



Office of Regulations and Interpretation
Employee Benefits Security Administration, Room N-5655
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
Attn.: Definition of Employer – Small Business Health Plans RIN 1210-AB85

March 5, 2018

Re: RIN 1210-AB85
Proposed Association Health Plan (“AHP”) Regulations

Dear Sir or Madam,

We are writing you on behalf of the MEWA Association of America (the “MAA”), a recently formed trade association which represents the interests of the self-insured multiple employer welfare arrangement (“MEWA”) plans and their employer members. We thank you for the opportunity to provide our comments on the proposed Association Health Plan regulations.

As background, you should know that our membership consists of both self-insured MEWAs and persons who support the business they conduct. These MEWAs are entities regulated by both federal agencies (principally the Department of Labor (the “DOL”) and the various States, pursuant to the amendments made to the Employee Retirement Income Security Act of 1974 (“ERISA”) in 1983. We reiterate: these are regulated entities, ones whose financial solvency is overseen by the States. These are not fly-by-night entrepreneurial entities. The member MEWAs are governed by their sponsoring associations, which is an important characteristic of successful self-funded MEWA programs.

That said, we commend your Department on its efforts to make affordable health care benefits available to more of the general population, notably small businesses and sole proprietors (or “working owners”), especially with respect to their ability to cross state lines to get benefits packages they deem best suited to their and their companies’ needs. (in that regard, most state friendly MEWA laws and regulations already provide a registration process for an out-of-state MEWA.) But we believe some changes would enhance the proposal. More specifically, we would make the following comments and suggestions:

Same Industry or “Commonality-of-Interest” Requirement - Under the proposed regulations, entities like small employers would, under certain circumstances, be allowed to cross state lines to purchase benefits packages. The MAA strongly supports this effort. However, under the proposal, there are two ways in which an AHP may be formed, viz., 1) nationwide if the membership consists of businesses in the same trade, industry, etc. (i.e., if there’s a commonality of interest among the members) or 2) within a single State or metropolitan area (including across state lines) if there is no commonality of interest among the AHP’s membership. The MAA strongly recommends that all AHPs, even those which don’t have a commonality of interest, be permitted to operate nationwide.

One major objective of the proposed regulations is to permit entities like small employers to cross state lines in the event they find benefit packages offered in jurisdictions other than their own to be more attractive. The commonality of interest requirement curtails their ability to do so, unless they happen to find an AHP limited to their trade, industry, etc. (i.e., a nationwide one which they would be eligible to join), doing business in areas other than their own which offer benefit packages which they find more attractive. But this may not always be possible. There may not always be an appropriate nationwide AHP which they would be eligible to join. If entities like small businesses are thereby precluded from getting a product they might really prefer, does that not thwart the reason for letting businesses cross state lines to get more attractive benefits? So, the MAA would prefer that the regulations not require that an AHP or self-insured MEWA have a commonality of interest among its members before it may operate nationwide.

Working Owners as “Employees” – By making clear that “working owners” or sole proprietors who do not themselves have common law employees may not only join but also get healthcare coverage through AHPs or self-insured MEWAs, the proposed regulations would eliminate existing confusion. Many MEWA practitioners believe that the definition of “multiple employer welfare arrangement” codified in Section 3(40) of ERISA already permits self-insured MEWAs to cover working owners but the interpretations over the years have caused some confusion on this point. In fact, some MEWAs (perhaps being non- ERISA plans) are known to provide coverage for working owners who otherwise meet the sponsoring association’s eligibility requirements. But some regulators are skeptical of such arrangements. Favorable resolution in this respect is commendable. Accordingly, the MAA strongly support this clarification although we wonder if there might not be a better way to write it into the wording of the proposal. (See the attached **Exhibit A** for more discussion on the subject of a self-insured MEWA’s being able to cover working owners or sole proprietors).

We question, however, the proposed provision that would prevent working owners from obtaining coverage in an AHP if they could otherwise obtain coverage, e.g., through a spouse or through another health plan. It may sometimes be the case that available AHP or self-insured MEWA coverage is less expensive or otherwise more attractive than that other coverage. So why restrict the working owner’s (or sole proprietor’s) options. This would seem to be contrary to one of the basic purposes behind the proposed regulations.

Membership Control over Their Associations – The MAA certainly has no objection to the concept behind this proposal. Indeed, even before there were State requirements in this regard, it was typical for the control and management of most self-insured MEWAs to be vested in their members. And, as mentioned, many States now require membership control before a self-insured MEWA can obtain a license to do business in those jurisdictions.

Our concern is that the regulations may not go far enough in delineating what constitutes acceptable “control” by an AHP’s or self-insured MEWA’s membership. For example, a large multi-state AHP may have hundreds or, even, thousands of member companies, many of which might be quite small in the number of their employees. In such a situation, what would constitute member “control”? Would just having a vote in determining the entity’s leadership be sufficient for this purpose? Perhaps the regulations could be amended to give further guidance. Or can more examples

be provided, ones which would better clarify what's expected from the federal regulators' perspective? AHPs and self-insured MEWAs need to be able to satisfy themselves that they're meeting their obligations in this respect.

Speed-to-market Concerns – “Speed-to-market” is an issue that the insurance industry has been concerned about – and, therefore, addressed in various ways – over the last twenty-five years. Solutions have been developed in different areas of the business, e.g., SERFF (the System for Electronic Rate & Form Filing) is now in use for specific products in the life and health insurance environment and the Liability Risk Retention Act (“LRRA”) serves a similar function in the liability/risk retention environment. Both were developed to permit companies to start marketing their products once minimum levels of financial protection have been met. The MAA believes a similar procedure should be adopted with respect to AHPs and self-insured MEWAs going forward. To that end, therefore, we strongly recommend that the proposed regulations be expanded to incorporate standards similar to those in the LRRA.

The Ability to Underwrite and Nondiscrimination – This is unquestionably a controversial issue. Indeed, eligibility and underwriting based on health factors has been restricted, but not entirely prohibited, by the Health Insurance Portability and Affordability Act (“HIPAA”). The same concept is, of course, a keystone of the Patient Protection and Affordable Care Act (“ACA”). We would submit, however, that the same concepts do not necessarily make the same sense when it comes to self-insured MEWAs as they do in the fully insured environment. That is why, even now, that some States permit limited underwriting in the case of self-insured MEWAs. See the attached Exhibit C for a more thorough discussion of this issue from an actuarial perspective.

Essentially, the reason for this distinction is the law of large numbers. Health insurers are typically licensed in more than one State (the largest in all States) and the risks they incur are spread over their entire large population, small and large group business. Large insurers also typically have multiple product lines to be able to spread risk across. As a result, legislators have come to the conclusion that they really don't need underwriting in order to protect their solvency.

The same is not true as to self-insured MEWAs and, we would submit, many AHPs. This is particularly true in the start-up phase of their operations. Without a large population over which to spread their risks, they need at least limited underwriting to protect their solvency. Until a minimum size, e.g., fifty (50,000) thousand, is achieved, then, the MAA would recommend that limited underwriting be permitted at the group level (but not individual level) and would like to see the concept incorporated into the proposed regulations.

We might add that this is another argument in favor of eliminating the commonality of interest requirement mentioned at the outset. To the extent that AHPs or self-insured MEWAs which don't meet the “same industry” or “commonality-of-interest” requirement cannot expand beyond a State's or metropolitan area's boundaries, they are, obviously, circumscribed in their ability to achieve the size necessary to make underwriting unnecessary. Since, as we firmly believe, self-insured MEWAs have and can continue to offer attractive products to prospects, allowing limited underwriting – at least, until a certain size is reached - is in the public interest and would further the objectives behind the proposed regulations.

Preemption – The issue of preemption is not really addressed in the proposed regulations (nor could it be, really). The proposed regulations would do nothing to alter the current preemption

provisions in Section 514 of ERISA, as amended in 1983. Self-insured MEWAs are governed by both State – to the extent a given State has chosen to regulate them – and federal law. Presumably, then, the States will still be able to regulate self-insured MEWAs, even in ways contrary to what is specifically addressed by the proposed regulations. For example, they could prohibit a self-insured MEWA operating in their jurisdiction from covering employers – even those in the same industry as their existing employer members – in the same metropolitan area but across a state line. Alternatively, they could impose “control” requirements which differ in some respects from what has now been proposed. We would suggest that, in order to avoid confusion in this area, an appropriate amendment to Section 514 of ERISA would be desirable. And we offer our assistance in drafting such an amendment.

Class Exemption – Alternatively, Subsection 514(b)(6)(B) of ERISA, 29 U.S.C. 1144(b)(6)(B) already provides that the Secretary of Labor (the “Secretary”) has the authority to issue a class exemption for self-insured MEWAs under that law. We anticipate submitting a request to the Secretary for such a class exemption, one that incorporates most, if not all, of the issues previously mentioned in this letter. We believe that the class exemption is the only way, absent legislation, to achieve all of the objectives of the President’s Executive Order 13813. In reply to the Department’s Request for Information regarding a class exemption, please see the attached **Exhibit B**, which provides a proposed regulatory outline for such an exemption.

Grandfathering – Finally, it is the case that some existing self-insured MEWAs may not be in compliance with all the requirements in the proposed regulations. For example, some which consist of employers who do not have a commonality of interest are operating across state lines; others are doing some limited medical underwriting, albeit in accordance with applicable State requirements. At some point, the proposed regulations, even if amended, will go into effect and the operations of all our members may not then be in total compliance. While it may be quite easy to bring them into compliance in some instances, it may take considerable time in others. The MAA would, therefore, like to see a grace period for our members to bring their operations into total compliance. We suggest that the grace period run until the third January 1st following the date of final adoption of the regulation. Assuming that the regulation’s effective date is somewhere mid-year, this time period effectively allows two full plan years to effectuate the necessary changes without overnight plan disruptions, since most MEWA plan years start on January 1.

We, again, thank you for the opportunity to present our comments and suggestions on these important proposed regulations. If you would like elaboration on any of these points or if we can be of further assistance in any respect, please don’t hesitate to (609) 773 – 6150 or e-mail wmegna@genovaburns.com.

Sincerely,



William F. Megna,
Vice President and General Counsel, MEWA Association of America



EXHIBIT A

SOLE PROPRIETORS

RE: Sole Proprietors and Association Health Plans

A literal reading of the definition of “multiple employer welfare arrangement” (or “MEWA”) in section 3 of ERISA, 29 U.S.C. 1002, would clearly lead to the conclusion that it should be permissible to include sole proprietors (defined, for purposes of this memo, to mean working owners of a business who have no other employees) under the coverage provided by a self-insured MEWA. That’s because the definition, codified at 29 U.S.C. 1002(40) provides, in relevant part, that a “multiple employer welfare arrangement” is one that’s established or maintained to provide ERISA benefits to the employees of “two or more employers (including one or more self-employed individuals)” (emphasis added). Unfortunately, we have been unable to find relevant legislative history on Congress’ intent in defining MEWAs this way. And because of the other definitions in section 3, the Department of Labor (the “DOL”) has historically taken the position that self-insured MEWAs could not cover sole proprietors – if the arrangement is to remain an ERISA plan. Indeed, in many the opinions hereinafter summarized and quoted, the opinions specifically noted that the arrangements described therein were, in fact, MEWAs (as defined in section 3) even though the arrangements were not themselves ERISA plans. But that did not preclude those arrangements from covering sole proprietors.

The Definitions

Because of the problems resulting from so-called “self-insured METs” in the late 1970s and early ‘80s, Congress added a definition of “multiple employer welfare arrangement” to section 3 of ERISA in 1983 (simultaneously, Congress authorized the States to regulate non-fully insured MEWAs, if they chose to do so). In relevant part, it states that a multiple employer welfare arrangement is:

... an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) [the benefits defined to be “welfare” benefits, more fully described below], to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained— [three exceptions are listed]

However, in enacting the 1983 amendment, Congress did not amend many of the definitions that already existed in that law. More specifically, they relate to the definitions of “employee welfare benefit plan” (or “welfare plan”), “employee organization,” “employer,” and “employee”. These terms are defined (also in section 3) as follows:

- (1) The terms “employee welfare benefit plan” and “welfare plan” mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A)

medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions) (emphasis added).

(4) The term “employee organization” means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees’ beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term “employer” means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(6) The term “employee” means any individual employed by an employer.

Unfortunately, nowhere in the 1983 amendments to the definitions is there anything that specifically addresses or defines the term “self-employed individuals.”

The Relevant Regulation

29 C.F.R. 2510.3-3 is the regulation promulgated by the DOL in 1975 which addresses the general subject of when a plan covering only sole proprietors or partners (and their spouses) can be considered an ERISA “employee benefit plan,” i.e., a plan subject to ERISA (which can be either a welfare or pension plan). In relevant part, it reads:

(a) *General.* This section clarifies the definition in section 3(3) of the term “employee benefit plan” for purposes of title I of the Act and this chapter. It states a general principle which can be applied to a large class of plans to determine whether they constitute employee benefit plans within the meaning of section 3(3) of the Act. Under section 4(a) of the Act, only employee benefit plans within the meaning of section 3(3) are subject to title I.

(b) *Plans without employees.* For purposes of title I of the Act and this chapter, the term “employee benefit plan” shall not include any plan, fund or program … under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. For example, a so-called “Keogh” or “H.R. 10” plan under which only partners or only a sole proprietor are participants covered under the plan will not be covered under title 1. However, a Keogh plan under which one or more common law employees [this is where the common law concept is articulated], in addition to the self-employed individuals, are participants covered under the plan, will be covered under title 1 (emphasis added). …

(c) *Employees.* For purposes of this section:

(1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and

(2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.

Though the example relates to a type of pension plan, the regulation goes on to indicate that the concept it illustrates relates to both welfare and pension plans.

DOL Advisory Opinions as to Sole Proprietors

A 1994 opinion, viz., 1994-07, dealt with an entity called the United Service Association for Health Care and the benefit plans it made available to small employer participants. The Association had originally been formed to promote equitable tax treatment for small employers but its services were later expanded to include a welfare benefit arrangement for participants. The arrangement also permitted self-employed individuals to apply for coverage. The Connecticut Commissioner of Insurance sought an opinion as to whether or not that State's insurance laws could apply to the arrangement. The opinion concluded that the plan was a MEWA (as defined in section 3 of ERISA) but, because of its makeup, was not an ERISA plan. That being the case, Connecticut's insurance laws could apply.

In a 2007 opinion, the DOL stated in passing that sole proprietors could not be included in ERISA plans. Advisory Opinion 2007-06A dealt with employers in the short-line railroad industry and the welfare trust fund established to provide welfare benefits to their employees. The opinion also finds that the arrangement described is a MEWA but goes on to say:

The Department has expressed the view that where several unrelated employers merely execute identically worded trust agreements or similar documents as a means to fund or provide benefits, in the absence of any genuine organizational relationship between the employers, no employer group or association exists for purposes of ERISA section 3(5). Similarly, where membership in a group or association is open to anyone engaged in a particular trade or profession regardless of their status as employers (i.e., the group or association members include persons who are not employers) or where control of the group or association is not vested solely in employer members, the group or association is not a bona fide group or association of employers for purposes of ERISA section 3(5). *See, e.g.*, Advisory Opinion 95-01A, and Advisory Opinion 88-07A. In that regard, the Department has previously concluded that sole proprietors without common-law employees are not eligible to be treated as "employers" for purposes of participating in a bona fide group or association of employers within the meaning of ERISA section 3(5). *See* Advisory Opinion 94-07A ("[A]lthough USA represents that its membership is composed of employers, the Articles and Bylaws indicate that USA's membership class includes self-employed persons. Because self-employed persons are not necessarily employers of common-law employees, it appears that membership eligibility in USA is not limited to 'employers.'").

A fairly recent opinion again came to the conclusion that, although self-employed individuals might be covered under a MEWA, the MEWAs described in that opinion were not ERISA plans. That being the case, the arrangements were subject to all state insurance laws. That opinion was 2011-02A and involved benefit plans sponsored by Depawix Health Resources and the Green Cross Managed Health System. Besides making the benefit plans available to small employers, "Research Testers" (people hired to fill out health risk assessment questionnaires) could also get coverage. Applying the factors typically used to determine the existence of an employer-employee relationship, the opinion concluded that, as to such "Testers," an employment relationship did not always exist and went on to state:

For the foregoing reasons, and based on your representations and the materials we reviewed, it is the Department's view that the Research Testers are not employees of Depawix for purposes of ERISA. Rather, the Research Testers appear to be self-employed individuals and/or employees of other employers. Accordingly, because the Depawix Plan offers or provides health benefits to the employees of two or more employers, "including one or more 'self-employed' individuals," it is the Department's view that the Depawix Plan is a MEWA within the meaning of ERISA section 3(40).

...

ERISA section 514(a) does not preempt application of Florida insurance laws to the Green Cross Program or the Depawix Plan

Section 514(a) of ERISA generally preempts state laws that "relate" to ERISA-covered employee benefit plans. ERISA section 514(b)(6)(A), however, provides certain exceptions to this broad preemption provision in the case of ERISA-covered employee welfare benefit plans that are also MEWAs within the meaning of ERISA section 3(40). Pursuant to ERISA section 514(b)(6)(A), if an employee welfare benefit plan MEWA is not "fully insured," state insurance laws may be applied to the MEWA to the extent that such laws are "not inconsistent" with the provisions of Title I. If such a plan MEWA is considered "fully insured" for ERISA purposes, application of state insurance laws is limited to laws pertaining to the maintenance of specified levels of contributions and reserves. See ERISA 514(b) (6) (A); Advisory Opinion 2007-06A. On the other hand, and more pertinent to your request, if a MEWA is not *itself* an ERISA-covered employee welfare benefit plan, nothing in Title I of ERISA would preclude a state from applying its insurance laws to regulate the MEWA.

As noted above, the Green Cross Program and the Depawix Plan are MEWAs within the meaning of ERISA section 3(40). The materials we reviewed do not suggest, however, that either the Green Cross Program or the Depawix Plan is also an employee welfare benefit plan within the meaning of ERISA section 3(1). Because neither arrangement is an employee welfare benefit plan for purposes of ERISA, section 514(a) of ERISA would not limit application of state insurance laws to either arrangement. Accordingly, ERISA would not prohibit the State of Florida from applying its insurance laws directly to the Green Cross Program, the Depawix Plan, or to any persons or entities who sell or market the Program or the Depawix Plan in Florida.

One very interesting opinion, viz., 99-04A, did reach the conclusion that, in the pension area, a "working owner" or sole proprietor could be covered under the pension plan established

under a multiemployer arrangement. That situation involved the National Electric Benefit Fund and persons who may have been covered through a participating employer but who then established their own businesses. The opinion notes:

In our view, the statutory provisions of ERISA, taken as a whole, reveal a clear Congressional design to include "working owners" within the definition of "participant" for purposes of Title I of ERISA. Congress could not have intended that a pension plan operated so as to satisfy the complex tax qualification rules applicable to benefits provided to "owner-employees" under the provisions of Title II of ERISA, and with respect to which an employer faithfully makes the premium payments required to protect the benefits payable under the plan to such individuals under Title IV of ERISA, would somehow transgress against the limitations of the definitions contained in Title I of ERISA. Such a result would cause an intolerable conflict between the separate titles of ERISA, leading to the sort of "absurd results" that the Supreme Court warned against in *Nationwide Mutual Insurance Co. v. Darden*, 503 U.S. 318 (1992).

Therefore, it is the view of the Department that there is nothing in the definitions of Title I of ERISA that would preclude a pension plan, including the NEBF, from extending plan coverage to "working owners," as described in your submission, where such coverage is otherwise consistent with the documents and instruments governing the plan and does not violate any other provisions of Title I.

The Yates Decision

The cite for *Yates v. Hendon* is 541 U.S. 1 (2004). The involved fact pattern involved a pension plan and the question before the court boiled down to whether "working owners" could be covered under such an arrangement. The opinion makes clear that, at all times involved, the "working owner" had at least one employee working for him. In reaching the conclusion that, under the facts presented, the plan could, in fact, cover working owners, the court stated:

"In its regulation at 29 C. F. R. 2510.3-3, the Department clarified that the term 'employee benefit plan' as defined in section 3(3) of Title I does not include a plan the only participants of which are ' [a]n individual and his or her spouse . . . with respect to a trade of business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse' or ' [a] partner in a partnership and his or her spouse.' The regulation further specifies, however, that a plan that covers as participants 'one or more common law employees, in addition to the self-employed individuals' will be included in the definition of 'employee benefit plan' under section 3(3). *The conclusion of this opinion, that such 'self-employed individuals' are themselves 'participants' in the covered plan, is fully consistent with that regulation.*" (Citing Advisory Opinion 99-04A, mentioned above.) ...

(T)he regulation addresses only what plans qualify as "employee benefit plans" under Title I of ERISA. Plans that cover only sole owners or partners and their spouses, the

regulation instructs, fall outside Title I's domain. Plans covering working owners *and* their nonowner employees, on the other hand, fall entirely within ERISA's compass.

Analysis and Conclusions

Advisory Opinion 99-04A and the Yates decision both stand for the proposition that MEWAs (including association health plans) may, in fact, cover sole proprietors, even if those sole proprietors do not have common law employees (the plans may not be ERISA plans but that wouldn't preclude them from covering sole proprietors). While both involved pension, as opposed to welfare, plans, the same rationale should apply to welfare plans. Stated simply, there is nothing in the definitions cited above or in the DOL's regulation on the subject (also cited above) which would lead to a contrary conclusion.

The commentary to the proposed regulations confirms this view and the proposed amendments to the DOL's regulations would clarify what has, at times, been a murky area of the law. It is the MAA's contention, however, that this clarification, though obviously welcome, does not alter that fact that, even as to welfare plans, it has historically been permissible for MEWAs (including association health plans) to cover sole proprietors.



EXHIBIT B

DRAFT CLASS EXEMPTION REGULATION

.101 Initial registration of a self-funded Federally Qualified MEWA (“FQM”)

(a) An FQM when first operating in a State of Domicile shall file an application for initial registration with the Insurance Commissioner (“Commissioner”) of that State. The application for registration shall include the following:

1. A certification of an officer, director or trustee of the FQM that states:
 - i. The name of the FQM, which shall not include the terms “insurance,” “mutual,” “casuity,” “surety,” “indemnity,” “HMO,” “assurance” or any other name likely to mislead;
 - ii. The names and addresses of the employers who are members of the FQM;
 - iii. The names and addresses of the trustees or other persons responsible for the operations of the FQM;
 - iv. The mailing address and telephone number at which communications to the FQM are to be received;
 - v. The eligibility requirements for membership in the association, if any, to which the FQM provides a health benefit plan or plans; and
 - vi. The fees, if any, charged for membership in the association, if any, to which the FQM provides a health benefit plan or plans;
2. A specimen form of the following notice to be provided to employers and employees advertising

NOTICE

THIS SELF-FUNDED FEDERAL QUALIFIED MULTIPLE EMPLOYER WELFARE ARRANGEMENT (“FQM”) IS NOT AN INSURANCE COMPANY AND DOES NOT PARTICIPATE IN ANY OF THE GUARANTEE FUNDS CREATED BY STATE LAW. THESE FUNDS WILL NOT PAY YOUR CLAIMS OR PROTECT YOUR ASSETS IF A FQM BECOMES INSOLVENT AND IS UNABLE TO MAKE PAYMENTS AS PROMISED.

THE HEALTH CARE BENEFITS THAT YOU HAVE PURCHASED OR ARE APPLYING TO PURCHASE ARE BEING ISSUED BY A FQM. THE FQM IS REQUIRED TO MAINTAIN SUFFICIENT RESERVES TO PAY FOR ALL INCURRED LOSSES INCLUDING UNPAID CLAIMS.

IT IS IMPARTANT THAT YOU CHECK WITH YOUR EMPLOYER TO DETERMINE, WHICH IF ANY, STATE MANDATED HEALTH CARE BENEFITS MAY BE COVERED BY YOUR ARRANGEMENT.

FOR ADDITIONAL INFORMATION ABOUT THE FQM YOU SHOULD ASK QUESTIONS OF YOUR TRUST ADMINISTRATOR AT

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3. A copy of the trust agreement or other organizational documents relating to the FQM, including the agreement to establish a separate trust account for the health benefits plans;
 4. A copy of any documents executed by an employer to become a member of the association, if any, to which the FQM provides a health benefit plan or plans; and/or obtain coverage from the

FQM, including the application for membership in the FQM;

5. A description of the eligible employers that constitute the association, if any, to which the FQM provides a health benefit plan or plans, including their common or similar type of trade or business: the common trade association, professional association or other associations;
6. Biographical affidavits, on a form prescribed by the Commissioner, for all trustees and other persons responsible for the operations of the FQM. A majority of the board of trustees of a self-funded multiple employer welfare arrangement shall represent participating employer members, and at least one trustee shall be a non-participating independent trustee chosen by the majority vote of the trustees;
7. The names and addresses of all administrators and servicing organizations responsible for the operations of the FQM with respect to its health benefits plans.
8. The most recent audited financial statement of the FQM;
9. Three-year financial projections for the separate trust account;
10. If applicable, an actuarial opinion, prepared by a qualified actuary, that the reserves for health benefits are adequate;
11. If applicable, a calculation of the regulatory action level RBC;
12. A demonstration, such as a binder, that the applicant will obtain "stop-loss" coverage as defined and an actuarial certification with supporting documentation that the retention level for stop-loss coverage is based on sound actuarial principles; and

(b) Upon receipt and review of a complete application, the Commissioner shall approve the application if he or she finds that the MEWA meets the following standards:

1. All of the required application materials described in (a) above have been filed;
2. The persons responsible for conducting the MEWA's affairs are competent, trustworthy, possess good reputations and have appropriate experience, training and education; and
3. The Commissioner is satisfied that the plan of operation of the separate trust account is sound, supports the continuing operations of the MEWA

(c) Within 15 days of notification to the applicant by the Commissioner that the application has been approved, and prior to the issuance of the registration, the applicant shall:

1. Deposit with the Commissioner securities having a market value of \$200,000;
2. Provide a signed copy of the stop-loss or reinsurance agreement; and
3. Provide evidence that the separate trust account for the health benefit plans has been established.

.102 Subsequent annual registration of FQMs

(a) An application for subsequent annual registration following the initial registration shall be filed annually. The application for the subsequent annual registration shall consist of the certification of an officer, director or trustee of the FQM a form prescribed by the Commissioner, and shall include the certification of an officer, director or trustee of the FQM that the MEWA continues to comply with all the requirements provided herein.

(b) Within 90 days of receipt of the registration, the Commissioner shall issue a registration unless the Commissioner finds that the registrant is not in compliance with said requirements or that the continued operations of the FQM with respect to the provision of health benefits are hazardous to enrollees, members, providers or residents of the State.

.103 Eligibility requirements for FQM coverage

(a) No FQM, and no association that obtains health coverage from a FQM, shall refuse to provide coverage or deny membership in the MEWA or association to any employer, employee or dependent based on any of the following characteristics of the employer, employee or dependent:

1. Health status;
2. Medical condition, including physical and mental illness;
3. Claims experience of the employer or any employee or dependent;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including conditions arising out of acts of domestic violence;
8. Partial or total disability;
9. Age;
10. Gender; or
11. Any other health status-related factor.

.104 Loss Ratio, Minimum Benefits and Rating Methodology

(a) the anticipated incurred loss ratio for a FQM shall not be less than 75 percent and an annual loss ratio report shall be filed with the Commissioner;

(b) if preceding calendar year loss ratio is less than 75 percent, the FQM shall include with the loss ratio report a plan to be approved by the Department for the retention to surplus or the distribution of all dividends and credits against future assessments for all members in the preceding calendar year. Such distribution amount shall be sufficient to assure that the claims in the preceding calendar year, plus the amount of dividends and credits, shall equal 75 percent of the assessment in the preceding calendar year. In no event shall a distribution be made if it would adversely impact the FQM's ability to meet its targeted RBC levels.

(c) distributed dividends or credits shall be issued to each small employer who was covered for any period in the preceding calendar year.

(d) distributed dividend or credit amount per participant shall be determined by multiplying AxB. where A is the assessment for each participant, and B is the percentage calculated by dividing the total dividend or credit by the total assessment; or on the basis of a practical and equitable alternate methodology filed by the FQM in accordance with (a) above.

(e) all distributed dividends and credits shall be distributed by December 31 of the reporting year. A certification that all dividends have been paid shall be provided to the Department within 30 days of the payment.

(f) the minimum level of benefits offered under an FQM plan shall be the same as for a single employer health welfare benefit plan under ERISA.

(g) the rating methodology for a FQM plan shall be the same as a MEWA that is an AHP.

.105 Notice of change in documents of FQMs

A registered FQM shall not modify any information or document furnished pursuant to this subchapter unless the MEWA files with the Commissioner a notice of the change or modification, together with any additional information to explain the change or modification, at least 60 days prior to the use or adoption of the change. If the Commissioner fails to affirmatively approve or disapprove the change or modification within 60 days of receipt of the notice, the notice of modification shall be deemed approved. The Commissioner may extend the 60—day review period for not more than 30 additional days by providing the MEWA with written notice of the extension before the expiration of the 60—day period. If a change or modification is disapproved. The Commissioner shall notify the MEWA in writing, and specify the reason for the disapproval.

.106 Financial requirements of FQMs

(a) A FQM shall establish and maintain a separate trust account with respect to that segment of its operations that provides for self-funded health benefits plans. The trust account shall reflect the income, disbursements, assets and liabilities associated with providing health benefits. At all times the trust account shall contain assets in an amount at least equal to the sum of its liabilities, including the claim reserve account plus the required RBC.

(b) The separate trust account described in (a) above shall maintain capital and surplus at the following minimum levels:

- a. the regulatory action level RBC determined in accordance with the RBC instructions.

(c) If the total adjusted capital of the FQM's separate trust account is less than its regulatory action level RBC, the FQM shall implement and file with the Commissioner a plan to correct the inadequacy. Such plan shall:

1. Identify the conditions that contribute to the inadequacy;
2. Contain proposals of corrective actions that the MEWA intends to take and that would be expected to result in the elimination of the inadequacy;
3. Provide projections of the separate trust account's financial results for the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels; and
4. Identify the key assumptions impacting the projections, and the sensitivity of the projections to the assumptions, and identify the quality of, and problems associated with, the operations of the separate trust account.

(d) The FQM shall correct the inadequacy described in (c) above within 90 days of implementation of the plan, or no later than June 30 of each year.

(e) The FQM shall maintain a deposit in the amount of not less than \$200,000 in cash or securities.

(f) The FQM shall maintain a cash reserve for loss in an amount established by a qualified actuary as being adequate to provide for all incurred losses, including unpaid claims.

(g) The FQM shall maintain stop-loss coverage, which shall meet the following requirements:

1. Aggregate stop-loss coverage shall be maintained with a retention level of 125 percent of expected claims per year;
2. Aggregate stop-loss coverage shall provide coverage for claims in excess of the retention limit in an amount of at least 25 percent of expected claims;
3. Specific stop-loss coverage shall be maintained with a retention level determined

annually by a qualified actuary based on sound actuarial principles:

4. The stop-loss agreement shall provide a minimum run-out period for reporting claims of 12 months beyond the incurred period, except that the Commissioner shall permit a run-out period for reporting claims of six months beyond the incurred period if, upon written request of the FQM, the Commissioner determines that it has been demonstrated that coverage with a 12-month run-out period is not commercially available or is unreasonably priced; and
5. The stop-loss agreement shall contain a provision that the stop-loss insurer shall give the FQM and the Commissioner a minimum of 180 days' notice of cancellation or nonrenewal.
6. The FQM shall advise each member in the application for benefits and the benefit plan the following:
 - a. The liability of each member for the obligations of the FQM arrangement shall be individual, several and proportionate, but not joint, except as provided in this section.
 - b. In contrasting color, not less than 10 point type, this statement; "this is a fully assessable benefit plan. In the event that the self-funded multiple employer welfare arrangement is unable to pay its obligations, members shall be required to contribute on a pro rata earned premium basis the funds necessary to meet any unfilled obligation."

.107 Financial reporting of FQMs

(a) A FQM shall file with the Commissioner an annual report for the separate trust account no later than May 15 of each calendar year, or four months and 15 days after the end of each fiscal year of the FQM for the immediately preceding year.

1. The annual report shall be completed as prescribed by the National Association of Insurance Commissioners (NAIC) Health Annual Statement Instructions, and completed on a statutory accounting principles basis, in accordance with the NAIC Accounting Practices and Procedures Manual, effective January 1, 2001, both incorporated herein by reference as amended and supplemented (NAIC, 2301 McGee Street, Kansas City, MO 64108).
2. The annual report shall include a certification of, and an opinion by, a qualified actuary that the reserves required and included on the FQM's annual report, are sufficient.
 - a. The actuarial certification shall identify the specific methodology used to determine the reserves, and shall specify whether and how the methodology has changed since the last report.
 - b. The actuarial opinion shall include the work papers prepared by the actuary in support of the certification.
3. The annual report shall be submitted using the NAIC health blank in effect at the time of the year reported

(b) A FQM shall file with the Commissioner quarterly reports for the separate trust account as follows:

1. The quarterly report shall be filed no later than 60 days following the close of each fiscal quarter;
2. The quarterly report shall be completed as prescribed by the NAIC Health Annual Statement Instructions;
3. The quarterly report shall be completed on a statutory accounting principles basis, in accordance with the NAIC Accounting Practices and Procedures Manual; and
4. The quarterly report shall be submitted using the NAIC health blank in effect at the time of

the quarter submitted.

(c) A FQM shall file with the Commissioner the following audited annual financial reports for the immediately preceding calendar or fiscal year:

1. For the separate trust account, completed on a statutory accounting basis; and
2. With respect to all of its operations, completed on a generally accepted accounting principles basis.
3. The reports shall be filed no later than May 15th (if on a calendar year basis) or four months and 15 days after the end of the fiscal year.
4. The audited annual reports shall be certified by a qualified independent certified public accountant, who shall be in good standing with the American Institute of Certified Public Accountants and in all states in which the accountant is licensed to practice, and who conforms to the standards of his or her profession as contained in the Code of Professional Ethics of the American Institute of Certified Public Accountants and the Rules and Regulations, Code of Ethics, and Rules of Professional Conduct of the New Jersey Board of Public Accountancy or similar code.

(d) A FQM shall file with the Commissioner a Risk—Based Capital Health Report for the separate trust account on or before March 1 of each year for the immediately preceding calendar year, completed as prescribed in a form and containing such information as is required by the instructions adopted by the NAIC.

(e) A FQM shall file with the Commissioner proof of the stop-loss coverage within 15 days of the renewal date of the stop-loss agreement.

(f) A FQM shall file with the Commissioner within 60 days after the end of each fiscal quarter a report certifying that it maintains, in a claim reserve account within the trust account, cash or liquid assets sufficient to provide for all incurred losses, including paid claims.

.108 Financial examinations of FQMs

(a) The Commissioner may upon reasonable notice, conduct an examination of a registered FQM at least once every 5 years or sooner as he or she deems necessary upon a showing of cause in order to protect the interests of enrollees, members, providers and the residents of the State. A registered FQM shall make its books and records available for examination by the Commissioner, and retain its records for not less than seven years.

(b) The Commissioner may commission and employ such persons to conduct or assist in conducting the examination as he or she may deem advisable.

(c) The FQM being examined shall bear the reasonable cost of the examination.

.109 Federally Qualified MEWA and Exemptions from State laws, rules, regulations, or orders

(a) A self-funded MEWA complying with all of the above requirements shall be deemed an FQM and an ERISA health welfare benefit plan.

(b) Except as provided in this section, an FQM is exempt from any State law, rule, regulation, or order to the extent that such law, rule, regulation, or order would —

1. make unlawful, or regulate, directly or indirectly, the operation of an FQM except that the domicile jurisdiction in which it is initially registered may reasonably regulate the

formation and operation of such a group as provided in [need to add cite for this regulation] and any State may require such a group to —

- a. comply with the unfair claim settlement practices law of the State;
- b. register with and designate the State insurance commissioner and its agent solely for the purpose of receiving service of legal documents or process;
- c. submit to an examination by the State insurance commissioner in any State in which the group is doing business to determine the group's financial condition, if —
 - (i) the commissioner of the jurisdiction in which the group is initially registered has not begun or has refused to initiate an examination of the group as required by [add cite to paragraph in a previous section]; and
 - (ii) any such examination shall be coordinated to avoid unjustified duplication and unjustified repetition;
- d. comply with a lawful order issued —
 - (i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph c. ; or
 - (i) in a voluntary dissolution proceeding;
- e. comply with any State law regarding deceptive, false, or fraudulent acts or practices, except that if the State seeks an injunction regarding the conduct described in the subparagraph, such injunction must be obtained from a court of competent jurisdiction;
- f. comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the group is in hazardous financial condition or is financially impaired; and

2. require' or permit an FQM to participate in any insurance insolvency guaranty association to which an insurer licensed in the State is required to belong; or

3. otherwise discriminate against an FQM or any of its members, except that nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

(c) A State may require that a person acting, or offering to act, as an agent or broker for an FQM obtain a license from that state, except that a state may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

(d) Nothing in this section shall be construed to affect the authority of any Federal or State court to enjoin-

1. the solicitation or sale of coverage by an FQM to any person who is not eligible for

- membership in such group; or
- 2. the solicitation or sale of coverage by, or operation of, an FQM that is in hazardous financial condition or is financially impaired.

(e)

- 1. A state has the authority to make use of any of its powers to enforce the laws of such State with respect to which an FQM is not exempt under this chapter.
- 2. If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (d) of this section, such injunction must be obtained from a Federal or State court of competent jurisdiction.

(f) Nothing in this chapter shall affect the authority of any State to bring an action in any Federal or State court.

.110 DOL is the FQMs Principal Regulator

If there is disagreement between an FQM and a state regarding the application of state law to FQMs, either party may take the dispute to DOL for final and exclusive agency determination and action pursuant to the federal Administrative Procedure Act.

.111 DOL Certification and Document Submissions

- (a) Upon receipt of a FQM's approval from its domiciliary state, DOL shall issue a certificate to the FQM acknowledging its federally qualified status.
- (b) All filings and correspondence between the FQM and a state shall be copied to DOL by the FQM within 15 days of its submission or receipt by the FQM.

.112 ERISA Advisory Counsel

Pursuant to the authority contained in Section 512 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1142, the ERISA Advisory Council shall form a sub-committee to report annually to the Secretary of Labor on the effectiveness these regulations and any suggested amendments thereto.



EXHIBIT C

ACTUARIAL OPINION



Office of Regulations and Interpretation
Employee Benefits Security Administration, Room N-5655
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
Attn.: Definition of Employer – Small Business Health Plans RIN 1210-AB85

March 5, 2018

Re: RIN 1210-AB85
Proposed Association Health Plan (“AHP”) Regulations

Dear Sirs:

The Department of Labor has proposed rules for the regulation of Association Health Plans and asked for comments. The American Academy of Actuaries has already commented on the actuarial implications of typically unseen subsidies in rate-making prescribed by the ACA in their letter dated February 9, 2018 to the Office of Regulations and Interpretations (“AAA Letter” attached as Exhibit 1). I will expand on those concepts and provide some rationale for allowing self-funded AHPs more flexibility in rating versus fully insured small group carriers.

Lessons learned from the Failure of Co-Ops

Most of the HHS approved Consumer Oriented and Operated Plans have become insolvent. I believe only 4 of the original 24 plans are still operating as of this date. There are many lessons in these failures. First and foremost is that if you are a new entrant competing with established insurers you need to have some strategic advantage until you get established and have the necessary experience to price the true risk of your membership. Second, you need to get the rating correct from the first entrance to the market and rating is complicated. There is no time or capital to “try it and fix it”.

The United States Senate Report, Failure of the Affordable Care Act Health Insurance CO-OPs MAJORITY STAFF REPORT, (“the Senate Report” attached as Exhibit 2), provides an analysis of these failures. Many of these new market entrants wrote business that was on average healthier than the larger incumbent insurance market competitors and they still failed. Even if CO-OPs could compete with comparable costs to the incumbents, they couldn’t compete for the long term with unsupportable pricing assumptions. The incumbents had markets to protect and the capital and surplus to crush competitors who were forced to play by the same set of rating and underwriting rules.

The Need for Rating Flexibility

The AAA Letter provides an excellent summary of all of the various factors that drive healthcare cost and rates as well as the implications of the rating limitations enacted in the small group market as part of the changes driven by the ACA. While we can debate public policy on the subsidies created by these rules, the reality is the current small group rating rules prescribed by the ACA “flatten” the real differences in expected cost by age and gender. While this “flattening” may make rates more affordable for some groups and demographic classes, they also make rates less affordable for younger males and employers with a younger male census. If the Government truly wants to provide affordable alternatives for employers via AHPs then the rules need to permit more accurate reflections of the factors that drive healthcare cost, namely age, gender, geographic location, smoker status, health status and industry. As an example, the ACA prescribes a maximum demographic adjustment of 3 to 1. I would recommend a minimum 5 to 1 allowance. In general, the simpler the approach to rating the more assumptions the actuary must make before going to market. Allowing a more complex rating scheme that prescribed by the ACA will produce more accurate risk rating and less solvency risk for the AHP.

Managing Growth and Solvency

We work with a self-funded MEWA that has operated in New Jersey for many years. I usually describe the regulatory environment as similar to that of a small mutual insurance company. The MEWA is required to meet certain solvency standards relative to a calculation of Risk Based Capital. Granted these standards are lower than for a true insurance company but they are based on the NAIC standard calculation. The most critical time in the development of a Self-Funded AHP is early on in their operations when enrollment is still relatively low. We were lucky the MEWA flew under the competitive radar until it gained some membership volume. The MEWA had some relatively poor experience years early on but the regulatory platform worked, corrections were made and the plan’s solvency improved. The MEWA had to compete on a similar rating and underwriting framework as the large insurers operating in New Jersey but had some pricing advantages driven by ERISA rules as well as an exceptional provider network and administrative platform and dedicated, supportive association sponsors. We were lucky. If the large incumbents had adopted predatory pricing strategies, the plan could not have survived playing with the same set of rating rules and limited capital. In fact, the plan may have flown under the competitive radar during implementation of the ACA because the incumbent insurers were focused on the local CO-OP competitors at that time.

Assuming the plan is rated accurately, volatility will still be an issue when the membership is below 50,000 members. One of the drivers of the CO-OP insolvencies was trying to grow membership with no clear cost, rating or underwriting advantage in their markets versus the incumbents. Self-funded AHPs will have increased solvency risk if required to rate and underwrite using the same rules as the much larger established insurers. The Senate Report also placed some blame for the insolvencies on poor actuarial assumptions. Growth won’t help a plan recover from poor pricing assumptions. The “flatter” rate-making rules prescribed by the ACA require more assumptions to be made by the pricing actuaries. More assumptions mean more chances for adverse developments versus assumptions. I would recommend self-funded AHPs be allowed more freedom to reflect the true risk their enrollment brings until they reach critical mass and have the experience history at that membership mass. After three years’ experience and at membership exceeding 50,000 members, the rating and underwriting rules could be moved closer to the same rules applying to the insurers operating in the same markets.

Non-Discrimination

A frequently raised concern if AHPs are permitted more rating and underwriting flexibility is discrimination. This is often referred to as “cherry picking” or selecting the most favorable risk. I believe AHPs should be allowed to use objective rating algorithms that are subject to regulatory oversight, which more accurately price the risks presented to them. Generally, the argument is that if these plans are allowed to rate more accurately, they will select younger and healthier groups and leave the incumbents with a more substandard pool. One assumption often made is that AHPs could refuse to offer coverage to less desirable groups. Under the ACA, self-funded MEWAs currently are required to offer coverage on a guaranteed issue/renewable basis with no annual or lifetime limits for any employer eligible to be a member of the plan sponsor, which eligibility again could not be denied on the basis of health factors. Prior to the ACA, insurers were allowed to rate groups up and down relative to an “index rate” (see, the initial NAIC Small Group Availability Law). We could set certain limits on the amount of rating flexibility allowed to avoid overt discrimination. Realistically underwriting or detailed rating is discrimination. The actuary and the underwriter are discriminating between low expected cost and high expected cost risks. Remember from the Senate Report, favorable selection is not a guarantee of solvency.

Large Group Underwriting

The preliminary rules prescribed by the Department of Labor would require an AHP to rate large groups (more than 49 employees) by the same methods as small group. Currently in New Jersey, we can experience rate large groups which is consistent with the insurers operating in the state. If this proposed rule isn’t changed, insurers will be able to select against AHPs. Needless to say, solvency concerns would follow unless this rule is fixed.

Summary

I believe self-funded AHPs need certain advantages in pricing and underwriting until they reach critical mass measured by enrollment and years of experience at that enrollment. I also believe that fences can be built around those advantages to temper discrimination. I further believe the proposed rules put AHPs at a competitive disadvantage versus insurers with respect to underwriting large (50+) employers. If Government wants alternatives that will work, AHPs should be allowed to rate and underwrite on a more actuarially refined basis than prescribed by the ACA. The AAA Letter clearly points to all the areas where the ACA has prescribed the “flattening” of rating versus true actuarial cost. The Senate Report clearly points out the consequences of erroneous assumptions and the consequences of competing against well capitalized competitors.

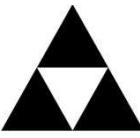


Sincerely,
David Wilson, FSA, FCIA, MAAA
President
Windsor Strategy Partners, Inc.



EXHIBIT 1

Academy of Actuaries Letter



AMERICAN ACADEMY *of* ACTUARIES

Objective. Independent. Effective.™

February 9, 2018

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

Attention: Definition of Employer—Small Business Health Plans RIN 1210-AB85

Re: Considerations Related to Modeling the Potential Impact of Association Health Plans

To Whom It May Concern,

On behalf of the Individual and Small Group Markets Committee of the American Academy of Actuaries,¹ I would like to offer comments in response to the Department of Labor's proposed rules that would broaden the ability for association health plans (AHPs) to be treated as large groups and for self-employed individuals to be eligible for AHPs. Our comments offer considerations that should be made when analyzing the potential impacts of these more broadly defined AHPs on individuals, employer groups, and the individual and small group health insurance markets. Different stakeholders will be affected differently, depending on allowable rating factors, plan design flexibility, and strategic considerations.

Considerations may differ for fully insured AHPs and self-funded AHPs (e.g., self-funded multiple-employer welfare arrangement (MEWA) plans). The applicability of the Employee Retirement Income Security Act of 1974 (ERISA) and limitations on the ERISA pre-emption for MEWAs, as well as the ability of states to impose their laws and regulations on AHPs due to

¹ The American Academy of Actuaries is a 19,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

such limitations on the ERISA pre-emption, should be considered in developing an analysis of the potential impact of AHPs on the current health plan environment.²

The Academy will be providing more detailed comments on the proposed rules in a subsequent comment letter.

Rating Factor Considerations

If treated as large groups, as proposed, AHPs would be subject to more flexible rating rules compared to Affordable Care Act (ACA)-compliant plans. Due to this increased flexibility, AHPs could offer lower premiums for lower-cost groups and higher premiums for higher-cost groups. As a result, AHPs could benefit from positive selection—that is, they would attract a lower-cost enrollee population. In contrast, ACA plans would be subject to adverse selection—they would attract a higher-cost enrollee population, which would lead to higher ACA premiums.

Age Rating

- Age rating restrictions. The ACA restricts age rating factors used in the individual and small group markets to a 3:1 range for adults, with no variation by gender. Several states have more restrictive allowable age ranges (e.g., New York does not allow premium variations by age). When allowable age rating ranges are more narrow than the actual range in health spending by age, such restrictions result in younger people subsidizing the costs incurred by older people.

Unless limited by state law, AHP issuers can use age ranges based on actuarial experience. The range can vary by plan design and insurer. For instance, high-deductible plans typically exhibit a greater range than lower-deductible plans, but all exceed the 3:1 limit imposed by the ACA. This provides a competitive advantage to the AHP in that it could offer lower premiums to young adults and higher, less attractive premiums to older people.

- Age rating curve. Regulations for the ACA dictate the age-by-age factors that must be used by insurers operating in Federally Facilitated Exchange (FFE) states; most, but not all, other states also use the federal age curve. In contrast, each AHP can determine its own set of age factors, which can vary by plan design and other case characteristics. This flexibility allows AHPs to better target subsets of the population that it would like to attract to its plans. However, rate variations for enrollees age 40 and older must be justifiable by cost data to avoid violating the Age Discrimination in Employment Act.
- Child rating factors. The ACA sets premium factors for children, and the factor for a newborn is identical to those for other children under age 14. An AHP can set its child rating factors based on actuarial expectations. Newborns typically experience health care costs much higher than those of older children.

² Although not discussed in this letter, currently operating AHPs could be using rating practices that would not be allowed under the proposed rules. For instance, they could be using health status as a rating factor. An analysis of the impact of the proposed rules would also need to consider the implications associated with these AHPs.

- Per person rating. The ACA uses an “each person” rating structure, but allows an issuer to charge for only up to three children. That is, additional premiums cannot be charged for the fourth or any additional children. An AHP can use whatever child and family rating structure it wishes. It can charge for each child, irrespective of the number of children (which would make AHPs less attractive for large families) or it can use other family composition rating structures.

Industry/Occupation

The ACA does not allow premium variations by industry or occupation for any group or individual. Unless prohibited by state regulation, an AHP could vary its rates based on the industry or occupation of the applicant. Industry rating is common in the large group market and was common in the small group market prior to the ACA. Some states limit the percentage differential that can be used for groups, but not all have such restrictions.

Being able to charge higher rates to groups operating in industries that tend to have higher health costs and lower rates to groups in lower cost industries provides a key rating advantage to AHPs over plans subject to ACA restrictions.

Geographic Area

Under the ACA, geographic rating zones are determined through federal regulation with input by the states. All insurers within a state must set their premiums using identical rating zones, although they can vary the area factor used for each pre-established zone to reflect cost differences, but not morbidity differences, by zone. Some states set their ACA zones such that a mix of higher-cost and lower-cost areas were included in a zone so as to help limit rates that otherwise would be charged in the higher-cost area of the zone.

Subject to state regulations, an AHP can determine its own rating zones as well as its geographic area factors by zone. This allows it a strategic advantage over an ACA issuer that operates in multiple zones within a state. For instance, an AHP could split an ACA geographic zone into two rating areas in order to be more competitive in the lower-cost area and charge higher rates in the higher-cost area. It could also choose not to market in the higher cost area.

Gender Rating

The ACA prohibits varying rates based on gender for plans issued in the individual and small group markets. Rating by gender in the small group and individual markets was commonplace prior to the ACA. If gender rating is not prohibited, AHPs could vary rates by gender, at least at the participating group level; small groups would not be allowed to pass along gender-specific premiums to their members. Females at younger ages exhibit health care costs well in excess of males of the same ages. Gender rating would allow AHPs the ability to rate the small groups that comprise its membership more accurately, minimizing the gender rating risks that are faced by ACA issuers. As a result, AHPs could be more attractive to small groups comprised of younger men.

Group Size

The ACA prohibits varying premiums based on the size of the small employer group. Group size rating was widely used by small group insurers prior to the ACA, although many states limited the rating variation that could be applied, typically to no more than 20 percent.

If group size rating is allowed for AHPs, this rating factor would likely be employed for competitive positioning. Historically smaller groups tend to have higher costs than larger groups, all other things equal. This is particularly true of groups of fewer than 10 employees, especially if sole proprietors are eligible to join an AHP. By using group size rating factors, AHPs could offer more attractive premiums than ACA plans for what are typically more desirable small groups with more than 10 (or 20) employees and less attractive rates for the “micro groups” of fewer than 10 employees and sole proprietors.

Single Risk Pool

The ACA requires rating using a single risk pool. Subject only to allowing rating variations based on age, locality, family composition, and tobacco use, each ACA insurer must determine its rates based on the combined experience of all of its members within each state market (i.e., individual, small group). Through required participation in the ACA risk adjustment program, this essentially becomes a statewide single rating pool, encompassing all insurers in the market. As such, premium rates need to reflect the expected morbidity level of the entire state for the small group market and for the individual market.

AHPs set rates based on the expected experience of all their members, but are not subject to the ACA risk adjustment program. Therefore, AHP rates do not have to incorporate the expected experience of ACA compliant competitors. Given the various rating factor advantages that it has, as described above, an AHP may attract healthier-than-average groups. Such a bifurcated situation could lead to potential rate spirals in the ACA markets as healthier groups move to the AHP market, leaving less-healthy groups in the ACA market.

Plan Design Considerations

When treated as a large group, AHPs would be regulated by more flexible rules regarding benefit and cost-sharing requirements compared to ACA-compliant plans. AHPs could lower premiums by offering less-comprehensive plans than ACA plans. Similar to more flexible rating rules, more flexible benefit rules could allow AHPs to create plans more attractive to lower-cost groups, resulting in positive selection (and lower premiums) for AHPs and adverse selection (and higher premiums) for ACA plans.

Covered Services

ACA issuers in both the individual and small group markets must provide coverage for 10 essential health benefits (EHBs). Although large groups are not required to provide such coverage under the ACA, most provide comprehensive coverage, although not necessarily to the same extent as required for ACA individual and small group health plans.

AHPs would not need to meet the EHBs or state-benchmark requirements under the ACA. This would provide AHPs some flexibility in its plan benefit designs that could result in lower premiums and make them less attractive to higher-cost groups and individuals. For example, benefits that might be covered to a lesser extent in an AHP include rehabilitative and habilitative services (including chiropractic, physical therapy, and other therapies) and behavioral health services. AHPs that include prescription drug coverage might have narrower formularies than ACA-compliant plans.

Cost-Sharing Provisions

Under the ACA, individual and small group health plans must meet actuarial value (AV) requirements for the various metal tiers—60 percent AV for bronze plans, 70 percent AV for silver plans, 80 percent AV for gold plans, and 90 percent AV for platinum plans.³ ACA plans also have maximum out-of-pocket limits and cannot impose annual lifetime benefit limits. To avoid employer-shared responsibility penalties, large group plans must meet at least a 60 percent minimum value (akin to an actuarial value, but using a different federal calculator) with at least one of the plans that is offered to its employees. Unlike small employers, large employers can also offer plans with AVs lower than 60 percent and are not restricted to the metal level tiers, making plan design much more flexible.

AHPs have much more flexibility in their plan benefit designs and cost-sharing provisions. In particular, the ability to offer plans with AVs less than 60 percent could be attractive to many groups, as they are not subject to the shared responsibility provisions of the ACA. This could lower premiums for AHPs compared to small group ACA-compliant plans.

Provider Network Considerations

The ACA statute and regulations impose certain requirements on the makeup and accessibility of the health care provider networks being used for an ACA-compliant health plan. In addition to assuring access to primary care, specialty care, and hospital care, ACA plans must include at a minimum a specified percentage of certified community health centers in their networks.

Unless required by state law, an AHP will have more flexibility than an ACA-compliant plan in constructing its health care provider networks. However, it may be difficult for an AHP to secure the same level of negotiated reimbursement arrangements (i.e., provider discounts) as many of the ACA plans, particularly those with large blocks of business in a state or locality. If an AHP uses an administrator that can provide net discounts similar to the ACA competition, its advantage of having more flexible design options would be meaningful. However, “rent-a-network” arrangements generally do not produce discounts as large as those that major ACA players and many local HMO plans are able to secure from their provider networks.

³ Although catastrophic plans in the individual market are not subject to AV requirements, the AV of catastrophic plans is similar to that of bronze plans.

Other Key Modeling Considerations

Regulatory Environment

Insurance laws and regulations vary by state, and AHPs would likely carefully consider the regulatory environment before determining whether to enter a state market. AHPs would need to consider the rules of the AHP state of domicile as well as any applicable rules in the other states in which the AHP wants to participate.

As noted earlier, some states like New York require pure community rating. States with strict rating rules are less desirable candidates for an AHP's state of domicile, because the state rules would limit their rating flexibility and thus their potential advantage over ACA plans. However, states with strict rating rules would be good candidates for states in which an AHP might choose to market—AHP rating flexibility would allow them to offer more attractive premiums for younger adults, for instance. AHPs might be less inclined to market coverage in states that allowed individuals to keep their prior non-ACA-compliant coverage (i.e., so-called “transition” or “grandmothered” plans); in these states lower-cost individuals and small groups may already have plans with more rate flexibility than ACA plans.

The applicability of state laws regarding MEWAs based in other states will be a key determinant of how effectively AHPs can compete, particularly in the event such laws subject the AHP to many, if not all, of the rating and underwriting requirements the state has in place for its ACA business.

Competitive Considerations

Some issuers have more market power than others. This can be due not only to having more competitive rates, but also to other characteristics that are more difficult to measure and model. Some of these characteristics include insurer reputation, plan structure (e.g., HMO, PPO), provider networks, care management, and administration. How an AHP compares to competing plans across these characteristics can affect its potential market share.

* * * * *

We appreciate the opportunity to provide these comments and would welcome the opportunity to speak with you in more detail and answer any questions you have. If you have any questions or would like to discuss further, please contact David Linn, the Academy's senior health policy analyst, at 202.223.8196 or linn@actuary.org.

Sincerely,

Barbara Klever, MAAA, FSA
Chairperson, Individual and Small Group Markets Committee
American Academy of Actuaries



EXHIBIT 2

Majority Staff Report on the Failure of CO-OPs

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

SENATOR ROB PORTMAN
Chairman

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

BRIAN CALLANAN
Staff Director & General Counsel

MATTHEW S. OWEN
Chief Counsel

ANDREW POLESOVSKY
Counsel

WILL DARGUSCH
Investigator

JOHN KASHUBA
Legal Fellow

KELSEY STROUD
Chief Clerk

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%: CoOpportunity'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 to 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 CoOpportunity’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 CoOpportunity’s additional solvency loan, the Iowa Insurance Division suspended and later liquidated it. CoOpportunity’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

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-coopportunity-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

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

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

<u>CO-OP States</u>	<u>Start-up Loan Award</u>	<u>Solvency Loan Award</u>	<u>Total Award Amount</u>
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-coopportunitiy-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 2012³⁶ and an additional \$91

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/coopportunity/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]

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

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, 2015⁶⁶—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

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

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 market⁷⁹—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

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

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.

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.

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

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

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 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

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,

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

¹³⁵ Deloitte Review – New York 3; South Carolina 6; Tennessee 5; Colorado 5; Michigan 4; Nevada 4; Louisiana 5, CoOpportunity 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

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 case¹⁵⁶ and violation of state and federal

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

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

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.*

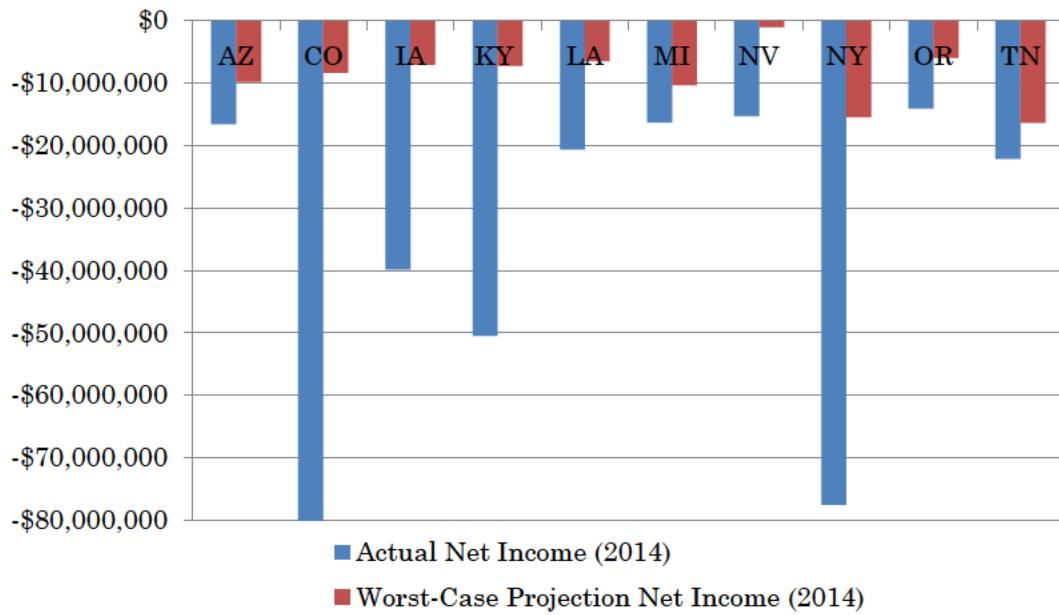
In most cases, the difference between projected and actual performance was staggering. As outlined below, the losses of 11 of the 12 failed CO-OPs ranged from 261% to 7,196% of their base projections—displayed in the far right column below.¹⁷⁴

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.

Failed CO-OP Losses Exceeded Worst-Case Forecast



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

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.*

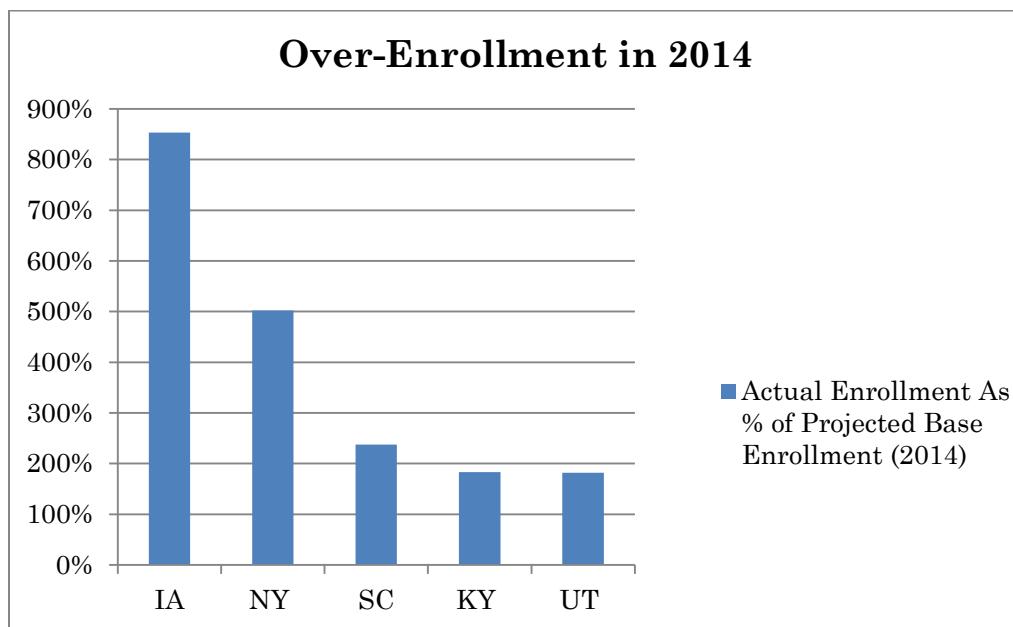
¹⁸⁵ Scott E. Harrington, *The Financial Condition and Performance of CO-OP Plans*, Univ. of Penn. Leonard Davis Institute of Health Economics, Data Brief, 6 (Feb. 2015).

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 CoOpportunity 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.

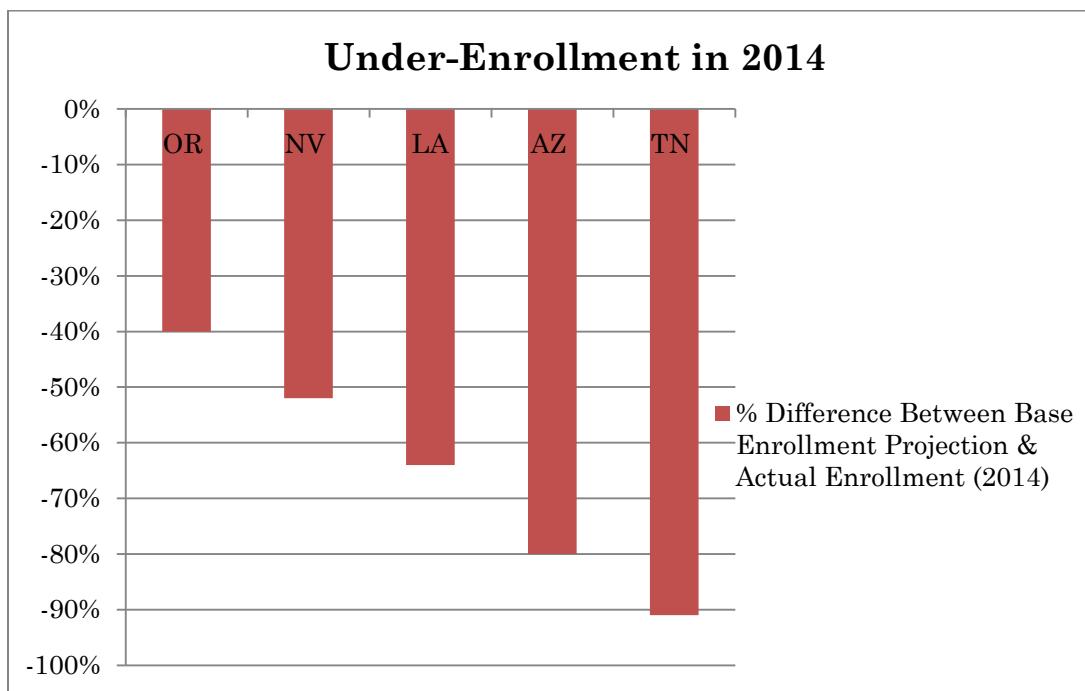
¹⁹¹ Appendix B.

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 CoOpportunity 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 CoOpportunity, 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

¹⁹⁹ Appendix A. In the case of CoOpportunity, 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.

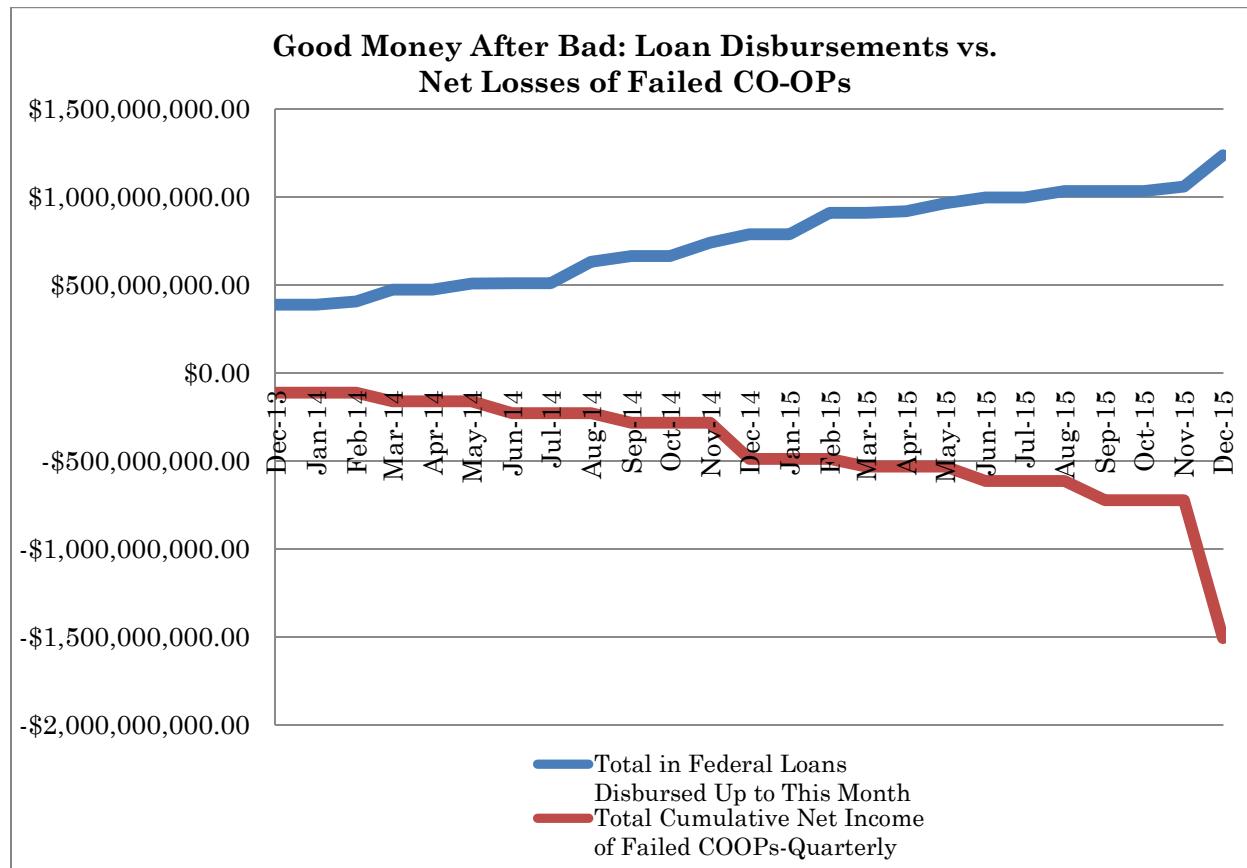
²⁰¹ Final Order of Liquidation, *Iowa ex rel. Gerhart, Comm. of Ins. v. CoOpportunity Health, Inc.*, Equity No. EQCE077579, at 4 (Mar. 2, 2015), <http://www.doi.nebraska.gov/legal/coopportunity/FINAL%20ORDER%20OF%20LIQUIDATION.pdf>; Scott E. Harrington, *The Financial Condition and Performance of CO-OP 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 million²⁰⁶ 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

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
CoOpportunity 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

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

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

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,

²⁵² *Id.* at 3–4.

²⁵³ *Id.* at 4.

²⁵⁴ Dep’t of Health & Human Servs., Ctrs. for Medicaid and Medicare 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

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

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

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/coopportunity/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 on 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

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, CoOpportunity'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

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

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.

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

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

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

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

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

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

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

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

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

Tennessee CO-OP		Utah CO-OP	
Total Assets	\$41,777,566	Total Assets	\$53,514,834
Total Liabilities	\$25,082,097	Total Current Liabilities	\$43,993,836
Surplus (excluding loans)	\$16,695,469	Surplus (excluding loans)	\$9,520,998
Solvency Loan	\$54,802,000	Solvency Loan	\$79,544,300
Start-up Loan	\$18,504,700	Start-up Loan	\$10,106,003
Source: Jan. 31, 2016 Statement		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

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

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 Célebre 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.

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).

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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

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.

³³⁷ Appendix C.

³³⁸ *Id.*

³³⁹ *Id.*

³⁴⁰ 42 U.S.C. § 18042(b)(2)(A)(iii).