. I think what happened was there were folks that had coverage that was below a standard that the Affordable Care Act set, and some of those people did, in fact, lose their coverage, as you well know.

Chairman JOHNSON. You also understand that insurance products change as networks narrow.

Mr. SLAVITT. Sure.

Chairman JOHNSON. People might lose—if they lose a health care plan, let us face it, they lose a plan they could afford, that they liked in a high-risk pool that gave them access to a doctor. If they were forced onto a different plan, maybe a comparable plan, maybe one with better deductibles, although it has not happened, that being forced into another health care plan might cause them to lose access to a doctor they trusted, correct?

Mr. SLAVITT. The Affordable Care Act created a higher standard——

Chairman JOHNSON. So President Obama's repeated assurance that if you like your doctor, you can keep that doctor, period, was incorrect, wasn't it?

Mr. SLAVITT. Here is my perspective——

Chairman JOHNSON. No. I just really want an answer to the question.

Mr. SLAVITT. I think hospitals and physicians have been moving in and out of health care networks for 20 or 30 years, and I do not think anything in the Affordable Care Act changed that fact. So, yes, I guess is the answer to that.

Chairman JOHNSON. I mean, my point is that those promises by President Obama were ruled PolitiFact's 2013 Lie of the Year. Coming from the private sector, had you made those kind of assurances to your policyholders, do you think your company would still be in business? Had your business, had you as the CEO or as a senior manager of one of those businesses conducted that level of massive consumer fraud, what would have happened to a private sector business? You would not be around, would you? You would be facing an enormous number of lawsuits.

Mr. SLAVITT. I think our interpretations are a little bit different, but I understand your point.

Chairman JOHNSON. So, again, getting back to the issue at hand, part of this hearing, is that CMS has loaned $2.4 or $2.5 billion to CO–OPs that obviously were not going to be able to survive. We

continued to pump money into these CO–OPs knowing they would never be able to repay them. You have not done the due diligence. The review of these things have not been rigorous. It was obvious they were never going to be able to pay them back. Now the American taxpayers are going to be on the hook for about $2.5 billion, and that is assuming you do not continue to pump money into these failing enterprises. Anybody want to refute that?

Mr. SLAVITT. I guess what I would suggest—and I do not know that I will not repeat a lot of the things that we have said so far today, but, clearly, starting up a small insurance company is one of the biggest challenges imaginable, particularly because, as you said, they face significant entrenched competitors with years of history, thousands of people, and these are small enterprises. And I think it is very fair to say that the risk of failure of these CO–OPs is quite high.

What we have tried to do to the best we can—and I think we will accept our share of responsibility and criticism certainly—is to oversee these programs, to maximize the opportunity, to get these CO–OPs through the early 3-to 4-year startup stage to a point where they can be stable, and the Federal taxpayer can get its money back. In some cases, we have not been able to do that, and in some cases, those companies have not put forward strategies which have succeeded in those markets. And I would certainly acknowledge that, Senator.

Chairman JOHNSON. That is great you are accepting the responsibility, but the American taxpayer will be on the hook for the $2.4, $2.5 billion, and that is unfortunate.

Thank you, Mr. Chairman.

Senator PORTMAN. Thank you, and, again, gentlemen, thank you for coming today and giving us your perspective. I want to just end, if I could, on two points.

One is there was a discussion earlier about the States' role here, and I just wanted to be very clear about one thing, and I am happy to hear your response to this. But to shift the blame to the States I think is inappropriate. HHS had authority and sole authority to be able to stop these disbursements when it became clear that the CO–OPs were not likely to be financially viable and sustainable, and we have talked a lot about that today. It is not the States. The loan guarantee does not give that power to the States. It says HHS, and I quote, "has sole and absolute discretion" to terminate a loan agreement, and HHS had the power to withhold these disbursements when the CO–OPs did not perform under the corrective action plans we talked about, which were not put in place—for 5 of the 12 failed CO–OPs, they were never put in place. Never. For another five, you waited until September 2015. So I just want to be clear in the record here, and I would be happy to hear your comments on this, that shifting the blame to the States is not where the appropriate accountability ought to be here. It was HHS, despite plenty of warnings, that watched these CO–OPs lose, on net, about $1.4 billion, even as they failed to take corrective action for more than a year, and in some cases, again, not at all.

Any comments?

Mr. SLAVITT. Sure. You are correct, there is no question that we had the discretion to hold back cash to disburse from these CO–

OPs. And in about a third of the cases, when the team had a request for cash, the team did not make that disbursement. But I think the challenge—and I think it is the challenge that we have, and it is an important question—is ultimately if we do not disburse the cash at some point to a startup CO–OP, we are most assuredly putting that CO–OP out of business and most assuredly putting some of their consumers at risk.

So the team has to make very tough choices. If they fund the CO–OP, there is certainly not going to be any guarantee that those CO–OPs are going to succeed if they fund the grant that has already been made. If they do not fund it, they are almost certainly putting them out of compliance and putting them out of business. So I do not suggest for a second that the team made every decision the right way. I would suggest that it is not as if the team was turning a blind eye and that there were lots of good choices in this oversight process. As you very well know, overseeing a small company in a complex environment is challenging, and I will say that in my defense of the team, it is not a defense of every decision they made. It is certainly not to point fingers at the States. It is to say as I have gone back and continually tried to ask the questions with the information that they made available, given the two choices they had, and I think notwithstanding the fact that we could put them on an oversight plan, at the end of the day if we do not withhold cash, you cannot force an action. And once we withhold cash, people do not get paid, claims do not get paid, and the loans never come back to us. And that is the difficult challenge that we faced, and recognizing that your report suggests that you think we could have done a better job.

Senator PORTMAN. Well, again, there were plenty of tools, including the corrective action plans we have talked about and the enhanced oversight plans, short of even terminating. But the reality is there are 700,000 consumers who now find themselves not just, again, dislocated, but some of them actually facing the possibility of paying twice, once for their premium and now for claims that were never paid to health care providers. And that is a tragedy.

We thank you for your testimony today and appreciate it. We will go on to the second panel. Thank you.

[Pause.]

Dr. Harrington, thank you for being here. We are going to move ahead quickly here because we have a vote coming up, and we have lots of questions for you, and I know you have a presentation for us.

Dr. Scott Harrington is the Alan B. Miller Professor of Health Care Management, Insurance, and Risk Management, and Business Economics and Public Policy at the University of Pennsylvania Wharton School. He is also the Chair of the Health Care Management Department. He is a Senior Fellow with the Leonard Davis Institute for Health Economics and an adjunct scholar at the American Enterprise Institute and was president of the American Risk and Insurance Association and Risk Theory Society. His recent policy research focuses on the Affordable Care Act's impact on insurance markets and insurance financial regulatory issues. He is a true expert, and we appreciate his input to our report and his being here today.

We look forward to your testimony. It is the custom of the Subcommittee to swear in our witnesses, Dr. Harrington, so if you would not mind, please stand and raise your right hand. Do you swear the testimony you are about to give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. HARRINGTON. I do.

Senator PORTMAN. Excellent. Let the record reflect the witness answered in the affirmative. Your written testimony will be printed entirely in the record, as we have talked about, and we would ask you to try to limit your oral testimony. I think we initially asked you to do it in 10 minutes. If you would do it even a little shorter, that would be great just because I know we are going to have some questions for you. But, again, thank you for your input today, and we look forward to your testimony.

TESTIMONY OF SCOTT E. HARRINGTON, PH.D.,[1] ALAN B. MILLER PROFESSOR, AND CHAIR, HEALTH CARE MANAGEMENT DEPARTMENT, THE WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA

Mr. HARRINGTON. Thank you, Chairman Portman and Chairman Johnson. I publish widely on insurance pricing and price regulation, capital and insolvency risk, the causes of insolvencies, solvency prediction and regulation, risk-based capital requirements, and State guaranty funds. I have done some prior work on CO–OPs' financial conditions. I have not read the Majority Report. I have not seen anything about corrective action plans. I did review a lot of documents for preparing my testimony, especially for Iowa, Nebraska, New York, South Carolina, and Tennessee, including business plans, feasibility studies, pro forma financials, pricing analysis, additional funding requests, Deloitte reviews, and some financial information provided to the Subcommittee staff.

As we know, the CO–OP Program ultimately awarded $2.44 billion of low-or zero-interest Federal loans to 23 CO–OPs; $358 million was for startup loans, $2.09 billion was for solvency loans to meet State regulatory capital requirements.

Twelve of the CO–OPs have closed. The longevity of the 11 CO–OPs still providing coverage in 2016 is uncertain. Future closures seem likely. Eight of the 11 are reported to be subject to some CMS corrective action plan.

The closed CO–OPs' ultimate deficits are going to depend on the resolution of a lot of claims, and the final tally of what their claim costs are, as I will elaborate a little bit, very little, if any, of the $1.24 billion in Federal loans will be repaid from those closed CO–OPs. At least several will be unable to meet their obligations to enrollees and health care providers, and some will require significant State guaranty fund assessments.

The CO–OPs did face significant operational challenges, and the ACA 2014 reforms posed major challenges and risks associated with pricing and utilization of the previously uninsured and transition of previously insured people to ACA-compliant plans. The CO–OPs were inherently vulnerable to unpredictably high claim

[1] The prepared statement of Mr. Harrington appears in the Appendix on page 60.

costs, including from any adverse selection from established carriers renewing their pre-2014 plans, especially if enrollee growth outpaced projections. They had little ability to diversify pricing and claims risks across geographies and products. CO–OPs had none of their own experience and data to consider in pricing. They were plausibly prone to a winner's curse, pricing too low, generating large enrollment and losing lots of money. Pricing uncertainty remained high for 2015 premium rates, which had to be filed in the summer of 2014 when the CO–OPs still had relatively little data to assess claim experience in the adequacy of premiums.

Insurers must hold substantial capital to achieve a high solvency probability. Academic literature stresses that insurers and other financial firms' solvency incentives depend on the amount of owner's capital at risk, on the firm's value as a going concern, which could be lost in financial distress, on the sensitivity of customers' demand to insolvency risk, and on external monitoring by lenders and other counterparties.

CO–OPs' financial strength, growth, and potential for underpricing should have been a central focus from the program's inception. CO–OPs faced considerable pressure to capture market share. They had almost no private capital, no going-concern value, no financial ratings, and it was likely that many potential customers would be insensitive to insolvency risk.

Very importantly, history indicates that insolvent insurers often have charged low prices and grown rapidly with inadequate reported claim liabilities, ultimately producing claim costs much larger than reported. There is also risk that insurers will try to grow their way out of financial trouble, hoping, or gambling, for survival. This history and context also suggest that CO–OPs' financial strength and potential adverse consequences of rapid growth should have been paramount, especially given slow development of information on claims.

The approved CO–OPs' award applications included detailed business plans, feasibility studies, including actuarial projections of growth, profitability, and ability to repay government loans. Originally, their startup loans were recorded as debt on their financial statements. But to meet State regulatory requirements, all solvency loans were treated as "surplus notes," subordinate to all claims and counted as capital for the purpose of meeting regulatory requirements.

Actuarial analyses supporting solvency loan awards and disbursements relied on pricing, claim cost, and enrollment assumptions over a long horizon. The analyses I reviewed contained what I would consider modest stress tests. They did not combine or consider much higher than projected enrollment, combined with worse than expected claim costs. The baseline pricing assumptions, however, did build in something for a potentially sicker population.

Now, as we have heard this morning, some CO–OPs experienced vastly larger enrollment than projected, greatly increasing their need for capital. This should have been a cause for alarm. Those CO–OPs generally had low premium rates compared with competitors. Other CO–OPs generally with relatively high premiums had very low enrollment in 2014. Some CO–OPs continued rapid growth in 2015, further increasing their need for capital. Some

with low enrollment reduced premium rates and grew rapidly in 2015.

Six CO–OPs were approved for $355.5 million in additional solvency loans in the last 4 months of 2014. Three later closed. The regulatory takeover of CoOportunity Health in late December occurred just 6 weeks after disbursement of its additional $32.7 million solvency loan award approved in September, and following the denial of a late October request for another $55 million.

Health Republic of New York sought an additional $70.5 million in late October 2014, which was denied following CMS approval of an additional $90.7 million in September.

The additional solvency loans exhausted the CO–OP Program's $2.44 billion in funding. CMS did not have the funds to approve additional requests from CoOportunity Health, Health Republic, or any other CO–OPs. With State regulators' approval, however, CMS permitted seven CO–OPs to convert startup loans to surplus notes so that they could be counted as capital for meeting target capital requirements. Five CO–OPs converted a total of $82.1 million in startup loans to surplus notes before their closure. CMS also accelerated disbursements of solvency loan funding to many CO–OPs during 2014 and 2015.

A couple quick comments on growth, and we have heard this this morning. By September 2014, CoOportunity Health had over eight times the originally projected number of enrollees for 2014 and 14,000 more enrollees than projected for 2020. It generally had the lowest rates in Nebraska and the lowest rates in the Iowa small group market and the lowest rates in at least one rating region in the Iowa individual market.

Regarding New York, Health Republic of New York, its June 2015 enrollment was over four times the baseline 2015 projection, over three times the projected high enrollment scenario for 2015, and more than double the baseline projection for 2020. Health Republic generally had the lowest premiums in the regions it operated. It received rate increases for 2015, but its rates still generally remained low compared with competitors.

I have done some analysis to back out the ACA risk stabilization programs just on Health Republic of New York's June 2015 financials. If they had received their entire risk corridor requested at that time, they still would have lost $50 a month for their entire 18 months of operation on a per member basis. Without risk corridor receivables, they were losing about $150 per month.

Updated financials provided to the Subcommittee for 10 other closed CO–OPs suggest little, if any, of their Federal loans will be repaid. Assets were less than claim and other obligations for 7 of the 10 and only marginally greater than those obligations in the other three States. Colorado and South Carolina project substantial guaranty fund assessments.

The CO–OP Program's experience raises a number of key questions—beyond the fundamental issue of whether the program made economic sense when enacted, which, while difficult to do, should be evaluated without the benefit of 20/20 hindsight. I will quickly conclude with these.

First, was it appropriate and prudent to push for the CO–OPs to begin operations in 2014 as opposed to wait a year or two before selling tens of thousands of policies in an uncertain environment?

Second, why were the low premium rates charged by some CO–OPs not viewed as a signal of potential trouble from the get-go, especially when their plans and rate filings anticipated relatively high provider reimbursement and administrative expenses?

Third, why were some CO–OPs permitted to enroll far more customers than their projections as opposed to having some formal or informal speed limits imposed by CMS and/or State regulators?

And, fourth, why didn't CMS delay solvency loan disbursements or possibly terminate loan agreements when confronted with enrollments far greater than projected and early evidence of operating losses?

My time is up, so I am happy to take questions.

Senator PORTMAN. Thank you, Dr. Harrington. You were right on time for what we asked you to do, and you have asked key questions, many of which, as you know, have been discussed today with HHS.

I would like to go to my colleagues first for their questions in that they have come back to the hearing. I know they are busy. We have a vote at 11:30, so we will try to keep the questions and answers as short as possible. Senator Johnson.

Chairman JOHNSON. Thank you, Mr. Chairman.

Dr. Harrington, I want to kind of just go to basic economics on this. Let us talk about premiums that real people would be paying. We have Janice Fenniman in Spooner, Wisconsin, who, before the health care law was implemented, was paying about $276 per month. This year she is paying $787 per month. I held a telephone town hall yesterday, and I do not have permission to use the gentleman's name, but he was claiming that, prior to Obamacare, he was pay $400 a month; now he is paying $1,000 per month. And, by the way, these are for lesser policies. Their deductibles are higher. Their premiums are higher.

Because of the CO–OPs—and, again, as I said in my earlier questioning, to me, a private sector guy, it was obvious what was going to happen here. I mean, you used the words "inherently vulnerable." It was obvious what was going to happen.

The experience people have already had of skyrocketing premiums, these have been actually constrained because of these CO–OPs, correct, in the marketplace? They are underpricing their premiums, which puts pressure on the other health insurers. So, if anything, premiums have not skyrocketed to the point they are going to. Would you agree with that?

Mr. HARRINGTON. I would agree that at least in 2014 and 2015, the CO–OPs had a restraining influence on premiums. I am not as sure about 2016 because I have not reviewed the filings.

Chairman JOHNSON. Well, kind of the game is up right now, but going forward, we know how these losses are going to be recovered. Certainly, the American taxpayer lose the loans, but also the payments to providers, these losses are going to be spread over other insurers in States, and then their reaction is going to be what?

Mr. HARRINGTON. Well, I think the big issue is that it is becoming more apparent that the cost of the new risk pools under the Af-

fordable Care Act is higher than anticipated, and that that will produce higher premiums, and that the rating restrictions in the Affordable Care Act are going to lead to especially high premiums for certain cohorts.

Chairman JOHNSON. Describe that in greater detail. What do you mean certain cohorts?

Mr. HARRINGTON. I think one thing that has happened is that prior to the Affordable Care Act rating restrictions, people in, say, their 50s and 60s that were in relatively good health were able to get premiums on a risk-rated basis, guaranteed renewable coverage so that their rates would not go up with deterioration in their health status. Under the new regime, if you are not eligible for any kind of subsidy, you now have to buy insurance in a risk pool that limits the amount that can be paid based on your age, but, nonetheless, is based on a risk pool that includes lots of unhealthy people.

So I think more and more evidence will show that healthy people that try to buy coverage outside of an employment-based market going forward, if they are in their 50s and early 60s, probably are going to face quite a bit higher premiums than what they would have prior to the Affordable Care Act. So that is one of the cohorts.

The other cohort would be very young people that are facing higher premiums because of the rating restrictions.

Chairman JOHNSON. We have already seen that the first year in Wisconsin. A 27-year-old male I think on average experienced like a 127-percent rate increase; a 27-year-old female, a little under 100 percent, still, dramatic increases.

Let us talk a little bit about adverse selection and the gaming of the system. We have heard anecdotal reports of this, of people—one of the reasons you need a high level of participation in dental insurance, for example, is otherwise people will just delay getting dental care until they have one month's worth of premiums and go in there and get all their care and then they stop coverage. Isn't that also what is going to happen with Obamacare? To a certain extent. I mean, you cannot totally predict, but you can certainly time certain medical procedures and people will game the system, correct?

Mr. HARRINGTON. Yes, to a certain extent, and the evidence is that it is occurring not only in open enrollment but in special enrollment periods.

Chairman JOHNSON. Our Committee staff did a pretty good job looking at the fact—President Obama said, Trust me, no illegal immigrants are going to be qualifying for Obamacare. But the way they set up the system is CMS is forced to enroll individuals without documentation of eligibility. And so what has been happening is people sign up, they get the subsidies, they get the prepaid premium tax credits. They also get some tax credits or subsidized deductibles and that type of thing as well. Our Committee report showed that about $750 million of prepaid premium tax credits were paid on behalf of individuals who in the end were unable to prove their eligibility. Just speak a little bit to that in terms of, again, that was just totally predictable, correct?

Mr. HARRINGTON. I have not studied the particular issue. I am familiar with the reports. I think anytime you impose a gigantic

program with mind-numbing complexity, there are going to be many slippages and unintended consequences.

Chairman JOHNSON. Let me finish up, because I know one of the big reasons people passed Obamacare is they just hated the idea of anybody making a profit off of health care. So I just kind of want to go through the actual figures. This was in 2012. America in total spent about $2,800 billion, about $2.8 trillion worth, $2,800 billion. I have just taken a look at the profitability of the top seven companies in health care for 2012, and the after-tax profits are about 4.4 percent. Of the $2.8 trillion, about $1 trillion of that is paid through third-party payers, basically insurance companies. So if you take 4.4 percent of $1 trillion, that is about $45 billion of profit out of an industry, a sector of the economy that is $2,800 billion large. Does that seem like a grotesque level of profit to allocate pricing efficiently and do all the things that a free market system actually does? Is that out of whack?

Mr. HARRINGTON. No.

Chairman JOHNSON. And what is the result of having government come in there and try and stamp out literally 1.6 percent—that is what that profit represents, 1.6 percent of total health care spending was profit of insurance companies. And in order to wipe that out, which is really the goal of Obamacare, take a look at the dislocations. We have again, Janice Fenniman paying $276 before Obamacare, now paying $787 for a lesser policy. In the end, do you think this is a pretty foolish law, a pretty damaging law to real people?

Mr. HARRINGTON. I opposed the law when it was enacted. I think there were better ways of promoting the growth of insured people in the United States than passing this particular law.

Chairman JOHNSON. I would agree with that assessment.

Thank you, Mr. Chairman.

Senator PORTMAN. Thank you, Chairman Johnson. Senator Lankford.

Senator LANKFORD. Thank you, Mr. Chairman.

I appreciate you being here and bringing some other facts to bear in this. Like others on this panel, I would tell you that person after person that I talk to in my State, in Oklahoma, talk to me about the same issue. They are spending more on health care than they ever have. Their deductibles are high. All their premiums are going higher. They have fewer options than they had before. The hospitals that I talk to now have more benevolent care than they have had in the past because though they have "insurance" when they walk through the door, they cannot afford to use it. We have failed State exchanges around the country from States that tried to start their own exchange that have gone through the process, and that is millions of dollars that has been lost in that process.

And then when we walk into the CO–OP issue, and it is one more piece of this process where in the original design there would be these nonprofit institutions that would stand up to go compete. In theory, they would be nonprofit insurance institutions that were created to compete in areas where there was not good insurance available or was not enough available.

So my initial question to you is: Did you find the CO–OPs and their distribution around the country to be in places where insurance was not available?

Mr. HARRINGTON. That is an excellent question, and I have not studied that.

Senator LANKFORD. What I have seen is that they were not competing in areas where they were not available. They were trying to startup in places where there was a good market already. And if there is a good market already, there were other companies that are already available in that area.

We put out loans that they expected to have a 40-percent loss rate, which, by the way, the Consumer Financial Protection Board (CFPB) is aggressively going after payday lenders who have a 40-percent loss rate on it, a 40-percent interest rate that they are putting down, and for whatever reason, they thought that was a good idea at the beginning to do this with the CO–OPs, which is baffling to me. But then they seemed to also have this unique challenge in places that they were in that I am trying to determine what happened here. When the CO–OPs came in and gave arbitrarily low amounts that were not business possible—and that has been proven now by more than half of them already failing and the rest of them struggling. They put out a pricing strategy. Other companies in the area, other insurance companies in the area, had to try to compete with those CO–OPs that had these arbitrarily low costs on it that were clearly not sustainable, which forced them down, which I believe some of those insurance companies have now left those markets. We have many States that have fewer insurance options now, not only the CO–OP leaving but other companies leaving as well.

Do we know a connection here, or is it too early to know whether the CO–OPs in those markets were driving prices low, forcing other companies to have to try to compete with them, and then now they have since left the market as well, giving even fewer options to the consumer?

Mr. HARRINGTON. That is an issue that really needs to be subject to high-quality investigation and research. Clearly, in principle, low prices can have a negative effect on the market overall when they are written really well below what the consensus estimate of costs is. And I think we will find out more over time as people start to dig into this.

I would add that, of course, there was a lot of variation in 2014 among the 23 CO–OPs. Some had relatively high prices. They sold very little business. So in those cases, any negative spillovers from pricing were not there. But in a few cases where we had this enormous explosive growth during 2014, I think it is at least plausible that there were adverse effects in terms of pricing in the overall market that could have contributed to poor results in the overall market. But one thing we know for sure is that when you have a new entrant with no experience that comes in with a very low price, someone should be paying very close attention to their early enrollment and getting whatever data they can about early claims and really asking the hard question of: When is enough enough? Should we not be putting some sort of speed limit or brake on this

enrollment so that they cannot run up an enormous tab that they will not be able to pay?

Senator LANKFORD. So if the CO–OPs were competing on the open market and they were trying to get private lending, private capital either from a bank or outside equity groups, would they have been able to get these loans in your suspicion based on their model? CMS has testified that only 16 percent of the applicants actually got the loan, which gives the impression, we were very limiting, 84 percent we returned away, so we really were getting the cream of the crop. Obviously, the cream of the crop, more than half of them are now out of business.

So my question is: Of the business models that were presented, could they have gotten private funding? Or are these individuals presenting a business model that only government would have actually provided a loan for them?

Mr. HARRINGTON. That is an important question. The business models that I reviewed, I think it would have been really difficult to make a sell to any private investors with those models. What private investors would be looking for is: Do you have something here that we really think is disruptive and beneficial that will allow you to have a better model going forward? And I think it is highly unlikely they would have seen that.

Now, I hasten to add that some significant private money has gone into health insurance startups, and some of them have reported pretty large losses for 2014 and 2015. So private investment does not have a monopoly here on any kind of wisdom.

Senator LANKFORD. Right, but private investment is also tracking the day-to-day operations, trying to figure out are you going to make it, are you not going to make it. Are we going to keep dumping money into this? Or are we going to force you to make some changes internally to actually be successful?

Mr. HARRINGTON. Yes, and private investment in these sort of situations, the money will be paid out over time based on clear evidence that the performance is being met, and if there are warning signs that things are problematic, the spigot gets shut off.

Senator LANKFORD. Rather than changing the rules and saying, OK, you can now use this money and count it as capital and count it as assets, and the rules change through the middle of it, they are not going to do that in a private setting.

Mr. HARRINGTON. No.

Senator LANKFORD. Let me ask another question that is a quick one as well. The CLASS Act was a long-term-care insurance program that was created by Obamacare. At the very beginning it was studied to be implemented, it was in the law, do it. Secretary Sebelius came out and said this is totally unsustainable at the very beginning and said if we try to implement this, it cannot be done under this current model. Congress agreed, in 2013 to pull out the funding for that program—that program went away.

They saw immediately that the long-term-care insurance that was put into place is not sustainable, studied it, and pulled it. The CO–OPs, they aggressively went after, started it, and put $2 billion into something that we are now discovering is just as totally unsustainable. What is different about the CLASS Act and their research behind the scenes or the CO–OPs?

Mr. HARRINGTON. That is a very difficult question. I think one thing that is different, as I recall with the CLASS Act, you had various independent government agencies doing the actuarial projections and forecasts with an eye toward budget implications from the beginning, and recognizing that the program had to be financially sustainable in order to go forward.

In the CO–OPs' case, there may have been much more uncertainty in the short run about what was likely to happen, and the CO–OP business plans were accompanied by actuarial feasibility studies by major actuarial firms and advisers that were putting out scenarios that suggested that they might be viable.

Senator LANKFORD. Thank you. I yield back.

Senator PORTMAN. Thank you, Senator Lankford. And, again, Dr. Harrington, thanks for your help on this, and your expertise has been helpful to us as we have gone through this report and tried to figure out how this could have happened. I think you have raised a lot of great questions about whether this should have happened or not.

One question you asked in your testimony that I would like you to answer is: Should they have launched these at a time when there was so much regulatory uncertainty? Or should they have waited for a year or two?

Mr. HARRINGTON. There was this real concern that if you missed 2014, you were going to miss the boat, and I am very reluctant to be influenced by hindsight here, but my opinion is that it would have made more sense to wait at least a year, if not longer.

Senator PORTMAN. Yes. I mean, look, it was a lousy time to start a health startup in any category, and certainly in the insurance sector. You talked about enrollment being a key determinant of a health insurer's financial performance, and if you would not mind just talking about that for a second, you said there should have been, I think you said in your testimony, some speed limits at least in place, incredibly sharp deviation from what they projected, both under and over. We talked earlier about this with regard to the overenrollment. The overenrollment multiplied the problem, where you already had a problem, then to have this massive overenrollment compared to projections. And yet there were no red flags apparently, or at least there was no reaction by the Federal Government in pulling back the taxpayer support. Can you talk about why that is so important?

Mr. HARRINGTON. Well, it is very important given the history of insurance insolvencies and the pricing problem. You can sell a lot of insurance at low prices because the claims do not come home until a bit later. So you always really have to be on your toes in order to guard against this sort of underpricing and rapid growth. Given that context, it made sense to really be on top of enrollment.

I was puzzled, as things rolled out, I was very puzzled by the lack of public discussion, the lack of commentary about insolvency risk whatsoever in this market. It is as if no one understood that insurance companies do fail, and those that fail often have been underpriced and grown rapidly. That background, that context, as well as the lack of incentives for safety and soundness given this type of government funding, should have overall made the environ-

ment be one of much greater caution about how these things would be permitted to grow.

Senator PORTMAN. And, again, just to be clear, as compared to some of the testimony we heard earlier, there was information. We had monthly and quarterly reports, including on enrollment, an issue that you talked about.

Let me just ask you this, and it is kind of, speculation in your part, but why did this happen? I mean, it was so obvious that the underpricing and the overenrollment and the other business factors were problematic and there were reports, and there was plenty of data. Why did they keep putting money out the door and not take the obvious step, which is to cut the losses to the taxpayer and cut the losses to all these families who ended up losing health care insurance, some of whom now are facing the risk of actually having providers have claims against them? Even though they paid their premiums, did everything right, the providers were not paid because these companies went insolvent. And now these consumers are told they might have to pay for what the companies did not pay when they were required to do so. How did this happen?

Mr. HARRINGTON. I think in part what happens is even though you are getting information, the accuracy of the information about claim costs was not there, so there could be a much bigger bill than what had been anticipated.

I have to speculate, but it seems there was a very strong commitment to the CO–OP Program, a very strong belief that this new model would work in an environment where insurance companies were viewed as making excessive profits with excessive administrative costs in markets that were regarded as not being sufficiently competitive. It seems to me there was an ideological commitment to the program and to the success of the program.

Having said that, I will also point out that once you get information that a company might be in trouble, there always has been a fine line that regulators have to draw about doing something that definitely will put the company over the edge or giving it a little more runway to try to work things out. But in those scenarios, when you give a little more runway to let companies try to work things out, you want to make sure that they grow, if at all, at a very orderly pace. You want to make sure that you have the speed limits. The last thing you want to do is to provide more funding to enable greater growth, especially when you have maybe soft information about claims experience at that point in time.

Senator PORTMAN. Well, look, given your academic background here and lots of experience, I respect what you are saying, and I think you are right, there was an ideological commitment, your quote, and I think it blinded some of these folks who otherwise would have seen these warning signs. And as you say, it was a commitment maybe to CO–OPs or maybe against the insurance companies that, as you said, were making excessive profits. I think it also was to get enrollment numbers up under Obamacare, which was part of the desire by the White House at the time, and continues to be.

So I do believe that we have to learn from this. We have to come up with ways to ensure that we are not going to lose even more, hemorrhage even more taxpayer dollars. At a minimum $1.2 billion

now appears to be lost. We talked earlier about that, and we could not get HHS to acknowledge that. But when you look at it, the companies who would have to repay that actually have assets that are far lower than their liabilities, even taking out the loans, forgetting the money that they owe the Federal taxpayer. And not a single one has paid a penny in principal or interest.

So I appreciate your focus on this. I hope you will continue to work with us on trying to figure out moving forward how we avoid this problem even growing further and how we deal with this very real problem we have now in some States where you have consumers who actually might get tagged with additional costs so they lose their health care, they have this dislocation, hopefully they have now found health care, but they are now looking at the possibility that these claims might come back on them.

Do you have any final comments before we go to our vote, on that or other topics? And, again, I want to thank you very much for your willingness to come before us, Dr. Harrington. Any final thoughts?

Mr. HARRINGTON. No. Thank you for allowing me to testify.

Senator PORTMAN. Thank you. Thanks for your good work in this area. It has been very helpful to have you.

Do you have any additional questions?

Chairman JOHNSON. Just to thank you for holding this hearing. What this underscores is literally what a spectacular failure this ideological effort was. You had States that know how to do these things, know how to regulate, know how to prevent insurers getting into too much trouble. If they start getting in trouble, they know how to resolve those things. And you have the arrogance of a Federal Government walking in here spending at least $1.5, probably $2.5 billion in support of these things.

So this is an incredibly important hearing. We are just not getting the press attention to what a spectacular failure Obamacare is, how couples lost health care plans and high-risk pools that they could afford. The premiums have skyrocketed. Out-of-pocket maximums have skyrocketed.

So I hope this hearing gets a lot of attention, and I hope your testimony gets a lot of attention. I hope we actually learn lessons. I am not convinced we will. But thank you, Mr. Chairman. Excellent hearing.

Senator PORTMAN. Thank you for your attendance today. And, again, to all our witnesses, thanks, particularly here at the end. Dr. Harrington, thanks for your expertise.

I want to thank also my colleague Senator McCaskill for her hard work on this Subcommittee, her support of the Subcommittee. We missed having her here today and look forward to her return soon and her good health.

I will say that, we have talked a lot today about how this money was lent to these dozen CO–OPs that failed. Others, as you have said, Dr. Harrington, are in big trouble. And at a minimum, we are talking about $1.2 billion of taxpayer money that is going to be lost. It will be more than that at the end. We all know that. While this happened, there was not corrective action taken—in some cases not all, in other cases it took more than a year. And what we are looking for today is someone to take accountability for it.

We heard a little of that, and I appreciate that. But this was not the fault of these consumers. This was not the fault of the States. This was the fault of HHS, the way the program was structured, and then even once it was structured, the lack of adherence to the basic requirements in these loan agreements.

So I would hope that we will learn from this and that we can avoid further disruption in this case to over 700,000 consumers, in addition, again, to them having the possibility of actually having to pay out-of-pocket more than their premiums because there are claims that, from our analysis, could be brought against the consumers, which would be adding an additional insult to the taxpayers who have already been out so much money.

So this hearing record will remain open for 15 days for additional comments or questions by any of the Subcommittee Members, and with that, we are adjourned.

[Whereupon, at 11:36 a.m., the Subcommittee was adjourned.]

APPENDIX

STATEMENT OF CHAIRMAN ROB PORTMAN
U.S. SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
HEARING: REVIEW OF THE ACA HEALTH INSURANCE CO-OP PROGRAM
MARCH 10, 2016

This hearing will come to order. [gavel]

Thank you all for being here. I want to begin by noting that our Ranking Member, Senator McCaskill, cannot be with us today. As many of you know, she is at home in Missouri attending to an important health issue. All of us in the Senate are thinking of her, know she will be back with us soon, and we wish her the best. I suggested to Claire that we should postpone this hearing until she gets back, but she said the Senate's business should go on. She will be submitting questions for the record. And on behalf of the Subcommittee, I want to thank Sen. McCaskill's staff for their hard work preparing for this hearing.

We are here today to discuss the Administration's unfortunate adventure in the health insurance start-up business. The Affordable Care Act created something called the Consumer Operated and Oriented Plan (or "CO-OP") Program as a gesture to those who favored a public option. Under that program, the Department of Health and Human Services awarded $2.4 billion of taxpayer money to 23 non-profit health insurance CO-OPs. As of today, twelve of them have failed. Those twelve collectively received $1.2 billion in taxpayer money that is almost certainly lost. And their collapse caused 740,000 people in 14 states to lose their health insurance provider and have to scramble to find new coverage in little to no time.

Over the last 9 months, our Subcommittee investigated those failures. We wanted to know whether HHS, when it played the role of angel investor, made good or bad decisions with taxpayer money.

The answer is *bad* decisions. In a Majority Staff Report released today, we detail our findings that HHS was aware of serious problems

concerning the failed CO-OPs' enrollment strategies, pricing, financial forecasts, and management before the Department ever approved the initial loans. Once the CO-OPs got going in 2014, things went south in a hurry—both in terms of financial losses and enrollment figures that wildly deviated from the CO-OPs' projections. The failed CO-OPs ultimately racked up $376 million in losses in 2014, and more than a billion dollars in losses in 2015. But despite getting regular reports that the CO-OPs were hemorrhaging cash, HHS took no corrective action for over a year.

Worse, the Department approved ***additional*** loan awards to three of the now-failed CO-OPs in 2014, despite clear warning signs that those CO-OPs did not have reliable plans for turning things around.

The Majority Staff Report explains these findings in further detail. And without objection, that report and its appendix are ordered to be made part of the record. But let me give you some highlights.

When HHS approved startup loans for the failed CO-OPs in 2012, it asked a reputable firm, Deloitte Consulting, to evaluate the CO-OPs' proposed loan applications and business plans. We reviewed Deloitte's analysis as part of our investigation. Here's what we found:

Although Deloitte gave the CO-OPs a "passing" score based on a grading scale set by HHS, the firm warned HHS of specific concerns with the failed CO-OPs that foreshadowed the problems to come.

- Many of the failed CO-OPs could not identify their senior leadership team.
- Seven of the 12 had serious deficiencies in their enrollment strategy—which later turned out to be a chief reason for CO-OP failure.

- Many of them submitted budgets that were incomplete, unreasonable, not cost-effective, or that didn't align with the CO-OPs' own financial projections.
- Those financial projections were not so hot, either. Deloitte warned that several CO-OPs relied on unreasonable projections about their own growth. As just one example, Deloitte noted that CoOportunity—the CO-OP for Iowa and Nebraska— had a target profit "much lower than the industry benchmark" of 4.8%. That was an understatement: CoOportunity's stated target profit margin was *zero percent*.

Nevertheless, HHS approved *all* the loan applications to the failed CO-OPs, to the tune of $1.2 billion.

After they entered the marketplace in 2014, the CO-OPs' financial health deteriorated rapidly. And HHS knew it. The Department regularly received key financial information from the CO-OPs, including monthly reports and audited quarterly financial statements. Those reports showed that, starting almost immediately, the failed CO-OPs experienced severe financial losses that exceeded even the worst-case scenarios outlined in their loan applications to HHS. Cumulatively, by the end of 2014, the failed CO-OPs exceeded their projected worst-case-scenario losses by at least $263.7 million—which is four times above the projection.

The CO-OPs' enrollment numbers were no less problematic. According to the 2014 monthly reports submitted to HHS, five of the failed CO-OPs dramatically underperformed enrollment projections, while five others overshot their projections by wide margins. Both errors can cause serious financial losses. Low enrollment means insufficient income to cover expenses. Excessively high enrollment is an even greater threat to solvency because it multiplies *losses* rather than profits when premiums are underpriced—as many of the CO-OPs' premiums were.

But despite having that information at its fingertips, HHS did not step in. The Department's loan agreements with the CO-OPs entitled it to invoke a number of accountability tools for borrowers who were missing the mark, but here HHS took a pass. Inexplicably, for over a year, the agency took *no* corrective action, nor did it put any CO-OP on enhanced oversight. Five of the 12 failed CO-OPs were *never* subject to corrective action by HHS, and HHS waited until September 2015 to put five others on corrective action or enhanced oversight. Two months later, all twelve CO-OPs had failed.

HHS also had the power to stop disbursing funds if a CO-OP's financial viability was in doubt. It never did, to the bitter end. Instead, over the course of 2014–2015, HHS disbursed $848 million in federal loan dollars to the failed CO-OPs, even as those entities lost more than $1.4 billion. That's about $1.65 in losses for every $1 HHS gave them.

More unbelievable, near the end of 2014, HHS approved *additional* solvency loans for three of the failed CO-OPs that were in danger of being shut down by state regulators for having insufficient capital—despite clear warning signs that those CO-OPs could not turn things around. Here again HHS asked Deloitte to complete an external review of the CO-OPs' application for additional solvency loans and their plans to improve their finances going forward. But according to Deloitte, HHS truncated its review of those applications. Deloitte did *not* evaluate, for example, "the likelihood that each CO-OP would achieve sustainable operations based on the revised business plan"—which I would have thought was the whole point. But even the limited analysis that HHS allowed Deloitte to conduct pointed to clear warning signs that CoOportunity, the New York CO-OP, and the Kentucky CO-OP did not have a sound plan to regain their footing.

Nevertheless, those three CO-OPs alone received $355 million in additional solvency loans. All have failed. The Kentucky CO-OP collapsed after suffering losses of $50.4 million in 2014 and another $114.8 million in 2015. At the time of CoOportunity's closure, that

company's operating losses exceeded $163 million. And most staggering of all, after HHS gave the New York CO-OP $90 million to prolong its financial life rather than allow it to scale down, that CO-OP went on to lose another $544 million in 2015.[1]

The financial aftermath of all this is dire. The Subcommittee obtained the failed CO-OPs' most recent financial statements, and those statements show that *none* of the failed CO-OPs have repaid a single dollar, principal or interest, of the $1.2 billion in federal loans they received. It is unlikely they will pay any significant fraction back. The latest statements show that the failed CO-OPs' *non-loan* liabilities exceed $1.13 billion—which is 93% greater than their reported assets, including money they expect to receive. On top of that, they owe $1.2 billion to federal government. We should not hold our breath on repayment.

The American taxpayer is not the only creditor that stands to suffer large losses due to the failure of the CO-OP program. The latest balance sheets we obtained show the failed CO-OPs have more than $700 million in unpaid medical claims to doctors and hospitals. In some states, those losses will be absorbed by other insurance companies—which means, by the policyholders of other insurance companies who have to pay increased premiums. In other states, doctors, hospitals and individual patients stand to suffer large out-of-pocket losses due to the CO-OP failures—as our report details.

These failed CO-OPs were a costly experiment gone wrong, and real people got hurt—including the more than 700,000 Americans who lost their health plans. Today I plan to ask HHS whether they accept any responsibility for the taxpayer waste, disruption to consumers, and losses to doctors and hospitals that the CO-OPs' failures have wrought.

[1] Health Republic of New York, Statement of Financial Performance (Dec. 31, 2015) (unaudited).

Homeland Security & Governmental Affairs Permanent Subcommittee on Investigations,
"Review of the Affordable Care Act Health Insurance CO-OP Program"

March 10, 2016, 9:30 am

Statement from Senator Ben Sasse

As prepared for delivery:

Chairman Portman and Ranking Member Tester, thank you for holding this important hearing today. I first want to acknowledge our colleague and ranking member, Senator Claire McCaskill. We all wish her well and a speedy return to the Senate.

Today's hearing is about the families who lost their health care plans, the taxpayers who were swindled, the bureaucrats who mismanaged the program, and the local governments who had to cut budgets from firefighters and schools to make up for Washington's failures. Everyone in this room— Republican or Democrat— has a duty to their constituents to get the whole story.

The Affordable Care Act's Consumer Operated and Oriented Plan program created 23 non-profit health insurers using $2.4 billion in "loans" from federal taxpayers.

Less than a year into operation, the financial condition of many of these CO-OPs was unstable at best. As today's report shows, CMS's own private consultant, Deloitte, warned that this was the case. Despite this, CMS continued to disburse loans and even awarded additional loans. Since then, 12 have gone out of business, representing a CO-OP program failure rate of more than 50 percent.

Sadly, there were about 740,000 people covered by these 12 defunct insurance companies that were given $1.2 billion in "loans" from taxpayers. As we've suspected for sometime, this subcommittee's report concludes the loans will probably never be repaid.

When these companies failed, they imposed varying degrees of disruption on their enrollees and the market within which they operated.

Unfortunately, the mess caused by this program began in my state with the abrupt failure of CoOportunity Health.

While CoOportunity was headquartered in Iowa, it operated in both Nebraska and Iowa. The newly created insurer was given a total of $145 million in taxpayer-funded loans. Things seemed to be going well at first when CoOportunity announced they had signed-up far more enrollees that they had originally anticipated.

However, despite ample funding and enrollees, on December 16, 2014, as people were signing up for 2015 coverage, the Iowa Insurance Commissioner placed CoOportunity under a supervision order. By January 2015, the Iowa Insurance Commissioner said rehabilitation of

CoOportunity would be impossible and sought a court order for liquidation. After just one year of operation, the new nonprofit health insurer collapsed.

When CoOportunity failed, a total of 120,000 enrollees, a majority of which are Nebraskans, had their coverage canceled and were forced to find a new insurance company.

But the collateral damage from CoOportunity's failure does not end there for Nebraskans.

CoOportunity owed millions of dollars to doctors and hospitals for claims made by its enrollees.

To address this kind of thing, the State of Nebraska has a guaranty fund that pays claims in the event that an insurance company, such as CoOportunity, fails. The guaranty fund is primarily financed by assessments on insurance companies selling similar health plans in the state. To help pay for CoOportunity's unpaid claims, insurers in Nebraska were assessed fees totaling $46.8 million in 2015. It should be noted that this sum was not even enough to cover CoOportunity's losses and that the guaranty fund had to take out a loan. As CoOportunity has no remaining assets, it's improbable that the guaranty fund will ever be repaid the $46.8 million that was assessed onto insurers in the market.

In other words, these insurers had to pay CoOportunity's outstanding bills and there is no reason to believe that CoOportunity will pay them back. As a result, Nebraska tax revenues will decrease by $46.8 million because insurers are able to reduce their tax liability by the amount of their contribution.

This means that the state government will have this much less revenue to pay for state priorities like education, roads, and firefighters. Thus, Nebraskans have to pay for this Obamacare failure again, on top of the $145 million in federal loans given to CoOportunity.

As previously mentioned, 11 other CO-OPs failed in addition to CoOportunity, likely initiating variations of this story across 11 other states in 2015.

Moreover, depending on the viability of the 11 remaining CO-OPs, it could happen in more states this year to more consumers. Indeed, of the 11 CO-OPs remaining in operation, we know that as of February 25, CMS had placed eight on Corrective Action Plans. In addition, updated financial reports show that conditions have gravely worsened for the four CO-OPs with data available for the fourth quarter of 2015.

Despite this mess, CMS has offered little in terms of a significant explanation.

I've been questioning the Department of Health and Human Services since last May about all of this. I've sent four letters over that period and working alongside Chairman Portman to request documents to unearth the cause of this CO-OP debacle.

HHS owes all CO-OP enrollees, federal taxpayers, and taxpayers in my state answers. I look forward to finding some today from our witness panel.

STATEMENT OF

ANDY SLAVITT

ACTING ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND

KEVIN COUNIHAN

MARKETPLACE CHIEF EXECUTIVE OFFICER AND

DEPUTY ADMINSTRATOR,

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"REVIEW OF THE AFFORDABLE CARE ACT HEALTH INSURANCE CO-OP PROGRAM"

BEFORE THE

UNITED STATES SENATE COMMITTEE ON HOMELAND SECURITY & GOVERNMENT AFFAIRS

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

MARCH 10, 2016

"Review of the Affordable Care Act Health Insurance CO-OP Program"
U.S. Senate Committee on Homeland Security and Government Affairs
Permanent Subcommittee on Investigations
March 10, 2016

Chairman Portman, Ranking Member McCaskill, and members of the Subcommittee, thank you for the invitation to discuss the Consumer Operated and Oriented Plan (CO-OP) program. The Centers for Medicare & Medicaid Services (CMS) is committed to overseeing the CO-OP program and is hard at work providing CO-OP consumers and taxpayers important protections as CO-OPs expand access, choice, and competition, helping Americans access high quality, affordable health insurance coverage.

CMS's priority is to provide Marketplace customers with access to quality, affordable coverage. In the years since the passage of the Affordable Care Act, we have seen increased competition among health plans and more choices for consumers.[1] During the third Marketplace Open Enrollment, nine out of ten returning customers were able to choose from three or more issuers for 2016 coverage, up from seven in ten in 2014.[2] The CO-OPs have played an important role in the Marketplace, particularly in the early years of the Affordable Care Act by providing additional options for access to affordable health coverage from local, non-profit health insurers. Moving forward, CMS is eager to build on the progress in reducing the number of uninsured Americans – an estimated 17.6 million Americans gained coverage since the Affordable Care Act's coverage provisions have taken effect,[3] and the Nation's uninsured rate is at its lowest level since data collection began over five decades ago.[4,5] During the third open enrollment that concluded at the end of January, 12.7 million Americans selected affordable, quality health plans for 2016 coverage through the Marketplaces.[6]

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[1] www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html
[2] www.hhs.gov/about/news/2015/07/30/competition-and-choice-in-the-health-insurance-marketplace-lowered-premiums-in-2015.html
[3] http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-september-2015
[4] http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201602.pdf
[5] http://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf
[6] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html

CMS Implementation of the CO-OP Program

Section 1322 of the Affordable Care Act established the CO-OP Program to foster the creation of non-profit health insurance issuers to give more choices and control to consumers, promote local competition, and improve diversity in the health insurance market. To this end, the law provided funding for loans to eligible entities to help establish and maintain these new plans. The funding initially provided by the law was intended to provide capital sufficient to support start-up costs, such as establishing provider network relationships, claims and financial operations, developing products, and meeting regulatory surplus requirements through the initial phase of operations. In implementing the CO-OP Program as required by statute and with the funds available, CMS evaluated loan applications, monitors financial performance, conducts financial and operational oversight, and supports state departments of insurance (DOIs), which are the primary regulators of insurance issuers in the states.

CMS established the CO-OP Program as outlined in the CO-OP Program Funding Opportunity Announcement[7] and the CO-OP Program Final Rule.[8] The framework for implementing the CO-OP Program was based on a report submitted by a Federal Advisory Committee appointed by the Government Accountability Office (GAO) under section 1322(a)(3) of the Affordable Care Act to advise the Secretary of Health and Human Services (HHS) regarding the award of CO-OP loans. The report included recommendations on governance, finance, infrastructure, criteria, process, and compliance for CO-OPs and a timeline for the CO-OP Program.[9] This report guided the major elements of how CO-OPs were selected, awarded loans, and monitored.

The CO-OP application review process was rigorous, objective, and conducted with input and expertise from an independent party, Deloitte Consulting, LLP. Deloitte used a team of insurance experts, actuaries, former state insurance regulators, and other experts to verify eligibility and evaluate each element of the application, such as the business plan, financial projections, and a feasibility study, using the criteria established in the Funding Opportunity Announcement. The Deloitte findings and recommendations were then sent to the internal CMS review committee,

[7] https://www.cms.gov/CCIIO/Resources/Funding-Opportunities/Downloads/final_premium_review_grant_solicitation_with_disclosure_statement.pdf
[8] https://www.gpo.gov/fdsys/pkg/FR-2011-12-13/pdf/2011-31864.pdf
[9] https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf

which was led by insurance experts and an actuary who was not on the CO-OP program staff. A July 2013 HHS Office of Inspector General (OIG) Report found that "CMS established a prospective oversight system to safeguard CO-OP funding and ensure timely implementation of the program."[10]

Of 147 applications,[11] 24 were selected to receive loan funds and ultimately entered into CO-OP loan agreements with CMS. Ultimately, CMS awarded $2.5 billion in loan funding to the 24 CO-OPs, over $2.1 billion, or 85 percent, of which was awarded before coverage began on January 1, 2014. The Federal Advisory Group emphasized the importance of awarding the funds "as expeditiously as possible" in order for CO-OPs to be able to compete in the 2014 Open Enrollment period.[12] As the statute required, loans were made in two forms:[13] start-up loans and solvency loans. Start-up loan obligations were specific to each CO-OP in an amount based on estimated costs of particular start-up activities. A disbursement schedule that governed the basis, timing, and amount of sequential disbursements of start-up loan funding was incorporated into each CO-OP borrower's loan agreement.

As set forth in the statute, solvency loan funds assisted loan recipients with meeting regulatory capital and surplus requirements of the state(s) in which they are licensed, as well as additional CMS CO-OP Program requirements. CO-OPs requested disbursements of solvency loan funding to maintain state and CO-OP loan agreement required solvency levels. Solvency loan award levels were made based on the particular business plan included in the loan agreement and state regulatory capital requirements.

After the start of coverage on January 1, 2014, CMS awarded additional solvency funding to several existing CO-OPs. In making subsequent loan decisions, CMS undertook a rigorous review process substantially similar to what was conducted for the initial round of loans. This included both an external and internal review of updated business plans, feasibility studies,

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[10] http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf
[11] Including 34 applications that were not subject to a full review process, but were subsequently denied due to funding rescissions.
[12] https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf
[13] Sec. 1322(b) the Affordable Care Act

programmatic and regulatory compliance, actuarial soundness, and financial statements. Requests were made for more funding than was available, so the comparative level of need was also an important factor. The applications included actuarially-certified analysis and financial projections, which incorporated data regarding the current and projected level of enrollment. During 2014, CMS provided approximately $352.5 million in additional solvency loan funding.

CMS used information available after the first round of funding about the size of enrollment and operational compliance to evaluate applications for additional loan funding. The enrollment, claims, and financial data available during the review of applications for both the first and second rounds of opportunity for additional solvency loan funding was limited in scope because these CO-OPs were in their initial stages of operation, and a substantial number of CO-OP members enrolled on or after the January 1, 2014 coverage start date. The late enrollment and the length of time it takes to receive, process, and pay claims and for those claims to have actuarial meaning, meant that at that time, CO-OPs had six to nine months of enrollment data and claims experience for Deloitte and CMS to review.

While the Affordable Care Act appropriated $6 billion for the program, the Congress made a number of substantial rescissions to that initial funding level. The Department of Defense and Full Year Continuing Appropriations Act, 2011, rescinded $2.2 billion; the Consolidated Appropriations Act, 2012, rescinded an additional $400 million; and the American Taxpayer Relief Act of 2012 further reduced the remaining $3.4 billion of CO-OP funding by rescinding 90 percent of funds unobligated as of the date of enactment. Finally, an additional $13 million was reduced due to sequester in Fiscal Year 2013. The remaining balance was assigned to a new contingency fund available for oversight and assistance to the existing CO-OP loan recipients.

CO-OP Accomplishments and Challenges

CO-OPs have provided health insurance coverage to more than one million consumers, helping people access needed medical care. This program has increased competition and provided more consumer choices and control in choosing health insurance coverage. For example, Maryland's

CO-OP (Evergreen Health) was the first new issuer to enter the state's market in 25 years,[14] and New Jersey's CO-OP (Health Republic of New Jersey) was the first new issuer to enter the state's market in 19 years.[15] In Maine, the CO-OP (Maine Community Health Options) was one of two issuers on the Exchange in 2014; that year, it enrolled 83 percent of individuals who used the Marketplace to sign up for coverage. The CO-OP began offering coverage to the residents of New Hampshire in 2015.[16] Overall, CO-OPs have added both choice and affordability to health insurance coverage options available to consumers.

CO-OPs are also introducing local innovation. Ohio's CO-OP (InHealth Mutual) offers a disease management program for six different conditions that includes education, case management, and no copays for any visit, prescription, or supplies associated with management of the disease.[17] New Jersey's CO-OP (Health Republic of New Jersey) implemented a harm reduction program to help enrollees quit and reduce smoking.[18] CMS will continue our work to support CO-OPs as they pursue innovative approaches to coverage.

However, new entrants to any market, especially the insurance market, face numerous pressures and must overcome multiple barriers, particularly in their early stages of operations. In its July 2013 report, HHS OIG found that "the extent to which any particular CO-OP can achieve program goals and remain financially viable depends on a number of unpredictable factors. These factors include the CO-OP's State's Exchange operations, the number of people who enroll in the CO-OP and their medical costs, and the way in which competing plans will affect the CO-OP's market share."[19] CO-OPs entered the health insurance market facing a variety of challenges, including building a provider network and customer support, no previous claims experience on which to base pricing, and competition from larger, experienced issuers. The Federal Advisory Group found that many of the challenges the CO-OPs faced were the same as

[14] http://www.nytimes.com/2015/09/16/business/health-cooperatives-find-the-going-tough.html?_r=0
[15] http://docs.house.gov/meetings/IF/IF02/20151105/104146/HHRG-114-IF02-Wstate-MorrisonJ-20151105.pdf
[16] http://www.pressherald.com/2014/09/30/maine-insurance-co-operative-accelerates-plans-to-cover-new-hampshire/
[17] http://www.inhealthohio.org/shop-for-insurance/individuals-and-families/2016-enrollment-material-individual-family-benefits
[18] https://newjersey.healthrepublic.us/smoking-cessation/smoking-cessationtobacco-harm-reduction-faq/
[19] http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf

any new health insurance entity.[20] The Commonwealth Fund published a report on the factors that contributed to the CO-OPs' challenges, which provided further evidence of the issues faced by new entrants into the market, including having to outsource important functions, in particular network contracting, limited information about existing provider practices and referral habits, and initial enrollment that diverged from expectations.[21]

CMS Oversight

CMS has obligations to operate as a proper steward of the taxpayer dollars issued through the loan program and to administer the CO-OP Program for the benefit of consumers. Since awarding both start-up and solvency loans, CMS has been closely monitoring and evaluating the CO-OPs to assess performance and compliance, and has engaged regularly with state DOIs, which are the primary regulators of insurance issuers in the states. Twelve CO-OPs are no longer selling coverage in the Marketplace and are in various stages of winding down operations. The remaining eleven CO-OPs, serving thirteen states, are being monitored closely.

CMS's oversight approach, informed by the work of both HHS OIG and GAO, consists of four parts. First, all CO-OPs are subject to standardized, ongoing reporting to and interactions with CMS that include weekly, biweekly, or monthly calls to monitor goals and challenges; periodic on-site visits; performance and financial auditing; and monthly, quarterly, semi-annual, and annual reporting obligations. Since March 2015, CMS has conducted site visits of CO-OPs in 15 states. We believe these visits are a benefit to plans, consumers, and taxpayers. These visits provide CMS with an opportunity to verify whether and how a CO-OP meets its obligations. During these visits, CMS reviews management structure and staffing, financial status, business strategy, the policies and procedures of the CO-OP, marketing and sales information, and operations, including vendor management and oversight. CMS also reviews whether a CO-OP is meeting their obligations for medical management and member relations. CMS also collaborates with DOIs concerning each CO-OP loan recipient.

[20] https://www.cms.gov/CCIIO/Resources/Files/Downloads/coop_faca_finalreport_04152011.pdf
[21] http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/1847_corlette_why_are_many_coops_failing.pdf?la=en

Second, CMS monitors the CO-OPs' overall financial condition using several factors of the Federal Deposit Insurance Corporation's Uniform Financial Institutions Rating System. CO-OPs have monthly, semi-annual, and annual reporting requirements, including financial statements, balance sheets, income statements, statements of cash flow, and enrollment statistics. Last year, CMS increased the data and financial reporting requirements for CO-OPs. Each CO-OP is required to provide a semi-annual statement of its compliance with all relevant State licensure requirements, and, if necessary, an explanation of any deficiencies, warnings, additional oversight, or any other adverse action or determination by DOIs received by the CO-OP. If the CO-OP is experiencing compliance issues with State regulators, the CO-OP is required to describe the steps being taken to resolve those issues. CMS meets monthly with the state insurance regulators regarding each CO-OP. This additional financial data collection has helped CMS to identify underperforming CO-OPs and gives CMS the opportunity to work with the CO-OPs and DOIs to help correct issues that are identified.

Third, CMS regularly uses enhanced oversight plans (EOPs) and corrective action plans (CAPs) as part of our CO-OP monitoring and oversight process, as laid out in the CO-OP loan agreements and recommended by the HHS OIG. CMS places a CO-OP on an EOP or CAP when it identifies an issue that can be resolved through corrective action. A CO-OP can be on an EOP or CAP for a variety of reasons relating to its operations, compliance, management, or finances. A CAP could require a CO-OP to make improvements to its claim payment processes, customer service, premium billing, or other administrative functions. The reasons for an EOP or a CAP are often common issues for any issuer in the difficult, competitive, and complicated health insurance market, and are not unique to the CO-OPs.

Finally, CMS can terminate its loan agreement with a CO-OP if we determine it is no longer viable, sustainable, or serving the interests of the community. CMS works closely with DOIs and shares information to assist in their assessments of CO-OPs. If a loan agreement is terminated, CMS works with the state DOI and the CO-OP board to wind down operations in an orderly way to mitigate impact to the consumer. While it is too early to tell how much money may be recovered, CMS has begun the recovery process, and once the wind down of these CO-OPs is complete, we will use every available tool to recoup Federal funding, based on applicable law

and the loan agreements. During closeout, most CO-OPs exiting the market were placed into a receivership or supervisory status that controls assets, expenses, and contractual rights and obligations including ongoing operating costs and claims payment. These arrangements help protect remaining funds.

In addition to protecting taxpayer dollars, CMS also works to protect consumers. For the CO-OPs that are closing, we are working closely with the CO-OP and state regulators to facilitate a smooth transition for consumers to retain access to coverage and ensure providers are reimbursed for covered services rendered to CO-OP enrollees. Each of the consumers in the CO-OPs that closed at the end of 2015 maintained coverage until the end of the year, and nearly three-quarters[22] of the CO-OP Marketplace consumers have continued their coverage in a new plan in 2016. Affected CO-OP enrollees had access to a special enrollment period, and were able to shop for 2016 coverage on the Marketplace until February 28, 2016. In all cases, CMS is focused on making sure consumers continue to receive medical services.

Moving Forward

Since the enactment of the Affordable Care Act, CMS has worked to increase access to quality, affordable coverage through the Marketplaces and to be responsible stewards of taxpayer dollars. The CO-OP program was designed to give consumers more choices, promote competition, and improve quality in the health insurance market. Though not all CO-OPs have continued to offer coverage, consumers continue to have a variety of affordable health insurance coverage choices that meet the health care needs of their families. While CO-OPs are primarily responsible for their own success, CMS will continue to help them identify and correct issues and make improvements. CMS is committed to continuing its work with the CO-OPs offering coverage this year to facilitate progress and expand into new markets when appropriate. CMS has also clarified our policies on important topics[23] and is exploring what changes could be made to help CO-OPs diversify their boards and grow and raise capital, while still preserving the fundamentally member-run nature of the CO-OP program. Working with state DOIs and the CO-OPs, CMS will continue its rigorous ongoing monitoring and oversight processes in order to

[22] Does not include consumers who enrolled in new plans outside the Marketplace.
[23] https://www.cms.gov/CCIIO/Resourees/Fact-Sheets-and-FAQs/Downloads/CO-OP-Questions-Final-1-27-16.pdf

prevent consumers from experiencing potential disruption in health insurance coverage. Additionally, we will use every tool available to recoup Federal dollars, where appropriate. We appreciate the Committee's interest and are happy to answer your questions.

Statement of Scott E. Harrington
Alan B. Miller Professor
The Wharton School
University of Pennsylvania

On "Review of the Affordable Care Act Health Insurance CO-OP Program"

Before the
Permanent Subcommittee on Investigations
Committee on Homeland Security and Government Affairs
U.S. Senate

March 10, 2016

Chairman Portman, Ranking Member McCaskill, and members of the subcommittee:

I am pleased to provide testimony today on the Consumer Operated and Oriented Plan (CO-OP) program established by the Patient Protection and Affordable Care Act (ACA). I am the Alan B. Miller Professor and Chair of the Health Care Management Department of the University of Pennsylvania's Wharton School. During my nearly 40-year academic career I have published extensively on the economics and regulation of insurance, including analyses of pricing and price regulation, capital and insolvency risk, the causes of insolvencies, solvency prediction and regulation, risk-based capital requirements, and state guaranty funds. I have conducted several previous analyses of the CO-OPs' financial condition and performance based on data reported in CO-OPs' statutory financial statements.[1]

In preparing this testimony I have reviewed a variety of documents for closed CO-OPs in Iowa/Nebraska, New York, South Carolina, and Tennessee, including original applications to the CO-OP program, business plans, feasibility studies, pro forma financials, actuarial pricing analyses, additional funding requests, and reviews for the Center for Medicare and Medicaid Services (CMS) conducted by Deloitte LLC. I have also reviewed selected financial

[1] See The Financial Condition and Operation of CO-OP Plans, Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation, February 2015, http://www.rwjf.org/en/library/research/2015/02/the-financial-condition-and-performance-of-co-op-plans.html; Effects of the ACA's 3Rs on the Bottom Line, Part II, July 30, 2015, http://ldi.upenn.edu/effects-aca%E2%80%99s-3rs-reinsurance-risk-adjustment-and-risk-corridors-bottom-line-part-ii; How the Largest Obamacare CO-OP Went Broke, http://www.forbes.com/sites/realspin/2015/10/12/how-the-largest-obamacare-co-op-went-broke/#57d6f09d71c7; Financial Status of ACA CO-OPs, American Enterprise Institute CO-OP Briefing, October 22, 2015.

information for the closed CO-OPs that has been provided to the Permanent Subcommittee on Investigations (PSI). I have not received or reviewed any information on enhanced oversight or correction action plans instituted by CMS for any of the CO-OPs.

The CO-OP program was intended to promote competition in health insurance by non-profit, consumer-focused, and consumer-governed insurers that would provide an alternative to traditional insurance companies—whether for profit or not for profit—and focus on financing and delivering high quality medical care with improved care coordination and integration. The program ultimately awarded $2.44 billion of federal loans to 23 CO-OPs in the form of startup loans ($358 million) and solvency loans ($2.09 billion) to be disbursed over time to meet state regulatory capital requirements.

Twelve of the 23 CO-OPs that began selling policies in 2014 have closed. As I elaborate below, very little, if any, of the $1.24 billion in federal startup and solvency loans to establish those CO-OPs will be repaid, and at least several will be unable to meet all of their obligations to policyholders and health care providers. Some closures in states with guaranty fund coverage will likely require significant state guaranty fund assessments. The future of the 11 CO-OPs still providing coverage in 2016 is uncertain, but future closures seem likely.

The CO-OPs faced significant challenges as new entrants during a time of extraordinary uncertainty. Operational challenges included product design, development of distribution and claims administration systems, and contracting with provider networks, including efforts to promote greater coordination and integration of care.[2] The ACA reforms effective in 2014 posed major challenges and risk associated with pricing coverage in view of uncertain takeup and utilization of coverage by the previously uninsured, as well as uncertainty as to the rate and scope of transition of previously insured people to policies complying with the ACA's new rules.

The CO-OPs had none of their own experience and data to consider in pricing. They were plausibly more prone to a "winner's curse" phenomenon, where CO-OPs with prices too low in relation to expected medical and administration costs would grow rapidly and lose money,

[2] According to a Department of Health and Human Services Office of Inspector General (OIG) study, Early Implementation of the Consumer Operated and Oriented Plan Loan Program, OEI-01-12-00290, July 2013, all CO-OPs reported major challenges in hiring staff, obtaining licensure, marketing plans, and enrolling consumers within 18 to 24 months of being awarded funding.

especially in an environment of strong political and public pressure for affordable health insurance. Pricing uncertainty remained high for 2015 premium rates, which had to be filed with state regulators in the summer of 2014, when CO-OPs still had relatively little data to assess claim experience and the adequacy of their 2014 rates. Compared with many established players, the CO-OPs had very little ability to diversify pricing and claims risk across geographic regions and different health insurance products.

The challenges and risks confronting CO-OPs notwithstanding, the April 2011 report of the 15 member advisory board to CMS on the design of the CO-OP program argued that it was fundamentally important for CO-OPs to begin operating on January 1, 2014 to capture market share during the "critical first open enrollment period".[3] Several CO-OP business plans and feasibility studies I reviewed also stressed the importance of establishing a market presence in 2014. It was believed that the ACA's risk stabilization programs—risk adjustment, reinsurance, and risk corridors (the "3Rs")—would help protect CO-OPs in the event of inadequate pricing and higher than expected medical and administrative costs.

Capital and Insolvency Risk

Insurance companies need to hold substantial capital—assets in excess of liabilities—to achieve a high probability of meeting their obligations to policyholders and other claimants. The scholarly literature on capital and insolvency risk for insurers and other financial institutions stresses that firms' incentives for solvency and achievement of high financial ratings depend on the amount of owners' capital at risk, on the value of the firm as a going concern (from previous investments in infrastructure and building a customer base and brand) that could be lost in the event of financial distress, on the sensitivity of customers' demand to insolvency risk, and on the extent of external monitoring by lenders and other counterparties. Solvency regulation, including risk-based capital requirements, is broadly intended to promote greater capitalization and reduce insolvency risk in cases where firms' incentives otherwise could be insufficient to promote a high probability of solvency.[4]

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[3] Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program, April 15, 2011, Center for Consumer Information and Insurance Oversight, p. 5.

[4] As is the case for banking, the scholarly literature on insurance capital and insolvency risk has considered potential moral hazard that could arise from state insurance guaranty fund protection and how such protection increases the

Viewed on these dimensions, the financial strength of CO-OPs should have been a central focus from the program's inception. CO-OPs faced considerable pressure to capture early market share. They had (almost) no private capital, no going-concern value, and no financial ratings, and it was likely that many potential CO-OP customers would not be sensitive to insolvency risk.[5]

Moreover, the history of insurance company insolvencies indicates that—due to inadequate incentives for financial strength, bad decisions, bad luck, or some combination thereof—insolvent companies often charged low prices and grew rapidly, with inadequate reported claim reserve liabilities, ultimately producing claim costs much larger than reported in their pre-insolvency financial statements. There also is always a risk that insurers facing significant financial stress will try to sell their way out of trouble, hoping (or gambling) that claim costs will turn out to be lower than projected. Early detection of such behaviors is a major goal of solvency regulation. But early detection is often difficult given lags in receiving information and inherent uncertainty in projecting a company's claim costs. This history and context also suggest that the financial strength of CO-OPs and the potential consequences of rapid enrollment growth should have been a central focus from their inception.

CO-OP Capitalization

The approved CO-OP applications to CMS contained and were accompanied by detailed business plans and feasibility studies, including actuarial projections of growth, profitability, and ability to repay government loans. Deloitte reviewed the applications and supporting materials for CMS. Low interest startup loans awarded to CO-OPs were to be disbursed over time with a five-year term for each disbursement. Low interest solvency loans with a 15-year term were to be disbursed over time to fund growth while meeting regulatory capital targets.

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need for solvency regulation. My own analyses of this issue have stressed that the moral hazard problem is much smaller for insurance than banking.

[5] The ACA specified that evidence of private support was one of three selection criteria to be given priority in awarding CO-OP loans (along with providing integrated care models and offering statewide coverage). An OIG study, The Center for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Loans in Accordance with Federal Requirements, and Continued Oversight is Needed, A-05-12-00043, July 2013, p. 4, reported that investigators "saw little evidence of private support in any of the 16 applications reviewed."

CO-OPs were required to report startup loan amounts as debt on their regulatory financial statements. (As I discuss below this later changed for some CO-OPs.) In order to meet regulatory capital requirements, solvency loans had to be approved by state regulators as "surplus notes", which are subordinate to all other claims and counted as capital rather than debt for meeting capital requirements. Surplus notes cannot be repaid without the permission of state regulators. Solvency loans essentially accounted for all of CO-OP capital. The amount of solvency loan disbursements generally were set to enable the CO-OP to achieve a projected capital of 500 percent of the National Association of Insurance Commissioners risk-based capital requirement. The 500 percent figure is roughly consistent with the average ratio of capital to risk-based capital among all health insurers.

The actuarial analyses supporting solvency loans and disbursements necessarily relied on numerous pricing, claim cost, and enrollment assumptions over a long projection period. The analyses involved some stress testing, for example, by projecting a baseline (best estimate) scenario, low and high enrollment scenarios, and scenarios with higher claim costs. The documents I reviewed contained what I regard as relatively modest stress scenarios. They did not include a scenario of significantly higher than projected enrollment combined with worse than projected claim costs. The baseline pricing assumptions, however, allowed for the possibility that newly insured enrollees would be sicker on average than previously insured people and for some degree of "pent up demand" by newly insured enrollees.

CO-OP Experience

Exhibit 1 shows the projected 2014 enrollment for the 23 CO-OPs in their award applications, year-end 2014 enrollment reported in their annual regulatory financial statement (3rd quarter 2014 statement for CoOpportunity Health), and enrollment as of June 30, 2015 as reported in their 2nd quarter financial statements (not available for Freelancers, NJ). Exhibit 2 shows, as of June 30, 2015, CO-OPs' cumulative reported net income since January 1, 2014, reported assets (including projected risk corridor receivables), reported obligations (startup loans, solvency loans, and operating liabilities), and the ratio of reported obligations to assets.[6] It also

[6] CoOpportunity Health was in liquidation. The June 30, 2015 financial statement was not available for Freelancers, NJ.

shows the amount of projected risk corridor receivables included in reported assets, which assumed full payment of risk corridor requests.

Some CO-OPs experienced vastly larger enrollment in 2014 than had been projected in their applications and feasibility studies, greatly increasing their need for capital. Those CO-OPs generally had low premium rates compared with competitors. Other CO-OPs, generally with relatively high premium rates, had very low enrollment in 2014.[7] All but one CO-OP reported losing money in 2014 (even assuming full payment of projected risk corridor receivables, if any), with relatively high administrative costs.[8]

Some CO-OPs continued to grow rapidly in 2015, despite significant rate increases in some cases, further increasing their need for capital. Some CO-OPs with low 2014 enrollment lowered their premium rates and grew rapidly in 2015. Three CO-OPs (ME/NH, TN, and WI) reported small operating profits for the first half of 2015.[9]

For the 18 months ending June 30, 2015, only one CO-OP (ME/NH) reported positive net income (Exhibit 2). The 11 closed CO-OPs submitting June 30, 2015 financials reported a cumulative loss of $417.5 million during that period. The 10 CO-OPs still operating with June 30 financials reported a cumulative loss of $202.3 million.

Projected risk corridor receivables, which were much larger for the closed than operating CO-OPs ($441.5 million vs. $69.6 million), are included in reported revenues and assets (along with projected receivables and/or payments for the risk adjustment and reinsurance programs). Without risk corridor receivables, or incorporating only the amounts to be paid for 2014 based on CMS's October 1, 2015 announcement, the reported operating loss and ratio of obligations to assets would be much greater for many of the closed CO-OPs.

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[7] The Ohio CO-OP did not offer coverage on the exchange until 2015 but offered coverage off the exchange in 2014.
[8] For further discussion of CO-OPs' 2014 experience, see The Financial Condition of ACA CO-OPs, supra note 1; GAO, Private Health Insurance—Premiums and Enrollment for New Nonprofit Health Issuers Varied Significantly in 2014, GAO-15-304, April 2015; and OIG, Actual Enrollment and Profitability was Lower Than Projections Made by The Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loans Provided Under the Affordable Care Act, A-05-14-00055, July 2015.
[9] Community Health Alliance of Tennessee, which froze enrollment on January 15, 2015, reported a profit of $4,837.

Analysis of reported premiums (which include projected risk corridor receivables), medical expenses, and administrative expenses for 2014 and the first six months of 2015 indicates that reported medical expenses for the CO-OPs (excluding CoOpportunity Health and Freelancers, NJ) equaled 98 percent of premiums for the subsequently closed CO-OPs and 89 percent of premiums for those still operating. Administrative expenses equaled 31 percent of premiums for both groups combined in 2014 and 24 percent of premiums during the first two quarters of 2015.

Additional Loan Awards, Accelerated Loan Disbursements, and Closures

Many commentators praised the substantial enrollments of some CO-OPs in the first half of 2014 as indicators of program success. Instead, enrollment growth and early profit reports for CO-OPs with low premiums should have been a major cause for alarm given the uncertain environment and history of insurance company insolvencies. CO-OP viability was much more likely with slow and steady expansion.

CO-OP enrollment growth was accompanied by additional loan awards for six CO-OPs in 2014 to meet capital targets. Exhibit 3 shows for the 12 closed CO-OPs dates of announced closures, total award amounts, additional awards made in 2014, and, from data supplied to the PSI, total disbursements and the amount and date of the last solvency loan disbursement.[10]

CO-OPs in Connecticut, Iowa/Nebraska, Kentucky, Maine/New Hampshire, New York, and Wisconsin applied for and were approved for $355.5 million in additional solvency loans in the last four months of 2014.[11] The CO-OPs in Iowa/Nebraska, Kentucky, and New York were later closed. The closure of CoOpportunity Health in Iowa and Nebraska was announced in late December 2014, six weeks after disbursement of its additional $32,700,000 solvency loan award approved in September, and following the denial of a late October request for another $55 million. Health Republic of New York requested an additional $70.5 million in late October

[10] Some disbursements were made after the announcement of closure, apparently to permit the CO-OP to continue policies in force until the end of 2015.
[11] Loan Program Helps Support Customer-Driven Non-Profit Health Insurers (updated December 26, 2014), CMS, Center for Consumer Information & Insurance Oversight. In addition, the Massachusetts CO-OP received an additional $66 million solvency loan award in December 2013.

2014, following CMS approval of an additional $90.7 million solvency loan in September. The latter request was denied.

The Wisconsin CO-OP, still operating, received additional solvency loan awards of $28.5 million in September 2014 and $22.7 million in December 2014. The latter award exhausted the CO-OP program's authorized funding of $2.44 billion. CMS did not have the funds to approve the additional requests from CoOpportunity Health, Health Republic of New York, or any other CO-OPs.

CMS therefore lacked funding to make additional solvency loan awards in 2015. With the approval of state regulators, however, CMS permitted seven CO-OPs to convert their startup loans to surplus notes, thus allowing the startup loans to be counted as capital for meeting target capital ratios. Five CO-OPs that subsequently closed converted a total of $82.1 million in startup loans to surplus notes prior to closure (Exhibit 3).

Beyond additional loan awards and startup loan conversions, disbursements of solvency loans from CMS to many CO-OPs were accelerated during 2014 and 2015. According to data reported to the PSI, the disbursements generally were made during and following months in which claim costs were substantially greater than premiums.

Following its announced takeover in December 2014, state regulators determined in January 2015 that CoOpportunity Health (IA/NE) would be liquidated. CoOpportunity Health's award application, business plan, and actuarial feasibility study submitted to CMS in late 2011 projected slow enrollment growth beginning in 2014. Specifically, the October 2011 feasibility study by its actuarial consultant projected 11,142 enrollees in 2014, 31,500 enrollees in 2015, and 76,940 enrollees in 2020. The company's September 30, 2014 financial statement reported 50,746 enrollees as of March 31, 2014, 79,762 enrollees as of June 30, and 91,477 enrollees as of September 30. Thus, by September of its first year of operation, CoOpportunity Health had eight times the originally projected number of enrollees for 2014 and close to 15,000 more enrollees than originally had been projected for the year 2020.

Actuarial projections in 2013 supporting CoOpportunity Health's premium rate filings for 2014 included a 30 percent factor to allow for greater medical costs in the newly insured

population. Even so, the company's individual market rates were the lowest among insurers in three of Nebraska's four rating regions, lowest throughout Nebraska's small group market, lowest for one rating region in Iowa's individual market, and lowest in most rating regions for Iowa's small group market.

CoOpportunity Health's additional solvency loan request of $32.7 million in July 2014, which was supported by its actuarial consultant, reviewed by Deloitte, and approved by CMS, indicated that claims volume had been higher than expected and that a 17 percent average rate increase would be needed. Without additional funding, the company indicated that it would either have to merge with another insurer or freeze enrollment. CoOpportunity Health's October 2014 request (denied) for another $55 million to enable it to keep operating given continued enrollment growth indicated that it would need 40 percent rate increases over time following a 19 percent increase for 2015.

It appears that very little, if any, of CoOpportunity Health's $147 million in startup loans, solvency loans, and accrued interest will be repaid. The Special Deputy Liquidator for the company's liquidation reported that as of June 30, 2015 the estate had assets of $108.7 million, excluding risk corridor receivables, and claim liabilities of $109 million.[12] An update as of December 31, 2015 provided to the PSI showed assets of $61.6 million including CoOpportunity Health's actual $16.4 million risk corridor receivable for 2014, remaining claim obligations of $54.5 million, and a variety of other liabilities apart from federal loans.

Closures of much smaller CO-OPs in Louisiana and Nevada were announced in July and August 2015. Then in was announced on September 25, 2015 that Health Republic of New York, by far the largest CO-OP, would be closed. On October 1, CMS announced that risk corridor payments for 2014 would be limited to 12.6 percent of requests. Seven more CO-OP closures were announced prior to the onset of open enrollment on November 1, and the closure of the Michigan CO-OP was announced a few days later. Although no additional closures have since been announced, eight of the remaining CO-OPs are reported to be operating under CMS corrective action plans. The Illinois CO-OP Land of Lincoln Health limited enrollment in

[12] In the Iowa District Court for Polk County, In Re Liquidation of CoOpportunity Health, Special Deputy Liquidator's Second Status Report. Upon liquidation, the Iowa and Nebraska guaranty associations assumed claim payments pending resolution of the estate.

October 2015 and recently reported a net loss of $90.8 million for 2015 in conjunction with substantial enrollment growth during the year.[13]

Health Republic of New York's closure was a watershed event. Its 2011 application and feasibility studies contained baseline (best estimate) projections of 30,864 enrollees in 2014, 50,535 enrollees in 2015, and 100,323 enrollees in 2020. An alternative "high enrollment" scenario projected 44,492 enrollees in 2014 and 65,179 enrollees in 2015. The company reported 155,402 enrollees at year-end 2014 and 209,136 enrollees on June 30, 2015. Its 2015 enrollment was thus over three times the projected high enrollment scenario for 2015 and more than double its baseline enrollment projection for the year 2020.

Health Republic generally had the lowest 2014 premium rates in the regions it operated. It requested rate increases of 15 percent and 6 percent in the individual and small group markets for 2015. It received increases of 12.9 percent and 3.5 percent, respectively. Its rates remained generally low compared with other insurers.

Health Republic's additional solvency loan request for $90.7 million in July 2014 was based—with permission of New York regulators—on lower state capital standards than the previous target of 500 percent of risk-based capital. Its October 2014 request (denied) for another $70.5 million returned to the 500 percent target. That request projected 8 percent greater enrollment for 2014 and approximately 25 percent greater enrollment in 2015 and 2016 than had been projected four months earlier. A March 2015 study by its actuarial consultant nonetheless projected that the company would be economically viable based on baseline projections that assumed substantial reductions in administrative expenses and claims utilization.

CMS announced on June 30, 2015 that Health Republic was due $58.2 million in reimbursement from the ACA reinsurance program but owed $80.2 million for the risk adjustment program. Health Republic's June 30, 2015 financials projected $243.3 million in risk corridor program receivables. The company reported a cumulative loss of $130.2 million from January 1, 2014 through June 30, 2015 (Exhibit 2), assuming full collection of projected risk

[13] Kristen Schorsch, Crain's Chicago Business, March 1, 2016.

corridor receivables. This represents a loss of about $50 per member per month (three times that amount if projected risk corridor receivables are excluded).

The final tally of any closed CO-OP's deficits will depend on numerous factors including in particular the ultimate amounts owed for medical claims. The December 31, 2015 financial report for Health Republic of New York provided to the PSI makes it clear that none of its federal loans will be repaid. The entity's assets are projected to fall over $200 million short of amounts needed to pay providers and policyholders. New York does not have a guaranty fund or related mechanism for licensed health insurance company obligations.

I also reviewed updated financial data provided to the PSI for the 10 closed CO-OPs in addition to CoOpportunity Health and Health Republic of New York. Reported assets were less than claim and other obligations apart from startup and solvency loans for seven of the 10 CO-OPs and only marginally greater than those obligations in the other three states (Oregon, Tennessee, and Utah). Two of the states (Colorado and South Carolina) project substantial guaranty fund assessments. The data therefore suggest that little, if any, of federal loans will be repaid.

Unanswered Questions

The CO-OP program's experience raises a number of key questions—beyond the fundamental issue of whether the program made economic sense when enacted. When considering these questions, it is important to avoid 20-20 hindsight given the enormous degree and slow resolution of uncertainty concerning the magnitude of insured medical costs with the onset of the ACA's coverage expansion in 2014, as well as inherent uncertainty concerning the likelihood that a given CO-OP experiencing financial stress might achieve viability if allowed to continue operating. The following questions remain despite this caveat:

1. Was it appropriate and prudent to push for the CO-OPs to begin operations in 2014, as opposed to delaying start up for a year or two before selling tens of thousands of policies, in order to permit resolution of some uncertainty concerning the characteristics of the newly insured population and facilitate the development of necessary infrastructure, relationships, and care models?

2. Why were low premium rates charged by some CO-OPs not viewed as a signal of potentially inadequate rates, especially when their rate filings anticipated relatively high provider reimbursement and administrative expenses?

3. Why were some CO-OPs permitted to enroll far more customers than anticipated in financial projections supporting their applications, as opposed to having some formal or informal limits on growth imposed by CMS and/or state regulators?

4. Why didn't CMS delay solvency loan disbursements, or possibly terminate loan agreements, when confronted with enrollments far greater than anticipated and evidence of operating losses?

5. Why was the customary financing timeline seemingly reversed in some cases, with CO-OPs expanding rapidly and then seeking accelerated loan disbursements and/or additional loan awards from CMS to support that expansion, as opposed to obtaining funds in advance to finance anticipated growth?

6. Given the history of insurance insolvencies and the highly uncertain environment, why didn't the actuarial analyses supporting CO-OP applications and subsequent financial projections report a broader range of stress tests, including scenarios where higher than expected enrollment was accompanied by significantly higher than expected claim costs?

Marketing, Risk Stabilization Programs, and Funding Cuts

I believe that many if not most of the major players involved in the formation, funding, and operation of CO-OPs significantly underestimated the challenges and risks of launching new health insurance companies in 2014. The CO-OPs were inherently vulnerable to unpredictably high medical claim costs, including from any adverse selection associated with established carriers renewing pre-2014 policies, especially if enrollee growth outpaced projections.

Some commentators and CO-OP representatives have argued that restrictions on the use of federal loans for marketing undermined CO-OPs' ability to grow and diversify.[14] The loan

[14] A related argument is that program rules constraining CO-OPs' ability to expand into large group health insurance impeded their success. I regard it a more likely that expansion into large group markets would have made some CO-OPs' financial problems worse.

agreements, however, appear to have a relatively narrow interpretation of the term "marketing," which does not preclude activities related to community outreach and membership development. More important, restrictions on spending for marketing did not prevent explosive growth for some CO-OPs at unsustainable prices. Fewer constraints plausibly could have made matters worse.

With respect to the ACA risk stabilization programs, CO-OPs benefitted substantially from the transitional reinsurance program, including CMS decisions to lower the 2014 threshold for reimbursement from $60,000 to $45,000 and pay 100 percent of claims between $45,000 and $250,000 rather than 80 percent. On the other hand, 16 of the 22 CO-OPs subject to the CMS risk adjustment program (Massachusetts has its own system) owed payments for 2014 experience, including Health Republic of New York ($80.2 million), Kentucky Health CO-OP ($23.2 million), and 11 others ranging from $1 million to $8 million.[15] These CO-OPs had lower than average risk scores for their enrollees in their state of operation. Two of the closed CO-OPs were owed risk adjustment payments (Meritus, $0.8 million, and CoOpportunity Health, $4.1 million) due to higher than average risk scores. The risk adjustment formula could have flaws that disproportionately affect small insurers. It also has been argued that CO-OPs were disadvantaged versus established insurers in ensuring that all enrollee health conditions affecting risk scores and risk adjustment were recorded.

As discussed earlier, shown in Exhibit 2, and consistent with large operating losses, a number of the closed CO-OPs had projected substantial risk corridor receivables. They therefore were disproportionately affected by the payment of only 12.6 percent of risk corridor reimbursement requests for 2014 and the likelihood of much smaller reimbursement over time. Some closed CO-OPs' representatives argue that they would have been able to achieve viability if substantially more of their risk corridor requests were paid. But those requests were high in large part because of rapid growth at inadequate premium rates. While perhaps anything is possible, the evidence suggests that using taxpayer funds for greater risk corridor payments

[15] CMS, Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year, June 30, 2015.

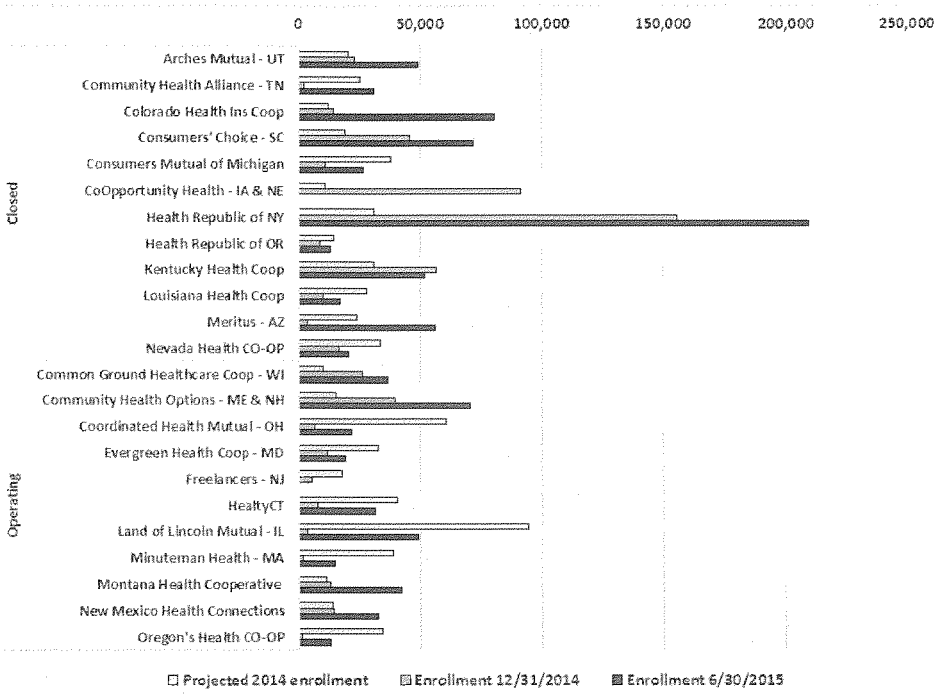
would very likely have risked having some CO-OPs expand even further, with inadequate premium rates and relatively high administrative costs.

Finally, some commentators and CO-OP representatives have blamed closures on Congressional reductions in CO-OP program funding. But by preventing CO-OPs from being established in more states and limiting CMS's ability to provide additional solvency loans to existing CO-OPs, the reductions very likely prevented both the funding of more CO-OPs that would not have been viable and able to repay government loans and the extension of additional funding to at least some CO-OPs that would ultimately fail.

Thank you for the opportunity to testify.

Exhibit 1

CO-OP Projected 2014 Enrollment and Reported Enrollment 12/31/2014 and 6/30/2015



Reported enrollment from 12/31/2014 and 6/30/2015 statutory financial statements; projected 2014 enrollment from OIG A-05-14-00055, July 2015. CoOpportunity Health reported enrollment as of 9/30/14. Freelancers, NJ not available 6/30/2015.

Exhibit 2
CO-OP Reported Financial Results through 6/30/2015

		Reported income, 1/1/14 - 6/30/2015 ($000)	Reported obligations 6/30/2015 ($000)	Reported assets 6/30/2015 ($000)	Reported risk corridor receivables 6/30/2015 ($000)	Obligations / assets 6/30/2015
Closed	Arches Mutual - UT	-$24,160	$108,669	$77,195	$0	141%
	Colorado Health Ins Coop	-$27,633	$146,516	$108,691	$40,540	135%
	Community Health Alliance - TN	-$22,126	$110,048	$78,460	$8,821	140%
	Consumers' Choice Health Ins - SC	-$4,225	$150,728	$135,228	$31,276	111%
	Consumers Mutual of Michigan	-$27,419	$97,596	$60,401	$6,085	162%
	Health Republic of NY	-$130,229	$685,362	$525,301	$243,288	130%
	Health Republic - OR	-$18,690	$82,490	$40,905	$2,504	202%
	Kentucky Health Coop	-$54,399	$252,982	$189,503	$81,600	133%
	Louisiana Health Coop	-$34,832	$92,497	$49,327	$9,714	188%
	Meritus - AZ	-$28,054	$131,686	$72,853	$1,463	181%
	Nevada Health CO-OP	-$45,717	$89,608	$47,923	$16,200	187%
	Total	-$417,484	$1,948,182	$1,385,787	$441,491	141%
Operating	Common Ground Healthcare Coop - WI	-$35,820	$184,269	$141,736	$47,866	130%
	Community Health Options - ME and NH	$9,250	$103,102	$100,884	$0	102%
	Coordinated Health Mutual - OH	-$14,963	$115,956	$79,178	$0	146%
	Evergreen Health Coop - MD	-$20,643	$75,461	$43,512	$0	173%
	HealthyCT	-$37,518	$178,295	$118,258	$0	151%
	Land of Lincoln Mutual - IL	-$43,502	$145,155	$84,570	$515	172%
	Minuteman Health - MA	-$28,778	$103,440	$61,924	$3,449	167%
	Montana Health Cooperative	-$9,979	$101,920	$85,849	$12,070	119%
	New Mexico Health Connections	-$8,716	$88,779	$62,375	$5,414	142%
	Oregon's Health CO-OP	-$11,654	$56,057	$32,770	$320	171%
	Total	-$202,323	$1,152,434	$811,056	$69,634	142%

Obligations include startup and solvency loans. Assets include projected risk corridor receivables as of June 30, 2015 (prior to CMS announcement concerning reduced payment). Data from statutory financial statements. Freelancers, NJ, June 30, 2015 financials not available.

Exhibit 3
Loan Awards and Disbursements for Closed CO-OPs

	Announced Closure	Total Award	Total Disbursed	Additional Award in 2014		Last Solvency Loan Disbursement		2015 Startup Loan Conversion
				Amount	Date	Amount	Date	
CoOpportunity Health - IA & NE	12/23/2014	$145,312,100	$145,312,100	$32,700,000	9/26/2014	$32,700,000	11/14/2014	
Louisiana Health Coop	7/24/2015	$65,790,660	$65,790,660			$9,263,798	11/27/2015	
Nevada Health CO-OP	8/26/2015	$65,925,396	$65,900,396			$5,854,666	6/29/2015	$17,105,047
Health Republic of NY	9/25/2015	$265,133,000	$264,966,400	$90,688,000	9/26/2014	$32,512,852	6/29/2015	
Kentucky Health Coop	10/9/2015	$146,494,772	$144,066,123	$65,000,000	11/10/2014	$45,800,000	12/23/2014	
Community Health Alliance - TN	10/14/2015	$73,306,700	$73,306,700			$34,297,300	2/26/2015	
Health Republic of OR	10/16/2015	$60,648,505	$60,623,505			$8,378,610	4/30/2015	$10,252,005
Consumers' Choice - SC	10/22/2015	$87,578,208	$87,578,208			$36,458,608	2/26/2015	
Arches Mutual - UT	10/27/2015	$89,650,303	$85,637,146			$10,250,000	11/23/2015	
Meritus - AZ	10/30/2015	$93,313,233	$93,313,233			$19,449,102	8/14/2015	$20,890,333
Colorado Health Coop	10/30/2015	$72,335,129	$72,335,129			$4,837,116	2/2015	$15,205,529
Consumers Mutual of Michigan	11/3/2015	$71,534,300	$71,534,300			$5,362,712	11/19/2015	$18,687,000
Total		$1,237,022,306	$1,230,363,900	$188,388,000		$245,164,764		$82,139,914

Award amounts from CMS; disbursement data from PSI.

United States Senate
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS
Committee on Homeland Security and Governmental Affairs
Rob Portman, Chairman

Failure of the Affordable Care Act Health Insurance CO-OPs

MAJORITY STAFF REPORT

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

UNITED STATES SENATE

March 10, 2016

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Chairman

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Failure of the Affordable Care Act Health Insurance CO-OPs

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I. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) created the Consumer Operated and Oriented Plan Program—known as the CO-OP Program. Under the CO-OP Program, the Department of Health and Human Services (HHS) distributed loans to consumer-governed, nonprofit health insurance issuers. HHS ultimately received $2.4 billion of taxpayer money to fund 23 CO-OPs that participated in the program. Twelve of those 23 CO-OPs have now failed, leaving 740,000 people in 14 states searching for new coverage and leaving the taxpayer little hope of recovering the $1.2 billion in loans HHS disbursed to those failed insurance businesses.

The Senate Permanent Subcommittee on Investigations (PSI) has completed an investigation of that failure—and whether HHS exercised good stewardship of public money when it poured billions of dollars into these insurance startups. Our investigation revealed that it did not. HHS was alerted to weaknesses in the failed CO-OPs' business plans and financial forecasts before it approved their initial loans; failed to use major accountability and oversight tools available to it throughout 2014 even though it knew of the CO-OPs' severe financial distress; continued to disburse loans to failing CO-OPs despite warning signs; and allowed CO-OPs to continue to book risk corridor payments as assets despite credible warnings that those payments would not materialize. We summarize some of our key findings below.

First, HHS approved the failed CO-OPs despite receiving specific warnings from a third-party analyst about weaknesses in their business plans. Before it approved the now-failed CO-OPs, HHS retained Deloitte Consulting LLP to evaluate the CO-OPs' loan applications and business plans. Deloitte's analysis, reviewed by the Subcommittee, notified HHS of several significant weaknesses in the CO-OPs' business proposals. Those weaknesses included:

- **Defective Enrollment Strategies**. Deloitte identified serious problems in the enrollment strategy of seven of the 12 failed CO-OPs. Those problems ranged from inadequate actuarial analysis, to unsupported assumptions about sustainable premiums, to a lack of demonstrated understanding of the health demographics of the CO-OP's target population.

- **Budgetary and Financial Planning Problems**. Deloitte's reports reveal that the proposed budgets of 10 of the 12 failed CO-OPs were incomplete, and Deloitte thought that many were unreasonable, not cost-effective, or not aligned with the CO-OP's own financial projections. Deloitte also expressed skepticism about the risk-taking and unreasonable assumptions reflected in some of the CO-OPs' financial projections. The firm warned that Colorado, Utah, and Louisiana all relied on unreasonable projections of their own growth.

It cautioned that it could not trace the assumptions underlying the budgets of the Nevada, Tennessee, and Kentucky CO-OPs to their actual business plans. And, perhaps tongue-in-cheek, it observed that Iowa and Nebraska's CO-OP, CoOpportunity, had a target profit "much lower than the industry benchmark" of 4.8%: CoOportunity's stated target profit margin was *zero*.

- **Management Weaknesses**. HHS required the CO-OP applicants to identify their management teams, including the qualifications and experience of its leadership. In Deloitte's reports to HHS, the firm identified some leadership concerns for all of the 12 failed CO-OPs. Several prospective CO-OPs had not even identified their senior leadership team, and others had executives for whom background checks turned up red flags.

Despite these identified weaknesses, Deloitte gave each CO-OP a "passing" score based on a grading scale set by HHS, and HHS approved the loans in spite of the warning signs.

Second, even though HHS was aware of serious financial distress suffered by the CO-OPs in 2014, it failed to take any corrective action or enhance oversight for more than a year. The CO-OP loan agreements armed HHS with significant accountability tools for borrowers who were missing the mark, but here HHS took a pass. Inexplicably, for over a year, the agency took *no* corrective action, nor did it put any CO-OP on enhanced oversight. Five of the 12 failed CO-OPs were *never* subject to corrective action by HHS, and HHS waited until September 2015 to put five others on corrective action or enhanced oversight. Two months later, all twelve CO-OPs had failed.

That failure to take action is difficult to understand. Throughout 2014 and 2015, HHS regularly received key financial information from the CO-OPs, including monthly reports on enrollment and financial data sufficient to calculate net income, along with audited quarterly financial statements. Those reports showed that the failed CO-OPs experienced severe financial losses that quickly exceeded even the *worst-case* loss projections they had provided to HHS as part of the business plans in their loan applications. Cumulatively, by the end of 2014, the failed CO-OPs exceeded their projected worst-case-scenario losses by at least $263.7 million—— four times greater than the expected amount. The CO-OPs' enrollment numbers were similarly alarming. According to the 2014 reports they submitted to HHS, five of the failed CO-OPs dramatically underperformed enrollment expectations (leading to insufficient income for premiums), while five others *overshot* their enrollment projections (which also causes losses due to underpriced premiums). HHS was aware of these problems in *early* 2014, but took no corrective action and continued to disburse loans to the distressed CO-OPs.

Third, despite serious financial warning signs, HHS did not withhold any loan disbursements from the now-failed CO-OPs—and in many cases accelerated planned disbursements. Instead, over the course of 2014–2015, HHS disbursed $848 million in taxpayer dollars to the failed CO-OPs, even as those entities lost more than $1.4 billion. For every dollar that HHS sent them over this period, the failed CO-OPs lost about $1.65.

Fourth, HHS approved *additional* solvency loans for three of the failed CO-OPs in danger of being shut down by state regulators, despite obvious warning signs that those CO-OPs will not be able to repay the taxpayer. State regulators require health insurers to maintain a certain amount of capital reserve—called the "risk based capital" requirement. HHS made solvency loans available to the CO-OPs at risk of failing to meet these requirements, and to date has issued additional solvency loans to six CO-OPs, for a total of $352 million. As with CO-OPs' initial loan applications, Deloitte completed the external assessment for these additional solvency loans. But according to Deloitte, HHS required a truncated analysis of the applications; for example, Deloitte did not even evaluate the "the likelihood that each CO-OP would achieve sustainable operations based on the revised business plan."

Three of the CO-OPs that received additional solvency funds from HHS have since failed. The Subcommittee's investigation revealed that HHS issued those additional loans despite clear warnings that the CO-OPs were in financial trouble.

- **Kentucky CO-OP**. HHS approved a $65 million additional solvency loan to the Kentucky CO-OP. It did so even though Deloitte's review of the CO-OP's application revealed several problems, including failure to provide any detail for its plans to remedy enrollment difficulties; an unsupported explanation of its plans to raise premiums by 15%; an unexplained projection that the CO-OP would reduce its medical loss ratio by 74% in the coming year; and questionable income projections.
    - **Result:** The Kentucky CO-OP eventually collapsed after suffering losses of $50.4 million in 2014 and another $114.8 million in 2015.
- **New York CO-OP**. The New York CO-OP received $90.7 million in additional solvency funding despite severe financial difficulties brought on largely by too-high enrollment in 2014, after the CO-OP dramatically underpriced its premiums. In its application for additional solvency funds, the CO-OP proposed to solve this problem by raising premiums by 10%, but Deloitte told HHS that the CO-OP had failed to analyze the effect that would have on enrollment and failed provide any concrete data supporting the effectiveness of its proposed plan. Deloitte noted the option that the CO-OP could forego

additional loans and "scale down its operation." But rather than scale down, in September 2014, HHS granted the New York CO-OP a $90.7 million additional solvency loan that would allow it to *scale up*—in every respect but profits.

- **Result**: The New York CO-OP's losses reached a staggering $544 million by the end of 2015. It was shut down by the New York Department of Financial Services near the end of 2015, leaving more than 215,000 policyholders to search for new insurance policies.

- **Iowa and Nebraska CO-OP (CoOpportunity).** CoOpportunity, the CO-OP serving Iowa and Nebraska, received $32.7 million in additional solvency loan funding. But given the unsupported assumptions underlying the CO-OP's proposed solutions to its financial woes, Deloitte warned HHS that the loan may not be enough to permit the CO-OP to maintain its solvency. In addition, Deloitte cautioned that CoOportunity's financial projections depended heavily—to the tune of $94.6 million—on the availability of so-called 3R funds from ACA risk sharing measures.

  - **Result:** Less than three months after HHS approved CoOportunity's additional solvency loan, the Iowa Insurance Division suspended and later liquidated it. CoOportunity's operating losses exceeded $163 million, and its liabilities exceeded its assets by $50 million. The CO-OP's closure left 120,000 policyholders scrambling to find a new insurance plan mid-year.

Fifth, HHS looked on as the CO-OPs booked, as assets, massive uncertain payments from the ACA's risk corridor program. That program requires profitable insurers to pay into a government fund to compensate insurers suffering a loss; but because it is intended to be budget-neutral, if there are not enough payments *into* the fund, insurers with losses have no source of risk corridor income. By October 2014, a research arm of Citibank had publicly warned that HHS would not collect "nearly enough" from profitable insurers to cover risk corridor payments to the unprofitable. And Deloitte specifically cautioned HHS that the struggling CO-OPs were relying heavily on uncertain risk corridor payments to prop up their financial forecasts. But HHS continued to predict, as recently as July 2015, that "risk corridor collections will be sufficient to pay for all risk corridor payments." In reality, HHS was able to pay only 12.6 cents on the dollar. That shortfall further destabilized the CO-OPs.

Sixth, the heavy costs of failed CO-OPs will be borne by taxpayers, doctors, patients, and other insurers. None of the failed CO-OPs have repaid a single dollar,

principal or interest, of the $1.2 billion in federal solvency and start-up loans they received. Our investigation suggests no significant share of those loans ever will be repaid based on the latest balance sheets we obtained. In the aggregate, the failed CO-OPs' *non-loan* liabilities exceed $1.13 billion—which is 93% greater than their reported assets. All 12 failed CO-OPs told PSI they had no "planned payments" on any of their CO-OP loans. And when the Subcommittee asked HHS for its projections or assessment of the prospects for repayment, the Department could not provide any.

The American taxpayer is not the only creditor that stands to suffer large losses due to the failure of the CO-OP program. The closed CO-OPs currently owe a substantial amount of money in medical claims to doctors and hospitals. At least six failed CO-OPs currently owe more in medical claims than they hold in assets. Three of those (Colorado, South Carolina, and CoOpportunity) will be able to access funds from statewide insurance guaranty associations—meaning *other* insurance companies must cover the CO-OPs losses, ultimately through increased premiums to their policyholders. But the other three—New York, Louisiana, and Kentucky—have no recourse to guaranty funds, so the burden of unpaid medical claims may be borne by doctors, hospitals, and enrolled individuals. The New York CO-OP, for example, reported that it had approximately $380 million in unpaid medical claims and $158 million in assets as of December 31, 2015—a shortfall of *$222 million.*

* * *

After detailing these findings, this report briefly addresses two misconceptions about the CO-OP program. First, HHS officials and others have sometimes suggested that the CO-OPs' financial difficulty was caused by "adverse selection"—by attracting enrollees with above-average health risks. But the agency's own data from the ACA's risk adjustment program indicates otherwise. That program redistributes money from insurers with healthier enrollees to those with less healthy enrollees. Our analysis of the data shows that the failed CO-OPs were net *payors* of risk corridor charges (by $116 million), which indicates that as a class they enrolled healthier—not sicker—policyholders than others in their states.

Second, HHS officials have suggested publicly that a series of budget cuts to the CO-OP program contributed to the collapse of the 12 failed CO-OPs. There is no evidence to support that claim. The failed CO-OPs received $350 million *more* than they requested in their loan applications, and HHS was aware of the first two of three budget cuts before it made any awards. The primary consequence of CO-OP budget cuts was to prevent HHS from launching *additional* CO-OPs—one for each state, as the law directed—and thus limit future losses to the taxpayer.

II. BACKGROUND

The Patient Protection and Affordable Care Act (ACA) created the Consumer Operated and Oriented Plan program—known as the CO-OP program.[1] Under the CO-OP program, the Department of Health and Human Services (HHS) distributed loans to consumer-governed, nonprofit health insurance issuers. Congress initially allocated $6 billion for the CO-OP Program,[2] with the goal of establishing CO-OPs in all 50 states and the District of Columbia.[3] Subsequent legislation reduced funding for the program, and HHS ultimately awarded $2.4 billion to fund 23 CO-OPs that participated in the program.[4]

In early 2015, CoOportunity Health, the CO-OP established in Iowa and Nebraska, failed.[5] Since then, an additional 11 CO-OPs have failed.[6] In total, the failed CO-OPs received $1.2 billion in federal loans, and their collapse left 740,000 people in 14 states searching for new coverage.[7]

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[1] *See* 42 U.S.C. § 18042(a)(1) ("The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO-OP) program."). HHS's Centers for Medicare & Medicaid Services (CMS) administered the program, but for simplicity we refer to HHS throughout this report.

[2] *See id.* § 18042(g) ("There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $6,000,000,000 to carry out this section.").

[3] *See id.* § 18042(b)(2)(B) ("If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.").

[4] Robert Pear, *Most Health Insurance Co-ops Are Losing Money, Federal Audit Finds*, NY TIMES (Aug. 14, 2015) (explaining that the 23 CO-OPs "have received $2.4 billion in federal loans to help pay start-up costs and to meet state solvency requirements"), http://www.nytimes.com/2015/08/15/us/most-health-insurance-co-ops-are-losing-money-federal-audit-finds.html?mtrref=www.google.com&gwh=BB95458959A76808E77C498EB0AD76B9&gwt=pay&_r=0.

[5] *See* Anna Wilde Mathews, *State Regulator to Shut Down Insurer CoOportunity Health*, WALL ST. J. (Jan. 23, 2015) ("Iowa's insurance regulatory plans to shut down insurer CoOportunity Health, making it the first failure of one of the nonprofit cooperatives created under the Affordable Care Act."), http://www.wsj.com/articles/state-regulator-to-shut-down-insurer-cooportunity-health-1422052829.

[6] The list of failed CO-OPs is as follows: CoOportunity Health (Iowa and Nebraska); Louisiana Health Cooperative, Inc.; Nevada Health Cooperative, Inc.; Health Republic Insurance of New York; Kentucky Health Care Cooperative (Kentucky and West Virginia); Community Health Alliance Mutual Insurance Company (Tennessee); Colorado HealthOp; Health Republic Insurance of Oregon; Consumers' Choice Health Insurance Company (South Carolina); Arches Mutual Insurance Company (Utah); Meritus Health Partners (Arizona); Michigan Consumer's Healthcare CO-OP.

[7] Amy Goldstein, *More Than Half of ACA Co-ops Now Out Of Insurance Marketplaces*, WASH. POST (Nov. 3, 2015), https://www.washingtonpost.com/national/health-science/more-than-half-of-aca-co-

A. HHS's Loan Decisions.

HHS received loan applications between July 2011 and December 2012.[8] Among other things, an organization was eligible to become a CO-OP if it was owned and operated by its customers, was a nonprofit organization, and could demonstrate to HHS a high probability of financial viability.[9] As part of the application to become a CO-OP, HHS required applicants to describe the proposed CO-OP's governance structure, including its plans to conform with regulations established in 45 C.F.R. §§ 156.500-520; describe its operational, financial, and administrative strategies; and disclose its bylaws.[10] HHS also required applicants to submit a feasibility study and a business plan. The feasibility study included an actuarial analysis examining the likelihood of success for the CO-OP.[11] The business plan included information about the applicant's management team; the markets to be served; the plans the CO-OP would offer; a description of why plans would be appropriate for the target market; a description of the CO-OP's strategy for enrolling members; and information about the CO-OP's budget and plans to repay HHS-provided loans.[12]

HHS reviewed these applications with the assistance of outside consultants and, based on its own review, decided whether to make a loan. HHS also decided how large a loan to make, and in doing so, considered four factors: (1) the results of the external review; (2) the size of the loan request and the CO-OP's anticipated results; (3) the CO-OP's ability to repay the loan; and (4) the likelihood that the CO-OP would meet program objectives.[13]

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ops-now-out-of-insurance-marketplaces/2015/11/03/5ba95b86-824b-11e5-9afb-0c971f713d0c_story.html.

[8] *See generally* Dep't of Health & Human Servs., Centers for Medicare & Medicaid Servs., *Loan Funding Opportunity Number: OO-COO-11-001* (July 28, 2011, rev. Dec. 9, 2011), http://apply07.grants.gov/apply/opportunities/instructions/oppOO-COO-11-001-cfda93.545-instructions.pdf.

[9] *Id.* at 43.

[10] *Id.* at 32-33.

[11] *Id.* at 33.

[12] *Id.* at 33-36.

[13] Dep't of Health & Human Servs., Office of Inspector Gen., *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance With Federal Requirements, and Continued Oversight Is Needed*, at 2 (July 30, 2013), http://oig.hhs.gov/oas/reports/region5/51200043.pdf.

There were two types of available loans, both distributed pursuant to a Loan Agreement between HHS and the CO-OP: start-up loans and solvency loans.[14] Start-up loans covered certain specified costs of establishing a CO-OP, including employee salaries and benefits, consultant costs, and equipment.[15] Solvency loans were used to cover capital reserve requirements and other solvency requirements established and monitored by state insurance regulators.[16] Under the CO-OP loan agreements, solvency loans were disbursed as needed to meet those risk-based capital requirements as well as HHS's own risk-based capital standard.[17] But HHS retained discretion to withhold any disbursement if, *inter alia*, the CO-OP failed to meet performance levels set by a corrective action plan; it could also terminate the agreement.[18]

The process for receiving loans was as follows: CO-OPs applied for both start-up loans and solvency loans at the same time. HHS then decided whether and how much to award the CO-OP. Once it did so, HHS distributed a portion of the start-up loan; additional disbursements of funds were contingent on the CO-OP meeting milestones established by the Loan Agreement.[19] With respect to solvency loans, HHS first distributed a portion of the funds and then distributed additional funds as needed to meet risk-based capital requirements.[20] Start-up loans were due to be repaid within five years; solvency loans were due within 15 years.[21]

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[14] 45 C.F.R. § 156.520(a) ("Applicants may apply for the following loans under this section: Start-up Loans and Solvency Loans.").

[15] *See* Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *Loan Funding Opportunity Number: OO-COO-11-001*, at 10, 35 (July 28, 2011, rev. Dec. 9, 2011) ("Start-up Loans are intended to assist applicants with approved start-up costs associated with establishing a new health insurance issuer."), http://apply07.grants.gov/apply/opportunities/instructions/oppOO-COO-11-001-cfda93.545-instructions.pdf.

[16] 45 C.F.R. § 156.520(a)(2)("Solvency Loans awarded under this section will be structured in a manner that ensures that the loan amount is recognized by State insurance regulators as contributing to the State-determined reserve requirements or other solvency requirements (other than debt) consistent with the insurance regulations for the States in which the loan recipient will offer a CO-OP qualified health plan.").

[17] *See, e.g.*, Loan Agreement Between Michigan CO-OP and HHS § 5 (executed Aug. 29, 2012).

[18] *See id.* §§ 5.3, 12.1, 16.2.

[19] *See* Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *Loan Funding Opportunity Number: OO-COO-11-001*, at 10 (July 28, 2011, rev. Dec. 9, 2011) ("After the first drawdown of Start-up Loan funds, subsequent drawdowns will be conditioned on the submission of evidence of the loan recipient's successful completion of milestones described in loan recipients' Business Plan and Loan Agreement."). http://apply07.grants.gov/apply/opportunities/instructions/oppOO-COO-11-001-cfda93.545-instructions.pdf; *id.* at 12 (same for Solvency Loans).

[20] 45 C.F.R. § 156.520(b)(1), (c)(1).

[21] *Id.* § 156.520(b)(2), (c)(2).

By January 1, 2014—the date the program took effect—HHS awarded $2.4 billion to 23 CO-OPs operating in 26 states. The following table summarizes loan award amounts allotted to each of the 23 CO-OPs.[22]

CO-OP States	Start-up Loan Award	Solvency Loan Award	Total Award Amount
Health Republic Insurance of New York (New York)	$23,767,000	$241,366,000	$265,133,000
Minutemen Health, Inc. (Massachusetts/New Hampshire)	$25,091,995	$131,351,000	$156,442,995
Kentucky Health Care Cooperative (Kentucky/West Virginia)	$21,996,872	$124,497,900	$146,494,772
CoOportunity Health (Iowa/Nebraska)	$14,700,000	$130,612,100	$145,312,100
Maine Community Health Options (Maine)	$12,506,124	$119,810,000	$132,316,124
InHealth Mutual Ohio (Ohio)	$15,977,304	$113,248,300	$129,225,604
HealthyCT (Connecticut)	$21,011,768	$106,969,000	$127,980,768
Health Republic Insurance of New Jersey (New Jersey)	$14,757,250	$94,317,300	$109,074,550
Common Ground Healthcare Cooperative (Wisconsin)	$7,635,155	$100,104,199	$107,739,354
Land of Lincoln Health (Illinois)	$15,940,412	$144,214,400	$160,154,812
Meritus Health Partners (Arizona)	$20,890,333	$72,422,900	$93,313,233
Arches Mutual Insurance Company (Utah)	$10,106,003	$79,544,300	$89,650,303
Consumers' Choice Health Insurance Co. (South Carolina)	$18,709,800	$68,868,408	$87,578,208
Montana Health Cooperative (Montana/Idaho)	$8,556,488	$76,463,200	$85,019,688
New Mexico Health Connections (New Mexico)	$13,050,282	$64,267,500	$77,317,782
Community Health Alliance Mutual Insurance Co. (Tennessee)	$18,504,700	$54,802,000	$73,306,700
Colorado HealthOp (Colorado)	$15,205,529	$57,129,600	$72,335,129

[22] U.S. Gov't Accountability Off., GAO-15-304, *Private Health Insurance: Premiums and Enrollment for New Nonprofit Health Insurance Issuers Varied Significantly in 2014,* at 24 (Apr. 2015), http://www.gao.gov/assets/670/669945.pdf.

Consumer's Mutual Insurance of Michigan (Michigan)	$18,687,000	$52,847,300	$71,534,300
Louisiana Health Cooperative, Inc. (Louisiana)	$13,176,560	$52,614,100	$65,790,660
Nevada Health Cooperative, Inc. (Nevada)	$17,105,047	$48,820,349	$65,925,396
Evergreen Health Cooperative, Inc. (Maryland)	$13,341,700	$52,109,200	$65,450,900
Health Republic Insurance of Oregon (Oregon)	$10,252,005	$50,396,500	$60,648,505
Oregon's Health CO-OP (Oregon)	$7,156,900	$49,500,000	$56,656,900
TOTAL award amounts:	**$358,126,227**	**$2,086,275,556**	**$2,444,455,783**

B. CO-OPs Begin to Fail.

Of the 23 CO-OPs, 12 have already failed.[23] In this section, we provide brief summaries of each of the failed CO-OPs. Throughout this report, for simplicity, we generally refer to the failed CO-OPs below by their state (*e.g.*, The Louisiana CO-OP) rather than their formal names.

- **CoOportunity Health (Iowa and Nebraska).** CoOportunity Health was awarded an initial $112 million HHS loan in February 2012,[24] followed by an additional $32 million solvency loan award in September 2014.[25] Less than three months later, on December 16, 2014, it was placed under supervision by the Iowa Insurance Division.[26] It was liquidated on February 28, 2015.[27] According to the Insurance Division, liquidation was necessary because "rehabilitation of CoOportunity [was] not possible . . . and medical claims

[23] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[24] *Id.*
[25] *Id.*
[26] Pet. for Order of Liquidation, *Iowa v. Gerhart,* Equity Case No. EQCE077579, ¶ 14, http://www.iid.state.ia.us/sites/default/files/press_release/2015/01/29/petition_pdf_11438.pdf.
[27] *Insurers Should Learn From CoOportunity Health Collapse,* LAW360 (Mar. 18, 2015) (noting that "CoOportunity Health was ordered into liquidation on March 2, 2015"), http://www.law360.com/articles/631678/insurers-should-learn-from-cooportunity-health-collapse.

currently exceed cash on hand."[28] At the time, CoOportunity had operating losses over $163 million and $50 million more in liabilities than in assets.[29]

- **Louisiana Health Cooperative, Inc.** The Louisiana CO-OP was awarded a $65 million HHS loan in September 2012 and an additional $750,000 loan in December 2013.[30] On July 7, 2015, the CO-OP's Board of Directors agreed to wind down its activities.[31] As the Louisiana Insurance Commission explained, "the continued operation and further transaction of business by [Louisiana Health Cooperative] would be hazardous to policy holders, subscribers, members, enrollees, creditors, and/or the public."[32]
- **Nevada Health Cooperative, Inc.** The Nevada CO-OP was awarded a $66 million HHS loan in May 2012.[33] On August 21, 2015, the Nevada Division of Insurance suspended the CO-OP's operations.[34] According to the Division of Insurance, in the previous six months, the CO-OP's "operating loss . . . [wa]s greater than 50 percent of [its] surplus" and the CO-OP likely could not satisfy the state's capital and reserve requirements.[35]
- **Health Republic Insurance of New York.** HHS awarded the New York CO-OP an initial $175 million loan in February 2012[36] and an additional $91

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[28] Press Release, Iowa Insurance Division, http://www.iid.state.ia.us/node/10074702.
[29] Final Order of Liquidation, *Iowa ex rel. Gerhart, Comm. of Ins. v. CoOportunity Health, Inc.*, Equity No. EQCE077579, at 4 (Mar. 2, 2015), http://www.doi.nebraska.gov/legal/cooportunity/FINAL%20ORDER%20OF%20LIQUIDATION.pdf.
[30] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[31] Pet. for Rehabilitation, Injunctive Relief, and Rule to Show Cause of Louisiana Health Cooperative, Inc., *Donelon v. Louisiana Health Cooperative, Inc.*, No. 641928, ¶ 11 (Sept. 1, 2015), https://www.ldi.la.gov/docs/default-source/documents/financialsolvency/receivership/Louisiana-Health-Cooperative/petition-for-rehabilitation.pdf?sfvrsn=0.
[32] *Id.* ¶¶4, 5.
[33] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[34] Pet. for Appointment of Commissioner as Receiver and Other Permanent Relief, Case No. A-15-725244-C, at 5 (Sept. 25, 2015) ("On August 21, 2015, the Commissioner issued an Order of Voluntary Suspension."), http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/News-Notes/2015-09-25%20File%20Stamped%20Appointment%20Petition%20re%20CO-OP%20Receivership.pdf.
[35] *Id.* at 7.
[36] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit*

million loan in September 2014.[37] On September 25, 2015, the New York Department of Financial Services (NYDFS) directed the CO-OP to cease writing new health insurance policies and announced that the CO-OP would commence an orderly wind down after the expiration of its existing policies.[38] When the CO-OP began its wind down, the NYDFS had an ongoing investigation "specifically focused on the New York CO-OP's inaccurate financial reporting"—with particular focus on "collecting and reviewing evidence related to the New York CO-OP's substantial underreporting to [the NYDFS] of its financial obligations."[39]

- **Kentucky Health Care Cooperative (Kentucky and West Virginia).** HHS awarded the Kentucky CO-OP an initial $58.5 million loan on June 19, 2012.[40] In 2013 and 2014, it received an additional $85 million in loans, including a $65 million solvency loan in late 2014.[41] The CO-OP announced on October 9, 2015 that it would stop offering health plans on the ACA marketplace.[42] A court order liquidating the CO-OP concluded that "the further transaction of business would be hazardous, financially or otherwise, to its policy holders and to the public."[43]

Health Insurers (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[37] Press Release, House Energy & Commerce Committee (Nov. 25, 2015), https://energycommerce.house.gov/news-center/press-releases/committee-leaders-press-administration-status-remaining-1-billion.

[38] Press Release, New York Dep't of Fin. Servs. (Oct. 30, 2015), http://www.dfs.ny.gov/about/press/pr1510301.htm.

[39] Press Release, New York Dep't of Fin. Servs. (Nov. 13, 2015), http://www.dfs.ny.gov/about/press/pr1511131.htm.

[40] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[41] *Id.; see* Adam Beam, *Health Insurer Receives $65 Million Federal Loan*, WASH. TIMES (Dec. 18, 2014) ("A Kentucky nonprofit that is one of the largest insurance providers on the state's health exchange received a $65 million federal loan last month to keep it afloat just days before the second open enrollment period began."), http://www.washingtontimes.com/news/2014/dec/18/health-insurer-receives-65-million-federal-loan/.

[42] Press Release, Kentucky Health Cooperative, Inc. (Oct. 9, 2015), http://www.prnewswire.com/news-releases/kentucky-health-cooperative-not-offering-plans-in-2016-300157384.html.

[43] Order of Liquidation, *Maynard v. Kentucky Health Cooperative, Inc.*, at 3.

- **Community Health Alliance Mutual Insurance Company (Tennessee).** HHS awarded a $73 million loan to the Tennessee CO-OP in August 2012.[44] On October 14, 2015, it announced its plans to wind down and not sell health plans in 2016.[45] The Tennessee Department of Insurance stated that "the risk of the [Tennessee CO-OP's] potential failure in 2016 was too great" to allow it to continue operations.[46]
- **Colorado HealthOp**. HHS awarded the Colorado CO-OP a $69 million loan in July 2012 and an additional $3 million loan in October 2013.[47] On October 16, 2015, the Colorado Division of Insurance announced that it would bar the Colorado CO-OP from selling health plans in 2016.[48] In approving a liquidation plan, a court concluded that "the CO-OP is in such condition that the further transaction of business would be hazardous, financially or otherwise, to the CO-OP's policy holders, its creditors, or the public."[49]
- **Health Republic Insurance of Oregon.** HHS awarded a $59 million loan to the Oregon CO-OP in February 2012 and an additional $1 million loan in November 2013.[50] On October 16, 2015, the CO-OP announced it was no longer offering new health insurance policies and would not be participating in open enrollment for 2016.[51] The CO-OP explained that "[i]n 2014 and 2015 [it] had medical expenses that exceeded the amount of money [it]

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[44] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[45] Tennessee Dep't of Commerce and Insurance, *Tennessee CO-OP Community Health Alliance Voluntarily Enters Runoff* (Oct. 14, 2015), https://tn.gov/commerce/news/18562.
[46] *Id.*
[47] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[48] Colorado Dep't of Regulatory Agencies, *Division of Insurance Moves to Protect Colorado Consumers, Takes Action Against HealthOp* (Oct. 16, 2015), https://www.colorado.gov/pacific/dora/Division-of-Insurance-action-HealthOP.
[49] Order of Liquidation and Finding of Insolvency, *Salazar v. Colorado HealthOp*, Case No. 2015-CV-33680 (Jan. 4, 2016), at 2 ¶6, http://cohealthop.org/wp-content/uploads/2016/01/Certified-Copy-of-Order-of-Liquidation-and-Finding-of-Insolvency.pdf.
[50] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[51] Statement, Oregon Dep't of Consumer and Business Services, http://www.oregon.gov/DCBS/Insurance/news/Pages/2015/oct162015.aspx.

received in premiums."[52] Moreover, it explained that the only way it would be able to continue operations was if HHS guaranteed to pay for some of its losses.[53]

- **Consumers' Choice Health Insurance Company (South Carolina).** The South Carolina CO-OP was awarded an $87 million HHS loan in March 2012.[54] On October 21, 2015, it was placed under supervision of the South Carolina Insurance Department.[55] The next day, the CO-OP agreed to wind down its operations and announced that it would not offer health insurance coverage in 2016.[56] The Insurance Department determined that the CO-OP was "in hazardous financial condition rendering its continued operation hazardous to the public and/or its insureds, warranting supervision."[57]
- **Arches Mutual Insurance Company (Utah).** The Utah CO-OP was awarded an $85 million HHS loan in July 2012 and an additional $4 million loan in September 2013.[58] It announced it was withdrawing from the 2016 marketplace on October 27, 2015,[59] and was placed into receivership on November 2, 2015.[60] In a press release announcing the decision to close the CO-OP, the Utah Insurance Commission cited low capital resulting from a failure of federal payments as the reason for its closure."[61]

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[52] Health Republic Insurance, *Goodbye and Good Luck Oregon: Closure Announcement FAQ*, http://healthrepublicinsurance.org/.
[53] *Id.*
[54] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[55] Consent Order Commencing Rehabilitation Proceedings & Granting an Injunction & Automatic Stay of Proceedings, *Farmer v. Consumers' Choice Health Insurance Company*, Civil Action No. 2016-CP-40-00034, at 4 (Jan. 6, 2016), http://www.cchpsc.org/wp-content/uploads/2016/01/CCHP_receivershipdetails.pdf.
[56] *Id.*
[57] *Id.*
[58] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[59] Kristen Moulton, *Utah Shuts Down Arches, The State's Nonprofit Insurance CO-OP*, THE SALT LAKE TRIBUNE (Oct. 28, 2015), http://www.sltrib.com/home/3108049-155/utah-shuts-down-arches-utahs-nonprofit.
[60] Rehabilitation Order, *In re Arches Mutual Insurance Co.*, Civil No. 150907803, ¶¶ 1-2 (Nov. 2, 2015), https://archeshealth.org/media/pdf/Arches%20Rehabilitation%20Order.pdf.
[61] Utah Insurance Dep't, *Arches Health Plan to Cease Operation* (Oct. 27, 2015), https://insurance.utah.gov/news/documents/PR-ArchesCeasesOperation10-27-2015.pdf.

- **Meritus Health Partners (Arizona).** The Arizona CO-OP was awarded a $93 million HHS loan on June 7, 2012.[62] On October 30, 2015, it was placed under the supervision of the Arizona Insurance Commission.[63] According to the Insurance Commission, the Arizona CO-OP had "yet to make a profit and [has] lost over $78 million since [its] inception."[64]
- **Michigan Consumer's Healthcare CO-OP.** The Michigan CO-OP was awarded a $71 million HHS loan in May 2012.[65] It was placed on rehabilitation on November 3, 2015[66]—two days after the start of Open Enrollment for 2016. A court granted the Michigan state insurance regulator's petition for liquidation and a declaration of insolvency on February 10, 2016.[67]

C. Previous Reports Concerning the CO-OP Program.

HHS's Office of Inspector General and the Government Accountability Office (GAO) have released several studies reviewing HHS's application and selection process, examining HHS's early implementation of the program, and conducting performance reviews of CO-OPs. In July 2013—five months before any CO-OPs began operating—the Inspector General released two reports on the CO-OP Program.

In the first report, the Inspector General found that "11 of the 16 CO-OPs reported estimated startup expenditures . . . that exceeded the total startup funding provided by CMS."[68] The Inspector General found that, despite this funding

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[62] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[63] Press Release, Arizona Dep't of Insurance, *Meritus Health Placed Under Supervision* (Oct. 30, 2015), https://insurance.az.gov/press-release-meritus-health-placed-under-supervision.
[64] *Id.*
[65] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[66] *Michigan Places Consumers Mutual Insurance in Rehabilitation,* INSURANCE JOURNAL. (Nov. 25, 2015), http://www.insurancejournal.com/news/midwest/2015/11/25/390170.htm.
[67] *See generally* Order of Liquidation and Declaration of Insolvency, Case No. 15-948 CR (Feb. 10, 2016), http://www.michigan.gov/documents/difs/Liquidation_Order_2.10.16_514365_7.pdf.
[68] *See* Dep't of Health & Human Servs., Office of Inspector Gen., *The Centers for Medicare & Medicaid Services Awarded Consumer Operated and Oriented Plan Program Loans in Accordance With Federal Requirements, and Continued Oversight Is Needed*, at 5 (July 30, 2013), http://oig.hhs.gov/oas/reports/region5/51200043.pdf.

shortfall, the CO-OPs had received limited private funding.[69] To solve this issue, the Inspector General recommended that HHS ensure that CO-OPs do not exhaust their startup funds before becoming fully operational and that HHS monitor efforts to obtain private funding.[70] In the second report, the Inspector General found that, while CO-OPs were making significant progress in meeting milestones, CO-OPs were struggling to "hire staff, obtain[] licensure, and build[] necessary infrastructure such as provider network arrangements and technology systems."[71] The Inspector General also concluded that, ultimately, success in meeting program goals depended on "a number of unpredictable factors," including the "State's Exchange operations, the number of people who enroll in the CO-OP and their medical costs, and the way in which competing plans will affect the CO-OP's market share."[72]

The Inspector General issued a third report in July 2015.[73] The Inspector General found that, "[a]lthough CMS awarded CO-OP loans to applicants on the basis of their ability to become financially viable," "many CO-OPs have lower-than-expected enrollment numbers and significant net losses,"[74] with more than half of the CO-OPs suffering net losses of *at least* $15 million.[75] The Inspector General noted that these low enrollment numbers and high losses limited the ability of the CO-OPs to repay loans and remain viable.[76]

GAO published a review of CO-OP enrollment and premium costs in 2014.[77] GAO's review found that the 22 CO-OPs operating in 2014 failed to meet their enrollment projections by 559,000 and 14 of the 22 CO-OPs failed to meet their enrollment projections.[78] Moreover, GAO found that the average premium costs for

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[69] *Id.* at 3.
[70] *Id.* at 6.
[71] Dep't of Health & Human Servs., Office of Inspector Gen., *Early Implementation of the Consumer Operated and Oriented Plan Loan Program*, at 13 (July 30, 2013), http://oig.hhs.gov/oei/reports/oei-01-12-00290.pdf.
[72] *Id.*
[73] Dep't of Health & Human Servs., Office of Inspector General, *Actual Enrollment and Profitability Was Lower than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loans Provided under the Affordable Care Act*, at 5-6 (July 2015), http://oig.hhs.gov/oas/reports/region5/51400055.pdf.
[74] *Id.* at 11.
[75] *Id.* at 8.
[76] *Id.* at 5.
[77] *See* U.S. Gov't Accountability Off., GAO-15-304, *Private Health Insurance: Premiums and Enrollment for New Nonprofit Health Insurance Issuers Varied Significantly in 2014,* at 24 (Apr. 2015), http://www.gao.gov/assets/670/669945.pdf.
[78] *Id.* at 18.

CO-OP plans varied relative to health insurance plans offered on the private market[79]—perhaps suggesting that CO-OPs struggled to accurately price plans.

D. A Note on Terminology.

Throughout this report, we refer to three risk-spreading mechanisms utilized by the ACA: "reinsurance," "risk corridors," and "risk adjustment." We briefly explain those concepts here, which we sometimes refer to as the "3Rs." The ACA established "reinsurance" as a temporary measure, in place between 2014–2016, in order to safeguard insurers against claim payments to "high risk" people who have purchased health insurance on the individual market.[80] It works in the following way: Once an insurance policyholder has incurred a certain amount of medical costs, the government begins to reimburse the insurer some of the costs up to a specified threshold.[81] Although each state is permitted to establish and administer its own reinsurance plan, in practice the federal government has the job of administering reinsurance in most states.[82] In 2014, for example, only two states had their own reinsurance plans.[83] Funds for reinsurance payments are collected through fees levied on all health insurance plans.[84]

"Risk corridors"—another temporary mechanism in place between 2014-2016—limit insurers' allowable losses from qualified health plans in the individual and small group markets.[85] The program requires insurers calculate a "risk corridor ratio" using an established formula.[86] If the ratio is below a certain amount, it means that the insurer has likely made a profit and must share some of the profit with HHS; by contrast, if the ratio is above a certain amount, it means that the insurer has likely suffered a loss, and HHS must cover a portion of that loss.[87]

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[79] *See id.* at 15 ("The percentage of rating areas where the average premium for CO-OP health plans was lower than the average premium for other issuers varied significantly by each state and tier.").
[80] Angela Booth & Brittany La Couture, *The ACA's Risk Spreading Mechanisms: A Primer on Reinsurance, Risk Corridors and Risk Adjustment*, AMERICAN ACTION FORUM (Jan. 9, 2015), http://americanactionforum.org/research/the-acas-risk-spreading-mechanisms-a-primer-on-reinsurance-risk-corridors-a.
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.*
[85] *Id.*
[86] *Id.*
[87] *Id.*

Unlike reinsurance and risk corridors, the ACA's "risk adjustment" provision is permanent.[88] During the "risk adjustment" process, either the state or the federal government compares the actuarial risk of the insurance pool within each qualified health plan purchased on the individual and small group markets with the average actuarial risk in the state for all qualified plans.[89] Insurance pools with lower than average actuarial risk must make payments to insurance pools with higher than average actuarial risk.[90]

III. FINDINGS AND ANALYSIS

The Subcommittee's investigation focused on HHS's decision to approve the failed CO-OPs and HHS's management and monitoring of its multibillion-dollar CO-OP loan portfolio. The investigation reveals that HHS approved the failed CO-OPs notwithstanding flaws in their business plans. Once the CO-OPs began losing money at rates far worse than their worst-case projections, HHS barely used the corrective action or enhanced oversight tools available to it. HHS eventually approved additional solvency loans in an attempt to save failing CO-OPs, but again did so despite obvious warning signs. The end result was to exacerbate losses that will now be shouldered by taxpayers, doctors, and others — even as more than 700,000 consumers were forced to find new health insurance plans.

The financial toll of this failed experiment is much steeper than has been previously reported. The twelve closed CO-OPs ran up more than $1.4 billion in losses over just the two years they sold plans. Based on the latest balance sheets obtained by the Subcommittee, the failed CO-OPs' currently estimated *non-loan* liabilities (including unpaid medical bills) exceed $1.13 billion—which is 93% greater than their $585 million in reported assets. In addition, the CO-OPs' debt to the U.S. government stands at over $1.2 billion. Prospects for repayment are dim.

A. HHS Approved The Failed CO-OPs Despite Problems Identified By Deloitte In The CO-OPs' Business Plans.

HHS retained Deloitte Consulting LLP to evaluate loan applications and business plans submitted by health insurance CO-OPs seeking a federal award. Deloitte reviewed each Grant Application for compliance with the "essential CO-OP Program [Funding Opportunity Announcement] criteria established by CMS for funding."[91] According to the funding announcement, CMS "relied on the ACA, the CO-OP final rule, the proposed rule for exchanges on standards for qualified health

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[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] Deloitte Review – Utah 3.

plans, and the final report of the CO-OP Advisory Board to establish the review criteria" discussed in detail below.[92]

To conduct these reviews, Deloitte conducted in-person interviews with CO-OP applicants and "worked with CMS to specify procedures and acceptance criteria to be used in the review of the CO-OP applications."[93] As established by HHS, Deloitte evaluated the applicant CO-OPs based on the following 13 criteria:

Deloitte CO-OP Evaluation Criteria[94]	
Project Narrative	Feasibility
Qualifications of Management & Key Personnel	Provider Arrangements, Target Market, & Products
Pro Forma Financials	Operations
Budget	Governance & Licensure
Enrollment Strategy & Regulatory Capital Requirements	Loan Funding & Repayment Schedule
Integrated Care Plan	Statewide Basis
Evidence of Private Support	

Deloitte analyzed the strengths and weaknesses of the loan applications using these criteria. HHS provided Deloitte with a detailed breakdown of what Deloitte should consider when evaluating each criterion and provided scores for each category.[95] Each criteria carried a maximum point value, and under HHS's instructions, 70 points (out of a possible 100) was enough to "pass" Deloitte's review.[96] HHS and Deloitte told the Subcommittee that a "pass" did *not* constitute Deloitte's recommendation to approve or disapprove the loan, but rather was the result of HHS's scoring guidance.[97] HHS received all Deloitte reviews for the 12 failed CO-OPs by June 2012 and approved the applications by September 27, 2012.

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[92] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement*, 38 (Dec. 9, 2011).
[93] *Id.*
[94] Deloitte Review – Utah 1.
[95] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement*, 38-42 (Dec. 9, 2011).
[96] Interview with Deloitte (Mar. 2, 2016); *see* Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement* (Dec. 9, 2011) (setting maximum point value).
[97] *Id.*; Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).

Once submitted to HHS, Deloitte's evaluations were reviewed by an HHS "Selection Committee" that made final decisions about CO-OP approval. The Selection Committee was made up of internal subject-matter experts, internal actuaries, and others. [98] The Selection Committee reviewed the prospective CO-OP's application, considered Deloitte's reports, and conducted its own interviews with CO-OP officials.

According to HHS, the Deloitte reports were an important part of this review and approval process.[99] Indeed, Deloitte's reports were the *only* written reviews of the applications; HHS did not create a comparable written review of its own.[100] Nor did the Selection Committee produce a formal review or report memorializing the basis for its approval recommendation for a particular CO-OP application.[101]

The Subcommittee obtained and reviewed Deloitte's evaluations of each of the approved CO-OPs, with particular attention to the failed CO-OPs. Each of the failed CO-OPs received a "pass" based on the criteria that HHS instructed Deloitte to consider. Those evaluations reveal that Deloitte identified and, to some extent, foreshadowed problems that contributed to the failure of the CO-OPs.

For some CO-OPs, HHS issued "Requests for Additional Information" (RAIs) in an effort to obtain missing documents, seek clarifications, or ask follow-up questions to inform its review of an application. According to documents received by the Subcommittee, HHS sent RAIs to six of the failed CO-OPs. No evidence was provided to the Subcommittee showing that HHS formally requested *any* additional information to consider in its application process for the other half of the failed CO-OPs. The weaknesses described in detail below take into account HHS's documented attempts to fill in missing or insufficient information through its RAI process.

As explained below, Deloitte called HHS's attention to weaknesses in three crucial evaluation criteria across all plans. *First*, Deloitte identified substantial weaknesses in enrollment strategy and enrollment forecasts. *Second*, Deloitte identified many budget-planning and financial-projection deficiencies. *Third*, Deloitte raised concerns about the proposed management (and in some cases, the sponsors) of the now-failed CO-OPs.

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[98] Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).
[99] Interview with Kevin Counihan, Dir., Ctr. for Consumer Information and Insurance Oversight (CCIIO) (Mar. 1, 2016).
[100] *Id.*; Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).
[101] *Id.*

1. Enrollment Strategy Weaknesses.

Enrollment is a central component of any health insurer's business plan. As outlined in Part III, the enrollment projections for all but two of the failed CO-OPs' business plans diverged dramatically from reality. Based on our review of Deloitte's evaluations, it is clear that HHS knew that there were significant problems in the enrollment plans of 7 of the 12 failed CO-OPs well *before* HHS approved their loan applications.[102]

Those problems ranged from inadequate actuarial analysis, to unsupported assumptions about sustainable premiums, to a lack of demonstrated understanding of the health demographics of the target patient population. Overall, HHS knew that nearly half of the now 12 failed CO-OPs expected to gain market share by underpricing competitors but were unable to provide sufficient documentation and evidence that those lower premiums would be financially sustainable.[103] According to Deloitte, when its employees discovered informational gaps or insufficient detail, it sought the missing information from HHS, and Deloitte wrote its reports based on all records provided.[104]

Deloitte raised especially pointed concerns about two failed CO-OPs that ultimately missed their 2014 enrollment projections by extreme margins: Arizona and Tennessee.[105] Deloitte advised HHS that the Arizona CO-OP's enrollment forecasts were "aggressive, particularly for a start-up" and that the CO-OP's strategy was "unlikely to achieve the target enrollment figures in accordance with its timeline."[106] According to Deloitte, the CO-OP's "financial projections related to enrollment appear[ed] to be unreasonable and lacking in thoroughness based on the actuarial review of [the CO-OP's] feasibility study."[107] The Arizona CO-OP responded to HHS's request for additional information on its aggressive enrollment strategy by restating its projections and stating it was "in the process of developing" detailed staffing plans and expanding its provider network, among other steps.[108]

The Tennessee CO-OP suffered from a similar problem. It proposed an enrollment strategy that counted on underpricing its competitors and attracting new customers seeking to escape the individual mandate penalty, but it "fail[ed] to explain how a competitive price [would] be achieved and can be offered recognizing

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[102] *See* Deloitte Review – Kentucky 7; Louisiana 8; Tennessee 7; Arizona 5; Colorado 7; Michigan 8; and Nevada 8.
[103] *See* Deloitte Review – Kentucky 6; Louisiana 6; Tennessee 6; Utah 7; Oregon 6.
[104] Interview with Deloitte (Mar. 2, 2016).
[105] *See* Part III.B.2, *infra*. The Arizona CO-OP and Tennessee CO-OPs missed their base-case enrollment projections for 2014 by 85%, 64%, and 91%, respectively. *See id.*
[106] Deloitte Review – Arizona 7.
[107] Deloitte Review – Arizona 7.
[108] HHS RAI – Arizona 58.

that affordability may challenge growth."[109] CO-OP executives "did not explain how they would be able to offer a price competitive product or how savings would be achieved."[110]

Deloitte also noted during their application evaluation process that a number of the now extinct CO-OPs failed to identify and analyze the *types* of enrollees their plans would attract—that is, their target market. That weakness was significant: An insurer's largest expenditure is the cost of paying medical claims, and no insurer can accurately forecast its claims costs without understanding its target market and its risk profile. For example, Deloitte concluded that both Kentucky's enrollment forecasts and "the likelihood that [its] enrollment will be sufficient to create a financially viable CO-OP" were "difficult to determine since the market is highly concentrated and [the CO-OP] has not provided a thorough enough enrollment forecast analysis or details on why their plans will be attractive to its target market."[111] Likewise, the Louisiana CO-OP did "not provide any relevant health demographics related to illnesses."[112] Nor did the Tennessee CO-OP "address why the plans they intend to offer would be appropriate for their target market."[113]

As explained in Part III.B, *infra,* unexpected enrollment levels and higher than expected claims costs contributed significantly to financial difficulties of the failed CO-OPs. Although Deloitte's evaluations foreshadowed those problems, HHS nevertheless approved the applications.

2. Budgetary and Financial Planning Weaknesses.

As part of their applications, all prospective CO-OPs submitted operating budgets and pro forma financial statements (that is, long-term projections of revenue, profit, assets, liabilities, etc.). HHS instructed Deloitte to evaluate the proposed budgets for completeness as well as "reasonableness and cost-effectiveness."[114] The Department told Deloitte to review the pro forma financial statements for completeness, clarity of assumptions, and consistency with each CO-OP's business plan.[115] In its review, Deloitte identified numerous problems ranging

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[109] Deloitte Review – Tennessee 7.
[110] Deloitte Review – Tennessee 9.
[111] Deloitte Review – Kentucky 5–6. In response to an RAI concerning its enrollment strategy, the Kentucky CO-OP answered vaguely that it would to seek to "understand fully the diverse Commonwealth-wide population" through community meetings and market research and "develop benefit plans based on understanding of the diverse target markets." HHS RAI – Kentucky 5.
[112] Deloitte Review – Louisiana 6.
[113] Deloitte Review – Tennessee 5.
[114] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement,* 12 (Dec. 9, 2011).
[115] *Id.* at 34.

from comparatively minor issues, such as omitting needed expenses, to more significant concerns, like presenting an unreasonable budget.

Deloitte reported that the budgets submitted by 10 of the 12 failed CO-OPs were incomplete to varying degrees, and only *one* of them fully remedied those concerns through supplemental information.[116] The Michigan and Nevada CO-OPs, for example, failed to account for all uses of their requested loan funds,[117] while the Colorado CO-OP failed to link its loan drawdowns to "milestones" (such as building out a provider network) as required.[118] Several of the budgets also suffered from inconsistencies. For example, the Arizona CO-OP's application contradicted itself concerning when the CO-OP would spend its start-up loan funds, and Deloitte noted that "inconsistencies such as this are common throughout the [Arizona CO-OP's] budget."[119] The Louisiana CO-OP similarly listed conflicting start-up costs and filled out "several sections of [its budget form] incorrectly."[120]

In addition to inconsistencies, Deloitte noted that many of the CO-OPs' budgets appeared to be unreasonable or did not align with their own financial projections. The Arizona CO-OP's budget "lack[ed] reasonableness and cost-effectiveness," and its loan drawdown schedule was also unreasonable "due to the risk involved in using premiums in 2014 to fund start-up costs."[121] The Utah CO-OP's budget narrative also "may not be reasonable or cost-effective," Deloitte warned, because the budget "does not link to their loan funding and repayment schedule or pro forma financials."[122] The Nevada CO-OP's budget "may not be reasonable, as they do not clearly lay out how start-up costs will be funded," and their loan requests conflicted with their budget and "other parts of their application."[123] The Kentucky CO-OP's start-up costs did "not appear to be well thought out," and the timing of its loan drawdown "cannot be tied to any of the financial[]" projections.[124] Similarly, the budget for Iowa and Nebraska's CoOportunity CO-OP did not align with its financial statements.[125]

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[116] *See* Deloitte Review – New York 4; South Carolina 4; Colorado 8; Michigan 9; Nevada 10; Louisiana 7, CoOportunity Health 4; Arizona 6; and Oregon 4. Deloitte expressed similar concerns about the Tennessee CO-OP, but the CO-OP addressed those concerns fully in its response to an HHS request for additional information. *See* HHS RAI – Tennessee 15.
[117] Deloitte Review – Michigan 6; Nevada 7.
[118] Deloitte Review – Colorado 8.
[119] Deloitte Review – Arizona 6. In response to an RAI, Arizona stated that its 2014 "operational costs" would be covered by premiums for three quarters and loan dollars for one quarter. HHS RAI – Arizona 3.
[120] Deloitte Review – Louisiana 7.
[121] Deloitte Review – Arizona 6.
[122] Deloitte Review – Utah 6.
[123] Deloitte Review – Nevada 7.
[124] Deloitte Review – Kentucky 6.
[125] Deloitte Review – CoOportunity 3.

Deloitte also expressed skepticism about the risk-taking and unreasonable assumptions reflected in some of the CO-OPs' financial projections. The Colorado CO-OP, for example, assumed "a potentially unreasonable level of growth in revenue compared to growth in membership" using a growth rate that "far exceeds the average annual premium increase for individuals and families" without justification.[126] Deloitte also warned that the Colorado CO-OP planned to be overleveraged, with a debt-to-equity ratio that is "more than triple the health insurance industry average" and raises the risk that "the applicant may have potential loan repayment problems."[127] Deloitte noted that both the Louisiana CO-OP and Utah CO-OP might be counting on "an unreasonable level of growth in revenue as compared to growth in membership," and the Utah CO-OP *planned* to "operate at a loss until 2018."[128] Turning to CoOportunity's financial projections, Deloitte noted that the CO-OP's target profit margin was "much lower than the industry benchmark" of 4.8% and "substantially low even for a nonprofit company."[129] That was perhaps tongue-in-cheek: CoOportunity's target "profit margin" was *zero*.[130] HHS requested additional information from the CO-OP regarding its low profitability, but CoOportunity did not change its projections.[131] In addition, many of the CO-OPs' financial projections did not align with their business plans and budgets. Colorado's income statement, for example, could not be "tied to the applicant's start-up budget" and Deloitte could not determine "whether or not the applicant's income statement ties to the business plan/operations forecast."[132] The Nevada CO-OP, Tennessee CO-OP, and Kentucky CO-OP each produced financial projections using "key assumptions" that Deloitte was unable to trace to their actual business plans.[133]

3. Management Weaknesses.

Each CO-OP loan applicant was required to "identify its management team, explain their qualifications and experience, and submit an organizational chart and detailed position descriptions, including the qualifications required for each position."[134] Based on its review of this portion of the CO-OP's business plans,

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[126] Deloitte Review – Colorado 11.
[127] *Id.*
[128] Deloitte Review – Utah 8–9; Louisiana 9.
[129] Deloitte Review – CoOportunity 5.
[130] *Id.*
[131] HHS RAI – CoOportunity 15.
[132] Deloitte Review – Colorado 11.
[133] Deloitte Review – Nevada 10; Tennessee 10; Kentucky 9.
[134] Dep't of Health & Human Servs., *Funding Opportunity Announcement* OO-COO-11-001, 33 (Dec. 9, 2011).

Deloitte consultants expressed concern over key leadership position gaps or thin industry expertise for all of the 12 failed CO-OPs.[135]

For starters, despite the HHS requirement, several prospective CO-OPs had not even *identified* their senior leadership team. The Kentucky CO-OP's interim management team had "adequate health plan experience," but it had identified no permanent CEO and its description of job responsibilities did "not adequately describe an organization capable of leading, managing, and implementing the [CO-OP] project."[136] The Louisiana CO-OP's management team was "limited to just three individuals" and its application failed to identify "most key management positions."[137] The Nevada CO-OP, too, had no chief operating officer or medical director, and its application "lack[ed] a strong vetting process."[138] The Tennessee CO-OP also had openings for leadership positions, but had no "strong vetting process" for applicants.[139] Colorado had identified no medical director.[140] Michigan had assembled a complete team, but its senior executives had "limited direct commercial experience in managing a health plan"—the core work of CO-OP management—and would be relying on external advisors.[141]

Deloitte conducted background checks on proposed CO-OP executives identified in loan applications. That vetting turned up red flags in more than half of the failed CO-OPs—problems that, in Deloitte's view "could influence the likelihood of the CO-OP's success and should be brought to the attention of CMS."[142] The problems varied but included insider trading, personal bankruptcy, racketeering lawsuits, labor disputes, and various liens and unpaid money judgments. The top executive who ran both the Louisiana CO-OP and the Kentucky CO-OP, for example, had been charged by the SEC with unlawful insider trading in his previous role as CEO at a health care management firm. That 1998 case resulted in a permanent injunction and court order requiring the executive to disgorge ill-gotten gains and pay a civil penalty.[143] In one case, a proposed Chief Financial Officer had declared a personal bankruptcy. After Deloitte brought this to the HHS's attention, the individual withdrew his name for consideration.[144]

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[135] Deloitte Review – New York 3; South Carolina 6; Tennessee 5; Colorado 5; Michigan 4; Nevada 4; Louisiana 5, CoOportunity Health 3; Arizona 4; Oregon 3; Utah 4; Kentucky 4.
[136] Deloitte Review – Kentucky 4.
[137] Deloitte Review – Louisiana 7, 9.
[138] Deloitte Review – Nevada 4.
[139] Deloitte Review – Tennessee 5.
[140] Deloitte Review – Colorado 5.
[141] Deloitte Review – Michigan 4.
[142] Deloitte Review – Utah 4–5; Arizona 4; Tennessee 5; Kentucky 4; Louisiana 5; Michigan 4–5.
[143] Deloitte Review – Louisiana 5; Kentucky 4–5.
[144] HHS RAI – Tennessee 19.

Deloitte's background check of the CO-OPs' sponsoring organizations also turned up problems. For example, sponsors and personnel of the Nevada CO-OP "demonstrate[d] a record of involvement in multiple federal civil cases, liens and judgments."[145] In total, Deloitte identified 285 ongoing, completed, or dismissed federal cases involving one of the Nevada CO-OP's sponsors. Deloitte provided additional detail of the records in some cases "due to the significant nature of the matters" involving the sponsor.[146] In addition, Deloitte noted that the sponsor was the subject of nine outstanding liens or unpaid monetary judgments nationwide, ranging up to $96,000.[147]

* * *

Adhering to HHS's criteria and scoring methodology, Deloitte gave a passing score to each of the now-failed CO-OPs. HHS approved their awards between February and September of 2012.

B. Despite Glaring Financial Warning Signs, HHS Failed To Take Any Corrective Action or Enhance Oversight Until The Second Enrollment Year.

The loan agreements with the CO-OPs gave HHS several valuable tools to monitor and ensure the viability of CO-OPs in financial distress. Yet, as this section explains, even after it became apparent that the failed CO-OPs were suffering losses well beyond worst-case projections and deviating dangerously from their enrollment targets, the agency took *no* corrective action, nor did it put any CO-OP on enhanced oversight. Five of the 12 failed CO-OPs were *never* subject to these measures, and HHS waited until September 2015 to put five others on corrective action or enhanced oversight. Two months later, all twelve CO-OPs had failed.

1. HHS Scarcely Used the Major Accountability and Oversight Measures Available for Distressed CO-OPs.

The CO-OP loan agreements armed HHS with powerful tools to heighten its monitoring of CO-OPs in financial distress and require reforms as needed. Beyond routine monitoring, three key instruments available to HHS were *corrective action plans*, *enhanced oversight plans*, and *termination* of the loan agreement.[148]

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[145] Deloitte Review – Nevada 4.
[146] Deloitte Review – Nevada 5.
[147] Deloitte Review – Nevada 5.
[148] Dep't of Health & Human Servs., *Funding Opportunity Announcement* OO-COO-11-001, 48 (Dec. 9, 2011). *See, e.g.*, Loan Agreement Between Louisiana CO-OP and HHS, § 11.1 (executed June 19, 2012) ("Loan Agreement").").

The first tool, the corrective action plan, allows HHS to direct a CO-OP not in compliance with program requirements to develop and implement a plan specifying "the actions that the loan recipient will take to . . . correct any deficiencies and remain in compliance with program requirements."[149] During a corrective action plan, HHS monitors the CO-OP to ensure deficiencies are corrected.[150] HHS also has authority to place financially distressed CO-OPs on an enhanced oversight plan, which would consist of "detailed and more frequent review of the loan recipient's operations and financial status."[151] Under the CO-OPs' loan agreements, an enhanced oversight plan could be imposed when a CO-OP "consistently underperforms relative to the [CO-OP's] Business Plan."[152] The loan agreements provided that HHS could supply technical assistance to correct the problems that gave rise to a corrective action plan or enhanced oversight.[153] Finally, HHS had the authority to cut its losses by terminating the loan agreements and cease all loan disbursements—if it no longer believed that the loan recipient could establish a "viable and sustainable CO-OP that serves the interests of its community and the goals of the CO-OP program."[154]

Although each of the failed CO-OPs dramatically underperformed their business plans, HHS made sparing use of these accountability tools. Indeed, five of the 12 failed CO-OPs were *never* subject to corrective action or enhanced oversight measures,[155] and despite severe industry-wide financial distress beginning in January 2014, HHS did not place any of the others on a corrective action plan or enhanced oversight plan for over a year. Two of the failed CO-OPs were placed on corrective action or enhanced oversight plans in the first quarter of 2015—in reaction to dire warnings from state insurance commissioners concerning "hazardous financial condition[s]" in one case[156] and violation of state and federal

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[149] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement,* 49 (Dec. 9, 2011).
[150] *Id.*
[151] *Id.*
[152] *Id. see also* Loan Agreement.
[153] Dep't of Health & Human Servs., Centers for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement,* 48 (Dec. 9, 2011).
[154] *See* Loan Agreement § 16.2 ("Lender may elect to terminate this Agreement if it determines in its sole and absolute discretion that Borrower will not be likely to be able to establish a viable and sustainable CO-OP that serves the interests of its community and the goals of the CO-OP Program.").
[155] Specifically, the Utah, New York, Nevada, South Carolina, and Iowa/Nebraska CO-OPs were never placed on an enhanced oversight or corrective action plan.
[156] Letter from Kelly O' Brien, Dep't of Health & Human Servs. to Ron Bramm, Community Health Alliance (Feb. 3, 2015); Letter from Commissioner Julie McPeak, Tennessee Dep't. of Ins., to Secretary Burwell, Dep't of Health & Human Servs. (Jan. 8, 2015).

law in the other.[157] As for the remaining five failed CO-OPs, the agency waited until September 2015 to place them on a corrective action or enhanced oversight plan; within less than two months, all five had gone under.[158]

The CMS CO-OP Program Director, Kelly O'Brien, told the Subcommittee that both corrective action and enhanced oversight plans were valuable tools.[159] But according to O'Brien, despite receiving information about the CO-OPs' financial performance on a monthly basis, the agency never developed a standard for when enhanced oversight would be triggered.[160] Based on our review of financial data available at the time each corrective action plan or enhanced oversight plan was implemented, it is difficult to discern any objective basis for whether a CO-OP was "consistently underperform[ing]" such that an enhanced oversight plan was advisable.[161]

The Subcommittee also sought to determine how frequently HHS made use of two other important tools—audits and site visits—but HHS has not responded to the Subcommittee's request for that information despite repeated efforts.

2. HHS Knew In 2014 That The CO-OPs Were Performing Worse Than Even The Worst-Case Net-Income Scenarios Outlined In Their Business Plans.

As part of their 2011 loan applications to HHS,[162] each CO-OP provided HHS with a feasibility study outlining financial projections for a number of potential scenarios—such as variations in enrollment and variation in claims costs.[163] The actuarial consulting firm Milliman prepared the feasibility studies for 9 of the 12

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[157] Letter from Kelly O'Brien, Dep't of Health & Human Servs. to William Oliver, Louisiana Health Cooperative (Jan. 2, 2015); Letter from Louisiana Insurance Commissioner to Kelly O'Brien, Dep't of Health & Human Servs. (Dec. 11, 2015).

[158] *See* Letter from Kevin Counihan, CCIIO Director, to Thomas Zumtobel, Meritus Health Partners (Sept. 28, 2015) (advising Arizona CO-OP of placement in an EOP); Letter from Kevin Counihan, CCIIO Director, to Dennis Litos, Consumers Mutual of Michigan (Sept. 22, 2015) (advising Michigan CO-OP of placement in a CAP and an EOP); Letter from Kevin Counihan, CCIIO Director, to Julia Hutchins, CEO, Colorado CO-OP (Sept. 10, 2015) (advising Colorado CO-OP of placement in an EOP); Letter from Kevin Counihan, CCIIO Director, to Glenn Jennings, CEO, Kentucky Health Cooperative (Sept. 18, 2015); Letter from Kevin Counihan, CCIIO Director, to Dawn Bonder, CEO, Oregon Health Republic Insurance Company (Sept. 22, 2015).

[159] Interview with Kevin Counihan, Director, CCIIO (Mar. 1, 2016); Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).

[160] *Id.*

[161] *Id.*

[162] *See* Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Loan Funding Opportunity Announcement* (Dec. 9, 2011).

[163] *See, e.g.*, Milliman Feasibility Study Prepared for New York CO-OP (Oct. 15, 2011).

failed CO-OPs.[164] Milliman's studies were based on a number of key assumptions provided by the CO-OPs, including enrollment projections.[165] Two other actuarial consulting firms, Wakely Consulting Group and Optum, prepared similar feasibility studies for the other three failed CO-OPs.[166] All of the Milliman feasibility studies included projected net income under different enrollment and pricing scenarios.[167] The feasibility studies reveal that every failed CO-OP underperformed their *worst-case* net-income expectations in 2014 (except for the two that did not provide worst-case projections).[168]

The losses came fast. One of the failed CO-OPs experienced losses greater than even its worst-case year-end projection *within the first quarter* of 2014.[169] That trend continued: By the second quarter of 2014, six of the 12 failed CO-OPs had exceeded their worst-case year-end net income projections.[170] By the third quarter of 2014, that number was seven;[171] by the fourth quarter, ten.[172] Cumulatively, the failed CO-OPs exceeded their projected worst-case scenario net income losses for 2014 by at least $263.7 million—four times greater than the expected amount.[173]

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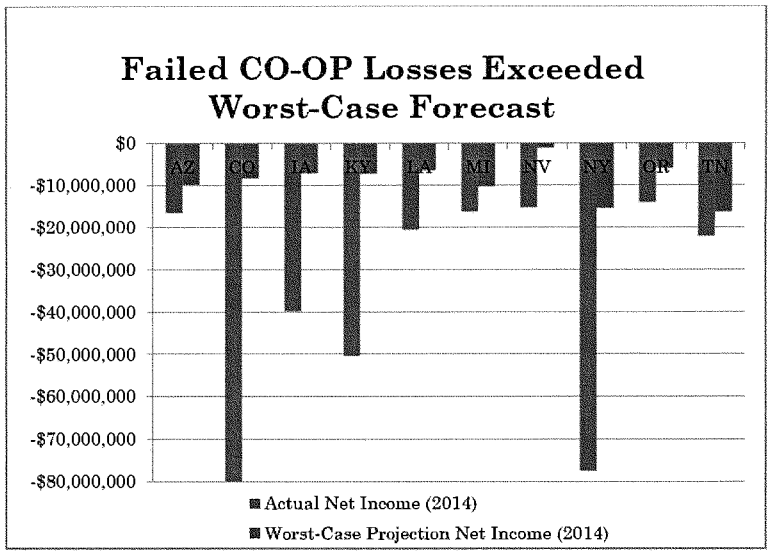
[164] Milliman Feasibility Study Prepared for New York CO-OP (Oct., 15, 2011); Milliman Feasibility Study Certification and Analysis Prepared for Arizona CO-OP (Oct. 23, 2011); Milliman Feasibility Study Certification and Business Plan Prepared for Nevada CO-OP (Dec. 21, 2011); Milliman Feasibility Study Certification and Business Plan Support Prepared for Kentucky CO-OP (Dec. 28, 2011); Milliman Feasibility Study Certification and Business Plan Support Prepared for Louisiana CO-OP (March 30, 2012); Milliman Feasibility Study Certification and Business Plan Support Prepared for Michigan CO-OP (Dec. 23, 2011); Milliman Feasibility Study Certification and Business Plan Support Prepared for Oregon CO-OP (Oct. 14, 2011); Milliman Feasibility Study Certification and Business Plan Support Prepared for Iowa CO-OP (Oct. 14, 2011); Milliman Feasibility Study Certification and Business Plan Support Prepared for Utah CO-OP (March 20, 2012);
[165] Interview with Milliman (Dec. 21, 2015). Milliman reviewed the enrollment forecasts for reasonableness but relied on the CO-OPs' assumptions.
[166] Optum Feasibility Study for Tennessee CO-OP (Mar. 31, 2012); Optum Feasibility Study for South Carolina CO-OP (Mar. 27, 2012); Wakely Feasibility Study Prepared for Colorado CO-OP (Mar. 30, 2012).
[167] Interview with Milliman (Dec. 21, 2015).
[168] Appendix A is a data spreadsheet that is available on the PSI website at http://www.hsgac.senate.gov/subcommittees/investigations/hearings/review-of-the-affordable-care-act-health-insurance-co-op-program. All original sources for the data are identified. For "worst-case" net income projections, we identified the feasibility study scenarios that resulted in the largest projected net loss in 2014.
[169] *Id.* The CO-OP is Nevada.
[170] *Id.* The six CO-OPs are Arizona, Colorado, Iowa, Kentucky, Louisiana, and Nevada.
[171] *Id.* The seven are Arizona, Colorado, Iowa, Kentucky, Louisiana, Nevada, and Oregon.
[172] *Id.* The ten are Arizona, Colorado, Iowa, Kentucky, Louisiana, Nevada, Oregon, Michigan, New York, and Tennessee.
[173] *Id.*

In most cases, the difference between projected and actual performance was staggering. As outlined below, the losses of 11 of the 12 failed CO-OPs ranged from of 261% to 7,196% of their base projections—displayed in the far right column below.[174]

CO-OP Projections v. Reality Actual Net Income as a % of Base Projection (2014)[175]				
CO-OP State	**Actual Net Income (2014)**	**Worst Case Projection Net Income (2014)**	**Base Case Projection Net Income (2014)**	**Actual Net Income as a % of Base Projection**
AZ	-$16,593,439	-$9,820,000	-$6,140,000	270%
CO	-$80,080,349	-$8,326,000	-$5,659,000	1,415%
IA	-$39,847,903	-$7,059,000	-$7,059,000	564%
KY	-$50,445,923	-$7,263,000	-$1,047,000	4,818%
LA	-$20,655,020	-$6,481,000	-$287,000	7,196%
MI	-$16,336,646	-$10,307,000	-$2,756,000	592%
NV	-$15,295,456	-$1,067,000	$371,000	4,122%
NY	-$77,539,370	-$15,457,000	-$5,306,000	1,461%
OR (HRI)	-$12,920,763	-$5,983,000	-$2,268,000	570%
SC	-$3,808,177	None Listed	-$8,016,000	47%
TN	-$22,130,737	-$16,378,000	-$8,474,095	261%
UT	-$21,001,844	None Listed	-$5,729,000	366%

[174] The feasibility studies for three (IA, NY, OR) of the failed CO-OPs express net losses as "margin." Six others (AZ, KY, LA, MI, NV, UT) express net losses as "projected change in unrestricted net assets." Those figures serve as the net loss projections described above. This is the same methodology that the HHS IG used to assess net income projections by the CO-OP. *See* Dep't of Health & Human Servs., Office of Inspector Gen., *Actual Enrollment and Profitability Was Lower than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loans Provided under the Affordable Care Act*, at 10 (July 2015), http://oig.hhs.gov/oas/reports/region5/51400055.pdf.

[175] *See* Appendix A.



HHS was well aware of the CO-OPs' devolving financial picture. The failed CO-OPs sent HHS key financial information on a regular basis, in the form of monthly reports reflecting enrollment, total premiums and considerations, total uncollected premiums, total claims paid, total claims unpaid, accrued administrative expenses, and cash on-hand.[176] Those reports were submitted within 30 days after each month's end.[177] Although HHS did not require net income to be included in these reports until March 2015, the 2014 monthly reports provided the agency all the revenue and expense data necessary to recognize the large deficits the CO-OPs were running.

[176] *See* CMS Monthly Enrollment Reports Submitted by CO-OPs, Appendix B is a data spreadsheet that is available on the PSI website at http://www.hsgac.senate.gov/subcommittees/investigations/hearings/review-of-the-affordable-care-act-health-insurance-co-op-program. All original sources for the data are identified.
[177] Interview with Kevin Counihan, Dir., CCIIO (Mar. 1, 2016); Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).

HHS also received copies of the CO-OPs' standard audited quarterly financial statements required of all health insurers.[178] Those statements were generally submitted within two months after the end of each quarter.[179] The first quarterly reports for 2014 were submitted to HHS mid-May 2014.[180] At that point, *all but one* failed CO-OP reported a negative net income of $1.7 million or worse.[181] By the end of June 2014,[182] 11 of the 12 failed CO-OPs had negative net incomes of $4 million or worse.[183] And at the end of 2014, all but two failed CO-OPs had a negative net income of at least $14 million.[184]

Despite these financial warning signs, HHS entered 2015 open enrollment season with *no* corrective action or enhanced oversight plans in place. Worse, the pace of HHS's large disbursements of start-up and solvency loans to the failed CO-OPs did not abate. Indeed, as described in Part III.D, *infra*, throughout 2014 and 2015, HHS disbursed money to the CO-OPs almost as fast as they were losing it.

3. HHS Knew Early In 2014 That Enrollment Numbers For The Failed CO-OPs Deviated Sharply From Normal Projections.

Enrollment is a key determinant of a health insurer's financial performance and viability, and sharp deviation (in either direction) from the insurer's planned enrollment can be spell trouble.[185] Low enrollment can weaken an insurer by reducing expected premium income. Higher-than-expected enrollment can be even more destabilizing for insurers who underprice their premiums by setting their rates too low to cover claims and expenses.[186] As one leading health insurance scholar has explained, "[r]apid customer growth with inadequate prices and adverse claims experience has played a major role historically in insurance company insolvencies."[187]

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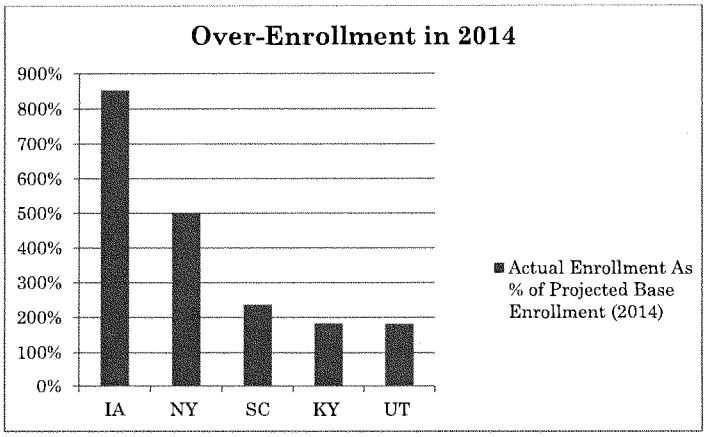
[178] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Guidance Manual*, 8 (July 29, 2015), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CO-OP-Guidance-Manual-7-29-15-final.pdf.
[179] *Id.*
[180] *Id.*
[181] Appendix A.
[182] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *CO-OP Program Guidance Manual*, 8 (July 29, 2015), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CO-OP-Guidance-Manual-7-29-15-final.pdf.
[183] Appendix A.
[184] *Id.*
[185] Scott E. Harrington, *The Financial Condition and Performance of CO-OP Plans*, Univ. of Penn. Leonard Davis Institute of Health Economics, Data Brief, 6 (Feb. 2015).
[186] *Id.*
[187] *Id.*

The failed CO-OPs were plagued by both varieties of enrollment trouble, and HHS knew it early in 2014. Throughout 2014, the CO-OPs submitted regular monthly and quarterly reports to HHS that showed that their enrollment projections were widely off the mark—in many cases, by financially hazardous margins. A comparison between projected and actual enrollment tells the story. The CO-OPs' business plans included annual enrollment projections,[188] and those enrollment projections were built into feasibility studies that projected financial performance in three enrollment scenarios: low, normal (also called "base"), and high.[189]

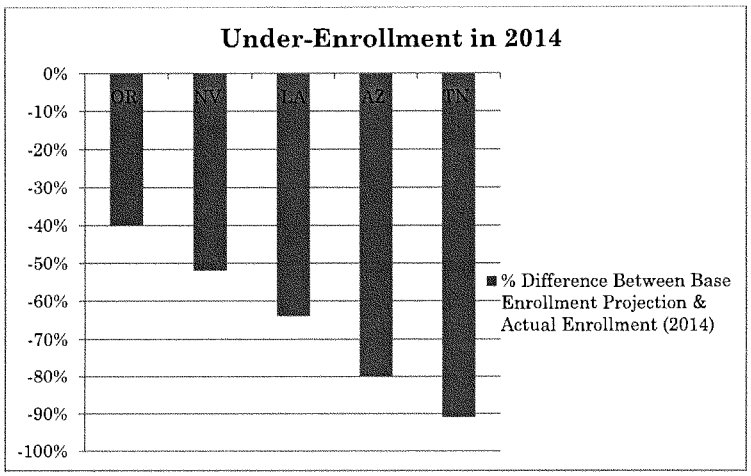
The failed CO-OPs' 2014 enrollment reports to HHS showed dramatic deviation from their plans and key financial assumptions.[190] Five of the failed CO-OPs underperformed their base enrollment projections by 40% or more—with one CO-OP missing its projection by 90%.[191] Two of the 12 failed CO-OPs did not even achieve half of their *low* enrollment scenarios forecast in the feasibility studies.[192] Another five CO-OPs *overshot* their base enrollment projections by 81% or more, with CoOportunity enrolling eight times more consumers than projected.[193]



[188] *Supra*, note 90.
[189] *Id.*
[190] This is based on a comparison of the start-up loan disbursement schedules set forth in the loan agreements, solvency loan disbursement schedules set forth in the business plans, and actual disbursement records.
[191] Appendix B.
[192] *Id.*
[193] *Id.*

These deviations manifested themselves early in 2014. By March 2014, two CO-OPs (CoOportunity and the New York CO-OP) had already exceeded their *high* enrollment projections for the year.[194] CoOportunity exceeded its high enrollment scenario by more than 150% within the first month of enrollment.[195] And by the end of March 2014, the New York CO-OP attracted 89,577 enrollees—more than double the high enrollment scenario in its feasibility study.[196] Because both fast-growing CO-OPs had mispriced their plans, that dramatic enrollment growth multiplied the CO-OPs' *losses* rather than gains—as HHS was seeing on a monthly and quarterly basis throughout 2014.[197]

CO-OPs with low enrollment also manifested problems early. By the end of the fourth month of 2014 open enrollment (January 2014), it was evident that many CO-OPs had seriously failed to attract their projected enrollees. At that point, five CO-OPs enrolled less than 2,000 members, and two CO-OPs enrolled less than 1,000 members.[198] Because open enrollment was the prime period for a surge in sign-ups, failure to perform well during that period was an important warning sign of deepening financial difficulties.



[194] *Id.*
[195] *Id.*
[196] *Id.*
[197] *See* Deloitte Additional Solvency Loan Review – CoOportunity; Deloitte Additional Solvency Loan Review – New York.
[198] Appendix B.

Because the CO-OPs reported enrollment data to HHS on a monthly basis, the Department was aware of these deviations from targets early in 2014—even as HHS continued to make multimillion-dollar start-up and solvency loan disbursements. Enrollment reports did not prompt HHS corrective action or place any failed CO-OP on an enhanced oversight plan throughout 2014.

As the CO-OPs with weak enrollment struggled to generate revenue, the CO-OPs with dangerously high enrollment racked up massive losses throughout 2014—losses reported on a regular basis to HHS.[199] CoOportunity and the New York CO-OP lost $39.8 million and $77.5 million, respectively, in 2014; they would go on to lose another $60 million and $544 million, respectively, in 2015.[200] Rapid enrollment growth, combined with underpriced premiums, contributed to the demise of both CO-OPs.[201] In the case of CoOportunity, 120,000 enrollees were sent searching for new insurance beginning on December 14, 2014, when the CO-OP was placed under supervision by the Iowa Insurance Division.[202] Likewise, in New York, 150,000 enrollees were informed that they would need to find new health insurance for 2016.[203]

C. Through 2014 And 2015, The Failed CO-OPs Were Losing Money Faster Than HHS Could Disburse It.

Despite serious financial warning signs, HHS did not withhold any planned disbursements from the now-failed CO-OPs—every dollar was paid, many on an accelerated basis compared to the CO-OPs' business plans.[204] Nor did it terminate

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[199] Appendix A. In the case of CoOportunity, cumulative net income was -$3,700,252 for Q1, -$13,421,327 for Q2, and -$39,847,903 for Q3. In the case of the Kentucky CO-OP, cumulative net income was -$1,720,156 for Q1, -$23,531,532 for Q2, -$24,033,077 for Q3, and -$50,445,923 at the end of 2014.

[200] Appendix A.

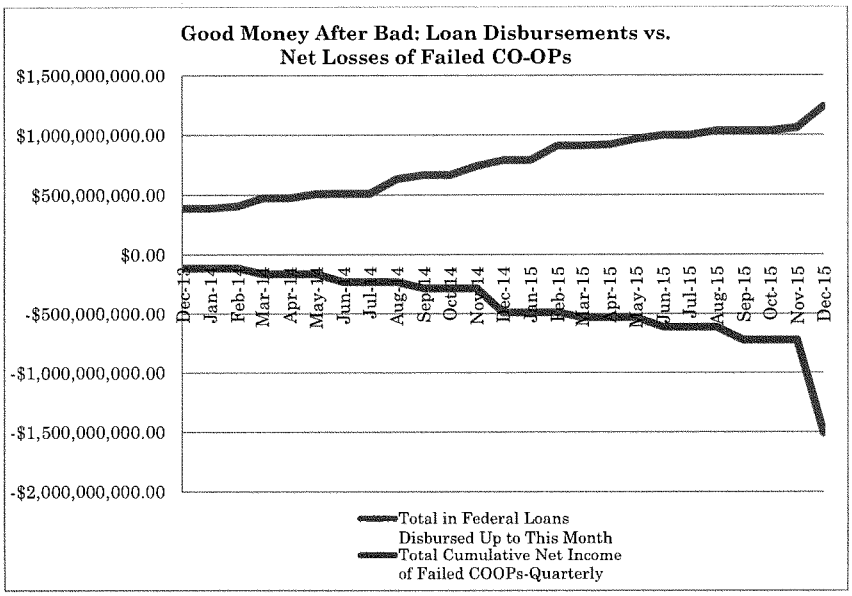
[201] Final Order of Liquidation, *Iowa ex rel. Gerhart, Comm. of Ins. v. CoOportunity Health, Inc.*, Equity No. EQCE077579, at 4 (Mar. 2, 2015), http://www.doi.nebraska.gov/legal/cooportunity/FINAL%20ORDER%20OF%20LIQUIDATION.pdf.; Scott E. Harrington, *The Financial Condition and Performance of CO-OP Plans*, U. Penn. Leonard Davis Institute of Health Economics, Data Brief, 6 (Feb. 2015).

[202] Pet. for Order of Liquidation, *Iowa v. Gerhart,* Equity Case No. EQCE077579, ¶ 14, http://www.iid.state.ia.us/sites/default/files/press_release/2015/01/29/petition_pdf_11438.pdf.

[203] Grace Marie-Turner, *400,000 Citizens to Lose Health Insurance (Again) Because of Obamacare CO-OP Failures*, GALEN INSTITUTE (Oct. 13, 2015).

[204] For example, the Michigan CO-OP received $19.4 million in solvency loan disbursements in 2014 against $3 million planned in its business plan. Similarly, the Arizona CO-OP received $26.9 million in 2015 in solvency loans against $15.4 million projected. *See* Disbursement Spreadsheets Submitted to PSI by Arizona CO-OP in Response to Nov. 23, 2015 Request; Michigan CO-OP Start-Up and Solvency Loan Disbursement Schedule, Ex. 1.0d (May 15, 2012); Arizona CO-OP Start-Up and Solvency Loan Disbursement Schedule.

any loan agreements. Instead, the agency continued to disburse taxpayer-backed loans to entities despite alarming signs of financial deterioration—and, ultimately, inability to repay the taxpayer. The Subcommittee analyzed the annual net incomes identified in the quarterly and annual financial statements of the now-failed CO-OPs and compared them on a quarterly basis to the HHS disbursement records provided by the CO-OPs.[205] Over the course of 2014 and 2015, HHS disbursed approximately $840 million[206] in federal loan dollars to the failed CO-OPs, even as they lost more than $1.5 billion.[207] For every $1 that HHS sent them during this period, the failed CO-OPs lost more than $1.65.



[205] Appendix D is a data spreadsheet that is available on the PSI website at http://www.hsgac.senate.gov/subcommittees/investigations/hearings/review-of-the-affordable-care-act-health-insurance-co-op-program. All original sources for the data are identified.
[206] *Id.*
[207] Appendix A. Net income losses are based on annual and quarterly NAIC filings by the CO-OPs, in addition to the 2015 year-end balance sheets provided to the Subcommittee. The 2015 year-end balance sheets have not yet been filed and finalized. Actual losses are likely to be significantly larger as several CO-OPs have not yet reported or provided their losses for the second half of 2015.

Indeed, HHS's disbursements of taxpayer loans continued well after several of the CO-OPs had announced their plans to close. The Utah CO-OP received $10.25 million on November 23, 2015—about a month after it announced its closure.[208] On July 7, 2015, the Louisiana CO-OP's Board of Directors agreed to wind down its activities, yet it received $9.2 million on November 27, 2015.[209] And Michigan received $5.4 million two weeks after it was placed on rehabilitation.[210]

D. HHS Approved Additional Solvency Loans For Three Of The Failed CO-OPs Despite Obvious Financial Warning Signs.

As financial reports poured into HHS, it soon became apparent that many of the CO-OPs were running out of money—some projecting cash shortfalls that could place them in conflict with risk-based capital requirements set by state regulators. If a CO-OP failed to meet those capital requirements, its state insurance regulator could effectively shut it down.

In response, HHS moved forward with awarding large additional solvency loans, well in excess of what was previously requested in the CO-OPs' applications and business plans. According to HHS, these additional solvency loans "were intended to assist applicants with meeting the capital reserve requirements of states in which the applicants sought to be licensed to issue health insurance."[211] After the start of coverage on January 1, 2014, HHS started an application and award process for additional funds specifically to assist with these state solvency requirements.[212] As of this report, six CO-OPs (three failed and three surviving) received additional solvency loan awards totaling more than $350 million.[213]

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[208] Kristen Moulton, *Utah Shuts Down Arches, The State's Nonprofit Insurance CO-OP*, THE SALT LAKE TRIBUNE (Oct. 28, 2015), *available at* http://www.sltrib.com/home/3108049-155/utah-shuts-down-arches-utahs-nonprofit.

[209] Pet. for Rehabilitation, Injunctive Relief, and Rule to Show Cause of Louisiana Health Cooperative, Inc., *Donelon v. Louisiana Health Cooperative, Inc.*, No. 641928, ¶ 11 (Sept. 1, 2015), https://www.ldi.la.gov/docs/default-source/documents/financialsolvency/receivership/Louisiana-Health-Cooperative/petition-for-rehabilitation.pdf?sfvrsn=0.

[210] *Michigan Places Consumers Mutual Insurance in Rehabilitation,* INSURANCE JOURNAL (Nov. 25, 2015), http://www.insurancejournal.com/news/midwest/2015/11/25/390170.htm.

[211] Dep't of Health & Human Servs., Office of Inspector Gen., *Actual Enrollment and Profitability Was Lower than Projections Made by the Consumer Operated and Oriented Plans and Might Affect Their Ability to Repay Loans Provided under the Affordable Care Act,* 5-6 (July 2015), http://oig.hhs.gov/oas/reports/region5/51400055.pdf.

[212] Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.

[213] *Id.*

Failed CO-OPs	Additional Solvency Loan Award
Health Republic Insurance of New York (New York)	$90,688,000
Kentucky Health Care Cooperative (Kentucky/West Virginia)	$65,000,000
CoOportunity Health (Iowa/Nebraska)	$32,700,000

Surviving CO-OPs	Additional Solvency Loan Award
HealthyCT (Connecticut)	$48,427,000
Maine Community Health Options (Maine)	$64,810,000
Common Ground Healthcare Cooperative (Wisconsin)	$51,117,899

To obtain additional solvency loans, CO-OPs were required to submit applications to HHS, including modified and updated business plans showing how the CO-OP would use the additional funds.[214] According to Mandy Cohen, CMS's Chief Operating Officer, "CMS undertook a rigorous review process substantially similar to what was conducted for the initial round of loans. This included both an external and internal review of updated business plans."[215] As with the initial loan review process, Deloitte completed the external assessment for all additional solvency loan applications. Deloitte evaluated the applicant CO-OPs based on the following criteria: enrollment, pricing, medical costs and losses, financials, and the quality of their contingency plans.[216]

According to Deloitte, HHS required a quick turnaround on analysis of each additional solvency loan application. While the firm initially requested two months to complete its work, HHS asked for responses in just four weeks.[217] As a result, Deloitte told the Subcommittee that it did not provide the same in-depth analysis as it did for the initial loan application.[218] For example, Deloitte specifically refrained from evaluating or commenting on "the reasonableness of the proposed changes to

[214] *See, e.g.*, Deloitte Additional Solvency Loan Review – Kentucky 1.
[215] *Review of Obamacare Consumer Operated and Oriented Plans (Co-Ops): Hearing Before the Subcommittee on Health Care, Benefits, and Administrative Rules*, 114th Cong. (Feb. 25, 2016) (statement of Dr. Mandy Cohen MD, MPH, Chief Operating Officer and Chief of Staff, Ctrs. for Medicare and Medicaid Servs.).
[216] Deloitte Additional Solvency Loan Review – Utah 1.
[217] Interview with Deloitte (Mar. 2, 2016).
[218] *Id.*

each CO-OP business plan" or "the likelihood of each CO-OP achieving sustainable operations based on the revised business plan."[219] Further, Deloitte did not provide any comment on "the reasonableness or the propriety of any of the amounts of the 3Rs" provided by the CO-OPs.[220] That meant neither Deloitte nor HHS analyzed whether the CO-OPs were correct to rely on funds from reinsurance, risk corridors, and risk adjustment.

The findings that Deloitte did express were troubling. This section examines Deloitte's reviews of the three approved additional solvency funding requests of the failed CO-OPs operating in Kentucky, New York, and Iowa and Nebraska.

1. The Kentucky CO-OP Receives $65 Million in Additional Solvency Loan Funding.

In October 2014, Deloitte submitted its report on the Kentucky CO-OP's additional solvency loan request to HHS. The CO-OP had previously been awarded $20.2 million in expansion funding in November 2013 and additional start-up funding of $2.5 million in December 2013.[221] According to its application, the Kentucky CO-OP requested "additional solvency loan funding because of higher than expected enrollment and primarily to address solvency issues caused by the treatment of the risk corridors receivable as a nonadmitted asset."[222] Deloitte found that without further solvency loans and if its 3R receivables were not treated as admitted assets, "the CO-OP will have both critical liquidity and solvency issues."[223]

Notwithstanding these serious outcomes if the Kentucky CO-OP did not receive additional solvency awards, the documents it provided to Deloitte were incomplete in several key areas—leaving the firm without sufficient information to analyze many of the proposed strategies. As with the initial loan application review process, when Deloitte found there was inadequate information, it sought the information from HHS.[224]

The Kentucky CO-OP failed to provide sufficient information in all four key categories examined by Deloitte. First, with respect to enrollment, the CO-OP had experienced greater than predicted total enrollment, but fell dramatically short of

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[219] *See, e.g.*, Deloitte Additional Solvency Loan Review – Kentucky 1.
[220] *Id.*
[221] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[222] Deloitte Additional Solvency Loan Review – Kentucky 3.
[223] *Id.* at 4.
[224] Interview with Deloitte (Mar. 2, 2016).

its plans to enroll 10,000 members *outside* the ACA Marketplace (it enrolled none).[225] But its revised enrollment strategy "did not provide any detail on how it plans to achieve its target enrollment" in its planned new markets.[226] Additionally, according to Deloitte, it was unclear how the CO-OP's plans would actually increase small-group enrollment (*i.e.,* small business employer plans)—a key market that Kentucky failed to previously engage.[227]

Second, with respect to the key issue of pricing, Deloitte expressed skepticism and noted gaps in the Kentucky CO-OP's proposal. The CO-OP planned to raise premiums by "an average of 15% in 2015 for individual products."[228] According to Deloitte, the CO-OP claimed "that its additional solvency needs [were] 'not due to inadequate or inappropriate pricing' in 2014," but Deloitte noted that "[t]his statement appears contradictory to the fact that [the Kentucky CO-OP] will remain 5-25% below the lowest priced competitor" even after adopting its premium increases.[229] Deloitte explained that it remains "unclear how [the Kentucky CO-OP] intends to avoid adverse selection if it remains the lowest priced competitor on the Kentucky Marketplace," and that the CO-OP "did not provide sufficient information to determine how [its proposed] premium increase will affect[ ] individual enrollment levels in Kentucky."[230] In yet another important gap, the CO-OP failed to explain how it would "raise its small group rates while also closing the price gap between [the Kentucky CO-OP] and the lowest priced competitor."[231]

Third, the Kentucky CO-OP told HHS that high medical claims costs also posed a financial threat—and were running higher than its 2014 projections. Yet according to Deloitte, "there [was] no information provided in the application detailing how [the CO-OP] intends to return to a normal level [of medical claims]."[232] Deloitte noted that if Kentucky did not reduce its medical loss ratio (*i.e.*, share of premium an insurer spends on medical claims), it would continue to lose money.[233] The Kentucky CO-OP projected an ambitious 74% reduction in medical loss ratio from 2014 (161.3%) to 2015 (86.8%), but there was "not enough

[225] Deloitte Additional Solvency Loan Review – Kentucky 5.
[226] *Id.* at 6.
[227] *Id.*
[228] *Id.* at 8.
[229] *Id.* at 7.
[230] *Id.*
[231] *Id.*
[232] *Id.* at 12.
[233] *Id.*

detail within the application" for Deloitte to even analyze the reasonableness of that decrease.[234]

Fourth, the Kentucky CO-OP's pro forma financial statements showed troubling projections on a number of levels. Even if the CO-OP realized its projected 3R recoveries, the Kentucky CO-OP was effectively requesting one government loan to pay another government loan. Deloitte's analysis found that the CO-OP was not projected "to earn enough net income through 2017 to repay its initial start-up loan payments of $6.3 million. Therefore, it appears [Kentucky] may need to use solvency loans to make the start-up loan repayment in 2017."[235]

The Kentucky CO-OP's precarious financial health depended largely on 3R receivables—including a projected $115.5 million for 2014. Deloitte noted that, without those 3R receivables, the CO-OP was projecting to have "losses of $139.3 million, $63 million, and $7.2 million in 2014, 2015, and 2016, respectively."[236] If those 3Rs did not materialize in full, or if they were not paid until the third quarter of 2015, Deloitte warned that "CMS may want to consider that [the Kentucky CO-OP] could suffer significant liquidity issues."[237] Deloitte noted the alternative: The Kentucky CO-OP had stated that, if its solvency loan request was denied, it could transition its members to other insurers "and remove the health plan from [2015] open enrollment."[238]

Instead, HHS chose to prolong the Kentucky CO-OP's operations, fueled by a $65 million additional solvency loan approved on November 10, 2014.[239] One year and $65 million in federal disbursements later, the Kentucky CO-OP was placed in rehabilitation due to insolvency risk and its health plan was removed from the 2016 open enrollment.[240] By that point, the CO-OP had deepened its losses to $50.4 million for 2014 and another $114.8 million in 2015.[241] Ultimately, more than 50,000 Kentucky CO-OP members would need to find new health insurance when the CO-OP collapsed.[242]

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[234] *Id.*
[235] *Id.* at 14.
[236] *Id.* at 4.
[237] *Id.* at 14.
[238] *Id.*
[239] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[240] Order of Liquidation, *Maynard v. Kentucky Health Cooperative, Inc.*, at 3.
[241] Kentucky CO-OP, Statutory Balance Sheet (Dec. 31, 2015).
[242] *See* Appendix B.

2. The New York CO-OP Receives $90.7 Million in Additional Solvency Loan Funding.

On June 18, 2014, the New York CO-OP requested $90.7 million to maintain solvency in the face of far greater enrollment than expected and underpriced premiums.[243] The CO-OP reported a financially precarious position that required an infusion of additional funds to maintain solvency. Deloitte warned that estimating the 3Rs receivables was difficult and "may create issues if relied upon to generate profit,"[244] yet without those receivable the CO-OP was projecting losses of $68.2 million and $23.1 million for 2014 and 2015, respectively.[245] Losses would swell to $77.5 million and an estimated $544 million in 2014 and 2015, respectively.[246]

The New York CO-OP's 2014 enrollment was dramatically higher than anticipated "due to its rates being among the lowest in most products and markets across the state."[247] The CO-OP's principal solution was to increase premiums by 10% above market trend, but Deloitte noted that the CO-OP failed to include "estimates of the sensitivities of demand to prices"—that is, the effect that proposed premium increases would have on consumer demand for its health plans.[248] In addition, the effectiveness of its proposed plan to raise premiums was "only substantiated in [the CO-OP's] *assertion*" that it performed an "in-depth" analysis, "but no concrete data was provided from the study in the business plan or the Milliman feasibility study."[249] More broadly, Deloitte found that while the CO-OP had laid out a strategy for maintaining its enrollment figures and market competitiveness, it failed to "quantify the impact this business strategy will have on enrollment projects and financial sustainability."[250]

The CO-OP also appeared to be seeking enrollment growth in some respects. Unplanned enrollment growth had been a main driver of the CO-OP's financial difficulties, but the New York CO-OP projected to grow substantially in 2015 and 2016—to levels 319% and 339% (respectively) greater than original projections.[251] In fact, the CO-OP told HHS that it planned to *expand* its offering into "the

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[243] Deloitte Additional Solvency Loan Review – New York 1; Letter from Debra Friedman, President and CEO, Health Republic Insurance of New York to Nicole Gordon, Dep't of Health & Human Servs. (June 18, 2014).
[244] Deloitte Additional Solvency Loan Review – New York 9.
[245] Deloitte Additional Solvency Loan Review – New York 1.
[246] New York CO-OP, Statement of Financial Performance (Dec. 31, 2015).
[247] Deloitte Additional Solvency Loan Review – New York 6.
[248] *Id.* at 3.
[249] *Id.* at 6 (emphasis added).
[250] *Id.* at 6.
[251] *Id.* at 2.

remaining 30 New York counties in which it does not currently serve."[252] The CO-OP planned to "move into the large group market starting in 2015" in order to "diversify its business," among other goals, but it provided "no substantiation" for its enrollment projections in that more profitable market.[253]

Finally, there were obvious concerns about the New York CO-OP's ability to meet state and federal capital requirements. As previously discussed, the governing loan agreements required CO-OPs to maintain a risk-based capital (RBC) level of 500% of its authorized control level (ACL). According to HHS, "RBC is a method of measuring the minimum amount of capital appropriate for an issuer to support its overall business operations in consideration of its size and risk."[254] But HHS decided to deviate from its recommended capital requirements.[255] Deloitte wrote: "Based on discussions with CMS, Deloitte confirmed that CMS has chosen to fund [the New York CO-OP] based on state solvency requirements rather than a risk-based capital (RBC) level of 500% of authorized control level (ACL) normally recommended by CMS."[256] According to Deloitte, "The amount of funding required to meet the recommended RBC level of 500% of ACL is greater than the amount required [by the New York state standard]"—meaning that HHS lowered its own standard to accommodate the New York CO-OP.[257]

Deloitte summarized the "contingency plan" submitted by the New York CO-OP in the event it did not receive its solvency loan. "If [the New York CO-OP] does not receive the requested solvency loan funding, it may identify outside financing or scale down operations in order to meet solvency requirements. However, [the CO-OP] still projects that it will be able to repay both the start-up and current solvency loan funding in this scenario."[258] Deloitte explained that, failing private financing,

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[252] *Id.* at 3–4.
[253] *Id.* at 4.
[254] Dep't of Health & Human Servs., Ctrs. for Medicaid and Medicaid Servs., *CO-OP Program Guidance Manual* (July 29, 2015), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CO-OP-Guidance-Manual-7-29-15-final.pdf.
[255] Deloitte Additional Solvency Loan Review – New York 2.
[256] *Id.*
[257] *Id.*; New York CO-OP, CMS First Amended Loan Agreement, 2 (Feb. 17, 2012). The New York State Department of Financial Services (NYDFS) later effectively reversed HHS's decision to lower the bar for the New York CO-OP. NYDFS required the CO-OP to revert to the 500% RBC level, and that prompted the New York CO-OP to ask for an additional $70.5 million in a second request for additional solvency loan funding in September of 2014. HHS denied that second request in mid-December 2014—by which point it had exhausted its CO-OP loan award authority.
[258] Deloitte Additional Solvency Loan Review – New York 2.

the CO-OP intended to "scale down its operation by increasing its rates, by reducing its membership . . . and by eliminating all non-essential administrative costs."[259]

But rather than scale down, in September 2014, the New York CO-OP sought and obtained from HHS a $90.7 million additional solvency loan that would allow it to *scale up*—in every respect but profits.[260] Twelve months and $109 million in federal loan disbursements later, the New York Department of Financial Services directed the CO-OP to cease writing new health insurance policies and announced that the CO-OP will commence an orderly wind down after the expiration of its existing policies in December 2015.[261] By that point, the CO-OP had deepened its net losses to $77.5 million in 2014 and *more than $544 million* in 2015,[262] while adding 58,208 enrollees in 2015. All of those enrollees were sent searching for new health insurance policies when the New York CO-OP became insolvent.

3. CoOportunity Health Receives $32.7 Million in Additional Solvency Loan Funding.

On May 5, 2014, CoOportunity applied for an additional $32.7 million in solvency loan funds on top of the $112 million HHS originally awarded.[263] The CO-OP told HHS that it needed the infusion of cash to head off "cash flow and liquidity problems" driven by unexpectedly high losses, rapid growth and a "higher risk profile" than expected.[264] To slow its losses, the CO-OP planned to increase its rates and to focus on urban areas and other markets it had not penetrated (among other steps). But given the unsupported assumptions underlying the CO-OP's proposed solutions, Deloitte warned that the additional funds sought by CoOportunity may *not* be enough to maintain its solvency for long. "Due to the uncertainty of its enrollment projections and the risk profile of future enrollees," Deloitte wrote, "*it is unclear* that the requested amount of additional solvency loan

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[259] *Id.* at 14.
[260] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Information & Insurance Oversight, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers* (Dec. 16, 2014), https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html.
[261] Appendix C is a data spreadsheet that is available on the PSI website at http://www.hsgac.senate.gov/subcommittees/investigations/hearings/review-of-the-affordable-care-act-health-insurance-co-op-program. All original sources for the data are identified; *see* Press Release, New York Dep't of Fin. Servs. (Oct. 30, 2015), http://www.dfs.ny.gov/about/press/pr1510301.htm.
[262] Appendix A.
[263] Letter from Comm. Stephen Ringlee, Dir. and Chief Fin. Officer, CoOportunity Health to CO-OP Program Division, Dep't of Health & Human Servs. (May 5, 2014).
[264] Deloitte Additional Solvency Loan Review – Iowa 3.

funding reflects the amount required to meet the CO-OP's future capitalization and liquidity requirements during growth projected during 2014–2017."[265]

Deloitte also pointed to concerns about CoOportunity on the crucial issue of enrollment. The firm's consultants noted that "no documentation or explanation is provided substantiating the reason or discrepancies in the actual current enrollment level"[266]—an obvious first step in addressing the problem. More fundamentally, CoOportunity's enrollment projections rested on a "list of assumptions," but it failed to "provide additional information discussing the impacts of these assumptions on its ability to meet enrollment projections in a specific target market or targeted market."[267] Finally, CoOportunity provided, without explanation, conflicting enrollment projections that "differ, at times, by over 20,000 per year."[268]

CoOportunity Health's forecast of financial health relied heavily on the 3Rs, despite uncertainty concerning its projections.[269] The CO-OP projected a net profit of $8.5 million for 2014–2016, but "[a]bsent recoveries from risk sharing, risk corridors, and risk adjustment," the CO-OP stood to lose $86.1 million from 2014–2016. Deloitte cautioned that "[t]he 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit."[270] The largest receivable on CoOportunity's books for 2014, however, was a $41 million risk corridor payment.[271]

This was not CoOportunity's only additional solvency loan request. On September 22, 2014, four days before HHS approved CoOportunity's $32 million application, HHS received a second request from the CO-OP asking for an additional $55 million.[272] Knowing this information, however, HHS still approved the first application. Less than three months later, on December 16, 2014, it was placed under supervision by the Iowa Insurance Division and later liquidated.[273] CoOportunity had operating losses of over $163 million and $50 million more in

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[265] *Id.* at 6 (emphasis added).
[266] *Id.* at 2.
[267] *Id.* at 3.
[268] *Id.* at 5.
[269] *Id.* at 11.
[270] *Id.* at 11.
[271] *Id.*
[272] Letter from Commissioner Stephen Ringlee, Director and Chief Financial Officer, CoOportunity Health to CO-OP Program Division, Dep't of Health & Human Servs. (Sept. 22, 2014).
[273] Pet. for Order of Liquidation, *Iowa v. Gerhart,* Equity Case No. EQCE077579, ¶ 14, http://www.iid.state.ia.us/sites/default/files/press_release/2015/01/29/petition_pdf_11438.pdf.

liabilities than in assets.[274] The CO-OP's closure left its 120,000 members scrambling with little time to find a new insurance plan that best fit their needs. There were still nearly 10,000 former CoOportunity members without a new insurance plan by the time of the CO-OP's liquidation.[275]

E. HHS Permitted The CO-OPs To Rely On Massive Risk Corridor Projections With No Sound Basis For Doing So.

The risk corridor program is a temporary measure in the ACA that requires health insurers to share gains and losses. Insurers are required to calculate a "risk corridor ratio" that reflects their profitability using a formula prescribed by the ACA.[276] Using that ratio, more profitable insurers must remit a portion of their profits to HHS, and those collections are in turn to be directed to unprofitable insurers to offset a portion of their losses.[277]

As HHS has repeatedly acknowledged in the past, the risk corridor program was intended to be budget-neutral—meaning payments to insurers suffering losses would come entirely from those experiencing gains. The Congressional Budget Office (CBO) originally scored the cost of the risk corridor program on the assumption that "aggregate collections from some issuers would offset payments made to other issuers."[278] Subsequent CBO scores have varied, but all have projected either budget-neutrality or better.[279] More importantly, in 2013 and 2014, HHS stated that the agency "intend[s] to implement [the risk corridor] program in a budget neutral manner, and may make future adjustments either upward or

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[274] Final Order of Liquidation, *Iowa ex rel. Gerhart v. CoOportunity Health, Inc.*, Equity No. EQCE077579, at 4 (Mar. 2, 2015), http://www.doi.nebraska.gov/legal/cooportunity/FINAL%20ORDER%20OF%20LIQUIDATION.pdf.

[275] Joe Gardyasz, *Insurers still scrambling to process former CoOportunity members,* IOWA BUS. RECORD (Feb. 10, 2015), http://www.businessrecord.com/Content/Default/-All-Latest-News/Article/Insurers-still-scrambling-to-process-former-CoOportunity-members/-3/248/67513#ixzz42BbdzuvY.

[276] The formula is: (Medical claims + quality improvement) / (Premiums collected – administrative costs).

[277] *See generally* The Robert Wood Johnson Foundation, *Analysis of HHS Final Rules On Reinsurance, Risk Corridors And Risk Adjustment* (Apr. 2012); *see also* Angela Boothe & Brittany La Couture, *The ACA's Risk Spreading Mechanisms: A Primer on Reinsurance, Risk Corridors and Risk Adjustment*, AMERICAN ACTION FORUM (Jan. 9, 2015), http://americanactionforum.org/research/the-acas-risk-spreading-mechanisms-a-primer-on-reinsurance-risk-corridors-a#_edn11.

[278] *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014*, 78 Fed. Reg. 15516 (Mar. 11, 2013).

[279] Congressional Budget Office, The Budget and Economic Outlook: 2014 to 2024 (Feb. 4, 2014), https://www.cbo.gov/publication/45010; Congressional Budget Office, The Budget and Economic Outlook: 2015 to 2025 (Jan. 26, 2015), https://www.cbo.gov/publication/49892.

downward to this program . . . to the extent necessary to achieve this goal."[280] In April 2014, the agency explained that "if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be *reduced pro rata to the extent of any shortfall.* Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year."[281] In other words, HHS would not spend more in risk corridor payments in a given year than it collected. A December 2014 appropriations law codified that commitment to budget-neutrality in the risk corridor program.[282]

But the gains necessary for the risk corridor program to work as intended did not materialize—as many analysts had warned. In an October 2014 report, Citibank concluded that HHS would not collect "nearly enough" from profitable insurers to meet the risk corridor requests of unprofitable insurers. The report was based an analysis of mid-year financial statements of 85 health plan subsidiaries representing "approximately 80% of the total individual market."[283] Remarkably, Citibank reported that, as of June 2014, the insurers that it studied had accrued $410 million in risk corridor receivables (*owed to them*) and only $2.3 million in risk corridor payments *owed by them* to HHS. In other words, it was a staggering imbalance. The study's authors concluded: "The sizeable risk corridor receivable assumptions by the plans make us nervous. . . . With no change in assumptions, we estimate the full year liability to HHS could exceed $1 billion. There won't be nearly enough plan contributions to fund these requests."[284] Citibank also questioned the empirical basis for HHS's assumption that any 2014 risk corridor shortfall could be covered by excess risk corridor collections in 2015: "[I]t isn't clear to us why health plans will suddenly start earning excess individual profits in 2015,"[285] the analysts noted, particularly considering "the losses being incurred by many plans this year."[286] Citibank's study echoed earlier skepticism in a publication by the Society of Actuaries, which concluded that it is "likely" that risk

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[280] *Patient Protection and Affordable Care Act*; HHS Notice of Benefit and Payment Parameters for 2015, 45 CFR Parts 144, 13,787 (Mar. 11, 2014), https://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf.

[281] Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs., *FAQ: Risk Corridors and Budget Neutrality* (Apr. 11, 2014) (emphasis added), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.

[282] Consolidated and Further Continuing Appropriations Act, Pub. L. 113–235, 128 Stat. 2130 (Dec. 16, 2014).

[283] Carl McDonald and Sahil Choudhry, *Blessed Are Those Who Can Give Without Remembering & Take Without Forgetting: Analyzing The Industry's Individual 3 R Accruals In 1H14*, Citi Research 1, 2, 5 (Oct. 21, 2014), https://ir.citi.com/T75ur7JO9TmjgZE8xXjGDxftykEMbKPXghCs4GqkDqE%3D.

[284] *Id.* at 1.

[285] *Id.*

[286] *Id.* at 5.

corridor collections would not be sufficient to cover receivables.[287] And Citibank was not alone in its analysis.[288]

Deloitte warned HHS that several struggling CO-OPs were relying heavily on large, uncertain risk corridor projections to boost their balance sheets.[289] Throughout 2014, HHS received information showing that most of the now-extinct CO-OPs were booking massive projected payments from the risk corridor program—payments that were crucial to their forecasts of profitability.[290] For example, at the time of its first additional solvency loan application, CoOportunity's largest receivable for 2014 was its projected risk corridor payments. In its review of each additional solvency loan application, however, Deloitte cautioned HHS against the risks of relying on risk corridor projections to sustain CO-OPs experiencing losses.[291]

HHS did not heed these warnings. Rather than caution the CO-OPs against relying too heavily on risk corridor receivables that were very much in doubt, HHS issued repeated assurances throughout 2014 and 2015 that risk corridor collections would be sufficient to cover receivables. As recently as July 21, 2015, the agency continued to assure state insurance commissioners: "As stated in our final payment notice for 2016, 'We anticipate that risk corridor collections will be sufficient to pay for all risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers.'"[292]

When asked about this July 2015 letter in an interview, HHS officials stated that the letter was not referring to 2014 in isolation but rather to the three-year

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[287] Doug Norris, *Risk Corridors Under the Affordable Care Act*, HEALTH WATCH, SOCIETY OF ACTUARIES (Oct. 2013). The article continued: "The risk corridor program appears to be symmetric, with some plans paying into the program and some plans receiving funds from the program .... However, if all of the plans in a market (or even just the most popular ones) end up pricing their products too low and so suffer losses, the government will end up needing to fund this program, and the required funds could be substantial." *Id.*

[288] A May 2014 report by Standard and Poor added to the chorus of skepticism about the risk corridor payments and projected a pro rata shortfall that would permit payment of only 10 cents on the dollar. *See* Zachary Taylor, *Obamacare Risk Fund May Pay Just 10% of Insurer Claims, S&P Says* (May 1, 2015), http://www.bloomberg.com/news/articles/2015-05-01/obamacare-risk-fund-may-pay-just-10-of-insurer-claims-s-p-says.

[289] *See* Part III. E, *supra*.

[290] *Id.*

[291] Deloitte cautioned that "[t]he 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit." *See* Part III.E, *supra* (additional solvency loan applications).

[292] Letter from Kevin Counihan, Director, CCIIO, to State Insurance Commissioners (July 21, 2015); *see also* CMS Public Mem., Risk Corridors & Budget Neutrality (Apr. 11, 2014) ("We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments."); The Affordable Care Act's Premium Stabilization Programs: Hearing Before House Comm. on Oversight & Gov't Reform, 113th Cong. (June 18, 2014) (statement of Dr. Mandy Cohen MD, MPH, Acting Deputy Administrator and Director, CCIIO) (same).

period 2014–2016.[293] To say the least of it, that explanation is certainly not clear from the face of the letter, which specifically addresses "the 2014 reinsurance program" and "2014 risk corridor payments."[294] But even accepting HHS's reading, those assurances were no less unfounded: A November 2015 report by Standard & Poor's has already estimated that "the 2015 ACA risk corridor will be significantly underfunded, as was the case the previous year."[295] If true, that means there will be no surplus in 2015 to make up the 2014 shortfall—as Citibank predicted in October 2014.

Widespread concerns about booking risk corridor payments were ultimately justified. On October 15, 2015, HHS announced that 2014 risk corridor collections from profitable insurers had fallen far short of risk corridor payments requested by unprofitable insurers: HHS was able to pay only 12.6 cents on the dollar.[296] As predicted, the ensuing risk corridor shortfall further destabilized the CO-OPs.

F. The Heavy Costs of Failed CO-OPs Will Be Borne By Taxpayers, Doctors, And Other Insurers.

1. Financial Information Obtained By The Subcommittee Indicates That No Significant Share of the $1.2 Billion in Failed CO-OP Loans Will Likely Be Repaid.

None of the failed CO-OPs have repaid a single dollar, principal or interest, of the $1.2 billion in federal solvency and start-up loans they received.[297] The Subcommittee asked each of the failed CO-OPs to describe any "planned payments" on any principal or interest payments on any of their federal CO-OP loans. All twelve responded that, as of February 2016, there are no planned payments.[298]

The most up-to-date balance sheets obtained by the Subcommittee confirm that eight of the failed CO-OPs report multimillion-dollar deficits, *excluding their federal CO-OP loans*. In the aggregate, the failed CO-OPs' currently estimated *non-loan* liabilities exceed $1.13 billion—which is 93% greater than their $585 million in

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[293] Interview with Kevin Counihan, Director, CCIIO (Mar. 1, 2016); Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).
[294] Letter from Kevin Counihan, Director, CCIIO, to State Insurance Commissioners (July 21, 2015).
[295] Sarah Ferris, *ObamaCare Risk Fund Nearly Depleted, S&P Warns*, THE HILL (Nov. 5, 2016), http://thehill.com/policy/healthcare/259337-obamacare-risk-fund-nearly-depleted-sp-warns.
[296] Dep't of Health & Human Servs., Cntrs. for Medicare & Medicaid Servs., *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.
[297] CO-OP Resp. to Nov. 23, 2015 PSI Request (on file with Subcommittee).
[298] *Id.*

reported assets.[299] Their debt to the U.S. government stands at over $1.2 billion.[300] Several of the CO-OPs owe substantially more in unpaid medical claims alone than they hold in assets. The New York CO-OP, for example, estimates that it has $379.5 million in unpaid claims to doctors, hospitals, and patients, while it registers only $157 million in assets (including expected 3R receivables).[301] Only three failed CO-OPs report greater assets than non-loan liabilities and those surpluses represent only a fraction of their federal loans.[302]

Below are the best estimates of the CO-OPs' current deficits or surpluses, *assuming zero repayment* of any federal CO-OP loan. Specifically, the Subcommittee asked each CO-OP to produce their most recent available balance sheet, and the tables below summarize those documents. "Assets" refers to cash and investments as well as projected receivables from 2015. "Liabilities" refers to unpaid medical claims and other liabilities, *excluding* the CO-OP's federal start-up and solvency loans. We estimated current "deficit" or "surplus" by subtracting non-loan liabilities from assets. On separate lines, each table identifies the current amounts of solvency and start-up loans owed to the federal government; start-up loans that were subsequently converted to surplus notes are identified as solvency loans.

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[299] The total numbers for liabilities, assets, and the percentages do not include the Nevada CO-OP because it was not able to provide a complete, recent balance sheet.
[300] Arizona CO-OP, Balance Sheet (Dec. 31, 2015); Colorado CO-OP, Balance Sheet (Dec. 31, 2015); Iowa CO-OP, Balance Sheet (Jan. 29, 2016); Kentucky CO-OP, Balance Sheet (Jan. 2016); Louisiana CO-OP, Balance Sheet (Jan. 31, 2016); Michigan CO-OP, Balance Sheet (Dec. 31, 2015); Nevada CO-OP, Balance Sheet (Dec. 31, 2015); New York CO-OP, Balance Sheet (Dec. 31, 2015); Oregon CO-OP, Balance Sheet (Jan. 31, 2015); South Carolina CO-OP, Balance Sheet (Jan. 31, 2016); Tennessee CO-OP, Balance Sheet (Jan. 31, 2016); Utah CO-OP, Balance Sheet (Dec. 31, 2015).
[301] New York CO-OP, Statement of Financial Position (Dec. 31, 2015).
[302] Oregon CO-OP, Balance Sheet (Jan. 31, 2016); Tennessee CO-OP, Balance Sheet (Jan. 31, 2016); Utah CO-OP, Balance Sheet (Dec. 31, 2015).

Arizona CO-OP	
Total Assets	$27,474,302
Subtotal Liabilities	$31,752,963
Deficit	**$(4,278,661)**
Solvency Loan	$93,313,233
Source: Dec. 31, 2015 Statement	

Colorado CO-OP	
Total Admitted Assets	$48,891,384
Total Liabilities	$130,792,031
Deficit	**$(81,900,647)**
Solvency Loan	$72,335,129
Source: Dec. 31, 2015 Statement	

Iowa CO-OP	
Total Assets	$61,567,500
Total Liabilities	$87,172,375
Deficit	**$(25,604,875)**
Solvency Loan	$132,000,000
Start-up Loan	$14,700,000
Source: Jan. 29, 2016 Statement	

Kentucky CO-OP	
Total Admitted Assets	$70,507,439
Total Liabilities	$105,573,751
Deficit	**$(35,066,312)**
Solvency Loan	$124,497,900
Start-up Loan	$19,568,223
Source: Jan. 31, 2016 Statement	

Louisiana CO-OP	
Total Assets	$34,695,964
Total Current Liabilities	$51,501,925
Deficit	**$(16,805,961)**
Solvency Loan	$52,614,100
Start-up Loan	$13,176,560
Source: January 31, 2016 Statement	

Michigan CO-OP	
Total Assets	$28,483,244
Total Current Liabilities	$30,816,455
Deficit	**$(2,333,211)**
Solvency Loan	$71,534,300
Source: Dec. 31, 2015 Statement	

New York CO-OP	
Total Admitted Assets	$157,544,125
Total Short Term Liabilities	$547,408,164
Deficit	**$(389,864,039)**
Solvency Loan	$241,366,000
Start-up Loan	$23,600,400
Source: Dec. 31, 2015 Statement	

Oregon CO-OP	
Net Admitted Assets	$13,917,872
Total Liabilities	$9,436,938
Surplus (excluding loans)	**$4,480,934**
Solvency Loan	$60,623,505
Source: Jan. 31, 2016 Statement	

South Carolina CO-OP	
Total Assets	$47,066,188
Total Liabilities	$67,443,408
Deficit	**$(20,377,220)**
Solvency Loan	$68,868,408
Start-up Loan	$18,709,800
Source: Jan. 31, 2016 Statement	

Tennessee CO-OP	
Total Assets	$41,777,566
Total Liabilities	$25,082,097
Surplus (excluding loans)	**$16,695,469**
Solvency Loan	$54,802,000
Start-up Loan	$18,504,700
Source: Jan. 31, 2016 Statement	

Utah CO-OP	
Total Assets	$53,514,834
Total Current Liabilities	$43,993,836
Surplus (excluding loans)	**$9,520,998**
Solvency Loan	$79,544,300
Start-up Loan	$10,106,003
Source: Dec. 31, 2015 Statement	

The figures above are, by necessity, estimates. The largest liability—unpaid claims—includes fully processed 2015 claims as well as incurred but unprocessed 2015 claims. The CO-OPs report that they continue to receive some 2015 medical claims through the first quarter of 2016, and many received claims are still being processed to determine coverage. Other liabilities depend to some extent on claims data and could change as well. For example, payments owed by insurers under the federal risk adjustment program will turn on still-incomplete data.

One failed CO-OP—Nevada's—was unable to provide a complete recent balance sheet. The CO-OP did, however, provide the Subcommittee with some currently available figures that suggests a large deficit: $16.75 million in valid unpaid medical claims, $14.7 million in other liabilities, $60.4 in *unadjudicated* medical claims, and only $19 million in cash.[303] Significantly, this does not include expected receivables under the risk-sharing programs, and the CO-OP expects the $60.4 million unadjudicated claims liability to decline.[304] But based on this information, the Nevada CO-OP's assets will not likely be sufficient to cover its *non-loan* liabilities, much less sufficient to repay any significant portion of its federal solvency and start-up loans.[305] Moreover, Nevada has no guaranty fund capable of covering unpaid medical claims.[306]

Based on currently available information, it is unlikely that the failed CO-OPs will be able to repay any significant share of their outstanding $1.2 billion in federal loans. The Subcommittee has repeatedly asked HHS for any projections or

[303] PSI Correspondence with Mark F. Bennett, Receiver, Authorized Representative of the Special Deputy Receiver of the Nevada Health CO-OP (Mar. 4, 2016) (on file with Subcommittee).
[304] *Id.*
[305] *Id.*
[306] Nevada CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).

estimates of the prospects for repayment by the failed CO-OPs, and the agency provided none. Instead, HHS officials responded that it is too early to assess and stated that the Department of Justice has assumed responsibility for collection on these unpaid debts.[307]

2. Doctors and Hospitals Are At Risk Of Not Getting Paid In Some States, While Guaranty Funds Will Be Hard Hit In Others.

The American taxpayer is not the only creditor that stands to suffer large losses due to the failure of the CO-OP program. Based on the most recent balance sheets provided to the Subcommittee, the failed CO-OPs currently owe an estimated $742 million to doctors and hospitals for plan year 2015, including incurred claims.[308] An insolvent health insurer's debt to providers takes priority over other liabilities, so those claims are likely to be the first to be paid out of remaining assets. But if a CO-OP's medical claims alone exceed assets, payment to providers can be in doubt—as detailed below.

Based on their submissions, at least six CO-OPs currently owe more in medical claims alone than they hold in assets.[309] Three of those CO-OPs—the Colorado CO-OP, the South Carolina CO-OP, and CoOportunity—have access to guaranty associations capable of paying some or all unpaid medical claims.[310] Guaranty associations serve as a mechanism to pay covered claims occurring as a result of an insurer's insolvency. Associations were created to alleviate these problems and ensure the stability of the insurance market.[311] The Colorado CO-OP projects that substantially all of its $96.6 million in unpaid medical claims will be paid by the state's guaranty fund.[312] Similarly, the South Carolina CO-OP

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[307] Interview with Kevin Counihan, Dir., CCIIO (Mar. 1, 2016); Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).
[308] CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).
[309] Specifically, the Kentucky CO-OP reports $70.5 million in assets and $77.46 million in unpaid medical claims. Kentucky CO-OP, Jan. 2016 Balance Sheet (Jan. 31, 2016). The Louisiana CO-OP reports $34.4 million in assets and $43.3 million in unpaid medical claims. Louisiana CO-OP, Jan. 2016 Balance Sheet (Jan. 31, 2016). The New York CO-OP reports $157.54 million in assets, $379.5 million in unpaid claims, and $106.9 million in risk adjustment liability. New York CO-OP, Dec. 2015 Balance Sheet (Dec. 31, 2015). The South Carolina CO-OP reports $47 million in assets and $47.7 million in unpaid claims. South Carolina CO-OP, Jan. 2016 Statement of Assets, Liabilities and Surplus (Jan. 31, 2016). The Colorado CO-OP reported $48.9 million in assets and $96.6 million in unpaid claims. Colorado CO-OP, Dec. 2015 Statement of Assets, Liabilities and Surplus (Dec. 31, 2015).
[310] Throughout this report, Subcommittee's references to information provided by a closed CO-OP refers to information from the CO-OP's remaining personnel *or* the CO-OP's receiver.
[311] *See* Nat. Ass'n.of Insurance Commissioners, *Briefing: Guaranty Associations* (Dec. 14, 2015), http://www.naic.org/cipr_topics/topic_guaranty_associations.htm.
[312] PSI Staff Correspondence with Colorado CO-OP on file with Subcommittee.

estimates that all of its $48 million in unpaid claims will be paid by the state's guaranty fund.[313]

The first CO-OP to close, CoOportunity, reports that $114.1 million of its unpaid medical claims have now been paid by the Iowa and Nebraska guaranty associations.[314] These guaranty fund payments are not, however, a proverbial free lunch. To the contrary, large obligations charged to guaranty funds mean that, within those states, "[s]urviving companies—or actually their policy holders—will pay for the co-ops' losses, ultimately in the form of higher premiums."[315] In addition, most states permit the surviving insurers to obtain tax credits for those payments, so state treasuries (and, in turn, taxpayers) will effectively subsidize guaranty fund bailouts for some of the CO-OPs.[316] Importantly, however, the CO-OPs that received guaranty fund coverage are required to reimburse the guarantee funds with the 2015 reinsurance and risk corridor recoveries they receive—which are currently listed as "assets" on the CO-OP balance sheets—before paying back any federal loans.[317]

The other three CO-OPs with serious shortfalls, however, will not be bailed out by guaranty funds. The New York CO-OP reports that it had $379.5 million in unpaid medical claims and $157.54 million in assets as of December 31, 2015—*a $222 million shortfall*, excluding any other liabilities.[318] No portion of that shortfall

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[313] *Id.*

[314] Specifically, the Iowa guaranty association has paid $37 million to date and the Nebraska guaranty association has paid $77 million to date. That amount represents all of CoOportunity's claims, except for claims that exceeded $500,000/person limits. Those excess claims were settled. *See* CoOportunity Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee). One CO-OP whose medical claims do *not* exceed its assets nevertheless project some degree of guaranty fund coverage. The Michigan CO-OP estimates that $14.3 million in unpaid medical claims will be covered by a guaranty association. *See* Michigan CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).

[315] Grace-Marie Turner & Thomas P. Miller, *ObamaCare Co-ops: Cause Célèbre or Costly Conundrum?*, AMERICAN ENTERPRISE INSTITUTE & GALEN INSTITUTE 7 (June 29, 2015), http://www.galen.org/assets/ObamaCare-Co-ops.pdf. "For 2015, the Nebraska Guaranty Association assessed commercial carriers the highest amount allowed by law to pay outstanding claims for CoOportunity members. 'Under each state's guaranty fund association laws, $170 million of CoOportunity Health's policyholder health claims are, in part, now funded and paid out of proportional assessments levied on each of the insurance company members of the respective guaranty associations,' health law attorney William Schiffbauer writes. 'The size of the unpaid claims necessitated the association to secure a line of credit from a commercial bank with additional guarantees.'" *Id.*

[316] Nat. Org. of Life & Health Ins. Guaranty Ass'ns, *State Laws and Provisions Report* (Oct. 12, 2015), https://www.nolhga.com/factsandfigures/main.cfm/location/lawdetail/docid/9.

[317] *See* CoOportunity Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).

[318] New York CO-OP, Statement of Financial Performance (Dec. 31, 2015).

will be covered by New York's guaranty fund.[319] Most of the New York CO-OP's unpaid claims are owed to doctors and hospitals, and a non-negligible share—$373,000 as of January 31, 2016—is owed directly to patients.[320] Similarly, the Louisiana CO-OP reports $34.4 million in assets and $43.3 million in unpaid medical claims as of January 31, 2016, and none of that $9 million shortfall will be covered by a guaranty fund.[321] The same is true of the $7 million shortfall on the Kentucky CO-OP's January 2016 balance sheet, which shows $77.5 million in unpaid claims and only $70.5 million in assets.[322] If these claims estimates hold or grow, a significant number of doctors, hospitals, and individual enrollees stand to shoulder part of the financial burden of the CO-OPs' collapse.[323]

Finally, it is important to note that, in 2015, HHS permitted at least four of the failed CO-OPs—the Arizona CO-OP, Michigan CO-OP, Colorado CO-OP, and Oregon CO-OP—to convert their combined $65 million in start-up loans to surplus notes.[324] According to HHS, this action allowed to the CO-OPs to "record those [start-up] loans as *assets* in financial filings with regulators"[325]—an accounting anomaly. As a consequence, those start-up loans are now subordinated below all other liabilities—on par with solvency loans—meaning that they are last in the priority of creditor repayment.[326] HHS told the Subcommittee that it estimated the likely loss to the Treasury from CO-OP start-up loan conversions,[327] but it has thus far failed to provide that estimate to the Subcommittee.

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[319] Interview with Kevin Counihan, Dir., CCIIO (Mar. 1, 2016); Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).
[320] New York CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).
[321] Louisiana CO-OP SAP Balance Sheet (Jan. 31, 2016); Louisiana CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).
[322] Kentucky CO-OP Balance Sheet (Jan. 2016); Kentucky CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).
[323] The Nevada CO-OP, Oregon CO-OP, Tennessee CO-OP, and Utah CO-OP told the Subcommittee that they do not expect any unpaid medical claims to be covered by a guaranty association. The Arizona Department of Insurance informed the Subcommittee that only $6.8 million of the Arizona CO-OP's estimated $21.8 million in unpaid claims is eligible for coverage by a guarantee fund. Arizona Department of Insurance CO-OP Resp. to Feb. 19, 2016 PSI Request (on file with Subcommittee).
[324] *Review of Obamacare Consumer Operated and Oriented Plans (Co-Ops): Hearing Before the Subcommittee on Health Care, Benefits, and Administrative Rules*, 114th Cong. (Feb. 25, 2016) (statement of Dr. Mandy Cohen MD, MPH, Chief Operating Officer and Chief of Staff, Ctrs. for Medicare and Medicaid Servs.).
[325] Mem. from Kelly O'Brien, CO-OP Division Director, to CO-OP Project Officers (July 9, 2015), http://cagw.org/sites/default/files/users/user98/Converting%20Start-up%20Loans%20to%20Surplus%20Notes%20Guidance%207-9-15%20final.pdf.
[326] Interview with Kelly O'Brien, CO-OP Division Dir., Ctrs. for Medicare & Medicaid Serv. (Mar. 1, 2016).
[327] *Id.*

IV. MISCONCEPTIONS CONCERNING THE CO-OP PROGRAM

A. HHS Data Indicates That The Failed CO-OPs Had, On Average, Healthier Enrollees Than Average Health Insurers In Their States.

HHS officials and others have suggested that adverse selection—that is, attracting enrollees with above-average health risks—played a role in the financial difficulties of the CO-OPs.[328] But the agency's own data from the risk adjustment program indicates otherwise. The risk adjustment program redistributes money from insurers with healthier enrollees (those with lower than average actuarial risk) to insurers with less healthy enrollees (those with higher than average actuarial risk).[329] The basic aim is to offset the cost impact of adverse selection so no single insurer in a state bears the burden.

Interestingly, however, the failed CO-OPs as a group were net *payors* of risk adjustment charges—with combined 2014 liabilities of $116 million.[330] Under HHS's formula, this indicates that the failed CO-OPs as a class enrolled *healthier* people—enrollees with lower risk—than the average health insurer in their states for each market segment.

Risk Adjustment Transfers—2014 Benefit Year

CO-OP	Risk Adjustment (Combined Individual and Small Market)
Louisiana Health Cooperative	-$7,493,608.15
Nevada Health Co-Op	-$3,629,890.49
CoOpportunity Health (NE)	-$6,466,848.45
CoOpportunity Health (IA)	$4,142,837.12
Health Republic Insurance of New York	-$80,235,543.57

[328] *See Review of Obamacare Consumer Operated and Oriented Plans (Co-Ops): Hearing Before the Subcommittee on Health Care, Benefits, and Administrative Rules*, 114th Cong. (Feb. 25, 2016).
[329] *See* Angela Boothe & Brittany La Couture, *The ACA's Risk Spreading Mechanisms: A Primer on Reinsurance, Risk Corridors and Risk Adjustment*, AMERICAN ACTION FORUM (Jan. 9, 2015).
[330]

Michigan Consumer's Healthcare CO-OP	-$1,130,276.61
Consumers Choice Health Insurance Co. (SC)	-$6,257,753.43
Kentucky Health Cooperative	-$7,878,488.98
Community Health Alliance Mutual Insurance (TN)	-$117,298.98
Health Republic Insurance of Oregon	-$1,251,545.14
Colorado Health Insurance Cooperative	-$4,491,378.92
Meritus Mutual Health (AZ)	$788,761.50
Meritus Health Partners (AZ)	$2,044,412.81
Arches Mutual Insurance Company (UT)	-$4,144,806.27
Total	-$116,121,427.56

B. Congressional Budget Cuts Prevented The Creation Of New CO-OPs And Limited Losses To The Taxpayer.

HHS officials have suggested publicly that a series of budget cuts to the CO-OP program—passed by Congress, and signed by President Obama—contributed to the collapse of the 12 failed CO-OPs. For example, Mandy Cohen, CMS's Chief Operating Officer, said that Congress itself also played a role in the CO-OP's failures because of these budget cuts.[331] All available evidence collected by the Subcommittee indicates otherwise. Cuts to the CO-OP program budget clearly prevented the launch of *additional* CO-OPs, including up to 40 complete applications that were summarily disapproved due to lack of funds.[332] But the failed CO-OPs received every dollar promised to them in their loan agreement *and more.*

More importantly, most of the budget cuts at issue took place well before HHS ever even approved the first round of CO-OP applications. The Affordable Care Act appropriated $6 billion for the CO-OP program. The largest budget cut came in April 2011, when Congress passed and President Obama signed a continuing resolution that rescinded $2.2 billion from the program.[333] Eight months later, in December 2011, Congress passed the 2012 omnibus appropriations act that rescinded an additional $400 million.[334] HHS was well aware of those funding reductions *before* it started approving applications in February 2012.[335] Finally, in January 2013, the American Tax Payer Relief Act of 2012 rescinded $2.3 billion in unobligated CO-OP appropriations.[336]

Disbursement schedules provided by the failed CO-OPs confirm that these budget cuts did not deprive them of a single dollar awarded to them. In fact, most of the failed CO-OPs received *more* than they had even requested to begin their

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[331] Robert Pear, *Failed Co-ops Add Ammunition to G.O.P. War on Health Law,* N. Y. TIMES (Nov. 3, 2015), http://www.nytimes.com/2015/11/04/us/politics/failed-co-ops-add-ammunition-to-gop-war-on-health-law.html?emc=edit_tnt_20151103&nlid=58462464&tntemail0=y&_r=1.
[332] Jerry Markon, *Health co-ops, created to foster competition and lower insurance costs, are facing danger,* WASH. POST (Oct. 22, 2013) ("The last-minute cut eliminated the remaining co-op funding, leaving only a small contingency fund, and prevented the administration from lending additional money. Applications from more than 40 proposed co-ops were junked."), https://www.washingtonpost.com/politics/health-co-ops-created-to-foster-competition-and-lower-insurance-costs-are-facing-danger/2013/10/22/e1c961fe-3809-11e3-ae46-e4248e75c8ea_story.html.
[333] Pub. L. No. 112–10, 125 Stat. 38 (April 15, 2011).
[334] Pub. L. No. 112-74, 125 Stat. 786 (Dec. 23, 2011).
[335] Dep't of Health & Human Servs., Ctr. for Consumer Info. & Ins. Oversight, *Consumer Operated and Oriented Plan [CO-OP] Program Amended Announcement Invitation to Apply,* Loan Funding Opportunity No.: 00-COO-11-001, CFDA: 93.545 (Dec. 9, 2011).
[336] Pub. L. No. 112-240, 126 Stat. 2313, 2362 (Jan. 2, 2013).

operations—and many on an accelerated basis. Four received a total of $33.6 million more in start-up loans than they requested in their business plans.[337] In addition, according to information provided by the CO-OPs, HHS ultimately awarded at least $324 million *more* in solvency loans than the failed CO-OPs requested in their loan applications.[338] In short, the failed CO-OPs actually received at least $350 million dollars more than they requested in their 2011 loan applications, based on 10-year business plans.[339]

The primary consequence of the budget cuts was to prevent HHS from launching *additional* CO-OPs—and thus to limit future losses to the taxpayer. The Affordable Care Act specifically required HHS to "ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State."[340] Consequently, even if subsequent appropriations laws had not reduced the program's budget, HHS would not have been permitted to freely allocate additional loans to the existing 23 CO-OPs as needed. Instead, the ACA required the agency to conserve its CO-OP loan resources to *ensure* it would have sufficient funds to create still more CO-OPs in the remaining states. Given the failure rate and costs of this program to date, it is probably for the best that Congress conserved those resources itself.

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[337] Appendix C.
[338] *Id.*
[339] *Id.*
[340] 42 U.S.C. § 18042(b)(2)(A)(iii).

United States Senate

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Committee on Homeland Security and Governmental Affairs

Rob Portman, Chairman

Failure of the Affordable Care Act Health Insurance CO-OPs

HEARING EXHIBITS

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

UNITED STATES SENATE

March 10, 2016

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Freelancers Health Service Corporation, d/b/a Health Republic Insurance of New York Additional Solvency Loan Funding Request

Date Submitted to CMS: 7/18/2014

Scope Summary & Assumptions:

- Deloitte will not provide an opinion regarding the reasonableness of the proposed changes to each CO-OP's business plan. Nor will Deloitte provide an opinion regarding the likelihood of each CO-OP achieving sustainable operations based upon the revised business plan.
- Deloitte assumes that the information provided by each CO-OP in its modified business plan is complete and accurate. Deloitte will perform its assessment of the data provided "as is". Deloitte will also use other data sources that are publicly accessible or information provided directly from the Centers for Medicare and Medicaid Services (CMS). Deloitte will notify CMS if we believe that there is insufficient information to complete our review.
- The impact of the Reinsurance, Risk Adjustment and Risk Corridors Program (the 3Rs, reinsurance, risk adjustment, and/or risk corridors) was reviewed when making observations and comments throughout this report. Observations and comments relating to the impact of the 3Rs are included for informational purposes only. There was no consideration of the reasonableness or propriety of any of the amounts relating to the 3Rs. Based on the scoring criteria provided by CMS, observations and comments relating to the 3Rs had a net neutral effect on the scoring.
- In reviewing applications from CO-OPs for additional solvency loan funding requests, Deloitte reviewed supporting documentation requested of the applicants by CMS in a memo to the CO-OPs distributed on April 30, 2014. The format of the reports, as well as the section scoring, was approved by CMS during the week of June 2, 2014. The score for the Contingency Plan section should be viewed independently of scoring for the other sections of this report. For all sections, Deloitte provided comments on issues only for which the applicant provided data. Observations relating to the pro forma financial statements are based on the base case with additional solvency award scenario, unless otherwise noted.

Executive Summary:

Freelancers Health Service Corporation d/b/a Health Republic Insurance of New York (HRINY or applicant or CO-OP) has submitted a request to CMS for $90.7M in additional solvency loan funding. HRINY has exceeded enrollment projections in the original funding application, which the CO-OP attributes to underpriced premiums and statewide network availability. As a result of higher than expected enrollment, HRINY is projecting a combined ratio of 102.2% for 2014, 99.6% in 2015, and 97.5% in 2016, including the impact of the 3Rs and excluding Affordable Care Act (ACA) adjustments. Excluding the impact of the 3Rs and the ACA adjustments, the combined ratio for these years is 115.3%, 102.4%, and 98.9%, respectively. ACA adjustments include such items as quality improvement expenses and taxes/fees. Including the impact of the 3Rs only, HRINY is projecting a loss in 2014, but expects to be profitable in 2015 and 2016. Without the 3Rs, the CO-OP is projecting losses of $68.2M and $23.1M for 2014 and 2015, respectively, and expects to become profitable in 2016. The CO-OP intends to correct losses to achieve profitability by increasing premium rates, improving medical management, and reducing administrative costs. HRINY stated in the application that it is requesting additional solvency loan funding in order to meet the New York Department of Insurance state specific requirement for reserves of

12.5% of net premium income. If HRINY does not receive the requested solvency loan funding, it may identify outside financing or scale down operations in order to meet solvency requirements. However, HRINY still projects that it will be able to repay both the start-up and current solvency loan funding in this scenario.

HRINY was originally awarded $150.7M in solvency loan funding, of which $48.4M has been disbursed. HRINY projects an additional $70M disbursement from the current obligated solvency loan funding in 2014. Based on discussions with CMS, Deloitte confirmed that CMS has chosen to fund HRINY based on state solvency requirements rather than an risk based capital (RBC) level of 500% of authorized control level (ACL) normally recommended by CMS. The amount of funding required to meet the recommended RBC level of 500% of ACL is greater than the amount required for reserves of 12.5% of net premium income. See further details in the CO-OP Financials section.

Critical Assertions:

1. **Enrollment:**

Based on HRINY's most recent enrollment projections submitted in June 2014, overall enrollment for 2014 is expected to be 251% more than projections included in the original application[1]. While the projected growth rate is expected to slow in subsequent years, the most recent projections for 2015 and 2016 are 319% and 339% more than original projections, respectively. New York operates on a State-based Marketplace (Marketplace).

Figure 1: Projected Enrollments are up Compared to Original (2011) Projections for 2014-2016

Source: Applicant's 2011 Original Application; 4/10/2014 and 6/17/2014 Pro Formas

The breakout of enrollment by business segment (individual, small group, large group) or method of enrollment (Marketplace vs. off Marketplace) was not provided in any of the pro forma financial statements (pro formas) submitted. However, this detail was provided in the business plan submitted with the request for additional solvency loan funding. According to the business plan, the 2011 feasibility study projected 28,102 members from the individual market and 2,762 members from the small group market (SHOP). In addition, the business plan states that as of May 2014, 81,000 members were enrolled from the individual market, and 38,000 members were enrolled from the small group market (pg. 4). However, because this breakout was not reflected in the pro formas, it cannot be determined if the CO-OP will have two-thirds of its enrollment from the Marketplace in 2016, as required by Title 45, Code of Federal Regulations (CFR) §156.515(c)(1) and (d) related to the requirements of CO-OPs pursuant to the Affordable Care Act (ACA).

Additionally, there are variances between the enrollment projections provided to CMS in the 4/30/2014 pro formas and the pro formas provided with the request for additional solvency loan funding. For example, for 2014, the 4/30/2014 pro formas projected 98,876 average enrollees, whereas the 6/1/2014 pro formas project 108,311 enrollees. The applicant does not provide a reason for this difference in the application.

Documentation for Change in Enrollment Projections

[1] All references to "original" – including, but not limited to, "original funding application", "original application", and "original projections"—refer to HRINY's 2011 application for CMS start-up and solvency loan funding , operations commencing in 2014.

The applicant expects that its pricing advantage, product offerings, and state-wide presence will allow it to achieve its enrollment goals for the foreseeable future, as described in Table 1 below (P. 87). According to the applicant, HRINY premiums were significantly lower than market rates in 2014. HRINY has concerns that given the unexpected growth rate to date, it will not be able to "maintain financial sustainability and market competitiveness" without raising premiums in 2015 by approximately 15% (P. 9). Please refer to the Product Pricing section for further details.

HRINY is requested additional funding due to increases in projected enrollment (P. 89). Based on discussions with CMS, HRINY is being funded based on the state-specific solvency requirements rather than the normally recommended threshold of 500% of ACL. Additional details on this issue can be found in the CO-OP Financials section.

Table 1: Documentation for Change in Enrollment Projections

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
Underpriced Premiums	1. **Raise Premium Rates for 2015.** HRINY projects having to raise average individual premium rates by 15.2% and average small group rates by 6% in 2015 in order to maintain financial sustainability and market competitiveness moving forward.	HRINY provided an actuarial analysis prepared by Milliman, the external actuary for the CO-OP, which provides details on the proposed adjustment to HRINY's 2014 pricing and market position analysis. According to HRINY, these price increases are necessary in order to "maintain financial sustainability and market competitiveness in 2014 to 2015" (P. 9). The applicant contends that even with these price increases, HRINY will remain competitive enough to achieve its projected enrollment numbers due in part to "other plans increasing [its] rates to cover medical cost trend and changes in federal reinsurance" (P. 4). The actuarial support for the application did not include estimates of the sensitivities of demand to prices. HRINY states that, despite these price changes, it intends "to maintain [its] current price position in most of its regions and will increase [its] premiums to sustainably reduce the gap between [its] plans and those offered by the next lowest-priced carrier (based on the June 13, 2014 rate filings)." The applicant contends that "this price change is especially important for achieving sustainability in regions where HRINY is priced more than 15% below the next lowest priced health insurer" (P. 7).
Geographic Availability	2. **Achieve state-wide availability.** HRINY intends to move into the remaining 30 New York counties in which it does not currently serve.	HRINY currently covers 32 of the state's 62 counties. These 32 counties are home to 92% of the New York's population and include complete coverage in Downstate New York, which includes the Hudson Valley (P. 7). In 2015, HRINY intends to add the POMCO provider network in the Upstate New York region as a complement to MagnaCare's Downstate network. According to HRINY, it will be able to reach residents in the 30 counties it does not currently cover by partnering with POMCO, which has a more comprehensive provider network in the Upstate New York region (P. 11). The

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
		applicant did not provide any information about the competitive landscape in these 30 counties. In addition, no premium information was provided in the 2015 rate filing for these 30 additional counties. Please refer to the Product Pricing section for additional information.
Increase Product/network Offerings	3. **Increase the number of products offered and increase network offerings.** HRINY intends to offer two new products, one targeting the individual market, and one targeting the small group market. Additionally, HRINY intends to compete in the large group market.	In 2015, HRINY intends to offer two new product lines in addition to its current three (Primary Select EPO, Primary Select, and Essential Care). The first of the two new offerings is the Active Living Line, which, according to HRINY, will target the individual market exclusively. HRINY stated that as HRINY's lowest priced product, the Active Living line will be marketed to a younger, healthier demographic as a "lean package" with a higher deductible than HRINY's other offerings. According to the applicant, "Active Living was filed as a statewide product, but may be deployed in more limited test markets based on feedback from the state and other market analyses" (P. 13). The second new offering is the All Access Line, available to all small group customers regardless of whether or not they're on the SHOP Marketplace. The key distinction between the All Access offering and HRINY's existing lines is its out-of-network option. According to the applicant, "there is a significant demand for access to physicians (both in- and out-of-network) from a niche group of customers." HRINY created this option as a way to attract small group customers that want "more competition in the out-of-network product space" (P. 13). No additional comments are available describing the specifics of this product's out-of-network options. In addition to these new products, HRINY intends to move into the large group market starting in 2015. According to the applicant, "this expansion will diversify its business and provide greater access to affordable, high-quality healthcare for employers and their employees" (P. 6). HRINY projects enrollment of 4,500 in 2015 and 18,000 in 2016 from large group (P. 22). The applicant provided no substantiation as to why it expects to see this increase in its large group membership from 2015 to 2016. This expansion will focus on companies in the 51-100 range in anticipation of the redefinition of small group in 2016. This will result in HRINY being in the large group market for only 2015.

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
Increase in Sales and Marketing	4. **Continue to develop and distribute communications and advertisements to key audiences.** HRINY will continue to develop targeted communications in the form of member satisfaction surveys, member advisory discussion groups, and advertising, as well as engage in market research going into 2015.	To gain an increased understanding of the needs of its customers, HRINY stated that it will engage in continued marketing efforts going into 2015. One such effort includes continued use of member satisfaction surveys aimed at gauging "member satisfaction strengths, weaknesses, opportunities and needs." By understanding the desires of its members, HRINY may be in a position to adapt and retain some customers, despite increased premiums in 2015 (P. 36). HRIC conducted a member satisfaction survey in 2014; out of the applicant's 119,000 current members in 2014, 396 enrollees responded to the survey. It is unclear why this group would be taken as a representative sample of the total membership's sentiments. Another marketing effort is the applicant's Member Advisory Discussion Groups. These are quarterly sessions where current members are able to provide input on the plan's past performance and future plans. According to the application, "Outputs from the sessions will be shared both internally and externally as appropriate, starting second quarter 2015" (P. 36). Additionally, in an effort to target new customers, HRINY plans to partner with an advertising agency "to develop and execute targeted campaigns focused on building brand awareness and supporting open enrollment initiatives in key markets." This partnership will begin in the summer of 2014 with the advertising campaigns set to start during the year's fourth quarter (P. 36). HRINY does not provide a budget detailing how much it intends to spend on these marketing efforts, nor do the pro formas provide any insight into marketing expenses. Additionally, the application provides no information on the applicant's efforts to obtain private funds.

Summary of Observations:

- **Increased enrollment projections from original application.** Although HRINY plans to increase premium rates starting in 2015, the applicant is still projecting to outperform enrollment projections in both its initial application and its 4/30/2014 pro formas. HRINY's original application pro formas projected 30,864 enrollees in 2014 and 50,535 enrollees in 2015. Per HRINY's most recent pro formas, to date, the applicant has already enrolled 119,000 enrollees and projects 211,818 enrollees for 2015.
- **Increased premiums planned for 2015.** In order to "maintain financial sustainability and market competitiveness" the applicant intends to raise premium rates to become more in line with its competitors in the market (P. 9). Pending approval, individual and small group premiums will increase by 15.2% and 6% in 2015, respectively.

- **Plans for new products and state-wide availability**. In order to achieve increased enrollment projections in the face of rising premium rates, HRINY plans to increase enrollment by offering two new product lines, and expanding into the state's remaining 30 counties. The new lines include the All Access line, a small group product offering out-of-network care, and the Active Living line, a less expensive product available exclusively for the individual market marketed to young and healthy customers. Additionally, HRINY will be moving into the large group market in 2015 in anticipation of the 2016 redefinition of "small group". HRINY projects enrollment of 4,500 in 2015 and 18,000 in 2016 from the large group market.
- **Insufficient quantification of business plan's impact**. While HRINY does lay out a strategy for maintaining enrollment numbers and market competitiveness, it does not quantify the impact this business strategy will have on enrollment projections and financial sustainability. Additionally, the plan to raise premiums is only substantiated in HRINY's assertion that, "HRINY conducted an in-depth investigation of its 2014 actuarial assumptions and their impact on 2014 pricing, as well as extensive research on trends and data for 2015", but no concrete data was provided from the study in the business plan or the Milliman feasibility study.
- **Support for marketing funds not provided:** The applicant did not specify how its partnership with an advertising agency, detailed in the marketing strategy, will be funded. Since solvency loan funds cannot be used for marketing purposes, the applicant may need to acquire outside funds to realize this portion of its marketing strategy.
- **Breakout of on and off Marketplace enrollment not provided in the pro formas.** it cannot be determined if the CO-OP will have two-thirds of its enrollment from the Marketplace in 2016, as required by Title 45, Code of Federal Regulations (CFR) §156.515(c)(1) and (d) related to the requirements of CO-OPs pursuant to the Affordable Care Act (ACA).

2. **Product Pricing:**

HRINY's 2014 enrollment was higher than anticipated due to its rates being among the lowest in most products and markets across the state. Also, fewer plans have been offering small group health insurance coverage. Emblem Health (a competing New York insurer) terminated all small group plans with Health Pass, a commercial health insurance exchange that has been operational since 1999 in New York (P. 8). After Emblem Health terminated these plans, many small businesses had to find coverage and enrolled with HRINY. However, no further information was provided on how many enrollees were previously enrolled through Health Pass.

The CO-OP plans increase its premiums, if approved, in 2015 by 15.2% for individual and 6% for small group products (P. 5). HRINY wants to hold its current price position in most of the regions and expects to reduce the gap between the next closest competitor by increasing premium rates. According to the applicant, these premium increases are especially important for achieving sustainability in regions where the next closest competitor's premiums are higher by 15% or more (P. 73). The CO-OP anticipates that the competitors will also be increasing their premiums to account for medical cost trend and changes in federal reinsurance and therefore, HRINY's products will still be competitive with these planned increases in premiums (P. 70). HRINY projects to achieve profitability beginning in 2015 and is profitable throughout the whole performance period, with the exception of the period 2018-2022, if projections are realized. In addition, the RBC level is below the normally recommended 500% of ACL by CMS. The amount of funding necessary to reach an RBC level of 500% of ACL is greater than the amount needed to reach the New York Department of Insurance requirement for reserves, 12.5% of net premium income. Per discussions with CMS, the CO-OP is currently funded at 12.5% of net premium income. Please refer to the CO-OP Financials section for further discussion.

The actual adjustments attributing to the total rate increase of 15.2% for individual and 6% for small group are not provided; however, the drivers of the rate increase are listed (P. 373 and 574). They are inclusive of, but not limited to, the following:

- Anticipated changes to demographics based on state average ACA Marketplace enrollment published to date

- Anticipated changes to medical inflation and increased utilization
- Changes in taxes, fees, and administrative expenses
- Changes to benefit and payment parameters of the federal transitional reinsurance program
- Changes to provider network contracting

Table 2 provides a comparison of the premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence. Highlighted areas denote the lowest premium for the particular region. HRINY is the lowest cost plan in many areas of New York which resulted in 20% market share in the individual market on the Marketplace.[2]

Table 2: Premiums on the 2014 New York Marketplace for individual market by Rating Region/Area

Insurer	ON/OFF Marketplace	Metal/ Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Freelancers	ON/OFF	Platinum	397.25	371.87	446.23	523.23	365.57	386.06	375.65	523.23
New York Fidelis	ON	Platinum	506.02	500.18	510.27	577.18	501.78	504.96	499.12	532.57
Oxford HMO	OFF	Platinum			965.24	965.24				965.24
United	ON	Platinum			913.99	913.99				913.99
Freelancers	ON/OFF	Gold	338.56	316.93	380.31	445.93	311.56	329.03	320.15	445.93
New York Fidelis	ON	Gold	418.82	413.99	422.34	477.71	415.31	417.94	413.11	440.79
Oxford HMO	OFF	Gold			817.98	817.98				817.98
United	ON	Gold			749.13	749.13				749.13
Freelancers	ON/OFF	Silver	299.57	280.43	336.51	394.58	275.68	291.14	283.29	394.58
New York Fidelis	ON	Silver	342.05	338.11	344.93	390.15	339.18	341.34	337.39	360.00
Oxford HMO	OFF	Silver			691.69	691.69				691.69
United	ON	Silver			635.60	635.60				635.60
Freelancers	ON/OFF	Bronze	236.70	221.58	265.89	311.77	217.83	230.04	223.84	311.77
New York Fidelis	ON	Bronze	270.32	267.20	272.59	308.33	268.05	269.75	266.63	284.50
Oxford HMO	OFF	Bronze			589.91	589.91				589.91
United	ON	Bronze			548.06	548.06				548.06
Freelancers	ON/OFF	Catastrophic	162.73	152.33	182.79	214.33	149.75	158.15	153.88	214.33
New York Fidelis	ON	Catastrophic	166.46	164.54	167.85	189.86	165.06	166.11	164.19	175.19
Oxford HMO	OFF	Catastrophic								
United	ON	Catastrophic			334.94	334.94				334.94

Table 3 provides a comparison for the premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence in the small group market. Highlighted areas denote the lowest premium for the particular region.

[2] Data Source for Tables 1 and 2: http://www.dfs.ny.gov/about/press2013/pr1307171_health_rates_2014.pdf

Table 3: Premiums on the 2014 New York Marketplace for small group market by Rating Region/Area

Insurer	ON/OFF Marketplace	Metal/ Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Freelancers	ON/OFF	PLATINUM	432.86	405.21	486.23	570.13	398.34	420.67	409.33	570.13
MVP Services	OFF	PLATINUM	535.71	593.73	602.68	767.86	448.10	582.03	546.32	690.84
MVPHP-HMO	ON/OFF	PLATINUM	539.61	446.29	607.05	773.42	451.35	586.25	550.28	
Oxford HMO	OFF	PLATINUM			733.00	733.00				733.00
Oxford OHI	ON/OFF	PLATINUM			774.73	774.73				774.73
United	OFF	PLATINUM								751.88
Freelancers	ON/OFF	GOLD	369.00	345.42	414.49	486.02	339.57	358.60	348.93	486.02
MVP Services	OFF	GOLD	447.88	496.39	503.87	641.96	374.63	486.60	456.75	577.58
MVPHP-HMO	ON/OFF	GOLD	458.22	378.99	515.49	656.78	383.29	497.85	467.30	
Oxford HMO	OFF	GOLD			632.80	632.80				632.80
Oxford OHI	ON/OFF	GOLD			656.70	656.70				656.70
United	OFF	GOLD	693.74	568.84	742.34		635.93	591.17	589.07	605.37
Freelancers	ON/OFF	SILVER	316.68	296.44	355.72	417.10	291.42	307.76	299.46	417.10
MVP Services	OFF	SILVER	363.15	402.48	408.55	520.52	303.76	394.55	370.34	468.32
MVPHP-HMO	ON/OFF	SILVER	381.31	315.38	428.99	546.56	318.96	414.28	388.86	
Oxford HMO	OFF	SILVER								
Oxford OHI	ON/OFF	SILVER			555.48	555.48				555.48
United	OFF	SILVER	596.18	488.84	637.94		546.50	528.52	506.23	509.57
Freelancers	ON/OFF	BRONZE	257.94	241.46	289.75	339.75	237.37	250.68	243.92	339.75
MVP Services	OFF	BRONZE	303.72	336.60	341.67	435.32	254.04	329.97	309.72	391.66
MVPHP-HMO	ON/OFF	BRONZE	294.63	243.69	331.46	422.31	246.44	320.10	300.47	
Oxford HMO	OFF	BRONZE								
Oxford OHI	ON/OFF	BRONZE			473.91	473.91				473.91
United	OFF	BRONZE								

Summary of Observations:

- **The CO-OP is expecting large enrollment growth based on 2015 pricing as compared to the competition.** The CO-OP believes that the Marketplace in New York is one of the most competitive Marketplaces in the nation. There are 17 carriers who have filed individual products on the Marketplace for the 2014 open enrollment period. According to the CO-OP, a majority of the competition is focused in the southern part of the state where the enrollment is expected to be the highest and also expects it to grow substantially for the individual products. The CO-OP estimates 2014 enrollment for individual

products on the Marketplace to increase by 56% in 2015 and then by 16% in 2016 (P. 73). Additionally, HRINY is offering a wider variety of products in 2015 than in 2014.

- **2015 premiums will increase compared with the 2014 premiums, pending approval by the New York Department of Insurance.** According to the applicant's estimate, 2014 enrollment was much higher than anticipated due to its rates being the lowest in many areas of New York which resulted in 20% of the Marketplace share in the individual market. The applicant believes that a member survey showed a "deep resonance with the member-led, not-for-profit model" (P. 8). However, survey responses were received from only 396 of the 100,000 plus members (P. 74). The CO-OP plans for increases in 2015 of 15.2% for individual and 6% for small group products (P. 373) out of which 5% is attributable to trend (P.378 and P.447).
- **Potential expansion of target market in 2015.** The CO-OP is considering including 30 new counties in its Upstate New York coverage area for 2015 (P. 78). No information was provided on the competitors in the 30 additional counties. The CO-OP plans to expand its coverage to mid/large group market but keep a focus on employers with 51-100 employees as it transitions to the small group market in 2016 (P. 88). There appears to be no information relating to the expansion in the 2015 rate filing provided with the application.
- **The 2015 individual and small group rate filings includes a breakdown of taxes and fees which does not include an estimate for the health insurer fee.** Milliman published a research report titled " ACA Health Insurer Fee – Estimated Impact of the US health insurance industry" dated April 2013, which states the 2014 health insurer fee estimate is 1.7% to 2.4% and increases to 2% to 2.9%. Since HRINY is a 501c (29) not-for-profit entity, the insurer fee estimate would be lower than the industry average. HRINY includes an estimate for Marketplace fees associated with selling plans on the Marketplace. The CO-OP assumed 0.44% of premiums for this fee. However, the applicant stated that the Marketplace fees are eliminated for 2014 and 2015 and this fee was "not built into the rates per New York instructions" (P. 91 and 210). No supporting documentation as provided to verify this statement.
- **HRINY is projecting a $10.7M loss in 2014 and established a premium deficiency reserve (PDR) of $5.2M in 2013.** It is unclear how the CO-OP determined the PDR, as a detailed analysis was not provided. Additionally, the stress test scenario shows a PDR of $87M for 2014. It is unclear how the $87M is determined differently from the $5.2M in the base case. Supporting documentation of the analysis was not provided.

3. **Medical Costs and Losses:**

HRINY projects combined medical loss ratios (MLR) for ACA purposes of 84.3%, 87.8%, and 86.9% for years 2014, 2015 and 2016, respectively, which includes the impact of the ACA and the 3Rs. This includes individual, small group and large group business. The large group minimum loss ratio is 85% while individual and small group are 80%. Taking into account the receivables for reinsurance relating to the 3Rs, the 2014 projected individual MLR, excluding the impact of projected ACA adjustments, is 101% and is expected to decrease to 89% in 2015, 86% in 2016, and 84% in 2017 based on a plan to fix the mispricing of 2014 and greater claims cost efficiencies. For small group business, the MLR will remain near 80% throughout the performance period. According to the applicant, combined with greater administrative efficiencies, these efforts are projected to bring HRINY's profit margin to 2.8% of premiums by 2017. The 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit. Including the $64M in receivables for risk corridors and reinsurance for 2014 would result in a $10.7M loss and result in an MLR of 79% for all products combined, excluding any adjustments for the ACA. Removing the estimated $64M in receivables would result in a $75M loss and raise the MLR, excluding any adjustments for the ACA, for all products combined to 91%. Based on the calculation of the risk corridors, it would be difficult to quantify a receivable without fully understanding the calendar year experience.

Based on a review of the 3/31/2014 regulatory filing, the combined medical loss ratio is approximately 76%, excluding any impact of the ACA adjustments. If this experience were to continue, the CO-OP could be in a

situation to pay rebates depending on its ACA loss ratio. Typically, one quarter's experience cannot be extrapolated to the entire year, and, therefore more months of experience will be needed to make a conclusion. The CO-OP is projecting the 2014 combined medical loss ratio to be 94%, excluding any impact for the ACA. The loss ratios include large group business which has a separate minimum loss ratio of 85%

The CO-OP plans to make changes to provider arrangements to increase the value being delivered by its provider networks. Since HRINY had a significantly larger member volume, it decided to renegotiate its vendor contracts in hopes of achieving lower vendor costs by about 7% for 2015 (P. 83). The CO-OP plans on adding a new product to its product portfolio and offer products in 30 counties in New York where it doesn't currently serve (P. 78).

According to the applicant, short term performance improvements will be driven primarily by the following factors (P. 86):

- **"Corrective pricing":** HRINY anticipates increasing rates by approximately 10% beyond trend in 2015 and 4% beyond trend in 2016 for the individual line of business and by 1% beyond trend in 2015 and 0% beyond trend in 2016 for the small group business. It cannot be determined what the impact of a 15% rate increase will be on the retention of membership. HRINY expects that its 2015 rates will be competitive and will improve its gross margins.
- **"Improved medical cost management":** HRINY plans to negotiate better network rates, rationalize its network offerings, and improve utilization management. HRINY anticipates that these changes will help offset increases in medical costs by approximately 3.5% in 2015 for individual plans and almost 1% for small group plans.
- **"Greater administrative efficiencies":** HRINY plans to reduce its per member total administrative expenses burden by 37% in 2015, 11% in 2016, and 9% in 2017 with administrative expenses increasing at the rate of inflation thereafter. Additionally, the CO-OP's administrative cost ratio (ACR) falls from 21.5% to 14.5% from 2014 to 2017. According to the applicant, although fixed administrative expenses are projected to grow from approximately $30M in 2014 to $40M by 2017, it expects to achieve these efficiencies due to growth in membership, renegotiated contracts, and supplier efficiencies (P. 86). The CO-OP stated that increasing its enrollment will be a driving factor in mitigating administrative costs.

As part of its enrollment strategy, HRINY expects to sell to the large group market in 2015. However, the expansion to the large group market will focus on companies in the 51-100 range in anticipation of the redefinition of small group in 2016. This will result in HRINY being in the large group market for only 2015. HRINY intends to build awareness in this market segment without increasing marketing expenses by leveraging existing broker relationships (P. 87).

The CO-OP is projecting morbidity to be equal to the state average. As such, no risk adjustment receipts or payable relating to 3Rs is projected in the rate filing. The CO-OP is expecting to get $54M in reinsurance receivables from the 3Rs which is 11% of the total premium during 2014 and $36M in reinsurance receivables relating to 3Rs which is 4% of the total premium in 2015. The estimates of relative risk and risk transfer payments are dependent not only on the membership enrolled by HRINY but also by the other carriers in the state (P. 381).

Due to the timing of this application, HRINY does not have enough of its own experience in the base period to use in rate development; therefore, the 2015 rate development is based solely on manual rates.

Summary of Observations:

- **HRINY expects 2015 morbidity to be similar to 2014 pricing morbidity.** The small group market forms the basis of the CO-OP's manual rates. HRINY assumes the current small group market morbidity to be the same as that before ACA was passed. When pricing for 2015, the expected morbidity of the small

group population in New York was used and adjustments were made to it to calculate the individual market morbidity. Based on research conducted by HRINY, individual markets have higher health risk than group markets and thus, the CO-OP is assuming that the individual market morbidity will be 40% higher than the small group market (P. 328).

- **2015 medical costs are based on industry data.** HRINY does not have enough 2014 experience to have its own data to rely upon; therefore, industry assumptions are necessary to estimate the morbidity of the projected membership.
- **Expanded provider arrangements.** HRINY intends to replace MagnaCare with POMCO's network in Upstate New York. HRINY plans to "increase the value delivered by [its] provider networks by analyzing [its] performance (i.e., efficiency), introduce additional types of networks (such as narrow and/or tiered networks) and introduce gain-sharing to provider contracts" (P. 97).
- **The risk corridors receivable estimate is difficult to quantify with the results relying upon the risk adjustment estimate.** Without the risk corridors receivables, HRINY would have larger losses in 2014.

4. **CO-OP Financials:**

HRINY's pro forma financial statements project recoveries from the federal reinsurance programs for 2014 through 2016. In the base case with additional solvency loan scenario (baseline scenario), HRINY projects cumulative federal reinsurance recoveries of $117.3M for 2014 through 2016, while it projects to recover $78.5M in the contingency scenario during the same period. HRINY also projects to receive an additional $10.4M from the risk corridors program in 2014 in all scenarios. HRINY projects a net loss of $10.7M in 2014, but expects to achieve profitability in 2015 with a projected net income of $3.8M in 2015 and $38.6M in 2016 (P. 44, 54). HRINY projects capital and surplus as a percentage of net premium to stay above 12.5% during the entire performance period in all projected scenarios.

Based on CMS's CO-OP Summary Report by Borrower as of 6/14/2014 (Loan Tracker), the CO-OP has been awarded total funding of $174.5M ($23.8M in start-up loans and $150.7M in solvency loan funding), and began issuing health insurance products beginning in 2014. $48.4M of the total solvency loan obligated is disbursed to HRINY with $102.3M of obligated but undisbursed solvency loan funds. HRINY is requesting additional solvency loan funding of $90.7M. Combined with the current solvency loan funding award, the total solvency loan for HRINY would be $241.4M.

New York's Section 4310 of the Insurance statutes requires the CO-OP to maintain a minimum reserve balance of 12.5% capital and surplus as a percent of net premium income. In its application for additional solvency loan funding, HRINY stated that the additional solvency loan funding is necessary to meet the New York's Department of Insurance reserve requirements. HRINY stated further that 15% of gross premium "has been budgeted to ensure sufficient reserves" (P. 89). Based on discussions with CMS, the CO-OP is being funded based on the state requirement, rather the normally recommended RBC level of 500% of ACL. As noted in the pro formas, the CO-OP does not reach an RBC level above the normally recommended CMS level of 500% of ACL until 2018, even with the additional funding of $90.7M.

HRINY's surplus as percent of net premium income is projected to stay above the 12.5% threshold for all years, if the additional solvency loan is awarded. As noted above, the CO-OP is requesting the additional $90.7M solvency loan funding to maintain a 15% capital and surplus as a percent of gross premiums. Table 4 below presents the excess (deficit) in projected capital and surplus with and without additional solvency loan funding to the CO-OP.

Table 4: Projected capital and surplus - Baseline scenario

	$ in 000s			
	2014	2015	2016	2017
Reserve Balance Required per New York Section 4310 of Insurance statutes	59,110	127,386	196,998	250,495
HRINY's projected capital & surplus amount with additional solvency loan funding	72,306	158,298	243,800	308,601
Excess (Deficit) in projected capital & surplus with additional solvency loan funding	13,196	30,912	46,802	58,106
HRINY projected capital & surplus with no additional solvency loan funding	72,306	120,009	159,480	217,913
Excess (Deficit) in projected capital & surplus - with no additional solvency loan funding	13,196	(7,377)	(37,518)	(32,582)
HRINY's projected capital & surplus amount with additional solvency loan funding, but without impact from 3Rs	14,790	73,894	140,076	204,877
Excess (Deficit) in projected capital & surplus without impact from 3Rs	(44,320)	(53,492)	(56,922)	(45,618)

Baseline Scenario:

If projections are realized, HRINY projects a loss of $10.7M in 2014, but projects to be profitable thereafter, with earnings of $3.8M and $38.6M in 2015 and 2016, respectively, and with related profit margin of 0.4% and 2.4%, respectively. The applicant projects an average profit margin as a percent of premium of 1.5%, which would result in cumulative profits of $1.1B from 2015-2033. HRINY is projecting receivables from the 3Rs program in 2014 to 2016, specifically $10.4M in risk corridors in 2014, and federal reinsurance recoveries in the amounts of $53.9M, $36.2M, and $27.1M in 2014, 2015, and 2016, respectively. Despite the total $64.3M of receivables that HRINY is projecting to receive from the 3Rs, it is projecting a loss in 2014. Absent these recoveries, HRINY's projected loss would be $68.2M in 2014. Additionally, HRINY is projected to incur a loss of $23.1M in 2015 absent recoveries from the federal reinsurance program. HRINY projects a PDR of $4.5M in 2014 and $687K in 2015. However, details were not provided with the analysis for the PDR estimate.

The applicant asserts that premium increases are required to break even in 2015, while its ability to break even in 2015 will enable it to pay back its original solvency loan award of $150.7M and the additional $90.7M in solvency loans by year-end 2032 (P. 4 and 84). HRINY expects to increase its premium rates by 15.2% for the individual market and 6% for SHOP in 2015 to drive its performance improvements (P. 86). In its pro forma income statement, its revenues per average number of enrollees increase by 11.9% in 2015 and by 7.7% in 2016. In its individual market rate filing for existing plans, HRINY is requesting a statewide average price increase of 15.2% (P. 373).

HRINY plans to make two changes to ensure its medical cost structure is in-line with its pricing in 2015. It will introduce a new network partnership, POMCO, in Upstate New York, thus, furthering its ability to reach all New York residents. Please refer to the Enrollment section for further details. The applicant also aims to increase the value delivered by its provider networks through three actions. First, HRINY is analyzing the performance of its network providers so it can decide whether to drop some of its providers, leading HRINY to believe that it can offer better care at competitive prices (P. 86). Second, HRINY plans to introduce narrow or tiered networks, which it states could offer rates 10-15% below the rates of broad networks. Finally, the applicant plans to introduce gain-sharing to provider contracts, which it believes will increase the predictability of claims costs (P. 77). Please refer to the Medical Costs section for further details.

The applicant states that it intends to become profitable by increasing its premiums and improving its processes; specifically through investing in technology to enable automation in enrollment and claims, and by renegotiating and reducing its vendor costs by 7% by 2015. The applicant explains that the automation of enrollment and claims processes should reduce its costs due to avoiding incremental administrative staffing during open enrollment. To achieve a 7% reduction in vendor costs, HRINY is currently pursuing a process to integrate independent vendors to achieve efficiency in its operations and also pursue a renegotiation of its vendor contracts (P. 5 and 82). HRINY claims that its vendors are responsible for billing and enrollment, member and brokerage services, medical management, claims adjudication, provider and facility network, pharmacy benefits management, and website and data warehouse management (P. 82). While HRINY describes its vendor functions in detail, it does not provide a budgeted schedule for its current vendor costs nor for its costs following contract renegotiations; therefore, it is difficult to determine the viability of the cost reductions, and also how it flows through to the reductions in total general administrative costs. Furthermore, no evidence was provided by the applicant to support a 7% reduction in vendor costs.

Additionally, as described in the April 30, 2014 memo from CMS, the CO-OP was required to file an SF 424A (budget form) as part of its application which would detail its expenses for 2014 and 2015. However, HRINY did not provide the SF 424A. As a result, the details of its 2014 and 2015 budgeted amounts are unknown.

Excluding the lack of detail laid out in its budgeted costs, HRINY's pro forma income statement ties to its business plan, as the ACR, which includes costs for commissions and loss adjustment expense (LAE) reserve, is projected to decrease from 21.3% in 2014 to 16.6% in 2015 and 15.5% in 2016. HRINY's ACR ranges from 16% down to 11.8% through 2034, with an average ACR of 13.5%. Additionally, HRINY stated that a reduction in general and administrative costs per member will be 37% in 2015 and 11% in 2016 (P. 86). The applicant states that it expects to achieve these efficiencies; "despite growing fixed G&A expenses... due to greater scale, renegotiated contracts, and supplier efficiencies" (P. 86). However, as previously noted, the applicant does not provide a breakout of its administrative costs, nor does it provide a detailed summary of its expected costs savings or specifics on its renegotiated vendor contracts. Additionally, it doesn't appear HRINY accounts for Marketplace fees within its projections. However, the applicant stated that the Marketplace fees are eliminated for 2014 and 2015 and this fee was "not built into the rates per New York instructions" (P. 91 and 210). No supporting documentation as provided to verify this statement. The applicant does not project Marketplace fees in the pro forma throughout the entire performance period.

The applicant's MLR, including the impact of the 3Rs, is 81.8% and 83.1% for 2015, without including impact of ACA adjustments. As noted above, HRINY projects to recover $53.9M, $36.2M, and $27.1M in 2014, 2015, and 2016, respectively, from the federal reinsurance programs. Additionally, HRINY projects to receive payment of $10.4M from risk corridors in 2014. Absent these recoveries from the 3Rs, HRINY's MLR will be 94% in 2014 and 85.8% in 2015, without including impact of ACA adjustments.

HRINY projects to receive additional solvency loan funding in the amount of $90.7M and projects to draw down its full solvency awards by 2017, bringing the total solvency loan funding amount to $241M (P. 143). The applicant plans to fully repay the solvency loan by 2032, if projections are realized. Per the baseline pro forma

balance sheet, HRINY's RBC level would range from 371% in 2014 to 469% in 2017, until reaching 500% in 2018, a year after fully drawing its solvency loan in 2017, and would remain above 500% through 2022. However, it does fall below 500% for the rest of the performance period. However, as noted above, HRINY is funded per the requirement under Section 4310 of the New York Department of Insurance statutes, which requires the CO-OP to maintain a reserve level of 12.5% of net premium income. As presented in the baseline pro formas, the applicant projects to maintain the state requirement of 12.5% of net premium income as surplus for all years.

Stress Test Scenario:

Under the base case with a mild stress test scenario (stress test scenario), HRINY projects to receive increased additional solvency loan funding of $275.7M to combat a 10% increase in claims cost due to uncertainty in pricing. In this scenario, the applicant asserts that rate increases were assumed to maintain a reasonable level of profitability to generate a surplus to enable it to pay off its solvency loan (P. 37). Revenues and administrative costs remain static, as evidenced by the same ACR as in the baseline. Additionally, the MLR is projected to stay at the same level as the baseline scenario.

The primary difference of the stress test scenario as compared to the baseline scenario is its projection of PDR. In the stress test scenario, HRINY projects an $82.3M change in reserves due to PDR in 2014. However, details relating to projecting this level of PDR were not provided in the application. This represents a net change of $86.8M in total expenses, resulting in a projected net loss of total $97.6M in 2014, with the assumption of receiving $53.9M in federal reinsurance recoveries and a receipt of $10.4M in risk corridors payments. Absent recoveries from federal reinsurance program and risk corridors payments, 2014 losses would near $162M. Under this scenario, according to the applicant's pro forma balance sheet, year-end capital and surplus is projected to stay above 12.5% of net premium income during the entire performance period.

Summary of Observations:

- **HRINY projects average statewide premium increase of 15% in 2015.** HRINY's ability to break even is contingent on an average statewide rate increases 15% in 2015 and 9% in 2016. It is difficult to determine whether HRINY will be able to meet its projected enrollment and premium revenues as well as retain current members with this level of premium increases.
- **$82.6M PDR projected in 2014 in stress test scenario.** In the stress test scenario, HRINY projected a change in PDR of $82.6M in 2014. However, no documentation supporting the analysis of the PDR was provided. The applicant does not project PDR to be recorded in 2014 in the baseline scenario.
- **Budget not provided for 2014 and 2015 to support proposed reductions in administrative expenses.** In the baseline scenario, the applicant projects a 7% reduction in vendor costs through renegotiated contracts and also projects to reduce its administrative expenses in 2015 and 2016. However, no details are provided by HRINY as to what the actual cost reductions are and with what vendors it expects to renegotiate its contracts. HRINY did not provide its budget to support the projected cost reductions.

5. **Contingency Plan:**

As outlined in its application, HRINY discusses two scenarios in the event that the additional solvency of $90.7M is not awarded: either identifying outside financing or scaling down its operations so it can meet solvency requirements, though the applicant does not provide further detail on how it would secure outside financing (P. 5). HRINY would scale down its operations by increasing its rates, by reducing its membership size; especially in low margin counties, and by eliminating all non-essential administrative costs, such as marketing and customer service (P. 7).

Premium Increases: HRINY stated that in the event the additional solvency loan funding is not awarded, premium rate increases will be "higher than those planned for 2016 and presented in the business plan pro forma" (P. 7). Additionally, the applicant stated that while the increase in premium will help the CO-OP to improve its profit margin, it will "result in a loss of market share" (P. 7). However, no specific detail is provided

on the level of rate increase projected in the contingency scenario. Additionally, it is not clear how increasing rates and eliminating administrative costs relating to customer service fits into the overall mission of the CO-OP.

Reduce membership size: In the contingency plan, the applicant plans to reduce its membership level by "production rationalization and service area reduction" (P. 7). HRINY stated that it will "reduce product offerings to EssentialCare in the individual market, the product New York State requires, and discontinue non-required individual products on- and off-exchange to both decrease overall membership and shift some members to the higher margin EssentialCare product line" (P. 7). Additionally, the applicant plans to retract from counties that generate the lowest profit margin. As presented in the pro formas, HRINY projected enrollment for 2015 is less than the average enrollment as projected in the baseline scenario by 109,500 members.

Expedite reduction in administrative and medical cost to essential: The applicant stated that it will take action to eliminate non-essential administrative expenses such as marketing expenses and cut in customer service level. However, no further detail is provided on the level of cuts that the CO-OP is projecting.

The applicant's contingency plan represented in its pro forma income statement shows reduced enrollment projections starting in 2015 and increased premium revenues per member as compared to its baseline scenario. Table 5 below highlights enrollment projections, premium revenues, average premium revenues per member, and ACR for 2015 through 2020:

Table 5: Premiums per Member and ACR Comparison: Baseline vs. Contingency Plan

	2015	2016	2017	2018	2019	2020
Baseline Scenario						
Average Members	211,818	302,818	360,318	367,524	374,875	382,372
Net Premium Earned ($000)	1,055,320	1,625,336	2,057,342	2,208,329	2,370,411	2,549,706
Average Annual Premium per Member ($000)	5.0	5.4	5.7	6.0	6.3	6.7
ACR	16.5%	15.4%	14.5%	14.4%	14.2%	14.1%
Contingency Plan Scenario						
Average Members	102,318	95,318	87,318	78,586	70,727	63,655
Net Premium Earned ($000)	538,834	543,238	535,553	518,438	500,568	485,282
Average Annual Premium per Member ($000)	5.3	5.7	6.1	6.6	7.1	7.6
ACR	17.8%	16.7%	16.5%	16.1%	15.8%	15.4%

HRINY believes its ability to negotiate provider contracts may be reduced due to the projected reduction in the membership size (P. 128). This is expected to increase costs due to lower network discounts. An additional increase in premiums would be necessary to account for fixed costs across a smaller membership base. HRINY's calculation of the net impact of this change in HRINY's cost structure would cause the 2015 margin as a percentage of premiums to decline from 0.40% and $3,804,000 under the business plan to 0.05% and $138,000 under the contingency plan (P.128). The 2015 rate has already been submitted and therefore the change in pricing could not be reflected until 2016.

Under the contingency plan, HRNY believes it will need to increase its 2016 individual market rates by 10% and Small Group Market rates by 6% (assuming regulatory approval), as compared to the 9% and 5% increase projected in the business plan (P. 129). These rate increases are in addition to steering members to higher margin plans and exit lowest margin counties. HRINY also plans to eliminate higher cost medical providers from

networks in 2014 and beyond, reduce customer service levels to drive down variable administrative costs; and reduce health management efforts to essential requirements only (P. 129-130).

One of the secondary effects anticipated by HRINY from the above actions is an overall sicker population, as the CO-OP expects higher cost individuals to be the first to keep their coverage due to "generous benefits and broader network" (P. 131). This is expected to accelerate the overall claim costs trend. However, it is unclear if HRINY's benefits and network are enough to entice the sicker population to retain their coverage.

In the event the applicant does not receive the $90.7M additional solvency loan request, the contingency plan is projected to commence in 2015. The pro forma income statement in the contingency plan shows that the applicant projects to realize a profit of $138K in 2015. The applicant is projecting MLR and ACR in contingency scenario to stay at the same level as in the baseline scenario. Surplus is also projected to stay above 12.5% of net premium income during the entire performance period.

Summary of Observations:

- **HRINY projects $965.4M less in total profits as compared to its baseline scenario due to lower enrollment.** In its contingency scenario, the applicant projects a cumulative net profit of $101.4M from 2014 – 2033, while projecting to incur a loss in 2032 and operate at break even in 2033. As compared to the baseline scenario, HRINY projects $1.1B in cumulative net profits from 2014 – 2034, which is higher than the projected profit in the contingency scenario. The reduction in projected cumulative profit may be attributable to the reduction in enrollment projections, as HRINY plans to retract from certain counties that generate low profit margins. For the entire performance period, HRINY projects an average enrollment of 49,908 members in the contingency scenario as compared to 397,056 average members projected in its baseline scenario. Furthermore, while the baseline scenario enrollment is projected to increase each year up to 504,532 members in 2034, the contingency scenario enrollment is forecasted to decline each year, down to 14,562 members in the same year. This represents a projected 86.6% decline in enrollment in its contingency plan.
- **No specific detail provided on projected increases on premium rates.** HRINY stated that premiums will increase "higher than planned in the baseline for 2016" (P. 37). However, no further detail was provided on the projected level of increases.

Solvency Loan Request Points

Sections	Potential	Total
Enrollment	15	11.25
Product Pricing	20	11.5
Medical Costs and Losses	15	12
CO-OP Financials	15	9.5
Score	**65**	**44.25**

Contingency Plan Points

Contingency Plan	Potential	Total
Overall	10	9
Score	**10**	**9**

Freelancers Health Service Corporation, d/b/a Health Republic Insurance of New York Additional Solvency Loan Funding Request Report Round II

Date Submitted to CMS: 10/24/2014

Scope Summary & Assumptions:

- Deloitte will not provide an opinion regarding the reasonableness of the proposed business plan changes of each Consumer Operated and Oriented Plan (CO-OP) Program. Nor will Deloitte provide an opinion regarding the likelihood of each CO-OP achieving sustainable operations based upon the revised business plan.
- Deloitte assumes that the information provided by each CO-OP in its modified business plan is complete and accurate. Deloitte will perform its assessment of the data provided "as is". Deloitte will also use other data sources that are publicly accessible or information provided directly from the Centers for Medicare and Medicaid Services (CMS). Deloitte will notify CMS if we believe that there is insufficient information to complete our review.
- In these applications for solvency loan requests, some of the CO-OPs have cited a need for additional solvency loans to cover projected cash shortfalls as a result of nonadmitting risk-sharing receivables provided in the Affordable Care Act (ACA). The National Association of Insurance Commissioners (NAIC) is charged with developing accounting guidance for these risk-sharing provisions which are utilized by the state departments of insurance in monitoring the financial solvency of the insurers domiciled in their state. The NAIC is continuing their deliberations on this issue, which previously included potential nonadmittance for risk-sharing receivables in excess of any payables. However, as a result of the most recent NAIC meeting on August 17, 2014, the adopted minutes of that meeting reflects that the NAIC is "replacing the nonadmission guidance with criteria that incorporates conservatism and sufficiency of data and removing the exposed 90-day guidance and adding language to be consistent with other government receivables". This Findings Report will provide relevant information, as necessary, on the accounting treatment for the risk-sharing receivables used by the CO-OPs in their financial projections.
- The impact of the Reinsurance, Risk Adjustment and Risk Corridors Program (the 3Rs, reinsurance, risk adjustment, and/or risk corridors) was reviewed when making observations and comments throughout this report. Observations and comments relating to the impact of the 3Rs are included for informational purposes only. We are not commenting on the reasonableness or propriety of any of the amounts relating to the 3Rs. Nor are we commenting on the underlying accounting policy. Based on the scoring criteria provided by CMS, observations and comments relating to the 3Rs had a net neutral effect on the scoring.
- In reviewing applications from CO-OPs for additional solvency loan funding requests, Deloitte reviewed supporting documentation requested of the applicants by CMS in a memo to the CO-OPs distributed on August 22, 2014. The format of the reports as well as the section scoring was approved by CMS during the week of June 2, 2014. These reports are scored on the basis of a total of 65 points, plus 10 points for the contingency plan. The scoring reflects Deloitte's assessment of the degree to which the application complies with the funding loan announcement of August 22, 2014. The score for the Contingency Plan section should be viewed independently of scoring for the other sections of this report. For all sections, Deloitte provided comments on issues only for which the applicant provided data. Observations relating to the pro forma financial statements are based on the base case with additional solvency loan award scenario (base case), unless otherwise noted.

Executive Summary:

Health Republic Insurance of New York (HRINY or the applicant or CO-OP) has submitted a request to CMS for $70.5M in additional solvency loan funding. HRINY states that additional funding is needed in order to meet the State-determined solvency requirements relating to maintaining risk-based capital (RBC) of 500% of authorized control level (ACL). HRINY states that since the June 18, 2014 submission, new developments have occurred which "directly affect solvency needs" (P. 2)[1]. These developments include increased membership projections for 2014 and 2015, updated financial data, competitive positioning, and a new surplus target of 500% of ACL rather than the 15% of net premium income that was targeted in the June 2014 submission projections (P. 2). New York's Section 4310 of the insurance statutes requires the CO-OP to maintain a minimum reserve balance of 12.5% of net premium income as capital and surplus. However, HRINY stated that the New York State Department of Financial Services (DFS) is now requiring the CO-OP to maintain an RBC level of 500% of ACL as recommended by CMS (P.2). This change supports $18.8M of the total request of $70.5M. (P.2) No further documentation or information was provided to substantiate the reason for the CO-OP to now maintain RBC levels of 500% of ACL.

Based on CMS's CO-OP Summary Report by Borrower as of 10/3/2014 (Loan Tracker), the CO-OP was obligated $23.8M in start-up loans and $241.3M in solvency loan funding, totaling $265.1M. As of 10/3/2014, a total of $155.6M has been disbursed, specifically $23M of obligated solvency loan funding and $132.6M of the $241.4M of obligated start-up loan funding. The CO-OP was recently awarded $90.7M as a result of a solvency loan request in June 2014, which is included in the total obligated amount but has not yet been disbursed.

Although HRINY plans to increase premium rates starting in 2015, the applicant is still projecting to outperform all previous enrollment projections. HRINY's original[2] application pro forma financial statements projected 30,864 average enrollees [3]in 2014 and 50,535 in 2015. Per HRINY's most recent pro forma financial statements, the applicant projects to enroll 116,439 average members in 2014 and 261,839 in 2015. Additionally, HRINY's ability to meet its projected break-even is contingent on premium increases of more than 10% in 2015 and 2016.

In discussing its competitors, the CO-OP mentions a new entrant to the individual market place, Freelancers Insurance Company (Freelancers or FIC) (P.87). Although Freelancers is discussed as a competitor in the application, FIC is actually a for-profit insurer run by the Freelancers Union which is the same organization that founded and currently sponsors HRINY. Additionally, while FIC originally planned to enter the individual market at the time of HRINY's application, the insurer has since decided to cease its insurance activity starting in 2015. FIC currently enrolls approximately 25,000 of Freelancers Union members. Given the relationship between FIC and HRINY, it is unclear how FIC's pending closure will impact the CO-OP's enrollment in 2015 and beyond[4].

HRINY is projecting receivables from the 3Rs program from 2014 through 2016, specifically $12.6M in risk corridors receivables in 2014, and net federal reinsurance recoveries in the amounts of $50.2M, $51.8M, and $20.3M in 2014, 2015, and 2016, respectively. Absent the impact of the 3Rs, HRINY projects a loss of $74.5M in 2014 and $46.6M in 2015. The 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit. Additionally, HRINY's latest projection of net federal reinsurance recoveries has increased by $29M as compared to the net cumulative federal reinsurance recoveries projected by HRINY in its June 2014 pro forma submissions to CMS. No further information was provided as to the reason for this increase. Based on the pro forma financial statements, if the CO-OP does not receive additional solvency loan funding and given the timing of the cash receipts of the 3Rs receivables being several months after expenditures, CMS may want to consider that HRINY could suffer from a liquidity issue.

[1] Page numbers in this report refer to the consolidated application.
[2] All references to "original" -- including, but not limited to, "original funding application", "original application", and "original projections"—refer to HRINY's 2011 application for CMS start-up and solvency loan funding , operations commencing in 2014.
[3] Annual enrollment projections provided in the pro formas reflect average membership over a 12 month period.
[4] Source: http://www.nytimes.com/2014/10/01/nyregion/freelancers-union-to-end-its-health-insurance-plan-in-new-york.html?_r=1

Critical Assertions:

1. **Enrollment:**

In this application, HRINY is requesting $70.5 million in additional solvency loan funding. The CO-OP states that $44.2 million of this request will be used to address "the continuation of higher-than-expected growth" (P. 3). Based on HRINY's most recent pro forma financial statements submitted in September of 2014 (9/24 Pro Formas or pro formas), average enrollment for 2014 is almost 8% larger than the projections in June of 2014 (6/1 Pro Formas). This growth continues in 2015 and 2016, where average enrollment projections are 24% and 25% greater than the projections in the 6/1 Pro Formas, respectively. According to the CMS CO-OP Enrollment Comparison Report as of 8/05/2014, HRINY's current enrollment is 135,494. The enrollment projections, as outlined in the 9/24 Pro Formas, the 6/1 Pro Formas, and the pro forma financial statements from the original application (2011 Pro Formas), are presented in Figure 1.

Figure 1: Projected Enrollments are up Compared to Original (2011) Projections for 2014-2016

Source: Applicant's 2011 Original Application, 6/1 pro formas, and 9/24 pro formas

Although the CO-OP's 9/24 Pro Formas do indicate "higher-than-expected growth", discrepancies exist between what the applicant reports in its business plan/project narrative, and what exists in the 9/24 Pro Formas and feasibility study (P. 3). In the project narrative, the CO-OP states, "As you will see in the enclosed pro forma, we are now projecting a 2014 year-end membership of approximately 160,000, up from the estimate of 134,000 submitted in the June 2014 Business Plan" (P. 3). Additionally, the CO-OP's business plan reports end-of-year projections of 314,839 and 404,839 enrollees for 2015 and 2016 respectively (P. 85). However, the base case of the 9/24 Pro Formas submitted with this application projects an average enrollment of 116,439, 261,839, and 373,339 for 2014, 2015, and 2016 respectively (P. 115). It is, therefore, unclear how the CO-OP arrived at the projections in the business plan and why they differ from enrollment projections in the 9/24 Pro Formas.

The breakout of enrollment by business segment (individual, small group, large group) or method of enrollment in the New York state-run Marketplace (Marketplace) vs. off Marketplace was not provided in any of the pro forma financial statements submitted. However, some of the details regarding business segment were provided in the body of the feasibility study provided with this application, as well as the feasibility studies provided with the June 2014 application and original application. Table 1 shows the change in the CO-OP's enrollment projections by business segment for the years 2014, 2018, and 2023, illustrating the evolution of HRINY's enrollment strategy over time. No breakout was provided for the years in between those listed below.

Table 1: Enrollment Projection Comparison, 2014-2023

	2014			2018			2023		
	Individual	Small Group	Large Group	Individual	Small Group	Large Group	Individual	Small Group	Large Group
Original Application Projection	28,102	2,762	0	77,721	12,115	0	86,981	13,559	0
June 2014 Projection	69,404	38,907	0	171,486	164,418	31,620	189,334	181,531	34,911
September 2014 Solvency Loan Funding Request	73,466	42,973	0	186,467	221,368	31,620	205,875	244,408	34,911
% Change Original Application-	161.43%	1455.87%	N/A	139.92%	1727.22%	N/A	136.69%	1702.55%	N/A

Sep-14									
% Change June 2014-September 2014	5.85%	10.45%	N/A	8.74%	34.64%	0.00%	8.74%	34.64%	0.00%

In 2014, HRINY is expecting 63% of its enrollment to be comprised of individual enrollees, and 37% to be comprised of small group enrollees. In the June application, the CO-OP projected individual enrollees would comprise 64% of its enrollment, with small group enrollees comprising 36%.

The applicant describes its efforts to attract large group enrollees in its business plan, stating only, "HRINY's large group efforts will primarily focus on companies with 51 to 100 employees in 2015, serving as a one-year bridge to [the] new upper-limit definition of small group in 2016" (P. 69). The applicant does not mention its large group enrollment strategy past 2015. However, as noted in Table 1, the applicant projects that 31,620 of its total average enrollment of 439,546 will come from the large group business segment by 2018.

HRINY did not provide a breakout of projected enrollment for on and off Marketplace. As a result, it is unknown if the applicant is projected to achieve the two-thirds enrollment from the Marketplace as required by Title 45, Code of Federal Regulations (CFR) §156.515(c)(1) and (d) related to the requirements of CO-OPs pursuant to the ACA.

Documentation for Change in Enrollment Projections

The applicant expects that its pricing advantage, product offerings, geographic availability, and marketing efforts will allow it to achieve its enrollment goals for the foreseeable future, as described in Table 2 below. The applicant states that its rates were "too low because the actual population risk mix in the 2014 market was higher risk than expected". HRINY, therefore, decided it would not be able to achieve "financial sustainability and market competitiveness" without raising rates by approximately 13% (P. 72). Please refer to the Product Pricing section for further details.

Table 2: Documentation for Change in Enrollment Projections

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
Underpriced Premiums	1. **Raise Premium Rates for 2015.** HRINY is approved to raise average individual premium rates by 12.9% and average small group rates by 3.5% in 2015	According to HRINY, these price increases are necessary in order to "maintain financial sustainability and market competitiveness" in 2015 and beyond. In the applicant's June 2014 solvency loan request, it originally projected increasing individual premium rates by 15% and small group premium rates by 6%. However the DFS did not approve the proposed rates, only granting increases for the individual and small group segments of 12.9% and 3.5% respectively (P. 73). The applicant contends that even with these price increases, HRINY will remain competitive enough to achieve its projected enrollment numbers. It points to the fact that the approved rates still place their products "fourth or fifth from the bottom of the market in many regions". (P. 5) The CO-OP therefore expect to "retain membership and achieve growth" through its geographic expansion and competitive price-point (P. 5). See Product Pricing section for more information. HRINY does discuss potential challenges to the CO-OP achieving

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
		its enrollment projections as they relate to the proposed price increases and the price points of its competitors. The applicant states, "Should HRINY's competitors significantly change the design of their products, HRINY's enrollment projections will be impacted" (P. 87). The CO-OP goes on to point out that, for the individual segment, HRINY's products "will remain among the most affordable products in all rating areas" even with the price increases (P. 72). Similarly, HRINY states that for the small group segment it has the lowest average rate for every tier and every region, with the exception of New York City Platinum plan where it has the second lowest average rate (P. 87). In discussing its competitors, the CO-OP mentions a new entrant to the individual Marketplace, Freelancers Insurance Company. Although Freelancers is discussed as a competitor in the application, FIC is actually a for-profit insurer run by the Freelancers Union which is the same organization that founded and currently sponsors HRINY. Additionally, while FIC originally planned to enter the individual market at the time of HRINY's application, the insurer has since decided to cease its insurance activity starting in 2015.[5] FIC currently enrolls approximately 25,000 of Freelancers Union members. Given the relationship between FIC and HRINY, it is unclear how FIC's pending closure will impact the CO-OP's enrollment in 2015 and beyond. In addition to HRINY, and FIC, the Freelancers Union formed a brokerage company called the Freelancers Brokerage Inc. in April 2014.[6] Although HRINY currently lists Dubraski & Associates as its independent insurance brokerage (P. 18), it does state its intention to expand its broker program in 2015 (P. 84). HRINY does not provide any information alluding to a relationship with FIC or Freelancers Brokerage Inc. in its application.
Geographic Availability	2. **Move into 11 new counties in Upstate New York.** Starting in 2015, HRINY intends to expand its operations into 11 counties in Upstate New York.	According to the applicant, part of HRINY's enrollment strategy is to move into 11 counties in Upstate New York where it currently does not provide coverage. Currently, according to the applicant, HRINY covers 32 of New York's 62 counties, which are home to approximately 88% of the state's population. By moving into these 11 counties, HRINY will be making its products available to another 1 million members, and "bringing the company one step closer to its goal of

[5] Source: http://www.nytimes.com/2014/10/01/nyregion/freelancers-union-to-end-its-health-insurance-plan-in-new-york.html?_r=1
[6] Source: http://www.dos.ny.gov/corps/

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
		statewide coverage" (P. 70). Although these 11 counties only comprise a small fraction of the state's total population, HRINY states that this extension allows the CO-OP to build "a more complete delivery system" with providers that don't currently exist in its network (P. 75). In the applicant's previous request for additional solvency loan funding in June 2014, HRINY also discussed its intended 2015 expansion, proposing moving into all 30 of New York's Upstate counties in which the CO-OP does not operate. It is unclear why, with this most recent application, the CO-OP reduced the number of proposed counties from 30 to 11, The CO-OP expects its enrollment to grow to 261,839 average members in 2015 in its 9/24 Pro Formas, when it only projected 211,818 average enrollees in its 6/1 Pro Formas. It cannot be determined what percentage of the projected growth is attributable to this geographic expansion and what percentage is attributable to growth within the current service area.
Increase Product offerings	3. **Increase the number of products offered.** HRINY intends to offer two new products, one targeting the individual market, and one targeting the small group market.	In 2015, HRINY intends to offer two new product lines in addition to its current three (Primary Select EPO, Primary Select, and Essential Care). The first of the new options is called Total Independence, and is described as a low cost option available to individuals exclusively in the New York City and Long Island regions. The second, Total Freedom, is described as the CO-OP's new out-of-network product offered exclusively to the small group market (P. 76).
Increase in Sales and Marketing	4. **Continue to develop and distribute communications and advertisements to key audiences.** HRINY will continue to develop targeted communications in the form of member satisfaction surveys, member advisory discussion groups, and advertising, as well as engage in market research going into 2015.	To gain an increased understanding of the needs of its customers, HRINY stated that it will engage in continued marketing efforts going into 2015. One such effort includes continued use of member satisfaction surveys aimed at gauging "member satisfaction strengths, weaknesses, opportunities and needs." (P. 96). By understanding the desires of its members, HRINY may be in a position to adapt and retain some customers, despite increased premiums in 2015. HRINY conducted a member satisfaction survey in June of 2014; out of the applicant's current members in 2014, 396 enrollees responded to the survey. It is unclear why this group would be taken as a representative sample of the total membership's sentiments. Another marketing effort is the applicant's Member Advisory Discussion Groups. These are quarterly sessions where current members are able to provide input on the CO-OP's past performance and future plans. According to the application, "Outputs from the sessions will be shared both internally and externally as appropriate, starting second quarter 2015" (P.

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
		97). Additionally, in an effort to target new customers, HRINY plans to partner with an advertising agency "to develop and execute targeted campaigns focused on building brand awareness and supporting open enrollment initiatives in key markets." This partnership will begin in the summer of 2014 with the advertising campaigns set to start during the year's fourth quarter (P. 97). HRINY does not provide a budget detailing how much it intends to spend on these marketing efforts, nor do the pro formas provide any insight into marketing expenses. Additionally, the application provides no information on the applicant's efforts to obtain private funds.

Summary of Observations:

- **Increased enrollment projections from original application.** Although HRINY plans to increase premium rates starting in 2015, the applicant is still projecting to outperform all previous enrollment projections. HRINY's 6/1 Pro Formas projected 108,311 enrollees in 2014 and 211,818 enrollees in 2015. Per HRINY's 9/24 Pro Formas, the applicant now projects to enroll 116,439 average members in 2014 and 261,839 in 2015. It is unclear how the pending redefinition of "small group" and the CO-OP's pending expansion into 11 new counties influences its updated enrollment projections. It cannot be determined how much turnover the CO-OP expects to experience within its membership. Growth in projected enrollments due to expansion into new counties may offset anticipated losses in existing members due to planned increases in premiums. There is insufficient information in the applicant's application to analyze the impact of the projected premium increases on the retention of existing members and any mitigation strategies the CO-OP may intend to implement.
- **Increased premiums planned for 2015.** In order to "maintain financial sustainability and market competitiveness" the applicant intends to raise premium rates to become more in line with its competitors in the market (P. 72). With recent DFS approval, individual and small group premiums will increase by 12.9% and 3.5% in 2015, respectively. These rates were lowered by the DFS after HRINY requested an initial rate increase of 15.2% for the individual market, and 6% in the small group market.
- **Plans for new products and state-wide availability**. In order to achieve increased enrollment projections in the face of rising premium rates, HRINY plans to increase enrollment by offering two new product lines, and expanding into 11 counties in Upstate New York. This number has been reduced from 30 new counties since the applicant's last solvency loan request in June of 2014. The new product lines include the Total Freedom line, a small group product offering out-of-network care, and the Total Independence line, a less expensive product available exclusively for the individual market that will be marketed to customers in New York City and Long Island. Additionally, HRINY will be moving into the large group market in 2015 in anticipation of the 2016 redefinition of "small group".
- **Support for marketing funds not provided.** The applicant did not specify how its partnership with an advertising agency, detailed in the marketing strategy, will be funded. Since solvency loan funds cannot be used for marketing purposes, the applicant may need to acquire outside funds to realize this portion of its marketing strategy.
- **Breakout of on and off Marketplace enrollment not provided in the pro formas.** It cannot be determined if the CO-OP will have two-thirds of its enrollment from the Marketplace in 2016, as required by Title 45, Code of Federal Regulations (CFR) §156.515(c)(1) and (d) related to the requirements of CO-OPs pursuant to the ACA.

2. Product Pricing:

As noted in Tables 3 and 4 below, HRINY's 2014 enrollment was higher than anticipated due to its rates being among the lowest in most products and markets across the state (P. 87). HRINY had estimated their 2014 enrollment to be 134,000 but is now projecting it to be close to 160,000 (P. 3 and 85). As of August 31, 2014, their actual enrollment across individual and small group markets is 145,998 (P. 68).

One of the reasons the CO-OP is requesting an increase in premiums in 2015 of 15.2% for individual and 6% for small group products is to fix the mispricing in 2014 (P. 67). The state approved an increase in premiums in 2015 of 12.9% for individual and 3.5% for small group products (P. 73) which are reflected in the pro formas (P. 36). In the June 2014 application, HRINY had exhibited that it would like to hold its price position in most of the regions and expected to reduce the gap between the next closest competitor by increasing premium rates. Per tables 3, 4, 5 and 6[7] below, HRINY has been able to still hold the lowest premiums in most of the regions across the different tiers in spite of the rate increase approved by DFS. The CO-OP had anticipated that the competitors would also be increasing their premiums to account for medical cost trend and changes in federal reinsurance which is verified by the amount of rate increases filed for and approved by DFS listed in a press release[8]. HRINY still projects to achieve profitability beginning in 2015 and is profitable throughout the whole performance period, if projections are realized. In addition, the application is updated to achieve a minimum RBC level of 500% of ACL which is recommended by CMS. The higher RBC level required has been cited by the CO-OP as one of the reasons for this solvency loan application (P. 2). Please refer to the CO-OP Financials section for further discussion.

No new information has been provided by the CO-OP in this application with regards to the adjustments made to develop the premium rates in light of being approved for lower than requested rate increases by DFS.

Table 3 provides a comparison of the 2014 premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence in the individual market. The competitors listed have the lowest rate for at least one of the regions in 2014 in the individual market. In the June 2014 application, HRINY noted that it is the lowest cost plan in many areas of New York which HRINY cites as a primary contributor to its 20% market share in the individual market on the Marketplace (P. 71). Highlighted areas denote the lowest premium for the particular area.

Table 3: Premiums in the 2014 New York Marketplace for Individual Market by Rating Region/Area

[7] Data Source for Tables 3, 4, 5 and 6: http://www.dfs.ny.gov/consumer/health/2014_and_2015_approved_rates.pdf
[8] Source: Press Release about approved 2015 rates: http://www.dfs.ny.gov/about/press2014/pr1409041.htm

Insurer	Metal/Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Health Republic	Platinum	391.62	366.60	439.90	515.81	360.38	380.59	370.32	515.81
Metro Plus	Platinum				484.13				
North Shore LIJ	Platinum				572.20				572.20
Health Republic	Gold	333.06	311.78	374.13	438.69	306.50	323.68	314.96	438.69
Metro Plus	Gold				432.28				
North Shore LIJ	Gold				490.83				490.83
Fidelis	Silver	359.16	355.01	362.17	409.66	356.14	358.40	354.26	378.00
Health Republic	Silver	294.14	275.35	330.41	387.42	270.68	285.86	278.15	387.42
North Shore LIJ	Silver				422.62				422.62
Fidelis	Bronze	283.84	280.56	286.22	323.75	281.45	283.24	279.97	298.73
Health Republic	Bronze	233.18	218.28	261.93	307.12	214.58	226.61	220.50	307.12
North Shore LIJ	Bronze				332.48				332.48
Affinity	Catastrophic			287.72	294.67				300.85
Empire HMO	Catastrophic	173.37		204.48	186.20			275.96	171.38
Health Republic	Catastrophic	161.51	151.19	181.43	212.73	148.63	156.96	152.73	212.73
MVP Health	Catastrophic	149.56	135.89	183.07	238.09	131.22	170.90	160.23	
North Shore LIJ	Catastrophic				180.53				180.53

Table 4 provides a comparison for the 2015 premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence in the individual market. The competitors listed have the lowest rate for at least one of the regions in 2015 in the individual market. Highlighted areas denote the lowest premium for the particular region.

Table 4: Premiums in the 2015 New York Marketplace for individual market by Rating Region/Area

Insurer	Metal/Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Health Republic	Platinum	455.80	405.65	512.01	588.99	419.42	392.05	430.96	588.99
Metro Plus	Platinum				558.38				
North Shore LIJ	Platinum				515.48				550.76
Health Republic	Gold	387.65	345.00	435.46	500.93	356.71	333.44	366.53	500.93
Metro Plus	Gold				474.35				
North Shore LIJ	Gold				449.82				479.22
Fidelis	Silver	374.74	353.86	418.09	402.71	377.10	379.08	373.95	398.78
Health Republic	Silver	331.74	295.24	372.65	428.69	305.27	285.35	313.67	428.69
North Shore LIJ	Silver				396.90				423.36
Fidelis	Bronze	301.07	284.30	335.91	323.55	302.97	304.56	300.45	320.39
Health Republic	Bronze	271.39	241.53	304.86	350.69	249.73	233.43	256.60	350.69
North Shore LIJ	Bronze				315.56				336.14
Affinity	Catastrophic			150.62	154.48				157.87
Empire HMO	Catastrophic	184.11		217.14	197.74			293.05	181.99
Health Republic	Catastrophic	142.56	126.88	160.14	184.22	131.18	122.62	134.80	184.22
MVP Health	Catastrophic	164.44	149.42	201.30	170.72	144.29	187.91	176.19	
North Shore LIJ	Catastrophic				171.50				183.26

Table 5 provides a comparison for the 2014 premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence in the small group market. The competitors listed have the lowest rate for at least one of the regions in 2014 in the small group market. Highlighted areas denote the lowest premium for the particular region.

Table 5: Premiums in the 2014 New York Marketplace for small group market by Rating Region/Area

Insurer	Metal/Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Health Republic	Platinum	426.04	398.81	478.57	561.14	392.06	414.04	402.87	561.14
Metro Plus	Platinum				523.74				
North Shore LIJ	Platinum				687.84				687.84
Empire HMO	Gold	523.88		613.61	573.68			779.73	518.32
Health Republic	Gold	362.34	339.19	407.01	477.24	333.44	352.13	342.64	477.24
North Shore LIJ	Gold				598.33				598.33
EMBLEM-HIP	Silver			404.32	404.32				459.48
Health Republic	Silver	310.10	290.28	348.33	408.44	285.36	301.36	293.24	408.44
Health Republic	Bronze	253.67	237.46	284.95	334.11	233.44	246.52	239.88	334.11
MVP Health	Bronze	286.70	237.13	322.53	410.93	239.81	311.49	292.38	

Table 6 provides a comparison of the 2015 premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence in the small group market. The competitors listed have the lowest rate for at least one of the regions in 2015 in the small group market. Highlighted areas denote the lowest premium for the particular region.

Table 6: Premiums in the 2015 New York Marketplace for small group market by Rating Region/Area

Insurer	Metal/Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Health Republic	Platinum	461.59	432.12	518.53	577.81	411.51	448.59	436.43	577.81
Metro Plus	Platinum				620.14				
North Shore LIJ	Platinum				559.00				596.00
Empire HMO	Gold	567.75		664.99	621.73			845.04	561.74
Health Republic	Gold	392.58	367.51	441.01	491.42	349.99	381.52	371.18	491.42
North Shore LIJ	Gold				483.00				515.00
EMBLEM-HIP	Silver	540.31		540.55	450.90		540.31	540.31	512.44
Health Republic	Silver	335.96	314.51	377.41	420.55	299.52	326.50	317.65	420.55
Health Republic	Bronze	274.84	257.29	308.74	344.04	245.02	267.10	259.86	344.04
MVP Health	Bronze	334.26	276.44	376.01	440.77	279.61	363.15	340.85	

The CO-OP states that the approved rates place its products "fourth or fifth from the bottom of the market in many regions" and that it expects to "retain membership and achieve growth" through its geographic expansion and competitive price-point (P. 5). However, based on the tables above, HRINY seems to be in a better position than that listed in the application. It has been able to hold its rates lowest in 2015 across all the rating areas from 2014 other than Mid Hudson for Catastrophic; New York for Silver and Bronze; and Long Island for Platinum and Gold tiers on the individual market. However, its rates are now the lowest in Albany, Buffalo and Rochester for the Catastrophic tier. On the small group market, HRINY has the lowest rates in 2015 across all the rating areas from 2014 other than New York for the Gold level whereas HRINY now has the lowest rates across New York for Silver and Buffalo for Bronze. No information was provided regarding the number of enrollees in these counties and thus it cannot be determined what impact these rate changes will have upon enrollment. Also, as noted by the CO-OP, "Should HRINY's competitors significantly change the design of their products, HRINY's enrollment projections will be impacted" (P. 87).

Summary of Observations:

- **New York Department of Financial Services has approved premium increases of 12.9% for individual and 3.5% for small group products for 2015.** Based on a press release by the New York Department of Financial Services, they have reduced the premiums requested for 2015 but still approved a net rate increase over 2014 premiums for both

individual and small products. The press release also provided an exhibit with rates for all insurers across the different regions and tiers.

- **HRINY has competitive rates in 2015.** In many regions and tiers, HRINY is the lowest cost plan for individual and small group markets. It is not clear why the CO-OP indicated that the approved rates place their products "fourth or fifth from the bottom of the market in many regions". Also, HRINY expects to "retain membership and achieve growth" through its geographic expansion and competitive price-point (P. 5).
- **Expansion of target market in 2015.** According to the June 2014 application, the CO-OP was considering including 30 new counties in its Upstate New York coverage area for 2015. However, in this application the CO-OP is expanding to only 11 new counties; the applicant does not specify which 11 counties (P. 11). However, considering that the applicant currently provides products in all rating areas within the state, this expansion area can be viewed as greater penetration into some of the rating areas. There is also no mention of why the applicant cuts back from 30 counties.
- **HRINY is now projecting an $11.6M loss in 2014 and, therefore, more of the 2013 established premium deficiency reserve (PDR) is still being held in 2014.** Upon comparing the pro forma financial statements provided in the June 2014 application and the current application, the CO-OP is projecting a higher loss in 2014 (P. 115). Therefore, more of this PDR is still being held in 2014. It is unclear how the CO-OP determined the PDR, as a detailed analysis was not provided. Supporting documentation of the analysis was also not provided.

3. <u>Medical Costs and Losses:</u>

HRINY projects combined medical loss ratios (MLR) for ACA purposes of 83.9%, 87.2%, and 87.2% for years 2014, 2015 and 2016, respectively, which includes the impact of the projected ACA adjustments and the 3Rs. This includes individual, small group and large group business. With regards to MLRs, no information has been provided split by the individual, small and large groups. Excluding the impact of the projected 3Rs and other ACA adjustments, the projected MLR for 2014, is 93.1% and is expected to decrease to 86.4% in 2015, and 83.1% in 2016, based on a plan to fix the mispricing of 2014 and greater claims cost efficiencies. Based on eight months of actual claim data, the applicant has increased the 2014 individual claim projection by approximately 1.7% and lowered the 2014 small group claim projection by 2.6% (P. 4). According to the applicant, combined with greater administrative efficiencies, these efforts are projected to bring HRINY's profit margin to 3.1% of premiums by 2017 (P. 83). The 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit.

The CO-OP plans to make several changes to their provider arrangements to increase the value being delivered by its provider networks. In the June application, the CO-OP planned to terminate its contract with MagnaCare but based on this application, its three primary core vendor partners – POMCO, MagnaCare and Morneau Shepell have voluntarily agreed to renegotiate their contracts (P. 4). The CO-OP has since decided that it would be best to maintain the MagnaCare network statewide (P. 73). The CO-OP plans to engage in direct contracting with providers to ensure the cost structure of its provider network is in line with the pricing for 2015. HRINY also plans to independently contract specialty services managers for behavioral health, laboratory, and radiology services (P. 74). Freelancers Union Independent Practice Association (IPA) LLC was formed on September 12, 2014[9]. It cannot be determined if the IPA will be involved in provider contracting or other roles for the CO-OP.

In 2015, the CO-OP plans to offer its existing array of products and two new products which it hopes will meet unmet needs in the marketplace (P. 5). The CO-OP also plans on expanding to 11 counties in New York where it currently does not operate, which is less than the 30 counties proposed in its June 2014 application. The applicant did not provide sufficient information with which to analyze the impact of the geographic expansion and the addition of two new products on medical costs and losses. However, based upon the rates available for the individual and small group segments, HRINY has been operating in the rating regions that contain the planned expansion counties. Therefore, the

[9] Source: http://www.dos.ny.gov/corps/

CO-OP's medical cost and loss data to date may reflect, at least in part, its experience within these rating regions for existing products.

As part of its enrollment strategy, HRINY expects to sell to the large group market in 2015. However, the expansion to the large group market will focus on companies in the 51-100 range in anticipation of the redefinition of small group in 2016. HRINY intends to build awareness in this market segment without increasing marketing expenses by leveraging existing broker relationships (P. 84).

The CO-OP has projected morbidity to be equal to the state average. As such, no risk adjustment receipts or payable relating to 3Rs is projected in the rate filing. The CO-OP is expecting to get $57.6M in reinsurance receivables and $12.6M in risk corridors receivables from the 3Rs which is 11% and 2% of the total premium respectively during 2014 and $63.3M in reinsurance receivables relating to 3Rs which is 5% of the total premium in 2015. The estimates of relative risk and risk transfer payments are dependent not only on the membership enrolled by HRINY but also by the other carriers in the state (P. 381). Additionally, there was no information provided on how the commercial reinsurance program will impact claim costs.

Summary of Observations:

- **HRINY expects 2015 morbidity to be similar to 2014 pricing morbidity.** The small group market forms the basis of the CO-OP's manual rates. HRINY assumes the current small group market morbidity to be the same as that before ACA was passed. When pricing for 2015, the expected morbidity of the small group population in New York was used and adjustments were made to it to calculate the individual market morbidity. Based on research conducted by HRINY, individual markets have higher health risk than group markets, therefore the CO-OP is assuming that the individual market morbidity will be 40% higher than the small group market. No changes were made since the June 2014 application.
- **Expanded provider arrangements.** HRINY intended to replace MagnaCare with POMCO's network in Upstate New York. However, the CO-OP has decided that it would be best to maintain the MagnaCare network statewide (P. 73). HRINY plans to engage in direct contracting with providers and plans to independently contract specialty services managers for behavioral health, laboratory, and radiology services (P. 74). Engaging in contracts that are more favorable to the CO-OP would help reduce its claims costs and help reduce its MLR.
- **Specific details on the reinsurance program/strategy were not provided, which may result in a gap in coverage.** Since no details were provided on the reinsurance strategy, it cannot be determined whether there will be a gap in coverage for both individual and small group business.
- **The 3Rs receivables are difficult to quantify.** This is because of the uncertainty of the industry average morbidity which is needed to accurately estimate risk adjustment. Risk corridors is calculated after risk adjustment, and, therefore, it relies upon the risk adjustment estimate. Without these receivables, HRINY would have a loss of $81.8M for 2014 instead of the $11.6M projected in the pro formas.

4. <u>CO-OP Financials:</u>

HRINY's pro forma financial statements project recoveries from the federal reinsurance programs for 2014 through 2016. In the baseline with additional solvency loan scenario (base case scenario), HRINY projects cumulative net federal reinsurance recoveries of $122.3M for 2014 through 2016, while it projects to recover $121.6M in the contingency scenario during the same period. HRINY also projects to receive an additional $12.6M from the risk corridors program in 2014 in all scenarios (P. 50).

Despite the total $62.9M in net receivables that HRINY is projecting to receive from the 3Rs in 2014, it is projecting a loss of $11.6M in 2014. Absent the recoveries from the 3Rs, HRINY's projected 2014 loss would be $74.5M. With consideration of the impact of the 3Rs, the applicant expects to achieve profitability in 2015 with a projected net income of $5.1M in 2015 and $32.4M in 2016 (P. 50). Absent recoveries from the 3Rs, HRINY is projected to incur a loss of $46.6M in 2015, and achieve profitability in 2016 with projected net income of $12.1M. Per the quarterly regulatory

filing as of June 30, 2014, HRINY has recorded a PDR of $5.2M in 2013. HRINY projects the change in PDR to decrease by $3.8M in 2014 and $1.4K in 2015. However, details were not provided for the analysis of the PDR estimate.

Based on the Loan Tracker, the CO-OP has been awarded total funding of $174.5M during the original loan application ($23.8M in start-up loans and $150.7M in solvency loan funding), and began issuing health insurance products beginning in 2014. In September 2014, an additional solvency loan funding of $90.7M was obligated to HRINY, bringing the total solvency loan award to $241.4M. As of 10/3/2014, $23.0M of the total obligated start-up loan and $132.6M of the total obligated solvency loan is disbursed to the CO-OP, leaving $736.5K in undisbursed start-up loan and $108.8M in undisbursed solvency loan funds obligated to the CO-OP. HRINY is requesting additional solvency loan funding of $70.5M. Combined with the current solvency loan funding award, the total solvency loan for HRINY would be $311.8M. As noted in Table 7 below, the CO-OP had originally projected to draw down solvency loan funds from 2014-2017; however, the applicant's most recent application projects drawing upon the obligated funds, including the $70.5M requested in this application, from 2014-2016. As a result, the solvency loan award per enrollee will increase from $982 to $1,245.

Table 7: Solvency Loan Award Per Enrollee

Solvency Loan Award per Enrollee	
June 2014 Enrollment Projection (Average: 2014 - 2017)	245,816
Current Solvency Loan Funding Obligated	241,366,000
Projected Solvency Loan Per Enrollee (Current Award)	$982
September 2014 Enrollment Projection (Average: 2014 - 2016)	250,539
Additional Solvency Loan Funding Requested to be Awarded	$70,476,000
Total Solvency Loan Funding Request	$311,842,000
Projected Solvency Loan Per Enrollee	$1,245

HRINY stated that, the additional solvency loan funding is necessary to support (P. 2):

- **Increased membership projections in 2014 and 2015 as compared to enrollment projections provided to CMS in June 2014.** HRINY projects the 2015 increase in membership despite a 12.9% increase in premiums in individual rates and a 3.5% increase in small group premiums. HRINY stated that the approved 2015 rates place its products "fourth or fifth from the bottom of the market in many regions" (P. 5). Despite this product positioning and increased competition in the market, HRINY projects to retain its members and grow, as its products have "broader network than lower priced plans" (P. 5). $44.2M of the total additional solvency loan funding is being requested to support the projected enrollment increase in 2014 and 2015.
- **$7.5M additional funding needed to support changes in financial data due to updates and changes in assumptions.** HRINY stated that it has increased the 2014 individual claim projection by approximately 1.7% and lowered the 2014 small group claim projection by 2.6% based on eight months of actual claim data. However, no further detail was provided to quantify the impact of the changes in assumptions to substantiate the need for the requested additional funding.

- **$18.8M in additional solvency loan funding needed to meet the 500% RBC requirement per loan agreement.** New York's Section 4310 of the insurance statutes requires the CO-OP to maintain a minimum reserve balance of 12.5% of net premium income as capital and surplus. However, HRINY stated that the DFS is requiring the CO-OP to maintain an RBC level of 500% of ACL as recommended by CMS, rather than the 15% of net premium income stated in its application of additional solvency loan funding submitted to CMS in June 2014 (P. 5). No further documentation is provided to substantiate this requirement. Additionally, there was no further documentation provided to support the assumptions used in the calculation. HRINY's projected RBC level remains above 500% of ACL with the additional solvency loan funding.

Base Case Scenario:

If projections are realized, HRINY projects a loss of $11.6M in 2014, but projects to be profitable thereafter, with earnings of $5.1M and $32.4M in 2015 and 2016, respectively, and with related profit margin of 0.4% and 1.6%, respectively (P. 50). The applicant projects an average profit margin as a percent of premium of 1.7%, which would result in cumulative net income of $1.5B from 2015-2034. HRINY projects RBC levels to stay above 500% of ACL during the entire performance period in the base case scenario, which assumes the requested additional solvency loan funding of $70.5M will be awarded in full (P. 51).

HRINY is projecting receivables from the 3Rs program from 2014 through 2016, specifically $12.6M in risk corridors in 2014, and net federal reinsurance recoveries in the amounts of $50.2M, $51.8M, and $20.3M in 2014, 2015, and 2016, respectively (P. 50). HRINY's latest projection of federal reinsurance recoveries has increased by $29M as compared to the cumulative federal reinsurance recoveries projected by HRINY in its June 2014 pro forma submissions to CMS. No further information was provided as to the reason for this increase.

The applicant is approved to increase its individual premium by 12.9% in 2014, which is 2% lower than its projected premium increase. HRINY is also approved to increase its small group premium by 3.5% in 2014, which is 2.4% less than projected premium increase for the small group market (P. 5). The applicant stated that the pro formas provided with this application and the additional solvency loan request is based on the average approved premium pricing (P. 36, 67). Despite these lower than projected premium increases, HRINY projects net income of $5.1M in 2015. The applicant projects premium increases of 11% and 10% in 2016 and 2017, respectively in the individual market (P. 73). If projections are realized, HRINY projects a cumulative net income of $1.5B from 2015 – 2034, which is higher than the total start-up and solvency loan obligations, including the additional solvency loan request of $70.5M. HRINY projects to start repayment of solvency loans in 2021 and continue to make repayments through 2031, until the total solvency loan obligation is paid in full.

The applicant states that it intends to become profitable in 2015 by increasing its premiums, making changes to its medical cost structure, and improving its processes; specifically through investing in technology to enable automation in enrollment and claims, and by renegotiating and reducing its vendor costs by 7% by 2015. The applicant also explains that the automation of enrollment and claims processes should reduce its costs due to avoiding incremental administrative staffing during open enrollment. To achieve a 7% reduction in vendor costs, HRINY notes it is currently pursuing a process to integrate independent vendors to achieve efficiency in its operations and also pursue a renegotiation of its vendor contracts (P. 80). HRINY relies upon its vendors for billing and enrollment, member and brokerage services, medical management, claims adjudication, provider network management, pharmacy benefits management, and website and data warehouse management (P. 79). While HRINY describes its vendor functions in detail, the applicant does not provide a budgeted schedule for its current vendor costs nor for its costs following contract renegotiations; therefore, the nature and impact of these cost reductions cannot be determined. Furthermore, no information was provided by the applicant to substantiate a 7% reduction in vendor costs.

Additionally, as described in the August 22, 2014 memo from CMS, the CO-OP was required to file a budget form as part of its application which would detail its expenses for 2014 through 2016. However, HRINY did not provide a budget detailing its expenses for 2014 through 2016. Additionally, per the New York State Department of Corporations, during 2014, the Freelancers Union has created two entities, Freelancers Union IPA, LLC and Freelancers Brokerage, Inc. There

is no information provided in the application that describes a relationship with these new entities. Excluding the lack of detail laid out in its budgeted costs, HRINY's pro forma income statement ties to its business plan, as the administrative cost ratio (ACR) is projected to decrease from 21.6% in 2014 to 16.9% in 2015 and 15.7% in 2016. HRINY's ACR ranges from 21.6% down to 12.5% through 2034, with an average ACR of 14.2%. Additionally, HRINY stated that a reduction in general and administrative costs per member will be 37% in 2015 and 10% in 2016 (P. 83). The applicant states that it expects to achieve these efficiencies; "despite growing fixed G&A expenses... due to greater scale, renegotiated contracts, and supplier efficiencies" (P. 83). However, as previously noted, the applicant does not provide a breakout of its administrative costs, nor does it provide a detailed summary of its expected costs savings or specifics on its renegotiated vendor contracts. Additionally, it doesn't appear that HRINY accounts for Marketplace fees within its projections. However, the applicant stated that the Marketplace fees are eliminated for 2014 and 2015 (P. 88). No supporting documentation was provided to verify this statement. The applicant does not project Marketplace fees in the pro forma throughout the entire performance period. Additionally, no detail was provided on the Marketplace fee the state would require insurers to pay beginning in 2016.

The applicant's MLR, including the impact of the 3Rs and without including the impact of ACA adjustments, is 81.6% and 82.7% for 2014 and 2015 respectively. As noted above, HRINY projects net recoveries of $50.2M, $51.8M, and $20.3M in 2014, 2015, and 2016, respectively, from the federal reinsurance programs. Additionally, HRINY projects to receive payment of $12.6M from risk corridors in 2014. Absent these recoveries from the 3Rs, HRINY's MLR will be 93.9% in 2014 and 87.0% in 2015, without including the impact of ACA adjustments.

HRINY projects to receive additional solvency loan funding in the amount of $70.5M and projects to draw down its full solvency awards by 2016 (P. 118). The applicant plans to fully repay the solvency loan by 2031, if projections are realized. Per the base case pro forma balance sheet, HRINY projects RBC level to remain above 500% throughout the performance period.

Stress Test Scenario:

Under the base case with a mild stress test scenario (stress test scenario), HRINY projects to receive increased additional solvency loan funding of $283.9M to combat a 10% increase in claims cost due to uncertainty in pricing. In the stress test scenario, the applicant asserts that rate increases were assumed to maintain a reasonable level of profitability to generate a surplus to enable it to pay off its solvency loan (P. 43). Revenues and administrative costs remain static, as evidenced by the same ACR as in the base case.

The primary difference of the stress test scenario as compared to the base case scenario is its projection of PDR. In the stress test scenario, HRINY projects a $102.M increase in change in reserves due to PDR in 2014. However, details relating to projecting this level of PDR were not provided in the application. This represents a net change of $105.8M in total expenses, resulting in a projected net loss of total $117.7M in 2014, with the assumption of receiving net reinsurance recoveries of $50.2M and a receipt of $12.6M in risk corridors payments. Absent recoveries from federal reinsurance program and risk corridors payments, 2014 losses would near $180.5M. Under this scenario, according to the applicant's pro forma balance sheet, the RBC level is projected to stay above 500% of ACL until 2029.

Summary of Observations:

- **10% or more in premium increases projected through 2017 for the individual market.** HRINY's ability to break even is contingent on increase in premiums by higher than 10% in 2015 and 2016. The applicant is approved to increase its 2015 premium for the individual market by approximately 13% in 2015 and projects to increase its premium by 11% in 2016 and 10% in 2017. It cannot be determined whether HRINY will be able to meet its projected enrollment and premium revenues as well as retain current members with this level of premium increases.
- **$102 M PDR projected in 2014 in stress test scenario.** In the stress test scenario, HRINY projected a change in PDR of $102.0M in 2014. However, no documentation supporting the analysis of the PDR was provided. The applicant recorded PDR of 5.2M in 2013.
- **Budget not provided for 2014 through 2016 to support proposed reductions in administrative expenses.** In the base case scenario, the applicant projects a 7% reduction in vendor costs through renegotiated contracts and also

projects to reduce its administrative expenses in 2015 and 2016. Additionally, the applicant stated that the overall reduction in administrative expenses per member will be 37% in 2015 and 10% in 2016. However, no details are provided by HRINY as to what the actual cost reductions are and with what vendors it expects to renegotiate its contracts. HRINY did not provide its budget or administrative costs per member to support the projected cost reductions.

- **Change in reserve requirement by the state DFS not substantiated.** HRINY stated that $18.8M of the total additional solvency loan funding request is to meet DFS's requirement for the applicant to meet the 500% RBC requirement as recommended by CMS. As noted within the Findings Report[10] the CO-OP is required to maintain a 12.5% of net premium income as capital and surplus per New York's Section 4310 of the Insurance statutes. However, HRINY stated that the New York DFS is now requiring the CO-OP to maintain an RBC level of S00% of ACL as recommended by CMS. No further documentation was provided to substantiate this requirement.

5. Contingency Plan:

The contingency scenario assumes $36.2M in additional solvency loan funding will be awarded rather than the $70.5M assumed in the base case scenario (P. 43). Combined with the current solvency loan funding award, the total solvency loan for HRINY under the contingency scenario would be $277.6M. The applicant did not provide pro formas for contingency scenario with no additional solvency loan funding as outlined in the August 22, 2014 memo from CMS.

As outlined in its application, HRINY discusses two scenarios in the event that the full additional solvency loan of $70.5M is not awarded: either identifying outside financing or scaling down its operations by increasing premiums higher than rates projected in base case scenario, withdrawing products, or withdrawing from service areas, so it can meet solvency requirements (P. 12 and 13). The applicant does not provide further detail on how it plans to secure outside financing (P. 5). However, the applicant mentions having taken outside expert counsel's opinion on "multiple alternative funding options, including lender financing, additional investments, and foundation grants" and concluded that none of the alternative financing options are feasible (P. 12).

HRINY stated that if only $36.2M of additional solvency loan funding is awarded, it relies on requesting premium rate increases of 12.5% for the individual market and 6.5% for the small group market in 2016 to self-fund its solvency (P. 12). In the event the $36.2M in additional solvency loan funding is not awarded to HRINY, the applicant projects 2016 rates for the individual market to increase by 14% while projecting rates for small group market to increase by 8% (P. 43). HRINY projects such increase in premium will slow membership growth by 50,000 in 2016 and an additional 30,000 in 2017 (P. 107). The applicant further stated that while the increase in premium will help the CO-OP to sustain its operation, "the impact would reduce the success and positive benefits of the CO-OP program in New York and diminish Health Republic's ability to execute on its mission" (P. 6).

In the contingency plan, the applicant plans to reduce its membership level by "product rationalization and service area withdrawal" (P. 107). However, no further detail is provided on which service areas the applicant plans to withdraw in the event of no additional solvency loan funding. As presented in the pro formas for the contingency scenario, HRINY projects average enrollment level to stay static through 2015 as projected in the base case scenario. HRINY projects enrollment projections in the contingency scenario to go down beginning in 2016 as compared to projections in the base case scenario. The pro formas provided for the contingency scenario assumes HRINY will receive an additional solvency loan funding of $36.2M.

The applicant's contingency plan represented in its pro forma income statement shows increased premium revenues per member as compared to its base case scenario. Table 8 below highlights enrollment projections, premium revenues, average gross premium revenues per member, and ACR for 2015 through 2020.

Table 8: Gross Premiums per Member and ACR Comparison: Base case vs. Contingency Plan

[10] HRINY Cooperative 7/18/2014 Findings Report (7/18/2014 Findings Report) provided to CMS on July 18, 2014

	2015	2016	2017	2018	2019	2020
Base Case Scenario						
Average Members	261,839	373,339	430,839	439,456	448,245	457,210
Net Premium Earned ($000)	1,234,680	1,916,341	2,384,669	2,557,487	2,742,791	2,948,450
Average Annual Gross Premium per Member ($000)	4.8	5.3	5.7	6.0	6.3	6.6
ACR	16.9%	15.7%	14.7%	14.5%	14.4%	14.3%
Contingency Plan Scenario (With $36.3M in Additional Solvency Loan Funding)						
Average Members	261,839	360,339	404,339	412,426	420,674	429,088
Net Premium Earned ($000)	1,234,680	1,875,481	2,269,186	2,433,725	2,610,161	2,806,011
Average Annual Gross Premium per Member ($000)	4.9	5.4	5.8	6.1	6.4	6.7
ACR	16.9%	15.6%	14.6%	14.5%	14.3%	14.2%

Summary of Observations:

- **HRINY projects $2.5B in cumulative profits through 2034 compared to its base case scenario.** In its contingency scenario, the applicant projects a cumulative net profit of $2.5B from 2015 – 2034. HRINY projects to earn $1.5B in cumulative net profits from 2015 – 2034 in the base case scenario, which is lower than the projected cumulative profit in the contingency scenario. The increase in projected cumulative profit in the contingency scenario may be attributable to the increase in premiums, as HRINY plans to increase its rates in the event the full amount of the requested additional solvency loan funding is not awarded.
- **Pro formas presenting enrollment and financial projection for a contingency scenario with no additional solvency funding not provided.** HRINY discussed several actions that it will implement in the event no additional solvency funding is awarded. However, no detail was provided to substantiate the impact of the proposed actions. Additionally, the proposed increases in premiums were not reflected in its pro formas for the contingency scenario. As a result, the impact of the contingency scenario with no additional solvency loan funding cannot be assessed.

Solvency Loan Request Points

Sections	Potential	Total
Enrollment	15	13
Product Pricing	20	16
Medical Costs and Losses	15	14
CO-OP Financials	15	9.5
Score	**65**	**52.5**

Contingency Plan Points

Contingency Plan	Potential	Total
Overall	10	0
Score	**10**	**0**

CoOportunity Health

Domiciled in Iowa

Additional Solvency Loan Funding Request Report

Date Submitted to CMS: 07/18/2014

Scope Summary & Assumptions:

- Deloitte will not provide an opinion regarding the reasonableness of the proposed changes to each CO-OP's business plan. Nor will Deloitte provide an opinion regarding the likelihood of each CO-OP achieving sustainable operations based upon the revised business plan.
- Deloitte assumes that the information provided by each CO-OP in its modified business plan is complete and accurate. Deloitte will perform its assessment of the data provided "as is". Deloitte will also use other data sources that are publicly accessible or information provided directly from the Centers for Medicare and Medicaid Services (CMS). Deloitte will notify CMS if we believe that there is insufficient information to complete our review.
- The impact of the Reinsurance, Risk Adjustment and Risk Corridors Program (the 3Rs, reinsurance, risk adjustment, and/or risk corridors) was reviewed when making observations and comments throughout this report. Observations and comments relating to the impact of the 3Rs are included for informational purposes only. There was no consideration of the reasonableness or propriety of any of the amounts relating to the 3Rs. Based on the scoring criteria provided by CMS, observations and comments relating to the 3Rs had a net neutral effect on the scoring.
- In reviewing applications from CO-OPs for additional solvency loan funding requests, Deloitte reviewed supporting documentation, requested of the applicants by CMS in a memo to the CO-OPs distributed on April 30, 2014. The format of the reports as well as the section scoring was approved by CMS during the week of June 2, 2014. The score for the Contingency Plan section should be viewed independently of scoring for the other sections of this report. For all sections, Deloitte provided comments on issues only for which the applicant provided data. Observations relating to the pro forma financial statements are based on the base case with additional solvency award scenario, unless otherwise noted.

Executive Summary:

CoOportunity Health (COH or CO-OP or applicant) has submitted a request to CMS for $32.7M of additional solvency loan funding. Of this request, $9.8M appears designed to cover 2014 operating losses. See the CO-OP Financials section for further details.

COH has exceeded its enrollment projections in the original[1] funding application, which the CO-OP attributes to the Medicaid/Iowa Marketplace Choice Plan (IMCP) federal waiver in Iowa, Exclusive Provider Product (EPO) product offering in select areas of Iowa, growth opportunities in urban areas, and tailored product strategies. As a result, COH is projecting a loss in 2014, but expects to be profitable in 2015 and 2016. The CO-OP intends to correct losses to achieve profitability by increasing premium rates by 17% in 2015. Rate increases above 10% proposed for any product will require federal review. No information was provided as to how this premium rate increase will impact the enrollee retention. COH does not project to reduce its administrative expenses in 2015, as it projects its administrative cost ratio (ACR) to stay at or above 15% of its premium revenue through 2020. COH states in its application if it does not receive the requested funding,

[1] All references to "original" – including, but not limited to, "original funding application," "original application," and "original projections" – refer to HCT's 2011 application for CMS start-up and solvency loan funding, operations commencing in 2014.

it may merge with another CO-OP or large healthcare entity or freeze enrollment. See the Contingency Plan section for further details.

When COH's requested $32.7M is combined with the current solvency loan funding award of $97.9M, COH's total solvency loan would be $130.6M. NOTE: the total solvency loan funding recorded in COH's pro forma financial statements (pro formas) in the best scenario is $116.7M, which is $13.9M less than the applicant requested. However, the applicant will still meet the risk based capital (RBC) level of 500% of authorized control level (ACL) throughout the entire performance period in the expected case, best case, and contingency plan scenarios. See the CO-OP Financials section for further details.

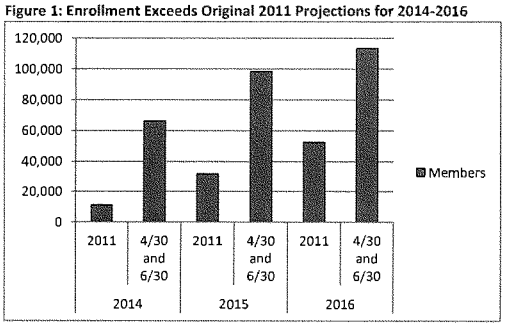
COH projects to receive a total of $94.8M in solvency loan funding by year end 2014, leaving $3.1M of obligated solvency loan funding undisbursed as of year end 2014. The original application's pro formas projected average enrollees of 53,332, which yields a per enrollee cost of $1,836. The updated pro formas are projecting average enrollees of 115,947 based on projected solvency loan proceeds of $116.7M, which yields a per enrollee cost of $1,006.

It appears COH may be utilizing CM5-funded infrastructure intended for commercial business to offer HSA eligible plans as part of its product mix. It is unclear whether this product option is only available to members enrolling on the Marketplace. In addition, the CO-OP may intend to use its CM5-funded infrastructure to target self-insured populations that will not contribute to the overall growth of actual CO-OP membership within the small and large group market segments. It cannot be determined what portion of the CO-OP's enrollment, if any, relates to this business. Please see the Enrollment section for further details.

Critical Assertions:

1. Enrollment

Figure 1: Enrollment Exceeds Original 2011 Projections for 2014-2016



Source: Applicant's 2011 Original Application, 4/30/14, and 6/30/14 Pro Formas

COH provided a revised business plan in June 2014, which includes updated enrollment projections. The updated enrollment projections indicate COH will achieve a total enrollment of 66,101 by year end 2014, which is 55,000 more than original projections. Based on the revised business plan, COH states current membership is 76,000 members but projects to achieve 75,000 by year end 2014 (P.3 and 90). Additionally, the pro forma financial statements (pro formas) submitted with the revised business plan indicate a total projected enrollment of 66,101 for 2014. In its additional solvency loan funding application, COH indicated it has achieved an enrollment level of more than 68,000 members by close of the open enrollment period in 2014 (P. 49). However, COH's regulatory filing for the first quarter in 2014 indicates that, as of March 31, 2014, COH has enrolled 50,740 members. While it is clear that COH has achieved more enrollment than its original application projection, no documentation or explanation is provided substantiating the reason for discrepancies in the actual current enrollment level.

Through April 2014, COH reports that approximately 40% of members were individuals that enrolled on the IA State Partnership Marketplace (IA Marketplace) or the NE Federally-facilitated Marketplace (NE Marketplace), while another 25% were individuals that enrolled off Marketplace (P. 4). The term 'Marketplace' indicates that a statement is applicable to both the Iowa and Nebraska Marketplaces. The remaining third is comprised of employer-sponsored plans, the vast majority (over 95%) of which is small businesses who enrolled in the open market (P. 4). As employer-sponsored plans are self-insured plans, the CO-OP would exclude the members from employer-sponsored plans in enrollment in its regulatory filings. Additionally, no further detail is provided to determine whether the CO-OP has included enrollments from employer-sponsored plans in its current enrollment projections.

As a result of this unexpectedly rapid growth, the CO-OP is experiencing challenges due to "higher premium and claims volume" (P. 3). Higher loss ratios, caused by the higher risk profile of a larger than expected number of its enrollees, are leading to cash flow and liquidity concerns relating to the timing of 3Rs payment receipts (P. 3). For these reasons, COH is applying for additional solvency loan funding to meet these challenges.

Membership growth is lower for 2015 and 2016 as compared to original projections. The majority of this decrease has been attributed to the "CO-OP having already captured some of these members and the fact that the Iowa regulator continues to allow Wellmark to renew non-compliant pre-ACA policies" (P. 7). The application does not break out the impact of non-compliant pre-ACA policies in its enrollment projections for 2014.

Overall enrollment for 2014 in Iowa and Nebraska is projected to exceed original projections by approximately 55,000 members. COH also projects to exceed original 2015 and 2016 projections by approximately 67,000 and 61,000, respectively. Over the entire performance period, COH expects to enroll 380,000 additional members than originally projected. The applicant did not provide any additional information on the projected breakout between on and off Marketplace enrollment. Therefore, it cannot be determined if the CO-OP will be in compliance with Title 45, Code of Federal Regulations (CFR) § 156.515(c)(1) and (d) relating to requirements for CO-OPs under the Affordable Care Act (ACA), which requires two-thirds of total members to be from the Marketplace.

The applicant does not provide a breakdown of its revised enrollment projections for individual, small group, and large group market segments. As a result, it cannot be determined whether its projected enrollment accounts for the change in small group and large group definitions in 2016, when the small group size changes from 1-50 to 1-100 employees, and therefore the large group size changes to begin at 101 enrollees. However, the applicant anticipates it will experience ongoing growth rates at much the same rate as the original projections, but from a higher base due to the higher capture rate in 2014. According to the applicant, due to its relative success in rural areas, COH projects it will maintain growth rates through the targeting of the more populous urban areas in both Nebraska and Iowa. It expects to meet its enrollment growth goals of 15,000 additional members per year in 2015 and 2016 through the growth of its individual and small group membership base (P. 7). However, it predicts the enrollment growth of 18,000 in 2017 will be "primarily due to changes opening up the large group market to the Marketplace" (P. 61). It is unclear whether this projected gain in large group enrollment includes enrollment from self-insured business. The applicant provides a list of assumptions underlying these estimates, but does not provide additional information discussing the impacts of these assumptions on its ability to meet enrollment projections in a specific market segment or targeted market (P. 62). Overall, COH expects that growth will ramp down to 7,000 new members in 2018, to 6,000 in 2019, and to 5,000 members in subsequent years (3-4% annually) (P. 62).

COH provided reasons in its revised business plan for the change in enrollment projections in specific market segments as compared to those provided in its original business plan. These reasons, along with COH's proposed actions, are provided in Table 1 below.

Table 1: Documentation Provided for Change in Enrollment Projections

Reasons Cited by COH for Higher Than Projected Enrollment	COH's Proposed Action	COH's Justification
Medicaid/Iowa Marketplace Choice Plan (IMCP) federal waiver in Iowa	1. **Target IMCP-eligible population.** Due to the federal waiver, individuals in Iowa earning between 101% and 138% of the Federal Poverty Level were allowed to enroll in private plans. COH was able to enroll nearly 33% more of the IMCP-eligible population than originally expected through June 2014 (8,000 total) (P. 92). COH will focus on using its customer service experience to retain current members and prevent enrollment shifts between carriers. While the CO-OP has not hired additional staff specifically targeting this population, it has added staff to accommodate additional customer call traffic (P. 92).	The applicant states projecting additional Medicaid enrollment is difficult because another carrier could be included in the statewide program and offered to existing members (P. 92). Determining enrollment rate shifts among existing members remains difficult to estimate as well. The applicant did not provide details on the source of its projection estimates. In addition, relative to its original application, the applicant increased its full-time equivalent level from 11 to 40 to accommodate increased customer traffic. However, it is not clear if the additional staff members are accounted for in the revised budget.
EPO product offering in select areas of Iowa	1. **Invest in staff to support narrow networks.** The applicant reached agreements with large health care organizations to bring narrow network products to the market featuring these large providers (P. 93). The CO-OP's product portfolio mix has been expanded to include an EPO and a "tiered" network providing customers with the best benefits if it used the affiliated providers (P. 93). The CO-OP added two additional staff members at an incremental cost of approximately $180,000 to negotiate provider contracts and manage ongoing provider communications.	COH states that among individual purchasers in Iowa, 75% (9,000 of 12,000 members) have chosen the EPO or tiered product (P. 93). Conversely, fewer than 20% of small or large group purchasers chose the narrower network options. Compared to original estimates, the CO-OP was able to expand upon its non-Medicaid enrollment by 17,000 due to these new products (P. 93). It cannot be determined if the costs for these additional staff members are included in administrative expenses. (P. 93) Additionally, no information was provided for costs other than staff.
Growth opportunities in urban areas	1. **Focus on meeting needs of consumers in key metropolitan areas.** COH formed relationships with the University of Iowa Health Alliance (UIHA) and providers in the major metropolitan areas of Iowa to attain	COH stated it developed a more price competitive EPO product in partnership with new providers and health care institutions in urban areas. The applicant did not provide documentation of the impact these price changes would have on enrollment in specific market segments.

	a better price position vis-à-vis competitors.	
Tailored product strategies	1. **Target minority communities.** COH continues to use "innovative" marketing tools to target specific populations (P. 53). It enrolled in the IMCP, tailored to low-income populations, and worked with community groups and community health centers to capture minority groups, young people and families.	COH stated that it captured 33% more IMCP-eligible enrollees than projected (8,000 vs. 6,000) in 2014 (P. 62). However, the applicant did not provide a breakdown of the demographics of these enrollees. While it did provide a general demographic breakdown of its enrollees in Iowa and Nebraska, COH did not provide a comparison to its original projections among these populations.
	2. **Target employers.** COH will continue to form alliances with associations, technology companies, and other affinity organizations to provide a tailored set of products to the employer market, especially small employers (P. 53).	The applicant introduced features such as "Three-for-Free" and "Healthy Rewards," as well as standard plans and HSA-eligible plans at each metal level. While this was cited as a reason for increased market share on the Marketplace, the applicant did not provide any documentation of this claim.
	3. **Utilize health systems.** COH introduced a "tiered" product option to the Iowa market after reaching an agreement with UIHA to feature it as the "top tier" in a product that offered better benefits to people using that network. UIHA ultimately offered to use the tiered product in every county in Iowa and the EPO in 76 of the 99 counties.	The applicant states the strategy ultimately led to most individual purchasers choosing the tiered or EPO product based on price and that group purchasers overwhelmingly chose the broad PPO plan (P. 10). The applicant did not provide a breakdown of the enrollment in each of these plans or their direct impact on future enrollment projections.

Summary of Observations:

- **Enrollment projections were exceeded.** According to the CMS CO-OP Enrollment Comparison Report as of 4/30/2014 (Data Summary) and the applicant's 4/30/2014 pro formas, the enrollment projections were exceeded by nearly 16% through the end of the first enrollment period. The revised business plan's projection of 75,000 total enrollees for all of 2014 has already been exceeded, as of the June 2014 application for additional solvency loan funding. The applicant has not provided a breakdown of future enrollees into the large, small, and individual market segments beyond 2015. Although the revised business plan discusses the markets to be targeted going forward, it does not provide any enrollment projection estimates for these markets. Finally, the enrollment estimates summarized in the revised business plan are based upon the figures provided in Exhibit 1. (P. 90).
- **The enrollment estimates between application and pro formas differ, at times, by over 20,000 per year.** The assumed enrollment levels in Exhibit 1 in the application are 75,000 in 2014, 90,000 in 2015, 105,000 in 2016, and 123,000 in 2017 (P. 90). By comparison, the estimates in the pro formas provide enrollment estimates of approximately 66,000 in 2014, 116,000 in 2015, 133,000 in 2016, and 148,000 in 2017. (P. 127). The reason for the differences is not described in the application; where application and pro formas assumption differ, it is the numbers in the pro formas that are assumed to take precedence.
- **Enrollment population is higher risk than previously forecast.** The applicant states the primary reason for requesting additional solvency loan funding is due to higher premium and claims volume, higher loss ratios, and a

higher risk enrollment population than previously forecast. Due to the uncertainty of its enrollment projections and the risk profile of future enrollees, it is unclear that the requested amount of additional solvency loan funding reflects the amount required to meet the CO-OP's future capitalization and liquidity requirements during the growth projected during 2014-2017.

- **Use of CMS-funded infrastructure to offer HSA eligible plans and self-insured administration.** It appears the CO-OP may be utilizing CMS-funded infrastructure intended for commercial business to offer HSA eligible plans as part of its product mix. It is unclear whether this product option is only available to members enrolling on the Marketplace. In addition, the CO-OP may intend to use its CMS-funded infrastructure to enroll self-insured populations that would not be included in the overall enrollment projections for the small and large group market segments. It cannot be determined what portion of the CO-OP's enrollment, if any, relates to self-insured business. CMS may want to consider discussing this issue further with the CO-OP.
- **Breakout of on and off Marketplace enrollment not provided.** It cannot be determined if the CO-OP will be in compliance with Title 45, Code of Federal Regulations (CFR) § 156.515(c)(1) and (d) relating to requirements for CO-OPs under the Affordable Care Act (ACA), which requires two-thirds of total members to be from the Marketplace.

2. **Product Pricing**

COH's 2014 enrollment was higher than anticipated. The applicant's products are distributed through multiple channels and, according to the applicant, have growing acceptance. The growth in enrollment has been higher than expected. These levels were not forecasted to occur until 2020 in the original application (P. 3).

In Iowa, Wellmark Blue Cross Blue Shield has captured more than 80% of the individual product and 50% of the small-group product market share. In Nebraska, Blue Cross and Blue Shield of Nebraska has captured about 60% of the individual product and 40% of the small-group product market share (P.16).

The CO-OP has lower 2014 premiums in three of the four rating areas of Nebraska in the individual market and in the small-group market everywhere. In Iowa, the CO-OP has higher silver plan premiums than competitors by as much as 20% in most rating areas, other than one, where its premiums are the lowest. According to the CO-OP, its small-group rates were very competitive statewide (P. 12). Tables 2, 3, 4 and 5 below show the CO-OP's premiums compared to other competitors within each area. COH does not have the lowest premiums for individual for most rating areas on the IA Marketplace; however, COH does have the lowest premiums for most rating areas on the NE individual Marketplace. For the small group market, COH has the lowest premiums in all rating areas on the IA and most of the rating areas on the NE Marketplace.

According to the applicant, the effects of early renewal, transitional policies, and steerage of high risk customers in both IA and NE have all combined to raise their average claims loss ratio significantly. COH believes part of this increase may be due to "pent-up demand" factors (P. 40). COH is also projecting a $10M loss in 2014. As a result, COH may need to consider establishing a premium deficiency reserve (PDR) to address the loss in 2014, as well as any need for PDR related to these products. The PDR would also impact the applicant's surplus.

Per page 3 of 'Milliman Memo IA Indvdl Rate Filing.pdf,' for the Iowa individual market, COH's proposed rates effective January 1, 2015 reflect a 7.0% and 12.3% rate increase for the Premier and Preferred products, respectively. The proposed rate change does not vary by region but does vary by plan. There are no significant changes in cost sharing or rating factors (e.g., age, tobacco) in this rate filing, other than changes to the base premium rate and rate relativities by plan. The requested rate change varies by plan due to provider reimbursement changes and revised benefit relativities. Base rate changes are the result of medical inflation, utilization, provider contracts, taxes and fees, federal reinsurance program changes, morbidity, expenses, and profit margin.

The projected loss ratio, including the impact of the ACA adjustments, is 85.4%. ACA adjustments include such items as quality improvement expenses and taxes/fees. With rate increase of upwards of 10%, there is no mention of how it will impact retention of current members. The pro formas show an average increase in premiums of 17% in aggregate from

2014 to 2015 and a 6% decrease in costs. It is unclear how the rate increases discussed within the 2015 rate filings tie to the aggregate changes within the pro formas.

Per page 3 of 'Milliman Memo Indvdl Rate Filing.pdf,' for the Nebraska individual market, COH's proposed rates effective January 1, 2015 reflect a 7.9% rate increase for the Premier product. The proposed rate change varies by region and plan. There are no significant changes in cost sharing. This rate filing includes changes to the base premium rate, rate relativities by plan, and area factors. The requested rate change varies by plan due to provider reimbursement changes and revised benefit relativities. Base rate changes are similar to those mentioned above for the Iowa market.

The projected loss ratio, including the impact of the ACA adjustments, is 81.3%.

Per page 5 of 'IA 5m Grp Milliman.pdf,' for Iowa small group market, preliminary 2015 pricing indicates COH needs to increase rates approximately 3.9% and 8.6% for its Premier and Preferred products, respectively. COH will be terminating its Choice Product at the end of 2014 and introducing its CorePlus product during 2015 in the Iowa small group market. No explanation was provided in the 2015 rate filing for these changes in products.

The applicant has provided the 2015 rate filing memos for Iowa and Nebraska individual markets, but only a preliminary 2015 pricing memo for the Iowa small group market. The applicant does not provide a 2015 rate filing memo or a preliminary 2015 pricing memo for the Nebraska small-group market. This component of the market represents approximately 10% of the total enrollment within the two states (P. 336-337).

The applicant is considering expanding coverage into eight counties in far western Illinois. Per the applicant, people from this area go to hospitals in the Quad Cities as well as Dubuque, Clinton, Muscatine, Burlington, and the University of Iowa. COH has "had discussions with Illinois regulators, who are receptive to the plan assuming support comes from the Department of Human Services (DHS) and CMS" (P. 7). The applicant does not identify how much, if any, of the additional solvency loan funding would be used for expansion into Illinois.

Per page 3 of 'Milliman Memo Indvdl Rate Filing.pdf' and 'Milliman Memo IA Indvdl Rate Filing.pdf,' since the CO-OP is a start-up operation, the initial estimates for the individual business are based on industry data and adjusted by the CO-OPs external actuary to fit COH's specific situation.

Tables 2 and 3 provide a comparison for the 2014 single age 27 premiums for the CO-OP versus competitors with the lowest premium product across one of the same rating areas in the Iowa and Nebraska individual Marketplaces, whereas, Tables 4 and 5 provide similar information in the Iowa and Nebraska small group Marketplaces. Highlighted areas denote the lowest premium for the particular area.

Table 2: 2014 Premiums on the Iowa Individual Marketplace

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Bronze	Bronze	168.86	145.28	172.79	178.53	171.98	168.54	169.36
Coventry Health Care of Iowa Inc.								
Bronze Deductible Only HMO HSA Eligible Methodist Health Partners	Bronze				162.28			
Bronze Deductible Only POS HSA Eligible Patient Preferred	Bronze			157.94				
Bronze Deductible Only POS HSA Eligible UnityPoint Health	Bronze					133.48	132.22	140.15
Bronze Deductible Only POS HSA Eligible UnityPoint Health û Des Moines	Bronze	166.28	122.17					
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Silver	Silver	209.39	180.15	214.27	221.38	213.26	208.99	210.01
Coventry Health Care of Iowa Inc.								

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Silver $10 Copay HMO Methodist Health Partners	Silver				209.23			
Silver $10 Copay POS Patient Preferred	Silver			203.65				
Silver $10 Copay POS UnityPoint Health	Silver					172.14	170.52	180.74
Silver $10 Copay POS UnityPoint Health û Des Moines	Silver	214.42	157.54					
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Gold	Gold	246.76	212.29	252.51	260.88	251.30	246.28	247.47
Coventry Health Care of Iowa Inc.								
Gold $5 Copay HMO Methodist Health Partners	Gold				236.22			
Gold $5 Copay POS Patient Preferred	Gold			229.92				
Gold $5 Copay POS UnityPoint Health	Gold					194.37	192.53	204.08
Gold $5 Copay POS UnityPoint Health û Des Moines	Gold	242.10	177.88					
Avera Health Plans								
Avera MyPlan $250 / 10% Coinsurance	Platinum			385.12				385.12
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Platinum	Platinum	295.72	254.42	302.61	312.65	301.17	295.16	296.59
Gundersen Health Plan, Inc.								
Platinum $500 - 20%	Platinum						407.13	407.13
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Catastrophic	Catastrophic	154.09	132.57	157.68	162.91	156.93	153.79	154.54
Coventry Health Care of Iowa Inc.								
Catastrophic 100% HMO Methodist Health Partners	Catastrophic				110.64			
Catastrophic 100% POS Patient Preferred	Catastrophic			107.67				
Catastrophic 100% POS UnityPoint Health	Catastrophic					90.96	90.10	95.50
Catastrophic 100% POS UnityPoint Health û Des Moines	Catastrophic	113.33	83.27					

Table 3: 2014 Premiums on the Nebraska Individual Marketplace

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus $4750 HDHP Bronze	Bronze	161.58	161.58		
CoOportunity Health					
CoOportunity Premier HSA Bronze	Bronze	205.85	164.49	153.30	152.92
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus $1500 HDHP Silver	Silver	210.13	210.13		
CoOportunity Health					
CoOportunity Premier HSA Silver	Silver	240.98	192.56	179.45	179.01

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Blue Cross and Blue Shield of Nebraska					
BlueEssentialsPlus $1000 Gold	Gold	329.62	329.62	329.62	329.62
CoOportunity Health					
CoOportunity Premier HSA Gold	Gold	280.75	224.33	209.08	208.55
Coventry Health Care of Nebraska Inc.					
Gold $5 Copay HMO Methodist Health Partners	Gold	251.81			
CoOportunity Health					
CoOportunity Premier Platinum	Platinum	333.00	266.10	247.99	247.37
Blue Cross and Blue Shield of Nebraska					
BlueEssentialsPlus $6350 Catastrophic	Catastrophic	157.57	157.57	157.57	157.57
CoOportunity Health					
CoOportunity Premier Catastrophic	Catastrophic	191.26	152.83	142.42	142.08
Coventry Health Care of Nebraska Inc.					
Catastrophic 100% HMO Methodist Health Partners	Catastrophic	113.51			
Catastrophic 100% POS Plan	Catastrophic	133.18	128.81	129.60	133.18

Table 4: 2014 Premiums on the Iowa Small Group Marketplace

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Avera Health Plans								
Avera $2,000 / 50% coinsurance	Bronze			265.61				265.61
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Bronze	Bronze	151.12	130.01	154.63	159.77	153.90	150.83	151.55
Gundersen Health Plan, Inc.								
Bronze HSA $5000 - 30%	Bronze						196.05	196.05
Health Alliance-Alegent Creighton Health Partner								
Guide HMO QHDHP 3150/6300 40% 6350/12700 Rx3	Bronze				220.53			
Sanford Health Plan								
Simplicity $3,000	Bronze			214.11				214.11
Avera Health Plans								
Avera $2,000 / $4,000 Out-of-Pocket	Silver			262.68				262.68
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Silver	Silver	190.32	163.74	194.75	201.21	193.83	189.95	190.87
Gundersen Health Plan, Inc.								
Silver HSA $2000 - 20%	Silver						262.28	262.28
Health Alliance-Alegent Creighton Health Partner								
Guide HMO 30/60 2400/4800 30% 6000/12000 Rx3	Silver				247.21			
Sanford Health Plan								
Simplicity $2,000	Silver			263.14				263.14

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Avera Health Plans								
Avera $750 / 30% coinsurance	Gold			316.34				316.34
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Gold	Gold	220.50	189.70	225.63	233.12	224.57	220.07	221.14
Gundersen Health Plan, Inc.								
Gold $2000 - 0%	Gold						304.59	304.59
Health Alliance-Alegent Creighton Health Partner								
Guide HMO 25/50 1600/3200 10% 4000/8000 Rx2	Gold				302.14			
Sanford Health Plan								
Simplicity $1,500	Gold			297.18				297.18
Avera Health Plans								
Avera $250 / 10% coinsurance	Platinum			361.49				361.49
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Platinum	Platinum	257.55	221.57	263.54	272.28	262.29	257.04	258.29
Gundersen Health Plan, Inc.								
Platinum $500 - 20% $15 OV	Platinum						335.17	335.17
Sanford Health Plan								
Simplicity $500	Platinum			337.22				337.22

Table 5: 2014 Premiums on the Nebraska Small Group Marketplace

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 403 HDHP Bronze	Bronze	201.85	201.85	195.85	209.84
CoOportunity Health					
CoOportunity Premier HSA Bronze	Bronze	213.70	170.72	159.07	158.67
Coventry Health Care of Nebraska Inc.					
Bronze Essential #2 HMO Plan S	Bronze	272.62	263.67	265.29	272.62
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 402 HDHP Silver	Silver	255.28	255.28	247.70	265.39
CoOportunity Health					
CoOportunity Premier HSA Silver	Silver	251.74	201.11	187.38	186.91
Coventry Health Care of Nebraska Inc.					
Silver Security #2 HMO Plan S	Silver	314.39	304.07	305.95	314.39
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 401 Gold	Gold	355.81	355.81	345.24	369.90
CoOportunity Health					
CoOportunity Premier HSA Gold	Gold	289.57	231.33	215.54	215.00
Coventry Health Care of Nebraska Inc.					
Gold Freedom #3 HMO Plan S	Gold	368.21	356.12	358.31	368.21

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Health Alliance-Alegent Creighton Health Partner					
Guide HMO 25/50 1600/3200 10% 4000/8000 Rx2	Gold	287.01	275.64		
CoOportunity Health					
CoOportunity Premier Platinum	Platinum	339.35	271.10	252.60	251.96

Summary of Observations:

- **COH is projecting a $10M loss in 2014.** To address these losses, the CO-OP may need to consider establishing a PDR. This would also impact the applicant's surplus.
- **2015 premiums will increase compared with the 2014 premiums, pending approval.** According to the applicant, 2014 enrollment was much higher than anticipated. For the Iowa individual market, COH's proposed rates effective January 1, 2015 reflect a 7.0% and 12.3% rate increase for the Premier and Preferred products, respectively, and for Nebraska individual market, proposed rates reflect a 7.9% rate increase for the Premier product. For the Iowa small group market, COH proposes a 3.9% and 8.6% rate increase for its Premier and Preferred products, respectively. No information was provided about rate increases for the Nebraska small group market. With rate increase of upwards of 10%, there is no mention of how the applicant hopes to retain its members.
- **Change in products in 2015.** COH will be terminating its Choice Product at the end of 2014 and introducing its CorePlus product during 2015 in the Iowa small group market. No explanation was provided in the 2015 rate filing for these changes in products.
- **Changes to small group premiums could not be determined.** The 2015 individual rate filing memorandum for Nebraska small group and Iowa small group was not provided. This document typically provides the detailed reasoning for changes from the prior year premiums. Additionally, the pro formas do not provide premiums for each market.
- **The 2015 small group rate filing includes a breakdown of taxes and fees, which does not include an estimate for the health insurer fee.** Milliman published a research report titled " ACA Health Insurer Fee – Estimated Impact of the US health insurance industry," dated April 2013, which states the 2014 health insurer fee estimate is 1.7% to 2.4% and increases to 2% to 2.9%. Since COH is a 501c(29) not-for-profit entity, the insurer fee estimate would be lower than the industry average. COH does not include an estimate for the health insurer fee; however, it includes an estimate for Marketplace fees associated with selling plans on the Marketplace. The CO-OP assumed 0.9% of premiums for this fee.

3. Medical Costs and Losses

COH projects combined medical loss ratios (MLR), including the impact of the ACA adjustments, of 100.8%, 82.7%, and 83.2% for years 2014, 2015 and 2016, respectively. The MLR for 2014 includes individual and small group business only. For 2015 and 2016 estimates, large group business is included. COH also is estimating receivables for risk adjustment, reinsurance and risk corridors for 2014. The largest receivable is risk corridors with $41M in receivables estimated for 2014. Including the $64M in 3Rs receivables for risk corridors and reinsurance for 2014 would result in a $10.5M loss and result in an MLR of 101%, including the impact of the ACA adjustments. Removing the estimated $64M in receivables would result in a $70.1M loss and increase the MLR, excluding any adjustments for the ACA for all products combined to 109%. The 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit.

Based on a review of the regulatory filing as of 3/31/2014, the MLR is approximately 89%, excluding any impact of the ACA. If this experience were to continue, the CO-OP would face losses. Typically, one quarter's experience cannot be extrapolated to the entire year and, therefore, more months of experience will be needed to make a conclusion. The CO-OP is projecting the 2014 MLR to be 84%, excluding any impact for the ACA.

The CO-OP's product offerings in the Nebraska and Iowa Marketplace are noted in Tables 2, 3, 4 and 5 below. The CO-OP was able to get more than 60,000 members enrolled in the individual market, even though Blue Cross and Blue Shield of Nebraska had a majority of the individual product market share since its premiums were lower than competitors in three of the four rating areas. The applicant believes by "utilizing three key general agencies and a number of retail brokerages, it was able to market successfully across the state" (P. 49). The CO-OP believes that it was able to roll out innovative and competitive products, which helped fill market voids in both the individual and small group market by utilizing the broad-based provider network of Midlands Choice, a PPO owned by Nebraska's largest provider system (P. 5).

In Iowa, the premiums for products by its only statewide Marketplace competitor, Coventry Health, were lower than the CO-OP in most rating areas. The applicant believes it was able to enroll more than expected membership through strong branding, favorable media coverage, targeted communications, affiliations with key constituencies, and a partnership with the University of Iowa Health Alliance (UIHA), a collaborative of Mercy Health Network (about 40 hospitals), Mercy Medical Center in Cedar Rapids, Genesis Health System, and the University of Iowa Hospitals and Clinics (P. 5).

COH is anticipating a different morbidity estimate for 2015 compared to 2014 business. Because of this, the applicant is making an adjustment to the premiums. This change is, in part, due to the pent-up demand of individuals in the first year of coverage. The 2014 rate filings show the adjustments COH used to estimate to account for the pent-up demand, among other items. For Iowa, the CO-OP applied a 30.2% adjustment to premium. For Nebraska, the CO-OP applied a 25.6% adjustment to premium.

COH does not have enough experience in the base period to use in rate development; therefore, the 2015 rate development is based solely on manual rates.

Summary of Observations:

- **COH expects 2015 morbidity to be worse than 2014 pricing morbidity.** The applicant is projecting its individual 2014 claims per member per month (PMPM) with a 30.2% morbidity adjustment to account for the anticipated health status change for Iowa and 25.6% for Nebraska.
- **2015 medical costs are based on industry data.** COH does not have enough 2014 experience to have data to rely upon; therefore, industry assumptions are necessary to estimate the morbidity of the projected membership.
- **The risk corridors and risk adjustment receivables are difficult to quantify.** This is because of the uncertainty of the industry average morbidity. Risk corridors is calculated after risk adjustment therefore relies upon the risk adjustment estimate. Without these receivables, COH would have a loss of $70.1M for 2014 instead of the $10.4M projected in the pro formas.

4. CO-OP Financials

COH's pro formas project recoveries from the 3Rs for 2014 through 2016. In the best case membership scenario, COH projects cumulative federal reinsurance recoveries of $71.5M for 2014 through 2016, while it projects to recover $64M under the expected membership scenario and $54.8M under the worst case membership scenario during the same period. COH also projects to receive an additional $41.4M from risk corridors and $686K from risk adjustment in 2014 under all scenarios. From 2014 through 2016, COH projects a cumulative net profit of $11.8M, $8.5M, and $4.1M under the best, expected, and worst case membership scenarios, respectively (P. 124-133). However, absent recoveries from risk sharing and risk corridors, and risk adjustment, COH will incur a cumulative net loss of $89M, $86.1M, and $82.9M in the best, expected, and worst case membership scenarios, respectively, during the same 2014-2016 period. COH projects RBC levels to stay above 500% of ACL during the entire performance period under all scenarios projected by the applicant, if realized.

COH is requesting additional solvency loan funding of $32.7M, of which $9.8M is requested for the purpose of covering operational losses during 2014. COH states that the additional solvency loan funding is requested to meet state RBC requirements in light of higher than projected enrollment and also to add incremental cash flow that may result as a result of delay in receipts relating to receivables from transitional reinsurance recoveries (P. 41). The CO-OP has entered into a

line of credit and believes that required CMS waiver will be received to enable the 3R receivables to be acceptable to the lender as "collateral" (P. 87). The applicant provides a breakout of solvency loan funding requested based on solvency needs as presented below (P. 41).

Meet 500% RBC requirement per Best Case enrollment	$20.9 million
Added RBC to offset private credit line	$2.0 million
Increment to meet potential cash deficit	$9.8 million
Total Solvency Loan funding Request	**$32.7 million**

Combined with the current solvency loan funding award, the total solvency loan for COH would be $130.6M. However, the total solvency loan funding recorded in the COH's expected scenario pro formas, including the loan funding schedule for the expected scenario, is $108.5M, which is $22.1M less than the applicant requested. The observations noted in this section are based on the loan amounts reflected in the expected scenario pro formas.

Per CMS's CO-OP Summary Report by Borrower (Loan Tracker), as of June 2014, the CO-OP has been awarded total funding of $112.6M ($14.7M in start-up loans and $97.9M in solvency loan funding), and began issuing health insurance products beginning in 2014. $70.8M of the total solvency loan obligated has been disbursed to COH, with $27.1M of obligated but undisbursed solvency loan funds. A review of the original application indicates the solvency loan disbursement of $97.9M was to be disbursed from 2013-2020. The current pro formas are projecting $108.5M to be disbursed from 2013-2017. It is not clear why the applicant revised the timing of the loan disbursements, as it appears the applicant continues to project RBC levels of at least 500% of ACL throughout the entire performance period. Also, with no further award of solvency loans, COH claims it will continue to meet the recommended 500% throughout the entire performance period in the contingency plan scenario.

To cover short term cash flow issues, COH received a $2M revolving credit that was available beginning in 2014. This loan amount is recorded as a liability in the pro forma balance sheet. According to the CO-OP, this revolving credit line was obtained to cover short term working capital needs that will result due to the delay of receipt of the recoveries from the federal reinsurance program s. COH projects to receive approximately $21.8M in recoveries from the federal reinsurance program for 2014. In its application for additional solvency loan funding, the applicant stated that "the collateral in the form of an account receivable is created as claims are incurred and is not dependent upon market averages or future data. The asset is a federal receivable from CMS although to be usable as collateral it will require written assignability from the holder to the lender which will require a CMS waiver" (P. 42). Per COH's pro forma cash flow statement, it appears the applicant projects to repay the loan on an annual basis and projects to utilize the revolving credit through 2016, the year risk sharing and risk corridors will be eliminated. It appears COH is relying on the recoveries from 3Rs to cover the repayment for this loan. In the absence of these recoveries, COH will be incurring losses through 2016 and it is not clear how it projects to repay this loan if projections are not realized.

Best Case Scenario

The original solvency loan award was provided to COH based on enrolling 53,332 average members from 2014-2020. The average enrollment based on the best case scenario is 115,947 average members for the same period, which is projected to support the $116.7M of expected total solvency loan funding. If no additional solvency loan funding is awarded, the current award of $97.9M is projected to support 66,101 members. Per COH's regulatory filing for the first quarter of 2014, it appears it has enrolled 50,740 members, which is greater than the original application enrollment projection (COH Quarterly Statement, as of March 31, 2014, P. 7). The most recent enrollment projection indicates that COH projects to grow its 2014 membership level to 66,101 by the end of the year. The best case scenario projects the current enrollment level to be "increased by higher numbers in early years reflecting the potential for both higher retention of existing customers as well as less competition from both BCBS plans and Coventry in IA and NE markets" (P. 39). However, details were not provided to document why the applicant is assuming less competition from its competitors.

COH's loan schedule projects to receive the disbursement of the entire amount of the originally obligated solvency loan funding by 2017. If projections are realized, COH projects to start repayment of interest on the solvency loan in 2019 and

interest and principal payments in 2021. COH projects to continue to make annual repayment through 2032, until the loan is paid in full, if projections are realized. However, given that the solvency loan amount reported COH's pro formas is less than the cumulative solvency loan amount (current award plus additional requested funding), the impact of the full solvency loan amount on COH's pro formas is unknown.

COH projects to achieve profitability beginning in 2015, with projected net income of $8.2M. If projections are realized, it projects to make a cumulative net profit of $854.5M from 2014-2033 (P. 128), with related average profit margins of 2.2% over the same period. These net income projections consider a cumulative reinsurance recoveries of $71.5M from 2014 through 2016 (P. 127). Absent these recoveries, COH will incur losses through 2016.

COH projects a MLR of 84% in 2014, 80% in 2015, and 81% in 2016, which does not include the impact of the ACA adjustments. COH projects to recover $21.8M, $28.8M, and $20.8M of its incurred claims from federal reinsurance programs in 2014, 2015, and 2016, respectively (P. 127). Absent the level of federal reinsurance recoveries and excluding the impact of the ACA, the MLR for 2014, 2015, and 2016 is projected to be 106%, 85%, and 84%, respectively. No detail was provided in the application to explain the decline in the projected MLR of 21% between 2014 and 2015.

In its business plan, COH states it has a reinsurance agreement with Partner Re with an attachment point beginning at $500,000, a reinsurance rate above the attachment point of 90%, and a reinsurance limit of $5M per member per agreement period (P. 83). The projected medical loss recoveries from its commercial reinsurance policy is projected at $2.3M, $4.3M, and $5.3M for 2014, 2015, and 2016, respectively (P. 127). Given the federal reinsurance for 2014 and 2015 are capped at $250,000 for individual reinsurance coverage, the CO-OP may have a gap in its reinsurance policy from $250,000 to $350,000 in years 2014 and 2015. The 2016 federal reinsurance cap has not yet been determined.

COH projects an ACR of 22% in 2014 and 18% in 2015. COH's administrative expenses for 2014 are budgeted at $24.3M, which consists of salaries and wages of $5.2M, contractual expenses of $15.8M; and $3.3M of other expenses. COH does not project to reduce its administrative expenses in 2015. COH projects its ACR to stay at or above 15% of its premium revenue through 2020.

Expected Membership Scenario

Under base case with additional solvency loan funding scenario (expected scenario), COH projects lower enrollment growth than the best case scenario. COH projects to break even and begin profitability in 2015 with projected net income of approximately $7M in 2015 and $11.9M in 2016. These net income projections consider reinsurance recoveries of $24.4M in 2015 and $17.7M in 2016 (P. 123). Absent these recoveries, COH will incur a loss of 17.4M and $5.8M in 2015 and 2016, respectively.

If projections are realized, COH projects to make a cumulative net income of $659.6M from 2014-2033 (P. 124). COH does not project its MLR and ACR to change between the best case and expected membership scenarios.

COH projects to draw down a cumulative solvency loan amount of $108.5M under the expected membership scenario, which is $22.1M less than the total solvency loan funding (original funding plus additional solvency loan requested) (P. 124). No explanation is provided detailing the discrepancies between the cumulative solvency loan funding amount recorded in the pro formas and total solvency loan funding requested in the application. COH projects the solvency loan draw down and repayment schedule for the expected membership scenario to remain the same as the best case membership scenario.

Summary of Observations

- **Total solvency loan amount per COH loan schedule does not agree with CMS loan disbursement schedule.** COH is requesting an additional solvency funding of $32.7M. When added to the current solvency loan funding level of $112.6M per the Loan Tracker, total solvency loan disbursements to this CO-OP will be $130.6M. However, per the COH's pro formas, including the loan schedule, the total solvency loan amount recorded is $116.7M.

- **Losses are projected absent recoveries from federal reinsurance programs.** COH projects to break even and achieve profitability in 2015. At the same time, it projects to recover $28.8M and $20.8M from federal reinsurance programs in 2015 and 2016, respectively, under the best case scenario. Absent these recoveries, COH is projected to incur a net loss of $20.5M and $6.9M in 2015 and 2016, respectively. Also, COH projects to recover a cumulative amount of $63.2M in 2014 from the 3Rs ($41.4M from risk corridors and $21.8 from risk sharing). Despite these projected recoveries, COH still projects to sustain a loss of $10.5M in 2014.

5. Contingency Plan

COH stated that the underwriting losses it experienced during the first quarter of 2014 is averaging over 5% in excess of premium, which is causing an underlining liquidity concern (P. 42). See the Product Pricing section for further details. Additionally, COH projects a recovery of $41.4M from the risk corridors. This may indicate the applicant's 2014 premium is underpriced as compared to the market. As noted in the CO-OP Financials section, COH's projected MLR for 2014 is 84%, excluding the impact of the ACA. MLR and ACR are projected to stay at the same level as the best case membership scenario. RBC levels are also projected to stay above 500% of ACL at all times under all scenarios. The contingency plan projects to draw down the remaining balance of the current solvency loan funding in 2014 (P. 134).

COH considers the following options under its contingency plan. CMS may want to consider discussing this contingency plan with the CO-OP to further understand its implication in the context of program compliance requirements of the CO-OP program.

- **Merger with another CO-OP:** COH intends to merge with another failing CO-OP with unexpended solvency loan funding to indirectly acquire solvency loan funding (P. 43). However, it is not clear how COH plans to identify and incentivize failing CO-OP. Additionally, the applicant did not detail a plan to manage the impact of its expansion into another failing CO-OP's state on current operations.
- **Merge or affiliate with another large healthcare entity:** COH considers the opportunity to merge with another large healthcare entity if additional solvency loan funding is not provided by CMS. COH further stated that "---, the ability of a nonprofit Section 1322 cooperative insurer to seek additional external capital for other than known and collateralized operating cash flow requirements is quite limited due in part to the restrictions of the enabling statute and in part to the limitations of a non-profit cooperative" (P. 44). It is not clear how COH intends to achieve this plan without a technical default on its loan agreement with CMS.
- **Freeze enrollment:** COH projects to freeze enrollment by withdrawing from "small and large group markets in either or both of Iowa or Nebraska; consider withdrawing from the FFM in one or the other state; raise product prices...[for on and off Marketplace for] individual products to shift enough customers away from coverage so that the solvency capital required for that level of enrollment is less than the $97.9 million currently available" (P. 44). The total solvency loan funding amount recorded on COH's pro formas for the contingency plan, including the loan funding schedule, is $94.8M, which is $3.1M less than the current award amount (P. 133, 134).

COH indicated the purpose of the additional solvency loan funds request is to meet the state solvency requirement, and also to cover working capital shortfalls that will result due to high medical losses experienced during the first quarter of 2014. As of June 2014, COH has obligated but undisbursed solvency loan funding totaling $27.1M.

In the contingency plan, COH projects a cumulative net profit of $423.7M from 2014-2033. COH also projects to start repayment of interest on solvency loan in 2019 and start principal and interest repayment in 2021. If projections are realized, COH projects to make annual principal and interest payments on the solvency loan funding through 2019 until the loan is paid in full.

Summary of Observotions

- **Consideration to merge with another healthcare entity might result in non-compliance with program requirements.** Under the contingency (worst) scenario, COH indicates its intention to merge or affiliate with another large healthcare entity, which may result in non-compliance with the CO-OP program compliance requirements. CMS may want to consider discussing this plan further with the CO-OP.
- **Consideration to merge with failing CO-OP.** COH stated it intends to merge with another failing CO-OP with undisbursed solvency loan funding balance, if the request for additional solvency loan funding is not approved. However, no detail is provided on this proposal, including the CO-OP's intended plan to expand into the failing CO-OP's state.
- **Pro formas contain different solvency loan amounts than loan schedule.** Comparison of COH's pro formas and CMS's Loan Tracker indicate the total solvency loan finding amount recorded in the applicant's pro formas for the contingency plan, including the loan funding schedule, is less than the solvency loan funding amount awarded to COH by $3.9M. No detail was provided in the business plan to explain the reason for these variances.

Solvency Loan Request Points

Sections	Potential	Total
Enrollment Projections	15	12.5
Pricing	20	14.5
Medical Costs and Losses	15	14
Financials	15	8.5
Score	**65**	**49.5**

Contingency Plan Points

Contingency Plan	Potential	Total
Overall	10	8
Score	**10**	**8**

CoOportunity Health
Additional Solvency Loan Funding Request Report

Date Submitted to CMS: 10/24/2014

Scope Summary & Assumptions:

- Deloitte will not provide an opinion regarding the reasonableness of the proposed business plan changes of each Consumer Operated and Oriented Plan (CO-OP) Program. Nor will Deloitte provide an opinion regarding the likelihood of each CO-OP achieving sustainable operations based upon the revised business plan.
- Deloitte assumes that the information provided by each CO-OP in its modified business plan is complete and accurate. Deloitte will perform its assessment of the data provided "as is". Deloitte will also use other data sources that are publicly accessible or information provided directly from the Centers for Medicare and Medicaid Services (CMS). Deloitte will notify CMS if we believe that there is insufficient information to complete our review.
- In these applications for solvency loan requests, some of the CO-OPs have cited a need for additional solvency loans to cover projected cash shortfalls as a result of nonadmitting risk-sharing receivables provided in the Affordable Care Act (ACA). The National Association of Insurance Commissioners (NAIC) is charged with developing accounting guidance for these risk-sharing provisions which are utilized by the state departments of insurance in monitoring the financial solvency of the insurers domiciled in their state. The NAIC is continuing their deliberations on this issue, which previously included potential nonadmittance for risk-sharing receivables in excess of any payables. However, as a result of the most recent NAIC meeting on August 17, 2014, the adopted minutes of that meeting reflects that the NAIC is "...replacing the nonadmission guidance with criteria that incorporates conservatism and sufficiency of data and removing the exposed 90-day guidance and adding language to be consistent with other government receivables". Our Findings Report will include relevant information, as necessary, on the accounting treatment for the risk-sharing receivables used by the CO-OPs in their financial projections.
- The impact of the Reinsurance, Risk Adjustment and Risk Corridors Program (the 3Rs, reinsurance, risk adjustment, and/or risk corridors) was reviewed when making observations and comments throughout this report. Observations and comments relating to the impact of the 3Rs are included for informational purposes only. There was no consideration of the reasonableness or propriety of any of the amounts relating to the 3Rs. Based on the scoring criteria provided by CMS, observations and comments relating to the 3Rs had a net neutral effect on the scoring.
- In reviewing applications from CO-OPs for additional solvency loan funding requests, Deloitte reviewed supporting documentation requested of the applicants by CMS in a memo to the CO-OPs distributed on August 22, 2014. The format of the reports as well as the section scoring was approved by CMS during the week of June 2, 2014. These reports are scored on the basis of a total of 65 points, plus 10 points for the contingency plan. The scoring reflects Deloitte's assessment of the degree to which the application complies with the funding loan announcement of August 22, 2014. The score for the Contingency Plan section should be viewed independently of scoring for the other sections of this report. For all sections, Deloitte provided comments on issues only for which the applicant provided data. Observations relating to the pro forma financial statements are based on the base case with additional solvency award scenario (base case), unless otherwise noted.

Executive Summary:

CoOportunity Health (COH or applicant or CO-OP) has submitted a request for $55M in additional solvency loan funding. The application and underlying pro forma financial statements do not discriminate between projected Iowa and Nebraska operations on a standalone basis. Therefore, a distinction was unable to be made between the solvency loan funding needs for Iowa and Nebraska in this Findings Report. Any additional solvency loan funding received by the CO-OP is required to be aggregated with funds used for both Iowa and Nebraska operations. The CO-OP has stated "if additional solvency capital cannot be secured, the CO-OP will begin shutdown procedures prior to the end of 2014" (P. 64)[1].

The CO-OP has stated "if additional solvency capital cannot be secured, the CO-OP will begin shutdown procedures prior to the end of 2014" (P. 64)[2]. Based on CMS's CO-OP Summary Report by Borrower (Loan Tracker) as of 10/3/2014, COH has been obligated $14.7M in start-up funding and $130.6M in solvency loan funding for operations in Iowa and Nebraska, of which $97.9M of solvency loans and $14.7M of start-up funding has been disbursed. This total award amount reflects $32.7M in solvency loan funding awarded as a result of COH's solvency loan funding request submitted in June 2014 which has not been disbursed. It should be noted, in the original application, COH projected the solvency loan of $97.9M would be disbursed from 2013-2020. However, the Loan Tracker indicates that $97.9M has been disbursed as of 10/3/2014. Updated projections have COH disbursing $185.9M (total solvency loan plus current solvency loan request) from 2013-2017. It is not clear why the applicant revised the timing of the loan disbursements, as it appears the applicant continues to project RBC levels of at least 500% of ACL throughout the entire performance period. The applicant's solvency loan request for $55M is projected to be disbursed from 2014-2017, specifically, $30M in 2014, $5M in 2015, $9M in 2016 and $11M in 2017. Since the CO-OP projects no profits during 2014-2017, the solvency loan funds being disbursed in 2015-2017 appear to be intended to make payments on the private loan of $68M and start-up loan repayment of $3.6M which are due during the same period.

Furthermore, COH has applied to National Cooperative Bank in Washington for a $68.2M cash flow operating loan for 2013-2016 to cover short term working capital needs that will result due to the delay of receipt of the recoveries of $48.5M from the federal reinsurance program. The reinsurance recoveries of $48.5M will be used as collateral to obtain the private loan. It is also important to note that the pro forma financial statements include the assumption that the CO-OP will receive both additional solvency loan funds and the private loan. The loan is contingent upon COH receiving additional solvency loans from CMS. It has been included in the base case scenario with the repayments made over the period of 2013-2017. Because the CO-OP does not have any profits from 2014-2017, even after consideration of the 3R receivables, as a result, the loan is projected to be repaid with solvency loan funds. The CO-OP has projected $291.9M of 3R receivables for 2014-2016 with $144.9M of 3R receivables recorded at year end 2014. Based on the pro forma financial statements, if the CO-OP does not receive additional solvency loan funding and given the timing of the cash receipts of the 3Rs receivables being several months after expenditures, CMS may want to consider that CoOportunity Health could suffer from a liquidity issue.

COH has attributed their request for additional solvency loan funding to higher than projected enrollment, delay in receipt of 3R receivables and higher than expected claim costs. In 2014, the overall enrollment in Iowa and Nebraska is projected to exceed original 2011 projections by about 64,000 members[2]. However, COH is projecting fewer enrollees for 2015 and 2016 in the pro forma financial statements submitted to CMS on September 22, 2014 as part of this application (9/22 Pro Formas) than it did in the pro forma financial statements submitted to CMS on May 2, 2014 (5/2 Pro Formas) because of its plans to terminate three lines of business. These three lines of business involve approximately 11,500 enrollees and no information was provided as to how the CO-OP will replace this membership. According to the samples of COH's Silver plan premiums for 2015 provided by the Iowa Insurance Division (IID) and the Nebraska Department of Insurance (Nebraska DOI), the CO-OP will not have the lowest cost plan in any region except for three cities in Nebraska and will be the highest cost plan in area 2, 4 and 5 in Iowa. It is unclear how the CO-OP will reach its enrollment targets. Additionally,

[1] Page numbers in this report refer to the consolidated application based on materials received from the CO-OP for request for additional solvency loan funding dated September 22, 2014.

[2] All references to "original" – including, but not limited to, "original funding application", "original application", and "original projects" – refer to COH's 2011 application for CMS start-up and solvency loan funding, operations commencing in 2011.

the IID published approved rates which showed the CO-OP revised their rate filing estimates. We do not have these revised rate filings and cannot determine if the pro formas reflect this information.

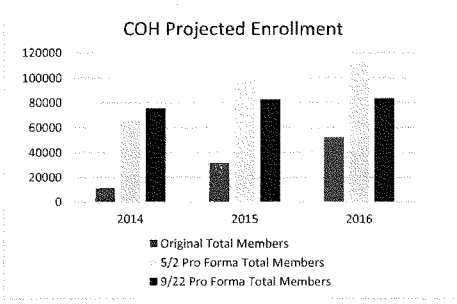
COH is projecting a $60.4M loss in 2014 and the CO-OP's pro formas include a $25M premium deficiency reserve (PDR), though it provides no details to support it. It should also be noted that there is no reference to the need for a PDR in the 12/31/13 and 6/30/14 regulatory filings which the CO-OP filed with state regulators. According to the applicant, the IID has also been in contact with COH about its risk profile and solvency needs in 3Q14. The applicant stated that the Iowa Commissioner of Insurance has been reviewing the risk profile of COH throughout the year and has indicated "he anticipates that it will be necessary for him to require COH to increase its capital and surplus at some point in the third quarter of calendar year 2014" (P. 64). However, it is unclear if that discussion took place before or after the $32.7M in additional solvency loans were awarded to COH in September 2014. The CO-OP presented other contingency scenarios of merging with other CO-OPs or a larger healthcare entity such as HealthPartners, though COH has not secured interested parties. "If additional solvency capital cannot be secured, the CO-OP will begin shutdown procedures prior to the end of 2014." (P. 64). The contingency plan was also not submitted to Milliman, the external actuary for the CO-OP, for review and, therefore, not included in the actuarial certification.

Critical Assertions:

1. <u>Enrollment:</u>

COH provided a revised business plan in this application, which includes updated enrollment and financial projections. The updated enrollment projections in this submission (9/22 Pro Formas or pro formas) [3] indicate that overall enrollment for 2014 in Iowa and Nebraska is projected to exceed enrollment estimates in the May 2014 pro forma financial projections submitted to CMS on May 2, 2014 (5/2 Pro Formas) by approximately 9,460 members. According to the 6/30/2014 regulatory filing, the CO-OP currently has 79,762 members. According to the CMS CO-OP Enrollment Comparison Report as of August 5, 2014, COH has enrolled 84,936 members. COH was awarded $32.7M in additional solvency loan funding related to its June 2014 solvency loan request to account for increased enrollment from original projections.

Figure 1: September 2014 Enrollment Projections exceed Original Projections



Source: Applicant's 2011 Original Application, 5/2/14 Pro Formas, and 9/22/14 Pro Formas

The pro formas provided with this solvency loan application show that the CO-OP projects to enroll 16% fewer members in 2015 and 25% fewer members in 2016 than projected in the May 2 Pro Formas. Membership growth year over year is also lower for 2015 and 2016 as compared to the 5/2 Pro Formas. The 5/2 Pro Formas projected a 49% growth in membership from 2014 to 2015. However, the 9/22 Pro Formas show a 9% increase for the same period. From 2015 to 2016, the 9/22 Pro Formas show a 1% growth, down from a 15% membership increase shown in the 5/2 Pro Formas for the same period. See Documentation for Change in Enrollment Projections section below for further information.

COH did not provide a breakout of enrollment between Iowa and Nebraska in the pro formas,

[3] Annual enrollment projections provided in the pro formas reflect average membership over a 12 month period.

but indicated in the business plan that its "cost position was more favorable in Nebraska than Iowa" (P. 33). COH stated in the business plan that it has enrolled 40,000 enrollees in Nebraska, with over half from rural areas of the state. In Iowa, COH has enrolled approximately 25,000 members (P. 33). The CO-OP did not provide detail to clarify the date of these estimates. Iowa operates on a State-Partnership Marketplace (Iowa Marketplace) and Nebraska (Nebraska Marketplace) operates on a Federally-Facilitated Marketplace. The term 'Marketplace' indicates that a statement is applicable to both the Iowa and Nebraska Marketplaces.

Although COH did not provide the breakout enrollment by on and off Marketplace enrollment, approximate break outs are provided in the business plan. Approximately 40% of members enrolled through the Marketplace and approximately 25% of members enrolled off Marketplace. Based on the information provided with this solvency loan request, it appears the CO-OP will be in compliance with Title 45, Code of Federal Regulations (CFR) § 156.515(c)(1) and (d) relating to requirements for CO-OPs under the Affordable Care Act (ACA), which requires two-thirds of total members to be from the Marketplace in 2016.

Additionally, although the applicant does state that its enrollment projections are predicated on the assumption that "employers with 50-99 employees transition to 'small group' in 2016", the impact of that assumption is unclear because the CO-OP does not breakout enrollment by individual, small group, and large group segments (P. 44).

The remaining third of COH's enrollment was "employer sponsored plans", the majority of which are small businesses purchasing in the "open market" (P. 34). This enrollment was not broken out between Iowa and Nebraska. COH also states in the business plan that it is partnering with Health Partners (HP) to offer self-insured products. Health Partners sells self-insured products in Iowa "through co-located staff at the CO-OP's offices in West Des Moines" (P. 54). As employer-sponsored plans are self-insured plans, the CO-OP would need to exclude these types of members from the enrollment in its regulatory filings. However, no further detail is provided to determine whether the CO-OP has included enrollments from employer-sponsored plans in its pro formas or in its regulatory filings.

Documentation for Change in Enrollment Projections

COH expects to exceed original enrollment projections for 2014 through 2016. However, COH is projecting fewer enrollees in 2015 and 2016 in the 9/22 Pro Formas than in its 5/2 Pro Formas. COH attributes the decrease in projected enrollment to three changes made to its business plan made in response to "extraordinarily high claims costs and cash outflows" (P. 60). First, COH will no longer offer Platinum plans, with the exception of the Nebraska group market. COH did not provide further detail on the reference to the 'group' market and therefore the composition of small and large group enrollment cannot be determined. Second, the CO-OP will no longer offer coverage to individuals off Marketplace in Iowa and will terminate existing plans. Last, the CO-OP will stop offering coverage through the Iowa Medicaid Choice Plan (the IMCP program). These changes will affect approximately 11,500 members, effective January 1, 2015. Approximately 10,000 of the affected members are currently enrolled in the Iowa Medicaid Choice Plan (P. 38).

As stated above, COH has been more successful attracting enrollees in Nebraska than in Iowa. According to the applicant, lower enrollment in Iowa is the result of Wellmark Blue Cross and Blue Shield (Wellmark) early renewing individual members in 2013, which the CO-OP claims "dissuaded some consumers who were eligible for premium subsidies from going to the Health Insurance Marketplace to shop while encouraging older and sicker customers to explore their Marketplace options" (P. 36).

Table 1: Documentation for Change in Enrollment Projections

Reason Cited by COH for Changes in Enrollment	COH Proposed Action	COH Justification
	1. **Will not offer a Platinum plan, with the exception of the**	In response to high claims costs, COH will not offer a Platinum plan on the Marketplace, with the exception of the Nebraska group market. In Iowa, COH attributes

Reason Cited by COH for Changes in Enrollment	COH Proposed Action	COH Justification
High claims cost with existing enrollee pool	**Nebraska group market**	the influx of high cost enrollees to Wellmark's early-renewal of individual policies, which the CO-OP claims "dissuaded some consumers who were eligible for premium subsidies from going to the Health Insurance Marketplace to shop while encouraging older and sicker customers to explore their Marketplace options" (P. 36). Insufficient detail was provided to determine if COH will offer large group or small group. The breakout of small and large group was not provided in the most current pro formas.
	2. **Terminate Iowa off Marketplace individual coverage in late 2014**	As stated above, COH is terminating this line of business in response to high claims costs. Terminating this coverage will affect less than 1,000 enrollees.
	3. **Discontinue coverage in Iowa Medicaid expansion (the IMCP program)**	As stated above, COH is terminating this line of business in response to high claims costs. The 60-day notice of termination for the Iowa Choice Medicaid Plan was submitted to the Iowa Department of Insurance on September 19, 2014. This change will impact approximately 10,000 members.
	4. **Increase Premiums in both Iowa and Nebraska**	For example, for the Silver metal level plans in Iowa, COH cites they filed a 15.6% rate increase for individual products and a 10.9% rate increase for small group. In Nebraska, COH cites they filed a 10.6% rate increase for individual and an 11.4% rate increase for small group Silver metal level products. The business plan did not provide detail around how COH expects these increases to affect enrollment levels (P. 43). See Product Pricing section for further details.
Wellmark entrance into Iowa Marketplace in 2015	5. **Budgeted additional marketing expenses**	Wellmark is entering the Iowa Marketplace for the 2015 open enrollment period. COH states in the application that is has budgeted marketing expenses to address the additional competition on the Iowa Marketplace. It is not clear how the CO-OP intends to fund these marketing expenses.

Summary of Observations:

- **9/22 Pro Formas show fewer enrollees in 2015 and 2016 than projected in the 5/2 Pro Formas.** COH is expecting to enroll fewer members in 2015 and 2016 due to the additional competition, increased rates, and the termination

of three lines of business. Because COH did not provide the breakout of on and off Marketplace enrollment, the breakout of individual and small group enrollment, and the breakout of enrollment between Iowa and Nebraska, the impact of these factors to specific states or plan types could not be determined, except where explicitly stated in the application.

- **COH is terminating three lines of business.** The CO-OP will no longer offer Platinum plans (with the exception of Nebraska group business), ICMP program enrollment, or Iowa individual off Marketplace products, affecting approximately 11,500 members. The CO-OP states that these lines of business contribute to high cash outflows and claims costs. The CO-OP attributes fewer expected enrollees in 2015 and 2016 to the discontinuation of these lines of business. It is not clear how this loss in membership in 2014 will be replaced in 2015.
- **COH is raising individual and small group rates for Silver plans in Iowa and Nebraska in 2015.** The application did not address how the CO-OP intends to retain membership in light of rate increases in both states. For the Silver level plans in Iowa, COH filed a 15.6% rate increase for individual products and a 10.9% rate increase for small group. In Nebraska, COH filed a 10.6% rate increase for individual and an 11.4% rate increase for small group products. On September 4th, 2014, the applicant filed and was approved for an amended rate increase request of 19% for all regions and plans in Iowa. It is unclear if this amended request is reflected in its pro formas. Please see the Product Pricing section for more information.
- **New competitors on the Iowa Marketplace.** Wellmark will offer coverage on the Iowa Marketplace during the 2015 open enrollment period. The CO-OP stated in the business plan that it intends to address the additional competition by increasing marketing. It is not clear how COH will fund the costs of marketing.

2. Product Pricing:

As noted above, COH's 2014 enrollment was higher than anticipated. The applicant states that the original 2017 enrollment projections were reached within the first three months of 2014 (P. 43). This increase in enrollment is, at least, partially due to the 2014 pricing. The CO-OP has lower 2014 premiums in three of the four rating areas of Nebraska in the individual market and in the small group market statewide. In Iowa, the CO-OP has higher Silver plan premiums than competitors by as much as 20% in most rating areas, other than one, where its premiums are the lowest. According to the CO-OP, its Iowa small group rates were very competitive statewide (P. 42).

According to the applicant, "material" underwriting losses have occurred during the first eight months of 2014 due to the effects of early renewal, transitional policies, and "pent-up demand" (P. 62). In the June 2014 submission, the CO-OP projected a $10M loss for 2014 and did not include a premium deficiency reserve (PDR). The pro formas indicate losses have increased by approximately $50M from the June 2014 solvency loan request to an overall loss estimate of $60.4M for 2014. COH has projected a PDR of $25M for 2014 in this application. However, the CO-OP did not provide an explanation of the PDR or any of the underlying data that went into the calculation. The PDR estimate directly impacts the solvency amount needed to maintain the required surplus level.

The September 2014 solvency loan request did not include the rate filing memoranda for either small group or individual products in either IA or NE. Actuarial rate filing memoranda typically include the premium formula, trend assumptions, and other specific factor changes. The 2014 Unified Rate Review Template (URRT) files, which capture information at the market level to set premium rates using a single risk pool, were provided and match those provided in June 2014. Additionally, COH's rate submission screenshots show the CO-OP waiting on approval of rates as of September 18th. Therefore, it appears that no changes were made to COH's prior rate filing submissions, and the rates were approved after the solvency loan request was submitted. As a result, the majority of the information in this section is, therefore, similar to information provided in the CoOpportunity Health Findings Report provided to CMS on July 18, 2014 (7/18/2014 Findings Report)[4] and discussion in the business plan and feasibility studies provided in the current submission. However, it should be noted the IID approved higher rate increases based on updated rate filing memoranda that were not provided. More discussion of this update is included later in this section.

[4] CoOportunity Health 7/18/2014 Findings Report (7/18/2014 Findings Report) provided to CMS on July 18, 2014.

Per the 7/18/2014 Findings Report, COH's proposed rates effective January 1, 2015 reflect a 7.0% and 12.3% rate increase for the Premier and Preferred products, respectively, for the Iowa individual market. The proposed rate change does not vary by region but does vary by plan. There are no apparent changes in cost sharing or rating factors (e.g., age, tobacco) in this rate filing, other than changes to the base premium rate and rate relativities by plan. The requested rate change varies by plan due to provider reimbursement changes and revised benefit relativities. Base rate changes are the result of medical inflation, utilization, provider contracts, taxes and fees, federal reinsurance program changes, morbidity, expenses, and profit margin (7/18/2014 Findings Report). The premium rate increases shown within the 2015 rate filings are not large enough to produce profits in 2015 without a corresponding reduction in medical costs. The CO-OP indicates that an approximate rate increase of 40% would be needed to mitigate the emerging claims experience, and has spread the increase over 2016 and 2017 (P. 9). It is unknown if an approximate rate increase of 20% would be approved by the IID. Please see below for a further description of the changes to medical costs.

The projected medical loss ratio, including the impact of the 3Rs and other ACA adjustments, is 92.9% based on information in the pro formas. ACA adjustments include such items as quality improvement expenses and taxes/fees. With rate increases of upwards of 10%, there is no mention of how it will impact retention of current members. The current pro formas show an average increase in premiums of 9% in aggregate from 2014 to 2015 and a 10% decrease in costs. However, the aggregate premium per member per month (PMPM) for 2014 has increased by 5% from the June submission while the 2014 claim estimates have increased by 45% in aggregate. It is unclear how the rate increases discussed within the 2015 rate filings tie to the aggregate changes within the pro formas.

Per the 7/18/2014 Findings Report, for the Nebraska individual market, COH's proposed rates effective January 1, 2015 reflect a 7.9% rate increase for the Premier product. The proposed rate change varies by region and plan. There are no significant changes in cost sharing. This rate filing includes changes to the base premium rate, rate relativities by plan, and area factors. The requested rate change varies by plan due to provider reimbursement changes and revised benefit relativities. Base rate changes are similar to those mentioned above for the Iowa market.

Per the 7/18/2014 Findings Report, preliminary 2015 pricing indicates COH needs to increase rates approximately 3.9% and 8.6% for its Premier and Preferred products, respectively, for the Iowa small group market. COH will be terminating its Choice Product at the end of 2014 and introducing its CorePlus product during 2015 in the Iowa small group market. No explanation was provided in the 2015 rate filing for these changes in products.

Additionally, the September 2014 application states that, effective 1/1/2015, COH will be terminating business in the following three areas – the Iowa Marketplace Choice Plan (IMCP), Platinum plans, and the off Marketplace Iowa individual market (P. 38). The CO-OP believes this will help reduce current negative cash flows by removing high cost individuals who purchased these products. The request indicates these lines of business total 11,500 members which reflect approximately 15.2% of the average members reported in the pro forma financials. COH has assumed claim decreases of 3% from exiting the IMCP program and an additional 20% from the improved morbidity in the single risk pool (P. 13). Without further detail, it is difficult to determine the actual impact these business decisions will have as pro formas have been provided in the aggregate for all lines of business.

Per the 7/18/2014 Findings Report, COH previously provided the 2015 rate filing memos for the Iowa and Nebraska individual markets, but only a preliminary 2015 pricing memo for the Iowa small group market and nothing for the Nebraska small group market. The applicant did not provide a 2015 rate filing memo for the Nebraska small-group market in either solvency loan request. Insufficient information was provided to review the detail behind the premium methodology for 2015 such as expenses, fees and additional adjustments to 2014 premium rates. As noted within the Findings Report, this component of the market represents approximately 10% of the total enrollment within the two states.

The applicant is still considering expanding coverage into eight counties in far western Illinois. Per the applicant, people from this area go to hospitals in the Quad Cities as well as Dubuque, Clinton, Muscatine, Burlington, and the University of Iowa. Projections assume that "no geographic expansion will occur except potentially adding border counties in western Illinois (pending CMS and Illinois State regulatory authority) between 2017-2019" (P. 44). The applicant does not identify how much, if any, of the additional solvency loan funding would be used for expansion into Illinois.

Per the 7/18/2014 Findings Report, the initial estimates for the individual business are based on industry data and adjusted by the CO-OPs external actuary to fit COH's specific situation as the CO-OP is a start-up operation.

Tables 2 and 3 provide a comparison for the 2014 single age 27 premiums for the CO-OP versus competitors with the lowest premium product across one of the same rating areas in the Iowa and Nebraska individual Marketplaces, whereas, Tables 4 and 5 provide similar information in the Iowa and Nebraska small group Marketplaces. Highlighted areas denote the lowest premium for the particular area. The data from the table is from www.healthcare.gov. Similar premium information for 2015 is not available.

Table 2: 2014 Premiums on the Iowa Individual Marketplace

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Bronze	Bronze	168.86	145.28	172.79	178.53	171.98	168.54	169.36
Coventry Health Care of Iowa Inc.								
Bronze Deductible Only HMO HSA Eligible Methodist Health Partners	Bronze				162.28			
Bronze Deductible Only POS HSA Eligible Patient Preferred	Bronze			157.94				
Bronze Deductible Only POS HSA Eligible UnityPoint Health	Bronze					133.48	132.22	140.15
Bronze Deductible Only POS HSA Eligible UnityPoint Health û Des Moines	Bronze	166.28	122.17					
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Silver	Silver	209.39	180.15	214.27	221.38	213.26	208.99	210.01
Coventry Health Care of Iowa Inc.								
Silver $10 Copay HMO Methodist Health Partners	Silver				209.23			
Silver $10 Copay POS Patient Preferred	Silver			203.65				
Silver $10 Copay POS UnityPoint Health	Silver					172.14	170.52	180.74
Silver $10 Copay POS UnityPoint Health û Des Moines	Silver	214.42	157.54					
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Gold	Gold	246.76	212.29	252.51	260.88	251.30	246.28	247.47
Coventry Health Care of Iowa Inc.								

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Gold $5 Copay HMO Methodist Health Partners	Gold				236.22			
Gold $5 Copay POS Patient Preferred	Gold			229.92				
Gold $5 Copay POS UnityPoint Health	Gold					194.37	192.53	204.08
Gold $5 Copay POS UnityPoint Health û Des Moines	Gold	242.10	177.88					
Avera Health Plans								
Avera MyPlan $250 / 10% Coinsurance	Platinum			385.12				385.12
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Platinum	Platinum	295.72	254.42	302.61	312.65	301.17	295.16	296.59
Gundersen Health Plan, Inc.								
Platinum $500 - 20%	Platinum						407.13	407.13
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Catastrophic	Catastr-ophic	154.09	132.57	157.68	162.91	156.93	153.79	154.54
Coventry Health Care of Iowa Inc.								
Catastrophic 100% HMO Methodist Health Partners	Catastr-ophic				110.64			
Catastrophic 100% POS Patient Preferred	Catastr-ophic			107.67				
Catastrophic 100% POS UnityPoint Health	Catastr-ophic					90.96	90.10	95.50
Catastrophic 100% POS UnityPoint Health û Des Moines	Catastro phic	113.33	83.27					

Table 3: 2014 Premiums on the Nebraska Individual Marketplace

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus $4750 HDHP Bronze	Bronze	161.58	161.58		
CoOportunity Health					
CoOportunity Premier HSA Bronze	Bronze	205.85	164.49	153.30	152.92
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus $1S00 HDHP 5ilver	Silver	210.13	210.13		
CoOportunity Health					
CoOportunity Premier HSA Silver	Silver	240.98	192.56	179.45	179.01
Blue Cross and Blue Shield of Nebraska					
BlueEssentialsPlus $1000 Gold	Gold	329.62	329.62	329.62	329.62
CoOportunity Health					
CoOportunity Premier HSA Gold	Gold	280.75	224.33	209.08	208.55

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Coventry Health Care of Nebraska Inc.					
Gold $5 Copay HMO Methodist Health Partners	Gold	251.81			
CoOportunity Health					
CoOportunity Premier Platinum	Platinum	333.00	266.10	247.99	247.37
Blue Cross and Blue Shield of Nebraska					
BlueEssentialsPlus $6350 Catastrophic	Catastrophic	157.57	157.57	157.57	157.57
CoOportunity Health					
CoOportunity Premier Catastrophic	Catastrophic	191.26	152.83	142.42	142.08
Coventry Health Care of Nebraska Inc.					
Catastrophic 100% HMO Methodist Health Partners	Catastrophic	113.51			
Catastrophic 100% POS Plan	Catastrophic	133.18	128.81	129.60	133.18

Table 4: 2014 Premiums on the Iowa Small Group Marketplace

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Avera Health Plans								
Avera $2,000 / 50% coinsurance	Bronze			265.61				265.61
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Bronze	Bronze	151.12	130.01	154.63	159.77	153.90	150.83	151.55
Gundersen Health Plan, Inc.								
Bronze HSA $5000 - 30%	Bronze						196.05	196.05
Health Alliance-Alegent Creighton Health Partner								
Guide HMO QHDHP 3150/6300 40% 6350/12700 Rx3	Bronze				220.53			
Sanford Health Plan								
Simplicity $3,000	Bronze			214.11				214.11
Avera Health Plans								
Avera $2,000 / $4,000 Out-of-Pocket	Silver			262.68				262.68
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Silver	Silver	190.32	163.74	194.75	201.21	193.83	189.95	190.87
Gundersen Health Plan, Inc.								
Silver HSA $2000 - 20%	Silver						262.28	262.28
Health Alliance-Alegent Creighton Health Partner								
Guide HMO 30/60 2400/4800 30% 6000/12000 Rx3	Silver				247.21			
Sanford Health Plan								

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Simplicity $2,000	Silver			263.14				263.14
Avera Health Plans								
Avera $750 / 30% coinsurance	Gold			316.34				316.34
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Gold	Gold	220.50	189.70	225.63	233.12	224.57	220.07	221.14
Gundersen Health Plan, Inc.								
Gold $2000 - 0%	Gold						304.59	304.59
Health Alliance-Alegent Creighton Health Partner								
Guide HMO 25/50 1600/3200 10% 4000/8000 Rx2	Gold				302.14			
Sanford Health Plan								
Simplicity $1,500	Gold			297.18				297.18
Avera Health Plans								
Avera $250 / 10% coinsurance	Platinum			361.49				361.49
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Platinum	Platinum	257.55	221.57	263.54	272.28	262.29	257.04	258.29
Gundersen Health Plan, Inc.								
Platinum $500 - 20% $15 OV	Platinum						335.17	335.17
Sanford Health Plan								
Simplicity $500	Platinum			337.22				337.22

Table 5: 2014 Premiums on the Nebraska Small Group Marketplace

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 403 HDHP Bronze	Bronze	201.85	201.85	195.85	209.84
CoOportunity Health					
CoOportunity Premier HSA Bronze	Bronze	213.70	170.72	159.07	158.67
Coventry Health Care of Nebraska Inc.					
Bronze Essential #2 HMO Plan S	Bronze	272.62	263.67	265.29	272.62
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 402 HDHP Silver	Silver	255.28	255.28	247.70	265.39
CoOportunity Health					
CoOportunity Premier HSA Silver	Silver	251.74	201.11	187.38	186.91
Coventry Health Care of Nebraska Inc.					
Silver Security #2 HMO Plan S	Silver	314.39	304.07	305.95	314.39
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 401 Gold	Gold	355.81	355.81	345.24	369.90

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
CoOportunity Health					
CoOportunity Premier HSA Gold	Gold	289.57	231.33	215.54	215.00
Coventry Health Care of Nebraska Inc.					
Gold Freedom #3 HMO Plan S	Gold	368.21	356.12	358.31	368.21
Health Alliance-Alegent Creighton Health Partner					
Guide HMO 25/50 1600/3200 10% 4000/8000 Rx2	Gold	287.01	275.64		
CoOportunity Health					
CoOportunity Premier Platinum	Platinum	339.35	271.10	252.60	251.96

The IID published a sample of 2015 Iowa individual silver plan premiums. Based on this sample, COH will be between 9.9% and 30.0% more than the least expensive plan in rating area 1. COH will be at least 24.8% and as high as 84.9% more than lowest cost plans in all other rating areas. The CO-OP has the highest cost plan in rating areas 2, 4, and 5. Sample data is based on non-tobacco premium rates for individuals age 27 for silver level plans.

The Nebraska DOI published a sample of 2015 Nebraska individual premium rates that show COH will be approximately 23.7% more than the least expensive plan for a 30 year old on a silver plan in Omaha. However, the CO-OP does have the lowest rates for 30 year old non-tobacco users on silver plans in Norfolk, Lincoln, and Hastings.

The Iowa Insurance Division also published review decision on COH's rate proposal. In the letter, dated October 8th, the IID noted COH submitted a supplemental rate proposal request dated September 4th. In this request the CO-OP has requested an average rate increase of 19% instead of the original 2015 rate request that showed an average increase of 14.3%. The company stated *"The original rate increase request for 2015 was based on claims experience which lacked sufficient credible information on which to base trend estimates and projected member movement from the entire insured and uninsured population. As claims experience developed in 2014 and more data became available, the carrier demonstrated that the claims experience is considerably higher than was projected in the initial rates filed in 2013. Therefore, a significant portion of the rate request is due to higher than expected claims experience."* It was not clear from the detail provided within the application that COH had submitted a revised rate filing to the State which included higher premiums than the original 2015 rate filings. Further, it is unclear if the updated 2015 rate filing analysis was used in the development of the pro formas.

Summary of Observations:

- **COH submitted a supplemental premium rate increase for 2015 individual rates in Iowa dated September 4th, 2014.** The initial rate increase was for 7.0% and 12.3% for the Premier and Preferred products; however, the updated request was for 15.6% and 21.2%. It is unclear if the updated premium rates are reflected in the pro formas. The pro formas were provided in aggregate without breakouts by state or market. The sample rates provided by IID show COH is not the lowest cost plan in any Iowa region.
- **COH is projecting a $60.4M loss in 2014.** Pro formas include a $25M PDR, but no details were provided to support this amount. The PDR impacts the applicant's surplus and ultimately impacts the amount requested from COH.
- **2015 premiums will increase compared with the 2014 premiums.** According to the applicant, 2014 enrollment was much higher than anticipated. For the Iowa individual market, COH's proposed rates effective January 1, 2015 reflect a 7.0% and 12.3% rate increase for the Premier and Preferred products, respectively, and for Nebraska individual market, proposed rates reflect a 7.9% rate increase for the Premier product. However, based on the Iowa published Individual rate decision, COH received a 19% average rate increase based on a supplemental rate proposal dated September 4th. It is unclear if the pro formas include updates for this supplemental rate increase. For the Iowa small

group market, COH proposes a 3.9% and 8.6% rate increase for its Premier and Preferred products, respectively. No information was provided about rate increases for the Nebraska small group market. COH has not addressed its strategy for retaining members while considering a rate increase of upwards of 10%. Additionally, it is not clear if the rate increases will be enough to produce a profit in 2015.

- **Change in products in 2015.** COH will be terminating its Choice Product at the end of 2014 and introducing its CorePlus product during 2015 in the Iowa small group market. No explanation was provided in the 2015 rate filing for these changes in products. Insufficient detail was provided in the application so the impact on enrollment cannot be determined. COH will also be terminating business in the Iowa Marketplace Choice Plan (IMCP) and the off Marketplace Iowa individual market as well as eliminating Platinum plans effective 1/1/2015.
- **Changes to small group premiums could not be determined.** The 2015 individual rate filing memorandum for Nebraska small group and Iowa small group was not provided. This document typically provides the detailed reasoning for changes from the prior year premiums. Additionally, the pro formas do not provide premiums for each market. The pro formas were provided on a combined basis for all lines of business.
- **The 2015 small group rate filing includes a breakdown of taxes and fees, which does not include an estimate for the health insurer fee.** Milliman published a research report titled " ACA Health Insurer Fee – Estimated Impact of the US health insurance industry," dated April 2013, which states the 2014 health insurer fee estimate is 1.7% to 2.4% and increases to 2% to 2.9%. Since COH is a 501c(29) not-for-profit entity, the insurer fee estimate would be lower than the industry average. COH does not include an estimate for the health insurer fee; however, it includes an estimate for Marketplace fees associated with selling plans on the Marketplace. The CO-OP assumed 1.3% of premiums for this fee.

3. <u>Medical Costs and Losses:</u>

COH's pro formas show combined medical loss ratios, including the impact of the 3Rs and other ACA adjustments, of 128.5%, 112.3%, and 99.7% for years 2014, 2015 and 2016, respectively. It is unclear how the applicant arrived at these MLR estimates as the details provided in the pro formas indicate MLRs of approximately 92.9%, 91.4%, and 89.6% for years 2014, 2015, and 2016, respectively. The COH pro forma financials for Iowa (IA) and Nebraska (NE) business were provided on a combined basis for all lines of business. COH has revised estimates including receivables for risk adjustment, reinsurance and risk corridors based on 2014 membership and emerging experience through August 2014 (P. 9). The largest receivable is risk corridors with $87.7M in receivables estimated for 2014 (P. 72). Including the receivables for the 3Rs (risk corridors, risk adjustment, and reinsurance) for 2014 would result in a $60.3M loss and result in an MLR of 92.9%, including the impact of the ACA adjustments, if projections are realized. Removing the estimated $149.6M in 3R receivables would result in a $210M loss and increase the MLR, excluding any adjustments for the 3Rs or other ACA adjustments for all products combined to 138.0%. The 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit.

Based on a review of the regulatory filing as of 6/30/2014, the MLR is approximately 93.1%, excluding any impact of the ACA, resulting in a loss of $13.4M. It should be noted that in the 2Q14 regulatory filing, COH netted the cost sharing reductions ("CSR") with claims in error, affecting the MLR. The result would be an increase in claims from those reported in regulatory filing. Typically, two quarters' experience cannot be extrapolated to the entire year and, therefore, more months of experience will be needed to make a conclusion. For comparison, the pro formas show a 2014 loss of $60.3M, including the impact of 3Rs. This may indicate the CO-OP assumes to lose more money in the second half of 2014 than the first half of 2014. It is not clear from the detail provided whether the CSR was built into the pro formas for 2014. The CO-OP is projecting the 2014 MLR to be approximately 138%, excluding any impact for the 3Rs or other ACA adjustments. Please refer to CO-OP Financials section for additional information.

The feasibility study acknowledges that the risk corridors receivable of $87.7M included in this solvency loan request is "substantially higher" than June 2014 projections of $41.4M and indicates that some claims were "inadvertently excluded" in the data provided by COH for the risk corridors calculation for the prior projections (P. 14). Details on the calculation of the risk corridors were not provided in this application. Additionally, COH indicates that the largest current cash claims loss ratios are coming from three areas – the Iowa Marketplace Choice Plan (IMCP), platinum plans, and the off

Marketplace Iowa individual market (P. 38). The CO-OP is terminating this business effective 1/1/2015. The solvency request indicates these lines of business total 11,500 members. COH has assumed claim decreases of 3% from exiting the IMCP program and an additional 20% from the improved morbidity in the single risk pool (P. 13). The pro formas do show improvement in the MLR from 2014 to 2015, but specific details for these lines of business are not provided. Additional analysis on how COH determined the 20% morbidity improvement factor was not provided.

COH acknowledges the need for reinsurance to avoid significant annual fluctuations in claims that could threaten solvency (P. 18) and has secured 2 year policy coverage with Partners Re which has an attachment point of $500,000 for both individual and small group (P. 59). The federal reinsurance program has a cap of $250,000; therefore, there is a gap in reinsurance coverage between $250,000 and $500,000.

The June 2014 submission did not include a PDR. The current pro formas indicate that the CO-OP has set up a PDR of $25M for 2014. However, COH did not provide an explanation of the PDR or any of the underlying figures that went into the calculation. This figure does directly impact solvency amounts and the request for additional solvency loans.

COH does not have enough experience in the base period to use in rate development; therefore, the 2015 rate development is based solely on manual rates.

Summary of Observations:

- **2015 medical costs are based on industry data**. COH does not have enough 2014 experience to have data to rely upon; therefore, industry assumptions are necessary to estimate the morbidity of the projected membership.
- **The 3Rs receivables are difficult to quantify.** This is because of the uncertainty of the industry average morbidity which is needed to accurately estimate risk adjustment. Risk corridors is calculated after risk adjustment and, therefore, relies upon the risk adjustment estimate. Without these receivables, COH would have a loss of $210M for 2014 instead of the $60.3M projected in the pro formas.
- **Reinsurance is identified as a strategy, however contract leaves a gap in coverage.** An attachment point of $500,000 for both individual and small group will leave a gap in coverage between $250,000 and $500,000 due to the federal reinsurance cap.

4. **CO-OP Financials:**

In the base case, COH projects a $60.3M net loss during 2014 after projected $144.9M of 3R net recoveries. From 2014-2016, the CO-OP expects cumulative recoveries of $79.4M in federal reinsurance, $203.9M in risk corridors and $8.7M in risk adjustments, totaling $291.9M. Even with the $291.9M in recoveries, the CO-OP is still projecting to lose $77.6M during those years. Under the stress case scenario, COH is projected to lose $87.4M from 2014-2017 that includes the 3R recoveries of $323.8M. The CO-OP is expecting cumulative recoveries of $81.6M in federal reinsurance, $233.5M in risk corridors and $8.7M in risk adjustments totaling $323.8M from 2014 through 2016. However, without the 3Rs, COH will incur a cumulative net loss of $369.5M in the base case and $411.1M in stress test during 2014-2016, respectively. Throughout the life of the loan, COH is projected to keep its RBC levels above 500% of ACL under all scenarios presented by the applicant, assuming projections are realized.

According to the applicant, the Iowa Commissioner of Insurance has been reviewing the risk profile of COH throughout the year and has indicated "he anticipates that it will be necessary for him to require COH to increase its capital and surplus at some point in the third quarter of calendar year 2014" (P. 64). No further information has been provided. It is also unclear if this discussion took place before COH received the additional $32.7M award of solvency loan funds in September 2014 as a result of the prior round of solvency loan requests in June2014. COH has requested additional solvency loan funding of $55M in light of higher than projected enrollment, delay in receipt of 3R receivables and higher than expected claim costs. Combined with the current solvency loan funding award, the total solvency loan for COH would be $185.9M. However, the request of $55M would result in a total solvency loan amount of $185.6M, but the pro formas are based on a loan of $185.9M which is the amount on which this review will be based. The applicant asserts that "if the risk corridor program is not available in 2015 and 2016, we project COH total solvency loan to be $300.7M" (P. 9).

Under the stress test scenario, COH requires an additional $9.7M in solvency loans, totaling $195.6M. COH expects to start repayment of interest on the solvency loans in 2019, and will begin payments of interest and principal in 2021. COH projects to continue making annual repayments through 2032, until the loan is paid in full, if projections are realized. COH states it "will have sufficient capital to repay its solvency loans within fifteen years of its specific draw down dates while meeting State reserve requirements and solvency regulations" (P. 12). Conversely, COH's ability to repay the $3.6M in start-up loan funding due in 2017 relies on the receipt of 3Rs receivables totaling $291.9M from 2015-2017, the $55M in solvency funding and its ability to maintain enrollment despite a projected average premium increase of 9%, 22% and 21% in 2015, 2016 and 2017, respectively. See further detail in the Product Pricing section.

In addition to the requested solvency loan request from CMS, COH also applied with National Cooperative Bank in Washington for a $68M cash flow operating loan for 2014-2017 to cover short term working capital that results from delays in the federal reinsurance program. The loan is contingent upon COH receiving additional solvency loans from CMS and the external party obtaining "a senior, secured position in Transitional Reinsurance receivables" (P. 63). In its application for additional solvency loan funding, the applicant stated that "the collateral in the form of an account receivable is created as claims are incurred and is not dependent upon market averages or future data. The asset is a federal receivable from CMS although to be usable as collateral it will require written assignability from the holder to the lender which will require a CMS waiver" (P. 42). COH projects to receive approximately $48.5M in recoveries from the federal reinsurance program for 2014 to be used as collateral. However, COH built both its base and stress case scenario under the assumption COH will receive additional solvency and private funding in 2014. Subsequently, the cash flow statement shows COH taking drawdowns from the private loan during 2015 and 2016 while making annual payments through 2017. However, since COH does not turn a profit until 2018, repaying the private loan appears to require recoveries from the 3Rs and solvency loan funding to payback both the private loan and loan to CMS.

Per the Loan Tracker, the CO-OP has been awarded total funding of $145.3M ($14.7M in start-up loans $97.9M in solvency loan funding and $32.7M from the latest round), and began issuing health insurance products beginning in 2014. Of the $130.6M of solvency loans, $97.9M disbursed as of October 3, 2014. A review of the original application indicates the solvency loan disbursement of $97.9M was to be disbursed from 2013-2020. The current pro formas are projecting $185.9M to be disbursed from 2013-2017. In addition to the $32.7M that was dispersed in September 2014, the CO-OP, if awarded the $55M, is requesting to receive; $30.2M in 2014, $5M in 2015, $9M in 2016 and $11M in 2017. Instead of taking the lump sum in 2014, COH has requested to receive distribution over 4 years; this appears to cover the shortfall in cash the CO-OP will suffer from due to payments of the startup loans and private loans. If COH doesn't receive any additional funding and the 3R payment of $144.9M is not received till Q3 2015, CMS may want to consider that COH could suffer from a liquidity issue. Not enough information was provided to substantiate the need and as a result, the impact on its pro formas cannot be assessed.

Base Case

If projections are realized, COH expects losses of $60.3M, $15.2M and $2.1M from 2014-2016, while breaking even in 2017. However, absent recoveries from the reinsurance program, COH projects to incur losses of $205.2M, $107.2M and $57.1M from 2014-2016, while still breaking even in 2017. Once COH reaches 2018, the CO-OP projects cumulative profits of $546.5M for the remainder of the loan from 2018-2034.

COH projects an MLR with 3Rs of 93.3% in 2014, 90.4% in 2015, and 87.9% in 2016 which does not include the impact of the ACA adjustments. COH projects to recover $48.5M, $19M, and $11.9M of its incurred claims from federal reinsurance programs in 2014, 2015, and 2016, respectively. Absent the level of reinsurance recoveries and excluding the impact of the ACA, the MLR for 2014, 2015, and 2016 is projected to be 139.1%, 114.2%, and 99.2%, respectively. It should be noted that in the 2Q14 regulatory filing, COH netted the cost sharing reductions ("CSR") with claims in error, affecting the MLR. With the impact of CSR excluded from claims, the MLR would be 103% at June 30, 2014. It is unable to be determined if COH also netted the CSR in the pro formas. See further comments in the Medical Costs and Losses section.

In the pro formas, COH's ACR is 20.4% in 2014, 18.3% in 2015 and 16.6% in 2016. The ACR ranges from 20.4% down to 13% in 2034, with an average ACR of 14% from 2014-2034. The decrease in administrative expenses is not substantiated or explained in the application. The administrative budget is comprised of Salary/Wages/Benefits, Travel, Equipment, Supplies, Contractual and Other Budgeted Items. The largest expense is contractual expenses related to HP which accounts for 49%, 55%, 57%, respectively from 2014-2016. No further information was provided as to whether these functions would eventually be brought in house or continue to be outsourced.

Stress Test

The stress test scenario projects the financial impact COH would encounter if it incurred a 10% increase in claim costs in 2015, before returning to baseline levels in 2016. The claim spike led to a $9.7M increase in solvency request from approximately $185.9M to $195.6M. Then, in 2028, COH increases its revenue by $11.1M or 1% with no other changes from the base case scenario.

The stress test projects COH to commence profitability in 2018, with a gain of $18.9M, after sustaining losses of $87.4M from 2014 through 2017. The CO-OP projects a cumulative net income of $556.3M from 2018 to 2034, with RBC levels projected to stay above the CMS recommended level of 500% of ACL through 2034. COH projects to continue to make annual repayments through 2032, until the loan is paid in full, if projections are realized. However, COH's ability to repay its loans relies on its 3R recoveries and its ability to maintain its enrollment figures despite a projected premium increase of 9%, 22% and 21% from 2015 to 2017, respectively.

COH projects a MLR with 3Rs of 93.3% in 2014, 93.1% in 2015, and 87.9% in 2016 this does not include the impact of the ACA adjustments. COH projects to recover $48.5M, $21.2M, and $11.9M of its incurred claims from federal reinsurance programs in 2014, 2015, and 2016, respectively. Absent the level of reinsurance recoveries and excluding the impact of the ACA, the MLR for 2014, 2015, and 2016 is projected to be 139.1%, 125.7%, and 99.2%, respectively. It's likely that similar to the base case, COH has netted the CSRs and claims together, but this assumption cannot be confirmed with the information provided.

Summary of Observations:

- **Potential liquidity issue:** Based on the pro forma cash flow statement, if COH doesn't receive any additional funding and the 3R payment of $144.9 are not received until Q3 2015, CMS may want to consider that COH could suffer from a liquidity issue. Not enough information was provided to substantiate the need and as a result, the impact on its pro forma financials cannot be assessed.
- **COH's enrollment assumption:** The pro formas indicate COH will be able to repay its solvency, start-up and private loan, if projections are realized. However, it is not clear how COH projects maintain its membership projections for 2015, 2016, and 2017 with the projected increases in premium rates of 9%, 22% and 21% respectively.
- **Solvency loan funds being used to pay Start Up and Private loans.** Since COH doesn't turn a profit until 2018, it appears COH will be using solvency loans to help pay off its start-up and private loans from 2015-2017.
- **Potential request for more solvency loan funding from Iowa Insurance Division: According to the applicant,** the IID has been in contact with COH about its risk profile and likely needs more solvencies in 3Q14. No further information was provided. Also, it's unclear if that discussion took place before or after the $32.7M in additional solvency was awarded to COH.
- **Unsubstantiated revenue increase in stress test:** The COH pro formas for the stress test have an $11M or 1% increase in premiums during 2028 that is not explained. It's unclear what is causing the unanticipated increase in premiums from the base vs stress case.

5. Contingency Plan:

COH considered the following options as part of its contingency plan:

- **Merger with another CO-OP. To gain additional solvency, COH considered merging with another CO-OP and utilizing its unused capital for operations.** However, "no CO-OPs have been approached for such an arrangement to date" (P. 63/64)
- **Merge or affiliate with another large healthcare entity.** COH contemplated merging or affiliating with a large healthcare entity, unfortunately, due to "its liquidity challenges yet unresolved." (P. 64), no interest was identified in the market.
- **Enrollment cuts.** Excluding the already removed business lines from the base case, COH has determined no other business units can be terminated. The CO-OP believes if they were to cut the off Marketplace individual business in Nebraska, it would have a "catastrophic effects on distribution channels and is tantamount to a shutdown but at greater cost over a longer time" (P. 64).However, no information was provided to substantiate this claim.
- **Shutdown operations.** If no additional solvency loans are awarded, COH believes its only viable option is to shut down operations. It has exhausted all aforementioned options (P. 64).

After assessing the options, in the event no loan award is made, COH believes the only realistic alternative is to shut down operations starting November 1st, 2014, after notification of loan decision. COH provided a financial forecast showing cash flows and enrollment numbers through 2015. However, this was not submitted to Milliman for review, thus not included in the actuarial certification. The financial forecast is based on closing individual enrollment for 2015 while maintaining small and large group through the anniversary date, ceasing coverage completely in October 2015. The projected forecast shows that COH believes it can pay back the start-up and solvency loans to CMS, if the projections are realized. However, the ability to pay back the loans hinges on the 3R payments in 3Q15.

Summary of Observations

- **Private loan is contingent on CMS funding and a senior secured position.** The private loan COH is attempting to obtain is contingent upon CMS awarding additional solvency funds and the lender receiving a senior secured position on the transitional reinsurance receivable. Without those requirements, it is unlikely that COH can obtain the private loan. The effect on the pro formas cannot be determined.
- **If solvency funding is not provided, COH will shut down.** If no funding is awarded, COH will approach the DOI to begin shutting down operations as of 11/1/14 and any future losses will be covered by the guarantee fund (P. 81). COH will cease individual enrollment for 2015 while maintaining small and large group until the anniversary date hits in 2015 (P. 81). In the application, COH provided a financial forecast of enrollment and cash flow for the next 14 months. The forecast predicts that COH will be able to repay its CMS loans if projections are met.

Solvency Loan Request Points

Sections	Potential	Total
Enrollment	15	10.25
Product Pricing	20	10
Medical Costs and Losses	15	11
CO-OP Financials	15	8
Score	**65**	**39.25**

Contingency Plan Points

Contingency Plan	Potential	Total
Overall	10	0
Score	**10**	**0**

Kentucky Health Cooperative, Inc.
Additional Solvency Loan Funding Request Report
Date Submitted to CMS: 10/09/2014

Scope Summary & Assumptions:

- Deloitte will not provide an opinion regarding the reasonableness of the proposed changes to each CO-OP's business plan. Nor will Deloitte provide an opinion regarding the likelihood of each CO-OP achieving sustainable operations based upon the revised business plan.
- Deloitte assumes that the information provided by each CO-OP in its modified business plan is complete and accurate. Deloitte will perform its assessment of the data provided "as is". Deloitte will also use other data sources that are publicly accessible or information provided directly from the Centers for Medicare and Medicaid Services (CMS). Deloitte will notify CMS if we believe that there is insufficient information to complete our review.
- In these applications for solvency loan requests, the CO-OPs have cited a need for additional solvency loans to cover projected cash shortfalls as a result of nonadmitting risk-sharing receivables provided in the Affordable Care Act (ACA). The National Association of Insurance Commissioners (NAIC) is charged with developing accounting guidance for these risk-sharing provisions which are utilized by the state departments of insurance in monitoring the financial solvency of the insurers domiciled in their state. The NAIC is continuing their deliberations on this issue, which previously included potential nonadmittance for risk-sharing receivables in excess of any payables. However, as a result of the most recent NAIC meeting on August 17, 2014, the adopted minutes of that meeting reflects that the NAIC is "replacing the nonadmission guidance with criteria that incorporates conservatism and sufficiency of data and removing the exposed 90-day guidance and adding language to be consistent with other government receivables". This Findings Report will provide relevant information, as necessary, on the accounting treatment for the risk-sharing receivables used by the CO-OPs in their financial projections.
- The impact of the Reinsurance, Risk Adjustment and Risk Corridors Program (the 3Rs, reinsurance, risk adjustment, and/or risk corridors) was reviewed when making observations and comments throughout this report. Observations and comments relating to the impact of the 3Rs are included for informational purposes only. We are not commenting on the reasonableness or propriety of any of the amounts relating to the 3Rs. Nor are we commenting on the underlying accounting policy. Based on the scoring criteria provided by CMS, observations and comments relating to the 3Rs had a net neutral effect on the scoring.
- In reviewing applications from CO-OPs for additional solvency loan funding requests, Deloitte reviewed supporting documentation requested of the applicants by CMS in a memo to the CO-OPs distributed on August 22, 2014. The format of the reports as well as the section scoring was approved by CMS during the week of June 2, 2014. These reports are scored on the basis of a total of 65 points, plus 10 points for the contingency plan. The scoring reflects Deloitte's assessment of the degree to which the application complies with the funding loan announcement of August 22, 2014. The score for the Contingency Plan

section should be viewed independently of scoring for the other sections of this report. For all sections, Deloitte provided comments on issues only for which the applicant provided data. Observations relating to the pro forma financial statements are based on the base case with additional solvency award scenario (base case), unless otherwise noted.

Executive Summary:

Kentucky Health Cooperative, Inc. (KYHC or the applicant or CO-OP) has submitted a request for additional solvency loan funding relating to KYHC's Kentucky operations. However, the application and underlying financials do not discriminate between projected Kentucky and West Virginia operations. Therefore, a distinction was unable to be made between the solvency loan funding needs for Kentucky and West Virginia in this report. Any additional solvency loan funding received by the CO-OP is required to be aggregated with funds for West Virginia.

KYHC provided two versions of the base scenario; first, if the risk corridors receivable is treated as a nonadmitted asset, KYHC will request one of three potential funding options, each resulting a different level of RBC. Conversely, if the risk corridors receivable is admitted, KYHC requests two additional funding options. These two funding options are predicated on KYHC's ability to receive a private loan of $15M. There is no further information provided in the application as to whether the CO-OP will need to collateralize assets to obtain this private loan or whether it is contingent upon receiving additional solvency loan funds from CMS. In the event that KYHC does not receive private loan funding, KYHC will request the total "Solvency Loan Requested" amount for each option as outlined in Table 1 below. However, KYHC "acknowledges that receiving $103 million in funding just to maintain a RBC of 500% is not necessarily the correct solution" (P. 119). Presented in Table 1 below is a summary of the base case and each of the suggested funding options. See the CO-OP Financials and Contingency Plan sections for further details.

Table 1: Funding Options for 2014

Base Case 2014	Risk Corridors not admitted			Risk Corridors admitted		
Line	Funding Option 1	Funding Option 2	Funding Option 3	Funding Option 1	Funding Option 2	Funding Option 3
Solvency Loan Requested	103,000,000	69,100,000	45,000,000	103,000,000	69,100,000	45,000,000
Solvency Loan from CMS	103,000,000	69,100,000	45,000,000	N/A	54,100,000	30,000,000
Private Loan Proceeds*	-	-	-	N/A	15,000,000	15,000,000
Risk Corridors	74,609,827	74,609,827	74,609,827	N/A	74,609,827	74,609,827
RBC Level	500%	200%	< 200%	N/A	> 700%	> 500%
Enrollees	47,186	47,186	47,186	N/A	47,186	47,186
MLR with 3Rs	95.4%	95.4%	95.4%	N/A	95.4%	95.4%
MLR without 3Rs	161.3%	161.3%	161.3%	N/A	161.3%	161.3%

* Private loans will not be used in solvency calculation

The results under 'Risk Corridors admitted' are based on the assumption that the CO-OP will obtain a private loan. KYHC "acknowledges that receiving $103M in funding just to maintain a RBC level of 500% of ACL is not necessarily the correct solution" (P. 119)[1].

In practice, however, none of the funding options above represent the break even financial need of the CO-OP. The amount in solvency loan funding required by the CO-OP will also be affected by:

- Status of West Virginia start-up loan funding: KYHC was obligated $7,000,000 in start-up funding and $12,652,200 of solvency loan funds for West Virginia operations
- Impact of the 3Rs receivables
- CO-OP's access to a private loan
- KYHC's participation in open enrollment

KYHC has stated that "if additional solvency funding is not awarded, [KYHC] stand[s] ready to move our approximately 55,000 existing lives to other carriers and remove the health plan from the open enrollment as an unfortunate but appropriate option" (P. 118).

Based on CMS's CO-OP Summary Report by Borrower as of 10/3/2014 (Loan Tracker), the CO-OP was originally obligated $81,494,772 of start-up, and solvency loan funding and began issuing health insurance products beginning in 2014. As of 10/3/2014, a total of $78,933,123 has been disbursed, specifically $59,497,900 of obligated solvency loan funding and $19,435,223 of the $21,996,872 of obligated start-up loan funding. Out of these totals, KYHC was obligated $7,000,000 in start-up and $12,652,200 in solvency loan funding for West Virginia. Because this is a single entity, the start-up and solvency loan funds awarded for West Virginia operations have been commingled with the start-up and solvency loan funds initially awarded to KYHC. KYHC is currently requesting additional solvency loan funding because of higher than expected enrollment and primarily to address solvency issues caused by the treatment of the risk corridors receivable as a nonadmitted asset.

It is important to note that the applicant did not include a business plan with this solvency loan request. The most recent business plan available is out of date, submitted to CMS in May of 2014 for Kentucky, and October of 2013 for West Virginia, but they were used to the extent necessary in this review. The lack of an updated business plan for both Kentucky and West Virginia leaves information gaps regarding enrollment as well as necessary support for financial related observations. Materials provided by the CO-OP in the application, in addition to supplemental information that is publicly accessible or was provided by CMS, have been considered in this report. Differences, when observed within the materials, are noted within the report. Deloitte has not taken any actions to verify the accuracy of the data or reconcile any observed discrepancies between this application and data previously submitted by the CO-OP.

KYHC did not provide the breakout of Kentucky and West Virginia enrollees in the current solvency loan funding request. Therefore, all discussion of enrollment projections for all years refer to combined West Virginia and Kentucky membership. In addition, KYHC did not provide an updated enrollment strategy with this request and stated in the application that the information be referenced in the business plan submitted to CMS in May 2014. The term 'Marketplace' indicates that it is applicable to both the Kentucky and West Virginia Marketplaces. KYHC stated that it expects Kentucky-only enrollment to decrease in 2015 due to premium increases and the introduction of two new competitors in the Marketplace. It is unclear why the CO-OP expects these factors to negatively impact enrollment as the application states the CO-OP's individual rates for 2015 remain 5-25% below that of the lowest competitor. Insufficient information was provided to assess changes to Kentucky standalone enrollment in this report.

[1] Page numbers in this report refer to the consolidated application.

By including the 3R receivables, KYHC is projecting a loss of $22.5M, a profit of $513K, and $501K for 2014, 2015, and 2016, respectively. Without consideration of the 3R receivables, the CO-OP is projected to have losses of $139.3M, $63M, and $7.2M for 2014, 2015, and 2016, respectively. If the benefit of Affordable Care Act (ACA) adjustments is included, KYHC projects a medical loss ratio (MLR) of 96% in 2014, 81% in 2015, and 82% in 2016. Excluding the 3R receivables and the impact of the ACA adjustments, the MLR for 2014, 2015, and 2016 is projected to be 161%, 86.8%, and 86%, respectively. KYHC projects to recover $115.5M, $10M, and $8.1M from the 3Rs recoveries in 2014, 2015, and 2016, respectively. KYHC has increased premiums for 2015 from 2014 in order to adjust for enrollment of high-risk populations, among other things, and plans to deploy medical management strategies. However, KYHC did not provide sufficient information to analyze these strategies.

As stated above in the Scope Summary and Assumptions section, pending accounting guidance relating to accounting treatment has been updated to reflect risk corridors receivables as an admitted asset as long as there is supporting documentation. Kentucky's solvency loan funding application is conservative and reflects $74.6M in assets that it is currently reporting as nonadmitted. The CO-OP's position for accounting treatment relating to these receivables does not reflect the current direction of NAIC. However, it is also noted that the NAIC has not issued final guidance, which is expected in November 2014. If projections are realized, it is apparent that if the accounting rule is not resolved in KYHC's favor by year end 2014 and no further solvency loans are awarded, the CO-OP will have both critical liquidity and solvency issues.

If the funding options presented in Table 1 above are not awarded, KYHC proposes delaying its West Virginia implementation from 2015 to 2016 and converting $5M of start-up funds into solvency loan funds in order to reduce its funding request from $54.1 to $49.1M. KYHC did not provide the pro forma financial statements for the other contingency scenarios outside of the base case where it projects to receive $103M in solvency loan funds. Therefore, the impact of the additional scenarios on its pro forma financial statements cannot be assessed.

The CO-OP states, "KYHC was awarded their start-up and solvency loans for both the initial request and the West Virginia expansion based on the 2017+ Adverse Experience scenario (3% unanticipated increase in claims every fourth year) that was included in their original feasibility analysis. Because of this, it was necessary (and still appropriate) to use this scenario as the baseline scenario so that the results of this feasibility analysis could be used to isolate the change in solvency loans necessary to operate at 500% RBC given emerging 2014 claims and membership experience. " (P. 17). This makes it difficult to review the solvency for the true baseline projections. Solvency loans needed under an alternative stress scenario would be larger than under a base case scenario. Applications for solvency loan funding were generally funded using a base case scenario.

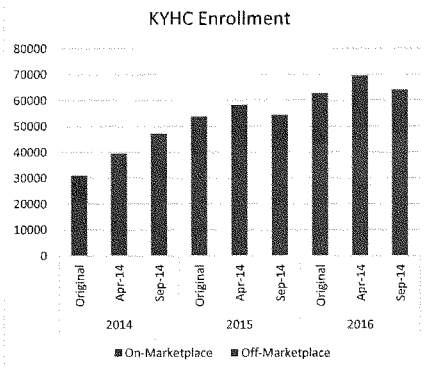
Critical Assertions:

1. <u>Enrollment:</u>

KYHC did not provide the breakout of enrollment between Kentucky and West Virginia with the current solvency loan request. While 2014 enrollment projections reflect membership in Kentucky only, projections for 2015 and 2016 also include enrollees from KYHC's operations in West Virginia, d/b/a West Virginia Health Cooperative, Inc.. KYHC's operations in West Virginia are projected to commence with 2015 open enrollment in November 2014.

Kentucky operates on a state-based marketplace, Kynect (Kentucky Marketplace). The operations for West Virginia, involve a state-partnership marketplace (West Virginia Marketplace). The term 'Marketplace' indicates that it is applicable to both the Kentucky and West Virginia Marketplaces.

Figure 1: September 2014 Enrollment Projections exceed Original Projections



Source: Original 2011 pro formas. 10/2013 pro formas, 5/2/2014 pro formas, and 9/22/2014 pro formas

Based on KYHC's most recent pro forma financial statements submitted in September 2014 (9/22 Pro Formas or pro formas), enrollment for 2014 is expected to be 53% more than original application projections[2] (2011 Pro Formas) and 19% more than enrollment projections in a business plan provided to CMS in May 2014 (5/2 Pro Formas). Despite exceeding the original projections of total 2014 enrollment, KYHC did not achieve expected off Marketplace or Small Business Health Options Program (SHOP) enrollment. In the 2011 Pro Formas, KYHC projected to enroll 10,085 members in Kentucky off Marketplace in 2014 but pro formas submitted with this solvency loan request and the 5/2 Pro Formas indicate the CO-OP has no off Marketplace enrollment[3]. The lack of off-marketplace enrollment in 2014 is consistent with the data reported in the CMS CO-OP Enrollment Comparison Report as of August 5, 2014.

KYHC stated in the application that it expects 13,000 enrollees in West Virginia in 2015, although this information was not reflected in the pro formas. Based on this figure, KYHC is expecting 41,346 enrollees in Kentucky in 2015. This represents a 12% decrease from 2014 average enrollment levels in Kentucky. The breakout of on and off Marketplace enrollment and the breakout of individual and small group enrollment was not provided.

The application states that Kentucky only enrollment is expected to decrease from 2014 to 2015 for two reasons. First, there are two new entrants on the Kentucky Marketplace in 2015, CareSource Kentucky Co. and WellCare Health Plans of Kentucky, Inc.. Second, KYHC filed for a 15% rate increase for individual products offered on Kentucky Marketplace in 2015 in response to high medical costs in 2014. Despite stating in the application that Kentucky only enrollment will decrease in 2015, the 9/22 Pro Formas show a 15% increase in enrollment from 2014 to 2015.

Based on the 9/22 Pro Formas, KYHC expects to enroll 54,346 members in 2015 and 64,088 members in 2016, representing an 18% growth in membership from one year to the next. However, compared to the 5/2 Pro Formas, KYHC is expecting 7% fewer enrollees in 2015 and 8% fewer enrollees in 2016. Because a breakout of

[2] All references to "original" – including, but not limited to, "original funding application", "original application", and "original projects" – refer to KYHC's 2011 application for CMS start-up and solvency loan funding, operations commencing in 2011.
[3] Annual enrollment projections provided in the pro formas reflect average membership over a 12 month period.

enrollment data was not provided, it cannot be determined whether these decreases between projections impact Kentucky or West Virginia membership in 2016. See Documentation for Change in Enrollment Projections section below for further information.

Documentation for Change in Enrollment Projections

KYHC is requesting additional funding due, in part, to an increase in projected enrollment from the 2011 Pro Formas to the 9/22 Pro Formas and to cover higher than expected claims costs in 2014 (P. 4). The applicant attributes higher than expected enrollment in 2014 to its pricing and the elimination of 4,500 individuals from the state's high risk pool as of 12/31/2013. KYHC was the only carrier on the Kentucky Marketplace to offer a Platinum plan and the applicant believes that this product attracted a "high concentration of individuals with high costs associated with health status", specifically those terminated from the high-risk pool (P. 4). KYHC stated in the application that it captured 75% of Kentucky Marketplace enrollment in 2014. This estimate could not be independently verified. Please see the Product Pricing and Medical Costs and Losses sections for further details.

In its May 2014 business plan, KYHC cited competitors' "extensions of non-compliant plans" as the key factor in failing to enroll off the Kentucky Marketplace in 2014 (P. 3848). It is not clear from the business plan how this extension impacted off Marketplace business as enrollees in non-compliant plans would have otherwise been expected to enroll on Marketplace. No further detail was provided in the application to support this statement.

KYHC cited the delay of SHOP functionality for the lack of small group enrollment in 2014 although the CO-OP did not market these offerings (P. 3548). KYHC now projects to have off Marketplace and SHOP enrollment beginning in 2015. However, it is not clear from the information provided in which state KYHC intends to enroll these members or how the CO-OP plans to attract them to these products.

KYHC did not provide any detail on how it plans to achieve its target enrollment in West Virginia given the presence of a dominant insurer, Highmark, Inc. in the West Virginia Marketplace. Additionally, KYHC did not provide detail on how it intends to address challenges experienced in Kentucky in 2014 for 2015 West Virginia operations, with the exception of not offering a Platinum plan on the West Virginia Marketplace.

Table 2: Documentation for Change in Enrollment Projections

Reason Cited by KYHC for Changes in Enrollment	KYHC Proposed Action	KYHC Justification
Only Carrier Offering a Platinum plan on the Kentucky Marketplace	1. **Will not offer a Platinum plan in the West Virginia market in 2015.**	The Kentucky and West Virginia high risk pools were terminated in 2013. KYHC believes that the elimination of the risk pool in Kentucky put high-cost individuals onto the Kentucky Marketplace and that these individuals chose KYHC because it was competitively priced and the only carrier to offer a Platinum plan (P. 4). KYHC believes that by also eliminating the Platinum plan offering from the West Virginia Marketplace that the CO-OP can "avoid the likely adverse-selection of prior high risk pool enrollees" experienced in Kentucky (P.5). Kentucky will continue to offer a Platinum plan on the Kentucky Marketplace in 2015.
	2. **Raise individual premiums rates by**	According to the applicant, KYHC premiums "were not unreasonably lower or higher than other competitor's rates" in 2014 (P. 5). However,

Reason Cited by KYHC for Changes in Enrollment	KYHC Proposed Action	KYHC Justification
Price Competitiveness	**an average of 15% in Kentucky for 2015.**	KYHC states that it is raising individual rates to account for adverse selection in 2014. Please see the Product Pricing section for additional information. Despite this rate increase, KYHC expects to be the "lowest priced plan at between 5-25% below the closest competitor" in five of eight rating areas (P. 30). In the remaining rating areas, KYHC expects to be between 10-40% higher than the lowest priced competitor (P. 30). No documentation was provided to support these statements. It is unclear how KYHC intends to avoid adverse selection if it remains the lowest priced competitor on the Kentucky Marketplace. KYHC did not provide sufficient information to determine how this increase will affected individual enrollment levels in Kentucky. KYHC states that additional solvency needs are "not due to inadequate or inappropriate pricing" in 2014 (P. 5). This statement appears contradictory to the fact that KYHC will remain 5-25% below the lowest priced competitor and to the high medical costs experienced by the CO-OP to date.
	3. Raise small group premiums by an average of 6.5% in Kentucky for 2015	KYHC filed for an average 6.5% rate increase for small group products across all rating areas in Kentucky. KYHC states that its small group rates will be 0-10% higher on average than the lowest priced competitor. According to the applicant, this price position is an improvement from 2014, when the CO-OP's small group plans were priced 10-15% higher than the lowest priced competitor on average (P. 30). Insufficient detail was provided to determine how the CO-OP will raise its small group rates while also closing the price gap between KYHC and the lowest priced competitor.
Delay in SHOP functionality	4. **Increase marketing for small business product offerings.**	KYHC cited "SHOP design challenges" that "resulted in a slow start to participation by employer groups in the latter part of 2013" as explanation for the lack of small group enrollment in 2014 (P. 3548). The CO-OP noted that it decided to delay "aggressive marketing" of small group products off Marketplace as a result but did not provide further detail (P. 3548). KYHC did not provide detail on the change in off Marketplace small group enrollment. SHOP delays would be expected to impact small group enrollment on Marketplace only. The feasibility study states that KYHC expects a "one-year delay in our initially anticipated small group market behavior" and, therefore, is now projecting these members in 2015 (P. 27). No further information was provided on the impact of the delay in small group enrollment in 2015.
New entrants on Kentucky Marketplace	5. **No action proposed.**	KYHC stated in the application that the entrants of two new carriers on the Kentucky Marketplace will have a "noticeable impact" on Kentucky enrollment in 2015 (P. 30). The CO-OP did not substantiate this statement. It is unclear why the CO-OP expects these new carriers to

Reason Cited by KYHC for Changes in Enrollment	KYHC Proposed Action	KYHC Justification
		negatively impact enrollment given the CO-OP also states it will be priced 5-25% below the next lowest priced competitor in five of eight rating areas (P. 30). KYHC did not provide detail as to how the CO-OP plans to address additional competition in the Kentucky Marketplace despite stating that it believes the new entrants will impact enrollment levels.
Extension of non-compliant health plans	6. **Distribute advertisements to key audiences**	According to the applicant, off Marketplace individual enrollment was, in part, lower than expected due to the extension on non-compliant health plans in Kentucky. To address this issue in 2015, the CO-OP intends to "develop and implement retention programs aimed at retaining our individual market share and complete the build out of direct enrollment and lead generation programs designed to position the CO-OP competitively going forward" (P. 3849). No further detail was provided to support these plans in the May 2014 business plan. Further detail was not provided with the current solvency loan request. KYHC did not provide sufficient information to analyze the assertion that the extension impacted off Marketplace enrollment in 2014.

Summary of Observations:

- **Increased 2014 enrollment from 2011 and 5/2 Pro Formas.** KYHC exceeded original enrollment projections in both the original 2011 and May 2014 submissions by 53% and 19%, respectively. KYHC cites higher than expected enrollment as one justification for requesting additional solvency loan funding.
- **Decreased in projected 2015 and 2016 Kentucky enrollment from 5/2 Pro Formas.** KYHC is projecting a decrease in Kentucky only enrollment in 2015 due to premium increases and the entrance of two new competitors in the Kentucky Marketplace. It unclear why the CO-OP expects premium increases to negatively impact Kentucky enrollment since the CO-OP states it will be 5-25% below the next lowest priced competitor in five of eight rating areas in Kentucky. Further, it is unclear why the CO-OP expects these new carriers to negatively impact Kentucky enrollment given the CO-OP's price position (P. 30). Enrollment losses in Kentucky are partially offset by the introduction of enrollees from West Virginia in 2015 and 2016. KYHC stated in the application that it expects 13,000 members in 2015 from West Virginia operations (P. 3844).
- **Increased premiums planned for 2015 in Kentucky.** In response to higher than expected enrollment and the "adverse selection of prior high risk pool enrollees" in 2014, KYHC is raising premiums by an average of 15% in 2015 for individual products (P. 3548). Despite this rate increase, KYHC expects to be the "lowest priced plan at between 5-25% below the closest competitor" in five of eight rating areas (P. 30). No documentation was provided to support this statement. In the small group market for 2015, KYHC filed a 6.5% average rate increase with small group rates "approximately 0-10% higher than the lowest priced plans" (P. 30). Despite rate increases, KYHC expects its small group offerings to be "more competitive" in 2015 (P. 30). No detail was provided to support this statement.

- **Lack of detail around correction of adverse selection issues in Kentucky in 2015 and 2016.** KYHC stated that is requesting additional solvency loan funding to account for higher than expected medical costs (P. 4). Because KYHC also states that it will be the lowest priced plan by 5-25% on the Kentucky exchange in five of eight rating areas, it is not clear why the CO-OP expects it will avoid enrolling high-cost members in Kentucky, whom the CO-OP describes as "very sensitive" to price differences (P. 5). KYHC will also continue to offer a Platinum plan in Kentucky for 2015. In West Virginia, the CO-OP will not offer a Platinum plan to avoid enrolling individuals with high medical costs (P. 4).

2. Product Pricing:

KYHC's 2014 enrollment was almost 53% higher than projected in the 2011 Pro Formas and captured a market share of about 75% of Kentucky Marketplace enrollment (P. 4). According to the applicant, one of the contributing factors for the higher than anticipated enrollment is their rates being competitive and other carriers "adopting a thin network strategy of participating only in select regions (urban) or operating statewide with only a thin network" (P. 4). No further information was provided on issues related to network strategy. The state's high risk pool terminated enrollment of approximately 4,500 individuals effective 12/31/2013. KYHC was the only carrier to offer a Platinum plan in 2014 and, believes that because of this, the CO-OP enrolled a high concentration of individuals with high health costs (P. 4). The 2014 Kentucky Marketplace premiums were not published on the Kentucky Department of Insurance (DOI) website so no information could be obtained as to which insurers were offering products for the different tiers and who amongst them had the lowest rates.

Projected enrollment for 2014 is 47,186 and the CO-OP has enrolled 55,852 as of 6/30/2014 according to the Q2 regulatory filing (P. 15).

The CO-OP is raising premiums in 2015 on average by 15% for individual and 6.5% for small group products. Actual increases for specific plans range from 8% to 18.4% for individual and -2.2% to 11.9% for small group (P. 622 and 1084). There is no information available to confirm that the CO-OP was the lowest priced in one or more plans offered and how the other insurers compared against the CO-OP across the different tiers. Changes in premium rates between 2014 and 2015 being made by insurers in Kentucky are noted in Table 3 below. However, it is unclear what impact the rate increases by the CO-OP will have on existing members or how competitive the rates will be in the 2015 Kentucky Marketplace. KYHC has requested a 15% average rate increase in the Kentucky individual market and 6.5% average rate increase in the Kentucky small group market (P. 30). Rates across all individual market plans provided in 2014 are increasing in 2015 (P. 682). Small group rates are all increasing in 2015 except one (P. 1194).

The CO-OP states, "...KYHC was awarded their start-up and solvency loans for both the initial request and the West Virginia expansion based on the 2017+ Adverse Experience scenario (3% unanticipated increase in claims every fourth year) that was included in their original feasibility analysis. Because of this, it was necessary (and still appropriate) to use this scenario as the baseline scenario so that the results of this feasibility analysis could be used to isolate the change in solvency loans necessary to operate at 500% RBC given emerging 2014 claims and membership experience. " (P. 17). This makes it difficult to review the solvency loan request for the true baseline projections. Solvency loans needed under an alternative stress scenario would be larger than under a base case scenario. Solvency loan funding applications generally use a base case scenario.

In the Kentucky Marketplace, the CO-OP is not terminating any products being offered in 2014 and not adding any new products in 2015. However, the CO-OP does plan to begin doing business in West Virginia starting in

2015. Considering the worse than expected claims cost, the CO-OP is not providing a Platinum plan under the West Virginia Marketplace.

Per the application, KYHC is projecting a $22M loss in 2014 for existing KY operations. KYHC includes a $105k premium deficiency reserve (PDR) which is recovered in 2015 (P. 45). No details are provided to support the PDR established by the CO-OP. The PDR impacts the applicant's surplus and ultimately impacts the amount of solvency loan requested by KYHC.

For both small group and individual plans, changes to the overall premium level are needed, in part, because of required changes in federal/state taxes and fees. In addition, there are anticipated changes in the administrative expenses and commission arrangements. Taxes and fees are expected to contribute a 1.4% increase to 2014 premiums for individual and small group products (P. 681 and 1193).

The adjustments contributing to the total rate increase of 15% for individual are the following (P. 681):

- Total Paid Claims Trend / Benefit Change Factor / Morbidity Shift
- Administrative Expense Change Factor
- Transitional Federal Program Factor
- Federal and State Taxes & Fees Change Factor
- Profit Change Factor

The adjustments contributing to the total rate increase of 6.5% for small group are the following (P. 1193):

- Total Paid Claims Trend/Benefit Change Factor
- Administrative Expense Change Factor
- Transitional Reinsurance Benefit Factor (No Impact for Small Group Market)
- Federal and State Taxes & Fees Change Factor
- Profit Change Factor

The Kentucky Department of Insurance's website shows that the 2015 rate increases requested by the CO-OP for the individual and small group markets have been approved.

According to the applicant, Anthem Health Plans of Kentucky, Inc. was the dominant player in 2012 (P. 110). However, KYHC has captured a market share of about 75% of Marketplace enrollment during 2014 (P. 4). Table 3[4] below provides a comparison of rate changes approved for the different individual market and small group market plans approved by the Kentucky Department of Insurance. Per Table 3 below, Anthem Health Plans of Kentucky, Inc. are reducing rates whereas the CO-OP is increasing rates. Since 2014 rates were not provided, it cannot be determined whether the changes in these rates will put the dominant player from 2012 in a competitive position in 2015 or whether the CO-OP will still be the lowest priced competitor.

[4] Table Data Source: http://insurance.ky.gov/RateFil/

Table 3: 2015 Rate Changes in the Kentucky Individual and Small Group markets

State Tracking Number	Individual Market Plan	2015 Rate Change
2014-005414-R	CareSource Kentucky Co.	N/A (new)
2014-005575-R	CareSource Kentucky Co.	N/A (new)
2014-005485-R	WellCare Health Plans of Kentucky, Inc.	N/A (new)
2014-005572-R	Anthem Health Plans of Kentucky, Inc.	-4.30%
2014-005459-R	Anthem Health Plans of Kentucky, Inc.	-3.06%
2014-005415-R	Golden Rule Insurance Company	0.00%
2014-005501-R	Humana Health Plan, Inc.	12.80%
2014-005511-R	Time Insurance Company	15.00%
2014-005502-R	Kentucky Health Cooperative, Inc.	15.00%

State Tracking Number	Small Group Market Plan	2015 Rate Change
2014-005471-R	UnitedHealthcare of Ohio, Inc.	-1.70%
2014-005469-R	UnitedHealthcare of Kentucky, Ltd.	-1.00%
2014-005470-R	UnitedHealthcare Insurance Company	-0.70%
2014-005537-R	Time Insurance Company	5.00%
2014-005538-R	John Alden Life Insurance Company	5.00%
2014-005419-R	Bluegrass Family Health Inc.	5.50%
2014-005503-R	Kentucky Health Cooperative, Inc.	6.51%
2014-005529-R	Anthem Health Plans of Kentucky, Inc.	7.10%

Summary af Observatians:

- **Removal of 3R recoveries for reinsurance would put KYHC in a loss position for 2014 through 2016.** Reinsurance recoveries were estimated to be $42M, $10M, and $8M in 2014 through 2016 respectively. These are federal and commercial reinsurance amounts combined as the CO-OP did not distinguish between the two in the application. The 2014 recoveries are 17% of net premiums and decreases to 1% in 2017. KYHC includes a $105k premium deficiency reserve (PDR) which is recovered in 2015 (P. 45). No details are provided to support the PDR established by the CO-OP. The PDR impacts the applicant's surplus and ultimately impacts the amount of solvency loan requested by KYHC.
- **Premium increases for 2015 in Kentucky.** According to the applicant's estimate, 2014 enrollment was much higher than anticipated due competitive rates. KYHC was the only carrier to offer a Platinum plan in 2014 and other carriers adopted a "thin network strategy of participating only in select regions (urban) or operating statewide with only a thin network." The CO-OP plans for increases in 2015 of 15% for individual and 6.5% for small group products. There is no discussion of a plan for retaining members as the premium increases take effect.
- **Enrollment strategy adjusted to reduce the enrollment of higher risk population.** The state's high risk pool terminated enrollment of approximately 4,500 individuals effective 12/31/2013. KYHC was the only carrier to offer a Platinum plan in 2014 and, believes that this factor contributed to the high concentration of individuals with high health costs (P. 4). KYHC raised the Platinum plan rates for 2015

in hopes of reducing the high risk population in the Kentucky Marketplace. KYHC will not be introducing a Platinum plan in the West Virginia Marketplace in 2015 to avoid taking on high risk population.

- **Breakdown of taxes and fees.** The health insurer fee is estimated as 0.8% of individual premium and small group premium and is included in the 2015 rate filing (P. 681 and 1193). Milliman published a research report titled " ACA Health Insurer Fee – Estimated Impact of the US health insurance industry" dated April 2013, which states the 2014 health insurer fee estimate is 1.7% to 2.4% and increases to 2% to 2.9%. Since KYHC is a 501c(29) not-for-profit entity, the insurer fee estimate is lower than the industry average.

3. Medical Costs and Losses:

Medical costs in 2014 were double what was expected and KYHC depends on 3R recoveries to get through this period. There is no information provided in the application detailing how KYHC intends to return to a normal level. KYHC's pricing loss ratio for 2014 was 77% based on the rate filing (P. 167). KYHC is now projecting MLR to be 93.4%, including reinsurance and risk corridors recoveries. The MLR excluding ACA adjustments, reinsurance, and risk corridors recoveries is 161.3%. The reinsurance recoveries noted are both federal and commercial combined as the CO-OP did not distinguish between the two in this application. KYHC is projecting a 74% reduction in MLR from 2014 (161.3%) to 2015 (86.8%). There is not enough detail within the application to analyze the appropriateness of the decrease in MLR. If KYHC does not reduce MLR by the 74% then the CO-OP will continue to be in a loss position, if projections are realized. Finally, KYHC is expecting to be one of the lowest priced competitors in 2015. Typically, this would result in many current enrollees remaining with the plan.

Including the $42M in receivables for reinsurance and $74.6M in receivables for risk corridors for 2014 would result in a $22M loss. Removing the estimated $117M in receivables would result in a $139M loss. These losses might be attributable to worse than expected claims cost recognized during the year. However, the amount of money that will be recovered by the CO-OP through risk adjustment receivables is uncertain as the estimates of relative risk and risk transfer payments are dependent not only on the membership enrolled by KYHC but also by the other carriers in the state. It should be noted that the 3R receivables are difficult to estimate and may create issues, such as liquidity, if relied upon to generate a profit.

The CO-OP is making changes to benefits across nearly all the plans being offered. The changes made are related to the deductibles and copays across the plans (P. 682 and 1194). The CO-OP plans on deploying medical management strategies to improve health and health outcomes (P. 6). It is noted that the CO-OP has included medical management, quality improvement, commercial reinsurance, and various fixed PMPM ACA fees in the administrative expense allocation (P. 168). However, no detailed information is provided with respect to the medical management and commercial reinsurance.

Due to emerging 2014 experience indicating that the initial assumption for pre- to post-ACA morbidity shift was understated, KYHC has assumed a 5.5% increase in expected population morbidity of the Single Risk Pool from the level that was assumed in 2014 (P. 686). The state's high risk pool terminated enrollment of approximately 4,500 individuals effective 12/31/2013. Even if assumed that all of them were enrolled under the CO-OP's plans, these individuals would only constitute about 10% of KYHC's enrolled population. Since KYHC was the only carrier to offer a Platinum plan in 2014, the applicant concludes that this led to a high concentration of individuals with high health costs (P. 4). However, it is unclear as to why the claims would be so high just because of 10% of KYHC's enrolled population.

KYHC provided a draft independent auditor report which refers to a reinsurance agreement and the reinsurer is advancing an allowance to the CO-OP to cover certain start-up costs. KYHC has purchased reinsurance to avoid significant annual fluctuations in claims that could threaten solvency (P. 1233). The draft audit report dated 4/29/2014 references a reinsurance arrangement that also includes a $600,000 allowance to the CO-OP to cover certain start-up costs (P. 1233). However, information was not provided with regards to medical management and commercial reinsurance related specifics like attachment points, years the contract are in place or affected markets.

KYHC mentions other insurers on the Kentucky Marketplace "adopting a thin network strategy of participating only in select regions (urban) or operating statewide with only a thin network" (P. 4). However, since the applicant did not provide an updated business plan, the application does not provide any details about the CO-OP's network and if any changes to the network are planned for 2015. Thus, it cannot be determined if the CO-OP's network coverage is any better than those of its competitors.

KYHC does not have enough of its own experience in the base period to use in rate development; therefore, the 2015 rate development is based solely on manual rates (P. 688).

Summary of Observations:

- **Change in combined MLR for 2014.** The loss ratio without the impact of 3Rs is projected to be 161.3%. Additionally, KYHC is projecting a 74% reduction in MLR from 2014 (161.3%) to 2015 (86.8%).
- **The 3Rs receivables are difficult to quantify.** This is because of the uncertainty of the industry average morbidity which is needed to accurately estimate risk adjustment. Risk corridors is calculated after risk adjustment therefore relies upon the risk adjustment estimate. Without these receivables, KYHC would have a loss of $97M for 2014 instead of the $22M projected in the pro formas.
- **2015 medical costs based on industry data.** KYHC does not have enough 2014 experience to have its own data to rely upon; therefore, industry assumptions are necessary to estimate the morbidity of the projected membership.
- **Support for medical management and commercial reinsurance.** The CO-OP has included medical management, quality improvement, commercial reinsurance, and various fixed PMPM ACA fees in the administrative expense allocation. However, commercial reinsurance related specifics were not provided regarding attachment points, years the contract are in place or affected markets and medical management related specifics were not provided as well.

4. CO-OP Financials:

KYHC's pro forma financial statements show reinsurance recoveries of $42.2M in 2014, $10M in 2015, and $8.1M in 2016. However, the reinsurance line item is a combination of the commercial and federal reinsurance. Based on information provided, KYHC is projecting $1.3M in commercial reinsurance and $40.9M in federal reinsurance, totaling $42.2M in 2014. However, due to the lack of information in 2015 and 2016, the breakout of reinsurance could not be completed. Therefore, all calculations in this report will exclude commercial reinsurance in 2014 and include the combined reinsurance amount for 2015 and 2016. In addition, the projected 3R recoveries by KYHC will also remain the same given that claim projections remained unchanged between the base and the stress case scenario. Furthermore, the pro forma income statement includes a projected payment of $74.6M from the risk corridors program in 2014 while providing no projections for 2015 and 2016. On the pro forma income statement, the risk corridors is recorded in premium revenue, but is then treated as a

nonadmitted asset which reduces surplus by $74.6M. Please see Scope and Summary section for further information. It should be noted that the 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit.

KYHC projects a net loss of $22.4M in the base case scenario for 2014, but is expecting to achieve profitability in 2015 with a projected net income of $513K in 2015 and $501K in 2016 (P. 45). However, according to the 2Q14 regulatory filing, KYHC is currently showing a net loss of $23.5M which would require KYHC to generate $1.1M of income in the second half of 2014 or alternatively, the current projections may not fully consider the actual operating results for the first half of 2014. For the years 2015 through 2017, a net profit of approximately $500K is projected in each year. In 2018, KYHC projects a net profit of $7.1M which is projected to grow steadily in future years. However, absent 3R recoveries from reinsurance and risk corridors, KYHC will incur a cumulative net loss of $137.9M, $9.5M, and $7.6M for 2014, 2015, and 2016 respectively.

Per the Loan Tracker, the CO-OP has been awarded total funding of $81.5M ($22M in start-up loans and $59.5M in solvency loan funding), and began issuing health insurance products beginning in 2014. According to the Loan Tracker, the full $59.5M of solvency loan obligated has been disbursed to KYHC and of the $22M of obligated start-up loan funding, $19.4M has been disbursed. The pro formas indicate that total start-up funding received is projected to be $21.6M at year end 2014, $21.9 by year end 2015 and the full disbursal of $22M by the end of 2016. If KYHC receives the $103M requested in the base and stress cases, the solvency draw will total $162.5M.

Based on both the base and stress case of $103M, KYHC plans to start repayment of interest on the solvency loan in 2019 and interest and principal payments in 2023. KYHC projects to continue making annual repayments through 2033, until the loan is paid in full, assuming projections are realized. KYHC stated that it "will have sufficient capital to repay its solvency loans within fifteen years of its specific draw down dates while meeting State reserve requirements and solvency regulations" (P. 7). However, if projections are realized, KYHC does not project to earn enough net income through 2017 to repay its initial start-up loan payment of $6.3M. Therefore, it appears KYHC may need to use solvency loans to make the start-up loan repayment in 2017, if projections are realized.

Kentucky Health Cooperative, Inc. is requesting additional solvency loan funding of $103M. According to the applicant, this amount is primarily needed to address solvency issues that arise from KYHC's treatment of a risk corridor receivable for $74.6M as a nonadmitted asset. The feasibility analysis states "If this projected risk corridor receivable, which is an estimated $74.6M for 2014 in the base scenario, were made available immediately, it would eliminate much of the current need for additional solvency loan funding as well as alleviating the operating cash issues highlighted in the contingency scenario" (P.17). By including the risk corridor receivable as an admitted asset, KYHC is able to meet the CMS mandated RBC level of 500% of ACL. However, based on the pro forma cash flow statement, if KYHC does not receive any additional funding and the 3R payments of $115.5M are not received till Q3 2015, CMS may want to consider that KYHC could suffer significant liquidity issues. Not enough information was provided to substantiate the need and as a result, the impact on its pro forma financials cannot be assessed. As noted above, KYHC has stated that "if additional solvency funding is not awarded, [KYHC] stand[s] ready to move our approximately 55,000 existing lives to other carriers and remove the health plan from the open enrollment as an unfortunate but appropriate option"(P. 118).

Base Case Scenario:

As described in the executive summary, the CO-OP has used the base case to project its solvency loan request of $103M. However, KYHC "acknowledges that receiving $103M in funding just to maintain a RBC level of 500% of ACL is not necessarily the correct solution" (P. 119). For that reason, the CO-OP provided a range of funding options to reflect the status of the risk corridor and the mandated RBC levels, see Table 1 above. Additionally, the Contingency Plan section will outline each alternative funding options utilizing private loans.

Based on the solvency loan funding request of $103M, KYHC projects a loss of $22.4M in 2014, but anticipates profitability thereafter, with earnings of $513K and $501K in 2015 and 2016 and profit margin of 0.3% and 0.2%, respectively. The application is currently projecting cumulative profits of $200M from 2015-2034. This includes the cumulative reinsurance amount of $59M from 2014 to 2016, and $74.6M for risk corridor amounts in 2014. Despite the total $115.5M of 3R receivables in 2014, KYHC is still expecting a loss. The CO-OP has established a PDR of $105k for 2014. Additionally, KYHC is projected to incur a loss of $9.5M and $7.6M in 2015 and 2016 absent recoveries from the federal reinsurance program. See Product Pricing for more details.

The applicant asserts that premiums will increase by 15% in 2015 for the individual market and 6.5% for SHOP in 2015 to drive its performance improvements. In its pro forma income statement, its revenues per average number of enrollees increase by 8% in 2015 and by 12% in 2016. However, KYHC is expecting a "23% reduction in Kentucky average monthly membership in the individual market in 2015 compared to 2014" (P. 30) due to the increase in premiums. KYHC expects to help offset those losses with the expansion into West Virginia and increases in SHOP membership in Kentucky.

The base case scenario presented by KYHC is based off the stress case scenario used in the initial funding application to CMS. This case includes a 3% unanticipated medical cost increase every four years. However, the pro formas include amounts different then described. In the pro forma income statement, starting in 2022, there is a 3% increase in claims every 4 years, but that increase is followed by a 6% reduction in the 5th year, for example, 5%, 8%, 8%, 11%, 5%. The trend normalizes to an 8% increase in claims from 2022-2034. Likewise, KYHC follows a similar trend with premiums of 4%, 7%, 7%, 10%, 4% which normalizes to a 7% increase in premiums from 2022-2034. The increases in premiums and claims effectively negate any effect on MLR which holds relatively constant in these years.

KYHC projects an MLR, including 3Rs recoveries, of 95.4% in 2014, 81.3% in 2015, and 82.1% in 2016. KYHC projects to recover $115.5M, $10M, and $8.1M from the 3Rs recoveries in 2014, 2015, and 2016, respectively. Absent the 3Rs recoveries, the MLR for 2014, 2015, and 2016 is projected to be 161.3%, 86.8%, and 85.6%, respectively.

In the pro formas, the administrative cost ratio ("ACR") is 19.7% in 2014, 18.6% in 2015 and 17.9% in 2016. KYHC's ACR ranges from 19% to a low of 10.7% in 2034, with an average ACR of 13% from 2014-2034. The decrease in administrative expenses is listed as resulting from economies of scale (P.5), although no detail was provided to substantiate the claim. KYHC's administrative expenses for 2014 are budgeted at $31.9M; the administrative budget is comprised of Salary/Wages/Benefits, Travel, Rent, Equipment, Consulting, Commission, Outsourced Services and Other Budgeted Items. The largest expense is Outsourced Services which accounts for 45%, 41%, 42%, of expenses respectively from 2014-2016. No further information was provided as to whether these functions would eventually be brought in-house or continue to be outsourced.

In the base case scenario, KYHC has requested the $103M of additional solvency loan funds in 2014, bringing total solvency draw to $162.5M. It should be noted that KYHC "acknowledges that receiving $103M in funding

just to maintain a RBC of 500% is not necessarily the correct solution" (P. 119). Furthermore, at that level of funding, KYHC will reach an RBC level of 500% of ACL in 2014, then remain over 1,000% till 2024, before it begins trending down to 500% of ACL in 2034. By providing the additional $103M, KYHC will maintain elevated levels of RBC throughout most of the performance period.

Stress Case Scenario:
The stress case scenario with additional solvency loan funding projects KYHC to achieve profitability in 2015. KYHC is currently requesting the same $103M from the base case to address an additional 3% unanticipated claim increases every two years while premiums remain the same. This increase is in addition to the unanticipated 3% claim increase every four years as stated in the base case. However, the pro formas do not appear to follow the 3% increases every four years as the claims increase by 5%, 11%, 5% and 11% respectively. Contrary to the scenario description, premiums are also increased to offset the unanticipated claims in an amount that keeps the MLR relatively constant. In this scenario, KYHC projects to incur a cumulative net income of $201M from 2015 – 2034 and reinsurance recoveries of $40.9M, $10M, and $8.1M in 2014, 2015, and 2016 respectively. RBC levels are projected to hit 500% of ACL in 2014, 2068% in 2015, and remain above 500% for the life of the loan. Identical to the base case scenario, the funding request is based on the risk corridors being treated as a nonadmitted asset. With the updated accounting treatment, KYHC will no longer need the $103M to meet the CMS recommended level of 500% of ACL.

KYHC projects an MLR, including 3Rs of 95.4%, 81.3% and 82.1% from 2014 - 2016. Absent 3R recoveries, the MLR for 2014, 2015, and 2016 is projected to be 161.3%, 86.8%, and 85.6% respectively. KYHC projects to recover the same amount as the base case scenario from its commercial reinsurance policy and projects its ACR to stay nearly the same as ACR projected in the base case scenario.

In the stress case with additional solvency loan funding, KYHC projects to draw down a total of $103M in solvency loan funding. The applicant projects to start repayment of interest on the solvency loan in 2019 and interest and principal payments in 2023. KYHC projects to continue to make annual repayments through 2033, until the loan is paid in full, if projections are realized.

Summary of Observations:

- **Accounting treatment of risk corridors receivable.** KYHC's application for solvency loan funds is predicated on the risk corridors receivable being treated as a nonadmitted asset. Based on that assumption, KYHC has requested three funding options, $103M to reach the RBC levels of 500% of ACL in 2014, $69.1M to reach the state minimum RBC levels of 200% of ACL or $45M to remain solvent but unable to hit the CMS recommended RBC levels. By including the risk corridors receivable as an admitted asset, all funding options will enable KYHC to meet the CMS recommended RBC of 500% of ACL. However, based on the pro forma cash flow statement, if KYHC doesn't receive any additional funding and the 3R payments of $115.5M are not received till 3Q15, CMS may want to consider that KYHC could suffer from a critical liquidity event. Not enough information was provided to substantiate the need and as a result, the impact on its pro forma financials cannot be assessed.
- **No pro forma financials provided for additional alternatives.** KYHC discussed several scenarios in which the CO-OP receives different levels of funding to keep them solvent. However, no detail was provided to substantiate the impact of the proposed actions on the applicant's pro formas. As a result, the impact of the additional scenarios on its pro forma financials cannot be assessed.
- **The stress case scenario is adding unanticipated claims to an already stressed base case.** The base case scenario in this application contains the unanticipated claims increases from the stress scenario of the

original application. Consequently, the presented stress test scenario, by adding additional unanticipated claims increases, is effectively "double stressing" a base scenario.

5. Contingency Plan:

KYHC's contingency plan includes three scenarios, "Base Case with Additional Funding Options", "Defer West Virginia" and "Base Case with no additional funding." Pro formas are only presented for the "Base Case with no additional funding" scenario.

In the "Base Case with Additional Funding Options," the CO-OP proposed a series of options to keep them solvent through fiscal year 2014. The options (all exclude recognizing risk corridors receivables as an admitted asset) range from receiving as low as $30M to as high as $103M from CMS. In the base scenario, KYHC requests $103M in order to reach the CMS recommended RBC level of 500% of ACL in 2014 (P.119), however, KYHC "acknowledges that receiving $103M in funding just to maintain a RBC of 500% is not necessarily the correct solution" (P.119). The applicant states that a more realistic solution would be to obtain $69.1M which allows KYHC to remain both solvent in 2014 and achieve the state minimum RBC level of 200% of ACL (P.119). The scenario involves the CO-OP obtaining a $15M private loan and the remaining $54.1M from CMS. It should be noted that the private funds would be used towards paying administrative and operational expenses, but would not be considered a solvency loan (P.118/119). Lastly, KYHC could request $30M from CMS and obtain the additional $15M from a private loan just to achieve solvency in 2014 (P.119). Although this option keeps KYHC solvent, it does not allow them to reach the minimum RBC level of 200% of ACL required by the state. By including the risk corridors receivable as an admitted asset, KYHC is able to meet the CMS recommended RBC level of 500% of ACL. However, based on the pro forma cash flow statement, if KYHC doesn't receive any additional funding and the 3R payments of $115.5M are not received until Q3 2015, CMS may want to consider that KYHC could suffer from a liquidity issue. Not enough information was provided to substantiate the need and, as a result, the impact on its pro forma financials cannot be assessed.

The "Deferment of West Virginia" option requests additional solvency loan funds of $69.1M to allow KYHC to remain both solvent and above the RBC level of 200% of ACL from 2014 and beyond. However, under this option, Kentucky proposes delaying the West Virginia expansion from 2015 to 2016 in order to request a lower amount of solvency loan funds from CMS. In this scenario, KYHC will obtain a $15M private loan, request $49.1M from CMS and transfer $5M in start-up funds from West Virginia to the solvency loan funds subject to the approval of CMS. No pro formas that reflect these options were provided. As a result, the true impact of the scenarios on KYHC's operation cannot be assessed.

As outlined in KYHC's application, "if additional solvency funding is not awarded, [KYHC] stand[s] ready to move our approximately 55,000 existing lives to other carriers and remove the health plan from the open enrollment as an unfortunate but appropriate option" (P. 118). KYHC stated that if the minimum requested amount of $45M of additional funding is not awarded and/or a decision made by October 15th, KYHC will request the Kentucky DOI to assist in taking over the health plan. A major event in determining KYHC solvency hinges on the accounting treatment of the risk corridor receivables. "The key issue driving this fact is the delay in federal risk corridor receivables on 2014 business until the latter part of 2015. If this projected risk corridor receivable, which is an estimated $74.6M for 2014 in the base scenario, were made available immediately, it would eliminate much of the current need for additional solvency loan funding as well as alleviating the operating cash issues highlighted in the contingency scenario." (P. 17). If projections are

realized, it is apparent that if the accounting rule is not resolved in KYHC's favor by year end 2014 and no further solvency loans are awarded, the CO-OP will have both critical liquidity and solvency issues.

Summary of Observations:

- **No pro forma financials provided for base case with additional options or deferment of West Virginia.** KYHC discussed three funding options in which KYHC receives different levels of funding to keep them solvent. However, no details were provided to substantiate the impact of the proposed actions on the applicant's pro forma financials. As a result, the impact of the additional funding options on its pro forma financials cannot be assessed.
- **Accounting treatment of risk corridors receivable.** KYHC's application for solvency loan funds is predicated on the risk corridors receivable being treated as a nonadmitted asset. Based on that assumption, KYHC has requested 1 of 3 scenarios, $103M to reach the RBC levels of 500% of ACL in 2014, $69.1M to reach the state minimum RBC level of 200% of ACL or $45M to remain solvent but unable to achieve the CMS recommended RBC levels. By including the risk corridors receivable as an admitted asset, KYHC is able to meet the CMS recommended RBC level of 500% of ACL for all funding scenarios. Conversely, based on the pro forma cash flow statement, if KYHC doesn't receive any additional funding and the 3Rs payments of $115.5M are not received until Q3 2015, CMS may want to consider that KYHC may suffer from a liquidity issue. Not enough information was provided to substantiate the need and as a result, the impact on its pro forma financials cannot be assessed.
- **October 15, 2014 KYHC stated deadline for action.** KYHC stated that if the minimum requested amount of $45M of additional solvency loan funding is not awarded and/or a decision made by October 15th, KYHC will request the Kentucky DOI to assist in taking over the health plan.

Solvency Loan Request Points

Sections	Potential	Total
Enrollment	15	8.75
Product Pricing	20	14
Medical Costs and Losses	15	10
CO-OP Financials	15	7.5
Score	**65**	**40.25**

Contingency Plan Points

Contingency Plan	Potential	Total
Overall	10	0
Score	**10**	**0**

The excel Appendix A, B, C, D documents referenced in the PSI Majority Staff Report can be found here:

http://www.hsgac.senate.gov/subcommittees/investigations/hearings/review-of-the-affordable-care-act-health-insurance-co-op-program

Or by special request by contacting the Permanent Subcommittee on Investigations 202-224-3721.

Post-Hearing Questions for the Record
Submitted to Andy Slavitt and Kevin Counihan,
Centers for Medicare and Medicaid Services
From Senator Claire McCaskill

"Review of the Affordable Care Act Health Insurance CO-OP Program"
March 10, 2016

Q. How many complete CO-OP applications were submitted in response to the July 28, 2011 Funding Opportunity Announcement (FOA) for the CO-OP program, per funding cycle?
Q. Of the CO-OP applications submitted in response to the FOA, please provide the action taken with respect to each application (approved, disapproved, deferred, no action due to unavailability of funds).

Answer to 1&2: CMS approved and funded a total of 24 CO-OP applications. 10 applications were successful in the first round, 6 were successful in the second round, and 8 were successful in the third round.

Across all rounds of review, an additional 118 applications were not successful (some CO-OPs submitted multiple applications). An application could be unsuccessful for several reasons. For example, an application could be incomplete, or submitted by an entity that was not eligible for consideration to receive a CO-OP loan. An application could also be withdrawn voluntarily by the applicant for a variety of reasons.

Q. When the American Taxpayer Relief Act of 2012 was signed into law on January 2, 2013, how many CO-OP applications were pending?

Answer: Forty four applications were pending at the time of the enactment of the American Taxpayer Relief Act (ATRA) of 2012 and are included in the total of applications that were not successful.

Q: For the eleven operational CO-OPs, how many consumers have health insurance coverage through each CO-OP?

Answer:

CO-OP	Enrollment as of year-end 2015 (NAIC Annual report)
Connecticut: HealthyCT	41,238
Illinois: Land of Lincoln	50,280
Maine/New Hampshire: Maine Community Health Options	74,981
Maryland: Evergreen Health Cooperative	29,679
Massachusetts/New Hampshire: Minuteman	13,726
Montana/Idaho: Montana Health Cooperative	40,663
New Jersey: Health Republic of New Jersey	51,248
New Mexico: New Mexico Health Connections	34,410
Ohio: Coordinated Health Mutual	23,968
Oregon: Community Care of Oregon	15,039
Wisconsin: Common Ground Healthcare Cooperative	33,140

Q: For the states in which the eleven operational CO-OPs sell coverage, how many other health insurance issuers sell coverage in each state?

Answer:

State	Number of Issuers in 2016 Marketplace (Individual Market) Other Than CO-OP
Connecticut	3
Illinois	9
Maine/New Hampshire	2 (Maine) /4 (New Hampshire)
Maryland	4
Massachusetts/New Hampshire	10 (Massachusetts) /4 (New Hampshire)
Montana/Idaho	2 (Montana)/4 (Idaho)
New Jersey	4
New Mexico	3
Ohio	16
Oregon	10
Wisconsin	15

Q. Please explain in detail the responsibilities of a state Department of Insurance with respect to a CO-OP.

Answer: Since awarding both start-up and solvency loans, CMS has, in collaboration with state Departments of Insurance (DOIs), been closely monitoring and evaluating the CO-OPs to assess performance and compliance. State DOIs, which are the primary regulators of insurance issuers in the states, oversee CO-OPs in the same manner as other health issuers in their states. Each state may differ based on the specifics of state law, but in general, state insurance regulators are responsible for protecting the interests of consumers and the public by ensuring the ongoing solvency and financial stability of insurers. State regulators are also routinely responsible for

approving health insurance plan rates and policy forms; market conduct and regulatory compliance; fraud detection and prevention, and agent and broker licensing.

Q. Could a start-up loan made to a CO-OP be converted to a surplus note without the state Department of Insurance requesting the conversion?

Answer: A surplus note is an instrument that is exclusive to statutory accounting, which applies to the business of insurance only. Approval of the insurance commissioner, both as to the form of the note and the amount to which it applies, are essential to the note's validity.

Furthermore, as to a CO-OP Start-up loan, a CO-OP may request a loan conversion, but both CMS, as the loan holder, and the state Department of Insurance, as the regulator, must review and approve the request before a start-up loan can be converted to a surplus note.

Q. Please describe the impact on the risk corridor program when it was made budget neutral by the Consolidated and Further Continuing Appropriations Act of 2015.

Answer: As you noted, Section 227 of Division G of the Consolidated and Further Continuing Appropriations Act of 2015 (PL 113-235) required that none of the funds made available to CMS' Program Management account from the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds for fiscal year 2016 may be used for risk corridor payments. Risk corridors claims for program year 2014 have been paid from program year 2014 collections. These claims will also be paid out of program year 2015 risk corridors collections, and if necessary, program year 2016 collections. In the event of a shortfall at the conclusion of the three-year risk corridors program, the agency will work with Congress to provide necessary funds for outstanding payment.

Q. Please describe the impact of the ACA's prohibition against using federal CO-OP funds for marketing activities (codified at 42 U.S.C. § 18042(b)(2)(C)(ii)) on the CO-OP program.

Answer: The Affordable Care Act prohibits the use of Federal funds for marketing. Under the CO-OP Funding Opportunity Announcement, "marketing" means activities that promote the purchase of a specific health care plan or explain a product's benefit structure to a specific customer. It does not prohibit CO-OPs from using Federal funds for community outreach and general membership development. All CO-OPs now have membership in the tens of thousands, generating millions in operating income each month. As a result, these CO-OPs are able to use this revenue for marketing.

Post-Hearing Questions for the Record
Submitted to Dr. Scott Harrington,
The Wharton School, University of Pennsylvania
From Senator Claire McCaskill

"Review of the Affordable Care Act Health Insurance CO-OP Program"
March 10, 2016

Q: In your opinion, of the failed CO-OPs for which you reviewed data, do the state Departments of Insurance bear any responsibility for the failure of those CO-OPs?

No, although the question arises as to whether relatively low premiums charged by some CO-OPs should have been subject to pushback by regulators concerned with solvency.

Q. In your opinion, of the CO-OPs for which you reviewed actuarial feasibility studies, do the actuarial firms who prepared those studies bear any responsibility for the failure of those CO-OPs?

No. I was somewhat surprised, however, that the studies did not devote more attention to downside risk.

Q. In your testimony, you stated that at least two cohorts – healthy individuals in their 50s and 60s and young people – are experiencing higher premiums as a result of the Affordable Care Act (ACA). Are there any cohorts that are experiencing lower premiums as a result of the ACA?

The evidence with which I am familiar and some of my own co-authored research suggests that newly insured people in relatively poor health have been able to obtain coverage at lower premiums than would be true without the ACA.

Q. In your testimony, you explained to Senator Portman that CMS may have continued disbursing money to now-defunct CO-OPs because even though CMS was receiving some information from the CO-OPs, "the accuracy of the information about claim costs was not there, so there [was] a much bigger bill than what had been anticipated." Why was the accuracy of claim costs not there? How long does it typically take for an insurer to get an accurate picture of what claim costs will be?

Given ACA coverage requirements, the influx of previously uninsured people into the market in 2014 and 2015, and transitional policies in various states that permitted previously insured people to maintain their prior plans, substantial uncertainty existed about the characteristics of the risk pool and associated medical costs. It typically takes 15-18 months for an insurer to to know its ultimate costs for coverage provided in a given year with a high degree of accuracy. A well-managed insurer, however, should begin to have an understanding by mid-year of whether its costs for the year are likely to deviate substantially from the cost projections used in pricing.

Q: In your testimony, you stated that "[O]nce you get information that a company might be in trouble, there always has been a fine line that regulators have to draw about doing something that definitely will put the company over the edge or giving it a little more runway to try to work things out." In your opinion, how much time should CMS have given CO-OPs that began offering coverage to consumers effective January 1, 2014 to work things out?

I cannot provide a general answer to this question. It very much depends on a specific CO-OP's relative pricing and enrollment growth.

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