United States Senate

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Committee on Homeland Security and Governmental Affairs

Rob Portman, Chairman

Failure of the Affordable Care Act Health Insurance CO-OPs

HEARING EXHIBITS

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

UNITED STATES SENATE

March 10, 2016

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Freelancers Health Service Corporation, d/b/a Health Republic Insurance of New York Additional Solvency Loan Funding Request

Date Submitted to CMS: 7/18/2014

Scope Summary & Assumptions:

- Deloitte will not provide an opinion regarding the reasonableness of the proposed changes to each CO-OP's business plan. Nor will Deloitte provide an opinion regarding the likelihood of each CO-OP achieving sustainable operations based upon the revised business plan.
- Deloitte assumes that the information provided by each CO-OP in its modified business plan is complete and accurate. Deloitte will perform its assessment of the data provided "as is". Deloitte will also use other data sources that are publicly accessible or information provided directly from the Centers for Medicare and Medicaid Services (CMS). Deloitte will notify CMS if we believe that there is insufficient information to complete our review.
- The impact of the Reinsurance, Risk Adjustment and Risk Corridors Program (the 3Rs, reinsurance, risk adjustment, and/or risk corridors) was reviewed when making observations and comments throughout this report. Observations and comments relating to the impact of the 3Rs are included for informational purposes only. There was no consideration of the reasonableness or propriety of any of the amounts relating to the 3Rs. Based on the scoring criteria provided by CMS, observations and comments relating to the 3Rs had a net neutral effect on the scoring.
- In reviewing applications from CO-OPs for additional solvency loan funding requests, Deloitte reviewed supporting documentation requested of the applicants by CMS in a memo to the CO-OPs distributed on April 30, 2014. The format of the reports, as well as the section scoring, was approved by CMS during the week of June 2, 2014. The score for the Contingency Plan section should be viewed independently of scoring for the other sections of this report. For all sections, Deloitte provided comments on issues only for which the applicant provided data. Observations relating to the pro forma financial statements are based on the base case with additional solvency award scenario, unless otherwise noted.

Executive Summary:

Freelancers Health Service Corporation d/b/a Health Republic Insurance of New York (HRINY or applicant or CO-OP) has submitted a request to CMS for $90.7M in additional solvency loan funding. HRINY has exceeded enrollment projections in the original funding application, which the CO-OP attributes to underpriced premiums and statewide network availability. As a result of higher than expected enrollment, HRINY is projecting a combined ratio of 102.2% for 2014, 99.6% in 2015, and 97.5% in 2016, including the impact of the 3Rs and excluding Affordable Care Act (ACA) adjustments. Excluding the impact of the 3Rs and the ACA adjustments, the combined ratio for these years is 115.3%, 102.4%, and 98.9%, respectively. ACA adjustments include such items as quality improvement expenses and taxes/fees. Including the impact of the 3Rs only, HRINY is projecting a loss in 2014, but expects to be profitable in 2015 and 2016. Without the 3Rs, the CO-OP is projecting losses of $68.2M and $23.1M for 2014 and 2015, respectively, and expects to become profitable in 2016. The CO-OP intends to correct losses to achieve profitability by increasing premium rates, improving medical management, and reducing administrative costs. HRINY stated in the application that it is requesting additional solvency loan funding in order to meet the New York Department of Insurance state specific requirement for reserves of

12.5% of net premium income. If HRINY does not receive the requested solvency loan funding, it may identify outside financing or scale down operations in order to meet solvency requirements. However, HRINY still projects that it will be able to repay both the start-up and current solvency loan funding in this scenario.

HRINY was originally awarded $150.7M in solvency loan funding, of which $48.4M has been disbursed. HRINY projects an additional $70M disbursement from the current obligated solvency loan funding in 2014. Based on discussions with CMS, Deloitte confirmed that CMS has chosen to fund HRINY based on state solvency requirements rather than an risk based capital (RBC) level of 500% of authorized control level (ACL) normally recommended by CMS. The amount of funding required to meet the recommended RBC level of 500% of ACL is greater than the amount required for reserves of 12.5% of net premium income. See further details in the CO-OP Financials section.

Critical Assertions:

1. **Enrollment:**

Based on HRINY's most recent enrollment projections submitted in June 2014, overall enrollment for 2014 is expected to be 251% more than projections included in the original application[1]. While the projected growth rate is expected to slow in subsequent years, the most recent projections for 2015 and 2016 are 319% and 339% more than original projections, respectively. New York operates on a State-based Marketplace (Marketplace).

Figure 1: Projected Enrollments are up Compared to Original (2011) Projections for 2014-2016

Source: Applicant's 2011 Original Application; 4/10/2014 and 6/17/2014 Pro Formas

The breakout of enrollment by business segment (individual, small group, large group) or method of enrollment (Marketplace vs. off Marketplace) was not provided in any of the pro forma financial statements (pro formas) submitted. However, this detail was provided in the business plan submitted with the request for additional solvency loan funding. According to the business plan, the 2011 feasibility study projected 28,102 members from the individual market and 2,762 members from the small group market (SHOP). In addition, the business plan states that as of May 2014, 81,000 members were enrolled from the individual market, and 38,000 members were enrolled from the small group market (pg. 4). However, because this breakout was not reflected in the pro formas, it cannot be determined if the CO-OP will have two-thirds of its enrollment from the Marketplace in 2016, as required by Title 45, Code of Federal Regulations (CFR) §156.515(c)(1) and (d) related to the requirements of CO-OPs pursuant to the Affordable Care Act (ACA).

Additionally, there are variances between the enrollment projections provided to CMS in the 4/30/2014 pro formas and the pro formas provided with the request for additional solvency loan funding. For example, for 2014, the 4/30/2014 pro formas projected 98,876 average enrollees, whereas the 6/1/2014 pro formas project 108,311 enrollees. The applicant does not provide a reason for this difference in the application.

Documentation for Change in Enrollment Projections

[1] All references to "original" – including, but not limited to, "original funding application", "original application", and "original projections"—refer to HRINY's 2011 application for CMS start-up and solvency loan funding , operations commencing in 2014.

The applicant expects that its pricing advantage, product offerings, and state-wide presence will allow it to achieve its enrollment goals for the foreseeable future, as described in Table 1 below (P. 87). According to the applicant, HRINY premiums were significantly lower than market rates in 2014. HRINY has concerns that given the unexpected growth rate to date, it will not be able to "maintain financial sustainability and market competitiveness" without raising premiums in 2015 by approximately 15% (P. 9). Please refer to the Product Pricing section for further details.

HRINY is requested additional funding due to increases in projected enrollment (P. 89). Based on discussions with CMS, HRINY is being funded based on the state-specific solvency requirements rather than the normally recommended threshold of 500% of ACL. Additional details on this issue can be found in the CO-OP Financials section.

Table 1: Documentation for Change in Enrollment Projections

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
Underpriced Premiums	1. **Raise Premium Rates for 2015.** HRINY projects having to raise average individual premium rates by 15.2% and average small group rates by 6% in 2015 in order to maintain financial sustainability and market competitiveness moving forward.	HRINY provided an actuarial analysis prepared by Milliman, the external actuary for the CO-OP, which provides details on the proposed adjustment to HRINY's 2014 pricing and market position analysis. According to HRINY, these price increases are necessary in order to "maintain financial sustainability and market competitiveness in 2014 to 2015" (P. 9). The applicant contends that even with these price increases, HRINY will remain competitive enough to achieve its projected enrollment numbers due in part to "other plans increasing [its] rates to cover medical cost trend and changes in federal reinsurance" (P. 4). The actuarial support for the application did not include estimates of the sensitivities of demand to prices. HRINY states that, despite these price changes, it intends "to maintain [its] current price position in most of its regions and will increase [its] premiums to sustainably reduce the gap between [its] plans and those offered by the next lowest-priced carrier (based on the June 13, 2014 rate filings)." The applicant contends that "this price change is especially important for achieving sustainability in regions where HRINY is priced more than 15% below the next lowest priced health insurer" (P. 7).
Geographic Availability	2. **Achieve state-wide availability.** HRINY intends to move into the remaining 30 New York counties in which it does not currently serve.	HRINY currently covers 32 of the state's 62 counties. These 32 counties are home to 92% of the New York's population and include complete coverage in Downstate New York, which includes the Hudson Valley (P. 7). In 2015, HRINY intends to add the POMCO provider network in the Upstate New York region as a complement to MagnaCare's Downstate network. According to HRINY, it will be able to reach residents in the 30 counties it does not currently cover by partnering with POMCO, which has a more comprehensive provider network in the Upstate New York region (P. 11). The

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
		applicant did not provide any information about the competitive landscape in these 30 counties. In addition, no premium information was provided in the 2015 rate filing for these 30 additional counties. Please refer to the Product Pricing section for additional information.
Increase Product/network Offerings	3. **Increase the number of products offered and increase network offerings.** HRINY intends to offer two new products, one targeting the individual market, and one targeting the small group market. Additionally, HRINY intends to compete in the large group market.	In 2015, HRINY intends to offer two new product lines in addition to its current three (Primary Select EPO, Primary Select, and Essential Care). The first of the two new offerings is the Active Living Line, which, according to HRINY, will target the individual market exclusively. HRINY stated that as HRINY's lowest priced product, the Active Living line will be marketed to a younger, healthier demographic as a "lean package" with a higher deductible than HRINY's other offerings. According to the applicant, "Active Living was filed as a statewide product, but may be deployed in more limited test markets based on feedback from the state and other market analyses" (P. 13). The second new offering is the All Access Line, available to all small group customers regardless of whether or not they're on the SHOP Marketplace. The key distinction between the All Access offering and HRINY's existing lines is its out-of-network option. According to the applicant, "there is a significant demand for access to physicians (both in- and out-of-network) from a niche group of customers." HRINY created this option as a way to attract small group customers that want "more competition in the out-of-network product space" (P. 13). No additional comments are available describing the specifics of this product's out-of-network options. In addition to these new products, HRINY intends to move into the large group market starting in 2015. According to the applicant, "this expansion will diversify its business and provide greater access to affordable, high-quality healthcare for employers and their employees" (P. 6). HRINY projects enrollment of 4,500 in 2015 and 18,000 in 2016 from large group (P. 22). The applicant provided no substantiation as to why it expects to see this increase in its large group membership from 2015 to 2016. This expansion will focus on companies in the 51-100 range in anticipation of the redefinition of small group in 2016. This will result in HRINY being in the large group market for only 2015.

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
Increase in Sales and Marketing	4. **Continue to develop and distribute communications and advertisements to key audiences.** HRINY will continue to develop targeted communications in the form of member satisfaction surveys, member advisory discussion groups, and advertising, as well as engage in market research going into 2015.	To gain an increased understanding of the needs of its customers, HRINY stated that it will engage in continued marketing efforts going into 2015. One such effort includes continued use of member satisfaction surveys aimed at gauging "member satisfaction strengths, weaknesses, opportunities and needs." By understanding the desires of its members, HRINY may be in a position to adapt and retain some customers, despite increased premiums in 2015 (P. 36). HRIC conducted a member satisfaction survey in 2014; out of the applicant's 119,000 current members in 2014, 396 enrollees responded to the survey. It is unclear why this group would be taken as a representative sample of the total membership's sentiments. Another marketing effort is the applicant's Member Advisory Discussion Groups. These are quarterly sessions where current members are able to provide input on the plan's past performance and future plans. According to the application, "Outputs from the sessions will be shared both internally and externally as appropriate, starting second quarter 2015" (P. 36). Additionally, in an effort to target new customers, HRINY plans to partner with an advertising agency "to develop and execute targeted campaigns focused on building brand awareness and supporting open enrollment initiatives in key markets." This partnership will begin in the summer of 2014 with the advertising campaigns set to start during the year's fourth quarter (P. 36). HRINY does not provide a budget detailing how much it intends to spend on these marketing efforts, nor do the pro formas provide any insight into marketing expenses. Additionally, the application provides no information on the applicant's efforts to obtain private funds.

Summary of Observations:

- **Increased enrollment projections from original application.** Although HRINY plans to increase premium rates starting in 2015, the applicant is still projecting to outperform enrollment projections in both its initial application and its 4/30/2014 pro formas. HRINY's original application pro formas projected 30,864 enrollees in 2014 and 50,535 enrollees in 2015. Per HRINY's most recent pro formas, to date, the applicant has already enrolled 119,000 enrollees and projects 211,818 enrollees for 2015.
- **Increased premiums planned for 2015.** In order to "maintain financial sustainability and market competitiveness" the applicant intends to raise premium rates to become more in line with its competitors in the market (P. 9). Pending approval, individual and small group premiums will increase by 15.2% and 6% in 2015, respectively.

- **Plans for new products and state-wide availability**. In order to achieve increased enrollment projections in the face of rising premium rates, HRINY plans to increase enrollment by offering two new product lines, and expanding into the state's remaining 30 counties. The new lines include the All Access line, a small group product offering out-of-network care, and the Active Living line, a less expensive product available exclusively for the individual market marketed to young and healthy customers. Additionally, HRINY will be moving into the large group market in 2015 in anticipation of the 2016 redefinition of "small group". HRINY projects enrollment of 4,500 in 2015 and 18,000 in 2016 from the large group market.
- **Insufficient quantification of business plan's impact**. While HRINY does lay out a strategy for maintaining enrollment numbers and market competitiveness, it does not quantify the impact this business strategy will have on enrollment projections and financial sustainability. Additionally, the plan to raise premiums is only substantiated in HRINY's assertion that, "HRINY conducted an in-depth investigation of its 2014 actuarial assumptions and their impact on 2014 pricing, as well as extensive research on trends and data for 2015", but no concrete data was provided from the study in the business plan or the Milliman feasibility study.
- **Support for marketing funds not provided:** The applicant did not specify how its partnership with an advertising agency, detailed in the marketing strategy, will be funded. Since solvency loan funds cannot be used for marketing purposes, the applicant may need to acquire outside funds to realize this portion of its marketing strategy.
- **Breakout of on and off Marketplace enrollment not provided in the pro formas.** it cannot be determined if the CO-OP will have two-thirds of its enrollment from the Marketplace in 2016, as required by Title 45, Code of Federal Regulations (CFR) §156.515(c)(1) and (d) related to the requirements of CO-OPs pursuant to the Affordable Care Act (ACA).

2. <u>Product Pricing:</u>

HRINY's 2014 enrollment was higher than anticipated due to its rates being among the lowest in most products and markets across the state. Also, fewer plans have been offering small group health insurance coverage. Emblem Health (a competing New York insurer) terminated all small group plans with Health Pass, a commercial health insurance exchange that has been operational since 1999 in New York (P. 8). After Emblem Health terminated these plans, many small businesses had to find coverage and enrolled with HRINY. However, no further information was provided on how many enrollees were previously enrolled through Health Pass.

The CO-OP plans increase its premiums, if approved, in 2015 by 15.2% for individual and 6% for small group products (P. 5). HRINY wants to hold its current price position in most of the regions and expects to reduce the gap between the next closest competitor by increasing premium rates. According to the applicant, these premium increases are especially important for achieving sustainability in regions where the next closest competitor's premiums are higher by 15% or more (P. 73). The CO-OP anticipates that the competitors will also be increasing their premiums to account for medical cost trend and changes in federal reinsurance and therefore, HRINY's products will still be competitive with these planned increases in premiums (P. 70). HRINY projects to achieve profitability beginning in 2015 and is profitable throughout the whole performance period, with the exception of the period 2018-2022, if projections are realized. In addition, the RBC level is below the normally recommended 500% of ACL by CMS. The amount of funding necessary to reach an RBC level of 500% of ACL is greater than the amount needed to reach the New York Department of Insurance requirement for reserves, 12.5% of net premium income. Per discussions with CMS, the CO-OP is currently funded at 12.5% of net premium income. Please refer to the CO-OP Financials section for further discussion.

The actual adjustments attributing to the total rate increase of 15.2% for individual and 6% for small group are not provided; however, the drivers of the rate increase are listed (P. 373 and 574). They are inclusive of, but not limited to, the following:

- Anticipated changes to demographics based on state average ACA Marketplace enrollment published to date

- Anticipated changes to medical inflation and increased utilization
- Changes in taxes, fees, and administrative expenses
- Changes to benefit and payment parameters of the federal transitional reinsurance program
- Changes to provider network contracting

Table 2 provides a comparison of the premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence. Highlighted areas denote the lowest premium for the particular region. HRINY is the lowest cost plan in many areas of New York which resulted in 20% market share in the individual market on the Marketplace.[2]

Table 2: Premiums on the 2014 New York Marketplace for individual market by Rating Region/Area

Insurer	ON/OFF Marketplace	Metal/ Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Freelancers New York	ON/OFF	Platinum	397.25	371.87	446.23	523.23	365.57	386.06	375.65	523.23
Fidelis	ON	Platinum	506.02	500.18	510.27	577.18	501.78	504.96	499.12	532.57
Oxford HMO	OFF	Platinum			965.24	965.24				965.24
United	ON	Platinum			913.99	913.99				913.99
Freelancers New York	ON/OFF	Gold	338.56	316.93	380.31	445.93	311.56	329.03	320.15	445.93
Fidelis	ON	Gold	418.82	413.99	422.34	477.71	415.31	417.94	413.11	440.79
Oxford HMO	OFF	Gold			817.98	817.98				817.98
United	ON	Gold			749.13	749.13				749.13
Freelancers New York	ON/OFF	Silver	299.57	280.43	336.51	394.58	275.68	291.14	283.29	394.58
Fidelis	ON	Silver	342.05	338.11	344.93	390.15	339.18	341.34	337.39	360.00
Oxford HMO	OFF	Silver			691.69	691.69				691.69
United	ON	Silver			635.60	635.60				635.60
Freelancers New York	ON/OFF	Bronze	236.70	221.58	265.89	311.77	217.83	230.04	223.84	311.77
Fidelis	ON	Bronze	270.32	267.20	272.59	308.33	268.05	269.75	266.63	284.50
Oxford HMO	OFF	Bronze			589.91	589.91				589.91
United	ON	Bronze			548.06	548.06				548.06
Freelancers New York	ON/OFF	Catastrophic	162.73	152.33	182.79	214.33	149.75	158.15	153.88	214.33
Fidelis	ON	Catastrophic	166.46	164.54	167.85	189.86	165.06	166.11	164.19	175.19
Oxford HMO	OFF	Catastrophic								
United	ON	Catastrophic			334.94	334.94				334.94

Table 3 provides a comparison for the premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence in the small group market. Highlighted areas denote the lowest premium for the particular region.

[2] Data Source for Tables 1 and 2: http://www.dfs.ny.gov/about/press2013/pr1307171_health_rates_2014.pdf

Table 3: Premiums on the 2014 New York Marketplace for small group market by Rating Region/Area

Insurer	ON/OFF Marketplace	Metal/ Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Freelancers	ON/OFF	PLATINUM	432.86	405.21	486.23	570.13	398.34	420.67	409.33	570.13
MVP Services	OFF	PLATINUM	535.71	593.73	602.68	767.86	448.10	582.03	546.32	690.84
MVPHP-HMO	ON/OFF	PLATINUM	539.61	446.29	607.05	773.42	451.35	586.25	550.28	
Oxford HMO	OFF	PLATINUM			733.00	733.00				733.00
Oxford OHI	ON/OFF	PLATINUM			774.73	774.73				774.73
United	OFF	PLATINUM								751.88
Freelancers	ON/OFF	GOLD	369.00	345.42	414.49	486.02	339.57	358.60	348.93	486.02
MVP Services	OFF	GOLD	447.88	496.39	503.87	641.96	374.63	486.60	456.75	577.58
MVPHP-HMO	ON/OFF	GOLD	458.22	378.99	515.49	656.78	383.29	497.85	467.30	
Oxford HMO	OFF	GOLD			632.80	632.80				632.80
Oxford OHI	ON/OFF	GOLD			656.70	656.70				656.70
United	OFF	GOLD	693.74	568.84	742.34		635.93	591.17	589.07	605.37
Freelancers	ON/OFF	SILVER	316.68	296.44	355.72	417.10	291.42	307.76	299.46	417.10
MVP Services	OFF	SILVER	363.15	402.48	408.55	520.52	303.76	394.55	370.34	468.32
MVPHP-HMO	ON/OFF	SILVER	381.31	315.38	428.99	546.56	318.96	414.28	388.86	
Oxford HMO	OFF	SILVER								
Oxford OHI	ON/OFF	SILVER			555.48	555.48				555.48
United	OFF	SILVER	596.18	488.84	637.94		546.50	528.52	506.23	509.57
Freelancers	ON/OFF	BRONZE	257.94	241.46	289.75	339.75	237.37	250.68	243.92	339.75
MVP Services	OFF	BRONZE	303.72	336.60	341.67	435.32	254.04	329.97	309.72	391.66
MVPHP-HMO	ON/OFF	BRONZE	294.63	243.69	331.46	422.31	246.44	320.10	300.47	
Oxford HMO	OFF	BRONZE								
Oxford OHI	ON/OFF	BRONZE			473.91	473.91				473.91
United	OFF	BRONZE								

Summary of Observations:

- **The CO-OP is expecting large enrollment growth based on 2015 pricing as compared to the competition.** The CO-OP believes that the Marketplace in New York is one of the most competitive Marketplaces in the nation. There are 17 carriers who have filed individual products on the Marketplace for the 2014 open enrollment period. According to the CO-OP, a majority of the competition is focused in the southern part of the state where the enrollment is expected to be the highest and also expects it to grow substantially for the individual products. The CO-OP estimates 2014 enrollment for individual

products on the Marketplace to increase by 56% in 2015 and then by 16% in 2016 (P. 73). Additionally, HRINY is offering a wider variety of products in 2015 than in 2014.

- **2015 premiums will increase compared with the 2014 premiums, pending approval by the New York Department of Insurance.** According to the applicant's estimate, 2014 enrollment was much higher than anticipated due to its rates being the lowest in many areas of New York which resulted in 20% of the Marketplace share in the individual market. The applicant believes that a member survey showed a "deep resonance with the member-led, not-for-profit model" (P. 8). However, survey responses were received from only 396 of the 100,000 plus members (P. 74). The CO-OP plans for increases in 2015 of 15.2% for individual and 6% for small group products (P. 373) out of which 5% is attributable to trend (P.378 and P.447).
- **Potential expansion of target market in 2015.** The CO-OP is considering including 30 new counties in its Upstate New York coverage area for 2015 (P. 78). No information was provided on the competitors in the 30 additional counties. The CO-OP plans to expand its coverage to mid/large group market but keep a focus on employers with 51-100 employees as it transitions to the small group market in 2016 (P. 88). There appears to be no information relating to the expansion in the 2015 rate filing provided with the application.
- **The 2015 individual and small group rate filings includes a breakdown of taxes and fees which does not include an estimate for the health insurer fee.** Milliman published a research report titled " ACA Health Insurer Fee – Estimated Impact of the US health insurance industry" dated April 2013, which states the 2014 health insurer fee estimate is 1.7% to 2.4% and increases to 2% to 2.9%. Since HRINY is a 501c (29) not-for-profit entity, the insurer fee estimate would be lower than the industry average. HRINY includes an estimate for Marketplace fees associated with selling plans on the Marketplace. The CO-OP assumed 0.44% of premiums for this fee. However, the applicant stated that the Marketplace fees are eliminated for 2014 and 2015 and this fee was "not built into the rates per New York instructions" (P. 91 and 210). No supporting documentation as provided to verify this statement.
- **HRINY is projecting a $10.7M loss in 2014 and established a premium deficiency reserve (PDR) of $5.2M in 2013.** It is unclear how the CO-OP determined the PDR, as a detailed analysis was not provided. Additionally, the stress test scenario shows a PDR of $87M for 2014. It is unclear how the $87M is determined differently from the $5.2M in the base case. Supporting documentation of the analysis was not provided.

3. <u>Medical Costs and Losses:</u>

HRINY projects combined medical loss ratios (MLR) for ACA purposes of 84.3%, 87.8%, and 86.9% for years 2014, 2015 and 2016, respectively, which includes the impact of the ACA and the 3Rs. This includes individual, small group and large group business. The large group minimum loss ratio is 85% while individual and small group are 80%. Taking into account the receivables for reinsurance relating to the 3Rs, the 2014 projected individual MLR, excluding the impact of projected ACA adjustments, is 101% and is expected to decrease to 89% in 2015, 86% in 2016, and 84% in 2017 based on a plan to fix the mispricing of 2014 and greater claims cost efficiencies. For small group business, the MLR will remain near 80% throughout the performance period. According to the applicant, combined with greater administrative efficiencies, these efforts are projected to bring HRINY's profit margin to 2.8% of premiums by 2017. The 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit. Including the $64M in receivables for risk corridors and reinsurance for 2014 would result in a $10.7M loss and result in an MLR of 79% for all products combined, excluding any adjustments for the ACA. Removing the estimated $64M in receivables would result in a $75M loss and raise the MLR, excluding any adjustments for the ACA, for all products combined to 91%. Based on the calculation of the risk corridors, it would be difficult to quantify a receivable without fully understanding the calendar year experience.

Based on a review of the 3/31/2014 regulatory filing, the combined medical loss ratio is approximately 76%, excluding any impact of the ACA adjustments. If this experience were to continue, the CO-OP could be in a

situation to pay rebates depending on its ACA loss ratio. Typically, one quarter's experience cannot be extrapolated to the entire year, and, therefore more months of experience will be needed to make a conclusion. The CO-OP is projecting the 2014 combined medical loss ratio to be 94%, excluding any impact for the ACA. The loss ratios include large group business which has a separate minimum loss ratio of 85%

The CO-OP plans to make changes to provider arrangements to increase the value being delivered by its provider networks. Since HRINY had a significantly larger member volume, it decided to renegotiate its vendor contracts in hopes of achieving lower vendor costs by about 7% for 2015 (P. 83). The CO-OP plans on adding a new product to its product portfolio and offer products in 30 counties in New York where it doesn't currently serve (P. 78).

According to the applicant, short term performance improvements will be driven primarily by the following factors (P. 86):

- **"Corrective pricing":** HRINY anticipates increasing rates by approximately 10% beyond trend in 2015 and 4% beyond trend in 2016 for the individual line of business and by 1% beyond trend in 2015 and 0% beyond trend in 2016 for the small group business. It cannot be determined what the impact of a 15% rate increase will be on the retention of membership. HRINY expects that its 2015 rates will be competitive and will improve its gross margins.
- **"Improved medical cost management":** HRINY plans to negotiate better network rates, rationalize its network offerings, and improve utilization management. HRINY anticipates that these changes will help offset increases in medical costs by approximately 3.5% in 2015 for individual plans and almost 1% for small group plans.
- **"Greater administrative efficiencies":** HRINY plans to reduce its per member total administrative expenses burden by 37% in 2015, 11% in 2016, and 9% in 2017 with administrative expenses increasing at the rate of inflation thereafter. Additionally, the CO-OP's administrative cost ratio (ACR) falls from 21.5% to 14.5% from 2014 to 2017. According to the applicant, although fixed administrative expenses are projected to grow from approximately $30M in 2014 to $40M by 2017, it expects to achieve these efficiencies due to growth in membership, renegotiated contracts, and supplier efficiencies (P. 86). The CO-OP stated that increasing its enrollment will be a driving factor in mitigating administrative costs.

As part of its enrollment strategy, HRINY expects to sell to the large group market in 2015. However, the expansion to the large group market will focus on companies in the 51-100 range in anticipation of the redefinition of small group in 2016. This will result in HRINY being in the large group market for only 2015. HRINY intends to build awareness in this market segment without increasing marketing expenses by leveraging existing broker relationships (P. 87).

The CO-OP is projecting morbidity to be equal to the state average. As such, no risk adjustment receipts or payable relating to 3Rs is projected in the rate filing. The CO-OP is expecting to get $54M in reinsurance receivables from the 3Rs which is 11% of the total premium during 2014 and $36M in reinsurance receivables relating to 3Rs which is 4% of the total premium in 2015. The estimates of relative risk and risk transfer payments are dependent not only on the membership enrolled by HRINY but also by the other carriers in the state (P. 381).

Due to the timing of this application, HRINY does not have enough of its own experience in the base period to use in rate development; therefore, the 2015 rate development is based solely on manual rates.

Summary of Observations:

- **HRINY expects 2015 morbidity to be similar to 2014 pricing morbidity.** The small group market forms the basis of the CO-OP's manual rates. HRINY assumes the current small group market morbidity to be the same as that before ACA was passed. When pricing for 2015, the expected morbidity of the small

group population in New York was used and adjustments were made to it to calculate the individual market morbidity. Based on research conducted by HRINY, individual markets have higher health risk than group markets and thus, the CO-OP is assuming that the individual market morbidity will be 40% higher than the small group market (P. 328).

- **2015 medical costs are based on industry data**. HRINY does not have enough 2014 experience to have its own data to rely upon; therefore, industry assumptions are necessary to estimate the morbidity of the projected membership.
- **Expanded provider arrangements.** HRINY intends to replace MagnaCare with POMCO's network in Upstate New York. HRINY plans to "increase the value delivered by [its] provider networks by analyzing [its] performance (i.e., efficiency), introduce additional types of networks (such as narrow and/or tiered networks) and introduce gain-sharing to provider contracts" (P. 97).
- **The risk corridors receivable estimate is difficult to quantify with the results relying upon the risk adjustment estimate.** Without the risk corridors receivables, HRINY would have larger losses in 2014.

4. **CO-OP Financials:**

HRINY's pro forma financial statements project recoveries from the federal reinsurance programs for 2014 through 2016. In the base case with additional solvency loan scenario (baseline scenario), HRINY projects cumulative federal reinsurance recoveries of $117.3M for 2014 through 2016, while it projects to recover $78.5M in the contingency scenario during the same period. HRINY also projects to receive an additional $10.4M from the risk corridors program in 2014 in all scenarios. HRINY projects a net loss of $10.7M in 2014, but expects to achieve profitability in 2015 with a projected net income of $3.8M in 2015 and $38.6M in 2016 (P. 44, 54). HRINY projects capital and surplus as a percentage of net premium to stay above 12.5% during the entire performance period in all projected scenarios.

Based on CMS's CO-OP Summary Report by Borrower as of 6/14/2014 (Loan Tracker), the CO-OP has been awarded total funding of $174.5M ($23.8M in start-up loans and $150.7M in solvency loan funding), and began issuing health insurance products beginning in 2014. $48.4M of the total solvency loan obligated is disbursed to HRINY with $102.3M of obligated but undisbursed solvency loan funds. HRINY is requesting additional solvency loan funding of $90.7M. Combined with the current solvency loan funding award, the total solvency loan for HRINY would be $241.4M.

New York's Section 4310 of the Insurance statutes requires the CO-OP to maintain a minimum reserve balance of 12.5% capital and surplus as a percent of net premium income. In its application for additional solvency loan funding, HRINY stated that the additional solvency loan funding is necessary to meet the New York's Department of Insurance reserve requirements. HRINY stated further that 15% of gross premium "has been budgeted to ensure sufficient reserves" (P. 89). Based on discussions with CMS, the CO-OP is being funded based on the state requirement, rather the normally recommended RBC level of 500% of ACL. As noted in the pro formas, the CO-OP does not reach an RBC level above the normally recommended CMS level of 500% of ACL until 2018, even with the additional funding of $90.7M.

HRINY's surplus as percent of net premium income is projected to stay above the 12.5% threshold for all years, if the additional solvency loan is awarded. As noted above, the CO-OP is requesting the additional $90.7M solvency loan funding to maintain a 15% capital and surplus as a percent of gross premiums. Table 4 below presents the excess (deficit) in projected capital and surplus with and without additional solvency loan funding to the CO-OP.

Table 4: Projected capital and surplus - Baseline scenario

	$ in 000s			
	2014	2015	2016	2017
Reserve Balance Required per New York Section 4310 of Insurance statutes	59,110	127,386	196,998	250,495
HRINY's projected capital & surplus amount with additional solvency loan funding	72,306	158,298	243,800	308,601
Excess (Deficit) in projected capital & surplus with additional solvency loan funding	13,196	30,912	46,802	58,106
HRINY projected capital & surplus with no additional solvency loan funding	72,306	120,009	159,480	217,913
Excess (Deficit) in projected capital & surplus - with no additional solvency loan funding	13,196	(7,377)	(37,518)	(32,582)
HRINY's projected capital & surplus amount with additional solvency loan funding, but without impact from 3Rs	14,790	73,894	140,076	204,877
Excess (Deficit) in projected capital & surplus without impact from 3Rs	(44,320)	(53,492)	(56,922)	(45,618)

Baseline Scenario:

If projections are realized, HRINY projects a loss of $10.7M in 2014, but projects to be profitable thereafter, with earnings of $3.8M and $38.6M in 2015 and 2016, respectively, and with related profit margin of 0.4% and 2.4%, respectively. The applicant projects an average profit margin as a percent of premium of 1.5%, which would result in cumulative profits of $1.1B from 2015-2033. HRINY is projecting receivables from the 3Rs program in 2014 to 2016, specifically $10.4M in risk corridors in 2014, and federal reinsurance recoveries in the amounts of $53.9M, $36.2M, and $27.1M in 2014, 2015, and 2016, respectively. Despite the total $64.3M of receivables that HRINY is projecting to receive from the 3Rs, it is projecting a loss in 2014. Absent these recoveries, HRINY's projected loss would be $68.2M in 2014. Additionally, HRINY is projected to incur a loss of $23.1M in 2015 absent recoveries from the federal reinsurance program. HRINY projects a PDR of $4.5M in 2014 and $687K in 2015. However, details were not provided with the analysis for the PDR estimate.

The applicant asserts that premium increases are required to break even in 2015, while its ability to break even in 2015 will enable it to pay back its original solvency loan award of $150.7M and the additional $90.7M in solvency loans by year-end 2032 (P. 4 and 84). HRINY expects to increase its premium rates by 15.2% for the individual market and 6% for SHOP in 2015 to drive its performance improvements (P. 86). In its pro forma income statement, its revenues per average number of enrollees increase by 11.9% in 2015 and by 7.7% in 2016. In its individual market rate filing for existing plans, HRINY is requesting a statewide average price increase of 15.2% (P. 373).

HRINY plans to make two changes to ensure its medical cost structure is in-line with its pricing in 2015. It will introduce a new network partnership, POMCO, in Upstate New York, thus, furthering its ability to reach all New York residents. Please refer to the Enrollment section for further details. The applicant also aims to increase the value delivered by its provider networks through three actions. First, HRINY is analyzing the performance of its network providers so it can decide whether to drop some of its providers, leading HRINY to believe that it can offer better care at competitive prices (P. 86). Second, HRINY plans to introduce narrow or tiered networks, which it states could offer rates 10-15% below the rates of broad networks. Finally, the applicant plans to introduce gain-sharing to provider contracts, which it believes will increase the predictability of claims costs (P. 77). Please refer to the Medical Costs section for further details.

The applicant states that it intends to become profitable by increasing its premiums and improving its processes; specifically through investing in technology to enable automation in enrollment and claims, and by renegotiating and reducing its vendor costs by 7% by 2015. The applicant explains that the automation of enrollment and claims processes should reduce its costs due to avoiding incremental administrative staffing during open enrollment. To achieve a 7% reduction in vendor costs, HRINY is currently pursuing a process to integrate independent vendors to achieve efficiency in its operations and also pursue a renegotiation of its vendor contracts (P. 5 and 82). HRINY claims that its vendors are responsible for billing and enrollment, member and brokerage services, medical management, claims adjudication, provider and facility network, pharmacy benefits management, and website and data warehouse management (P. 82). While HRINY describes its vendor functions in detail, it does not provide a budgeted schedule for its current vendor costs nor for its costs following contract renegotiations; therefore, it is difficult to determine the viability of the cost reductions, and also how it flows through to the reductions in total general administrative costs. Furthermore, no evidence was provided by the applicant to support a 7% reduction in vendor costs.

Additionally, as described in the April 30, 2014 memo from CMS, the CO-OP was required to file an SF 424A (budget form) as part of its application which would detail its expenses for 2014 and 2015. However, HRINY did not provide the SF 424A. As a result, the details of its 2014 and 2015 budgeted amounts are unknown.

Excluding the lack of detail laid out in its budgeted costs, HRINY's pro forma income statement ties to its business plan, as the ACR, which includes costs for commissions and loss adjustment expense (LAE) reserve, is projected to decrease from 21.3% in 2014 to 16.6% in 2015 and 15.5% in 2016. HRINY's ACR ranges from 16% down to 11.8% through 2034, with an average ACR of 13.5%. Additionally, HRINY stated that a reduction in general and administrative costs per member will be 37% in 2015 and 11% in 2016 (P. 86). The applicant states that it expects to achieve these efficiencies; "despite growing fixed G&A expenses… due to greater scale, renegotiated contracts, and supplier efficiencies" (P. 86). However, as previously noted, the applicant does not provide a breakout of its administrative costs, nor does it provide a detailed summary of its expected costs savings or specifics on its renegotiated vendor contracts. Additionally, it doesn't appear HRINY accounts for Marketplace fees within its projections. However, the applicant stated that the Marketplace fees are eliminated for 2014 and 2015 and this fee was "not built into the rates per New York instructions" (P. 91 and 210). No supporting documentation as provided to verify this statement. The applicant does not project Marketplace fees in the pro forma throughout the entire performance period.

The applicant's MLR, including the impact of the 3Rs, is 81.8% and 83.1% for 2015, without including impact of ACA adjustments. As noted above, HRINY projects to recover $53.9M, $36.2M, and $27.1M in 2014, 2015, and 2016, respectively, from the federal reinsurance programs. Additionally, HRINY projects to receive payment of $10.4M from risk corridors in 2014. Absent these recoveries from the 3Rs, HRINY's MLR will be 94% in 2014 and 85.8% in 2015, without including impact of ACA adjustments.

HRINY projects to receive additional solvency loan funding in the amount of $90.7M and projects to draw down its full solvency awards by 2017, bringing the total solvency loan funding amount to $241M (P. 143). The applicant plans to fully repay the solvency loan by 2032, if projections are realized. Per the baseline pro forma

balance sheet, HRINY's RBC level would range from 371% in 2014 to 469% in 2017, until reaching 500% in 2018, a year after fully drawing its solvency loan in 2017, and would remain above 500% through 2022. However, it does fall below 500% for the rest of the performance period. However, as noted above, HRINY is funded per the requirement under Section 4310 of the New York Department of Insurance statutes, which requires the CO-OP to maintain a reserve level of 12.5% of net premium income. As presented in the baseline pro formas, the applicant projects to maintain the state requirement of 12.5% of net premium income as surplus for all years.

Stress Test Scenario:

Under the base case with a mild stress test scenario (stress test scenario), HRINY projects to receive increased additional solvency loan funding of $275.7M to combat a 10% increase in claims cost due to uncertainty in pricing. In this scenario, the applicant asserts that rate increases were assumed to maintain a reasonable level of profitability to generate a surplus to enable it to pay off its solvency loan (P. 37). Revenues and administrative costs remain static, as evidenced by the same ACR as in the baseline. Additionally, the MLR is projected to stay at the same level as the baseline scenario.

The primary difference of the stress test scenario as compared to the baseline scenario is its projection of PDR. In the stress test scenario, HRINY projects an $82.3M change in reserves due to PDR in 2014. However, details relating to projecting this level of PDR were not provided in the application. This represents a net change of $86.8M in total expenses, resulting in a projected net loss of total $97.6M in 2014, with the assumption of receiving $53.9M in federal reinsurance recoveries and a receipt of $10.4M in risk corridors payments. Absent recoveries from federal reinsurance program and risk corridors payments, 2014 losses would near $162M. Under this scenario, according to the applicant's pro forma balance sheet, year-end capital and surplus is projected to stay above 12.5% of net premium income during the entire performance period.

Summary of Observations:

- **HRINY projects average statewide premium increase of 15% in 2015.** HRINY's ability to break even is contingent on an average statewide rate increases 15% in 2015 and 9% in 2016. It is difficult to determine whether HRINY will be able to meet its projected enrollment and premium revenues as well as retain current members with this level of premium increases.
- **$82.6M PDR projected in 2014 in stress test scenario.** In the stress test scenario, HRINY projected a change in PDR of $82.6M in 2014. However, no documentation supporting the analysis of the PDR was provided. The applicant does not project PDR to be recorded in 2014 in the baseline scenario.
- **Budget not provided for 2014 and 2015 to support proposed reductions in administrative expenses.** In the baseline scenario, the applicant projects a 7% reduction in vendor costs through renegotiated contracts and also projects to reduce its administrative expenses in 2015 and 2016. However, no details are provided by HRINY as to what the actual cost reductions are and with what vendors it expects to renegotiate its contracts. HRINY did not provide its budget to support the projected cost reductions.

5. Contingency Plan:

As outlined in its application, HRINY discusses two scenarios in the event that the additional solvency of $90.7M is not awarded: either identifying outside financing or scaling down its operations so it can meet solvency requirements, though the applicant does not provide further detail on how it would secure outside financing (P. 5). HRINY would scale down its operations by increasing its rates, by reducing its membership size; especially in low margin counties, and by eliminating all non-essential administrative costs, such as marketing and customer service (P. 7).

Premium Increases: HRINY stated that in the event the additional solvency loan funding is not awarded, premium rate increases will be "higher than those planned for 2016 and presented in the business plan pro forma" (P. 7). Additionally, the applicant stated that while the increase in premium will help the CO-OP to improve its profit margin, it will "result in a loss of market share" (P. 7). However, no specific detail is provided

on the level of rate increase projected in the contingency scenario. Additionally, it is not clear how increasing rates and eliminating administrative costs relating to customer service fits into the overall mission of the CO-OP.

Reduce membership size: In the contingency plan, the applicant plans to reduce its membership level by "production rationalization and service area reduction" (P. 7). HRINY stated that it will "reduce product offerings to EssentialCare in the individual market, the product New York State requires, and discontinue non-required individual products on- and off-exchange to both decrease overall membership and shift some members to the higher margin EssentialCare product line" (P. 7). Additionally, the applicant plans to retract from counties that generate the lowest profit margin. As presented in the pro formas, HRINY projected enrollment for 2015 is less than the average enrollment as projected in the baseline scenario by 109,500 members.

Expedite reduction in administrative and medical cost to essential: The applicant stated that it will take action to eliminate non-essential administrative expenses such as marketing expenses and cut in customer service level. However, no further detail is provided on the level of cuts that the CO-OP is projecting.

The applicant's contingency plan represented in its pro forma income statement shows reduced enrollment projections starting in 2015 and increased premium revenues per member as compared to its baseline scenario. Table 5 below highlights enrollment projections, premium revenues, average premium revenues per member, and ACR for 2015 through 2020:

Table 5: Premiums per Member and ACR Comparison: Baseline vs. Contingency Plan

	2015	2016	2017	2018	2019	2020
Baseline Scenario						
Average Members	211,818	302,818	360,318	367,524	374,875	382,372
Net Premium Earned ($000)	1,055,320	1,625,336	2,057,342	2,208,329	2,370,411	2,549,706
Average Annual Premium per Member ($000)	5.0	5.4	5.7	6.0	6.3	6.7
ACR	16.5%	15.4%	14.5%	14.4%	14.2%	14.1%
Contingency Plan Scenario						
Average Members	102,318	95,318	87,318	78,586	70,727	63,655
Net Premium Earned ($000)	538,834	543,238	535,553	518,438	500,568	485,282
Average Annual Premium per Member ($000)	5.3	5.7	6.1	6.6	7.1	7.6
ACR	17.8%	16.7%	16.5%	16.1%	15.8%	15.4%

HRINY believes its ability to negotiate provider contracts may be reduced due to the projected reduction in the membership size (P. 128). This is expected to increase costs due to lower network discounts. An additional increase in premiums would be necessary to account for fixed costs across a smaller membership base. HRINY's calculation of the net impact of this change in HRINY's cost structure would cause the 2015 margin as a percentage of premiums to decline from 0.40% and $3,804,000 under the business plan to 0.05% and $138,000 under the contingency plan (P.128). The 2015 rate has already been submitted and therefore the change in pricing could not be reflected until 2016.

Under the contingency plan, HRNY believes it will need to increase its 2016 individual market rates by 10% and Small Group Market rates by 6% (assuming regulatory approval), as compared to the 9% and 5% increase projected in the business plan (P. 129). These rate increases are in addition to steering members to higher margin plans and exit lowest margin counties. HRINY also plans to eliminate higher cost medical providers from

networks in 2014 and beyond, reduce customer service levels to drive down variable administrative costs; and reduce health management efforts to essential requirements only (P. 129-130).

One of the secondary effects anticipated by HRINY from the above actions is an overall sicker population, as the CO-OP expects higher cost individuals to be the first to keep their coverage due to "generous benefits and broader network" (P. 131). This is expected to accelerate the overall claim costs trend. However, it is unclear if HRINY's benefits and network are enough to entice the sicker population to retain their coverage.

In the event the applicant does not receive the $90.7M additional solvency loan request, the contingency plan is projected to commence in 2015. The pro forma income statement in the contingency plan shows that the applicant projects to realize a profit of $138K in 2015. The applicant is projecting MLR and ACR in contingency scenario to stay at the same level as in the baseline scenario. Surplus is also projected to stay above 12.5% of net premium income during the entire performance period.

Summary of Observations:

- **HRINY projects $965.4M less in total profits as compared to its baseline scenario due to lower enrollment.** In its contingency scenario, the applicant projects a cumulative net profit of $101.4M from 2014 – 2033, while projecting to incur a loss in 2032 and operate at break even in 2033. As compared to the baseline scenario, HRINY projects $1.1B in cumulative net profits from 2014 – 2034, which is higher than the projected profit in the contingency scenario. The reduction in projected cumulative profit may be attributable to the reduction in enrollment projections, as HRINY plans to retract from certain counties that generate low profit margins. For the entire performance period, HRINY projects an average enrollment of 49,908 members in the contingency scenario as compared to 397,056 average members projected in its baseline scenario. Furthermore, while the baseline scenario enrollment is projected to increase each year up to 504,532 members in 2034, the contingency scenario enrollment is forecasted to decline each year, down to 14,562 members in the same year. This represents a projected 86.6% decline in enrollment in its contingency plan.
- **No specific detail provided on projected increases on premium rates.** HRINY stated that premiums will increase "higher than planned in the baseline for 2016" (P. 37). However, no further detail was provided on the projected level of increases.

Solvency Loan Request Points

Sections	Potential	Total
Enrollment	15	11.25
Product Pricing	20	11.5
Medical Costs and Losses	15	12
CO-OP Financials	15	9.5
Score	**65**	**44.25**

Contingency Plan Points

Contingency Plan	Potential	Total
Overall	10	9
Score	**10**	**9**

Freelancers Health Service Corporation,
d/b/a Health Republic Insurance of New York
Additional Solvency Loan Funding Request Report Round II

Date Submitted to CMS: 10/24/2014

Scope Summary & Assumptions:

- Deloitte will not provide an opinion regarding the reasonableness of the proposed business plan changes of each Consumer Operated and Oriented Plan (CO-OP) Program. Nor will Deloitte provide an opinion regarding the likelihood of each CO-OP achieving sustainable operations based upon the revised business plan.
- Deloitte assumes that the information provided by each CO-OP in its modified business plan is complete and accurate. Deloitte will perform its assessment of the data provided "as is". Deloitte will also use other data sources that are publicly accessible or information provided directly from the Centers for Medicare and Medicaid Services (CMS). Deloitte will notify CMS if we believe that there is insufficient information to complete our review.
- In these applications for solvency loan requests, some of the CO-OPs have cited a need for additional solvency loans to cover projected cash shortfalls as a result of nonadmitting risk-sharing receivables provided in the Affordable Care Act (ACA). The National Association of Insurance Commissioners (NAIC) is charged with developing accounting guidance for these risk-sharing provisions which are utilized by the state departments of insurance in monitoring the financial solvency of the insurers domiciled in their state. The NAIC is continuing their deliberations on this issue, which previously included potential nonadmittance for risk-sharing receivables in excess of any payables. However, as a result of the most recent NAIC meeting on August 17, 2014, the adopted minutes of that meeting reflects that the NAIC is "replacing the nonadmission guidance with criteria that incorporates conservatism and sufficiency of data and removing the exposed 90-day guidance and adding language to be consistent with other government receivables". This Findings Report will provide relevant information, as necessary, on the accounting treatment for the risk-sharing receivables used by the CO-OPs in their financial projections.
- The impact of the Reinsurance, Risk Adjustment and Risk Corridors Program (the 3Rs, reinsurance, risk adjustment, and/or risk corridors) was reviewed when making observations and comments throughout this report. Observations and comments relating to the impact of the 3Rs are included for informational purposes only. We are not commenting on the reasonableness or propriety of any of the amounts relating to the 3Rs. Nor are we commenting on the underlying accounting policy. Based on the scoring criteria provided by CMS, observations and comments relating to the 3Rs had a net neutral effect on the scoring.
- In reviewing applications from CO-OPs for additional solvency loan funding requests, Deloitte reviewed supporting documentation requested of the applicants by CMS in a memo to the CO-OPs distributed on August 22, 2014. The format of the reports as well as the section scoring was approved by CMS during the week of June 2, 2014. These reports are scored on the basis of a total of 65 points, plus 10 points for the contingency plan. The scoring reflects Deloitte's assessment of the degree to which the application complies with the funding loan announcement of August 22, 2014. The score for the Contingency Plan section should be viewed independently of scoring for the other sections of this report. For all sections, Deloitte provided comments on issues only for which the applicant provided data. Observations relating to the pro forma financial statements are based on the base case with additional solvency loan award scenario (base case), unless otherwise noted.

Executive Summary:

Health Republic Insurance of New York (HRINY or the applicant or CO-OP) has submitted a request to CMS for $70.5M in additional solvency loan funding. HRINY states that additional funding is needed in order to meet the State-determined solvency requirements relating to maintaining risk-based capital (RBC) of 500% of authorized control level (ACL). HRINY states that since the June 18, 2014 submission, new developments have occurred which "directly affect solvency needs" (P. 2)[1]. These developments include increased membership projections for 2014 and 2015, updated financial data, competitive positioning, and a new surplus target of 500% of ACL rather than the 15% of net premium income that was targeted in the June 2014 submission projections (P. 2). New York's Section 4310 of the insurance statutes requires the CO-OP to maintain a minimum reserve balance of 12.5% of net premium income as capital and surplus. However, HRINY stated that the New York State Department of Financial Services (DFS) is now requiring the CO-OP to maintain an RBC level of 500% of ACL as recommended by CMS (P.2). This change supports $18.8M of the total request of $70.5M. (P.2) No further documentation or information was provided to substantiate the reason for the CO-OP to now maintain RBC levels of 500% of ACL.

Based on CMS's CO-OP Summary Report by Borrower as of 10/3/2014 (Loan Tracker), the CO-OP was obligated $23.8M in start-up loans and $241.3M in solvency loan funding, totaling $265.1M. As of 10/3/2014, a total of $155.6M has been disbursed, specifically $23M of obligated solvency loan funding and $132.6M of the $241.4M of obligated start-up loan funding. The CO-OP was recently awarded $90.7M as a result of a solvency loan request in June 2014, which is included in the total obligated amount but has not yet been disbursed.

Although HRINY plans to increase premium rates starting in 2015, the applicant is still projecting to outperform all previous enrollment projections. HRINY's original[2] application pro forma financial statements projected 30,864 average enrollees [3]in 2014 and 50,535 in 2015. Per HRINY's most recent pro forma financial statements, the applicant projects to enroll 116,439 average members in 2014 and 261,839 in 2015. Additionally, HRINY's ability to meet its projected break-even is contingent on premium increases of more than 10% in 2015 and 2016.

In discussing its competitors, the CO-OP mentions a new entrant to the individual market place, Freelancers Insurance Company (Freelancers or FIC) (P.87). Although Freelancers is discussed as a competitor in the application, FIC is actually a for-profit insurer run by the Freelancers Union which is the same organization that founded and currently sponsors HRINY. Additionally, while FIC originally planned to enter the individual market at the time of HRINY's application, the insurer has since decided to cease its insurance activity starting in 2015. FIC currently enrolls approximately 25,000 of Freelancers Union members. Given the relationship between FIC and HRINY, it is unclear how FIC's pending closure will impact the CO-OP's enrollment in 2015 and beyond[4].

HRINY is projecting receivables from the 3Rs program from 2014 through 2016, specifically $12.6M in risk corridors receivables in 2014, and net federal reinsurance recoveries in the amounts of $50.2M, $51.8M, and $20.3M in 2014, 2015, and 2016, respectively. Absent the impact of the 3Rs, HRINY projects a loss of $74.5M in 2014 and $46.6M in 2015. The 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit. Additionally, HRINY's latest projection of net federal reinsurance recoveries has increased by $29M as compared to the net cumulative federal reinsurance recoveries projected by HRINY in its June 2014 pro forma submissions to CMS. No further information was provided as to the reason for this increase. Based on the pro forma financial statements, if the CO-OP does not receive additional solvency loan funding and given the timing of the cash receipts of the 3Rs receivables being several months after expenditures, CMS may want to consider that HRINY could suffer from a liquidity issue.

[1] Page numbers in this report refer to the consolidated application.

[2] All references to "original" – including, but not limited to, "original funding application", "original application", and "original projections"—refer to HRINY's 2011 application for CMS start-up and solvency loan funding , operations commencing in 2014.

[3] Annual enrollment projections provided in the pro formas reflect average membership over a 12 month period.

[4] Source: http://www.nytimes.com/2014/10/01/nyregion/freelancers-union-to-end-its-health-insurance-plan-in-new-york.html?_r=1

Critical Assertions:

1. Enrollment:

In this application, HRINY is requesting $70.5 million in additional solvency loan funding. The CO-OP states that $44.2 million of this request will be used to address "the continuation of higher-than-expected growth" (P. 3). Based on HRINY's most recent pro forma financial statements submitted in September of 2014 (9/24 Pro Formas or pro formas), average enrollment for 2014 is almost 8% larger than the projections in June of 2014 (6/1 Pro Formas). This growth continues in 2015 and 2016, where average enrollment projections are 24% and 25% greater than the projections in the 6/1 Pro Formas, respectively. According to the CMS CO-OP Enrollment Comparison Report as of 8/05/2014, HRINY's current enrollment is 135,494. The enrollment projections, as outlined in the 9/24 Pro Formas, the 6/1 Pro Formas, and the pro forma financial statements from the original application (2011 Pro Formas), are presented in Figure 1.

Figure 1: Projected Enrollments are up Compared to Original (2011) Projections for 2014-2016

Source: Applicant's 2011 Original Application; 6/1 pro formas; and 9/24 pro formas

Although the CO-OP's 9/24 Pro Formas do indicate "higher-than-expected growth", discrepancies exist between what the applicant reports in its business plan/project narrative, and what exists in the 9/24 Pro Formas and feasibility study (P. 3). In the project narrative, the CO-OP states, "As you will see in the enclosed pro forma, we are now projecting a 2014 year-end membership of approximately 160,000, up from the estimate of 134,000 submitted in the June 2014 Business Plan" (P. 3). Additionally, the CO-OP's business plan reports end-of-year projections of 314,839 and 404,839 enrollees for 2015 and 2016 respectively (P. 85). However, the base case of the 9/24 Pro Formas submitted with this application projects an average enrollment of 116,439, 261,839, and 373,339 for 2014, 2015, and 2016 respectively (P. 115). It is, therefore, unclear how the CO-OP arrived at the projections in the business plan and why they differ from enrollment projections in the 9/24 Pro Formas.

The breakout of enrollment by business segment (individual, small group, large group) or method of enrollment in the New York state-run Marketplace (Marketplace) vs. off Marketplace was not provided in any of the pro forma financial statements submitted. However, some of the details regarding business segment were provided in the body of the feasibility study provided with this application, as well as the feasibility studies provided with the June 2014 application and original application. Table 1 shows the change in the CO-OP's enrollment projections by business segment for the years 2014, 2018, and 2023, illustrating the evolution of HRINY's enrollment strategy over time. No breakout was provided for the years in between those listed below.

Table 1: Enrollment Projection Comparison, 2014-2023

	2014			2018			2023		
	Individual	Small Group	Large Group	Individual	Small Group	Large Group	Individual	Small Group	Large Group
Original Application Projection	28,102	2,762	0	77,721	12,115	0	86,981	13,559	0
June 2014 Projection	69,404	38,907	0	171,486	164,418	31,620	189,334	181,531	34,911
September 2014 Solvency Loan Funding Request	73,466	42,973	0	186,467	221,368	31,620	205,875	244,408	34,911
% Change Original Application-	161.43%	1455.87%	N/A	139.92%	1727.22%	N/A	136.69%	1702.55%	N/A

Sep-14									
% Change June 2014-September 2014	5.85%	10.45%	N/A	8.74%	34.64%	0.00%	8.74%	34.64%	0.00%

In 2014, HRINY is expecting 63% of its enrollment to be comprised of individual enrollees, and 37% to be comprised of small group enrollees. In the June application, the CO-OP projected individual enrollees would comprise 64% of its enrollment, with small group enrollees comprising 36%.

The applicant describes its efforts to attract large group enrollees in its business plan, stating only, "HRINY's large group efforts will primarily focus on companies with 51 to 100 employees in 2015, serving as a one-year bridge to [the] new upper-limit definition of small group in 2016" (P. 69). The applicant does not mention its large group enrollment strategy past 2015. However, as noted in Table 1, the applicant projects that 31,620 of its total average enrollment of 439,546 will come from the large group business segment by 2018.

HRINY did not provide a breakout of projected enrollment for on and off Marketplace. As a result, it is unknown if the applicant is projected to achieve the two-thirds enrollment from the Marketplace as required by Title 45, Code of Federal Regulations (CFR) §156.515(c)(1) and (d) related to the requirements of CO-OPs pursuant to the ACA.

Documentation for Change in Enrollment Projections

The applicant expects that its pricing advantage, product offerings, geographic availability, and marketing efforts will allow it to achieve its enrollment goals for the foreseeable future, as described in Table 2 below. The applicant states that its rates were "too low because the actual population risk mix in the 2014 market was higher risk than expected". HRINY, therefore, decided it would not be able to achieve "financial sustainability and market competitiveness" without raising rates by approximately 13% (P. 72). Please refer to the Product Pricing section for further details.

Table 2: Documentation for Change in Enrollment Projections

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
Underpriced Premiums	1. **Raise Premium Rates for 2015.** HRINY is approved to raise average individual premium rates by 12.9% and average small group rates by 3.5% in 2015	According to HRINY, these price increases are necessary in order to "maintain financial sustainability and market competitiveness" in 2015 and beyond. In the applicant's June 2014 solvency loan request, it originally projected increasing individual premium rates by 15% and small group premium rates by 6%. However the DFS did not approve the proposed rates, only granting increases for the individual and small group segments of 12.9% and 3.5% respectively (P. 73). The applicant contends that even with these price increases, HRINY will remain competitive enough to achieve its projected enrollment numbers. It points to the fact that the approved rates still place their products "fourth or fifth from the bottom of the market in many regions". (P. 5) The CO-OP therefore expect to "retain membership and achieve growth" through its geographic expansion and competitive price-point (P. 5). See Product Pricing section for more information. HRINY does discuss potential challenges to the CO-OP achieving

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
		its enrollment projections as they relate to the proposed price increases and the price points of its competitors. The applicant states, "Should HRINY's competitors significantly change the design of their products, HRINY's enrollment projections will be impacted" (P. 87). The CO-OP goes on to point out that, for the individual segment, HRINY's products "will remain among the most affordable products in all rating areas" even with the price increases (P. 72). Similarly, HRINY states that for the small group segment it has the lowest average rate for every tier and every region, with the exception of New York City Platinum plan where it has the second lowest average rate (P. 87). In discussing its competitors, the CO-OP mentions a new entrant to the individual Marketplace, Freelancers Insurance Company. Although Freelancers is discussed as a competitor in the application, FIC is actually a for-profit insurer run by the Freelancers Union which is the same organization that founded and currently sponsors HRINY. Additionally, while FIC originally planned to enter the individual market at the time of HRINY's application, the insurer has since decided to cease its insurance activity starting in 2015.[5] FIC currently enrolls approximately 25,000 of Freelancers Union members. Given the relationship between FIC and HRINY, it is unclear how FIC's pending closure will impact the CO-OP's enrollment in 2015 and beyond. In addition to HRINY, and FIC, the Freelancers Union formed a brokerage company called the Freelancers Brokerage Inc. in April 2014.[6] Although HRINY currently lists Dubraski & Associates as its independent insurance brokerage (P. 18), it does state its intention to expand its broker program in 2015 (P. 84). HRINY does not provide any information alluding to a relationship with FIC or Freelancers Brokerage Inc. in its application.
Geographic Availability	2. **Move into 11 new counties in Upstate New York.** Starting in 2015, HRINY intends to expand its operations into 11 counties in Upstate New York.	According to the applicant, part of HRINY's enrollment strategy is to move into 11 counties in Upstate New York where it currently does not provide coverage. Currently, according to the applicant, HRINY covers 32 of New York's 62 counties, which are home to approximately 88% of the state's population. By moving into these 11 counties, HRINY will be making its products available to another 1 million members, and "bringing the company one step closer to its goal of

[5] Source: http://www.nytimes.com/2014/10/01/nyregion/freelancers-union-to-end-its-health-insurance-plan-in-new-york.html?_r=1
[6] Source: http://www.dos.ny.gov/corps/

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
		statewide coverage" (P. 70). Although these 11 counties only comprise a small fraction of the state's total population, HRINY states that this extension allows the CO-OP to build "a more complete delivery system" with providers that don't currently exist in its network (P. 75). In the applicant's previous request for additional solvency loan funding in June 2014, HRINY also discussed its intended 2015 expansion, proposing moving into all 30 of New York's Upstate counties in which the CO-OP does not operate. It is unclear why, with this most recent application, the CO-OP reduced the number of proposed counties from 30 to 11, The CO-OP expects its enrollment to grow to 261,839 average members in 2015 in its 9/24 Pro Formas, when it only projected 211,818 average enrollees in its 6/1 Pro Formas. It cannot be determined what percentage of the projected growth is attributable to this geographic expansion and what percentage is attributable to growth within the current service area.
Increase Product offerings	3. **Increase the number of products offered.** HRINY intends to offer two new products, one targeting the individual market, and one targeting the small group market.	In 2015, HRINY intends to offer two new product lines in addition to its current three (Primary Select EPO, Primary Select, and Essential Care). The first of the new options is called Total Independence, and is described as a low cost option available to individuals exclusively in the New York City and Long Island regions. The second, Total Freedom, is described as the CO-OP's new out-of-network product offered exclusively to the small group market (P. 76).
Increase in Sales and Marketing	4. **Continue to develop and distribute communications and advertisements to key audiences.** HRINY will continue to develop targeted communications in the form of member satisfaction surveys, member advisory discussion groups, and advertising, as well as engage in market research going into 2015.	To gain an increased understanding of the needs of its customers, HRINY stated that it will engage in continued marketing efforts going into 2015. One such effort includes continued use of member satisfaction surveys aimed at gauging "member satisfaction strengths, weaknesses, opportunities and needs." (P. 96). By understanding the desires of its members, HRINY may be in a position to adapt and retain some customers, despite increased premiums in 2015. HRINY conducted a member satisfaction survey in June of 2014; out of the applicant's current members in 2014, 396 enrollees responded to the survey. It is unclear why this group would be taken as a representative sample of the total membership's sentiments. Another marketing effort is the applicant's Member Advisory Discussion Groups. These are quarterly sessions where current members are able to provide input on the CO-OP's past performance and future plans. According to the application, "Outputs from the sessions will be shared both internally and externally as appropriate, starting second quarter 2015" (P.

Reason Cited by HRINY for Higher than Projected Enrollment	HRINY Proposed Action	HRINY Justification
		97). Additionally, in an effort to target new customers, HRINY plans to partner with an advertising agency "to develop and execute targeted campaigns focused on building brand awareness and supporting open enrollment initiatives in key markets." This partnership will begin in the summer of 2014 with the advertising campaigns set to start during the year's fourth quarter (P. 97). HRINY does not provide a budget detailing how much it intends to spend on these marketing efforts, nor do the pro formas provide any insight into marketing expenses. Additionally, the application provides no information on the applicant's efforts to obtain private funds.

Summary of Observations:

- **Increased enrollment projections from original application.** Although HRINY plans to increase premium rates starting in 2015, the applicant is still projecting to outperform all previous enrollment projections. HRINY's 6/1 Pro Formas projected 108,311 enrollees in 2014 and 211,818 enrollees in 2015. Per HRINY's 9/24 Pro Formas, the applicant now projects to enroll 116,439 average members in 2014 and 261,839 in 2015. It is unclear how the pending redefinition of "small group" and the CO-OP's pending expansion into 11 new counties influences its updated enrollment projections. It cannot be determined how much turnover the CO-OP expects to experience within its membership. Growth in projected enrollments due to expansion into new counties may offset anticipated losses in existing members due to planned increases in premiums. There is insufficient information in the applicant's application to analyze the impact of the projected premium increases on the retention of existing members and any mitigation strategies the CO-OP may intend to implement.
- **Increased premiums planned for 2015.** In order to "maintain financial sustainability and market competitiveness" the applicant intends to raise premium rates to become more in line with its competitors in the market (P. 72). With recent DFS approval, individual and small group premiums will increase by 12.9% and 3.5% in 2015, respectively. These rates were lowered by the DFS after HRINY requested an initial rate increase of 15.2% for the individual market, and 6% in the small group market.
- **Plans for new products and state-wide availability**. In order to achieve increased enrollment projections in the face of rising premium rates, HRINY plans to increase enrollment by offering two new product lines, and expanding into 11 counties in Upstate New York. This number has been reduced from 30 new counties since the applicant's last solvency loan request in June of 2014. The new product lines include the Total Freedom line, a small group product offering out-of-network care, and the Total Independence line, a less expensive product available exclusively for the individual market that will be marketed to customers in New York City and Long Island. Additionally, HRINY will be moving into the large group market in 2015 in anticipation of the 2016 redefinition of "small group".
- **Support for marketing funds not provided.** The applicant did not specify how its partnership with an advertising agency, detailed in the marketing strategy, will be funded. Since solvency loan funds cannot be used for marketing purposes, the applicant may need to acquire outside funds to realize this portion of its marketing strategy.
- **Breakout of on and off Marketplace enrollment not provided in the pro formas.** It cannot be determined if the CO-OP will have two-thirds of its enrollment from the Marketplace in 2016, as required by Title 45, Code of Federal Regulations (CFR) §156.515(c)(1) and (d) related to the requirements of CO-OPs pursuant to the ACA.

2. Product Pricing:

As noted in Tables 3 and 4 below, HRINY's 2014 enrollment was higher than anticipated due to its rates being among the lowest in most products and markets across the state (P. 87). HRINY had estimated their 2014 enrollment to be 134,000 but is now projecting it to be close to 160,000 (P. 3 and 85). As of August 31, 2014, their actual enrollment across individual and small group markets is 145,998 (P. 68).

One of the reasons the CO-OP is requesting an increase in premiums in 2015 of 15.2% for individual and 6% for small group products is to fix the mispricing in 2014 (P. 67). The state approved an increase in premiums in 2015 of 12.9% for individual and 3.5% for small group products (P. 73) which are reflected in the pro formas (P. 36). In the June 2014 application, HRINY had exhibited that it would like to hold its price position in most of the regions and expected to reduce the gap between the next closest competitor by increasing premium rates. Per tables 3, 4, 5 and 6[7] below, HRINY has been able to still hold the lowest premiums in most of the regions across the different tiers in spite of the rate increase approved by DFS. The CO-OP had anticipated that the competitors would also be increasing their premiums to account for medical cost trend and changes in federal reinsurance which is verified by the amount of rate increases filed for and approved by DFS listed in a press release[8]. HRINY still projects to achieve profitability beginning in 2015 and is profitable throughout the whole performance period, if projections are realized. In addition, the application is updated to achieve a minimum RBC level of 500% of ACL which is recommended by CMS. The higher RBC level required has been cited by the CO-OP as one of the reasons for this solvency loan application (P. 2). Please refer to the CO-OP Financials section for further discussion.

No new information has been provided by the CO-OP in this application with regards to the adjustments made to develop the premium rates in light of being approved for lower than requested rate increases by DFS.

Table 3 provides a comparison of the 2014 premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence in the individual market. The competitors listed have the lowest rate for at least one of the regions in 2014 in the individual market. In the June 2014 application, HRINY noted that it is the lowest cost plan in many areas of New York which HRINY cites as a primary contributor to its 20% market share in the individual market on the Marketplace (P. 71). Highlighted areas denote the lowest premium for the particular area.

Table 3: Premiums in the 2014 New York Marketplace for Individual Market by Rating Region/Area

[7] Data Source for Tables 3, 4, 5 and 6: http://www.dfs.ny.gov/consumer/health/2014_and_2015_approved_rates.pdf

[8] Source: Press Release about approved 2015 rates: http://www.dfs.ny.gov/about/press2014/pr1409041.htm

Insurer	Metal/Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Health Republic	Platinum	391.62	366.60	439.90	515.81	360.38	380.59	370.32	515.81
Metro Plus	Platinum				484.13				
North Shore LIJ	Platinum				572.20				572.20
Health Republic	Gold	333.06	311.78	374.13	438.69	306.50	323.68	314.96	438.69
Metro Plus	Gold				432.28				
North Shore LIJ	Gold				490.83				490.83
Fidelis	Silver	359.16	355.01	362.17	409.66	356.14	358.40	354.26	378.00
Health Republic	Silver	294.14	275.35	330.41	387.42	270.68	285.86	278.15	387.42
North Shore LIJ	Silver				422.62				422.62
Fidelis	Bronze	283.84	280.56	286.22	323.75	281.45	283.24	279.97	298.73
Health Republic	Bronze	233.18	218.28	261.93	307.12	214.58	226.61	220.50	307.12
North Shore LIJ	Bronze				332.48				332.48
Affinity	Catastrophic			287.72	294.67				300.85
Empire HMO	Catastrophic	173.37		204.48	186.20			275.96	171.38
Health Republic	Catastrophic	161.51	151.19	181.43	212.73	148.63	156.96	152.73	212.73
MVP Health	Catastrophic	149.56	135.89	183.07	238.09	131.22	170.90	160.23	
North Shore LIJ	Catastrophic				180.53				180.53

Table 4 provides a comparison for the 2015 premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence in the individual market. The competitors listed have the lowest rate for at least one of the regions in 2015 in the individual market. Highlighted areas denote the lowest premium for the particular region.

Table 4: Premiums in the 2015 New York Marketplace for individual market by Rating Region/Area

Insurer	Metal/Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Health Republic	Platinum	455.80	405.65	512.01	588.99	419.42	392.05	430.96	588.99
Metro Plus	Platinum				558.38				
North Shore LIJ	Platinum				515.48				550.76
Health Republic	Gold	387.65	345.00	435.46	500.93	356.71	333.44	366.53	500.93
Metro Plus	Gold				474.35				
North Shore LIJ	Gold				449.82				479.22
Fidelis	Silver	374.74	353.86	418.09	402.71	377.10	379.08	373.95	398.78
Health Republic	Silver	331.74	295.24	372.65	428.69	305.27	285.35	313.67	428.69
North Shore LIJ	Silver				396.90				423.36
Fidelis	Bronze	301.07	284.30	335.91	323.55	302.97	304.56	300.45	320.39
Health Republic	Bronze	271.39	241.53	304.86	350.69	249.73	233.43	256.60	350.69
North Shore LIJ	Bronze				315.56				336.14
Affinity	Catastrophic			150.62	154.48				157.87
Empire HMO	Catastrophic	184.11		217.14	197.74			293.05	181.99
Health Republic	Catastrophic	142.56	126.88	160.14	184.22	131.18	122.62	134.80	184.22
MVP Health	Catastrophic	164.44	149.42	201.30	170.72	144.29	187.91	176.19	
North Shore LIJ	Catastrophic				171.50				183.26

Table 5 provides a comparison for the 2014 premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence in the small group market. The competitors listed have the lowest rate for at least one of the regions in 2014 in the small group market. Highlighted areas denote the lowest premium for the particular region.

Table 5: Premiums in the 2014 New York Marketplace for small group market by Rating Region/Area

Insurer	Metal/Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Health Republic	Platinum	426.04	398.81	478.57	561.14	392.06	414.04	402.87	561.14
Metro Plus	Platinum				523.74				
North Shore LIJ	Platinum				687.84				687.84
Empire HMO	Gold	523.88		613.61	573.68			779.73	518.32
Health Republic	Gold	362.34	339.19	407.01	477.24	333.44	352.13	342.64	477.24
North Shore LIJ	Gold				598.33				598.33
EMBLEM-HIP	Silver			404.32	404.32				459.48
Health Republic	Silver	310.10	290.28	348.33	408.44	285.36	301.36	293.24	408.44
Health Republic	Bronze	253.67	237.46	284.95	334.11	233.44	246.52	239.88	334.11
MVP Health	Bronze	286.70	237.13	322.53	410.93	239.81	311.49	292.38	

Table 6 provides a comparison of the 2015 premiums for the CO-OP versus the competitors in each of the areas the CO-OP has a presence in the small group market. The competitors listed have the lowest rate for at least one of the regions in 2015 in the small group market. Highlighted areas denote the lowest premium for the particular region.

Table 6: Premiums in the 2015 New York Marketplace for small group market by Rating Region/Area

Insurer	Metal/Tier	Albany	Buffalo	Mid Hudson	New York	Rochester	Syracuse	Utica	Long Island
Health Republic	Platinum	461.59	432.12	518.53	577.81	411.51	448.59	436.43	577.81
Metro Plus	Platinum				620.14				
North Shore LIJ	Platinum				559.00				596.00
Empire HMO	Gold	567.75		664.99	621.73			845.04	561.74
Health Republic	Gold	392.58	367.51	441.01	491.42	349.99	381.52	371.18	491.42
North Shore LIJ	Gold				483.00				515.00
EMBLEM-HIP	Silver	540.31		540.55	450.90		540.31	540.31	512.44
Health Republic	Silver	335.96	314.51	377.41	420.55	299.52	326.50	317.65	420.55
Health Republic	Bronze	274.84	257.29	308.74	344.04	245.02	267.10	259.86	344.04
MVP Health	Bronze	334.26	276.44	376.01	440.77	279.61	363.15	340.85	

The CO-OP states that the approved rates place its products "fourth or fifth from the bottom of the market in many regions" and that it expects to "retain membership and achieve growth" through its geographic expansion and competitive price-point (P. 5). However, based on the tables above, HRINY seems to be in a better position than that listed in the application. It has been able to hold its rates lowest in 2015 across all the rating areas from 2014 other than Mid Hudson for Catastrophic; New York for Silver and Bronze; and Long Island for Platinum and Gold tiers on the individual market. However, its rates are now the lowest in Albany, Buffalo and Rochester for the Catastrophic tier. On the small group market, HRINY has the lowest rates in 2015 across all the rating areas from 2014 other than New York for the Gold level whereas HRINY now has the lowest rates across New York for Silver and Buffalo for Bronze. No information was provided regarding the number of enrollees in these counties and thus it cannot be determined what impact these rate changes will have upon enrollment. Also, as noted by the CO-OP, "Should HRINY's competitors significantly change the design of their products, HRINY's enrollment projections will be impacted" (P. 87).

Summary of Observations:

- **New York Department of Financial Services has approved premium increases of 12.9% for individual and 3.5% for small group products for 2015.** Based on a press release by the New York Department of Financial Services, they have reduced the premiums requested for 2015 but still approved a net rate increase over 2014 premiums for both

individual and small products. The press release also provided an exhibit with rates for all insurers across the different regions and tiers.

- **HRINY has competitive rates in 2015.** In many regions and tiers, HRINY is the lowest cost plan for individual and small group markets. It is not clear why the CO-OP indicated that the approved rates place their products "fourth or fifth from the bottom of the market in many regions". Also, HRINY expects to "retain membership and achieve growth" through its geographic expansion and competitive price-point (P. 5).
- **Expansion of target market in 2015.** According to the June 2014 application, the CO-OP was considering including 30 new counties in its Upstate New York coverage area for 2015. However, in this application the CO-OP is expanding to only 11 new counties; the applicant does not specify which 11 counties (P. 11). However, considering that the applicant currently provides products in all rating areas within the state, this expansion area can be viewed as greater penetration into some of the rating areas. There is also no mention of why the applicant cuts back from 30 counties.
- **HRINY is now projecting an $11.6M loss in 2014 and, therefore, more of the 2013 established premium deficiency reserve (PDR) is still being held in 2014.** Upon comparing the pro forma financial statements provided in the June 2014 application and the current application, the CO-OP is projecting a higher loss in 2014 (P. 115). Therefore, more of this PDR is still being held in 2014. It is unclear how the CO-OP determined the PDR, as a detailed analysis was not provided. Supporting documentation of the analysis was also not provided.

3. Medical Costs and Losses:

HRINY projects combined medical loss ratios (MLR) for ACA purposes of 83.9%, 87.2%, and 87.2% for years 2014, 2015 and 2016, respectively, which includes the impact of the projected ACA adjustments and the 3Rs. This includes individual, small group and large group business. With regards to MLRs, no information has been provided split by the individual, small and large groups. Excluding the impact of the projected 3Rs and other ACA adjustments, the projected MLR for 2014, is 93.1% and is expected to decrease to 86.4% in 2015, and 83.1% in 2016, based on a plan to fix the mispricing of 2014 and greater claims cost efficiencies. Based on eight months of actual claim data, the applicant has increased the 2014 individual claim projection by approximately 1.7% and lowered the 2014 small group claim projection by 2.6% (P. 4). According to the applicant, combined with greater administrative efficiencies, these efforts are projected to bring HRINY's profit margin to 3.1% of premiums by 2017 (P. 83). The 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit.

The CO-OP plans to make several changes to their provider arrangements to increase the value being delivered by its provider networks. In the June application, the CO-OP planned to terminate its contract with MagnaCare but based on this application, its three primary core vendor partners – POMCO, MagnaCare and Morneau Shepell have voluntarily agreed to renegotiate their contracts (P. 4). The CO-OP has since decided that it would be best to maintain the MagnaCare network statewide (P. 73). The CO-OP plans to engage in direct contracting with providers to ensure the cost structure of its provider network is in line with the pricing for 2015. HRINY also plans to independently contract specialty services managers for behavioral health, laboratory, and radiology services (P. 74). Freelancers Union Independent Practice Association (IPA) LLC was formed on September 12, 2014[9]. It cannot be determined if the IPA will be involved in provider contracting or other roles for the CO-OP.

In 2015, the CO-OP plans to offer its existing array of products and two new products which it hopes will meet unmet needs in the marketplace (P. 5). The CO-OP also plans on expanding to 11 counties in New York where it currently does not operate, which is less than the 30 counties proposed in its June 2014 application. The applicant did not provide sufficient information with which to analyze the impact of the geographic expansion and the addition of two new products on medical costs and losses. However, based upon the rates available for the individual and small group segments, HRINY has been operating in the rating regions that contain the planned expansion counties. Therefore, the

[9] Source: http://www.dos.ny.gov/corps/

CO-OP's medical cost and loss data to date may reflect, at least in part, its experience within these rating regions for existing products.

As part of its enrollment strategy, HRINY expects to sell to the large group market in 2015. However, the expansion to the large group market will focus on companies in the 51-100 range in anticipation of the redefinition of small group in 2016. HRINY intends to build awareness in this market segment without increasing marketing expenses by leveraging existing broker relationships (P. 84).

The CO-OP has projected morbidity to be equal to the state average. As such, no risk adjustment receipts or payable relating to 3Rs is projected in the rate filing. The CO-OP is expecting to get $57.6M in reinsurance receivables and $12.6M in risk corridors receivables from the 3Rs which is 11% and 2% of the total premium respectively during 2014 and $63.3M in reinsurance receivables relating to 3Rs which is 5% of the total premium in 2015. The estimates of relative risk and risk transfer payments are dependent not only on the membership enrolled by HRINY but also by the other carriers in the state (P. 381). Additionally, there was no information provided on how the commercial reinsurance program will impact claim costs.

Summary of Observations:

- **HRINY expects 2015 morbidity to be similar to 2014 pricing morbidity.** The small group market forms the basis of the CO-OP's manual rates. HRINY assumes the current small group market morbidity to be the same as that before ACA was passed. When pricing for 2015, the expected morbidity of the small group population in New York was used and adjustments were made to it to calculate the individual market morbidity. Based on research conducted by HRINY, individual markets have higher health risk than group markets, therefore the CO-OP is assuming that the individual market morbidity will be 40% higher than the small group market. No changes were made since the June 2014 application.
- **Expanded provider arrangements.** HRINY intended to replace MagnaCare with POMCO's network in Upstate New York. However, the CO-OP has decided that it would be best to maintain the MagnaCare network statewide (P. 73). HRINY plans to engage in direct contracting with providers and plans to independently contract specialty services managers for behavioral health, laboratory, and radiology services (P. 74). Engaging in contracts that are more favorable to the CO-OP would help reduce its claims costs and help reduce its MLR.
- **Specific details on the reinsurance program/strategy were not provided, which may result in a gap in coverage.** Since no details were provided on the reinsurance strategy, it cannot be determined whether there will be a gap in coverage for both individual and small group business.
- **The 3Rs receivables are difficult to quantify.** This is because of the uncertainty of the industry average morbidity which is needed to accurately estimate risk adjustment. Risk corridors is calculated after risk adjustment, and, therefore, it relies upon the risk adjustment estimate. Without these receivables, HRINY would have a loss of $81.8M for 2014 instead of the $11.6M projected in the pro formas.

4. <u>CO-OP Financials:</u>

HRINY's pro forma financial statements project recoveries from the federal reinsurance programs for 2014 through 2016. In the baseline with additional solvency loan scenario (base case scenario), HRINY projects cumulative net federal reinsurance recoveries of $122.3M for 2014 through 2016, while it projects to recover $121.6M in the contingency scenario during the same period. HRINY also projects to receive an additional $12.6M from the risk corridors program in 2014 in all scenarios (P. 50).

Despite the total $62.9M in net receivables that HRINY is projecting to receive from the 3Rs in 2014, it is projecting a loss of $11.6M in 2014. Absent the recoveries from the 3Rs, HRINY's projected 2014 loss would be $74.5M. With consideration of the impact of the 3Rs, the applicant expects to achieve profitability in 2015 with a projected net income of $5.1M in 2015 and $32.4M in 2016 (P. 50). Absent recoveries from the 3Rs, HRINY is projected to incur a loss of $46.6M in 2015, and achieve profitability in 2016 with projected net income of $12.1M. Per the quarterly regulatory

filing as of June 30, 2014, HRINY has recorded a PDR of $5.2M in 2013. HRINY projects the change in PDR to decrease by $3.8M in 2014 and $1.4K in 2015. However, details were not provided for the analysis of the PDR estimate.

Based on the Loan Tracker, the CO-OP has been awarded total funding of $174.5M during the original loan application ($23.8M in start-up loans and $150.7M in solvency loan funding), and began issuing health insurance products beginning in 2014. In September 2014, an additional solvency loan funding of $90.7M was obligated to HRINY, bringing the total solvency loan award to $241.4M. As of 10/3/2014, $23.0M of the total obligated start-up loan and $132.6M of the total obligated solvency loan is disbursed to the CO-OP, leaving $736.5K in undisbursed start-up loan and $108.8M in undisbursed solvency loan funds obligated to the CO-OP. HRINY is requesting additional solvency loan funding of $70.5M. Combined with the current solvency loan funding award, the total solvency loan for HRINY would be $311.8M. As noted in Table 7 below, the CO-OP had originally projected to draw down solvency loan funds from 2014-2017; however, the applicant's most recent application projects drawing upon the obligated funds, including the $70.5M requested in this application, from 2014-2016. As a result, the solvency loan award per enrollee will increase from $982 to $1,245.

Table 7: Solvency Loan Award Per Enrollee

Solvency Loan Award per Enrollee	
June 2014 Enrollment Projection (Average: 2014 - 2017)	245,816
Current Solvency Loan Funding Obligated	241,366,000
Projected Solvency Loan Per Enrollee (Current Award)	$982
September 2014 Enrollment Projection (Average: 2014 - 2016)	250,539
Additional Solvency Loan Funding Requested to be Awarded	$70,476,000
Total Solvency Loan Funding Request	$311,842,000
Projected Solvency Loan Per Enrollee	$1,245

HRINY stated that, the additional solvency loan funding is necessary to support (P. 2):

- **Increased membership projections in 2014 and 2015 as compared to enrollment projections provided to CMS in June 2014.** HRINY projects the 2015 increase in membership despite a 12.9% increase in premiums in individual rates and a 3.5% increase in small group premiums. HRINY stated that the approved 2015 rates place its products "fourth or fifth from the bottom of the market in many regions" (P. 5). Despite this product positioning and increased competition in the market, HRINY projects to retain its members and grow, as its products have "broader network than lower priced plans" (P. 5). $44.2M of the total additional solvency loan funding is being requested to support the projected enrollment increase in 2014 and 2015.
- **$7.5M additional funding needed to support changes in financial data due to updates and changes in assumptions.** HRINY stated that it has increased the 2014 individual claim projection by approximately 1.7% and lowered the 2014 small group claim projection by 2.6% based on eight months of actual claim data. However, no further detail was provided to quantify the impact of the changes in assumptions to substantiate the need for the requested additional funding.

- **$18.8M in additional solvency loan funding needed to meet the 500% RBC requirement per loan agreement.** New York's Section 4310 of the insurance statutes requires the CO-OP to maintain a minimum reserve balance of 12.5% of net premium income as capital and surplus. However, HRINY stated that the DFS is requiring the CO-OP to maintain an RBC level of 500% of ACL as recommended by CMS, rather than the 15% of net premium income stated in its application of additional solvency loan funding submitted to CMS in June 2014 (P. 5). No further documentation is provided to substantiate this requirement. Additionally, there was no further documentation provided to support the assumptions used in the calculation. HRINY's projected RBC level remains above 500% of ACL with the additional solvency loan funding.

Base Case Scenario:

If projections are realized, HRINY projects a loss of $11.6M in 2014, but projects to be profitable thereafter, with earnings of $5.1M and $32.4M in 2015 and 2016, respectively, and with related profit margin of 0.4% and 1.6%, respectively (P. 50). The applicant projects an average profit margin as a percent of premium of 1.7%, which would result in cumulative net income of $1.5B from 2015-2034. HRINY projects RBC levels to stay above 500% of ACL during the entire performance period in the base case scenario, which assumes the requested additional solvency loan funding of $70.5M will be awarded in full (P. 51).

HRINY is projecting receivables from the 3Rs program from 2014 through 2016, specifically $12.6M in risk corridors in 2014, and net federal reinsurance recoveries in the amounts of $50.2M, $51.8M, and $20.3M in 2014, 2015, and 2016, respectively (P. 50). HRINY's latest projection of federal reinsurance recoveries has increased by $29M as compared to the cumulative federal reinsurance recoveries projected by HRINY in its June 2014 pro forma submissions to CMS. No further information was provided as to the reason for this increase.

The applicant is approved to increase its individual premium by 12.9% in 2014, which is 2% lower than its projected premium increase. HRINY is also approved to increase its small group premium by 3.5% in 2014, which is 2.4% less than projected premium increase for the small group market (P. 5). The applicant stated that the pro formas provided with this application and the additional solvency loan request is based on the average approved premium pricing (P. 36, 67). Despite these lower than projected premium increases, HRINY projects net income of $5.1M in 2015. The applicant projects premium increases of 11% and 10% in 2016 and 2017, respectively in the individual market (P. 73). If projections are realized, HRINY projects a cumulative net income of $1.5B from 2015 – 2034, which is higher than the total start-up and solvency loan obligations, including the additional solvency loan request of $70.5M. HRINY projects to start repayment of solvency loans in 2021 and continue to make repayments through 2031, until the total solvency loan obligation is paid in full.

The applicant states that it intends to become profitable in 2015 by increasing its premiums, making changes to its medical cost structure, and improving its processes; specifically through investing in technology to enable automation in enrollment and claims, and by renegotiating and reducing its vendor costs by 7% by 2015. The applicant also explains that the automation of enrollment and claims processes should reduce its costs due to avoiding incremental administrative staffing during open enrollment. To achieve a 7% reduction in vendor costs, HRINY notes it is currently pursuing a process to integrate independent vendors to achieve efficiency in its operations and also pursue a renegotiation of its vendor contracts (P. 80). HRINY relies upon its vendors for billing and enrollment, member and brokerage services, medical management, claims adjudication, provider network management, pharmacy benefits management, and website and data warehouse management (P. 79). While HRINY describes its vendor functions in detail, the applicant does not provide a budgeted schedule for its current vendor costs nor for its costs following contract renegotiations; therefore, the nature and impact of these cost reductions cannot be determined. Furthermore, no information was provided by the applicant to substantiate a 7% reduction in vendor costs.

Additionally, as described in the August 22, 2014 memo from CMS, the CO-OP was required to file a budget form as part of its application which would detail its expenses for 2014 through 2016. However, HRINY did not provide a budget detailing its expenses for 2014 through 2016. Additionally, per the New York State Department of Corporations, during 2014, the Freelancers Union has created two entities, Freelancers Union IPA, LLC and Freelancers Brokerage, Inc. There

is no information provided in the application that describes a relationship with these new entities. Excluding the lack of detail laid out in its budgeted costs, HRINY's pro forma income statement ties to its business plan, as the administrative cost ratio (ACR) is projected to decrease from 21.6% in 2014 to 16.9% in 2015 and 15.7% in 2016. HRINY's ACR ranges from 21.6% down to 12.5% through 2034, with an average ACR of 14.2%. Additionally, HRINY stated that a reduction in general and administrative costs per member will be 37% in 2015 and 10% in 2016 (P. 83). The applicant states that it expects to achieve these efficiencies; "despite growing fixed G&A expenses… due to greater scale, renegotiated contracts, and supplier efficiencies" (P. 83). However, as previously noted, the applicant does not provide a breakout of its administrative costs, nor does it provide a detailed summary of its expected costs savings or specifics on its renegotiated vendor contracts. Additionally, it doesn't appear that HRINY accounts for Marketplace fees within its projections. However, the applicant stated that the Marketplace fees are eliminated for 2014 and 2015 (P. 88). No supporting documentation was provided to verify this statement. The applicant does not project Marketplace fees in the pro forma throughout the entire performance period. Additionally, no detail was provided on the Marketplace fee the state would require insurers to pay beginning in 2016.

The applicant's MLR, including the impact of the 3Rs and without including the impact of ACA adjustments, is 81.6% and 82.7% for 2014 and 2015 respectively. As noted above, HRINY projects net recoveries of $50.2M, $51.8M, and $20.3M in 2014, 2015, and 2016, respectively, from the federal reinsurance programs. Additionally, HRINY projects to receive payment of $12.6M from risk corridors in 2014. Absent these recoveries from the 3Rs, HRINY's MLR will be 93.9% in 2014 and 87.0% in 2015, without including the impact of ACA adjustments.

HRINY projects to receive additional solvency loan funding in the amount of $70.5M and projects to draw down its full solvency awards by 2016 (P. 118). The applicant plans to fully repay the solvency loan by 2031, if projections are realized. Per the base case pro forma balance sheet, HRINY projects RBC level to remain above 500% throughout the performance period.

Stress Test Scenario:

Under the base case with a mild stress test scenario (stress test scenario), HRINY projects to receive increased additional solvency loan funding of $283.9M to combat a 10% increase in claims cost due to uncertainty in pricing. In the stress test scenario, the applicant asserts that rate increases were assumed to maintain a reasonable level of profitability to generate a surplus to enable it to pay off its solvency loan (P. 43). Revenues and administrative costs remain static, as evidenced by the same ACR as in the base case.

The primary difference of the stress test scenario as compared to the base case scenario is its projection of PDR. In the stress test scenario, HRINY projects a $102.M increase in change in reserves due to PDR in 2014. However, details relating to projecting this level of PDR were not provided in the application. This represents a net change of $105.8M in total expenses, resulting in a projected net loss of total $117.7M in 2014, with the assumption of receiving net reinsurance recoveries of $50.2M and a receipt of $12.6M in risk corridors payments. Absent recoveries from federal reinsurance program and risk corridors payments, 2014 losses would near $180.5M. Under this scenario, according to the applicant's pro forma balance sheet, the RBC level is projected to stay above 500% of ACL until 2029.

Summary of Observations:

- **10% or more in premium increases projected through 2017 for the individual market.** HRINY's ability to break even is contingent on increase in premiums by higher than 10% in 2015 and 2016**.** The applicant is approved to increase its 2015 premium for the individual market by approximately 13% in 2015 and projects to increase its premium by 11% in 2016 and 10% in 2017. It cannot be determined whether HRINY will be able to meet its projected enrollment and premium revenues as well as retain current members with this level of premium increases.
- $**102 M PDR projected in 2014 in stress test scenario.** In the stress test scenario, HRINY projected a change in PDR of $102.0M in 2014. However, no documentation supporting the analysis of the PDR was provided. The applicant recorded PDR of 5.2M in 2013.
- **Budget not provided for 2014 through 2016 to support proposed reductions in administrative expenses.** In the base case scenario, the applicant projects a 7% reduction in vendor costs through renegotiated contracts and also

projects to reduce its administrative expenses in 2015 and 2016. Additionally, the applicant stated that the overall reduction in administrative expenses per member will be 37% in 2015 and 10% in 2016. However, no details are provided by HRINY as to what the actual cost reductions are and with what vendors it expects to renegotiate its contracts. HRINY did not provide its budget or administrative costs per member to support the projected cost reductions.

- **Change in reserve requirement by the state DFS not substantiated.** HRINY stated that $18.8M of the total additional solvency loan funding request is to meet DFS's requirement for the applicant to meet the 500% RBC requirement as recommended by CMS. As noted within the Findings Report[10] the CO-OP is required to maintain a 12.5% of net premium income as capital and surplus per New York's Section 4310 of the Insurance statutes. However, HRINY stated that the New York DFS is now requiring the CO-OP to maintain an RBC level of 500% of ACL as recommended by CMS. No further documentation was provided to substantiate this requirement.

5. <u>Contingency Plan:</u>

The contingency scenario assumes $36.2M in additional solvency loan funding will be awarded rather than the $70.5M assumed in the base case scenario (P. 43). Combined with the current solvency loan funding award, the total solvency loan for HRINY under the contingency scenario would be $277.6M. The applicant did not provide pro formas for contingency scenario with no additional solvency loan funding as outlined in the August 22, 2014 memo from CMS.

As outlined in its application, HRINY discusses two scenarios in the event that the full additional solvency loan of $70.5M is not awarded: either identifying outside financing or scaling down its operations by increasing premiums higher than rates projected in base case scenario, withdrawing products, or withdrawing from service areas, so it can meet solvency requirements (P. 12 and 13). The applicant does not provide further detail on how it plans to secure outside financing (P. 5). However, the applicant mentions having taken outside expert counsel's opinion on "multiple alternative funding options, including lender financing, additional investments, and foundation grants" and concluded that none of the alternative financing options are feasible (P. 12).

HRINY stated that if only $36.2M of additional solvency loan funding is awarded, it relies on requesting premium rate increases of 12.5% for the individual market and 6.5% for the small group market in 2016 to self-fund its solvency (P. 12). In the event the $36.2M in additional solvency loan funding is not awarded to HRINY, the applicant projects 2016 rates for the individual market to increase by 14% while projecting rates for small group market to increase by 8% (P. 43). HRINY projects such increase in premium will slow membership growth by 50,000 in 2016 and an additional 30,000 in 2017 (P. 107). The applicant further stated that while the increase in premium will help the CO-OP to sustain its operation, "the impact would reduce the success and positive benefits of the CO-OP program in New York and diminish Health Republic's ability to execute on its mission" (P. 6).

In the contingency plan, the applicant plans to reduce its membership level by "product rationalization and service area withdrawal" (P. 107). However, no further detail is provided on which service areas the applicant plans to withdraw in the event of no additional solvency loan funding. As presented in the pro formas for the contingency scenario, HRINY projects average enrollment level to stay static through 2015 as projected in the base case scenario. HRINY projects enrollment projections in the contingency scenario to go down beginning in 2016 as compared to projections in the base case scenario. The pro formas provided for the contingency scenario assumes HRINY will receive an additional solvency loan funding of $36.2M.

The applicant's contingency plan represented in its pro forma income statement shows increased premium revenues per member as compared to its base case scenario. Table 8 below highlights enrollment projections, premium revenues, average gross premium revenues per member, and ACR for 2015 through 2020.

Table 8: Gross Premiums per Member and ACR Comparison: Base case vs. Contingency Plan

[10] HRINY Cooperative 7/18/2014 Findings Report (7/18/2014 Findings Report) provided to CMS on July 18, 2014

	2015	2016	2017	2018	2019	2020
Base Case Scenario						
Average Members	261,839	373,339	430,839	439,456	448,245	457,210
Net Premium Earned ($000)	1,234,680	1,916,341	2,384,669	2,557,487	2,742,791	2,948,450
Average Annual Gross Premium per Member ($000)	4.8	5.3	5.7	6.0	6.3	6.6
ACR	16.9%	15.7%	14.7%	14.5%	14.4%	14.3%
Contingency Plan Scenario (With $36.3M in Additional Solvency Loan Funding)						
Average Members	261,839	360,339	404,339	412,426	420,674	429,088
Net Premium Earned ($000)	1,234,680	1,875,481	2,269,186	2,433,725	2,610,161	2,806,011
Average Annual Gross Premium per Member ($000)	4.9	5.4	5.8	6.1	6.4	6.7
ACR	16.9%	15.6%	14.6%	14.5%	14.3%	14.2%

Summary of Observations:

- **HRINY projects $2.5B in cumulative profits through 2034 compared to its base case scenario.** In its contingency scenario, the applicant projects a cumulative net profit of $2.5B from 2015 – 2034. HRINY projects to earn $1.5B in cumulative net profits from 2015 – 2034 in the base case scenario, which is lower than the projected cumulative profit in the contingency scenario. The increase in projected cumulative profit in the contingency scenario may be attributable to the increase in premiums, as HRINY plans to increase its rates in the event the full amount of the requested additional solvency loan funding is not awarded.
- **Pro formas presenting enrollment and financial projection for a contingency scenario with no additional solvency funding not provided**. HRINY discussed several actions that it will implement in the event no additional solvency funding is awarded. However, no detail was provided to substantiate the impact of the proposed actions. Additionally, the proposed increases in premiums were not reflected in its pro formas for the contingency scenario. As a result, the impact of the contingency scenario with no additional solvency loan funding cannot be assessed.

Solvency Loan Request Points

Sections	Potential	Total
Enrollment	15	13
Product Pricing	20	16
Medical Costs and Losses	15	14
CO-OP Financials	15	9.5
Score	**65**	**52.5**

Contingency Plan Points

Contingency Plan	Potential	Total
Overall	10	0
Score	**10**	**0**

CoOportunity Health

Domiciled in Iowa

Additional Solvency Loan Funding Request Report

Date Submitted to CMS: 07/18/2014

Scope Summary & Assumptions:

- Deloitte will not provide an opinion regarding the reasonableness of the proposed changes to each CO-OP's business plan. Nor will Deloitte provide an opinion regarding the likelihood of each CO-OP achieving sustainable operations based upon the revised business plan.
- Deloitte assumes that the information provided by each CO-OP in its modified business plan is complete and accurate. Deloitte will perform its assessment of the data provided "as is". Deloitte will also use other data sources that are publicly accessible or information provided directly from the Centers for Medicare and Medicaid Services (CMS). Deloitte will notify CMS if we believe that there is insufficient information to complete our review.
- The impact of the Reinsurance, Risk Adjustment and Risk Corridors Program (the 3Rs, reinsurance, risk adjustment, and/or risk corridors) was reviewed when making observations and comments throughout this report. Observations and comments relating to the impact of the 3Rs are included for informational purposes only. There was no consideration of the reasonableness or propriety of any of the amounts relating to the 3Rs. Based on the scoring criteria provided by CMS, observations and comments relating to the 3Rs had a net neutral effect on the scoring.
- In reviewing applications from CO-OPs for additional solvency loan funding requests, Deloitte reviewed supporting documentation, requested of the applicants by CMS in a memo to the CO-OPs distributed on April 30, 2014. The format of the reports as well as the section scoring was approved by CMS during the week of June 2, 2014. The score for the Contingency Plan section should be viewed independently of scoring for the other sections of this report. For all sections, Deloitte provided comments on issues only for which the applicant provided data. Observations relating to the pro forma financial statements are based on the base case with additional solvency award scenario, unless otherwise noted.

Executive Summary:

CoOportunity Health (COH or CO-OP or applicant) has submitted a request to CMS for $32.7M of additional solvency loan funding. Of this request, $9.8M appears designed to cover 2014 operating losses. See the CO-OP Financials section for further details.

COH has exceeded its enrollment projections in the original[1] funding application, which the CO-OP attributes to the Medicaid/Iowa Marketplace Choice Plan (IMCP) federal waiver in Iowa, Exclusive Provider Product (EPO) product offering in select areas of Iowa, growth opportunities in urban areas, and tailored product strategies. As a result, COH is projecting a loss in 2014, but expects to be profitable in 2015 and 2016. The CO-OP intends to correct losses to achieve profitability by increasing premium rates by 17% in 2015. Rate increases above 10% proposed for any product will require federal review. No information was provided as to how this premium rate increase will impact the enrollee retention. COH does not project to reduce its administrative expenses in 2015, as it projects its administrative cost ratio (ACR) to stay at or above 15% of its premium revenue through 2020. COH states in its application if it does not receive the requested funding,

[1] All references to "original" – including, but not limited to, "original funding application," "original application," and "original projections" – refer to HCT's 2011 application for CMS start-up and solvency loan funding, operations commencing in 2014.

it may merge with another CO-OP or large healthcare entity or freeze enrollment. See the Contingency Plan section for further details.

When COH's requested $32.7M is combined with the current solvency loan funding award of $97.9M, COH's total solvency loan would be $130.6M. NOTE: the total solvency loan funding recorded in COH's pro forma financial statements (pro formas) in the best scenario is $116.7M, which is $13.9M less than the applicant requested. However, the applicant will still meet the risk based capital (RBC) level of 500% of authorized control level (ACL) throughout the entire performance period in the expected case, best case, and contingency plan scenarios. See the CO-OP Financials section for further details.

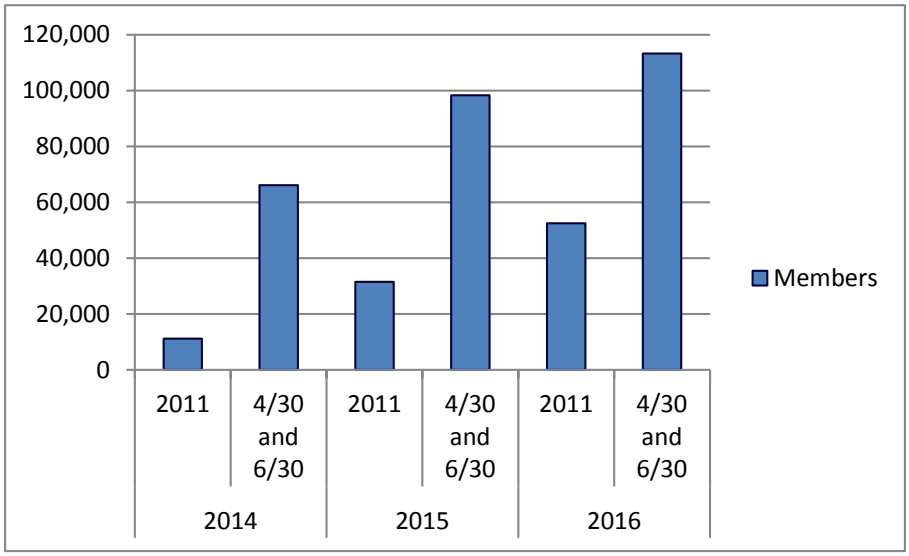
COH projects to receive a total of $94.8M in solvency loan funding by year end 2014, leaving $3.1M of obligated solvency loan funding undisbursed as of year end 2014. The original application's pro formas projected average enrollees of 53,332, which yields a per enrollee cost of $1,836. The updated pro formas are projecting average enrollees of 115,947 based on projected solvency loan proceeds of $116.7M, which yields a per enrollee cost of $1,006.

It appears COH may be utilizing CMS-funded infrastructure intended for commercial business to offer HSA eligible plans as part of its product mix. It is unclear whether this product option is only available to members enrolling on the Marketplace. In addition, the CO-OP may intend to use its CMS-funded infrastructure to target self-insured populations that will not contribute to the overall growth of actual CO-OP membership within the small and large group market segments. It cannot be determined what portion of the CO-OP's enrollment, if any, relates to this business. Please see the Enrollment section for further details.

Critical Assertions:

1. Enrollment

Figure 1: Enrollment Exceeds Original 2011 Projections for 2014-2016



Source: Applicant's 2011 Original Application, 4/30/14, and 6/30/14 Pro Formas

COH provided a revised business plan in June 2014, which includes updated enrollment projections. The updated enrollment projections indicate COH will achieve a total enrollment of 66,101 by year end 2014, which is 55,000 more than original projections. Based on the revised business plan, COH states current membership is 76,000 members but projects to achieve 75,000 by year end 2014 (P.3 and 90). Additionally, the pro forma financial statements (pro formas) submitted with the revised business plan indicate a total projected enrollment of 66,101 for 2014. In its additional solvency loan funding application, COH indicated it has achieved an enrollment level of more than 68,000 members by close of the open enrollment period in 2014 (P. 49). However, COH's regulatory filing for the first quarter in 2014 indicates that, as of March 31, 2014, COH has enrolled 50,740 members. While it is clear that COH has achieved more enrollment than its original application projection, no documentation or explanation is provided substantiating the reason for discrepancies in the actual current enrollment level.

Through April 2014, COH reports that approximately 40% of members were individuals that enrolled on the IA State Partnership Marketplace (IA Marketplace) or the NE Federally-facilitated Marketplace (NE Marketplace), while another 25% were individuals that enrolled off Marketplace (P. 4). The term 'Marketplace' indicates that a statement is applicable to both the Iowa and Nebraska Marketplaces. The remaining third is comprised of employer-sponsored plans, the vast majority (over 95%) of which is small businesses who enrolled in the open market (P. 4). As employer-sponsored plans are self-insured plans, the CO-OP would exclude the members from employer-sponsored plans in enrollment in its regulatory filings. Additionally, no further detail is provided to determine whether the CO-OP has included enrollments from employer-sponsored plans in its current enrollment projections.

As a result of this unexpectedly rapid growth, the CO-OP is experiencing challenges due to "higher premium and claims volume" (P. 3). Higher loss ratios, caused by the higher risk profile of a larger than expected number of its enrollees, are leading to cash flow and liquidity concerns relating to the timing of 3Rs payment receipts (P. 3). For these reasons, COH is applying for additional solvency loan funding to meet these challenges.

Membership growth is lower for 2015 and 2016 as compared to original projections. The majority of this decrease has been attributed to the "CO-OP having already captured some of these members and the fact that the Iowa regulator continues to allow Wellmark to renew non-compliant pre-ACA policies" (P. 7). The application does not break out the impact of non-compliant pre-ACA policies in its enrollment projections for 2014.

Overall enrollment for 2014 in Iowa and Nebraska is projected to exceed original projections by approximately 55,000 members. COH also projects to exceed original 2015 and 2016 projections by approximately 67,000 and 61,000, respectively. Over the entire performance period, COH expects to enroll 380,000 additional members than originally projected. The applicant did not provide any additional information on the projected breakout between on and off Marketplace enrollment. Therefore, it cannot be determined if the CO-OP will be in compliance with Title 45, Code of Federal Regulations (CFR) § 156.515(c)(1) and (d) relating to requirements for CO-OPs under the Affordable Care Act (ACA), which requires two-thirds of total members to be from the Marketplace.

The applicant does not provide a breakdown of its revised enrollment projections for individual, small group, and large group market segments. As a result, it cannot be determined whether its projected enrollment accounts for the change in small group and large group definitions in 2016, when the small group size changes from 1-50 to 1-100 employees, and therefore the large group size changes to begin at 101 enrollees. However, the applicant anticipates it will experience ongoing growth rates at much the same rate as the original projections, but from a higher base due to the higher capture rate in 2014. According to the applicant, due to its relative success in rural areas, COH projects it will maintain growth rates through the targeting of the more populous urban areas in both Nebraska and Iowa. It expects to meet its enrollment growth goals of 15,000 additional members per year in 2015 and 2016 through the growth of its individual and small group membership base (P. 7). However, it predicts the enrollment growth of 18,000 in 2017 will be "primarily due to changes opening up the large group market to the Marketplace" (P. 61). It is unclear whether this projected gain in large group enrollment includes enrollment from self-insured business. The applicant provides a list of assumptions underlying these estimates, but does not provide additional information discussing the impacts of these assumptions on its ability to meet enrollment projections in a specific market segment or targeted market (P. 62). Overall, COH expects that growth will ramp down to 7,000 new members in 2018, to 6,000 in 2019, and to 5,000 members in subsequent years (3-4% annually) (P. 62).

COH provided reasons in its revised business plan for the change in enrollment projections in specific market segments as compared to those provided in its original business plan. These reasons, along with COH's proposed actions, are provided in Table 1 below.

Table 1: Documentation Provided for Change in Enrollment Projections

Reasons Cited by COH for Higher Than Projected Enrollment	COH's Proposed Action	COH's Justification
Medicaid/Iowa Marketplace Choice Plan (IMCP) federal waiver in Iowa	1. **Target IMCP-eligible population.** Due to the federal waiver, individuals in Iowa earning between 101% and 138% of the Federal Poverty Level were allowed to enroll in private plans. COH was able to enroll nearly 33% more of the IMCP-eligible population than originally expected through June 2014 (8,000 total) (P. 92). COH will focus on using its customer service experience to retain current members and prevent enrollment shifts between carriers. While the CO-OP has not hired additional staff specifically targeting this population, it has added staff to accommodate additional customer call traffic (P. 92).	The applicant states projecting additional Medicaid enrollment is difficult because another carrier could be included in the statewide program and offered to existing members (P. 92). Determining enrollment rate shifts among existing members remains difficult to estimate as well. The applicant did not provide details on the source of its projection estimates. In addition, relative to its original application, the applicant increased its full-time equivalent level from 11 to 40 to accommodate increased customer traffic. However, it is not clear if the additional staff members are accounted for in the revised budget.
EPO product offering in select areas of Iowa	1. **Invest in staff to support narrow networks.** The applicant reached agreements with large health care organizations to bring narrow network products to the market featuring these large providers (P. 93). The CO-OP's product portfolio mix has been expanded to include an EPO and a "tiered" network providing customers with the best benefits if it used the affiliated providers (P. 93). The CO-OP added two additional staff members at an incremental cost of approximately $180,000 to negotiate provider contracts and manage ongoing provider communications.	COH states that among individual purchasers in Iowa, 75% (9,000 of 12,000 members) have chosen the EPO or tiered product (P. 93). Conversely, fewer than 20% of small or large group purchasers chose the narrower network options. Compared to original estimates, the CO-OP was able to expand upon its non-Medicaid enrollment by 17,000 due to these new products (P. 93). It cannot be determined if the costs for these additional staff members are included in administrative expenses. (P. 93) Additionally, no information was provided for costs other than staff.
Growth opportunities in urban areas	1. **Focus on meeting needs of consumers in key metropolitan areas.** COH formed relationships with the University of Iowa Health Alliance (UIHA) and providers in the major metropolitan areas of Iowa to attain	COH stated it developed a more price competitive EPO product in partnership with new providers and health care institutions in urban areas. The applicant did not provide documentation of the impact these price changes would have on enrollment in specific market segments.

	a better price position vis-à-vis competitors.	
Tailored product strategies	**1. Target minority communities.** COH continues to use "innovative" marketing tools to target specific populations (P. 53). It enrolled in the IMCP, tailored to low-income populations, and worked with community groups and community health centers to capture minority groups, young people and families.	COH stated that it captured 33% more IMCP-eligible enrollees than projected (8,000 vs. 6,000) in 2014 (P. 62). However, the applicant did not provide a breakdown of the demographics of these enrollees. While it did provide a general demographic breakdown of its enrollees in Iowa and Nebraska, COH did not provide a comparison to its original projections among these populations.
	2. Target employers. COH will continue to form alliances with associations, technology companies, and other affinity organizations to provide a tailored set of products to the employer market, especially small employers (P. 53).	The applicant introduced features such as "Three-for-Free" and "Healthy Rewards," as well as standard plans and HSA-eligible plans at each metal level. While this was cited as a reason for increased market share on the Marketplace, the applicant did not provide any documentation of this claim.
	3. Utilize health systems. COH introduced a "tiered" product option to the Iowa market after reaching an agreement with UIHA to feature it as the "top tier" in a product that offered better benefits to people using that network. UIHA ultimately offered to use the tiered product in every county in Iowa and the EPO in 76 of the 99 counties.	The applicant states the strategy ultimately led to most individual purchasers choosing the tiered or EPO product based on price and that group purchasers overwhelmingly chose the broad PPO plan (P. 10). The applicant did not provide a breakdown of the enrollment in each of these plans or their direct impact on future enrollment projections.

Summary of Observations:

- **Enrollment projections were exceeded.** According to the CMS CO-OP Enrollment Comparison Report as of 4/30/2014 (Data Summary) and the applicant's 4/30/2014 pro formas, the enrollment projections were exceeded by nearly 16% through the end of the first enrollment period. The revised business plan's projection of 75,000 total enrollees for all of 2014 has already been exceeded, as of the June 2014 application for additional solvency loan funding. The applicant has not provided a breakdown of future enrollees into the large, small, and individual market segments beyond 2015. Although the revised business plan discusses the markets to be targeted going forward, it does not provide any enrollment projection estimates for these markets. Finally, the enrollment estimates summarized in the revised business plan are based upon the figures provided in Exhibit 1. (P. 90).
- **The enrollment estimates between application and pro formas differ, at times, by over 20,000 per year.** The assumed enrollment levels in Exhibit 1 in the application are 75,000 in 2014, 90,000 in 2015, 105,000 in 2016, and 123,000 in 2017 (P. 90). By comparison, the estimates in the pro formas provide enrollment estimates of approximately 66,000 in 2014, 116,000 in 2015, 133,000 in 2016, and 148,000 in 2017. (P. 127). The reason for the differences is not described in the application; where application and pro formas assumption differ, it is the numbers in the pro formas that are assumed to take precedence.
- **Enrollment population is higher risk than previously forecast.** The applicant states the primary reason for requesting additional solvency loan funding is due to higher premium and claims volume, higher loss ratios, and a

higher risk enrollment population than previously forecast. Due to the uncertainty of its enrollment projections and the risk profile of future enrollees, it is unclear that the requested amount of additional solvency loan funding reflects the amount required to meet the CO-OP's future capitalization and liquidity requirements during the growth projected during 2014-2017.

- **Use of CMS-funded infrastructure to offer HSA eligible plans and self-insured administration.** It appears the CO-OP may be utilizing CMS-funded infrastructure intended for commercial business to offer HSA eligible plans as part of its product mix. It is unclear whether this product option is only available to members enrolling on the Marketplace. In addition, the CO-OP may intend to use its CMS-funded infrastructure to enroll self-insured populations that would not be included in the overall enrollment projections for the small and large group market segments. It cannot be determined what portion of the CO-OP's enrollment, if any, relates to self-insured business. CMS may want to consider discussing this issue further with the CO-OP.
- **Breakout of on and off Marketplace enrollment not provided.** It cannot be determined if the CO-OP will be in compliance with Title 45, Code of Federal Regulations (CFR) § 156.515(c)(1) and (d) relating to requirements for CO-OPs under the Affordable Care Act (ACA), which requires two-thirds of total members to be from the Marketplace.

2. **Product Pricing**

COH's 2014 enrollment was higher than anticipated. The applicant's products are distributed through multiple channels and, according to the applicant, have growing acceptance. The growth in enrollment has been higher than expected. These levels were not forecasted to occur until 2020 in the original application (P. 3).

In Iowa, Wellmark Blue Cross Blue Shield has captured more than 80% of the individual product and 50% of the small-group product market share. In Nebraska, Blue Cross and Blue Shield of Nebraska has captured about 60% of the individual product and 40% of the small-group product market share (P.16).

The CO-OP has lower 2014 premiums in three of the four rating areas of Nebraska in the individual market and in the small-group market everywhere. In Iowa, the CO-OP has higher silver plan premiums than competitors by as much as 20% in most rating areas, other than one, where its premiums are the lowest. According to the CO-OP, its small-group rates were very competitive statewide (P. 12). Tables 2, 3, 4 and 5 below show the CO-OP's premiums compared to other competitors within each area. COH does not have the lowest premiums for individual for most rating areas on the IA Marketplace; however, COH does have the lowest premiums for most rating areas on the NE individual Marketplace. For the small group market, COH has the lowest premiums in all rating areas on the IA and most of the rating areas on the NE Marketplace.

According to the applicant, the effects of early renewal, transitional policies, and steerage of high risk customers in both IA and NE have all combined to raise their average claims loss ratio significantly. COH believes part of this increase may be due to "pent-up demand" factors (P. 40). COH is also projecting a $10M loss in 2014. As a result, COH may need to consider establishing a premium deficiency reserve (PDR) to address the loss in 2014, as well as any need for PDR related to these products. The PDR would also impact the applicant's surplus.

Per page 3 of 'Milliman Memo IA Indvdl Rate Filing.pdf,' for the Iowa individual market, COH's proposed rates effective January 1, 2015 reflect a 7.0% and 12.3% rate increase for the Premier and Preferred products, respectively. The proposed rate change does not vary by region but does vary by plan. There are no significant changes in cost sharing or rating factors (e.g., age, tobacco) in this rate filing, other than changes to the base premium rate and rate relativities by plan. The requested rate change varies by plan due to provider reimbursement changes and revised benefit relativities. Base rate changes are the result of medical inflation, utilization, provider contracts, taxes and fees, federal reinsurance program changes, morbidity, expenses, and profit margin.

The projected loss ratio, including the impact of the ACA adjustments, is 85.4%. ACA adjustments include such items as quality improvement expenses and taxes/fees. With rate increase of upwards of 10%, there is no mention of how it will impact retention of current members. The pro formas show an average increase in premiums of 17% in aggregate from

2014 to 2015 and a 6% decrease in costs. It is unclear how the rate increases discussed within the 2015 rate filings tie to the aggregate changes within the pro formas.

Per page 3 of 'Milliman Memo Indvdl Rate Filing.pdf,' for the Nebraska individual market, COH's proposed rates effective January 1, 2015 reflect a 7.9% rate increase for the Premier product. The proposed rate change varies by region and plan. There are no significant changes in cost sharing. This rate filing includes changes to the base premium rate, rate relativities by plan, and area factors. The requested rate change varies by plan due to provider reimbursement changes and revised benefit relativities. Base rate changes are similar to those mentioned above for the Iowa market.

The projected loss ratio, including the impact of the ACA adjustments, is 81.3%.

Per page 5 of 'IA Sm Grp Milliman.pdf,' for Iowa small group market, preliminary 2015 pricing indicates COH needs to increase rates approximately 3.9% and 8.6% for its Premier and Preferred products, respectively. COH will be terminating its Choice Product at the end of 2014 and introducing its CorePlus product during 2015 in the Iowa small group market. No explanation was provided in the 2015 rate filing for these changes in products.

The applicant has provided the 2015 rate filing memos for Iowa and Nebraska individual markets, but only a preliminary 2015 pricing memo for the Iowa small group market. The applicant does not provide a 2015 rate filing memo or a preliminary 2015 pricing memo for the Nebraska small-group market. This component of the market represents approximately 10% of the total enrollment within the two states (P. 336-337).

The applicant is considering expanding coverage into eight counties in far western Illinois. Per the applicant, people from this area go to hospitals in the Quad Cities as well as Dubuque, Clinton, Muscatine, Burlington, and the University of Iowa. COH has "had discussions with Illinois regulators, who are receptive to the plan assuming support comes from the Department of Human Services (DHS) and CMS" (P. 7). The applicant does not identify how much, if any, of the additional solvency loan funding would be used for expansion into Illinois.

Per page 3 of 'Milliman Memo Indvdl Rate Filing.pdf' and 'Milliman Memo IA Indvdl Rate Filing.pdf,' since the CO-OP is a start-up operation, the initial estimates for the individual business are based on industry data and adjusted by the CO-OPs external actuary to fit COH's specific situation.

Tables 2 and 3 provide a comparison for the 2014 single age 27 premiums for the CO-OP versus competitors with the lowest premium product across one of the same rating areas in the Iowa and Nebraska individual Marketplaces, whereas, Tables 4 and 5 provide similar information in the Iowa and Nebraska small group Marketplaces. Highlighted areas denote the lowest premium for the particular area.

Table 2: 2014 Premiums on the Iowa Individual Marketplace

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Bronze	Bronze	168.86	145.28	172.79	178.53	171.98	168.54	169.36
Coventry Health Care of Iowa Inc.								
Bronze Deductible Only HMO HSA Eligible Methodist Health Partners	Bronze				162.28			
Bronze Deductible Only POS HSA Eligible Patient Preferred	Bronze			157.94				
Bronze Deductible Only POS HSA Eligible UnityPoint Health	Bronze					133.48	132.22	140.15
Bronze Deductible Only POS HSA Eligible UnityPoint Health û Des Moines	Bronze	166.28	122.17					
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Silver	Silver	209.39	180.15	214.27	221.38	213.26	208.99	210.01
Coventry Health Care of Iowa Inc.								

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Silver $10 Copay HMO Methodist Health Partners	Silver				209.23			
Silver $10 Copay POS Patient Preferred	Silver			203.65				
Silver $10 Copay POS UnityPoint Health	Silver					172.14	170.52	180.74
Silver $10 Copay POS UnityPoint Health û Des Moines	Silver	214.42	157.54					
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Gold	Gold	246.76	212.29	252.51	260.88	251.30	246.28	247.47
Coventry Health Care of Iowa Inc.								
Gold $5 Copay HMO Methodist Health Partners	Gold				236.22			
Gold $5 Copay POS Patient Preferred	Gold			229.92				
Gold $5 Copay POS UnityPoint Health	Gold					194.37	192.53	204.08
Gold $5 Copay POS UnityPoint Health û Des Moines	Gold	242.10	177.88					
Avera Health Plans								
Avera MyPlan $250 / 10% Coinsurance	Platinum			385.12				385.12
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Platinum	Platinum	295.72	254.42	302.61	312.65	301.17	295.16	296.59
Gundersen Health Plan, Inc.								
Platinum $500 - 20%	Platinum						407.13	407.13
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Catastrophic	Catastrophic	154.09	132.57	157.68	162.91	156.93	153.79	154.54
Coventry Health Care of Iowa Inc.								
Catastrophic 100% HMO Methodist Health Partners	Catastrophic				110.64			
Catastrophic 100% POS Patient Preferred	Catastrophic			107.67				
Catastrophic 100% POS UnityPoint Health	Catastrophic					90.96	90.10	95.50
Catastrophic 100% POS UnityPoint Health û Des Moines	Catastrophic	113.33	83.27					

Table 3: 2014 Premiums on the Nebraska Individual Marketplace

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus $4750 HDHP Bronze	Bronze	161.58	161.58		
CoOportunity Health					
CoOportunity Premier HSA Bronze	Bronze	205.85	164.49	153.30	152.92
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus $1500 HDHP Silver	Silver	210.13	210.13		
CoOportunity Health					
CoOportunity Premier HSA Silver	Silver	240.98	192.56	179.45	179.01

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Blue Cross and Blue Shield of Nebraska					
BlueEssentialsPlus $1000 Gold	Gold	329.62	329.62	329.62	329.62
CoOportunity Health					
CoOportunity Premier HSA Gold	Gold	280.75	224.33	209.08	208.55
Coventry Health Care of Nebraska Inc.					
Gold $5 Copay HMO Methodist Health Partners	Gold	251.81			
CoOportunity Health					
CoOportunity Premier Platinum	Platinum	333.00	266.10	247.99	247.37
Blue Cross and Blue Shield of Nebraska					
BlueEssentialsPlus $6350 Catastrophic	Catastrophic	157.57	157.57	157.57	157.57
CoOportunity Health					
CoOportunity Premier Catastrophic	Catastrophic	191.26	152.83	142.42	142.08
Coventry Health Care of Nebraska Inc.					
Catastrophic 100% HMO Methodist Health Partners	Catastrophic	113.51			
Catastrophic 100% POS Plan	Catastrophic	133.18	128.81	129.60	133.18

Table 4: 2014 Premiums on the Iowa Small Group Marketplace

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Avera Health Plans								
Avera $2,000 / 50% coinsurance	Bronze			265.61				265.61
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Bronze	Bronze	151.12	130.01	154.63	159.77	153.90	150.83	151.55
Gundersen Health Plan, Inc.								
Bronze HSA $5000 - 30%	Bronze						196.05	196.05
Health Alliance-Alegent Creighton Health Partner								
Guide HMO QHDHP 3150/6300 40% 6350/12700 Rx3	Bronze				220.53			
Sanford Health Plan								
Simplicity $3,000	Bronze			214.11				214.11
Avera Health Plans								
Avera $2,000 / $4,000 Out-of-Pocket	Silver			262.68				262.68
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Silver	Silver	190.32	163.74	194.75	201.21	193.83	189.95	190.87
Gundersen Health Plan, Inc.								
Silver HSA $2000 - 20%	Silver						262.28	262.28
Health Alliance-Alegent Creighton Health Partner								
Guide HMO 30/60 2400/4800 30% 6000/12000 Rx3	Silver				247.21			
Sanford Health Plan								
Simplicity $2,000	Silver			263.14				263.14

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Avera Health Plans								
Avera $750 / 30% coinsurance	Gold			316.34				316.34
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Gold	Gold	220.50	189.70	225.63	233.12	224.57	220.07	221.14
Gundersen Health Plan, Inc.								
Gold $2000 - 0%	Gold						304.59	304.59
Health Alliance-Alegent Creighton Health Partner								
Guide HMO 25/50 1600/3200 10% 4000/8000 Rx2	Gold				302.14			
Sanford Health Plan								
Simplicity $1,500	Gold			297.18				297.18
Avera Health Plans								
Avera $250 / 10% coinsurance	Platinum			361.49				361.49
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Platinum	Platinum	257.55	221.57	263.54	272.28	262.29	257.04	258.29
Gundersen Health Plan, Inc.								
Platinum $500 - 20% $15 OV	Platinum						335.17	335.17
Sanford Health Plan								
Simplicity $500	Platinum			337.22				337.22

Table 5: 2014 Premiums on the Nebraska Small Group Marketplace

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 403 HDHP Bronze	Bronze	201.85	201.85	195.85	209.84
CoOportunity Health					
CoOportunity Premier HSA Bronze	Bronze	213.70	170.72	159.07	158.67
Coventry Health Care of Nebraska Inc.					
Bronze Essential #2 HMO Plan S	Bronze	272.62	263.67	265.29	272.62
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 402 HDHP Silver	Silver	255.28	255.28	247.70	265.39
CoOportunity Health					
CoOportunity Premier HSA Silver	Silver	251.74	201.11	187.38	186.91
Coventry Health Care of Nebraska Inc.					
Silver Security #2 HMO Plan S	Silver	314.39	304.07	305.95	314.39
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 401 Gold	Gold	355.81	355.81	345.24	369.90
CoOportunity Health					
CoOportunity Premier HSA Gold	Gold	289.57	231.33	215.54	215.00
Coventry Health Care of Nebraska Inc.					
Gold Freedom #3 HMO Plan S	Gold	368.21	356.12	358.31	368.21

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Health Alliance-Alegent Creighton Health Partner					
Guide HMO 25/50 1600/3200 10% 4000/8000 Rx2	Gold	287.01	275.64		
CoOportunity Health					
CoOportunity Premier Platinum	Platinum	339.35	271.10	252.60	251.96

Summary of Observations:

- **COH is projecting a $10M loss in 2014.** To address these losses, the CO-OP may need to consider establishing a PDR. This would also impact the applicant's surplus.
- **2015 premiums will increase compared with the 2014 premiums, pending approval.** According to the applicant, 2014 enrollment was much higher than anticipated. For the Iowa individual market, COH's proposed rates effective January 1, 2015 reflect a 7.0% and 12.3% rate increase for the Premier and Preferred products, respectively, and for Nebraska individual market, proposed rates reflect a 7.9% rate increase for the Premier product. For the Iowa small group market, COH proposes a 3.9% and 8.6% rate increase for its Premier and Preferred products, respectively. No information was provided about rate increases for the Nebraska small group market. With rate increase of upwards of 10%, there is no mention of how the applicant hopes to retain its members.
- **Change in products in 2015.** COH will be terminating its Choice Product at the end of 2014 and introducing its CorePlus product during 2015 in the Iowa small group market. No explanation was provided in the 2015 rate filing for these changes in products.
- **Changes to small group premiums could not be determined.** The 2015 individual rate filing memorandum for Nebraska small group and Iowa small group was not provided. This document typically provides the detailed reasoning for changes from the prior year premiums. Additionally, the pro formas do not provide premiums for each market.
- **The 2015 small group rate filing includes a breakdown of taxes and fees, which does not include an estimate for the health insurer fee.** Milliman published a research report titled " ACA Health Insurer Fee – Estimated Impact of the US health insurance industry," dated April 2013, which states the 2014 health insurer fee estimate is 1.7% to 2.4% and increases to 2% to 2.9%. Since COH is a 501c(29) not-for-profit entity, the insurer fee estimate would be lower than the industry average. COH does not include an estimate for the health insurer fee; however, it includes an estimate for Marketplace fees associated with selling plans on the Marketplace. The CO-OP assumed 0.9% of premiums for this fee.

3. Medical Costs and Losses

COH projects combined medical loss ratios (MLR), including the impact of the ACA adjustments, of 100.8%, 82.7%, and 83.2% for years 2014, 2015 and 2016, respectively. The MLR for 2014 includes individual and small group business only. For 2015 and 2016 estimates, large group business is included. COH also is estimating receivables for risk adjustment, reinsurance and risk corridors for 2014. The largest receivable is risk corridors with $41M in receivables estimated for 2014. Including the $64M in 3Rs receivables for risk corridors and reinsurance for 2014 would result in a $10.5M loss and result in an MLR of 101%, including the impact of the ACA adjustments. Removing the estimated $64M in receivables would result in a $70.1M loss and increase the MLR, excluding any adjustments for the ACA for all products combined to 109%. The 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit.

Based on a review of the regulatory filing as of 3/31/2014, the MLR is approximately 89%, excluding any impact of the ACA. If this experience were to continue, the CO-OP would face losses. Typically, one quarter's experience cannot be extrapolated to the entire year and, therefore, more months of experience will be needed to make a conclusion. The CO-OP is projecting the 2014 MLR to be 84%, excluding any impact for the ACA.

The CO-OP's product offerings in the Nebraska and Iowa Marketplace are noted in Tables 2, 3, 4 and 5 below. The CO-OP was able to get more than 60,000 members enrolled in the individual market, even though Blue Cross and Blue Shield of Nebraska had a majority of the individual product market share since its premiums were lower than competitors in three of the four rating areas. The applicant believes by "utilizing three key general agencies and a number of retail brokerages, it was able to market successfully across the state" (P. 49). The CO-OP believes that it was able to roll out innovative and competitive products, which helped fill market voids in both the individual and small group market by utilizing the broad-based provider network of Midlands Choice, a PPO owned by Nebraska's largest provider system (P. 5).

In Iowa, the premiums for products by its only statewide Marketplace competitor, Coventry Health, were lower than the CO-OP in most rating areas. The applicant believes it was able to enroll more than expected membership through strong branding, favorable media coverage, targeted communications, affiliations with key constituencies, and a partnership with the University of Iowa Health Alliance (UIHA), a collaborative of Mercy Health Network (about 40 hospitals), Mercy Medical Center in Cedar Rapids, Genesis Health System, and the University of Iowa Hospitals and Clinics (P. 5).

COH is anticipating a different morbidity estimate for 2015 compared to 2014 business. Because of this, the applicant is making an adjustment to the premiums. This change is, in part, due to the pent-up demand of individuals in the first year of coverage. The 2014 rate filings show the adjustments COH used to estimate to account for the pent-up demand, among other items. For Iowa, the CO-OP applied a 30.2% adjustment to premium. For Nebraska, the CO-OP applied a 25.6% adjustment to premium.

COH does not have enough experience in the base period to use in rate development; therefore, the 2015 rate development is based solely on manual rates.

Summary of Observations:

- **COH expects 2015 morbidity to be worse than 2014 pricing morbidity.** The applicant is projecting its individual 2014 claims per member per month (PMPM) with a 30.2% morbidity adjustment to account for the anticipated health status change for Iowa and 25.6% for Nebraska.
- **2015 medical costs are based on industry data**. COH does not have enough 2014 experience to have data to rely upon; therefore, industry assumptions are necessary to estimate the morbidity of the projected membership.
- **The risk corridors and risk adjustment receivables are difficult to quantify.** This is because of the uncertainty of the industry average morbidity. Risk corridors is calculated after risk adjustment therefore relies upon the risk adjustment estimate. Without these receivables, COH would have a loss of $70.1M for 2014 instead of the $10.4M projected in the pro formas.

4. CO-OP Financials

COH's pro formas project recoveries from the 3Rs for 2014 through 2016. In the best case membership scenario, COH projects cumulative federal reinsurance recoveries of $71.5M for 2014 through 2016, while it projects to recover $64M under the expected membership scenario and $54.8M under the worst case membership scenario during the same period. COH also projects to receive an additional $41.4M from risk corridors and $686K from risk adjustment in 2014 under all scenarios. From 2014 through 2016, COH projects a cumulative net profit of $11.8M, $8.5M, and $4.1M under the best, expected, and worst case membership scenarios, respectively (P. 124-133). However, absent recoveries from risk sharing and risk corridors, and risk adjustment, COH will incur a cumulative net loss of $89M, $86.1M, and $82.9M in the best, expected, and worst case membership scenarios, respectively, during the same 2014-2016 period. COH projects RBC levels to stay above 500% of ACL during the entire performance period under all scenarios projected by the applicant, if realized.

COH is requesting additional solvency loan funding of $32.7M, of which $9.8M is requested for the purpose of covering operational losses during 2014. COH states that the additional solvency loan funding is requested to meet state RBC requirements in light of higher than projected enrollment and also to add incremental cash flow that may result as a result of delay in receipts relating to receivables from transitional reinsurance recoveries (P. 41). The CO-OP has entered into a

line of credit and believes that required CMS waiver will be received to enable the 3R receivables to be acceptable to the lender as "collateral" (P. 87). The applicant provides a breakout of solvency loan funding requested based on solvency needs as presented below (P. 41).

Meet 500% RBC requirement per Best Case enrollment	$20.9 million
Added RBC to offset private credit line	$2.0 million
Increment to meet potential cash deficit	$9.8 million
Total Solvency Loan funding Request	**$32.7 million**

Combined with the current solvency loan funding award, the total solvency loan for COH would be $130.6M. However, the total solvency loan funding recorded in the COH's expected scenario pro formas, including the loan funding schedule for the expected scenario, is $108.5M, which is $22.1M less than the applicant requested. The observations noted in this section are based on the loan amounts reflected in the expected scenario pro formas.

Per CMS's CO-OP Summary Report by Borrower (Loan Tracker), as of June 2014, the CO-OP has been awarded total funding of $112.6M ($14.7M in start-up loans and $97.9M in solvency loan funding), and began issuing health insurance products beginning in 2014. $70.8M of the total solvency loan obligated has been disbursed to COH, with $27.1M of obligated but undisbursed solvency loan funds. A review of the original application indicates the solvency loan disbursement of $97.9M was to be disbursed from 2013-2020. The current pro formas are projecting $108.5M to be disbursed from 2013-2017. It is not clear why the applicant revised the timing of the loan disbursements, as it appears the applicant continues to project RBC levels of at least 500% of ACL throughout the entire performance period. Also, with no further award of solvency loans, COH claims it will continue to meet the recommended 500% throughout the entire performance period in the contingency plan scenario.

To cover short term cash flow issues, COH received a $2M revolving credit that was available beginning in 2014. This loan amount is recorded as a liability in the pro forma balance sheet. According to the CO-OP, this revolving credit line was obtained to cover short term working capital needs that will result due to the delay of receipt of the recoveries from the federal reinsurance program s. COH projects to receive approximately $21.8M in recoveries from the federal reinsurance program for 2014. In its application for additional solvency loan funding, the applicant stated that "the collateral in the form of an account receivable is created as claims are incurred and is not dependent upon market averages or future data. The asset is a federal receivable from CMS although to be usable as collateral it will require written assignability from the holder to the lender which will require a CMS waiver" (P. 42). Per COH's pro forma cash flow statement, it appears the applicant projects to repay the loan on an annual basis and projects to utilize the revolving credit through 2016, the year risk sharing and risk corridors will be eliminated. It appears COH is relying on the recoveries from 3Rs to cover the repayment for this loan. In the absence of these recoveries, COH will be incurring losses through 2016 and it is not clear how it projects to repay this loan if projections are not realized.

<u>Best Case Scenario</u>

The original solvency loan award was provided to COH based on enrolling 53,332 average members from 2014-2020. The average enrollment based on the best case scenario is 115,947 average members for the same period, which is projected to support the $116.7M of expected total solvency loan funding. If no additional solvency loan funding is awarded, the current award of $97.9M is projected to support 66,101 members. Per COH's regulatory filing for the first quarter of 2014, it appears it has enrolled 50,740 members, which is greater than the original application enrollment projection (COH Quarterly Statement, as of March 31, 2014, P. 7). The most recent enrollment projection indicates that COH projects to grow its 2014 membership level to 66,101 by the end of the year. The best case scenario projects the current enrollment level to be "increased by higher numbers in early years reflecting the potential for both higher retention of existing customers as well as less competition from both BCBS plans and Coventry in IA and NE markets" (P. 39). However, details were not provided to document why the applicant is assuming less competition from its competitors.

COH's loan schedule projects to receive the disbursement of the entire amount of the originally obligated solvency loan funding by 2017. If projections are realized, COH projects to start repayment of interest on the solvency loan in 2019 and

interest and principal payments in 2021. COH projects to continue to make annual repayment through 2032, until the loan is paid in full, if projections are realized. However, given that the solvency loan amount reported COH's pro formas is less than the cumulative solvency loan amount (current award plus additional requested funding), the impact of the full solvency loan amount on COH's pro formas is unknown.

COH projects to achieve profitability beginning in 2015, with projected net income of $8.2M. If projections are realized, it projects to make a cumulative net profit of $854.5M from 2014-2033 (P. 128), with related average profit margins of 2.2% over the same period. These net income projections consider a cumulative reinsurance recoveries of $71.5M from 2014 through 2016 (P. 127). Absent these recoveries, COH will incur losses through 2016.

COH projects a MLR of 84% in 2014, 80% in 2015, and 81% in 2016, which does not include the impact of the ACA adjustments. COH projects to recover $21.8M, $28.8M, and $20.8M of its incurred claims from federal reinsurance programs in 2014, 2015, and 2016, respectively (P. 127). Absent the level of federal reinsurance recoveries and excluding the impact of the ACA, the MLR for 2014, 2015, and 2016 is projected to be 106%, 85%, and 84%, respectively. No detail was provided in the application to explain the decline in the projected MLR of 21% between 2014 and 2015.

In its business plan, COH states it has a reinsurance agreement with Partner Re with an attachment point beginning at $500,000, a reinsurance rate above the attachment point of 90%, and a reinsurance limit of $5M per member per agreement period (P. 83). The projected medical loss recoveries from its commercial reinsurance policy is projected at $2.3M, $4.3M, and $5.3M for 2014, 2015, and 2016, respectively (P. 127). Given the federal reinsurance for 2014 and 2015 are capped at $250,000 for individual reinsurance coverage, the CO-OP may have a gap in its reinsurance policy from $250,000 to $350,000 in years 2014 and 2015. The 2016 federal reinsurance cap has not yet been determined.

COH projects an ACR of 22% in 2014 and 18% in 2015. COH's administrative expenses for 2014 are budgeted at $24.3M, which consists of salaries and wages of $5.2M, contractual expenses of $15.8M; and $3.3M of other expenses. COH does not project to reduce its administrative expenses in 2015. COH projects its ACR to stay at or above 15% of its premium revenue through 2020.

Expected Membership Scenario

Under base case with additional solvency loan funding scenario (expected scenario), COH projects lower enrollment growth than the best case scenario. COH projects to break even and begin profitability in 2015 with projected net income of approximately $7M in 2015 and $11.9M in 2016. These net income projections consider reinsurance recoveries of $24.4M in 2015 and $17.7M in 2016 (P. 123). Absent these recoveries, COH will incur a loss of 17.4M and $5.8M in 2015 and 2016, respectively.

If projections are realized, COH projects to make a cumulative net income of $659.6M from 2014-2033 (P. 124). COH does not project its MLR and ACR to change between the best case and expected membership scenarios.

COH projects to draw down a cumulative solvency loan amount of $108.5M under the expected membership scenario, which is $22.1M less than the total solvency loan funding (original funding plus additional solvency loan requested) (P. 124). No explanation is provided detailing the discrepancies between the cumulative solvency loan funding amount recorded in the pro formas and total solvency loan funding requested in the application. COH projects the solvency loan draw down and repayment schedule for the expected membership scenario to remain the same as the best case membership scenario.

Summary of Observations

- **Total solvency loan amount per COH loan schedule does not agree with CMS loan disbursement schedule.** COH is requesting an additional solvency funding of $32.7M. When added to the current solvency loan funding level of $112.6M per the Loan Tracker, total solvency loan disbursements to this CO-OP will be $130.6M. However, per the COH's pro formas, including the loan schedule, the total solvency loan amount recorded is $116.7M.

- **Losses are projected absent recoveries from federal reinsurance programs.** COH projects to break even and achieve profitability in 2015. At the same time, it projects to recover $28.8M and $20.8M from federal reinsurance programs in 2015 and 2016, respectively, under the best case scenario. Absent these recoveries, COH is projected to incur a net loss of $20.5M and $6.9M in 2015 and 2016, respectively. Also, COH projects to recover a cumulative amount of $63.2M in 2014 from the 3Rs ($41.4M from risk corridors and $21.8 from risk sharing). Despite these projected recoveries, COH still projects to sustain a loss of $10.5M in 2014.

5. Contingency Plan

COH stated that the underwriting losses it experienced during the first quarter of 2014 is averaging over 5% in excess of premium, which is causing an underlining liquidity concern (P. 42). See the Product Pricing section for further details. Additionally, COH projects a recovery of $41.4M from the risk corridors. This may indicate the applicant's 2014 premium is underpriced as compared to the market. As noted in the CO-OP Financials section, COH's projected MLR for 2014 is 84%, excluding the impact of the ACA. MLR and ACR are projected to stay at the same level as the best case membership scenario. RBC levels are also projected to stay above 500% of ACL at all times under all scenarios. The contingency plan projects to draw down the remaining balance of the current solvency loan funding in 2014 (P. 134).

COH considers the following options under its contingency plan. CMS may want to consider discussing this contingency plan with the CO-OP to further understand its implication in the context of program compliance requirements of the CO-OP program.

- **Merger with another CO-OP:** COH intends to merge with another failing CO-OP with unexpended solvency loan funding to indirectly acquire solvency loan funding (P. 43). However, it is not clear how COH plans to identify and incentivize failing CO-OP. Additionally, the applicant did not detail a plan to manage the impact of its expansion into another failing CO-OP's state on current operations.
- **Merge or affiliate with another large healthcare entity:** COH considers the opportunity to merge with another large healthcare entity if additional solvency loan funding is not provided by CMS. COH further stated that "---, the ability of a nonprofit Section 1322 cooperative insurer to seek additional external capital for other than known and collateralized operating cash flow requirements is quite limited due in part to the restrictions of the enabling statute and in part to the limitations of a non-profit cooperative" (P. 44). It is not clear how COH intends to achieve this plan without a technical default on its loan agreement with CMS.
- **Freeze enrollment:** COH projects to freeze enrollment by withdrawing from "small and large group markets in either or both of Iowa or Nebraska; consider withdrawing from the FFM in one or the other state; raise product prices…[for on and off Marketplace for] individual products to shift enough customers away from coverage so that the solvency capital required for that level of enrollment is less than the $97.9 million currently available" (P. 44). The total solvency loan funding amount recorded on COH's pro formas for the contingency plan, including the loan funding schedule, is $94.8M, which is $3.1M less than the current award amount (P. 133, 134).

COH indicated the purpose of the additional solvency loan funds request is to meet the state solvency requirement, and also to cover working capital shortfalls that will result due to high medical losses experienced during the first quarter of 2014. As of June 2014, COH has obligated but undisbursed solvency loan funding totaling $27.1M.

In the contingency plan, COH projects a cumulative net profit of $423.7M from 2014-2033. COH also projects to start repayment of interest on solvency loan in 2019 and start principal and interest repayment in 2021. If projections are realized, COH projects to make annual principal and interest payments on the solvency loan funding through 2019 until the loan is paid in full.

Summary of Observations

- **Consideration to merge with another healthcare entity might result in non-compliance with program requirements.** Under the contingency (worst) scenario, COH indicates its intention to merge or affiliate with another large healthcare entity, which may result in non-compliance with the CO-OP program compliance requirements. CMS may want to consider discussing this plan further with the CO-OP.
- **Consideration to merge with failing CO-OP.** COH stated it intends to merge with another failing CO-OP with undisbursed solvency loan funding balance, if the request for additional solvency loan funding is not approved. However, no detail is provided on this proposal, including the CO-OP's intended plan to expand into the failing CO-OP's state.
- **Pro formas contain different solvency loan amounts than loan schedule.** Comparison of COH's pro formas and CMS's Loan Tracker indicate the total solvency loan finding amount recorded in the applicant's pro formas for the contingency plan, including the loan funding schedule, is less than the solvency loan funding amount awarded to COH by $3.9M. No detail was provided in the business plan to explain the reason for these variances.

Solvency Loan Request Points

Sections	Potential	Total
Enrollment Projections	15	12.5
Pricing	20	14.5
Medical Costs and Losses	15	14
Financials	15	8.5
Score	**65**	**49.5**

Contingency Plan Points

Contingency Plan	Potential	Total
Overall	10	8
Score	**10**	**8**

CoOportunity Health
Additional Solvency Loan Funding Request Report
Date Submitted to CMS: 10/24/2014

Scope Summary & Assumptions:

- Deloitte will not provide an opinion regarding the reasonableness of the proposed business plan changes of each Consumer Operated and Oriented Plan (CO-OP) Program. Nor will Deloitte provide an opinion regarding the likelihood of each CO-OP achieving sustainable operations based upon the revised business plan.
- Deloitte assumes that the information provided by each CO-OP in its modified business plan is complete and accurate. Deloitte will perform its assessment of the data provided "as is". Deloitte will also use other data sources that are publicly accessible or information provided directly from the Centers for Medicare and Medicaid Services (CMS). Deloitte will notify CMS if we believe that there is insufficient information to complete our review.
- In these applications for solvency loan requests, some of the CO-OPs have cited a need for additional solvency loans to cover projected cash shortfalls as a result of nonadmitting risk-sharing receivables provided in the Affordable Care Act (ACA). The National Association of Insurance Commissioners (NAIC) is charged with developing accounting guidance for these risk-sharing provisions which are utilized by the state departments of insurance in monitoring the financial solvency of the insurers domiciled in their state. The NAIC is continuing their deliberations on this issue, which previously included potential nonadmittance for risk-sharing receivables in excess of any payables. However, as a result of the most recent NAIC meeting on August 17, 2014, the adopted minutes of that meeting reflects that the NAIC is "…replacing the nonadmission guidance with criteria that incorporates conservatism and sufficiency of data and removing the exposed 90-day guidance and adding language to be consistent with other government receivables". Our Findings Report will include relevant information, as necessary, on the accounting treatment for the risk-sharing receivables used by the CO-OPs in their financial projections.
- The impact of the Reinsurance, Risk Adjustment and Risk Corridors Program (the 3Rs, reinsurance, risk adjustment, and/or risk corridors) was reviewed when making observations and comments throughout this report. Observations and comments relating to the impact of the 3Rs are included for informational purposes only. There was no consideration of the reasonableness or propriety of any of the amounts relating to the 3Rs. Based on the scoring criteria provided by CMS, observations and comments relating to the 3Rs had a net neutral effect on the scoring.
- In reviewing applications from CO-OPs for additional solvency loan funding requests, Deloitte reviewed supporting documentation requested of the applicants by CMS in a memo to the CO-OPs distributed on August 22, 2014. The format of the reports as well as the section scoring was approved by CMS during the week of June 2, 2014. These reports are scored on the basis of a total of 65 points, plus 10 points for the contingency plan. The scoring reflects Deloitte's assessment of the degree to which the application complies with the funding loan announcement of August 22, 2014. The score for the Contingency Plan section should be viewed independently of scoring for the other sections of this report. For all sections, Deloitte provided comments on issues only for which the applicant provided data. Observations relating to the pro forma financial statements are based on the base case with additional solvency award scenario (base case), unless otherwise noted.

Executive Summary:

CoOportunity Health (COH or applicant or CO-OP) has submitted a request for $55M in additional solvency loan funding. The application and underlying pro forma financial statements do not discriminate between projected Iowa and Nebraska operations on a standalone basis. Therefore, a distinction was unable to be made between the solvency loan funding needs for Iowa and Nebraska in this Findings Report. Any additional solvency loan funding received by the CO-OP is required to be aggregated with funds used for both Iowa and Nebraska operations. The CO-OP has stated "if additional solvency capital cannot be secured, the CO-OP will begin shutdown procedures prior to the end of 2014" (P. 64)[1].

The CO-OP has stated "if additional solvency capital cannot be secured, the CO-OP will begin shutdown procedures prior to the end of 2014" (P. 64)[2]. Based on CMS's CO-OP Summary Report by Borrower (Loan Tracker) as of 10/3/2014, COH has been obligated $14.7M in start-up funding and $130.6M in solvency loan funding for operations in Iowa and Nebraska, of which $97.9M of solvency loans and $14.7M of start-up funding has been disbursed. This total award amount reflects $32.7M in solvency loan funding awarded as a result of COH's solvency loan funding request submitted in June 2014 which has not been disbursed. It should be noted, in the original application, COH projected the solvency loan of $97.9M would be disbursed from 2013-2020. However, the Loan Tracker indicates that $97.9M has been disbursed as of 10/3/2014. Updated projections have COH disbursing $185.9M (total solvency loan plus current solvency loan request) from 2013-2017. It is not clear why the applicant revised the timing of the loan disbursements, as it appears the applicant continues to project RBC levels of at least 500% of ACL throughout the entire performance period. The applicant's solvency loan request for $55M is projected to be disbursed from 2014-2017, specifically, $30M in 2014, $5M in 2015, $9M in 2016 and $11M in 2017. Since the CO-OP projects no profits during 2014-2017, the solvency loan funds being disbursed in 2015-2017 appear to be intended to make payments on the private loan of $68M and start-up loan repayment of $3.6M which are due during the same period.

Furthermore, COH has applied to National Cooperative Bank in Washington for a $68.2M cash flow operating loan for 2013-2016 to cover short term working capital needs that will result due to the delay of receipt of the recoveries of $48.5M from the federal reinsurance program. The reinsurance recoveries of $48.5M will be used as collateral to obtain the private loan. It is also important to note that the pro forma financial statements include the assumption that the CO-OP will receive both additional solvency loan funds and the private loan. The loan is contingent upon COH receiving additional solvency loans from CMS. It has been included in the base case scenario with the repayments made over the period of 2013-2017. Because the CO-OP does not have any profits from 2014-2017, even after consideration of the 3R receivables, as a result, the loan is projected to be repaid with solvency loan funds. The CO-OP has projected $291.9M of 3R receivables for 2014-2016 with $144.9M of 3R receivables recorded at year end 2014. Based on the pro forma financial statements, if the CO-OP does not receive additional solvency loan funding and given the timing of the cash receipts of the 3Rs receivables being several months after expenditures, CMS may want to consider that CoOportunity Health could suffer from a liquidity issue.

COH has attributed their request for additional solvency loan funding to higher than projected enrollment, delay in receipt of 3R receivables and higher than expected claim costs. In 2014, the overall enrollment in Iowa and Nebraska is projected to exceed original 2011 projections by about 64,000 members[2]. However, COH is projecting fewer enrollees for 2015 and 2016 in the pro forma financial statements submitted to CMS on September 22, 2014 as part of this application (9/22 Pro Formas) than it did in the pro forma financial statements submitted to CMS on May 2, 2014 (5/2 Pro Formas) because of its plans to terminate three lines of business. These three lines of business involve approximately 11,500 enrollees and no information was provided as to how the CO-OP will replace this membership. According to the samples of COH's Silver plan premiums for 2015 provided by the Iowa Insurance Division (IID) and the Nebraska Department of Insurance (Nebraska DOI), the CO-OP will not have the lowest cost plan in any region except for three cities in Nebraska and will be the highest cost plan in area 2, 4 and 5 in Iowa. It is unclear how the CO-OP will reach its enrollment targets. Additionally,

[1] Page numbers in this report refer to the consolidated application based on materials received from the CO-OP for request for additional solvency loan funding dated September 22, 2014.

[2] All references to "original" – including, but not limited to, "original funding application", "original application", and "original projects" – refer to COH's 2011 application for CMS start-up and solvency loan funding, operations commencing in 2011.

the IID published approved rates which showed the CO-OP revised their rate filing estimates. We do not have these revised rate filings and cannot determine if the pro formas reflect this information.

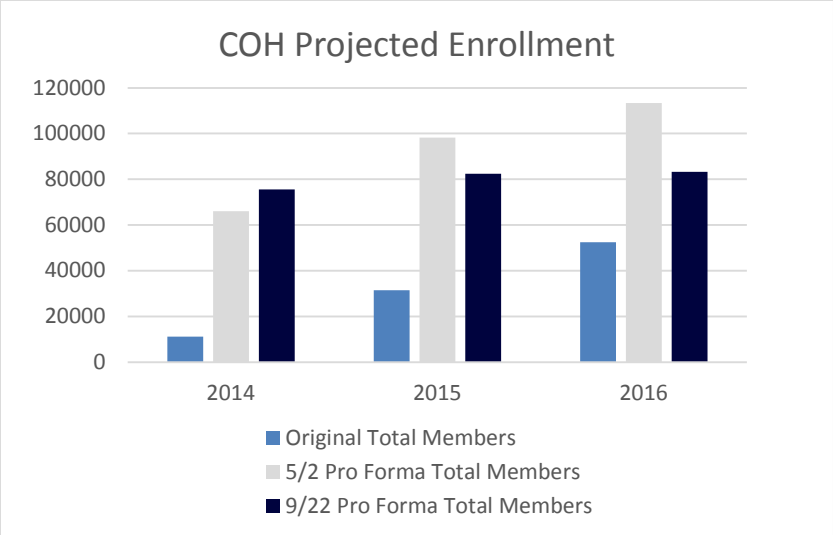
COH is projecting a $60.4M loss in 2014 and the CO-OP's pro formas include a $25M premium deficiency reserve (PDR), though it provides no details to support it. It should also be noted that there is no reference to the need for a PDR in the 12/31/13 and 6/30/14 regulatory filings which the CO-OP filed with state regulators. According to the applicant, the IID has also been in contact with COH about its risk profile and solvency needs in 3Q14. The applicant stated that the Iowa Commissioner of Insurance has been reviewing the risk profile of COH throughout the year and has indicated "he anticipates that it will be necessary for him to require COH to increase its capital and surplus at some point in the third quarter of calendar year 2014" (P. 64). However, it is unclear if that discussion took place before or after the $32.7M in additional solvency loans were awarded to COH in September 2014. The CO-OP presented other contingency scenarios of merging with other CO-OPs or a larger healthcare entity such as HealthPartners, though COH has not secured interested parties. "If additional solvency capital cannot be secured, the CO-OP will begin shutdown procedures prior to the end of 2014." (P. 64). The contingency plan was also not submitted to Milliman, the external actuary for the CO-OP, for review and, therefore, not included in the actuarial certification.

Critical Assertions:

1. <u>Enrollment:</u>

COH provided a revised business plan in this application, which includes updated enrollment and financial projections. The updated enrollment projections in this submission (9/22 Pro Formas or pro formas) [3] indicate that overall enrollment for 2014 in Iowa and Nebraska is projected to exceed enrollment estimates in the May 2014 pro forma financial projections submitted to CMS on May 2, 2014 (5/2 Pro Formas) by approximately 9,460 members. According to the 6/30/2014 regulatory filing, the CO-OP currently has 79,762 members. According to the CMS CO-OP Enrollment Comparison Report as of August 5, 2014, COH has enrolled 84,936 members. COH was awarded $32.7M in additional solvency loan funding related to its June 2014 solvency loan request to account for increased enrollment from original projections.

Figure 1: September 2014 Enrollment Projections exceed Original Projections



Source: Applicant's 2011 Original Application, 5/2/14 Pro Formas, and 9/22/14 Pro Formas

The pro formas provided with this solvency loan application show that the CO-OP projects to enroll 16% fewer members in 2015 and 25% fewer members in 2016 than projected in the May 2 Pro Formas. Membership growth year over year is also lower for 2015 and 2016 as compared to the 5/2 Pro Formas. The 5/2 Pro Formas projected a 49% growth in membership from 2014 to 2015. However, the 9/22 Pro Formas show a 9% increase for the same period. From 2015 to 2016, the 9/22 Pro Formas show a 1% growth, down from a 15% membership increase shown in the 5/2 Pro Formas for the same period. See Documentation for Change in Enrollment Projections section below for further information.

COH did not provide a breakout of enrollment between Iowa and Nebraska in the pro formas,

[3] Annual enrollment projections provided in the pro formas reflect average membership over a 12 month period.

but indicated in the business plan that its "cost position was more favorable in Nebraska than Iowa" (P. 33). COH stated in the business plan that it has enrolled 40,000 enrollees in Nebraska, with over half from rural areas of the state. In Iowa, COH has enrolled approximately 25,000 members (P. 33). The CO-OP did not provide detail to clarify the date of these estimates. Iowa operates on a State-Partnership Marketplace (Iowa Marketplace) and Nebraska (Nebraska Marketplace) operates on a Federally-Facilitated Marketplace. The term 'Marketplace' indicates that a statement is applicable to both the Iowa and Nebraska Marketplaces.

Although COH did not provide the breakout enrollment by on and off Marketplace enrollment, approximate break outs are provided in the business plan. Approximately 40% of members enrolled through the Marketplace and approximately 25% of members enrolled off Marketplace. Based on the information provided with this solvency loan request, it appears the CO-OP will be in compliance with Title 45, Code of Federal Regulations (CFR) § 156.515(c)(1) and (d) relating to requirements for CO-OPs under the Affordable Care Act (ACA), which requires two-thirds of total members to be from the Marketplace in 2016.

Additionally, although the applicant does state that its enrollment projections are predicated on the assumption that "employers with 50-99 employees transition to 'small group' in 2016", the impact of that assumption is unclear because the CO-OP does not breakout enrollment by individual, small group, and large group segments (P. 44).

The remaining third of COH's enrollment was "employer sponsored plans", the majority of which are small businesses purchasing in the "open market" (P. 34). This enrollment was not broken out between Iowa and Nebraska. COH also states in the business plan that it is partnering with Health Partners (HP) to offer self-insured products. Health Partners sells self-insured products in Iowa "through co-located staff at the CO-OP's offices in West Des Moines" (P. 54). As employer-sponsored plans are self-insured plans, the CO-OP would need to exclude these types of members from the enrollment in its regulatory filings. However, no further detail is provided to determine whether the CO-OP has included enrollments from employer-sponsored plans in its pro formas or in its regulatory filings.

Documentation for Change in Enrollment Projections

COH expects to exceed original enrollment projections for 2014 through 2016. However, COH is projecting fewer enrollees in 2015 and 2016 in the 9/22 Pro Formas than in its 5/2 Pro Formas. COH attributes the decrease in projected enrollment to three changes made to its business plan made in response to "extraordinarily high claims costs and cash outflows" (P. 60). First, COH will no longer offer Platinum plans, with the exception of the Nebraska group market. COH did not provide further detail on the reference to the 'group' market and therefore the composition of small and large group enrollment cannot be determined. Second, the CO-OP will no longer offer coverage to individuals off Marketplace in Iowa and will terminate existing plans. Last, the CO-OP will stop offering coverage through the Iowa Medicaid Choice Plan (the IMCP program). These changes will affect approximately 11,500 members, effective January 1, 2015. Approximately 10,000 of the affected members are currently enrolled in the Iowa Medicaid Choice Plan (P. 38).

As stated above, COH has been more successful attracting enrollees in Nebraska than in Iowa. According to the applicant, lower enrollment in Iowa is the result of Wellmark Blue Cross and Blue Shield (Wellmark) early renewing individual members in 2013, which the CO-OP claims "dissuaded some consumers who were eligible for premium subsidies from going to the Health Insurance Marketplace to shop while encouraging older and sicker customers to explore their Marketplace options" (P. 36).

Table 1: Documentation for Change in Enrollment Projections

Reason Cited by COH for Changes in Enrollment	COH Proposed Action	COH Justification
	1. **Will not offer a Platinum plan, with the exception of the**	In response to high claims costs, COH will not offer a Platinum plan on the Marketplace, with the exception of the Nebraska group market. In Iowa, COH attributes

Reason Cited by COH for Changes in Enrollment	COH Proposed Action	COH Justification
High claims cost with existing enrollee pool	**Nebraska group market**	the influx of high cost enrollees to Wellmark's early-renewal of individual policies, which the CO-OP claims "dissuaded some consumers who were eligible for premium subsidies from going to the Health Insurance Marketplace to shop while encouraging older and sicker customers to explore their Marketplace options" (P. 36). Insufficient detail was provided to determine if COH will offer large group or small group. The breakout of small and large group was not provided in the most current pro formas.
	2. Terminate Iowa off Marketplace individual coverage in late 2014	As stated above, COH is terminating this line of business in response to high claims costs. Terminating this coverage will affect less than 1,000 enrollees.
	3. **Discontinue coverage in Iowa Medicaid expansion (the IMCP program)**	As stated above, COH is terminating this line of business in response to high claims costs. The 60-day notice of termination for the Iowa Choice Medicaid Plan was submitted to the Iowa Department of Insurance on September 19, 2014. This change will impact approximately 10,000 members.
	4. Increase Premiums in both Iowa and Nebraska	For example, for the Silver metal level plans in Iowa, COH cites they filed a 15.6% rate increase for individual products and a 10.9% rate increase for small group. In Nebraska, COH cites they filed a 10.6% rate increase for individual and an 11.4% rate increase for small group Silver metal level products. The business plan did not provide detail around how COH expects these increases to affect enrollment levels (P. 43). See Product Pricing section for further details.
Wellmark entrance into Iowa Marketplace in 2015	**5. Budgeted additional marketing expenses**	Wellmark is entering the Iowa Marketplace for the 2015 open enrollment period. COH states in the application that is has budgeted marketing expenses to address the additional competition on the Iowa Marketplace. It is not clear how the CO-OP intends to fund these marketing expenses.

Summary of Observations:

- **9/22 Pro Formas show fewer enrollees in 2015 and 2016 than projected in the 5/2 Pro Formas**. COH is expecting to enroll fewer members in 2015 and 2016 due to the additional competition, increased rates, and the termination

of three lines of business. Because COH did not provide the breakout of on and off Marketplace enrollment, the breakout of individual and small group enrollment, and the breakout of enrollment between Iowa and Nebraska, the impact of these factors to specific states or plan types could not be determined, except where explicitly stated in the application.

- **COH is terminating three lines of business.** The CO-OP will no longer offer Platinum plans (with the exception of Nebraska group business), ICMP program enrollment, or Iowa individual off Marketplace products, affecting approximately 11,500 members. The CO-OP states that these lines of business contribute to high cash outflows and claims costs. The CO-OP attributes fewer expected enrollees in 2015 and 2016 to the discontinuation of these lines of business. It is not clear how this loss in membership in 2014 will be replaced in 2015.
- **COH is raising individual and small group rates for Silver plans in Iowa and Nebraska in 2015**. The application did not address how the CO-OP intends to retain membership in light of rate increases in both states. For the Silver level plans in Iowa, COH filed a 15.6% rate increase for individual products and a 10.9% rate increase for small group. In Nebraska, COH filed a 10.6% rate increase for individual and an 11.4% rate increase for small group products. On September 4th, 2014, the applicant filed and was approved for an amended rate increase request of 19% for all regions and plans in Iowa. It is unclear if this amended request is reflected in its pro formas. Please see the Product Pricing section for more information.
- **New competitors on the Iowa Marketplace**. Wellmark will offer coverage on the Iowa Marketplace during the 2015 open enrollment period. The CO-OP stated in the business plan that it intends to address the additional competition by increasing marketing. It is not clear how COH will fund the costs of marketing.

2. <u>Product Pricing:</u>

As noted above, COH's 2014 enrollment was higher than anticipated. The applicant states that the original 2017 enrollment projections were reached within the first three months of 2014 (P. 43). This increase in enrollment is, at least, partially due to the 2014 pricing. The CO-OP has lower 2014 premiums in three of the four rating areas of Nebraska in the individual market and in the small group market statewide. In Iowa, the CO-OP has higher Silver plan premiums than competitors by as much as 20% in most rating areas, other than one, where its premiums are the lowest. According to the CO-OP, its Iowa small group rates were very competitive statewide (P. 42).

According to the applicant, "material" underwriting losses have occurred during the first eight months of 2014 due to the effects of early renewal, transitional policies, and "pent-up demand" (P. 62). In the June 2014 submission, the CO-OP projected a $10M loss for 2014 and did not include a premium deficiency reserve (PDR). The pro formas indicate losses have increased by approximately $50M from the June 2014 solvency loan request to an overall loss estimate of $60.4M for 2014. COH has projected a PDR of $25M for 2014 in this application. However, the CO-OP did not provide an explanation of the PDR or any of the underlying data that went into the calculation. The PDR estimate directly impacts the solvency amount needed to maintain the required surplus level.

The September 2014 solvency loan request did not include the rate filing memoranda for either small group or individual products in either IA or NE. Actuarial rate filing memoranda typically include the premium formula, trend assumptions, and other specific factor changes. The 2014 Unified Rate Review Template (URRT) files, which capture information at the market level to set premium rates using a single risk pool, were provided and match those provided in June 2014. Additionally, COH's rate submission screenshots show the CO-OP waiting on approval of rates as of September 18th. Therefore, it appears that no changes were made to COH's prior rate filing submissions, and the rates were approved after the solvency loan request was submitted. As a result, the majority of the information in this section is, therefore, similar to information provided in the CoOpportunity Health Findings Report provided to CMS on July 18, 2014 (7/18/2014 Findings Report) [4] and discussion in the business plan and feasibility studies provided in the current submission. However, it should be noted the IID approved higher rate increases based on updated rate filing memoranda that were not provided. More discussion of this update is included later in this section.

[4] CoOportunity Health 7/18/2014 Findings Report (7/18/2014 Findings Report) provided to CMS on July 18, 2014.

Per the 7/18/2014 Findings Report, COH's proposed rates effective January 1, 2015 reflect a 7.0% and 12.3% rate increase for the Premier and Preferred products, respectively, for the Iowa individual market. The proposed rate change does not vary by region but does vary by plan. There are no apparent changes in cost sharing or rating factors (e.g., age, tobacco) in this rate filing, other than changes to the base premium rate and rate relativities by plan. The requested rate change varies by plan due to provider reimbursement changes and revised benefit relativities. Base rate changes are the result of medical inflation, utilization, provider contracts, taxes and fees, federal reinsurance program changes, morbidity, expenses, and profit margin (7/18/2014 Findings Report). The premium rate increases shown within the 2015 rate filings are not large enough to produce profits in 2015 without a corresponding reduction in medical costs. The CO-OP indicates that an approximate rate increase of 40% would be needed to mitigate the emerging claims experience, and has spread the increase over 2016 and 2017 (P. 9). It is unknown if an approximate rate increase of 20% would be approved by the IID. Please see below for a further description of the changes to medical costs.

The projected medical loss ratio, including the impact of the 3Rs and other ACA adjustments, is 92.9% based on information in the pro formas. ACA adjustments include such items as quality improvement expenses and taxes/fees. With rate increases of upwards of 10%, there is no mention of how it will impact retention of current members. The current pro formas show an average increase in premiums of 9% in aggregate from 2014 to 2015 and a 10% decrease in costs. However, the aggregate premium per member per month (PMPM) for 2014 has increased by 5% from the June submission while the 2014 claim estimates have increased by 45% in aggregate. It is unclear how the rate increases discussed within the 2015 rate filings tie to the aggregate changes within the pro formas.

Per the 7/18/2014 Findings Report, for the Nebraska individual market, COH's proposed rates effective January 1, 2015 reflect a 7.9% rate increase for the Premier product. The proposed rate change varies by region and plan. There are no significant changes in cost sharing. This rate filing includes changes to the base premium rate, rate relativities by plan, and area factors. The requested rate change varies by plan due to provider reimbursement changes and revised benefit relativities. Base rate changes are similar to those mentioned above for the Iowa market.

Per the 7/18/2014 Findings Report, preliminary 2015 pricing indicates COH needs to increase rates approximately 3.9% and 8.6% for its Premier and Preferred products, respectively, for the Iowa small group market. COH will be terminating its Choice Product at the end of 2014 and introducing its CorePlus product during 2015 in the Iowa small group market. No explanation was provided in the 2015 rate filing for these changes in products.

Additionally, the September 2014 application states that, effective 1/1/2015, COH will be terminating business in the following three areas – the Iowa Marketplace Choice Plan (IMCP), Platinum plans, and the off Marketplace Iowa individual market (P. 38). The CO-OP believes this will help reduce current negative cash flows by removing high cost individuals who purchased these products. The request indicates these lines of business total 11,500 members which reflect approximately 15.2% of the average members reported in the pro forma financials. COH has assumed claim decreases of 3% from exiting the IMCP program and an additional 20% from the improved morbidity in the single risk pool (P. 13). Without further detail, it is difficult to determine the actual impact these business decisions will have as pro formas have been provided in the aggregate for all lines of business.

Per the 7/18/2014 Findings Report, COH previously provided the 2015 rate filing memos for the Iowa and Nebraska individual markets, but only a preliminary 2015 pricing memo for the Iowa small group market and nothing for the Nebraska small group market. The applicant did not provide a 2015 rate filing memo for the Nebraska small-group market in either solvency loan request. Insufficient information was provided to review the detail behind the premium methodology for 2015 such as expenses, fees and additional adjustments to 2014 premium rates. As noted within the Findings Report, this component of the market represents approximately 10% of the total enrollment within the two states.

The applicant is still considering expanding coverage into eight counties in far western Illinois. Per the applicant, people from this area go to hospitals in the Quad Cities as well as Dubuque, Clinton, Muscatine, Burlington, and the University of Iowa. Projections assume that "no geographic expansion will occur except potentially adding border counties in western Illinois (pending CMS and Illinois State regulatory authority) between 2017-2019" (P. 44). The applicant does not identify how much, if any, of the additional solvency loan funding would be used for expansion into Illinois.

Per the 7/18/2014 Findings Report, the initial estimates for the individual business are based on industry data and adjusted by the CO-OPs external actuary to fit COH's specific situation as the CO-OP is a start-up operation.

Tables 2 and 3 provide a comparison for the 2014 single age 27 premiums for the CO-OP versus competitors with the lowest premium product across one of the same rating areas in the Iowa and Nebraska individual Marketplaces, whereas, Tables 4 and 5 provide similar information in the Iowa and Nebraska small group Marketplaces. Highlighted areas denote the lowest premium for the particular area. The data from the table is from www.healthcare.gov. Similar premium information for 2015 is not available.

Table 2: 2014 Premiums on the Iowa Individual Marketplace

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Bronze	Bronze	168.86	145.28	172.79	178.53	171.98	168.54	169.36
Coventry Health Care of Iowa Inc.								
Bronze Deductible Only HMO HSA Eligible Methodist Health Partners	Bronze				162.28			
Bronze Deductible Only POS HSA Eligible Patient Preferred	Bronze			157.94				
Bronze Deductible Only POS HSA Eligible UnityPoint Health	Bronze					133.48	132.22	140.15
Bronze Deductible Only POS HSA Eligible UnityPoint Health û Des Moines	Bronze	166.28	122.17					
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Silver	Silver	209.39	180.15	214.27	221.38	213.26	208.99	210.01
Coventry Health Care of Iowa Inc.								
Silver $10 Copay HMO Methodist Health Partners	Silver				209.23			
Silver $10 Copay POS Patient Preferred	Silver			203.65				
Silver $10 Copay POS UnityPoint Health	Silver					172.14	170.52	180.74
Silver $10 Copay POS UnityPoint Health û Des Moines	Silver	214.42	157.54					
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Gold	Gold	246.76	212.29	252.51	260.88	251.30	246.28	247.47
Coventry Health Care of Iowa Inc.								

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Gold $5 Copay HMO Methodist Health Partners	Gold				236.22			
Gold $5 Copay POS Patient Preferred	Gold			229.92				
Gold $5 Copay POS UnityPoint Health	Gold					194.37	192.53	204.08
Gold $5 Copay POS UnityPoint Health û Des Moines	Gold	242.10	177.88					
Avera Health Plans								
Avera MyPlan $250 / 10% Coinsurance	Platinum			385.12				385.12
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Platinum	Platinum	295.72	254.42	302.61	312.65	301.17	295.16	296.59
Gundersen Health Plan, Inc.								
Platinum $500 - 20%	Platinum						407.13	407.13
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Catastrophic	Catastr-ophic	154.09	132.57	157.68	162.91	156.93	153.79	154.54
Coventry Health Care of Iowa Inc.								
Catastrophic 100% HMO Methodist Health Partners	Catastr-ophic				110.64			
Catastrophic 100% POS Patient Preferred	Catastr-ophic			107.67				
Catastrophic 100% POS UnityPoint Health	Catastr-ophic					90.96	90.10	95.50
Catastrophic 100% POS UnityPoint Health û Des Moines	Catastro phic	113.33	83.27					

Table 3: 2014 Premiums on the Nebraska Individual Marketplace

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus $4750 HDHP Bronze	Bronze	161.58	161.58		
CoOportunity Health					
CoOportunity Premier HSA Bronze	Bronze	205.85	164.49	153.30	152.92
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus $1500 HDHP Silver	Silver	210.13	210.13		
CoOportunity Health					
CoOportunity Premier HSA Silver	Silver	240.98	192.56	179.45	179.01
Blue Cross and Blue Shield of Nebraska					
BlueEssentialsPlus $1000 Gold	Gold	329.62	329.62	329.62	329.62
CoOportunity Health					
CoOportunity Premier HSA Gold	Gold	280.75	224.33	209.08	208.55

Insurer and Product Name	Metal/Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Coventry Health Care of Nebraska Inc.					
Gold $5 Copay HMO Methodist Health Partners	Gold	251.81			
CoOportunity Health					
CoOportunity Premier Platinum	Platinum	333.00	266.10	247.99	247.37
Blue Cross and Blue Shield of Nebraska					
BlueEssentialsPlus $6350 Catastrophic	Catastrophic	157.57	157.57	157.57	157.57
CoOportunity Health					
CoOportunity Premier Catastrophic	Catastrophic	191.26	152.83	142.42	142.08
Coventry Health Care of Nebraska Inc.					
Catastrophic 100% HMO Methodist Health Partners	Catastrophic	113.51			
Catastrophic 100% POS Plan	Catastrophic	133.18	128.81	129.60	133.18

Table 4: 2014 Premiums on the Iowa Small Group Marketplace

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Avera Health Plans								
Avera $2,000 / 50% coinsurance	Bronze			265.61				265.61
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Bronze	Bronze	151.12	130.01	154.63	159.77	153.90	150.83	151.55
Gundersen Health Plan, Inc.								
Bronze HSA $5000 - 30%	Bronze						196.05	196.05
Health Alliance-Alegent Creighton Health Partner								
Guide HMO QHDHP 3150/6300 40% 6350/12700 Rx3	Bronze				220.53			
Sanford Health Plan								
Simplicity $3,000	Bronze			214.11				214.11
Avera Health Plans								
Avera $2,000 / $4,000 Out-of-Pocket	Silver			262.68				262.68
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Silver	Silver	190.32	163.74	194.75	201.21	193.83	189.95	190.87
Gundersen Health Plan, Inc.								
Silver HSA $2000 - 20%	Silver						262.28	262.28
Health Alliance-Alegent Creighton Health Partner								
Guide HMO 30/60 2400/4800 30% 6000/12000 Rx3	Silver				247.21			
Sanford Health Plan								

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4	Rating Area 5	Rating Area 6	Rating Area 7
Simplicity $2,000	Silver			263.14				263.14
Avera Health Plans								
Avera $750 / 30% coinsurance	Gold			316.34				316.34
CoOportunity Health								
CoOportunity Preferred HSA UI Health Alliance Gold	Gold	220.50	189.70	225.63	233.12	224.57	220.07	221.14
Gundersen Health Plan, Inc.								
Gold $2000 - 0%	Gold						304.59	304.59
Health Alliance-Alegent Creighton Health Partner								
Guide HMO 25/50 1600/3200 10% 4000/8000 Rx2	Gold				302.14			
Sanford Health Plan								
Simplicity $1,500	Gold			297.18				297.18
Avera Health Plans								
Avera $250 / 10% coinsurance	Platinum			361.49				361.49
CoOportunity Health								
CoOportunity Preferred UI Health Alliance Platinum	Platinum	257.55	221.57	263.54	272.28	262.29	257.04	258.29
Gundersen Health Plan, Inc.								
Platinum $500 - 20% $15 OV	Platinum						335.17	335.17
Sanford Health Plan								
Simplicity $500	Platinum			337.22				337.22

Table 5: 2014 Premiums on the Nebraska Small Group Marketplace

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 403 HDHP Bronze	Bronze	201.85	201.85	195.85	209.84
CoOportunity Health					
CoOportunity Premier HSA Bronze	Bronze	213.70	170.72	159.07	158.67
Coventry Health Care of Nebraska Inc.					
Bronze Essential #2 HMO Plan S	Bronze	272.62	263.67	265.29	272.62
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 402 HDHP Silver	Silver	255.28	255.28	247.70	265.39
CoOportunity Health					
CoOportunity Premier HSA Silver	Silver	251.74	201.11	187.38	186.91
Coventry Health Care of Nebraska Inc.					
Silver Security #2 HMO Plan S	Silver	314.39	304.07	305.95	314.39
Blue Cross and Blue Shield of Nebraska					
SelectBluePlus Option 401 Gold	Gold	355.81	355.81	345.24	369.90

Insurer and Product Name	Metal/ Tier	Rating Area 1	Rating Area 2	Rating Area 3	Rating Area 4
CoOportunity Health					
CoOportunity Premier HSA Gold	Gold	289.57	231.33	215.54	215.00
Coventry Health Care of Nebraska Inc.					
Gold Freedom #3 HMO Plan S	Gold	368.21	356.12	358.31	368.21
Health Alliance-Alegent Creighton Health Partner					
Guide HMO 25/50 1600/3200 10% 4000/8000 Rx2	Gold	287.01	275.64		
CoOportunity Health					
CoOportunity Premier Platinum	Platinum	339.35	271.10	252.60	251.96

The IID published a sample of 2015 Iowa individual silver plan premiums. Based on this sample, COH will be between 9.9% and 30.0% more than the least expensive plan in rating area 1. COH will be at least 24.8% and as high as 84.9% more than lowest cost plans in all other rating areas. The CO-OP has the highest cost plan in rating areas 2, 4, and 5. Sample data is based on non-tobacco premium rates for individuals age 27 for silver level plans.

The Nebraska DOI published a sample of 2015 Nebraska individual premium rates that show COH will be approximately 23.7% more than the least expensive plan for a 30 year old on a silver plan in Omaha. However, the CO-OP does have the lowest rates for 30 year old non-tobacco users on silver plans in Norfolk, Lincoln, and Hastings.

The Iowa Insurance Division also published review decision on COH's rate proposal. In the letter, dated October 8th, the IID noted COH submitted a supplemental rate proposal request dated September 4th. In this request the CO-OP has requested an average rate increase of 19% instead of the original 2015 rate request that showed an average increase of 14.3%. The company stated "*The original rate increase request for 2015 was based on claims experience which lacked sufficient credible information on which to base trend estimates and projected member movement from the entire insured and uninsured population. As claims experience developed in 2014 and more data became available, the carrier demonstrated that the claims experience is considerably higher than was projected in the initial rates filed in 2013. Therefore, a significant portion of the rate request is due to higher than expected claims experience.*" It was not clear from the detail provided within the application that COH had submitted a revised rate filing to the State which included higher premiums than the original 2015 rate filings. Further, it is unclear if the updated 2015 rate filing analysis was used in the development of the pro formas.

Summary of Observations:

- **COH submitted a supplemental premium rate increase for 2015 individual rates in Iowa dated September 4th, 2014**. The initial rate increase was for 7.0% and 12.3% for the Premier and Preferred products; however, the updated request was for 15.6% and 21.2%. It is unclear if the updated premium rates are reflected in the pro formas. The pro formas were provided in aggregate without breakouts by state or market. The sample rates provided by IID show COH is not the lowest cost plan in any Iowa region.
- **COH is projecting a $60.4M loss in 2014.** Pro formas include a $25M PDR, but no details were provided to support this amount. The PDR impacts the applicant's surplus and ultimately impacts the amount requested from COH.
- **2015 premiums will increase compared with the 2014 premiums.** According to the applicant, 2014 enrollment was much higher than anticipated. For the Iowa individual market, COH's proposed rates effective January 1, 2015 reflect a 7.0% and 12.3% rate increase for the Premier and Preferred products, respectively, and for Nebraska individual market, proposed rates reflect a 7.9% rate increase for the Premier product. However, based on the Iowa published Individual rate decision, COH received a 19% average rate increase based on a supplemental rate proposal dated September 4th. It is unclear if the pro formas include updates for this supplemental rate increase. For the Iowa small

group market, COH proposes a 3.9% and 8.6% rate increase for its Premier and Preferred products, respectively. No information was provided about rate increases for the Nebraska small group market. COH has not addressed its strategy for retaining members while considering a rate increase of upwards of 10%. Additionally, it is not clear if the rate increases will be enough to produce a profit in 2015.

- **Change in products in 2015.** COH will be terminating its Choice Product at the end of 2014 and introducing its CorePlus product during 2015 in the Iowa small group market. No explanation was provided in the 2015 rate filing for these changes in products. Insufficient detail was provided in the application so the impact on enrollment cannot be determined. COH will also be terminating business in the Iowa Marketplace Choice Plan (IMCP) and the off Marketplace Iowa individual market as well as eliminating Platinum plans effective 1/1/2015.
- **Changes to small group premiums could not be determined.** The 2015 individual rate filing memorandum for Nebraska small group and Iowa small group was not provided. This document typically provides the detailed reasoning for changes from the prior year premiums. Additionally, the pro formas do not provide premiums for each market. The pro formas were provided on a combined basis for all lines of business.
- **The 2015 small group rate filing includes a breakdown of taxes and fees, which does not include an estimate for the health insurer fee.** Milliman published a research report titled " ACA Health Insurer Fee – Estimated Impact of the US health insurance industry," dated April 2013, which states the 2014 health insurer fee estimate is 1.7% to 2.4% and increases to 2% to 2.9%. Since COH is a 501c(29) not-for-profit entity, the insurer fee estimate would be lower than the industry average. COH does not include an estimate for the health insurer fee; however, it includes an estimate for Marketplace fees associated with selling plans on the Marketplace. The CO-OP assumed 1.3% of premiums for this fee.

3. <u>Medical Costs and Losses:</u>

COH's pro formas show combined medical loss ratios, including the impact of the 3Rs and other ACA adjustments, of 128.5%, 112.3%, and 99.7% for years 2014, 2015 and 2016, respectively. It is unclear how the applicant arrived at these MLR estimates as the details provided in the pro formas indicate MLRs of approximately 92.9%, 91.4%, and 89.6% for years 2014, 2015, and 2016, respectively. The COH pro forma financials for Iowa (IA) and Nebraska (NE) business were provided on a combined basis for all lines of business. COH has revised estimates including receivables for risk adjustment, reinsurance and risk corridors based on 2014 membership and emerging experience through August 2014 (P. 9). The largest receivable is risk corridors with $87.7M in receivables estimated for 2014 (P. 72). Including the receivables for the 3Rs (risk corridors, risk adjustment, and reinsurance) for 2014 would result in a $60.3M loss and result in an MLR of 92.9%, including the impact of the ACA adjustments, if projections are realized. Removing the estimated $149.6M in 3R receivables would result in a $210M loss and increase the MLR, excluding any adjustments for the 3Rs or other ACA adjustments for all products combined to 138.0%. The 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit.

Based on a review of the regulatory filing as of 6/30/2014, the MLR is approximately 93.1%, excluding any impact of the ACA, resulting in a loss of $13.4M. It should be noted that in the 2Q14 regulatory filing, COH netted the cost sharing reductions ("CSR") with claims in error, affecting the MLR. The result would be an increase in claims from those reported in regulatory filing. Typically, two quarters' experience cannot be extrapolated to the entire year and, therefore, more months of experience will be needed to make a conclusion. For comparison, the pro formas show a 2014 loss of $60.3M, including the impact of 3Rs. This may indicate the CO-OP assumes to lose more money in the second half of 2014 than the first half of 2014. It is not clear from the detail provided whether the CSR was built into the pro formas for 2014. The CO-OP is projecting the 2014 MLR to be approximately 138%, excluding any impact for the 3Rs or other ACA adjustments. Please refer to CO-OP Financials section for additional information.

The feasibility study acknowledges that the risk corridors receivable of $87.7M included in this solvency loan request is "substantially higher" than June 2014 projections of $41.4M and indicates that some claims were "inadvertently excluded" in the data provided by COH for the risk corridors calculation for the prior projections (P. 14). Details on the calculation of the risk corridors were not provided in this application. Additionally, COH indicates that the largest current cash claims loss ratios are coming from three areas – the Iowa Marketplace Choice Plan (IMCP), platinum plans, and the off

Marketplace Iowa individual market (P. 38). The CO-OP is terminating this business effective 1/1/2015. The solvency request indicates these lines of business total 11,500 members. COH has assumed claim decreases of 3% from exiting the IMCP program and an additional 20% from the improved morbidity in the single risk pool (P. 13). The pro formas do show improvement in the MLR from 2014 to 2015, but specific details for these lines of business are not provided. Additional analysis on how COH determined the 20% morbidity improvement factor was not provided.

COH acknowledges the need for reinsurance to avoid significant annual fluctuations in claims that could threaten solvency (P. 18) and has secured 2 year policy coverage with Partners Re which has an attachment point of $500,000 for both individual and small group (P. 59). The federal reinsurance program has a cap of $250,000; therefore, there is a gap in reinsurance coverage between $250,000 and $500,000.

The June 2014 submission did not include a PDR. The current pro formas indicate that the CO-OP has set up a PDR of $25M for 2014. However, COH did not provide an explanation of the PDR or any of the underlying figures that went into the calculation. This figure does directly impact solvency amounts and the request for additional solvency loans.

COH does not have enough experience in the base period to use in rate development; therefore, the 2015 rate development is based solely on manual rates.

Summary of Observations:

- **2015 medical costs are based on industry data**. COH does not have enough 2014 experience to have data to rely upon; therefore, industry assumptions are necessary to estimate the morbidity of the projected membership.
- **The 3Rs receivables are difficult to quantify.** This is because of the uncertainty of the industry average morbidity which is needed to accurately estimate risk adjustment. Risk corridors is calculated after risk adjustment and, therefore, relies upon the risk adjustment estimate. Without these receivables, COH would have a loss of $210M for 2014 instead of the $60.3M projected in the pro formas.
- **Reinsurance is identified as a strategy, however contract leaves a gap in coverage.** An attachment point of $500,000 for both individual and small group will leave a gap in coverage between $250,000 and $500,000 due to the federal reinsurance cap.

4. <u>CO-OP Financials:</u>

In the base case, COH projects a $60.3M net loss during 2014 after projected $144.9M of 3R net recoveries. From 2014-2016, the CO-OP expects cumulative recoveries of $79.4M in federal reinsurance, $203.9M in risk corridors and $8.7M in risk adjustments, totaling $291.9M. Even with the $291.9M in recoveries, the CO-OP is still projecting to lose $77.6M during those years. Under the stress case scenario, COH is projected to lose $87.4M from 2014-2017 that includes the 3R recoveries of $323.8M. The CO-OP is expecting cumulative recoveries of $81.6M in federal reinsurance, $233.5M in risk corridors and $8.7M in risk adjustments totaling $323.8M from 2014 through 2016. However, without the 3Rs, COH will incur a cumulative net loss of $369.5M in the base case and $411.1M in stress test during 2014-2016, respectively. Throughout the life of the loan, COH is projected to keep its RBC levels above 500% of ACL under all scenarios presented by the applicant, assuming projections are realized.

According to the applicant, the Iowa Commissioner of Insurance has been reviewing the risk profile of COH throughout the year and has indicated "he anticipates that it will be necessary for him to require COH to increase its capital and surplus at some point in the third quarter of calendar year 2014" (P. 64). No further information has been provided. It is also unclear if this discussion took place before COH received the additional $32.7M award of solvency loan funds in September 2014 as a result of the prior round of solvency loan requests in June2014. COH has requested additional solvency loan funding of $55M in light of higher than projected enrollment, delay in receipt of 3R receivables and higher than expected claim costs. Combined with the current solvency loan funding award, the total solvency loan for COH would be $185.9M. However, the request of $55M would result in a total solvency loan amount of $185.6M, but the pro formas are based on a loan of $185.9M which is the amount on which this review will be based. The applicant asserts that "if the risk corridor program is not available in 2015 and 2016, we project COH total solvency loan to be $300.7M" (P. 9).

Under the stress test scenario, COH requires an additional $9.7M in solvency loans, totaling $195.6M. COH expects to start repayment of interest on the solvency loans in 2019, and will begin payments of interest and principal in 2021. COH projects to continue making annual repayments through 2032, until the loan is paid in full, if projections are realized. COH states it "will have sufficient capital to repay its solvency loans within fifteen years of its specific draw down dates while meeting State reserve requirements and solvency regulations" (P. 12). Conversely, COH's ability to repay the $3.6M in start-up loan funding due in 2017 relies on the receipt of 3Rs receivables totaling $291.9M from 2015-2017, the $55M in solvency funding and its ability to maintain enrollment despite a projected average premium increase of 9%, 22% and 21% in 2015, 2016 and 2017, respectively. See further detail in the Product Pricing section.

In addition to the requested solvency loan request from CMS, COH also applied with National Cooperative Bank in Washington for a $68M cash flow operating loan for 2014-2017 to cover short term working capital that results from delays in the federal reinsurance program. The loan is contingent upon COH receiving additional solvency loans from CMS and the external party obtaining "a senior, secured position in Transitional Reinsurance receivables" (P. 63). In its application for additional solvency loan funding, the applicant stated that "the collateral in the form of an account receivable is created as claims are incurred and is not dependent upon market averages or future data. The asset is a federal receivable from CMS although to be usable as collateral it will require written assignability from the holder to the lender which will require a CMS waiver" (P. 42). COH projects to receive approximately $48.5M in recoveries from the federal reinsurance program for 2014 to be used as collateral. However, COH built both its base and stress case scenario under the assumption COH will receive additional solvency and private funding in 2014. Subsequently, the cash flow statement shows COH taking drawdowns from the private loan during 2015 and 2016 while making annual payments through 2017. However, since COH does not turn a profit until 2018, repaying the private loan appears to require recoveries from the 3Rs and solvency loan funding to payback both the private loan and loan to CMS.

Per the Loan Tracker, the CO-OP has been awarded total funding of $145.3M ($14.7M in start-up loans $97.9M in solvency loan funding and $32.7M from the latest round), and began issuing health insurance products beginning in 2014. Of the $130.6M of solvency loans, $97.9M disbursed as of October 3, 2014. A review of the original application indicates the solvency loan disbursement of $97.9M was to be disbursed from 2013-2020. The current pro formas are projecting $185.9M to be disbursed from 2013-2017. In addition to the $32.7M that was dispersed in September 2014, the CO-OP, if awarded the $55M, is requesting to receive; $30.2M in 2014, $5M in 2015, $9M in 2016 and $11M in 2017. Instead of taking the lump sum in 2014, COH has requested to receive distribution over 4 years; this appears to cover the shortfall in cash the CO-OP will suffer from due to payments of the startup loans and private loans. If COH doesn't receive any additional funding and the 3R payment of $144.9M is not received till Q3 2015, CMS may want to consider that COH could suffer from a liquidity issue. Not enough information was provided to substantiate the need and as a result, the impact on its pro formas cannot be assessed.

Base Case

If projections are realized, COH expects losses of $60.3M, $15.2M and $2.1M from 2014-2016, while breaking even in 2017. However, absent recoveries from the reinsurance program, COH projects to incur losses of $205.2M, $107.2M and $57.1M from 2014-2016, while still breaking even in 2017. Once COH reaches 2018, the CO-OP projects cumulative profits of $546.5M for the remainder of the loan from 2018-2034.

COH projects an MLR with 3Rs of 93.3% in 2014, 90.4% in 2015, and 87.9% in 2016 which does not include the impact of the ACA adjustments. COH projects to recover $48.5M, $19M, and $11.9M of its incurred claims from federal reinsurance programs in 2014, 2015, and 2016, respectively. Absent the level of reinsurance recoveries and excluding the impact of the ACA, the MLR for 2014, 2015, and 2016 is projected to be 139.1%, 114.2%, and 99.2%, respectively. It should be noted that in the 2Q14 regulatory filing, COH netted the cost sharing reductions ("CSR") with claims in error, affecting the MLR. With the impact of CSR excluded from claims, the MLR would be 103% at June 30, 2014. It is unable to be determined if COH also netted the CSR in the pro formas. See further comments in the Medical Costs and Losses section.

In the pro formas, COH's ACR is 20.4% in 2014, 18.3% in 2015 and 16.6% in 2016. The ACR ranges from 20.4% down to 13% in 2034, with an average ACR of 14% from 2014-2034. The decrease in administrative expenses is not substantiated or explained in the application. The administrative budget is comprised of Salary/Wages/Benefits, Travel, Equipment, Supplies, Contractual and Other Budgeted Items. The largest expense is contractual expenses related to HP which accounts for 49%, 55%, 57%, respectively from 2014-2016. No further information was provided as to whether these functions would eventually be brought in house or continue to be outsourced.

Stress Test

The stress test scenario projects the financial impact COH would encounter if it incurred a 10% increase in claim costs in 2015, before returning to baseline levels in 2016. The claim spike led to a $9.7M increase in solvency request from approximately $185.9M to $195.6M. Then, in 2028, COH increases its revenue by $11.1M or 1% with no other changes from the base case scenario.

The stress test projects COH to commence profitability in 2018, with a gain of $18.9M, after sustaining losses of $87.4M from 2014 through 2017. The CO-OP projects a cumulative net income of $556.3M from 2018 to 2034, with RBC levels projected to stay above the CMS recommended level of 500% of ACL through 2034. COH projects to continue to make annual repayments through 2032, until the loan is paid in full, if projections are realized. However, COH's ability to repay its loans relies on its 3R recoveries and its ability to maintain its enrollment figures despite a projected premium increase of 9%, 22% and 21% from 2015 to 2017, respectively.

COH projects a MLR with 3Rs of 93.3% in 2014, 93.1% in 2015, and 87.9% in 2016 this does not include the impact of the ACA adjustments. COH projects to recover $48.5M, $21.2M, and $11.9M of its incurred claims from federal reinsurance programs in 2014, 2015, and 2016, respectively. Absent the level of reinsurance recoveries and excluding the impact of the ACA, the MLR for 2014, 2015, and 2016 is projected to be 139.1%, 125.7%, and 99.2%, respectively. It's likely that similar to the base case, COH has netted the CSRs and claims together, but this assumption cannot be confirmed with the information provided.

Summary of Observations:

- **Potential liquidity issue:** Based on the pro forma cash flow statement, if COH doesn't receive any additional funding and the 3R payment of $144.9 are not received until Q3 2015, CMS may want to consider that COH could suffer from a liquidity issue. Not enough information was provided to substantiate the need and as a result, the impact on its pro forma financials cannot be assessed.
- **COH's enrollment assumption:** The pro formas indicate COH will be able to repay its solvency, start-up and private loan, if projections are realized. However, it is not clear how COH projects maintain its membership projections for 2015, 2016, and 2017 with the projected increases in premium rates of 9%, 22% and 21% respectively.
- **Solvency loan funds being used to pay Start Up and Private loans.** Since COH doesn't turn a profit until 2018, it appears COH will be using solvency loans to help pay off its start-up and private loans from 2015-2017**.**
- **Potential request for more solvency loan funding from Iowa Insurance Division: According to the applicant,** the IID has been in contact with COH about its risk profile and likely needs more solvencies in 3Q14. No further information was provided. Also, it's unclear if that discussion took place before or after the $32.7M in additional solvency was awarded to COH.
- **Unsubstantiated revenue increase in stress test:** The COH pro formas for the stress test have an $11M or 1% increase in premiums during 2028 that is not explained. It's unclear what is causing the unanticipated increase in premiums from the base vs stress case.

5. Contingency Plan:

COH considered the following options as part of its contingency plan:

- **Merger with another CO-OP. To gain additional solvency, COH considered merging with another CO-OP and utilizing its unused capital for operations.** However, "no CO-OPs have been approached for such an arrangement to date" (P. 63/64)
- **Merge or affiliate with another large healthcare entity.** COH contemplated merging or affiliating with a large healthcare entity, unfortunately, due to "its liquidity challenges yet unresolved." (P. 64), no interest was identified in the market.
- **Enrollment cuts.** Excluding the already removed business lines from the base case, COH has determined no other business units can be terminated. The CO-OP believes if they were to cut the off Marketplace individual business in Nebraska, it would have a "catastrophic effects on distribution channels and is tantamount to a shutdown but at greater cost over a longer time" (P. 64).However, no information was provided to substantiate this claim.
- **Shutdown operations.** If no additional solvency loans are awarded, COH believes its only viable option is to shut down operations. It has exhausted all aforementioned options (P. 64).

After assessing the options, in the event no loan award is made, COH believes the only realistic alternative is to shut down operations starting November 1st, 2014, after notification of loan decision. COH provided a financial forecast showing cash flows and enrollment numbers through 2015. However, this was not submitted to Milliman for review, thus not included in the actuarial certification. The financial forecast is based on closing individual enrollment for 2015 while maintaining small and large group through the anniversary date, ceasing coverage completely in October 2015. The projected forecast shows that COH believes it can pay back the start-up and solvency loans to CMS, if the projections are realized. However, the ability to pay back the loans hinges on the 3R payments in 3Q15.

Summary of Observations

- **Private loan is contingent on CMS funding and a senior secured position.** The private loan COH is attempting to obtain is contingent upon CMS awarding additional solvency funds and the lender receiving a senior secured position on the transitional reinsurance receivable. Without those requirements, it is unlikely that COH can obtain the private loan. The effect on the pro formas cannot be determined.
- **If solvency funding is not provided, COH will shut down.** If no funding is awarded, COH will approach the DOI to begin shutting down operations as of 11/1/14 and any future losses will be covered by the guarantee fund (P. 81). COH will cease individual enrollment for 2015 while maintaining small and large group until the anniversary date hits in 2015 (P. 81). In the application, COH provided a financial forecast of enrollment and cash flow for the next 14 months. The forecast predicts that COH will be able to repay its CMS loans if projections are met.

Solvency Loan Request Points

Sections	Potential	Total
Enrollment	15	10.25
Product Pricing	20	10
Medical Costs and Losses	15	11
CO-OP Financials	15	8
Score	**65**	**39.25**

Contingency Plan Points

Contingency Plan	Potential	Total
Overall	10	0
Score	**10**	**0**

Kentucky Health Cooperative, Inc.
Additional Solvency Loan Funding Request Report
Date Submitted to CMS: 10/09/2014

Scope Summary & Assumptions:

- Deloitte will not provide an opinion regarding the reasonableness of the proposed changes to each CO-OP's business plan. Nor will Deloitte provide an opinion regarding the likelihood of each CO-OP achieving sustainable operations based upon the revised business plan.
- Deloitte assumes that the information provided by each CO-OP in its modified business plan is complete and accurate. Deloitte will perform its assessment of the data provided "as is". Deloitte will also use other data sources that are publicly accessible or information provided directly from the Centers for Medicare and Medicaid Services (CMS). Deloitte will notify CMS if we believe that there is insufficient information to complete our review.
- In these applications for solvency loan requests, the CO-OPs have cited a need for additional solvency loans to cover projected cash shortfalls as a result of nonadmitting risk-sharing receivables provided in the Affordable Care Act (ACA). The National Association of Insurance Commissioners (NAIC) is charged with developing accounting guidance for these risk-sharing provisions which are utilized by the state departments of insurance in monitoring the financial solvency of the insurers domiciled in their state. The NAIC is continuing their deliberations on this issue, which previously included potential nonadmittance for risk-sharing receivables in excess of any payables. However, as a result of the most recent NAIC meeting on August 17, 2014, the adopted minutes of that meeting reflects that the NAIC is "replacing the nonadmission guidance with criteria that incorporates conservatism and sufficiency of data and removing the exposed 90-day guidance and adding language to be consistent with other government receivables". This Findings Report will provide relevant information, as necessary, on the accounting treatment for the risk-sharing receivables used by the CO-OPs in their financial projections.
- The impact of the Reinsurance, Risk Adjustment and Risk Corridors Program (the 3Rs, reinsurance, risk adjustment, and/or risk corridors) was reviewed when making observations and comments throughout this report. Observations and comments relating to the impact of the 3Rs are included for informational purposes only. We are not commenting on the reasonableness or propriety of any of the amounts relating to the 3Rs. Nor are we commenting on the underlying accounting policy. Based on the scoring criteria provided by CMS, observations and comments relating to the 3Rs had a net neutral effect on the scoring.
- In reviewing applications from CO-OPs for additional solvency loan funding requests, Deloitte reviewed supporting documentation requested of the applicants by CMS in a memo to the CO-OPs distributed on August 22, 2014. The format of the reports as well as the section scoring was approved by CMS during the week of June 2, 2014. These reports are scored on the basis of a total of 65 points, plus 10 points for the contingency plan. The scoring reflects Deloitte's assessment of the degree to which the application complies with the funding loan announcement of August 22, 2014. The score for the Contingency Plan

section should be viewed independently of scoring for the other sections of this report. For all sections, Deloitte provided comments on issues only for which the applicant provided data. Observations relating to the pro forma financial statements are based on the base case with additional solvency award scenario (base case), unless otherwise noted.

Executive Summary:

Kentucky Health Cooperative, Inc. (KYHC or the applicant or CO-OP) has submitted a request for additional solvency loan funding relating to KYHC's Kentucky operations. However, the application and underlying financials do not discriminate between projected Kentucky and West Virginia operations. Therefore, a distinction was unable to be made between the solvency loan funding needs for Kentucky and West Virginia in this report. Any additional solvency loan funding received by the CO-OP is required to be aggregated with funds for West Virginia.

KYHC provided two versions of the base scenario; first, if the risk corridors receivable is treated as a nonadmitted asset, KYHC will request one of three potential funding options, each resulting a different level of RBC. Conversely, if the risk corridors receivable is admitted, KYHC requests two additional funding options. These two funding options are predicated on KYHC's ability to receive a private loan of $15M. There is no further information provided in the application as to whether the CO-OP will need to collateralize assets to obtain this private loan or whether it is contingent upon receiving additional solvency loan funds from CMS. In the event that KYHC does not receive private loan funding, KYHC will request the total "Solvency Loan Requested" amount for each option as outlined in Table 1 below. However, KYHC "acknowledges that receiving $103 million in funding just to maintain a RBC of 500% is not necessarily the correct solution" (P. 119). Presented in Table 1 below is a summary of the base case and each of the suggested funding options. See the CO-OP Financials and Contingency Plan sections for further details.

Table 1: Funding Options for 2014

Base Case 2014	Risk Corridors not admitted			Risk Corridors admitted		
Line	Funding Option 1	Funding Option 2	Funding Option 3	Funding Option 1	Funding Option 2	Funding Option 3
Solvency Loan Requested	103,000,000	69,100,000	45,000,000	103,000,000	69,100,000	45,000,000
Solvency Loan from CMS	103,000,000	69,100,000	45,000,000	N/A	54,100,000	30,000,000
Private Loan Proceeds*	-	-	-	N/A	15,000,000	15,000,000
Risk Corridors	74,609,827	74,609,827	74,609,827	N/A	74,609,827	74,609,827
RBC Level	500%	200%	< 200%	N/A	> 700%	> 500%
Enrollees	47,186	47,186	47,186	N/A	47,186	47,186
MLR with 3Rs	95.4%	95.4%	95.4%	N/A	95.4%	95.4%
MLR without 3Rs	161.3%	161.3%	161.3%	N/A	161.3%	161.3%

* Private loans will not be used in solvency calculation

The results under 'Risk Corridors admitted' are based on the assumption that the CO-OP will obtain a private loan. KYHC "acknowledges that receiving $103M in funding just to maintain a RBC level of 500% of ACL is not necessarily the correct solution" (P. 119)[1].

In practice, however, none of the funding options above represent the break even financial need of the CO-OP. The amount in solvency loan funding required by the CO-OP will also be affected by:

- Status of West Virginia start-up loan funding: KYHC was obligated $7,000,000 in start-up funding and $12,652,200 of solvency loan funds for West Virginia operations
- Impact of the 3Rs receivables
- CO-OP's access to a private loan
- KYHC's participation in open enrollment

KYHC has stated that "if additional solvency funding is not awarded, [KYHC] stand[s] ready to move our approximately 55,000 existing lives to other carriers and remove the health plan from the open enrollment as an unfortunate but appropriate option" (P. 118).

Based on CMS's CO-OP Summary Report by Borrower as of 10/3/2014 (Loan Tracker), the CO-OP was originally obligated $81,494,772 of start-up, and solvency loan funding and began issuing health insurance products beginning in 2014. As of 10/3/2014, a total of $78,933,123 has been disbursed, specifically $59,497,900 of obligated solvency loan funding and $19,435,223 of the $21,996,872 of obligated start-up loan funding. Out of these totals, KYHC was obligated $7,000,000 in start-up and $12,652,200 in solvency loan funding for West Virginia. Because this is a single entity, the start-up and solvency loan funds awarded for West Virginia operations have been commingled with the start-up and solvency loan funds initially awarded to KYHC. KYHC is currently requesting additional solvency loan funding because of higher than expected enrollment and primarily to address solvency issues caused by the treatment of the risk corridors receivable as a nonadmitted asset.

It is important to note that the applicant did not include a business plan with this solvency loan request. The most recent business plan available is out of date, submitted to CMS in May of 2014 for Kentucky, and October of 2013 for West Virginia, but they were used to the extent necessary in this review. The lack of an updated business plan for both Kentucky and West Virginia leaves information gaps regarding enrollment as well as necessary support for financial related observations. Materials provided by the CO-OP in the application, in addition to supplemental information that is publicly accessible or was provided by CMS, have been considered in this report. Differences, when observed within the materials, are noted within the report. Deloitte has not taken any actions to verify the accuracy of the data or reconcile any observed discrepancies between this application and data previously submitted by the CO-OP.

KYHC did not provide the breakout of Kentucky and West Virginia enrollees in the current solvency loan funding request. Therefore, all discussion of enrollment projections for all years refer to combined West Virginia and Kentucky membership. In addition, KYHC did not provide an updated enrollment strategy with this request and stated in the application that the information be referenced in the business plan submitted to CMS in May 2014. The term 'Marketplace' indicates that it is applicable to both the Kentucky and West Virginia Marketplaces. KYHC stated that it expects Kentucky-only enrollment to decrease in 2015 due to premium increases and the introduction of two new competitors in the Marketplace. It is unclear why the CO-OP expects these factors to negatively impact enrollment as the application states the CO-OP's individual rates for 2015 remain 5-25% below that of the lowest competitor. Insufficient information was provided to assess changes to Kentucky standalone enrollment in this report.

[1] Page numbers in this report refer to the consolidated application.

By including the 3R receivables, KYHC is projecting a loss of $22.5M, a profit of $513K, and $501K for 2014, 2015, and 2016, respectively. Without consideration of the 3R receivables, the CO-OP is projected to have losses of $139.3M, $63M, and $7.2M for 2014, 2015, and 2016, respectively. If the benefit of Affordable Care Act (ACA) adjustments is included, KYHC projects a medical loss ratio (MLR) of 96% in 2014, 81% in 2015, and 82% in 2016. Excluding the 3R receivables and the impact of the ACA adjustments, the MLR for 2014, 2015, and 2016 is projected to be 161%, 86.8%, and 86%, respectively. KYHC projects to recover $115.5M, $10M, and $8.1M from the 3Rs recoveries in 2014, 2015, and 2016, respectively. KYHC has increased premiums for 2015 from 2014 in order to adjust for enrollment of high-risk populations, among other things, and plans to deploy medical management strategies. However, KYHC did not provide sufficient information to analyze these strategies.

As stated above in the Scope Summary and Assumptions section, pending accounting guidance relating to accounting treatment has been updated to reflect risk corridors receivables as an admitted asset as long as there is supporting documentation. Kentucky's solvency loan funding application is conservative and reflects $74.6M in assets that it is currently reporting as nonadmitted. The CO-OP's position for accounting treatment relating to these receivables does not reflect the current direction of NAIC. However, it is also noted that the NAIC has not issued final guidance, which is expected in November 2014. If projections are realized, it is apparent that if the accounting rule is not resolved in KYHC's favor by year end 2014 and no further solvency loans are awarded, the CO-OP will have both critical liquidity and solvency issues.

If the funding options presented in Table 1 above are not awarded, KYHC proposes delaying its West Virginia implementation from 2015 to 2016 and converting $5M of start-up funds into solvency loan funds in order to reduce its funding request from $54.1 to $49.1M. KYHC did not provide the pro forma financial statements for the other contingency scenarios outside of the base case where it projects to receive $103M in solvency loan funds. Therefore, the impact of the additional scenarios on its pro forma financial statements cannot be assessed.

The CO-OP states, "KYHC was awarded their start-up and solvency loans for both the initial request and the West Virginia expansion based on the 2017+ Adverse Experience scenario (3% unanticipated increase in claims every fourth year) that was included in their original feasibility analysis. Because of this, it was necessary (and still appropriate) to use this scenario as the baseline scenario so that the results of this feasibility analysis could be used to isolate the change in solvency loans necessary to operate at 500% RBC given emerging 2014 claims and membership experience. " (P. 17). This makes it difficult to review the solvency for the true baseline projections. Solvency loans needed under an alternative stress scenario would be larger than under a base case scenario. Applications for solvency loan funding were generally funded using a base case scenario.

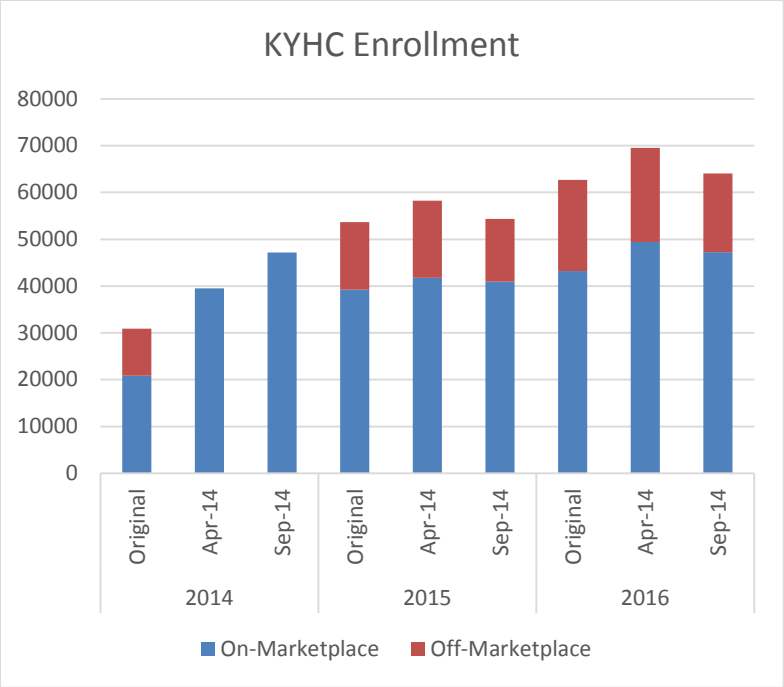
Critical Assertions:

1. <u>Enrollment:</u>

KYHC did not provide the breakout of enrollment between Kentucky and West Virginia with the current solvency loan request. While 2014 enrollment projections reflect membership in Kentucky only, projections for 2015 and 2016 also include enrollees from KYHC's operations in West Virginia, d/b/a West Virginia Health Cooperative, Inc.. KYHC's operations in West Virginia are projected to commence with 2015 open enrollment in November 2014.

Kentucky operates on a state-based marketplace, Kynect (Kentucky Marketplace). The operations for West Virginia, involve a state-partnership marketplace (West Virginia Marketplace). The term 'Marketplace' indicates that it is applicable to both the Kentucky and West Virginia Marketplaces.

Figure 1: September 2014 Enrollment Projections exceed Original Projections



Source: Original 2011 pro formas. 10/2013 pro formas, 5/2/2014 pro formas, and 9/22/2014 pro formas

Based on KYHC's most recent pro forma financial statements submitted in September 2014 (9/22 Pro Formas or pro formas), enrollment for 2014 is expected to be 53% more than original application projections[2] (2011 Pro Formas) and 19% more than enrollment projections in a business plan provided to CMS in May 2014 (5/2 Pro Formas). Despite exceeding the original projections of total 2014 enrollment, KYHC did not achieve expected off Marketplace or Small Business Health Options Program (SHOP) enrollment. In the 2011 Pro Formas, KYHC projected to enroll 10,085 members in Kentucky off Marketplace in 2014 but pro formas submitted with this solvency loan request and the 5/2 Pro Formas indicate the CO-OP has no off Marketplace enrollment[3]. The lack of off-marketplace enrollment in 2014 is consistent with the data reported in the CMS CO-OP Enrollment Comparison Report as of August 5, 2014.

KYHC stated in the application that it expects 13,000 enrollees in West Virginia in 2015, although this information was not reflected in the pro formas. Based on this figure, KYHC is expecting 41,346 enrollees in Kentucky in 2015. This represents a 12% decrease from 2014 average enrollment levels in Kentucky. The breakout of on and off Marketplace enrollment and the breakout of individual and small group enrollment was not provided.

The application states that Kentucky only enrollment is expected to decrease from 2014 to 2015 for two reasons. First, there are two new entrants on the Kentucky Marketplace in 2015, CareSource Kentucky Co. and WellCare Health Plans of Kentucky, Inc.. Second, KYHC filed for a 15% rate increase for individual products offered on Kentucky Marketplace in 2015 in response to high medical costs in 2014. Despite stating in the application that Kentucky only enrollment will decrease in 2015, the 9/22 Pro Formas show a 15% increase in enrollment from 2014 to 2015.

Based on the 9/22 Pro Formas, KYHC expects to enroll 54,346 members in 2015 and 64,088 members in 2016, representing an 18% growth in membership from one year to the next. However, compared to the 5/2 Pro Formas, KYHC is expecting 7% fewer enrollees in 2015 and 8% fewer enrollees in 2016. Because a breakout of

[2] All references to "original" – including, but not limited to, "original funding application", "original application", and "original projects" – refer to KYHC's 2011 application for CMS start-up and solvency loan funding, operations commencing in 2011.
[3] Annual enrollment projections provided in the pro formas reflect average membership over a 12 month period.

enrollment data was not provided, it cannot be determined whether these decreases between projections impact Kentucky or West Virginia membership in 2016. See Documentation for Change in Enrollment Projections section below for further information.

Documentation for Change in Enrollment Projections

KYHC is requesting additional funding due, in part, to an increase in projected enrollment from the 2011 Pro Formas to the 9/22 Pro Formas and to cover higher than expected claims costs in 2014 (P. 4). The applicant attributes higher than expected enrollment in 2014 to its pricing and the elimination of 4,500 individuals from the state's high risk pool as of 12/31/2013. KYHC was the only carrier on the Kentucky Marketplace to offer a Platinum plan and the applicant believes that this product attracted a "high concentration of individuals with high costs associated with health status", specifically those terminated from the high-risk pool (P. 4). KYHC stated in the application that it captured 75% of Kentucky Marketplace enrollment in 2014. This estimate could not be independently verified. Please see the Product Pricing and Medical Costs and Losses sections for further details.

In its May 2014 business plan, KYHC cited competitors' "extensions of non-compliant plans" as the key factor in failing to enroll off the Kentucky Marketplace in 2014 (P. 3848). It is not clear from the business plan how this extension impacted off Marketplace business as enrollees in non-compliant plans would have otherwise been expected to enroll on Marketplace. No further detail was provided in the application to support this statement.

KYHC cited the delay of SHOP functionality for the lack of small group enrollment in 2014 although the CO-OP did not market these offerings (P. 3548). KYHC now projects to have off Marketplace and SHOP enrollment beginning in 2015. However, it is not clear from the information provided in which state KYHC intends to enroll these members or how the CO-OP plans to attract them to these products.

KYHC did not provide any detail on how it plans to achieve its target enrollment in West Virginia given the presence of a dominant insurer, Highmark, Inc. in the West Virginia Marketplace. Additionally, KYHC did not provide detail on how it intends to address challenges experienced in Kentucky in 2014 for 2015 West Virginia operations, with the exception of not offering a Platinum plan on the West Virginia Marketplace.

Table 2: Documentation for Change in Enrollment Projections

Reason Cited by KYHC for Changes in Enrollment	KYHC Proposed Action	KYHC Justification
Only Carrier Offering a Platinum plan on the Kentucky Marketplace	1. **Will not offer a Platinum plan in the West Virginia market in 2015**.	The Kentucky and West Virginia high risk pools were terminated in 2013. KYHC believes that the elimination of the risk pool in Kentucky put high-cost individuals onto the Kentucky Marketplace and that these individuals chose KYHC because it was competitively priced and the only carrier to offer a Platinum plan (P. 4). KYHC believes that by also eliminating the Platinum plan offering from the West Virginia Marketplace that the CO-OP can "avoid the likely adverse-selection of prior high risk pool enrollees" experienced in Kentucky (P.5). Kentucky will continue to offer a Platinum plan on the Kentucky Marketplace in 2015.
	2. **Raise individual premiums rates by**	According to the applicant, KYHC premiums "were not unreasonably lower or higher than other competitor's rates" in 2014 (P. 5). However,

Reason Cited by KYHC for Changes in Enrollment	KYHC Proposed Action	KYHC Justification
Price Competitiveness	**an average of 15% in Kentucky for 2015.**	KYHC states that it is raising individual rates to account for adverse selection in 2014. Please see the Product Pricing section for additional information. Despite this rate increase, KYHC expects to be the "lowest priced plan at between 5-25% below the closest competitor" in five of eight rating areas (P. 30). In the remaining rating areas, KYHC expects to be between 10-40% higher than the lowest priced competitor (P. 30). No documentation was provided to support these statements. It is unclear how KYHC intends to avoid adverse selection if it remains the lowest priced competitor on the Kentucky Marketplace. KYHC did not provide sufficient information to determine how this increase will affected individual enrollment levels in Kentucky. KYHC states that additional solvency needs are "not due to inadequate or inappropriate pricing" in 2014 (P. 5). This statement appears contradictory to the fact that KYHC will remain 5-25% below the lowest priced competitor and to the high medical costs experienced by the CO-OP to date.
	3. Raise small group premiums by an average of 6.5% in Kentucky for 2015	KYHC filed for an average 6.5% rate increase for small group products across all rating areas in Kentucky. KYHC states that its small group rates will be 0-10% higher on average than the lowest priced competitor. According to the applicant, this price position is an improvement from 2014, when the CO-OP's small group plans were priced 10-15% higher than the lowest priced competitor on average (P. 30). Insufficient detail was provided to determine how the CO-OP will raise its small group rates while also closing the price gap between KYHC and the lowest priced competitor.
Delay in SHOP functionality	4. **Increase marketing for small business product offerings.**	KYHC cited "SHOP design challenges" that "resulted in a slow start to participation by employer groups in the latter part of 2013" as explanation for the lack of small group enrollment in 2014 (P. 3548). The CO-OP noted that it decided to delay "aggressive marketing" of small group products off Marketplace as a result but did not provide further detail (P. 3548). KYHC did not provide detail on the change in off Marketplace small group enrollment. SHOP delays would be expected to impact small group enrollment on Marketplace only. The feasibility study states that KYHC expects a "one-year delay in our initially anticipated small group market behavior" and, therefore, is now projecting these members in 2015 (P. 27). No further information was provided on the impact of the delay in small group enrollment in 2015.
New entrants on Kentucky Marketplace	**5. No action proposed.**	KYHC stated in the application that the entrants of two new carriers on the Kentucky Marketplace will have a "noticeable impact" on Kentucky enrollment in 2015 (P. 30). The CO-OP did not substantiate this statement. It is unclear why the CO-OP expects these new carriers to

Reason Cited by KYHC for Changes in Enrollment	KYHC Proposed Action	KYHC Justification
		negatively impact enrollment given the CO-OP also states it will be priced 5-25% below the next lowest priced competitor in five of eight rating areas (P. 30). KYHC did not provide detail as to how the CO-OP plans to address additional competition in the Kentucky Marketplace despite stating that it believes the new entrants will impact enrollment levels.
Extension of non-compliant health plans	6. **Distribute advertisements to key audiences**	According to the applicant, off Marketplace individual enrollment was, in part, lower than expected due to the extension on non-compliant health plans in Kentucky. To address this issue in 2015, the CO-OP intends to "develop and implement retention programs aimed at retaining our individual market share and complete the build out of direct enrollment and lead generation programs designed to position the CO-OP competitively going forward" (P. 3849). No further detail was provided to support these plans in the May 2014 business plan. Further detail was not provided with the current solvency loan request. KYHC did not provide sufficient information to analyze the assertion that the extension impacted off Marketplace enrollment in 2014.

Summary of Observations:

- **Increased 2014 enrollment from 2011 and 5/2 Pro Formas.** KYHC exceeded original enrollment projections in both the original 2011 and May 2014 submissions by 53% and 19%, respectively. KYHC cites higher than expected enrollment as one justification for requesting additional solvency loan funding.
- **Decreased in projected 2015 and 2016 Kentucky enrollment from 5/2 Pro Formas.** KYHC is projecting a decrease in Kentucky only enrollment in 2015 due to premium increases and the entrance of two new competitors in the Kentucky Marketplace. It unclear why the CO-OP expects premium increases to negatively impact Kentucky enrollment since the CO-OP states it will be 5-25% below the next lowest priced competitor in five of eight rating areas in Kentucky. Further, it is unclear why the CO-OP expects these new carriers to negatively impact Kentucky enrollment given the CO-OP's price position (P. 30). Enrollment losses in Kentucky are partially offset by the introduction of enrollees from West Virginia in 2015 and 2016. KYHC stated in the application that it expects 13,000 members in 2015 from West Virginia operations (P. 3844).
- **Increased premiums planned for 2015 in Kentucky.** In response to higher than expected enrollment and the "adverse selection of prior high risk pool enrollees" in 2014, KYHC is raising premiums by an average of 15% in 2015 for individual products (P. 3548). Despite this rate increase, KYHC expects to be the "lowest priced plan at between 5-25% below the closest competitor" in five of eight rating areas (P. 30). No documentation was provided to support this statement. In the small group market for 2015, KYHC filed a 6.5% average rate increase with small group rates "approximately 0-10% higher than the lowest priced plans" (P. 30). Despite rate increases, KYHC expects its small group offerings to be "more competitive" in 2015 (P. 30). No detail was provided to support this statement.

- **Lack of detail around correction of adverse selection issues in Kentucky in 2015 and 2016.** KYHC stated that is requesting additional solvency loan funding to account for higher than expected medical costs (P. 4). Because KYHC also states that it will be the lowest priced plan by 5-25% on the Kentucky exchange in five of eight rating areas, it is not clear why the CO-OP expects it will avoid enrolling high-cost members in Kentucky, whom the CO-OP describes as "very sensitive" to price differences (P. 5). KYHC will also continue to offer a Platinum plan in Kentucky for 2015. In West Virginia, the CO-OP will not offer a Platinum plan to avoid enrolling individuals with high medical costs (P. 4).

2. <u>Product Pricing:</u>

KYHC's 2014 enrollment was almost 53% higher than projected in the 2011 Pro Formas and captured a market share of about 75% of Kentucky Marketplace enrollment (P. 4). According to the applicant, one of the contributing factors for the higher than anticipated enrollment is their rates being competitive and other carriers "adopting a thin network strategy of participating only in select regions (urban) or operating statewide with only a thin network" (P. 4). No further information was provided on issues related to network strategy. The state's high risk pool terminated enrollment of approximately 4,500 individuals effective 12/31/2013. KYHC was the only carrier to offer a Platinum plan in 2014 and, believes that because of this, the CO-OP enrolled a high concentration of individuals with high health costs (P. 4). The 2014 Kentucky Marketplace premiums were not published on the Kentucky Department of Insurance (DOI) website so no information could be obtained as to which insurers were offering products for the different tiers and who amongst them had the lowest rates.

Projected enrollment for 2014 is 47,186 and the CO-OP has enrolled 55,852 as of 6/30/2014 according to the Q2 regulatory filing (P. 15).

The CO-OP is raising premiums in 2015 on average by 15% for individual and 6.5% for small group products. Actual increases for specific plans range from 8% to 18.4% for individual and -2.2% to 11.9% for small group (P. 622 and 1084). There is no information available to confirm that the CO-OP was the lowest priced in one or more plans offered and how the other insurers compared against the CO-OP across the different tiers. Changes in premium rates between 2014 and 2015 being made by insurers in Kentucky are noted in Table 3 below. However, it is unclear what impact the rate increases by the CO-OP will have on existing members or how competitive the rates will be in the 2015 Kentucky Marketplace. KYHC has requested a 15% average rate increase in the Kentucky individual market and 6.5% average rate increase in the Kentucky small group market (P. 30). Rates across all individual market plans provided in 2014 are increasing in 2015 (P. 682). Small group rates are all increasing in 2015 except one (P. 1194).

The CO-OP states, "…KYHC was awarded their start-up and solvency loans for both the initial request and the West Virginia expansion based on the 2017+ Adverse Experience scenario (3% unanticipated increase in claims every fourth year) that was included in their original feasibility analysis. Because of this, it was necessary (and still appropriate) to use this scenario as the baseline scenario so that the results of this feasibility analysis could be used to isolate the change in solvency loans necessary to operate at 500% RBC given emerging 2014 claims and membership experience. " (P. 17). This makes it difficult to review the solvency loan request for the true baseline projections. Solvency loans needed under an alternative stress scenario would be larger than under a base case scenario. Solvency loan funding applications generally use a base case scenario.

In the Kentucky Marketplace, the CO-OP is not terminating any products being offered in 2014 and not adding any new products in 2015. However, the CO-OP does plan to begin doing business in West Virginia starting in

2015. Considering the worse than expected claims cost, the CO-OP is not providing a Platinum plan under the West Virginia Marketplace.

Per the application, KYHC is projecting a $22M loss in 2014 for existing KY operations. KYHC includes a $105k premium deficiency reserve (PDR) which is recovered in 2015 (P. 45). No details are provided to support the PDR established by the CO-OP. The PDR impacts the applicant's surplus and ultimately impacts the amount of solvency loan requested by KYHC.

For both small group and individual plans, changes to the overall premium level are needed, in part, because of required changes in federal/state taxes and fees. In addition, there are anticipated changes in the administrative expenses and commission arrangements. Taxes and fees are expected to contribute a 1.4% increase to 2014 premiums for individual and small group products (P. 681 and 1193).

The adjustments contributing to the total rate increase of 15% for individual are the following (P. 681):

- Total Paid Claims Trend / Benefit Change Factor / Morbidity Shift
- Administrative Expense Change Factor
- Transitional Federal Program Factor
- Federal and State Taxes & Fees Change Factor
- Profit Change Factor

The adjustments contributing to the total rate increase of 6.5% for small group are the following (P. 1193):

- Total Paid Claims Trend/Benefit Change Factor
- Administrative Expense Change Factor
- Transitional Reinsurance Benefit Factor (No Impact for Small Group Market)
- Federal and State Taxes & Fees Change Factor
- Profit Change Factor

The Kentucky Department of Insurance's website shows that the 2015 rate increases requested by the CO-OP for the individual and small group markets have been approved.

According to the applicant, Anthem Health Plans of Kentucky, Inc. was the dominant player in 2012 (P. 110). However, KYHC has captured a market share of about 75% of Marketplace enrollment during 2014 (P. 4). Table 3[4] below provides a comparison of rate changes approved for the different individual market and small group market plans approved by the Kentucky Department of Insurance. Per Table 3 below, Anthem Health Plans of Kentucky, Inc. are reducing rates whereas the CO-OP is increasing rates. Since 2014 rates were not provided, it cannot be determined whether the changes in these rates will put the dominant player from 2012 in a competitive position in 2015 or whether the CO-OP will still be the lowest priced competitor.

[4] Table Data Source: http://insurance.ky.gov/RateFil/

Table 3: 2015 Rate Changes in the Kentucky Individual and Small Group markets

State Tracking Number	Individual Market Plan	2015 Rate Change
2014-005414-R	CareSource Kentucky Co.	N/A (new)
2014-005575-R	CareSource Kentucky Co.	N/A (new)
2014-005485-R	WellCare Health Plans of Kentucky, Inc.	N/A (new)
2014-005572-R	Anthem Health Plans of Kentucky, Inc.	-4.30%
2014-005459-R	Anthem Health Plans of Kentucky, Inc.	-3.06%
2014-005415-R	Golden Rule Insurance Company	0.00%
2014-005501-R	Humana Health Plan, Inc.	12.80%
2014-005511-R	Time Insurance Company	15.00%
2014-005502-R	Kentucky Health Cooperative, Inc.	15.00%

State Tracking Number	Small Group Market Plan	2015 Rate Change
2014-005471-R	UnitedHealthcare of Ohio, Inc.	-1.70%
2014-005469-R	UnitedHealthcare of Kentucky, Ltd.	-1.00%
2014-005470-R	UnitedHealthcare Insurance Company	-0.70%
2014-005537-R	Time Insurance Company	5.00%
2014-005538-R	John Alden Life Insurance Company	5.00%
2014-005419-R	Bluegrass Family Health Inc.	5.50%
2014-005503-R	Kentucky Health Cooperative, Inc.	6.51%
2014-005529-R	Anthem Health Plans of Kentucky, Inc.	7.10%

Summary of Observations:

- **Removal of 3R recoveries for reinsurance would put KYHC in a loss position for 2014 through 2016.** Reinsurance recoveries were estimated to be $42M, $10M, and $8M in 2014 through 2016 respectively. These are federal and commercial reinsurance amounts combined as the CO-OP did not distinguish between the two in the application. The 2014 recoveries are 17% of net premiums and decreases to 1% in 2017. KYHC includes a $105k premium deficiency reserve (PDR) which is recovered in 2015 (P. 45). No details are provided to support the PDR established by the CO-OP. The PDR impacts the applicant's surplus and ultimately impacts the amount of solvency loan requested by KYHC.
- **Premium increases for 2015 in Kentucky.** According to the applicant's estimate, 2014 enrollment was much higher than anticipated due competitive rates. KYHC was the only carrier to offer a Platinum plan in 2014 and other carriers adopted a "thin network strategy of participating only in select regions (urban) or operating statewide with only a thin network." The CO-OP plans for increases in 2015 of 15% for individual and 6.5% for small group products. There is no discussion of a plan for retaining members as the premium increases take effect.
- **Enrollment strategy adjusted to reduce the enrollment of higher risk population.** The state's high risk pool terminated enrollment of approximately 4,500 individuals effective 12/31/2013. KYHC was the only carrier to offer a Platinum plan in 2014 and, believes that this factor contributed to the high concentration of individuals with high health costs (P. 4). KYHC raised the Platinum plan rates for 2015

in hopes of reducing the high risk population in the Kentucky Marketplace. KYHC will not be introducing a Platinum plan in the West Virginia Marketplace in 2015 to avoid taking on high risk population.

- **Breakdown of taxes and fees.** The health insurer fee is estimated as 0.8% of individual premium and small group premium and is included in the 2015 rate filing (P. 681 and 1193). Milliman published a research report titled " ACA Health Insurer Fee – Estimated Impact of the US health insurance industry" dated April 2013, which states the 2014 health insurer fee estimate is 1.7% to 2.4% and increases to 2% to 2.9%. Since KYHC is a 501c(29) not-for-profit entity, the insurer fee estimate is lower than the industry average.

3. <u>Medical Costs and Losses:</u>

Medical costs in 2014 were double what was expected and KYHC depends on 3R recoveries to get through this period. There is no information provided in the application detailing how KYHC intends to return to a normal level. KYHC's pricing loss ratio for 2014 was 77% based on the rate filing (P. 167). KYHC is now projecting MLR to be 93.4%, including reinsurance and risk corridors recoveries. The MLR excluding ACA adjustments, reinsurance, and risk corridors recoveries is 161.3%. The reinsurance recoveries noted are both federal and commercial combined as the CO-OP did not distinguish between the two in this application. KYHC is projecting a 74% reduction in MLR from 2014 (161.3%) to 2015 (86.8%). There is not enough detail within the application to analyze the appropriateness of the decrease in MLR. If KYHC does not reduce MLR by the 74% then the CO-OP will continue to be in a loss position, if projections are realized. Finally, KYHC is expecting to be one of the lowest priced competitors in 2015. Typically, this would result in many current enrollees remaining with the plan.

Including the $42M in receivables for reinsurance and $74.6M in receivables for risk corridors for 2014 would result in a $22M loss. Removing the estimated $117M in receivables would result in a $139M loss. These losses might be attributable to worse than expected claims cost recognized during the year. However, the amount of money that will be recovered by the CO-OP through risk adjustment receivables is uncertain as the estimates of relative risk and risk transfer payments are dependent not only on the membership enrolled by KYHC but also by the other carriers in the state. It should be noted that the 3R receivables are difficult to estimate and may create issues, such as liquidity, if relied upon to generate a profit.

The CO-OP is making changes to benefits across nearly all the plans being offered. The changes made are related to the deductibles and copays across the plans (P. 682 and 1194). The CO-OP plans on deploying medical management strategies to improve health and health outcomes (P. 6). It is noted that the CO-OP has included medical management, quality improvement, commercial reinsurance, and various fixed PMPM ACA fees in the administrative expense allocation (P. 168). However, no detailed information is provided with respect to the medical management and commercial reinsurance.

Due to emerging 2014 experience indicating that the initial assumption for pre- to post-ACA morbidity shift was understated, KYHC has assumed a 5.5% increase in expected population morbidity of the Single Risk Pool from the level that was assumed in 2014 (P. 686). The state's high risk pool terminated enrollment of approximately 4,500 individuals effective 12/31/2013. Even if assumed that all of them were enrolled under the CO-OP's plans, these individuals would only constitute about 10% of KYHC's enrolled population. Since KYHC was the only carrier to offer a Platinum plan in 2014, the applicant concludes that this led to a high concentration of individuals with high health costs (P. 4). However, it is unclear as to why the claims would be so high just because of 10% of KYHC's enrolled population.

KYHC provided a draft independent auditor report which refers to a reinsurance agreement and the reinsurer is advancing an allowance to the CO-OP to cover certain start-up costs. KYHC has purchased reinsurance to avoid significant annual fluctuations in claims that could threaten solvency (P. 1233). The draft audit report dated 4/29/2014 references a reinsurance arrangement that also includes a $600,000 allowance to the CO-OP to cover certain start-up costs (P. 1233). However, information was not provided with regards to medical management and commercial reinsurance related specifics like attachment points, years the contract are in place or affected markets.

KYHC mentions other insurers on the Kentucky Marketplace "adopting a thin network strategy of participating only in select regions (urban) or operating statewide with only a thin network" (P. 4). However, since the applicant did not provide an updated business plan, the application does not provide any details about the CO-OP's network and if any changes to the network are planned for 2015. Thus, it cannot be determined if the CO-OP's network coverage is any better than those of its competitors.

KYHC does not have enough of its own experience in the base period to use in rate development; therefore, the 2015 rate development is based solely on manual rates (P. 688).

Summary of Observations:

- **Change in combined MLR for 2014.** The loss ratio without the impact of 3Rs is projected to be 161.3%. Additionally, KYHC is projecting a 74% reduction in MLR from 2014 (161.3%) to 2015 (86.8%).
- **The 3Rs receivables are difficult to quantify.** This is because of the uncertainty of the industry average morbidity which is needed to accurately estimate risk adjustment. Risk corridors is calculated after risk adjustment therefore relies upon the risk adjustment estimate. Without these receivables, KYHC would have a loss of $97M for 2014 instead of the $22M projected in the pro formas.
- **2015 medical costs based on industry data**. KYHC does not have enough 2014 experience to have its own data to rely upon; therefore, industry assumptions are necessary to estimate the morbidity of the projected membership.
- **Support for medical management and commercial reinsurance.** The CO-OP has included medical management, quality improvement, commercial reinsurance, and various fixed PMPM ACA fees in the administrative expense allocation. However, commercial reinsurance related specifics were not provided regarding attachment points, years the contract are in place or affected markets and medical management related specifics were not provided as well.

4. CO-OP Financials:

KYHC's pro forma financial statements show reinsurance recoveries of $42.2M in 2014, $10M in 2015, and $8.1M in 2016. However, the reinsurance line item is a combination of the commercial and federal reinsurance. Based on information provided, KYHC is projecting $1.3M in commercial reinsurance and $40.9M in federal reinsurance, totaling $42.2M in 2014. However, due to the lack of information in 2015 and 2016, the breakout of reinsurance could not be completed. Therefore, all calculations in this report will exclude commercial reinsurance in 2014 and include the combined reinsurance amount for 2015 and 2016. In addition, the projected 3R recoveries by KYHC will also remain the same given that claim projections remained unchanged between the base and the stress case scenario. Furthermore, the pro forma income statement includes a projected payment of $74.6M from the risk corridors program in 2014 while providing no projections for 2015 and 2016. On the pro forma income statement, the risk corridors is recorded in premium revenue, but is then treated as a

nonadmitted asset which reduces surplus by $74.6M. Please see Scope and Summary section for further information. It should be noted that the 3R receivables are difficult to estimate and may create issues if relied upon to generate a profit.

KYHC projects a net loss of $22.4M in the base case scenario for 2014, but is expecting to achieve profitability in 2015 with a projected net income of $513K in 2015 and $501K in 2016 (P. 45). However, according to the 2Q14 regulatory filing, KYHC is currently showing a net loss of $23.5M which would require KYHC to generate $1.1M of income in the second half of 2014 or alternatively, the current projections may not fully consider the actual operating results for the first half of 2014. For the years 2015 through 2017, a net profit of approximately $500K is projected in each year. In 2018, KYHC projects a net profit of $7.1M which is projected to grow steadily in future years. However, absent 3R recoveries from reinsurance and risk corridors, KYHC will incur a cumulative net loss of $137.9M, $9.5M, and $7.6M for 2014, 2015, and 2016 respectively.

Per the Loan Tracker, the CO-OP has been awarded total funding of $81.5M ($22M in start-up loans and $59.5M in solvency loan funding), and began issuing health insurance products beginning in 2014. According to the Loan Tracker, the full $59.5M of solvency loan obligated has been disbursed to KYHC and of the $22M of obligated start-up loan funding, $19.4M has been disbursed. The pro formas indicate that total start-up funding received is projected to be $21.6M at year end 2014, $21.9 by year end 2015 and the full disbursal of $22M by the end of 2016. If KYHC receives the $103M requested in the base and stress cases, the solvency draw will total $162.5M.

Based on both the base and stress case of $103M, KYHC plans to start repayment of interest on the solvency loan in 2019 and interest and principal payments in 2023. KYHC projects to continue making annual repayments through 2033, until the loan is paid in full, assuming projections are realized. KYHC stated that it "will have sufficient capital to repay its solvency loans within fifteen years of its specific draw down dates while meeting State reserve requirements and solvency regulations" (P. 7). However, if projections are realized, KYHC does not project to earn enough net income through 2017 to repay its initial start-up loan payment of $6.3M. Therefore, it appears KYHC may need to use solvency loans to make the start-up loan repayment in 2017, if projections are realized.

Kentucky Health Cooperative, Inc. is requesting additional solvency loan funding of $103M. According to the applicant, this amount is primarily needed to address solvency issues that arise from KYHC's treatment of a risk corridor receivable for $74.6M as a nonadmitted asset. The feasibility analysis states "If this projected risk corridor receivable, which is an estimated $74.6M for 2014 in the base scenario, were made available immediately, it would eliminate much of the current need for additional solvency loan funding as well as alleviating the operating cash issues highlighted in the contingency scenario" (P.17). By including the risk corridor receivable as an admitted asset, KYHC is able to meet the CMS mandated RBC level of 500% of ACL. However, based on the pro forma cash flow statement, if KYHC does not receive any additional funding and the 3R payments of $115.5M are not received till Q3 2015, CMS may want to consider that KYHC could suffer significant liquidity issues. Not enough information was provided to substantiate the need and as a result, the impact on its pro forma financials cannot be assessed. As noted above, KYHC has stated that "if additional solvency funding is not awarded, [KYHC] stand[s] ready to move our approximately 55,000 existing lives to other carriers and remove the health plan from the open enrollment as an unfortunate but appropriate option"(P. 118).

Base Case Scenario:

As described in the executive summary, the CO-OP has used the base case to project its solvency loan request of $103M. However, KYHC "acknowledges that receiving $103M in funding just to maintain a RBC level of 500% of ACL is not necessarily the correct solution" (P. 119). For that reason, the CO-OP provided a range of funding options to reflect the status of the risk corridor and the mandated RBC levels, see Table 1 above. Additionally, the Contingency Plan section will outline each alternative funding options utilizing private loans.

Based on the solvency loan funding request of $103M, KYHC projects a loss of $22.4M in 2014, but anticipates profitability thereafter, with earnings of $513K and $501K in 2015 and 2016 and profit margin of 0.3% and 0.2%, respectively. The application is currently projecting cumulative profits of $200M from 2015-2034. This includes the cumulative reinsurance amount of $59M from 2014 to 2016, and $74.6M for risk corridor amounts in 2014. Despite the total $115.5M of 3R receivables in 2014, KYHC is still expecting a loss. The CO-OP has established a PDR of $105k for 2014. Additionally, KYHC is projected to incur a loss of $9.5M and $7.6M in 2015 and 2016 absent recoveries from the federal reinsurance program. See Product Pricing for more details.

The applicant asserts that premiums will increase by 15% in 2015 for the individual market and 6.5% for SHOP in 2015 to drive its performance improvements. In its pro forma income statement, its revenues per average number of enrollees increase by 8% in 2015 and by 12% in 2016. However, KYHC is expecting a "23% reduction in Kentucky average monthly membership in the individual market in 2015 compared to 2014" (P. 30) due to the increase in premiums. KYHC expects to help offset those losses with the expansion into West Virginia and increases in SHOP membership in Kentucky.

The base case scenario presented by KYHC is based off the stress case scenario used in the initial funding application to CMS. This case includes a 3% unanticipated medical cost increase every four years. However, the pro formas include amounts different then described. In the pro forma income statement, starting in 2022, there is a 3% increase in claims every 4 years, but that increase is followed by a 6% reduction in the 5th year, for example, 5%, 8%, 8%, 11%, 5%. The trend normalizes to an 8% increase in claims from 2022-2034. Likewise, KYHC follows a similar trend with premiums of 4%, 7%, 7%, 10%, 4% which normalizes to a 7% increase in premiums from 2022-2034. The increases in premiums and claims effectively negate any effect on MLR which holds relatively constant in these years.

KYHC projects an MLR, including 3Rs recoveries, of 95.4% in 2014, 81.3% in 2015, and 82.1% in 2016. KYHC projects to recover $115.5M, $10M, and $8.1M from the 3Rs recoveries in 2014, 2015, and 2016, respectively. Absent the 3Rs recoveries, the MLR for 2014, 2015, and 2016 is projected to be 161.3%, 86.8%, and 85.6%, respectively.

In the pro formas, the administrative cost ratio ("ACR") is 19.7% in 2014, 18.6% in 2015 and 17.9% in 2016. KYHC's ACR ranges from 19% to a low of 10.7% in 2034, with an average ACR of 13% from 2014-2034. The decrease in administrative expenses is listed as resulting from economies of scale (P.5), although no detail was provided to substantiate the claim. KYHC's administrative expenses for 2014 are budgeted at $31.9M; the administrative budget is comprised of Salary/Wages/Benefits, Travel, Rent, Equipment, Consulting, Commission, Outsourced Services and Other Budgeted Items. The largest expense is Outsourced Services which accounts for 45%, 41%, 42%, of expenses respectively from 2014-2016. No further information was provided as to whether these functions would eventually be brought in-house or continue to be outsourced.

In the base case scenario, KYHC has requested the $103M of additional solvency loan funds in 2014, bringing total solvency draw to $162.5M. It should be noted that KYHC "acknowledges that receiving $103M in funding

just to maintain a RBC of 500% is not necessarily the correct solution" (P. 119). Furthermore, at that level of funding, KYHC will reach an RBC level of 500% of ACL in 2014, then remain over 1,000% till 2024, before it begins trending down to 500% of ACL in 2034. By providing the additional $103M, KYHC will maintain elevated levels of RBC throughout most of the performance period.

Stress Case Scenario:
The stress case scenario with additional solvency loan funding projects KYHC to achieve profitability in 2015. KYHC is currently requesting the same $103M from the base case to address an additional 3% unanticipated claim increases every two years while premiums remain the same. This increase is in addition to the unanticipated 3% claim increase every four years as stated in the base case. However, the pro formas do not appear to follow the 3% increases every four years as the claims increase by 5%, 11%, 5% and 11% respectively. Contrary to the scenario description, premiums are also increased to offset the unanticipated claims in an amount that keeps the MLR relatively constant. In this scenario, KYHC projects to incur a cumulative net income of $201M from 2015 – 2034 and reinsurance recoveries of $40.9M, $10M, and $8.1M in 2014, 2015, and 2016 respectively. RBC levels are projected to hit 500% of ACL in 2014, 2068% in 2015, and remain above 500% for the life of the loan. Identical to the base case scenario, the funding request is based on the risk corridors being treated as a nonadmitted asset. With the updated accounting treatment, KYHC will no longer need the $103M to meet the CMS recommended level of 500% of ACL.

KYHC projects an MLR, including 3Rs of 95.4%, 81.3% and 82.1% from 2014 - 2016. Absent 3R recoveries, the MLR for 2014, 2015, and 2016 is projected to be 161.3%, 86.8%, and 85.6% respectively. KYHC projects to recover the same amount as the base case scenario from its commercial reinsurance policy and projects its ACR to stay nearly the same as ACR projected in the base case scenario.

In the stress case with additional solvency loan funding, KYHC projects to draw down a total of $103M in solvency loan funding. The applicant projects to start repayment of interest on the solvency loan in 2019 and interest and principal payments in 2023. KYHC projects to continue to make annual repayments through 2033, until the loan is paid in full, if projections are realized.

Summary of Observations:

- **Accounting treatment of risk corridors receivable.** KYHC's application for solvency loan funds is predicated on the risk corridors receivable being treated as a nonadmitted asset. Based on that assumption, KYHC has requested three funding options, $103M to reach the RBC levels of 500% of ACL in 2014, $69.1M to reach the state minimum RBC levels of 200% of ACL or $45M to remain solvent but unable to hit the CMS recommended RBC levels. By including the risk corridors receivable as an admitted asset, all funding options will enable KYHC to meet the CMS recommended RBC of 500% of ACL. However, based on the pro forma cash flow statement, if KYHC doesn't receive any additional funding and the 3R payments of $115.5M are not received till 3Q15, CMS may want to consider that KYHC could suffer from a critical liquidity event. Not enough information was provided to substantiate the need and as a result, the impact on its pro forma financials cannot be assessed.
- **No pro forma financials provided for additional alternatives.** KYHC discussed several scenarios in which the CO-OP receives different levels of funding to keep them solvent. However, no detail was provided to substantiate the impact of the proposed actions on the applicant's pro formas. As a result, the impact of the additional scenarios on its pro forma financials cannot be assessed.
- **The stress case scenario is adding unanticipated claims to an already stressed base case.** The base case scenario in this application contains the unanticipated claims increases from the stress scenario of the

original application. Consequently, the presented stress test scenario, by adding additional unanticipated claims increases, is effectively "double stressing" a base scenario.

5. Contingency Plan:

KYHC's contingency plan includes three scenarios, "Base Case with Additional Funding Options", "Defer West Virginia" and "Base Case with no additional funding." Pro formas are only presented for the "Base Case with no additional funding" scenario.

In the "Base Case with Additional Funding Options," the CO-OP proposed a series of options to keep them solvent through fiscal year 2014. The options (all exclude recognizing risk corridors receivables as an admitted asset) range from receiving as low as $30M to as high as $103M from CMS. In the base scenario, KYHC requests $103M in order to reach the CMS recommended RBC level of 500% of ACL in 2014 (P.119), however, KYHC "acknowledges that receiving $103M in funding just to maintain a RBC of 500% is not necessarily the correct solution" (P.119). The applicant states that a more realistic solution would be to obtain $69.1M which allows KYHC to remain both solvent in 2014 and achieve the state minimum RBC level of 200% of ACL (P.119). The scenario involves the CO-OP obtaining a $15M private loan and the remaining $54.1M from CMS. It should be noted that the private funds would be used towards paying administrative and operational expenses, but would not be considered a solvency loan (P.118/119). Lastly, KYHC could request $30M from CMS and obtain the additional $15M from a private loan just to achieve solvency in 2014 (P.119). Although this option keeps KYHC solvent, it does not allow them to reach the minimum RBC level of 200% of ACL required by the state. By including the risk corridors receivable as an admitted asset, KYHC is able to meet the CMS recommended RBC level of 500% of ACL. However, based on the pro forma cash flow statement, if KYHC doesn't receive any additional funding and the 3R payments of $115.5M are not received until Q3 2015, CMS may want to consider that KYHC could suffer from a liquidity issue. Not enough information was provided to substantiate the need and, as a result, the impact on its pro forma financials cannot be assessed.

The "Deferment of West Virginia" option requests additional solvency loan funds of $69.1M to allow KYHC to remain both solvent and above the RBC level of 200% of ACL from 2014 and beyond. However, under this option, Kentucky proposes delaying the West Virginia expansion from 2015 to 2016 in order to request a lower amount of solvency loan funds from CMS. In this scenario, KYHC will obtain a $15M private loan, request $49.1M from CMS and transfer $5M in start-up funds from West Virginia to the solvency loan funds subject to the approval of CMS. No pro formas that reflect these options were provided. As a result, the true impact of the scenarios on KYHC's operation cannot be assessed.

As outlined in KYHC's application, "if additional solvency funding is not awarded, [KYHC] stand[s] ready to move our approximately 55,000 existing lives to other carriers and remove the health plan from the open enrollment as an unfortunate but appropriate option" (P. 118). KYHC stated that if the minimum requested amount of $45M of additional funding is not awarded and/or a decision made by October 15th, KYHC will request the Kentucky DOI to assist in taking over the health plan. A major event in determining KYHC solvency hinges on the accounting treatment of the risk corridor receivables. "The key issue driving this fact is the delay in federal risk corridor receivables on 2014 business until the latter part of 2015. If this projected risk corridor receivable, which is an estimated $74.6M for 2014 in the base scenario, were made available immediately, it would eliminate much of the current need for additional solvency loan funding as well as alleviating the operating cash issues highlighted in the contingency scenario." (P. 17). If projections are

realized, it is apparent that if the accounting rule is not resolved in KYHC's favor by year end 2014 and no further solvency loans are awarded, the CO-OP will have both critical liquidity and solvency issues.

Summary of Observations:

- **No pro forma financials provided for base case with additional options or deferment of West Virginia**. KYHC discussed three funding options in which KYHC receives different levels of funding to keep them solvent. However, no details were provided to substantiate the impact of the proposed actions on the applicant's pro forma financials. As a result, the impact of the additional funding options on its pro forma financials cannot be assessed.
- **Accounting treatment of risk corridors receivable.** KYHC's application for solvency loan funds is predicated on the risk corridors receivable being treated as a nonadmitted asset. Based on that assumption, KYHC has requested 1 of 3 scenarios, $103M to reach the RBC levels of 500% of ACL in 2014, $69.1M to reach the state minimum RBC level of 200% of ACL or $45M to remain solvent but unable to achieve the CMS recommended RBC levels. By including the risk corridors receivable as an admitted asset, KYHC is able to meet the CMS recommended RBC level of 500% of ACL for all funding scenarios. Conversely, based on the pro forma cash flow statement, if KYHC doesn't receive any additional funding and the 3Rs payments of $115.5M are not received until Q3 2015, CMS may want to consider that KYHC may suffer from a liquidity issue. Not enough information was provided to substantiate the need and as a result, the impact on its pro forma financials cannot be assessed.
- **October 15, 2014 KYHC stated deadline for action.** KYHC stated that if the minimum requested amount of $45M of additional solvency loan funding is not awarded and/or a decision made by October 15th, KYHC will request the Kentucky DOI to assist in taking over the health plan.

Solvency Loan Request Points

Sections	Potential	Total
Enrollment	15	8.75
Product Pricing	20	14
Medical Costs and Losses	15	10
CO-OP Financials	15	7.5
Score	**65**	**40.25**

Contingency Plan Points

Contingency Plan	Potential	Total
Overall	10	0
Score	**10**	**0**