

**Testimony of John Morrison, Co-founder and Former President of
the National Alliance of State Health CO-OPs (NASHCO)
Before the U.S. House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
November 5, 2015**

Mr. Chairman, My name is John Morrison. I am the founder and past president of the National Alliance of State Health CO-OPs and Vice Chair of the Montana Health CO-OP. I served as State Auditor and Insurance Commissioner of Montana 2001-2008 and chaired the NAIC Health Insurance and Managed Care Committee. I serve on the boards of four health insurance companies. Although this is the first time I have testified about CO-OPs, it is the fourth time I have been asked to testify about health insurance issues and I have testified before committees in both the House and the Senate. I also serve as an expert to the U.S. Department of Labor regarding ERISA. I have been involved in the CO-OP project since before the Advisory Committee first met in early 2011. I became involved at the request of others, on a pro bono basis, because I believe that consumers need more choices in their health coverage and that CO-OPs have the potential to provide that additional choice.

**CO-OPs Have Already Shown Promise in Expanding Choice and
Increasing Competition**

Consumer Oriented and Operated Plans were added to the Affordable Care Act in 2009 after the U.S. Senate scuttled the popular “Public Option” proposal. The rationale behind creating these non-profit, consumer-governed health plans was to infuse competition and innovation into the new Marketplaces, offer consumers an alternative coverage option, and prompt existing insurers to become more efficient and consumer focused. CO-OPs have started to deliver on all of those promises.

**1. CO-OPs defied expectations and overcame obstacles to
cover more than a million Americans.**

CO-OPs entered the Marketplaces in 23 states in 2014 and, by mid-2015, were providing coverage to one million Americans. As Healthinsurance.org reported last month: “While enrollment in private plans through the exchanges increased by 46 percent in 2015 (from 8 million people in the first open enrollment period, to 11.7 million in the second open enrollment period), overall enrollment in CO-OPs increased by 150 percent.”

2. CO-OPs have increased competition and saved consumers and taxpayers money.

In many parts of the country, CO-OPs provided a much-needed dose of competition to highly consolidated insurance markets.

Consumers Mutual Insurance of **Michigan**, for example, has been the only carrier to bring meaningful competition to the Upper Peninsula of Michigan since anyone can remember; BCBS has dominated the market. The Michigan CO-OP was welcomed by all the hospitals and the insurance agents in the UP. Two thirds of CMI's 28,000 members are in the UP. Health Republic of **New Jersey** was the first new carrier to enter that market in 19 years. Without Community Health Options, Anthem would have been the only company on the **Maine** Exchange in 2014. The **Montana** Health CO-OP is one of three plans on the exchange in our state and accounts for 4 of 9 silver plans and 4 of 6 gold plans. These are just a few examples of the very real competition and choice that CO-OPs have brought to their marketplaces.

CO-OPs helped to increase price competition too. In 2014, states with CO-OPs had average silver plan rates 8% lower than states without CO-OPs. Montana, where I live, has a CO-OP. Wyoming does not. Both

states are on the FFM. In 2013, before the CO-OP began operating, the average individual monthly premium in Montana was \$243 and in Wyoming, it was \$297. Montana was 18% lower. Enter the CO-OP: In 2015, the second-lowest silver plan in Montana is \$241 per month and the SLS in Wyoming is 407. Montana is now 40% lower.

In 2015, among all FFM states, the average premium in CO-OP states was \$325 compared to an average monthly premium of \$369 in states without CO-OPs - a delta of approximately 13%. That comes out to an average annual savings in CO-OP states of over \$500 per person. With roughly 3.7 million Americans enrolled in CO-OP states in 2015 (according to acasignups.net), consumers in those states all told have already saved more than the total cost of the CO-OP program. *Moreover, when rates are lower, subsidy costs to the federal government are lower.* The taxpayers have already saved hundreds of millions in subsidies and would have saved billions over the decade ahead. One study published in *Health Affairs* projected that if CO-OPs held rates down by just 2-5%, the savings to taxpayers over the next 10 years would be \$7-17 billion.¹

¹ <http://healthaffairs.org/blog/2013/07/08/countdown-to-the-health-insurance-marketplaces-four-actions-essential-to-success>.

So, the question is not how much CO-OP loans have cost the taxpayer. Rather, the question is this: *how much has the closing of CO-OPs and their removal from the Marketplaces cost the consumer and the taxpayer?* This question should be studied carefully in order to guide future policy decisions. It appears that, even in their infancy, CO-OPs have already more than paid for themselves and would have saved taxpayers billions in the years ahead.

3. CO-OPs have offered innovative products and serve as change agents in the states where they are available.

All CO-OPs are nonprofit, consumer-driven health plans that focus, first and foremost, on the well-being of their members. CO-OPs' priorities include keeping people healthy, lowering premium costs, and delivering appropriate levels of care at the right time to keep members home and out of unnecessary hospital stays. Any profits are reinvested into expanded benefits and/or lower premiums for plan members.

CO-OPs approached the market with a different mindset than other insurers because they are governed by members and are truly non-profit. That mindset has motivated the CO-OP entrepreneurs to be

creative and implement exciting initiatives to change the game and bend the health care cost curve. For example:

- To incentivize quality care, **New Mexico Health Connections** developed a Shared Savings Program (SSP) with doctors' groups and health centers. The program compensates providers for participation in educational events, care coordination and reductions in the CO-OP's medical loss ratio.
- **InHealth Mutual** (Ohio) created a member portal for its Behavioral Health Depression Disease Management Program, providing members with daily opportunities to track their symptoms. The portal also contains a self-teaching program supported by behavioral health specialists to empower enrollees to better manage their health conditions.
- **Maine Community Health Options** has created a Chronic Illness Support Program. The program covers five prevalent conditions: diabetes, asthma, COPD, Cardiovascular Disease, and hypertension. It reduces the financial barriers associated with managing routine treatment of those diseases by eliminating co-

- pays for office visits, generic drugs, durable medical equipment, and lab tests.
- Through an affiliate, **Evergreen Health** (Maryland) operates four patient-centered medical homes focused on coordinated care and wellness. Evergreen Health's model is a collaborative, team-based approach that fully integrates behavioral health with primary care.
 - **Health Republic of New Jersey** implemented a harm-reduction program to use FDA approved medications to reduce smoking and promotes preventive services covering items such as colon cancer screening and biopsies.

Unfortunately, the residents of a number of states have now lost access to the important health care delivery innovations, alternative coverage options, and price competition that CO-OPs continue to make available in other states.

Multiple Factors Endangered the CO-OPs

A series of actions, including federal funding cuts made by Congress as part of budget agreements, changed the rules for CO-OPs in

the middle of the game and presented them with obstacles few small companies could overcome.

1. Repeated funding cuts by Congress deprived the CO-OPs of capital.

Opponents of reform hindered the CO-OPs from the outset to prevent them from fulfilling their mission.

In early 2011, dozens of community groups and insurance entrepreneurs, driven by a passion to reform America's broken health insurance system, began weekly phone meetings and formed a national alliance in order to turn the CO-OP concept into a nationwide reality. The CO-OP teams worked with private sector partners to develop business plans and submit loan applications to HHS. Seeing this, Congress slashed CO-OP loan funding from \$6 billion to \$3.4 billion. The Office of Management and Budget capped CO-OP loans to prevent CO-OPs from achieving more than 5% market share. CO-OP developers, unfazed, marched forward.

By late 2012, 24 CO-OPs had survived intensive public and private vetting and signed loan contracts worth \$2 billion. More than 40 additional groups had submitted complete applications and were

awaiting review for a final round of CO-OP loan awards. To some, this outpouring of interest was not only unanticipated; it was unacceptable.

Congress responded in the 2012 year-end “Fiscal Cliff” deal by rescinding the remaining lending authority and prohibiting the Department of Health and Human Services from authorizing a single additional CO-OP.² Although CO-OPs had not yet opened their doors, Republicans in Congress attacked them in hearings and press releases and tied the CO-OPs up with burdensome demands.

Moreover, under federal regulatory requirements that the Department of Health and Human Services put into place, CO-OPs were required to meet higher insurance reserve requirements than other insurers and were prohibited from offering necessary terms to outside investors to access private capital, even as they were also prohibited from limiting their enrollment during the open enrollment period on state exchanges and the FFM. Simply put, CO-OPs were given the wood to build a boat for 50 people and then, in some cases, ordered to board 200 passengers.

² See section 1857 of the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. No. 112-10), section 523 of the Consolidated Appropriations Act, 2012, (P.L. No. 112-74), and P.L. No. 112-240 § 644.

2. CO-OPs did not receive the risk corridor funding they were promised.

Congress recognized that the ACA would result in significant changes for all health insurers and that pricing in this new environment, where competition was based mainly on price, would mean high risk in the first few years. That is why the ACA included the temporary federal reinsurance and risk corridor provisions (in addition to the permanent risk adjustment program). The purpose was to mitigate the risk in these first few years until insurers better understood their markets. This was especially important to CO-OPs because they did not have any claims experience on which to base their premium assumptions, nor did they have large pools of existing capital to offset losses.

But in 2014, the risk-corridor program, in particular, came under fire from critics in Congress, who misleadingly called it a “bailout” for insurance companies and sought to defund or eliminate the program, even though the Medicare drug benefit includes a *permanent* risk corridor program.³ Under intense pressure from critics, the Obama Administration announced last fall that the 2014 risk-corridor

³ Paul Demko, “Reform Update: Partisan standoff looms over crucial risk-corridor payments,” *Modern Healthcare*, October 24, 2014.

payments would be limited to the amount contributed by insurers, with any remaining payments owed to insurers for 2014 coming from future contributions. Congress then enacted a provision as part of the 2015 appropriations bill that prohibited HHS from using other available funding to make 2014 risk corridor payments. Despite repeated assurances from CMS that the risk corridor funds would be paid, which many CO-OPs and their actuaries accepted as true, the Administration recently announced the risk corridor would pay insurers less than 13 cents on the dollar. For some CO-OPs, this was the fatal blow. CO-OPs in Kentucky, South Carolina, Tennessee, Utah, Oregon, Colorado and Arizona attributed their closure to the reduced risk corridors. Deprived of tens of millions in promised revenue, barred from seeking equity investors, required to keep larger reserves than other insurers, and unable to control enrollment, one CO-OP after another announced it could not offer plans in 2016.

3. The continuation of pre-ACA plans put CO-OPs at a competitive disadvantage.

The Administration allowed insurers in many states to temporarily extend pre-ACA individual plans until as far out as 2017 – even though the plans failed to meet most of the ACA’s market rules. In

states where insurers were permitted to extend these plans, the effect was a more segmented marketplace than the ACA envisioned and a risk pool for all ACA-compliant plans including CO-OP plans that was more costly than it would otherwise have been. While insurers that existed pre-ACA and continued to offer such plans could benefit from this “transition” policy, CO-OPs were not able to do so. All of their products were ACA compliant and they had no pre-selected good risk to balance the costlier Marketplace risk pools. The unfairness was compounded when many CO-OPs were required to write risk adjustment checks to the same insurers, which were complaining of poor experience in the Marketplace while excluding their better transition business from the risk adjustment formula.

4. CO-OP pricing was reasonable, but all types of insurers have lost money in the marketplaces, and CO-OPs don't have the deep pockets to absorb the losses.

The purpose of the exchanges was to stop the slicing and dicing of risk pools and to create a transparent marketplace where insurers would compete for business through price and service. CO-OPs have advanced this mission by competing and driving competition, but their rates generally were consistent with other competitive carriers. A

report done by McKinsey in the fall of 2013 showed that CO-OPs were usually not the lowest priced plan but were within 10% of the lowest price plan 42% of the time.

CO-OPs lost money in the first two years of the exchanges, but so did other carriers. For example, Health Care Service Corp., which owns Blue Cross Blue Shield companies in several states including Montana, reported that it lost \$282 million in first year of ACA exchanges. Crane's Chicago Business (10/3/13) reported that HCSC deliberately priced aggressively in "a bold grab for more market share." Forbes magazine last month estimated that insurers overall lost \$4 billion in 2014 on the exchanges due to underpricing. (A new McKinsey report puts the number at \$2.5 billion.)⁴

No insurers like to lose money, but some are better able to absorb the losses than others. As *US News and World Report* wrote last week "[F]or-profit insurers remain resolute...because they have deeper pockets that allow them to wait out early losses while the exchanges develop. They also think the potential in this new market makes the wait worthwhile." The article notes, "Aetna, the nation's third-largest insurer, lost money last year on the exchange business, and it is losing

⁴ <http://www.wsj.com/articles/health-laws-strains-show-1446423498>.

money this year too. But that business only amounts to about 6 percent of its operating revenue, and exchange enrollment makes up only 3 percent of its customer base of more than 23 million people.” Aetna Chairman and CEO Mark Bertolini predicted he expects the exchange markets to stabilize over time and said they still represent a “big opportunity” for the company. The main obstacle Bertolini sees is that “the political environment in Washington doesn't currently allow for that type of compromise.”⁵

Congress, the Administration, and State Regulators Must Act to Prevent Additional CO-OP Closings

The following steps, at least, should be taken to maximize the chance of success for the existing CO-OPs and increase the likelihood that Americans will have the opportunity to choose a CO-OP for their health insurance coverage:

- A. Pay the risk corridor funds that were promised. These stabilization funds are critical to CO-OPs and other small carriers in this early stage of the Marketplace rollout. In the alternative,

⁵ <http://www.usnews.com/news/business/articles/2015/10/29/big-insurers-remain-upbeat-on-fledgling-aca-exchanges>

- immediately increase reinsurance program payments to make up the difference.
- B. Convert existing start up loans for the CO-OPs to surplus notes so that they may become equity rather than debt on the balance sheet and restructure the loans over 15 years instead of five.
 - C. Redeploy remaining solvency capital and risk corridor payments of the closing CO-OPs to the surviving CO-OPs to ensure that they have enough risk-based capital to accommodate the consumer demand.
 - D. Give priority in risk corridor fund allocation to insurers that need the funds in order to meet RBC requirements.
 - E. Allow CO-OPs to establish a maximum enrollment before they enter the open enrollment period each year.
 - F. Fix the permanent Risk Adjustment program in the following ways: 1) Change the formula to reflect that existing carriers early enrolled business before the first open enrollment, gaming the system by making their ACA enrollment less desirable; 2) Provide that no carrier is required to make a full risk adjustment payment when it would threaten its solvency to do so; 3) Add to the formula other indicators of bad risk, such as prescription drug

utilization data; 4) Reduce the time lag that exists before risk adjustment determinations are available and speed up the consideration of the health conditions of new members; 5) reflect a “Care Coordination Factor” in the risk transfer formula; 6) Reflect relative plan efficiency instead of simply using the statewide market average premium in the risk transfer formula for all plans.

- G. Allow CO-OPs to negotiate terms that permit them to access private equity capital.
- H. Restore the CO-OP funding that has been eliminated and allow consideration of the CO-OP applications that were turned away when the program was terminated at the end of 2012. Fulfill the ACA’s original objective of creating a CO-OP in every state.

Conclusion

The loss of CO-OPs that have been forced to close deprives the marketplaces of a much-needed catalyst for competition and innovation. It also costs consumers and taxpayers billions of dollars that would have been saved if the CO-OPs had been permitted to remain in business. The CO-OP closures were the direct result of repeated politically

motivated attacks designed to hobble them so they could not meet consumer demand for their products and could not have a competitive impact in the marketplace. An investigation of this matter is, indeed, appropriate. And Congress should do everything in its power to make certain that the remaining CO-OPs survive.