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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

November 3, 2015

To: Subcommittee on Oversight and Investigations Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Examining the Costly Failures of Obamacare's CO-OP Insurance Loans"

On Thursday, November 5, 2015, at 10:00 a.m. in room 2322 of the Rayburn House Office Building, the subcommittee will hold a hearing on the Consumer Operated and Oriented Plan (CO-OP) Program under the Affordable Care Act (ACA). The hearing will explore the recent shutdown of several co-ops throughout the country; 13 of the original 23 co-ops remain operational.

I. BACKGROUND

The ACA established the CO-OP program, which was intended to "foster the creation of new, qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets."[1] Co-ops are customer-directed plans that are designed to offer additional affordable and consumer-friendly health insurance options to compete with major insurers. Co-ops can offer health plans through the health care marketplaces in each state or they can offer plans off the exchanges. They may operate locally, state-wide, or in multiple states and must be licensed as issuers in each state in which they operate.[2]

[1] Centers for Medicare & Medicaid Services, *Consumer Operated and Oriented Plan Program* (online at www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html) (accessed Oct. 29, 2015) and 42 U.S.C. § 18042(a)(2).

[2] Centers for Medicare & Medicaid Services, *New Federal Loan Program Helps Nonprofits Create Customer-Driven Health Insurers* (online at www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/coop_final_rule.html) (accessed Oct. 22, 2015).

Established health insurers are barred from participating in the co-op program.[3] Regulations prohibit co-ops from using any federal loans for marketing expenses.[4] Co-ops are also severely limited from selling insurance to large employers. Any profits made by the organization are required to be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.[5] Co-ops are required to meet all the requirements that other issuers of qualified health plans are required to meet in any State where the issuer offers a qualified health plan, including solvency and licensure requirements.[6]

A. Initial Loan Funding

The co-op program offered low-interest loans to eligible private, nonprofit groups to set up and maintain their plans. First, the program offered start-up loans to assist with initial activities associated with developing a co-op. These loans were required to be repaid in five years.[7] Next, the program offered solvency loans to assist with state reserve requirements, which must be repaid, with interest, in 15 years from the date of disbursement.[8]

When the ACA passed, the co-op program was initially intended to receive $6 billion in federal funds over time.[9] In the 2012 budget negotiations, however, Congress cut funding to $2.4 billion.[10] Ultimately, the $2.4 billion was loaned to 23 nonprofit health insurers, which began offering health plans on January 1, 2014.[11]

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[3] The Commonwealth Fund, *The Affordable Care Act CO-OP Program: Facing Both Barriers and Opportunities for More Competitive Health Insurance Markets* (Mar. 12, 2015) (online at www.commonwealthfund.org/publications/blog/2015/mar/aca-co-op-program).

[4] *Health co-ops, created to foster competition and lower insurance costs, are facing danger*, Washington Post (Oct. 22, 2013) (online at 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).

[5] 42 U.S.C. § 18042(c)(4).

[6] 42 U.S.C. § 18042(c)(5).

[7] 42 U.S.C. § 18042(b)(1)(A).

[8] 42 U.S.C. § 18042(b)(1)(B); 42 U.S.C. § 18042(b)(3).

[9] *Health co-ops, created to foster competition and lower insurance costs, are facing danger*, Washington Post (Oct. 22, 2013) (online at 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).

[10] *Health Care Co-op Closings Narrow Consumers' Choices*, New York Times (Oct. 25, 2015) (online at www.nytimes.com/2015/10/26/business/health-care-co-op-closings-narrow-consumers-choices.html?_r=0).

[11] Center for Medicare & Medicaid Services, *Loan Program helps Support Consumer-Driven Non-Profit Health Insurers* (Dec. 16, 2014) (online at www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html).

B. Risk Mitigation Mechanisms (The Three R's)

The ACA established three mechanisms to manage risk in the early years of implementation.[12] Collectively, these three programs—risk adjustment, reinsurance, and risk corridors—are often referred as the "three Rs." The "three Rs" were established to address uncertainty for insurance companies in the initial years of the marketplace as they tried to establish premiums for a new group of people and implemented a higher standard of coverage under the ACA. The reinsurance and risk corridors programs are temporary, while the risk adjustment program is permanent.[13]

The *risk adjustment* program is meant to reduce incentives for insurers to insure only healthy individuals in order to protect consumers' access to a range of robust coverage options.[14] The program requires issuers with healthier consumers in a state to pay charges to offset some of the costs of insurance companies with sicker consumers in that state. For 2014, the program will transfer about $4.6 billion among insurance companies nationwide.[15]

The *reinsurance* program is meant to keep premiums affordable for consumers by spreading the cost of very large insurance claims across all insurers.[16] For 2014, the program will be paying out $7.9 billion in reinsurance claims. Health insurance plans are being paid for 100 percent of their filed claims, rather than the expected 75 percent, because claims were not as high as expected.

The *risk corridors* program is meant to support the marketplace by providing insurers with additional protection against uncertainty in claims during the first three years of the marketplace. Payments depend on how closely the premiums insurers charge cover their consumers' medical costs. Insurers whose premiums exceed claims and other costs by more than a certain amount pay into the program and those whose claims and other costs exceed premiums by a certain amount receive payments for their shortfall.[17] A provision in the Consolidating and Further Continuing Appropriations Act of 2015 (known as the "Cromnibus") made it so the

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[12] Centers for Medicare & Medicaid Services, *The Three R's: An Overview* (Oct. 1, 2015) (online at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-1.html).

[13] The Commonwealth Fund Blog, *The Three R's of Health Insurance* (Mar. 5, 2014) (online at www.commonwealthfund.org/publications/blog/2014/mar/the-three-rs-of-health-insurance).

[14] Centers for Medicare & Medicaid Services, *The Three R's: An Overview* (Oct. 1, 2015) (online at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-1.html).

[15] *Id.*

[16] *Id.*

[17] *Id.*

insurer payments into the risk corridor program are the only source of funding to reimburse claims, effectively making the program budget neutral.[18]

II. CHALLENGES FACING THE CO-OP PROGRAM

For various reasons, some co-ops established under the ACA have faced substantial challenges. As of October 29, 2015, 13 of the original 23 co-ops remain in operation.[19] At least 500,000 Americans stand to lose their current health insurance plan as a result of co-op closures.[20]

Several co-ops faced enrollment challenges, falling short of their projected enrollment. Nine co-ops met or exceeded their 2014 enrollment goals, while 13 others fell short of their 2014 projections. Low enrollment and claims expenses exceeding premiums contributed to the co-ops' losses. Overall, losses in 2014 ranged from a high of $50.4 million in Kentucky to $3.4 million in Montana.[21] While most co-ops had projected losses for 2014, actual losses tended to be higher.[22]

A number of the co-ops have also faced financial difficulties, largely due to risk adjustment and risk corridor payments. The 2014 assessments under the risk adjustment program had the unintended consequence of requiring new plans (including co-ops) to make the biggest payments to large insurers already established in the insurance market.[23] A combination of potential factors, including lack of prior claims data, new provider and administrative relationships, and a relatively small share of the market, all contributed to these difficulties and

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[18] Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. 113-235 (2014).

[19] *Utah's Arches Health Plan marks 10th co-op closure*, Modern Healthcare (Oct. 27, 2015) (online at www.modernhealthcare.com/article/20151027/NEWS/151029892).

[20] *Health Care Co-op Closings Narrow Consumers' Choices*, New York Times (Oct. 25, 2015) (online at www.nytimes.com/2015/10/26/business/health-care-co-op-closings-narrow-consumers-choices.html?_r=0).

[21] Department of Health and Human Services 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* (July 2015) (A-05-14-00055).

[22] *Maine health insurance co-op is only one of its kind to earn profit last year*, Portland Herald Press (July 31, 2015) (online at www.pressherald.com/2015/07/30/affordable-care-acts-health-insurance-co-ops-struggling-federal-audit-shows/).

[23] *ACA 'Premium Stabilization' Program Hits Co-Ops, Small Plans*, Bloomberg BNA (Aug. 26, 2015) (online at www.bna.com/aca-premium-stabilization-b17179935263/).

hardships for co-ops.[24] For 2014, new health plans made net payments of $142 million into the risk adjustment pool.

The co-ops were further harmed by imbalances in the 2014 risk corridor payments. On October 1, 2015, CMS announced that claims in the risk corridors program far outweighed contributions to the program for 2014. Insurers submitted approximately $2.87 billion in risk corridor claims based on their 2014 results, while insurers only owed $362 million in risk corridor contributions.[25] Therefore, those seeking reimbursement for claims will only receive 12.6 percent of the money (or an estimated 13 cents on every dollar) that they requested from the program.[26] If possible, shortfalls for 2014 claims will be paid from 2015 contributions.[27] Many co-ops could not afford to remain operational without these payouts from the risk corridors program.[28]

III. HHS OIG REPORT ON CO-OP PERFORMANCE

The Department of Health and Human Services Office of the Inspector General (OIG) released a report in July 2015, analyzing the co-ops' financial and operational status to determine whether enrollment and profitability met the co-ops' projections on their initial loan applications.[29] The report found that member enrollment and profitability for most co-ops were considerably lower than their initial loan applications projected and might limit the co-ops' ability to repay loans. Specifically, 13 co-ops did not meet enrollment projections and 19 had medical claims that exceeded premiums. The OIG report also found that, as of the end of 2014, 21 of the 23 co-ops were losing money.

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[24] Milliman, *ACA risk adjustment: Special considerations for new health plans* (July 2, 2015) (online at www.milliman.com/insight/2015/ACA-risk-adjustment-Special-considerations-for-new-health-plans/).

[25] *Risk Corridor Claims By Insurers Far Exceed Contributions*, Health Affairs Blog (Oct. 1, 2015) (online at healthaffairs.org/blog/2015/10/01/implementing-health-reform-risk-corridor-claims-by-insurers-far-exceed-contributions/).

[26] *Health Law's Program to Ease Insurers' Risks Has Shortfall*, Wall Street Journal (online at www.wsj.com/articles/health-laws-program-to-ease-insurers-risks-has-shortfall-u-s-officials-say-1443739671).

[27] *Risk Corridor Claims By Insurers Far Exceed Contributions*, Health Affairs Blog (Oct. 1, 2015) (online at healthaffairs.org/blog/2015/10/01/implementing-health-reform-risk-corridor-claims-by-insurers-far-exceed-contributions/).

[28] *Obamacare marketplaces shutting down amid cash crunch*, Bloomberg (Oct. 29, 2015) (online at www.msn.com/en-us/money/personalfinance/your-health-plan-will-now-self-destruct/ar-BBmz1WH?ocid=se).

[29] Department of Health and Human Services 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* (July 2015) (A-05-14-00055).

The OIG made several recommendations. First, the OIG recommended that CMS continue to place underperforming co-ops on enhanced oversight or corrective action plans. Second, the OIG advised that CMS work with state insurance regulators to identify and correct underperforming co-ops. The OIG also recommended that CMS provide guidance or establish criteria to determine when a co-op is no longer viable or sustainable and pursue available remedies for recovery of funds from terminated co-ops. CMS concurred with these recommendations.

IV. WITNESSES

The following witnesses have been invited to testify:

Panel 1

The Honorable Ben Sasse
U.S. Senator
Nebraska

Panel 2

James J. Donelon
Commissioner of Insurance
State of Louisiana

Julie McPeak
Commissioner of Commerce and Insurance
State of Tennessee

Peter Beilenson
Member of the Board of Directors
National Alliance of State Health Co-Ops

John Morrison
Vice Chair
Montana Health Co-Op

Panel 3

Gloria L. Jarmon
Deputy Inspector General for Audit Services
U.S. Department of Health and Human Services

Mandy Cohen
Chief of Staff
Office of the Administrator
Centers for Medicare and Medicaid Services