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Subcommittee on Oversight & Investigations

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Chairman Murphy, Ranking Member DeGette, and other Members of the Subcommittee, thank you for inviting me to testify before the Subcommittee today. My name is Peter Beilenson, and I am President and CEO of Evergreen Health Cooperative, a Maryland-based, non-profit Consumer Oriented and Operated Plan ("CO-OP") founded in 2012. As a leader of a state health CO-OP, I also serve as a board member for the National Alliance of State Health CO-OPs ("NASHCO"). I appreciate the opportunity to appear before you today to discuss the general issues presently facing Evergreen Heath and other healthcare CO-OP members of NASHCO in the current healthcare market and regulatory environment. However, I cannot speak with authority on specific matters related to any state CO-OPs other than Evergreen Health, which I believe to be one of the success stories of the CO-OP Program.

As you are aware, the CO-OP Program was established by Section 1322 of the Affordable Care Act, which initially appropriated $6 billion in loans to establish CO-OPs in each state. Subsequent budget cuts and other Congressional action reduced the loan funds to $2.4 billion, thus freezing the number of CO-OPs that could be funded at twenty-four. While many elements of the ACA have engendered significant partisan disagreement, the notion of establishing local, consumer-driven, and innovative healthcare options, while enhancing competition in the marketplace, should be appealing across the ideological spectrum. The question that we now confront is how to ensure that CO-OPs can succeed.

Unlike the difficulties experienced by many other state CO-OPs in their first two years, Evergreen Health's current fiscal condition is strong, due to our quick and nimble response to unforeseen conditions in our first year of operations. Following low initial enrollment due to significant operational deficiencies in Maryland's state health exchange and aggressive pricing by competitors in Maryland's individual insurance market, Evergreen Health quickly altered its business plan in 2014 to focus on the small group market. We priced our plans appropriately for the level of expected risk. Through competitive but actuarially sound pricing, well-designed plans, and supportive brokers, Evergreen Health achieved enrollment of 12,000 members by the end of 2014.

In more recent months, enrollment through Maryland's now-functional healthcare exchange, coupled with increases in our competitors' prices, have led to a

ten-fold year-over-year increase in individual enrollment for Evergreen Health in the most recent open enrollment period compared to the 2014 period. Small group sales have steadily increased, and we are now approved for—and have sold—large group plans (exceeding 50 members). All of these factors have resulted in an enrollment expected to exceed 30,000 by the end of 2015, and we expect to capture an even larger share of the individual market in 2016.

Going into the current open enrollment period, we have a healthier than average enrolled population, greater than $50 million in assets, and Risk Based Capital ("RBC"), a measure of solvency adequacy, of nearly 800%. In addition, our strong relationship with Maryland Governor Larry Hogan's new Insurance Commissioner, Al Redmer, and his staff continues to provide us with significant support.

Evergreen, like all other CO-OPs, takes very seriously its obligation to pay back the loan funds granted to it by the federal government, and the last thing anyone wants is for any more CO-OPs to fail without paying back their loans. However, additional solvency needs will create pressures for Evergreen Health and other state CO-OPs if certain current CMS requirements are not changed. Several requirements and regulations developed by CMS and CCIIO at their discretion, not as required by the provisions of the ACA, are significantly impeding the ability of the eleven remaining CO-OPs, including Evergreen, to successfully innovate and compete with the few carriers left in each state's commercial insurance markets. In light of these concerns, I would like to highlight solutions that could forge a successful path forward for the remaining CO-OPs.

First, CMS requires that CO-OPs maintain an arbitrarily high level of 500% RBC, despite state regulations in place to ensure the financial viability of other regulated insurers that require only a 200% RBC level in Maryland and many other states. Evergreen Health is therefore required to have 2.5 times higher RBC than all of its Maryland competitors. As the CO-OPs successfully market themselves and capture larger enrollment, they need additional solvency dollars to continue to meet the 500% RBC level. However, CMS has no additional funds to assist with the solvency needs of the growing CO-OPs. Although CMS has indicated that it will consider requests for waivers of the 500% RBC requirement on a case-by-case basis, CO-OPs have been told they will still come under increased oversight at 450% RBC.

A possible solution is to allow individual CO-OPs to raise capital to meet these solvency needs. CMS has recently indicated that they may entertain this potential solution, and it would seem to be an important step in the right direction. In fact, the ability to obtain private capital was one of the measures by which the original CO-OP applications were judged. CMS could amend the loan agreements, as this prohibition on obtaining additional capital is not required under ACA Section 1322.

Second, risk adjustments under the ACA may create additional issues for the CO-OPs, as formulas applied by CMS are skewed to the benefit of large, pre-existing insurers with enhanced administrative capabilities and years of claims experience data for their members (with some optimization processing perfected through insuring Medicare Advantage plans). Because many CO-OPs with particularly high enrollment took on a sicker, higher-cost insured population, it was anticipated that the ACA's "3 R's" (Risk Adjustment, Risk Corridor and Re-Insurance) would assist in securing their financial stability while caring for such a population. Yet, while many CO-OPs needed significant receivables through the Risk Adjustment Program, all but two of the 23 CO-OPs had significant *payables* due to the Risk Adjustment formulaic calculations.

In this sense, the administration of the Risk Adjustment Program has hindered competition in the healthcare market, especially as many large, pre-existing insurers were able to enroll their healthier populations in grandfathered policies—allowed by the Administration shortly before the start of Open Enrollment in 2014—and their sicker populations in QHP plans, thus scoring higher in risk adjustment on the individual and group lines of business and qualifying for greater assistance. Based on Evergreen Health's experience, the Risk Adjustment formula therefore requires review and revision to correct its disproportionately beneficial impact on larger carriers.

Third, Risk Corridor payments represent another potential issue for the CO-OPs. Although CMS has promised to eventually make all requested payments under the ACA's Risk Corridor Program, the CO-OPs have received little information regarding how these payments will be made, especially in light of certain statutory restrictions. The importance of these payments is much more immediate and acute for CO-OPs and other small insurers than it is for our large commercial competitors. A swift resolution to the current funding deficit for this program will go a long way toward improving CO-OPs' balance sheets and long term outlook.

Finally, we at Evergreen Health hope that Congress will recognize that the non-profit, member governed CO-OPs are trying to forge a new and innovative path for health insurance and give consumers increased choice in their coverage—enhancing competition that has been lacking in many states for years. This competition and consumer choice has had demonstrable effects on the markets where CO-OPs participate: in 2014, states with a CO-OP on the Federal Exchange had 6-9% lower rates than states without. CO-OPs also bring innovative approaches to the marketplace and thus additional choices to consumers. For example, Evergreen Health offers a Value-Based Insurance Design for diabetics, which removes virtually all financial barriers—co-pays, co-insurance, and deductibles—to services, medications, and care that is needed to keep a diabetic patient from developing the myriad complications of that disease.

In conclusion, I share Congress' concern with protecting the federal government's initial investment in CO-OPs. The solutions I have proposed today do not entail an act of Congress or any additional appropriations—I am simply asking for CMS to revise the Risk Adjustment formula to ensure fairness, to make promised Risk Corridor payments in full, to allow smaller insurers to effectively compete in the marketplace, and to eliminate CO-OPs' current barriers to obtaining additional capital—an ability that truly free markets provide.

Evergreen Health welcomes a working partnership with CMS and Congress to forge a successful path forward for the remaining CO-OPs. Thank you again for allowing me to testify today, and I look forward to your questions.